

# THE USAID-NIGERIA REVISED COUNTRY IMPLEMENTATION STRATEGY UPDATE

## OVERVIEW

The goal of USAID-Nigeria's (USAID-N) program of action is a more productive society contributing to market-oriented economic growth. The sub-goal of reduced fertility and decreased morbidity and mortality is driven by two strategic objectives: (1) increased voluntary use of family planning and (2) improved maternal and child health practices. **The two strategic objectives for the Nigeria program have not been modified and remain as originally stated in the Nigeria Country Program Strategic Plan (1992). The proposed modifications are directed to implementation modalities to achieve these strategic objectives.**

The current portfolio is entirely humanitarian in character. It consists of three major undertakings:

- NFHS: Nigeria Family Health Services Project (\$65 million)
- NCCCD: Nigeria Combating Childhood Communicable Diseases Project (\$40 million)
- AIDS Prevention and STD Control

In recent years, the Nigerian economy has dramatically deteriorated, contributing to a substantive breakdown in the public sector's capacity to deliver health services. The USAID-N program has also felt the effect of the intent and letter of political sanctions and decertification. The annulment of elections in 1993 led to a State Department statement that USAID is not to enter into agreements with the Government of Nigeria (GON) at any administrative level. In April 1994, program implementation was suspended due to decertification and, when restarted in June 1994, was limited to close out activities. Only on July 16, 1994 did USAID-N receive the go ahead to proceed with its program under the terms of the Administrator's waiver and Congressional Notification.

USAID-N now has a strong in-country staff confident of its ability to perform effectively in a complicated environment. Since July 94, we have been working to analyze and evaluate changes in the political, economic and administrative environment that impact on our programs - in order to develop a strategic approach that will facilitate the provision of continuous support and accomplishment of the Mission's strategic objectives. This process has been our first priority. Throughout, USAID-N has maintained its focus on long term development. Our approach to program restructuring extends beyond legal and political considerations, and attempts to critically examine the current situation and propose reasonable management and implementation changes to improve the overall quality of our engagement and promote sustainable development within a rapidly changeable Nigerian environment.

This briefing document presents USAID-N's revised implementation strategy. This is supported by a discussion of the background and contextual issues that have influenced USAID-N's decision-making and re-focusing of its implementation strategy. The document will also present a description of the process by which proposals for programmatic redirection are being formulated.

## BACKGROUND

### ***The Political Situation in Nigeria***

In recent years, Nigeria has experienced significant setbacks in its political transition to democratic Government. The current political crisis has its roots in the long standing struggle for supremacy between ethnic groups in the country. The situation deteriorated precipitously some five years ago when the northern dominated military began a pattern of delays in handing over of Government to civilian authority. Elections were eventually held on June 12, 1993 but, faced with the apparent election of Moshood Abiola, a southern businessman, the military annulled the election results. Civilian protests eventually forced a change to an interim civilian Government, but this was short lived and the military returned to rule in November 1993. Since then there has been a reversal of progress toward democratization with the dissolution of political parties and local Governments, restrictions on the freedom of the press and an escalating confrontation between civilian leaders and the Military Government. In the last month, Government's non-conciliatory position has been reinforced by a series of presidential decrees exempting the Government from the rule of law.

**Nigeria's current unstable political situation may persist for some time. Leadership at the community level is unstable and frequent turnovers undermine the potential for programmatic continuity and accountability.** This reality contributed to the Mission's position that a critical rethinking of the strategic approach to the implementation of USAID programs was needed.

### ***State Department Prohibitions on Government Agreements and US Decertification***

When Nigeria's Military Government annulled the June 12, 1993 civilian elections, US policy was articulated as, amongst other things, prohibiting agreements between the US Government (USG) and the GON at any administrative level. Subsequently, on April 1, 1994, the President of the United States signed Presidential Determination 94-22 which decertified Nigeria for US assistance. NCCCD and AIDS qualified for technical exemptions from decertification. A waiver permitting the continuation of USAID's family planning program was issued on June 16, 1994. All programs however, remained subject to the State Department prohibition on agreements with the GON. The terms of that waiver for family planning provide that direct USAID support to the Government of Nigeria (GON) is no longer permissible. USAID, however, is authorized to provide assistance in support of programs of NGOs.

Sanctions and decertification, as well as the developmental context described later, mandate changes in the way USAID does business. In proposing operational modifications, USAID-N is seeking to comply with both the spirit and letter of Administration direction. We also believe it is important for USAID to have a consistent policy posture in our relations with the GON and are proposing an implementation strategy that can apply to the entire USAID-N portfolio. **We believe that this new operational strategy is the only effective way to insulate the humanitarian program from further political repercussions.**

### ***Economic Decline And Impact On The Health Sector***

Nigeria's economy has been in a sharp steady downward spiral for the last decade. Declining oil revenues and deficit spending coupled with a discontinuation by the Government of structural adjustment and economic reform programs have driven inflation upward. Inflation is currently

estimated to be slightly more than 400% annually. Government's attempts to re-value the Naira has hurt both the public and private sectors by creating a major shortfall in the availability of foreign exchange. The value of the Naira continues downward on the international market and this has dramatically lowered GDP per capita from USD 1000 in 1980 to less than USD 300 in 1994.

Nigeria's health and social sector programs have been particularly hard hit. Since 1980, the resources allocated to health have shown a steep downward trend. Over the medium term, public sector spending is expected to continue downward. Indeed, the commercial section of the US Embassy estimates that funds available for states and local Governments budgets next year may be cut by as much as 20 to 40 percent. Given the sharp decline in Nigeria's oil revenues this seems a realistic projection.

Because the states and local Governments have been experiencing declines in both the size and real purchasing value of their Federal allocations for many years, it is clear that further cuts will affect social sector programs. The majority of funding currently given to states and local Governments is used to pay salaries and emoluments with little available for capital development. There is simply nothing left for them to cut except personnel, and health and social service personnel are among the most vulnerable.

<i>Year</i>	<i>Recurrent</i>	<i>Capital</i>	<i>Total</i>	<i>Percent of Total Federal Budget</i>	<i>Total in 1981 Naira</i>
1980	112.60	77.80	190.40	1.88	
1981	153.40	142.10	295.50	2.64	295.50
1982	182.20	120.50	302.70	0.26	100.90
1983	153.20	116.60	269.80	2.34	67.45
1984	168.10	42.80	210.90	1.80	42.18
1985	177.10	45.30	222.40	1.10	31.77
1986	245.70	131.50	377.20	2.37	37.72
1987	229.10	125.60	354.70	1.39	27.28
1988	379.60	117.20	496.80	1.97	33.12
1989	381.80	119.90	501.70	1.76	26.41
1990	485.10	419.70	904.80	2.28	36.19
1991	619.40	137.60	757.00	1.96	27.04
1992			843.90	3.06	28.13

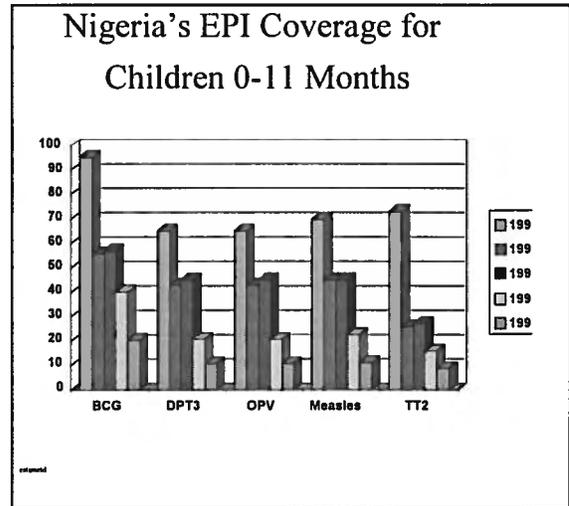
This is not a short term problem and it is unrealistic to expect that there will be a short term solution. Nigeria's health sector is bankrupt and donor funds are being used "in place of" rather than "in addition to" local resources. **We have had to conclude that over the middle-term sustainable program development, with rare exceptions, is simply not possible in the public sector.**

### ***Administrative Failure In The Health Sector***

One of the most unfortunate consequences of the political and the economic misfortunes in Nigeria has been the inability of Government to maintain minimal public sector services. Although in recent years the GON has benefited from somewhat greater assistance from the international community, this support has not enabled it to overcome its severe economic handicaps and vulnerability. **The prospects for continued maintenance of health and social services is bleak, with little hope in the foreseeable future for success in implementing management reforms and improving efficiency.**

Conditions in Government facilities still attempting to provide services have declined. Essential commodities such as drugs and vaccines are generally unavailable. Hospital hotel and basic sanitation services have been discontinued reducing hospitals to dirty unattended wards where patients have little hope of survival. Neither the public nor the professional community has confidence that health services will be delivered.

Primary health care services have been severely affected. Vaccines, ORS supplies and essential drugs are generally out of stock. Some states are reporting that facilities have been looted and cold chain equipment removed. EPI is one important indicator of capacity in the public sector and reflective of the generalized health sector decline. **EPI coverage peaked at approximately 80% in 1990 is now estimated to be between 20% and 10% for all antigens.**



Two recent fuel crises limited the ability of health workers to get to the facilities on a regular basis. In many states and local Governments, salaries for primary health care workers have not been paid for several months and many of the best are seeking employment elsewhere.

Over the past three years, essential health sector personnel (physicians and nurses) have engaged in frequent labor actions in an effort to secure improved working conditions and salaries. This has been exacerbated by strikes several months ago that have effectively closed the secondary and tertiary level facilities operated by Government across the nation. Only one of Nigeria's seventeen university teaching centers (UCH, Ibadan) is still providing a minimal package of services. A substantial proportion of Government personnel have now left to seek opportunities in the private sector.

One of the more distressing consequences of the collapse of public sector services has been the virtual disintegration of the already frayed public sector "social safety net". For all practical purposes, Government has ceased to provide essential services and, with the significant erosion of state infrastructure, there is little left functioning to responsibly absorb USAID inputs. The underlying conditions that led to this collapse (economic decline; fraud and waste; crisis in leadership; and lack of accountability) have not been remedied. There is no longer the expectation that resources put into the public system will be used for the public good.

Throughout this period, the NGO community increasingly (but only partially) filled the void of a collapsed public sector. Nigeria's elite continue to receive care in private clinics. The poor rely to a great extent on the care provided by Mission hospitals and clinics, community organizations, and other philanthropic health care providers. A partial "safety net" through the NGO community is in place. More critically, the NGO community is clearly the better investment in the interests of the truly poor - providing a stronger, more resilient and equitable access to services.

## **USAID-N'S ANALYTIC APPROACH**

As detailed above, the context in Nigeria has changed and adjustments of USAID-N's strategy are required. In the three plus months since the issuance of waivers from decertification, our staff have invested considerable energies in the collection and analysis of data (subjective and objective) to support a decision making process based on information and participation.

Our analytic approach has included:

- Consultations with
  - a) key Government counterparts at the Federal, State and local levels
  - b) other donors
  - c) US Cooperating Agencies
  - d) knowledgeable private sector based Nigerians, and
  - e) US based and local NGOs
- An assessment of current Government capacities
- Specific focus studies

### ***Consultations With Key Partner Organizations***

USAID-N staff have held a number of formal and informal meetings with key members of the Federal Ministry of Health and Social Services (Minister of Health, Minister of State for Health, Director-General of Health, Members of the Top Management Committee), State Commissioners and Directors-General of Health and Directors of the National Primary Health Care Development Agency (NPHCDA). Given the profoundly negative public perception of the consequences of decertification on Government programs (often described as "You are leaving Nigeria") these meetings were surprisingly cordial. Federal and State Ministry counterparts have indicated their gratitude for USAID's continued humanitarian assistance on behalf of the Nigerian people. State and local officials have expressed their support for institutional development and support for private sector projects as this is seen as consonant with and supportive of Government's own plan of action. Privately, Government officials concede their frustration and despair with public sector health delivery. While, of course interested in obtaining "resources", Government's primary requests have been for a collaborative relationship, a sense of participation and an open exchange of information regarding private sector initiatives. These requests are consistent with USAID-N's own perceptions of what is necessary.

Meetings have been held with representatives from the ODA, WHO, UNICEF, World Bank and UNFPA. These meetings are part of the continuing subject-based consultative process USAID has instituted with the donor community. While concern has been voiced about the discontinuing of direct financial support for Government programs, there has been unanimity about the desirability of supporting private sector initiatives. There is a strong recognition of USAID's comparative advantage in the private sector arena and a willingness of some donors to fill necessary gaps created by USAID's programmatic direction. For example, ODA, UNFPA and the World Bank will assist Government with contraceptive commodities and logistics after USAID shifts its principal mode for providing Nigeria with contraceptive supplies to the private sector social marketing project (see below). UNICEF has provided an important data base of private sector providers.

USAID also consulted with local and US based consultants, US Cooperating Agencies, and NGOs. We acknowledge, and through targeted support of philanthropic organizations, hope to address their concerns as to private sector ability to provide coverage for segments of the population in remote areas and to those economically disadvantaged. There is consensus, however, that public sector service delivery is currently negligible and that public sector programs are unlikely to regain momentum over the middle term and in the absence of massive external inputs. There was also a consensus that a serious private sector engagement in health care has yet to be undertaken and is long overdue.

### ***An Assessment Of Current Government Capacities***

Government services have been declining for several years, but events in the past years have dramatically brought into basic question Government's potential role. For example, Nigeria has 17 university teaching hospitals. All 17 were closed in April 94 by a nationwide strike by doctors and nurses seeking better working conditions and salaries. Though the strike was "settled" in October, only one center (UCH) has re-opened - with minimal services.

There are daily reports that drugs and essential supplies are unavailable for most health facilities. Indeed, Government has not financed purchase of essential drugs in the past two years. There are confirmed reports of significant vaccine loss when the cold chain in Government storehouses failed as a result of national power outages. Currently, there are reports that, with professional personnel on strike and support personnel (secretaries and guards) unable to reach facilities during the recent two month long national fuel shortage, many facilities have been looted. Much of the cold chain and other equipment previously provided to the public sector have been lost.

A recently conducted study of Maternal Health Services in the South-Western part of Nigeria revealed major health delivery deficiencies. In Lagos State, as but one example, there are currently no functioning ambulances and 60% of facilities surveyed lacked basic equipment for MCH services such as stethoscopes, sphygmomanometers and scales.

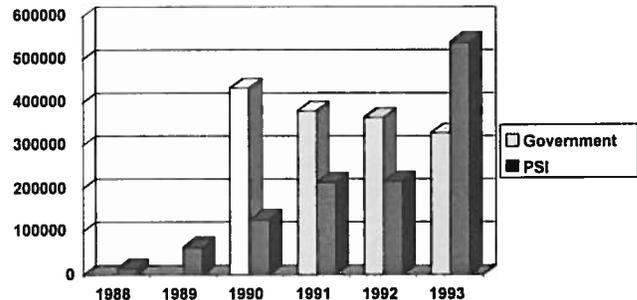
We are faced with the reality that Government's capacity to deliver public sector health services in Nigeria has effectively collapsed. Donor support has been reduced significantly with the recognition that resources alone are not the answer. Leakage is extensive and delivery is not happening. With the most competent health workers rapidly abandoning the system, the specter of further economic constraints and the likelihood of an extended period of political instability, it is unlikely that the public system can be revitalized in the medium term. Even if direct support to the public sector were not proscribed because of sanctions and decertification, continued expenditures in support of a public sector program would be difficult to justify.

USAID understands the role of the public sector in providing services for those at the lower end of the economic spectrum, i.e. the "safety net". We also understand Nigeria's desire to have a centrally supported and financed health program. However, given the current and foreseeable situation, it would be inappropriate to continue US investments in the public sector (other than a few rare documented exceptions) until there is real evidence of political, administrative and budgetary commitment to health and a willingness of Nigerian leadership to invest in its own system.

## Assessment Of Government and Private Sector Performance: Some Comparative Examples

One important indicator of the relative strengths of the public and private sectors has been USAID-N's experience with the provision of contraceptive supplies. USAID's fledgling Nigerian social marketing program provided 540,000 couple years of protection (CYP) in 1993 and is expected to provide close to one million in 1994. Private sector sales have grown from 14,752 CYP in 1988 increasing by more than 3660 percent. This program now delivers approximately 80% of all family planning services in Nigeria. **While social marketing sales were soaring, public sector services have declined from 433,710 in 1990 to less than 100,000 (est.) in 1994.**

### Summary of CYP Data for Nigeria 1988-1993



A second indicator comes from the AIDS program.

AIDS control program development has been a Government priority since 1986. However, despite substantial inputs from donors, public sector AIDS control program efforts are still in the planning stages with no effective implementation. This, in part, reflects inadequate funding. The few posters and public service announcements produced to date have been donor driven. Surveillance and monitoring activities are ineffective. In contrast, local NGO have displayed an admirable capacity to design workable programs. For example, STOPAIDS, a local NGO that targets long distance transport workers and commercial sex workers has increased AIDS awareness in its target population from 10% in 1989 to 90% in 1993. Condom use in this population increased from 0.025% to 49% in the same period. In 1993, they established a social marketing program and trained more than 120 peer health educators and 60 community based distributors. All this with a fraction of the resources made available to the public sector programs.

A third indicator is drug supplies. The successes of Christian Health Association of Nigeria's (CHAN) pharmaceutical supply program have already been widely publicized. This philanthropic NGO has consistently demonstrated its ability to provide essential drugs at affordable prices to its members. In 1992, CHAN delivered more than N28,100,000 (approximately \$1,000,000) worth of essential drugs and maintained four regional depots. Government, on the other hand, has been unable to maintain purchases of essential drugs or vaccines. Cost-recovery and Bamako Initiative programs have failed in most local Governments. Only in 13 Overseas Development Agency (ODA) and UNICEF supported local Governments are the programs functioning well. An interesting note is the Federal Ministry's suggestion to USAID that it support CHAN and other NGOs as an alternative cold chain modality for vaccine delivery.

Recently USAID staff had the opportunity to visit the FOMWAN Hospital, Kaduna. This modest private hospital run by the "Federation of Muslim Women's Association in Nigeria" provides a full range of health services to approximately 9,000 clients. It is a well run enterprise offering high quality clinical services. The facility receives no public donor support and recurrent expenditures including drugs are paid through cost-recovery. It stands in sharp contrast to the public sector where facilities are often without drugs, supplies, trained personnel or minimal sanitation.

**There are many other comparative examples. The lesson is that Government has consistently failed in its efforts to deliver clinical services despite massive donor support programs. In the same environment, the NGO community has some striking examples of its capacity to “get the job done” with economy, efficiency and self-reliance.**

### ***Special Focus Studies***

We have attempted to clarify the partnership potential in the private sector (commercial and philanthropic) with several special studies. We are acutely aware that the NGO community in Nigeria is heterogeneous. Some NGOs are dependable but others may be less so. The challenge for USAID-N and its US Implementing Partners will be to identify and cultivate those with the potential to become fully responsible and accountable partners. Studies relied upon include:

- NCCCD staff study of 265 private sector (philanthropic and for profit) organizations in the nine NCCCD focus states. The majority of facilities listed maintained bank accounts and had fiscal management structures in place. Most were supported by revenues generated and contributions (September 1994).
- FHS staff interim report (with final report to be completed) on NGOs in all 4 zones (September 1994).
- UNICEF annotated roster of not-for-profit health provider NGOs (June 1994).
- AIDSCAP annotated registry for NGOs working in AIDS control in Nigeria (October 1994).
- 1992 study by the Nigerian Medical Association (NMA) documenting that 36.4% of Nigeria’s 11,757 health facilities are privately operated. The same study showed that there were 20,208 registered, licensed medical practitioners in Nigeria. Almost all participated in some private medical service provision.
- May 1994 national study of 3944 persons indicated that they last received care in a private facility. Only 5% stated that they got free health services. The average costs for a health visit was N35.00 (\$0.70) with an additional N92.00 (\$1.84) average payment for drugs. Surprisingly, 58% of those surveyed felt that the cost of services was reasonable and 82% replied that they would be willing to pay more for “higher quality” services. There were no statistical differences in the responses of those from urban and rural communities and responses were similar for those from the northern, southern and eastern parts of the country.
- Tomaro et al paper entitled “Strategy for Increasing the Private Provision of Health and Family Planning Services in Nigeria” provided much food for thought on what can be done in the private sector. The paper, for example, reports that 50% of all health care facilities in urban areas of Ogun State were private. Numerous private sector initiatives were suggested - few of which have seen follow-up. The study further observed that “for a number of reasons, neither the Government of Nigeria (GON) nor A.I.D. has studied in any depth the current and potential role of the private sector in the provision of health and family planning products and services” (May 1992)
- World Bank paper entitled “Private Sector Assessment” (June 1993)

■ Horn et al paper entitled “Private Sector Assessment” (July 1992)

Although the analytic base for a modified implementation strategy is well established, the Mission will continue its research process. For example, the Mission plans to commission additional studies of selected private sector providers to refine information on:

- f) opportunities for specific engagement by zone
- g) types and magnitude of support required.

The Nigerian National Council for Population and Environmental Activities (NCPEA) and others have expressed an interest in conducting studies on this topic.

Note: Two private sector organizations (CHAN and NKST) are already well researched and analyzed. The largest of these, CHAN, has more than 300 hospitals, maternities and clinics with over 15,000 hospital beds and 10 million outpatient visits annually. There are approximately 1000 outreach facilities. CHAN member institutions serve an estimated 40 million Nigerians and employ 16,000 workers. CHAN has an internationally recognized central drug procurement scheme that effectively meets the needs of CHAN member organizations.

### ***Conclusions***

The public sector’s capacity to provide health services has been deteriorating for several years despite significant donor inputs. Political and economic factors have contributed to a precipitous decline in capacity in recent months. Currently, the public sector is for all practical purposes unable to deliver health services. This situation is unlikely to be reversed in the near term.

There is evidence that the private sector has a potential for health care provision. The willingness of these providers to coordinate their efforts and collaborate with others is evidenced by the fact that they currently support two NGO umbrella organizations, the Nigerian Association of Non-Governmental Organizations in Health (NANGO) and the Nigerian Network of Non-Government Organizations (NNNGO). These umbrella organizations are supported by their NGO members and have benefited little from donor or public sector grants. Preliminary discussions suggest that these may be useful apex organizations.

## **USAID-N: STRATEGIC IMPLEMENTATION PLAN**

### ***Principles***

USAID-N’s proposed strategy is straightforward, incorporating the following basic principles:

- In order to reach the programmatic goals established in the CPSP and project papers, USAID-N will aggressively seek to develop sustainable, community responsive programs of service delivery in and through the private, non-Governmental (commercial and not-for-profit) sector. Implementation through NGOs has always been a critical element of the USAID-N program and is well described in existing documentation. The principle thrust of the revised strategy will be a shift of implementation modality away from the public sector with concerted implementation through non-governmental programs.

- USAID-N will continue to maintain a cooperative relationship and policy dialogue with the GON, necessary for program implementation.
- USAID-N will rely on its Implementing Partners (US CAs, Nigerian and US NGOs) to “get the job done”, i.e. be the assistance delivery vehicle. This will require an investment in strengthening the management capability and sustainability of these organizations. Targets detailed in the Nigeria CPSP will be modified to reflect a shift in emphasis from strengthening public sector management to strengthening and maximizing the sustainability of these private sector organizations.
- USAID-N will focus on the development of indigenous Nigerian organizations by encouraging partnerships with US organizations and carefully monitored programs of institutional development.
- USAID-N will be responsible for effectively coordinating the work of our Implementing Partners to fulfill our strategic objectives.
- USAID-N will maximize integration of our Family Planning, Child Survival and HIV/AIDS Prevention strategies to maximize efficiency and assistance delivery. Additional targets in the Nigeria CPSP will be developed to reflect this emphasis on integration.

### ***Private Sector Focus***

Because the collapse of public service delivery and support programs is so complete there is little expected impact resulting from the discontinuation of USAID support to these programs. USAID support was suspended in April (after decertification) but by the time the Presidential waiver was executed in July much of the pre-existent national infrastructure had effectively ceased to function. It is important to note that this collapse of the public sector was an event independent of USAID withdrawal. Nigeria’s social services have collapsed in virtually all sectors, e.g. health, education, industrial development. USAID staff and the Implementing Partners have reviewed with USAID-W staff those activities that are being curtailed and/or transferred from the public to the private sector and the limited impact of this shift away from dysfunctional public sector services.

An underlying premise in the USAID-N approach is that the private sector can be used to provide equitable, efficient, quality primary health services. The experience of CHAN and PSI suggests that this is the case but careful monitoring will be necessary as we better define the potential and limitations of private sector partners - both philanthropic and commercial. We are aware of the fact that the private sector includes organizations with differing objectives and professional ethics. The potential for fraud and corruption are real and will be met with committed monitoring and an insistence on accountability at every level. The challenge is to identify and build the capacity, capability and commitment of those reputable organizations that share our mission of public support or have compatible “self interest”. We are confident of our ability and that of our US CAs to form effective partnerships with such organizations.

Over the short-term, many indigenous partners will need special attention on development of administrative programs that can assure accountability and efficiency. There are some risks. We plan to encourage involvement of NGO strengthening US CAs, and “sister” and/or umbrella relationships with US based organizations to provide this support.

USAID-N staff see the opportunity to explore and develop the energies of the Nigerian private sector as a major challenge and opportunity. We note with gratification that revised private sector focused workplans and concept papers have already been prepared and submitted by eight IPs (AVSC, PCS, Mothercare, Wellstart, ARCSS, CEDPA, Pathfinder and CDC). An interesting observation of many IPs and project staff is how little they really knew about the private sector..... until they looked!!

### ***A Cooperative Relationship And Policy Dialogue With Government***

The major change in USAID-N's strategy is the cessation of direct financial support to the GON. This is clearly the intent of decertification and sanctions. However, beyond these political considerations, we must deal realistically with the political and administrative deterioration that characterizes Nigeria today. As stated earlier, we see the public sector as lacking the capacity to deliver health services. Further, the political and economic prospects are such that this situation is unlikely to improve in the short-term. Nigeria currently lacks the political will and leadership to mobilize needed resources in support of social sector programs.

USAID's shift away from direct support to GON programs necessarily "hurts" the public sector. But, it is also clear that USAID's focus on the private sector is consistent with and supportive of Nigeria's established policies for health and family planning. **This is the acknowledged point of common interest.**

Maintaining a policy environment that supports development efforts in the private sector is essential and will continue to be fostered by an open, collaborative, information sharing dialogue with the GON. Informal contacts with Government have been nurtured and will continue. USAID-N has already clearly stated its recognition of Government's need to be fully appraised of all program activities and has pledged to maintain an open, transparent administration assuring Government full access to information about program activities. While we cannot predict the responses of the Military Government, we are confident that our professional colleagues within the Federal and State Ministries will largely continue to be supportive.

USAID-N expects that it will cooperate with Ministries of Health in key areas such as monitoring and evaluation, policy reform, the development of standards and regulatory legislation targeting key public health problems such as child marriages, ethical medical practice, etc. We will take opportunities, such as donor's meeting, seminars, and meetings, to make Nigeria's national leaders aware of the importance of assuring access by all Nigerians to safe, affordable health and family planning services.

### ***Reliance on Implementing Partners/ Collaboration with Donors***

If the USAID strategy is to succeed, it will require the technical skills and resources of many groups. The US based Implementing Partners are our greatest source of technical strength in family planning, child survival and AIDS prevention. Their collective experience with NGO development programs worldwide is an essential tool. Similarly, the many Nigerian NGOs bring insights into the unique social, political and economic climate of this country. They are a critical resource and the Mission believes that they are key to the successful continuation of health and family planning service delivery over both the short and long term. For both US based and Nigeria based Implementing Partners, we see the need to establish clear requirements for programmatic and financial accountability. This will be a theme running through our program. It is also worth noting that the Mission sees the IPs as a unit of

management sufficiently discrete to be held accountable - and NOT to succumb to bureaucratic finger pointing.

USAID-N will also need to continue its collaborative ties with other donors. We intend to foster collaboration whenever possible. For reasons of GON sensitivity to donors “ganging up” and in order to obtain greater efficiency, donor coordination has been subject matter driven rather than based on a pre-set schedule. For example, USAID-N staff are providing technical assistance to UNFPA, ODA, the World Bank and GON to assure continuity in the provision of family planning commodities for the public sector. When USAID-N recognized that it should no longer be represented for the supply of public sector family planning commodities, meetings were held with other donors and key Government staff. A strategy to transfer the commodities logistics and warehousing functions to the ODA and UNFPA was developed. USAID-N staff provided training to facilitate this transfer. USAID-N also worked to assist in the development of a commodity procurement scheme through the World Bank’s Population Action Fund Activity (PAFA) that should assure an uninterrupted supply of essential commodities through the public sector. To provide adequate lead time for the new procurement system, USAID-N also provided a “topping off” of public sector commodities through its PSI social market distribution system. This effectively gave the public sector a six month buffer supply of commodities with which to accelerate cost-recovery programs.

### ***Nigerianization***

Too often, donors, eager for short term results, invest heavily in the development of US led, Nigerian staffed administrative units. The superficial nature of Nigerian participation in this construct creates many problems. Agendas are externally driven and resources are concentrated in activities that often benefit external partners more than indigenous ones. Smaller and less developed organizations are disempowered, often by being overwhelmed with externally directed technical assistance. Nigerian staff trained to respond to donor requirements and owing their loyalty to donor administrations, cease to reflect a Nigerian perspective and outlook. But perhaps most damaging is the observation that these organizations take on a life of their own, become bureaucratically entrenched in the system, are not sustainable and undermine the potential development of truly indigenous organizations.

Ultimately, the health and family planning needs of Nigeria’s people must be met by Nigerian organizations. We believe that the private sector is robust and is the key to the development of sustainable Nigerian programs.

## **PROGRAM PLAN**

### ***Personnel***

USAID-N is formulating a strategy to address significant personnel issues. It is important to note that, over the past two years, declining performance of Government partners, an eroding economy, heightened political tensions, a protracted period of program transition have all taken their toll. Staff are understandably demoralized over the failure of Government programs they supported and nurtured. They are uncertain about the role they can play in a revitalized program.

Two steps are being taken to improve this situation, and protect our human resource investments:

- 1) The necessity of dealing with the shifting Nigerian context has been recognized as an opportunity to redirect staff energies to productive efforts - through a private sector strategy. The challenge of building on past private sector successes has given the staff clear direction and a sense of purpose. Rapidly moving the staff away from a debilitating “transition” psychology was critical.
- 2) A substantial core of highly skilled Nigerian personnel is being retained to staff the Program Coordination Unit and Logistic Support Unit. This will facilitate the operation of the US Implementing Partners. They will bring their established expertise and years of practical experience in the development and implementation of field programs.

On the USAID personnel side, it is important to recognize that we are now “fully staffed” - for the first time.

## MANAGEMENT PLAN

The USAID-N Management Plan is based on four key elements:

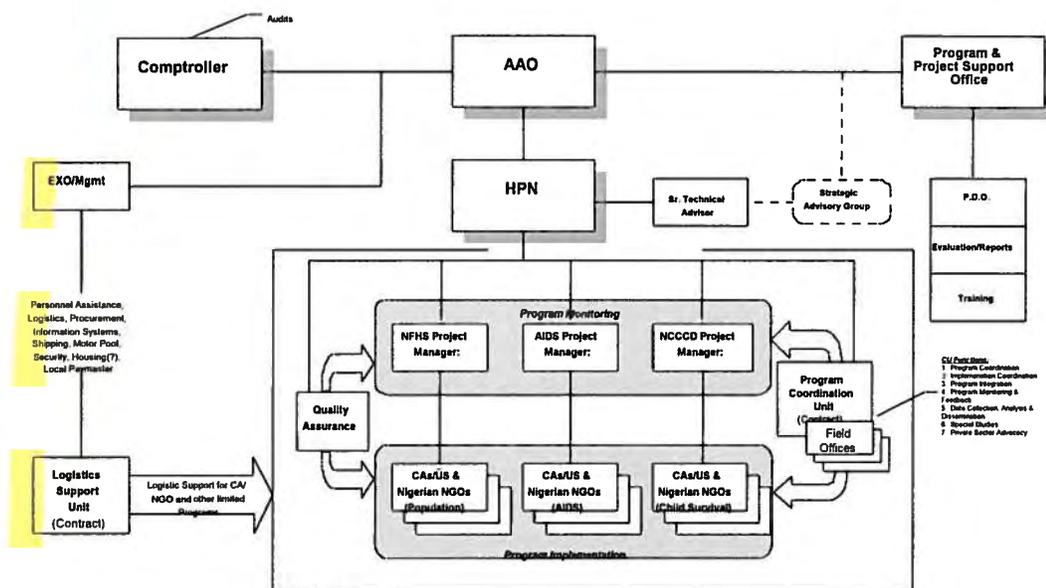
- 3) Assisting the Implementing Partners to “deliver the goods”.
- 4) Creating an administrative structure that can facilitate, coordinate and monitor IP activities to assure a coherent program to achieve the USAID-N CPSP Strategic Objectives.
- 5) Re-energizing project staff who have been demoralized by the events of recent years.
- 6) Retaining or redeploying key staff to assure program continuity and preserve needed technical skills.

### ***Administrative Structure***

Our proposed administrative restructuring will assist in the transition to an NGO based program. Three units, the Logistic Support Unit (LSU), Program Coordination Unit (PCU) and the Strategic Advisory Group (SAG) require description. More details on their functions are available as annexes, but briefly they will do the following:

- **Logistic Support Unit:** This unit, (as in the past) will be responsible for logistic support to all components of the USAID portfolio. We believe that this is a logical and cost effective way to avoid duplication and to minimize the “difficulty of doing business in Nigeria” for the IPs. The unit will be contracted by USAID with an independent organization. The LSU will manage the infrastructure (office, vehicles, and equipment) and provide key services (foreign currency exchange, import and customs clearances, logistics, etc.) from a centralized office. The LSU will facilitate the ability of IPs to implement projects and provide the Mission with a key accountability center for logistic requirements of project activities.

## USAID/Nigeria: Program Implementation Organogram



- **Program Coordination Unit:** The PCU will be contracted by USAID-N with an independent organization. Its orientation will be to meld the diversity of IP activities into a cohesive program and document performance. The PCU will maintain a Lagos office and field offices. It will provide continuous feedback to USAID and the IPs on performance as well as provide the documentation base for generating reports required by USAID/W. The PCU is responsible for:

- 7) program coordination, including facilitating country entrance and proposal development by the IPs;
- 8) coordination of implementation within each sector;
- 9) program integration (across the portfolio);
- 10) program monitoring and feedback to the IPs;
- 11) maintenance of a data collection, analysis and dissemination center;
- 12) advocacy of the private sector strategy;
- 13) special studies, and;
- 14) external audit.

To accommodate the lead time required for contracting the PCU, leadership of the project staff has been redeployed as a “task team” to perform PCU functions required at this juncture. It can be expected that the contracted PCU will retain these core personnel.

- **Strategic Advisory Group:** The Strategic Advisory Group (SAG) will ensure that USAID-N policy and operational decisions are realistic and consonant with the thinking of Nigerian development leadership. Nigerian advisors will work with USAID staff to expand the analytic framework for USAID-N programs by providing an in-depth understanding of contextual

factors (e.g. sociocultural, economic, environmental, etc.) that affect the USAID-N program. The group will focus on clarifying the impact of these factors on the health of Nigeria's people and on the success of public health intervention programs. As a part of this effort, the SAG will be responsible for systematically identifying lessons learned in the implementation of Nigerian health and family planning programs and assuring their integration into the project development and implementation process.

## **PROGRAM PLAN**

USAID-N's program is defined by the strategic objectives detailed in the Mission CPSP. As previously stated, **these strategic objectives have not changed.**

The Mission's approach to program implementation is truly collaborative, based on participatory discussions with all our Implementing Partners (US and Nigerian), consultations with USAID-Washington, analytic studies and concept papers from Implementing Partners. Much work has gone into the formulation of a program matrix to guide the allocation of resources and the monitoring of program impact. Given the number and diversity of anticipated IP programs, this matrix will facilitate both the planning and monitoring of program implementation activities is vital.

In structuring and focusing the USAID-N program, emphasis has been placed on: a) geographic concentration including a "Northern" strategy; b) responding to the needs of urban centers; c) enhancing women's health care decision-making; d) the special needs of adolescents; and e) integrated programming.

### ***Geographic Concentration***

Nigeria is a country of 923,766 square kilometers, with an estimated 300 separate major ethnolinguistic groups. There are almost 100 million people living in 30 states and the FCT. Terrain is varied and difficult. Communication infrastructure is poor.

For many years, USAID-N has had a policy of geographic concentration in its program implementation. CCCD Project focused its activities in selected local governments in Anambra, Enugu, Kebbi, Lagos, Niger, Osun, Oyo, Plateau and Sokoto States. FHS Project undertook activities in Abia, Anambra, Niger, Osun and Plateau States and AIDSCAP focused in Cross River, Jigawa and Lagos States. **USAID-N intends to continue its program with a focus in selected geographic areas - including Nigeria's Northern region.** Areas of geographic focus will be selected on the basis of the collective input from the Implementing Partners, and an assessment of the degree to which areas fit into the Mission paradigm emphasizing integration, urban, Northern, adolescent and women's healthcare decision making activities. Latitude, however, will be built in for high impact and/or experimental investments outside geographic concentration areas.

### ***Urban/Rural Mix***

Nigeria is one of the most rapidly urbanizing societies in the world. Those now residing in the African "megacities" face very special and serious challenge to their health and well-being. In the urban setting, people are often uprooted and divorced from traditional family and community ties. Many live in crowded, squalid housing without access to basic supports such as safe water. They suffer from all

the ills common to rural societies (malaria, parasites, tropical infections, malnutrition) compounded by diseases associated with urban living (tuberculosis, stress related illnesses, etc.). USAID-N will focus significant resources on urban populations. The Implementing Partners (Nigerian and US) are exploring approaches given Nigeria's complex social fabric. Mission intends to consolidate inputs received from IPs into a cohesive urban strategy for program implementation.

### ***Women's Health Care Decision-Making and Adolescent Health Care***

More than 50% of Nigeria's population is less than 15 years of age and this segment of the population is the fastest growing. Approximately 48% of Nigeria's population are women. These demographic facts are key to understanding and addressing the health status of Nigeria's people. Adolescents and young people have special needs for health education, targeted IEC programs and service delivery approaches that guarantee their access while respecting the societal norms of Nigerian communities. Women carry a huge burden of responsibility for their own health and health of their children and families, but traditionally receive little support from families and communities. Empowerment of women, especially in the area of health care decision-making, is increasingly recognized as an essential component of programs that successfully reach the most needy in a society. USAID-N has asked its Implementing Partners to propose aggressive strategies for meeting the special needs of these two target populations. CPSP Targets are being developed with the assistance of the IPs and Task Team to reflect these areas of emphasis.

### ***Integrated Programming***

USAID-N is committed to maximizing integration throughout the portfolio, e.g. Reproductive Health/Family Planning, Child Survival and HIV/AIDS prevention. There is a general consensus, reinforced at the first Implementing Partners Discussion Group: Child Survival, that Integration is not only cost-effective but is demanded by our "clientele" and will provide synergy and mutual benefit in the sub-sectors. Focus studies support this demand for integrated service delivery. Although there has been a "stove-pipe" tradition in USAID's approach to the multiple aspects of health care, current USAID leadership has forcefully made the case for a more holistic approach.

## **IMPLEMENTING PARTNERS MEETING**

The Implementing Partners Discussion Group for Child Survival Meeting held on October 19-21, 1994 in Lagos brought together many of the potentially important actors under the USAID program. The meeting was attended by:

- Eleven child survival CAs
- Four resident Family Planning CAs and AIDS/HIV prevention CA
- Thirty-seven Nigerian NGOs
- Representatives from key USAID/W offices (Afr Bureau; Global)
- USAID-N staff

This professionally facilitated conference gave USAID-N the opportunity to:

- bring together Nigerian and US partners to begin the process of establishing mutually beneficial relationships;
- begin the process of delineating the responsibilities of the Implementing Partners, maximizing coordination within each sector and integration between sectors;
- provide guidance and opportunity for feedback re policy directions that underpin this new intensive engagement in Nigeria; and
- describe and solicit feedback on the logistic and program coordination mechanisms being put in place in Lagos and the field to maximize operational efficiency and direction in achieving our strategic objectives.

The positive response to this first meeting has been nothing short of overwhelming. Nigerian and US IPs worked together to explore both the challenges and the opportunities that accompany implementation through NGOs. The following basic principles were discussed as a conceptual framework for activities in Nigeria.

- Enhance sustainable private sector capacity
- Strive and be accountable for integration of activities throughout the portfolio
- Ensure quality of services
- Collaborate with other CAs/IPs - break away from exclusivity
- Consider areas of disadvantaged groups to health care
- Increase women's health decision-making capacity
- Share information and lessons learned with other CAs/IPs and with the public sector
- Develop socio-culturally responsive strategies, especially for the North
- Target adolescents wherever possible
- Ensure coverage of key urban areas

In this dynamic environment, we continue to evolve.

Prepared by:

USAID/Nigeria's Mission Collective

November 15, 1994