Enhancing Ownership of the Strategic Health Development Plan II in Ebonyi, Nigeria

Critical Steps in Policy Development

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Context

In Nigeria, the 2010-2015 Ebonyi State Strategic Health Development Plan (SSHDP I) was the state's first-ever integrated health plan. Guided by and in line with Nigeria's National Strategic Health Development Plan (NSHDP I), SSHDP I harmonized Ebonyi's state and local government health plans, creating a unified plan with the overarching goal to "significantly improve the health status of all citizens."[1] When the plan was developed, Ebonyi State was struggling with a declining life expectancy for women and men (46 years for females in 2006, down from 54 years in 1991, and 45 years for males in 2006, down from 53 years in 1991), as well as a high infant mortality rate (99 per 1,000 live births); a high under-5 mortality rate (191 per 1,000 live births); one of the highest maternal mortality ratios in the country (estimated 1,500 per 100,000 live births); and high levels of morbidity because of malaria, diarrhea, acute respiratory infection, and malnutrition.[2] To improve these statistics, SSHDP I was intended to guide and coordinate all health activities in the state for a five-year period.

> A goal for the new SSHDP is to help "reposition the state health sector" such that by 2022 Ebonyi will be closer to "achieving universal health coverage at affordable cost" and "effectively deliver[ing] quality health and social welfare services to the people of Ebonyi State." *Ebonyi SMOH and MCSP, Report of the Review of the 2010-2015 Ebonyi SSHDP, February 2016*

Although SSHDP I was ambitious and comprehensive, achievement under the plan was limited, with an end-term review finding that "overall performance [completion rate of activities] for the 2010-2015 SSHDP I was 29.94% by the end of 2015."[3] According to the review, of the 167 planned SSHDP I sub-activities, "four were completely implemented, 46 were 50% or more completed, 58 were less than 50% implemented, and 59 sub-activities were not commenced at the end of 2015." Poor performance was attributed to a variety of factors, including lack of funding, human resource shortages, and inadequate infrastructure.

[1] Ebonyi SMOH, Ebonyi State Government Strategic Health Development Plan (2010-2015), March 2010
[2] Ebonyi SMOH, Ebonyi State Strategic Health Development Plan II (2018-2022), November 2017
[3] Ebonyi SMOH and MCSP, Report of the Review of the 2010-2015 Ebonyi SSHDP, February 2016

As SSHDP I came to a close, the Ebonyi State Ministry of Health (SMOH) reached out to partners including the United States Agency for International Development (USAID)-funded Maternal and Child Survival Program (MCSP) to support the development of SSHDP II (2018-2022). Given the state's limited success under SSHDP I, SSHDP II needed to be "designed to significantly improve on the performance of the first SSHDP."[3]

The potential impact of effective SSHDP II implementation is large. According to the SSHDP II Monitoring and Evaluation (M&E) Plan, "when fully implemented, [SSHDP II activities] will improve the quality and coverage of health services. The overall benefits will translate into strengthening of the state health system and provision of health infrastructure, equipment, capacity building of health service providers, strategies for task sharing and shifting, and ultimately in reduction in morbidity and mortality."

Approach and MCSP Contributions

Beginning in October 2014, MCSP supported the Nigerian Ministry of Health in two states, Ebonyi and Kogi, to improve the quality of reproductive, maternal, newborn, and child health (RMNCH) services. Focused on a combination of clinical- and community-based health service strengthening and health policy/health system improvements, MCSP has been an important partner in the Nigerian government's efforts to improve the health and quality of life for women, children, and families in these states.

> *"MCSP came with a unique, organized, systematic, system-wide approach to planning. In addition, they brought a quality of care orientation that can be applied to services across the state."*
> – Dr. Boniface Onwe, Principal Medical Officer in the Ebonyi SMOH

In Ebonyi, MCSP worked closely with the SMOH between 2016 and 2018 to develop SSHDP II. Highlighted below are major milestones achieved during the development process, MCSP's contributions toward each milestone, and an approximate timeline.[4]

- **Reviewing SSHDP I:** Beginning in February 2016, MCSP provided technical and financial support to the Ebonyi SMOH to conduct the end-term review of SSHDP I. A wide variety of government and non-governmental partners (the United Nations Children's Fund [UNICEF], the Ananda Marga Universal Relief Team, the European Union Support to Immunisation Governance and Nigeria [EU-SIGN] project, the Health Strategy and Delivery Foundation, the Center for Clinical Care and Clinical Research–Nigeria, multiple professional associations, etc.) participated in the review process. Conclusions about the reasons for SSHDP I's poor performance informed the design of the more realistic, strategic, and targeted SSHDP II.

- **Forming a SSHDP II technical working group (TWG):** The Honorable Commissioner for Health initiated a TWG to develop the SSHDP II framework. TWG members included SMOH directors and program managers, World Health Organization (WHO) representatives, WHO-funded planning and costing consultants, MCSP staff, and representatives from other select partners. MCSP served as the TWG's secretariat and provided technical, financial, and administrative support to all stages of the SSHDP II development process.

- **Developing the SSHDP II framework:** After review of the relevant national policy, program, and survey documents, TWG members (supported by WHO consultants and MCSP) drafted the SSHDP II framework and situation analysis, including the SSHDP II vision, mission, values, and guiding principles. The SSHDP II framework was consistent with the NSHDP II framework and customized for the Ebonyi State context.

- **Drafting SSHDP II:** In August 2017, the SMOH held a five-day workshop, during which 67 participants from the State Planning Commission, the unified Local Government System, the Ministry of Finance, professional associations, and implementing agencies reviewed SSHDP I end-term evaluation findings and began drafting the SSHDP II. For the latter, participants were given a NSHDP II Excel-based template to complete, containing: (1) the NSHDP II framework (linked to SSHDP strategic goals,

[4] MCSP/Nigeria quarterly and other internal project reports, 2014-2018

objectives, interventions), (2) the NSHDP II plan (where state-specific activities, level of implementation, stakeholders responsible, timeframe, and costs could be entered), and (3) the NSHDP II program costing sheet. The initial SSHDP II activity development process took two weeks, and WHO consultants compiled and consolidated the results. For some national programs (e.g., immunization), SSHDP II guided development of separate state-level program strategies. For programs such as RMNCH, family planning, and HIV with existing national strategies, SSHDP II activities matched those strategies.

During the workshop, participants were divided into smaller groups. MCSP participated in two working groups (the health service delivery [HSD] and partnership for health working groups), helping to draft RMNCH activities. MCSP helped group members to align their proposed SSHDP II activities with federal guidelines, Ebonyi State priorities, and MCSP work plans and ensured that all activities were based on high-impact, evidence-based interventions, and best practices. Importantly, within the HSD group, MCSP also ensured that quality of care, gender mainstreaming, and equity principles were prioritized across all activities. To help build strong health partnerships, **MCSP helped SMOH bring diverse stakeholders to the table, helping to coordinate participation from professional associations (such as the Society of Gynecology and Obstetrics of Nigeria, the Pediatric Association of Nigeria, and the National Association of Nigerian Nurses and Midwives) and the private sector**.

- **Costing SSHDP II:** In a process led by the SMOH and the WHO costing consultant, the TWG used the One Health Tool (a unified costing template) to cost SSHDP II activities. The TWG modeled three costing scenarios: (1) the baseline scenario, which assumed "no coverage scale-up and no significant change in health system strengthening (HSS) investment across the horizon of the plan;" (2) the essential service moderate scenario, which assumed "scale-up of essential services and HSS investments required for implementation of the Primary Health Revitalization Agenda;" and (3) the essential service aggressive scenario, which assumed "scale-up of health service and HSS investments aimed at achieving universal health coverage."[2] MCSP advised on the costing of the RMNCH implementation sub-plans. The SMOH and others will use these sub-plans to advocate with the Ministry of Finance and donors for needed resources at the national level.

- **Reviewing and validating SSHDP II:** Beginning in September 2017, **the draft SSHDP II was reviewed and validated in a lengthy, iterative process during which key actors at federal and state levels (including ministries, departments, agencies, local government area [LGAs], and partners) provided inputs.** A quality assurance core team at the federal level reviewed SSHDP II drafts and provided detailed feedback that the WHO consultants used to revise the plan. The SMOH held a validation meeting during which stakeholders reviewed, revised, and endorsed the plan. At this meeting, stakeholders also unanimously adopted the essential service moderate scenario (second cost scenario described above) that proposed an SSHDP II implementation budget of NGN 45.8 billion over five years.

- **Developing the SSHDP II M&E plan:** In October 2017, an M&E TWG was formed, headed by the director of planning, research, and statistics. TWG members included SMOH program directors, managers, and M&E officers; State Primary Health Care Development Agency (SPHCDA) members; MCSP; and representatives from partners. The state health management information system officer served as TWG secretary. The TWG drafted the M&E plan in line with national guidelines and presented it to the full SSHDP II TWG for review and approval. The plan describes the SSHDP II evaluation goals: "determine the effectiveness of the SSHDP II interventions, assess the achievement and progress towards reaching the objectives of the plan, and identify areas that are performing optimally so that they can be replicated with best practices."[5,4] It calls for routine monitoring as well as annual joint review missions coordinated by the SSHDP II TWG in collaboration with Federal Ministry of Health representatives. The plan also requires SMOH to conduct a mid-term (in 2019) and end-term (in 2022) evaluation of SSHDP II.

[5] Ebonyi SMOH, SSHDP II (2017-2021) Monitoring and Evaluation Plan, October 2017

In addition to supporting overall M&E plan development, MCSP supported the HSD working group to identify indicators and set annual objectives and targets for the RMNCH (including immunization, malaria, and nutrition) portions of SSHDP II. These indicators will be used to track progress across these activities and measure health outcomes.

- **Obtaining SSHDP II Approval and Dissemination**: The Ebonyi SSHDP II was approved by Dr. Daniel Umezurike, the Honorable Commissioner for Health (HCH), for implementation in 2018 during a widely attended dissemination meeting. Participants at the dissemination meeting include all stakeholders in the state, both within and outside the health sector–government, civil society organizations (CSOs), development partners, and some members of the general public. Because of the state government being in the driver seat through the whole process, approval was swift and smooth. The approval was easy to obtain because the state government and its key agencies drove the process from the beginning with support from MCSP and other partners. The plan was disseminated and shared widely across the state to stakeholders.

> *"Areas that were in the MCSP work plan have been included in the [second] state plan so the state can sustainably continue these activities" after MCSP has ended.*
> Dr. Boniface Onwe, Principal Medical Officer in the Ebonyi SMOH

- **Implementing SSHDP II**: Between SSHDP I and II, the National Health Act of 2014 empowered states to establish an SPHCDA. Within the Ebonyi SPHCDA, an executive secretary, LGA administrative secretaries, and all health workers are organized under one agency. SPHCDA oversees SSHDP II implementation at LGA and community levels, and SMOH oversees implementation at the secondary care level. State agencies and LGAs use the SSHDP II to develop state annual operational plans (AOPs) and budgets. SSHDP II implementation began in Ebonyi in 2018, with participation and support coming from the public, private (which provides about 40% of health care in the state according to the SSHDP II), and non-governmental sectors.

  The planning process for SSHDP II was slow and late in starting, which created confusion for implementation priorities after 2015. But MCSP supported the SMOH and LGAs in incorporating SSHDP activities into MCSP's annual work plans. For example, MCSP strengthened the government's ability to operationalize SSHDP/annual work plans and improve the quality of health care by focusing on management and accountability mechanisms. Once SSHDP II was in place, MCSP made efforts to synchronize activities in the RMNCH sub-plans with MCSP's annual work plans.

Results

Differences used in the SSHDP II planning and development *process* relative to SSHDP I development likely influenced the ultimate tone and contents of the SSHDP II plan. Deliberate choices were made based on lessons learned from the SSHDP I review to revise the SSHDP planning and development process, with the intent of producing a more strategic, targeted, achievable, and evidence-based second state plan. Differences in how the plans were developed, and the potential impacts of these differences, are shown below:

SSHDP I	SSDHP II
SSHDP I followed the NSHDP I framework, which had eight strategic priority areas.	SSHDP II followed the NSHDP II framework, which had five strategic pillars, 15 priority areas, 15 strategic goals, 49 strategic objectives, and 290 strategic interventions. Though the NSHDP II's strategic pillars tracked closely with the NSHDP I's strategic priority areas, the more detailed NSHDP II framework may have been easier for state-level stakeholders to use. The additional structure in NSHDP II provided space for more detailed planning within the essential service delivery section, which may have made activity development, costing, and M&E planning more efficient, clear, and accurate relative to NSHDP I planning.
SSHDP I was developed through a top-down approach, with content developed at the national level and sent to the state level.	SSHDP II was developed through a more consultative participatory process, with content from states compiled to feed into the national plan framework. The bottom-up approach may have resulted in a more realistic, targeted, and achievable plan. State- and local-level involvement from the start also may have fostered a greater sense of ownership in the final product and investment in its success.
SSHDP I development involved a small group of stakeholders.	A larger, more diverse group developed SSDHP II. Notably, there was more involvement from the Ministry of Finance, the Ministry of Budget and Planning, the House of Assembly, and civil society organizations than for SSHDP I.
Since SSHDP I was the first of its kind, developers could not incorporate lessons learned from past plan development processes.	Stakeholders were able to learn from the SSHDP I experience and incorporate substantive (and more localized) changes, improvements, innovations, and priorities into SSHDP II. Stakeholders also had better health information/data available to them. Along with making improvements to the SSHDP planning process, stakeholders incorporated new content into SSHDP II to reflect updated priorities and realities on the ground. Relative to SSHDP I, SSHDP II places greater emphasis on: • Primary health care, which SSHDP II refers to as the "fulcrum" for service delivery; • Quality of care, with priority on evidence-based interventions and policies; • Human resources for health, with emphasis on recruiting and preservice education; • Financial risk protection, toward the goal of equity and universal health coverage; • Strengthened private sector involvement, including effective regulations, capacity building of care providers for improved quality, collection of service data, and public-private partnerships; • Research, with stronger links between SMOH and universities within and outside the state; and • Joint annual reviews, to be completed in time to ensure that findings are used to improve subsequent years' planning and budgeting.

The improved SSHDP II planning process, which featured a bottom-up approach, a broader, more diverse group of stakeholders, clearer tools and templates, and data from the previous six years of SSHDP I implementation likely resulted in a high-quality SSHDP II. Ebonyi State policymakers, program managers, health care providers, and communities will be able to use this comprehensive, unified plan to guide action in the health sector for the next few years.

Way Forward

A major determinant of the level of impact SSHDP II has on the health of Ebonyi's people will be the amount of funding made available for implementation. The budget for SSHDP I implementation was NGN 43.3 billion over five years, with funds anticipated to come from federal and state government, LGAs,

development partners, the private sector, and patient out-of-pocket contributions. Unfortunately, even at the outset, expectations were that available resources would fall well short of the NGN 43.3 billion projected need, with SMOH stating in the SSHDP I plan that it could likely only provide "10%-15% of the required funds" from internal state resources and that, historically, federal releases to Ebonyi had been "very low" (e.g., in 2007-2008, federal releases were "between 5%-10%").[1] The SSHDP I end-term review report highlighted that, as expected, the SSHDP I implementation period was marked by significant budget shortfalls, with less than 10% of total health expenditure contributed by government.[3] The review's top two recommendations were for the government to "increase health funding" and "ensure timely release of approved fund[s]."[3] The Global Financial Facility (GFF) is providing resources to Nigeria, and the Ebonyi State has a clear plan on how it could benefit from those resources.

The budget for SSHDP II is NGN 45.8 billion. As with SSHDP I, required funds are expected to come from federal and state government, LGAs, development partners, the private sector, and out-of-pocket contributions. Additional resources may become available from new financing mechanisms, such as pooled and prepaid private financing and social health insurance schemes, though it is unclear how much impact these mechanisms could have on narrowing budgetary gaps. Still, in his foreword to SSHDP II, Dr. Umezurike, the HCH of Ebonyi State, sounded a highly optimistic note, warmly inviting all health stakeholders to work with his "health-friendly administration" in meeting SSHDP II goals and delivering "sustainable health care for all Ebonyians."[2]

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