ADDRESSING ROOT CAUSES FOR HEALTH SYSTEM STRENGTHENING

Our Evolving Work in Nigeria

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COVERAGE INDICATORS OF KEY INTERVENTIONS HAVE BEEN STAGNANT IN NIGERIA

Nigeria DHS indicators 1990-2013, Percent

- Antenatal care from skilled provider (% of women age 15-49)
- Births attended by skilled provider (% of births)
- Immunization, DPT3 (% of children age 12-23 months)
- ARI treatment (% of children under 5 for whom treatment was sought from health facility or provider)
- Delivery in health facility (% of births)
- Diarrhea treatment (% of children under 5 taken to health facility or provider)
- Contraceptive prevalence (% of women age 15-49 using any method)

North vs. South: While coverage for key interventions is higher in the South, coverage gains have been slow or nonexistent in both the South and North (except in immunization which has increased in the South since 1999).

OUTCOMES HAVE NOT IMPROVED OVER TIME – A ROOT CAUSE IS WEAK UNDERLYING PRIMARY HEALTH CARE SYSTEMS

Outcomes are not improving over time (according to the latest MICS/NICS)

- IMR & U5MR: Rates of Decline are Slowing
- TFR: Virtually Stagnant since 1990
- Child Nutritional Status: May be Getting Worse
- TFR may be increasing among the poor and uneducated
- DPT3/ Penta3: for poorest quintiles is lowest in W. Africa

Driven by weak PHC Systems

- Poor governance and lack of accountability
- Weak management and governance especially at sub national levels
- Poor health worker knowledge and skills
- Insufficient and untimely government funds
- Weak supply chain infrastructure and systems
- Poor data quality and suboptimal use of data for action
- Weak demand for services
- Poor quality of services in public and private
VERTICAL MODELS CAN PRODUCE RESULTS, WITH LIMITED SUSTAINABILITY AND UNANTICIPATED OUTCOMES
OUR APPROACH IN NIGERIA IS EVOLVING

- NURHI (FP)
- Primary Health Care Under One Roof Policy
- Data and Performance Management Grant (HSS)
- Borno, Gombe, Kaduna, Sokoto, Yobe state MOUs (RI)

Abuja Commitments to Polio Eradication in Nigeria

- Kano State MOU
- SFH Gombe State (MNCH)
- NURHI2 (FP), Alive & Thrive (nutrition)
- Kaduna and Niger State PHC Diagnostic
- Niger State MOU (HSS)

EVOLVING ENGAGEMENT MODEL
# KEY MILESTONES (JULY – DECEMBER 2017)

<table>
<thead>
<tr>
<th>Priority</th>
<th>Due date</th>
<th>Status</th>
<th>Comments</th>
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<tbody>
<tr>
<td>1</td>
<td>July 2017</td>
<td></td>
<td>NA</td>
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<tr>
<td>100% of Routine Immunization funds for Q3 and Q4, 2017 deposited into RI bank account</td>
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<td>2</td>
<td>Oct 2017</td>
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<td>50% (30 of 60) health facilities selected for the 2017 DRF expansion have fully commenced DRF operations</td>
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<td>Expand Drug Revolving Fund (DRF) scheme to additional 60 primary health facilities</td>
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<td>3</td>
<td>Oct 2017</td>
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<td>Referral network design finalized.</td>
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<td>Strengthen two-way referral linkages between all primary and 38 secondary health facilities</td>
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<td>4</td>
<td>Nov 2017</td>
<td></td>
<td>NA</td>
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<tr>
<td>Set-up monitoring and evaluation unit in Hospitals Management Board</td>
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<td>5</td>
<td>Nov 2017</td>
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<td>Kano State recorded 103% coverage during the last measles campaign</td>
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<td>Successful execution of 2017 measles campaign</td>
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<td>6</td>
<td>Dec 2017</td>
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<td>91% (40 of 44) LGA chairmen participated in October IPDs</td>
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<td>LGA chairmen participation sustained during October IPDs and counterpart funds released</td>
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<td>7</td>
<td>Dec 2017</td>
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<td>AOP not yet finalized and shared with all stakeholders</td>
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<tr>
<td>Develop 2018 Annual Operational Plan (AOP)</td>
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NIGERIA: ENGAGEMENT MODEL

Weak systems are driving stagnant health and development outcomes in Nigeria. We are tackling the root causes of these weak systems via a spectrum of state engagement models...

**Intensive Engagement**

- **Kano – RI MOU with Child Health Addendum**
  - Purpose: Strengthen routine immunization in high risk polio state, evolve to child health and add PHC elements, transfer responsibilities for sustaining and building on gains to state.

- **Kaduna – MOU + PHC MOU**
  - Purpose: Targets PHCUOR and PHC transformation initiative across nine major domains, while pursuing RI systems strengthening.

**Moderate Engagement**

- **Borno, Bauchi, Sokoto, Yobe – RI MOU**
  - Purpose: To achieve immunization coverage of ≥80% at LGA level, stop polio transmission, maintain polio-free status, transfer responsibilities for sustaining and building on gains to state

- **Lagos – FP, Nutrition, MNCH**
  - Purpose: Leverage private sector delivery mechanisms as well as supply chain and health financing components to advance FP and Nutrition strategies

- **Niger – Limited PHC MOU**
  - Purpose: Leverage strong political leadership, less donor fragmentation and BHCPF pilot funding to support a “lighter touch” transformation of the PHC system

**Light Touch Engagement**

- **Gombe – MNCH MOU**
  - Purpose: To improve MNCH services and implement village health worker program – MOU will end in Sept 2019 and the state will take over the program

- **Nasarawa – PHC Grant**
  - Purpose: To mainstream successful WB (NSHIP) financing facility and management/monitoring systems

...with impact amplified and scaled via our support to national levers

**Institutional Strengthening**

NPHCDA capacity building at federal and zonal levels

**Federal Ministry of Health – DPRS**

Capacity building for policy and data

**Engagement with Nigeria Governors’ Forum**

Support promising PHC initiatives including SOML’s $500m IDA operation and World Bank’s NSHIP success and proposed expansion

**Advocacy**

Stronger/more strategic use of foundation voice; combined with longer-term investment in local champions in government, civil society, and the media

Diffuse successful state level engagement models to non-focus states