

Nigeria Global Health Initiative Strategy 2010 – 2015

United States Government Interagency Team
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Nigeria Global Health Initiative Strategy

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Acronyms

AFP	Acute Flaccid Paralysis
AFPAC	Armed Forces Programme on AIDS Control
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Anti-Retroviral Therapy
BCC	Behavior Change Communication
CDC	Centers for Disease Control and Prevention
CHEW	Community Health Extension Worker
CIDA	Canadian International Development Agency
CPR	Contraceptive Prevalence Rate
CSO	Civil Society Organization
cVDPV	Circulating Vaccine-Derived Poliovirus
DFID	Department For International Development
DHIS	Decentralized Health Information System
DOD	Department of Defense
DP	Development Partner
DPT	Diphtheria, Pertussis, and Tetanus
EPIC	Emergency Plan Implementation Committee
FCT	Federal Capital Territory
FHI	Family Health International
FMOH	Federal Ministry of Health
FOBTAC	Armed Forces Blood Transfusion and AIDS Control Committee
FP	Family Planning
GBV	Gender-Based Violence
GHI	Global Health Initiative
GON	Government of Nigeria
HCT	HIV Counseling and Testing
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HMOSD	Honorable Minister of State for Defense
HRH	Human Resources for Health
HRIS	Human Resource Information System
HSS	Health Systems Strengthening
IDSR	Integrated Disease Surveillance and Response
IMR	Infant Mortality Rate
INMNCH	Integrated Maternal, Neonatal and Child Health Strategy
IP	Implementing Partner
IRB	Institutional Review Board
ITN	Insecticide Treated Net
LB	Live Births
LGA	Local Government Area
MDG	Millennium Development Goal
M&E	Monitoring and Evaluation
MICS	Multi-Cluster Indicator Survey
MMR	Maternal Mortality Rate
MNCH	Maternal, Neonatal and Child Health

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MR	Mortality Rate
MTCT	Mother To Child Transmission
NACA	National AIDS Control Agency
NACP	National AIDS Control Programme
NDHS	Nigeria Demographic and Health Survey
NFELTP	Nigeria Field Epidemiology and Laboratory Training Program
NGO	Non-Governmental Organization
NHIS	National Health Insurance Scheme
NHREC	National Health Research Ethics Committee
NICS	Nigeria's Immunization Coverage Survey
NMCP	National Malaria Control Program
NMOD	Nigerian Ministry of Defense
NMR	Neonatal Mortality Rate
NPHCDA	National Primary Health Care Development Agency
NSHDP	National Strategic Health Development Plan
OGAC	Office of the Global AIDS Coordinator
ORS	Oral Rehydration Solution
OVC	Orphans and Vulnerable Children
PEPFAR	President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PHCC	Primary Health Care Clinic
PLWHA	People Living With HIV/AIDS
PMI	President's Malaria Initiative
PMTCT	Prevention of Mother To Child Transmission
PMV	Patent Medicine Vendor
PNC	Postnatal Care
QA	Quality Assurance
QC	Quality Control
RH	Reproductive Health
SFH	Society for Family Health
TB	Tuberculosis
TFR	Total Fertility Rate
TT	Tetanus Toxoid
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDESA	United Nations Department of Economic and Social Affairs
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VHC	Village Health Committee
WDC	Ward Development Committee
WHO	World Health Organization
WRAIR	Walter Reed Army Institute of Research
WRP-N	Walter Reed Program – Nigeria
U.S.	United States
USG	United States Government

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1. Global Health Initiative (GHI) - A Vision for Nigeria

The GHI is a strategy to improve the efficacy and impact of all U.S. international health programs through closer inter-agency, bilateral, and multi-lateral coordination. It comes at a particularly opportune time. GHI is positioned to build upon the priorities of the Government of Nigeria (GON) and the Nigerian private sector, the successes of United States (U.S.) health assistance programs to date, and the rich collaboration that the U.S. has with other development partners (DPs) and donors. The launch of the GHI coincides with the development of the GON's National Strategic Health Development Plan (NSHDP) 2010 – 2015. The NSHDP includes new and updated strategic objectives, activities, and intended results for maternal, neonatal and child health (MNCH) including routine immunization and campaigns, reproductive health (RH), family planning (FP), nutrition, malaria, human immunodeficiency virus /acquired immune deficiency syndrome (HIV/AIDS), tuberculosis (TB), other infectious/communicable diseases, and strengthening of health systems (HSS). The NSHDP provides a framework with which other existing GON policies, strategies, programs, and partnerships are to be aligned. Although the GON has made recent measurable advances in improving access to basic health care services, the NSHDP expresses concern over relatively slow progress towards achievement of Millennium Development Goals (MDGs) 4, 5, and 6 by 2015.

The USG Inter-Agency Team for GHI in Nigeria (hereafter, the “USG” or “USG Team”) is comprised of: the U.S. Agency for International Development (USAID); the U.S. Centers for Disease Control and Prevention (CDC); the Department of State, represented by the Coordinator of the President's Emergency Plan for AIDS Relief (PEPFAR) and the Environment, Science, Technology, and Health Officer (ESTH); and the Walter Reed Program - Nigeria (DOD WRP-N) of the U.S. Department of Defense. The USG Team reports to the Ambassador who in turn coordinates with the Executive Director for GHI in the U.S. Department of State.

The USG GHI effort supports priority health policies, projects, and activities through the public and private health sectors as well as through the military health system. The USG addresses the same areas prioritized by the GON in the NSHDP: MNCH and women's health more generally, RH, FP, and prevention and treatment of specific diseases especially those that disproportionately affect women and children and cause the extremely high maternal and child mortality and morbidities experienced by the population.

The USG is committed to reducing rates of maternal and child mortality and morbidity in Nigeria under GHI from 2010 through 2015 and will address these and other health issues by finding operational efficiencies and making more effective use of funding already allocated through PEPFAR; the President's Malaria Initiative (PMI); U.S. Congressional Budget Accounts for RH/FP, MCH and nutrition; the Pandemic Influenza Response Plan; the Animal and Human Interface Project; the U.S. Army Medical Research and Material Command, Navy and other sources of military assistance. These resources have made the U.S. the largest bilateral donor for health in Nigeria. The GHI Country Strategy describes a coordinated approach to U.S. health assistance using these resources, working in close

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partnership with Nigerian entities and other national and international DPs and donors, in order to improve the health of the most vulnerable segments of the population.

The USG vision for GHI in Nigeria is to use existing relationships to build a health care delivery system which better meets the needs of the country's population. GHI builds on long-standing collaborations with the GON at all levels: the private sector including non-governmental organizations (NGOs), civil society organizations (CSOs), and commercial, for-profit entities; and DPs including other donors, international organizations, and U.S. and technical organizations.

Increased country ownership¹ by the GON and the private sector, supported by GHI technical assistance, policy dialogue, funding and other DP/donor assistance, will improve the health status of young girls during pregnancy; women of reproductive age; newborns and children under five; and families and young men experiencing or at high risk of malaria, HIV/AIDS, and TB.

The GHI will increase access to quality health information, counseling, and services and will enable Nigerians to participate more effectively in health decision-making. Priority GHI results are:

- Reduced maternal, neonatal, and child mortality and morbidity;
- Decreased unintended pregnancies, and
- Reduced incidence of communicable diseases (HIV, TB, and malaria).

Under GHI, one of the most important “deliverables” will be primary health care (PHC), provided through health facilities closest to communities as well as in and by communities themselves. Here is “where the rubber hits the road” for improvements in the health status of women and children. Health promotion, prevention of death and disease, treatment, care and support, and HSS inputs under GHI will be aimed for maximum impact closest to the rural and urban poor.

The most important outcomes to monitor and evaluate under GHI are increased use of quality services in both the public and private sectors; adoption of healthy behaviors; and demand for and access to quality services. This will be possible only by improvements in GON and private sector stewardship of the health system and increased community participation. USG resources will support the GON and private sector to professionalize leadership and management and improve accountability in the health sector along with increased GON budgets and private sector resources and other DPs/donor investments. The USG will bring together an intricate “mosaic” of health interventions and resources in order to achieve measurable outcomes and results.

¹ “Country ownership” in Nigeria means that the GON, the private sector, non-governmental organizations (NGOs), civil society organizations (CSOs), commercial health sources, and community leaders share a clear commitment to work together to improve the health of women and children using all available GON, private sector and development partner resources. This, if effective, will be shown by sharp decreases in mortalities and morbidities resulting from increased access to and the improved quality of basic health services.

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Fundamental to achieving GHI objectives are improvements in the capacity of the public and private health sectors to serve the population at federal, state, local government area (LGA), ward, and community levels and to ensure community participation in health programs. The USG's collective experience to date, analysis of health data, and discussions with the GON, private sector, and other DPs/donors identified three priority "cross-cutting" GHI objectives:

- Improved human resources for health;
- Improved delivery of highest-impact interventions, particularly at the PHC level; and
- Strengthened leadership, management, governance and accountability.

2. Nigeria's Health Priorities and Context

Nigeria has 158 million people (United Nations Department of Economic and Social Affairs [UNDESA] 2010), 250 ethnic groups, 380 languages, and a diverse range of cultural and religious beliefs and practices. At the current estimated rate of growth at 3.2 percent, the population is expected to double in roughly 25 years. Ranked 197 out of 200 countries on health indicators, Nigeria has some of the poorest health indicators in the world (United Nations Population Fund [UNFPA]/World Health Organization [WHO]). Literacy among primary school pupils is low. Adult illiteracy is 40 percent among women and 30 percent among men. Despite strong economic performance over the past five years and substantial oil reserves, over half of Nigerians still live below the poverty line. Corruption and weak government processes, systems, and structures severely constrain progress in providing PHC particularly to women and children and education and employment opportunities for youth. PHC (that includes MNCH, RH and FP, and prevention and treatment of diseases that disproportionately and severely affect women and children) has been accorded low priority by politicians and bureaucrats at federal and lower governmental levels. This has been evidenced by wholly insufficient GON funding for this program at all levels of the health care system which is an example is the continued shortage of skilled midwives and community-based health workers.

2.1 The Health System

Nigeria operates a Federal System of Government with three levels; the federal, state, and LGAs/Councils. There are 774 LGAs within the 36 states and Federal Capital Territory (FCT) Abuja. The 774 LGAs are further sub-divided into 9,565 wards. The states and FCT are grouped into six geo-political zones: the South-South, South-East, South-West, North-East, North-West, and the North Central. The 774 LGAs are the constitutionally-designated provider of PHC. However, they are the weakest arm of the health system. There are about 25,000 PHC facilities nationwide with a population to health facility ratio of about 5,600 residents to one. The Nigeria Ministry of Defense (NMOD) operates medical centers around the country which provide mostly secondary and tertiary care to both military personnel and civilians. In addition to the FMOH, the National Primary Health Care Development Agency (NPHCDA) - another centrally-funded agency - has the mandate to

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support the promotion and implementation of high quality and sustainable PHC at state and lower levels. The NPHCDA, in collaboration with state governments and LGAs, is active in development of community-based systems and functional infrastructure, as well as ensuring that women deliver in safe conditions and infants are fully immunized against vaccine-preventable diseases. The NPHCDA also implements the national campaign against polio and measles in collaboration with states. The National AIDS Control Agency (NACA), the National Malaria Control Program (NMCP) and numerous other health units at federal and state level have the lead in the development and implementation of policies, strategies, and high-impact programs that directly affect the survival and health of women and children.

Generally, the federal budget covers tertiary care, disease control programs, and some sectoral programs such as FP, for which it shares responsibility with states. State budgets pay for secondary level care and LGA budgets cover primary care. The amount of GON spends on health is difficult to determine. Funding levels vary and actual spending does not always match the stated budget – when budgets are made transparent to the public. The flow of funds from federal to state and state to LGA levels is neither timely nor efficient. In all, it is estimated that less than 5 percent of the national budget is spent on health. Yet, Nigeria is not as poor as many other countries that have improved PHC for their populations and reduced the mortality and morbidity from preventable causes affecting women and children.

The private health care system provides care for a substantial proportion of the population. For example, in 2008, 60 percent of women using contraception received their services from the private sector (Nigeria Demographic and Health Survey [NDHS], 2008). From 2005 – 2008, it has been estimated from National Health Account data that private expenditure on health as a percent of total health expenditure continued to grow and accounted for 75.3 percent of health expenditures (National Health Accounts, 2003-5; NDHS, 2008). The private sector consists of tertiary, secondary, PHC facilities, patent medicine vendors (PMVs), drug sellers, and traditional practitioners. More than 70 percent of all secondary facilities and about 35 percent of PHC facilities are private. Services provided by the private sector are either subsidized (e.g. faith-based health facilities) or full-cost (e.g. privately owned clinics and hospitals). Payment for these services may be in currency or in kind. About two-thirds of the population in rural areas lives within five kilometers of a public or private sector PHC clinic (“PHCC”). There are about 36,000 PMVs nationwide, fairly evenly distributed between urban and rural areas. However, quality of care in both the public and private health sectors needs substantial improvement.

2.2 Health Conditions and Statistics

Nigeria’s demographic and health indicators are among the worst in the world, especially when compared to other countries with similar income per capita.

Population growth adds 4.8 million people each year. Serious inequalities in health outcomes (including mortality and fertility) exist between rural and urban areas; northern and southern zones and states; and across income groups. Nationally, the maternal mortality ratio (MMR) is 545 per 100,000 births. The total fertility rate (TFR) as a whole is

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5.7 but in the north it is over 7.0. Only 9.7 percent of women use modern methods of contraception. The unmet need for family planning is 20 percent (NDHS, 2008), but the contraceptive prevalence rate (CPR) in the north is much lower than the national average at around 2-4 percent. Childbearing begins early and births are closely spaced (NDHS, 2008).

Under-five mortality rates (MRs) vary from 83/1,000 live births (LB) in the south-west to 201/1,000 LB in the north-west. Malaria is the leading cause of child mortality with an estimated 300,000 children dying each year. It accounts for about 60 percent of outpatient visits and 30 percent of hospitalizations. Malaria also contributes to an estimated 11 percent of maternal mortality (NMCP Strategic Plan, 2009-2013). More than half of patients with suspected malaria first seek treatment in the private sector (Situational Analysis of Malaria Control in Nigeria, FMOH, 2000). Children fully immunized in the north ranges from 6 – 8 percent, compared with 23 percent nationally.

Although child mortality has had a marked decrease from 2003 (201/1,000 LB) to 2008 (157/1,000 LB), 16 percent of children die before reaching their fifth birthday. This figure represents about 10 percent of global child deaths even though it is just 2 percent of the world's population. Under-five deaths are largely due to preventable diseases such as malaria, measles, respiratory infections, and diarrhea. More than ten million children under five are chronically malnourished and the stunting rate is 41 percent. While breast feeding is nearly universal (97 percent of children are breast fed [NDHS, 2008]), only 13 percent of children under the age of six months are exclusively breast fed, which is one of the lowest rates in the world. These indicators are driven by the fact that for the majority of women and children life-saving, high quality PHC and referral services (clinic or community-based) are unavailable. This makes it unlikely that Nigeria will achieve the health-related MDGs reflected in the GON's own NSHDP by 2015.

Despite various large-scale responses over a period of about two decades, the challenge of HIV/AIDS has continued to increase, as measured by the number of people infected and affected. Estimates from the Joint United Nations Programme on HIV/AIDS (UNAIDS) show an increase of 670,000 in the number of people living with HIV/AIDS (PLWHA) between 2001 and 2010. Based on the National HIV Sero-prevalence Sentinel Survey (2010), the prevalence of HIV stands at about 4.1 percent in the general adult population. It is estimated that there are 3.14 million PLWHAs. This figure ranks Nigeria third among countries with the highest burden of HIV infections in the world after India and South Africa. It is estimated that there are 2.2 million HIV orphans in the country. HIV is also straining the health system. Approximately 1, 512, 720 PLWHAs require ARV drugs with less than half able to access them. ARVs are still largely delivered at tertiary and secondary care level but a major effort has commenced in 2011 to scale-up decentralization of ARV service delivery to PHCCs. The prevalence of HIV among TB patients increased from 2.2 percent in 1991 to 19.1 percent in 2001 and is estimated to be 27 percent in 2009, indicating that TB will continue to be HIV-driven. Nigeria ranks fourth among the 22 high-burden TB countries in the world. WHO estimates that 460,000 new cases of all forms of TB occurred in the country in 2009. The emergence of multi-drug

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resistant TB also poses a threat which may wipe out previous achievements in controlling TB if not effectively addressed.

Nigeria is still one of the few polio endemic countries and has been a source of re-infection in neighboring countries. Vaccine-preventable diseases coupled with infectious and parasitic diseases continue to exact a heavy toll on the health and survival of Nigerians.

Military treatment sites in tertiary and secondary health facilities across the country are accessible to surrounding communities. Civilians make up approximately 90 percent of the client load. Many of the military medical units are close to rural and disadvantaged communities which have a high HIV/AIDS burden and often poorly served by modern health facilities. In addition to the provision of free and comprehensive HIV/AIDS care and treatment services, communities are able to access other health services such as laboratory testing.

Table #1 Key Health Indicators in Nigeria

Indicator		Source
Population	158 million	UNDESA, 2010
GDP Per capita income	US \$803	World Bank, 2005
Life expectancy at birth	47 years	NDHS, 2008
TFR	5.7 children	NDHS, 2008
Modern method CPR	9.7%	NDHS, 2008
Unmet need for FP	20%	NDHS, 2008
Maternal Mortality Ratio	545/100,000 LB	NDHS, 2008
Women with at least 4 antenatal care (ANC) visits	45%	NDHS, 2008
Births delivered by a skilled provider	39%	NDHS, 2008
Women receiving full tetanus toxoid (TT) immunization	48%	NDHS, 2008
Neonatal mortality rate (NMR)	40/1,000 LB	NDHS, 2008
Infant mortality rate (IMR)	75/1,000 LB	NDHS, 2008
Under-five MR	157/1,000 LB	NDHS, 2008
Children 12-23 months receiving 3 doses of diphtheria, pertussis, and tetanus (DPT)	23%	NDHS, 2008
Children under 5 who are underweight for age	23%	NDHS, 2008
Children under 6 months exclusively breastfed	13%	NDHS, 2008
TB MR	67/100,000	WHO, 2011
Households with at least one insecticide treated net (ITN)	8%	NDHS, 2008
Children under 5 who slept under an ITN the night before the survey	23%	Malaria Indicator Survey, 2010
HIV prevalence	4.1%	FMOH, 2010
HIV prevalence among 15-24 years	4.1%	FMOH, 2010

2.3 Health System Challenges and Opportunities

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Despite considerable investment in the health sector over the years, health services are delivered through a weak and badly understaffed public sector health care system. There is also a lack of political will and an absence of strong bureaucratic support on the part of the GON for PHC. The NSHDP (2010-2015) states that despite considerable investment, health services are characterized by inequitable distribution of resources, decaying infrastructure, poor management of human resources for health, negative attitudes of health care providers, weak referral systems, poor coverage with high impact cost-effective interventions, unavailable or shortages of essential drugs and other health commodities, a lack of integration, poor supportive supervision, and financial barriers experienced by the population that prevent access to services. Consequently, the public sector health care system is unable to provide basic, cost-effective services for the prevention and management of common health problems especially at LGA, ward and community levels. Many people use home treatments and access advice and drugs through market vendors, PMVs, and private sector clinic-based providers for treatment of adults and sick children. As stated previously, quality is a concern in both public and private sector health care. Nevertheless, Nigerians heavily patronize private sector health services.

Physicians and nurses are relatively sufficient in number but are largely urban-based. If they were better distributed and utilized in the public health system, they could help hasten the pace of improvements in health status. Midwives and Community Health Extension Workers (CHEWs) are the primary cadres delivering PHC but they are in short supply and their numbers need to be increased for effective PHC services for women and children.

Nigeria has sufficient GON revenues to support an effective PHC system but lacks the will to make the decisions and budget allocations necessary to support PHC and improve the health of women and children. In 2010-11, the GON gave some indication of increased willingness to provide additional resources for FP and HIV/AIDS as key health program areas. It remains to be seen if the promised commitments materialize. FP, malaria, and HIV/AIDS services with strong DP/donor support have seen some improvement in PHC, particularly in states targeted by donors.

2.4 GON Response

Nigeria's comprehensive NSHDP (2010-2015) was developed by the FMOH in 2010 in extensive consultation with other ministries and levels of the GON, the private sector, CSOs, DPs/donors (including the U.S.), and other partners. Similar plans were developed by 36 states and the FCT as well. The overarching NSHDP goal is "to significantly improve the health status of Nigerians through the development of a strengthened and sustainable health care delivery system." The NSHDP is focused on strengthening health systems for delivery of PHC and prioritizes all of the GHI program focus areas with the exception of neglected tropical diseases.

NSHDP priorities are leadership and governance for health; health service delivery; human resources for health; financing for health; a national health information system; community participation and ownership; partnerships for health; and research for health. Specific

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health program areas have their own strategy documents and the NSHDP serves as an overarching framework for these strategies. The NSHDP Results Framework includes ambitious targets against MNCH, RH, FP, nutrition, and disease prevention/treatment indicators, as well as for overall HSS in both public and private health care facilities. In many cases, objectives and targets laid out in the NSHDP are overly ambitious because they are based on the assumption that Nigeria will meet the MDGs when in fact in 2011 it is not on track to do so. Nevertheless, the USG intends to align GHI programming to the greatest extent possible with the NSHDP and encourage the GON to provide the resources and leadership necessary to accelerate implementation of the NSHDP and state plans. If implemented even partially, results would substantially benefit women and children.

2.5 The USG's GHI Approach in Nigeria

The USG team approach to GHI implementation will leverage the PEPFAR interagency model which has been successfully implemented. This platform will be expanded to ensure the appropriate linkages are established and enhanced across agency-specific health portfolios.

HIV/AIDS: Through the PEPFAR program, the USG is the largest donor for HIV/AIDS in Nigeria. PEPFAR support has led to progress in saving lives through HIV prevention, treatment and care, and support services since its start in 2004. The number of sites providing anti-retroviral therapy (ART) services increased from 24 in 2005 to over 374 in March 2011. As of March 2011, PEPFAR provides cost-effective anti-retroviral drugs for more than 367,000 patients in 374 sites in all 36 states and the FCT. An estimated 70 percent of people on HIV/AIDS treatment are covered by USG funding through PEPFAR. PMTCT sites have increased from 80 in 2006 to 472 in 2008. PEPFAR is the largest donor in OVC programming and has provided support to more than 200,000 OVCs. In general, more than 1 million people infected and affected by HIV/AIDS have been provided with care and support through PEPFAR. PEPFAR currently supports 977 HIV counseling and testing (HCT) sites. To date, more than 5,000,000 adults have been counseled and tested for HIV in addition to the counseling and treatment services that have been provided to pregnant women and TB suspects. More than 2 million pregnant women have been provided with services for PMTCT. PEPFAR efforts have helped reduce HIV prevalence from 5 percent in 2003 to 4.1 percent in 2010 (FMOH 2010).

In addition to providing services, the USG continues to contribute to HSS efforts by upgrading facilities and laboratory services; provide institutional support; train staff; and improve logistics, supply chain management systems, and health management information systems (HMIS). The USG continues to seek increased funding and ownership of the HIV/AIDS response from the GON through a new Partnership Framework Agreement outlining anticipated U.S. and GON investments from 2010-2015.

MNCH, RH, FP, Nutrition, and Malaria: The GHI will address these areas by emphasizing stronger coordination of activities, increased focus on geographic and technical implementation, and integration of programs and resources at all levels. GHI interventions work to achieve NSHDP goals, objectives, activities, and intended results. If the President

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of Nigeria signs the pending Health Bill, significant GON funding should become available for NSHDP implementation. This would be important for: PHC in the public sector, the implementation of already-developed FMOH strategies that are quite good but stagnant (e.g. the Integrated Maternal, Neonatal and Child Health Strategy [INMNCH]); the integration of FP and RH into the National Health Insurance Scheme's (NHIS) basic benefits package; and multi-year funding for FP, including timely and sufficient contraceptives procurement.

In addition, the USG through GHI will collaborate with the GON, private sector, and DPs/donors to improve forecasting, procurement, access, and distribution of health commodities; advocate for an increase in the number and quality of health providers, primary health care clinics (PHCCs) and referral hospitals; and encourage an improvement in the quality, analysis, dissemination, and use in advocacy and decision-making of major survey, surveillance, and service statistics data by officials and the public (i.e. the NDHS, United Nations Children's Fund Multi-Cluster Indicator Survey [UNICEF MICS], Nigeria's Immunization Coverage Survey [NICS], the Malaria Indicator Survey, other epidemiologic and demographic data sources, service statistics; and subject-specific operations research studies). The USG will focus on promoting adherence to national standards of health care practice in public and private sector PHC service providers in order to improve quality of care with GON, private sector, and DP/donor partners.

GHI activities will be expanded nationally through the PEPFAR-funded HIV/AIDS effort and by using social marketing of FP and health products. The USG will also target states considered high-risk based on significant indicators relating to high malaria rates, low contraceptive prevalence rates (CPRs), etc. Decisions on the scope, intensity, and location of GHI-supported MNCH, RH, FP, and malaria activities and interventions will be based on the analysis of national, zonal, state and community-level health data and the scope of GON and other DP/donor investments to avoid duplication of efforts and resources.

GHI projects and activities in MNCH, RH, FP, and disease prevention/treatment will ensure state-wide coverage by targeting all facilities/communities within each state to measure state-wide impact rather than focus on site-specific output. At the state, LGA, and community levels, emphasis will be for PHC service providers to implement cost-effective clinic- and community-based high-impact health interventions, focusing on midwives, CHEWs and village health workers, physicians, and nurses.

In facilities, GHI activities in MNCH, RH, FP, and disease prevention/treatment promotes an integrated basic services "package" prioritizing ANC and postnatal care (PNC), deliveries in facilities attended by skilled midwives, FP, routine immunization, participation in polio and measles campaigns, oral rehydration to prevent deaths from dehydration resulting from a number of causes, prevention and treatment of HIV/AIDS, malaria, and TB, and sustained breastfeeding and micronutrient supplementation. The USG through GHI will increasingly move its focus to PHCCs and communities. Resources will be used to better integrate PMTCT, ANC and FP, and upgrade PHCCs. In addition, GHI activities will be coordinated with U.S. assistance programs in governance, education, water, and sanitation.

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Polio, Meningitis, Influenza and other Communicable Diseases: The USG will continue to support efforts to eradicate polio through different strategies integrated with other health intervention activities - for example, ensuring acute flaccid paralysis (AFP) surveillance indicators are met at national and sub-national levels and strengthening routine immunization to reduce the transmission of circulating vaccine-derived polioviruses (cVDPVs). Both routine immunization and disease-specific campaigns will be supported to collaborate with the GON, private sector and other DPs/donors to help control meningitis, measles and other vaccine-preventable diseases. The USG's support in response to avian and pandemic influenza outbreaks will be utilized as the platform to strengthen health emergency responses in general.

3. Nigeria GHI Objectives, Program Structure and Implementation

The objectives of GHI are to reduce maternal, neonatal and child mortality and morbidity; decrease unintended pregnancies; and reduce the incidence of communicable diseases (HIV, TB, and malaria). To reach these outcomes, the USG will contribute to implementation of the GON's NSHDP, which provides the overall strategic direction and program priorities for achievement of the MDGs. The USG has selected three cross-cutting HSS priority objectives for greater effort through GHI that are in line with the NSHDP's focus on HSS:

- human resources for health
- delivery of highest impact health interventions, particularly at PHC level, and
- leadership, governance, management and accountability.

These were selected because, if intensively implemented, they have the potential to make the most significant and sustainable impact on mortality and morbidities while strengthening country capacity and ownership, scaling up aligned or integrated health services, and complementing GON, private sector and other DP/donor resources.

Health programming is an intricate mosaic of collaborations with many GON agencies at all levels, private sector partnerships with NGOs, CSOs and commercial entities, and other DPs/donors. Therefore, achievement of GHI goals articulated in this Country Strategy is heavily dependent upon continued joint efforts of these collaborators – including the USG - as well as on determined implementation of U.S. policy initiatives, projects and activities.

3.1 Improved Human Resources for Health (HRH)

Until recently, USG investments in human resources for health centered on increasing the availability of high-quality health workers were largely through in-service training. The USG focus through GHI is shifting to improving pre-service training as well as continuing in-service training, recognizing that a consistent source of quality, multipurpose, multi-skilled and gender sensitive health workers is needed over a sustained period of time. It is increasingly apparent that corollary investments in human resources systems and structures are required in order to ensure that training has the desired sustainable impact on health services and health outcomes. Therefore, the USG will increase its attention to decision-making with regard to deployment, motivation and retention of public sector

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health staff. Concerted efforts to ensure that all levels of the health system are staffed with highly-skilled, motivated and qualified staff are already underway in a USG integrated MNCH/RH/FP and disease prevention/treatment project in two northern states. This effort will be expanded and intensified by leveraging PEPFAR funds under GHI.

The USG, along with other DP/donors, plans to respond directly to the challenges highlighted in the GON's National Human Resources Strategic Plan (NHRSP). Specifically, through GHI, the USG will address the shortages of professional staff in the north and oversupply in the South; distribution of health workers skewed toward urban centers, with acute shortages in rural locations; poor utilization of health professionals across the public/private sector divide resulting in duplication of functions in some locations and poor coverage by skilled personnel in other locations; misalignment of pre-service training programs to health priorities and policies; the absence of systematic in-service training; and poorly coordinated continuing education programs. The USG has also identified an oversupply of male PHC workers unable to attend to pregnant women, and a corresponding undersupply of females, as an issue that must be addressed.

The USG through GHI intends to pursue a coordinated set of activities designed to further HRH strategic interventions outlined in the NSHDP by:

- **Improving human resource planning and management:** Program activities in this area will try to ensure that unlike the present situation, health workforce requirements and recruitment are based on assessed needs and aligned with NSHDP priorities; the health workforce is equitably and effectively distributed; and staff is supervised, motivated and retained. To achieve this, the USG will support interventions to build the capacity of the GON to effectively oversee and forecast health workforce needs and requirements through evidence-based planning, distribution and management of staff - including achieving a gender balance in recruitment and deployment that facilitates services for women. The USG will also work with the GON, private sector professional associations and other DPs/donors on developing effective staffing strategies and policies for PHCs; introducing and utilizing staffing norms; and establishing coordinating mechanisms for consistency in HRH planning and budgeting. The USG will provide technical assistance to strengthen the Human Resource Information System (HRIS) and through operations research will pilot innovative mechanisms for retaining health workers in rural areas. In target states, the USG will work to institutionalize supportive supervision by building capacity of managers and assisting with adaptation and dissemination of tools and guidelines.
- **Increasing the quality of professional training programs:** A reliable and sustainable supply of quality health workers capable of delivering services that the population desperately needs can only be obtained by investing in both pre- and in-service training programs in the public and private sectors. Interventions will seek to transfer critical skills and competencies that are currently lacking, in academic and training institutions (both public and private) through faculty development, training of trainers, reviewing and updating training curricula, and other forms of

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technical assistance. Particular emphasis will be placed on preparing for the revitalization of PHC and the concurrent decentralization and alignment or integration of HIV/AIDS, antenatal care and FP services at the PHC level through the provision of in-service, competency-based clinical and non-clinical training covering a range of GHI priority health areas.

The USG will also continue to support the establishment of an accredited field epidemiology training program that provides a system for the annual output and recurrent training of disease-detection-and-response frontline staff to ensure that there is a cadre of health professionals with the capacity to quickly and effectively detect and respond to disease outbreaks. The USG will institutionalize continuous education by supporting the creation of a continuous professional development system. In target states, the USG will institute refresher training for midwives and CHEWs, and training in high impact interventions for other community-based health deliverers. Through its Military partnership, the USG will continue to roll out training in various aspects of diagnosis and management of HIV/AIDS and other infectious diseases, both locally and abroad to both Military and civilian personnel.

- **Promoting implementation of the HRH policy:** A supportive policy environment is critical to codifying, regulating, enforcing and sustaining systemic public and private sector HRH changes that are achieved through the activities mentioned above. The USG, working with DFID and other DPs/donors, will facilitate implementation and decentralization of the HRH policy to all levels of the system, and build capacities of key state and local decision-makers and managers to ensure its implementation. Priority actions include supporting the GON's implementation of the national HRH strategy and targets, and capacity-building to ensure that states and LGAs understand and implement HRH guidelines and policies. The USG will support the development of HRH plans at state and LGA levels in target states.
- **Increasing the capacity of professional and technical associations/regulatory bodies:** Professional and technical associations and bodies (public and private) have a key role to play in ensuring that health policies and health worker training programs reflect evidence-based standards and result in delivery of quality, cost-effective care. The USG will work with DFID and other DPs/donors to increase the organizational capacity of such bodies to set and enforce norms; support and sustain improvements in pre-service, in-service and continuous education training programs to increase the availability and quality of professional training; manage facility/laboratory accreditation and quality assurance; and influence the development and implementation of policies that impact health workers. Professional bodies overseeing the protection of human subjects in both research and delivery of services will be specific targets of capacity building given their unique and critical role in upholding ethical standards in health care and research – these include the National Health Research Ethics Committee (NHREC) and Institutional Review Boards (IRBs) at the sub-national level.

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3.2 Improved delivery of highest impact interventions, particularly at the PHC level

The USG expects to significantly accelerate improvements in key health outcomes by integrating HIV/AIDS services wherever possible with established MNCH, RH, FP and prevention/treatment of malaria and other disease activities and services, while harmonizing efforts to strengthen the full complement of high impact, needs-based and aligned or integrated services delivered at the PHCC level. This simultaneous decentralization and alignment or integration will expand ongoing efforts to align HIV/AIDS testing, counseling and treatment with these services, in particular, FP. The USG will work closely with the NPHCDA to encourage leadership in this effort at federal, state and LGA levels and ensure sustainable PHC services. An overall goal is to build skills in planning, implementation, coordination and monitoring of PHC services within the NPHCDA at federal and state levels, and in related state government agencies.

USG MNCH, RH and FP interventions have focused on PHC and referral facilities for some time in order to bring critical, quality services as close to communities as possible and increase service availability, access and use. PEPFAR - a health service delivery program that needed to establish and quickly scale up treatment – originally utilized tertiary and secondary level facilities; more recently, it has decentralized treatment to PHCC level. PEPFAR will accelerate decentralization of HIV/AIDS services to the lowest levels possible under GHI, with greatest emphasis on PHCCs – and this has been agreed upon by both the GON and U.S. in the Partnership Framework and Partnership Framework Implementation Plan. Services currently available primarily at secondary and tertiary institutions account for only 14 percent and 0.2 percent respectively of all facilities. A major thrust of this initiative, therefore, will be to scale up PMTCT services at sub-national levels and particularly in PHCCs, in order to achieve wider PMTCT coverage and utilization.

The USG will engage in a comprehensive and rigorous program in full support of the GON's own plans to revitalize PHC through implementation of a minimum integrated package of care that would ensure availability of drugs and equipment at all levels, strengthen the referral system, foster collaboration with the private sector, and develop and institutionalize quality assurance models by:

- **Strengthening health infrastructure and public health laboratory capacity, with a special focus on PHCCs and referral facilities:** Dilapidated, dysfunctional facilities with limited diagnostic or treatment capabilities and insufficient capacity to effectively refer patients to higher levels of care do not attract clients let alone serve them. GHI activities will center on upgrading facility structures and processes with a priority on those at the PHC level. PHC and network assessments will be carried out to focus on and prioritize PHCCs that are in proximity to current PEPFAR networks of secondary and tertiary facilities, in order to ensure that candidate PHCCs can be easily incorporated into existing laboratory and referral networks. The assessments will address current infrastructure, staffing and service delivery profiles of PHCCs; their level of inclusion into existing referral, laboratory and

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supply-chain networks; and the level and types of investments required to begin delivery of a standard minimum integrated package of priority health interventions.

PHCs will be selected for coordinated GHI investments in infrastructure, logistics, laboratories and equipment to enable delivery of aligned or integrated services. A key objective is to develop a network of public health reference laboratories to ensure uniform quality and consistency. Later-stage investments will emphasize institutionalization of quality improvement processes, including standardization of laboratory testing procedures and implementation of expanded and harmonized laboratory quality assurance/quality control (QA/QC) systems.

Federal, state and local government entities with a legislative mandate to support PHC service delivery will be considered for direct funding where possible and appropriate. These investments will be coordinated via the NPHCDA standing committee on decentralization, which has the role of assessing and selecting PHCCs for incorporation into the decentralization strategy. This coordination will exploit synergies among HIV, MNCH, RH, FP, malaria, and TB investments from USG and other DPs/donors, including DFID, the World Bank, GAVI, GFATM and the U.N. system.

In a complementary effort, in collaboration with the NMOD, the USG will work to strengthen the network of Military clinics by assisting in the development of a continuous quality improvement program; providing state-of-the-art equipment; fortifying referral and tracking systems particularly those that contribute to the greater integration of HIV/AIDS, FP/RH and cervical cancer screening services; and building capacity for pharmacy management and procurement of commodities.

- **Increasing availability of essential drugs, health commodities, and supplies at all facility levels:** Successful decentralization of services to the PHC level will depend heavily on strengthening forecasting, procurement, warehousing/storage, handling, distribution and monitoring systems at federal and state levels that must collaborate to ensure that PHCCs are regularly stocked with drugs, vaccines, contraceptives, medical supplies, and equipment. In contrast to the private sector Society for Family Health (SFH) warehouse established under the USG social marketing project, which is in excellent condition and distributes effectively to market vendors and communities, the public sector warehouse infrastructure in states and LGAs is owned and managed by the GON and is in poor repair. In many locations, the existing warehouses are unable to handle the volumes of product required for PHCCs to deliver a minimum package of services that includes HIV/AIDS.

The USG has made significant investments in strengthening the GON's ability to develop and operate reliable and sustainable procurement and distribution systems at federal and state levels to ensure dependable commodity supplies, although HIV/AIDS, malaria and FP/RH commodities procured with USG resources are still largely warehoused and distributed through USG IPs. For a period of about four

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years, up to 2010, SFH warehoused and distributed social marketing contraceptives provided by the USG and condoms supplied by DFID throughout the country, helping to compensate for contraceptive stock-outs in the public sector.

The thrust of future efforts in this area will be to consolidate gains and facilitate the process of transitioning distribution of PEPFAR-funded commodities to the GON system while accelerating improvements in commodity logistics across all health areas building on past successes. To do so, the USG will provide technical assistance and build capacity at federal, state and facility levels for forecasting, procurement, distribution system improvements, commodity logistics management, stock monitoring and assessments of the effectiveness of the logistics system. The USG will explore how different commodities can be funded, procured and delivered together to PHCCs, to the extent that is cost-effective, with an eye towards eventually having at least an aligned and coordinated system.

- **Strengthening integrated data collection, analysis and use:** A functional HMIS that operates across health elements and levels of the health system is critical to the functioning of a health system overall. Nigeria's current system fails on all counts with multiple and sometimes conflicting systems at state and national levels. However, recent actions taken by the GON to institutionalize decentralized health information systems (DHIS) that aggregate data up to the federal level are a step in the right direction. The USG will continue to support the roll out of the DHIS through GHI and will work with local institutions, including universities and private sector consultancy services, to build capacity for the generation and use of the data. The USG will also support operations research, surveys, surveillance and other forms of data-gathering and research for decision-making.

Also, the USG will provide direct technical assistance to consolidate and rationalize the various sectoral health and disease prevention/treatment data collections systems, and develop management information systems aligned with GON systems to support planning, implementation, monitoring and evaluation of policies and programs in target states. Finally, through GHI, the USG will assist private sector clinic-based service providers and social marketing staff and vendors to improve data collection, reporting and analysis.

- **Increasing quality and availability of private sector services:** The private sector will likely remain a dominant player in the health sector even with a revitalized public sector. In the past, private sector outlets (clinicians including nurses, midwives and CHEWs as well as physicians; pharmacists; patent medicine vendors; traditional healers; and other private sector providers) have had limited ability to provide information, counseling, outreach and communications to encourage behavior change or a wide range of low-cost and highly effective health products. Information, counseling and quality of care improvements that donors fund through the public health system typically have not been extended to improve private sector services. The USG's social marketing project and DFID's complementary support for social marketing have been the exception. Social marketing has provided

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consumers with high quality, price-subsidized contraceptives and associated information.

The USG will expand social marketing through GHI to include not only a full range of contraceptives but also selected high impact health products such as oral rehydration solution (ORS). The USG will also more broadly enhance the overall quality of private sector clinic-based FP services and has started to discuss integrating MCH services in USG-assisted private sector clinics as well. In addition, the USG will train and supply community-based distributors and depot-holders in states and communities with low CPR and that lack access to functioning PHCCs or nearby markets, in order to provide community-based access to commodities, information and counseling. Under the GHI, the USG will expand access to micro- and small business bank loans through a Development Credit Authority guarantee, to enable clinic-based FP providers to expand their practices and improve the quality of their services.

- **Strengthening community-based health promotion, service provision and linkages between communities and facilities:** Nigeria has a very weak community health system. Although the GON's PHC policy intends that CHEWs provide outreach to communities, due to a shortage of clinic-based midwives, CHEWs remain stationary in PHCCs and function as clinic managers.

The decentralization and alignment or integration of HIV/AIDS services at the PHCC level, and the general strengthening of the PHCCs, presents a significant opportunity for improving health promotion and service provision in communities as well as in primary care and referral facilities. As noted earlier, the decentralization of HIV/AIDS services and integration process will entail a substantial, phased effort to increase PHCC functionality through infrastructure upgrades, referral system advances, laboratory capacity expansion, commodity logistics and management improvements, and enhancements to training institutions and curricula that will increase the quality of health workers. HRH activities will influence recruitment and deployment of midwives and CHEWSs, and therefore free up CHEWs to perform the outreach function originally intended.

To ensure that no opportunity is missed to reach a woman or child with PMTCT, antenatal care and FP services, PMTCT services will be delivered using a four-pronged approach: 1) preventing HIV infection; 2) preventing unintended pregnancies; 3) preventing transmission of HIV from mothers to their infants; and 4) ensuring follow-up for linkages to long-term prevention, care and support services for mothers, their children and families. Community-level communications and counseling activities will create demand and produce an increase in PMTCT, ANC and FP attendance, facility-based deliveries and utilization of other related services. Efforts to engage men in PMTCT and HIV counseling and testing through the use of innovative approaches (e.g. "Love Letters" and "Champion Fathers") will increase access for their wives to ANC including FP. Clinic- and community-based

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services initiatives will produce opportunities to address gender-based violence (GBV).

Community-based services will be progressively established with USG support through GHI, accompanying improvements in the functioning of PHCCs. One important step the USG will take is to promote implementation of GON-adopted “task-shifting” policies and guidelines and provide technical assistance to systematize accreditation and recognition of CHEWs, reinforcing their outreach and community-support functions. The USG will also expand social marketing to include non-product-specific FP and health messaging and community-based delivery of limited key services in communities that lack health and have very poor health profiles.

- **Strengthening capacity in epidemiology, disease surveillance, and response:** Infectious and communicable diseases are the cause of many deaths annually. Effective prevention and control requires a well-functioning surveillance system that is sensitive enough to identify early warning signs of disease outbreaks, and a health system that is prepared for and capable of investigating and adequately responding to outbreaks and epidemics in a timely manner. The GON developed a national policy on Integrated Disease Surveillance and Response in 2005 and revised the technical guideline in 2009. At present; however, neither the disease surveillance system nor the health system as a whole can perform these tasks optimally. Although the policy and technical documents provide guidance and a framework for planning, implementation, monitoring and evaluation of an integrated disease surveillance and response system by all levels of the GON, implementation remains limited.

The USG provides technical assistance and support to build national capacity in public health epidemiology, surveillance and response. It supports the FMOH’s Field Epidemiology and Laboratory Training Program (NFELTP) short course that has produced over 250 graduates, and a two-year full-time training and service program in applied epidemiology that has produced 56 graduates. This training will continue to produce experts to respond to national and sub-national disease prevention and control needs, as demonstrated by the graduate’s response to several high profile disease outbreaks across the country including renal failure outbreak among children (diethylene glycol poisoning), lead poisoning, and cholera outbreaks.

Through its Military partnership, the USG is poised to extend to surveillance of other emerging and re-emerging infectious diseases of relevance to the Nigerian Military and the West African sub-region. It continues to promote technical collaboration and support in clinical, laboratory diagnostic and research capabilities through international cooperation and exchange programs. This Nigerian-driven collaboration is well placed for transition of PEPFAR activities to the NMOD program as demonstrated by leveraged funding from both governments. The enhanced capability and assets position the Nigerian Military services to play a

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significant role in national health care delivery, confrontation of emerging epidemic diseases, and emergency preparedness.

The USG plans to continue strengthening public health systems, epidemiology and surveillance through technical support and direct assistance to the FMOH, building on initiatives and achievements to date. The USG will continue to support the implementation of the integrated disease surveillance and response (IDSR) system and build capacity for monitoring, early detection, preparedness and response to diseases of national and international public health importance including pandemic influenza and other health emergencies. Support under GHI will be provided in development, implementation and testing of public health emergency response plans both at the national level and in target states. The “One Health Principle” will be promoted by encouraging cross-disciplinary approaches to human and animal health research and service delivery as appropriate. Technical assistance also will be provided to the GON to develop and implement environmental health intervention and emergency control strategies such as lead poisoning in target states.

3.3 Strengthened leadership, management, governance and accountability

The GON recognizes that leadership and governance are key to accomplishing the goals, objectives and results in the NSHDP in all articulated priority areas. Through GHI, the USG will pursue coordinated activities to build the capacity of officials at all levels of the GON to lead and manage health sector reforms responsive to the NSHDP. Recent investments in this area have been relatively small scale and focused on health element-specific leadership and governance issues. Although such efforts will continue and be expanded, they will be complemented and accelerated by an integrated policy project to build governance capacity across health and non-health areas. The USG aspires through this more comprehensive set of activities to:

- **Increase political commitment and capacity at national, state, LGA, ward and community levels, and in the private sector, in order to implement the NSHDP:** Many excellent health policies and strategies exist. However, few have been implemented and thus have had little impact on health system functionality or health outcomes. The USG will expand activities to transfer to national, state, LGA, and ward officials, public and private sector program managers and community leaders, the skills and competencies needed to effect change through implementation of the NSHDP. The focus will be on expansion and institutionalization of strategic leadership, planning and management in practical applications within the broad context of the public health system. The USG has already been working with traditional, religious, political, and civil society leaders at all levels including the community to increase policy dialogue and understanding on the part of decision-makers of community health priorities. In addition, the USG through GHI will support the establishment and/or expansion of independent pressure groups and consumer action association to represent community views and needs on health care and to encourage policy debate. Special attention will be

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given to including significant numbers of women in these activities and as beneficiaries of these activities.

- **Improve coordination and linkages between levels of the health system:** Nigeria's health system is highly fragmented and characterized by cumbersome institutional arrangements and divided GON responsibilities. Often this means that health is everyone's responsibility and no one's responsibility at the same time which results in duplication of efforts at best and inaction at worst. The USG through GHI will provide support to strengthen linkages and collaborations between GON departments with public health and PHC mandates at the different levels to counter these tendencies. The USG will build the capacity of GON bodies at all levels to improve financial management and oversight of service delivery by clearly delineating management and oversight functions and tasks, and lines of communication particularly those intended to increase coordination.
- **Improve resource allocation and expenditures:** Nigeria has sufficient GON revenues to support a good health care system, yet the health sector remains seriously underfunded. Where budgets exist the minimal resources that do get allocated are disbursed late or expended inconsistently because the process is complicated and often incomprehensible. As an important priority through GHI, the USG seeks to increase the GON's regular budget contribution to the health sector at all levels to support NSHDP goals and activities, and to produce results. The Partnership Framework Agreement establishes ambitious targets specifically related to the GON's contribution to HIV/AIDS. The GON commitment to fund 50 percent of HIV/AIDS spending by 2015 will be continuously monitored by the USG, other DPs/donors and civil society.

The USG has also strongly encouraged the GON to budget for multi-year procurement of contraceptives that have been provided almost exclusively by donors. In 2011, the GON contributed a first-ever US\$3 million for procurement of contraceptives through UNFPA as a result of coordinated advocacy by the USG and donor partners and based on USG technical assistance provided to the FMOH for commodity forecasting in 2010. However, this is not yet a multi-year, regular budget funding commitment and, therefore, under GHI, strong advocacy efforts must be redoubled.

The USG intends to use all available fora and opportunities to advocate for increased GON financial commitments for health to meet the GON's own expressed NSHDP goals, objectives and intended results. The USG will also build on excellent collaborative relationships with CSOs to enlarge the capacity of civil society to provide leadership in this regard. In addition, in collaboration with other DPs/donors active in these areas, the USG will build the capacity of federal and state agencies/departments to develop appropriate budgets and release funding in a timely manner, carry out National Health Accounts and Expenditure Reviews, national and state HIV/AIDS Spending Assessments and other sector-specific audits, to track and substantiate that funding is used for its intended purpose and is

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efficiently allocated, disbursed and expended. Other key USG-supported activities to improve financial resource management may include providing technical assistance to strengthen the public financial management system, exploring PHC financing mechanisms and piloting performance-based financing.

- **Strengthen organizations, mechanisms and systems for transparency, accountability and responsiveness:** As mentioned above, the GON is not structured well for openness and participation which contributes significantly to the weak governance of the health system. It will take time for the public interest in openness and participation demonstrated in the recent national elections to be reflected in GON operations. Meanwhile, the USG through GHI can promote reforms that improve coordination and linkages among GON entities, enable and encourage greater transparency and accountability, and provide assistance that enables communities to become active in health advocacy and service provision.

At present, community empowerment is limited. Although there are many CSOs (many of which work with USG support in various capacities), few embrace their roles as watchdogs or have the skills to perform that role effectively. A small number of structures that enable community participation exist such as Ward Development Committees (WDCs) and Village Health Committees (VHCs), but are not consistent across all communities and some are not functional. Primary GHI actions in this area will be to support the revitalization of the WDCs that had been established to act as advocates to the GON for better services; strengthen CSOs and other NGOs for advocacy purposes; mobilize community involvement to interact with GON bodies and personnel to both demand improved health care and support facility improvements; and provide skills and support to communities to provide some of their own basic health care. The GHI will build CSO capabilities to represent community constituencies to GON decision-making bodies and to mobilize other support in the private sector (e.g. to work with health professional societies and associations, and health unions), particularly to advocate for increased funding for and access to services. Special emphasis will be placed on supporting women-led groups in line with the women, girls and gender equality principle of GHI. The USG will build their capacity to promote the rights of women and bring the views of women on health care to WDCs and to the GON at all levels, and to work effectively with other CSOs and advocacy organizations.

- **Enhance the policy environment:** The GON has a plethora of policies, strategies and plans that in large part sit on federal- and state-level GON shelves. The NSHDP is only one of them, albeit an extremely important one. It provides an overarching framework for the numerous other health sector-specific policies and strategies, not yet implemented, that are critical to the success of USG programs. For example, the GON's own public-private partnerships policy seeks to put in place the regulatory structure that will allow leveraging of the potential of the private sector to improve the availability and use of quality health services. Without a clear GON commitment and action to implement this policy, USG efforts to support contracting out and expansion of private sector health care services will proceed slowly. The INMNCH is

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another shelf-bound document at the moment. The USG will put greater effort through GHI into understanding the reasons why these important policies, strategies, and plans have not been implemented and will advocate more effectively with the GON to implement them. The USG will offer assistance in implementation in collaboration with the private sector and other DPs/donors, as resources permit.

A fundamental barrier to the implementation of such policies is the limited capacity of CSOs to monitor and evaluate these policies, strategies and plans and then effectively interact with the GON and the media on implementation. An emphasis of GHI policy programming will be efforts to build this capacity. For example, the USG assisted in the development of an advocacy tool demonstrating discussing the relationships between FP and MCH outcomes and a second tool focusing on the relationships between population changes, environmental changes and security (the “RAPIDS”), which will be used by FP advocates to influence GON program and budget decisions. The USG will continue to educate the media on health issues through the behavior change communications (BCC) component of the FP and health social marketing project and through a Hausa language broadcasting project. The USG will also train CSOs in the use of “report cards” and other monitoring and evaluation tools and approaches to increase the effectiveness of interactions with the GON on health issues including resource constraints.

4. Monitoring, Evaluation and Learning

The Nigeria GHI Strategy Matrix (Appendix A) and Results Framework (Appendix B) will guide implementation of the GHI Country Strategy through the measurement of key inputs, outputs, outcomes and impacts. The USG will support many measurement activities to produce dependable data to judge results in collaboration with the GON, private sector and other DPs/donors. For example, the GON, USAID, UNFPA and UNICEF provide the resources for and work together on dependable national and state-level surveys and surveillance networks to measure progress in health programs - the NDHS, the MICS, the NICS, the NARHS, the IBBS, the Malaria Indicator Survey and many others. The highly-respected NDHS 2008 will continue to serve as the primary tool for collecting data on impact-level health indicators including maternal, neonatal, under-five health and HIV/AIDS status. The data from the next MICS in 2012 and the NDHS round in 2012-13 will provide the baseline measurements for almost all health programming affecting women and children in the coming years and will be used to measure progress towards achievement of GHI objectives. Under GHI, even greater effort will be put into data analysis and its dissemination and use in decision-making by the GON, the private sector including communities and CSOs, and the media.

In addition, the National Strategic Framework II and the Partnership Framework include the goal to strengthen and embed a sustainable systems-based approach in efforts to deliver a cost-effective, multidimensional monitoring and evaluation system which supports the continuous improvement of the national response to HIV/AIDS. The national monitoring and evaluation (M&E) system is designed to support continued improvements

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of the national HIV response by providing timely information on the nature of the epidemic, behaviors and access to quality of services by the general population and key target groups including women, children and most-at-risk groups. Output level program data on prevention, care, and treatment activities across the health sector is generated at service delivery points through the national HMIS. As previously stated, the USG through GHI will be working closely with the GON and other DPs/donors to strengthen the national HMIS. The USG will also build the capacity of private sector service providers to produce dependable and verifiable data on MNCH, RH, FP and disease prevention/treatment so that national data more accurately reflects the contributions of the private sector.

5. Communications and Management Plan

The GHI is guided by the U.S. Ambassador. He has the responsibility to ensure that the USG implements GHI in accordance with GHI principles and that the USG Inter-Agency Team has established and is maintaining effective collaboration on implementation in the context of a “whole of Government approach.” The Ambassador will clear and submit all GHI “deliverables” including the Country Data Slide Set, Results Framework, and Country Strategy Matrix which provide the basis for the GHI Country Strategy, to the GHI Executive Director in the U.S. Department of State. The Ambassador and Executive Director will share them with USG collaborating organization and agency headquarters in the U.S.

The Ambassador will designate a GHI Lead to serve a convening function, as needed to bring together the USG organizations/agencies working in health to monitor GHI implementation and ensure that results are captured in timely submission of an annual progress report as required by the GHI Executive Director Coordinator. Existing Country Team (weekly) and “Investing in People” (bi-monthly) meetings between the USG organizations/agencies and the Ambassador will serve as opportunities for reporting on GHI progress. The USG will also use existing GON, private sector and DP/donor mechanisms and meetings to report on GHI progress. As part of its public advocacy efforts, the U.S. Embassy’s Public Affairs Office will support the USG GHI Inter-Agency Team with outreach on USG health programs in Nigeria to the media as deemed necessary and appropriate by the Ambassador.

6. Linking High-Level Goals to Programs

Focus on Women, Girls and Gender Equality: For practical health-care reasons described throughout this report, a focus on women, girls and gender equality is critical to ensuring GHI success. The USG will address social, economic, legal and cultural determinants of health through a multi-sectoral approach that utilizes multiple community-based programmatic approaches such as behavior change communication, community mobilization, advocacy, and engagement of community leaders/role models to improve health for women and girls. For example, the USG will work to strengthen the capacity of institutions that set policies, guidelines, norms and standards that impact access to, and quality of, health-related outreach and services to improve health outcomes for women and girls and promote gender equality.

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Under GHI, the USG will emphasize programs that encourage delays in pregnancy among adolescents and empower young women. Additionally, the USG will facilitate access to a wide range of FP services for women of reproductive age that provide safe and effective choices to space births and preserve the health of women of childbearing age, ensuring equitable access to essential health services in facilities and at the community level. A major USG goal is to decrease the high national and state-specific MMRs. The survival of women is important, for its own sake, to ensure the full participation of women in society and because reduced maternal mortality and morbidities directly improves family health and welfare. Reducing the number of unintended pregnancies, unsafe childbirth, and episodes of malaria, TB, sexually-transmitted infections, and HIV/AIDs are all gender equality priorities under GHI. The USG through GHI will also intensify support for the integration of the PMTCT program with other MNCH programs. Most PMTCT program elements parallel a safe motherhood program including quality ANC, normal labor and delivery, prevention and management of emergency obstetric complications, postpartum care and FP, and infant feeding support.

The USG will continue to promote policies, programs and advocacy that support gender equality. For example, a USG-assisted Nigerian IP works with female as well as male traditional and religious leaders in the northern to introduce them and their constituencies to the services that will improve the health profile for girls and women. This project has reduced opposition to FP in the north. The USG uses community-based programs, including the social marketing of contraceptives and health products in markets close to communities, and community-based distribution of commodities. A USG project has encouraged the formation of savings groups at village level to enable women to pool their assets to transport neighbors to a health facility when there is a pregnancy-related emergency.

The USG works on creating a favorable policy environment to support gender programming by raising gender concerns and gender biases with GON officials and project personnel. For example, the HIV/AIDS “Champion Fathers” initiative in PMTCT program that engages males has been supported by the USG and will be expanded to address other health concerns that affect girls, women, male partners, and families. The USG analyzes data to expose gender issues (e.g. a secondary analysis of data on orphans and vulnerable children was carried out to determine gender dimensions). Harmful practices such as adolescent pregnancies, multiple concurrent partnerships, forced marriages and stigmas that threaten the health of women have been addressed and gender-based violence has been incorporated in PMTCT counseling for clients and their partners. These initiatives will be continued and expanded under GHI.

The USG collaborates and interacts on gender issues with a range of GON bodies that include the FMOH, the Ministries of Women’s Affairs, Local Government and other federal and state-level GON and private sector groups. The goal of these efforts is to increase the participation of healthy girls and women in all stages of programs and provision of services; strengthen the capacity of institutions to understand the health status of girls and women and to set guidelines; establish policies and implement strategies to improve the

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status of girls and women; increase access to resources and services; and improve measurable health outcomes for girls and women.

Encourage country ownership and invest in country-led plans: The USG participated at the invitation of the GON in the development of the NSHDP 2010-15. In collaboration with other DPs/donors, the USG has been asked by the GON to support its attempts to implement the program and achieve targets in the NSHDP's Results Framework. The GON's decision to remove client-level charges for contraceptives and to strengthen the contraceptives distribution system at the level of states and facilities has already produced increases in demand for FP at service sites throughout the country, and stock-outs have been eliminated in 2011. The USG participates at the invitation of the GON in innumerable subject-specific GON/donor expert group and coordinating meetings.

The FMOH and state governments have invited and collaborated with the USG and other DPs/donors in the design and implementation of state-level integrated MNCH, RH, FP, and disease prevention/treatment projects. The FMOH participates in donor coordination group meetings on PHC and HIV/AIDS. The GON either leads or joins with the USG and other DPs/donor partners in producing program assessments and evaluations. For example, the FMOH and the USG collaborated in a recent re-assessment of fistula prevalence and will work together on community assessments of incidence and prevalence to make strategic revisions in the fistula care and treatment strategy.

The USG/GON Partnership Framework Agreement emphasizes country ownership of HIV/AIDS programs and includes a GON commitment to provide substantial additional budget resources for HIV/AIDS. The GON has taken steps to improve its data information systems, commodities, and logistics systems. The GON has extended universal access to HIV/AIDS services; increased integrated and wraparound programs on HIV prevention, treatment and care and support; integrated HIV/AIDS and MCH/FP at respective service sites in the public sector health system; and reached out to underserved and marginalized populations at the PHC level through, for example, decentralization of ART from tertiary to secondary and primary care public sector service sites.

Promote research and innovation: Research and evaluation provides the evidence base for all health decisions and as such is central to GHI. The USG is well positioned to conduct research and produce strong evaluations given its presence in health services across the country. It will continue to promote quality data collection practices, encourage evidence-based decision-making and strive for innovation through clinical, therapeutic and operational research. (See Appendix C)

The USG has facilitated reference laboratories and training centers, which will continue to host national and international training, programs, and support medical research. The number of research protocols submitted, reviewed and monitored by US supported ethical review boards is expected to increase.

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Conclusion

The 2012 U.S. Mission Strategic Resource Plan states that Nigeria is "one of the USG's most important strategic partners on the Continent because:

- Its long term political stability, grounded in democratic, transparent, and effective governance, is essential to stabilize and inspire West Africa and the continent as a whole;
- Its leadership role in peacekeeping and its influential voice in regional and multilateral forums are important to a wide range of USG strategic objectives, from counter-terrorism to women's development;
- Its proven reserves of 36 billion barrels of oil (8-9 percent of U.S. imports), and 184 trillion cubic feet of natural gas, are vital to our trade and investment; and
- Its huge potential as an emerging market, especially for agricultural goods and information technology, is largely untapped.

Confounding Nigeria's ability to achieve its full potential is its acute political, economic, and social fragility due to a daunting array of long-term problems: 1) endemic corruption at all levels of society; 2) poor governance; 3) grossly inadequate infrastructure for a country, particularly power and transportation; 4) weak health and education systems; 5) widespread unemployment in an unbalanced economy that ranks Nigeria at 114 on the UNDP human poverty index; 6) recurring outbreaks of sectarian, ethnic, and communal tensions and violence in multiple parts of the country; 7) high rates of crime; 8) growing efforts by external terrorist groups to expand their profile in Nigeria."

The U.S. has a long-standing strategic interest in Nigeria and has been providing development assistance for more than 50 years. The USG partnership in supporting Nigeria is based on five socio-political-economic arenas which the U.S. deems essential to the country's future prosperity: governing justly and democratically; investing in people (i.e., health, education, etc.); improving peace and security; promoting food security and agriculture development; and promoting economic growth and sustainable development. Improvements in health care delivery under GHI or any other health initiative will depend on progress in these arenas and on political will and mature governance, and many Nigerians have invested their hopes in a newly-elected Government. The GHI, therefore, comes at a critical moment, which provides the U.S. and its health partners an opportunity to forge stronger relationships with the GON, the private sector and local communities and together build a more effective, self-sustaining health system and reduce the very high rates of maternal and child mortality and morbidities.

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Appendix A: Nigeria Global Health Initiative Strategy Matrix

Improved Human Resources for Health				
GHI GOAL	GON GOALS/TARGETS FROM THE NSHDP (2010-2015)	KEY PRIORITIES FROM THE NSHDP (2010-2015)	USG INTERAGENCY KEY PRIORITY ACTIONS AND INITIATIVES <u>NOTE: COLUMN 5 INDICATORS DO NOT DIRECTLY CORRESPOND TO EVERY KEY PRIORITY ACTION/INITIATIVE IN COLUMN 4.</u> <u>ALSO, WHERE POSSIBLE DATA WILL BE DISAGGREGATED BY GENDER.</u>	KEY INDICATORS <u>NOTE: HEALTH IMPACT INDICATORS WILL BE REPORTED ON USING DATA FROM THE MULTI-INDICATOR CLUSTER SURVEY 2012 AND THE NIGERIA DEMOGRAPHIC AND HEALTH SURVEY 2012-13 AND ARE NOT REFERENCED HERE.</u>
Reduce maternal mortality by 30% across assisted countries	Decrease maternal mortality rate Baseline: 545/100,000 (2008 NDHS) Target: 136/100,000	Implementation of the National Human Resource Policy	Improve human resource planning and management Nationally <ul style="list-style-type: none"> Build the capacity of the GON to effectively oversee and forecast health workforce needs and requirements through evidence-based planning, distribution, and management Collaborate with the NPHCDA and state and local government institutions to develop effective staffing strategies and policies for PHCs Support the introduction and utilization of staffing norms and establishment of coordinating mechanisms for consistency in HRH planning and budgeting Provide technical assistance to strengthen the Human Resource Information System (HRIS) Pilot innovative mechanisms for retaining health workers in rural areas <u>In target states</u>	Input <ol style="list-style-type: none"> Number of professional bodies and training institutions provided with technical assistance on HRH training and regulation Output <ol style="list-style-type: none"> Number of public/private health care workers, including community health care extension workers (CHEWs) and para-social workers, who successfully completed (respectively)- an in-service and/or pre-service training program supported by the USG (disaggregated by program area and profession) Number of community-based health workers trained to provide high
Reduce under-five mortality rates by 35% across assisted countries	Reduce under-five mortality rate Baseline: 157/1000 live births (2008 NDHS) Target: 75/1000 live births	Supporting lower levels of government (state, LGA, etc.) to develop HRH plans		
	Proportion of 1 year old immunized against measles Baseline: 41.4% (2008 NDHS) Target: 95%	Establishing a system of continuing professional development		
Reduce child undernutrition by 30% across assisted food insecure countries	Reduce prevalence of children under five who are underweight Baseline: 27.1% (2008 NDHS) Target: 17.9%	Addressing critical human resource shortages in some parts of the country		
		Task-shifting		
		Periodic curriculum		

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Improved Human Resources for Health				
GHI GOAL	GON GOALS/TARGETS FROM THE NSHDP (2010-2015)	KEY PRIORITIES FROM THE NSHDP (2010-2015)	<u>USG INTERAGENCY KEY PRIORITY ACTIONS AND INITIATIVES</u> <i>NOTE: COLUMN 5 INDICATORS DO NOT DIRECTLY CORRESPOND TO EVERY KEY PRIORITY ACTION/INITIATIVE IN COLUMN 4.</i> <i>ALSO, WHERE POSSIBLE DATA WILL BE DISAGGREGATED BY GENDER.</i>	<u>KEY INDICATORS</u> <i>NOTE: HEALTH IMPACT INDICATORS WILL BE REPORTED ON USING DATA FROM THE MULTI-INDICATOR CLUSTER SURVEY 2012 AND THE NIGERIA DEMOGRAPHIC AND HEALTH SURVEY 2012-13 AND ARE NOT REFERENCED HERE.</i>
Prevent 54 million unintended pregnancies by reaching a MCPR of 35% across assisted countries; reducing from 24% to 20% the proportion of women aged 18-24 who have their first birth before age 18	Increase MCPR Baseline: 9.7% Target: 30%	reviews by training institutions and regulatory bodies	<ul style="list-style-type: none"> Institutionalize supportive supervision by building capacity of managers and assisting with the adaptation and dissemination of tools and guidelines Provide technical assistance and build state government capacity to determine minimum numbers of staff that need to be recruited and deployed at peripheral levels 	impact basic services at the household and community levels with USG support (paid or volunteers) <u>Process</u>
Support the prevention of more than 12 million new HIV infections; provide direct support for more than 4 million people on treatment; support care for more than 12 million people including 5 million OVC	Reduce the incidence of HIV (NSF2) Reduce HIV prevalence among population aged 15-24 years Baseline: 19.4% (2007 MICS) Target: 5%			4. % of states with costed HRH plans 5. % of health facilities/ institutions reporting consistently to the national HRIS system <u>Outcome</u>
Halve the burden of malaria for 450 million people	Increase percentage of children under five sleeping under insecticide treated bed nets Baseline: 5.5% (2008 NDHS), 29% (2010 MIS) Target: 60%			6. Density by state of HRH categories (physicians, nurses, midwives, CHEWs, epidemiologists, others) per 1000 population 7. Norms and standards for professional practice developed together by levels of GON, regulatory bodies, and professional associations 8. Number of submitted protocol violations

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Improved Human Resources for Health				
GHI GOAL	GON GOALS/TARGETS FROM THE NSHDP (2010-2015)	KEY PRIORITIES FROM THE NSHDP (2010-2015)	<u>USG INTERAGENCY KEY PRIORITY ACTIONS AND INITIATIVES</u> <i><u>NOTE: COLUMN 5 INDICATORS DO NOT DIRECTLY CORRESPOND TO EVERY KEY PRIORITY ACTION/INITIATIVE IN COLUMN 4.</u></i> <i><u>ALSO, WHERE POSSIBLE DATA WILL BE DISAGGREGATED BY GENDER.</u></i>	<u>KEY INDICATORS</u> <i><u>NOTE: HEALTH IMPACT INDICATORS WILL BE REPORTED ON USING DATA FROM THE MULTI-INDICATOR CLUSTER SURVEY 2012 AND THE NIGERIA DEMOGRAPHIC AND HEALTH SURVEY 2012-13 AND ARE NOT REFERENCED HERE.</u></i>
Contribute to the treatment of a minimum of 2.6 million new sputum smear positive TB cases and 57,200 MDR cases of TB; contribute to a 50 percent reduction in TB deaths and disease burden relative to the 1990 baseline	Proportion of TB cases cured under DOTS Baseline: TBD Target: 80%		<p>and response frontline staff at national and subnational levels</p> <ul style="list-style-type: none"> • Support in-service competency-based clinical and non-clinical trainings in range of GHI priority health areas in an integrated manner where appropriate • Support the development of continuous professional education system <p><u>In target states</u></p> <ul style="list-style-type: none"> • Institute refresher training for CHEWs and midwives, and other critical community and PHC-level health workers • Conduct training in high impact services • Increase the number of community based health workers that can provide high impact services at household and community levels <p><i>Implement the HRH policy</i></p> <p><u>Nationally</u></p> <ul style="list-style-type: none"> • Support implementation of the national HRH strategy and targets • Strengthen capacities of states and LGAs to access and implement guidelines and policies related to HRH 	<p>reviewed, monitored, and resolved by ethical review boards including IRBs and HREC receiving USG support</p>

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Improved Human Resources for Health				
GHI GOAL	GON GOALS/TARGETS FROM THE NSHDP (2010-2015)	KEY PRIORITIES FROM THE NSHDP (2010-2015)	<u>USG INTERAGENCY KEY PRIORITY ACTIONS AND INITIATIVES</u> <u>NOTE: COLUMN 5 INDICATORS DO NOT DIRECTLY CORRESPOND TO EVERY KEY PRIORITY ACTION/INITIATIVE IN COLUMN 4.</u> <u>ALSO, WHERE POSSIBLE DATA WILL BE DISAGGREGATED BY GENDER.</u>	<u>KEY INDICATORS</u> <u>NOTE: HEALTH IMPACT INDICATORS WILL BE REPORTED ON USING DATA FROM THE MULTI-INDICATOR CLUSTER SURVEY 2012 AND THE NIGERIA DEMOGRAPHIC AND HEALTH SURVEY 2012-13 AND ARE NOT REFERENCED HERE.</u>
			<p><u>In target states</u></p> <ul style="list-style-type: none"> • Support development of HRH plans at state and LGA levels <p><i>Increase the capacity of professional and technical associations/regulatory bodies</i></p> <ul style="list-style-type: none"> • Build capacity of associations/regulatory bodies to set norms and standards for practice, training, including continuing education and facility accreditation and quality assurance including for laboratories • Build capacity of associations/regulatory bodies to influence policy development and implementation • Build capacity of national and subnational regulatory bodies (e.g., National Health Research and Ethical Committee [HREC] and IRBs) to oversee and ensure understanding of and adherence to human subject protections in research and service delivery 	

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Improved Human Resources for Health				
GHI GOAL	GON GOALS/TARGETS FROM THE NSHDP (2010-2015)	KEY PRIORITIES FROM THE NSHDP (2010-2015)	<u>USG INTERAGENCY KEY PRIORITY ACTIONS AND INITIATIVES</u> <i>NOTE: COLUMN 5 INDICATORS DO NOT DIRECTLY CORRESPOND TO EVERY KEY PRIORITY ACTION/INITIATIVE IN COLUMN 4.</i> <i>ALSO, WHERE POSSIBLE DATA WILL BE DISAGGREGATED BY GENDER.</i>	<u>KEY INDICATORS</u> <i>NOTE: HEALTH IMPACT INDICATORS WILL BE REPORTED ON USING DATA FROM THE MULTI-INDICATOR CLUSTER SURVEY 2012 AND THE NIGERIA DEMOGRAPHIC AND HEALTH SURVEY 2012-13 AND ARE NOT REFERENCED HERE.</i>
<p>Key principles: Encourage country ownership and invest in country-led plans by building capacity of all levels of GON, the private sector, and at community level to implement the HRH strategic objectives and interventions outlined in the NSHDP; build sustainability through health systems strengthening by addressing key public/private HRH issues impacting the effective delivery of highest impact interventions; focus on women, girls and gender equality by emphasizing recruitment, training, and effective deployments of women health care workers generally and in the provision of key MNCH/RH/FP services specifically to overcome a key cultural/social barrier of access to services by women and girls</p>				
<p>Key partners:</p> <ul style="list-style-type: none"> • GON entities at all levels—federal, state, LGAs—including elected and appointed officials (e.g. National Assembly; State governors, legislatures; Permanent Secretaries/Commissioners of Health and staff) and ministries, departments and agencies (e.g., Federal Ministry of Health; National Aids Control Agency; National Malaria Control Agency; National Primary Health Care Development Agency; National Institute for Medical Research; National Food and Drug Administration and Control; Federal Ministry of Agriculture and Water Resources; National Ministry of Defense; Emergency Plan Implementation Committee, etc.) • Private sector including NGOs (e.g. Family Planning Action Group; Advocacy Health; etc.); CSOs (e.g. numerous Muslim and Christian faith-based organizations operating at community level with assistance from USG-funded Development Research and Project Centre [DRPC]); and commercial entities (e.g. wholesale drug distributors through USG-funded social marketing project) • Universities (e.g., Ahmadu Bello University/Zaria; Universities of Ibadan, Usman Danfodio/Sokoto and Calabar) • Development Partners (DP) and Donors (e.g. WHO, UNFPA, UNICEF, UNAIDS, Global Fund; DFID, CIDA; Rotary International; Gates Foundation and Institute; and many other members of the two DP/Donors Groups) • Community-level leadership and community activists (e.g. political, traditional and/or religious leaders such as Emirs; village leaders; neighborhood depot holders; etc.) 				

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Improved delivery of highest impact interventions, particularly at the PHC level				
GHI GOAL	GON GOALS/TARGETS FROM THE NSHDP (2010-2015)	KEY PRIORITIES FROM THE NSHDP (2010-2015)	USG INTERAGENCY KEY PRIORITY ACTIONS AND INITIATIVES	KEY INDICATORS
Reduce maternal mortality by 30% across assisted countries	Decrease maternal mortality rate Baseline: 545/100,000 (2008 NDHS) Target: 136/100,000	Strengthening health services management Implementing the ward minimum health care package	<i>Strengthen health infrastructure and public health laboratory capacity with special focus on PHCs and referral facilities</i> <i>Nationally (with emphasis on target states)</i> <ul style="list-style-type: none"> Rehabilitate PHC centers and referral facilities Expand laboratory capacity and upgrade infrastructure by developing a network of public health reference laboratories through a controlled, phased approach to ensure uniform quality and consistency Institute and/or improve referral systems and tracking mechanisms including among military clinics Support quality improvement processes including implementation of standardized procedures for laboratory testing for priority diseases and expanded laboratory quality assurance/quality control (QA/QC) systems to meet national and international standards 	<u>Input</u> 9. Number of GON health facilities rehabilitated with USG support (disaggregated by levels) 10.% of public and private laboratories supported in the provision of comprehensive services for priority diseases and health conditions in accordance with national standards (disaggregated by type and level of service) 11. Number of USG supported public and private facilities providing basic package of high impact services in accordance with national standards and guidelines <u>Process</u> 12.% of health facilities and institutions supported by the USG that are reporting consistently
Reduce under-five mortality rates by 35% across assisted countries	Reduce under-five mortality rate Baseline: 157/1000 live births (2008 NDHS) Target: 75/1000 live births Proportion of 1 year old immunized against measles Baseline: 41.4% (2008 NDHS) Target: 95%	Increasing access to quality health services Rehabilitating health infrastructure Ensuring availability of drugs and equipment at all levels Rational use of drugs		
Reduce child undernutrition by 30% across assisted food insecure countries	Reduce prevalence of children under five who are underweight Baseline: 27.1% (2008 NDHS) Target: 17.9%	Strengthening the referral system Fostering collaboration with the private sector		
Prevent 54 million unintended pregnancies by reaching a MCPR of 35% across assisted countries and reducing from 24% to 20% the proportion of women aged 18-24 who have	Increase MCPR Baseline: 9.7% Target: 30%	Institutionalizing staff motivation and establishing quality assurance mechanisms Creating effective demand for services		

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Improved delivery of highest impact interventions, particularly at the PHC level				
GHI GOAL	GON GOALS/TARGETS FROM THE NSHDP (2010-2015)	KEY PRIORITIES FROM THE NSHDP (2010-2015)	USG INTERAGENCY KEY PRIORITY ACTIONS AND INITIATIVES	KEY INDICATORS
their first birth before age 18			<p><i>Increased availability of essential drugs and health commodities and supplies at all facility levels</i> <i>Nationally (with emphasis on target states)</i></p> <ul style="list-style-type: none"> • Provide technical assistance at federal/state and facility levels to the GON and other donors for procurement forecasting, distribution system improvements, stock monitoring and assessments of the effectiveness of the logistics system • Build the capacity of all levels of the GON for commodity logistics management • Explore how commodities can be funded, procured, and delivered together to PHC facilities <p><i>Strengthen integrated data collection, analysis and use</i> <i>Nationally</i></p> <ul style="list-style-type: none"> • Support the rollout of the DHIS as an integrated, harmonized national HMIS system • Work with GON and local institutions including universities to build capacity for the generation (e.g., operations research, surveys, surveillance), 	<p>to the national HMIS systems</p> <p>13.% of USG-assisted service delivery points experiencing stock-outs of essential drugs, contraceptives, equipment, and supplies including (ARVs, ACTs, test kits, other)</p> <p>14.% of IRBs with international certification</p> <p>15.Number of USG-supported evaluation/research studies – to be determined on issues of efficiency, effectiveness, equity, impact that facilitate decision-making for USG program improvements (disaggregated by type – e.g. surveys, surveillance, operations research, etc.)</p> <p>16.% of states with health emergency plans</p> <p>Output</p>
Support the prevention of more than 12 million new HIV infections and provide direct support for more than 4 million people on treatment; support care for more than 12 million people, including 5 million OVC	<p>Reduce the incidence of HIV (NSF2)</p> <p>Reduce HIV prevalence among population aged 15-24 years Baseline: 19.4% (2007 MICS) Target: 5%</p>			
Halve the burden of malaria for 450 million people	<p>Increase percentage of children under five sleeping under insecticide treated bed nets Baseline: 5.5% (2008 NDHS), 29% (2010 MIS) Target: 60%</p>			
Contribute to the treatment of a minimum of 2.6 million new sputum smear positive TB cases and 57,200 MDR cases of TB; contribute to a 50 percent reduction in TB deaths and disease burden relative to the 1990 baseline	<p>Proportion of TB cases cured under DOTS Baseline: TBD Target: 80%</p>			

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Improved delivery of highest impact interventions, particularly at the PHC level				
GHI GOAL	GON GOALS/TARGETS FROM THE NSHDP (2010-2015)	KEY PRIORITIES FROM THE NSHDP (2010-2015)	USG INTERAGENCY KEY PRIORITY ACTIONS AND INITIATIVES	KEY INDICATORS
			<p>analysis and use of data in health decision-making and design of evidence-based programming</p> <ul style="list-style-type: none"> Support the full roll out of the OVC database <p><u>In target states</u></p> <ul style="list-style-type: none"> Provide technical assistance to consolidate and rationalize conflicting state disease prevention/treatment data collections system Provide technical assistance to LGAs and PHCs to design and develop management information systems to support planning, monitoring, and evaluation of policies and program implementation <p><i>Increase the quality and availability of private sector services</i></p> <p><u>Nationally</u></p> <ul style="list-style-type: none"> Expand selection of subsidized products distributed through social marketing program Expand the delivery of quality high impact services through individuals at community level and private sector providers Train community-based 	<p>17.Number of HIV-positive pregnant women who received ARV prophylaxis to reduce the risk of mother-to-child transmission</p> <p>18.Number of people reached with individual or small group level HIV prevention messages that are based on evidence or meet the minimum standard with support from the USG</p> <p>19.Number of individuals who received testing and counseling (T&C) services for HIV and received their test results (including PMTCT, TB/HIV, infants)</p> <p>20.% of HIV-positive patients in HIV care or treatment (pre-ART or ART) who started TB treatment</p> <p>21.Number of MDR TB cases diagnosed and initiated on treatment</p> <p>22.Number of adults and children with advanced</p>

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Improved delivery of highest impact interventions, particularly at the PHC level				
GHI GOAL	GON GOALS/TARGETS FROM THE NSHDP (2010-2015)	KEY PRIORITIES FROM THE NSHDP (2010-2015)	USG INTERAGENCY KEY PRIORITY ACTIONS AND INITIATIVES	KEY INDICATORS
			<p>distributors and depot-holders to counsel and sell products (e.g., contraceptives, ORS, zinc, ACTs, point-of-use water treatments) in areas in selected states that lack access to PHC providers and facilities and supply them with subsidized commodities</p> <ul style="list-style-type: none"> • Support training of private sector clinic-based providers (nurses, midwives, CHEWs, physicians) in evidence-based standards • Enable banks to offer loans to providers in urban and rural areas to strengthen their ability to expand FP services through their clinics through a Development Credit Authority • Provide technical assistance to the GON and private sector to support contracting out <p><i>Strengthen community-based health promotion and service provision and linkages between the community and facilities</i> <u>Nationally</u></p> <ul style="list-style-type: none"> • Support decentralization of HIV/AIDS services by building capacity for integration of HIV/TB, ART, as well as SRH 	<p>HIV infection receiving ART (current) with USG support</p> <p>23. Number of pregnant women with known HIV status (includes women who tested for HIV and received their results)</p> <p>24. Number of eligible adults and children provided with a minimum of one care and support service</p> <p>25. Number of HIV positive adults and children receiving a minimum of one clinical service</p> <p>26. Reduction in % of HIV patients lost to follow up.</p> <p>27. % of women ages 15-49 receiving full TT vaccination</p> <p>28. % infants under 6 months exclusively breastfed</p> <p>29. Number of women of reproductive age who accessed family planning services in USG-supported facilities</p>

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Improved delivery of highest impact interventions, particularly at the PHC level				
GHI GOAL	GON GOALS/TARGETS FROM THE NSHDP (2010-2015)	KEY PRIORITIES FROM THE NSHDP (2010-2015)	USG INTERAGENCY KEY PRIORITY ACTIONS AND INITIATIVES	KEY INDICATORS
			<p>services into the primary health care network</p> <ul style="list-style-type: none"> Support provision of quality PMTCT services at PHCs promoting a holistic approach that incorporates PMTCT within the context of a safe and healthy pregnancy, delivery and postpartum care, including family planning and partner testing Support implementation of GON-adopted task-shifting policies and guidelines and provide technical assistance in the development and recognition of accredited CHWs Expand BCC component of social marketing to include non-product-specific marketing <p><u>In target states</u></p> <ul style="list-style-type: none"> Utilize the media to promote awareness of health issues and create demand for services Provide additional technical assistance to the NPHCDA to facilitate implementation of the Midwives Service Scheme (MSS) <p><i>Strengthen capacity in epidemiology, disease surveillance, and response</i></p>	<p>30.% of women with at least 4 ANC visits during the last/current pregnancy</p> <p>31.% of birth deliveries attended by skilled provider</p> <p>32. % of children 12-23 months receiving 3 doses of DPT</p> <p>33.Number of disease outbreaks/public health emergencies of international and national concern detected and reported to WHO</p> <p>34.% of (respectively)- children under five years old and pregnant women who slept under an ITN the previous night</p> <p>35.% of households with at least one ITN</p> <p>36.% of women who received two or more doses of IPT during their last pregnancy leading to a live birth within the previous two years</p> <p>37.% of children under five</p>

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Improved delivery of highest impact interventions, particularly at the PHC level				
GHI GOAL	GON GOALS/TARGETS FROM THE NSHDP (2010-2015)	KEY PRIORITIES FROM THE NSHDP (2010-2015)	USG INTERAGENCY KEY PRIORITY ACTIONS AND INITIATIVES	KEY INDICATORS
			<ul style="list-style-type: none"> Support the establishment of an integrated disease surveillance and response system and build capacity for ensuring monitoring, early detection, preparedness, and response to diseases of public health importance including but not limited to pandemic influenza and other health emergencies Support the development, implementation, and testing of public health emergency response plans Support the promotion of the One Health Principle by encouraging cross-disciplinary approaches to human and animal health research and service delivery Provide technical assistance to the GON to develop and implement environmental health intervention and emergency control strategies <p><u>In target states</u></p> <ul style="list-style-type: none"> Provide technical assistance on advanced laboratory diagnosis, clinical management, and environment risk assessment/remediation on lead poisoning and other heavy metal poisoning 	<p>years of age with fever in the last two weeks who received treatment with ACTs within 24 hours</p> <p>Outcome</p> <p>38. Contraceptive prevalence rate (modern methods) by state and nationwide</p> <p>39. TB case notification rate</p> <p>40. TB treatment success rate</p> <p>41. % of unmet need for family planning</p> <p>42. % of under-five children who are underweight for age</p> <p>43. HIV incidence and prevalence rates by state and nationwide (disaggregated by age)</p>

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Improved delivery of highest impact interventions, particularly at the PHC level				
GHI GOAL	GON GOALS/TARGETS FROM THE NSHDP (2010-2015)	KEY PRIORITIES FROM THE NSHDP (2010-2015)	USG INTERAGENCY KEY PRIORITY ACTIONS AND INITIATIVES	KEY INDICATORS
Key principles: Encourage country ownership and invest in country-led plans by building capacity of all levels of GON, in the private sector and at community level to implement the service delivery strategic objectives and highest impact interventions outlined in the NSHDP; build sustainability through health systems strengthening by addressing access to essential drugs, contraceptives, equipment etc. and helping to resolve health information systems issues impacting the effective delivery of those highest impact interventions; increase impact through strategic integration and coordination by focusing on the revitalization of the primary health care network and links with communities—where all of the highest impact interventions converge—and decentralization, alignment and integration of HIV/AIDS, FP/RH and other MCH services; strengthen and leverage other efforts by concentrating MNCH/RH/FP programming in two Northern states in which other donors are not working and collaborating with DFID on social marketing and other private sector initiatives, and supporting the social marketing of Global Fund-procured ACTs				
Key partners: Same as above section				
Strengthened leadership, management, governance and accountability				
GHI GOAL	GON GOALS/TARGETS FROM THE NSHDP (2010-2015)	KEY PRIORITIES FROM THE NSHDP (2010-2015)	USG INTERAGENCY KEY PRIORITY ACTIONS AND INITIATIVES	KEY INDICATORS
Reduce maternal mortality by 30% across assisted countries	Decrease maternal mortality rate Baseline: 545/100,000 (2008 NDHS) Target: 136/100,000	Strengthen regulatory functions of government Reaching consensus on health at all levels	Increase political commitment and capacity at national, state and LGA levels to implement the NSHDP in the public and private sectors <ul style="list-style-type: none"> Support and institutionalize strategic leadership, planning, management, and development programs within the broad context of the Nigerian public health system Establish and expand pressure groups and forums for policy debate on health issues 	Input 44. Number of Nigerian and international NGOs, CSOs, CBOs, and media entities supported for policy advocacy Process 45. % of federal agencies, states and LGAs that publicly disclose
Reduce under-five mortality rates by 35% across assisted countries	Reduce under-five mortality rate Baseline: 157/1000 live births (2008 NDHS) Target: 75/1000 live births Proportion of 1 year old immunized against measles Baseline: 41.4% (2008	Decentralization of decision making Intergovernmental, multi-sectoral collaboration, and coordination Public-private partnership Improve accountability and transparency	Improve coordination and linkages between levels of the health system	

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Improved delivery of highest impact interventions, particularly at the PHC level				
GHI GOAL	GON GOALS/TARGETS FROM THE NSHDP (2010-2015)	KEY PRIORITIES FROM THE NSHDP (2010-2015)	USG INTERAGENCY KEY PRIORITY ACTIONS AND INITIATIVES	KEY INDICATORS
	NDHS) Target: 95%	Empowering the community and civil society as health sector watch dogs	<ul style="list-style-type: none"> Support national coordination bodies and mechanisms including those involving donors Support GON to strengthen linkages and collaborations between federal and state departments with public health-related mandates Assist in establishing linkages between laboratories at all levels of the health system Support capacity building of GON bodies at all levels (e.g., FMOH, NPHCDA, NHIS, NACA, SACAs, LACAs, Ministry of Women Affairs) and of CSOs for improved program and financial management and oversight of service delivery 	<p>the PHC component of their annual health budget (e.g. for FP)</p> <p>Outcome</p> <p>46.% of GON budget that is allocated and expended for key high impact health services at federal, state, and LGA levels</p> <p>47. % of GON contribution to HIV/AIDS and FP funding</p>
Reduce child under-nutrition by 30% across assisted food insecure countries	Reduce prevalence of children under five who are underweight Baseline: 27.1% (2008 NDHS) Target: 17.9%			
Prevent 54 million unintended pregnancies by reaching a MCPR of 35% across assisted countries reducing from 24% to 20% the proportion of women aged 18-24 who have their first birth before age 18	Increase MCPR Baseline: 9.7% Target: 30%			
Support the prevention of more than 12 million new HIV infections; provide direct support for more than 4 million people on treatment; support care for more than 12 million people, including 5 million OVC	Reduce the incidence of HIV (NSF2) Reduce HIV prevalence among population aged 15-24 years Baseline: 19.4% (2007 MICS) Target: 5%			
Halve the burden of malaria for 450 million people	Increase percentage of children under five sleeping under insecticide treated bed nets Baseline: 5.5% (2008 NDHS), 29% (2010 MIS)			
			<p><i>Improve resource allocation and expenditures</i></p> <p><u>Nationally</u></p> <ul style="list-style-type: none"> Strengthen public financial management system Pilot and institutionalize mechanisms for linking financing and budgeting to performance Provide technical assistance to and build capacity of federal and state agencies and departments in budget 	

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Improved delivery of highest impact interventions, particularly at the PHC level				
GHI GOAL	GON GOALS/TARGETS FROM THE NSHDP (2010-2015)	KEY PRIORITIES FROM THE NSHDP (2010-2015)	USG INTERAGENCY KEY PRIORITY ACTIONS AND INITIATIVES	KEY INDICATORS
Contribute to the treatment of a minimum of 2.6 million new sputum smear positive TB cases and 57,200 MDR cases of TB; contribute to a 50 percent reduction in TB deaths and disease burden relative to the 1990 baseline	Target: 60% Proportion of TB cases cured under DOTS Baseline: TBD Target: 80%		development and application of audit principles <u>In target states</u> <ul style="list-style-type: none"> Provide technical assistance and build the capacity of state governments to determine adequate budget commitments and timely releases of funding <i>Strengthen organizations, mechanisms and systems for transparency, accountability, and responsiveness</i> <u>Nationally</u> <ul style="list-style-type: none"> Increase the capacity of civil society to engage with and hold government accountable at all levels by building CSOs' leadership, management, governance, and advocacy skills Build capacity of affected groups to serve on decision-making bodies, and advocate for increased funding for and access to services Expand and institutionalize public expenditure reviews Support production of periodic National Health Accounts and National and State HIV/AIDS Spending Assessments Support women-led and focused groups to develop and implement plans promoting the rights of women 	

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Improved delivery of highest impact interventions, particularly at the PHC level				
GHI GOAL	GON GOALS/TARGETS FROM THE NSHDP (2010-2015)	KEY PRIORITIES FROM THE NSHDP (2010-2015)	USG INTERAGENCY KEY PRIORITY ACTIONS AND INITIATIVES	KEY INDICATORS
			<p>living with or at risk for HIV <u>In target states</u></p> <ul style="list-style-type: none"> Support the re-vitalization of Ward Development Committees (WDCs) and Village Health Committees (VHCs), which serve as the liaison between communities and peripheral health facilities <p><i>Enhance the overall policy environment for health</i> <u>Nationally</u> (with emphasis on target states)</p> <ul style="list-style-type: none"> Build capacity of policy makers and CSOs and media to advocate for policy change Support implementation of policies critical to the implementation of USG programs (e.g., PPP policy, control of environmental hazards) Build capacity for monitoring and evaluation of policy implementation 	
<p>Key principles: Encourage country ownership and invest in country-led plans by building the capacity of all levels of the GON to implement the leadership and governance objectives and interventions outlined in the NSHDP; build sustainability through health systems strengthening by addressing leadership and governance issues impacting the effective delivery of highest impact interventions; strengthen and leverage other efforts by promoting public-private partnerships (PPP) through implementation of the PPP policy</p>				
<p>Key partners: Same as above sections</p>				

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Appendix B: Nigeria Global Health Initiative Results Framework

Goal	Improved health status of Nigerians		
Impact	Reduced maternal, neonatal, and child mortality, and morbidity Decreased unintended pregnancies Reduced incidence of communicable diseases (HIV, TB, Malaria)		
Long-term Outcomes	Increased utilization of quality public and private sector health services Increased adoption of healthy behaviors		
Short-term Outcomes	Increased access to, demand for, and quality of health services Increased stewardship of the health sector		
Intermediate Results	Improved human resources for health	Improved delivery of highest impact interventions, particularly at the PHC level	Strengthened leadership, management, governance, and accountability
	<ul style="list-style-type: none"> Improved human resource planning and management Increased quality of health professional training programs Implemented HRH policy Increased capacity of professional and technical associations/bodies 	<ul style="list-style-type: none"> Strengthened health and laboratory infrastructure with special focus on PHCs and referral facilities Increased quality and availability of private sector services Increased availability of essential health/FP commodities and supplies at all facility levels Strengthened community-based health promotion and service provision, linkages between the community, and facilities Strengthened integrated data collection, analysis, and use Strengthened capacity in epidemiology, disease surveillance, and response 	<ul style="list-style-type: none"> Increased political commitment and capacity at national, state, and LGA levels to implement the NSHDP in the public and private sectors Improved coordination and linkages between levels of the health system Improved resource allocation and expenditures Strengthened organizations, mechanisms and systems for transparency, accountability, and regulation Enhanced policy environment
Critical Assumptions	<ul style="list-style-type: none"> Recognition of the importance of programming collaborations with GON agencies at all levels, the Nigerian private sector and other Development Partners /Donors Increased GON political will to support and fund primary health care, consistent with GON commitments Through 2015, subject to the availability of funds, USG funding remains at 2011 level (PEPFAR, PMI, FP/RH, MCH, and Nutrition accounts) with contingency plans in place in case of changes to levels Stability in governance, increasing responsiveness to communities and community participation in health decisions 		

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Appendix C: Illustrative Examples of GHI Nigeria's Planned Innovations and Operations Research

Category	Summary of Innovations/Operations Research
Operations Research	Evaluation of feasibility and target populations for HIV vaccine cohort development in Nigeria.
	Characterization of humoral and cellular immune responses in Nigerian HIV-infected volunteers.
	Malaria amongst patients with HIV-infection and immune response.
	What is the effect of mass media plus interpersonal communication (IPC) versus mass media alone on behavioral outcomes?
	FoQus traders: A qualitative study to examine beliefs, attitudes, drivers and barriers to desired stocking behavior, and the selling context of traders of social-marketed products.
	What are the costs of family planning uptake in communities using community-based distribution (CBD) versus those using other interventions (e.g., direct from proprietary patent medicine vendors (PPMVs)/chemists)?
	What is the difference in the rate of uptake of family planning (FP) in communities using different approaches to community distribution?
	Community-based access to FP pilot: Expanded to other areas to assess community-based access to injectable contraceptives and to explore complementing facility-based FP provision with community-based access.
Assessments & Analysis	A virological assessment of patients on antiretroviral therapy in the Walter Reed Program-Nigeria, President's Emergency Plan for AIDS Relief (PEPFAR).
	DATE (Data Analysis and Triangulation for Evaluation): use of data synthesis and integration to inform decision making for HIV-prevention priorities.
	The effect of health facility capacity improvement on service providers and quality of care.
	Measuring the effectiveness of oral rehydration therapy (ORT) corners and zinc tablet supply in health facilities on the management of diarrhea.
Surveillance & Studies	HIV study: A viral panel for patients who are not currently on treatment.
	MSM HIV risk assessment: A cohort study of men who have sex with men (MSM).
	IBBSS: Behavior and prevalence of HIV-infection among high risk groups, including commercial sex workers (brothel and non-brothel based), commercial drivers (long-distance and within city), armed forces, intravenous drug users (IDUs) and MSM.
	HIV-incidence study: To determine the HIV-incidence using the antenatal care (ANC) sample as a proxy for the general population.
	HIV drug resistance threshold study: To determine the prevalence of transmitted resistance among newly infected individuals.
	Nigeria HIV/AIDS Reproductive Health Survey (NARHS): Survey of behaviors, knowledge and perceptions.

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Appendix D: Nigeria Global Health Initiative Country Coverage by State and Region

GHI Nigeria Country Coverage FY 2011															
	State	Region	HIV Prevention	HIV Treatment	HIV Care & Support	HIV Policy & Governance	MNCH/RH/FP/Nutrition Policy & Advocacy	MNCH/RH/FP/Nutrition Services	Polio	Malaria	TB	Influenza	Animal-Human Interface Project	Health Diplomacy	Environmental Health
1	Abia	South East													
2	Adamawa	North East													
3	Akwa Ibom	South South													
4	Anambra	South East													
5	Bauchi	North East													
6	Bayelsa	South South													
7	Benue	North Central													
8	Borno	North East													
9	Cross River	South South													
10	Delta	South South													
11	Ebonyi	South East													
12	Edo	South South													
13	Ekiti	South West													
14	Enugu	South East													
15	FCT	North Central													
16	Gombe	North East													
17	Imo	South East													
18	Jigawa	North West													
19	Kaduna	North West													
20	Kano	North West													
21	Katsina	North West													
22	Kebbi	North West													
23	Kogi	North Central													
24	Kwara	North Central													
25	Lagos	South West													
26	Nasarawa	North Central													
27	Niger	North Central													
28	Ogun	South West													
29	Ondo	South West													
30	Osun	South West													
31	Oyo	South West													
32	Plateau	North Central													
33	Rivers	South South													
34	Sokoto	North West													
35	Taraba	North East													
36	Yobe	North East													
37	Zamfara	North West													
	Nationwide														