Executive Summary

During September 16-22, an inter-agency team representing the Country Support Working Group (CSWG) of the PMNCH visited Nigeria in response to an invitation from the Federal Ministry of Health (FMoH) of the Government of Nigeria (GoN). The objectives of the visit were to:

- work with the FMoH and partners in further development of Nigeria’s proposal for PMNCH support;
- identify areas where the PMNCH might provide additional value-added (non-funding) support;
- at the request of the FMoH and the Nigerian MNCH Partnership, participate in advocacy activities aimed at increasing political and partner support for MNCH and implementation of the country’s new “Integrated Maternal, Newborn, and Child Health (IMNCH) Strategy.”

Nigeria is the most populous country and the fourth largest economy in Africa. However, at an estimated $350 per capita annually, Nigeria ranks near the bottom (158 out of 177 countries) in terms of per capita income, with over half of the population living in poverty. The situation of MNCH in Nigeria is among the worst in Africa and has not improved substantially – and in some areas of the country, has worsened during the past decade. Under five mortality is estimated to be 201 deaths/1,000 live births, maternal mortality 800 deaths/100,000 live births, and total fertility to be 5.7 births per woman. Coverage and utilization of key interventions are correspondingly low. The north of the country has generally worse indicators. These high rates of mortality – especially of maternal mortality and mortality among one to four year old children - reflect a significant dysfunctionality of basic health services, and particularly of primary health care, in the country.

Nigeria’s health situation makes it a major factor in the achievement of MDGs 4 and 5 globally. With approximately 2.5 per cent of the world’s population, Nigeria has over 10 per cent of all under five and maternal deaths - more than 1 million newborn, infant and child deaths and more than 50,000 maternal deaths every year. Within the past year the federal government has joined with partners and stakeholders to create a national Partnership for Maternal, Newborn and Child Health modeled on the global PMNCH and to develop a national “Integrated Maternal, Newborn, and Child Health (IMNCH) Strategy.” The new President has appointed one of the leaders of this strategy development – and member of the global PMNCH – as Federal Minister of Health. The PMNCH has grant funding available to support catalytic activities in Nigeria, and the Nigerian PMNCH has submitted a proposal for funding of specific activities.

During the visit, the PMNCH team worked together with the Secretariat and Core Technical Group (CTG) of the Nigeria PMNCH (N-PMNCH). Activities included:

- Initial briefings and press meeting with the Federal Minister of Health;
- Meetings with donor partners;
- Meeting with Heads of UN Agencies;
- Group meeting with NGOs;
- Group meeting with professional associations;
- Advocacy visits with key legislators, including the Chairman and several key members of the House Committee on Health and Human Services, the Chairwoman and key members of the
recently constituted House Committee on the MDGs, the Speaker of the House of Representatives, and the Chairwoman of the Senate Committee on Health and Human Services;

- Advocacy visit with the Governor of Niger State;
- Meeting with the Senior Special Assistant to the President for the MDGs, in charge of the office that controls the substantial Debt Relief funds available for support of progress toward the MDGs.
- Debriefing and press conference with the Honorable Federal Minister of Health; and,
- Working discussions of the N-PMNCH proposal to the global Partnership and of potential additional assistance.

Observations of interest to the global PMNCH from these activities include:

- Partners generally welcomed the new political commitment and the IMNCH Strategy, especially the focus on moving from vertical approaches to a more integrated approach and the focus on revitalization of PHC; there appeared to strong consensus on these points across the partners.
- However, awareness of and involvement in the IMNCH Strategy and the N-PMNCH was variable among donor, NGO, and professional association partners; it will be important to sustain the practice of inclusion of all major partners as planning and implementation go forward.
- Needs identified by NGOs and professional associations for strengthened capacity, coordination, and participation are valid and would likely enhance their effective contribution to implementation of the IMNCH strategy; since it is unlikely that the FMoH has the person power or capacity to take on these tasks, this may be an area where the NGO and professional association constituencies of the global PMNCH and of the CSWG can be of assistance, with support from the global Secretariat.
- Key political leaders at national and state level were aware of the urgent unmet needs in MNCH. This made them receptive to advocacy regarding their support for the IMNCH Strategy and its operationalization. The ability to reach this level of political leadership reflects a key “catalytic” role that the Partnership approach can play, creating political access that can be leveraged by the in-country Partnership to substantial advantage.
- The Administration’s approach to using Nigeria’s Debt Relief funds apparently aims to achieve progress by leveraging reforms within government itself, so that progress represents fundamental and durable change and not just the use of money to deliver results. This is an important principle that the N-PMNCH and the global Partnership need to keep in view.

In discussion of the current draft grant proposal to the global PMNCH, the team identified several areas where modifications might be considered. These will be explored further during the upcoming planning retreat with N-PMNCH Partners, with a revised proposal expected to be developed during the first week of October. The team also preliminarily discussed several areas where the global PMNCH (through the Secretariat or through constituent partners) might offer technical assistance or support, including support for strengthening coordination among and with NGOs and professional associations and consultation with the M&E WG regarding appropriate baseline data collection activities.

Next steps for the CSWG will include a conference call to discuss this report and potential follow-up actions; establishing regular contact with the N-PMNCH through the identified focal person; communicating with the Chair of the M&E WG to explore support to the N-PMNCH regarding appropriate monitoring approaches; communicating with the CSWG representatives of the NGO and professional association constituencies regarding possible assistance to those constituencies in Nigeria; and discussions with the Chair and co-Chairs of the PMNCH Board and the Director of the global Secretariat the possibility of a high level visit to Nigeria, to build upon the present momentum.
As the first organized activity of the post-Forum CSWG, this Nigeria visit also provides some useful lessons in regard to planning and implementation of the country support process.
Report of Visit

During September 16-22, an inter-agency team representing the Country Support Working Group (CSWG) of the PMNCH visited Nigeria in response to an invitation from the Federal Ministry of Health (FMoH) of the Government of Nigeria (GoN). The team consisted of:

- Dr. Alfred Bartlett, USAID, Co-Chair, Country Support Working Group
- Dr. Mamadou Hady Diallo, Senior Advisor for Country Support, PMNCH Secretariat
- Dr. Brigitte Toure, Regional Advisor on Child Survival, UNICEF West & Central Africa Regional Office
- Dr. Emmanuel Otolorin, Country Director, ACCESS/Nigeria (CSWG NGO representative)

The objectives of the visit were to:

- work with the FMoH and partners in further development of Nigeria’s proposal for PMNCH support;
- identify areas where the PMNCH might provide additional value-added (non-funding) support;
- at the request of the FMoH and the Nigerian MNCH Partnership, participate in advocacy activities aimed at increasing political and partner support for MNCH and implementation of the country’s new “Integrated Maternal, Newborn, and Child Health (IMNCH) Strategy.”

Throughout the visit, the PMNCH team worked together with the Secretariat and Core Technical Group (CTG) of the Nigeria PMNCH (N-PMNCH).

Background

With a total population of over 140 million, Nigeria is the most populous country in Africa. Nigeria is also the fourth largest economy in Africa. Its status as a major petroleum producer, the presence of some of the largest shipping, production, and commercial industries in West Africa, and its historic importance in regional trade and agriculture make it an economic motor of West Africa. The size of the economy, and an increasing trend toward privatization, have created a proportionately small but highly influential class of extremely wealthy citizens along with a small but growing middle class. However, at an estimated $350 per capita annually, Nigeria ranks near the bottom (158 out of 177 countries) in terms of per capita income. Indices of economic equity are among the world’s least favorable, with over half of the population living in poverty.

Nigeria’s government is a federal system, with authority shared among the central federal government, 36 autonomous states (plus a Federal Capital Territory), and 774 Local Government Areas. While state and local governments have some revenue-generating authority, most revenue comes from a formula-based allocation of the national budget, with 50 per cent remaining at the federal level, 30 per cent going to states, and 20 per cent divided among LGAs. A potentially important source of additional revenue for development is the country’s Virtual Poverty Fund, resources generated by Debt Relief and managed by the federal government.

Nigeria’s MNCH situation

The situation of MNCH in Nigeria is among the worst in Africa and has not improved substantially – and in some areas of the country, has worsened - during the past decade. The 2003 Nigeria Demographic and Health Survey (NDHS) estimated the national average under five mortality rate to be 201 deaths/1,000 lives births. Of this, mortality among 1-4 year olds was 121/1,000, post-neonatal infant mortality (months
2-11) was 56, and neonatal mortality was 53 (total infant mortality 109). The FMoH estimate of the maternal mortality ratio is 800 deaths/100,000 live births. The NDHS found the national average total fertility rate to be 5.7 births per woman.

For all these health outcomes, there is substantial variation among geographic areas. The north of the country has generally worse indicators: the NDHS found under-five mortality to range from 260/1,000 in the North East region and 269/1,000 in the North West, compared to 103/1,000 in the South East. Maternal mortality estimates vary even more widely - by almost a factor of 10 - from over 1,500/100,000 in the North East to 165/100,000 in the South West. Fertility ranges from 7.0 births per woman in the North East to 4.1 in the South East and South West.

These high rates of mortality – especially of maternal mortality and mortality among one to four year old children - reflect a significant dysfunctionality of basic health services in the country. This statement is confirmed by data on the status of specific high impact interventions. Just over 1 in 3 women has a skilled attendant at birth, with rates as low as 12.3 per cent in the North West and 11.6 per cent in the lowest wealth quintile nationwide. Modern contraceptive use among women of reproductive age is under 9 per cent. Only 52 per cent of women receive at least one tetanus toxoid injection during pregnancy, contributing to Nigeria’s being one of the few countries that have not achieved the target for neonatal tetanus reduction.

Child vaccination coverage is similarly low, with DPT3 at 20.1 per cent, measles at 31.4 per cent, and the proportion of children fully immunized by age one at just 11.3 per cent. Again, the north is worst served: DPT3 and measles coverage in the North West region average 5.8 and 15.6 per cent, respectively. Treatment of child illness is similarly deficient: only 40 per cent of children with diarrhea received any form of additional fluid (and over one-third of children actually had fluid intake reduced during illness); less than one-third of children with symptoms of fever or signs of acute respiratory infection were taken to a health facility or presumably qualified health care provider. Despite a sharp increase in malaria investment in recent years, the NDHS found only 1.2 per cent of under-five children and 1.3 per cent of pregnant women sleeping under insecticide-treated bednets.

These data are particularly disheartening in view of the fact that in the early 1990s, Nigeria accomplished significant progress in child survival programming, attaining some of the highest immunization rates in Africa. During that time, ORT - largely using home solutions - was one cornerstone of an increasingly strong system of primary health care. The deterioration of these programs during Nigeria’s era of military dictatorship and wholesale corruption was the initial cause of such low coverage.

However, the lack of recovery of basic health care services in the decade since the end of that dictatorship reflects continuing failure of the health system and of political commitment in Nigeria’s multi-tiered approach to health and government. In Nigeria’s federal system, the central government’s role is limited to policy, technical support, budget allocation, and direct management of tertiary care. The national budget share and per capita spending for health remain low, with about 5.6 per cent of the national budget allocated for health (less than 5.5 per cent of GDP), amounting to less than $7.00 per capita. Maternal and child health allocations have been very small fractions of total health spending at the federal level. Budgeted funds are often diminished in the steps between allocation and disbursement. Budget, decision-making, and management are devolved to states – who get 30 per cent of total budget to use at their discretion and who manage secondary level health care – and to hundreds of Local Government Areas – who receive 20 per cent of total funds for discretionary use and who are supposed to support a network of primary and community health services.

There is general consensus that this system is substantially broken. Assessments and anecdote are consistent in reporting that government primary health care services suffer from poor working conditions,
absence and lack of motivation of personnel, lack of drugs and supplies, and in many cases “informal charges” to patients. The result is generally low levels of utilization of public sector primary services, contributing to overload of better supplied secondary level facilities and to more than half of health services being provided by private sector providers with widely variable (and often questionable) qualification. A corollary result is that the bulk of health spending is borne by households, a situation that especially threatens the poor.

Nigeria’s health situation makes it a major factor in the achievement of MDGs 4 and 5 globally. With approximately 2.5 per cent of the world’s population, Nigeria has over 10 per cent of all under five and maternal deaths. Without progress in Nigeria, the rest of the world will have to work much harder to achieve the MDGs. Even more important, the more than 1 million newborn, infant and child deaths and more than 50,000 maternal deaths occurring every year in Nigeria demand the attention of the global community and of the PMNCH. However, progress in this complex and difficult environment has proven elusive.

A potential opportunity – the Nigeria Partnership for Maternal, Newborn and Child Health and the “Integrated Maternal, Newborn and Child Health (IMNCH) Strategy”

Against this background, within the past year the federal government has joined with U.N. and donor partners and other stakeholders to create a national Partnership for Maternal, Newborn and Child Health modeled on the global PMNCH. A major product of this new commitment to collaboration has been the development of a national “Integrated Maternal, Newborn, and Child Health (IMNCH) Strategy,” which was launched at a national consultation in Spring of 2007.

This strategy addresses many of the key issues that must be dealt with to improve MNCH outcomes in Nigeria. It includes:

- identification of an essential package of evidence-based MNCH interventions that address the major causes of mortality, as well as identification of the community, outreach, primary health care, and referral level delivery approaches needed to increase coverage and use of these interventions in the Nigerian health system context (this analysis was developed through application of the UNICEF/WHO/World Bank “Marginal Budgeting for Bottlenecks” tool);
- a special focus on revitalizing primary health care (PHC), which is seen as key to increasing coverage within the Nigerian health system context;
- a resource analysis and identification of the needs and possibilities for mobilizing the resources required to extend coverage;
- recognition of the importance of engaging the State and Local Government levels in a process that will clarify the roles and accountability of each level in providing the inputs and reforms required;
- recognition of the need for political support at all levels, and promotion of internal advocacy to gain that support.

Since the launch of the IMNCH Strategy, new national, state, and local elections have occurred, bringing to power a new President and many new federal legislators, governors, and local authorities. This election has created what some partners consider to be a potential “political window” for generating fundamental change and achieving greater progress in development and health. One important signal of political commitment to such change in MNCH was the new President’s appointment of Dr. Adenike Grange as Federal Minister of Health. At the time of her appointment, Dr. Grange was serving as President of the International Pediatric Association and as the IPA member of the global PMNCH’s Country Support Working Group. More important, Dr. Grange was one of the leading forces in
development of Nigeria’s new IMNCH Strategy. To support the roll-out of this strategy and collaboration among government and partners, the Honorable Minister has created a Secretariat for the Nigeria PMNCH (N-PMNCH) within her own office, led by the Head of the FMoH’s Family Health Division.

Nigeria is one of three large African countries for which funding for catalytic activities is available from the global MNCH. In response, the “Core Technical Group” (CTG) and Secretariat of the N-PMNCH submitted in June a proposal that would largely focus on extending the national Partnership’s coordination, planning, and advocacy processes to the critical state and local levels, beginning in at least one state of each of the country’s six geopolitical regions. This proposal was revised and re-submitted in August in response to comments and requests for additional detail by the global PMNCH Secretariat and the CSWG co-chairs. At that time, it was agreed that a next step would be in-country discussions to move the proposal toward finalization. These in-country discussions were also anticipated to identify additional areas of assistance that the global PMNCH might provide to the Nigeria Partnership.

**Activities and Associated Observations**

The activities of the visit were organized by the Secretariat and CTG of the N-PMNCH and personally led throughout the visit by the Head of the National PMNCH Secretariat (Head of the Family Health Division). All visits and activities included the participation of multiple staff of the FMoH as well as members of the CTG (WHO, UNICEF, UNFPA and non-U.N. partners), with the team at times numbering more than 20 people. At the request of the N-PMNCH, the first four days of the visit were largely focused on visits to donor partners to reinforce the Partnership approach and on advocacy activities to engage key federal and state level political leaders. The final day was largely spent discussing the grant proposal and potential additional support to the N-PMNCH by partners and the global Partnership.

**Initial briefings and press meeting with the Federal Minister of Health**

On the first day of the visit, the team participated in two large meetings within the Federal Ministry of Health, to be briefed on the status and plans of the Ministry and the N-PMNCH. These briefings had both information sharing and advocacy dimensions, leveraging the presence of the global PMNCH CSWG team to reinforce the importance of MNCH and of the partnership approach to roll-out of the IMNCH Strategy. The second briefing was chaired by the Federal Minister herself and included press coverage.

**Meetings with donor partners**

During the week, the CSWG team and representatives of the Secretariat and members of the N-PMNCH together visited major donors actively or potentially supporting programming for MNCH: CIDA (Canada), DfID, the European Union, JICA, Norway, USAID, and the World Bank. Key points conveyed in these visits were:

- the purpose of the global PMNCH CSWG visit, including recognition of Nigeria’s new Partnership, plans for modest PMNCH funding support of value-added catalytic activities by the N-PMNCH, and the primary role of in-country partners in the global Partnership’s approach to working with countries;
- the new Federal government’s commitment to implementing the IMNCH Strategy developed under the past administration;
- reiteration of the strategy’s key elements;
- solicitation of donor partners’ participation in and support for the planning and implementation of the strategy’s roll-out, through alignment of their ongoing program support and in planning of future investment;
- specific invitation of each partner to be represented in the N-PMNCH’s upcoming retreat aimed at developing approaches and operational plans for implementation of the IMNCH Strategy.
Observations:

- Awareness of the IMNCH Strategy and the N-PMNCH was variable among donor partners. Some partners (e.g., CIDA, DfID, USAID) had apparently participated to some degree in the strategy development process. Others (e.g., EU, JICA) were essentially unaware of the strategy and process. At the same time, the N-PMNCH team was not consistently cognizant of the programs and investment strategies of some of the donors. These observations suggest that the partnership approach in Nigeria is new to most parties. The N-PMNCH now plans to request support for a process of “mapping” the programs and investments of its in-country partners, and this will be helpful. It will also be important to sustain the practice of inclusion of all major partners as planning and implementation go forward.

- Donor partners generally welcomed the political commitment and the strategy – especially the focus on moving from vertical approaches to a more integrated approach and the focus on revitalization of PHC. There appeared to strong consensus on these points across the donor partners.

- Timing of this new effort seems to be fortuitous – several partners (World Bank, E.U., CIDA) reported that they are approaching re-design points in their program cycles, potentially allowing for greater alignment of their investments with the IMNCH strategy and possibly allowing change or addition of states in which they are engaged. Norway reported that its potential bilateral collaboration with Nigeria is still under discussion in Oslo.

Meeting with Heads of UN Agencies

A meeting was held with the WHO and UNICEF Country Representatives and a Senior UNFPA representative. These three agencies played a key role in the development of the IMNCH Strategy, are represented in the N-PMNCH CTG, and work closely with the Secretariat and the FMoH Family Health Division. They also provide support to health programs at sub-national levels through decentralized offices at the State or Regional level. The IMNCH strategy was developed and costed using the Marginal Budgeting for Bottleneck (MBB) tool developed jointly by UNICEF, WHO and the World Bank. The tool and the approach have already been decentralized to state level, where it is being used as a planning tool focused on achieving MDGs 4 and 5.

The UN representatives were consistent in affirming their support and active engagement in the N-PMNCH. They stated that they will continue playing their advocacy roles with the national authorities and support the implementation of the roll-out plan at State and LGA levels. They found the PMNCH visit to be very timely, supporting both political action and the FMoH’s intention to develop a National Health Investment Plan that would serve as a template for the states.

The possibility of channeling PMNCH grant funding to the N-PMNCH through WHO was also discussed.

Group meeting with NGOs

A group meeting was held with representatives of the NGO community. Those represented included “international NGOs,” a small number of indigenous NGOs, and one group representing a network of local NGOs. (In reality, the “international NGOs” were organizations supported by bilateral donors such as USAID and DfID for program implementation; the large, self-funded international NGOs such as Save the Children, World Vision, or Aga Khan Foundation were not represented and were reported not to be substantially present in Nigeria.) This meeting included an overview of the IMNCH strategy and the process of its development, presentation of the PMNCH CSWG team and of their mission and activities during the visit, and open discussion. Again, the NGOs were generally appreciative of the opportunity and in agreement with the approach of the strategy. However, there was also a great deal of discussion of the need for government at all levels to be more open to NGOs, of the need to build NGO capacity, and of
the need for a coordination mechanism. The need for a coordination mechanism at central and state levels was raised by NGOs, as well as the ideas of establishing an “NGO forum” and election of NGO representatives to the N-PMNCH.

Observations:

- As with the donors, it appeared that some relevant NGOs were unengaged in the IMNCH strategy and in the N-PMNCH. Several of the “international NGOs” (donor-supported programs) had participated in the strategy development and are members of the CTG. Some others had attended the launch of the strategy in May, but had not been engaged since then; for others, the strategy and Partnership were new. The sorts of issues discussed – need for NGO participation, capacity, and coordination – are characteristic of conversations among government and NGOs at the early stages of collaboration. Again, it appears that the partnership process is nascent and will need proactive commitment to inclusiveness on the part of the Secretariat and the CTG.

- The needs identified by the NGOs – capacity, coordination, and participation – are valid and would likely enhance their effective contribution to implementation of the IMNCH strategy, especially at LGA and community level. However, it is unlikely that the FMoH has the person power or capacity to take on these tasks. This may be an area where the NGO constituency of the global PMNCH and of the CSWG can be of assistance, with support from the global Secretariat.

Group meeting with professional associations

A similar group meeting was held with executive level representatives of the major professional associations. Participating organizations included the Society of Obstetricians and Gynaecologists of Nigeria, The Paediatric Association of Nigeria, the Nursing and Midwifery Council, the Nigerian Medical Association, the Private Medical Practitioners of Nigeria, and others. The substance of the meeting was similar to that of the NGO meeting, slanted toward the interests and roles of the professional associations. The response was also similar: general support for the intention and direction of the strategy as presented, variability of pre-existing awareness and involvement, and discussion of general issues about the professional associations’ roles in relation to government, again characteristic of the early phases of collaboration.

Observations:

- Again, considering the limited staff time and capabilities of the FMoH and the huge task they are taking on, the global Partnership may be able to facilitate the systematic participation of professional associations in Nigeria through engagement of this constituency of the global Partnership and of the CSWG.

Advocacy visits with key legislators

The N-PMNCH team and the CSWG representatives visited a number of key legislators who have substantial influence in the federal budget for health and in legislation potentially relevant to MNCH implementation. Specifically, the team had interactive meetings with:

- The Chairman and several key members of the House Committee on Health and Human Services;
- The Chairwoman and key members of the recently constituted House Committee on the MDGs;
- The Speaker of the House of Representatives; and,
- The Chairwoman of the Senate Committee on Health and Human Services.

The points and messages conveyed in these visits were:

- The situation of maternal, newborn and child health in Nigeria;
• The growing global commitment to achieving MDGs 4 and 5, and Nigeria’s importance in that achievement;
• The constituencies and objectives of the global PMNCH, and the current CSWG mission in Nigeria as an expression of that commitment;
• The key elements of Nigeria’s IMNCH strategy and the importance of the N-PMNCH in operationalizing that strategy.

The “Ask” to each of these legislators included requests for:
− increased resource allocation to MNCH;
− supportive legislation;
− specifically, support for implementation of the IMNCH strategy;
− personal commitment as “champions” of MNCH in the Nigerian political process.

The reception by each of these legislative leaders was extremely positive. In all cases – especially among the chairs and members of the specific committees – there was substantial awareness of the issues and needs related to improving MNCH in Nigeria. These legislators expressed personal commitment and referred to two pieces of legislation that they are currently involved in moving forward, the Nigeria Health Bill (which would support the IMNCH strategy and also clarify roles for health service delivery at the federal, state, and LGA levels) and a “Maternal and Child Health Bill.”

Observations:

➢ The ability to reach this level of legislative leadership – and the success of the Chairwoman of the House Committee on MDGs in setting up an on-the-spot unscheduled meeting with the Speaker (which became a combined briefing and press conference) – reflect a key “catalytic” role that the Partnership approach can play. The presence of external representatives of the global PMNCH, combined with the representation of multiple in-country organizations standing shoulder-to-shoulder with the FMoH, create a level of political access that can be leveraged by the in-country Partnership to substantial advantage.

Advocacy visit with the Governor of Niger State

In addition to meetings with federal legislators, a large number of representatives of the N-PMNCH Secretariat and CTG accompanied the CSWG team to a briefing for the Governor of Niger State. This meeting was strategic, since this Governor also serves as chair of the Forum of Governors of all the northern states of Nigeria.

At the Governor’s request, the team made a brief visit to a secondary level hospital facility in Suleja to get a sense of the situation of health care delivery in the state. The hospital has 144 beds; is staffed with 15 doctors (including one specialist), 6 Pharmacists, 20 Midwives, and 88 Nurses; receives 350 outpatients daily; and consistently has 100% occupancy. Much of the patient load and demand on resources consists of cases that should be able to be managed at the PHC level; the physician director of the hospital identified the dysfunctionality of PHC as the major reason why the hospital was not able to carry out is secondary level care functions adequately.

In the visit to the Governor, the combined presence of the global PMNCH representatives and a large multi-organization delegation from the Secretariat and CTG of the N-PMNCH again resulted in this visit taking on an extremely high profile. In addition to the Governor and his Lieutenant, participants included all members of the State Cabinet, the senior state health authorities, and the press.
This newly elected governor, too, was extremely conversant with the situation of MNCH in his state and in the North, and expressed strong commitment to making improvements. He welcomed the IMNCH Strategy, especially the calls for revitalization of PHC and for appropriate actions by federal, state, and local government (since there is much sensitivity at the state level to the possibility of the federal government overstepping its constitutional mandate). He pledged to take the message of support for the IMNCH Strategy and for the concept of partnership at the state level to the Forum of Northern Governors when they meet in October. He invited the N-PMNCH to provide a similar briefing to the all the governors on that occasion.

Meeting with the Senior Special Assistant to the President for the MDGs.
This senior official is in charge of the office that controls the substantial Debt Relief funds available for support of progress toward the MDGs. She is clearly influential and effective, since she was originally appointed under the last President and specifically asked to continue her work by the new President. She made a number of key points during the team’s meeting with her. Supportive points included:

- An expressed priority for MNCH and MDGs 4 and 5;
- Support for the approaches of integration and collaboration set out in the IMNCH Strategy;
- Support for the concept of partnership between the federal, state, and LGA levels, with appropriate and clear roles and accountability for each level.

She also announced that she had just approved funding for initiation of a “Midwifery Corps,” a program that will increase the number of skilled birth attendants.

At the same time, she presented several challenges to the N-PMNCH and especially to the FMoH, including:

- Stating that her office will only approve funding for any sector or program after the relevant Ministry has demonstrated its own commitment through concrete plans and spending of their own resources;
- Stating that there must be mechanisms in place to assure that funds provided through the Debt Relief program are additive to existing funds, and do not displace other government funds;
- Emphasizing that there are many strategies and initiatives in Nigeria, and that her office only wants to fund concrete programs of action that will lead to results on the ground;
- Stressing the need to work with states that are themselves firmly committed to producing such results;
- Identifying the importance of making sure that the operational approach works in relation to the critical constraints posed by corruption and human resource capacity, among others; and,
- Emphasizing the need for the FMoH to implement the management reforms already started under the last Administration, and in terms of MNCH, to clearly define roles and lines of authority within the Ministry and to define the relationship of MNCH and the Secretariat to other programs such as malaria.

Observations:

- Nigeria’s Debt Relief funds obviously have tremendous potential for supporting the roll-out of the IMNCH strategy. At the same time, this meeting clearly indicates that the approach of the Administration to using these funds – and to making progress - is not simply to support good programs aimed at the MDGs. Rather, they aim to achieve progress by leveraging reforms within government itself, so that progress represents fundamental and durable change and not just the use of money to deliver results.

This is an important principle that the N-PMNCH needs to take into account, and that the global Partnership also needs to keep in view in its engagement with Nigeria.
Debriefing with the Honorable Minister of Health
On the next to last night of the visit, the CSWG team gave a presentation of its experiences and findings to the Honorable Minister, several other high level government officials, and the First Lady of Kwara State. This was an official public affairs event and included significant press coverage. The Minister expressed her satisfaction with the conclusions and next steps identified by the team in its debriefing.

Working discussions of the N-PMNCH proposal to the global Partnership and of potential additional assistance
On the last day of the visit, the CSWG team met with representatives of the N-PMNCH Secretariat and CTG to review the present draft of the grant proposal, identify potential areas for modification or clarification, and discuss possible additional assistance that might be requested of the global Partnership.

In relation to the grant proposal, the following points were discussed, with final decision subject to further internal discussion by the N-PMNCH and partners:

- The detailed cost estimates that underlie the line item totals in the proposal will be included in an annex.
- The substantial amount of funding requested for zonal level activities will be re-considered, because the FMoH has determined that the zonal level does not have substantial administrative or budgetary authority. It is felt that approaching local government through state governments will be a more effective approach. However, because there are periodic consultative activities at zonal level that involve representatives of local government, some funds may be retained for zonal activities.
- The funding for baseline data collection activities is important and will be maintained. However, because there is a recently completed MICS survey, and because a new DHS survey (with sample size adequate to give state-specific values for key indicators) will be conducted in 2008, it was decided that the N-PMNCH Secretariat and CTG should re-visit the issue of what sorts of data collection should be undertaken under this grant. The CSWG team suggested that consultation with the global Partnership’s M&E Working Group might be helpful in this regard.
- A “mapping” of donor and NGO partners’ programs and investments is planned, and initial indications were that it could be carried out with support from the World Bank. However, this has recently become uncertain. The N-PMNCH team will clarify this issue, and may need to include this activity within the PMNCH grant proposal. It was felt that this “mapping” could largely be carried out by desk analysis of partner reports.
- There is also a strongly felt need for an assessment of the status of key categories of human resource. Given the magnitude of Nigeria, there would clearly need to be a systematic sampling approach to this issue. Since none of the participants in the meeting had the expertise to identify the appropriate methodology, the cost implications are not clear. It is therefore not clear whether support for this activity will be asked for under the grant.
- Finally, it was agreed that the proposal should identify some funds to be used for “catalytic action,” such as sharing with a state or local government the cost of a highly important assessment, evaluation, or other activity that will promote change.

The team also preliminarily discussed several areas where the global PMNCH (through the Secretariat or through constituent partners) might offer technical assistance or support. As already noted, these included support for strengthening coordination among and with NGOs and professional associations and consultation with the M&E WG regarding appropriate baseline data collection activities.
In addition, the N-PMNCH Secretariat and the CTG both expressed a perceived need for some sort of assistance in strengthening the organization and process of coordination of the Partnership itself, to define optimum roles for the senior level Steering Committee, the Secretariat, and the CTG, and to assure effective inclusion of all partners as implementation moves forward.

In all these discussions, the CSWG team reinforced the principle that the global Partnership intends to assure that all possible assistance and support is provided through in-country partners, with the global Partnership adding support in ways that are value-added, complementary, and best use the comparative advantage of an external, multi-partner source.

**Next Steps**

*For the N-PMNCH*

During the week of September 24-28, the Secretariat and CTG will participate in a retreat that will include donor, NGO, professional, and possibly political partners to begin development of an operational plan for implementation of the IMNCH Strategy. During that retreat, they will discuss the issues related to the grant proposal and possible modifications to the proposal, as well as other areas for potential Partnership support. It is expected that a revised proposal will be developed immediately following this consultative process.

*For the global PMNCH*

The Co-Chairs of the CSWG and the Senior Advisor for Country Support will hold a conference call to discuss this report and potential follow-up actions. We will maintain contact with the N-PMNCH through the identified focal person, the Head of the Family Health Division of the FMoH.

We will also contact the Chair of the M&E WG to suggest establishing contact with the N-PMNCH regarding appropriate monitoring approaches. In addition, we will discuss with the CSWG representatives of the NGO and professional association constituencies the possibility of providing assistance in helping those constituencies in Nigeria organize themselves to participate effectively in the N-PMNCH.

Finally – given the receptivity to advocacy experienced in this visit – we will discuss with the Chair and co-Chairs of the PMNCH Board and the Director of the global Secretariat the possibility of a high level visit to Nigeria, to build upon the momentum that presently exists.

**Lessons for the CSWG**

As the first organized activity of the post-Forum CSWG, this Nigeria visit holds some useful operational lessons for the WG:

- This visit was scheduled on a very short time line. Longer lead time will allow for better planning and establishing adequate participation of appropriate WG representatives.
- Although many PMNCH Partner organizations were substantially engaged in Partnership at the country level – and in some cases at the regional level - this was not consistently the case. In addition, for most members of the global PMNCH, the headquarters levels were not substantially aware of or engaged in the preparation for the visit, nor in the development and support of the N-PMNCH. Implementing the Partnership approach systematically will require sustained
commitment by Partners’ headquarters and regional levels (where applicable) in support of in-country partnership in focus countries. Generating this headquarters level support will require longer lead times and more thorough preparation for specific activities, along with continued promotion of this approach by the Secretariat and the Board.

- The anticipated definition of specific follow-up activities and lines of work for continued support and technical assistance to the N-PMNCH will allow for development of a real work plan related to Nigeria. As we engage in additional countries, such definition and planning of specific activities will allow the CSWG to produce a reality-based work plan, in contrast to the theoretical plans developed in the past.

- There are program experiences in other countries that may be of benefit to Nigeria’s efforts, such as pay-for-performance schemes and other innovative models of using incentives to improve service delivery and quality. This possibility should be pursued for Nigeria and other partner countries, and may lead to Partnership investment in systematic south-to-south exchanges in key program areas.

- The identified need in Nigeria for support in organizing and coordinating the NGO and professional constituencies – and the limited capacity of government and U.N. partners to do this – will require additional thinking about how those constituencies of the global PMNCH can assist in this process, and what sort of inputs would be needed for them to do so.