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PATHS2 Annual Review 2010

Final Narrative Report

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Contents

Acronyms and abbreviations

ACT	Artemisinin Based Combination Therapy
AfDB	African Development Bank
ANC	Antenatal Care
BCC	Behaviour Change Communication
BOC	Basic Obstetric Care
CBHIS	Community Based Health Insurance Scheme
CMS	Central Medical Stores
CSO	Civil Society Organisation
D&E	Deferrals and Exemptions
DFID	Department for International Development
DHS	District Health System
DMA	Drug Management Agency
DPRS	Department of Planning, Research and Statistics
DRF	Drug Revolving Fund
ENR	Enhancing Nigeria's Response to HIV/AIDS
EOC	Essential Obstetric Care
EOP	End of Project
ESSPIN	Education Sector Support Programme in Nigeria
FHCs	Facility Health Committee
FMNCH	Free Maternal, Newborn and Child Health
FMOH	Federal Ministry of Health
GAVI	Global Alliance for Vaccines and Immunisations
GF	Global Fund for HIV/AIDS, Tuberculosis and Malaria
GHAIN	Global HIV/AIDS Initiative in Nigeria
GHS	Gunduma Health System
HCP	Health Commodities Programme
HDCC	Health Data Consultative Committee
HMIS	Health Management Information Systems
HMO	Health Maintenance Organization
HRH	Human Resources for Health
HSS	Health Systems Strengthening
ICB	Institutional Capacity Building
IDRC	International Development Research Center
IHP+	International Health Partnership Plus
ISS	Integrated Supportive Supervision
ITN	Insecticide Treated Nets
JSI	John Snow International
KHF	Kaduna Health Forum
LGA	Local Government Area
LMIS	Logistics Management Information System
LSHTM	London School of Hygiene and Tropical Medicine

MCH	Maternal and Child Health
MDGs	Millennium Development
MICS	Multiple Indicator Cluster Survey
MoAs	Memorandum of Agreement
MoU	Memorandum of Understanding
MSH	Management Sciences for Health
MTSS	Medium Term Sector Strategy
NAFDAC	National Agency for Food and Drugs Administration and Control
NCH	National Council on Health
NDHS	National Demographic Health Survey
NHA	National Health Accounts
NHIS	National Health Insurance Scheme
NHMIS	National Health Management Information System
NPHCDA	National Primary Health Care Development Agency (NPHCDA)
NSHDP	National Strategic Health Development Plan
OR	Operations Research
OSSAP	Office of the Senior Special Assistant to the President on MDGs
PATHS	Partnership for Transforming Health Systems
PEMR	Public Expenditure Management Review
PPRHAA	Peer and Participatory Rapid Health Appraisal for Action
PRINN	Partnership for Reviving Routine Immunization in Northern Nigeria
PSM	Procurement Supply Chain Management
SAVI	State Accountability and Voice Initiative
SHA	State Health Accounts
SIACC	State Inter-Agency Coordination Committee
SLP	State Level Programmes
SMOH	State Ministry of Health
SMS	State Medical Store
SPARC	State Partnership for Accountability, Responsiveness and Capability
SSHDP	State Strategic Health Development Plan
SUNMAP	Support to National Malaria Programme
SWAp	Sector Wide Approach
TA	Technical Assistance
TAG	Technical Advisory Meeting
TB	Tuberculosis
ToR	Terms of Reference
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
US	United States
USAID	United States Agency for International Development
V&A	Voice & Accountability
VFM	Value for Money
WHO	World Health Organization

Executive summary

The Partnership for Transforming Health Systems 2 (PATHS2) was launched in August 2008 as the health sector component of DFID's suite of state led programmes (SLPs). PATHS2 aims to build on and consolidate the gains of PATHS1 and the complimentary DFID funded Health Commodities Programme (HCP). PATHS2 shares with other SLPs, the goal of "Nigeria's own resources are used efficiently and effectively to achieve MDGs".

Though mostly focused on governance, PATHS2 also has a service delivery component. The programme's purpose is "to improve the planning, financing and delivery of sustainable and replicable pro-poor services for common health problems in up to 6 states" PATHS2 has 5 outputs carefully defined to contribute to achieving the purpose and goal of the programme. These outputs are: a) stewardship role for health at national level strengthened; b) state systems to support appropriate health services improved; c) delivery of, and access to, sustainable, appropriate health services and supplies improved; d) ability of citizens and civil society to increase the accountability and responsiveness of the health system improved; e) capacity of citizens to make informed choices about prevention, treatment, and care strengthened.

PATHS2 started operations at the federal level and four states (Enugu, Jigawa, Kaduna and Kano) from inception in 2008 and added a fifth state (Lagos) in January 2010. PATHS2 has been on the ground for almost 20 months now, but much of the early part of the programme was the inception phase, examined in the Inception Review.

This review focused on the previous nine months of implementation and was commissioned by DFID to assess progress during the first year of implementation; assess progress against recommendations made during the inception review; and propose recommendations for future action.

The review process included; review of programme documents; meetings with DFID, national level PATHS2 management and technical staff, management of other SLPs, and representatives of collaborating federal health institutions; visits to the 5 PATHS2 states to meet with PATHS2 teams, state teams of other SLPs, other DFID programmes, development partners, CSOs, SMOH officials, FHCs and to assess state medical stores and health facilities. The review team was composed of an external reviewer, staff from DFID, WHO, FMOH and SMOHs. General achievements were noted and the DFID Standard Aries Form was used to assess progress and score the programme against logframe goal, purpose and outputs.

The review observed numerous achievements, including:

- Establishment of a good and influencing relationship with government and other stakeholders at the different levels which has provided a platform to contribute to improvements in policy and strategic direction. A key contributory factor is the good understanding of the local context engendered by Nigerian led management at the national and state levels;
- Government representatives applauded the important role PATHS2 played in developing national and state level health plans, with good participation of civil society organizations;

- A lot of preparatory activities such as baseline assessments and establishment of government working groups for different thematic areas had been concluded;
- Continued consolidation on PATHS1 work, for example human resource assessments conducted by PATHS1 are being used to develop HRH strategies and the DRF scheme initiated by PATHS1 and HCP is being rolled out in all programme states.

Using the Aries Form, to assess progress against specific goal, purpose and output indicators, the programme had an overall score of 61%.

Major issues and risks identified include:

- Government commitment to development. Poor health budgetary allocations and execution, and expectations that PATHS2 should continue to fund services, were major concerns observed during the state visits. This raises serious concerns in the face of increasing DFID focus on service delivery outcomes as even the old states that had received significant governance support under PATHS1 did not seem to have increased funding of services;
- Lack of clear service delivery and health financing (including pro poor) strategies to guide PATHS2's support. There were unrelated service interventions supported by PATHS2 and multiple and sometimes confusing health financing initiatives in all the states visited;
- SLP coordination is weak and SLPs didn't seem to share a common vision. This decreases the synergy and complementarity between SLP programmes and is reflected in the continued non-prioritization of health and education in the states visited;
- Inadequate decentralization between Abt headquarters and PATHS2 national office, and between PATHS2 national office and state offices. While the national office were critical of the delay in centrally processed staff and consultant recruitments, the states complained of delays causing by waiting for approval from the national office for activities in their workplans. States were implementing similar activities so it didn't seem state strategies were "state grown" or state specific.

To address the issues, our recommendations include:

- DFID should meet with all the SLPs to review and address the issue of state governments' commitment, monitoring MoUs, and SLPs working together to make health and education a priority for the state governments;
- PATHS2, DFID and other stakeholders should review and agree on the governance and service delivery balance and review expectations (and the logframe) to match the agreements;
- PATHS2 should support states to develop a service delivery strategy and align their support with the strategy. They should provided technical assistance to the federal and state governments to map and analyse current financing initiatives and come up with a coherent strategy or framework;
- Abt should quickly decentralize sufficient decision-making authority to allow the national office and states to respond quickly to change. Specific areas recommended for full decentralization to the programme office in Nigeria are; recruitment of local staff, procurement of local TA and financial management of approved programme budgets. Activities contained in the approved state workplans should not require approvals before they can be implemented.

1. Introduction

1.1 Background

The Partnership for Transforming Health Systems 2 (PATHS2) is DFID's governance programme for strengthening health systems in Nigeria. It was launched in August 2008 and is a component of DFID's suite of state led programmes (SLPs). The SLPs "are a set of interlocking sectoral and governance programmes at the state level designed to complement each other"[1]. They were designed to be delivered as a single package (though contracted to different contractors) and share a common goal which is *"Nigeria's own resources are used efficiently and effectively to achieve MDGs".* Their individual purposes and outputs are designed to contribute to this common goal. The SLPs were designed with DFID's understanding of the fact that cross-government plans impact on sector initiatives, may affect success of sector plans and vice versa, so strong governance is needed at central government as well as sector levels, to achieve the MDGs. The other SLPs are:

- State Programme for Accountability Responsiveness and Capability (SPARC) – focused on central government strengthening.
- Education Sector Support Programme in Nigeria (ESSPIN) – education sector support.

1.2 State Accountability and Voice Initiative (SAVI) – focused on demand side.

Though PATHS2, like the other SLPs is mostly focused on governance, it has a service delivery component designed to ensure the availability of quality, pro-poor services in the supported States. The service delivery component of PATHS2 was designed to demonstrate good practice, act as pilots, and to act as a catalyst for collaboration with government. This mixed governance and service delivery model is captured in PATHS2 purpose which is "*to improve the planning, financing and delivery of sustainable and replicable pro-poor services for common health problems in up to 6 states"* PATHS2 has 5 outputs carefully selected to contribute to achieving the purpose and goal of the programme. These outputs are:

1. Stewardship role for health at national level strengthened
2. State Systems to sup-port appropriate health services improved
3. Delivery of, and access to, sustainable, appropriate health services and supplies improved
4. Ability of citizens and civil society to increase the accountability and responsiveness of the health system improved
5. Capacity of citizens to make informed choices about prevention, treatment, and care strengthened

PATHS2 aims to build on and consolidate the gains of PATHS1 and the complimentary DFID funded Health Commodities Programme (HCP)[2]. One of the key differences between the structure of PATHS1 and PATHS2 is that PATHS2 has the HCP component integrated into it. PATHS2 started operations at the federal level and four states (Enugu, Jigawa, Kaduna and Kano) from inception in 2008 and added a fifth state (Lagos) in January 2010.

[1] DFID Nigeria: State Level Programmes (SLPs). Draft terms of reference for independent external monitoring and evaluation
[2] DFID Nigeria Concept Note: PATHS2

PATHS2 is managed by a consortium led by Abt Associates. The consortium partners and areas of work are shown below:

- **Abt Associates, Inc:** Overall project management, health systems strengthening (HSS), public private partnerships (PPP), policy/financing, service delivery and donor coordination
- **LSHTM:** Health sector analysis, operations research (OR), public private partnerships (PPP), institutional capacity building (ICB)
- **JSI:** Policy & ICB for procurement & Logistics, logistics management information systems (LMIS)
- **AXIOS:** Logistics & procurement, blood safety/laboratory strengthening
- **OPTIONS :** Voice & accountability (V&A), demand creation, maternal and child health (MNCH)
- **YozuMannion/New Media Network:** Donor coordination/sector wide approach (SWAp) and behaviour change communication (BCC)

1.3 Review Objectives

A review of PATHS2 was conducted at the end of the inception phase, to assess progress during the inception phase and validate the proposed future direction of the PATHS2 programme[3]. This annual review was commissioned by DFID to "assess progress during the first year of implementation of PATHS2, assess progress against recommendations made during the inception review and propose recommendations for future action"[4]. The full terms of reference is attached as Annex 8.

1.4 Review Methodology

This review focused on the previous nine months of implementation. PATHS2 has been on the ground for almost 20 months now, but much of the early part of the programme was the inception phase, examined in the Inception Review. The proposed review team was not complete due to the inability of some of the proposed team members to make the trip to Nigeria as a result of the temporary closure of European airports. This led to re-arrangements to ensure that the review was successfully conducted and completed using those who were available. Despite this setback, the review was highly participatory with a review team that comprised of:

- An external reviewer – team lead
- DFID key staff Federal Ministry of Health (FMOH) representatives – department of planning of research and National Primary Health Care Development Agency (NPHCDA)
- WHO – Health systems adviser
- State Ministries of Health (SMOH) – Representatives of the ministry of health from each of the 5 states joined the review of another state, making it a kind of peer review and experience sharing.
- PATHS2 representatives: Technical coordinator and state programmes coordinator

Programme documents and reports were reviewed by the team before the commencement of the review. These documents include the PATHS2 memorandum, technical briefs, inception report by Abt Associates, end of inception review report, PATHS2 revised logframe and indicator dictionary, PATHS2 quarterly reports, PATHS2 first annual self assessment, HCP final report, SLPs inception review report,

[3] Inception review of PATHS2

[4] Terms of Reference for annual review of Partnership for Transforming Health Systems (PATHS2). April 2010

the National Health Strategic Development Plan, and State Health Strategic Plans from the supported states. The readings provided the reviewers especially the external reviewer with an insight into the PATHS2 programme and SLPs.
The team met with DFID in Abuja, key Federal level stakeholders including the Permanent Secretary of the FMOH, management of the National Agency for Food and Drugs Administration and Control (NAFDAC), the National Health Insurance Scheme (NHIS) and the NPHCDA. The review team was split into sub teams that visited each of the 5 PATHS2 states. Stakeholders engaged with at the State level include the commissioners of health, SMOH officials, Local Government Area (LGA) officials, facility health committees (FHCs), facility staff, other SLPs, other DFID funded programmes and development partners. The state medical stores and select health facilities were visited.

There was primary debrief on findings at every level, from facility, through SMOH, to PATHS2 state staff. There was a long debrief of the PATHS2 team (national office staff and state team leaders) in Abuja on the 29th of April 2010. The session also provided opportunity for the team to respond to some of the observations from the stakeholder engagements and visit to the states. The final debrief to DFID and stakeholders was on the 30th of April 2010. Besides DFID staff, others that attended the final debrief include PATHS2 staff, FMOH staff, SMOH staff from PATHS2 states, WHO, SUNMAP and USAID.

The findings from the review, challenges/risks identified and recommendations are presented in subsequent sections. References to “all the supported states” refer to Enugu, Jigawa, Kaduna and Kano. The states are arranged in alphabetical order all through this report. Lagos was only treated in the state specific reports because it is too early to review it by same parameters as the other states. Detailed state specific reports and the 2 focus areas (policy/planning and health commodities) are attached as annexes.

2. Review Findings

2.1 General Findings

Overall, PATHS2 have established a good and influencing relationship with governments and other stakeholders at the different levels, providing a platform to contribute to policy and strategic direction improvement. These relationships have led to significant progress in strengthening governance structures that can lead to improvement in services delivery, responsiveness and accountability. Good examples include the key role played in developing national and state level health plans and enabling the involvement of civil society organizations in policy development and revisions. A key contributory factor is the good understanding of the local context, engendered by a Nigerian led management at the national and State levels. A lot of preparatory activities such as situational analyses have been concluded and provide good information for designing and guiding implementation. There is considerable consolidation on PATHS1 work, for example human resource assessments conducted by PATHS1 are being used to develop HRH strategies and the DRF scheme initiated by PATHS1 and HCP is being rolled out in all programme States. Achievements varied across outputs and across States, and a key determinant has been the level of commitment of the different partner States.

Start-up has been very slow and some of the reasons provided by the DFID and PATHS2 team members interviewed include: long transition from PATHS1 because a new consortium is managing the programme, delays experienced in filling up key positions, an initial high staff attrition rate due to non-competitive compensation packages, an over centralized structure and delayed response time between consortium lead headquarters and national office and between national office and state offices. Though a lot have been done on strengthening governance, same cannot be said of improving service delivery. Most achievements so far relate to improving processes and are yet to materialize in demonstrable improved access or utilization of quality pro-poor health services. The service delivery strategy for achieving the programme purpose is still not clear and adequate emphasis is yet to be placed on achieving and measuring quantitative outputs and outcomes.

Key areas for concern are:

- The numerous health financing strategies being promoted by the Federal Government, without an articulated umbrella strategy as to how the harmonise with each other or contribute to health goals. This hampers PATHS2'strategic effectiveness in achieving various outputs.
- Disconnect between political and bureaucratic systems in the states. While focus is on strengthening systems at the bureaucratic level, politicians sometimes move in another direction. An example is the free MCH schemes, which have not been costed and whose actual and potential impact has not been analysed. Without more concerted effort to work with these realities, sustainability and impact of PATHS2 will be compromised.
- There would seem to be an absence of coherent service delivery strategies and plans at State level. This results in PATHS2' service delivery strengthening work being less effective than it could be.
- Commitment to change and to absorb programme inputs has been absent in certain examples. One such example is the procurement of drugs and commodities in Kaduna State. PATHS1 and 2 have trained staff and

equipped CMS staff with M-Supply. Though the skills are there to use it, use has stopped and procurement decisions are made without consumption data.

- The impact of pro-poor programme initiatives is uncertain. Drug Revolving Funds are not necessarily pro-poor and the Deferrals and Exemptions strategy has been ineffective.

2.2 Progress against Purpose

S/N	Indicator	Milestone	Progress
1	Level of compliance with the medium term sector strategy (MTSS) processes in the preparation of annual performance based budgeting at federal and state levels	20%	Despite initial slow pace in the adoption and or lack of compliance with MTSS as a process for annual planning and budgeting, there is evidence at both federal and state levels to show increasing acceptance of the process. During the period under review, of the 13 step MTSS processes, compliance was 30% at the FMOH, 20% in Kano and Kaduna States and 10% in Enugu and Jigawa.
2	Antenatal care coverage (4 visits)	None	The next assessment of progress on this indicator is expected from the NDHS in 2013. Work in the last one year to support the achievement of this indicator includes work on human resources (mapping, midwife recruitment and deployment, training of health workers), and supply of drugs and health commodities.
3	Proportion of 1 year-old children immunised against measles.	45%	Achievement could not be measured as data source is NDHS and MICS. MICS 2010 is not out and next NDHS is in 2013
4	Number of states implementing systems strengthening approaches to increase access to quality health services for women and the poorest	4	Most system support activities are still at the preparatory phase. PATHS2 is using many platforms and fora to share system strengthening approaches and successes from PATHS2 states, with non-PATHS2 states. The definition of health systems strengthening approaches was however not very clear.
5	Percentage of Local Government Areas (LGAs) in PATHS2 supported states with at least one functioning pro-poor health financing mechanism (safety nets) (target to be determined)	None	70% of LGAs in PATHS2 states had at least one pro-poor financing mechanism. There was no baseline so it was not possible to determine how many of these are as a result PATHS2 support.

The purpose is: To improve the planning, financing and delivery of sustainable and replicable pro-poor services for common health problems in up to 6 states.

While progress has been slow, there is some evidence of increasing buy-in at Federal and State levels to the Medium Term Sector Strategy (MTSS) process

(Purpose Indicator 1). However, compliance is only at an estimated 30% at the FMOH and, 20% in Kano and at 10% in Enugu and Jigawa.

Progress towards Indicators 2 and 3 (ANC and immunization coverage respectively) has not been possible to gauge effectively. It was stated that the only means of collecting data on these areas is from the NDHS and MICS, both of which have not been conducted this year. Human resource mapping and the provision of basic EOC kits and other commodities has taken place in support of these indicators, however.

Progress towards Indicator 4 concerning functioning pro-poor health financing mechanisms is also questionable. While 70% of LGAs in programme States have at least one form of pro-poor health financing mechanism (e.g. community based health insurance schemes and free MNCH services) it was not possible to determine which of these have been as a result of PATHS2 support. None of the programme States have begun implementing the Deferrals and Exemptions policies of the Drug Revolving Funds.

2.3 Progress against Outputs

This section looks at progress against outputs and in some cases, highlights areas of concern. Recommendations are discussed in the recommendations section (section 8) of the report.

Output 1: Stewardship role for health at national level strengthened

S/N	Indicator	Milestone	Progress
1	New and revised federal policies, plans, and legislation developed with PATHS2 support are consistent with National Strategic Health Development Plan (NSHDP) and meet a minimum quality standard	2	Development of National Health Management Information System (NHMIS) and Human Resource for Health (HRH) strategic plans are underway and the programme reported that these 2 will be completed by end of 2010
2	Level of compliance with the National Health Accounts (NHA) institutionalisation processes	30%	33%
3	Number of federal agencies with institutional capacity for HMIS.	1	Though some HMIS support has been provided to the FMOH, the capacity assessment needed to report achievement on this indicator has not been conducted

PATHS2 have provided acknowledged support for the development and revision of federal policies and plans. Particularly commendable is the support for the development of the (National Strategic Health Development Plan (NHSDP) and performance framework. This plan for the first time provides a broad stakeholder agreed plan for improving health outcomes and a framework for measuring progress. PATHS2 supported the convocation of the presidential health summit which culminated in 35 out of the 36 state governors signing a compact to increase financial commitment to achieving the MDGs. PATHS2 have also supported sub-sector policy and strategy development. These include situation analysis to inform the development of the NHMIS strategic plan, concluding staffing projections for 2010 to 2015 to provide information for the finalization of the HRH draft strategic plan developed with support from PATHS1 and assessment and gap analysis of

legislations, policies and systems impacting on sustainable commodities supplies. The PATHS2 team also provided support for the development of the medium term sector strategy (MTSS) process for health and institutionalization of the national health accounts (NHA) process. The MTSS will be based on the new NHSDP to provide coherence between priorities, strategy and budgets. PATHS2 have supported the conclusion of 4 out of the 11 steps for NHA institutionalization.

PATHS2 have supported capacity building for the planning and research department of FMOH for improved coordination of the federal HMIS. The health data consultative committee (HDCC) has been reconstituted and has already met this year to deliberate on improving HMIS and using data for decision making. Drafts of two HMIS publications, "Health in Nigeria Annual Health Report" and "Semi-Annual NHMIS Report" have been developed and are awaiting finalisation and dissemination.

Though the review did not explicitly assess the quality of these plans and strategies, the International Health Partnership (IHP+) have asked the country to write up the NSHDP development as a case study of good partnership for national policy development.

The major concern here is the numerous health financing initiatives supported by the national level without any umbrella strategy that makes it possible to understand how they are coherently contributing to achieving health goals. There was no evidence that any of these initiatives had been independently evaluated to determine their benefits. These initiatives include, the contributory NHIS, conditional cash transfers, MDG funding of target areas and community based health insurance schemes (CBHIS).

Output 2: State systems to support appropriate health services improved

S/N	Indicator	Milestone	Progress
1	New and revised state policies, plans, and legislation developed with PATHS2 support are consistent with the NSHDP and meet a minimum quality standard. Baseline for 2009 is zero (Source, PATHS2 Policy Review instrument and reports)	4	10 At least 10 state plans, policies and legislations that are consistent with the NSHDP were developed or revised in Enugu, Jigawa, Kaduna and Kano states with support from PATHS2.
2	Percent of budgeted State & LGA funds for health being disbursed (dis-aggregated by level of care & type of service if possible). Baseline to be determined from Public Expenditure Review.	0	Baseline not yet established. Report on this indicator is due in 2012 PATHS2 is planning to use the MTSS and public expenditure management reviews (PEMR) for identifying expenditures. PATHS2 has initiated the MTSS process in all the states and is collaborating with the World Bank to initiate PEMR in Kaduna and Lagos
3	Percentage of health facilities submitting timely and complete HMIS reports. Baseline to be determined.	0	Baseline not yet established. Report on this indicator is due in 2012 Percentage of facilities reporting in PATHS2 supported states has improved (or in case of Kano, maintained) from

			last half of 2008 to first half of 2009 (last available data, FMOH). Enugu Jul-Dec 08 0%, Jan-Jun 09 31%; Jigawa Jul-Dec 08 0%, Jan-Jun 09 69%; Kaduna Jul-Dec 08 0%, Jan-Jun 09 99%; Kano Jul-Dec 08 83%, Jan-Jun 09 83%.
	Number of states with adequate institutional capacity for human resource planning	0	None of the states have reached the "adequate" capacity which is defined in the indicator dictionary as having a (a) HRH policy, (b) strategic plan and (c) HRH database. PATHS2 supported HRH situational analysis in Enugu, Kano and Kaduna states to support evidence based planning. These will inform the development of state specific HRH policy and strategic plans, aligned with the national HRH policy. In Jigawa, draft HRH policy and strategic plans have been developed

PATHS2 supported the development of state strategic health development plans (SSHDPs) in Enugu, Jigawa, Kaduna & Kano, within the framework of the NSHDP. They also supported sub-sector policy and strategy development, as well building the capacity of the states in planning, policy development, budgeting (marginal budgeting for bottle necks) and managing service delivery. PATHS2 support has led to the achievements below.

Jigawa, Kaduna and Kano developed and costed their 2010 operational plans following the completion of their SSHDP and have incorporated their health plans into the overall state development plans. Enugu reviewed the law that established the state's District Health System (DHS) with the participation of 10 CSOs. The Jigawa state's Gunduma Health System (GHS) was significantly repositioned with the transfer by of over 5000 personnel from the LGAs to the GHS, bringing health workers for secondary and primary health facilities under one roof to improve coordination. Enugu, Kaduna and Kano were supported to develop public PPP for health policies to leverage the huge private sector patronage, to scale up services and Enugu has validated their PPP policy. To improve HRH planning and management, Jigawa have developed draft HRH policy and strategic plan while HRH situational analysis have been conducted in Enugu, Kaduna and Kano states to inform the development of their HRH policy and strategic plans. The Enugu HRH situation analysis have yielded earlier results as the commissioner informed the team that it led to the recruitment of 500 additional staff (managerial and technical) for the SMOH. All the states have set up committees for MTSS, state health accounts (SHAs) and CBHIS pilots.

To strengthen their drug revolving fund (DRF) schemes, PATHS2 is supporting all the states create drug management agencies (DMAs) to ring fence the funds and their management. Jigawa and Kano have established their state drug management agencies (DMAs), Kaduna state DMA bill has been approved by the legislature and is awaiting the governor's assent while Enugu is working on its draft bill.

Good progress has been made on this output especially with the approach of starting from the development of broad health sector strategic plans before moving down to specific sub-sector strategies. This should help ensure coherence between plans and contribution of the different departments to achieving overall sectoral goals.

PATHS 2 have paid insufficient attention to developing strategic coherence between the systems and planning work on one hand, and the explicit or implicit political priorities in each State on the other. For instance, even though all the supported States appear to view Free MCH schemes as politically important and are implementing schemes to that effect, none of the Free MCH schemes have been properly costed, no analysis has taken place of their expected impact on health outcomes, and little work has been done on developing appropriate systems to deliver them such as provider reimbursement or monitoring and evaluation. This would have provided the opportunity to leverage political support for reforms in health financing, human resources, institutional organisation and even HMIS.

Output 3: Delivery of, and access to, sustainable, appropriate health services and supplies improved

S/N	Indicator	Milestone	Progress
1	Percentage of health facilities in PATHS2 supported states with essential drugs consistently available	N/A	The reporting frequency for this indicator is at baseline (2009), midterm (2012) and end of project (2014). Records showed that 517 facilities were provided drugs as capitalization for their DRF in Enugu, Jigawa, Kaduna and Kano (this is part of PATHS1/HCP's commodities) and many other facilities already had their DRF running from earlier capitalizations by PATHS1/HCP. The review team visited only a few facilities within the time available and about 50% of these had the full complement of essential drugs available.
2	Percentage of health facilities in PATHS2 supported states providing basic emergency obstetric care services	N/A	.The reporting frequency for this is at baseline (2009), midterm (2012) and end of project (2014). The programme has provided some components needed to provide basic obstetric care. These include: (a) support for the midwives service scheme (b) provision of basic emergency obstetric care kits and other health commodities to over 150 health facilities in 4 states (c) training of health workers in Life Saving Skills and Modified Life Saving Skills
3	Percentage of clients in PATHS2 supported states reporting satisfaction with primary health care services	0	Activities are still largely at the design and planning state. The reporting frequency for this is at baseline (2009), midterm (2012) and end of project (2014)

4	Number of communities in PATHS2 supported LGAs with effective mechanisms to overcome socio-cultural and/or financial barriers to access emergency obstetric care.	0	.The reporting frequency for this is at baseline (2009), midterm (2012) and end of project (2014). Some of the preparatory work PATHS2 is doing to achieve this indicator's target include: (a) agreeing criteria for selecting focal LGAs in collaboration with the SMOHs (b) concluding strategy for CBHIS with NHIS and identification of pilot communities in 2 states

It is good to note that the transition of HCP into PATHS2 has been successfully concluded in all the states*. All the commodities procured through HCP have been received and are either in storage or have been distributed to facilities. PATHS2 have continued to support the DRF scheme initiated by PATHS1 to ensure availability of drugs in the health facilities. 517 facilities in Enugu, Jigawa, Kaduna and Kano received drugs to capitalize their DRF while 150 facilities in same states received basic emergency obstetric care kits. PATHS2 supported training of health care workers in all the states on basic and extended obstetric practices. Of all the states visited, only Jigawa was using the M-Supply commodities management software provided by HCP. There was evidence that store staff had been trained in all the states but were still not using the package. In Kaduna, the store team could use the M-Supply but stopped using it as the state decision makers ignored the reports they produced and procured without recourse to requests. In Enugu and Kano it was an issue of weak capacity.

All the states visited have free mother, newborn and child health (FMNCH) programmes aimed at providing free medical care for pregnant women and children under 5years as part of the national commitment to MNCH. Financing and implementation of the programme varied from state to state. Jigawa, Kaduna and Kano states procured the drugs and facilities requisitioned and received commodities for the target population based on consumption. In Enugu, the state government reimbursed facilities for services and commodities for the target groups. The Enugu facilities were expected to retain the fees for services and use that for commodities to procure from the central medical store (CMS) DRF commodities. The Enugu state government has owed most of the facilities for over a year, leading to gross decapitalisation of the DRF as commodities used for the FMCH could not be replenished. Of all the states, only Jigawa have costed their FMNCH programmes to determine actual resource needs. This was not done properly, however, and is therefore not usable. There is confusion between the operations of the DRF and FMNCH in all the states visited and the full range of FMNCH commodities were not always available.

It was obvious across the states that there was no clear service delivery strategy. PATHS2 support could not be seen to fit into a coherent strategy. The service delivery expectations to be achieved was not defined from the start and assessments/mapping was not done to decide how many facilities already had these services, how many had gaps and how many will be supported to achieve the results. This lack of clear strategy and baseline made it difficult to assess effect of support so far on utilization of services though a lot of had been done to make commodities available and improving services. PATHS2 mentioned that it was in advanced stages of developing a service delivery strategy in collaboration with stakeholders like UNICEF and NPHCDA.

Output 4: Ability of citizens and civil society to increase the accountability and responsiveness of the health system improved

S/N	Indicator	Milestone	Progress
1	Percentage of functioning primary health facilities in PATHS2 supported LGAs with FHCs meeting an agreed standard for community participation	N/A	Milestone/report in 2012 Work is at the preparation level. Activities completed include: (a) mapping strategy for PATHS2 support to FHCs in each of the 4 initial PATHS2 States, with clear PATHS2 inputs identified. (b) development of training manuals and training of 40 master trainers in Jigawa. Considerable attention is being given to how finding ways to ensure women's voices are heard within FHCs.
2	Number of PATHS2 supported states formally committed to civil society organizations (CSO) participation in policy development and resource tracking	N/A	4 PATHS2 ensured civil society organizations (CSO) participation in the development of state strategic health development plans in 4 states (Enugu, Jigawa, Kaduna and Kano). . CSOs are already being drawn into MTSS Sector Planning Teams in states.
3	Percentage of advocacy objectives achieved by PATHS2 supported issue-based coalitions	0	Milestone/report in 2012 Advocacy objectives to be measured has not been agreed with coalitions. Work towards this indicator has focused on the SAVI supported health sector partnerships. Whilst good relations exist between SAVI and PATHS2 in the states, PATHS2 role in supporting the partnerships remains small.
4	Percentage of functioning facilities within PATHS2 supported LGAs with functioning systems for enforcing health entitlements	N/A	No evidence that health entitlements have been agreed. Milestone/report in 2012 PATHS2 strategy for achieving this is a combination of using FHCs and communication packages. FHCs in Enugu, Jigawa, Kaduna and Kano are being trained to take on the role of a citizen's complaints mechanism. FHCs are also being trained on taking up the complaints with the relevant authorities, or effecting change where it is within their purview.

This output has been described by PATHS2 as focusing on strengthening the relationship between a) citizens/civil society and service providers and b) between citizens/civil society and policymakers/politicians.

A key achievement was the involvement of CSOs in the development of the SSHDPs in Enugu, Jigawa, Kaduna and Kano. PATHS2 supported a 2 day workshop in each State to assist CSOs to appraise the draft plans and to develop recommendations on

how it could be strengthened and made more responsive. CSOs were supported to become part of the MTSS health sector planning teams in 3 States. PATHS2 have instituted a desk review of international experience of CSO policy and budget influencing. Lessons from the review will be applied in the design of a programme of PATHS2 support to CSOs to become active partners in the health MTSS in focal States. There was clearly very good collaboration with SAVI and ESSPIN in this area of work and the CSOs PATHS2 is working with, are either those already selected by SAVI or were assessed and selected in collaboration with SAVI.

To strengthen the relationship between citizens/civil society and service providers, PATHS2 is supporting FHCs in all the focal states. The FHCs in Kaduna were particularly active in mobilizing additional resources for the facilities to fill the gaps in government funding. The FCHs are currently not very active in holding government accountable and demanding change. A strategy for strengthening FHCs to take on increased voice and accountability roles has been agreed with government in all the states, with clear PATHS2 inputs identified. Implementation of this strategy has started in 2 States, Jigawa and Kaduna. PATHS2 supported the development of FHC operational guidelines and training manual for Jigawa State, building on earlier versions drafted by PATHS and PRRINN-MNCH. The manual is now being adapted for the other states. 40 FHC trainers have been trained in Jigawa, through joint PATHS2-PRRINN-MNCH effort.

Output 5: Capacity of citizens to make informed choices about prevention, treatment, and care strengthened

S/N	Indicator	Milestone	Progress
1	Percentage of people in focal LGAs who have heard of and/or participated in PATHS2 supported public dialogue on key health issues	0	Preparatory activities are ongoing. Milestone/report in 2012 Preparatory activities are ongoing to launch a public dialogue programme called "Ask Nigeria". The activities will be focused on three LGAs in Enugu, Jigawa, Kaduna and Kano. Polling is due to start in April / May 2010 and the process will culminate with state wide public debate to openly discuss the findings of the process. Public Service announcements for TV and radio have been produced along with promotional materials and polling tools and discussion guides for community participation groups have been developed
2	Number of people participating in public health dialogue events in PATHS2 supported LGAs, with good recall of public health issues	N/A	Preparatory activities are ongoing. Milestone/report in 2012 PATHS2 funded a health promotion capacity assessment of government and based on the findings designed a health promotion training course which has been implemented in Enugu and Jigawa. In 2009, PATHS2 convened a consultative feedback forum between the Lere community in Kaduna state and the Honourable

			Minister for Health. 1500 community members participated.
3	Percentage of people in PATHS2 supported LGAs who have adequate knowledge on the signs and prevention of common health conditions	N/A	Preparatory activities are ongoing. Milestone/report in 2012 This indicator relates to indicator 2 above and is intended to show impact of the public health dialogue activities. Baseline survey shows that knowledge is low across the PATHS2 supported states and no significant client targeted communication strategies has been implemented to suggest that there be a change in this.
4	Percentage of people in PATHS2 supported LGAs who can correctly identify health service entitlements	0	Health service entitlements yet to be made available to the people. Milestone/report in 2012 PATHS2 strategies for this include the uploading of entitlements on the federal and state ministry of health websites. PATHS2 provided assistance to the FMOH to reactivate its website and is developing websites for the all the states ministries of health

For this output, PATHS2 has utilized a combination of mass media, direct consultations and community participation, strengthening health promotion organs of government, creating active websites for ministries of health, targeting youths and building capacity for research to assess client knowledge and monitor effect of communication interventions. The implementation of this strategy is already well advanced at the federal and state levels.

PATHS2 has highly advanced communications capacity going by the quality and effectiveness of communication strategies and products they have developed so far. The agenda for health documentation and Lere feedback forum have been very successful in putting community health issues and expectations on the front burner at the national level. The Lere Consultative Feedback Forum with the Hon. Minister for Health was an innovative and highly commendable initiative. It brought the Minister for Health, State and local government authorities in direct contact with the community in a forum where the community aired their opinions on the health sector and its services, expressed their expectations and made their requests known. We are yet to see the long-term impact or whether there will be follow-up, however. Though it will not be possible for the Minister to visit every community in Nigeria, this initiative has great potentials and should be scaled down to local consultative forums for health between the community and decision makers.

A new vehicle for public dialogue named “Ask Nigeria” has been designed and developed by PATHS2, building on the approach used for the “Agenda for Health Documentary”. State versions called “Ask Enugu”, “Ask Jigawa”, “Ask Kaduna” and “Ask Kano” have been developed and preparations for implementation are well advanced.

To improve health promotion capacity of government, PATHS 2 have conducted health promotion capacity assessment of government and based on the findings have designed and implemented health promotion training courses in Enugu and Jigawa with the other states to follow later in the year. They also provided support for

the establishment of health communication groups in all the states and have trained member of the communication groups. PATHS2 is working closely with ESSPIN on assessment of in-school and out of school youth heath programmes.

The FMOH officials were particularly pleased with PATHS2 support for the reactivation of the FMOH website. The ministry reported extensive downloading of the health promotion policy from the website and the site was reported to have received 5532 visitors in March 2010 alone. All the states visited were working on developing their SMOH websites with PATHS2 support.

2.4 Cross cutting issues

2.4.1 Pro poor measures

The purpose of PATHS2 clearly indicates that it should be pro-poor focused and as such, any assessment of success will probably look at implicit and explicit pro-poor strategies across all outputs, even though the only indicator that mentions pro-poor is found under output 3. At the federal level, PATHS2's pro-poor strategy for now seems to be centred on support for government to implement CBHIS schemes. A lot of support has gone into building capacity of NHIS staff and other stakeholders in CBHIS and developing tools for the roll out of CBHIS. At the state level, the emphasis has been on pilot of CBHIS and FMNCH. Enugu, Jigawa, Kaduna and Kano all had in their workplans, piloting of CBHIS. In some cases, DRF was also mentioned as one of the pro-poor strategies however there is no evidence that it is pro-poor.

So far, there has been mixed results on the scalability and sustainability of CBHIS from pilots across the globe. Having a CBHIS does not always guarantee access for the poor except if the scheme is deliberately designed to be able to identify and exempt the poor. During the Lagos state visit, enrolees of the state's CBHIS complained that the monthly premium of N800 was too high even though that was less than 40% of the actual cost of care as government covered over 60% of costs. None of the states visited had functioning deferral and exemption (D&E) systems and since the FMNCH covers only pregnant women and children under 5, there was nothing to protect the poor outside the FMNCH target population.

2.4.2 Gender mainstreaming

There was active effort in ensuring gender equity and mainstreaming across all areas of PATHS2 work that was observed. The FHCs' terms of reference (ToRs) were reviewed to ensure adequate participation of women. Women's groups were also visible as some of the CSOs that were selected by PATHS2 for capacity building, to contribute to policy development, voice and accountability work. It is commendable that the documentaries on the "state of health" and Lere dialogue had active and unrestricted participation of women.

2.4.3 Knowledge management

Given the delayed start up of the programme, the amount of success stories and best practices available to share are still limited. PATHS2 have established some useful platforms that can be utilized for knowledge management, especially sharing successes and lessons with non-PATHS2 states. These platforms include positive relationships and collaborative partnerships made with various partners such as the World Bank, WHO, UNFPA, UNICEF, IDRC, MDG office and MSH, amongst others. These collaborations should provide partners with knowledge of PATHS2 successes

which they can implement in the states they are supporting. Specific areas of collaboration include public expenditure management with World bank, HRH planning and management with WHO and MSH, improving coverage of health services/strengthening of supply and demand side health services with PRINN-MNCH and ENR and strengthening HMIS with GHAIN. The FMOH and SMOHs were also supported to present memos and papers at the National Council on Health which has in attendance, health decision makers from all the states. The re-activation of the FMOH website will also provide an avenue to share information on outputs of collaborative work between the ministry and PATHS.

2.4.4 Value for money study (VFM)

Due to the scope of this review, the time and team composition, value for money analysis was not explicitly carried out. The logframe does not currently have VFM indicators and there was not enough time to compare cost of programme approaches and interventions to costs from similar programmes. The programme's approach of directly funding mutually agreed activities (with government) rather than transferring cash to government, reducing financial incentives traditionally associated with donor funded projects (per diems), utilization of government facilities and negotiating favourable venue rates for meetings, is considered good value for money. The outputs from inputs put in some areas such as the NSHDP, SSHDPs, and presidential compact is also considered good VFM. The yield from service delivery support such as drugs and medical equipments could not be determined as most service utilization indicators were yet to be measured so it was not possible to make VFM judgements for those.

3. Progress against inception report recommendations

S/N	Area of Recommendation	Progress on recommendation
1	Management	All recommendations have been implemented. Senior management team is now complete and roles are clear.
2	Log frame	Logframe has been revised and output 1 is now clear as a federal level output .The indicator on '"reduction in % of counterfeit and sub-standard drugs in public and no-state outlets by 10% by EoP", was dropped contrary to recommendation
3	Resources for health	State governments' allocation to health is still low. SLP meetings have been holding but actual collaboration to influence government decisions is still limited
4	Donor coordination	Development partners meeting is bringing donors together and NHSDP provides platform for harmonization and alignment of donor support. Government's coordination of donor efforts is still weak at all levels
5	Knowledge management	PATHS2 knowledge management strategy has been revised but could not be reviewed in detail due to time constraints
6	MoUs	MoUs have been signed between DFID and state governments. Monitoring of MoUs is still not strong enough
7	Budgeting	Work is going on to improve budgeting through MTSS but this is still at the early stages and all states still have unrealistic budgets
8	HMIS	Some of the national tools have been harmonised, but programmes/projects are still developing more new tools and there were too many vertical tools at the facilities visited. Donor agreement on harmonization of tools and government coordination of this is still very weak
9	PPP	Regulatory framework and strategy yet to be developed. Mapping of private sector has been concluded in most states, to guide strategy development
10	Absorptive capacity of states for technical assistance	Not much has changed in this area. States' ability to absorb TA needs to be assessed especially in the old PATHS1 States like Enugu, Kaduna and Kano where one finds it hard to see changes from TA received over the last 6 years. It is unclear whether this is due to lack of political commitment or absorptive capacity.
11	Embedded staff	These groups work could not be assessed due to lack of time
12	Health financing	Support is being provided to different financing schemes but there no clear health financing strategy at the federal or state level. Evidence based policy papers to guide government with options on merits/demerits of different schemes have not been developed and the implementation of the national insurance still needs to receive a scientifically sound and independent evaluation

13	V&A	There has been active collaboration between PATHS2 and SAVI in working on CSOs on V&A at the state level. States now have V&A officers
14	HCP	From the interaction with the states, they still expect PATHS2 to continue some funding of commodities. Enugu actually expects complete recapitalization of their DRF and it does not sound like they understand that the HCP is not a permanent commodities financing programme
15	Work plan	The federal and state programmes have revised their workplans in line with the revised log frame. It is not clear if the revision took into account an assessment of resources available to government at the different levels especially the LGAs. There is still need to prioritise the allocation of TA inputs to achieve key indicators. The current review shows that achievement on outputs is currently skewed towards governance with less emphasis on service delivery. The balance this time needs to be corrected especially with the service delivery implications of achieving the output

4. Management Arrangements

4.1 Programme management

PATHS2 now has a complete senior management team. The PATHS2 national senior management meets weekly and the expanded management meeting involving STLs is held quarterly. Consortium meetings are held twice a year, while the technical advisory meetings (TAGs) are held once a year

These clear improvements in management structures have significantly stabilised PATHS2 management, when compared to the inception period. The organogram for the national office is still somewhat complex and there is some blurring of roles between “the technical” and “management” units that needs fixing.

4.2 Decentralization

Interactions with the team revealed that decisions for human resources (full time and consultants) and financial matters are still highly centralized at Abt headquarters in the US. All staff recruitment have to be finalized by Abt headquarters and procurement of technical assistance above N10, 000 also have to pass through Abt headquarters. This centralization has been noted to affect PATHS2’s ability to attract and retain good quality staff and consultants as the packages negotiated by Abt headquarters were said not to be competitive enough for the Nigerian development sector. The centralization was also said to create delays in recruiting staff and consultants as the time lag between sending concluded interview results to Abt headquarters and receiving a final contract from Abt for selected personnel took more than a month in most cases. DFID staff also complained of difficulty and delays in getting financial reports and responses to queries from PATHS2, as this had to be sent from Abt headquarters.

The state offices said there was good communication between them and PATHS2 national office, but there were also complaints about delay in responding to state specific needs due to requirements for approval from the national office, even when in the approved workplan, and the time it takes to get such. It was observed that some activities designed at the national office such as CBHIS pilots and PPP mapping were uniformly accepted and implemented by all states even in cases where they did not fit into individual state’s peculiarities.

4.3 Human Resources (HR)

There was a good HR management system with probationary assessments, annual performance appraisals and accompanying incentives/disincentives. They also have robust learning and development initiatives that include tuition reimbursement for staff based on on-the-job needs and brown bag sessions at the national office

5. Coordination

5.1 Coordination with other SLPs

The PATHS2 team clearly appreciated the fact that all SLPs needed to work together. They attended SLPs's meeting but admitted that it was sometimes difficult to attend the meetings due to conflicting activities. In all the states, they have met with the other SLPs and identified nodes to work together on. During interaction with PATHS2 and the other SLPs, a sense of inter-dependence between the SLPs was not evident. Collaboration seemed to be more of a fulfilment of DFID's request for collaboration and was more focused on identifying and working on nodes than concerted effort to achieving a common goal. At the meeting in Abuja with other SLPs, there were complaints of the challenges of synchronizing activities because they were are at different stages of implementation and PATHS2 was particularly behind given its delayed start up. They also complained of the challenge of collaboration in areas where their work was determined by their government partners who were neither interested nor understood collaboration. PATHS2 management complained of cases of non-response by other SLPs to invitations to participate in their activities. According to PATHS2 management, it seemed other SLPs' management viewed them as "outsiders" and not partners. There were also complaints at the national level of PATHS2 not attending some of the SLP meetings, sending staff that are not senior enough to take decisions and changing attendees often. Good collaboration with PATHS2 was reported by SAVI in selecting and training CSOs in all the states. PATHS2's work in encouraging states to increase health workforce seemed contradictory to SPARC's support for public sector reforms (that included reducing staff size) in the state's except Kaduna where PATHS2 is working together with SPARC on the public sector management reform programme.

It is encouraging to note that the SLPs programme managers in Abuja said collaboration with PATHS2 has improved significantly and expected to continue to improve, with the full take-off of implementation and stabilisation of the programme. The co-location of SLPs at the State level was said to have improved communication between SLPs. It is also encouraging to learn that the SLPs, led by SPARC, plan to start the development of joint political engagement strategies. This will provide the opportunity for much more meaningful and strategic collaboration around specific governance issues, and enable clearer synergy with PATHS2's service delivery interventions

5.2 Coordination with other DFID programmes

PATHS2 attends monthly meetings with other DFID health programmes in Abuja. In the states, representatives of the other DFID programmes reported good collaboration with PATHS2 especially in leveraging resources and capacities. In Enugu, it was not possible to meet with the representatives of the other DFID programmes as they were out of the state. The collaboration between PATHS2 and PRRINN-MNCH in Jigawa is exemplary. They hold coordination meetings once every 2 weeks to discuss plans and agree on areas of work. These have resulted in the development of joint concept papers and implementation in areas such as HRH improvement, HMIS strengthening, ISS and PPRHAA, operations research and community engagement. There is good collaboration between PATHS2 and ENR in Kaduna. The 2 programmes worked together to support the development of the state HIV/AIDS strategic plan and are supporting the Kaduna SACA to develop its operational plan. In Kano, PATHS2 provided logistics support to SUNMaP for successful ITN distribution during the ITN campaigns. PATHS2 Kano and SUNMAP

have identified further areas of collaboration that include training, commodity distribution, HMIS, HRH and ISS.

5.3 Coordination with development partners

PATHS2's role in development partner coordination was commended by development partners met during the development partners' meeting in Abuja. The development partners group in Abuja were happy with PATHS2's role in supporting development partners' coordination towards the development of the NSHDP and SSHDPs.

PATHS2 is working with the World Bank on PEMR, with WHO on documenting the NHSDP development, supporting for two years the position of a health systems specialist with the WHO and working with USAID funded MSH on human resources for health.

PATHS2 have had much less collaboration with other development partners (or their local funding recipients) funding or implementing other Health Systems Strengthening initiatives in Nigeria, such as the Global Fund (Health Systems Strengthening (HSS) grant, GAVI (HSS grant), the World Bank/ AfDB (Health Systems Development Project) and the OSSAP-MDGs (Health Systems Strengthening project). As a result HSS interventions in Nigeria are disorganized and poorly coordinated, and are being implemented using unsustainable vertical approaches.

In Enugu, PATHS2 supported the collapse of the multi-sectoral SLPs steering group into the donor coordination group. They supported the development of clear terms of reference for the group and attend the quarterly donor coordination meetings. PATHS2 is also a member of the state immunization committee with UNICEF and WHO.

In Jigawa, PATHS2 supported the mapping of development partners and NGOS working in the state and supported the establishment of the development partners' forum. They also supported the revitalization of the State Inter-Agency Coordination Committee (SIACC) which reviews development partners' monthly and quarterly plans and activities.

The Kaduna state PATHS2 team supported the development of a ToR for the state's donor coordination group and the Kaduna Health Forum (KHF) which was formed at the end of PATHS1. The KHF has representation from the donor group and other stakeholders including the state ministries of health, LGA affairs and finance, state legislature, private sector and consumers.

The Kano team supports the meeting of the development partners' forum. They need to further support the forum to develop a ToR to make them more effective. PATHS2 in Kano collaborated with the USAID funded Deliver Project to support the SMOH to develop supply chain segmentation strategy for health commodities. All the major development partners had signed an MoU outlining their specific contributions to strengthening routine immunization.

6. Challenges and Risks

The review team feels that generally, the risk assessment undertaken before the take off of the programme and documented in the programme memorandum remains valid. For emphasis, some areas of major concern identified by the team are highlighted below. Recommended mitigation strategies are contained in the recommendations section.

6.1 Government commitment

As a primarily governance programme, PATHS2's success will depend on government commitment to reforms and prioritizing achievement of MDGs. Federal and State government officials expressed commitment to achieving the MDGs and appreciated PATHS2 support. A look at budgets for health at the different levels did not however reflect this commitment. The Federal Government's budgetary allocation to health averaged significantly less than the 15% of total budget which Nigeria signed up to in the Abuja Declaration. This target may be too high, though.

At the federal level a key change is frequent change in key government officials. The FMOH have had 3 substantive ministers since 2007. There have also been frequent movement of permanent secretaries and directors. This makes it difficult to sustain direction and requires continuous relationship building which is time and resource intensive. The Health Bill is yet to be signed and this remains a big concern as the bill's focus on financing primary health and health for the poor and vulnerable provides an opportunity for real change.

The States reported that the enthusiasm for PATHS2 support was not always matched by keeping the promises or terms agreed in MoUs with DFID or in the MoAs with PATHS2. Budgetary allocation for health remained low and actual releases even lower, across the States. Due to the report on very low budgetary allocation for health by the Enugu state government (averaged less than 5% in the last 4 years), a more in-depth analysis of their 2009 and 2010 budgets was undertaken. This analysis was further made possible by the fact that SPARC had done a recent budget performance analysis in the state and this information was available for the team to review. The results are presented below.

In Enugu, only 16% of the 2009 budget for the social sector (includes health and education) was released compared to 85% release of the economic sector (road construction constituted a large part)[5] budget. Allocation to health in their 2010 budget proposal is approximately 3.4% of the entire budget. Out of this low health allocation, 31% is for constructing a new diagnostic centre. Works (mostly road construction) remained the government's priority and was allocated 24% of the entire budget.

In Kaduna, low budgetary allocation and release was also a problem. The bulk of the state's health budget was going into the building of a 300 bed hospital.

6.2 Unrealistic budgets

In all the states, unrealistic budgets were a big problem. The state's health budgets are not based on realistic revenue projection and are usually much higher than realistic revenue profiles. This makes total release of budgeted funds impossible with

[5] Enugu budget analysis summary by SPARC Jan 2010

the social sector suffering the most as capital projects like road construction are given out as contracts early enough in the year before the money runs out.

6.3 Disconnect between political and bureaucratic systems at state level

While PATHS2 works mostly with bureaucrats and systems, interactions with state officials revealed that decisions are made mostly by the political class without recourse to the bureaucrats and systems. This creates a big disconnect between policies and systems supported by PATHS2 and the resource decisions needed to implement programmes. The key decision makers even for health sector specific issues are the governors, legislators and political appointees.

6.4 Fungibility

There was clear fungibility by the states and in some cases PATHS2 support replaced rather added to government spending on achieving the MDGs. Enugu State government is spending a significant proportion of its health budget on a new diagnostic centre; Kaduna state is building a 300 bed hospital. It seems that while PATHS2 is supporting MDGs focused strategies, the States are spending their own funds to these huge resource consuming projects. State governments may well have spent funds on these glamorous projects with or without PATHS2 presence, however.

6.5 Linking service delivery with governance

The inception review describes the “tension between governance and service delivery” and the potential effect of providing commodities and equipments on weakening the governance objectives of making government use its own resources to improve health. This review encountered the disturbing finding of states expecting PATHS2 to continue with the PATHS1 provision of drugs, equipments and refurbishment of facilities. Rather than “tension”, this review views this as more of a question of finding the balance between governance and service delivery and fostering synergy between them. Improving governance should improve government’s ability to improve services, but the timing of outcome expectations for governance and services is different. Strengthening governance to the level where government will use its resources efficiently to provide the level of services expected will take time. Achieving the MDGs is time bound and therefore necessitates supporting a virtuous circle through improved service delivery fostering better governance and vice versa. Determining what amount of services and strategies for service delivery that does not undermine the governance support will be tricky but is inevitable for a mixed governance and service delivery programme like PATHS2. It will be critical to ensure that PATHS2 support for service delivery is targeted at leveraging greater and more sustainable investment by partner Governments.

6.6 Sustainability

Though the programme is just in its first year of implementation, the review found signs of the usual government dependence on donor funded programmes. The review team was inundated with long lists of requests ranging from more training for staff in areas they had previously been trained, to provision of laptops and basic office equipment and furniture. This was particularly the case at the state level, even from staff of departments with huge budgets and departments that prepared the budgets. There was also the sense that some of the programmes like the DRF were seen as PATHS2’s and so PATHS2 was expected to resolve any problems related to

such programmes. It didn't seem the understanding of the responsibilities of government and that of PATHS2 had permeated well enough.

7. Recommendations

7.1 Focusing on outcomes

Though the programme has successfully completed a lot of activities within the first 9 months of proper implementation, it seemed there was little focus on the logframe outputs and their indicators until just before the review. For a lot of the activities, even though they were clearly contributing to achieving the outputs, they were either not designed or reported in a way that progress by indicator could be easily measured. For every indicator, baselines should be quickly established and activities designed in such a way that progress on the indicator can be measured at any given time.

7.2 Service delivery

PATHS2 needs to quickly finalize its service delivery strategy. The starting point should be each programme State's service delivery strategy and plan. PATHS2 can then contribute to certain elements. The strategy should be clear on PATHS2's and each State's minimum service expectation in terms of service packages, structures, commodities, human resources et cetera. This should be followed by a baseline assessment in each state to establish number of facilities (by population and spread) that meet the expectation. Such an approach will help them develop a coherent support strategy and not the current provision of commodities in some places, establishment of TB services, training et cetera in others. It will help them decide number and location of LGAs or facilities to support and exact support package. This will also make it easier for them to assess progress and contribution to overall health improvement in the states during internal or external reviews. The service delivery strategy should also incorporate a clearly agreed sustainable exit strategy for the scale down of PATHS 2 from certain kinds of support.

A service delivery strategy should provide the central theme for all outputs to contribute to. It will provide a focus for governance support (supply and demand side interventions designed to support implementation of the strategy), provide the needed coherence to the entire programme and establish the balance between governance and service delivery support.

7.3 Health financing

Health financing is another area that needs coherence. Governments at the federal and state level are implementing multiple financing schemes ranging from DRF, FMNCH, CBHIS, contributory schemes through the NHIS, private health insurance (directly with HMOs), conditional cash transfers and targeted strategy funding from the MDG office. There is a lot of confusion, duplication and sometimes conflict between these funding schemes. Rather than help address this, PATHS2 has probably helped add to the confusion by pushing alternate models of its own, such as the CBHIS pilots, without clear evidence to support this direction.

PATHS2 should support the federal and state governments to develop evidence based health financing policies/strategies. This should be preceded by analysis of the different financing options, to help them understand the benefits and challenges of each, as recommended in the inception review report. These strategies will help match the different options or mixes with sectoral goals and objectives and make it possible to evaluate their effectiveness. It will also optimize the use of available resources by avoiding duplication and waste.

PATHS2 also needs a more comprehensive approach to ensuring pro-poor services. Just like is done for gender, a pro-poor tool or checklist should be developed or adapted and run across all PATHS2 programmes, irrespective of output, from the design to the implementation and evaluation stages. States and LGAs should be supported to design and implement safety nets for the poor not covered by the FMNCH programme and exploration of options should go beyond CBHIS.

7.4 Health Management Information System

One of the areas where difference would be expected between PATHS2 supported and non-PATHS2 supported states is rate of reporting and quality of reports. Support should be intensified for facilities, LGAs and states to generate, analyse, use and report quality data to the next level. These needs to run in parallel with support for strengthening HMIS stewardship and does not need to wait until new systems are developed or old systems revised.

There are still too many vertical and mostly duplicative tools in the facilities, leading to tool/information overload for facility staff. In some of the facilities visited, the tools constituted more work than service delivery. Government should be supported at the national level to coordinate donors and all stakeholders to harmonize and align health information requirements and systems. It will help to have a minimum national indicator list for the different levels of service delivery, for routine reporting. Such a minimum dataset will help harmonization of HMIS tools to limit them to information required to meet the minimum reporting requirements. Programmes and projects with additional information needs should be encouraged to collect these through none routine methods such as surveys.

Emphasis should shift from collecting loads of information to actually utilizing what is collected. No evidence was found that the excessive information generated from the facilities was being utilized for improved decision making at the facility, LGA or state level.

PATHS2 should actively support national data collection studies, such as NDHS, MICS and NICS.

7.5 Knowledge Management

There should be increased collaboration with FMOH agencies especially NPHCDA, so the agency can carry best practices from PATHS2 states to other states and vice versa. PATHS2 state offices need to step up the development and distribution of communication tools. Though the FMOH is happy with its re-activated site, the quality of the site in terms of aesthetics, organization and content needs improvement.

7.6 Management

There is need to decentralize enough decision making authority to allow the national office and states respond quickly to change. Abt headquarters can develop and monitor a quality assurance system to ensure quality and compliance with Abt policies, while management decision making is fully devolved to the in-country programme management. This will help the programme deal quickly and appropriately with the dynamic local environment. Specific areas that are recommended for full decentralization to the programme office in Nigeria based on this review are, recruitment of local staff, procurement of local TA and financial management of approved programme budgets. To allow for quick programming and flexibility, it is recommend that PATHS2 develops and costs an annual work plan and Abt headquarters reviews and approves this. Once approved, the programme in

Nigeria should take responsibility for the approved resources to implement programmes.

More authority should be devolved from the national office to the state offices to also enable them take and implement state specific actions. State grown solutions and strategies should be encouraged within the framework of the overall programme goal, purpose and outputs. Generic national office designed strategies should be broad and not prescriptive so the states have the flexibility to identify what works and what does not based on their state specific contexts. The brown bag sessions should be decentralized to the state offices and the knowledge gap between the national and state offices should be narrowed.

Good quality staff and technical assistance are vital for the success of the programme and strategies to recruit and retain them should be quickly put in place. PATHS2 as a primarily governance programme relies on TA to achieve its objective and should be able to hire the best to provide effective TA. PATHS2 also needs to put in place a more robust system for quality assurance of technical consultancies.

7.7 Coordination between outputs

There should be more synergy between the outputs. Currently there seems to be more focus on achieving specific output targets than each output providing a needed part of an overall strategy to improve governance and services. The demand side outputs have great potentials for improving governance and service delivery and should be woven into all supply side interventions. The demand side should be exploited to make health a political (perception of government and election scoring point) issue so governments can give it the priority that is currently given road construction and other capital projects.

7.8 Coordination between SLPs

One of the SLP national programme managers correctly said that “the nodes system for collaboration between SLPs was useful at the beginning but it is now time to go beyond the nodes”. What is now needed is joint planning and implementation, with a focus on specific governance and political issues and bottlenecks. The issue of unrealistic budgets and low allocation and release for health (and education as well), can only be addressed by the SLPs working together. PATHS2 should engage with SPARC to use its position with the central government planning ministries to put health on their priority list. This contrary to concerns raised by SPARC will not amount to dictating to government if the approach is to use evidence and importance of achieving MDGs (which I believed is contained in the MoUs), to convince government. The demand side potential for increasing allocation to health as well as holding government accountable for transparent and effective use of resources, requires closer working with SAVI. The

DFID should consider organizing a workshop with the SLPs at the national and state levels to look at specific areas and strategies especially around increasing budget allocation, release and expenditure. The workshop should also look at how to work together while trying to meet individual programme specific targets. DFID should also coordinate more closely, the SLP meetings at all levels to ensure attendance and productivity of the meetings.

7.9 Monitoring Relationships with Governments

The issue of government commitment disconnect between political decision makers and government systems and low health sector funding needs DFID’s urgent

attention. This review did not have the opportunity of looking at a copy of the MoUs, but it is recommended that all MoUs include key programme specific indicators and DFID should institute regular monitoring of adherence to MoUs and discuss options with SLPs as part of the SLP meetings.

Government commitment is something that affects all development partners work in the states. DFID should engage with other development partners to forge a coalition for holding government accountable to commitments to partnership. This will have stronger affect that each partner going it alone.

It is also recommended that DFID have a review of its relationship with each of the states and decide if it is necessary to determine when a relationship with a state will not lead to achieving joint DFID/state agreed goals. Agreement with states should include terms for review or even discontinuation of partnerships.

Bridging the gap between the technical and the political is fundamental to the success of PATHS2 and the SLPs. PATHS2 should have as top priority - improving the capacity of health ministries, departments and agencies to increase the political relevance of their work in response to the health needs of the State. Without this happening, it is unlikely that any health governance improvements achieved during the life of the project will be sustainable. It will be useful to develop appropriate indicators that measure the ability of State health institutions to positively influence policy at the political level, demonstrate the political value of their work, and implement political health priorities.

7.10 Matching PATHS2 support with NSHDP priority areas and performance framework

The FMOH specifically requested that PATHS2 should lead by example by showing how its outputs and activities contribute to achieving specific NSHDP and SSHDP objectives and the targets in the performance framework. There is very important and will show that PATHS2 is aligned with the sector plans it helped develop. This will serve as a best practice and encourage other programmes and development partners to do the same. A simple matrix matching PATHS2 outputs and activities against specific NSHDP and SSHDP objectives, indicators and targets should suffice.

7.11 Review of governance and service delivery mix

DFID should meet with PATHS2 and stakeholders (including DFID service delivery programmes) to review the governance and service delivery expectations and synergies. The timing of expected outputs from each should also be analysed as governance takes longer to improve than service delivery. Service delivery interventions may also increase government's dependence on PATHS2 and undermine the objectives of governance support if not clearly thought through.

7.12 Logframe revision

The logframe should be revised urgently to develop indicators and milestones which are achievable and measurable on an annual basis. Baseline data should be gathered for those indicators without them. Targets and milestones should be disaggregated by States.

7.13 Mini Review by DFID

It is recommended that the DFID team (can be made of DFID staff only) conducts a mini review by November 2010, to monitor progress against specific urgent governance and service delivery implementation centred on a clear service delivery strategy. Key areas that the mini review should focus on are:

- Service delivery support strategy and plan showing how each output will contribute to strategy
- Clear health financing support strategy for PATHS2 (including comprehensive pro-poor strategies and how they will be measured)
- Baseline established for each of the output indicators
- Progress against each output indicator

This should not become a regular process, as routine monitoring to capture these issues, but an extraordinary measure.

7.14 Value for money study (VFM)

Due to the scope of this review and the time and team composition, of value for money analysis was not explicitly carried out. The logframe does not currently have VFM indicators and there was not enough time to compare cost of programmes against costs of similar programmes. The programmes approach of directly funding mutually agreed activities (with government) rather than transferring cash to government, reducing financial incentives traditionally associated with donor funded projects (per diems), utilization of government facilities and negotiating favourable venue rates for meetings, is considered good value for money. The outputs from inputs put in so far, especially the NSHDP, SSHDPs, and presidential compact is also considered good VFM. The yield from commodities support could not be determined as most indicators were not yet measured so it is not possible to make VFM assessments for those. The logframe should be revised to include at least 2 VFM indocators and some VFM benchmarks such as per diem rates, consultancy rates et cetera should be established. the next annual review should focus on VFM, comparing costs and cost effectiveness of different programme approaches.

Annexes

Annex 1: Focus A - Health Policy and Planning

PATHS2's strongest area so far is probably its support for policy and planning at the different levels in a manner that provides coherence between plans within and between different levels of government.

The Approach
PATHS2 supports a commendable approach to policy and planning for health at the different levels. The approach was consistent at the federal and state levels and across the different thematic areas reviewed. So far the process has consisted of:

- Assessment to determine current situation
- Analysis of findings to determine strengths, weakness and gaps
- Presentation of findings to stakeholders and validation of findings
- Participatory (multi-stakeholder) development of policy or strategy based on findings
- Develop of operational plan/implementation

The participatory approach has provided a lot of buy-in, political commitment and government ownership of the policies and plans supported by the PATHS2 programme. These processes have been supported by PATHS2 through a combination of approaches that include funding the activities, providing technical assistance through PATHS2 staff, embedded staff or consultants.

PATHS2 has provided support for medium term planning such as development of policies and strategies as well as short term planning such as development of annual operational plans.

Federal Level
At the federal level, PATHS2 convened the future search programme that provided some of the push and content for the development of the NSHDP. Besides the NHSDP, all other support for policy or planning followed same process as outlined in 9.1.1 above. The multi-stakeholder support for the development of the NHSDP is already considered a best practice in partnership for policy development and is currently being written up. The support for conclusion of NHSDP before delving into sub-sector strategies and policies (e.g. HMIS and HRH) is considered very apt as it ensures that the sub-sector strategies fit into the overall sector strategy and performance framework. The support for the first ever presidential health summit that culminated in 35 out of the 36 state governor's signing the compact on improving resourcing of health is also very commendable. PATHS2 have also provided support for development and finalization of sub-sector policies and strategy such as the draft HMIS strategy, HRH strategy and NAFDAC's draft medium term sector plan.

State level
PATHS2 have been providing states same kind of policy and planning support provided at the federal level. All the PATHS2 states were supported to develop SSHDP before developing or revising sub-sectoral policies, plans and strategies. The approach was same across all states though they are not all at same stage in the development of specific sub-sectoral plans (see section 3.2.2). All 4 states have all been supported to establish MTSS committee while Kaduna has actually started review of high level budget commitments and previous budgets. Support has also been provided for developing annual workplans and budget for different departments.

LGA level
None of the LGAs visited had a structured support plan similar to what was seen at the federal and state levels. None of the LGAs visited had a health plan or visible structures for planning. The LGAs were however aware of the SSHDP and made inputs in their development.

Facilities and communities
From the review, it was clear that the major vehicles PATHS2 is using to involve communities in health decision making are public dialogues and feedback, FHCs and CSOs. The Lere health dialogue with the minister for health and Kaduna state government was a good way of getting the community to engage decision makers. FHCs are designed to act as link between the facilities and the communities and LGAs and help ensure that the LGAs live up to their responsibility of making health care available for their citizens. The FHCs that were seen to be active in the states visited worked on assisting facilities mobilize resources from the community. None of the FHCs visited had started any significant work on channelling community voice into government health plans or holding government accountable for implementation of plans and budgets. The CSOs contributed to the development of the SSHDPs in Enugu, Jigawa, Kaduna and Kano. It was not clear if the CSOs held prior discussions with the communities to help shape their contributions.

Recommendations
- Better engagement of LGAs: None of the PHCs visited received imprest from the LGAs. The LGAs in states not running DHS or GHS should be supported to develop health plans and develop mechanisms for engaging with the citizens to determine their needs.
- Policy and strategy implementation: PATHS2 should support research to understand factors affecting implementation of policies and strategies.
- Engaging with actual decision makers: The obvious disconnect between politicians and bureaucrats/systems at the state level require revision of engagement strategies to also include the politicians.

Annex 2: Focus B - Essential Drugs and Commodities

The transition of HCP into PATHS2 has been successfully concluded. It will be impossible for an outsider to know that the essential drugs component was once a programme of its own as it is well integrated within the PATHS2 programme at the Federal and State level. The HCP Project Completion Review in October 2009 highlighted decapitalisation of facilities in some programme States. These issues will need to be addressed and plans for future procurement developed.

Approach
PATHS2's approach to availability of essential drugs revolves around strengthening and expanding the DRF scheme initiated by PATHS1. Activities were directed mostly towards assessment of procurement, supply chain management (PSM) capacity, building capacity of government staff on commodities logistics management, direct provision of commodities and creating an enabling environment for the operations of the DRF.

Federal level
At the federal level, PATHS2 strategy is to support the development and implementation of effective policies for drug PSM in the country. PATHS2 is mapping existing PSM policies and systems to guide government in developing or revising policies and strategies. Some of the ongoing activities include:

- Mapping of key health policies like the National Drug Policy, National Health Policy, National Procurement Policy and Essential Drug Program
- Mapping of key national supply chain systems such as those for drug selection, drug quantification, LMIS and inventory control systems.

It is expected that findings from these mappings will be used to develop recommendations for improvement and pilot interventions.

State level
PATHS2's strategy at the state is sustaining, strengthening and scaling up the DRF system initiated by PATHS1 and HCP. To sustain the DRF, PATHS2 is supporting the states to establish DMAs through the development, passage and signing of DMA bills that will empower DMAs manage the DRF and ring fence their funds. The Kaduna state bill has been passed by the state legislature and is awaiting the governor's signature. Kano state DMA is operational already. The Jigawa bill is in waiting for passage by the state legislature. Enugu is in the process of developing a draft bill. Distribution of commodities procured by HCP under PATHS1 is continuing, to capitalize facilities.

The PATHS2 supported states all have FMNCH programmes that the governments have put in place to provide free health services (including drugs) to pregnant women and children under 5. There was one form of tension or the other between the DRF and FMCH in all the states visited. In Enugu, the non-reimbursement of FMNCH expenses to facilities has led to gross de-capitalization of the DRF. In Kaduna, the DRF has funds in its account but is not getting approval to procure commodities and replenish its stores because the state is more interested in procurement for FMNCH. Jigawa is working towards an integrated and better coordinated system with the DRF committee's expansion to take responsibility for FMNCH as well. They have also costed their FMNCH to determine and present to the state the resources needed to implement it effectively. In Kano, there is an FMNCH policy and also a DMA but some LGAs are not mobilizing resources to pick up their drugs from the DMA. The

state budget for the FMNCH is grossly inadequate and only ANC and deliveries are actually covered.

The M-supply (electronic platform) provided by PATHS1/HCP for commodities logistics management by the DMAs/SMSs is viewed as a good software with the capability to improve commodities management from forecasting, procurement, warehousing/inventory management, to consumption. Unfortunately, it was not being used in Enugu, Kaduna and Kano. In Enugu, there were complaints about technical problems, but the review team observed that the real issue seemed to be the willingness of SMS staff to use the software even though they had been trained. The Kaduna M-supply was working; the staff use it for inventory control but were not using it for forecasting or procurement because these functions were performed by the central government without reference to the DMA. In Kano the M-supply has been down for years and affects the functioning of the DMA who have to rely on paper based management of increasing supplies and demands.
Deferrals and exemptions for those who cannot afford the DRF commodities were not operational in any of the States. Some facilities in Jigawa have substantial D&E funds in their accounts but are not implementing the D&E.

LGA level
The observed role of the LGAs in ensuring commodities availability varied across state but was generally very limited in all states. In Jigawa and Enugu, the LGAs had no clear role in the DRF because the Enugu DHS and Jigawa GHS were multi-LGA based. The Districts and Gundumas were more responsible for health than the LGAs and comprised of more than one LGA. In Enugu, the LGA was expected to contribute to the funding of the FMNCH though it took state government coercion and deduction of their contribution from source for this to happen.

In Kaduna and Kano, the LGAs were expected to pick up commodities for their facilities from the SMSs. This was seen to be happening in one of the LGAs visited in Kaduna. The LGAs visited in Kano had not been picking up their drugs even though their facilities were requesting and the store was complaining. Due to time constraints, it was not possible to meet with the LGA officials to find out why.

Facility/community level
Given the varied implementation of the essential drug list by states, the review team selected 5 key tracer drug groups to assess in the facilities, as an indication of drug availability. The groups are listed below:

- Modern contraceptives
- ACTs
- Antibiotics
- Anti fungals
- Analgesics

Approximately 50% of facilities visited had all the drugs available as part of their DRF commodities. None of the facilities had the full expected complements of MNCH drugs so some of those that were eligible for FMNCH ended up buying some of the drugs from the DRF. This caused confusion in some facilities as the clients accused facility staff of selling drugs to them when government had announced they were free. To mitigate this, facilities used the FHCs to disseminate information to the communities about the reality that government was not providing all the FMNCH drugs as at when due.
There were too many LMIS tools in the facilities visited. The DRF alone had 7 registers, most requiring same information.

Recommendations

- DRF viability and sustainability: the DRF approach needs to be reviewed to determine its suitability on a state by state basis. In some states, it seemed more like a PATHS programme (PATHS1 & 2) than a state programme and so state decision makers expected PATHS2 to resolve any issues related to it. Factors critical for its successful implementation should be assessed and used to review its implementation if necessary.
- All the states should be supported to cost their FMNCH and development implementation plans that align it with existing systems
- Provision of commodities should be strategic so as not to undermine support for governance. It should also fit into an overall service delivery strategy and should not just be a continuation of PATHS1 support.
- States should be supported to eliminate bottle necks to use of M-supply as its non-use affects transparency, efficiency and undermines the DMA implementation
- LMIS tools should be harmonized to reduce the current tool chaos in the facilities

Annex 3: Enugu State Report

1. Meetings/consultations

PATHS2 team
Honourable Commissioner for Health
SMoH (all the directors)
Chairman of Association of LGAs
Ozalla Primary Health Centre
Ovu Orie, Ugbawka Health Centre
Asata Polyclinic
Central Medical Stores
Ogui Nike Health Centre
Civil society organisations
SPARC Team Lead
ESSPIN State Program Officer

2. Situation analysis

Enugu state is located in the South Eastern geo-political region of Nigeria. It has 17 Local Government Authorities (LGAs), 39 Local Development Areas and a population of 3,257,298[6]. Enugu operates a district health system with 7 districts, each consisting of 1 to 3 LGAs and managed by a district health board. The districts are made up of all publicly owned secondary and primary health facilities within the catchment LGAs, and are designed to improve referrals within the districts and from the districts to the tertiary hospitals. The state has 4 federal health institutions, 1 state owned tertiary health institution, 6 district hospitals, 3 sub-district hospitals, 45 cottage hospitals, 382 primary health centres, and 488 private hospitals. 11.3% of women use modern contraceptives (national average is 9.7%), 68.1% of women receive ANC from a trained provider (national average is 57.7), 53% deliver in a health facility (national average is 35%) and 28.1% of children between 12-23 months receive all basic vaccinations (national average is 22.7%).

3. Key achievements July 2009 – April 2010

- Enugu state developed its Strategic Health Development Plan (SHDP) with broad stakeholder participation, including 18 CSOs. The SHDP now provides the framework for strong state and local government stewardship, harmonization and better tracking of resources for health across all stakeholders.
- The State DHS law was reviewed with participation of 10 CSOs
- The SMOH technical working group (TWG) on PATHS2 have been merged with the donor coordination forum (DCF). This presents opportunity for leveraging resources across partners and has helped revive the DCF. The DCF has held 2 meetings so far.
- There has been improved engagement of the Chairs of the LGAs. Commitment for allocating more resources to health was obtained from 17 LGA Chairs.
- The recent recruitment of over 500 health care workers by the State was said by the Commissioner for Health to be a result of the PATHS2 funded HRH assessment. The state HRH profile is presently being finalized.

[6] National Census, National Planning Commission 2006

- PATHS2 improved the state's capacity for effective participation in the NCH. The State presented 2 memos at the 2010 NCH, highlighting the State's health achievements to all the other States. This has good knowledge management potential.
- PATHS2 provided technical assistance that led to the review of the state's DRF operational guideline.
- Strategic alliances built with print and electronic media have resulted in discounts for dissemination of health information.
- The Enugu SMOH website is almost complete.

4. Major issues, risks and challenges

- Weak State commitment to health as a key priority. In Enugu, only 16% of the 2009 budget for the social sector (health and education) was released, compared to 85% for the economic sector (road construction constituted a large part). Allocation to health in the 2010 budget proposal is approximately 3.4% of the entire budget. Out of this low health allocation, 31% is for constructing a new diagnostic centre. Works (mostly road construction) remained the government's priority and was allocated 24% of the total budget.
- The State's budget proposal is consistently based on unrealistic revenue profiles. Budgets are many times higher than realistic revenue projections making it impossible for government to fully execute their budgets even if they spent the entire amount they have. Capital projects, which are mostly contracts, are awarded early in the year and by the time the money runs out, services (health and education are mostly services) suffer.
- From the interaction with the Commissioner and SMOH staff, the State did not seem to be willing to explore other options for improving the performance of their DRF. Offers to study other States with better functioning DRFs were not accepted.
- There is an apparent disconnect between bureaucratic and political systems. It appeared that key decisions were taken by political decision makers without seeking the input of the State Ministry of Health.
- Gross decapitalisation of the DRF by the State's Free MNCH programme. The State, under its FMNCH, is expected to reimburse facilities for the cost to the target groups; the facilities keep the service component of the reimbursement for their overheads and use the drugs component to procure drugs from the CMS. Most of the facilities have been owed money since last year and so are not able to restock their FMNCH stores. The DRF commodities have been used in most cases to make up for the FMNCH shortfall and this has led to gross decapitalisation of the DRF store. At the time of the visit, the DRF balance (stock balance and cash in the bank) was less than 40% of the initial capitalisation value.
- Imprest for facilities. None of the facilities visited had received imprest from the LGA or State in the last year. Facility staff resorted to personal contributions and community donations to cater for emergencies. They also charged fees to raise money for running the facilities.
- The CSOs engaged by the review team were disillusioned with the Government and would rather provide services than facilitate the community voice and hold government accountable. They felt that voice and accountability work will yield no benefits.

- Private providers in Enugu constitute a significant proportion of providers and enjoy a bigger share of the market than public providers. Public-private partnership in the State is being approached as identifying private sector providers who can be contracted by Government to provide services. Government may never be able to contract enough of these providers as they already have good patronage and may see no additional value in becoming government contractors.
- Coordination with other SLPs. There is poor collaboration between the SLPs, especially between PATHS2 and SPARC. For instance, there were issues around PATHS not involving SPARC in the MTSS process for the health sector. SPARC did not see itself as having a major role to play in increasing budget allocation and expenditure for health. They saw their role as supporting the government with its priorities and if health was not one of the priorities, then so be it. Besides CSO engagement, it did not seem there was much else that PATHS2 and SAVI were working on. This poor collaboration robs the SLPs of the opportunity of having stronger influence on Government priority setting.

5. Recommendations and action points

1. DFID and PATHS2 should review the state's commitment to health and development and make a decision on the level and direction of further support. DFID top management and PATHS2 management should engage with the state governor and leadership of state legislature to discuss the issue of commitment, funding of the development sector, terms of further engagement and monitoring arrangements for the MOU.
2. PATHS2 should develop a joint strategy with SPARC, SAVI and ESSPIN for improving the budgeting process for the development sector and fast track full MTSS implementation. PATHS2 with support from SPARC should build the capacity of the SMOH officials in budget analysis and institute quarterly review of budget release and expenditure.
3. The proposed high level engagement between DFID, PATHS2 and Enugu state government should also be used to resolve the DRF issues which should include speedy reimbursement of the facilities, recapitalization of the state medical store (SMS) and change in the management of the SMS.
    - The state should take responsibility for recapitalizing the SMS while PATHS2 should conclude capitalization of remaining health facilities.
    - PATHS2 should provide the state technical assistance to the state to cost its FMNCH programme and to improve the drugs logistics management information system (LMIS) to reduce the number of LMIS tools currently in use before the end of 2010.
    - In the deployment of new staff from the ongoing recruitment to the SMS, the commissioner should prioritize sending those with capacity to use information technology.
    - All old and new staff should be trained in the use of M-Supply and the use should be decentralized to all key staff and not just one focal person.
    - The state should consider reimbursing the SMS rather than facilities for FMNCH commodities so the facilities just pick up commodities from the SMS based on consumption data and forecast. PATHS2 should arrange a study tour for key technical and management staff to visit Ekiti, Jigawa or other PATHS2 states to observe how they structured and run their DRF.
4. The SMOH with support from PATHS2 should determine imprest for the different facility types, based on their utilization and historical expenditure pattern. This is

important because even with full facility reimbursement for the FMNCH, the facilities may not be able to cover their overheads as they cater for more than just pregnant women and children below 5 years.

5. The state and LGA should start releasing monthly or quarterly facilities' imprest or factor this into the FMNCH reimbursements.
6. PATHS2 should support the state to review its service delivery strategy to articulate the state's minimum expectations for the different facility types: location/population served, structure, services, staffing, essential services and drugs et cetera. Based on the strategy, facilities should be assessed to establish those meeting the expected standards, those not and plans to bring them up to scale including the state's, LGAs' PATHS2's and other partners' responsibilities
7. PATHS2 should provide the state technical assistance to map availability of private providers, quality and cost of service and help the state strengthen regulatory frameworks. Private providers should be factored in the state service delivery strategy, given the number of private facilities and the huge patronage they enjoy.
8. The commissioner for health should hold weekly formal meetings with the permanent secretary and departmental heads to review progress on workplans, identify bottlenecks, and consolidate action points for the state executive council meeting. This was strongly advocated by the departmental heads as one of the ways to improve communication and coordination within the health sector.
9. PATHS2 should work with SAVI to reorient CSOs in the state and build their capacity in contributing to policy, budget advocacy and monitoring and holding government accountable. This should include exposure of CSOs in Enugu to CSOs involved in voice and accountability work in other states.
10. DFID should ensure that the monthly SLPs meetings hold and the relevant level of staff attend. DFID staff should attend these meetings and should review progress on collaborative work and issues with collaboration. The DFID regional coordinator should meet with the state PATHS2 and SPARC teams to resolve the current issues between them. The meeting should also be used to agree on expanded areas of work that should include the entire public sector reform.
11. DFID should recruit additional technical staff(s) for the South East region as the regional coordinator alone will be hard pressed to effectively coordinate the growing DFID portfolio in the zone.

Annex 4: Jigawa State Report

1. Meetings/consultations

PATHS2 Team
SMOH (directors)
State Gunduma Board
SLPs (SPARC, SAVI, ESSPIN) and PRRINN-MNCH
UNICEF
CSOs
Kiyawa Primary Health Care Center and Facility Health Committee
Jigawa Central Medical Stores (JIMSO) Birnin Kudu
Duhuwa community

2. Situation analysis

Jigawa State is located in the North Western geo-political region of Nigeria. It has 27 LGAs, 288 Wards and a population of 4,348,649[7]. The health sector has been reorganized into a district (Gunduma) health system made up of 9 Gunduma Councils each with between 2 and 4 LGAs, managed by a Gunduma Board. More than 5,000 staff were recently transferred from the responsibility of LGAs to the Gundumas. Funds started flowing through the Gunduma system in mid-2009. The State has 1 Federal Health institution, 1 State owned specialist hospital, 8 general hospitals, 4 cottage hospitals, 589 primary health facilities and 10 private health facilities.. 0.2% of women use modern contraception (national average is 9.7%), 20.1% of women receive ANC from a trained provider (national average is 57.7), 4.5% deliver in a health facility (national average is 35%) and 0% of children between 12-23 months (amongst those surveyed) received all basic vaccinations (national average is 22.7%)[8].

3. Key achievements July 2009 – April 2010

- PATHS2 supported the development of 2010-2015 State Strategic Health Development Plans in line with the National Strategic Health Development Plan and 2010 operational plan, with the participation of 20 Civil Soceity Organisations.
- The State has developed a Comprehensive Development Framework, with health sector priorities well represented.
- The Health Data Consultative Committee has been reconstituted and is meeting regularly. HMIS reporting has increased from 51% to 65% and backlog HMIS data, from 2005 to 2008, has been collated and sent to the FMoH.
- PATHS2 have provided to the State, well appreciated inputs to improve Human Resources for Health (HRH). These include leading the development of a draft HRH policy and strategy, facilitating the establishment of a School of Midwifery, supporting orientation of 96 midwives from the Midwifery Services Scheme and State training of 3,000 TBAs.

[7] National Census, National Planning Commission, 2006
[8] National Demographic Health Survey 2008

- The State's FMNCH programme has been costed and a FMNCH bill drafted. PATHS2 have further supported the State to develop phased implementation of minimum service package with 90 facilities being selected for the first 2 years.
- PATHS2 have contributed significantly to strengthening the State's procurement, distribution and logistics information system. A new distribution system has been agreed to harmonize Drug Revolving Fund and Free MNCH systems and the Jigawa Drug Management Agency bill has been drafted. JIMSO was observed to be operating well and efficiently. PATHS2 supported distribution of equipment to 90 facilities
- The primary health centre in Kiyawa received capitalisation for a drug revolving fund in 2004 from HCP/PATHS1. This has been topped up annually by the SMOH and current stock equalled the value of stock supplied, with an additional N300,000 in their account. Everyone was enthusiastic about the difference this had made to the facility and how it has significantly increased patient load.
- The partnership between PATHS2 and PRRIN-MNCH in Jigawa is exemplary and has led to numerous success stories in improving maternal and child health using a systems approach. The community at Duhuwa at Kiyawa was an excellent example of the safe motherhood initiative. Men, women and girls could all recite danger signs in pregnancy and labour. Women were travelling to Dutse (the State capital and nearest secondary facility) for antenatal care and delivery, as part of the Free MNCH.
- The Ministry of Womens Affairs and Social Development is being assisted by PATHS2 to conduct an assessment of safe motherhood demand side work.
- The capacity of Civil Society Organisations in the State has been strengthened in policy development, and they contributed to the development of the SSHDP and Free MNCH bill.
- 40 stakeholders have been trained as master trainers in the improved Facility Health Committee (FHC) concept to provide a pool of trainers for strengthening FHCs across the State.
- A health promotion unit has been established at the Gunduma Board.

4. Major issues, risks and challenges

- The Gunduma system is now functioning, but sustainability will depend on continued political support. This is not certain with elections in 2011 and will require strong advocacy from DFID and PATHS2 so the system is sustained even if government changes.
- There is acute shortage of human resources and this poses a big challenge for scaling up services and other reforms.
- Though there is clear evidence that the DRF system is working well, deferral and exemption (D&E) is not being implemented even in facilities like Kiyawa Primary Care Centre that have significant money in their D&E accounts.
- The most visible PATHS2 contribution to service delivery was the provision of equipment, which was based on the Gunduma's approach to implementing the minimum service package in 90 health facilities between 2010 - 2011PATHS2 have helped cost the FMNCH policy, but the costing wasn't properly done and there is still some evidence that the policy is leading to decapitalisation of the DRF.
- There is no clear health financing policy or strategy. The State is involved in free health services; user fees (including DRF); community based insurance, national health insurance etcetera, with no coordination across these mechanisms.

- 160 partners have been identified as part of the PPP policy, however it is not clear what strategy is being planned and if PPP should be a focus in a State like Jigawa. This looks a clear example of implementing a centrally decided strategy without considering the State context.
- The State PATHS2 team and State partners including the Gunduma board raised concerns about the need to get permission from the national level to implement activities, even if they are in the work plan. This, they said, caused delays.
- There are multiple community committees/facility committees. Should PATHS2 focus on rationalising and reaching agreement about these, rather than supporting the establishment of one particular model?

5. Recommendations and action points

1. PATHS2 should support the State to start implementing D&E and other mechanisms for protecting the poor from financial barriers to health.
2. The Free MNCH costing should be improved to paint a true picture of needed resources. Besides the costing, a clear plan for implementing it and harmonizing systems with the DRF should be developed.
3. PATHS2 should assist the State to analyse different health financing options including the ones they are currently implementing, provide policy briefs for government decision makers and guide the State through developing a comprehensive health financing strategy.
4. There is need to decide if PPP is an appropriate priority for Jigawa and if it is, options should be better defined so it is not just a benevolent/social responsibility approach.
5. The State team should be given more autonomy to implement activities in their work plan once the work plans are approved, without having to wait for permission from the national office.
6. PATHS2 needs a focused service delivery strategy aligned with the State's service delivery plan, the strategy should outline what PATHS2 wants to achieve and how.
7. On coordination with SLPs, PATHS2 should work with DFID and other SLPs to agree on what they are trying to achieve on common areas. For example SPARC may be aiming to reduce the size of the civil service whereas PATHS2 may want to increase the size of the health sector.
8. PATHS2 should focus more on outcomes/results not just on coordinating activities.

Annex 5: Kaduna State Report

1. Meetings/consultations

PATHS2 team
SLPs (ESSPIN, SPARC)
ENR
Partners (ICAP, UNICEF and WHO)
State Ministry of Health (Permanent Secretary and Directors)
Kaduna Health Forum (representatives of the State legislature, private providers, SMOH, ministry of LGAs and LGA service commission)
Barau Dikko Specialist Hospital
Zangon Aya Primary Health Care Centre
Unguwar Shanu Primary Health Care Centre
Central Medical Stores
Facility Health Committees (FHCs)

2. Situation analysis

Kaduna State is located in the North Western geo-political region of Nigeria. The State has 23 LGAs and a population of 6,066,562[9] The State has 5 federal owned health institutions, 1 State owned tertiary health institution, 31 general hospitals, 937 primary health centres and 676 private hospitals.. 8.4% of women use modern contraceptives (national average is 9.7%), 62.1% of women receive ANC from a trained provider (national average is 57.7), 18.4% deliver in a health facility (national average is 35%) and 21.4% of children between 12-23 months receive all basic immunizations (national average is 22.7%)[10]. Kaduna State has a free MNCH, Malaria and HIV/AIDS policies in place

3. Key achievements July 2009 – April 2010

- PATHS2's was hailed by the State government officials as playing a lead role in the development of the SSHDP. The SMOH's 2010 operational plan, based on the SSHDP, has also been developed and costed with assistance from PATHS2.
- The collaboration between PATHS2, the other SLPs and development partners is very strong and PATHS2's collaboration with SPARC is exemplary:
    - PATHS2 is working with SPARC beyond just MTSS, on broad public sector reforms. They have worked with worked with SPARC and office of the Head of Service (OHoS) to review and clarify mandates of the SMOH, related ministries, departments and agencies;
    - State Government, DFID and the UN Aid Cooperation framework have been signed with a joint collaboration matrix developed between UNICEF and PATHS2;
    - PATHS2 contributed to the review and adaptation of the MICS Questionnaire for the UNICEF proposed household survey;
    - Joint planning and concept development on the roll out of the IMNCH strategy is ongoing, in collaboration with UNICEF;

[9] National Census 2006, National Population Commission
[10] National Demographic Health Survey 2008

  - Action plan developed on revamping Baby Friendly Initiatives on breast feeding in collaboration with UNICEF.
- The terms of reference clarification and membership reconstitution of Kaduna Health Forum (KHF) has been done. The KHF provides oversight for health programmes in the State. Membership includes the public sector, private for profit, private not-for-profit, development partners, cross cutting groups and consumer groups. The forum meets quarterly.
- The State Health Donor Coordination Forum has been established with the secretariat at the SMOH
- A State HRH and training needs assessment has been conducted and stakeholders have reviewed, validated the draft report and produced policy briefs for government. There are advanced collaboration arrangements with the World Bank on linking the HRH database with the State-wide human resource management information system.
- PATHS2 supported the State to develop a HMIS strategic plan and 2010 HMIS operational plan. The State Health Data Consultative Committee (HDCC) has been reconstituted and is now meeting regularly. This has led to uniform use of the District Health Information System (DHIS) summary forms in most facilities. PATHS2 coordinated the orientation of 23 LGA M&E Officers on DHIS software in collaboration with KADSACA, ENR and GHAIN
- The State bill for a Drug Management Agency (DMA) has been passed by the State Legislature and Executive.
- The bill for the establishment of the State Primary Health Care Development Agency (SPHCDA) has also been approved
- A draft Free MNCH bill to enshrine health entitlements is now before the SMOH for presentation to the State Ministry of Justice and State Legislature.
- There is strong PATHS2 participation in improving routine immunization coverage. PATHS2 worked with the State and other partners to develop plans for improving immunization services: support to routine feedback forums for State and LGA immunization officers to use field experiences to improve supportive supervision; facilitated training of task force members for 23 LGAs, and ward focal persons for 255 wards to “reach every ward” with immunization.
- PATHS2 partnered with the State to develop a strategy for availability of quality and safe blood for emergency obstetric care (EOC) and facilitated linkage of secondary health facilities with the National Blood Transfusion Service (NBTS), for quality assurance.
- PATHS2 also provided EOC and maternity kits to 52 out of 60 basic EOC and comprehensive EOC facilities (based on PATHS1 supported facilities inventory) and engaged 7 professional bodies and the private sector in promoting EOC services.
- The FHCs visited are all well organized and have been prominent in mobilizing resources from the community to sustain facilities, in the absence of imprest from government.
- The central medical stores staff have the capacity to use the M-supply software
- PATHS2 convened the successful health consultative forum in Lere LGA that brought together the community, LGA authorities, State authorities and Minister for Health to discuss the community’s health problems and jointly develop solutions.
- The State is showing improved ownership in some areas:
  - For the first time the SMOH has taken over the responsibility for distribution of equipment provided by PATHS2;

- Local Government budgetary allocation to the tune of N69 million has been approved for all FHCs in the 23 LGAs in Kaduna State (as a result of wide stakeholder consultation on strengthening the FHC);
- PATHS2 led advocacy on CBHIS has made the State Ministry of LGAs to vote money for its implementation in the LGAs.

4. Major issues, risks and challenges

- The State budget for health has been fluctuating in the last 4 years and health budget implementation in the State is not encouraging. The State 2010 budget for health laid too much emphasis on building an ultra modern 300 bed hospital
- There is no budgetary provision for the implementation of the State Primary Health Care Agency and DMA.
- None of the primary care centres visited received imprest from government in the last year.
- The State's response to redeeming their counterpart contributions is slow.
- The State's budget proposal is consistently based on unrealistic revenue profiles. Budgets are many times higher than realistic revenue projections making it impossible for the Government to fully execute their budgets, even if they spent the entire amount they have available.
- There is a wide divide between the State bureaucratic and political system. It appeared that high level decisions for health seem to be made outside the health system without recourse to the recommendations of relevant staff in the SMOH.
- Against the plan to scale up FMNCH, the budget is dwindling. Not all the promised FMNCH commodities were provided by Government (the facilities visited did not have most of the peadiatric drugs) and clients did not know this so they accused facility staff of diverting drugs.
- The DRF system is stifled under the State's FMNCH and there are vertical systems for the DRF and FMNCH:
  - While the FMNCH stores in the facilities and Central Stores seem well stocked, the DRF stores are under stocked. The government has not approved DRF procurement in the last 3 quarters even though SMOH staff have made several requests and have enough money in the DRF account;
  - Commodity selection, forecast and procurement of FMNCH commodities are handled directly by the Governor's Office. The staff are frustrated that even though they have the capacity to use the M-supply, and have used it to generate forecasts, the results are not considered in procuring commodities.
- There was no visible strategy for deferral and exemptions.
- There was reported pilfering of drugs and supplies at the central medical and other stores.
- Dependence of implementation of activities in PATHS2 work plan on approval of dates by the SMoH, slows down activities.
- There are persisting coordination issues:
  - The DCF have not been meeting because they are still waiting inauguration by the Governor;
  - The State Council of Health has not met in the last year.

- There are still overlaps between the terms of reference of the KHF and the DCF and the individual committees under the KHF are mostly weak and not taking forward issues form the KHF.

5. Recommendations and action points

1. DFID top management and PATHS2 management should meet with the State governor and leadership of State legislature to discuss the issue of commitment, funding of the development sector, terms of further engagement and monitoring arrangements for the MOU and MoA. The meeting should also be used to advocate for the integration of the Free MNCH programme with the DRF, funding and operationalisation of the DMA and SPHCDA and inauguration of the State DCF.
2. PATHS2 should develop a joint strategy with SPARC, SAVI and ESSPIN for improving the budgeting process for the development sector and fast track full MTSS implementation. PATHS2, with support from SPARC, should build the capacity of the SMOH officials in budget analysis and institute quarterly review of budget release and expenditure.
3. PATHS2 should leverage the strength of the Facility Health Committees and build their capacity in voice and accountability work.
4. PATHS should support the State to cost the FMNCH programme and develop a State health financing strategy that harmonizes the FMNCH with other funding arrangements for health in the State and tie them to the SSHDP. They should also provide technical assistance to the State to develop and implement a strategy for fully integrating the procurement supply chain of the FMNCH within the DMA. This should include harmonization of the LMIS which is currently very confusing with too many tools.
5. The State government should urgently approve the procurement of DRF commodities using the DMA (including the use of results from the M-supply).
6. The SMOH should, on a quarterly basis, make available to the public and facilities information on commodities available for the FMNCH, to avoid confusion in the facilities between providers and clients.
7. PATHS2 should build the capacity of the stores managers in good warehousing practices including stores arrangements. PATHS2 should provide Central Stores with shelves and pallets as necessary to improve the current situation.
8. The SMOH should quickly conclude investigations into the pilfering of commodities at the Stores, reinforce securities at the Stores and make the findings of their investigations available to all stakeholders.
9. PATHS2 should help further improve the terms of reference of the KDF and reactivate the Steering Committees to be able to take forward action points from the KDF. PATHS2 should also provide financial and technical support to the State to convene a State council on health before the end of the year
10. PATHS2 should support the State to review its service delivery strategy to articulate the State's minimum expectations for the different facility types: location/population served, structure, services, staffing, essential services and drugs etc. Based on the strategy, facilities should be assessed to establish those meeting the expected standards, and those not, and plans to bring them up to scale including the State's, LGA's, PATHS2's and other partners' responsibilities.
11. The Lere Consultative Forum should be replicated in all the other LGAs.

12. One-off annual or quarterly approvals should be given by the SMOH for jointly agreed PATHS2 workplans and no further approvals should be needed for individual activities

Annex 6: Kano State Report

1. Meetings/consultations

PATHS2 State team
State Commissioner for Health
State Ministry of Health (directors)
Drug Management Agency
State Ministry of Local Government (SMOLG)
Primary Health Care Facility and Facility Health Committee in Ungogo
District Head of Ungogo
Secondary Health Care Facility
Development partners (WHO, UNICEF, EU-SRIK, FHI, M-CHIP, CEDPA, NPHCDA Zonal Office)
Other SLPs (SAVI, SPARC, ESSPIN) and SUNMAP

2. Situation analysis

Kano State is located in North Western geo-political region of Nigerian. The State has 44 LGAs, 484 wards and a population of 9,383,382[11]. The State has 2 federal owned tertiary health institutions, 34 secondary level hospitals, 1043 primary health centres and 177 private hospitals[12].. 0.7% of women use modern contraceptives (national average is 9.7%), 49.8% of women receive ANC from a trained provider (national average is 57.7), 11.1% deliver in a health facility (national average is 35%) and 5.5% of children between 12-23 months receive all basic immunizations (national average is 22.7%)[13]. The State has a free maternal, newborn and child health (FMNCH) policy in place.

3. Key achievements July 2009 – April 2010

- State budgetary allocation to health has increased from 5.5% in 2008 to 8% in 2010, although there was limited information regarding actual release of funds.
- The SSHDP was developed in collaboration with LGAs and CSOs.
- The MTSS/MTEF process has started in the State.
- There are good examples of joint development partner working eg. Joint MOU between EU-SRIK, PATHS, WHO, SMOH and SMOLG on strengthening routine immunisation.
- HRH assessment has been conducted and report produced. The State is making efforts to improve human resources for health. They are building new schools of midwifery and health technology; and harmonising health worker salaries with federal institutions. As a result the State is beginning to attract health workers from other States.
- PATHS2 have completed drug distribution and DRF rollout to 67 of 146 health facilities in phase 3.
- PATHS2 supported the State to establish 7 TB-DOTs centers in 7 LGAs, 15 doctors have been trained on extended live saving skills (ELSS), and 30 nurses and midwives have been trained on life saving skills.

[11] Nigerian Census 2006 , National Population Commission
[12] Only public sector facilities were classified as tertiary, secondary and primary
[13] National Demographic Health Survey 2008

- In conjunction with SAVI and CSO coalition partners, PATHS2 supported advocacy for new legislation: free MNCH bill (currently with the State Executive Council), DMA bill (passed by State legislature and awaiting dissemination), and SPHCDA bill (being reviewed at the State Ministry of Justice preparatory to being sent to State legislature.

Completed the distribution of equipment to 53 health facilities

4. Major issues, risks and challenges

- The State did not demonstrate a clear plan for progressively improving the functionality of facilities. There are currently no plans by the State to progressively roll out the minimum service package or capitalise any facilities itself, at least until the SPHCDA is active. Despite clarifications by DFID, the Commissioner is still looking forward to capitalisation of more facilities by PATHS2 in future phases of drug and commodity support.
- Poor commitment from LGAs. Despite pressure from PATHS2/SMOH/SMOLG, many LGAs have yet to mobilise to collect the phase 3 DRF drugs from DMA, or to prepare the facilities for the roll-out, resulting in drugs for 79 facilities still stuck at the DMA.
- There are still issues with the SPHCDA. The SMOH is working on SPHCDA law as the main vehicle for addressing issues with service delivery at the LGA level. The draft SPHCDA bill includes provisions for the transfer of responsibilities and resources for PHCs from LGAs to the SPHCDA. However the SMOLG is of the contrary view that the responsibility should remain with the LGAs. Getting this law passed (particularly in a pre-election year) will be difficult.
- There is limited FMNCH coverage and resourcing. Services actually covered are limited and the State budget for this is limited and unclear. In practice the only services covered are ANC drugs and delivery. Coverage for other essential drugs and paediatric drugs were not available under the FMNCH. SMOH/HMB suggested that work has been done on costing the FMNCH and are working out processes for implementation, although the costed FMNCH document is not yet accessible to PATHS2
- The DMA is underperforming. This is partly due to the failure of the M-supply software which has not been fixed for several years.
- The State has shown limited capacity and commitment to coordinate development partners in health. The major development partners have managed to coordinate themselves informally and in an ad hoc manner, leading to some confusion and duplication.
- The PATHS2 strategy for supporting service delivery is not clear and they are supporting many unrelated interventions. This is worsened by the lack of a State plan for progressively improving the functionality of facilities and rolling out the minimum service package developed with support from PATHS1
- Persistent management issues:
    - SLP coordination. There have been issues, particularly between SPARC and PATHS2, with the timing of joint interventions that should be coordinated. In addition there is a view among the other SLPs that PATHS2 decision making is unnecessarily slow and centralised, making meaningful coordination difficult.
    - The State team complains about over centralisation of decision making. Consultancies above N10,000 per day, even if already included in the approved work plan, have to be additionally approved by PATHS2 states

programme coordinator, and Abt offices in Mali and Bethesda. This process can take two months.

- There is a clear lack of strategic coherence among outputs. Staff responsible for various outputs appear to be working in silos. This is more pronounced with outputs 4 and 5. There are serious issues with the management of activities carried out by the various output leads, particularly output 4. Some of the activities are carried out outside the ambit of PATHS2, causing deep confusion to stakeholders.

5. Recommendations and action points

1. DFID top management and PATHS2 management should meet with the State Governor, leadership of State legislature and LGA chairmen to discuss the issue of commitment, funding of the development sector, terms of further engagement and monitoring arrangements for the MOU and MoA. The meeting should also be used to clarify the State's stand on the SPHCDA increased responsibility of the State for work previously or currently supported by PATHS.
2. PATHS2 should develop clear service deliver strategies that leverage and support clear State plans for improving service delivery in the State.
3. PATHS2 should provide technical assistance to the Commissioner/SMOH to think through other options for improving service delivery at PHC level, besides the SPHCDA.
4. PATHS2 should support the State to cost the FMNCH bill, consider it alongside other mechanisms for health financing, and help the State to make a clear strategic decision on health financing that can be supported with the appropriate budgeting frameworks.
5. The Development Partner Forum needs to be formalised with terms of reference, and workplans should be shared and agreed. More non-traditional partners such as the Global Fund principal recipients and sub-recipients, who are increasingly handling greater levels of donor resources, should be sought and included.
6. PATHS2 should assist the DMA to quickly resolve the issues with M-supply which may require replacing the software and re-training users.
7. Coordination with the other SLPs needs to be more strategic and issue focused, rather than just harmonizing around nodes.
8. PATHS2 should decentralise more decision making and management to Abuja and the States. The PATHS2 Abuja team should support the State team to change their approach from output focused technical work led by consortium leads, to providing more technical support to the State to enable improved issue focused and coherent State strategies.

Annex 7: Lagos State Report

1. Meetings /consultations

PATHS2 team
SLPs (ESSPIN and SPARC)
SUNMAP
Ikosi Isheri Mutual Health Plan.
Community Health Insurance Scheme (CBHIS) located at Olowora Pimary Health Care Center)
DFID Regional Coordinator
State Ministry of Health (Permanent Secretary and Directors)

2. Situation Analysis

Lagos State is located in the South Western part of Nigeria. The State has 56 LGAs and Local Council Development Areas. According to the National Population Commission (2006 Census), Lagos has a population of 9,013,534, though the State believes it's population is actually 17,500,000. The State has 3 federal health institutions, 1 State owned tertiary health institution, 3 specialist hospitals, 21 general hospitals, 237 primary health centres and 1548 private hospitals. Lagos has a maternal mortality ratio of 650/100,000 live births and an infant mortality rate of 85/1000 live births[14]. 27.5% of women use modern contraceptives (national average is 9.7%), 87.6% of women receive ANC from a trained provider (national average is 57.7), 76.9% deliver in a health facility (national average is 35%) and 52.8% of children between 12-23 months received all basic immunizations (national average is 22.7%)[15].

Lagos has only just begun to work with PATHS2. The first engagement was in November 2009 and two consultants and an assistant have been recruited. They have moved into the 'SLP' building, but are currently accommodated by SUNMAP until their office is ready. Renovation of the office is well advanced and should be completed in a few weeks time. Some staff have been identified while others have been lined up for interview.

3. Key Achievements November 2009 – April 2010

- The start up engagement with the Ministry has been excellent:
  - They have developed their work plan together, the work plan looks credible and the Ministry seem to have a good understanding of PATHS2;
  - The ministry has identified a specific focal person who has the responsibility of coordinating partner support to the Lagos State ministry of Health. The ministry assigned focal person seems very competent and is influential in the Ministry.
- The State Government appears to be clearly in the driving seat.
- Coordination of SLPs is good. Weekly diary updates seem to have worked, and the DFID Regional Coordinator has been proactive in ensuring a working relationship between the programmes.

[14] Lagos State Strategic Health Development Plan 2009 - 2013
[15] National Demographic Health Survey 2008

4. Major issues, risks and challenges

- Start up has been slow from the perspective of staffing and office, given that the administrative team in Abuja has had experience of this in other States.
- Risk of rolling out PATHS2 as opposed to State specific strategies without good evidence that they really work. Observed examples include:
    - DRF: Lagos State has a policy for free health care for children under 12 years, pregnant women, adults over 60 years, certain diseases such as TB and Malaria, and for those considered destitute. It is possible that less that 5% of all clients will be fee paying, making the transaction costs of running a DRF unviable.
    - CBHIS: While Lagos State considers the Ikosi Isheri Mutual Health Plan to be a success, it does not seem that the State has analysed the costs and risks before further roll out. The facility which has a catchment population of 1.5 million people has at present enrolled 2,484 clients, of which only 300 regularly pay the N800 (per 6 person family contribution). The services are provided by a private provider identified by the community. It includes 3 doctors, 9 nurses and other staff, all paid for by the private provider. Drugs are all provided free through the scheme. N150,000 is provided for the non-drug, non-salary running costs (maintenance, generator etc.). Given the low income from the contributions, the State Government is heavily subsidising the plan. The Ministry of Health reported that they are subsidising to the level of 60%, however given the figures obtained from the clinic, it may be much more. The Chairman of the Mutual Plan was not aware of the costs provided to the provider per month. Another consideration is that N800 is quite a high contribution for the poor.
- The allocation to the health budget, as a percentage of the total budget, has reduced. Data from the Ministry show that while the absolute value of the SMOH budget has gone up each year, over recent years the proportion of the total budget has reduced. It currently stands at about 5% from about 9.9% in 1999.
- The State is concerned that the costing of SSHDP is unrealistic.
- PATHS2 is focusing on PPP for health, but not much on improving and regulating quality within the private sector, given the huge number of private health facilities.
- SLPs reported challenges associated with working at different places. This will be a challenge especially for PATHS2 as a new programme in Lagos. The nodes document was available but it looks like more work is needed on finding areas for further collaboration.

5. Recommendations and action points

1. PATHS2 in Lagos needs to be Lagos specific and State strategies and activities should be carefully assessed before being considered as best practice and rolled out:
    - In deciding whether to embark on a DRF, there should be an assessment of the proportion of those not qualified for free services to determine viability of a DRF system;
    - PATHS2 should support the State to cost its free services and develop guidelines and standards to improve existing systems where they are found to be suitable and sustainable;
    - Given concerns about the N800 monthly contribution being too high, the State, with assistance from PATHS2, should analyse the costs and risks of the CBHIS before scaling it up. PATHS2 should also provide support to

the State to determine the profile (health and economic status etc) of those registering with the CBHIS facility to determine if the poor are actually benefiting from the services.

2. PATHS2 should identify some quick wins with the State Government. One of these should be the baseline study which should be designed with the State government, and should specifically provide them with useful information as well as being a baseline for PATHS2. The SMOH consider this baseline to be a priority.
3. To help the State develop proper health resource plans and budgets PATHS should support the State to do further work on prioritising and costing the SSHDP as a matter of urgency.
4. PATHS2 should develop more work on improving and regulating the quality of care by private providers. These should include improving the capacity of State regulatory agencies and working with professional associations.
5. DFID Lagos should organize a session with all the SLPs for PATHS2 to present its areas of work and also understand what the other SLPs are working on. The session should also be used to identify further areas of collaboration beyond the current nodes.
6. PATHS2 should utilize the opportunity of having ENR and SUNMAP in Lagos to show how vertical programmes can be integrated into a health systems approach. SUNMAP will be supporting a massive 4 million bed net distribution in September and PATHS2 should work with SUNMAP to look for health systems strengthening opportunities that this provides.
7. PATHS2 should fast track development of relationships with other development partners. The current UNDAF work plan should be keyed into by PATHS2 to harmonize and align UNDAF's programmes with the State's plan, as well as to leverage resources.

Annex 8: Terms of Reference

Objective
The objective of this annual review is to assess progress during the first year of implementation of PATHS2, assess progress against recommendation made during the inception review and propose recommendations for future action.

Recipient
The recipients of the work are the state government of Kano, Kaduna, Lagos, Enugu and Jigawa; Federal Ministry of Health and DFID Nigeria.

Scope of Work
The Review Team will review progress made so far, focusing in particular on the following:

- Quantitative and qualitative progress against PATHS2 programme outputs and purpose. This will include a full assessment against the revised PATHS2 log-frame milestones and targets as well as progress against the work-plan.
- For two areas (HMIS, Output 2; Essential drugs, Output 3), the reviewers will consider the full 'chain' of PATHS2 work at community and facility level, through to local government, state and Federal level – looking at PATHS2 assessment of the situation, action taken to date and future plans.
- Review approach, strategic direction, and risk mitigation strategies within PATHS2, including any strategies relating to the forthcoming period of political elections.
- Status of coordination arrangements at national and state level; including coordination with;
  - other development partner programmes;
  - other State Level Programmes (SPARC, SAVI and ESSPIN);
  - other DFID funded health programmes (SUNMAP, HERFON, PRRINN-MNCH)
- Effectiveness of management arrangements within PATHS2, including effectiveness of decentralisation of authority to states, effective utilisation of consortium partners and utilisation of oversight structures in the management of the programme (including TAG and PATHS2 Consortium Partners Meetings).
- Effectiveness of knowledge management and the wider replication of reforms (i.e. beyond PATH2 focal states) to other state governments, and also other development partner's health programmes.
- Efficiency of approach with respect to Value for Money, in terms of (i) the deployment of resources (including utilisation within the consortium), (ii) balance of TA to service delivery with respect to influencing governance effectiveness.

Method

- The PATHS2 review team will be made up of two independent consultants, a representative from the Federal Ministry of Health (in addition ?NPHCDA, ?NPC ?WHO or other development partner - To be confirmed) and DFID Nigeria staff. Senior Health officials from states may undertake some peer review between PATHS2 states and contribute to the overall review.
- The PATHS2 review will cover Enugu, Kaduna, Kano, Jigawa and Lagos States, as well as the Federal/National components in Abuja. Field visits will be organised to all these states – including visits to local governments and supported facilities. The review team will divide into two teams, each led by an external consultant, so as to enable more detailed review in each state.
- One consultant will be appointed overall PATHS2 team leader and will be responsible for finalising the report emanating from this review. S/he will lead one of the field teams and be responsible for reviewing the overall governance, coordination and management aspects of PATHS2 within the annual review.
- The second consultant will lead the other field team and focus more on the health systems aspects of the review (drugs and information systems). It should be noted that both external consultants, in addition to their lead responsibilities, will also be expected to contribute to all objectives of the review.
- The consultant will liaise closely with DFID Nigeria through the DFID Abuja Health Advisor and Human Development Team Leader.
- Although part of a suite of State Level Programmes (ESSPIN, SPARC, PATHS2 and SAVI); the reviews of each programme will not be done jointly. However, each review will be looking at issues relating to SLP coordination. At the end of May, there will be a meeting, led by the lead advisors for each of the programmes, to present key findings in relation to coordination between the various programmes, including: where it is going well, where there are challenges, where there are opportunities to do more. Each SLP review will use a common set of questions. These questions will be asked during the review in each state and the consultants will be expected to provide the information to DFID which can be used for this meeting. It will be important there is communication between the programme reviews to ensure there is not multiple meetings with certain stakeholders!
- The review will meet the requirements of a standard DFID Annual Review Process, including evaluation of the revised format logical framework and completion of the standard annual review report.
- The Review Team will complete preparatory reading in advance of the inception review (see list below for background reading requirements). The review team will be required to interview PATHS2 programme managers (both National and State level), and key government, development partners and civil society partners.
- There will be a session in Abuja to start the review and engage with the national programme management and Federal Government officials and one day wrap up session at the end of the review facilitated by the PATHS2 Review Team Leader. Development partners will be invited to the end of review meeting.
- Each of the State visits should also start with a briefing from the PATHS2 State Team and will end with a joint feedback session to the Programmes.
- The DFID / Nike Foundation Girl Hub programme is currently starting in Nigeria and opportunities for how PATHS2 (as part of the SLP suite) could engage with Girl Hub should be explored.

Reporting and Outputs
The review team will be responsible for:

- ***Reviewing progress made by PATHS2 to end of April 2010*** – based on state visits, PATHS2 progress reports[16], factual evidence and recommendations made by the 2009 inception review. Key issues should be identified and recommendations made.
- ***Propose adjustments to the PATHS2 2010/11 work-plans and logical frameworks (programme and state level)***
- ***Reviewing the strategic direction of reforms being promoted by PATHS2, evaluate risks and identify forward looking, opportunities to adjust the programme beyond 2011.***

The consultants will be responsible for ensuring that the information gathered by the full review team is captured in the final report.

The independent consultants will be required to produce the following reports:

- PATHS2 Annual Review Report including the standardised DFID ARIES format for programme/project monitoring. The main report (excluding annexure) should be no longer than 20 pages. The annexes will include:
    - A 1-2 pages progress summary for each state highlighting progress and any significant issues; and
    - 3-4 page reports on each of the two focus issues: health management information systems (HMIS) and essential drug supply chains (from community to national) looking at issues of PATHS2 coherence, strategy and plans.

Deliverable	Timing
Initial presentation of key findings and recommendations of the review to DFID and PATHS2 NPM / Management Team and other key stakeholders	Friday 29 April 2010
Draft PATHS2 Annual Review Report, including Programme Reports and ARIES forms as annexes submitted to DFID	Monday 10th May 2010
Final agreed report submitted to DFID	Monday 24th May 2010

Duration and Timing
The review will take place in Nigeria from 19th to 30th April 2010. Two day of preparatory work will be carried out before the start of the review. Background reading for the review will be supplied to the Review Team members before the 5th April 2010.

It is currently estimated this consultancy will require a total of 20 days for the PATHS2 Review Team Leader, and 16 days for the second independent consultant. The tasks, their duration and timing are:

- 2 days prior to commencement of the assignment for examination and analysis of key documentation;

[16] It is suggested the PATH2 Q1 2010 progress report should include a specific Annex summarising key progress made since August 2009 (implementation phase start) and tabulate how PATHS2 has been adapted following the inception review recommendations.

- 11 full working days in Nigeria for the main review mission (excl. Sunday);
- 7 days after completion of the mission to complete draft deliverables and follow up editing. (3 days for the second consultant)

Co-ordination
The PATHS2 coordination from DFID Nigeria will be through Dr Ebere Anyachukwu and Jane Miller.

PATHS2 Review Team Members
- Independent consultants- tbc
- Federal Ministry of Health and State representatives - tbc
- Ebere Anyachukwu (f/t)
- Jane Miller (f/t)
- Carolyn Sunners (p/t)
- Solvi Taraldsen (p/t)
- David Ukagwu (p/t)

Logistics and Planning for the review will be provided by PATHS2 and assisted by David Ukagwu, Assistant Programme Manager, HD, DFID Nigeria.

The consultants will arrange international travel as agreed for this assignment. Accommodation and transport in Nigeria will be arranged by DFID Nigeria/PATHS2, but Nigeria is a cash economy and consultants are advised that they may be responsible for settling hotel bills in cash themselves

Background
PATHS2 is one of a suite of State Level Programmes (SLPs) including SAVI (Strengthening Accountability and Voice Initiative), SPARC (State Programme for Accountability, Responsiveness and Capability) and ESSPIN (Education Sector Support Programme in Nigeria).

PATHS2 began in 4 states (Jigawa, Kaduna, Kano and Enugy) and expanded to Lagos in late 2009

The goal of PATHS2 is to support Nigeria in using its own resources efficiently and effectively to achieve the Millennium Development Goals (MDGs) set for the country. This programme has set itself the ambitious purpose of improving the planning, financing and delivery of sustainable and replicable pro-poor services for common health problems in up to six States across the country.

Achieving the health MDGs in Nigeria is a challenge and will require major improvements in the Health System over the next few years. The health indicators including those for maternal and child health, immunisation, HIV and AIDS as well as information on financing and human resources for health show clearly the current Health Gap.

The PATHS2 programme has established 5 key outputs or deliverables, each supporting a different aspect of the health sector. These outputs are all designed to leverage resources for health, improve governance, encourage participation and improve service delivery.

The PATHS2 programme will support the stewardship role of government and support States in the development of effective health systems and affordable and

efficient health services for all their populations. At the same time the programme will work on the demand side engaging civil society and improving the knowledge and understanding of citizens on health and health systems issues.

PATHS2 has been designed to achieve an ambitious set of results. These can be summarised as:

- Better PHC services across the country
- Including rural clinics to support pregnant mothers and provide immunisations to children
- Emphasis on preventive rather than curative health care
- To ensure people are better prepared to fight disease and illness
- More training of staff and new incentive packages
- To retain doctors and nurses in the poorest areas
- Faster and better managed flow of drugs
- Across all states
- Better government planning and management
- Ensuring that money is spent where health needs are greatest

PATHS2: Project Outputs

The five outputs all contribute to meeting the purpose of the programme: Nigeria's own resources used efficiently and effectively to meet the MDGs.

PATHS2: Leveraging Resources for Health

Output 1: National Stewardship

Stewardship at the national level involves setting and enforcing the rules of the games for the actors in the health sector. It is about ensuring careful and responsible management of the well-being of the population. Interventions will include articulation of policy objectives and clear definition of roles and responsibilities of all the stakeholders.

Output 2: Effective State Systems

The goal for Output 2 is to improve health systems' ability to effectively deliver health services in existing four lead states namely Kano, Kaduna, Jigawa, and Enugu. There are two more states to be identified later for support. The Output plays a crucial role in linking the implementation of national-level policy in lead states with improvements in service delivery at facility levels, and with awareness-raising and communication efforts at the community level. In addition, each state will be supported to develop, implement, and evaluate health-sector reforms that address priority needs.

Output 3: Pro-Poor Services
Recognizing that the ultimate goal of the health system is to improve people's health through provision of essential, equitable and good quality health services, the services must therefore be organized and managed in such a way that effective and affordable health interventions can reach the beneficiary populations.

Output 4: Engaged Civil Society
Nigeria's existing health policy should be providing its citizens with important rights and entitlements to good, quality health care. However, for the majority of its people the reality is sadly starkly different.

Output 5: Informed Citizens
To strengthen capacity of citizens to make informed choices about prevention, treatment and care. This includes an improved understanding of health issues. Greater awareness of rights, entitlements and responsibilities. Establishing a more enabling environment. Awareness of health issues among youth.

Pre-review required background reading

- PATHS2 quarterly reports 2009/2010
- Cross Co-ordination Arrangements – Roles / Responsibilities; Key Principles set out in August 2008. ***EDRM.***
- PATHS2 Programme Memorandum***. EDRM***
- PATHS2 Inception report (August 2010)
- PATHS2 Programme Log-frame, ***PATHS2 management team***
- PATHS2 work-plans ***PATHS2 management team***
- Access to PATHS2 online documentation system
- NPM Meeting Minutes and SLP Structure Approach Papers. (latest / final versions) ***John Sanchez*** (SPARC) / ***DFID Nigeria***
- National Strategic Health Development Plan – and relevant state plans.

Annex 9: List of persons met

National Level meetings		
Meeting with Permanent Secretary Federal Ministry of Health		
S/N	Name	Designation
1	Linus Awute	Permanent Secretary
2	Dr. Muhammed Lecky	Director Planning, Research and Statistics
3	Jane Miller	Senior Health Adviser/Head Human Development Team DFID
4	Solvi Taraldson	Health Adviser DFID Kano
5	Mike Egboh	NPM PATHS2
Meeting with the National Agency for Food and Drugs Administration (NAFDAC)		
1	Mrs Uche Elenuwa	NAFDAC
2	Mrs Adenuke Adegbenro	NAFDAC
3	O.O. Adeleke	NAFDAC
4	Mrs P.C. Monwuba	NAFDAC
5	Mrs Osayi Emem	NAFDAC
6	Mrs B. A. Agim	NAFDAC
7	Dr. Monica Eimunjeze	NAFDAC
8	Pharm. H.A. Aboje	NAFDAC
9	DR. Thomas Bisikat	Health systems Adviser WHO
10	Dr Solomon Mengiste	PRRINN-MNCH
11	Dr Ebere Anyachukwu	Health Adviser DFID
12	Vimal Kumar	Senior Logistics Advisor PATHS2
13	Nkata Chuku	Consultant/Review Team Leader
Meeting with the SLPs		
1	Steve Baines	Technical team Coordinator ESSPIN
2	Ron Tuck	NPM ESSPIN
3	John Sanchez	NPM SPARC
4	Joe Garba	Deputy NPM SPARC
5	Ebere Anyachukwu	Health Adviser DFID
6	Nkata Chuku	Consultant/Review Team Leader
Meeting with the National Primary Health Care Development Agency (NPHCDA)		
1	Dr. Muhammed Pate	Executive Director
2	Dr Emmanuel Odu	Deputy Director PRS
3	Dr E. Abanida	Director Immunization
4	Abdul Fatai	Director Administration
5	Prof C. O. Akpala	Consultant NPHCDA
6	Dr. Weyimi Ogbe	Technical Assistant to Executive Director
7	Dr. O. Olubajo	Health Economist NPHCDA
8	Garba Safiyanu	State Programmes Coordinator PATHS2
6	Jane Miller	Senior Health Adviser/Head Human Development Team DFID
7	Solvi Taralsden	Health Adviser DFID Kano
Meeting with the National Health Insurance Scheme		
1	Dr Hope Uweja	General Manager Technical Operations
2	Dr. Christopher Okoh	Head Urban Self Employed Social Health Insurance

		Programme
3	Mr. N. N. Ajobi	Head Rural Communities Social Health insurance Scheme
4	Mr Okechukwu Nduaguba	Asst manager Urban Self Employed Social Health Insurance Scheme
5	Kenneth Ojo	Health Financing Advisor PATHS2
6	Ebere Anyachukwu	Health Adviser DFID
7	Solvi Taraldson	Health Adviser
8	Jane Miller	Senior Health Adviser/Team Leader Human Development Team
9	Thomas Bisika	Health Systems Adviser
10	Nkata Chuku	Consultant/Review Team Leader

Annex 10: Documents reviewed

1. DFID Nigeria Concept Note: PATHS2
2. PATHS2 memorandum
3. PATHS2 Technical briefs
4. Inception report by Abt Associates
5. End of inception review report – DFID
6. PATHS2 revised logframe and indicator dictionary
7. PATHS2 quarterly reports
8. HCP final report
9. DFID Nigeria: State Level Programmes (SLPs). Draft terms of reference for independent external monitoring and evaluation
10. SLPs structured approach paper
11. SLPs Inception review report
12. Eliminating World Poverty: Making Governance Work for the Poor
13. National Health Strategic Development Plan
14. State Health Strategic Plans for Enugu, Jigawa, Kaduna, Kano and Lagos
15. PATHS2 2010 self assessment

Annex 11: PATHS2 Logframe

Version Dated 15 December, 2009

Note: An appendix to this logframe will include "indicator summary tables" covering description of each indicator, definitions of key terms, measurement issues, etc.

NOTE: All baseline, milestone, and target figures which are blank in this version of the logframe will be included in the next version of the logframe to be submitted at a time to be agreed upon by PATHS2 and DFID.

PROJECT NAME	PARTNERSHIP FOR TRANSFORMING HEALTH SYSTEMS 2 (PATHS2), NIGERIA						
GOAL	Indicator	Baselines	Milestone 2010	Milestone 2011	Milestone 2012	Milestone 2013	Target 2014
Nigeria's own resources are efficiently and effectively used to achieve the MDGs	G1.Under 5 mortality rate (disaggregated by location [urban, rural])	157 deaths per 1000 live births (NDHS 2008) 138 deaths per 1000 live births (MICS 2007)	130 deaths per 1000 live births (NDHS)	117 per thousand live births (NDHS)	103 deaths per 100 live births (NDHS)	90 deaths per 1000 live births (NDHS)	77 deaths per 1000 live births (NDHS)[17]
		Source:					
		[18]NDHS, MICS					
	Indicator	Baselines	Milestone 2010	Milestone 2011	Milestone 2012	Milestone 2013	Target 2014
	G2. Proportion of births attended by skilled health personnel[19]	*Overall:* 38.9% (NDHS 2008), 46.4%				Overall: 50% (NDHS),	

[17] Target/milestones for goal 1 (U5MR) are based on MDG target which aims to reduce by 2 thirds, the 1990 U5MR level by 2015. The figures given are based on the assumption of linear change.

[18] DHS will be available every 4-5 years; DHS does not provide disaggregation by state for this indicator.

[19] Maternal mortality ratio was considered as an indicator during development of the logframe but was replaced with indicator G2 because of measurability issues.

	(disaggregated by wealth quintile and location [urban, rural])	(NARHS 2007) *Rural:* 27.7% (NDHS 2008); 36.7% (NARHS 2007) *Urban:* 65.4% (NDHS 2008); 66.0% (NARHS 2007) Wealth quintile (NDHS 2008) Lowest: 8.3% Second: 17.6% Middle: 37.5% Fourth: 63.%% Highest: 85.7%				55% (NARHS) Rural: 38% (NDHS), 46% (NARHS) Urban: 76% (NARHS and NDHS)		
		Source: NDHS, NARHS						
	Indicator	Baselines (2008)	Milestone 2010	Milestone 2011	Milestone 2012	Milestone 2013	Target 2014	
	G3. TB case detection rate[20] (disaggregated by state)	Overall: 29.1% Enugu: 45.5% Jigawa: 23.3% Kaduna: 65.9% Kano: 58.7%						

[20] TB incidence was considered as an indicator during development of the logframe but was replaced with indicator G3 because of measurability issues. This indicator is included as a proxy for access to quality health care as PATHS2 programming will not have an explicit focus on TB.

		Source:						
		NTBLCP Annual Report						

Purpose	Indicator	Baselines	Milestone 2010	Milestone 2011	Milestone 2012	Milestone 2013	Target 2014	Assumptions
To improve the planning, financing and delivery of sustainable and replicable pro-poor[21] services for common health problems in up to 6 states	P1. Level of compliance with the MTSS processes in the preparation of annual performance based budgeting at federal and state levels	10%	20%	40%	50%	60%	80%	• Appropriate levels of political and economic stability exist • Political support for reforms remains consistent and sensitive to the needs of the poor and other marginalised groups • SLPs and development partners work together effectively and achieve their intended objectives • Enhanced governance supports institutional reforms in public sector
		Source: MTSS Progress Report produced annually in October. Public Expenditure Review report produced annually in March (will be part of the MTSS report)						
	Indicator	Baselines	Milestone 2010	Milestone 2011	Milestone 2012	Mile stone 2013	Target 2014	
	P2. Antenatal care coverage (4 visits) (disaggregated by location [urban, rural])	Overall: 44.8% Urban: 68.8% Rural 34.4 (NDHS 2008)						
		Source: NDHS, NARHS						
	Indicator	Baselines	Milestone 2010	Milestone 2011	Milestone 2012	Milestone 2013	Target 2014	
	P3. Proportion of 1 year-old children immunised against measles (disaggregated by sex, wealth quintile, state, and location [urban, rural])	Overall: 41.4% Urban: 60% Rural: 33.2% Male: 41.5% Female: 41.4% States: Enugu: 53.6% Jigawa: 8.3% Kaduna: 56.9% Kano: 17.8%	Overall: 45% Urban: 62% Rural: 38% Male: 45% Female: 45% (DHS)		Overall: 55% Urban: 66% Rural: 50% Male: 55% Female: 55% (DHS)		Overall: 80%[22] Urban: 70% Rural: 60% Male: 65% Female: 65% (DHS	

[21] The PATHS2 team understands the term 'pro-poor' as meaning all citizens have equitable access to health services, irrespective of their financial means.

		Wealth quintile: Lowest: 17.3% Second: 28.1% Middle: 40.5% Fourth: 57.9% Highest: 74.9% (NDHS 2008)						• Appropriate levels of international commitment to the MDGs are retained • Major disease outbreak does not negate benefits/gains • Interventions commenced with PATHS2 are sustained after the programme ends
		Source:						
		NDHS, ICS[23]						
	Indicator	Baselines	Milestone 2010	Milestone 2011	Milestone 2012	Milestone 2013	Target 2014	
	P4. Percentage of LGAs in PATHS2 supported states with at least one functioning pro-poor health financing mechanism (safety nets)	TBD – March 2010						
		Source:						
		PATHS2 survey						
	Indicator	Baselines	Milestone 2010	Milestone 2011	Milestone 2012	Milestone 2013	Target 2014	
	P5. Number of states implementing systems strengthening approaches to increase access to quality health services for women and the poorest	States: 0/36	States: 4/36	States: 6/36	States: 8/36	States: 10/36	States: 12/36	
		Source:						
		Periodic evaluations, state scoping missions						
INPUTS (£)[24]	DFID (£)	Govt. (£)	Other (£)	Total (£)	DFID Share (%)			
	130,427,154							
INPUTS (FTEs)	DFID FTE							
	1.2							

[22] PATHS2 has used the NPHCDA target of 80% as the logframe target, but believe that 65% is a more realistic target based on recent trends.

[23] ICS figures, milestones, and target will be inserted when the 2010 survey is conducted.

[24] Information on government and other partner spending is currently unavailable, therefore only DFID spending (total for all years) is captured in the logframe and DFID's share is not calculated. This should not be interpreted to mean that DFID is the only partner funding work related to the PATHS2 purpose.

OUTPUT 1	Indicator	Baselines	Milestone 2010	Milestone 2011	Milestone 2012	Milestone 2013	Target 2014	Assumptions
Stewardship role for health at national level strengthened	1.1 New and revised federal policies, plans, and legislation developed with PATHS2 support are consistent with National Strategic Health Development Plan (NSHDP) and meet a minimum quality standard[25]	0	2	4	5	6	6	• States open to be influenced by federal government policies • Changes in policy and decision makers at national and state level does not adversely affect implementation of national health sector reform agenda • Federal government agrees to involve states in the policy and systems development process • Government is sensitive to the needs of the poor and other marginalised groups (Continued below)
		Source: PATHS 2 Policy Review instrument						
	Indicator	Baselines	Milestone 2010	Milestone 2011	Milestone 2012	Milestone 2013	Target 2014	
	1.2 Level of compliance with NHA institutionalisation processes[26]	20%	30%	50%	70%	80%	90%	
		Source: NHA progress reports including public expenditure reports						
IMPACT WEIGHTING	Indicator	Baselines	Milestone 2010	Milestone 2011	Milestone 2012	Milestone 2013	Target 2014	RISK RATING
15%[27]	1.3 Number of federal	0	1	2	3	4	5	High
		Source:						

[25] "Minimum quality standard" is defined in the PATHS2 M&E Framework and addresses the evidence base, attention to gender and equity, responsiveness to citizen views, and consistency with achievement of the MDGs.

[26] There are 12 steps involved in NHA process, one of which is PER so compliance will capture the completeness of NHA institutional process. Details of the steps are contained in the PATHS2 M&E Framework.

[27] PATHS2 attributed impact weighting according to the following rationale. Outputs 1 and 4 were allocated somewhat lower impact weightings because of the potential to leverage fellow SLPs SPARC and SAVI in these areas of work. The lower impact weighting for Output 4 also reflects the high risk rating of this area of work in the complex Nigerian socioeconomic and political environment. Outputs 2 and 3 were allocated somewhat higher impact weightings because they contain the bulk of the programme's state-level work on systems strengthening and service delivery.

	agencies with institutional capacity[28] for HMIS	PATHS2 HMIS capacity assessment						
INPUTS (£)[29]	DFID (£)	Govt. (£)	Other (£)	Total (£)	DFID Share (%)			
	18,478,888							
INPUTS (FTEs)	DFID FTE							
	0.24							

OUTPUT 2	Indicator	Baselines	Milestone 2010	Milestone 2011	Milestone 2012	Milestone 2013	Target 2014	Assumptions
State Systems to support appropriate health services improved	2.1 New and revised state policies, plans, and legislation developed with PATHS2 support are consistent with National Strategic Health Development Plan (NSHDP) and meet a minimum quality standard[30]	0	4	8	12	16	16	(Continued from above) • Oil revenue and economic growth are sustained and support reform processes • Continued support for health care reform at state level • Budgetary allocation for health not affected by worldwide recession • Health continues to be seen as a priority area for
		Source: PATHS2 Policy Review instrument						
	Indicator	Baselines	Milestone 2010	Milestone 2011	Milestone 2012	Milestone 2013	Target 2014	
	2.2 Percent of budgeted State & LGA funds for health being disbursed (disaggregated by level of care & type of service if	TBD from PER in March 2010		15% above baseline			25% above Baseline	
		Source: Public Expenditure Review; CSO budget monitoring reports						

[28] Generate annual reports, have a strategic plan, strategic plan is being implemented.
[29] Accurate information on government and other partner spending is unavailable, therefore only DFID spending is captured in the logframe and DFID's share cannot be calculated. This should not be interpreted to mean that DFID is the only partner funding work related to PATHS2 Output 1.
[30] "Minimum quality standard" is defined in the PATHS2 M&E Framework and addresses the evidence base, attention to gender and equity, responsiveness to citizen views, and consistency with achievement of the MDGs.

	possible)		government in states after the 2011 election (Continued below)

	Indicator	Baselines	Milestone 2010	Milestone 2011	Milestone 2012	Milestone 2013	Target 2014	
	2.3 Percentage of health facilities submitting timely and complete HMIS reports	HF: 50.7%	HF: 55%	HF: 60%	HF: 65%	HF: 70%	HF: 80%	
		Source: NHMIS; Health Facility Survey; HMIS capacity assessments						
IMPACT WEIGHTING	Indicator	Baselines	Milestone 2010	Milestone 2011	Milestone 2012	Milestone 2013	Target 2014	RISK RATING
25%	2.4 Number of states with adequate institutional capacity for human resource planning	0		2		4	6	[31] High
		Source: HRH assessment						
INPUTS (£)[32]	DFID (£)	Govt. (£)	Other (£)	Total (£)	DFID Share (%)			
	30,478,122							
INPUTS (FTEs)	DFID FTE					.		
	0.24							

[31] Political instability after the 2011 elections may significantly slow progress already being achieved in the health sector

[32] Accurate information on government and other partner spending is unavailable, therefore only DFID spending is captured in the logframe and DFID's share cannot be calculated. This should not be interpreted to mean that DFID is the only partner funding work related to PATHS2 Output 2.

OUTPUT 3	Indicator	Baselines	Milestone 2010	Milestone 2011	Milestone 2012	Milestone 2013	Target 2014	Assumptions
Delivery of, and access to, sustainable, appropriate health services and supplies improved	3.1 Percentage of health facilities in PATHS2 supported states with essential drugs consistently available (disaggregated by level of care [primary, secondary])	48% PHC 72% SHC		63% PHC 87% SHC			73% PHC 97% SHC	(Continued from above) • Population migration does not strain the health sector • Private sector provision for health needs continues to meet demand (Continued below)
		Source:						
		PATHS2 Health Facility Survey						

Indicator	Baselines	Milestone 2010	Milestone 2011	Milestone 2012	Milestone 2013	Target 2014	
3.2 **Percentage of health facilities in PATHS2 supported states providing basic emergency obstetric care services**	Overall: 5.8% Enugu: 0.0% Jigawa: 3.3% Kaduna: 10.0% Kano: 7.6%		Baseline + 15%			Baseline + 25%	• Demand for healthcare does not outstrip sector and States' capacity • Water and sanitation priorities are addressed through initiatives in State education plans • Sustainable and replicable basic education services are improved
	Source:						
	PATHS2 Health Facility Surveys						
Indicator	Baselines	Milestone 2010	Milestone 2011	Milestone 2012	Milestone 2013	Target 2014	
3.3 Percentage of clients in PATHS2 supported states reporting satisfaction with primary health care services	29.1% (overall) 29.0% (male) 30.2% (female) 33.2% (urban) 27.6% (rural)			55% (overall) 55% (male) 55% (female) 58% (urban) 52% (rural)		80% (overall) 80% (male) 80% (female) 80% (urban) 80% (rural)	
	Source:						
	PATHS2 Household Survey						

	(disaggregated by sex and location [urban, rural])							
IMPACT WEIGHTING	Indicator	Baselines	Milestone 2010	Milestone 2011	Milestone 2012	Milestone 2013	Target 2014	RISK RATING
25%	3.4 **Number of communities in PATHS2 supported LGAs with effective mechanisms to overcome socio-cultural and/or financial barriers to access emergency obstetric care**	TBD Source: PATHS2 surveys						Medium
INPUTS (£)[33]	DFID (£)	Govt. (£)	Other (£)	Total (£)	DFID Share (%)			
	47,610,922							
INPUTS (FTEs)	DFID FTE							
	0.24							

OUTPUT 4	Indicator	Baselines	Milestone 2010	Milestone 2011	Milestone 2012	Milestone 2013	Target 2014	Assumptions
Ability of citizens and civil society to increase the accountability and responsiveness of the health system	4.1 Percentage of functioning primary health facilities in PATHS2 supported LGAs with FHCs meeting an agreed	12% Source: PATHS2 Facility Survey;			45%		70%	(Continued from above) • Policy makers, authorities, and health providers are willing to engage with civil society and respond to citizen

[33] Accurate information on government and other partner spending is unavailable, therefore only DFID spending is captured in the logframe and DFID's share cannot be calculated. This should not be interpreted to mean that DFID is the only partner funding work related to PATHS2 Output 3.

<table>
<tr><td rowspan="8">improved</td><td rowspan="2">standard for community participation</td><td colspan="6">PATHS2 Facility Survey;</td><td rowspan="8">voice
• Voice and accountability of civil society is enhanced across sectors

(Continued below)</td></tr>
<tr><td>Indicator</td><td>Baselines</td><td>Milestone 2010</td><td>Milestone 2011</td><td>Milestone 2012</td><td>Milestone 2013</td><td>Target 2014</td></tr>
<tr><td rowspan="2">4.2 Number of PATHS2 supported states formally committed to civil society participation in policy development and resource tracking</td><td>0</td><td>0</td><td>0</td><td>2</td><td>3</td><td>5</td></tr>
<tr><td colspan="6">Source:

PATHS2 reports; (JD, Minutes, FGDs, KII)</td></tr>
<tr><td>Indicator</td><td>Baselines</td><td>Milestone 2010</td><td>Milestone 2011</td><td>Milestone 2012</td><td>Milestone 2013</td><td>Target 2014</td></tr>
<tr><td rowspan="2">4.3 Percentage of advocacy objectives achieved by PATHS2 supported issue-based coalitions</td><td>0</td><td>0</td><td>30%</td><td>40%</td><td>60%</td><td>80%</td></tr>
<tr><td colspan="6">Source:

CSO monitoring & periodic external evaluations; Independent review of advocacy initiatives; SAVI civil society capacity assessments</td></tr>
<tr><td>IMPACT WEIGHTING</td><td>Indicator</td><td>Baselines</td><td>Milestone 2010</td><td>Milestone 2011</td><td>Milestone 2012</td><td>Milestone 2013</td><td>Target 2014</td><td>RISK RATING</td></tr>
<tr><td rowspan="2">15%</td><td rowspan="2">4.4 Percentage of functioning facilities within supported LGAs with functioning systems for enforcing health entitlements</td><td>0</td><td>0</td><td>10%</td><td>20%</td><td>40%</td><td>60%</td><td>High</td></tr>
<tr><td colspan="6">Source:

PATHS2 Facility Survey</td></tr>
</table>

INPUTS (£)[34]	DFID (£)	Govt. (£)	Other (£)	Total (£)	DFID Share (%)			
	17,901,490							
INPUTS (FTEs)	DFID FTE							
	0.24							

OUTPUT 5	Indicator	Baselines	Milestone 2010	Milestone 2011	Milestone 2012	Milestone 2013	Target 2014	Assumptions
Capacity of citizens to make informed choices about prevention, treatment, and care strengthened	5.1 Percentage of households with individual who have participated in public dialogue on key health issues (disaggregated by location [urban, rural])	Overall: 3.4% Urban: 3.2% Rural: 3.5% Enugu: 3.1% Jigawa: 3.0%, Kaduna: 4.5% Kano: 2.9%			Overall: 10%		Overall: 30%	(Continued from above) • Communications professionals have appropriate editorial direction and public freedom of expression
		Source: PATHS2 Household Survey, Qualitative Audience Focus Group Discussions						
	Indicator	Baselines	Milestone 2010	Milestone 2011	Milestone 2012	Milestone 2013	Target 2014	
	5.2 Percentage of people who have adequate knowledge on the prevention and home management of common health conditions (disaggregated by location [urban, rural])	Overall: 2.9% Urban: 4.6% Rural: 2.3% Enugu: 0.2% Jigawa: 1.8% Kaduna: 7.3% Kano: 1.3%			Overall: 10%		Overall: 25%	
		Source: PATHS2 Household Survey, Qualitative Audience Focus Group Discussions						

[34] Accurate information on government and other partner spending is unavailable, therefore only DFID spending is captured in the logframe and DFID's share cannot be calculated. This should not be interpreted to mean that DFID is the only partner funding work related to PATHS2 Output 4.

IMPACT WEIGHTING	Indicator	Baselines	Mile stone 1 (2010)	Mile stone 2 (2011)	Mile stone 3 (2012)	Mile stone 4 (2013)	Target (2014)	RISK RATING
20%	5.3 Percentage of people who can correctly identify at least 3 health service entitlements (disaggregated by location [urban, rural])	Overall: 10.0% Urban: 10.9% Rural: 9.7% Enugu: 16.2% Jigawa: 8.3% Kaduna: 10.1% Kano: 8.5%			Overall: 20.0%		Overall: 30.0%	Low
		Source:						
		PATHS2 Household survey, Qualitative Audience Focus Group Discussions						
INPUTS (£)[35]	DFID (£)	Govt. (£)	Other (£)	Total (£)	DFID Share (%)			
	15,957,733							
INPUTS (FTEs)	DFID FTE							
	0.24							

[35] Accurate information on government and other partner spending is unavailable, therefore only DFID spending is captured in the logframe and DFID's share cannot be calculated. This should not be interpreted to mean that DFID is the only partner funding work related to PATHS2 Output 5.

ACTIVITY LOG

OUTPUT 1	Activity 1.1	Milestone 2010	Milestone 2011	Milestone 2012	Milestone 2013	Milestone 2014	Risks	Monitoring officer
Stewardship role for health at national level strengthened	Review and strengthen Policy, planning, and budgeting arrangements, in collaboration with other partners, especially SPARC	Developed the framework for review, training and collaboration with other relevant partners including SPARC. Establish system for appropriate budgeting processes including MTSS.	Continued support for appropriate budgeting processes including MTSS.	Acquired capacity for implementing policies and to develop MTSS processes.	MTSS processes established and functioning. Assessment of MTSS performance.	Established planning processes and implementation of comprehensive budgets.	Financial and employment incentives for developing primary healthcare do not exist Demand for healthcare outstrips sector and State's capacity Private sector unwilling to cooperate and contribute to healthcare reforms Human resource availability in public sector healthcare compromised by demands of vertical health sector initiatives Civil society is unable to make use of opportunities to articulate demand	M&E
	Activity 1.2	**Milestone 2010**	**Milestone 2011**	**Milestone 2012**	**Milestone 2013**	**Milestone 2014**		**Monitoring officer**
	Review and strengthen: Systems for public financial and expenditure management including National Health Accounts (NHA), in collaboration with SPARC	Completed framework for public expenditure management review and NHA. Conduct PER as part of MTSS. Capacity Building and Construction of the 2006-2008 NHA.	Conduct Public Expenditure Review. Improved capacity for generating continuous flow of expenditure data for the construction and uses of annual NHA exercise.	Improved capacity to perform annual performance review and construction and uses of national and Sub national Health Accounts.	Established Database on National Health Expenditure information and indicators.	Improved capacity to use public expenditure data including NHA for policy and planning.		M&E
	Activity 1.3	**Milestone 2010**	**Milestone 2011**	**Milestone 2012**	**Milestone 2013**	**Milestone 2014**		**Monitoring officer**
	Develop and implement: National Strategic Health Development Plan (NSHDP) with other stakeholders	Completed NSHDP framework and plan. NSHDP will guide MTSS development; establish system for appropriate budgeting processes including MTSS (as per Activity 1.1 above)	Implementation of NSHDP and SSHDP. Developed capacity to use the NSHDP and SSHDP for MTSS processes, annual budgeting and planning.	Continued implementation of NSHDP and SSHDP Improved capacity to use the NSHDP and SSHDP for MTSS processes, annual budgeting and planning.	NSHDP and SSHDP plan midterm evaluation and review.)	Continued implementation of revised plan.		M&E

	Activity 1.4	**Milestone 2010**	**Milestone 2011**	**Milestone 2012**	**Milestone 2013**	**Milestone 2014**	and need HIV/AIDS, TB, and malaria incidence negate gains	**Monitoring officer**
	Develop and implement: Mechanisms for integrating health service delivery at all levels	TORs for coordination platforms at various levels (HPCC, HSSF at Federal and DCFs at the State level) agreed and operationalized	Regular reporting of partner contributions using agreed tools/matrix	Integrated Plans reflecting activities and resources by different partners at different levels institutionalized	Donor and partner contributions regularly reported and captured as part of sector resource envelop at federal and state levels	Donor and partner contributions regularly reported and captured as part of sector resource envelop at federal and state levels		M&E
	Activity 1.5	**Milestone 2010**	**Milestone 2011**	**Milestone 2012**	**Milestone 2013**	**Milestone 2014**		**Monitoring officer**
	Develop and implement a sustainable and pro-poor health commodities supply policy	Assessment and gap analysis.	Assessment and gap analysis. Begin implementation of strategies identified through gap analysis.	Continue with implementation of strategies identified through gap analysis.	Improved capacity for National Logistics Management.	Improved linkage between logistics management system and planning and budgeting systems.		M&E
	Activity 1.6	**Milestone 2010**	**Milestone 2011**	**Milestone 2012**	**Milestone 2013**	**Milestone 2014**		**Monitoring officer**
	Develop and implement: National regulatory frameworks, the National Health Bill, other health reform bills, and other quality assurance standards for the health sector	Capacity to implement regulatory framework assessed. Passage of the National Health Bill supported.	Implementation of the regulatory framework strengthened. Increase advocacy on the content and implications of the health bill.	Functional regulatory framework institutionalised. Monitoring of the National Health law implementation.	Performance of the regulatory framework reviewed.			M&E
	Activity 1.7	**Milestone 2010**	**Milestone 2011**	**Milestone 2012**	**Milestone 2013**	**Milestone 2014**		**Monitoring officer**
	Strengthen: National Health Information System in collaboration with other partners	HDCC or M&E TWG established at meet regularly at national level	National level M&E plan developed in line with NSHDP Regular Publications of health information from the NHMIS	Better integration of M&E subsystems with the NHMIS Implementation of data quality/ supervisory & monitoring system in 2 states	Sustainment of the NHMIS system with improvement in data quality from states Improved reporting from states	Sustainment of the NHMIS system with improvement in data quality from states Improved reporting from states		M&E

	Activity 1.8	**Milestone 2010**	**Milestone 2011**	**Milestone 2012**	**Milestone 2013**	**Milestone 2014**	**Monitoring officer**
	Strengthen: Performance monitoring and mutual accountability among all stakeholders in the health sector	Development of performance monitoring and accountability tools for FMOH. Development of the IHP+ compact	Development of performance monitoring and accountability tools at State and LGA levels. Use and roll out of tools at FMOH level. Implementation and monitoring of the IHP+ compact agreement	Use and roll out of tools at all levels	Continued use of monitoring and accountability tools	Institutionalization of monitoring and accountability systems	M&E
	Activity 1.9	**Milestone 2010**	**Milestone 2011**	**Milestone 2012**	**Milestone 2013**	**Milestone 2014**	**Monitoring officer**
	Strengthen: Institutional capacity for implementing the human resources for health policy and strategic plan, with attentions to gender and equity issues, in collaboration with SPARC	National HRH Database established	HRH Workforce observatory enhanced Programs developed with National Collaborating Centers for continuous professional development of Managers for the health sector.	Job descriptions and specifications for all categories of health workers developed Staffing norms based on workload developed and utilized to guide HRH planning	Performance mechanisms of health workers established at National and State levels	Dissemination of HRH Best practices	M&E
	Activity 1.10	**Milestone 2010**	**Milestone 2011**	**Milestone 2012**	**Milestone 2013**	**Milestone 2014**	**Monitoring officer**
	Strengthen knowledge management systems in collaboration with other SLPs and development partners	KM strategy developed at national level	Implementation of KM strategy	Non-PATHS2 supported states aware of success stories and improvements in health governance in PATHS2 supported states		At least 2 non-PATHS2 supported states adopting health systems strengthening initiatives introduced in supported states	M&E
	Activity 1.11	**Milestone 2010**	**Milestone 2011**	**Milestone 2012**	**Milestone 2013**	**Milestone 2014**	**Monitoring officer**

	Promote: Effective donor coordination in the health sector	Assessment of donor coordination system. Support the establishment of the relevant framework for donor coordination.	Capacity of FMOH on donor coordination enhanced. Collaborative work program institutionalised.	Effective donor coordination mechanisms established including the use of NSHDP	Aid effectiveness and donor coordination mechanisms reviewed.	Functional donor coordination.		M&E
	Activity 1.12	**Milestone 2010**	**Milestone 2011**	**Milestone 2012**	**Milestone 2013**	**Milestone 2014**		**Monitoring officer**
	Promote: Public-private partnerships as an effective and efficient means of service delivery	Capacity of federal PPP unit strengthened at national level. Implementation of national PPP policy including communication strategy. Collaboration between federal and state PPP units. Mobilization of private sector resources for improved health care delivery	Specific PPP projects aimed at improved service delivery functioning Increased collaboration between state and Federal level PPP units Increased mobilization of private sector resources for improved health care delivery	Increased specific PPP projects aimed at improved service delivery functioning Increased collaboration between state and Federal level PPP units Capacity to implement policy strengthened at national level	Evaluation of PPP policy implementation	Commencement of PPP policy review		M&E
	Activity 1.13	**Milestone 2010**	**Milestone 2011**	**Milestone 2012**	**Milestone 2013**	**Milestone 2014**		**Monitoring officer**
	Promote: Research as a basis for evidence-based decision-making in health policy and planning	Development of operations research agenda	Capacity building for FMOH in operational research Conduct of operations research	Conduct of operations research Dissemination of proceeds of priority OR undertaken				M&E

OUTPUT 2	Activity 2.1	Milestone 2010	Milestone 2011	Milestone 2012	Milestone 2013	Milestone 2014	Risks	Monitoring officer
State systems to support appropriate health services improved	Support and facilitate the adaption and implementation of the gender and equity sensitive national HRH policy in PATHS2 supported states	HRH assessment undertaken and profile developed	HRH policy adapted for 4 states	Implementation of policy commenced in at least 2 states	Implementation of policies commenced in at least 4 states	continued Implementation of policies in at least 4 states	As above	M&E
	Activity 2.2	**Milestone 2010**	**Milestone 2011**	**Milestone 2012**	**Milestone 2013**	**Milestone 2014**		**Monitoring officer**
	Put in place policies and regulatory systems that will strengthen public-private partnerships for the delivery of health services	National PPP policy adopted in at least 2 states PPP units established in at least 2 states. 2 states have commenced at least one PPP initiative	National PPP policy adopted in 4 states PPP units established in 4 states 4 states have commenced at least one PPP initiative	Increase in PPP initiatives and specific activities at the states. Implementation of PPP policy in all PATHS2 states	Increase in PPP initiatives and specific activities at the states. Evaluation of PPP initiatives	Review policy and evaluation findings to improve functioning of PPP units and initiatives; recommend and initiate improvements in policy implementation		M&E
	Activity 2.3	**Milestone 2010**	**Milestone 2011**	**Milestone 2012**	**Milestone 2013**	**Milestone 2014**		**Monitoring officer**
	Strengthen gender sensitive and pro-poor state-level health planning and implementation processes in	Joint SLP planning and capacity building of SMOH stakeholders on MTSS process	4 state understand and begin the MTSS process	2 states have adopted MTSS process in the health sector	4 states have adopted MTSS process in the health sector	At least 4 states are continuing to use the MTSS process in the health sector		M&E

	collaboration with SPARC and other state-level health programmes							
	Activity 2.4	**Milestone 2010**	**Milestone 2011**	**Milestone 2012**	**Milestone 2013**	**Milestone 2014**		**Monitoring officer**
	Strengthen: State systems for public financial and expenditure management including the State Health Accounts in collaboration with SPARC	Joint SLP planning and capacity building of SMOH stakeholders on State Health Accounts process	At least 2 states have developed policy or framework for state health accounts	At least 4 states have developed policy or framework for state health accounts At least 2 states are implementing State health accounts	At least 4 states are implementing State health accounts	At least 4 states are regularly conducting state health accounts		M&E
	Activity 2.5	**Milestone 2010**	**Milestone 2011**	**Milestone 2012**	**Milestone 2013**	**Milestone 2014**		**Monitoring officer**
	Strengthen: HMIS systems at the state, LGA, and community level	HDCC or M&E TWG established and meet regularly in at least 2 states	Develop M&E framework in line with SHSSDP (state health sector strategic plans)in at least 2 states HDCC or M&E TWG established and meet regularly in at least 4 states 4 States report regularly through the NHMIS to Federal	Develop M&E framework in line with SHSSDP (state health sector strategic plans)in at least 4 states At least 2 states implementing M&E framework At least 30% reporting by facilities & LGA in 2 states	At least 50% reporting by facilities & LGA in 4 states	At least 60% reporting by facilities & LGA in 4 states		M&E
	Activity 2.6	**Milestone 2010**	**Milestone 2011**	**Milestone 2012**	**Milestone 2013**	**Milestone 2014**		**Monitoring officer**
	Develop and implement sustainable and pro-poor health commodities management system	Assessment and gap analysis	Continue with assessment and gap analysis Start developing state level systems for pro-poor health commodities management based on findings of gap analysis	Start implementation of state level systems for pro-poor health commodities management in 4 states	State level systems for pro-poor health commodities management implemented in 4 states	State level systems for pro-poor health commodities management implemented in 6 states		M&E
	Activity 2.7	**Milestone 2010**	**Milestone 2011**	**Milestone 2012**	**Milestone 2013**	**Milestone 2014**		**Monitoring officer**

	Strengthen and promote appropriate knowledge management systems in collaboration with other SLPs and development partners	KM strategy for health sector in 2 states developed and adopted	KM strategy for health sector in 4 states developed	Implementation of KM strategy for 2 states well	Sharing of best practices by PATHS2 supported states with non-PATHS2 supported states occurs Implementation of KM strategy for 4 states well	Sustained sharing of best practices		M&E

OUTPUT 3	**Activity 3.1**	**Milestone 2010**	**Milestone 2011**	**Milestone 2012**	**Milestone 2013**	**Milestone 2014**	**Risks**	**Monitoring officer**
Delivery of, and access to, appropriate health services and supplies improved	Support the state government to provide pro-poor and gender sensitive quality health services	Review of necessary documents to guide pro-poor health service delivery	Pilot schemes adopted in at least 2 states to support pro-poor health services	Review of pilot and finalisation of scheme	Implementation of scheme in at least 2 states	Implementation of scheme in at least 4 states	As above Government unable to supply human resources to deliver and essential package of care in most facilities	M&E
	Activity 3.2	**Milestone 2010**	**Milestone 2011**	**Milestone 2012**	**Milestone 2013**	**Milestone 2014**		**Monitoring officer**
	Support state government in developing and implementing pro-poor and gender sensitive Essential Package of care	TBD	TBD	TBD	TBD	TBD		M&E
	Activity 3.3	**Milestone 2010**	**Milestone 2011**	**Milestone 2012**	**Milestone 2013**	**Milestone 2014**		**Monitoring officer**
	Support the state government to improve experience-sharing among service providers	Development of mechanisms for experience sharing amongst HCW	2 states regularly sharing experiences amongst HCW	4 states regularly sharing experiences amongst HCW	4 states regularly sharing experiences amongst HCW	4 states regularly sharing experiences amongst HCW		M&E
	Activity 3.4	**Milestone 2010**	**Milestone 2011**	**Milestone 2012**	**Milestone 2013**	**Milestone 2014**		**Monitoring officer**
	Strengthen the involvement and capacity of the private sector (profit and not-for-profit) in the provision of quality health care services	TNA for private sector in states	Regulatory framework for the private health service provision established in at least 2 states	Regulatory framework for the private health service provision established in at least 2 states	Implementation of regulatory framework in 4 states	Implementation of regulatory framework in 4 states		M&E

	Activity 3.5	**Milestone 2010**	**Milestone 2011**	**Milestone 2012**	**Milestone 2013**	**Milestone 2014**		**Monitoring officer**
	Strengthen capacity development of service providers on supply chain and health commodity logistics [SDSS including DRF], in collaboration with related programmes and partners [e.g., UN agencies]	Support the development of immediate capacity to manage existing DFID support in 4 states	Support development of immediate capacity to manage existing DFID support in 4 states and conduct TNA based on the proposed logistics management system	Develop training programme based on the proposed logistics management system and TNA for all PATHS2 supported SD Points (HFs) in 4 states	Training of all HFs in all states in collaboration with other development partners	SDP capacity strengthened and practicing SCMS		M&E
	Activity 3.6	**Milestone 2010**	**Milestone 2011**	**Milestone 2012**	**Milestone 2013**	**Milestone 2014**		**Monitoring officer**
	Strengthen integration, linkages, and referrals of service delivery at all levels, and especially PHC, in collaboration with other health programmes	Assessment and gap analysis of referral systems	Development of workplan to address gaps including training	Implementation of developed workplan Referral system operating in at least 1 state	Implementation of developed workplan Referral system operating in at least 2 states	Improved service integration and referrals at all levels		M&E
	Activity 3.7	**Milestone 2010**	**Milestone 2011**	**Milestone 2012**	**Milestone 2013**	**Milestone 2014**		**Monitoring officer**
	Strengthen service providers' capacity for data management and utilisation, including the use of gender disaggregated data to improve health service delivery	Assessment of HMIS training needs	Development of training plan Development of curricula	Training plan implementation 30% of personnel trained	Training plan implementation 60% of personnel trained			M&E
	Activity 3.8	**Milestone 2010**	**Milestone 2011**	**Milestone 2012**[36]	**Milestone 2013**	**Milestone 2014**		**Monitoring officer**
	Promote financial, social and physical access of poor and vulnerable groups, especially women and children in collaboration with other SLPs	State governments in Jigawa and Kano consolidate SMI-D and agree plan for expansion Enugu and Kaduna State	State governments in Jigawa and Kano roll out SMI-D to at least X communities in each state					M&E

[36] Milestones for 2012-2014 will be determined through later work planning.

		governments decision on whether to introduce SMI-D in their states and, if appropriate, an action plan for doing so Kaduna SMOH plans for the further development of the Community Health Volunteers Scheme agreed.	State governments in Kaduna and Enugu introduce SMI-D to at least X communities in each state Kaduna SMOH rolls out the CHV programme to at least X communities					

OUTPUT 4	**Activity 4.1**	**Milestone 2010**	**Milestone 2011**	**Milestone 2012**	**Milestone 2013**[37]	**Milestone 2014**	**Risks**	**Monitoring officer**
Ability of citizens and civil society to increase the accountability and responsiveness of the health system improved	Develop and implement models of inclusive community participation in facility health committees, which include community oversight of DRF/D&E structures where they are operational, to ensure responsive and accountable services	In each PATHS2 supported state, at least X FHCs with more inclusive representation are active and involved in DRF/D&E oversight (where operational)	In each PATHS2 supported state, at least X FHCs with more inclusive representation are representing community views on health services, involved in DRF/D&E oversight (where operational) and are tracking health facility resources	In each PATHS2 supported state, X% of PATHS2 supported FHCs have evidence of: i) effectively representing diverse community views; ii) delivering service improvements; iii) advocating with government officials for improved health systems			As above Government interest in and capacity to support the emergence of active community participation and voice does not exist Social norms do not permit inclusive community participation in	M&E
	Activity 4.2	**Milestone 2010**	**Milestone 2011**	**Milestone 2012**	**Milestone 2013**	**Milestone 2014**		**Monitoring officer**

[37] Milestones for Output 4 activities for 2013 and 2014 will be determined through later work planning.

Develop and implement issue-based coalitions which deliver more responsive and accountable services and address the needs of women and the poorest, in collaboration with SAVI	Free maternal and child health civil society partnersihps are operating in each PATHS2 supported state	In each PATHS2 supported state, FMCH civil society partnerships are working with FHCs to monitor the implementation of free MCH services and are using data gathered by FHCs in policy advocacy Additional issue-based coalitions identified and a programme of work agreed to be supported by PATHS2	FMCH civil society partnership members have increased capacity in: i) research and data analysis; ii) policy analysis; iii) evidence-based policy advocacy; iv) working with partners			FHCs Competition for resources amongst civil society threatens the emergence of issue-based coalitions Incentives to develop strong links with constituencies do not exist leaving CSOs unable to represent the voices of poor citizens SAVI and PATHS2 are unable to work together effectively	M&E
Activity 4.3	**Milestone 2010**	**Milestone 2011**	**Milestone 2012**	**Milestone 2013**	**Milestone 2014**		**Monitoring officer**
Develop and implement mechanisms to enable citizens, especially women and the poorest, to claim their health entitlements	Kaduna SMOH decision on whether to introduce SERVICOM in the State and if appropriate, an action plan for doing so	One mechanism for the enforcement of health entitlements operational in 4 PATHS2 supported states	In 4 PATHS2 supported states X% of FHCs act as a forum for addressing citizen complaints about health service			Government does not perceive addressing community-based barriers to accessing health services as part of its remit Local capacity for qualitative research is weak	M&E
Activity 4.4	**Milestone 2010**	**Milestone 2011**	**Milestone 2012**	**Milestone 2013**	**Milestone 2014**		**Monitoring officer**

Support Federal, State and Local Governments to engage effectively with civil society on health policy and service delivery, especially for women and the poorest	State/LGA teams able to support the development of FHCs in 4 PATHS2 supported states Evidence of civil society involvement in the development/review of State Strategic Health Development Plans in 4 PATHS2 supported states	X% of LGAs in 4 PATHS2 supported states have platforms to engage with FHCs and communities Evidence of civil society involvement in MTSS process in 4 PATHS2 supported states State Govt and CSOs meeting regularly to discuss health policy and service delivery in at least 2 PATHS2 supported states					M&E
Activity 4.5	**Milestone 2010**	**Milestone 2011**	**Milestone 2012**	**Milestone 2013**	**Milestone 2014**		**Monitoring officer**
Provide technical assistance to support the roll out of the Safe Motherhood Demand-Side Initiative and other key initiatives addressing community-based barriers to accessing health services	State Governments in Jigawa and Kano consolidate SMI-D and agree plan for expansion Enugu and Kaduna State Governments decision on whether to introduce SMI-D in their states and, if appropriate, an action plan for doing so Kaduna SMOH plans for the further development of the Community Health Volunteers Scheme agreed	State Governments in Jigawa and Kano roll out SMI-D to at least X communities in each state State Governments in Enugu and Kaduna introduce SMI-D to at least X communities in each state Kaduna SMOH rolls out the CHV programme to at least X communities					M&E
Activity 4.6	**Milestone 2010**	**Milestone 2011**	**Milestone 2012**	**Milestone 2013**	**Milestone 2014**		**Monitoring officer**

Strengthen local capacity to monitor process and outcomes from output 4 and other PATHS2 work, especially for women and the poorest, including through community sentinel monitoring and formative research	In 2 communities in 4 PATHS2 supported states, selected community members are trained and engaged in monitoring PATHS2 work	In 2 communities in 4 PATHS2 supported states, monitoring and data analysis skills of selected community members are extended and deepened					M&E
Activity 4.7	**Milestone 2010**	**Milestone 2011**	**Milestone 2012**	**Milestone 2013**	**Milestone 2014**		**Monitoring officer**
Strengthen effective knowledge management, including the identification, documentation and dissemination of good practices and lessons learnt from output 4 experience	State and civil society partners in 4 PATHS2 supported states are familiar with international and Nigerian best practice in community participation through FHCs and in addressing community barriers to accessing EOC	Lessons from output 4 work presented at PATHS2 lesson learning workshop					M&E
Activity 4.8	**Milestone 2010**	**Milestone 2011**	**Milestone 2012**	**Milestone 2013**	**Milestone 2014**		**Monitoring officer**

	Support the professional development and mentoring of PATHS2 staff and national consultants in areas related to output 4	Health equity skills development workshop held for all PATHS2 technical staff Quarterly meetings between the O4 technical team and state O4 staff	Quarterly meetings between the O4 technical team and state O4 staff					M&E

OUTPUT 5	**Activity 5.1**	**Milestone 2010**	**Milestone 2011**	**Milestone 2012**	**Milestone 2013**[38]	**Milestone 2014**	**Risks**	**Monitoring officer**
Delivery of, and access to, appropriate health services and supplies improved	Review and, where appropriate, develop and implement targeted communication vehicles utilising a variety of platforms to raise public awareness of citizens' rights, entitlements, and responsibilities for priority health conditions in partnership with government and other key partners	Ask Nigeria media polling is rolled out in the states with FMOH providing a coordinating role	Ask Nigeria media polling begins to yield more qualitative discussion with live audiences around health issues of entitlements in print and electronic media platforms across the states	Media polling is sustained and it begins to feed qualitative public discussion of key health entitlement issues on platforms such as village/community meetings, town hall meetings, road shows and more interpersonal interventions in wards and Lags across the states.			As above	M&E
	Activity 5.2	**Milestone 2010**	**Milestone 2011**	**Milestone 2012**	**Milestone 2013**	**Milestone 2014**		**Monitoring officer**

[38] Milestones for Output 4 activities for 2013 and 2014 will be determined through later work planning.

	Review and, where appropriate, develop and implement targeted communication vehicles utilising a variety of platforms to increase understanding of evidence-based information on prevention, treatment, and care for priority health conditions in partnership with communications departments of key government agencies and health partners	Ask Nigeria media polling is rolled out in the states with FMOH providing a coordinating role	Ask Nigeria media polling begins to yield more qualitative discussion with live audiences around health issues of prevention, treatment and cure of priority health conditions in print and electronic media platforms across the states	Media polling is sustained and it begins to feed qualitative public discussion of key issues on prevention, treatment and cure of priority health conditions on platforms such as village/community meetings, town hall meetings, road shows and more interpersonal interventions in wards and LGs across the states.			M&E

Activity 5.3	Milestone 2010	Milestone 2011	Milestone 2012	Milestone 2013	Milestone 2014	Monitoring officer
Convene and stimulate informed debate and dialogue at different levels to support an environment where health-related issues can be discussed more openly	At least one national level debate with live audience on a selected health related issue, convened and aired on National networks (radio and television)	Two or more national and state level debates with live audience on selected health issues convened and aired on National and state channels (radio and television)	Ten or more public debates convened on selected health issues in wards and communities across the states using platforms like road shows, town hall meetings, interpersonal communication interventions etc			M&E
Activity 5.4	**Milestone 2010**	**Milestone 2011**	**Milestone 2012**	**Milestone 2013**	**Milestone 2014**	**Monitoring officer**
Strengthen and improve harmonisation of State-level health communications	The health promotion, media and PR units of FMOH and SMOH are technically refocused to provide pro poor health communications	Pro poor health communication is been rolled out on multiple platforms in the states with the FMOH and SMOH providing a coordinating role	Appropriate pro poor health communication is been rolled out in the wards and LGs using platforms like town hall meetings, road shows, market place interventions etc with SMOH providing a coordinating role			M&E
Activity 5.5	**Milestone 2010**	**Milestone 2011**	**Milestone 2012**	**Milestone 2013**	**Milestone 2014**	**Monitoring officer**
Strengthen and improve capacity of SMOH to provide adequate information flow and accountability to the public	Same as above	Same as above	Same as above			M&E
Activity 5.6	**Milestone 2010**	**Milestone 2011**	**Milestone 2012**	**Milestone 2013**	**Milestone 2014**	**Monitoring officer**

	Strengthen and improve: capacity of key State institutions and professionals to effectively design, implement, and monitor targeted, pro-poor health communications accurately and accessibly	Participatory capacity assessment of selected institutions carried out and first level trainings/ mentoring schemes developed and rolled out	TOT for key personnel of selected institutions carried out across the states	Trainers employed within selected institutions begin to design and roll out training /mentoring schemes within and between institutions across the states				M&E
	Activity 5.7	**Milestone 2010**	**Milestone 2011**	**Milestone 2012**	**Milestone 2013**	**Milestone 2014**		**Monitoring officer**
	Develop appropriate responses to health and well-being education for children and young people in and out of school settings, in collaboration with ESSPIN and government partners	Participatory assessment of current youth health interventions completed and first level interventions across the states rolled out	Establishment of a state school health communication coordinating forum					M&E
	Activity 5.8	**Milestone 2010**	**Milestone 2011**	**Milestone 2012**	**Milestone 2013**	**Milestone 2014**		**Monitoring officer**
	Promote sharing of national and international best practice in communication in collaboration with other SLPs	Refurbished FMOH website is running and mechanism for the take off of mirror sites in the SMOH is put in place PATHS 2 bulletin is up and running	Mirror sites in the SMOH across states is fully functional	The production of best practice documentaries, spots and web materials starts and its sustained till end of project				M&E

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