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Twenty years of UK health system strengthening programming in Nigeria - Thematic Evaluation

Final evaluation report

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Prepared for:
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Nigeria

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Cadmus acquired Nathan Associates in February 2023, deepening Cadmus' commitment to international development and significantly expanding our technical expertise and global footprint information. This independent evaluation was conducted by Cadmus.

The lead author of this evaluation is Ashley Craft, with contributions from Mike Naylor, Tarry Asoka and Ramatu Daroda. Nora Geiszl and Steven Chen also contributed to writing the report.

MEL practice lead Enrico Neumann and senior MEL expert Subira Bjornson have provided technical quality assurance of all deliverables before submission to FCDO. The core team is supported by academic advisor, evaluation expert and national health systems expert Professor Sophie Witter, who led on the literature review and evidence gaps.

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Acronyms and abbreviations

ACCESS	Access to Clinical and Community Maternal, Neonatal and Women's Health
ANC	Antenatal Care
AOP	Annual Operational Plan
APHCR	Advocacy for Primary Health Care reform
AR	Annual Review
BC	Business Case
BCC	Behaviour Change Component
BHC	British High Commission
BHCPF	Basic Health Care Provision Fund
CAP	Change Agents Programme
CBHI	Community-Based Health Insurance
CDC	Centres for Disease Control and Prevention
CEO	Chief Executive Officer
CF	Contextual Factor
CHEWs	Community Healthcare Extension Workers
CHIPs	Community Health Influencers, Promoters, and Services
CMS	Central Medical Store
CoI	Conflicts of Interest
CSO	Civil Society Organisation
DALY	Disability Adjusted Life Years
DFATD	Department of Foreign Affairs, Trade and Development
DFID	Department for International Development
DHIS	District Health Information System
DHS	District Health System
DMCSA	Kano State Drugs and Medical Consumables Supply Agency
DRF	Drug Revolving Fund
ENR	Enhancing Nigeria's Response to HIV/AIDS
EQ	Evaluation Questions
EQUALS	Evaluation Quality Assurance and Learning Service
ESSPIN	Education Sector Support Programme in Nigeria
ESUHCS	Enugu State Universal Health Coverage Scheme
FCAS	Fragile and conflict-affected settings
FCDO	Foreign, Commonwealth and Development Office
FCT	Federal Capital Territory
FETP	Field Epidemiology Training Program
FGD	Focus Group Discussions
FHC	Facility Health Committee
FHCW	Frontline healthcare worker
FMoH	Federal Ministry of Health
FP	Family Planning
Free-MCH	Free Maternal and Child Health
GAVI	The Vaccine Alliance
GDP	Gross Domestic Product
GEMS	Growth and Employment in [Nigerian] States
GESI	Gender equality and social inclusion
GoN	Government of Nigeria
HCP	Health Commodities Programme
HEAT	Hostile Environment Awareness Training
HERFON	Health Reform Foundation of Nigeria
HIV/AIDS	Human immunodeficiency virus / Acquired immunodeficiency syndrome

HMG	His Majesty's Government
HMIS	Health Management Information System
HRH	Human resources for health
HRHIS	human resources for health system
HSRC	Health Sector Reform Coalition
HSS	Health Systems Strengthening
IDIs	In-depth interviews
IMR	Infant Mortality Rate
INGO	International Non-Governmental Organisation
ITN	insecticide-treated nets
JICHMA	Jigawa Contributory Health Management Agency
KSCHMA	Kano State Contributory Health Management Agency
KCDC	Kano Centre for Disease Control
KII	Key Informant Interview
KNCDC	Kano Centre for Disease Control and Prevention
LGA	Local Government Areas
LICs	Lower Income Countries
LMICs	Lower- and Middle-Income Countries
MCHIP	Maternal and Child Health Integrated Programme
MDAs	Ministries, Departments, and Agencies
MDG	Millennium Development Goals
MICS	Nigeria Multiple Indicator Cluster Survey
MNCH	Maternal and Newborn Child Health Programme
M4P	Making Markets Work for the Poor
MSS	Midwives Service Scheme
NAFDAC	National Agency for Food and Drug Administration and Control
NDHS	Nigeria Demographic and Health Survey
NEEDS	National Economic and Empowerment Development Strategy
NEHSI	Nigeria Evidence-based Health System Initiative
NGAP	Nigeria Governance and Accountability Programme
NGO	Non-governmental Organisation
NHA	National Health Act
NHIS	National Health Insurance Scheme
NHOCAT	National Harmonised Organisational Capacity Assessment Tool
NHREC	National Health Research Ethics Committee
NHS	National Health Service
NMEP	National Malaria Elimination Programme
NPHCDA	National Primary Health Care Development Agency
NPHI	National Public Health Institutes
NPHI	National Public Health Institutes
NSHDP	National Strategic Health Development Plan
OECD-DAC	Organisation for Economic Cooperation and Development - Development Assistance Committee
PATHS1	Partnership for Transforming Health Systems 1
PCR	Project Completion Report
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PERL	Partnership to Engage, Reform and Learn
PER	Public Expenditure Review
PFM	Public Financial Management
PHC	Primary healthcare
PHCUOR	Primary Health Care Under One Roof
PMD	Prevention of Maternal Deaths

PMI	U.S. President's Malaria Initiative
PPP	Public private partnership
PPRHAA	Peer and Participatory Rapid Health Appraisal for Action
PRRINN/MNCH	Partnership for Reviving Routine Immunisation in Northern Nigeria – Maternal, Newborn and Child Health Programme
RI	Routine immunisation
RSM	Risk and Strategic Management
SDG	Sustainable Development Goal
SEEDS	State Economic Empowerment and Development Strategies
SLGP	State and Local Governance Programme
SMEP	State Malaria Elimination Programme
SNR	Strengthening Nigeria's Response to HIV/AIDS
SPARC	State Partnership for Accountability, Responsiveness, and Capability
SRO	Senior Responsible Owner
SSHDP	State Sector Health Development Plans
SUNMAP	Support to the National Malaria Programme
SWAp	Sector-wide approach
ToC	Theory of Change
TOR	Terms of Reference
U5MR	Under Five Mortality Rate
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
UNITED	Nigeria: Tackling Neglected Tropical Diseases through an Integrated Approach
USAID	U.S. Agency for International Development
VfM	Value for money
W4H	Nigeria—Women for Health
WDC	Ward Development Committee
WHO	World Health Organisation
WISH	Women's Integrated Sexual Health Programme

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Glossary of key terms

Basic Health Care Provision Fund: National fund designed to finance essential health services, particularly for vulnerable populations.

Community-Based Health Insurance: Local insurance model designed to pool resources and reduce financial barriers to healthcare.

Disability-Adjusted Life Year: Measure used to assess the burden of disease and the effectiveness of health interventions.

Drug Revolving Fund: Cost-recovery system for essential medicines to ensure a sustainable supply through patient fees and reinvestment.

Facility Health Committee: Community-based governance structure that enhances transparency, accountability and participation in health service planning.

Health Management Information System: System for collecting, analysing and reporting health data to support evidence-based decision-making.

Health Reform Foundation of Nigeria: Organisation promoting health policy reforms and advocacy.

Health Systems Strengthening: Strategies and interventions aimed at improving the performance of health systems to enhance access, quality, efficiency and sustainability of healthcare services.

Human Resources for Health: Workforce involved in healthcare delivery, including doctors, nurses and community health workers.

National Health Insurance Scheme: Government initiative to provide health insurance and financial protection for citizens.

National Primary Health Care Development Agency: Agency responsible for developing and coordinating primary healthcare policies in Nigeria.

Nigeria Demographic and Health Survey: National survey collecting data on health indicators such as maternal mortality, immunisation and nutrition.

Primary Health Care Under One Roof: Policy aimed at integrating and coordinating primary healthcare services under one management structure for better efficiency

Sustained change: Intervention which was still operating after programme closure or end of FCDO support, even in a reduced or adapted capacity.

Transformational change: Intervention which significantly altered how the government of Nigeria or its implementing partners worked, and the change continued at least until the end of the programme.

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0. Executive summary

Context

This evaluation was commissioned by the Foreign, Commonwealth and Development Office (FCDO) to analyse its portfolio of health programming in Nigeria over the last 20 years, covering nearly £1bn of official development assistance (ODA). Health programmes in Nigeria operate in a challenging and complex political environment, requiring continuous adaptation. Nigeria is a federal country, with 36 states and 774 Local Government Authorities (LGAs). Public policy decisions at all levels are products of bargaining and compromise between conflicting interests. Oil wealth accounts for over 95% of government revenues, and drives intense competition for control of national resources among elite groups and regional factions representing ethnic groups including Hausa and Fulani, Yoruba and Igbo.

Nigeria's return to democracy in 1999 paved the way for DFID to establish its Nigeria office to deliver development assistance, including in healthcare. The last 20 years have seen an impressive portfolio of different interventions in Nigeria's health system, starting with the first flagship health systems strengthening (HSS) programme, Partnership for Transforming Health Systems 1 (PATHS1, 2002-2008). This was followed by Partnership for Reviving Routine Immunisation in Northern Nigeria – Maternal, Newborn and Child Health Programme (PRRINN-MNCH, 2006-2013), Partnership for Transforming Health Systems 2 (PATHS2, 2008-2016), and the current Lafiya programme (2019-2027), alongside several rounds of advocacy, maternal and child health, and vertical disease-specific programmes (see Table 1 for a full list). This portfolio covers a wide range of interventions across different Nigerian states and various timelines.

Our theory-based approach facilitates thematic and case-based analysis

This thematic evaluation aims to understand what has worked and what hasn't worked across FCDO's extensive portfolio of health interventions over the last 20 years. The primary purpose is learning rather than accountability, so it does not aim to provide extensive evaluation of individual programmes. Instead, it provides a framework for drawing out lessons on what has worked and what hasn't worked for different programmes, while acknowledging differences in contextual factors.

Our evaluation applies a theory-based approach based on a portfolio-level theory of change of FCDO's health programming in Nigeria, which we developed in close collaboration with FCDO, informed by Professor Sophie Witter's research on factors for sustainable health systems strengthening (Witter et al., 2019, Witter et al., 2022, Bertone et al., 2023). Based on the newly developed portfolio-level theory of change, we have derived five intermediate outcome themes that can be mapped across FCDO's interventions for health systems strengthening over 20 years. These themes align with latest research on factors that are essential for health systems strengthening, and structure our analysis and findings:

- IO1: Improved quality of public healthcare facilities and skilled frontline healthcare workers.
- IO2: Building capacity of government decision-making, budgeting and policymaking.
- IO3: Timely procurement and distribution of medicine, supplies and vaccines.
- IO4: Awareness-raising and communication.
- IO5: Improved reporting and information management systems.

Full theories of change for these outcome areas are found in Annex H.

To provide evidence on what works and what doesn't work, we apply a case-based approach, closely analysing intervention cases and their contextual factors to inform findings, lessons and recommendations. Intervention cases are those interventions that have been implemented as part of an FCDO health programme in a specific Nigerian state, and may have been supported by more than just one programme over the last 20 years. We give a detailed analysis of all identified intervention cases and provide references throughout where these have informed specific findings.

This evaluation draws on the perspectives and reflections of over 150 stakeholders involved in the delivery of Nigeria HSS programming. In addition, we obtained first-hand feedback from frontline health workers to triangulate which interventions led to health system transformations, and which of these were sustained. We held 64 key informant interviews (KIIs) and 14 focus group discussions (FGDs) with 96 participants (55 male, 41 female) across the three target states of Kano, Enugu and Jigawa.

We applied a purposive sampling approach to identify a range of key stakeholders across six different stakeholder groups, including UK and Nigerian government officials (federal and state level), implementing partners (federal and state level), civil society organisations and other accountability mechanisms, frontline primary healthcare workers, and other development partners. We ensured that the sampling strategy was appropriate and proportionate to ensure robust triangulation of findings, through consultations with a variety of different stakeholders at different levels of the Nigerian health system.

We ensure robust triangulation by only including findings that were corroborated by at least three different sources. Qualitative statements were coded in Atlas.ti and linked to stakeholders. This allows us to identify, which statements were repeated by different kinds of stakeholders, with different viewpoints from within the health system. We only used statements that could be triangulated through at least three different stakeholder groups, and additionally cross-referenced findings with secondary data from project completion reports (PCRs), monitoring data and evaluations, as well as third-party monitoring sources such as the Nigeria Multiple Indicator Cluster Survey (MICS). Annex N provides an extensive list of mapped statements and shows the number of stakeholders that could be mapped against it.

Findings

FCDO's health systems strengthening programmes achieved transformational changes over the 20-year period. We identified cases where transformations were well sustained and expanded through the health system. This worked best when respective programmes were well aligned to federal priorities and state governors' agendas. Where delivery was well-adapted to state and local context, it was more likely that government and communities would continue resourcing and sustaining the transformations brought about by FCDO's health programmes. We also identified cases where initially successful transformations were not sustained. These were mostly programmes that did not sufficiently tailor their activities to the local context.

Health indicators in Nigeria and focus states, 2002-2022

Nigeria has demonstrated notable improvement in several key health indicators over the period of FCDO support. In FCDO supported states:

- Child mortality dropped significantly over the period 2003-2024. Nationally, under-5 mortality rates dropped by 45%, infant mortality dropped by 37% and neonatal mortality decreased by 15% (NDHS).
- The LiST methodology estimates that FCDO Nigeria programmes saved the lives of 75,550 children and 4,800 mothers between 2011 and 2015 (Lafiya BC, Annex 10).
- Women receiving at least four antenatal care visits jumped from 35% to 90% in Enugu during PRRINN-MNCH, and increased from below 20% in Kano and below 10% in Jigawa to almost 50% (MICS).
- The percentage of under-1s fully immunized rose by over 35 percentage points in Enugu and Jigawa and by over 20 percentage points in Kano. In Jigawa and Kano these were near zero at baseline.
- Malaria prevalence in under-5s decreased by 37% in Kano, Jigawa, and Enugu. The percentage of children sleeping under insecticide-treated nets (ITNs) rose from almost zero to 80% in Kano, 90% in Jigawa, and 60% in Enugu.
- HIV/AIDS prevalence more than halved in Kano, Jigawa, and Enugu, exceeding the national average.
- The percentage of state budget dedicated to health more than doubled in Kano and tripled in Jigawa.
- The percentage of women receiving at least 4 ANC visits increased in Kano, Jigawa, and Enugu.
- The number of women giving birth with a skilled birth attendant increased by 10 percentage points in Enugu and over 15 percentage points in Kano and Jigawa.

FCDO support for key HSS legislation and policies

UK Government HSS interventions have supported key HSS legislation and policies over the 20-year period. This evolved over time from supporting change agents to catalyse change from within to advocating for policy changes to overcome the fragmentation of financing and management of primary health care services.

FCDO supported the drafting of the National Health Bill (NHB) until its passage as the National Health Act (NHA) and implementation throughout the portfolio period. The NHB was initiated by the Change Agents Programme (CAP) and taken later over by HERFON. PATHS2 and PRRINN-MNCH continued with advocacy work to get the NHA passed in 2014. The NHA provided reasonable legal backing for Primary Health Care Under One Roof (PHCUOR), a policy which aims to establish a single management body at the state level with adequate capacity that has control over services and resources, including personnel, funding, and material. The NHA also mandated the creation of the Basic Health Care Provision Fund (BHCPF), a statutory federal programme guarantees funding and access to a Basic Minimum Package of Health Services for all Nigerians.

Subsequent programmes MNCH2 and Lafiya followed through with the implementation of these policies to improve access and health outcomes, but have also pivoted to respond to major political opportunities for change such as the Sector Wide Approach (SWAp) under the current Pate administration and the ensuing financial autonomy being granted to the Local Governments by the 2024 Supreme Court of Nigeria decision. The current Federal administration intends to use the BHCPF as the basis of its Health Sector Renewal Initiative that will be executed through a SWAp and get LGAs actively involved in the planning and management of PHC services at community level.

Thus, the NHA intervention along with its provisions, including BHCPF and PHCUOR, have been sustained they continue to endure after the programmes that initiated them have closed. Similarly, they are also transformational since they have introduced significant changes in health sector programming of the Government of Nigeria and the ways of working of other implementing partners that have aligned their support to these outcomes. PHCUOR has leveraged more funding for PHC through earmarked deductions of 5% to 10% made from LGAs accounts in each state, and has initiated structural reforms with clear mandates for each tier of government with respect to the funding, planning and management of the PHC system in Nigeria, including the NPHCDA at federal level, PHC Management Boards at state level, and LGA Health Authorities at LGA level. Likewise, BHCPF funds channelled directly to frontline facilities have supplemented routine budget allocations being made by states and LGAs.

Effectiveness

HSS programmes in Nigeria demonstrated effectiveness by achieving sustained and transformational change in key areas. Programmes that successfully strengthened institutional capacity, such as Women for Health (W4H) and PATHS2, contributed to an increased supply of skilled healthcare workers, while infrastructure upgrades, including facility renovations and solar power installations, enhanced service quality. Strengthening supply chain systems through drug revolving funds (DRFs) and public-private partnerships improved access to essential medicines and thus contributed to better service delivery. Improvements in governance, policy implementation and data systems, including the expansion of the Health Management Information System (HMIS), enabled an increase in evidence-based decision-making. Advocacy efforts also increased the likelihood of sustainable impact, by advancing health sector reforms and securing financial commitments

While transformations in the health system could be traced back to FCDO's interventions, ensuring that these were sustained proved challenging. Factors that hindered sustainability of transformations include inconsistent government support and unpredictable funding, making long-term planning a challenge. Changes in leadership often stalled health reforms before they could take root. Many health facilities continued to struggle with staff shortages, particularly in rural areas, limiting the reach of essential services. Governance issues and financial inefficiencies also slowed efforts to expand successful programmes. Though HSS initiatives made a real difference, sustaining their impact will require stronger government ownership, steady funding and accountability measures that keep reforms moving forward.

Relevance

HSS interventions have been highly relevant to Nigeria's healthcare challenges, aligning with federal policies and legislation, and with state-level priorities. Programmes have built up over successive phases to strengthen the capacity of government departments and healthcare facilities and have supported community structures to hold state and local government accountable for delivering on healthcare. In spite of these successes, challenges remain, particularly with regard to sustainability, consistency and engaging the right stakeholders. While the programmes have been adjusted for different state contexts, gaps in local expertise and inconsistent funding mean that some areas have seen greater benefits than others.

Coherence

FCDO health systems strengthening interventions were designed to complement each other. Some coordination has been achieved between health programmes, and between health programmes and other sectoral programmes, notably governance. However, this tended to be achieved through shared implementing partners rather than formal coordination mechanisms. Coordination with the government of Nigeria (GoN) was evident in formal planning structures, long-standing professional relationships and embedded staff. State-level coordination among development partners was most effective under GoN leadership. We found evidence of other development partners replicating or adapting HSS interventions in other states, such as the Emergency Transport Scheme (ETS) and the drug revolving funds (DRFs). HSS interventions broadly aligned with international best practices, particularly in political engagement, long-term commitment, alignment with national priorities and adaptive learning. Gaps remain in addressing Human Resources for Health, leadership and other soft skills, and strengthening data collection.

Value for money (VfM)

This category was more challenging to assess, due to VfM programme data being largely missing and the broad range of programme outputs and outcomes. Disability-adjusted life years (DALY) was the most common measure of cost-effectiveness that could be used to compare programmes over time, but measurement methodologies varied across programmes, including assumptions around attribution. Notably, we found that while HSS flagship programmes show stronger indications of transformation and sustainability, and therefore cost-effectiveness, there is no VfM-related programme data to support this. Data is more often available for disease-specific programmes, but focusses more on economy and efficiency, as this is easier to collect during the lifetime of the programme and can be attributed to direct programme activities more easily. Some evidence shows that delivery costs may differ widely between states due to differing costs of living and security risks, and may be greater when catering to rural and underserved areas.

Lessons

Building on the findings identified across our evaluation questions, we have formulated the following lessons:

- Lesson 1: Health systems strengthening interventions often require over 15 years of commitment from development partners to demonstrate results.
- Lesson 2: Primary healthcare interventions require support at all levels of government to succeed.
- Lesson 3: Support across all building blocks is needed to achieve transformational change.
- Lesson 4: A planned transition to other development programmes or sustainable domestic sources of funding is needed when FCDO is looking to scale down funding or change scope.

  Lesson 5: Government-backed coordination mechanisms have been successful in facilitating development partner cooperation.

Health workforce

- Lesson 6: Training programmes build up capacity of frontline healthcare workers but require locally tailored training to be most effective.

- Lesson 7: Shortage of frontline health workers limits provision and access to health services, and targeted recruitment programmes are key to filling staffing gaps.

Service delivery

- Lesson 8: Raising awareness through targeted communication can increase demand for and use of essential health services but requires affordability and accessibility
- Lesson 9: Support from the community, and traditional and religious leaders and local organisations is important to improving awareness and ensuring access and wider coverage, particularly amongst marginalised groups.

Health financing

- Lesson 10: Building capacity in federal and state governments in targeted ways can improve health decision-making, budgeting and policymaking.
- Lesson 11: GoN funding was not sufficient to sustain programmes after withdrawal.
- Lesson 12: Grassroots organisations, private sector enterprise, and community resources can adapt and sustain FCDO interventions which are aligned with local interests

Leadership and governance

- Lesson 13: Capacity-building in pro-health decision-making, budgeting and policymaking are effective in driving pro health outcomes when federal, state and local governments are aligned on priorities and there is close coordination between different levels of government.
- Lesson 14: Community driven accountability mechanisms are key to improved capacity and pro-health decision-making, budgeting and policymaking in state governments and LGAs.
- Lesson 15: Government capacity is key to facilitating coordination between different donors and development partners, particularly at the state level.

Medical products, vaccines and technologies

- Lesson 16: Timely procurement and distribution of medicines and supplies can be ensured through a centralised system at the federal or state levels
- Lesson 17: Decentralised supply and distribution systems owned by local or grassroot actors can ensure strong local supply chains and consistent supply to facilities.

Health information systems

- Lesson 18: Effective reporting and information management systems require quality data, robust quality assurance and trained staff with adequate resources
- Lesson 19: Improved information management systems can drive evidence-based decision-making and increased accountability in government at the federal, state and local levels.
- Lesson 20: Structured value-for-money assessments can improve efficiency when tailored to programme and state context

Recommendations

Based on our findings and lessons learned, we offer the following recommendations for future programming:

For FCDO

- Recommendation 1: FCDO should play to its strengths in supporting legislative advocacy, convening and coordinating among development partners, and civil society and accountability mechanisms
- Recommendation 2: FCDO needs to coordinate and leverage resources from the government of Nigeria, grassroots and the private sector, and other development partners to ensure interventions address all HSS building blocks
- Recommendation 3: Refresh the Change Agents Programme to support the next generation of leaders in Nigerian health reform

For the Government of Nigeria

- Recommendation 4: Be straightforward about what interventions are of interest and sustainable by the Government of Nigeria after development partner support has ended
- Recommendation 5: Consider a Ministerial Challenge fund or the Social Action Fund to leverage community, enterprise, and NGO/CSO resources at grassroots level

For other development partners

- Recommendation 6: Coordinate with FCDO and GoN and, where possible, give support at state, LGA, and facility level

Caveats and limitations

Findings have been generated from primary fieldwork in Enugu, Jigawa and Kano, and are therefore limited in how applicable they are to other states, to interventions by other development partners, or to different sectors and countries. We have presented states that are most comparable to the states we visited in Table 2. Responses can be subject to recall bias, self-selection bias and self-reporting bias. We have guarded against these through a robust and extensive approach to triangulating primary data through at least three different stakeholder groups, as well as cross-referencing secondary sources, including programme documentation and existing evaluations.

This evaluation focuses on learning, and we have not attempted to assess contribution or attribution to outcomes or impact, or to account for other programmes that may have contributed to intermediate outcomes in the targeted states.

The international development landscape has changed significantly since fieldwork for the evaluation was conducted, with the UK government and other donors significantly reducing funding for health programmes. The lessons and recommendations sections have been revised to reflect this new operational context, but the evaluation was not conducted with these changes in mind, so supporting evidence is limited.

See the Limitations Section under Methods for further details.

1. Purpose and objectives

The terms of reference (ToR) for this evaluation (Annex A) state that 'the primary purpose of the evaluation is to help the FCDO, government and health development partners understand what has and has not worked in health systems strengthening in Nigeria.' This includes internal learnings for British High Commission (BHC) Nigeria, lessons for the Nigerian government and partners in preparation for upcoming reforms in the Nigerian health system, learnings for other FCDO country offices and across FCDO more generally for designing health systems programmes, and learnings more generally across the health systems community, for example through publication of its findings or presentations at conferences.

A secondary objective in the ToR is to help BHC Nigeria leverage understanding of key lessons from suppliers for other internal processes, including informing the mid-term review of Lafiya and developing the UK-Nigeria roadmap with the new Nigerian Coordinating Minister of Health, Professor Muhammad Pate.

The aim of this evaluation is therefore learning rather than accountability; programmes have already undergone individual reporting, and some have had independent evaluations. The ToRs note that 'this is a supportive formative evaluation project rather than an impact evaluation or audit'. The Evaluation Quality Assurance and Learning Service (EQUALS) conducted an independent quality assurance of the evaluation to ensure high quality in FCDO's evaluation processes. The review identified that evaluation questions needed to be prioritised to support the learning question of what works in terms of HSS, over and above accountability purposes.

The evaluation addresses several key evidence gaps identified in the ToRs and literature review for HSS programmes both globally and in Nigeria specifically. The evaluation is on a larger scale, focusing on several states and the national policy environment over a 20-year period, with a focus on context specificity, identifying those conditions which are necessary to obtain certain HSS outcomes in Nigeria.

The evaluation answers several evaluation questions grouped by coherence, relevance, value for money and effectiveness. These were pared down from the original list of evaluation questions given in the ToRs. See Annex I for more details.

Target audience for the evaluation findings

The primary audiences for the evaluation findings are UK FCDO and BHC Nigeria. The Development Director, Head of Profession for Health, health team and Human Development and Demography Block and the BHC Nigeria Governance and Social Development team have all shown a strong interest in the evaluation.

The evaluation is intended to inform the Nigerian Minister of Health's ongoing health reform agenda, as well as health systems programmes by other donors. The evaluation will be presented to the FCDO Health Network, the BHC Nigeria Delivery Board, the Human Development and Demography Block at a dedicated seminar, the Nigeria Health Development Partners Group currently co-chaired by BHC Nigeria, the BHC Health Programme (Lafiya) Steering Board chaired by the Nigerian Minister of Health, and the Global Symposium on Health Systems Research.

Learning is shared across the FCDO Nigeria office and wider donor and government networks to inform the design of HSS initiatives by the GoN and other development partners in Nigeria and of the next generation of FCDO Nigeria HSS programmes. See Annex J - Use and Influence Plan for more details.

Scope

The evaluation covers the portfolio of health systems strengthening interventions the UK FCDO implemented in Nigeria between 2004 and 2024. We adopted Witter et al.'s (2019) definition of health systems strengthening programmes (See Annex B: Inception Report, Section 3.1 for more detail). We identified 18 programmes that met these criteria (Table 1) and two programmes that didn't (Annex F).

The evaluation had the budget to collect primary data in three states plus FCT Abuja, so findings were limited to these three target states. The three states selected were Kano, Jigawa and Enugu. See Section 3 Sampling strategy for primary data for more details. All programmes within the scope of the evaluation were present in at least one of these states, and many were present in two or all three states.

Secondary data was limited to programme documents, publicly available data and data made available by the BHC Nigeria health team. Primary data were limited to respondents who were identified, interested and available to participate in fieldwork, either in person or remotely, from June 2024 to January 2025.

We built up several case studies, including paired cases, to answer EQs 4.2, 4.5 and 4.6. These case studies were based on interventions mentioned by several primary respondents in sufficient detail and supported by secondary sources including programme documents.

Programmes covered by the evaluation

Table 1 below lists the FCDO programmes that met the definition of health systems strengthening programmes, including their active dates and budgets. Annex F contains more details of the programmes included in the evaluation, including short descriptions, measures, geographic coverage, relevant HSS building block outcomes and impact, reasons for their inclusion, and links to documentation on Devtracker. It further details programmes excluded from the evaluation and the reasons for their exclusion.

Table 1: Programmes in the scope of the evaluation

	Programme Name	Acronym	Date	Value	Enugu	Jigawa	Kano
1	Change Agents Programme	CAP	2001-2004	£1.8m			
2	Partnership for Transforming Health Systems 1	PATHS1	2002 - 2008	£55m	X	X	X
3	Strengthening Nigeria's Response to HIV/AIDS	SNR	2004 - 2011	£21.3m	X		
4	Health Commodities Programme	HCP	2005 – 2009	£27m	X	X	X
5	Health Reform Foundation of Nigeria Phase 1	HERON /HERFON1	2005 - 2009	£3.5m			
6	Partnership for Reviving Routine immunisation in Northern Nigeria – Maternal, Newborn and Child Health Programme	PRRINN - MNCH	2006 - 2013	£61m		X	
7	Enhancing Nigeria's Response to HIV/AIDS	ENR	2007 - 2016	£118m	X		
8	Partnership for Transforming Health Systems 2	PATHS2	2008 - 2016	£176m	X	X	X
9	Support to the National Malaria Programme in Nigeria	SUNMAP	2008 - 2016	£83m		X	X
10	Health Reform Foundation of Nigeria Phase 2	HERFON2	2009 - 2013	£3.6m	X	X	X
11	Prevention of Maternal Deaths and Unplanned Pregnancies	PMDUP	2011 - 2018	£144m (all countries)			X
12	Nigeria: Tackling Neglected Tropical Diseases through an Integrated Approach	UNITED	2012 - 2019	£14.7m			X
13	Women for Health	WFH	2012-2020	£36.7m		X	X
14	Advocacy for Primary Health Care Reform	APHCR / HERFON3	2013 - 2016	£2.2m	X	X	X
15	Maternal and Newborn Child Health Programme	MNCH2	2014 - 2019	£86m		X	X
16	Women's Integrated Sexual Health programme	WISH	2017 - 2024	£280m (all countries)		X	X
17	Support to the National Malaria Programme - Phase II in Nigeria	SUNMAP2	2018 - 2021	£50m		X	X
18	Lafiya - UK Support for Health in Nigeria	Lafiya	2019 - 2027	£235m		X	X

Evaluation team and management

This independent evaluation is being conducted by Cadmus, formerly Nathan Associates. The evaluation is led by Ashley Craft, with contributions from Mike Naylor, Tarry Asoka, and Ramatu Daroda. The core team is supported by academic advisor, evaluation expert and national health systems expert Professor Sophie Witter.

MEL practice lead Enrico Neumann and senior MEL expert Subira Bjornson have provided technical quality assurance of all deliverables before submission to FCDO. Sophie Witter has led on the literature review and evidence gaps. Nora Geiszl and Steven Chen contributed to writing the report.

Independence of the evaluation

The evaluators were able to work freely and without interference throughout the evaluation.

Conflicts of interest (CoI)

The terms of reference (ToR) state that as the primary purpose of the evaluation is for learning, the CoI limitations apply to the Team Leader only. The Team Leader has declared no conflicts of interest in undertaking this evaluation.

Copyright, storage, and accessibility

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Comment on use of evaluation

For FCDO – commitment to understand how the evaluation outputs have been used and monitor the impact of the evaluation findings.

2. Context

The UK government's support to strengthening the Nigeria health system in the past 20 years has been largely informed by its understanding of the prevailing political and economic context in which the health sector operates and how this has been changing over time.

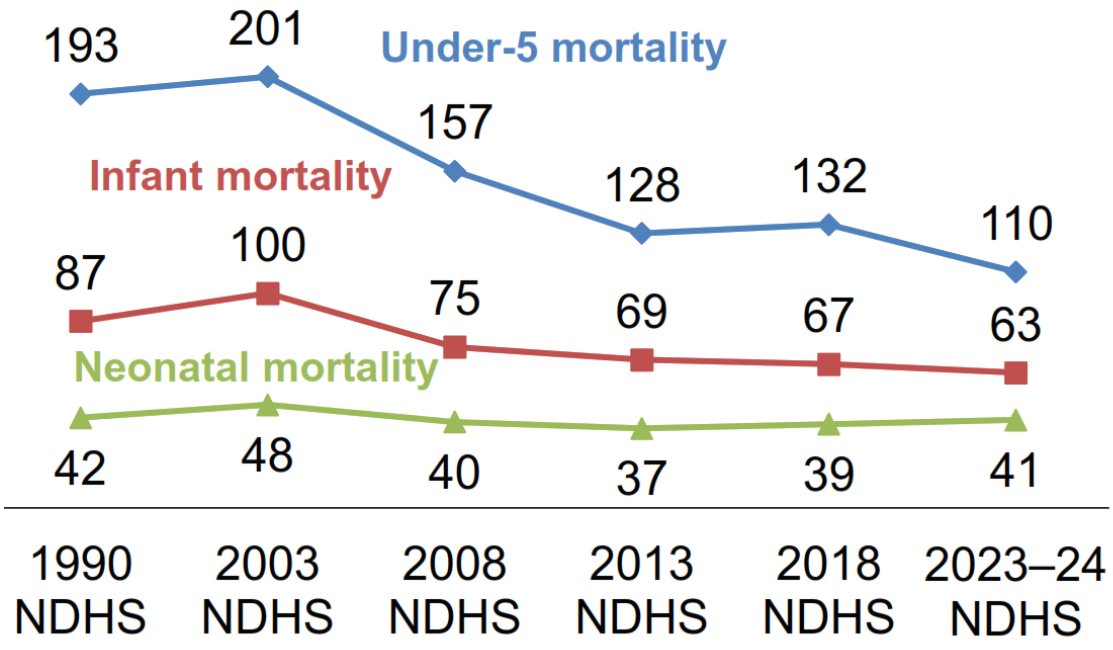
Progress in health systems strengthening in Nigeria over the last 20 years:

Nigeria has seen significant progress in health systems strengthening over the portfolio period. We have grouped these results by thematic area, or outcome, which broadly align with the World Bank's health system strengthening building blocks (see Section 3 for more details).

Outcome 1 – Improved quality of public healthcare facilities and frontline healthcare workers

- Child mortality dropped significantly over the period 2003-2024. Nationally, under-5 mortality rates dropped by 45%, infant mortality dropped by 37% and neonatal mortality decreased by 15%.
- Women receiving at least four antenatal care visits jumped from 35% to 90% in Enugu during PRRINN-MNCH, and increased from below 20% in Kano and below 10% in Jigawa to almost 50%.
- Births attended by skilled health workers increased by 10 percentage points in Enugu and over 15 percentage points in Kano and Jigawa, quadrupling in Jigawa from 5% to 21% between 2008 and 2016.
- PATHS1 provided training and supply kits for emergency obstetric care, including establishing training centres, curricula and course materials.
- The LiST methodology estimates that FCDO Nigeria programmes saved the lives of 75,550 children and 4,800 mothers between 2011 and 2015 (Lafiya BC, Annex 10).

Figure 1: Child Mortality Rate, per 1,000 children (2005-2021)



Source: Nigeria Demographic and Health Survey 2023-24, p.25

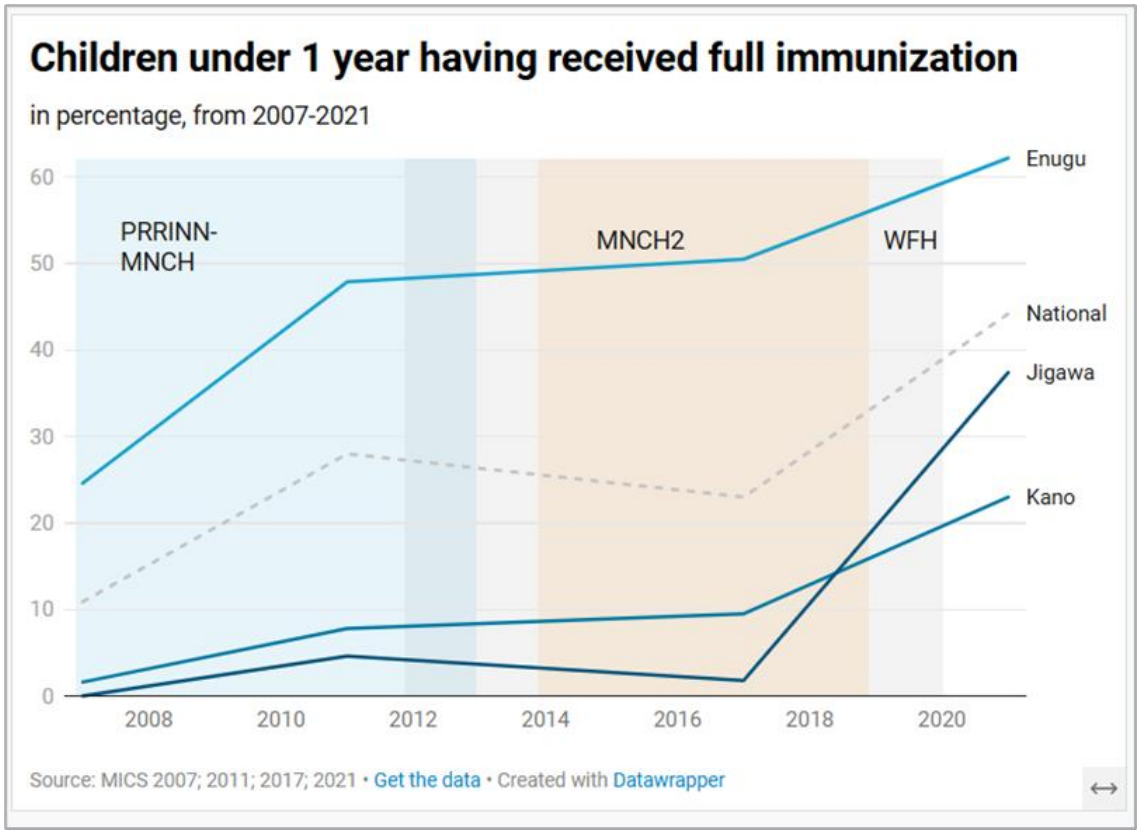
Outcome 2 - Building capacity of government decision-making, budgeting and policymaking

- The Jigawa State government has significantly improved planning, budgeting and information management, and in 2017 committed to providing one primary healthcare (PHC) facility per ward to improve access.
- MNCH2 established functional Facility Health Committees (FHCs) across all target states, with 88% meeting good standards against all three FHC key roles.
- State-led accountability mechanisms were established and strengthened across all six states.
- The Lafiya programme established Departments of Family Health in Jigawa and Kano, and functional PHC committees in all LGAs in all target states
- Following advocacy from DFID programmes, state health budgets as a proportion of state budgets more than doubled in Kano, from 5.2% to 12%, and more than tripled in Jigawa, from 4% to 14.9%. Under Lafiya support, all designated BHCPF facilities across all target states were receiving direct facility financing disbursements.

Outcome 3 - Timely procurement and distribution of medicine, supplies and vaccines

- PATHS1 trained personnel and developed management systems for drug revolving funds as well as mechanisms for local distribution of medicines, vaccines and basic medical supplies necessary to address childhood diseases and routine immunisation, in five states including Enugu, Kano and Jigawa.
- PATHS2 developed essential stock-out lists and replicated the DRF model to other states. The proportion of primary healthcare facilities in PATHS2 states with a defined stock of essential medical supplies rose from 4% to 88%.
- Fully immunised under 1s rose by over 35 percentage points in Enugu and Jigawa and by over 20 percentage points in Kano. In Jigawa and Kano these were near zero at baseline.

Figure 2: Full immunization among infants (2005-2021)



Outcome 4 – Awareness-raising and communication

- PATHS2 set up nearly 4,000 facility and non-facility health committees across five states, including Enugu, Kano and Jigawa, 92% of which were operating well at programme end.
- Mothers' awareness of managing diarrhoea increased from 18% to 62%, and their maternal danger signs increased from 3% to 47%, in five states supported by PATHS2 between 2009 and 2014.
- HIV/AIDS prevalence more than halved in Kano, Jigawa and Enugu, exceeding the national average.
- Modern contraceptive prevalence rates in Kano increased 11-fold, from 0.5 in 2011 to 5.7 in 2017 (Nigeria MICS).
- Malaria prevalence in under 5s decreased by 37% in Kano, Jigawa and Enugu, while use of insecticide-treated nets by children rose from almost zero to 80% in Kano, 90% in Jigawa and 60% in Enugu.

Outcome 5 – Improved reporting and information management systems

- PATHS1 conducted monitoring surveys on population utilisation of key services, including curative care, immunisation, attendance at delivery and some quality of care information.
- The percentage of healthcare facilities timely reporting HMIS data rose from 0% to over 90% in Jigawa and 70% in Enugu.

For more detail and the graphs for each indicator, please see Annex K.

Key legislative and policy improvements:

- **National Health Act (NHA):** FCDO supported drafting of the National Health Bill (NHB) to its passage as the NHA in 2014 and subsequent implementation. The NHB was initiated by the Change Agents Programme (CAP) and later taken over by HERFON. PATHS2 and PRRINN-MNCH continued with advocacy for implementation of the NHA and secondary legislation at federal and state level.
- **Basic Health Care Provision Fund (BHCPF):** The BHCPF, mandated by the NHA, is a statutory federal programme which ringfences 1% of federal income to fund primary healthcare guarantees and provide access to a basic minimum package of health services for all Nigerians. The government of Nigeria included the 1% commitment in its budget for the first time in 2018.
- **Structural reforms to the funding and management of primary healthcare services:** Primary Health Care Under One Roof (PHCUOR) legislation established a single management body at federal and state levels (NPHCDA and SPHCDAs) with adequate capacity and control over services and resources, including personnel, funding and material. FCDO advocacy programmes HERFON2 and APHCR supported development of PHCUOR at federal and state level, and developed scorecards to track progress in implementation.

Sustained policy implementation through successor programmes

The MNCH2 and Lafiya programmes continued to support implementation of these policies to improve access and health outcomes but also responded to major political opportunities for change, such as a sector wide approach (SWAp) under the current Pate administration, and the financial autonomy granted to local governments by a Supreme Court of Nigeria decision in 2024. The current federal administration intends to use the BHCPF as the basis for its Health Sector Renewal Initiative, which will be executed through a SWAp and will actively involve LGAs in planning and managing primary healthcare services at community level.

Thus, the interventions supporting the NHA and its provisions, including BHCPF and PHCUOR, continue to resonate after the programmes that initiated them closed. Similarly, they are also transformational as they have introduced significant changes in the government's health sector programming and in other implementing partners that have aligned their support to these outcomes. PHCUOR has leveraged more funding for public healthcare through earmarked deductions of 5% to 10% made from LGAs accounts in each state, and has initiated structural reforms with clear mandates for each tier of government with respect to the funding, planning and management of the PHC system in Nigeria, including the National Primary Health Care Development Agency (NPHCDA) at federal level, PHC management boards at state level, and

local health authorities at LGA level. BHCPF funds channelled directly to frontline facilities have supplemented routine budget allocations made by states and LGAs.

Political and governance context

Nigeria is a federal country in which the Federal Government of Nigeria, the 36 States and the Federal Capital Territory (FCT), and the 774 LGAs derive their power from the national constitution (FRoN, 2004). Oil wealth accounts for over 95% of government revenues, and drives intense competition for control of national resources among elite groups and regional factions (Anyebe, Bezzano & Foot, 2005). As a political system modelled on the American style of democracy, public policy decisions at all levels can be seen as the result of bargaining and compromise between conflicting interests, alongside a federal system of checks and balances (Knoke & Chen, 2008). Nigeria's governance has also been shaped by historical legacies and social alliances rooted in the cultural, political and religious institutions of ethnic groups such as the Hausa and Fulani, Yoruba and Igbo (Fagbenro-Bryon, 2024). This has influenced the nuanced power-sharing mechanisms at work in Nigeria's political landscape, demanding delicate negotiation between diverse groups. Zoning practices within political parties exemplify these balancing strategies. While oil contributes to funding these arrangements, the deeper influences of historical, ethnic and social factors continue to shape Nigeria's governance and stability.

Overall, public governance systems, including financial management systems, tend to be weak, but are sometimes influenced by the values and behaviour of those outside government (World Bank, 2009). This is because a large proportion of social, economic and political transactions take place outside the formal system – even where a formal system exists. It was clear from the outset that reform initiatives could not engage only with the formal system, as the strength of informal arrangements often circumvent or replace it, through patronage politics, traditional authority, and extra-legal arrangements and activities.

Institutional challenges and their impact on health reforms

In the meantime, healthcare service agents are brought into this picture with respect to their role as part of the public service, or in the private and voluntary sectors (Anyebe, Bezzano & Foot, 2005). Nevertheless, in as much as these agents are identified by their place in the health sector, they have been swept along by events and forces at play elsewhere in the economy. At the same time, some aspects of Nigeria's institutional make-up have come to assume structure-like characteristics (Heymans & Pycroft, 2003). In particular, the dominance of the political elite has become self-perpetuating, and this is rooted in structural realities and institutional patterns like oil wealth, ethnic and other cleavages and traditional systems of patronage. This has in turn weakened other aspects of the institutional framework related to democracy, free markets and accountable service delivery.

Key political milestones in health system strengthening

Three major turning points in the broader political economy have shaped the development assistance that FCDO has provided over twenty years to strengthen the health system in Nigeria:

1999 - Nigeria's return to democracy, which afforded new opportunities for governance reforms.

2014 - Enactment of the **National Health Act**, which laid the groundwork for health sector improvements.

2021 - Enactment of **Primary Health Care Under One Roof (PHCUOR),** which centralised and streamlined public healthcare management.

Several major development partners have also operated alongside FCDO programming, including Canada, the UN Population Fund and the US, including the US Agency for International Development (USAID) and the President's Malaria Initiative. For more details, see Annex L.

State-level policy context

While tensions between federal and state governments are manifest in vested interests displayed by both federal and state health authorities (DFID, 2007). State health ministries are protective of their independence in decision-making and tend to favour large, visible, capital-intensive physical projects.

The 2014 National Health Act has failed to address this tension. Constitutionally, state commissioners for health are accountable to state governors and not to the Federal Minster of Health (FMoH). State governors and chairs of local governments often follow their own agendas rather than the health sector strategic direction set by the FMoH.

The limited political prominence of health sector reforms in the states remains one of the main barriers to implementing health systems strengthening in Nigeria (Tulloch et al., 2017). States are creating an appearance of change by setting up agencies as demanded by the Act, without addressing the functions these agencies are meant to carry out. The Act itself is also an unfunded mandate, and required secondary legislation to create actual funding mechanisms like the Basic Health Care Provision Fund (BHCPF).

States themselves also have widely different demographics and political economies; some of these differences for selected states are illustrated in Table 2 above. These differences help explain the differences in implementation between states noted in the analysis.

Table 2: Comparison of target states by selected characteristics

Characteristic	States included in field research			States with similar characteristics targeted through FCDO programming					
	Enugu	Kano	Jigawa	Kaduna	Katsina	Zamfara	Borno	Yobe	Source
Population (Projected, 2020)	4.5m 7,161 sq. km Urban	14.7m (largest) 20,131 sq. km Urban	7.0m 22,410 sq. km Rural	8.6m 46,053 sq. km Urban	9.6m 24,971 sq. km	5.5m 38,418 sq. km	5.9m 57,799 sq. km	3.5m 45,502 Rural	NBS Demographic Bulletin 2021
Zone	South-East	North-West	North-West	North-West	North-West	North-West	North-East	North-East	
Demographics	Igbo Christian	Hausa / Fulani Muslim	Hausa / Fulani Muslim	Mixed Muslim/Christian	Hausa / Fulani Muslim	Hausa / Fulani Muslim	Kanuri / mixed Muslim/Christian	Kanuri / mixed Muslim	Wapor.org
Political Zones	17 LGAS	44 LGAs 5 Emirates	27 LGAs 5 Emirates	23 LGAs 3 Emirates	34 LGAs 2 Emirates	14 LGAs 17 Emirates	27 LGAs 27 Emirates	17 LGAs 14 Emirates	State Websites
FCDO flagship programmes	PATHS1 PATHS2	PATHS1 PATHS2 MNCH2 Lafiya	PATHS1 PRRINN-MNCH PATHS2 MNCH2 Lafiya	PATHS1 PATHS2 MNCH2 Lafiya	PRRINN-MNCH MNCH2	PRRINN-MNCH MNCH2	Lafiya	PRRINN-MNCH MNCH2 Lafiya	FCDO documents
Primary Health Care facilities	63% private 37% public	9% private 81% public	1% private 99% public	34% private 64% public	3% private 97% public	2% private 98% public	3% private 97% public	100% public	PHCUOUR Scorecard 6
Conflict	None	Low	Low	High	High	High	High	High	FCDO travel advice (RAG)
Security of tenure of governors	Three governors with the same power base over a 20-year period	High level of political competition, political insecurity	3 Governors over 20 years with consistent agenda; switch from PDP to APC in 2015	Political competition until El-Rufai elected in 2015	Changeover in 2015, with continuity of delivery	Contested election, new party in 2024. Dominated by security issues.	Three two-term APC governors	APC in power since 1999 bringing political stability	Flagship UK Governance Review
Civil society organisations (CSOs)	Older, developed CSOs, independent media	Better organised at outset, but conflicting relationships with state authorities	Established by civil servants with existing skills and good access to state governments	More urban/elite CSOs and professional groups	Young CSOs, educational and professional background	Younger CSOs, young professionals	Young CSOs, focus on internally displaced persons and humanitarian situation	Younger CSOs, associated with (retired) civil servants	Flagship UK Governance Review

3. Evaluation approach and methodology

Our theory-based evaluation approach

To evaluate what has worked and what hasn't worked in FCDO health programming in Nigeria, we followed a theory-based evaluation approach. This defines a set of common themes based on a portfolio theory of change covering all of FCDO's health programming in the country over the last 20 years (See Annex E, Figure 1). We further identified contextual factors and differences in delivery methods that could explain why some interventions were sustained and/or transformational. shows the overall portfolio theory of change and (See Annex B for more detail on our approach). We identified five thematic intermediate outcome areas that are common across FCDO's HSS portfolio in Nigeria and structured our research and analysis to provide findings across the evaluation questions. (See Annex H for theory of change models for all outcomes).

Evaluation questions

This evaluation set of evaluation questions defined by four evaluation OECD DAC criteria of relevance, coherence, value for money and effectiveness. Table 3 below shows the evaluation questions that guided the evaluation. The evaluation matrix in Table 2 of Annex E sets out the judgement criteria, analytical methods and data sources, including thematic codes used throughout the evaluation.

Table 3: Evaluation Questions by domain

No.	Evaluation Question
Effectiveness	
1.1	What approaches work and don't work to strengthen health systems in various Nigerian contexts? What contextual factors have aided or impeded progress?
1.2	Why have health systems strengthening interventions succeeded or failed?
1.3	What examples are there of effective health systems strengthening in UK programmes in Nigeria?
1.4	Is there evidence of health systems strengthening interventions that appear not to have worked well and why?
1.5	How well do they mitigate risks (such as dependency) of longer-term damage to health and governance systems?
1.6	How have outcomes and impacts been measured for FCDO Nigeria health programmes, and could this be improved?
Relevance	
2.1	Are HSS interventions appropriate to the local context?
2.2	Are the health systems strengthening interventions and methodologies sensitive to the situation and needs of people in Nigeria and the targeted states?
2.3	How well are HSS interventions aligned to national or state health priorities and plans?
2.4	Do FCDO HSS programmes consider social inequalities relating to gender, age, disability and other relevant identities?
Coherence	
3.1	Were HSS interventions well-coordinated with the government of Nigeria?
3.2	How well do the health systems strengthening interventions relate to and co-ordinate with each other, as well as with other BHC Nigeria programmes? Are they complementary or in competition?
3.3	Are HSS interventions coordinated with other development partners?
3.4	Do the approaches to health systems strengthening used by BHC Nigeria in Nigeria align with those that the international evidence suggests are effective?
3.5	Where are the gaps? What isn't being covered?
Value for money	
4.1	Under what conditions are health systems strengthening interventions able to provide better value for money?

A mixed methods approach based on thematic and case-based analysis

Thematic analysis

We identified five themes at intermediate outcome level, aligned with latest research on health systems strengthening allowing us to test how far different interventions across FCDO's health programming have contributed to them:

- IO1: Improved quality of public healthcare facilities and skilled frontline healthcare workers,
- IO2: Building capacity of government decision-making, budgeting and policymaking.
- IO3: Timely procurement and distribution of medicine, supplies and vaccines.
- IO4: Awareness-raising and communication.
- IO5: Improved reporting and information management systems.

We constructed theories of change for each of the five identified intermediate outcome themes (see Annex H) by reviewing programme design documents, and refined them following primary data gathered. Annex I explains how cross-cutting issues were addressed in the evaluation.

Our five intermediate outcome themes align with the WHO health system building blocks (WHO, 2010), as shown in Annex E, Table 1. These inform our analysis and findings across evaluation questions, as indicated in the evaluation matrix. We draw on the themes more extensively for responses to EQs 4.2, 4.5 and 4.6 and structure the intervention cases below by theme.

Case-based approach and paired cases

As most HSS interventions are a bundle of activities which result in different outcomes in different contexts (Witter, 2019, 2021), we analyse individual cases of interventions implemented through FCDO programmes. We constructed 19 intervention cases around HSS interventions across all five thematic areas, which we reference where they have informed a finding or lesson.

Cases were built inductively based on primary data from multiple respondent categories, and supported by secondary sources. We used a paired cases approach to analyse the differences in delivery and context of the states where we identified a quasi-experimental setup in which one programme achieved different results across different states during the same period.

Data collection methods

Literature review and secondary data

Our literature review was led by Professor Sophie Witter who led a comprehensive review of HSS for FCDO in 2019 and 2021 and an evidence review of monitoring and evaluation of HSS frameworks in 2023, which we updated to include the most recent evaluation material in health in Nigeria and elsewhere.

The Nigeria governance portfolio review found that context was a key determinant in the success or failure of FCDO health programming in Nigeria. Secondary data sources included programme business cases, annual reviews, project completion reports, monitoring reports and evaluation reports, as well as the Nigeria MICS, Nigeria Demographic Health Survey (NDHS) and WHO country reports.

Primary data collection

Stakeholder identification and mapping
We used purposive quota sampling to select three states and identify respondents from five different stakeholder groups (Annex E, Table 3). We mapped and stakeholders by programme and outcome area to ensure adequate coverage of each outcome and to triangulate responses between stakeholder groups. (See Annex D for list of respondents).

Sampling strategy for primary data
We selected Enugu, Jigawa and Kano for primary data collection, states that had large numbers of active FCDO programmes during the period under review. and considering a balance of geographic and social diversity (south v. north, rural v. urban, Christian v. Muslim),

- **UK-focused:** Jigawa and Enugu have limited international donor presence while Kano has been targeted by other donors.
- **Programme coverage:** Four programmes – PATHS1, HCP, PATHS2 and APHCR – were present in all three states, for comparison in context and implementation, with the remaining present in two states fora paired cases approach.
- **Regional representation:** Jigawa and Kano are in the north of the country, where the UK has more recent and concentrated programming, while Enugu represents a different operational context, with initial UK engagement withdrawing over time as the focus shifted to the north. Inclusion of Enugu provides a window on the sustainability of UK programming after withdrawal of programming.
- **Governance review:** Two states – Jigawa and Kano – were included in the FCDO governance review (Piron et al., 2021).

Annex G lists which FCDO programmes were active in each state.

Target and achieved sample
The evaluation draws on the perspectives of over 150 stakeholders involved in Nigeria HSS programming. We conducted 62 key informant interviews (KIIs) (50 male, 12 female) and 14 focus group discussions (FGDs) with 96 participants (55 male, 41 female). The selection of participants, particularly for FGDs, was designed to promote a mix of gender, age and location, and for KIIs was based primarily on seniority (see the sampling frame in Annex E Table 4, with the number of KIIs and FGDs in each state and stakeholders interviewed).

Development of tools
General topic guides for KIIs and FGDs, based on the evaluation questions, intermediate outcome areas and contextual factors relevant to each type of respondent were used to facilitate semi-structured respondent interviews. Annex B gives further details.

Digital tools were not employed in data collection, except for digital audio recordings of KIIs and FGDs.

Nigerian consultants conducting the primary qualitative research in Abuja were trained, including pre-testing or piloting the tools with respondent groups in Abuja.

Analytical methods

Thematic coding against contextual factors and deriving sub-codes
We coded cases based on themes using Atlas.ti qualitative coding software. Initial themes were the contextual factors identified in the overall programme theory of change and developed sub-codes iteratively as we assigned cases to intermediate outcome areas. See Annex N for a list of codes and sub-codes.

Triangulation of data
We improved the rigour of our analysis by triangulating our findings robustly. To guard against bias in primary and secondary sources of data, including primary respondents' self-reporting bias and recall bias (see Table 5 in Annex E) we triangulated findings from multiple stakeholder categories and secondary sources including programme documentation (see Annex E, Table 2 for data sources used for each evaluation question).

All findings in Section 4 Findings were supported by data from a minimum of three different types of sources; including at least one primary respondent and different categories of primary respondent, programme documents, and/or other secondary sources including third party programme monitoring and evaluation, academic or other professional publications, or government or other sources of standard health indicator.

Primary respondents are most prone to self-reporting bias, and may exaggerate the successes of their interventions, which we guarded against this by drawing from multiple categories of respondent. and recall bias, as some interventions were concluded years or decades ago, so we triangulated findings with programme documents. FCDO programme documentation is also prone to self-reporting bias, which we guarded against by triangulating with primary sources, particularly when assessing the sustainability. ,

Participation of stakeholders in evaluation design; use and influence plan

The EQUALS review of the evaluation inception report suggested an iterative approach to developing the evaluation within the time available. The evaluation team built up our understanding of the portfolio programmes, with a review of programme documentation and wider literature and engaging with the programme team and constructing outcome logic models for the five outcome areas and conducting an interview, refining the logic models and coding categories, and going back for supplemental stakeholder interviews (see Annex B, Inception Report, Section 4 for wider literature). FCDO Nigeria has led on producing the use and influence plan for the evaluation (see Annex J).

The evaluation team engaged frequently with the BHC Nigeria Health team through a kick-off meeting, scope discussions with the senior responsible owner (SRO), identifying stakeholders, ToC discussions, validated the evaluation plan with the FCDO Nigeria Health team, gathered input from FCDO Nigeria on the draft report, and engaged with FCDO Nigeria on identifying respondents from other development partners.

Limitations

Although this evaluation does provide valuable insights into health systems strengthening in Nigeria, several methodological and contextual limitations may affect applicability, completeness and scope of the findings.

- **Limitation 1 - Respondent reach and bias:** Assessing programmes spanning a 20-year period means that some potential respondents were no longer identifiable, which hindered efforts to gather insights on earlier interventions.
- **Limitation 2 - Applicability and selection bias:** Findings centre on only three states (Enugu, Kano and Jigawa) so may not hold in all contexts or under future conditions.
- **Limitation 3 - Interview reliability:** Respondents may have struggled with recall accuracy. and more assertive participants may have overshadowed contributions by others. To mitigate, interviewers used structured questioning and promoted inclusive participation.
- **Limitation 4 - Recording issues:** Initial interviews in Abuja and Enugu were not recorded so the team may have missed certain details.
- **Limitation 5 - Qualitative limits:** While the evaluation does span 20 years the qualitative findings may not be fully applicable.
- **Limitation 6 - Time constraints:** Respondents had limited availability to engage in in-depth discussions, so follow-up interviews were conducted to expand on key points.
- **Limitation 7 - Scope limitations:** By focusing on five intermediate outcomes, the evaluation does not assess broader HSS impacts such as government and CSO capacity or evidence use in decision-making.
- **Limitation 8 - Impact data:** Few programmes (e.g., UNITED, PATHS, HCP, WISH) underwent independent evaluations so there is limited access to independent outcome data.
- **Limitation 9 - Coding bias:** Given qualitative analysis is inherently subjective, double-coding was applied to ensure consistency across data interpretation and thus minimise bias.
- **Limitation 10 - Sustainability assessment:** Although the evaluation identifies the conditions necessary for achieving HSS outcomes, it does not systematically assess long-term sustainability or transformational impact across all 20 states where FCDO operated.
- **Limitation 11 – Change in delivery context since completion of fieldwork:** The international development landscape changed significantly[1] such that FCDO will no longer be able to fund comprehensive multi-level HSS programmes going forwards. Section 5 lessons learned and section 6 recommendations have been revised to reflect this new operational context, but the evaluation was not conducted with these changes in mind, so supporting evidence is limited.

[1] The changeover of the US administration has resulted in the closure of around 90% of USAID programmes by February 2025, including all Nigeria health programmes, and substantial reduction of budget for the WHO and UN, among other development partners. FCDO followed suit in March by announcing a further reduction of ODA to 0.3% of GNI by 2027.

Coordination with policies and evaluations of other donors

The midterm evaluation for Lafiya started on 25 November 2024. Draft findings and lessons from the HSS evaluation were presented to the FCDO Nigeria Health team on 25 November and one team member, the senior national health systems expert, is also on the Lafiya review team, and has conveyed messages from the present evaluation to Lafiya. FCDO has identified that USAID may be conducting an evaluation of the joint-sponsored HERON component in 2025; the final evaluation report will be available to inform this.

‘Do no harm’ and adherence to international best practice and standards of ethical conduct

We have adhered to FCDO’s Ethical Guidance for Research, Evaluation and Monitoring Activities, which includes the principles of maximising benefit and 'do no harm’, respecting people’s rights and dignity, acting with honesty, competence and accountability, and delivering work of integrity and merit.

This includes confidentiality, informed consent, and data integrity and data protection. We did not identify specific safeguarding risks based on geographic, thematic or political sensitivities of the content of the questions or any vulnerability of targeted respondents. (See Annex M for our approach to ethics and safeguarding)

Ethical review board approval: The National Code of Health Research Ethics (NHREC) for Nigeria states that programme evaluations are exempt from ethical review requirements.

Stipend payments and compensation: FGD participants and selected KII participants were offered a small travel stipend as compensation for participation in the interview to incentivise those who otherwise might not have had the time or resources to participate, particularly those from remote areas or low socio-economic status. Participants signed to acknowledge receipt of the stipend, and these were paid by mobile money. Bias was guarded against by explaining that the valuation was not looking for certain answers, and that participants could stop at any time and this did not affect their receipt of a stipend.

4. Findings

This evaluation defines intervention success as sustained and transformational change. We defined a programme component as sustained if at least three different sources confirmed it was still operating after programme closure, even in a reduced or adapted capacity. Transformational change was identified if at least three sources provided evidence that programming had significantly altered how the government of Nigeria or its implementing partners worked, and if the change continued at least until the end of the programme. Interventions can therefore be transformational or sustained (or both, or neither).

Over 20 years, FCDO's health systems strengthening programmes achieved transformational changes. However, many of the changes were not sustained after programmes closed. Programmes worked best when aligned to federal priorities and state governors' agendas, and were sustained when delivery was adapted to state and local contexts and resourced by the government or communities.

We used thematic analysis of primary responses to identify the different contextual factors associated with each evaluation question (EQ). For EQs 4.2, 4.5 and 4.6, we identified key case studies and paired comparisons to support our analysis. These cases were highlighted by multiple respondents and then built out using available secondary data, including programme logframes and project completion reports (PCRs). Cases are referenced in brackets (e.g. Case 14; Paired Case 1).

Effectiveness

Health systems strengthening (HSS) programmes in Nigeria demonstrated effectiveness by achieving sustained and transformational change in key areas. Programmes that successfully strengthened institutional capacity, such as Women for Health (W4H) and PATHS2, contributed to an increased supply of skilled healthcare workers, while infrastructure upgrades, including facility renovations and solar power installations, enhanced service quality. Strengthening supply chain systems through drug revolving funds (DRFs) and public-private partnerships improved access to essential medicines and so contributed to better service delivery. Improvements in governance, policy implementation and data systems, including expansion of the health management information system (HMIS), enabled an increase in evidence-based decision-making. Advocacy efforts also increased the likelihood of sustainable impact by advancing health sector reforms and securing financial commitments

While there were clear improvements, keeping that progress on track proved difficult. Government support was inconsistent and funding remained unpredictable, making long-term planning a challenge. Changes in leadership often stalled health reforms before they could take root. Many health facilities continued to struggle with staff shortages, particularly in rural areas, limiting the reach of essential services. Governance issues and financial inefficiencies also slowed efforts to expand successful programmes. Though HSS initiatives made a real difference, sustaining their impact will require stronger government ownership, steady funding and accountability measures that keep reforms moving forward.

EQ1.1 What approaches work and don't work to strengthen health systems in various Nigerian contexts? What contextual factors have aided or impeded progress?

Summary: The success of FCDO's HSS efforts in Nigeria depended on political support, local adaptability, sustained funding and community involvement. Programmes that gained government support, aligned with national and state priorities and had flexible, locally driven approaches were more likely to create lasting change. Locally tailored approaches helped interventions fit Nigeria's diverse social and economic landscape. Community-led accountability, including efforts by CSOs and WDCs, played a key role in keeping initiatives going after FCDO funding ended. Progress was challenging to maintain given frequent political changes, inconsistent funding and limited local ownership, which often served to stall progress. Securing lasting progress will require greater government commitment and stronger community involvement.

Key findings
• Training programmes strengthened frontline healthcare workers, improving essential skills and increasing the presence of skilled birth attendants in key regions. • Government capacity-building has increased GoN ownership of planning and budgeting processes and the quality of these has increased over time. • Public- and private-sector partnerships and decentralised drug supply systems helped supply essential medicines and health commodities to the general public.
Challenges identified
• Shortage of healthcare workers restricts access to essential services, especially in rural areas. • Inconsistent government funding for health programmes made it difficult to maintain progress. • Supply chain gaps cause delays in getting essential supplies to facilities, disrupting patient care. • Political instability and leadership changes disrupt health sector and policy reforms. • Data collection and management systems need high levels of resources, and suffer ongoing problems of accuracy, timeliness and harmonisation of datasets.
Intervention spotlights
• Training programmes like W4H and PATHS2 equipped frontline health workers with essential skills. • Public-private partnerships strengthened drug supply chains by reducing shortages. • DRF models kept medicine stock levels consistent and improved affordability. • Strengthening government agencies through MNCH2 and PATHS2 improved decision-making, budgeting and oversight in healthcare management.
Analytical methods
• Thematic analysis of primary data by intermediate outcome area, IO1-IO5 • FCDO, GoN, IP, CSO, FHCW and DP responses • Theory-based evaluation of intermediate outcome theories of change • Cases 1, 3, 9, 10, 12, 13 and 18, Paired Cases 1-4 • Programme document review, including PCRs • Secondary sources

We used a theory-based evaluation approach to construct theories of change for each thematic intermediate outcome area identified for portfolio programmes (See Annex H). These ToCs were initially based on programme documentation, including business cases and programme logframes, and were then refined after consultation with primary stakeholders. We aimed to identify the conditions necessary to achieve the outcome and then tested the extent to which each held for different interventions.

Outcome 1 - Improved quality of public healthcare facilities and frontline healthcare workers

Programmes focused on improving the quality of public health facilities and frontline healthcare workers by training staff to deliver basic reproductive, maternal, child and neonatal care (RMNCH) and to diagnose and treat communicable diseases including tuberculosis, HIV/AIDS and malaria. While FCDO programmes focused on providing training and commodities, PATHS2 also renovated healthcare facilities.

Table 4: Necessary conditions to achieve outcome 1

Component	Necessary Conditions
Staffing	• Healthcare facility has appropriate staff levels and positions filled. • Right staff are identified and participate in capacity-building. • Personnel are willing and able to use the capacity-building to improve the performance of their official duties.
Capacity-building	• Training, technical assistance, mentorship and knowledge-sharing must be tailored to staff needs. • Capacity-building methods must be sustainable and support long-term retention. • Resources must be available to deliver effective capacity-building initiatives.

Facility readiness	• Facilities have adequate resources to be able to provide a basic level of care.
Access and use	• Health facilities must be accessible to the target population. • Community awareness of and demand for services offered must be strengthened.

Strengthening the healthcare workforce

Nearly all portfolio programmes – flagship programmes PATHS1, PATHS2 and Lafiya, maternal health programmes PRRINN-MNCH, MNCH2, W4H and PMDUP, and disease-specific programmes SUNMAP, SUNMAP2 and UNITED – provided basic training to frontline medical staff. Programme outputs on this training were rated A or above, and a key outcome indicator – the percentage of women having a skilled birth attendant – rose 10 percentage points in Enugu and over 15 percentage points in Kano and Jigawa during the periods of FCDO support (see Annex K, Figure 10).

Successful training programmes under W4H and PATHS/PATHS2 have ensured that frontline healthcare workers acquired essential life-saving skills. The training of individual medical staff has been a large part of the focus of the programmes. It has had various modalities in terms of time, content, target groups and content. Programmes found that short, skills-focused training around integrated supportive supervision such as life-saving skills (LSS) or integrated management of childhood illness (IMCI) training, were cost-effective and recognise and remedy specific gaps in quality of care or medical skills among medical staff. A senior government official in Jigawa state explained that ISS and other quality of care measures are:

"designed to be implemented even by junior staff, making it a valuable strategy for our healthcare system. as they are easily replicable and may overcome some of the issues in the turnover of staff. They are practical in targeting gaps in certain skills and standardising healthcare practices across facilities and places."

However, programming often fell short in addressing broader workforce challenges such as recruiting, retention, and filling skill gaps in underserved areas. Human Resources for Health (HRH) was identified as a key risk/assumption and was included as a workstream in all flagship health programmes from PATHS1 to Lafiya, but FCDO support was initially only given to developing policies and strategic plans (see Case 12). FCDO programming only directly addressed primary healthcare worker under-staffing through one programme, W4H (Case 1), and while this was successful, a chronic shortage of staff in both public healthcare facilities and government ministries, departments and agencies remains.

Case 12: Human Resources for Health

Human Resources for Health (HRH) is a WHO building block and one of the recurring policy strands for FCDO HSS programmes in Nigeria. PATHS1 helped the GoN formulate a federal health sector plan and develop policy and costed strategies around HRH at the federal level. PRRINN-MNCH supported HRH management systems at federal, state and LGA level, and the logframe acknowledged the risk of insufficient health care workers for the first time

The PRRINN-MNCH PCR found "all states have draft HR policies and plans, but these have not yet been formally approved, except in Jigawa [...] Many health workers do not secure employment after graduation and many leave to work in other states, despite there being a shortage of health workers to serve population needs in programme states. PRINN-MNCH has not adequately addressed these issues with states and so although HR policies and plans have been developed, further work remains to rationalise HR strategies and implement state-level HR policies and plans" (p.9).

The PATHS2 capacity development report found that "each state now has an HRH policy and strategic plan", with supporting structures, human resources for a health system (HRHIS), and job descriptions for frontline workers" (p.13)..."Key informants' assessments of the results of PATHS2's interventions in HRH development were positive although they said that they do not have adequate capacity currently in terms of trained workforce and need more staff, training for them and more exposure on HRH through meetings and conferences with HRH experts" (p.18). "Funding was identified as the greatest challenge. HRH does not have a budget line and is fully donor-funded, and used the HRH partners' forum to leverage resources for their work" (p.19).

MNCH2 placed less emphasis on HRH because it was complemented by W4H (2012-2020), the first FCDO programme that attempted to explicitly address the lack of personnel in northern states (Case 1). Although W4H contributed to an increase in trained frontline healthcare workers and the number of skilled birth attendants in the north (see Annex K, Figure 10), these levels are still far below southern states like Enugu, and problems have persisted. The Lafiya MTR noted that staffing at all BHCPF-supported facilities in northern states was substantially below expectations, with only 34% of facilities in Jigawa and 24% in Kano maintaining the minimum workforce.

When long-term impacts have not been considered, training, often targets staff likely to relocate. These trainings were also reported to be inconsistent in their delivery and support, as well as underfunded. Training activities were only partially successful, with a lack of continuity or use of training by staff. See CHEW training in Jigawa (Case 13) and training traditional leaders and healthcare workers (Case 3).

FCDO support for GoN Human Resources for Health (HRH) training and capacity-building efforts had limited success. In PATHS2's HRH, the state government created a progressive transition from programme to state funding for new healthcare workers over a four-year period, ultimately integrating them into the state healthcare system. State involvement in workforce planning and retention of healthcare workers enhanced long-term sustainability.

Case 13: Training of Community Health Extension Workers (CHEWs) in Jigawa

The training received by CHEWS in Jigawa covered various aspects of healthcare, from family planning and maternal health care to data collection. However, the training was intermittent and did not plan for the long-term effects or specific needs of local facilities. The workers explained that they remained understaffed, with unfilled gaps in positions and skills, and workers often wearing many hats. One staff member mentioned that the training days sometimes conflicted with busy schedules, taking workers away from already understaffed services. While the training was beneficial and valued, and "service delivery improved along with an upsurge of service utilisation", it did not work to place people in appropriate positions based on the needs of the facility in the long run. The understaffing and poor working conditions meant that services had a low up-take rate among users.

"Among all stakeholders there is agreement that the most significant constraint on better outcomes and particularly in northern Nigeria is the severe shortage of qualified health workers (and particularly midwives and doctors). We find it difficult to understand why this was not given more attention in PATHS1, was given little attention in the initial period of PATHS2 and still does not seem to have sufficient priority in MNCH2. While it is understood that the Women for Health (W4H) project will have some impact in the medium term, the problems are here and now and have been for 15 years of our observations." - PATHS2 PCR, p.10.

"PATHS2 also focused a lot on infrastructure, it renovated hundreds of primary healthcare facilities and also secondary facilities. In secondary facilities it focused mainly on areas pertaining to maternal, newborn and child health services, while the government renovated the rest of the facilities." - GoN official, Jigawa

Addressing infrastructure and facility needs

Identifying facility and infrastructure needs is a component of improving the quality of healthcare service delivery, though it is not always essential. As one HERFON Enugu member put it, "A building doesn't make a [clinic] - it's the people, the healthcare workers and the community that make it work." However, frontline healthcare workers in Jigawa suggested that clients may be less willing to visit facilities with leaky roofs or no electricity: "The doors and windows are broken, there are no beds and the equipment is inadequate. As the clinic is not good, we don't have much client." Some respondents suggested that infrastructure and renovation may have been offered as a quid pro quo, since secondary facilities were not a PATHS2 focus.

PATHS1, PATHS2 and MNCH2 assessed facility needs and helped to replace equipment and repair facilities. MNCH2's Support to Health Infrastructural Development helped install solar power in some facilities and is estimated to have renovated up to 1,000 health facilities in Kano. Some training facilities also regained their

accreditation, which allowed staff to obtain certifications and helped address gaps in trained staff. Another successful approach was WHO's 'Reaching Every Ward Strategy' deployed by PATHS1.

Medical staff reported that help for many infrastructural improvements was sustained over time, especially in free government MNCH facilities. However, maintaining improvements requires government commitment to aid dependency. Some healthcare workers described this as a "partnership whereby any hospital that PATHS2 renovated, the government also did their part". Government policy to match renovations and sustain the quality of the services is essential in sustaining these beyond the end of the programme.

Outcome 2 - Building capacity of government decision-making, budgeting and policymaking

FCDO provided continuous support to government health departments at federal, state, LGA and facility levels while also building the capacity of CSOs to manage facilities and hold the government to account. Most capacity-building efforts focused on training for producing key documents – strategies, budgets, plans and policies – while little attention was given to soft skills like leadership.

Table 5: Necessary conditions to achieve outcome 2

Component	Necessary Conditions
Staffing	• Ministries, departments and agencies have appropriate staff levels and key positions filled. • The right staff are identified and participate in capacity-building. • Personnel are willing and able to use the capacity-building to improve the performance of their official duties.
Capacity-building	• Training, technical assistance, mentorship and knowledge-sharing must be tailored to staff needs.

Capacity-building in government agencies

All government-partnered programmes in the portfolio had at least one output related to capacity-building. The most common modalities used were developing organisational policies and procedures, creating planning and budgeting documents and delivering training, largely at the individual level.

Programmes were largely successful in strengthening government decision-making, budgeting and policymaking across various levels. Progress was recorded in programme logframes, first by the production of various strategic and financial documents, such as annual operational plans, and later by improvements to the National Harmonised Organisational Capacity Assessment Tool (NHOCAT).

- MNCH aimed to establish state-led annual reviews and planning processes and improve LGA performance.
- MNCH2 built LGA and PHC agency capacity in governance, partnerships, planning, budgeting and resource mobilisation.
- PATHS2 introduced Government Institutional Assessments, while PMDUP trained local organisations in advocacy.
- SUNMAP/SUNMAP2 focused on national and state-level capacity-building for service delivery and programme management, developing national protocols, reporting and surveillance sites.
- Lafiya aimed to establish functional EPR committees, PHC advisory committees and WDCs.

These programmes aimed to build dynamic, well-functioning organisations by addressing poor management, inefficiencies and lack of ownership in government institutions.

Several conditions are necessary for programmes to successfully build the capacity of government at the local, state and federal levels. These include appropriate training and capacity-building; suitable supervisory committees with power to carry out their mandates; and political will and alignment with government priorities. When these factors are in place, programmes can drive improvements in organisational capacity, policymaking, planning and budgeting within ministries, departments and agencies, LGAs and other agencies. Establishing and operationalising committees further strengthens governance structures.

Leveraging local third-party accountability structures can be important for effectively holding governments and organisations to account in producing workable policies, plans and budgets. Such improvements can enhance health outcomes over the medium term.

"A key concern is the availability of the right leadership, know-how and adequate number of capable staff in ministries and state primary health care development agencies to translate ambitious policies into effective implementation." - PATHS2 PCR, p.11

Key factors for effective training and capacity-building

Effective training and capacity-building require selecting the right personnel for the training and ensuring that content, frequency and delivery meet the needs of the target audience. Programmes have widely supported government agencies and officials through training and capacity-building, including study trips to leverage cross-state and cross-country learnings. It is necessary for the right staff to attend appropriate training sessions that are well-resourced and comprehensive enough to affect change. For example, CAP effectively provided mid-level government officials in targeted states with the necessary tools and capacity to perform better, and encouraged them to develop a reform mindset. CAP arranged visits to the Benue Health Fund and to South Africa to understand health accounts, which led to the first State Health Accounts being produced in 2002, serving as a key basis for the National Health Accounts at the federal level.

Capacity-building should also ensure adequate staffing, retention and succession planning to sustain institutional knowledge and leadership. Government offices often struggle to attract and retain the right personnel to fill positions. Slow recruitment processes and vacant positions often lead to gaps in governance, which slows progress in building capacity. As a result, government often did not have the manpower to implement legislation and policies. High attrition rates at the management level in state ministries, departments and agencies often limited the retention of institutional memory and resources. Many experienced professionals retired without replacements or a structured succession plan. These challenges limit the benefits offered by training and capacity-building.

“Senior persons who went through the reform process but retired were brought back as government appointees to keep the wheel running. Many of them provided technical assistance through FDCO programmes as consultants. Besides sustaining institutional memory, they added value by identifying what works […] and what could be done differently.” – Implementing partner national-level senior staff, Jigawa

Governance and institutional strengthening

Appropriate leadership needs to be appointed to ministries, departments, committees and other agencies, with clear terms of reference and the power to make decisions or to hold organisations accountable. It is essential that government agencies have adequate budgets and allocated resources to carry out their mandates. Programmes have advocated widely over the selection of committees, supported the development of mandates and guided the allocation of budget and resources.

Political commitment and a ‘reform mindset’ among government officials, as well as alignment with federal and state government priorities, are needed to build the capacity of government decision-making, budgeting and policymaking. Political interests must be aligned and there should be coordination with the government’s priorities and implementation mechanisms. In Enugu, PATHS2 built capacity and supported the state government’s efforts to develop the State Strategic Health Development Plan, which was aligned to the federal government’s priority to develop the National Strategic Health Development Plan to inform annual health budgets and serve as the basis for planning, implementation and reviews. In Jigawa, under the Lafiya, MNCH2, PATHS and PHC REFORM programmes, political commitment and well-minded people were essential to efforts to drive health sector reforms, given the resource-poor setting, fragmented public healthcare systems and lack of governor support in the state. Reform-minded officials were well trained over many years and so had sufficient capacity to know what works, and to provide necessary resources to implement key changes. Political will, openness to new ideas, and creating a welcoming environment for collaboration with partners was key to successful development of the state health system.

"[In] the government and the public sector, you have to support broader governance. [There is a] big focus on stewardship. [...] What we wanted was the government taking stewardship over the whole sector and there was lots of discussion and thinking about what good governance was." - FCDO Nigeria official

Leveraging local partnerships and third-party accountability

Leveraging collaboration and strong partnerships with local third parties for advocacy and accountability in line with the needs of local people is necessary for programmes to ensure that gains in government capacity and progress towards better pro-health policymaking and budgeting are sustained. Programmes have leveraged state-level, third-party accountability systems by partnering with and supporting local CSOs and community groups. These worked to influence the government to improve decision-making and policymaking in health and to increase budgetary allocation to the health sector, as well as to identify and address capacity gaps at the Ministry of Health and related agencies. Programmes should adapt to the state context and should use local accountability to identify and address the needs of the population, including vulnerable groups. PATHS2 engaged elected officials including governors, legislators and political office holders including ministers and commissioners by forming partnerships with leaders and stakeholders at all levels, including traditional and religious leaders and community groups, on their roles in improving health services. While these civil service accountability groups are often at odds with government officials, they are key for rooting out corruption and mismanagement and sustaining reforms through driving voice and accountability.

Outcome 3 - Timely procurement and distribution of medicine, supplies and vaccines

Early flagship programmes addressed distribution networks for essential supplies, including central medical stores, government warehouses and drug revolving funds. Some programmes used private sector or hybrid distribution networks to get commodities such as mosquito nets to every household.

Table 6: Necessary conditions to achieve outcome 3

Component	Necessary Conditions
Procurement	• Timely, centralised system at the federal or state level to enable bulk purchasing, with streamlined shipping and customs.
Distribution	• Central mechanism to deliver commodities to states efficiently.
Last-Mile	• Reliable system to ensure commodities reach facilities or consumers.
Demand	• Public healthcare facilities, private clinics and individuals must be aware of and seek the commodities.

Public-private partnerships in health supply chains

Establishing efficient supply chains for procuring and distributing commodities requires political consensus to develop innovative public-private partnerships (PPPs). In northern states such as Kano and Jigawa, government officials recognised the importance of PPPs to address health challenges, thus leveraging private sector expertise to improve the efficiency and effectiveness of government management systems and domestic resource mobilisation. For example, the 2020-2025 Kano State Development Plan highlighted the need for PPPs to fund initiatives in the health sector. Similarly, Jigawa implemented a decentralised drug supply and procurement system through the Jigawa Medicare Supply Organisation (JiMSO). In southern states like Enugu, state governments preferred to prioritise state-controlled logistics. Although the private sector was supported by UNFPA to identify third-party logistics firms, in the end these firms were contracted by the states to operate through an integrated logistics system.

Drug revolving fund and alternative supply models

The drug revolving fund (DRF) and alternative supply models offer varied approaches to sustainable drug supply chain management and last-mile delivery efforts. In northern states, the DRF scheme was seen as a more successful basis to stabilise the supply chain for essential medicines and to enhance service delivery at primary healthcare level. Before the involvement of DFID programmes, Jigawa relied on open market drug sourcing, despite PATHS1's collaboration with NAFDAC to improve quality assurance. Although PATHS1 did collaborate with the National Agency for Food and Drug Administration and Control (NAFDAC) to improve drug quality assurance, counterfeit or poor-quality drugs and stockouts or shortages remain common issues

for healthcare facilities, exacerbated by demand. PATHS2 implemented centralisation of drug procurement and supply in Kano and capitalised DRFs with ready-for-delivery seed stock of health commodities.

"Medicine vendors stock only what the community can afford. They cannot sell expensive anti-malarials, so they rely on cheap chloroquine, which are not expensive – they don't stock the quality medicines, you can't go to the chemist and get [name-brand] medicines, but you can get cheaper medicines which are not recommended. And when you take those medicines, you can't clear the parasites." - Senior federal government official, Abuja

"There were a lot of problems with accessing drugs and their availability in Kano State – out of stock, fake drugs etc. With the coming of PATHS2 they tried to centralise drug procurement and supply. PATHS2 capitalise us …they gave us seed stock not money. The drug is given to the community not the facility." - CSO, Kano

Strengthening health commodity management and distribution

Following the launch of DRF, all facilities in Jigawa, including public healthcare centres and hospitals, were obliged to purchase their drugs from JiMSO, the central medical store (CMS), marking a significant step forward in managing health commodities, and ensuring a consistent supply of essential equipment, medicines and other consumables across various facility levels, as well as the reliability and effectiveness of medications prescribed at health facilities. Alternative supply models, such as free medical supplies for MNCH services, helped encourage service use, particularly for antenatal clinic attendance and facility-based deliveries. In Kano, a similar setup with DRF has become an assured source of medical supplies, with a legal framework that helped strengthen the operational capacity of health facilities (see Case 9, Case 10 and Paired Case 3).

"A lot of the emphasis was on government to build supply chains, now SFH Access Ltd[2] are literally moving all those malaria nets for Global Fund – finest example of a national supply chain being built and sustained. We have a warehouse, maintaining it – have provided millions of savings to donors – DFID, Global Fund and the rest." - Implementing partner national-level senior staff member, Abuja

"Before DFID programmes came to Jigawa state, every institution had to go outside to procure drugs. In those days the drug stores were empty, and people did not know how to manage the drugs. […] Then DFID came with that 200 million Naira of drug support, which was the seed stock for the operation of the drug revolving scheme. Since 2004 that money we had is now almost a billion Naira. It is one of the success stories in Jigawa State, how the DRF matured to the level where we have the central store, three regional stores, 27 LGA stores and stores in every health facility. The DRF has supported not only drug supply but also the systems because through the mark-up we are able to do other things to supervise the system and so on." - Senior official, SMoH, Jigawa

Faith-based and community-led supply systems

Despite the success of the DRF model in the north, the faith-based central medical stores in the south, particularly in Enugu, adopted a different mode of delivery. Under SUNMAP and UNITED, local partners, including CSOs and NGOs, have taken on a more important role for health commodities delivery to rural and underserved areas in some states. The wide service coverage of central medical stores in each district increased the overall quality and quantity of drugs without overstocking. To ensure that health commodities reached beneficiaries, local community-managed systems also played a role in successful distribution efforts. In the case of PATHS1, the programme in its inception phase integrated community-based accountability measures to build community confidence in the management of health commodities. This approach empowered communities to monitor distribution, fostering trust and transparency in the process.

[2] SFH Access Ltd is a private company that was spun off from ENR's implementing partner SFH, which built local capacity with the production and distribution of condoms and other family planning methods.

Real-time inventory management and distribution efficiency

Regardless of delivery modes chosen, the importance of timely delivery of commodities to those in need should be promoted. As evidenced by UNFPA, in the case of contraceptive procurement, 70% of procurement resources were allocated to distribution, to avoid expiry risks of large quantities of commodities in storage. Initially implemented in 13 states, the approach to scale up nationwide delivery has ensured that commodities were not only procured but promptly distributed. State government officials in Kano emphasised the importance of inventory control connecting hospitals and warehouses to strengthen the health commodities supply chain. Supported by real-time inventory management, the system has been essential for maintaining the quality and availability of health commodities, allowing for accurate tracking of stock levels, timely restocking, and ensuring that commodities were handled correctly to preserve their efficacy. Additionally, real-time monitoring helped prevent leakages and wastage by minimising the risk of overstocking or stockouts, contributing to a more efficient, timely and accountable drug supply chain.

Outcome 4 - awareness-raising and communication

Disease-specific and reproductive, maternal, neonatal and child health programmes promoted knowledge and awareness of certain illnesses, treatments and services to lead to behaviour change. They spread information through several different media, including radio and TV, word-of-mouth and government extension workers going door-to-door. FCDO programmes overcame cultural resistance to family planning and vaccination practices to achieve substantial uptake of services.

Table 7: Necessary conditions to achieve outcome 4

Component	Necessary Conditions
Awareness	• Target audience must be informed about the product or service through trusted communication channels such as: radio, jingles, TV and flyers; government roadshows and marketplace events; and CHIPs and CHEWs.
Accessibility	• Product or service must be available within a reasonable distance.
Affordability	• Product or service must be priced appropriately for the target audience, whether free, subsidised or for-profit.
Demand	• Target audience must have interest and willingness to use the product or service.

Effectiveness of awareness campaigns

Evidence for awareness-raising contributing to behaviour change from programme reporting is limited both due to a lack of programme evaluations and because this was a component in only four programme logframes. The weak assessment of communications campaigns in PATHS1 set the stage for future engagement.

"Comparison of the baseline and follow-up surveys does not show consistent improvement in the key indicators [around communication and awareness-raising]. While some improve, others get worse, and there is considerable variability in this pattern across states. This is true of measures of exposure to messages; of carers' knowledge about malaria or respiratory infection; and of measures of perceptions about the usefulness of complaining about poor services. These results raise concerns about cost-effectiveness, and would suggest either that investment in communications work should be much smaller in PATHS2, given the apparent lack of impact, or that a larger and/or more sustained investment is necessary to bring about change." (PATHS1 Final Review Report, p.6.)

Community-led approaches to behaviour change

Despite this assessment, PRRINN-MNCH started utilising CHEWs to increase community demand for maternal health, having trained them in referrals and other practical skills. The PRRINN-MNCH project completion report found that "the community engagement approach employed to increase demand for MNCH and routine immunisation services was wide reaching and comprehensive in scope. However, the approach was resource intense, and while PRRINN-MNCH has demonstrated that much can be achieved (at low cost) through community volunteers, a significant degree of oversight is necessary to sustain this approach. It is uncertain if states and LGAs will be able to maintain capacity to oversee these activities, across the whole state and without partner support, in the long term" (p.2). (See Case 13 for more details.)

Cost and sustainability of direct communication strategies

Evidence from PRRINN-MNCH, ENR, SUNMAP and UNITED all showed that individual, door-to-door communication was the most effective means of awareness-raising and communication for disease-specific programmes (see Case 10 and Case 18) but came at a significant cost. Some programmes struggled to create the right messaging around products, particularly around mass communication campaigns, or struggled to show the impact of these campaigns.

"UNITED was working on supply chain management, behaviour change, communications strategies. They had left one of the consortium partners to look at that, strategy was not evidence-based, messages had not been tested really not successful – they didn't really take technical responsibility for trying to fix it – really a shame because you have all this supply work, if you have the demand that doesn't follow." - Implementing partner, national level senior staff

Overcoming cultural barriers to health practices

Programmes needed to overcome significant cultural resistance to modern practices such as family planning (use of condoms) and antenatal care to ensure there was demand for the service. Our primary research and programme outcome data showed that this was largely achieved through engagement with traditional and community leaders (See 'Community support' section above).

Outcome 5 – Improved reporting and information management systems

Many programmes had an output on evidence-based learning and decision-making, and most programmes included support to gathering and/or strengthening health data, including the government's Health Management Information System (HMIS) and supplementary Demographic Health Information System (DHIS). This work went hand-in-hand with government capacity-building to help government at all levels understand and make decisions based on good-quality and timely data.

Table 8: Necessary conditions to achieve outcome 5

Component	Necessary Conditions
Data Entry	• Quality data must be consistently recorded at the local level.
Data Tools	• Staff must have access to essential equipment, including laptops, mobile phones, motorbikes or vehicles, to effectively collect, input and manage data.
Data Reliability	• Quality assurance measures must be in place. • Data users at higher levels must trust the accuracy, quality assurance and aggregation of data.
Data Integration	• Data must be harmonised with national-level systems like DHIS or HMIS.
Capacity and Support	• Staff must have proper training and capacity to input data. • Staff at higher levels must be trained to interpret and use data effectively. Federal, state and LGA officials must endorse the dataset, its indicators and its use.

FCDO's role in strengthening health information systems

FCDO programmes PATHS1, PRRINN-MNCH, PATHS2 and MNCH2 supported the development of the Nigeria Health Management Information System (NHMIS). This support aimed to harmonise a suite of indicators collected across states, build capacity at facility level to input quality data, and increase confidence and build capacity at LGA, state and federal level to make informed decisions based on the HMIS data. These data were also used to track progress on programme indicators. There is evidence that support for HMIS and other data collection systems has been transformational, but evidence also suggests that gains are limited to states like Enugu, where FCDO support has ended and the HMIS approach was not fully embedded. See Annex K, Figure 13.

Variability in HMIS implementation across states

Differences in reporting between the three focus states may be a result of differences in reporting culture and institutionalisation of HMIS reporting, more than financial support. The percentage of facilities timely reporting HMIS data (Annex K, Figure 13) was a measure included in several programme logframes and in periodic national HMIS reporting; we have used this as a proxy for the quality of HMIS between states. A second indicator, HMIS data reported to a minimum quality standard, was tracked by MNCH2, but we have

not found a consistent secondary source disaggregated by state. The graph shows that, despite concerns about sustainability expressed by FCDO at the end of PATHS2, reporting in Enugu has remained steady, with around 70% of facilities reporting since FCDO support ended in 2013. In contrast, reporting in both Jigawa and Kano has remained steady at around 95% with continuing FCDO support. All three target states received around the same support for HMIS under PATHS1. The PATHS1 review report (2008) found "clear evidence of a 'planning culture' beginning to emerge" in all states and that PATHS1 "has also developed the capacity of stakeholders to manage and analyse such data" (p.29).

Enugu did not receive support from PRRINN-MNCH, and its funding was reduced in the PATHS2 extension phase. By the end of PATHS2, the state government had not taken over funding of monthly M&E meetings, and Enugu trialled mobile-based reporting to address this funding shortfall. The independent monitoring and evaluation partner for PATHS2 conducted a capacity development study which found that "reporting rates [in Enugu] have increased with the introduction of mobile reporting but are still lower than when the meetings were used. The PHCs complain of connectivity and technical challenges with using the phones" (p.35).

Kano received support for HMIS under PRRINN-MNCH, PATHS2, and MNCH2. The PATHS2 independent monitoring and evaluation partner found that "In Kano, PATHS2 had been very successful in helping to establish [HMIS] in the state. Monthly M&E review meetings were institutionalised, as well as support and supervisory visits. [Data quality assurance] was also put in place as well. Reporting timelines were defined and adhered to from the health facilities to the LGA to the state and national levels. Despite lack of funds, the health facility M&E officers are still reporting M&E data on a monthly basis […] and the LGA M&E officer provides quality assurance."

Jigawa received sustained donor support through PATHS1, PATHS2, PRRINN-MNCH and the World Bank HSDP II programmes (Anifalaje, 2012) as well as MNCH2. The PATHS2 independent monitoring and evaluation partner found that "in Jigawa the reporting system was effectively run by the Gunduma council officers through a dedicated HMIS lead, who oversaw the collection of data at facility level" (p. 35-36).

Sustainability challenges in HMIS

By the end of PATHS2, the sustainability of HMIS improvements was uncertain. The PATHS2 project completion report (2016) noted *"the persistent weaknesses of Health Management Information System (HMIS) data in spite of the considerable investments in this area (p.1) […] Both PATHS1 and PATHS2 invested heavily in the improvement of HMIS systems and achieved impressive results. However, without external pressure and resources it is apparent that performance may fall off rapidly. This may in part be explained by lack of incentives but also reflects the low priority and resources provided for data collection and use by governments" (p.7).* FCDO's assessment of HMIS sustainability was limited to a few lines in the MNCH2 project completion report.

An assessment of the Nigeria HMIS conducted by Bosch-Capblanch et al. in 2017 at national level and in Cross River State found that HMIS faced challenges of limited funding and inadequate human resources, irregular supply of data tools, lateral data collection by partners, lack of data analysis at the level of data collection, and lack of data use in decision-making. In addition, data digitalisation was hampered by frequent power cuts, limited internet access and ICT skills, and insufficient computers and mobile phones for data entry (p.11). Bosch-Capblanch found that LGAs were responsible for implementation, but most LGAs lacked the political will and funding capacity to deliver quality services, which also affected the NHMIS. Numerous vertical donor-funded disease control programmes may have weakened overall HMIS. Disease-focused demands driven by heavily funded donor projects and international reporting obligations towards specific diseases like HIV/AIDS, tuberculosis and malaria have compromised the overall running of the HMIS. Parallel donor-supported data collection at facility level was also seen as a threat (p.12). Primary respondents in our fieldwork raised issues around ownership of the data, lack of integration and parallel datasets for disease-specific data, problems with IT systems, and limited resources.

Successes and areas of progress in HMIS

Respondents at federal level from both GoN and implementing partners credited FCDO with transforming the culture around data-driven decision-making at federal level, but it is not clear whether this has been sustained. Confidence in the data is undermined by quality problems at facility and LGA level.

Enugu seems to have struggled to adapt to DHIS2 mobile-based reporting and the withdrawal of PATHS2 funding, but the culture of data-driven decision-making does not seem to have been embedded. By contrast, HMIS has been sustained in Kano and Jigawa. This appears to be supported by adequate resourcing at facility and community level, in part through volunteers, all the way through to demand at state level. A facility manager in Jigawa explained the process at their clinic. There is some evidence that HMIS in northern states has been sustained through volunteerism. This aligns with Bosch-Capblanch et. al (2017) who found that volunteers (Village Health Workers and CHEWs) filled out the monthly HMIS reporting at facility level in Cross River State due to general lack of health information managers (p.16).

"[Under PATHS2] we produced a one-page report fact sheet every week and sent it to top management staff" – Directors, Permanent Secretary and Commissioner.

"We knew they were not reading them but later they started demanding them. Later we also published health bulletins monthly." – Senior official, FMoH

"[Under PATHS1], health facility staff were trained and given phones for data collection. They were also given transport to deliver data." - Senior official, SMoH, Enugu

"HMIS works. We had very good people that were able to grasp the process. It was well established right from PATHS1. I think to a large extent the capacity that was built has been sustained. The only snag is that it does not really align with sometimes the national, but eventually with the coming of the DHIS2 and the kind of the work MNCH2 did, they brought it back and aligned with the national HMIS." - Implementing partner national-level senior staff member, Kano and Jigawa

"We rely on [HMIS] data for our decision-making processes, especially for programmes like malaria and reproductive health." – GoN official, Kano State

"In my facility, each and every week, I will go round each and every unit to see how their data is and validate it [...] My records officer is responsible for collecting the data, but I'm the one that does the validation. At the end of the month, data from all the units are gathered, compiled into a Monthly Summary Form (MSF) and sent to the LGA M&E Officer." – Frontline healthcare worker, Jigawa

"There's been a lot of focus on how to sustain the programmes we have started. For instance, last year, we implemented a project where community members could transmit data via Android phones, which was a great success. But sustainability remains a challenge." – State-level Civil Society Organisation, Kano

"On surveillance, there are people we call key informants like traditional healers, barbers, teachers who are educated to provide data for conditions like polio myelitis – when they identify such cases, they tell us and we inform the LGA disease surveillance officer and also the M&E." – Frontline healthcare worker, Jigawa

EQ1.2 Why have health systems strengthening interventions succeeded or failed?

Summary: To promote transformational change and sustainability, future initiatives must prioritise the integration of programmes within established governance frameworks, ensure consistent governmental support, and reinforce community-driven accountability mechanisms.

Key findings
• FCDO's health system strengthening programmes led to sustained and transformational changes, with government buy-in at federal and state levels playing a crucial role in their success. • State-level initiatives were successful when they were tailored to local socio-economic, cultural and political contexts. • State-level reforms were heavily influenced by federal funding mechanisms. • Civil society organisations (CSOs) strengthened health sector accountability by pressuring state and local governments to uphold pro-health policies and improve budget allocations. • Volunteer networks, traditional leaders, CSOs, and local enterprises helped ensure sustainability.

Challenges identified
• Programmes achieved transformative changes but many changes were not sustained. • Changes in leadership and policy direction make it difficult to maintain momentum in health interventions. • Reliance on federal funding restricts state and local governments from sustaining initiatives. • Weak transparency and accountability mechanisms hinder the efficiency and reach of programmes. • Cultural norms can hinder acceptance of services such as immunisation and reproductive healthcare.
Intervention spotlights
• Strong government commitment at both federal and state levels led to lasting improvements and strengthened national health priorities. • Strategic state selection directed resources towards high-need areas, through strong local leadership. • Local and community resourcing promoted long-term sustainability. • Civil society advocacy led to increased health funding and long-term policy commitments. • Sensitisation through religious and community leaders strengthened acceptance and expanded reach of modern health practices in Northern Nigeria.
Analytical methods
• Thematic analysis of contextual factors CF2, CF3 and CF4, coding of transformational, sustainable cases • FCDO, GoN, IP, CSO, FHCW and DP responses • Programme document review, including ARs and PCRs • Cases 2, 5, 7, 8 and 17; paired case 3 • Secondary sources

Assessing programme success – transformational change and sustainability

The FCDO programme management cycle assesses the success or failure of programmes primarily through a series of output indicators in its annual reviews (ARs) and the project completion report (PCR). FCDO has rated its HSS programming in Nigeria highly, scoring nearly straight As, with just one programme output ever scoring a C at PCR stage. However, as they are conducted before programme closure, PCRs do not show whether programme gains have been sustained.

This evaluation defines intervention success as sustained and transformational change. Given that few impact evaluations have been conducted across the programme portfolio, we defined a programme component as sustained if at least three different sources confirmed it was still operating after programme closure, even in a reduced or adapted capacity. Transformational change was identified if at least three sources provided detailed evidence that programming had significantly altered how the government of Nigeria or its implementing partners worked, and if the change continued at least until the end of the programme. Interventions can therefore be transformational or sustained (or both, or neither).

Assessing whether a change is sustained is easier in states where FCDO is no longer providing support, including Enugu in the south. Jigawa and Kano states still receive FCDO support through the ongoing WISH and Lafiya programmes, although some initiatives from prior programmes are no longer receiving programme support. In this section we first present successful approaches common to all thematic areas, followed by more specific examples by thematic area. Paired case studies illustrate key contextual differences between states with different levels of success.

Achieving transformational change through government buy-in

Programmes achieved transformational changes where they had strong support from key stakeholders at federal and state levels. This success was largely due to FCDO aligning programming to government priorities and engaging in quid pro quo with officials, especially at state level. The governance review (Piron et al., 2021) found that FCDO Nigeria had demonstrated awareness of ‘thinking and working politically from the outset, using Drivers of Change (DoC) analysis and issues-based approaches to understand the power relations of key individuals involved in the reform’ (p.62-63). This approach was evident in health programming, starting with the Change Agents Programme (CAP), which aimed to influence GoN thinking around health systems reform from the inside by building the capacity of key individuals. Most programme

plans assumed continued government support, and flagship programmes, including NEEDS and SEEDS, the National Health Act, free MNCH, PHCOUR and the One Million Lives Saved Campaign, demonstrated alignment with federal government policies.

"There is a big political agenda from where the money is coming, also an agenda from where the money is being spent, and the [Nigerian] politicians have their own agenda. If what you're bringing in does not align with their agenda, it is not a done deal, you are lost, because they will not put in their money, they won't put in their political commitment and it will go dry." – Implementing partner, federal level

Adapting health system strengthening to Nigeria's political economy: federal level

FCDO Nigeria recognised the importance of working at federal level, building relationships with ministers and other key stakeholders. In Nigeria, a single influential individual can block entire reforms. For example, one respondent described how the Minister of Finance delayed passage of the National Health Act because she objected to the 2% commitment of funds, requiring a coordinated response from the donor community to push it through. The HERFON1 programme was designed to advocate for NHA and other legislative priorities at the federal level. Several FCDO staff noted that working at the federal level helped make the most of limited donor funds. As one staff member observed, "[DFID] money was not going to have an impact countrywide in Nigeria. So we had to be focused on strategy." However, this unintentionally led to a top-down approach with more inefficiencies, as resources are expended at each level of government.

Adapting health system strengthening to Nigeria's political economy: state level

Nigeria's 36 states have pronounced cultural, socio-economic and demographic differences, which translates to different starting points with regards to key HSS indicators, ways of working, strength of civil society organisations, and other accountability mechanisms. Because Nigeria follows a federal system, each state passes and enacts health legislation in different ways. These variations mean that delivery at state level needs to be tailored to the state and local culture, demographics, economy, geography and political economy. Table 2 gives a partial comparison.

"A lot of it boils down to the governor – if he's open to reform, then things can be done – if you've got someone who's just interested in the status quo and things just carry on as they are, and he has his own power base, then it doesn't." - Implementing partner, state-level senior staff

For HSS initiatives to succeed, support from the state government was necessary. In most cases, this came from the state governor, but in a couple of cases, the state commissioner of health provided sufficient support. Under the current system, LGA officials are appointed by the state governor, so LGAs are of the same political party but beholden to state government.

When choosing which states to operate in, FCDO initially considered whether governors were reform-minded as well as the opportunities or needs of the state. As one implementing partner put it, 'State selection was on a combination of needs and potential.' However, HSS programmes did not tend to carry much political weight at state level, as their results were not as visible as other programmes. As politically elected representatives, governors often prioritised initiatives such as opening hospitals and distributing bed nets. FCDO recognised that quid pro quos were sometimes necessary to unlock state-level political support.

"Because PATHS supported the Governor's ambition for Park Lane Hospital, he was also ready to support other reforms like the [District Health System]." – Implementing partner, Enugu

As with all political systems, FCDO had to navigate changes in government and key personnel, which required re-engagement. When a new administration took office, they sometimes ended ongoing health programmes to distinguish themselves from their predecessors.

"Eventually it was not enough, you know, to sustain, with the change of governor."
- Implementing partner, Enugu

Role of federal policy and funding in state-level reforms

Federal policy and funding play a major role in shaping state-level health reforms, so individual states have trouble trying to depart from federal-level funding arrangements. Several respondents in Jigawa and Enugu noted that state governments had to dismantle the District Health System not because it was ineffective but because they needed access to federal money disbursed through the BHCPF. Even as respondents questioned whether the new sector wide approach (SWAp) will work, they noted that no state will opt out, as doing so would mean losing federal money. While states have political and financial autonomy, financial incentives from the federal government deter states from pursuing independent reforms, even if those reforms might be more beneficial.

Adapting health system strengthening to Nigeria's political and social context: LGA-level

Local government authorities have limited control over healthcare services because their leaders are appointed by the state government. Besides paying health workers' salaries, LGAs also contribute most of the funds for running public healthcare services, deducted at source by state governments. As a result, PHC management boards often micro-manage public healthcare services facilities and community-level health programmes, leaving LGAs with little influence over decision-making.

Political support and funding at LGA level have been important for programme success. The Gunduma health system in Jigawa and the district health system in Enugu, introduced under programmes including PRINN-MNCH and MNCH2, failed because they did not align with existing political and local governance structures. As a result, they received limited support from LGA and state governors (see Case 16). Community leaders have played a critical role in holding government officials accountable. In Kano, KanSLAM (see Case 7) successfully advocated for the government to set up the KSCHMA scheme by adapting national health insurance to the state context. In Jigawa, the corresponding JICHMA scheme has been well-supported by the government, providing free maternal and newborn child health (MNCH) services to people in poverty.

Strengthening local government and community engagement

Community-led initiatives such as ward development committees (WDCs), facility health committees (FHCs) and drug revolving funds (DRFs) were more successful in Kano and Jigawa than in Enugu. In Kano and Jigawa, DRFs enjoyed consistent political support from the LGA through funding and accountability measures. In Kano, the WDC, which relies on unpaid volunteers, has struggled due to lack of resources, so it has been difficult for it to maintain hospitals and buy medicines for the DRF, and relies on funds from local and state governments. In contrast, DRFs in Enugu faced challenges such as limited political support, lack of resources, frequent changes in political leadership, lack of accountability, and mismanagement by the local and state governments (paired case 3).

Paired case 3: Drug Revolving Funds (DRF) / Central Medical Stores (CMS)

Context

Availability of essential and affordable drugs at PHC facilities is a key element of health system strengthening. Without it there will be no confidence in the facility among those it should serve, and they will revert to attending higher level institutions at greater cost to themselves, as well as impacting on overall system efficiency; or rely on local pharmacies and drug vendors.

This issue was well recognised in Nigeria before the advent of UK support, with prior attempts to fund and build arrangements based on the Bamako Initiative – essentially to create local outlets for low cost and effective pharmaceuticals, with an initial seed stock replenished by payment from those who can afford it, and any surplus used to fund exemptions of the poorest and other local health initiatives.

These early initiatives eventually failed due to "decapitalisation" related to substantial high-level fraudulent behaviour and accumulation of small-scale dishonesty and malpractices at the PHC facility level. However, there was widespread understanding of how such an arrangement should work.

The situation found on the ground by the early projects – PATHS, HCP, PATHS2 – was similar in all the states. Central and LGA stores existed as physical structures, but drug stocks were expired except for commodities related to vertical programmes. DRFs were not operating, being typically replaced by small pharmacies and vendors, and sale of drugs by facility health staff. Faith based systems were in existence but largely for the supply of their own hospital and clinic facilities.

Intervention

The approaches to strengthening emerged from PATHS and the HCP but were essentially the same across the different programmes: strengthen systems, then capitalise the central stores and DRFs, build institutional capacity in the central stores/drug agency, train facility staff in basic management of stocks, replenishment, and accounting, support supervisory teams, empower facility health committees in oversight and use of surpluses, embed the arrangements in law, build high level political support including among traditional and religious leaders, and move to autonomous agencies with considerable independence from the State bureaucracies.

Viewed conceptually the strategy was to create circumstances in which the countervailing factors to corruption (large and small) – as well as well-intentioned diversion of resources - would prevail.

In Jigawa a seed stock of 186m naira in 2007 had grown to 648m naira in 2022 (probably maintaining value in dollars). It supports about 700 DRF outlets. Sales have increased from 460m naira in 2011 to over 2 billion naira in 2021 (reflecting a considerable increase in dollar terms). It has progressed along the path described above and the central agency – JiPHARMA – is now a private company although owned 100% by the government. Key informants ascribe this success to: government commitment without interference in operations; motivated staff; prompt payment to suppliers; and state monitoring teams with mechanisms for punishing erring persons and recovering debts.

In Kano, there was a strong start and by 2009 the central drug agency – Kano State Drugs and Medical Consumables Supply Agency (DMCSA) – was established in law. About 850 DRF outlets were supported, with gradual additions over time. However, between 2009 and 2013 there was considerable ‘political interference’, with the misappropriation of funds or drug stocks, leading to decapitalisation and frequent stockouts. The system has continued to face considerable challenges.

Information from Key Informants

In Kano, the DRF “has survived despite all the challenges – out of stock of drugs and commodities in the agency and health facilities, drugs were expensive and substandard because they were sourced outside. When we came in last year, 2023, the availability of drugs in health facilities was 30%. So, there was 70% out of stock. Patients were also complaining about the high cost of drugs, so the affordability issue was there. Quality was also an issue – the agency failed to satisfy the demands of the health facilities such that the facilities sourced their drugs outside. And most of the suppliers deserted the agency because of the huge debt to them. We inherited debt of about 1.2 billion naira.” – Senior GoN official, Kano State

The problems encountered were associated with non-compliance with operational guidelines; government instructions to provide free drugs during “emergencies” but without reimbursement, outright fraud and lack of accountability, inconsistent political support, and no further capitalisation since PATHS2.

This adverse situation has been turned around in just a year – inherited debt has been paid back, drug availability is now above 95%, and the CMS is aggressively modernising and expanding its stores. This is attributed by the agency to the in-depth and comprehensive training and support they received, as well as legal and institutional foundations built during the PATHS2 years.

“A Sustainable Drugs Supply System (SDSS) committee is set up at the state level. Several states: Katsina, Yobe, Jigawa, Bauchi, Sokoto, even some southern states, have come to learn from the Kano experience. We have even sent our people to train their people.” – Senior GoN official, Kano State

Analysis

The sustainability of the drug revolving fund in Jigawa, survival in Kano and partial collapse in Enugu can be attributed to three main contextual factors which differed between the states:
– Political support but not operational and financial interference.
– Strength of local accountability through facility health committees.
– Strength of supervisory arrangements and dealing with transgressions.

Therefore, Jigawa, Kano and Enugu can be seen on a continuum of likely sustainability in which the key variables were not technical inputs (which although essential were common to all) but the strength of the "countervailing factors".

Overall, it is reasonable to assume that the continuation of the DFID/FCDO programmes has contributed to sustainability in Jigawa and Kano. However, it is also clear that the analysis and supportive actions related to the means of achieving and consolidating the 'countervailing factors' was strong in Jigawa, sufficient in Kano and inadequate in Enugu.

The DRF model has been replicated by other donors in other states. USAID supported Ebonyi, Bauchi, Sokoto, Kebbi and Nasarawa State to develop operational guidelines to develop their respective DRFs (USAID GHSC-PSM, 2022).

"We focus on finding resources to keep the health centres running […] The DRF ensures we never run out of medicine at the clinics […] Getting resources ourselves is super important […] to raise money within our own community so we don't have to depend entirely on outsiders. We've built trust and gotten support from both our local government and the state government […] and thanks to that we managed to get 70 million Naira for our health centre." – Senior staff, state civil society organisation, Kano

The 2024 Supreme Court decision on LGA autonomy will see FCDO reconsider its support at LGA level. Legislative commitments signal political support and resourcing for initiatives but are not themselves sufficient to achieve results. Many programme plans identified continuing political support as a risk or assumption in their logframes; the outputs of PMDUP, PATHS and PATHS2 programmes, and the entire HERFON series of programmes, aimed to support the passage or implementation of legislation or policies at federal or state level to provide both frameworks and accountability for the government to act.

The National Health Act, which took 14 years to pass (Case 5), still requires substantial development partner support to implement at both federal and state level. Alongside the 1% of federal funds, the NHA identifies grants from international donors and private sector donations as other funding sources. Nigeria, like almost all signatories, has fallen short of the Abuja Declaration target of spending 15% of its GDP to improve healthcare. Currently, the country spends only 4% (HRW, 2024). Despite all three target states nominally increasing healthcare funding, only two states, Kaduna and Sokoto, have consistently hit the 15% target (One.org, 2022), with Kano reaching it this year (Lafiya MTR).

Health systems strengthening, like all organisational development, takes time (Witter et al., 2021). Examples of transformational and sustained programming (as outlined in the response to EQ1.3) are the result of years or decades of support from FCDO, often throughout multiple flagship programmes. For example, the Emergency Transport Scheme (Case 2) was supported through four consecutive FCDO programmes. Similarly, Jigawa has had FCDO presence and support for nearly 20 years. The shortest time taken to achieve transformational and sustainable change came from the Schools of Nursing Certifying Bodies (Case 1, 2012-2020), which received support from a single FCDO programme, W4H, to enhance recruitment of poor women from rural areas.

Sustaining HSS interventions remains a challenge due to persistent issues with continuity of funding from the GoN. However, interventions have been more successful when they align with the needs of local communities and draw on existing power structures. There is also a significant divide between northern and southern Nigeria in terms of development and healthcare needs. The south faces fewer pressing health

challenges, due to a stronger tradition of accountability, well-established civil society organisations (CSOs) and a more urbanised population. It is also more economically developed and predominantly Christian. In contrast, the north has a more rural and dispersed population, weaker CSOs and traditional governance structures through its emirates. It faces higher levels of poverty, poorer health indicators and greater healthcare needs, with a predominantly Muslim population.

"The success of FCDO programming often depends on having the right legislative and policy frameworks in place at both the national and state levels. However, while these frameworks are crucial, they are not always enough on their own. Their impact largely depends on how well they are designed, implemented and adapted to local realities." - State-level implementing partner, senior staff, Enugu

Community involvement in health programme sustainability

Community involvement helped adapt programme delivery to local contexts. This was achieved through discussions held with community members to assess their needs and involve them directly in the programming. Efforts were made to incorporate traditional medical practices and power structures as well as aligning with government priorities in that area. These approaches helped ensure programmes were sensitive to local needs. Programmes engaged with community leaders or medical practitioners through traditional community structures. For example, PATHS2 worked to include traditional birth attendants in the south and religious leaders like imams in the north, rather than attempting to overlook them. One respondent said that the Gunduma health system initially succeeded in the northern states because it aligned with the pre-existing emirate system. The Safe Motherhood Initiative in the north enabled men to collectively give their wives permission to access care. In the case of an emergency when husbands were absent, women could be taken to a facility without needing prior approval. The initiative ensured care for women by working with social structures and cultural practices.

Programmes that aligned with existing local community practices, structures and needs remained sustainable even post programme in both northern and southern focus states. In Kano, the DRFs could leverage the continuous in-depth and comprehensive training and support, as well as the legal and institutional foundations built under PATHS2 (Paired Case 3). The Kano WDC (Case 8) successfully led resource mobilisation to support health facilities and access to services for people in poverty by raising funds from local governments and community leaders and establishing a loan system to cover costs upfront for people in poverty. The WDC acted as an accountability platform to LGAs and was an integral element of the BHCPF. Kano and Jigawa State contributory healthcare schemes (KSCHMA and JICHMA) have worked to address financing for patients in poverty. Services have been delivered consistently to women and children in poverty despite some funding challenges in extending coverage. In contrast, in Enugu, the DRFs shifted back to the faith-based system, which continues with limited success without further funding (Paired Case 3, Case 17). Without financial commitment from the government of Nigeria, community support is key for sustaining HSS interventions. Although programmes have pushed for states to develop costed budgets, sustainable exit plans and allocations to support certain initiatives, FCDO typically provided more than 90% of the overall programme budget, with GoN typically contributing around 7-10% or nothing in some cases (See Annex G, 'Programme overview' tab, 'Co-financing' column). It is therefore not surprising that the government of Nigeria is unable to sustain programme interventions to the level supported by FCDO after programme closure.

The Emergency Transport Scheme (Case 2), facility health committees and ward development committees (Case 8) were all sustained by drawing on the support of community volunteers post programme closure.

"Most important factors are resilience of the community – even with nothing, you can do something for yourself, so if [the community] have done nothing [about addressing an issue being promoted by the programme], it is a red flag." - Implementing partner, national-level senior staff

"It is really clear to me now that you have to involve the community right from the start. When people feel like they are part of the planning, they are more likely to support it and keep it going. Programmes that can adapt to what is actually happening on the ground always do better than those that try to follow a rigid plan." - Implementing partner, Kano

Engaging civil society for accountability and programme longevity

Across all thematic areas, community support was an essential driver of acceptance and sustainability of HSS programming. Continual discussions with stakeholders in communities helps when there is cultural resistance, which arises when policies conflict with people's beliefs. Discussions about medical issues such as antenatal care, routine immunisation, HIV/AIDS and family planning have helped communities navigate concerns and find common ground. Routine immunisation and family planning initiatives were initially opposed by Islamic leaders in northern Nigeria due to religious and cultural reasons. However, discussion sessions helped reframe family planning from a broader health perspective, which made it more acceptable. Religious leaders became advocates on the importance of these issues for communities. This strategy was effective in shifting perspectives, increasing acceptance and improving uptake rates by disseminating information through trusted structures. Traditional leaders in Kano shared that they now 'collaborate with religious leaders, like the imams, who help spread important health messages during mosque gatherings, Friday prayers, weddings and naming ceremonies.' This engagement allowed them to change their perspective on family planning, while the programme also changed their approach to family planning and improved uptake rates. Without the collaboration, uptake rates would likely have been lower.

The training and incorporation of traditional medical practitioners, particularly birth attendants, into programming have helped healthcare service delivery align with trusted local practices. This approach has made the services more accessible and has increased practitioner knowledge. Excluding traditional practitioners could have created friction between powerful local leaders and modern 'Western' medical practices. Community support is essential to the sustainability of initiatives after programme closure. In the absence of government funding, community volunteers and leaders have continued implementing initiatives such as the Emergency Transport Scheme (Case 2) and supporting mechanisms such as KanSLAM, which hold government to account (see Case 7). Reliance on volunteers taps into local resourcing and shows alignment with community interests.

PATHS2, MNCH2 and Lafiya extensively supported KanSLAM and other state-level accountability mechanisms (SLAMs) to build effective partnerships with local third parties to advocate for community health needs and hold authorities accountable. Leveraging engagement and strong partnership with local third parties for advocacy and accountability has been essential for influencing LGAs to prioritise local health needs, sustain pro-health measures and improve health outcomes. This has helped ensure that gains in government capacity and progress towards pro-health measures are sustained.

EQ1.3 What examples are there of effective health systems strengthening in UK programmes in Nigeria?

We identified a series of paired cases to analyse how different contextual factors influence different outcomes in health systems strengthening initiatives. Policy initiatives are difficult to evaluate due to the lack of counterfactuals. However, cases in which the same FCDO programme was implemented in different states with different outcomes present a quasi-experimental setup for comparison. We identified outcome differences using available secondary data and then identified differences in contextual factors through thematic analysis of primary and secondary data.

These positive cases referenced throughout the findings section of the report are listed in Table 9 below.

Table 9: Interventions that worked well, by location

Case #	Intervention	Location
Case 1	Institutional capacity-building - Schools of Nursing certifying bodies	Northern states
Case 2	Emergency Transport Scheme	Jigawa
Case 3	Training traditional leaders and healthcare workers	Northern states
Case 4	Change Agents Programme	National
Case 5	Support to the National Health Act (NHA)	National
Case 6	Support to the Basic Health Care Provision Fund (BHCPF)	National
Case 7	Kano State-Led Accountability Mechanism (KanSLAM)	Kano
Case 8	Ward Development Committees (WDCs)	Kano
Case 9	Distribution of health commodities through public and private sectors	Enugu, Kano, Jigawa
Case 10	Condom social marketing (SFH)	National
Case 11	*Waqf* ethical finance initiative	Muslim communities in northern States

Case 1: Institutional capacity-building - Schools of Nursing certifying bodies

The W4H programme was designed to address a systematic shortage of qualified female frontline healthcare workers in northern states. It addressed these shortages through institutional capacity-building, working to set up Colleges of Nursing and Midwifery and working at the federal level to loosen the minimum requirements so that more young women from rural areas in the north could enrol. Those trained through this programme had to work in their communities for three years before being able to move on to other areas, allowing the training to target the specific needs of the community members. The number of skilled birth attendants in Jigawa and Kano went up by over 5% during the period (see Annex K, Figure 10).

This approach stood out for identifying women from communities where these carers were most needed and in catering to these needs, successfully remedying gaps in skilled healthcare workers and training them to respond to needs in those specific areas. One former senior staff from the implementing partner, now based in Jigawa, explained that “the foundation programme [...] requires communities to identify young girls that are trainable to qualify as nurses and midwives and later return back to their communities to work”. The training programme considered the future repercussions of such training on local needs. The enhanced sustainability of encouraging the trained staff to work in their communities where maternal care was lacking avoided the movement of qualified staff to better served areas. It also ensured that frontline medical workers had contextual and cultural understanding of these communities. Thus, the design of the training focused on retention of staff and the long-term impact of their training, especially on local care recipients rather than simply increasing their skills. It remained consistent over time, leading to similar quality of training for staff attending these colleges.

Case 2: Emergency Transport Scheme

The Emergency Transport Scheme (ETS) provides emergency transport in hard-to-reach areas for pregnant women to reach delivery facilities. It currently operates in several states including the target state of Jigawa. ETS was piloted under PATHS1 and supported further by PATHS2, PRRINN-MNCH, and MNCH2. The Gates Foundation has replicated the model in other states, and our respondents indicated there was interest in bringing the model to countries like Ghana and Zambia. The transportation is free and every ward in the state is connected. The drivers are community volunteers trained to handle pregnancy and paid in the form of a voucher upon arrival in a facility. ETSs have been an essential solution to overcoming transportation challenges that prevent access for women and children to maternal and newborn health care during emergencies in rural communities (Oguntunde et al., 2018). Business cases show that these programmes thought about exit strategies for the scheme at inception, demonstrating a successful intentional engagement of local community structures and incorporation of local gender dynamics into HSS programmes.

The ETS scheme **leverages community organisation and knowledge to improve the access to healthcare enjoyed by pregnant women.** As a result, women experience fewer complications in

childbirth as they are more regularly admitted to the hospital in time for delivery. It also relies on community knowledge, with drivers servicing their own communities fostering trust and accessibility. One example of a driver who kept track of pregnant women's expected due dates to anticipate transport needs.

The **voucher system provides an incentive for drivers and ensures the sustainability of the ETS** in the long-term, so volunteers do not run out of resources to continue their services. The vouchers being redeemed through state funds also ties the scheme into a more centralised organisation which ensures its funding while sourcing staff in communities. The way the scheme was developed also shows intentional adaptation of the programme to community structures with understanding of gender dynamics in the area, as it worked with the SMI (see above). There is also evidence in business cases that the exit strategy surrounding this scheme was already thought about at inception.

Case 3: Training traditional leaders and healthcare workers

Certain programmes, notably MNCH2, went the extra step of training religious or traditional leaders and healthcare workers on certain medical issues. These included Ante Natal Care (ANC), Routine Immunisation (RI), HIV/AIDS, and Family Planning (FP). The training of traditional leaders on the one hand has sensitised these leaders on the importance of these issues and reduced resistance to certain practices, allowing for better service delivery. For example, routine immunisation was originally rejected by Islamic leaders in northern Nigeria, as were family planning initiatives. However, these training sessions allowed for common ground to be found in the reframing of family planning from a broader health perspective and insisting on the importance of these issues for communities. This strategy was effective in shifting people's perspectives and making this care more acceptable while disseminating this information through trusted structures, leading to better acceptability and uptake rates. Similarly, the training and use of traditional medical practitioners has allowed for healthcare service delivery to align with already existing trusted practices making the services more accessible to people and increasing the knowledge of the practitioner.

Case 4: Change agents

The Change Agents Programme (CAP, 2001-04, £1.8m) was developed with support and involvement of the FMoH and designed to promote healthcare and immunisation reform through training selected individuals. Participants in CAP went on to found HERFON (Case 15) and its work continued through the HERFON phases.

CAP supported the development of key health care sector policy and legislation at federal level, including the first National Health Sector Policy under democratic government and a draft National Health Care Bill. The PCR noted that 'The immediate impact of the Project has been great, both in national health policy development, advocacy for change, research and analysis, Governments' improved impetus to take on the change agenda; the institutionalisation of the Change Agent Movement into HERFON and increasing State government commitment for reform' (p.6).

The influence of CAP agents was both transformational and sustained; we encountered a half dozen programme alumni in senior positions in both federal and state government, implementing partners and CSOs (as well as one member of our evaluation team), and they mentioned other alumni at NGOs and DPs. The CAP gave mid- to senior-level stakeholders in the Nigerian health system a network and common language to discuss health reform, or as one implementing partner respondent described, 'the nature of that is that it is ultimately transformative for the institution, and a revolution for the ecosystem.' The only downside to the CAP is that it has not been refreshed, and these individuals are now retiring; see Recommendation 3.

Case 5: Support to the National Health Act (NHA)

Several FCDO programmes, including the Health Reform Foundation of Nigeria (HERFON), which led the broader Health Sector Reform Coalition (HSRC), and PATHS2, provided advocacy and support for the passage and implementation of the National Health Act (NHA). The NHA started as the National Health Bill in 2000 and was passed into law in 2014, spanning four election cycles which required renewed advocacy at each change of administration. The Act established a National Health System and provided a framework for its regulation, development, and management. The Act then needed to be passed by each state. Subsequent FCDO support under PATHS2 assisted focal states to develop SSHDPs, which were aligned to the NSHDP.

Enugu passed the National Health Insurance Scheme (NHIS) Bill into law in 2010, aiming to provide affordable healthcare services to civil servants in the state, and passed the Enugu State Health Reform Bill in 2017, which aimed to strengthen health care delivery through significant reforms including the Enugu State Universal Health Coverage Agency.

Jigawa State established the Jigawa State Contributory Healthcare Management Agency (JICHMA) in 2019 and began implementing the federal government's Basic Health Care Provision Fund (BCHPF) in nine LGAs.

Kano passed the State Contributory Healthcare Scheme in 2016 and set up the Kano Contributory Healthcare Management Agency (KSCHMA) through the support of FCDO programmes.

A review of the NHA by Croke and Ogbuoji (2024) found that 'nine years after the Act's passage, disbursements have been sporadic, and implementation remains incomplete…the Act's governance reforms led to conflict between health sector agencies…horizontal and vertical fragmentation of authority within the sector impeded coordination, electoral cycles led to frequent turnover of sectoral leadership, [with no] support from senior politicians' (p.22.).

A case study commissioned by FCDO about the NHA found that "Implementation of the NHA has been slow…with poor progress blamed on lack of leadership and interest from successive Federal Ministers of Health and Presidents." (Tulloch et al., 2017). The case study identified lack of funding for implementation committees, tussles over management of funding and poor communication between the Ministry of Finance, Ministry of Health, NHIS, and, and lack of political gain from implementing the Act as the main obstacles to implementation. "In the absence of federal government funding, donors are now providing support to pilots of the domestication and financing provisions of the Act to go ahead in Abia, Niger, and Osun states" (*Ibid.*).

The end of FCDO funding to HERFON programmes, including APHCR (2012-2020), and HERFON's struggle for sustainability (see Case 15) may have contributed to the slow and weak implementation of the NHA after its passage. Nevertheless, the NHA:

- Symbolised the need and momentum for reform; its passage represented a watershed moment in the reform process, and provided primary legislation for key policies including PHCUOR and the BHCPF (see cases below), which are key funding mechanisms for PHC in Nigeria,

- Elevated the National Council on Health from an advisory body to the highest policymaking body, giving it a role in current initiatives like the Sector-Wide Approach (SWAp), and

- Gave citizens and organisations standing to sue federal and state government for non-compliance.

Case 6: Support to the Basic Health Care Provision Fund (BHCPF)

The Basic Health Care Provision Fund (BHCPF) was established under the National Health Act and launched in 2019. It provides funding for essential health services, facilities, and health insurance coverage for poor and underserved Nigerians. It is funded by the federal government, which has committed 1% of the Consolidated Revenue Fund, alongside development partners and other approved sources; participating states are expected to contribute 25% counterpart funding towards PHC projects. 50% of its funding is used to provide national health insurance, while most of the rest (45%) is used by the NPHCDA to support primary healthcare centres, with the remaining 5% going to the National Health Emergency and Epidemic Response.

MNCH2 pivoted to support the roll-out of the BHCPF in four states in its final year and provided technical assistance to the Federal Ministry of Health and State Contributory Health Management Schemes. The MCNH2 PCR found that "the supported Local Government Areas (LGAs) and states have had demonstrable improvements in their governance, resource mobilisation and organisational planning and budgeting exceeding programme targets" (p. vii). The MTR found that Lafiya has contributed to 'BHCPF fund releases consistently meeting milestones…and four states to surpass the Abuja Declaration target of allocating 15% of budgets to health' (p.8). Lafiya has also supported disbursement of BHCPF funding at the facility level, and frontline healthcare workers in both Jigawa and Kano confirmed that this had made an impact.

"The BHCPF has greatly improved the operations of health facilities – provision of drugs, recruitment of ad hoc staff, renovation of facilities, provision data tools etc. Each participating facility (one per Ward) receives

funding, which is additional to the regular budget from two sources. (i) direct facility financing of NGN 300,750 per quarter through the National PHC Development Agency channelled through the State PHC Agency and (ii) capitation payments of NGN 570 per enrolee for vulnerable groups – pregnant women, children under 5 years, persons with disability, the elderly and the very poor; registered in each facility." (FHCW in-charges, Kano).

However, several stakeholders questioned the structure and effectiveness of the BHCPF. One implementing partner noted, "When they set up [the BHCPF] it was typical Nigerian style. So much overlays and everything and how the money was allocated and to the periphery was hugely complex and basically siphoned off one way or other..."

The BHCPF is still being supported by Lafiya and it is too soon to judge its long-term effectiveness, but it represents a much-needed funding mechanism for states and PHC facilities.

Case 7: Kano State Led Accountability Mechanism (KanSLAM)

KanSLAM is a collaborative body between government and civil society organisations, responsible for accountability and advocacy for better health policy and influencing health legislation and policies for improved health outcomes in Kano state (Options Consulting, 2018). PATHS2, MNCH2 and Lafiya set up state led accountability mechanisms in all FCDO focus states, including Kano and Jigawa, and extensively supported and collaborated with KanSLAM to improve government capacity in Kano state.

KanSLAM delivered effective and well-tailored training and capacity-building to the right personnel, with the training well-resourced and tailored to the needs of targeted officials. Under PATHS2, MNCH2, and Lafiya, the programmes supported KanSLAM in identifying and addressing capacity gaps in the Ministry of Health and related agencies. They identified that there was a poor release of funds due to the weak capacity of officials responsible for writing memos and carrying out procedures to request funds from the treasury, for which they provided tailored training, securing funds for family planning and other health services. KanSLAM is continuing to work to fill capacity gaps in the system to advance its training and capacity-building efforts.

"The allocation for family planning was NGN 200Mn in this year's annual budget, but up to July no funds have been released from the budget. It was through our advocacy and engagement with the government that we discovered [that] staff were not able to write memos to get funds from the treasury. We linked them with those who can support them [...]. Their capacity has been built [...] and they are writing memos to access the funds for family planning and other activities." - Senior staff, state CSO, Kano

In KanSLAM, the right leadership was in place in MDAs with political will for change and a committee with a clear mandate and resources to carry this out. With support under PATHS2, MNCH2, and Lafiya, KanSLAM advocated the state governor to take initiative to prioritise the health sector and revitalise primary and secondary health facilities. KanSLAM influenced the government to improve decision- and policymaking in health and increase budgetary allocation to the health sector. Persistent advocacy led the state to increase annual state budget allocation to the health sector, with health representing the second highest sectoral allocation in the state budget. As a result of engagement with the Ministry of Health and Ministry of Budget and Planning, KanSLAM also secured a budget code for family planning. The committee is designed to be led by co-chairs from both the government and CSOs, which ensures strong collaboration and synergies leveraged through trust and confidence between the private and public sector. KanSLAM is continuing to deliver on its mandate to overcome challenges of advocating for budget release, capacity gaps within the system despite training and capacity-building efforts, and accountability issues due to political inference.

"SLAM has been part of government planning […] including sector performance reviews, which shows the confidence and trust that government and non-government actors have for each other in working together to achieve a common goal. With training and capacity-building provided by FCDO for both parties, there is better understanding of […] how their roles are complementary." - Senior staff, state CSO, Kano

KanSLAM successfully leveraged collaboration and strong partnership with local third parties for advocacy and accountability in line with the needs of local people. KanSLAM closely engaged communities in Kano to identify the needs of local people and advocate for changes in government decision-

making and policy that are tailored to serve these priority areas. It leveraged and built on existing structures for community engagement, including the National Primary Health Care Agency, Ward Development Committee and Village Development Committee to collaborate on community sensitisation, awareness creation, town hall meetings, citizen input and other areas of community engagement. The programmes worked to build the capacity of CSOs in Kano, which are considered essential to sustaining reforms, especially in driving voice and accountability.

"When [...] talking about accountability and what SLAM is able to do, [...] you have to consider what does the community need as far as healthcare is concerned. [...]. For many years, SLAM [has been supported by] PATHS, Lafiya and other partners, has been [working to] find out what does the community need to come into the budget, [and influence what] the government is providing for different interventions and which communities are targeted." - FGD with KanSLAM members, Kano

Case 8: Ward Development Committee (WDC) in Kano

"We, the WDC, are a group of about 15 people. Our team is made up of all sorts of individuals—teachers, artisans, retirees—everyone plays a part. Our main job is to find ways to gather resources for our community and ensure people know about the health programmes that benefit us. We also keep an eye on the government's budget, especially when it comes to health programmes and developing our local clinics. We act as the bridge between the community and the health centres, making sure everything runs smoothly. WDC is a requirement of the National Health Policy, in order to create a platform for organising and managing health activities in communities – both partner and government-funded programmes. The WDC composition comprises not less than 15 people from various categories of people in the ward – teachers, artisans, retirees, representatives of women, and youths, including persons with disability. These are people who are trusted and believe they can represent their people. We have our aims and objectives: Provide accountability platform in our wards Mobilise resources – financial and human to upgrade health facilities As a means of sensitisation and mobilisation towards achieving all these programmes that come to our ward We serve on budget planning, and tracking and Annual Operation Plan of LGA on health We are an integral factor of the Basic Health Care Provision Fund …we are signatories to the facility bank account Part of planning meetings and quarterly reviews of the performance of our facilities In fact, WDC is the sole mediator between the facility and the community. There is a requirement that at least 45% of the membership of each WDC will be made up of women." - WDC members, Kano

Case 9: Distribution of health commodities through public and private sectors

Building on the work on commodities by PATHS1 from 2002, the Health Commodities Programme (HCP) was launched in 2005 to focus on the timely procurement, supply, and distribution of health commodities including essential vaccines, medicines, and equipment. Other programmes, including ENR, SUNMAP, and UNITED, also focused on supply of programme specific essential health commodities. PATHS2 incorporated previous interventions of HCP into its overall programme of systems strengthening.

Programmes took different approaches to the distribution of health commodities, broadly working either through the private sector (ENR, SUNMAP, UNITED) or through government drug management agencies with procurement, warehouse and distribution hubs typically known as Central Medical Stores (PATHS1, HCP, PATHS2, SUNMAP2). Faith based organisations had parallel structures.

HCP and PATHS2 used Crown Agents to procure essential commodities used to capitalise drug stocks in Central Medical Stores and at the facility level in focal states, including Enugu, Kano, and Jigawa. This was accompanied by considerable system strengthening technical assistance and empowerment of Facility Health Committees aimed at ensuring revolving of funds and special measures to assist the poorest. Whilst the choice of Crown Agents was in line with the country agreements with the UK government, its systems were such as to create considerable delays between establishment of need and actual supply. Their reputation was built on probity rather than speed of response.

The HCP PCR found that "HCP has had a considerable impact. Making drugs, commodities and equipment available in a large number of facilities in the programme states has encouraged a large and sustained increase in OPD attendance. The single most-quoted reason for this is the availability of drugs, and to a

lesser extent, equipment. The PATHS[1] programme objectives would not have been realised without the vital kick-start of HCP*" (p.5).*

ENR supported the development of a private sector actor, SFH, which developed and marketed Gold Circle brand condoms as well as other family planning products aimed at the mid-market. The PCR found that "In the final years of ENR SFH made a major push to get Gold Circle condoms into shops in rural areas in the 8 ENR states [including Enugu but not Kano or Jigawa], with impressive results" (p.6) and almost 95% availability. See Case 10 below for further details.

SUNMAP (2008-16) successfully distributed long-lasting insecticide-treated nets (LLINs) to every household in targeted states in Nigeria and worked with other donors to develop private-sector markets for malaria commodities, using a Making Markets Work for the Poor (M4P) approach. It also improved government capacity at the federal level in logistics and commodities tracking and for case tracking in 10 targeted states including Enugu, Kano, and Jigawa. The PCR found that SUNMAP contributed to the decline in child deaths, especially over 2010-15 (p.2). A follow-up programme, SUNMAP2 (2018-21), struggled to get off the ground due to COVID19 and FCDO budget cuts and was closed early.

SUNMAP used Crown Agents to procure malaria commodities but had significant delays in procurement and clearing customs; Crown Agents stated that it was unable to procure from Nigerian suppliers due to EU procurement laws (PCR p.12). SUNMAP worked with partner states to develop logistics supply systems and transfer malaria commodities from CMS to health facilities.

The SUNMAP PCR noted that "The target on distribution through retail outlets was not met. Since 2013, the commercial sector component of the programme has been implementing a revised strategy using the M4P approach to support LLIN retail market development with mixed success. A major on-going challenge is the reluctance of the private sector to engage in the marketing of bed-nets in the face of the replacement campaigns that distribute free bed-nets and leakages of nets from these campaigns into the commercial sector."

SUNMAP2 took a different approach to distribution, working with the Global Fund, the World Bank, and the GoN to procure supplies and send them to CMSs. They relied on the government's Community Health Influencers and Promoters (CHIPs) to distribute anti-malarial medicines door-to-door.

The SUNMAP2 PCR stated as a lesson learned: "parallel supply chains for malaria commodities and other essential medicines are a key constraint to greater effectiveness and efficiency of the commodity supply chain. While SUNMAP2 attempted to address this issue through facilitating supply chain integration, it remains a complex matter that will require more time and resources than the programme had, as well as close collaboration with other partners… FCDO's health system strengthening efforts (Lafiya) should collaborate with the Global Fund and other partners to take forward this workstream (iv)".

UNITED (2012-2019) was run by a consortium including Crown Agents. They procured donated medicines for a Mass Drug Administration once or twice a year against four neglected tropical diseases in northern states including Kano. UNITED built capacity of federal and state government officials to integrate supply chains and developed Standard Operating Procedures for stock control, storage, transportation, delivery, receipt, inventory management, and recovery of drugs from CMSs to community level facilities. The programme also trained community drug distributors and health workers in supply chain and logistics management, including introducing reverse logistics to recover and redistribute unused drugs.

The PCR found that UNITED "exceeded the original milestones, delivering over 15m more treatments than planned, and making significant contributions to elimination and control of the targeted NTDs. The programme has demonstrated the success of an integrated approach to procurement and supply chain of drugs and delivery of MDA targeting multiple NTDs. This has led to improved coordination, cost savings and efficiencies in activities, and an increased awareness of NTD control within government and other stakeholders" (p.2).

Analysis

There is general agreement that the DRF concept, complementing not replacing retail pharmacies, is a valuable one in facilitating access of affordable drugs for the poor. It is also a key element in increasing utilisation at primary care level and can form part of facility financing and staff incentive strategies.

It is also clear that multiple strategies can be utilised to ensure that commodities such as bed nets and condoms are readily available at affordable prices with a "safety net" of free availability that is well targeted and does not overly disrupt the paying market.

The key question is whether the creation and support of government agencies for procurement and distribution is more efficient than use of contracts with private sector organisations. For example, the RBF model promoted by the World Bank favours local purchasing by government facilities for DRFs from retail pharmacies.

The theoretical argument for government organisations is strong. Government can make use of bulk purchasing to drive down prices and pass-on the benefits of this to the poor both directly through DRFs and indirectly through competitive pressure on retail pharmacists. However, in practice there has been a repetition of the cycle of capitalisation-decapitalisation-recapitalisation with resulting additional costs and inefficiencies.

The argument for the use of the private sector also has merit. By its nature a private market is able to react more rapidly to a new source of demand and may be particularly relevant where public health messages can help to create demand. However, where demand is weak and profits cannot be made (in poorer communities) effective supply may not be sustained (and health needs not met).

"We have considered working with private sector on a number of fronts. The perception that all warehousing should be handled by the private sector is debatable – I do think that if the governments are supported that warehouses can be managed – however we also take advantage of private sector to distribute commodities in some states – for instance Lagos and the southern states. We should explore all the options that are available, PPP, strengthen the government's systems to ensure they can manage the facilities better." – Development partner, federal level

Thus, the key lessons learned are around hybrid organisations and arrangements. Government Drug Management Agencies need to have sufficient financial autonomy and protection from politically inspired leakage. Government storage and distribution may provide an efficient means of last mile supply to the poor for otherwise private sector arrangements. In other words, make use of the private sector but be clear about the objectives of an intervention and the protection of the interests of the poor.

Case 10: Condom social marketing

The Society for Family Health (SFH) increased awareness and demand under condoms and other modern family planning methods under the ENR programme, and produced and marketed the Gold Circle brand to fill a gap in the market, reduce the transmission of HIV. The ENR programme received an A+ in its final year, with the PCR noting 95% urban and 93% rural access to condoms by the end of the programme. The product development and marketing of the Gold Circle brand were successful, and 15 years later SFH has spun off an NGN 5bn private company - SFH Access Limited – which focuses on production and supply of condoms, oral contraception, and emergency contraception.

Factors necessary for success: Awareness of and demand for condoms was promoted through ENR's 5/5 and 4/4 knowledge campaigns, where they sent workers house to house in Akwa Ibom, Nasarawa, and Ogun states. SFH also marketed Gold Circle, including the premium Flex brand, through road shows, TV adverts, and through wholesalers and merchandisers. The National Survey of HIV/AIDS showed a steady increase in accurate knowledge of HIV prevention from 2013-15 amongst both men and women, with 41% recognising that 'using a condom every time' could prevent infection, as well as acceptance of condom use. An independent evaluation found that males were 36-73% more likely to have used a condom in ENR supported states compared to four non-ENR supported states.

Gold Circle condoms were available to the majority of consumers. SFH's Measuring Access & Performance (MAP) survey found that Gold Circle condoms were available for sale in at least one shop in 91% of local government areas, including 85% of rural and 95% of urban areas.

Contextual factors contributing to the success or failure

Gold Circle condoms were designed to target the bottom of the market, although SFH realised that their price point might put them out of reach of the poorest 25% of the country, who would either use free or inferior quality condoms or go without. SFH sold over 126 million condoms, just short of its projected 132 million target, despite a competing brand, Kiss, entering the market, and raising prices twice. At programme close, the price included a 56% subsidy; a major contextual factor for this was the devaluation of the naira, which lost over 50% of its value in 2016. (ENR PCR and logframe).

Case 11: Waqf ethical finance initiative

Waqf**,** which in Arabic means 'restricted,' has been an innovative, community approach to easing financial constraints to healthcare based on an old cultural concept. Waqf is an Islamic charitable endowment, which has been used to pool resources from community leaders and zakat, or Islamic donation of a proportion of community members' wealth to charitable causes, to fund healthcare for the people in poverty. It overcame the challenge of identifying those most in need, as the community was responsible for contributions and invested in delivering services effectively. There have been efforts to incorporate these into state health spending through the Kano and Jigawa State Contributory Healthcare Schemes (KSCHMA and JICHMA), making it complementary to BHCPF, and local governments have increasingly financed healthcare through this programme. Nevertheless, the initiative has faced challenges due to a lack of trust or confidence by the Islamic and further local government support has been needed to build up and ensure the sustainability of the system (Ahmad, 2019).

EQ1.4 Is there evidence of health systems strengthening interventions that appear not to have worked well and why?

We have identified cases of HSS initiatives that didn't work well, based on examples given through our primary fieldwork. This was an inductive process, in which cases were built up and supported by multiple primary respondents from different categories, supported by secondary source data. We aimed to build up at least one negative case for each of the five thematic intermediate outcome areas identified.

Few, if any, FCDO health systems strengthening interventions in Nigeria were failures, but several provided mixed results that can generate lessons learned. We assessed interventions as having not worked well if we found insufficient evidence from primary and secondary sources that they were transformational or sustained. Interventions that were transformational but not sustained, or vice versa, can appear in this section. These negative cases are referenced throughout the findings section of the report, and are listed in Table 10 below.

Table 10: Interventions that did not work well, by location

Case #	Intervention	Location
Case 14	FCDO support to health insurance schemes	National
Case 15	Health Reform Foundation of Nigeria (HERFON)	National, chapters in Enugu, Kano, Jigawa
Case 16	Support to District Health Systems and Gunduma Councils	Enugu, Kano, Jigawa
Case 17	Central Medical Store (CMS)	Enugu
Case 18	Promoting knowledge of disease prevention and surveillance, UNITED programme	States including Kano
Case 19	Demographic Health Information Survey (DHIS)	National, support to Enugu, Kano, Jigawa

Case 14: FCDO support to health insurance schemes

Context

Health insurance is an important part of universal health care, its aim is to ensure that healthcare services are affordable for all citizens, including the poorest, by pooling risk across a large population, and guard against catastrophic expenditure by families facing chronic illnesses and disabilities. Around 80% of healthcare expenditure in Nigeria is out of pocket, a figure which has risen over the portfolio and is currently at amongst its highest level (See Annex K, Figure 8), and 70% still finance their healthcare through out-of-pocket expenditure (Alawode and Adewole, 2021).

The NHIS was launched in 2005, and piloted by a rollout to federal government employees. Following from state demand, social health insurance systems were created by legislation, including the Enugu State Universal Health Coverage Scheme (ESUHCS) in 2017, Jigawa Contributory Health Management Agency (JICHMA) and Kano State Contributory Healthcare Management Agency (KSCHMA) in 2016.

A study in Enugu found that 78% of respondents found the NHIS scheme improved their access to care, and had marginally improved access to medicine over the years (Uguru et al., 2024). However, in 2018 Nigeria Demographic and Health Survey estimated that only 3% of people aged 15-49 nationally had any form of health insurance coverage (Awosusi, 2022). Pillah (2023) and others have found that the “objective of achieving full coverage in the country is still very far from [being] achieved” with problems including “delay in payments to health facilities by HMOs, inadequate public awareness, public apathy, poor management, rural exclusion, lack of standard facilities, inadequate medical personnel and poor services” (p.36). The NHIS was replaced by the National Health Insurance Agency (NHIA) in 2022, which moved the target for providing universal healthcare to all Nigerians to 2030. NHIA manages part of the BHCPF (Case 6) to provide subsidised healthcare to vulnerable people.

FCDO interventions

FCDO programming provided limited support to Nigerian health insurance schemes over the portfolio period. PATHS1 supported the National Policy on Health Care Financing, which aimed at reduction of out-of-pocket expenses in health including the expansion of the coverage of the NHIS. HERFON supported both the NHIS and Community-Based Health Insurance (CBHI). PATHS2 provided capacity development for the NHIS, and supported the development of health insurance and pre-payment mechanisms, including creating a framework for the country-wide expansion of CBHI schemes (MTR p.24). MNCH2 furthered this work in northern states, providing technical and financial support towards State Contributory Health Care Schemes including Kano and Jigawa. Lafiya has been supporting the development of the NHIA accountability framework, which clarified responsibilities of stakeholders involved in the emerging national health insurance system, and how they will be held accountable (AR 2022 p.17), as well as frameworks for state-level accountability.

The Lafiya 2022 AR found that “despite GoN prioritising national health insurance as a critical driver for improving access to quality health services for the poorest, progress has been slow and difficult due to limited technical capacity in most states, as well as limited fiscal space” (p.6).

Jigawa Contributory Health Management Agency (JICMA)

“Health care financing, [in Jigawa] there is the contributory management agency which was set up by adapting the national health insurance law to the state context. The agency was also supported with the development of road map and communication strategy. Enrolment has started with government employees but there are still a lot of things that need to be done to get more enrolled, especially those in the informal sector. The premium rate even with the inflation is not affordable by many persons. There are also plans to get government to fund the coverage for vulnerable groups through an equity fund that will also generate funding from philanthropists.” (IP, Jigawa)

“In Jigawa State, only about 10% of the population is covered by any insurance. More than 90% of the uninsured are unable to pay contributions for social health insurance.” (GoN, Jigawa)

Kano State Contributory Health Management Agency (KSCHMA)

"We supported the establishment of 3 new agencies in the State Ministry of Health: State Contributory Health Care Management Agency – there was an attempt to establish the agency before my time – but the term 'health insurance' was controversial in Islam, so it was change to 'Health Care Contributory scheme'. There was advocacy to the Ulamas, operational guidelines were developed …it is working work well. As at the time I left, most civil servants were enrolled. [My predecessor] established three new agencies during his time and MNCH2 helped to institutionalise them. These include: State Contributory Healthcare Management Agency (SCHMA) – Which Ulamas changed from NHIS to contributary scheme for religious reasons." (GoN, Kano).

"The issue of out-of-pocket payments for health services, which has been a major problem that deter people from seeking health was tackled by the CSO. With sustained advocacy in collaboration with other partners, we were able to convince the government to establish an agency, which of course aligns with the federal government directive to establish state health insurance schemes. So, the Kano State Contributory Healthcare Scheme was established to address the financing of healthcare for the general population of the state. And to demonstrate the level of engagement the CSO, a member of the SLAM is part of the Board of the Kano state Contributory Healthcare Management Agency.

"The State Contributory Healthcare Scheme, …when Kano started it, it was not mandatory for states to establish health insurance schemes. MNCH2 helped the state to develop a Road Map, engaged stakeholders, in particular, the labour unions, CSOs, State House of Assembly etc to reach a common goal. The law was passed in 2016, access to care commenced in 2017. About 90% of civil servants are now enrolled, the organised private sector and informal sector workers are being mobilised. The agency to manage the scheme – KSCHMA (Kano Contributory Healthcare Management Agency) is also now fully established through the support of successive FCDO programmes." Implementing partner, Kano

Case 15: Health Reform Foundation of Nigeria (HERFON)

The HERFON programmes (HERFON1, HERFON2, and APHCR) achieved transformational changes, including supporting the passage of the National Health Act in 2014, but the organisation has struggled to sustain itself outside of development partner funding, especially at state level.

The **HERFON** initiative aimed to advance and advocate for broad sector reforms to drive improved health outcomes for Nigerians. It collaborated with stakeholders to carry out health policy advocacy, capacity-building and generation of evidence to influence policy decisions on health reforms at local, state and federal levels. HERFON1 set up a federal lobbying and accountability mechanism, while HERFON2 sought to establish chapters in each of the 36 states in Nigeria. APHCR supported the implementation of NHA-related government policies including Primary Health Care Under One Roof (PHCUOR) and Free Maternal and Child Health (MCH).

Questions about HERFON's sustainability had been consistently flagged throughout the programme phases. The PCR for HERFON1 found that 'fundraising is a critical priority, particularly given the risks of over-reliance on DFID funding. A broader funding base is important both for HERFON's independence and on sustainability grounds. This is true both for HERFON's work at national and Federal levels, and for Zonal and State chapters" (p.6) … "HERFON efforts at executing its self-sustaining strategy can best be described as 'some motions and no movement'" (p.27). The HERFON2 PCR found that "of serious worry was also the fact that despite being very much aware of the need to be self-sustaining, HERFON had [not] taken bold steps to make the leap from depending on donors", scoring a B on the output for institutional, human, and financial capacity, with only 30% of funding coming from non-development partner sources at project end (p.7). The APHCR PCR scored the programme output around strengthening institutional sustainability a C and noted that "a lack of serious attention by HERFON to [sustainability], particularly in the final year of the project, leaves HERFON, after more than 10 years of DFID support, in a no better position than it was prior to the project" and identified that only 29% of funding came from sources other than DFID (p.5). Our evaluators noted that state HERFON chapters in Enugu and Kano had not met regularly and appeared to have been convened for the first time in a while to meet with the evaluators.

Despite HERFON's initial successes, the initiative increasingly suffered from lack of political will in leadership and misalignment between local, state and federal governments. Initially, HERFON played a crucial role in shaping key health policies, providing technical support to the Ministry of Health to draft the

National Health Bill, review the National Health Policy (2004), develop and implement the Health Sector Reform Programme (2004-2007) and implement the Primary Health Care Under One Roof (PHCUOR) integrating the financing and management of PHC services. HERFON conducted a series of town hall meetings in the six political zones on healthcare financing at community levels. The Advocacy for Primary Health Care Reform (APHCR) project achieved the establishment of State Primary Health Care Development Agencies. The passage of the National Health Act (2014) for health legislation and the regulation, development, and management of the health system is a major accomplishment of HERFON (see Case 14).

However, despite these initial achievements, HERFON has been increasingly unsuccessful at driving meaningful policy change. It increasingly faced the challenge of declining political commitment, and local- and state-level efforts became less well-aligned to and coordinated with federal government priorities. Several initiatives supported by HERFON at the local level were not aligned to the federal level and there was lack of autonomy and capacity at LGA level. For example, the state health law enacting the District Health Systems in Enugu was repealed by the state government to align it with the new federal structure, despite the DHS working well at the local level. The NHA had a negative effect on Enugu's health system as it dismantled the district health system developed under PATHS1. As a result, while advocacy activities remain active at the state level through 36 state chapters, efforts have weakened at the federal level. As these efforts require ample funds and resources, HERFON continues to struggle with lack of funding and financial instability and unpredictability, which puts activities and strong member engagement at risk.

"Convincing politicians at every level remains a constant struggle, and even when laws are passed, translating them into implementation takes time. It took four years for the National Health Act to kick in." - Implementing partner, national-level senior staff, Abuja

"Sustaining member engagement and financial stability has been tough, especially given the reliance on project-based funding. When projects dry up, so does the funding [which] makes it hard to keep everyone engaged. This financial unpredictability presents a significant risk to the continuity of HERFON's advocacy and operational activities." - Implementing partner, national-level senior staff, Abuja

HERFON had limited collaboration with CSOs, community groups or other local third parties and instead leveraged evidence-based tools for advocacy in health policy design and planning. It developed a performance measurement tool for tracking the establishment of the State Primary Healthcare Development Agency. It published three editions of Nigerian Health Review on a range of issues in providing equitable and accessible healthcare. It organised immunisation study tours to Egypt and Malaysia for religious and traditional leaders in Northern Nigeria to gain their support for immunisation, particularly polio eradication, following the widespread rejection of such services in the north. While these achieved some successes in improving budgeting, decision- and policymaking in health, HERFON had limited adaptations to the state context or tailoring to use community engagement and local accountability to identify and address the needs of people. There was also limited consideration of social inequalities in programme design and implementation to target vulnerable groups.

Case 16: Support to District Health Systems and Gunduma Councils

Context

The Constitution of Nigeria vests control over different parts of the health care system with three respective tiers of government – tertiary institutions with Federal Government; secondary institutions with State Governments, and primary health clinics and facilities with LGAs. In principle, funds for operations including staffing and running costs follow the roles. In practice, however, the arrangement is often referred to as 'fragmentation' since all three types of institution will typically be operating within a single State. The fragmentation can be further exacerbated by the presence of 'vertical' / disease specific programmes As observed elsewhere but Nigeria in particular, the complexities of organising better service provision in the health sector go beyond technical fixes to include political dimensions that require the proactive management of stakeholder interests[1]. And this was recognised as a risk during the District Health System (DHS) experiments in Jigawa and Enugu by PATHS and PATHS2.

Since states and LGAs are responsible for secondary and primary care services respectively, FCDO thinking was that structural integration between these two levels of care could overcome this challenge. This was the notion behind a District Health System, which has been championed by the WHO elsewhere in Southern and Eastern Africa. Under a DHS, all health care services are headed-up by a District Medical Officer and a team of senior staff with responsibility for all aspects of health care services and preventive programmes. Vertical programmes will operate under the local direction of the District Team. This arrangement facilitates a joined-up approach to planning and service delivery. Tertiary institutions typically have their own management arrangement, and faith-based institutions would accept the overall direction of the District.

Interventions

The PATHS1 leadership was well versed in the District System, with experience implementing in South Africa, and convinced of its advantages. They also judged that the LGAs were in practice dominated by the State Governor and Ministries at the State Level. They saw organisational fragmentation as a significant barrier to effective delivery of services and that at LGA level many staffing roles were not contributing to delivery.

Gunduma Councils – piloted in Jigawa and rolled out in other PRINN-MNCH States – and the District Health System in Enugu were an attempt to integrate primary and secondary health care at a sub-state level by grouping LGAs and a secondary institution together under common management. Gunduma Councils were created by the state legislatures of Jigawa and Kano with local input, managed by a health systems board, and following the political contours of the local Emirates. The District Health System (DHS) in Enugu was patterned on the Gunduma Councils in the Northern states, but did not have the same traditional grouping of LGAs. These structures centralised the planning of healthcare budgets, staffing, and administration across multiple LGAs. These structures emerged during PATHS1 (2005-2007) and were abolished in 2016.

Although respondents across all three states cited transformational changes as a result of this restructuring, these structures fell apart due to opposition from both state and local government authorities, and because they presented a challenge to the three levels of government as set out in the Nigerian Constitution. The operationalisation of PHCUOR also created State Primary Health Care Development Agencies with budget to fund PHC.

Information from KIIs

"There were a lot of pluses in the Gunduma Health System – drug revolving fund, management systems, quality of care, planning processes, PPRAA processes that is participatory peer rapid appraisal for action, integrated supportive supervision, safe motherhood initiative …these were all established in the Gunduma system, but it also had its issues." (GoN state official, Jigawa).

"The Gunduma Health System was designed to streamline health services at both state and local government levels. Reflecting back, it was the best system for a state with limited capacity at the LGA level. The LGAs were actively involved, ensuring that key health indicators were being addressed, and much progress was made. Looking back, the Gunduma Health System was an efficient way to provide health services, ensuring that all key indicators were attended to." (GoN state official, Jigawa).

"The main focus was on health sector reforms, which led to the establishment of the District Health System – the Gunduma Health System, which also recorded a lot of success depending on where you stand. I know what the health system was before Gunduma – most of our PHCs were in shambles, in terms of infrastructure, human resources, governance, HMIS. There was wastage, mass absenteeism and other vices. Gunduma made people to fall in line, as it led to decentralisation of health services.

This reform helped us to integrate primary and secondary care under one roof, though a lot more was achieved with PHC services than in hospitals. This was because the key players of the Gunduma were moved from the PHC services in the Ministry, as such much attention was not paid to hospital services. But overall, if you rank the performance of the Gunduma on a scale of 1 to 5, it is either 3.5 or 4. Most of the improvements where in HRH, HMIS, governance and also in the area of service delivery." (Senior official, Jigawa state government)."

"Considerable time and money was put into a restructuring of health sector governance in Jigawa since 2001. An important lesson is the importance of creating allies and managing resistance: health reforms risk creating resentment and lead to reversal if they reduce the powers and resources of state level ministries" (Tulloch et. al 2017, p.2).

"What happened to the Gunduma Councils? We got them established, we used cultural and traditional institutions, we even got the traditional name, Gunduma means district, we consulted with the local people. The issue with the Gunduma system was it was 100 years ahead in terms of perception and design of what is should be, the problem was that you have limited resources in terms of staff, infrastructure, all that." (GoN official, Kano).

Analysis

The championing of these arrangement by the DFID projects was based on the belief intellectually in the District System and the ability to carry the Governor and Health Commissioner with the changes. There is little evidence of a more thorough political economy analysis which might well have raised a number of red flags about threats to the power of existing institutions at all levels.

The system building-block activities of the programmes were much easier to implement within this structure and the success of these activities (e.g. DRFs, DHIS, skills training, etc) was associated with the Gunduma and DHS.

PATHS2 adopted a different approach of creating networks of service delivery irrespective of formal management arrangements and did not press the case for the District System in its championing of the National Health Act. Attention shifted to the concept of Primary Health Care Under One Roof (which included elements of the DHS / Gunduma arrangements) and was championed by National Institutions (NPHCDA and NHIF).

This provided the opportunity for reassertion of the power of LGA and State bureaucracies and the patronage they could exercise. The experiment with creating structures at odds with the constitution came to an end in spite of undoubted success across a number of building blocks.

There is a close to compelling argument that whilst the experiments did not last, they provided important learning about what a joined-up system looks like. However, our judgment is that if a prior and thorough PEA had been conducted it would have given rise to greater caution and the exploration of alternatives to structural creations.

Case 17: Central Medical Store, Enugu

Central Medical Stores are centralised state-level warehouses for drugs and other health commodities, usually run by the government. CMSs were supported by PATHS1, HCP, and PATHS2 in all three focus states.

In Enugu, after a strong start, the government CMS was beset with operational difficulties and indications of corruption by 2015 and is currently largely non-functional. Respondents from categories including the GoN, IPs, and CSOs, detailed ongoing problems with the government CMS, highlighting changes in political leadership, including a law that provided for an autonomous Drug Management Agency that was not operationalised; destockages, corruption, lack of personnel and capacity after the closing of PATHS2, lack of patronage even from other government customers. One state government respondent noted that the Enugu MoH "attempted to mirror PATHS 2's structure, from STL, logistics managers and M&E officers, assigning staff to shadow PATHS 2 personnel. But most of these staff were either moved to other departments or retired before they could really make an impact…only ten pharmacists [were] hired and trained."

FCDO supported the development of a parallel faith-based CMS in Enugu which a former implementing partner said "is a vital part of the drug supply chain in Enugu today." A government respondent said that the faith-based CMS was more successful than the government one because "they don't have that much bureaucracy…also their staff lasted longer in the same post."

Most primary respondents expressed reservations around building the capacity of government supply chains.

"We feel that donors get it wrong around supply chain, they are often focused around government systems doing supply chain. Even in the US – you procure supplies from the private sector. I really struggle when

donors / partners look at building supply chain – government can set the framework to do procurement arrangements but when it comes to managing that, it is the private sector who delivers. I would build the capacity-building of government on strategic purchasing, but not for the government to own warehouses, be involved in distribution. Even the US army uses third parties to move their stuff. Even under HCP. That mistake is still ongoing." - Implementing partner, ENR

"On ENR, DFID understood that for supply chain and commodity security, they needed to take a dual track approach – one that is private sector efficiency focused and one that is 'politically correct' and seen to support government desires, i.e. warehouses. Our support was on the private sector side, I don't know whether that was the conception but looking back now, they figured out that they have been managing the private sector side, if we continue the way we are doing, we will be here for another 20-30 years." Implementing partner, ENR.

"[Nigeria] has contraceptive logistic management systems which is in place to manage distribution – over the last 3 years or so there have been improvements in that system – the tools and guidelines have not been revised for well over a decade. So in 2022, we started the process of revising those tools – quite a number of tools and guidelines, so we actually didn't complete until 2023 – right now we are in a phase where we are prioritising the capacity-building – you need to train everybody afresh from warehouses down to health facilities on how to use those tools." - Development partner, federal level.

"Our facilities, especially the warehouses, are a major challenge. Many of them are old, colonial structures that are difficult to maintain. We have made some progress with the help of global funds, demolishing three old warehouses to construct a new permaculture warehouse. However, there are still several older warehouses that need attention. We are currently working on upgrading these facilities, but it is a slow and expensive process" (GoN, Kano state).

"The renovation of the CMS is good, but corruption, as well as inefficiencies in the procurement processes, needed to be addressed for institutional long-term improvement." (GoN, Enugu state)

Outcome 4 – Awareness-raising and communication

Case 18: Behaviour Change, UNITED programme

The UNITED programme (2012-19) used Mass Drug Administration to target four neglected tropical diseases in several states including Kano and achieved overall success, scoring an A+ overall with the PCR noting 'UNITED has exceeded the original milestones, delivering 15m more treatments than planned, and making significant contributions to the elimination and control of the targeted NTDs' (p.2). The Behaviour Change Component (BCC), led by Hellen Keller International, slightly exceeded its target of reaching 23.2m people with BCC messages, but was identified as the weakest component of the programme.

The BCC was informed by a knowledge, attitudes, and practices survey conducted at the start of the programme, but the resulting BCC strategy did not seem to have been adopted across the programme. The midterm evaluation (Meredith, Kabatereine, and Tesfazghi, 2016) found that the BCC component 'requires strengthening. Levels of community sensitisation appeared to be low in the states visited. The M&E plan is not being implemented' (p.5). In 2017 the programme started developing BCC implementation plans for each state.

A final evaluation question asked which communication channel worked best for spreading MDD and found that Community Drug Distributors were most effective, with community leaders, friends and family, and places of worship playing supporting roles. Radio messages had low reach, with only about 1% of people exposed to them. The final evaluation found that messaging focused more on logistics – when and where drugs were distributed, and the need to accept the drugs – than on disease prevention, elimination, and surveillance, leading to limited community understanding of disease transmission and prevention. The evaluation also highlighted confusion over whether the BCC component lay solely with HKI or with each consortium partner.

Lessons learned (Weaver et al. 2019) included that the deliverables-based contract approach 'was a double-edged sword. While it may have driven performance, contributed to cost savings, and pushed teams to find innovative ways to deliver, it also led to comprised standards...An overly narrow focus on economy and efficiencies may have come at the cost of programme quality, hence its effectiveness' (p.18).

Outcome 5 – Improved reporting and information management systems

Case 19: District Health Information System

The District Health Information System (DHIS) is the data platform underpinning the Health Management Information System (HMIS) in Nigeria. the DHIS was supported by PATHS1 and PATHS2. Although it was initially paper-based, PATHS1 worked to define a manageable data set and put it into an electronic format so that it could be analysed (PATHS final review report). DHIS Version 2 was a digitised system of collecting data at facility level and aggregating up to ward, LGA, State, and national level. PATHS provided training for M&E officers and LGA information officers and organised data reviews, while PATHS2 bought laptops and motorcycles for data officers and then provided support for the mobile phone-based M-health programme.

Digitisation of the data gathering and aggregation has streamlined the process and improved the quality and reliability of reports. However, this requires new technological dependencies such as a stable internet connection for data upload and access and training of responsible staff on new systems. Because of technological advancements, existing M&E systems can rapidly become obsolete and need replacement. PATHS2 for example saw a shift from paper-based reporting (Epi and Epi map) to computer-based reporting (DHIS), and then a mobile-based reporting system (m-Health) during its lifetime.

The PATHS2 study on capacity development noted that 'There has been no funding for HMIS at the federal level for the last 3 years apart from salaries and the N50 million allocated in 2014 to print tools. The HMIS division is mostly funded by donors and partners including PATHS2. There were concerns about what would happen to programmes supported by PATHS2 when it ended" (p.18).

"The District Health Information System struggled due to lack of funding, and our m-health initiatives faced logistical issues. We couldn't establish a sustainable system for those." - Implementing partner, state-level senior staff, Enugu

"Regrettably the culture of strong input of data and use of data for decision making that was instituted when the state had PATHS2 support was not sustained. I came to [my position] to find out that there was not a lot of use of data for decision making". Senior government official, Enugu

In general, health monitoring systems were aligned with national systems including the NDHS and HMIS, but there are still datasets on specific diseases that have not been integrated. This may be a function of separate programmes for NTDs, malaria, and HIV/AIDs. The UNITED endline evaluation report noted that "there appears to be no link with any of the [UNITED neglected tropical diseases] databases in the FMoH such as the DHIS. At federal level, the recently designed community-based information systems using DHIS2 have incorporated NTD variables but they are not being populated right now" (p.33). Later FCDO programmes including MNCH2 and Lafiya have relied on the DHIS for monitoring programme outcomes (MNCH PCR p.5, Lafiya MTR p.4-5)

Like the broader federal system, some respondents noted lack of communication and integration between levels of government.

"DHIS, at times it would work and at times it would not work. We have control room in the state …we review data and look at the gaps. The technology has its own problem. DHIS is controlled by the national …we are using national data tools. Me as a [senior official], I can only view …the only person that can key in data is the M&E. In addition, we have a lot of parallel data that is not integrated – Neglected Tropical Diseases, Non-

Communicable Diseases, HIV etc. ... and apart from the issue of parallel data, a lot of data is not captured in the HMIS. That is why they are doing the NDHS[3]." – Senior official, SMoH, Kano

Several respondents also identified issues of insufficient capacity in terms of data officers to run the DHIS. The resources FCDO put into NDHS2 resulted in transformational change to the system, and the level of investment inspired confidence that the data could be used for decision-making.

"Who really owns the data at each level and how do we strengthen that ownership technically? We need to have the right cadres for this role, use of dashboards and generally the promotion of use of data." - Implementing partner, national level senior staff

"There are huge data sets to be entered – just one person entering up to 15 data sets." - Senior official, SMoH, Kano

EQ1.5 How well do HSS programmes mitigate risks (such as dependency) of longer-term damage to health and governance systems?

Summary: FCDO's approach to health finance has been to secure government allocations and distribution for primary healthcare. This is slowly increasing, but we found evidence that the GoN has not been able to sustain interventions as funded by donors. FCDO programming has mitigated the risk of donor dependency where programme interventions have secured local and community resources, including volunteers, CSOs, faith-based organisations, and support from community and traditional leaders.

Key findings
• Programmes with long-term government funding were able to remain sustainable. • Budget planning helped close funding gaps and ensure health programmes kept running. • Training healthcare workers improved service delivery and expanded access. • Close coordination among government agencies made implementation more efficient and ensured effective use of resources. • Robust community involvement helped advance local ownership and lasting impact. • Enhancing infrastructure and supply chains reduced shortages and expanded service availability. • Strengthened data collection and reporting improved GoN's informed policy decisions.
Challenges identified
• Changes in leadership tend to shift priorities and thwart long-term progress. • Sustainability remains difficult due to minimal government support once external aid ends. • Rising healthcare costs make budgeting harder and put pressure on securing affordable supplies. • Corruption and weak governance make it a challenge to use resources. • Delays and unused allocations result in gaps in programme implementation.
Intervention spotlights
• Some states allocated funding to continue donor-supported programmes within their health budgets. • Better distribution systems made essential medicines more consistently available to patients. • FHCs and WDCs took on greater responsibility in overseeing local healthcare services. • Training and recruitment programmes helped fill staffing gaps and expand service coverage. • Stronger accountability measures led to better resource management and reduced inefficiencies in healthcare funding.

[3] The Nigeria Demographic Health Survey (NDHS) is a large-scale, nationally representative survey designed to collect data on demographics and health indicators across the country. It is used as a source for many programme outcome and impact indicators and to track progress against the Government of Nigeria's health strategies and Sustainable Development Goal targets and is designed to be complementary to the Health Management Information System (HMIS) developed and run by the Government of Nigeria. USAID has discontinued support to the NDHS in Nigeria and other countries as part of its aid review.

Analytical methods
• Programme document review, including mapping of risks in logframes, BCs and PCRs. • Thematic analysis of CF0 and CF1. • GoN and implementation partner responses. • Cases 1, 6, 7, 10, 11 and 14.

Key risks identified in programme implementation

We categorised the risks stated in programme logframes at impact, outcome and output levels. The most frequent assumptions/risks were continuing political support and support from other programmes (8 programmes), followed by government funding (7 programmes) and minimal corruption (6 programmes).

Political and security risks

This is addressed at length in the previous section, EQ4.1. Conflict and violence were only mentioned in two programme logframes, UNITED and SUNMAP2, both of which looked to distribute medicines door-to-door in conflict-affected states in the northern region beyond Jigawa and Kano. Conflict and violence were not mentioned by any respondents as having affected programming. However, the final choice of target states for the evaluation was influenced by concerns around violence in Kaduna and Yobe (see Table 2. Methodological Approach and Limitations in Section 3), so findings here may not fully reflect the extent to which conflict and violence affected delivery across all states in FCDO's portfolio.

Macroeconomic and financial pressures

Economic stability was mentioned as a risk in five programme logframes and was mentioned in passing by five respondents in three different categories. The PATHS2 capacity development report noted that the government of Nigeria suffered severe fiscal pressures resulting from the collapse of oil prices from late 2014 (p.43). Only SUNMAP2 identified specific macroeconomic risks of currency devaluation and decline in the price of oil. The ENR project completion report noted currency devaluation had affected the pricing of commodities but that the market appeared to be adaptive.

Financial sustainability and donor dependency

The most common category of risk reported in programme logframes was around reliance on inputs from other FCDO or donor programmes (8 programmes) or Government of Nigeria funding (7 programmes). To a limited extent FCDO programmes mitigated dependency on donor funding by seeking to influence the GoN or other donors for funding commitments, but funds committed by the GoN have been consistently disbursed or utilised, though significant shortfalls still remain. Lack of government funding after programme closure was one of the main factors for interventions not being sustained (see EQ1.4). However, flagship HSS programmes such as PATHS1, PATHS2 and Lafiya, as well as other DFID/FCDO governance programmes, have always offered technical assistance to strengthen the stewardship role of government at all levels (federal, state and LGAs), with a view to increasing total per capita public expenditure on health through better public financial management practices. Similarly, the programmes also supported a broad range of CSO coalitions in each state to advocate for health funding to reach the 15% Abuja declaration, for budgetary allocations to be released as and when due, and to hold government accountable for funds disbursed to the health sector. Some of the supported states such as Jigawa, Kano, and Kaduna have standing joint government and CSO accountability mechanisms in the health sector, whereby health sector budgets and audit reports are informed by participatory planning and performance feedback.

The PATHS1 final review report did not flag major sustainability issues because it identified that PATHS2 would broadly support similar activities (p.46). Sequential project completion reports have highlighted significant risks that programme gains are not sustainable. FCDO have been able to identify successor programmes or partners to continue building on the work of past programmes, but this does not address development partner dependency. Table 11 below shows the successor programmes identified in programme PCRs by component; most programmes hand over to the next phase of FCDO programme. HCP attempted to hand over procurement of commodities to central medical stores, but sustainability has been mixed (Paired Case 3). ENR successfully handed over procurement of contraceptives to SFH, a private company (Case 10). Successful handovers to GoN have been achieved with W4H (Case 1) and UNITED, for which the endline evaluation noted that 'drug supply management processes and tools developed under

UNITED and subsequently adopted by FMoH were often cited as having filled an important gap in NTD implementation in Nigeria, as a necessary foundation to sustainability' (p.17), but this assessment was made in 2019 at programme closure. The current flagship programme, Lafiya, has no clear outputs on health commodities or stakeholder influencing and accountability, and FCDO is not currently running any vertical disease-specific programmes.

Table 11: Programme succession or handover between phases

Component	Phase 0 (Pre-2002)	Phase 1 (2002-2009)	Phase 2 (2010-2019)	Phase 3 (2019-2027)
Government capacitation		PATHS1 HCP PRRINN-MNCH	PATHS2 MNCH2	Lafiya
Training skilled healthcare workers			W4H	BCONM HRHLH
Maternal health and child immunisation		PRRINN-MNCH PMDUP	MNCH2 WISH	Lafiya DRF KHETFUND
Prevention of communicable diseases (HIV/AIDS, malaria, NTDs)	PSRHH	SNR SUNMAP	ENR SUNMAP2 UNITED	SFH Global Fund GoN
Advocacy for legislation and policies	CAP	HERFON1	HERFON2 APHCR	
Procurement of commodities	HCP	CMS	MNCH2	

Key: PSRHH = Promoting Sexual and Reproductive Health and HIV/AIDS Reduction, BCONM = Borno College of Nursing and Midwifery, HRHLH = Human Resources for Health Learning Hub, Bayero University Kano, KHETFUND = Kano State Health Equity Trust Fund

Challenges in government funding and disbursement

FCDO programmes have sought to 'support Nigeria in using its own resources efficiently' (PATHS2 project completion report, p.3). FCDO's approach has been to influence the GoN to allocate and disburse funds to meet its commitments to improving the healthcare system at all levels, rather than providing funding to the GoN directly. This has been supplemented by technical assistance and capacity-building of government ministries, departments and agencies at federal, state and sometimes LGA level in planning, budgeting and disbursement of funds.

In early programming, FCDO's assumption was that Nigeria, as a middle-income country with significant oil revenue, had the money to pay for health reform, and that FCDO's job was to focus on unlocking this by securing government commitments like the Abuja Declaration and allocations of funding to health, like the 1% set out in the NHA (Case 14) and the BHCPF mechanism (Case 6).

Over time, the gap between funding allocated for health and the amounts actually disbursed and utilised has become apparent. FCDO has shifted the emphasis from influencing GoN's budgetary allocation to the health sector (PATHS1 and PATHS2 logframes) to ensuring funds are disbursed at facility level (Lafiya). In the absence of government funding, an unintended consequence of FCDO's approach to utilising Nigerian resources efficiently has been to tap into community funding and resourcing mechanisms (see EQ2.1and Lesson 4). Lafiya illustrates this shift by including an output for LGAs implementing ethical financing (see *waqf*, Case 11) to support basic service delivery.

Addressing corruption and governance challenges

FCDO has largely found work-arounds to Nigeria's endemic culture of corruption by not giving money directly to GoN and including significant governance and accountability interventions in their healthcare programming, often alongside FCDO governance programmes in the same states. FCDO has recognised corruption, or 'problems of governance', as a programme risk since the PATHS1 Business Case. FCDO has used partnership principles to not give money directly to any level of government. Most programmes include outputs or components for setting up or strengthening accountability mechanisms using CSOs and communities (see KanSLAM, Case 7). Due to its sequential approach to programming and need to

concentrate resources, FCDO has tended to work top-down from federal to state to LGA level. Several respondents identified problems with this arrangement.

> *'You should have a pyramid with most of the funding at the base but instead you have an inverse pyramid, where federal government gets something like 43%, states 26%, LGAs 17%. You should send 50% of the budget to LG, state 30%, federal 20%.' – Implementing partner, federal level*
>
> *'When I saw the [BHCPF] design, I could just see again all the tentacles of all the people in power up at the top trying to control it all the way through.' – Implementing partner, federal level*

EQ1.6 How have outcomes and impacts been measured for FCDO Nigeria health programmes, and could this be improved?

Summary: FCDO Nigeria health programmes measured a range of intermediate outcomes, outcomes and impacts, but gaps remain in evaluation methodologies. While programmes tracked improvements in service quality, workforce capacity and access to medicines, inconsistencies in measurement approaches – such as limited use of financial protection indicators and weak tracking of accountability and health financing – hindered comprehensive assessment. Reliable data was more difficult to guarantee due to strong reliance on subjective assessments and household surveys. A clearer and more accurate picture of programme outcomes by means of standardised frameworks, data breakdown by socio-economic level, and inclusion of financial protection measures, would help to guide next interventions.

Key findings
• Health workers received training, but effectiveness, attendance and performance were not tracked. • Monitoring of supply efficiency, such as wastage rates, storage conditions and prescribing practices, was limited. • Few programmes focused on improving data quality and ensuring systematic reporting. • Most interventions had no evidence of lasting impact after donor funding ended.
Challenges identified
• Analysis restricted to programme logframes because key measurement tools were unavailable. • Not enough tracking of whether health workers were showing up and/or staying in their positions. • Clinical evaluations were resource-intensive, and satisfaction surveys were unreliable. • NHOCAT tool that measures governance capacity was not regularly applied. • Intermediate measures such as wastage and storage problems were not addressed because medicine supply chains were not well-monitored. • Financial protection indicators such as out-of-pocket costs and catastrophic health expenses were not consistently tracked.
Analytical methods
• Programme document review, including logframes. • Expert review.

Health systems strengthening interventions have measured a range of intermediate outcomes, outcomes and impacts in their logframes. We mapped and grouped programme intermediate outcomes, outcomes and impacts across the portfolio and identified thematic intermediate outcome areas, which we have used as the basis of our modelling and analysis. For a full mapping, please see Annex G, 'Outcomes and Impact' tab. Our analysis of this question was limited because the methodologies and tools used to measure various indicators were not made available. We therefore looked at the indicators as written in programme logframes.

Table 12: Health sector achievements and key programmes

Achievement	Relevant programmes
Intermediate outcome level	
Improving the quality of public healthcare facilities and increased the number of skilled health workers	PATHS2, PMD, MNCH2, Lafiya, WFH
Strengthened capacity of government of Nigeria and partner organisations in governance, policy, planning, budgeting and accountability	ENR, PATHS2, MNCH2, SUNMAP2, Lafiya
Improved supply, distribution, storage and access to medicines, supplies and vaccines	ENR, SNR, HCP, PATHS1, PATHS2, UNITED, SUNMAP, SUNMAP2
○ Availability of essential medicines and equipment	HCP, PATHS1, PATHS
○ Access to contraception	ENR, PRRINN-MNCH, MNCH2
○ Distribution of nets, disease-specific medicine	SUNMAP1&2, UNITED
Strengthened knowledge and demand for quality healthcare among beneficiaries	PATHS1, ENR, SUNMAP1&2, WISH, MNCH2
Enhanced reporting and information management systems	PATHS2, WFH, MNCH2, LAFIYA, SNR, ENR, UNITED, SUNMAP2, WISH
Outcome level	
Improving use of maternal health services	PRRINN-MNCH, MNCH2, PATHS2, Lafiya
○ Maternal health services including skilled birth attendants, antenatal care and postnatal checks	PRRINN-MNCH, MNCH2, PATHS2, Lafiya
○ HIV/AIDS testing and counselling	SNR, ENR
○ Malaria prevention, treatment and support services	SUNMAP1&2
○ Increased use of formal services	PATHS1
○ Women receiving post-abortion care and family planning services	PMD
Increasing vaccination and immunisation rates	PATHS1, PRRINN-MNCH, UNITED, WFH
○ Increased immunisation coverage for 12-23 month-olds	PATHS1, MNCH2
Improving use of voluntary contraception methods	MNCH2, WISH, Lafiya
Implementation of supportive government policies, including the National Health Act (NHA) and Primary Health Care Under One Roof (PHCUOR)	PHCUOR) (HERFON1&2, APHCR, PATHS2, Lafiya
Timely and accurate reporting	PATHS1, PATHS2, MNCH2, SNR, WISH, Lafiya
Use of accurate data in decision-making	PATHS1, PRRINN-MNCH, MNCH2, ENR, HERFON, APHCR, SUNMAP 1&2, PMDUP, W4H, WISH, Lafiya
Impact level	
Reducing neonatal, infant and maternal mortality rates	PRRINN, MNCH2, PATHS2, PMD, Lafiya
○ Reduced neonatal and under 5 mortality	HCP, PATHS1&2, PMDUP, PRRINN-MNCH, MNCH2, HERFON, APHCR, SUNMAP1&2, WISH, Lafiya
○ Reduced maternal mortality	HCP, PATHS2, PRRINN-MNCH, MNCH2, HERFON2, PMDUP, WISH, Lafiya
Decreased prevalence of communicable diseases	
○ Reduced HIV/AIDS cases	SNR, ENR, HCP
○ Lower malaria rates	SUNMAP, SUNMAP2

Intermediate outcome level: Strengthening health systems for sustainable impact

Outcome 1 – Enhancing healthcare quality and workforce

Early measures of 'skilled workers' were mainly measuring 'workers trained in certain skills', an activity/output level measure. Lafiya alone examined maintenance of minimum staffing. A more nuanced picture of whether workers were in the right place, doing the right things, without illegal charging, etc. would have involved additional monitoring, for example proportion of posts filled or absenteeism rates, and using

tools such as exit interviews (for quality perceptions and to check on informal fees, for example) or mystery shoppers.

Measuring quality of service is difficult. Subjective measures such as satisfaction are poor indicators of use, and the notion of quality of care itself didn't appear in logframes until MNCH2. Measuring clinical quality is resource-intensive, requiring supervisors travelling to clinics. Approaches such as Integrated Support Supervision were geared towards this. Scoring linked to such measures, including qualitative reporting on problems identified and how they were resolved, could have helped track this important but elusive aspect of services.

Outcome 2 – Strengthening government decision-making

Different programmes have used different measures of capacity, the most common being the National Harmonised Organisational Capacity Assessment Tool (NHOCAT). NHOCAT was first used on the SNR programme to measure the capacity of national, state and sector ministries, departments and agencies, and used subsequently by ENR, PRRINN-MNCH and MNCH2. It evaluates organisations in different areas, including governance and leadership, human resources management, financial management and sustainability, programme management and performance monitoring, partnerships and networking, service delivery and technical capacity, resource mobilisation, and compliance and accountability.

NHOCAT has been revised and harmonised by the GoN over multiple rounds and so is a suitable measure of organisational capacity. Consistent application of the tool across programmes and supported ministries, departments and agencies will increase comparability of results and show trends over time. We did not have access to this data and so were unable to compare capacity-building efforts over time as we were for other outcome indicators (see Annex K).

Outcome 3 – Optimising medicine supply and distribution

PATHS1, HCP and PATHS2 built up methods for monitoring the availability of drugs at facilities, developing lists of essential drugs and commodities and using facility health committees (FHCs) to monitor drug availability and stockout rates. MNCH2 introduced quality of care measurements which have been maintained in Jigawa but not in Enugu (see Paired Case 1).

Future programmes could strengthen monitoring of medicine supply and distribution by measuring intermediate measures such as wastage rates, effective storage of medicines (e.g., cold chain) and rational prescribing practices. These have been done on a programme-by-programme basis but not systematically

Price of commodities and drugs could also be tracked systematically, to monitor value for money and inform centralised procurement. HCP started recording data on price comparisons with the open market (see EQ4.1), but this approach does not seem to have been extended to PATHS2.

Paired Case 1: Integrative Supportive Supervision, Jigawa v. Enugu

Integrated Supportive Supervision (ISS) is a cost-effective means of assuring a minimum quality of care across healthcare facilities at all levels. ISS has undergone several iterations. It was introduced during PATHS1 as Peer and Participatory Rapid Health Appraisal for Action (PPRHAA) and supported by HERFON, which trained health managers on ISS and MNCH2 as a comprehensive but streamlined way of monitoring and supervising work in primary healthcare facilities. ISS also dovetailed with later quality of care work, and MHCH2 worked to integrate these measures into HMIS reporting.

Monitoring activities are resource-intensive, and as with all initiatives, securing adequate resourcing post-programme closure is necessary to sustain the initiative. The MNCH2 PCR (pp. xiii-xiv) noted in its recommendations that 'ISS should be included in budget lines for sustainability. ISS has been strengthened in most MNCH2 supported states, with a budget line included in the annual health sector budget. The SLAMs and CSOs will need to continue advocacy for the release of funds, as ISS is currently implemented with support and coordination from external sources and therefore not sustainable.'

Lack of state government resources explains why ISS is continuing in Jigawa but not in Enugu.

"[ISS] has begun to develop a culture of performance management and has played a useful role in strengthening links between different levels in the system, with supervisors often drawn from different bodies

and levels. In Enugu and Jigawa, it is now an integral part of the new arrangements; and in Jigawa it has attracted ongoing government budget allocations." - PATHS final review report, p.4, 2008.

"Participatory Rapid Appraisal and Integrated Supportive Supervision were valuable tools for us. They helped with data collection and on-the-job training. ISS, in particular, was great for gathering information and improving service delivery. But its effectiveness really depended on consistent funding. These were good initiatives but they were expensive and this made sustainability difficult. But the approaches remained as part of the mindset. " - Implementing partner state-level senior staff member, Enugu

"One of the initiatives that has worked well is the Integrated Support Supervision (ISS), which was supported by the MNCH2 programme. The ISS structure remains active and continues to help us monitor health facilities and services. ISS uses a checklist to supervise and monitor health facilities. It covers a range of components such as reproductive health, child health and nutrition. The state government funds it through a health basket with contributions from partners like BMGF and UNICEF. The integrated support supervision has allowed us to maintain oversight on service delivery and ensure the implementation of quality standards in healthcare facilities." - Mid-level official, SMoH, Jigawa

Outcome 4 – Awareness-raising and communication

This outcome area was used primarily with disease-specific programmes as opposed to flagship HSS programmes, and more at the outcome level of increased knowledge of symptoms, transmission and prevention, and treatment of HIV/AIDS, malaria, etc. Indicators were also used to monitor increased demand and use of RMNCH. Gathering reliable data around knowledge, attitudes and practices is essential to understanding the effectiveness of communications campaigns; the best data sources to understand barriers are representative household surveys, as surveys at PHC clinics only include those who are actively seeking care. Moreover, existing vehicles for representative household surveys such as the DHIS and MICS are semi-annual, have limited length for survey items, and cannot easily be 'piggy-backed' by programmes targeting new or specific areas, e.g., neglected tropical diseases. This has led to the development of parallel donor-funded surveys, rather than strengthening existing GoN-sponsored surveys.

Understanding population awareness and communication effectiveness requires bespoke surveys, which are programme- or campaign-specific and cannot usefully be integrated into national representative household surveys. HSS programmes do not seem to have struggled to achieve behaviour change and have effectively promoted modern family planning methods and vaccines in the face of potential cultural opposition, through engagement with community and traditional leaders and CHEWs going door-to-door (see EQs 2.2 and 2.1 above). However, programme documents and respondents have found programme communication weak, and monitoring of these messages could be improved (Case 18). A suggestion would be to use focus groups with representatives from different areas as well as different demographics, first to understand persistent barriers to adoption and then to understand effectiveness of programme messaging and adjust accordingly.

Outcome 5 – Enhancing reporting and data management

Improved reporting and information systems was only tracked by a minority of programmes, with PATHS1 and 2 mainly reporting on timeliness of reporting. Lafiya has introduced a quality component to the data. Data use was incorporated in intermediate outcome measures in the majority of programmes in some form – for example, use of data in state plans for PRRINN-MNCH – but it was not clear how reliably these were measured. Evidence-based decision-making has appeared as a separate output for operational research and programme monitoring in several programme logframes. However, this indicator has tended to be assessed subjectively and on an ad-hoc basis rather than systematically. EQ1.6 shows that HSS programming can promote a 'planning culture' fostered by confidence in timely quality data. Given that health systems data tends to be aggregated up from facility level, the chain is as strong as its weakest link, so these gains can soon be reversed.

Outcome level: Expanding access to healthcare services

Improving use of health services is positive, especially if one accounts for switching (so programmes need to look at overall change, not just an increase in public services, which reflects people who used to get the

same services privately - though that switch can have financial protection benefits). Use of household survey data by many of the programmes will have enabled this analysis.

Impact level: Assessing health progress and financial protection

Impact level indicators align with WHO, SDG and other internationally recognised indicators and definitions. These indicators are all solid, although measles, mumps, and rubella (MMR) vaccination data always has huge confidence intervals, with indicators lagging based on the latest available NDHIS or MICS data. There is a broader issue with attribution to FCDO programming: due to the complexity of the context in which interventions are operating and the lack of counterfactual, most programme PCRs and evaluations have settled for demonstrating contribution to these indicators.

Financial protection indicators are, with coverage, the measures of Universal Health Care, but FCDO programmes rarely use them to measure programme performance. There is also a general lack of disaggregation of indicators by socio-economic status (see EQ2.4). PATHS2 and Lafiya were the only FCDO programmes to track out-of-pocket expenditure on health. Out-of-pocket spend is a proxy for financial protection, and none of the programmes reported on trends in catastrophic spend, impoverishing spend or financial barriers, which link to reducing household poverty and would have improved tracking of UHC as a whole. Globally, there is considerable concern over financial protection indicators, which have been stagnating or deteriorating.

Relevance

HSS interventions have been highly relevant to Nigeria's healthcare challenges, aligning with federal policies and legislation and state-level priorities. Programmes have built up over successive phases to strengthen the capacity of government departments and healthcare facilities, and have supported community structures to hold state and local government accountable for delivering on healthcare. In spite of these successes, challenges remain, particularly with regard to sustainability, consistency and engaging the right stakeholders. While the programmes have been adjusted for different state contexts, gaps in local expertise and inconsistent funding mean that some areas have seen greater benefits than others.

EQ2.1 Are HSS interventions appropriate to the local context?

Summary: HSS interventions worked best when tailored to suit the local political context and community dynamics. Success largely depended on state buy-in, traditional and religious leader engagement, and grassroots participation. Political economy analysis helped navigate competing interests, while locally driven approaches such as PATHS2's engagement with market women and faith-based medical stores proved more sustainable than rigid, top-down models. However, political challenges, corruption and lack of consistent government support often got in the way of lasting progress.

Key findings
• Locally designed programmes with support from the community, traditional and religious leaders proved the most sustainable, and aligned with political, economic and social realities. • Private and non-governmental actors took on a greater role in healthcare delivery, which improved access and service quality through faith-based and citizen-led initiatives.
Challenges identified
• FCDO's attempt to reform healthcare that did not align with existing political structures failed. • Over-emphasis on state-level interventions overlooked LGAs' role in sustaining reforms. • Political interference and policy non-compliance weakened programme impact. • Resistance to health initiatives required targeted engagement of traditional and religious leaders.

Intervention spotlights
• The Change Agents Programme (CAP) created an ecosystem of health reform advocates whose presence is still felt 20 years later. • Governance and financial reforms, including DRFs and FHCs, increased accountability. • Lafiya improved private sector regulation, ensuring better oversight of patent medicine vendors and alternative healthcare providers.
Analytical methods
• Thematic analysis of primary codes CF2, CF3 and CF8. • FCDO, GoN, IP, CSO and FHCW responses. • Cases 3, 4 and 13, Paired Case 3.

Community and religious leader engagement for impact

Support from local community and traditional and religious structures and leaders has been important to the success of programmes across the country. Such non-governmental actors proved to be key in the Nigerian context, in which the government is not generally perceived as a strong driver of development, and post-holders are viewed as occupying positions for personal prestige and enrichment.

Programmes that actively engaged existing community structures and leveraged participatory design and implementation early on were successful in addressing local needs. PATHS1, PATHS2 and MNCH2 leveraged engagement with actors at the local level, including traditional and religious leaders and collective organisations. PATHS2 engaged street market women groups and MNCH engaged transport operators. Involving community members and leaders through assessment of their needs or decision-making in programming has helped adapt delivery to the local context, including incorporating traditional medical practices and power structures and aligning with LGA priorities. For example, in Enugu PATHS2 engaged traditional birth attendants within local communities, and in Kano and Jigawa it engaged religious structures and leaders such as imams. In Enugu, PATHS and PATHS2 have engaged primarily Christian, faith-based central medical stores (CMSs) supplying health facilities to better supply people in poverty with affordable essential drugs.

Several HSS programmes, including PATHS2, ENR and MNCH, have successfully involved communities in health service delivery through community volunteers, for example, in the maintenance of Ward Development Committees (WDCs), Facility Health Committees (FHCs) and DRFs across all three focus states. Engaging community actors directly in implementation has widely helped to reach more users and overcome resistance when interventions have not aligned with local beliefs. For example, under MNCH2 discussions in Islamic communities in the north about antenatal care, routine immunisation, HIV/AIDS and family planning has helped reduce resistance and led leaders to advocate on their importance, successfully shifting local perspectives and improving uptake rates.

Interventions at the level where citizens believed they could exercise real influence have had success. In particular, the role of FHCs allied with drug revolving funds provided a real element of accountability between health staff and those they serve. This also created a sense of confidence to seek other resources within communities and advocate for resources from higher levels. Further examples are the involvement of communities and traditional leaders in sponsorship of young women for midwifery training in northern Nigeria and the development of Emergency Transport Schemes through mobilising and incentivising private operators. Later programmes have been effective in leveraging opportunities for engaging Islamic institutions in financing initiatives and identifying the most vulnerable community members.

"Most important factors are resilience of the community – even with nothing, you can do something for yourself, so if [the community] have done nothing [about addressing an issue being promoted by the programme], it is a red flag." – Implementing partner, national-level senior staff member, Abuja

"You have to involve the community right from the start. When people feel like they are part of the planning, they are more likely to support it and keep it going. Programmes that can adapt to what is happening on the ground always do better than those that try to follow a rigid plan" – Implementing partner, national-level senior staff member, Kano

Adapting interventions to state and local realities

All programmes except HERFON1 had state level engagement, and all these programmes made efforts to adapt their programming to state or local context. The programmes and interventions which were designed with local input and had the support of local communities and leaders in addition to support from the state governor were the most likely to be successful and sustainable. From the beginning, FCDO HSS interventions have been tailored to state or local political contexts. Early programming recognised the need for political economy analysis to tailor interventions to the local political context. Programmes recognised that good technical solutions on paper did not necessarily translate to practice, and it was important to understand the exercise of power and often competing political interests at different levels in Nigeria.

Influencing political structures and governance challenges

Programmes aiming to influence Nigerian political structures have had mixed success in achieving sustained improvements. The Change Agents Programme (CAP) was an FCDO programme designed to influence Nigerian political structures from the inside by shifting stakeholders' mentality around healthcare reform and getting them to see the process of systemic change. This influence was both transformational and sustained and gave mid- to senior-level stakeholders in the Nigerian health system a network and common language to discuss health reform (see Case 4).

FCDO's attempt to influence political structures at an institutional level failed, however, when PATHS tried to transplant the structures of Gunduma Councils and District Health Systems (see Case 16). Respondents in both states mentioned that the failure of the District Health Systems to endure was not lack of its merit in implementation but because it challenged the prevailing institutional arrangements in the country, including the constitutional recognition of three levels of government.

It has been important to recognise that reforms require attention to the institutions at all three levels. In the system of federal, state and local governments, there are allocations for health at all levels, with all impacting the health of the people in a particular geography. The early assumption that the concentration should be at the state level proved vulnerable in the face of interventions from the federal or national level. The recent Supreme Court decision empowering LGAs will require adjustments in FCDO's approach.

Enhanced governance and transparency in health systems

FCDO has recognised and tried to work around effects of corruption on the health system at all levels. FCDO decided from the outset not to give money directly to GoN due to concerns about corruption, and HSS programmes have been supported by governance initiatives, either as separate programmes like SLGP and SPARC; as embedded outputs around budgeting, disbursement of funding and accountability; or through support to accountability bodies like KanSLAM (Case 7). In some instances, while the strengthening of systems was necessary it was insufficient to counter corrupt practices due to political interference and non-adherence to written rules (see Paired Case 3). All programmes have recognised the difficulties caused by the need to create personal incentives to get things done, and the spill-over into corrupt practices.

Strengthening non-governmental and private sector involvement in health systems

Working through traditional and religious establishments ensured the programme activities matched their values and addressed their needs and concerns. In contrast to some other countries in Africa with different political legacies, the Nigerian government is generally not perceived as the driver of development. The more dynamic traditions and institutions are those of the private sector and of the different religious groups.

Political parties lack ideological loyalty and programmatic distinction. Post holders are viewed as occupying positions for personal prestige and enrichment. In the health sector there is often distrust between the private and public sectors.

The faith-based Drug Revolving Fund in Enugu was supported by PATHS1 and continues to operate even when the government DRFs have collapsed (paired case 3, case 17). In the north, there has been growing private sector health service delivery that is largely unregulated, including patent medicine vendors, as well as traditional and alternative practitioners. Lafiya is supporting to put in place institutional mechanisms to supervise these non-state health service providers. The number of private nursing and midwifery schools that have increased following reforms in nursing and midwifery regulatory institutions supported by W4H attests to the contribution of the private sector to health system strengthening. Strong leadership and citizen participation, including reform-minded governors and strong traditional leaders, have also helped to drive success. This has been an important feature of the success of drug supply arrangements in northern states.

"The Emirate Council committee is structured across the traditional tiers of governance from the Emirate Council through the districts to the wards and villages. […] People were collecting information of their daily happenings by themselves and pushing it forward. […] We were analysing this data ourselves and sending it out. So, you know that it happened and not somebody coming from outside telling you that this is what happened. You have the idea that you have the knowledge". – Traditional community leader, Kano

EQ2.2 Are the health systems strengthening interventions and methodologies sensitive to the situation and needs of people in Nigeria and the targeted states?

Summary: HSS interventions were designed to be sensitive to context and to align with the needs of the people in Nigeria and the targeted states. While programmes adapted to local health priorities – particularly in northern states with high MNCH burdens – effectiveness varied due to governance, financing and implementation challenges. Some states integrated interventions with existing community structures, but limited engagement with local expertise in programme design reduced responsiveness elsewhere.

Key findings
• Programmes adapted effectively to state and local priorities, in particular in northern states. • Flexibility to adjust programmes helped keep interventions relevant and responsive. • Programmes that integrated with existing community structures saw stronger engagement and better sustainability.
Challenges identified
• Shifting focus to northern states reduced engagement elsewhere. • Limited engagement with local expertise weakened adaptability and sometimes led to delays. • Many programmes missed opportunities to target vulnerable populations within states.
Intervention spotlights
• PATHS2 improved health financing by helping set up DRFs and strengthening government funding. • Community-led initiatives (FHCs and WDCs) have been sustainable and increased accountability. • W4H increased the number of female healthcare workers and skilled birth attendants.
Analytical methods
• Thematic analysis of primary code CF8 • FCDO, GoN, IP, CSO and FHCW responses • Review of programme documents, BCs and PCRs • Case 1 and 9, Paired Case 3

Strengthening local leadership for sustainable impact

Shifting from non-Nigerian leadership to local leadership improved programme effectiveness and promoted sustainability. Earlier programmes (PATHS, PRRINN-MNCH and PATHS2) had several non-Nigerian experts leading design and engagement at both federal and state level. This may have somewhat hindered programmes' ability to think and work politically and understand and adapt to the local context. FCDO's continuous support in successive programmes has deepened the pool of Nigerian technical expertise, and

MNCH2 and Lafiya has drawn more extensively on Nigerian leadership, where possible from the same state or region. These leaders would frequently have direct experience of working in the government and have strong personal networks.

"In PATHS1 and PATHS2 you had some very bright, capable internationals […] No matter how clever these people are, they're not going to feel like part of the fabric when they're talking to Nigerian senior officials or to governors or whatever." – FCDO advisor

"When programmes were being designed, I didn't get a sense that there was enough input from actual Nigerians – my colleagues were doing short postings and [left]. [At the state level] it didn't quite pan out how it was expected. In the first year in implementation [of PATHS2] they had to do a lot of adjustments … Experimentation, which could have been avoided, saving time and money." – FCDO advisor

Strategic adaptation and responsive programming

FCDO programming has considered the needs of people in Nigeria both at design phase and throughout implementation, adapting programming to fit with local contexts and needs and coming up with some innovative local delivery mechanisms. Each intervention's rationale was outlined in the Business Case or project design document. Under PATHS, FCDO shifted focus almost exclusively to northern states, exiting Benue and Ekiti during PATHS1 (2002-2008) and Enugu and Lagos after PATHS2 (2008-2016). The MNCH2 and Lafiya Business Cases stated that maternal and child mortality rates were worse in the northern states, particularly compared to southern states, and specified the northern 'priority' states in which the programmes would work. This choice may also have been driven by the DFID results agenda – 'We wills' and progress towards MDGs and SDGs – to which Nigeria, with its large population and need, contributed significantly.

In programme design, FCDO interventions won praise from GoN and implementing partners for its flexibility and adaptability to local context. Unlike donors such as USAID and the World Bank, FCDO's programming is characterised by its ability to make changes in outputs on an annual basis, and this flexibility has helped FCDO adapt to changing risk profiles and situations. Flexible programme design and ability to adapt are beneficial design dimensions that allow programmes to be sensitive to local needs. Indeed, programmes that have been able to react to differences or changes in context have had positive feedback from implementing personnel and seem to have reached the appropriate target populations better.

"Having donors who let us be flexible was a game-changer. They understood that we had to adjust our plans based on what each state needed, and that made a huge difference. More donors should think like that." – Implementing partner, state-level senior staff member

"In terms of PATHS […] allowing different contexts to have different priorities, but towards the same end game I think was very important. And I think FCDO is one of the very few donors allowing for that kind of flexibility at the time." – Implementing partner, national-level senior staff member

"A lot of things that were quite remarkable about [SUNMAP 2]. One thing was the adaptive form of programming. [...] but from SUNMAP2, you could adapt yourself to the community preventative issues and change a bit of what you wanted to do, it was not the same, that was remarkable for me." – Implementing partner, national-level senior staff member

Addressing demographic and social contexts in programme implementation

A minority of programmes addressed the needs of different demographic groups in their design and implementation in targeted states. The adaptability of programmes to local contexts along social, political and religious lines has been a key factor in their success and sustainability. However, few programmes have integrated this explicitly into their design and implementation. Programme design has been sensitive to the situation and the needs of people in Nigeria through the research which informed design, the programmes' in-built capability for adaptation, the use of appropriate staff with relevant contextual knowledge, and community participation and engagement. These include programmes such as WISH, SUNMAP II, HCP, that explicitly targeted people in poverty, and PRRINN-MNCH, PMDUP and MNCH2, that were designed to target

women and children. See Annex F for details on how programmes are tailored to address cross-cutting issues such as poverty and gender inequality; See EQ 2.4 for the extent to which programmes consider social inequalities.

"There are 36 different countries in Nigeria. [...] If you're in a deep HSS, you need to really focus on states. If you spread yourself too thin, you won't achieve anything." - Implementing partner, national level

FCDO has considered the needs of populations in different states through co-creation of programmes, state-centred political economy analysis, and investment and reliance on localised data sources. Where in-depth research was carried out about the state contexts in which the programmes operate, this has allowed programme design to adapt to these. Programmes such as PATHS1, PATHS2 and SUNMAP considered religious power structures and their influence on programming in northern states, and engaged with them to make initiatives more successful. Programmes also considered the local cultural and social contexts in relation to healthcare and the state of the health system in different states, which allowed design to be sensitive to the needs of the population. For example, W4H considered the need for healthcare workers in different states, and designed support accordingly (Case 1), while PATHS2 targeted states with the greatest shortages, for increased provision of drug supplies and materials (Case 9). Nevertheless, sensitivity to the local situation requires engaging the relevant people with experience and contextual knowledge, which most programmes failed to do effectively at the design phase, or lost track of during implementation.

EQ2.3 How well are HSS interventions aligned to national or state health priorities and plans?

Summary: HSS interventions were well-aligned with national and state health priorities and adapted to shifting policies and governance structures. Programmes closely coordinated with federal and state governments to develop policies, advocate for reforms, and strengthen planning and budgeting processes. However, alignment varied due to political commitment and financial flows.

Key findings

- HSS interventions were integrated with national and state health plans.
- FCDO focused on getting money for healthcare allocated, disbursed and utilised at federal, state and LGA level, but avoided giving money to GoN directly.
- FCDO-supported advocacy enabled key health reforms, including passage of the National Health Act.
- Technical assistance supported healthcare financing by helping states secure national funding.
- Malaria and HIV/AIDS programmes aligned with national strategies, improving data systems and supply chains.

Challenges identified

- Inconsistent political commitment at the state level made it difficult to implement and sustain health reforms.
- Shifting political priorities and delays in disbursements of federal funding left states and LGAs unable to plan or allocate resources effectively.
- Disease-specific programmes fragmented health financing.
- Weak state contributions to health funding continued GoN dependency on development partners.

Intervention spotlights

- PRRINN-MNCH, PATHS2 and MNCH2 built political support for major health reforms, including the National Health Act and Primary Health Care Under One Roof.
- Drug Supply and Midwife Training programmes expanded access to medicines and strengthened the health workforce in underserved areas.
- Mutual Accountability Frameworks under Lafiya secured government co-financing and tied FCDO contributions to state commitments.

Analytical methods
• Thematic analysis of primary codes CF2 and CF3 • FCDO, GoN, IP, CSO and FHCW responses • Cases 1 and 9, Paired Case 3 • Document review, BCs and PCRs.

Driving health system reforms through political engagement

PRRINN-MNCH, PATHS2 and MNCH2 each realised quite early during implementation that project results cannot be delivered by any of them working on their own, and success is largely dependent on the level of political commitment and willingness to make fundamental reforms to health services. Thus, the APHCR initiative was activated alongside these programmes to engage with political leaders, civil society and the media to raise the political profile of health issues; draft, advocate for and support the passage of crucial health reform bills and policies; support internal change champions who can drive reforms from within; and in some cases, confront political leaders and hold them to account. Through an accountable grant to HERFON, the following three key national health reforms were taken forward:

1. **PHCUOR:** Reform aimed at eliminating fragmentation, increasing funding and improving management of primary healthcare at the heart of Nigeria's underperforming health system.
2. **Free Maternal and Child Health (Free MCH)**: Policy that guarantees access to basic healthcare free at the point of use for pregnant women and children.
3. **National Health Bill:** Landmark legislation which clarifies rights to health services, ringfences 1% of federal revenue every year for primary healthcare, and streamlines the organisation of health services in Nigeria.

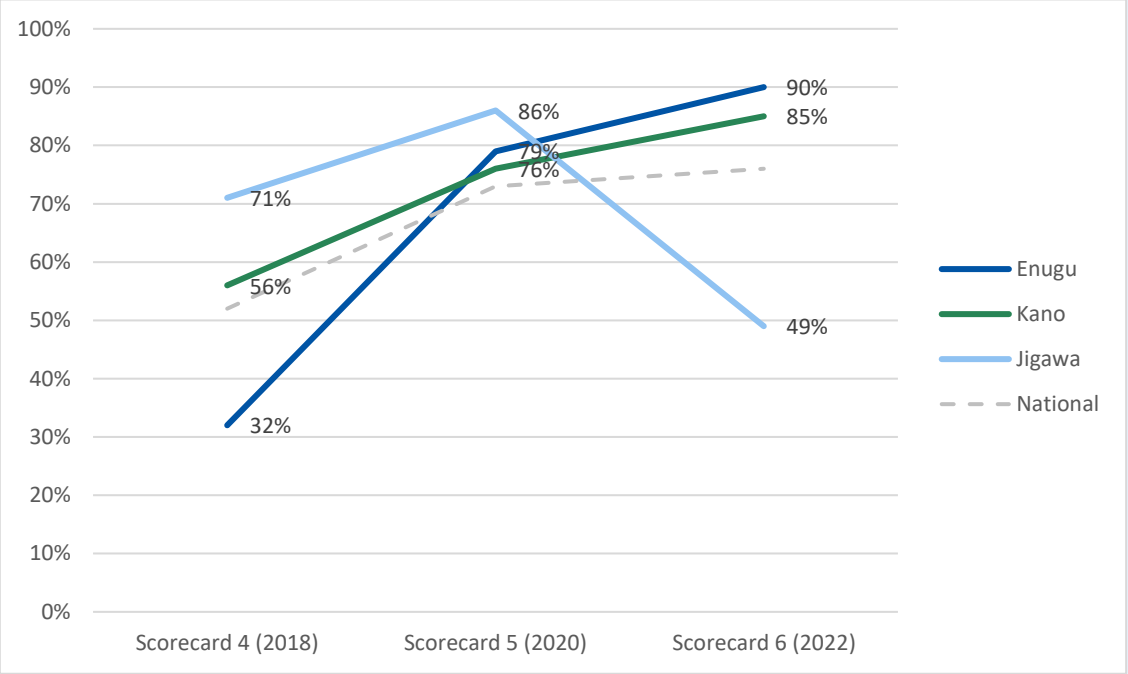
The result was enactment of the National Health Act and the implementation of key mandates such as the BHCPF, which is being taken forward by Lafiya. PATH2 and PRRINN-MNCH also assisted focal states to develop State Strategic Health Development Plans (SSHDPs), which were aligned to the National Strategic Health Development Plan (NSHDP). Lafiya has also supported and instilled a culture of developing Annual Operational Plans (AOPs) in focal states, and built their capacity to review AOPs on a quarterly basis.

Paired case 2: PHCUOR implementation, Kano and Enugu vs. Jigawa

Primary Health Care Under One Roof (PHCUOR) is a national policy passed in 2011, aligned with the National Health Act of 2014. It was designed to integrate, strengthen and improve primary healthcare services under state-level agencies, with a single management structure. PHCOUR established State Primary Health Care Development Agencies (SPHCDAs) under the NPHCDA to take over coordination, maintenance and human resource functions.

Several implementing partners credit FCDO's PRRINN-MNCH programme with initiating PHCUOR in the north, with additional advocacy funded by the Gates Foundation. FCDO programmes HERFON and APHCR developed a Scorecard to measure progress against nine dimensions of implementation, with the goal of 90%, and trained state-level officials to increase their capacity to deliver. FCDO flagship programmes have been building state-level capacity in policy since PATHS1. HERFON2 supported the development of PHCUOR at federal level and APHCR supported the roll-out of supportive legislation at the state level, including in the focus states of Kano and Jigawa, with PHCUOR scorecards used as an outcome indicator to track progress. The NPHCDA has issued six scorecards, with the first in 2011 and the latest in 2022.

Figure *3: PHCUOR overall scores, by target state*



Shobowale (2023) noted "below average implementation of PHCUOR at sub-national levels, based on scorecard assessments, with inadequate human resources, weak governance and gaps in funding, infrastructure, essential drugs and other supplies" (p.5). Progress on implementing PHCOUR has progressed unevenly in the three focus states of this evaluation; scores for the North East and North West regions, which both have states that have received FCDO support, were the highest. On the latest scorecard, 6 (2022), both Enugu and Kano have more or less reached the target, although Jigawa has fallen back to 49%. Areas of improvement included transferring staff to the State Primary Health Care Board (SPHCB), setting up a functional, independent office for the SPHCB, developing operational guidelines for administrative procedures, and developing a minimum service package (MSP) document for each facility (NHPCDA, 2022).

A state government official spoke frankly about the problems Jigawa faced in implementing PHCUOR. These included lack of coordination among multiple state-level stakeholders and agencies, with no reporting mechanisms and nobody held accountable for successes or failures. He also pointed out that the NPHCDA could not find counterparts at the state level to work with in implementing BHCPF.

"In the last 20 years, Jigawa state has recorded huge successes, though there are challenges. I joined the government service in 2004 during PATHS1. By the time the programme closed in 2007, PATHS1 was synonymous with the State Ministry of Health. It had a small staff but was very efficient in its delivery." – Senior official, SMoH, Jigawa

Using strategic partnerships and conditional funding to improve health systems

A fruitful approach is what might be described as 'deal making' and quid pro quos which are a natural feature of transactions in Nigeria. Significant levels of PATHS2 funds were used for facility renovations, with a focus on maternal and child health and complementing other building blocks in terms of staff training and availability of commodities and equipment. These investments were frequently used to leverage matching contributions from governments and to encourage mobilisation of community resources. This has been recognised formally in the later programmes – for example in Lafiya, with the Mutual Accountability Frameworks agreed with states, linking what FCDO contributes to what states will actually fund and do.

A further counterweight to arbitrary release is where allocations of national funds to states are conditional on conformity with nationally defined priorities. This has tended to increase over time. In particular, in situations where state priorities structurally do not fully align with national agendas, as in the District Health System (DHS) reforms in Enugu and Jigawa (Case 16), states risk losing out from such funding. Currently the

approach of health minister Professor Pate is for a Health Sector Strategic Blueprint applicable to all levels, and to leverage the Basic Health Care Provision Fund to influence priorities and funding at other levels, including local governments. This is providing an opening for FCDO programmes to offer technical support that helps state and local government levels to gain release of national funds.

Strengthening state-led health planning and policy implementation

There is no formal political process of manifesto proposals being translated into government plans and priorities. Much depends on the personal priorities of governors (and those close to them) post-election; and while some of them have a good grasp of what a good health system looks like, others do not. Hence effective alignment depends very much on the ability to influence a governor, seize opportunities and build HSS initiatives around his personal interests. Policies and plans developed at federal or national level were open to interpretation at state level, with greater influence when accompanied with conditional resources.

Therefore, it was important for FCDO to maintain flexibility and be able to respond to expressed priorities at state level. Successive HSS flagship programmes explicitly focused on national and state level policy development and planning. Notably, PATHS2 supported advocacy for the enactment of the National Health Act and its implementation in collaboration with the HERFON-led Health Sector Reform Coalition (HSRC), and assisted focal states to develop SSHDPs, which were aligned to the NSHDP. HERFON2 set up state chapters to support state-based policy work. Lafiya has also supported a culture of developing AOPs in focal states, and has built their capacity to review AOPs on a quarterly basis.

Alignment with government health plans and priorities

PATHS1 (2002-2008) and HCP (2005-2009) were aligned to support the National Economic and Empowerment Development Strategy (NEEDS) and State Economic Empowerment and Development Strategies (SEEDS). In PATHS1, this led to “reposition[ing] the work within the NEEDS/SEEDS process and as a result ultimately led to closure in Ekiti and Benue and beginning work in Kano and Kaduna” (PATHS1 final review report, p.1).

SUNMAP and SUNMAP2 were aligned with the National Malaria Elimination Programme (NMEP) and State Malaria Elimination Programmes (SMEPs). In addition to being co-located and sharing resources, both programmes worked very closely with NMEP to enhance its capacity to coordinate/harmonise the efforts of multiple donors, as well as the actions of the tiers of government. Their workstreams were directly related to advancing the twin aims of the NMEP, which were improving capacity for scale up and getting malaria on the political agenda. In this instance, FCDO investments tended to be catalytic in drawing other people to engage through shared vision, accountability and delivery of outcomes and achievements.

Institutional relationships and financial planning for health system growth

Alignment was helped by a ‘revolving door’ of key personnel in the healthcare space, many of whom had worked for the government of Nigeria before joining implementing partners, or vice versa. During the PATHS period there was a particularly close relationship with the Federal Ministry, with the head of CAP becoming the Minister of Health. In many instances, project staff would effectively be embedded in federal or state ministries and making direct contributions to key strategic documents, for example PATHS2’s contributions to the National Health Strategic Development Plan. FCDO programmes were strongly influential in advocacy and testing of the government’s Primary Care Under One Roof policy. In other words, alignment was furthered by a revolving door of key personnel, and speaks well of FCDO’s abilities to influence government health agendas.

HSS flagship programmes also focused on strengthening planning and budgeting at federal and state levels. This improved the quality of both, and probably had an influence on better use of government funds. However, such efforts aligned with AOPs have often been confounded by the in-year process of actual releases of funds at the discretion of the governor, and influenced by factors well outside the control of the projects.

Improving fund flow and strengthening financial alignment

The period after the passage of the National Health Act showed that a promise of allocation of funds was not sufficient, as there were significant delays in the disbursement of funds from federal to state and state to LGA level which affected downstream departments' and facilities' abilities to plan and budget.

In the later period, following enactment of the National Health Act, Federal Government has become clearer about what it is trying to achieve in health, and particularly how to achieve it through structural arrangements and by leveraging flow of funds to incentivise performance. In this context alignment is natural, and technical assistance can be used to influence improved health outcomes on the pretext of helping states and local governments to access conditional flows of funds. This is well demonstrated by Lafiya, which has proven adept in the face of reduced resources at such deal-making and has positioned itself well as local governments become more significant in funding services.

Shift from external to domestic resource mobilisation

In the PATHS1 and PATHS2 periods, greater emphasis was placed on mobilising state resources. While FCDO rhetoric increasingly emphasised helping Nigeria to use its own resources more effectively, meeting FCDO targets caused projects to focus on the use of their own considerable resources, with adverse impact on sustainability. Transformational change occurred where the use of such resources catalysed and re-enforced locally driven change, e.g. in drug supply (Case 9) and training midwives in the north (Case 1). While the W4H programme was inspired by the work of PRINN-MNCH it was also a response to the GoN Midwives Service Scheme (MSS) programme to increase qualified health worker availability in the north.

EQ2.4 Do FCDO HSS programmes consider social inequalities relating to gender, age, disability and other relevant identities?

Summary: FCDO HSS programmes have consistently undertaken measures intended to mitigate social inequities, particularly with regard to gender, age and poverty. Multiple programmes, such as W4H, MNCH2, SUNMAP2 and Lafiya, were specifically designed to improve healthcare accessibility for women, children and economically disadvantaged areas. WISH and Lafiya worked to also include people with disabilities. However, many interventions took a broad approach and did not consistently demonstrate evidence of reaching the most vulnerable populations, which reduced their overall effectiveness. Limited funding and unreliable government support further hampered efforts to maintain equitable health financing. Adopting a more targeted and sustainable strategy would ensure that healthcare services reach those most in need.

Key findings
• FCDO programmes expanded healthcare access for women, children and rural communities. • Support for persons with disabilities, young people and lower socio-economic status was limited.
Challenges identified
• Programmes broadly targeted need but did not always reach vulnerable populations within states. • Community attitudes towards women in the north meant that adaptation of delivery was critical.
Intervention spotlights
• W4H made MNCH care more accessible by producing more rural female health professionals. • JICHMA and KSCHMA expanded health insurance coverage for low-income patients. • Strong commitment to improving healthcare was evidenced by the increase of funding for MNCH in Kano from NGN 35m to NGN 165m. • Programmes mobilised local resources (WDCs, *waqf*) to keep healthcare facilities running.
Analytical methods
• Thematic analysis of CF8. • FCDO, GoN, IP, CSO and FHCW responses. • Cases 1 and 8. • Document review, including BCs, logframes and PCRs.

Expanded healthcare access for women and underserved communities

HSS programmes and interventions have considered social inequalities to some extent, including relating to gender, age and socio-economic status. Several programmes were designed to target women, youth, children and/or people in poverty, including WISH, SUNMAP2, PRRINN-MNCH, PMDUP, MNCH2, ENR and W4H.

- W4H explicitly targeted young women in poor rural areas.
- Lafiya focused on service provision and financing for the poorest and for women.
- SUNMAP2 had a pro-poor focus and targeted vulnerable groups.
- PRRINN-MNCH and MNCH2 were designed to improve maternal and child health.
- PATHS2 focused on pro-poor healthcare, with maternal services have been central to the programme.
- HCP targeted people in poverty in its mission.
- ENR focused on women's inclusion and empowerment.

However, most interventions were not explicitly designed to address poverty and gender inequality, and have targeted poverty only generally, i.e. by working in northern states without targeting poorer communities within these states. Annex F details how, if at all, the design and implementation of each programme have addressed cross-cutting issues such as poverty and gender inequality.

Several programmes, including PRRINN-MNCH, PMDUP, MNCH2, WISH and W4H, were specifically designed to focus on access to quality health services by women and children to drive positive health outcomes.

- MNCH2 improved access to and use of quality healthcare and routine immunisation for pregnant women, newborns and children in six northern states.
- WISH expanded access to women's sexual and reproductive health services for adolescents and women to reduce maternal deaths, unsafe abortions and unintended pregnancies.

Other programmes worked to reduce gender inequalities in programme delivery and healthcare staff to drive positive health outcomes for vulnerable groups. W4H tackled the shortage of women health workers in northern Nigeria by increasing female staff in training to serve in rural facilities to improve children's and women's healthcare.

Programmes including PATHS, PATHS2 and Lafiya had elements that were explicitly designed to target maternal and child health services used by women and children, so had some consideration for addressing gender and age inequalities in health. A minority of programmes partnered with vulnerable groups in the community to more effectively reach women, children and youth targeted by programmes. For example, in Enugu DRFs engaged women's groups as members and partners, and in Kano the WDC (Case 8) included representatives of women and youths as partners. This way, programmes aimed to encourage women to engage others in the community to better reach them with quality care and increase their demand for health services. By providing female staff to attend to women, W4H (Case 1) was designed to overcome cultural factors preventing women from seeking and accessing care, particularly family planning.

Programmes that better targeted and reached women and children were often flexibly designed to adapt well to the state context and needs of local populations, leveraging partnerships with local third parties, including CSOs. W4H in Kano addressed female health staffing and hospital systems, and the needs of women and children targeted in the state. Programmes in Jigawa have leveraged CSO advocacy in encouraging men to allow their wives to access healthcare facilities in its work to improve quality and access to care for women.

Efforts to reach poor and marginalised populations

PATHS, PATHS2, HCP, Lafiya, SUNMAP2 and WISH have been designed to serve poor populations through free health services and supplies, and aimed to target those in poverty. PATHS, PATHS2 and HCP were designed to help Nigeria improve the planning, financing and delivery of sustainable and replicable pro-poor services and essential health commodities, specifically targeting to improve health among poor Nigerians. Lafiya aimed to improve the government's political and financial commitment to health through improving basic health and nutrition service provision, with a focus on reducing catastrophic health expenditure for the poorest populations. WISH focused on sexual and reproductive health of poor and marginalised women.

Most of these programmes targeted poor populations by supporting and leveraging existing government, community- and faith-based support structures provided to people in poverty. In Kano, the BHCPF provided health facilities with additional funding specifically for vulnerable groups, including poor enrolees. Through sustained advocacy, KanSLAM pushed the government to set up the Kano State Contributory Healthcare Scheme (KCHMA) to address financing of healthcare targeted at poor patients by adapting national health insurance to the state context. Also in Kano, PATHS and MNCH programmes supported free MNCH services in government-owned facilities, with government funding increasing as a result. The Kano WDC led resource mobilisation to support health facilities and the poor's access to services by raising funds from local governments and community leaders and establishing a loan system to cover costs upfront for the poor. In Jigawa, the corresponding contributory scheme (JICHMA) was a robust programme funded by the state government that provided free MNCH services and benefitted poor populations. The government increased funding for health programmes as a result, and worked to integrate health insurance schemes to ensure broader coverage. In Enugu, programmes engaged with faith-based CMSs supplying health facilities to better supply the poor with affordable essential drugs.

"The BHCPF is already covering some vulnerable persons. It is expected that synergy [with community and faith-based] approaches would increase financial risk protection […] We really have to see how the efforts of these initiatives are harmonised." – Implementing partner national-level senior staff, Kano

Addressing disability in health interventions

Programmes have shown limited consideration for targeting persons with disabilities. Ongoing programmes WISH and Lafiya have actively supported people with disabilities by improving sexual and reproductive health including for adolescents with disabilities, and including persons with disabilities into technical working groups for reproductive and adolescent health programmes. WDCs included persons with disabilities as members while KCHMA advocated and raised funds from the state government to pay the contributions for vulnerable groups, specifically targeting patients with disabilities. Nevertheless, most programmes relied on existing, often limited, support structures provided to people with disabilities by community groups and state or local governments.

"Under the Safe Motherhood Initiative (SMI), [it was key to ensure] demand creation and empowering communities that enabled men to allow their wives to access care. [We were] working through community leaders to allow community members to serve as volunteers […] to disseminate the right messages and facilitate access to services." – Implementing partner, national-level senior staff, Kano.

"Inclusion of people with disabilities into the SRH programme has been a huge success […] We included people with disabilities into the Technical Working Groups for reproductive health and adolescent health programmes. This kind of inclusion has been a game-changer." – Mid-level officials, SMoH, Jigawa.

Financial barriers and sustainability challenges

However, most of these structures are limited due to a lack of funds, relying on government funding and capacity to sustain, and fail to consider that finances disproportionately prevent vulnerable groups from accessing healthcare. Most government, community and faith-based support structures have limited coverage and are unsustainable due to a lack of funds, relying on the state and local government funding and capacity. Several respondents noted that in Jigawa, JICHMA faced challenges in extending coverage to the entire population, even with increased funding. The health insurance scheme currently covers a small proportion of the state's population, and government and donor support are required to expand this. It was the commissioner who pushed for the introduction of free MNCH services and care for illnesses such as malaria, which were consistently delivered and benefited many women and children in poverty. In Kano, the WDC lacks resources to maintain clinics and hospitals and buy medicines and essential supplies for the DRF, and relies heavily on raising funds from communities and local and the state government. Notably, only a minority of programmes have considered the interplay of social and economic inequality, failing to recognise that financial constraints disproportionately prevent vulnerable groups from accessing healthcare, including poor women, children and disabled. PATHS2 supported the establishment of a community-based contributory healthcare programme focused on poor women's pregnancy and their children's health.

"The people they identified were genuinely in need, and because they were responsible for their contributions, more invested in making sure the services were delivered effectively […] Waqf has become a model for achieving universal health coverage. Local governments are increasingly willing to pay for the healthcare of their residents through this program, and it has supported […] identifying those who need help the most." – Senior official, state government implementing body, Kano"

"The BHCPF is already covering some vulnerable persons. It is expected that synergy [with community and faith-based] approaches would increase financial risk protection […] We really have to see how the efforts of these initiatives are harmonised." – Implementing partner national-level senior staff, Kano

"We focus on finding resources to keep the health centres running […] to raise money within our own community so we don't have to depend entirely on outsiders. We've built trust and gotten support from both our local government and the state government […] and thanks to that we managed to get 70 million naira for our health centre." – Senior staff, state civil society organisation, Kano

Coherence

FCDO health systems strengthening interventions were designed to complement each other. Some coordination has been achieved both between health programmes and between health programmes and other sectoral programmes, notably governance, but this tended to be more through shared implementing partners than formal coordination mechanisms. Coordination with GoN was evident in formal planning structures, long-standing professional relationships and embedded staff. State-level coordination among development partners was most effective under GoN leadership. We found evidence of FCDO as a thought leader in HSS, with other development partners replicating or adapting HSS interventions like the Emergency Transport Scheme (ETS) and DRF in other states. HSS interventions broadly aligned with international best practices, particularly in political engagement, long-term commitment, alignment with national priorities and adaptive learning, but gaps remain in addressing Human Resources for Health, leadership and other soft skills, and in strengthening data collection.

EQ3.1 Were HSS interventions well-coordinated with the government of Nigeria?

Summary: Efforts by the FCDO HSS programmes and the Nigerian government to coordinate could be characterised as robust at both federal and state levels. Formal planning structures, long-standing professional relationships and embedded staff all served to facilitate effective collaboration. Establishing and maintaining strong relationships between project staff and government officials was crucial for effective coordination. Collaboration on malaria and AIDS interventions helped align programme activities with government priorities at the national level. Regular involvement in planning and budgeting processes ensured that programmes were integrated effectively, while FCDO's participation in national coordination efforts helped keep project implementation on track.

Key findings
• HSS interventions were generally aligned with the country's national and state-level health priorities. • At the federal level, HSS programmes coordinated with the Federal Ministry of Health to create stronger policies and enhanced processes, which in turn helped maximise donor contributions and strengthen the health system longer-term. • At the state level, coordination varied more, relying on government buy-in and administrative capacity, and was dependent on a combination of formal arrangements and informal relationships.
Challenges identified
• At the federal level, while disease-specific programmes aligned well with federal priorities, their top-down approach conflicted with broader HSS efforts. • At the state level, differences in political priorities by state leaders created challenges in achieving coordination within and across states.

Intervention spotlights
• PATHS1, PATHS2, PRRINN-MNCH and MNCH2 contributed to the development and implementation of key policy frameworks, including the National Health Act (NHA), PHCUOR and Basic Health Care Provision Fund (BHCPF). • Disease-specific programmes, including SUNMAP and SUNMAP2, closely coordinated with the NMEP and SMEPs to support national disease control strategies.
Analytical methods
• Thematic analysis of CF6. • GoN and IP responses. • Programme document review, including annual monitoring reviews.

Challenges in coordination

In spite of significant efforts to align with government priorities, several challenges remained. Implementation success depended on the engagement of individual state governors. HSS intervention outcomes were affected by some states prioritising health reforms, with others focusing more on competing political interests. The passage of the National Health Act did not immediately translate into timely funding for state and local health programmes. Delays in fund allocation at the state level disrupted service delivery and long-term planning. While disease-specific programmes aligned well with federal priorities, their top-down approach sometimes conflicted with broader health systems strengthening efforts at the state level.

"Delayed fund releases made it difficult for states to plan and execute health programmes effectively. Even when policies were in place, financing gaps created major setbacks." – Programme Implementer

Federal and state-level coordination

At the federal level, HSS programmes coordinated with the Federal Ministry of Health (FMoH) to create stronger policies and enhance planning. Initiatives like Lafiya and PATHS2 enhanced health sector governance, and ensured decisions relied on solid evidence. In addition, organisations such as HERFON and the Advocacy for Primary Health Care Reform (APHCR) helped ensure that policies moved beyond paperwork and took effect. One of the greatest successes resulted from the close partnership between FCDO-funded programmes and federal institutions. This partnership advanced major policy initiatives like PHCUOR and BHCPF, made reforms more effective, and created new funding opportunities. Beyond improving processes, these efforts helped maximise donor contributions and strengthen the health system for the long haul.

At the state level this depended both on formal participation and support to planning arrangements and on close informal relationships and continuing contacts around activities. This was further strengthened where staff were embedded or spent considerable time working directly with counterparts. Increasingly these relationships were based on prior working relationships of project staff and counterparts while in government employment.

At the state level, coordination varied widely depending on government buy-in and administrative capacity. Programmes such as MNCH2 and PRRINN-MNCH recognised early on that project success depended on the political commitment of state governments. So, initiatives such as the State Strategic Health Development Plans (SSHDPs) were implemented to better align with national policies. In some states, programme staff worked directly within state health ministries to contribute to health sector planning and implementation. Close collaboration enabled states to successfully integrate donor-funded interventions into their existing health systems. Differences in political priorities and institutional capacities did create some challenges in achieving uniform coordination across all states.

"Embedding technical assistance within government institutions helped drive reforms from within. This approach strengthened national ownership and capacity." – Health Policy Expert

"Some states fully embraced health reforms, while others lacked the political commitment needed to sustain them. This inconsistency impacted implementation outcomes." – State Health Official

Alignment with national and state health priorities

HSS interventions in Nigeria were in general aligned with the country's national and state-level health priorities. Programmes including PATHS1, PATHS2, PRRINN-MNCH and MNCH2 contributed to the development and implementation of key policy frameworks, including the National Health Act (NHA), PHCUOR and Basic Health Care Provision Fund (BHCPF). These interventions contributed to governance reforms and strategic planning at all levels of government. Disease-specific programmes, including SUNMAP and SUNMAP2, closely coordinated with the NMEP and SMEPs to support national disease control strategies. These programmes not only shared resources but also helped advance coordination between different government levels and international partners. However, programme effectiveness required the commitment and engagement of state leaders. Implementation across states was uneven, since some governors took an active role in advancing federal health policies while others focused less on reforms.

EQ3.2 How well do the health systems strengthening interventions relate to and co-ordinate with each other, as well as with other BHC Nigeria programmes? Are they complementary or in competition?

Summary: HSS interventions in Nigeria were intended to complement each another, as evidenced by flagship programmes like PATHS1, PATHS2, MNCH2 and Lafiya working alongside more targeted initiatives in malaria control and reproductive health. While there was coordination, much of it occurred informally through shared personnel and implementing partners rather than through structured frameworks. Knowledge loss and gaps in continuity often resulted from transitions between major initiatives, although some programmes, particularly in workforce development, functioned well together. Coordination of HSS interventions with governance and education initiatives was limited, as seen with the inconsistent collaboration between PATHS2 and SPARC. In short, while the HSS programmes were designed to complement each other, and managed to do so, improved coordination and smoother transitions would have helped boost their impact.

Key findings
• Flagship and complementary health programmes were mutually reinforcing, as core HSS initiatives strengthened health systems and disease-specific and advocacy programmes filled gaps. • Health programmes built on governance, accountability and health financing reforms of prior phases. • Governance and institutional capacity improved at federal, state and LGA levels thanks to programmes shaping policies and strengthening planning, budgeting and implementation. • Collaboration and knowledge-sharing came mostly from consultants working across programmes. • Cross-sectoral coordination among programmes was partly successful, mostly in governance.
Challenges identified
• Transitions between flagship health programmes sometimes led to knowledge gaps because changes in contractors disrupted continuity, knowledge-sharing and consistency of approach. • State-level implementation depended on political leadership, which led to inconsistent results where government commitment was weak. • Programme integration within states was hindered by weak leadership and coordination.
Intervention spotlights
• PATHS2 and MNCH2 supported state-level budgeting and planning by incorporating best practices that allowed states to integrate health policies into long-term strategic plans. • Lafiya strengthened health governance and financial planning by helping states to establish Departments of Family Health and to secure BHCPF equity funds.
Analytical methods
• Thematic analysis of CF5. • FCDO, GoN, IP and CSO responses. • Document review including BCs, logframes and PCRs.

Strengthening governance and institutional capacity

FCDO flagship programmes over the 20-year period showed a sequential and iterative layering of support to GoN. Earlier programmes laid the groundwork for change at federal level by developing national strategies and primary legislation and then extended these through to the states. PATHS1 worked to develop national and state level health sector plans, while HERFON worked at building capacity at the federal level, partnering with FMoH, NPHCDA, NHIS and national NGOs (HERFON2 PCR). PRRINN-MNCH extended this support for capacity-building to selected LGAs through their Annual Operational Plans. PATHS2 provided support at all three levels. Support to the federal level was through budgeting and planning as well as development of new policies and legislation, notably the National Health Act (see Case 14).

Support to state level was similarly through best practice budgeting and planning approaches, costs incorporated into state budgets, and state-level policies, plans and legislation, as well as a regulatory framework for private health provision in southern states. Although its focus was on RMNCH, MNCH2 built organisational capacity at state and LGA level. Lafiya, like PATHS2, provided support at all three levels of government, with a focus on providing technical assistance, particularly at the state level. At mid-term, Lafiya has states including Kano and Jigawa to establish Departments of Family Health, receive disbursements from the BHCPF, establish the Kano Centre for Disease Control (KCDC), and support SWAp arrangements (Lafiya MTR). CAP (Case 4) helped unify a fragmented system by fostering collaboration across interventions. Individuals in mid-career exposed through the programme to best practices in aspects of health system strengthening would subsequently occupy positions of influence in government and within projects and organisations working with government. This made working together easier through a common understanding of desirable changes.

Key personnel as drivers of programme continuity and collaboration

Programme continuity and coordination benefited from key personnel – both international and Nigerian – moving between health programmes despite changes in implementing partners and administrations. For example, the key advisor on the Health Commodities Programme took on the senior role for commodities on PATHS2. Benefits were apparent as thinking on integrated service delivery was carried forward, using the District Health System (DHS) from PATHS for PRINN-MNCH's work on streamlining the financing and management of primary healthcare through Primary Health Care Under One Roof (PHCUOR) policy reforms. Key individuals from PATHS and PRINN-MNCH also helped to develop the work of SUNMAP and W4H. Continuities between MNCH2 and Lafiya were strongly enhanced by continuity of senior staff.

Where projects were managed by the same lead organisation and common consortium members, there was a greater propensity towards collaboration. PATHS1, PRINN-MNCH and W4H overlapped in delivery but shared a common implementing partner, Grid Consulting. The projects identified where each could work to greatest advantage, with W4H taking the greater role in support to training institutions and student recruitment, with PRINN-MNCH focusing on wider HR policy and planning. Implementation by the same consortium member clearly assisted such collaboration.

Connecting HSS and health programmes for greater impact

Overall, there was coordination between HSS programmes and some coordination with other FCDO programmes in the health, governance and education sectors. FCDO health programmes were designed to be complementary, with one larger flagship programme focussing on health systems strengthening and smaller side programmes focussing on specific issues or diseases. Coordination between health programmes was often done informally at the individual level, through common advisors or implementing partners. For most of the programming period, FCDO Nigeria has delivered HSS programmes in phases, with one larger flagship programme supported by several smaller complementary side programmes. PATHS1 (2002-2008) ran alongside an advocacy programme (HERFON1, 2004-2009), a programme targeting a major communicable disease, HIV/AIDS (SNR, 2004-2010), and a programme focused on health commodities (HCP, 2005-2009).

PATHS2 ran from 2008 to 2016 and replicated this delivery approach, supported by two advocacy programmes (HERFON2, targeting passage of the NHA, 2009-2013; and APHCR, targeting primary healthcare reform, 2012-2020), two programmes targeting communicable disease (SUNMAP/SUNMAP2 for malaria, 2008-2021; and UNITED for neglected tropical diseases, 2012-2019), and a programme targeting the lack of qualified female healthcare workers in northern states (WFH, 2012-2020).

"We raise money within our own community so we don't have to depend entirely on outsiders. We've built trust and gotten support from both our local government and the state government [...] and thanks to that we managed to get 70 million Naira for our health centre." – Senior staff, state civil society organisation, Kano

"If you take a state like Jigawa or Kano, the flagship programme is the anchor, and the ancillary like SUNMAP or HIV sits with them, so it all fits together. Connections across advisors, with some coming in for one programme but advising on another." – Implementing partner, federal level

Enhancing cross-sectoral coordination in health programmes

Coordination between BHC Nigeria programmes in other sectors was limited and could have been strengthened. The closest areas of coordination were in governance, where in anticipation of the current SWAp, FCDO ran health and governance programmes simultaneously. The ESSPIN education programme was mentioned by only two respondents, as part of a suite of programmes designed around the PATHS2 era.

Where programmes were active in the same states there is evidence of some collaboration and re-enforcement of interventions. However, for other programmes, this seemed to be episodic and opportunistic rather than evidencing a jointly agreed approach. The SUNMAP1 PCR referred to overlap with PATHS2 states stating that while the programmes kept each other informed of their activities, the integration of interventions were passive, and opportunities for synergy were not always fully utilised.

"When these programmes were designed, some of them they were designed to start almost at the same time. And they never happened that way. And so with PERL [governance programme] last year and the education programme, they were supposed to start at the same time. But there were delays in the procurement process, so PERL started much earlier and engaged deeply in some of those sectors in the locations." – FCDO staff

Evolution of flagship health programmes

A dedicated reproductive, maternal, newborn and child health (RMNCH) thematic area was launched by the flagship PRRINN-MNCH programme, which bridged flagship programmes PATHS1 and PATHS2. The RMNCH theme was followed by MNCH2 (2014-2019) and contributions from two centrally managed reproductive health programmes, PMDUP (2011-2018) and WISH (2017-2024). The current flagship programme, Lafiya (2019-2027), was designed to be flexible and responsive to government demand. It has undergone several significant changes since its inception, due to COVID and budget cuts. Lafiya has continued with governance, accountability, human resources for health, health financing, capacity-building and support to HMIS workstreams from other flagship programmes, and has picked up family planning and maternal health from MNCH2. It does not have concurrent disease-specific or advocacy programmes.

By its design and implementation Lafiya has several delivery mechanisms focusing on specific areas, with different implementing partners collectively aiming towards achieving a common programme outcome and impact. First, it has a core component strengthening existing health systems at federal level and in its five focal states - Kano, Kaduna, Jigawa, Borno and Yobe. Secondly, it provides extra resilience healthcare for particularly vulnerable areas in Borno and some parts of Yobe. And finally, it increases availability of family planning commodities and improves access to family planning across Nigeria.

Lessons learned on programme design and coordination

The concept of a suite of programmes per state was well conceived. Several informants point to the value of the governance programmes providing a helpful context to work on planning and budgeting in the health

sector, and the importance of having entry points to the centre of government ministries closer to the governor. However, the impact was less than expected in practice. As one programme implementer recounted, “PATHS2 design was good in placing health within a wider context with the associated suite of programmes – SPARC, ESSPIN, SAVI […] the design was well thought out […] how health is connected to the bigger governance issues.” However, this design was not well exploited in practice, with insufficient joint working. “Seemed like there was a lack of overall leadership […] not much orientation about big picture at implementation […] We were not really able to optimise that thinking.” While there was no evidence of competition between programmes, tensions arose between PRRINN-MNCH and the PATHS1 consortium. As such, PATHS2, which was won by a different consortium, took a different approach to implementing, with some overlap in states.

Managing transitions for stronger programme continuity

There were, however, discontinuities between successive HSS flagship programmes and even follow-on phases of disease-specific programmes like malaria, due to the different remits of each programme. For example, by design PATHS1 was meant to provide technical assistance and not material support, so it was difficult to get people interested in what was offered. “When we started, we were providing software, […] TA, not hardware,” noted an implementer. But soon this changed with the supply of medical equipment and drugs along with technical support, which was the approach PATHS2 adopted. The PATHS2 PCR noted that “much of the knowledge and experience of PATHS was lost in a poorly organised transition to PATHS 2 (with a change of contractor). Such transitions are naturally difficult and need to be resourced and actively managed” (p.6).

Furthermore, MNCH2 mandate of direct health facility support was in contrast to Lafiya’s focus on technical assistance and engaging government to improve efficiency and effectiveness of public health services. Similarly, while SUNMAP was meant to focus on improving capacity for scale up, it was the intention that SUNMAP2 will work on getting malaria on the political agenda. Thus, even if there was lack of any significant arrangements for handover and briefings, as was the case between PATHS and PATH2, discontinuity is likely to be a major feature resulting from individual programme agendas.

EQ3.3 Are HSS interventions coordinated with other development partners?

Summary: Coordination of HSS interventions across development actors has been most successful where efforts have been led by government. This has been further strengthened by technical assistance from FCDO flagship HSS programmes. Coordination was generally stronger at federal level and more challenging at the state and grassroots levels. At the federal level, co-ordination has strengthened over the 20-year period, due to increased leverage of federal institutions within the system acting as a magnet to development partners. At the state level, coordination has been varied and generally weak, with examples of parallel interventions being implemented without full integration and some development partners operating across regions rather than state by state, making state level coordination difficult.

Key findings
• Donor coordination improved as government leadership and FCDO’s technical support helped bring partners together at both federal and state levels. • State-level coordination among development partners was most effective under GoN leadership. • State Health Plans helped integrate and coordinate donor programmes, such as PRINN-MNCH in Jigawa and joint funding efforts for immunisation and emergency transport. • Development partners adopted DFID-led health system strengthening models, applying best practices in workforce recruitment, supply chain improvement and institutional capacity-building.
Challenges identified
• Donor coordination fell apart in states with weak engagement. • Ineffective state-level coordination made it harder for states to carry out their health programmes. • Parallel systems created by some development partners, such as separate supply chains and monitoring and data collection, weakened efforts to build a unified health system.

Intervention spotlights
• FCDO improved donor coordination by helping align funding and technical support with GoN. • PRRINN-MNCH brought together GAVI and other donor contributions in key states to set up a basket fund for immunisation and primary healthcare. • SUNMAP and USAID's MAPS programme coordinated malaria control efforts while providing technical support across states.
Analytical methods
• Thematic analysis of CF7. • FCDO, GoN and IP responses. • Cases 9 and 17. • Programme document review, including PCRs.

Strengthening collaboration and maximising impact

In some respects, the activities of other development partners undermined a consolidated health system strengthening approach. An example of this was development partners developing parallel commodities distribution systems rather than harmonising their approaches (Case 9 and Case 17).

However, in other respects development partners adopted mechanisms in health system strengthening that were developed and maintained by DFID. Some examples include GAVI adopting the system initiated by PATHS2 of recruiting and deploying additional health workers whose salaries were initially fully paid by the programme, then by cost sharing with government, and finally by being absorbed into the state government service; or UNICEF upgrading warehouses of state sustainable drug supply agencies that had been established by PATHS2.

Collaboration with other development partners

UK-funded HSS programmes engaged with other international development partners, including the World Bank, WHO, Global Fund, USAID and UNICEF. Coordination was achieved through joint working groups, technical assistance partnerships and participation in national and state-level health sector meetings. Disease-specific programmes such as SUNMAP and SUNMAP2 worked closely with the Global Fund's malaria programming, ensuring efficient distribution of resources and reducing duplication of efforts. MNCH2 and Lafiya collaborated with UNICEF and WHO to align maternal and child health strategies with broader global and national frameworks. Although UK-funded programmes were in general viewed as key partners, some gaps with collaboration were noted. Stakeholders reported that collaboration between UK-funded initiatives and other donors could have been stronger. In some cases, parallel interventions were implemented without full integration, which limited the potential for a more unified approach.

"Uk programmes played a leading role in policy reforms, but there were missed opportunities to work more closely with other donors on funding alignment and implementation at scale." – Development Partner Representative

Expanded coordination through state health plans and partnerships

State Health Plans incorporated donor programmes, including UNICEF and WHO programmes, and DFID-supported programmes such as SUNMAP and the WINNN nutrition programme. Practical collaboration extended to mobilisation of funds from several sources during the 2013 measles outbreak. A later example is the collaboration between MNCH2 and CHAI in support of Emergency Transport Schemes (Case 2). PRINN-MNCH provided support beyond co-ordination and individual initiatives to the establishment of a basket fund for routine immunisation and PHC activities in Zamfara and Yobe States. This included GAVI funds in Zamfara State. Thus, it considerably pre-dates the current SWAp initiative. During the MNCH2 period, monthly meetings took place at federal and state level.

The SUNMAP mandate emphasised the fostering of collaboration. It was certainly assisted in this by the leadership of the National Malaria Elimination Programme. Good collaboration was achieved with USAID and Global Fund, including a set of technical working groups. The key to the success of the SUNMAP approach was to keep government in the driving seat of harmonisation efforts but to provide close technical support. This continued in the SUNMAP2 period. Of particular note was the replication or continuation of

project initiatives through Global Fund, including the integrated community case management approach, the quality of management of severe malaria and seasonal malaria chemoprevention in Jigawa. Support to institutional capacity-building of the National Malaria Elimination Programme was transitioned to the Gates Foundation.

Under Lafiya, greater attention is being given to this in the form of discussions on health minister Pate's Sector-Wide Approach (SWAp), which aims to align the efforts of government, donor agencies and other groups with pooling of funding in the health sector across the tiers of government. FCDO and Lafiya engagement with the Health Development Partners Group and the Nigeria Development Partners Group is strong.

Improved donor coordination in the health sector

FCDO Nigeria and its implementing partners actively supported donor co-ordination. Donor co-ordination needs to be led by government both at federal and state levels, and to align with government policy priorities; at times this coordination can also be consulted by FCDO Nigeria. Where government was active in this respect co-ordination was more effective. Over the 20-year period, donor co-ordination has increased due to increased leverage of the federal/national institutions within the system acting as a magnet to development partners. FCDO flagship programmes provided technical assistance to strengthen this process.

Strengthening coordination at the state level

In PATHS1, the Federal Minister of Health was looking to strengthen co-ordination, but state-level coordination was varied and generally weak. Multilateral organisations such as UNICEF and WHO operated across regions rather than state by state, making state-level coordination difficult. In the PATHS2 period, co-ordination was strengthened with project support at federal level, but the translation of this into effective state-level collaboration remained varied.

> *"One of the main thrusts of PATHS2 is donor coordination. While there is donor coordination at the Abuja level, the same cannot be said at the grassroots level, where harmonising activities is still a major challenge. […] This has led to missed opportunities for leveraging resources, and to duplication of efforts. SLP [State Led Programmes] coordination has also not worked as expected, with joint planning and development of interventions to implement ideas agreed upon, not done in a systematic way. As a result, the SLP's structured approach papers have not been followed through." (PATHS2 midterm progress report, final corrected, p.96)*

Leveraging financial and technical tools for coordination

PATHS2 also benefited from the public financial management database and pivot tables that were routinely developed by SPARC and which were beneficial as a source of information for health expenditure analysis and public expenditure reviews in health in each state, including Kano and Jigawa. In Lafiya, a mutual accountability framework (i.e. through the mechanism of SPARC) was established as a platform to ensure mutual benefits between state governments and FCDO were possible. For instance, the appearance of SPARC in Kano and Jigawa helped initiate a robust donor coordination platform to motivate collaboration and coordination across development partners and state authorities. An implementing partner recalled their mandate to outreach and collaborate with other development partners, for example with UNICEF on CHIPS programme. The depth of co-ordination varied; respondents reported coordination mechanisms with FCDO support in several states. In Enugu during the PATHS2 period, the success of such a health co-ordination mechanism led the governor to establish a broader meeting covering all donor support.

An implementing partner described how SUNMAP and MAPS, a programme funded by USAID and President's Malaria Initiative, worked in parallel to ensure consistency in malaria control efforts across Nigeria. While SUNMAP and MAPS operated in different states and were not formally planned together, the two programmes still aligned in their approach and interventions, due to shared implementation personnel and endorsement from the national malaria programme.

EQ3.4 Do the approaches to health systems strengthening used by BHC Nigeria in Nigeria align with those that the international evidence suggests are effective? and

EQ3.5 Where are the gaps? What isn't being covered?

Summary: FCDO's health systems strengthening approach in Nigeria broadly aligns with international best practices, particularly in political engagement, long-term commitment, alignment with national priorities and adaptive learning. Programmes built strong relationships with political stakeholders and adapted to shifting policies, with much of the capacity-building focused on technical health skills. However, gaps remain in impact evaluation, digital health innovation and multisectoral collaboration – areas that have recently gained more attention in FCDO policy discussions. Although coordination with the Nigerian government was clearly strong, collaboration with external donors and other stakeholders was notably less consistent. Addressing these gaps would result in interventions that are more sustainable and have a greater overall impact.

Key findings
• Government expenditure improved health systems; however, its impact was constrained by difficulties in adapting to political changes. • Capacity-development enhanced technical skills, but insufficient leadership and governance training prevented more comprehensive institutional change. • Community participation enhanced accountability, but state and local governments encountered reduced financial and technical support following programme closure. • Government coordination was robust, but inadequate donor collaboration restricted pooled funding and sector-wide integration.
Challenges identified
• GoN funds were allocated but were frequently not disbursed, so donor dependency persisted. • Rural areas were beset by staff shortages, with retention affected by low and delayed salaries • Data collection improved but was discontinued after donor departure. • Essential medications and vaccines were often unavailable and/or inconsistently distributed. • Primary care did improve; however, referrals and advanced care remain weak.
Intervention spotlights
• Engaging directly with government leaders and aligning efforts closely with national policies to build lasting ownership. • Maintaining long-term commitment across multiple programme cycles to ensure continuous improvement and adaptation. • Matching interventions with Nigerian health priorities such as PHCUOR and Saving One Million Lives, while also shaping these policies. • Training government and frontline health workers, particularly in practical maternal, child health and disease management skills.
Analytical methods
• Literature review and evidence synthesis • Programme BCs, ARs, PCRs, logframes and VfM frameworks. • Cases 1, 2, 6, 7, 8, 9 and 11, and Paired Case 7

Matching interventions to local needs

International evidence on the topic is limited (See EQ3.4 and 3.5) but the Witter et al.'s review (2021) offers a useful starting point for examining the patterns of investment made by the portfolio programmes. Effective HSS involves matching local needs with appropriate interventions but also delivering in an adapted manner. So how you work is as important as what you put your funds into, in terms of effective HSS.

Key approaches that strengthened health system interventions

Picking out some of the factors highlighted as favourable to HSS effectiveness in terms of ways of working (Witter et al. 2021), we find some evidence of good practices across the FCDO programmes. For example:

- **Building political commitment:** Engagements in support of the National Health Act and CAP show evidence of the recognition of the need to work politically and to encourage ownership, as well as taking advantage of political windows of opportunity. Programmes were politically savvy and spent time cultivating relationships with the right power brokers at national and state level (and later, starting with Lafiya, at the LGA level) and trying to harness local structures.
- **Sustained commitment:** Long term investment is a testament to sustained commitment, although focal areas within the programme did shift over time.
- **Alignment with national priorities:** Output mapping shows FCDO programming was aligned with GoN policy priorities, including NEEDS and SEEDS, the National Health Plan, PHCUOR, and the Saving One Million Lives campaign, and also influenced them (see EQ2.3). Due to decentralisation, states operate independently and thus most programming was at state level, with ample support to federal level frameworks. Some programmes supported at facility level and a few at LGA level.
- **Iterative learning and adaptation:** Programming was adaptive from one phase to the next and even within the programming cycles, with some evidence of lessons being learned and acted on (e.g. recognising the need to bring in a focus on commodities in the HCEP project) and of FCDO supporting different states' policy priorities at different times.
- **Capacity-development and mentoring:** Capacity-building efforts were provided for both government officials and frontline healthcare workers, though this seems to have focused more on 'hard skills' relating to maternal and child health, and malaria and other targeted diseases, rather than 'soft skills' such as teamwork, collaboration, adaptation and organisational flexibility and learning.
- **Donor coordination:** There was evidence of good coordination with GoN at various levels, but less of coordination with external donors or stakeholders.

Assessing FCDO investments and identifying gaps

Below we highlight promising practices from the evidence review, and examine whether FCDO programmes invested in them, while also recognising that they may have varying relevance in the Nigerian context. The practices are detailed in Table 13 below. Some potential gap areas are also highlighted, although we recognise that FCDO needed to prioritise and could not cover all investment areas. Those areas which have received more focus in recent FCDO position papers include better impact assessment, investments in transforming health services through digital technologies, and multisectoral collaboration. These were not prominent in the programmes reviewed.

Table 13: Assessment of programmes in terms of focus areas

Good practices from previous review	Comment on focus within FCDO programmes	Comments and potential gaps
Leadership and governance		
Studies suggest that complex leadership programmes blending skills development, mentoring and promotion of teamwork can bring about improvements in service quality, management competence and motivation	Perhaps because the programmes were not initially framed as HSS and were also able to benefit from independent FCDO governance programmes in the states, there was limited focus on leadership development per se in these programmes, with training more focused on technical skills such as antenatal care for frontline health staff, and financing and budgeting for managers, with some mentoring as part of handing over to GoN staff. However, CAP seemed effective, with participants still in many cases engaged in mid to senior roles in government and linked but non-government roles.	Reflecting on the HS process goals, potentially important but less focused areas including developing transformational leadership capacity at all levels in the sector and supporting more effective multisectoral collaboration.
Civil participation and community engagement		
Civil participation (engaging community members with health service structures and processes, and increasing accountability) was found to be among the effective areas of HSS investment. It was also an enabler to other programme areas.	Some emphasis was placed on participatory design early on, and on supporting accountability mechanisms through CSOs, traditional leaders, Facility Health Committees or Ward Development Committees, with one programme also supporting the use of scorecards. There is also evidence that sustainability was enhanced when communities adopted and supported useful elements of the programming (see also the section on sustainability).	
Health workforce		
Bundled retention packages for health staff in underserved areas were highlighted as potentially effective.	The focus in terms of human resources for health (HRH) seems to have varied across the programmes and period. There has been some attention to policies and strategies around staffing and capacity but no direct attempt to address issues around salaries, late government payments and lack of staff motivation at PHC facilities and in government. One programme, Women for Health (W4H), sought to specifically address personnel in rural and underserved areas in the north, and was partially successful in doing so because it worked at system-level (in state schools for nursing and midwifery), and supported policies for graduates to be 'bonded' to their communities for two years after graduation, to prevent brain drain. There is also some evidence of using CHIPs and CHEWs, and some evidence that these were partly sustainable. Performance management schemes seem only to have been addressed in earlier programmes (PATHS1 and PRRINN-MNCH).	More attention could have been paid to the large disparities in health workforce between the north and south of Nigeria. Only Women for Health addressed this area. Issues of staff remuneration and management are perennially important in systems with maldistribution and high dual practice, but there was limited attention to this area.
Health financing		
Most interventions within health financing can be effective, though the importance is less the formal labelling of arrangements than shifting towards accepted good practices in revenue raising, pooling, purchasing and provision.	FCDO's approach to health financing has been to support legislation committing government at federal and state level, and to allocate funding to healthcare, especially primary healthcare. Later, when commitments and allocations did not translate to actual disbursements, FCDO focused on disbursement of allocated funding, and accountability mechanisms. There have been some limited successes around funding at local level, from sources such as *waqf* (see Case 11), community emergency transport (Case	FCDO programmes aimed for many programme initiatives to be taken over by GoN funding but this met with limited success. Donor funding does not incentivise governments to commit to an area (seeing it as likely to continue to be covered by external funders); the NHA exemplifies this, as it commits 1% of the CRF and identifies donors and development partners as integral sources of funding. Later

	2) and drug revolving funds (Paired Case 3), as well as insurance from the BHCPF (Case 6). It seems that state funding dried up in states like Enugu which FCDO exited. There have been limited attempts to hand initiatives over to other donors to ensure sustained support to programmes when it was clear that FCDO funding would diminish, most recently to World Bank, Global Fund, GAVI and USAID funding.	programmes, including W4H and Lafiya, placed more emphasis on leveraging government funds. In terms of strengthening national health financing systems, there has been increased focus in recent years internationally on the link with public financial management systems to ensure efficient allocation, better fund flow and accountability, for example. A key dimension for UHC is financial protection, which has been stagnating or even deteriorating in many contexts recently; an estimated 90-95% of Nigerians are without any coverage.
Health information		
The 2021 review found a lack of published evidence in this area, which does not negate its importance.	FCDO supported HMIS systems, including the DHIS/2 (Case 19) and ISS (paired case 1), through multiple programmes to promote data-driven decision-making. There is evidence that programmes improved the quality of the data, and senior leadership started looking at and demanding reports, but this is an expensive undertaking and does not seem to have been sustained in states where FCDO has exited.	
Supply chain strengthening		
The 2021 review found a lack of published evidence in this area, which does not negate its importance.	There are parallel private and government supply chains in Nigeria, and FCDO programmes have utilised different supply chains or a hybrid of both to deliver essential medicines and supplies. See Case 9 for more details.	
Service delivery		
Many of the service delivery reforms were effective, including strengthening community-level services, introducing integrated care packages such as IMCI and ICCM, PHC strengthening, service integration (especially comprehensive approaches) and some quality improvement initiatives.	The FCDO programmes focused almost exclusively on the public healthcare level, rather than secondary or tertiary care, with greater emphasis on training frontline heath care workers, although PATHS1 and 2 also looked at renovating PHC facility infrastructure. Efforts were also made to ensure that PHC facilities were adequately stocked with drugs, vaccines and supplies, which are key for quality of care and patient satisfaction. Quality of service was measured only in later programmes (from MNCH2, 2014-2019, onwards); earlier ones seemed to be focused on having at least one trained staff in PHC facilities in specific areas. There is however good evidence that basic or essential packages of health services focused on HIV/AIDS and RMNCH/ANC have improved outcomes in the northern states.	The emphasis on PHC was appropriate to targeting more vulnerable populations, however, referral links are also crucial. More effort could arguably have been put into quality improvement initiatives from earlier on, and improving organisational culture to support continuous improvement. We recognise however that this issue has risen on the international agenda over the period. Equally, a focus on essential public health functions to support resilience, as per the FCDO HSS position paper, may now warrant more attention.

Value for money

Value for money was difficult to assess given limited VfM programme data and the broad range of programme outputs and outcomes. DALY was the most common measure of cost-effectiveness, but this varied widely based on assumptions of attribution. HSS flagship programmes appeared to offer worse value for money compared to disease-specific programmes, because of attenuated results chains. Some evidence shows that delivery costs may differ widely between states, based on cost of living and security risks, and may be greater when catering to rural and underserved areas.

EQ4.1 Under what conditions are health systems strengthening interventions able to provide better value for money?

Summary: Evaluating value for money across FCDO HSS programmes in Nigeria has proved challenging due to gaps in data availability and the standardised indicators not being used in earlier programmes. While VfM reporting became more structured after 2006, measuring impact, cost-effectiveness and equity outcomes remains a challenge. The metric most commonly used was cost per DALY, although application did vary. In an effort to reduce costs, programmes prioritised recruiting local staff, obtaining government funding and streamlining procurement. Programmes that target underserved communities and people with disabilities tend to entail higher expenses, which can make balancing cost-effectiveness with equity difficult. For future programming, long-term financial sustainability and impact will call for better data collection, standardised VfM frameworks and more reliable funding.

Key findings
• Value for money assessments improved with time, as evidenced by later programmes incorporating more structured VfM frameworks and cost-effectiveness measures. • Cost-effectiveness tracking became more consistent, with cost per DALY a standard measure. • Economy was achieved by making more use of local consultants and competitive procurement. • Equity was embedded in some programmes, especially in gender-focused initiatives and efforts.
Challenges identified
• Better state-level monitoring would make it easier to track costs and measure long-term impact. • Future programmes should build in value-for-money metrics from the start to improve efficiency and justify continued investment. • Cost differences across states – driven by security risks, living expenses and external disruptions – need to be factored into financial planning, and make like-for-like comparison difficult. • Expanding healthcare in rural and underserved areas requires more resources.
Analytical methods
• Programme document review, including BCs, VfM and PCRs. • Cost-benefit analysis and comparison. • Cases 1 and 10.

Limitations in VfM data availability

Analysis of this question was challenging based on limited availability of detailed programme monitoring data, including disaggregated data broken down by state (or country, for centrally managed programmes), details on methodologies used, programme VfM frameworks, and respondents' limited recall about the details of costs of programmes that finished years or decades ago.

The first programmes in the HSS Nigeria portfolio – PATHS1, HERFON, SNR and HCP – had no VfM indicators or assessments, and so no data exists. HCP started recording data on price comparisons with the open market for its PCR. Value for money measures and reporting started being incorporated in FCDO programming around 2006. Centrally managed programmes illustrate the difficulty in attempting to compare VfM between countries. Reports for centrally managed programmes did not break data down by country and this information was not made available to the consultants at the time of the present evaluation. The multi-

country WISH programme business case did not have VfM targets and did not include VfM reporting by output. See Annex G – Programme VfM by Category tab for a mapping of VfM indicators by programme.

Measuring cost-effectiveness and VfM Indicators

Value for money comparisons between programmes is hindered by inconsistent data. The most consistent measure of value for money across the entire programme portfolio is cost per DALY. This was applied to all HSS Nigeria programmes that used a VfM framework except for HERFON (HERFON1, HERFON2 and APHCR), due to issues around attribution of a programme designed to support policymaking. DALYs would have been appropriate to apply to ENR/SNR as well, and was included in the framework for SUNMAP2 but not measured because funding for the longitudinal study was cut.

Table 14 below shows the types of VfM indicators used to monitor and evaluate programmes in the portfolio. Programme extensions, continuity of providers and handover to FCDO were all linked with improving economies of scale and cost-efficiency.

Programme-level cost analysis and variability

PATHS1: The median cost per training session was $1,974, or about $40 per person-day, including all associated costs. The highest average cost per person-day was for Abuja communications training ($172), and the lowest in Jigawa ($33). There was appreciable variation in the cost per person day between the different outputs, being highest for stewardship and communication (which may partly reflect location). SUNMAP2 noted that higher operations costs in some states may be related to higher running costs (Lagos, Abuja) and security (Yobe), as well as external factors such as COVID-19.

Strategies for cost savings and efficiency (VfM measures of economy)

Around half of programme VfM frameworks[4] tracked the use of short-term technical assistance (STTA) vs long-term technical assistance (LTTA) or international vs local consultants, aiming to reduce consultant and staff costs by using more LTTAs and local consultants or staff. PRRINN-MNCH and MNCH2 drove down staff costs by:

- **Increased use of local staff:** Shifting reliance from international to local staff (PRRINN-MNCH PCR p.3).
- **Community-based technical assistance:** Using local technical assistance in the communities or local areas, which 'built up the knowledge of individuals in those populations and reduced problems such as language or cultural barriers.' (MNCH2 PCR, p.20).
- **Government-led implementation:** Using government staff instead of consultants to strengthen institutional knowledge and improve government ownership.' (MNCH2 PCR, p.20).

Around half of programmes reported achieving economy through contracting – using competitive procurement processes or commercial negotiation during selection of implementing partners or the inception phase, or generating savings through a programme extension or handover to another FCDO health programme. Four programme VfM frameworks tracked training costs; some benchmarked their rates favourably against those achieved by partners such as the Federal Ministry of Health. The PCRs did not give much detail on training sessions, and differences in the depth of training and cost of venue hire in different states mean that these may not be entirely comparable across programmes. APHCR, for example, notes that the cost of training per individual ranged from NGN 7,000 to NGN 48,000, representing a range in the depth of training provided (APHCR PCR, p.12). Four programmes with community outreach, sensitisation or mass communication components measured the cost per individual reached. This is a mixed bag, as different programmes used different methods to reach their target beneficiaries, ranging from courtesy calls to advocacy events and mass media messaging.

Procurement and commodity pricing comparisons

Programmes with large commodities components looked at driving down unit costs through procurement mechanisms and economies of scale. Although it did not have a formal VfM framework, HCP led the way in benchmarking costs against WHO and Chan Medi-pharm wholesale prices. SUNMAP2 benchmarked prices against those obtained by the Global Fund and UNICEF, and found that these compared favourably, and that they had negotiated the cost of freight and export formalities to be included in the overall price. Lafiya benchmarked prices against USAID.

Procurement was done nationally or at a programme level, so contextual factors explaining differences in commodity prices were generally outside the control of the programme. For example, economy gains under PMDUP were tied to the decrease in global drugs prices, while the COVID-19 crisis meant that SUNMAP2 needed to use air shipment to meet project targets. Two flagship programmes, PATHS2 and MNCH2, as well as the malaria-targeted SUNMAP2, tracked overheads as a measure of economy and noted economies of scale in increasing programme spend or outputs against the same fixed administrative costs. The SUNMAP2

[4] This and other references exclude the five programmes that had no VfM frameworks.

PCR (p.24) noted variability in overheads and administrative costs in different states due to living expenses (i.e. Lagos vs Kano) and security provision. They also noted differences from 2019 to 2020 due to remote programme delivery during COVID-19.

Resource leverage and government contributions (VfM measures of efficiency)

The most common measure of efficiency, used in about half of programme VfM frameworks, was leverage of resources or resources-in-kind from the government of Nigeria, other donors and/or the community. Many programmes sought to achieve sustainability by lobbying the federal and state governments for legislation or policy allocating or disbursing money to health, including co-financing specific programme initiatives. MNCH2 raised 7-11% of programme expenditure.[5] W4H raised 22% of forecasted expenditure. PATHS2 raised 8% of programme expenditure. (For details, see Annex G, 'Programme overview' tab, Column K 'Co-financing'). A recurrent theme in FCDO programme PCRs is the significant risk that programme achievements could not be sustained without a similar level of financial commitment from the GoN.

Assessing effectiveness in health programmes (VfM measures of effectiveness and cost-effectiveness)

Most programmes measured efficiency based on achievements against outcome targets. The most common measure of cost-effectiveness was cost per DALY. This measure was applied to all programmes with a VfM framework except for the influence programmes HERFON and APHCR.

> *"In spite of the limitations of this VfM assessment, good value is evident for the ~£1.9m allocated by DFID compared to an attributable, additional £6.24m allocated to PHC annually and indefinitely as a result of the project. If the supported states continue with FMNCH reforms, and the Federal Government allocates 1% of the budget to PHC from 2017, there is potential for 1.5 million lives to be saved by 2022." – APHCR Business Case*

As previously noted, HERFON's role in drafting and advocating for this legislation was critical, and regarded as the single most important factor in this effort: "At the conservative attribution rate of 20% set in the business case, the APHCR project will have saved 300,000 lives by 2022" (APHCR PCR p.13). The cost per DALY varied widely by programme, from around £2.70 for ENR to around £185 for PATHS2.

[5] The MNCH Business Case chose its preferred option based on a cost-benefit analysis in which it assumed government would cover 17% of the programme costs.

Table 14: Cost per DALY and life saved, by programme

Programme	Cost per DALY – achieved or estimated	Cost per DALY – business case assumption	Cost per life saved/ maternal death averted
ENR	$4	-	-
PATHS2	£184-187	£154 (£192 (existing) / £72 (extension)	£7,264
SUNMAP	£44.52	$52 (existing) / $30 (extension)	£3,125 (attributable)
HERFON2	-	-	-
PMDUP	£8	£19.55 (extension, both lots)	$3,312
APHCR	-	-	£30[6]
UNITED	£74-£135	<$10	-
WFH	-	£28-55	-
MNCH2	£14-28	£35	£1,320
WISH	£7.10 (Lot 1 Africa)	£15 (Africa)	$4,000 - $10,000 £5,973 (Africa, BC estimate)
SUNMAP2	not calculated	£52-£226	£630
Lafiya	-	£128	$1,928

Equity considerations in assessing value investment (VfM measures of equity)

Except for gender, which was included across the portfolio, with interventions and outcome indicators to address gender-specific issues such as maternal mortality and antenatal care, programmes emphasised and measured different equity categories. ENR measured uptake by age category. After criticism in an ICAI report, PMDUP shifted its focus to targeting the poorest and young people in its final years, with specific mention of young abortion advocates in Nigeria.

> *"MSI's recent work on cost effectiveness of reaching young people shows that the service is either of equal or less cost than normal business but does require a different way of communicating and reaching people." – PMDUP PCR, p.21*

W4H targeted young women from poor rural communities to be trained as healthcare workers. PRRINN-MNCH and MNCH2 targeted young women for safe space interventions. The 'demographic dividend' component of Lafiya was cancelled due to funding cuts.

PATHS1, ENR, PMDUP and SUNMAP2 were the only programmes that measured uptake by beneficiaries' socio-economic status. PATHS1 looked at utilisation by the poorest third of the population, while PMDUP looked at the percentage of beneficiaries below the poverty line. SUNMAP2 set up a framework to analyse use of bed nets and ACT malaria treatment by wealth quintile, but was not able to collect data. W4H (Case 1) targeted poor women to be trained as nurses, while ENR found that the poorest 20% were less likely to use Gold Circle condoms due to sensitivity around price (Case 10). MNCH2 noted a 'pro-poor' design of its interventions but did not measure their effect.

Improving access for the poorest and most marginalised was not the major focus of the PATHS programme. "Its social development work promoted these issues in its policies and, in practical terms, particularly through developing deferral and exemption schemes, and more recently in its support to the development of 'free health' policies." (PATHS1 Final Review Report – Narrative, p.49). MNCH2, SUNMAP2, UNITED, W4H and Lafiya specifically targeted rural, underserved or hard to reach areas. W4H specifically targeted training women from rural areas. Lafiya's support for CHIPs was an attempt to address the lack of healthcare workers in rural areas. W4H and Lafiya were the only programmes measuring the impact on persons with disabilities, while MNCH2 considered the needs of persons with physical disabilities in renovating health facilities.

[6] Based on a 'conservative' attribution of 20% of 500,000 lives saved from the passage of the National Health Act, which APHCR has been instrumental in passing, and total cost of £3m.

Balancing cost-efficiency and equity goals

Delivery to underserved/rural beneficiaries and persons with disabilities cost more than other beneficiary groups. An extract from the PMDUP PCR highlights the tension between efficiency and equity:

> *"A tension between effectiveness and equity arose from DFID's efforts to reduce the cost per couple year of protection (CYP). A number of country programmes decided to curtail community engagement activities, behavioural change communication (especially with men and boys), and longer-term policy influencing work in order to keep costs down per couple year of protection delivered. The programme engaged a range of strategies to drive up equity and sustainability outcomes throughout the life of the programme – not least through the advent of the 'high impact client' indicator. However, DFID is aware of the need to evaluate, on an ongoing basis, the incentive structures that derive from its payment by results and costing models to be sure these do not compromise objectives regarding reaching the most underserved populations and ensuring sustainable investments." – PMDUP PCR, p.21*

5. Lessons learned

Current context

The context for international development has shifted considerably since this evaluation was conducted. The new US administration has terminated around 90% of USAID grants, including all health programmes in Nigeria, and has announced its intention to withdraw from the World Health Organisation and scale down funding to the United Nations. The UK government announced a further reduction in overseas development assistance (ODA) from 0.5% to 0.3% of GNI by 2027. Similarly, health minister Pate's sector-wide approach (SWAp) has shifted to accelerate the transition to domestic funding of HSS interventions. Future FCDO HSS programming in Nigeria and elsewhere will be significantly limited, and needs to demonstrate value for money and alignment with reform of Global Health initiatives under the Lusaka Agenda. At FCDO's request, we have tailored our lessons so they are applicable to the current context.

To develop the lessons learned listed below, we consolidated the main findings from our analysis of the evaluation questions described above to formulate valid generalisations that build on what worked and what didn't work across 20 years of FCDO health programming in Nigeria. Findings were triangulated from multiple primary and secondary sources, and supported, where relevant, by the cases and paired cases. Although these findings were generated from primary and secondary data from three states only – Enugu, Jigawa and Kano – we are confident that the lessons presented below have relevance to inform future programming across Nigeria more broadly.[7] We validated findings and lessons with the FCDO Nigeria health team and wider office.

General lessons learnt

Lesson 1: Health systems strengthening interventions often require over 15 years of commitment from development partners to demonstrate results.

FCDO worked in Enugu for nearly 15 years and has been working in Jigawa and Kano for 25 years. Successive phases of programming built on and reinforced each other, as implementing partners gained experience on several programmes in the same states and key individuals built relationships and ways of working with counterparts in state government (see EQ1.5 and EQ4.5 case studies).

Lesson 2: Primary healthcare interventions require support at all levels of government to succeed.

Responsibility for healthcare is split across the federal, state and LGA levels, with responsibility for primary healthcare invested at the LGA level. Previous FCDO programmes supported multiple levels of government simultaneously or in successive phases, with flagship programmes from PATHS2 to Lafiya providing support at LGA and facility level. Alignment with state governor agendas in particular was key (EQ1.1), as LGAs were previously largely controlled by the state government. The 2024 Supreme Court decision on LGA autonomy will empower LGAs but also multiply the number of agencies needing support and capacity-building. Even before the most recent budget cuts, it was cost-prohibitive for FCDO to support the dozens of LGAs in each state (17 in Enugu, 27 in Jigawa and 44 in Kano).

Lesson 3: Support across all building blocks is needed to achieve transformational change.

We mapped the necessary conditions for achieving improvements in the health systems building blocks that can ultimately enable transformational change (Annex H). HSS initiatives failed when one or more building blocks were ignored or not sufficiently addressed. FCDO emphasis has been on financing coupled with accountability, but this approach was not sufficient, and neither are budget allocations or promises on paper – funds need to be disbursed to be used. Direct interventions to address barriers across all building blocks can be more effective at health systems strengthening. For example, under Outcome 1, lack of skilled healthcare workers and government officials, or Human Resources for Health, has been a persistent barrier

[7] We identify states in Nigeria that have similar attributes to the states included in our research, specifically in the South-East, North-West, and North-East zones. We provide a list of comparable states in Table 2 to which lessons learnt presented here may be more relevant when compared to other states.

to improving health indicators in Nigeria (HRH, Case 12), and lack of leadership and other soft skills in training have not been addressed (EQ3.4). FCDO's approach to addressing these barriers was mainly through indirect interventions, including helping states produce HR policies and plans. More direct interventions to address these barriers may be more effective and catalyse the success of HSS interventions. A later programme, W4H (Case 1), was the first to systematically address chronic skills shortages, and while some progress has been made, the numbers of midwives and skilled birth attendants are still low in the north compared to other regions.

Lesson 4: A planned transition to other development programmes or sustainable domestic sources of funding is needed when FCDO is looking to scale down funding or change scope.

For much of the portfolio under review, FCDO HSS programmes passed the baton to the next phase of programming, i.e. PATHS1 to PATHS2 or SUNMAP to SUNMAP2 (See Table 11). However, in recent years FCDO has looked to other development partners to carry on components. SUNMAP2 (2018-2021) closed early due to budget cuts, and transitioned institutional capacity-building support to the Gates Foundation, implementation of quality improvement interventions for case management of severe malaria to the Global Fund, and support for the End Malaria Council to the African Leaders Malaria Alliance. MNCH2 and Lafiya have looked to pass responsibility for MNCH to government organisations like KHETFUND and the Departments of Family Health they helped establish. Discontinuation of FCDO support needs to be communicated clearly with all levels of government; where possible, the FCDO can use its influence to identify other development partners who are willing and able to pick up support. Respondents from both FCDO, implementing partners and GoN noted that the sudden withdrawal of FCDO support to Enugu state and early closure of SUNMAP2 damaged the sustainability of FCDO interventions.

Lesson 5: Government-backed coordination mechanisms have been successful in facilitating development partner cooperation.

Government support at the federal and state level plays a key role in successfully facilitating development partner cooperation. Coordination between donors at federal level was enhanced by government initiatives, including joint working groups, technical assistance partnerships and health sector meetings, and through activities like the National Strategic Health Development Plan. Health minister Pate's SWAp is designed to pool funding and integrate sectoral support. Lack of donor coordination can undermine consolidated HSS as donors develop parallel commodities distribution and data collection systems (Cases 9, 17 and 19).

Coordination between development partners at state level was generally weaker than at federal level, unless enhanced by strong GoN leadership. This may be as a result of development partners like UNICEF and WHO operating at a regional level, making state-level coordination difficult (EQ3.2). Coordination between FCDO health programmes, and health and other sectoral programmes, at state level was achieved largely through individual consultants or implementing partners working across several programmes. Coordination between FCDO programmes has been hindered by programmes having different KPIs, start dates and delivery timescales, by a focus on programmes' short-term results delivery, and by lack of contractual mechanisms to encourage programmes to work together (EQ3.1).

Health system building block specific lessons

Most health systems strengthening programmes are designed to cover health system building blocks, and these thematic areas are familiar to healthcare practitioners. There is a general correspondence between health systems building blocks and the thematic areas identified in this evaluation (see Annex E, Table 1), but building blocks are more at final outcome or impact level whereas the thematic areas are at intermediate outcome level. We have grouped lessons by the more familiar building block terminology below.

Health workforce

- **Lesson 6: Training programmes build up capacity of frontline healthcare workers but require locally tailored training to be most effective**. Training programmes like W4H and PATHS2 equipped frontline health workers with essential skills, particularly in maternal and child health and in disease management, which has improved service delivery and expanded access to care (EQ1.2).

Nevertheless, training was often not suitable, its effectiveness and attendance were not tracked, and limited engagement with local expertise weakened its adaptability to local conditions (EQ1.6). Transitions between flagship FCDO health programmes such as PATHS to PATHS2, and MNCH2 to Lafiya sometimes led to knowledge gaps among senior health staff as it disrupted knowledge-sharing and consistency of approach that were often only partially addressed (EQ3.2). Programmes needed to identify the right staff to participate in capacity-building, while technical assistance and knowledge-sharing have achieved greater successes when tailored to staff needs and when addressing skill gaps (EQ1.2).

- **Lesson 7: Shortage of frontline health workers limits provision and access to health services, and targeted recruitment programmes are key to filling staffing gaps.** Shortages of healthcare workers restricts access to essential services, especially in rural areas that have often suffered from staff shortages, where worker retention has been negatively impacted by low and delayed salaries (EQ1.5). FCDO's W4H programme supporting midwife training programmes and recruitment of women has addressed this gap somewhat, systematically strengthening the workforce of skilled birth attendants in underserved areas of the country (EQ2.3, Case 1).

Service delivery

- **Lesson 8: Raising awareness through targeted communication can increase demand for and use of essential health services but requires affordability and accessibility (EQ1.2**). To ensure demand and increase coverage, public healthcare facilities, private clinics and individuals must be aware of and have interest in and willingness to seek health commodities and services. Audiences must be informed about health services through trusted communication channels, including radio, TV, flyers, government roadshows, marketplace events and extension workers. To improve use and coverage, health services need to be accessible and available within a reasonable distance to local populations. Medicines, vaccines and health services must be priced appropriately to be affordable for the target audience, whether provision is free or subsidised, or for profit.

- **Lesson 9: Support from the community and traditional and religious leaders and local organisations was important for improving awareness and ensuring access and wider coverage, particularly among marginalised groups**. Private and non-governmental actors have played a key part in raising awareness, through faith-based and citizen-led initiatives, including community volunteers, WDCs and FHCs (EQ2.1). Communities and local organisations played an important role in ensuring facilities are accessible to target populations, particularly expanding healthcare to marginalised groups including women, children and rural communities. Many programmes missed opportunities to reach vulnerable populations, as support for persons with disabilities, young people and lower socio-economic status was limited (EQ2.2). Overcoming resistance to health initiatives required targeted engagement by traditional and religious leaders to influence social norms (EQ2.1). Community attitudes towards women in northern Nigeria meant that adaptation of delivery was critical, and sensitisation through religious and community leaders was effective at strengthening acceptance and overcoming cultural barriers to expand reach of modern health practices in the north (EQ2.4).

Health financing

- **Lesson 10: Building capacity in federal and state governments in targeted ways can improve health decision-making, budgeting and policymaking.** Government capacity building increased the GoN's ownership of planning and budgeting, and the quality of these has increased over time. MNCH2, PATHS2 and Lafiya strengthened state and LGA agencies, PHC agencies and EPR committees, which strengthened governance structures and improve decision-making and oversight in healthcare management, including through establishing functional committees under Lafiya, state-led annual reviews under MNCH2, and government institutional assessments under PATHS2. PATHS2 and MNCH2 supported state-level budgeting and planning by incorporating best practices that allowed states to integrate health policies into long-term strategic plans (EQ1.2). Lafiya strengthened health governance and financial planning by helping states establish Departments of Family Health and secure BHCPF equity funds (EQ3.2). Training to strengthen data collection and reporting improved GoN's informed policy decisions. Nevertheless, government capacity-building

can suffer when training and technical assistance are not tailored to the needs of staff in key ministries and agencies, and the right staff are not identified to participate in capacity building (EQ1.2).

- **Lesson 11: GoN funding was not sufficient to sustain programmes after withdrawal.** Evidence around sustainability of interventions was difficult to gather in the Northern states of Kano and Jigawa because FCDO support is still ongoing through Lafiya. However, we saw evidence that key interventions were not sustained in Enugu when FCDO withdrew support (ISS, Paired Case 1; DRFs, Paired Case 3; HERFON, Case 15; CMS, Case 17). Co-financing from the GoN at federal or state level did not happen in most programmes, and when it did, it was around 7-10% of total programme spend (EQ1.1). This means that the GoN structurally could not sustain most FCDO interventions as they were designed and delivered when FCDO support ended.

- **Lesson 12: Grassroots organisations, private sector enterprise and community resources can adapt and sustain FCDO interventions which are aligned with local interests** Despite this, we found evidence of interventions that were sustained in the absence of FCDO support, particularly through community volunteers and CSOs (see EQ2). FCDO programming set out to utilise Nigerian resources efficiently, and as an unintended consequence of problems with government funding, programmes tapped into community resources and funding, for example in the case of Facility Health Committees (FHCs), Ward Development Committees (WDCs), the Emergency Transport Scheme (ETS, Case 2), young women from rural areas (W4H, Case 1), ethical financing initiatives (*waqf*, Case 11), and Community Based Health Insurance (CBHIs). The private sector took up and sustained some interventions (ETS, Case 2, and condom social marketing, Case 10), and so did the faith-based sector (CMSs, Case 17), NGOs, and CSOs. Ensuring closer collaborations with these actors may offer alternative pathways to sustainability (see Lesson 5).

Leadership and governance

- **Lesson 13: Capacity-building in pro-health decision-making, budgeting and policymaking are effective in driving pro-health outcomes when federal, state and local governments are aligned on priorities and there is close coordination between different levels of government.** Close coordination among government agencies at the federal and state levels made implementation more efficient and ensured effective use of resources (EQ 1.1). Changes in leadership tended to disrupt state health sector and policy reforms and differences in political priorities by state leaders posed a challenge to coordination within and across states, hindering long-term progress (EQ1.5). State-level reforms were influenced by federal health priorities, and strong government commitment at both federal and state levels led to lasting improvements and strengthened national health priorities (EQ1.1).

- **Lesson 14: Community-driven accountability mechanisms were key to improved capacity and pro-health decision-making, budgeting and policymaking in state governments and LGAs.** CSOs strengthened health sector accountability by pressuring state and local governments to uphold pro-health policies and improve budget allocations (EQ1.1). Civil society advocacy led to increased health funding and long-term policy commitments. CSOs and Ward Development Committees were crucial in moving initiatives forward after FCDO funding ended by helping to secure resources and hold governments accountable (EQ1.1). Stronger accountability measures led to better resource management and reduced inefficiencies in healthcare funding (EQ1.5).

- **Lesson 15: Government capacity was key to facilitating coordination between different donors and development partners, particularly at the state level.** State-level coordination among development partners was most effective under GoN leadership, while coordination was limited in states with weak government engagement, which restricted pooled funding and sector-wide integration (EQ3.4). State Health Plans helped integrate and coordinate donor programmes such as PRINN-MNCH in Jigawa and joint funding efforts for immunisation and emergency transport (EQ3.3). FCDO improved coordination between donors and development partners by working to align funding and technical support with the government (EQ2.3).

Medical products, vaccines and technologies

- **Lesson 16: Timely procurement and distribution of medicines and supplies was ensured through a centralised system at the federal or state levels (EQ1.2).** Enhancing infrastructure and supply chains reduced shortages and expanded availability and access to health services, as better distribution systems made essential medicines more consistently available to patients. For effective distribution, centralised mechanisms at the federal and/or state levels that enable bulk purchasing with streamlined shipping and customs delivered commodities to state health facilities efficiently.

- **Lesson 17: Decentralised supply and distribution systems owned by local or grassroot actors ensured strong local supply chains and consistent supply to facilities.** Public and private sector partnerships and decentralised drug supply systems strengthened drug supply chains by reducing shortages and helped supply essential medicines and commodities at the local level to the public (EQ1.2). DRF models kept medicine stock consistent and made medicines more affordable, while drug supply programmes expanded access to medicines in underserved areas (EQ2.3). Local community-managed systems also played a role in successful distribution efforts (EQ1.2).

Health information systems

- **Lesson 18: Effective reporting and information management systems required quality data, robust quality assurance and trained staff with adequate resources (EQ1.2**). Data collection and management systems need large amounts of resources, and suffer from low accuracy, lack of timeliness, and limited harmonisation of datasets. Effective reporting and information management systems require quality data to be consistently recorded at the local level, with staff having access to essential equipment and data tools, as well as training and capacity to effectively collect, input and manage data. Data must be reliable, with robust quality assurance measures, and higher-level staff must trust the accuracy and quality of data and be trained to interpret and use it effectively. Data must be harmonised with national-level systems like the DHIS or the HMIS, and federal, state and LGA officials must endorse the dataset and its use.

- **Lesson 19: Improved information management systems can drive evidence-based decision-making and increased accountability in government at the federal, state and local levels.** Monitoring was often limited and only a few programmes focused on improving data quality and ensuring systematic reporting (EQ1.6). For example, there was inconsistent tracking of health worker attendance and retention, the NHOCAT tool for measuring governance capacity was not consistently used across programmes, and tracking of financial protection indicators like out-of-pocket and catastrophic health expenses has only been restarted under Lafiya (EQ1.6). In cases where data collection improved, this was often discontinued after donor departure, and parallel monitoring and data collection systems created by some development partners limited creation of a unified system. Nevertheless, improvements in data systems, including the expansion of the HMIS, contributed to better informed, evidence-based decision-making and improved governance, policymaking and implementation at the federal, state and local levels of government (EQ1.2). Better state- and local-level monitoring ensured performance tracking and measurement of long-term impact. PHC Under One Roof reforms increased HMIS reporting from 0% to 70-90%, which enabled evidence-based resource allocation, driving significant state health budget increases in Kano and Jigawa.

- **Lesson 20: Structured value-for-money assessments can improve efficiency when tailored to programme and state context (EQ 4.1).** VfM assessments and metrics improved over time as later programmes increasingly incorporated structured VfM frameworks and cost-effectiveness measures. Equity was embedded in programmes to a limited extent, primarily in explicitly gender-focused initiatives and efforts. Building in VfM metrics from the outset can improve efficiency and justify continued investment. VfM frameworks and metrics that are tailored to the programme context and that consider cost differences across states and incorporate it into financial planning can be most effective at identifying areas for improvement.

6. Recommendations

The context for international development has shifted considerably since this evaluation was conducted. The new US administration has terminated around 90% of USAID grants, including all health programmes in Nigeria, and has announced its intention to withdraw from the World Health Organisation and scale down funding to the United Nations. The UK government announced a further reduction in overseas development assistance (ODA) from 0.5% to 0.3% of GNI by 2027. Similarly, health minister Pate's sector-wide approach (SWAp) has shifted to accelerate the transition to domestic funding of HSS interventions. Future FCDO HSS programming in Nigeria and elsewhere will be significantly limited, and needs to demonstrate value for money and alignment with reform of Global Health initiatives under the Lusaka Agenda. At FCDO's request, we have tailored our recommendations so they are applicable to the current context and presented them for three different stakeholder groups.

These recommendations follow from the lessons presented above, informed by the analysis presented in the findings section. Findings were triangulated from multiple primary and secondary sources and supported where relevant by the cases and paired cases presented in EQs 1.2-1.4 below. We validated findings and lessons with the FCDO Nigeria health team and wider office. Recommendations were co-created with FCDO to ensure they were appropriate given the change in delivery context and to suit stakeholder needs going forwards.

For FCDO

Recommendation 1: FCDO should play to its strength in supporting legislative advocacy, convening power, and civil society and accountability mechanisms

- Evidence from the portfolio review highlighted FCDO's strengths in legislative advocacy and support, convening other development partners, promoting civil society and accountability mechanisms, supporting service delivery, and implementation of new and sustainable approaches of delivery such as drug revolving funds (DRFs).
- Lafiya has placed FCDO in an advisory position to the Coordinating Minister of Health, and promoted Mutual Accountability Frameworks ensuring communication and accountability between FCDO and state governors. FCDO should continue to leverage its convening power amongst other donors at federal level through the SWAp to support greater alignment, coordination, and national ownership of HSS initiatives. Based on the findings of this evaluation and other literature, FCDO should push for HSS interventions to support all building blocks, even if this needs to be done through cooperation between multiple development partners and GoN, rather than interventions that address only a few.
- Twenty years of HSS programming have resulted in deep understanding and individual relationships within FCDO focus states and previously supported states which can still be leveraged; even small engagements or continuing technical assistance makes FCDO a repeat actor and promotes accountability at the state level.

Recommendation 2: FCDO needs to coordinate and leverage resources from the government of Nigeria, grassroots and the private sector, and other development partners to ensure interventions remain holistic

- Discontinuation of FCDO support needs to be communicated clearly and in a timely manner with government and implementing partners because when done too abruptly it can erase results (Lesson 6 and the current USAID withdrawal). Where possible, FCDO can use its influence to identify other development partners and government agencies who are willing and able to pick up support.
- To be successful, interventions need to work at all levels of government (Lesson 2), including with the now-empowered LGA level; and across all health systems strengthening building blocks (Lesson 3). In future, FCDO will not have the resources to directly support all levels of government, and so will need to work in partnership with the government of Nigeria, other development partners, NGOs, CSOs and the

private sector (Lesson 12) to make sure that every piece of the puzzle is in place for supported interventions.

- The Sector-Wide Approach (SWAp) is a good coordinating mechanism between GoN and development partners, and evidence from other countries suggests this has worked well. However, there is no real evidence one way or the other on the viability of Disbursement-Linked Indicators through the World Bank HOPE-PHC multilateral funding mechanism. Clear objectives for FCDO funding through the SWAp should be set, so it is clear that resources are aligned with HMG priorities and programme outcomes, and FCDO should consider running complementary bilateral programmes that play to its strengths or achieve strategic results.

Recommendation 3: Refresh the Change Agents Programme

- FCDO's Change Agents Programme (£1.8m, Case 4) provided good value for money and, given that this generation is retiring, can be refreshed within the current context. The programme needs to be inclusive, involving health professionals from different positions and parts of the country. Consider knowledge exchanges and health partnerships between UK and Nigerian universities or institutions, limited-time professional placements with the UK NHS, and other ways to promote circular migration of healthcare professionals.
- FCDO could consider supporting the establishment of a training or certification body for leadership and other skills gaps, similar to the approach taken by the Women For Health programme (Case 1).
- FCDO can share lessons from Change Agents with the Government of Nigeria in designing, selecting for, and implementing the National Health Fellows scheme.

For the Government of Nigeria

Recommendation 4: Be straightforward and realistic about what interventions are of interest and sustainable by the Government of Nigeria after development partner support has ended

- We found that most development partner interventions were not sustained by the Government of Nigeria after they finished and FCDO exited (Lesson 11).
- The government should sit down with FCDO and other development partners at federal and state level before programmes have started, rather than after they have ended, to identify interventions which are of mutual interest and which can be sustained using existing government resources and technical capacity.
- FCDO-style Mutual Accountability Frameworks should be signed with all development partners, to make it clear what the government is asking for and what it is giving in return; and the government should be prepared to account for broken promises.

Recommendation 5: Consider a Ministerial Challenge fund or the Social Action Fund to leverage community, enterprise, and NGO/CSO resources at grassroots level

- We found that health systems strengthening interventions which were adapted and resourced at grassroots level were more likely to be sustained (Lesson 5).
- To tap into the ingenuity and enterprise of Nigerian communities, CSOs, local NGOs and small businesses, at the grassroots level, consider a Ministerial Challenge Fund, or the existing Social Action Fund to provide small grants for innovative solutions to healthcare problems. Traditional and community leaders should be integrated into the process of selecting recipients, as their buy-in is crucial for success at grassroots level. Windows for digital or technical innovations for health, solutions for rural or hard to reach areas, and solutions for vulnerable or disadvantaged populations should be considered. Capacity building for grant recipients should be provided to help them scale and replicate their ideas elsewhere.

For other development partners

Recommendation 6: Coordinate with FCDO and GoN and, where possible, give support at state, LGA, and facility level

- It is important to coordinate with other development partners and the GoN at all levels, play to your unique strengths and deploy your resources wisely. FCDO will not have the reach to work at LGA and facility level in future, but these will need support for initiatives to succeed.
- All health systems strengthening building blocks need to be supported. Scaled down but comprehensive support should be privileged over programmes supporting single building blocks, unless these are clearly supported by others.
- FCDO has in the past supported vertical disease programmes targeting HIV/AIDS, malaria and immunisations, but development partners including GAVI and Gates Foundation have expertise in this area. Duplication of efforts, such as setting up parallel distribution systems or data collection mechanisms, should be avoided.
- If resources allow, look for opportunities to replicate or scale up HSS interventions which have been transformational and sustained in other states. See EQ1.3 for examples of FCDO initiatives that worked.

7. List of annexes provided separately

Annex A – Terms of Reference

Annex B – Inception Report

Annex C – Bibliography

Annex D – List of people consulted

Annex E – Evaluation approach and methodology

Annex F – Programmes considered for the evaluation

Annex G – Programme mapping: Active states, Co-financing, outputs, outcomes, VfM, risks

Annex H – Intermediate outcome level ToCs

Annex I – Departures from the ToRs and cross-cutting

Annex J – Use and influence plan

Annex K – Changes in headline health indicators

Annex L – Timeline of FCDO Nigeria programmes

Annex M – Ethical considerations

Annex N – Qualitative coding framework