HPP NIGERIA CELEBRATES FIVE YEARS OF PROGRESS IN FAMILY PLANNING

Presentations from the
Knowledge-Sharing Event

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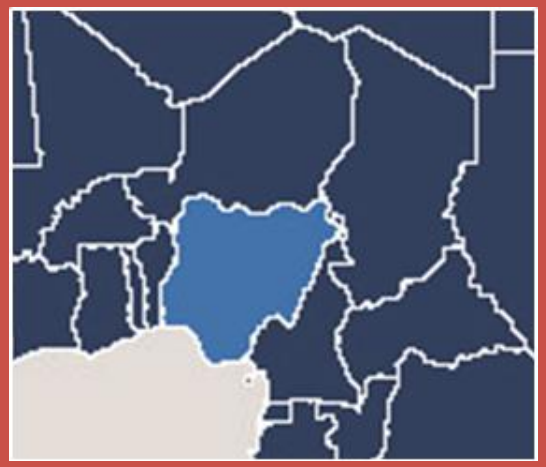
HEALTH POLICY PROJECT



Using Evidence for Budget Advocacy: The Cross River State Experience

July 23, 2015

Uko Ekott
PM, Health- Cuso International

Former, Executive Secretary, Budget Transparency and Accountability Initiative Nigeria (BTAN)

5 Esighi Street off Bateba Street, Calabar
Cross River State, Nigeria
btan.nigeria@yahoo.co.uk

Identifying the Advocacy Issue

- April 2012: free procurement and delivery of Family Planning Commodities (FPCs) to all States
- States responsible for the distribution of FPCs to all Service Delivery Points (SDPs)
- Cross River:
  - Commodities only get to the SDPs by efforts of the State FP unit
  - The FP unit had little or no structured support from the State Government

Advocacy Approach

- Goal: the creation of, and funding for, a budget line for FPCs distribution in Cross River State
- Approach:
  - 1) Gathering evidence on the state of FPCs and their distribution in Cross River
    - Budget tracking
  - 2) Carrying out advocacy to sensitize decision makers and compel them to act
    - Family Planning Advocacy Working Group (FPAWG)

(1) Gathering Evidence

- BTAN monitored the FPC distribution process in Cross River, carried out by the FP unit and development partners
- Key findings:
  - There were no funds to run the office (FP unit)
  - Insufficient funds to support the LG supervisors
  - Commodities were not stored properly
  - The FP unit was housed in a dilapidated building infested with ants

(2) Advocacy

- Creation of FPAWG
- Identifying decision makers, influencers and allies
  - Budget Office- Dept. Of Budget Monitoring and Evaluation
  - CRSHA- Cross River State House of Assembly
  - DIDC- Dept. Of International Development Cooperation
  - CRSMoH- Cross River State Ministry of Health
  - CRSMoLGA- Cross River State Ministry of Local Government Affairs
- Mounting advocacy campaign: visits, forum participation, presentations

Advocacy Visits

Presentations

Meetings with the FP Unit

- Share information on:
  - Outcome of visits
  - Challenges of the unit
  - Progress of work in FPCs data management
  - Procurement and handover of equipment for the unit

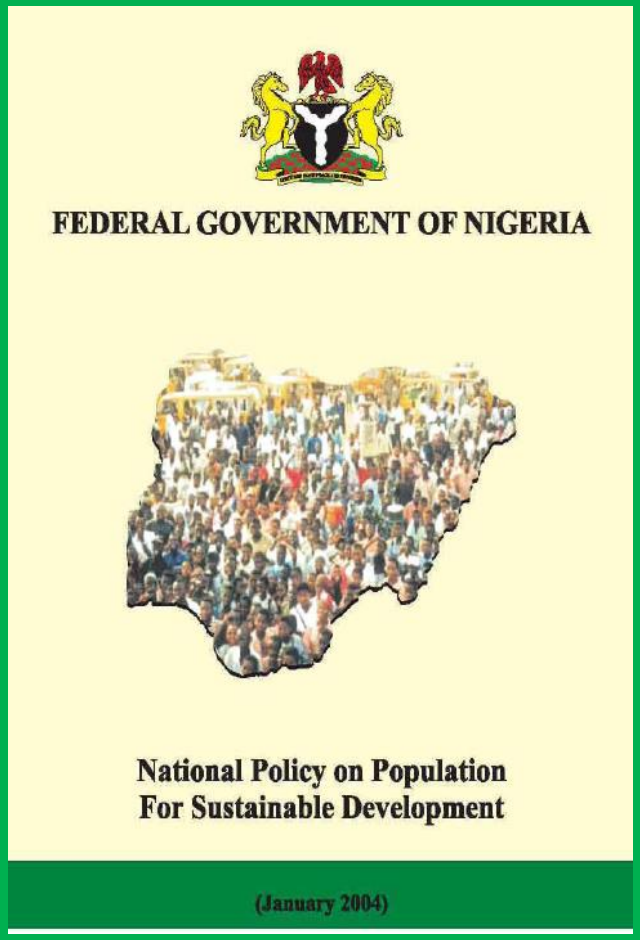
Results

- Creation of a budget line for family planning activities in Cross River State
- **N10 million** in funding for FPC distribution budget line
- By addressing barriers to access, the new budget line will help increase the uptake of contraceptives state-wide
- Next steps for continued improvements to commodity security in Cross River State

Best practices & lessons learned

- What worked well:
  - Consistency
  - Persistence
  - Maintenance of relationships
  - Engagement of support staff of the chief executives
- What did not work well:
  - Reliance on only the chief executives and formal meetings
  - CRSMoH dragging their feet on the issue

Thank You!



Using Evidence to Drive Policy Formulation:
The Implementation Review of Nigeria's Population Policy

July 23, 2015

Dr Ghaji I. Bello
Director-General
National Population Commission

National Population Commission: Driving Change

The Chairman NPopC, Eze Duruiheoma SAN, the DG NPopC Dr Ghaji Bello, Hon Commissioner Dr Tunde Lakoju driving the NPP review, championing change

Nigeria in Numbers

- With more than 182 million people (projected), Nigeria is the most populous country in Africa and the seventh in the world.
- Rapid rate of population growth of 3.2 percent (2006 Census estimates); at this rate, Nigeria's population would double in just 21 years.
- Each woman gives birth to 5.5 children on average, with much variation across states (NDHS 2013).
- There are approximately 35 million women of reproductive age in Nigeria, and the country had nearly 7 million births in 2012 alone (NDHS 2013).
- 84.9% of sexually active Nigerian women and girls do not use modern contraception (NDHS 2013).
- Half of pregnant women do not access antenatal care (NDHS 2013).

Nigeria's Development Picture

- High level of poverty nationwide:
  - Data show that 69% of people are living below the poverty line (NBS, 2012, Harmonized Nigeria Living Standard Survey) .
- GDP growth rate of 5.49% has stagnated at below the double digit margin (NBS 2011).
- Inflation is on the rise (NBS 2011).
- Threat of climate and environmental change on livelihoods and food security.

The Challenge Ahead

- Slowing the rate of population growth for improved development outcomes.
  - Key: ensuring that each woman and couple can space and limit births as desired.
- Ensuring that children and mothers are healthy, for improved education outcomes and livelihoods.
- Employing the millions of un- and under-employed youth.
- Generating buy-in—and *funds*—for the interactions between demographics and development.
- Combined, this will help Nigeria achieve a demographic dividend!

Rationale for Population Policy Review

- Eleven years since the formulation of Nigeria's Policy on Population for Sustainable Development (2004).
  - Supporting the practice of reviewing, updating and revising policies.
- The need to be aligned with the new development agenda, the Sustainable Development Goals.
- The importance of managing Nigeria's current demographic profile.
- To see the birth of a demographic transition that will ensure, long, healthy productive lives of Nigerians, in an environment that is sustainable for future generations.

The Review of the 2004 NPP

- Idea originated at a retreat organized for the Commission by HPP in April 2013.
- A roadmap of the review process was developed.
- In May 2013, the Commission agreed to the review process and mandated the Population Technical Working Group (PTWG) as facilitator.

3.1 Below is the approved Roadmap by the Commission and the adaptation

S/N	ACTIVITY	TIME FRAME	ADAPTATION	Status
1.	Commission agrees to review the NPP	May, 2013		Done
2.	Commission mandates the PTWG to work out details of the Review process.	June , 2013		"
3.	PTWG works out and submits a draft review process to NPopC.	February, 2015		"
4.	NPopC adopts the Draft Review Process and engages Development Partners and other key stakeholders.	February, 2015		"
5.	NPopC adopts the final Review Process and refers this to PTWG.	February, 2015		"
6.	PTWG and Partners carry out the Review Process and submits the Draft review document to NPopC.	March – April 2015	April -June	Ongoing
7.	NPopC studies, consults and presents the draft document at a Stakeholders' Forum.	May, 2015	June	Delayed - proposed
8.	Final Review by PTWG Core Team based on	June, 2015	July	August

(1) Review Process and Milestones

- March: NPP Implementation Review Consultant seconded to NPopC
- March-May: internal coordination of review activities
  - NPP Core Team formed, terms of reference created
- March-June: interview protocol finalized
  - Adapted from the Health Policy Initiative's "Policy Implementation Assessment Tool"
  - One core tool and 8 sectoral tools
- April: NPP Review announced at the 48th Session of the Commission on Population and Development
- April: interview tool pretesting and preliminary data collection in two states

(2) Review Process and Milestones

- May: Donor forum
- July-early August: national- and state-level interviews
  - State interviews: Lagos, Kaduna, Nasarawa, Gombe
  - Multisectoral national interviews
- July- early August: secondary data collection and analysis
  - Programme reports, policies and guidelines across sectors
- August: data analysis and NPP Implementation Review report finalization
- August-September: draft position paper on next policy

NPopC Chairman Eze Duruiheoma SAN and NPopC DG, Dr Ghaji Bello at the Donors Forum for the Review of the 2004 National Population Policy
28th May, 2015
Cross section of Donors – WHO, UNFPA, HPP/USAID, MacArthur Foundation in attendance

Implementation Review: Preliminary Findings

- Poor knowledge of policy and implementation framework
  - Don’t know of policy, or any of it’s content = poor policy dissemination
  - Poor institutional knowledge of implementation roles, even of those indicated as key implementers
  - Wrong assumption that interviewees have interacted with the policy before, and not possible to evaluate residual knowledge
- Weak national and state platforms for population activities
- Poor policy coordination and feedback
- Need for deeper stakeholder role analysis and dependence on secondary data for review

Best practices and lessons learned

- Deepening the policy review methodology from the rapid appraisal techniques to deeper stakeholder analysis.
- The failure of the policy and strategic plan to impact on the Nigerian polity is not unrelated to poor stakeholder policy role acknowledgement and resource limitation.
- Need for strengthening of the coordination role of NPopC by Government and partners to execute its lead agenda in coordination and implementation.
- Poor funding of population activities by Government at National and State levels inimical to any policy provision

Thank You

HPP TECHNICAL ASSISTANCE TO NHIS

FOR EFFECTIVE COSTING, PROGRAM DESIGN, MONITORING AND EVALUATION

July 23, 2015

SHUAIBU AHMED B. INDABAWA,
KANO STATE NHIS COORDINATOR

Presentation Layout

NHIS Programs Overview

- **FORMAL SECTOR (25% of the Population)**
  - Public Sector
  - Private Sector
  - Educational Institute
- **INFORMAL SECTOR (75% of the Population)**
  - Community
    - CBSHIP
  - Voluntary Contributors
  - Vulnerable Group
- Other programs: NHIS has been implementing MDG/MCH program in 12 states and the benefit package is similar to the CBSHIP

NHIS-HPP Collaboration

The following NHIS Departments' capacity was strengthened:

- **Planning Research and Monitoring Department:**
  - Development of M&E system, Performance Monitoring Plan (PMP) and capacity-building of staff

- **Technical Operations Department:**
  - Capacity-building of staff on evidence for more effective advocacy
  - Program costing and benefit package for CBSHIP and MDG/MCH

Costing and Advocacy

- Training of NHIS Senior Management Staff in advocacy to generate state-level buy-in for Formal Sector & CBSHIP
- Costing analysis for MDG/MCH Project in collaboration with other partners
- Development of briefers on “Scaling up National Health Insurance in Nigeria: Learning from Case Studies of India, Colombia, and Thailand”
- Training of NHIS Staff to cost changes to two benefits packages (CBSHIP and MDG/MCH) in collaboration with WHO, MSH etc.
- TA to develop benefit packages for NHIS’ MCH and CBSHIP in collaboration with WHO, MSH etc.

Monitoring & Evaluation

- TA on development of M&E strategy and general guidelines to monitor NHIS programs
- TA on development of PMP for the CBSHIP program
- Capacity-building of NHIS staff to monitor CBSHIP program and ensure that MCH/FP products reach underserved clients
- Training of PRM and others on M&E
- Sponsoring two staff to attend International Workshop on Monitoring of Public Health Programmes at OAU, Ile-Ife, Nigeria
- NHIS sponsored two staff to attend International Workshop on Participatory Planning, Monitoring & Evaluation in Netherlands on recommendation of HPP

CBSHIP Approaches

- The Community Based Social Health Insurance Programme (CBSHIP) is designed to target the informal sector
  - Largely rural/semi-urban domiciled
  - Constitutes over 70% of the Nigerian population
  - Highly heterogeneous
  - Characterized by extreme poverty, high parity and low literacy, bearing a disproportionately large burden of disease
- NHIS started implementing the CBSHIP in 2011
- The problems:
  - CBSHIP lacked proper M&E system and tools
  - Need review to include FP as a core benefit in MDG/MCH program

In Focus: PMP for CBSHIP

- The PMP assists the NHIS in monitoring the CBSHIP
- Ensures inclusion of indicator for tracking MNC and FP
- Tracks issues relating to equity in access by rural and hard-to-reach communities
- If the CBSHIP is successfully implemented, it will mean helping the Government achieve its targets for UHC, quality health services and improved health outcomes in Nigeria

Process of Creating the PMP

- Three consultants engaged (2 = HPP and 1 = NHIS)
- CBSHIP PMP Team constituted:
  - Staff of M&E Division DPRM
  - All Heads of Planning in the seven Zonal offices
  - One representative from all the Departments & two from Technical Operations
- Workshop for the CBSHIP Team from 25th – 30th November, 2013 to develop the first draft of the PMP
- Development of data collection tools and pre-testing in 7 States where CBSHIP was launched

CBSHIP PMP Description

SECTION A: CBSHIP PROGRAM DESCRIPTION

a). BOTs as Programme Managers without Technical Facilitators
b). BOT as Programme Managers with external technical Facilitators (HMOs/CSOs)
c). Technical Facilitators (HMOs/CSOs) as Programme Managers.

MODEL 1: BOTs as Programme Managers without Technical Facilitators

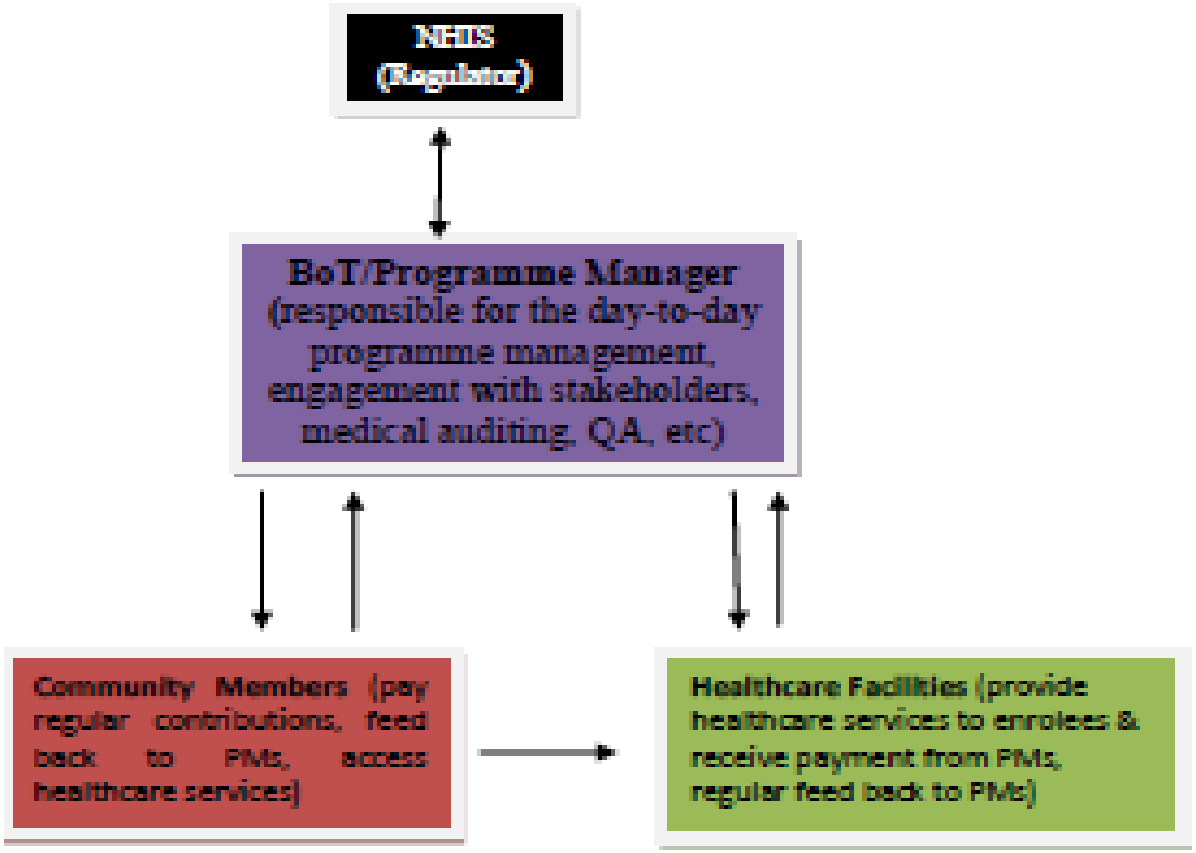


Figure 1 (1.2.1.7a BOTs as Programme Managers)

SECTION B: CBSHIP RESULTS FRAMEWORK

Result Level	Indicators	Baseline Values	Targets (2014)
Inputs	Indicator 1.1.5: % of funds provided by NHIS as subsidy for vulnerable individuals (pregnant women and children under five) against total mutual contribution		
Activities	Indicator 1.1.4.: Number of community sensitization activities conducted		330 Community visits in 108 LGA across 36 state and FCT in Nigeria
	Indicator 1.2.3: Number of meetings conducted by enrollees at the ward level		12 monthly meetings conducted by each community/MHAs
	Indicator 2.1.4: Number of trainings conducted for health care facility staff		
	Indicator 3.2.3: Number of supervisory visit to MHAs by NHIS		
	Indicator 5.2.2: Number of training conducted for Mutuals on Gender mainstreaming		
Outputs	Indicator 1.1.2: Number of enrolees accessing health care services (disaggregated by months)		Per state target = 350,000 enrolees targeted for 2014 (70% of the total targets given to state controllers) x 37 states/FCT = 12,950,000 enrolees
	Indicator 1.1.3: Number of enrolees registered (disaggregated by financial and non-financial) Indicator 1.2.2: Number of mutuals established		
	Indicator 2.1.2: Number of mutuals making prompt payments to health care facilities		
	Indicator 2.1.3: Number of health care facility staff trained on CBSHIP		
	Indicator 2.3.2: Amount of funds collected by mutual (disaggregated by source of funds)		
	Indicator 2.2.1: Number of health care facilities reaccredited		
	Indicator 5.2.1: % of enrolees by socioeconomic group		
	Indicator 4.1.1: Number of new enrolees joining the mutual		
	Indicator 4.1.2: Number of enrolees exiting MHAs		
Outcomes	Indicator 1.1.1: % of enrolees satisfied with services received Indicator 1.2.1: % change in total contribution within the mutual		
	Indicator 2.1.1: % change in enrolees accessing health care services		

SECTION C: INDICATOR DEFINITIONS MATRIX

Community Based Health Insurance (CBHIS) PERFORMANCE MONITORING PLAN MATRIX

INDICATOR	DEFINITION AND UNIT OF MEASUREMENT	DATA SOURCE & COLLECTION	FREQ	BY WHOM	Baseline	TARGET FY14
Objective 1: Serve as a mechanism for mobilizing community resources to share in the financing of local health services for the informal sector between December 2011 – June 2014						
Indicator 1.1.1: % of enrolees satisfied with services received	**Definition:** Enrolees reporting that they are satisfied with the services provided at the health care facilities **Unit of Measurement**: Percentage **Disaggregated by:** None	Health Care Facility Survey	Annually	HQ M&E Division and HQ Community Division		
Indicator 1.1.2: Number of enrolees accessing health care services (disaggregated by sex)	**Definition:** Enrollees are fully registered, contributing and accessing care at the HCFs **Unit of Measurement**: Number **Disaggregated by:** Sex and age	Health Care Facility Records	Monthly	State Offices And Mutuals		
Indicator 1.1.3: Number of enrolees registered	**Definition:** Card carrying enrolees registered under MHAs	MHAs records	Monthly	State Offices and		

SECTION D: PERFORMANCE DATA TABLES (PDTS)

Strategic Objective: SO9: To ensure the availability of funds to the health sector for improved services			
Element: Access To Health Care **IR: Sub- IR 1.1:** Increased access to health care services among the enrolees			
Strategic Objective ID: NHIS2013 – X1			
Approved: November 2013 **Department:** DTOP - CBSHIP			
Objective 1: Serve as a mechanism for mobilizing community resources to share in the financing of local health services for the informal sector between December 2011 – June 2014			
Indicator 1.1.1: % of enrolees satisfied with services received			
Disaggregated By: None			
Unit Of Measure: Percentage	**Year**	**Planned/Target**	**Actual**
Source:	2013		
	2014		
Definition: Enrolees reporting that they are satisfied with the services provided at the health care facilities **Denominator**: **Numerator:**	2015		
Comments:			

SECTION E: PERFORMANCE INDICATOR REFERENCE SHEETS (PIRS)

SO9: To ensure the availability of funds to the health sector for improved services **NHIS Performance Indicator Reference Sheet:** **Indicator 1.1.1: % of enrolees satisfied with services received**
Objective 1: Serve as a mechanism for mobilizing community resources to share in the financing of local health services for the informal sector between December 2011 – June 2014 **Element:** Access To Health Care
Program Area: Rural Community Projects **Program Sub-Element:** N/A
Program Intermediate Results (IR): 1.1: Increased access to health care services among the enrolees
DESCRIPTION
Precise Definition(s): Enrolees reporting that they are satisfied with the services provided at the health care facilities
Disaggregated by: None
Justification /Management Utility or Rationale: To show the standards or quality of HCFs
PLAN FOR DATA ACQUISITION BY NHIS
Data Collection Method: Questionaire (Survey)
Method of Acquisition by NHIS: Visits
Data Source(s): Health Care Facility
Geographic focus: State Level **(TBD)**
Frequency/Timing of Data Acquisition: Annually
Estimated Cost of Data Acquisition: Within DTOP MTSS/Budget
Responsible Agency: DTOP, DPR&M, State Offices
Responsible Individual(s): Head of Unit/ RCSHIP and Head of Department M&E

DATA QUALITY ISSUES			
Date of Initial Data Quality Assessment: N/A			
Date of Most Recent Data Quality Assessment: N/A			
Known Data Limitations and Significance (if any): N/A			
Actions Taken or Planned to Address Data Limitations: N/A			
Date of Future Data Quality Assessments: TBD			
Procedures for Future Data Quality Assessments: TBD			
PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING			
Data Analysis: Percentages			
Presentation of Data: **Histogram**			
Review of Data: Bi-annually			
Reporting of Data: TBD			
Notes on Baselines & Targets:			
Other Notes:			
BASELINE, TARGETS & ACTUALS			
Year	**Target Value**	**Actual Value**	**Notes**
2013			
2014			
2015			
End of Project Target:_____			
THIS SHEET LAST UPDATED ON: 29th November 2013			

Path to Impact

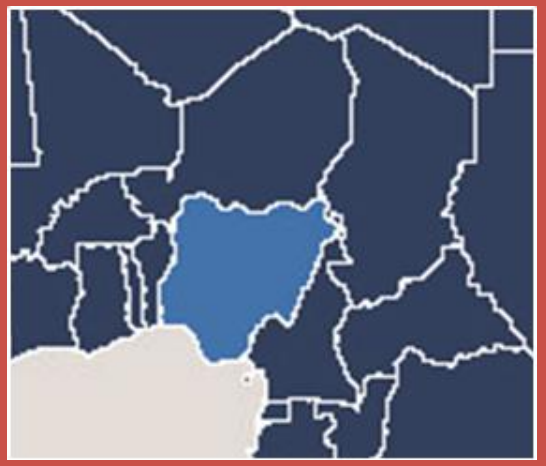
- Through the NHIS-HPP collaboration, foundation set for strong CBSHIP M&E
- Next steps in order to use the PMP
  - With future HPP support, need to increase efforts in basic data/information collection, such as Baseline Targets and Actual data to complete the Performance Data Tables (PDTS)
  - State-level application of PMP to determine CBSHIP implementation

Conclusion

- The documents developed with support from HPP are very valuable to the scheme
- The TA has encouraged the NHIS Management to prioritise M&E and allocate more resources towards strengthening the department
- Best practices:
  - Continuity of support
  - Holistic TA, across full spectrum of M&E
  - Not about resources, but about institutional strengthening through TA
- I commend the HPP for supporting the NHIS and look forward for more beneficial relationship in future


NATIONAL HEALTH INSURANCE SCHEME
EASY ACCESS TO
HEALTH CARE FOR ALL

Thank You!



Evidence for Advocacy: The Kaduna State Experience

July 23, 2015

Shehu U Muhammad

Chair, Initiative for Social Sector Advocacy, Kaduna

Kaduna State: Health Challenges

- High maternal and child mortality
  - Service delivery sites are not well equipped and have staffing and commodity shortages
  - While about 30% all pregnant women attend antenatal care (ANC), only 10% women deliver in a health facility
  - Less that 25% health care facilities **offer** or have the **capacity** to offer childbirth spacing/family planning services
- Family planning services are not well-supported
  - FP is not openly discussed
  - People hold many misconceptions about FP services, fearing negative effects on their health and future fertility
  - There are **few leaders who speak publicly in support of family planning**, especially among the religious and traditional leadership communities

Family Health Plus (FH+): Building Support for Family Planning

- Multi-pronged approach for growing FP support in Kaduna undertaken by the **Family Health Plus (FH+) Project**
- Three-year (2014-2017) USAID-funded project
- Goal of FH+ project is to:
  - Strengthen the overall **health system**
  - Build **provider capacity** to delivery quality services
  - Empower users to demand quality FP and **improve their access** to long-acting FP
- The FH+ Approach:
  1. Supporting an Advocacy Core Group/Working Group
  2. Establishing a state-level advocacy strategy for the Group
  3. Generating evidence on the benefits of investment in FP
  4. Presenting evidence and advocating to policymakers for action on FP policies, program and funding

(1) Supporting an FP Advocacy Core Group

- Strong, multi-sectoral FP Advocacy Core Group (ACG) already in existence in Kaduna state
- Established by NURHI in November 2010 to support its advocacy portfolio within its 3 LGAs of operation – Namely KN. KS & Chukun LGAs later extended to Zaria, SG, Giwa, Kudan and Soba LGs.
- ACG key goals:
  - Develop advocacy strategies to guide advocacy implementation at the national and local (site) levels
  - Catalyze high level and visible support for Healthy Timing and Spacing of Pregnancy/Family Planning in selected urban sites

(1) Supporting an FP Advocacy Core Group

- With NURHI's support ACG institutionalized as the **Initiative for Social Sector Advocacy (ISSA)**
- 32 person diverse membership including community leaders, religious leaders, opinion leaders, key government officials and more
- Key achievements under the NURHI project:
  - Created a an opportunity for the youth to express their opinions and ask questions on FM in different Media programmes
  - Created of FB BL and budgetary provision in the State Min for LG
  - Built the capacity of its members on advocacy process, procedures and had several step down trainings
- **Engaged in November 2014 under the FH+ Project**

(2) Establishing a State-Level Advocacy Strategy

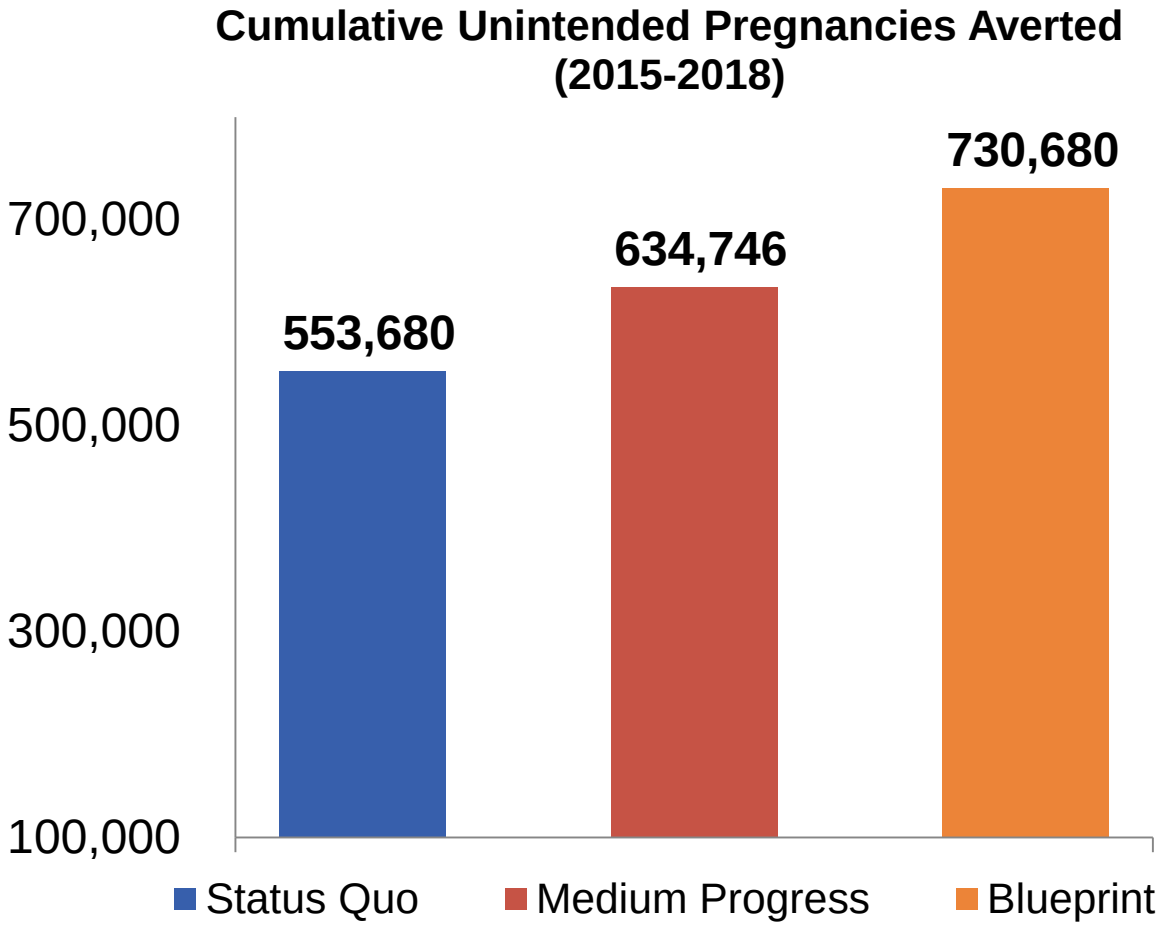
- ACG/ISSA engaged under FH+ in November 2014
- Initial meetings held with leadership and members in Kaduna
- March 2015: Advocacy Strategy Development Meeting hosted by FH+ and the Health Policy Project (HPP). State-level advocacy objectives developed in Abuja
- **Key Kaduna objectives:**
  - The state executive governor approves and **releases fund** for FP services to SMOH by 2016
  - The state executive governor approves and release N2 million for FP services in each of the 23 LGAs in Kaduna State
  - Commissioner of health domesticates the national FP policies by the end of 2016

(3) Generating Evidence on the Benefits of Investment in FP

- ACG/ISSA collaborated with FH+ and HPP in March 2014 to create an **ImpactNow Model** for Kaduna State
- ImpactNow is an Excel-based model that estimates the **health** and **economic** benefits of family planning (FP)
- Scenario-based, designed to show the impacts of three FP policy options and compare results
- The outcomes are focused on near-term reproductive health metrics, as well as economic metrics

KADUNA IMPACTNOW MODEL RESULTS

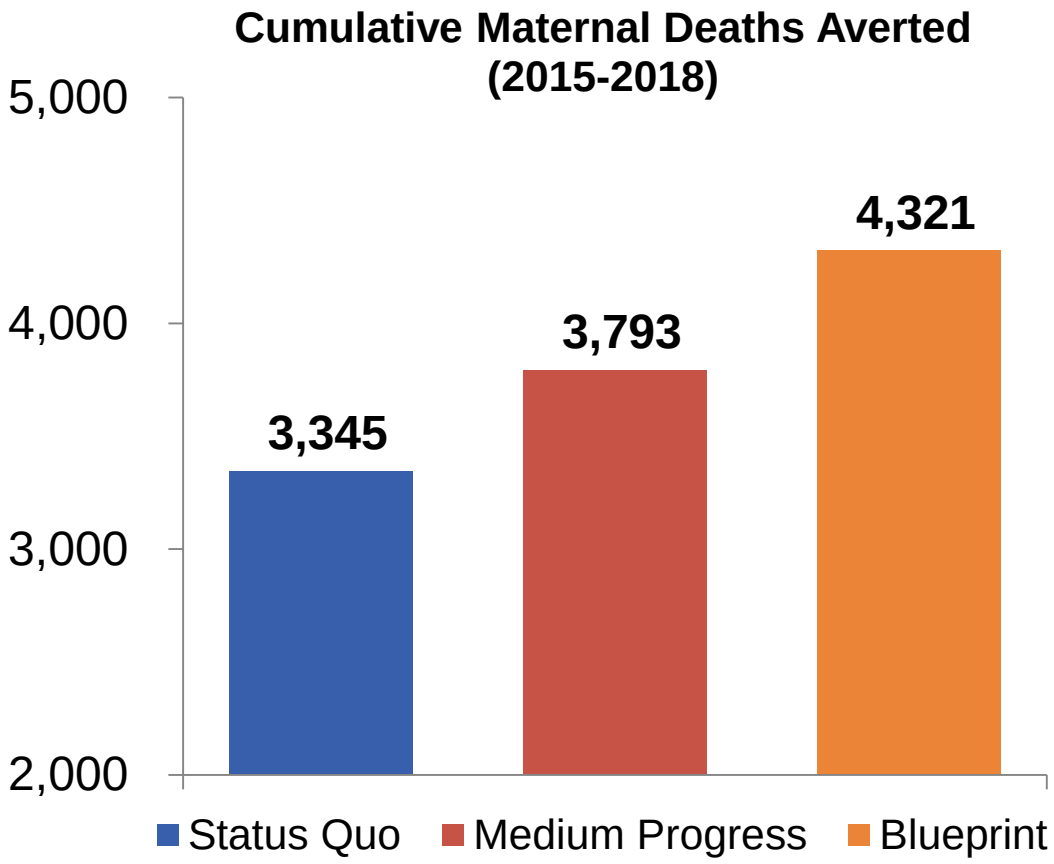
Unintended pregnancies averted



By achieving its share of the National Blueprint--increase its CPR to 46.5% by 2018--Kaduna would prevent more than 730,000 unintended pregnancies by 2018

Source: ImpactNow Kaduna State Model.

Mothers' lives saved

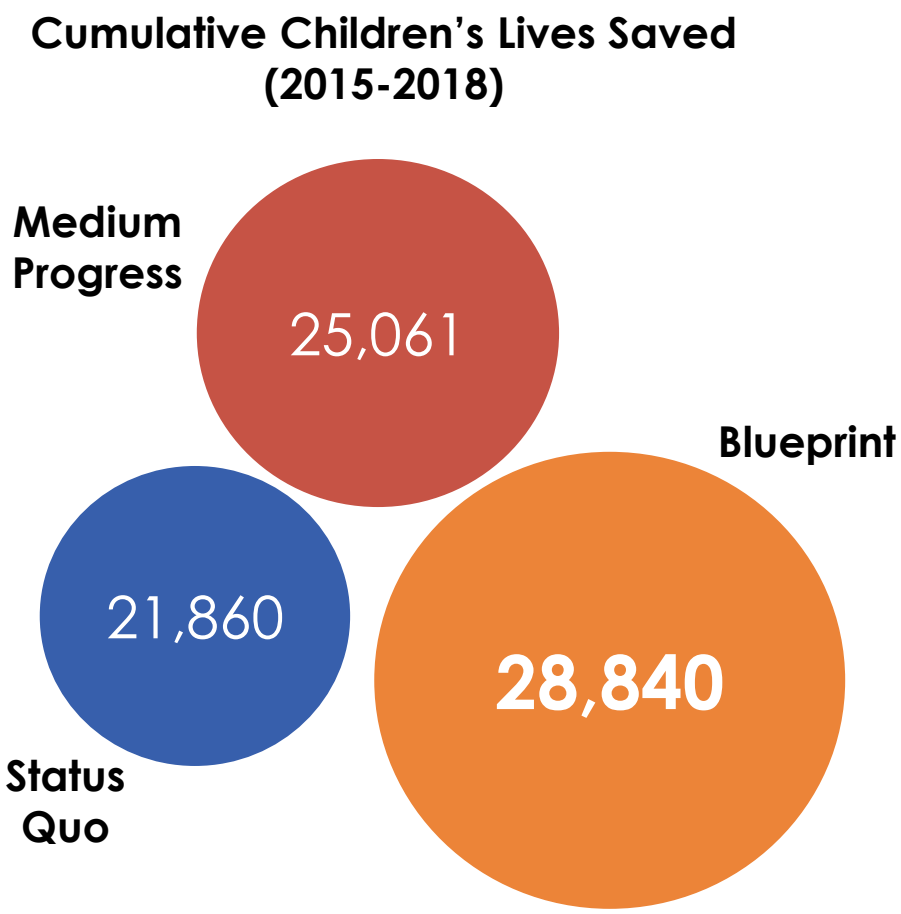


Currently, 1025 of every 100,000 live births in Kaduna result in a maternal death

Achieving Kaduna's share of the FP Blueprint would save an additional 976 mothers' lives by 2018

Source: ImpactNow Kaduna State Model.

Children's lives saved



1 in 8 children in Nigeria does not live to see his/her fifth birthday

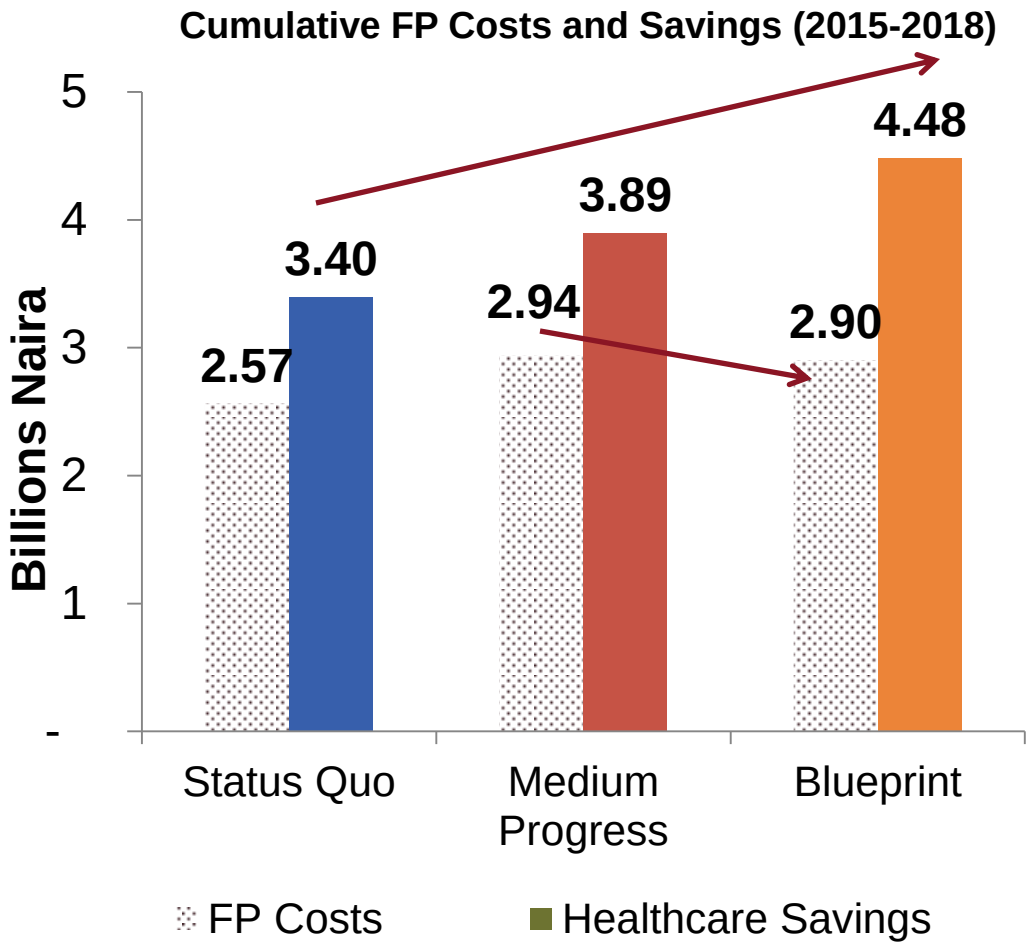
Increasing the uptake of FP, in line with the Blueprint goal, would save an additional 6,980 children in Kaduna

Source: ImpactNow Kaduna State Model.

Healthcare cost savings

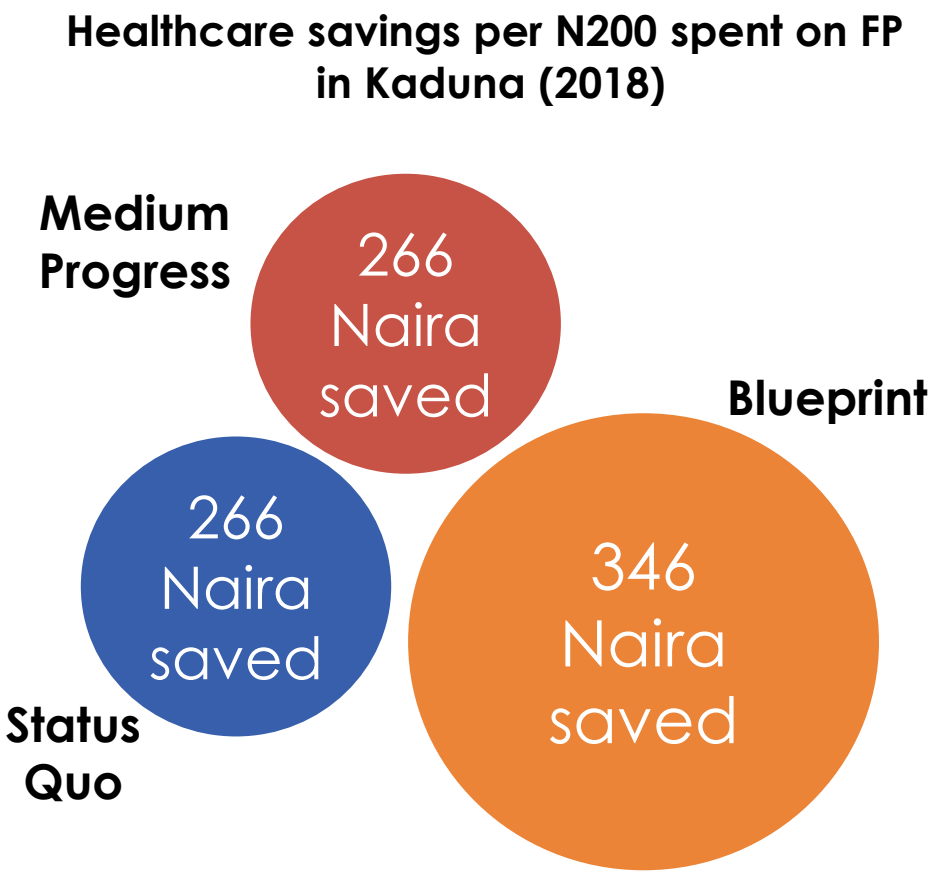
Total maternal and infant healthcare cost savings far outweigh FP costs for Kaduna, particularly when the state's Blueprint goal is achieved

By achieving its goal, Kaduna would save an additional **1 billion Naira in healthcare costs by 2018**



Source: ImpactNow Kaduna State Model.

Cost-benefit analysis



Kaduna currently saves N264 in direct healthcare costs for every N200 spent on FP.

Increasing use of FP, particularly long-acting methods, would increase these savings to N346 on N200 spent

Source: ImpactNow Kaduna State Model.

(4) Presenting Evidence for Action

- Next steps under FH+: ACG/ISSA undertakes activities in support of the advocacy objectives, using the ImpactNow model as evidence

5. Costed Plan of Action

5.1. Objective 1

Advocacy Objective		The state executive governor approves and releases fund for FP services in SMOH by 2016.				
Outcome Measure		Approved and released funds for FP in the SMOH				
Data Source		Budget of SMoH, State Budget				
Activity		**Cost (₦)**	**Person Responsible**	**Time frame**	**Output Indicator**	**Data source**
1.1	2-day meeting of Advocacy core group to revise, adopt work plan and finalize the ask contents	834,500	FPAWG	April, 2015	number of core group meetings conducted	Activity report
1.2	Advocacy Visit to Finance Commissioner	77,000	FPAWG	April, 2015	Number of Advocacy briefs developed	Activity report
1.3	Advocacy Visit to Health Commissioner	77,000	FPAWG, Chairman and Secretary	April, 2015	confirmed appointment letter to visit the Commissioner of Health	Copy of appointment letter
1.4	Advocacy visit to the Commissioner for economic planning	77,000	FPAWG Chairman and selected delegates	April, 2015	Number of advocacy visits to the commissioner	Minutes of meeting, activity report
Total Costs (₦)		**1,065,500**				

Thank You!

RAPID for National Advocacy

Bilkisu Yusuf
Executive Director
AdvocacyNigeria Presented at Health Policy Project Event
July 23, 2015 Abuja

Problem Statement

- Activity: Creating a national **RAPID model for advocacy**
- “RAPID” stands for “Resources for the Awareness of Population Impacts on Development”
  - Demonstrates the impact of population growth on development prospects
- Purpose: Development of RAPID was undertaken to target advocacy at policy makers at national level for improved health outcomes
- Target: Legislators, policy makers in relevant MDAs using evidence generated from NDHS
- RAPID analysis helps us determine how to raise our quality of life and become a more healthy, prosperous nation

Rationale

- RAPID was designed in 2011 for advocacy to motivate policy makers to take action on reducing maternal newborn and child death and improving family planning services. WHY?
- The MDG goal for child mortality is 64 child deaths per 1,000 live births by 2015.
  - We've made minimal progress over the last 20 years, lowering child mortality to about 157 deaths per every 1,000 live births in 2008.
  - Still far from the MDG goal.

(1) Process of RAPID Development

- Decision to develop RAPID taken at FPAG meeting and National Population Commission was identified as key partner for ownership
- AdvocacyNigeria trained in use of Spectrum and RAPID model, including results interpretation
- AdvocacyNigeria as FPAG Secretariat invited all stakeholders identified by FPAG to RAPID development meetings
  - Development of model = highly consultative

(2) Process of RAPID Development

Stakeholder engaged in RAPID development

MDAs	Implementers & Development Partners	Civil Society
NPopC	USAID	FPAG
FMOH	HPP	AdvocacyNigeria
FMWASD	UNFPA	Cislac
FME	AFP	White Ribbon Alliance
FMA&RD	DELIVER	DRPC Kano
NPC	Pathfinder	
NPHCDA		
NBS		

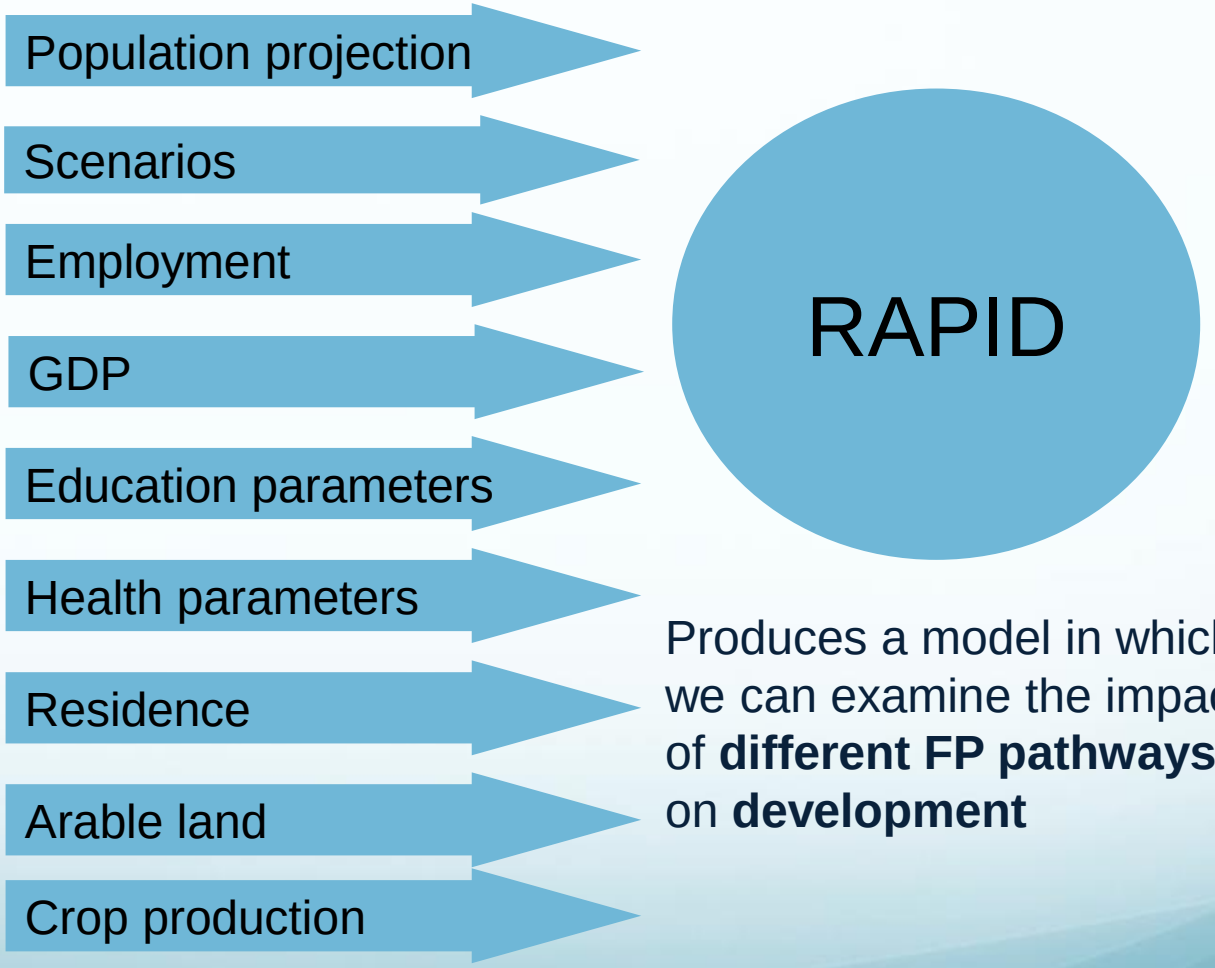
…and many more!

(2) Role of Individuals

- FPAG—Co chairs Drs Ladipo, Mairo Mandara
- FPAG members
  - Professor Emmanuel Otolorin Country Director of Jhpiego
  - Dr Moji Odeku, the E. D. of Nigerian Urban Reproductive Health Project NURHI
  - Udeme Abia of the Federal Ministry of Women Affairs and Social Development
  - Mike Egbo
  - Chinwe Onumonu of Pathfinder International
  - Don Dickerson, Brian Briscombe and Aliyu Aminu Ahmed of HPP
  - Mr Sumuila Makama Chairman NPC

(3) Process of RAPID Development

RAPID Model Inputs



Produces a model in which we can examine the impact of **different FP pathways** on **development**

(3) Process of RAPID Development

RAPID Model Outputs

- New jobs required
- Income per person over time
- Teachers required
- Schools required
- Education expenditures required
- Doctors required
- Annual health expenditures

…and many more!

RAPID

The Change We Seek

Nigeria

Resources for the Awareness of Population Impacts on Development

FEDERAL GOVERNMENT OF NIGERIA

Photos (cover & top,down): Plotter, Banjii, Mike Blyth, Brian Briscombe

Photo by Jeffrey Smith

“Low Fertility” Scenario:

Nigeria meets its National Strategic Plan targets

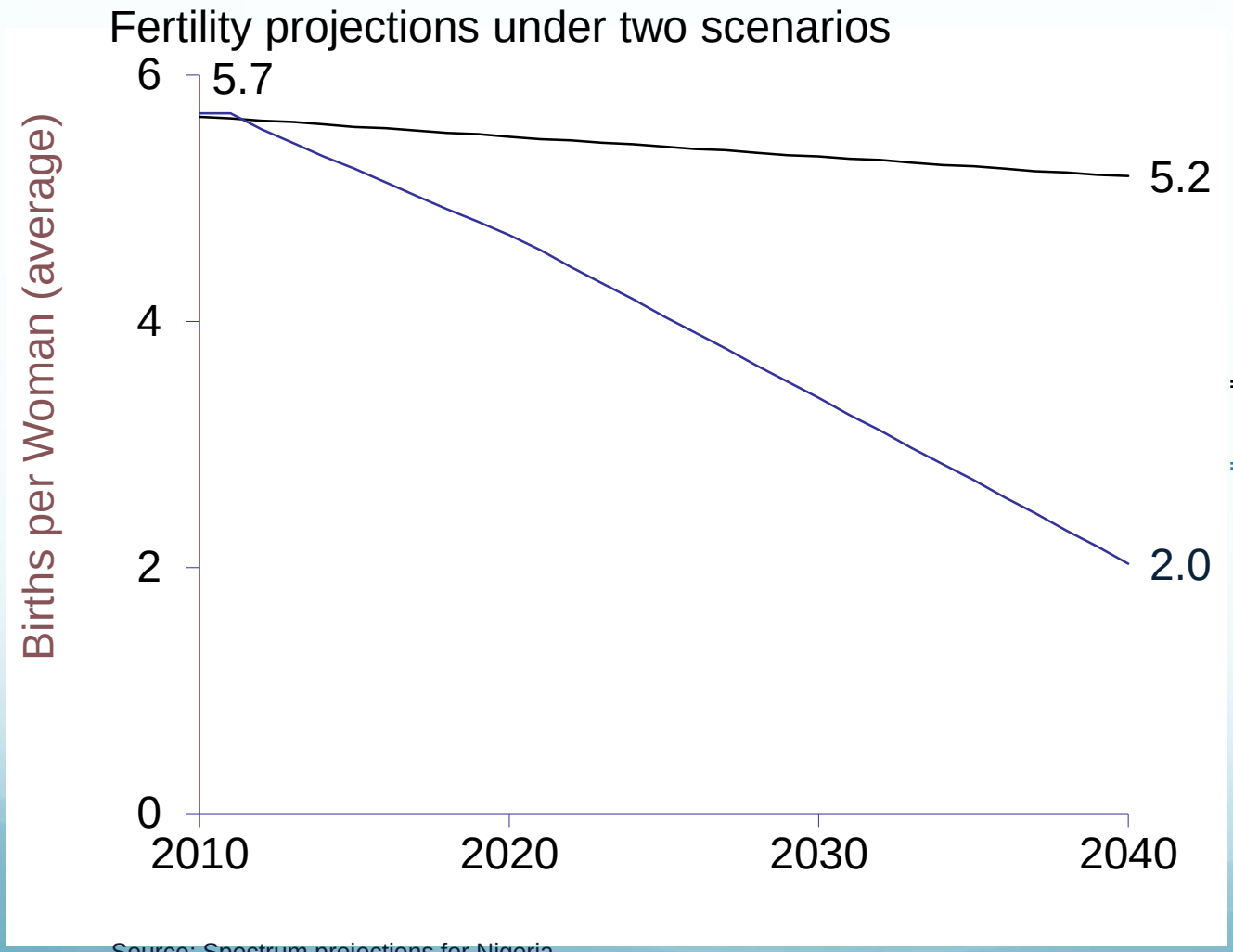
- Contraceptive use rises 2 percentage points each year
- Takes 10 years to meet current unmet need

“High Fertility” Scenario:

Nigeria’s current path

Photo by IITA Image Library

Two Paths



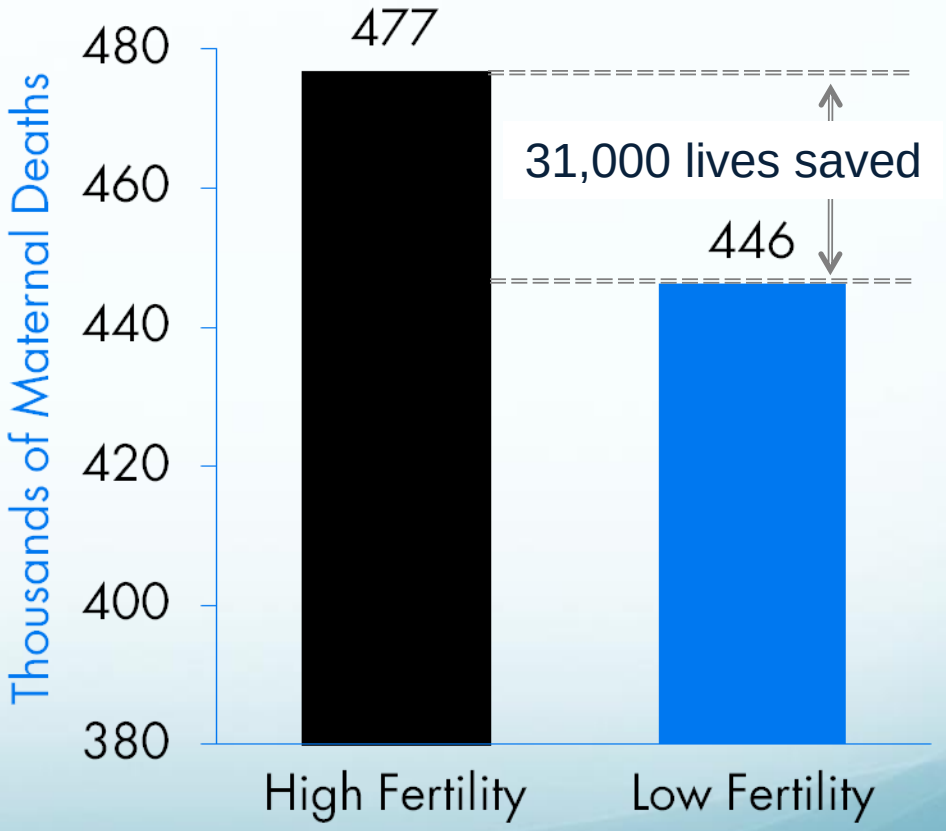
Source: Spectrum projections for Nigeria

Photo by Lindsay Mgbor/Department for International Development

Meeting Unmet Need Saves Lives

Mothers' lives would also be saved

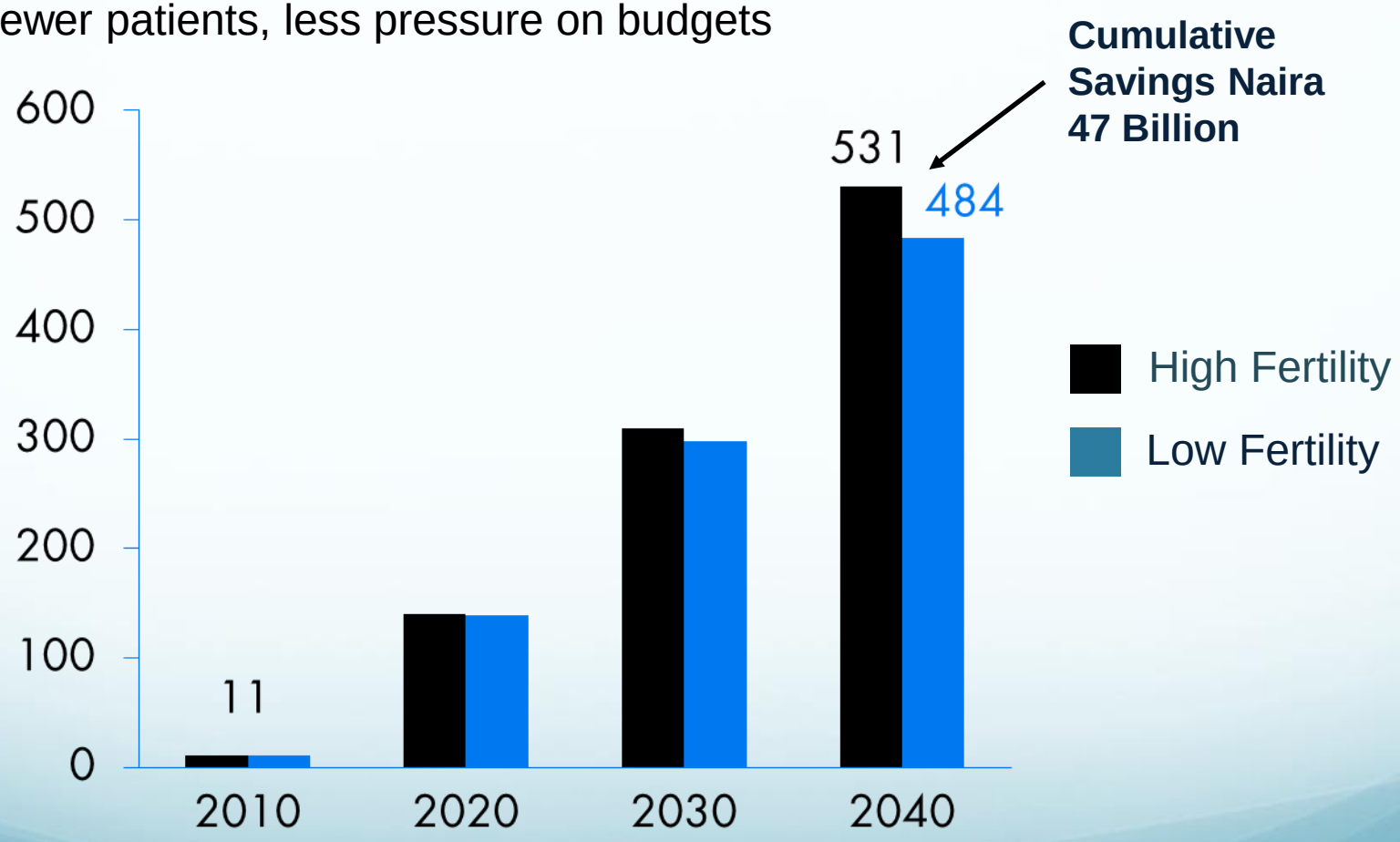
(2011–2021)



Sources: Spectrum and MDG Model projections for Nigeria

Health Expenditures

Fewer patients, less pressure on budgets



Source: Spectrum projections for Nigeria

In Summary

Lower fertility in Nigeria means during the next 10 years would result in…

Photo by Jeremy Weate

1.5 million child deaths averted (MDG #4)

31 thousand maternal lives saved (MDG #5)

Lower maternal and child health complications

Less burden on midwives and other resources to meet ALL the MDGs

Photo by by Banjii

Let's Take Action

Help Nigerians achieve their desire for healthier families through access to family planning by:

- Passing the National Health Bill to help fund quality health care in Nigeria
- Approving a permanent annual budget line item for family planning starting in 2012
- Releasing the committed 2011 MDG funds for family planning commodities

(4) RAPID Use: Presentations to Policy-Makers

- RAPID was presented to the Senate Committee on Health, the Ministers of Health, Finance, Exe Dir. NPHCDA, President was listed for presentation– NPC Cman's tenure ended
- The results were used for advocacy at various levels as listed above and to influence London summit pledge
- It influenced the bold policy move to make FP/ Maternal health commodities free nationwide.
- Smaller RAPID meetings were held by FPAG members to train themselves on making the presentations
- Chairman NPC Was trained to present RAPID

(4) RAPID Use: Networking and Partnership

- RAPID National influenced the development of RAPID at state level and sharing data on health outcomes in various zones
- TSHIP in Bauchi- networking at community level
- Repositioning the need for Evidence based approach to advocacy FPAG and National Family Planning conferences
- AAFP and continuing engagement with National Family Planning activities

The Way Forward

- Current advocacy efforts are directed at the new government to influence critical areas of focus
  - Stakeholders' demands on the current administration (technical paper): presentation to the Transition Committee of the President
- Meeting with Governor's Forum on going: July 22 2015
- Advocacy is continuous and data generation should continue to ensure review/update of RAPID
- Issues addressed in RAPID four years ago are still current

Thank You