Federal Government of Nigeria

SECOND NATIONAL STRATEGIC HEALTH DEVELOPMENT PLAN 2018 – 2022

Ensuring healthy lives and promoting the wellbeing of Nigerian populace at all ages

Foreword

The Government of the Federal Republic of Nigeria, through the Federal Ministry of Health, led the development of the first National Strategic Health Development Plan 2010-2015. The development of the Plan involved active participation of national, subnational and international stakeholders. The Plan was launched in 2010 at the national level and subsequently many States launched their plans.

The joint annual reviews, mid-term and end-term evaluations of NSHDP I showed variable success at state and national levels. According to the end-term evaluation, significant achievements include state domestication of the Primary Health Care under One Roof policy, passage of the National Health Act which includes the Basic Health Care Provision Fund for Universal Health Coverage and the launching of a comprehensive National Health Policy. Furthermore, significant progress was recorded in key public health programmes. Notably, increased investments in procurement and distribution of insecticide-treated-bed nets led to significant reduction in malaria incidence and reduction in HIV prevalence, especially among the youth. While innovative programmes such as the Midwifery Service Scheme, the free Maternal and Child Health policy contributed to increased access to, and utilisation of RMNCH+N services, more still need to be done to accelerate reduction of maternal and neonatal mortality in Nigeria. These indicators are relevant to the Sustainable Development Goals and have been prioritised in the NSHDP II.

The NSHDP II builds upon the successes and challenges of NSHDP I which was implemented over the past six years. Some of the challenges identified in the NSHDP I end term evaluation and which have been considered in NSHDP II include: gaps in political will and poor programme ownership at lower levels especially state and LGA levels; weak donor coordination and harmonisation of development and technical assistance; low level of government financing of healthcare at the three levels of government; weak M&E systems to monitor implementation of the state Strategic Health Development Plans and weak Primary Health Care structures.

The development of NSHDP II could not commence as scheduled and so the 58th session of the National Council on Health, the highest policy-making body on health matters in Nigeria, approved a one-year extension of implementation of NSHDP I in order to allow time for comprehensive development of a successor plan which would cover the period of 2017-2021 and which should reflect the 2016 National Health Policy. However, the NSHDP II development took much longer than scheduled and the plan was only finalized in June 2018. This led the 61st NCH to change the implementation period of NSHDP II to 2018-2022.

NSHDP II is anchored on the 2016 National Health Policy which recognizes Nigeria's aspiration to attain Universal Health Coverage by operationalizing the policy to have one functional Primary Health Clinic per ward. The NSHDP II also considers the expansion of pre-payment social health insurance schemes for UHC, the unfinished business of the Millennium Development Goals, the Sustainable Development Goals and the Global Post 2015 Development Agenda including the renewed Global Commitment for countries to progressively attain Universal Health Coverage. The plan further aligns with the Economic Recovery and Growth Plan (2017-2020) and the National Vision 20:2020. The National Health Act serves as a major legislative framework for effective articulation and delivery of the strategies of the NSHDP II.

At the initial stage of the development process, a NSHDP II framework to provide uniform guidance for States to produce their respective plans was developed and validated by all

stakeholders. The second stage was the use of the framework to guide the development of specific costed plans by the 36 States, the FCT and the Federal level. The final stage involved harmonisation of the State and Federal plans into one National Plan and its subsequent validation by stakeholders.

The NSHDP II addresses lingering and emerging health sector challenges. It also offers the opportunity to ensure better health outcomes by 2022 through consolidation of the gains made and incorporation of the lessons learned from NSHDP I. The NSHDP II will ensure, among other things that we collectively achieve better cohesion that guarantees greater participation, ownership, sustainability and full implementation of the Plan at all levels of government including communities. This bottom–up approach is geared towards the realisation of our goal of ONE FRAMEWORK, ONE PLAN AND ONE M&E for the Nigerian health sector.

It is important to point out that while the NSHDP I primarily addressed the health system building blocks under eight priority areas of the 2004 Health Policy, the second Plan takes a more comprehensive, inclusive and holistic approach to address both health service delivery and systems strengthening. Therefore NSHDP II is organized into the following five strategic pillars:

1. Enabled environment for attainment of sector outcomes which focuses on Leadership & Governance, Community Participation and Partnership for Health;
2. Increased utilization of Essential Package of Health Care Services which covers RMNCAH and Nutrition, Communicable and Non-Communicable Diseases, Mental Health, Care of the Elderly, and NTDs;
3. Strengthened health system for delivery of Essential Package of Health Care Services which focuses on Human resources, Health Information System, Medicines, Vaccines and other Technologie
4. Protection from health emergencies and risks, and
5. Increased Sustainable, Predictable Financing and Risk Protection.

Unlike the first Plan, NSHDP II is accompanied by a dedicated Monitoring and Evaluation plan which shall facilitate our tracking of progress towards the targets and attainment of our goal to ensure healthy lives and promote the wellbeing of the Nigerian populace at all ages.

I believe that Nigeria is now well positioned to attain Universal Health Coverage in line with our commitment to SDGs. Therefore, I beckon on all our stakeholders including health professionals, civil society groups, development partners and others to work together with the State and Federal Governments for us to jointly achieve the NSHDP II goals. I have no doubt that with the unwavering political commitment of government, engagement and ownership of the pursuit of health by all Nigerians, active community participation, coupled with the steadfast commitment of our health workers, the support of our development partners and other stakeholders, we will succeed in achieving the NSHDP II goals.

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Acknowledgements

Nigeria's second National Strategic Health Development Plan (2018-2022) has emerged as a Federal Ministry of Health-led process, mandated by the National Council on Health, as a successor to the First National Strategic Health Development Plan (2010-2015) which was subsequently extended by a year.

The NSHDP II was prepared with a more inclusive and participatory process than NSHDP I. The process involved all major stakeholders, Departments, Agencies and Parastatals of Federal Ministry of Health, the Ministry of Budget and National Planning, Federal Ministry of Finance, the Senate and House Committees on Health, all State Ministries of Health and the FCT Secretariat for Health and Human Services, all State Ministries of Budget and Planning; the Academia, Public Health experts and Development Partners including the WHO, UNICEF, UNFPA, Pathfinder International, the World Bank through the SOML Programme, EU through EU-SIGN, USAID through HP+ and HFG, DFID through MNCH2 and Women for Health, JICA, GAC, BMGF through HSCL and many other bilateral organisations; Civil Society Organisations, Private Sector Organisations. The Federal Ministry of Health, on behalf of the Government of the Federal Republic of Nigeria, greatly appreciates the collaboration and support received, both technically and financially, from all our stakeholders, especially the Development Partners, Civil Society Organisations and Private Sector Organisations.

The development of the NSHDP II was coordinated by the Department of Health Planning, Research & Statistics of the Federal Ministry of Health in close collaboration with the NSHDP II Technical Working Group, the National Lead Consultants and the State Consultants. The Nigerian health sector is indebted to all the former Heads of Health Planning, Research & Statistics Department, particularly, the immediate past head, Dr Akin Oyemakinde, all members of the TWG, the Consultants and the Planning Secretariat for their commitment to the development of this very important document which has given a clear direction towards the attainment of Universal Health Coverage.

Finally, our gratitude goes to the National Council on Health for mandating and supporting the preparation of this ONE Health Plan for Nigeria.

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Abbreviations

3TC	Lamivudine
ACT	Artemisinin-based Combination Therapy
AIDS	Acquired Immune Deficiency Syndrome
AMR	Antimicrobial Resistance
ANC	Antenatal Care
AOP	Annual Operational Plan
ARH	Adolescent Reproductive Health
ART	Anti-retroviral Therapy
ARV	Anti-retroviral
BCC	Behaviour Change Communication
BEmONC	Basic Emergency Obstetric and New-born Care
BHCPF	Basic Health Care Provision Fund
BMGF	Bill and Melinda Gates Foundation
BMI	Body Mass Index
BP	Blood Pressure
CA	Cancer
CAP	Common African Position
CAT-Lab	Cardiac Catheterization Laboratory
CBO	Community Based Organisation
CBW	Community Based Worker
CD4	Cluster of Differentiation 4
CDC	US Centers for Disease Control and Prevention
CEmONC	Comprehensive Emergency Obstetric and New-born Care
CERF	Central Emergency Response Fund
CHC	Comprehensive Health Centre
CHEW	Community Extension Health Worker
CHIPS	Community Health Influencers, Promoters and Services
CHO	Community Health Officer
CMAM	Community Management of Acute Malnutrition
CORPS	Community Resource Persons
CPAP	Continuous Positive Airway Pressure
CPR	Contraceptive Prevalence Rate
CQI	Continuous Quality Improvement
CRF	Consolidated Revenue Fund
CSM	Cerebrospinal Meningitis
CSO	Community Service Organisation
CSR	Corporate Social Responsibility
CVD	Cardiovascular Disease
DALYs	Disability Adjusted Life Years
DFAT	Australian Department of Foreign Affairs and Trade
DFID	UK Department for International Development
DHIS2	District Health Information System 2
DPRS	Department of Planning, Research and Statistics
DPT	Diphtheria, Pertussis and Tetanus
DQA	Data Quality Assurance
DRM	Domestic Resource Mobilisation
DSM	Diagnostic and Statistical Manual
EBF	Exclusive Breast Feeding
ECG	Electrocardiogram
EID	Early Infant Diagnosis
EMS	Emergency Medical Services
EOC	Emergency Operations Centre
eMTCT	Eliminating Mother-To-Child Transmission of HIV
ERGP	Economic Recovery and Growth Plan
ESG	Echitab Study Group
EPHS	Essential Package of Health care Services
ETS	Emergency Transport Scheme
EU	European Union
EU-SIGN	European Union Support to Immunisation Governance in Nigeria
FCT	Federal Capital Territory
FEC	Federal Executive Council
FHC	Facility Health Committee
FMC	Federal Medical Centre
FMOH	Federal Ministry of Health
FP	Family Planning
FRSC	Federal Road Safety Corps
FTC	Emtricitabine
GAC	Global Affairs Canada
GAVI	The Vaccine Alliance
GBV	Gender Based Violence
GDP	Gross Domestic Product
GIS	Geographic Information System
HAART	Highly Active Anti-retroviral Therapy
HBFI	Hospital Baby Friendly Initiative
HBV	Hepatitis B Virus
HCF	Health Care Financing
HCT	HIV Counselling and Testing
HCV	Hepatitis C Virus

HDGC	Health Data Governance Council
HDI	Health Development Index
HFG	USAID Health Governance and Financing Program
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HMO	Health Maintenance Organisation
HP+	USAID Health Policy Plus
HPCC	Health Partners Coordination Committee
HPV	Human Papilloma Virus
HRH	Human Resources for Health
HSS	Health Systems Strengthening
HTP	Harmonised Training Package
iCCM	Integrated Community Case Management
ICT	Information Communication Technology
IDP	Internally Displaced People
IDSR	Integrated Disease Surveillance and Response
IDU	Injecting Drug Use
IEC	Information Education Communication
IHP+	International Health Partnership (UHC2030)
IHR	International Health Regulations
IHVN	Institute of Human Virology Nigeria
IMCI	Integrated Management of Childhood Illnesses
IPC	Infection Prevention and Control
IPT	Intermittent Preventive Therapy
IPV	Inactivated Polio Vaccine
IRS	Indoor Residual Spraying
ISO	International Organization for Standardization
ISS	Integrated Supportive Supervision
ITN	Insecticide Treated Net
IVM	Integrated Vector-control Management
IYCF	Infant and Young Child Feeding
JANS	Joint Assessment of National Health Strategies
JCHEW	Junior Community Health Extension Worker
JICA	Japan International Cooperation Agency
LAC	Long Acting Contraceptive
LARC	Long Acting Reversible Contraceptive
LGA	Local Government Area
LLINs	Long Lasting Insecticide Treated Nets
LMCU	Logistics Management Coordination Unit
LMIS	Logistics Management Information System
LSM	Larval Source Management
LSS	Life Saving Skills
LUTH	Lagos University Teaching Hospital
M&E	Monitoring and Evaluation
MCH	Maternal Child Health
mCPR	modern Contraceptive Prevalence Rate
MDAs	Ministries, Departments and Agencies
MDG	Millennium Development Goals
MDR-TB	Multi-drug resistant Tuberculosis
MDT	Multi-drug Treatment
MICS	Multiple Indicator Cluster Survey
MIS	Malaria Indicator Survey
MLSS	Modified Life Saving Skills
MMR	Maternal Mortality Ratio
MNCH2	Maternal New-born and Child Health Programme
MNS	Mental, Neurological and Substance
MOU	Memorandum of Understanding
MPDSR	Maternal Perinatal Death Review and Surveillance
MPPI	Minimum Prevention Package Intervention
mRDT	Malaria Rapid Diagnostic Test
MSM	Men who have Sex with Men
MSP	Minimum Service Package
MSS	Midwifery Service Scheme
MTB-Rif	Rapid diagnosis of TB and detection of rifampicin resistance
MTEF	Medium Term Expenditure Framework
MUAC	Mid Upper Arm Circumference
NAFDAC	National Agency for Food and Drug Administration and Control

NASCP	National AIDS and STD Control Programme
NCDC	Nigeria Centre for Disease Control
NCDs	Non Communicable Diseases
NCH	National Health Council
NDHS	Nigeria Demographic and Health Survey
NEMA	National Emergency Management Agency of Nigeria
NGN	Nigerian Naira
NGO	Non-Governmental Organisation
NHA	National Health Accounts
NHAct	National Health Act
NHIS	National Health Insurance
NHMIS	National Health Management Information System
NHP	National Health Policy
NHREC	National Health Research and Ethics Committee
NHRHIS	National Human Resources for Health Information System
NHRHP	National Human Resources for Health Policy
NHRHSP	National Human Resources for Health Strategic Plan
NMR	Neonatal Mortality Rate
NPF	Nigeria Police Force
NPHCDA	National Primary Health Care Development Agency
NPopC	National Population Commission
NSCDC	Nigeria Security and Civil Defence Corps
NSCIP	National Supply Chain Integration Programme
NSHDP	National Strategic Health Development Plan
NSHIP	Nigeria State Health Investment Project
NTD	Neglected Tropical Disease
NTLCP	National TB and Leprosy Control Programme
OCV	Oral Cholera Vaccine
ODA	Overseas Development Assistance
OF	Obstetric Fistula
OOPE	Out of Pocket Health Expenditure
OPV	Oral Polio Vaccine
OSH	Occupational Safety and Health
OSS	One Stop Shop
PAP	Papanicolaou test
PBF	Performance Based Financing
PCV	Pneumococcal Conjugate Vaccine
PEPFAR	Presidential Emergency Program for AIDS Relief
PET	Positron Emission Tomography
PFM	Public Financial Management
PHCUOR	Primary Health Care Under One Roof
PHE	Public Health Emergencies
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission of HIV
PNC	Post Natal Care
PPE	Personal Protective Equipment
PPH	Post-Partum Haemorrhage
PPMV	Patent and Proprietary Medicine Vendors
PPP	Private Public Partnership
PSA	Prostate Specific Antigen
QA	Quality Assurance
QC	Quality Control
R&D	Research and Development
RBF	Results Based Financing
RDS	Respiratory Distress Syndrome
RDT	Rapid Diagnostic Test
RMNCAH+N	Reproductive, Maternal, New-born, Child, Adolescent Health and Nutrition
RRT	Rapid Response Team
RTA	Road Traffic Accident
RUTF	Ready-to-Use Therapeutic Food
SBA	Skilled Birth Attendance
SCH	State Council on Health
SDG	Sustainable Development Goal
SERVICOM	Service Compact with All Nigerians

SHA	State Health Accounts
SHDP	Strategic Health Development Plan
SHIS	State Health Insurance Scheme
SHREC	State Health Research and Ethics Committee
SMI	Serious Mental Illness
SMOH	State Ministry of Health
SOML	Saving One Million Lives
SOPS	Standard Operating Procedures
SP	Sulfadoxine-Pyrimethamine
SPHCB	State Primary Health Care Board
STG	Standard Treatment Guidelines
STI	Sexually Transmitted Infection
SURE-P	Subsidy Reinvestment and Empowerment Program
SWOT	Strengths, Weaknesses, Opportunities and Threats
TB	Tuberculosis
TBA	Traditional Birth Attendant
TDF	Tenofovir
TOC	Theory of Change
TSS	Task Shifting and Sharing
TT	Tetanus Toxoid
TWG	Technical Working Group
U5MR	Under 5 Maternal Mortality
UATH	University of Abuja Teaching Hospital
UCH	University College Hospital Ibadan
UHC	Universal Health Coverage
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
USAID	United States Agency for International Development
USD	United States Dollar
VAT	Value Added Tax
VFM	Value for Money
VHW	Volunteer Health Worker
WASH	Water, Sanitation and Hygiene
WDC	Ward Development Committee
WHA	World Health Assembly
WHO	The World Health Organisation
WHOPES	WHO Pesticide Evaluation Scheme
WRA	Women of Reproductive Age

Executive Summary

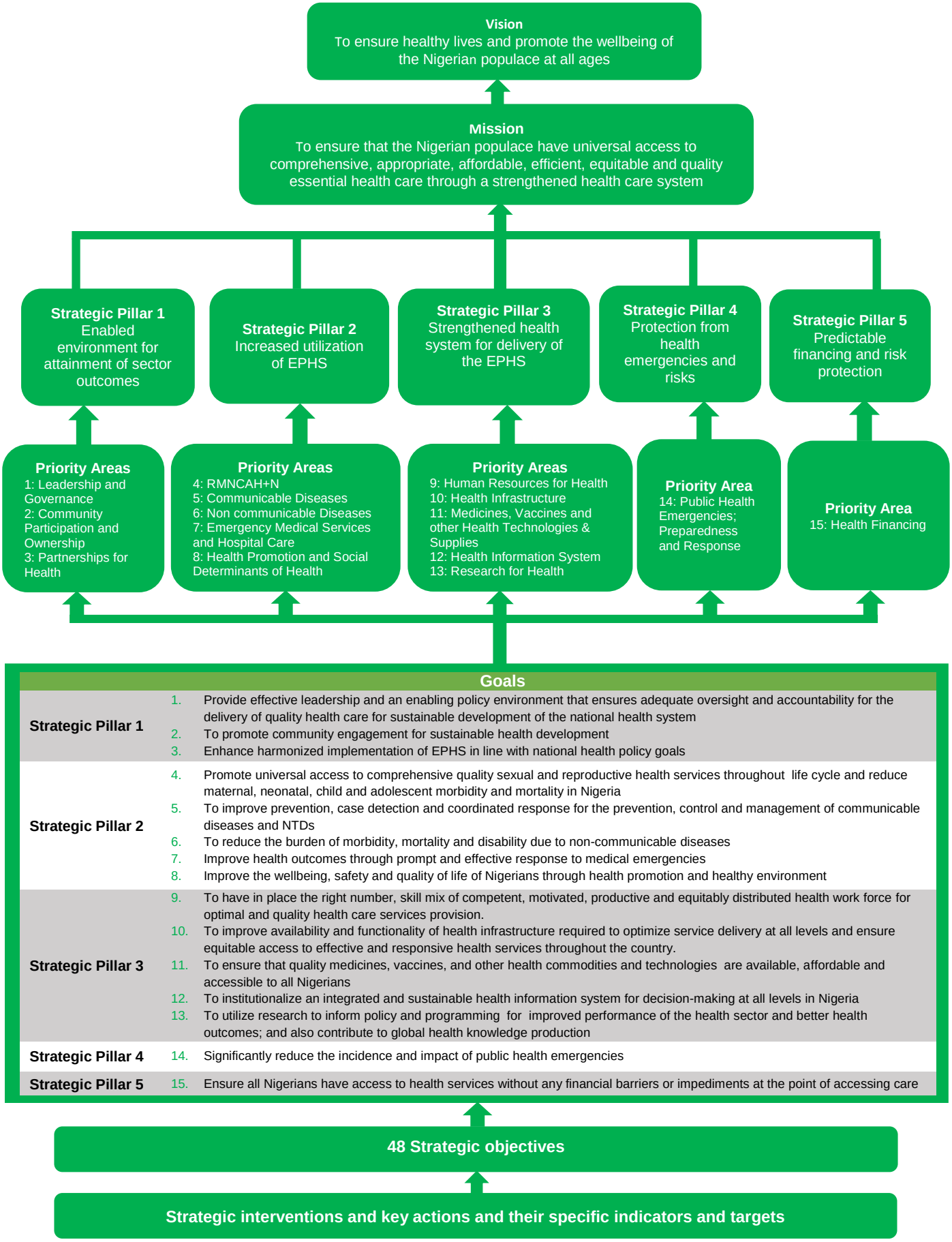
Nigeria's health sector is guided by Vision 20:2020, the medium-term Economic Recovery and Growth Plan (ERGP). The overarching goal of the Nigerian Constitution and the National Health Act (NHAct) is to guarantee the right to health for all Nigerians. The 2016 National Health Policy provides an implementation framework to translate the provisions of the NHAct and the Sustainable Development Goals into healthy lives and wellbeing for all Nigerian citizens. The tenets of Universal Health Coverage are central to the goal of National Health Policy "*To strengthen Nigeria's health system, particularly the Primary Health Care sub-system, to deliver quality, effective, efficient, equitable, accessible, affordable, acceptable and comprehensive health care services to all Nigerians"*.

Therefore this second National Strategic Health Development Plan (NSHDP II) provides the Health Sector Medium Term roadmap to move the country towards the accomplishment of National Health Policy goals and objectives. NSHDP II will guide national and subnational governments on the health sector priorities. Additionally, it recognises and identifies key actions that other sectors should collaborate with, or jointly implement with the health sector in order to address the social determinants of health in the pursuit of health-related SDGs.

NSHDP II builds on the successes of and lessons learned from implementation of Nigeria's first National Strategic Health Development Plan (2010-2016) which focussed on strengthening the health system and prioritising primary health care. The end term evaluation (ETE) of the NSHDP I showed that while some progress has been made, a lot more needs to be done to improve the nation's poor health indices which still rank among the poorest in the world. Recommendations from ETE of the NSHDP I included the following priorities for subsequent strategic health development plans:

- Greater focus on service delivery through the Essential Package of Health Care Services (EPHS)
- Define norms and standards of care at various levels of the health care system
- Accelerate actions towards UHC by strengthening PHC by consolidation of ward health care system and strengthening referrals and emergency medical services
- Strengthen the supply chain management system to ensure sustainable supply of drugs, vaccines and commodities, especially life-saving commodities
- Review and strengthen community-based healthcare services provision through harmonisation of community-based healthcare providers and promotion of community participation
- Step up actions to expand coverage and reducing financial barriers through social health insurance and improving government funding to the health sector
- Improve the performance of Health Management Information Systems (HMIS), generation and use of health data and evidence for decision-making and institute a system for continuous improvement of quality of healthcare
- Strengthen coordination of the health sector investments and response

NSHDP II was developed through a participatory process and with inputs from the health plans of all the 36 States of the Federation as well as the Federal Capital Territory (FCT) and Federal strategic health plans. NSHDP II is arranged into five Strategic Pillars and fifteen Priority Areas with 15 Goals and 48 Strategic Objectives. Strategic Interventions and Key Actions, specific indicators and targets are also outlined. Detailed arrangements for tracking implementation are provided in the NSHDP II Monitoring & Evaluation Plan.



	Goals
Strategic Pillar 1	1. Provide effective leadership and an enabling policy environment that ensures adequate oversight and accountability for the delivery of quality health care for sustainable development of the national health system 2. To promote community engagement for sustainable health development 3. Enhance harmonized implementation of EPHS in line with national health policy goals
Strategic Pillar 2	4. Promote universal access to comprehensive quality sexual and reproductive health services throughout life cycle and reduce maternal, neonatal, child and adolescent morbidity and mortality in Nigeria 5. To improve prevention, case detection and coordinated response for the prevention, control and management of communicable diseases and NTDs 6. To reduce the burden of morbidity, mortality and disability due to non-communicable diseases 7. Improve health outcomes through prompt and effective response to medical emergencies 8. Improve the wellbeing, safety and quality of life of Nigerians through health promotion and healthy environment
Strategic Pillar 3	9. To have in place the right number, skill mix of competent, motivated, productive and equitably distributed health work force for optimal and quality health care services provision. 10. To improve availability and functionality of health infrastructure required to optimize service delivery at all levels and ensure equitable access to effective and responsive health services throughout the country. 11. To ensure that quality medicines, vaccines, and other health commodities and technologies are available, affordable and accessible to all Nigerians 12. To institutionalize an integrated and sustainable health information system for decision-making at all levels in Nigeria 13. To utilize research to inform policy and programming for improved performance of the health sector and better health outcomes; and also contribute to global health knowledge production
Strategic Pillar 4	14. Significantly reduce the incidence and impact of public health emergencies
Strategic Pillar 5	15. Ensure all Nigerians have access to health services without any financial barriers or impediments at the point of accessing care

The OneHealth Tool was used to cost NSHDP II. The total cost of the strategy presented below is the aggregate of costs of health system inputs and programme management activities to be carried out by the 36 States, the FCT, the Federal Ministry of Health and its agencies. Other costs captured include estimates for delivering services to achieve the desired NSHDP II coverage targets and impact goals.

Impact and cost estimates for the NSHDP II were modelled for the period 2018-2022. Impact targets of NSHDP II were determined in line with national commitment towards the attainment of reduced global maternal, new-born and under-five mortality targets by 2030. With the 2022 projected mortality ratio agreed upon, coverage parameters for high impact health services were iteratively scaled until the desired targets to yield the mortality ratios were achieved. Guided by this approach, three NSHDP II Policy Scenarios have been modelled to estimate the overall cost for implementing NSHDP II.

1. **Baseline Scenario:** no coverage scale-up and no significant change in HSS investment during the life of the plan (total cost ₦ 4.369 Trillion).
2. **Moderate Scale-up Scenario:** scale-up essential services and HSS investments required for the implementation of the Primary Health Care Revitalization Agenda, a key policy thrust of Economic Recovery and Growth Plan (total cost ₦ 6.071 Trillion).
3. **Aggressive Scale-up Scenario:** scale-up Health Service and Health Systems Strengthening investments aimed at achieving universal health coverage while implementing components of the primary health care revitalization agenda contained in the Moderate Scenario (total cost ₦ 7.321 Trillion).

Policy Scenario	Coverage increase	Cost per year in ₦ Trillion						Average cost per capita
		2018	2019	2020	2021	2022	2018-2022	
Baseline	0%	₦ 0.859	₦ 0.859	₦ 0.899	₦ 0.879	₦ 0.873	₦ 4.340	US$ 24
Moderate Scale-up	17.5%	₦ 0.947	₦ 1.087	₦ 1.220	₦ 1.325	₦ 1.492	₦ 6.071	US$ 34
Aggressive Scale-up	30%	₦ 1.115	₦ 1.365	₦ 1.492	₦ 1.559	₦ 1.790	₦ 7.321	US$ 41

Mechanisms to ensure sustainable financing of the NSHDP II and the EPHS have been established with a particular focus on strengthening primary health care and referral systems, establishing emergency medical care services, and removing financial barriers to access health care. These health care financing mechanisms include the national health insurance scheme (NHIS), state social health insurance scheme (SSHIS) and the Basic Health Care Provision Fund as specified in the NHAct.

Chapter 1
Introduction

1.1 Background

Health is both a precondition for, and an outcome of sustainable development. Health is also a basic human right that everyone should be able to enjoy to the highest level in order to live a socially and economically productive life.

Various development agenda over the years recognised poor health as a major contributor to the low level of development of the country and have always invested in health development as part of its overall strategy. To this end, the Federal and State governments have over the years, invested in the development and implementation of various health sector reform programmes geared towards the overall development of a modern, efficient and effective healthcare delivery system that guarantees the productivity and wellbeing of all Nigerians.

Previous health sector development has been guided by the Health Sector Reform Programme (2004 -2007)[1] and the First National Strategic Health Development Plan (2010 – 2015)[2] that sought to operationalise the National Health Policy of 1988[3] which was subsequently revised in 2004 and 2016. Despite these investments, efforts at health system strengthening have not had the desired effect, resulting in limited health care coverage and persistently poor health status of the population.

The National Council on Health (NCH) extended implementation of NSHDP I by a year to end in 2016 to allow sufficient time to develop a successor that would build from NSHDP I as well as incorporate the unfinished MDG agenda while aligning with a broader health focus within the SDG framework.

The persistent health system weaknesses, the emerging health challenges and the need for the nation to develop a framework to adapt the health-related SDGs necessitated the revision of the National Health Policy in 2016. The NHSDP II elaborates this policy.

The NSHDP II provides a common strategic framework for health sector development that will guide all health interventions by all stakeholders during the period 2018 – 2022. Specifically, the NSHDP II provides a framework for:

- mobilising resources for the health sector;
- guiding the development of a Medium-Term Sector Strategy, Medium-Term Expenditure Framework, health sector Annual Operational Plans and budgets at all levels; and
- aligning and coordinating the partner support in health development in the country

1.2 National Development Context

The current national development agenda, Vision 20:2020, notes the influence of poor health in failure to significantly reduce poverty and proposes investments in human capital development, notably health and education, as key to sustainable development. Vision 20:2020, sets the goal for Nigeria to become one of the twenty largest economies in the World by the year 2020.[4] It envisions the development of a large diversified, sustainable, and competitive economy that effectively harnesses the talents and energies of her people and natural resources to guarantee a high standard of living and quality of life for her citizens. Specifically, the vision aims at increasing national productivity and significantly improving Nigeria's Human Development Index (HDI) ranking.

The health sector is expected to contribute to the attainment of Vision 20:2020 by ensuring a healthy, vibrant and productive labour force. This will be achieved through strengthening of primary health care and expansion of secondary health care services in every Local Government Area (LGA). The strategic role of the health sector is also recognised in the Economic Recovery and Growth Plan (ERGP) 2017-2020 whose overall objectives are to restore growth; invest in people, and build a globally competitive economy. The ERGP has specified the following health sector policy objectives which have been considered in the development of NSHDP II:

- Improve the availability, accessibility, affordability and quality of health services;
- Expand healthcare coverage to all Local Governments;
- Provide sustainable financing for the health care sector;
- Reduce infant and maternal mortality rates.

1.3 National Health Policy Context

The Nigerian constitution of 1999 (as amended) puts health on the concurrent legislative list, thus placing responsibility for healthcare delivery and its management on the three tiers of government – Federal, State and LGA. The National Health Act (NHAct) defines the organisation of the health care system, the service providers, the relationship between various tiers, and provides the framework for standards and regulation of health services. The NHAct provides the overall legal framework for the development and implementation of the National Health Policy.[5]

Nigeria is committed to the attainment of globally agreed Sustainable Development Goals (SDGs) and Universal Health Coverage (UHC). This commitment is reflected in the 2016 revised National Health Policy whose theme is *"Promoting the Health of Nigerians to Accelerate Socio-economic Development".*

The 2016 National Health Policy's (NHP) mission statement is: "To provide stakeholders in health with a comprehensive framework for harnessing all resources for health development towards the achievement of UHC, as encapsulated in the National Health Act, and in tandem with the SDGs". The goal is: "*To strengthen Nigeria's health system, particularly the PHC sub-system, to deliver quality, effective, efficient, equitable, accessible, affordable, acceptable and comprehensive health care services to all Nigerians".*[6] Nigeria has also articulated a structure that incorporates the dual components of increased access to PHC and financial risk protection, the two strategies for attainment of UHC. Related to this, is the NHAct that guarantees minimum service package for all through the establishment of the Basic Health Care Provision Fund (BHCPF). The strategies for achieving these objectives have been

adequately situated in this NSHDP II in order to operationalise the NHP. The NSHDP II also draws from policies that guide specific vertical health programme in the country to ensure complementarity and synergy in the provision of health services in the country. A list of the key policy and strategy documents that were reviewed during the NSHDP II development is provided in the Bibliography.

1.4 Global and Regional Contexts

Nigeria is a signatory to the following regional and international commitments which contribute to shaping the NSHDP II priorities:

1. ***Sustainable Development Goals (2015)*** – seek to address the 'unfinished MDG health agenda', the burgeoning epidemic of non-communicable diseases and mental disorders, the health challenges of acute epidemics, disasters and conflict situations through universal access to health including addressing broader social determinants of health.

2. **The *Common African Position (CAP) on the Post 2015 Agenda*** (African Union 2014) - seeks to achieve universal and equitable access to quality health care on the continent, prioritising improvement in MNCH, enhanced access to sexual and reproductive health and family planning, with special focus on vulnerable groups, including youths, unemployed, children, elderly and people with disabilities; reduction in incidence of communicable diseases (HIV and AIDS, Malaria and TB), and Non-Communicable Diseases (NCDs) including mental health and emerging diseases; as well as strengthening health systems including health financing, improved hygiene and sanitation, and improving monitoring and evaluation and quality assurance systems.

3. ***Abuja 2001 Declaration and Abuja+12 Declaration (2013)*** - committed the African Union Member States to allocate at least 15% of their annual national budgets to health.

4. ***Ouagadougou Declaration on Primary Health Care (2008)*** - seeks to reactivate the principles of PHC within the context of health systems strengthening.

5. ***Universal Health Coverage (UHC)*** - the World Health Assembly Resolution 58:33 in 2005 urged countries to develop strategies that will ensure all people have access to needed healthcare services without the risk of financial ruin at the point of accessing care or after accessing care. UHC is enshrined in the National Constitution - the right to health.

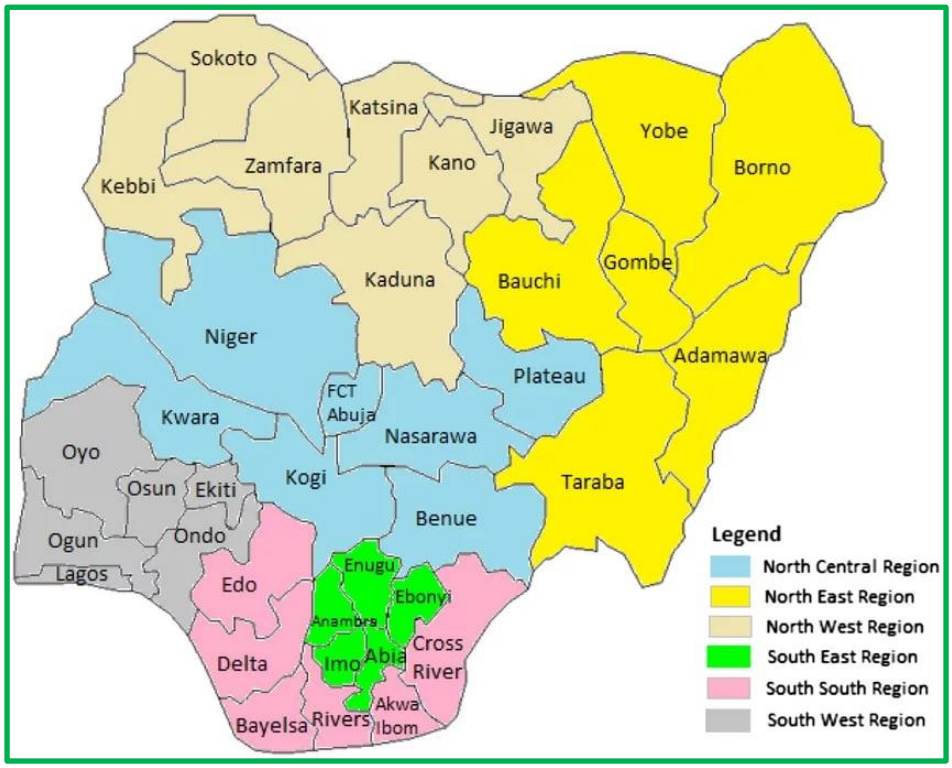
6. ***International Health Regulations (2005)*** - provide the guidelines for the country to implement key actions needed to comply with international requirements to prevent and respond to acute public health risks and emergencies that have the potential to cross borders and threaten people globally.

7. ***Paris Declaration on Aid Effectiveness (2005)*** - seeks to improve the quality of aid effectiveness and its impact on development through ownership, alignment, harmonization, results and mutual accountability.

1.5 Country Profile

Nigeria is located on the west coast and shares boundaries with Benin, Niger, Cameroon and Chad. Administratively, the country operates a three-tiered federal system of governance comprising Federal, the 36 States and the FCT, and 774 Local Government Areas or Councils (LGAs). The LGAs are further divided into 9,565 political wards, which are the focus of PHC revitalisation to achieve UHC. For political and administrative purposes, the country is divided into 6 geopolitical zones (North East, North West, North Central, South East, South West and South South). These geo-political zones comprise states with similar culture, ethnic groups, and common history.

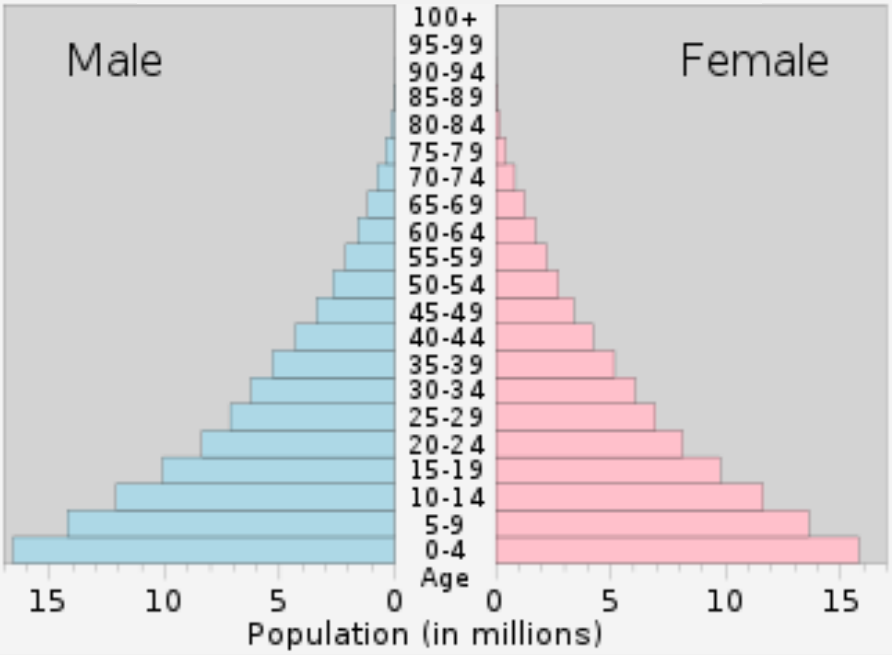
Figure 1: Map of Nigeria



With an estimated population of 198 million in 2018, Nigeria is the most populous country in Africa and is ranked the seventh most populous country in the world. The population is projected to grow to 210 million by 2022 and 396 million by 2050, making Nigeria the world's third largest population - behind India and China.

The country has a young population structure wherein children aged under 15 years constitute 45% and young people (10-24 years) make up 33% of the population. Women in the reproductive age group, children under five and the elderly (at least 65 years) make up 22%, 20% and less than 5% of the population respectively. Consequently, Nigeria has a high dependency ratio of 73.3%, which is worsened by the very high rates of youth unemployment and high total fertility rate of 5.8 in 2017[7].

Figure 2: Nigeria's Population Pyramid



Gender disparities exist in the social indicators, with only 49.7% of adult females literate compared to 69.2% of males. The relative employment of women in the formal sector is low; only 36% of Nigerian women are in the adult workforce. Overall, Nigeria ranks 152 out of 188 countries on the gender-related development index.[8]

The sheer size and complexity of the country presents huge challenges to health policy makers. While the predominant ethnic groups are the Yoruba in the South West, the Igbo in the South East and Hausa/Fulani in the North, there are more than 350 ethnic groups and more than 500 languages in the country. Social, cultural, economic and geographical diversities abound. This heterogeneity is reflected in varying disease patterns, health resource availability and health outcomes in the country.

Subsistent agriculture is the predominant occupation; but, the national revenue is derived mainly from oil, accounting for 90% of export earnings and over 75% of government revenue. GDP grew from NGN 54.6 trillion in 2010 to NGN 80 trillion ($502 billion) in 2013, largely from the non-oil sector. This growth has made Nigeria the largest economy in Africa. However, the country has experienced a sluggish economic growth, with the GDP dropping sharply from 6.2% in 2014 to 2.8% in 2015, minus 1.5% in 2016 and 0.7% in 2017 while inflation rate increased from 7.8% to 18.7% within the same time period.[9] The country went into recession in 2016-17 largely as a result of a sharp decline in the global price of crude oil. The decline in earnings from oil poses significant challenges to Nigeria's external balance of payment and public finances, including health and related expenditure. This has serious implications for financing health development as States' and LGAs' funding for health care is largely dependent on allocations from the Federal Government

In spite of Nigeria's huge resource endowments, development shortfalls remain pervasive as evidenced by low per capita income, poor social indicators and significant disparities by income, gender and education, with these disparities deepening as one moves from the southern to the northern parts of the country.[10] Furthermore, poverty is found to be

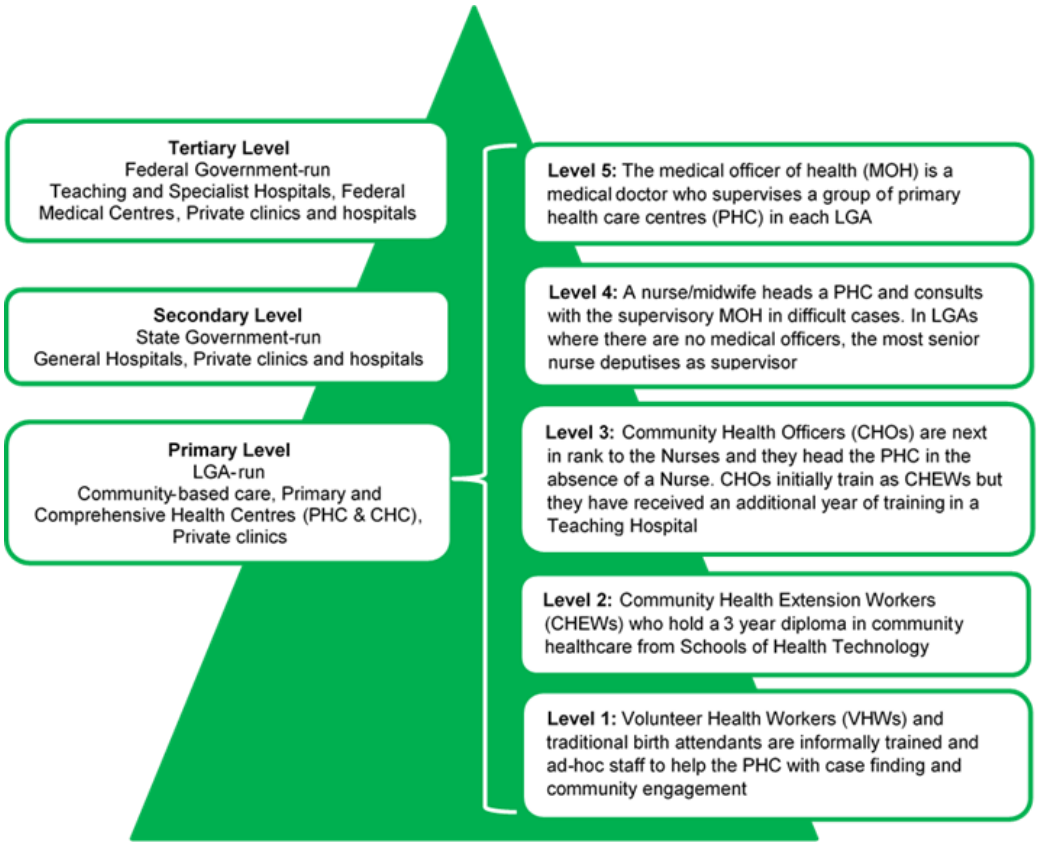
predominant in the rural areas compared with the urban areas and major regional disparities exist, with 90% of the poorest people living in the northern part of the country.[11]

Instability due to insurgency activities in recent years, resulted in serious reversals in health and development gains in the North Eastern region, one of the most socio-economically deprived zones. Since 2009, attacks by this militant terrorist group have caused the collapse of health and social infrastructure and destruction of the economy in this region. Additionally, it has created a public health emergency of gigantic proportions, including an estimated 9.6 million of internally displaced persons (IDP). The recent Fulani herdsmen attacks on communities and farmlands, mainly in the middle belt region of the country further escalates the social and humanitarian crisis in the country.

1.6 Health System Organization and Delivery Structure

Nigeria runs a pluralistic health care system with public and private sectors, modern and traditional systems providing health care. Public sector healthcare is concurrently the responsibility of the three tiers of government. As shown in the diagram below, LGAs have responsibility for PHC services, State Governments provide secondary level care while the Federal Government provides tertiary level care. In addition to tertiary health care provision, the FMOH leads the development and implementation of specific public health programmes, e.g. National AIDS and STDs Control Programme (NASCP), National Malaria Elimination Programme (NMEP), National Tuberculosis and Leprosy Control Programme (NTLCP). The Federal and State Health Ministries, Departments and Agencies (MDAs) manage the implementation of these programmes at all levels.

Figure 3: Nigeria's Health System



The FMOH has prioritised strengthening its PHC system in order to achieve UHC. As enunciated in the NHAct and the National Health Policy (NHP), primary health care is the bedrock of Nigeria's health care delivery system. The Basic Health Care Provision Fund (BHCPF),[12] as prescribed by the NHAct, will fund delivery of the Basic Minimum Package of Health Services including basic emergency obstetric and new-born care (BEmONC).[13] Through the Reach Every Ward strategy (population of 10,000-20,000 per ward), FMOH aims to have at least one functional primary health centre (PHC) in each political ward with involvement of the Ward Development Committee (WDC) comprising selected community members to ensure community participation and accountability.

In addition, community based health care services are provided by various cadre of Volunteer Health Workers (VHWs) who are engaged by different public health programmes through inconsistent standards and incentives. However, the recently launched Community Health Influencers and Promoters of Services (CHIPS) initiative aims to harmonise CHWs and to better define their roles and coordination. In addition, Community Health Extension Workers (CHEWs) are expected to spend at least 60% of their time on community-based health care service delivery.

Nigeria has a growing private health sector which provides 60% of the health care services through 30% of the country's conventional health facilities – this includes not-for-profit services provided by faith-based and non-governmental organizations; and private-for-profit providers. The broader private health sector also includes traditional medicine providers, patent and proprietary medicine vendors (PPMVs), drug shops and complementary and alternative health practitioners.

1.7 Lessons Learned from Implementation of the NSHDP I

- The end-term evaluation of NSHDP I revealed that while some progress had been made, achievements were lower than expected and the 2015 targets were largely unmet for most indicators.
- The plan focused on health systems strengthening to the exclusion of services, perhaps because the evidence used to inform the strategy development was inadequate resulting in key priority areas not receiving the needed attention, for example, disease specific programmes.
- NSHDP I matrix was prescriptive and not sufficiently robust consequently, it did not provide sufficient space for people to use it to develop operational plans. This led to a disconnection between the strategy and annual operational plan development and budgeting.
- Furthermore, the FMOH did not put in place any structure or institutional arrangement to drive the implementation of the Plan and to provide guidance to the States.
- The frequent changes in leadership of DHPRS at federal and state levels also affected effective implementation and monitoring of NSHDP I (loss of champions, changes in priorities and loss of institutional memory).
- Lastly, the NSHDP I M&E framework was not developed until almost midway into the implementation of the Plan.
- The gaps identified, and the lessons learned from implementation of the Plan informed NSHDP II.

1.8 Process of Development of the NSHDP II

The NSHDP II development was participatory and driven by available evidence through a bottom-up and inclusive process which aimed to engender decentralisation, collective ownership, equity, harmonisation and mutual accountability.

A 36-member NSHDP II Technical Working Group, under the Chairmanship of the FMOH Permanent Secretary, was constituted and inaugurated by the Honourable Minister of Health on 26th November 2016 with a mandate to lead the development of the NSHDP II. The TWG membership comprised Directors and Programme Managers from the FMOH, Commissioners for Health representing the six geo-political zones of the country, and representatives of the private sector, civil society organisations and development partners.

At the inaugural meeting, the members were presented with the Health Agenda of the FMOH and the proposed timeframe and concept note for the development of the NSHDP II, to which they made inputs. The primary responsibility of the TWG was to lead the development of the NSHDP II and to mobilise technical and financial support for the process.

The TWG reviewed the concept note which was produced by the DPRS. Subsequently, three national planning consultants and a costing consultant were recruited to support the process and ensure alignment of the Plan with Vision 20: 2020, ERGP, National Health Policy and SDG.

The TWG commissioned an end-term evaluation of the NSHDP I to determine the level of implementation, outcomes, challenges and lessons learned; a National Health Accounts study; and a desk review of all relevant background documents including relevant international declarations, national developmental agendas, national laws and policies, programme specific documents, evaluation and review reports. This led to the development of the NSHDP II Framework with its accompanying vision, mission, values and guiding principles, and priority areas.

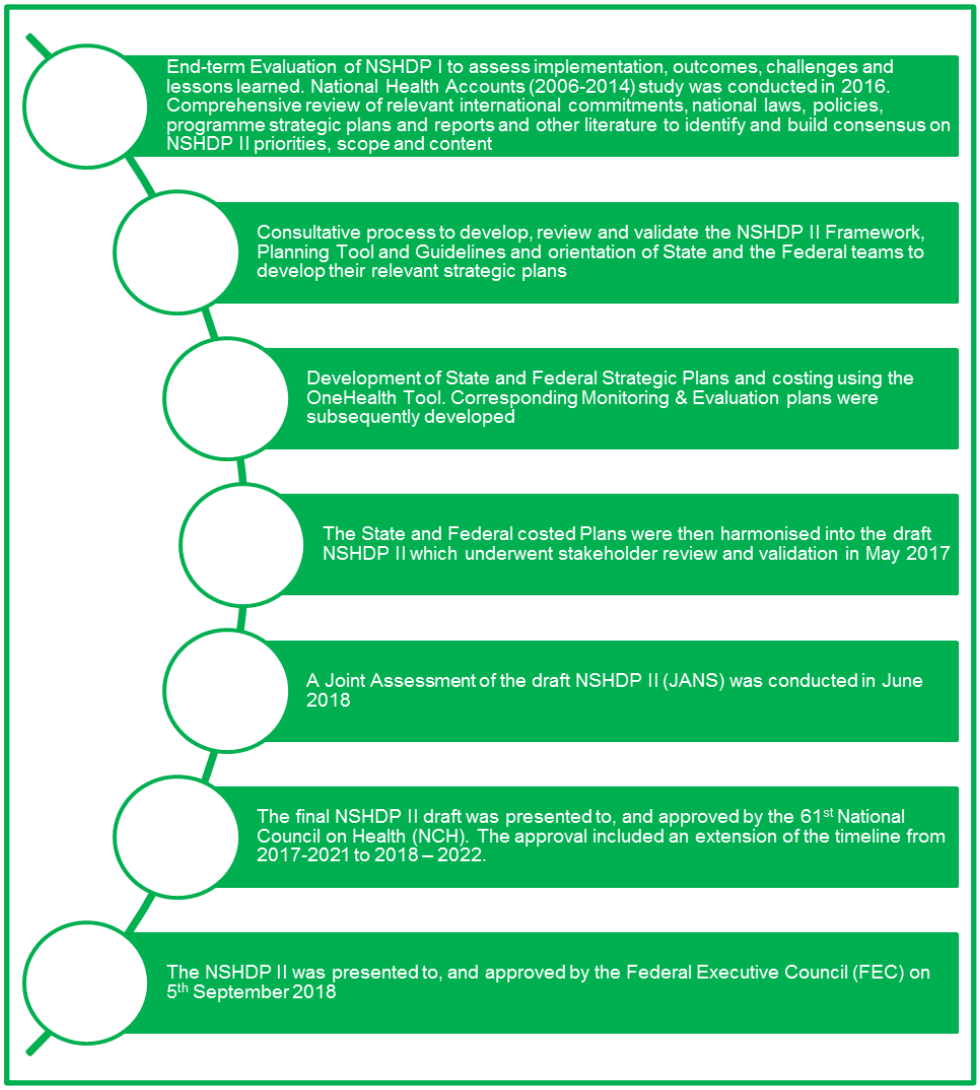
The TWG established thematic working groups for each of the NSHDP II priority areas. The working groups, comprising key national programme officers, development partners, and other stakeholders under the leadership of relevant FMOH directors were responsible for the articulation of the situation analysis (using SWOT), development of goals, strategic objectives, targets, interventions and proposed actions for each of the thematic areas.

The NSHDP II Framework served as a reference guide for the development of costed Federal, and State plans. The following steps were followed in the development of these plans:

- Recruitment of state and federal consultants: Using guidelines provided by the TWG, each State recruited a planning and a costing consultant while four planning and two costing consultants were recruited for the federal level plan
- Between 24th – 28th July, 2017 three-day orientation/training meetings on use of the NSHDP II framework the NSHDP planning tool, the guidelines for the development and writing of the plan, the M&E toolkit as well as tool for costing of plans were conducted with the consultants, State DPRS and M&E officers.
- Using the NSHDP II guidelines, each State constituted a SSHDP II planning team comprising a broad range of stakeholders. Technical Committees were also established to provide oversight to the SSHDP II development.
- A 5-day training of zonal costing resource persons/consultants was held from 29th May to 2nd June, 2017 on the OneHealth Tool for the harmonised costing of the SSHDP II.

- State teams conducted their costing exercises initially using Excel and subsequently migrated the data into the OneHealth Tool with technical assistance from the zonal costing consultants.
- Three-day quality assurance workshops were held from 27th November - 2nd December 2017 for a final review of state/federal plans in preparation for the harmonisation exercise.
- The SSHDP II plans were validated by stakeholders in each State;
- Using the M&E toolkit, each State constituted a team which developed their State M&E Plan for the SSHDP II
- The SSHDP II were consolidated into the NSHDP II and the draft was shared with all key stakeholders, including the federal MDAs and development partners for input before the national stakeholders' validation meeting'
- A national Stakeholders' validation meeting, chaired by the Honourable Minister of State for Health, was held on 24th April 2018.
- WHO supported a JANS review of the draft NSHDP II before it was adopted by the National Council on Health on 21st June, 2018.

Figure 4: The process of NSHDP II development



Chapter 2

Situation Analysis of the Health Sector

This first section of this chapter presents an overview of the leading causes of morbidity and mortality in Nigeria. The second section presents an overview and status of implementation of the Essential Package of Health Care Services (EPHS) which have been defined by the Federal Government of Nigeria. Programme documents (policies and strategic plans, programme reports, reviews, annual evaluation reports) and national surveys were reviewed for this situation analysis.

2.1 Overview of the Performance of the Health Sector

Life expectancy is an important health indicator and is a key component of the Human Development Index (HDI) which ranks the social and economic development of nations globally. The life expectancy at birth in 2016 was 54.5 years, an increase of 7.5 years from 2007, but still remains below the national target of 70 years by 2015 and the global average of 71 years.[14] The Healthy Life Expectancy of Nigerians was 47.4 years in 2016, which implies 6.8 years of compromised health[15]. Regionally, Nigeria compares poorly - the life expectancy of Ghanaians is 10 years more. According to the 2016 Global Burden of Disease Study, while Nigeria is undergoing an epidemiological transition, communicable diseases still constitute the bulk of disease burden.

Figure 5: Leading causes of morbidity in Nigeria (2016 Global Burden of Disease Report)

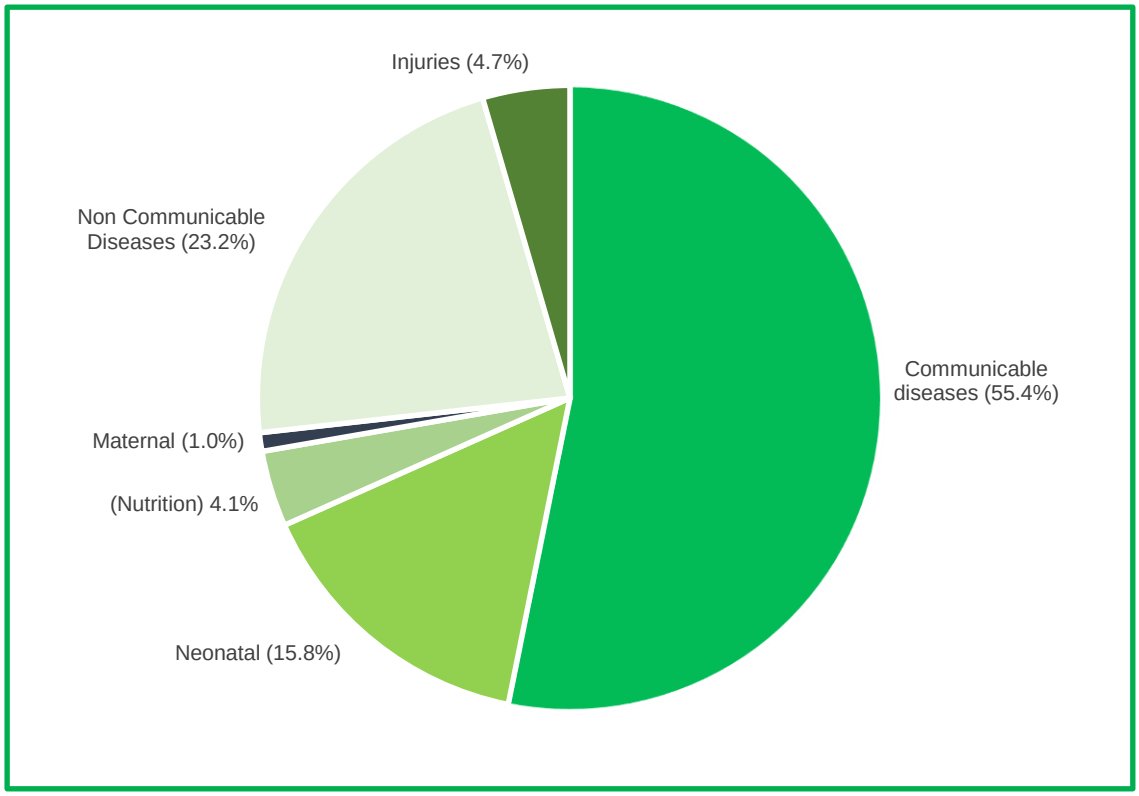
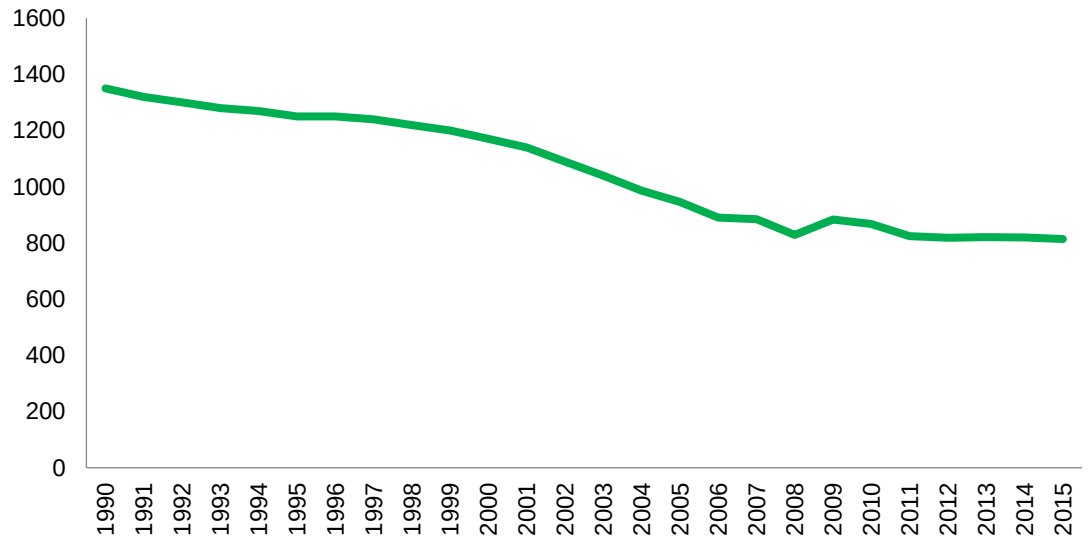


Table 1: Top ten causes of mortality and morbidity as at 2016

Rank	Proportion of total deaths	%	Rank	Proportion of DALYs	(%)
1	Malaria	17.1	1	Malaria	18.3
2	Diarrhoeal diseases	10.0	2	Diarrhoeal diseases	9.6
3	HIV/AIDS	10.0	3	HIV/AIDS	7.2
4	Lower respiratory diseases	8.3	4	Birth asphyxia & trauma	6.5
5	Cardiovascular diseases	6.5	5	Lower respiratory infections	6.5
6	Birth asphyxia & trauma	5.8	6	Injuries	4.7
7	Preterm birth complications	3.9	7	Preterm birth complications	4.5
8	Meningitis	2.9	8	Congenital birth defects	3.7
9	Neonatal sepsis	2.8	9	Neonatal sepsis	3.2
10	Hepatitis	2.6	10	Mental disorders	3.0

Trends in maternal and child mortality are important markers of the general performance of a nation's health sector. While the 2013 National Demographic and Health Survey (NDHS)[16] reported a national Maternal Mortality Ratio (MMR) of 576, the trend over the past decade has remained unacceptably high. Availability and accuracy of MMR data is an ongoing challenge. For example, NDHS does not disaggregate MMR data sub-nationally.

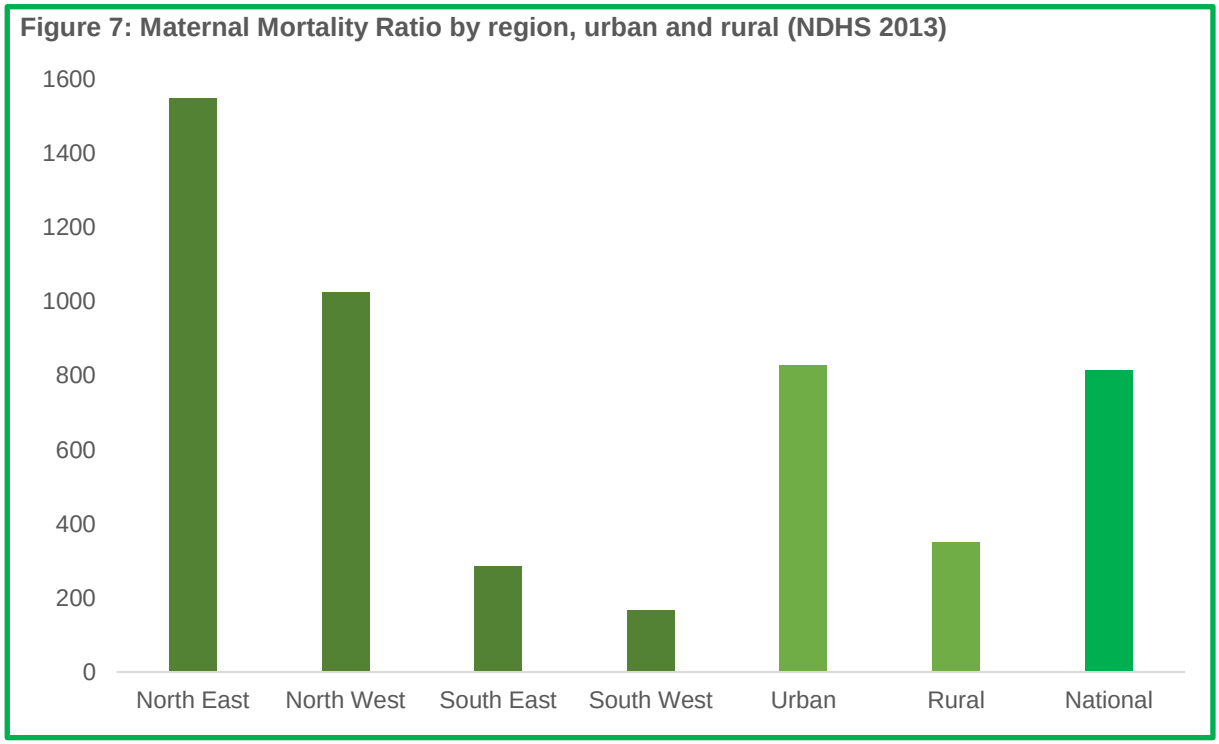
Figure 6: Trend in Nigeria's MMR (1990-2015)



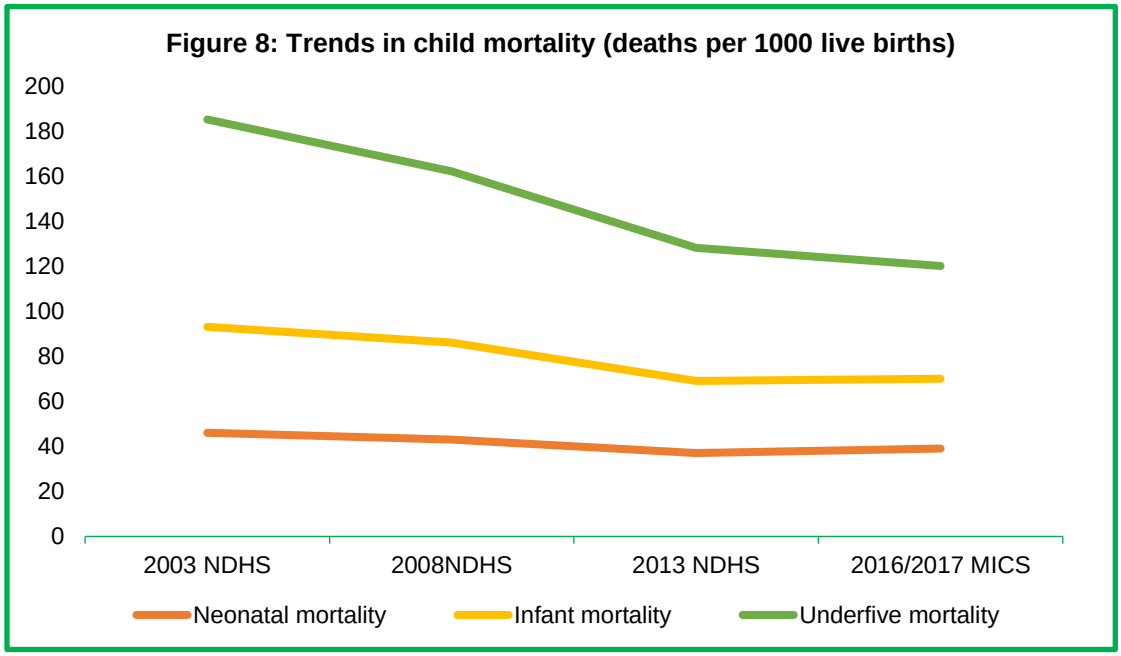
Although there has been some decline in maternal and childhood mortality since 2003, the pace of reduction and geographical disparities in the distribution of remain a huge concern. The data quoted in national documents, which is dated, shows gross regional inequities with maternal mortality rate of North East and North West zones of the country being almost 10 and 6 times higher than that of the South West zone of the country (the zone with the lowest rate) respectively[17].

Women in rural areas and/or from northern Nigeria are at higher risk of maternal death compared to those in urban areas and/or from the southern part of the country. The women at higher risk of maternal death are less likely to deliver at formal health facilities using skilled

birth attendants at delivery but they tend to deliver at home without a skilled attendant. Other notable risk factors for maternal mortality in Nigeria include high fertility and early marriage with adolescent girls at increased risk obstructed labour and maternal death.



Child and infant mortality remain much higher than the national targets of 75/1000 and 30/1000 by 2015 respectively. The trends in child mortality (neonatal, infant and under-five mortality) since 2003 are shown in the graph below. Similar to MMR patterns described above, child mortality follows the same inequitable pattern like maternal mortality.



Children from the northern part of the country more likely to die before they reach their fifth birthday compared to those from the southern parts of the country. These at-risk children are

more likely to be born to uneducated women in lowest wealth quintile and living in rural compared to urban areas.

2.2 Overview of Essential Package of Health Care Services

2.2.1 Reproductive, Maternal, New-born, Child and Adolescent Health, plus Nutrition Services (RMNCAH + N)

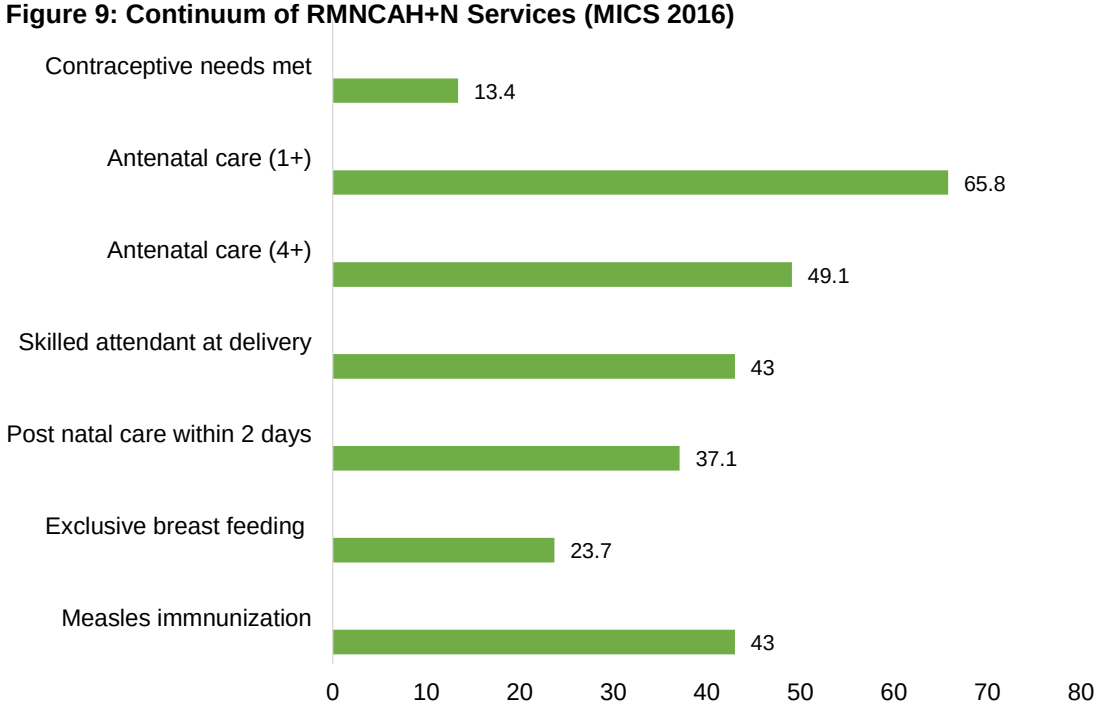
RMNCAH+N is an important component of the EPHS provided through different channels at all levels of the health care system.

- At PHC level, RMNCAH+N services include antenatal, delivery and postnatal care; family planning (healthy timing and spacing of pregnancy); integrated management of childhood illnesses (IMCI) including immunisation; integrated Community Case Management of Childhood Illness (iCCM) and nutrition programmes
- Ward PHC facilities provide basic emergency obstetric and new-born care provide services (BEmONC)
- General and teaching hospitals are referral facilities which provide comprehensive emergency obstetric and new-born care (CEmONC) and other specialised RMNCAH+N services.

Trends in Maternal Health services

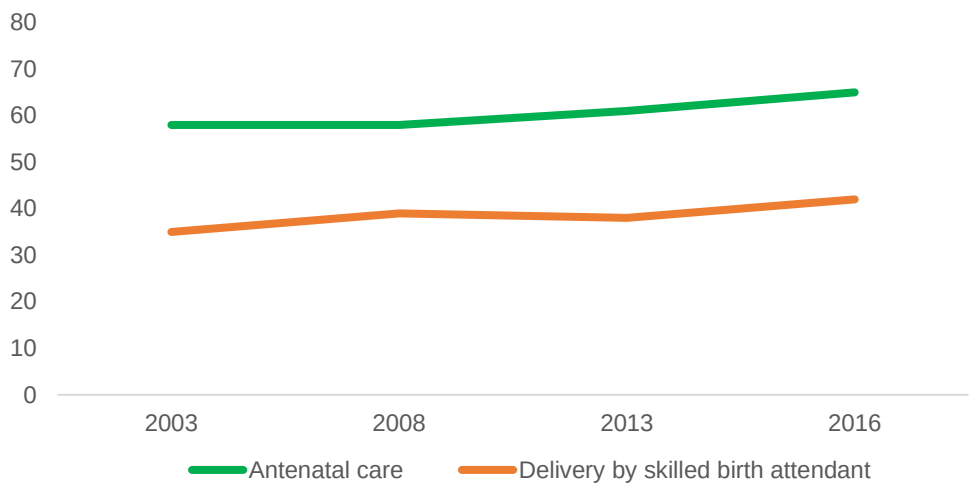
The coverage of selected components of the RMNCAH+N Health Care Services in 2016 as assessed by the Multi-Indicator Cluster Survey (MICS) is shown below[18].

Figure 9: Continuum of RMNCAH+N Services (MICS 2016)



Between 2003 and 2016, there was only marginal increase in antenatal coverage and skilled birth attendance. The quality of ANC was variable with only 55.4% of the pregnant women received tetanus toxoid vaccine while 63.4% received iron supplements.[18] The 2015 MICS reported that less than half of pregnant women slept under long lasting treated mosquito nets, while only 36% of women in need of PMTCT services were tested, received results and were commenced on ART.

Figure 10: Trends in ANC and SBA coverage

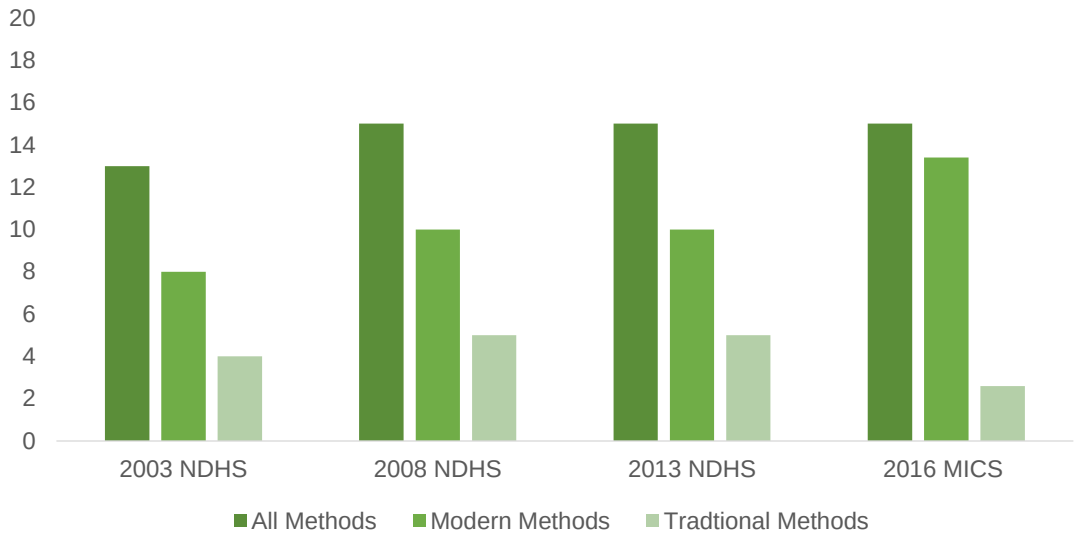


Less than 20% of health facilities in the country offer emergency obstetric care.[19] As part of the strategy to end all preventable maternal deaths, the National Guidelines for Maternal and Perinatal Death Surveillance and Response (MPDSR) were developed in 2015.[20] The MPDSR is being rolled out with support of partners in about half the States but is yet to be extended to community level.

Family Planning

Nigeria has one of the lowest modern contraceptive prevalence rates (mCPR) in Africa. Based on its FP2020 pledge, Nigeria developed a Blueprint for raising contraceptive prevalence rate (CPR) for all methods from 15% in 2014 to 36% in 2018.[21] However as shown in the graph below, the uptake of modern family panning methods has only increased marginally to 13.4% as reported by the MICS 2016 survey. Supply-related causes of the low mCPR include inadequate availability of contraceptives, inadequate human resources, limited financial and physical access to high quality services, and poor infrastructure. Low levels of awareness, cultural and religious aversion to family planning are some of the main demand-related impediments to FP uptake in Nigeria. Current efforts of government aimed at addressing some of these bottlenecks to service access and uptake include introducing the policy of free contraceptives, increased funding for family planning, task shifting and sharing and increased collaboration with the private sector.

Figure 11: Trends in Contraceptive Prevalence Rate (%)



Post-Abortion Care Services

Complications from unsafe abortions account for about 10% of maternal mortality in Nigeria. Unsafe abortion is more prevalent among unmarried young women. The abortion law is still restrictive in Nigeria and so accurate information on abortion is scanty. Management of complications of abortion is one of the components of reproductive health in the country and the service is supported mainly by development partners, thus coverage with the service is limited. Health care providers up to primary health care level have been trained in the provision of manual vacuum aspiration for the treatment of incomplete abortion. While policies and guidelines exist on integration of post-abortion care and family planning services, implementation has been limited.

Obstetric Fistula

Obstetrics Fistula (OF) is a major public health problem in Nigeria. With an estimated 150,000 prevalent cases and an annual incidence of 12,000 cases, the country is estimated to contribute 15% to the global burden of the disease.[22] The risk factors for OF are the same for maternal mortality. Therefore, addressing the social determinants of health, increasing use of Skilled Birth Attendance at delivery (SBA), use of partographs to monitor labour and improving access to emergency obstetric care and family planning services are essential in prevention OF.

Since 2010, the FMOH has established three national OF treatment centres. Some State governments with the support of development partners have establishment more OF treatment centres bringing the total to about 20 treatment centres across the country. While teaching hospitals have a pool of skilled personnel who can repair OFs, access barriers (e.g. cost and bed space) limit their involvement in OF repairs. At the current rate of 6,000 OF repairs annually, it will take more than 30 years to clear the OF repair backlog.

Child Health

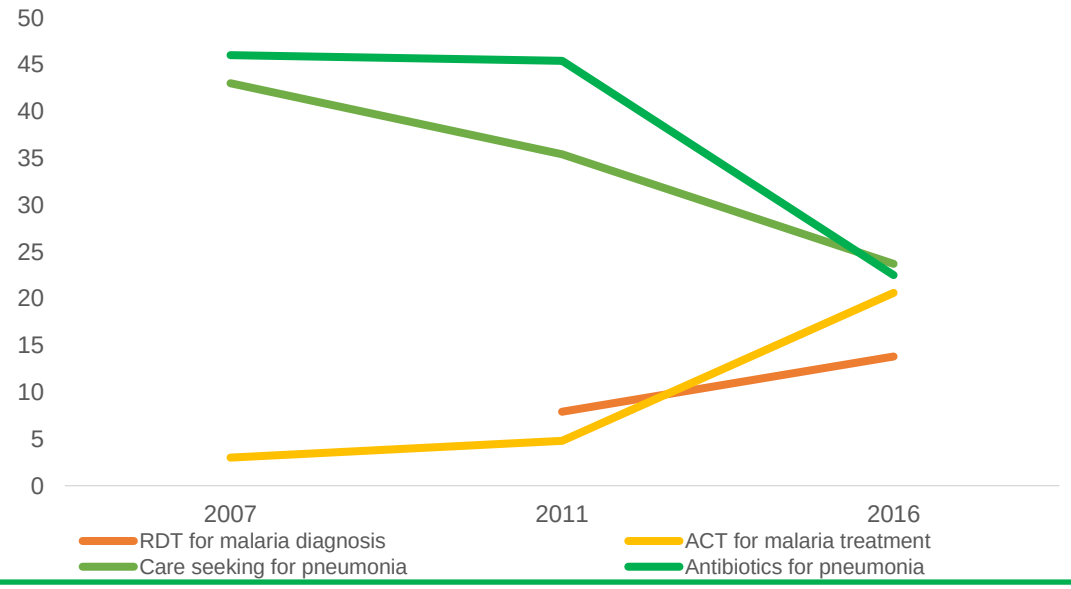
While new-born and child health care services should be available at all levels of the health care system throughout the country, there is limited subnational coverage information, especially at LGA and facility levels.

Table 2: performance of child health care services between 2007 and 2017

Coverage indicator	National baseline data	Most recent national data
Proportion of infants under 6 months exclusively breast-fed	11.7 (MICS 2007)	23.7 (MICS 2016-17)
Proportion of children 12-23 months of age vaccinated against measles before 12 months	41.4 (NDHS 2008)	42.0 (MICS 2016-17)
Proportion of children 12-23 months of age who received DPT3/Penta 3	35.4 (NDHS 2008)	33.0 (MICS 2016-17)
Proportion of children 12 – 23 months fully immunized	23.0 (NDHS 2008)	23.0 (MICS 2016-17
Proportion of under-5 children who slept under an ITN the previous night	3.5 (MICS 2007)	69.1 (MICS 2011)

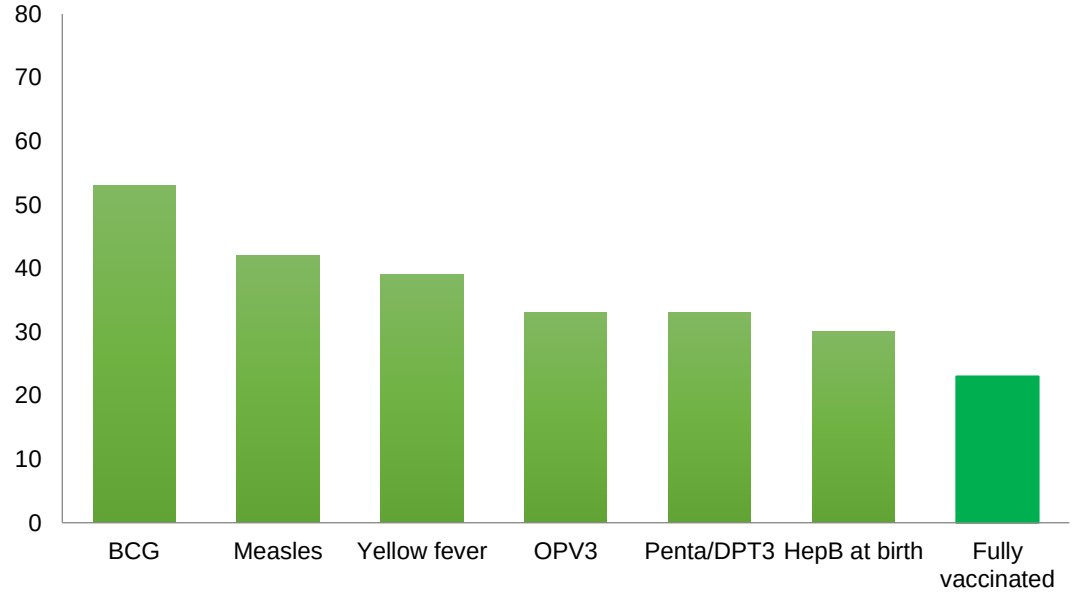
The trends in IMCI coverage using coverage of malaria and pneumonia case management as proxies are shown in Figure 12.

Figure 12: Trends in IMCI Coverage 2007-2016



Routine immunisation for children is coordinated by the National Primary Heath Care Development Agency (NPHCDA) as a key part of child health services at PHC level. As shown in the following chart, 2017 immunisation coverage was poor with less than a quarter of children aged 12-23 months being fully immunised, much below the national target of 80%. Globally, Nigeria also remains one of three countries yet to be certified polio free. Under the Global Vaccine Action Plan, measles and rubella are targeted for elimination in five WHO Regions by 2020, but the measles coverage is well below target. Penta vaccine and Pneumococcal Conjugate Vaccine (PCV) and IPV were introduced in 2012, 2014 and 2015 respectively. Rotavirus and Human Papilloma Virus (HPV) vaccines are yet to be introduced to the immunisation schedule.

Figure 13: Immunisation Coverage among chn aged 12-23 months (2017)



Adolescent Reproductive Health

The majority of the Nigerian population is below the age of 25 years, with the adolescent population (10 -19 years) making up 22% of the country's population. Global evidence shows that adolescents bear a higher burden of maternal mortality. There are several policies aimed at meeting the reproductive health needs of adolescents but implementation has been limited. Efforts are being made to integrate adolescent reproductive health services into PHC services but this remains suboptimal and limited in scale. Significant change is yet to be realised in adolescent reproductive health service uptake and improved outcomes.

Availability of adolescent-friendly health services in the public sector is critically limited. In addition, ignorance, socio-cultural and religious barriers limit demand and utilisation of the limited adolescent reproductive health services. Adolescent reproductive health in Nigeria is still characterised by early onset of childbearing, with almost a quarter of the adolescent girls commencing childbearing before the age of 18 years and having relatively low levels of uptake of reproductive health services. While HIV testing among adolescents has doubled from 4% in 2008 to 7.6% in 2013, it is still much lower than the national target of 80%.

Nutrition

Nutrition interventions provided at PHC and community levels include growth monitoring, vitamin A supplementation, multiple micronutrient distribution and Community Management of Acute Malnutrition (CMAM). As shown in the following table, the overall performance in almost all nutritional impact indicators is poor, with the trend worsening between 2007 and 2016. The National Nutrition and Health Survey (NNHS) findings revealed an increase in severe maternal malnutrition rate by about 50% from 2.5% in 2014 to 3.7% in 2015[23]. Wide regional variations in prevalence of malnutrition have been observed with the worst indices occurring in the North West, North East and North Central zones.

Table 3: Trends in nutritional status among children under 5 years and WRA

Nutritional status of children under 5 years age as assessed by MICS		MICS 2007	MICS 2011	MICS 2016
Weight-for-age (underweight)		25.3	24.2	31.5
Weight-for-height (wasting)		10.8	10.2	10.8
Height-for-age (stunting)		34.3	34.8	43.6
Nutritional status of women of reproductive age group as assessed by NDHS and NNHS	**NDHS 2008**	**NDHS 2013**	**NNHS 2014**	**NNHS 2015**
Malnutrition in women of reproductive age group (BMI<18.5)	12	11.4	-	-
Severe malnutrition in women of reproductive age group (MUAC<214mm)	-	-	2.5	3.7

Prevailing inequities in MCH service coverage and outcomes

All the NDHS and MICS surveys conducted over the years show wide disparities in access to health care services and coverage with interventions across the geopolitical zones and States of the country. Furthermore, disparities are persistent between rural and urban areas and across educational and socio-economic status. Higher disease burden and much lower access to health care services are most common in the northern zones of the country, rural areas, among people of lower educational status and the lowest wealth quintiles.

The charts below highlight the extent of inequities of the RMNCAH+N services by wealth quintile and comparisons of skilled birth attendance at delivery and immunisation coverage across all the 37 States of the Federation.

Figure 14: Inequitable access to the continuum of RMNCAH services by wealth quintile

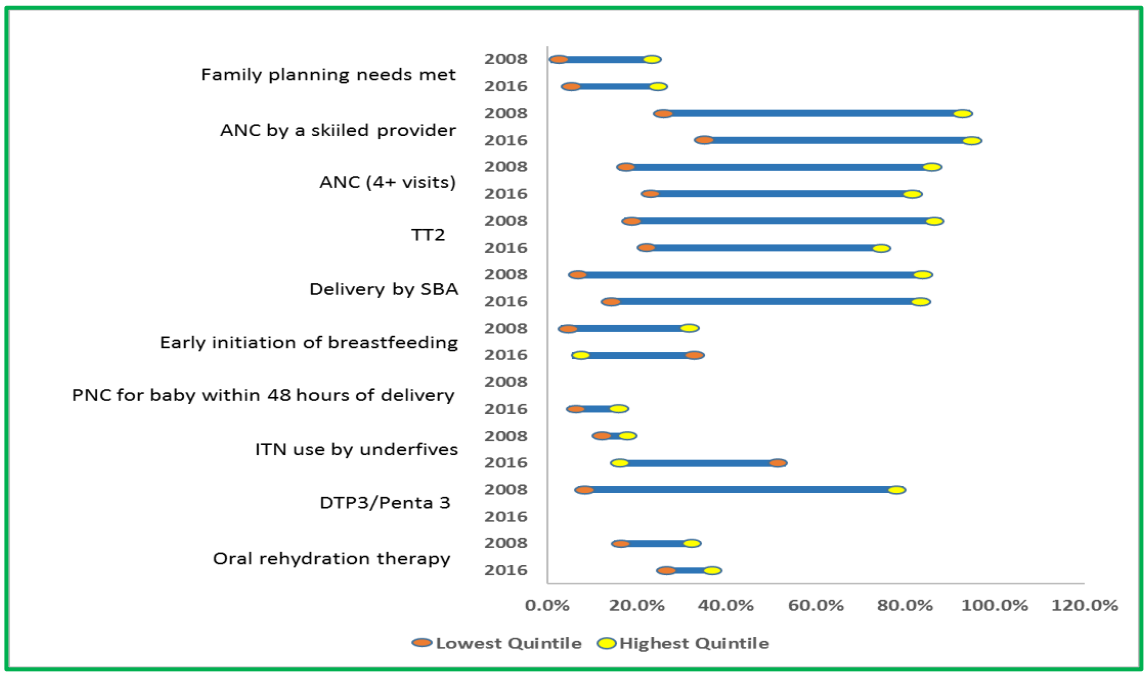


Figure 15: Skilled birth attendance at birth coverage in all States (2016)

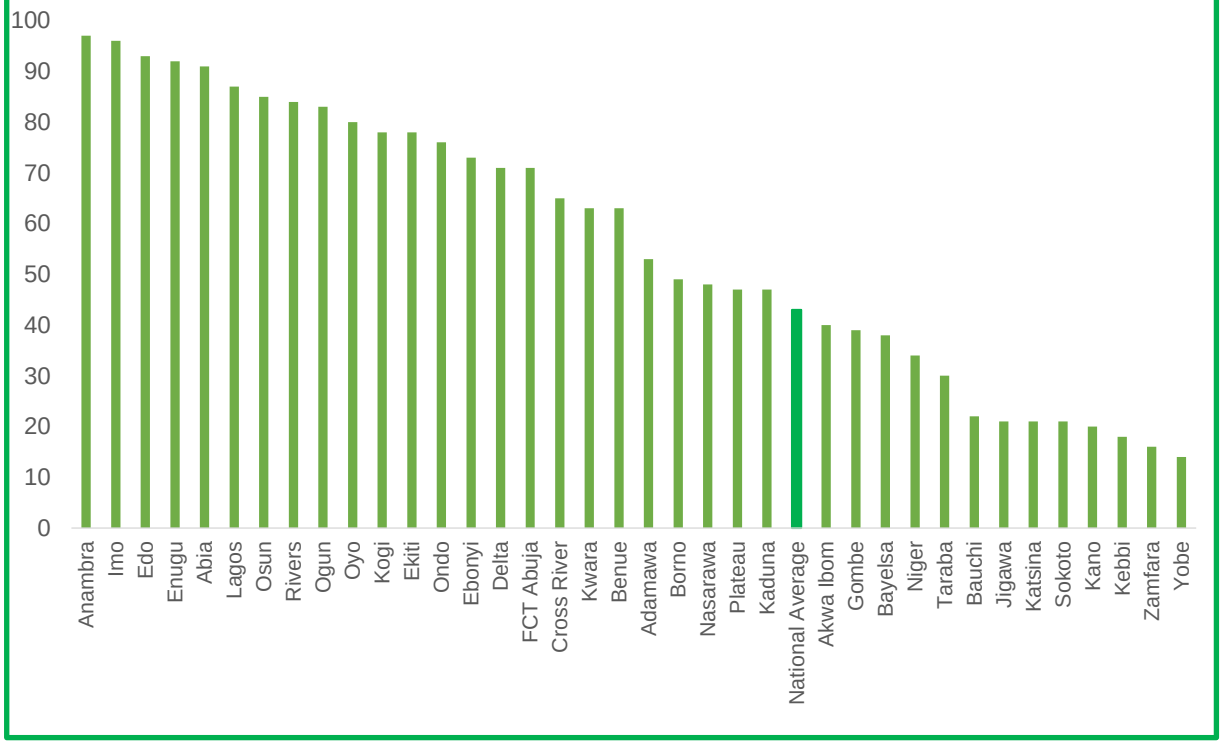
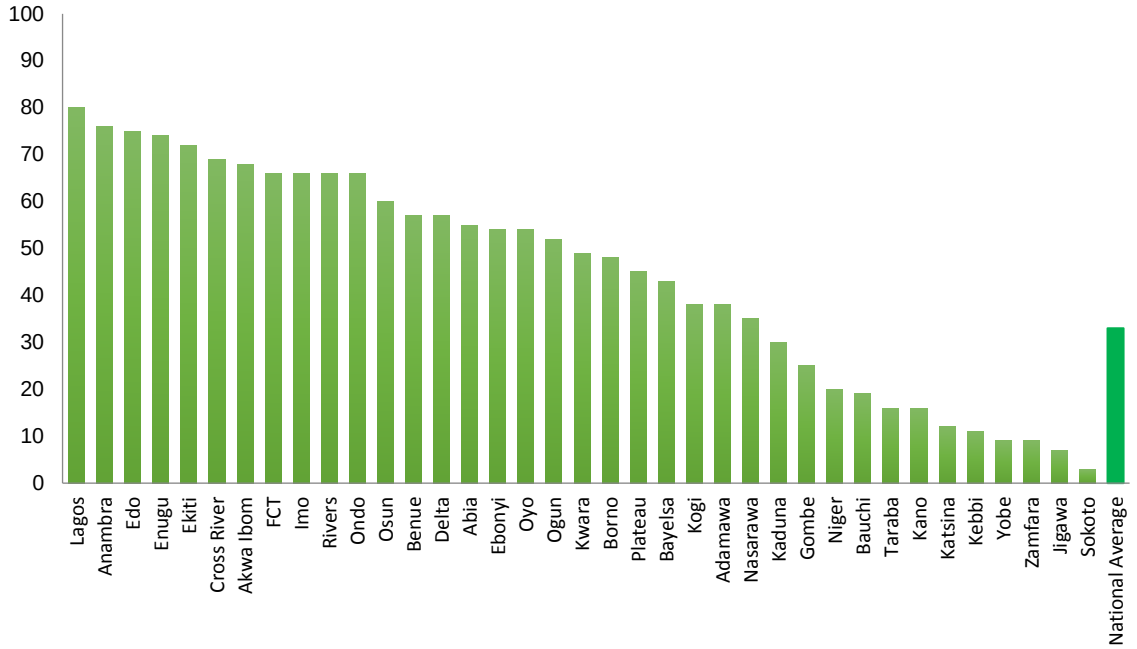


Figure 16: Immunisation coverage (Penta 3) in all States (2016)



Redressing the foregoing inequities was a key focus of NSHDP I which aimed to increase coverage in underserved areas and to reduce economic and socio-cultural barriers to accessing and utilising health care services. Consequently, in order to accelerate attainment of MNCH-related MDGs under NSHDP I, Nigeria made significant investments into the development of policies, plans and interventions. Specifically, to expand access to, and quality of maternal and child health services, the following interventions were introduced and/or scaled up:

- ✓ Saving One Million Lives Programme (SOML), a World Bank funded project, launched in October 2012 sought to save one million lives of under-fives and mothers by 2015 through improving quality and expanding access to high impact RMNCAH+N interventions. This innovative PBR initiative has been institutionalised in all States as the SOML PforR programme.
- ✓ The National Health Insurance Scheme (NHIS)-MDG Free Maternal and Child Health (MCH) programme was initiated against the backdrop of Nigeria's poor performance on maternal and child health indices. The Free MCH was a special intervention to increase access to MCH services through removal of financial barriers through exemption of user fees. The project ran from 2008 and 2015 in 115 LGAs in six States and was subsequently expanded.
- ✓ Donor programmes have complemented NHIS and other State-led initiatives to expand access to MNCH services. However, scale and sustainability of free MNCH services is highly variable across the country.
- ✓ Nigerian government's Midwife Service Scheme (MSS) was aimed at bridging human resource gaps in MCH by recruiting and deploying skilled birth attendants to underserved rural communities. Other efforts to further address gaps in availability of trained health workers include the re-introduction of training programme of midwifery as a basic qualification and the task shifting and sharing policy which has been formulated and is being implemented for some components of maternal and child health.

- ✓ The government-led Subsidy Reinvestment and Empowerment Programme (SURE-P) invested in reducing maternal and child mortality by up-scaling the MSS to provide the much needed human resources in underserved areas, and upgrading/building primary health care facilities, strengthening secondary health facilities to serve as referral centres and promoting demand for, and utilisation of services through conditional cash transfers.
- ✓ The ongoing 10,000 PHC initiative will increase access to MNCH services by upgrading at least one PHC per ward to be capable of providing BEmONC services. In addition, one comprehensive PHC per LGA will be upgraded to provide CEmONC services.
- ✓ New cost-effective and high impact PHC interventions have been introduced and/or scaled up e.g. use of magnesium sulphate for the management of pre-eclampsia and eclampsia, use of misoprostol for prevention of post-partum haemorrhage including home deliveries, the introduction of chlorhexidine for cord care in new-borns and addition of zinc to the community and home management of childhood diarrhoea.
- ✓ The Nigeria State Health Investment Project (NSHIP) builds on lessons from the Health Systems Development Projects (HSDPs) and principles of fiscal decentralization to support targeted health systems reforms in three states in Nigeria (Adamawa, Nasarawa and Ondo States). It has been extended to additional five states in the North East zone. The goal of the project is to enhance the effective use of public resources to deliver high impact maternal and child health services to the poor through strategic use of Results Based Financing (RBF) to strengthen accountability at all levels of the health system**.** The objective of NSHIP is to increase the delivery and use of high impact maternal and child health interventions and improve quality of care at selected health facilities in the participating states.

2.2.2 Major Communicable Diseases

Malaria

Significant domestic and external investments targeted at achieving pre-elimination status by 2020 have yielded positive results. However, malaria remains the leading cause of morbidity and mortality in Nigeria.[24]

Most malaria prevention and control activities are carried out at the PHC level, as part of the Ward Minimum Care Package, including prevention of malaria in pregnancy and IMCI. The key prevention strategies have been promotion of use of Long Lasting Insecticide Treated Nets (LLINs), Intermittent Preventive Therapy (IPT) for prevention of malaria in pregnancy, Indoor Residual Spraying (IRS), and Integrated Vector-control Management (IVM).

Over time, the prevention strategy has shifted from targeting vulnerable groups to efforts directed at establishing equitable and universal access to a package of malaria interventions as a prelude to Nigeria's target of attaining pre-elimination status by 2020.[25] The country has also shifted from presumptive diagnosis of malaria to testing all care seekers with suspected malaria with Rapid Diagnostic Test (RDT) or microscopy and treating all cases with Artemesinin-based Combination Therapy (ACT).

- ✓ Ownership of LLIN has risen significantly from 42% in 2010 to 76% in 2015, leading to a remarkable decrease in the prevalence of Malaria among under-fives from 42% in 2010 to 27% in 2015.[26]
- ✓ It is noteworthy that ownership of mosquito nets is one of the few interventions where there is a reversal in inequity, with the poor, the proportion of families at the lowest

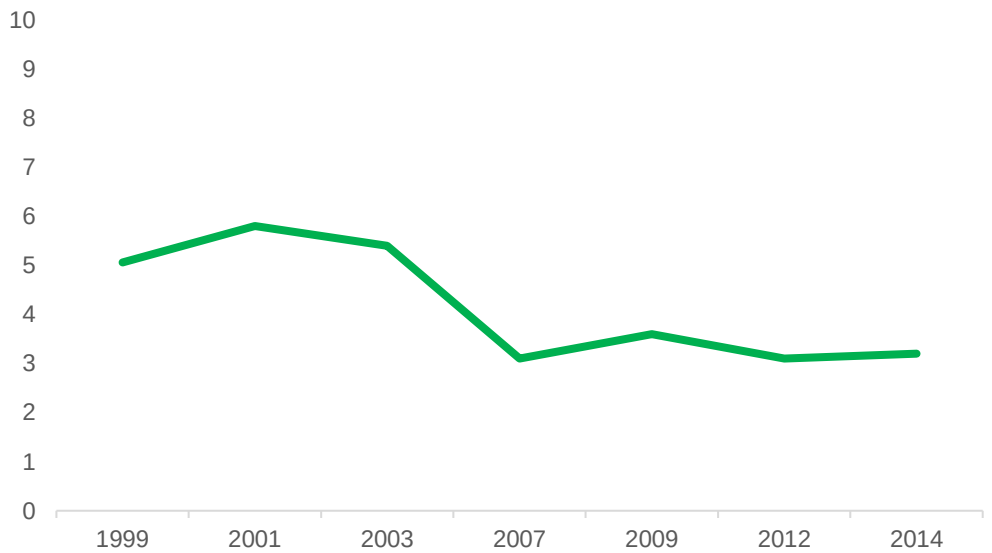
wealth quintile owning mosquito nets being significantly higher than the highest wealth quintile (53.2% versus 38.4%) and net ownership in the northern is higher than in the southern parts of the country.

- ✓ Treatment of children with malaria through iCCM community resource persons (CORPs) has been introduced in most States since 2014 resulting in improved case management of malaria. Between 2010 and 2015, the number of children with symptoms of malaria being tested has risen from 5% to 13% and the percentage of children taking ACT for malaria treatment has risen from 12% to 38%.[27]
- ✓ The 2015 Malaria Indicator Survey (MIS) showed a decline in malaria prevalence from 42% in 2010 to 27% in 2015.

HIV and AIDS

The HIV prevalence rate has been on the decline, from the highest prevalence rate of 5.8% in 2001 to 3.2% in 2014. However, given the size of Nigeria' population, this translates into an estimated 3.2 million people living with HIV – the second highest burden globally.

Figure 17: Trends in Nigeria's HIV Prevalence 15-49 years



Recent attempts towards universal access to HIV and AIDS prevention and control interventions include decentralization of treatment and care services to the PHC level (through task shifting), integration of HIV and AIDS services into RMNCAH+N and TB control programmes. These efforts have led to significant improvements in the uptake of HIV Counselling and Testing (HCT), improved access of people living with HIV to treatment, and an increase in the proportion of children accessing HIV treatment, care and support.

- ✓ The number of health facilities providing HCT has increased eight-fold and multiple strategies are used to increase access to HCT including community outreaches. The number of people ever tested for HIV has increased to 26.3% from 14% in 2009.
- ✓ The number of health facilities providing Anti-Retroviral Therapy (ART) services has also increased significantly. In 2016, there were 3.2 million people living with HIV, among whom 30% were accessing treatment, up from 5% a decade ago.
- ✓ Decentralization of Prevention of Mother to Child Transmission (PMTCT) services to 7,265 health facilities mostly at PHC level has led to increase in coverage rate to 46%

with 32% of HIV positive pregnant women receiving ART to prevent HIV transmission to their children.

Despite these improvements in HIV and AIDS services, only 60,000 PLHIV are receiving ART out of one million who need treatment. Poor government funding, stigma and discrimination, infrastructural and human resource gaps continue to pose challenges to universal coverage of HIV and AIDS services.

Tuberculosis

TB remains a major public health problem making Nigeria one of the four highest TB burdened countries globally. The estimated prevalence TB in Nigeria is 323 cases per 100,000 population and incidence rate is 338 cases per 100,000 population. With this incidence rate, more than 4 million cases of TB will have occurred in the country between 2015 and 2020. Of these, approximately 901,365 will be co-infected with HIV and 196,661 will have multidrug-resistant TB[28].

Current efforts at promoting universal coverage to TB services include expanding TB case detection and treatment services at all PHC facilities. Additionally, the programme is integrating TB screening and referral/case-finding into the routine activities of public non-TB service providers, military and paramilitary providers, private providers, community providers and community-based organizations so as to increase case notification and shift from passive to active case detection.

- ✓ As of 2014, 1,602 health facilities were providing acid-fast bacilli (AFB) sputum smear microscopy services and 5,389 health facilities provide treatment services for TB (DOTS centres).
- ✓ TB case notifications to the National Tuberculosis and Leprosy Control Programme (NTLCP) have increased steadily from 31,164 in 2002 to 100,401 in 2013.
- ✓ Treatment success reached 86% in 2013, surpassing the national target of 85% set for 2015. More than 85% of people with TB were counselled and tested for HIV and had access to life-saving cotrimoxazole preventive therapy.
- ✓ New diagnostic technologies, including *GeneXpert MTB-Rif*, line probe assay and liquid culture have been introduced to improved detection of tuberculosis and drug-resistance.
- ✓ 12 hospitals now have the capacity to treat multidrug-resistant tuberculosis (MDR-TB).

In spite of these notable achievements in TB control, the national TB survey carried out in 2013 pointed to the gross under estimation of the burden of disease. Case detection rate among most-at-risk population groups remains critically low at only 15%.

Viral Hepatitis

The World Health Assembly 2010 resolution WHA63.18 recognised viral hepatitis as a global health problem and highlighted the need for a global action towards universal access to its prevention, diagnosis and treatment. In 2012, a baseline study on the prevalence of hepatitis was conducted to inform the establishment of a national programme. The study revealed a prevalence of 11% for Hepatitis B and 2.2% for Hepatitis C - this corresponds to more than 20 million people infected with hepatitis in the country[29]. Based on these findings, in 2013 the

FMOH established the viral hepatitis control programme within the National AIDS and STI Control Programme (NASCP). A national policy, strategic plan and treatment guidelines for the control of viral hepatitis have been developed and are being rolled out. Hitherto, the focus had been on prevention of hepatitis B by integrating HBV vaccination into the national immunisation programme of children and provision of the vaccine to HBV negative adult populations. The guidelines recommend the decentralisation and integration of viral hepatitis intervention to the PHC level and the use of interferon-based ART for treatment of all HCV positive individuals, and an algorithm for the treatment of HBV positive individuals. However, the high cost of these drugs is a major barrier to treatment.

Neglected Tropical Diseases

Nigeria has the highest prevalence of Neglected Tropical Diseases (NTDs) in Africa and accounts for 25% of the global burden. Of the 19 known NTDs, 13 are endemic in Nigeria with most being co-endemic in all the States of the Federation. The NTDs at-risk populations are estimated as follows[30]:

- 122 million - Lymphatic filariasis
- 33.3 million - Onchocerciasis
- 20.8 million – Schistosomiasis
- 29.4 million - Soil Transmitted Helminthiasis
- 5.3 million – Trachoma
- 6.5 million - Human African Trypanosomiasis

Zoonotic NTDs including Rabies and Snakebites are also very common and neglected public health problems especially in rural communities. For instance, snakebites occur very often in the North East zone and some parts of the Benue valley in the North Central Zone. Most of the victims are women, children/pupils, peasant farmers, herdsmen and hunters. Nigeria contributes one-fifth of the burden of snakebites in the African Region with a case fatality rate of almost 65%. The shortage of anti-venom leads to increased morbidity and mortality. Previous attempts to establish an anti-venom production facility in the country through the Echitab Study Group (ESG) project were unsuccessful.

Although safe and cost-effective interventions for prevention and control of NTDs are available, these diseases have continued to cause immense suffering and often life-long disabilities for those affected. This is largely due to inadequate investment in NTDs prevention and control. The majority of the medicines needed for NTDs treatment are donated by development partners with little or no domestic funding. There is an urgent need for improved domestic support to the country to achieve the global target of elimination of the NTDs by 2020.[31]

2.2.3 Non-Communicable Diseases

Developing countries are experiencing rapid epidemiological and demographic transitions from communicable to non-communicable diseases (NCDs) resulting in so-called double burden of diseases. NCDs contribute significantly to adult mortality and morbidity. The major NCDs in Nigeria include cardiovascular diseases (hypertension, stroke, and coronary heart disease), diabetes mellitus, cancers, sickle cell disease and chronic obstructive airways diseases including asthma. Others include mental health disorders, violence, road traffic injuries, oral and eye pathologies. The prevalence of NCDs is predicted to rise even more in the coming decades.

National data on NCDs is outdated, with the only ever national NCD survey conducted in 1992. The survey showed that 4.3 million Nigerians over 15 years of age have hypertension. However, with the definitional shift of 140/90mmHg in 1999,[32] the prevalence of hypertension now exceeds 20%. The 1992 survey also showed that a 2.7% prevalence of diabetes mellitus. The 2015 Integrated Disease Surveillance and Response (IDSR) showed that there were 105,981 cases of diabetes with 252 related deaths.

Mental Health

Mental, Neurological and Substance (MNS) use disorders collectively contribute 25% to years of potential life lost due to premature mortality and the years of productive life lost due to ill-health and disability (DALYs) in Nigeria.[33] Mental health has a major impact on quality of life, as well as social and economic viability of families, communities and the nation. A community study estimated that 1 in 5 persons would experience a significant mental health problem in their lifetime requiring long-term commitment to treatment.

Psychotic disorders are the most easily identifiable form of mental illness, which include the schizophrenia, manic illness and organic psychosis, affecting about 1% of the general population. Depression, anxieties and somatoform disorders are far more prevalent. Depression alone accounted for 4.3% and is among the largest single causes of disability worldwide, particularly for women.[34] There is evidence that depression is particularly common among the elderly with over 7% reporting major depressive disorder in a 12-month period and over 25% reporting same during a lifetime. At least 10% of the population will be suffering from those poorly identifiable disorders. These conditions run a chronic course and are responsible for more morbidity.[35] The 12-month prevalence of adult mental disorder was estimated to be 5.2%. Only 20% of Nigerians with serious mental illnesses (SMI) have received treatment in the prior 12 months, showing the level of neglect for mental healthcare in the country.

Although there has not been any survey for over a decade to ascertain the mental health epidemiology, it is estimated that about 20% of children aged 7 – 14 years meet criteria for a Diagnostic & Statistics Manual (DSM)-III disorder, commonly including depression, conduct and anxiety disorders.

Mental illnesses frequently co-exist with peripartum conditions, HIV-related diseases and non-communicable diseases. Other risk factors for mental illness include use of illicit drugs such as marijuana, cocaine and organic solvents, accidents and social conflicts such as wars. As a result of the high prevalence, relatively low mortality rate, low identification rate and poor utilization of treatment, the MNS disorders are the largest single group, among NCDs contributing to disability.

There are many challenges confronting mental healthcare in Nigeria. They include poor policy and legislative environment, poor budgetary allocation (only 3.3% of federal health budget goes to mental health, with 90% of it spent on tertiary care), acute shortages of skilled human resource at tertiary level and dearth of non-specialised skills at lower levels of the health system to detect and manage mental health problems, failure to implement the integration of mental health into primary health care and lack of mental health programmes especially at lower levels of care,

Oral Health

Oral diseases constitute major public health problems worldwide because poor oral health has a profound effect on general health and quality of life. The burden of oral disease is increasing particularly among the disadvantaged and poor population groups which follows a pattern of deterioration associated with poverty. The risk factors for oral diseases include unhealthy diet, tobacco use, harmful use of alcohol and poor oral hygiene. The major oral health challenges include the low level of awareness of an average Nigerian about oral health care, poor funding, limited availability of services, limited access, high cost of services, shortage of and/or inequitable distribution of skilled personnel and services, limited focus on prevention, and the non-integration of oral health into PHC services.

A survey of oral health manpower, facilities and training institutions carried out by the Inter-country Centre for Oral Health, Jos, in 2014, showed only 679 dental clinics and only about 3000 dentists available, which are inequitably distributed to the neglect of settlements outside State capitals. Furthermore, there has been limited expansion of services to the PHC level and available services tend to focus on curative care to the neglect of prevention.

Eye Health

In May 2013, the World Health Assembly adopted resolution WHA66.4 on Universal Eye Health, setting a global target of 25% reduction in the prevalence of avoidable visual impairment by 2019 from the 2010 baseline. Globally, there is an estimated 253 million people worldwide who are visually disabled. Of these, 36 million are blind and, by definition, cannot walk about unaided. They are usually in need of vocational and/or social support. Approximately 50% of the world's blind suffer from cataract. The majority of the remaining persons are blind from conditions that include, among others, glaucoma, trachoma, onchocerciasis (also known as river blindness) and different conditions of childhood blindness. Despite a half century of efforts, commencing with organized trachoma control activities, the global burden of blindness is growing largely because of the population growth and ageing.

In Nigeria the prevalence of blindness is 0.78% in all ages. The major cause of blindness is cataract, others are glaucoma, age related macular degeneration, diabetic and hypertensive retinopathies. The National Blindness and Low vision survey found the prevalence of blindness among children aged 10-15yes who were examined to be 0.6%, with measles, Vitamin A deficiency and traditional eye medication accounting for 3%.

It is in recognition of this that the national health policy made promotion and improvement of eye care services it's priority in Nigeria. This would be achieved by integrating eye care services into existing national health programmes, building capacity for eye care delivery at all levels, improving public awareness of eye health and strengthening the evidence base for eye health problems and care. The FMOH through the National Eye Health Programme with the support of partners is doing a lot to reduce the backlog of cataract and trichiasis cases in the country.

In eight (8) local Governments Areas (LGAs) of Plateau, Nasarawa and Zamfara States, blinding trachoma – once thought to be an inevitable part of aging has been eliminated as a public health problem. As a result, fear of the future has been replaced with hope and optimism – and blinding trachoma is no longer a barrier to well-being in these LGAs.

Care of the Elderly

It is estimated that older people make up about 10% of the Nigerian population[36] and with increasing life expectancy; the proportion of the aged population is on the increase. Older people are at increased risk of chronic degenerative diseases especially cardiovascular diseases, stroke and diabetes. The fast-declining traditional social security system is aggravating the problems of care of the elderly as this is yet to be replaced with planned services for this population group. There is an apparent neglect of the elderly people in health care planning and minimal services to meet their needs. Apart from the University College Hospital, Ibadan, there are few public sector geriatric health facilities. The FMOH has established an Elderly Health Unit charged with the responsibility of coordinating the health services of the elderly.

The National Council on Health's resolution in 2010 directed that geriatric centres be established in all government health institutions. Key challenges in this regard include, the absence of a guiding ageing policy, the seemingly low priority given to elderly care by government in terms of funding and leadership, the lack of development partner support for issues concerning the elderly, and the erosion of traditional family and communal values. The increasing global attention on the health risks of the elderly and their need for financial protection as reflected in SDG3, underscores the necessity for government to consider the introduction of community-based cost effective, equitable and dignified elderly care centres in the country. The NSHDP II has articulated strategies to address gaps and challenges in the provision of improved health services for the elderly.

2.2.4 Emergency Medical Services

An Emergency Medical Service (EMS) is a comprehensive system that coordinates resources (personnel, facilities, equipment, transportation and communication) for the effective organisation and timely delivery of health and safety services to victims of severe and life threatening acute illnesses and injuries. Medical emergencies include, but are not limited to, trauma, obstetric emergencies, medical, surgical, paediatric and trauma-related emergencies. The aim of EMS is to ensure that critically ill or injured people get the right care, in the right place, at the right time, and in the right amount so as to prevent needless mortality and long-term disability. The components of the care include: care at home/community; care in transit to a health facility; and care received at the health facility. WHO recognises EMS as an integral part of any effective and functional health care system and represents the first point of contact of critically ill patients with life threatening conditions with the health care system. For EMS to be effective, a policy and plan including an effective communication system with dedicated emergency numbers must be in place, first responders trained (ambulance drivers and paramedical personnel) for provision of life-saving care on-site and while in transit to health facilities, and emergency units appropriately staffed with needed resources must be available.

In Nigeria, EMS is poorly developed. Until recently, there is no formal legal framework for coordination and regulation of ambulance services. The absence of a policy framework to guide ambulance service providers led to many disparate, uncoordinated and unregulated ambulance services operated by government agencies such as Federal Road Safety Commission (FRSC), National Emergency Management Agency (NEMA), Nigeria Police Force (NPF), Nigeria Security and Civil Defence Corps (NSCDC), as well as private and voluntary organisations. It is estimated that the 1,000 ambulances available nationwide can only meet

20% of national needs. Most first responders seen at emergency scenes do not have prerequisite knowledge and skills to provide appropriate care in emergency situations. Except for Lagos and Abia States, coordinated Emergency Medical Services are non- existent at state level. In most States, public sector ambulances are attached to hospitals and are not used for the provision of emergency medical services. Trained and competent first responders hardly exist. There are no dedicated emergency telephone lines - even the NEMA 112 emergency number is not functional. In many secondary and tertiary health facilities, emergency care is provided in emergency outpatient units that are ill-equipped and under-resourced to provide any meaningful care and patients usually have to find their way to the facilities. FRSC runs a few trauma centres and some tertiary centres but the services are underfunded and there is a shortage of skilled personnel and other resources for effective EMS response.

The BHCPF allocates 5% of resources for EMS. Recognising the absence of a national EMS, the FMOH in February 2018 launched the National Emergency Medical Services Policy[37] and also, developed guidelines for National Ambulance Services.[38]

2.2.5 Health Promotion and Social Determinants of Health

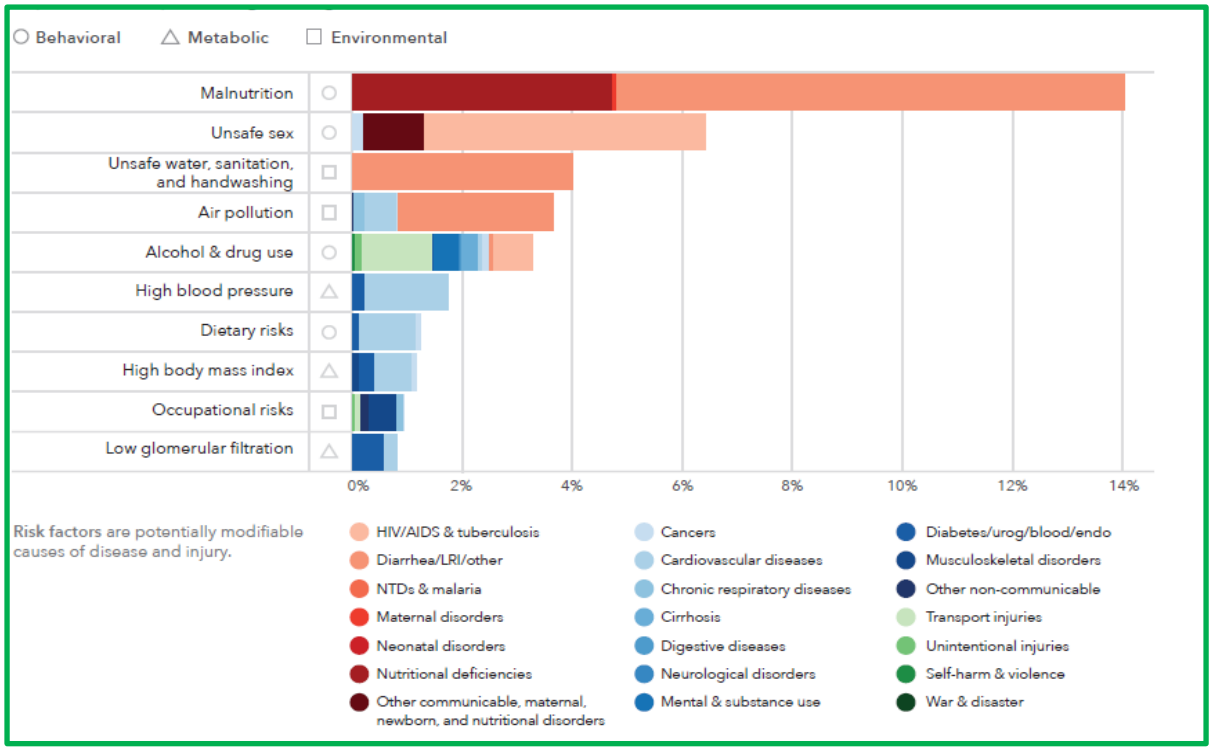
Health promotion is defined as 'the process of enabling people to increase control over and to improve their health.[39] It comprises actions aimed at fostering good health and wellbeing, focusing on populations, within the context of their everyday lives aimed at promoting health and preventing diseases. It addresses many factors that influence health such as individual factors (biological, socio-demographic, lifestyle and health care seeking behaviour) and environmental factors (cultural, social, economic, physical, etc.). Environmental health conditions include water supply, sewage disposal, housing, food availability and safety, vector control while social conditions – poverty, employment, income, availability and access to health and other social services, climate change etc. form the crux of social determinants of health in the country. The country has been making concerted efforts to address these factors so as to promote the health of her people. Some of the actions initiated over the years include: development of relevant health policies including the National Health Promotion Policy (2006), the National Food and Nutrition Policy, the Infant and Young Child Feeding Policy, legislation on seat belts and use of telephones while driving, reorienting health services, increasing focus on primary health care as a strategy to reduce geographic and economic inequities to access, strengthening community action and promoting the concept of Ward Development Committees. These actions have been limited and have failed to make significant impact in improving the nation's health status, redressing inequalities in health outcomes and dealing with the root causes of diseases including poor access to health services and other social services, poverty and lack of education.

Key factors militating against effective health promotion interventions include limited understanding of concepts of Health Promotion and consumer rights; lack of a strong platform for multi-sectoral action and the promotion of supportive environment for social and health behaviour change; inconsistent and poor implementation of health education and health promotion activities across all levels of the health care system; poor integration of health promotion with curative services; weak coordination of organizations providing health education; and lack of clear health promotion and behavior change communication strategy, training materials and skills.

Addressing these challenges will require empowering individuals and communities with appropriate knowledge to take control of actions that promote their health, prevent disease,

address factors in the community that influence and impede health and wellbeing leading to inequities in health outcomes.

Figure 18: Risks associated with national disease burden (2016 Global Disease Burden Report)



Nigeria has outdated regulations and standards related to the quality of food and food additives. The quality of food sold in the markets in terms of nutritional content is far from acceptable and falls far short of the SDG Target 2.2 to end all forms of malnutrition by 2030.[40] Concerted efforts by various government and the private sector is critical to foster dialogue and coordination among Health, Agriculture, Environment and Trade sectors.

Limited access to improved water supply and sanitation facilities especially in rural communities and urban slums increases the incidence and prevalence of water borne and related diseases, thus contributing to the overall disease burden. While there are various national policy documents on water and sanitation, these require a pragmatic and integrated multi-sectorial approach for effective implementation to achieve the desired objectives of provision of clean, potable and wholesome water, fit for consumption and other activities.

Health and safety in the work place, especially in hazardous work settings, is riddled with poor safety regulations and general lack of compliance with occupational health policy and standards. This is demonstrated, for example, by the absence or inadequate supply of protective clothing, personal protective equipment (PPE) and other items required to protect workers from occupational health threats, industrial accidents, injuries and various forms of hazards.

There is no established Occupational Safety and Health (OSH) programme domiciled in the FMOH and in the States. Even though an OSH policy is in place, most companies do not provide workers health services that they require to protect and prevent them from occupational health hazards. Consequently there is overreliance on the PHC system, which does not adequately address occupational health needs.

2.2.6 Public Health Emergencies and Risks

Nigeria has witnessed many natural and man-made disasters constituting Public Health Events (PHE) of significant importance that have resulted in high-level mortalities, ill-health, destruction of properties and infrastructure, environmental degradation, and massive displacement of populations. In the past few years, there have been progressive attempts to strengthen national preparedness and response to public health emergencies, especially as it relates to disease outbreaks. These initiatives include the establishment of the Nigeria Centre for Disease Control (NCDC), with the mandate to lead the prevention, detection and response to infectious diseases and strengthening the health security structure.

While Nigeria is not yet IHR compliant, notable achievements in PHE preparedness and response include the following:

- ✓ NCDC provided effective leadership to the control of the Ebola outbreak in the country in 2014 and has led the response to other subsequent outbreaks.
- ✓ Establishment of the Nigeria Field Epidemiology and Laboratory Training Programme (FELTP) to build a critical mass of field epidemiologists
- ✓ Development of emergency response plans and establishment of emergency response and rapid response teams up to LGA levels
- ✓ Establishment of a national Emergency Operations Centre (EOC)
- ✓ Determination of epidemic threshold levels for epidemic prone diseases,
- ✓ Additionally, NCDC is rebuilding the surveillance infrastructure and supporting the establishment of EOCs at State level (13 States have established EOCs)
- ✓ Incident Command system through which coordination of outbreak response activities are carried out in the country
- ✓ Establishment of a national reference laboratory

Key challenges to effective epidemic and other emergencies response include the following:

- Under-utilised disease surveillance and alert system
- Limited capacity of health facilities to effectively manage outbreaks and other emergencies
- Lack of or grossly inadequate dedicated fund and shortage of skilled human resources
- Limited/prepositioning of drugs and supplies
- Lack of legal backing for certain control measures (isolation and quarantine)
- Absence of leadership at LGA level (e.g. Medical Officer of Health) for local response, and lack of data and evidence to inform planning and decision-making
- Weak collaboration among key sectors involved in emergency response
- Demand-related gaps include non-involvement of communities in epidemic planning and response, ignorance, misconceptions and poor health care seeking behaviour.

Different hazards and emergencies can cause similar problems in a community and such measures as planning, early warning, inter-sectoral and intra-sectoral coordination, developing one harmonized plan, one coordinating structure and one management structure are essential. For early alert system and response, the need for strengthening the Integrated Disease Surveillance and Response (IDSR) strategy and other innovative means of sourcing real time data on diseases of public health importance is inevitable.[41] WHO recommends that public

health emergencies and preparedness should be implemented based on the "All-Hazard/Whole health approach", which entails developing and implementing emergency management strategies for the full range of likely risks and emergencies (natural, biological, technological and societal) but is yet to be operationalised.

Epidemic Prone Diseases

The country has experienced seasonal and endemic outbreaks of lassa fever, measles, cholera, cerebrospinal meningitis (CSM), yellow fever and monkey pox among several infectious disease epidemics. The Nigerian Centre for Disease Control has been leading the response to these outbreaks.

- In 2017 significant outbreaks of CSM, lassa fever, cholera and hepatitis E occurred across several States. Lassa fever epidemic is ongoing and has spanned more than 20 States in the country.
- The largest outbreak of CSM was recorded in Northern Nigeria, between December 2016 and June 2017.
- In 2017, Borno State experienced a large outbreak of cholera with most cases among Internally Displaced People (IDP). During this outbreak, the use of Oral Cholera Vaccines (OCV) was implemented for the first time in Nigeria.
- After 21 years of not reporting a confirmed case of yellow fever in Nigeria; a case was confirmed in Ifelodun LGA of Kwara State on the 12 September 2017. Since then, confirmed cases of Yellow Fever have been reported from 20 States in the country.

Man-made disasters

Since 2009, the insurgencies in the North Eastern zone resulted in death and displacement of about 10 million people - one of the worst humanitarian crises in the world. The conflict caused widespread socio-economic devastation, generating a crisis that affects the health of more than 6.9 million people in Adamawa, Borno and Yobe States, the worst affected states.

- Of the estimated 700 health facilities in these States, a third have been destroyed, and another third are not functional. Food insecurity is widespread with consequent effects on the nutritional status of the population.
- The insurgency has frustrated the polio eradication efforts, limiting access of trapped populations to vaccinations and frustrating polio surveillance, with consequent outbreak of the disease in 2016 in Borno, after 18 months of interruption of transmission nationally.
- In response, the government launched the Presidential Committee on the North East Initiative in October 2016, with the aim of developing and implementing a comprehensive response to the crisis.
- In 2017, the President inaugurated a Joint Inter-Ministerial Task Team to develop a humanitarian response to the crisis. The health sector response is the development of North East Health Sector Response Strategy[42] aimed at rebuilding health infrastructure, provision of minimum package of health care, integrated PHC services, providing critical life-saving humanitarian assistance to the affected population and strengthening disease surveillance in the three worst hit States.

Other disasters include the Herdsmen Crisis with ongoing attacks across different parts of the country particularly prevalent in the Middle Belt region and Road Traffic Accidents (RTA) which

are the second highest cause of violent death in Nigeria.[43] The country records between 100-120 road crashes per week resulting in up to 480 deaths in a month.[44]

2.3 Health Care Investments and Challenges

Generally, economic growth leads to health gains, but despite Nigeria becoming the largest economy in Africa and it being re-classified as a middle-income country, health outcomes have stagnated over the past two decades. The health system is characterised by gross underfunding, poor coordination of different stakeholders, inadequate numbers and skills of health care workers, poor infrastructure, limited availability of evidence for planning and decision-making, inequities in distribution of health resources and poor access to services and limited financial protection at the point of care.

PHC, which forms the bedrock of the national health system, remains weak. In addition, the health system is overstretched by a rapidly growing population. This underperformance is more pronounced at the primary health care level, threatening the attainment of universal health coverage. The root causes of the under-performance of the PHC system are gross underfunding and major weakness in leadership and governance[45].

The end-term evaluation of NSHDP I showed major gaps in funding of key PHC services, maternal and child health[46]. Before the introduction of PHCUOR in 2012, PHC governance in the country was characterised by fragmentation, multiple management structures, poor coordination, overlapping and lack of clarity of roles and responsibilities, inefficiencies in resource deployment and utilisation, including human resources and weak referral systems.

2.3.1 Human Resources for Health

The performance of a health system and its impact on health outcomes is influenced significantly by the size, distribution, and skill mix of its health workforce. Nigeria has one of the largest stocks of human resources for health in Africa. For example, the doctor population ratio in Nigeria is 38.9 per 100,000 population compared to the sub-Saharan African average of 15 per 100,000 population. Similarly the country boasts of a nurse/midwife population ratio of 148 per 100,000 population compared to a regional average of 72 per 100,000 population. Despite these HRH availability ratios, Nigeria still suffers a significant and chronic shortage of health workers for its population needs, especially in the northern parts of the country.

The NHAct, the National Human Resources for Health Policy (NHRHP) and National Human Resources for Health Strategic Plan (NHRHSP) provide the policy framework to guide States and the Federal Capital Territory (FCT) to develop their Human Resources for Health. The National Task Shifting and Task Sharing (TSS) Policy[47] with Standard Operational Procedures (SOPs) has been developed to optimise performance of the available HRH. The National Human Resources for Health Information System (NHRHIS) is being established with a Health Workforce Registry project to inform efficient HRH management and enable tracking and accounting for health workers. However, huge gaps still exist in deploying the NHRHIS at all levels.

In order to mitigate severe shortages of skilled workers in critical areas, the Federal n Government intervened with special schemes such as the Midwives Service Scheme (MSS) and Subsidy Re-investment and Empowerment Programme (SURE-P), which sought to improve the availability of nurses and midwives to provide maternal and child health services in underserved areas of the country. Additionally, to meet the critical shortfall in need of skilled

midwives, there has been a re-introduction of midwifery as a basic qualification by the Nigeria Nurses and Midwifery Council. The task shifting policy also ensured devolution of service provision to lower level cadres that can be trained to provide such services. However, many States are yet to domesticate this policy. The following table illustrates the HRH production capacity, which if fully harnessed and complemented by appropriate funding, deployment and retention of health workers, can produce sustainable HRH to meet the UHC vision of the National Health Policy and the goals of the NSHDP II.

Table 5: Institutional HRH production capacity

Type of Institution	Category of health professionals produced	Accredited institutions
Medical Schools	Medical Doctors and Dentists	27
Nursing/Midwifery Schools	Nurses and Midwives	89
Colleges of Health Technology	Community Health Extension Workers and Technicians	56
Pharmacy Schools	Pharmacists	35
Nigerian Universities Faculties of Health Technology and Faculties of Health Management	Medical Laboratory Scientists, Physiotherapists, Radiographers, Nutritionists, Health Managers	>50
Regulatory Bodies	Regulation of practice of health professionals in Nigeria	14

A key challenge in HRH production is asynchrony in needs and production. This is partly attributable to the non - implementation of the HRH policies and plans in most States. The result is over production of some categories of health professionals such as CHEWs and shortage in others e.g. midwives. There are, however, general inadequacies in the capacity of health training institutions to produce the required number and quality of frontline health workers. Mal-distribution of available workforce persists, to the disadvantage of rural areas, northern zones of the country, and lower level health facilities. Furthermore, northern zones of the country, with relatively higher disease burden, and severe shortage of skilled personnel, have restrictive recruitment policies that limit recruitment of skilled staff from other parts of the country.

Deployment to and retention of health workforce in rural areas remain a challenge, as incentives to get people to work in rural areas are scarcely in place. This is in part due to lack of institutionalised motivation and retention mechanisms for health workers. There are inefficiencies in the performance management systems, including lack of clear job descriptions for health workers. There are general complaints of poor remuneration, poor condition of service, irregular payment of salaries at sub-national levels, disharmony among professional groups and perennial strikes that often times paralyse the sector for long periods.

In recent times, a national crisis has been observed where doctors are unable to find placements for internships. However, government is making efforts to address the situation by making plans for the centralization of placement of house officers. The outdated HRH data in the following table highlights the lack of a reliable human resources for health information management system in the country.

Table 6: The availability of all cadres of health workers as at 2012

Health Professional Category	Total number registered	Number per 100,000 population	Ratio
Doctors	65,759	38.9	1:2,572
Dentists	3,129	1.9	1:54,056
Optometrist	2,676	1.6	1:63,207
Dispensing Optician	168	0.10	1:1,006,793
Nurses and Midwives	249,566	148	1:677
Dental Nurses	266	0.15	1:635,868
Radiographers	1,286	0.76	1:131,525
Pharmacists	16,979	10	1:9,961
Physiotherapists	2,818	1.7	1:60,022
Community Health Officers	5,986	3.5	1:28,256
Senior CHEWs	42,938	25.3	1:3,939
Junior CHEWs	28,458	16.8	1:5,914
Medical Lab Scientists	19,225	11.3	1:8,798
Medical Lab Assistant	11,067	6.5	1:15,283
Medical Lab Technicians	8,202	4.8	1:20,622
Environmental Health Officers	6,542	3.9	1:25,854
Health Records Officers	2,926	1.73	1:57,806
Dental Technologists	730	0.43	1:227,646
Dental Therapists	3,253	1.9	1:51,995
Dental Technicians	1,885	1.1	1:89,730
Dental Surgery Assistant	886	0.5	1:190,904
Chattered Chemist	2533	1.5	1:66,775
Public Analysts	717	0.4	1:235,901
Pharmacy Technician	1,849		
Health Technicians	8,739	5.15	1:19,354
Occupational Therapists	34	-	-
Occupational Therapist Assistant	104	-	-
Speech Therapists	28	0.01	1:17,000,000
Audiologists	25	-	-
Physio-Technician	65	-	-
Prosthetist and Orthotists	8	-	-

2.3.2 Health Infrastructure

Health infrastructure comprises buildings, both medical & non-medical equipment, furniture and hospital plant, communications (ICT equipment) and ambulatory systems (ambulances, cars, pick-up vans, trucks, etc.) required for healthcare delivery at different levels of the health system. It also includes water, power supply and sanitation facilities in health facilities. The following table shows the distribution of health facilities as at 2015 according to the National Planning Commission.[48] While at least 88% of the health facilities are PHC, access to PHC services is estimated to be about 61%.

Table 7: Distribution of Health Facilities as at 2015

Type of health facility	Public	Private	Total
Primary Health Centres	21,808	8,290	30,098
Secondary Health Facilities	969	3,023	3,992
Tertiary Health Facilities	76	10	86
Total	**22,853**	**11,323**	**34,176**

For healthcare infrastructure to meet desired health outcomes, it must be effective, safe to use, qualitative, and also appropriate, affordable, available, accessible and acceptable. About 80% of health facilities are reportedly at different states of dysfunctionality ranging from dilapidation, lack of water and electricity. Secondary and tertiary levels of care have obsolete and non-functional equipment due to lack of maintenance. In 2005, the FMOH established basic requirements for delivery of the EPHS across the tiers of healthcare services, but this standard is not being followed in most health facilities in the country. The delivery of this package was accompanied by specified standards in infrastructure, human resources and health commodities, which are yet to be implemented. The Federal Government has set the following infrastructural priorities relating to health sector:

- At least 1 functional PHC per ward linked to a functional secondary health facility in each LGA.
- At least 1 functional secondary health facility in each LGA with qualified personnel and the establishment of a strong referral system to a contiguous tertiary health facility.
- Upgrade specialist and tertiary hospitals to meet local needs including the establishment of a comprehensive and efficient referral system.

2.3.3 Medicines, Vaccines, Health Technology and Supplies

There are many policies, guidelines and institutions that facilitate sustainable supply of high quality, safe and affordable medicines, vaccines and other health products. The National Agency for Food and Drugs Administration and Control (NAFDAC) regulates and controls the manufacture, importation, exportation, distribution, advertisement, sale and use of Food, Drugs, Cosmetics, Medical Devices, Packaged Water, Chemicals and Detergents (collectively known as regulated products). The Nigeria Institute for Pharmaceutical Research and Development (NIPRD) is a parastatal under the FMOH responsible for developing drugs, biological products and pharmaceutical raw materials from indigenous resources.

Despite the existence of relevant institutions, the availability of medicines, vaccines and health technologies in Nigeria is characterised by disproportionate underfunding for essential medicines and other health products resulting in persistent stock-outs and high expirations at service delivery points, irrational drug use, poor and parallel supply chain management systems, and inadequate warehousing with available ones not meeting minimum standards. Local manufacture is plagued by poor infrastructure and protection from unfair international competition. Local manufacture only supplies about 5% of the local needs of medicines and other health products. Therefore, Nigeria largely depends on importation to meet its local needs for medicines, vaccines and health technologies.

The National Vaccine Production Laboratory has not been producing vaccines for more than two decades, though efforts are ongoing to revamp vaccine production in the country. The increasing prevalence of Anti-Microbial Resistance (AMR) in the country is a growing public health concern. In 2017, the Federal Government through NCDC launched and commenced implementation of the National Plan of Action on AMR. In addition, a National Supply Chain Product Management Programme has been established to ensure integration of supply chain systems, effective logistics and supply system for medicines and other health products to service delivery points with support from the Global Fund.

While traditional medicines are widely used, the practice remains unregulated. There have been minimal investments in research and development for traditional medicines. Coordination between conventional and alternative medical systems is weak or non-existent. A policy on Traditional Medicine has been developed but it is yet to be implemented.

2.3.4 Health Information System

The revised Health Information System (HIS) policy provides the framework for inter-sectoral, comprehensive and integral structure for collection, collation, analysis, storage, dissemination and use of health and health-related data and information. The development of the HIS Strategic Plan 2014-2018 was guided by the Policy.

Investments on HIS across the three tiers of government have been inadequate to meet the minimum requirements for HIS in terms of human resources and infrastructure. The roles and responsibilities of all stakeholders in the National Health Management Information System (NHMIS) are not clearly defined in the national HIS policy.

The country's Health Information System (HIS) remains weak. The HIS is fragmented with numerous vertical programmes, which are mostly donor-driven, running parallel HIS systems. Despite significant past investments aimed at improving the nation's HIS, the sub-sector coordination remains challenged due to multiplicity of data collection tools and non-availability of data reporting tools. Routine health facility data collection is done through the DHIS 2 platform, which harvests data from 38,500 private and public primary and secondary facilities. While DHIS 2 average reporting rate in 2017 was 72%, timeliness remained low at 63%. Completeness is also a huge challenge with reported service data being significantly lower than national estimates from other known sources. There is very little to no reporting from the private sector despite the fact that the private sector provides 60% of healthcare services in the country. Compared to primary and secondary health facilities, tertiary health institutions have been noted to significantly under-report into DHIS 2.

Overall, poor data quality still persists at all levels. There is no systematic analysis of HMIS data and feedback to health institutions thereby limiting the use of HMIS data for health planning and decision-making.

A situation analysis of the M&E system performance carried out in 2016 led to the development of a roadmap for strengthening the M&E system. Progress to date includes:

- The Health Data Governance Council (HDGC), chaired by the Honourable Minister of Health, has been inaugurated.
- The HDGC serves as the coordinating body that provides oversight and governance for health information including the Health Data Consultative Committee (HDCC).
- Both the HDGC and HDCC are replicated at the State and LGA levels.
- The existence of funds within vertical programmes for monitoring and evaluation is an opportunity that could be leveraged to enhance HIS in the country. This will also facilitate the development of an investment framework for M&E.

2.3.5 Health Research and Development

Research and Development is the backbone of innovative and sustainable development of the health sector. Research findings enhance evidence-based policy and decision making at all levels of government and ensure more targeted health interventions that have a higher impact on reduction of the country's diseases burden. There are several institutions involved in health research at the academic level and as government research agencies. These institutions are faced with serious challenges ranging from gross under funding, leadership and governance issues, poor legal and regulatory environment, infrastructural challenges, non-commercialisation of research findings, non-passage of intellectual property rights laws, and weak linkages between health research institutes, the private sector and local needs.

Despite the NCH ratification of the African Health Ministers' commitment to allocate 2% of health budgets to research, only 0.08% of national health expenditure at the federal level is allocated to research. There is hardly any domestic funding for research at sub-national level. The private investment in health research and development is also very poor. Finally there is a disconnection between research in academic institutions in the country and the consumers of research findings. This calls for a pragmatic national research agenda that can inform public health policy and practice.

2.3.6 Health Care Financing

The optimal utilisation of health care services is influenced by the financing mechanism which removes the financial barriers to access. The gap in demand for service, the availability, quality and coverage of the country with health care services is due largely to inadequate health care financing at all levels. The Nigerian government passed the National Health Insurance Scheme (NHIS) under Act 35 of 1999 with the aim of improving access to healthcare and reducing the financial burden of out-of-pocket payment for health care services. The National Health Act of 2014 provides for the allocation of 1% of the consolidated revenue fund (CRF) to fund selected priority health services under the Basic Health Care Provision Fund. In 2017, the federal government approved a new National Health Care Financing and Equity Policy and developed guidelines for its implementation. However, implementation of the policy has been poor.

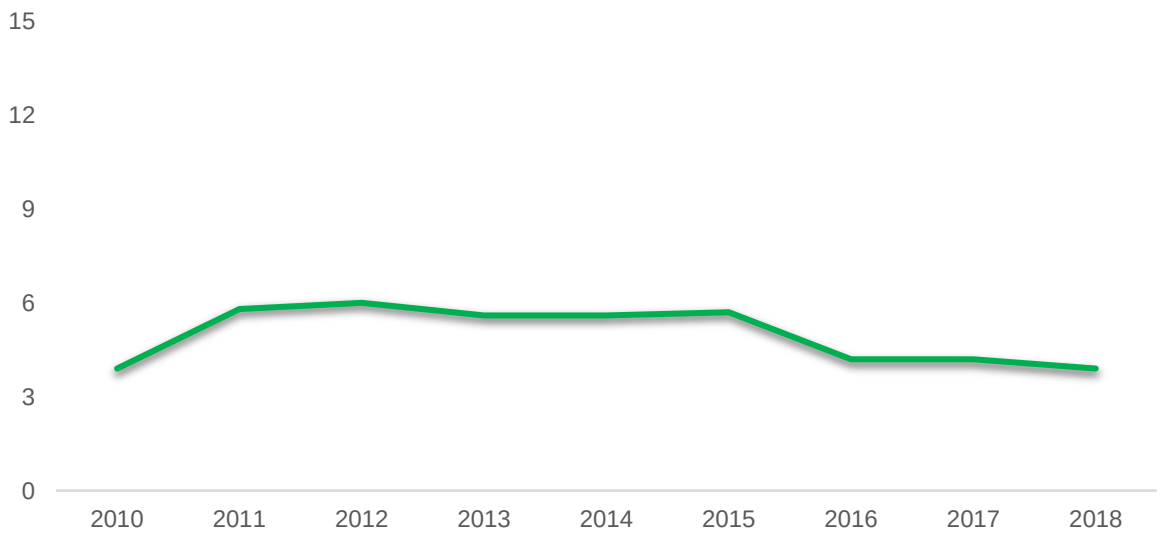
While WHO recommends out-of-pocket expenditure (OOPE) on health of no more than 30-40%, in Nigeria OOPE ranged from 78% in 2010 to 73% in 2016. This high level in OOPE poses a barrier to accessing health services, worsening inequities in health outcomes and further exposing the poor to impoverishment as a result of catastrophic health spending. Health insurance coverage is very low with only 5% of Nigerians able to access prepaid health care

through social and voluntary private insurance. A few States have established their own community-based and social health insurance schemes.

The NHIS has been affected by inefficiencies that limit its utility. There are weaknesses in procurement of services from the NHIS fund. For instance, the role of Health Management Organisations (HMOs) as both purchaser and provider of health services under NHIS creates significant asymmetry in the relationship with users of the fund. Furthermore, the monitoring and regulatory framework for HMOs is weak. The NHIS is a voluntary scheme which excludes the informal sector and has been affected by little buy-in by States. However, by 2017, twenty five States were at various stages in enacting laws and putting in place structures to establish their State Health Insurance Schemes while two States have started enrolling.

The weaknesses in the Health Care Financing (HCF) arrangements include weak institutional structure and inconsistent policy implementation and low government investment in health. As shown in the following table, government's policy commitment and proclamations are not mirrored by its budget allocation to the health sector which has not exceeded 6% since 2010. This is far below the Abuja Declaration of 15% budget allocation to health. Government financing of health is worsened by poor budget releases which have consistently fallen short of the budget allocations.

Figure 19: Nigeria Budget Allocation to Health (% of total national budget)



Opportunities to broaden the revenue base for public health care financing including, sin taxes, aviation, VAT, health insurance, public-private partnerships e.g. corporate social responsibility, health impact bond and philanthropy have not been fully harnessed. Allocative inefficiencies is prevalent at all levels of the health system. The proportionately low funding for PHC compared to secondary and tertiary care does not support the National Health Policy to strengthen PHC towards attainment of UHC.

A few successful innovative pilots have been conducted to improve efficiency, transparency and accountability in health financing. These include two World Bank supported performance-based financing (PBF) schemes - SOML PforR and NSHIP. The BHCPF and State Health Insurance Schemes are promising opportunities to scale up PBF and PHC funding. Other innovative financing approaches such as conditional cash transfers, deferrals and exemption schemes for pregnant women and children under five years and other vulnerable groups are limited in scale and largely donor-funded.

2.3.7 Leadership and Governance

The Nigerian constitution places health in the concurrent legislative list thereby providing for federal, state and local governments to legislate on health services with guidance from a robust health governance and policy framework including the following:

- The National Health Policy
- The National Council on Health
- The National Health Act which includes the recently appropriated Basic Health Care Provision Fund
- Specific policies to strengthen PHC e.g. Primary Health Care Under One Roof.
- Institutional structures including MDAs and Health Management Boards, Regulatory Committees and other complementary committees.

While the governance and management structures exist, the capacity for transparent and accountable health systems governance and leadership remains weak.

2.3.8 Partnerships for Health

Nigeria is a signatory to the 2008 Global Compact of the International Health Partnerships and related initiatives (IHP+), an international partnership that aimed to improve effective development cooperation in health to help meet the Millennium Development Goals which in 2016, expanded its scope to include HSS towards the achievement of UHC (UHC2030). The IHP+ approach includes supporting the development of strong and comprehensive country and government-led national health plans which should be implemented in an effectively coordinated manner. To this end, the NSHDP II underwent the JANS review which is recommended under the IHP+ approach.

The Nigerian Government recognises the multi-dimensional nature of the health system and the need for strategic partnerships in health as expounded in the National Health Policy. Partnership with the private sector, non-governmental organisations, communities and development partners as well as other social and economic sectors is essential in order to comprehensively deliver health services that can meet the needs of the population on a sustainable basis. Although there are various national health coordination platforms, including the Health Partners Coordinating Committee chaired by the Honourable Minister of Health, the Development Partners Group for Health and the different Thematic Technical Groups and Task Teams (including at state level), there is poor coordination of these groups, leading to duplication of functions and inefficient use of scarce resources.

In 2005, the FMOH developed the PPP Policy to provide a framework for the involvement of the private sector in the development of infrastructure and services in the country including health infrastructure and services. The FMOH PPP unit has facilitated these partnerships:

- ✓ The ‘Warehouse in a Box’ project (in Abuja and Lagos),
- ✓ The CAT-Lab and geriatric Wards in UCH
- ✓ Installation of dialysis machines in FMC and Owerri
- ✓ The LUTH/General Electric partnerships
- ✓ Joint Venture Agreements between Crystal Thorpe Nigeria Ltd. and University of Abuja Teaching Hospital (UATH) for the management of the Trauma and Multi-specialist Centre at the Hospital and the concession of the Garki Hospital

Despite these few PPP successes, coordination and regulation of the private sector has remained weak.

2.3.9 Community Participation

Community participation and ownership is key for the successful delivery and sustainability of health care, especially PHC services. In resource-constrained settings with weak health systems and socio-cultural challenges, empowerment of individuals, families and communities to get more involved and take greater control over their health is essential for the attainment of UHC. LGAs and community traditional and religious structures are well positioned to strengthen community participation in health care. Notable successes include the following:

- ✓ Traditional and religious leaders are playing a critical leadership and gatekeeping role to improve access to and utilisation of health care services
- ✓ The establishment of Ward Development Committees (WDCs) in more than 800 political wards across the country under the leadership of community members
- ✓ Community representation in Hospital Management Committees
- ✓ Facility health committees comprising community members and staff of the health facility have been established and are functional
- ✓ Active engagement and involvement of various cadre of community health workers in different public health programmes. Plans to harmonise the different community-based health workers under the CHIPS initiative are underway.

The following challenges still require attention in order to foster strong and durable community participation in health:

- Poor knowledge and awareness of determinants and risk factors of poor health outcomes
- Poor understanding of the concept of health prevention and the role of community members in health
- Weak coordination of community engagement initiatives
- Weak linkages between community structures and the health system
- Weak or non-existent community health information systems
- Inadequate supportive supervision of existing community health structures
- Absence of and/or inconsistent implementation of clearly defined policy instruments to guide community participation

Gender inequity affects health in many dimensions as it results in differential vulnerabilities, exposures, access to information and services, quality of care and health outcomes. As discussed in detail in Section 2.2.1 above, women suffer higher poverty levels, lower educational attainment and lower rates of formal employment thereby limiting their ability to access health information and services. Women have been marginalised in almost all aspects of the decision-making process even in matters that affect their health. For example, in some parts of the country where patriarchy is dominant, women cannot seek health care without the express permission of their husbands. Even though national reproductive health policies and strategies mention male participation, engagement and participation of men remains limited. For instance, men are hardly seen at ANC or in delivery rooms.

Gender-based violence is a major public health concern and it remains a neglected area. The FMOH recently developed health workers guidelines for management of Gender Based Violence (GBV) at clinic level[49]. Implementation of these guidelines has not commenced.

The following tables summarise the strengths, weaknesses, opportunities and threats of the health system which in turn informs the strategy direction of NSHDP II.

Table 8: SWOT Summary of the Health Sector by NSHDP II Priority Areas

Leadership and Governance	Community Participation in Health

Strengths
• Legal, policy and coordination framework exists
 	
Weaknesses
• Delayed or poor implementation of policies and Plans and programmes and key provisions of the NHAct
  ○ Implementation of core provision of the act such as the BHCPF yet to commence
  ○ Poor resourcing of health programmes
  ○ Weak implementation of sectoral and programmatic plans
  ○ Poor reflection of inequities in planning, programming and programmatic approaches.
  ○ Suboptimal regulation and standardization of services and practice provided by the public, private sector, including traditional medical practice
• Weak coordination mechanisms
  ○ Weak coordination of governments at all tiers/interface of the health systems at these tiers
  ○ Weak inter/intra sectoral collaboration
  ○ Programmes compartmentalization, fragmentation and weak collaboration and role conflict / overlap of functions
• Weak mechanisms for accountability, transparency and responsiveness
  ○ Weak responsiveness, rigidity in structure and bureaucracy, reviews not being undertaken
  ○ Limited voice and accountability and Community Participation in Health
	Strengths
	• Existence of ward development committees at ward level and of Facility Health Committees in some facilities.
	• Structures for the engagement and participation of traditional rulers and religious leader exist and are functional
	• Strong community-based health programmes exist e.g. IMCI and iCCM
	• Existence of multiple cadre community health workers and volunteers
	
	Weaknesses
	• Poor understanding of the concept and weak implementation of community participation in health.
	• Fatalistic outlook to disease causation and outcome
	• Increasing and differential financial incentives for CBW threatening sustainability
	• Lack of harmonization and integration of community-based services leading to verticalisation, duplication and waste of resources at the community level

Partnerships	**EPHS**
Strengths • PPP Policy, partnership platforms and guidelines for partnerships in place • Operationalization of PPP arrangements at federal, state and LG levels of care • Strong presence of development partners • Existence of partner coordinating forum at all levels • Availability of basket funding for some public health programmes (RI, PHC) in some States • Improved inter-governmental partnerships (State and Federal institutions to leverage HRH for service delivery) **Weaknesses** • Weak alignment of development partner support with national/state plans • Ineffective coordination of health partners at all levels leading to inefficiency, duplication and/or overlap • Poor transparency and accountability by some development partners • Promotion of vertical programming and reporting that frustrates integration	**Strengths** • Policies, guidelines, SOPs and/or treatment guidelines, etc. for delivery of health services are in place • Expansion and scale up of services such as immunization, malaria and TB control, HIV services - leading to better coverages • Improved malaria control activities and outcomes • Improved integration of services such as the RMNCAH+N, TB and HIV integration • Intentional focus on PHC strengthening showing promising signs of improved access **Weaknesses** • Poor and inequitable coverage with high impact cost-effective interventions • Poor implementation of the Minimum Health Services Package (MSP) resulting in poor quality of services • Inequity in access to information and services (geographic, socio-economic and gender) • Weak referral system and weak ISS • Rudimentary emergency medical services • Poor linkage of community-based health care providers to the formal health care system. • Non/limited availability of services for some conditions/target groups (e.g. care of the elderly,

	mental health, youth friendly ARHS, services for persons with disabilities) • Inadequate demand creation leading to low utilization of available services. • Inadequate attention to social determinants of health
Human Resources for Health	**Health Infrastructure**
Strengths • National HRH policy and strategic plan are in place have been domesticated by some States • Infrastructure for National Human Resources for Health Information System (NHRHIS) is in place • National task shifting and sharing policy and its SOPs have been developed and rolled out • Variable capacity for HRH production exists in all States • 14 regulatory bodies for HRH production, practice control and accreditation **Weaknesses** • Poor implementation of HRH policy and strategy at all levels • Maldistribution of HRH precipitating significant inequity in the health system • Acute shortage of skilled health workers, especially at PHC level • Gender inequity in the health workforce adversely affects service utilization, especially by women • Lack of reliable information for HRH planning and management • Embargo on employment across many states worsens HRH availability • Poor motivation leading to recurrent strikes • Tremendous tension among health professions hindering collaboration and synergy in the health system • Lack of scheme/standards of practice for some health cadre e.g. M&E Officers • Weak systems for integrated supportive supervision (ISS)	**Strengths** • National Infrastructure Policy and defined minimum standards for health facilities exist • Large number of health facilities across the country **Weaknesses** • No health infrastructure development master plan to guide systematic implementation of the infrastructure policy Poorly equipped health facilities, most in severe state of disrepair • Inadequate funding and capacity for effective infrastructure maintenance • Limited investment in ICT and communication infrastructure in the health sector • Poor public power supply, water and basic sanitary facilities. • Critical shortage of reliable transport for referral and general health facility management and operations • No fleet management plan
Medicines, Vaccines, Commodities and Health Technologies	**Laboratory Services**
Strengths • Policies, guidelines and institutions exist • Available and willing to engage local manufacturers with WHO certification • NSCIP project made progress in integrating supply chains at all levels **Weaknesses** • Gross underfunding for medicines and other health products and equipment • Poor availability of essential and life-saving medicines • Poor storage conditions coupled by weak last mile distribution • Poor infrastructure and incentivisation of local pharmaceutical production • National vaccine production moribund • Increasing prevalence of anti-microbial resistance • Low investment in alternative medicine	**Strengths** • Some public and private laboratory services capacity exists • National and Blood Transfusion Services Policies exist • Increasing pool of qualified laboratory personnel **Weaknesses** • Poor quality assurance and control of laboratory services and ineffective regulation of laboratory services • Poor networking of laboratory services • Inadequate availability and poor maintenance of lab equipment • Limited availability and inequitable distribution of skilled lab personnel • Poor supply chain management for laboratory consumables and supplies • Poor laboratory information management system

	• Poor linkage between clinical and research laboratory services
Health Information System	**Health Research**
Strengths • Establishment of the Health Data Governance Council (HDGC) and Health Data Consultative Committee (HDCC) which are chaired by the Honorable Minister of Health. • Cascading of health data governance structures at subnational levels • Draft roadmap for strengthening the M&E system in place • DHIS 2.0 expanded and rolled out to all the States • Community based HMIS tools developed and field tested **Weaknesses** • Fragmentation of reporting lines due to vertically funded programmes and huge burden for multiple reporting by limited health workers • Non-availability of reliable data for health planning and decision-making • Weak capacity for data analysis and use at all levels • DHIS 2 does not capture community-level health information • Poor feedback mechanisms and suboptimal ISS • Ineffective coordination of the M&E system at all levels • Lack of HMIS tools especially at health facility level • Poor reporting (service and financial) by the private sector and some development partners	**Strengths** • National health research policy and guidelines and research institutions exist • Research governance and regulatory structures in place at all levels (NHREC) • Specific funds for research exist e.g. TETFUND and NUC • Legal arrangements and institutions for IPR and technology transfer exist **Weaknesses** • National health research agenda exists but lacks funding and capacity for implementation • Lots of health research being conducted out of alignment with the national research priorities • Poor alignment between academic research and policy and/or implementation priorities • Weak promotion, coordination and regulation for health research and development • Limited investment by public and private sector in Research and Development • Weak enforcement of patent and intellectual propriety rights legislation • Poor networking/linkages between researchers • Weak repository of research products and information • Brain drain of researchers from health research institutes to universities
Public Health Risks and Emergencies	**Health Care Financing**
Strengths • Existence of relevant and functional institutions e.g. NCDC and EOCs, NEMA and SEMA • Increasing pool of trained field epidemiologists • Availability of policy, strategic plan, guidelines and tools for IDSR **Weaknesses** • Delays in IHR compliance • Weak surveillance system/ early warning signs • Poor sub-national capacity for preparedness and response planning and implementation • Surge capacity of health facilities to respond to public health emergencies is poorly developed • Weak network and capacity of public health laboratories	**Strengths** • Existence of HCF governance structures including the HCF unit of the FMOH and the NHIS • A detailed NHCF & E Policy and implementation plan in place. • Provision of BHCPF in the NHAct is a catalyst for UHC • Development partner commitment and support for key public health programmes RMNCAH+N, Malaria, TB, HIV. • Most States have established SSHIS to reduce financial hardship at point of health care **Weaknesses** • Very low budget allocation to health and poor release of budgeted funding to the health sector at all levels • Very high OOPE risk catastrophic health expenditure • Poor national health insurance coverage and nascent SSHIS • Weak health care financing implementation and tracking systems e.g. no subnational health accounts

	• Weak overall regulatory mechanisms for health care financing actors and schemes including HMOs, CBHIS, SHIAs) • Donor dependence at all levels for key public health programme funding
Cross-cutting Opportunities	**Cross-cutting Threats**
• Positive economic outlook for the country • Increasing donor presence and support • Strong health leadership and enabling policy environment • NHAct and BHCPF are excellent opportunities to advance UHC	• Unpredictable, and unsustainable health care financing • As Nigeria moves to middle income country status, donor funding is decreasing • Fragility, civil unrest and emergence of public health disasters • Changes in political leadership at all levels may affect policy consistency • Weak multisectoral coordination limits effectiveness of response to health related SDGs

The following chapter seeks to outline the nationally agreed strategies and interventions to address the challenges and gaps while leveraging the opportunities and strengths that were identified in the situation analysis and SWOT summaries above.

Chapter 3

NSHDP II Strategic Directions

3.1 Vision of the NSHDP II

Vision
To ensure healthy lives and promote the wellbeing of Nigerian populace at all ages

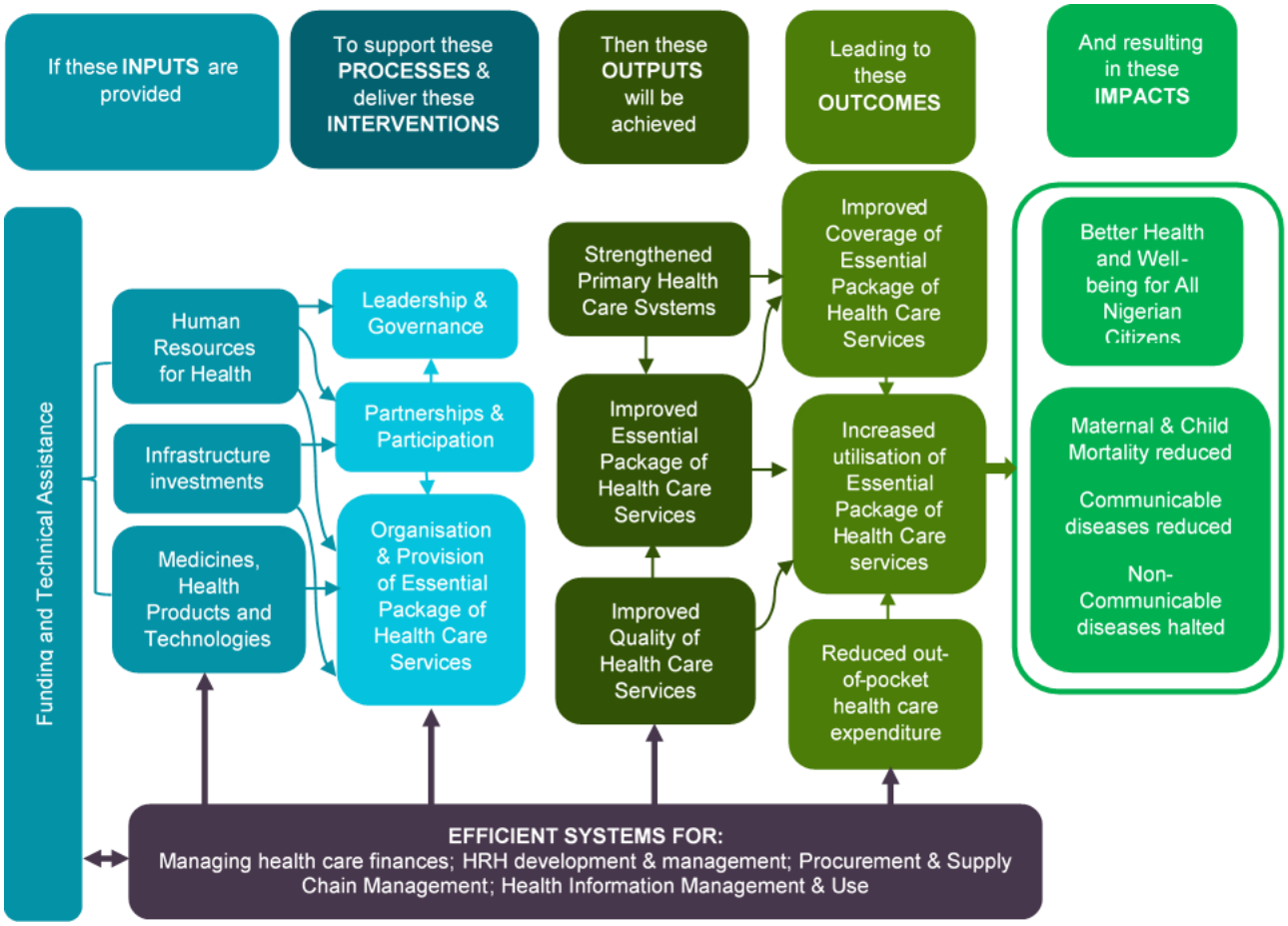
Mission
To ensure that the Nigerian populace have universal access to comprehensive, appropriate, affordable, efficient, and equitable and quality essential health care through a strengthened health care system

Guiding Principles	
Accountability and transparency	Good governance, openness and responsiveness will be integrated and imbibed into the implementation of NSHDP II at all levels of the health system in order to serve all the Nigerian populace in an honest, trustworthy, and transparent manner.
Quality of care	Stakeholders will endeavor to guarantee all Nigerian citizens the highest level of health care standards with fast and efficient services with special focus and attention to Primary Health Care.
Ethics and Respect for human rights	Both providers and consumers of health care at all levels of health care delivery particularly communities will be treated with courtesy, dignity, impartiality and respect for all persons.
Accessibility, affordability and acceptability	The NSHDP II will be fully funded, structured and supported in a way that ensures stability and efficient use of human, financial and material resources with long-term affordability, accessibility and availability in mind.
Equity and Gender Sensitivity	Fairness, trustworthiness, respect and justice will be watchwords mainstreamed into the entire NSHDP II roll out in addition to ensuring that planned interventions and activities address the health needs of women, men, girls, and boys across all levels and sectors of society. Key stakeholders will advocate for establishment and/or strengthening of structures, systems and processes that facilitate attainment of NSHDP II goals and objectives.
Community engagement	NSHDP II will be people-centered and promotes health through a primary health care system where the community is at the heart of health services delivery. The interests of people are of central priority when making decisions. The needs of individuals, families, and communities are identified and addressed by implementing a coordinated approach to service delivery and helping individuals participate in decision-making to improve their health and well-being through proactive engagements using participatory approaches.
Teamwork and Industrial harmony	NSHDP II will be implemented in the spirit of team work, cordial relationships and consensus building including having a clear peer review mechanism where processes and results will be well documented, disseminated and communicated to all stakeholders thus creating synergy and cohesiveness in a collaborative atmosphere.
Innovation	Innovation and continuous learning will form the basis for successful implementation of the NSHDP II where commitment to service excellence will be demonstrated by continuous service improvements through creativity and approaches that work.
Alignment and harmonization	All stakeholders and partners will align their programmes and activities with the NSHDP II priorities in the spirit of effectiveness and harmonization. Health policies, plans and programmes will be integrated and synchronized at all levels to optimize efficiency and effectiveness of the health care delivery system.
Partnership and collaboration	NSHDP II implementation will be consultative and participatory, involving all key stakeholders in the public and private sector including beneficiaries and decision-makers at all levels. Effective stakeholder consultation will be undertaken from development through implementation of NSHDP II. This is critical to producing the desired result of better health outcomes for all Nigerians.
Sustainability and resilience	NSHDP II will be delivered through entrenchment and institutionalization of policies and practices that will make for effective and durable health care services delivery bearing in mind innovative strategies and solutions that work where individuals, groups and communities deploy appropriate technology where local knowledge, skills, and capacity to address all issues related to their health are in existence.

3.2 NSHDP II Theory of Change

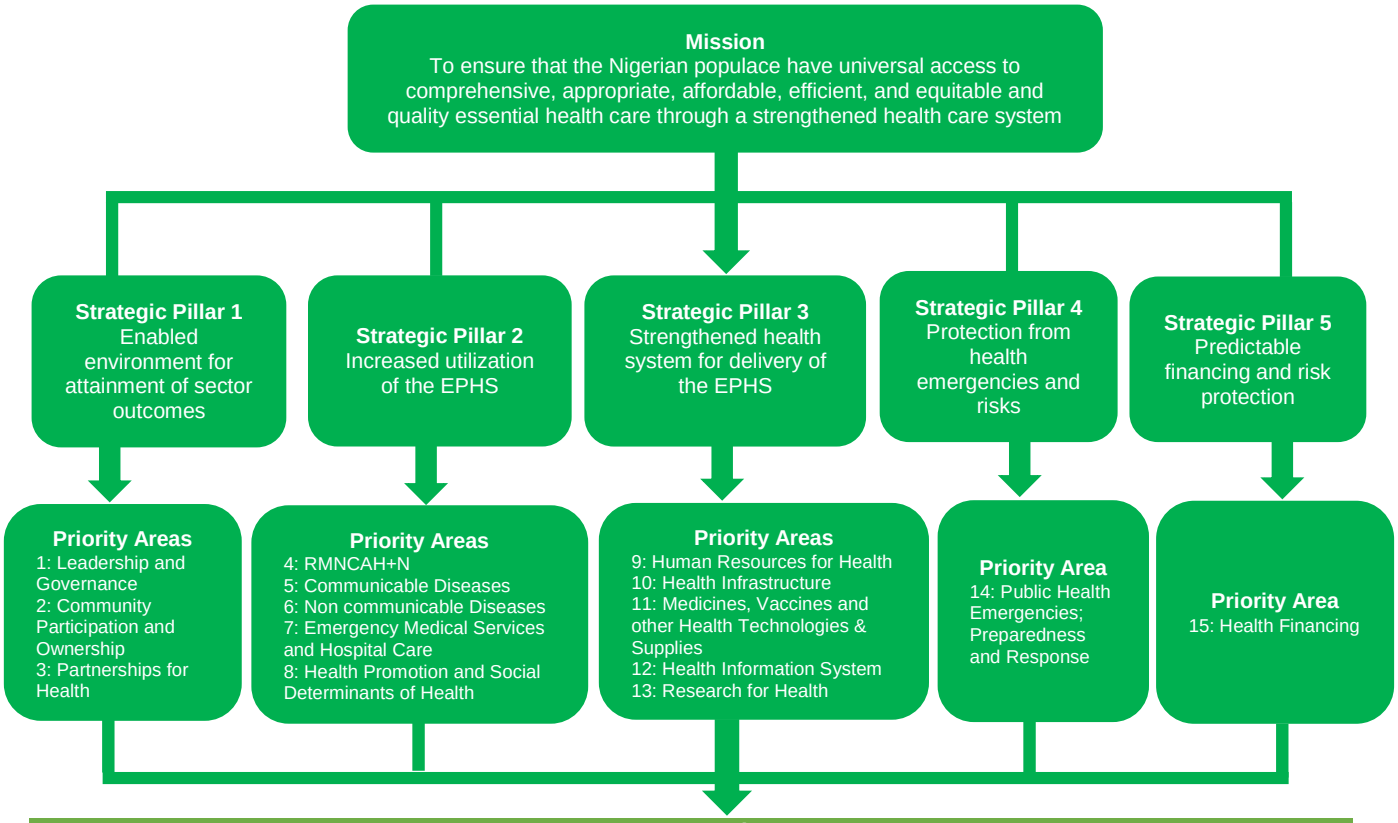
Figure 21 shows the Theory of Change underlying the NSHDP II. The promotion of healthy lives and improved wellbeing of the Nigeria populace is premised on ensuring universal access to quality health care services built on a foundation of a revitalised primary health care, with adequate health services support inputs – infrastructure, laboratory support, essential medicines etc. and effective partnerships and community participation. This is supported by strengthening the management systems that support health care services delivery – human resources for health, health information system, supply chain management and predictable and sustainable financing. Critical to ensuring a healthy populace is a transparent and accountable governance system that ensures a functional health care system and universal access to health care services in a sustainable manner.

Figure 21: NSHDP II Theory of Change



3.3 Structure of NSHDP II

NSHDP II is arranged into five Strategic Pillars and fifteen Priority Areas with 15 Goals and 48 Strategic Objectives. Strategic Interventions and Key Actions, specific indicators and targets are also outlined. Detailed arrangements for tracking implementation are provided in the NSHDP II Monitoring & Evaluation Plan



Goals		
Strategic Pillar One	1.	Provide effective leadership and an enabling policy environment that ensures adequate oversight and accountability for the delivery of quality health care for sustainable development of the national health system
	2.	To promote community engagement for sustainable health development
	3.	Enhance harmonized implementation of the EPHS in line with national health policy goals
Strategic Pillar Two	4.	Promote universal access to comprehensive quality sexual and reproductive health services throughout life cycle and reduce maternal, neonatal, child and adolescent morbidity and mortality in Nigeria
	5.	To improve prevention, case detection and coordinated response for the prevention, control and management of communicable diseases and NTDs
	6.	To reduce the burden of morbidity, mortality and disability due to non-communicable diseases
	7.	Improve health outcomes through prompt and effective response to medical emergencies
	8.	Improve the wellbeing, safety and quality of life of Nigerians through health promotion and healthy environment
Strategic Pillar Three	9.	To have in place the right number, skill mix of competent, motivated, productive and equitably distributed health work force for optimal and quality health care services provision.
	10.	To improve availability and functionality of health infrastructure required to optimize service delivery at all levels and ensure equitable access to effective and responsive health services throughout the country.
	11.	To ensure that quality medicines, vaccines, and other health commodities and technologies are available, affordable and accessible to all Nigerians
	12.	To institutionalize an integrated and sustainable health information system for decision-making at all levels in Nigeria
	13.	To utilize research to inform policy and programming for improved performance of the health sector and better health outcomes and also contribute to global health knowledge production
Strategic Pillar Four	14.	Significantly reduce the incidence and impact of public health emergencies
Strategic Pillar Five	15.	Ensure all Nigerians have access to health services without any financial barriers or impediments at the point of accessing care

48 Strategic objectives

Strategic interventions and key actions and their specific indicators and targets

Chapter 4

Strategic Pillar One

Enabled Environment for Attainment of Sector Outcomes

Priority Area 1 - Leadership and Governance

GOAL: To provide effective leadership and an enabling policy environment that ensures adequate oversight and accountability for the delivery of quality health care for sustainable development of the national health system.

Table 9: Strategic Objectives and Key Results for Leadership and Governance

Strategic Objective	Indicator	Target
Provide clear policy, plans, legislative and regulatory framework for the health sector	% of coordination organs at national and subnational levels (NCH, SCH, WDC, Health Partners Coordination Committee) are established/functional	70%
Strengthen transparency and accountability in planning, budgeting and procurement process	% of States that increase annual budget implementation rate by 25%	80
Improve health sector performance through regular integrated reviews and reports	FMOH and 36 SMOH+ FCT HSS publish annual state of health report	38 reports
Strengthen coordination, harmonization and alignment at all levels	% of coordination organs at national and subnational levels that are functional	70%

Table 10: Strategic Interventions and Key Activities

Objective 1: Provide clear policy, plans, legislative and regulatory framework for the health sector	
Strategic Interventions	**Key Activities**
Promote review and development of polices and laws as necessary	Conduct annual reviews of National, Federal, and States Strategic Health Development Plans
	Train and strengthen human resource capacities at National, State and LGA levels on gender and equity-responsive policy development, planning and implementation of health plans
	Develop/review and support States to domesticate relevant health legislation, policies, and guidelines.
	Conduct stakeholders sensitization and dissemination meeting on the developed/revised health policies, guidelines, acts and laws
Scale-up strategic and operational planning at all levels	Develop evidence based, costed and prioritized operational health plans from the SHDP II for Programmes, National health MDAs
	Conduct joint annual reviews of implementation of the NSHDP II
	Conduct high level advocacy to the executive and legislatures on the need for increased appropriation and spending on health and BHCPF.
	Convene annual/quarterly collaborative strategic and operational planning meetings of stakeholders for harmonization of plans
Objective 2: Strengthen transparency and accountability in planning, budgeting and procurement process	
Strategic Interventions	**Key Activities**
Strengthen Public Finance Management system including oversight in Fund disbursement and utilization at all levels	Conduct joint annual reviews of implementation of the NSHDP II
	Produce and disseminate reports of NSHDP II implementation including financial reports
	Coordinate the development of annual budgets at National and State levels (including LGAs)
	Track and publish reports of quarterly/annual budget performance

Strengthen the linkages between various planning and budgeting process	Conduct joint review and alignment meeting between health planning and budgeting health departments and other stakeholders
Strengthen voice and accountability, including community participation and engagement with civil society organisations (CSOs).	Update database of all CSOs in health and map their thematic/geographic areas of focus
	Build capacity of the unit responsible for coordination of CSO activities at the FMOH
	Hold Quarterly review meetings with registered CSOs
	Empanel CSOs as watchdogs to assess and report on performance of all aspects of NSHDP II implementation
Objective 3: Improve health sector performance through regular integrated reviews and reports	
Strategic Interventions	**Key Activities**
Strengthen annual operational/work-plan for the health sector	Support the development of evidence based, costed, and prioritized operational health plans for programmes, departments and agencies in the health sector (Refer to 1.1.2 a) guided by the strategic health plan at all levels
	Improve information generation and sectoral information base for decision-making to enhance sectoral performance
Institutionalize the mechanism for sector progress status and performance review	Collate and review end of year reports from States
	Prepare and disseminate National annual health reports
Disseminate sector performance reports and score cards in compliance with NHAct and other channels	Develop and disseminate real time National score cards on health sector performance
	Conduct regular meetings with CSOs and other stakeholders to review health sector performance through application of score cards developed
	Develop and implement remedial action based on score card findings
Design and institutionalise an incentivisation and reward system for the efficient performance of the health sector at all levels	Establish an independent performance award committee
	Establish and roll out a mechanism for implementation of performance-based incentivisation at all levels
	Conduct annual award ceremony to beneficiaries at all levels
Objective 4: Strengthen coordination, harmonisation and alignment at all levels	
Strategic Interventions	**Key Activities**
Strengthen governance structures, rules and processes at all levels	Plan, conduct and participate in the National/State Council on Health meetings
	Develop a framework/mechanism for vertical coordination of Federal and State Health MDAs and their LGAs
Strengthen development and review of sectoral policies and plans	Develop and harmonize all state policies on health and health related issues, guidelines for policy implementation and monitoring
	Review of all state policies on health and health related issues, guidelines for policy implementation and monitoring
	Build capacity for policy analysis and briefs
	Create platform for stakeholders' involvement in the review of policy and plans
Strengthen inter-sectoral collaboration at all levels.	Establish inter-Ministerial forum at DPRS levels to promote health in all policies and address social determinants of health (e.g. women affairs, education, agriculture, works and housing, finance, planning commission, transport, information, budget & planning etc.)
	Conduct quarterly inter-ministerial forum meetings on health and related issues
	Facilitate and monitor mainstreaming of health issues into all sector policies
Improve partnership with professional groups and other relevant stakeholder for effective service delivery and industrial harmony	To improve efficiency, effectiveness in service delivery to all citizens in a timely, fair, hones and transparent manner
Strengthen implementation of Health Service Charters at all levels	Facilitate the implementation of the service charters of the Ministry and the MDAs under the Ministry
Strengthen coordinating mechanism of health development partners (Development Partners and Private Sector Partners)	Establish the Health Partners Coordinating Committee (HPCC) as a government coordinating body with all other health development partners
	Develop a framework and guidelines for the harmonization and alignment of development partners, support and review it yearly
	Strengthen mechanism for coordination of partner resource in States
	Conduct review meeting with Development Partners

Priority Area 2 - Community Participation in Health

GOAL: To promote community engagement for sustainable health development

Table 11: Strategic Objectives and Key Results for Community Participation in Health

Strategic Objective	Indicator	Target
To strengthen community level coordination mechanisms and capacities for health planning. framework for the health sector	% of PHC that are linked to Community Health Committees	80%
	% of Community Health Committees that are functional	70%

Table 12: Strategic Interventions and Key Activities for Community Participation in Health

Objective 5: Strengthen community level coordination mechanisms and capacities for health planning	
Strategic Interventions	**Key Activities**
Strengthen institutional and coordinating mechanisms for promotion of community participation	Establish and monitor the functioning of WDCs and other community coordinating structures
	Support establishment of Community Health Influencers and Promoters of Services (CHIPS)
Strengthen financial management systems at the community levels	Build capacity of community committees and structures (CBOs, FBOs, WDCs, FHCs etc.) on resource mobilization, financial management system and accountability at the community level
	Institute a system for financial monitoring and auditing at community level
Strengthen capacities of communities to participate in the planning of health interventions at all levels.	Build capacity of community structures including WDCs in the planning and implementation of health interventions
	Establish and support platforms for community engagement and participation in health planning and implementation
Objective 6: Strengthen community engagement in the implementation, monitoring and evaluation of health programmes	
Strategic Interventions	**Key Activities**
Strengthen capacities of communities to facilitate the implementation of community and facility level Minimum Service Package (MSP)	Support training and functioning of community-based providers (CHIPS) on MSP and other community-based initiatives
	Establish linkage between community-based providers (CHIPS) and primary health care facilities for referrals, data management, supportive supervision, and replenishment of commodities stocks
	Support establishment of a community-based health information system linked to DHIS2.0
	Conduct regular Data Quality Assurance (DQA)

Priority Area 3 – Partnerships for Health

GOAL: To enhance harmonised implementation of the EPHS in line with national health policy goals.

Table 13: Strategic Objectives and Key Results for Partnerships for Health

Strategic Objective	Indicator	Target
Ensure that collaborative mechanisms are put in place for involving all partners in the development and sustenance of the health sector	% of funding of health from partners (development partners and private sector) by 2022	30%
	% of all health facilities at all levels to be implementing SERVICOM by 2022	70%
	% increase in the proportion of institutions administering health services through Public Private Partnerships (PPP)	50%

Table 14: Strategic Interventions and Key Activities for Partnerships for Health

Objective 7: Ensure that collaborative mechanisms are put in place for involving all partners in the development and sustenance of the health sector	
Strategic Interventions	**Key Activities**
Promote the adoption and utilization of national policies and guidelines on PPP	Support implementation of PPP policy and guideline at all levels
	Support routine monitoring of PPP MoU/contracts at all levels to ensure compliance
Strengthen legal and coordinating framework for PPP at all levels	Develop legal framework to guide PPP at all levels
	Establish and build capacity of PPP units/TWGs of health MDAs at all levels
Establish a single Development Partners Forum at federal and state levels, which comprises of only health development partners;	Establish the Health Partners Coordinating Committee (HPCC) as a government coordinating body with all other health development partners
	Facilitate operational oversight and dialogue to monitor implementation of health partners activities at all levels
Strengthen mechanisms for the implementation of PPP (e.g. contracting or out-sourcing, leases, concessions, social marketing, franchising mechanism)	Explore the feasibility of Performance-Based Financing (PBF) in public and private health facilities
	Establish pilot PBF mechanism in private health facilities to involve more private facilities across the states
	Explore the feasibility of different models of implementation of health programmes
	Advocate to/engage private investors and service providers e.g. telecom providers and media houses on social marketing of PPP and other PPP mechanisms
Scale-up PPP in planning and implementation of health programmes	Support scale-up of PPP implementation across the country including private sector involvement in development of strategic/annual plans
Promote joint (public and private sector) monitoring and evaluation of health programs	Establish & strengthen a joint public-private sector monitoring and health performance review teams
	Build capacity of private providers on monitoring, evaluation and supervision of health programmes and services at all levels
	Support development of reporting mechanisms for informed decision making on PPP activities for health (including format and production of periodic PPP M&E reports)
Scale up resource mobilization interventions(funding, skills - e.g.	Establish a framework for domestic resource mobilization (DRM) from corporate organizations, private sector, and philanthropists for health interventions at all levels

managerial approaches) targeting the private sector	Support development of innovative strategies for DRM across the country
Establish mechanisms for resource coordination through common basket funding models such as Joint funding Agreement, Sector Wide Approaches, and sectoral multi-donor budget support.	Develop a joint funding model involving the Ministry of Finance, Budget & National Planning and development/funding partners (basket fund)
	Facilitate oversight of the joint funding model
Promote the establishment of an inter-sectoral ministerial forum at all levels to facilitate inter-sectoral collaboration, involving all relevant MDAs directly engaged in the implementation of specific health programmes	Establish & strengthen an inter-agency coordination committee
	Establish & strengthen an inter-sectoral/inter-ministerial Working Group comprising of relevant Directors and program officers
Promote effective partnership with professional groups and other relevant stakeholders through jointly setting standards of training by health institutions, subsequent practice and professional competency assessments.	Support development and implementation of standards of professional training institutions, practice and practitioners at all levels
Strengthen collaboration between government and professional groups including Nigerian health professionals in diaspora to advocate for increased coverage of the EPHS, particularly increased funding	Create a mechanism for engaging and harnessing contributions of Nigerian's in diaspora for health interventions at all levels (including organizing conferences, seminars, exhibitions etc.)
Leverage human resources for health from partners, health professionals, other levels of government to optimize resource use and improve service delivery	Establish a mechanism for a scheme that will leverage resource capacity of partners and Federal health professionals to support healthcare providers at lower levels (e.g. technical assistance on-the-job mentorship for public officers in the health sector)
	Facilitate and monitor implementation of the scheme/MoU between Federal, States and LGAs
Promote linkages with academic institutions to undertake research, education and monitoring through existing networks	Conduct a resource and capacity mapping of academic institutions across the country
	Create/establish a functional forum for all training and research institutions and stakeholders in the state for developing a research and implementing training and research linkage interventions/activities
	Promote health research and development through implementation of MoUs/agreement with training institutions and academia
	Mobilise technical assistance from research bodies to build the capacity of relevant officers on health research at all levels
Promote partnerships with communities to address felt needs of the communities	Strengthen implementation of Health Service Charters at all levels, with Civil Society Organisations, traditional and religious institutions to promote the concept of citizen's rights and entitlement to quality, accessible basic health services
	Training, development and production of service charters of the Ministry and the MDAs under the Ministry (Establishment & Review)

Chapter 5

Strategic Pillar Two

Increased utilization of the Essential Package of Health Care Services

The goal of the 2016 National Health Policy is to ensure that every Nigerian has access to the essential package of health care services. The policy, in alignment with the Sustainable Development Goal 3, identified some key health care services to be provided as part of the Essential Package of Health care Services (EPHS). These essential services include the minimum service package (MSP) contained in the Basic Health Care Provision Fund and are further elaborated in the NSHDP II. In order to accelerate the attainment of universal coverage with the EPHS, NSHDP II will ensure the following:

1. **Revitalisation of Primary Health Care:** Rapid upgrading/strengthening of at least one PHC per ward to improve access and utilisation of the MSP, including provision of BEmONC services. One secondary health facility per LGA shall be strengthened to serve as referral centre for the PHCs as well as providing CEmONC services. The Primary Health Care under One Roof (PHCUOR) initiative which provides the policy guidance for PHC strengthening at State level will be strengthened to ensure more effective coordination and integration of services.

2. **Removing financial hardship at the point of care:** Health insurance including strengthening the NHIS and establishing social health insurance at State level will be a key strategy to ensure that benefit packages include the EPHS. The BHCPF will catalyse progress towards UHC as provided for in the NHAct.

3. **Innovative health care financing models are much needed:** While the BHCPF as provided for in the NHAct is aimed at UHC, it only covers selected elements of the MSP. The benefit packages of SSHIS also leave some gaps in the full coverage of the EPHS. As such, the need for more innovative health care financing models to ensure predictable and sustainable funding of the EPHS cannot be overemphasised.

4. **Addressing inequity and leaving no one behind:** The revitalisation of the PHC system to ensure a functional PHC in every ward will go a long way towards addressing prevalent geographic inequities in access to, utilisation of health care services across the country. Newer approaches to address availability of health workers at all levels of the health system including the community will be a key focus of NSHDP II. For instance the task-shifting and sharing policy and the CHIPS programme will be excellent opportunities to increase access to services, especially in underserved rural areas. Multisectoral approaches that address social determinants of health including safety net schemes targeting vulnerable populations will be scaled up. Finally NSHDP II will be deliberate in addressing gender, socio-economic and other cultural and religious norms and barriers to health care service uptake.

Priority Area 4 - Reproductive, Maternal, New-born, Child & Adolescent Health plus Nutrition (RMNCAH+N)

GOAL: To promote universal access to comprehensive , quality, sexual and reproductive health services throughout the life cycle and reduce maternal, neonatal, child and adolescent morbidity and mortality in Nigeria.

Table 15: Strategic Objectives and Key Results for RMNCAH+N

Strategic Objective	Indicator	Target
Reduce maternal mortality and morbidity through the provision of timely, safe, appropriate and effective healthcare services before, during and after child birth	Maternal mortality ratio (deaths per 100,000 live births)	288
	Skilled attendance at delivery	57
	% pregnant women attending 8 ANC visits	80
	% mothers receiving postnatal services within 48hrs of their delivery	50
	% PHC providing BEmONC services	80
	% LGAs with health facilities providing CEmONC services	50
Strengthen prevention, treatment and rehabilitation services for fistula care in Nigeria	% reduction in national incidence of obstetric fistulae	50
	% reduction of treatment backlog of obstetric fistula cases	30
Promote demand and increase access to sexual and reproductive health services (family planning and post abortion care)	Contraceptive prevalence rate	43
	% reduction in unmet FP need among all females of reproductive age	50
	% of all health facilities offering post abortion care	7
Reduce neonatal and childhood mortality and promote optimal growth, protection and development of all new-borns and children under five years of age	Neonatal mortality rate (neonatal deaths per 1000 live births)	18
	Infant mortality rate (infant deaths per 1000 live births)	38
	Under-five mortality rate (deaths among children under 5 year per 1000 live births)	64
Improve access to adolescent health and young people information and services	% increase in proportion of health facilities offering comprehensive adolescent friendly reproductive and sexual health services	50
	% increase in utilisation of adolescent reproductive health services	50
	% reduction in incidence of unplanned pregnancies among adolescent females	50
Improve the nutritional status of Nigerians throughout their life cycle with a particular focus on vulnerable groups especially children under five years, adolescents, women of reproductive age and the elderly	% increase in exclusive breastfeeding rate in the first six months of life	60
	Incidence of low birth weight	10%
	Prevalence of childhood wasting	10%
	Prevalence rate of stunting in under-fives	20%
	% reduction in childhood overweight	50
	Prevalence of malnutrition among women of reproductive age	5%

The key elements of the RMNCAH+N package of services and strategic interventions to deliver them are summarised in the following tables. Full details to guide programmatic implementation are provided in the RMNCAH+N strategy and its accompanying policy documents, including the Roadmap for Accelerated Reduction of Maternal and New-born Mortality.

Table 16: Package of maternal health services along continuum of care at all levels

	Intervention	Community	Primary	Referral
Pre-pregnancy	Family planning	✓	✓	✓
	Prevent and manage sexually transmitted infections	✓	✓	✓
	Cervical cancer screening	✓	✓	✓
	Tetanus toxoid	✓	✓	✓
	Screening for HIV	✓	✓	✓
Pregnancy - Antenatal care package	Antiretrovirals for HIV-positive pregnant women		✓	✓
	Pregnancy surveillance of all pregnant women and their unborn children		✓	✓
	Iron and folic acid supplementation		✓	✓
	Presumptive treatment of malaria		✓	✓
	Use of long-lasting insecticide treated net		✓	✓
	Tetanus toxoid		✓	✓
	Deworming		✓	✓
	Screening for HIV		✓	✓
	HAART for all HIV positive pregnant women		✓	✓
	Recognition and management of complications in pregnancy (screening for PET, syphilis, anaemia, hepatitis etc.		✓	✓
	Antenatal administration of steroids to prevent Respiratory Distress Syndrome (RDS)		✓	✓
	Birth preparedness and complication readiness plan development		✓	✓
	At least one abdominal ultrasound scan (before 24 weeks of gestation)		✓	✓
	Home visit		✓	✓
Labour and Delivery including management of complications	Post-abortion care		✓	✓
	Supervision by skilled birth attendant	✓	✓	✓
	Partograph use to monitor labour		✓	✓
	Active management of third stage of labour to prevent postpartum haemorrhage		✓	✓
	Administration of uterotonics to prevent PPH (misoprostol)	✓	✓	✓
	Magnesium Sulphate for eclampsia		✓	✓
	Induction of labour to manage pre-labour rupture of membranes at term			✓
	Antibiotics for preterm pre-labour rupture of membranes		✓	✓
	Corticosteroids to prevent respiratory distress in unborn babies and new-borns			✓
	Pneumatic anti-shock garments for haemorrhage		✓	✓
	Induction of labour for prolonged pregnancy			✓
	Prophylactic uterotonics to prevent postpartum haemorrhage	✓	✓	✓
	Management of postpartum haemorrhage (e.g. uteretonics, uterine massage)	✓	✓	✓
	Manual removal of placenta	✓	✓	✓
	Removal of retained products of conception	✓	✓	✓
	Assisted vaginal delivery		✓	✓
	Caesarean section for maternal/foetal indication			✓
	Prophylactic antibiotics for caesarean section			✓
Postpartum (Mothers)	Family planning	✓	✓	✓
	Prevent and treat anaemia		✓	✓
	Screen for HIV and initiate treatment from HIV		✓	✓

Table 17: Package of services to prevent and treat Obstetric Fistula at all levels

	Intervention	Community	Primary	Referral
Prevent OF	Promote inter-sectoral collaboration for OF prevention	✓	✓	✓
	Conduct joint OF-related activities to create synergy	✓	✓	✓
	Promote integration of OF into MNCH and PHC	✓	✓	✓
	Mainstream OF into MNCH and PHC protocols and guidelines		✓	✓
Reduce the prevalence of obstetrics fistula by 30% by 2021	Conduct periodic OF pool effort repairs to underserved areas (at least 2 zones per quarter) targeting 800 repairs annually			✓
	Expand free OF treatment services to all Federal Teaching Hospitals and FMCs, targeting 8,200 repairs annually			✓
	Facilitate the dissemination and implementation of the Urethral catheterization guidelines in obstetric service delivery at primary & secondary level facilities.		✓	✓
	Review and update existing SOPs relating to OF treatment, rehabilitation and re-integration.	✓	✓	✓
	Support routine fistula Repairs in all State designated fistula centres, targeting 4000 repairs annually			✓
	Build capacity of health workers in OF management			✓
	Train doctors in OF repair (standard, advanced and expert trainings as appropriate)			✓
	Train nurses in pre and post-operative OF nursing care			✓
	Advocate for the compulsory rotation of OBGYN and Urology residents in OF centres as part of the residency training			✓
	Conduct Mapping of OF services in all Federal Teaching Hospitals, Federal Medical Centres, National Obstetric Fistula Centres and State Own Fistula Centres.			
Rehabilitation	Rehabilitate and re-integrate 75% of Obstetric Fistula patients	✓	✓	✓
	Strengthen capacity for OF rehabilitation and reintegration	✓	✓	✓
	Mapping of Rehabilitation Centres, Tutors and potential Stakeholders for OF rehabilitation and re-integration	✓	✓	✓
	Develop training modules for OF rehabilitation and re-integration	✓	✓	✓
	Support vocational skills and entrepreneurship training for 75% (9,750) of mobilized OF survivors annually	✓	✓	✓
	Capacity building for social workers on OF and provision of psychosocial counselling for OF survivors, targeting 20 per state annually	✓	✓	✓
	Promote inter-sectoral collaboration for OF rehabilitation and re-integration	✓	✓	✓
	Conduct advocacy to relevant sectors, programmes, institutions, philanthropists to invest in OF rehabilitation and re-integration	✓	✓	✓
	Promote community participation in re-integration of fistula survivors	✓	✓	✓
	Empower communities to support re-integration process of fistula survivors	✓	✓	✓
	Follow up OF survivors in communities to support and monitor re-integration process	✓	✓	✓
Communication	Create an enabling environment and promote behaviour change for OF prevention and control	✓	✓	✓
	Create an enabling environment for OF-related work in Nigeria	✓	✓	✓
	Collaborate with key stakeholders to develop a comprehensive OF communication plan	✓	✓	✓
	Develop briefs, playsets and IEC materials (banners, flyers, handbills, posters, etc.)	✓	✓	✓
	Collaborate with Ministries of Information, Television/Radio Stations (Government and Private) in implementation of relevant SBCC interventions			✓
	Partner with media organizations to air TV and radio programs and jingles on OF at states and national level	✓	✓	✓

Research	To strengthen OF research and development to significantly contribute to the national OF response			✓
	Strengthen the development of a national OF research agenda			✓
	Develop a national OF research agenda			✓
	Build capacity of Research Teams (qualitative and quantitative) at National and state levels			
	Mobilize resources and strengthen strategic partnerships for OF research			✓
	Support Mobilization of Resources for research activities at State and National levels			✓
	Advocate for the allocation of 2% of OF funds for research by Federal and States			✓
	Promote multidisciplinary, multi-centre national and international OF research			✓
	Promote dissemination of research findings			✓
	Convene biennial meetings for fistula work and research dissemination			✓
	Support conference attendance for presentation of research findings			✓
	Conduct workshops to disseminate research works to stakeholders			✓
	Support the publication of research findings			✓
	Create repository of OF research work in Nigeria			✓
	Promote use of evidence to inform policy and action			✓
	Prepare policy brief and disseminate to stakeholders on OF research findings			✓
	Share research findings during fistula surgeons network meetings			✓
	Monitor use of research findings into practice			✓
Leadership and governance	To provide effective policy leadership and an enabling environment that ensures adequate oversight and accountability for the delivery of quality OF care			✓
	Promote development of OF policy and mobilize resources			✓
	Mainstream OF into National Health Policy, and National Strategic Health Plan			✓
	Develop annual operational plans at federal and state levels from the strategic plan			✓
	Identify champions for OF at National, State and LGA levels			✓
	Conduct advocacy for resource mobilization for OF work and establishment of budget lines for OF at National and states			✓
	Support advocacy for policies on free ANC, skilled attendance at delivery, free fistula treatment services, girl-child education and challenges of early marriages			✓
	Strengthen coordination at all levels and improve performance			✓
	Build capacity of VVF desk officers on programme management and Result Based Management			✓
	Convene biannual coordination meeting of the National OF Technical Working Group			✓
	Convene annual meetings of the fistula practitioners			✓
Monitoring and Evaluation	Strengthen OF monitoring at all levels			✓
	Develop an M & E Plan			✓
	Identify core set of indicators for reporting of OF activities			✓
	Review NHMIS data tools to mainstream OF			✓
	Develop standardized tools for data capture			✓
	Conduct regular analysis of data and report of activities nationally			✓
	Establish computerized national database			✓
	Provide computer for all state VVF desk officers for data compilation and reporting			✓
	Adapt/develop a software for real time data capture			✓
	Set up an OF information repository			✓
	Provide regular maintenance for ICT in all sites			✓
	Strengthen evaluation of OF interventions			✓
	Conduct midterm and end-line evaluation			✓

Table 18: Strategic interventions and key activities to deliver Reproductive and Maternal Health Services

Objective 8: Reduce maternal mortality and morbidity through the provision of timely, safe, appropriate and effective healthcare services before, during and after child birth	
Strategic Interventions	**Key Activities**
Improve access to essential Antenatal and Postnatal Care	Strengthen primary health care facilities to provide essential ANC and PNC services
	Build capacity of health care workers to provide essential ANC and PNC services at all levels
	Remove economic barriers to access (Free MCH/Pre-payment schemes etc.)
Expand coverage of skilled delivery services	Upgrade at least 1 PHC facility per ward to provide skilled delivery services
	Train and retrain skilled birth attendants on life saving skills (LSS and MLSS for CHEWs).
	Strengthen secondary health facilities to support PHCs on current practice on delivery services
Promote advocacy, community Mobilization and Behaviour Change Communication for Safe Motherhood Services	Promote the conduct advocacy to create an enabling environment and support for safe motherhood initiative
	To mobilize and support engagement of CBOs, community structures (WDC, CHIPS etc.) in safe motherhood initiatives at all levels
	Support the development and implementation of BCC interventions at all levels.
	Support the development of a framework for engagement of media in safe motherhood initiatives
Increase access to basic and comprehensive Emergency Obstetric Services	Upgrade at least one PHC per political ward and one General hospital per local government to provide basic and comprehensive Emergency Services (including blood banking and functional operating theatre) respectively
	Support training of skilled birth attendants (e.g. Doctors, Nurses, Midwives, CHEWs) on life saving skills and Emergency Obstetric and New-born Care (EmONC)
	Provide ambulances for emergency transport and communication services for referrals at all levels
	Remove economic barriers to access (Free MCH/Pre-payment schemes etc.)
Improve quality of care for safe motherhood services	Promote and ensure nationwide implementation of the MMT QOC strategy and operational plan and Maternal and Perinatal Death Surveillance Response (MPDSR)
Strengthen referral and feedback mechanisms	Establish/strengthen emergency transport services
	Establish a functional communication system along referral pathway (from community level)
	Develop and implement use of 2 way referrals
Expand access to life saving commodities	Establish system for community distribution of life-saving commodities as appropriate (e.g. misoprostol for prevention of PPH at home births)
	Strengthen the supply chain management for the life- saving commodities
Improve Maternal and Perinatal Death Surveillance and Response	Nationwide scale-up of MPDSR implementation and electronic MPDSR data platform facilities and states in Nigeria.
Objective 9: Strengthen prevention, treatment and rehabilitation services for fistula care in Nigeria	
Strategic Interventions	**Key Activities**
Promote Obstetric Fistula preventive interventions	Increase access to skilled birth attendants and emergency obstetric care services
	Establish use of catheterization in prolonged obstructed labour, including training of health workers in the procedure
	Collaborate with other sectors to address the determinants of obstetrics fistula
Strengthen /expand services for treatment of obstetric fistula	Establish at least one OF treatment centre in the state
	Intensify client mobilization at community level and referral to treatment centres

	Train various categories of health workers in OF management
	Conduct periodic fistula pooled treatment efforts
	Establish a system of sustainable supply of OF treatment commodities
	Monitor quality of treatment of OF patients
Foster community participation for the rehabilitation and re-integration of fistula patients	Develop an OF mitigation and rehabilitation plan
	Integrate counselling into the continuum of OF patient management
	Build capacity of CBOs to conduct OF rehabilitation interventions
	Establish collaboration with NGOs, social workers and other stakeholders/sectors in OF rehabilitation
Objective 10: Promote demand and increase access to sexual and reproductive health services (family planning and post abortion care)	
Strategic Interventions	**Key Activities**
Scale up sexual and reproductive health services	Establish/strengthen and promote uptake of RH cancer screening services (cervical cancer, breast cancer and prostrate)
	Scale up screening and treatment of STIs to PHC level
	Integrate HIV screening into STI management
	Establish gender-based violence counselling and treatment services
Increase demand for Reproductive health services	Develop a RH communication strategy
	Conduct advocacy for enabling legislations, policies and funding for RH (specify specific actions)
	Develop communication materials for BCC
	Conduct BCC interventions at all levels (from community to health facility, etc., including use of media)
Expand access to comprehensive, quality family planning services	Advocate for enabling environment, funding and policy for family planning
	Conduct training of health care providers in comprehensive FP services provision, including LAC
	Establish a sustainable FP commodity supply chain management
	Develop/adapt produce and distribute job aids and IEC materials on FP
Strengthen and integrate Family Planning and Post Abortion Care services at all levels	Provide emergency post-abortion care services in health facilities, including PHC
	Train health care providers in post-abortion care services and FP integration provision
	Provide counselling and family planning services for post-abortion care clients
	Conduct public enlightenment and community engagement interventions
Scale up Prevention, counselling and treatment of rape and other gender based violence such as Rape, intimate partner violence etc.	Conduct public education and community sensitization on HTP and GBV
	Develop training manuals, treatment guidelines and job aids for HTP and GBV
	Train health care providers in the detection and management of GBV and rape/intimate partner violence
	Establish treatment and reporting protocols
	Establish linkages between health care providers, law enforcement agencies, social services etc. for comprehensive service provision for Gender Based Violence
Build capacity of service providers on gender-sensitive respectful & safe service	Mainstream information on gender sensitive respectful and safe care services into all in-services training and pre-service (during reviews) training manuals and documents
	Train health providers on gender norms for them to offer gender sensitive respectful and safe services

Table 19: Package of new-born health care services provided at all levels

Intervention	Community	Primary	Referral
Immediate thermal care	✓	✓	✓
Initiation of exclusive breastfeeding (within 30 mins)	✓	✓	✓
Chlorhexidine gel for cord care	✓	✓	✓
Basic neonatal resuscitation	✓	✓	✓
Advanced neonatal resuscitation			✓
Management of possible severe bacterial infection where referral is infeasible	✓		
Case management of neonatal sepsis, meningitis and pneumonia		✓	✓
Kangaroo mother care for preterm and for less than 2000g babies		✓	✓
Management of children with jaundice		✓	✓
Surfactant to prevent respiratory distress syndrome in preterm babies			✓
Continuous Positive Airway Pressure (CPAP) to manage babies with respiratory distress syndrome			✓
Administration of vitamin K for new-borns		✓	✓
Extra support for feeding small and preterm babies		✓	✓
Presumptive antibiotics therapy for new-borns at risk of bacterial infections			✓
Postnatal visit within 48 hours of birth	✓	✓	✓
Erythromycin ointment for prophylactic eye care		✓	✓
Nevirapine for HIV exposed babies		✓	✓
Long-Lasting Insecticide Net (LLIN) use by households	✓	✓	✓
Home visits	✓	✓	✓
Birth registration	✓	✓	✓

Table 20: Package of child health care services provided at all levels

Intervention	Community	Primary	Referral
Exclusive breastfeeding for 6 months	✓	✓	✓
Continued breastfeeding to 24 months and complementary feeding from 6 months	✓	✓	✓
Prevention of childhood malaria	✓	✓	✓
Long-lasting insecticide net (LLIN) use by households	✓	✓	✓
Amodiaquine plus sulfadoxine-pyrimethamine (AQ+SP) chemoprevention for seasonal malaria chemoprophylaxis in Sahelian States	✓	✓	✓
Rapid Diagnosis Test (RDT) + appropriate antimalarial treatment	✓	✓	✓
Vitamin A supplementation from 6 months of age	✓	✓	✓
Routine childhood immunization	✓	✓	✓
Management of severe acute malnutrition and provision of Ready to Use Therapeutic Food (RUTF)	✓	✓	✓
Case management of childhood pneumonia	✓	✓	✓
Case management of diarrhoea (Low osmolar ORS + Zinc tabs)	✓	✓	✓
Long-Lasting insecticide net (LLIN) use	✓	✓	✓
Comprehensive care of children infected with or exposed to HIV	✓	✓	✓
Nevirapine prophylaxis	✓	✓	✓
PCR at 6weeks	✓	✓	✓
Cotrimoxazole prophylaxis	✓	✓	✓
Antiretrovirals	✓	✓	✓
Deworming	✓	✓	✓
Folate supplementation		✓	✓
Screening for sickle cell disease			✓
Pulse oximetry in pneumonia			✓
Detection and reporting of violence in children	✓	✓	✓
Promotion of handwashing and sanitation	✓	✓	
Prevention and management of home accidents	✓	✓	
Home visits	✓	✓	✓

Table 21: Strategic interventions and key activities to deliver New-born and Child Health Services

Objective 11: Reduce neonatal and childhood mortality and promote optimal growth, protection and development of all new-borns and children under five years of age	
Strategic Interventions	**Key Activities**
Strengthen postnatal and new-born care	Train health care providers in essential and emergency new-born care
	Promote early initiation of breastfeeding including promotion of Hospital Baby Friendly Initiative
	Provide essential new-born care in all delivery service points (thermal care, including kangaroo mother care, hygienic cord care using chlorhexidine, neonatal resuscitation
Strengthen emergency obstetric, new-born and childhood care.	Establish special care baby units for emergency new-born care in LGA general hospitals where CEmOC is being provided
	Develop and implement emergency obstetrics, new-born and child health treatment guidelines and protocols along the different levels of care, from community level, including effective referral systems
Intensify the promotion of exclusive breastfeeding for the first six months of life and appropriate complimentary feeding	Re-introduce Hospital Baby Friendly Initiative (HBFI), so that every maternity home practices the 10 steps to successful breast feeding
	Intensify public education and community engagement/sensitization on EBF
	Develop and distribute IEC materials on EBF
Strengthen routine child immunization including new antigens	Establish State Routine Immunization Coordination Centre
	Conduct advocacy for enabling support and funding for |RI
	Develop and implement MOU on accountability for RI (with all stakeholders, including Private Sector)
	Develop micro plans, using GIS to map out populations/aid immunization micro-planning
	Implement Community Influencers/Promoters and Service (CHIPS) Program for demand creation
	Establish and implement real time reporting of RI data using dashboard
Improve quality of new-born and child healthcare services	Develop/adapt and produce new-born and child health treatment guidelines and protocols for different levels of care
	Strengthen capacity of health care providers and facilities to provide quality new-born care
Promote advocacy, community mobilisation and behavioural change communication for new-born and child healthcare services	Advocate to policy makers and legislators for enabling policies, funding and prioritization of new-born and child health
	Conduct public education and community mobilization/engagement for promotion of and uptake of new-born and child health services
	Develop and distribute new-born and child health communication materials
	Engage and train WDC and community volunteers in community sensitization and education
	Expand neonatal and child healthcare including community risk detection and welfare
Expand coverage of IMCI (Community-IMCI, Community Case Management (ICCM) & IMCI)	Increase the number of facilities and LGAs providing IMCI managing sick children using cIMCI
	Scale-up implementation of Community Case Management of Childhood Illness (IMCI) using national protocols
	Scale up implementation Community IMCI (promotion of key household practices for child survival and development)
	Train health care providers IMCI (case management) and community-based health care providers and CHEWs in cIMCI and CIMCI)

Table 22: Package of adolescent health care services provided at all levels

Intervention	Community	Primary	Referral
Comprehensive sexual and reproductive health education	✓		
HPV immunisation	✓	✓	
Tetanus immunisation	✓	✓	
Screening for HIV and comprehensive HIV treatment for young people living with HIV	✓	✓	✓
Family planning for sexually active adolescents	✓	✓	
Menstrual hygiene promotion	✓	✓	
Prevention and management of sexually transmitted infections	✓	✓	✓
School health services	✓		
School feeding	✓		
Screening for drug use, internet addiction, self-harm, mental health, nutritional disorders, and other leading adolescent health problems	✓		
Intermittent iron and folic acid supplementation for girls, especially pregnant adolescents	✓	✓	
Motivational counselling	✓	✓	✓
Care in pregnancy, childbirth and postpartum period for adolescent mother and new-born infant	✓	✓	✓
Post abortion care		✓	✓

Table 23: Strategic interventions and key activities to deliver Adolescent Health Services

Objective 12: Improve access to adolescent health and young people information and services	
Strategic Interventions	**Key Activities**
Promote demand for adolescent reproductive health services	Intensify advocacy, social mobilization and behaviour change communication for positive adolescent behaviour
	Boy/male involvement in promoting adolescent sexual reproductive health.
	Conduct peer to peer education for in and out of school young people
	Promote sexual and reproductive health services through mass media interventions
	Develop internet based platforms to disseminate information on SRH and linkage to health care workers
	Educate adolescents and young people in SRH and other health related needs using the social media
Expand access to quality adolescent reproductive health services	Implement comprehensive sexual and reproductive health education for in- and out-of- school adolescents
	Provide HPV and TT immunization to adolescent girls
	Provide FP for sexually active adolescents
	Establish youth friendly ARH Centre
	Integrate Adolescent and youth friendly Health services in Primary Health Care Centres
Strengthen prevention, detection, and management of HIV and STIs among adolescents	Improve and strengthen school health programmes/clinics
	Promote access of young people to HIV counselling & testing services
Promote Menstrual hygiene among adolescents	Encourage free distribution of sanitary pads in school
	Improve/promote availability of toilet facilities
Scale-up implementation of adolescent sexual and reproductive health education in the school curriculum	Implement the FLHE school programme in all states of federation
	Introduction of peer to peer education in school
	Training of teachers/whole site orientation of school on Adolescent sexual reproductive health

Scale up screening and management of drug use, internet addiction, self- harm, mental health, nutrition disorders and other leading adolescent health problems	Integrate adolescent nutrition education and counselling services into adolescent health programs for both in-school and out of school youths
	Promote health literacy among youths
	Establish motivational counselling and integrate into adolescent health services
	Develop and distribute Behaviour change communication materials on adolescent health and development
	Integrate adolescent drug addiction into mental health
Promote school health services including deworming by conducting biannual deworming of school age children	Conduct biannual deworming of school age children
	Increase awareness on benefits of deworming

Table 24: Package of nutrition interventions especially for children under five, adolescents, women of reproductive age and the elderly provided at all levels

Intervention	Community	Primary	Referral
Early initiation of breastfeeding within the first 30 minutes of birth	✓	✓	
Exclusive breastfeeding for 6 months	✓	✓	
Continued breastfeeding and complementary feeding from 6 months	✓	✓	
Complimentary feeding from 6 months to 2 years	✓	✓	
Micronutrient powder supplementation	✓	✓	
Management of acute malnutrition	✓	✓	
Baby-Friendly Hospital Initiative (BFHI)	✓	✓	✓
Nutrition for children with persistent diarrhoea	✓	✓	✓
School feeding	✓	✓	✓
Nutrition for children with special needs (e.g. children born to HIV-positive mothers, infants and young children in emergency situations, children with cleft palate and other developmental disabilities	✓	✓	✓
Iron-folic acid supplementation in pregnant women	✓	✓	✓
Nutritional assessment, counselling and support services at all ages	✓	✓	✓

Table 25: Strategic interventions and key activities to deliver Nutrition Health Services

Objective 13: Reduce maternal mortality and morbidity through the provision of timely, safe, appropriate and effective nutritional health services before, during and after child birth	
Strategic Interventions	**Key Activities**
Promote hospital baby friendly initiative	Reactivate the Hospital Baby Friendly Initiative and ensure every maternity practices 10 steps to successful breastfeeding
	Enforce adherence of all health workers to the National Code of Marketing of Breast Milk Substitute
	Conduct biannual deworming of children aged 12 - 59 months
	Conduct nutritional education on consumption of bio-fortified foods
Promote exclusive breastfeeding for the first six months of life	Conduct public enlightenment and community sensitization on importance of EBF
	Train health care providers on EBF
	Establish commemorative activities for promotive EBF
	Advocate for enabling environment for promotion of EBF -- extended maternity leave, crèches at places of work
Scale-up continued breastfeeding and appropriate complementary feeding from six months	Conduct advocacy and social mobilization to address the mandates of relevant stakeholders, up to community level on IYCF
	Create awareness about optimal IYCF at all levels
	Develop and implement a communication and social marketing strategy to address all issues relating to IYCF
	Promote IYCF through events like World Breastfeeding Day, MNCH week etc.

	Encourage local production of appropriate complementary feeds
	Promote adoption of principles of frequency, adequacy, density, utilization and safety of complementary feeds
Expand coverage with micronutrient powder supplementation	Introduce distribution of multi Micronutrient Powder for fortification of home feeds for children aged 6 to 23 months
	Provide biannual doses of Vitamin A for children aged 6 - 59 months, integrate distribution with measles campaign, RI and in CWC
	Provide Zinc supplements as routine constituent of diarrhoea management for children aged 6 - 59 months
Scale-up prevention, detection, control and management of acute malnutrition	Develop and implement social mobilization and communication strategy to increase awareness of CMAM at all levels
	Promote active detection and case management of children with CMAM
	Establish CMAM sites in primary and secondary health facilities to increase access to CMAM services
	Procure and distribute to all primary and secondary health care facilities, essential drugs for the management of malnutrition and nutrition commodities for management of severe acute malnutrition including Ready to Use Therapeutic Foods (RUTF)
Scale up nutrition for children with special nutritional needs including (children born to HIV positive mothers; infants and young children in emergencies with persistent diarrhoea etc.	Adhere to national guidelines in the management of nutritional needs of children in difficult situations
Promote implementation of school feeding programme	Collaborate with Ministry of Education and other relevant agencies to ensure adequacy of national and state school feeding programs
Promote optimal nutrition of adolescents and Women of Reproductive Age (WRA)	Foster Iron and Folic Acid supplementation in pregnant women; and vitamin A supplementation in lactating women.
	Integrate provision of iron, folic acid and vitamin A supplementation into ANC package and vitamin A for lactating mothers --- Link to ANC
Promote healthy diets for the elderly	Establish nutritional needs of the elderly
	Develop and implement guidelines on healthy nutrition for the elderly
	Conduct public enlightenment and community sensitization on nutritional needs of the elderly
	Promote community support and community-based interventions for improved nutrition for elderly persons

Priority Area 5 – Communicable Diseases (Malaria, TB, Leprosy) and Neglected Tropical Diseases (NTDs)

GOAL: To improve prevention, case detection and coordinated response for the prevention, control and management of communicable diseases and NTDs

Table 26: Strategic Objectives and Key Results for Communicable Diseases and NTDs

Strategic Objective	Indicator	Target
Significantly reduce morbidity and mortality due to malaria and move towards pre-elimination levels	% of care seeking persons with suspected malaria that are tested using mRDT or microscopy	80%
	% of all individuals with confirmed malaria seen in private or public facilities who are treated with effective anti-malarial drugs	80%
	% reduction in prevalence of malaria among pregnant women and children	80%
	% of quality artemisinin-based combination therapy (ACT) locally produced	60%
	Stock out rate of diagnostic kits and ACTs lasting more than one week in the past three months	<10%
Ensure universal access to high quality, client-centred TB/Leprosy diagnosis and treatment services for the reduction in the incidence and prevalence of Tuberculosis/Leprosy in Nigeria.	% reduction in TB prevalence rate	60%
	% reduction in TB deaths	50%
	Case notification rate of all forms of TB	27
	Case detection rate of all forms of TB	70%
	Access to high-quality integrated services for all people co-infected with tuberculosis and HIV	100%
	Access to diagnosis and treatment of multi-drug resistant tuberculosis	100%
	Access to diagnosis and treatment of paucibacillary and multi-bacillary leprosy	100%
	Leprosy cure rate	70%
Significantly reduce the incidence and prevalence of HIV/AIDS	% reduction in incidence of HIV infections among the key and general populations	70%
	% of the general population who know their HIV status	90%
	Mother-to-child transmission of HIV	0
	% of PLHIV receiving quality HIV treatment services	90%
	% of those on PLHIV receiving ART who achieve sustained virological suppression	90%
	% of PLHIV, vulnerable children, and PABA who have access to comprehensive rights-based care	100%
Reduce the incidence, morbidity and mortality due to viral hepatitis.	% of persons infected with hepatitis B and C who are aware of their infection status	50%
	% reduction in prevalence of vaccine-preventable viral hepatitis reduced	50%
	% reduction in prevalence of viral hepatitis	50%
	% of all persons eligible for hepatitis B treatment receiving treatment	50%
Reduce morbidity, disability and mortality due to targeted Neglected Tropical Diseases (NTDs) and improve quality of life of those affected.	% of States implementing integrated vector management for targeted NTDs	70%
	% increase in proportion of school-aged children regularly dewormed	50%
	Coverage with preventive chemotherapy for selected tropical diseases	50%
	% reduction in prevalence of targeted NTDs	60%
Reduce morbidity and mortality from snake bites in Nigeria	% reduction in case fatality rate from snake bites	50%
	% reduction in the incidence of snakebites	50%

The key elements of the Communicable Diseases and NTD packages of services and strategic interventions to deliver them are summarised in the following tables. Full details to guide service delivery are provided in the relevant programmatic strategic plans and policy documents.

Table 27: Package of services for key communicable diseases and NTDs at all levels

Malaria	**Community**	**Primary**	**Referral**
Long lasting Insecticide treated nets for pregnant women and children aged less than 5 years	✓	✓	
Indoor Residual Spraying	✓		
Intermittent Preventive Therapy for pregnant women	✓	✓	
Seasonal chemoprevention with SP for under-fives in 9 Sahel States	✓	✓	
Parasitological diagnosis of malaria (RDT or microscopy)	✓	✓	✓
Treatment of uncomplicated malaria with ACT	✓	✓	✓
Treatment of Complicated malaria			✓
Hepatitis	**Community**	**Primary**	**Referral**
Immunization of infants and high risk groups (health workers, commercial sex workers and their clients, IDU, MSM, all ANC hepatitis negative clients TBAs, Barbers etc.)		✓	✓
Screening and diagnosis of chronic Hepatitis infection	✓	✓	✓
Treatment of chronic progressive Hepatitis C infection (with interferon or Lamuvidine (3TC)/Tenofovir (TDF)/Emtricitabine(FTC)			✓
Tuberculosis/Leprosy	**Community**	**Primary**	**Referral**
Tuberculosis case detection	✓	✓	
Microscopic diagnosis of TB	✓	✓	✓
Integrating TB screening and diagnosis in HIV interventions		✓	✓
Diagnosis (with GeneXpert) and treatment of MDR-TB			✓
Diagnosis of Leprosy (microscopy)		✓	✓
Treatment of Leprosy with Multidrug therapy (MDT)		✓	✓
Management of Leprosy complications and rehabilitation	✓	✓	✓
HIV and AIDS	**Community**	**Primary**	**Referral**
Provision of HIV testing and counselling services including RDT for personal testing	✓	✓	✓
Distribution of condoms (male and female) and microbicides	✓	✓	
Prevention of mother-to-child transmission services	✓	✓	✓
Early infant diagnosis		✓	✓
Chemoprophylaxis for HIV positive persons (cotrimoxazole)		✓	✓
Monitoring treatment (CD4)			✓
Treatment of all HIV positive people with HAART		✓	✓
Treatment of opportunistic infection	✓	✓	✓
Home-based care	✓		
Support groups for PLHIV	✓	✓	
Neglected Tropical Diseases	**Community**	**Primary**	**Referral**
Integrated vector control	✓	✓	
Periodic mass/targeted Preventive chemotherapy			
Albendazole for soil transmitted helminths	✓	✓	
Praziquantel for schistosomiasis	✓	✓	
Ivermectin or diethycarbamicide for lymphatic filariasis	✓	✓	
Ivermectin for onchocerciasis	✓	✓	
Topical antibiotics (tetracycline) for trachoma	✓	✓	
Case management		✓	✓
Water and Sanitation (WASH) interventions	✓	✓	
Rabies post exposure vaccination		✓	✓

Table 28: Strategic interventions and key activities to deliver services for key communicable diseases and NTDs

Objective 14: Reduce significantly morbidity and mortality due to Malaria and move towards pre-elimination levels	
Strategic Interventions	**Key Activities**
Expand access to integrated vector control interventions	Expand coverage of households with at least two LLINs through universal access and keep-up strategy through continuous and mass free distribution by LGAs
	Monitor distribution and use of LLINs
	Conduct mapping and geographic reconnaissance of areas to benefit from Indoor Residual Spraying (IRS) especially in areas of poor LLINs use and high prevalence
	Conduct baseline entomological survey and selection of insecticides from WHOPES list and approved by NAFDAC
	Build Capacity for IRS and LSM
Strengthen laboratory services for diagnosis of malaria at all levels	Deploy RDT and or microscopy for malaria diagnosis to public and private facilities
	Deploy RDT at community level
	Implement guideline for the use of RDTs and microscopy for malaria diagnosis
Build capacity of personnel in public and private health facilities for parasitological confirmation of malaria.	Develop guidelines and tools for quality control of parasitological confirmation of malaria diagnosis
	Standardise /harmonise malaria RDT and or microscopy training manuals
	Train and retrain Health workers in RDT or microscopy, in both public and private facilities and at community level (PMVs and CBW in RDT)
	Develop innovative and cost effective capacity building of health workers in laboratory diagnosis of malaria
Promote the local production of quality artemisinin-based combination therapy (ACT) to make antimalarial drugs widely affordable	Promote domestic production of Artemisia plant among stakeholders who are farmers.
	Promote partnerships between local producers of the plant and domestic manufacturers for manufacture of ACTs using local products
	Establish mechanisms for quality assurance, pharmacovigilance and necessary coding in line with existing regulations
	Establish partnerships with pharmaceutical companies to promote local production of ACT
Improve availability of and access to commodities and supplies for treatment of uncomplicated and severe malaria	Strengthen system for quantification and procurement of anti- malaria drugs and commodities as part of integrated logistics supply chain management (see Priority Area on Medicines, Vaccines and Health Technologies)
	Engage with the private sector (Pharmaceutical companies) in appropriate packaging and pricing of ACT
	Expand use of IPTp among pregnant women attending ANC
Strengthen systems for quality assurance and quality control of malaria diagnosis and treatment.	Develop/adapt guidelines and tools for quality control of parasitological confirmation of malaria
	Conduct training of Q&A/QC teams
	Strengthen/establish existing National and state Malaria QA/QC centres
	Conduct supervision of Malaria QA/QC teams
Promote active community participation in malaria control initiative	Conduct public enlightenment and sensitization for malaria control initiative
	Build capacity and support ward development committee to mobilize communities for malaria control initiatives, prevention and control
	Train community volunteers including CHIPS for malaria prevention activities
	Train and support community based workers for diagnosis and treatment of malaria under community case management of childhood illnesses

Objective 15: Ensure universal access to high quality, client-centred TB/Leprosy diagnosis and treatment services for the reduction in the incidence and prevalence of Tuberculosis/Leprosy	
Strategic Interventions	**Key Activities**
Strengthen TB case detection, diagnostic capacity and access to quality treatment services.	Expand access to TB diagnostic and treatment services expanding services to all PHCs and private care providers, promoting active case detection
	Integrate TB screening and referral/case-finding into the routine activities of non-TB public and private healthcare service providers including providers at community level to increase case detection and notification
	Introduce active case-finding in key high-risk populations (e.g. PLHIV, prisoners, slum dwellers etc.)
	Build capacity of health care workers in TB diagnosis and management, including DR TB
Promote demand for TB services	Create awareness by mobilising and sensitizing communities on information and location of TB services
	Organise advocacy and sensitization meeting with religion and community leaders
Expand access to TB diagnosis and treatment services for persons co-infected by TB and HIV	Integrate TB diagnosis and treatment into HIV services and vice versa
	Build capacity of health workers to deliver integrated TB/HIV integrated services
	Increase TB case detection among PLWHA, including children through universal implementation of TB screening tools in HIV sites and in community-based care
	Expand HIV counselling and testing services to all people with TB symptoms and disease.
Scale up paediatric TB diagnosis and treatment services	Integrate TB services into child health services (IMCI, CWC etc.)
	Strengthen and scale up capacity to diagnosis TB in children though training of health workers and laboratory strengthening
	Strengthen referral system from PHC facilities to higher levels of care
Increase access to diagnosis and management services for DR-TB	Strategically expand drug resistant TB diagnostic sites
	Institute a standardized TB specimen transport system from the point of collection from the presumptive drug-resistant TB case to drug resistant diagnostic centres
	Train health workers in the detection and management of DR-TB
	Strengthen the DR-TB surveillance system
Strengthen collaboration with and capacity of CBOs to support TB programming.	Build on the existing community system strengthening for AIDS, TB and Malaria (ATM) activities to coordinate activities of CBOs engaged in TB control
	Build capacity of CBOs to provide support for TB control activities
	Strengthen capacities of communities to plan, monitor and implement TB control activities
Strengthen mechanism for coordination of TB/HIV collaborative activities at all levels of health care.	Conduct quarterly meetings of TB/HIV groups
	Conduct regular coordinating meetings of TB and HIV stakeholders at all levels
Promote innovative advocacy, social mobilization and behaviour change intervention for the prevention and control of TB	Development of advocacy tool kits with State-specific data
	Sensitization on TB using the mass media (print, electronic and social handles)
	Engage former TB patient who can lead education around TB treatment, addressing myth and misconception around TB
Expand and improve access to quality Leprosy and TB Services	Develop and disseminate IEC materials to increase access to information on Leprosy to patients, their family and the community
	Integrate TB/Leprosy services into the general health care services, including PHC
	Provide high quality and adequate stock of MDT drugs and commodities for leprosy
	Conduct training of health workers for prevention and treatment of Leprosy

Build capacity of all cadres of health staff (GHW, Physicians, and specialist) and community members on Leprosy case finding and case management	Revise/develop training curriculum for the prevention and management of Leprosy
	Integrate Leprosy training into pre-service training programmes of health workers
	Conduct in-service training of various cadres of health care providers on leprosy prevention and control, including case detection
	Conduct training of community volunteers on case detection and referral of leprosy patients
Integrate Leprosy control into the general health services	Develop of SOPs for management of leprosy
	Train general health care workers in the management of leprosy
	Integrate leprosy detection and management into PHC services
Promote community based TB/Leprosy control initiatives	Train community structures (WDCs, CHIPS, CBOs) in leprosy case detection, referral and rehabilitation
	Conduct community sensitization and education for the early detection and referral of leprosy cases
Strengthen physical and socio-economic rehabilitation for leprosy	Establish/strengthen leprosy rehabilitation hospitals and centres
Objective 16: Significantly reduce the incidence and prevalence of HIV/AIDS in Nigeria by 2022	
Strategic Interventions	**Key Activities**
Expand access to Minimum Package of Preventive Interventions (MPPI) for HIV targeting key and general populations	Adopt the national MPPI Package and protocols and/develop a plan for MPPI implementation in the state
	Build capacity and support community structures (CBOs, Ward Development Committees, community volunteers) for provision of equitable HIV prevention interventions and addressing the structural determinants of HIV
	Develop and implement preventive interventions using the MPPI approach (BCC, condom programming, Peer education, screening and treatment of STIs, HTC, PMTCT etc.) for general, key and vulnerable populations
	Increase one stop shop (OSS) to promote access to HIV prevention services
Expand access of people living with HIV and AIDS to ART and co-infection management services.	Establish referral linkages between HIV testing services and ART services
	Revise, produce and disseminate HIV/AIDS treatment protocols and job aids
	Strengthen the implementation of the test and treat programme at all ART sites.
	Build capacity of health care workers and community structures (CBOs, Community-based health workers) for treatment and provision of home-based care respectively
	Develop/implement policy of task shifting for treatment of HIV
	Expand laboratory capacity to monitor treatment
Promote universal access to quality PMTCT services	Integrate and strengthen referral and linkages between antenatal care, family planning, sexual and reproductive health services, maternal and child health and HIV services
	Decentralize PMTCT services to primary health care level
	Strengthen logistics supply system for sustainable supply of drugs and commodities for PMTCT services
	Strengthen Early Infant Diagnosis (EID) services and access to prophylactic antiretrovirals and cotrimoxazole for all HIV exposed new-borns
	Strengthen supportive supervision for ePMTCT services
Strengthen referral and linkages between HIV/AIDS services and other health and social services	Provision of smooth referral system both intra-facility and extra-facility flow
	Develop escort services for facilitated referral
	Provision of referral tools
Improve access to safe blood and blood products	Implement National policies and guidelines as it relates to blood donor mobilization, storage, collection and use

	Improve blood drive campaign to mobilize voluntary and non-remunerated blood donors.
	Strengthen tertiary and secondary public and private health facilities to provide safe blood and blood products.
	Promote injection safety and health care waste management practices
Strengthen community systems to support HIV/AIDS programming for key and general populations	Creation of platform for the engagement of facility and community-based HIV and AIDS support group
	Strengthen Public and Private health facilities to provide community base referral system
	Strengthen relationship with Traditional birth attendance in the community towards the provision of PMTCT services
Improve the logistics and supply chain management for all HIVAIDS-related drugs and commodities.	Strengthen and support commodity supplies and logistics system for sustainable supply of ART, test kits etc., ensuring integration into the integrated commodity supplies logistic system
Promote HIV/AIDS research for improved evidence-based response	Develop a HIV/AIDS research agenda at all levels
	Mobilize resources for research
	Implement the research agenda
Strengthen advocacy, legislation, social mobilization and behaviour change communication for improved HIV response	Develop and implement a comprehensive HIV/AIDS communication strategy (advocacy, BCC, social mobilization) across all levels
	Engage the media in the HIV/AIDS response
Objective 17: Reduce the incidence, morbidity and mortality due to viral hepatitis	
Strategic Interventions	**Key Activities**
Strengthen advocacy, social mobilization and behaviour change communication on viral hepatitis	Develop and implement a comprehensive hepatitis communication strategy (advocacy, BCC, social mobilization) across all levels
	Engage the media in the hepatitis response
	Conduct health worker sensitization on viral hepatitis
Expand access of key and general populations to viral hepatitis prevention, screening and treatment services	Develop/adopt and produce national guidelines on the prevention and control of viral hepatitis
	Develop and implement preventive interventions (safe injection practices, harm reduction strategies for IDUs, universal precautions etc.)
	Conduct regular screening of high risk population and provide hepatitis vaccines as appropriate
	Establish screening programmes for viral hepatitis for the general and high risk populations
Scale-up interventions for the prevention of iatrogenic transmission of viral Hepatitis	Develop guidelines/adapt for the prevention of hepatitis in health care settings
	Implement blood safety strategies, including blood supplies based on voluntary non-remunerated blood donations, effective public education on blood donation, donor selection, and provision of quality assured screening of blood and blood products for transfusion
	Implement infection control and safe injection practices in health care and community settings
	Establish routine screening of health care workers for hepatitis and provide hepatitis vaccination
Expand coverage of interventions for prevention of mother-to-child transmission of viral hepatitis	Screen all pregnant women for HBV
	Provide ARV (tenofovir) prophylaxis for HBV positive women from 28 weeks of pregnancy
	Integrate hepatitis immunization into maternity care and immunize all children with first dose of HBV vaccine within 24 hours of delivery; additionally give HBV exposed infants Hepatitis immunoglobulin
Strengthen HBV vaccination for adult populations, especially those at occupational risk	Implement hepatitis vaccination for the general population of hepatitis negative individuals, prioritizing health workers
Promote universal coverage of HBV vaccination at birth and other doses according to national schedule	Strengthen provision of routine immunization services (HBV already in schedule)
Expand access and delivery of hepatitis prevention, care and	Build capacity of health care workers on hepatitis prevention and management

treatment services in health care facilities and closed settings	Develop, produce and disseminate hepatitis prevention and treatment guidelines and job aids
	Scale up Hepatitis care and treatment services to all secondary health facilities in the State
	Strengthen referrals and linkages for those screened positive to treatment centres
Objective 18: Reduce morbidity, disability and mortality due to targeted Neglected Tropical Diseases (NTDs) and improve quality of life of those affected.	
Strategic Interventions	**Key Activities**
Strengthen advocacy, social mobilization and behaviour change communication for NTDs	Develop and implement a comprehensive NTDs communication strategy (advocacy, BCC, social mobilization) across all levels
	Engage the media in NTD prevention and control education interventions
Scale up delivery of integrated preventive chemotherapy packages and other packages.	Develop/adopt, produce and disseminate guidelines for NTD preventive chemotherapy
	Integrate NTD into service delivery in health facilities, relevant social services (e.g. water and sanitation,) education and local government
	Develop and implement plan for integrated mass campaign (CDTI) for NTDs depending on epidemiology (Lymphatic filariasis, Onchocerciasis, Schistosomiasis - twice a year, and Trachoma - once a year and school-based campaign for schistosomiasis and intestinal helminthic infestations)
	Train personnel (health personnel, teachers, community volunteers, social mobilizers) for service delivery
	Establish/scale up community treatment sites for NCD
Strengthen integrated vector control and environmental management for targeted NTDs.	Promote the distribution and use of ITNs (diseases to be covered - Malaria, Dengue fever, Filariasis, Leishmaniasis) in collaboration with Malaria Control Programme
	Scale-up Indoor Residual Spraying
	Promote collaboration with Ministry of Water Resources and Sanitation (WATSAN) to access potable water and sanitary sewage disposal in schools and communities
	Integrate NTD prevention and control into other relevant health programmes
Increase access to integrated case management for NTDs (Buruli Ulcer, Leishmaniasis, Trypanosomiasis, Loasis, Schistosomiasis, Zoonosis , soil-transmitted helminthic infections, onchocerciasis, filariasis)	Integrate case-management-based diseases interventions, especially for leprosy, Guinea worm disease, HAT, Buruli Ulcer and endemic Loasis, Leishmaniasis and human Rabies prevention into health care services at community and PHC levels
	Strengthen the procurement and distribution system of relevant chemotherapeutic drugs and equipment to all health facilities and communities for the management of NTDs
	Develop and distribute prevention, treatment and control guidelines
	Establish system for supervising services provision, including services being provided In schools and communities
Strengthen capacity for NTD programming and implementation.	Build capacity of program managers and service providers at all levels in NTD programming and service provision, monitoring and evaluation
	Build capacity of CBOs, other stakeholders and community structures/persons involved in the NTD interventions in programming, self-monitoring and reporting
Strengthen the integration and linkages of NTD programme and financial plans into sector-wide and national budgetary and financing mechanisms.	Sensitize FMOH Policy Makers on strengthening linkages & enhancing integration with other divisions & departments.
	Visit Line Ministries & Agencies to buy into the NTD Master Plan
	Hold Meeting with Other Community-Based Programmes
	Engagement and sensitization of Joint Military Task force, Red Cross, Local community vigilante and emergency rescue committee
	Develop structures in the non-Community Directed Intervention (CDI) State and LGAs for scale up
Strengthen and foster partnerships and inter-sectoral collaboration at all levels.	Establish collaborative platforms with relevant IPs, sectors, NGOs, CBOs and community structures for harmonization and alignment of effort in NTD programming and implementation

Promote research on NTDs for evidence-based response	Develop appropriate NTD epidemiological, bio-medical, clinical, entomological, socio-cultural research agenda for the state
	Mobilize resources and implement the research agenda
Objective 19: Reduce morbidity and mortality from snake bites in Nigeria	
Strategic Interventions	**Key Activities**
Promote the development and the implementation of policies, plans, legislations and regulations for the reduction of snake bites in Nigeria.	Scale up sustainable supply of anti-snake venom in Nigeria, including local production
	Build capacity of health care workers on snakebite management at all levels.
	Promote partnerships for national snakebite response
	Scale up generation of local evidence to inform more responsive snakebite programming
	Promote snakebite prevention and control interventions.

Priority Area 6 – Non-Communicable Diseases (NCDs), Elderly, Mental, Oral and Eye health care

GOAL: To reduce the burden of morbidity, mortality and disability due to non-communicable diseases

Table 29: Key Results for NCDs, Mental, Oral and Eye health care

Strategic Objective	Indicator	Target
Reduce morbidity and mortality due to NCDs (Cancers, Cardiovascular Diseases, Chronic Obstructive Airway Diseases, Diabetes and Sickle Cell Disease)	% reduction in overall mortality from NCDs	20%
	Prevalence rate of tobacco use among adults	3.9%
Promote the health and wellbeing of the elderly in Nigeria	% of the elderly people accessing basic and long term care	50%
	% of the elderly people benefiting from financial support schemes to meet their health care needs	40%
Improve the mental health and psychosocial wellbeing of Nigerian populace by reducing prevalence of serious, moderate and mild mental illnesses and substance use disorders.	% reduction in incidence of mental illnesses	20%
	% increase in coverage of mental health care services including substance use	60%
	% increase in social welfare support to persons with established serious mental Illnesses and substance use	40%
Promote optimal oral health in Nigeria	% reduction in prevalence of oral diseases	40%
	Oral health awareness	70%
	% of PHCs providing basic package of oral care	60%
Eliminate avoidable blindness, and reduce the burden of various visual impairment conditions	Access to eye treatment and rehabilitative services by people with blindness and visual impairment	70%
	% of health facilities with capacity to deliver appropriate quality eye care services	30%
	% reduction in prevalence of avoidable visual impairment	25%

The key elements of the NCDs packages of services and strategic interventions to deliver them are summarised in the following table. Full details to guide service delivery are provided in relevant programmatic strategic plans, guidelines and treatment protocols.

Table 30: Package of key NCDs, Elderly, Mental, Oral and Eye health care at all levels

Cardiovascular diseases	Community	Primary	Referral
Screening and treatment of hypertension	✓	✓	✓
Nutritional assessment (including BMI for overweight and obesity assessment, lipid profile), counselling and support services	✓	✓	
Health promotion (nutrition education, exercise and smoking control)	✓	✓	
Lipid profiling		✓	✓
Diagnosis (X-rays, ECG, MRI, etc.) and management of CVD		✓	✓
Rehabilitation and long-term care	✓	✓	✓
Diabetes	**Community**	**Primary**	**Referral**
Screening for diabetes (routine sugar testing) and risk factors	✓	✓	✓
Nutritional assessment (including BMI and MAC), counselling and support services	✓	✓	✓
Health promotion (e.g. exercise promotion and smoking control education)	✓	✓	✓
Diagnosis and management of diabetes		✓	✓
Management of diabetic complications and rehabilitation	✓	✓	✓
Cancers	**Community**	**Primary**	**Referral**
Health education on lifestyle modification for all cancers	✓	✓	
Radio, chemotherapy and surgical cancer services for all cancers		✓	✓
Cancer of the Cervix			
Human Papilloma Vaccine for cervical cancer		✓	
PAP smears for pre-cervix cancer screening		✓	✓
Diagnosis and treatment services			✓
Annual Prostrate cancer screening (PSA)		✓	✓
Cancer of the breast			
Breast self-examination	✓		
Clinical breast examination		✓	✓
Mammography to screen for breast cancer			✓
Treatment of breast cancer			✓
Cancer of the liver			
HBV vaccination		✓	
Diagnosis and treatment services			✓
Cancer of the prostate			
Screening using PSA			✓
Diagnosis of cancer of the prostate			
Treatment of cancer of the prostate			✓
Sickle Cell Disease	**Community**	**Primary**	**Referral**
Genetic counselling for general population	✓	✓	
Genotype profiling		✓	✓
Haematinic supplements and malaria prophylaxis		✓	✓
Diagnosis and management of SCD complications			✓
Care of the Elderly	**Community**	**Primary**	**Referral**
Health promotion activities for elderly	✓		
Home-based care and support services	✓		
Annual medical check-ups (screen for nutritional and chronic diseases, CA prostate, breast, colon and appropriate referrals)		✓	✓
Nutrient supplements (e.g. calcium)		✓	
In-patient treatment services			✓
Long term care (old people's home)			✓
Mental Health (Including substance abuse)	**Community**	**Primary**	**Referral**
Health education and promotion on mental health	✓	✓	
Promote mental health literacy (in collaboration with other sectors)	✓	✓	
Provide community-based youth mental health care services that combines mental health, alcohol and other substances	✓		
Community-based mental health care services by lay workers	✓		
Provision of primary mental health care services - identifying mental illness, provision of basic medication and psychosocial interventions,		✓	

educating families on mental health issues, referrals to specialist mental health services			
Rehabilitative services for drug and substance abuse addicts	✓		✓
Psychiatric treatment services in general hospitals			✓
Provision of long stay facilities and specialist psychiatric services			✓
Oral Health	**Community**	**Primary**	**Referral**
Oral health education and promotion (proper dental hygiene, nutrition and diet education, alcohol and tobacco reduction etc.)	✓	✓	
Regular dental check-up		✓	✓
Preventive dental services (e.g. scaling, polishing of teeth, preventive restorations and use of pit and fissure sealants for dental caries)			✓
Restorative and orthodontic treatment			✓
Diagnosis and treatment of dental diseases		✓	✓
Eye Health	**Community**	**Primary**	**Referral**
Health education on eye health promotion and disease prevention	✓	✓	
Screen for eye diseases (visual defects, blindness etc.)	✓	✓	✓
Diagnosis and provision of basic eye treatment services & referrals	✓	✓	✓
Medical and surgical management of eye problems in general and specialist centres			✓
Rehabilitative care for persons with eye disabilities	✓	✓	✓

Table 31: Strategic interventions and key activities to deliver NCD, Elderly, Mental, Oral and Eye health care

Objective 20: Reduce morbidity and mortality due to NCDs	
Strategic Interventions	**Key Activities**
Promote generation of evidence for decision-making for planning and implementation of NCD interventions	Establish a multi-sectoral national task force with representation from relevant stakeholders for NCDs prevention and control
	Conduct a National survey of all NCDs for generation of baseline data for evidence-based policy formulation and management.
	Adopt the multisectoral community based health planning services system as the National model for Community Health Care in collaboration with National Primary Health Care Development Agency (NPHCDA), State Ministry of Health (SMOH), Local Government Health Department (LGHD) and communities to integrate NCDs control into Primary Health Care (PHC) services with community plans according to local need with a view to ensuring community ownership
	Maintain a database for NCDs including integrated disease surveillance and response (IDSR)
	Establish NCD registries in at least one state in each of the 6 geopolitical zones
Intensify advocacy, legislation, social mobilization and behaviour change communication for NCD prevention and control	Develop, enact and implement relevant legislation that promote prevention and control of NCDs.
	Develop and implement a communication strategy (BCC, advocacy and social mobilization) to address all issues relating to NCDs at all levels
	Comprehensively implement the WHO Framework Convention on Tobacco Control (FCTC) and its protocols and guidelines
Promote healthy lifestyles and behaviours for the prevention of NCDs	Implement public awareness programmes to promote healthy lifestyles
	Implement policies, plans, standards and guidelines that promote physical activity and the production and consumption of healthy diets
	Establish programmes to address NCD risk factors such as physical inactivity, unhealthy diet, tobacco use and harmful use of alcohol
Expand access (geographic and financial etc.) to NCD prevention, screening, control and treatment services	Scale-up and integrate NCD prevention, screening and treatment services at all levels of the health care system
	Establish a system for sustainable supply of essential medicines and technologies consumables at all levels
	Provide a budgetary line and allocate adequate resources to support NCDs prevention and control
	Integrate NCD services into NHIS/SHIS benefit package

Improve the quality of life of those affected by NCDs	Build Capacity of health workers at all levels of care on integrated management of essential NCDs
	Update the national essential medicines list to include cost-effective and efficacious medicines for managing NCDs
Build capacity of health care providers, especially at lower levels (PHC) in prevention and screening for NCDs	Build capacity of primary health care workers to be able to implement NCD prevention and control according to National Guideline including piloting and scaling up of WHO PEN plus SCD
	Develop and disseminate guidelines and SOPs for the management of NCDs
	Periodically review and update Community Health Workers' Standing Orders to include current trends in the management of major NCDs
Promote demand for NCD services	Implement public awareness programmes to promote healthy lifestyles
Objective 21: Promote the health and wellbeing of the elderly in Nigeria	
Strategic Interventions	**Key Activities**
Promote generation of evidence for planning, implementation and monitoring of geriatric services	Conduct baseline survey on the on the needs of the elderly
	Establish a database and information system on the health of the elderly
	Develop appropriate policy and strategic plan at all levels of the health delivery services on the health of the elderly
Promote enabling policy environment for programming for the elderly	Review legal and policy constraints for the care of the elderly and advocate for necessary revision (e.g. employment and life-long learning, that discriminate directly or indirectly and prevent older people's participation in and access to benefits that would address their needs and right)
	In collaboration with all relevant stakeholders national and state level, develop strategic and operational plans to foster Healthy Ageing
Scale-up appropriate health services for the promotion of health and care of the elderly at all levels	Develop and implement an elderly persons' minimum care package to include nutrition, recreational activities, vaccination, old people's home
	Develop age friendly environments and health services e.g. Assistive technologies to help them maintain maximum control over their lives despite declining capacity
	Establish various models of comprehensive care services for the elderly based on needs e.g. Home and community- based healthy nutrition and social support care services, day-care services and long term care facilities.
	Support the formation of organizations and support groups of the elderly
Build human resource capacity for the care and support of elderly at all levels of the health care system	Build capacity of social and health care workers on integrated management of care of the elderly at all levels
	Design and implement a programme for production of critical mass of HRH for care of the elderly
Strengthen Behaviour Change Communication (BCC) and Social Mobilization interventions for the elderly	Develop/adapt and implement a communication strategy for the elderly
	Engage the media in promoting care of the elderly
Promote community participation and partnerships for sustainability of health programmes for the elderly	Identify, build capacity and support NGO/CBOs and community structures for engagement in care of the elderly
	Promote various PPP models for care of the elderly
	Establish elderly persons' recreational centres for psycho-social health promotion
Objective 22: To improve the mental health and psychosocial wellbeing of Nigerian populace by reducing prevalence of serious, moderate and mild mental illnesses and substance use disorders.	
Strategic Interventions	**Key Activities**
Promote legal framework for mental health practice and services in Nigeria;	Develop and implement laws to reduce stigma and discrimination of persons with neurological and mental health, sustained financial support, and restriction of access to substance abuse
Strengthen the generation of evidence for planning and programming	Develop and M&E system for collection and management of data on mental health including a survey of persons affected by mental illness disaggregating the population by diagnosis and gender
	Develop mental health strategic and operation plans, guidelines, tools and job aids
	Define mental health research gaps and conduct researches to respond to the gaps

Scale-up provision of comprehensive, integrated and responsive mental health services particularly, in primary health care and community-based settings	Provide mental health services across all levels including PHC
	Strengthen specialized mental hospitals as well as tertiary and secondary hospitals to manage substances use dependence and serious mental illnesses.
	Provide and expand functional drug/substance and alcohol treatment and rehabilitation centres
	Collaborate with the NHIS/SHIS/Contributory schemes to explore inclusion of mental health into the benefit package of social health insurance scheme.
	Develop and implement community models of mental health care using the Aro model
Expand access to psychosocial support services as component of mental health services in communities	Establish community level psychosocial support services, especially during public health and other health emergencies (e.g. rape, GBV)
Strengthen interventions for mental health prevention and promotion at all levels;	Develop and implement communication packages aimed at community education and BCC for prevention of life styles and behaviours that increase risk of mental health
	Enforce laws and policies that limit access to substances (e.g. drugs, alcohol, codeine-based cough syrup etc.) that increase risk to mental health
	Promote the development of youth clubs and youth friendly centres
	Provide recreational facilities, especially in urban areas
Strengthen coordination mechanism for mental health service delivery at all levels	Establish mental health units at SMOH and hospitals
	Create a platform to promote coordination of partners and other sectors involved in mental health services provision
Promote advocacy for improved financing for mental health	Conduct resource mobilization for mental health care, targeting private sector, development partners, philanthropists and communities
Strengthen the supply chain system for the sustainable supply of mental health drugs and commodities at all levels	Integrate mental health drugs and commodities into the logistics supply management system at all levels
Build capacity of health care providers for mental health service delivery at all levels	Develop needs-based training plan and curricula for various cadre of mental health care providers
	Conduct capacity building for non-specialists to manage mild and moderate mental illnesses and substances use disorders in-specialist/ non-specialized mental health settings
	Conduct capacity building for specialists , and also non-specialists to manage severe and mild / moderate mental illnesses respectively, including substances use disorders in non-specialized mental health settings;
	Design multi-level training programmes to empower all members of the society on coping with mental health patients in different settings - the workplace, school, on the streets, etc. adapting modules in violence control, parenting training, self-control, mentoring, marriage counselling.
Objective 23: Promote optimal oral health in Nigeria	
Strategic Interventions	**Key Activities**
Scale-up BCC for oral health promotion, disease prevention and early care seeking for oral diseases	Develop and implement an oral health prevention and promotion strategy
	Develop and distribute IEC materials for oral health awareness creation among the general population
	Integrate oral health education into school curricula
	Integrate oral health education into health education activities at PHC level
Expand access to oral health care services by integrating oral health into the mainstream of service delivery at all levels of the health care system	Develop/adapt norms and standards for oral health at different levels of the health care system
	Integrate oral health care at all levels of the health care system, from primary level in line with defined norms and standards
	Strengthen the capacity of the health facilities to provide dental care services as appropriate for the level of care (dental clinic from level of general hospital with at least one dental unit per LGA)
	Establish/strengthen oral health referral centres
	Develop/adapt and implement a needs-based training programme for oral health

Strengthen capacity of health workers at all levels to deliver oral health care services	Establish/strengthen schools of dentistry in an equitable manner across the country
	Secure more equitable distribution of Oral health professions throughout the country
	Train CHEWS and JCHEWs for early diagnosis of oral diseases and provision of the basic package of oral care at the PHCs
Promote oral health focused research and information system in order to ensure that oral health policies, decisions and practice are evidence based;	Develop a national oral health research agenda
	Collaborate with relevant departments in universities (e.g. Chemistry Departments) , Raw Materials Research Council and other relevant agencies to conduct research for developing dental materials locally
	Create a National Oral Health Database and strengthen monitoring and evaluation
Promote regulations, policies, and legislation that address oral health	Establish/Strengthen appropriate regulatory bodies for training, practice, discipline and monitoring of oral health professionals under the supervision of Ministry of Health
Promote school based oral health programming(to link to school health programme)	Include oral health promotion into the school curricula of primary schools
	Develop and provide school-based Oral Health Services, for example screening for oral health pathologies, health education and treatment of simple oral health conditions
	Promote school diets that promote oral health
Objective 24: Eliminate avoidable blindness and reduce the burden of various visual impairment conditions.	
Strategic Interventions	**Key Activities**
Improve coordination of eye care services	Establish a functional unit for eye health at the Federal and State Ministries of Health.
	Promote establishment of a multi-sectoral coordination platform for eye health
Promote the development of health plans and policies at all levels to be in consonance with the WHO Global Eye Health Action Plan 2014 - 2019	Develop/adapt policies, plans and programmes for eye health and prevention of visual impairment
Strengthen eye health focused research and information system;	Assess the magnitude of visual impairment; determine the prevalence of the causes of visual impairment with trends over time to generate more current data.
	Conduct biomedical and operational researches related
Strengthen advocacy, social mobilization and behaviour change communication on eye health	Develop and implement an eye health communication strategy (BCC, advocacy, and social mobilization)
	Identify, strengthen and support CBOs and community structures e.g. WDC for engagement in eye health initiatives
	Engage media in eye health education
Expand access (financial, geographical, social etc.) to comprehensive (promotive, preventive, curative and rehabilitative), appropriate and quality eye health services at all levels.	Establish/adapt norms and standards for eye health services provision
	Scale-up provision of comprehensive (preventive, curative and rehabilitative) and equitable eye care services across all levels of the health care system, from PHC level , with emphasis on vulnerable groups such as children and the elderly
	Integrate provision of essential eye health medicines, equipment and technologies into the logistics supply chain management system at all levels

Priority Area 7 – Emergency Medical Services and Hospital Care

GOAL: Improve health outcomes through prompt and effective response to medical emergencies

Table 32: Key Results for Emergency Medical Services and Hospital Care

Strategic Objective	Indicator	Target
Strengthen emergency medical services	% of States that have EMS policies, plans and services in place	50%
Increase provision and access to quality, affordable & integrated emergency medical services	% of States that have dedicated centres for integrated emergency medical services	80%
	% of States that have coordinated functional ambulance services	70%
Improve provision, access, quality and responsiveness of Ambulatory (outpatient) Services at all levels of health care	% of health emergencies that are responded to within 1 hour	30%
	% of health facilities providing general outpatient services as appropriate to the level of care	100%
Strengthen the provision of health services at public and private health facilities that are appropriate, accessible, and meet the minimum quality and safety standards for optimised health outcomes	% reduction in case fatality from medical emergencies	30%
	% increase in level of client satisfaction	50%
	% increase in utilisation of general medical services	100%
Promote the provision of and access to palliative and end-of-life care services at public and private health facilities that meet defined minimum quality and safety standards	% of Public & Private health facilities operating functional palliative and end-of-life care services	10%
	% of patients needing palliative and end-of-life services who receive community system support	30%

The key elements of the Emergency Medical and Hospital Care services and strategic interventions to deliver them are summarised in the following tables. Full details to guide service delivery are provided in relevant strategic plans, guidelines and treatment protocols.

Table 33: Package of key Emergency Medical Services and Hospital Care at all levels

Emergencies (trauma, violence, medical and obstetrics)	Community	Primary	Referral
Health promotion and education on accident, injury and violence prevention	✓	✓	
Pre-hospital care (i.e. first aid) and management of minor accidents	✓	✓	
Evacuation (Emergency transportation and first aid by first responders)	✓	✓	✓
OPD Emergency hospital care services (triage, Initial Evaluation, Diagnosis & Resuscitation and In-Hospital Care)			✓
Emergency Unit management: Initial Assessment & Resuscitation, Monitoring and Re-evaluation, Detailed Assessment, Diagnostic Studies, Additional Therapeutics			✓
In-patient care - treatment, surgery and critical care			✓
Rehabilitation services		✓	✓
Public Health Emergencies Preparedness and Response	**Community**	**Primary**	**Referral**
Mitigation	✓	✓	
Information, education and risk communication to build culture of health, safety and resilience of households and communities with a focus on promoting healthy behaviours to reduce risks and prepare for disasters	✓		
Emergency planning	✓	✓	✓
Stockpile and pre-position health supplies	✓	✓	✓

Strengthen surveillance and monitoring of potential hazards to health, including public health laboratory	✓	✓	✓
Emergency response	✓	✓	✓
Early warning system	✓	✓	✓
Provide triage, immediate emergency first aid and evacuation services	✓	✓	
Triage emergency medical and surgical services		✓	✓
Provide appropriate patient management (surgical and medical) services			✓
Provide primary care services	✓		
Food and nutrition support services	✓	✓	
Immunizations	✓	✓	
Environmental sanitation services (water, sanitation and disposal of the dead)	✓	✓	
Reproductive and sexual health services	✓	✓	
Psychosocial support services	✓	✓	✓
Infection prevention and control		✓	✓

Table 34: Strategic interventions and key activities to deliver Emergency Medical Services and Hospital Care

Objective 25: Strengthen emergency medical services (EMS)	
Strategic Interventions	**Key Activities**
Promote the development/adaptation and implementation of regulatory framework, policy and plans for Emergency Medical Services (EMS) across all levels of care	Support states to adapt national EMS policy, plans and guidelines on EMS services
	Set up a coordinating framework for EMS and ETS at national and state levels
	Strengthen institutional structures for the implementation of the EMS and ETS services
	Mobilize resources (financial, human, infrastructure etc.) for the functioning of the EMS and ETS services
Build capacity of health care providers for emergency medical services including training for first responders and ambulance drivers	Conduct a needs assessment with to identify HR gaps on EMS and ETS services
	Develop and implement training programmes for EMS (Training of paramedics in basic and advanced life support, ETS drivers, EMS Doctors, Nurses and other relevant health care workers)
Create/Strengthen coordination of various emergency medical services (NEMA/SEMA, FRSC, Police, Public, Private etc.)	Establish a coordinating framework for harmonization, integration and alignment of all public sector medical emergency services
	Promote PPP in EMS and ETS services
Strengthen infection prevention and control (IPC) in health care settings	Review the policy on infection, prevention and control
	Develop/adapt, produce and disseminate IPC guidelines and SOPs
	Establish/activate IPC committees in health facilities in line with WHO standards
	Establish a system for sustainable supply of IPC equipment
	Set up a system for surveillance of nosocomial infections in healthcare settings
	Procure and install proper waste management and hygiene equipment (standard incinerators and hand sanitizers) at all levels of health care
Promote demand for appropriate use of medical services	Develop and implement a communication strategy to foster knowledge and demand for EMS and ETS
Objective 26: Increase provision and access to quality, affordable & integrated emergency medical services	
Strategic Interventions	**Key Activities**
Ensure provision and access to emergency medical services	In line with the National Health act, awareness creation
	For Health care providers, health workers or health establishment shall not refuse a person emergency medical treatment for any reason

Build capacity (human and institutional) of emergency medical services units/departments of receiving health facilities	Conduct training of healthcare providers (first responders, nurses, doctors, drivers etc.) in EMS
	Ensure sustainable supply of emergency medicines and consumables including infection control materials (PPEs)
Strengthen coordinated and integrated ETS	Conduct training for ETS providers across all ETS level e.g. basic life support, advance life support and recommended ways to evacuate victims/emergency cases
Objective 27: Improve provision, access, quality and responsiveness of Ambulatory (outpatient) Services at all levels of health care	
Strategic Interventions	**Key Activities**
Promote the development of practice standards and guidelines for ambulatory services	Organize NEEDS assessment on ambulatory services
	Develop and/ adapt national guidelines and SOPs on ambulatory care
	Train Health Workers and Volunteers on the provision of ambulatory services
Scale-up functional and integrated ambulatory services (general, and specialized) in all facilities according to standards	Conduct needs assessment for outpatient, general and specialized ambulatory services (e.g. special, medical, surgical, psychiatric, paediatric clinics etc.)
	Strength/establish ambulatory, general, ambulatory specialized clinics based on needs
	Deploy resources (human, material) to ensure functionality of the ambulatory services
	Provide adequate infrastructure including laboratory and logistics support for ambulatory care services
Promote & enhance capacity (human and institutional) for continuous quality improvement of Outpatient services	Training and retraining of relevant key officers on continuous quality improvement of outpatient services
	Provide SOPs for practitioners and institutions
	Monitor and Evaluate programs periodically
	Collect feedback from end- users
Objective 28: Strengthen the provision of health services at public and private health facilities that are appropriate, accessible, and meet the minimum quality and safety standards for optimised health outcomes	
Strategic Interventions	**Key Activities**
Promote the development and implementation of policies, plans, legislations, regulations and clinical standards for safety and quality improvement of Medical Services across all levels of care	Operationalise the national blood policy at all levels of health care delivery
	Establish a blood transfusion unit in the Ministry of Health
	Develop/adapt, produce and disseminate guidelines, SOPs and job aids on blood transfusion services
	Formulate/adapt and implement blood ordering policy in all health facilities
Scale up provision of accessible medical services	Increase the number of zonal blood transfusion centres to senatorial district levels
	Establish functional hospital and zonal blood transfusion users' committees
	Provide facilities for cold chain in blood supply
	Mount extensive voluntary blood donation campaigns
Intensify continuous quality improvement in medical service provision at all levels	Organise and scale-up massive voluntary blood donation campaigns, recognise voluntary blood donors as heroes on radio, social media, notices and television
	Form voluntary blood donor cheer groups e.g. Secondary school students (voluntary blood donor clubs) etc.
	Entrench the practice of autologous blood transfusion in elective surgery
	Align voluntary non-remunerated blood donation to other health packages like safe motherhood, child survival, accident rescue and care for cancer patients
	Produce blood donor education materials e.g. Leaflets, flyers, jingles, drama sketches
	Develop strategies for blood donor retention at all levels
Build capacity of health care providers for quality medical services	Engage the organised private sector as partners in transfusion safety as part of CSR

	Identify and engage key infrastructure providers for supply and sustainable post-purchase equipment maintenance
	Align programmes with partners for technical support and service delivery
	Build partnerships with non-health sectors like youth, sports, tourism, justice and education
Promote demand for appropriate use of medical services	Strengthen/establish quality assurance in haemoglobinopathy, HIV, HBV, HCV and Syphilis screening and testing
	Develop/adapt haemovigilance systems in all levels
	Develop/adapt guidelines for clinical use of blood in the state
	Establish quality management systems at all levels and make each facility self-accounting in transfusion safety including blood safety monitoring tools
Strengthen Infection, Prevention and Control (IPC) practices in health care settings.	Conduct a needs assessment for blood transfusion information management system
	Based on the needs assessment, strengthen or establish a blood transfusion information system and directory
	Establish a bone marrow registry in Nigeria (FMOH level)
	Conduct public education and enlightenment for BTS and bone marrow registry
Objective 29: Promote the provision of and access to palliative and End-of-life care services at public and private health facilities that meet defined minimum quality and safety standards.	
Strategic Interventions	**Key Activities**
Promote the development and implementation of policies, plans, legislations, regulations and clinical standards for palliative and end-of - life care services	Provide/adapt a regulatory framework for establishing laboratories in compliance with ISO 15189:2003; existing laboratories to align with ISO 15189:2003
	Develop laboratory monitoring policy and accreditation benchmarks in line with ISO 15189:2003
	Establish/strengthen a National Public Health Reference laboratory to provide leadership in research and service provision as centre of excellence in laboratory services
	Provide regulatory framework for both public and private lab operation
Build capacity (human and institutional) for continuous quality improvement of palliative and End-of-life care services	Develop policy and guidelines for procurement and maintenance of equipment and consumables
	Integrate laboratory services into the minimum health care package at all levels
	Refurbish and construct suitable laboratory facilities
	Engage private sector service providers in PPP modes
Strengthen community systems to support Palliative and End-of-life care services	Establish a referral system between the lower laboratories (hospital and private sector) and public health reference laboratory in outbreak investigations and epidemiologic research
	Maintain strong communication networks between stakeholders (council officials, clinicians, policy makers, judiciary, legislators etc.
	Create a participatory network of medical laboratory professionals for increased interaction
	The proficiency testing scheme available to all medical laboratories
Promote appropriate disposal of dead bodies	Provide accurate and reliable laboratory data at all levels
	Develop and implement standard training program for Laboratory Quality Management
	Market and promote quality lab services nationally
	Develop Quality Assurance (QA) and Continuous Quality Improvement (CQI) programmes for laboratory services validated by a number of laboratories in compliance with the relevant standards for operation

Priority Area 8 – Health Promotion and Social Determinants of Health

GOAL: To improve the wellbeing, safety and quality of life of Nigerians through health promotion and healthy environment.

Table 35: Key Results for Health Promotion and Social Determinants of Health

Strategic Objective	Indicator	Target
Promote the wellbeing of individuals and communities through protection from health risks, and promotion of healthy lifestyle and environment	% of communities that have capacity for health promotion	25%
	% of community members who make healthy lifestyle choices	40%
Promote food hygiene and safety for the reduction of illnesses associated with unwholesome food.	% increase in compliance with the Hazard analysis and critical control points approach and adherence to standards of food safety and hygiene by institutions and outlets involved in the food production and consumption	50%
	% of designated sentinel sites across the Federation established and equipped to collect, collate and transmit foodborne illness data to the National Centre for Disease Control	60%
Promote universal access to safe drinking water and acceptable sanitation	% reduction in incidence of diseases resulting from consumption of unwholesome water and poor sanitation	50%
	% of drinking water sources assessed for quality standards	50%
	% of the population that have access to improved sanitation	70%
Protect human health, environment and infrastructure from chemical hazard, medical & Bio waste and poisoning	% reduction in mortality associated with hazardous chemicals and poisons	30%
	% of healthcare facilities meet the minimum standards for medical waste management	70%

The key elements of the Health Promotion Services and strategic and multisectoral interventions to address Social Determinants of Health are summarised in the following tables. Full details to guide service delivery are provided in relevant strategic plans and guidelines.

Table 36: Package of key Health Promotion Services at all levels

Health Promotion	Community	Primary	Referral
Promote healthy living behaviour and harm reduction (exercise, diet, tobacco use, alcohol, rest, social activities etc.)	✓	✓	
Provide IEC on various relevant health issues	✓	✓	
Provide well women and men clinical services and other services (screening for obesity, hypertension, cancer of the cervix, cancer of the prostrate, diabetes, etc.); exercises, yoga, massage	✓	✓	
Collaborate with other sectors to integrate health promotion into their activities (schools, workplaces, including communities for recreational activities)	✓		
Educate and promote uptake of health promotive and preventive services	✓	✓	
Food Safety and Hygiene	**Community**	**Primary**	**Referral**

Conduct public education and enlightenment on variety of safe foods to meet dietary needs, correct methods of food handling, preparation, consumption, importance of food security and proper nutrition.	✓		
Train and monitor the activities of food vendors and handlers	✓		
Conduct bi-annual medical examination of food handlers, including screening for typhoid and hepatitis) and issue medical certificate of fitness	✓	✓	✓
Conduct inspection, control and regulation of food markets and abattoirs, restaurants and other places of sales of foods to the public, including surveillance	✓		
Conduct mobilization of community structures, including Ward development Committees for safe and hygienic nutrition-related activities, from production to consumption	✓		
Establish early warning system that has the capacity to detect, trace and prevent outbreak of food borne illnesses before they spread	✓		
Water and Sanitation	**Community**	**Primary**	**Referral**
Public education on sanitation	✓	✓	
Promote proper hand washing techniques	✓	✓	
Community sensitization on safe water and health risks of unwholesome water	✓	✓	
Provide tippy tap points	✓	✓	
Environment, chemical products and medical waste	**Community**	**Primary**	**Referral**
Promote public health education on health impacts of climate change	✓	✓	
Safe disposal of health waste according to National guidelines	✓	✓	✓
Promote public education on poisoning	✓	✓	✓
Poisons surveillance and reporting	✓	✓	✓
Manage acute and chronic poisoning conditions	✓	✓	✓
Promote chemical hazards education	✓	✓	✓
Promote occupational health education and safety	✓	✓	
Occupational Health	**Community**	**Primary**	**Referral**
Promote the development and implementation of legal regulatory framework, policies and plans for occupational health in Nigeria.			✓
Build capacity of health workers to response to occupational health needs in the country.	✓	✓	✓
Scale up occupational preventive and promotive activities.	✓	✓	
Expand access to appropriate occupational health services for health workers.	✓	✓	✓
Promote health and safety in workplaces.	✓	✓	✓
Promote collaboration between the key stakeholders (Ministry of labour and private sector)			✓
Strengthen regulation, mentoring and evaluation of Occupational Health services in workplace.		✓	✓

Table 37: Strategic interventions and key activities to deliver Health Promotion and address Social Determinant of Health

Objective 30: Promote the wellbeing of individuals and communities through protection from health risks, and promotion of healthy lifestyle and environment	
Strategic Interventions	**Key Activities**
Promote the development and implementation of policies, plans, legislation and regulations that prevent health risks and ensures healthy life styles	Revise/adapt revised national policy and guidelines on health promotion
	Domesticate national legislations relating to health promotion
	Create platforms for engagement of partners and other relevant sectors to facilitate comprehensive health promotion programming
	Identify and implement local activities such as community profiling to determine health inequalities for responsive programming
Strengthen community capacity for responses and ownership of health promotion.	Build capacity of community structures (CBOs WDCs) in health promotion programming and implementation, including community development approaches

	Train multi-sectoral partners (e.g. education, community development, health sector, social services, etc.) on participatory approach to empowerment of communities, strengthening their capacity to take collaborative action on health
Strengthen health promotion coordination mechanisms at all levels	Establish a coordinating mechanism for health promotion at all levels
Scale-up health promotion activities at all levels.	Conduct advocacy and community sensitization to raise awareness, create an enabling policy and funding environment and raise awareness on health promotion
	Invest in IEC production and distribution and media engagement to raise awareness and promote demand for health promotion
	Conduct routine and annual health promotion activities at State, LGA and community levels (e.g. health walks, annual health promotion commemorative events, flag-off/celebration of specific programmes -- World Tobacco Day, MNCH week etc.)
Promote the inclusion of health promotion in workplace health programs	Include health promotion activities and services in work places
	Advocate for the development of healthy work environment
Promote the inclusion of health promotion in school curricula at all levels	Conduct advocacy and collaborate with Education Ministry and SUBEB for inclusion of health promotion in school curricula and promotion of healthy schools concept
	Collaborate with the education sector in provision of health promotion content and promotion of healthy schools concept (environmental sanitation, school garden, types of foods provided in schools, exercise and recreation etc.)
	Build capacity and encourage lifelong learning on disease prevention and active lifestyle
	Advocate for a whole systems approach to school health promotion to include management, staff, parents, students and the wider community
Intensify multi-sectoral and intra-sectoral collaboration and partnerships in planning, implementation and health promotion activities	Collaborate and forge partnership with relevant MDAs, partners, private sector, civil society organizations etc. to develop and implement plans on health promotion
Objective 31: Promote food hygiene and safety for the reduction of illnesses associated with unwholesome food	
Strategic Interventions	**Key Activities**
Strengthen system for food and water safety surveillance.	Develop and implement a plan to coordinate the activities of the existing food risk assessment systems
	Provide adequate and appropriate human and material resources to ensure regular inspection
	Conduct needs assessments of the sentinel sites to identify the gaps
	Facilitate continuous manpower development in critical areas such as surveillance, investigation, control and prevention of outbreaks
Strengthen the legal, and regulatory framework for food safety in line with international guidelines.	Review and update regulations, corresponding guidelines and codes of practice
	Develop protocol for collecting, collating and evaluating food-borne illnesses outbreak data including its review and follow-up action
Intensify awareness and sensitization on food safety and quality particularly at the rural community level.	Develop and implement communication strategy to raise awareness on food safety and quality
Scale up the training of food inspectors that will ensure that foods sold within the country are in compliance with current standards and regulations.	Support the training of food inspectors and other stakeholders on compliance with food safety standards and regulations
Promote the practice of food safety across the food production pipe line from farm to the table.	Update and disseminate approved list and dosage of food additives, processing aids, agro-chemicals, feeds and veterinary drugs
	Facilitate the training of distributors and users on the proper methods of application
	Enforce proper storage of food additives, processing aids, agro-chemical, feeds and veterinary drugs as indicated by the manufacturers and supervised by a professional

	Institute mechanisms for traceability and recall
Objective 32: Promote universal access to safe drinking water and acceptable sanitation	
Strategic Interventions	**Key Activities**
Promote the development and the implementation of policies, plans and legislation and regulation for the provision of safe water supply and promotion of environmental health	Support enactment of appropriate legislation for the enhancement of sanitation delivery at all levels
	Promote collaboration with water and sanitation agencies for development and implementation of policies and guidelines as it relates to water and sanitation
	Promote preventive and curative healthcare for water and sewage borne diseases
Strengthen behavioural change communication, social mobilization and advocacy for the promotion of safe water and sanitation.	Establish intensive and sustained social marketing to stimulate the demand for the installation, use and maintenance of safe and appropriate sanitation facilities in households, communities and institutions in urban, semi urban and rural areas of the state
	Establish health and hygiene clubs in schools and empower Parent Teachers Associations (PTAs) to promote sanitation and hygiene education
	Implement gender sensitive awareness creation and promotion of hygiene practices in communities
	Train and establish partnerships with NGOs to increase their participation in water and sanitation sector
Strengthen the regulatory and supervisory frame work for production of commercial water to ensure water safety	Conduct training and retraining of drinking water utilities personnel on development and implementation of water safety plan
	Provide regular update on water facilities characteristics and status to Ministry of Water Resources and Ministry of Health
	Develop regulations for the use of water treatment
	Enforce laboratory quality assurance and conduct system certification
Objective 33: Protect human health, environment and infrastructure from chemical hazard, medical & Bio waste and poisoning	
Strategic Interventions	**Key Activities**
Strengthen legal, regulatory framework, policies and implementation of plans for chemical hazards and poisoning, medical and Bio waste and climate change	Reviewing of National Policy on chemical management and revive the National Committee on Chemical Management (NCCM)
	Harmonizing all extant legal, Policies & Plans relating to chemical hazards, poisoning, medical and Bio-waste and climate change in line with international requirement.
	Develop a plan for the review of laws and legislations guiding the regulatory systems at State & LG levels.
Scale-up advocacy, community sensitization and education on chemical wastes and poisoning, medical and Bio waste and climate change	Advocacy and sensitization of policy makers, chemical industry and the general public on the health implication of chemical wastes, poisoning, medical and bio-waste and climate change.
	Capacity building of healthcare personnel on identifying the risk in hazardous chemical management wastes (poison, medical, bio-waste, and climate change)
Build capacity of health workers for effective management of medical and Bio waste and hazardous chemicals at all levels of the health care system	Develop guidelines or manuals on the surveillance, assessment and management of chemical events, intoxications and poisoning cases.
	Develop partnership with training institutions, professional bodies, private organization and skill acquisition centres.
	Organize capacity building for healthcare workers on treatment of poison cases and chemical hazards across health facilities.
Build capacity to appropriately respond to health effects of climate change	Organize capacity building for healthcare workers on health effects of climate change
Deepen collaboration with relevant stakeholders on Chemicals Management, medical & Bio waste management and climate change	Strengthen the collaboration with relevant stakeholders on chemical management, medical and Bio-waste management and climate change
	Establish sentinel sites at each of the State and FCT to analyse chemical hazards, medical and bio-waste outbreaks in all facilities
Improve systems for data collection, management and utilization for	Establish a National surveillance system for chemical waste, poison cases, medical and bio-waste.

chemical hazards and poisons, medical and Bio waste and climate change	Establish an electronic database system for chemical hazards, poisons, medical and bio-waste and climate change in the health sector
	Reporting of the database form at established sentinel sites in each of the States and LGAs
Objective 34: Promote optimal health and safety of workers in their work environment	
Strategic Interventions	**Key Activities**
Promote the development and implementation of legal, regulatory framework, policies and plans for occupational health in Nigeria	Stakeholders meetings to develop/ review legal regulatory framework, policies and plan for the implementation of occupational health in Nigeria
Build capacity of health care workers to respond to occupational health needs in the country	Stakeholders meetings to Develop and harmonize training modules
	Printing of copies of training modules
	Training of trainers (TOT) on Occupational Health
	Training of health workers nationwide
Scale up occupational preventive and promotive activities	Develop and print advocacy tools
	Advocacy visits to Federal, States and Local Government Officials, International and National NGOs, lawmakers, Organized private sectors, Industries, mining sectors etc.
	Training of workers on the use of Personnel Protective Equipment (PPE)
	Provision of Technical assistance to agencies, private sector, media, NGOs, on OHS planning and implementation
Expand access to appropriate occupational health services for health workers	Development of guidelines for partnership, collaboration and coordination for OHS.
	Establish and support the deployment of zonal OHS coordinators for effective coordination of OHS services at all levels
	Development of Mechanisms for feedback from Ministries, NGOs, Agencies, Private sectors and work places
Strengthen regulation, mentoring and evaluation of occupational health services in workplace	Development of recording and reporting tools
	Printing of recording and reporting tools
	Dissemination of the recording and reporting tools
	Training of health workers on the use of recording and reporting tools
	Development of standard guidelines on Occupational Health and Safety for health providers and facilities
	Development of standard checklist for Occupational health and safety risk Assessment
	Annual review meeting with staff from Federal, States, zonal and other stakeholders to review performance
	Routine monitoring and supervisory visits from Federal to states and zones
Promote health and safety in the workplace	Build Model occupational Health centre in FCT
	Establish model occupational health centres in each of the six geopolitical zones of the country
	Equip all the model occupational health centres in FCT and the six zonal centres
	Visitation to workplaces in each of the zonal offices while the headquarters will take care of workplaces in FCT
	Operational Research of Occupational Health and Safety
Promote collaboration between the key stakeholders (Ministry of Health, Ministry of Labour and the private sector)	Partner with different stakeholders to identify Occupational and safety issues in workplace and carry out operational research
	Stakeholders meeting to address occupational health risk identified in workplaces. Other areas of collaboration include observations of world day for safety and health, Organization of local and international conferences and seminars on occupational health and safety.

Chapter 6

Strategic Pillar Three

Strengthened health system for delivery of the EPHS

Priority Area 9 – Human Resources for Health

GOAL: To have in place the right number, skill mix of competent, motivated, productive and equitably distributed health work force for optimal and quality health care services provision.

Table 38: Strategic Objectives and Key Results for Human Resources for Health

Strategic Objective	Indicator	Target
Ensure coordination and partnership for aligning investment of current and future needs and institutional strengthening for HRH agenda	Number of States implementing HRH policies and strategic plans	37
Ensure the production of adequate numbers of qualified health workers	% of health training institutions that are accredited by the relevant regulatory institutions	70%
Ensure the development of monitoring and evaluation for HRH including systems for HRHIS and Registry	Number of States that have functional HRHIS	37
	% of States that are producing annual HRH review reports according to HRHIS data	100%
Ensure effective health workforce management through retention, deployment, work condition, motivation and performance management	% reduction in attrition rate among health workers in all health institutions and health facilities	50%
	% of health facilities at all levels that have the appropriate skill mix of health providers	60%
Strengthen Health workforce planning for effective management	Number of States that have harmonised HRH Annual Operational Plans	37

Table 39: Strategic interventions and key activities to manage Human Resources for Health

Objective 35: Ensure coordination and partnership for aligning investment of current and future needs and institutional strengthening for HRH agenda	
Strategic Interventions	**Key Activities**
Strengthen regulatory, policy, planning and institutional capacities of HRH structures	Strengthen HRH units at national and state level
	Build capacity of HRH Unit staff to enhance performance
	Review/Adapt HRH policy, guidelines, norms and standards at all levels, including staffing norms
	Develop and implement HRH strategic and annual plans to ensure a link between production pipeline and current/future HRH needs across all levels
	Support the development of scheme of service and job descriptions for all cadre of health care workers
Strengthen coordination of public, private, regulatory, Health workforce association and development partners at all levels	Establish/strengthen a broad stakeholder coordinating platform and ensure regular meeting of an HRH working group
	Support the mapping and development of a database of health workforce association, human resource training institutions, and partners at all levels

	Develop/strengthen and regularly update a comprehensive HRH database
Enhance funding for HRH development for the current and future needs	Support resource mobilization activities including funding for HRH (Link to health care financing)
Objective 36: Ensure the production of adequate numbers of qualified health workers	
Strategic Interventions	**Key Activities**
Strengthen the quality assurance for HRH training institutions especially for producing frontline health workers	Support the conduct of needs assessment of health training institutions using the information to upgrade them in line with approved regulatory standards
	Develop continuing professional development programmes targeting HR trainers
	Review and revise training curricula in line with current market needs
	Develop and implement a quality assurance framework for health training institutions
Strengthen the linkage between HRH training institutions, regulatory bodies and other stakeholders to ensure alignment between health workforce production and needs	Create/strengthen platforms for alignment between HRH Training institutions, regulatory bodies and other stakeholders
	Establish evidence-based staffing norms for all levels of human resources for health based on workload analysis
	Train and retrain healthcare personnel for effective and efficient staff utilization according to training needs (e.g. Train NPHCDA staff on IMCI and Community IMCI, LSS, MLSS etc.)
	Develop/implement other training programmes as appropriate e.g. community midwifery, community-based care providers
Improve gender sensitivity in the production of health work force for all cadres at all levels	Advocate and train on gender gap needs across the production pipeline
	Support collaboration with education sector to promote female education through enforcement of relevant gender, child rights act and other education policies
	Promote enrolment, retention and completion of female education in health and allied professions through provision of incentives
	Maintain a database disaggregated by gender to track gender disparities in training of healthcare workers
Objective 37: Ensure the development of monitoring and evaluation for HRH including systems for HRHIS and Registry	
Strategic Interventions	**Key Activities**
Strengthen/establish HRHIS at state and federal levels	Establish/strengthen HRH information System (HRHIS) at all levels
	Establish a performance management system (performance of individual workers using job aids, job descriptions, scheme of service and work plans)
	Conduct periodic facility-based and health workers' performance assessment, monitoring and supervision
Establish mechanisms for annual HRH reviews and reporting for evidence and decision making at the Federal, State, and LGA levels	Conduct joint reviews (at least annually) to assess progress made in implementing HRH action plans by thematic area
	Conduct mid-term and final evaluation of HRH strategic plan implementation
Improve the production of HRH research evidence through monitoring and evaluation mechanisms	Conduct relevant research to improve the production and utilization of relevant professional cadres and skill mix required for a responsive health system
	Promote and build capacity for HRH research
	Create a platform for translating HRH research findings to action (evidence to action)
Objective 38: Ensure effective health workforce management through retention, deployment, work condition, motivation and performance management	
Strategic Interventions	**Key Activities**
Improve HRH performance management systems at all levels	Review existing HRH recruitment and deployment policies to remove barriers/embargo to competitive recruitment, deployment and retention of appropriate health workforce
	Strengthen mechanism for deployment and retention of HRH at all levels
	Establish/strengthen performance based reward systems
	Create an enabling work and living environment to promote health worker recruitment and retention

	Institutionalize the Midwifery Service Scheme and other flagship interventions to increase HRH availability especially in hard to reach areas
	Deploy/redeploy/recruit qualified personnel(Clinical and Non Clinical Staff) based on needs and established gaps
	Develop and implement a system for measuring performance of health workers in line with the civil service Performance Monitoring System (PMS)
Strengthen the task shifting and task sharing implementation with required guidelines.	Adapt and Implement the national Task Shifting and Task Sharing (TSTS) policy in response to state specific HR needs
	Develop and implement a costed framework for TSTS
Objective 39: Strengthen Health workforce planning for effective management	
Strategic Interventions	**Key Activities**
Improve capacity for HRH planning at all levels	Strengthen mechanisms for HRH joint planning at primary, secondary and tertiary levels
	Support the development of scheme of service and job descriptions for all cadre of health care workers

Priority Area 10 – Health Infrastructure

GOAL: To improve availability and functionality of health infrastructure required to optimize service delivery at all levels and ensuring equitable access to effective and responsive health services throughout the country.

Table 40: Strategic Objectives and Key Results for Health Infrastructure

Strategic Objective	Indicator	Target
To improve availability and functionality of health infrastructure required to optimize service delivery at all levels	% of the LGAs that have functional general hospitals for referral from PHCs	50%
	% of health facilities at all levels of the health system that have fully functional health infrastructure (related to: medical equipment; water supply; electricity supply; roads; waste disposal; ICT; and security) needed for supporting and facilitating health service delivery	80%

Table 41: Strategic interventions and key activities to manage Health Infrastructure

Objective 40: To improve availability and functionality of health infrastructure required to optimise service delivery at all levels	
Strategic Interventions	**Key Activities**
Strengthen legal, policy and institutional framework and coordinating mechanism for health infrastructure planning and maintenance in Nigeria	Establish departments/units for health infrastructure at federal, state and LGA levels
	Develop a national/state strategic health infrastructure plan
	Develop/adapt/review policies, laws and guidelines on health infrastructure, equipment maintenance and management
	Set up a functional health infrastructure coordinating committees at different levels

Promote the establishment of norms and standards for health infrastructure for all levels of the health care system in the country	Establish norms and standards for health infrastructure (Physical facilities including laboratory services and municipal services e.g. water, sanitation, electricity facilities), ICT, Communication, equipment, transport, etc. including critical infrastructure (e.g. blood banks, energy supply systems, laboratories, etc.) at all levels of the healthcare system
Ensure availability of equipment and other health infrastructure in line with established norms and standards for the different levels of health care and other health institutions	Conduct a gap analysis of health infrastructure at all levels of health care delivery based on established norms and standards
	Establish a system for procurement of health infrastructure (e.g. vehicle, ICT, communication, equipment etc.) in partnership with the private sector
	Upgrade/construct health facilities including laboratories etc. in line with established norms and standards
	Advocate for dedicated funds for health infrastructure development and management in Nigeria
Strengthen the monitoring of health infrastructure, including inventories and performance	Develop and regularly update a database for health infrastructure in the country/states
	Support the deployment of Electronic Medical Record (EMR) system to all health facilities
Strengthen capacities and partnerships for health infrastructure Maintenance and management	Establish/strengthen health infrastructure maintenance units at all levels of health care
	Build human capacity in the use and maintenance of health infrastructure
	Establish a plan and system for planned preventive maintenance of all health infrastructure in partnership with private suppliers
	Establish PPP platform on health infrastructure procurement, service provision and maintenance (e.g. Build and maintain, outsource, contract, concession etc.)
Promote partnerships between Equipment Manufacturers/ Suppliers and government at all levels for technology transfer/training/ maintenance agreements.	Ensure the execution of Equipment Leasing Agreements (with Service Contracts)/Managed Equipment Scheme between Equipment Vendors/Manufacturers and Federal Tertiary Health Institutions.
	Organise Sensitisation seminars on Equipment Leasing/Managed Equipment Scheme across the Federal Tertiary Health Institutions
Scale up training of Biomedical Engineers and health infrastructure equipment maintenance officers, in order to increase stock availability.	Develop and implement a scaling up training programme for Biomedical Engineers, technicians and health maintenance officers with major equipment manufacturers
Accelerate the revitalization of primary health care infrastructure for improved access to health services	Conduct a situation analysis including mapping and establish a database of PHC facilities
	Develop a plan for equitably upgrading and construction of new PHC facilities based on needs
	Establish/strengthen at least 1 PHC per ward to provide Essential Package of Health Care Services (EPHS) including BEmONC
	Provide PHC infrastructure and HRH in relation to defined norms and standards
Improve Secondary and Tertiary levels infrastructure to support referrals systems	Establish standard diagnostic centres at all senatorial zones of the State that are WHO certified
	Revitalize, upgrade and expand centres of excellence in the State
	Establish/strengthen logistics support including transportation and communication systems to aid referral
	Strengthen/establish at least 1 general hospital as a referral centres for PHCs in the LGA

Priority Area 11 – Medicines, Vaccines and Other Health Technologies and Supplies

GOAL: To ensure that quality medicines, vaccines, and other health commodities and technologies are available, affordable and accessible to all Nigerians.

Table 42: Strategic Objectives and Key Results for medicines, vaccines and other health technologies and supplies

Strategic Objective	Indicator	Target
Strengthen the availability and use of affordable, accessible and quality medicines, vaccines, and other health commodities and technologies at all levels.	Increase local production of quality medicines, vaccines and other commodities by 40%	40%
	% increase in local production of simple active pharmaceutical ingredients strictly complying with all relevant regulatory laws	50%
	Number of States that have a functional logistic management coordinating Unit	37
	Number of States that have a medicine and therapeutic committee at the state and facility levels	37
	% increase in public awareness and understanding of antimicrobial resistance through effective communication, education and training	50%

Table 43: Strategic interventions and key activities to manage medicines, vaccines and other health technologies and supplies

Objective 41: Strengthen the availability and use of affordable, accessible and quality medicines, vaccines, and other health commodities and technologies at all levels.	
Strategic Interventions	**Key Activities**
Strengthen the development and implementation of legal, regulatory framework, policies and plans for drugs, vaccines , commodities and health technologies at all levels	Advance the development/review and full implementation of enabling legal and regulatory frameworks, policies, guidelines and SOPs for medicines, vaccines, laboratory supplies, equipment and other health commodities
	Develop strategic and annual operational plans for medicines, vaccines, commodities, and health technologies etc.
	Harmonize and integrate national/state supply chain management systems in line with the National Supply Chain Management Programme
	Advocate for favourable fiscal policies (e.g. tariffs for importation of drugs, free health services, customs clearance etc.)
Strengthen effective coordination of structures that ensures accessibility to medicines, vaccines, commodities and other technologies at all levels and at all times	Establish/strengthen a state and LGA product supply chain management/Logistics Management Coordinating Unit (LMCU) including coordinating committees or working groups
	Promote robust QA mechanism and adoption of applicable models for all health commodities procurement, storage, distribution and usage in the State
	Collaborate with regulatory agencies in performing their statutory mandates in the state (NAFDAC, PCN, etc.).
	Explore PPP and outsourcing to competent companies on appropriate supply chain functions
Enhance production and use of locally manufactured medicines and vaccines that meet global standards	Develop partnerships to promote local production of medicines, vaccines, and technologies that comply with global standards
	Create an enabling environment for local production of drugs and vaccines (removal of tariffs, provision of power supply, water and sanitation, and other incentives)

Strengthen effective procurement systems (forecasting, orders, and procurement) to ensure 40% local content) and commodity security on a sustainable basis at all levels.	Strengthen institutions that are responsible for product selection through training, capacity building and infrastructural enhancement
	Implement the procurement policy on medicines, vaccines and health technologies
	Develop user friendly standardized tools for data capture and analysis for decision-making for all aspects of medicines, vaccines and health technologies management
	Develop/strengthen product use database
	Build capacity of all relevant officers in forecasting, quantification, drug use and procurement of medicines, vaccines, and health technologies
	Establish a database of consumers and clients, consumption patterns and cost implication
Strengthen integrated supply chain management system and quality assurance models for medicines, vaccines, commodities and other technologies with a functional logistics management information system (LMIS)	Establish Supply Chain coordination structures in line with national policy, guidelines and international best practices.
	Establish a sustainable system for end to end real-time supply chain data visibility for all health commodities across all intervention areas in the State
	Strengthening the Monitoring and Evaluation Systems
	Institute price intelligence approach to guide procurement which ensures that prices of health care products and services reflects best market rates.
Strengthen rational drug use and antimicrobial stewardship at all levels	Regularly update, produce and disseminate Standard Treatment Guidelines (STGs)
	Provide continuing education to product users (e.g. clinicians, patients, general population, and technicians) on appropriate product use
	Conduct community sensitization and education especially in rural areas to increase understanding and capacity on product use
	Establish a quality system for pharmacovigilance, which will cover organizational structure, responsibilities, procedures, processes and resources as well as appropriate resource, compliance and record management.
	Conduct community education on AMR
Strengthen existing systems for the management of biological and non-biological wastes including expiries of medicines, vaccines and other commodities at all levels	Establish and implement an effective safe health commodities waste management system in the State
Strengthen the development of traditional medicine in Nigeria	Adopt/adapt national policy on traditional medicine
	Formulate laws and regulatory guidelines for the practice of Traditional Medicine Practitioners (TMP) including codes of ethics and practice
	Promote research and development (R&D) of traditional medicine
	Establish standards of safety, efficacy and quality for traditional medicine practice

Priority Area 12 – Health Information

GOAL: To institutionalise an integrated and sustainable health information system for decision-making at all levels in Nigeria.

Table 44: Strategic Objectives and Key Results for health information

Strategic Objective	Indicator	Target
Improve the health status of Nigerians through the provision of timely, appropriate and reliable health information services at all levels, for evidenced based decision making.	% of all health facilities (public and private) generating and transmitting routine HMIS data on time	80%
	Quality of HMIS data as assessed through DQA	80%

Table 45: Strategic interventions and key activities to strengthen health information management

Objective 42: Improve the health status of Nigerians through the provision of timely, appropriate and reliable health information services at all levels, for evidenced based decision making.	
Strategic Interventions	**Key Activities**
Strengthen institutional framework and coordination for HIS at all levels	Revise/adapt national policy, guidelines and tools on HMIS
	Strengthen HMIS units at all levels
	Support recruitment and deployment of HMIS and M&E officer for health programmes at all levels. Link to HRH
	Strengthen Heath Data Consultative Committee (HDCC) on data demand, data use and overall data management at all levels
Strengthen capacity to generate, transmit, analyse and utilize routine health data, from all health facilities, including private health facilities.	Develop and implement M&E plans at Federal and State levels
	Strengthen capacity of M&E/HMIS Officers, OIC s of HFs and other programme officers at all levels on development of M&E plans, data generation, data analysis, data communication and data use for both public and private sector.
	Provide infrastructure and tools for effective data collection, transmission and management at the state and LGA health facility and community levels (offices space accommodation, ICT, furniture and accessories, DHIS2 access) link to infrastructure
	Institute and support production of data management and surveillance tools and routine publications of feedback
Improve integration of existing surveillance systems and diseases registries into the overall health information system	Integrate the surveillance system into the DHIS2 platform to enhance inter-operability
Improve the mechanism for an integrated data repository for data sharing among stakeholders at all levels	Establish and maintain a comprehensive and accessible data bank for all health data in the state
Strengthen monitoring of the sub-sector performance	Coordinate regular sector/sub-sector Data Quality Assurance (DQA) for public and private health facilities across the state
	Intensify quarterly review meetings of State HDCC Team and LGAs IHDMT
	Institutionalize quarterly NHMIS supportive supervision to public and private health facilities across the state
	Institute a mechanism for pooling resources from MDAs and Partners for HMIS activities

Priority Area 13 – Research for Health

GOAL: To utilise research to inform policy and programming for improved performance of the health sector and better health outcomes; and to contribute to global health knowledge production.

Table 46: Strategic Objectives and Key Results for research for health

Strategic Objective	Indicator	Target
Strengthen health research and development to significantly contribute to the overall improvement of Nigeria's health system performance.	% increase in budgetary support to health research Institutions	20%
	% of health research institutions meeting international standards	60%
	% health research studies that are responsive to jointly set national health priorities/agenda.	50%
	% of health institutions at all levels of government that spend a minimum of 2% of their health budgets for health research	50%
	% of external aid for health projects and programmes allocated to research and research capacity building	5%

Table 47: Strategic interventions and key activities for Research for Health

Objective 43: Strengthen health research and development to significantly contribute to the overall improvement of Nigeria's health system performance.	
Strategic Interventions	**Key Activities**
Strengthen coordination and regulatory mechanisms for health research and development by all relevant stakeholders, in line with the National Health Act 2014	Revise/adapt national health research policy, guidelines, norms, standards, and tools
	Support the platform for linking academia with the health sector on linking research to national/state priorities and translating research to action
	Establish/strengthen health research ethics committees across all levels
Strengthen the development and implementation of the national research agenda	Develop and disseminate a health research agenda and strategy
	Create a framework for mobilization and funding of health research activities based on national research agenda/priorities
	Promote development of research products
	Promote PPP in research and development (R&D)
Increase resource mobilization and allocation for research activities at all levels in line with agreed international declarations, especially Algiers Declaration on Health Research	Build capacity for resource mobilization for health research (e.g. proposal writing, grant-making, fund-raising etc.)
Strengthen the national health research institutions (the National Institute of Medical Research and the National Institute of Pharmaceutical Research and Development) to contribute to evidence-based decision making and R&D	Conduct needs assessment on capacity of national health research institutions to identify gaps
	Develop and implement plans to address identified capacity gaps of national health research institutions
	Advocate for increased funding for research institutions in the country
	Foster strategic partnerships at national and international levels for improved quality health research output
Strengthen institutions and systems at all levels for the promotion,	Establish/strengthen health research and ethic committee in all states and relevant institutions

regulation and ethical oversight of essential national health research	Conduct training of members of the National Health Research Ethical Committee/ State Health Research Ethical Committee (NHREC/SHREC)
	Establish/strengthen functional committees (e.g. IRBs) for review and monitoring implementation of approved health research on human subjects across all levels
Enhance strategic partnerships at the national and international levels for the promotion and timely dissemination of research findings	Map existing and potential health research entities at national and international level and maintain a database
	Establish/strengthen linkages between research institutes, private sector organisations, and health MDAs at national and state level
Strengthen the utilization of research findings to inform policy, programming and practice	Create platforms and support dissemination of research findings (e.g. journal publications, seminars, conferences etc.)
	Develop and support communication strategy for dissemination of research findings to different target audiences (e.g. policy makers, politicians, practitioners, consumers, development partners and the general public)
	Develop a platform to promote commercialization of research findings
	Create and support a platform for regular dialogue between researchers and policy makers for evidence-based decisions
Facilitate the development of a repository for the collation and archiving of health-related research findings for improved knowledge management	Establish/strengthen an electronic research repository at the federal and state levels
	Create a mechanism for harvesting, collating, documenting and uploading of health researches on the website
	Build capacity of the data managers and web masters for handling and processing of research documents

Chapter 7

Strategic Pillar Four

Protection from health emergencies and risks

This strategic pillar will ensure there is a strong public health emergency management and surveillance system that is well equipped, committed, and versed in climate change issues and its consequences on health. Access to comprehensive services for the prevention, treatment and impact mitigation of public health emergencies shall be promoted through development of a national/state emergency resilience and response plan. This requires the establishment of a functional incident and command and control structure, including Emergency Operating Centre (EOC) and the availability of a surge capacity to respond to public health emergencies in each State.

NSHDP II also recognises that climate change has the potential to adversely affect population health and environment. Failure to mitigate the consequences of climate change over time could result in elevated levels of deaths from infectious diseases, obesity, diabetes and heart disease among others. The robustness of the country's surveillance and alert system will enable forecast and prevention of unusual occurrence of events capable of generating disaster or emergency situations of huge or proportionate magnitude. Therefore, adequate measures, preparation and response will need to be instituted to reduce, mitigate and/or eliminate all factors capable of further worsening or contributing to climate change. This will be done in a way that it does not affect the routine activities of people and the nation.

A concerted effort will be made to ensure that capacity is strengthened for emergency preparedness and readiness for effective health response and recovery at all levels and core capacities are developed in line with International Health Regulations.

Priority Area 14 – Public Health Emergencies, Preparedness and Response

GOAL: To significantly reduce the incidence and impact of public health emergencies.

Table 48: Strategic Objective and Key Results for Public Health Emergencies

Strategic Objective	Indicator	Target
Reduce incidence and impact of public health emergencies in Nigeria	% of all health facilities participating in disease surveillance and reporting using IDSR tools	50%
	% of the population covered with surveillance alert systems	75%
	% of responses to all confirmed epidemics that fall within the 24 - 48 hour window	80%
	% of responses to road traffic accidents that fall within the 1-hour window (golden hour)	50%

Table 49: Strategic interventions and key activities for Public Health Emergencies, Preparedness and Response

Objective 44: Reduce incidence and impact of public health emergencies in Nigeria	
Strategic Interventions	**Key Activities**
Promote the development and implementation of legal, regulatory framework, policies and plans for emergency preparedness at all levels	Develop/adapt multi-hazard response national policy and plans on emergency preparedness and disease outbreak management for health sector at all levels
	Establish/strengthen committees on Public Health Emergencies and Response at all levels
	Support the development of guidelines and procedures including the EPHS to be offered to populations after a disaster
	Support the conduct of regular review meetings on public health emergencies and response plans at all levels
Promote an integrated national disease surveillance system in line with International Health Regulation (IHR) and IDSR	Develop human capacity for disease surveillance at all levels
	Institutionalize risk reduction and emergency preparedness programmes at all levels of the health system (establishing an effective 'all-hazard/whole-health' programmes)
	Assess and monitor baseline information on the status of risk reduction and emergency preparedness and response
	Support the development of health sector response coordination and management mechanisms based on incident management system
Promote integration of disease surveillance activities at all levels of the health care system	Develop a framework for involvement of both public and private sectors on disease surveillance at all levels
	Support the production and distribution of diseases surveillance tools
	Support provision of logistic support for surveillance activities
	Develop a system for regular feedback of surveillance information for action
Expand/strengthen a network of public health laboratories in Nigeria	Build capacity of laboratories and officers to support surveillance activities
	Support networking of public health laboratories nationwide
Scale-up public education and awareness creation on public health emergencies	Support public education and enlightenment on disaster preparedness and response
Build institutional capacity to effectively respond to public health emergencies and risks	Strengthen capacity of Rapid Response Teams (RRT) at all levels
	Build surge capacity of the RRT at Federal, State and LGA levels
	Build capacity of health facilities to respond to public health emergencies and risks (isolation units, PPEs, drugs, supportive therapy, mortuary services etc.)
Build human resource capacity and equitably distribute them for appropriate and optimal response to public health emergencies	Develop and implement training programmes on disaster preparedness and response
Strengthen coordination mechanisms for public health emergencies at all levels	Strengthen coordinating framework between NEMA/SEMA, and the relevant institutions in the health sector (NCDC, Public Health departments etc.)
	Establish/strengthen multi-sectoral coordinating platform for disaster preparedness and response interventions at all levels (agriculture/veterinary departments, immigration, law enforcement agents, military etc.)
Promote community participation in disease surveillance activities	Build capacity of communities to develop and implement disaster prevention and response plans
	Establish community based surveillance system (Ref. above)

Chapter 8

Strategic Pillar Five

Predictable financing and risk protection

There is an urgent need to establish systems for health financing evidence generation and management and aligning health allocations to national priorities. The NHAct in general and the BHCPF in particular present an opportunity for Nigeria to accelerate progress towards UHC at the backdrop of increase political and financial commitment. The momentum to expand access to NHIS and State Social Health Insurance Schemes is a welcome development in the country's journey toward UHC.

Priority Area 15 – Health Financing

GOAL: To ensure all Nigerians have access to health services without any financial barriers or impediments at the point of accessing care.

Table 50: Strategic Objectives and Key Results for Health Financing

Strategic Objective	Indicator	Target
Strengthened governance and coordination for actualizing stewardship and ownership of health financing reforms	% of States with functional Healthcare Financing Equity & Investment Units	70%
	% of States with approved Health Financing Policy & Strategy	70%
	% of States that have approved investment cases for UHC priorities	70%
	% of States that have conducted and/or updated State Health Accounts (SHA)	70%
Increase sustainable and predictable funding for health	% of health budget allocated to PHC	35%
	% of national budget allocated to the health sector	15%
Enhance financial risk protection through pooled funds at federal and state levels	% of Nigerian population covered by risk protection mechanisms for health financing	30%
	OOPE on health	35%
Enhance transparency and accountability in strategic purchasing of Health Services	% of Health MDAs operating PBF as a results based provider payment mechanism	40%
	Nigeria HTA Agency established	
	% of States with health financing integrated into functional PFM Systems	70%

Table 51: Strategic interventions and key activities for Health Financing

Objective 45: Strengthened governance and coordination for actualizing stewardship and ownership of health financing reforms	
Strategic Interventions	**Key Activities**
Strengthen Health Financing Equity and Investment Units at Federal, 36 States, and FCT	Create/strengthen a Healthcare Financing Equity and Investment (HCFE&I) Unit within DPRS for giving policy and strategic direction for UHC at all levels.
	Establish a National / State HCFE&I Technical Working Group (TWG)
Strengthen Coordination Frameworks and TWGs for health financing at Federal, 36 States, and FCT	Constitute Health Financing Equity Coordinating Committee to develop framework and guidelines for health financing mechanisms
	Advocate for the implementation of Health Financing Equity framework/guidelines at all levels and MDAs
	Establish a platform for strategic collaborative linkages between NHIS and state health insurance schemes as well as NPHCDA and SPHCDAs by FMOH,NHIS, NPHCDA, and State governments
	Establish mechanisms for fostering inter-sectoral collaborations, public-private partnerships, and collaboration with community members, CSOs, and Development Partners to ensure improvement and coordination of health financing functions
Develop Health Financing Policy & Strategy and Investment case at Federal, 36 States, and FCT	Adapt /Domesticate National Health Financing Policy and Strategy
	Develop a national/state health Investment and business case for health priorities
Establish systems for health financing evidence generation and management at Federal, 36 States, and FCT	Establish/strengthen systems for routine health financing evidence generation and management, including annual National/State Health Accounts
	Establish/strengthen institutional capacity for integrated financial management system development for all health financing functions (resource mobilization, pooling and purchase of services)
	Establish/update information system for resource mapping for revenue generation
	Develop mechanism for sector-wide participation in the budgeting process for public and non-private funds
	Conduct regular expenditure tracking surveys
Coordinate phased implementation of the BHCPF	Domesticate national guidelines on BHCPF
	Adapt national manuals and procedures for accessing and disbursing funds from the BHCPF
Objective 46: Increase sustainable and predictable funding for health	
Strategic Interventions	**Key Activities**
Alignment of health allocations to national priorities	Advocate for allocation of 15% of Federal, State and LGAs budgets to health in compliance with Abuja declaration.
	Include national health priorities into MTEF and align all States, agencies and donors to it.
Expand the BHCPF by crowding in Donor Funding and Funding from other sources (including the private sector)	Develop the framework for operationalization of BHCPF as a basket fund to include donor partners and the private sector
Advocate for increase in government annual budget and spending on health	Develop and implement advocacy strategy for increased and timely release of health budgets
	Support health advocacy committee to advocate for increase in health budget, timely budgetary releases and adequate expenditure tracking.
Strengthen legal and coordinating framework for PPP at federal and state levels	Support Federal and State PPP Units /Agency to adapt National PPP policy and Coordination framework and its implementation.
	Strengthen the legal framework for PPP transactions at all levels.
Develop and implement resource mobilization strategy and guideline including Sin Taxes, Telecom Taxes, VAT, Aviation Taxes, etc.	Support Health Finance Equity Committee to develop and implement health resource mobilization strategy and guidelines to include introduction of special taxes to develop domestic resource mobilization strategy fund for the health sector.

Objective 47: Enhance financial risk protection through pooled funds at federal and state levels	
Strategic Interventions	**Key Activities**
Engage Stakeholders to increase enrolment and contribution to Health Insurance	Constitute health advocacy and mobilization committee to engage communities, policy makers, implementers and other stakeholders on health issues including SHIS
	Support public education and enlightenment for raising awareness on health insurance and contributory scheme
	Support sensitization workshops for engaging employers of labour to key into health insurance / contributory scheme for their employers
	Support the production and dissemination of IEC materials on health Insurance
Strengthen laws and regulations for the implementation of the NHIS	Support amendment of NHIS/SHIS Acts to make them more functional and mandatory, for all population groups (including the equity fund)
	Develop framework for consolidation of fund pools at all levels
Strengthen technical capacity of health personnel on health insurance and contributory schemes	Build institutional and human capacity of Health Care Financing (HCF) units, health insurance agencies, and other personnel involved in the planning, implementation and management of the health insurance/contributory schemes at all levels
Establish and expand Mandatory State Health Insurance and contributory Schemes in 36 States & FCT	Support the establishment of SHIS Agency to regulate and set guidelines for implementation of the State Health Insurance/contributory scheme and its investments.
	Establish a platform for engagement with stakeholders to increase enrolment and contribution to Health Insurance/contributory schemes
	Establish/expand Community Health Insurance Schemes (CBHIS)
Objective 48: Enhance transparency and accountability in strategic purchasing of Health Services	
Strategic Interventions	**Key Activities**
Review Provider Payment mechanisms in the Nigerian health sector to focus on RBF	Support the development of a system for Operational Research on Providers payment mechanisms.
	Support the development of a mechanism for Provider Payment System based on Results Based Financing (RBF) e.g. Performance Based Financing (PBF) model and institutional framework for its implementation
	Support the mainstreaming of equity-based financing in all schemes at all levels
	Strengthen regulatory framework for health care financing actors and schemes including HMOs, State Health Insurance Agencies, and Community Based Health Insurance Schemes
Develop Framework for competition between public and private sector providers in the allocation of new resources for healthcare	Develop framework for competitive access to health funds and advocate to Private Healthcare Providers on opportunities for accessing health financing options to include SHIS, PBF, Partners support, financial institutions etc.
	Establish National Quality Review & Health Technology Assessment Systems to determine which health interventions are cost effective (FMOH only)
Institutionalize routine NHA and expenditure tracking mechanisms at State and Federal levels	Establish State Health Account Unit with subunits in Health Agencies and LGA PHC departments.
	Develop a State Health Account framework for monitoring and tracking of health expenditures at all levels
Institute Public Finance Management (PFM) reforms at the Federal and State levels	Review Health budgets performance and preparation in accordance with new Chart of Accounts and in compliance to IPSAS standards for effective tracking of revenues and expenditures

Chapter 9

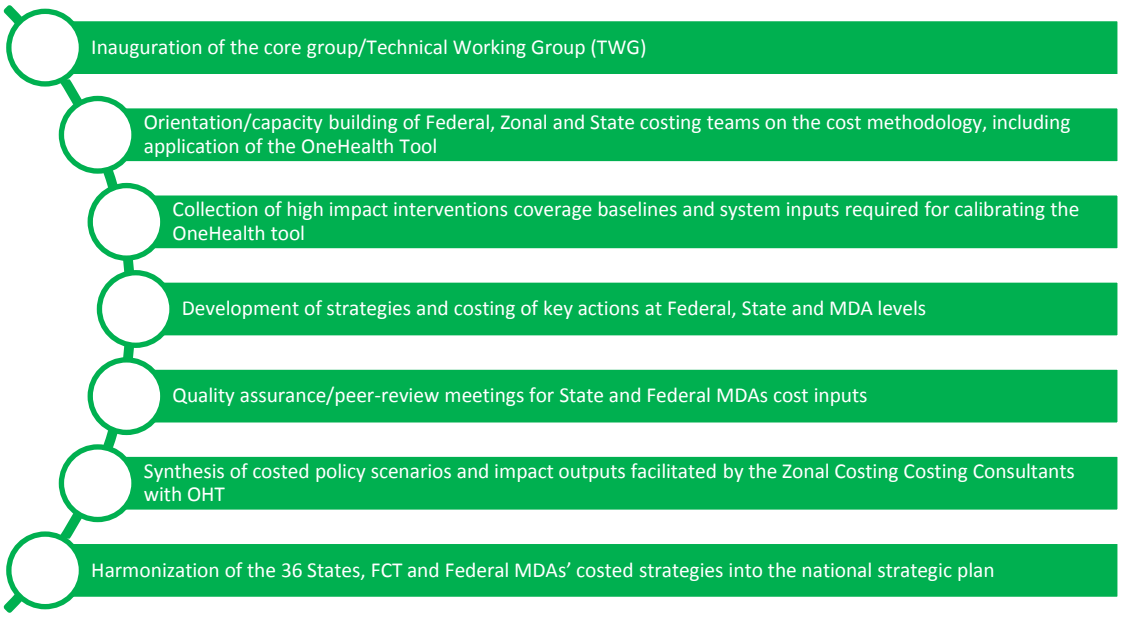
Financial Resources: NSHDP II Costing and Budget

NSHDP II cost estimates and resources available for its implementation are vital preconditions to ensure realistic levels of ambition for the strategy. This will leverage the prioritisation of planned investments and the design of appropriate measures to finance the emerging resource gaps. This section outlines the methodology used in costing the NSHDP II, and the estimates of available resource commitments within the country over the strategy period. Recommendations to bridge the emerging financing gap in the strategy are also presented.

9.1 NSHDP II Costing Methodology

A bottom-up costing approach was used in line with the constitutional provision that places health on the concurrent legislative list, empowering all the States and FCT to make decisions on health within the context of the national framework. Therefore, NSHDP II cost projections are based on state-specific coverage targets and planned strategic actions. The total NSHDP II cost presented in this Plan is the aggregate of costs of health system inputs and programme management activities that will be carried out by the 36 States, the FCT, the FMOH and its agencies. Additional costs estimate for delivering services to achieve the desired NSHDP II coverage and impact targets are also presented. In order to facilitate the cost projections and ensure consistent methods were used across all 36 States and FCT, the OneHealth Tool (OHT) version 4.63 was used. OneHealth Tool is a unified costing template that estimates the overall cost of delivering the package of health services identified in the strategy. The costing exercise was done through a consultative and iterative process of data collection, target setting and quality assurance to ensure alignment with the National Health Policy, validation and harmonisation to ensure accuracy of estimates.

Figure 23: NSHDP II Costing Process



In order to guide the overall costing of the NSHDP II, cost inputs were generated for the following health services and health system strengthening direct and management costs.

Table 52: Cost Inputs Components for NSHDP II Costing

Health Services Component	HSS Component
✓ RMNCAH+N ✓ Communicable diseases and NTDs ✓ NCDs and Mental Health ✓ Health Promotion ✓ Emergencies & Epidemic Preparedness ✓ General & Emergency Hospital Services	✓ HR (admin and service delivery) ✓ Logistics ✓ Infrastructure including blood safety and laboratories ✓ Governance ✓ Health Financing
Health Services Management Costs	**HSS Management Costs**
✓ Specific HR ✓ In-service and refresher training ✓ ISS ✓ Annual Planning ✓ Data collection	✓ Specific HR ✓ In-service and refresher training ✓ Blood safety ✓ Annual Planning ✓ Data collection

In addition to the total cost of the strategy, impact estimates are presented for different cost scenarios. Three policy scenarios have been modelled for costs and impact to guide stakeholders in arriving at the more cost-effective investment pathway for improving the nation's health status, within the limit of available resources. The cost outputs for the three scenarios have been organised by programme area and health system block. Additional outputs for programme management costs are also presented.

9.2 Overview of Costing Assumptions and Data sources

While a more detailed description of each of the three policy scenarios is discussed in the next section, the following 15 assumptions were considered in arriving at the total NSHDP II cost.

1. 2016 was adopted as the baseline year and the duration of the Plan was set as 2018-2022 in accordance with the National Council of Health (NCH) resolution
2. The population estimate for the three policy scenarios was based on National Population Commission (NpopC) projections
3. The currency exchange rate was set at ₦305 to 1 US$.
4. Baseline mortality ratios for maternal, neo-natal and under-five were obtained from DHS 2013 and MICS 2016-17
5. In response to the challenge of accessing service coverage, baseline from routine health statistics, survey data from MICS 2016-17 and DHS 2013 were applied.

6. Where there were MNCH data gaps in MICS and DHS, studies on the relationship between coverage of skilled birth attended deliveries and other childbirth interventions were used in estimating some of the missing baselines.[51]
7. The coverage baselines of NSHDP II scenarios were derived mainly from population-based surveys such as DHS 2013 and MICS 2016-17
8. For the dedicated programmes with existing country strategies and funding such as RMNCAH+N, Family Planning, HIV and TB, efforts were made to align the intervention targets of NSHDP II with those of the country strategies.
9. It was assumed that the services modelled for NSHDP II would be delivered at both public and private facilities.
10. National baselines for health infrastructure cost estimation were guided by State submissions. The FMOH DHPRS provided guidance in cases where the States were unable to provide the data.
11. There was general paucity of data for estimating costs for medicines and supply management at all levels. While the unit costs of each medicine and supply was obtained from global price lists, in-country investments required for warehousing, handling, and last mile distribution to the points of care, were determined through historical estimates and expert opinion. Consequently, 30% of the total amount allocated to Procurement and Supply Management was allocated to warehousing, handling, and distribution.
12. HRH investment is crucial for delivering the health service targets. Aggregated State-specific HR data for Human Resources costs were used as estimates for the baseline policy scenario. However, existing capacities of skilled staff (i.e. Doctors, Nurses, and Midwives) were scaled-up to meet the demand of the scaled NSHDP II scenarios.
13. As part of the NSHDP II governance activities, allocations were provided to strengthen private sector engagement including funds for effective regulations, capacitation of care providers for improved quality and collection of service data.
14. Government estimates for the resource analysis were derived from the 2016 budget and projected using population growth.
15. Data on development partners' health funding were collected using the resource mapping tool. The NSHDP II is expected to guide the development partners' future funding priorities.

9.3 Limitations of the NSHDP II Costing

- There was limited availability and/or access to community and health facility input data.
- Unlike service statistics, availability of HSS data to guide the scenario modeling process was also critically limited.
- Lack of service coverage baselines was noted across a number of the health programme areas, particularly TB, NCDs and NTDs. A baseline coverage placeholder of 10% for the affected interventions was used, pending the determination of baselines.
- More than 20% of the NSHDP II interventions lacked unit cost estimates which were required for cost modelling. The most affected services were NCDs, Mental Health and NTDs. These interventions were included in the model for impact estimation.
- As for Health System cost inputs, information provided for HR, Logistics and Infrastructure were insufficient to support the national aggregate. While some

States and FCT provided cost inputs for infrastructure and HR, no information was provided for the management and distribution of medicines and supplies.

- Similarly, in aggregating the national infrastructure cost, access to state-specific unit costs for building and equipping of health facilities (primary, secondary and tertiary) was challenging. This gap was addressed using harmonised estimates across States and FCT.
- Accessing data on resource commitments from development partners for financial sustainability analysis was very challenging. Development partners in 31 out of 36 states and FCT provided some measure of their commitments to health.

9.4 Overview of NSHDP II Costing Scenarios

Impact and cost estimates for the NSHDP II were modelled for the period 2018-2022 in line with the national commitment towards the attainment of global mortality targets for maternal, new-born, and under-fives by 2030. With the 2022 mortality ratio agreed upon, coverage parameters for high impact health services were iteratively scaled until the desired targets to yield the mortality ratios were achieved. Guided by this approach, three NSHDP II Policy Scenarios have been modelled with estimated costs of responding to the causes of mortality, and the overall cost of implementing the strategic plan. The three scenarios are as follows:

- Baseline – no coverage scale-up and no significant change in HSS investment during the life of the NSHDP II.
- Moderate Scenario – scale-up of EPHS and HSS investments required for the implementation of the Primary Health Revitalization Agenda, a key policy thrust of Economic Recovery and Growth Plan (ERGP).
- Aggressive Scenario – scale-up of EPHS and HSS investments aimed at achieving universal health coverage while implementing components of the primary health care revitalization agenda contained in the Moderate Scenario.

Overview of the Baseline Scenario

Although the coverage profile for this scenario was modelled as “baseline,” measures were put in place to sustain the quality of existing health services through targeted allocation of programme management funds. HSS investment under this scenario were limited to recurrent expenditure required to maintain functionality of the health system without expansion in scale. This includes but is not limited to funding for maintenance of health infrastructure, payment of salaries for the existing staff establishment and relevant logistics funding to maintain service delivery. In summary, this scenario was modelled to demonstrate impact and missed opportunities of sustaining the current trend in service delivery.

Overview of the Moderate Scenario

The moderate scenario aimed at reducing mortality by implementing government’s primary health care revitalisation agenda and increasing access to the EPHS at all levels of care. The NSHDP II identifies inequitable coverage of MSP and EPHS, suboptimal quality of services, inequity in access to information and linkage to services (geographic, socio-economic and gender) as key factors contributing to high mortality.

- ✓ For this policy scenario, a year-on-year exponential interpolate profile has been proposed, while the baseline coverages for health services were increased by a mean value of 17.5% to address the key causes of mortality. However, a scale up of 7.5% was used for FP based on historical trends. Attainment of a modern FP method mix of 75% from a baseline of 20.9% was also assumed. The HIV treatment scale-up was guided by the recently adopted 90-90-90 policy.
- ✓ With a 17.5% average increase in service coverage, sufficient allocation was provided to address the associated health system's demands. Skilled provider density was scaled-up to meet the demands for frontline health workers.
- ✓ Based on data provided across the States, the modelled number of key health providers required for the moderate scenario include 97% increase in medical Doctors (8,322), 185% increase in nurses (63,118) and 150% increase in midwives (39,000).

Overview of the Aggressive Scenario

The aggressive scenario assumed scale up of the coverage of EPHS towards the attainment of Universal Health Coverage with incorporation of the primary health care revitalisation agenda modelled in the moderate scenario.

- ✓ A year-on-year frontloaded interpolate profile was used to arrive at 30% general increase in coverage for most health interventions and a 10% increase in CPR coverage compared to 7.5% under the moderate scenario.
- ✓ Human resources and infrastructure capacities were scaled to accommodate the HSS requirements for service delivery ate all levels of care.
- ✓ Based on the existing HR, the required frontline health workers modelled for the aggressive scenario included 39,000 medical doctors, 69.700 nurses and 39,188 midwives to guarantee skilled staff adequacy.
- ✓ Funds were also allocated to strengthen the referral systems including the capacity of the secondary and tertiary health facilities to support referral process.

The moderate scenario investment would yield the following outcomes

- MMR reduction from 576 to 400 per 100,000 live births representing a 31% reduction towards the attainment of global target
- NMR reduction from 39 to 26 per 1,000 live births representing a 33% reduction towards the attainment of global target
- U-5MR reduction from 120 to 85 per 1,000 live births representing a 29% reduction towards the attainment of global target

The aggressive scenario investment would yield the following outcomes:

- MMR reduction from 576 to 359 per 100,000 live births representing a 38% reduction towards the attainment of global target
- NMR reduction from 39 to 23 per 1,000 live births representing a 41% reduction towards the attainment of global target
- U-5MR reduction from 120 to 73 per 1,000 live births representing a 39% reduction towards the attainment of global target

9.5 Detailed analysis of the costs of scale up scenarios

Table 53: The overall cost estimates for the three policy scenarios

Policy Scenarios	Average coverage increase	Total NSHDP II cost by scenarios in Trillion (₦)						Mean Cost Per Capita
		2018	2019	2020	2021	2022	TOTAL	
Baseline	0%	₦ 0.859	₦ 0.859	₦ 0.899	₦ 0.879	₦ 0.873	₦ 4.340	(USD 24)
Moderate	17.5%	₦ 0.947	₦ 1.087	₦ 1.220	₦ 1.325	₦ 1.492	₦ 6.071	(USD 34)
Aggressive	30%	₦ 1.115	₦ 1.365	₦ 1.492	₦ 1.559	₦ 1.790	₦ 7.321	(USD 41)

Table 54: Detailed breakdown of NSHDP II programme costs for the moderate scenario

NSHDP II Programme Areas	Moderate scenario costs by programme area (Billion ₦)						%
	2018	2019	2020	2021	2022	Total	
Maternal and newborn health	₦ 34	₦ 38	₦ 38	₦ 40	₦ 42	₦ 191	31.5%
Child health	₦ 14	₦ 15	₦ 15	₦ 15	₦ 15	₦ 75	12.3%
Immunization	₦ 6	₦ 7	₦ 8	₦ 9	₦ 10	₦ 38	6.3%
Adolescent health	₦ 4	₦ 5	₦ 7	₦ 9	₦ 13	₦ 38	6.3%
Malaria	₦ 4	₦ 4	₦ 8	₦ 6	₦ 5	₦ 27	4.4%
TB	₦ 1	₦ 1	₦ 2	₦ 2	₦ 2	₦ 7	1.2%
HIV and AIDS	₦ 11	₦ 10	₦ 12	₦ 13	₦ 15	₦ 62	10.2%
Nutrition	₦ 10	₦ 13	₦ 15	₦ 17	₦ 20	₦ 75	12.4%
Environment Health & WASH	₦ 3	₦ 3	₦ 3	₦ 4	₦ 4	₦ 17	2.8%
Non-communicable diseases	₦ 5	₦ 8	₦ 10	₦ 13	₦ 16	₦ 52	8.6%
Mental, neurological, and substance use disorders	₦ 2	₦ 3	₦ 3	₦ 4	₦ 5	₦ 17	2.8%
Neglected tropical diseases	₦ 0	₦ 0	₦ 0	₦ 0	₦ 0	₦ 1	0.2%
Health promotion and Social determinants of health	₦ 0.11	₦ 1	₦ 0	₦ 0	₦ 0	₦ 2	0.3%
Emergency Hospital Services	₦ 0.38	₦ 1	₦ 1	₦ 1	₦ 1	₦ 4	0.6%
Public Health Emergencies, Preparedness and Response	₦ 0.0	₦ 0.1	₦ 0.1	₦ 0.1	₦ 0.1	₦ 0.3	0.1%
Total Cost (Trillion ₦)	**₦0. 947**	**₦ 1.087**	**₦ 1.220**	**₦ 1.325**	**₦ 1.492**	**₦ 6.071**	**100%**

Table 55: Detailed breakdown of NSHDP II HSS costs for the moderate scenario

HSS Cost Categories	Moderate scenario costs by HSS pillar (Billion ₦)						%
	2018	2019	2020	2021	2022	Total	
Programme Activity Costs	₦ 22	₦ 68	₦ 57	₦ 53	₦ 50	₦ 251	4.1%
Human Resources	₦ 421	₦ 437	₦ 459	₦ 482	₦ 523	₦ 2,321	38.2%
Infrastructure	₦ 84	₦ 90	₦ 89	₦ 87	₦ 86	₦ 436	7.2%
Logistics	₦ 125	₦ 146	₦ 183	₦ 210	₦ 249	₦ 913	15.1%
Medicines, commodities, and supplies	₦ 288	₦ 324	₦ 414	₦ 476	₦ 568	₦ 2,070	34.1%
Health Financing	₦ 2	₦ 10	₦ 9	₦ 8	₦ 7	₦ 35	0.6%
Health Information Systems	₦ 3	₦ 5	₦ 4	₦ 3	₦ 4	₦ 19	0.3%
Governance	₦ 3	₦ 7	₦ 6	₦ 5	₦ 5	₦ 26	0.4%
Total Cost (Trillion ₦)	**₦ 0.947**	**₦ 1.087**	**₦ 1.220**	**₦ 1.325**	**₦ 1,.492**	**₦ 6.071**	**100%**

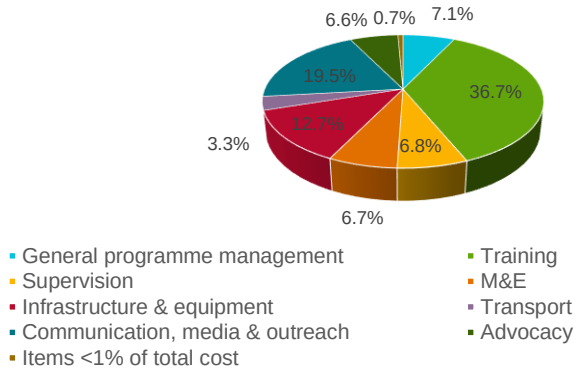
Table 56: Detailed breakdown of NSHDP II programme costs for aggressive scenario

NSHDP II Programme Areas	Aggressive scenario costs by programme area (Billion ₦)						%
	2018	2019	2020	2021	2022	Total	
Maternal and newborn health	₦ 360	₦ 417	₦ 431	₦ 449	₦ 471	₦ 2,128	29.1%
Child health	₦ 104	₦ 94	₦ 82	₦ 72	₦ 137	₦ 488	6.6%
Immunization	₦ 51	₦ 53	₦ 52	₦ 51	₦ 118	₦ 325	4.4%
Adolescent health	₦ 94	₦ 133	₦ 159	₦ 180	₦ 199	₦ 764	10.4%
Malaria	₦ 42	₦ 32	₦ 66	₦ 47	₦ 69	₦ 256	3.5%
TB	₦ 13	₦ 23	₦ 24	₦ 26	₦ 27	₦ 114	1.6%
HIV and AIDS	₦ 137	₦ 164	₦ 177	₦ 188	₦ 180	₦ 846	11.6%
Nutrition	₦ 135	₦ 182	₦ 205	₦ 226	₦ 246	₦ 994	13.6%
Environmental Health and WASH	₦ 31	₦ 36	₦ 39	₦ 42	₦ 44	₦ 193	2.6%
Non-communicable diseases	₦ 108	₦ 156	₦ 179	₦ 198	₦ 214	₦ 855	11.6%
Mental, neurological, and substance use disorders	₦ 31	₦ 44	₦ 51	₦ 57	₦ 63	₦ 247	3.4%
Neglected tropical diseases	₦ 2	₦ 5	₦ 5	₦ 5	₦ 4	₦ 20	0.3%
Health promotion and Social determinants of health	₦ 2	₦ 8	₦ 6	₦ 6	₦ 5	₦ 28	0.4%
Emergency Hospital Services	₦ 6	₦ 15	₦ 15	₦ 12	₦ 10	₦ 58	0.8%
Public Health Emergencies, Preparedness and Response	₦ 1	₦ 1	₦ 1	₦ 1	₦ 1	₦ 5	0.1%
Total Cost (Trillion ₦)	**₦ 1.115**	**₦ 1.365**	**₦ 1.492**	**₦ 1.559**	**₦ 1.790**	**₦ 7.321**	**100%**

Table 57: Detailed breakdown of NSHDP II HSS costs for the aggressive scenario

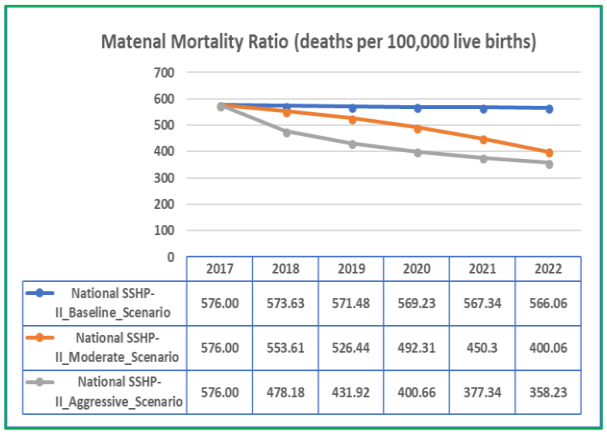
HSS Cost Categories	Aggressive scenario costs by HSS pillar (Billion ₦)						%
	2018	2019	2020	2021	2022	Total	
Programme Activity Costs	₦ 34	₦ 105	₦ 87	₦ 82	₦ 78	₦ 386	5.3%
Human Resources	₦ 428	₦ 458	₦ 485	₦ 510	₦ 543	₦ 2,423	33.1%
Infrastructure	₦ 86	₦ 96	₦ 94	₦ 92	₦ 90	₦ 458	6.3%
Logistics	₦ 168	₦ 207	₦ 244	₦ 260	₦ 321	₦ 1,200	16.4%
Medicines, commodities, and supplies	₦ 385	₦ 459	₦ 548	₦ 585	₦ 729	₦ 2,708	37.0%
Health Financing	₦ 2	₦ 15	₦ 13	₦ 12	₦ 11	₦ 54	0.7%
Health Information Systems	₦ 4	₦ 8	₦ 7	₦ 5	₦ 6	₦ 30	0.4%
Governance	₦ 6	₦ 16	₦ 13	₦ 13	₦ 13	₦ 62	0.8%
Total Cost (Trillion ₦)	**₦ 1.115**	**₦ 1.365**	**₦ 1.492**	**₦ 1.559**	**₦ 1.790**	**₦ 7.321**	**100%**

Figure 24: Distribution of programme management costs

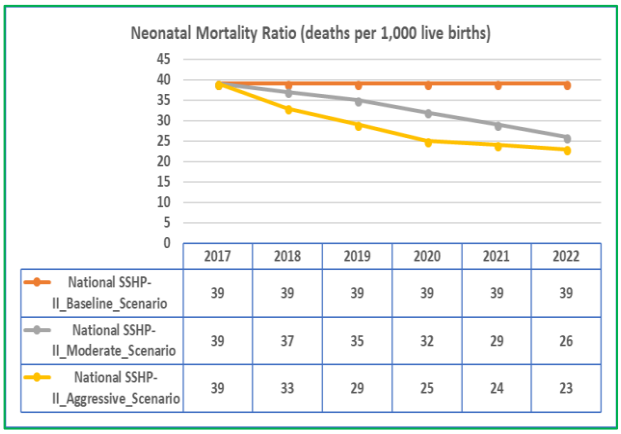


9.6 Impact of the scale up scenarios

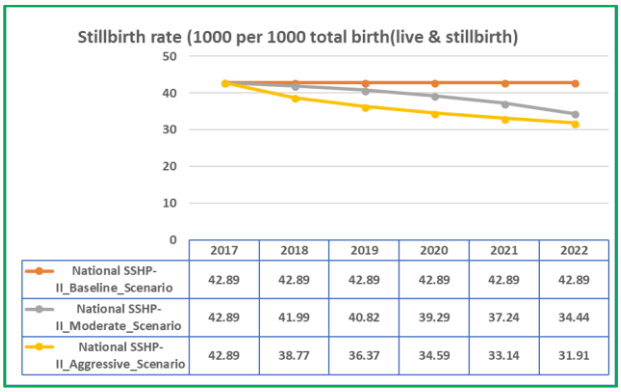
Figure 25: The impact of scaling up was modelled on RMNCAH and HIV/AIDS



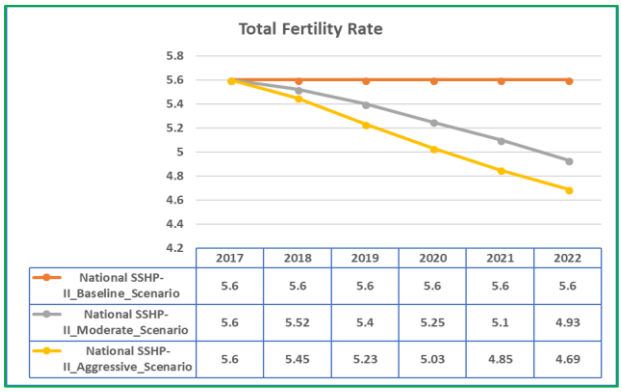
	2017	2018	2019	2020	2021	2022
National SSHP-II_Baseline_Scenario	576.00	573.63	571.48	569.23	567.34	566.06
National SSHP-II_Moderate_Scenario	576.00	553.61	526.44	492.31	450.3	400.06
National SSHP-II_Aggressive_Scenario	576.00	478.18	431.92	400.66	377.34	358.23



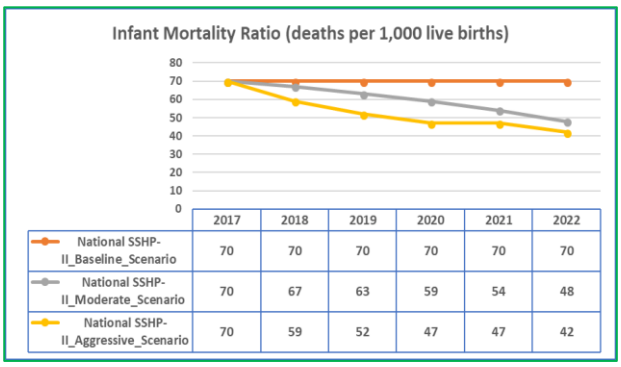
	2017	2018	2019	2020	2021	2022
National SSHP-II_Baseline_Scenario	39	39	39	39	39	39
National SSHP-II_Moderate_Scenario	39	37	35	32	29	26
National SSHP-II_Aggressive_Scenario	39	33	29	25	24	23



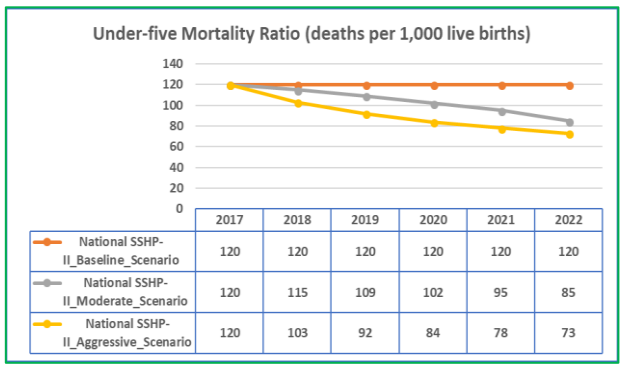
	2017	2018	2019	2020	2021	2022
National SSHP-II_Baseline_Scenario	42.89	42.89	42.89	42.89	42.89	42.89
National SSHP-II_Moderate_Scenario	42.89	41.99	40.82	39.29	37.24	34.44
National SSHP-II_Aggressive_Scenario	42.89	38.77	36.37	34.59	33.14	31.91



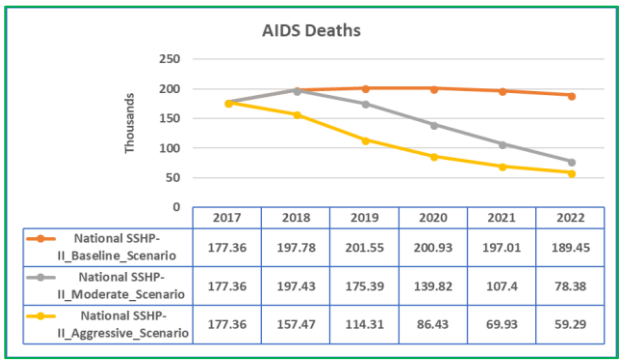
	2017	2018	2019	2020	2021	2022
National SSHP-II_Baseline_Scenario	5.6	5.6	5.6	5.6	5.6	5.6
National SSHP-II_Moderate_Scenario	5.6	5.52	5.4	5.25	5.1	4.93
National SSHP-II_Aggressive_Scenario	5.6	5.45	5.23	5.03	4.85	4.69



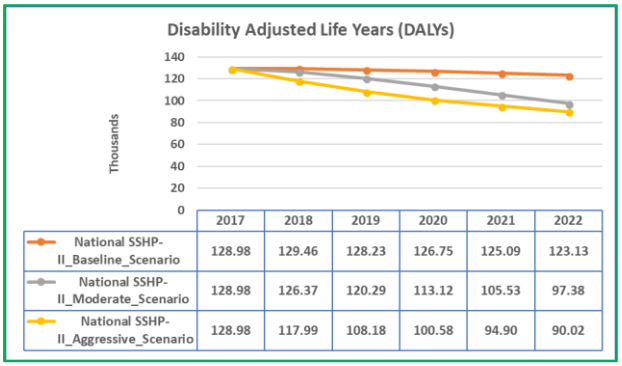
	2017	2018	2019	2020	2021	2022
National SSHP-II_Baseline_Scenario	70	70	70	70	70	70
National SSHP-II_Moderate_Scenario	70	67	63	59	54	48
National SSHP-II_Aggressive_Scenario	70	59	52	47	47	42



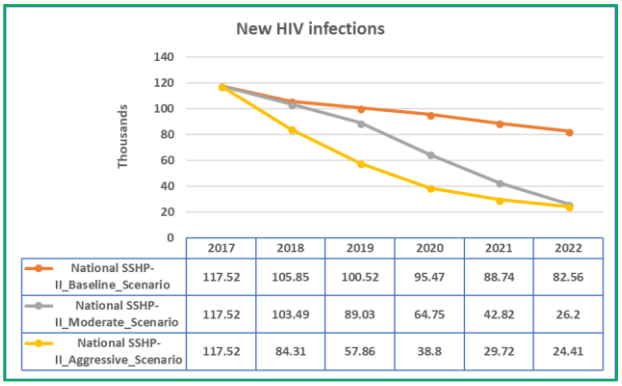
	2017	2018	2019	2020	2021	2022
National SSHP-II_Baseline_Scenario	120	120	120	120	120	120
National SSHP-II_Moderate_Scenario	120	115	109	102	95	85
National SSHP-II_Aggressive_Scenario	120	103	92	84	78	73



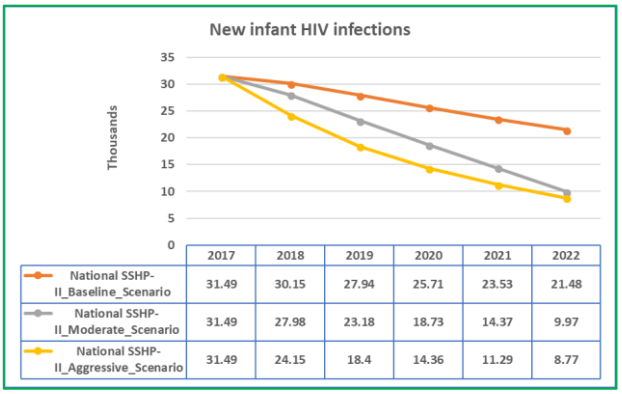
	2017	2018	2019	2020	2021	2022
National SSHP-II_Baseline_Scenario	177.36	197.78	201.55	200.93	197.01	189.45
National SSHP-II_Moderate_Scenario	177.36	197.43	175.39	139.82	107.4	78.38
National SSHP-II_Aggressive_Scenario	177.36	157.47	114.31	86.43	69.93	59.29



	2017	2018	2019	2020	2021	2022
National SSHP-II_Baseline_Scenario	128.98	129.46	128.23	126.75	125.09	123.13
National SSHP-II_Moderate_Scenario	128.98	126.37	120.29	113.12	105.53	97.38
National SSHP-II_Aggressive_Scenario	128.98	117.99	108.18	100.58	94.90	90.02



	2017	2018	2019	2020	2021	2022
National SSHP-II_Baseline_Scenario	117.52	105.85	100.52	95.47	88.74	82.56
National SSHP-II_Moderate_Scenario	117.52	103.49	89.03	64.75	42.82	26.2
National SSHP-II_Aggressive_Scenario	117.52	84.31	57.86	38.8	29.72	24.41



	2017	2018	2019	2020	2021	2022
National SSHP-II_Baseline_Scenario	31.49	30.15	27.94	25.71	23.53	21.48
National SSHP-II_Moderate_Scenario	31.49	27.98	23.18	18.73	14.37	9.97
National SSHP-II_Aggressive_Scenario	31.49	24.15	18.4	14.36	11.29	8.77

Health System Capacity/Utilization Analysis

Whereas the total NSHDP II costs were based on the required health system capacity, it is important to highlight the limitations of implementing the strategy with existing HSS capacity. While it is desirable for the NSHDP II policy goals to target ambitious service coverages, ensuring HSS capacities (particularly skilled care providers and infrastructure) are sufficient to deliver on these targets remains pertinent. Effective and comprehensive implementation of the strategy will not be possible if the critical HSS gaps are not addressed. To this end, existing HR and Infrastructure were costed against the projected HSS capacity utilisation for the NSHDP II scenarios. For HR, the key assumption considered in the analysis is the average daily work-time of skilled frontline providers (doctors, nurses, and midwives); this was set at 8 hours per working day (260 days annually). Available staff time for the specified staff types was compared against the proposed staff time required for service delivery for each of the NSHDP scenario. A similar capacity utilisation assessment was conducted for health infrastructure - measuring the current bed day capacity against the need for each scenario. However, it should be noted that not all health services provided through the Health System were modelled using the OneHealth tool. For example, a large share of health workers' time, may be spent on addressing conditions that are not specified within the projections, e.g. ear infection and general injuries were not modelled. As a result, the staff time needs captured in the table below underestimates the gap and should be considered as the minimum requirement. Private sector inputs were also omitted from the modelling. According to NDHS 2013, 53.5% of health care is provided by the private sector. Therefore it is important to recognise the contributions of the private sector to service delivery and attainment of the NSDHP II goals.

The following table presents the utilisation analysis highlighting gaps and estimates including costs for the additional staff or infrastructure required to achieve the desired service and impact targets. In both policy scenarios, the existing nurse and midwife capacities are insufficient to deliver service coverage required to achieve mortality reduction targets by 2022. For medical doctors, especially with moderate scenario, the existing capacity appears sufficient when assessed at the national level since 97% of doctor capacity is utilised. However, when this analysis is conducted at subnational level, the doctor density drops significantly especially at in States. Most of the doctors in the health system are resident doctor based at the Federal Tertiary facilities. In order to effectively implement the moderate policy scenario, an additional HR investment of ₦244 billion is required. Similarly, an additional HR investment of ₦329 billion is required to achieve UHC under the aggressive scenario. In interpreting the utilisation analysis, it is important to note that the total NSDHP II cost for both scenarios is estimated to cover the required health system capacity to deliver the modelled service coverage.

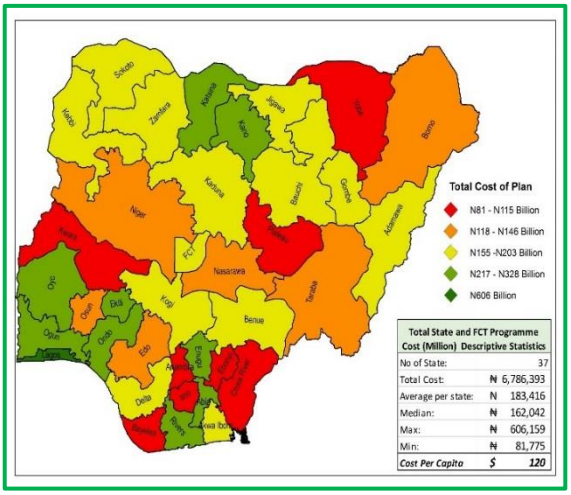
Table 58: Capacity utilisation assessment for NSHDP II cost scenarios

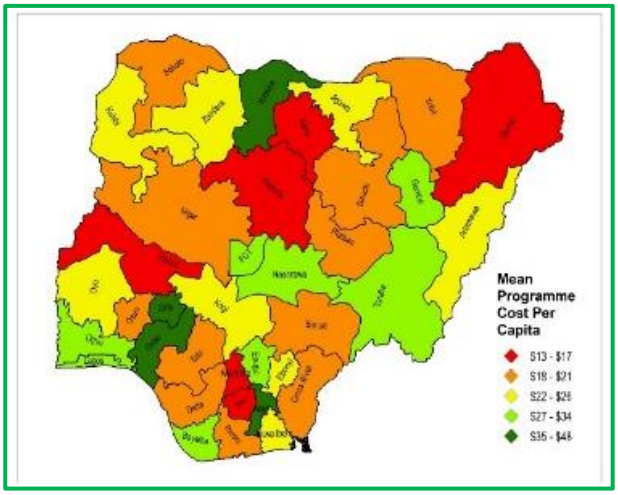
	Health impact	Existing utilisation	Additional requirement	Cost at existing capacity (Trillion ₦)	Cost of additional capacity (Billion ₦)	Cost of scale up (Trillion ₦)
Moderate scenario	MMR 400	A. Doctors - 97%	A. Doctor – 0%	₦ 5.828	₦ 244	₦ 6.071
		B. Nurses - 185%	B. Nurses - 85% (29,000)			
	U5MR 85	C. Midwives - 150%	C. Midwives - 50% (13,000)			
		D. Bed days - 35%	D. Bed days N/A			
Aggressive scenario	MMR 359	A. Doctor - 118%	A. Doctors 18% (6,000)	₦ 6.992	₦ 329	₦ 7.321
		B. Nurses - 220%	B. Nurses 120% (38,000)			
	U5MR 73	C. Midwives - 169%	C. Midwives 69% (16,000)			
		D. Bed days - 43%	D. Bed days - N/A			

9.7 Distribution of NSDHP II costs by State

This section presents the distribution of total NSDHP II costs for each State and FCT using the moderate scenario. State-by-state costs of selected priority services are also presented, i.e. RMNCAH+N, Immunization, Malaria, HIV, TB, NTDs, NCDs and Mental Health, Environmental Health and WASH, Emergency Medical Services and Public Health Emergencies.

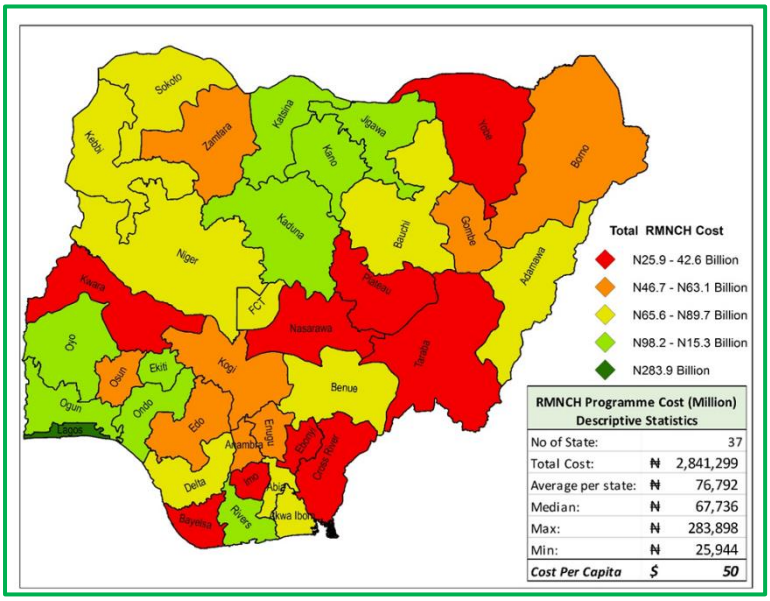
Figure 26: Distribution of NSDHP II moderate scenario costs by State





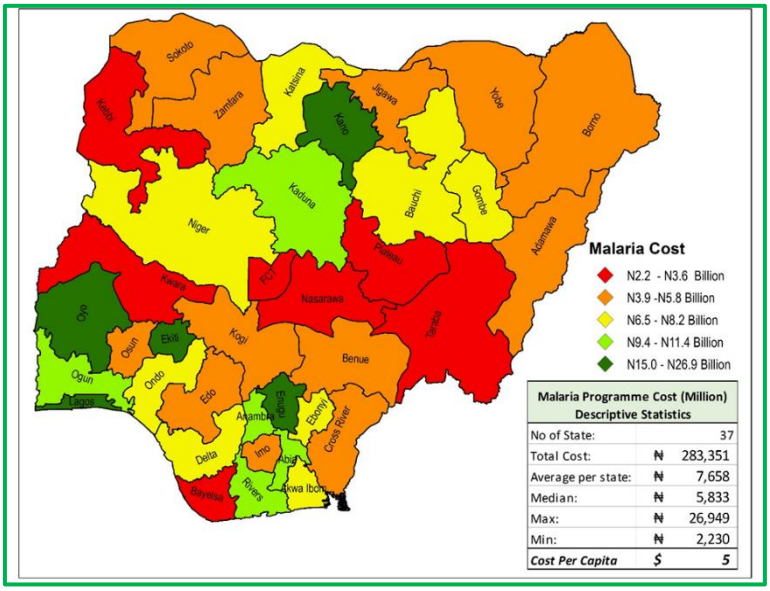
The analysis shows that 14 States are at the average SSDHP costs of ₦183.4 billion. Lagos State has the largest health sector spend at ₦606 billion. Anambra, Bayelsa, Cross River, Ebonyi, Imo, Kwara, Plateau and Yobe States have the lowest SSDHP costs. Per capita spending on health ranges from $35 and $48 across the States with Abia, Ekiti, Katsina and Ondo States having the largest health allocation per capita during the NSDHP II period. The estimate budget allocation per capita falls short of the reported average spending need of $54[52] to provide a basic package of essential health services in low income countries.

Figure 27: Distribution of RMNCAH+N funding by States



The total national allocation of funding for RMNCAH+N services is estimated at ₦2.8 trillion with an average of ₦76 billion and median of ₦67 billion. Almost 50% of the States of the Federation allocated more than national average for RMNCAH+N service delivery.

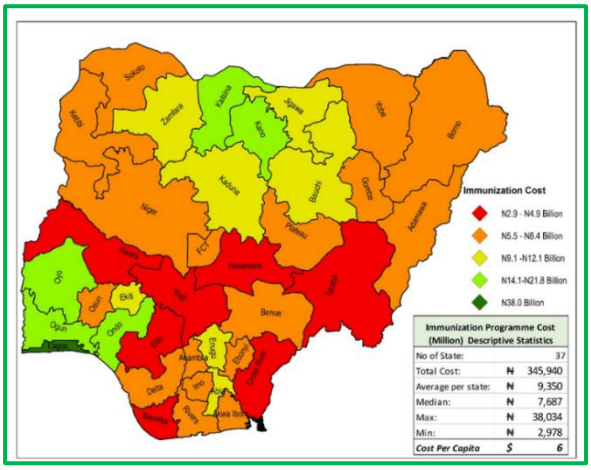
Figure 28: Distribution of malaria funding allocation by State



The total national cost of malaria intervention is estimated as ₦283 billion. Key interventions include distribution of ITN, IRS, IPT for pregnant women, malaria case management for children 5-14 years and adults. Nineteen States allocated below the national average of ₦7.6 billion for their malaria interventions.

A total sum of ₦346 billion has been planned for immunisation for the duration of NSHDP II. Twenty-four States have immunisation allocations below the national average of ₦9.4 billion compared to Abia, Bauchi, Ekiti, Enugu, Jigawa, Kaduna and Zamfara states which fell within or above the national average.

Figure 29: Allocative distribution of immunisation costs by State



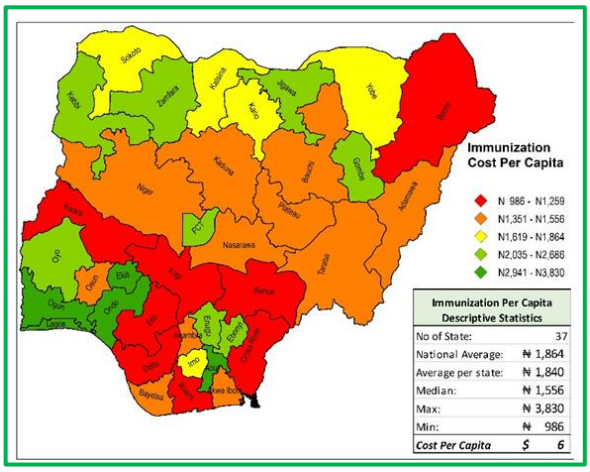
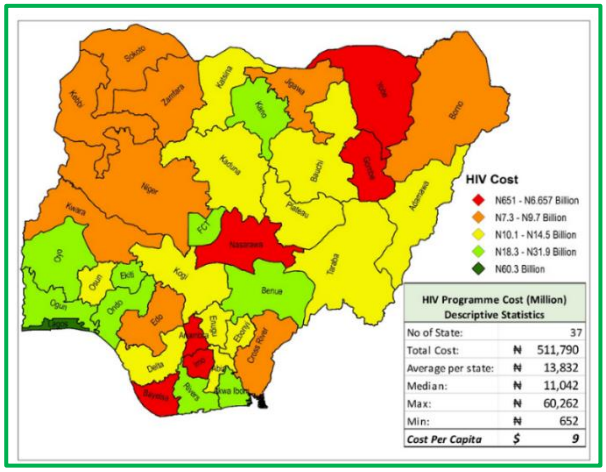
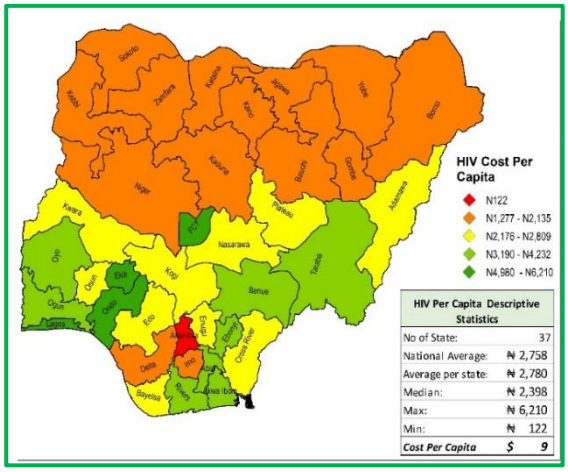


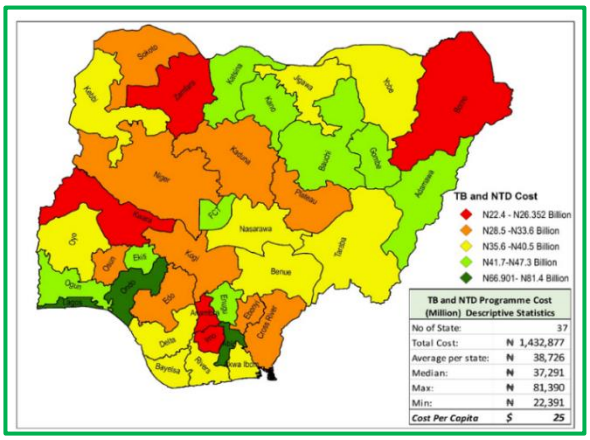
Figure 30: Distribution of HIV cost allocation by State plus per capita state spend

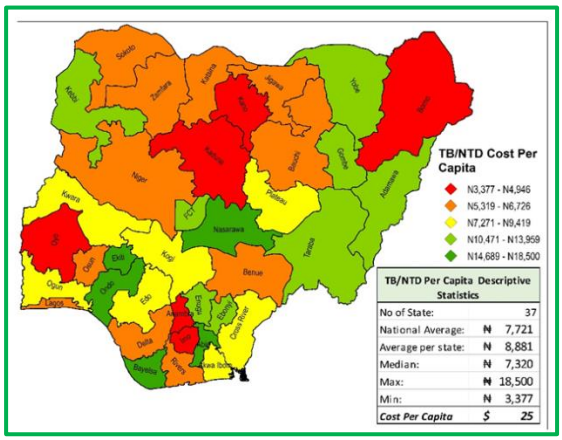




The projected total spend on HIV and AIDS during the tenure of the NSHDP II is ₦512 billion. Fifteen States are estimated to fall below the national HIV funding average.

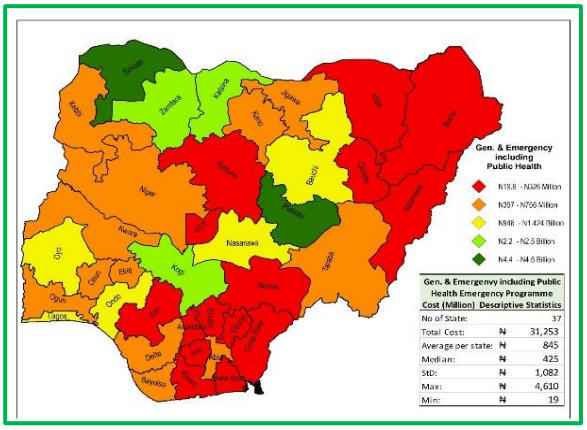
Figure 31: Distribution of TB and NTDs costs by State and per capita state spend

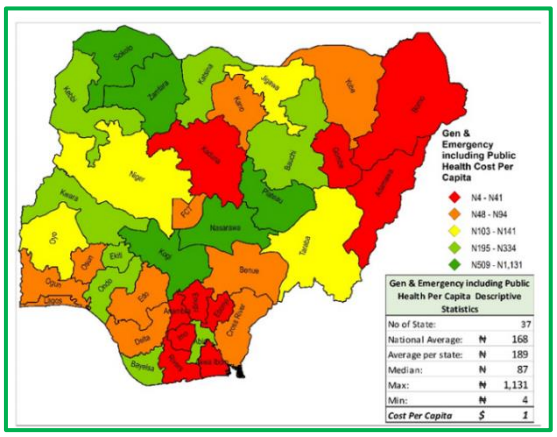




The projected total national allocation to TB and NTD interventions is ₦1.43 trillion with an average of ₦38.7 billion across the States. Abia, Lagos and Ondo have the highest projected financial investments in TB and NTDs.

Figure 32: Distribution of General & Emergency Medical Services costs by State





A total of ₦31billion has been planned for General and Emergency Services including Public Health Emergencies across the States and the FCT over the 5 year NSHDP II period. This is needed to ensure equitable and effective medical and laboratory services. The States with the highest investments are Plateau and Sokoto.

9.8 Funding Gap and Sustainability Analysis

The two NSHDP II policy scenarios were subjected to a financial sustainability analysis to compare the costs and the available funding including the affordability of the plan. This assessment enabled the NCH to decide which scenario to adopt and to determine whether there was need to adjust the scale of the adopted scenario.

Health care is funded by government, development partners, the private sector, and households. Federal and State Government domestic funding for health is derived from three sources: budget allocation, earmarking in the consolidated revenue funds (CRF) and innovative mechanisms such as health insurance schemes.

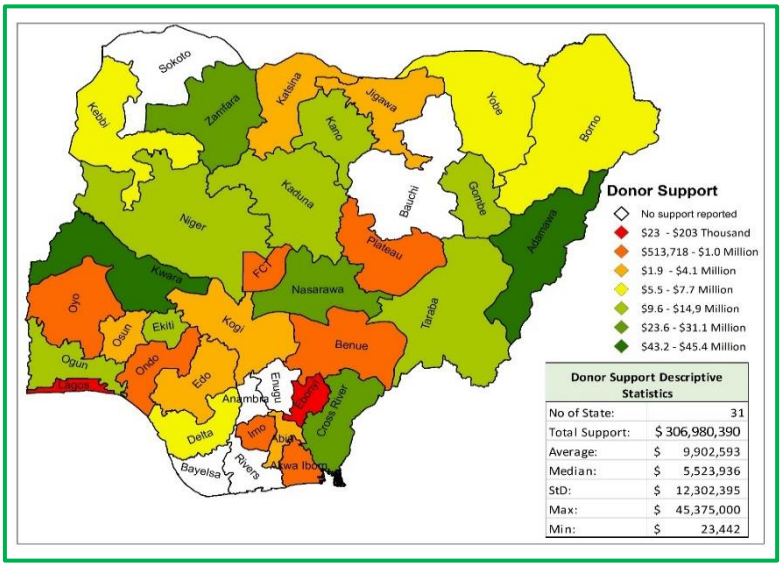
With government commitments established, a forward-looking five-year resource mapping of bilateral and multilateral development partners conducted as part of the NSHDP II costing process. Future funding commitment data was available for at least 3 years from 2018 to 2020 (disaggregated by State and FCT).

The following table presents the NSHDP II funding gap analysis capturing domestic and external funding sources. These external funding commitments should be interpreted with caution, as they may not have sufficiently captured all the in-country commitments of the development partners. Development partner commitments were reported for only 31 States and there was no external funding data in Anambra, Bauchi, Bayelsa, Enugu, Rivers and Sokoto States.

Table 59: Health Sector Funding Landscape and Funding Gap for Moderate Scenario

	USD million					
Sources of Funds	**2018**	**2019**	**2020**	**2021**	**2022**	**Total**
Federal Government Budget Allocation	$ 845.3	$ 865	$ 886.1	$ 906.7	$ 927.2	$ 4430.8
Total State Government & FCT Budget Allocation	$ 1321.1	$ 1358.9	$ 1396.7	$ 1434.5	$ 1471.9	$ 6983.1
UNICEF	$ 14.2	$ 1.4	$ 1.3	-	-	$ 16.9
WHO	$ 136.8	$ 132.1	$ 132.1	-	-	$ 401.0
UNFPA	$ 0.2	$ 0.1	$ 0.1	-	-	$ 0.3
NSHIP	-	$ 4.0	$ 3.0	$ 3.0	-	$ 10.0
EU/UNICEF	$ 8.0	$ 7.0	$ 6.0	$ 5.0	-	$ 26.0
SOML	$ 2.2	$ 9.5	$ 2.5	-	-	$ 14.3
USAID	$ 4.1	$ 2.4	$ 1.9	-	-	$ 8.3
Global Fund	$ 2.1	$ 1.7	$ 1.7	-	-	$ 5.5
DFID/UKAID	$ 7.7	$ 5.9	$ 2.3	-	-	$ 15.9
Sight Savers	$ 0.3	$ 0.3	$ 0.0	-	-	$ 0.6
CBM/DFAT	$ 0.1	$ 0.1	-	-	-	$ 0.2
NHF, CERF, DFID, EU	$ 1.9	$ 1.9	$ 1.9	-	-	$ 5.6
World Bank	$ 47.7	$ 53.2	$ 31.3	-	-	$ 132.2
Global Environment Fund (GEF)	-	$ 0.2	-	-	-	$ 0.2
Special Climate Change Fund	-	$ 0.2	-	-	-	$ 0.2
United Purpose	-	$ 3.1	-	-	-	$ 3.1
UN	$ 11.8	$ 17.2	$ 8.3	-	-	$ 37.3
EU	$ 3.2	$ 0.7	$ 0.7	-	-	$ 4.6
GAVI	$ 0.1	$ 0.1	$ 0.1	-	-	$ 0.2
IHVN	$ 0.0	$ 0.0	$ 0.0	-	-	$ 0.1
Global Affairs Canada	$ 1.4	$ 1.4	-	-	-	$ 2.8
Bill and Melinda Gates Foundation	$ 5.8	$ 4.3	$ 3.4	-	-	$ 13.5
Queen Elizabeth Jubilee Trust	$ 0.2	$ 0.1	$ 0.1	-	-	$ 0.4
Federal Government Funded Projects	$ 2.5	$ 1.5	-	-	-	$ 4.0
Pathfinder International	$ 0.1	-	-	-	-	$ 0.1
CERF UNOCHA	$ 1.3	$ 0.1	$ 0.1	-	-	$ 1.5
BMC-CDC	$ 0.1	-	-	-	-	$ 0.1
PSI	$ 0.1	$ 0.1	-	-	-	$ 0.1
PEPFAR	$ 303.3	$ 383.6	$ 288.2	-	-	$ 975.1
Total Available Funds	$ 2721.2	$ 2856.5	$ 2767.8	$ 2349.1	$ 2399.1	$ 13,093.8
Cost of NSHDP II moderate scenario	$ 3,103.9	$ 3,564.6	$ 4,000.5	$ 4,344.1	$ 4,893.3	$ 19,906.5
Funding gap for moderate scenario	$ 383	$ 708	$ 1,233	$ 1,995	$ 2,494	$ 6,813
Moderate scenario funding gap %	12.3%	19.9%	30.8%	45.9%	51.0%	34.2%
Cost of NSHDP II aggressive scenario	$ 3,655.8	$ 4,474.1	$ 4,891.1	$ 5,110.7	$ 5,870.3	$ 24,002.1
Resource gap for aggressive scenario	$ 1,780	$ 2,483	$ 3,009	$ 3,668	$ 4,398	$ 15,339
Aggressive scenario funding gap %	25.6%	36.2%	43.4%	54.0%	59.1%	45.4%

Figure 33: Distribution of domestic and external health funding by State



The funding gap for moderate and aggressive scenario was estimated to be 36% and 51% respectively – thereby reflecting significant fiscal constraints to achieve the PHC revitalization agenda or UHC. As the country recovers from the 2016-2017 recession, the assumption of significant growth in domestic health expenditure is uncertain. In fact the national health budget allocation has consistently fallen short of the Abuja commitment[53]. On the other hand, external donor funding has gradually declined further narrowing the fiscal space for NSHDP II resourcing.

In light of limited capacity to increase revenue generation, poor prioritisation of health in most States and other constraining factors such as fragility and economic recession, the aggressive scale-up scenario was considered to be unfeasible. The moderate scale-up scenario estimated at $34 per capita with a funding gap of 36% presents a more sustainable and realistic financial pathway to implementing NSHDP II within the prevailing health system constraints.

9.9 Bridging the Resource Gap

With the adoption of the moderate scenario and its attendant 36% funding gap, resource mobilisation for NSHDP II implementation is an urgent imperative. Advocacy to increase the General Government Health Expenditure (GGHE) from the current 5.1% of General Government Expenditure (GGE) is needed more than ever. The 71.5% OOPE[54] is unacceptably high as it exacerbates the financial risk to households. Consequently, adopting pooled and prepaid private financing presents a promising health financing option. Optimising Overseas Development Assistance (ODA) and philanthropy; and engaging the private and informal sectors will be essential to NSHDP II funding.

As the country undertakes to implement the NSDHP II, funds required to resource the plan can be mobilized from the social health insurance scheme. Currently, States are at differnet stages of implementation of their social health insurance schemes. 84% of the States have drafted bills, while 30% have laws in place and 24% of the States have operationalised their schemes.

When fully operational, States are expected to contribute 0.5-1.0% of their Consolidated Revenue Fund (CRF) as statutory allocation to the State Health Insurance/Contributory Scheme, while growing the subscriber base. The National Health Act (NHAct) provides for a BHCPF of at least 1% of the Federal Consolidated Revenue Fund (CRF) for the coverage of basic minimum package of health services, PHC operational costs (HRH, medicines, infrastructure, transport) and public emergency services.

In determining the financial space available for NSHDP II implementation, three funding options have been modelled, specifically by varying the coverage of the social health insurance scheme to the NSHDP II global budget while maintaining the asumptions of other sources.

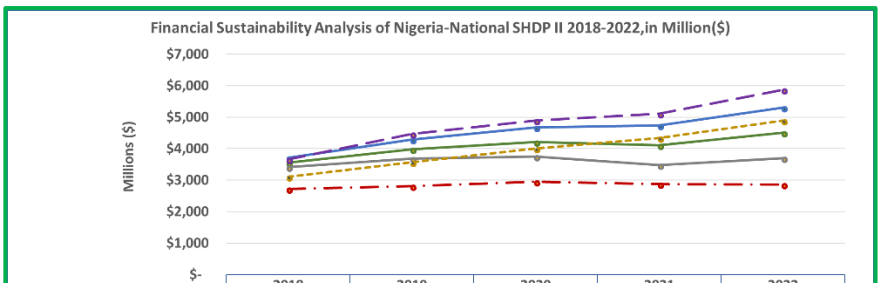
Key assumptions maintained across the three funding options include:

1. Development partner commitments estimated at $1.8 billion for the NSHDP II period
2. Total government (Federal and States) allocation to health increased by at least 4%
3. At least ₦60.8 billion will be allocated to the 36 States and the FCT from NHIS and BHCPF
4. An annual deduction of 0.75% from State's and FCT consolidated revenue funds towards SSHIS
5. A minimum SSHIS subscriber premium of ₦1,000 per month as the schemes mature in scale and coverage by 2022

The three funding options have been modelled to demonstrate the amount of revenue generated by varying the targets of the health insurance subscriber base as follows:

- **Funding Option One**: The health insurance coverage was scaled to 10% using the linear year-on-year interpolate as NSHDP II implementation approaches the target year of the plan.
- **Funding Option Two**: The health insurance coverage was scaled to 20% using the linear year-on-year interpolate as NSHDP II implementation approaches the target year of the plan.
- **Funding Option Three:** The health insurance coverage was scaled to 30% using the linear year-on-year interpolate as NSHDP II implementation approaches the target year of the plan.

Figure 34: NSHDP II Financial sustainability analysis in USD million



	2018	2019	2020	2021	2022
30% SHIS Subcribers base	$3,705	$4,288	$4,669	$4,742	$5,308
20% SHIS Subcribers base	$3,558	$3,987	$4,207	$4,112	$4,502
10% SHIS Subcribers base	$3,411	$3,686	$3,745	$3,482	$3,697
Cost of N/SHDP II Plan Aggressive Scenario	$3,656	$4,474	$4,891	$5,111	$5,870
Cost of N/SHDP II Plan Moderate Scenario	$3,104	$3,565	$4,001	$4,344	$4,893
Cost of N/SHDP II Plan Base Scenario	$2,726	$2,816	$2,947	$2,881	$2,861

The sustainability modelling presented above showed that the moderate scenario could be sufficiently resourced throughout the NSHDP II period through Funding Option Three. Options

One and Two would only cover the moderate scenario funding requirement for the first two years. With government allocation to health accounting for more than 75% of the domestic resource for each of the three funding options, the prevailing low budget performance and poor fiscal discipline at all levels, do not favour successful implementation of NSHDP II. A mean budget performance of 75% across 36 States, FCT and Federal MDAs would be required for the feasibility of the above funding options to successfully deliver NSHDP II.

9.10 Conclusions and Recommendations

The NSHDP II moderate scenario was approved at a total cost of ₦ 6,071 trillion over five years but with an estimated funding gap of 34%. When fully funded at the moderate scale up scenario, the NSHDP II is expected to yield the following health impact:

- MMR reduction from 576 to 400 per 100,000 live births representing a 31% reduction towards the attainment of global target
- NMR reduction from 39 to 26 per 1,000 live births representing a 33% reduction towards the attainment of global target
- U5MR reduction from 120 to 85 per 1,000 live births representing a 29% reduction towards the attainment of global target

As the State governments commit to implementing the NSHDP II, it is important to ensure adherence to the resource mobilisation assumptions of the recommended funding option which entails increasing health insurance coverage from 5% in 2018 to 30% by 2022.

The following principles will ensure that the NSHDP II is effectively implemented at all levels:

1. In order to reduce duplication and improve allocative efficiency, all development partner support and funding must be aligned with this strategy and its priorities.
2. A robust M&E framework must be in place to ensure that all the interventions and their targets are regularly tracked and updated throughout the NSHDP II implementation.
3. An accompanying Value for Money (VfM) framework must be developed and implemented in tandem with the M&E Framework to guide efficient and effective use of resources for NSHDP II.
4. Regular health facility and inventory assessments in both private and public sectors are essential to identify NSHDP II implementation bottlenecks and to generate much needed data to guide allocation of human resources, infrastructure and logistics.
5. Performance-based resource allocation needs to be strengthened in order to maximise the impact of available resources.

Chapter 10

Institutional Arrangements

The NSHDP II is a flexible, living document developed as a roadmap to provide strategic direction and collective action by the government, its partners and stakeholders to promote and protect health for the Nigerian populace. The Nigerian health system is complex in structure and delivery scope and challenges which the NSHDP II seeks to address. This chapter presents a thorough understanding and articulation of the key structures, roles and responsibilities of different institutions that will be involved in implementation of NSHDP II with a special focus on PHC revitalisation and progress towards UHC.

Institutional coordination mechanisms

An implementation steering committee will be established at the Federal and State levels to oversee implementation of the SHDP II. The steering committee will be chaired by the Honourable Minister of Health at federal level or the Honourable Commissioners for Health at the state level or the LGA Chairmen at local government level. The SHDP II steering committee will comprise relevant health MDAs, Planning Commission Ministry, Ministries of Finance, other relevant ministries, development partners, civil society and community representatives. The committee will be responsible for high level tracking of SHDP II implementation, advocacy and resource mobilisation, awareness creation and engagement with key stakeholders. The Country Compact on the NSHDP II requires all development partner agencies to align with and support the implementation of the plan at all levels. In line with this compact therefore, development partner agencies are important and key stakeholders in the implementation of the SHDP II at all levels.

The implementation of the SHDP II will require budgetary allocation to the health sector and resource mobilisation from other sources to fill gaps and complement domestic funding. Dedicated resources are required to strengthen the DPRS at all levels for planning and monitoring; and reporting on progress and implementation of the M&E plan. MDAs at all levels will extract strategic activities from their SHDP II to develop their MTEF, MTSS and/or Annual Operational Plans (AOPs). These plans will show detailed activities that are linked to key deliverables towards the achievement of the targets of the plans. Technical assistance will be provided to develop plans with realistic costing and stakeholder participation in facilitating the implementation. The Departments of Planning Research and Statistics (DPRS) at all levels will ensure that plans are developed annually and monitored using suitable tools that can track SHDP II results/targets. While the implementation of the NSHDP II requires ownership and leadership by the Federal, State and Local governments, participation of other stakeholders including, but not limited to the private sector, development partner agencies, civil society and communities is essential. The required ratification, approvals and final policy decisions required for NSHDP II implementation at all levels will be provided by and through various health sector governance and stewardship bodies as specified in the NHP, NHAct, relevant state policies and laws and coordination mechanisms.

The private sector will be actively involved and engaged, through public-private-partnership (PPP) arrangements and relevant coordination and consultative mechanisms. The private sector actors, institutions and bodies, whether for profit or not-for-profit, working in the health system or providing healthcare services will be an integral part of NSHDP II implementation. The need to ensure an enabling and regulatory environment for meaningful private sector engagement is key to the success of NSHDP II.

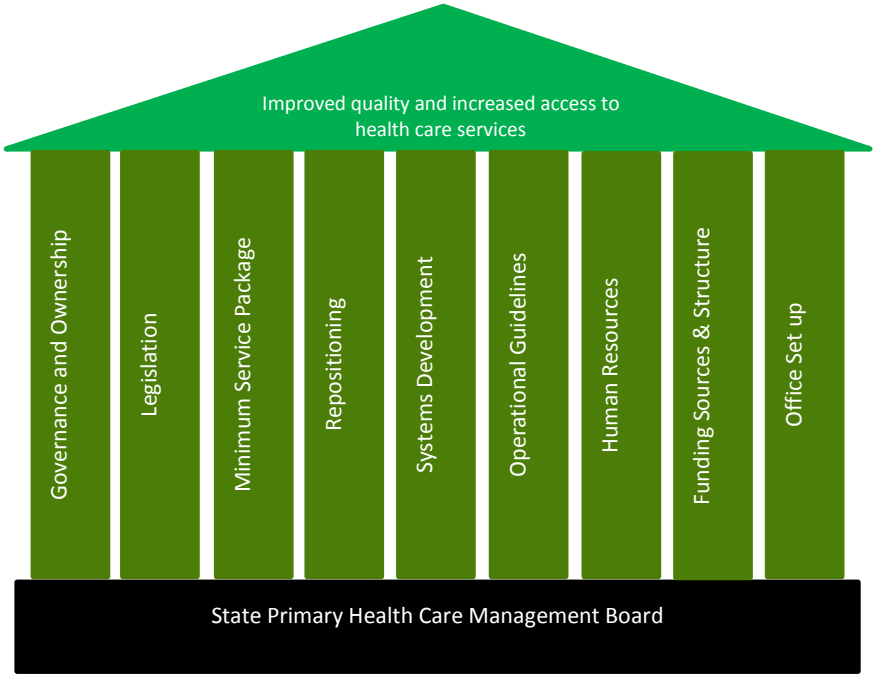
The coordination of NSHDP II at all levels is discussed below.

Federal level: Through its departments, agencies and inter-related parastatals, the FMOH shall coordinate, supervise and provide technical oversight for the implementation of the NSHDP II. The Honourable Minister of Health shall serve as the chief executive responsible for the attainment of the set goals and objectives of the plan. This will be done through various departments of the FMOH, TWGs and multiple coordination platforms for resource mobilisation and management, periodic performance review, accountability and oversight of implementation activities. The Minister shall have the responsibility of reporting progress towards targets to the National Council on Health.

State level: The SMOH under the leadership of the Honourable Commissioner for Health shall be custodian of implementation reporting to the Governor and the State Council on Health (SCH).

Local government level: According to the NHP, LGAs are responsible for the financing and managing of PHCs. The Medical Officer of Health (MOH) working closely with the LGA Health Management Team, provides overall stewardship of all health matters at the LGA level. In May 2011, the 54th NCH approved the Primary Health Care under One Roof (PHCUOR) Policy aimed at reducing fragmentation in primary healthcare services through the promotion of integrated management systems under one authority, with a single management body - the State Primary Health Care Board (SPHCB). The Board advises Commissioners for Health and LGAs in all matters concerning PHC activities.

Figure 35: The PHCUOR Policy has nine pillars guiding its operationalisation.



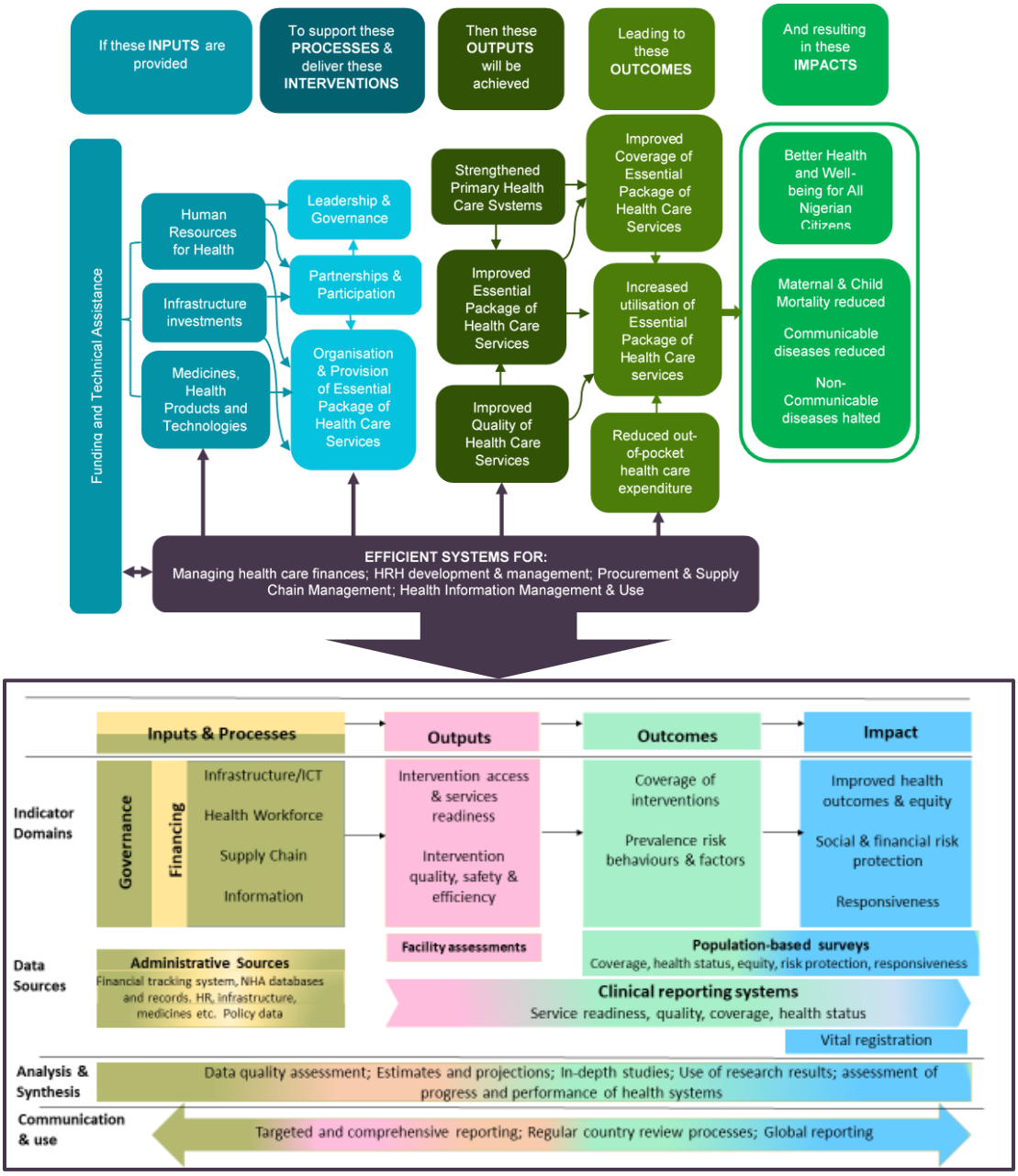
Community level: Nigeria has a diverse and vibrant community structure comprising of various traditional, religious and other normative groups – all of which are pertinent to the country's health outcomes. Pursuant to the PHC revitalisation agenda, it is critical that all the community structures e.g. Traditional and religious leaders, Ward Development Committees (WDCs), Facility Health Committees (FHCs), CBOs and CSOs are meaningfully and continuously engaged at all stages of the NSHDP II – planning, implementation, monitoring and evaluation.

Chapter 11

Monitoring Implementation and Risk Management

While a **detailed NSHDP II M&E Framework** has been developed, its implementation will be monitored through the existing health information management system at all levels. As such, integration, simplification, and standardisation will be essential to ensure effective tracking of the NSHDP II targets. The NSHDP II M&E Framework serves as a management tool for promoting efficiency, effectiveness, accountability and transparency towards achieving the NSHDP II goals and objectives. It outlines various roles and responsibilities regarding the M&E, organising plans for data collection, data quality, analysis and use – as per existing national health information management system. As shown in the following diagram, the NSHDP II M&E Framework builds from Theory of Change (TOC) and traces results chains that are necessary to deliver the targets set out in the plan (see logic framework below the TOC).

Figure 36: Linking NSHDP II Theory of Change to its Results Chains



A core set of indicators to measure NSHDP II progress to UHC were developed through a consultative process involving key stakeholders, programme managers and M&E experts from FMOH and States. Data for tracking and evaluating NSHDP II implementation will be drawn from administrative and programme reports, facility assessments and population-based surveys. The results of the interventions will be communicated using different existing channels targeting a diverse audience and multiple stakeholder groups.

Table 60: NSHDP II Core Indicators

Health Services Coverage
Contraceptive Prevalence Rate
% of deliveries supervised by skilled birth attendants
Proportion of women having essential ANC (at least one visit, at least 8 visits)
% of primary/Ward Health centres providing basic /emergency obstetric and neonatal care services disaggregated by level of care
Measles immunization coverage
TB case detection rate
Malaria prevalence in the general population
Prevalence of malaria in children under-five
Coverage of HIV Testing Services (HTS)
% of diagnosed PLHIV receiving HIV treatment services
% of diagnosed PLHIV on ARV who achieve sustained virological suppression
Mortality rate attributable to unsafe water, unsafe sanitation and lack of hygiene (WASH)
Core Equity Indicators (disaggregated data by zones/states, urban/rural, wealth quintiles, etc.)
% of deliveries by Skilled Birth Attendance
% wards with of primary health care health centres providing Basic Emergency Obstetrics Care
Prevalence of acute malnutrition in children aged 0-59 months
Prevalence of wasting among under-fives
Prevalence of stunting among under-fives
Under five mortality rate
Infant mortality rate
Maternal mortality ratio
Quality of Care (QOC)
% of Health facilities that report stock out of anti-malarial commodities, diagnostic kits lasting more than one week in the past three months
% of all health facilities (public and private) generating and transmitting routine HMIS data by 2022
Client satisfaction level
Proportion of Secondary/Tertiary hospitals with functional ambulance services
PHC coverage & Referral
% of Wards in the country with at least one fully functional PHC centre providing comprehensive primary health care services in line with the EPHS
% of the LGAs that have functional general hospitals for referral from PHCs
% of Primary/Ward Health Centres providing basic Emergency Obstetric and neonatal care services disaggregated by Level of care
Financial Risk Protection
% of Nigerian population covered by any risk protection mechanism
Number of states that have established functional state health insurance schemes

Evaluation of the NSHDP II will include Joint Annual Reviews (JARs) which should be completed in time to ensure that the findings feed into the planning and budgeting cycle. Review teams will be set up and deployed to support the States. Ongoing evaluation will be done at each level through DPRS departments. This will include, but will not be limited to development and dissemination of briefs, factsheets, bulletins and reports for a variety of audiences. State level bi-annual and annual reports will be generated and submitted to the NCH. Formal mid and end-term evaluations will be conducted.

Communication Plan

A clear communication strategy and guide will be developed to deepen the understanding of the NSHDP II, build consensus and secure buy-in among stakeholders, build a robust knowledge repository and providing relevant support and materials for ongoing advocacy during implementation of the plan. The communication plan will have multiple and diverse audiences and will therefore require timely availability of accurate and appropriately synthesized and packaged information at all levels. For this to be efficiently done, care must be taken to plan and analyze the different messages and information required to effect the needed change in the health system. This will be carried out using simple, user-friendly communication guides as a key strategy for delivering the NSHDP II.

The communication strategy, which will be integrated into the implementation of NSHDP II and will be updated regularly to keep pace with results, lessons and evidenced generated from the NSHDP II implementation. As a living document, the communication strategy will capture emerging and re-emerging issues that have the potential of affecting implementation of the NSHDP II and attainment of its vision. Appropriate communication platforms will be used to connect the various strands and tiers of the health care delivery system including public and private sector and multisectoral collaborations. As such, the communication strategy will serve as a coordination mechanism leveraging information sharing, knowledge management and dissemination.

Existing communication structures and tools with FMOH and State governments will provide necessary leadership for designing and implementing appropriate communication plans for the NSHDP II.

Risk management

A number of risks with the potential of adversely affecting implementation of the NSHDP II were identified. These are organised by NSHDP II priority areas in the following table.

Table 61: NSHDP II Risk Matrix

	Risk description	Mitigation strategy
Leadership and Governance	• Lack of sustained political will, poor coordination, alignment and harmonisation between the different levels of government, and across departments and programmes frustrates policy implementation and limits responsiveness.	• Full implementation of the National Health Act and the fact that revised National Health Policy is informed by current global agenda (SDG). • Existing programmatic policies and plans should be fully implemented. • Political commitment to health, especially PHC. Implementation of PHCUOR will enhance performance of PHC
Community participation	• Poor understanding of concept and implementation of community participation at all levels. • Uncoordinated financial incentives for volunteer community-based workers threatens sustainability of community engagement. • Ignorance, fatalistic outlook to disease causation and outcome in some parts of the country and differential incentive package by partners for community-based health workers threaten harmony among workers and partners.	• WDCs at ward level are a springboard for continuing community education and mobilisation. • Availability of an organised platform for traditional rulers and religious leaders' involvement in health is a strong tool for community participation and ownership of health programmes. • Availability of various community-based health care providers engenders wider community participation and harmonisation of programmes.
EPHS	• Lack of, or outdated data for planning of some interventions (e.g. NCDs, care of the elderly, mental health) • Limited capacity at all levels	• Availability of policies, guidelines, SOPs etc. for established programmes. • Targeted and flexible technical assistance with support from development partners
Public health emergencies	• Capacity of NEMA and SEMA to respond to emergencies is poor and the health component of the response is hardly visible. • Surge capacity of health facilities to respond to public health emergencies is poorly developed • Emergency preparedness and response, including pre-positioning of drugs, vaccines and consumables is poor.	• Establishment of NCDC and Emergency operations centres (EOC) • Available policies, strategic plan, guidelines and tools for IDSR can be fully implemented for better impact. • Build the capacity of NEMA and SEMA through provision of required equipment and regular retraining of the staff.
Laboratory services	• Lack of standardisation of laboratory services • Poor maintenance of lab equipment. • Absence of public health laboratories • Poor linkage between clinical and research laboratory services	• TA and recruitment of adequate, well trained personnel. • Effective regulation of laboratory services is a strong factor.
Human resources for health	• Inadequate number and capacity of human resources for health to meet the needs of NSHDP II at all levels	• National HRH policy and strategic plan have been domesticated by some states and will be implemented. • National Human Resources for Health Information System (NHRHIS) will be developed and implemented. • The national task shifting and sharing policy will be implemented

Health infrastructure	• Inadequate infrastructure at all levels of the health system and no infrastructure development and maintenance master plan. • Unreliable supply of water and power • Dilapidated buildings and lack of basic medical equipment affects quality of care	• Rehabilitation of health facilities as part of the PHC revitalisation agenda. • Adoption and implementation of health infrastructure maintenance policy
Health information system	• Many vertical programmes with fragmented data collection systems • Quality and availability of health data remains a huge gap especially at community level • Private sector not incentivised to report health data • Poor human and material resources capacity at sub-national levels.	• Health Data Governance Council chaired by the Honourable Minister of Health will reduce fragmentation and parallel M&E systems. • Health Data Consultative Committee at state level chaired by the Honourable Commissioner of Health • Ongoing TA for HMIS strengthening
Health research	• Weak promotion, coordination and regulation for health research and development • Limited investment by private sector in Research and Development • Disconnect between researchers and consumers of research findings (policy makers and industry) • Poor utilization of research findings to inform policy, programming and practice in the health sector	• Available Health Research Institutions and Training Institutions • Research governance and regulatory structures in place at all levels (NHREC) • Availability of many local and international journals for dissemination of health research findings • Development partners funding HSR and ongoing TA
Health financing	• High OOPE and low health insurance coverage threatens UHC • Persistent poor domestic financing of health • Weak public financial management system and accountability mechanisms • Weak overall regulatory mechanisms for health care financing actors and schemes in Nigeria including HMOs, CBHIS, SHIAs)	• A detailed NHCF & E Policy and implementation plan • BHCPF is an excellent opportunity for PHC funding towards UHC • SSHIS are being rolled out in most states and will increase health insurance coverage • Advocacy for increased budget allocation to health and releases

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