FEDERAL GOVERNMENT OF NIGERIA





SECOND NATIONAL STRATEGIC HEALTH DEVELOPMENT PLAN (NSHDP II) 2018-2022

Ensuring healthy lives, promoting the health of all Nigerians

JUNE 2018

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 (NSHDPI) 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 thereafter many states launched their strategic plans. The State Governments and and development partners provided immeasurable support.

NSHDPThe Joint Annual Review, Mid-Term Review and the End Term Evaluation of NSHDPI implementation showed variable success at state and national levels. According to the End Term Evaluation, notable achievements include state domestication of the Primary Health Care Under One Roof (PHCUOR) 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. For instance, Moreover, increased investments in procurement and distribution of insecticide-treated-bednets (ITN) led to notable reduction in malaria incidence. ; reductions in HIV prevalence, especially among the youth were achieved.,While innovative programmes such as the Midwifery Service Scheme (MSS), the free Maternal and Child Health (MCH) policy contributed to increased access to and utilisation of RMNCH services, more still needs to be done to accelerate reduction of maternal and neonatal mortality in Nigeria. .These indicators are relevant to the Sustainable Development Goals (SDGs) and have been prioritized in the NSHDPII.

The NSHDPII builds upon the successes and challenges of the first NSHDP implemented over the past 6 years. Some of the challenges identified in the NSHDPI End Term evaluation and which have been considered in NSHDPII include: gaps in political will and poor programme ownership at lower levels especially state and LGA levels; weak donor coordination and harmonization 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 (SHDPs) and weak Primary Health Care structures.

The development of NSHDPII could not commence as scheduled and so the 58th session of the National Council on Health (NCH), the highest policy-making body on health matters in Nigeria, approved a one year extension of implementation of NSHDPI 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 NSHDPII development took much longer than scheduled and the plan was only finalised in June 2018. This led the 61st NCH to change the implementation period of NSHDPII to 2018-2022. .

NSHDPII is anchored on the 2016 National Health Policy which recognises Nigeria's aspiration to attain Universal Health Coverage (UHC) by operationalising the policy to have one functional Primary Health Clinic (PHC) per ward. The NSHDPII also considers the expansion of pre-payment social health insurance schemes for UHC, the unfinished business of the Millennium Development Goals (MDGs), the Sustainable Development Goals (SDGs) 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 (ERGP) 2017-2020 and the National Vision 20:2020.

The National Health Act (2014) serves as a major legislative framework for effective articulation and delivery of the strategies of the NSHDPII.

At the initial stage of the development process, a NSHDPII framework to provide uniform guidance for States to develop 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 NSHDPII addresses lingering and emerging health sector challenges. It also offers the opportunity to ensure better health outcomes for Nigerians by 2022 by consolidating the gains made and incorporatings lessons learned from NSHDPI. . The NSHDPII 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 first Plan 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. NSHDPII 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, NTD's etc.;
3. Strengthened Health System for Delivery of Package of Essential Health Care Services which focuses on Human resources, Health Information System, Medicines, Vaccines and other Technologies, Research etc.;
4. Protection from health emergencies and risks; and
5. Increased Sustainable, Predictable Financing and Risk Protection.

Unlike the first plan, NSHDPII is accompanied by a dedicated Monitoring and Evaluation plan which shall facilitate our tracking of progress towards the targets.

I believe that Nigeria is now well positioned to attain Universal Health Coverage and the goal of Health for All Nigeria Populace at all Ages, in line with SDG 3. 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 NSHDPII goals. NSHDPI have no doubt that with the unwavering political commitment of the 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 meeting the NSHDPII goals.

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Honourable Minister of Health,
Federal Republic of Nigeria.

Acknowledgements

The 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 second Plan was prepared with a more inclusive and participatory process than the first Plan. 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, JICA, GAC, , BMGF through HSDF and many other bilateral organisations; Civil Society Organisations, Private Sector Organisations etc. 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 the Private Sector Organisations.

The development of the Plan was coordinated by the Department of Health Planning, Research & Statistics of the Federal Ministry of Health in close collaboration with the NSHDPII Technical Working Group (TWG), 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 in Nigeria.

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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Executive Summary

Nigeria's health sector strategic focus is guided by Vision 20:2020 and the medium term Economic Recovery and Growth Plan. Its actions are guided by the National Constitution and the National Health Act (NHA) that guarantee the right to health for all Nigerians. The 2016 National Health Policy derived from the NHA provides policy guidance on implementation of the NHA and attainment of the Sustainable Development Goal 3 of 'Health for All at All Ages'.

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 Universal Health Coverage, as encapsulated in the National Health Act, in tandem with the SDGs". The goal is "*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".* The policy directions are developed along ten strategic thrusts aimed at health system strengthening and expansion of health care services coverage.

The second National Strategic Health Development Plan (NSHDPII) provides the Health Sector Medium Term roadmap to move the country towards the accomplishment of National Health Policy goals and objectives. It will guide national and subnational governments on the priorities they should focus on in the health sector priorities. Additionally, it recognises and identifies actions that other sectors need to collaborate on in order to address the social determinants of health.

NSHDPII is a successor to the First National Strategic Health Development Plan (NSHDPI) implemented from 2010 to 2016. NSHDPI focussed on strengthening the health system, prioritizing primary health care, with the aim of improving the nation's poor health indices, which still rank among the poorest in the world. At the end of the implementation of the NSHDPI, the evaluation showed that while some progress has been made, the desired results were not achieved. Consequently, there are persisting weaknesses in the health system with coverage of high impact interventions remaining limited and health outcomes only marginally improved.

Recommendations from implementation of the NSHDPI included the following priorities for subsequent strategic health development plans:

- Greater focus on service delivery
- Developing a package of essential health care services
- Defining norms and standards of care at various levels of the health care system
- Improving evidence generation for decision-making
- Accelerating actions towards UHC
- Strengthening PHC by consolidation of ward health care system and strengthening referrals
- Establishing Emergency Medical Services
- Strengthening the supply chain management system to ensure sustainable supply of drugs, vaccines and commodities, especially life-saving commodities
- Reviewing, and strengthening community-based healthcare services provision through harmonisation of community-based healthcare providers and promotion of community participation
- Stepping up actions to expand coverage and reducing financial barriers through social health insurance and improving government funding to the health sector
- Instituting a system for continuous improvement of quality of healthcare

- Strengthening systems for coordinating health sector investments
- Improving the performance of health management information systems (HMIS) and use of health data for decision-making, programming and monitoring.

NSHDPII was developed in a very participatory manner and it is derived draws from the 36 States, Federal Capital Territory (FCT) and Federal strategic health plans. The goal of the NSHDPII is to ensure healthy lives and promote the health of the Nigeria populace at all ages. The mission is to ensure that the Nigerian populace have universal access to comprehensive, appropriate, affordable, efficient, equittable and quality essential health care through a strengthened health care system. This will be achieved through the articulation and provision of the following essential packages of health care services and appropriate, evidence-based interventions at community, primary health care and referral levels:

- Reproductive, Maternal, Newborn, Child and Adolescent Health, plus Nutrition (RMNCAH +N)
- Prevention and control of communicable diseases (prioritising , HIV and AIDS, tuberculosis, hepatitis and neglected tropical diseases (NTDs) – other high burden of diseases covered under child health – acute respiratory tract infections, diarrhoeal disease and measles)
- Non-Communicable Diseases Prevention and Control (diabetes, cancers, cardiovascular diseases, chronic obstructive airways disease, sickle cell disease, oral health, mental health, eye health and care of the elderly)
- Health promotion and social determinants on health (focusing on water supply, food hygiene, medical waste disposal)
- Protection from Health Risks and Emergencies,

The health sector investments to support universal coverage with these health care services have also been articulated, focusing on strengthening primary health care and referral systems, establishing emergency medical care services, and removing financial barriers to access through scaling up and efficient and accountable management of the national health insurance scheme (NHIS), state social health insurance and the implementation of the basic health care provision fund as specified in the NHA. Strategies to ensure continuous quality improvement have been defined amd the NSHDPII implementation and M&E frameworks have also been developed..

The NSHDPII is arranged into five strategic pillars which are further subdivided into 15 priority areas and strategic objectives as follows:

Strategic Pillar 1: Enabled Environment for Attainment of Sectoral Goals

Priority Area 1: Leadership and Governance
Priority Area 2: Community Participation
Priority Area 3: Partnerships for Health

Strategic Pillar 2: Increased Utilization of Essential Package of Health Interventions

Priority Area 4: Reproductive, Maternal, Newborn, Child and Adolescent Health plus Nutrition
Priority Area 5: Communicable Diseases Prevention and Control
Priority Area 6: Non-Communicable Diseases Prevention and Control

Priority Area 7: Emergency Medical Services and General Hospital Services
Priority Area 8: Health Promotion and Social Determinants of Health

Strategic Pillar 3: Strengthened Health System for Delivery of Package of Essential Health Services

Priority Area 9: Human Resources for Health
Priority Area 10: Health Infrastructure
Priority Area 11: Medicines, Vaccines and other Health Technologies & Supplies
Priority Area 12: Health Information System
Priority Area 13: Research for Health

Strategic Pillar 4: Protection from Health Emergencies and Risks

Priority Area 14: Protection from Health Risks and Emergencies

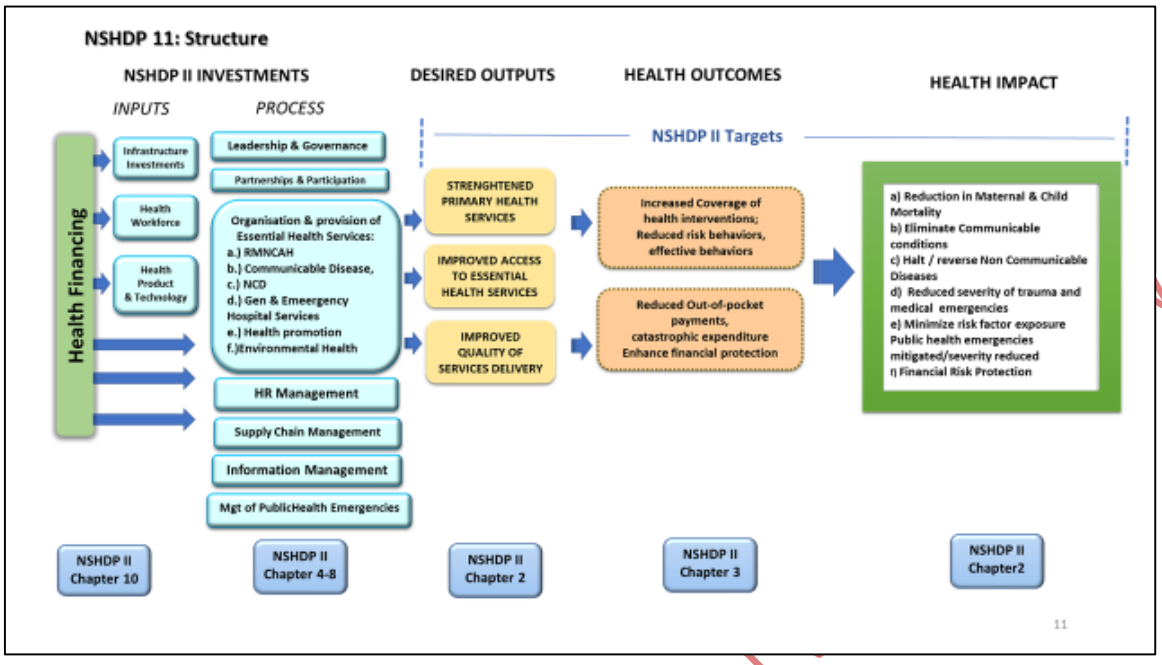
Strategic Pillar 5: Predictable Financing and Risk Protection

Priority Area 15: Health Financing

Each of the priority areas have a goal, strategic objectives, key interventions and actions needed to achieve a set of defined targets for the priority area.

Conceptually, NSHDPII is structured as shown in Figure 1, which depicts the relationship between the health system investments, the desired outputs, outcomes and impact.

Figure 1: Structure of NSHDP II



The key indicators to track progress include indicators to track coverage, equity gap, quality of care have been articulated (see the detailed NSHDPII M&E Plan).

Costing of the NSHDP II

The OneHealth Tool was used to cost NSHDPII. 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 NSHDPII coverage targets and impact goals.

Impact and cost estimates for the NSHDPII were modelled for the period 2018-2022. Impact targets of NSHDPII were determined in line with national commitment towards the attainment of global maternal, new-born, and under-five mortality targets 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, the following three NSHDPII Policy Scenarios have been modelled and costed to respond to the causes of high mortality as well as to estimate the cost of the strategic plan (Table 1):

1. Baseline – with no coverage scale-up and no significant change in HSS investment during the life of the plan (total cost ₦ 7,321B).
2. Essential Service Moderate 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 (ERGP) (total cost ₦ 6,071B).
3. Essential Service Aggressive Scenario – scale-up Health Service and HSS investments aimed at achieving universal health coverage while implementing components of the primary health care revitalization agenda contained in the Moderate Scenario (total cost ₦ 4,369B).

The mean cost per capita for each scenario was estimated at $41, $32 and $24 for Essential Package Aggressive Scale-up, Essential Package Moderate Scale-up and Baseline respectively.

Table 1: Total Cost of National SHDP II 2018-2022 by Scenarios, in Billion (₦)

Total Cost of Nigeria-National SHDP II 2018-2022 by Scenarios, in Billion (₦)								
NSHDP II Policy Scenarios	**Coverage increase Across Scenarios**	**2018**	**2019**	**2020**	**2021**	**2022**	**TOTAL**	**Mean Cost Per Capita**
NSHDP II Essential Package Aggressive Scale-up Scenario	30%	₦ 1,115	₦ 1,365	₦ 1,492	₦ 1,559	₦ 1,790	₦ 7,321	**$ 41**
NSHDP II Essential Package Moderate Scale-up Scenario	17.5%	₦ 947	₦ 1,087	₦ 1,220	₦ 1,325	₦ 1,492	₦ 6,071	**$ 34**
NSHDP II Baseline Scale Scenario	0%	₦ 859	₦ 859	₦ 899	₦ 879	₦ 873	₦ 4,340	**$ 24**

Table 2: Summary costs by Programme area of National SHDP II 2018-2022 Essential Package Moderate Scale-up Scenario, in Billion (₦)

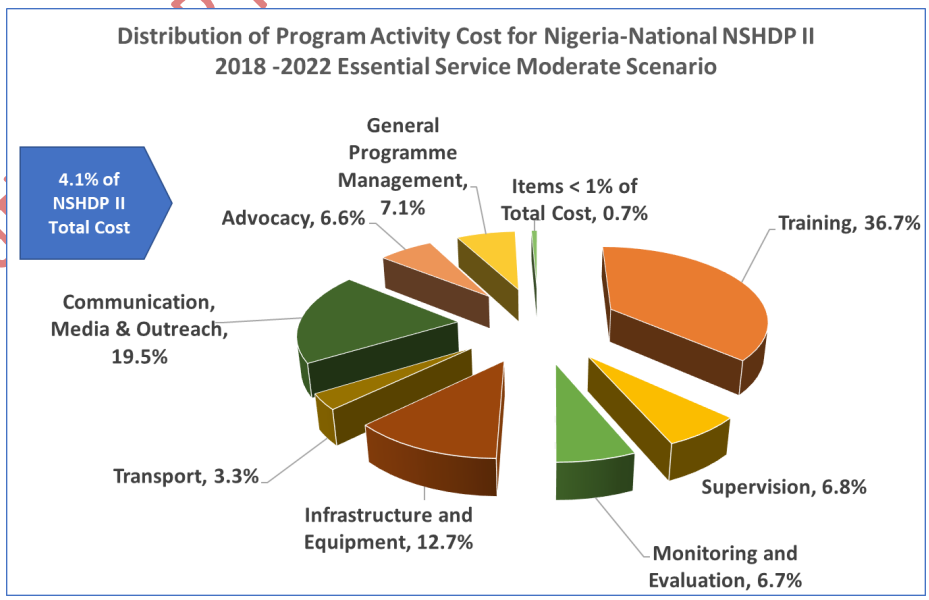
Summary costs by Programme area of Nigeria-National SHDP II 2018-2022 Essential Package Moderate Scale-up Scenario, in Billion (₦)							% of Total Cost
NSHDP II 2018-2022 Programme Areas	**2018**	**2019**	**2020**	**2021**	**2022**	**Total**	
Maternal/newborn and reproductive health	₦ 34	₦ 38	₦ 38	₦ 40	₦ 42	₦ 191	**31.5%**
Child health	₦ 14	₦ 15	₦ 15	₦ 15	₦ 15	₦ 75	**12.3%**
Immunization	₦ 6	₦ 7	₦ 8	₦ 9	₦ 10	₦ 38	**6.3%**
Malaria	₦ 4	₦ 4	₦ 8	₦ 6	₦ 5	₦ 27	**4.4%**
TB	₦ 1	₦ 1	₦ 2	₦ 2	₦ 2	₦ 7	**1.2%**
HIV/AIDS	₦ 11	₦ 10	₦ 12	₦ 13	₦ 15	₦ 62	**10.2%**
Nutrition	₦ 10	₦ 13	₦ 15	₦ 17	₦ 20	₦ 75	**12.4%**
Environmental Health and 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%**
Adolescent health	₦ 4	₦ 5	₦ 7	₦ 9	₦ 13	₦ 38	**6.3%**
Neglected tropical diseases	₦ 0	₦ 0	₦ 0	₦ 0	₦ 0	₦ 1	**0.2%**
Health Promotions and Social Determinant	₦ 0.11	₦ 1	₦ 0	₦ 0	₦ 0	₦ 2	**0.3%**
Emergency Hospital Services	₦ 0.38	₦ 1	₦ 1	₦ 1	₦ 1	₦ 4	**0.6%**
Public Health Emergencies,	₦ 0.0	₦ 0.1	₦ 0.1	₦ 0.1	₦ 0.1	₦ 0.3	**0.0%**

Summary costs by Programme area of Nigeria-National SHDP II 2018-2022 Essential Package Moderate Scale-up Scenario, in Billion (₦)							% of Total Cost
NSHDP II 2018-2022 Programme Areas	**2018**	**2019**	**2020**	**2021**	**2022**	**Total**	
Preparedness and Response							
NSHDP II Total Cost	**₦ 947**	**₦ 1,087**	**₦ 1,220**	**₦ 1,325**	**₦ 1,492**	**₦ 6,071**	

Table 3: Summary costs of NSHDP II 2018-2022 Essential Package Moderate Scale-up Scenario, in Billion (₦)

Summary costs of Nigeria-National SHDP II 2018-2022 Essential Package Moderate Scale-up Scenario, in Billion(₦)							% of Total Cost
HSS Cost Categories	**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	**15.0%**
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%**
NSHDP II Total Cost	**₦ 947**	**₦ 1,087**	**₦ 1,220**	**₦ 1,325**	**₦ 1,492**	**₦ 6,071**	

Figure 2: Distribution of Program Activity Cost for NSHDP II 2018-2022 Essential Service Moderate Scenario



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. Nigeria's various development agendas over the years recognized 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 national and sub national 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 in Nigeria 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 persistent poor health status of the Nigerian population.

The five-year period for NSHDPI implementation lapsed in 2015 but it was extended to 2016 by the NCH. The successor plan, needed to take over where the first plan did not achieve the desired results became imperative. The end of NHSDPI coincided with the global Post-MDG agenda with a broader health focus within the SDG framework, necessitating the need to develop a more comprehensive national health response.. The persisting health system weaknesses, the emerging health challenges and the need for the nation to develop a framework adapt the global SDG 3 goal led to the revision of the National Health Policy in 2016. The NHSDPII elaborates this policy.

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

- mobilising resources for the health sector;
- developing a Medium-Term Expenditure Framework, annual operational plans and budgets in the health sector; and
- aligning and coordinating the participation of all stakeholders in health development in the country

[1] Federal Republic of Nigeria (2004). Revised National Health Policy. Federal Ministry of Health. Abuja, Nigeria.
[2] Federal Republic of Nigeria *(2012) National Strategic Health Development Plan (NSHDP 1)*. Federal Ministry of Health. Abuja, Nigeria.
[3] Federal Republic of Nigeria (1988). *The National Health Policy and Strategy to achieve Health for all Nigerians*. Federal Ministry of Health. Lagos, Nigeria.

1.2 National Development Context

- The current national development agenda, Vision 20:2020, noted the influence of poor health in failure to significantly reduce poverty in Nigeria, and proposed 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 the Vision through ensuring a healthy, vibrant and productive labour force. The health sector is to achieve this through strengthening of primary health care and expansion of secondary health care services to each Local Government Area. In the same vein, the medium-term plan, Nigeria's Economic Recovery and Growth Plan (ERGP) 2017-2020, sets three broad strategic objectives - restoring growth; investing in our people, and building a globally competitive economy. The ERGP also recognizes the strategic role of the health sector in contributing to the achievement of these objectives. It identifies the following 4 specific policy objectives for health which have been considered in the development of NSHDPII:
- 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

Nigeria's constitution of 1999 (as amended) places health on the concurrent legislative list, thus placing responsibility for healthcare delivery and 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 Act provides the overall legal framework for the development and implementation of the National Health Policy.[5]

[4] Federal Government of Nigeria (2010). "Nigeria Vision 20:2020, Abridged Version", National Bureau of Statistics, Abuja, Nigeria.
[5] Federal Republic of Nigeria. National Health Act, 2014. Official gazette No.145 vol.101

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 which has as its theme "Promoting the Health of Nigerians to Accelerate Socio-economic Development".

Rationale for 2016 National Health Policy

--It has become necessary to develop a new national health policy to reflect new realities and trends, including the unfinished agenda of the Millennium Development Goals (MDGs), the new Sustainable Development Goals (SDGs), emerging health issues (especially epidemics), the provisions of the *National Health Act 2014*, the new PHC governance reform of bringing PHC Under One Roof (PHCUOR), and Nigeria's renewed commitment to universal health coverage. It has also become imperative to develop strategies to respond adequately to globalization, climate change, and the challenges of insurgency and its impact on the Nigerian health system".

National Health Policy 2016

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 package of essential health care services for all through establishment of the National Basic Health Care Provision Fund (BHCPF). The strategies for achieving these objectives have been adequately situated in this NSHDPII, which is developed to operationalize the NHP. The NSHDPII also draws from policies that guide specific vertical health programmes in the country to ensure complementarity and synergy in the provision of health services in the country. Appendix 1 is a list of the some of the policy and strategy documents that were reviewed during the NSHDPII development.

1.4 Global and Regional Contexts

Nigeria is signatory to the following regional and international commitments which contribute to shaping the NSHDPII priorities:

- ***Sustainable Development Goals (2015)*** – seeks 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..

- ***International Health Regulations (2005) -*** provides 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 risks that have the potential to cross borders and threaten people globally.

- **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

[6] Federal Republic of Nigeria. National Health Policy. Abuja, Nigeria. Federal Ministry of Health 2016

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.

- ***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

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

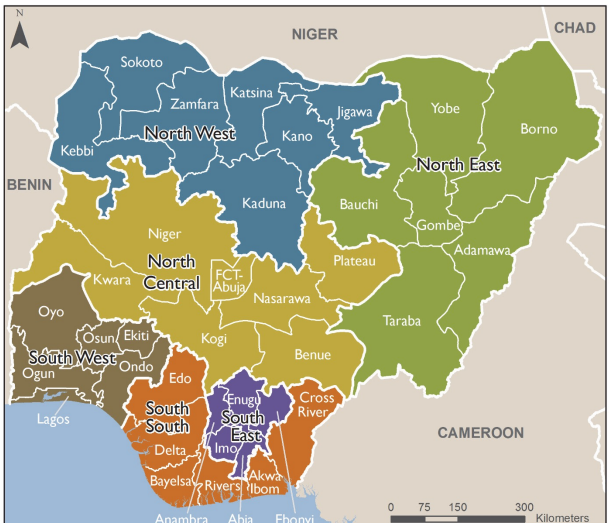
- ***Abuja 2001 Declaration and Abuja+12 Declaration (2013)*** - committed the African Union Member States to allocate at least 15% of their annual national budgets to health.

1.5 Country Profile

Nigeria, the most populous country in Africa, 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 currently the focus of PHC development.

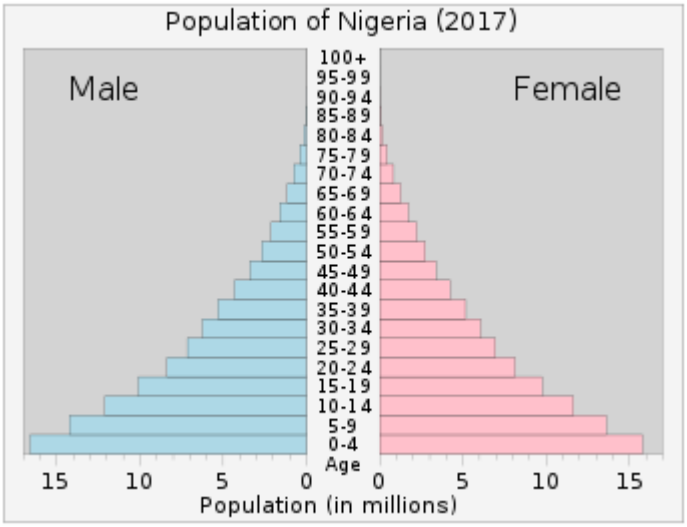
Figure 2: Map of Nigeria

NIGERIA



For political and administrative purposes, Nigeria 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.

Nigeria is ranked the seventh most populous country in the world, with an estimated population of 198 million in 2018 and is projected to grow to 210 million by 2022. With a population projection of 396 million by 2050, Nigeria will have 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 fertility (TFR x in 2018).

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.[7]

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. Nigeria's 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, Nigeria 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.[8] The country went into recession in 2016-17. This volatile and challenging economic scenario was due to the sharp decline in the global price of crude oil. The decline in earnings from oil poses significant challenge 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.[9] 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 north of the country.[10]

In recent years, there have been serious reversals in health and development gains in the north-eastern zone of the country, one of the most socio-economically deprived zones. This is as a result of activities of *Jamā'at Ahl as-Sunnah lid-Da'wah wa'l-Jihād,* commonly known as Boko Haram. This militant terrorist group has, since 2009, been carrying out bombing raids in the zone, resulting in the collapse of health and social infrastructure, and destruction of the economy. 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.

[7] United Nations Development Programme (2016). *National Human Development Report*: UNDP in Nigeria, pp 144. http://hdr.undp.org/sites/default/files/2016_national_human_development_report_for_nigeria.pdf
[8] Trading Economics (2017). Nigeria GDP Survey, 2017
[9] Nigeria United Nations Development Program (UNDP 2007). National Human Development Report: UNDP in Nigeria, 2007. Abuja, Nigeria. UNDP.

[10] Nigeria, UNDP (2009). Human Development Report, Nigeria, 2008-2009. United Nation Development Programme, 2009. Abuja, Nigeria. UNDP.

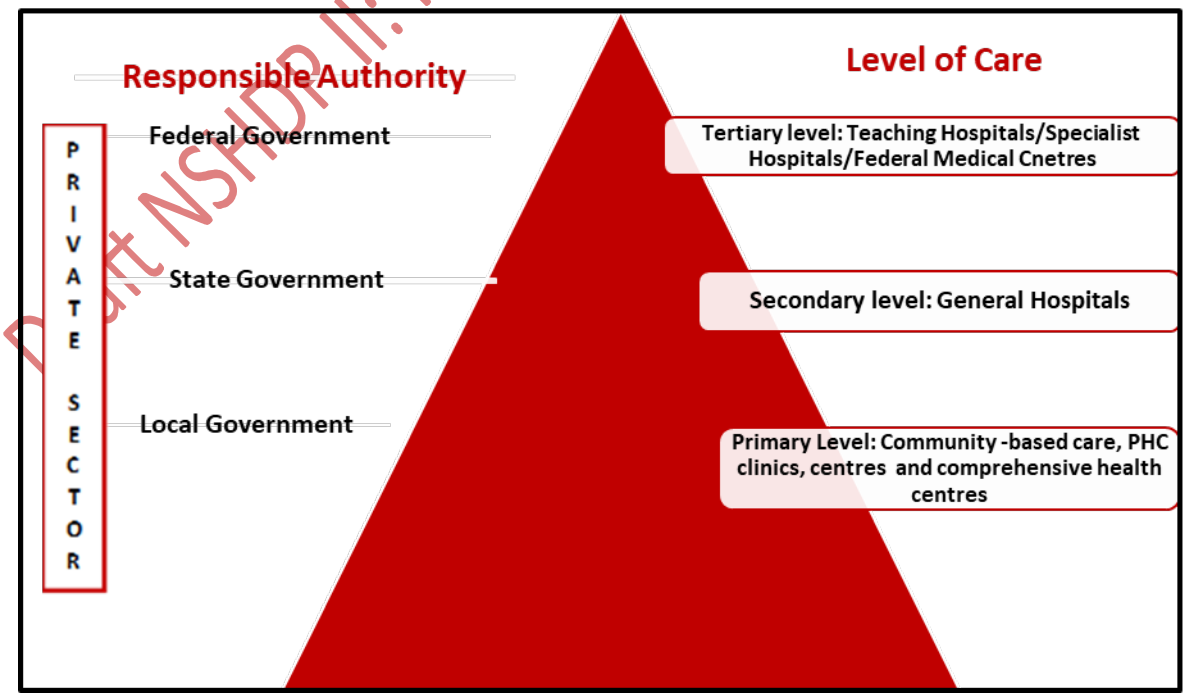
1.6 Health Services Organization and Delivery Structure

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. The LGAs have responsibility for PHC services provision, the State government provides secondary level care while the Federal government provides tertiary level care (Figure 3). In addition to tertiary health care provision, the Federal government leads the development and implementation of specific public health programmes, e.g. HIV and AIDS, xxxxxx. The Federal and State Health Ministries, Departments and Agencies (MDAs) manage the implementation of these programmes at all levels.

Public sector health care facilities include large referral hospitals, secondary health facilities (mainly general hospitals) and primary health centres. Included in the PHC system are a variety of community-based health care providers who are increasingly becoming a prominent delivery channel for promotive, preventive and curative services at community level. The three-tiered public health care system is associated with each of the administrative levels of government.

The private sector care providers play a significant role in health care service provision. They provide an estimated 60% of the health care services, even though they own only 30% of the health facilities in the country. The private sector is made up of the formal private health care sector, which includes private not-for-profit (operated by missionaries and nongovernmental organizations) and private for-profit organizations, and the informal sector, which includes traditional medicine providers, patent and proprietary medicine vendors (PPMVs), drug shops, and complementary and alternative practitioners.

Figure 3: Structure of Health Services in Nigeria



Services provided at the various levels of the health care system

Community level Services

The community level, though not a component of the formal health care service, is the first level of primary health care as some community-based primary health care interventions and services are provided at this level. Services at this level are provided by Community-Based Workers (CBWs) that go by a variety of nomenclature, depending on the project. There is however a move by the National Primary Health Care Development Agency (NPHCDA) to harmonize all Community Based Workers (CBW) and name them 'Community Health Influencers and Promoters of Services (CHIPS)' and define roles for them. These CBWs are involved in demand creation, and depending on the programme, may be involved in the provision of basic promotive, preventive and disease treatment services. In addition, there are Community Health Extension Workers (CHEWs), who are formally trained health workers that are expected to spend at least 60% of their time providing some community-based health care services. Several health interventions target the community as their delivery mode.

Primary Health Care Centres

These are the immediate referral sites for community-based health care providers. These facilities provide PHC services, with some offering diagnostic laboratory services. In each political ward, a PHC centre is upgraded to serve as the referral site for other PHCs in the ward. The ward, which bas average population of 10,000 - 20,000 persons, is currently the operational level of primary health care development in the country. The Ward Minimum Health Package for Nigeria proposed a primary care facility at the level of each ward that would provide basic package of PHC services, including basic emergency obstetric and newborn care (BEmONC) services.[11] The Ward Development Committee (WDC) comprises of selected key members of the community who foster community participation and provide an accountability framework for the health system.

General Hospitals

The secondary health care comprises services provided at the general hospitals. They provide specialized services to patients referred from the PHC level through the out-patient and in-patient services. They also provide general medical, surgical, paediatrics, obstetrics and gynaecology services including provision of Comprehensive Emergency Obstetrics and Newborn Care (CEmONC) services. The general hospitals offer specialized supportive services such as laboratory diagnosis, blood banking, medical rehabilitation and physiotherapy services, among others.

Teaching/Specialist hospitals/Federal Medical Centres

[11] National Primary Health Care Development Agency (2007). *Ward Minimum Health Care Package 2007-2012.* NPHCDA. Abuja, Nigeria.

The health facilities at this level serve as the apex referral facilities in the country and they provide specialized care for specific disease conditions or a specific group of patients. They operate specialties and subspecialties. Appropriate supporting services are incorporated into the development of these tertiary facilities to provide effective referral services.

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 National Health Bill (2006), identified the Ward Minimum Care Package as the minimum essential care package for Nigerians. The BHCPF aims to strengthen primary health care and remove financial barrier to access especially for the vulnerable populations.

1.7 Lessons Learned from Implementation of the NSHDPI

The end-term evaluation of the NSHDPI revealed that while some progress had been made, achievements were lower than expected and the 2015 targets were largely unmet for most indicators. Several factors were identified that militated against the attainment of the stated goals and objectives of the Plan. The plan focused on health systems system 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. Additionally, the matrix was prescriptive and not sufficiently robust consequently, it did not provide sufficient space for people to use it to develop operational plans. These led to adisconnect between the strategy and annual operational plan development and budgeting. Added to this, the FMOH did not put in place any structure or institutional arrangement to drive the implementation of the Plan and no appropriate guidance to the states. Also, the frequent changes in leadership of DPRS at federal and state levels and of Ministers of Health also adversely affected implementation as it led to attrition of champions, changes in priorities and loss of institutional memory. Finally, the M&E framework was not developed until almost midway into the implementation of the strategy. The gaps identified, and the lessons learned from implementation of the plan have been used to improve on the development of NSHDP II. The key issues raised and the recommendations from the end-term evaluation have all been considered in the development of this new Plan.

1.8 Process of Development of the NSHDPII

The NSHDPII development was participatory and driven by available evidence. The development of the Plan was preceded by agreement of a generic framework to guide Federal and States officers in the identification of evidence-based priority interventions and actions, expected to contribute to achieving the desired health outcomes for Nigerians. This bottom-up approach and inclusive process aimed to engender decentralization, collective ownership, equity, harmonization and mutual accountability.

[12] Federal Ministry of Health, National Health Insurance Scheme, and the National Primary Health Care Development Agency (2016). *Guidelines for the Administration, Disbursement, Monitoring and Fund Management of the Basic Healthcare Provision Fund (BHCPF).* FMoH, NHIS, and NPHCDA. Abuja, Nigeria.

The process started with an end-term evaluation of the first NSHDP to determine level of implementation, outcomes, challenges and lessons learned. In addition, a National Health Accounts (2006-2014) study was conducted to give strategic financial directions for the NSHDPII.

A 36-member Technical Working Group (TWG) was commissioned by the Honourable Minister of Health to oversee the development of the Plan. The TWG membership comprised Directors and Programme Managers from the Federal Ministry of Health (FMOH), Commissioners of Health representing states in the six geo-political zones of the country, and Development Partners.

The NSHDPII development process is summarised below:

I. Comprehensive review of relevant international declarations and commitments, extent national laws, health policies, program annual reports and plans, guidelines, annual, midterm review end-term evaluation reports of NSHDPI, research reports and other relevant background documents to build consensus around priorities, scope and content of the NSHDPII.
II. Development of the National Strategic Health Development Plan II Framework (NSHDPII) and Planning Tool by the TWG. These were designed to provide uniform guidance to states and the federal level for planning and costing of their respective plans. In addition, a guideline for the development of state and federal plans were developed.
III. Subjection of the NSHDPf II to wide stakeholder consultations, reviews and validation before finalization.
IV. Engagement and training of state and federal teams in the use of the NSHDPf II and tools. The teams included state and federal planning and costing consultants; they provided leadership in establishing and training the federal/ state planning and technical teams. Subsequently, using the validated NSHDPf II and guidelines developed, states and the federal level officers developed their plans, which subsequently were costed using the OneHealth Tool (OHT). They also concurrently developed their monitoring and evaluation plans
V. These costed federal and state plans were then harmonized into the National Strategic Health Development Plan.
VI. The National Plan was subjected to Joint Assessment of National Strategies (JANS) and validated by national stakeholders

The detailed steps and the list of persons that participated in the development of the NSHDP II are shown in Appendices 2 and 3 respectively.

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Chapter Two
Situation Analysis

2.1 Health Status: Impact and Outcomes

This chapter presents the current health status, progress made in the implementation of the NSHDPI and the outstanding challenges. Programme documents (policies and strategic plans, annual program reports and review/evaluation reports) and the following studies provided data for the NSHPDII situation analysis:

- Multiple Indicator Cluster Survey 2016
- National Demographic and Health Survey 2013
- National Nutrition and Health Survey 2014
- WHO Global Burden of Diseases 2016
- NSHDP I end-term evaluation and mid-term review reports

2.1.1. Overall Health Outcome

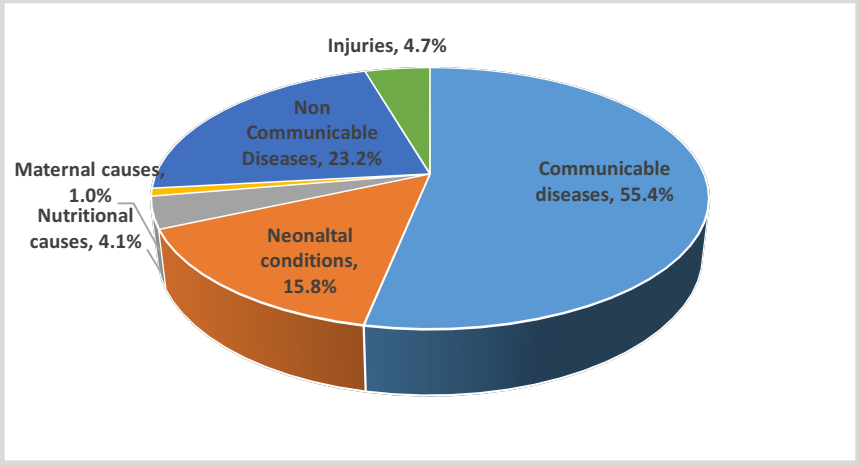
Life Expectancy

Life expectancy is an important health indicator and is strongly associated with the level of socio-economic development of a country. It is a component of the Human Development Index (HDI) which ranks and compares nations in terms of their social and economic development. The life expectancy at birth in Nigeria 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.[13] Regionally, Nigeria compares poorly to other countries, for example the life expectancy of Ghanaians is 10 years mores. The Healthy Life Expectancy of Nigerians was 47.4 years in 2016, which implies 6.8 years of compromised health[14].

[13] World Health Organization (WHO 2016). World Health Statistics 2016. Monitoring health for the Sustainable Development Goals (SDGs). WHO. Geneva.

[14] Global Burden of Disease Collaborative Network. Global Burden of Disease Study 2016 (GBD 2016) Cause-Specific Mortality 1980-2016. Seattle, United States: Institute for Health Metrics and Evaluation (IHME), 2017

Figure 4: Burden of Disease by Categories in Nigeria, 2016



Burden of Disease

Communicable and non-communicable diseases, and injuries exert a heavy toll on the health of the population, adversely affecting survival. While the country is undergoing epidemiological transition, communicable diseases remain the leading causes of morbidity and mortality. The 2016 Global Burden of Disease study shows that communicable diseases account for more than half of premature deaths in the country, and the trend is likely to continue. Non-communicable diseases and neonatal conditions are the next leading causes accounting for 23.2% and 15.6% of burden of disease respectively as indicated in Figure 5.

Table 1: Leading Causes of Mortality and Disease Burden in Nigeria, 2016

Ranking	Cause of mortality	% total deaths		Ranking	Cause of DALYs	% DALYS
1.	Malaria	17.1		1.	Malaria	18.3
2.	Diarrheal diseases	10.0		2.	Diarrheal diseases	9.6
3.	HIV/AIDS	10.0		3.	HIV/AIDS	7.2
4.	Lower respiratory diseases	8.3		4.	Neonatal encephalopathy due to birth asphyxia trauma	6.5
5.	Cardiovascular diseases	6.5		5.	Lower respiratory infections	6.5
6.	Neonatal encephalopathy due to birth asphyxia & trauma	5.8		6.	Injuries	4.7
7.	Neonatal preterm birth complications	3.9		7.	Neonatal 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 and substance abuse disorders	3.0
11.	Tuberculosis	2.5		11.	Injuries	3.0
12.	Protein energy malnutrition	2.1		12.	Meningitis	3.0

13.	Cerebrovascular disease	2.0		13.	Cardiovascular disease	2.5
14.	Road Transport Accidents	1.4		14.	Protein energy malnutrition	2.3
15.	Cirrhosis and other liver conditions			15	Iron deficiency anaemia	1.6
16.	Maternal causes	1.3		16	Lower back & neck pain	1.5

The leading causes of mortality for all ages?? remain malaria, HIV/AIDS, diarrheal diseases and lower respiratory tract infection, accounting for 17%, 10% and 10% of the proportionate mortality respectively. The Disability-Adjusted Life Year (**DALY**) is a measure of overall disease burden, expressed as the number of years lost due to ill-health, disability or early death. As shown in Table 4, malaria, diarrheal diseases and HIV/AIDS remain the top 3 leading causes of high disease burden in the country[15].

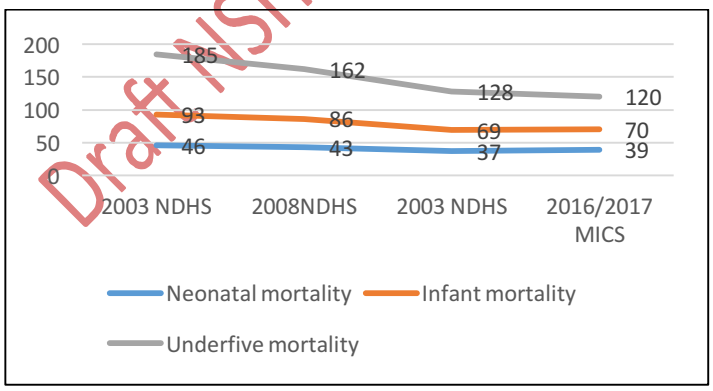
2.1.2. Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition

2.1.2.1. Impact Indicators: Maternal and Child Mortality

Child Mortality

Trend: Nigeria has experienced some decline in child mortality. Between 2008 and 2016, under-five mortality rate dropped by 25% from 162/1000 to 120/1000 while infant mortality rate recorded an 18.6% reduction from 93/1000 to 70/1000 within the same period (Figure 6). Despite these reductions, child and infant mortality remain much higher than the national targets of 75/1000 and 30/1000 by 2015 respectively.

Figure 5 Trend in neonatal, infant and under-five mortality



[15] Global Burden of Disease Collaborative Network. Global Burden of Disease Study 2016 (GBD 2016) Cause-Specific Mortality 1980-2016. Seattle, United States: Institute for Health Metrics and Evaluation (IHME), 2017

Figure 6: Equity Gap in under-five mortality by geopolitical zones, 2011 and 2016

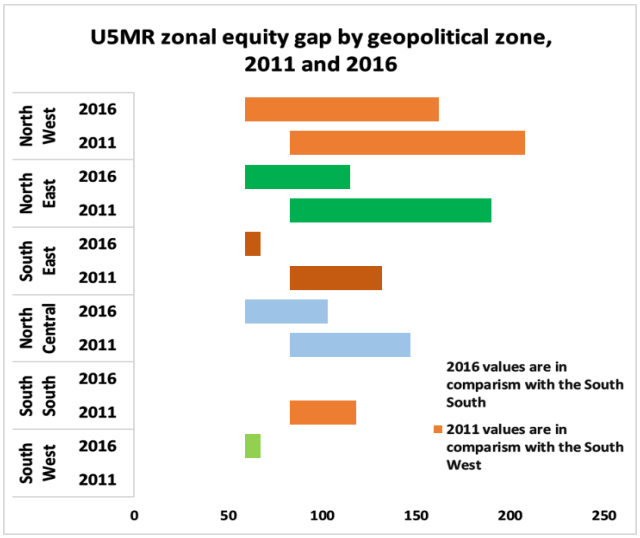
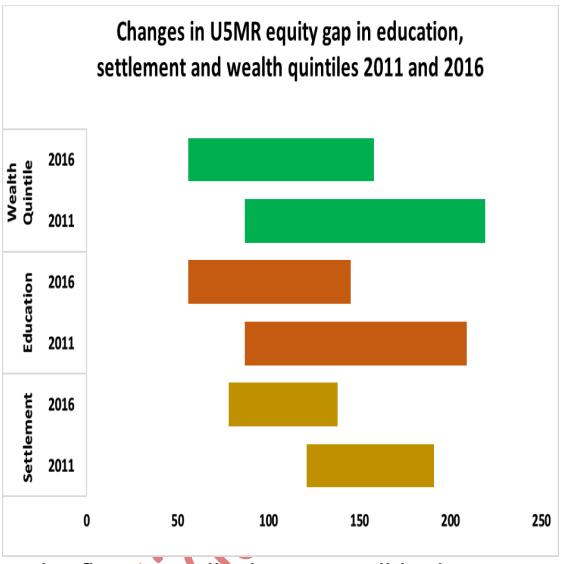


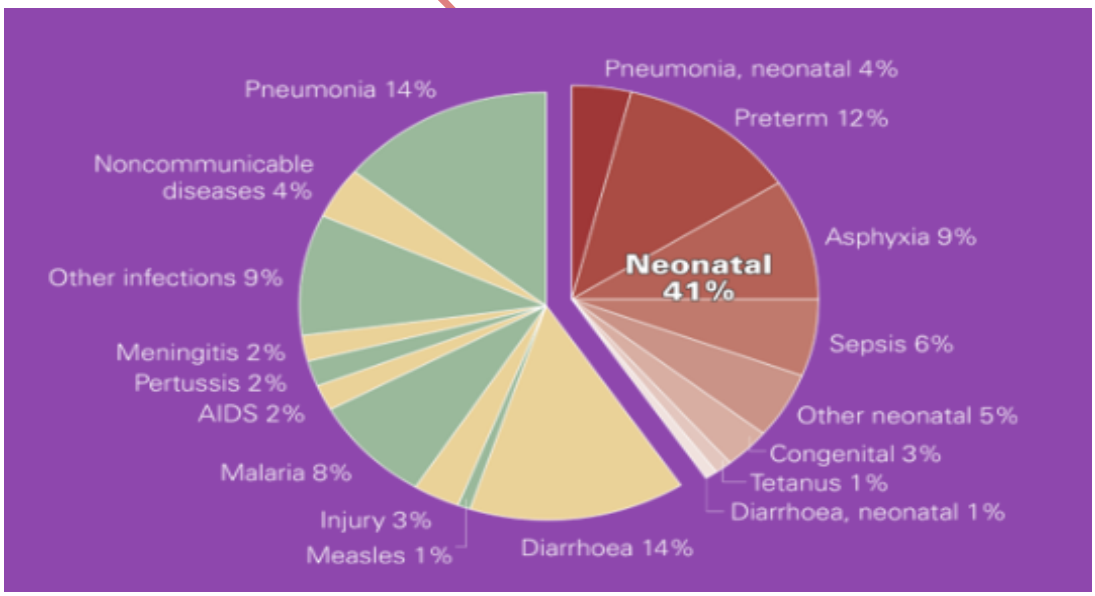
Figure 7: Equity gap in u-five mortality by wealth quintile, place of residence and education, 2011 and 2016



Equity Gap: Figures 6 and 7 shows the equity gap in under five mortality by geo-political zone, urban-rural residence, wealth quintiles and maternal education for 2011 and 2016, with data drawn from MICS 2011 and 2016/2017. While there appears to be marginal reduction in inequities between 2011 and 2016, child mortality remains inequitable. The Northwest and Northeast zones have the largest mortality gap when compared with the Southwest zone/South South Zone. The mortality rates of children of uneducated and the poorest women is about twice that of mothers with above secondary school education and mothers in the highest wealth quintile respectively. A child in a rural area is three times more likely to die before the age of 5 years compared to a child from urban areas of Nigeria.

Causes of Child Mortality are presented in Figure 9.

Figure 8: Causes of newborn and under-five mortality in Nigeria

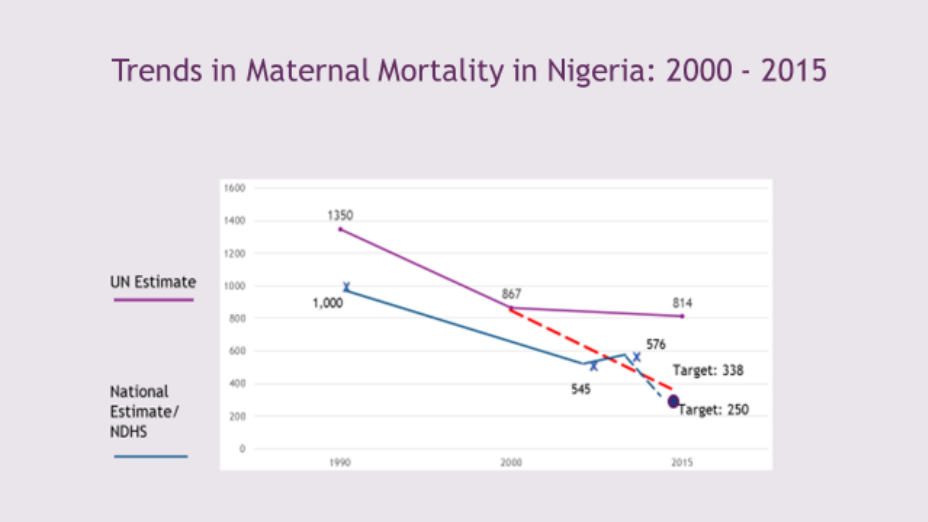


Source FMOH, RMNACH Strategy 2016

Maternal Mortality

Magnitude and Trend: maternal mortality remains a major public health problem in the country, with the country far from attaining its target of reduction of MMR to 200/100.000 by 2015[16] The 2013 National Demographic and Health Survey (NDHS) report shows that the Maternal Mortality Ratio (MMR) slightly increased from 545/100,000 to 576 between 2008 and 2013, though the increase is not significant.[17,18] However,

Figure 9: Trend in Maternal Mortality



Source: WHO, 2015; NPC & Macro ICF 2009; NPC & ICF International, 2014

Equity Gap: Current data on differences in maternal mortality disaggregated at subnational level and by maternal socio-demographic characteristics is not available as NDHS no longer disaggregates maternal mortality data. 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[19].

Causes: One of the contributory factors to the high maternal mortality is fertility. Fertility levels have not shown any change, the total fertility rate has stagnated at 5.5 children per woman between 2008 and 2018. More than 90% of maternal deaths are due to heamorrhage, sepsis, unsafe abortion, hypertensive diseases of pregnancy and obstructed labour.

[16] Global Burden of Disease Collaborative Network. Global Burden of Disease Study 2016 (GBD 2016) Cause-Specific Mortality 1980-2016. Seattle, United States: Institute for Health Metrics and Evaluation (IHME), 2017.
[17] National Population Commission (NPC) [Nigeria] and ICF International. 2014. *Nigeria Demographic and Health Survey 2013.* Abuja, Nigeria, and Rockville, Maryland, USA: NPC and ICF International.
[18] National Population Commission (NPC) [Nigeria] and ICF International. 2008. *Nigeria Demographic and Health Survey 2018.* Abuja, Nigeria, and Rockville, Maryland, USA: NPC and ICF International.
[19] Federal Ministry of Health. Maternal, Newborn and Child Health Strategy 2007.

2.1.2.2. Reproductive, Maternal Newborn, Child and Adolescent Health, plus Nutrition Services (RMNCAH + N) Provision and Coverage

RMNCAH+N is a significant component of the package of primary health care services provided through different channels in the country. RMNCAH+N Services at PHC level include antenatal, delivery and postnatal services, family planning, immunization and nutrition services, Integrated Management of Childhood Illness (IMCI), integrated Community Case Management of Childhood Illness iCCMand community nutrition programmes. Basic emergency obstetric care services are provided in Ward PHC facilities, while general and teaching hospitals serve as referral facilities for the provision of comprehensive emergency obstetric and newborn care and for the provision of other specialized RMNCAH + N services.

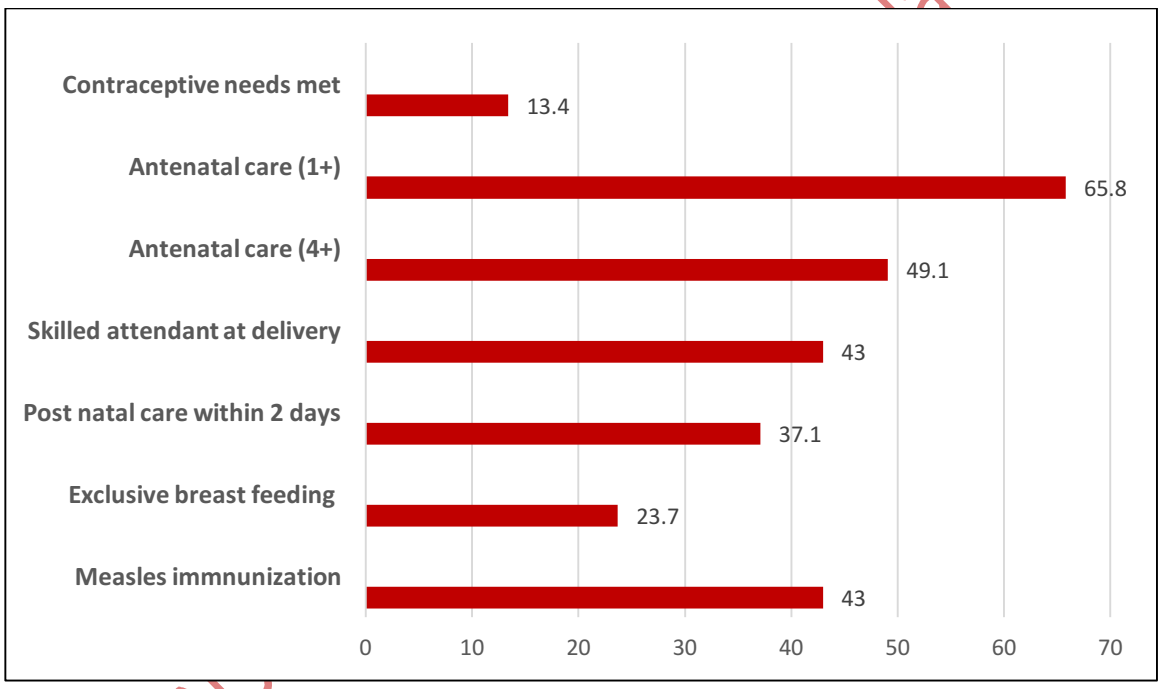
To accelerate the attainment of the maternal and child health MDG goals, the country made significant investments in the development of maternal and child health policies, plans and interventions. Specifically, to expand access to, and quality of maternal and child health services, the following interventions were introduced and/or scaled up:

- Saving One Million Lives Programme for Results (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. SOML has continued beyond 2015 and has been institutionalized in all States.
- 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 address the high mortality among women and children by increasing access to MCH services through removal of financial barriers to access by exemptions. The project ran from 2008 and 2015 in about 115 LGAs spread across six states of the country initially and later extended to other states.
- 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.
- Midwife Service Scheme (MSS), which is 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 health workers include the re-introduction of training programme of midwifery as a basic qualification and the task shifting policy which has been formulated and is being implemented for some components of maternal and child health.. The Subsidy Reinvestment and Empowerment Programme (SURE –P) invested in reducing maternal and child mortality by up-scaling Midwifery Service Scheme 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 utilistion of services through conditional cash transfers.
- The 10,000 PHC initiative will increase access to emergency obstetric care services by upgrading at least one PHC per ward to provide Basic Emergency Obstetrics and Newborn Care (BEmONC) and a secondary facility per LGA to provide Comprehensive Emergency Obstetrics and Newborn Care (CEmONC).

- Introduction of new cost-effective technologies for increasing access to appropriate high impact interventions at lower levels. Such interventions include the introduction 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 newborns and addition of zinc to the community and home management of childhood diarrhea.and.

Figure 11 shows coverage with key maternal and child health interventions along the continuum of care, as documented in the 2016 Multiple Indicator Cluster Survey remains suboptimal and below national targets[20]

Figure 11: Coverage with Maternal Child Health Services along Continuum of Care



Source: MICS 5

Child Health

Most of the services relating to newborn and child health, including IMCI and immunization, are available at most levels of the health care system and in all parts of the country. However, there is a dearth of information on coverage of services at LGA and facility levels. For example, information on the proportion of LGAs and facilities implementing IMCI and the quality of care offered is not available.

[20] National Bureau of Statistics (NBS) and United Nations Children's Fund (UNICEF). 2017. *Multiple Indicator Cluster Survey 2016-17, Survey Findings Report*. Abuja, Nigeria: National Bureau of Statistics and United Nations Children's Fund.

The MICS survey results showed that the prevalence rate of exclusive breast feeding doubled from 11.7% in 2007 to 23.7% in 2016. Within the same period, there was a significant improvement in the use of ITNs, with the proportion of children aged less than five sleeping under LLIN increasing 20-fold from 3.5% to 69.1%.[21] (Table 5).

The 2016 MICS reported that except for fever where majority of care-givers (64.4%) sought treatment for the children from health care provider, proper case management of childhood illness remain poor as only 26.7% and only 23.7% of children with diarrhea and acute respiratory tract infection were taken to a health care provider for treatment respectively.

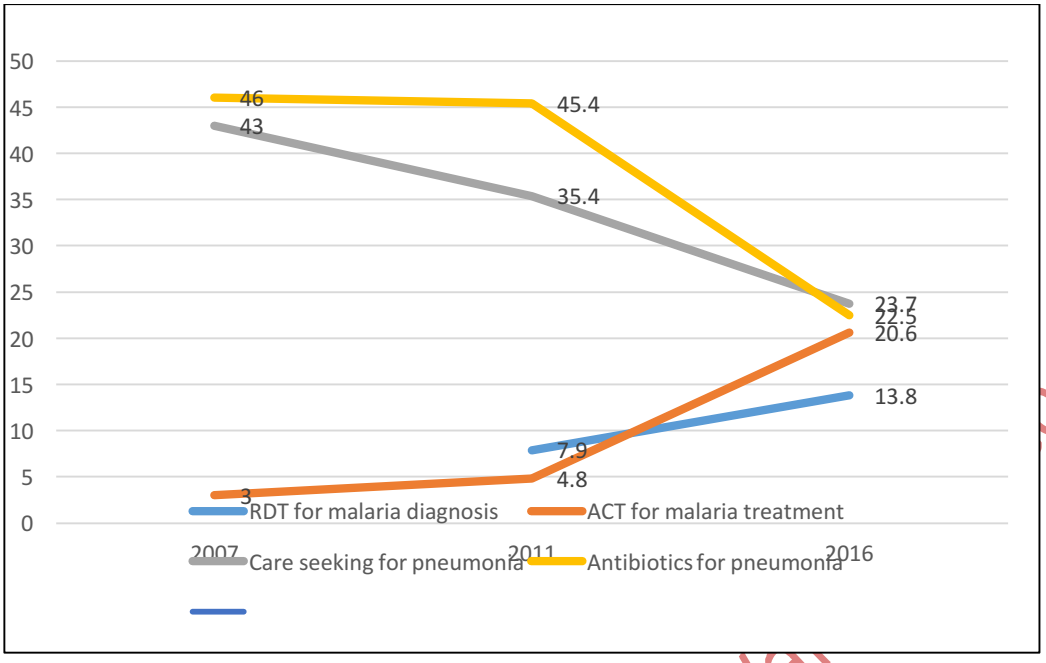
Table 5: Selected IMCI Indicators

Coverage measures	Baseline data (year and source)	Most recent (year and source)	Differences by region or groups (highest/ lowest)
Proportion of infants under 6 months exclusively breast-fed	11.7 (MICS 2007)	23.7 (MICS 2016-7)	NC=30.9/NE=4.1 (MICS 2007) SW=43.9/ NW=13.5 (MICS 2016-17)
Proportion of children 12-23 months of age vaccinated against measles before 12 months	41.4 (NDHS 2008)	42. (MICS 2016 - -17)	SW=65.5/ NW=19.5 (NDHS 2008) SS=74.0/ NW=22.3 (NDHS 2013)
Proportion of children 12-23 months of age who received DPT3/Penta 3	35.4 (NDHS 2008)	38.2(NDHS2013) 33.0 (MICS2016-7)	SE=66.9/NW-9.1**(NDHS 2008)** SE=80.7/ NW=13.9(NDHS 2013) SE=78.2/NW=13.2 (MICS 2011)
Proportion of children 12 – 23 months fully immunized	23.0 (NDHS 2008)	23% (MICS 2016 – 2017	SE & SW 43/NW 6 (NDHS 2008) SW 50/NW 8 (MICS 2016-7)
Proportion of under-5 children who slept under an ITN the previous night	3.5 (MICS 2007)	69.1 (MICS 2011)	SS=7.9 /NE=0.8 (MICS 2007) NE=79.8/SW= 40 (MICS 2016-7)

Using some components of care as proxy for quality of services, quality of care is poor. For example, as shown in Figure 12, only 13.8% of the children with fever were tested for malaria (RDT) and only 20.6% were treated with ACT for malaria and 22.8% received antibiotics for pneumonia. As shown in the graph, between 2007 and 2016, the use of RDT and ACT for the diagnosis and treatment of malaria respectively increased whereas there were declines in appropriate care seeking and antibiotics use for pneumonia.

[21] National Bureau of Statistics (NBS) and United Nations Children's Fund (UNICEF). 2017. *Multiple Indicator Cluster Survey 2016-17, Survey Findings Report*. Abuja, Nigeria: National Bureau of Statistics and United Nations Children's Fund

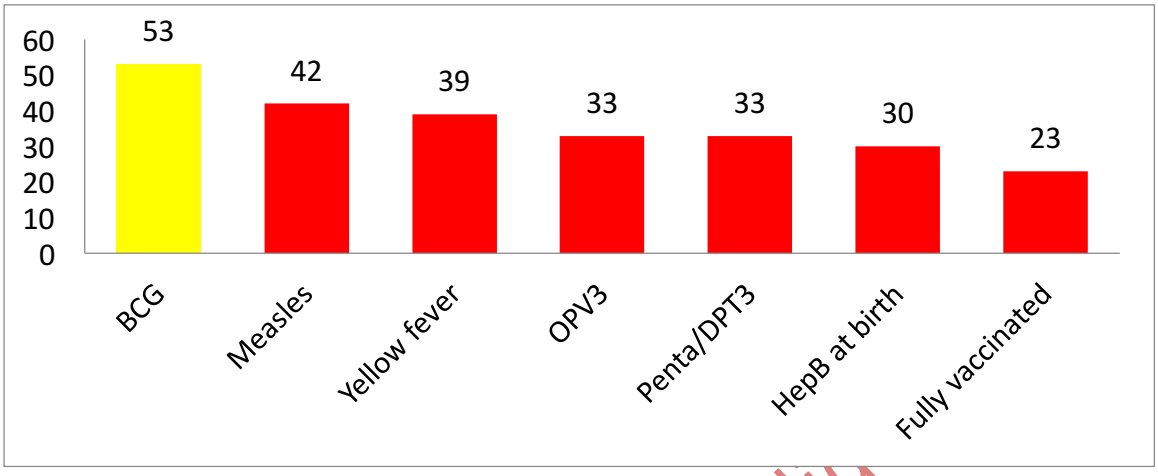
Figure 12: Coverage with Childhood Illness Treatment Services



Routine immunization for children is coordinated by the National Primary Heath Care Development Agency as a key part of child health services at PHC level. Penta vaccine and Pneumococcal Conjugate Vaccine (PCV) and IPV were introduced in 2012, 2014 and 2015 respectively. Rota virus vaccine and Human Papilloma Vaccine (HPV) are yet to be introduced to Nigeria's immunization schedule.

Coverage with immunization services remain poor, stagnating in the last decade at less than a quarter of children aged 12 – 23 months fully immunized, much below the national target of 80%. Current measles and Penta 3 immunization coverage are 42% and 33% respectively. (Figure 13). Under the Global Vaccine Action Plan, measles and rubella are targeted for elimination in five WHO Regions by 2020 (WHO), but the measles coverage in Nigeria is well below target. Globally, Nigeria also remains one of three countries yet to be certified polio free.

Figure 13 Immunization Coverage in Nigeria, 2017



Maternal Health services

Antenatal care

Between 2003 and 2016, there was only marginal increase in antenatal coverage by 7% from 58% to 65%. (Figure 14). However, the content of the ANC, which is indicative of quality was variable. The 2016/17 MICS indicated that only 55.4% of the pregnant women received Tetanus toxoid vaccine while 63.4% received iron supplements.[22] The 2015 Malaria Indicator Survey reported that less than half (49%) of pregnant women slept under LLIN. Only 36% of women in need of PMTCT services were tested, received results and were commenced on ART. The use of magnesium sulphate for the prevention and treatment of eclampsia is still limited.

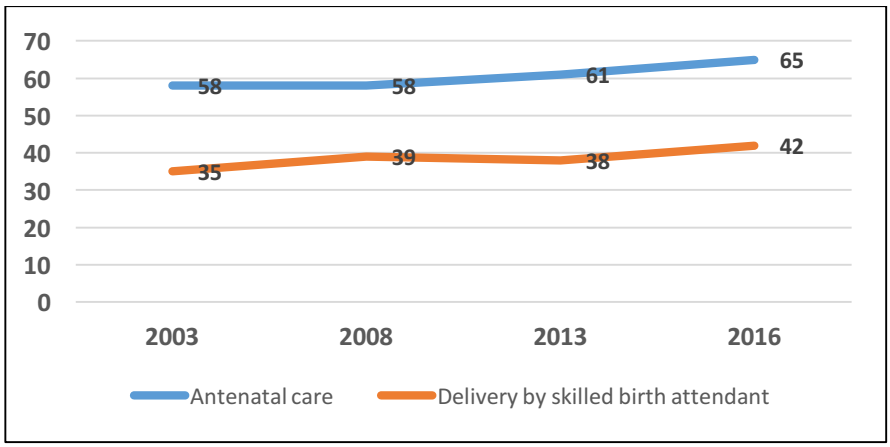
Delivery Services

Delivery by skilled birth attendant has only slightly increased from 35% in 2003 to 42% in 2016.[23] (Figure 14).

[22] National Bureau of Statistics (NBS) and United Nations Children's Fund (UNICEF). 2017. *Multiple Indicator Cluster Survey 2016-17, Survey Findings Report*. Abuja, Nigeria: National Bureau of Statistics and United Nations Children's Fund

[23] ibid

Figure 14: Trends in antenatal care and delivery by skilled birth attendants



Emergency Obstetric Care Services

Access to basic emergency obstetrics care services remains limited. Presently, less than 20 per cent of health facilities offer emergency obstetric care.[24]

Postnatal Care

The immediate postpartum period is a critical phase in the lives of mothers and newborn babies as most maternal and neonatal deaths take place during this period. Therefore, postnatal care is one of the high impact interventions planned in the NSHDP 1I. Thirty-seven percent of mothers and their newborns received their first postnatal check within 2 days of delivery.

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.[25] The risk factors for OF are the same for maternal mortality, therefore strategies and interventions to reduce maternal mortality will concurrently reduces the incidence of OF. In addition to addressing the social determinants of the condition, ensuring Skilled Birth Attendance at delivery (SBA), use of partographs to monitor labour, access to emergency obstetric care and family planning are essential in the prevention of OF. Specific interventions for the treatment of OF include use of catheterization for conservative management of fresh OF and surgical repair. Since 2010, the FMOH has established 3 national fistula treatment centres. Some State governments and development partners have supported the establishment of 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 significant involvement in OF repairs. This potential needs to be unlocked in order to clear the backlog.

[24] UNICEF. Maternal and child health. http://www.unicef.org/nigeria/children_1926.html. Accessed on 12th January 2016

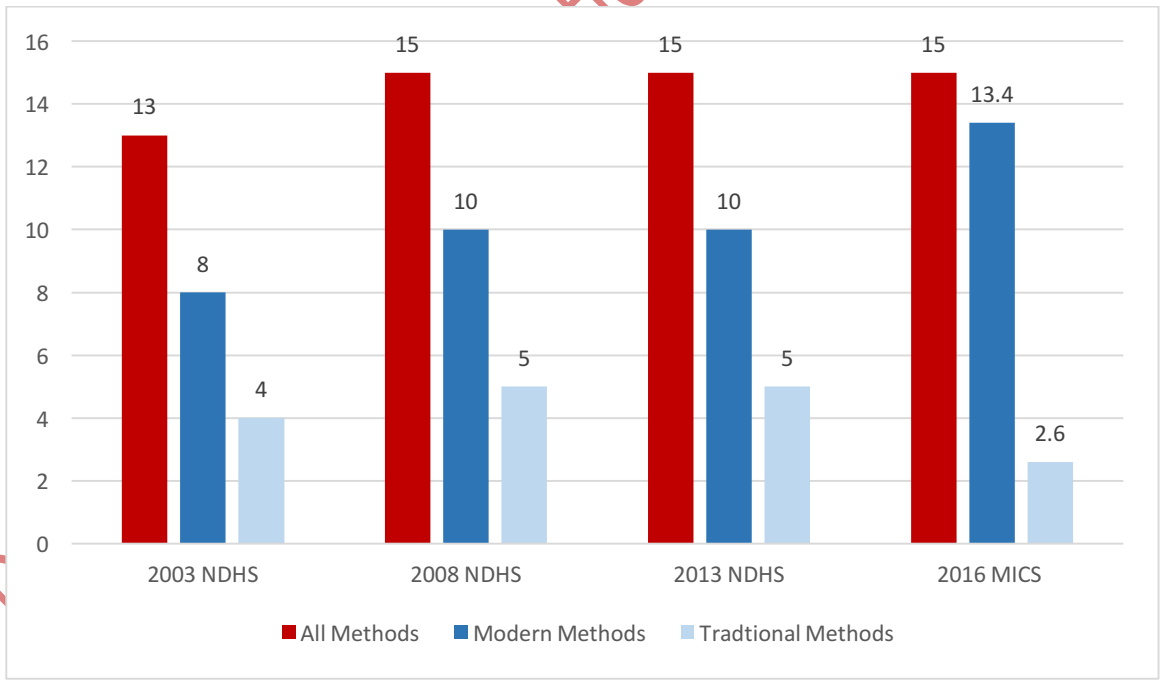
[25] Federal Ministry of Health 2018. Draft Obstetric Fistula strategic plan 2018 -2022. Abuja, Nigeria. FMoH

At current rate of repairs of 6000 cases annually, it will take more than 30 years to clear the backlog[26].

Family Planning and Post-Abortion Care Services

Based on its FP2020 pledge, Nigeria developed a blueprint for raising contraceptive prevalence rate (CPR) for all methods from 15% to 36% between 2014 and 2018.[27] In spite of this, uptake with modern contraceptives has stagnated at 10% modern CPR between 2003 and 2013 and only marginally increasing from 10% in 2008 to 13.4% as reported in the MICS 2016 survey. (Figure 15). Nigeria has one of the lowest contraceptive rates in Africa. 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 increased collaboration with the private sector.

Figure 15: Trend in Contraceptive Prevalence Rate



Complications from unsafe abortions account for about 10% of maternal mortality in Nigeria. Unsafe abortion is more prevalent among unmarried young womens. 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

[26] Ibid

[27] Federal Government of Nigeria. Family Planning Blueprint (Scale up plan: 2014 – 2018) . FMoH, Oct 2014

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.

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 percent 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 primary health care, but this remains suboptimal and limited in scale. Significant change is yet to be realized 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 services. Adolescent health in Nigeria is still characterized by early onset of childbearing, with almost a quarter of the adolescent girls commencing childbearing before the age of 18 years and 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 programmes provided at primary health care and community levels include growth monitoring, vitamin A supplementation, multiple micronutrient distribution, Community Management of Acute Malnutrition (CMAM). The NDHS reports showed an increase in coverage with vitamin A supplementation, with the proportion of children receiving the supplement within six months of the survey increasing from 25.8% to 41.3%. (Table 6).

Table 6::Trends in Nutritional Status of Women and Children, 2007 – 2015

Nutritional Status	MICS3 2007 (%)	MICS4 2011 (%)	MICS5 2016-17 (%)	Differences by Region (highest/lowest for most recent survey
Children				
Weight-for-age (underweight)	25.3	24.2	31.5	NW =42.6/SE=17.7
Weight-for-height (wasting)	10.8	10.2	10.8	NW = 58.5/SE = 16.9
Height-for-age (stunting)	34.3	34.8	43.6	NE =13/SS=6.8
WRAG				
Malnutrition in Women of reproductive age group (BMI<18.5)	12. (NDHS 2008)	**11.0**	11.4 (NDHS 2013)	NW=16/SE=7 (NDHS 2013)

Severe malnutrition in women of reproductive age group (MUAC<214mm)	2.5 (NNHS 2014)		3.7 (NNHS 2015)	NE=7.3/SE&SW =1 .1 (NNHS 2015)

The overall performance in almost all nutritional impact indicators is poor, with the trend worsening. (Table 6). Between 2008 and 2013, prevalence of underweight in children increased from 24.6% to 31.5% while stunting increased from 34.3% to 43.8%. The National Nutrition 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[28]. Wide regional variations were observed in prevalence of malnutrition with the worst indices found in the NW zone, while the worst prevalence of acute malnutrition was recorded in the North-East zone.

Maternal and Perinatal Death Surveillance and Response

As part of the strategy to end all preventable maternal deaths, Nigeria developed the National Guidelines for Maternal and Perinatal Death Surveillance and Response (MPDSR) in 2015.[29] The system aims to implement a maternal and perinatal death surveillance system that tracks the number of maternal deaths and provides information on the causes and underlying contributory factors and actions that could be taken to avert such future deaths. The MPDSR is being rolled out with support of partners in about half the states but is yet to be extended to community level.

Equity Gap in MCH Services coverage

All the NDHS and MICS surveys conducted in the country over the years show that very wide disparities exist in access to health care services and coverage with interventions across the zones and states of the federation, between rural and urban areas and by educational and social status and the gaps do not appear to be declining over time. Higher disease burden, but lower access to services are found in the northern zones of the country, rural areas, among people of lower educational status and poor people. For some maternal and child health indicators along continuum of care, using wealth quintiles, wide variations exist in uptake of services, with the least difference shown in services provided outside the health facility. With use of ITNs and breast feeding, there is a reversal where poorer women have a higher uptake than richer women, Figure 16

[28] National Bureau of Statistics (2015). *National Nutrition and Health Survey 2015*

[29] Federal Ministry of Health (2015) *National Guidelines for Maternal and Perinatal Death Surveillance and Response.*

Figure 16 Coverage with maternal and child health services by wealth quintile

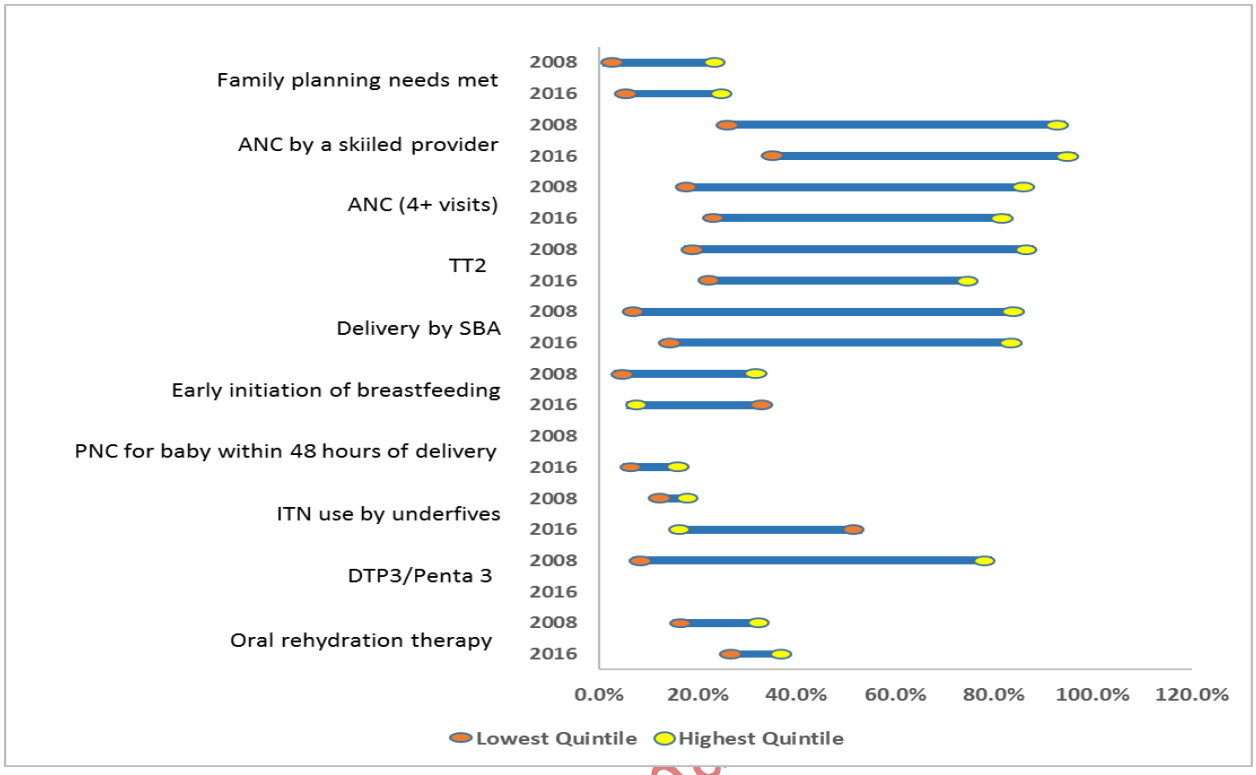


Figure 17: Percentage deliveries supervised by skilled birth attendants by state, 2016

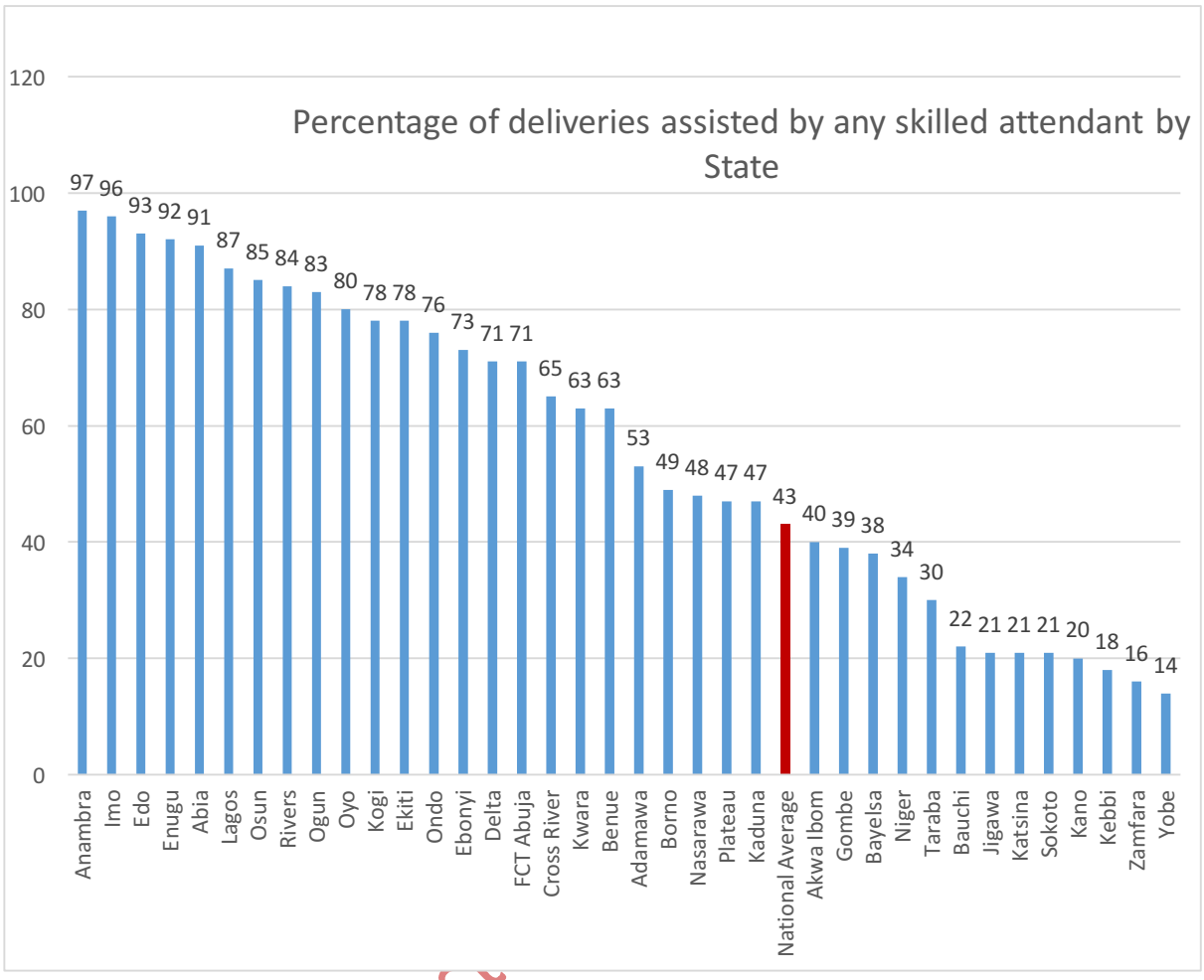


Figure 18: Immunization Coverage by States, 2016

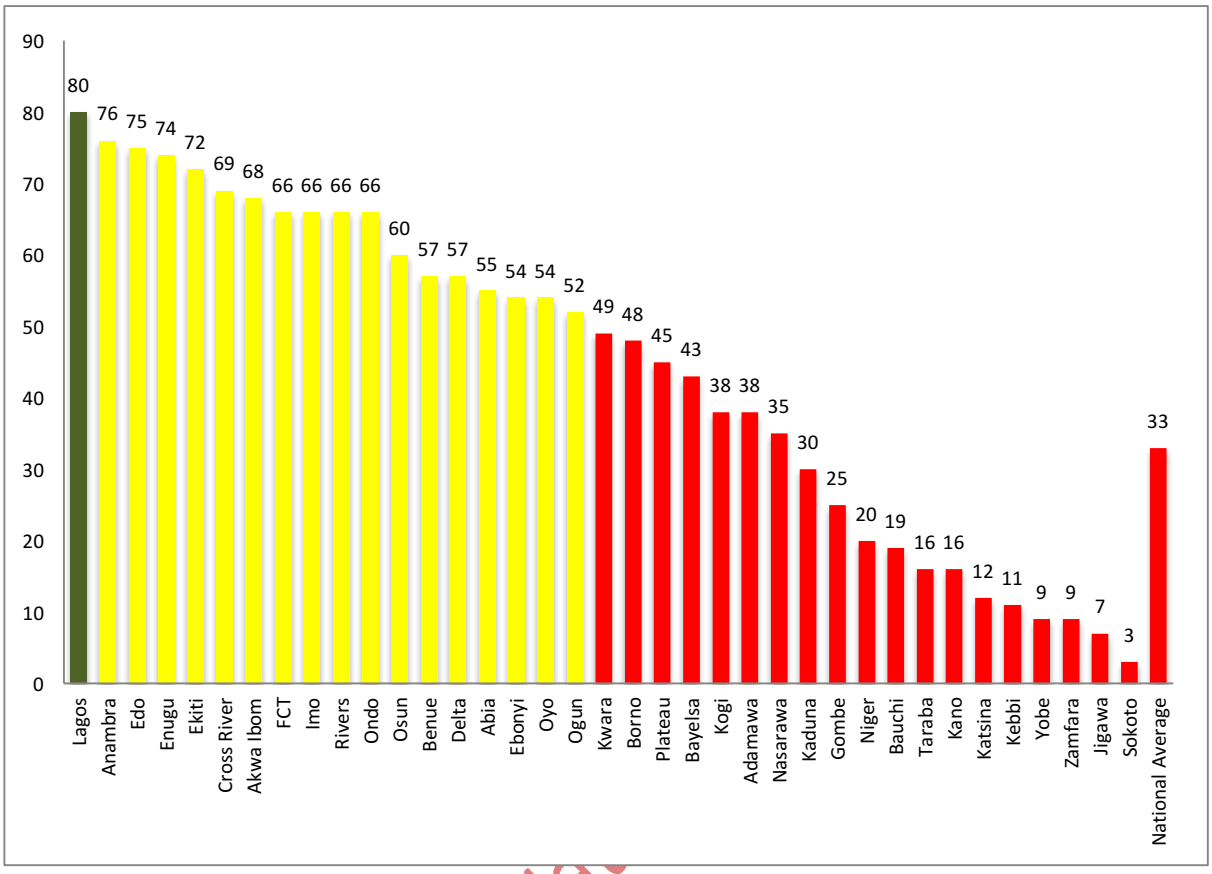


Figure 19: Equity gap in skilled attendance at delivery by zones, 2011 and 2016

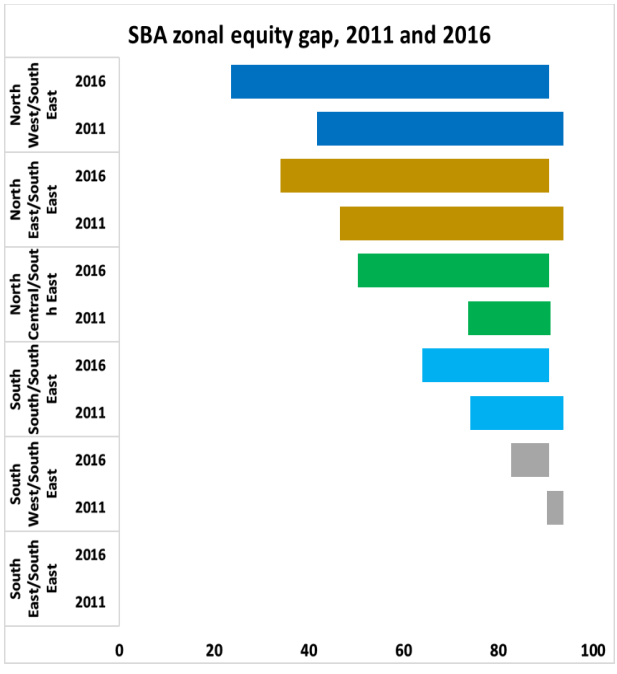


Figure 20: Equity gap in skilled attendance at delivery by wealth quintiles, place of residence and education, 2011 2016

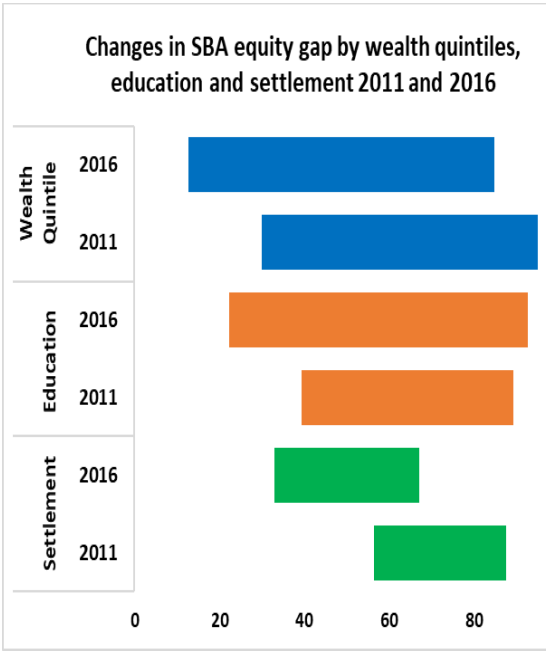


Figure 18 provides information on immunization coverage by states. The overall national Penta 3 coverage is 33%, There is very wide variation in coverage ranging from as low as 3% in Sokoto State to 80% in Lagos State; 18 states have coverage values below the national rate. Similar wide variations are observed in coverage by skilled birth attendance, ranging from 14% in Yobe State to 97% in Anambra State, while the national value is 42%, Figure 17. Redressing inequities in SBA attendance coverage was one of the areas of focus during the period of implementation of NSHDP 1. Interventions included those targeted at increasing geographic access to underserved areas and those aimed at reducing economic barriers. As shown in Figures 19 and 20, between 2011 and 2016 while equity gaps appears to be increasing when compared to the South East, the reduction in the North East and North West zones, the zones having the widest gaps. Similarly, between 2011 and 2016, the equity appears to be increasing across wealth quintlies, urban/rural place of residence and by education.

For some minority populations, legislative restrictions may be a major limiting factor driving them underground. For others, it may be lack of deliberate planning to provide for or address their special health needs e.g. destitute, street children, people with disability etc. Few efforts aimed at provisions of safety nets for vulnerable groups are ongoing, and they include cash/conditional cash transfer schemes, deferrals and exemptions, and other similar schemes. However, they are very limited in scope and scale and majorly donor-driven except the conditional cash transfers under the MDG and SURE_P schemes where women were given incentives to access ANC and ensure their infants complete their series of immunizations.

2.1.3. Major Communicable Diseases

Malaria

There have been significant investments in malaria control activity in the country, targeted at achieving pre-elimination status by 2020. This has yielded some positive results. The 2015 Malaria Indicator Survey showed a decline in malaria prevalence from 42% in 2010 to 27% in 2015. Despite this, malaria remains the leading cause of morbidity and mortality in Nigeria. [30]

Most Malaria prevention and control activities are carried out at the primary health care level - community and PHC facility levels, as part of the Ward Minimum Care Package, with some being provided as components of antenatal care for prevention of Malaria in pregnancy or through IMCI for children. Prevention efforts have focused on 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 strategy has shifted from targeting vulnerable groups to efforts directed at establishing equitable and universal access to a package of Malaria

[30] National Malaria Elimination Programme (NMEP), National Population Commission (NPopC), National Bureau of Statistics (NBS), and ICF International. 2016. *Nigeria Malaria Indicator Survey 2015.* Abuja, Nigeria, and Rockville, Maryland, USA: NMEP, NPopC, and ICF International.

interventions as a prelude to its target of attaining pre-elimination status by 2020[31]. 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).

The country has made remarkable progress in its malaria control efforts as evidenced by increased coverage in Malaria prevention and control interventions and decrease in malaria incidence. 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.[32] At community level, treatment of children with malaria through Integrated Community Case Management (iCCM) of childhood illness by community resource persons (CORPs) has been introduced in a number of states from 2014. These efforts have 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%.[33] 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 north is higher than in the south.

HIV/AIDS

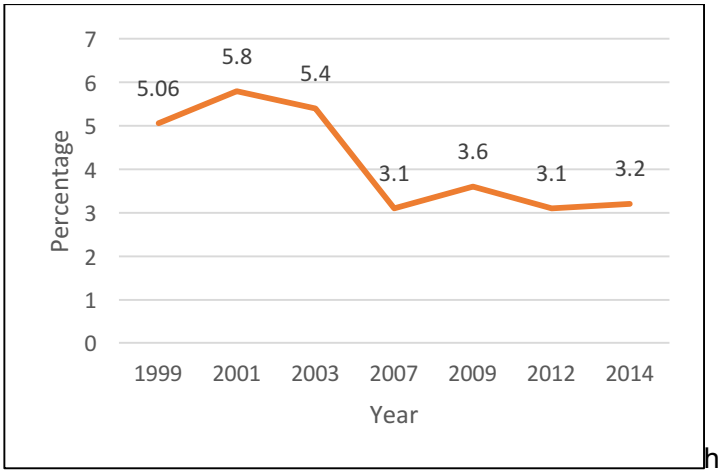
The HIV prevalence rate has been on the decline, from the highest prevalence rate of 5.8% recorded in 2001 to the current rate of 3.2% (2014), Figure 21. However, given the size of the population, this translates into an estimated 3.2 million HIV positive people in Nigeria, the second highest prevalence globally.

[31] Federal Ministry of Health. *National Malaria Strategic Plan 2015 - 2020*

[32] National Malaria Elimination Programme (NMEP), National Population Commission (NPopC), National Bureau of Statistics (NBS), and ICF International. (2016). *Nigeria Malaria Indicator Survey 2015*. Abuja, Nigeria, and Rockville, Maryland, USA: NMEP, NPopC, and ICF International.

[33] National Bureau of Statistics (NBS) and United Nations Children's Fund (UNICEF).(2017). *Multiple Indicator Cluster Survey 2016-17, Survey Findings Report*. Abuja, Nigeria: National Bureau of Statistics and United Nations Children's Fund

Figure 21: Trends in HIV Prevalence in Nigeria



Recent attempts to promote universal access to HIV/AIDS prevention and control interventions include decentralization of treatment to primary health care level, integration of HIV/AIDS services into reproductive health and TB control programmes and task-shifting. These efforts have led to significant improvements in the uptake of HIV testing, improved access of people living with HIV to treatment, and an increase in the proportion of children with access to HIV care and support. The number of facilities providing HIV Counseling and Testing (HCT) has increased eight-fold and multiple strategies are used to increase access to HCT including community outreaches. The number of health facilities providing Anti- Retroviral Therapy (ART) services has increased. These have resulted in increased service uptake.

The number of people ever tested for HIV has increased to 26.3% from 14% in 2009. In 2016, there were 3.2 million people living with HIV, among whom 30% (19%-42%) were accessing treatment, up from 5% a decade ago. However, government is only providing treatment for about 60,000 out of the one million treatments currently being offered. Decentralization of Prevention of Mother To Child Transmission (PMTCT) services to PHC level has led to increase in coverage rate to 46% with 32% of the HIV pregnant women receiving ART to prevent infection in their children, through 7,265 health facilities. Generally, in spite of progress, coverage remains persistently low. Poor government funding, stigma and discrimination, infrastructural and human resource gaps continue to pose challenges to universal HIV/AIDS services coverage.

Tuberculosis

TB remains a major public health problem in the country. Nigeria is among the four highest burdened countries globally. The estimated prevalence rate of TB in Nigeria is 323/100,000 and incidence rate is 338/100,000. With this incidence rate, between 2015 and 2020, an estimated 4,097,114 cases of TB will occur in the country. Of these, approximately 901,365

will be co-infected with HIV and 196,661 will have multidrug-resistant TB[34]. This demonstrates the magnitude of work that needs to be done to ensure universal coverage with TB services.

Current effort at promoting universal coverage to TB services include expanding TB case detection and treatment services to all primary health care facilities in the country. 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 shifting 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 (NTBLCP) have increased steadily from 31,164 in 2002 to 100,401 in 2013[35]. Treatment success reached 86% in 2013, surpassing the national target of 85% set for 2015. More than 85% of people with TB received HIV counselling and testing (HTS) and had access to life-saving co-trimoxazole preventive therapy.

New diagnostic technologies, including *GeneXpert MTB-Rif*, line probe assay and liquid culture have been introduced that can rapidly detect tuberculosis and drug-resistance and 12 hospitals now have the capacity to treat multidrug-resistant tuberculosis (MDR-TB). In spite of the impressive gains in TB control, the national TB survey carried out in 2013 pointed to the gross under estimation of the burden of disease. Despite the gains made in the control programme, case detection rate for the estimated population affected with TB remains critically low at only 15%, though success rate among those who were commenced on treatment is impressive.

Viral Hepatitis

A baseline study on the prevalence of hepatitis was conducted in 2012, as a prelude to setting up a national programme, in line with the World Health Assembly in 2010 resolution WHA63.18. This resolution recognized viral hepatitis as a global health problem and highlighted the need for a global action towards universal access to its prevention, diagnosis and treatment. The study revealed a prevalence of 11% for Hepatitis B and 2.2% for Hepatitis C; this corresponds to more than 20 million infected people in the country[36].

Based on these findings, the FMoH, in 2013 established the viral hepatitis control programme within the National AIDS and STI Control Programme (NASCP) and has since developed a national policy, strategic plan and treatment guidelines for the control of viral hepatitis. These are being rolled out. Hitherto, the focus had been on prevention of hepatitis B by integrating HBV vaccination into the national immunization programme of children and provision of the vaccine to HBV negative adult populations. The guidelines recommend decentralization and integration of viral hepatitis intervention to primary health care level and use of interferon-based ART for treatment of all HCV positive individuals, and an algorithm for the treatment of HBV positive individuals. The high cost of these drugs is a major limitation to treatment access.

[34] Federal Ministry of Health 2015. The National Strategic Plan for Tuberculosis Control 2015 - 2020: Towards Universal Access to Prevention, Diagnosis and Treatment. Abuja FMOH, TB Control Programme

[35] Ibid

[36] Federal Ministry of Health (2016) *National Strategic Plan for the Control of Viral Hepatitis in Nigeria*

Neglected Tropical Diseases

The country has the highest prevalence of Neglected Tropical Diseases (NTD) in Africa and accounts for 25% of the global burden. Of the 17 NTDs, 13 are endemic in Nigeria. Most of these diseases are co-endemic in all the states in Nigeria. The at-risk population for the following diseases have been estimated to be 122 million for Lymphatic filariasis, 33.3 million for Onchocerciasis, 20.8 million for Schistosomiasis, 29.4 million for Soil Transmitted Helminths, 5.3 million for Trachoma, and 6.5 million for Human African trypanosomiasis.[37] There are also the zoonotic NTDs in Nigeria such as Rabies and snakebites.

Although safe and cost-effective interventions for prevention and control are available, these diseases have continued to cause immense suffering and often life-long disabilities for those affected, because of inadequate investment in their prevention and control. Currently, majority of the medicines needed for treatment of these diseases are donated by partners with little or no domestic funding. There is a need for an improved domestic support to the country to achieve the global target of elimination of the NTDs by 2020.[38]

Snake bite is another largely neglected health problem occurring especially in rural communitiesv, especially 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 to one-fifth of the burden of snake bites in the African Region with cases and the case fatality being on the increase (CFR is currently estimated to be 65%) and is worsened by the shortage of anti-venom leading to increased morbidity and mortality with severe disabilities that affect extremities (gangrene leading to amputated limbs). Past effort from 2000 to establish an anti-venom production facility in the country through the Echitab Study Group (ESG) Nigeria /United Kingdom project was not successful. Non-availability of anti-snake venom remains a major challenge.

Some of the challenges in the delivery of interventions for communicable diseases and NTDs in the country are largely hinged on issues limiting the optimal functioning of the health system, ranging from gaps in governance and stewardship, inadequate human resources for health and physical infrastructure; paucity of quality data; inadequate logistics management systems, inadequate and poor utilization of drugs, low awareness, and poor funding.

2.1.4. Non-Communicable Diseases

Developing countries are experiencing rapid epidemiological and demographic transition from communicable diseases to Non-Communicable Diseases (NCDs) thus resulting in double burden of diseases. In Nigeria, 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 Airway 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.

[37] FMoH, 2010
[38] FMoH, 2013

National statistics on NCDs is outdated, as the only national survey on NCD was conducted in 1992. That survey showed that 4.3 million Nigerians over 15 years of age have hypertension. However, with the definitional shift of 140/90mmHg in 1999,[39] the prevalence of hypertension now exceeds 20%. Current estimates indicate the prevalence rate to be between 22% - 28%[40,41]. The 1992 survey also showed that prevalence of Diabetes mellitus was 2.7% (1.05 million Nigerians over 15 years). The 2015 IDSR showed that there were 105,981 cases of diabetes with 252 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 disability (DALYs) in Nigeria.[42] 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 in Nigeria estimates 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 schizophrenias, manic illness and organic psychosis, which affect 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.[43] There is evidence that depression is particularly common among Nigerian 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.[44]

Although there has not been any mental health epidemiological survey for over a decade in Nigeria to ascertain the current prevalence, 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 disorder, and anxiety disorder. 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.

Mental illnesses frequently co-occur 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. The proportion of Nigerians with mental illness receiving any treatment, orthodox or otherwise, within the previous 12 months is about 10%. As a result of the high prevalence, relatively low

[39] WHO/ISH, 1999

[40] Ekwunife OI, Nze Aguwa C. A meta-analysis of prevalence rate of hypertension in Nigerian populations. Journal of Public Health and Epidemiology 2011; 3 (13): 604-7 10

[41] Adeloye D, Basquill C, Aderemi AV, Thompson JY, Obi FA. An estimate of the prevalence of hypertension in Nigeria: a systematic review and meta-analysis. J Hypertens. 2015; 33(2):230-42 11

[42] WHO 2013. Comprehensive Mental Health Action Plan 2013-2020. Geneva: WHO.

[43] WHO 2014. World Mental Health Atlas. Geneva: WHO.

[44] WHO 2016. WHO-AIMS Report on Mental Health System in Nigeria. Ibadan: WHO

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-specialized skills at lower levels of the health system to detect and manage mental health problems, and failure to implement the integration of mental health into primary health 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, dearth of skilled personnel, limited access, high cost of services which limits affordability, inequitable distribution of personnel and services, limited focus on prevention, and the non-integration of oral health into the primary health care level.

A survey of oral health manpower, facilities and training institutions in Nigeria carried out by the Inter-country Centre for Oral Health, Jos in 2014 showed that presently there are only 679 dental clinics and only about 3000 dentists available in Nigeria, which are inequitably distributed to the neglect of settlements outside State capitals. Also, there has been no scaling up of services to primary health care 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. Available national data on eye health indicate 4.2% prevalence rate of blindness among people aged 40 years and above and an overall prevalence rate of 0.78% in the country. The rate of severe visual impairment was 1.7%. Overall, 1.13 to 3.1 million persons are blind or visually impaired in Nigeria. Higher rates of blindness/visual impairment were found in the North East/North West, among women, and illiterates. About 75% of blindness is caused by cataract. Other leading causes of blindness are glaucoma, trachoma, retinal disease and uncorrected aphakia while refractory errors are the leading cause of visual impairment. In response, the FMOH has developed the National Eye Policy and set up the National Eye Health Programme (2006). There is high level of self-medication among individuals with visual challenges in Nigeria.

Care of the Elderly

In Nigeria, it is estimated that older people make up about 10% of the Nigerian population[45] 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. In Nigeria, these disease conditions have their origin partly from the prevailing social, economic and environmental factors, which include poverty, loneliness and depression. 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 group. There is an apparent neglect of the elderly group of people in health care planning and minimal services to meet their needs. Currently, there are few standard government-owned geriatric health facilities in Nigeria including that of University College Hospital, Ibadan.

The Federal Ministry of Health has established, an Elderly health unit, charged with the responsibility of coordinating the health needs of the elderly. The National Council on Health's resolution in 2010 directed that geriatric centres be established in all government 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 partners support for issues concerning the elderly in Nigeria, 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 articulated strategies to address gaps and challenges in the provision of improved health services to the elderly.

2.1.5 Emergency Medical Services

An Emergency Medical Service is a comprehensive system that coordinates resources (personnel, facilities, equipment, transportation and communication) for the effective coordination and timely delivery of health and safety services to victims of sudden illness and injuries. Medical emergencies include trauma, obstetric emergencies, medical, surgical, paediatric and trauma-related emergencies. The aim of EMS is to ensure that critically ill or injured persons 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 enroute the hospital; and care received at the health facility. WHO recognizes 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 enroute to health facilities, and emergency units appropriately staffed with needed resources must be available.

[45] Global Age Watch Report, 2015

In Nigeria, EMS is poorly developed. Until recently, there is no formal legal framework for coordination and regulation of Ambulance services. The absence of policy framework to guide ambulance service providers led to many disparate uncoordinated 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 Defense Corps (NSCDC), as well as private and voluntary organizations. However, it is estimated that the 1,000 ambulances available nationwide can meet only 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. At state level, except for Lagos and Abia, state coordinated Emergency Medical Services are non- existent. In most states, public sector ambulances are attached to hospitals and are not used for provision of emergency medical services. Trained and competent first responders hardly exist. There are no dedicated 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. A few trauma centres exist, run by FRSC, but the services are also underfunded and there is a dearth of skilled personnel and other resources for effective response.

The BHCPF allocates 5% of resources for EMS. Recognizing the absence of a national EMS, the FMOH in February 2018 launched the National Emergency Medical Services Policy[46] and also, developed guidelines for National Ambulance Services.[47]

2.1.6 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'.[48] 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. Nigeria has been making concerted efforts to address them 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

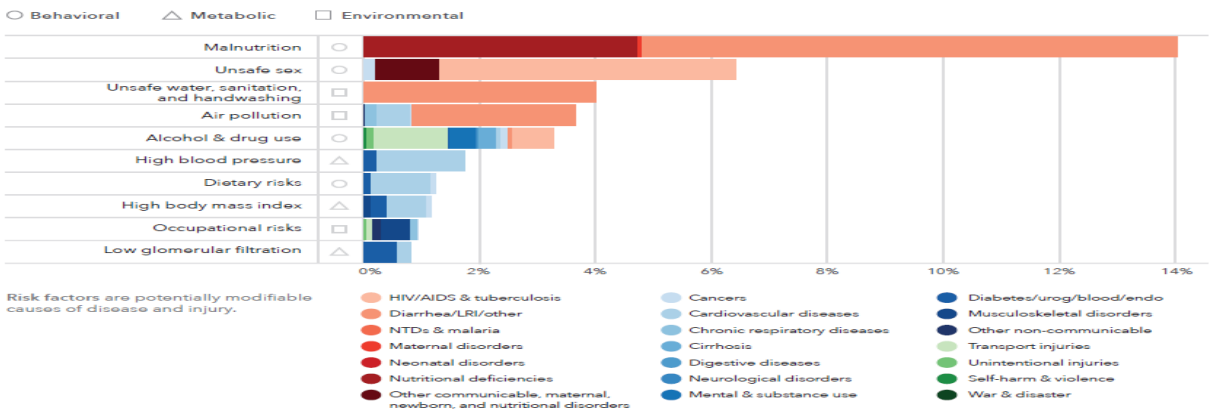
[46] Federal Ministry of Health (2016) National Policy on Emergency Medical Services. FMOH, Abuja
[47] FMOH Guidelines for the Operations of Emergency Ambulance Services in Nigeria
[48] WHO 1986

significant impact in improving the nation's health status, redressing inequalities in health outcomes and dealing with the root causes of disease.

The risk factors for diseases are poor environmental sanitation (water, sewage and housing, air pollution), and unhealthy lifestyles (sexual behaviour, inadequate/inappropriate food intake, lack of exercise). From the 2013 Global Burden of disease study, the leading modifiable risk factors for disease in Nigeria, in order of ranking, is shown in Figure 22. Nigeria faces the challenges of poor access to health services and other social services, and inequitable distribution of health outcomes, with the poor, rural populations, uneducated populations, and females having worse indices. These problems are compounded by low investments in disease prevention, health education and health promotion, poor health care seeking behaviour and failure to address the social determinants of health. Addressing these challenges will require empowering individuals and communities with appropriate knowledge to take control of actions that promote their health and prevent disease and addressing factors in the community that influence and impede health and wellbeing leading to inequities in health outcomes.

Some of the key factors militating against effective health promotion interventions therefore 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 environments for health behaviour change; inconsistent and poor implementation of health education and health promotion activities across all levels of the health care system, non-integration of health promotion in curative services, and dearth of communication strategy and materials skills. There is also non-integration of health promotion efforts across programmes, lack of a framework for coordination of organizations providing health education, and hardly any investments in empowering communities beyond giving them health talks. Finally, dedicated funding for health promotion and community empowerment in the health sector is very low.

Figure 22: Burden of Diseases attributable to leading Risk Factors as Percentage of Nigeria's DALYs



Source: The Commonwealth and IHME Health Data .org

Food availability and safety in Nigeria have to do with accessibility, quality and adequacy. The quality of food sold in the markets in terms of nutritional content is far from acceptable. The SDG (Target 2.2) targeted that by 2030, all forms of malnutrition, including under-nutrition,

obesity and micronutrient deficiencies be ended.[49] Currently, Nigeria has outdated regulations and standards related to the quality of food and food additives. Concerted efforts from various government and private sectors will therefore have to be instituted to foster dialogue and coordination especially between Health, Agriculture, Environment and Trade.

In terms of water and sanitation, limited access to improved water supply and sanitation facilities especially in rural communities and urban slums increase the incidence and prevalence of water borne and related diseases, thus contributing to the overall disease burden in Nigeria. For example, diarrheal diseases constitute one of the major causes of mortality in children under five years. There exist various national policy documents on water and sanitation, which require pragmatic integrated multi-sectorial approach for their effective implementation to achieve the desired objectives of provision of clean, potable and wholesome water, fit for consumption and other activities. Their implementation has however been sub-optimal with worsening and attendant poor health outcomes.

Nigeria has up to a million-people exposed each year to various toxic and hazardous chemicals which through ingestion and/or inhalation lead to deaths.

Workers' health and safety in the work place, especially those 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 wears, Personal Protective Equipment (PPE), and other items required to protect workers from occupational health threats occasioned by increasing exposure to diseases and public health conditions like the viral haemorrhagic fevers (Ebola, Lassa), industrial accidents, injuries and various forms of hazards that workers are exposed to daily in the work place. There is no established Occupational Safety and Health (OSH) programme domiciled in the FMOH and in the states. Though we have an occupational health and safety (OSH) policy, most industries and work places do not provide workers health services that they require to protect and prevent them from occupational health hazards. Most of them depend on the PHC which, does not adequately address their health care needs.

2.1.7 Public Health Emergencies and Risks

Nigeria has witnessed many natural and man-made disasters, 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. Notable among recent/ongoing disasters experienced in Nigeria are:

Epidemic Prone Diseases

The country has experienced outbreaks of Lassa fever, Measles, Cholera, Cerebro-Spinal Meningitis (CSM), Yellow fever and Monkeypox. In 2017, there were outbreaks of CSM, Lassa fever, Cholera and Hepatitis E across a number of states in the country. The Lassa fever epidemic is ongoing and has spanned more than 20 states in the country. The continuous

[49] ICSU, 2015, p. 20

reporting of Lassa fever cases even during rainy seasons as seen in 2017 suggests either an evolving epidemiology of Lassa fever in the country. The largest outbreak of CSM was recorded in the North of Nigeria, between December 2016 and June 2017 with a total of suspected cases of meningitis reported during the outbreak. In 2017, Borno State experienced a large outbreak of cholera with most cases in Internally Displaced Persons (IDP) camps. 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 12th of September 2017. Since then, confirmed cases of Yellow Fever have been reported from 20 States in the country. The Nigerian Centre for Disease Control has been leading the response to these outbreaks.

Man-made disasters

These include:

- Herdsmen attacks (on-going) across different parts of the country particularly prevalent in the middle belt region;
- Road Traffic Accidents (RTA) is currently the second highest source of violent death in Nigeria today.[50] This has been attributed to bad roads infrastructure and human attitude. The country records between 100-120 road crashes per week resulting in 400-480 deaths in a month.[51]
- Insurgencies, notably the *Boko Haram* terrorism in the North-Eastern zone of the country, which has been ongoing since 2009 leading to deaths, and displacement of about 10 million people; a humanitarian crisis that is considered to be one of the worst in the world. The current picture is one of protracted conflict and active insurgency in the six states in the North East Zone. The conflict has 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 these, 5.9 million people including all IDPs, children under 5 years, females of reproductive health age, the elderly, and the host community population under the poverty level are the most vulnerable. 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. There have been reports of Cholera and Measles outbreaks. The insurgency has frustrated the polio eradication efforts, limiting access to 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 of Nigeria 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[52]. The strategy, which is being implemented with about 60 development partners is aimed at

[50] Nigerian Pilot 2016. Disturbing Road Traffic Accidents statistics in Nigeria. March 2016.
[51] FRSC, 2016
[52] Federal Ministry of Health (2017) North East Health Sector Response Strategy 2017 -2018

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.

Environmental contamination, poor environmental sanitation, poverty, high rate of youth unemployment religious and socio-cultural intolerance, and climate change are some of the underlying causes of Public Health Emergencies (PHEs).

In the past few years, there has been some other 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 in Nigeria. The Agency gave effective leadership to the control of the Ebola outbreak in the country in 2014 and has led the response to other subsequent outbreaks. The establishment of a training programme aimed at building a critical mass of field epidemiologists – Nigeria Field Epidemiology and Laboratory Training Programme (NFELTP), development of emergency response plans, establishment of emergency response and rapid response teams up to LGA levels, determination of epidemic threshold levels for epidemic prone diseases, establishment of an Emergency Operations Centre (EOC), Incident Command through which coordination of outbreak response activities are carried out in the country and the establishment of a national reference laboratory have strengthened the health security structure in the country. Additionally, NCDC is rebuilding the surveillance infrastructure and supporting the establishment of EOCs across the states in the country.

Key challenges to effective epidemic and other emergencies response include under-utilised disease surveillance and alert system; very poor capacity of health facilities to effectively manage outbreaks and other emergencies; lack of or grossly inadequate dedicated fund and dearth of skilled human resource. Others are poor preparedness for outbreaks and emergencies, and low level of awareness and knowledge of IDSR among health workers. Additionally, there are gaps in availability and capacity of public health laboratories, limited availability of EOC (only 13 states currently have them), 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 poor evidence to inform planning. Weak collaboration among key sectors involved in emergency response is another major issue. Demand-related issues include non-involvement of communities in epidemic planning and response, ignorance, misconceptions, poor health care seeking behavior and poverty.

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.[53] 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

[53] WHO 2005. International health regulations

management strategies for the full range of likely risks and emergencies (natural, biological, technological and societal). This is yet to be operationalized in the country.

Summary of Key bottlenecks with service delivery

- Absence of a defined package of essential health care package and defined service package at all levels of care
- Absence of organized programmes for many of the NCDs
- Abundance of policies and plans, but limited implementation
- Low and inequitable coverage with interventions because of gaps in service delivery
- Poor service integration
- Limited scaling up of some services, especially EMS to primary and community levels
- Gaps in quality of care
- Absence of emergency medical services
- Dysfunctional referral services
- Gaps in availability of data for programming and tracking progress, especially for NCDs
- Weak surveillance system

2.2 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. One of the reasons is the comparatively very poor performance of the health system. The system is characterized by gross underfunding, poor coordination of different stakeholders, dearth of human resources, poor infrastructure, limited availability of evidence for planning, inequities in distribution of health resources and access to services. Primary Health Care (PHC), which forms the bedrock of the national health system, is especially weak. In addition, the health system is overstretched by a burgeoning population. There is almost no financial risk protection. The weakness of the health system largely accounts for the low levels of coverage of services and the poor health indices of Nigeria.

This underperformance is more pronounced at the primary health care level, the level that is key to the attainment of our national health goals, including universal health coverage. Compared to other African countries there is a relative abundance of PHC facilities, reasonable geographic access, high health worker density but lower performance especially in utilization rates of the PHC facilities and output of health workers[54]. The system is characterized by poor infrastructure, dearth of equipment, fragmented supply chain management, poor economic access and demotivated staff. The root causes of the under-performance of the PHC system is gross underfunding and major weakness in leadership and governance.[55] The end-term evaluation provided evidence of poor funding of PHC and major gaps in funding of key PHC services, maternal and child health[56]. Before the introduction of Primary Health Care Under One Roof in 2012, PHC governance in the country was

[54] Kress DH, Su Y, Wang H. Assessment of the Primary Health Care performance in Nigeria: using the Primary Health Care performance conceptual framework. Health System Reform. 2016; 2(4) 302 - 318

[55] Ibid

[56] Federal Ministry of Health (2017) End-term evaluation of the National Strategic Health Development Plan (2010 -2015). FMoH, Abuja

characterized by fragmentation, multiple management structures, poor coordination, overlapping and lack of clarity of roles and responsibilities, inefficiencies in resource deployment and utilization, including human resources and weak referral systems. These all undermined PHC services delivery, making it difficult for people to access quality health services, contributing to the poor results.

2.2.1 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: 100,000 compared to the sub-Saharan African average of 15: 100,000. The nurse/midwife: population ratio is 148:100,000 in the country while the average in the region is 72: 100,000. However, the quantity is inadequate to meet the country health needs.

The NHAct 2014 provides enablement for HRH development. The National Human Resources for Health Policy (NHRHP) and National Human Resources for Health Strategic Plan (NHRHSP) provide guidelines for States and the Federal Capital Territory (FCT) to develop their Human Resources for Health. The National Task Shifting and Task Sharing (TSS) Policy[57] with Standard Operational Procedures (SOPs) has been developed to maximize performance of the 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 HRH Information System at the federal and sub-national levels. In order to mitigate severe shortages of skilled workers in critical areas, the Nigerian 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 HRH production capacity of Nigeria is summarized in Table 4.

Table 7 Accredited Human Resources Training Institutions in Nigeria

Type of Institution	Category of Health professional	Number accredited
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

[57] Federal Ministry of Health 2014. Task shifting and task sharing policy. Abuja, Nigeria. FMoH.

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 major 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 majority of the states. The result is over production of some categories of Health workforce such as CHEWs and inadequacies in the production of some critical health workforce such as midwives. There are, however, general inadequacies in the capacity of health training institutions to produce the required number and quality of frontline health workers.

Table 8: Human resources availability by categories

Health Workers Categories	Year	No Registered	Density/ 100,000 population	Ratio	% increase over previous year
Doctors	2009	65,759	38.9	1:2,572	18
Dentists	2009	3,129	1.9	1:54,056	20
Optometrist	2010	2,676	1.6	1:63,207	26
Dispensing Optician	2010	168	0.10	1:1,006,793	250
Nurses/Midwives	2009	249,566	148	1:677	
Dental Nurses		266	0.15	1:635,868	86
Radiographers	2009	1,286	0.76	1:131,525	39
Pharmacists	2009	16,979	10	1:9,961	18
Physiotherapists	2009	2,818	1.7	1:60,022	43
Community Health Officers	2009	5,986	3.5	1:28,256	22
SCHEW	2009	42,938	25.3	1:3,939	
JCHEWs	2009	28,458	16.8	1:5,914	
Medical Lab Scientists	2009	19,225	11.3	1:8,798	29
Medical Lab Assistant	2009	11,067	6.5	1:15,283	9
Medical Lab. Technicians	2009	8,202	4.8	1:20,622	57
Environ. Health Officers	2009	6,542	3.9	1:25,854	53%
Health Records Officers	2009	2,926	1.73	1:57,806	
Dental Technologists	2009	730	0.43	1:227,646	
Dental Therapists	2010	3,253	1.9	1:51,995	66
Dental Technicians	2010	1,885	1.1	1:89,730	80
Dental Surgery Assistant	2010	886	0.5	1:190,904	33

Chattered Chemist	2010	2533	1.5	1:66,775	13
Public Analysts	2009	717	0.4	1:235,901	32
Pharmacy Technician		1,849			48
Health Technicians	2009	8,739	5.15	1:19,354	
Occupational Therapists	2009	34			21%
Occupational Therapist Assistant	2009	104			41%
Speech Therapists	2009	28	0.01	1:17,000,000	300
Audiologists	2009	25			200
Physio-Technician	2009	65			25
Prosthetist and Orthotists	2009	8			30%

Source: Human Resources for Health Country Profile Nigeria 2012 (published, July 2013)

The national population growth rate is outpacing the production rate of health professionals, such as Doctors, Dentists, Pharmacists, Radiographers, Physiotherapists, etc. In the last three years, the average annual growth rate for Nurses and Midwives remained at 2.6% whereas the population growth rate is occurring at 3.2%. The available HRH profile in Nigeria is summarized in Table 8.

While at the national level, an HRH policy and strategic plan have been developed, there is little domestication of these at the state level, thus most states lack human resource plans. The gaps in quality of available work force remains a challenge. Mal-distribution of available workforce persists, to the disadvantage of rural areas, northern zones of the country, and lower level health facilities. As a result of better remuneration packages, many health professionals prefer to work in federally managed health facilities rather than local government managed health facilities. Furthermore, northern zones of the country, with relatively higher disease burden, and dearth 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 institutionalized motivation and retention mechanisms for health workers. There are inefficiencies in the performance management systems, including lack of clear job descriptions for health workers in Nigeria 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 oftentimes paralyze 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.

2.2.2 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.) as required for healthcare delivery at different levels. It also includes water, power supply and sanitation facilities in health institutions. The National

Planning Commission in 2015 gave the number of health facilities in Nigeria as over thirty-four thousand with 88% of the facilities being Primary Healthcare Centers.[58] (Table 6).

Table 9: Distribution of Health Facilities in Nigeria by level of care and ownership

Description	Public	Private	Total
PHC	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

Source: National Population Commission, 2015

The breakdown indicates about 1 healthcare facility to 6000 Nigerians. Access to PHC services is currently at about 61% with 15 available beds per 1000 population and only 30 PHCs per 100,000 people.

For healthcare infrastructure to meet the desired outcome, it must be effective, safe to use, qualitative, and also appropriate, affordable, available, accessible and acceptable. However, about 80 percent of health facilities in Nigeria is 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 Federal Ministry of Health developed basic requirements for delivery of the essential/minimum care package 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; minimal number of PHCs linked to contiguous secondary health facilities in each LGA, States having functional secondary Health Facilities in each LGA with qualified personnel and the establishment of a strong referral system to a contiguous tertiary health facility. Also, the revamping of specialist and tertiary hospitals is to meet local needs including the establishment of a robust health information system.

2.2.3 Medicines, Vaccines, Health Technology and Supplies

There are many policies, guidelines and institutions in Nigeria to facilitate sustainable supply of quality and affordable medicines, vaccines and other health products in Nigeria. The National Agency for Food and Drugs Administration and Control (NAFDAC) is responsible for the regulation of production, quality and distribution of medicines. The Nigeria Institute for Pharmaceutical Research and Development (NIPRD) is a public agency responsible for research and production of quality active pharmaceuticals for local use.

Despite these strengths, this aspect of the health care system is characterized by disproportionate underfunding for medicines and other health products for meeting the health care needs of the population, stock-outs and high expiries at service delivery points, irrational

[58] National Planning Commission 2015. National Integrated Infrastructure Master Plan. The Presidency, Federal Republic of Nigeria, pp81-85

drug use, poor and parallel supply chain management systems, and inadequate warehousing with available ones not meeting minimum standards. Additionally, there is poor infrastructure and protection for local manufacturers. The situation means that Nigeria depends largely on importation to meet its local needs for medicines and vaccines. The local Manufacturers are reportedly only able to produce about 5% of the local needs of medicines and other health products. 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, sequel to rising trend of irrational drug use has become an issue of concern. To address this, the Federal Government through NCDC has launched and commenced implementation of the National Plan of Action on AMR in 2017 for full implementation. In addition, a National Supply Chain Product Management Programme has been established to ensure integration of supply chain systems and effective logistics and supply system for medicines and other health products to service delivery points with support from the Global Fund.

While traditional medicine is widely utilized, the practice remains unregulated and unstandardized and there have been minimal investments in research into it and collaboration with the allopathic medical system is yet to be established. A policy on Traditional Medicine has been developed but it is yet to be implemented.

2.2.4 Health Information System

The revised Nigeria 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 remains challenged due to multiplicity of data collection tools and non-availability of data reporting tools. Routine data collection is currently through the DHIS 2 platform, which harvests data from 38,500 private primary and secondary facilities. However, while reporting rate in 2017 was averaged at 72%, timeliness is still low at 63% with the major weakness being that the data being reported is much less than national estimates from other sources, thus limiting its utility value. Although the private sector provides 60% of healthcare services in the country, there is still very limited capture of their data into the HMIS. Similarly, there is no capture of tertiary health institutions' data into the DHIS 2 as they are still not reporting to the LGAs within their domain. In addition, other data subsystems such as vital statistics, survey and implementation of research for health are performing sub-optimally. Overall, poor data quality still persists at all levels. There is no systematic process of routine analysis of HMIS data and with feedback to health institutions. This inadequacy has limited the use of HMIS data as a management tool for health planning and improvement. Other challenges include: weak mechanism for coordination of M&E at all levels; poor human resource capacity, lack of

material resources especially at sub-national levels and non-reflection of issues relating to data quality in the HIS policy.

In spite of the lingering challenges, significant progress has been made in improving governance and coordination in M&E in line with the National Health Information System Policy 2016. The Health Data Governance Council (HDGC), chaired by the Honorable 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 expected to have similar structures at the State and LGA levels. The existence of funds within vertical programs for monitoring and evaluation is an opportunity that could be leveraged to enhance HIS in the country. Lack of sense of ownership of data by government remains a persisting threat. The 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. This will also facilitate the development of an investment framework for M&E.

2.2.5 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- commercialization of research findings, to non- passage of intellectual property rights, and weak linkages between health research institutes, the private sector and local needs.

Funding for health research in Nigeria is meager at only 0.08% of health expenditure at the federal level. There is hardly any funding at lower levels. This is contrary to the prescription of 2% allocation to research for health by African Health Ministers and agreed to by the National Council on Health. Also, there is an internationally accepted guideline that donor agencies should allocate 5% of their Aid to research which is not being complied with. Additionally, there is poor investment by the private sector in health research and development in the country. This poor funding of health research impacts the quality and depth of health research. Health research should be informing effective health policy development and programming, and contributing to the advancement of global health knowledge. Unfortunately, there is adisconnect between research in academic institutions in the country and the consumers of research findings.

2.2.6 Health Care Financing

The optimal utilization 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 gaps in health care financing. 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.[59] The National Health Act of 2014 provides for the dedication of a deduction of 1% of the consolidated revenue to health services provision to be known as Basic Health Care Provision Fund. In 2017, the federal government approved a new National Health Care Financing and Equity Policy as well as developed guidelines for implementation of the policy. While these provisions are available, implementation has been poor. The appropriation of the 1% Basic Health Care Fund is yet to commence.

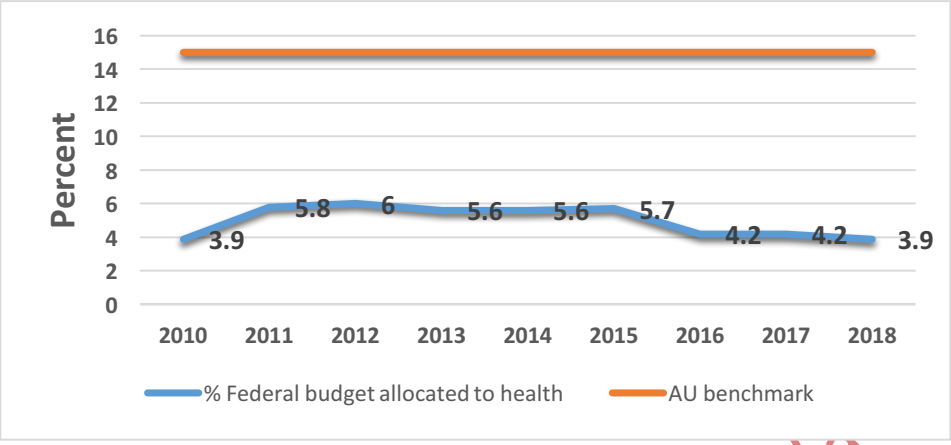
The overall, out-of-pocket expenditure (OOPE), as a proportion of total health expenditure is high, ranging from 78% in 2010 to 73% in 2016. The high level in OOPE poses a barrier to accessing health services, thereby fueling inequity in health outcomes and further exposing the poor to impoverishment and financial catastrophe. There is a l*ow level of coverage of health insurance and other pre-payment and financial risk protection mechanisms. At present, only about 5% of Nigerians have prepaid health care through social and voluntary private insurance.* This proportion cover mainly federal level civil servants. A few states have started community-based health insurance schemes that target the informal sector. There are weaknesses in procurement of services from the NHIS fund. In Nigeria, Health Management Organizations (HMOs) are the purchasers of care on behalf of the NHIS. These HMOs are private organizations that enroll both NHIS populations and other private health insurance populations. Although there are issues of vested interests and powerful HMO groups, the monitoring and regulatory framework for HMOs is weak. To make purchasing strategic in line with international evidence, there is a need to ensure that a large monopolist, e.g. the National Health Insurance Fund, is created holding a large share of pooled funds to purchase health services for the entire population. Other weaknesses of the NHIS is that the scheme remains voluntary, there is little buy-in by states, the funding schemes are fragmented and there appears a limited interest to target the 70% of the population in the informal sector.

The weaknesses in the Nigerian Health Care Financing (HCF) system include weak institutional structure and policy environment and low government investment in health. Government's prioritization of health is determined by the funds it spends on the sector relative to the overall expenditure outlay. The percentage of government allocation to health sector rose from 3.9% in 2010 to peak at 5.7% in 2015 and by 2017 it dropped to 4.2%. This is much below the Abuja Declaration benchmark of 15%, (Figure 23). The low government health spending stood at NGN 3.1 trillion in 2014, with an annual growth of 12.3% per year.[60]

Other health financing indicators for Nigeria point to the fact that more than 70% of health expenditure is out-of-pocket, even though it has decreased marginally from 78% in 2010 to 73% in 2014. The OOPE is much higher than the 30-40% recommended by WHO. The proportion of GDP devoted to healthcare is less than 2.5% instead of the WHO benchmark of at least 4%.

[59] NHIS, 2012
[60] Federal Ministry of Health, 2017

Figure 23: Trend in Federal Government health budget as percentage total health budget 2010-2018



The appropriation of the 1% Basic Health Care Fund is yet to commence.

The out-of-pocket spending in Nigeria is high. The overall, Out-Of-Pocket Expenditure (OOPE), as a proportion of total health expenditure is high, ranging from 78% in 2010 to 73% in 2014. The high level in OOPE poses a barrier to accessing health services, thereby fueling inequity in health outcomes and further exposing the poor to further impoverishment and financial catastrophe. There is a low level of coverage of health insurance and other pre-payment and financial risk protection mechanisms. At present, only about 5% of Nigerians have prepaid health care through social and voluntary private insurance. Whereas the National Health Insurance Scheme (NHIS) and private insurance has gained sufficient traction in providing coverage to federal public-sector workers, their families and workers of large private organizations, state governments have been slow in the uptake of the social health insurance and currently very few states are participating in the scheme. However, 25 states are currently at various stages in enacting laws and putting in place structures to establish their State Health Insurance Schemes while a two states have started enrolling.

There are weaknesses in procurement of services from the NHIS fund. In Nigeria, Health Management Organizations (HMOs) are the purchasers of care on behalf of the NHIS. These HMOs are private organizations that enroll both NHIS populations and other private health insurance populations. Although there are issues of vested interests and powerful HMO groups, the monitoring and regulatory framework for HMOs is weak. To make purchasing strategic in line with international evidence, there is a need to ensure that a large monopolist (e.g. the National Health Insurance Fund) is created holding a large share of pooled funds to purchase health services for the entire population.

There are issues in resource mobilization and utilization. The public health sector relies solely on government funding with little or no effort at mobilization of resources from other sources. There are opportunities for increased domestic funding from corporate social responsibility funds, health impact bond, sin taxes, aviation, VAT, mandatory health insurance, public-private partnerships and philanthropy which are only marginally exploited. Allocative

inefficiencies persist and systems for monitoring and reporting health expenditures or for assessing efficiency of resource use are being poorly implemented allowing poor transparency and leakages. While primary health care is the fulcrum of the national health policy and the key strategy to attainment of universal coverage with health care services, that level of care remains grossly underfunded. Because health resource allocation remains skewed in favour of secondary and tertiary care, a direct consequence is that people bypass PHC facilities to seek care at secondary and tertiary facilities. This situation is inefficient and promotes inequities. The cost of primary care provision at secondary and tertiary level is higher (economically inefficient) and poor people, especially in rural areas, cannot access care because it is either not available or too expensive (inequity in access and payment).

There are however a few initiatives aimed at improving efficiency, transparency and accountability in health financing. These include the World Bank supported Saving One Million Lives Initiative (SOML) Program for Results (PforR) financing mechanism, a government initiative through which high impact maternal and child health interventions are funded in all the states based on performance. Another World Bank-supported Results-based/ Performance-based financing scheme, the Nigeria State Health Investment Project (NSHIP), is being implemented in Nasarawa, Ondo and Adamawa where funding is directed at health facilities. It allows the health facility to motivate its staff based on performance and use the funds to upgrade infrastructure/facilities within the limits of the funds generated by the health facility. If the coverage of health insurance improves significantly in the country, PBF will be an avenue for reducing health inequity as virtually all health facilities will receive sufficient funds for upgrade of facilities, provision of drugs and supplies and other services.

A number of financing schemes, though very limited, and mainly donor-driven are providing safety nets for vulnerable populations, mainly women and children. These include conditional cash transfer schemes, deferrals, exemption schemes (notably for Obstetric Fistulae (OF) patients and free MCH services.

In order to overcome these constraints, there will be a need for all levels of government to develop health financing strategies consistent with the national health financing strategy, increase the level of funding to the health sector, develop financing mechanisms for wider financial risk protection, promote allocative efficiency and the predictability, accountability, transparency, equity and sustainability of the Nigerian health financing system.

2.2.7 Leadership and Governance

The Nigerian constitution places health in the concurrent legislative list, which implies that federal, state governments and LGAs can legislate on health services. The National Health Policy 2016 assigns clear responsibility for the management of tertiary, secondary and primary healthcare delivery to federal, states and local governments respectively. To improve governance of the health system, government initiated innovative strategies, and coordination platforms such as the National Council on Health; Systems of Health Accounts; National Health Policy, Basic Health Care Provision Fund, Primary Health Care Under One Roof, PHC

revitalization and passed the NHAct in 2014,[61] among others. The NHAct establishes the Tertiary Hospitals Standards and Regulatory Committees and other complementary committees for tertiary health facilities. Nigeria is a signatory to the Global Compact of the International Health Partnerships and related initiatives of 2008. However, some areas of weakness in governance of the health system in Nigeria persists. Although there are various national health coordination platforms, including the Health Partners Coordinating Committee chaired by the Minister of Health, the Development Partners Group for Health and the different Thematic Technical Groups and Task Teams, there is poor coordination and harmonization of these groups, leading to duplication of functions and waste of scarce resources. There is also ineffective coordination among the three levels of government and between the private and public sectors. There is poor regulation of the activities of the private sector and general challenges in enforcing regulations. Other challenges include low political will as evidenced by the low allocation to the health sector, poor implementation of laws and policies, poor accountability, frequent changes in leadership and lack of voice and accountability. Others include dearth of capacity in strategic planning, lack of involvement of consumers in planning of health services and near absence of voice and accountability.

2.2.8 Partnerships for Health

The Nigerian Government recognizes the multi-dimensional nature of the health system and the need for strategic partnerships in health. Partnership with the private sector, non-governmental organizations, 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. It is estimated that over 60% of health care services is being provided by the private sector in Nigeria and private out-of-pocket expenditure accounts for three quarters of the total health expenditure in the country[62]. Nigeria developed the PPP Policy in 2005.

The PPP Policy of 2005 provides the framework for the involvement of the private sector in the development of infrastructure and services in the country including health infrastructure and services. A PPP unit has been established in the FMOH. This unit has been facilitating partnerships such as the 'Warehouse in a Box' project (in Abuja and Lagos), sundry PPP arrangements in Federal Tertiary Institutions such as CAT-Lab in UCH, Geriatric Wards in UCH, Dialysis machines in FMC, Owerri, and the LUTH/GE partnerships. The Unit also facilitated Joint Venture Agreements between Crystal Thorpe Nigeria Ltd. and University of Abuja Teaching Hospital (UATH) for the operation/management of the Trauma and Multi-specialist Centre at the Hospital and the concession of the Garki Hospital within the NSHDP I plan period.

[61] Federal Government of Nigeria (2014) *National Health Act*

2.2.9 Community Participation

Community participation and ownership is imperative for the success of any health care delivery programme and services. It is particularly essential as it serves as a vehicle for attainment of universal health coverage (UHC) especially in resource constrained settings like Nigeria. It empowers individuals, families and communities to get more involved and take greater control over their health; thereby engendering resilience and program sustainability.

The NPHCDA established Ward Development Committees (WDCs) in more than 800 political wards across the country under the leadership of community members. There is community representation in Hospital Management Committees and in some states, facility health committees comprising community members and staff of the health facility have been established. A few Health Programmes have extended their services to community level and there is increasing use of community-based health care workers for health care services delivery. The NPHCDA is currently working to harmonize the different community-based health workers being used by different programmes into one group to be called Community Health Influencers, Promoters and Service Providers (CHIPS). These initiatives have resulted in significant improvement in community participation in health. The introduction of the National Health Insurance Scheme (NHIS) opened the opportunity to further foster community participation in health through community-based social health insurance scheme for the informal sector.

Myriad of challenges have been identified as weaknesses and threats to effective community participation in health care delivery ranging from poor understanding of the concept, practice and role of community members in community participation for health to gross underfunding, lack of harmonization and integration of community based structures and services, differential financial incentives occasioned by varying programme approaches/interests, non-involvement of private sector stakeholders, poor community linkages with the health system, gaps in record keeping and monitoring, inadequate supportive supervision of existing community health structures and absence of clearly defined policy instruments to guide community participation.

2.3 Gender and Health

Gender inequities affects health in many dimensions as it results in differential vulnerabilities, exposures, access to information and services, quality of care and health outcomes. The pattern of manifestation is varied with differential affectation of males and females; however, the women are disproportionately impacted.

Women's higher poverty levels, lower educational attainment and lower rates of formal employment limits their ability to access information and services. This is worsened by the dominant means for paying for services, OOPE, which affects women more than men, further pushing into financial catastrophe. Women have been marginalized 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 very rife, women cannot go to seek health care outside the home without the express permission of their husbands, even spatial mobility is restricted to within the confines of the home.

Generally, Reproductive Health (RH) services are targeted at women, particularly married women. Even though our national policies and RH strategy talk about male participation as one of their key policy thrusts, investments in male participation remains limited. There is a general lack of attention to the reproductive health needs of men and the crucial role they could play in reproductive health outcomes of women. Also, adolescents, young people and other minority groups are excluded from and have limited access to health care.

Gender-based violence is a major public health concern, affect both women and men, but women are most affected. Until recently, it remained a neglected area. However, just recently the Federal Ministry of Health (FMOH) developed guidelines for management of Gender Based Violence (GBV) at clinic level for health workers[63]. Implementation is however yet to fully commence.

Services as currently organized, do not encourage the participation of men in women's and children's health. For instance, men are hardly seen at ANC or delivery rooms. In Tanzania, for example, and as obtains in some parts of Nigeria, the gender-division of labour and power relations between a wife and husband or a man and woman determine, to a large extent, how, why, when and where they exercise their bargaining power to access financial resources.[64] This greatly impacts on their health and treatment-seeking behaviour.
Infrastructural deficits are major problems in the country that hinder gender based access to health care by most population groups. Most of the PHC facilities target women leaving out the men, adolescents and the unmarried. Also, a large proportion of health facilities lack amenities like toilets, water supply and electricity, limiting their utility.

Table 10: Summary of Nigeria's socio-demographic and health indicators

Indicator	Values	Source
Demographic		
Total population (2017)	194,026,767	NPC/NBS 2017
Males	98,250,809	NPC/NBS 2017
Females	95,775,958	NPC/NBS 2017
Children aged < 1 year		
Children< 5 years	31,109,000	Countdown to 2015-Maternal, Newborn & Child Survival 2015 report
Percent of population under 15	44%	Demographic dividend www.demographicdividend.org
Pregnant women		
Women of child bearing age		
Total fertlity rate	5.6%*	Countdown to 2015-Maternal, Newborn &

[63] Federal Ministry of Women Affairs and Social Development and Federal Ministry of Health. National Guidelines and Referral Standards on Gender-based Violence in Nigeria. Undated
[64] National Bureau of Statistics, with MEASURE DHS, and Macro International Inc. (2008): "Tanzania HIV/AIDS and Malaria Indicator Survey 2007-08. Preliminary report." Draft version 20 May 2008, National Bureau of Statistics, Dar es Salaam. Cited as "THMIS (2007-08) draft

		Child Survival 2015 report
Adolescent birth rate	120	MICS 2016-2017
Mortality		
Neonatal mortality rate	39 per 1000 live births (LB) 33.3/1000LB	MICS 2016/17 WHO 2015
Infant mortality rate	70/1000 LB	MICS 2016/17
Under five mortality rate	120/1000 LB	MICS 2016/17
Maternal Mortality ratio	576/100,000 LB	NDHS 2013
Nutrition		
Children 0-5 months exclusively breastfed	23.7%	MICS 2016/17
Children <5 yrs underweight below -2 SD (weight-for-age)	31.5%	MICS 2016/17
Children <5 yrs stunted below -2 SD (height-for-age)	43.6%	MICS 2016/17
Children <5 yrs wasted below -2 SD (weight-for-hheight)	10.8%	MICS 2016/17
Health Services Coverage		
1. Reproductive Health		
Antenatal care (ANC) coverage	49.1%	MICS 2016/17
Antenatal care by skilled health provider	65.8%	MICS 2016/17
Deliveries supervised by a skilled health provider	43.0%	MICS 2016/17
Women who had a live birth delivered in a health facility	37.5	MICS 2016/17
Currently married women who used any modern method of contraception (CPR)	10.8%	MICS 2016/17
Unmet need for contraception	27.6%	MICS 2016/17
Tetanus Toxoid (women age 15-49 received TT)	55.3%	MICS 2016/17
2. Immunization		
DPT-3/Penta-3 coverage	38.8%	MICS 2016/17
Measles coverage	22.9%	MICS 2016/17
Fully immunized	23.0%	MICS 2016/17
3. Management of childhood illnesses		
Children < 5 yrs with ARI symptoms who sought for treatment from health provider	23.7%	MICS 2016/17
Children < 5 yrs with Diarrhoea who sought for treatment from health facility/provider	26.7%	MICS 2016/17
Children < 5 yrs with diarrhoea given solution from ORT packet	18.5%	MICS 2016/17
Children <5 yrs with fever who took anti-malarial (ACT) drugs same/next day	36.8%	MICS 2016/17
% of care seeking for children < 5 yrs with suspected malaria that are tested using RDT or microscopy	13%	Malaria Indicator Survey (MIS) 2015
4. Malaria		
Prevalence	45% (RDT); 27% (microscopy)	MIS 2015
Households who slept under ITN	69.1%	MICS 2016/17

Pregnant women who slept under ITNs	39.6%	MICS 2016/17
Children <5 yrs who slept under ITNs	49.1%	MICS 2016/17
Pregnant women who received IPT during ANC visit (*Presumptive treatment of malaria*)	31.1%	MICS 2016/17
5. HIV		
HIV prevalence	3.2%	HIV Sentinel Survey 2014
Population of PLWHAs	3,391,600 (2014 est.)	CIA World factbook 2017
HIV/AIDS deaths	174,300 (2014 est.)	CIA World fact book 2017

2.4 Recent Developments and Challenges

By the end of the implementation period of the Millennium Development Goals (MDGs), some of the targets could not be met due to challenges of insecurity and commitment at all levels as well as transparency. It thus meant that the MDGs implementation in Nigeria remains an unfinished business that needs to be rolled over to the successor Sustainable Development Goals (SDGs) framework. The unfinished agenda of the MDGs, the new SDGs, emerging health issues (especially epidemics), the provisions of the *NHAct 2014*, the new PHC governance reform of bringing PHC Under One Roof (PHCUOR), and Nigeria's renewed commitment to Universal Health Coverage (UHC) call for development and implementation of new policies and guidelines.

Some emerging challenges include globalization, climate change, and the impact of insurgency on the Nigerian health system. Climate change has serious adverse consequences on the environment and on threats of emerging and re-emerging diseases and epidemics. A key aspect of the *NHAct*, namely the CRF charge of at least 1% is are yet to be appropriated. The Community Based Social Health Insurance scheme in many states are not working adequately. There is increased demand for health humanitarian activities due to insurgency, emerging and re-emerging diseases.

2.5 SWOT Analysis

1. LEADERSHIP AND GOVERNANCE

Strengths

Improved legislative and policy framework and Programme Plans:

- A National Health Act in 2014 with provision for a basic health care provision fund
- A revised National Health Policy which is informed by current global agenda (SDG)
- Programmatic policies and plans abound

Improved Coordination

- The PHCUOR operationalized through the establishment of SPHCDAs
- Improved Partners/Donor/Aid coordination platforms at state and federal levels

Weaknesses

Delayed or poor implementation of policies and Plans and programmes and key provisions of the Act

- 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.

Regulation and Standards

- 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

Accountability, Transparency and Responsiveness

- Weak responsiveness, rigidity in structure and bureaucracy
- Annual reviews and reports not being undertaken
- Limited voice and accountability and CPH

2. COMMUNITY PARTICIPATION

Strengths

- Existence of ward development committees at ward level and of Facility Health Committees in some facilities.

Weaknesses

- Poor understanding of the concept and weak implementation of community participation in health.
- Fatalistic outlook to disease causation and outcome.

- Availability of an organized platform for traditional rulers and religious leaders' involvement in health
- Devolving some health programmes to community level (e.g. IMCI, Community nutrition programme etc.)
- Harmonization of various categories of community-based workers (CBW) into Community Health Influencers and Promoters of Service (CHIPS).

- Increasing and differential financial incentives for CBW threatening sustainability.
- Lack of harmonization and integration of community based services leading to verticalization, duplication and waste of resources at the community level.

3. PARTNERSHIP

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 programmes (RI, PHC) in some states
- Improved inter-governmental partnerships (State and Federal institutions to leverage HRH for service delivery)

Weaknesses

- Weak alignment of partners programmes with national/state plans
- Weak partner coordination forum
- Poor transparency and accountability by partners
- Duplication and overlapping of work by partners leading to wastages and inefficiencies
- Promotion of vertical programming and reporting that frustrates integration
- Non-provision of data (service and financial) by the private sector and some development partners
- Inadequate harnessing of potential partnerships opportunities by Governments

4. ESSENTIAL HEALTH CARE SERVICES

Strengths

- Revised/updated policies, guidelines, SOPs/treatment guidelines, etc. for delivery of health services
- Expansion and scale up of services such as in TB control and HIV services
- Scaled up immunization services leading to better coverages
- Improved malaria control activities and outcomes
- Improved integration of services such as the RMNCAH+N, TB and HIV integration

Weaknesses

- Poor and inequitable coverage with high impact cost-effective interventions
- Poor implementation of the Minimum Health Services Package (MSP)
- Inequity in access to information and services (geographic, socio-economic and gender)
- Suboptimal quality of services.
- Weak referral system
- Rudimentary emergency medical services.
- Weak supportive supervision of HRH
- Poor integration / verticalization of 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.
- Poor implementation of health programmes.
- Inadequate attention to social determinants of health.

5. PUBLIC HEALTH RISKS AND EMERGENCIES

Strengths	Weaknesses
• Establishment of functional NCDC and Emergency operations centres (EOC) • Increasing pool of trained epidemiologists. • Availability of policy, strategic plan, guidelines and tools for IDSR • Existence of NEMA and SEMA	• Weak surveillance system/ early warning signs. • Poor planning, preparedness and management of public health risks and emergencies. • Weak network and capacity of public health laboratories. • Delayed and poor capacity to respond to public health emergencies and risks • Surge capacity of health facilities to respond to public health emergencies is poorly developed.

6. LABORATORY SERVICES

Strengths	Weaknesses
▪ Existence of public and private laboratory services. ▪ Existence of National and Blood Transfusion Services Policies ▪ Increasing pool of qualified Laboratory scientists	▪ Poor standardization of laboratory services ▪ Limited quality assurance and control protocols ▪ Poor networking of laboratory services ▪ Dearth of competent personnel ▪ Inadequate availability and poor maintenance of lab equipment ▪ Poor supply chain management for laboratory consumables and supplies ▪ Poor laboratory information management system ▪ Poor linkage between clinical and research laboratory services ▪ Ineffective regulation of laboratory services

7. HUMAN RESOURCES FOR HEALTH

Strengths	Weaknesses
▪ Availability of national HRH policy and strategic plan and their domestication by some states ▪ Existence of National Human Resources for Health Information System (NHRHIS) infrastructure ▪ Availability of a national task shifting policy and SOP ▪ Country has capacity for variety of human resource for health production. ▪ Existence of 14 regulatory bodies to regulate the production and practice of HRH.	▪ Low level of implementation and domestication of HRH policy and strategy at federal and state levels respectively. ▪ Maldistribution of HRH (geographic – urban-rural and regional, level of care) in relation to numbers and skills mix ▪ Disconnect between the production pipeline and HRH needs. ▪ Poor motivation of health workers ▪ Recurrent strikes and poor working relationship between various professional groups. ▪ Dearth of skilled health workers, especially at PHC level. ▪ Embargo on employment across many states. ▪ Gender of health worker adversely influencing uptake of services in some parts of the country. ▪ Lack of scheme of service for some cadre of health workers, e.g. M&E officers ▪ Weak supportive supervisory system

8. HEALTH INFRASTRUCTURE

Strengths	Weaknesses
▪ Availability of many health facilities across the country ▪ Availability of National infrastructure Policy and programmes.	▪ Dearth of basic and critical care equipment. ▪ No health infrastructure development master plan • Weak infrastructure maintenance culture ▪ Poor state of health infrastructure ▪ Limited investment in ICT and communication infrastructure in the health sector ▪ Poor public power supply, water and basic sanitary facilities. ▪ Dilapidated physical infrastructure, especially in older health institutions. ▪ Available vehicles in a poor state of repair

9. Medicines, Vaccines, Commodities and Health Technologies

Strengths	Weaknesses
• Availability of policy, guidelines and institutions	• Gross underfunding for medicines and other products

• Availability of domestic manufacturers of drugs certified by WHO • Establishment of a national supply chain production management to integrate all supply chain management systems for medicines and other products	• Frequent stock outs and high rates of expiry at delivery points • Parallel supply chain management systems still operating • Inadequate warehousing with available ones not meeting needs • Poor infrastructure and protection for domestic manufacturers • Local production meeting only 5% of needs • National vaccine production moribund • Increasing prevalence of anti-microbial resistance • Irrational drug use • Low investment in and harnessing of in traditional

10. HEALTH INFROMATION SYSTEM

Strengths	Weaknesses
▪ Establishment of the Health Data Governance Council (HDGC) which is chaired by the Honorable Minister of Health. ▪ Existence of Health Data Consultative Committee (HDCC) at the national level chaired by the HMH and existence of similar structures in some states. Together with HDGC, provides oversight and governance for Health Information. ▪ Draft roadmap for strengthening the M&E system. ▪ DHIS 2.0 expanded and rolled out to all the states. ▪ Development of community based HMIS tools developed and field tested.	▪ Fragmentation and duplications of reporting lines because of vertical health programmes ▪ Multiplicity of data collection tools resulting in stress on health workers ▪ Non-availability of data for planning of some interventions (E.g. NCD, care of the elderly, mental health etc.) and where available, such data are outdated ▪ DHIS with poorly defined and not harmonized indicators and the platform is not sufficiently robust. It also does not capture community-level health information ▪ Low routine data completion, accuracy, timeliness and reporting rate. ▪ Persistent overall poor data quality at all levels ▪ Limited data capture from private sector providers ▪ Gross inadequacy in capacity to analyse and utilise data for decision making at all level. ▪ Poor feedback mechanisms. ▪ Weak coordination of M/E structure at all levels. ▪ Dearth of HMIS tools at facility level ▪ Inadequate training programmes and lack of scheme of service.

11. **HEALTH RESEARCH**

Strengths	Weaknesses

- Availability of national health research policy and guidelines
- Research governance and regulatory structures in place at all levels (NHREC)
- Availability of national research institutes
- Existence of some health research skills
- Availability of some funding agencies e.g. TETFUND, NUC
- Availability of many local and international journals for dissemination of health research findings
- Availability of Intellectual property, technology transfer offices and incubation centers

- Non-availability of national health research Agenda
- Weak promotion, coordination and regulation for health research and development
- Limited investment by public and private sector in Research and Development
- Disconnect between researchers and consumers of research findings (policy makers and industry) resulting in researchers driven by personal or donor agenda with limited connection to research needs of the market place.
- 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

12. **HEALTH FINANCING**

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 at least 1% of the consolidated revenue fund as enacted in the NHF.
- Many Nigerian States are now evolving sundry health financing/contributory schemes and Health Care Financing Agencies (SHIA) to foster UHC and provide financial risk protection for the citizens.
- Increased funding from donor partners
- Implementation of free care programmes for vulnerable populations e.g. free MCH, Malaria, TB, HIV treatments etc.

Weaknesses

- High rate of medical tourism because of poor condition of the health care services
- Out of pocket expenditure is 75%; 0nly about 5% of Nigerians have prepaid health care through social and voluntary private insurance.
- Many programmes are donor-driven / funded (e.g. HIV/AIDS, Malaria, TB, Nutrition, Immunization)
- Very poor coverage with social health insurance
- The systems: for monitoring and reporting health expenditures is poorly implemented.
- Percentage of GDP devoted to healthcare funding in Nigeria remains at less than 2.5% of GDP instead of the WHO benchmark of 4% - 5%;
- Weak overall regulatory mechanisms for health care financing actors and schemes in Nigeria including HMOs, CBHIS, SHIAs)

Cross-cutting Opportunities and Threats

OPPORTUNITIES	THREATS
▪ Positive economic outlook for the country ▪ Increasing donor presence and support ▪ Enabling policy environment ▪ Strong leadership ▪ UHC is a global health agenda which Nigeria has signed into	▪ Unpredictable domestic revenue ▪ Changes in government resulting in inconsistencies in policies and programmes. ▪ Changing donor priority ▪ Donor fatigue ▪ Rising militancy and terrorism ▪ Civil unrest ▪ Public health disasters ▪ Labour and trade union disputes • Ignorance, Poverty, Corruption, Globalization • Absence of an enabling environment for research • Poor public infrastructure and facilities including roads, power supply, water supply • Socio-cultural inhibitors to researching certain issues ▪ Environmental threats e.g. insurgency

Chapter 3

Strategic Directions

3.1 Vision, Mission Goal and Values/Principles of the NSHDP II

The vision, mission and goal of the National Health Strategy are outlined as follows:

Goal

Ensure healthy lives and promote well-being of the Nigerian populace at all ages

3.2 Core Values and Principles

The implementation of the NSHDP II will be guided by the following key principles as parameters that will guide the successful and sustained implementation of the NSHDP II. This is demonstrated by the following core principles:

Accountability and transparency: The principles of good governance, openness and responsiveness will be integrated and imbibed in the implementation of the NSHDP II at all levels of the health care delivery and will strive to serve all Nigerian citizens 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 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 the NSHDP II set goals and objectives.

Community engagement: The 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: The NSHDP 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: This 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: process of implementing the plan will be as consultative and participatory as possible, involving all key stakeholders in the public and private sector including beneficiaries and decision-makers at all levels. Effective stakeholder consultation and management will be undertaken all through the strategic plan development and implementation process that is critical to producing the desired result of better health outcomes for all Nigerians.

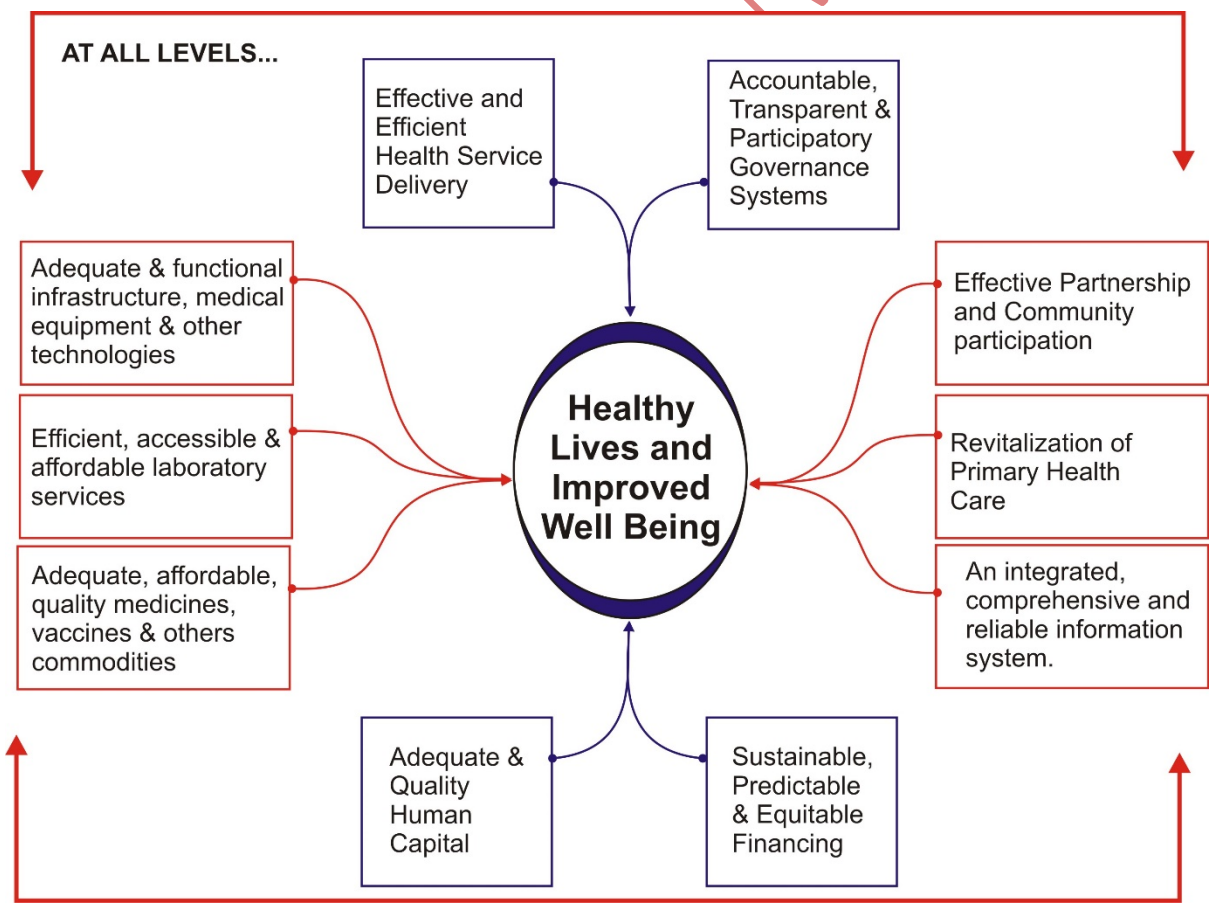
Sustainability and resilience: It will be delivered through entrenchment and institutionalization of policies and practices that will make for effective and durable health care services delivery bearing in mind innovative strategies and solutions that work where

individuals, groups and communities deploy appropriate technology where local knowledge, skills, and capacity to address all issues related to their health are in existence.

3.3 Conceptual Framework of NSHDP II

The conceptual framework used for developing the NSHDP II is shown in Figure 24. 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 revitalized 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 system that supports health care services delivery – human resources for health, health information system, 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 22: Conceptual Framework of the National Strategic Health Development Plan II



3.4 NSHDP II Strategic Objectives

The central strategic objectives of the NSHDP II are as outlined in this section.

1. **Promote an enabling environment for attainment of sector goals:**
    a. Strengthen coordination at all levels
    b. Ensure harmonization and alignment within the sector
    c. Strengthen regulatory systems and processes
    d. Enhance multi-sectoral collaboration

2. **Equitably Increase coverage with packages of quality essential health care services**

The essential health care services package comprise a) reproductive, maternal, newborn, child and adolescent health plus nutrition, b) prevention and control of communicable diseases, c) prevention and control of non-communicable diseases, and d) health promotion and environmental health):

    a. Increase access to package of essential health care services
    b. Create demand for essential health care services
    c. Improve quality of essential health care services.

3. **Strengthen health system for delivery of packages of essential health care services:**
    a. Equitably improve the quantity, skill mix, motivation and distribution of health workforce
    b. Increase funding to health sector, allocative and technical efficiencies
    c. Improve sustained availability of medicines, vaccines, commodities and health technologies
    d. Improve availability and distribution of functional infrastructure for health services delivery
    e. Strengthen the health information system for timely evidence-based decision-making

4. **Improve protection for health emergencies and risks**
    a. Strengthen national surveillance system and early warning mechanisms
    b. Strengthen mechanisms for timely response to public health emergencies

5. **Enhance healthcare financial risk protection:**
    a. Increase coverage with social health insurance

3.5 Health Sector Priorities

The priorities of the NSHDP II articulated for the plan period 2018 to 2022, as stated in the succeeding sections, are designed to address indicated contextual gaps in service delivery (scope and quality), improve on the systems for delivery of health care services as well as promote reporting and use of evidence in planning and for improvements of plans and implementation.

Health Service Delivery Priorities

Adopting a national essential health care package with a focus on:

a. Reproductive, maternal, newborn, child and adolescent health plus nutrition (RMNCAH+ Nutrition)
b. Communicable Diseases, including environmental health, health emergencies and preparedness response, and neglected tropic diseases (NTDs)
c. Non- communicable Diseases, including mental health, injuries, and care of the elderly

Health System Strengthening Priorities

a. Leadership and governance: emphasis is on strengthening coordination and regulatory institutions and processes aimed at reducing geographic and socio-economic barriers to access
b. Health human resources: priority is on ensuring availability and equitable distribution of productive, highly motivated, customer-centred health workers, with the right skills and in the right mix
c. Sustainable Health financing: the focus is on increasing resource mobilization and public-sector funding in line with Abuja Declaration, improving equity and efficiency in resource allocation and utilization; improving Public Finance Management; increasing financial risk protection to reduce out of pocket expenditure, and rapid expansion of social health insurance coverage
d. National Health Management Information System: emphasis is on ensuring that the National Health Information System promotes evidence-based decision making.
e. Essential Medicines, Vaccines, Equipment, Supplies and logistics: the focus is on increasing access to safe, affordable and quality essential medicines vaccines, equipment and supplies through the building and maintaining of an integrated supply chain system.
f. Partnerships for Health: the priority is on building and strengthening collaborative mechanisms for involving all partners in the development and sustenance of the health sector
g. Community Participation and Ownership; The focus will be on deepening community participation and ownership of health initiatives
h. Research and Development: priority is on generation of baseline indicators through surveys for many of the indicators, implementation research and evaluation.

Fig 25: Results Framework of the NSHDP 11

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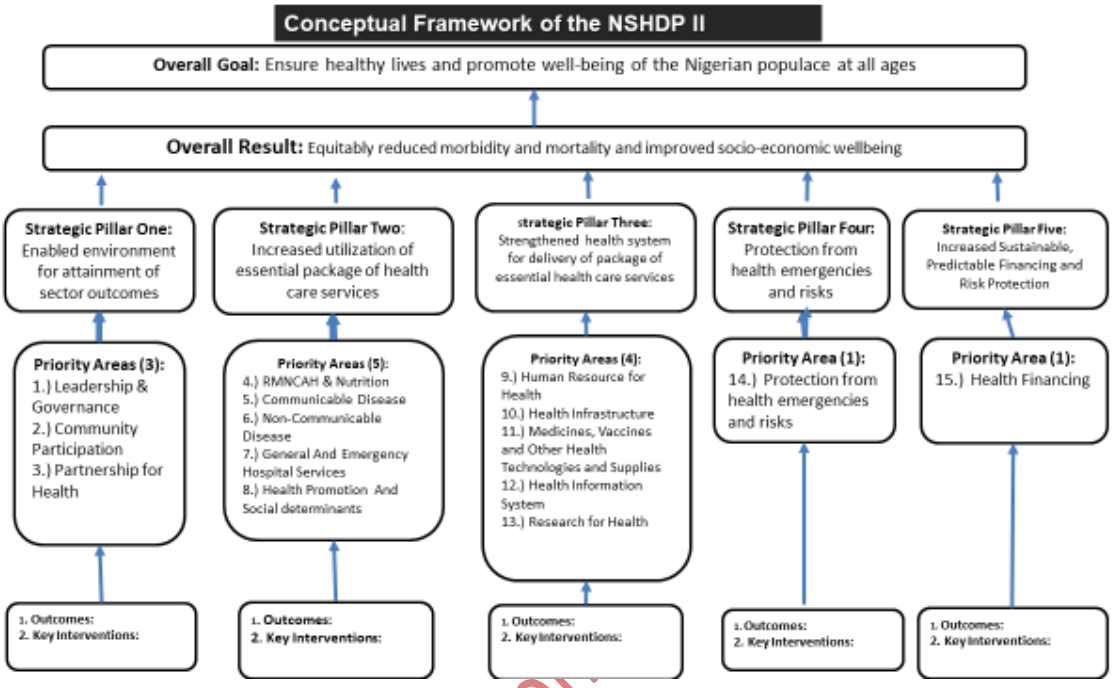


- Strategic Pillar One: Enabled environment for attainment of sector outcomes
- Strategic Pillar Two: Increased utilisation of essential package of health care services
- Strategic Pillar Three: Strengthened health system for delivery of package of essential health care services
- Strategic Pillar Four: Protection from health emergencies and risks
- Strategic Pillars Five: Predictable Financing and Risk Protection

As indicated in the Results Framework (Figure 25), for each pillar, the prioritized areas were identified and for each prioritised area, the core interventions were developed targeting specific outcomes and an ultimate goal to '*Ensure healthy lives and promote well-being of the Nigerian populace at all ages'.*

The context and core interventions for each strategic pillar have been elaborated in specific sections of this plan to provide overall guidance for lower level planning activities by Federal and State Health Ministries, Departments and Agencies.

The details of the plan, including the sub-goals, strategic objectives, interventions, activities and targets for each priority area in the NSHDP II Matrix are in Appendix 3.

Chapter 4

Strategic Pillar 1: Enabled Environment for Attainment of Sectoral Goal

4.1 Leadership and Governance

Context

The Federal Government provides overall leadership in setting the national health agenda including policy directions. It also provides the framework and guidelines for delivery of standardised health services across the country. However, the health system continues to face challenges. These include low budgetary allocation, suboptimal reflection of inequities in planning and programming, ineffective coordination and interface of the health system at different level of governance - federal, state and local governments, health MDAs and related sectors and inadequate responsiveness in aligning plans to needs. Many health programmes are compartmentalised leading to fragmentation, overlap of functions and conflicts. Also, some key provisions of the NHAct such as the BHCPF are yet to be operationalised. There are weak voice and accountability mechanisms and ineffective monitoring and supervisory processes at all levels of the health system. There are also weaknesses in regulatory processes and limited implementation of existing regulations. To address these challenges, interventions of the NSHDP II will seek to address these challenges and leverage current opportunities and strengths of the health system.

Strategic Goal

Provide effective leadership and an enabling policy environment that ensure adequate oversight and accountability for the delivery of quality health care for sustainable development of the national health system

Strategic Objectives

- To provide clear policy, plans, legislative and regulatory framework for the health sector
- To strengthen transparency and accountability in planning, budgeting and procurement process
- To improve health sector performance through regular integrated reviews and reports
- Strengthen coordination, harmonization and alignment at all levels

Targets

	Targets	2018	2019	2020	2021	2022
Provide clear policies, plans, legislative and regulatory framework for the health sector						
1	Percentage of coordination organs at national and subnational levels (NCH, SCH, WDC, HPCC) that are established and are functional increased to 70% by 2022	30%	40%	50%	60%	70%
2	Number of states, FCT and Federal that have developed operational plans from the SHDP II.	0	38	38	38	38
3	Number of states, FCT and Federal that have developed their annual health budget from annual operational plans	0	38	38	38	38
4	Number of states, FCT and Federal that undertake annual review of their SSHDP II implementation	0	38	38	38	38
5	Number of states undertaking regulatory and standardization visits to public and private health facilities in their states	0	38	38	38	38
6	Number of federal, states + FCT conducting JAR of implementation of SHDP II	0	38	38	38	38
Strengthen transparency and accountability in planning, budgeting and procurement processes						
1	Percentage of states that increase annual budget implementation rate by 25%	TBD				Increase by 25%
2	Number of states producing and disseminating annual progress reports including financial reports.	2	15	30	35	38
Improve health sector performance through regular integrated reviews and reports						
1	Proportion of federal level MDAs and 36 SMOH plus FCT HSS that publish annual and state of health reports increase by 50% of baseline	TBD				Increase by 50% of baseline
Strengthen coordination, harmonization and alignment at all levels						
1	Percentage of PHCs with functional ward development committees increase by 50% of baseline	TBD				Increase by 50% of baseline
2	Percentage of WDCs carrying out health activities increased to 50%	TBD				Increase to 50% from baseline
3	Percentage of funding of health from partners (development partners and private sector) that is aligned to the National Health Policy and National Strategic Health Plan by 2022.	TBD				30%

Strategic Interventions and Actions

The interventions shall be in four strategic areas to address determined weakness and threats in leadership and governance, taking advantage of opportunities and strengths. To provide clear legislative, policy, plans and regulatory framework for the health sector, key personnel

at all levels will be trained in gender-responsive policy and plan development, states will be supported to domesticate relevant national laws, policies and guidelines and investments will be made to ensure that annual costed operational plans are drawn at federal and state levels from the N/SHDP II. High level advocacy shall be conducted to legislature to increase funding allocation to the health sector in line with Abuja Declaration and appropriate the BHCPF. Legal and regulatory framework shall be strengthened for more effective health system governance, including measures to strengthen implementation of existing laws and regulations. The interventions and actions that are expected to promote equity, transparency and accountability in policy development, planning, programming, budgeting, procurement, implementation and reporting have been defined. They include strengthening the Public Finance Management System including oversight in Fund disbursement and utilization at all levels by conduct of joint annual reviews of the implementation of NSHDP II, production and dissemination of reports of NSHDP II implementation, coordination of development of annual budgets at all levels and the tracking, publishing and dissemination of annual performance reports. Linkages between various planning and budgeting process (MTEF/MTSS will be strengthened through conduct joint review and alignment meeting between health planning and budgeting health departments and other stakeholders. Voice and accountability, including community participation, CSO engagement will be strengthened through the following: enabling CSOs so serve as watchdogs, regular engagement with CSOs, establishment and strengthening of community structures to facilitate a more effective community participation in health at all levels. To improve the performance of the health system, regular, joint and integrated systems for reviews and reporting shall be put in place. During the plan period, overall coordination of the health system shall be strengthened through the creation of coordination platforms and mechanisms at all levels including vertical coordination of the different levels of the health care system, coordination of inter-governmental, inter-agency and inter-sectoral actions in health.

4.2 Community Participation

This priority area seeks to address the gaps poor understanding of the concepts of community participation, absence of policy and plans, poor coordination and monitoring and evaluation of community-based health care services and the need to consolidate and implement the plan for the harmonization of various cadres of community-based workers into CHIPS.

Goal

To promote community engagement for sustainable health development'

Strategic Objectives

1. Strengthen community level coordination mechanisms and capacities for health planning; and
2. Strengthen community -participation in the implementation, monitoring and evaluation of health programmes.

Specific Targets

- Percentage of PHCs with functional ward development committees increased by 50% of baseline, which is to be determined (TBD).
- Percentage of WDCs carrying out health activities increased to 50% from baseline (TBD)
- Percentage of wards with functional CHIPs programme

Key interventions and actions

To achieve these targets, key interventions and activities identified were to strengthen institutional and coordinating mechanisms for promotion of community participation in health planning. The capacities of WDCs, the key structures established nationwide to anchor community participation and provide the coordinating framework for community participation shall be strengthened for improved participation in participatory planning for health interventions, community mobilization and financial management of health interventions through establishment/strengthening and monitoring of functionality of WDCs, health facility committees and other community structures (CHIPS), ensuring equitable representation of the private sector, CSO's and women in health committees. Mapping of all community-based health workers shall be carried out as a prelude to their harmonization into CHIPs, in line with agreed guidelines. Capacity building to facilitate the implementation of community and facility level minimum service package (MSP) through trainings of CHIPS and other community level structures will be carried out. Appropriate linkages between CHIPS and primary health care facilities for referrals, supportive supervision, and replenishment of commodities stocks. Also, mechanisms will be strengthened to improve community level data collection, analysis, storage, utilization and accountability through establishment of a community-based health information system and conduct of routine data quality assurance checks at all levels.

4.3 Partnerships

Government alone cannot secure the health of the people of Nigeria. Partnership with the private sector, non-governmental organisations, communities and development partners (donors) as well as other social and economic sectors is essential to deliver sustainable health services that can meet the needs of the population. The basis for undertaking public-private partnership (PPP) in improving health service delivery is to leverage additional resources and managerial approaches from the private sector and partners with social orientation for the public sector to improve the delivery of health services. However, the activities of both the public and private sectors have been left uncoordinated. Tthere is weak alignment of partners' programmes with national / state plans, with duplication and overlapping of work by partners leading to wastages and inefficiencies. Furthermore, the private sector and some development partners do not provide necessary data for national planning, partly due to vertical programming and reporting that frustrate integration. The NSHDP II addresses these gaps

Goal

To enhance harmonized implementation of essential health services in line with national health policy goals.

Strategic Objective

To ensure that collaborative mechanisms are put in place for involving all partners in the development and sustenance of the health sector.

Specific Target

1 To increase the percentage of funding of health from partners (development partners and private sector) that is aligned to the National Health Policy and National Strategic Health Plan to at least 30% by 2022.
2 To increase by 50% the proportion of public health institutions and government programmes having partnerships with the private sector.
3 To increase to 50% the number of states having common basket funding model and establish one at the national level by 2022

Key interventions and activities

These shall include promotion of the adoption and utilization of national policies and guidelines on PPP and strengthening of the legal and coordinating framework for PPP at all levels. Effort shall also be directed at promoting joint (public and private sector) monitoring and evaluation of health programmes while also scaling up resource mobilization interventions (funding, skills - e.g. managerial approaches) targeting the private sector. Furthermore, mechanisms shall be established for resource coordination through common basket funding models such as Joint Funding Agreement, Sector Wide Approaches, and sectoral multi-donor budget support. Also, an inter-sectoral ministerial forum shall be established at all levels to facilitate inter-sectoral collaboration, involving all relevant MDAs directly engaged in the implementation of specific health programmes so as to promote health in all policies. Collaboration between government and professional groups including Nigerian health professionals in diaspora to advocate for increased coverage of essential interventions, particularly increased funding and leverage human resources for health from partners, health professionals, other levels of government to optimize resource use and improve service delivery will be pursued. Collaborative MOU shall be developed/strengthened between state governments and tertiary institutions/federal so as to leverage the skilled human resource that abound in tertiary health facilities to support health care provision in the states. Innovate ways of promoting public-private partnerships in the areas of vaccines and drugs production and service delivery shall be strengthened. Innovative approaches shall be strengthened to promote PPP in health care services delivery in public facilities across the levels of care.

Chapter 5

Pillar 2: Provision of Essential Package of Health Care Services

5.1 Essential Package of Health Care Services

The goal of the 2016 National Health Policy is to ensure that every Nigerian has universal access to essential health care services. The policy, in alignment with the goals of Sustainable Development Goal 3, identified some key health care services to be provided as part of the essential health care services. This was further elaborated in the National Strategic Health Development Plan 2 for the period 2018-2022. These essential services include the minimum service package contained in the Basic Health Care Fund and are listed below

Maternal, Newborn, Child and Adolescent Health plus Nutrition

Maternal Health

Table 11: Essential Package according to levels of Care

Intervention	Community	Primary	Referral
1. Pre-pregnancy			
Family planning	X	X	X
Prevent and manage sexually transmitted infections	X	X	X
Cervical cancer screening	X	X	X
Tetanus toxoid	X	X	X
Screening for HIV	X	X	X
Antiretrovirals for HIV-positive pregnant women	-	X	X
2. Pregnancy (at least 8 visits, 3 by a trained provider)			
Appropriate antenatal care package 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 RDS* *Birth preparedness and complication readiness plan development* *At least one abdominal ultrasound scan (before 24 weeks of gestation)* *Home visit*		X	X
3. Post-abortion care for abortions	-	X	X
4. Labour and Delivery including management of complications			
Supervision by skilled birth attendant	X	X	X
Partograph use to monitor labour		X	X
Active management of third stage of labour to prevent postpartum haemorrhage		X	X

Administration of uterotonics to prevent PPH (misoprostol)	X	X	X
Magnesium Sulphate for eclampsia	-	X	X
Induction of labour to manage pre-labour rupture of membranes at term	-	-	X
Antibiotics for preterm pre-labour rupture of membranes	-	X	X
Corticosteroids to prevent respiratory distress in unborn babies and newborns	-	-	X
Pneumatic anti-shock garments for hemorrhage	-	X	X
Induction of labour for prolonged pregnancy	-	-	X
Prophylactic uterotonics to prevent postpartum haemorrhage	X	X	X
Management of postpartum haemorrhage (e.g. uteretonics, uterine massage)	X	X	X
Manual removal of placenta			
Removal of retained products of conception			
Assisted vaginal delivery			
Caesarean section for maternal/foetal indication	-	-	X
Prophylactic antibiotics for ceaserean section	-	-	X
5. Postpartum (Mothers)			
Family planning	X	X	X
Prevent and treat anaemia	-	X	X
Screen for HIV and initiate treatment from HIV	-	X	X

Priority Interventions for Newborn and Child Health

Intervention	Community	Primary	Referral
Postnatal (Newborn)			
Immediate thermal care	X	X	X
Initiation of exclusive breastfeeding (within 30 mins)	X	X	X
Chlorhexidine gel for cord care	X	X	X
Basic neonatal resuscitation	X	X	X
Advanced neonatal resuscitation	-	-	X
Management of possible severe bacterial infection where referral is infeasible	X		
Case management of neonatal sepsis, meningitis and pneumonia	-	X	X
Kangaroo mother care for preterm and for less than 2000g babies	-	X	X
Management of children with jaundice	-	X	X
Surfactant to prevent respiratory distress syndrome in preterm babies	-	-	X
Continuous positive airway pressure (CPAP) to manage babies with respiratory distress syndrome	-	-	X
Administration of vitamin K for newborns		X	X
Extra support for feeding small and preterm babies	-	X	X
Presumptive antibiotics therapy for newborns at risk of bacterial infections	-	-	X
Postnatal visit within 48 hours of birth	X	X	X
Erythromycin ointment for prophylactic eye care		X	X
Nevirapine for HIV exposed babies			
Long-lasting insecticide net (LLIN) use by households	X	X	X
Home visits	X	X	X
Birth registration	X	X	X
Infancy and Childhood			
Exclusive breastfeeding for 6 months	X	X	X
Continued breastfeeding to 24 months and complementary feeding from 6 months	X	X	X
Prevention of childhood malaria *Long-lasting insecticide net (LLIN) use by households*	X	X	X

Amodiaquine plus sulfadoxine-pyrimethamine (AQ+SP) chemoprevention for seasonal malaria chemoprophylaxis in sahelian states			
Rapid Diagnosis Test (RDT) + appropriate antimalarial treatment	X	X	X
Vitamin A supplementation from 6 months of age	X	X	X
Routine childhood immunization	X	X	X
Management of severe acute malnutrition and provision of Ready to Use Therapeutic Food (RUTF)	X	X	X
Case management of childhood pneumonia	X	X	X
Case management of diarrhea (Low Osmolar ORS + Zinc tabs)	X	X	X
Long-Lasting insecticide net (LLIN) use	X	X	X
Comprehensive care of children infected with or exposed to HIV *Nevirapine prophylaxis* *PCR at 6weeks* *Cotrimoxazole prophylaxis* *Antiretrovirals*	X	X	X
Deworming	X	X	X
Folate supplementation	-	X	X
Screening for sickle cell disease	-	-	X
Pulse oximetry in pneumonia	-	-	X
Detection and reporting of violence in children	X	X	X
Promotion of handwashing and sanitation	X	X	
Prevention and management of home accidents	X	X	
Home visits	X	X	X

Essential Package of Newborn and Child Health where interventions are provided in current national programmes

Intervention	Impact	Packages	Level of Intervention		
			Community	Primary	Referral
Antenatal corticosteroids for preterm delivery	Reduces risk of respiratory distress syndrome (RDS)	Antenatal care			X
Basic resuscitation	Prevents severe asphyxia, reduces fresh still birth (FSB)	Essential newborn care/ Life-saving skills	X	X	
Advanced resuscitation	Prevents severe asphyxia, reduces FSB	Expanded life-saving skills initiative			X
Bubble continuous positive airway pressure (CPAP)	Reduces respiratory distress and mortality				X
Keeping babies clean, dry and warm	Prevention of hypothermia	Essential newborn care	X	X	X
Kangaroo mother care for low birth weight	Promotes survival of LBW babies, successful breastfeeding and promotes maternal health	Essential Newborn Care (ENC)	X	X	X
Antibiotics for Premature rupture of membrane	Reduces risk of neonatal sepsis	Antenatal care			X
Chlorhexidine gel for cord care	Prevents neonatal sepsis	ENC/Integrated community case management (ICCM)/Integrated	X	X	X

		management of childhood illnesses (IMCI)/ community IMCI (cIMCI)/CBNC			
Erythromycin ointment for prophylactic eye care	Prevents ophthalmia neonatorium and NNS	ENC	X	X	X
Antibiotics for newborn sepsis	Reduces morbidity and mortality	ENC/IMCI		X	X
Nevirapine prophylaxis		Early infant diagnosis (EID)/ Prevention of mother-to-child transmission (PMTCT)		X	X
PCR at 6weeks		EID/PMTCT		X	X
Cotrimoxazole prophylaxis	Prevents mother to child transmission of HIV	PMTCT		X	X
Immunization	Protects against pertussis, diphtheria, neonatal tetanus, TB, Hepatitis and polio	National Programme on Immunisation (NPI)/ENC/IMCI/iCCM/cIMCI	X	X	X
Antibiotics for newborn sepsis	Reduces morbidity and mortality	ENC/IMCI		X	X
Nevirapine prophylaxis		EID/PMTCT		X	X
PCR at 6weeks		EID/PMTCT		X	X
Cotrimoxazole prophylaxis	Prevents mother to child transmission of HIV	PMTCT		X	X
Vitamin K1	Prevents haemorrhagic disease of the newborn	ENC		X	X
Early initiation of breast feeding	Helps establishment of exclusive BF, prevents hypoglycaemia, reduces neonatal, and child mortality,	ENC/IYCF	X	X	X
Immunization	Protects against pertussis, diphtheria, neonatal tetanus, TB, Hepatitis and polio	IYCF/ENC/IMCI	X	X	X
Exclusive breastfeeding in first 6months		IYCF/ENC/IMCI	X	X	X
Post-natal visit within 7 days	Facilitates early detection of danger signs, facilitates community participation in newborn care	CBNC	X		
Early detection of jaundice	Reduces NeoNatal Jaundice (NNJ) mortality and long term morbidity	ENC/IMCI	X	X	X
Preconception folate	Prevention of neural tube defect			X	X
Birth Registration	Enables better planning		X	X	X

Long-Lasting insecticide net (LLIN) use by households	Prevents malaria transmission	cIMCI/iCCM	X	X	
Rapid Diagnosis test (RDT) + appropriate Antimalarial	Facilitates early detection and treatment	iCCM/IMCI	X	X	X
Low Osmolar ORS + Zinc tabs	Prevents dehydration and metabolic derangement in diarrhea, facilitates recovery	iCCM/IMCI/cIMCI	X	X	X
Antibiotics for dysentery		IMCI		X	X
Rotavirus vaccine into routine immunization	Prevents viral diarrhoeal disease in infants and reduces mortality from diarrhea	NPI		X	
Amoxicillin DS for pneumonia	Prevents morbidity and mortality from diarrhea	iCCM/IMCI	X	X	X
Pulse oximetry in pneumonia	Facilitates identification of severe cases of pneumonia and prioritization interventions	IMCI/iCCM	X	X	X
Bronchodilator for wheezing		IMCI		X	X
Routine immunization	Protects against VPDs	NPI/IMCI/cIMCI/ iCCM	X	X	X
Vitamin A supplementation	Protects against respiratory infections, diarrhea	IYCF/CMAM/IMCI/ cIMCI	X	X	X
Ready-to-use-therapeutic food (RUTF)	Facilitates rehabilitation of malnourished children	Community-based management of malnutrition (CMAM)/ Infant and Young Child Feeding (IYCF)		X	X
Screening for malnutrition		CMAM/IYCF/iCCM/IMCI/cIMCI	X	X	X
Deworming	Protects against worm infestation and its consequences including anaemia	CMAM/IYCF/IMCI	X	X	X
Screening for sickle cell disease					X
Folate Supplementation		IMCI		X	X
Amodiaquine plus sulfadoxine-pyrimethamine (AQ+SP) chemopreventi on for malaria		Seasonal Malaria Chemoprophylaxis (SMC)	X	X	

Sexual and Reproductive Health

Intervention	Community	Primary	Referral
Family Planning	X	X	X
Screening for HIV and comprehensive treatment for all HIV-positive people	X	X	X
Treatment of non-HIV sexually transmitted infections	X	X	X
Screening for Cervical Cancer	X	X	X
Education, counselling, early detection and treatment of breast cancer	X	X	X
Screening for Prostate Cancer			X
Provision of integrated sexual and reproductive health services	X	X	X
Education, counselling and treatment of rape, and other gender-based violence	X	X	X

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

Integrate adolescent health services into primary health care

Nutrition

Intervention	Community	Primary	Referral
Early initiation of breastfeeding within the first 30 minutes of birth	X	X	-
Exclusive breastfeeding for 6 months	X	X	-
Continued breastfeeding and complementary feeding from 6 months	X	X	-
Complimentary feeding from 6 months to 2 years	X	X	-
Micronutrient powder supplementation	X	X	-
Management of acute malnutrition	X	X	-
Baby-Friendly Hospital Initiative (BFHI)	-	X	X
Nutrition for children with persistent diarrhea	X	X	X
School feeding	X (Schools)		
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	X	X	X
Iron-folic acid supplementation in pregnant women	X	X	X

Nutritional assessment, counseling and support services at all ages	X	X	X

Communicable Diseases

Intervention	Community	Primary	Referral
Malaria			
Long lasting Insecticide treated nets for pregnant women and children aged less than 5 years	X	X	
Indoor Residual Spraying	X		
Intermittent Preventive Therapy for pregnant women	X	X	
Seasonal chemoprevention with SP for under-fives in 9 Sahel States	X	X	
Parasitological diagnosis of malaria (RDT or microscopy)	X	X	X
Treatment of uncomplicated malaria with ACT	X	X	X
Treatment of Complicated malaria			X
Hepatitis			
Immunization of infants and high risk groups (health workers, c=sew workers and their clients, IDU, MSM, all ANC hepatitis negative clients TBAs, Barbers etc.)		X	X
Screening and diagnosis of chronic Hepatitis infection	X	X	X
Treatment of chronic progressive Hepatitis C infection (with interferon or lamuvidine (3TC)/tenofovir (TDF)/emtricitabine(FTC)			X
Tuberculosis/Leprosy			
Tuberculosis case detection	X	X	
Microscopic diagnosis of TB	X	X	X
Integrating TB screening and diagnosis in HIV interventions		X	X
Diagnosis (with GeneXpert) and treatment of MDR-TB			X
Diagnosis of Leprosy (micrpscopy)		X	X
Treatment of Leprosy with Multidrug therapy (MDT)		X	X
Management of Leprosy complications and rehabilitation	X	X	X
HIV/AIDS			
Provision of HIV testing and counselling services including RDT for personal testing	X	X	X
Distribution of condoms (male and female) and microbicides	X	X	
Prevention of mother-to-child transmission services	X	X	X
Early infant diagnosis		X	X
Chemoprophylaxis for HIV positive persons (cotrimoxazole)		X	X
Monitoring treatment (CD4)			X
Treatment of all HIV positive people with HAART		X	X
Treatment of opportunistic infection	X	X	X
Home-based care	X		
Support groups for PLPs	X	X	
Neglected Tropical Diseases **Diseases: Schistosomiasis, soil-transmitted helminthic infections (STH), lymphathic filiariasis, onchocerciasis, leishmaniasis, yaws, Buruli ulcer, scabies, trachoma, snake bite**			
Integrated vector control	X	X	
Periodic mass/targeted Preventive chemotherapy			
Albendazole for soil transmitted helminths	X	X	
Praziquantel for schistosomiasis	X	X	
Ivermectin or diethycarbamicide for lymphatic filariasis	X	X	
Ivermectin for onchocerciasis	X	X	
Topical antibiotics (tetracycline) for trachoma	X	X	

Case management		X	X
Water and Sanitation (WASH) interventions	X	X	
Rabies post exposure vaccination		X	X
Snake Bite (anti-venom and treatment)		X	X

Non-Communicable Diseases

Intervention	Community	Primary	Referral
Cardiovascular diseases			
Screening and treatment of hypertension	X	X	X
Nutritional assessment (including BMI for overweight and obesity assessment, lipid profile), counselling and support services	X	X	
Health promotion (nutrition education, exercise promotion and smoking control education)	X	X	
Lipid profiling		X	X
Diagnosis (X-rays, ECG, MRI, etc.) and management of CVD		X	X
Rehabilitation and long-term care	X	X	X
Diabetes			
Screening for diabetes (routine sugar testing) and risk factors	X	X	X
Nutritional assessment (including BMI and MAC), counselling and support services	X	X	X
Health promotion (e.g. exercise promotion and smoking control education)	X	X	X
Diagnosis and management of diabetes		X	X
Management of diabetic complications and rehabilitation	X	X	X
Cancers			
Health education on lifestyle modification for all cancers	X	X	
Radiotherapeutics, chemotherapeutic and surgical cancer services for all cancers		X	X
Cancer of the Cervix			
Human Papilloma Vaccine for cervical cancer		X	
PAP smears for pre-cervix cancer screening		X`	X
Diagnosis and treatment services			X
Annual Prostrate cancer screening (PSA)		X	X
Cancer of the breast			
Breast self-examination	X		
Clinical breast examination		X	X
Mammography to screen for breast cancer			X
Treatment of breast cancer			X
Cancer of the liver			
HbV vaccination		X	
Diagnosis and treatment services			X
Cancer of the prostate			
Screening using PSA			X
Diagnosis of cancer of the prostate			
Treatment of cancer of the prostate			X
Sickle Cell Disease			
Genetic counselling for general population	X	X	
Genotype profiling		X	X
Haematinic supplements and malaria prophylaxis		X	X
Diagnosis and management of SCD complications			X
Oral Health			
Oral health education and promotion (proper dental hygiene, nutrition and diet education, alcohol and tobacco reduction etc.)	X	X	

Intervention	Community	Primary	Referral
Regular dental check-up		X	X
Preventive dental services (e.g. scaling and polishing of teeth, preventive restorations and use of pit and fissure sealants for dental caries)			X
Restorative and orthodontic treatment			X
Diagnosis and treatment of dental diseases, including surgical treatment		X	X
Mental Health (Including substance abuse)			
Health education and promotion on mental health	X	X	
Promote mental health literacy (in collaboration with other sectors)	X	X	
Provide community-based youth mental health care services that combines mental health, alcohol and other substances	X		
Community-based mental health care services by lay workers	X		
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		X	
Rehabilitative services for drug and substance abuse addicts	X		X
Psychiatric treatment services in general hospitals			X
Provision of long stay facilities and specialist psychiatric services			X
Eye Health			
Health education on eye health promotion and disease prevention	X	X	
Screen for eye diseases (visual defects, blindness etc.)	X	X	X
Diagnosis and provision of basic eye treatment services & referrals	X	X	X
Medical and surgical management of eye problems in general and specialist centres			X
Rehabilitative care for persons with eye disabilities	X	X	X
Care of the Elderly			
Health promotion activities for elderly	X		
Home-based care and support services	X		
Annual medical check-ups for elderly (screen for nutritional problems and chronic diseases of elderly -- annual screening for CA prostate, CA breast, CA colon and biannual BP checks and appropriate referrals		X	X
Nutrient supplements (e.g. Calcium)		X	
In-patient treatment services			X
Long term care (Old people's home)			X

Emergency Medical and Hospital Services

Intervention	Community	Primary	referral
Emergencies include trauma, violence, all medical and obstetrics emergencies			
Health promotion and education on accident, injury and violence prevention	X	X	
Pre-hospital care (i.e. first aid) and management of minor accidents	X	X	
Evacuation (Emergency transportation and first aid by first responders)	X	X	X
OPD Emergency hospital care services (triage, Initial Evaluation, Diagnosis & Resuscitation and In-Hospital Care)			X
Emergency Unit management: Initial Assessment & Resuscitation, Monitoring and Re-evaluation, Detailed Assessment, Diagnostic Studies, Additional Therapeutics			X
In-patient care - treatment, surgery and critical care			X

Rehabilitation services		X	X
Public Health Emergencies Preparedness and Response			
Intervention	Community	Primary	Secondary
Mitigation	X	X	
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	X		
Emergency planning	X	X	X
Stockpile and pre-position health supplies		X	X
Strengthen surveillance and monitoring of potential hazards to health, including public health laboratory	X	X	X
Emergency response	X	X	X
Early warning system	X	X	X
Provide triage, immediate emergency first aid and evacuation services	X	X	
Triage emergency medical and surgical services		X	X
Provide appropriate patient management (surgical and medical) services			X
Provide primary care services	X		
Food and nutrition support services	X	X	
Immunizations	X	X	
Environmental sanitation services (water, sanitation and disposal of the dead)	X	X	
Reproductive and sexual health services	X	X	
Psychosocial support services	X	X	X
Infection prevention and control		X	X

Social Determinants of Health (food hygiene, water, sanitation and Occupational Health)

Health Promotion

Focus: prevent disease, improve health and quality of life

Targets: individuals, communities, schools, workplaces and health care settings

Intervention	Level of Intervention		
	Community	Primary	Referral
Promote healthy living behaviour and harm reduction (exercise, diet, tobacco use, alcohol, rest, social activities etc.)	X	X	
Provide IEC on various relevant health issues	X	X	
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	X	X	
Collaborate with other sectors to integrate health promotion into their activities (schools, workplaces, including communities for recreational activities)	X		
Educate and promote uptake of health promotive and preventive services	X	X	

Food Safety and Hygiene

Intervention	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.	X		
Train and monitor the activities of food vendors and handlers	X		

Conduct bi-annual medical examination of food handlers, including screening for typhoid and hepatitis) and issue medical certificate of fitness		X	X
Conduct inspection, control and regulation of food markets and abattoirs, restaurants and other places of sales of foods to the public, including surveillance	X		
Conduct mobilization of community structures, including Ward development Committees for safe and hygienic nutrition-related activities, from production to consumption	X		
Establish early warning system that has the capacity to detect, trace and prevent outbreak of food borne illnesses before they spread	X		

Water and Sanitation

Intervention	Community	Primary	Referral
1. Public education on sanitation	x	X	
2. Promote proper hand washing techniques	x	X	
3. Community sensitization on safe water and health risks of unwholesome water	x	X	
4. Provide tippy tap points	x	X	

Environment, chemical products and medical waste

Intervention	Community	Primary	Referral
1. Promote public health education on health impacts of climate change	x	X	
2. Safe disposal of health waste according to National guidelines	x	X	x
3. Promote public education on poisoning	x	X	x
4. Poisons surveillance and reporting	x	X	x
5. Manage acute and chronic poisoning conditions	x	X	x
6. Promote chemical hazards education	x	X	x
7. Promote occupational health education and safety	x	X	

Occupational Health

Intervention	Level of Intervention		
	Community	Primary	Referral

Towards achieving universal coverage with Essential Package of Health Care Services

The Essential healthcare Service Package (ESP) in the NSHDP II has been articulated to ensure that the essential health needs of Nigerians are being provided and for more impactful changes in the health indices of the country. It is expected to be implemented at three levels - community, PHC facility and Referrals to higher levels of care.

To accelerate the attainment of universal coverage with this Essential Package of Health Care Services, the Health Sector during the period of implementation of the NSHDP II will work towards achieving the following:

1. Revitalization of Primary Health Care: There will be acceleration of progress towards upgrading/strengthening of at least one PHC per ward across the country to provide the components of services to be implemented at that level to increase service availability and accessibility. The planned harmonization of community-based health care providers into CHIPS will be consolidated and will be used for provision of services at community level and also, for demand creation. The Primary Health Care Under One Roof (PHCUOR) will be strengthened to improve coordination and integration of services. One secondary health facility per LGA shall be strengthened to serve as referral outlets for the PHCs.

2. To remove economic barriers to access, the NHIS shall be reviewed to make social health insurance mandatory and the benefit package reviewed to ensure accommodation of this essential service package. Thus, ESP shall form the minimum package of care obtainable in health benefit package of health financing schemes as a way of ensuring universal health coverage (UHC) with essential health care for Nigerians.

   While the BHCPF as provided for in the NHAct is aimed at UHC, it covers only some elements of the essential package, which is called the minimum package of care (ANC, delivery, post-natal care, family planning, diagnosis and treatment of malaria, screening for diabetes and hypertension). This should be viewed as a funding mechanism for some components of the essential package and additional funds sourced to fund the other components.

3. To redress inequity, several interventions will be pursued: the expansion of PHC to every ward will redress geographic inequities. The implementation will be in each state preceded by service availability and readiness assessment to determine needs and implementation will be needs-based. The CHIPS Programme will further increase access to services, especially in underserved rural areas. The current safety net schemes targeting vulnerable populations will be scaled up. Targeting of plans and interventions to disadvantage groups- geographic, gender socio-economic and other minority groups- will be implemented during the planned period.

Appendix 4 presents the complete NSHDP II Matrix.

5.2 Reproductive, Maternal, Newborn, Child and Adolescent Health Plus Nutrition

Context

Inadequate coverage with high impact cost-effective interventions, poor and inequitable geographic and socio-economic access, poor quality, and low utilization are the key bottlenecks to RMNCAH +N programme impact. These are worsened by limited expansion of some of the key services to community level and poor integration of others. Socio-cultural barriers to demand, cost of care and poor implementation of policies and plans are additional bottlenecks. The RMNACH investment case was developed in 2017 at the national level. Its implementation shall be pursued during this planned period even as efforts are made to deepen the key RMNACH interventions, even as innovative strategies are explored to expand coverage. The current interventions and programmes being implemented shall be deepened within the context of primary health care strengthening, even as innovative approaches are being identified for coverage expansion and quality improvement.

5.2.1 Maternal Health

Strategic Objective

To reduce maternal mortality and morbidity through the provision of timely, safe, appropriate and effective healthcare services before, during and after child birth.

Targets

Serial No.	Target	2018	2019	2020	2021	2022
4.1.1	Maternal Mortality Ratio reduced from 576/100,000 to 374/100,000	576/ 100,000	526/ 100,000	492/ 100,000	450/ 100,000	400/ 100,000
4.1.2	Proportion of women having Essential ANC (formerly focused ANC) increased from 49% to 74%	49%	55%	62%	68%	74%
4.1.3	Percentage of deliveries supervised by skilled birth attendants increased from 43% to 57%	43%	45%	48%	55%	57%
4.1.4	Percentage of primary/ward primary healthcare facilities providing basic emergency obstetric and neonatal care services disaggregated by level of care increased to 80%	TBD				increase to 80% from baseline
4.1.5	Proportion of pregnant women who have received PMTCT services increased from 36% to 66%	36%	45%	55%	60%	66%

Key interventions and actions

Key interventions earmarked under this domain are: improve access to essential ANC and PNC services through strengthening of primary health care facilities and capacity of health care providers on essential ANC, delivery, essential and emergency obstetrics and newborn care and PNC services. Expanding coverage of skilled delivery services will be through upgrade of at least 1 PHC facility per ward and capacity building of skilled birth attendants on life saving skills and current delivery practices. Access to emergency obstetrics and newborn care will be expanded through strengthening of at least one PHC per ward to provide basic emergency obstetrics and newborn care and upgrading at least one general hospital per LGA to provide comprehensive emergency obstetrics and newborn care. Access to life saving commodities through establishment and implementation of sustainable supply and distribution system for equipment and life-saving commodities at all levels shall be strengthened. Strategies to expand use at community level with life-saving high impact maternal and child health communities, like use of misoprostol at home births and chlorhexidine for cord care shall be consolidated and scaled up using community structures and agents (CHIPs) while effort shall be increased to ensure the provision of these commodities in each Mama Kit.

The necessary work tools (job aids, SOPs and protocols) shall be provided while referral systems shall be strengthened. Also, targeted advocacy, community mobilization and behaviour change communication for Safe Motherhood services through mobilization of community structures such as WDCs, CHIPS and other stakeholder groups shall be expanded and strengthened to create demand for services and foster accountability. Other strategies to create demand for maternal health services will include demand-side financing, especially in underserved areas. SMI quality improvements, feedback mechanisms and improved Maternal, Perinatal Death Surveillance and Response (MPDSR) at facility and community levels will be strengthened, including integrated supportive supervision. Male participation in maternal health shall be promoted.

5.2.2 Obstetric Fistula

Strategic Objective

Strengthen prevention, treatment and rehabilitation services for fistula care in Nigeria

Specific Targets

1. Incidence of obstetrics fistula decreased by 50% of baseline (TBD)
2. Percentage of treated obstetric fistula cases re-integrated into their communities increased by 50% of baseline (TBD)
3. Reduce the backlog of obstetric fistula cases by 30% (from 150,000 to 105,000)

Strategic Interventions and actions

Interventions include the promotion of Obstetric Fistula (OF) preventive interventions within the context of improved access to family planning, skilled delivery and emergency obstetrics care and collaboration with other sectors to address the social determinants of OF. Effort shall be directed at increasing access and strengthening obstetric fistula management services, and fostering community participation for the rehabilitation and re-integration of fistula patients. Strategic actions or activities earmarked include increasing the number of national obstetric fistula centres, unlocking potentials in tertiary institutions (OBGYN departments) for fistula surgeries, strengthening and building the capacity of institutions and health care workers, establishing sustainable drugs and commodities supply chain management system, exempting OF patients from payment for services, promoting inter-sectoral collaboration, for rehabilitation, development and implementation of communication strategy for the prevention, treatment, control, rehabilitation/reintegration of OF cases.

5.2.3 Sexual and Reproductive Health services (Family Planning and Post Abortion Care)

Interventions covered here include:

- Family planning
- Post-abortion care
- Gender-based violence
- Reproductive cancers (covered under NCD)

Poor uptake and limited demand for Sexual and Reproductive Health (SRH) services especially Family Planning (FP) and Post Abortion Care (PAC) continue to militate against effective delivery of SRH services. To attain the goal and objectives set in increasing access and improved utilization of these services therefore, a set of interventions were identified and presented in the NSHDP II as follows.

Strategic Objectives

The strategic objectives of the planned interventions are to:

1. Promote demand for and increase access to comprehensive and integrated reproductive health services (including family planning services and management of unsafe abortion), and
2. Build capacity of service providers to offer gender-sensitive, respectful and safe RH services.

Specific Targets

	Target	Milestone				
		2018 (Baseline)	2019	2020	2021	2022
	Contraceptive prevalence rate increased from 13% to 23% (CPR modern method)	13%	16%	19%	21%	23%
	Proportion of women of reproductive age (15-49years) who have their needs for family planning satisfied with modern methods increased from 3%-7%	3%	4%	5%	6%	7%

Key interventions and actions

Strategic interventions and actions described under this include support for review, development, and implementation of policies and guidelines for RH services including screening for RH cancers through expansion of RH services coverage, capacity building, and ensuring sustainable supply of equipment, drugs and commodities; increase demand and access to RH services including FP, scale-up and promotion of services for management of rape and other gender-based violence. Integration of family planning into PAC shall be strengthened. Strategic interventions for expansion of coverage of FP services to meet 20:2020 targets as contained in the national blueprint for FP[65] expansion shall be pursued, including task shifting to increase coverage with long acting contraceptives and innovative approaches for demand creation. Deliberate targeting of excluded populations shall be fostered, including promotion of male participation.

5.2.4 Newborn and Child Health

Strategic Objectives

The strategic objective is to reduce neonatal and childhood mortality and promote optimal growth, protection and development of all newborn and children under five years of age.

Specific Targets

	Targets	Milestones				
		2018	2019	2020	2021	2022
1	Neonatal mortality rate decreased from 33/1000 to 24/1000 by 2022	39/1000	35/1000	30/1000	28/1000	26/1000
2	Infant mortality rate decreased from 75/1000 to 38/1000 by 2022	70/1000	65/1000	58/1000	43/1000	48/1000
3						

[65] Federal Government of Nigeria. Nigeria Family Planning Blueprint (Scale-up Plan). FMOH, Abuja 2014

	Targets	Milestones				
		2018	2019	2020	2021	2022
	Under-five mortality rate decreased from 102/1000 to 74/1000 by 2022	120/1000	115/1000	105/1000	951000	85/1000
4	Percentage of children fully immunized under one year of age increased from 23% to 50% by 2022	23%	25%	30%	40%	50%
5	Measles immunization coverage increased from 42% to 72% by 2022	42%	50%	60%	67%	72%

Key interventions and activities

These shall consist of strengthening emergency obstetric, newborn, postnatal and childhood care through appropriate support for development of guidelines, SOPs and protocols, building capacity of healthcare workers at all levels to provide child health services. IMCI, Community IMCI and community Case Management of childhood Illness shall be scaled up to all LGAs in the country. To this end also, the promotion of EBF for the first six months of life and appropriate complementary feeding shall be intensified through support for the review, re-introduction and scale-up of BFHI, building capacity of health care providers and EBF support groups, and intensifying promotion of infant and young child feeding. Furthermore, continuation of breast feeding for 24 months, and use of appropriate complementary feeding shall be supported through creation of demand activities aimed at promoting IYCF practices, and promotion of the implementation of the Code on marketing of breast milk substitute.

Furthermore, routine child immunization including new antigens shall be strengthened by supporting the development, coordination and implementation of the national RI emergency plan at all levels, provision and strengthening of sustainable supply chain management for vaccines and commodities including local production, strengthening advocacy, social mobilization, supportive supervision and demand creation activities for RI services through CHIPS. In addition, accountability framework for RI services shall be established at all levels including management of performance.

Also, quality of newborn and child healthcare services will be improved by supporting the development and application of guidelines, SOPs and protocols for newborn and child health care, building capacity of health care workers in provision of newborn and child health services including community-based workers, strengthening referral and supportive supervision systems for newborn and child health care services. Also, advocacy, community mobilization and BCC for newborn and child healthcare services shall be promoted through support for the engagement of media, CBOs, community structures (WDC, CHIPS etc.). Additionally, neonatal and child healthcare community risk detection and welfare shall be expanded through support for establishment of appropriate systems and building capacity of community-based workers and other stakeholders on community risk detection for neonatal and child health issues. Finally, coverage of IMCI (Community-IMCI, Community Case Management (iCCM)

and IMCI shall be expanded through advocacy to create an enabling environment and support for IMCI services.

5.2.5 Adolescent Health

The goal is to 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.

The Strategic Objective

Improve access to adolescent health and young people information and services.

Targets

Target	2018	2019	2020	2021	2022
Adolescent birth rate per 1000 women aged 10 to 19 years decreased from 120/1000 to 60/1000	120/1000	110/1000	95/1000	80/1000	60/1000

Strategic Interventions and Actions

NSHDP II will deepen advocacy, social mobilization and behaviour change communication for creating a more enabling environment for Adolescent Reproductive Health (ARH) programming and more positive behavior. Other interventions will include support for the review and implementation of adolescent-friendly communication strategies, building institutional and human resource capacity to deliver adolescent-friendly health services across all levels, expanding access to ARH services by integrating ARH services into primary health care, making the services more youth- friendly, scaling up the implementation of adolescent sexual and reproductive health education in school curriculum, promoting education on menstrual hygiene among female adolescents, strengthening the prevention, detection, and management of HIV and STIs among adolescents and scaling up screening and management of drug use, internet addiction, self-harm, mental health, nutrition disorders and other leading adolescent health problems . Also, there will be exploration and implementation of innovative, contextual adolescent reproductive health strategies and investments in demand creation for ARH services (community engagements and outreaches using CHIPS, social media, etc.) through the design and implementation of BCC strategy for ARH services across all levels. Support shall be given to the inclusion of menstrual hygiene practice/culture in school health curriculum

5.2.6 Nutrition

Context

The overall performance in almost all nutritional impact indicators is poor. The wasting rate among U5 children increased as clearly shown in the increased prevalence of low weight for height from 11% in 2008 to 18% in 2013 and the prevalence of low weight for age which also increased from 23.1% in 2008 to 28.7% in 2013. Some progress though inadequate, was made in the reduction of stunting rate among U5 children as depicted by the prevalence of low height for age of 36.8% in 2015 as compared to 40.6% in 2008.

Strategic Objective

This is to improve the nutritional status of Nigerians throughout their lifecycle, with a particular focus on vulnerable groups especially women of reproductive age and children under five years of age.

Specific targets

S/N	Targets	2018	2019	2020	2021	2022
1	Exclusive breastfeeding rate in the first six months of life increased to 60% by 2022	33.3%	43%	50%	55%	60%
2	Incidence of low birth weight reduced from 17% to 10% by 2022	17%	15%	13%	11%	10%
3	Prevalence of childhood wasting reduced from 18% to less than 10% by 2022	18%	17%	15%	12%	10%
4	Prevalence of stunting in under-fives reduced from 37% to less than 20% by 2022	37%	34%	30%	25%	20%
5	Incidence of anaemia among women of reproductive age reduced by 15%	TBD				
6	Prevalence of childhood overweight reduced by 50% by 2024.	TBD				
7	Prevalence of malnutrition among women of reproductive age reduced from 11% to less than 5% by 2022	11%				5%
8	Malnutrition among the elderly reduced by 50% by 2024	TBD				

Key interventions and activities

These shall include promoting delivery of effective interventions that will ensure adequate nutrition to all Nigerians, especially vulnerable groups. These include advocacy and resource mobilization, enhancing capacity to deliver effective and appropriate nutrition key interventions such as early initiation of breastfeeding within the first 30 minutes of birth, exclusive breast feeding, continued breastfeeding and complementary feeding, micronutrient powder supplementation, management of acute malnutrition, school feeding, iron-folic acid supplementation in pregnant women and vitamin A supplementation in lactating women. To ensure sustainable delivery of these interventions, it is pertinent to promote and strengthen research, monitoring and evaluation, facilitate community participation for nutrition interventions, strengthen nutrition coordination and multi-sectoral collaborations.

5.3 Communicable Diseases Prevention and Control

The goal of this priority area is to reduce the high burden of communicable diseases, including NTDs in the country to a level where it is no longer a public health problem by improving prevention, case detection and coordinated response for their prevention, control and management. Health conditions causing the highest disease burden will be prioritized. During the planned period, effort will be geared towards expansion of coverage of communicable diseases interventions in an equitable and integrated manner by increasing access to services, improving service quality and creating demand for services. There will be greater focusing on service integration.

A number of the diseases have ongoing control programmes. Moreover, effort will be invested in integration and strengthening the disease control programmes for attainment of targets.

Table 12 Notifiable Diseases in Nigeria

Categories of diseases	Diseases	Programmes/Strategies for implementation
Epidemic prone disease	Cholera, Cerebrospinal Meningitis, Measles, Yellow fever, Viral Haemorrhagic fevers (Lassa fever)	Nigeria Centre for Disease Control
Diseases for eradication	Poliomyelitis	Polio Eradication Initiative/Routine Immunizations
Diseases for elimination	Measles Tetanus Paediatric HIV/AIDS (MTCT) Leprosy Malaria Emerging diseases	Routine Immunization TT in ANC PMTCT TB/Leprosy Control Programme Malaria Control Programme
Diseases for control including epidemic prone diseases	Vaccine Preventable Diseases of children (Tuberculosis, Yellow fever, diphtheria, pertussis, hepatitis, tetanus, pneumococcal pneumonia) HIV/AIDS Yellow Cholera Sexually transmitted infections Diarrheal diseases Hepatitis B, VHF Tuberculosis Onchocerciasis NTDs	Routine Immunization and IMCI HIV/AIDS Control Programme TB/Leprosy Control Programme Onchocerciasis Control Programme

Table 12 shows the notifiable communicable diseases in Nigeria. They are all covered in the essential service package proposed and services and services are available from the primary health care level.

The subsequent sections address priority diseases targeted in the National Health Policy – malaria, tuberculosis, tuberculosis, hepatitis B and NTDs

Strategic Goal

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

Strategic Objectives

1. Reduce significantly morbidity and mortality due to Malaria and move towards pre-elimination levels.

2. 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.

3. Significantly reduce the incidence and prevalence of HIV/AIDS in Nigeria by 2022

4. Reduce the incidence, morbidity and mortality due to viral hepatitis.

5. Reduce morbidity, disability and mortality due to targeted Neglected Tropical Diseases (NTDs) and improve quality of life of those affected.

Specific Targets

S/No.	Target	2018	2019	2020	2021	2022
Malaria						
5.1.1	Percent of children with suspected malaria tested with mRDT or microscopy increased from 13% to 80%	13%	25%	40%	60%	80%
5.1.2	Prevalence of malaria in children under-five reduced from 45% to 9% (80% reduction based on mRDT)	45%	30%	20%	15%	9%
5.1.3	Percentage of children <5yrs sleeping under an ITN increased from 49% to 80%	49%	60%	70%	75%	80%

5.1.4	Percentage of pregnant women sleeping under an ITN increased from 40% to 70%	40%	50%	55%	65%	70%
5.1.5	Percentage of pregnant women who receive IPT from 15% to 80%	15%	45%	65%	75%	80%
Tuberculosis						
5.2.1	To increase TB case detection from 15% to 50%	15%	20%	30%	40%	50%
5.2.2	To reduce TB prevalence by 25% from 323/100,000 to 244/100,000	323/100,00	310/100,00	284/100,000	264/100,000	244/100,000
5.2.3	Decrease the incidence of TB by 60% from 338/100,000 to 129/100,000	338/100,000	290/100,000	240/100,000	180/100,000	129/100,00
5.2.4	To increase TB treatment success rate from 86% to 100%	86%	80%	85%	95%	100%
HIV/AIDS						
5.3.1	Incidence of HIV among key and general population (disaggregated by age and sex) reduced by 70%	TBD				Reduced by 70% of baseline
5.3.2	Prevalence of HIV among the general adult population reduced from 3.3% by 70% to 1%	3.3%	3.0%	2.6%	1.8%	1%
5.3.3	Increase coverage of HIV HTS from 30% to 60%	30%	35%	40%	50%	60%
5.3.4	Incidence of mother-to-child transmission of HIV reduced to 0% from 35%	35%	15	10	5	0%
5.3.5	Percentage of HIV positive persons receiving HIV treatment services increased from 30% to 90%	30%	40%	55%	70%	90%

5.3.6	Percentage of the population age 15-49 years tested for HIV (VCT and collected result) increased from 15% to 60%	15%	30%	40%	50%	60%
5.3.7	% of HIV positive pregnant women who received ART increased from 34% to 66%	34%	45%	55%	60%	66%
Viral Hepatitis						
5.4.1	Prevalence of vaccine-preventable viral hepatitis reduced by 50% of baseline (hepatitis B prevalence reduced from 11% to 5.5%)	11%	10%	8%	6%	5.50%
5.4.2	50% of HCW vaccinated against hepatitis by 2022	TBD				50%
5.4.3	50% of persons infected with HBV and HCV aware of their infection status by 2022	TBD				
5.4.4	Incidence of hepatitis reduced by 50% of baseline	TBD				50% of baseline
5.4.5	50% of all persons eligible for HBV treatment received treatment	TBD				50% of baseline
Neglected Tropical Diseases (NTDs)						
5.5.1	Proportion of States implementing integrated vector management for targeted NTDs increased to 70% by 2022	TBD				Increased to 70% of baseline
5.5.2	Attain 50% coverage in preventive chemotherapy for selected Neglected Tropical Diseases (NTDs) by 2022	TBD				Increased to 50% of baseline

5.5.3	Prevalence of targeted NTDs reduced by 60% of baseline by 2022	TBD				Reduced by 60% of baseline
5.5.4	Attain 50% coverage in preventive chemotherapy for selected NTDs by 2022	TBD				Increased to 50%

Key interventions and actions

Malaria

Key interventions and activities earmarked to reduce the burden of Malaria among Nigerians, especially women of reproductive age and children under five years, are strengthening systems for effective delivery of quality services using Artemisinin-based Combination Therapy (ACT) including expanded use of presumptive Intermittent Preventive Therapy (IPT) among pregnant women; and building the capacity of health care providers in the management of Malaria cases (clinical, laboratory diagnosis and treatment) at all levels including private and public sectors. Active participation of communities in malaria control initiatives, expanded access to integrated vector control interventions as well as local production of potent, qualitative, and affordable antimalarial drugs will also be promoted based on policy, guidelines, and set standards.

Leprosy and Tuberculosis

In terms of addressing Tuberculosis and Leprosy, health systems will be strengthened to expand access to Leprosy and TB diagnosis and treatment services for the Nigerian populace especially for paediatric cases and persons co-infected with TB and HIV, and for effective management of drug resistant TB (DR-TB). This will include building the capacity of health care providers in Leprosy and TB case detection and diagnosis, communities' capacity to demand for quality care through collaboration, advocacy, social mobilization, and behaviour change communication including re-integration and rehabilitation of those affected. These will be carried out through strengthened coordination mechanisms at all levels of the health care delivery system.

HIV/AIDS

Interventions geared towards addressing HIV cover the spectrum from prevention to rehabilitation. Strategic activities lined up for prevention of HIV infection are enhancing access of the general, key and vulnerable populations to HIV prophylaxis, condom programming, and lubricant use including roll-out of harm reduction strategies, strengthening service delivery model(s), referrals and linkages that can provide a combination of quality HIV prevention, other health/social services to key and vulnerable populations and improved access to safe blood and blood products including injection safety and health care waste management practices. HIV testing services (HTS), which are key to identifying and management of those infected, is another key activity in the NSHDP II plan. To deliver these services, an enabling environment for improved access to HTS and screening services including establishment/strengthening of coordination structures, HIV co-infection management and community systems to support

testing and re-testing of key populations, vulnerable populations and pregnant women will be instituted. Targeted HTS demand generation activities will also be conducted. Additionally, integration of, and strengthened referrals and linkage systems between HTS, other HIV management services, blood transfusion services, and other health-related services will be promoted.

The logistics and supply chain management for all testing and treatment commodities and conduct of appropriate research to identify strategies that support improved access to HTS formed part of activities to be implemented. The drive to eliminate mother-to-child transmission of HIV in Nigeria by 2022 is key to attaining the targets set for HIV/AIDS prevention and control. This will be done through expanding access to antiretroviral therapy (ART), opportunistic infection management, and diagnostic services (e.g. serology, early infant diagnosis (EID) for all persons including HIV positive pregnant women, breastfeeding mothers, and HIV exposed infants, among others. Community-based care and support services that include nutritional assessment, adherence counselling, mental health, sexual and reproductive health, rights and psychosocial support form part of the demand creation activities geared towards improving access to and utilization of all HIV services. Quality assurance mechanisms for facility, community and rights-based care, research, and surveillance activities are mainstreamed into all aspects of the HIV programming (prevention, treatment, care and support services).

Viral Hepatitis

Key interventions here include expanding access to viral hepatitis prevention, screening, and treatment services in health care and closed settings using instruments/tools developed to guide prevention, screening, treatment and other control measures for the general and high-risk population groups. These include: safe injection and universal precaution practices, harm reduction strategies for Injection Drug Users (IDUs), supply of appropriate ARVs for hepatitis B and C infections, promoting universal coverage of HBV vaccination at birth and other doses according to national schedule through provision of routine immunization services, strengthen HBV vaccination for adult populations, especially those at occupational risk, expand coverage of interventions for prevention of mother-to-child transmission of viral hepatitis through integration of hepatitis immunization into maternity and child care services, scale-up interventions for the prevention of iatrogenic transmission of viral Hepatitis through safe blood and injection safety practices, strengthening conduct of advocacy, social mobilization and behaviour change on viral hepatitis using a comprehensive communication strategy and media engagement across all levels.

Neglected Tropical Diseases

NTD control/elimination plans will be integrated into national and subnational health plans and capacity of programme managers, service providers and CBOs built in NTD programming and service implementation. Guidelines for the prevention and control of NTDs shall be developed and training of service providers at facility and community level will be conducted. A communication strategy for NTDs, comprising advocacy, social mobilization and behaviour change communication will be developed and implemented. Integrated preventive chemotherapy packages shall be implemented at community level, the frequency of which administration depends on the specific disease. In collaboration with Malaria control

programme, integrated vector control interventions, including IRS and ITN distribution for the control of Lymphatic filariasis and Dengue fever will be implemented. Case-management-based diseases interventions, especially for Leprosy, Guinea worm disease, HAT, Buruli Ulcer and endemic Loasis, Leishmaniasis and human Rabies will be scaled up and integrated into care services at community and PHC levels. Additionally, mass campaigns for Community Directed Treatment Initiative (CDTI) will be planned and implemented. For snake bites, local production of anti-venoms will be established. A system for ensuring sustainable supply of anti-snake venom, especially in high risk parts of the country will be strengthened and health workers trained in the management of snakebites.

5.4 Non-Communicable Diseases

Brief context

In Nigeria, the main Non-Communicable Diseases (NCDs) are Cancers (e.g. breast, cervical, prostate, skin and liver cancers), cardiovascular diseases (e.g. Hypertension), Chronic Obstructive Airway Diseases (e.g. Asthma), Diabetes and Sickle Cell Disease. Others are mental health disorders, oral health diseases, violence and injuries, which are equally important and given prominence in this plan. The major barriers to their prevention and control, which this plan seeks to address, include: gross underfunding, ignorance leading to late diagnosis, high cost of treatment, lack of donor support, poor legislation and enforcement of laws linked to prevention and control, inadequate screening particularly at the PHC level, paucity of adequately trained staff to manage the different forms of NCDs, weak health systems, prohibitive cost of treatment, non-coverage of NCDs in health insurance/contributory schemes (e.g. NHIS), and lack of multi-sectoral approach to their prevention, treatment, control and overall coordination. The burden of NCDs is further compounded by the ignorance and misconceptions about the diseases evident in most parts and communities across the country. The NSHDP II therefore has some key interventions and activities planned to address the gaps identified in their prevention, control, and management for the period 2018 to 2022.

Specific Objective

To reduce the morbidity and mortality due to NCDs (Cancers, Cardiovascular Diseases, Chronic Obstructive Airway Diseases, Diabetes and Sickle Cell Disease) in Nigeria by 20% from current levels by 2022

Targets

Specific targets are to:

1. Reduce overall mortality from NCDs (cardiovascular diseases, Cancer, Diabetes, sickle cell diseases or chronic respiratory diseases.) by 20% by 2022
2. Reduce the prevalence of modifiable risk factors for NCDs in Nigeria from current levels by:
    a. 30% for tobacco use (current prevalence rate is 5.6% among adults)
    b. 30% for insufficient physical activity

c. 30% for mean adult (aged ≥18) population salt intake, with aim of achieving recommended level of <5g per day.

3. Increase uptake of vaccines for carcinogenic viruses (HBV, high risk HPV serotypes and pneumococcal vaccination among children) to 50% by 2022.
4. Increase proportion of adults who are aware of their genotype by 50% by 2022.
5. Increase proportion of eligible population screened for early detection and management of NCDs to 50% by 2022. (These include: mammography for breast cancer, pap smear for cancer of the cervix, Prostate Specific Antigen (PSA) for cancer of the prostate; and screening for Diabetes mellitus, Hypertension and sickle cell disease).
6. Increase access to quality treatment facilities for persons with NCDs to 50% by 2022.

Key Interventions and Actions

One of the key interventions geared towards addressing the prevalence and impact of NCDs in Nigeria is to promote generation of evidence for decision-making including planning and implementation of health care services for NCDs. In order to do this, assessments and surveys will be conducted to generate baseline data and information needed for effective planning, implementation, monitoring and evaluation of the conditions at all levels. A multi-sectoral task force will be set-up to coordinate the prevention and control of NCDs at national and state levels including facilitation of research and surveillance, establishment and maintenance of a database and registry for each type of NCD. Another intervention articulated is to expand access (geographic and financial etc.) to NCD services through establishment of a sustainable supply chain of essential medicines, consumables and technologies and provision of a dedicated budgetary line with attendant timely release. Also advocacy to decision-makers to allocate adequate resources to support NCDs prevention, screening, control and treatment services including integration of NCD services into NHIS/SHIS benefit package shall be given priority. Prevention and screening services will be scaled to primary health care level and diagnosis and treatment services strengthened at secondary and higher levels.

The capacity of health care providers, especially those at the lower levels (PHC), will be built in prevention and screening for NCDs including providing them necessary guidelines, protocols and tools that will aid provision and scale up of NCD services based on WHO standards. An enabling legal atmosphere will be created, through legislation for prevention and control of NCDs. This will be supported through enactment of laws that will address all issues relating to NCDs including development and implementation of guidelines and protocols that make for comprehensive treatment and control (e.g. the WHO Framework Convention on Tobacco Control (FCTC).

To create demand and promote healthy lifestyles and behaviors for the prevention of NCDs, the NSHDP II planned activities include the adaptation and implementation of relevant policies, plans, standards and guidelines that enhance individuals and communities' ability and willingness to adopt healthy practices such as increased physical activity, production and consumption of healthy diets, cessation of smoking/tobacco use, and limitation of alcohol consumption among others. This will be done through rigorous implementation of public awareness programmes and other community based-activities targeted at preventing and improving the quality of life of those affected by NCDs. To this end, an effective communication

strategy, incorporating advocacy, social mobilization and behaviour change communication (BCC) elements will be intensified to address all issues relating to NCDs at all levels.

Mental Health

Context

Mental health has a major impact on quality of life, as well as social and economic viability of families, communities and the nation. People with mental disorders experience disproportionately higher rates of disability and mortality. The proportion of Nigerians with mental illness receiving any treatment, orthodox or otherwise, within the previous 12 months is about 10%. As a result of the high prevalence, relatively low mortality rate, low identification rate and poor utilization of treatment, the mental disorders are the largest single group, among NCDs contributing to disability. There are myriad of challenges confronting mental health in Nigeria sub-sector and limiting effective response. They include: poor policy and legislative environment, poor budgetary allocation, acute shortages of skilled human resource at tertiary level and dearth of non-specialized skills at lower levels of the health system to detect and manage mental health problems. Other challenges are failure to integrate mental health into PHC, and lack of programming for mental health with no program officer at any level of the health care system with responsibility for mental health. Given the fact that addressing mental health requires a multi-disciplinary and multi-sectoral approach, the focus during the plan period will be on improving leadership and governance to resolve the constraints, addressing the risk factors and improving access to effective and efficient mental health services delivery.

Goal and Strategic objective: The goal is 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 objective is to build capacity of health care providers for mental health service delivery at all levels.

Specific targets: These include (1) incidence of mental illnesses in Nigeria reduced by 20% by 2022. (2) Healthcare coverage of patients with mental illnesses and substance use dependence increased to 60% by 2022; (3) Social welfare support to persons with established serious mental Illnesses and substance use dependence raised to 40% by 2022

Key interventions and activities: This shall include: promoting legal framework for mental health practice and services in Nigeria by enacting laws to reduce stigmatization and discrimination of persons with neurological and mental health, providing legislative framework for sustained financial support of mental and neurological health challenges, developing a mechanism to include mental health and wellbeing impact assessments in the development or review of policy and legislation and enforcing laws that restrict access to substances of abuse, developing laws to protect the mental health care users from vulnerability in all settings of childhood, gender-based, pregnancy. Other key interventions and key activities include strengthening the generation of evidence for planning and programming by conducting baseline surveys on mental health including a survey of persons affected by mental illness disaggregating the population by diagnosis, establishing data base and MIS for the mental health care services and creating register of users, developing mental health strategic and operation plans, guidelines, tools and job aids. It involves defining mental health research gaps and conduct researches to respond to the gaps, creating formal structures, making available opportunities, capacity and activities for translation of research and evidence to inform policy-making. Furthermore, scale-up provision of comprehensive, integrated and

responsive mental health services particularly, in primary health care and community-based settings through strengthening primary healthcare centres to provide non-specialized mental health services, strengthening specialized mental hospitals as well as tertiary and secondary hospitals to manage substances use dependence and serious mental illnesses, providing and expanding functional drug/substance and alcohol treatment and rehabilitation centres, collaborating with the National Health Insurance Scheme (NHIS) to explore inclusion of mental health into the benefit package of social health insurance scheme, defining and implement minimum care packages for mental health and developing/implementing community models of mental health care using the Aro model shall be implemented. Additionally, expanding access to psychosocial support services as component of mental health services in communities by establishing community level psycho-social support services, especially during public health and other health emergencies (e.g rape, GBV) shall be addressed in this Plan. Strengthening interventions for mental health prevention and promotion at all levels by developing and implementing communication packages aimed at community education and BCC for prevention of lifestyles and behaviours that increase risk of mental health, enforcing laws and policies that limit access to substances (e.g. drugs, alcohol, codiene-based cough syrup etc.) that increase risk to mental health, promoting the development of youth clubs and youth friendly centres and providing recreational facilities, especially in urban areas shall be part of the key interventions. Furthermore, strengthening coordination mechanism for mental health service delivery at all levels by establishing mental health units at SMOH and hospitals; creating a platform to promote coordination of partners and other sectors involved in mental health services provision will go a long way to promote mental health. Moreover, promoting advocacy for improved financing for mental health by conducting advocacy for provision of funding stream for mental health, advocating to NHIS for inclusion of mental health into benefit package and conducting resource mobilization for mental health care, targeting private sector, development partners, philanthropists and communities shall be given due attention. Strengthening the supply chain system for the sustainable supply of mental health drugs and commodities at all levels by developing mechanism for drug and commodity purchase from source on a large scale. Include drugs and commodities for mental health on the list of essential drugs for primary health care; and building capacity of health care providers for mental health service delivery at all levels. Finally, needs-based training plan and curricula shall be developed for various cadre of mental health care providers by first building capacity for non-specialists to manage mild and moderate mental illnesses while substances use disorders will be managed in specialist/ non-specialized mental health settings. Multi-level training programmes shall be designed 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 and marriage counseling.

Oral Health

Context

The major challenges of oral Health in Nigeria include the low level of awareness of an average Nigerian about oral health care, poor funding, limited availability of services, dearth of skilled personnel, limited access as a result of high cost of services, inequitable distribution of personnel and services, limited focus on prevention and the non-integration of oral health into PHC. The interventions of the NSHDP II have been designed to address these challenges.

Goal

To reduce the burden of morbidity, mortality and disability due to noncommunicable diseases

Strategic objectives

The strategic objective of Oral Health in Nigeria for this plan period is to promote optimal oral health in Nigeria.

Target

Target	2018	2019	2020	2021	2022
Percent decrease in the prevalence of oral diseases (e.g. dental caries, gingivitis, cancrum oris etc.)	TBD	10	20	30	Decreased by 40%
Percent increase in the proportion of PHCs providing basic package of oral care by 60% of baseline	TBD	10	30	40	Increased by 60%
Proportion of Nigerians that have adequate access to oral health care by 2022	TBD	20	30	40	50%
Percent of PHCs that provide basic package of oral care by 2022	0	20	30	40	50%
Percent of secondary level health care facilities providing oral health care appropriate for that level	TBD	30	40	50	60%

Interventions and Actions

The planned interventions for addressing the deficits in oral health care in Nigeria consists of scaling up public awareness and behaviour change communication for the prevention of oral health and expansion of access to care by integration of the services into mainstream of health care delivery including the PHC. This will require capacity building of care providers at these levels whilst ensuring the collection, analysis and use of the information to better guide development of policies, regulations and practice of oral care in Nigeria. The interventions will include the promotion of school based oral health programming as part of the overall school health programme. Some of the actions that will be required include the development of comprehensive national oral health strategy and standards of practice for all tiers of the healthcare delivery system. In doing this, oral health referral centres shall be strengthened and a database shall be developed as a repository of oral health care in Nigeria through inclusion of oral health indicators in the national and states M&E systems. To expand access to oral health services, advocacy shall be mounted for the inclusion of oral health in the benefit packages of the NHIS and other state schemes across the country. A notable action that shall be undertaken during this plan period will be to 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.

Care of the Elderly

Context

Despite the large population of the aged and their myriad of health problems, there is a seeming neglect of this group of people in health care planning and provision. There is an apparent dearth of health facilities in Nigeria with the basic personnel with skills to address the health needs of older persons. The absence of a guiding ageing policy, the seeming low priority given to elderly care by government in terms of funding and leadership, the lack of development partners' support for issues concerning the elderly in Nigeria and the erosion of traditional family and communal values are some of the challenges faced with care of the elderly. The NSHDP II has articulated interventions that will mitigate the challenges of care of the elderly in Nigeria in the next five years.

Strategic objectives

The strategic objective is to promote the health and wellbeing of the elderly in Nigeria

Target

Target	2018	2019	2020	2021	2022
To increase access to basic and long-term care by the elderly by 50% of baseline	TBD	10	30	40	50%

Interventions and Actions

In order to ensure a comprehensive response to the weaknesses in the care for the elderly, evidence will be generated to articulate clear policy direction and programming for geriatric services in Nigeria. This is expected to be followed up with the institution of appropriate services building required human resource capacity for the care and support of elderly at all levels of the health care system. Other interventions will include promotion of Behaviour Change Communication (BCC), social mobilization interventions for the elderly, community participation and partnerships for sustainability of health programmes for the elderly and creating a database of management information that will guide programmatic improvements. These interventions will require specific actions that will consist of development of appropriate policy and strategic plan at all levels of the health delivery services on the health of the elderly, review of 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 rights)

It might be necessary to seek for collaboration with all relevant stakeholders to have national and state level strategic and operational plans that foster healthy ageing and development and the implementation of an elderly persons' minimum care package to include nutrition, recreational activities, vaccination, and old people's home.

5.5 Emergency Medical Services and General Hospital Services

Context

Organized Emergency Medical Services is yet to be developed in Nigeria. The National Policy for Emergency Medical Services and the guidelines for Emergency Ambulance Services were launched in 2018. This is yet to cascade to the states. At best EMS remains rudimentary. The provision of 5% of the BHCPF for emergency medical services is providing the impetus to begin to develop a coherent system, in addition to the need to significant reduce adverse outcomes from emergencies because of low availability and access to quality emergency medical services. During the period of implementation of NSHDP II, concerted efforts will be made to establish a functional EMS service across the country and to expand access to quality referral health care services.

Goal

Improve health outcomes through prompt and effective response to medical emergencies.

Strategic Objectives

1. Strengthen Emergency Medical Services.

2. Increase provision and access to quality, affordable and integrated EMS.

3. Improve provision, access, quality and responsiveness of ambulatory (OPD) services at all leves of the health care system.

4. 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.

Targets

1. At least 50% of states have EMS policies, plans and services in place by 2022.
2. 80% of the states have dedicated centres for integrated emergency medical service.
3. 70% of states have coordinated functional ambulance services.
4. Case fatality rates reduced by 30% by 2022.
5. Client satisfaction level improved by 50 % by 2022.
6. Adherence to quality measures improved by 50% by 2022.

Strategic Interventions and Actions

The following key actions and interventions shall be prioritized: promotion of development/adaptation and implementation of regulatory framework, policy, plans and guidelines for Emergency Medical Services (EMS), including emergency ambulance and referral care, developing harmonized and coordinated ambulance services by merging all public-sector ambulance services and forging partnerships with the private sector. Adequate number of appropriate ambulances (vehicles, air ambulances, boats) equipped to provide basic/advanced life support services shall be procured and equitably distributed. Dedicated telephone lines for emergency medical services shall be established and made functional across the nation. Training programmes shall be developed and implemented for building capacity of first responders (paramedics) in provision of basic and emergency life support and doctors, nurses trained in emergency medical care provision in health facilities. EMS departments/units shall be established in secondary and health facilities and investments made for establishing the sub-specialty in the country. Referral health facilities shall be strengthened while efforts to promote and enhance human and institutional capacity for continuous improvement of services, including developing and implementation of SOPs, strengthening clinical laboratories and blood supply services, infection prevention and control and other quality shall be instituted. Interventions to educate the public and promote service demand shall be instituted.

5.6 Health Promotion and Environmental Health

Context

Promoting health and preventing diseases address many factors that influence health such as individual and environmental factors. Nigeria faces the challenges of inequitable distribution of health services, poor access to health and other social services leading to poor health outcomes, with the poor, rural populations, uneducated populations, and females having worse indices. These problems are compounded by low investments in disease prevention, health education and promotion, poor health care seeking behaviour and failure to address the social determinants of ill-health. Addressing these challenges will require empowering individuals and communities with appropriate knowledge to take control of actions that promote their health and prevent diseases, address factors in the community that influence health and wellbeing and impede inequities in health outcomes.

The problems with foods in Nigeria have to do with availability, accessibility, quality and safety of the foods. Water related diseases contribute the highest proportion to the overall disease burden in Nigeria being one of the leading causes of mortality in children under-five years as a result of limited access to improved water source and sanitation especially in rural communities and urban slums. Snake bite is another major public health problem especially in rural communities of Nigeria. There is gross shortage of anti-venom and as a result, increasing number of patients bleed to death or survive with very severe disabilities, such as amputated extremities. Toxic chemicals are a significant public health problem globally and also in Nigeria. Though policies, regulations and standards related to chemical issues are available in Nigeria, their implementation is poor. Implementation need to be strengthened to substantially reduce morbidity and mortality arising from poor chemical management.

Nigeria's international commitments and protocols such as the United Nations SDGs also necessitate the inclusion of such environmental health issues as a priority area of investment.

The health and safety of workers at their various work places have been considered in developing interventions of the NSHDP II. Currently, there is no established Occupational Safety and Health (OSH) programme domiciled in the FMOH and in the states. NSHDP II will address challenges of weak regulations and poor implementation of available safety regulations in the face of inadequate occupational health professionals/practitioners in order to promote optimal health and safety of workers at work places.

Goal: is to improve the wellbeing, safety and quality of life of Nigerians through health promotion and healthy environment.

Strategic objectives

The strategic objectives are to:

1. Promote the wellbeing of individuals and communities through protection from health risks, and promotion of healthy lifestyle and environment.
2. Promote food hygiene and safety for the reduction of illnesses associated with unwholesome food.
3. Promote universal access to safe drinking water and acceptable sanitation.
4. Protect human health, environment and infrastructure from chemical hazard, medical & bio-waste and poisoning.
5. Promote optimal health and safety of workers in their work environment.

Specific Target:

Specific targets set are presented below:

1. Percentage of communities that have capacity for health promotion increased by 25% of baseline (TBD) by 2022.
2. Percentage of community members making healthy life style choices increased by 40% of baseline (TBD) by 2022.
3. Number of designated sentinel sites established and equipped to report on foodborne illnesses (Baseline TBD).
4. Mortality rate attributable to unsafe water, unsafe sanitation and lack of hygiene (WASH) reduced by 50%.
5. Mortality associated with hazardous chemicals and poisons reduced by 30% from baseline (TBD) by 2022.
6. Proportion of health workers that have access to occupational health services increased by 25% from baseline (TBD) by 2022.

Strategic Interventions and Actions

Health Promotion

During the planned period, the development and implementation of policies, plans, legislation and regulations that prevent health risks and ensure healthy life styles will be promoted. Other interventions are strengthening health promotion coordination mechanisms at all levels and the community capacity for response and ownership of health promotion.

Health promotion activities will be scaled up at all levels and the inclusion of health promotion in school curricula at all levels will be promoted. Multi-sectoral and intra-sectoral collaboration and partnerships in planning, implementation of health promotion activities will be intensified

Environmental Health

a. *Food Hygiene and Safety:* Strengthen the legal and regulatory framework for food safety in line with international guidelines, strengthen system for food and water safety surveillance, Intensify awareness and sensitization on food safety and quality particularly at the rural community level, scale up the training of food inspectors that will ensure that foods sold within the country are in compliance with current standards and regulations and promote the practice of food safety across the food production pipe line from farm to the table.

b. *Water and sanitation:* Create awareness on water borne diseases, promote the mainstreaming of water and sanitation as a health- related priority programme and strengthen the platforms for inter-ministerial collaboration and other partnerships for addressing the social determinants of health.

Occupational Health

Interventions will focus on promoting the development and implementation of legal, regulatory framework, policies and plans for occupational health in Nigeria, building capacity of health care workers to respond to occupational health needs in the country, scaling up occupational preventive and promotive activities, expanding access to appropriate occupational health services for health workers, strengthening regulation, mentoring and evaluation of occupational health services in workplace, promoting health and safety in the workplace and promoting collaboration between the key stakeholders (Ministry of Health, Ministry of Labour and the private sector)

Chapter 6

Strategic Pillar 3: Health System Support

6.1 Human Resources for Health

Context

The NSHDP II will address agreed weaknesses of Human Resources for Health across the country by aligning HRH production to needs, facilitating HRH motivation, which is currently very low and addressing maldistribution of HRH along geographic, level of care, urban-rural divide. This will include facilitating availability of HRH at the PHC level to address the dearth of HRH especially at that level. Also, poor skill-mix, weak supervisory system and absence of mechanisms for HRH performance review will be addressed.

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.

Strategic objectives

1. Ensure coordination and partnership for aligning investment on current and future needs and institutional strengthening for HRH agenda.
2. Ensure the production of adequate numbers of qualified health workers.
3. Strengthen monitoring and evaluation of HRH including systems for HRH-Information System (HRHIS) and the registry.
4. Ensure effective health workforce management through retention, deployment, work condition, motivation and performance management.
5. Strengthen health workforce planning for effective management.

Targets

Target	2018	2019	2020	2021	2022
Percent of states that are implementing HRH policy and strategic plans increased to 100% of baseline	TBD	30	60	80	100
Percent of health training institutions accredited by the relevant regulatory bodies each year increased to 90% of baseline	TBD	30	50	70	90
Percent of health workers who have received in-service training (all forms) based on performance assessments, task analysis, or development needs at least once every 2-3 years, by cadre, location, and type of training increased to 50% of baseline	TBD	20	30	40	50

Target	2018	2019	2020	2021	2022
Number of FMOH, 36 states and FCT with functional HRHIS.	TBD	10	20	30	38
Percent of health facilities at all levels with the appropriate skill mix of health providers increased to 60% of baseline.	TBD	20	30	50	60
Percent of health workers with job descriptions or written performance expectations for their current positions increased to 100% of baseline.	TBD	30	60	90	100
Percent of health workers who have received supportive supervision in last six months and left copy of the checklist increased from 13.6% to 50%.	13.6	25	35	40	50
Number of FMOH, 36 States and FCT with harmonized HRH Annual Operational Plan increased by 50% of baseline.	TBD	10	20	40	50

Key interventions and Actions

The planned interventions for achieving the goal for HRH investments in the NSHDP II shall consist of strengthening the regulatory and policy frameworks for HRH such as building capacities of HRH management structures to ensure better human resources management and development. Mechanisms shall be put in place to strengthen coordination of public and private health professionals and their regulatory bodies. The interventions will include a continuous monitoring and standardization system of HRH training institutions while fostering collaboration between these institutions, the regulatory bodies and other stakeholders to align production of HRH to actual needs in the sector. A process of training and retraining of healthcare personnel has been planned for effective and efficient staff utilization according to training needs. The training interventions have been planned to promote enrolment, retention and completion of female education in health and allied professions through provision of incentives. This plan has actions to assure gender mainstreaming in HRH production, deployment and development. A functional Human Resources for Health Information System shall be set up to provide accurate information for better human resources planning and management. The system will include annual review of the national HRH profile to guide the production, recruitment and deployment of additional HRH requirements for effective implementation of the NSHDP II.

To further address the weaknesses in the HRH system, mechanisms shall be implemented to improve HRH performance management processes. This will include regular performance reviews of HRH at all levels. During the plan period, a system for supportive supervisory system shall be institutionalised to enhance the performance of HRH at all levels of the health care delivery system. The task shifting and task sharing policy for HRH shall be strengthened using clear guidelines and according to contextual needs.

During the plan period the mechanism for deployment and retention of HRH at all levels shall be strengthened through actions that will include reviewing existing HRH recruitment and deployment policies to remove barriers to competitive recruitment, deployment and retention of appropriate health workforce across the tiers of the Nigerian health care system.

6.2 Health Infrastructure

Context

Health Infrastructure comprises buildings - both medical & non-medical, equipment - medical equipment, furniture and hospital plant; communications (ICT equipment), ambulatory systems (ambulances, cars, pick-up vans, trucks, etc.) and municipal services – water, sanitation power as required for healthcare delivery at different levels. For healthcare infrastructure to meet the desired outcome, it must be effective, safe to use, qualitative, and also appropriate, affordable, available, accessible and acceptable across the three tiers of our healthcare services. However, about 80% of health facilities (particularly PHCs) are in different states of dysfunctionality ranging from dilapidation to lack of water and electricity. The secondary and tertiary levels also suffer from obsolete and non-functional equipment and vehicles due to lack of health infrastructure development master plan and weak maintenance culture. Furthermore, there is dearth of basic and critical care equipment and limited investment in ICT, transport and communication infrastructure in the health sector. The health sector priority for health infrastructure should be to design and develop an infrastructure master plan, embark on provision and reconstruction of physical infrastructure and regular maintenance of vehicles especially in older health institutions.

Goal and strategic objective

These include: improving 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.

Specific Target

1. 80% of Wards in the country have at least one fully functional PHC centre with capacity to provide comprehensive primary health care services by 2022.
2. 50% of the LGAs have functional general hospitals for referral from PHCs.
3. 70% of appropriate laws, policies and regulations including the National Health Equipment Policy are available by 2022.
4. 80% of health facilities at all levels of the health system 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, by 2022.

Key interventions and activities

These shall include strengthening legal, policy and institutional framework and coordinating mechanism for health infrastructure planning and maintenance in Nigeria by establishing infrastructure departments/units at federal, state and LGA levels, developing a national/state strategic health infrastructure plan, adapting/reviewing policies, laws and guidelines on health infrastructure, equipment maintenance and management and setting up a functional health infrastructure coordinating committees at different levels. Other interventions include: promote the establishment of norms and standards for health infrastructure for all levels of the health care system in the country by establishing 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.

Furthermore, other actions are to 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 by conducting a gap analysis of health infrastructure at all levels of health care delivery based on established norms and standards, establishing a system for procurement of health infrastructure (e.g. vehicle, ICT, communication, equipment etc.) in partnership with the private sector, upgrading/constructing health facilities including laboratories etc. in line with established norms and standards and advocating for dedicated funds for health infrastructure development and management in Nigeria.

In addition, NSHDP 11 shall strengthen the monitoring of health infrastructure, including inventories and performance by developing and regularly updating a database for health infrastructure in the country/states and supporting the deployment of Electronic Medical Record (EMR) system to all health facilities. Part of the strategy is to strengthen capacities and partnerships for health infrastructure maintenance and management by establishing/strengthening health infrastructure maintenance units at all levels of health care, building human capacity in the use and maintenance of health infrastructure, establishing a plan and system for planned preventive maintenance of all health infrastructure in partnership with private suppliers and establishing PPP platform on health infrastructure procurement, service provision and maintenance (e.g. build and maintain, outsource, contract, concession etc.)

Training of Biomedical Engineers and health infrastructure equipment Maintenance Officers shall be scaled up to increase stock availability and this shall be accomplished by developing and implementing a scaling up training programme for Biomedical Engineers, Technicians and Health Maintenance Officers in partnership with major equipment manufacturers. Within the plan period, government shall accelerate the revitalization of primary health care infrastructure for improved access to health services which will achieved by first conducting a situation analysis including mapping and establishing a database of PHC facilities, developing a plan for equitably upgrading and construction of new PHC facilities based on needs, establishing/strengthening at least 1 PHC per ward to provide essential healthcare service package (ESP) including BEmONC and providing PHC infrastructure with requisite HRH in relation to defined norms and standards. Finally, secondary and tertiary levels infrastructure shall be improved to support referrals systems by establishing standard diagnostic centres at all senatorial zones of the State that are WHO certified. Centres of excellence in the State shall be revitalized, upgraded and expanded including establishing/strengthening logistics support, transportation and communication systems to aid referral with the aim of having at least one general hospital as a referral centre for PHCs in the LGAs.

6.3 Medicines, Vaccines, Health Technologies and Supplies

Context

Access to essential medicines is critical to achieving universal health coverage. This is a situation where essential medicines are available, affordable, and people can choose, obtain and use high quality medicines and medical supplies, as at when needed. The Nigerian government has established the National Pharmaceutical Research Centre and promoted local manufacturing of drugs. The National Agency for Food, Drug Administration and Control (NAFDAC) has provided, appropriate guidelines and regulations to ensure compliance with Good Manufacturing Practices (GMP), sales and distribution of medicines, vaccines and

products. Despite these achievements, there are still many challenges which impede the health products management practices and health commodities supply chain in the country, which will be addressed in this plan. These include: gross underfunding for medicines and other products, frequent stock outs and high rates of expiry at delivery points, parallel supply chain management systems, inadequate warehousing with available ones not meeting needs, poor infrastructure and protection for domestic manufacturers, local production meeting only 5% of needs, moribund national vaccine production, increasing prevalence of anti-microbial resistance and irrational drug use.

Goal and strategic objective

The goal is to ensure that quality medicines, vaccines, and other health commodities and technologies are available, affordable and accessible to all Nigerians. The strategic objective is to strengthen the availability and use of affordable, accessible and quality medicines, vaccines, and other health commodities and technologies at all levels.

Specific Targets

Targets	2018	2019	2020	2021	2022
Increase local production of quality medicines, vaccines and other commodities from 5% to 40%.	5%	10%	20%	30%	40%
Increase local production of simple active pharmaceutical ingredient to 70%.	30%	35%	40%	55%	70%
Proportion of federal level MDAs, 36 states and FCT with functional logistics management coordinating units increased to 80%.	5%	40%	60%	70%	80%
Percentage of health facilities with no stock-out of tracer drugs or vaccines within the last three months increased to 80%.	35%	45%	60%	70%	80%
36 states + FCT have a medicine and therapeutic committee at the state and facility levels.	0%				36 states + FCT

Key interventions and activities

These include: Strengthening the development and implementation of legal, regulatory framework, policies and plans for drugs, vaccines, commodities and health technologies at all levels, by advancing the development/review, harmonization and full implementation of enabling legal and regulatory frameworks, policies, guidelines and SOPs; developing the necessary strategic and annual operational plans; harmonizing and integrating national/state supply chain management systems in line with the National Supply Chain Management Programme; advocating for favourable fiscal policies and developing an investment case for drugs, vaccines and health technologies; and strengthening the Drug Revolving Fund at all levels. Furthermore, effective coordination of structures that ensures accessibility to medicines, vaccines, commodities and other technologies shall be strengthened at all levels, through support for state and LGA product supply chain management/Logistics management, establishing coordinating unit including coordinating committees or working groups.

Collaboration with regulatory agencies in performing their statutory mandates will be enhanced. Also, production and use of locally manufactured medicines and vaccines that meet global standards will be improved. This shall be done by developing partnerships to promote local production to comply with global standards; creating an enabling environment for local production (removal of tariffs, provision of power supply, water and sanitation, and other incentives). .

In addition, effective procurement systems (forecasting, orders, procurement) shall be strengthened to ensure 40% local content and commodity security on a sustainable basis at all levels, by strengthening institutions that are responsible for product selection through training, capacity building and infrastructural enhancement; implementing the procurement policy on medicines, vaccines and health technologies; developing user friendly standardized tools for data capture and analysis for decision-making for all aspects of products and health technologies management; developing /strengthening product use database; strengthening the system for product dissemination, review and feedback; building capacity of all relevant officers in forecasting, quantification, drug use and procurement; establishing a database of consumers and clients, consumption patterns and cost implication; establishing efficient drug procurement systems at all levels (including community) and establishing/strengthening warehousing (e.g. power supply, cooling facilities, metal shelves, pallets etc.)

Others shall include strengthening integrated supply chain management system and quality assurance models for medicines, vaccines, commodities and other technologies with a functional LMIS, accomplished by establishing supply chain coordination structures in line with national policy, guidelines and international best practices; establishing a sustainable system for end to end real-time supply chain data visibility for all health commodities across all intervention areas; strengthening the M&E Systems; instituting price intelligence approach to guide procurements; creating and sustaining a viable distribution network that ensures timely delivery of supplies. Also, rational drug use and antimicrobial stewardship shall be strengthened at all levels by regularly updating, producing and disseminating standard treatment guideline; providing continuing education to product users (e.g. clinicians, patients, general population, and technicians) on appropriate product use; conducting community sensitization and education especially in rural areas; establishing a quality system for pharmacovigilance, which will cover organizational structure, responsibilities, procedures, processes and resources as well as appropriate resource compliance and record management; identifying/establishing sentinel laboratories for monitoring anti-microbial resistance (AMR), and strengthening existing systems for the management of biological and non-biological wastes including expiries of medicines, vaccines and other commodities at all levels.

To strengthen development of traditional medicine in Nigeria, appropriate national policy shall be adopted/adapted; laws and regulatory guidelines shall be formulated for the practice of traditional medicine practitioners (TMP) including codes of ethics and practice; Research and Development (R&D) of traditional medicine shall be promoted; standards of safety, efficacy and quality for traditional medicine practice shall be established; partnerships between traditional medicine and conventional healthcare system; regulatory agency for the registration, regulation, standardization and training with respect to traditional practice shall be established. Additionally, traditional/alternative medicines and practice will be promoted through the establishment of functional regulatory council and commencement of training in herbal medical in medical schools in Nigeria.

6.4 Health Information

Context

The Nigerian health information system is characterised by fragmentation and duplications of reporting lines due to vertical health programmes and programming and use of a multiplicity of reporting tools and indicators. The other weaknesses include low reporting rates due to poor data collection and dearth of data tools. The and coordination of the M&E/health information systems remains weak in addition to institutional and human capacity deficits of data management units at all levels. Data quality assurance mechanisms are weak leading to low quality of health data. There is a general lack of health data for planning and programming at all levels of the health system in Nigeria.

Goal

To institutionalize an integrated and sustainable health information system for decision-making at all levels in Nigeria

Strategic objectives

The strategic objective for the Health Information System in the current plan shall be to 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.

Targets

Target	2018	2019	2020	2021	2022
Percent of health facilities (public and private) generating and transmitting routine HMIS data increased by 50% of the baseline.	TBD	20	30	40	50
Percent of timeliness, completeness and accuracy of reporting from facilities (reporting rate) for each LGA/State increased by 30% of the baseline.	TBD	10	15	25	30
Percent improvement in in data quality using standard DQA tools increased by 50% of the baseline	TBD	20	30	40	50

Interventions and Actions

The strategic interventions to address the assessed weaknesses of the health information system in the NSHDP II shall consist of strengthening the coordination mechanisms for HIS at all levels, building human and institutional capacity to generate, transmit, analyse and utilize routine health data from all health facilities, including private health facilities. This will ensure that analysed health information is continually available for guided decision- making. The NSHDP II articulated interventions that will improve the integration of existing surveillance systems and diseases registries into the overall national health information platform, the DHIS 2.0, and create an integrated data repository for data sharing among stakeholders while continually tracking the performance of the sub sector at all levels. This intervention includes activities that will ensure continual data quality assurance as a means to improving health data

quality across the system. A key action will include conducting monthly data review meetings and the quarterly review meetings of State HDCC Team and of the LGAs' IHDMT

In line with the equity principles of the NSHDP II, data generation and analysis shall be disaggregated by gender. During the plan period, data governance bodies shall be to provide governance of health data management and use at federal and state levels. In particular, the Heath Data Consultative Committee (HDCC) and HDGC shall be strengthened. Other key actions to be undertaken during the plan period will be to provide critical data management tools and facilities for effective data collection, transmission and management at all levels.

6.5 Health Research

Context

Key weaknesses and challenges in health research in Nigeria include poor funding for research, absence of a clear research agenda and set priorities, disconnect between research and development and between researchers and policy makers. Also, there is limited networking and collaboration of the research institutions, lack of functional repository for research products and access to the research information. The regulatory framework is weak and there is poor implementation and enforcement, legislative protection of intellectual and proprietary rights.

Goal

To utilize 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

Strategic objectives

The strategic objective for health research and development in Nigeria during the period of the NSHDP II implementation is to significantly contribute to the overall improvement of the performance of the Nigerian health system.

Targets

Target	2018	2019	2020	2021	2022
Percent of federal and state health/ research institutions with functional ethics review committees.	TBD	30	50	70	100
Percent of health institutions at various levels of government that spend at least 2% of their health budget for research/ federal and state health MDAs and training institutions allocate 2% of their health budget to research increased by 40% of the baseline.	TBD	10	20	30	40
Percent of health research outputs that is responsive/aligned to jointly set national health priorities/agenda increased by 50% of the baseline.	0	15%	25%	35%	50%

Key Interventions and Actions

To address the weaknesses of research and development in Nigeria during this plan period, key interventions shall be on strengthening coordination and regulatory mechanisms and of the development and implementation of the national research agenda. This will require resources and therefore, interventions will include resource mobilization for research activities. This will include advocating for allocation of, at least, 2% of health budgets for research. It will therefore be necessary to strengthen health research institutions to enable them to contribute to evidence-based decision making through research. Health research shall be guided and regulated, so actions shall be taken to strengthen regulation and ethical oversight of essential national health research and promote the utilization of research findings to inform policy, programming and practice. The national, states' and institutional Health Research and Ethics Committee shall be strengthened and enabled to better provide respective oversight of health research as provided in the NHAct.

There shall be a framework for sustainable funding of research activities based on agreed national health research agenda and priorities. The plan proposes strategic actions to facilitate the development of a repository for the collation and archiving of health-related research findings for improved knowledge management. Activities shall be undertaken to foster strategic partnerships by the national and international research organisations. There shall be a platform for regular dialogue and coordination of research activities that shall include policy makers, researchers and other stakeholders for linking research to policy. A framework for the development and commercialisation of research findings/products shall be developed to protect intellectual and patent rights.

Chapter 7

Strategic Pillar 4: Protection from Public Health Emergencies and Risks

Context

A public health emergency is either a man-made or natural event that has the potential to cause loss of lives, ill-health or destruction of property or the environment. Nigeria has developed systems and institutions for containment of public health emergencies that require strengthening across all tiers of the health care system. The surveillance system/ early warning signs are still weak, with poor planning, preparedness and management of public health risks and emergencies; weak network and capacity of public health laboratories; delayed and poor capacity to respond to public health emergencies and risks. Furthermore, surge capacity of health facilities to respond to public health emergencies is poorly developed. The emphasis shall be to galvanize the surveillance / early warning system, build the capacity of health facilities and public health laboratories for improved emergency preparedness and response.

Strategic objective

The goal is to significantly reduce the incidence and impact of public health emergencies in Nigeria.

Specific Targets

1. Morbidity and mortality from public health emergencies reduced by 50% by 2022
2. At least 50% of all health facilities in the country participate in disease surveillance and reporting using IDSR tools.
3. At least 75% of the population is covered with surveillance alert systems
4. Proportion of responses to all confirmed epidemics that fall within the 24 - 48-hour window increased to 80% by 2022.
5. Proportion of road traffic accidents that fall within the 1-hour window (golden hour) increased to 50% by 2022.

Key interventions and activities

These shall include promotion of the development and implementation of legal, regulatory framework, policies and plans for emergency preparedness at all levels. This shall be by conducting continuous advocacy to policy and decision makers for resource mobilization and provision of adequate funding to support IDSR activities, establishing a functional multi-agency advisory coordinating committee; supporting the update and availability of IDSR epidemic management protocol and Standard Operating Procedures (SOPs) to health personnel at all levels; ensuring legal framework is in place for compliance with IHR; review laws and policies for outbreak and surveillance activities as it relates to isolation and

quarantine. Furthermore, interventions shall promote an integrated national disease surveillance system in line with International Health Regulations (IHR) and IDSR by the following activities: strengthen the epidemiology unit of the SMOH and the NCDC; conduct a gap analysis of the existing IDSR system in the country as a basis for developing a plan and policies for an improved and responsive surveillance system; develop and operationalize an evidence-based best practice surveillance system; develop and implement a competency-building plan for surveillance staff at all levels and deploy appropriate staff at different levels, including epidemiologist to provide surveillance leadership at state level. Other activities include: integrate and harmonize all vertical surveillance systems into IDSR and establish a system for sustainable production and distribution of all relevant IDSR guidelines, data collection forms and tools, SOPs for use at all levels, including community, and health facilities (public and private).

Other key interventions shall be to expand/strengthen a network of public health laboratories (PHL) in Nigeria by establishing a functional public health laboratory in each state, a laboratory network for state, central and reference public health laboratories in Nigeria; standards and guidelines for the operation of the public health laboratories at all levels, including MoU with network of Public Health Laboratories (PHLs) in the country; build capacity of laboratory staff for the PHLs; establish a system for communication with the LGA and adequate transportation of the samples from health facilities/LGAs to the PHLs; strengthen reference laboratories for confirmation of special pathogens and also act as quality control for State laboratories.

Scale-up of public education and awareness creation on public health emergencies through development and implementation of a communication strategy for public education on PHEs; production and dissemination of IEC materials on public health emergencies; and engagement of the media in public education and awareness creation on PHEs shall be addressed.

In addition, 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 for PHE; establishing a functional incident and command and control structure, including Emergency operating centre (EOC) in the State; developing and maintaining a surge capacity to respond to public health emergencies.

Further intervention shall include, promotion of integration of disease surveillance activities at all levels of the health care system and building human resource capacity and equitably distribute them for appropriate and optimal response to public health emergencies. This can be achieved through identification and building of capacity of a core of national/state level trainers that will conduct periodic training of health workers, including lab workers on all aspects of disease surveillance and public health emergencies. Also, capacity of health workers shall be built by adapting WHO generic materials/national training materials for disease surveillance, laboratory diagnosis and public health emergencies and response; sensitizing heads of training institutions and relevant regulatory and professional bodies for the integration of IDSR and public health emergencies into the pre-service training curricula of health professionals. The other activities shall include strengthening coordination mechanisms for public health emergencies at all levels by conducting assessment of implementation of IHR (2005) in Nigeria to determine gaps and developing and implementing a plan to redress the identified gaps and commence implementation of Global Health Security Agenda. Finally, community participation in disease surveillance activities shall be promoted.

With respect to the North East humanitarian crisis, the two-year North East Health Sector Response Plan, which ends in 2018 should be revised and a longer term strategic plan articulated as the crisis does not appear to end in the short term. Additionally, health sector

response plans should be developed for all areas of crises in the country where humanitarian challenges have become manifest, for example, the IDP situation in parts of the Middle Belt as a result of attacks of local communities by herdsmen.

Climate Change

One of the key threats to global health is climate change which 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 a 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. Adequate measures, preparation and response will therefore 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 nations. This therefore means that a strengthened health system requires 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.

Interventions

These are as follows: prioritise emergency risk management for health at all levels; conduct health risk assessment and establish early warning system with robust surveillance and monitoring of potential threats to health, particularly from biological, natural, ecological, and technological sources to enable early detection and warning; scale up education and information interventions to build a culture of health, safety, environment, and resilience at all levels and strengthen actions to reduce underlying risk factors to health and health systems. Additionally, capacity shall be strengthened for emergency preparedness and readiness for effective health response and recovery at all levels and build core capacities in line with International Health Regulations.

Chapter 8

Strategic Pillar 5: Health Financing

Context

Health financing is the underpinning of the health care system. The availability and quality of health care services are contingent on adequate funding. Optimal utilization of the health care services is influenced by the financing mechanism put in place that removes financial barriers to access. The low demand for health care services in Nigeria leading to poor health outcomes is not only due to poor health care seeking behavior but also, unaffordability of the services. The key bottlenecks that this strategy seeks to address is low government funding of health sector, allocative inefficiencies, poor coverage with pre-payment schemes, poor coordination of partner funding, inadequate transparency and accountability in fund utilization and limited exploitation of other funding options.

Goal

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

Strategic Objectives

- Strengthened governance and coordination for actualizing stewardship and ownership of health financing reforms
- Increase sustainable and predictable revenue for health
- Enhance financial risk protection through pooled funds at federal and state levels
- Enhance transparency and accountability in strategic purchasing of Health Services

Targets

Target	2018	2019	2020	2021	2022
Percentage of Federal level MDAs, States and FCT with approved health financing policy and strategy increased to 70%.	0%	10%	30%	50%	70%
Proportion of FMOH/ SMOH with institutionalized routine NHA / SHA increased to 70%.	0%	10%	30%	50%	70%
% Budgetary allocation to Primary Health Care increased from 21% to 35%.	21%	24%	28%	32%	35%
% of Nigerian population covered by any risk protection mechanism increased from 5% baseline to 30%.	5%	7%	10%	20%	30%
Number of states with functional state health insurance/ contributory schemes	0				36 states + FCT
% of health facilities operating any form of Results Based Financing (RBF) increased to 30% of baseline	TBD				30%

Strategic interventions and activities

Key interventions articulated in the NSHDP to address health financing gaps include establishing or strengthening existing Health Financing Equity and Investment Units as well as coordination frameworks and TWGs for health financing and developing states' Health Financing Policy & Strategy and Investment case. Also, there is a need to establish systems for health financing evidence generation and management and aligning health allocations to national priorities. Frameworks should be established to coordinate phased implementation of the BHCPF, expand the BHCPF by crowding in donor funding and funding from other sources (including the private sector), and advocacy for increase in government annual budget and spending on health across all levels (Federal, 36 States, and FCT). Other interventions are to strengthen legal and coordinating framework for PPP, develop and implement resource mobilization strategy and guideline including sin taxes, telecom taxes, VAT, aviation taxes, etc; engage stakeholders to increase enrolment and contribution to Health Insurance including strengthening of extant laws and regulations for the implementation of the NHIS, making health insurance mandatory; building the capacity of health personnel on health insurance and contributory schemes, establishing state health insurance and contributory schemes in the 36 States and the FCT and making it mandatory. Also, is the need to review provider payment mechanisms in the Nigerian health sector to focus on Result Based Financing (RBF) and essentially develop a framework for competition between public and private sector providers in the allocation of new resources for healthcare; establish a National Quality Review and Health Technology Assessment systems to determine, which health interventions are cost effective (responsibility for FMOH only); institutionalize routine NHA and expenditure tracking mechanisms at all levels; and institute Public Finance Management (PFM) reforms at the Federal and State levels. Safety nets will be scaled up for meeting the needs of vulnerable populations

Chapter 9
Financial Resources; Costing and Budget of NSHDP II

9.1 Introduction to the NSHDP Costing

National SHDP II cost estimates and resources available for its implementation are both vital preconditions to ensure realistic levels of ambition for the strategy. This will leverage the prioritization of planned investments and the design of appropriate measures to finance the emerging resource gaps. This section outlines the methodology used in costing the National SHDP II 2018-2022, and the estimates of available resource commitments within the Country over the strategy period. With both the Total Cost of the Plan and resource commitments estimated; recommendations have also been presented to bridge the emerging financing gap in the strategy.

9.2 NSHDP Costing Methodology

National SHDP II 2018-2022 cost projections are based on state-specific coverage targets and planned strategic actions. The total cost of the strategy presented in this section is the aggregate of costs of health system inputs and program 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 National SHDP II coverage targets and impact goals. The adopted bottom-up costing approach is in compliance with the constitutional provision that places health on the concurrent legislative list, empowering the 36 States and FCT to make decisions on health within the context of the national framework. To facilitate the cost projections and ensure consistent methods were used across all 36 states, the OneHealth tool[66] version 4.63 was used.

The National SHDP II 2018-2022 costing exercise is the result of a consultative and iterative process of data collection, targets setting and quality assurance to ensure alignment with Government's health policy thrust and accuracy of estimates. The costing process entailed the following:

(I) Inauguration of the core group/Technical Working Group (TWG);

(II) Orientation/capacity building of Federal, Zonal and State costing teams on the cost methodology, including application of the OneHealth Tool;

(III) Collection of high Impact interventions coverage baselines and System inputs required for calibrating the OneHealth tool;

(IV) Development of strategies and costing of key actions at Federal, State and MDA levels;

(V) Quality assurance/peer-review meetings for state and federal MDAs cost inputs;

(VI) Synthesis of costed policy scenarios and impact outputs facilitated by the Zonal Costing Costing Consultants with OHT.

[66] OneHealth Tool is a unified costing template that estimates the overall cost of delivering the package of health services identified in the strategy

(VII) Harmonization of the 36 states, FCT and Federal MDAs' costed strategies into the national strategic plan

To arrive at the cost of Strategy, inputs was generated for the following health Services and System components,

Health Services Component

- RMNCH+Nutrition, Adolescent Health
- Communicable Disease/NTDs
- NCDs, Mental Health
- Health Promotions
- Emergency & Epidemic Preparedness
- General And Emergency Hospital Services

HSS Component

- HR (Admin and Service Delivery)
- Logistics
- Infrastructure including Blood Safety, Labs
- Governance
- Health Financing

Health Service Management Costs

- Specific HR,
- In-service/Refresher training
- ISS, Annual Planning, Data collection
- Annual planning etc..

HSS Management costs

- Specific HR,
- In-service/Refresher training, Blood Safety,
- Annual Planning etc.,

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

9.2.1 Overview of NSHDP II Costing Assumptions and Data sources

While a more detailed description of each of the three scenarios is discussed in the next section, other assumptions considered in arriving at the total Cost of the National Strategy include the following:

- The population estimate for the three scenarios was based on NpopC projections, and currency rate is set at ₦305/US$. 2016 was adopted as the base year, in accordance with the National Council of Health (NCH) resolution stipulating 2018 – 2022 as the duration of the plan.
- Baseline mortality ratios for maternal, neo-natal and Under-five were obtained from DHS 2013 and MICS 2016-17.
- 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. For MNCH data gap not found in MICS and DHS, we were guided by studies on the relationship between coverage of skilled birth attended deliveries and other childbirth interventions in estimating some of the missing baselines.[67]
- Similarly, with the coverage baselines of the NSHDP II scenarios derived mainly from population-based surveys such as DHS 2013 and MICS 2016-17, it is assumed that

[67] Souza et al (2013), Moving beyond essential interventions for reduction of maternal mortality (the WHO Multicountry Survey on Maternal and Newborn Health): a cross-sectional study. Lancet. 2013

the services modeled for NSHDP II would be delivered at both public and private facilities.

- National baselines for health infrastructure cost estimation was guided by State submissions. The Directorate of Planning of the Federal Ministry of Health provided guidance in cases where the states were unable to provide the data.
- Costs for medicine and supply management was yet another category affected by the paucity of data 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, was determined through historical estimates and expert opinion. As recommended, 30% of the total amount allocated to Procurement and Supply Management was allocated to warehousing, handling, and distribution.
- Human Resource cost for the national harmonized strategy was based on aggregated State-Specific HR data, especially for the baseline 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. This HSS investment is crucial for delivering the health service targets of the strategy, particularly as the projections for staffing was not provided.
- As part of the NSHDP II governance activities, allocations were provided to strengthen private sector engagement; funds were set aside to cater for effective regulations, capacitation of care providers for improved quality and collection of service data.
- Government estimates for the resource analysis were derived from the 2016 budget and projected using population growth while partners funds were collected using the resource mapping tool.
- When completed, the NSHDP II is expected to guide the development of partners' strategy. However, for the Programs with existing country strategies such as RMNCHA+N, Family Planning, HIV and TB, effort were made to align the intervention targets of NSHDP II with those of the country strategies.

9.2.2 Data Limitations of the NSHDP II Costing

Although measures were put in place to mitigate the effects of the challenges encountered during the costing process, it is noteworthy to highlight some of these setbacks. From the required input data for costing, access to community and health facility information topped the list of challenges. Likewise, HSS information to guide the scenario modeling process. Others have been listed below:

- Dearth of service coverage baselines was recorded across a number of the health program areas, particularly TB, NCD and NTD. For the purpose of costing, these gaps were addressed by inserting an estimated base year coverage of 10% for the affected interventions, pending the determination of the baselines.
- Treatment inputs required for estimating intervention cost for the plan was not provided for 22% of the NSHDP II interventions modeled. The affected services include NCD, Mental Health and NTD. 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 harmonized 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.

9.3 Description of NSHDP II Costing Scenarios and assumption for Target Setting

Impact and cost estimates for the National SHDP II was modeled for the period 2018-2022. Impact targets of NSHDP II was determined in line with 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 modeled and costs estimated in response to the high causes of mortality, and also estimate the cost of the strategic plan. The three scenarios are as follows:

- Baseline – With no coverage scale-up and no significant change in HSS investment across the horizon of the plan.
- Essential Service Moderate Scenario – Scale-up of essential services and HSS investments required for the implementation of the Primary Health Revitalization Agenda, a key policy thrust of Economic Recovery and Growth Plan (ERGP).
- Essential Service Aggressive Scenario – Scale-up of health service 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 Baseline Scenario**

National SHDP II baseline scenario is one of the three policy scenarios modeled for the health sector strategy. For this scenario, service coverage between the base and target year remained unchanged across all health service areas. Consequently, targets for MMR, NMR, and U-5MR remained unchanged over the horizon of the strategy. Although the coverage profile for this scenario was modeled as "baseline," measures were put in place to sustain the quality of existing health services. Some of which include allocation of funds for programme management activities aimed at preserving the quality of service provision. Investment in HSS was limited to routine current expenditure. For infrastructure, allocations were provided to maintain office buildings and health facilities, while for human resource salaries for the existing staff capacity was provided. In summary, this scenario was modeled to demonstrate impact and missed opportunities of sustaining the current trend in service delivery.

- **Overview of Essential Service Moderate Scenario**

National SHDP II Essential Service moderate scenario is one of the two scaled scenarios aimed at implementing Government's primary health revitalization agenda. This policy scenario targets the reduction in mortality outcome by increasing access to the package of essential services across all levels of care. 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. The NSHDP II identifies inequitable coverage of minimum and essential health services, 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. In response to these issues, service coverage for essential package of services were scaled as part of this scenario. Targeted programmes and interventions include but not limited to: Family Planning services, Maternal & Child health- Ante-Natal Care Services, Skilled Attended Delivery including EmOC Services, Immunization, Malaria- prevention and case management, Nutrition-MAM and SAM, NCDs, Mental health, and NTDs. Of the 304 interventions modeled for this scenario, a different policy assumption was adopted for two – Family Planning-CPR and HIV-ART treatement. For Contraceptive Prevalence Rate, target was scaled by 7.5% based on historical trends. Other family planning assumptions upon which the moderate scenario was modeled include the attainment of the Family Planning Modern method mix of 75% from a baseline of 20.9%. while HIV treatment scale-up was guided by the recently adopted 90-90-90 policy.

Reports on the prevailing HSS situation suggest dearth of skilled health workers, maldistribution of human resource (geographic-urban-rural and regional, and in level of care) in relation to numbers and skills mix; weak referal systems and deteriorating health infrastructure are key factors inhibiting the effective delivery of services. Clinical diagnosis, surveillance and blood transfusion services are currently impacted by the weak laboratory services across the 36 States and FCT. In mitigating these HSS weaknesses, investments have been planned to increase access to primary health care with the improvement of existing PHC facilities. Referal systems have equally been targeted for strengthening. 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 modeled number of key health providers required for this scenario include Medical Doctors-8,322 (97%), Nurses-63,118 (185%), and Midwives- 39,000 (150%) . To improve quality of health HR, some of the activities programmed for include in-service refresher training, supervision of providers, etc.

With the investment proposed for this scenario, the following mortality outcomes are anticipated[68].

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

- **Overview Essential Service Aggressive Scenario**

The National SHDP II Essential Service Aggressive Scenario is the third policy scenario modeled for NSHDP II. In this instance, the coverage of essential services has been scaled optimally towards the attainment of Universal Health Coverage with components of primary health revitalization agenda modeled in the moderate scenario incorporated. A year-on-year frontloaded interpolate profile was implemented to arrive at 30% coverage increase across interventions for this scenario. Examples of programme and interventions modeled for the aggressive scenario include; Maternal & Child Health- Anti-Natal Care Services, Skilled Delivery including (EmOC Services), Immunization, Malaria- prevention and case management, Nutrition-MAM and SAM, NCDs, Mental health, and NTDs. Unlike the moderate scenario, Family Planning-CPR coverage was increased by 10%, which is 2.5% more than the estimates of moderate scenario. Moreso, the HSS investment proposed for aggressive

[68] As modelled by the impact modules within the OneHealth Tool

scenario cuts across all the three levels of care: Primary, Secondary and Tertiary. To this end, human resource and infrastructure capacities were scaled to accommodate the HSS requirements for service delivery. Based on the existing HR, the required frontline health workers modeled for this scenario is as follows: Medical Doctors- 39, 000 Nurses-69,700 (220%), and Midwives- 39,188 (169%) to guarantee skilled staff adequacy. As programme management investments, the following activities were planned: in-service refresher training, supportive supervisory visits, data collection and coordination meetings, etc., to ensure optimal quality in service provision. Funds were allocated to strengthen the referral systems including the capacity of the secondary and tertiary health facilities to support referral process. It is premised on these assumptions, that the aggressive scenario has been modeled to achieve the following mortality outcomes.

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

9.4 Costs and Impact of Scaling-up

The National SHDP II 2018- 2022 was estimated at a total nominal cost of ₦ 7,328B, ₦ 5,661B and ₦ 4,340B across the three scenarios; Essential Package Aggressive Scale-up Scenario, Essential Package Moderate Scale-up Scenario and Baseline Scenario respectively over the five-year period of the plan. With the mean cost per capita for each scenario estimated at ₦12,481 ($ 41), ₦10,342 ($32) and ₦7,372 ($24) for Essential Package Aggressive Scale-up, Essential Package Moderate Scale-up and Baseline respectively. (Table 13).

Table 13: Total Cost of National SHDP II 2018-2022 by Scenarios, in Billion (₦)

Total Cost of Nigeria-National SHDP II 2018-2022 by Scenarios, in Billion (₦)								
NSHDP II Policy Scenarios	**Average Coverage increase**	**2018**	**2019**	**2020**	**2021**	**2022**	**TOTAL**	**Mean Cost Per Capita**
NSHDP II Essential Package Aggressive Scale-up Scenario	30%	₦ 1,115	₦ 1,365	₦ 1,492	₦ 1,559	₦ 1,790	₦ 7,321	**₦ 12,481 ($ 41)**
NSHDP II Essential Package Moderate Scale-up Scenario	17.5%	₦ 947	₦ 1,087	₦ 1,220	₦ 1,325	₦ 1,492	₦ 6,071	**₦ 10,342 ($ 34)**
NSHDP II Baseline Scale Scenario	0%	₦ 859	₦ 859	₦ 899	₦ 879	₦ 873	₦ 4,340	**₦ 7,372 ($ 24)**

9.4.1 **NSHDP II Essential Package Moderate Scale-up Scenario cost outputs**

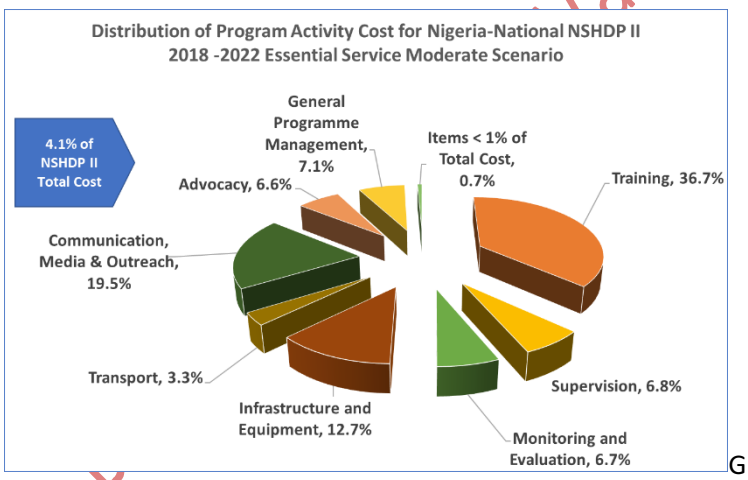
Table 13: Summary costs by Programme area of National SHDP II 2018-2022 Essential Package Moderate Scale-up Scenario, in Billion (₦)

Summary costs by Programme area of Nigeria-National SHDP II 2018-2022 Essential Package Moderate Scale-up Scenario, in Billion (₦)							% of Total Cost
NSHDP II 2018-2022 Programme Areas	**2018**	**2019**	**2020**	**2021**	**2022**	**Total**	
Maternal/newborn and reproductive 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%**
Malaria	₦ 4	₦ 4	₦ 8	₦ 6	₦ 5	₦ 27	**4.4%**
TB	₦ 1	₦ 1	₦ 2	₦ 2	₦ 2	₦ 7	**1.2%**
HIV/AIDS	₦ 11	₦ 10	₦ 12	₦ 13	₦ 15	₦ 62	**10.2%**
Nutrition	₦ 10	₦ 13	₦ 15	₦ 17	₦ 20	₦ 75	**12.4%**
Environmental Health and 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%**
Adolescent health	₦ 4	₦ 5	₦ 7	₦ 9	₦ 13	₦ 38	**6.3%**
Neglected tropical diseases	₦ 0	₦ 0	₦ 0	₦ 0	₦ 0	₦ 1	**0.2%**
Health Promotions and Social Determinant	₦ 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	**0.0%**
NSHDP II Total Cost	**₦ 947**	**₦ 1,087**	**₦ 1,220**	**₦ 1,325**	**₦ 1,492**	**₦ 6,071**	

Table 3: Summary costs of NSHDP II 2018-2022 Essential Package Moderate Scale-up Scenario, in Billion (₦)

Summary costs of Nigeria-National SHDP II 2018-2022 Essential Package Moderate Scale-up Scenario, in Billion (₦)							% of Total Cost
HSS Cost Categories	**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	**15.0%**
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%**
NSHDP II Total Cost	**₦ 947**	**₦ 1,087**	**₦ 1,220**	**₦ 1,325**	**₦ 1,492**	**₦ 6,071**	

Figure 26: Distribution of Program Activity Cost for NSHDP II 2018-2022 Essential Service Moderate Scenario



From figure 26, programme management cost accounts for 4.1% of total cost of essential service moderate scenario. Improving the quality of health service delivery was prioritized with the allocation of 36.7% of the programme management cost dedicated to refresher and in-service training. Infrastructure & equipment was assigned 12.7% (₦41B). Of this sum, equipment upgrades for facilities and laboratories amounts to ₦31B as an investment in revitalizing primary health care. To ensure increased uptake of service and adoption of healthy behaviour especially at community level, communication, media & outreach was allocated the sum of ₦0.8B. General programme management was allocated ₦17.8B to provide for activities such as annual operational planning, programme coordination meetings and strategic reviews across 36 States and FCT.

9.4.2 NSHDP II Essential Package Aggressive Scale-up Scenario cost outputs

Table 14: Summary costs by Programme area of NSHDP II 2018-2022 Essential Package Aggressive Scale-up Scenario, in Billion (₦)

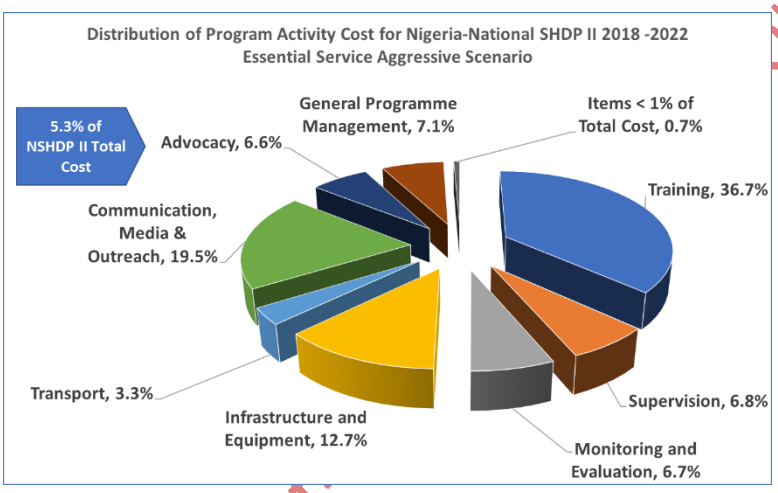
Summary costs by Programme area of Nigeria-National SHDP II 2018-2022 Essential Package Aggressive Scale-up Scenario, in Billion (₦)							% of Total Cost
NSHDP II 2018-2022 Programme Areas	**2018**	**2019**	**2020**	**2021**	**2022**	**Total**	
Maternal/newborn and reproductive health	₦ 360	₦ 417	₦ 431	₦ 449	₦ 471	₦ 2,128	**29.1%**
Child health	₦ 104	₦ 94	₦ 82	₦ 72	₦ 137	₦ 488	**6.7%**
Immunization	₦ 51	₦ 53	₦ 52	₦ 51	₦ 118	₦ 325	**4.4%**
Malaria	₦ 42	₦ 32	₦ 66	₦ 47	₦ 69	₦ 256	**3.5%**
TB	₦ 13	₦ 23	₦ 24	₦ 26	₦ 27	₦ 114	**1.6%**
HIV/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	**11.7%**
Mental, neurological, and substance use disorders	₦ 31	₦ 44	₦ 51	₦ 57	₦ 63	₦ 247	**3.4%**
Adolescent health	₦ 94	₦ 133	₦ 159	₦ 180	₦ 199	₦ 764	**10.4%**
Neglected tropical diseases	₦ 2	₦ 5	₦ 5	₦ 5	₦ 4	₦ 20	**0.3%**
Health Promotions and Social Determinant	₦ 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%**
NSHDP II Total Cost	**₦ 1,115**	**₦ 1,365**	**₦ 1,492**	**₦ 1,559**	**₦ 1,790**	**₦ 7,321**	

Table 15: Summary costs of NSHDP II 2018-2022 Essential Package Aggressive Scale-up Scenario, in Billion (₦)

Summary costs of Nigeria-National SHDP II 2018-2022 Essential Package Aggressive Scale-up Scenario, in Billion (₦)							% of Total Cost
HSS Cost Categories	**2018**	**2019**	**2020**	**2021**	**2022**	**Total**	
Programme Activity Costs	₦ 34B	₦ 105B	₦ 87B	₦ 82B	₦ 78B	₦ 386B	**5.3%**
Human Resources	₦ 428B	₦ 458B	₦ 485B	₦ 510B	₦ 543B	₦ 2,423B	**33.1%**
Infrastructure	₦ 86B	₦ 96B	₦ 94B	₦ 92B	₦ 90B	₦ 458B	**6.3%**
Logistics	₦ 168B	₦ 207B	₦ 244B	₦ 260B	₦ 321B	₦ 1,200B	**16.4%**
Medicines, commodities, and supplies	₦ 385B	₦ 459B	₦ 548B	₦ 585B	₦ 729B	₦ 2,708B	**37.0%**
Health Financing	₦ 2B	₦ 15B	₦ 13B	₦ 12B	₦ 11B	₦ 54B	**0.7%**

Summary costs of Nigeria-National SHDP II 2018-2022 Essential Package Aggressive Scale-up Scenario, in Billion (₦)							% of Total Cost
HSS Cost Categories	**2018**	**2019**	**2020**	**2021**	**2022**	**Total**	
Health Information Systems	₦ 4B	₦ 8B	₦ 7B	₦ 5B	₦ 6B	₦ 30B	**0.4%**
Governance	₦ 6B	₦ 16B	₦ 13B	₦ 13B	₦ 13B	₦ 62B	**0.8%**
NSHDP II Total Cost	**₦ 1,115B**	**₦ 1,365B**	**₦ 1,492B**	**₦ 1,559B**	**₦ 1,790B**	**₦ 7,321B**	

Figure 27: Distribution of Program Activity Cost for NSHDP II 2018-2022 Essential Service Aggressive Scenario

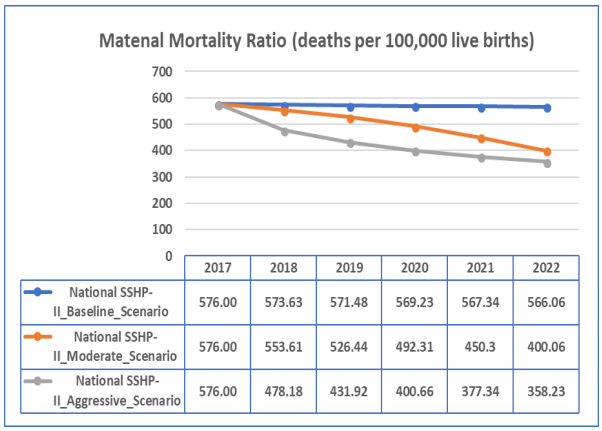


The total cost of the essential service aggressive scenario sums up to ₦7,321B, with programme management cost accounting for 5.3%. Investments in training was allocated ₦219B, of which in-service training amounts to ₦124B for health workers capacity building. Another key area prioritize is Infrastructure & equipment which is 12.7% accounts for ₦63B. Out of this equipment upgrade for facilities and laboratories accounts for ₦48B. To ensure increase uptake of services and adoption of healthy behaviour especially at community level, communication, media & outreach is 19.5% which accounts for ₦1.2B. Out of this amount, community mobilization has the highest amount of ₦824M. About ₦168B was prioritized to General programme management including annual operational planning, strategic review across 36 States and FCT.

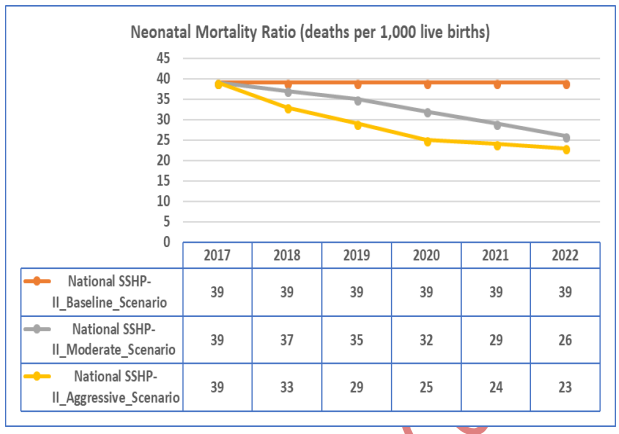
9.4.3 NSHDP II Impact outputs across the three scenarios

In this section impact results of the national strategy has been presented for the following health programmes, RMNCAH+N, HIVAIDS and NCDs.

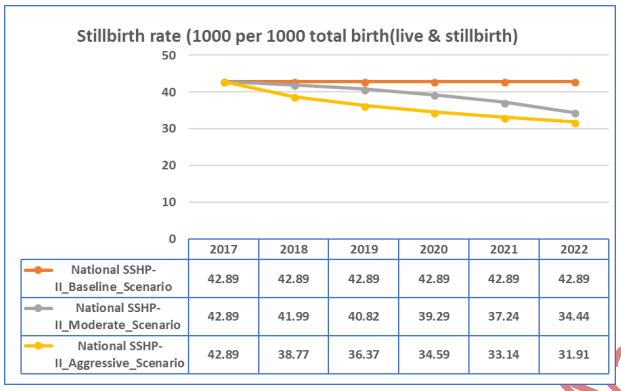
Figure 28: Impact results of health programmes: RMNCAH, HIV/AIDS & NCDs



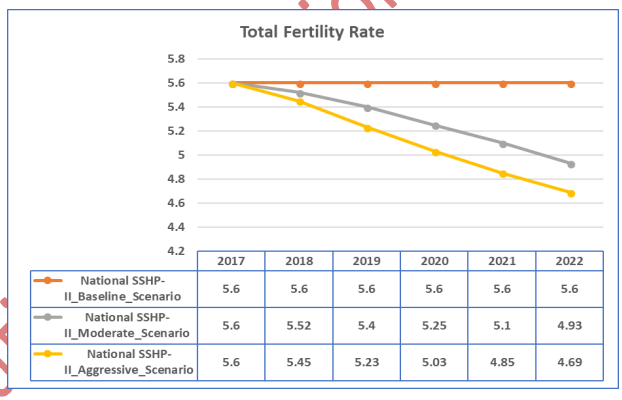
	2017	2018	2019	2020	2021	2022
National SSHP-II_Baseline_Scenario	576.00	573.63	571.48	569.23	567.34	566.06
National SSHP-II_Moderate_Scenario	576.00	553.61	526.44	492.31	450.3	400.06
National SSHP-II_Aggressive_Scenario	576.00	478.18	431.92	400.66	377.34	358.23



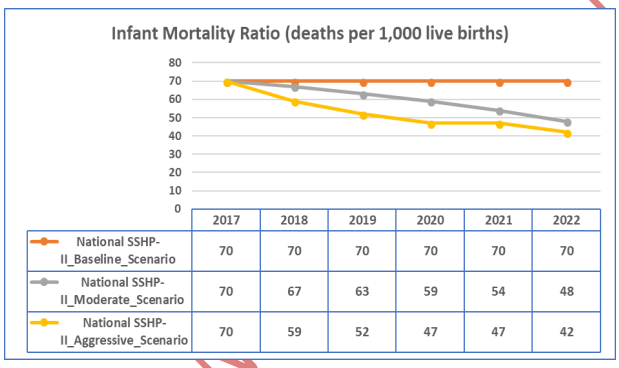
	2017	2018	2019	2020	2021	2022
National SSHP-II_Baseline_Scenario	39	39	39	39	39	39
National SSHP-II_Moderate_Scenario	39	37	35	32	29	26
National SSHP-II_Aggressive_Scenario	39	33	29	25	24	23



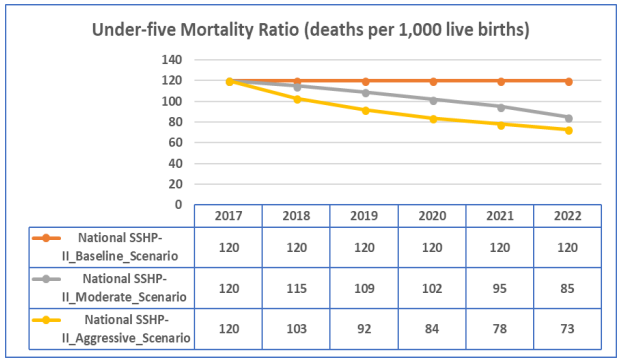
	2017	2018	2019	2020	2021	2022
National SSHP-II_Baseline_Scenario	42.89	42.89	42.89	42.89	42.89	42.89
National SSHP-II_Moderate_Scenario	42.89	41.99	40.82	39.29	37.24	34.44
National SSHP-II_Aggressive_Scenario	42.89	38.77	36.37	34.59	33.14	31.91



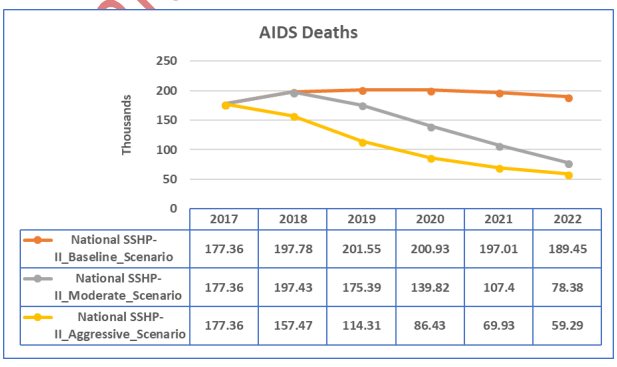
	2017	2018	2019	2020	2021	2022
National SSHP-II_Baseline_Scenario	5.6	5.6	5.6	5.6	5.6	5.6
National SSHP-II_Moderate_Scenario	5.6	5.52	5.4	5.25	5.1	4.93
National SSHP-II_Aggressive_Scenario	5.6	5.45	5.23	5.03	4.85	4.69



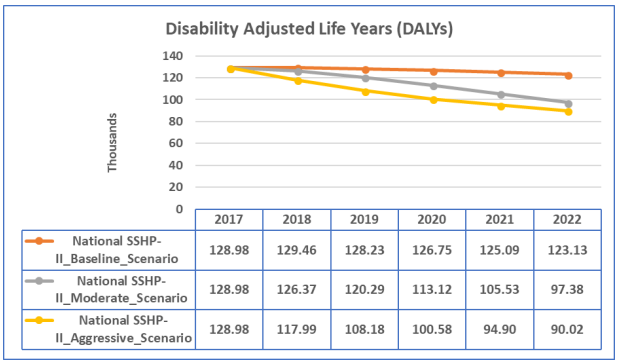
	2017	2018	2019	2020	2021	2022
National SSHP-II_Baseline_Scenario	70	70	70	70	70	70
National SSHP-II_Moderate_Scenario	70	67	63	59	54	48
National SSHP-II_Aggressive_Scenario	70	59	52	47	47	42



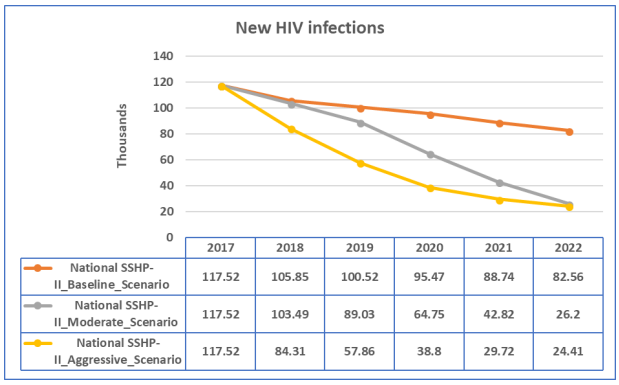
	2017	2018	2019	2020	2021	2022
National SSHP-II_Baseline_Scenario	120	120	120	120	120	120
National SSHP-II_Moderate_Scenario	120	115	109	102	95	85
National SSHP-II_Aggressive_Scenario	120	103	92	84	78	73



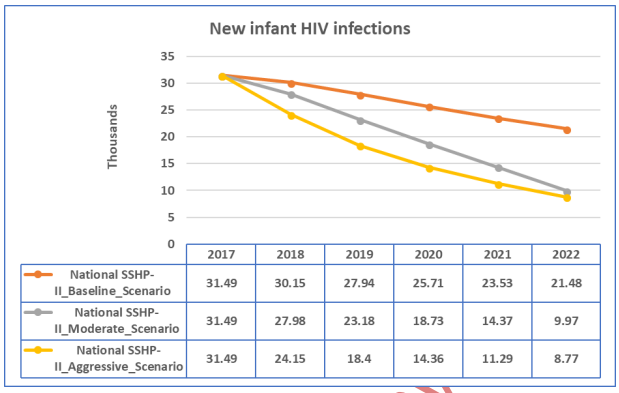
	2017	2018	2019	2020	2021	2022
National SSHP-II_Baseline_Scenario	177.36	197.78	201.55	200.93	197.01	189.45
National SSHP-II_Moderate_Scenario	177.36	197.43	175.39	139.82	107.4	78.38
National SSHP-II_Aggressive_Scenario	177.36	157.47	114.31	86.43	69.93	59.29



	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

9.5 Health System Capacity/Utilization Analysis

Whereas the National SHDP II Total Cost was calculated based on the required health system capacity, it is crucial 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 are sufficient to deliver on these targets remains pertinent, particularly skilled care providers and infrastructure capacities required to cater for clients' need. Without due consideration of the required HSS demands, effective and/or comprehensive implementation of the strategy will not be possible. Consequently, the anticipated NSHDP II outcomes would not be realized. In support of advocacy effort for HSS policy reform, existing HR and Infrastructure have been assessed against the HSS capacity utilization of the NSHDP II scenarios. For HR, the key assumption considered in the analysis is the average daily work-time of skilled frontline providers (Doctors, Nurse, and Midwives); this has been set at 8hours per day, over a period of 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.

Results of the analysis presented in table 16 below illustrate the percentage capacity utilization for each of the specified staff type currently in service. And where gaps were identified, estimates including costs for the additional staff required to achieve the desired service and impact targets has been provided. Similar capacity assessment has been conducted for health infrastructure, measuring the current bed day capacity against the need for each scenario. As we review the outputs in the table below, it should be noted that not all health services provided by the Health System were modeled in OneHealth tool. For example, a large share of health workers time, may be spent on addressing care seeking for conditions not specified within the projections, e.g., ear infection and general injuries were not modeled. As a result, the staff time needs captured in the table below underestimates the gap and should be considered as the minimum requirement. Another vital component of the health system though not captured in the capacity assessment is the staff time of the private care provider. While this analysis only focuses on public sector, it is important to highlight the contributions of the private sector to service delivery across the 36 States and the FCT. With the client uptake ratio across both Public and Private reported in DHS 2013 as 46.5% for public and 53.5% for private; engaging contribution of private sector remains imperative.

Table 16: Analysis of HSS Capacity Utilization across the three scenarios

HSS Capacity Utilization for Key Staff and Bed days						
NSHDP II Scenario	**Cost of Plan without HSS Scale-up**	**HSS Capacity utilization (%) (2022)**	**Mortality rates**	**Additional HSS Capacity Required for Service delivery (%)**	**Cost of Plan with HSS Scale-up (2022)**	**Additional Cost required with HSS Scale-up**
Moderate	₦ 5,828B	A.) Doctor - 97% B.) Nurses – 185% C.) Midwives - 150% D.) Bed days - 35%	MMR: 400/100,000 U-5MR: 85/1,000	A.) Doctor - N/A B.) Nurses – 85% (**29,000**) C.) Midwives -50% (**13,000**) D.) Bed days - N/A	**₦ 6,071B**	₦ 244B
Aggressive	₦ 6,992B	A.) Doctor - 118% B.) Nurses – 220% C.) Midwives - 169% D.) Bed days - 43%	MMR: 359/100,000 U-5MR: 73/1,000	A.) Doctor - 18% (**6,000**) B.) Nurses – 120% (**38,000**) C.) Midwives - 69% (**16,000**) D.) Bed days - N/A	**₦ 7,321B**	₦ 329B

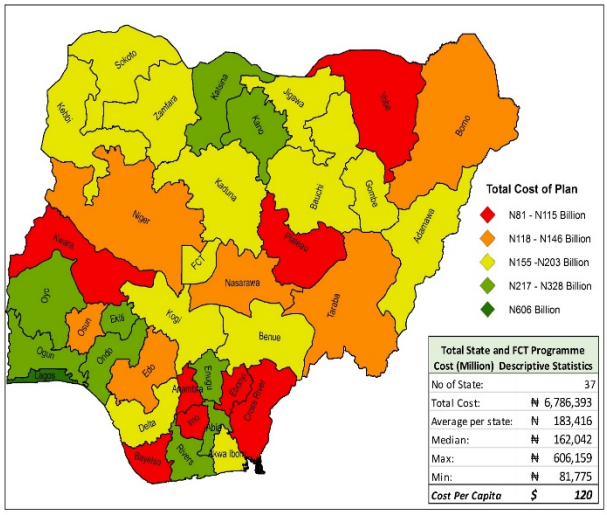
***NA: No scale-up required; **Nil: no baseline information was provided**

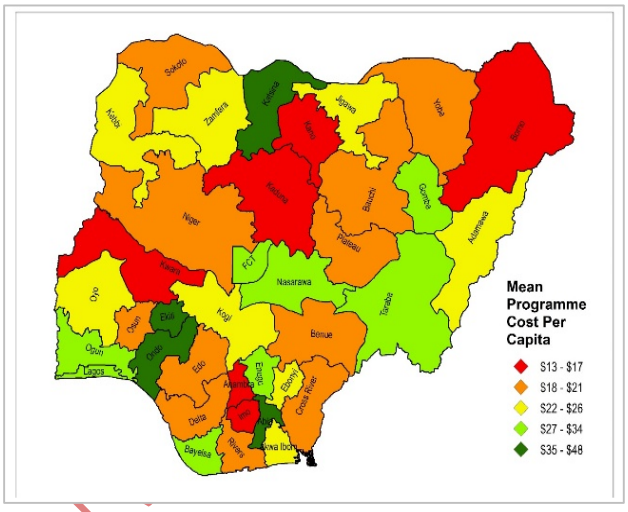
According to the information provided above on the capacity utilization of key staff, (Doctors, Nurses and Midwives) as well as bed day utilization, moderate and aggressive scenarios recorded shortfalls in staff capacity. In both policy scenarios, the existing nurse and midwife capacities are insufficient 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; as only 97% of Doctor capacity is utilized. But, when this analysis is conducted across the 36 States and FCT, the Doctor density drops significantly across the states. Resident doctor population at the Federal tertiary facilities was identified as the reason for the large pool of doctors. That said, skilled frontline staff in the public sector was exceeded by 85% (29,000) for nurse, and 50% (13,000) for midwives for moderate scenario. To effectively implement the moderate policy scenario, additional investments of ₦244B has been estimated as part of the total cost of plan.

Likewise, the aggressive scenario equally recorded capacity gaps for the following frontline staff; Doctors, Nurses and Midwives. Existing staff strength was exceeded by 18% for doctors, 120% (38,000) for nurses, and 69% (16,000) for midwives. With the view of achieving universal health coverage, an additional ₦329B is required to implement the aggressive scenario. On infrastructure, analysis of the bed day capacity utilization indicates the adequacy of available bed capacity to support the service needs modelled for the three policy scenarios. It is important to emphasize at this point that the total cost of the plan for both scenarios have been estimated to cover the required health system capacity to deliver the modelled service coverage.

9.6 Analysis of the 36 States and FCT SHDP II Costs

Figure 29: Distribution of SSHDP II Total Cost and Cost Per Capita across 36 States and FCT





As previously established, the cost of national health strategy is the aggregate of 36 States and FCT costed strategic plans. In this section, cost output is presented for each State and FCT with the view to highlighting the total cost proposed for the five years as well as priority investment targeted at the high causes of mortality documented in the NSHDP II. Across the 36 States and FCT, resource analysis is presented for the following intervention areas. (a) RMNCAH+N, (b) Malaria, (c) HIV, (d) NCD/Mental Health, (e) Environmental Health/WASH, (f) Emergency Medical Services including public health emergencies and risks, (g) Immunization and (h) TB/NTD.

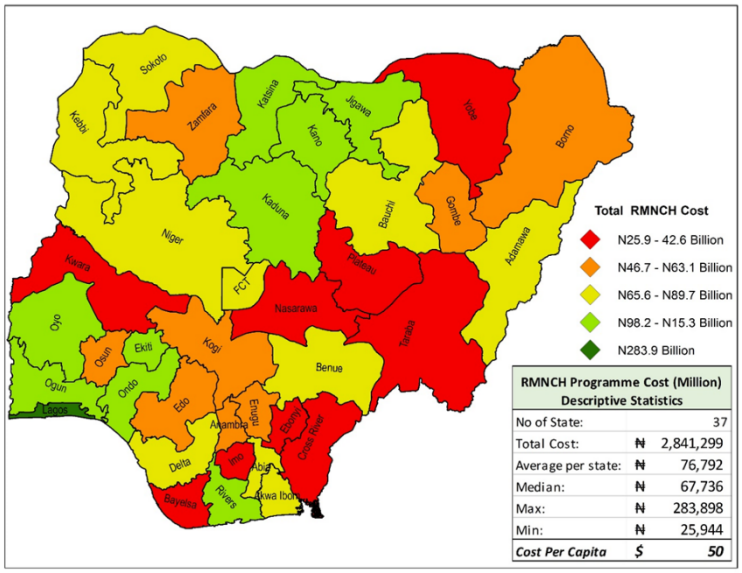
The total cost aggregate for 36 states and FCT SHDP-II is ₦6.8tr. This estimate represents the cost for health services, health system and programme management investment proposed for the five years duration of the strategy. However, it is important to highlight that this estimate represent the total cost for moderate scenario as validated by most States and FCT. The analysis across the five-cost bands in figure 29 above, indicate that 14 States have cost estimate below the band with the average cost of ₦183.4b. Lagos State has the largest planned sum of ₦606b, across the health sector. While States within the lowest cost band are Anambra, Bayelsa, Cross River, Ebonyi, Imo, Kwara, Plateau and Yobe.

However, when per capita spending on health is compared across the 36 State and FCT, Abia, Ekiti, Katsina and Ondo State recorded between $35 and $48 as the largest allocation per capita over the planned period. This estimate still falls short of the estimated average spending need of $54[69] in low income countries to provide a basic package of essential health services. Moreover, recent studies by WHO suggests that Low-and Middle-Income Countries on average would need to spend an additional $58 or a total of $146, by 2030[70], if planning is to attain the health SDGs.

[69] Taskforce on Innovative Health Financing for Health Systems (2009), *Working Group 1 Report: Constraints to Scaling Up and Costs*.

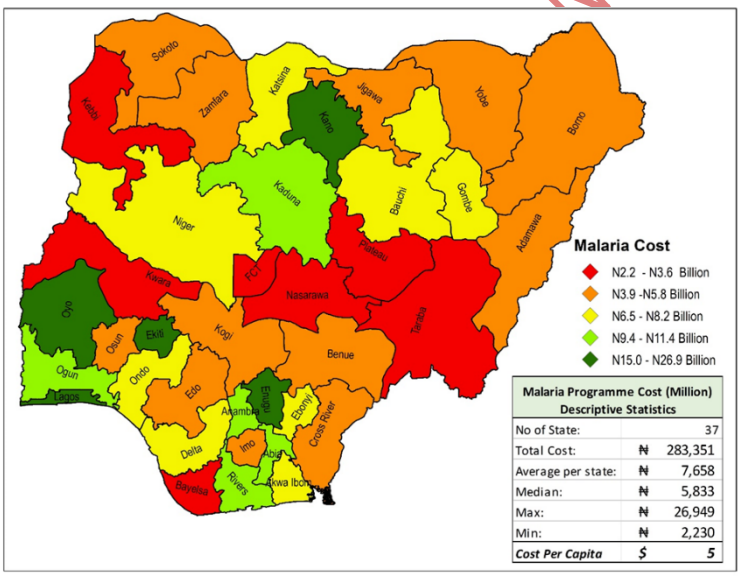
[70] Financing transformative health systems towards achievement of the health Sustainable Development Goals: a model for projected resource needs in 67 low-income and middle-income countries www.thelancet.com/lancetgh, Published online July 17, 2017, http://dx.doi.org/10.1016/S2214-109X(17)30263-2

Figure 30: Distribution of the RMNCAH+N Total Cost across the 36 States and FCT



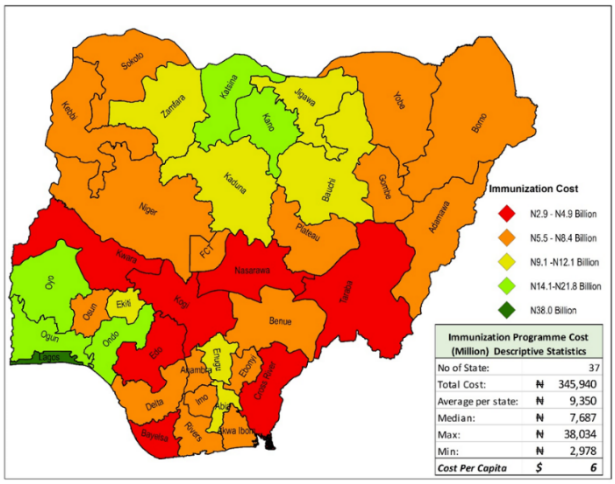
Across the 36 States and FCT, planned investments in Reproductive Health, Maternal, Neo-Natal, Nutrition, Child and Adolescent is estimated at ₦2.8t. Analysis of planned investment on RMNCAH+N for 36 States and FCT is presented. Prioritized interventions across States within this program area includes; (a) Family Planning _ improving CPR and attaining 75% modern method mix, (b) increased coverage with Skilled Birth Attendant (SBA) at delivery, (c) EmOC services, management of diarrheal diseases, respiratory tract infections, pre-natal, infant and young children nutrition, and services targeting adolescent health. From figure 30, seventeen States allocated sums more than national average of ₦76b. States within the band of the lowest allocation (₦25b-₦42.6b) includes Bayelsa, Cross River, Ebonyi, Imo, Kwara, Nasarrawa, Plateau, Taraba, and Yobe.

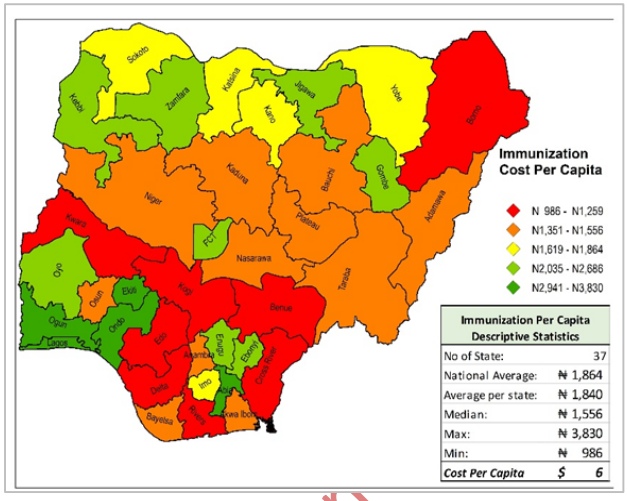
Figure 31: Distribution of Malaria Total Cost across the 36 States and FCT



The total cost of malaria intervention is estimated as ₦283b. Interventions prioritized includes distribution of ITN, IRS, IPT for pregnant women, Malaria case management for children 5-14 years and adult. Nineteen States planned below the national average of ₦7.6b. States within the highest cost band (₦15b – ₦26.9b) include; Ekiti, Enugu, Kano, Lagos and Oyo.

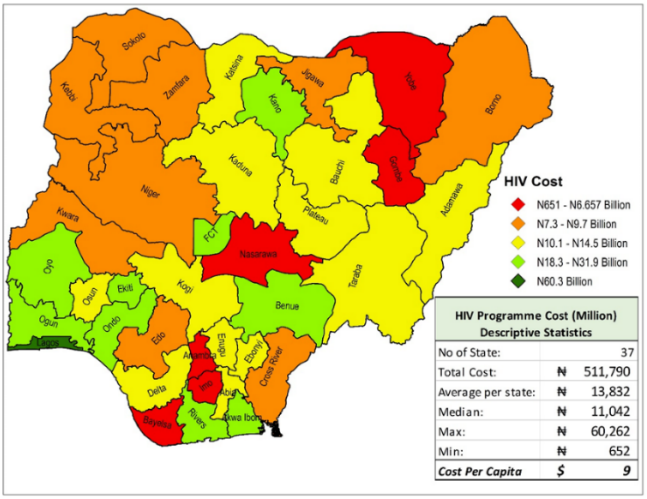
Figure 32: Distribution of the Immunization Total Cost and Cost Per Capita across the 36 States and FCT

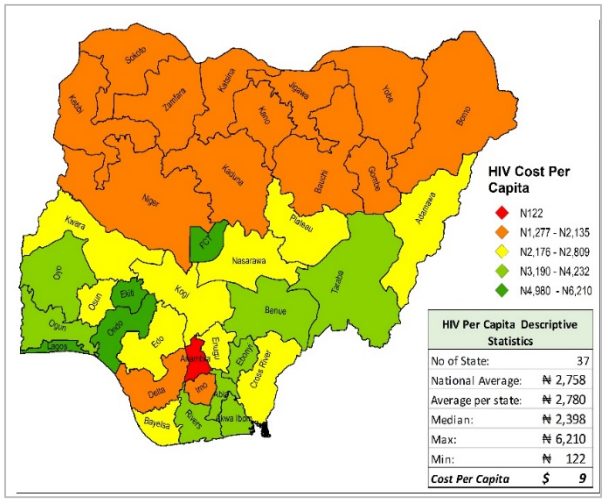




Immunization investment prioritized across the 36 States and FCT includes; increased vaccine coverage for Measles, DPT-3, Polio, HiB, BCG, Hepatitis B, targeting under 5s. A total sum of ₦346b was planned for the five years duration of the strategy. 24 States have cost estimate below the national average of ₦9.4b, while the States within the national average cost band (₦9b - ₦12b) are Abia, Bauchi, Ekiti, Enugu, Jigawa, Kaduna and Zamfara.

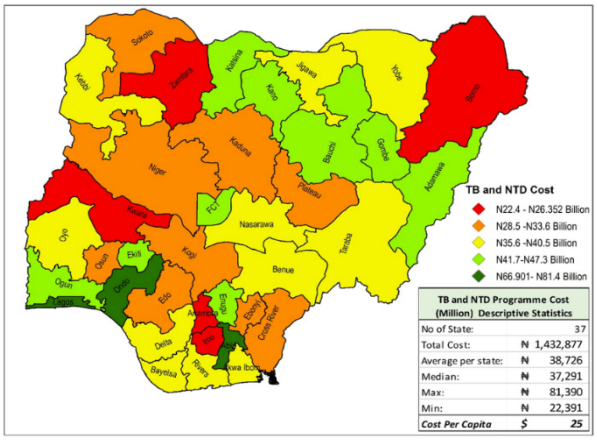
Figure 33: Distribution of the HIV Total Cost and Cost Per Capita across the 36 States and FCT

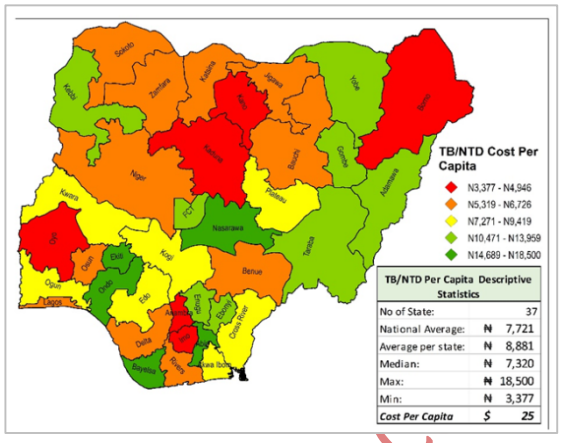




Over the next five years, HIV/AIDs interventions have been planned for prevention, treatment and care services. These interventions include; ART for Women and Men, PMTCT, PEP, and Paediatric ART. Total resource planned for HIV/AIDS is ₦512b to address interventions across the 36 States and FCT. Analysis of the HIV cost across the 36 State and FCT indicates that 15 States fall below the average cost band (₦10b - ₦14b).

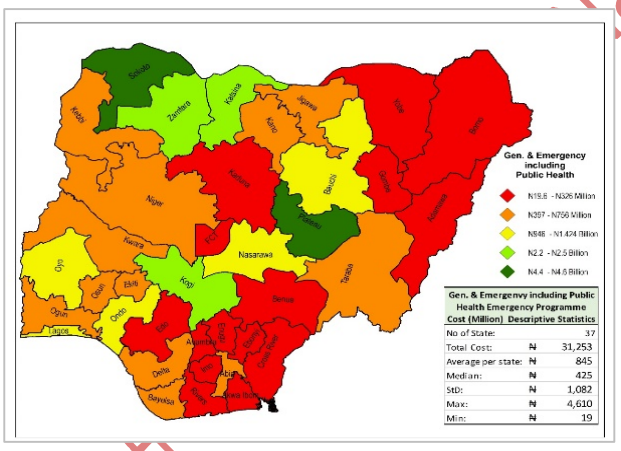
Figure 34: Distribution of TB/NTD Total Cost and Cost Per Capita across 36 States and FCT

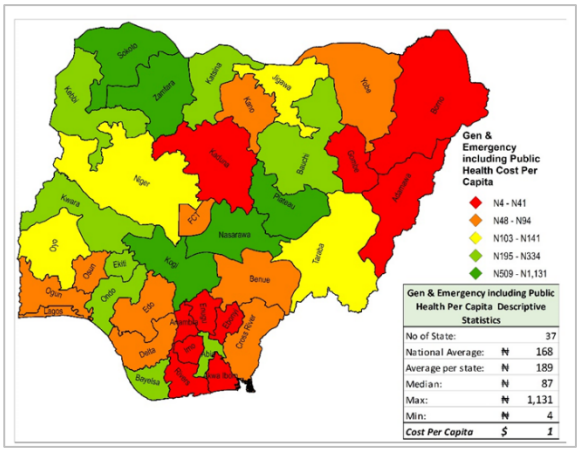




Areas costed under TB include TB diagnosis (microscopy, x-ray, and Xpert), treatment (first-line, MDR and XDR), and support. Provisions have also been made to cover collaborative TB and HIV/AIDS interventions costs. The treatment, management and control of NTDs such as leprosy, rabies, and buruli ulcer have also been costed. The cumulative cost for TB and NTDs across all the states and the FCT stands at ₦1.43tr. The State's average cost is ₦38.7b, while the states with the highest financial investments in TB and NTDs are Abia, Lagos and Ondo with invesments ranging from ₦66.9b - ₦81b.

Figure 35: Distribution of Emergencies Medical Services Total Cost and Cost Per Capita Across the 36 States and FCT





A total of ₦31b has been planned for General and Emergency Services including Public Health Emergencies across the states and the FCT over the 5 year period. This is needed to ensure equitable and effective medical and laboratory services.

Another component prioritized for funding is Public Health Emergencies required to reduce the occurrences and impacts of epidemics. The States with the highest investments are Plateau and Sokoto with ₦4.4b - ₦4.6b.

9.7 Sustainability/Financing Gap Analysis

In this section, the two scaled scenarios of the harmonized National SHDP II plan are subjected to a financial sustainability analysis to compare the costs and the available funding including the affordability of the plan. This assessment will enable the National Council on Health (NCH) to decide on which scenario to adopt and determine whether there is need to scale down the adopted scenario. More so, at what point in the planning horizon this should be done.

In Nigeria, health care is resourced by the following actors; government, development partner contributions, private sector, and household out-of-pocket. Government funding at federal and state levels are derived from three sources: budget allocation, earmark from consolidated revenue funds (CRF) and mandatory state health insurance (or contributory) schemes.

With Government's commitments established, a 5 year forward looking resource mapping was undertaken as part of the NSHDP II development process. This exercise covered actors across the entire health sector with emphasis on funding commitment from the following sources; Bilateral, Multilateral and Development Partners. Data was collected on resources available for a minimum of 3years; 2018 to 2020 disaggregated by State and FCT.

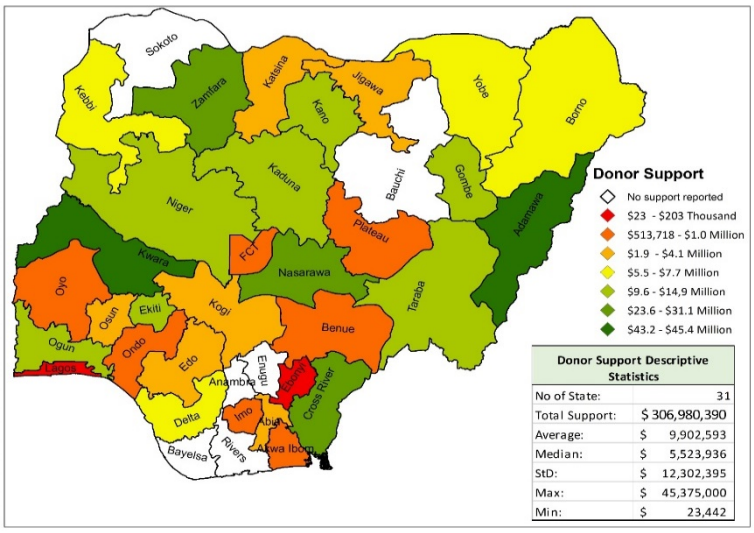
Estimates of partner support captured in table 17 below were generated from the different states where implementation is currently ongoing. These values should be interpreted with caution, as it may not have sufficiently captured all the in-country commitments of these partners.

Table 17: Health sector resource map for 2018-2022

Financial Sustainability Analysis of Nigeria-National SHDP II 2018-2022 Essential Package Moderate Scale-up Scenario, in Million($)						
Sources of Funds	**2018**	**2019**	**2020**	**2021**	**2022**	**TOTAL**
Fed Govt. Health Allocation	$ 845.3	$ 865.6	$ 886.1	$ 906.7	$ 927.2	$ 4430.8
36 State Govt Health Budget & FCT	$ 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/AusAID	$ 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 Environ Fund	-	$ 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
HSDF	$ 0.0	$ 0.0	$ 0.0	-	-	$ 0.0

Financial Sustainability Analysis of Nigeria-National SHDP II 2018-2022 Essential Package Moderate Scale-up Scenario, in Million($)						
Sources of Funds	**2018**	**2019**	**2020**	**2021**	**2022**	**TOTAL**
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
Fed Govt. 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
Malaria Consortium	-	-	-	-	-	-
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 N/SHDP II Plan Moderate Scenario	**$ 3,103.9**	**$ 3,564.6**	**$ 4,000.5**	**$ 4,344.1**	**$ 4,893.3**	**$ 19,906.5**
Resource Gap for Moderate Scenario	**$ 383**	**$ 708**	**$ 1,233**	**$ 1,995**	**$ 2,494**	**$ 6,813**
% of Resource Gap for Moderate Scenario	12.3%	19.9%	30.8%	45.9%	51.0%	**34.2%**
Cost of N/SHDP II Plan 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**
% of Resource Gap for Aggressive Scenario	25.6%	36.2%	43.4%	54.0%	59.1%	**45.4%**

Figure 36: Distribution of International and Domestic Resource across 36 States and FCT



From table 17 above, $11.8B was mapped as domestic resources and development assistance available to support the implementation of the plan. Projected commitments of the Federal and 36 States including FCT accounted for 37% and 59% of this amount respectively. $1.8B was mapped as Development Partners commitments. Of this amount, $0.31B was reported as resource commitments by the 36 States and FCT. The outstanding amount has been captured centrally from the partners.

According to figure 36, commitments of Development Partner assistance across 36 States and FCT, was reported for only 31 States as no data was available on partner support in Anambra, Bauchi, Bayelsa, Enugu, Rivers and Sokoto States.

From the sustainability analysis presented in table 17, the resource gap for moderate and aggressive scenario was reported as 36% and 51% respectively. To achieve either PHC revitalization agenda or UHC modelled in the moderate or aggressive scenario respectively, a critical review of the financial space is required. As the country recovers from the 2016-2017 recession, an assumption that growth in General Government Health Expenditure as a proportion of GDP would significantly increase over the next five years to support the implementation of the plan is rather uncertain. More so, recent trends in government allocation to health over the last five years have fallen below the recommended 15%[71] budgetary allocation to the health sector. On the other hand, the persistent decline in development assistance has further narrowed the financial space available to resource the plan. Considering low revenue-generating capacity, low prioritization of health and other constraining factors including the fragile economy occasioned by recession, adopting the aggressive scenario may appear ambitious. Consequently, the moderate scenario estimated at $34 per capita with a funding gap of 36% presents a more sustainable and realistic financial pathway to implementing the plan especially when considering the system constraints e.g., the health work force gap

9.8 Bridging the Resource Gap

With the adoption of the moderate scenario as the cost of the strategy, mobilizing sufficient resources for its implementation becomes imperative. A starting point would be to advocate for an increase in the General Government Health Expenditure (GGHE) which currently stands at 5.1% of General Government Expenditure (GGE). To this end, government is expected to increase the current 5.4% budgetary allocation to health towards the attainment of the 15% benchmark. While it is understood that government's allocation may not sufficiently address the funding need of the strategy, the large share of out-of-pocket payments (71.5%)[72] reported for the Total Health Expenditure (THE) estimate of ₦3,935B in national health account is equally unacceptable, especially as it exacerbates the financial risk of beneficiaries to health services. Consequently, adopting pooled and prepaid private financing presents a more-desirable opportunity to mobilize adequate resource, as well as reduce the burden of the out-of-pocket payments to finance the strategy.

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 operationalized their schemes. When fully operational, States are expected to contribute between 0.5 - 1% of their Consolidated Revenue Fund (CRF) as statutory allocation to the State Health Insurance/Contributory Scheme, while growing the subscriber base. Another domestic resource, potentially available to fund the national strategy is the allocation from the basic healthcare provision fund (BHCPF) of the National Health Act (NHAct). As stipulated in the National Health Act, the Federal Government is expected to allocate at least 1% of the Federal Consolidated Revenue Fund (CRF) for the coverage of basic minimum package of health services, and PHC operational costs (HRH, medicines, infrastructure, transport), and public emergency services.

[71] In 2001 the African Union held a special summit on AIDS in the Nigerian capital Abuja. The resulting Abuja Declaration, among other commitments, called for African countries to spend 15% of their public budgets on health.
[72] Nigeria National Health Account (NHA) 2016

In determining the financial space available for NSHDP II implementation, three funding options have been modeled, 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. The contribution of partner commitment estimated at $1.8B over the planned period of the strategy
2. Federal, 36 States and FCT allocation to health increased by a mean value of 4% towards the attainment of the Abuja declaration
3. The combined annual allocation to the 36 States and the FCT estimated at ₦60.8B to be allocated through NHIS and NPHCDA from the basic health care provision funds
4. The combined annual deduction of 0.75% from state's and FCT consolidated revenue fund in support of the state health insurance scheme
5. Finally, the premium of subscribers estimated at ₦12,000 (₦1,000per month) as the scheme is brought to scale by 2022

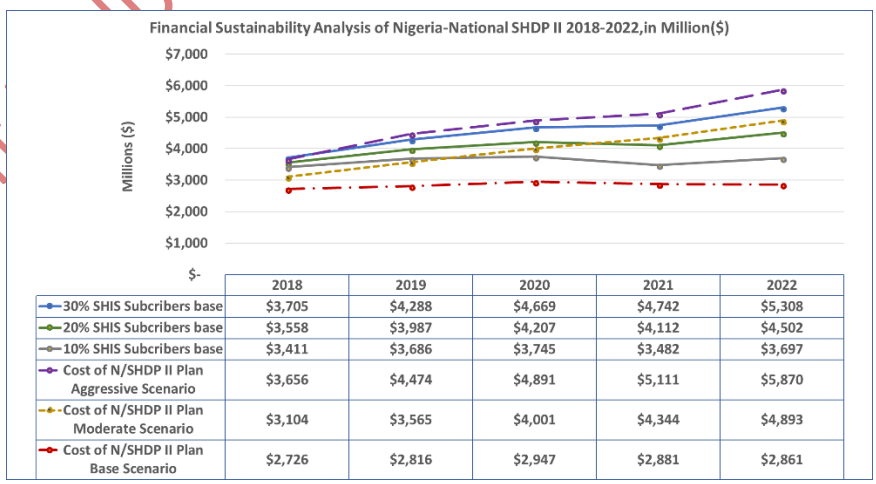
As previously established, 80% of the States have initiated action to operationalize their social health insurance scheme. The assumption also posits that a number of the States would desire to bring their schemes to scale by 2022. In the options presented below, three funding alternatives have been modeled to demonstrate the amount of resources acruable through the implementation of the strategy by varying the targets of the health insurance subscriber base as follows.

Funding option one: (***attaining 10% Health Insurance Subcribers base***), Subscriber base for this option 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: (***attaining 20% Health Insurance Subcribers base***), Subscriber base for this option 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: (***attaining 30% Health Insurance Subcribers base***), Subscriber base for this option was scaled to 30% using the linear year-on-year interpolate as NSHDP II implementation approaches the target year of the plan.

Figure 37 Financial sustainability analysis of Nigeria-National SHDP II 2018-2022, in Millions ($)



	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

From the model presented in figure 37, the recommended moderate scenario was the only scaled policy scenario sufficiently resourced by at least one of the proposed funding options; that is the option with the social health insurance subscriber base scaled to 30%. The first and second funding options was only able to support the implementation for two years, that is 2018 and 2019. 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 abysmal fiscal discipline associated with the tiers of government poses a significant threat to the success of the plan. For this plan to be resourced by any of the options highlighted above, a mean budget performance of 75% across 36 States, FCT and Federal MDA must be achieved.

Development Assistance and other reported contributions make up only 15% of the total sum of this funding option, thus necessitating the need to adopt innovative strategies for mobilizing the domestic resources posited for this funding option. It is imperative for government to strengthen resource mobilization mechanisms aimed at expanding the fiscal space for health and guarantee allocative efficiency of existing resources. Other potentially viable sources not sufficiently captured in the resource envelope for this funding option that should be engaged as part of the implementation strategy include organized private sector, philanthropy and informal sector.

9.9 Conclusions and Recommendations

In conclusion the National SHDP II 2018-2022 moderate scenario was estimated at the sum of ₦ 6,071B over the five-year period of the plan as the preferred policy scenario with an estimated funding gap of 34%. At mean cost per capita of ₦10,342 ($32), the moderate essential package scenario is expected to achieve the following mortality outcomes:

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

As government at all levels undertake to implement the NSHDP II, it is important to ensure adherence to the resource mobilization assumptions posited for the recommended funding option which entails increasing health insurance subscriber base from 5% in 2018 to 30% by 2022. Other assumptions to ensure that the plan is adequately implemented include the following:

i. All development partners' interests be aligned with this strategy and their resource commitments aligned to the priority interventions. This alignment will also reduce duplication of programs and improve allocative efficiency.
ii. It is important that a comprehensive list of interventions per program with baseline and targets generated in the course of the costing are continuously tracked and monitored and regularly updated during the entire period of the plan.
iii. Effort should be made to conduct regular health facility and inventory assessments in both private and public sectors to have real-time access to much needed data on human resources, infrastructure and logistics.
iv. Performance-based resource allocation needs to be strengthened in order to maximize the impact of available resources. it is recommended that each program develop Value-for-Money (VfM) indicators guided by an overall VfM framework to guide efficient and effective delivery.

v. A standardized costing guideline to support subsequent efforts to estimate national and subnational strategies.

Chapter 10

Institutional Arrangements

The second National Strategic Health Development Plan (NSHDP II) is a key document developed in accordance with the policy thrust, goals and aspirations of the Nigerian Government for health care delivery and development. The plan articulates actions and strategies to strengthen the national health system and provide guidance for the implementation of health care programmes and services across the nation for the next five years. The NSHDP II shall serve as the key instrument for collective mobilization for action by all stakeholders because it provides roadmap for pursuing the vision, goals and objectives of the Nigerian health sector.

The NSHDP II has been designed to ensure provision of essential and specialized care that is commensurate with the various levels of care and needs across the system. It seeks to address inherent and emerging issues that include inequities and disparities that hinder availability, accessibility and affordability of health care services across the nation. In line with the provisions of the 2016 National Health Policy, (NHP) and the NHAct, the NSHDP II is designed to deliver interventions targeted at addressing current weaknesses in the health system for the delivery of improved scope and quality of health services within the constraints of the country's financial resources.

The NSHDP II is a flexible, living document designed to address the national health and system priorities. It gives strategic direction for collective action by the Nigerian health system and its partners to achieve the vision and goal of the health sector, promote and protect health for all, eliminate health inequalities, and generally transform the health system. The plan is linked to the new Economic Recovery and Growth Plan (ERGP), the Vision 20:2020 and represents the national health policy goals and priorities as in the National Health Policy. The plan is aligned with the Federal Government's health agenda of improving the availability, accessibility, affordability and quality of health services by increasing access to primary health care services, expanding health coverage and improving the quality of the services provided in both public and private health sectors.

Given the current challenges, weaknesses and threats of the Nigerian health system, deliberate and clear mechanisms have been planned to ensure effective return on investments, particularly better health outcomes for the entire population. In this regard, it was necessary to clearly define and clarify key elements and parameters that can significantly affect the successful implementation of the plan. In order to ensure a steady progress towards the targets, it was necessary to proactively drive the process of implementation through dedicated, systematic and reformed institutional structures at all levels. This chapter is focused on defining the roles and responsibilities of these institutional arrangements, and how they relate and interface with each other to ensure seamless and synergistic implementation of the

NSHDP II. The institutional arrangements for a scale- up and improvement of primary health care delivery across the country have been elaborated in subsequent sections of this chapter in order to realise PHC revitalization which is a key objective of the NSHDP II.

10.1 National and Sub-National (LGA and Community) Institutional Structures

The implementation of the NSHDP II is the responsibility of the authorities at the three distinct levels of the health care delivery system – Federal, State and LGA, in collaboration with all the stakeholders in health: the private sector, development partner agencies, Civil Society Organizations (CSOs), including, Faith Based Organizations (FBOs) and Communities. The leadership for the implementation of the NSHDP II at each level will be provided by the responsible authority – Federal Ministry of Health (FMOH) at Federal Level, State Ministry of Health (SMOH) at the State Level, and Local Government Health Authority (LGHA) at the Local Government Level.

At the Federal level, the FMOH shall coordinate, supervise and provide technical oversight for the implementation of the NSHDP II in conjunction with its departments, agencies and inter-related parastatals. 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 platforms and mechanisms including resource mobilization and management, periodic performance review mechanism and oversight of implementation activities. The Minister shall have the responsibility of reporting progress towards targets to the National Council on Health.

At the state level, implementation shall be managed and reported to the State Council on Health (SCH) by the Honourable Commissioner for Health. The health MDAs at the federal and state levels as well as the Local Governments shall be responsible for implementation of the State Strategic Plan as well as related health issues that are emerging, re-emerging or concurrent in nature. The required ratification, approvals and final policy decisions granted within the timeline stipulated for the defined interventions will be provided through various health sector governance and stewardship instruments specified in the National Health Policy (NHP), the National Health Act (NHA), and other national and international development policies (e.g. IHR, Paris Declaration on Aid Effectiveness, UHC2030 etc.).

The private sector will be actively involved and engaged, through public-private-partnership (PPP) arrangements within the framework of the NSHDP II, as well as through coordination and consultative forums as planned. The private sector actors, institutions and bodies, whether for profit or not-for-profit, working in the health system or providing healthcare services will form an integral part of the delivery and implementation processes through their membership of relevant working groups and stakeholder platforms established to promote private sector participation.

At the community level, the Ward Development Committees (WDCs), Facility Health Committees (FHCs), CBOs, CSOs and other relevant platforms, have a key responsibility of ensuring that healthcare reaches the grassroots level including holding government responsible and advocating for UHC across board. Their active participation across all levels

of the NSHDP II development – planning, implementation, monitoring and evaluation – essentially promotes ownership of planned interventions and activities with potential for sustainability.

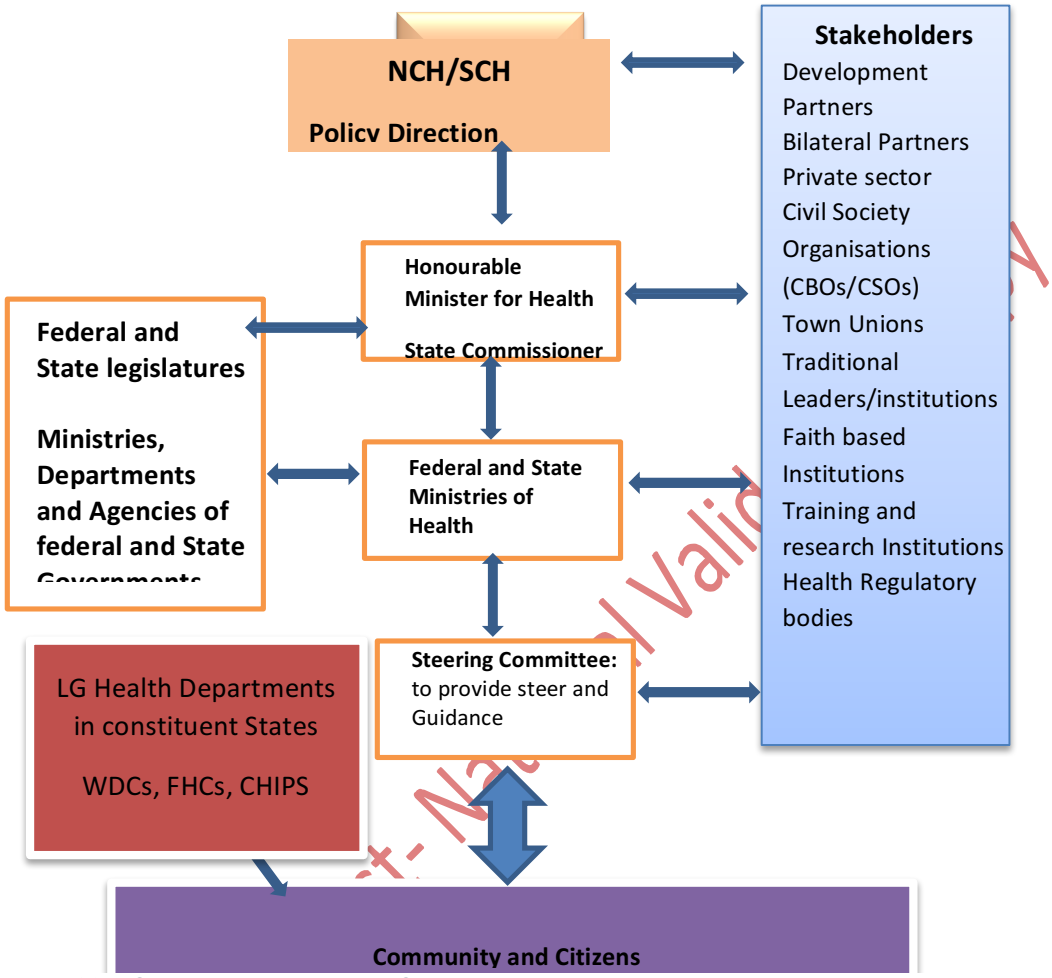


Figure 38: NSHDP II Implementation Governance

10.2 Strengthening Primary Health Care Delivery Services

The 2016 National Health Policy (NHP) recognizes and places premium on primary health care (PHC) as the medium and channel through which healthcare will be delivered to the Nigerian populace. The current NSHDP II plan has been designed with PHC as the fulcrum for its delivery. The facilities at this level form the entry point of the community into the health care system. They include health centers, health clinics and health posts, providing general, promotive, preventive, curative, rehabilitative and pre-referral care to the population.

At the Local government level, the Medical Officer of Health (MOH), gives leadership to health development. Local Government authorities were statutorily responsible for the financing and management of PHC facilities in the public sector as earlier captured in the 1988 NHP; however, resolution 29 of the 54th National Council on Health (NCH) meeting in May 2011

approved a framework for bringing Primary Health Care Under One Roof (PHCUOR). This reform is designed to improve Primary Health Care delivery by 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 Development Board. The PHCUOR was reinforced by the National Health Act of 2014, which empowers the States to establish State Primary Health Care Boards (SPHCB/A). The nine (9) pillars of PHCUOR are: Governance and Legislation, Minimum service package repositioning, System development, operational guidelines, human resources, funding sources and structure, community ownership, infrastructure and furniture. Funding for Primary Health Care in Nigeria is the mandate of the three tiers of Government of Nigeria (Federal, States and LGAs) while the management of PHC activities, LGA- Health authority, coordination of plans and budgets for PHC, Management of PHC Human resources are the responsibility of the State PHCDBs. The Board advises Commissioners for health and Local Governments in all matters concerning PHC activities.

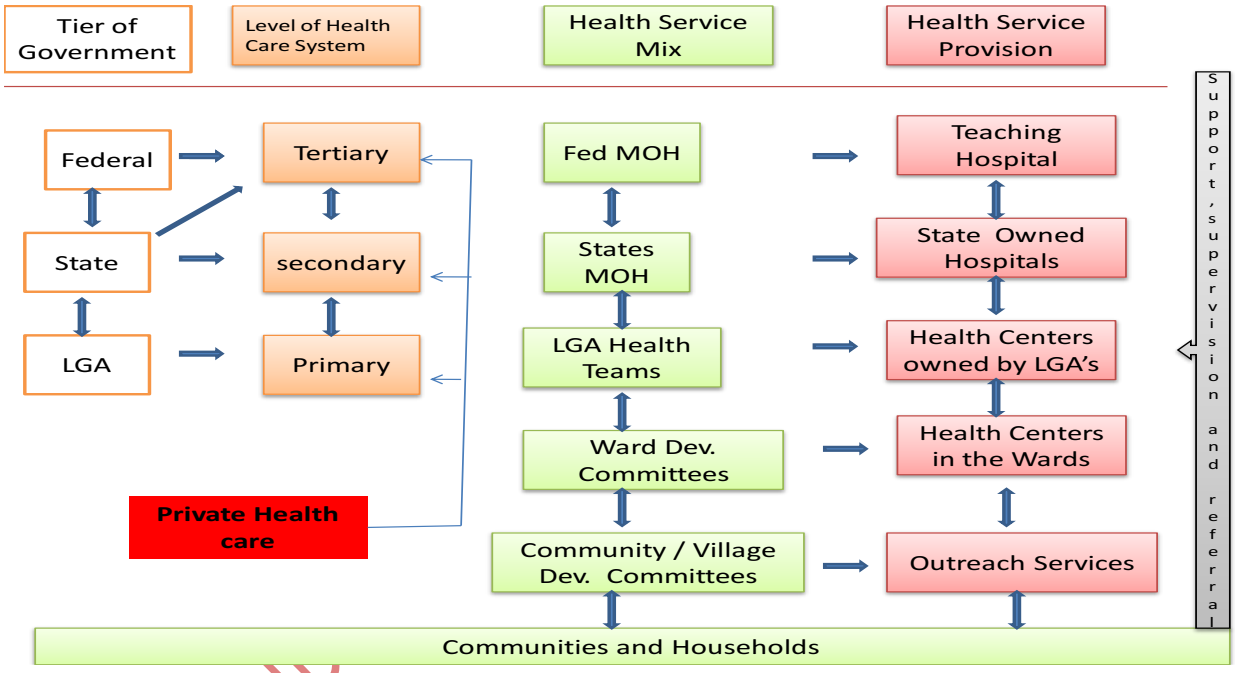


Figure 39: Interface of health care delivery system structures in Nigeria

Primary Health Care service delivery in Nigeria shall incorporate the following key elements:

1. Strengthening the LGA Health Systems
2. Providing comprehensive care in an integrated manner to the population of the LGA;
3. LGA Health Management Team (HMT) to organize and undertake core activities through the Essential Package of Care (EPC) at the household and community level in collaboration with existing ward health system structures.
4. Ward Development Committee (WDC) is an integral part of the ward health system and plays a major role in mobilizing support and resources for operationalizing the minimum health care package at the grass roots level.

5. Facility Health Team serves as the epi-center of delivery of basic health care services including coordination of outreaches and other community level activities on health.

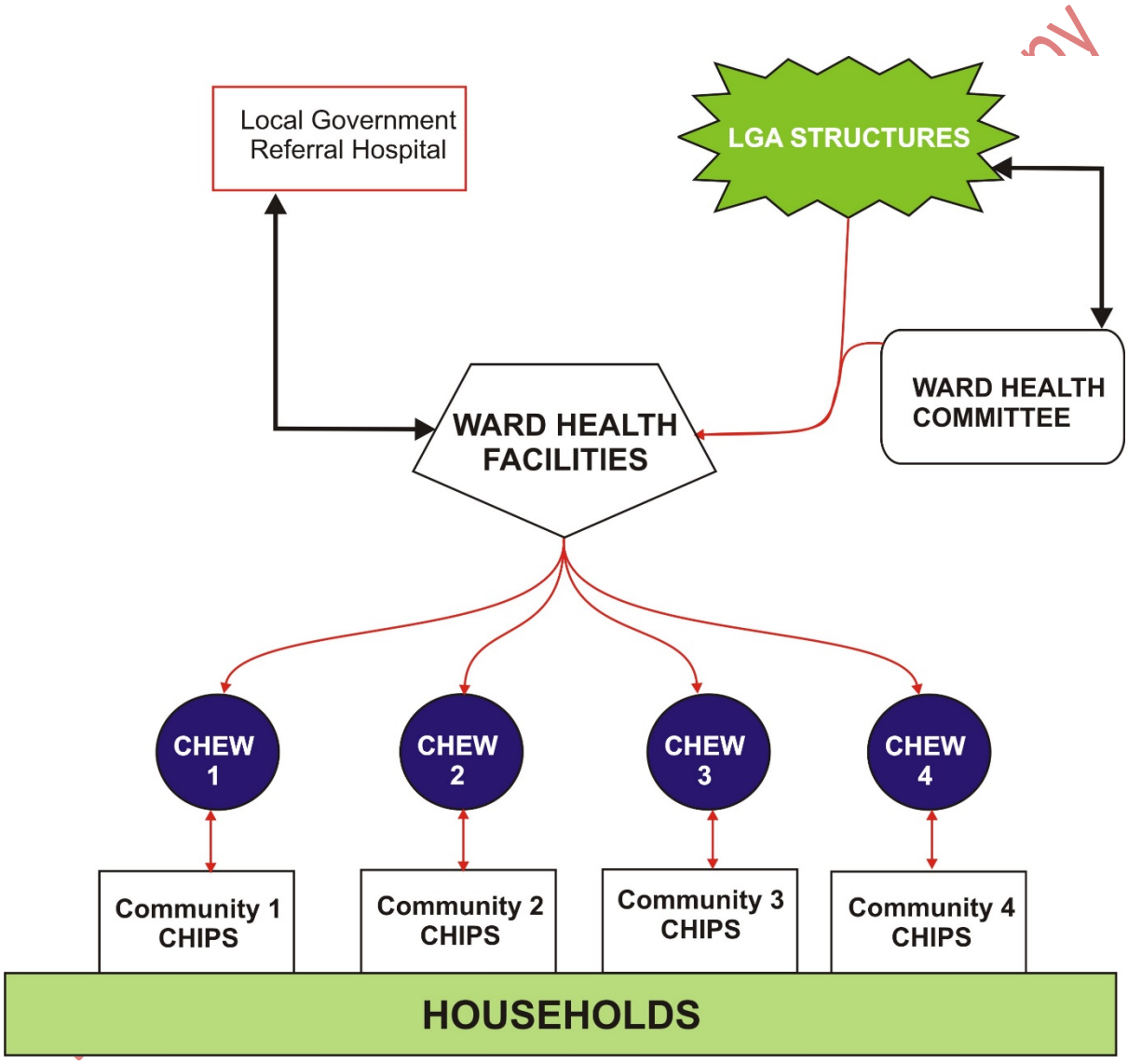


Figure 40: Organization and Planning of Primary Health Care service

Planning for delivery of health services

(i) LGA HMT should prepare operational plans annually in line with the National and State strategic health plans and based on the health situation analysis in the LGA, wards and communities; (ii) the health situation analysis should address issues related to the

operationality of the LGA health system, availability and utilization of health services, gaps in access to and quality of care and availability of human, financial and logistic resources; and (iii) Set targets in line with national and state strategic health plans to provide benchmarks for regular monitoring to assess the level of implementation of plans. This activity should be undertaken with support of the States' Primary Health Care Development Agencies.

10.3 NSHDP II Governance and Regulatory Framework

An N/SSHDP II implementation steering committee will be established at the Federal and State levels to oversight implementation of the plan. The steering committee will be chaired by the Honourable Minister of Health, the Honourable Commissioners for Health at the State Level and the Chairmen of the Local Government Areas and relevant members of the Health Management Team. It shall have representatives from the relevant departments/Units at the FMOH, SMOH and LGA Health Departments, representatives of the Planning Commission Ministries, Ministries of Finance at all levels, and relevant development partner agencies. The committee will be responsible for catalyzing the implementation of the plans at each of the levels; mobilizing government support for implementation through advocacy, planning and implementation; resource mobilization, awareness creation and engagement of all stakeholders that are crucial to the implementation of the plans.

i.) **Operational Plans**

The Federal, State and LGAs will extract strategic activities from their N/SSHDPs II, to develop their MTEF and annual operational plans. 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 the Federal, State and LGAs to develop plans with realistic costing and stakeholder participation in facilitating the implementation. It is the responsibility of the Departments of Planning Research and Statistics (DPRS) at all levels to ensure that these plans are developed annually and monitor their implementation using suitable tools that measure results/targets of the strategic plans.

ii.) **Resources**

The implementation of the national and state strategic plans will require budgetary allocation to the health sector and resource mobilization from other sources. The implementation of the NSHDP II or SHDPII at federal and state levels will also require committed human, financial and material resources. Dedicated resources are required to: facilitate the meetings of the steering committee; and to strengthen the DPRS at all levels of planning and monitoring; and reporting on progress and implementation of the M&E plan. Core technical staff will be identified in the DPRS at each level; they will be empowered with necessary skills in planning and monitoring and evaluation tools and processes. The SHDPII implementation steering committee is responsible for identifying and mobilizing resources from governments, development partner agencies, private sector and the diaspora. Resource mobilization and allocation will be directed towards addressing the health sector priority interventions to achieve the vision and goal of the strategic plans.

iii.) **Managing implementation**

The Honourable Minister of Health and the Commissioners for Health of the federal and state Ministries of Health shall be responsible for the overall management of the respective strategic

plans. The SHDPII implementation steering committee and the DPRS at each level will be responsible for managing the implementation of the SHDPIIs. Managing implementation of the SHDPIIs will require provision of technical assistance (TA) for development of operational plans where necessary; orientation of all stakeholders on the plan and required actions and responsibilities for achieving the targets of the plan; review of progress and feedback.

10.4 Strategic Partnerships and Inter-Sectoral Collaboration

Many of the planned interventions and activities in the NSHDP II would require inter-sectoral and multi-sectoral collaborations. The Nigerian health sector is richly endowed with a wide range of stakeholders at both public and private levels. These actors and stakeholders will need to continually partner and collaborate with each other, leverage their comparative strengths and advantages to pool resources and create synergy in health care delivery of Nigeria.

10.4.1 Roles and Responsibilities of stakeholders

The roles and responsibilities of the principal actors and stakeholders involved in the implementation of the NSHDP II have been identified in the planning framework and implementation strategy. Strict compliance and adherence to the stated roles and responsibilities by all actors and stakeholders is imperative to achieving the desired goals and strategic objectives.

The FMOH will periodically review the overall progress of the implementation of the NSHDPII and feedback to all the states highlighting their progress towards achieving set targets. All governments at all levels shall be committed to delivering on key results and targets of the NSHDPII, thus facilitate accountability, provide information and institute a reward system that will enable healthy competition among the States. The development partner agencies, CSOs and media will be closely involved in this process.

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 NSHDP II, and the SHDP II at Federal, State and LGA levels.

All development partner agencies in health will engage with responsible authority at respective levels to support implementation of the NSHDP and F/SHDPIIs, especially in providing technical support and building the capacity of the implementation teams at all levels of planning, monitoring and evaluating the progress of the implementation strategies among others. They will provide financial support for the implementation of the SHDPs.

10.5 Risks and Assumptions

A number of risks considered as having the potential of adversely affecting the implementation of the NSHDP II were identified during documents review and also during brainstorming on issues likely to impede the implementation of the plan.

Risks

- Poor economic growth limiting government allocation to the health sector

- Unpredictable donor funding
- High rates of unemployment, embargo on employment
- Rising poverty levels
- Changes in political leadership may result in changing priorities
- Increasing insecurity and escalating clashes expanding the scope and scale of humanitarian crisis in the country
- Rapid spread of emerging and re-emerging diseases
- Poor vertical and horizontal coordination within the health sector resulting in poor harmonization, alignment and integration of services
- Poor community participation

The strategies to address the risks within our control have been mainstreamed into the document. These have been pulled into Appendix 5

10.6 Communication Plan

A clear communication strategy and guide to complement the NSHDP II plan document has the main aim of deepening the understanding, building consensus, securing the buy-in, building a robust knowledge base, and providing needed support for relevant stakeholders and the public on quality healthcare delivery in Nigeria. It builds on timeliness and accuracy of information generated and transmitted through channels appropriate for various levels of care, and targeting diverse beneficiary groups or audiences. For this to be efficiently done, care must be taken to plan and analyse 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 and mainstreamed throughout the five-year plan period, will continually be updated in line with findings emanating from routine monitoring, supervision, evaluation and review processes. The communication strategy, just like the NSHDP II, is a living entity that will continually be revisited and/or updated to address emerging and re-emerging issues that have the potential of affecting the smooth implementation of the 5-year plan. To this end, the delivery will be done through a phased-approach and in line with the timing specified for the various planned interventions of the NSHDP II since not all communication needs will need to be accommodated at the beginning of the five-year period. The communication platform will also be used to connect the various strands and tiers of the health care delivery system comprising of the federal, state, LGA and community levels including public and private sector constituent stakeholder groups with focus on intra and inter-sectoral collaborations. Besides, this communication plan will provide additional means of enhancing health sector coordination efforts at all levels for the next five years through heightened information sharing, knowledge management and dissemination.
The quality of the leadership and management of implementation in the context of clarified roles and relationships of the various implementing bodies will significantly impact the quality and progress that can be recorded in the implementation of the NHSP II within the plan period.

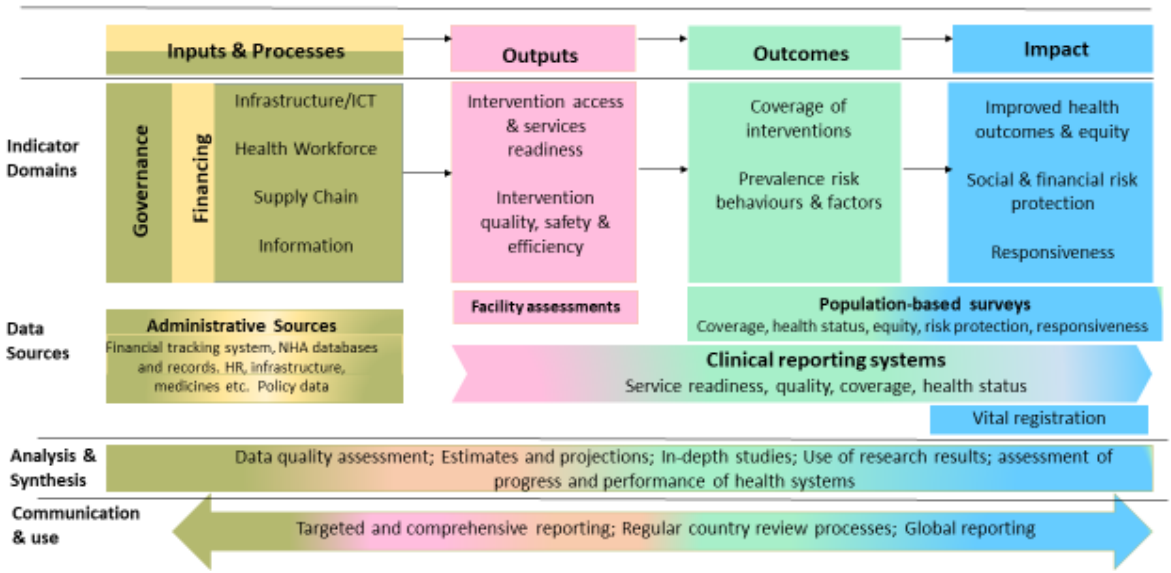
Chapter 11

Monitoring and Evaluation Arrangement

The Monitoring and Evaluation (M&E) framework, which is an integral part of the NSHDP II, builds on the existing M&E system with overarching principles of integration, simplification, and standardization. The detailed M&E plan is a free stand-alone document while this section is an overview. This M&E plan will be used 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, organizing plans for data collection, data quality, analysis, and use. In addition, as an effective information sharing and communication tool among stakeholders and project managers, the M&E plan outlines specific strategies and tools to encourage informed decision-making.

The framework for tracking progress of the NSHDP II implementation is based on the M&E logic model, which comprises of input, process, output, outcome and impact (Figure 41). Indicators have been developed for each level of measurement in line with the model. The data sources include administrative, reports of facility assessments, population-based surveys and other reporting systems across all levels. Quality assurance will be mainstreamed using different approaches that provide evidence for the best strategy in delivering the various interventions specified in NSHDP II. The M&E plan will also provide the basis for assessing progress and performance. The results of the interventions will be communicated using different media and platform appropriate for diverse audience and stakeholder groups. This will make for an enhanced decision-making process at all levels.

Figure 41: Logic Model for Monitoring and Evaluating Health Systems Strengthening



For this Strategic Plan, there are some global and national core indicators that will be tracked nationally while input and output indicators may vary at state level, because they are informed by the activities generated. These input and output indicators will be determined at state level.

The M&E system will strengthen the quality of health service through provision of information to individuals, families and communities for informed choices. It also focuses on providing information to health workers across organizational boundaries and continuum of care.

11.1 Monitoring Plan

The NSHDP II will be monitored for performance, using indicators reflecting on the following:

- Universal Health Coverage (UHC)
- Inequities
- Quality of Care (QOC)
- Primary Health Care (PHC) coverage
- Financial Risk Protection

This monitoring will be achieved through collection, collation, analysis, interpretation and dissemination of data using standardized tools. The selected core indicators are presented in Table 19. They are measured as rates (e.g.; Contraceptive Prevalence Rate), and proportions (e.g.; Proportion of women having essential ANC -formerly focused ANC, and % of children fully immunized under one year of age). In addition to measuring averages or aggregate levels of indicators, measures will be disaggregated by a range of factors such as demographic (i.e., age and sex), geographical (i.e., urban/rural and regional) and socio-economic (i.e. wealth and education), to provide information on equity. Specifically, the core equity indicators of % of deliveries by Skilled Birth Attendance will be disaggregated by geographical and socio-economic variables. The same approach will be applied to prevalence of malnutrition in children aged 0-59 months, prevalence of wasting, and stunting among under-fives, using in addition demographic variables for disaggregation. The % of health facilities providing general outpatient services appropriate for the level of care will be subjected to gender disaggregation.

Equity stratifiers that consist of two sub-groups (e.g., urban/rural, regional) will be compared by absolute values, reflecting the magnitude of difference in the health indicators between the sub-groups and ratios which reflect proportional differences in health among sub-groups. For equity stratifiers that consist of more than two sub-groups with natural ordering (i.e. wealth quintiles), complex measures are used to determine inequality across all subgroups: for example, the concentration index (visualized through the concentration curve) is a measure of relative inequality, expressing the disproportionate distribution of services.

Appraisal of this NSHDP II will include Joint Annual Reviews (JARs) which should be completed in time to ensure that the findings feed into the planning and budget process of the coming year. Review teams will be set up and deployed to support the States. Reviews at scheduled intervals such as daily, weekly and fortnightly will also be carried out at different levels, such as the Technical Working Group, facility and the community. Monitoring and supervisory visits, checks and observations are methods that will also be employed. Scorecards should also be utilized for tracking performance. Feedback should be provided. The policy thrust of the Federal Government is to provide health care for all, using the Universal Health Care strategy. This monitoring will therefore track equity. The NSHDP II should be able to commence the process of providing both nationally and globally relevant data, which is widely accessible, using different channels. Briefs, factsheets, bulletins and reports will be generated from the data analysis for appropriate audiences. These can be released monthly, quarterly, and annually. Bi-annual and annual performance reports will be

submitted to the relevant stakeholders, particularly to be presented to the National Council on Health.

11.2 Evaluation Plan

There is need to ensure health sector stewardship for overall sector budgeting, operational planning, implementation follow up and performance monitoring and evaluation. It is of utmost importance that timeline for budgeting, planning and reporting are aligned. This will ensure full implementation of each year's operational plan.

In situations where baseline data are not available, surveys will be carried out based on a schedule. Similar tools will be developed for mid-term (to review progress with implementation of the Plan by 2019) and end-term evaluation (to review final achievements). Where impact evaluation is required, this will be planned before the expiration of NSHDP II. The same indicators will be used to track performance, comparing rates and proportions and using equity stratifiers that are dichotomous (e.g. rural/urban) and multi-chotomous (e.g. wealth quintiles) as appropriate. The results will be used for strategic decision-making at all levels of the health system and the economy.

Table 18: Core Indicators to measure Universal Health Coverage

S/N	
	Health Services Coverage
1	Contraceptive Prevalence Rate
2	% of deliveries supervised by skilled birth attendants
3	Proportion of women having essential ANC (at least one visit, at least 8 visits)
4	% of primary/Ward Health centers providing basic emergency obstetric and neonatal care services disaggregated by level of care
5	Measles immunization coverage
7	TB case detection rate
8	Malaria prevalence in the general population
9	Prevalence of malaria in children under-five
10	Coverage of HIV Testing Services (HTS)
11	% of diagnosed PLHIV receiving HIV treatment services
12	% of diagnosed PLHIV on ARV who achieve sustained virological suppression
13	Mortality rate attributable to unsafe water, unsafe sanitation and lack of hygiene (WASH)
	Core Equity Indicators (equity gap generated by comparing disaggregated data by zones/states, place of residence and socio-economic parameters)- includes some impact indicators
14	% of deliveries by Skilled Birth Attendance
	% wards with of primary health care health centre providing Basic Emergency Obstetrics Care
15	Prevalence of acute malnutrition in children aged 0-59 months
16	Prevalence of wasting among under-fives
17	Prevalence of stunting among under-fives
18	Under five mortality rate
19	Infant mortality rate
20	Maternal mortality ratio
	Quality of Care (QOC)
21	% of Health facilities that report stock out of anti-malarial commodities, diagnostic kits lasting more than one week in the past three months
22	% of all health facilities (public and private) generating and transmitting routine HMIS data by 2022

23	Client satisfaction level
24	Proportion of Secondary/Tertiary hospitals with functional ambulance services
	PHC coverage & Referral
25	% of Wards in the country with at least one fully functional PHC centre providing comprehensive primary health care services in line with essential services package
26	% of the LGAs that have functional general hospitals for referral from PHCs
27	% of Primary/Ward Health Centers providing basic Emergency Obstetric and neonatal care services disaggregated by Level of care
	Financial Risk Protection
28	% of Nigerian population covered by any risk protection mechanism
29	Number of states that have established functional state health insurance schemes

11.3 Data Collection Plan and Management

The National Health Management Information System had been strengthened through such platforms as the DHIS 2.0, which is web based and allows for real time data entry and access from any part of the world. Data from both public and private sectors need to be gathered to provide a full picture of health system performance. Since many determinants of health are found outside the health system (i.e. education, road infrastructure, water and sanitation), it is crucial to harness data from other sectors and promote the use of inter-operable data platforms.

Multiple data sources will be used in the M&E framework. These sources will include:

- Routine administrative sources (such as the Health Management Information System)
- Surveys
- Household surveys such as the Demographic Health Survey,
- Multiple Indicator Cluster Survey (MICS), MIS, EPI coverage survey, NHA,
- Health-facility surveys (such as Service Provision Assessment – SPA+ and Service Availability and Readiness Assessment – SARA),
- Disease and behavioral surveillance,
- Civil registration and Vital statistics,
- Financial and Management Information,
- Censuses

The tools to be used include, patient records or registers, forms, worksheets, survey instruments, commodity management forms, etc. Information generated from data analyses should be warehoused properly for referencing and further analyses; and widely disseminated among stakeholders and other end-users. Additionally, there must be backups.

11.4 Data Quality Management Plan

Quality assurance which forms the bedrock of good systems, should be incorporated at the levels of data collection, collation, analysis and reporting. The issues affecting data quality have been a major challenge in the health sector. This will be addressed with the seriousness it deserves for the NSHDP II to meet its set targets and objectives of improving the health status of the Nigerian people. Identifying and managing potential risks to the quality of data

collected and information used is of utmost importance to success of implementation. Therefore, plans are to be made for ensuring quality of data through quality assurance and improvement strategies; such as Routine Data Quality Assessment, establishment of verification and feedback systems, harmonization and appropriate integration of all information sources.

Additionally, capacity building at all levels on data analysis and information use is essential. Technical factors (data-collection tools and processes and IT devices), organizational and behavioral factors will be properly addressed to ensure sustainable production and use of good quality information. Information from routine data sources such as HMIS and information reported from population based surveys such as DHS may have some discrepancies due to different methodologies implemented. This calls for caution in interpreting differences between DHS and HMIS estimates, and justifies the need for verification.

Appendices

Appendix 1: List of National Policy / Programme Documents

Table 19: Health Programmes, Policies in Nigeria considered in the development of the NSHDP II

Focal Area	Key Policy Documents
Health Financing	• Draft Health Financing Policy (2006)
Human Resources	• National Human Resources for Health Policy (2015) • National Human Resources for Health Strategic Plan (2016) • Task-shifting and Task-sharing Policy for Essential Health Care Services in Nigeria – (August 2014)
Equipment	• National Health Equipment Policy for Nigeria (2005)
HMIS	• Health Management Information Policy and Guidelines (2004)
Public–Private Partnership	• Public-Private Partnership Policy (2006)
HIV/AIDS	• National HIV/AIDS Policy (2010-2015) • National HIV/AIDS Strategic Plan 2017 – 2021)
Viral hepatitis	• National Policy for the Control of Viral Hepatitis (2014) • National Strategic Plan for the Control of Viral Hepatitis in Nigeria (2016)
Blood Transfusion	• Nigerian National Blood Policy (2005)
Health Promotion	• National Health Promotion Policy (2005)
Malaria	• National Malaria Strategic Plan (2014 -2020)
Tuberculosis	• The National Strategic Plan for Tuberculosis Control: Towards Universal Access to Prevention and Treatment (2015 – 2020) • National Strategic Plan for Tuberculosis (2016 – 2020)
Immunization	• National Immunization Policy (Revised) 2009
Maternal Health	• National Reproductive Health Policy (2010-2015) • Revised Integrated Reproductive, Maternal, Newborn and Child and Adolescence Health Strategy (2017) • Draft National Strategic Plan for the Elimination of Obstetrics Fistula (2017- 2021) • National Guidelines for maternal and perinatal deaths surveillance & response in Nigeria – (March, 2015) • National tools for maternal and perinatal deaths surveillance & response in Nigeria – (March, 2015)
Newborn and Child Health	• National Reproductive Health Policy (2010-2015) • National Child Health Policy (2013-2018) • Policy on infant and young children's feeding (2010-2015)
Family Planning	• National Family Planning Blueprint (Scale-up Plan) (October, 2014)
Sexual and Reproductive Health	• National RH Policy (2010-2015) • National Strategic Framework for the Elimination "Obstetrics Fistula) in Nigeria (2011 – 2015)

Focal Area	Key Policy Documents
Adolescent health	• the National Policy on Health and Development of Adolescent and Young People in Nigeria (2007-2012) • National training manual for Health and Development of Adolescent and Young People in Nigeria – (September, 2011)
Nutrition	• Infant and Young Children Feeding Policy • National Policy on Food Safety & Its Implementation Strategy (NPFSIS) (2014) • National Strategic Plan of Action for Nutrition (2014 – 2019)
Basic Healthcare provision fund	• Guidelines for the Administration, Disbursement, Monitoring and Fund Management of the Basic Healthcare Provision Fund
Foods & Drugs Services	• Guidelines for Donations of Medicines and Health Care Equipment in Nigeria – April 2007 • National Drug Policy (first revision 2003) • Essential Medicines List (5th edition – 2010) • National Policy on Food Safety and its Implementation Strategy – 2014 • National Drug Distribution Guidelines – (2nd Edition 2012) • National Quality Assurance Policy for Medicines and Other Health Products – (August 2015) • Nigeria Supply Chain Policy for Pharmaceuticals and Other Healthcare Products – (February, 2016) • Standard Treatment Guidelines – (2008) • Nigerian Standard for Drinking Water Quality – (2007) • Traditional Medicine Policy for Nigeria – (2007)
Family Health	• Clinical Protocol for the Health & Development of Adolescent & Young People in Nigeria – (September, 2011) • Manual for training Doctors and Nurse/Midwives on long-acting reversible contraceptive (LARC) methods (IUDs and contraceptive implants) – trainer's manual 2015 • Manual for the training of community health extension workers (chews) on long-acting reversible contraceptive (LARC) methods (IUDs and contraceptive implants) – participants' reference book 2015 • Manual for the training of community health extension workers (CHEWS) on long-acting reversible contraceptive

Focal Area	Key Policy Documents
	(LARC) methods (IUDs and contraceptive implants) – trainers' manual • Standard of Practice on Obstetric Fistula in Nigeria – Doctors' version (December, 2011) • Standard of Practice on Obstetric Fistula in Nigeria – Nurses' version (December, 2011) • National Family Planning/Reproductive Health – Service Protocols (revision edition) • National Guidelines on Promoting Access of young people to adolescent & Youth-friendly services in Primary Health Care facilities in Nigeria – (December, 2013) • National Guidelines for the Integration of Adolescent & Youth Friendly services into Primary Health Care Facilities in Nigeria – (June, 2013) • Follow-up of Health Care Providers trained on long acting reversible contraceptives (LARC) services post training follow-up tool (November 2015). • National Training Manual on Peer-to-peer youth Health Education – (December, 2013) • National Oral Health Policy (November, 2012)
	• Economic Recovery& Growth Plan (2017 – 2020) • National Strategic Health Development Plan (NSHDP) 2010 – 2015 • National Health Policy 2016 • Nigeria Demographic and Health Survey – 2013 • Universal Sustainable Development Goals (Understanding the Transformational Challenge for Developed Countries) – report of a study by stakeholder forum) – May, 2015 • Multiple Indicator Cluster Survey (2016-17), Survey Finding Report (August, 2017)
Health Infrastructure	• National Health ICT Strategic Framework (2015 – 2020) • National Health Information System Strategic Plan 2014 – 2018
Public health	• National Policy and Strategic Plan of Action on Non-Communicable Diseases (NCDs) – May, 2013

Focal Area	Key Policy Documents
	• Report – First National TB prevalence Survey 2012, Nigeria • Global Tuberculosis Report, 2015 (20th Edition) • National Strategic Plan for Tuberculosis Control (2015 – 2020) • National Policy and Strategic Plan of Action on Prevention and Control of Non-Communicable Diseases (September, 2015) • Non Communicable Diseases Policy • National Nutritional Guideline on Non-Communicable Disease Prevention, Control and Management (October, 2014) • National Guideline for the Control and Management of Sickle Cell Disease • Nigeria Master Plan for Neglected Tropical Diseases (NTDs) 2013-2017
PPP	• National Policy On Incentivising Healthcare Investments (January, 2017) • National Standards and Guidelines for the Conduct of Medical/Health Missions In Nigeria (April 2016) • Guidelines for public private partnerships/other partnerships in the health sector (January, 2017)
NPHCDA	• Ward Minimum Health Care Package **(**2007 – 2012)
NCDC	• NCDC Strategy & Implementation Plan 'IDEA TO REALITY' (2017–2021)
NBTS	• Nigerian National Blood Policy (Revised) November 2005
HOSPITAL SERVICES	• Policy on Emergency Medical Services (Ems) in Nigeria (March 2016) • Guidelines for the Operation of National Ambulance services in Nigeria.

Appendix 2: Process of Developing the National Strategic Health Development Plan

The process used for the development of the second NSHDP is shown in Figure 1 and comprised the following steps:

1. Constitution of the National Technical Working Group

A 36-member NSHDP II Technical Working Group, under the Chairmanship of the Permanent Secretary, FMOH was constituted and inaugurated by the Honorable 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 representing the six geo-political zones of the country 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, to which they made inputs. The primary responsibility of the TWG were the development of the NSHDP and mobilization of needed technical and financial support for the process. The concept note produced by the Department of Planning, Research and Statistics of the FMOH was reviewed by the TWG. Subsequently, three national planning and one costing consultants were recruited to support the process and ensure alignment of the Plan with Vision 20: 2020, ERGP, National Health Policy and SDG.

2. *End-term Evaluation of NSHDP I and National Health Accounts*

The TWG commissioned the conduct of an end-term evaluation of the first NSHDP to determine the level of implementation, outcomes, challenges and lessons learned. Additionally, a National Health Accounts study was undertaken. The findings contributed to determining the strategic directions of the second NSHDPf.

3. ***Development of the NSHDP II Framework***

The following process was adopted for the development of the first draft of the NSHDP Framework:

I. Review of all relevant background documents including relevant international declarations, national developmental agendas, national laws and policies, programme specific documents, evaluation and review reports etc.
II. Development of the vision, mission, values and guiding principles of the NSHDP II
III. Identification and harmonization of priority areas of concern from the 2016 National Health Policy, the end-term evaluation report, programme reports and strategies, and the Sustainable Development Goals.
IV. The following priority areas shown in Figure 2 cover were identified: delivery of essential package of health care services, strengthening of the health care delivery system, strengthening an integrated health system to support service delivery and improvement in governance of the health sector, health emergencies and risks and health financing. These areas were group into five strategic pillars which were subsequently decomposed into 15 priority areas.

V. Identification of priority area goals, strategic objectives, and interventions and setting targets

The TWG met several times (total of 8 meetings including inauguration), formed groups across thematic areas (RMNCHA+N, Communicable Diseases, NCDs, Mental Health, Elderly Care Services, Emergency, Epidemic, Preparedness & Response, Emergency and General and Hospital Services, Leadership & Governance, Human Resources for Health, Medicines, Vaccines & other Health Technologies, Health Financing, Community Participation & Ownership, Partnership for Health, Research for Health, Monitoring & Evaluation etc)

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.

Finalization of the NSHDP Framework from wide-stakeholder consultations involving key actors at Federal, State and LGAs. This included sharing of the first draft of the framework for the NSHDP II to all Development Partners and their inputs were incorporated into the document. Following this, a Health Partners Coordination Committee (HPCC) meeting was convened on 27th March 2017 to further build consensus around the Framework and mobilize support (technical & financial) for the process going forward. A two-day national stakeholders validation meeting was convened from 15th – 16th May, 2017. This brought together all stakeholders including four representatives per state (Commissioner for Health, Director Planning Research and Statistics, M&E officer and Representative from Ministry of Budget and Planning) who validated and adopted the NSHDP II framework following further inputs from group work and plenary sessions.

4. Development of states' and federal plans

The NSHDP 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:

I. 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
II. Conduct of a three-day orientation/training for the recruited consultants and state DPRS and M&E officers 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 . This was held in 3 batches from 24th – 28th July, 2017.
III. Each state, using the guidelines constituted a state SSHDP II planning team that comprised a broad range of stakeholders who were responsible for the conduct of state level situation analysis and development of the state plans. In addition, they constituted a technical committee that provided technical oversight. The composition of state teams in included in Appendix 3.
IV. Each state and the federal level held a workshop to orient the state/federal planning teams on the use of the planning tools.

V. The state/federal planning teams reviewed implementation of their first strategic plans, conduct a situation analysis, including a SWOT analysis. These were guided by relevant federal and state extant laws and policies and state specific program documents etc. Since the National Health Policy and National Health Act are recent documents and they are yet to be domesticated by the states, consequently, these national documents provided them the needed guidance.

VI. Conduct of a planning workshop at state/federal level where the planning teams developed state plans.

VII. A 5-day training of zonal costing resource persons/consultants was held from 29th May – 2nd June, 2017 on how migrate states/federal costed plans into the One Health Tool and collate/aggregate the costed federal/states plans into a harmonize costed National Strategic Health Development Plan.

VIII. Each state held another workshop where they costed the programme management component of the state plans, that is, the proposed activities contained in the plans using the Excel framework provided. These programme management costs were imputed into the OneHealth Tool by the zonal costing consultants alongside the relevant state specific data to cost the other components of the state plans.

IX. A three-day Quality Assurance workshop was held in 3 batches from 27th November - 2nd December 2017 for a final review of states/federal plans in reparation for the harmonization exercise before finalization of the state/federal plans;

X. The SSHDP II were validated by stakeholders in each state;

XI. Using the M&E toolkit, each state constituted a team which developed their state M&E plan for the SSHDP II

5. Development of the National Strategic Health Development Plan

The steps taken to produce the NSHDP II were

I. Conduct of a national situation analysis using SWOT analysis.

II. Using the framework, state plans and federal plans were reviewed to identify key actions across the different interventions that were common across the states and any innovations; these were captured in the national plan, in addition to defining national level actions.

III. Targets in the NSHDPf II were reviewed based on the costing scenarios generated from the OneHealth Tools. This was with a view to making them more realistic and achievable.

IV. For the costing of the NSHDP II, all the programme management related costs from the state and federal costing were added to generate the national programme-management related costs while other cost components were generated using three models, based on three target scenarios. (baseline, moderate and aggressive scenarios), for consideration and selection by stakeholders.

V. The M&E thematic team developed the national M&E Plan.

6. Validation of the National Strategic Health Development Plan

The process for validation of the NSHDP II were:

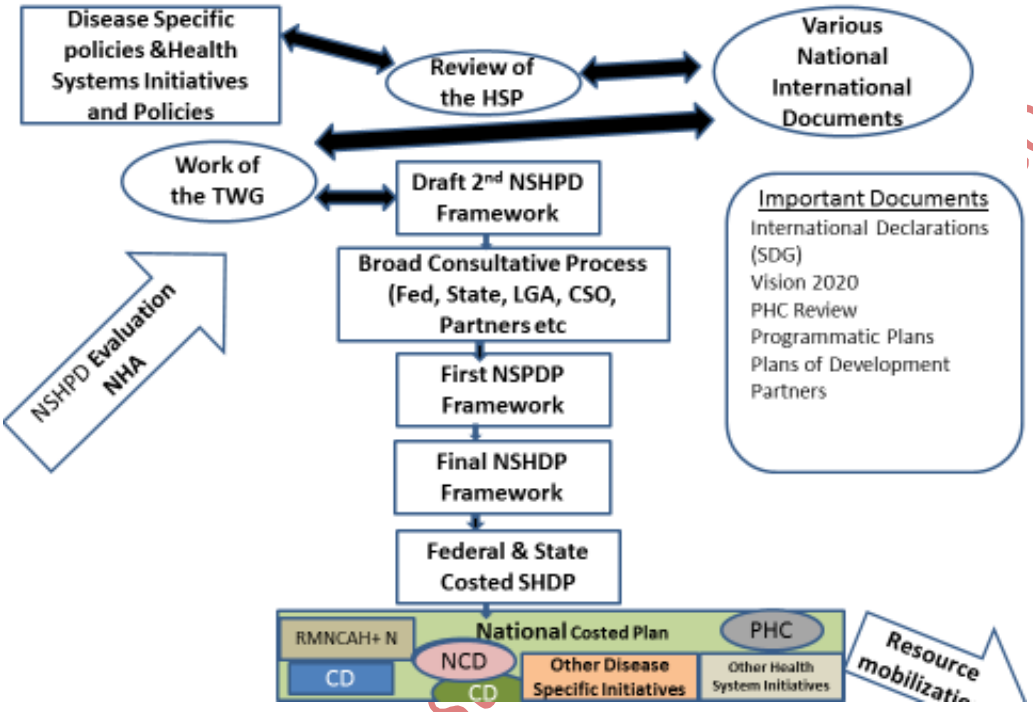
I. The draft NSHDP II was shared with all key stakeholders, including the federal MDAs and development partners for input before the national stakeholders' validation meeting'

II. A national Stakeholders' validation meeting was held on 24 April 2018, which was chaired by the Honorable Minister of State for Health, and had in attendance

States' Commissioners of Health and their Directors of Planning, Research and Statistics; all the planning consultants, zonal and national costing consultants, members of the TWG, development partners etc.

III. Final validation and adoption was done at the National Council on Health on 21 June, 2018. This was preceded by JANS.

Figure 1: NSHDP Development: Process Overview



Appendix 3: List of Participants Involved in Development of NSHDP II

LIST OF PARTICIPANTS INVOLVED IN THE DEVELOPMENT OF THE SECOND NATIONAL STRATEGIC HEALTH DEVELOPMENT PLAN (NSHDP II)

TECHNICAL WORKING GROUP

1.	Mr. Clement Osarenoma Uwaifo	Permanent Secretary	Chairman
2.	Dr. Emmanuel Meribole	Director, HPR&S	Secretary
3.	Dr. Adebimbe Adebiyi	Director, Family Health	Member
4.	Dr. Evelyn Ngige	Director, Public Health	Member
5.	Mr. Lawal Mashood	Director, Food and Drugs Services	Member
6.	Dr. Joseph Amedu	Director, Hospital Services	Member
7.	Dr. Ngozi Azodoh	Director, Special Projects	Member
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10.	Dr. Banji Filani	TA to HMH	Member
11.	Dr. Shuaibu Belgore	STA to HMSH	Member
12.	Mr. M. E. J. Bassey	STA to Permanent Secretary	Member
13.	Dr. Ahmed J. Baba	TA to Permanent Secretary	Member
14.	Mr. Adeleke Balogun	Ag. Head, M&E	Member
15.	Prof. O. O. Kunle	DG, NIPRD	Member
16.	Dr. Faisal Shuaibu	ED, NPHCDA	Member
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18.	Dr. Samson Adebayo	DPRS, NAFDAC	Member
19.	Dr. Thomas Agan	CMD, UCTH, Calabar	Member
20.	Prof. Temitope O. Alonge	CMD, UCH, Ibadan	Member
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24.	MOHAMMED Y. ADEBAYO	Ag. Registrar, CHPRB	Member
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27.	Samson Ezikeanyi	UNFPA	Member
28.	Anthony Ayeke	European Union	Member
29.	Olumide Okunola	IFC	Member
30.	Dr. A. Odutolu	World Bank	Member
31.	A. B. Okauru	NGF	Member
32.	Dr. Emmanuel Abanida	HERFON	Member
33.	Dr. Jabulani Nyenwa	MNCH2	Member
34.	Dr. Maxwell Kolawole	Malaria Consortium	Member
35.	Claire Omatseye	HFN	Member
36.	Mr. Remi Onobajo	FMF	Member
37.	Dr. Sampson Ebimaro	MBNP	Member
38.	Dr. Akabuike Joe	HCH, Anambra State	Member

39. Dr. Haruna Mshelia	HCH, Borno State	Member
40. Sir. Dr. Nick Azinge	HCH, Delta State	Member
41. Dr. Paul Manya Dogo	HCH, Kaduna State	Member
42. Dr. Jide Idris	HCH, Lagos State	Member
43. D. Mustapha Jibrin	HCH, Niger State	Member

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3.	Dr. H. A. Ameen	Costing Consultant

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10.	Mani Sufiyanu	MNCH2

LIST OF STAKEHOLDERS DURING THE VALIDATION OF THE NSHDP II FRAMEWORK

FEDERAL MINISTRY OF HEALTH

NATIONAL STAKEHOLDERS' VALIDATION MEETING OF THE SECOND NATIONAL STRATEGIC HEALTH DEVELOPMENT PLAN FRAMEWORK

VENUE SANDRALIA HOTEL, ABUJA NIGERIA.

DATE: MAY, 15-16TH 2017

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3.	DR. SAIDU ALIYU	PERM SEC.	SMOH, BAUCHI

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22	DR. CHIZOBA WENODI	DIRECTOR	IVAC
23	CHIKA OKPALA	INTERN	IVAC
24	DR. IBRAHIM YISA	TEAM LEADER	EU-SIGN
25	DR. KINGSLEY ODOGWU	MARIES STOPE	COP
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4.	FATAI OYEDIRAN	DD	FMOH
5	O.A. OWOLABI	P/P	AD
6	AJOKO JANET	PHEO	FMOH/GASHE
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10	OGALA MOSES	P&P	EO
11	ILOZOR IFEOMA	P&p	SAO
12	ITTOHOWO WILSON	" "	EO
13	JAMES, DOMINION.	" "	SOI
14	OMOTOSHO, F.A	DPRS	Prin. Conf. Secretary
15	DORIS IKEJI	" "	ACEO
16	HARKINS DICKSON	" "	HEO
17	OGUNLA SEYI BERNARD	P&P	PAO
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19	KALU ONYEMA ACHI	M&E	CCO
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21	MRS. S. B. OLADEJO	AD/EPID	FMOH

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24	ONWU EVANG. NGOZI	HEAD	MRTB
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34	ORDU DONALD	DD	FMOH/NCDC

COMPOSITION OF STATE PLANNING TEAMS

1. Permanent Secretary, State Ministry of Health, Chairman
2. Director of Planning, Research and Statistics, Secretary;
3. Director of Hospital Services;
4. Director of Primary Health Care (Public Health);
5. Director of Finance and Supplies
6. Director of Pharmaceutical Services;
7. Executive Director, State Primary Health Care Development Board
8. Director, of Nursing Services.
9. Chief Health Statistician or any senior officer in charge of Health Information System;
10. Heads of Programmes of SMOH;
11. Staff (at least 2) from the State Hospitals Management Board (i.e, Chief Medical Officer, Board Secretary, or Administrative Officer);
12. Staff from Federal Health Institutions in the State; Teaching Hospitals/Federal Medical Centres or any other Special Hospital.
13. Representative of the Ministries of Education and Social Welfare, State Water Board, Ministry of Local Government; Budget and Planning;
14. Representatives of NGOs and the Private Sector.
15. Representative of the State Ministry of Women Affairs;

16. Representatives of traditional and religious institutions;
17. Health Staff from several LGAs (Health and Medical Department)
18. Several staff from health-related training schools;
19. Representatives from Non-Governmental Organisations;
20. Representatives of Health Professional Bodies.

Appendix 4: The NSHDP II Plan Matrix

NATIONAL STRATEGIC HEALTH DEVELOPMENT PLAN II

Strategic Pillars			
Priority Areas			
Strategic Goals			
Strategic Objectives			**Targets/(Specific Obj)**
Strategic Interventions			**Key Activities**
Strategic Pillar One:			**Enabled environment for attainment of sector outcomes**
1.Leadership and Governance			
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			
1.1	**Provide clear policy, plans, legislative and regulatory framework for the health sector**		**• 70% of coordination organs at national and subnational levels (NCH, SCH, WDC, Health Partners Coordination Committee are established/functional**
	1.1.1	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
	1.1.2	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/quaterly collaborative strategic and operational planning meetings of stakeholders for harmonization of plans
1.2	**Strengthen transparency and accountability in planning, budgeting and procurement process**		**• 80% of States increase annual budget implementation rate by 25%**

			• 80% of national health priorities in MTEF
	1.2.1	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
	1.2.2	Strengthen the linkages between various planning and budgeting process(MTEF/MTSS)	• Conduct joint review and alignment meeting between health planning and budgeting health departments and other stakeholders
	1.2.3	Strengthen voice and accountability, including community participation, CSO engagement.	• 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 Civil society organizations • Enpanel CSOs as watchdogs to assess and report on performance of all aspects of NSHDP II implementation
1.3	**Improve health sector performance through regular integrated reviews and reports**		**• FMOH and 36 SMOH+ FCT HSS publish annual state of health report.**
	1.3.1	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
	1.3.2	Improve information generation and sectoral information base for decision-making to enhance sectoral performance	
	1.3.3	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
	1.3.4	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
	1.3.5	Design and institutionalize an incentivization and reward system for the	• Establish an independent performance award committee • Establish and roll out a mechanism for implementation

		efficient performance of the health sector at all levels	of performance - based incentivization at all levels • Conduct annual award ceremony to beneficiaries at all levels
1.4	**Strengthen coordination, harmonization and alignment at all levels**		**• 70% of coordination organs at national and subnational levels (NCH, SCH, WDC, Health Partners Coordination Committee are established/functional.2. 100% of SMOH+ FCT HHSS are have annual workplans**
	1.4.1	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
	1.4.2	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
	1.4.3	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
	1.4.4	Improve partnership with professional groups and other relevant stakeholder for effective service delivery and industrial harmony.	
	1.4.5	Strengthen implementation of Health Service Charters at all levels	
	1.4.6	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
2.Community Participation and Ownership			
2.To promote community engagement for sustainable health development			
2.1	**To strengthen community level coordination mechanisms and capacities for health planning.**		**• At least 80% of PHC are linked to Community Health Committees;** **• 70% of ward and health facility committees are functional** **• At least 80% of LGA with functional PHC management committees** **• Percentage of Wards with functional CHIPS programme**
	2.1.1	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)
	2.1.2	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
	2.1.3	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
2.2	**To strengthen community engagement in the implementation, monitoring and evaluation of health programs**		**• At least 80% of PHC are implementing MSP**
	2.2.1	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
	2.2.2	Strengthen mechanisms for data collection, analysis, storage, utilization and accountability at community level	• Support establishment of a community based health information system linked to DHIS2.0 • Conduct regular Data Quality Assurance (DQA)
3.Partnerships for Health			
3. Enhance harmonized implementation of essential health services in line with national health policy goals.			
3.1	**Ensure that collaborative mechanisms are put in place for involving all partners in the**		**• At least 30% of funding of health from partners (development partners and private sector) by 2022** **•At least 70% of all health facilities at all levels to be**

	development and sustenance of the health sector		**implementing SERVICOM by 2022** **• Increase by 50% the proportion of health institutions administered through PPP**
	3.1.1	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
	3.1.2	Strengthen legal and coordinating framework for PPP at all levels	• Develop legal framework to guide Public-Private Partnerships (PPP) at all levels • Establish and build capacity of PPP units/TWGs of health MDAs at all levels
	3.1.3	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
	3.1.4	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
	3.1.5	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
	3.1.6	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)
	3.1.7	Scale up resource mobilization interventions(funding, skills - e.g. managerial approaches) targeting the private sector	• Establish a framework for domestic resource mobilization (DRM) from corporate organizations, private sector, and philanthropists for health interventions at all levels • Support development of innovative strategies for DRM across the country
	3.1.8	Establish mechanisms for resource coordination through common basket funding models such as Joint	• Develop a joint funding model involving the ministry of finance, planning commission and development/funding partners (basket fund) • Facilitate oversight of the joint funding model

	funding Agreement, Sector Wide Approaches, and sectoral multi-donor budget support.	
3.1.9	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
3.1.10	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
3.1.11	Strengthen collaboration between government and professional groups including Nigerian health professionals in diaspora to advocate for increased coverage of essential interventions, 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.)
3.1.12	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, State and LGAs
3.1.13	Promote linkages with academic institutions to undertake research, education and monitoring through existing networks; and	• 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
	3.1.14	Promote partnerships with communities to address felt needs of the communities	
	3.1.15	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; and	
Strategic Pillar Two:			**Increased utilisation of essential package of health care services**
4.Reproductive, Maternal, Newborn, Child, Adolescent Health Services & Nutrition			
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			
4.1	**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 reduced by 50 percent, from 576 per 100,000 live births to 288 per 100,000 live births by 2022. • Skilled attendance at delivery increased from 38% to 57% by 2022. • Attendance at 8 ANC visits by pregnant women increased to 80% by 2022 • Attendance at postnatal services by mothers within 48hrs of delivery increased to 50 percent by 2022. • At least 80% of Primary/Ward Health Centers are providing basic Emergency Obstetric and Neonatal care services by 2022. •At least 50% of all LGAs have health facilities capable of providing Comprehensive Emergency Obstetric Services by 2022.**
	4.1.1	Improve access to focused 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.)
	4.1.2	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
	4.1.3	Promote advocacy, community Mobilization	• Promote the conduct advocacy to create an enabling environment and support for safe motherhood initiative

	and Behaviour Change Communication for Safe Motherhood Services	• 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
4.1.4	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) in Emergency Obstetric and Newborn 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.)
4.1.5	Improve quality of care for safe motherhood services	
4.1.6	Increase access to basic and comprehensive Emergency Obstetric Services	
4.1.7	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
4.1.8	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
4.1.9	Improve Maternal and Perinatal Death Surveillance and Response	
4.2	**Strengthen prevention, treatment and rehabilitation services for fistula care in Nigeria**	**• Incidence of obstetrics fistula reduced by 50% by 2022** **• Treatment of new cases and backlog increased by 30% by 2022** **• 75% of treated cases reintegrated into their communities**
4.2.1	Promote Obstetric Fistula preventive interventions	• Increase access to skilled birth attendants and emergency obstetric care services as in 4.1 • 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
	4.2.2	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
	4.2.3	Foster community participation for the rehabilitation and re-integration of fistula patients	• Develop an OF mitigation and rehabilitation plan • Integrate counseling 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
4.3	**Promote demand and increase access to sexual and reproductive health services (family planning and post abortion care)**		**• Contraceptive prevalence rate increased from 15% to 43% by 2022** **• 50% reduction in unmet needs of FP among all females of reproductive age** **• Proportion of health facilities offering post abortion care to increase from 3.3% to 7% by 2022**
	4.3.1	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 counseling and treatment services
	4.3.2	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)
	4.3.3	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
	4.3.4	Strengthen and integrate Family Planning and Post Abortion Care services at all levels	• Provide emergency post-abortal care services in health facilities, including PHC • Train health care providers in post-abortal care services and FP integration provision • Provide counseling and family planning services for post-abortal care clients • Conduct public enlightenment and community engagement interventions
	4.3.5	Promote prevention of harmful traditional practices and gender-based violence	• Conduct public education and community sensitization on HTP and GBV
	4.3.6	Scale up Prevention, counseling and treatment of rape and other gender based violence such as Rape, intimate partner violence e.t.c	• 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
	4.3.7	Build capacity of service providers to offer gender-sensitive respectful and safe service	
4.4	**Reduce neonatal and childhood mortality and promote optimal growth, protection and development of all newborns and children under five years of age.**		**• Neonatal mortality reduced by 50% from 37/1000 live births to 18/1000 live births by 2022** **• Infant mortality reduced by 50% from 75/1000 live births to 38/1000 live births by 2022** **• Under-five mortality reduced by 50% from 128/1000 live births to 64/1000 live births by 2022** **• Exclusive breastfeeding rate increased to 50% by 2022** **• 50% of all health facilities designated as "baby-friendly" facilities by 2024.** **• 50% of all health facilities designated as IMCI facilities.**
	4.4.1	Strengthen postnatal and newborn care	• Train health care providers in essential and emergency newborn care • Promote early initiation of breastfeeding including promotion of Hospital Baby Friendly Initiative • Provide essential newborn care in all delivery service points (thermal care, including kangaroo mother care, hygienic cord care using chlorhexidine, neonatal resuscitation

4.4.2	Strengthen emergency obstetric, newborn and childhood care.	• Establish special care baby units for emergency newborn care in LGA general hospitals where CEmOC is being provided • Develop and implement emergency obstetrics, newborn and child health treatment guidelines and protocols along the different levels of care, from community level, including effective referral systems
4.4.3	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
4.4.4	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
4.4.5	Improve quality of newborn and child healthcare services	• Develop/adapt and produce newborn and child health treatment guidelines and protocols for different levels of care • Strengthen capacity of health care providers and facilities to provide quality newborn care
4.4.6	Promote advocacy, community mobilisation and behavioural change communication for newborn and child healthcare services	• Advocate to policy makers and legislators for enabling policies, funding and prioritization of newborn and child health • Conduct public education and community mobilization/engagement for promotion of and uptake of newborn and child health services • Develop and distribute newborn and child health communication materials • Engage and train WDC and community volunteers in community sensitization and education
4.4.7	Expand neonatal and child healthcare including community risk detection and welfare	
4.4.8	Expand coverage of IMCI (Community-IMCI, Community Case	• Increase the number of facilities and LGAs providing IMCI managing sick children using IMCI

			Management (ICCM) & IMCI)	• Scale-up implementation of Community Case Management of Childhood Illness (cIMCI)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)
	4.5	**Improve access to adolescent health and young people information and services**		**• Awareness of availability of youth friendly sexual and reproductive health services among adolescents and young people raised to 80% by 2022** **• Access to comprehensive youth friendly sexual and reproductive health services increased by 60% by 2022** **• Proportion of health facilities offering comprehensive adolescent friendly reproductive and sexual health services increased to 50% by 2024.** **•Utilization of adolescent reproductive health services increased to 50% by 2022** **• Incidence of unplanned pregnancies among adolescent females reduced by 50% by 2024.** **• 50% maternal mortality among adolescent females reduced by 50%.**
		4.5.1	Intensify advocacy, social mobilization and behavior change communication for positive adolescent behaviour.	
		4.5.1	Promote demand for adolescent reproductive health services	
		4.5.2	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 • Conduct education of female adolescents and provide support for menstrual hygiene • Establish youth friendly ARH Centre
		4.5.3	Strengthen prevention, detection, and management of HIV and STIs among adolescents	
		4.5.4	Promote Menstrual hygiene among adolescents	• See 4.5.2 above
		4.5.5	Scale-up implementation of	

		adolescent sexual and reproductive health education in the school curriculum	
	4.5.6	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 counseling services into adolescent health programs for both in-school and out of school youths • Promote health literacy among youths• • Establish motivational counseling and integrate into adolescent health services • Integrate adolescent drug addiction into mental health
	4.5.7	Promote school health services including deworming	• Conduct biannual deworming of school age children
4.6	**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**		**• Exclusive breastfeeding rate in the first six months of life increased to 60% by 2022** **• Incidence of low birth weight reduced from 17% to 10% by 2022** **• Prevalence of childhood wasting reduced from 18% to less than 10% by 2022** **• Prevalence rate of stunting in under-fives reduced from 37% to less than 20% by 2022** **• Incidence of anaemia among women of reproductive age reduced by 15%** **• Prevalence of childhood overweight reduced by 50% by 2022.** **• Prevalence of malnutrition among women of reproductive age reduced from 11% to less than 5% by 2022** **• Malnutrition among the elderly reduced by 50% by 2022.**
	4.6.1	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
	4.6.2	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, creches at places of work
	4.6.3	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 FADUS (frequency, adequacy, density, utilization and safety) of complementary feeds
4.6.4	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 diarrhea management for children aged 6 - 59 months
4.6.5	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 CMAN • 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)
4.6.6	Scale up nutrition for children with special nutritional needs including (children born to HIV positive mothers; infants and young children in emergencies with persistent diarrhea etc.	• Adhere to national guidelines in the management of nutritional needs of children in difficult situations
4.6.7	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
4.6.8	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
4.6.9	Promote optimal nutrition of adolescents and Women of	

		Reproductive Age (WRA)	
	4.6.10	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
5.Communicable Diseases (Malaria, TB, Leprosy, HIV/AIDS) And Neglected Tropical Diseases			
5. To improve prevention, case detection and coordinated response for the prevention, control and management of communicable diseases and NTDs			
5.1	**Reduce significantly morbidity and mortality due to Malaria and move towards pre-elimination levels**		**• 80% of care seeking persons with suspected malaria are tested using mRDT or microscopy by 2022 • 80% of all individuals with confirmed malaria seen in private or public facilities are treated with effective anti-malarial drugs by 2022 • Prevalence of malaria reduced by 80% in pregnancy and children by 2022 • Attain 60% local production of quality artemisinin-based combination therapy (ACT) by 2022 • 80% of care seeking persons have access to antimalarial commodities by 2022 • Less than 10% of health facilities reported stock out of diagnostic kits and ACTs lasting more than one week in the past three months by 2022.**
	5.1.1	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
	5.1.2	Strengthen laboratory services for diagnosis of malaria at all levels	• Deploy RDT and or microscopy for malaria diagnosis to public and private facilities • Deploy of RDT at community level • Implement guideline for the use of RDTs and microscopy for malaria diagnosis
	5.1.3	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
	5.1.4	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
	5.1.5	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
	5.1.6	Expand use of IPTp among pregnant women attending ANC	• Refer to ANC 4.1.1 a-d
	5.1.7	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
	5.1.8	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
5.2	**Ensure universal access to high quality, client-centred TB/Leprosy diagnosis and treatment services for the reduction in the incidence and prevalence of**		**• TB prevalence rate reduced by 60% by 2022** **•TB mortality reduced by 50% by 2022** **•Case notification rate of all forms of TB increased from 57.3 per 100,000 to 27 per 100,000 by 2022** **•Case detection of all forms of TB increased to 70% by 2022** **•Ratio of TB diagnostic centres to population**

	tuberculosis/leprosy in Nigeria.		**improved from 1:109,285 to 1: 50,000 or less •70% level of implementation of the comprehensive strategies for case notification, management and control of tuberculosis and leprosy in the general population (Global Roadmap) attained by 2022 • 100% access to high-quality integrated services for all people co-infected with tuberculosis and HIV attained by 2022 • 100% access to diagnosis and treatment of multi-drug resistant tuberculosis attained by 2022 • 100% access to diagnosis and treatment of pauci-bacillary and multi-bacillary leprosy attained by 2022 Treatment cure rate increased to 70% by 2022**
	5.2.1	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
	5.2.2	Promote demand for TB services	
	5.2.3	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 counseling and testing services to all people with TB symptoms and disease.
	5.2.4	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
	5.2.5	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
5.2.6	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
5.2.7	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
5.2.8	Promote innovative advocacy, social mobilization and behaviour change intervention for the prevention and control of TB	
5.2.9	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
5.2.10	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
5.2.11	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
5.2.12	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

	5.2.13	Strengthen physical and socio-economic rehabilitation for leprosy	• Establish/strengthen leprosy rehabilitation hospitals and centres
5.3	**Significantly reduce the incidence and prevalence of HIV/AIDS in Nigeria by 2022**		**• Incidence of HIV infections among the key and general populations reduced by 70% by 2022** **• Coverage of HIV testing increased from the current rate of 30% to 60% by 2022** **• Mother-to-child transmission of HIV eliminated in Nigeria by 2022** **• All diagnosed PLHIV receive quality HIV treatment services, and at least 90% of those on ARV achieve sustained virological suppression by 2022** **• 100% of People living with HIV(PLHIV), vulnerable children, and people affected by HIV/AIDS (PABA) have access to comprehensive rights-based care by 2022.** **•90% of the population know their HIV status.** **• Provide quality HIV treatment services for all diagnosed PLHIV, and at least 90% of those on ARV achieve sustained virological suppression**
	5.3.1	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
	5.3.2	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 progamme 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
	5.3.3	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 anti- retrovirals and cotrimoxazole for all HIV exposed newborns • Strengthen supportive supervision for ePMTCT services
	5.3.4	Strengthen referral and linkages between HIV/AIDS services and other health and social services	
	5.3.5	Improve access to safe blood and blood products	• Implement National policies and guidelines as it relates to blood donor mobilization, storage, collection and use. See 7.4.1 • 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.
	5.3.6	Promote injection safety and health care waste management practices	
	5.3.7	Strengthen community systems to support HIV/AIDS programming for key and general populations	
	5.3.8	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
	5.3.9	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
	5.3.10	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
5.4	**Reduce the incidence, morbidity and mortality due to viral hepatitis.**		**• 50% of persons infected with hepatitis B and C are aware of their infection status by 2022** **• Prevalence of vaccine-preventable viral hepatitis reduced by 50% by 2022** **• Prevalence of viral hepatitis reduced by 50% by 2022**

			• 50% of all persons eligible for hepatitis B treatment receive treatment by 2022
	5.4.1	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
	5.4.2	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
	5.4.3	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
	5.4.4	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
	5.4.5	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
	5.4.6	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)
	5.4.7	Expand access and delivery of hepatitis prevention, care and treatment services in	• Build capacity of health care workers on hepatitis prevention and management • Develop, produce and disseminate hepatitis prevention and treatment guidelines and job aids

		health care facilities and closed settings	• 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
5.5	**Reduce morbidity, disability and mortality due to targeted Neglected Tropical Diseases (NTDs) and improve quality of life of those affected.**		**• Proportion of States implementing integrated vector management for targeted NTDs increased to 70% by 2022** **• Proportion of school-aged children regularly dewormed increased to 50% by 2022** **• Attain 50% coverage in preventive chemotherapy for selected tropical diseases by 2022** **• Prevalence of targeted NTDs reduced by 60% by 2022**
	5.5.1	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
	5.5.2	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
	5.5.3	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
	5.5.4	Increase access to integrated case management for NTDs (Buruli Ulcer, Leishmaniasis, Trypanosomiasis,	• 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

		Loasis, Schistosomiasis, Zoonosis , soil-transmitted helminthic infections, onchocerciasis, filariasis)	• 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
	5.5.5	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
	5.5.6	Strengthen the integration and linkages of NTD programme and financial plans into sector-wide and national budgetary and financing mechanisms.	
	5.5.7	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
	5.5.8	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
6.Non-Communicable Disease, Care of The Elderly, Mental Health, Oral Health, Eye Healthcare			
6. To reduce the burden of morbidity, mortality and disability due to non-communicable diseases			
	6.1	**Reduce morbidity and mortality due to NCDs (Cancers, Cardiovascular Diseases, Chronic Obstructive Airway Diseases, Diabetes and Sickle Cell Disease)**	**• Overall mortality from NCDs (cardiovascular diseases, cancer, diabetes, sickle cell diseases or chronic respiratory diseases.) reduced by 20% by 2022** **• Prevalence rate of tobacco use among adults reduced by 30% from current rate of 5.6%** **• Prevalence rate of insufficient physical activity and unhealthy diet reduced by 30%** **• Prevalence rate of salt intake for mean adult (aged ≥18) population reduced by 30%** **• Uptake of vaccines for carcinogenic viruses (HBV, high risk HPV serotypes and pneumococcal vaccination among children) increased to 50% by 2022** **• Proportion of Adults who are aware of their genotype increased by 50% by 2022** **• Proportion of eligible population screened for early detection and management of NCDs increased to 50% by 2022.** **• Access to quality treatment facilities for persons with NCDs increased to 50% by 2022**

6.1.1	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 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 data base for NCDs including integration with integrated disease surveillance and response (IDSR) • Establish NCD registries in at least one state in each of the 6 geopolitical zones
6.1.2	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
6.1.3	Promote healthy lifestyles and behaviors 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
6.1.4	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
6.1.5	Improve the quality of life of those affected by NCDs	

	6.1.6	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 of 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
	6.1.7	Promote demand for NCD services	• Implement public awareness programmes to promote healthy lifestyles
6.2	**Promote the health and wellbeing of the elderly in Nigeria**		**• 50% of the elderly in Nigeria access basic and long term care by 2022** **• 50% of the elderly in Nigeria are active and stay healthy by 2022.** **• 40% of the elderly have access to financial support schemes to meet their health care needs by 2022.**
	6.2.1	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
	6.2.2	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) • Develop strategy and guidelines, in collaboration with all relevant stakeholders national and state level strategic and operational plans to foster Healthy Ageing
	6.2.3	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, daycare services and long term care facilities. • Support the formation of organizations and support groups of the elderly

	6.2.4	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
	6.2.5	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
	6.2.6	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
6.3	**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.**		**• Incidence of mental illnesses in Nigeria reduced by 20% by 2022** **• Healthcare coverage of patients with mental illnesses and substance use dependence by increased to 60% by 2022;** **• Social welfare support to persons with established serious mental Illnesses and substance use dependence raised to 40% by 2022.**
	6.3.1	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
	6.3.2	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
	6.3.3	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 •

	6.3.4	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)
	6.3.5	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, codine-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
	6.3.6	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
	6.3.7	Promote advocacy for improved financing for mental health	• Conduct resource mobilization for mental health care, targeting private sector, development partners, philantropists and communties
	6.3.8	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
	6.3.9	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 counseling.
6.4	**Promote optimal oral health in Nigeria.**		**• Incidence and prevalence of oral diseases (e.g. dental caries, gingivitis, Cancrum oris etc.) reduced by 40% by 2022** **•Level of oral health awareness in the country raised from less than 45% to 70% by 2022**

			• 50% of Nigerians have adequate access to oral health care by 2022 **• 60% of PHCs provide basic package of oral care by 2022** **• 60% of secondary level health care facilities are providing oral health care appropriate for that level**
	6.4.1	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
	6.4.2	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
	6.4.3	Strengthen capacity of health workers at all levels to deliver oral health care services	• Develop/adapt and implement a needs-based training programme for oral health • 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
	6.4.4	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
	6.4.5	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
	6.4.6	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
6.5	**Eliminate avoidable blindness, and reduce the burden of various visual impairment conditions.**		**• 70% of blind and visually impaired persons have adequate access to eye treatment and rehabilitative services by 2022** **• 30% of health facilities in the country have capacity to deliver appropriate quality eye care services by 2022** **• 50% of blind and visually impaired needing rehabilitation have access to required services by 2022** **•Prevalence of avoidable visual impairment in the country reduced to 25% by 2022.**
	6.5.1	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
	6.5.2	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
	6.5.3	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
	6.5.4	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 eg. WDC for engagement in eye health initiatives • Engage media in eye health education
	6.5.5	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
7. Emergency Medical Services and Hospital Care			
7. Improve health outcomes through prompt and effective response to medical emergencies			
7.1	**Strengthen emergency medical services (EMS)**		**• At least 50% of states have EMS policies, plans and services in place by 2022**

	7.1.1	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
	7.1.2	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)
	7.1.3	Create/Strengthen coordination of various emergency medical services (NEMA/SEMA, FRSC, Police, Public, Private e.t.c.)	• Establish a coordinating framework for harmonization, integration and alignment of all public sector medical emergency services • Promote PPP in EMS and ETS services
	7.1.4	Strengthen infection prevention and control (IPC) in health care settings	• Review the policy on infection, prevention and control • Develop/adapt, produce and disseminate guidelines and SOPs on IPC • 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
	7.1.5	Promote demand for appropriate use of medical services	• Develop and implement a communication strategy to foster knowledge and demand for EMS and ETS services
7.2	**Increase provision and access to quality, affordable & integrated emergency medical services**		**• 80% of the states have dedicated centres for integrated emergency medical service** **• 70% of states have coordinated functional ambulance services** **• 30% of health emergencies responded to within 1-hour**
	7.2.1	Ensure provision and access to emergency medical services	
	7.2.2	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)

	7.2.3	Strengthen coordinated and integrated emergency transport system (ETS)	
7.3	**Improve provision, access, quality and responsiveness of Ambulatory (outpatient) Services at all levels of health care**		**• 100% of health facilities providing general outpatient services as appropriate to the level of care.**
	7.3.1	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
	7.3.2	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
	7.3.3	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
7.4	**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**		**• Case fatality rates reduced by 30% by 2022** **• Client satisfaction level improved by 50 % by 2022** **• Utilisation of general medical services increased by 100% by 2022** **• The proportion of LGAs with functional public health facility providing general medical services at secondary level increased to 70%.** **• Adherence to quality measures improved by 50% by 2022** **• Proportion of health facilities implementing IPC in line with standard guidelines**
	7.4.1	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

7.4.2	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
7.4.3	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
7.4.4	Bulld 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
7.4.5	Promote demand for appropriate use of medical services	• Strengthen/establish quality assurance in haemoglobinopathy, HBV,HIV 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
7.4.6	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
7.5	**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.**		**• 10% of Public & Private health Facilities operate functional Palliative and End-of-life care services** **• 30% of patients needing palliative and end-of-life services are receiving community system support**
	7.5.1	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
	7.5.2	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
	7.5.3	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
	7.5.4	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
8.Health Promotion And Social determinants of Health (Environmental Health)			

8. Improve the wellbeing, safety and quality of life of Nigerians through health promotion and healthy evironment			
8.1	**Promote the wellbeing of individuals and communities through protection from health risks, and promotion of healthy lifestyle and environment**		**• 25 % of communities have capacity for health promotion by 2022** **• 40% of community members are making healthy lifestyle choices by 2022**
	8.1.1	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
	8.1.2	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
	8.1.3	Strengthen health promotion coordination mechanisms at all levels	• Establish a coordinating mechanism for health promotion at all levels
	8.1.4	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.)
	8.1.5	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
	8.1.6	Promote the inclusion of health promotion in school curricula at all levels	• Conduct advocacy and collaborate with to Education Ministry and SUBEB for inclusion of health promotion in school curricula and promotion of healthy schools environment • Collaborate with the education sector in provision of health promotion content and promotion of health 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
	8.1.7	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
8.2	**Promote food hygiene and safety for the reduction of illnesses associated with unwholesome food.**		**• Incidence of foodborne diseases reduced by 20% by 2022** **• Compliance and adherence to standards (HACCP) of food safety and hygiene by institutions and outlets involved in the food production and consumption pipeline increased to 50% by 2022.** **• 60% 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 by end of 2018.** **• A functional and sustainable high-risk food data bank by end of 2018.** **• A comprehensive compilation of approved food additives used in the country by 2019.**
	8.2.1	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
	8.2.2	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
	8.2.3	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
	8.2.4	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

	8.2.5	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
8.3	**Promote universal access to safe drinking water and acceptable sanitation**		**• Incidence of diseases resulting from consumption of unwholesome water and poor sanitation reduced by 50% by 2022.** **• 50 % of drinking water sources assessed for quality standards** **• 70% of the population have access to improved sanitation by 2022.**
	8.3.1	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
	8.3.2	Promote preventive and curative healthcare for water and sewage borne diseases	
	8.3.3	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
	8.3.4	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

8.4	**Reduce morbidity and mortality from snake bites in Nigeria**		**• 50% reduction in case fatality rate from snake bites by 2022** **• 50% reduction in the incidence of snakebites by 2022**
	8.4.1	Promote the development and the implementation of policies, plans, legislations and regulations for the reduction of snake bites in Nigeria.	
	8.4.2	Scale up sustainable supply of anti-snake venom in Nigeria, including local production	
	8.4.3	Build capacity of health care workers on snakebite management at all levels.	
	8.4.4	Promote partnerships for national snakebite response	
	8.4.5	Scale up generation of local evidence to inform more responsive snakebite programming	
	8.4.6	Promote snakebite prevention and Control interventions.	
8.5	**Protect human health, environment and infrastructure from chemical hazard, medical & Bio waste and poisoning**		**• Mortality associated with hazardous chemicals and poisons reduced by 30% by 2022** **• 70% of healthcare facilities meet the minimum standards for medical waste management**
	8.5.1	Strengthen legal, regulatory framework, policies and plans for chemical hazards and poisoning, medical and Bio waste and climate change	
	8.5.2	Scale-up advocacy, community sensitization and education on chemical wastes and poisoning, medical and Bio waste and climate change	
	8.5.3	Build capacity of health workers for effective management of medical and Bio waste and hazardous chemicals at all levels of the health care system	
	8.5.4	Build capacity to appropriately respond	

		to health effects of climate change	
	8.5.5	Deepen collaboration with relevant stakeholders on Chemicals Management, medical & Bio waste management and climate change	
	8.5.6	Improve systems for data collection, management and utilization for chemical hazards and poisons, medical and Bio waste and climate change	
8.6	**Promote optimal health and safety of workers in their work environment**		**+**
	8.6.1	Promote the development and implementation of legal, regulatory framework, policies and plans for occupational health in Nigeria	
	8.6.2	Build capacity of health care workers to respond to occupational health needs in the country	
	8.6.3	Scale up occupational preventive and promotive activities	
	8.6.4	Expand access to appropriate occupational health services for health workers	
	8.6.5	Strengthen regulation, mentoring and evaluation of occupational health services in workplace	
	8.6.6	Promote health and safety in the workplace	
	8.6.7	Promote collaboration between the key stakeholders (Ministry of Health, Ministry of Labour and the private sector)	
Strategic Pillar Three:			**Strengthened health system for delivery of package of essential health care services**
9.Human Resource for Health			
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.			

9.1	**Ensure coordination and partnership for aligning investment of current and future needs and institutional strengthening for HRH agenda**		**• All states are implementing HRH policies and strategic plans**
	9.1.1	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 ensuring 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
	9.1.2	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
	9.1.3	Enhance funding for HRH development for the current and future needs	• Support resource mobilization activities including funding for HRH (Link to health care financing)
9.2	**Ensure the production of adequate numbers of qualified health workers**		**•At least 70% of health training institutions are accredited by the relevant regulatory institution**
	9.2.1	Strengthen the quality assurance for HRH training institutions esp. 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 programs 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
	9.2.2	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
	9.2.3	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
9.3	**Ensure the development of monitoring and evaluation for HRH including systems for HRHMIS and Registry**		**• FMOH, 36 states and FCT will have functional HRHIS** **• 100% of states with HRHIS are producing annual HRH review report**
	9.3.1	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 workplans) • Conduct periodic facility-based and health workers' performance assessment, monitoring and supervision
	9.3.2	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
	9.3.3	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)
9.4	**Ensure effective health workforce management through retention, deployment, work condition, motivation and performance management**		**•Health worker attrition rate reduced by 50% in all health institutions and SDP** **• At least 60% of health facilities at all levels have the appropriate skill mix of health providers**
	9.4.1	Strengthen mechanism for deployment and retention of HRH at all levels	• Review existing HRH recruitment and deployment policies to remove barriers/embargo to competitive recruitment, deployment and retention of appropriate health workforce

				• 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
		9.4.2	Improve HRH performance management systems at all levels	• Develop and implement a system for measuring performance of health workers in line with the civil service Performance Monitoring System (PMS)
		9.4.3	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
	9.5	**Strengthen Health workforce planning for effective management**		**• FMOH, 36 States and FCT have harmonized HRH Annual Operational Plan**
		9.5.1	Improve capacity for HRH planning at all levels	
		9.5.2	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
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.				
	10.1	**To improve availability and functionality of health infrastructure required to optimize service delivery at all levels**		**• 80% of Wards in the country has at least one fully functional PHC centre with capacity to provide comprehensive primary health care services by 2022.** **• 50% of the LGAs have functional general hospitals for referral from PHCs** **• 80% of health facilities at all levels of the health system has 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, by 2022;** **• 70% of appropriate laws, policies and regulations including the National Health Equipment Policy are available by 2022** **• 70% capacity for Health Infrastructure Planning and Health Technology Management Programme**
		10.1.1	Strengthen legal, policy and institutional framework and coordinating mechanism for health infrastructure planning	• 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

	and maintenance in Nigeria	health infrastructure, equipment maintenance and management • Set up a functional health infrastructure coordinating committees at different levels
10.1.2	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
10.1.3	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
10.1.4	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
10.1.5	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.)
10.1.6	Promote partnerships between Equipment Manufacturers/ Suppliers and government at all levels for technology transfer/training/ maintenance agreements.	•
10.1.7	Scale up training of Biomedical Engineers and health infrastructure equipment maintenance officers, in order to	• Develop and implement a scaling up training programme for Biomedical Engineers, technicians and health maintenance officers with major equipment manufacturers

		increase stock availability.	
	10.1.8	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 healthcare service package (ESP) including BEmONC • Provide PHC infrastructure and HRH in relation to defined norms and standards
	10.1.9	Improve Secondary and Tertiary levels infrastructure to support for referrals systems	• Establish standard diagnostic centers at all senatorial zones of the State that are WHO certified • Revitalize, upgrade and expand centers 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 center for PHCs in the LGA
11.Medicines, Vaccines and Other Health Technologies and Supplies			
11. To ensure that quality medicines, vaccines, and other health commodities and technologies are available, affordable and accessible to all Nigerians			
	11.1	**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%, • Increase local production of simple active pharmaceutical ingredients by 50% increase in the strict enforcement of all regulatory laws (NAFDAC, PCN and SON). • 36 states+ FCT have a functional logistic management coordinating Unit. • 36 states + FCT have a medicine and therapeutic committee at the state and facility levels • 50% increase in public awareness and understanding of antimicrobial resistance through effective communication, education and training by 2020.**
	11.1.1	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.)
	11.1.2	Strengthen effective coordination of structures that ensures	• Establish/strengthen a state and LGA product supply chain management/Logistics Management Coordinating Unit (LMCU) including coordinating committees or

	accessibility to medicines, vaccines, commodities and other technologies at all levels and at all times	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
11.1.3	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)
11.1.4	Strengthen effective procurement systems (forecasting, orders, procurement) to ensure (40% local content) and commodity security for 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
11.1.5	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.
11.1.6	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
	11.1.7	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
	11.1.8	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
12.Health Information System			
12. To institutionalize an integrated and sustainable health information system for decision-making at all levels in Nigeria			
12.1	**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.**		**• At least 50% of all health facilities (public and private) generating and transmitting routine HMIS data by 2022** **• 50% improvement in data quality by 2022** **• improve the use of the health Information System software (DHIS) in data management by 30%** **• 50% increase in data analysis by 2022** **• 40% increase data dissemination and use by 2022** **• 50% Improvement in Data Security by 2022** **• 30% Improvement in M&E of HIS by 2022**
	12.1.1	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
	12.1.2	Strengthen capacity to generate, transmit, analyze and utilize	• Develop and implement M&E plans at Federal and State levels

		routine health data, from all health facilities, including private health facilities.	• Strengthen capacity of M&E/HMIS Officers, OICs 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
	12.1.3	Improve integration of existing surveillance systems and diseases registries into the overall health information system	• Integrate the surveillance system into the the DHIS2 platform to enhance inter-operability
	12.1.4	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
	12.1.5	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
13.Research for Health			
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			
	13.1	**Strengthen health research and development to significantly contribute to the overall improvement of Nigeria's health system performance.**	**•At least 50% implementation of the Research Part of the National Health Act achieved by 2022. • At least 60 % of health research institutions meet international standards by 2022. • 50% health researches are responsive to jointly set national health priorities/agenda. • At least 20% increase in budgetary support to health research Institutions. • At least 50% of health institutions and various levels of government levels spend a minimum of 2% of their health budgets for health research and at least 5% of external aid for health projects and programmes to research and research capacity building ;**

13.1.1	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
13.1.2	Strengthen the development and implementation of the national research agenda	• Develop and disseminate a health research agenda and strategy • Establish/strengthen health research ethics committees across all levels • 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)
13.1.3	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, grantsmanship, fund-raising etc.)
13.1.4	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
13.1.5	Strengthen institutions and systems at all levels for the promotion, regulation and ethical oversight of essential national health research	• Establish/strengthen health research and ethic committee in all states and relevant institutions • Conduct training of members of the NHREC/SHREC committees • Establish/strengthen functional committees (e.g. IRBs) for review and monitoring implementation of approved health research on human subjects across all levels
13.1.6	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

	13.1.7	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
	13.1.8	Facilitate the development of a repository for he 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
Strategic Pillar Four:			**Protection from health emergencies and risks**
14.Public Health Emergencies: Preparedness and Response			
14. Significantly reduce the incidence and impact of public health emergencies			
14.1	**Reduce incidence and impact of public health emergencies in Nigeria**		**•Morbidity and mortality from public health emergencies reduced by 50% by 2022** **•At least 50% of all health facilities in the country participate in disease surveillance and reporting using IDSR tools** **•At least 75% of the population is covered with surveillance alert systems** **•Proportion of Responses to all confirmed epidemics that fall within the 24 - 48 hour window increased to 80% by 2022** **• Proportion of s to road traffic accidents that fall within the 1-hour window (golden hour) to 50% by 2012**
	14.1.1	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 basic set of essential services 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
	14.1.2	Promote an integrated national disease surveillance system in line with International	• Develop human capacity for disease surveillance at all levels • Institutionalize risk reduction and emergency preparedness programmes at all levels of the health

	Health Regulation (IHR) and IDSR	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
14.1.3	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
14.1.4	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
14.1.5	Scale-up public education and awareness creation on public health emergencies	• Support public education and enlightenment on disaster preparedness and response
14.1.6	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.)
14.1.7	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
14.1.8	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.)
14.1.9	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)
Strategic Pillars Five:			**Predictable Financing and Risk Protection**
15.Health Financing			
15. Ensure all Nigerians have access to health services without any financial barriers or impediments at the point of accessing care)			
15.1	**Strengthened Governance and Coordination for actualizing stewardship and ownership of Health Financing reforms**		**• 70% of States and FCT with Healthcare Financing Equity & Investment Units by 2022** **• 70% of States and FCT with Healthcare Financing Equity & Investment TWGs by 2022** **• Health financing policy approved and adopted by FMOH; 70% of States and FCT with approved Health Financing Policy & Strategy by 2019** **• FMOH, SMOH, & FCT HHSS have approved investment cases for UHC priorities by 2022** **• FMOH has institutionalized routine NHA; 70% of States and FCT that have updated SHA**
	15.1.1	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)
	15.1.2	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-sectorial collaborations, public-private partnerships, and collaboration with community members, CSOs, and Development Partners to ensure improvement and coordination of health financing functions
	15.1.3	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
	15.1.4	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
	15.1.5	Coordinate phased implementation of the BHCPF	• Domesticate national guidelines on BHCPF • Adapt national manuals and procedures for accessing and disbursing funds from the BHCPF
15.2	**Increase sustainable and predictable revenue for health**		**• Increase funding to PHC from 21% to 35% by 2022** **• Increase percentage of national budget to from 8% to 15% of GDP by 2022** **• Expand health financing options and increase the proportion of funding from other sources to 20% by 2022**
	15.2.1	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.
	15.2.2	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
	15.2.3	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.
	15.2.4	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.
	15.2.5	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.
15.3	**Enhance financial risk protection through pooled funds at federal and state levels**		**• 30% of Nigerian population covered by any risk protection mechanisms** **• 50% of states reduce OOP by 50%**
	15.3.1	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
	15.3.2	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
	15.3.3	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
	15.3.4	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)
15.4	**Enhance transparency and accountability in strategic purchasing of Health Services**		**• 40% of Health MDAs with PBF as provider payment mechanism** **• Nigeria HTA Agency established** **• Federal and 36 States +FCT producing Health Accounts annually.** **• 70% of States with functional PFM Systems**
	15.4.1	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
	15.4.2	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.
	15.4.3	Establish National Quality Review & Health Technology Assessment Systems to determine which health	

		interventions are cost effective(FMOH only)	
	15.4.4	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
	15.4.5	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

Appendix 5: Risks and Mitigation Strategies

Risk mitigation strategy for the NSHDP II

S/N	Risk assumption	Mitigation strategy
1	**Leadership and Governance** ▪ Poor coordination, alignment and harmonization between the different levels of government, and across departments and programmes thus frustrating policy implementation and limiting responsiveness. .	▪ Full implementation of the National Health Act an fact that revised National Health Policy is informe current global agenda (SDG) are strong mitigatin factors against the Leadership and Governance r assumptions. ▪ Existing programmatic policies and plans should fully implemented. ▪ Political commitment to health, especially PHC at federal level is also a mitigating factor. Also, full implementation of PHCUOR will enhance perform of PHC
2	**Community participation** ▪ Poor understanding of concept and implementation of community participation at all levels and increasing financial incentivization of volunteer community-based workers threaten sustainability. ▪ 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.	▪ Existence of WDCs at ward level to be used a springboard for continuing community educati and mobilization. ▪ Availability of an organized platform for traditi rulers and religious leaders' involvement in he is a strong tool for community participation an ownership of health programmes ▪ Devolving some health programmes to comm level (e.g. IMCI, Community nutrition program etc.) is a mitigating factor. ▪ Availability of various categories of community based health care providers can be explored engender wider community participation and harmonization of programmes.

3	**Essential healthcare services** ▪ High and double burden of diseases and Non availability of data for planning of some interventions (E.gNCD, care of the elderly, mental health etc) and where available, the data are dated ▪ Non- availability of emergency medical services including emergency transport system	▪ Availability of policies, guidelines, SOPs etc. f established programmes. The strict implemer of these policies will mitigate the problems of disease prevalence, poor quality and weak se integration ▪ The creation of new units/programmes will be respond to emerging concerns.
4	**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 • Dearth of public health emergency response and management system • Emergency preparedness and response, including pre-positioning of drugs, vaccines and consumables is poor	• Establishment of NCDC and Emergency operatio centres (EOC) is a strong mitigation factor. • Large pool of trained epidemiologists can be harnessed through regular retraining to better res to public health emergencies. • Available policies, strategic plan, guidelines and t for IDSR can be fully implemented for better impa • Build the capacity of NEMA and SEMA through provision of required equipment and regular retra of the staff.
5	**Laboratory services** ▪ Lack of standardization of laboratory services. ▪ Dearth of competent personnel and poor maintenance of lab equipment. ▪ Absence of public health laboratories ▪ Poor linkage between clinical and research laboratory services	▪ Full capacity utilization of some well-equippec public and private laboratory services by recruitment of adequate, well trained personn ▪ The National and Blood Transfusion Services Policies should be fully implemented. ▪ Effective regulation of laboratory services is a strong factor.
6	**Human resources for health** ▪ Maldistribution of HRH (geographic – urban-rural and regional, level of care) in relation to numbers and skills mix ▪ Gender of health worker adversely influencing uptake of services ▪ Disconnect between the production pipeline and HRH needs ▪ Dearth of skilled health workers, especially at PHC level.	▪ Available national HRH policy and strategic pl and their domestication by some states shoul implemented as a strong mitigation factor. ▪ Existence of National Human Resources for H Information System (NHRHIS) infrastructure s be put to full, productive use. ▪ The national task shifting policy and SOP sho fully implemented These should be fully implemented
7	**Health infrastructure** ▪ No infrastructure units/departments to anchor health infrastructure at all levels of the health system and no	• The large number of health facilities across the c should be properly equipped for better performan • Adoption of maintenance policy

	infrastructure development and maintenance master plan. ▪ Poor state of health infrastructure ▪ Challenges of availability/regular supply of basic sanitary facilities, water and power abound ▪ Dearth of basic and critical care equipment ▪ Physically infrastructure, especially in older health institutions decaying and dilapidated states.	
8	**Health information system** ▪ Verticalization and duplications of reporting lines because of verticaliztion of programmes ▪ DHIS with poorly defined and not harmonized indicators and the platform is not sufficiently robust. It also does not capture community-level health information ▪ Limited capture (into the HMIS)) of private sector data despite their 60% contribution to healthcare in the country. ▪ Gross inadequacy in capacity to analyse and utilise data for decision making at all level. ▪ Weak coordination of M/E structure at all levels. ▪ Dearth of HMIS tools at facility level ▪ Non-inclusion of community level data into HMIS ▪ Poor human and material resources capacity at sub-national levels.	▪ Inauguration of the Health Data Governance Counc (HDGC) which is chaired by the Honorable Minister Health will go a long way to reduce verticalization a multiplicity of programmes and data collection tools ▪ Existence of health data consultative committee (HI chaired by the HMH and plans are ongoing to replic same at state and LGA levels. Together with HDGC provides oversight and governance for Health Information. ▪ SITAN of the M&E system performance carried out 2016 to guide development of roadmap for strength the M&E system.
9	**Health research** • Non-availability of national health research Agenda • Weak promotion, coordination and regulation for health research and development • Limited investment by private sector in Research and Development • Gross underfunding for health research in Nigeria • Disconnect between researchers and consumers of research findings (policy makers and industry) resulting in researchers driven by agenda with limited connection to research needs of the market place	The following constitute strong mitigation fact • Available Health Research institutions and tra institutions • Availability of national health research policy a guidelines • Research governance and regulatory structur place at all levels (NHREC) • Existence of some health research skills • Availability of some funding agencies e.g. TETFUND, NUC • Availability of many local and international jou for dissemination of health research findings

	• Poor networking/linkages between researchers • Limited availability of research infrastructure in research and academic institutions • Poor utilization of research findings to inform policy, programming and practice in the health sector	
10	**Health financing** ▪ Rising OOP spending in Nigeria which is now above 70%; 0nly about 5% of Nigerians have prepaid health care through social and voluntary private insurance. ▪ Very poor coverage with social health insurance ▪ Less than 10 percent of the population have financial risk protection ▪ Percentage of GDP devoted to healthcare funding in Nigeria remains at less than 2.5% of GDP instead of the WHO benchmark of 4% - 5%; ▪ 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)	The following are strong mitigating factors and should reinforced and exploited:: ▪ Existence of HCF governance structures inclu the HCF unit of the FMOH and the NHIS ▪ A detailed NHCF & E Policy and implementat plan ▪ Dedication of a percent of the CRF to health c funding stream in Nigeria ▪ The National Basic Health Care Provision Fur Guidelines has been approved and this is bei piloted in three Nigerian states ▪ There has been a gradual improvement in the National Budget allocation to Health in the las three years ▪ Many Nigerian States are now evolving sundr health financing/contributory schemes and He Care Financing Agencies (SHIA) to foster UH provide financial risk protection for the citizens ▪ Increased funding from donor partner. ▪ Implementation of free care programmes for vulnerable populations e.g. free MCH, Malaria HIV treatments etc.