

FRAMEWORK

FOR

NATIONAL STRATEGIC HEALTH DEVELOPMENT PLAN II (2017 – 2021)

**FEDERAL MINISTRY OF HEALTH, NIGERIA**

**2017**

# **FOREWORD**

Six years ago, the Federal Ministry of Health, in collaboration with key stakeholders, took a bold step towards improving the efficiency and effectiveness of our healthcare delivery system, through the development of a health sector integrated planning platform that delivers on our national development objectives. The result was the crafting of the first five-year National Strategic Health Development Plan (NSHDPI) 2010-2015 aimed at engendering significant improvement in the health care delivery system to enable the nation meet the relevant MDGs by 2015, improve the wellbeing of Nigerians, as well as Nigeria's ranking in the global human development index (HDI). The launching of the health strategic plan in 2010 was a major breakthrough for all of us. It marked the beginning of a conscientious, collaborative and integrated effort by all tiers of government and major stakeholders, under a unified platform to collectively to move the health sector forward and it delivers on its mandate. The process of development of the National Strategic Health Development Plan was transparent and participatory. The preparation of the plan, commenced with the development of an evidence-based framework that guided the Federal, States and Local governments, as well as other stakeholders, in the formulation of their respective strategic plans, which were harmonized into a single National document.

**T**he National Council on Health (NCH), the highest policy making body on health matters in Nigeria, approved the implementation of the NSHDPI in 2010. To further strengthen the stewardship role of Government towards the provision of quality, efficient, affordable and equitable health care delivery services to the teeming Nigerian population, Council resolved at its 58thmeeting held in Sokoto State from 7th – 11th March, 2016, that the implementation of the first Plan (NSHDP 2010 - 2015) should continue until the completion of its successor Plan (NHSDPII)

Consequently, the process towards the development of the NSHDPII was set in motion through the constitution and the inauguration of the Technical Working Group (TWG) in October, 2016 by the Honourable Minister, with the mandate to produce the five-year Plan (2017 – 2021). In view of the importance attached to this national assignment, the TWG met severally and came up with a progress report which was presented to Council at the 59th NCH meeting which held in Umuahia, Abia State from 23rd – 27th January, 2017. The Council, while commending the efforts of the committee, and the support from stakeholders including Development Partners, the private sector, and Civil Society Organizations (CSOs), expressed the urgent need to fast track and finalize the 2ndPlan by June 2017, to form the basis for the preparation of the 2018 health budget at all levels of Government.

To assess the level of performance of the NSHDP I, a Mid-term Plan Review and an End-term Plan evaluation, were conducted in line with the plan design. The reports have shown minimal level of achievement. The overall poor implementation recorded at all levels of government is attributed to several factors ranging from plan design gaps, governance issues , poor funding , coordination and integration problems, to dwindling resources arising from the unprecedented collapse of oil prices in the world market that pushed Nigeria's economy into recession in 2015-2016.

We have taken stock of the lingering and emerging health challenges and government is committed to vigorously address them within the confines of resource limitations. The NSHDPII offers us great opportunity to consolidate the gains made and incorporate, lessons learnt to ensure better health sector outcomes by 2021. 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 realization of our goal of ONE FRAMEWORK, ONE PLAN AND ONE M&E for the Nigerian health sector

The NHSDP I addressed only the Health System building blocks under the eight priority areas of the old Policy (2004), the second plan takes a more comprehensive, inclusive and holistic approach. It is organized along three parts; Service delivery; which covers RMNCAH, Communicable and Non- Communicable diseases, Mental Health, Care of the Elderly, NTD’s etc., the Health Systems component which focuses on the nine thrusts of the National Health Policy, 2016; governance, human resources, financing, health information system, medicines, vaccines and other technologies, research etc., and the M&E component which cuts across all the programmes. The adoption of the framework for the development of the NSHDP II is consistent with the National Health Policy (NHP) 2016, and the National Health Act (NHAct) 2014 that provide the legal backing required towards Nigeria’s attainment of Universal Health Coverage (UHC) through PHC, and the reduction of the burden of diseases in Nigeria by 30% in year 2021.

**Prof. Isaac F. Adewole,** FSPSP, DSC, FROCG Hons

# **DECLARATION**

**1. CONTEXT**

We, the stakeholders involved in, or supporting the provision of health services in Nigeria with emphasis on Universal Health Coverage (UHC), through Primary Health Care;

* 1. Realising that health is a basic human right, subscribe to the achievement of the NSHDP II, Sustainable Development Goals (SDGs) in line with National Health Act 2014 and National Health Policy, (2016), and other national health development agenda;
  2. Acknowledging global (International Health Partnership {IHP+} and others) and regional efforts (e.g. Harmonization for Health in Africa {HHA}) aimed at strengthening partnerships for health;
  3. Affirming our need to be responsive to the principles of the Paris Declaration on Aid Effectiveness in terms of:
* **Ownership**: where the federal, state and LGAs exercise effective leadership over health development policies and, as well as plans, coordinate health development efforts;
* **Alignment**: where health development partners base their overall development assistance on this Framework, its resultant National Strategic Health Development Plan (NSHDPII), institutions and procedures;
* **Harmonisation:** where development partners effectively coordinate within the health development partner group to minimise the cost of delivering aid;
* **Managing for Results:** through which Nigeria and its health development partners work together to manage technical and financial resources towards achieving concrete results;
* **Mutual Accountability:** by which the Federal, State, LGAs, development partners, the private sector and other stakeholders at all levels hold each other accountable for health development results;
  1. Recognising that the Federal Ministry of Health (FMoH) has a broad mandate as the national coordinating authority on health;
  2. Acknowledging that the National Council on Health, is the highest decision making body in the Nigerian health sector and would bring together different constituencies of stakeholders for innovation and participation in policy formulation and action within the NSHDPII context, and
  3. Recognising the National Health Management Information System (NHMIS) as the One Monitoring and Evaluation Framework, to track, monitor and evaluate the NSHDPII

**2. PRINCIPLES**

We the undersigned this … day of …… ……….. declare our commitment to the following principles:

2.1 To ensure that the attainment of universal health coverage shall be the philosophy and strategy for national health development;

2.2 To strengthen PHC as the bedrock of the national health system that supports equitable distribution of services and resources to those in greatest need based on evidence and to uphold the right of consumers of health care, particularly vulnerable population;

2.3 To strengthen capacity for the active involvement of communities at all levels of health services delivery;

2.4 To promote the provision of quality care by all actors at all levels that is gender sensitive, evidence based, responsive, pro-poor and sustainable with a focus on outcomes;

2.5 To provide support for equitable distribution of services and resources to those in greatest need based on evidence and to uphold the rights of consumers of health care, particularly vulnerable populations;

2.6 To provide voluntary and timely information to feed into the nationally agreed M&E framework to track, monitor and evaluate the national health system;

2.7 To provide policy direction and adequate funding that facilitates the involvement of all stakeholders from both the public and the private sector towards joint collaboration between health and related sectors (water and sanitation, basic education, infrastructure, etc.), expanding utilization and delivery options and coordinating technical assistance;

2.8 To promote and strengthen inter-sectoral action for health through effective partnership among all stakeholders for health development by mainstreaming health in all policies not only within the context of prevention, but beyond; and

2.9 To strengthen development partners coordination mechanism to ensure the effectiveness of all aid assistance at all levels.

2.7 To support the Federal Ministry of Health in discharging its mandate as the coordinating authority for health in Nigeria.

**3. UNDERTAKINGS**

Bearing in mind that Nigeria is committed towards meeting the health related goals of the SDGs, we therefore resolve to take immediate and relevant actions in addressing the complexities and challenges posed by the stagnating health status through the NSHDPII Framework and as listed below, and build on these and other national, regional and global commitments for future health investments.

3.1 Promote the use of the NSHDPII Framework for the development of the respective health plans for each tier of government;

3.2 Ensure that the health plans encompass cost-effective interventions that strengthen the delivery of essential health services and referral services including secondary and tertiary care, which include Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) strategies, malaria control, immunization, TB, HIV/AIDS, public private partnerships;

3.3 Ensure equitable distribution and management of the human resource for health through appropriate strategies including capacity building, incentives; and task delegation;

3.4 Ensure adequate funding for health services at all levels in the country to meet its commitment on the Abuja declaration of ensuring 15% of total national budget is allocated to health as well as the 1% Basic Health Care Provision Fund as provided for in the NHAct, 2014.

3.5 Ensure that appropriate and broad -based partnerships are built with the community and media to promote behavioural change towards improved health;

3.6 Engage all stakeholders under the leadership of the FMoH to update programmes and projects to promote compatibility with the NSHDP Framework;

3.7 Strive towards synchronized planning and review cycles in line with the annual review and planning systems in order to maximize the use of national capacities and competencies;

3.8 Institutionalize the constitution of a standing committee to ensure strict adherence to standards and norms across all levels of health care delivery system.

3.9 Promote data collection, through harmonized reporting procedures and timelines within the national NHMIS framework; strengthen information sharing and knowledge management mechanisms for better planning;

3.10 Ensure constituency representation in the various subcommittees of the National Council on Health to facilitate FMoH’s task in effectively fulfilling its coordination role;

3.11 Create conducive environment for the advancement of science and research in Nigeria whilst adhering to highest ethical and scientific standards.

**IN WITNESS WHEREOF**, the undersigned, being duly authorized representatives of the parties hereto have signed this Declaration of Commitment on the day and year first above written.

**Signed:**

1. Honourable Minister of Health
2. Chair, All State Governors Forum
3. Chair, Association of Local Governments of Nigeria (ALGON)
4. Representatives of Multilateral and Bilateral Development partners

WHO

UNICEF

UNFPA

UNDP

WORLD BANK

AfDB

USAID

DFID

DFAD D

EU

JICA

1. Representatives of Private Health Care Providers
2. Representatives of Professional Groups
3. Representatives of Civil Society Organisations (CSOs)
4. Representatives of the community (Chairman, Traditional Rulers Council for each State)

# **ACRONYMS**

|  |  |
| --- | --- |
| ADRHS | Adolescent reproductive health services |
| AMR | Antimicrobial Resistance |
| BCC | Behaviour change communication |
| BFHI | Baby Friendly Hospital Initiative |
| BI | Bamako Initiative |
| CCT | Conditional cash transfer |
| CHEW | Community Health Extension Workers |
| CHPRBN | Community Health Practitioners’ Registration Board of Nigeria |
| CIDA | Canadian International Development Agency |
| CIMCI | Community integrated management of Childhood Illness |
| CORPS | Community oriented resource persons |
| CPHCB | State Primary Health Care Board |
| CSO | Civil society organization |
| DfID | Department for International Development |
| DHIS | District Health Information System |
| DHS | Nigeria Demographic and Health Survey |
| DP | Development Partners |
| DPGH | Development Partners Group for Health |
| DPRS | Department of Planning, Research and Statistics |
| EDP | Essential Drugs Programme |
| EML | Essential Medicines List |
| EMoC | Emergency obstetrics care |
| FANC | Focused antenatal care |
| FCT | Federal Capital Territory |
| FP | Family planning |
| GDP | Gross Domestic Product |
| GIS | Geographic Information System |
| GLASS | Global Antimicrobial Surveillance System |
| HDCC | Health Data Consultative Committee |
| HDGC | Health Data Governance Council |
| HF | Health Facility |
| HIS | Health Information System |
| HIV/AIDS | Human Immuno Deficiency Virus/Acquired Immune Deficiency Syndrome |
| HLM | High Level Ministerial Meeting on Health Research |
| HMIS | Health Management Information System |
| HPCC | Health Partners Coordinating Committee |
| HRH | Human resources for health |
| HW | Health Worker |
| ICCM | Integrated Community Case Management of Childhood Illness |
| IDRS | Integrated Disease Surveillance and Response |
| IEC | Information, Education and Communication |
| IMCI | Integrated management of Childhood Illnesses |
| IMNCH | Integrated maternal, newborn and child health |
| IPC | Interpersonal Communication skills |
| ISS | Integrated supportive supervision |
| IT | Information Technology |
| JFA | Joint Funding Agreement |
| JICA | Japan International Development Agency |
| LGA | Local Government Area |
| LIMS | Logistic Information Management System |
| LLIN | Long lasting insecticide treated nets |
| LSMC | Logistics supply management chain |
| LSMC | Life Saving Medicines and Commodities |
| M&E | Monitoring and Evaluation |
| MAM | Moderate acute malnutrition |
| MCH | Maternal and Child Health |
| MDA | Ministries, departments and agencies |
| MDCN | Medical Research Council of Nigeria |
| MFL | Master facility list |
| MNCH2 | Maternal, Newborn and Childhealth-2 |
| MNH | Maternal, newborn health |
| MRCN | Medical Research Council of Nigeria |
| MSS | Midwives Service Scheme |
| NAFDAC | National Agency for Food Drugs Administration and Control |
| NBP | National Blood Policy |
| NCH | National Council on Health |
| NDF | National Drug Formulary |
| NDF | National Drug Formulary |
| NDP | National Drug Policy |
| NDP | National Drugs Policy |
| NEDP | National Essential Drugs Programme |
| NGO | Non-governmental organization |
| NHA | National Health Account |
| NHA | National Health Act |
| NHIS | National Health Insurance Scheme |
| NHMIS | National Health Management Information System |
| NHREC | National Health Research Committee |
| NHRIS | National Human Resources for Health Information System |
| NIMR | Nigerian Institute for Medical Research |
| NIPRD | National Institute for Pharmaceutical Research and Development |
| NMLStP | Nigeria Medical Laboratory Strategic Plan |
| NPHCDA | National Primary Health Care Development Agency |
| NPSCMP | National Product Supply Chain Management Programme |
| NSHDP | National Strategic Health Development Plan |
| NSHDPf | National Strategic Health Development Plan Framework |
| NSTDA | National Science and Technology Development Agency |
| OAU | Organization of African Unity |
| ODA | Overseas Development Assistance |
| OOPE | Out-of-pocket expenditure |
| OPS | Organized private sector |
| PAC | Post- abortion care |
| PCN | Pharmacists Council of Nigeria |
| PEPFAR | President’s Emergency Plan for AIDS Relief |
| PFM | Public Finance Management |
| PHC | Primary health care |
| PHCMIS | Primary Health Care Management Information System |
| PHCUOR | Primary Health Care Under One Roof |
| PMG-MAN | Pharmaceutical Manufacturing Group of Manufacturers Association of Nigeria |
| PPP | Private-public partnership |
| PTF | Petroleum Trust Fund |
| QA | Quality Assurance |
| RDBs | Research data banks |
| RHIS | Routine Health Information System |
| RMNCAH+ N | Reproductive, maternal, newborn, child and adolescent health plus nutrition |
| SAM | Severe acute malnutrition |
| SMOH | State Ministry of Health |
| SOP | Standard Operating Procedures |
| SRH | Sexual and reproductive health |
| SSFFC | Substandard/Spurious/Falsely labelled/Falsified/Counterfeit |
| STG | Standard Treatment Guidelines |
| SURE-P | Subsidy Reinvestment and Empowerment Programme |
| SWAPs | Sector-wide approaches |
| TB | Tuberculosis |
| TBA | Traditional Birth Attendant |
| TBA | Traditional birth Attendant |
| TSS | Task Shifting Sharing |
| TWG | Technical Working Group |
| UHC | Universal Health Coverage |
| UNICEF | United Nations Children Fund |
| UN-System | United Nations System |
| VAT | Value Added Tax |
| vDC | Village Development Committee |
| VHW | Village Health Worker |
| VOC | Vote-of-charge |
| WHO | World Health Organization |

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# EXECUTIVE SUMMARY

Nigerian government considers health critical to engendering sustainable national development as it enhances national productivity and competitiveness. Thus, access to quality health care and prevention services are considered vital for poverty reduction and economic growth, which is key to the attainment of her Vision 2020. Expansion of access to health care services is also of urgency if the nation is to attain the Social Development Goal 3 target of universal access to health care services, particularly, as she failed to attain the health-related MDGs.

In pursuit of the national goal of achieving universal health coverage for Nigerians, the nation launched the first five-year National Strategic Health Development Plan (NSHDP) 2010-1015, in 2010. The first NSHDP sought to address gross weaknesses in Nigeria’s health system that have militated against effective health care service delivery and the inadequate coverage of high impact live-saving cost-effective interventions that largely accounts for the very poor health outcomes recorded in the country. Thus, the focus of the NSHDP I was on strengthening prioritised health system building blocks (leadership and governance, health financing, human resources for health, health information, service delivery, partnerships, community participation and health research). Since Primary health Care (PHC) is the fulcrum of the national health policy, the NSHDP I invested in strategies to strengthen PHC at the LGA level, the level that has the responsibility for PHC services provision

Final evaluation of the implementation of NSHDP showed that while there have been marginal gains in some areas, the health system remains prostrate. Provision of PHC services continue to pose challenges and coverage with key interventions remains low, much lower than the African averages. In terms of gains, the report indicates remarkable improvements in maternal and child health with impressive reduction in maternal and child mortality rates and a marginal increase in life expectancy. Despite these gains, the health status of Nigerians remains poor. The Second National Strategic Health Development Plan (NSHDP II) will seek to continue investing in strengthening the health system, but with an increasing focus on service delivery, which did not receive adequate attention in the NSHDP I.

The NSHPD II is being developed as a collaborative undertaking of the Federal and States’ Ministries of Health, Development Partners and other stakeholders. The plan is being prepared within the framework of Vision 2020, the Economic Recovery and Growth Plan (2017 2020), and the 2016 revised National Health Policy. It is also being guided by all relevant extant policies and legislations, notably the National Health Act and international declarations, majorly the UN-Social Development Goals (SDGs).

As a prelude to the development of the NSHDP II, a generic Framework was developed to serve as a guide to federal and states in the selection of evidenced-based priority interventions that would contribute to achieving the desired health outcomes for Nigerians. It is expected therefore, that in using this Framework, the Federal and States would develop their respective costed plans through participatory approaches to reflect their context and prevailing issues. The end product being a harmonized National Strategic Health Development Plan with its appropriate costing will thereafter serve as the basis for collective ownership, adequate resource allocation, inter-sectoral collaboration, decentralization, equity, harmonization, alignment, and mutual accountability in Nigeria. It would also stipulate requirements for future health investments towards achieving sustainable universal access and coverage within the planned period of 2017 - 2021

Major steps adopted in the development of the NSHDP framework include the inauguration of a Technical Working Committee comprising of government (Directors of the FMoH, programme managers and desk officers and Commissioners of health from the States), Development Partners, CSOs, private sector, academicians and experts in development planning. Through the review of the final evaluation report of NSHDP I and other technical resource materials, wide consultations and participatory techniques, it was decided that whereas the NSHDP 1’s priority concern was to improve the Nigerian health system for delivery of health services, the services to be delivered were not given adequate attention. Thus, a major shift from NSHDP I is the inclusion of technical health service programmes. These health service programmes, which are derived from the revised national health policy is being proposed as the essential health care package for Nigeria, and it comprises:

* Reproductive, maternal, new born, child health and nutrition –related programmes;
* Control of communicable diseases (malaria, tuberculosis, HIV/AIDS, hepatitis and neglected tropical diseases);
* Control of non-communicable diseases;
* Mental health;
* Care of the elderly;
* Public health emergencies;
* Oral health;
* Eye health;
* Environmental health (water and sanitation, food safety, snakebites and chemical programme);
* General and emergency hospital services;
* Health promotion.

Given major weaknesses in all domains of the health system building blocks, the plan intends to address key issues in all of them. The support services include health care financing, human resources for health, health infrastructure, information management system, essential medicines, vaccines, equipment supplies and logistics, research and development and governance (legal and regulatory framework, policy and planning, coordination). In addition partnerships for health and community participation and ownership for health development have also, been included.

This framework provides the context, goals, strategic objectives, and recommended evidence-based and cost-effective interventions required to deliver improved performance of the health system and health outcomes for Nigerians for each prioritized health system area.

Within the context of the priority areas, identified and included in the plan, it is proposed that the following should be given higher priority in NSHDP II:

* Ensuring effective leadership and governance with emphasis on increasing resource mobilization and aligning funding to UHC;
* Reducing geographic and socio-economic barriers to access, strengthening coordination of different levels of the health care system and also among various stakeholders and strengthening regulatory institutions to ensure effective functionality; and
* Improving human resource management through effective performance appraisals and reward systems based on performance;
* Review financing mechanisms to ensure functionality, allocative efficiency and rapid expansion of social health insurance so as to increase risk protection and increased funding, including government’s increased funding to the health sector in line with Abuja Declaration;
* Strengthen PHC and other levels of the health care system by defining and approving an essential health care package for all Nigerians;
* Strengthening LGA/primary health care services and community systems to ensure resilience and guarantee health security;
* Develop standards of practice at different levels of the health care system, referral guidelines and ensure functionality of the referral system;
* Reduce medical tourism by improvement in quality of care and enforcements of standards. Increase investments in health promotion and disease prevention;
* Redress human resource gaps, promote industrial harmony and reduce strikes within the sector, and invest in health research and innovations.

The overall purpose of the plan is to reduce disease burden from all causes of ill health in Nigeria, and reduce disparities therein through increasing access to a comprehensive package of appropriate, affordable, quality, equitable and integrated essential health care services within the context of strengthened health care system, aligning resources in relation to needs. Services to be provided and resources required for each level of the health care system will be properly defined. The entry point for the delivery of the essential package of health care services will be the strengthened LGA and ward primary health care system and appropriate referrals pathways to other levels of care that will support this level of care, which will be defined.

The plan bears from the result framework as schematised in Chapter 1. The situation analysis, strategies and interventions are detailed in the respective chapters of the framework.

# CHAPTER 1: INTRODUCTION

## 1.1. Background

Health is both a precondition and outcome of sustainable development: national productivity and longevity is contingent on the health status of the population while increasing national wealth improves the living condition and health of the people. Consequently, health is a major national resource that requires consistent investment and strategic development. In addition, health is also a basic human right that everyone should be able to enjoy to the highest level to be able to live a socially and economically productive life. Every Nigerian has a right to a supportive environment to be able to exercise this right. To this end, the government has, 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.

Prior to 2010, the efforts at health sector development had been fragmented and not well coordinated, resulting in the poor performance recorded in the country's health status, in comparison to other countries. This necessitated a paradigm shift, from a fragmented approach to a better coordinated, comprehensive and integrated strategic national health sector development planning. In this regard, the Government of the Federal Republic of Nigeria, through the Federal Ministry of Health (FMoH) and in collaboration with other stakeholders at the national and international levels, embarked on the formulation of the first five-year costed National Strategic Health Development Plan (NSHDPI 2010-2015). This second National Strategic Health Development Plan (NSHDP II) for the period 2017 – 2021 is a successor plan to NSHDP I. It is designed to build on the first NSHDP. In this regard, the NSHDP II strategic framework seeks to establish and provide specific guidance on the reasons to deepen investments in the health sector and the outcome objectives to be achieved, which include, substantial improvement in the health system and service delivery with the aim of reducing disease burden , increasing life expectancy and healthy years for all Nigerians.

## 1.2. Global and National Context

Cognizant of the synergistic relationship between health and development, health has been central to a number of international declarations aimed at sustainable development with a focus on ending extreme hunger and promoting peace and security. The first was the Millennium Declaration adopted by the UN General Assembly in 2000 committing to eight inter-related goals, the Millennium Development Goals (MDGs). Three of these goals, MDGs 4-6, addressed reducing child mortality; improving maternal health; and halting and reversing HIV/AIDS, Tuberculosis and Malaria; with specific targets to be achieved by 2015.

While at the global level impressive progress was made in achieving the MDGs, this was variable and much lower in Low and Middle Income Countries (LMIC). Lack of universal health coverage and financing gaps were identified as the major factors militating against the attainment of health-related MDGs in these countries. Recognizing the imperative to address the ‘unfinished MDG agenda’ and the need to address the ongoing public health challenges of acute epidemic disease, disasters and conflict situations, the burgeoning epidemic of non-communicable diseases and mental health disorders, these were incorporated in the follow-up Sustainable Development Goals (SDGs).

The SDG covers the period 2016 – 2030 and has 17 goals and 169 targets that are all interlinked, reflecting the fact that sustainable development in a country requires multi-sectoral and multidimensional policy interventions that address hunger, malnutrition, poverty, insecurity, universal health coverage (UHC), education, environmental protection and employment, within an equitable framework.

SGD 3 focuses on health and has as a goal to ‘*Ensure healthy lives and wellbeing for all ages’* The goal has 13 targets that include the unfinished agenda from MDG, new targets to address the other health threats and challenges and targets that cover the means of implementation. These are presented in table 1.

Table 1: The Health Sustainable Development Goal

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **SDG 3: ENSURE HEALTHY LIVES AND PROMOTE WELL BEING FOR ALL AT ALL AGES** | | | | |
| **TARGET 3.8: Achieve universal health coverage, including financial risk protection, access to quality essential health-care services, medicines and vaccines for all** | | | | |
| ***MDG unfinished and expanded agenda*** |  | ***New SDG 3 targets*** |  | ***SDG3 means of Implementation targets*** |
| **TARGET 3.1:** Reduce maternal mortality to less 70/100, 000 live births  **TARGET 3.2:** End preventable newborn and child deaths  **TARGET 3.3:** End the epidemics of HIV, TB, malaria and NTDand combat hepatitis, waterborne and other communicable diseases  **TARGET 3.7:** Ensure universal access to sexual and reproductive health-care services |  | **TARGET 3.4:** Reduce mortality from NCD and promote mental health  **TARGET 3.5:** Strengthen prevention and treatment of substance abuse  **TARGET 3.6:** Halve global deaths and injuries from road traffic accidents  **TARGET 3.9:** Reduce deaths from hazardous chemicals and air, water and soil pollution and contamination |  | **3.a:** Strengthen implementation of framework convention on tobacco control  **3.b:** Provide access to medicines and vaccines for all, support R&D of vaccines and medicines for all  **3.c:** Increase health financing and health workforce in developing countries  **3.d:** Strengthen capacity for early warning, risk reduction and management of health risks |
| **Implementation expected to interface with economic, other social and environmental SDGs and the SDG 17 can serve as the means of implementation** | | | | |

At the Regional level, the *Abuja 2001 Declaration and Abuja+12 Declaration* committed the African Union Member States to allocate at least 15% of their annual national budget to health. The *Common African Position (CAP) on the Post 2015 Agenda* (African Union 2014) seeks to achieve universal and equitable access to quality health care on the continent, prioritizing 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/AIDS, malaria and TB), and 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.

At the national level, Nigeria’s Development Agenda, Nigeria Vision 20:2020, sets the goal for Nigeria to become one of the twenty largest economies in the world by the year 2020. Nigeria envisions the development of a large diversified, sustainable, competitive economy that affectively 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 nation aims at increasing national productivity, raising the quality of life of all Nigerians and, improving significantly Nigerians ranking in HDI. The health sector is expected to contribute to the attainment of the Vision through ensuring a healthy, vibrant and productive labour force. In the same vein the medium-term plan, Nigeria's Economic Recovery Plan (EGRP) 2017-2020, sets three broad strategic objectives, which are; restoring growth; investing in our people, and building a globally competitive economy. The EGRP also, recognizes the strategic role of the health sector in contributing to the achievement of these objectives. Specifically, the EGRP sets 10 policy objectives for the health sector as follows:

* 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;
* Revitalize 10,000 primary health care centres and establish at least one functional primary health centre (PHC) in each ward to improve access to health care;
* Fully implement the primary health care refinancing programme to mobilize domestic resources;
* Drive progress to meet UN SDG health targets;
* Reduce infant and maternal mortality rates;
* Roll out universal health coverage (NHIS);
* Strengthen delivery beyond the primary health care system;
* Reduce infant and maternal mortality rates.

These policy goals have been considered in the development of the NHSDP II accordingly.

## 1.3. The NHSDP II and the National Health Policy (2016)

Nigeria constitution of 1999 (as amended) allows the three tiers of government – federal, state, and LGA – responsibilities for healthcare. The National Health Act 2014, articulates that the Nigerian Health System consists of: (a) The Federal Ministry of Health; (b) States’ Ministries of Health and the Federal Capital Territory’s Department of Health; (c) Parastatals under the federal and state Ministries of Health; (d) all Local Government health authorities; (e) the ward health committees; (f) the village health committees; and (g) the private health care providers. The National Health Act further defines the relationship between various tiers and provides a framework for standards and regulation of health services, as well as for the establishment of a Basic Health Care Provision Fund.

In addition to the National Health Act -2014, the National Health Policy-2016, with the theme “Promoting the Health of Nigerians to Accelerate Socio-economic Development” provides direction in health care delivery in the country. The NHP-2016 comes at a time when there is global re-commitment to a new development framework, the Sustainable Development Goals (SDGs); and an increasing global support for the attainment of Universal Health Coverage as well as a Presidential Summit on Universal Health Coverage, convened in March 2014. The summit reiterated the country’s commitment to achieving UHC and sustainable health development through the strengthening of Primary Health Care and providing access to suitable financial risk protection mechanisms.

The health policy's mission statement is "to provide stakeholdersin 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 Sustainable Development Goals (SDGs)”. The Policy has a primary focus on the health system. 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.” Furthermore, the Policy proposes strategic actions in ten health areas: Governance and Stewardship for Health; Health Service Delivery; Human Resources for Health; Health Financing; National Health Management Information System; Partnerships for Health; Health Promotion, Community Participation and Ownership; Health Research and Development; Medicine, Vaccines and other Health technologies and Health Infrastructures.

The strategies for achieving these objectives have been adequately situated in this NSHDP ll.

## **1.4. Country Profile**

The Federal Republic of Nigeria is ranked the 7th most populous country in the world, with an estimated population of 170 million (2016), of which 49% are female and 51% male. The country operates a three-tiered federal system of governance consisting of Federal, States, and Local Governments. Structurally, the country consists of 36 States and a Federal Capital Territory (FCT). The states are further divided into 774 local government areas (LGAs) while the FCT is divided into six area councils. Abuja, the Federal capital and the seat of the Nigerian government, is situated within the FCT. For political and administrative purposes, Nigeria is divided into six geopolitical zones - North-East, North-West, North-Central, South-East, South-West and South-South. These geo-political zones comprise states with some degree of similar culture, ethnic grouping, and common history. Wide regional, socio-cultural, economic and geographical diversities exist across the country.

While subsistence agriculture is the predominant occupation, the national revenue is derived mainly from oil, accounting for 81% of export earnings and over 80% of government revenue (National Population Commission, 2008). States and LGA revenues, contributing to funding for health care are largely dependent on allocations from the federal government as their internally generated revenues are low.

Nigeria’s GDP grew from NGN 54.6 trillion in 2010 to NGN 80 trillion ($502 billion) in 2013, making Nigeria the largest economy in Africa. The economy grew at a rate of 4.5 – 5% between 2010 and 2013 and by 6.2% in 2014. While Nigeria’s economy is still largely dependent on the oil revenues, the growth in GDP was driven largely by growth in the non-oil sectors. However, with declining oil revenues and ongoing security challenges in the North-East zone, the gross foreign and fiscal reserves declined steadily from 2014. The overall economic growth in 2015 was only 2.98%, and since 2016 Nigeria’s economy has fallen into recession.

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 location. It is also estimated that more than half of Nigerians (54.4%) live in poverty with 70.8% of this segment of the population living below the poverty line of less than $1 per day (UNDP, 2007). Furthermore, poverty is found to be predominant in the rural areas than urban areas and major regional disparities exist, with 90% of the poorest people living in the north of the country (UNICEF, 2015; UNDP, 2016). Unemployment rates are high; 9.9% of the population is unemployed while 16.6% are underemployed, with the urban areas worst affected.

While the 1999 Constitution (as amended) is silent on the roles of the different levels of government in health services provision; the National Health Policy ascribes responsibilities for primary health care to local governments, secondary care to states and tertiary care to the federal level. At the same time, the National Primary Health Care Development Agency (NPHCDA), a parastatal of the federal government, is also mandated to intervene in primary health care development.

In addition to the national health policy, there are many health programmes’ policies that were considered in the development of the NSHDP Framework. Some are shown in Table 1

Table 2: Health Programmes' Policies in Nigeria considered in the Development of the NHSDP 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 Sharing Policy (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 * National HIV/AIDS Strategic Plan |
| 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) |
| Non Communicable Diseases | * Non Communicable Diseases Policy |
| Malaria | * National Malaria Strategic Plan (2014 -2020) |
| Tuberculosis | * The National Strategic Plan for Tuberculosis Control: Towards Universal Access to Prevention and Treatment (2015 – 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) |
| 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) (2017 |
| Sexual and Reproductive Health | * National RH Policy (2010-2015) * National Policy on HIV/AIDS (2010-2015) |
| Adolescent health | * the National Policy on Health and Development of Adolescent and Young People in Nigeria (2007-2012) |
| Nutrition | * Infant and Young Children Feeding Policy * National Policy on Food Safety & Its Implementation Strategy (NPFSIS) (2014) |

## **1.5. Overview of the Health System**

Nigeria operates a pluralistic health care delivery system with the orthodox and traditional health care delivery systems operating alongside each other, albeit with hardly any collaboration. Both the private and public sectors provide orthodox health care services in the country.

The public health care system is divided into three tiers, each associated with one of the administrative levels of government. The federal government has responsibility for tertiary health care, policy formulation and technical support to the states; the states have responsibility for secondary level health care and technical support to the LGAs while the LGAs have responsibility for PHC. Whereas the LGAs are designated the providers of PHC, they are the weakest link in the health care system as they have the lowest capacity and commitment to health development in the country. The Ward Minimum Health Package for Nigeria (National Primary Health care Development Agency, 2008) proposed a primary care facility at the level of each ward that would provide basic emergency obstetric care services, but the implementation of this package has been slow. In an effort to strengthen PHC services with a view towards attaining Universal Health Coverage (UHC), the current administration at the federal level is investing in supporting the upgrading of 10, 000 primary health care centres, one PHC per political ward for qualitative PHC services provision, with a focus on maternal, newborn and child health. Geographic and economic access to health services remains a major challenge, so also the quality of care.

In spite of investments in the health sector, the health system remains weak and is characterized by gross underfunding, lack of allocative efficiency, poor coordination of the different stakeholders in the sector, dearth of skills and quantity 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 in a prostrate state because of gross under funding and lack of capacity at the LGA level, which is the main implementing body. Additionally, the health system remains overstretched by a burgeoning population. There is almost no financial risk protection and the health system is unresponsive. This very weak health system results in very limited coverage with proven cost-effective interventions.

## **1.6.** Overview of the Health Status in Nigeria

While there have been some improvements, Nigeria’s health status indicators are among the worst in the world. The life expectancy at birth is 54.5 years; vaccine-preventable diseases and infectious and parasitic diseases continue to exert their toll on health and survival of Nigerians, remaining the leading causes of morbidity and mortality. Nigeria has the highest number of HIV infected persons in the African continent. In addition to the high burden of communicable diseases, non-communicable diseases are increasingly becoming public health problems, especially among the affluent urban population.

Even though only 2% of the global population is in Nigeria, the nation contributes a disproportionate 10 - 14% to the global burden of maternal and under-five mortality respectively. The maternal mortality ratio is 576/100, 000 live births with an estimated 33,000 maternal deaths occurring annually; the infant mortality rate is 64/1000 live births while the under-five mortality rate is 128/1000 live births (NDHS, 2014). Wide urban-rural, regional variations and socio-economic differentials exist in these rates, with the Northern zones, poorer, rural and uneducated segments of the population having worse indices.

Coverage with key cost-effective interventions remains low. For example, only about a quarter of the children aged 12 – 23 months are fully immunized, while only two out of under five children sleep under LLIN, contraceptive prevalence rate is 10% (modern contraceptives) while only 38% of women deliver under the supervision of skilled birth attendants.

## **1.7. Overview of Performance of the First National Strategic Health Development Plan**

The first five- year National Strategic Health Development Plan 2010 -2015, was launched in 2010. The overarching goal  *was to significantly improve the health status of Nigerians through the development of a strengthened and sustainable health care delivery system.* This was the first integrated Health Plan for the nation, as it harmonised the Federal, State and Local Government health plans into a holistic agenda that serves as the overarching framework and a reference document for all stakeholders in the health sector, to ensure transparency and mutual accountability for result. Prior to the development of the NSHDP planning in the health sector had been fragmented and uncoordinated with little or no results to show for investments in the sector, resulting in Nigeria's poor health status. The NSHDP I, provided a roadmap for accelerated development of a sustainable, cost- effective and efficient national health system that improves the health status of the population. It also, provided the platform to strengthen inter-governmental collaboration in achieving the national health sector objectives as encapsulated in Nigeria’s Vision 20:2020.

The NSHDP was based on the principles of the Four Ones: one health policy, one national plan, one budget, and one monitoring and evaluation framework for all levels of government. It focused on eight strategic priority areas: Leadership and Governance for Health; Health Service Delivery; Human Resources for Health; Financing for Health; National Health Management Information System; Partnerships for Health; Community Participation and Ownership; and, Research for Health. These strategic areas broadly cover the globally recognised building blocks of the health system as defined by the World Health Organisation (World Health Organization, 2007).

During the preparation process of this plan, the FMOH received immeasurable support from the states and international development partners in both financial and technical terms.

In the past six years, the NSHDPI has been implemented to varying degrees by the Federal and State Ministries of Health, as evident from the Joint Annual and Mid-Term Reviews, as well as, the three-year Health Sector Performance Reports. The NSHDP I end-of-term evaluation showed mixed results. While there was some improvement in some impact indicators, like the MDG indicators, others did not show significant improvements and service coverage improvement remained limited. One of the major limitations of the first NSHDP was the limited focus on health services. Other key findings from the evaluation include:

* Persistence of governance and accountability weaknesses as evidenced by poor political will, inequitable and inefficient funding, weak coordination across levels of government and across departments and programs, poor donor coordination in spite of the NSHDP being instrument for engaging IHP+;
* Failure of the National Health Act to address the coordination gaps and its slow implementation, resulting in failure to access the financial provisions within the Act for strengthening PHC and for provision of package of essential health care services;
* Challenges in economic access to health care, as coverage of health insurance remains very low and out-of-pocket expenditure persists as the dominant method of financing health care; additional mechanisms for financial risk protection for vulnerable populations is lacking;
* Lack of ‘Smartness of some indicators, weak M&E system and persistence of vertical reporting, that makes tracking of indicators difficult.
* Poor awareness of the existence of strategic plans by some key actors and failure to use the plans for operational plans;
* Poor understanding of the concept of health system by some State actors, including their stewardship roles in health;
* Failure to meet targets for most of the indicators, including coverage indicators
* Weak PHC system; and
* Poor engagement of consumers

The focus of the NSHDP II includes the remediation these challenges with a view to improving efficiency and effectiveness of health service delivery in Nigeria. The Plan shall serve as the successor plan to NSHDPI.

## 1.8. Development of the Second National Strategic Health Development Plan (NHSDP II)

As a prelude to the development of the NSHDP II, a generic Framework was developed to guide Federal and States agencies in the development of evidenced-based priority interventions that would contribute to achieving the desired health outcomes for Nigerians and the goals and outcomes articulated in the NHSDP II. The Federal and States Ministries of Health are therefore expected to develop their respective costed plans through participatory approaches to reflect their context and prevailing issues. The end product will be a harmonized National Strategic Health Development Plan that should achieve collective ownership, resource allocation, inter-sectoral collaboration, decentralization, equity, harmonization, alignment, and mutual accountability in Nigeria.

The process for the development of the second NSHDP comprised of the following steps:

1. Conduct of an end-term evaluation of the first NSHDP to determine 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 NSHDP;
2. A 36-member Technical Working Group (TWG) was commissioned by the Honourable Minister of Health to support the development of the NSHDP Framework. 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 agenda for the development of the NSHDPII, to which they made inputs;
3. Consultants and costing experts were engaged to support the work of the TWGs.
4. Using the background documents, other national and international documents and declarations, the TWGs developed the draft NSHDP Framework.

The process of development of the framework by the TWGs involved the following steps:

1. Articulation of vision, mission statements, goals, values and guiding principles of the NSHDP;
2. Identification and harmonization of priority areas of concern that are in tandem with the 2016 National Health Policy objectives, recommendations of the NSHDPI end-term evaluation report and the Sustainable Development Goals;
3. Building consensus on identified priority areas including the delivery of essential package of health care services; strengthening the integrated health system to support service delivery and improving leadership and governance in the health sector;
4. Identification of specific priority health programmes, their goals and the strategic objectives; required interventions and expected outputs/ outcomes;
5. Development of a Results Framework and a Monitoring and Evaluation strategy
6. Finalization of the NSHDP Framework for wide-stakeholder consultations involving key actors at Federal, State and LGAs levels;
7. Organising of several Stakeholders validation workshops; and
8. Dissemination to Federal, State and LGAS to guide the formulation of their respective plans, which will be harmonized into NSHDP 11

The emergent conceptual framework that guided the subsequent plan development is schematised in figure I:

**NSHDPII DEVELOPMENT: PROCESS OVERVIEW**

Figure 1: Development Process of the NHSDP II

Draft 2nd NSHDP framework.

Broad Consultative Process

(Fed, State LGA, CSO Partners etc.)

Second NSHDP framework.

Final NSHDP framework.

Federal & State Costed SHDP

Disease Specific Policies & Health System Initiatives and Policies

**Important Documents**

Sustainable Development Goal (SDGs)

Vision 2020

Emergency Recovery & Growth Plan (ERGP)

National Health Act (NHA)

National Health Policy (NHP)

PHC Review

Evaluation of NSHDP 1

Other Disease specific initiatives

Other Health

Specific initiatives

National Costed Plan

**RMNCAH + N**

Specific initiative

Resource mobilisation

# CHAPTER 2: STRATEGIC DIRECTIONS OF THE SECOND NATIONAL HEALTH STRATEGIC DEVELOPMENT PLAN

## 2.0. Outline of the NHSDP II

The NSHDP II framework sets the broad strategic directions for developing the Health Sector in the next five years. It provides the vision, mission, goals and priority areas for investments. The overarching goal is “to ensure healthy lives and promote the wellbeing of all Nigerians through enhancing access to quality, affordable, cost- effective, preventive, curative, rehabilitative and promotive healthcare delivery’. NSHDP II when has cost estimates for public sector programmes and projects, as well as an overview of total financial resource requirements for implementing the plan over the five-year plan period (2017-2021).

## 2.1. Strategic Approach

Our strategic approach is to drive the implementation of NSHDP II through the National Council on Health (NCH), with FMoH coordinating the processes. This approach will continue to be guided by the principles of the Four Ones: one health policy, one national plan, and one budget, and one monitoring and evaluation framework; for all levels of government. The NCH will aim at achieving greater integration, collaboration and cohesion in the implementation of NSHDPII at all levels of government, while the FMoH will seek to strengthen the platforms for a multi-sectoral collaboration towards addressing social determinants of health. The PHC will remain the health-delivery-entry-point for majority of Nigerians, particularly the rural dwellers and the under-served populations estimated to be over 60% of Nigeria's 170 million people. The NSHDP II will focus on health system strengthening at all levels especially the LGAs' for improved service delivery.

A major improvement in our strategic approach towards health sector development is the increasing focus on provision of Essential Package of health to strengthen health services delivery. The National Health Policy of 2016 outlined the direction and thrusts of the NSHDP II. Specifically, the 10 thematic areas of the National Health Policy form the basic system building blocks for the NSHDP II. Each of these building blocks has been designed to address specific systems’ challenges, required to upscale coverage for identified priority health thematic areas.

## 2.2 Vision, Mission, Goal and Core Values and Principles

**Our Vision**

**Our Mission**

***TO GUARANTEE A HEALTHY AND PRODUCTIVE NATION***

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

## 2.3. The Core Values and Principles of the NHSDP II

The development of the plan was based on some core values and principles.

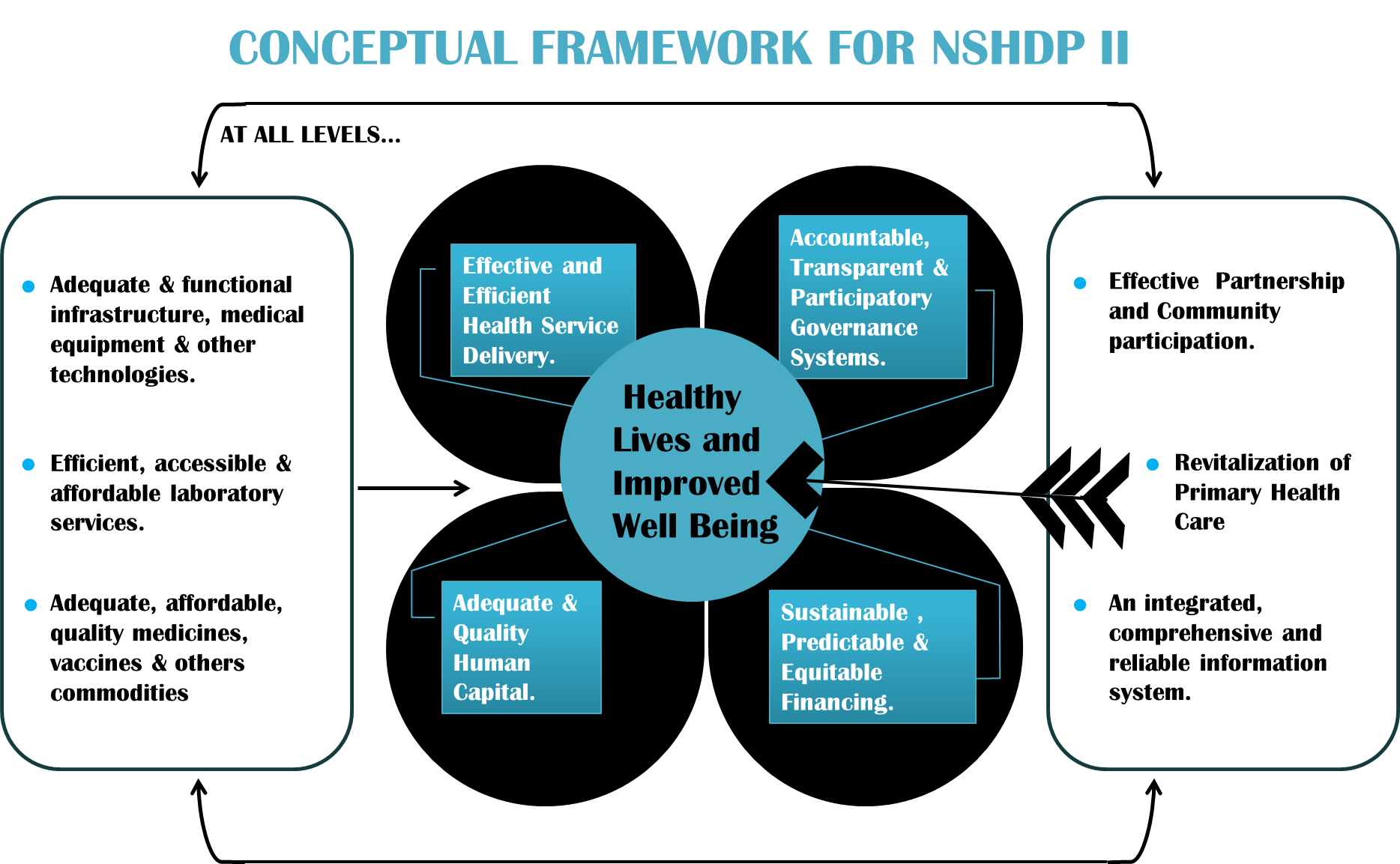
* Accountability
* Equity-driven
* Alignment
* Multi-sectoral collaboration
* Efficiency and effectiveness
* Ethics and respect for human rights
* Industrial harmony Teamwork
* Innovativeness
* Community participation
* Evidence-based measures
* Sustainability
* Transparency
* Quality of care
* Partnership(s)
* People-centred
* Gender-sensitivity

These core values and principles have been reflected across the strategies and approaches in the NHSDP II.

## 2.4. The Conceptual Framework of the NHSDP II

The overall development of the plan was guided by the agreed conceptual framework as depicted in figure 2.

Figure 2: The Conceptual framework of the NHSDP II

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## 2.5. NHSDP II Strategic Objectives

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

1. **Promote an enabling environment for attainment of sector goals:**
   1. Strengthen coordination at all levels
   2. Ensure harmonization and alignment within the sector
   3. Strengthen regulatory systems and processes
   4. 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, d) health promotion and environmental health):*

1. Increase access to package of essential health care services
2. Create demand for essential health care services
3. Improve quality of essential health care services.
4. **Strengthen health system for delivery of packages of essential health care services:**
   1. Equitably improve the quantity, skill mix, motivation and distribution of health workforce
   2. Increase funding to health sector and allocative and technical efficiencies
   3. Improve sustained availability of medicines, vaccines, commodities and health technologies
   4. Improve availability and distribution of functional infrastructure for health services delivery
   5. Strengthen the health information system for timely evidence-based decision-making
5. **Improve protection for health emergencies and risks:**
   1. Strengthen national surveillance system and early warning mechanisms
   2. Strengthen mechanisms for timely response to public health emergencies
6. **Enhance healthcare financial risk protection:**
   1. Increase coverage with social health insurance

## 2.6. NHSDP Health Sector Priorities

The priorities of the NHSDP II articulated for the plan period 2017 to 2021, 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.

### 2.6.1. Health Service Delivery Priorities:

1. RMNCAH+ Nutrition
2. Communicable Diseases, including environmental health, health emergencies and preparedness response, and neglected tropic diseases (NTDs)
3. Non- communicable Diseases, including mental health, injuries, and care of the elderly

### 2.6.2. Health System Strengthening Priorities

Given major weaknesses in all domains of the health system, the plan provides for strengthening of health financing, human resources for health, health infrastructure, information management system. In addition, improvements in partnerships for health, and community participation and ownership for health development were included.

1. Leadership and governance: Emphasis will be on strengthening coordination and regulatory institutions and processes aimed at reducing geographic and socio-economic barriers to access;
2. Health human resources: The emphasis will be to ensure availability and equitable distribution of productive, highly motivated, customer-centred health workers, with the right skills and in the right mix;
3. Sustainable Health financing: The focus will be on increasing resource mobilization and public sector funding in line with Abuja Declaration , improving equity and efficiency in resource allocation and utilization; improving PFM ; increasing financial risk protection to reduce out of pocket expenditure and rapid expansion of social health insurance coverage;
4. National Health management Information System: Emphasis will be on ensuring that the National Health Information System promotes evidence-based decision making.
5. Essential Medicines, Vaccines, Equipment Supplies and logistics: The focus will be on increasing access to safe, affordable and quality essential medicines vaccines equipment supplies through the building and maintaining of an integrated supply chain system.
6. Partnerships for Health; The emphasis will be on *building and strengthening collaborative mechanisms for involving all partners in the development and sustenance of the health sector*
7. Community Participation and Ownership; The focus will be on deepening community participation and ownership
8. Research and Development

### 2.6.3. Monitoring and Evaluation

Monitoring and Evaluation of this plan during the plan period shall focus on generating quality evidence for informed decision making across the health sector, and to track progress against targets as set in the NHSDP II. A separate volume on the M&E of the NHSDP II has been developed.

## 2.7. The Results Framework of the NSHDP II

The NHSDP II is hinged on five strategic pillars namely:

* 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 3), 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.

Figure 3: The Results Framework of the NHSDP II

**Strategic Pillar One:** Enabled environment for attainment of sector outcomes

**Strategic Pillar Two**:

Increased utilization 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 Pillar Five:** IncreasedSustainable, Predictable Financing and Risk Protection

**Priority Areas (3):**

1.) Leadership & Governance

2.) Community Participation

3.) Partnership for Health

**Priority Areas (5):**

4.) RMNCAH & Nutrition

5.) Communicable Disease

6.) Non-Communicable Disease

7.) General & Emergency Hospital Services

8.) Health Promotion and Social determinants

**Priority Areas (4):**

9.) Human Resource for Health

10.) Health Infrastructure

11.) Medicines, Vaccines and Other Health Technologies and Supplies

12.) Health Information System

13.) Research for Health

**Priority Area (1):**

14.) Protection from health emergencies and risks

**Priority Area (1):**

15.) Health Financing

**1. Outcomes:**

**2. Key Interventions:**

**1. Outcomes:**

**2. Key Interventions:**

**1. Outcomes:**

**2. Key Interventions:**

**1. Outcomes:**

**2. Key Interventions:**

**1. Outcomes:**

**2. Key Interventions:**

**Overall Goal:** Ensure healthy lives and promote well-being of the Nigerian populace at all ages

**Overall Result:** Equitably reduced morbidity and mortality and improved socio-economic wellbeing

STRATEGIC PILLARS

***(Guide for the Development and Alignment of Strategies for Operational Plans and for the Monitoring and Evaluation of the NHSDP II)***

# CHAPTER 3: ENABLED ENVIRONMENT FOR ATTAINMENT OF SECTOR OUTCOMES

## 3.1. Leadership & Governance

***Context***

The Nigerian constitution places health in the concurrent legislative list, which implies that that the federal and State governments can legislate on health services while the National Health Act 2014 assigns specific responsibility areas; tertiary, secondary and primary healthcare delivery to Federal, States and Local governments respectively. However, prolonged absence of appropriate legislative environment has resulted in widespread lack of quality basic health services and accountability.

The health system in Nigeria is beset by several challenges such as poor leadership, low budgetary allocation, frequent change in leadership of the FMOH and the SMOHs, ineffective coordination and weak governance and partnership structures among others. The decentralized system of government in Nigeria further complicates healthcare delivery and governance in the health system. While it is the responsibility of the Federal government to lead in setting polices, laws and guidelines, there is no strong enforcement structure to ensure compliance at the sub-national levels of government. In addition, poor managerial and governance capacity remain a major challenge.

Nigeria has over the years made efforts to create the right policy environment to strengthen partnership in the delivery of health services. Examples of results of these efforts have included developing a Public-Private-Partnership for Health policy in 2005; and signing up to the Global Compact of the International Health Partnerships and related initiatives in 2008. . Additionally, there has been an increased effort to include other stakeholders, such as the private sector and civil society in policy and planning processes for health care delivery.

There has been considerable progress in multi-sectoral collaboration as exemplified by the comprehensive response to epidemics and disasters and the HIV programme in Nigeria. However, a lot still needs to be done to strengthen inter-sectoral collaboration. In spite of the existence ofplatforms and policies for partnership, all these have not translated to a greater good of the overall health system.

There is efficiency and accountability challenges, with most of government funds expended on recurrent expenditures and very small amounts are expended on capital expenditures. The Nigeria Public Finance Management (PFM) system is often characterised by breach of established due processes and accountability; and ineffective monitoring and supervisory roles, among others. All these result to ineffective service delivery. The easy access to oil revenues has undermined public institutions and accountability, lowered citizens’ expectations of government and weakened relations between state and society.

In an attempt to address these bottlenecks, and to significantly impact governance by strengthening coordination in the health system, the government has initiated innovative strategies, statutes and coordination platforms such as National Council on Health; System of Health Accounts; National Health Policy, Basic Health Care Provision Fund; Primary Health Care Under One Roof; PHC revitalization and much needed legislation in the form of the National Health Act 2014, among others. Furthermore, in order to improve the quality of health service delivery, National Health Act (NHAct) directs the FMOH to institute a Tertiary Hospitals Standards and Regulatory Commission and other complementary committees. There may be a need to introduce mechanisms for quality assurance in the health at all levels.

***Strategic and specific objectives/Targets***

The core strategic objective is to provide effective leadership and an enabling policy environment that ensures adequate oversight and accountability for the delivery of quality health care and sustainable development of the National Health System. The interventions shall target that:

* 80% of Federal & States health MDAs increase annual budget implementation rate by 25%;
* 80% of national health priorities are included in the MTEF (States and Federal);
* FMOH and 36 SMOH+ FCT HSS publish annual state of health report;
* 70% of coordination organs at national and subnational levels (NCH, SCH, WDC, Health Partners Coordination Committee, etc.) are established and functional;
* 20% of all health establishments achieve more than 50% of Service Charter standards.

***Strategic Interventions***

The interventions shall be in four strategic areas.

1. Strengthen legal and regularly framework for the health system

* Promote legal and regulatory processes for governance of the health system

1. Strengthen transparency and accountability in planning, budgeting, procurement, and reporting systems:

* Strengthen Public Finance Management systems including oversight in Fund disbursement and utilization at all levels
* Strengthen mechanism for planning and budgeting at all levels including MTEF/MTSS/Annual Budget linkage.
* Strengthen community participation, and CSO engagement in planning and budgeting, and budget implementation

1. Improve health sector performance through regular integrated reviews and reporting:

* Strengthen annual operational/work-planning for the health sector at all levels
* Improve information generation and sectoral information basis for decision-making to enhance performance
* Strengthen mechanisms for institutionalizing sectoral performance review
* Promote Sector performance reporting & dissemination in line with the NH Act
* Promote an incentivization and reward system for the efficient performance of the health sector at all levels

1. Strengthen coordination of the health sector at all levels:

* Strengthen health governance structures, rules and processes at all levels
* Strengthen intra-sectoral and inter-sectoral collaboration at all levels.
* Improve partnership with professional groups and other relevant stakeholder for effective service delivery and industrial harmony.
* Strengthen implementation of Health Service Charters at all levels
* Strengthen coordinating mechanism of health development partners (Development Partners and Private Sector Partners)

## 3.2. Community Participation

***Context***

Effective partnership between government and rural communities in improving health care service delivery remains critical for the achievement of universal health coverage in Nigeria. Community participation ensures that the underserved population are reached, community capacity to manage their health challenges is built and health promotion gets to the grassroots. Entrenchment of ownership enables individuals, families and communities to get more involved and take greater control over their health; thereby engendering resilience and program sustainability.

In order to strengthen community participation and ownership, the Nigerian government had taken some giant strides in the establishment of health committees in the recent past. These efforts include the formation of Ward Development Committees in more than 800 wards, and construction of Model Health Centres (by the NPHCDA) between 2000 and 2014; the creation and strengthening of State Primary Health Care Boards (SPHCBs) and Local Government Health Authorities (LGHAs) to support Community Health Committees (WDCs & VDCs) initiative and the development of national guidelines for community participation. It also includes the provision of very prescriptive guidelines for setting up Village Health Committees (VHC) across the country with definitions on size, composition and functions**.** These have resulted in significant improvement in community mobilization, and ensured community representations at high level health management through participation in Primary Health Care and Hospital management Committees**.**

The introduction of the National Health Insurance Scheme (NHIS) opened another window of opportunity to foster community participation in health care through the community-based social health insurance scheme for the informal sector. Government will continue to promote community participation in the planning, implementation, utilization, monitoring and evaluation of health services, through the PHC, to ensure optimal maximization of healthcare benefits arising from increased self-reliance and community control on their health issues. In this respect, government intends to strengthen existing structures and infrastructure for effective collaboration and partnership between communities and government at all levels that will translate into better health outcomes for the rural communities.

The major issues and challenges facing community participation and ownership in healthcare delivery, include issues of poor funding to support community based interventions, non-involvement of private sector, poor community linkage with the health system, gaps in record keeping and monitoring, absence of policy document to enforce community participation, inadequate supportive supervision of existing community health committee, lack of awareness of the community on their roles and responsibilities, weak strong linkage between community and health facility among others.

***Strategic Objectives and Targets:***

The strategic objectives of the planned interventions are to strengthen community level coordination mechanisms and capacities for health planning and to strengthen community participation in the implementation, monitoring and evaluation of health programmes.

* At least 80% of PHC are linked to Community Health Committees;
* 70% of Wards have functional Ward Development Committees;
* At least 80% of LGA with functional PHC management committees;
* At least 80% of PHC are implementing minimum service package (MSP)

***Strategic Interventions***

* Formulate appropriate policies and guidelines on community partnership and ownership and disseminate them to the health committees and other relevant stakeholders
* Update guideline for establishment of health committees
* Ensure equitable representation of the private sector, CSO’s and women, in the health committees.
* Develop and institutionalize effective supportive supervisory scheme for the health committees
* Facilitate the training and capacity building of members of health committees to enable them adequately understands their roles and responsibilities and effectively participates in health planning, monitoring and evaluation for decision making.

## **3.3. Partnerships in Health**

***Context***

Health is a multidimensional issue and 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 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 said to be provided by the private sector in Nigeria. And private out-of-pocket expenditure account for 70% of the total health expenditure in the country[[1]](#footnote-1). Yet the activities of both the public and private sector have been left uncoordinated. 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 with the social orientation of the public sector in order to improve the delivery of health services. Although no one definition has been agreed upon, the essential feature is that there is collaboration between the public and private sectors to achieve specific goals with the public sector having a degree of supervision. Public-private partnership in health is not the same as privatization, which involves complete transfer of public assets to private owners.

### 3.3.1. Partnership with Private for profit Health Care Providers

There is a growing, but poorly regulated, private sector and a plethora of private sector providers ranging from private hospitals, clinics, to pharmaceutical stores, patent medicine stores and traditional healers used increasingly by growing numbers of people to access health services. Most of such facilities are unregistered; employ unqualified health workers and dispense counterfeit drugs despite the regulatory framework provided by the National Agency for Food and Drugs Administration and Control (NAFDAC Report, 2005). Other surveys have however indicated a higher utilisation of private facilities, in its entirety than public ones due to the perceived better quality of care (Health Reform Foundation of Nigeria, 2007). Despite the high costs, the poor represent a significant proportion of beneficiaries of varied forms of private health care, although effectively priced out of the health care market.

There are numerous active non-governmental organisations providing health care in Nigeria and significantly among these are faith-based organizations (*private not for profit*). Their services are generally perceived to be of better quality and more accessible to the poor, however, unlike other African countries, in Nigeria, this sub-sector has received little government and external support. Judicious and focused support to this sub-sector could in areas of need secure improved health benefits to the poor and the vulnerable.

### 3.3.2. Health Development Partners (DP)

The coordination of international and national based health development partners including Multilaterals, Bilateral agencies, NGOs, and others is the responsibility of the Departments of Planning, the Ministries of Budget and the Planning Commissions at federal and state levels. Within the health sector, there are coordinating mechanisms such as inter-agency coordinating committee (ICC) for immunization, Country Coordinating Mechanism (CCM) for the Global Fund and the Roll Back Malaria (RBM) partnership, Health Partners Coordination Committee and Health Systems Forum. However, there has been a lack of a harmonized framework for coordination between the FMOH and health development partners. As a result, effective coordination has been poor with donors working separately through various departments and agencies within the sector. The lack of an overarching framework specifying priority needs has allowed for donor driven aid deployed in sub-optimal areas of need or non -geographical spread. The Health Sector Reform Programme (2004 – 2007) in recognition of this captured improved donor coordination as essential to increasing the effectiveness of aid resources. There is some work in progress in the development of a Joint Funding Agreement (JFA) under the guidance of Federal government agencies such as NACA. The increasing focus on implementing the principles of the Paris Declaration on Aid Effectiveness towards achieving the MDGs is a propelling force to improve harmonization amongst donors and the subsequent alignment to national priorities.

### 3.3.3. Other Sectoral Ministries, Department and Agencies (MDAs)

Presently, there is little or no inter-sectoral collaboration with key relevant Ministries such as Finance (adequate budgetary allocation and prompt release of funds); Education (school health and health promotion, girl-child education); Agriculture (food security, adequate and proper nutrition); Water Resources (adequate and safe, clean water); Environment (pollution and vector control); Industry (production of critical inputs such as food and drugs and occupational health); Planning Commissions (Economic development and Poverty Reduction Strategies) to mention a few. For a holistic approach to health, all sectors must be mobilized through good governance, strong political will and commitment to galvanize all stakeholders towards a common purpose – better health for all.

### 3.3.4. Health Professional Groups

Health professionals and health workers require strong, integrated health systems at both national and local levels to support the delivery of universal care and services. Proven, affordable interventions implemented in collaboration with professional groups within an integrated network of care, from community to referral centres have recorded success. Throughout the cycle of life, individuals and communities rely on health professionals to not only save lives, but to maintain and promote wellbeing. These professionals groups include those for Doctors (Nigerian Medical Association and its affiliates), Nurses and Midwifery (NANNM), Pharmacists (PSN), Medical Lab Technician, anaesthetists and other professional bodies. Health professional associations and societies therefore have vital roles to play in ensuring that health professionals are well equipped to deliver their important roles in improving health outcomes.

### 3.3.5. Communities

Significant healthcare is undertaken by households at the community level and households are also the main consumers of health care at the facility levels. Health facilities are located in communities and are expected to respond to their needs. However, there is poor engagement of the community by State and LGA health authorities. ‘Community empowerment’ has been an overused word that has become a mere rhetoric for health planners. Community/Village Health Committees where in existence have very limited role in determining the course of events as they affect the health of the community. Consequently, duty bearers (health authorities) are presently not accountable to the right holders (the community) resulting in lack of ownership by the communities.

The overall goal of partnership in health is this context is to harmonize implementation of essential health services in line with the national health policy goals.

***Strategic Objective and Targets***

The strategic objective is to ensure that collaborative mechanisms are put in place for involving all partners in the development and sustenance of the health sector by 2021. The targets are that:

* At least 30% of funding of health is from partners (development partners and private sector) by 2021
* At least 70% of all health facilities at all levels are implementing SERVICOM by 2021
* Increase by 50% the proportion of health institutions administered through PPP by 2021.

***Strategic Interventions***

* Promote the adoption and utilization of national policies and guidelines on PPP
* Strengthen legal and coordinating framework for PPP at all levels
* Establish a single Development Partners Forum at federal and state levels, which comprises of only health development partners;
* Strengthen mechanisms for the implementation of PPP (e.g. contracting or out-sourcing, leases, concessions, social marketing, and franchising mechanism)
* Scale-up PPP in planning and implementation of health programmes
* Promote joint (public and private sector) monitoring and evaluation of health programs
* Scale up resource mobilization interventions (funding, skills - e.g. managerial approaches) targeting the private sector
* Establish mechanisms for resource coordination through common basket funding models such as Joint funding Agreement, Sector Wide Approaches, and sectoral multi-donor budget support.
* 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
* 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;
* Strengthen collaboration between government and professional groups including Nigerian health professionals in diaspora to advocate for increased coverage of essential interventions, particularly increased funding;
* Leverage human resources for health from partners, health professionals, other levels of government to optimize resource use and improve service delivery
* Promote linkages with academic institutions to undertake research, education and monitoring through existing networks; and
* Promote partnerships with communities to address felt needs of the communities
* Strengthen implementation of Health Service Charters at all levels, with Civil Society Organisations, traditional and religious institutions to promote the concept of citizen’s rights and entitlement to quality, accessible basic health services.

# CHAPTER 4: INCREASED UTILISATION OF ESSENTIAL PACKAGE OF HEALTH CARE SERVICES

## 4.1. Introduction

As presented in section two of this framework, Nigeria's health status remains among the worst globally. Nigeria ranks 152 out of 188 countries in the 2016 UNDP human development report, a position the nation has occupied in the past two years, indicating lack of progress in human development indicators. Also the increasing health needs of the elderly and the outrageous out-of-pocket expenses on health, estimated to be over 65% are becoming a major public health concern. These, and other emerging health challenges, have necessitated the inclusion of social determinants of health in the framework and the development of an essential health package for the nation. The section presents the proposed essential health care package for the plan period. It provides the context, the objectives and proposed interventions for each area of focus.

The proposed Essential Package intended for delivery within the plan period comprises of:

1. Reproductive, maternal, neonatal, child, adolescent health and nutrition (including Focused antenatal care; Skilled delivery and emergency obstetric care; Obstetrics fistula care; Sexual and reproductive health services, including family planning; Newborn and child health care (essential newborn care, IMCI and C-IMCI and Nutrition)
2. Control of communicable diseases and neglected tropical diseases (malaria, tuberculosis, HIV/AIDS, hepatitis, and NTD)
3. Control of non-communicable diseases (cardiovascular diseases, diabetes, cancers, sickle cell disease)
4. Mental health
5. Oral health
6. Eye Health
7. Care of the elderly
8. Public health emergencies
9. Environmental health (water and sanitation, food safety, chemicals and snake bites
10. Essential medical and emergency services

## 4.2. Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition

***Context***

The Reproductive, Maternal, Newborn, Child and Adolescent Health *plus* Nutrition (RMNCAH + N) program aims to promote health through the life course. It is a strategy to integrate an existing range of interventions, improve the use of resources and greatly expand health care coverage to improve access to quality health services for women, newborns, children and adolescents along the continuum of care. Covered in this thematic area are reproductive, maternal, newborn, child and adolescent health as well as nutrition programmes. The RMNCAH+N services are organized in different components and are described along their programmatic areas. To this end, national policies and associated strategic plans addressing RMNCAH + N are in place to provide direction to programming.

Globally, significant strides have been made in improving maternal and child health outcomes due to investments in MDGs 4 and 5. Preventable child deaths are down by more than half; and maternal mortality is down by almost as much. Despite these global achievements Nigeria has made very little progress in improving RMNCAH + N outcomes. The indicators for RMNCAH +N indicators are as in table 3 below.

Table 3: Key Reproductive, Maternal, Newborn and Child and Adolescent Health Indicators

|  |  |  |  |
| --- | --- | --- | --- |
| **Coverage measures** | **Baseline data (year and source)** | **Most recent (year and source)** | **Differences by region or groups (highest/ lowest)** |
| Proportion of mothers who received at least 4 ANC visits | 44.8 (NDHS 2008)  N/A | 51 (NDHS 2013)  56.6 (MICS 2011) | Urban:68.8/ rural:33.8 (NDHS 2008)  Urban:74.5/ rural:38.2  (NDHS 2013)  SW: 85.7 /NW:32.8 (MICS 2011) |
| Proportion of mothers who received TT2+ during pregnancy | 45.3 (NDHS 2008) | 49 (NDHS2013)  50.9(MICS 2011) | SE:77.7 / NW:17.9 (NDHS 2008)  SE:82.0 / NE:27.1 (NDHS 2013)  SE:84.2/ NW:26.4 (MICSSS 2011) |
| Proportion of newborns protected against neonatal tetanus at birth | 50.8  (MICS 2007) | 55.2  (MICS 2011) | SE:83.5/ NW:23.5  (MICS 2007)  SE:87.2 /NW:31.0 (MICS 2011) |
| Proportion of women who received iron during pregnancy | 14.5(NDHS 2008) | 20.5  (NDHS2013) | SW:44.2/ NW:4.8  (NDHS 2008)  SW: 42.0/ NW:5.8 (NDHS 2013) |
| Proportion of pregnant women who slept under an ITN the previous night( in all households) | 4.8 (NDHS 2008) | 16.4 (NDHS 2013  35.4 (MICS 2015) | NC&SW:3.4/ SW:7.2 (NDHS 2008)  SE:23.2/ NE:13.2 (NDHS 2013)  NE:55.5 /SE:12.0 (MICS 2015) |
| Proportion of pregnant women who received at least 2 doses of IPT in pregnancy | 6.5 (NDHS 2008) | 14.6 (NDHS 2013)  17.4% (MICS 2015) | SS:9.3/ NE:4.0  (NDHS 2008)  SE:18.3/ SS:10.1 (NDHS 2013)  SS:25.0/NC:10.4 (MIS 2015) |
| Proportion of HIV+ mothers who received ART prophylaxis | N/A | 29% (2015) (End-of-term evaluation of NSP 2010-2015) |  |
| Proportion of women delivered by skilled birth attendants |  | 61% |  |
| Still birth rate | 228/1000 | 396/1000 |  |
| Neonatal Mortality rate (per 1000 live births) |  |  |  |
| Infant Mortality rate (per 1000 live births) | 75/1000 | 69/1000 |  |
| Under 5 Mortality rate (per 1000 live births) | 157/1000 | 128/1000 |  |
| Exclusive breastfeeding rate | 13% (2008) NDHS  22% (MICS, 2011) | 17% (2013)NDHS |  |
| Coverage with Penta 3/Immunization coverage |  |  |  |
| Maternal mortality ratio (per 100, 000 live births) | 545/100,000 live births | 576/100,000 live births |  |
| Contraceptive prevalence rate (CPR %) | 14.6% | 16% |  |
| Unmet need for family planning |  |  |  |
| Adolescent Birth rate (%) | 121/1000 | 122/1000 |  |
| Total Fertility rate (%) | **5.5%** | **5.7%** |  |

Source of data: NDHS and MICS surveys, 2008, 2013

### 4.2.1. Maternal Health

***Context***

Maternal Mortality remains persistently high with no significant improvement and is currently 576 per 100, 000 live births (NDHS, 2013). The country contributes a disproportionate 14% to the global maternal mortality burden. These maternal deaths account for 32 percent of all deaths among women of reproductive age group (National Health Policy 2016). One of the maternal morbidities of significant public health importance in Nigeria is obstetric fistula, largely caused by obstructed labour, with iatrogenic fistulae assuming increasing importance (ref needed). Nigeria is said to account for 40% of the global burden of obstetric fistula. The high burden of maternal mortality is largely due to suboptimal uptake and quality of ANC, low utilization of skilled birth attendance (38%), high rates of home deliveries, poor quality of delivery services, limited access to emergency obstetric care services and adverse reproductive behaviours. Additionally, fertility remains persistently high while use of modern contraceptives has remained low at 10%. These are major contributors to the poor maternal health outcomes. In spite of improvement in antenatal care coverage, which currently stands at 61%, maternal malnutrition is on the increase from 2% in 2014 to 4% in 2015 (NNHS).

Focused antenatal services are provided in public and private health care facilities, however, in line with the revised WHO policy, there is a current national shift from 4 ANC visits to at least 8 visits. While uptake of ANC is generally high, it varies according to geographical location and socio-economic status. Uptake is characterized by late booking, lack of continuity as only 58% of the women complete at least four ANC visits. Also, the quality of ANC is suboptimal as coverage with key interventions remains poor (e.g. PMTCT, 15%, IPT, 15%, 2nd TT, 48%) and many of the health facilities do not screen for sexually transmitted infections.

In addition to low uptake of facility delivery, the quality of services is poor. A large proportion of PHC facilities, for a variety of reasons are unable to provide delivery services. Furthermore, the quality of services delivered, for example use of partograph, infection control and availability of skilled personnel to take delivery are poor. Very wide inequalities exist in the use of delivery services. The ward health centres are expected to be able to provide basic emergency obstetric care services while facilities from the level of general hospitals should offer comprehensive emergency obstetric care services. Access to and quality of both basic and emergency obstetric care services are however limited.

***Strategic Objective, Specific Objectives and Targets***

The strategic objective of the planned interventions is to reduce maternal morbidity and mortality. The specific objectives and targets are:

* Maternal mortality ratio reduced by 50 percent, from 576 per 100,000 live births to 288 per 100,000 live births by 2024.
* Skilled attendance at delivery increased from 38% to 57% by 2024.
* Attendance at 8 ANC visits by pregnant women increased to 80% by 2021
* Attendance at postnatal services by mothers within 48hrs of delivery increased to 50% by 2024.
* At least 80% of Primary/Ward Health Centres are providing basic Emergency Obstetric and neonatal care services by 2024.
* At least 50% of all LGAs have health facilities capable of providing Comprehensive Emergency Obstetric Services by 2024.

***Interventions and strategies***

The strategies shall include the following:

* Strengthen the enabling environment for the delivery of quality maternal health interventions in Nigeria.
* Strengthen Community participation and ownership to support efficient and effective delivery of high impact MH programmes.
* Strengthen operational partnership, resource mobilisation and multi-sectoral coordination of maternal health programmes (including the WHS).
* Advocacy strategies / groups on:
* the supply and distribution of **free** Maternal life-saving medicines and commodities (LSMC) through the National supply chain & logistic management system (LMIS) for health and related products
* Availability of two-way referral ambulance/transport system at service delivery points (especially primary and secondary care levels).
* Implementation of the minimum service package for HRH/Equipment for PHCs.
* Improve coverage of MH service delivery through innovative approaches: - Awareness creation and behavioural change & communication strategies at the grassroots and Development of a national operational plan/policy for performance based financing (PBF), vouchers, conditional cash transfers (CCTs) etc.
* Improve quality of MH care through Capacity building of service providers especially on EmONC/life-saving skills (LSS); Standardization of PHC facilities requirement (infrastructure, equipment, operating hours – 24 hour/seven days a week), and Inclusion of training on EmONC/life-saving skills into institutional curricula for training of CHO and CHEWS.
* Strengthen MH data management through: Promotion and Strengthening of Vital Statistics component of CRVS at facility levels and integration into the NHMIS; Bi-annual supervisory and monitoring visits to states for MH interventions particularly LSS/EmONC services, MPDSR etc.

*Interventions*

The proposed key interventions for maternal health and levels for their delivery are as shown in table 3 below:

Table 4: Key Interventions for Maternal Health

|  |  |  |  |
| --- | --- | --- | --- |
| Intervention | Community | Primary | Referral |
| Pre-pregnancy |  |  |  |
| Family planning | X | X | X |
| **Prevent and manage sexually transmitted infections** | X | X | X |
| **Cervical cancer screening** | **-** | **X** | **X** |
| Tetanus toxoid | - | X | X |
| Screening for HIV | - | X | X |
| Antiretroviral for HIV-positive pregnant women | - | X | X |
| Pregnancy |  |  |  |
| Appropriate antenatal care package |  | X | X |
| *Iron and folic acid supplementation* | X | X | X |
| *Presumptive treatment of malaria* | X | X | X |
| *Use of long-lasting insecticide treated net* | X |  |  |
| *Tetanus toxoid* |  | X | X |
| *Screening for HIV* | X | X | X |
| *Treatment for HIV-positive pregnant women (PMTCT)* | X | X | X |
| *Home visit* | X |  |  |
| *At least one abdominal ultrasound scan (before 24 weeks of gestation)* |  |  |  |
| Post-abortion care for abortion cases | - | X | X |
| Labour and Delivery |  |  |  |
| Partograph |  | X | X |
| Magnesium Sulphate for eclampsia | - | X | X |
| Induction of labour to manage prelabour rupture of membranes at term | - | - | X |
| Antibiotics for preterm prelabour rupture of membranes | - | X | X |
| Corticosteroids to prevent respiratory distress in newborns | - | - | X |
| Pneumatic anti-shock garments for haemorrhage | - | X | X |
| Induction of labour for prolonged pregnancy | - | - | X |
| Prophylactic uterotonics to prevent postpartum haemorrhage | X | X | X |
| Active management of third stage of labour to prevent postpartum haemorrhage | - | X | X |
| Management of postpartum haemorrhage (e.g. uteretonics, uterine massage) | X | X | X |
| Caesarean section for maternal/foetal indication | - | - | X |
| Prophylactic antibiotics for caesarean section | - | - | X |
| Postpartum (Mothers) |  |  |  |
| Family planning | X | X | X |
| Prevent and treat anaemia | - | X | X |
| Screen for HIV and initiate treatment from HIV | - | X | X |

### 4.2.2. Fistula Care

***Context***

Obstetric Fistula is one of the most severe and debilitating maternal morbidities, with serious social, physical, economic and psychological consequences. Globally, it is estimated that 1, 000, 000 women live with obstetric fistula with majority of the cases from Africa and South East Asia (Direct Relief et al. 2015). The prevalence of obstetrics fistula in Nigeria is 150, 000 cases. This is a disproportionate 15% of the global burden (Engender Health 2010). The estimated number of annual incidence of obstetrics fistula is 13,000 (Engender Health 2010).

The commonest cause of obstetrics fistula in Nigeria is prolonged obstructed labour; this accounts for between 65.9% - 96.5% of cases seen in various treatment centres in Nigeria (Ijaiya et al. 2010). Iatrogenic fistula is becoming an increasing source of concern and many VVF treatment centres are reporting rising proportions of fistula resulting mainly from faulty C/S by poor skilled doctors and quacks.

Anywhere a woman labours for days at home without access to emergency obstetric services, obstetric fistula may result. Since access to emergency obstetric care services is limited across Nigeria, obstetric fistula is found in all parts of the country. However, the prevalence is higher in the northern zones than the southern zones, a reflection of differentials in the distribution of the health system and socio-cultural factors associated with the disease. Early marriage and early onset of child bearing, poor utilization of antenatal and skilled attendants at delivery, poor quality of delivery services, especially non utilization of partographs to monitor labour, poor access to delivery and emergency obstetric services, increasing use of churches for delivery services and high cost of delivery services, especially C/S are some of the main risk factors.

Nigeria has a strategic plan for elimination of fistula and with the support of partners, notably UNFPA and Fistula Care; effort has been ongoing to clear the fistula backlog through establishment/support to fistula treatment centres. However, major constraints to optimizing the VVF efforts in Nigeria are poor funding, limited donor interest, lack of integration of fistula work into the broad RMNCAH+ N programming, dearth of skilled personnel, poor commitment to fistula care at state levels and poor investment in preventive interventions. Eliminating Fistulae in Nigeria will invariable lead to significant reduction in maternal morbidity and mortality rates in Nigeria and globally. The goal is toeliminate obstetric fistula in Nigeria, thus contributing to maternal mortality and morbidity reduction

***Strategic Objective, Specific Objectives and Targets***

The strategic objective is to strengthen prevention, treatment and rehabilitation of fistula services in Nigeria. The interventions shall target to:

* Incidence of obstetrics fistula reduced by 50% by 2021
* Treatment of new cases and backlog increased by 30% by 2021
* 75% of treated cases reintegrated into their communities

***Strategic Interventions***

* Develop and implement an OF Communication strategy that includes advocacy, social mobilization and behaviour change communication strategy
* Increase access to quality delivery and emergency obstetric services
* Invest in provision of family planning services
* *Expand access to treatment services*
* Establish more treatment sites and provide support to all sites to ensure functionality
* Build capacity/train health workers to run the OF centres
* *Reintegrate treated OF patients into their communities*
* Foster collaboration with Ministry of Women Affairs, NGOs and other partners to develop and implement rehabilitation programmes

### 4.1.3. Sexual and Reproductive Health (Family Planning and Post-abortion care)

***Context***

The total fertility rate (TFR) and median age of birth for ages 25-49 years have remained almost stagnant over the past five years at 5.5% in 2013 as compared to 5.7% in 2008 and a median age of 20.2 years in 2012 as compared to 20.4 years in 2008 respectively. The contraceptive prevalence rate (CPR) has remained low at 10% for modern contraceptives and is characterized with wide regional and state level variations. Several supply related factors such as poor commodity logistic supply chain leading to stock outs; dearth of skilled and adequate number of healthcare workers; Non-involvement of private sector; Gaps in record keeping and monitoring and demand side issues such as poor knowledge of modern contraceptives, which varies by regions, states, education and socio-economic of women and poor motivation for use of modern contraceptives as adjudged by unmet need of 16%.

Complications from unsafe abortion are one of the major causes of maternal morbidity and mortality especially the youths. The annual abortion rate is 33 per 1,000 women aged 15–49 years and the Abortion ratio of 19 abortions per 100 live births in Nigeria is high. However, socio-cultural and religious factors militate against the interventions to reduce abortion related maternal mortality.

***Strategic Objective, Specific Objectives and Targets***

The strategic objective of the planned interventions is to create demand for and increase comprehensive reproductive health services (family planning services and management of unsafe abortion)

* Contraceptive prevalence rate increased from 15% to 43% by 2021
* 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 2021

***Interventions***

The proposed interventions for sexual and reproductive health are detailed in table 5 below:

Table 5: Key Interventions for Reproductive health

|  |  |  |  |
| --- | --- | --- | --- |
| Intervention | Community | Primary | Referral |
|  |  |  |  |
| Family Planning and PAC Services | 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 |

***Interventions and Strategies***

* Establish budget lines for key SRH interventions - Family planning commodities and Post Abortion Care (PAC)
* Build capacity of health care workers across all cadre of practitioners in public and private facilities on Family planning and PAC services
* Involvement and sensitization of key stakeholders – faith based women groups, men groups, media and professional associations on key SRH interventions – FP/PAC.
* Improve data management at all levels for tracking service delivery for FP and PAC services in Nigeria.

### 4.1.4. Newborn and Child Health

***Context***

Nigeria contributes a disproportionate 10% to the global burden of child mortality however in the pre-2015 era, Nigeria, has recorded an improvement in child health with a positive decline in infant mortality rate (IMR) from 75/1,000 live births in 2008 to 69/1,000 live births in 2013, with neonatal deaths accounting for 53.6% of IMR. There is also a positive decline in under five mortality rate (U5MR) from 157/1,000 live births in 2008 to 128/1,000 live births in 2013. Prematurity, asphyxia, and infections account for 28% of all U5 deaths.

Coverage of high impact cost-effective child survival interventions remain much below the target with wide regional and state variations. Reports show that only 57.3% of babies received pre-lacteal feed in 2013 and exclusive breast feeding rate is 17% (NDHS 2013) as against the National target of 50%. Immunization coverage has remained low as only a quarter of children aged 12 – 23 months are fully immunized (NDHS) and the proportion of U5 children who slept under insecticide treated net the night preceding the survey reduced from 49.8% to 16.6% in 2013 whereas the proportion of children with fever who received appropriate antimalarial drugs reduced from 35.9% in 2008 with 18 points in 2013.

There is inequity in service delivery and uptake which have been attributed to both supply and demand related issues such as maldistribution of health care workers, poor knowledge and involvement of the community in home based care, high out-of-pocket expenses, inadequate funding, poor commodity logistic supply chain leading to frequent stock outs and lack of information on the skill and population of health workers in specific child-related services. Table 6 below shows the trends in coverage of selected integrated management of child illness services in Nigeria.

Table 6: Trends in coverage of components of elements of integrated management of childhood illnesses, Nigeria 2007-2015

|  |  |  |  |
| --- | --- | --- | --- |
| **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) | 15.1 (MICS 2011) | NC=30.9/NE=4.1 (MICS 2007)  SW=27.0/ NW=6.2 (MICS 2011) |
| Proportion of infants 6-8 months who were breastfed and ate solid and semi-solid foods at least 2 times yesterday | 31.4  (MICS 2007) | 32 .2  (MICS 2011) | SE=55.0/ NE=16.3(MICS 2007)  SE=48.3 / SW=28.3 (MICS 2011) |
| Proportion of HH that use iodised salt (15+ ppm) | 74.9 (MICS 2007) | 87.4 (MICS 2011) | SE=85.9/NW=59.2 (MICS 2007)  SE=89.7 /NW=62.6 ( MICS 2011) |
| Proportion of children 12-23 months of age vaccinated against measles before 12 months | 41.4 (NDHS 2008) | 42.1 (NDHS 2013) | 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 | 35.4 (NDHS 2008) | 38.2(NDHS2013)  37.0 (MICS2011) | 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 under-5 children who slept under an ITN the previous night | 3.5 (MICS 2007) | 16.4 (MICS 2011) | SS=7.9 /NE=0.8 (MICS 2007)  NW=22.4/SW= 9.8 ( MICS 2011) |

***Strategic Objective, Specific objectives and Targets:***

The strategic objective is to reduce neonatal and childhood mortality and ensure optimal growth, protection and development for all newborns and children under-five. The targets for the interventions are:

* Neonatal mortality reduced by 50% from 37/1000 live births to 18/1000 live births by 2021
* Infant mortality reduced by 50% from 75/1000 live births to 38/1000 live births by 2021
* Under-five mortality reduced by 50% from 128/1000 live births to 64/1000 live births by 2021
* Exclusive breastfeeding rate increased to 50% by 2021
* 50% of all health facilities designated as “baby-friendly” facilities by 2024.
* 50% of all health facilities designated as IMCI facilities***."***

***Interventions and Strategies***

The strategies to be adopted in the delivery of the interventions have been identified.

* Improved partnership and multi-sectoral coordination
* Advocacy and resource mobilization at all levels of governance to scale-up high impact interventions at all levels of care.
* Community mobilisation and active participation in child health interventions
* Capacity building of service providers to improve delivery of quality neonatal care services.
* Expand coverage by partnering with the private sector.
* Improve data management at all levels for tracking progress.

The proposed interventions are presented in the table below:

Table 7: Key interventions for Newborn and Child Health and levels of Delivery

|  |  |  |  |
| --- | --- | --- | --- |
| 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 |
| 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 |
| Extra support for feeding small and preterm babies | - | X | X |
| Presumptive antibiotics therapy for newborns at risk of bacterial infections | - | - | X |
| Postnatal visit within first seven days of birth |  | X | X |
| Erythromycin ointment for prophylactic eye care |  | X | X |
| Long-lasting insecticide net (LLIN) use by households | X | X | X |
| Home visits | X | X | X |
| Infancy and Childhood |  |  |  |
| Exclusive breastfeeding for 6 months | X | X | X |
| Continued breastfeeding and complementary feeding from 6 months | X | X | X |
| Prevention of childhood malaria | X | X | X |
| *Long-lasting insecticide net (LLIN) use by households* |  |  |  |
| *Amodiaquine plus sulfadoxine-pyrimethamine (AQ+SP) chemoprevention for seasonal malaria chemoprophylaxis* |  |  |  |
| 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 | X | X | X |
| Case management of childhood pneumonia Amoxicillin dispersible tabs | X | X | X |
| Case management of diarrhoea (Low Osmolar ORS + Zinc tabs) | X | X | X |
| Case management of confirmed malaria with positive RDT (ACT | X | X | X |
| Long-lasting insecticide net (LLIN) use by households | X | X | X |
| Comprehensive care of children infected with or exposed to HIV | X | X | X |
| *Nevirapine prophylaxis* |  |  |  |
| *PCR at 6weeks* |  |  |  |
| *Cotrimoxazole prophylaxis* |  |  |  |
| *Antiretrovirals* |  |  |  |
| Deworming | X | X | X |
| Folate supplementation | - | X | X |
| Screening for sickle cell disease | - | - | X |
| Pulse oximetry in pneumonia | - | - | X |
| Ready-to-use-therapeutic food (RUTF) Facilitates rehabilitation of malnourished children |  |  |  |
| Home visits | X | X | X |

### 4.1.5. Adolescent Health

***Context***

There has been no significant change recorded in the Adolescent birth rate of 121/1,000 live births in 2008 and 122/1,000 live births in 2013 and the proportion of young people (15-24 years) who have started bearing children has not changed significantly (22.9% in 2008 vs 22.4% in 2013).HIV testing rate has remained low among adolescents, it however doubled among girls from 4.0% in 2008 to 7.6% in 2013, but is still far below the national target of 80%.3.8% of males tested and received HIV testing result in 20081 as against 4.0%5 in 2013. Availability of adolescent-friendly health services in the public sector was far lower than the desired level, even at that, access to them are always met with socio-cultural and religious barriers.

***Strategic Objective, Specific Objectives and Targets***

The strategic objective of the interventions is to improve access to adolescent health information and services. The targets are:

* Awareness of availability of youth friendly sexual and reproductive health services among adolescents and young people increased to 80% by 2021
* Access to comprehensive youth friendly sexual and reproductive health services increased by 60% by 2021
* 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 2021
* Incidence of unplanned pregnancies among adolescent females reduced by 50% by 2024.
* Maternal *mortality among adolescent females reduced by 50%.*

***Interventions and Strategies***

* Integration of adolescent sexual and reproductive health (ASRH) care services into the continuum of care from community to referral facilities
* Increased awareness and education of adolescents via use of innovative ways like the social media and mobile technology to increase uptake of services.
* Increased Sensitization and mobilization of the community and opinion leaders as key change agents
* Integration of adolescent sexual and reproductive health education into our school system
* Involve parents / guardians through PTAs and other viable platforms to expand coverage of Adolescent health and development information

The proposed key interventions are presented on table 8 below:

Table 8: Key Interventions for Adolescent Health

|  |  |  |  |
| --- | --- | --- | --- |
| 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 for post-abortion cases | - | X | X |
| Integration of adolescent health services into primary health care | X | X |  |

### 4.1.6. 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 prevalence of low weight for height which increased 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. A marginal reduction in maternal malnutrition from 12.2% in 2008 to 11.4% in2013 (NDHS) was recorded however, the malnutrition rate doubled from 2% in 2014 to 4% in 2015 (NNHS).

***Strategic Objective, Specific objectives and targets***

The strategic objective 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.

* Exclusive breastfeeding rate in the first six months of life increased to 60% by 2021
* Incidence of low birth weight reduced from 17% to 10% by 2021
* Prevalence of childhood wasting reduced from 18% to less than 10% by 2021
* Prevalence of stunting in under-fives reduced from 37% to less than 20% by 2021
* Incidence of anaemia among women of reproductive age reduced by 15%
* Prevalence of childhood overweight reduced by 50% by 2024.
* Prevalence of malnutrition among women of reproductive age reduced from 11% to less than 5% by 2021
* Malnutrition among the elderly reduced by 50% by 2024.

***Interventions and Strategies***

* Promote delivery of effective interventions that will ensure adequate nutrition to all Nigerians, especially vulnerable groups.
* Advocacy and Resource Mobilisation
* Enhance capacity to deliver effective and appropriate nutrition interventions.
* Promote and strengthen research, monitoring and evaluation.
* Promote and facilitate community participation for nutrition interventions.
* Promote and strengthen nutrition coordination and multi-sectoral collaborations

Table 9 outlines the proposed key interventions and levels of health Care where specific interventions can be delivered.

Table 9: Key Interventions for 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 diarrhoea | X | X | X |
| School feeding | X (Schools) |  |  |
| Nutrition for (children born to HIV-positive mothers, and infants and young children in emergency | X | X | X |
| Nutrition for infants with cleft palate, and children with developmental disabilities) | X | X | - |
| Iron-folic acid supplementation in pregnant women | X | X | X |
| Vitamin A supplementation in lactating women | X | X | X |

## 4.2. Communicable Disease ((Malaria, TB, Leprosy, HIV/AIDS) and Neglected Tropical Diseases)

***Context***

Communicable diseases continue to pose major challenges to the global community accounting for over 60% of all causes of deaths in 2015*(World Health Organization, 2015).* In Nigeria, communicable diseases (AIDS/HIV, Viral Hepatitis, Malaria, Tuberculosis, Leprosy and neglected tropical diseases (filariasis, onchocerciasis, trachoma, worm infestation, and schistosomiasis), account for 66% of the total burden of morbidity. However, with advances in medicine, most of these diseases are now treatable (HIV, Viral Hepatitis B) and curable (Tuberculosis, Malaria and Viral Hepatitis C and NTDs). The SDG 3, Target 3.3, explicitly seeks to end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases (filariasis, onchocerciasis, trachoma, worm infestation, schistosomiasis, leprosy etc.) and combat hepatitis, waterborne diseases and other communicable diseases by 2030 *(https://sustainabledevelopment.un.org*). These diseases have also been listed as priority concerns in the National Health Policy.

### 4.2.1. HIV/AIDS

Nigeria bears 9% of the global burden for HIV (Joint United Nations Programme on AIDS*,* 2014) and has the second highest generalized HIV epidemic with adult prevalence of 3.4%. At the end of 2015, it was estimated that Nigeria had 3,037,363 people living with the disease; these includes 238,504 children and 1,639,593 women (Federal Ministry of Health, 2015). In recent years there has been progress in HIV/AIDS control: uptake of HIV testing has increased, access of people living with HIV to treatment has improved, and there is an increase in the proportion of children with access to HIV care and support. This has resulted in a decline in the HIV prevalence among the general population from 3.6% in 2007 to 3.4% in 2012 with the South East zone (1.8%) and South South zone (5.5%) now having the lowest and highest prevalence respectively (Federal Ministry of Health, 2014*)*. Uptake of HIV counselling and testing among pregnant women has increased as 30.2% of the estimated 209,861 HIV-positive pregnant women are accessing interventions for prevention of mother-to-child transmission of HIV (PMTCT) through 7265 health facilities reaching a PMTCT service coverage rate of 46% *(*Federal Ministry of Health, 2015). About 12.4% of HIV-exposed infants have accessed early infant diagnosis (EID) services within two months of birth and received PCR test results. Over 853,992 (overall 28%, 18.7% for children, 20.7% for men, and 34.7% for women) PLHIV are receiving antiretroviral therapy.

### 4.2.2. Viral Hepatitis

The World Health Assembly in 2010 adopted the WHA63.18 resolution that recognized viral hepatitis as a global health problem, highlighting the need for a global action on the prevention, diagnosis and treatment of this disease. Following this resolution, a study was conducted by the FMOH in 2012, which revealed a prevalence of 11% for Hepatitis B and 2.2% of Hepatitis C in Nigeria, with regional, state as well as sub-population variations. Many cases were found among children and young adults (age 21-40.). Health care workers were also found to be at higher risk of these infections. 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.

### 4.2.3. Malaria

Malaria remains a major cause of morbidity and mortality in Nigeria, accounting for about 29% and 55% of the cases in Africa and West Africa respectively. In 2016, 26% of the estimated 430, 000 global malaria deaths were reported in Nigeria (World Health Organization, 2016). Malaria is endemic throughout the country with 97% of the estimated 182 million persons at risk, with more deleterious effects on children under five years of age and pregnant women. The disease exerts a huge social and economic burden on families, communities, resulting in an annual loss of approximately 132 billion Naira as payments for treatment and prevention as well as lost man -hours.

Over the last decade, the country recorded progress in the fight against malaria. The results of the 2015 Malaria Indicator Survey showed a decline in malaria prevalence from 42% in 2010 to 27%. This is however is marked by wide variation across the states, ranging from 0% in Lagos to 64% in Kebbi state. The country launched a massive scale up of malaria interventions with huge support from partners, distributing about 93 million long-lasting insecticidal nets (LLINs) between 2013 and 2015. Population coverage of households with at least one LLIN increased from 28% in 2010 to 69% in 2015 while the proportion of women receiving at least two doses of Intermittent Preventive Treatment (IPT) increased from 13% in 2010 to 37% in 2015. (National Population Commission, (MICS) 2015)

### 4.2.4. Tuberculosis

The WHO End TB Strategy, approved by the World Health Assembly in 2014, calls for a 90% reduction in TB deaths and an 80% reduction in the TB incidence rate by 2030 (Global TB Report 2015). Nigeria and five other countries (India, Indonesia, China, Pakistan and South Africa) account for 60% of the overall 10.4million new TB cases worldwide. In 2015, there were an estimated 480 000 new cases of multidrug-resistant TB (MDR-TB) and an additional 100 000 people with rifampicin-resistant TB (RR-TB) who were also newly eligible for MDR-TB treatment. Nigeria’s TB incidence rate stands at 322/100,000, and this accounts for the highest TB burden in Africa. Children & male adult population are most at risk. 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 at 87%. The high prevalence of HIV increases the risk of TB infections among people living with HIV and therefore the global and National focus on ensuring TB/HIV collaboration to reverse the effects of TB/HIV co-morbidity.

### 4.2.5. Neglected Tropical Diseases

Neglected Tropical Diseases (NTDs) are diseases that affect rural dwellers, where safe water supply, sanitation and hygiene are poor or totally lacking. Although safe and cost-effective interventions for prevention and control are available, these diseases have continued to cause immense sufferings and often life-long disabilities for the affected. One or more of these diseases affect about one billion people worldwide with Nigeria contributing about 25% of Africa’s NTDs burden. Most of these diseases are co-endemic in all the States. Over 122 million, over 33.3Million, 20.8 Million, 29.4 Million, 5.3 Million, and 6.5 Million people are estimated to be at risk for Lymphatic filariasis, Onchocerciasis, Schistosomiasis, Soil Transmitted Helminths, Trachoma, and Human African trypanosomiasis respectively ( FMoH*, 2010,)*. There are also the Zoonotic NTDs in Nigeria such as Rabies. 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 in order to achieve the global target of elimination of the NTDs by 2020 (FMoH, 2013).

Challenges plaguing the delivery of intervention for communicable diseases and NTDs are largely hinged on issues limiting the optimal functioning of the health system, ranging from issues on governance and stewardship, inadequate human resources for health and physical infrastructures; paucity of quality data; Inadequate logistics management systems, inadequate and poor utilization of drugs, low awareness and funding. The overall goal of the planned interventions is to end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases in Nigeria.

***Strategic Objectives***

* To fast track the national response towards achieving 90-90-90 targets by 2020 towards ending AIDS in Nigeria
* To reduce the transmission of, morbidity and mortality caused by viral hepatitis, and to minimize the socioeconomic impact of the disease
* To reduce the malaria burden to pre-elimination levels towards bringing malaria-related mortality to zero
* To reduce tuberculosis prevalence rate and the tuberculosis mortality rate in Nigeria by ensuring universal access to high quality, client-centred TB/Leprosy diagnosis and treatment services
* To reduce morbidity, disability and mortality through the control and elimination of targeted NTDs

***Specific Objectives/Targets***

*Malaria*

* *80% of care seeking persons with suspected malaria is tested using mRDT or microscopy by 2021*
* *80% of all individuals with confirmed malaria seen in private or public facilities are treated with effective anti-malarial drugs by 2021*
* *Prevalence of malaria reduced by 80% in pregnancy and children by 2021*
* *Attain 60% local production of quality artemisinin-based combination therapy (ACT) by 2021*
* *80% of care seeking persons has access to antimalarial commodities by 2021*
* *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 2021."*

*Tuberculosis and Leprosy*

* *TB prevalence rate reduced by 60% by 2021*
* *TB mortality reduced by 50% by 2021*
* *Case notification rate of all forms of TB increased from 57.3 per 100,000 to 27 per 100,000 by 6 2021*
* *Case detection of all forms of TB increased to 70% by 2021*
* *Ratio of TB diagnostic centres to population 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 2021*
* *100% access to high-quality integrated services for all people co-infected with tuberculosis and HIV attained by 2021*
* *100% access to diagnosis and treatment of multi-drug resistant tuberculosis attained by 2021*

*HIV*

* Incidence of HIV infections among the key and general populations reduced by 70% by 2021
* Coverage of HIV testing increased from the current rate of 30% to 60% by 2021
* Mother-to-child transmission of HIV eliminated in Nigeria by 2021
* All diagnosed PLHIV receive quality HIV treatment services, and at least 90% of those on ARV achieve sustained virological suppression by 2021
* 100% of People living with HIV (PLHIV), vulnerable children, and people affected by HIV/AIDS (PABA) have access to comprehensive rights-based care by 2021.
* 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"

*Viral Hepatitis*

* 50% of persons infected with hepatitis B and C are aware of their infection status by 2021
* Prevalence of vaccine-preventable viral hepatitis reduced by 50% by 2021
* Prevalence of viral hepatitis reduced by 50% by 2021
* 50% of all persons eligible for hepatitis B treatment receive treatment by 2021

*Neglected Tropical Diseases*

* Proportion of States implementing integrated vector management for targeted neglected tropical diseases increased to 70% by 2021
* Prevalence of targeted NTDs reduced by 60% by 2021
* Attain 50% coverage in preventive chemotherapy for selected neglected tropical diseases by 2021"

***Strategic Interventions***

*Malaria*

* Expand access to integrated vector control interventions
* Strengthen laboratory services for diagnosis of malaria at all levels
* Build capacity of personnel in public and private health facilities for parasitological confirmation of malaria.
* Promote the local production of quality artemisinin-based combination therapy (ACT) to make antimalarial drugs widely affordable
* Improve availability of and access to commodities and supplies for treatment of uncomplicated and severe malaria
* Expand use of IPTp among pregnant women attending ANC
* Strengthen systems for quality assurance and quality control of malaria diagnosis and treatment.
* Promote active community participation in malaria control initiative

*Tuberculosis*

* Strengthen TB case detection, diagnostic capacity and access to quality treatment services.
* Promote demand for TB services
* Expand access to TB diagnosis and treatment services for persons co-infected by TB and HIV
* Scale up paediatric TB diagnosis and treatment services
* Increase access to diagnosis and management services for DR-TB
* Strengthen collaboration with and capacity of CBOs to support TB programming.
* Strengthen mechanism for coordination of TB/HIV collaborative activities at all levels of health care.
* Promote innovative advocacy, social mobilization and behaviour change intervention for the prevention and control of TB
* Expand and improve access to quality Leprosy and TB Services
* Build capacity of all cadres of health staff (GHW, Physicians, and specialist) and community members on Leprosy case finding and case management
* Integrate Leprosy control into the general health services
* Promote community based TB/Leprosy control initiatives
* Strengthen physical and socio-economic rehabilitation for leprosy

*HIV/AIDs*

* Expand access to Minimum Package of Preventive Interventions (MPPI) for HIV targeting key and general populations
* Expand access of people living with HIV and AIDS to ART and co-infection management services.
* Promote universal access to quality PMTCT services
* Strengthen referral and linkages between HIV/AIDS services and other health and social services
* Improve access to safe blood and blood products
* Promote injection safety and health care waste management practices
* Strengthen community systems to support HIV/AIDS programming for key and general populations
* Improve the logistics and supply chain management for all HIVAIDS- related drugs and commodities.
* Promote HIV/AIDS research for improved evidence-based response
* Strengthen advocacy, legislation, social mobilization and behaviour change communication for improved HIV response

*Viral Hepatitis*

* Strengthen advocacy, social mobilization and behaviour change communication on viral hepatitis
* Expand access of key and general populations to viral hepatitis prevention, screening and treatment services
* Scale-up interventions for the prevention of iatrogenic transmission of viral Hepatitis
* Expand coverage of interventions for prevention of mother-to-child transmission of viral hepatitis
* Strengthen HBV vaccination for adult populations, especially those at occupational risk
* Promote universal coverage of HBV vaccination at birth and other doses according to national schedule
* Expand access and delivery of hepatitis prevention, care and treatment services in health care facilities and closed settings

*Neglected Tropical Diseases*

* Strengthen advocacy, social mobilization and behaviour change communication for NTDs
* Scale up delivery of integrated preventive chemotherapy packages and other packages.
* Strengthen integrated vector and management and activities for health education, access to clean water, sanitation, and environmental improvement for targeted NTDs.
* Increase access to integrated case management for NTDs (Buruli Ulcer, Leishmaniasis, Trypanosomiasis, Loasis, Schistosomiasis, Zoonosis , soil-transmitted helminthic infections, onchocerciasis, filariasis)
* Strengthen capacity for NTD programming and implementation.
* Strengthen the integration and linkages of NTD programme and financial plans into sector-wide and national budgetary and financing mechanisms.
* Promote research on NTDs for evidence-based response

## 4.3. Non-Communicable Disease

### 4.3.1. Non-communicable Diseases

***Context***

Nigeria is experiencing a 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. They impose a heavy economic burden on individuals, societies and health system as they affect the highly productive population. 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 and oral health. Although there is dearth of data on NCDs in Nigeria, as the last national survey on NCD was in 1992, the prevalence of NCDs is predicted to rise even more in the coming decades.

Cancers are among the leading causes of morbidity and mortality in Nigeria, with about 100,000 incident cases currently being reported annually and it is estimated that by the year 2015 the burden would have increased fivefold if nothing is done. Data from the 11 hospital-based cancer registries located in Nigeria showed that among females, the five commonest cancers are cancers of the breast (40%), Uterine cancer (17%), ovarian cancer (3.7%), Lymphomas (3.1%), and skin cancers , excluding malignant melanomas (2.3%) while among males prostate cancer (27.2%), colorectal cancer (7.1%) and lymphomas (6.6%), liver cancer (4.2%), and skin excluding malignant melanomas (4.2%) lead.

Available data indicate that the incidence of cervical cancer in Nigeria is about 33/100,000 and an estimated 14,089 cases are diagnosed every year, eight out of every ten of them presenting at an advance stage with mortality rate of about 25%. Nigeria is responsible for about 50% of new cases and deaths from cervical cancer in West Africa. The problem is further compounded by the lack of integration of routine screening into the primary health care, ignorance and low coverage with Human Papilloma vaccine.

Nigeria has the highest burden of SCD in Africa. About 150,000 - 200,000 babies are born each year in Nigeria with SCD and more than half of them die before their fifth birthday, 90% before attaining adulthood if poorly managed in childhood. Approximately 24% of Nigerians have the sickle cell trait (SCT). It is estimated that where prevalence of SCT is above 20%, SCD can be as high as 2%. This implies that over 3.4 million Nigerians currently have SCD. The 2015 IDSR showed that there were 17,764 cases with 42 deaths from SCD and 43,985 cases of Asthma with 41 deaths

The modifiable shared risk factors for NCDs include tobacco use, harmful use of alcohol, physical inactivity and unhealthy diets such as excessive consumption of red meat, salt, saturated fat, refined sugars in foods and drinks. Others include exposure to outdoor and indoor smoke from solid fuels, harmful radiation (domestic or industrial) contribute to an emerging increase in NCDs. The above risk factors are fuelled by increasing globalization, urbanization and industrialization in the last few years that imposed new lifestyle on the population with ascendancy in the occurrence of related chronic conditions.

According to the Nigeria Global Adult Tobacco Survey (GATS) (2013), 5.6% of Nigerian adults aged 15 years and older (4.5 million adults) currently use tobacco products; out of which 4.1 million are men and 0.45 million are women. It was estimated by WHO (2009) that per capita consumption of alcohol in Nigeria is 10.57 litres (ranking among the highest in Africa). The Nigerian Report Card on Physical Activity for Children and Youths shows that 30.3% to 74.6% of Nigerian children and youths aged 5 – 25 years are involved in some form of physical activity but not sufficient enough for health gains (Nigerian Heart Foundation, 2013). Annual reports of the Federal Road Safety Corps (FRSC) from 2008 to 2011, showed a total of 6,661, 5,693, 4,065, 4,372 deaths and 27,980, 27,270, 18,095, 17,464 injuries respectively. There is an observed reduction over the 4 years period probably as a result of the awareness campaign by the FRSC and FMOH. Data from the Nigeria Police showed that the prevalence of interpersonal violence is 31%, intimate partner violence - 18%, sexual violence - 7%, domestic violence - 28%, female genital mutilation - 29.7%, emotional violence (spousal) - 18%.

The Federal Ministry of Health through the Non-communicable Diseases Division is currently reviewing the National Policy and Strategic Plan of Action for the Prevention and Control of NCDs (2013), to ensure compliance with global best practices. . In addition, various sub-programme guidelines such as the National Nutrition Guideline on the Prevention, Control and Management of NCDs, Guideline for the management of Sickle cell, NCD Case Management Desk Guide for Clinicians and NCD education and lifestyle guide for health Educators have been developed. The Global Adult Tobacco use Survey (GATS) was conducted in 2012. It provides information on tobacco use in the country while the National Tobacco Control Act has been signed into law in May, 2015, the Regulations is being drafted for approval by the National Assembly. Also, the National Tobacco Control Committee (NATOCC) has been established to provide leadership for tobacco control implementation in the country. Sickle Cell centres have been established in six federal medical centres and equipped with high performance Liquid chromatographic machines for diagnosing sickle cell in newborns. Equally, six populations- based and19 hospital- based Cancer Registries have been established across the zones of the country. Some Global NCD Days are celebrated every year to sensitize and create awareness among the public on prevention and control of NCDs.

However, there is no current national statistics on NCDs and over the years Nigeria has relied on estimates from the 1990-1992 survey, which is outdated and unsuitable for planning purposes. Major barriers to prevention and control of NCDs in Nigeria include gross underfunding, lack of donor support, poor legislation and enforcement of laws linked to prevention and control. Others include inadequate screening equipment particularly at the PHC level, paucity of adequately trained staff, weak health systems, high cost of treatment, un-coverage of NCDs in the NHIS and lack of multi-sectoral approach to their prevention and control. The burden of NCDs is further compounded by ignorance and misconceptions about these diseases.

***Strategic Objective and Targets***

The strategic objective of the planned interventions is to reduce the morbidity and mortality due to NCDs in Nigeria by 20% from current levels by 2021. The targets for the plan period are:

* Overall mortality from NCDs (cardiovascular diseases, cancer, diabetes, sickle cell diseases or chronic respiratory diseases.) reduced by 20% by 2021
* 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 2021
* Proportion of Adults who are aware of their genotype increased by 50% by 2021
* Proportion of eligible population screened for early detection and management of NCDs increased to 50% by 2021.
* Access to quality treatment facilities for persons with NCDs increased to 50% by 2021"

***Interventions***

* Establish multi-sectoral Coordination Committee for NCDs prevention and control
* Increase funding for NCD and remove economic barriers to accessing services (expand social health insurance to cover NCDs)
* Promote evidence-based decision-making for planning NCD interventions
* Expand coverage of NCD prevention and treatment to all public hospitals and to private and PHC facilities
* Increase NCD information dissemination, education, and cancer outreach services nationwide.
* Build capacity of health care providers, especially at lower levels (PHC) in prevention and screening for NCDs
* Remove economic barriers to accessing NCD services
* Create demand for NCD services
* Promote healthy lifestyles and behaviours for the prevention of NCD*s*

### 4.3.2. Care of the Elderly

***Context***

The elderly, also variously described internationally as older persons, senior citizens or simply seniors, conventionally refer to persons aged 60 years and above. In Nigeria, it is estimated that older people make up about 10% of the Nigerian population (GlobalAge watch Report, 2015) 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. People over 60 accounted for 75% of the 35 million deaths from NCDs worldwide in 2004 alone, with the majority in low and middle-income countries including Nigeria (HelpAge International, 2011). In Nigeria these disease conditions have their origin partly from the prevailing social, economic and environmental factors, which include poverty, loneliness and depression. Most of these have their roots in the fast declining traditional social security system which was once our heritage (*Adebowale et al 2012).*

In spite of 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. Although there is dearth of data on the health of elderly persons in Nigeria, anecdotal evidence suggests that our health facilities lack basic personnel with skills to address the health needs of older persons. (*GlobalAge Report 2015).* Currently, there is only one standard government-owned geriatric health facility in Nigeria, located in the University College Hospital, Ibadan, known as Chief Tony Anenih Geriatric centre. The centre is run down and currently provides only minimal services through a voluntary insurance scheme.

The Federal Ministry of Health has established, an Elderly health unit, charged with the responsibility of coordinating the development and implementation of strategies and interventions aimed at addressing the health needs of older persons in Nigeria. This Unit carried out a survey to ascertain availability of geriatric services in 15 tertiary institutions across the country in 2010, leading to National Council on Health's resolution in 2010, to have geriatric centres established in all government institutions. The package of services to be provided for geriatrics is being determined. Despite these efforts, Nigeria’s overall performance in terms of elderly care has been sub-optimal.

Key challenges in this regard include, 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.

The increasing global attention on the health risks of the elders 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 inclusion of elderly care in the NSHDP2 is indicative of governments determination to accord Elderly care a deserved attention in line with national and international commitments.

***Strategic Objective and Targets***

The strategic objective of the interventions is to improve the health and wellbeing of the elderly in Nigeria. The targets for the interventions shall include:

* 50% of the elderly in Nigeria access basic and long term care by 2021
* 50% of the elderly in Nigeria are active and stay healthy by 2021.
* 40% of the elderly have access to financial support schemes to meet their health care needs by 2021.

*Interventions*

* Promote generation of evidence for planning, implementation and monitoring of geriatric services
* Promote enabling policy environment for programming for the elderly
* Scale-up appropriate health services for the promotion of health rand care of the elderly at all levels of care
* Build human resource capacity for the care and support of elderly at all levels of the health care system
* Strengthen Behaviour Change Communication (BCC) and Social Mobilization interventions for the elderly
* Promote community participation and partnerships for sustainability of health programmes for the elderly

### 4.3.3. Mental Health

***Context***

Mental illnesses are increasingly being recognized as a major chronic disability worldwide and one of the leading contributors to burden of diseases. In 2004, it was estimated that mental, neurological and substance use disorders accounted for 13 percent of global burden of disease (GBD) (WHO, 2013). Mental, Neurological and Substance use Disorders (MNS) together 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. 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 around 1 in 5 persons would experience a significant mental health problem in their lifetime requiring long-term commitment to treatment.

Psychotic disorders, the most easily identifiable form of mental illness, which include the schizophrenias, manic illness and organic psychosis, 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 (WHO, 2014). 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 in the course of 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 (WHO, 2006).

Although there has not been any mental health epidemiological survey for over a decade in Nigeria to ascertain the current mental health prevalence, it is estimated that **a**bout 20% of children aged 7 – 14 years meet criteria for a Diagnostic & Statistics Manual (DSM)-III disorder, commonly: depression, conduct disorder, and anxiety disorder. The 12 month prevalence of adult mental disorder was estimated to be 5.2% and 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.

People with mental disorders experience disproportionately higher rates of disability and mortality. For example, persons with major depression and schizophrenia have a 40% to 60% greater chance of dying prematurely than the general population, owing to physical health problems that are often left unattended such as cancers, cardiovascular diseases, diabetes, HIV infection and suicide.

The proportion 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 MNS disorders are the largest single group, among NCDs contributing to disability.

There are myriad challenges confronting the mental health in Nigeria sub-sector that limits effective response. 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, failure to integrate mental health into PHC, and lack of programming for mental health with no program officer at no 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 in order to resolve the constraints, address the risk factors and improve access to effective and efficient mental health services delivery.

***Strategic Objective and Targets:***

The strategic objective 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. The targets are:

* Incidence of mental illnesses in Nigeria reduced by 20% by 2021
* Healthcare coverage of patients with mental illnesses and substance use dependence by increased to 60% by 2021;
* Social welfare support to persons with established serious mental Illnesses and substance use dependence raised to 40% by 2021.

Table 4: Mental Health Personnel Availability in Nigeria (2017)

|  |  |
| --- | --- |
| **Professional Group** | **Available per 100,000 population** |
| **Psychiatrists** | 0.09 |
| **Neurosurgeons** | 0.009 |
| **Psychiatric nurses** | 0.4 |
| **Neurologists** | 0.02 |
| **Psychologists** | 0.02 |
| **Social workers** | 0.2 |

*Source: Not stated? No evidence? Suggest delete*

***Interventions:***

* Promote legal framework for mental health practice and services in Nigeria;
* Strengthen the generation of evidence for planning and programming
* Scale-up provision of comprehensive, integrated and responsive mental health services particularly, in primary health care and community-based settings
* Expand access to psychosocial support services as component of mental health services in communities
* Strengthen interventions for mental health prevention and promotion at all levels;
* Strengthen coordination mechanism for mental health service delivery at all levels
* Promote advocacy for improved financing for mental health
* Strengthen the supply chain system for the sustainable supply of mental health drugs and commodities at all levels
* Build capacity of health care providers for mental health service delivery at all levels

### 4.3.4. Oral Health

***Context***

Oral health is a natural, acceptable dentition which enables an individual to eat, speak and socialize without discomfort, pain or embarrassment for a life time and which contributes to general health (WHO)

Oral diseases includes dental caries, periodontal disease, tooth loss, oral mucosal lesions, oropharyngeal cancers, human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS)-related oral disease and orodental trauma. Other oral health problems include malocclusion, traumatised teeth, dental fluorosis, and oral tumours.

Oral diseases are major public health problems worldwide, as 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 in both developing and developed countries. The 2010 Global Burden of Diseases, Injuries and Risk factors Study estimated that oral conditions affected 3.9billion people and that the burden of oral conditions had increased by almost 21% between 1990 and 2010 (Marcenes et al, 2013).

There is a dearth of statistics on the current situation in the country, but data from experts indicates that dental caries (tooth decay) prevalence is between 6 to 23 per cent among Nigerians, of which 90 per cent of the patients are untreated, resulting in pain and tooth loss (Sofola, 2009)

Most oral health surveys in Nigeria have been sporadic and based on convenience samples. Periodontal disease with deep pocketing occurs in Nigerians at an early age, the prevalence being 15–58% in those aged above 15 years.

Prevalence of destructive periodontal diseases range from 15% in Northern Nigeria to 40% in Western Nigeria while oral health knowledge remain poor at 54% and 45.7% respectively (Sofola et al, 2009) The oral disease burden follows a pattern of deterioration closely associated with poverty and poor economic growth. There is particular concern about the high prevalence of Noma (Cancrum Oris), oral cancer, and the oral manifestation of HIV/AIDS, orofacial trauma, dental caries and periodontal diseases. The incidence of Noma an acute devastating orofacial gangrene that occurs mainly in children is on the increase in Nigeria. It is caused by a combination of factors that includes poor oral hygiene, malnutrition and weakened immune system.

Risk factors for oral diseases include unhealthy diet, tobacco use, harmful use of alcohol and poor oral hygiene. major 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 PHC. The survey of oral health manpower, facilities and training institutions in Nigeria carried out by the Intercountry Centre for Oral Health, Jos in 2014 showed that presently there are only 679 dental clinics available in Nigeria, which are inequitably distributed to the neglect of settlements outside State capitals.

***Strategic Objectives and Targets***

The strategic objective is to contribute to improvement in the quality of life and wellbeing of Nigerians through the promotion of preventive, curative and restorative oral health care. The interventions shall target:

* Incidence and prevalence of oral diseases (e.g. dental caries, gingivitis, cancrum oris etc.) reduced by 40% by 2021
* Level of oral health awareness in the country increased from less than 45% to 70% by 2021
* 50% of Nigerians have adequate access to oral health care by 2021
* 60% of PHCs provide basic package of oral care by 2021
* 60% of secondary level health care facilities are providing oral health care appropriate for that level"

***Interventions***

* Promote prevention and early care seeking for oral diseases
* Integrate oral health into primary health care.
* Expand access to oral health care services by integrating oral health at all levels of the health care system
* Train healthcare providers to meet the minimum international standards for different levels of care
* Provide oral health care based on minimum acceptable standards
* Increase oral health financing at all levels of health care
* Promote research and effective monitoring and evaluation of oral health activities
* Advocate for legislation to discourage habits that are harmful to oral health
* Provide school based oral health programming

### 4.3.5. Eye HealthCare

***Context***

The 2010 WHO report estimates that 39 million people worldwide are blind (VA<3/60 in better eye) and 285 million persons are living with low vision (VA<6/18 > 3/60 in better eye). This represents some 4.2% of the global population. 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.

The latest available national data on eye health is from the 2005 – 2007 survey report which indicated a prevalence rate of blindness 4.2% 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 the country. Higher rates of blindness/visual impairment were found in the North East/North West, among women, and illiterates. Among three quarters of blindness are 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 set up the National Eye Health Programme and has developed the National Eye Policy (2006)

***Strategic Objective and Targets***

The strategic objective of this plan is to contribute to the development of a healthy and productive population, through reduction in the prevalence and incidence of eye diseases in Nigeria. In particular, the interventions should aim to reduce the prevalence of avoidable visual impairment by 25% by the year 2021 (*National Blindness and Low Vision Survey of 2005 – 2007)* with targets as follows:

* 70% of blind and visually impaired persons have adequate access to eye treatment and rehabilitative services by 2021
* 30% of health facilities in the country have capacity to deliver appropriate quality eye care services by 2021
* 50% of blind and visually impaired needing rehabilitation have access to required services by 2021
* Prevalence of avoidable visual impairment in the country reduced to 25% by 2021."

***Interventions***

* Improve coordination of eye care services
* 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
* Strengthen eye health focused research and information system;
* Strengthen advocacy, social mobilization and behaviour change communication on eye health
* Expand access (financial, geographical, social etc.) to comprehensive (promotive, preventive, curative and rehabilitative); appropriate and quality eye health services at all levels.

## 4.4. General & Emergency Hospital/Health Facilities’ Services

***Context*** *(*covering all of the six sub areas)

The health care delivery system is divided into the primary, secondary and tertiary sub-systems. The primary and secondary sub-systems are under the supervision of the Local and State governments respectively and they are the weakest links. In many States, they are non-functional and this has severely weakened referral services. Most Nigerians have lost confidence in these two sub-systems and usually bypass them in their quest to access medical services. The result is that the tertiary system is over burdened with minor ailments which tend to distract health workers at that level from their other core mandates of training of health workers and health research.

The tertiary health care delivery sub-system is operated by the Federal Ministry of Health and there are fifty-four (54) institutions providing services in this sub-system. They are under the direct supervision of the Department of Hospital Services of the Ministry. Most of the hospitals have adequate manpower and some level of equipment to deliver reasonable services but this is not usually the case as a result of poor attitude of health workers, inter-professional wrangling, incessant strike actions, conflict of interest, poor housekeeping and unregulated Labour Unionism etc.

The result is that more Nigerians are fast losing confidence in this level of care and those who can afford it go outside the country to access care, which in some cases may not be up to the standard obtainable in the country. It has been estimated that Nigeria loses up to USD 1billion to medical tourism annually. To stem this tide, the framework for the NSHDP II should be designed in such a way as to address the causative factors of this menace.

### 4.4.1. Provision of Health Services at Public and Private Health Facilities

***Strategic objective and Targets***

The strategic objective is to strengthen the provision of health services at public and private health facilities that are appropriate, accessible and meet minimum quality and safety standard for optimized health outcomes. The targets include the following:

* Case fatality rates reduced by 30% by 2021
* Client satisfaction level improved by 50 % by 2021
* Utilisation of general medical services increased by 100% by 2021
* 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 2021
* Proportion of health facilities implementing IPC in line with standard guidelines

***Interventions***

* Promote the development and implementation of policies, plans, legislations, regulations and clinical standards for safety and quality improvement of medical services across levels of care
* Scale up provision of accessible medical services
* Intensify continuous quality improvement in medical service provision at all levels
* Build capacity of health care providers for quality medical services
* Promote demand for appropriate use of medical services
* Strengthen Infection, Prevention and Control (IPC) practices in health care settings.

### 4.4.2. Integrated Emergency and Trauma Care

***Strategic objective and Targets***

The strategic objective for the area is to increase provision and access to quality, affordable & integrated emergency and trauma care.

The targets have been set as follows:

* 80% of the states have dedicated centres for integrated emergency and trauma service
* 70% of Secondary and Tertiary hospitals have functional ambulances
* 30% of health emergencies responded to within 1-hour

***Interventions***

* Strengthen coordination and regulation mechanisms for emergency referral and trauma services at all levels care.
* Ensure provision and access to emergency and trauma services
* Strengthen integrated functional national and sub-national referral systems
* Strengthen coordinated and integrated transport systems for emergency and trauma services
* Build capacity (human and institutional) and infrastructure for continuous quality improvement of comprehensive emergency and trauma care.
* Intensify multi-sectoral and intra-sectoral collaboration and partnerships for emergency care and trauma service
* Promote demand for appropriate use of emergency and trauma care services

### 4.4.3. Provision of Ambulatory (outpatient) Services at all levels of Health Care

***Strategic objective and Targets***

The strategic objective of the interventions is to improve provision, access, quality and responsiveness of Ambulatory (outpatient) Services at all levels of health care with the following target:

* 100% of Health facilities providing general outpatient services as appropriate to the level of care.

***Interventions***

* Promote the development of practice standards and guidelines for ambulatory services
* Scale-up functional and integrated ambulatory services (general, and specialized) in all facilities according to standards
* Promote & enhance capacity (human and institutional) for continuous quality improvement of Outpatient services

### 4.4.4. Access to Safe Blood and Blood Products

***Context***

A blood transfusion service is provided by a variety of providers and at different levels of the health care system, with little regulation. Setting up of a National Blood Transfusion Service is a more recent event, aimed at streamlining and regulating the practice. A NLBTS policy is in place. There are currently 6 NBTLS centres across the country. All blood collected in these centres are screened for HIV, HBV, HCV, syphilis and malaria. Nigeria’s annual blood need stands at about 1% of its population (170 million) i.e. 1.7 million Units/ year whereas only about 64,000 units of safe screened blood were collected through the NBTS network in the 2015/2016 fiscal year.

The core functions of the Laboratory services are disease prevention, control, and surveillance; reference and specialized testing; Food safety; Emergency response; environmental health and protection; food safety; laboratory improvement and regulation; policy development; public health-related research; training and education; and integrated data management

A significant amount of laboratory investigations occur in the private sector, some of them referred .The blood safety program in Nigeria faces challenges of poor access to and availability of safe blood and blood products, as well as poor implementation of quality management systems for blood transfusion. Additionally, there is Inadequate budgetary provisions for the sub-sector, dwindling donor funding, fragmented and poorly coordinated blood services, absence of laws guiding the collection and use of blood and blood products as well as, inadequate manpower, lack of heamovigilance and documentation systems. Demand-related constraints include the unwholesome practices in the collection, distribution and use of blood and blood products, low public awareness of voluntary non-remunerated blood donation, deep cultural myths and misconceptions, increasing rise of commercial blood donors and lack of cooperation and collaboration between the secondary and tertiary health facilities where most blood transfusion activities take place. To address some of these challenges, the Nigerian government has put in place a National Medical Laboratory Policy (2007), the National Blood Transfusion Policy and Nigeria National Medical Laboratory Strategic Plan (2015-2017). The documents are meant to guide Laboratory Services in the country. However, the implementation of the plan has been rather slow. The little progress made in the development of Laboratory services in the country, has been donor driven, relying mainly on vertical programs with the consequence that the services respond largely to Donor requirements and reporting. These programs dependent laboratories serve as back bone to Nigeria’s response in terms of emergencies e.g. responses to polio, Lassa fever and Ebola in recent times.

Laboratories in the National Blood Transfusion Service are standalone laboratories that provide services to the blood service. Their core responsibility is to ensure that safe blood is made available for transfusion in the country by screening blood donations for the four transfusion transmissible infection makers (HIV, HBV, and HCV & Syphilis) made mandatory by WHO.

***Strategic objective and Targets***

The strategic objective is to promote provision of and access to effective, safe blood and blood products at appropriate levels of health care.

* Proportion of units of blood collected increased from current 4% to 70% of total need.
* Proportion of collected blood screened increased to 100% by 2021
* 100% of blood collection and utilisation centres meet the minimum quality standards by 2021 "

***Interventions***

* Promote the development and implementation of policies, plans, legislations, regulations and clinical standards for safe blood and safe blood products transfusion
* Expand the availability of and access to safe blood and blood products including strengthening of linkages between hospitals and NBTS screening centres.
* Promote and increase public awareness on blood transfusion services including voluntary non remunerated blood donation.
* Strengthen resource mobilisation for blood transfusion services including promotion of PPP.
* Develop quality management system and institutionalize hemovigilance for Blood and blood products services in all blood screening centres.
* Develop and institutionalize Data/Information Management system on blood transfusion (include developing a directory for public information and use) services in Nigeria

### 4.4.5. Public Health Laboratory Services

***Context***

Demands on laboratory services are increasing with increasing complexity in the practice of medicine, and public health. They are the first site for the detection of outbreaks and also serve as a major source of health information. Reliable and efficient laboratory services are therefore essential for an effective and well-functioning health system. They produce relevant information for patient care and treatment monitoring, epidemic investigation and surveillance. Optimal functioning of the public health system to reduce threats to health is contingent on availability of high quality network of laboratory facilities equitably distributed.

In Nigeria, public sector clinical laboratory services are provided in tertiary, secondary and primary health care facilities, owned by the different tiers of government. The number of the facilities providing these services is not readily available. There does not appear to be a policy or guidelines on the services to be provided by level of health facility. Thus, the range of services provided in the public health facilities laboratories vary not only by level of care but also, by the different governments involved in provision of laboratory services.

Public health laboratory services are provided by only the federal government and currently, there is only one functional PHL at Yaba. Information is not readily available on the number of laboratories and services provided in the different facilities and the services they provide. Private health facilities also provide laboratory services, and some of them are free standalone laboratories with some of them very well equipped.

Many of these private sector laboratories are not regulated and the quality of their services is not subject to audit. There is also very poor communication between the private and public health laboratories. In the public sector, the minimum package of services to be provided at each level has not been defined; coordination of activities in public sector laboratories run by the different governments providing the services is non-existent. The laboratory services in the public health sector remains grossly understaffed and specialist laboratory staff remains grossly inadequate and are mainly located in the tertiary health facilities. The infrastructures are dilapidated, water supply and power remain unreliable, laboratory equipment is grossly inadequate at all levels and maintenance of available ones is poor. Interruptions of supply of essential laboratory reagents and supplies, weak referral network among existing laboratories, little or no linkages between the clinical and public health laboratory, poor regulation and lack of sufficient and trained staff, uncoordinated and low utilization of laboratory research effort, as well as, poor coordination and governance are added challenges. The costs of laboratory services are major limitations to access by patients. These challenges contribute to low confidence in laboratory results in the country and the inability of the laboratories to effectively discharge their responsibilities. Over the years, there has been neglect of the public health services, with a greater focus on clinical services. Other constraints are poor compliance to professional ethics guidelines and poor funding and resources to support research and development activities. Finally there is a lack of updated and enforced legislation.

***Strategic objective and Targets***

Provide appropriate, efficient, quality, equitable and cost-effective public health and medical laboratory services at all levels of health care delivery. The targets are set as follows:

* 40% of laboratories at all levels equipped and staffed as defined for that level of care by the end of 2021.
* 40% of level 5 public health laboratories (SPHC, NBTS and NPHRL) are accredited by ISO by 2021
* 50% of all levels 1-4 laboratories are certified by 2021.
* 60% of laboratories comply to relevant Quality Standards
* Federal Laboratory Service Unit established by 2019.
* Data management system developed to address the type of data to be collected, frequency, flow, analysis, and use designed, for both disease surveillance and programme management by the end of 2021
* 40% of laboratory facilities utilizing and reporting according to agree upon data needs, flow and timelines by the end of 2021
* 50% of laboratories at level 3 and higher equipped with computers by the end of 2021.

***Interventions***

* Promote the development and implementation of policies, plans, legislations, regulations and clinical standards for laboratory services
* Ensure the availability and accessibility of quality laboratory services at all levels
* Strengthen coordination and networking of public health and medical laboratories for effective health care delivery
* Implement quality assurance (QA) and continuous quality improvement of laboratory services
* Build capacity of health care workers for delivery of effective laboratory services
* Promote a laboratory information system for integrated laboratory services that links with the NHMIS.

### 4.4.6. Access to Palliative and End of Life Care

***Strategic objective and Targets***

The strategic objective is to 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. The targets for the plan period shall include:

* 30% of Public & Private Health Facilities operates functional Palliative and End-of-life care services
* 30% of patients needing palliative and end-of-life services are receiving community system support

***Interventions***

* Promote the development and implementation of policies, plans, legislations, regulations and clinical standards for palliative and end-of -life care services
* Build capacity (human and institutional) for continuous quality improvement of palliative and End-of-life care services
* Strengthen community systems to support Palliative and End-of-life care services
* Promote appropriate disposal of dead bodies

## 4.5. Health Promotion and Social determinants of Health (Environmental Health)

***Context***

Health promotion is defined as ‘the process of enabling people to increase control over and to improve their health’ (WHO 1986). 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 disease. It addresses many factors that influence health such as Individual factors-(biological, socio-demographic and lifestyle and health care seeking behaviour); and Environmental factors (cultural, social, economic, physical, etc.). These are the social determinants of health.

Nigeria has been making concerted efforts aimed at promoting health and addressing some of the social determinants of health. Some of the actions initiated over the years include: Development of relevant Health Policies including the National Health Promotion Policy ( 2006), the National Food and Nutrition Policy, the Infant and Young Child Feeding Policy, Legislation on seat belts and use of telephones while driving, Reorienting health services, Increasing focus on primary health care as a strategy to reduce geographic and economic inequities to access, strengthening Community Action and promoting the concept of Ward Development Committees.

These actions have been limited and have failed to make significant impact in improving the nation's health status, redressing inequalities in health outcomes and dealing with the root causes of disease. Some of the leading causes of premature death and years lived with disability in 2013 are as shown on table 5 below:

Table 5: Ranked Leading Causes of Premature death and Years Lived with Disability, 2013

|  |  |
| --- | --- |
| **Leading causes of premature death** | **Leading Causes of Years Lived with Disability** |
| Malaria | Lower back and neck pain |
| Lower respiratory tract infection | Depressive disorders |
| Haemoglobinopathies | Sense organ diseases |
| HIV/AIDS | Skin diseases |
| Road Injuries | Schistosomiasis |
| Preterm birth complications | Malaria |
| Neonatal encephalopathy | HIV/AIDS |
| Diarrheal diseases | Road Injuries |
| Protein energy malnutrition | Chronic Obstructive Lung Diseases |
| Neonatal sepsis | Diarrheal diseases |

*Source: The Commonwealth and IHME Health Data .org*

The risk factors for diseases are poor environmental sanitation (water, sewage and housing, air pollution), 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 for Nigeria, in order of ranking is shown in Figure 5. 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 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 and actions that promote their health and prevent disease, address factors in the community that influence health and wellbeing and impede inequities in health outcomes.

Some of the key factors militating against effective health promotion interventions include:

1. Limited understanding of concepts of the Health Promotion and consumer rights,
2. Lack of a strong platform for multi-sectoral actions towards the promotion of supportive environments for health behaviour change,
3. Inconsistent and poor implementation of health education across the levels of the health care system,
4. Non-integration of health promotion in curative services and across programmes,
5. Dearth of communication strategy and materials skills,
6. Lack of a framework for coordination of organizations providing health education and
7. Absence of a dedicated funding for health promotion and community empowerment

Figure 4: Burden of Diseases attributable to leading Risk Factors as Percentage of Nigeria's DALYs



*Source: The Commonwealth and IHME Health Data .org*

### 4.5.1. Wellbeing of individuals and communities through protection from health risks, and promotion of healthy lifestyle and environment

The wellbeing of individual and communities arise from protection health risks and promotion of healthy lifestyle and of the environment.

***Strategic Objective and Targets***

The strategic objective of this plan is to empower Nigerians with appropriate health knowledge, through health promotion to enable them develop and practice healthy lifestyles. The targets are:

* 25 % of communities have capacity for health promotion by 2021
* 40% of community members are making healthy lifestyle choices by 2021

***Interventions***

* Promote the development and implementation of policies, plans, legislation and regulations that prevent health risks and ensures healthy life styles
* Strengthen community capacity for responses and ownership of health promotion.
* Strengthen health promotion coordination mechanisms at all levels
* Scale-up health promotion activities at all levels.
* Promote the inclusion of health promotion in workplace health programs
* Promote the inclusion of health promotion in school curricula at all levels
* Intensify multi-sectoral and intra-sectoral collaboration and partnerships in planning, implementation and health promotion activities

Figure 5: Health Promotion Strategic Framework (Nigeria)

TO DELIVER THE FOLLOWING

USING THE FOLLOWING STRATEGIES

IN THE FOLLOWING SETTINGS

HEALTH PROMOTION TO ADDRESS

IN PARTNERSHIP WITH: -

PREVENT AND REDUCE DISEASES

LINE MINISTRIES

IMPROVE HEALTH (WHO STANDARD)

COMMUNITIES

HEALTH EDUCATION

HEALTH FACILITY

EDUCATION /SCHOOL SETTING

PARASTATALS

DETERMINANTS OF HEALTH

RE-ORIENTATION OF HEALTH AND OTHER PUBLIC SERVICES

SERVICE IMPROVEMENT

MEDIA

COMMUNITY SETTING

CREATE HEALTHFUL ENVIRONMENT

DONOR/INT. COMMUNITIES

PRIVATE SECTOR

WORKING ENVIRONMENT SETTING

ADVOCACY

REDUCE COST TO HEALTH CARESYSTEM

NGOs / CSOs / CBOs ETC

ENABLES COMMUNITY OWNERSHIP AND SELF HELP

### 4.5.2. Food Hygiene and Safety

Environmental health covers a broad range of areas and for the plan will cover: water supply, sewage disposal, housing, refuse disposal, vector control, air pollution, food sanitation and hygiene etc. Poor environmental sanitation increases the risk of transmission of communicable diseases.

***Context***

Food safety is a global public health concern because foodborne illnesses account for loss of billions of dollars in healthcare related and industry costs annually. The recent WHO global burden of foodborne illnesses worldwide estimated annual impacts of food safety failures in Nigeria are 13.7 million cases of food related illnesses and 20,600 deaths, of which 14,400 are diarrhoeal, where the burden falls mostly on children and the elderly. Chemical intoxications (mostly due to aflatoxins in nuts and grains) are responsible for up to 5,160 deaths per year, as well as stunting in innumerable children due to chronic exposure (WHO, 2015).

From the Nigerian Integrated Disease Surveillance and Response, there were 1,049,550 recorded cases of Diarrhoea alone in the country with 1,164 deaths in 2012 (FMOH, 2014, p. 11). Other cases of foodborne illnesses such as typhoid fever, cholera, cancers etc. are becoming widespread and under-reported.

The problems with foods in Nigeria have to do with availability, accessibility, quality and safety of the foods. The quality of food sold in the market in terms of nutritional content is far from acceptable. The Sustainable Development Goals (*target 2.2*) targeted that by 2030, all forms of malnutrition, including undernutrition, obesity and micronutrient deficiencies be ended (ICSU, 2015, p. 20).

Currently, we have outdated regulations and standards related to the quality of food and food additives in the country. For instance, the National Agency for Food and Drug Administration & Control (NAFDAC), has three (3) of such outdated regulations. These are the Food Fortification Regulation (2005), the Food Fortification with Vitamin A Regulations (2005) and the Food Grade (Table or Cooking) Salt Regulation (2005). The existing food control and safety system in Nigeria is “not fit for purpose”. Apart from being obsolete and ineffective, the food legislations and institutional components require immediate reform to enable it meet its national and international obligations. The multi-agency food safety governance system which is fragmented among the various MDAs and the three (3) tiers of Government has created the challenge of overlapping functions, multi-jurisdictions, lack of coordination and general ineffectiveness. This scenario has led to Nigerian consumers being exposed to risk of health hazards arising from consumption of contaminated and unwholesome locally produced and imported foods, and loss of consumer confidence leading to rejections of Nigerian food produce in the international markets.

In order to have an effective and efficient food control system in any country, there must be a concerted effort from various government and private sectors to foster dialogue and coordination especially between Health, Agriculture, Environment and Trade. This is why in 2014, the multisectoral stakeholders in Nigeria produced the National Policy on Food Safety and its Implementation Strategy (NPFSIS) to foster proper collaboration and coordination of food safety activities from farm to table across relevant MDAs at all levels of government as well as the organised private sector.

Since the launching of the policy, two committees have been inaugurated (both committees are chaired by FMOH) to coordinate food safety activities across all relevant MDAs. These committees are the Inter-Ministerial Committee on Food Safety (IMCFS) *– made up of five Honourable Ministers including the Honourable Minister of Health as Chairman*; and the National Food Safety Management Committee (NFSMC)

With the support of International Partners, FMOH has led the NFSMC in the production of a draft National Food Safety & Quality Bill as well as a draft Food Safety Institutional Framework for the consideration and approval of the IMCFS and the Federal Executive Council (FEC).

***Strategic Objective and Targets***

The strategic objective is to ensure a modernised food control system that will reduce the incidence of illnesses and outbreaks associated with food, as well as assure that food is nutritious, wholesome and efficacious. The targets are:

* Incidence of foodborne diseases reduced by 20% by 2021
* 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 2021.
* 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."

***Interventions***

* Strengthen system for food and water safety surveillance.
* Strengthen the legal and regulatory framework for food safety in line with international guidelines.
* 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.
* Promote the practice of food safety across the food production pipe line from farm to the table.

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### **4.5.3. Safe Water and Sanitation**

***Context***

Water and sanitation play a crucial role to the health and wellbeing of people and there are many international and regional declarations and strategies calling for national actions to invest in water and sanitation because of the health dividends. Water and sanitation always appears conspicuous in every global discourse and resolutions on healthcare delivery.

Water borne / related diseases contribute the highest proportion to the overall disease burden in Nigeria, with diarrheal diseases being one of the leading causes of mortality in children under five years. Based on the National Demographic and Health Survey(NDHS, 2013), only 61% of the households in Nigeria have access to an improved source of drinking water while only 30% of household have access to improved toilet facility. According to the Water Sector Road Map(2016- 2030) launched by the Federal Ministry of Water Resources in 2016, 31% (52.7m) Nigerians, mostly in rural areas do not have access to improved water source while access to sanitation is on the decline. Nigeria did not meet its MDG target of at ensuring that at least 63% having improved sanitation facilities and at least 75% of the population having access to improved drinking water by 2015.

Currently, there are various national policy documents, such as Nigerian Standard for Drinking water Quality, National Water Supply and Sanitation Policy etc. which requires pragmatic integrated multi-sectorial approach for their effective implementation to achieve the desired objectives of their formulation. Implementation has however been sub-optimal.

***Strategic Objective and Targets***

* In order to promote universal access to safe drinking water and acceptable sanitation in Nigeria, the interventions have the following targets:
* Incidence of diseases resulting from consumption of unwholesome water and poor sanitation reduced by 50% by 2021.
* 50 % of drinking water sources assessed for quality standards
* 70% of the population have access to improved sanitation by 2021.

*Interventions*

* Promote the mainstreaming of water and sanitation as a health related priority programme
* Strengthen the platforms for inter-Ministerial collaboration and other Partnerships for addressing the social determinants of health
* Create awareness on Water borne disease
* Strengthen preventive, curative and rehabilitation health services for water borne diseases

### 4.5.4 Snake Bites Morbidity and mortality

***Context***

Snakebite is a major neglected public health problem in rural communities of Africa and Nigeria where three most important venomous snakes **Naja nigricolis** (**Cobra**), **Bitis arietans** (**Puff Adder**) and **Echis ocellatus** (**Carpet Viper**) are prevalent. It is also a major medical problem in rural communities of the Savannah Region of West Africa with countries such as Nigeria, Senegal, Ghana, Togo, Benin, Burkina-Faso, Niger, Mali and Cameron being mostly affected. Saw-scaled vipers are the most leading cause of snakebite mortality and morbidity in this region followed by Cobra and Puff adders.

The estimated incidence of snake bites in Nigeria is 174 bites/100,000 according to a 1994 Sample Epidemiological survey conducted by FMoH. Nigeria contributes 1/5 of the burden of snake bites in the l African Region, cases. It is estimated that 60% of deaths are caused by the most dangerous snake –the Carpet Viper. Snake bites are occurring mostly in very fertile areas of the country such as the Benue and Niger River valleys. Children, Farmers, Herdsmen and Hunters are at the greatest risk.

The case fatality is on the increase and is currently estimated to be 65% The increasing case fatality rate is as a result of the dire shortage of antivenom in the country, since traditional manufacturers/suppliers such as South African Vaccine Producers and Sanofi Pasteur are unable to meet orders from other countries, including Nigeria. As a result, increasing numbers of patients bleed to death or survive with severe disabilities, such as amputated extremities.

***The strategic objective and Targets***

The strategic objective is to reduce morbidity and mortality from snake bites in Nigeria. The targets of the interventions are as follows:

1. 50% reduction in case fatality rate from snake bites by 2021
2. 50% reduction in the incidence of snakebites by 2021

***Interventions***

1. Promote the development and the implementation of policies, plans, legislations and regulations for the reduction of snake bites in Nigeria.
2. Scale up sustainable supply of anti-snake venom in Nigeria, including local production
3. Build capacity of health care workers on snakebite management at all levels.
4. Promote partnerships for national snakebite response
5. Scale up generation of local evidence to inform more responsive snakebite programming Promote snakebite prevention and Control interventions.

### 4.5.5. Protect human health, environment and infrastructure from chemical hazard, medical & Bio-waste and poisoning

***Context***

Toxic chemicals are a significant global public health problem. About 25% of the global burden of disease in humans is thought to be linked to environmental factors, including exposures to chemicals. The production and use of chemicals continues to grow Worldwide particularly in developing countries for example, the Institute for Health Metrics and Evaluation (IHME) has estimated that in 2013 lead exposure accounted for 853 000 deaths per year, with the highest burden in low and middle income countries. (WHO, 2016) According to World Health Organization (WHO), there are ten chemicals or groups of chemicals of major public health concern namely: Lead, Air, Mercury, Asbestos, Arsenic, Cadmium, Benzene, Inadequate and excess fluoride, Dioxin and dioxin-like substances, highly hazardous pesticides.

In Nigeria, up to a million people are exposed each year to various toxic and hazardous chemicals which through ingestion and/or inhalation lead to deaths. In recent years, Nigeria has recorded “Lead poison outbreaks in Zamfara (2010) and Niger State (2015). Also the Jos Chlorine explosion was as a result of the excess Chlorine inhalation from an exploded Chlorine cylinder. (Ajijah, 2015). Recently, in Rivers State there was occurrence of black soot which made residents restless due to the health implications”. The Healthcare Systems in Nigeria does not have any Poison Information Control and Management Centres (PICMC), thus allowing toxic chemicals to remain in the realm of speculative diagnosis.

Currently, Nigeria has policies, regulations and standards related to chemical issues such as National Policy on Chemicals Management which is domiciled in Federal Ministry of Environment and the draft assessment report on Institutional capacity gaps and barriers, for implementation of the Minamata Convention on Mercury. FMoH was instrumental to assessing the short and long term health impact of toxic chemicals and provision of expertise for treatment of people exposed to chemicals. These efforts need to be scaled up in order to substantially reduce morbidity and mortality arising from poor chemical management. Beside, Nigeria's international commitments and protocols such as the United Nations SDGs necessitate the inclusion of environmental health as a priority area of investment.

***Strategic Objectives and Targets***

The strategic objective is to protect human health, environment and infrastructure from chemical hazard, medical and bio waste and poisoning. The targets are:

* Mortality associated with hazardous chemicals and poisons reduced by 30% by 2021
* 70% of healthcare facilities meet the minimum standards for medical waste management"

***Interventions***

* Strengthen legal, regulatory framework, policies and plans for chemical hazards and poisoning, medical and Bio waste and climate change
* Scale-up advocacy, community sensitization and education on chemical wastes and poisoning, medical and Bio waste and climate change
* Build capacity of health workers for effective management of medical and Bio waste and hazardous chemicals at all levels of the health care system
* Build capacity to appropriately respond to health effects of climate change
* Deepen collaboration with relevant stakeholders on Chemicals Management, medical & Bio waste management and climate change
* Improve systems for data collection, management and utilization for chemical hazards and poisons, medical and Bio waste and climate change

### 4.5.6. Promote optimal health and safety of workers in their work environment

***Context***

The health and safety of workers at their various work places have been considered in developing interventions of the NHSDP II. There have been weak regulations to promote optimal health and safety of workers at work places. In some cases, it has been that of poor implementation of available safety regulations. In general, this is linked to a dearth of occupational health professionals in the Nigeria.

***Strategic objective and Targets***

To promote optimal health and safety of workers in their work environment with targets as follows:

* 20% of workplaces have occupational health policy and procedures
* 10% increase in occupational health professionals in Nigeria.

***Interventions***

* Promote the development and implementation of legal, regulatory framework, policies and plans for occupational health in Nigeria
* Build capacity of health care workers to respond to occupational health needs in the country
* Scale up occupational preventive and promotive activities
* Expand access to appropriate occupational health services for health workers
* Strengthen regulation, mentoring and evaluation of occupational health services in workplace
* Promote health and safety in the workplace
* Promote collaboration between the key stakeholders (Ministry of Health, Ministry of Labour and the private sector)

## 4.6. Strengthening Primary Health Care Services and Service Delivery

**Primary Health Care (PHC)**:

The facilities at this level form the entry point of the community into the nation's health care system. They include health centres and health clinics, dispensaries and health posts, providing general, preventive, curative, promotive and pre-referral care to the population. The primary facilities are typically staffed by Nurses, Midwives, community health extension workers (CHEWs), junior CHEWs and Pharmacy Technicians, Laboratory Technicians, Medical record officers , Clerical officers, environmental health officers Village Health Workers(CORPs). Local Government authorities were statutorily responsible for the financing and management of PHC facilities in the public sector as earlier captured in the National health policy; however the resolution 29 of the 54th National Council on Health meeting in May 2011 approved the implementation guide on bringing PHCUOR Initiative. The initiative is part of Government's reform designed to improve Primary Health Care delivery. The aim was to reduce 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 Agency /Board. PHCOUR was backed by National Health Act of 2014, which empowers the States to establish State Primary Health Care Board. The nine (9) pillars of Primary Health Care are: Governance, Legislation, Minimum service package repositioning, System development, operational guidelines, human resources, funding sources and structure and office set-up. 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 PHCDA/B. The. SPHCDA/B advises commissioner for health and Local Government in all matters concerning PHC activities.

The National Health Policy regards primary health care as the bedrock to for achieving improved health for the population and stipulates that a comprehensive health care delivery system, the primary health facilities should be able to deliver quality and effective health service to the community that focuses on the components of primary Health Care such as: Health Education concerning prevailing health problems, Promotion of food supply and proper nutrition, adequate supply of safe water and basic sanitation, Maternal and Child care including Family Planning, Immunization against major infectious diseases, Prevention and Control of locally Endemic diseases, appropriate treatment for common ailments and injuries, supply of essential drugs, Oral Health, Mental Health(PHC guideline, NPHCDA) consists of at least maternal and child health care services including family planning.

Although the schematic below shows organization of health services, it is important to note that the norms and package of care that should be available at each level of service delivery from the community level, to tertiary level were yet to be properly determined

Figure 6: Levels of Healthcare in Nigeria



Primary health care is the fulcrum of the National Health Policy and one of the key strategies SDG3 goal for attainment of universal health coverage. Unfortunately it is the level that has the least capacity and political commitment towards health development.

Referral pathways are upwards along the levels of care. Unfortunately referral systems are dysfunctional and patients by pass primary health care settings to use secondary and tertiary facilities as points of first consultation, which renders the system inefficient and not cost effective.

The health services are characterized by wide regional disparities in human resources and service delivery capacities with more health service outlets located in the southern states than in the north and in the urban areas than rural areas. Consequently, coverage with health interventions vary along these parameters

Nigeria has achieved some milestones in recent years with the eradication of guinea worm, control of the Ebola Virus Disease outbreak and the interruption of Wild Polio Virus (WPV) transmission in the country in 2015 although the latter achievement was lost in 2016. The Federal Ministry of Health is leveraging the platform deployed for the above listed and other achievements for strengthening the delivery of health care.

The health system in Nigeria has been adjudged among the weakest in the world; this may in part be responsible for the very low coverage with key lifesaving interventions. Other notable weaknesses of the health care system include:

* Poor quality of care, characterized by dearth of skilled health workers, poor health worker skills, delays in getting prompt and appropriate treatment in health facilities, drug stock-outs poor infrastructure for service delivery. Competence in diagnosis and management of clinical illnesses is disproportionate, while adherence to clinical guidelines is low. The poor quality of care promotes the increasing rise in medical tourism and the bypassing of lower level care for those that have the funds.
* Gaps in provision of the Minimum Package of Care as articulated by the National Primary Health Care Agency
* Poor functioning of the referral system
* Major human resource gaps in terms of numbers, skills, mix, distribution and attitude to work
* Limited availability and access to specialized and emergency services
* Fragmentation and poor integration of services
* Distance to health care facilities and the cost of services , with out-of- pocket expenditure being the dominant method of care makes services inaccessible both geographically and economically for a large proportion of Nigeria
* Limited partnership between public and private sector in service provision and also between other critical stakeholders, for example, lack of exploitation of the huge skilled human resource base in tertiary hospitals to support states they are located in in expanding service coverage, especially to rural areas
* Non alignment of funding to needs with consequently huge proportion of funding going to curative services to the comparative neglect of preventive and promotive care.
* Poor demand for services
* Limited investments in community mobilization and participation in health development

In addition to these, there is poor regulation of the private sector. While State Ministries of Health issue licences to ensure that facilities comply with standards, monitoring of quality of services provided by the private sector is limited. Until the inception of the National Health Act 2014, there had been, for a long time, a lack of institutional framework that regulates quality and standards. And even though the National Health Act provides that facilities are required to obtain a certificate of standards, the requirements for obtaining this certificate are not provided in the Act.

A number of interventions have been undertaken to strengthen the health system, especially at Primary health care level. These include:

* Development of the Ward Health System and Primary Health Care under One Roof by the National Primary Health Care Agency. The Ward Health System stipulates the upgrading/building of a health centre per ward that is well staffed; and has facilities for providing a range of RMNCAH+N services, including basic emergency obstetric care services. This is being complemented by the current effort of the Minister of Health to ensure availability of one functional health centre for each of the 9670 wards in the country
* Establishment of the States’ Primary Health Care Agencies to enhance planning and coordination of PHC in their respective states
* The Saving One Million Lives Initiative and the defunct Midwives Services Scheme
* Implementation of performance based financing under Nigerian State Health Investment project (NSHIP).
* Implementation of one referral Health facility per ward

Despite these efforts, there is increasing need to strengthen Health Care Services in Nigeria for optimal service delivery in order to improve Nigeria's health status. The overall gaol is to revitalize integrated service delivery towards a quality, equitable affordable and sustainable healthcare.

***Strategic Objectives***

* To ensure universal access to an essential package of care
* To increase access to health care services
* To improve the quality of health care services
* To increase demand for health care services
* To provide financial access especially for the vulnerable groups
* Promote community participation
* Strengthen the organization of PHC services at LGA level

***Interventions***

A description of possible activities that could contribute to the achievement of each specific objective and intervention are presented below for consideration at Federal, State and LGA levels. It is expected that the identification of appropriate activities would be based on the stewardship role and mandate of each level.

**Essential Health Service Package:**

To provide package of essential care, there is a need to determine, cost, disseminate and implement the **essential package of care**, which should include the minimum package of care in an integrated manner and also, strengthen specific communicable and non-communicable disease control programmes as contained in the National Health Policy. Standard Operating procedures (SOPs) and guidelines are to be made available for delivery of services at all levels.

D**etermine norms and package of care at different levels and enforce referral system:**

There is a need for a comprehensive classification of health services by level of care and type of facility. This should be used to establish norms in terms of infrastructure, personnel (number and skill mix) and services. These norms and standards should be produced, following determination and widely disseminated. Referral pathways should also be determined and mechanisms put in place for enforcement.

**Improve geographical equity and access to health services:**

Improving geographical equity and access to quality care will involve mapping of health facilities, establishing GIS for all health facilities in the country as well as developing criteria for siting of new health facilities at all levels. In addition there will be the need to upgrade and refurbish all substandard facilities especially at PHC level. In doing these, effort should be made to ensure adherence to guidelines that stipulate standards for access and linkages of the different levels of care. Guidelines for outreach services will be developed and implemented, budget lines for the maintenance of health facilities provided and guidelines for task shifting established and implemented. The use of telemedicine will be strengthened *(This is addressed in greater detail under Health Infrastructure).*

**Ensure availability of drugs and equipment at all levels**

Another intervention to increase access to quality health care services will entail ensuring availability of drugs and equipment at all levels. This would involve a review of the essential drugs list and establishing a system to ensure procurement and distribution of essential drugs on a sustainable basis at all levels. Furthermore, there will be the need to develop/review an equipment list for different levels of health facilities in line with the essential package of care and ultimately procure and distribute equipment based on need.

**Establish a system for the maintenance of health facilities and equipment at all levels**

Availability of equipment is critical to service delivery. Therefore, there is a need to adapt, disseminate and implement the National Health Equipment Policy; also create budget lines for the maintenance of equipment and furniture at all levels. The optimal performance and longevity of equipment will be assured by establishing medical equipment and hospital furniture maintenance workshops and enhancing recruitment of Bio-medical Engineers and Technicians across the country, as well as explore public private partnership in maintenance of medical equipment and hospital furniture.

**Strengthen referral system**

Another key intervention is to strengthen referral systems. This can be done by mapping network linkages for two-way referral systems in line with national standards, with implementation guidelines for all cases such as emergency obstetric care, complicated malaria, road traffic accidents, etc.; Transportation, communication and other logistics for referrals need to be put in place to ensure effective referrals and a system put in place to monitor referral outcomes.

**Foster collaboration with the private sector**

The private sector plays a key role in provision of health services in the country. Therefore, collaboration with the private sector health care providers will be fostered. Specific action to promote this will include the mapping of all categories of private health care providers by operational level and location, development of guidelines and standards for regulation of their practice and their registration. For the full potential of the private sector to be realised, guidelines for partnership, training and outsourcing of services will be developed. In addition joint performance monitoring mechanism for the private sector will be developed and implemented. Also, the national policy on traditional medicine will be adapted and implemented at all levels.

**Strengthen professional regulatory bodies and institutions:**

The need to standardise and regulate practice cannot be over emphasised. To this end regulatory bodies and institutions will be strengthened through the following potential actions: review, update and implement operational guidelines of all regulatory bodies at all levels and build capacity of regulatory staff to monitor compliance of providers to the regulatory guidelines. Budget lines are to be created and necessary resources provided. Regular monitoring exercises with appropriate documentation and feedback will be strengthened and regulators empowered through the provision of necessary security.

**Develop and institutionalise quality assurance models:**

Another intervention is the development and institutionalisation of quality assuarance models. This will be done by reviewing available models and building consensus on the models to adopt. Furthermore, quality assurance training modules will be developed to build capacity of both public and private health care providers, training of trainers (TOT) conducted and cascaded to other health workers. Thereafter, quality assurance and improvement initiatives will be institutionalised and implemented at all levels. The quality of service delivery can be further assured by entrenching the ideals of SERVICOM at all levels of care. This will be achieved through the development of SERVICOM guidelines, building institutional capacity and training staff for its implementation at all levels. Strategies will be put in place for monitoring implementation of quality of care.

**Institutionalize Health Management and Integrated Supportive Supervision (ISS) mechanisms**

Integrated supportive supervision is an important strategy for ensuring that health workers are adequately supported in the process of providing health care services. This concept is predicated on the fact that many problems occur in the health facilities of which providers will not have immediate solutions. This helps in boosting the moral of the workers in their health facilities setting. To achieve comprehensive integrated supportive supervision the management capabilities of health managers and health teams especially at the LGA and Ward Levels will be strengthened through team building and leadership development programmes, institutionalization of comprehensive ISS at all levels, development of capacities of programme managers at all levels on the ISS mechanism; and development of ISS tools and guidelines specifying modalities and frequencies of the ISS visits at all levels.

**Creating effective demand for services**

In order to promote positive lifestyles for disease prevention and increase demand for health services, it is necessary to develop, disseminate and implement a national health promotion communication strategy based on the National Health Promotion Policy, and its corresponding adaptation to reflect local realities. To actualise the above intervention, budget lines for health promotion through" Behavioural Change Communication", will be provided at all levels and a programme monitoring and evaluation system put in place. *This intervention is further explored under Health Promotion section of this framework.*

**Improving financial access especially for the vulnerable groups**

The costs associated with health care can be a barrier to accessing health services especially for the vulnerable groups. Models for financial protection for the vulnerable groups ( e.g. Pregnant women, under-fives, orphans and the aged) such as exemption schemes vouchers, health cards, pre payment schemes will be explored and existing financial protection schemes scaled up.

*This intervention is further explored under Priority Area 4 of this framework.*

**Strengthening PHC at LGA level:**

Strengthening Primary Health Care service delivery in Nigeria will involve the following:

* Strengthening the LGA Health Systems
* Providing comprehensive care in an integrated manner to the population of the LGA; and
* LGA Health team to organize and undertake core activities through the Ward minimum Health Care Package at the household and community level in collaboration with existing Ward health system structures

**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 the implementation of plans. This activity should be undertaken with support of the States’ Primary Health Care Development Agencies.

Figure 7: LGA Health Services



**Mobilizing required resources to operationalise LGA Plans**

(i) Establish a coordinated approach to mobilize resources from Federal and State governments, development partners, LGA-based organizations such as NGOs and other actors, including the private sector; (ii) accord high priority to financing health at the local level by increasing the allocation to the LGA from the national health budget (at least 70% out of the pledged 15% of national budget reference Abuja Declaration); (iii) institutionalize a balanced distribution of resources (personnel, equipment and financial) between primary, secondary and tertiary care levels at the LGA level; (iv) LGAs should estimate the level of required resources to provide essential health services; and (v) equitably allocate and distribute resources to health facilities and communities within the LGA in line with set targets.

**Management of LGA health Systems to improve performance of health services**

(i) Implement operational plans at LGA level; (ii) strengthen health provision and management structures; (iii) build capacity for planning, monitoring, evaluation and reporting at all levels; (iv) provide technical and management support from higher to lower levels; (v) build partnerships and improve coordination; (vi) institute integrated financial management systems at LGA level to justify fiscal decentralization in line with administrative devolution of the health sector; (vii) develop a maintenance plan for essential medical equipment at LGAs; and (viii) build LGA capacities to institutionalize proactive evaluation and renovation of infrastructure.

**Scaling Up implementation of Comprehensive integrated essential health services**

(i) Scale up essential health interventions to achieve universal coverage and contribute towards attainment of SDGs through effective collaboration of all actors at all levels of the health system; (ii) strengthen integration at health facility and community levels; (iii) target vulnerable communities and groups, including the poor, women, children, and people in conflict and post-conflict situations and remote areas; (iv) involve communities in microplanning to scale up utilization of services; and (v) The LGAHMT should involve the private sector in a contractual arrangement to institutionalize sustainable public private partnerships that ensure protection of vulnerable populations during utilization of the services offered by the private institutions;

**Increasing use of evidence from health information and operational research**

(i) LGAs should develop an operational research plan covering locally-determined implementation issues, research agenda and training of potential researchers; (ii) mobilize resources for research and publication; and (iii) use and disseminate research results locally to improve implementation and decision-making.

**Supervision, monitoring and evaluation**

(i) Institute effective supervision of the implementation of operational plans in the LGA to ensure that planned activities are properly implemented; (ii) establish/strengthen monitoring and evaluation systems to track progress and changes, as well as correct negative practices or gaps in service availability, coverage, human resources, financing, information systems, and leadership and governance; (iii) examine the functionality and adequacy of monitoring and evaluation systems through the completeness, regularity and quality of reports as well as the level of use in improving the performance of local health systems; (iv) LGAs should develop monitoring frameworks based on set targets, using coverage and other performance indicators to clarify type of data, sources, analysis and periodicity of review; (v) Data should be disaggregated by geography, gender, age and income level for targeting those in greatest need; and (vi) Each level of service within the LGA health system should have a role and responsibility in monitoring and evaluation of their plans.

# Chapter 5: STRENGTHENED HEALTH SYSTEM FOR DELIVERY OF PACKAGE OF ESSENTIAL HEALTH CARE SERVICES

## 5.1. Human Resources for Health

***Context***

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 ratio of 15.100, 000 while the nurse/midwife 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 total number of health personnel by professional category as at 2006 is shown in table 7. However, there has been a high attrition rate not captured represented here.

Government has done much in the development of Human Resources for Health in Nigeria with the development of appropriate legislations and policies. The National Health Act 2014 (Section 5) also provides enablement for HRH development in the country. The FMoH has developed policies such as the National Human Resources for Health Policy (NHRHP) and National Human Resources for Health Strategic Plan (NHRHSP). Both the NHRHP and NHRHSP provide templates for guiding the States and the FCT Abuja, in the development of their respective policies and plans. However, as of date less than a half of them have leveraged this guidance. In line with the policy provisions, states, are expected to establish HRH units in their respective Ministries of Health (SMOH) , Departments of Planning, Research and Statistics to provide the institutional hub for HRH policy formulation, planning and management, but as at date about one third of the States and FCT were yet to do so. A National Task Shifting and Task Sharing (TSS) Policy with Standard Operational Procedures has also been developed by the FMoH.

In addition, a National Human Resources for Health Information System (NHRHIS) has been established with a Health Workforce Registry Project as its core component. The NHRHIS is to inform efficient performance of HRH management functions such as forecasting, recruitment, deployment, retention, motivation and performance management; while the Registry project is to enable tracking and accounting for health workers. The NHRHIS is to be extended to the state level and this measure has started with piloting in the two states of Bauchi and Cross River. Furthermore, Government has established fourteen (14) Health Regulatory Bodies to regulate the practices of various health professionals, accreditation of health training institutions, registering qualified candidates and issuing practicing licenses.

In terms of other physical facilities, a National HRH Survey (2012) showed that there were 27 accredited medical schools, 78% of which are in the southern part of the country, 89 nursing schools, with only 76 accredited in 2009, with 13 of the nursing schools losing their accreditation in 2012. Also there are 56 accredited colleges/schools of health technology offering training programmes for Community Health Extension Workers (CHEWs) and Junior Community Health Extension Worker (JCHEWs) and 14 Community Health Officer (CHO) training institutions under the year in review.

While relevant policies and plans are in place, especially at the federal level, successfully implementation has been limited. This has continued to pose major challenges resulting in major gaps in quantity, skills, mix and distribution of health workers. The management and development of human resources for health remains a major challenge to the implementation of health sector reforms in the country, leading to poor staffing needs assessment, utilization and coordination at federal, state and local levels. In addition, poor remuneration, discrepancies in salaries, allowances, incentives and other conditions of service leads to high attrition of health workers

A major challenge in HRP production is the asynchrony between human resource needs and production. This is partly attributable to lack of HRP plans in many States and the non-implementation of the plans where they exist. The result is an over production of some categories of Health workforce such as CHEWs with gross inadequacies in the production of some critical HW such as midwives who necessary for maternal health improvements. Maintaining adequate quality of training is a problem as many of the schools have poor infrastructure, shortages of teachers and teaching materials and equipment.

In terms of Primary Health Care workers, available statistics point to gross inequities in distribution, to the advantage of the northern zones, the zones with the comparatively lower numbers of higher level skilled personnel

The Human Resource Availability in Nigeria by category is depicted in table 7.

Table 7: Human Resource Availability by categories in Nigeria

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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)*

*Geographical distribution of HRH in Nigeria*

The geographical distribution of health workers in Nigeria shows a very uneven pattern with concentration skewed in favour of the southern parts as shown in Table 8. The distribution is also skewed in favour of urban areas and tertiary health care services. The uneven distribution of health workers is accentuated with respect to some categories of workers; like physician specialists being the most unevenly distributed and found mostly in tertiary health care facilities run by federal government, whereas secondary and lower levels of care run by states and local government do not have them and are unable to leverage these health workers in tertiary facilities to support their health care services delivery. The LGAs with responsibility for PHC services delivery are more disadvantaged as many of these LGAs do not have Medical Officers of Health to provide health services and they not have competent health workers in adequate numbers to deliver the minimum package of care. The distribution of the various categories of PHC workers is shown in Table 8.

Available data indicate a growth rate well above the population growth rate for many health professions, including: Doctors, Dentists, Pharmacists, Radiographers, Physiotherapists, Environmental Health Officers, Optometrists, Public Analysts, Chartered Chemists, Medical Laboratory Scientists, and Medical Laboratory Technicians. For the past three years, the average annual growth rate for Nurses and Midwives (2.6%) was less than the population growth rate (3.2%), implying a zero if not negative growth rate of the Nursing and Midwifery workforce.

Table 8: Regional distribution of health workers in Nigeria

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Health Workers Categories** | **Total Number** | **North Central %** | **North East %** | **North West %** | **South East %** | **South-South %** | **South West %** |
| **Doctors** | 52408 | 9.73 | 4.06 | 8.35 | 19.59 | 14.37 | 43.9 |
| **Nurses** | 128,918 | 16.4 | 11.65 | 13.52 | 15.29 | 27.75 | 15.35 |
| **Radiographers** | 840 | 14.3 | 3.66 | 5.97 | 15.0 | 18.3 | 43 |
| **Pharmacists** | 13,199 | 19.94 | 3.8 | 7.79 | 11.74 | 12.39 | 44 |
| **Physiotherapists** | 1,473 | 10.8 | 2.73 | 8.32 | 8.58 | 7.93 | 62 |
| **Medical Lab Scientists** | 12,703 | 6.82 | 1.72 | 3.6 | 35.26 | 23.89 | 29 |
| **Environmental & Pub HW** | 4,280 | 9.39 | 11.27 | 18.94 | 12.36 | 15.69 | 32.08 |
| **Health Records Officers** | 1,187 | 13.34 | 4.85 | 11.6 | 14.64 | 29.9 | 26 |
| **Dental Technologists** | 505 | 14.08 | 5.92 | 5.92 | 12.96 | 16.62 | 44.5 |
| **Dental Therapists** | 1,102 | 13.19 | 10.29 | 21.86 | 10.19 | 12.99 | 31.5 |
| **Pharmacy Technician** | 5,483 | 6.17 | 9.12 | 18 | 8.58 | 11.8 | 46 |

*Source:* Human Resources for Health Country Profile Nigeria, October 2008 (*Professional Regulatory Agencies 2008)*

**Human Resource Recruitment, deployment, Retention, Motivation and Welfare**

While Nigeria has made progress in development of human resource, major problems remain. Embargo on employment across the country has militated against employment of even staff trained by states. Deployment and retention of health workforce in rural areas remain major challenges, as incentives to get people to work in rural areas are not in place. Emigration of skilled workforce is a major problem with the country accounting for about 80% of total health workforce export from Africa. Poor remuneration, poor condition of service, disharmony among professional groups and tensions between health workers and employees leading to incessant and perineal strikes that oftentimes paralyses the health sector for months on end yearly are added problems. The gross maldistribution of health workers to the disadvantage of rural areas and the core northern zones of the country, where the burden of disease is highest is a major issue. This is compounded by recruitment policies that limit recruitment of skilled staff from other states to meet the needs of underserved stated. Previous planned interventions within the health sector have not been successfully implemented due to staff shortages, which have been driven by multiple factors, including poor conditions of service, unsatisfactory working conditions, poor motivation and uneven distribution of staff between urban and rural areas, weak human resources management systems, and inadequate training systems, and poor funding of Health System amongst others (FMoH, National HRH Strategic Development Plan 2015-2019).

Table 9: Regional distribution of Community Health Workers in Nigeria

|  |  |  |  |
| --- | --- | --- | --- |
| **Zones** | **Community Health Officers** | **Senior Community health Extension Workers** | **Junior Community Health Extension Workers** |
| **South East** | 393 | 7,491 | 4,434 |
| **South-South** | 749 | 7,674 | 4,758 |
| **South West** | 789 | 7,471 | 3,133 |
| **North Central** | 1,032 | 12,226 | 7,533 |
| **North East** | 547 | 6,646 | 5,604 |
| **North West** | 870 | 9,191 | 7,383 |

*Source: Community Health Practitioners Registration Board of Nigeria (CHPRBN) August 2015*

In recent times, inter-professional tensions have marred effort at team work, and the incessant industrial unrest resulting in perineal closure of health facilities militates against meeting the health needs of consumers of the service.

Towards mitigating severe shortages of skilled workers in critical areas, government intervened with special schemes such as the Midwives Service Scheme (MSS) and SURE-P which were aimed at ensuring availability of nurses and midwives to provide maternal and child health services, especially skilled birth attendance in underserved areas of the country The task shifting policy, recently developed is also aimed at devolution of service provision to lower level cadres that can be trained to provide such service, aimed at increasing service provision. There is also a recent policy on National Health Workforce Migration which was developed in line with the WHO Code of Practice on International Recruitment of Health Workforce, which would help in tracking of Health worker’s movement[[2]](#footnote-2). The overall goal is to ensure that all people, in all places have access to skilled health workers who are well equipped, motivated, and supported to meet their needs. In the succeeding parts of this section, interventions have been developed for various aspects of HRH including workforce planning and management each with specific interventions and targets.

### 5.1.1. Coordination and Partnership for HRH Development

***Strategic Objective and Targets***

The strategic objective of interventions for coordination and partnership for HRH development is to ensure effective coordination and partnership for institutional strengthening for HRH development and management

* All states are implementing HRH policies and strategic plans

***Interventions***

* Strengthen institutional capacities of HRH coordinating structures
* Strengthen coordination of public, private, regulatory, Health workforce association and development partners at all levels (HRH stakeholders)
* Enhance funding for HRH development for the current and future needs

### 5.1.2. Adequacy of Numbers of skilled Health workers

***Strategic objective and Targets***

The strategic objective of the interventions is to ensure the production of adequate numbers of qualified health workers. The targets for the plan period are:

* At least 70% of health training institutions are accredited by the relevant regulatory institution***"***

***Interventions***

* Strengthen quality assurance of HRH training institutions esp. for producing frontline health workers
* Strengthen the mechanisms for HRH training institutions, regulatory bodies and other stakeholders to increase health workforce production
* Improve gender sensitivity in the training of health work force for all cadres at all levels

### 5.1.3. M&E of HRH

***Strategic objective and Targets***

The strategic objective is to ensure the development of monitoring and evaluation system for HRH . The targets are:

* FMOH, 36 states and FCT will have functional HRHIS
* 100% of states with HRHIS are producing annual HRH review report

***Interventions***

* Strengthen HRHIS (including HRH Registry) at state and federal levels
* Strengthen mechanisms for annual HRH reviews and reporting for evidence and decision making at the Federal and State levels
* Improve the production of HRH research evidence through monitoring and evaluation mechanisms

### 5.1.4. Effective Workforce management

***Strategic objective and Targets***

The strategic objective is to ensure effective health workforce management through retention, deployment, work condition, motivation and performance management with the following targets:

* 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

***Interventions***

* Strengthen mechanism for deployment and retention of HRH at all levels "
* Improve HRH performance management systems at all levels
* Scale-up task shifting and task sharing policy implementation with required guidelines.

### 5.1.5. Effective Workforce planning

***Strategic objective and Targets***

The strategic objective is to strengthen Health workforce planning for effective management

* FMOH, 36 States and FCT have harmonized HRH Annual Operational Plan

***Interventions***

* Improve capacity for HRH planning at all levels
* Strengthen mechanisms for HRH joint planning at primary, secondary and tertiary levels

## 

## 5.2. Health Infrastructure

***Context***

Health Infrastructure comprises buildings - both medical & non-medical; equipment - 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.

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 Centres (NPC, 2015). Table 10 gives the breakdown of health facilities in Nigeria.

Table 10: Distribution of Health Facilities in Nigeria by ownership and level of care

|  |  |  |  |
| --- | --- | --- | --- |
| **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** |  |  |  |

*Source National Population Commission, 2015*

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

It must also be noted that 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 percent of these facilities (particularly PHCs) are in different states of dysfunctionality ranging from dilapidation, lack of water and electricity. The secondary and tertiary levels also suffer from obsolete and non-functional equipment due to lack of maintenance.

In 2005, the Federal Ministry of Health developed basic equipment requirements for essential/minimum care package across the three tiers [i.e. primary, secondary and tertiary] of healthcare services but this standard is not being followed in most of the health facilities in the country.

The Federal Government of Nigeria planned to have one functional Primary Healthcare (PHC) centre per ward in the country. The reason for this is to facilitate the provision of universal health coverage to over its 170 million citizens. The functionality referred to in the definition of a functional PHC is one that meets the minimum standards, which are for effective planning and continuous development of PHC in terms of infrastructure, human resources, availability of health commodities and service provision. However, the standards do not include building of new facilities but limited to infrastructural upgrade (Facility renovation, power supply, toilets and water amenities).

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 will be to meet local needs including the establishment of a robust health information system (NPC, 2005).

***Strategic Objective, Specific Objectives/ Targets***

The strategic objective is to improve availability and distribution of functional health facilities and equipment to ensure equitable access to health services in the country.

* To establish one functional PHC centre (facility renovation, power supply, toilets and water amenities) in 80% of Wards in Local Government Areas of the Country by 2018.
* To increase availability of appropriate equipment at all levels of healthcare services to 50% by 2020.
* To revise, disseminate and implement the National Health Equipment Policy by 2019
* To Strengthen Health Infrastructure Planning and Health Technology Management Programme

***Interventions***

* Strengthen legal, policy and institutional frameworks and coordinating mechanisms for health infrastructure planning and maintenance in Nigeria
* Promote the establishment of quality standards for health infrastructure for all levels of the health care system in the country
* Scale-up the provision of equipment and other health infrastructure in line with established standards appropriate for the different levels of health care and other health institutions
* Strengthen the monitoring of health infrastructure, including inventories and performance
* Strengthen capacities and partnerships for health infrastructure maintenance and management
* Promote partnerships between Equipment Manufacturers/ Suppliers and government at all levels for technology transfer/training/ maintenance agreements.
* Scale up training of Biomedical Engineers and Planned Preventive Maintenance (PPM) in order to increase stock availability.
* Accelerate the revitalization of primary health infrastructure for improved access to health service
* Improve Secondary and Tertiary levels infrastructure to support for referrals systems

## 5.3. Medicines, Vaccines and Other Commodities and Supplies

***Context***

Access to essential medicines is critical to achieving universal health coverage. It is one of the WHO key building blocks of a strong health system. The primary goal is to ensure **commodity security**. This is a situation where essential medicines are available, affordable, and people are able to choose, obtain and use high quality medicines and medical supplies, as at when needed. The supply chain activities include; product selection, quantification, procurement, warehousing, transportation, storage and rational use, among others. Supply chain management of commodity-related tasks is a crosscutting issue that requires inter-sectoral and inter-governmental collaboration to ensure that commodities are available to support the health sector goal and objectives. The Nigerian government is aware that optimal management of Nigeria's essential drugs and commodities supply chain, requires the development of an effective information system for facilitation and coordination of these interrelated functions at the three tiers of government as well as , efficient procurement procedures and controls.

To this effect, the Nigerian government has continued to make concerted effort towards ensuring availability of essential drugs and commodities in the country through formulation of policies and issuance of guidelines. A major achievement, in this respect, was the establishment of the National Pharmaceutical Research Centre, with the mandate to research into drugs and pharmaceuticals. In addition, local manufacturing of drugs is being promoted and currently four out of eleven Nigerian Pharmaceutical Companies that applied for have received WHO certification for Good Manufacturing Practices (GMP). The National Agency for Food and Drug Administration and Control (NAFDAC) has provided, appropriate guidelines and regulations that ensured compliance with Good Manufacturing Practices; and has continued to make efforts to check the prevalence of fake and substandard medicines, vaccines and products. Despite these efforts, there are still many challenges which impede the health products management practices and the health commodities supply chain in the country. These include:

* Inconsistent policies , low political commitment, and the non-compliance with existing policies/guidelines such as the National Drug Policy (NDP), National Standard Treatment Guidelines, the Essential Medicines List (EML), and the National Drug Formulary (NDF), as well as the weak implementation of the EPD.
* Disconnect between the Federal and State governments in the area of policy implementation.
* Poor fund allocation for medicines and commodities.
* Lack of transparency and accountability in commodities utilization.
* High prices of health commodities which lead to low spending on pharmaceuticals and vaccines as a proportion of health expenditure.
* Inadequate local production of medicines and vaccines due to poor infrastructures and Nigeria's inability to make progress in the local production of active pharmaceutical ingredients and vaccines to facilitate local production. Local manufacturers are not giving the tools and enabling environment to be competitive thus they function at only 30% capacity now and produce less than 5% of national drug needs. The resultant effect of this is the nation's high dependence on importation, which is increases susceptibility to low quality and adulterated medicine; and is unsustainable in the long run.
* Inefficient transportation system; Transporters are largely untrained and the transportation network is poor.
* Inadequate and over-centralized production process and warehouses which do not meet the minimum standards.
* Inefficient supply chain system and a dearth of skilled personnel at all levels of the supply chain.
* Lack of effective control systems which allow an indiscriminate influx of donated medicines, vaccines and other technologies that contravenes national guidelines for donations and lead to expiries and wastages.
* Poor infrastructure to support ICT and automation of the information system

Other constraints include: stock-outs of essential supplies that continue to be experienced in a number of health facilities even while expiries are noted in others; and uninformed drug use leading to increasing prevalence of antimicrobial resistance.

The establishment of the National Product Supply Chain Management Programme, under the Department of Food and Drug Services of the FMoH, is a strong indication of government’s commitment to address these challenges. While this programme has made significant progress in streamlining supply management efforts at the National level, more still needs to be done to strengthen the capacity at state and primary health care levels, leveraging on the recent ratification of the National Quality Assurance Policy for Medicines and other Health Products (2016) and the Nigeria Supply Chain Policy for Pharmaceuticals and other Healthcare Products (2016).

***Strategic Objective and Targets***

The strategic objective is to strengthen the provision and use of affordable, accessible and quality medicines, vaccines, and other health commodities and technologies at all levels of health care. The targets of the interventions in this plan period are as listed:

* 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.

***Interventions***

* Strengthen the development and implementation of legal, regulatory framework, policies and plans for drugs, vaccines, commodities and health technologies at all levels
* Strengthen coordination of structures to ensure accessibility to medicines, vaccines, commodities and other technologies at all levels.
* Enhance production and use of locally manufactured medicines and vaccines that meet global standards
* Strengthen procurement system to ensure local content (at least 40%) and commodity security on a sustainable basis at all levels.
* Strengthen integrated supply chain management system and quality assurance mechanisms for medicines, vaccines, commodities and other technologies with a functional logistics management information system (LMIS)
* Strengthen rational drug use and antimicrobial stewardship at all levels
* Strengthen existing systems for management of biological and non-biological wastes including expiries of medicines, vaccines and other health commodities at all levels
* Strengthen the development and regulation of traditional medicine in Nigeria.

## 5.4. Health **Information**

***Context***

The revised 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 HIS Policy.

The country’s Health Information System (HIS) remains weak and fragmented with numerous vertical programmes, which are mostly Donor driven. Despite significant past investments aimed at improving the nation’s HIS, the sub-sector remains challenged due to duplications and lack of a common investment framework. There are multiplicity of data collection tools and DHIS instances resulting from the use of poorly defined non-standardized indicators. Also, some of the Development Partners and the programmes they support (including programmes within the FMoH) are reluctant to utilise national tools. Routine data completion rate and timeliness is still low at 63%(National DHIS 2016. Although the private sector provides 60% of healthcare services in the country, there is very limited capture of their data into the HMIS. In addition, other data subsystems perform sub-optimally such as vital statistics, survey and implementation of research for health. Overall, poor data quality still persists at all levels. In addition, there is an absence of a systematic process of routine analysis of submitted HMIS data and feedback to health institutions. This inadequacy has limited the use of HMIS data as a management tool for health planning and improvement of health outcomes. Other challenges include; weak mechanism for coordination of M&E at all levels; poor human resource capacity and lack of material resources especially at the sub-national levels.

In spite of the lingering challenges, significant progress has been made in improving governance and coordination in M&E as proposed in the National Health Information System Policy 2016. The Health Data Governance Council (HDGC) chaired by the Honourable Minister of Health, has been inaugurated. The HDGC serves as the coordinating body that provides oversight and governance for Health Information including the Health Data Consultative Committee (HDCC). Both the HDGC and HDCC are expected to have similar structures at the State and LGA levels. However, while the HDCC will statutorily meet quarterly, the HDGC meets bi-annually. Additionally, a situation analysis of the M&E system performance was carried out in 2016 to guide development of a roadmap for strengthening the M&E system. This will also facilitate the development of an investment framework for M&E.

***Strategic Objective and Targets***

The strategic objective is to improve availability of quality and timely evidence for effective planning and decision-making for enhanced delivery of health services at all levels. The definite targets for the plan period are:

* At least 50% of all health facilities (public and private) generating and transmitting routine HMIS data by 2021
* 50% improvement in data quality by 2021
* improve the use of the health Information System software (DHIS) in data management by 30%
* 50% increase in data analysis by 2021
* 40% increase data dissemination and use by 2021
* 50% Improvement in Data Security by 2021
* 30% Improvement in M&E of HIS by 2021

*Interventions*

* Strengthen institutional framework and coordination for HIS at all levels "
* Strengthen capacity to generate, transmit, analyse and utilize routine health data, from all health facilities, including private health facilities
* Improve integration of existing surveillance systems and diseases registries into the overall health information system
* Improve the mechanism of data sharing amongst stakeholders at all levels
* Strengthen monitoring and supervision of MIS performance at all levels.

## 5.5. Research for Health

***Context***

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 both the academic level and government research Agency levels. 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 community needs.

Funding for health research in Nigeria is meager with evidence indicating at most 0.08% of health expenditure at the federal level with hardly any funding at lower levels. This is contrary to the 2% allocation to research for health prescribed by African Health Ministers and agreed to by the National Council on Health. The paucity of these allocations to the Health Sector had affected the quality and depth of health research in particular. There is also an internationally accepted guideline that Donor agencies provide 5% of Aid to research which is not complied with. The overall goal is to ensure that research is informing effective health policy and programming, and contributing to the advancement of global health knowledge.

***Strategic objective and Targets***

The strategic objective of health research in this plan is to strengthen health research and development to significantly contribute to the overall improvement of Nigeria’s health system performance. The targets include:

* At least 50% implementation of the Research Part of the National Health Act achieved by 2021.
* At least 60 % of health research institutions meet international standards by 2021.
* 50% health research is 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.

***Interventions***

* Strengthen coordination and regulatory mechanisms for health research and development in line with the National Health Act 2014
* Strengthen the development and implementation of the national research agenda
* Increase resource mobilization and allocation for research activities at all levels in line with agreed international declarations, especially Algiers Declaration on Health Research
* Strengthen the capacity of national health research institutions (the National Institute of Medical Research and the National Institute of Pharmaceutical Research and Development, etc.) to contribute to evidence-based decision making and R&D
* Strengthen institutions and systems at all levels for the promotion, regulation and ethical oversight of essential national health research.
* Enhance strategic partnerships with national and international organisations/institutions/private sector in collaboration and promotion of health research.
* Promote mechanisms for the dissemination and utilisation of research findings to inform effective policy-making, programming and health practice and overall economic development.

# CHAPTER 6: PROTECTION FROM HEALTH EMERGENCIES

***Context***

The Country has developing systems and institutions for containment of public health emergencies that require strengthening across all tiers of the health care system. The overall goal of the planned interventions is to significantly reduce the incidence and impact of public health emergencies in Nigeria.

***Strategic objective/Targets***

The strategic objective of the interventions is to reduce incidence and impact of public health emergencies in Nigeria. The targets are:

* Morbidity and mortality from public health emergencies reduced by 50% by 2021.
* 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 2021.
* Proportion of road traffic accidents that fall within the 1-hour window (golden hour) increased to 50% by 2012

***Strategic interventions***

* Promote the development and implementation of legal, regulatory framework, policies and plans for emergency preparedness at all levels
* Promote an integrated national disease surveillance system in line with International Health Regulation (IHR) and IDSR
* Expand/strengthen a network of public health laboratories in Nigeria
* Scale-up public education and awareness creation on public health emergencies
* Promote access to comprehensive services for the prevention, treatment and impact mitigation of public health emergencies
* Promote integration of disease surveillance activities at all levels of the health care system
* Build human resource capacity and equitably distribute them for appropriate and optimal response to public health emergencies.
* Strengthen coordination mechanisms for public health emergencies at all levels
* Promote community participation in disease surveillance activities

# CHAPTER 7: PREDICTABLE FINANCING AND RISK PROTECTION

## 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.

Government’s prioritization of health is seen from the amount it spends on health relative to its overall expenditure outlay. According to WHO (2014) data, general government expenditure on health in Nigeria as a proportion of total government expenditure was estimated at 8.2% in 2014. This represents a 2.3% increment from its value in 2000. Although there has been an increment in the share of general government expenditure to health, this is much below the Abuja Declaration target of 15% (Organization of African Unity, 2001). The health financing indicators for Nigeria is summarized in Table 10.

Table 11: Health Financing Indicators in Nigeria

|  |  |  |
| --- | --- | --- |
| **Health financing and universal coverage indicators** | | |
| **Percentage of GDP devoted to healthcare** | | Less than 2.5% of GDP instead of the WHO benchmark of at least 4% - 5%; |
| **Out-of-pocket spending** | | More than 60% of total health expenditure instead of the WHO recommended 30-40%; |
| **Level of financial risk protection** | | Less than 5% of the population is covered by pre-payment and risk pooling schemes instead of the WHO recommended 90%. |
| **Catastrophic health spending in Nigeria** | | |
| **Proportion of catastrophic health expenditure** | 14.8% (Onoka et al, 2011) and 22.0% (Onwujekwe et al, 2012) | |

A major weakness of the country’s health system is the poor functioning health financing building block as discussed below:

* ***Weak institutional structure and policy environment for health financing***

The federal government has made efforts to develop health financing policy and implementation strategy which will provide an enabling environment for the institutionalization of health financing efforts. Collaborative effort have been made between government and partners to develop health financing systems and strategy at the National and State level. These efforts are yet to produce a finalized health financing strategy and states are yet to adapt this strategy. Most states lack the institutional framework that will guide the development and implementation of health financing strategy.

* ***Low government health spending***

According to National Health Account (2010-2014), the health expenditure increased from N1.9 trillion in 2010 to 3.1 trillion in 2014, with an annual growth of 12.3% per year (Federal Ministry of Health, 2017). Although, current health expenditure grew from N1.8 trillion to N2.9 trillion over the period, at an average annual rate of 13.1%, government expenditures on health is still low.

The government health expenditure as a proportion of the total general government expenditure measures the extent to which government takes responsibility for the financing of health services. According to WHO, NHA data (1995-2014) health expenditure as percentage of general government expenditure was averaged at 6.65% for Nigeria, 4.39% for India, 11.53% for Ghana, 6.22% for Egypt and 13.62% for South Africa (Ataguba, 2017). Compared with Ghana and South Africa, Nigeria has not placed sufficient priority on health (Ataguba, 2017).

Another indicator of the level of a country’s prioritisation of health is the percentage of the GDP that is spent on health (The WHO recommends a minimum of 5%). The average figure for Nigeria is 3.53 % (1995-2014) compared to 10% in advanced countries (Ataguba, 2017). This ratio indicates the level of health expenditure in the economy relative to the overall level of economic development in Nigeria is low.

* *Very high levels of out-of-pocket spending*

One of the key strategies for attaining universal coverage, one of the targets of SDG3, is ensuring financial risk protection through pre-payment risk pooling financing mechanism that eliminates out-of-pocket health expenditure. The country’s out-of-pocket expenditure on health remains high. Overall, out-of-pocket expenditure (OOPE), as a proportion of total health expenditure is high, ranging from 78% in 2010 to 73% in 2014 (Federal Ministry of Health, 2017). The high level in OOPE poses a barrier to accessing health services, thereby fueling inequity in health outcomes and further exposing the already poor to impoverishment and financial catastrophe.

* *Low level of coverage of health insurance and other pre-payment and financial risk protection mechanisms*

The Nigerian government established 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 (NHIS, 2012). At present, only about 5% of Nigerians have prepaid health care through social and voluntary private insurance. Whereas the 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 only 2 states are currently participating in the scheme. The community-based health insurance scheme aimed at addressing the needs of the comparatively poorer 70% Nigerians in the informal sector and rural areas remain prostate, leaving majority of Nigerians without any form of coverage. This situation has made the aspiration for UHC difficult to attain.

One issue affecting the optimal functioning of the NHIS is how the services are purchased. The current model where HMOs are the purchasers for NHIS does not appear a feasible method for ensuring equitable access to health services for the entire population.  These HMOs are private organizations that enroll both NHIS populations and other private health insurance populations.  There are issues of vested interests and powerful HMO groups, inefficiencies and poor monitoring and regulatory framework (Onoka et al., 2016).

* *Poor resource mobilization*

The public health sector, at all levels relies solely on government funding with little or no effort for mobilization from other sources. Many opportunities exist for increased domestic funding of health such as corporate social responsibility funds, health impact bond, sin taxes, aviation, VAT, mandatory health insurance, philanthropy; these remain grossly underexploited. Governments have tendencies of depending on donor funding which may affect its drive for exploring other sources.

There is no framework within which resources are mobilized and allocated for health. Efforts are on-going by states and by the federal government to improve financing for health and scale up financial risk protection for the populations. However, these are uncoordinated and are not always based on evidence.

* *Allocative Inefficiency*

The systems for monitoring and reporting health expenditures is poorly implemented at all levels of government, or assessing the efficiency of resource use leading to lack transparency and leakages . Although Nigeria has conducted four rounds of the national health accounts, they have so far been conducted sporadically and often are completed too late to be useful for planning. Health care resource allocation in Nigeria is skewed in favor of secondary and tertiary care as against primary care and PHC. A direct consequence is that most people bypass PHC facilities to seek primary care at secondary and tertiary facilities. This situation is both 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 for them (inequity in access and payment). Other evidence of allocative inefficiency include funding recurrent expenditure more that capital expenditure, the use of branded drugs instead of generic drugs etc.

* *Purchasing Services*

The case of HMOs as purchasers for NHIS is important to mention here.  The current model cannot be used to ensure equitable access to health services for the entire population.  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, there should be a strong monitoring and regulatory framework that is put in place to reduce inefficiencies (Onoka *et al.*, 2016).  In order to make purchasing strategic and to be 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.  While this should be seen as a long-term goal in the country, in the interim, there is a need to develop a financing strategy that will outline the processes and pathways to achieve this long term goal.  Because the country has both public and private providers, strategic purchasing can draw on both sectors to ensure equitable access to health services across the country.

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 that will be sufficient to meet health development goals, ensure that develop financing mechanisms that ensures financial risk protection and catastrophic health expenditure and finally ensure allocative efficiency, predictability, accountability, transparency, equity and sustainability.

***Strategic Objectives and Targets***

The strategic objective of Health financing in the NHSDP II is to ensure adequate and sustainable funding that will be efficiently and equitably used to provide quality health services and ensure financial risk protection in access to health services for all Nigerians, particularly the poor and most vulnerable population. The targets for the plan period are:

* 70% of States and FCT have functional Healthcare Financing Equity & Investment Units by 2021
* 70% of States and FCT have functional Healthcare Financing Equity & Investment TWGs by 2021
* National Health financing policy approved and adopted by FMOH
* 70% of States and FCT have approved Health Financing Policy & Strategy by 2019
* FMOH, SMOH, & FCT HHSS have approved investment cases for UHC priorities by 2021
* FMOH has institutionalized routine NHA; 70% of States and FCT that have updated SHA
* Increase funding to PHC from 21% to 35% of health spending
* Increase percentage of health budget to at least 15% of General Government Budget
* 30% of Nigerian population covered by any risk protection mechanisms
* 50% of states reduce OOP by 50%"
* 40% of Health MDAs and service delivery points have 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

*Strategic Interventions*

The Strategic Interventions for the period shall be in four broad areas.

1. **Strengthened Governance and Coordination for actualizing stewardship and ownership of** Health Financing reforms.

* Strengthen Health Financing Equity and Investment Units at Federal, 36 States, and FCT
* Strengthen Coordination Frameworks for health financing at Federal, 36 States, and FCT
* Strengthen the development Health Financing Policy & Strategy and Investment case at Federal, 36 States, and FCT
* Strengthen the systems for health financing evidence generation and management at Federal, 36 States, and FCT

1. **Increase sustainable and predictable funding for health**

* Scale-up phased implementation of the Basic Healthcare Provision Fund (BHCPF)
* Strengthen advocacy for increase in government annual budgetary allocation and release for health
* Strengthen legal and coordinating framework for PPP at Federal and State levels
* Promote resource mobilization strategy for health including resourcing from special funds (Sin Taxes, Telecom Taxes, VAT, Aviation Taxes, etc.)

1. **Enhance financial risk protection through pooled funds at federal and state levels**

* Strengthen framework for the implementation of the NHIS laws and guidelines
* Strengthen technical capacity of health personnel on health insurance and contributory schemes
* Promote establishment and expansion of Mandatory State Health Insurance and contributory Schemes in 36 States & FCT

1. **Enhance strategic purchasing of Health Services at all levels**

* Promote Results-Based Financing (RBF) at all levels of the Nigerian health sector
* Promote competition among providers of healthcare (public and private sector) in allocation of health resources
* Promote establishment of National Quality Review & Health Technology Assessment Systems at all levels
* Strengthen NHA and expenditure tracking mechanisms at State and Federal levels
* Strengthen Public Finance Management (PFM) reforms at the Federal and State levels

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# APPENDIX 1: METHODOLOGY FOR DEVELOPING THE NSHDP II

The framework for the NHSDP II is presented as a spreadsheet with four levels of detail which are as indicated below:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Goals** | | | | **BASELINE YEAR 2009** | **RISKS AND ASSUMPTIONS** | **Stakeholder/ Responsibility** |
|  | **Strategic Objectives** | | | **Targets** |  |
|  |  | **Interventions** | | **Indicators** |  |
|  |  |  | **Activities** | **None** |  |

1. **Goals**

There is one overarching national goal. Each priority area has one goal. These are intended to be the **national focal priority areas** for the period 2017 to 2021. All health care service providers are therefore provided with a clear set of national goals to which the nation will strive. Since the goals are stated at a national level and for a long time period they provide the common direction in which the leadership is taking the health system and it services. It is not expected that the goals need to be added to by States

1. **Strategic Objectives**

For each Goal there are one or more Strategic Objectives. These are intended to elaborate the national focal priority areas for the period 2017 to 2021 and provide all health service providers with a common focus.

Strategic Objectives are also stated at a macro level and also for a long time period and try to concretise the goals. They have clear high-level (national) targets stated so that all service providers understand what the plan is aiming to achieve.

1. **Specific Objectives/ Targets** are stated very broadly and can be viewed as realistic medium- to long-term challenges to all role-players.
2. **Interventions**

For each Strategic Objective there are a number of interventions. The interventions provide more details on the major identified strategies that the leadership believes will take the provision of health services in a positive direction. There are clear high-level, national, indicators stated for each strategy. The efforts of all service providers collectively should make it possible to achieve the stated indicators. These indicators need to be SMART (specific, measurable, achievable, realistic, and time-bound) to be of any use. It can be a costly burden to monitor and evaluate services and progress towards the stated improvement. It is therefore important to remember that these ‘indicators’ are the few measurable pointers that represent a broad set of inputs, processes, outputs and outcomes, some of which are very difficult to measure. They are not a means in themselves but purely the chosen set of measurements that indicate progress or otherwise.

Health care access, service provision, infrastructure, personnel and other resources are not evenly or equitably distributed in the country. Therefore the emphasis that one administration (State or LGA) places on the Strategic Objectives will differ. It is therefore expected that the strategic objectives may be added to by States and LGAs, some may not be appropriate and may be ignored at local levels, or the national indicators may be modified by individual providers to make them realistic in their local context.

Up to this point, the document is a ‘Framework’ and has no plan of how it will be implemented. The last level is the ‘Plan’ of how to implement and is a statement of what is to be done.

1. **Proposed activities and actions**

Actions are unique to each service provider. It is expected that the collective set of all of the actions and activities embarked on by the individual providers across the country will contribute to the achievement of the indicators and targets for the country.

These actions and activities must be very practical, achievable and affordable. This is not an opportunity to provide a ‘wish-list’. It is rather the list of quantifiable steps and actions chosen by the management of each health provider because they are practical and affordable and will achieve the stated strategy. Actions are usually stated for only the current year. They must be very practical and must answer the question ‘**how** will the strategies be achieved?’

Actions and activities must be allocated resources and therefore costed so that a budget can be provided. Every year a new set of actions and activities is listed including those that have been rolled over from the preceding year where applicable but the Goals, Strategic Objectives and Strategies usually remain for the term of the plan, unless there is very good reason to amend them. Every action or activity **must** be allocated a responsible person (not a group or a committee of people). It may be useful to list the stakeholders that will be involved in achieving a strategy as a whole. It is not necessary to list indicators for every activity or action but there is no harm in providing them as statements by which to measure progress.

1. **Risks and Assumptions**

All strategies have risks and for all strategies, the management made certain assumptions where there is insufficient information available. Risks and assumptions are ‘red lights’ that warn of potential constraints to specific strategies or delivery of interventions. The risks are more amenable to management if they are clearly identified early. The information from the risk analysis is expected to guide, implementation thus guarding against wide disruptions.

1. **Timeframes**

As has been stated activities and actions emanating from the NHSDP may be for the current year as well as for rolled over and linked activities from the previous year within the plan period. However some may be recurrent activities (like scheduled quarterly or annual meetings). The framework has a timeframe stated in quarters (Q) as indicted here:

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Timeframe in quarters** | | | | | | | | | | | | | | | | | | | |
| **YEAR 1 (2009)** | | | | **YEAR 2 (2010)** | | | | **YEAR 3 (2011)** | | | | **YEAR 4 (2012)** | | | | **YEAR 5 (2013)** | | | |
|
| **Q1** | **Q2** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** | **Q4** |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

Not all actions and activities can happen at the same time. Some are dependent on the commencement or completion of others. The preparatory actions must be attended to before the concluding actions. It is important to show the sequence of the actions and activities to ensure that resources are available when needed.

1. **Budgeting**

As has been mentioned, actions and activities must be allocated resources and therefore costed so that a budget can be provided.

1. [↑](#footnote-ref-1)
2. WHO Code of Practice 2010 on International Recruitment of Health Personnel [↑](#footnote-ref-2)