FEDERAL MINISTRY OF HEALTH

Accelerating Progress to Achieve the Health MDGs in Nigeria

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Harmonized Country Plan of Priority Interventions for 2014-2015

(Drawn from existing National frameworks and strategic plans)

February, 2014

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Foreword

Nigeria is committed to meeting the Millennium Development Goals by 2015. Although Nigeria has mainstreamed MDGs targets into various National initiatives and strategies to fast track the attainment of the goals, more efforts are needed to ensure we attain the goals, come 2015. While some of these targets are being achieved, the country is making slow progress in the achievement of others, especially the health-related MDGs.

Nigeria has developed plans and strategies to address key reproductive, maternal and child health issues over the last seven years, with varying degrees of success. However, more needs to be done in order to drastically reduce maternal mortality and child mortality in the country. A range of key interventions, particularly those focused on the health of mothers, newborns and children, have been identified and prioritized to rapidly accelerate progress towards achieving the Health related goals.

This Harmonized Action Plan, developed by the Government of Nigeria and its partners seeks to outline specific areas of focus for stepped up efforts over the next two years in order to meet the health MDG targets. It is not designed to create a new platform or mechanism for implementation of programmes, but rather to align and strengthen existing ones. Core to the action plan is the identification of gaps in current programming efforts, available funding commitments and funding gaps which may hamper the country's ability to meet its targets, if not covered. This plan is a clarion call on all states and supporting partners to improve programming and focus on producing results in terms of better health outcomes. It calls for a shift in approach and increased efforts in activities within the priority areas identified, to save the lives of mothers and children. Through this plan, Nigeria aims to save an additional 420,000 maternal and children's lives by 2015.

We now invite all our friends, partners and stakeholders to share in this conviction that, within the next two years, together, we can strengthen and consolidate our partnership to reduce the gap. Excellent policies and programmes designed will not lead to an improvement in outcomes without strong execution and dramatic innovation in the way they are delivered. We enjoin all state governments and partners to support the plan by mobilizing additional funds to optimize and scale-up high impact cost effective interventions towards accelerating the achievement of the health related MDGs in Nigeria.

Prof. C.O. Onyebuchi Chukwu
Honourable Minister of Health
Federal Republic of Nigeria

Acknowledgements

This harmonized plan is intended to provide a clear direction as to the successful implementation of the "last push" to achieve the Health MDGs in Nigeria, taking into consideration the proximity of the deadline. The MDGs as signed by 159 countries including Nigeria seem to be elusive, despite several efforts by the Federal and State Governments, technical and development Partners. It is therefore imperative that more focused approaches with definite feasible interventions, requiring the highest level of political will be put in place in the final period, if Nigeria will be counted amongst the countries to have attained the MDGs. The health MDGs have shown promise of achievement with the different packages available in the country; pivotal requirement is the proper coordination of these numerous efforts and alignment of existing resources.

The Federal Ministry of Health and her agencies therefore wish to express gratitude to the numerous individuals and development partners who worked tirelessly with Ministry to develop this Harmonized Action Plan. Our sincere appreciation goes to our partners particularly CHAI,UNICEF, UNFPA, WHO, USAID, DFATD, EU, BMGF, HERFON amongst others who were consulted and participated in the retreat that formed the foundation for the finalization of this document.

Our special appreciation goes to the Honourable Minister of Health, Professor C. O. Onyebuchi Chukwu, for his strategic vision to consolidate the numerous efforts, and align resources towards one common goal. This is in line with President's Transformation Agenda and sets high bars for the Ministry of health to deliver on its mandate for Nigerians.

Special recognition and gratitude goes to the Permanent Secretary, Amb. Sani Bala, for his unflinching support, without which this would not have been possible. I also appreciate especially Dr. W.I. Balami, Dr. Emmanuel Meribole, Dr. N.R.C Azodoh, Dr. M.Lecky, Dr. Owens Wiwa and CHAI for their unrelenting commitment. Our special appreciation also goes to Dr Aboubakar Kampo and the UNICEF for their support and for providing some financial assistance to this process.

Finally, the efforts of the Coordinating Secretariat domiciled in the Division of International Health and staff of the Department of Health Planning, Research and Statistics and the national secretariat domiciled in the division of International Health and staff of the Departments of Planning, Research and Statistics, and Family Health of the Federal Ministry of Health (FMOH), who facilitated the process of the development of this plan and coordinated all the meetings, are highly appreciated.

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February 2014

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Acronyms and Abbreviations

ACTs	Artemisinin Combination Therapies
ACs	Antenatal Corticosteroids
ANC	Antenatal Care
ARFH	Association for Reproductive and Family Health
BEmONC	Basic Emergency Obstetric and Newborn Care
CCM	Community Case Management
CCTs	Conditional Cash Transfers
CGS	Conditional Grants Scheme
CHAI	Clinton Health Access Initiative
CHEWs	Community Health Extension Workers
CHOs	Community Health Officers
CIMCI	Community-Integrated Management of Childhood Illnesses
CORPS	Community Resource Persons
CPR	Contraceptive Prevalence Rate
DFID	United Kingdom Department for International Development
DHIS	District Health Information System
DRG	Debt Relief Gain
DTTU	Diarrhoea Treatment Training Unit
EDL	Essential Drugs List
ELSS	Extended Life Saving Skills
EML	Essential Medicines List
ETAT	Emergency Triage Assessment and Treatment
ETS	Emergency Transport Scheme
EWEC	Every Woman Every Child
EmONC	Emergency Obstetric and Newborn Care
FCT	Federal Capital Territory

FP	Family Planning
GDP	Gross Domestic Product
GMP	Good Manufacturing Practice
GoN	Government of Nigeria
HCW	Health Care Workers
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
iCCM I	ntegrated Community Case Management
IMCI	Integrated Management of Childhood Illnesses
IMNCH	Integrated Maternal Neonatal and Child Health
IMR	Infant Mortality Rate
IPTp	Intermittent Preventive Treatment of Malaria in Pregnancy
IRS	Improved Referral System
IUCD	Intra-Uterine Contraceptive Device
IYCF	Infant and Young Child Feeding
JCHEWs	Junior Community Health Extension Worker
KHHP	Key Household Practices
LARCs	Long Acting Reversible Contraceptives
LMIS	Logistic Management Information System
LGA	Local Government Area
LLIN	Long Lasting Insecticidal Nets
LMIS	Logistics Management Information System
LO-ORS	Low Osmolality Oral Rehydration Salts
LSS	Life Saving Skills
MAF	MDG Acceleration Framework
MDG	Millennium Development Goal
MDG	Millennium Development Goals
M&E	Monitoring and Evaluation
MgS04	Magnesium Sulfate

MI	Micronutrients Initiative
MLSS	Modified Life Saving Skills
MoH	Ministry of Health
MMR	Maternal Mortality Rate
MNCH	Maternal, Newborn, and Child Health
MNCHW	Maternal, Neonatal and Child Health Week
MSS	Midwives Service Scheme
NAFDAC	National Agency for Food and Drug Administration and Control
NAPP	National Action Plan for the Prevention and Control of Pneumonia
NASG	Non-Pneumatic Anti-Shock Garment
NDHS	Nigeria Demographic and Health Survey
NEEDS	National Economic Empowerment Development Strategy
NEMCM	National Essential Medicines Coordinating Mechanism
NHMIS	National Health Management Information System
NISONM	Nigeria Society of Neonatal Medicine
NMA	Nigerian Medical Association
NMCP	National Malaria Control Programme
NPHCDA	National Primary Health Care Development Agency
NURHI	Nigeria Urban Reproductive Health Initiative
NURTW	National Union of Road Transport Workers
ORS	Oral Dehydration Solution
OSSAP-MDGs	Office of the Senior Special Assistant on MDGs
OTC	Over-the-Counter
PACT	Prevention and Access to Care and Treatment Project
PAN	Paediatric Association of Nigeria
PATHS2	Partnership for Transforming Health Systems 2 (PATHS2)
PCN	Pharmacists Council of Nigeria
PHC	Primary Health Care
PHCs	Primary Health Care Centres

PNC	Post-Natal Care
POM	Prescription-Only Medicines
POS	Point-Of-Service
PPH	Post- Partum Haemorrhage
PPMV	Proprietary Patent Medicine Vendors
PSN	Pharmacists Society of Nigeria
RACE	Rapid Access Expansion Project
RHCS	Reproductive Health Commodity Security
RMNCH	Reproductive, Maternal, Neonatal and Child Health
SBAs	Skilled Birth Attendants
SFH	Society for Family Health
SHOPS	Strengthening Health Outcomes through the Private Sector
SMC	Seasonal Malaria Chemoprophylaxis
SMOH	State Ministry of Health
SMS	Short Message Service
SOGON	Society of Gynaecology and Obstetrics of Nigeria
SOMLi	Saving One Million Lives (SOML) initiative
SP	Sulfadoxine-Pyrimethamine
SP-AQ	Sulfadoxine – Pyrimethamine +Amodiaquine
SURE-P	Subsidy Reinvestment and Empowerment Programme
SURE-P MCH	Subsidy Reinvestment and Empowerment Programme Maternal and Child Health Programme
TBA	Traditional Birth Attendants
TSHIP	Targeted States High Impact Project
UN	United Nations
UNCoLSC	UN Commission on Life Saving Commodities
UNH4	United Nations Health 4
UNICEF	United Nations Children's Fund
VDCs	Village Development Committees
WDCs	Ward Development Committees

WHO	World Health Organization
WINNN	Working to Improve Nutrition in Northern Nigeria
WMHCP	Ward Minimum Health Care Package
YFHS	Youth Friendly Health Service

Executive Summary

With less than two years to the MDG 2015 deadline, Nigeria is on track for some targets and is making slow progress on some especially the health-related ones. As at 2012, Nigeria has achieved three targets: (i) Halving the proportion of population undernourished; (ii) gender parity in primary and secondary school enrolments; and (iii) reversing the trend on HIV/AIDS and malaria. Reducing maternal mortality is among the targets that have recorded appreciable progress since 1990: it declined from 1,100 per 100,000 live births in 1990 to 545 in 2008. Although this trend is encouraging, the rate of decline is inadequate for reducing the maternal mortality ratio (MMR) to 275 maternal deaths per 100,000 live births by 2015. Similarly, the target to reduce child deaths by two-thirds is yet to be met with 128 deaths per 1000 live births in 2013. Nigeria is still a major contributor to the global burden of child deaths and requires intensified efforts to rapidly drive down deaths in children under 5 most especially infant mortality rates.

The primary challenges that drive these outcomes include the high number of births at home (at over 60% of total births), weak health systems in rural parts of the country, which bear the dominant burden, and historically limited prioritization and coordination to ensure mothers and women of reproductive age have access to life-saving services and commodities. In addition to the relatively low outcomes, the distribution of the health outcomes and utilization of health services is highly inequitable. For example, the difference between the wealthiest and poorest quintiles in access to skilled birth attendance at delivery is almost eight fold. Achieving universal health coverage for a package of high impact and cost effective interventions including life-saving commodities is the target of the Government of Nigeria.

Based on the meeting held on 21st November 2013 with the Government of Nigeria and its Development Partners on the occasion of the visit of the representatives of the UNSG's Special Envoy for Financing the Health MDGs and for Malaria, a range of key interventions to rapidly accelerate progress to achieving the Health MDGs in Nigeria were discussed, particularly those goals focused on the health of mothers and children. There was a focus on ensuring the existing and potentially new domestic and external funding streams were even better coordinated and aligned against those priority interventions within the RMNCH continuum of care that could have the greatest health impact.

Therefore, the harmonized action plan prioritizes key interventions that are already underway for rapid scale up or improvements in programming, to accelerate impact and save more lives by 2015. The key activities identified within these existing programmes target the dominant causes of neonatal and maternal mortality with a focus on Post-Partum Haemorrage, eclampsia, preterm birth complications, birth asphyxia and the three major causes of childhood mortality: malaria, pneumonia and diarrhoea.

Focus areas of this plan include:

1. Maximizing RMNCH Weeks and Other Existing Campaigns
2. Essential Medicines Scale-up through Public-Private Sector Partnerships, with emphasis on Malaria, Pneumonia and Diarrheal Disease
3. Maximizing Utilization of Existing Primary Health Care Services
4. Maximizing Impact of Community Based Programs
5. Accelerating Access to Life Saving Maternal and Newborn Commodities
6. Health Systems Strengthening

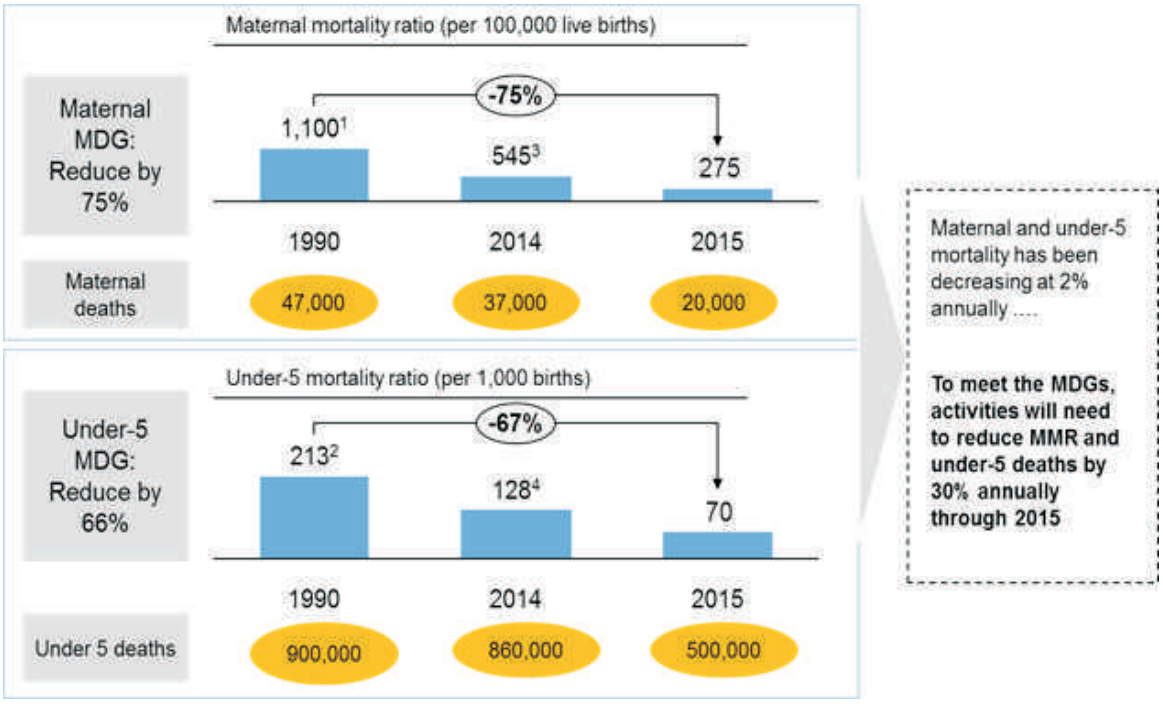
The plan is designed to be state-driven with strong coordination at the National level. Key government and partner leads have been identified for each priority area to coordinate ongoing implementation and tracking of results. The progress will be monitored through the Health Partners Coordinating Committee (HPCC), which meets with the Minister of Health every quarter. Leads will be expected to provide updates on milestones for each quarter as detailed and agreed in the plan. In addition, the States Coordinating Committee for Health, which is a forum where the Minister of Health and all 36 State Commissioners of Health plus the FCT meet every 6 months, will be reactivated to monitor progress towards meeting set targets for the identified intermediate outcome indicators. An RMNCH scorecard with 16 key intermediate outcome indicators will be developed and reported on by States on a bi-annual basis for review and corrective action.

Full execution of this plan over the next two years, will require $650 million. Existing government and partner resources and commitments towards each of the priority areas amount to approximately $258 million. This results in an estimated funding gap of $392 million. Nigeria will use this plan as a resource alignment and mobilization tool, starting with Ray Chambers' visit to Nigeria in February 2014.

It is hoped that government and donors will aim towards filling the financial gap, to support States and LGAs in the full implementation of the priority interventions and produce results. Results, in the context of this plan, are improvements in the maternal, neonatal, infant and under-5 child health outcomes. Anything short of saving additional lives between now and 2015 will be a significant setback for the country.

Introduction

Nigeria signed the Millennium Deceleration in 2000, and has since then invested substantially in the attainment of the Millennium Development Goals (MDGs). Starting with its establishment of the Presidential Committee on MDGs, conducting the MDG Costing and Countdown Strategy; establishing and continuously implementing the Debt Relief Gain (DRG) funds, including the Conditional Grants Scheme (CGS) and Conditional Cash Transfers (CCTs); mainstreaming the MDGs into Vision 20:2020 and the Transformational Agenda; and preparing an MDG Acceleration Priority action plan for maternal health, among others, Nigeria is committed to achieving the targets. With less than two years to the MDG 2015 deadline, Nigeria is on track for some targets and is making slow progress on some, especially the health-related ones. As at 2012, Nigeria has achieved three targets: ***(i) Halving the proportion of population undernourished; (ii) gender parity in primary and secondary school enrolments;*** and ***(iii) reversing the trend on HIV/AIDS and malaria.*** Reducing maternal mortality is among the targets that have recorded appreciable progress since 1990: it declined from 1,100 per 100,000 live births in 1990 to 545 in 2008. Although this trend is encouraging, the rate of decline is inadequate for reducing the maternal mortality ratio (MMR) to 275 maternal deaths per 100,000 live births by 2015. Similarly, the target to reduce child deaths by two-thirds is yet to be met with 128 deaths per 1000 live births in 2013. Nigeria is still a major contributor to the global burden of child deaths and requires intensified efforts to rapidly drive down deaths in children under 5 most especially infant mortality rates.



[1]World Bank Modelled Estimates
[2] World Bank National Estimates
[3] Nigeria DHS 2008
[4] Nigeria DHS 2013

In order to achieve the MDGs, Nigeria would need to ensure a ~30% annual decrease in neonatal and maternal mortality through 2015, resulting in ~22,000 maternal lives saved and ~400,000 lives saved under-5s. At the current rates of 2% and 4% reductions in maternal mortality and under-5 mortality,

[1] Nigeria Demographic Health Survey 2008
[2] Nigeria Demographic Health Survey 2013, preliminary report

respectively, Nigeria is far from meeting its MDG targets. Accelerated attention is required, therefore, for further improvement. Given the country's large population, Nigeria's attainment of the health MDG targets will significantly improve the health outcomes in Africa as a whole.

Based on the meeting held on 21st November 2013 with the Government of Nigeria and its Development Partners on the occasion of the visit of the representatives of the UNSG's Special Envoy for Financing the Health MDGs and for Malaria, a range of key interventions to rapidly accelerate progress to achieving the Health MDGs in Nigeria were discussed, particularly those goals focused on the health of mothers and children. There was a focus on ensuring the existing and potentially new domestic and external funding streams were even better coordinated and aligned against those priority interventions within the RMNCH continuum of care that could have the greatest health impact.

It was agreed that given the less than 2 years remaining and the strong initiatives already underway, the work in the coming years will build upon existing structures aimed at accelerating impact. These existing structures include His Excellency, President Goodluck Jonathan's ***MDG Acceleration Framework (MAF)***, the ***Saving One Million Lives (SOML) initiative,*** the ***United Nations Commodities' Commission country implementation plan*** and the ***National Health Strategic Development Plan*** – which, if fully implemented – would result in Nigeria's achievement of Goals 4, 5 and 6.

Based on these strong programmes, key activities have been identified and prioritized which: facilitate and maximize existing high impact interventions; reach populations with the highest levels of mortality; and can be operationalized rapidly.

This Harmonized Action plan, developed by the Federal Government, State Governments, Development and Implementing Partners seeks to outline specific areas of focus for stepped up efforts over the next two years in order to meet the health MDG targets. It is not designed to create a new platform or mechanism for implementation of programmes, but rather to align and strengthen existing ones. Core to the action plan is the identification of gaps in current programming efforts, available funding commitments, and funding gaps which may hamper the country's ability to meet its targets if not covered.

Background

Overview of Nigeria Health System

Nigeria is a federation of 36 states and a Federal Capital Territory (FCT), grouped into six geo-political zones: North Central, North East, North West, South East, South South, and South West. There are 774 constitutionally recognized local government areas (LGAs) and 9,565 wards. The 2006 Population and Housing Census puts Nigeria's population at 140,431,790 with a national growth rate estimated at 3.2% per annum. The current population estimate of about 170 million (2012) people makes Nigeria the most populous nation in Africa.

Nigeria operates a three-tier public healthcare system of primary, secondary and tertiary healthcare which is managed by the three tiers of government. However, the primary health care system remains

the cornerstone of Nigeria's health care delivery system and represents a vital component of the nation's strategy for accelerating progress towards achievement of the MDGs.
Nigeria's average population health outcomes are relatively low compared to other countries with similar levels of resources and endowments. According to the NDHS 2008 estimates, Nigeria has approximately 545 maternal deaths for every 100,000 live births and contributes about 14% of global burden of maternal deaths. The under-5 mortality rate of 128 per 1,000 live births and Infant mortality rate of 67 per 1,000 live births, based on the NDHS 2013 preliminary results, are on a steady decline, but still higher than that of several other countries.

In addition to the relatively low outcomes, the distribution of the health outcomes and utilization of health services is highly inequitable. For example, there is an almost eight-fold difference between wealthiest quintile and poorest quintile in terms of access to skilled birth attendance at delivery. Coverage of key interventions is low, quality of care is inadequate and the most basic services do not reach the poorest segments. Inter-regional and inter-state disparities in health outcomes are also wide. Consequently, it is estimated that approximately one million women and children die every year in Nigeria from largely preventable causes; 33,000 women are estimated to die from pregnancy-related causes, and about 946,000 children under-5 die of which 241,000 are newborns.

The preventable causes of morbidity and mortality among women include pregnancy anaemia due to malaria, intra-partum and post-partum haemorrhage, post-partum sepsis, eclampsia and complications from obstructed labour. Among children, these include neonatal conditions, malaria, vaccine preventable communicable diseases (tuberculosis, diphtheria, pertussis, tetanus, poliomyelitis, and measles), bacterial pneumonias, diarrhoeal diseases, paediatric HIV disease and the underlying problem of malnutrition.

Consistent with the Transformation Agenda of Mr. President, Dr Goodluck Ebele Jonathan's administration and in his role as Co-Chair of the UN Commission on Life-Saving Commodities for Women and Children, Nigeria's SOML Initiative was launched in Abuja in October 2012. In concert with this Initiative, the country has developed an implementation plan to prioritize life-saving commodities for women and children. The MDG acceleration framework has since 2013, been applied to MDG 5 to accelerate progress towards reducing maternal deaths in the country. This is part of Nigeria's concerted efforts to reverse the current situation, with strong emphasis on improving the health status of Nigerians, through the delivery of basic health services and enhancing access to priority life-saving commodities for women and children with a focus on saving lives.

Existing National Strategies, Policies, Programmes and Initiatives

The interventions in this action plan are adapted fully from existing programmes that the Government of Nigeria and partners are currently implementing across the RMNCH continuum. Additionally, the Nigerian government has developed key policy documents that lay the foundation for the strategic interventions in this proposal. Below is a summary of key documents used to develop the harmonized action plan.

National Strategic Health Development Plan (NSHDP) 2009 – 2015:

The strategic plan was developed by the Federal Ministry of Health (FMOH) as an overarching framework for health planning at local government levels. The plan is based on “four ones”: *one* health

policy, *one* national plan, *one* budget, and *one* monitoring and evaluation framework for all levels of government. It focuses on eight priority areas with specific goals and objectives: leadership and governance for health, health service delivery, human resources for health, health financing, health information systems, community ownership and participation, partnerships for health development and research for health. The document provides guiding principles for health improvements in Nigeria and highlights the importance of increasing commodity and service access under the IMNCH strategy.

MDG Acceleration Framework:

The MDG Acceleration Framework (MAF) has been globally recognized as one of the most effective tools for fast-tracking the lagging MDGs at both the national and sub-national levels. The MAF helps countries to focus attention on specific MDGs that are off-track, identify and prioritize bottlenecks impeding progress, and recommend appropriate collaborative solutions involving governments and all relevant stakeholders. It is against this background that the Federal Government of Nigeria through the Office of the Senior Special Assistant on MDGs (OSSAP-MDGs) and the Federal Ministry of Health in partnership with the United Nations System in Nigeria and the UK Department for International Development (DFID) are collaborating in the application of MAF to MDG 5.

Nigeria's MAF Action Plan identifies key bottlenecks impeding progress; it has prioritized five high-impact interventions for fast-tracking MDG 5 and consequently recommended accelerated solutions. The five key priority areas are: family planning (FP); skilled birth attendants (SBAs); emergency obstetric and newborn care (EmONC); universal coverage of antenatal care (ANC) and post-natal care (PNC); and the Improved Referral System (IRS). Given the wide variations among states in the achievement of MDG 5 targets, state governments are encouraged to further prioritize these interventions as their situation may require, meeting their specific gaps to accelerate progress. A key component in the MAF is the monitoring and evaluation (M&E) plan, which articulates clear set of milestones for measuring success. It is hoped, therefore, that the M&E plan will be effectively implemented in order to facilitate comprehensive and rigorous tracking of progress as we approach the 2015 MDG deadline.

United Nations Commodities' Commission Country Implementation Plan:

The United Nations (UN) Secretary-General's Global Strategy for Women's and Children's Health highlights the inequitable access to life-saving medicines and health supplies suffered by women and children around the world and calls the global community to work together to save 16 million lives by 2015. Nigeria's country implementation plan builds on the analyses and the ten recommendations of the UN Commission on life-saving commodities. It also applies the recommendations to each of the prioritized life-saving commodities identified by RMNCH stakeholders in the country. With the MDG deadline less than two years away, the country implementation plan represents Nigeria's efforts to effectively integrate important global initiatives such as UNCoLSC, Child Survival Call To Action: A Promised Renewed (APR), Family Planning (FP) 2020; to meet the common goal of achieving and sustaining results for women and children in an efficient manner.

The country implementation plan for priority life-saving commodities for women and children lays a detailed framework and roadmap for addressing the critical gaps and barriers that currently exist and limit the supply and demand for the priority commodities. The implementation plan outlines key activities that will lead to quick wins, medium term wins and long-term wins over the period 2013 - 2015. It leverages on pre-existing policies, strategies and programmes in place to maximize lessons learned and apply best practices at scale in a targeted approach.

Integrated Maternal, Newborn and Child Health (IMNCH) Strategy (2007):

The strategy was introduced in Nigeria in 2007 as an intervention package that addresses the six conditions responsible for over 90% of maternal deaths (haemorrhage, infection, obstructed labour, hypertension, malaria, and anaemia) and the most common conditions responsible for over 90% of under-five mortality (e.g., pneumonia, malaria, diarrhoeal disease, measles as well as underlying malnutrition, and more recently HIV/AIDS), while including neonatal conditions (e.g., prematurity, sepsis and birth asphyxia).

It promotes the integration of MNCH services, which involves the reorganization and reorientation of health systems to ensure the delivery of a set of essential interventions as part of the continuum of care for women,
newborns and children. A focus on the continuum of care replaces competing calls for mother, newborn or child, with a focus on high coverage of integrated evidence-based intervention packages including:

- Focused antenatal care;
- Intrapartum care;
- Emergency obstetric and newborn care;
- Routine postnatal care;
- Repositioning family planning/child spacing; and
- Newborn care

These interventions are packaged in three delivery modes:

1) Family-oriented, community based services;
2) Population-oriented outreach services which can be scheduled; and
3) Clinical services given on one-to-one basis.

Saving One Million Lives Initiative

"Saving One Million Lives" (SOML) is an approach to delivery that reflects lessons learned from previously implemented programs and analyses of the health sector in the country. It includes: (1) A shift in focus from inputs to focusing on results and outcomes; (2) Strengthened local ownership and accountability mechanisms, especially at the ward levels; (3) Better coordination and engagement across agencies, between different tiers of government and amongst development partners; (4) Testing of innovative approaches that fit the Nigerian context; (5) Strong capability and skill building and technical assistance to address constraints within the system. (6) Stringent monitoring and evaluation /performance management framework. Overall SOML was designed to focus significantly on execution and program delivery. It set clear, ambitious targets for real impact and a simple, yet laser focused system of performance management to achieve them.

Other Policy Documents:

Other policy documents used in the development of this action plan include the following:

- National Essential Medicines Scale up plan
- National Malaria strategy
- National Human Resources for Health strategic plan
- National Monitoring and evaluation framework
- National Strategic Plan of Action for Heath sector component of National food and nutrition policy (2014 – 2018)

Harmonized Action Plan to Meet MDG 4&5 Targets for 2014 – 2015

In order to meet the MDG 4 target, Nigeria must save additional lives of over 400,000 children by 2015. ***Over 85% of child mortality is attributable to deaths in the newborn period, malaria, pneumonia and diarrhea.*** Nigeria must save additional lives of at least 16,000 mothers by 2015 to achieve MDG5. While important progress has been made against maternal mortality, progress will fall short at the current trajectory. ***Over 50% of maternal mortality is attributable to post-partum haemorrhage and hypertension.***

Access to primary health care needs to be improved through increased investment in infrastructure, human resources, equipment and consumables, and better management. Implementation arrangements must target local needs, which vary hugely from community to community and state to state. Routine immunization is unsatisfactory but can be rapidly improved by building on the successes of the near-eradication of polio. The Midwives Service Scheme is expected to contribute substantially to ongoing shortfalls but its impact has yet to be reflected in the data. If the scheme is expanded in proportion to the national gap in the number of midwives, this will further accelerate progress. In addition, more mothers will be covered by antenatal care as access to quality primary healthcare improves and incentives attract health workers to rural areas.

Therefore, the harmonized action plan prioritizes key interventions that are already underway for rapid scale up or improvements in programming, to accelerate impact and save lives by 2015.

Focus areas of this plan include:

1. Maximizing RMNCH Weeks and Other Existing Campaigns
2. Essential Medicines Scale-up through Public-Private Sector Partnerships, with emphasis on Malaria, Pneumonia and Diarrheal disease
3. Maximizing Utilization of Existing Primary Health Care Services
4. Maximizing Impact of Community Based Programs
5. Accelerating Access to Life Saving Maternal and Newborn Commodities
6. Health Systems Strengthening (data, monitoring and coordination)

Focus area 1: Maximizing RMNCH Weeks and Other Existing Campaigns

The maternal, neo-natal, child health week (MNCHW) is a platform for immunizing pregnant women and children against killer diseases like polio, hepatitis, measles, and yellow fever. The weeks are intended to ensure that all children under 5 are reached with vaccines and other high impact interventions that are highly effective in reducing child mortality and improving mother and child health. They are organized bi-annually across all 36 states of the Federation and cover different wards, LGAs and health care facilities as determined by the state ministry officials.

Some of the services provided during the MNCH weeks, among others, are vitamin A supplementation, routine immunizations, deworming, screening for malnutrition – and long-lasting insecticide-treated nets. These vaccines/drugs are made available with the combined effort of the state government, National Primary Health Care Development Agency (NPHCDA) and UNICEF.

Given the wide reach of the MNCH weeks, it presents an opportunity for providing additional life-saving commodities and services to mothers and children such as the use of Zinc and ORS for the treatment of diarrhoea, family planning services including long-acting reversible contraceptives and distribution of SPAQ for seasonal malaria chemoprophylaxis.

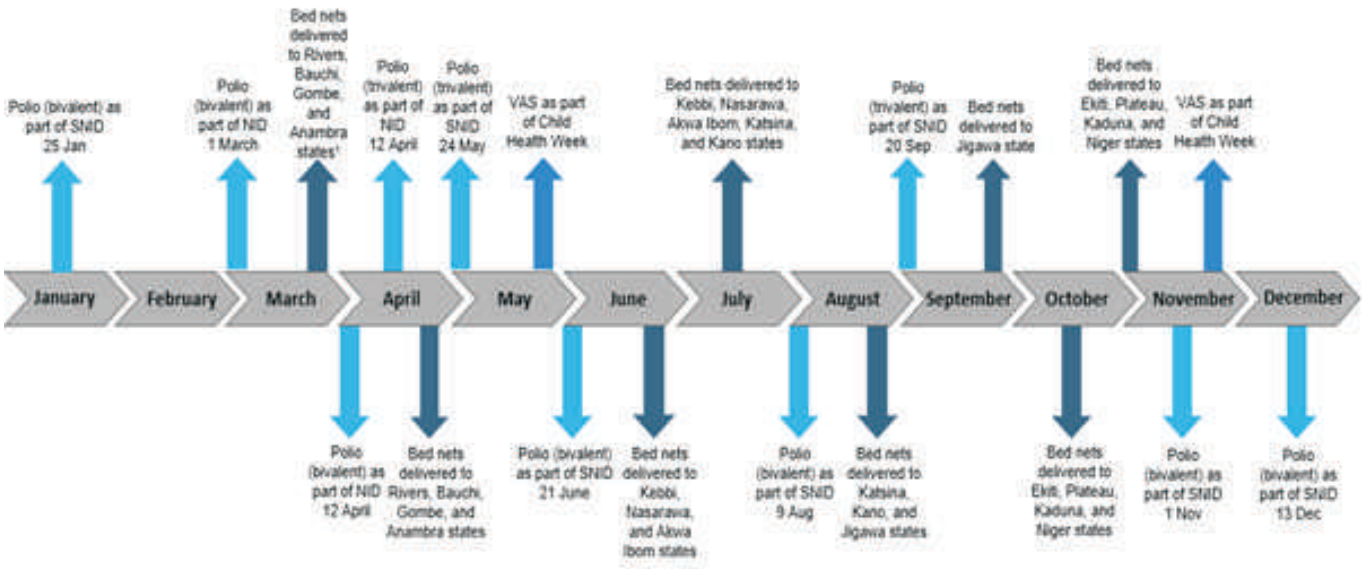
The vaccines campaigns, such as the measles and polio campaigns, also provide a platform for the rapid introduction of the pneumococcal and rotavirus vaccines. To achieve maximum impact, some of the key challenges around resource mobilization, planning, inadequate medicines and supplies at the facilities, need to be tackled, as this address quality of the services provided. Moreover, increasing the number of facilities participating in the MNCH weeks, will lead to a greater coverage and save more lives in a shorter period.

The objectives to maximize the RMNCH weeks include:

1. To improve the quality of RMNCH weeks (and frequency)
2. Increase the coverage of RMNCH weeks
3. Increase the number of essential commodities provided through the RMNCH weeks

Improve data collection and analysis through RMNCH weeks

Annual Calendar of Planned Child Survival Campaign & Outreach Activities in Nigeria



[1] Delivery of bed nets to Rivers, Bauchi, Gombe, and Anambra states from March through April 2014 is contingent upon the World Bank Booster project procurement of an additional 3.4 million LLINs over the initial commitments of 6.4 million.

Data collected on January 28, 2014. Schedules may be subject to change.

Focus area 2: Essential Medicines Scale-up through Public- Private Sector Partnership, with emphasis on Malaria, Pneumonia and Diarrheal Disease

To accelerate progress on MDG4, the Government of Nigeria is driving progress on both the prevention and treatment sides of the three biggest killers of children under 5 – malaria, diarrhoea and pneumonia. The Hib vaccine (one of the five vaccines included in the Pentavalent vaccine has been introduced in almost all Nigeria States and the pneumococcal vaccine is scheduled for introduction by 2014. The Ministry of Health's National Primary Health Care Development Agency (NPHCDA) has prepared and endorsed an Essential Medicines Scale-Up Plan which outlines the actions needed to dramatically reduce child mortality, in the context of expanding integrated Community Case

Management. The Essential Medicines Scale-Up Plan identifies four short-term interventions that will catalyze this transformation (i) Aggressively engaging the public to immediately seek treatment, (ii) Expanding and integrating the provision of treatment at the primary care level, (iii) Rapidly mobilizing private providers to promote effective treatments, and (iv)Partnering with pharmaceutical suppliers to increase affordability and availability.

Implementation of the National Essential Medicines Scale-Up Plan is overseen by a National Coordinating Mechanism (NEMCM) led by the Federal Ministry of Health (FMOH) and the National Primary Health Care Development Agency (NPHCDA).

The NEMCM is composed of the major stakeholders involved in the implementation of the scale-up plan and is responsible for adopting joint partner work plans and M&E frameworks, as well as compiling regular progress reports for NPHCDA and MoH leadership. To date, over $17 million has been committed by donor partners in support of the National Essential Medicines Scale-Up Plan, and an additional $26 million is under negotiation with three additional donors.

Substantial efforts are underway by various partners including CHAI, the SHOPS project, UNICEF to rapidly increase access to Zinc and ORS through the private sector, as well as to strengthen health education and training in the private sector. A lot more still needs to be done to achieve the maximum impact of unlocking the full private sector potential given that over 60% of Nigeria's population seeks health care services outside of the public sector.

The objectives to further accelerate the scale up of essential medicines nationally especially through the private sector especially for malaria, diarrhoea and pneumonia include:

1. Policy and Regulatory improvements
2. Strengthen demand generation efforts
3. Increase availability and affordability of essential medicines

Focus area 3: Maximizing Utilization of Existing Primary Health Care Services

In certain states, penetration and reach of government facilities is relatively high, yet services for women's and children's health are underutilized despite services being free. This could be an area of rapid improvement, if demand and supply are met more effectively. There is growing evidence of the impact of incentives being provided to facilities and health workers a model already being implemented by NPHCDA, SOML, MAF, with the SURE-P programs, and through the World Bank-supported Results Based Financing Program. These existing incentive schemes can be examined and strengthened in the appropriate geographic areas, such as where improved facility level incentives are most likely to generate greater demand for services.

The low use of services is indicated through the low proportion of births in the facilities (36%) and high rate of home births, especially in the Northern region of the country. In order to improve the utilization of primary health care services, providing of – and facilitating demand for – basic and sometimes comprehensive essential obstetric care services in health facilities to treat pregnancy and delivery-

[3] Nigeria Demographic Health Survey 2013 preliminary report

related complications, such as eclampsia, haemorrhage, obstructed labour, sepsis, abortion-related cases, and the other causes of maternal mortality identified earlier. The Government and its development partners have stepped up initiatives to increase the availability of basic emergency obstetric and newborn care (BEmONC) intervention projects across the country. These initiatives need to be further strengthened as outlined in the MAF through ensuring the consistent supply of life saving commodities at the facilities, continuous sensitization of communities and ongoing training and re-training of health care workers.

Objectives to maximize the utilization of existing primary care services include:

1. Increase skilled birth attendance
2. Increase the capacity of HCWs to provide essential delivery of maternal, newborn and child health services

Focus area 4: Maximizing the Impact of Community Based Programs

Nigeria has an extensive network of Community health practitioners which include the CHOs, CHEWs and JCHEWs. For example the polio eradication program alone employs more than 8,000 mobilisers living in communities with the highest mortality rates. These community workers are expected to spend 50% of their time in the communities conducting health promotion activities, and the other 50% of their time in the clinics
providing integrated primary care services. In addition, the NPHCDA has developed a scale-up plan as part of the One Million Community Health Workers Initiative.
Opportunities exist to maximize the impact of community based programmes. A more systematic approach to map out existing large scale CHEW programs, identify and implement strategies for them to maximize the mix of high impact interventions can be explored. In addition, understanding the healthcare seeking behaviours of communities will ensure that interventions can be targeted to make the greatest impact within specific local context.
Objectives to maximize the impact of community based programs include:

1. Develop context-specific strategies to increase health seeking behaviour in the communities
2. Strengthen and operationalize community-based structures
3. Demand generation for MNCH services
4. Strengthen community outreaches through linkage with primary health care facilities

Focus area 5: Accelerated Access to Life Saving Maternal and Newborn Commodities

With an estimated 545 maternal deaths for every 100,000 live births in 2008, according to some estimates, Nigeria contributes about 14% of the global burden of maternal deaths with about 37,000 Nigerian women dying annually from pregnancy-related causes. The obstetric causes of maternal mortality in Nigeria are well documented, and these are largely preventable. They include haemorrhage (23%), maternal sepsis (17%), eclampsia (11%) obstructed labour (11%),

[4] NDHS 2008

complicated/unsafe abortion (11%), anaemia in pregnancy (11%), and others (16%).
Based on Nigeria's local context, the following life-saving commodities were prioritized in the UNCoLSc country implementation plan: oxytocin, misoprostol, magnesium sulfate, female condom, contraceptive implants and emergency contraceptive pill. In addition, Nigeria has also prioritized intra-uterine contraceptive device (IUCD) and sulfadoxine – pyrimethamine (SP) for intermittent preventive treatment of malaria in pregnancy.

In addition, the Maternal and Child Health (MCH) component of SURE-P aspires to contribute to the reduction of maternal and newborn morbidity and mortality, and place Nigeria on track to achieve the 4th and 5th Millennium Development Goals (MDGs). This builds on the Midwives Service Scheme (MSS), which has been funded from the MDG Debt Relief Grant.

Efforts need to be stepped up to ensure that key commodities are available in the communities especially given the high rate of home deliveries, particularly in the Northern part of the country. Community-based delivery mechanisms for misoprostol, chlorhexidene are essential to saving maternal and newborn lives. Other game-changing devices such as the Non-pneumatic anti-shock garments and neonatal resuscitation devices if rapidly scaled up; will further contribute to saving more lives from the major cause of maternal and newborn mortality – postpartum haemorrhage.

Objectives for increasing access to life-saving commodities, especially for PPH include:

1. Policy and Regulatory improvements
2. Increase capacity of HCWs on RMNCH interventions
3. Ensure availability of essential commodities at primary care facilities
4. Increase demand generation for chlorhexidine through the public and private sectors

Focus area 6: Health System Strengthening

Health system strengthening is central to the success of the NSHDP and the accelerated achievement of the Health MDGs. The Federal Ministry of Health has identified this, and work on is underway at Federal, State and LGA Level to gather and track data of the health system in general and health information of public and private facilities. The MAF also has a component dedicated to monitoring and evaluation. A well-functioning, results-based monitoring and feedback system, established as an integral element of implementation management, is central to the success of the MAF Action Plan. In addition, the ICT4SOML effort is focused on four areas, two of which are supply chain management and Health Management Information System (HMIS) improvement. The consortium of partners can be leveraged to scale up already existing programs and enhance efforts, such as those underway at the Department of Research and Statistics in the FMOH.

The MSS remains a strategic intervention because of the recognition that improving the skills of birth attendants in areas with the greatest needs is achievable within a short period. The strategic redistribution of these health workers potentially serves as a model of an effective, realistic and efficient response. It can be adapted to suit the local situation to ensure successful implementation.

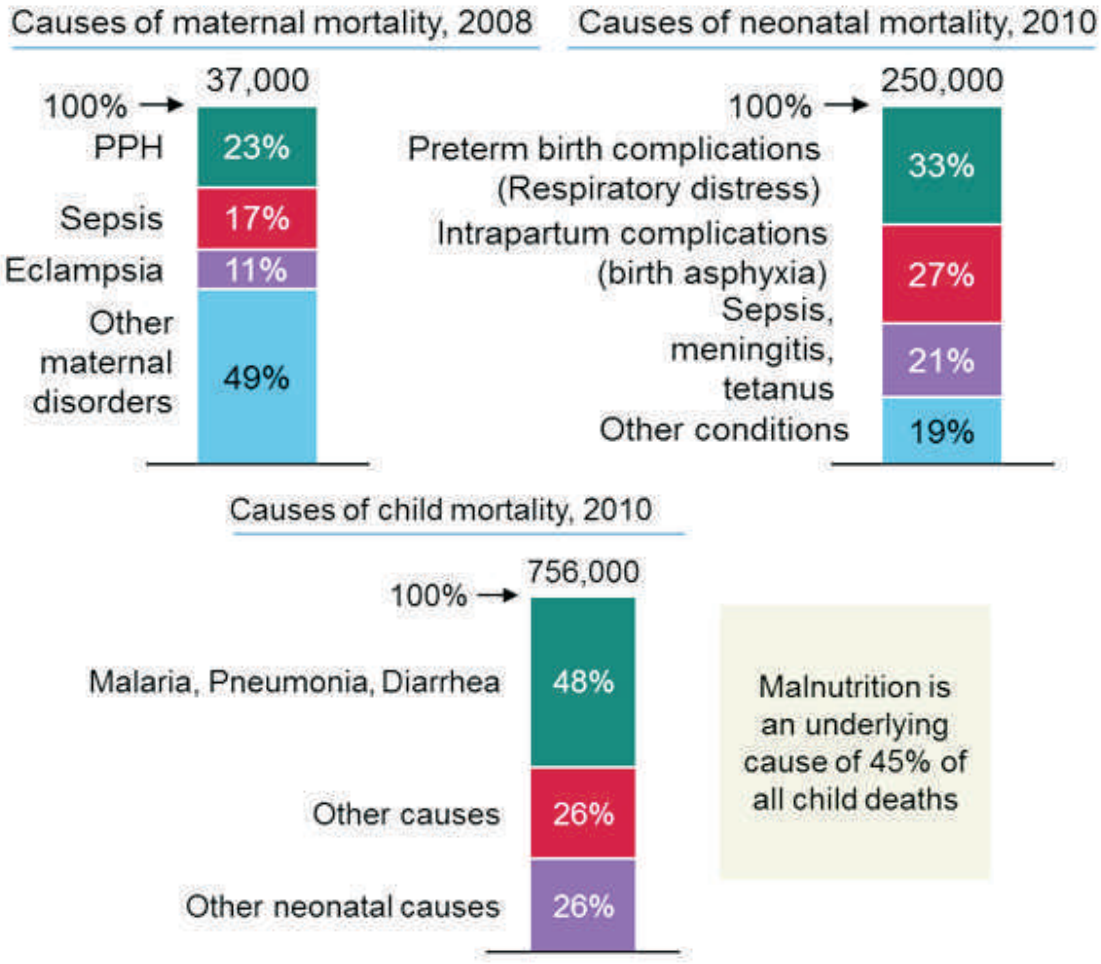
The benefits of the scheme also include raised awareness of the use of SBAs at delivery as a human resource intervention. It has created a platform for the effective implementation of other health interventions, particularly in the rural areas. In addition, the scheme adopted the approach of task shifting in areas where there are issues concerning the retention of the midwives.
In line with the aim of the National HRH policy, the action plan identifies key interventions to ensure that adequate numbers of skilled and well-motivated health workforce are available and equitably distributed to provide quality health services.

Objectives that have been identified to enhance health system strengthening efforts in Nigeria include:

1. Increase facility performance on delivery of essential services
2. Enhance cross-cutting health system development and coordination
3. Increase data utilization and accountability review
4. Provide support for human resources for health

Projected Impact

The key activities identified within these priority areas target the dominant causes of neonatal and maternal mortality with a focus on PPH, eclampsia, preterm birth complications, birth asphyxia and the three major illnesses of childhood mortality: malaria, pneumonia and diarrhoea.



Source: UNCoLSC country implementation plan 2013

In line with the Saving One Million Lives initiative, Nigeria still stands a chance to rapidly make progress towards saving women and children's lives through the consolidated and aligned efforts. Central to the "last push" will be ensuring that committed funds are released in a timely way and implementation is monitored closely at the state and LGA level, with outcome indicators tracked for performance.

By strengthening maternal and newborn service delivery through expansion of the MSS program, availability of commodities and increasing capacity of healthcare workers to provide skilled care services has the potential to save 22,000 maternal lives and 86,000 newborn lives.

Seasonal Malaria Chemoprophylaxis has been included in this plan given the potentially huge impact it can have on reducing malaria incidence among under-5 children. Our estimated impact for SMC scale up in 2014 if we provide treatment to the 9 Sahel states in Northern Nigeria is to avert 5.4 million new malaria cases and save and additional 24, 000 lives.

Introducing the pneumococcal conjugate vaccine in 2014 through 2015 will also contribute to lives saved, adding 40,000 lives saved. Achieving 80% coverage of recommended treatments for childhood diarrhoea, pneumonia, and malaria by 2015 will contribute to saving over 200,000 children's lives in 2015 alone.

Family planning services if scaled up will contribute to at least 62,000 deaths averted by 2015.

Table1. Estimated lives saved by different interventions

Intervention	Additional Lives saved (2015)
Vitamin A supplementation	29000
Routine Immunization	34000
CMAM	8000
Household Ownership of ITNs	91000
Pneumococcal conjugate vaccine	36000
HiB vaccine	27000
ACTs for Malaria	76000
Antibiotics for pneumonia	40000
ORS for diarrhoea	54000
Zinc for diarrhoea	16000
Skilled birth attendance	86000
Maternal health interventions	22000

Specific Activities by Focus Area

In order to achieve the targets for each intervention area that contributes to the MDG goals, Nigeria needs to accelerate specific activities to facilitate the wide-scale implementation of this plan. These activities, most of which are already ongoing, are intended to be implemented in a strategic manner to maximize impact based on local context and sustain gains made in the past. The successful implementation of these activities will be driven at the state and LGA level, and will require close collaboration of the government and its partners to achieve greater coordination of the broader RMNCH effort.

Maximizing RMNCH weeks and Other Existing Campaigns:

1.1. In order to mobilize additional resources from the states and LGAs to increase the frequency and scope of RMNCH weeks, there will be coordinated advocacy to all relevant policy makers in the states. This advocacy will be led by the Honourable Minister of Health and partners will use this plan as an advocacy tool to the states as part of their state engagement work. The advocacy will be geared towards increasing the allocations to the RMCNH weeks by the LGA councils and state governments.

1.2. Resources will be mobilized for increasing the scope of MNCH weeks from donors and partners. Partners will be encouraged to reprogram funds where possible towards supporting campaigns at the state level which will help increase access to essential commodities and services especially for the poor and vulnerable in the communities.

1.3. To raise the awareness of RMNCH weeks, all states will be required to develop specific schedules, in collaboration with LGA councils, for RMNCH weeks to be conducted during the year. This schedule will be collated at the National level and shared with all partners for better coordination of efforts and better planning towards supporting the state-driven weeks.

1.4. Based on the schedules developed for the RMNCH weeks, the states and partners will also engage with CBOs and local NGOs working in the communities to raise awareness about the available services and scheduled for the upcoming weeks. In addition, media campaigns, through radio, TV adverts and posters, and text messages will be used to reach a wide range of people in the communities to create increased awareness.

1.5. To increase the number of people that are reached with the range of services provided during RMNCH weeks, more health facilities in the LGA will be identified as access points for the campaigns and provision of the week-related services.

1.6. Additional funds mobilized for expanding the scope of the RMNCH weeks will be directed towards the purchase of supplies such as Nutrition screening tools, equipment and medicines.

1.7. Services provided through the RMNCH weeks will be increased. Provision will be made to increase access to family planning services, both the short and long acting methods. Ready to use

therapeutic foods will be procured and available for the manage malnutrition identified during the weeks. To further prevent the development of under-nutrition and manage chronic malnutrition, the weeks will be used as a platform to deliver pre-packaged high nutrient-dense foods for children 6 – 23 months of age, pregnant women and lactating mothers. There will be an increased focus on Infant Young Child Feeding (IYCF) activities, and the education of mothers on exclusive breastfeeding and the importance of continued breastfeeding for children aged 6-23 months.

1.8. In order to teach and encourage best practices; Zn/ORS samples, deworming tablets and LLINs will be available for distribution to caregivers through RMNCH weeks.

1.1. Other existing vaccines campaigns such as the measles and polio campaigns will be used for the rapid introduction of new vaccines such as the pneumococcal and rotavirus vaccines which can contribute to significant reductions in mortality from pneumococcal disease and diarrhoea. The PCV is expected to arrive Nigeria in the third quarter of 2014 and can be rapidly introduced across the country by bundling with the measles campaigns.

Critical to the success of bundled services to increase the coverage and effectiveness of the weeks, data needs to be available and utilized for the evaluation of the outcomes. An effective monitoring system will be built to appropriately capture the interventions delivered during the weeks and use the results to improve programming. Data tools will be made available in all the facilities and the LGAs to capture data of all people who visited these facilities through RMNCH weeks, and training will be provided for the appropriate facility staff so that these data are captured properly. Direct support will be provided to the state and LGA officials to improve the data collection process to ensure good quality data is generated and analyzed very quickly. Outcomes of each week will be shared with the facilities, LGAs and states with a feedback loop in place to address challenges to achieving increased effectiveness of the weeks.

Essential Medicines Scale-up through Public- Private Sector Partnership, with emphasis on Malaria, Pneumonia and Diarrheal Disease:

1.1. The development of strategy and materials for national demand generation campaign, provider training, and direct support and incentives to expand supplier promotion and distribution of commodities to strengthen the integrated community case management guidelines for the management of malaria, diarrhoea and pneumonia will be further enhance. These activities will be rolled out in a coordinated fashion to scale up from states where partners have started some implementation activities to more states and full saturation within states.

1.2. While the Ministry of Health has clearly indicated that amoxicillin dispersible tablets should be the preferred first-line treatment option in Nigeria, little progress to date has been in supplying the Nigerian market with this presentation of paediatric amoxicillin. Engagement with the private sector will be continued to develop a local supplier base for dispersible amoxicillin tablets.

1.3. In pursuance of the National Child health Policy's goal and to ensure that public and private providers are in alignment with iCCM guidelines, harmonized training materials will be printed and disseminated. Also locally adapted outreach materials will be developed and disseminated, trainings will be provided to public and private sector to rapidly increase adherence to the iCCM guidelines. Private sector providers such as PPMVs and local pharmacies will be targeted with trainings to improve stocking of essential commodities as well as to increase their capacity to identify danger signs and symptoms of pneumonia in order to refer patients to the hospitals for appropriate care.

1.4. To ensure that Zinc/ORS, malaria drugs and amoxicillin are available in the public and private sectors, procurement and tendering support will be provided to all states to apply best practices and ensure sufficient quantities of these commodities are provided. Part of the engagement with the private sector will include sales expansion strategies to further widen the reach of the local suppliers to get the commodities into rural and remote areas.

1.5. Following successful Seasonal Malaria Chemoprophylaxis (SMC) pilots in Kano state, NAFDAC approval for sulphadoxine Pyrimethamine and amodiaquine (SPAQ) for seasonal malaria chemoprophylaxis (SMC) is being sought and will be expedited in Q1 of 2014 to allow for large-scale roll out of SMC across all 9 sahelian states of the country.

1.6. Targeting the 9 Sahel states with an estimated combined population under-5 of 9 million, At least 36 million doses of SPAQ will be purchased and distributed during the 4 months of the rainy season from July-October, every year. This intervention alone will avert 5.4 million new cases of malaria and potentially save 24,000 lives. This single intervention is projected to be the most transformational intervention to turning the tide against malaria among children under 5. Targeted messages will be delivered in communities for the roll out of SMC, health care workers, local pharmacies and key opinion leaders will trained on SMC and routes of administration.

1.7. To increase access to affordable and quality diagnostics and treatment for malaria, the government will implement a financing scheme to subsidize the costs of the drugs and allow for the coverage of the projected 110 million malaria cases annually, through the use of appropriate medicines. In addition, SPs will also be massively purchased and distributed across all MSS and SURE-P MCH sites for pregnant women.

Maximizing Utilization of Existing Primary Health Care Services:

1.8. Building on the success of the Midwives Service Scheme (MSS), additional 4000 skilled birth attendants will be recruited and deployed to cover additional 1000 facilities by the Federal, State and LGA. In addition to the newly recruited SBAs, the implementation of the mandatory posting of NYSC doctors and nurses to rural areas will be enforced. An incentive scheme will be put in place to increase motivation of healthcare workers posted to rural areas and improve retention, as one of the lessons learned from the MSS.

1.9. The task-shifting policy for CHEWs, which make up the largest cadre of healthcare workers at the primary care level, will be promoted for quick adoption. The modified life-saving skills curriculum which allows CHEWs to administer loading dose of Magnesium sulphate before referral of a woman with eclampsia, and the administration of misoprostol in the communities, will be widely disseminated to ensure that states and partners are implementing according to updated guidelines. In addition, the injectables policy for FP, whereby CHEWs are allowed to administer the injectable contraceptives, will be scaled up from the pilot state to all states in the country.

1.10. To ensure that more tasks can be executed by HCWs (CHEWs and JCHEWs) there will be high level advocacy by Partners to Federal Government to promote and facilitate adoption of task-shifting policy for MLSS and FP for CHEWs.

1.11. There will be a huge focus on capacity building of healthcare workers on core RMNCH interventions. The in-service training model will be adapted to suit the rapid scale up of service provision. Strong mentoring schemes will be put in place, especially for the CHEWs to ensure that TOTs and step down trainings occur at the facility level. Teams of cadres of trainings will be set up to deliver high-impact trainings on the core interventions, including nutrition and cover all facilities in a short period of time. There will also be step down training of key household practices to CORPS. States will also provide health promotion update training to LGA health educators and procure training materials to support trainings for MNCH interventions.

1.12. The Federal Ministry of Health will work with tertiary hospitals to revive the practice of adopting primary healthcare and secondary facilities. This adoption involves the rotation of resident doctors to the PHC and secondary facilities where their specialized skills can be put into practice and save lives, especially in facilities that lack any skilled healthcare worker. The FMOH will encourage the technical backstopping by tertiary hospitals to primary and secondary facilities.

1.13. To reduce the number of deaths in health facilities especially during the first 24 hours of admission, Emergency triage assessment and treatment (ETAT) will be established for Emergency obstetrics and Newborn Care (EMONC) at 2500 health facilities.

Maximizing the Impact of Community-Based Interventions:

1.14. While ANC rates have gone up in the country to more than 60% of pregnant women attending at least one ANC visit, the rate of deliveries in the facilities is unacceptably low at 37%. In a bid to identify key challenges and barriers to uptake of facility-based services in the community an assessment of health seeking behaviours among pregnant women and mothers in the country will be conducted. This assessment will inform the development of context-specific strategies to address identified barriers to uptake of services.

1.15. Identified strategies will be piloted in 6 partner-supported states and FCT to increase attendance and uptake of facility-based services and improve the provision of community-

based care. Resources will be leveraged to implement these strategies at scale.

1.16. In order to strengthen and operationalize community based structures the reactivation of WDCs, VDCs and other community structures, monthly meetings of the WDCs and VDCs and implementation of committee action plans will be supported by states and partners.

1.17. To create demand for RMNCH services, women groups will be engaged at community level (this will be implemented by the states and LGAs), and bi-annual state, LGA and ward-level FGDs for community-based service providers including TBAs on community mobilization and awareness creation on available RMNCH services will be organized. Finally, sensitization and awareness creation meetings will be conducted and RH compact signed with Traditional and religious Leaders as well as CBOs and FBOs.

1.18. A mobile-based system to strengthen the linkage of communities to skilled healthcare workers will be implemented at scale. Technology solutions which leverage use of GSM services will be deployed to facilitate the rapid response of SBAs in community settings and provide Emergency Obstetrics and New born Care (EMONC).

1.19. Linkages with primary health facilities will be strengthened through outreach services in the communities. States will work with partners to: provide community outreaches for the provision of RMNCH services through the PHC system, identify and expand successful Emergency Transport scheme (ETS) in Nigeria focusing on high burden states, design and implement transport strategies to increase access to health care facilities in rural and hard to reach areas.

1.20. Additionally, States will: decentralize ambulances to rural areas, strengthen referral mechanism through improvisation of functional ambulance services, collaborate with NURTW members or community volunteer (Community resource person) to strengthen referral and strengthen two way referral system and tracking of referral through periodic monitoring and evaluation. Transportation is an extremely important component of this plan as it will ensure that complications due to the high rate of home deliveries in the country can be rapidly attended to and women and children can receive quality care at the facilities.

Accelerating Access to Life-Saving Maternal and Newborn Commodities:

1.21. To promote the rapid adoption of the new guidelines on community-based distribution of misoprostol, these guidelines and training curricula will be printed and disseminated. Also the emergency contraceptive pill will be included in the essential medicine list, so that through its free FP program, the federal government can include the emergency contraceptive pill as part of the FP commodities procured for the country.

1.22. Additional training to Nurses, Midwives and Community Volunteers on community based administration of Misoprostol will be conducted across the country. Community Volunteers across all states and LGAs will be trained on the proper identification of PPH, eclampsia, counselling on the management using misoprostol and referral of complications to healthcare

centres. Trained community Resource Persons will be trained to follow up on cases attended to and actions taken to monitor quality of care provided to women delivering at home. Trainings will also be provided to promote exclusive breastfeeding in children less than six months old.

1.23. The use of NASGs in the management of severe PPH will be promoted. While garments will be procured to cover at least 12,000 facilities in the country, a cadre of Master trainers will be trained on the holistic management of PPH in the facility and in the community. Master trainers across all states will be trained on the use of NASGs for prevention and management of shock in PPH and State governments will support the step down of NASG training to primary care centres across the country with focus on high burden states.

1.24. To ensure the availability of essential commodities at primary care facilities, in sufficient quantities, the following will be done: Review of the national quantification of maternal commodities for 2014-2015 by Federal government, state government and partners, procurement and distribution of delivery and MAMA kits for all functional PHCs by the state governments, procurement of NASGs and blood loss drapes for all functional PHCs, States and partners working together to procure essential live-saving commodities for Primary health care. Other essential commodities will be procured jointly by the states, LGAs and partners including FP commodities, maternal commodities, neonatal health commodities (such as resuscitation devices, injectable antibiotics, chlorhexidene) and nutrition commodities for maternal and infant nutrition.

1.25. NPHCDA, States and Partners will work together to procure and distribute essential maternal commodities including contraceptives to all functional PHCs.

1.26. As part of the evidence-based approach to identify a robust supply chain system for the priority life- commodities; there will be implementation of LMIS for essential maternal commodities to track usage of commodities at facility level; logistics systems for stocking and distributing essential drugs will be strengthened; selected PHCs and LGA drug stores will be rehabilitated. Also RI structures will be leveraged for improved supply chain for oxytocin and solar powered refrigerators will be distributed to MCH departments in all MSS and SURE-P facilities as well as appropriately staffed PHCs.

1.27. As a follow up to the catalytic funding received from the RMNCH trust fund to increase the use of chlorhexidene for newborn cord care, there will be a need to build on the market shaping strategy and develop training plans for public and private providers. Trainings for public and private providers on chlorhexidine will be implemented across all states with a focus on states with especially high mortality rates and low facility deliveries. States will procure and distribute 7.1% chlorhexidine digluconate to all public primary health care facilities.

1.28. The use of mobile application to provide refresher trainings to healthcare workers on essential lifesaving skills and for newborn care will be scaled up to cover remote and hard-to-reach facilities across the country.

Health Systems Strengthening (Data, Coordination and Monitoring):

1.29. To increase facility performance on delivery essential services, use of RMNCH scorecards will be scaled up in all states. This will shift focus from inputs and outputs to outcomes. From available data on the NHMIS indicators will be collected on a quarterly basis to compare the performance of facilities within states and performance of states against each other.

1.30. CORPS will be supervised on community based information system and the existing PHC review bottleneck analysis that assesses the performance of the system at the provider level, will be applied in all the states to identify areas requiring immediate attention and implement corrective actions will be used .

1.31. To enhance cross cutting Health system development and coordination, Health care financing processes will be strengthened, tracking of health system performance to provide the evidence-base necessary to improve implementation of health MDG related projects will be facilitated , FMOH's HSSI from 12 LGAs will scaled up and expanded, support will be provided by partners to conduct resource tracking processes and Health sector coordination for increased harmonization and alignment will be streamlined.

1.32. For increased data utilization and accountability review, the following activities will be done: baseline data for core indicators to track health MDGs using existing data, periodic health facility surveys to collect data on service provision and utilization will be conducted, there will be rapid scaling up of DHIS 2.0 platform to all LGAs, also availability of data collection tools for NHMIS at all facilities, LGAs and state M&E offices will be ensured.

1.33. For proper data dissemination, there will be quarterly meetings to disseminate data and progress review by steering committee which will be chaired by the HMH. Also progress report on MDGs disaggregated by states will be shared at the Governor's forum.

1.34. Human resources for health will be focused on in the plan. In line with the HRH strategy, continuing professional development of health staff will be strengthened and supportive supervision of all cadres of health workers will be strengthened. Each LGA will be divided into community nursing /midwifery areas and community nursing/midwifery personnel assigned to these areas for increased skilled care support. Integrated Supportive Supervision for MNCH services will be designed and implemented; the ISS checklist for MNCH will be finalized, printed and disseminated and finally, quarterly ISS visits will be promoted to ensure standard quality of care at facilities will be conducted.

Coordination and Results Tracking

The plan is designed to be state-driven with strong coordination at the National level. Key government and partner leads have been identified for each priority area to coordinate ongoing implementation and tracking of results. The progress will be monitored through the Health Partners Coordinating Committee (HPCC), which meets with the Minister of Health every quarter. Leads will be expected to provide updates on milestones for each quarter as detailed and agreed in the plan. In addition, the States Coordinating Committee for Health, which is a forum where the Minister of Health and all 36 state commissioners of Health plus the FCT meet every 6 months, will be reactivated to monitor progress towards meeting set targets for the identified intermediate outcome indicators.

The implementation of prioritized interventions in this harmonized action plan to achieve health MDGs will be closely monitored and coordinated to ensure maximum impact. This will be done through a coordinating mechanism, hosted by the Department of planning, research and statistics of the Federal ministry of health and chaired by the Honourable Minister of Health. All FMOH departments, agencies and partners will jointly develop quarterly workplans and report on progress every quarter. Health facility surveys and rapid demographic surveys will be conducted for the generation of data which will be used for effective planning and stakeholder coordination.

A scorecard will be developed using 16 intermediate outcome indicators and data will be collected for each state against each indicator. The scorecard will be used as a tool for comparing progress across states and for informing programming decisions to improve service delivery.

Table2. Intermediate outcome indicators for performance management tracking of interventions

	Target population	Intermediate outcomes for regular tracking through 2015	Ultimate outcome
1	Children under 5	Proportion of children with diarrhoea who receive Zinc/ORS treatment	Under- 5 mortality
2	Children under 5	Proportion of children with SAM who receive CMAM services	Under- 5 mortality
3	Children under 5	% of children under 5 with suspected pneumonia receiving appropriate treatment from a health provider	Under- 5 mortality
4	All	% of households with ITNs	Under- 5 mortality
5	Children under 5	Malaria incidence among children under-5	Under- 5 mortality
6	Children under 5	Proportion of 12-23 months-old children fully immunized	Under- 5 mortality
7	Children under 5	% of children 6-59 months receiving Vitamin A supplementation twice a year	Under- 5 mortality
8	Children under 1	% of children under 6 months exclusively breastfed	Infant mortality
9	Pregnant women	% of pregnant women with 4 ANC visits performed according to standards	Maternal mortality

10	Pregnant women	Proportion of births attended by a SBA	Maternal mortality
11	Women of reproductive age	Contraceptive prevalence rate	Maternal mortality
12	Pregnant women and newborn	Proportion of all births in Basic and Comprehensive EmOnC Facilities	Maternal mortality
13	Pregnant women	Proportion of HIV positive pregnant women receiving ARV prophylaxis	Contribution to all mortality indicators
14	Newborns	% of newborns and mothers visited within 72 hours of delivery by a skilled health care provider	Neonatal mortality
15	All	Health facilities experiencing stock-outs of key health commodities (especially Family planning) within the last one month	Contribution to all mortality indicators
16	All	% of federal, state and LGA budget allocated to the health sector and % that goes into RMNCH activities	Contribution to all mortality indicators

Funding Gap Analysis

The total estimated cost of accelerating efforts towards meeting the goals of the health-related MDGs is NGN 104 billion ($650 million). Existing commitments and resources by the Federal governments, state governments, LGAs and partners amount to NGN 41.1 billion ($257 million). Government funds (National and State) account for 30% of committed funds.

The funding gap for the full implementation of the activities as outlined in this plan is NGN62.7 billion ($392 million).

Table3. Funding requirements and existing commitments by priority area

Harmonized action plan - Areas of Focus through 2015	Required budget (USD Mn)	Existing commitments (USD Mn)	Funding gap (USD Mn)
1.Maximizing RMNCH Weeks and other existing campaigns	$176,587,520.0	$111,343,625.0	$65,243,895.00
2.Essential Medicines Scale-up through public-private sector partnerships, with emphasis on malaria, pneumonia and diarrheal disease	$100,362,000.0	$37,875,624.00	$62,486,376.00
3.Maximizing Utilization of Existing Primary Health Care Services	$65,323,324.07	$8,984,305.00	$56,339,019.07
4.Maximize impact of community based programs	$23,393,141.12	$2,550,000.00	$20,843,141.12
5.Accelerated access to Life Saving Maternal and Newborn Commodities	$202,348,863.2	$63,525,000.00	$138,823,863.22
6.Health System Strengthening	$82,063,272.0	$33,402,821.77	$48,660,450.23
Total costs	**$650,078,120.4**	**$257,681,375.8**	**$392,396,744.64**

The costs of coordinating the implementation of the plan have also been estimated for the National level, State and LGA levels. The National Level will comprise of the core team made up of the FMOH (departments and agencies), Development Partners and The Private Sector Health Alliance. Secretariat support will be provided by the FMOH, department of planning, research and statistics. Implementation will occur at the LGA level, and coordination support will be provided to ensure that similar structures are set up at the state level and LGA level to fast track progress to the MDGs in line with the Harmonized Action plan.

The estimated costs for coordination efforts are shown below:

	Required budget (USD Mn)	Existing commitments (USD Mn)	Funding gap (USD Mn)
National Level Coordination	$1,349,010.0	$0 .00	**$ 1,349,010.0**
State and LGA level Coordination	$6,077,400.0	$0.00	**$6,077,400.0**
Total costs	**$7,426,410.0**	**$0.00**	**$7,426,410.0**

Conclusion

Nigeria has developed a plan for the remaining time period to the MDGs deadline to meet the gaps and address the challenges that have hindered progress with the health-related MDGs by focusing and unifying the efforts of Government at all levels as well as development partners and other stakeholders. While not a new plan, the harmonized plan is a call to align activities and resources for the final push to attain the MDG 4 & 5 by 2015. Success in execution of this plan will set the stage for bending the curve and place Nigeria on a path to better health outcomes for its people, post-MDGs. It prioritizes 6 focus areas for increased efforts and resources, and aims to save an additional 420,000 maternal and child lives. While it is a highly ambitious plan, a strong coordination process and performance management tracking will form the basis of successful implementation at the state level.

Full execution of this plan over the next two years, will require $650 million. Existing government and partner resources and commitments towards each of the priority areas amount to approximately $258 million. This results in an estimated funding gap of $392 million over two years.

Nigeria will use this plan as a resource alignment and mobilization tool, starting with Ray Chambers' visit to Nigeria in February 2014. It is hoped that government and donors will aim towards filling the financial gap, to support states and LGAs in the full implementation of the priority interventions and produce results. Results, in the context of this plan, are improvements in the maternal, neonatal, infant and under-5 child health outcomes. Anything short of saving additional lives between now and 2015 will be a significant setback for the country.

Appendix 1. Action Plan – Quarterly Work Plans by Priority Area

o Focus Area 1: Maximizing RMNCH Weeks and Other Existing Campaigns				Timeline							
Objectives	Activities	Milestones/Outputs	Responsible partner	*Q1 '14*	*Q2 '14*	*Q3 '14*	*Q4 '14*	*Q1 '15*	*Q2 '15*	*Q3 '15*	*Q4 '15*
To enhance the quality of MNCH weeks	Advocate to relevant policy makers in the states on MNCH WEEKS	Advocacy visits conducted to all 36 states on MNCH weeks	FMOH/Partners	X							
	Mobilize resources from partners to support the expansion of activities during MNCH weeks in the states	Increased funding commitments secured from partners towards MNCH weeks	FMOH/States		X						
	Work with states to develop annual MNCH weeks schedules and plan in advance	MNCH weeks schedules developed for each state for 2014 and 2015, including participating facilities	States/Partners	X							
	Work with media and community volunteers, Civil Societies, NGOs to increase awareness of MNCH weeks	State-specific strategies to increase awareness of MNCH weeks developed and implemented	States/Partners		X						

To increase the coverage of MNCH weeks	Identify additional facilities at the LGA level to participate in MNCH weeks	Additional facilities to participate in MNCH weeks identified at the LGA level in all states	States/Partners	X							
	Advocate for increased state and LGA allocation to support the additional facilities participating in MNCH weeks	Increased funding commitments and allocations secured from state governments and LGA councils	FMOH/Partners		X						
	Procure additional supplies, equipment and medicines to cover additional sites' expansion for MNCH weeks	Quantification for commodities to be delivered through MNCH weeks finalized	States/Partners	X							
		Essential commodities for MNCH weeks procured and distributed by the states to participating facilities	States/Partners		X			X			
Increase number of essential commodities provided through MNCH weeks	Include the provision of FP services as part of services provided during MNCH weeks	FP services included in MNCH weeks	States/Partners		X		X		X		X

	Procure RUTF and provide CMAM services alongside increased IYCF activities during MNCH weeks	CMAM services included in MNCH weeks	States/Partners		X		X		X		X
	Provide Zn/ORS samples during MNCH weeks to improve behaviours and practices	Zn/ORS samples distributed during MNCH weeks	States/Partners		X		X		X		X
	Promote complementary feeding and continued breastfeeding for children aged 6 - 23 months	Education on complementary feeding and continued breastfeeding for children aged 6-23 months provided during MNCH weeks	States/Partners		X		X		X		X
	Procure and distribute deworming tablets to children under 5 years	Deworming tablets provided to all children under 5 years during MNCH weeks	States/Partners		X		X		X		X
	Procure and distribute LLINs to all caregivers through RMNCH weeks	LLINs distributed to all caregivers during MNCH weeks	States/Partners		X		X		X		X
Improve data collection and analysis from MNCH weeks	Provide timely data collection tools for MNCH weeks such as rapid SMS tool, smart phones	Data tools provided to all facilities participating in MNCH weeks	FMOH/States/Partners		X		X		X		X

	Train end users on the use of the data collection tools and analysis	End-users trained on data collection tools and analysis	FMOH/States/Partners		X			X			
	Provide data analysis support to states for quick turnaround on data	States supported to analyse MNCH weeks' data	Partners		X		X		X		X
	Provide regular feedback from evaluation and periodic review to better inform decision making processes at all levels during weeks	Report of MNCH weeks outcomes shared with policy makers at the LGA, state and National levels	FMOH/States/Partners			X		X		X	
o Focus Area 2: Essential Medicines Scale-up through Public-Private Sector Partnership, with emphasis on Malaria, Pneumonia and Diarrheal Disease				*Q1 '14*	*Q2 '14*	*Q3 '14*	*Q4 '14*	*Q1 '15*	*Q2 '15*	*Q3 '15*	*Q4 '15*
Objectives	Activities	Milestones/Outputs	Responsible partner								
Policy and Regulatory Improvements	Rapidly approve SPAQ for seasonal malaria chemoprophylaxis	SPAQ approved for SMC by NAFDAC	NAFDAC	X							
	Develop and implement financing mechanism for government funded affordable malaria medicines scheme	Government subsidy scheme for increasing access to malaria medicines in the private sector developed	FMOH		X						
		Government subsidy scheme for increasing access to malaria medicines in the private sector implemented	FMOH/Min. of Finance/Partners				X				

Generate Demand for Commodities	Print and disseminate harmonized training materials for public and private providers in alignment with iCCM guidelines	iCCM guidelines and training materials printed and disseminated to all states	FMOH/Partners	X							
	Develop and disseminate locally adapted outreach materials	Locally adapted outreach materials developed, printed and disseminated in the states	States/Partners		X						
	Train private sector providers on iCCM guidelines to rapidly increase access	Training for private providers on iCCM guidelines scaled up to all states	FMOH/States/Partners						X		
	Develop and roll out targeted messages to increase awareness and demand for SMC	Targeted messages to increase awareness of SMC developed and rolled out in 9 sahel states	States/Partners		X						
	Train healthcare workers on SMC administration	Health care workers in 9 sahel states trained on SMC administration	States/Partners		X				X		

Increase Availability and Affordability	Support Public-Sector Procurement and Distribution of essential commodities - Zn/ORS, Amoxicillin	2014 - 2015 State procurement and distribution plans for Zinc/ORS and Amoxicillin completed	States/Partners		X						
	Work with the private-Sector to promote sales and distribution expansion for Zinc and ORS	Sales and distribution strategy developed for accelerated expansion of Zinc and ORS to the whole country	FMOH/Partners		X						
	Provide technical support to manufacturers to reduce costs of locally manufactured essential commodities	Price reduction for locally manufactured Zinc and ORS confirmed	FMOH/Partners		X						
	Work with local manufacturers to establish Amoxicillin Dispersible Tablet supply base	Market shaping and demand generation strategies for Amoxicillin uptake developed	FMOH/Partners/Private sector	X							
		MOU for local manufacture of Amoxicillin DT signed	FMOH/Partners/Private sector				X				
	Procure 24 million doses of sulphadoxine-pyrimethamine +	24 million doses of SPAQ procured for the 9 sahel states	SMOH/Partners		X			X			

	Amodiaquine (SP-AQ)										
	Roll out SMC in 9 sahel states	SMC rolled out in 9 sahel states	SMOH/Partners			Xs				X	
		Evaluation report of SMC roll out in each state prepared and shared	SMOH/Partners				X				X
	Procure and distribute SPs for IPT across all MSS and SURE-P MCH sites for pregnant women	SPs procured for MSS and SURE-P MCH sites	FMOH/NPHCDA	X							
		SPs distributed to all pregnant women attending ANC at MSS and SURE-P MCH sites	NPHCDA/States				X				
o Focus Area 3: Maximizing Utilization of Existing Primary Health Care Services				*Q1 '14*	*Q2 '14*	*Q3 '14*	*Q4 '14*	*Q1 '15*	*Q2 '15*	*Q3 '15*	*Q4 '15*
Objectives	Activities	Milestones/Outputs	Responsible partner								
Increase skilled birth attendance	Recruit and deploy 4,000 additional Skilled Birth Attendants (SBA) to cover additional 1,000 facilities by the Federal, state and local governments	4000 SBAs recruited and deployed to 1000 additional facilities	FMOH/NPHCDA/States					X			
	Facilitate the implementation of the mandatory posting of NYSC Doctors and nurses to rural areas.	NYSC doctors and nurses are posted to rural areas across the country	FMOH/NYSC/States		X		X		X		X

	to rural areas.										
	Facilitate the adoption of task-shifting policy of MLSS and FP for CHEWS	Task-shifting policy for HCWs adopted	FMOH		X						
	Implement retention schemes for HCWs in the rural areas	Retention schemes for HCWs in rural areas implemented	FMOH/States/Partners			X					
	Work with tertiary hospitals to institutionalize technical backstopping to PHCs and General hospitals	PHCs and General hospitals technical backstopping adopted by all tertiary hospitals	FMOH/States		X						
Increase capacity of HCWs to provide essential delivery, of maternal, newborn and child health services	Provide trainings and refresher trainings to HCWs on core MNCH interventions - LSS, ELSS, MLSS, IMCI, FP, CIMCI, CNBC, IYCF, YFHS	National TOTs conducted for core MNCH interventions	FMOH/Partners		X						
	Ensure TOTs and step - down training to states and facilities occur	Zonal and state-level TOTs conducted for core MNCH interventions	States/Partners				X				
	Procure training materials to support trainings for MNCH interventions	Training materials procured for trainings on core MNCH interventions	FMOH/States/Partners	X							

	Ensure the provision of follow-up/supportive supervision to trained HCWs	Trained HCWs followed up with supportive supervision	States/Partners				X				X
	Establish ETAT for Emergency Obstetrics and Newborn Care (EMONC) at 2500 health facilities.	ETAT for EmONc established at 2,500 health facilities across the country	FMOH/States				X				
o Focus Area 4: Maximize Impact of Community Based Programs				*Q1 '14*	*Q2 '14*	*Q3 '14*	*Q4 '14*	*Q1 '15*	*Q2 '15*	*Q3 '15*	*Q4 '15*
Objectives	Activities	Milestones/Outputs	Responsible partner								
Develop context-specific strategies to increase health seeking behaviour in the communities	Conduct an assessment of health seeking behaviors among pregnant women and mothers in the country and Identify key challenges and barriers to skilled birth attendance at the community level	Report on barriers and challenges to skilled birth attendance at the community level prepared and shared	FMOH		X						
	Develop context specific strategies to address bottlenecks that will increase skilled birth attendance at the LGA and community levels	Comprehensive strategy to address bottlenecks and increase SBA attendance at the community level completed	FMOH/States/Partners		X						

	Pilot strategies in 6 partner-supported states (and FCT)	Pilot to increase SBA attendance at the community level commenced	States/Partners				X				
	Mobilize resources to implement strategy at scale	Resources mobilized to implement strategies at scale	States/Partners								X
Strengthen and operationalize community based structures (Ward Development Committee, Village Development Committee)	Support the Reactivation or establishment of the WDCs, VDCs and other community structures	WDCs and community structures reactivated	States/LGAs/Partners		X						
	Work with partners and states to support Monthly meetings of the WDC, VDC	Monthly meetings of WDCs and VDCs held	States/LGAs/Partners			X	X	X	X	X	X
	Support implementation of committee action plans	Committee action plans developed and implemented	States/LGAs/Partners				X				
Demand creation for MNCH services	Engage Women groups at community level on RMNCH issues – To be implemented by State & LGs	Women groups at the community level engaged on RMNCH issues	States/LGAs/Partners		X						
	Promote the use of GSM services (communication) between clients and Skilled Birth Attendants (SBA) on Emergency Obstetrics and Newborn Care (EMONC).	Hotline established for linking clients to SBAs for EmONC care	FMOH/NPHCDA/Partners			X					

	Organize bi-annual state, LGA and ward-level FGDs for community-based service providers including TBAs on community mobilization and awareness creation on available RMNCH services	State, LGA and ward-level FGDs conducted	NPHCDA/States/Partners		X						
	Conduct sensitization/ Awareness creation meetings and sign RH compact with Traditional & Religious leaders, CBO/FBO	RH compact signed with traditional and religious leaders, CBOs and FBOs in the states	NPHCDA/States		X						
Strengthen community outreaches through linkage with primary health care facilities	Work with partners to provide community outreaches for the provision of RMNCH services through the PHC system	RMNCH outreach schedules finalized in the states	States/Partners		X						
	Work with partners to identify and expand successful Emergency Transport Scheme (ETS) in Nigeria focusing on high burden states.	Emergency transport scheme expanded in high-burden states	States/Partners		X						

	Design and implement transport strategies to increase access to health care facilities in rural and hard to reach areas	Strategies to address transportation challenges in rural and hard to reach areas developed and implemented	States/Partners		X						
	Decentralize ambulances to rural areas	Ambulances provided for rural areas	States/LGAs			X					
	Strengthen referral mechanisms through improvisation of functional ambulance services. E.g. Tricycles, Speedboats	Additional functional ambulances purchased and distributed to hard-to-reach areas	States/Partners			X					
	Collaborate with NURTW members or any community volunteer (Community Resource Person) to strengthen referral	Agreement with NURTW to provide adhoc transportation support in rural areas, finalized	FMOH/States		X						
	Strengthen two way referral system and tracking of referrals through periodic monitoring and evaluation	Monitoring and evaluation of two way referral system conducted and report finalized	FMOH/States				X				

o Focus Area 5: Accelerated access to Life Saving Maternal and Newborn Commodities				Q1 '14	Q2 '14	Q3 '14	Q4 '14	Q1 '15	Q2 '15	Q3 '15	Q4 '15
Objectives	Activities	Milestones/Outputs	Responsible partner								
Policy and Regulatory Improvements	Print and disseminate national guidelines on community-based distribution of misoprostol	National guidelines on community-based distribution of misoprostol printed and disseminated	FMOH	X							
	Print and disseminate copies of the MLSS which allows HCWs to administer loading dose of MgSO4 at primary care level before referral	Updated MLSS curriculum printed and disseminated	FMOH	X							
	Include Emergency contraception in essential medicines list	Emergency contraception included in essential medicines list	FMOH	X							
		Emergency contraception included in procurement plan for FP commodities	FMOH			X					

Increase capacity of HCWs on RMNCH interventions	Provide additional training to Nurses, Midwives and Community Volunteers on community based administration of Misoprostol	Nurses, Midwives and community volunteers across all states trained on community-based administration of misoprostol	FMOH/NPHCDA/States /Partners				X				
	Train Community Volunteers across all states and LGAs on the proper identification of PPH, eclampsia, counseling on the management using misoprostol and referral of complications to healthcare centres	Community volunteers trained in all states on identification of pregnancy complications and referral	States/LGAs/ Partners				X				
	Register trained Community Resource Persons and follow up on cases attended to and actions taken to monitor quality of care provided to women delivering at home	Community resource persons registered	States/LGAs		X						
		Community resource persons followed up on cases attended to and care provided to women delivering at home	States/LGAs								
	Train master trainers across all states on the use of NASGs for prevention and management of shock in PPH	Master trainers trained on NASG application in all states	FMOH/NPHCDA/States /Partners		X						

	Support step down of NASG training to primary care centres across the country with focus on high-burden states	NASG trainings stepped down to all PHCs in high-burden states	States/Partners				X				
Ensure availability of essential commodities at primary care facilities	Review national quantification of maternal commodities for 2014 - 2015	National quantification of maternal commodities updated for 2014 - 2015	FMOH/Partners	X							
	Procure delivery and MAMA kits for all functional PHCs	Delivery and MAMA kits procured for all functional PHCs	FMOH/NPHCDA/States /Partners	X							
	Procure NASGs and blood loss drapes for all functional PHCs	NASGs and blood loss drapes procured for all functional PHCs	FMOH/NPHCDA/States /Partners		X						
	Ensure distribution of delivery and MAMA kits through existing channels - MSS, SURE-P MCH, FP	Delivery and MAMA kits distributed to PHCs	NPHCDA/States/Partners			X					
	Work with states to procure essential life-saving commodities for primary health care	Essential life-saving commodities procured and distributed by states	States/LGAs			X					

	Procure and distribute essential maternal commodities including contraceptives to all functional PHCs in collaboration with NPHCDA	Essential reproductive and maternal commodities procured and distributed by the FMOH	FMOH			X					
	Rapidly implement LMIS for essential maternal commodities to track usage of commodities at facility level	LMIS developed for essential maternal commodities	FMOH/Partners		X						
		LMIS rolled out in all states	FMOH/States/Partners				X				
	Strengthen logistics systems for stocking and distributing essential drugs at the state store	Stock and consumption data available for essential commodities at the state stores	States/Partners				X				
	Rehabilitation of Selected PHC Facilities and LGA Drug Stores	Selected PHC facilities and drug stores rehabilitated	NPHCDA/States/Partners				X				
	Leverage RI structures for the improved supply chain for oxytocin	Oxytocin distributed through cold chain system for vaccines	States/Partners				X				

	Distribute solar powered refrigerators to MCH departments in all MSS and SURE-P MCH facilities as well as appropriately staffed PHCs	Solar powered refrigerators procured and distributed to MCH departments in MSS and SURE-P MCH facilities	NPHCDA/Partners			X					
	Develop and implement a strategy to rapidly increase the uptake of NNRDs in primary care facilities and communities	Strategy to increase uptake of NNRDs developed	FMOH/Partners		X						
		Implementation of strategy to increase uptake of NNRDs commenced	FMOH/NPHCDA/States /Partners				X				
Increase demand generation for chlorhexidine use for cord care	Build on market shaping strategy for chlorhexidene to develop training plans for public and private providers	Training plans for demand generation for chlorhexidene developed	FMOH/States/Partners		X						
	Implement training plan for public and private providers for chlorhexidene	Trainings for public and private providers rolled out for chlorhexidene	NPHCDA/States/Partners				X				
	Procure and distribute 7.1% chlorhexidene digluconate to all primary health care facilities	7.1% chlorhexidene digluconate procured and distributed to all primary healthcare facilities	NPHCDA/States/Partners				X				
o Focus Area 6: Health System Strengthening				*Q1 '14*	*Q2 '14*	*Q3 '14*	*Q4 '14*	*Q1 '15*	*Q2 '15*	*Q3 '15*	*Q4 '15*

Objectives	Activities	Milestones/Outputs	Responsible partner								
Increase facility performance on delivery of essential services	Scale up the use of the RMNCH scorecard to all states	RMNCH scorecard developed for states	FMOH	X							
		RMNCH scorecard updated quarterly	States/Partners		X	X	X	X	X	X	X
	Supervision of CORPS on Community Based Information System	Community based data available from states	LGAs/Partners			X					
	Utilize the existing PHC review bottleneck analysis tool to rapidly assess the performance of the system at the provider level, identify areas requiring immediate attention and implement corrective actions	PHC BNA tool applied in all states	States/LGAs/Partners		X						
Enhance Cross Cutting Health System Development and Coordination	Strengthen health care financing processes (revenue allocation and timely release, resource mobilization, pooling, purchasing and efficient utilization of funds, etc)	Timely release of funds for healthcare programming at the state level	States/LGAs					X			

	Facilitate tracking of health system performance to provide the evidence-base necessary to improve implementation of health MDG related projects/programmes and demonstrate results/impact of investments	Health system performance data available for all states	States/LGAs/Partners				X				
	Scale up and Expansion of the FMOH's HSSI from 12 LGAs	HSSI expanded from 12 LGAs to all LGAs	FMOH/Partners		X						
	Support the conduct of resource tracking processes (National Health Account estimation and its sub-accounts, public expenditure reviews/tracking, fiscal space analysis, etc)										
	Streamline health sector coordination for increased harmonization and alignment	State coordinating committee for health reactivated and meeting semi-annually	FMOH		X						

		Health Partners' Coordinating Committee meeting used as platform for reporting on performance indicators	FMOH/Partners		X	X	X	X	X	X	X
Increase data utilization and accountability review	Establish baseline data for core indicators to track health MDGs using existing data sources - NDHS 2013, MICS 2012, NHMIS, vital statistics, SMART survey (*in conjunction with ongoing SOML initiative)*	Baseline data included in RMNCH scorecard for state reporting	FMOH/States/Partners	X							
	Conduct periodic health facility surveys (public and private) to collect data on service provision and utilization	Annual facility surveys conducted	States/Partners				X				X
	Rapidly scale up DHIS 2.0 platform to all LGAs (remaining 360 LGAs)	DHIS 2.0 scaled up to all LGAs	FMOH/NPHCDA/States /LGAs/Partners					X			
	Ensure availability of data collection tools for NHMIS at all facilities, LGAs and state M&E offices	NHMIS tools available at all levels	FMOH/States			X					

	Share progress report on MDGs disaggregated by states at Governors' forum	Progress report on MDGs disaggregated by states shared at Governor's forum	FMOH				X				X
Provide Support for Human resources for health	Work with professional councils to strengthen continuing professional development of health staff	Public health content of CPD courses expanded	FMOH/Professional councils			X					
	Divide each LGA into community nursing/midwifery areas and assign community nursing and midwifery personnel	Community nurses and midwives assigned to nursing/midwifery areas	States/LGAs/Partners		X						
	Design and implement integrated supportive supervisory arrangements	Integrated supportive supervisory scheduled developed and implemented	States/Partners			X					
	Finalize, print and disseminate integrated supportive supervision (ISS) checklist for MNCH	ISS checklist printed and disseminated	FMOH		X						

Appendix 2. Performance Management Tracking

Ultimate Goal: To achieve MDG goals 4 and 5 by December 31st, 2015			
			Targets
S/N	Indicators	Data Sources	***2015***
1	Proportion of children with diarrhoea who receive Zinc/ORS treatment	MICS/HFS/NDHS	80%
2	Proportion of children with SAM who receive CMAM services	SMART/NDHS/MICS	80%
3	% of children under 5 with suspected pneumonia receiving appropriate treatment from a health provider	SMART/NDHS/HFS	80%
4	% of households with ITNs	NARHSS/	100%
5	Malaria incidence among children under-5		5%
6	Proportion of 12-23 months-old children fully immunized	NDHS/MICS/HFS	95%
7	% of children 6-59 months receiving Vitamin A supplementation twice a year	ICS/NDHS/MICS/HFS	100%

8	% of children under 6 months exclusively breastfed	SMART/ICS/NDHS/MICS	50%
9	% of pregnant women with 4 ANC visits performed according to standards	SMART/ICS/MICS/NDHS	80%
10	Proportion of births attended by a SBA	HFS/MICS/NDHS	85%
11	Contraceptive prevalence rate	NHMIS/GPRHCS	30%
12	Proportion of all births in Basic and Comprehensive EmOnC Facilities	Federal and state annual reviews	80%
13	Proportion of HIV positive pregnant women receiving ARV prophylaxis	NDHS/MICS/ NARHSS	90%
14	% of newborns and mothers visited within 72 hours of delivery by a skilled health care provider	NHMIS/MICS/NDHS	50%
15	Health facilities experiencing stock-outs of key health commodities (especially Family planning) within the last one month	NHMIS/GPRHCS	<10%
16	% of federal, state and LGA budget allocated to the health sector and % that goes into RMNCH activities	Federal and state annual reviews	15%

Notes: Prioritized indicators can be obtained through the DHIS 2.0 platform, health facility surveys and special sentinel surveys for which provision has been made in the plan. SMART surveys will also be a source for most of these indicators. The SMART surveys will be conducted in all states and the FCT twice a year from 2014 onwards.

Appendix 3. Financial Requirements and Funding Gap Analysis

		Estimated costs			Existing commitments (2014 - 2015)			
		2014	2015	Total	Government	Partners	Total Available resources	Funding Gap
o Focus Area 1: Maximizing RMNCH Weeks and other existing campaigns				176,587,520.00	$ 38,180,000.00	$ 73,163,625.00	$ 111,343,625.00	$ 65,243,895.00
Objectives	**Activities**				$ -	$ -	$ -	$ -
To enhance the quality of MNCH weeks	Advocate to relevant policy makers in the states on MNCH WEEKS	$ 222,000.00	$ -	222,000.00	$ 600,000.00	$ 1,836,000.00	$ 2,436,000.00	$ -2,214,000.00
	Moblize resources (internal and external) to enhance the quality of MNCH weeks	$ -	$ -	-	$ 60,000.00	$ 5,336,000.00	$ 5,396,000.00	$ -5,396,000.00
	Work with states to develop annual MNCH weeks schedules and plan in advance	$ 185,000.00	$ -	185,000.00	$ 230,000.00	$ 1,886,000.00	$ 2,116,000.00	$ -1,931,000.00
	Work with media and community volunteers, Civil Socities, NGOs to increase awareness of MNCH weeks	$ 5,550,000.00	$ 2,775,000.00	8,325,000.00	$ 290,000.00	$ 1,836,000.00	$ 2,126,000.00	$ 6,199,000.00
To increase the coverage of MNCH weeks	Identify additional facilities at the LGA level to participate in MNCH weeks	$ -	$ -	-	$ -	$ 1,836,000.00	$ 1,836,000.00	$ -1,836,000.00
	Advocate for increased state and LGA allocation to suppport the additional facilities participating in MNCH weeks	$ -	$ -	-	$ -	$ 1,836,000.00	$ 1,836,000.00	$ -1,836,000.00
	Procure additional supplies, equipment and medicines to cover additional sites' expansion for MNCH weeks	$ 37,000,000.00	$ 37,000,000.00	74,000,000.00	$ -	$ 1,836,000.00	$ 1,836,000.00	$ 72,164,000.00
Increase number of essential commodities provided through MNCH weeks	Include the provision of FP services as part of services provided during MNCH weeks	$ 555,000.00	$ 555,000.00	1,110,000.00	$ -	$ 6,836,000.00	$ 6,836,000.00	$ -5,726,000.00
	Procure RUTF and provide CMAM services alongside increased IYCF activities during MNCH weeks	$ 22,200,000.00	$ 29,600,000.00	51,800,000.00	$ -	$ 30,328,000.00	$ 30,328,000.00	$ 21,472,000.00
	Provide Zn/ORS samples during MNCH weeks to improve behaviours and practices	$ 3,000,000.00	$ 3,500,000.00	6,500,000.00	$ -	$ 5,461,700.00	$ 5,461,700.00	$ 1,038,300.00
	Promote complementary feeding and continued breastfeeding for children aged 6 - 23 months	$ 11,544,000.00	$ 11,322,000.00	22,866,000.00	$ -	$ 4,472,700.00	$ 4,472,700.00	$ 18,393,300.00
	Procure and distribute deworming tablets to children under 5 years	$ 17,760.00	$ 17,760.00	35,520.00	$ -	$ -	$ -	$ 35,520.00
	Procure and distribute LLINs to all caregivers through RMNCH weeks	$ 2,960,000.00	$ 2,960,000.00	5,920,000.00	$ -	$ 2,319,225.00	$ 2,319,225.00	$ 3,600,775.00

Improve data collection and analysis from MNCH weeks	Provide timely data collection tools for	$ 740,000.00	$ 925,000.00	1,665,000.00	$ -	$ 1,836,000.00	$ 1,836,000.00	$ -171,000.00
	MNCH weeks such as rapid SMS tool, smart Train end users on the use of the data collection tools and analysis	$ 1,850,000.00	$ 1,850,000.00	3,700,000.00	$ -	$ 1,836,000.00	$ 1,836,000.00	$ 1,864,000.00
	Provide data analysis support to states for quick turnaround on data	$ 111,000.00	$ 148,000.00	259,000.00	$ -	$ 1,836,000.00	$ 1,836,000.00	$ -1,577,000.00
	Provide regular feedeback from evaluation and periodic review to better inform decision making processesat all level during weeks	$ -	$ -	-	$ -	$ 1,836,000.00	$ 1,836,000.00	$ -1,836,000.00
o Focus Area 2: Essential Medicines Scale-up through public-private sector partnership, with emphasis on malaria, pneumonia				$ 100,362,000.00	$ 5,845,000.00	$ 32,030,624.00	$ 37,875,624.00	$ 62,486,376.00
Objective	**Activities**				$ -	$ -	$ -	$ -
Policy and Regulatory Improvements	Adopt a national framework for expanded access to amoxicillin through iCCM	$ 510,000.00	$ 525,000.00	$ 1,035,000.00	$ -	$ 50,000.00	$ 50,000.00	$ 985,000.00
	Work with stakeholders to establish amoxicillin as unambiguous 1st-line pneumonia treatment	$ 25,000.00	$ -	$ 25,000.00	$ -	$ 350,000.00	$ 350,000.00	$ -325,000.00
	Reinforce Zinc/LO-ORS as the first-line treatment for childhood diarrhea	$ 25,000.00	$ -	$ 25,000.00	$ -	$ 450,500.00	$ 450,500.00	$ -425,500.00
	Rapidly approve SPAQ for seasonal malaria chemoprophylaxis	$ 25,000.00	$ -	$ 25,000.00	$ -	$ 2,281,000.00	$ 2,281,000.00	$ -2,256,000.00
Generate Demand for Commodities	Print and disseminate harmonized training materials for public and private providers in alignment with iCCM guidelines	$ 132,000.00	$ -	$ 132,000.00	$ -	$ -	$ -	$ 132,000.00
	Develop and disseminate locally adapted outreach materials	$ 150,000.00	$ -	$ 150,000.00	$ -	$ 215,000.00	$ 215,000.00	$ -65,000.00
	Train private sector providers on iCCM guidelines to rapidly increase access	$ 1,665,000.00	$ 1,665,000.00	$ 3,330,000.00	$ -	$ 6,490,000.00	$ 6,490,000.00	$ -3,160,000.00
	Develop targeted messages to increase awareness and demand for SMC	$ 2,250,000.00	$ 1,350,000.00	$ 3,600,000.00	$ -	$ -	$ -	$ 3,600,000.00
	Train healthcare workers on SMC administration	$ 2,250,000.00	$ 2,250,000.00	$ 4,500,000.00	$ -	$ -	$ -	$ 4,500,000.00

	Support Public-Sector Procurement and Distribution of essential commodities - Zn/ORS, Amoxicillin	$ 1,850,000.00	$ 1,850,000.00	$ 3,700,000.00	$ 5,845,000.00	$ 200,000.00	$ 6,045,000.00	$ -2,345,000.00
	Work with the private-Sector to promote sales and distribution expansion for Zinc and ORS	$ 2,775,000.00	$ 2,775,000.00	$ 5,550,000.00	$ -	$ -	$ -	$ 5,550,000.00
Increase Availability and Affordability	Provide technical support to manufacturers to reduce costs of locally manufactured essential commodities	$ 412,500.00	$ -	$ 412,500.00	$ -	$ 127,458.00	$ 127,458.00	$ 285,042.00
	Work with local manufacturers to establish Amoxicillin Dispersible Tablet supply base	$ 422,500.00	$ -	$ 422,500.00	$ -	$ 156,666.00	$ 156,666.00	$ 265,834.00
	Procure 36 million doses of sulphadoxine-pyrimethamine + Amodiaquine (SP-AQ)	$ 23,040,000.00	$ 23,040,000.00	$ 46,080,000.00	$ -	$ 64,000.00	$ 64,000.00	$ 46,016,000.00
	Roll out SMC in 9 sahel states	$ 13,500,000.00	$ 13,500,000.00	$ 27,000,000.00	$ -	$ 2,561,000.00	$ 2,561,000.00	$ 24,439,000.00
	Procure and distribute SPs for IPT across all MSS and SURE-P MCH sites for pregnant women	$ 2,187,500.00	$ 2,187,500.00	$ 4,375,000.00	$ -	$ 85,000.00	$ 85,000.00	$ 4,290,000.00
o Focus Area 3: Maximizing Utilization of Existing Primary Health Care Services				$ 65,323,324.07	$ 3,864,305.00	$ 5,120,000.00	$ 8,984,305.00	$ 56,339,019.07
	Recruit and deploy 4,000 additional Skilled Birth Attendants (SBA) to cover additional 1,000 facilities by the Federal, state and local governments	$ 5,832,915.00	$ 9,721,525.00	$ 15,554,440.00	$ 1,944,305.00	$ -	$ 1,944,305.00	$ 13,610,135.00
	Facilitate the implementation of the mandatory posting of NYSC Doctors and nurses to rural areas.	$ 5,462,308.61	$ 5,447,308.61	$ 10,909,617.22	$ -	$ -	$ -	$ 10,909,617.22
Increase skilled birth attendance	Promote the adoption of task-shifting policy for HCWs	$ -	$ -	$ -	$ -	$ 1,000,000.00	$ 1,000,000.00	$ -1,000,000.00
	Facilitate the adoption of task-shifting policy of MLSS and FP for CHEWS	$ -	$ -	$ -	$ -	$ 20,000.00	$ 20,000.00	$ -20,000.00
	Implement retention schemes for HCWs in the rural areas	$ 11,520,000.00	$ 15,360,000.00	$ 26,880,000.00	$ 1,920,000.00	$ -	$ 1,920,000.00	$ 24,960,000.00
	Work with tertiary hospitals to institutionalize tehnical backstopping to PHCs and General hospitals	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Increase capacity of HCWs to provide essential delivery, newborn and child health services	Provide trainings and refresher trainings of HCWs on core MNCH interventions - LSS,	$ 189,873.42	$ 189,873.42	$ 379,746.84	$ -	$ 6,700,000.00	$ 6,700,000.00	$ -6,320,253.16
	Ensure TOTs and step-down training to states and facilities occur	$ 3,568,747.35	$ 3,568,747.35	$ 7,137,494.70	$ -	$ -	$ -	$ 7,137,494.70
	Provide step down training of KHHP to CORPS	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	Provide health promotion update training to LGA health educators	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	Procure training materials to support trainings for MNCH interventions	$ 94,936.71	$ 94,936.71	$ 189,873.42	$ -	$ 500,000.00	$ 500,000.00	$ -310,126.58
	Establish ETAT for Emergency Obstetrics and Newborn Care (EMONC) at 2500 health facilities.	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	Ensure the provision of follow-up/supportive supervision to trained HCWs	$ 1,898,734.18	$ 2,373,417.72	$ 4,272,151.90	$ -	$ 600,000.00	$ 600,000.00	$ 3,672,151.90
o Focus Area 4: Maximize impact of community based programs				$ 23,393,141.12	$ -	$ 2,550,000.00	$ 2,550,000.00	$ 20,843,141.12
Objective	**Activities**			$ -	$ -	$ -	$ -	$ -
Develop context-specific strategies to increase health seeking behaviour in the communities	Conduct an assessment of health seeking behaviors among pregnant women and	$ 45,000.00	$ -	$ 45,000.00	$ -	$ 400,000.00	$ 400,000.00	$ -355,000.00
	Develop context specific strategies to address bottlenecks that will increase skilled birth attendance at the LGA and community levels	$ 35,000.00	$ -	$ 35,000.00	$ -	$ -	$ -	$ 35,000.00
	Pilot strategies in 6 partner-supported states (and FCT)	$ 266,517.00	$ 381,265.00	$ 647,782.00	$ -	$ -	$ -	$ 647,782.00
	Leverage resources to implement strategy at scale	$ -		$ -	$ -	$ -	$ -	$ -
Strengthen and operationalize community based structures (Ward	Support the Reactivation or establishment of the WDCs, VDCs and other community	$ 237,341.77	$ 316,455.70	$ 553,797.47	$ -	$ -	$ -	$ 553,797.47
	Work with partners and states to support Monthly meetings of the WDC, VDC	$ 6,000,000.00	$ 9,000,000.00	$ 15,000,000.00	$ -	$ -	$ -	$ 15,000,000.00
	Support implementation of committee	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Demand creation for MNCH services	Engage Women groups at community level on RMNCH issues – To be implemented by State & LGs	$ 1,080,000.00	$ 1,110,000.00	$ 2,190,000.00	$ -	$ 800,000.00	$ 800,000.00	$ 1,390,000.00
	Promote the use of GSM services (communication) between clients and Skilled Birth Attendants (SBA) on Emergency Obstetrics and Newborn Care (EMONC).	$ 18,987.34	$ 18,987.34	$ 37,974.68	$ -	$ -	$ -	$ 37,974.68
	Organize bi-annual state, LGA and ward-level FGDs for community-based service providers including TBAs on community mobilization and awareness creation on available RMNCH services	$ 337,500.00	$ 337,500.00	$ 675,000.00	$ -	$ -	$ -	$ 675,000.00
	Conduct sensitization/ Awareness creation meetings and sign RH compact with Traditional & Religious leaders, CBO/FBO	$ 622,784.81	$ -	$ 622,784.81	$ -	$ -	$ -	$ 622,784.81
Strengthen community outreaches through linkage with primary health care facilities	Work with partners to provide community outreaches for the provision of RMNCH services through the PHC system	$ 75,000.00	$ -	$ 75,000.00	$ -	$ 800,000.00	$ 800,000.00	$ -725,000.00
	Work with partners to identify and expand successful Emmergency Transport Scheme	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	Design and implement transport strategies to increase access to health care facilities	$ 544,030.00	$ 500,000.00	$ 1,044,030.00	$ -	$ -	$ -	$ 1,044,030.00
	Decentralize ambulances to rural areas.	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	Strengthen referral mechanimsm through improvisation of functional ambulance services. E.g. Tricycles, Speedboats	$ 1,107,594.94	$ 1,107,594.94	$ 2,215,189.88	$ -	$ -	$ -	$ 2,215,189.88
	Collaborate with NURTW members or any community volunteer (Community Resource Person) to strengthen referral	$ 99,683.54	$ 132,911.39	$ 232,594.94	$ -	$ -	$ -	$ 232,594.94
	Strengthen two way referral system and tracking of referrals through periodic monitoring and evaluation	$ 9,493.67	$ 9,493.67	$ 18,987.34	$ -	$ -	$ -	$ 18,987.34

Harmonized Country Plan of Priority Interventions for 2014-2015

o Focus Area 5: Accelerated access to Life Saving Maternal and Newborn Commodities				$ 202,348,863.22	$ 16,855,000.00	$ 46,670,000.00	$ 63,525,000.00	$ 138,823,863.22
Objective	**Activities**				$ -	$ -	$ -	$ -
Policy and Regulatory Improvements	Print and disseminate national guidelines on community-based distribution of misoprostol	$ 45,000.00	$ -	$ 45,000.00	$ -	$ 160,000.00	$ 160,000.00	$ -115,000.00
	Print and disseminate copies of the MLSS which allows HCWs to administer loading dose of MgSO4 at primary care level before referral	$ 45,000.00	$ -	$ 45,000.00	$ -	$ 160,000.00	$ 160,000.00	$ -115,000.00
	Include Emergency contraception in essential medicines list	$ 65,000.00	$ -	$ 65,000.00	$ -	$ 150,000.00	$ 150,000.00	$ -85,000.00
Increase capacity of HCWs on RMNCH interventions	Provide additional training to Nurses, Midwives and Community Volunteers on community based administration of Misoprostol	$ 660,960.00	$ 330,480.00	$ 991,440.00	$ -	$ 2,000,000.00	$ 2,000,000.00	$ -1,008,560.00
	Train Community Volunteers across all states and LGAs on the proper identification of PPH, eclampsia, counseling on the management using misoprostol and referral of complications to healthcare centres	$ 4,333,333.33	$ 2,166,666.67	$ 6,500,000.00	$ -	$ 1,000,000.00	$ 1,000,000.00	$ 5,500,000.00
	Register trained Community Resource Persons and follow up on cases attended to and actions taken to monitor quality of care provided to women delivering at home	$ 35,000.00	$ 30,000.00	$ 65,000.00	$ -	$ -	$ -	$ 65,000.00
	Train master trainers across all states on the use of NASGs for prevention and management of shock in PPH	$ 100,000.00	$ -	$ 100,000.00	$ -	$ 600,000.00	$ 600,000.00	$ -500,000.00
	Support step down of NASG training to primary care centres across the country	$ 5,000,000.00	$ 5,000,000.00	$ 10,000,000.00	$ -	$ 600,000.00	$ 600,000.00	$ 9,400,000.00

Ensure availability of essential commodities for the management of PPH at primary care facilities	Review national quantification of maternal commodities for 2014 - 2015	$ -	$ -	$ -	$ -	$ 900,000.00	$ 900,000.00	$ -900,000.00
	Procure delivery and MAMA kits for all functional PHCs	$ 1,661,392.91	$ 1,661,392.91	$ 3,322,785.82	$ -	$ 9,200,000.00	$ 9,200,000.00	$ -5,877,214.18
	Procure NASGs and blood loss drapes for all functional PHCs	$ 1,000,000.00	$ 600,000.00	$ 1,600,000.00	$ -	$ 640,000.00	$ 640,000.00	$ 960,000.00
	Ensure distribution of delivery and MAMA kits through existing channels - MSS, SURE-P MCH, FP	$ 33,333.00	$ 33,333.00	$ 66,666.00	$ -	$ 160,000.00	$ 160,000.00	$ -93,334.00
	Work with states to procure essential life-saving commodities for primary health care	$ 65,667,639.00	$ 65,667,639.00	$ 131,335,278.00	$ 6,000,000.00	$ 9,100,000.00	$ 15,100,000.00	$ 116,235,278.00
	Procure and distribute essential maternal commodities including contraceptives to	$ 7,120,253.16	$ 9,493,670.89	$ 16,613,924.05	$ 10,855,000.00	$ 6,000,000.00	$ 16,855,000.00	$ -241,075.95
	Rapidly implement LIMS for essential maternal commodities to track usage of commodities at facility level	$ 1,834,300.00	$ -	$ 1,834,300.00	$ -	$ 1,600,000.00	$ 1,600,000.00	$ 234,300.00
	Strengthen logistics systems for stocking and distributing essential drugs	$ 2,808,333.00	$ 2,808,333.00	$ 5,616,666.00	$ -	$ 1,000,000.00	$ 1,000,000.00	$ 4,616,666.00
	Rehabilitation of Selected PHC Facilities and LGA Drug Stores	$ 3,000,000.00	$ 3,000,000.00	$ 6,000,000.00	$ -	$ -	$ -	$ 6,000,000.00
	Leverage RI structures for the improved supply chain for oxytocin	$ 750,000.00	$ 750,000.00	$ 1,500,000.00	$ -	$ 200,000.00	$ 200,000.00	$ 1,300,000.00
	Distribute solar powered refrigerators to MCH departments in all MSS and SURE-P MCH facilities as well as appropriately staffed PHCs	$ 381,401.68	$ 381,401.68	$ 762,803.35	$ -	$ 200,000.00	$ 200,000.00	$ 562,803.35
	Develop and implement a strategy to rapidly increase the uptake of NNRDs in	$ 1,520,000.00	$ 1,520,000.00	$ 3,040,000.00	$ -	$ -	$ -	$ 3,040,000.00

Increase demand generation for chlorhexidine from PPMVs and public facilities	Build on market shaping strategy to develop training plans for public and	$ 45,000.00	$ -	$ 45,000.00	$ -	$ 50,000.00	$ 50,000.00	$ -5,000.00
	Implement training plan for public and private providers for chlorhexidene scale up	$ 4,000,000.00	$ 3,400,000.00	$ 7,400,000.00	$ -	$ 550,000.00	$ 550,000.00	$ 6,850,000.00
	Procure and distribute 7.1% chlorhexidene digluconate to all public primary health care facilities	$ 1,800,000.00	$ 3,600,000.00	$ 5,400,000.00	$ -	$ -	$ -	$ 5,400,000.00
o Focus Area 6: Health System Strengthening				$ 82,063,272.00	$ 9,057,821.77	$ 24,345,000.00	$ 33,402,821.77	$ 48,660,450.23
Objective	Activities			$ -	$ -	$ 200,000.00	$ 200,000.00	$ -200,000.00
Increase facility performance on delivery of essential services	Scale up the use of the RMNCH scorecard to all states	$ 150,000.00	$ 150,000.00	$ 300,000.00	$ -	$ -	$ -	$ 300,000.00
	Supervision of CORPS on Community	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	Utilize the existing PHC review bottleneck Based Information System analysis tool to rapidly assess the	$ 11,610,000.00	$ 11,610,000.00	$ 23,220,000.00	$ -	$ 7,000,000.00	$ 7,000,000.00	$ 16,220,000.00
Enhance Cross Cutting Health System Development and Coordination	performance of the system at the provider Strengthen health care financing processes (revenue allocation and timely release, resource mobilization, pooling, purchasing and efficient utilization of funds, etc)	$ 250,000.00	$ 250,000.00	$ 500,000.00	$ -	$ 400,000.00	$ 400,000.00	$ 100,000.00
	Facilitate Tracking of health system performance to provide the evidence-base necessary to improve implementation of health MDG related projects/programmes and demonstrate results/impact of investments	$ 9,250,000.00	$ 9,250,000.00	$ 18,500,000.00	$ -	$ 200,000.00	$ 200,000.00	$ 18,300,000.00
	Scale up and Expansion of the FMOH's HSSI from 12 LGAs	$ 100,000.00	$ 100,000.00	$ 200,000.00	$ -	$ -	$ -	$ 200,000.00
	Support the conduct of resource tracking processes (National Health Account estimation and its sub-accounts, public expenditure reviews/tracking, fiscal space analysis, etc)	$ 300,000.00	$ 300,000.00	$ 600,000.00	$ -	$ 44,000.00	$ 44,000.00	$ 556,000.00
	Streamline health sector coordination for increased harmonization and alignment	$ 350,000.00	$ 350,000.00	$ 700,000.00	$ -	$ 1,576,000.00	$ 1,576,000.00	$ -876,000.00

Increase data utilization and accountability review	Establish baseline data for core indicators to track health MDGs using existing data sources - NDHS 2013, MICS 2012, NHMIS, vital statistics, SMART survey (*in conjuction with ongoing SOML I PDU)*	$ 5,000.00	$ -	$ 5,000.00	$ -	$ -	$ -	$ 5,000.00
	Conduct periodic health facility surveys (public and private) to collect data on service provision and utilization	$ 9,250,000.00	$ 9,250,000.00	$ 18,500,000.00	$ -	$ 1,640,000.00	$ 1,640,000.00	$ 16,860,000.00
	Rapidly scale up DHIS 2.0 platform to all LGAs (remaining 360 LGAs)	$ 4,262,105.33	$ 4,262,105.33	$ 8,524,210.65	$ 4,528,910.89	$ 400,000.00	$ 4,928,910.89	$ 3,595,299.76
	Ensure availability of data collection tools for NHMIS at all facilities, LGAs and state M&E offices	$ 2,923,347.13	$ 2,923,347.13	$ 5,846,694.26	$ 4,528,910.89	$ 200,000.00	$ 4,728,910.89	$ 1,117,783.37
	Establish steering committee chaired by the HMH to conduct quarterly data and progress reviews	$ 18,000.00	$ 20,000.00	$ 38,000.00	$ -	$ -	$ -	$ 38,000.00
	Share progress report on MDGs disaggregated by states at Governors'	$ 25,000.00	$ 25,000.00	$ 50,000.00	$ -	$ 200,000.00	$ 200,000.00	$ -150,000.00

Provide Support for Human resources for health	Strengthen continuing professional development of health staff	$ 316,455.70	$ 316,455.70	$ 632,911.39	$ -	$ 2,261,000.00	$ 2,261,000.00	$ -1,628,088.61
	Strengthen supportive supervision of all cadres of health workers	$ 158,227.85	$ 158,227.85	$ 316,455.70	$ -	$ 1,224,000.00	$ 1,224,000.00	$ -907,544.30
	Divide each LGA into community nursing/midwifery areas and assign community nursing and midwifery personnel	$ 15,000.00	$ -	$ 15,000.00	$ -	$ -	$ -	$ 15,000.00
	Design and implement integrated supportive supervisory arrangements	$ 15,000.00	$ -	$ 15,000.00	$ -	$ -	$ -	$ 15,000.00
	At all levels, provide PPMVs opportunities (training and other) to improve their performance, in line with the PPMV policy	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	Finalize, print and disseminate integrated supportive supervision (ISS) checklist for MNCH	$ 200,000.00	$ 200,000.00	$ 400,000.00	$ -	$ -	$ -	$ 400,000.00
	Conduct quarterly ISS visits to ensure standard quality of care at facilities	$ 1,850,000.00	$ 1,850,000.00	$ 3,700,000.00	$ -	$ 3,000,000.00	$ 3,000,000.00	$ 700,000.00

Grand Total	$ 650,078,120.41	$ 73,802,126.77	$ 183,879,249.00	$ 257,681,375.77	$ 392,396,744.64

Coordination of implementation of plan

National coordination				$ 1,349,010.00	$ -	$ -	$ -	$ 1,349,010.00
State-level coordination support				$ 6,077,400.00	$ -	$ -	$ -	$ 6,077,400.00
Total				$ 7,426,410.00				$ 7,426,410.00

Developing the Harmonized Country Plan of Priority Interventions for 2014-2015: Process Milestones

21 November 2013: Meeting holds between representatives of the Federal Ministry of Health (Director Family Health, Director International Cooperation and others), its Development Partners and representatives of the UNSG's Special Envoy for Financing the Health MDGs and for Malaria (Mr. Alan Court; the team also included Dr. Mickey Chopra (Chief of Health, UNICEF) and Mr. Pascal Bijleveld (Senior Executive Manager, RMNCH Strategy & Coordination Team);

30th November 2013: Aide Memoire is sent to the HMH detailing the outcome of this meeting and listing out the six focus areas for Nigeria's last push to achieving the health MDGs by the end of 2015;
5th December, 2013: The Permanent Secretary for Health, Amb. Sani Bala convenes a meeting to discuss the outcome of the meeting with the representatives of the UNSG's Special Envoy, the six focus areas for the last push to 2015 and to reprioritize the FMOH's MDG Acceleration Framework (MAF) Action Plan for MDG 5 with the Director Family Health, the Director International Cooperation, members of the FMOH's MAF Steering Committee and the MDGs Coordination Branch;
15th to 16th January, 2014: The FMOH holds a retreat to conclude the reprioritization of its health MDGs related activities including those detailed in the MAF Action Plan and align them under the six areas of priority focus of the last push effort, identify amounts and sources of funding as well as funding gaps, giving rise to the draft of the Harmonized Action Plan which would be used as a resource mobilization tool and a coordination framework;

The meeting was chaired by the PSH and participants included FMOH Directors, the MAF Steering Committee, UNICEF, SOML, WHO, UNFPA, NPHCDA, NHMIS, NHIS, HERFON, CHAI, Representatives of the UNSG's Special Envoy for Financing the Health MDGs and for Malaria, among others;
As part of the outcome of the retreat a Committee was set up to review, edit and finalize the draft Harmonized Action Plan (HAP), as well as evaluate the impact of the activities in the Plan. The Committee which was chaired by the Director, International Cooperation included reps from the FMOH's International Cooperation Division and MDGs Coordination Branch, the Department of Family Health, NPHCDA, CHAI, UNICEF, UNFPA, SOML, HERFON and USAID;

17th January, 2014: Draft Harmonized Action Plan document is distributed by email to various stakeholders for their review and input including all departments of the FMOH, the NPHCDA, NHIS CHAI, UNICEF, UNFPA, SOML, HERFON and USAID among others;

24th January, 2014: Inputs are collated and incorporated into the draft Harmonized Action Plan in advance of the Committee's meeting;

25th January, 2014: The Honorable Minister of Health sets up a Committee to prepare for the visit of the UNSG's Special Envoy, with the Permanent Secretary Amb. Sani Bala as its chair. Members were: Director Family Health, Dr. W. Balami, Director Public Health, Dr. B. Okoeguale, Director International Cooperation, Dr. N.R.C. Azodoh, National Coordinator HIV/AIDs Division, Dr. E. Ngige, and the Senior Technical Assistant to the HMH on MDGs, Dr. E. Meribole. The Division of

International Cooperation/MDGs Coordination Branch provided the Secretariat;

27th January, 2014: The Committee to finalize the draft Harmonized Action Plan meets to review the updated plan - priority areas, objectives and activities and finalize the processes for performance management and tracking;

28th – 31st January 2014: The further updated draft Harmonized Action Plan is circulated for the final time to selected stakeholders, input is incorporated, the document is finalized and the first few copies are printed;

3rd February 2014: the UNSG's Special Envoy for Financing the Health MDGs and for Malaria Mr. Ray Chambers arrives Nigeria;

4th February 2014: the HMH formally presents the Harmonized Country Plan of Priority Interventions for 2014-2015 to Mr. Ray Chambers who receives with a commitment to use it as a resource mobilization tool to ensure implementation of the Harmonized Action a Plan. The FMOH thereafter commences next steps and implementation of the Plan. This process is coordinated in the Department of Health Planning, Research and Statistics with the Director International Cooperation as secretary and Head of Secretariat.

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