



**SUMMARY OF COUNCIL'S PROCEEDINGS AT THE  
61<sup>ST</sup> NATIONAL COUNCIL ON HEALTH MEETING  
KANO, KANO STATE  
JUNE, 2018**

**Federal Ministry of Health  
Federal Secretariat  
Abuja 2018**

### SUMMARY OF MEMORANDA FOR THE 61<sup>ST</sup> NATIONAL COUNCIL ON HEALTH MEETING

S/N	TOPICS/ORIGINATOR(S) FEDERAL AND STATES	ISSUES RAISED	NOTES/PRAYERS	NCH TECHNICAL COMMITTEE'S RECOMMENDATION	COUNCIL DECISION
1.	<b>PROCEEDINGS OF THE 60<sup>TH</sup> NATIONAL COUNCIL ON HEALTH MEETING</b>  HONOURABLE MINISTER OF HEALTH NCH/61/001	Consideration and adoption of the Proceedings of the 60 <sup>th</sup> National Council on Health Meeting held in Abeokuta, Ogun State, November, 6 <sup>th</sup> – 9 <sup>th</sup> 2017.	Council is hereby invited to consider and adopt the Proceedings of the 60 <sup>th</sup> National Council on Health meeting held in Abeokuta, Ogun State, November, 6 <sup>th</sup> – 9 <sup>th</sup> 2017.		
2.	<b>IMPLEMENTATION OF THE RESOLUTIONS OF THE 60<sup>TH</sup> NATIONAL COUNCIL ON HEALTH</b>  HONOURABLE MINISTER OF HEALTH NCH/61/002	The status of the implementation of the resolutions of the 60 <sup>th</sup> National Council on Health meeting held in Abeokuta, Ogun State, November, 6 <sup>th</sup> – 9 <sup>th</sup> 2017.	Council is hereby invited to consider and adopt the status of implementation of the resolutions of the 60 <sup>th</sup> National Council on Health meeting held in Abeokuta, Ogun State, November, 6 <sup>th</sup> – 9 <sup>th</sup> 2017.		
<b>STRATEGIC PILLAR ONE: ENABLED ENVIRONMENT FOR ATTAINMENT OF SECTOR OUTCOMES</b>					
3.	<b>THE APPROVAL OF THE SECOND NATIONAL STRATEGIC HEALTH DEVELOPMENT PLAN (NSHDP II: 2017-2021)</b>  HONOURABLE MINISTER OF HEALTH NCH/61/003	<p>The purpose of this memo is to seek Council's approval for the adoption and implementation of the second National Strategic Health Development Plan (NSHDP II) across all levels of government and by all stakeholders in the Health Sector.</p> <p>Background/Development Process</p> <p>2. The implementation of the first plan (2010-2015) was extended at the 58<sup>th</sup> National Council on Health (NCH) meeting pending the completion of the second National Strategic Health Development Plan (NSHDP II). The Honourable Minister of Health thereafter inaugurated a</p>	<p>Council is invited to note that:</p> <ul style="list-style-type: none"> <li>i. The implementation of the first national health plan (2010-2015) was extended by the 58<sup>th</sup> NCH pending the finalisation of the development of second plan (2017-2021);</li> <li>ii. The Honourable Minister of Health inaugurated a TWG to drive the process for development of the plan;</li> <li>iii. A national framework was developed to guide the 36 states, FCT and Federal in the development of their specific plans which was validated by all stakeholders;</li> </ul>		

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		<p>Technical Working Group (TWG) to drive the process for the development of the second plan (NSHDP II: 2017-2021). The membership of the TWG was drawn from stakeholders in the health sector, including the states and FCT. Consequently, a five-stage (5) process was adopted in the development of the second plan and they include the following:</p> <ul style="list-style-type: none"> <li>• Development of a framework;</li> <li>• Development of State and Federal Strategic Health Plans;</li> <li>• Harmonization of the State and Federal Health Plans into a National Health Plan;</li> <li>• Subjection of the National Health Plan to Joint Assessment of National Strategies (JANS); and</li> <li>• National / Sub-National Compacts with Development Partners - Agreement, Negotiation and Implementation</li> </ul> <p>3. The TWG and its sub-committees in collaboration with the consultants held several meetings and came up with a national framework which was validated by national stakeholders to serve as a guideline for the development of States, FCT and Federal specific plans. The progress made on the development of the second National Strategic Health Development Plan (NSHDP II) was presented to update the National Council on Health (NCH) at its 59<sup>th</sup> and 60<sup>th</sup> meetings. At both meetings, Council noted the slow progress and urged the Federal Ministry of Health and particularly the NSHDP II TWG to fast track the completion of the plan.</p>	<p>iv. The 36 States, FCT and Federal used the National framework to develop their specific and costed plans;</p> <p>v. The 36 States, FCT and Federal plans have been harmonised into ONE HEALTH PLAN to be implemented by all stakeholders in the health sector across all levels of governments;</p> <p>vi. The harmonised ONE HEALTH PLAN was validated by all stakeholders;</p> <p>vii. The validated ONE HEALTH PLAN was subjected to Joint Assessment of National Strategies (JANS) facilitated by WHO and certified to meet international standard for implementation by all stakeholders in health sector, including Development Partners;</p> <p>viii. The plan is aligned to the government's Medium Term Economic Recovery and Growth Plan (ERGP);</p> <p>ix. The NSHDP II and its associated 36 States, FCT and Federal plans have a stand-alone Monitoring and Evaluation Plans to track progress in implementation; and</p> <p>x. The plan shall form the basis for:</p> <ul style="list-style-type: none"> <li>• Annual health sector budget development across all levels;</li> <li>• Alignment of Sector-wide Operational Plans (SWAP);</li> <li>• Sector-wide Operational Plan</li> </ul>		

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		<p>Thus, the finalised and costed plans of the 36 States, FCT and Federal were harmonised into one Costed National Plan for implementation in the entire health sector over a five-year period. The harmonised One Health Plan was validated by national stakeholders on 24<sup>th</sup> April, 2018. Thereafter, the plan was subjected to an intensive Joint Assessment of National Strategies (JANS) facilitated by WHO to ensure that the plan meets international standard as well as secure the support of Development Partners and buy-in by stakeholders for collective implementation.</p> <p>NSHDP II Strategies</p> <p>4. The development of the strategies of the second plan took into consideration lessons learned from the implementation of the first plan, changes in global agenda from MDG to SDG, emerging health sector challenges, the National Health Act (2014), the New National Health Policy (2016) and the new government's Medium Term Economic Recovery and Growth Plan (ERGP - 2017).</p> <p>5. The NSHDP II has five (5) Strategic Pillars and Fifteen (15) Priority Areas as follows:</p> <p>Strategic Pillar 1: Enabled Environment for Attainment of Health Sector Goals;</p> <ul style="list-style-type: none"> <li>• Priority Area 1: Leadership and Governance</li> <li>• Priority Area 2: Community Participation</li> <li>• Priority Area 3: Partnerships</li> </ul> <p>Strategic Pillar 2: Increased Utilization of Essential Package of Health Care Services;</p>	<p>Implementation Peer Review;</p> <ul style="list-style-type: none"> <li>• Sector Performance Review</li> <li>• Measuring Results</li> <li>• One-stop shopping list for all Stakeholders - MDAs across all levels, DPs, NGOs, CSO, Private Sectors etc in the Health Sector.</li> </ul> <p>Council is further invited to:</p> <p>i. Approve the second National Strategic Health Development Plan (NSHDP II) and its associated 36 States, FCT and Federal plans;</p> <p>ii. Approve the implementation of the second National Strategic Health Development Plan (NSHDP II) by all stakeholders in the health sector, including Development Partners across all levels of government;</p> <p>iii. Approve that the plan should serve as a blueprint for the entire health sector over the next five years; and</p> <p>iv. Approve the M&amp;E Plans of the NSHDP II and its associated 36 States, FCT and Federal Plans for tracking progress during implementation.</p>		

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		<ul style="list-style-type: none"> <li>• Priority Area 4: RMNCAH +N</li> <li>• Priority Area 5: Communicable Diseases</li> <li>• Priority Area 6: Non-Communicable Diseases</li> <li>• Priority Area 7: Emergency Medical and General Hospital Services</li> <li>• Priority Area 8: Health Promotion and SDH</li> </ul> <p>Strategic Pillar 3: Strengthened Health System for Delivery of EHCP;</p> <ul style="list-style-type: none"> <li>• Priority Area 9: Human Resources for Health</li> <li>• Priority Area 10: Health Infrastructure</li> <li>• Priority Area 11: Medicines, Vaccines, Commodities &amp; Health Technologies</li> <li>• Priority Area 12: Health Information System</li> <li>• Priority Area 13: Research for Health</li> </ul> <p>Strategic Pillar 4: Protection from Health Emergencies and Risks</p> <ul style="list-style-type: none"> <li>• Priority Area 14: Protection from Health Emergencies and Risks</li> </ul> <p>Strategic Pillar 5: Health Financing</p> <ul style="list-style-type: none"> <li>• Priority Area 15: Health financing</li> </ul> <p>The NSHDP II has a total of 15 goals, 48 strategic objectives/targets and 282 interventions from which various specific activities were further drawn.</p> <p>Cost of NSHDP II Strategies</p> <p>6. The second National Strategic Health Development</p>			

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		<p>Plan (NSHDP II) was costed using the One Health Tool in order to:</p> <ul style="list-style-type: none"> <li>• Ensure alignment of all plans with overall national vision;</li> <li>• Streamline approach across all levels;</li> <li>• Ensure that actions/interventions costed were derived from NSHDP II Framework;</li> <li>• Ensure consistency in package of services modeled across all levels;</li> <li>• Ensure adequacy of the HSS capacity for the proposed service coverage;</li> <li>• Consistent cost assumptions (quantities and prices of medicines and supplies) across all levels; and</li> <li>• Generate evidence to support the adoption of the appropriate investment option/policy scenario for the NSHDP II implementation.</li> </ul> <p>7. The cost estimates of the NSHDP II is the aggregate of the 36 States, FCT and Federal Plans which were broken into Health Services and its management Component as well as the Health System Strengthening and their management Components, respectively.</p> <p>The NSHDP II moderate scenario was estimated at the sum of ₦ 6,071B over the five-year period of the plan with an estimated funding gap of 40% and at mean cost per capita of ₦ 10,342. The moderate essential package scenario is expected to achieve the following reduction in mortality outcomes:</p> <ul style="list-style-type: none"> <li>– MMR from 576/100,000 to 400/100,000 Life Birth</li> </ul>			

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		<p>representing a 31% reduction towards the attainment of global target</p> <ul style="list-style-type: none"> <li>– NMR from 39/1,000 to 26/1,000 Life Birth representing a 33% reduction towards the attainment of global target</li> <li>– U-5MR from 120/1,000 to 85/1,000 Life Birth representing 29% reduction towards the attainment of global target</li> </ul> <p>Implementation Plan</p> <p>8. The NSHDP II will henceforth serve as a blueprint for the health sector over the next five years and will be the basis for a number of activities, including:</p> <ul style="list-style-type: none"> <li>• Annual health sector budget development across all levels;</li> <li>• Alignment of Sector-wide Operational Plans (SWAP);</li> <li>• Sector-wide Operational Plan Implementation Peer Review;</li> <li>• Sector Performance Review</li> <li>• Measuring Results</li> <li>• One-stop shopping list for all Stakeholders - MDAs across all levels, DPs, NGOs, CSO, Private Sectors etc in the Health Sector.</li> </ul> <p>Next Steps</p> <p>9. The next step includes:</p> <ul style="list-style-type: none"> <li>• Presentation of the approved NSHDP II to Nigeria Governors Forum for States buy-in to foster implementation;</li> <li>• Presentation of the approved NSHDP II to the</li> </ul>			

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		<p>Federal Executive Council (FEC) for ratification;</p> <ul style="list-style-type: none"> <li>• Signing of Country Compact with Development Partners and National Stakeholders; and</li> <li>• Printing, Launch and Dissemination of the NSHDP II</li> </ul>			
4.	<p><b>ENCOURAGE THE ESTABLISHMENT OF STATE COUNCIL ON HEALTH MEETING</b></p> <p><b>HONOURABLE MINISTER OF HEALTH</b></p> <p><b>NCH/61/003A</b></p>	<p>The purpose of the memorandum is to inform Council on the need for States and Federal Capital Territory to conduct State Council on Health (SCH) meeting annually prior to the National Council on Health meeting.</p> <p>2.0 Introduction</p> <p>2.1 Presently, only a few numbers of the State Ministries of Health and Federal Capital Territory (FCT) Secretariat for Health &amp; Human Services conduct the annual meeting of the State Council on Health (SCH). The meeting which is the highest policy making body on health matters brings together representatives of governments at the State/FCT and LGA levels and is led by the SMOH and its Parastatals. The SCH involves the State Ministries of Health, State Health Institutions/Regulatory Bodies, the Medical Corps of the Military/Paramilitary within the state, Development Partners working on health and health-related projects in the state, Civil Society Organizations/Non-Governmental Organizations and the Organized Private Sector (OPS) in health are invited as observers to the meeting and is chaired by the Honourable Commissioner for Health.</p> <p>2.2 As the apex body responsible for providing policy and strategic direction in the health sector of the States and</p>	<p>The Council is hereby invited to note that:</p> <ol style="list-style-type: none"> <li>The State Ministries of Health and Federal Capital Territory Secretariat for Health and Human Services serve as the apex body responsible for providing policy and strategic direction in the health sector of the states and FCT;</li> <li>The State Ministries of Health and Federal Capital Territory Secretariat for Health and Human Services should provide the platform for dialogue, experience sharing, presentation of progress reports and achievements as well as addressing identified challenges of the health sector;</li> <li>The much needed effective implementation and monitoring of the resolutions of NCH will become seamless and yield the desired results for proper planning and decision making;</li> <li>There is immediate need to mandate the State Ministries of Health and</li> </ol>		



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		<p>Federal Capital Territory, the SCH at each of its meetings, serves as the platform for dialogue, experience sharing and presentation of progress reports and achievements while also addressing identified challenges within the health sector of the States and FCT.</p> <p>3.0 State Council on Health (SCH) Meetings</p> <p>3.1 There is the need to encourage States and FCT to hold their State Council on Health meeting two to three months before the NCH. This will serve as a spring board to the National Council on Health meeting where ideas generated via the various memoranda will feed into the NCH meeting. It is expected that this will foster improved coordination, cohesion and robust relationship among the States, LGAs, Health Partners and other relevant stakeholders within States and FCT as well as entrench ownership, sustainability, strengthened relationship, cooperation and understanding at all levels of government on health care delivery. The much needed effective implementation and monitoring of the resolutions of NCH will also become seamless and consequently yield the desired results for proper planning and decision making.</p> <p>4.0 Composition of the State Council on Health</p> <p>4.1 Membership of the State and FCT Council on Health (SCH) should reflect the composition as contained in the National Health Act 2014 including Local Government Area (LGA) representation.</p>	<p>Federal Capital Territory Secretariat for Health and Human Services to initiate and resuscitate State Council on Health meeting in their respective States;</p> <p>v. Functional State Council on Health meeting, when instituted, will foster improved coordination, cohesion and robust relationship among the States, LGAs, Health Partners and other relevant stakeholders within the State, FCT and at the Federal level; and</p> <p>Council is further invited to approve:</p> <p>i. States and the FCT should be encouraged to convene their respective State Council on Health meeting within two – three months prior to the National Council on Health meeting;</p> <p>ii. States and the FCT should notify the National Council on Health Secretariat each time the State Council on Health meeting is to be convened.</p>		

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5.	<p><b>THE MASTER FACILITY LIST (MFL) AND NIGERIA HEALTH FACILITY REGISTRY (HFR)</b></p> <p><b>HONOURABLE MINISTER OF HEALTH</b></p> <p><b>NCH/61/003B</b></p>	<p>The purpose of this memorandum is to update the Council on progress of the Master Facility List and Nigeria Health Facility registry development.</p> <p><b>INTRODUCTION</b></p> <p>The National Council on Health (NCH) was informed of the development of MFL and HFR at its 60<sup>th</sup> meeting in Abeokuta, Ogun State.</p> <p>The Master Facility List (MFL) is a complete listing of all the health facilities in the country with information on the signature domain (which identifies the health facility by location and unique identifier) and service domain elements (which show the kind of services that are provided by the health facility).</p> <p>The MFL is a dynamic document, which should change as new health facilities are registered and non-viable ones close out. It should also be able to document the upgrade or downgrade of health facilities whether from primary to secondary, secondary to tertiary or vice-versa.</p> <p>However, the Nigeria Health Sector, especially the National Health Information Management System has been using a paper based MFL updated last in 2013. This has been constrained by various challenges including the lack of defined processes and system to facilitate the continuous update of the MFL by the health facility registries in the states and the FCT.</p>	<p>Council is invited to note that:</p> <ol style="list-style-type: none"> <li>A National Health Facility Registry has been developed to ensure seamless updating of health facility list in Nigeria, and provide up-to-date health facility data for decision making</li> <li>The initial population and update of the registry would require the cooperation of all stakeholders, including all the States of the Federation and the Federal Capital Territory.</li> <li>The HFR has been populated with health facility list validated at state level.</li> <li>The guidance document has been developed and states will be contacted for review and provide updates to make it workable in the management of MFL process in States and LGAs.</li> </ol> <p>Council is further invited to:</p> <ol style="list-style-type: none"> <li>Enjoin States and Health Partners to support the rollout of HFR in their respective states and promote its use to manage facility updates;</li> <li>Request States and FCT to allocate resources to the ongoing management of facility list in the States and FCT.</li> </ol>		

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		<p>To address some of the shortcomings associated with the previous MFL, the Federal Ministry of Health with the support of the USAID funded MEASURE Evaluation project developed a Health Facility Registry (HFR). This HFR, an electronic information system, will permit each state to carry out continuous management of the list of health facilities within its jurisdiction. A major objective of HFR development is to enable interoperability with the District Health Information System (DHIS2), the official platform for National Health Management Information System (NHMIS).</p> <p><b>FURTHER ACHIEVEMENTS TO DATE</b></p> <p>The HFR has been populated with a base health facility data that was harvested from multiple health facility lists currently in circulation across the country (including the DHIS2). This list has been validated at state level.</p>			
6.	<p><b>ADOPTION OF THE GUIDELINES FOR PAIN MANGEMENT IN NIGERIA</b></p> <p><b>HONOURABLE MINISTER OF HEALTH</b></p> <p><b>NCH/61/003C</b></p>	<p>The purpose of this memo is to seek the approval of the Council to adopt the Guidelines for Pain Management in Nigeria.</p> <p><b>2. INTRODUCTION/ BACKGROUND</b></p> <p>Pain is a major problem accompanying disease entities, which has either been poorly, under or inconsistently treated or managed in patients. It continues to be a major public</p>	<p>Council is invited to note as follows:</p> <ul style="list-style-type: none"> <li>i. Pain management is a fundamental human right as provided for by international conventions, to which Nigeria is a signatory;</li> <li>ii. This maiden edition of the Guidelines for Pain Management in Nigeria was developed by the Federal Ministry of Health with inputs from key stakeholders</li> </ul>		

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		<p>health issue in Nigeria as it is in other parts of the world.</p> <p>There is no accurate data on the burden of pain and its management in Nigeria. Based on the World Health Organization's estimation of need for palliative care as 1% of a country's total population, Nigeria with a 2014 projected population of 182,867,631 inhabitants, at a 3.2% growth rate would have an estimated palliative care burden of about 1.8 million. This is made up of several thousands of cancer, HIV/AIDS and patients with sickle cell. In Nigeria today, a vast majority of patients with these diseases are living and dying in unrelieved pain.</p> <p>The 2015 report of the International Narcotic Control Board indicated that inadequate knowledge amongst healthcare professionals on rational use of controlled medicines is one of the major barriers militating against proper management of patients in pain. Under-treatment of pain is common in surgical wards, intensive care units, accident and emergency departments, dentistry, general practice, and in the management of all forms of other chronic pain conditions experienced by all age groups from neonates to the elderly. Problem areas related to acute pain include road traffic injuries, burn injuries, labour pain and postoperative pain.</p> <p>It was consequent upon this, that the Federal Ministry of Health in collaboration with relevant stakeholders developed the maiden edition of the Guidelines for Pain Management in Nigeria as part of efforts to ensure all patients with pain receive the highest quality care within a framework of ethics</p>	<p>and the support of the United Nations Office on Drugs and Crime (UNODC);</p> <p>iii. The Guidelines was adopted and validated by the stakeholders at a town hall meeting held in Abuja in November, 2017; and</p> <p>v. Implementation of the Guidelines for Pain Management in Nigeria will increase the utilization of, and access to standard pain treatment options and care in Nigeria.</p> <p>Council is further invited to approve:</p> <ul style="list-style-type: none"> <li>The adoption and subsequent implementation of the Guidelines for Pain Management in Nigeria in all the 36 States of the Federation and the FCT.</li> </ul>		

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		<p>and respect for human rights.</p> <p>3. <u>CONTENT</u></p> <p>The Guidelines for Pain Management in Nigeria is developed to provide informed guidance to healthcare practitioners in their management of pain in all categories of patients requiring pain relief. The key objectives are to:</p> <ol style="list-style-type: none"> <li>Provide all healthcare practitioners with standard of practice that will assist them in the effective assessment, treatment and monitoring of pain;</li> <li>Increase the utilization of, and access to standard pain treatment options and care in Nigeria</li> <li>Ensure all patients with pain receive highest quality care within a framework of ethics and respect for human rights.</li> </ol>			
7.	<p><b>APPOINTMENT OF COMMITTEE MEMBERS FOR EMERGENCY MEDICAL TREATMENT, AND OPERATIONALIZATION OF EMERGENCY MEDICAL TREATMENT, EMS POLICY AND GUIDELINES FOR NATIONAL AMBULANCE SERVICES</b></p> <p><b>HONOURABLE MINISTER OF</b></p>	<p>The purpose of this memorandum is to seek Council's approval of the recommended list of Committee members in line with NHAct 2014, Section 11, Sub-Section 3 (e) which states that "5 percent of the Fund shall be used for emergency Medical Treatment to be administered by a Committee appointed by the National Council on Health"</p> <p>1. <u>BACKGROUND</u></p> <p>The National Policy on Emergency Medical Services and Operational Guidelines for National Ambulance Services</p>	<p>The Council is invited to note as follows:</p> <ol style="list-style-type: none"> <li>The National Policy on Emergency Medical Services and Operational Guidelines for National Ambulance Services have been successfully launched on the 1<sup>st</sup> of February, 2018 at the NAF Conference Centre, Kado, Abuja, in the presence of all stakeholders on EMS in Nigeria.</li> <li>There was a follow-up stakeholder meeting to tease out implementation strategies of</li> </ol>		

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	HEALTH NCH/61/003D	<p>were successfully launched on 1<sup>st</sup> February, 2018 at the NAF Conference Centre, Kado, Abuja, followed by a 2-days stakeholder.</p> <p>The aim of the stakeholders meeting, which followed suit, was to bring together actors in emergency responses in Nigeria, and to deliberate on the implementation strategies of the policy documents and fashion a way forward for a coordinated, seamless, effective and efficient emergency services for the Nigerian health system.</p> <p>The implementation of the National Policy on Emergency Medical Service and of the Ambulance Service in Nigeria is expected to drive the creation of a regulated and coordinated Emergency care from pre-hospital to the hospital and then the post-hospital rehabilitative care. The components of the care system include, but not limited to trained emergency personnel, emergency communication systems, emergency ambulance system, minimum required infrastructure and equipment at receiving facilities and an efficient financing framework (funding mechanism).</p> <p>The Federal Ministry of Health has started implementation of EMS system by mapping emergency medical facilities and resources along the main highway corridors in the country. This began with the Abuja/Kaduna highway and, Abuja/Lokoja/Benin highway corridors. Gaps were noted and would be closed for the purpose of providing seamless coverage for emergency service at full implementation.</p>	<p>the national policy on EMS and Guidelines for Ambulance Services.</p> <p>iii. All the Commissioners of Health, and the Secretary of HHS were part of the stakeholders meeting</p> <p>iv. A Communique was issued after the Stakeholders meeting- the Abuja Declaration on EMS.</p> <p>v. The NHAct 2014, Section 11, Sub-Section 3 (e) states that "5 percent of the Fund shall be used for emergency Medical Treatment to be administered by a Committee appointed by the National Council on Health"</p> <p>vi. The proposed composition of the Committee for the Council's Adoption is as in para 8 of this memo.</p> <p>vii. An EMS Fund Account to be opened for the purpose of Managing the 5% of the 1% BHCF, and all other funds of EMS in Nigeria domiciled in FMOH.</p> <p>viii. Dr Nnamdi E. Nwauwa is recommended to chair the Committee</p> <p>and</p> <p>b). Council is further invited to approve:</p> <p>i. The Emergency Medical Services Implementation Plan as in para 3 above.</p> <p>ii. Creation of an EMS Fund Account to be opened for the purpose of Managing the 5% of the 1% BHCF, and all other funds of EMS in Nigeria domiciled in FMOH.</p>		

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		<p>2. <u>CONTENT</u></p> <p>i. Implementation of EMS and Ambulance Service Program entails database development, Information on capacity and capabilities of stakeholders, including assets of all registered health facilities and agencies providing emergency services in States and FCT. Other parameters to be gathered, includes address of facilities, location, phone numbers, human and material resources and number of serviceable ambulances, and type of Ambulance services in operation. The cooperation of States, FCT and Agencies involved is vital to achieving the set objectives.</p> <p>ii. The Committee members, if appointed, are expected to see to the coordination and regulation of EMS activities in Nigeria, ensuring prompt payment of medical emergencies treatment across the Country. Some of the other tasks of the Committee shall include:</p> <p>a) Production of a comprehensive records of Facility Inventory: Highway EMS Corridor map of Nigeria, Inventory of ambulances, Ambulance Service operators (both Government and privately owned) all over the nation, identification of coverages (whether National, Regional, States or LGA), manpower capacity, equipment capability and service types. All registered ambulances are to operate within the guidelines as approved.</p> <p>b) Personnel Resource and Development: To identify training needs and standard training programme, including creating a standard operating protocols (SOP), supervision template, evaluation and</p>	<p>i. The Appointment of Dr Nnamdi E. Nwauwa as the chairman of the Emergency Medical Treatment Committee.</p> <p>v. The appointment of the Emergency Medical Treatment Committee (EMTC) list as submitted</p>		

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		<p>monitoring of training schools, Sanctions and Reward systems.</p> <p>c) Registration of service providers such as health facilities, Ambulance services, Partner Service Providers, and to identify and also designate hospitals and health facilities for patient referrals.</p> <p>d) Funding and Payment mechanism: The committee is to manage the EMS Fund, and also work out the sources of funding as well as management of the funds for efficient service delivery. It will also propose for Minister's</p> <p>e) approval a payment modality for services provided within the EMS system.</p> <p>f) The Committee to function as a board to be chaired by an experienced Medical Practitioner, having not less than 10-years experiences as practitioner of Emergency medical services. The Board is to ensure full compliance with all the provisions of the National Health Act 2014, especially, Section 20 dealing with the provision of Emergency Medical Services.</p> <p>g) The committee will ensure the full implementation of the National Policy on Emergency Medical Services and Guidelines for Ambulance Services under the directives of the Honourable Minister of Health.</p> <p>h) An EMS Fund Account to be opened for the purpose of Managing the 5% of the 1% BHCF, and all other funds of EMS in Nigeria domiciled in FMOH.</p> <p>The proposed composition of the Committee for the Council's Appointment is: -</p> <ul style="list-style-type: none"> <li>• A Chairman, Nominated by the Honourable Minister of Health</li> <li>• The State Commissioners of Health: one from each Geopolitical Zones.</li> </ul>			



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		<ul style="list-style-type: none"> <li>• The Federal Ministry of Information and Culture, represented.</li> <li>• The Federal Ministry of Finance, represented.</li> <li>• National Emergency Management Agency</li> <li>• Nigerian Centre for Disease Control (NCDC)</li> <li>• Federal Road Safety Corps (FRSC), represented.</li> <li>• The Nigerian Police Force, represented.</li> <li>• Nigerian Security and Civil Defence Corps (NSCDC), represented.</li> <li>• Federal Fire Service (FFS), represented.</li> <li>• The Chairman, Committee of Chief Medical Directors of Federal Tertiary Hospital</li> <li>• The President, Association of General and Private Medical Practitioners of Nigeria</li> <li>• The President, Guild of Medical Directors</li> <li>• Nigeria Communication Commission (NCC), represented.</li> <li>• The National Union of Road Transport Workers (NURTW)</li> <li>• The Country Director, UNDASTIP</li> <li>• A Diaspora Emergency physician</li> <li>• Association of Medical Social Workers of Nigeria (AMSWON)</li> <li>• Director of Hospital Services -Member/Secretary.</li> </ul>			
8.	<b>APPROVAL AND IMPLEMENTATION OF NATIONAL EAR CARE PROGRAMME</b>  <b>HONOURABLE MINISTER OF HEALTH</b>	<p>The purpose of this memorandum is to seek Council's approval for the adoption and implementation of a National Ear Care Programme and Provision of free Hearing Aids to Public School Students in Nigeria towards a Strengthened Health System for Delivery of Essential Health Care Services.</p> <p>INTRODUCTION</p>	<p>Council is hereby invited to note that:</p> <ul style="list-style-type: none"> <li>• There is currently no existing National Strategic Health Policy on the improvement of hearing healthcare services in Nigeria;</li> <li>• With a fast-growing national population estimated at 180 million people, there is only one Federal Ear care Centre which</li> </ul>		

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	NCH/61/003E	<p>2. Background</p> <p>Hearing impairment is a silent disability with varying degree of severity ranging from mild to profound hearing impairment. An impairment in hearing, whether permanent or fluctuating, can adversely affect a child's educational performance.</p> <p>According to the World Health Organization, approximately 360 million people globally suffer from disabling hearing loss, out of which 328 million are adult and 32 million are children under the age of 15 years. This report further states that about 60% of these cases are due to preventable causes ranging from wax impaction to Otitis media in children. Over 80% of those living with hearing loss live in low and middle-income countries. In Sub-Saharan Africa, the prevalence of hearing loss in children has been estimated at 1.9% (Mulwafu, Kuper &amp; Ensink, 2016).</p> <p>In Nigeria, there is a dearth of literature on the prevalence of hearing loss. However, it has been estimated that Nigeria has about 3.5 million children with hearing loss and 75% of these cases are of preventable causes.</p> <p>3. Situation Analysis</p> <p>Due to the alarmingly disturbing statistics, Starkey Foundation seeks to reflect care and improve lives around the world by providing the gift of hearing to people who live in a silent world. Starkey Hearing Foundation (SHF) is a U.S based non-governmental organization founded by William F. Austin since 1984 with a vision "so the world would hear" as a counteraction against the increasing burden of hearing loss</p>	<p>is grossly insufficient;</p> <ul style="list-style-type: none"> <li>• There is lack of statistical analysis to support the level of morbidity associated with hearing impairment; and</li> <li>• There is need to institutionalize public health interventions towards reducing the prevalence of hearing loss in Nigeria.</li> <li>• That the Starkey Hearing Foundation has proposed to collaborate with the FMOH to conduct a hearing impairment Screening Programme for One Million School Children in Nigeria and this screening will serve as a baseline for identifying and correcting hearing impairment.</li> </ul> <p>Council is further invited to approve:</p> <ul style="list-style-type: none"> <li>• Development of a National Ear Health Policy and a National Strategic Plan for Ear Care towards improving hearing health services in Nigeria;</li> <li>• A National Ear/Hearing Screening Programme for public school children in Nigeria (2 million ears in 12 months) in collaboration with the Starkey Hearing Foundation;</li> <li>• The provision of free Hearing Healthcare services with hearing aids; and</li> <li>• Training of Hearing Healthcare workers by Starkey Hearing Foundation across</li> </ul>		

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		<p>across the globe. The Foundation has successfully carried out community-based hearing health programmes in 59 low and middle-income countries using WHO training resources on primary ear and hearing care as well as other standardized manuals.</p> <p>In Nigeria, Starkey Hearing Foundation has worked in partnership with Olusegun Obasanjo Foundation as well as six state Governments. These programmes have benefitted approximately 5,000 persons amongst which 4,000 of them were fitted with free hearing aids.</p> <p>In line with the resolutions of the World Health Assembly May 2017 on the prevention of deafness, Starkey Hearing Foundation has proposed to collaborate with the Federal Ministry of Health to conduct a Screening Programme for One Million School Children. This Screening programme for children is to serve as a baseline assessment to:</p> <ul style="list-style-type: none"> <li>• Identify the level of hearing impairment among school children in Nigeria;</li> <li>• Prevent hearing loss amongst children in Nigeria;</li> <li>• Identify the number of children suspected to be at risk of developing a hearing loss; and</li> <li>• Early detection of children already suffering from Educationally Significant Hearing Loss (ESHL).</li> </ul> <p>The Screening exercise would involve ear and hearing screening, while children identified to require primary ear and hearing services will be attended to immediately and those needing secondary and/or tertiary ear care would be referred</p>	the States.		

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		<p>appropriately.</p> <p>4. ISSUES AND JUSTIFICATION</p> <p>Hearing loss is an invisible health condition which as a result makes it under-treated and may result in a lifelong condition. Reports have shown that hearing impairments in children places them at risk of developing psychological problems, academic underachievement, and limited employment opportunities etc. all of which lead to a decline in the standard of living experienced. (Ciorba 2012; Hogan 2013; WHO 2016)</p> <p>It is alarming to know that the increasing number of people suffering from varying forms of hearing loss and how it affects their ability to carry out simple day-to-day activities. There is a need for Nigeria to actively play her part towards achieving the vision of the World Health Organization of having a world in which no person experiences hearing loss due to preventable causes and those with unavoidable hearing loss can achieve their full potential through appropriate interventions, education and empowerment.</p>			
9.	<p><b>ADOPTION OF THE NATIONAL CANCER CONTROL PLAN 2018-2022 AND ITS IMPLEMENTATION STRATEGIES</b></p> <p><b>HONOURABLE MINISTER OF HEALTH</b></p> <p><b>NCH/61/003F</b></p>	<p>The purpose of this memorandum is to notify Council of the development of the 2018 – 2022 Nigeria Cancer Control Plan (NNCCP) in line with WHO's global action plan for the prevention and control of NCDs and to seek Council's approval for its adoption and implementation in all the 36 States of the Federation and the FCT.</p> <p>2. <u>BACKGROUND</u></p> <p>Nigeria has one of the highest cancer related mortality incidence ratios in the world with 72,000 deaths for every of</p>	<p>Council is invited to note as follows:</p> <ul style="list-style-type: none"> <li>i. This is the first plan since the expiration of the 2008-2013 National Cancer Control Plan (NCCP);</li> <li>ii. The NCCP and its strategies of implementation were developed by the Federal Ministry of Health with inputs from relevant stakeholders both locally</li> </ul>		

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		<p>102,000 new cases recorded annually. This translates to 70% mortality incidence, or eight people dying of cancers every hour in Nigeria.</p> <p>Cancer though sometimes preventable, continues to remain a major cause of mortality and morbidity in the country, with scientific data acknowledging the fact that 40% of cancers are preventable, 40% are treatable whilst a further 20% are incurable. The Nigeria cancer environment is characterized by late presentation, high cost of treatment, low access to treatment and poor treatment outcomes. A huge factor heralding these negative mortality ratios is the delayed access to treatment that results in 80-90% of cancer cases presenting for treatment at advanced stages of the disease. .</p> <p>From the forgoing it is imperative that there should be a plan of action, on how to structure and channel the efforts of Government, and Non-Governmental organisations, spelling out targets and implementation strategies on how the country would tackle the scourge of cancer in Nigeria over the next five years and beyond.</p> <p>3. <u>CONTENT</u></p> <p>i. The National Cancer Control Plan explains practical methods required to reduce the incidence and prevalence of cancer in Nigeria.</p> <p>ii. The plan outlines the strategies required to reduce exposure to risk factors; establish a framework to ensure access to cancer screening, care and improved quality of life for people affected by cancer.</p>	<p>and internationally as part of efforts to address the core issues around cancer control;</p> <p>iii. The development of the plan is in line with the provisions of the WHO's 2013-2020 global action plan for the prevention and control of Non-Communicable Diseases (NCDs);</p> <p>iv. The Plan was validated and adopted by stakeholders in a stakeholder's meeting held in Abuja in August, 2017; and</p> <p>v. The Plan will restructure and standardize Cancer control efforts of Government and Non-Governmental efforts in the country.</p> <p>Council is further invited to approve:</p> <p>i. The adoption and implementation of the 2018-2022 National Cancer Control Plan (NCCP) in all the 36 States of the Federation and the Federal Capital Territory (FCT);</p> <p>ii. The adoption and adaptation of the implementation Strategies of the Plan at the Federal and States of the Federation and</p>		

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		iii. The NCCP document articulates a complete framework on how to make screening services and early detection of cancers available for all Nigerians, improve access to quality care, ensure the availability of cost effective and equitable diagnostic and treatment services and to achieve the best possible quality of life for patients and families facing terminal cancers.	the FCT; and  iii. Make appropriate budgetary provision for the implementation of the strategies at federal and state levels.		
10.	<b>THE REVISED IMPLEMENTATION GUIDELINES FOR PRIMARY HEALTH CARE UNDER ONE ROOF (PHCUOR)</b>  <b>HONOURABLE MINISTER OF HEALTH</b>  <b>NCH/61/003G</b>	<p>The purpose of this memorandum is to inform Council on production of revised implementation guidelines for Primary Health Care Under One Roof (PHCUOR) by the National Primary Health Care Development Agency, and to seek Council's approval for its implementation by the States and the FCT.</p> <p>INTRODUCTION</p> <p>NPHCDA developed, printed and distributed the Management (Implementation) Guidelines for Primary Health Care Under One Roof (PHCUOR) in June 2016 to guide all the 36 States and FCT. However, feedback from the State Primary Health Boards (SPHCBs) and partners indicated that there are gaps and omissions which should filled to enhance the effective use of the guidelines to provide the required guidance for the implementation of PHCUOR at State and LGA levels.</p> <p>After extensive discussions on Implementation of PHCUOR, a resolution was made to carry out a comprehensive review</p>	<p>Council is invited to note that:</p> <p>i. The National Primary Health Care Development Agency has successfully revised the June 2016 edition of the Implementation Guidelines for PHCUOR; and</p> <p>ii. Copies of the newly revised guideline for information to fast track the effective implementation of PHC in Nigeria are available.</p> <p>Council is further invited to approve that all the Commissioners of Health and Executive Secretaries of SPHCBs should use the guidelines for implementation of Primary Health Care Under One Roof in their various States and the FCT.</p>		

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		<p>of the June 2016 edition of the Implementation Guidelines for Primary Health Care Under One Roof (PHCUOR) and fill all identified gaps and reflect current realities.</p> <p>Identified gaps that led to the revision of Implementation Guideline for PHCUOR include:</p> <ul style="list-style-type: none"> <li>• Clearer definition of the nomenclature of the Boards and the head of the management team of the Board</li> <li>• Clearer reporting line between the board and the Honorable Commissioner of health.</li> <li>• Need to clearly indicate the functions of the Governing Board.</li> <li>• Provision of timeline for tracking progress of the PHCUOR roadmap.</li> <li>• Need to make the document more reader friendly and comprehensive.</li> <li>• Incorporation of recommendations of Executive Secretaries and other stakeholders into the document.</li> </ul> <p>BENEFITS</p> <p>The Implementation Guidelines have been revised, edited and printed with the support of NPHCDA partners. The benefits of the PHCUOR Implementation Guidelines to States are to:</p> <ul style="list-style-type: none"> <li>• Improve efficiency of SPHCB on coordination of all PHC activities delivered by LGAs and partners. This</li> </ul>			

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		<p>reduces duplication, wastage and improves efficient use of available resources to achieve better health outcomes;</p> <ul style="list-style-type: none"> <li>• Improve quality of health services by promoting equity and increased accessibility to affordable high quality basic health care services for all especially the poor and vulnerable at the grassroots towards the attainment of Universal Health Coverage (UHC);</li> <li>• Enhance transparency and accountability. With clearly defined roles and responsibilities, it is easier for the Governor, LGA Chairmen, Commissioner of Health and other stakeholders to know who to hold accountable at all levels for PHC service delivery; and</li> <li>• Increased access to more funding by enhancing eligibility for additional funding such as the Basic Health Care Provision Fund (BHCPF) and other national and international funding for PHC services.</li> </ul> <hr/> <p>ACHIEVEMENT SO FAR</p> <p>Remarkable progress has been made in bringing Primary Health Care Under One Roof in the 36 States and FCT of the country. As at now, most States and FCT have established their State Primary Health Care Boards. Akwa Ibom State is at an advanced stage of establishing her State PHC Board.</p>			



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11.	<p><b>NATION-WIDE WHO STEP-WISE SURVEY ON NON-COMMUNICABLE DISEASES</b></p> <p><b>HONOURABLE MINISTER OF HEALTH</b></p> <p><b>NCH/61/003H</b></p>	<p>The purpose of this memorandum is to intimate Council on the efforts by FMOH to conduct nation-wide step survey, last done in Nigeria in 1991, and seek Council's approval for all States to make financial commitments towards the conduct of the survey.</p> <p>2.0 BACKGROUND:</p> <p>2.1 Non-Communicable diseases (NCDs) are now the leading cause of death globally. In 2012, a total of 56 million deaths occurred worldwide, 38 million (63%) of which were due to NCDs and nearly three quarters (28 million) of these occurred in low and middle-income countries including Nigeria. In 2014, the WHO NCD country profile estimated that 24% of all deaths (500,000) in Nigeria were due to NCDs out of which 7% are due to cardiovascular disease, 3% cancers, 2% diabetes and 1% chronic respiratory disease.</p> <p>2.2 Surveillance is a key strategy contained in the Global Action Plan for the Prevention and Control of NCDs to track the trend of NCDs in member States with reporting implications. Besides, reliable data on NCDs is imperative to guide evidence-based policymaking, planning and formulation of effective and efficient programs that will reduce the burden of these chronic diseases in Nigeria.</p> <p>2.3 To this end, WHO developed a tool for conducting STEP-Wise survey for countries to deploy every four years. Unfortunately, Nigeria is one of the few countries in Africa that is yet to conduct a recent National NCD STEPs survey due to perennial budgetary constraints for NCDs in the country. This has placed the country at a disadvantaged position especially as the survey is one of the commitments</p>	<p>The Council is invited to:</p> <ul style="list-style-type: none"> <li>i. note that NCDs are fast outpacing communicable diseases as leading causes of evidenced by rising incidences of sudden death due to NCDs;</li> <li>ii. note that there is no current nationally representative data on NCDs to guide policy formulation and planning of interventions on NCDs in Nigeria;</li> <li>iii. note that perennial budgetary constraint has undermined the conduct of the NCD STEPS survey over the years;</li> <li>iv. note the efforts of the FMOH to actualize the survey in Nigeria;</li> <li>v. note that the Step Survey is a commitment made by Heads of Government at UNGA in 2014 and the president is expected to give an update at the next UN high level meeting slated for September this year;</li> <li>vi. note that financial commitments from States and FCT is needed to achieve this highly important survey for tracking the trend and effective control of NCDs in Nigeria; and</li> <li>vii. approve that every State and the FCT make financial commitments as indicated in Annex 2 to defray the cost of survey fieldwork in their States.</li> </ul>		

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		<p>contained in the Political Declaration by Heads of Government at the High-Level Meeting of UNGA in 2014, of which Mr. President is obligated to report on at the next High Level meeting in September 2018.</p> <p>2.4 The last nationally representative survey on NCDs was conducted in 1990/1991; hence, interventions on NCDs have been carried out in the country without evidence and therefore inefficient. Therefore, the FMOH recognized this as a priority and with the support of WHO initiated the process for a nation-wide survey in 2016. Efforts so far include several stakeholders' meetings, constitution of Survey Management and Survey Implementation Committees, development of protocol, NHREC approval, and development of budget, amongst others.</p> <p>2.5 The estimated budget for the survey is Five Hundred and Thirteen Million, One Hundred and Fourteen Thousand, Nine Hundred and Twenty Naira (₦ 513, 114,920) only, excluding cost of materials, which the WHO has pledged to provide. It has therefore become evident that the FMOH cannot bear the whole financial burden alone, and necessary for States to make financial commitments to defray fieldwork in the respective States. This informed the letter Ref NCD/5623/I, which the HMH endorsed to all the States on 15<sup>th</sup> December, 2017, copy attached as annex 1.</p> <p>3.0 CONTENT:</p> <p>3.1 The survey will provide the prevalence of the major NCDs and their risk factors in Nigeria, disaggregated at the Geopolitical Zones. The sample size of 27,750 obtained using the WHO recommended formula would be distributed</p>			

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		<p>equally to all the 36 states and Federal capital Territory (FCT), with each State having a sample size of 750.</p> <p>3.2 The survey will involve enumeration and house listing in the states/LGAs; different levels of trainings for those involved in the fieldwork, supervision and data processing; pilot testing and actual fieldwork. In each State, there would be 3 teams comprising of 5 personnel per team (2 interviewers, 1 Doctor, 1 lab scientist and 1 nurse). These teams would work for 3 weeks, covering 30 clusters/enumeration areas (EA) in each state with 25 households selected from each cluster/EAs. It is expected that most of the fieldworkers will be selected from the states using criteria set by the Survey Implementation Committee.</p> <p>3.3 The funds from the States will largely be used for the actual field work in the respective states. The States will be responsible for the direct disbursement of the allocated funds to all the field workers in the State, including the National monitors in line with the survey guidelines and upon approval from the Chairperson of the Survey Management Committee.</p> <p>3.4 Of the estimated budget of Five Hundred and Thirteen Million, One Hundred and Fourteen Thousand, Nine Hundred and Twenty Naira (513,114,920) only, which excludes WHO in-kind contribution, the FMOH will commit One Hundred and Fifty million Naira (₦ 150,000,000) only to cover pilot survey, training for fieldworkers in four geopolitical zones, data management, report writing, survey insurance cover, and lunching and dissemination of report. States are expected to provide a total of Two Hundred and Forty Two</p>			

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		Million, Seven Hundred and Six Thousand, Eight Hundred Naira (₦ 242,706,800) only for the survey fieldwork in their States, as detailed in annex 2. This leaves a balance of One Hundred and Twenty Million, Four Hundred and Eight Thousand, One Hundred and Twenty naira (₦ 120,408,120) only, which the FMOH is advocating to Development Partners to contribute. This would fill the gap for training of field workers in the remaining 2 geopolitical zones and house listing.			
12.	<p><b>THE ESTABLISHMENT OF THE NATIONAL/STATES/LGAs ROUTINE IMMUNIZATION COORDINATION CENTRES AND THE ADOPTION OF THE OPTIMIZED INTEGRATED ROUTINE IMMUNIZATION SESSIONS (OIRIS) APPROACH TO RAPIDLY REVAMP ROUTINE IMMUNIZATION PERFORMANCE IN THE COUNTRY</b></p> <p><b>HONOURABLE MINISTER OF HEALTH</b></p> <p><b>NCH/61/003I</b></p>	<p>The purpose of this memorandum is to inform Council Members on the progress made in the establishment of the National/States/LGAs Emergency Routine Immunization Coordination Centres (NERICC/SERICC/LERRIC) and the adoption of the Optimized Integrated Routine Immunization Sessions (OIRIS) in the eighteen (18) very poor performing states following the release of the 2016/2017 Multiple Cluster Indicator/National Immunization Cluster Surveys (MICS/NICS) to rapidly revamp routine immunization performance in the country.</p> <p><u>2. BACKGROUND:</u></p> <p>It is universally acknowledged that vaccination is the most significant public health intervention, saving over 3 million deaths annually. In Nigeria, vaccine preventable diseases account for over 40% of the deaths of children under five years of age with the 2016/2017 NICS/MICS results indicating that over 4.3 million children are unimmunized. In response to this dire situation, the National Primary Health Care Development Agency (NPHCDA) declared a state of</p>	<p>Council is invited to note that:</p> <ul style="list-style-type: none"> <li>i. Vaccine preventable diseases account for over 40% of the deaths of children under five years of age in the country; and 2016/2017 NICS/MICS results indicated that 4.3 million children were unimmunized in 2015 alone;</li> <li>ii. The National Primary Health Care Development Agency (NPHCDA) declared a state of Public Health Concern on routine immunization on the 17<sup>th</sup> of June 2017. The NERIC Centre was immediately established and inaugurated on the 4<sup>th</sup> of July 2017 to lead the efforts to rapidly revamp routine immunization performance nationwide;</li> <li>iii. NERICC Centre has prioritized and supported 18 States in the establishment of the State and LGA Emergency Routine Immunization</li> </ul>		

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		<p>Public Health Concern on routine immunization on the 17<sup>th</sup> of June 2017. The National Emergency Routine Immunization Coordination Centre (NERICC) was immediately established and inaugurated on the 4<sup>th</sup> of July 2017 to lead the efforts to rapidly revamp routine immunization performance nationwide.</p> <p>Since inception, NERICC, which comprises of key government staff (NPHCA) and all partners on routine immunization (RI) in the country, has worked in an emergency mode in the design and implementation of key strategies and targeted support to the eighteen (18) poor performing states with MICS/NICS results &lt;50%. These States included: Adamawa, Bauchi, Bayelsa, Kaduna, Kano, Katsina, Kebbi, Kogi, Jigawa, Niger, Nasarawa, Sokoto, Zamfara, Borno, Yobe, Gombe, Taraba and Zamfara. The NERICC Centre has prioritized and supported these 8 states in the establishment of the State and LGA Emergency Routine Immunization Coordination Centres (SERICC/LERICC). The NERICC/SERICC/LERICC centres are established to improve detection and responsiveness in the resolution of RI gaps; strengthen leadership and accountability; strengthen coordination; increase data visibility, quality and use for action at all levels; and increase fixed and outreach services for immunization especially in the very low performing States.</p> <p>NERICC has also launched the Optimized Integrated Routine Immunization Session (OIRIS) in the 18 lowest performing States to change the work culture and approach to rapidly</p>	<p>Coordination Centres (SERICC/LERICC);</p> <p>iv. The NPHCA and partners at NERICC in collaboration with the States have defined clear activities to further improve routine immunization in 2018 and beyond;</p> <p>v. NERICC has also launched the Optimized Integrated Routine Immunization Session (OIRIS) in the 18 lowest performing states to change the work culture and approach to improve service delivery and rapidly improve routine immunization performance;</p> <p>vi. All States have been supplied first and second quarter vaccines and devices for routine immunization based on forecast for the two quarters; and</p> <p>vii. There is need for close monitoring of the OIRIS approach to ensure it is appropriately implemented in the 18 poor performing States (and later scaled up to the medium and high performing States).</p>		

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		<p>improve routine immunization service delivery. OIRIS emphasizes the harmonization and synergy of efforts by all stakeholders at all levels to action. It is hinged on a strengthened coordination, improved planning and resource management, monitoring and use of data for action, an improved, better aligned and stronger community engagement for RI with integration and an overall strengthened PHC system. OIRIS strengthens the operationalization of the Reach Every Ward (REW) Strategy with the integration of Primary Health Care (PHC) services, interventions and commodities with immunization services.</p> <p>3. <u>CONTENT</u>:</p> <ul style="list-style-type: none"> <li>i. The NERICC/SERICC/LERICC structure elaborates practical approaches to strengthen coordination mechanism at national/state/LGA with a “business unusual” approach to driving improvements in routine immunization. A strong coordination mechanism between NERICC, SERICC, LERICC and also between government, partner and donors.</li> <li>ii. NERICC and SERICCs are led by a Program Manager, selected through a rigorous recruitment process and assisted by Deputy Program Managers who work through well-defined coordination structures (working groups) to strengthen leadership and improve detection and responsiveness in the resolution of routine immunization gaps.</li> <li>iii. A stronger accountability mechanism with defined roles for government and partner teams to increase data</li> </ul>			

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		<p>visibility, quality and use for action. NERICC has deployed the use of quarterly Lots Quality Assurance Sampling (LQAS) as a tool to measure improvements in RI at State and LGA levels. Similarly, NERICC has initiated the SMS project in Nasarawa, Zamfara and Adamawa to improve data quality and last mile visibility on the conduct of RI sessions. SERICC/LERICC are to ensure accurate reporting of all immunization related data for acceptability of the wide country RI data. Reward and sanction (for falsification of data and other offences) is being enforced at all levels.</p> <p>iv. Routine immunization service delivery has been strengthened through the initiation of the Optimized Integrated Routine Immunization Sessions (OIRIS), as a strategy to increase the number of immunization sessions and children immunized in focal communities integrating with other PHC services and health related commodities. The OIRIS approach involves a change in the culture of work for RI service delivery; a call for urgency to prioritize routine immunization; optimization of the REW strategy; sustaining ownership and drive for implementing quality RI programs at all levels; and the integration of RI with other PHC services and health related commodities. The urban PHC facilities, secondary / tertiary health facilities are expected to conduct daily fixed sessions and the rural PHCs at least one fixed session and one outreach per week, as per the REW micro-plan. OIRIS also involves targeted high level advocacy visits; standardization of RI</p>			

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		supportive supervision visits to health facilities and an improved community engagement strategy for RI, which is at various levels of implementation in the northern states.			
13.	<p><b>THE ESTABLISHMENT OF TECHNICAL SUPPORT UNIT IN THE NPHCDA TO PROVIDE ROBUST AND SUSTAINABLE TECHNICAL ASSISTANCE TO THE STATE PRIMARY HEALTH CARE BOARDS</b></p> <p><b>HONOURABLE MINISTER OF HEALTH</b></p> <p><b>NCH/61/003J</b></p>	<p>The purpose of this memorandum is to inform the Council on the introduction of technical support programme by the National Primary Health Care Development Agency for the State Primary Health Care Boards, and to seek Council's approval for the establishment of a technical support unit in the DPRS of each SPHCDA and the FCT.</p> <p><u>BACKGROUND:</u></p> <p>The National Primary Health Care Development Agency (NPHCDA) is a parastatal of Nigeria's Federal Ministry of Health with the mandate to develop and promote primary health care in Nigeria by ensuring the control of preventable diseases, improved access to basic health services, improved quality of care, development of a high-performing health workforce, strengthening of primary care institutions, partnerships, and community engagement. The agency achieves its goals by providing technical support for implementing the National Health Policy and mobilizing resources for the strengthening of primary health care (PHC), among others. However, due to limited resources and technical capacity and an absence of a system for coordination and tracking of technical assistance (TA) requests and delivery, NPHCDA has been unable to effectively fulfill its mandate of providing TA to State Primary Health Care Development Agencies (SPHCDA) across the</p>	<p>Council is invited to note as follows:</p> <ol style="list-style-type: none"> <li>I. The introduction of a technical support programme by NPHCDA to address the technical needs of the SPHCBs;</li> <li>II. NPHCDA will deliver TA to SPHCBs using a number of different approaches (On site consultation, sharing of knowledge resources and peer to peer learning among SPHCBs; and</li> <li>III. Technical Assistance needs identification will be done at both National and State levels.</li> </ol> <p>Council is further invited to approve that each SPHCDA and FCT establish a technical support unit in the Department of Planning, Research and Statistics to identify and collate TA needs.</p>		



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		<p>country.</p> <p>Repositioning NPHCDA to fulfill its institutional mandates of providing technical support to States requires the development of a sustainable system for providing, coordinating and tracking State-level technical assistance.</p> <p>Therefore, NPHCDA will develop a sustainable system for providing State-level technical assistance, and enable it to fulfil and operationalize its core mandate of strengthening PHC systems and services across the country.</p> <p><u>CONTENT:</u></p> <p>Currently, interactions between NPHCDA and States for Technical Assistance requests and fulfillment are very complex and there are too many players involved in communicating Technical Assistance needs between SPHCBs and NPHCDA using a mix of formal and informal communication channels. The implications of these are lacks of clarity on what SPHCB needs are and this hampers the ability of the NPHCDA to respond to SPHCB's Technical Assistance needs effectively and efficiently.</p> <p>There is also weak coordination of TA provided to SPHCBs via available in-house and external resources due to poor coordination of technical support within NPHCDA and fragmented TA delivery channels. The effects of these are inefficient and ineffective use of available resources for TA delivery as efforts are duplicated on some states and some states are completely neglected. Likewise, no transparency</p>			

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		<p>into TA provided by resource persons resulting in non-standardization of TA and limited opportunities for continuous quality improvement.</p> <p>The Technical Support Program (TSP) design is premised on 4 principles:</p> <ol style="list-style-type: none"> <li>1. Owned and driven by NPHCDA The program will be anchored by NPHCDA staff to ensure institutionalization and sustainability.</li> <li>2. Built on existing resources and structure The TSP will be domiciled in existing departments at both National and State level (DPRS) and staffed by career civil servants.</li> <li>3. Balance of customization and scale intervention Efforts will be made to deploy technical assistance that meets each state's specific needs, but consideration will be given to approaches that benefit multiple states.</li> <li>4. Inclusive of all stakeholders Knowledge and human capital inputs from appropriate departments within the Agency, its development partners and SPHCDA's will be included as TA resources.</li> </ol>			
14.	<b>THE ESTABLISHMENT OF TRADITIONAL, COMPLEMENTARY AND ALTERNATIVE MEDICINE</b>	The purpose of this memo is to inform the Council that approval has been granted by the Head of Service of the Federation for the establishment of Traditional, Complementary and Alternative Medicine Department in the	<p>Council is hereby invited to note that:</p> <ol style="list-style-type: none"> <li>i. The Federal Ministry of Health established the Division of Traditional Medicine Development in 2007 and</li> </ol>		

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	<p><b>DEPARTMENT</b></p> <p><b>HONOURABLE MINISTER OF HEALTH</b></p> <p><b>NCH/61/003K</b></p>	<p>Federal Ministry of Health, and to seek Council's approval for States of the federation and the FCT to establish their respective Traditional, Complementary and Alternative Medicine Department to facilitate the integration of Traditional Medicine into the main healthcare delivery system for the benefit of the populace.</p> <p><u>2. BACKGROUND:</u></p> <p>The World Health Organisation (WHO) estimates that about 80% of the world population use Traditional Medicine as primary form of healthcare. Across the world, traditional medicine (TM) is either the mainstay of health care delivery or serves as a complement to it. Nigeria is no exception.</p> <p>The WHO in its effort to promote the safe use of Traditional Medicine (TM) has put in place various strategies; The WHO Traditional Medicines Strategy 2002 – 2005 and The WHO Traditional Medicine Strategy 2014 -2023. These strategies are effective and proactive response to World Health Assembly (WHA) resolution on TM which encourages member states to consider T&amp;CM as an important part of the Health system.</p> <p>The African Union (AU) in 2000 developed a plan of action and declared the period 2001 – 2010 as the Decade of African Traditional Medicine, with the African Traditional Medicine Day celebrated on August 31<sup>st</sup> every year. The plan of action was renewed in 2010, from 2011 – 2020 to develop,</p>	<p>launched the Traditional Medicine Policy.</p> <p>ii. A herbal product initially used by a Traditional Medicine practitioner and submitted for further scientific research to National Institute for Pharmaceutical Research and Development, has been produced into NIPRISAN which is used in the management of Sickle Cell disease.</p> <p>iii. The determination of the Federal Ministry of Health to promote Traditional, Complementary and Alternative medicine led to the establishment of the Traditional, Complementary and Alternative Medicine Department.</p> <p>iv. The Traditional, Complementary and Alternative Medicine Department will enhance the regulation and control of Traditional, Complementary and alternative medicines, discovery of new herbal medicines, establishment of alternative medicine hospitals in the country, facilitate research for intervention in the area of priority diseases, and facilitate the documentation of Traditional, Complementary and Alternative medicine practices.</p>		

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		<p>recognise, accept and institutionalise Traditional Medicine (TM) and Complementary Medicine (CM) into the main healthcare delivery system.</p> <p>Experience from the last 10 years of operation as a division shows that for Nigeria to facilitate the realization of the objective and goals (Health and Economic) Traditional Medicine Policy 2007 there is need for a strong political will to focus attention and resources on Traditional Medicine Development and its integration into the Health care delivery system of the Country.</p> <p><u>3. CONTENT:</u></p> <p>As the Ministry's determination for achieving Universal Health Coverage (UHC), the Ministry proposed for the upgrading of the Traditional Medicine Division into a full-fledged department which was subsequently approved by the Head of Service of the Federation. Currently the Ministry has reached an advanced stage in the proposed bill of Traditional, Complementary and Alternative Medicine Council for final legislation by the National Assembly. This will promote research, job and wealth creation, and availability of herbal medicines for the management of diseases.</p>	<p>v. This new Department will foster better collaboration with national and international stakeholders.</p> <p>vi. The Federal Ministry of Health has reached advanced stages in forwarding of the bill for the establishment of the Traditional, Complementary and Alternative Medicine Council.</p> <p>Council is further requested to approve and encourage all states to establish their respective Traditional, Complementary and Alternative Medicine Department to facilitate the integration of Traditional Medicine into the main healthcare delivery system for the benefit of the populace.</p>		
15.	THE INTEGRATION OF NUTRITION SERVICES INTO THE NIGERIAN HEALTH CARE SYSTEM USING NUTRITION ASSESSMENT COUNSELLING AND SUPPORT (NACS) APPROACH	<p>The purpose of this memorandum is to request the approval of the Council for the integration of Nutrition into the Nigerian Health Care System using the Nutrition Assessment Counselling and Support (NACS) Approach.</p> <p>BACKGROUND</p>	<p>Council is hereby invited to note as follows:</p> <p>i. There is no policy statement to enable equitable and routine integrated access to nutrition services for all physiological age groups in all health</p>		

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	<b>HONOURABLE MINISTER OF HEALTH</b> <b>NCH/61/003L</b>	<p>The scourge of malnutrition in form of over nutrition, under nutrition and micronutrient deficiencies are conditions that weaken the immune system, worsen illnesses and contribute to economic losses through palliative care, therapeutic care and prolonged medications for management of communicable and non-communicable diseases.</p> <p>Malnutrition contributes to 53% of all deaths among under-five children According to the 2013NDHS, the stunting rate is put at 37% while 2015NNHS puts it at 33%. In the same vein, 2013 NDHS and 2015 NNHS put wasting rate at 18% and 7.2% respectively. The underweight indices have reported at 29% and 19.4% respectively for 2013 NDHS and 2015 NNHS. All forms of Malnutrition are silent killers including increase in obesity being observed among adolescent girls and women. The Sustainable Development Goals (SDGs) cannot be attained without addressing the problems of malnutrition through nutritional care services.</p> <p>Moreover, Infant and Young Child Nutrition data shows that Nigeria is below the average global index. Empirical data from 2013 NDHS and 2014 NNHS have shown indices of suboptimal Infant and Young Child Feeding (IYCF) practices in Nigeria: Early initiation of breastfeeding is put at 33% and 21.5% respectively while exclusive breastfeeding rates of 17% from 2013 NDHS and 25.2% from 2014 NNHS are reported. The mean duration of breastfeeding of 18.3months is still below the National Recommendation of two years or beyond. In fact, only 10% of the children 6-23months are fed optimally in line with recommended Infant and Young Child Feeding (IYCF) practices. Suboptimal feeding practices</p>	<p>facilities;</p> <p>ii. The NACS Training Manual was adopted by Federal Ministry of Health with inputs from relevant Stakeholders and endorsed by the Honourable Minister as evidence of political commitment to utilize the policy documents for quality service delivery across the Federation.</p> <p>iii. In accordance with the concept of one PHC per ward, which has Nutrition as part of the essential package of care, NACS approach will enhance promotion of optimal health, early detection of malnutrition and prevention of Diet-Related Non-Communicable Diseases (DRNCD).</p> <p>iv. NACS approach is in consonance with the Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition (RMNCAH+N) component of the Second National Strategic Health Development Plan {NSHDP II} as well as the National Strategic Plan of Action for Nutrition (NSPAN) of the National Policy on Food and Nutrition, which are aimed at achieving Universal Health Coverage in Nigeria.</p> <p>v. Utilization of the NACS Training</p>		

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		<p>compounded with the unhealthy lifestyles of the Women of Reproductive age has resulted to the maternal malnutrition indices of 7.4%.</p> <p>In addition, over nutrition indices among the infants and young children as well as the women of reproductive age show that Nigeria needs to be at alert considering the prevailing eating and sedentary lifestyles in the society. The Nutrition Assessment Counseling and Support (NACS) approach is a diagnostic, preventive and supportive measure for early detection of malnutrition and diet-related diseases that target every population in the human life cycle. NACS ensures that complete nutritional care package is offered to every client who visits health facilities with continuous nutrition education and counselling for optimal behavioral change and practices.</p> <p>2. ISSUES AND JUSTIFICATION</p> <p>In Nigeria, utilization and interpretation of nutrition status to clients among health workers is generally poor. Nutrition Services need to be made active and not passive in the health facilities by facilitating the implementation of complete nutrition package and strengthening Health Care Providers to deliver appropriate counselling and support routinely.</p> <p>Assessments are being carried out at various health facilities with disparity at different physiological ages. For instance, children 0-59months are assessed during Growth Monitoring and Promotion (GMP) and Community Management of Acute Malnutrition (CMAM) services while other age groups are left</p>	<p>manual for cascading training will provide harmony and quality service delivery for routine integrated nutrition services in basic health care delivery.</p> <p>Council is further invited to approve:</p> <ol style="list-style-type: none"> <li>I. The utilization of NACS approach at all levels of care for effective routine nutrition service delivery for optimal impact on the nutritional status of the Nigerian populace.</li> <li>II. The National roll out of training of Health workers at all levels using the developed training manuals.</li> </ol>		

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		<p>out. Presently, routine growth monitoring sessions which elapse by the child's fifth birthday is rarely conducted when immunization is completed at child's first birthday. Even when assessment is conducted, comprehensive counselling and support services are not offered. Moreover, there is need for nutrition assessment counseling and support at the other age groups including School age, Adolescents, Adults and Geriatrics/Elderly. This calls for integrated delivery of nutrition services for all age groups.</p> <p>In addition, Nutritional care beyond infant and young child needs to include all physiological age groups; i.e. School age children, Adolescents, Women of Child Bearing age and Adults) in the human life cycle. This will contribute to reduction of non-communicable diseases that are prevalent in the later years of life. Access to quality, functional nutrition services in the health facility being the basis for all clients will contribute to increased number of clients utilizing the services delivered at all levels of care {Primary Health Care Centres and Referrals} thereby making them functional.</p> <p>NACS strengthens and appropriately integrates nutritional care and support into routine health services. It strengthens effective quality data collection, collation, analysis and documentation in the facility and ensures service providers proffer solution according to clients' peculiarity.</p> <p>NACS also ensures proper documentation of Nutrition Routine activities to align with the consistent data flow in the National Health Management Information System (NHMIS).</p> <p>Nutrition Education/Counselling is an essential component of</p>			

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		<p>NACS for behavioral change on improved dietary habit. Maximizing the positive impact of NACS is therefore paramount that nutrition programme involving assessment, nutrition counselling and support for improved healthy life be comprehensively integrated into basic health Care Services in Nigeria.</p> <p>NACS Training Manual, Job Aids for Health workers and clients' fliers have been adapted for all levels and approved by Honourable Minister of Health to utilize them for quality service delivery across the Federation.</p>			
16.	<p><b>THE REVIEW OF THE NATIONAL CHILD HEALTH POLICY</b></p> <p><b>HONOURABLE MINISTER OF HEALTH</b></p> <p><b>NCH/61/003M</b></p>	<p>The purpose of this memo to inform Council of the revised National Child Health Policy which aims to provide a holistic platform for the systematic development and implementation of evidence-based interventions for improved child health.</p> <p><b>BACKGROUND</b></p> <p>The National Child Health Policy was last reviewed in 2012. Following the global adoption of the Global Strategy on Women, Newborn and Adolescent Health and the Sustainable Development Goals (SDGs), there is need to review the National Child Health Policy in line with the goals, objectives and strategies of these global documents. The process of finalizing the National Child Health Policy is on-going and will soon be disseminated for domestication and implementation at the State levels.</p> <p>According to the Nigeria Demographic Health Survey (NDHS) 2013, children under the age of five years constitute 17% of our estimated populations. Nigeria also contribute approximately 10% of the global deaths of children though</p>	<p>The Council is hereby invited to note that:</p> <ul style="list-style-type: none"> <li>i. The National Child Health Policy was last reviewed in 2012.</li> <li>ii. Following the global adoption of the Global Strategy on Women, Newborn and Adolescent Health and the Sustainable Development Goals (SDGs), there is need to review the National Child Health Policy in line with the goals, objectives and strategies of these global documents.</li> <li>iii. The process of finalizing the National Child Health Policy is on-going and will soon be disseminated for domestication and implementation at the State levels.</li> <li>iv. The National Child Health Policy is being reviewed in line with relevant global</li> </ul>		



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		<p>we contribute only about 1% to the global population.</p> <p>The Reproductive Maternal, Newborn, Child and Adolescent Health (RMNCAH) status is characterised by unacceptably high indices with Under-five Mortality Rate of 128/1000 live births and Neonatal Mortality Rate of 37/1000 live births (NDHS 2013). It is noteworthy that some improvements have been made with Under-five Mortality Rate but the decline in Maternal and Neonatal Mortality remains slow. Majority of the child deaths (about 58%) are attributable to malaria, pneumonia, diarrhoea, vaccine preventable diseases and neonatal causes with malnutrition underlying about 50% of them. All these disease conditions are preventable and if detected early are treatable with simple, cost effective essential medicines.</p> <p>The goal of the revised National Child Health Policy is to ensure the survival, optimal growth and development of children in Nigeria, while the main objective is to set outcome-oriented priorities to protect and promote the health of children, and identify strategies to achieve the Sustainable Development Goal 3 which aims to ensure healthy lives and promote well-being for all at all ages.</p> <p>CONTENT</p> <p>The protection, promotion and full enjoyment of human rights is one of the most important aspirations in today's world. As indicated in the Declaration of the Rights of the Child, "the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth", hence, the human</p>	<p>documents and policy guidelines and will soon be made available for domestication at the subnational levels in due course.</p>		

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		<p>rights of children must become an integral part of our education, our culture and our development.</p> <p>The Infant and child mortality rates are basic indicators of a country's socio-economic situation and quality of life. The rates are important for identifying population groups at risk, and for planning, monitoring and evaluating population and health programmes and policies. Nigeria has a high total fertility rate of 5.5 and at this rate, the total population is expected to remain high. An increasing population coupled with a poor economy stretches available resources and predisposes a relatively large proportion of the populace to live below the poverty line.</p> <p>JUSTIFICATION/COVERAGE</p> <p>This Child Health Policy document will serve to provide a holistic platform for the systematic development and implementation of evidence-based interventions for improved child health in Nigeria, based on a careful review of the Nigerian health situation. The document proposes strategies and actions that aim to reduce the unacceptably high rates of morbidity and mortality of children in Nigeria thereby securing a better future for them.</p> <p>There are nine thematic areas covered by the National Child Health Policy. These include: Perinatal and Neonatal Health, Major Childhood Illnesses, Infant and Young Child Feeding, HIV and AIDS Control, Childhood immunization, Child Healthcare Financing, School Health, Injury Prevention, Child Protection and Children Living Under Special Circumstances.</p>			

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17.	<p><b>THE REVISION OF THE NATIONAL HEALTH PROMOTION POLICY AND THE IMPLEMENTATION FRAMEWORK (2018)</b></p> <p><b>HONOURABLE MINISTER OF HEALTH</b></p> <p><b>NCH/61/003N</b></p>	<p>The purpose of this memo is to inform the Council on the on-going review process of National Health Promotion Policy and Implementation Framework (2018).</p> <p><b>BACKGROUND</b></p> <p>Nigeria is saddled with an unbearable increasing burden of Communicable and Non-Communicable Diseases (NCDs), negative effects of globalization manifesting as drastic changes in consumption patterns of food, tobacco and alcohol. Mental health conditions, road traffic accidents, domestic violence, unsafe sex and insufficient physical activity and other threats to the Nigerian populace such as floods, Lassa fever, Ebola and Avian influenza are also on the rise. Associated issues include low levels of health literacy, poor sanitation and inadequate attention to key Social Determinants of health such as poverty, declining education and poor food security. It is against this backdrop that Health Promotion becomes invaluable because it is the process of enabling people to increase control over their health and its determinants, thereby improving their health.</p> <p>In furtherance of the Government's efforts to improve the health status of Nigerians, the Federal Ministry of Health (FMoH) in collaboration with the World Health Organization (WHO) and other Development Partners developed the National Health Promotion Policy (NHPP) in 2006 to strengthen the Health Promotion capacity of the National Health System to deliver health care that is promotive, protective, preventive, restorative and rehabilitative to every citizen of the country.</p> <p>The NHPP (2006) serves as an institutional framework that</p>	<p>Council is hereby invited to note that:</p> <ol style="list-style-type: none"> <li>The National Health Promotion Policy (2006) has been in operation for over twelve years.</li> <li>The revised National Health Promotion Policy and Implementation Framework (2018) is in-line with the goals, objectives and strategies of the Regional WHO Health Promotion Strategy.</li> <li>The Federal Ministry of Health has taken steps to reactivate the NHPCF and reposition the Forum to drive Health Promotion programming nationwide through the expansion of membership to ensure Institutional and Multi-sectoral participation.</li> <li>NHPCF has been mandated to drive the revision, roll-out as well as facilitate the implementation of Health Promotion activities at all levels.</li> <li>That the draft Revised National Health Promotion Policy and Implementation Framework (2018) be presented to the Council for further inputs to ensure ownership and buy-in by all Stakeholders at all levels.</li> </ol>		

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		<p>promotes the creation of positive outcomes such as community empowerment for health action and community participation and ownership of Health Promotion programmes. It also empowers the Health Promotion Division of the Family Health Department (FHD), Federal Ministry of Health (FMOH) to coordinate Health Promotion activities at the Federal, State, Local Government Areas (LGAs) and Community levels.</p> <p>To ensure successful management of the coordination role, the Ministry utilized the Health Communication Forum Platform to engage the Development Partners and other Stakeholders in Health Promotion at the Federal Level. The Forum provided Technical and Financial support for the Nationwide Roll-out of the National Health Promotion Policy including institutionalization of Health Promotion at the 36 States and FCT, Abuja.</p> <p>The findings of the assessment of the status of implementation of the Policy after twelve years suggested poor performance due to the following key reasons; weak road map and process for translating the NHPP (2006) into interventions; weak management structures, systems and infrastructure across the three tiers of government; usurpation of Health Promotion functions by Programmes, Projects, other sectors and sub-sectors; Non-prioritization of Health Promotion by the Political class.</p> <p>The identified weaknesses, the WHO Regional Strategy for Health Promotion (2013) as well as emerging and re-emerging health issues of public health importance identified at various local and international health forum has led to the</p>			

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		<p>need to review the NHPP (2006).</p> <p>The goal of the revised National Health Promotion Policy and Implementation Framework (2018) is to empower the Nigerian populace to take timely actions in disease prevention, improving their health and wellbeing as well as taking measures that ensure a healthy society. The objectives are to:</p> <ul style="list-style-type: none"> <li>i. foster Health Promotional interventions targeted at Social Determinants of Health and priority burden of diseases in Nigeria;</li> <li>ii. facilitate Health Promotional interventions in support of the Sustainable Development Goals (SDGs), Universal Health Coverage (UHC) and other efforts directed at ensuring and sustaining healthy behaviour and lifestyle;</li> <li>iii. enhance Human Resource and Capacity strengthening for the delivery of Health Promotion Services; and</li> <li>iv. strengthen Systems to monitor, evaluate and manage evidence related to Health Promotion interventions.</li> </ul> <p>CONTENT</p> <p>The concept of Health Promotion started at the first Global Conference on Health Promotion held in Ottawa, Canada in 1986 as part of the search for effective means of preventing diseases and improving human living conditions. Health</p>			

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		<p>Promotion aims to increase community control and participation in health through an integrated response to the determinants of health.</p> <p>The revision process of the Policy factors modalities to ensure that Health Promotion steps out of its less successful past, into a formidable contributor to the achievement of the health-related Sustainable Development Goals, as well as the Universal Health Coverage thereby improving the health and wellbeing of the Nigerian populace. As Nigeria experiences a demographic transition resulting in increased demand on a fragile health system; the country requires a vibrant, robust and sustained Health Promotion system. Given its rightful place, Health Promotion will reduce morbidity, mortality and expenditure on health</p> <p>JUSTIFICATION/COVERAGE</p> <p>The revised Policy aims to provide a holistic platform for the systematic development and implementation of evidence-based Health Promotion interventions that will enhance disease prevention, improved health and wellbeing as well as a healthy society.</p> <p>From 2013 to March 2018, the Health Communication Forum was inactive largely due to weak coordination capabilities and the 5 years of the non functionality of the Forum was characterized by insufficient professional engagement and existence of health communication messages that were not adequately targeted to audience needs.</p> <p>The commencement of the review of the National Health Promotion Policy (2006) by the Federal Ministry of Health in</p>			

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		<p>collaboration with Development Partners and other Stakeholders was a major step towards re-positioning Health Promotion in Nigeria. The process provided Nigeria's frontline Health Promotion Managers, Practitioners and Technical Assistants a strategic opportunity to examine the evolution of Health Promotion in Nigeria over the past twelve years and reach consensus on possible way forward. This includes:</p> <ul style="list-style-type: none"> <li>i. Renaming of the Health Communication Forum as the National Health Promotion Communication Forum (NHPCF) to differentiate it from other existing communication coalitions in the country. To ensure meaningful engagement, the frequency of the meetings has been reviewed to quarterly basis instead of Monthly.</li> <li>ii. The expansion of the Membership of the NHPCF to include institutional representation with designated focal persons from Government (relevant Ministries, Departments and Agencies), Development Partners, Non-Government Organizations (NGO), Community Based Organisations (CBOs), Faith Based Organisations (FBOs), Professional Associations, Regulatory bodies, Academia, Media, Telecommunication, Financial Institutions, Research Institutions, Private Sector and Civil Society Organizations (CSO) working on communication activities related to health.</li> <li>iii. The NHPCF has been mandated to drive the revision,</li> </ul>			

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		<p>roll-out as well as facilitate the implementation of Health Promotion activities at all levels.</p> <p>The revised Policy strategically sets standards and provides accurate guidance on 'what' is right and should be done by Decision Makers, Managers and Service Providers of Health Promotion at the various levels. It has an Implementation Framework which clearly spells out 'how' the key implementation players will convert the Policy into action that will enhance the physical, social and emotional well-being of the general public in Nigeria.</p> <p>The thematic areas covered by the National Health Promotion Policy include: the context of the Policy; Policy Statement, Goals, Objectives and Action points; Guiding Principles and Values; Institutional Arrangements, Roles and Responsibilities; Policy Implementation; Monitoring and Evaluation.</p> <p>The Revised NHPP and Implementation Framework (2018) will serve to provide a holistic platform for the systematic development and implementation of evidence-based Health Promotion interventions for improved individual, family and community health in Nigeria, based on a careful review of the Nigerian health behaviour situation.</p>			
18.	<b>THE NATIONAL POLICY ON SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS OF PERSONS WITH DISABILITY, WITH EMPHASIS ON WOMEN AND GIRLS.</b>	The purpose of this memorandum is to present the draft National Policy on Sexual and Reproductive Health and Rights of Persons with Disability with emphasis on Women and Girls with Disabilities and to seek the Council's approval for its adoption, dissemination and implementation.	4.0. Council is hereby invited to consider and approve the Draft National Policy on the sexual and reproductive health and rights of Persons with Disability with Emphasis on Women and Girls for adoption, dissemination and implementation in all States of the		



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	<b>HONOURABLE MINISTER OF HEALTH</b>  <b>NCH/61/0030</b>	<p>1.0. Introduction/Background</p> <p>The World Report on Disability [2017] states that approximately 25 million Nigerians live with one form of disability or the other with an estimated 13 million of this population being women and girls. Persons with disabilities have the same Sexual and Reproductive Health [SRH] needs as other people. They need the minimum package of reproductive health services available to everyone but their special circumstances create barriers to access those services. This includes communication barriers, ignorance of service providers, societal attitude, and inadequate capacity of service providers to manage clients with disabilities.</p> <p>Women and girls with disability are particularly affected, because they are generally poor, live in remote areas without any economic power and they experience multiple forms of discrimination, first as women then as Women with Disabilities [WWDs]. They have often been denied the right to establish relationships and to decide whether, when and with whom to have a family. Many have been subjected to forced abortion and forced marriages; they are more likely to experience physical, emotional and sexual abuse and other forms of Gender Based Violence; they are more likely to become infected with HIV and other sexually transmitted infections [STIs].</p> <p>2.0. Rationale</p> <p>Apart from being a signatory to the Convention on the Rights of Persons with Disability, the basic rights of all Nigerians is enshrined in Chapter 4 of the Nigerian 1999 Constitution.</p>	federation and the FCT.		

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		<p>The most important of these Rights is the "Right to life", and unfortunately many persons with disabilities have been denied this right as health services is mainly available to those without disabilities. Persons with disability are yet to be counted, catered for, or allowed opportunities for meaningful inclusion. A Situation Analysis [SA] on access to Sexual and Reproductive Health Services by Women and Girls with Disability in Nigeria recently carried out by Disability Rights Advocacy Centre [DRAC] has highlighted the plight of WWDs in accessing health services in Nigeria with a focus on their sexual and reproductive health. The Situation Analysis revealed that women with disabilities experience barriers in accessing health care at multiple points of the health care process such as lack of accessible facilities and equipment, lack of accessible communication facilities, lack of skilled medical providers, economic barriers and negative attitude of healthcare workers. Respondents also admitted that there is no specific policy or framework solely aimed at enabling access to health for women and girls, with disabilities.</p> <p>Consequently, the Situation Analysis recommends the following amongst others:</p> <ol style="list-style-type: none"> <li>Appropriate measures to be taken to ensure access to health for WWDs through affordable health care, hospitals and diagnostic equipments that are physically accessible.</li> <li>Building capacity of healthcare professionals who are trained to serve people with disabilities and who have appropriate knowledge to provide them with appropriate knowledge to serve people with disabilities.</li> <li>Government to recognize WWDs in the implementation</li> </ol>			

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		<p>of the National Health Act [NH Act] which is a testament to the need for a framework for the regulation, development and management of health systems in Nigeria. It is therefore pertinent to optimize the platform presented by the implementation of the NH Act to advocate for a Specific Policy on access to sexual and reproductive health for persons living with disability.</p> <p>3.0. Justification:</p> <p>This Document is intended to provide a policy direction to Government, Civil Society Organizations, Development Partners and the organized Private Sector on how to deal with reproductive health concerns of women and girls with disabilities. It ensures that their issues are fully integrated into the National health and Social Welfare programmes.</p>			
19.	<p><b>THE ESTABLISHMENT/ STRENGTHENING OF DRUG TREATMENT/REHABILITATION CENTRES BY EACH STATE OF THE FEDERATION AND THE FCT</b></p> <p><b>HONOURABLE MINISTER OF HEALTH</b></p> <p><b>NCH/61/003P</b></p>	<p>The purpose of this memo is to seek approval of Council for the establishment/strengthening of Drug dependency Treatment/Rehabilitation Centres by each State of the Federation and the FCT.</p> <p><u>2. INTRODUCTION/ BACKGROUND</u></p> <p>Drug use and drug use disorders are associated with significant level of disease (morbidity) and disability, along with immeasurable social and economic consequences on the lean resources and security of nation. The World Health Organization (WHO) estimates that the global burden of disease attributable to alcohol and illicit drug use amounts to 5.4% of the total burden of disease.</p>	<p>4. Council is invited to note that:</p> <ul style="list-style-type: none"> <li>i. Drug use and drug use disorder is a public health problem;</li> <li>ii. There is rising menace of drug abuse across the states of the Federation;</li> <li>iii. There is urgent need for all the States of the federation to establish or strengthen at least one drug dependence treatment centre; or dedicate a ward within any of the existing hospital in the State to drug treatment services in support of national effort of the Federal Government to ensure all persons with drug problem are</li> </ul>		

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		<p>The Federal Ministry of Health (FMOH) and other stakeholders in collaboration with the United Nations Office on Drugs and Crime (UNODC), under the 10<sup>th</sup> European Development Fund (EDF) Modality conducted the first National Household Survey on Drug Use and Health between 2016 and 2017. This population-based survey will reveal the extent, pattern, social and health consequences of drug use in Nigeria when the report is finalized and released in September this year for informed and targeted interventions aimed at addressing and reversing the rising menace of drug abuse in a comprehensive and holistic manner.</p> <p>3. <u>CONTENT</u></p> <p>The widespread reported non-medical use of codeine containing cough syrup and other substances by school children, youths and women across the country informed the recent ban of importation, manufacture, distribution and use of the medicine in the country. The abuse of the medicines and other substances has exposed the users to numerous health challenges including drug addiction. Consequently, there is need for the treatment of these persons in an appropriate healthcare setting and by a team of healthcare providers with knowledge and skills in the management of drug dependence in order to ensure their rehabilitation and reintegrated into the society.</p> <p>The Federal Ministry of Health through the Response to Drugs and Related Organized Crime being implemented by the United Nations Office on Drugs and Crime (UNODC) under the 10<sup>th</sup> European Development Fund (EDF) Modality</p>	<p>treated in line with the international best practices;</p> <p>iv. The Minimum Standard for Drug Dependence Treatment developed by the Ministry will provide informed guidance to policy makers and hospitals desirous of establishing drug dependence treatment centre on assessment of compliance with standards by the health facilities.</p> <ul style="list-style-type: none"> <li>The 25 healthcare providers trained as National Master Trainers by the Ministry will support States in building the capacities of their healthcare providers in the provision of evidence based drug dependence treatment.</li> <li>Adoption of out-patient drop-in-centre in a community setting for provision of basic drug counselling services and medical care, with severe cases of drug use disorder being referred to higher level of care with in-patient facilities is also another cost-effective approach to increasing access to drug treatment services for indigent community members.</li> </ul>		

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		<p>has:</p> <p>i. upgraded 11 hospitals as Model Drug Dependence Treatment Centers across the 6 geo-political zones of the country, namely:</p> <ul style="list-style-type: none"> <li>• Aminu Kano Teaching Hospital, Kano State.</li> <li>• Federal Neuropsychiatric Hospital (FNPH) Aro, Abeokuta</li> <li>• National Hospital, Abuja</li> <li>• Federal Neuropsychiatric Hospital (FNPH) Kaduna, Kaduna State</li> <li>• Federal Neuropsychiatric Hospital (FNPH) Maiduguri, Borno State</li> <li>• Jos University Teaching Hospital, Plateau State.</li> <li>• Federal Neuropsychiatric Hospital (FNPH) Enugu, Enugu State</li> <li>• Federal Neuropsychiatric Hospital (FNPH) Benin, Edo state</li> <li>• University of Port-Harcourt, Rivers state</li> <li>• Quintessential Hospital, Jos, Plateau State</li> <li>• Federal Neuropsychiatric Hospital (FNPH) Yaba, Lagos</li> </ul> <p>ii. Trained 25 healthcare providers as Master Trainers and over 1200 healthcare practitioners on provision of evidence base drug treatment services between 2015 and 2017 with the support of European Union and UNODC;</p> <p>iii. Developed Minimum Standards for Drug Dependence Treatment in Nigeria.</p> <p>iv. Initiating development of drug treatment guidelines</p>	<ul style="list-style-type: none"> <li>• The drop-in-centre will have some full-time staff (psychologist/social worker, nurse, outreach workers, pharmacists etc.) while the doctor/psychiatrist will visit 3 times a week.</li> </ul> <p>Council is further invited to approve:</p> <ul style="list-style-type: none"> <li>• The establishment/strengthen of at least one drug dependence treatment centre, with community drop-in-centres attached to it, by each State of the Federation and the Federal Capital Territory (FCT).</li> </ul>		

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		including community-based approaches and opioid substitution therapy. v. Supported Nigeria's first national drug use survey across every state of Nigeria, the results of which will be ready for release in September 2018.			
20.	PROVISION OF SUPPORT FOR ANTIMICROBIAL RESISTANCE NATIONAL ACTION PLAN IMPLEMENTATION  HONOURABLE MINISTER OF HEALTH  NCH/61/003Q	<p>PURPOSE</p> <p>The purpose of this memorandum is to request for the approval by the National Council on Health on provision of support for Antimicrobial Resistance National Action Plan Implementation across the States in the country.</p> <p>INTRODUCTION</p> <p>Antibiotics (medicines) have saved millions of lives, reduced disease burden in humans and animals, improved quality of life, contributed to improved food production and safety and helped increase life expectancy. Modern human and veterinary medicine is built on access to effective antimicrobials.</p> <p>JUSTIFICATION</p> <p>The emergence and spread of resistance (antimicrobial resistance, AMR) to these medicines in several microorganisms is complicating management of many infectious diseases. The consequences of AMR are serious because resistant microbes fail to respond to standard treatment, resulting in prolonged illness, infectiousness, increased spread of disease, extended hospital stays, and greater risk of death. The impact of these adverse outcomes affects the functioning of both human and animal health</p>	<p>Council is hereby invited to note that:</p> <p>I. AMR be recognised as a priority for action in the Federal Government by designating State focal points at the Ministries of health and every health facility</p> <p>II. State Specific AMR Action Plans need to be developed and funding for implementation provided</p> <p>III. Data on the use of antimicrobial agents in human and animal health be collected at all health facilities and veterinary clinics to monitor trends and strengthen laboratory capacity for AMR surveillance</p> <p>IV. National policies for implementation of infection prevention and control activities in health facilities be developed</p> <p>V. Rational use of antibiotics in Animal health and agricultural practice should be strengthened through implementation of Codex standards</p> <p>VI. Regulation for distribution and use of</p>		

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		<p>systems and health economies more in the developing countries especially because of limited resources and their greater disease burden. AMR is decreasing the usefulness of modern antibiotics and jeopardises common and complex surgical procedures, while endangering animal health and welfare, as well as food production. In 2016, it was estimated that 10 million people will die annually from AMR by 2050 if current trends are unabated.</p> <p>This memorandum is proposed to draw the attention of the National Council on Health that the emergence and spread of antimicrobial resistance in several microorganisms is of critical importance, highlight that there is little or no support for research into production of new medicines alongside and emphasize the resultant immediate and long term implications of these on the health and life expectancy of Nigerians.</p> <p>AMR INTERVENTION UPDATE</p> <p>The 68th World Health Assembly, in May 2015, recognized the threat of AMR to global health security and adopted the global action plan on AMR. The WHA resolution 68.7 specifically, requests member States and relevant partners to participate in an integrated global programme for surveillance of antimicrobial resistance across all sectors in line with the adopted global action plan.</p> <p>Following the commitment of Nigeria to the WHA resolution,</p>	<p>antimicrobial medicines in human, animal health and crop agriculture needs to be enforced</p> <p>VII. New public-private partnerships for research and development of vaccines, new antimicrobial agents and diagnostic tools should be created while strengthening existing ones.</p> <p>VIII. Encourage rational therapy by encouraging clinicians to base therapeutic decisions and antimicrobial selection on the guidance from laboratory culture and susceptibility testing and/or surveillance</p> <p>Council is hereby invited to approve that:</p> <p>I. One-Health multi-sectoral AMR Technical Working Groups be created and funded in all States of the Federation</p> <p>II. NCH (in collaboration with the NCDC) celebrates the Global Antibiotic Awareness Week in November of each year as an annual event</p> <p>III. Infection Prevention and Control (IPC) and Hospital Antibiotic Stewardship (HAS) should be institutionalised in all secondary and tertiary health facilities in the country by the creation of IPC focal</p>		

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		<p>an inaugural meeting of the National Antimicrobial Resistance (AMR) Technical Working Group (TWG) was held at Abuja on the 16th and 17th of January 2017. So far; the NCDC has recorded significant progress with the development of the AMR Situation Analysis and National Action Plan (NAP) and both documents have been shared with stakeholders. The final draft of both documents was presented at the 71st World Health Assembly meeting, 22-31 May 2017.</p> <p>Nigeria has also enrolled in Global Antimicrobial Resistance Surveillance System (GLASS) following the assessment of her laboratory capacity for AMR surveillance. Eight (8) laboratories have been assessed in preparation for reporting on AMR in the country; while one of the laboratories will function as the national reference laboratory for AMR. This will generate data for evidence-based decision making.</p>	persons and IPC committees.		
21.	<p><b>THE ESTABLISHMENT OF STATE NCD PROGRAMME TO STRENGTHEN COORDINATION FOR THE PREVENTION AND CONTROL OF NON-COMMUNICABLE DISEASES IN NIGERIA</b></p> <p><b>HONOURABLE MINISTER OF HEALTH</b></p>	<p>The purpose of the memorandum is to alert members on the rising profile of NCDs as the major cause of death in the country and seek approval for every State Ministry of Health and FCT Health and Human Services to establish a programme/Branch/Unit on NCDs for a coordinated approach to address the issue nationally.</p> <p>2.0 BACKGROUND</p> <p>2.1 Non-Communicable Diseases (NCDs) are fast</p>	<p>4.1 Council is invited to note that:</p> <ul style="list-style-type: none"> <li>i. NCDs are fast outpacing communicable diseases as leading cause of death globally as well as in Nigeria;</li> <li>ii. the United Nations has recognized NCDs as developmental impediment and has included into the SDGs as SDG 3.4;</li> <li>iii. although Nigeria realized that NCDs constitute major public health concern as</li> </ul>		



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	NCH/61/003R	<p>outpacing communicable diseases as major cause of death globally due to the prevailing demographic and epidemiological transition.</p> <p>2.2 The four major NCDs of greater concern are cardiovascular diseases (CVDs), Cancers, Diabetes and chronic pulmonary obstructive diseases (COPDs). Sickle Cell Disease is also of concern being a significant contributor to infant mortality and also cause of so much misery.</p> <p>2.3 Out of the 56 million deaths worldwide each year, 38 million (68%) are due to NCDs, and 16 million (more than 40%) are premature (before the age of 70 years). 80% of the premature deaths occur in LMIC, which includes Nigeria. It is estimated that by 2030 the annual number of deaths from NCDs would increase to 52 million whilst communicable diseases mortality would reduce.</p> <p>2.4 There is no nationally representative data on NCDs at the moment, but pockets of research on NCDs conducted in various parts of the country indicate a worrisome trend of increasing burden of NCDs. Empirical observations also show rampant sudden deaths attributable to NCDs involving all segments of the population including prominent persons in</p>	<p>far back as 1988 and set up the NCD Control Programme in 1989 little has been done to strengthen the programme;</p> <p>iv. most States of the Federation do not have NCD desk at the SMOH;</p> <p>v. WHO promotes global coordination mechanism that flows from WHO via national to sub-national levels of member states; and</p> <p>vi. without a strong NCD programme at national and sub-national levels to ensure effective implementation of proven strategies to combat NCDs Nigeria will be left out in the attainment of SDG 3.4 by 2030.</p> <p>Council is further invited to approve the establishment of State/FCT Programme on NCDs.</p>		

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		<p>government.</p> <p>2.5 The global economic loss due to NCDs is estimated at US\$47trillion between 2011 and 2025. NCDs are chronic in nature and associated with high out-of-pocket expenditure and therefore a major cause of poverty at family and national levels. For these reasons, NCDs have now been recognized by the United Nations as developmental challenge.</p> <p>2.6 In view of the above the WHO and United Nations have instituted several initiatives to encourage member states to confront NCDs, including the Global Action Plan on the prevention and control of NCDs 2013-2025; High level meetings on NCDs (2011; 2014 and 2018 scheduled); Independent Commission on NCDs, of which the Honourable Minister of Health is a member; Global Coordination Mechanism on NCDs, which requires seamless flow of programmatic best-buy-activities to flow from global via national to subnational levels of governance; and the inclusion of NCDs in the Sustainable Development Goals (SDGs) as SDG 3.4, which is one third reduction of premature mortality from NCDs by 2030.</p>			

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		<p>3.0 ISSUES AND JUSTIFICATIONS</p> <p>3.1 National efforts towards the prevention and control of NCDs are currently domiciled in the Division of Non-Communicable Diseases in the Public Health Department of the FMOH.</p> <p>3.2 The NCD programme was launched in 1989 to coordinate the prevention, early diagnosis, control and formulation of policies and guidelines for NCDs in Nigeria, following the recommendation of the Expert Committee on NCDs, which was set up in 1988 by the then Honourable Minister of Health under the chairmanship of Professor O.O. Akinkugbe.</p> <p>3.3 However, the NCD Programme has not been very responsive to the rising NCD burden in the country due largely to poor funding and little or no link between the national and subnational levels. Worst still many of the States do not have even a desk for NCDs at the SMOH.</p> <p>3.4 With the inclusion of NCDs in the Sustainable Development Goals and declaration of 2018 as the year for action against NCDs, there is need to strengthen the coordination mechanism between the national and sub-national levels to ensure the country moves together in the</p>			

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		same direction towards the attainment of the targets for the Global Action Plan on NCDs as well as SDG 3.4			
22.	<b>THE STATUS OF IMPLEMENTATION OF THE NATIONAL POLICY ON FOOD SAFETY AND ITS IMPLEMENTATION STRATEGY</b>  <b>HONOURABLE MINISTER OF HEALTH</b>  <b>NCH/61/003S</b>	<p>The purpose of this memorandum is to inform the council on the level of implementation of the National Policy on Food Safety &amp; Its implementation Strategy (NPFSIS) that was adopted for implementation at all levels during the 58th National Council on Health (NCH) as well as to seek further approval for the creation of a State Food Safety Management Committee championed by the State Ministries of Health.</p> <p>2. Background</p> <p>In 2015, WHO estimated that food borne related diseases affect one of ten persons especially in children less than 5 years old. In recent years, preventable foodborne disease outbreaks such as Lassa Fever, Cholera, Diarrhoea, Methanol Poisoning have plagued different States with varied impact levels. These diseases are generally the consequence of poor Food Safety culture and poor hygiene practices in the country.</p> <p>This necessitated the need to have a Food Safety policy that will address the disjointed, chaotic and inefficient Food Safety governance in the country. The NPFSIS was therefore developed to modernise the food safety governance system to be more inclusive, effective, efficient and coordinated. One of the instruments established to ensure the proper implementation of the policy at all levels and across various stakeholders (public &amp; private) was the National Food Safety Management Committee (NFSMC).</p> <p>The policy focused on building the capacity framework of</p>	<p>4. Council is invited to note as follows:</p> <p>I. That the Federal Ministry of Health is currently implementing the NPFSIS, and this requires the urgent involvement of the states in escalating the overall national implementation towards attainment of desired goals and objectives at all levels.</p> <p>I. That the Federal Ministry of Health, through the National Food Safety Management Committee (NFSMC) has since 2016 been conducting awareness and sensitisation campaigns on Food Safety as well as the NPFSIS at geo-political zones across the country, and this has taken place in 13 States namely: Adamawa, Akwa-Ibom, Anambra, Ebonyi, Enugu, Gombe, Kaduna, Kano, Kogi, Kwara, Osun, Oyo and Rivers;</p> <p>I. That efforts are being made to visit and/or communicate with other States yet to be visited;</p> <p>I. That only few States have constituted or are in the process of constituting a State Food Safety Management Committee that will coordinate Food Safety activities across relevant MDAs in the State;</p> <p>I. That only few SMOH have a food safety desk</p>		

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		<p>both public and private sector for the overall aim of:</p> <ul style="list-style-type: none"> <li>Reducing the incidence of foodborne related diseases;</li> <li>Increasing acceptability of Nigerian foods in the international market, thereby, boosting the economy of the country;</li> <li>Ensuring consumer confidence in Nigerian foods.</li> </ul> <p>3. Issues</p> <p>Council in 2016 had approved the following:</p> <ol style="list-style-type: none"> <li>Adoption and implementation of the National Policy on Food Safety and its Implementation Strategy at all levels;</li> <li>Provision of adequate budgetary allocation for its operation;</li> <li>State Ministries of Health are to institutionalise Office of State Coordinator on Food Safety.</li> <li>Provide a Desk Officer(s) at the State Ministry of Health to coordinate all the activities of food safety at the State level.</li> </ol>	<p>as well as a State Coordinator on Food Safety.</p> <p>Council is further invited to approve:</p> <ol style="list-style-type: none"> <li>That adequate budgetary provisions are made available by FMOH and every SMOH for Food Safety activities as required by the NPFSIS;</li> <li>That all State Ministries of Health take the lead in establishing a State Food Safety Management Committee by securing appropriate approvals;</li> </ol> <p>That all States should have a food safety desk to ensure proper implementation of the NPFS and its implementation Strategy at all levels.</p>		
23.	THE INCLUSION OF THE REVISED TEN STEPS TO SUCCESSFUL BREASTFEEDING AS PART OF THE CRITERIA FOR REGISTRATION OF PRIVATE HEALTH FACILITIES IN THE NIGERIAN HEALTH SYSTEM TOWARDS THE INSTITUTIONALIZATION OF BABY FRIENDLY INITIATIVE	<p>The purpose of this memorandum is to request for the approval of Council for the inclusion of the revised ten steps to successful breastfeeding as part of the criteria for the registration of private health facilities in the Nigerian Health System towards the institutionalization of Baby Friendly Initiative.</p> <p>2.0 BACKGROUND</p>	<p>Council is invited to note that:</p> <ol style="list-style-type: none"> <li>Early Initiation and exclusive breastfeeding can contribute to reduction of child morbidity and mortality if scaled up.</li> <li>Early Initiation and exclusive breastfeeding in Nigeria is presently low and would impact on the morbidity and</li> </ol>		

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	<b>HONOURABLE MINISTER OF HEALTH</b>  <b>NCH/61/003T</b>	<p>Breastfeeding confers extensive and well-established benefits and is recognized as an extremely effective preventive health measure for both mothers and babies. Except in very few specific medical situations, breastfeeding should be universally encouraged for all mothers and infants.</p> <p>While breastfeeding is a natural act, it is also a learned behaviour. An extensive body of research has demonstrated that mothers and other caregivers require active support for establishing and sustaining appropriate breastfeeding practices. According to the Lancet series, in 2013, Health system and community interventions can increase exclusive breastfeeding by times 2.5</p> <p>The Baby-friendly Hospital Initiative (BFHI) was launched in 1991 to help motivate facilities providing maternity and newborn services worldwide. The Ten Steps to Successful Breastfeeding was the foundation for the Initiative. The Ten Steps summarize a package of policies and procedures that facilities providing maternity and newborn services should implement to support breastfeeding.</p> <p>The Ten Steps include the following:</p> <p>Every facility providing maternity services and care for newborn infants should:</p> <ol style="list-style-type: none"> <li>1. Have a written breastfeeding policy that is routinely communicated to all health care staff.</li> <li>2. Train all health care staff in skills necessary to implement this policy.</li> <li>3. Inform all pregnant women about the benefits and management of breastfeeding.</li> <li>4. Help mothers initiate breastfeeding within half an hour of</li> </ol>	<p>mortality statistics in the country.</p> <p>c. Inclusion of the Ten (10) steps to successful breastfeeding can save lives and at minimum cost.</p> <p>Council is further invited to approve:</p> <p>III. The inclusion of the critical management procedures of the ten steps to successful breastfeeding as part of the criteria for registering health care facilities which provide maternity services across the federation.</p>		

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		<p>birth.</p> <ol style="list-style-type: none"> <li>5. Show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants.</li> <li>6. Give newborn infants no food or drink other than breast milk, unless medically indicated.</li> <li>7. Practise rooming-in - that is, allow mothers and infants to remain together - 24 hours a day.</li> <li>8. Encourage breastfeeding on demand.</li> <li>9. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.</li> <li>10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic</li> </ol> <p>In 2015, the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) began a process to re-evaluate and reinvigorate the BFHI programme. This review focused on integrating the programme more fully in the health-care system, including private and public, facilities to ensure that all facilities in a country implement the Ten Steps with an emphasis on scaling up to universal coverage and ensuring sustainability over time.</p> <p>Accordingly, in 2018, WHO, UNICEF and all relevant multi stakeholders revised and modified the 10 Steps to successful breastfeeding into "2 Critical Management Procedures and 8 key clinical practices" as follows:</p> <p>A) Critical Management Procedures</p>			

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		<p>1a. Comply fully with the International Code of Marketing of Breast milk substitutes and relevant World Health Assembly resolutions</p> <p>1b. Have a written infant feeding policy that is routinely communicated to staff and parents.</p> <p>1c. Establish an ongoing monitoring and data management systems.</p> <p>2. Ensure that staffs have sufficient knowledge, competence and skills to Breastfeeding</p> <p>B) Key Clinical Practices</p> <p>3. Discuss the importance and management of breastfeeding with pregnant women and their families</p> <p>4. Facilitate immediate and uninterrupted skin-to-skin contact and support mothers to initiate breastfeeding as soon as possible after birth.</p> <p>5. Support mothers to initiate and maintain breastfeeding and manage common difficulties.</p> <p>6. Do not provide breastfed newborns any food or fluids other than breast milk, unless medically indicated.</p> <p>7. Enable mothers and their infants to remain together</p>			



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		<p>and to practice rooming –in 24 hours a day.</p> <p>8. Support mothers to recognize and respond to their infants' cues for feeding</p> <p>9. Counsel mothers on the use and risks of feeding bottles, teats and pacifiers</p> <p>10. Coordinate discharge so that parents and their infants have timely access to ongoing support and care.</p> <p>A key step to ensure integration and Sustainability is to make registration of facilities offering maternity services dependent on adherence to a full set of clinical standards and specific management procedures as outlined in the Revised Ten Steps.</p> <p>RATIONALE FOR THE PROPOSAL FOR THE INSTITUTIONALIZATION OF THE TEN STEPS</p> <p>There is substantial evidence that implementing the Ten Steps significantly improves breastfeeding rates. Studies have demonstrated clearly that adherence to the Ten Steps impacts early initiation of breastfeeding immediately after birth, exclusive breastfeeding and total duration of breastfeeding.</p> <p>Early initiation of breastfeeding is important for both the mother and the child. Early suckling stimulates the release of prolactin, which helps in the production of milk, and oxytocin, which is responsible for the ejection of milk. It also stimulates contraction of the uterus after childbirth and reduces postpartum blood loss. The first liquid to come from the</p>			

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		<p>breast, known as colostrum, is produced in the first few days after delivery. Colostrum is highly nutritious and contains antibodies that provide natural immunity to the infant.</p> <p>Exclusive breastfeeding for 6 months provides the nurturing, nutrients and energy needed for physical and neurological growth and development</p> <p>In Nigeria, The prevalence of exclusive breastfeeding in children below the age of six months is only 25 percent, which means that at least 5 million children each year do not get the powerful health and immunological benefits of breastfeeding. With the high under-five mortality rate and high birth rate in the Country, inadequate breastfeeding leads to 103,742 child deaths each year which in turn translates into almost \$12 billion in future economic losses for the country.</p> <p>Including the Ten Steps to Successful breastfeeding as part of the criteria for the registration of health care facilities providing maternity services would contribute to high prevalence of optimal breastfeeding and ultimately save lives.</p>			
25.	<b>ADOPTION OF THE POLICY ON MANDATORY TUBERCULOSIS SCREENING FOR ALL NEWLY EMPLOYED STAFF INTO THE FEDERAL AND STATE ESTABLISHMENT AS WELL AS NEWLY ADMITTED STUDENTS INTO THE TERTIARY AND</b>	<p>The purpose of this memo is to seek the approval of council on the mandatory Tuberculosis screening for all newly employed staff into the federal and state establishments as well as newly admitted students into the tertiary and secondary institutions of learning in the country.</p> <p>2. <u>BACKGROUND</u></p>	<p>Council is hereby invited to note the following:</p> <p>i. The country is currently detecting 25.8% of the estimated TB cases leaving a huge number of missed TB cases (25.8% for TB, 11% for DR-TB, 13% for childhood TB in 2017(NTBLCP 2017 annual report)</p>		

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	<b>SECONDARY INSTITUTION OF LEARNING IN THE COUNTRY</b>  <b>HONOURABLE MINISTER OF HEALTH</b>  <b>NCH/61/003V</b>	<p>Tuberculosis (TB) is a top infectious killer disease that continues to be a global threat with 11 million people developing the disease yearly. Nigeria is one of the countries with high burden of the disease globally. Every hour, 47 Nigerians develop active TB, 7 of these Nigerian are children. More worrisome is the fact that, every hour 18 Nigerians also die of TB, a disease that is preventable and curable. The burden of the disease is further fuelled by the huge number of undetected TB cases which serves as pool of reservoir for the continuous transmission of the disease. Evidence suggests that TB transmission is enhanced in settings where people tend to congregate, which includes workplaces, school hostels and dormitories.</p> <p>It is against this backdrop, that it is critically important to utilize all opportunities to screen, detect, and treat TB timely to interrupt the transmission of this disease for the realisation of the End TB target of the Sustainable Development goals by 2030.</p> <p><b>3.0 CONTENTS</b> According to the 2017 WHO Global TB report (and previous reports) Nigeria is among the 14 countries globally with high burden for TB, TB/HIV and MDR-TB. The country has the 2<sup>nd</sup> largest burden of TB and HIV in Africa. Evidence from our national TB prevalence survey conducted in 2012 indicate that as many as 400,000 TB cases occur annually in the country. Ironically, the survey result showed that 73% of the sputum positive (infectious) cases remain undetected, hence untreated, and thereby spreading the disease within our communities. Infection control measures are currently sub-optimal in most settings; and TB case finding is heavily reliant on passive approaches to identify and diagnose cases.</p>	<p>ii. The undetected TB cases, who remain untreated and infectious constitute a pool of reservoir for the continuous transmission of the disease in the community. One TB case has the potentials of infecting 10-15 persons annually,</p> <p>iii. National TB notification reports points to an increase in TB transmission in congregate (crowded) setting.</p> <p>iv The under-diagnosis and under-reporting of TB by health care workers at the Outpatient Department of secondary and tertiary health institutions despite the availability of Tuberculosis services at these facilities. According to the 2016 National Health facility survey report, Tuberculosis services are available in 75.8% of Secondary Health Facilities.</p> <p>v. The Thrust of the present administration's efforts to ensure universal access to TB services in the country and progress towards achieving the 90-90-90- targets of the End TB strategy.</p> <p>Council is further invited to approve</p> <p>I. Inclusion of TB screening as part of mandatory medical fitness assessment for all newly employed staff into the government establishments (Ministries, Department and agencies )</p>		

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		<p>Consistent with global best practices, the Ministry has adopted a more active approach to case finding including the implementation of innovative methods such as active house to house case search, especially in the slums in some states. These approaches have proved successful in improving our treatment coverage, which began to witness an increase again from 90,584 TB cases (17%) in 2015 to 109,904 TB cases (25.8%) in 2017.</p> <p>The State level analysis of CNR revealed that all the states recorded a very low CNR, with only 43% of the states have CNR for all forms of TB above the national average, an indication of very low TB case detection rate in all the states. The CNR for all forms of TB ranges from 11/100,000 pop in Ekiti state to 123/100, 00 pop in Sokoto state. Furthermore, the proportion of clinically diagnosed TB reduced from 31% in 2016 to 26% in 2017, the proportion in 2017 was below 20% in 9 of the states, with the proportion as low as 13% in Edo state suggesting under-diagnosis of clinical TB. This might be due to unawareness/skills among Health Care Workers at Out Patient Departments of Health facility; inadequate access to X-ray and/or poor supervisory capacity of the State and LGA programme to recognize these problems and provide rectifying solutions. Overall, there is under-diagnosis and under-reporting of TB cases.</p> <p>In spite of children making up around 41% of the population, notification rates for children remain far lower than expected, only 13% of the estimated TB cases among children were notified in 2017 with 87% of them still being missed contributing to the low treatment coverage rate (low TB case detection rate).</p>	<p>II. TB screening of all new entrants/admitted students into secondary schools and higher institutions of learning at state and Federal levels.</p> <p>Symptomatic TB screening at Outpatient Department of all Health care facilities especially Secondary and Tertiary Health institutions.</p>		

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		<p>The TB case-finding gap is much higher among drug resistant TB, even though there was 36% increase in number of diagnosed DR-TB cases from 1,686 in 2016 to 2,286 in 2017 however, 89% of the estimated MDR/RR-TB cases in 2017 were still being missed and not notified, thereby fueling continuous transmission of drug resistant TB in the community. The huge number of missed DR-TB cases is due to Low TB treatment coverage rate and suboptimal access to GeneXpert MTB/RIF tests among notified TB cases despite the policy of using Xpert MTB/RIF assay as the primary diagnostic tool.</p> <p>Our national notification reports indicate that TB cases have been detected among students in tertiary, secondary and primary schools as well as among the teaching staff. This development points to the likelihood of an increase in TB transmission rate occasioned by the congregate nature of settings like schools' hostels /dormitories, classrooms and work places in which persons from diverse backgrounds and communities are housed/interacting in close proximity for varying periods.</p> <p>As the Government of Nigeria is committed to achieving the Sustainable Development Goals including the End TB target by 2030, it has become imperative that the gap in TB case detection is closed. One of the strategies to achieve this is the inclusion of TB screening as part of mandatory medical fitness assessment for all newly employed staff into government establishments (Ministries, Department and agencies); newly admitted students into tertiary institutions and secondary students.</p>			
26.	<b>ADOPTION AND IMPLEMENTATION OF TELE-HEALTH INITIATIVE AS A MEANS OF INCREASING</b>	<p>The purpose of this memo is to keep Council abreast of the adoption and level of implementation of the tele-health initiative in Abia state.</p> <p>Background</p>	<p>Council is invited to note:</p> <p>i. That simple and available telecommunication like simple telephone can be leveraged on to improve access to (quantity) and enhance</p>		

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	<p><b>ACCESS TO QUALITY HEALTHCARE SERVICES IN NIGERIA: THE ABIA STATE EXAMPLE</b></p> <p><b>HONOURABLE COMMISSIONER FOR HEALTH, ABIA STATE</b></p> <p><b>NCH/61/003W</b></p>	<p>The Sustainable Development Goals (SDG) 3 highlights the pertinence of achieving universal health coverage for all by 2030. As at December 2016, the country recorded 154 million active telephony users. Nigeria presently has a record tele density of 110.4%, defining tele density as the number of active telephone connections per 100 inhabitants living within a target area. Abia State's telecoms market caters to almost 4 million active subscribers.</p> <p>The tremendous reach and substantial influence of telecommunication technology over almost all areas of our daily living, has ultimately made it an indispensable component with the potential to impact beyond our social lifestyle.</p> <p>The Abia tele- health initiative ABSTHi), is an indigenous inventiveness that leverages on simple and available telecommunication technology, hence the term "Tele-Health". The current access (35 – 45%) to basic, quality health care services in Nigeria pales in comparison to the exponential growth being witnessed in the telecommunications sector. This strongly positions the ubiquitous telecommunications technology as a veritable tool to drive other sectors service delivery, including health.</p> <p>ROLL OUT OF THE INITIATIVE IN ABIA STATE BY THE VICE PRESIDENT OF THE FEDERAL REPUBLIC OF NIGERIA ON 12TH APRIL, 2018.</p> <p>The Vice President, Prof. Yemi Osinbajo, physically rolled out the initiative on 12th April, 2018, at the International Conference Centre, Umuahia.</p> <p>The cardinal objectives of the telehealth initiative in the state</p>	<p>content of (quality) healthcare services;</p> <p>ii. That reliable, up-to-date clinical resources in the form of informal training and integrated supervisory support can be provided to local primary health care providers through telecommunication; thus advancing their knowledge, attitude, practice and skills towards making better health outcomes;</p> <p>iii. That connection between local residents to their local primary healthcare providers through telecommunication is possible, ensuring access to correct health information, education and care; and</p> <p>Council is further invited to:</p> <p>Approve the adoption and implementation of the Abia State Tele-Health Initiative in other states and FCT.</p>		

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		<p>include:</p> <ul style="list-style-type: none"> <li>i. To leverage on simple and available technology to improve quantity (access) and quality (outcome) of healthcare service, so that any person with a mobile phone, irrespective of the presence of a health institution or their proximity to one, is able to benefit remotely from a virtual healthcare system through transfer of simple health information via a vis healthcare services;</li> <li>ii. To advance simple health knowledge, attitude, practice and skill to health care workers and other individuals who for real reasons (lack of resources like money, time, human or infrastructural capital etc.) will ordinarily forego seeking clinical options for less palatable alternatives; and</li> <li>iii. To increase public awareness to public health matters, whether routine (like immunization), or non-routine (like newly emerging disease threats) events through targeted/mass dissemination of public or personal health information/intelligence to diverse or target population or person.</li> </ul> <p>The Abia State Tele-Health Initiative (ABSTHi) call center is manned by medical doctors (general/specialists) who provide services in response to demand. The state in collaboration with the vendor and MTN produced customised call cards with which the patient calls a doctor and accesses prompt quality care irrespective of where they are, hence the tag 'dial a doctor'. Services presently include:</p> <ul style="list-style-type: none"> <li>a. Remote supervisory clinical healthcare support services to Primary Health Care providers in local communities in</li> </ul>			

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		<p>Abia State, connecting local primary health care providers to reliable, up-to-date clinical resources in the form of informal training and integrated supervisory support; thus advancing their knowledge, attitude, practice and skills towards making better health outcomes.</p> <p>b. Connection between local residents in Abia State to their local primary healthcare providers ensuring access to correct health information, education and care towards self-empowerment, simply because people do better when they know better,</p> <p>AbSTHi also connects PHCs to their own permanent telecommunication identity, so that, despite operational and infrastructural maneuvers (facility relocation, personnel transfer etc.) this identity remains the same, guaranteeing long term sustainability of communication and constant connectivity to healthcare.</p>			
27.	<p><b>REQUEST FOR SUPPORT TO STRENGTHEN MALARIA ELIMINATION PROGRAM IN ABIA STATE</b></p> <p><b>HONOURABLE COMMISSIONER FOR HEALTH, ABIA STATE</b></p> <p><b>NCH/61/003S</b></p>	<p>The purpose of this memo is to secure the approval of Council for FMOH to support Abia State through linkages with partners and investors to reduce morbidity and mortality due to malaria in Abia state.</p> <p>Background Malaria has led to the tragic loss of lives and robbed many households and communities of their livelihoods, locking them in a vicious cycle of illness and poverty. Malaria is the major cause of death among the most vulnerable groups in Nigeria (a child under 5 dies from malaria every 30 minutes) and over 90% of the population is at risk. 50% of the population will have at least one episode per year; 30% childhood mortality and 11% maternal mortality is associated with malaria. In all, malaria is responsible for about 66% of all</p>	<p>Council is invited to graciously:</p> <p>iv. approve that the Federal Ministry of Health supports Abia State through linkages with investors and partners to reduce morbidity and mortality due to malaria as there is currently no partner in the state malaria program.</p> <p>v. promote increased inter-agency collaboration (Ministries of Health, Finance, Agriculture and Environment) as this will play a critical role in the drive towards elimination.</p> <p>vi. promote the conduct of joint operational</p>		



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		<p>clinic attendance. But mortality and morbidity due to malaria is preventable.</p> <p>The importance of partnerships and inter- sectoral cooperation to achieve program goals and more cost-effective interventions cannot be underscored, hence the need to strengthen human resources and national surveillance systems and to sustain funding for malaria control in Abia state. Effective malaria control and elimination require universal access of all at-risk populations to effective prevention , diagnosis and treatment measures as well as strong community involvement. Therefore, the success of the fight against malaria impacts positively on the achievement of the Sustainable Development Goals.</p> <p>Abia state focuses on eliminating malaria through support strengthening including the following:</p> <ul style="list-style-type: none"> <li>• ensuring access for all at-risk population to appropriate and effective vector control measures, early diagnosis and safe and effective anti-malarial treatment.</li> <li>• Conduct of replacement campaign of long lasting insecticidal treated nets (LLINS).</li> <li>• Strengthening state surveillance systems to monitor malaria trends and program impact, to detect and control outbreaks in a timely manner, and encouraging regular and transparent data reporting and sharing.</li> <li>• maximizing services utilization through appropriate advocacy, communication and community mobilization which is a powerful tool to support the long term political and financing commitment necessary for malaria elimination.</li> <li>• strengthening the capacity for research at all levels</li> </ul>	<p>research between the malaria programme and academia to fill programmatic gaps.</p>		

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		<p>through training, increased funding and networking. Promoting capacity building and training consistent with national malaria elimination plans to all stakeholders in the state.</p> <p>CONSIDERATION</p> <p>Council is invited to consider and note the efforts of Abia State government in eliminating malaria:</p> <p>I. widening the use of sports as a tool for malaria prevention. Our football development sector plays a role in educating the youth by providing mentors and recreational activities that keep them together with spectators. During this period, they are provided with support, they are sensitized on malaria prevention strategies, as well as availed access to early malaria diagnosis and treatment services.</p> <p>II. distribution of Long Lasting Insecticide Nets(LLINs) especially in Health Facilities through ANC,EPI and SOML during Maternal and Child Health Weeks.</p> <p>iii . In malaria elimination, Abia state is an orphan state with no partners and donors, leading to irregular availability of commodities and other resources.</p> <p>➤ There is therefor need for more concerted efforts and synergy in surveillance, integrated vector management (including promotion of alternative measures like insecticide treated mosquito nets), more coordinated inter-sectoral partnerships.</p> <p>➤ There is need for proper resource allocation.</p>			

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28.	<p><b>THE IMPLEMENTATION OF HIV AND TB INTERVENTION AMONG INTERNALLY DISPLACED POPULATIONS IN ADAMAWA STATE</b></p> <p><b>HONOURABLE COMMISSIONER FOR HEALTH, ADAMAWA STATE</b></p> <p><b>NCH/61/003Y</b></p>	<p>The purpose of this memorandum is to showcase experiences of Adamawa State Agencies for the Control of HIV/AIDS in coordinating Active HIV and TB Case finding among Internally Displaced Populations (IDPs) in Camps and Host Communities</p> <p>INTRODUCTION</p> <p>Adamawa States is affected by massive movement of IDPs as a result of the ongoing Boko Haram insurgency, With an estimated population of over 4.2 million (projected from 2006), the State has 21 Local Government Areas (LGA's). Activities of Boko Haram insurgents led to the destruction of communities and Health Facilities leading to a humanitarian crisis with the resultant displacement of over 1.76 million people; 56% were Children, 53% females and 7% were elderly above the age of 60 according to the IOM Displacement Tracking Matrix Report of June, 2017. With over 140,875 IDPs in 7 Camps and 419 Host Communities in the State as at June, 2017, the IDP population placed a remarkable strain on the already overstretched health service delivery system. IDPs are known to be at a higher risk of contracting HIV and TB compared to the General Population.</p> <p>This memorandum showcases efforts made by the Adamawa State Agency for the Control of HIV/AIDS in collaboration with a Community Based Organization in coordinating the implementation of HIV and TB Control activities among IDPs through the STOP TB Partnership's Wave 5 TB REACH grant.</p> <p>CONTENT</p>	<p>PRAYERS</p> <p>Council is hereby invited to note that:</p> <ul style="list-style-type: none"> <li>HIV and TB are serious public health problems among IDPs in Adamawa and other North-Eastern States of Nigeria</li> <li>The influx of IDPs including PLHIVs into Adamawa led to the overstretch of existing HIV/AIDS and TB services especially in IDP Camps and Host Communities</li> <li>The integration of IDPs including PLHIV into the host communities could lead to an increase in the transmission of HIV and TB which calls for an urgent need to strengthen HIV and TB interventions.</li> </ul> <p>Council is further invited to approve that:</p> <ul style="list-style-type: none"> <li>The FMOH intensify its support to Ministry of Health in States affected by insurgency in order to cope with increased demand for HIV/AIDS and TB services in IDP Camps and Host Communities</li> <li>The FMOH supports the scale up of this intervention across all IDP Camps and Host Communities in the North-East zone of Nigeria.</li> </ul>		

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		<p>Decreased funding for HIV/AIDS and TB Control, inadequate domestic funding and the IDP situation in the North-Eastern States of Nigeria threatens the investments made in the past and achievements recorded in HIV and TB Control. The Adamawa State Agency for HIV/AIDS Control in collaboration with the Gombe State Agency for HIV/AIDS Control jointly secured the Wave 5 TB REACH grant from the STOP TB Partnership which runs from 1<sup>st</sup> July 2017 to 30<sup>th</sup> June 2018. The grant is meant for the implementation of TB and HIV interventions among IDPs. The intervention is being coordinated by the Adamawa State Agency for the Control of HIV/AIDS (ADSACA) in Adamawa State.</p> <p>In collaboration with the State TB Control Programme, the State Emergency Management Agency, the State Primary Health Care Agency and other key stakeholders at the State and LGA levels, IDP Camps and Host Communities were mapped and clustered for the intervention. Community Based Organizations (CBOs) were engaged formally to coordinate the intervention which is being implemented through 60 Community Volunteers (CVs), 10 Health Workers (HWs) from DOTS centers and 10 laboratory staff from GeneXpert sites. A State Project Team (SPT) headed by the Executive Secretary of ADSACA coordinates the project.</p> <p>Active screening for HIV and TB in IDP camps and host communities were conducted through continuous house-to-house screening, monthly outreaches and systematic screening of IDPs on arrival in the Camps by the CVs. Quarterly joint supervision by the SPT and the State TB Programme and monthly supervision by the LGA TB</p>			

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		<p>Supervisors and</p> <p>. Data produced by LACA Coordinators was managed in accordance with the existing system for the TB and HIV control programmes.</p> <p>From 1<sup>st</sup> July to 31<sup>st</sup> December, 2017, 5,487 Internally Displaced Persons were screened for HIV out of which 92 (1.7%) were found to be HIV+. A total of 207 children were screened over the same period; one child was detected with HIV. Similarly, a total of 6,191 presumptive TB cases were screened for TB using GeneXpert out of which 396 (6.4%) were diagnosed with bacteriologically positive TB while 10 were diagnosed with Rifampicin Resistant TB. All HIV and TB cases detected, including pregnant women and children, were linked to designated treatment centers for further management,. Key challenges encountered include; Shortage of HIV RTKs, low capacity for HIV counselling and testing (especially among CVs), lack of appropriate HIV guidelines, shortage of GeneXpert Cartridges and inadequate numbers of CVs.</p>			
29.	<p><b>THE FORMATION OF LGA SAVING ONE MILLION LIVES PROGRAMME FOR RESULTS (SOML-P4R) IMPLEMENTATION STRUCTURE</b></p> <p><b>HONOURABLE COMMISSIONER</b></p>	<p>The purpose of this memo is to seek Council's approval for the establishment of LGA SOML-P4R Implementation Structures in all States and the Federal Capital Territory</p> <p>The implementation of the Saving One Million Lives Programme in all Thirty Six (36) States including the Federal Capital Territory has over the past few years repositioned the health sector for better health care service delivery with focus on the following (i) re-orienting the discussion of service delivery to results rather than just inputs; (ii) clearly</p>	<p>PRAYERS:</p> <p>The Council is hereby invited to note that:</p> <p>1. The establishment of LGA SOML-P4R Technical Consultative Group- Chaired by the Medical Officer of Health and Programme Management Unit manned by the LGA SOML P4R Desk Officer in all States of the Federation including the Federal Capital Territory will foster greater programme</p>		

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	FOR HEALTH, BAYELSA STATE  NCH/61/003Z	<p>articulating strategic priorities for the FGON and the rest of the health sector and strengthening the long term commitment to improving the delivery of high impact interventions. (iii) establishing a limited set of clear and measurable indicators to track success; (iv) strengthening data collection so that these indicators can be measured more frequently and more robustly; (v) bolstering accountability so that managers and health workers at all levels are engaged, encouraged, and incentivized to achieve better results; and (vi) fostering innovations that increase the focus on results and include greater openness to working with the private sector.</p> <p>The establishment of implementation structures for SOML P4R has engendered seamless implementation and enhanced productivity in all States of the Federation.</p> <p>JUSTIFICATION:</p> <ol style="list-style-type: none"> <li>1. While Implementation Structures have been established at both the Federal and State Leves I with the formation of Steering Committees, Technical Working Groups and Program Management Units, presently, there are no implementation structures at the Local Government Area level.</li> <li>2. The formation of LGA SOML- P4R Technical Consultative Group- Chaired by the Medical Officer of Health and Programme Management Unit manned by the LGA SOML P4R Desk Officer, will foster greater programme ownership, accountability and enhance programme implementation to achieve the objectives of</li> </ol>	<p>ownership, accountability and enhance programme implementation to achieve the objectives of the SOML- P4R.</p> <p>2. The development of guidelines for the formation of LGA SOML-P4R Technical Consultative Group and Programme Management Unit will expedite smooth implementation for quick-wins at the grassroot level of Primary Health Care Service Delivery</p>		

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		the SOML- P4R.			
30.	<p><b>THE IMPLEMENTATION STRATEGY OF THE NATIONAL DRUG DISTRIBUTION GUIDELINE AT THE STATE LEVEL</b></p> <p><b>HONOURABLE COMMISSIONER FOR HEALTH, BAYELSA STATE</b></p> <p><b>NCH/61/003AA</b></p>	<p>The purpose of this memorandum is to inform Council on the Implementation Strategy of the National Drug Distribution Guideline at the State level.</p> <p><b>BACKGROUND</b></p> <p>One of the major challenges of the Healthcare delivery system is the uncoordinated drug distribution system which is not in tandem with the National Drug Distribution Guideline as stipulated by the National Drug Policy. This has resulted in the number of fake, adulterated and substandard drugs in circulation.</p> <p>The guideline directs that States are to establish State Drug Distribution Centres, and it identifies sources of drugs at every level of healthcare delivery as well as mode of distribution thereby, introducing orderliness in the drug distribution system.</p> <p><b>CONTENT</b></p> <p>As a responsive government that craves to provide quality health services to its people, the Bayelsa State has recently constructed and commissioned a purpose-built State Drug Distribution Centre that will ensure the availability of safe, efficacious and affordable drugs in the healthcare delivery system.</p> <p>The implementation of this guideline at the State level will sanitize drug distribution, provide a one- stop shop for all drug needs for both the public and private health facilities in</p>	<p>PRAYERS</p> <p>The Council is invited to note as follows:</p> <ul style="list-style-type: none"> <li>i. The State Drug Distribution Center has effectively started providing services for its citizens.</li> <li>ii. Full implementation of the National Drug Distribution Guideline at all levels is earnestly required.</li> <li>iii. Expectations that set target dates for the closure of all open drug markets are maintained and achieved</li> </ul>		

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		the State, and thereby further protecting its citizens.			
31.	<p><b>THE ADOPTION OF PUBLIC – PRIVATE PARTNERSHIP (PPP) ON MENTAL HEALTH SERVICE DELIVERY</b></p> <p><b>HONOURABLE COMMISSIONER FOR HEALTH, BENUE STATE</b></p> <p><b>NCH/61/003AB</b></p>	<p>The purpose of this memorandum is to share with the Council of the benefits of the public- private partnership in mental health services which Benue State enjoyed with Methodist Church Nigeria (MCN).</p> <p>Background:</p> <p>Mental Health related condition(s) are fast becoming a cancer that is ravaging the fabric of our society by significantly affecting our population especially the youth and women. In our contemporary society, risk factors such as drugs abuse, substance abuse, chronic Health challenges, rising numbers of displaced persons and Economic hardship among other things accounts for high cases of Mental Health.</p> <p>Benue State therefore partners with Methodist Church Nigeria (MCN) to institute Comprehensive Community Mental Health Programme (CCMHP) at PHC to address these menaces. Under the partnership, the State Ministry of Health and Human Services is responsible to:</p> <ol style="list-style-type: none"> <li>1. Second a staff, preferably a Medical Officer to the CCMHP to work as a Mental Health Officer. This person will also be a natural liaison between CCMHP and the State Government.</li> <li>2. Designate a Desk Officer to act as a liaison between the CCMHP and LG health authorities in Benue State regarding the selection of health facilities, training and support supervision of healthcare providers, roll-out of services, and overall health systems strengthening.</li> </ol>	<p>PRAYER(S)</p> <p>Council is hereby invited to note that:</p> <ol style="list-style-type: none"> <li>1. The PPP arrangement between Benue State Ministry of Health and Human Services and MCN on CCMHP is significantly addressing mental health issues (10,982 new cases) and 33,992 on Treatment in the state.</li> <li>2. Through the partnership the State has integrated mental health services into PHC services, Prisons, and IDP camps and has increased access to mental health services in the state.</li> </ol> <p>Council is further invited to approve that;</p> <p>All states of the Federation initiate a PPP arrangement that would increase access to mental health services thereby reducing the menace of Mental Health illnesses in our society. These services are to be mainstreamed into prisons, IDP camps, HIV/AIDs and Reproductive Health (MCH) programs.</p>		



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		<p>3. Aid with selection and training of general practitioners and healthcare providers at primary and secondary levels of healthcare in identification, treatment and management of common mental disorders.</p> <p>4. Provide office space for CCMHP's use in Makurdi as Liaison office.</p> <p>5. Develop and implement plans for ownership of the project for the purpose of sustainability.</p> <p>6. Participate in advocacy, research development and dissemination within and outside Benue State.</p> <p>Content</p> <p>The project was a 5-year plan and 2<sup>nd</sup> phase of the CCMHP covers from January 2017 to December 2021. It intends to achieve its overall objective through the implementation of the following activities:</p> <p>a. Organizational development and coordination, capacity building for staff, &amp; partnership development.</p> <p>b. Scale-up of government-funded community mental health services and integration of MH into other aspects of Primary Health care like Maternal and New born Child Health care and HIV services across the state.</p> <p>c. Coordination at state level through Stakeholder Alliance, Strengthening activities of Self-help groups, and Economic integration of service users.</p> <p>d. Support improved mental health in the three prisons in</p>			

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		<p>Benue State.</p> <ul style="list-style-type: none"> <li>e. Health promotion in schools through addition of mental health to existing School Health Clubs.</li> <li>f. Support for persons with disabilities in emergency risk response (eg Humanitarian Emergencies in camps).</li> <li>g. Accountability, Monitoring and Evaluation, Research, Knowledge management and Dissemination.</li> </ul> <p>MethodistChurchNigeria (MCN) is investing in mental Health Services and socio-economic welfare of the people in the State. In 2010, the MethodistChurchNigeria,Otukpo diocese in collaboration with CBM International, Benue State Ministry of Health and Human Services, Federal Medical Centre - Makurdi (Department of Psychiatry) commenced Edawu Community Mental Healthcare Centre (Ainu – Oju), and Health and Restoration Centre for Psychiatric Illnesses (Agboke-Oglewu, Ohimni) through a project called Comprehensive Community Mental Health Programme (CCMHP). This project was piloted from 2010 to 2015 and during the period, mental health services were offered in 47 PHC facilities and in 17 Local Government Areas of the State. However, CCMHP has scaled up mental health services to 57 PHC facilities in the 23 LGAs from 47 PHC facilities in 2016. With the help of this partnership, about 33,992 patients are currently accessing mental health services in the State. Before the partnership, there was no PHC offering mental health service in the State. Within this partnership mental health services have also been extended</p>			

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		to Prisons, IDP camps and schools are being encouraged to form mental health clubs. Integration of Mental health services into PHC has made it accessible to the majority of our people.			
32.	<b>THE LONG LASTING INSECTICIDAL NETS REPLACEMENT CAMPAIGN IN 2017</b>  <b>HONOURABLE COMMISSIONER FOR HEALTH, EDO STATE</b>  <b>NCH/61/003AC</b>	<p>The purpose of this memorandum is to inform the Council of the success story recorded during the Long Lasting Insecticidal Nets (LLINs) replacement campaign in Edo State.</p> <p><u>BACKGROUND</u></p> <p>The last LLINs mass campaign was conducted in Edo State in 2012 when 1,157,307 LLINs were distributed. The insecticidal potency of the nets is said to depreciate after 3 years thereby losing its protective ability, thus the need for the replacement which was due since 2015 but was only conducted in 2017.</p> <p>The main objective of the campaign was to build the capacity of the State, Local Government Areas, Communities, Individuals and Partners on the benefits, management and use of the LLINs, to increase LLINs utilization in Households in the State and sustain a net culture through advocacy and community mobilization.</p> <p>The 2006 National Population census figure was used to project the population of Edo State thus 4,764,794 was arrived at. The Standard Operation Procedure of the LLINs replacement campaign stipulates that 1 net should be given to 2 persons in the same Household, however 2,678,900 nets were delivered to the Central Medical Store for</p>	<p>Council is hereby invited to note that:</p> <p>i. The LLINs replacement campaign in Edo State was supported by Global fund and implemented in the State by Catholic Relief Services in collaboration with the State Government. The Edo State Government provided funds to fill in the gaps that were not provided for in the Global Fund budget thus resulting in the huge success of the campaign in the State.</p> <p>ii. The success story is thus as follows;</p> <p>a. Household mobilization recorded a huge success covering 4,358,569 of the population which represented 91.5% of the total target population of 4,764,794.</p> <p>b. Out of the 2,464,900 net cards delivered to the Local Government Areas, 2,396,989 net cards were distributed to the Households during the process. This represents 90.6%.</p> <p>c. 2,110,150 nets were delivered as against the 2,396,989 net cards, thus making the redemption rate to be 88%.</p> <p>d. Post campaign evaluation by independent</p>		

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		<p>distribution to the citizenry of Edo State.</p> <p>The LLINs replacement campaign in Edo State was supported by Global fund and implemented in the State by Catholic Relief Services in collaboration with the State Government. The Edo State Government provided funds to fill in the gaps that were not provided for in the Global Fund budget thus resulting in the huge success of the campaign in the State.</p> <p><b>SUCCESS</b></p> <p>The success story is thus as follows;</p> <p>i. Household mobilization recorded a huge success covering 4,358,569 of the population which represented 91.5% of the total target population of 4,764,794.</p> <p>ii. Out of the 2,464,900 net cards delivered to the Local Government Areas, 2,396,989 net cards were distributed to the Households during the process. This represents 90.6%.</p> <p>iii. 2,110,150 nets were delivered as against the 2,396,989 net cards, thus making the redemption rate to be 88%.</p> <p>iv. Post campaign evaluation by independent monitors in the State revealed a hanging rate of the LLINs to be 85% while utilization rates for under five, pregnant women and others stood at 91%, 94% and 82% respectively.</p> <p>The following factors contributed to the success story of the LLINs replacement campaign in Edo State.</p> <p>i. Early engagement of the State by the implementing partner (Catholic Relief Services) before the commencement of the</p>	<p>monitors in the State revealed a hanging rate of the LLINs to be 85% while utilization rates for under five, pregnant women and others stood at 91%, 94% and 82% respectively.</p> <p>iii. . The following factors contributed to the success story of the LLINs replacement campaign in Edo State.</p> <p>a. Early engagement of the State by the implementing partner (Catholic Relief Services) before the commencement of the micro planning process.</p> <p>b. Involvement of Local Government Chairmen/ Head of Local Government Administration as members of coordination committee improved coordination and oversight of the campaign activities at all the LGA level.</p> <p>c. High level participation/political will improved State level commitment and filling of identified gaps.</p> <p>d. Engagement of independent monitors from LGAs where they reside helped to reduce the risks on travelling and improves monitoring time.</p> <p>e. Creation of platforms for communication among each category of personnel improves information dissemination e.g WhatsApp group.</p> <p>f. Joint submission of mobilization and distribution data by the State supervisors and the LGA team</p>		

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		<p>micro planning process.</p> <p>ii. Involvement of Local Government Chairmen/ Head of Local Government Administration as members of coordination committee improved coordination and oversight of the campaign activities at all the LGA level.</p> <p>iii. High level participation/political will improved State level commitment and filling of identified gaps.</p> <p>iv. Engagement of independent monitors from LGAs where they reside helped to reduce the risks on travelling and improves monitoring time.</p> <p>v. Creation of platforms for communication among each category of personnel improves information dissemination e.g Whatsapp group.</p> <p>vi. Joint submission of mobilization and distribution data by the State supervisors and the LGA team ensures ownership.</p> <p>vii. Involvement of security agencies in the transportation of LLINs improved commodity safety.</p>	<p>ensures ownership.</p> <p>g. Involvement of security agencies in the transportation of LLINs improved commodity safety.</p>		
33.	<p><b>THE NEED TO REVIEW DENTAL TRAINING IN THE COUNTRY</b></p> <p><b>HONOURABLE COMMISSIONER FOR HEALTH, EDO STATE</b></p> <p><b>NCH/61/003AD</b></p>	<p>The purpose of this memorandum is to seek Council's approval to increase the scope of dental training to medical students in medical schools, and make Dentistry a specialist training programme only.</p> <p>This memo is hinged on increasing utilization of essential package of health care services by increasing access to dental services in hospitals and clinics, especially in the rural areas.</p>	<p>PRAYERS</p> <p>Council is hereby invited to note that:</p> <p>i) Dental practice has not been widely embraced in this country due to dearth of Dental Medical Practitioner or ignorance on the part of our people;</p> <p>ii) the curriculum of medical students could be expanded to accommodate more</p>		

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		<p>BACKGROUND</p> <p>Dental practice is yet to be widely embraced by our people. The health benefits of training a Dental Doctor is much less than the time and financial commitment of becoming a dental practitioner because their services are not readily available due to limited number of dentists, especially in our rural areas.</p> <p>The relevance in our health sectors of most Dental practitioners after 8 years of training is usually not commensurate with the years put into acquiring the knowledge and skills. Despite the limited number of dentists turned out annually, many are unemployed. Those that go into private practice are usually idle. Meanwhile most medical doctors are on daily basis confronted with dental cases they cannot handle.</p> <p>CONTENT</p> <p>The medical/dental training stipulates the same curriculum in the 1<sup>st</sup> three years. Even after movement of dental students to the School of Dentistry, Medical students acquire limited dental trainings that they eventually put to use as medical doctors in managing some dental patients that visit the consulting room on daily basis.</p> <p>Ignorance on the part of the patients and dearth of dentists have also contributed to the low patronage of dentists by patients with dental problems, hence it will therefore be more rewarding to our patients and practice if medical students are</p>	<p>training in dental care/skill so that medical doctors can render more dental care to patients; and</p> <p>iii) access to dental care can be achieved when medical doctors have more basic dental training.</p> <p>Council is further invited to approve:</p> <p>i) the expansion of the curriculum of medical students to accommodate more dental training; and</p> <p>ii) that Dentistry be made a post graduate specialist programme only.</p>		

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		<p>given more basic training in dental care to expand their skills and ability to manage more dental problems. Consequently, dental medical students can train as medical students while the School of Dentistry only runs Post graduate for medical doctors who may wish to specialize in Dentistry at post graduate level.</p> <p>The advantages of the modification are as follow:</p> <ul style="list-style-type: none"> <li>(i) More space will be available for medical student's admission in our Medical Schools;</li> <li>(ii) Medical doctors will be able to manage more dental conditions before referral to specialist where necessary;</li> <li>(iii) Patients can have more access to dental care even in rural areas as long as there are medical doctor in such facilities;</li> <li>(iv) Dentists unemployment and idleness will be eliminated because doctors can still manage other medical conditions even when dental patients are not available at that particular point in time; and</li> </ul> <p>Funds would be saved because Preclinical School of Dentistry will merge with that of Medicine.</p>			

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34.	<p><b>THE ADOPTION OF POSTING OF NYSC MEMBERS TO HEALTH FACILITIES FOR THE PURPOSE OF COLLECTING AND COLLATING LOGISTICS DATA</b></p> <p><b>HONOURABLE COMMISSIONER FOR HEALTH, ENUGU STATE</b></p> <p><b>NCH/61/003AE</b></p>	<p>The purpose of this memo is to inform the Council on supporting the continuous improvement of health commodity logistics data reported by health facilities which ultimately will lead to product availability. It will also provide employment opportunities for NYSC members. Logistics management is a virgin ground in the labour market.</p> <p><b>INTRODUCTION</b></p> <p>A Logistics Management Information System (LMIS) is a record and report used to aggregate, analyse, validate and display data (for all level of Logistics System) that can be used to make Logistics decision and manage supply chain. LMIS data element include stock on hand, Losses and adjustment, Consumption, Demand Issues and Cost of Commodities managed in the system.</p> <p>LMIS linked different levels of in the system through information. It also provides information that each level needs to perform its supply chain role.</p> <p>Logistics Management Information System (LMIS) is the engine room of all logistics activities in any public health programmes.</p> <p><b>JUSTIFICATIONS</b></p> <p>This will help to improve</p> <ul style="list-style-type: none"> <li>Record keeping: incomplete or not updated stock and consumption data.</li> <li>Data Report on health commodity: Late, incomplete and poor quality report.</li> <li>Data not moving up and down the system: Facilities not</li> </ul>	<p><b>PRAYERS</b></p> <p>The Council is invited to note as follows</p> <ul style="list-style-type: none"> <li>That NYSC members are good human resources in logistics management irrespective of their field of studies. NYSC members posted to health facilities with the sole aim of collecting and collating Logistics data will address the common challenges of Logistics Management Information System.</li> </ul> <p>Council is further invited to approve:</p> <ul style="list-style-type: none"> <li>To adoption posting of NYSC members to Health facilities. This will encourage product availability at Health facilities and provide job opportunities for NYSC members after their service year.</li> </ul>		



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		<p>submitting to Districts, Districts not submitting to the State and State not providing feedback to Districts and Facilities.</p> <ul style="list-style-type: none"> <li>Data use for decision making</li> </ul>			
35.	<p><b>THE NEED FOR SYNERGY IN SUSTAINING CAMPAIGN FOR THE ELIMINATION OF NEGLECTED TROPICAL DISEASES (NTDs) IN GOMBE STATE BEYOND 2020 WHO NTDS ROAD MAP.</b></p> <p><b>HONOURABLE COMMISSIONER FOR HEALTH, GOMBE STATE</b></p> <p><b>NCH/61/003AF</b></p>	<p>The purpose of this memorandum is to inform the Council on the effort by the State Government in the area of elimination of Neglected Tropical Diseases (NTDs) and also to seek collaboration of Federal, neighboring States; WHO, UNICEF and other development partners towards building strong strategies to reduce these NTDs to barest minimum.</p> <p>Background:</p> <p>Neglected tropical diseases (NTDs) – Is a diverse group of communicable diseases that prevail in tropical and subtropical conditions in 149 countries – affect more than one billion people and cost developing economies billions of dollars every year. Populations living in poverty, without adequate sanitation and in close contact with infectious vectors and domestic animals and livestock are those worst affected.</p> <p>Effective control can be achieved when interventions are</p>	<p>The council is invited to note:</p> <ol style="list-style-type: none"> <li>The State Government is finding it hard to sustain the quarterly chemical spray around Dadin Kowa Dam and Environs, and also funding similar sprays around Balanga Dam; Gombe Abba; Nafada; Funakaye rivers and Environs so that the black flies spreading onchocerciasis would be eradicated from their breeding ground.</li> <li>Government is providing free distribution of treated insecticide nets to members of the public across the State; this effort is complemented by Saving One Million Lives Programme for Results in the State.</li> <li>Biannual dredging of drainages to stop them from becoming breeding areas for mosquitos and related vectors.</li> <li>The State Government has prioritized improved sanitation combined with delivering</li> </ol>		

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		<p>guided by the local epidemiology and the availability of appropriate measures to detect, prevent and control diseases. Implementation of appropriate measures with high coverage will contribute to achieving the targets of the WHO NTD roadmap on Neglected Tropical Diseases by 2020. The campaign for the elimination of some NTDs in Gombe State commences about 15years ago, and some were added in 2015 with elimination target of 2020 as stipulated in the WHO NTD roadmap.</p> <p>CHALLENGES POSE BY NTD / EFFECT OF NTD:</p> <p>Neglected Tropical Diseases</p> <p>Neglected tropical diseases (NTD) comprise several diseases that have a range of effects, from extreme pain to permanent disability to death. Here are some examples:</p> <p>Onchocerciasis (river blindness) A parasitic worm disease spread by infected black flies, onchocerciasis can cause extreme itching, blindness, and skin lesions. It can damage the genital part of an infected person, consequently cause fertility problem. 10 out of the 11 LGAs of the State are endemic with this disease, and these black flies has the ability to fly for more than 200km as such not only the entire State is vulnerable, but including all our four neighboring States of; Yobe; Bauchi; Adamawa; Borno respectively.</p> <p>Lymphatic filariasis (elephantiasis) A parasitic worm disease spread from human to human by mosquitoes, lymphatic filariasis can lead to disfiguring</p>	<p>preventive chemotherapy and health education to sustain reductions in prevalence of many of these diseases in the State.</p> <p>Council is further invited to Approve;</p> <p>I. The Federal Ministry of Health in collaboration with State Government and relevant bodies to create avenues for research and development in order to find new approaches and simplified strategies as well as novel diagnostics, medicines, vaccines and vector control methods to enhance interventions and advance progress towards the roadmap's targets of WHO on Neglected Tropical Diseases.</p>		

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		<p>swelling of the legs, scrotum, and breast. 10 out of 11LGAs of the State are endemic with Lymphatic Filariasis.</p> <p>Schistosomiasis:</p> <p>A parasitic worm disease transmitted by fresh water snails, schistosomiasis can lead to blood in the urine, impaired growth, and malfunctioning of the kidney, liver, and spleen. All the 11 LGAs of the State are endemic with Schistosomiasis with its attending consequences.</p> <p>Public health experts are concerned about schistosomes becoming resistant to the currently used drug praziquantel. If this were to occur, an alternative drug would be needed as a substitute, to fulfill this need; researchers are to be supported in conducting basic research to learn more about certain biochemical pathways that the schistosome worm requires for survival. If a drug could target these pathways and inhibit them, this would be a new and effective way to eliminate the parasite.</p>			
36.	<p><b>ADOPTION AND IMPLEMENTATION OF SHORT-TERM REFRESHER TRAINING FOR PRIMARY HEALTH CARE WORKERS ON ESSENTIAL HEALTH SERVICES.</b></p> <p><b>HONOURABLE COMMISSIONER FOR HEALTH, IMO STATE</b></p> <p><b>NCH/61/003AG</b></p>	<p>The purpose of this memorandum is to seek Council's approval for the adoption and implementation of Institutionalized and phased Capacity Building for all PHC workers on Essential Health Care Services in the areas of malaria, HIV/AIDS, Tuberculosis, Immunization, Nutrition and Reproductive Health Services, among others. This is in line with one of the pillars of the National Strategic Health Development Plan –to strengthen health system for effective delivery of Essential Health Care Services.</p> <p><u>Background</u></p> <p>The realization of health care services access by all is still impeded by poor capacity of the health care providers in</p>	<p>The council is invited to note that:</p> <ol style="list-style-type: none"> <li>1. There is presently no official policy guiding an Institutionalize Continuous Capacity Building on Essential Care Services for PHC workers.</li> <li>2. The parallel and selective capacity building carried out in individual areas of the essential health care services by government/donors consume lots of funds without commensurate results in quality essential health care services due to the fact that inadequate manpower are trained and attrition worsens the</li> </ol>		

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		<p>most facilities. Though there may be inadequate manpower, the already existing manpower are of poor capacity in most of the areas of the essential health care services.</p> <p>Attempts to boost capacity of the PHC workers are usually done along parallel lines in individual sectors of the health care services such as Malaria, HIV/AIDS, and Reproductive Health etc. through programmes supported by Development Partners, other Non-governmental Organization, FMOH and SMOTH. This results in unevenly distributed skilled work force among PHC facilities. This in turn leads to poor service delivery of the essential health care services in the communities.</p> <p>The end point is that the huge financial resources invested in the selective and parallel capacity building seem not to be commensurate with the eventual output.</p> <p>This memorandum therefore advocates the institutionalization of capacity building which will require all health workers to undergo training through established health institutions meant for this purpose at intervals. The financial contributions from government and donors are to be channeled to the institutions. The regular churning out of trained PHC facility personnel will result in fair distribution among the PHCs.</p> <p><u>Content:</u> The following procedures/steps are involved in the actualization of the Institutionalized Continuous Capacity building for the PHC workers on Essential Health Care Services.</p> <p>1. The Federal Ministry of Health and State Ministries</p>	<p>situation.</p> <p>The council is further invited to approve:</p> <ol style="list-style-type: none"> <li>1. The adoption and implementation of the Institutionalized and Continuous Capacity Building on Essential Health Care Services for PHC workers as a resolution of the Council.</li> <li>2. The adoption and implementation of the steps/procedures for actualization of this resolution by the State Ministries of Health.</li> </ol>		

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		<p>of Health are mandated to recognize or establish one health institution in each State that will mount a consultancy unit or institute for Institutionalized Continuous Training on essential health care services.</p> <p>2. The Federal Ministry of Health, State Ministries of Health, and Development/Donor Agencies have memorandum of understanding in financing the running of the institute or unit for the continuous training on essential health care services.</p> <p>3. The unit/institute established should offer short duration course (one to two months) on the existing (updated) policies, guidelines, standard operating procedures and basics in the best practices at least in Malaria, HIV/AIDs, Tuberculosis treatment and prevention services, Immunization, Nutritional and Reproductive Health Services.</p> <p>4. All PHCs are required to recommend/send their staff in batches to undergo the training. Also as soon as new staff are engaged, they equally undergo the training.</p> <p>5. They should undergo a refresher course now and thereafter.</p>			
37.	<p><b>INSTITUTIONALIZATION OF COMMUNITY BASED MASAKI NUTRITION INITIATIVE (CMNI)</b></p> <p><b>HONOURABLE COMMISSIONER FOR HEALTH, JIGAWA STATE</b></p> <p><b>NCH/61/003AH</b></p>	<p>The purpose of this memorandum is to inform Council on the institutionalization of Community based Masaki Nutrition Initiative (CMNI) and to encourage states to adopt and implement the initiative in order to reduce the menace of childhood malnutrition.</p> <p><u>2. BACKGROUND:</u></p> <p>Nutrition plays a significant role in child's growth. The nutritional status of children in the first 1000 days of life is</p>	<p>The Council is hereby invited to note this laudable initiative and to encourage states to adopt the CMNI strategy in order to reduce the menace of childhood malnutrition.</p>		

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		<p>critical for survival and future cognitive functions. The ultimate consequence of acute malnutrition is stunting if the child survives. Stunting in early childhood has been documented to result in impaired behaviour later in life. Globally, there are over 165 million children affected with chronic malnutrition out of which up to 3.1 million die annually. From 1990 to 2015, most regions of the world are recording declining numbers of stunted children, however, this is not the case for the sub Saharan Africa which according to Black, Cesar, Susan, Zulficar, Parul, Mercedes de, Majid, et, al. (2013), rate of stunting is actually increasing (45.7% in 1990 to 58.1 in 2015).</p> <p>With a national average of 32% stunting rate, Nigeria accounts for 7% of the global burden of stunting, which is only second to India, (Tigga, Sen &amp; Mondal, 2015). There is wide variation in child malnutrition within the various regions of Nigeria, for example, a south eastern state has stunting rate of 7%, which is far better than the national average (Nigeria SMART Survey report, 2013) while Jigawa state on the other hand, like many other states in the north, has unacceptably very high stunting rates (Nigeria SMART Survey report, 2015). The variation is related to a number of factors including disparity in the level of education, income and socio-cultural characteristics (Senbanjo, Oshikoya, Odusanya, &amp; Njokanma, 2011).</p> <p><u>4. JUSTIFICATION:</u></p> <p>The current approaches of addressing childhood malnutrition in Nigeria are expensive and mostly unsustainably donor</p>			

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		<p>driven, there is therefore the need for pro-poor strategies to overcome this challenge. Mothers and care givers still lack knowledge and skills for successful child feeding, including healthy weaning, complementary, supplementary as well as exclusive breast-feeding practices (Nigeria NDHS Report, 2013). Geographical, socioeconomic as well as financial accesses have been identified to pose unbreakable barriers to health facility-based nutrition programs. The global economic recession that is affecting many nations around the world calls for the deployment of low cost intervention for the improvement of nutritional status. Institutionalization of Community Masaki Nutrition Initiative (CMNI) can go a long way in not only reducing childhood malnutrition but also preventing it.</p> <p>In response to this high burden of high level of stunting, the Jigawa State PHCDA is piloting the institutionalization of CMNI in some communities. The aim of CMNI is to promote community growth monitoring and the deployment of the right interventions for children with growth faltering by the mothers and care-givers themselves within the community. The program involves the following stages</p> <ol style="list-style-type: none"> <li>1. Community gate keeping processes</li> <li>2. Identification of community resources</li> <li>3. Nutrition baseline assessment using simple MUAC measurement</li> <li>4. Identification and listing of all mothers with children under the age of five</li> <li>5. Training of community nutrition champions on growth</li> </ol>			

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		<p>monitoring using MUAC tapes, preparation of local recipes and referral</p> <p>6. Conduct of bimonthly growth monitoring</p> <p>7. Data management using pictorials</p> <p>8. The project is currently running in three communities in Jahun LGA and already yielding interesting results.</p> <p>5. <u>CONTENT:</u></p> <p>Studies have shown that around 80 percent of babies are exclusively breastfed on discharge from baby-friendly hospitals. However, this percentage drops significantly to 49 percent six weeks after birth, and then as low as 16.7 percent at six months. The Community Masaki Nutrition Initiative (CMNI) plays an important role in creating supportive breastfeeding services in the community, just as Baby Friendly Hospital Initiative (BFHI) has in maternity services.</p> <p>All communities participating in the CMNI are being supported by the closest local health facility; the facility in charge or any trained health worker attend the bimonthly growth monitoring session at the community. The officer records the data, guides the mothers of the best recipe to adopt for the level of the malnutrition each child has and takes over the management of very sick children at the facility level including referrals. CMNI is intended to make sure that there is consistent standard of breastfeeding knowledge and Infant and Young Child Feeding (IYCF) skills to be available for women and their families in the wider community, so that they will be encouraged to initiate and continue breastfeeding, and to also monitor the growth of</p>			



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		<p>their children themselves.</p> <p><u>6. KEY STRATEGIES:</u></p> <ul style="list-style-type: none"> <li>a. Advocacy: This would target community gate-keepers and opinion leaders to provide enabling environment for the practice of exclusive breastfeeding at farm, home and market.</li> <li>b. Pooling of local resources (food items) to provide support for very poor caregivers.</li> <li>c. Teaching mothers and caregivers on how to use locally available food items to prepare highly nutritional delicacies for their children.</li> <li>d. Sensitization of mothers and caregivers on the benefit of child growth monitoring and nutrition interventions.</li> <li>e. Peer support program: Women who exclusively breast-fed would be engaged in health education campaigns so as to convince others who are still contemplating.</li> <li>f. Provision of other health promotion interventions such as immunization, water and sanitation, acute care programs etc.</li> </ul>			
38.	<p><b>PILOTING THE INTEGRATION OF PEOPLE WHO INJECT DRUGS (PWID) INTERVENTION IN THE WORK OF "EMINENT PEOPLES FORUM".</b></p> <p><b>HONOURABLE COMMISSIONER FOR HEALTH, KANO STATE</b></p>	<p>The purpose of this memo is to inform the Council on piloting the integration of people who inject drugs (PWID) intervention in the work of "Eminent People forum".</p> <p><b>BACKGROUND</b></p> <p>For over 2 years, Kano State Agency for the Control of AIDS has partnered with Society for Family Health to implement a Global Fund supported intervention among persons who inject drugs (PWID) in the state. The intervention promotes behavior change using minimum prevention package of</p>	<p>PRAYERS</p> <p>Council is hereby invited to note that:</p> <ol style="list-style-type: none"> <li>1. for over 2 years, Kano State Agency for the Control of AIDS has partnered with Society for Family Health to implement a Global Fund supported intervention among persons who inject drugs (PWID) in the state</li> <li>2. the intervention promotes behavior change</li> </ol>		

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	NCH/61/003AI	<p>intervention (MPPI) leading to break in the transmission of HIV. The HIV prevention team in the state has worked directly with the PWIDs, parents of PWID, law enforcement agents, and relevant stakeholders to facilitate better access to prevention services. While this intervention is ongoing in about nine states, Kano SACA understood the peculiarity of the state and has initiated an add on to the intervention that empowers the PWID to sustain the behavior change and become better citizen. The state is piloting the integration of PWID intervention in the work of Eminent Peoples Forum.</p> <p>The Eminent Peoples Forum is a creation of the Inspector General of Police established at the state and LGA levels to support the Force in addressing security challenges through 'mediation and social control'. The membership of the forum includes community, traditional and religious leaders, retired senior security officers and other stakeholders.</p> <p>CONTENT</p> <p>The integrated prevention initiative is being piloted in Gwarzo LGA, with high cases of drug abuse and its consequences. The EPF in the LGA is fully functional and it comprised of membership from diverse background. The forum is chaired by a former Director General of Federal Radio Corporation of Nigeria and with members that include the District Head, LGA Chairman, DPO, NDLEA Coordinator, representative of civil society, leaders of major tribes, and youth groups among others. The forum created Youth and education sub-committee that focuses on drug abuse among the youth in the LGA. The sub-committee works closely with the project team to create awareness and educate the local public on</p>	<p>using minimum prevention package of intervention (MPPI) leading to break in the transmission of HIV</p> <ol style="list-style-type: none"> <li>in order to ensure improved community support for the intervention Kano State decided to involve the Eminent Peoples Forum in the implementation.</li> <li>the Eminent Peoples Forum is a creation of the Inspector General of Police established at the state and LGA levels to support the Force in addressing security challenges through 'mediation and social control'</li> <li>the membership of the forum includes community, traditional and religious leaders, retired senior security officers and other stakeholders.</li> <li>the integrated prevention initiative is being piloted in Gwarzo LGA, with high cases of drug abuse and its consequences</li> <li>the partnership with the eminent Peoples Forum has encouraged more PWID to participate in peer education and other HIV prevention services which resulted in marked reduction in the intake of drugs among the PWID, increasing support of families and communities to PWID in terms of</li> </ol>		

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		<p>the consequences of injecting drugs and other forms of drug abuse; promote acceptance and support for drug abusers, encourage community to be open about drug abuse at family or community level and create enabling environment for the conduct of peer sessions and referral services for PWID.</p> <p>The partnership with the eminent Peoples Forum has encouraged more PWID to participate in peer education and other HIV prevention services that has resulted in marked reduction in the intake of drugs among the PWID, increasing support of families and communities to PWID in terms of rehabilitation and other social support and there has been a refocus of the NDLEA attention from the users to the sellers of the illicit drugs in the community. More so, the project team has facilitated access of the Forum to information about PWIDs who require specific support including, graduates who need employment, artisans who are in need of work tools, drop out who want to return back to school and students who requested for WAEC fees to write SSCE.</p> <p>The integration is yielding positive results as the community is owning and actively participating in the intervention and hopefully achieves better outcome of reduced HIV prevalence among the youth and improved security within the communities.</p>	<p>rehabilitation and other social support and there has been a refocus of the NDLEA attention from the users to the sellers of the illicit drugs in the community.</p> <p>8. the integration is yielding positive results as the community is owning and actively participating in the intervention and hopefully achieves better outcome of reduced HIV prevalence among the youth and improved security within the communities.</p> <p>Council should also note the interesting collaboration between the Eminent Peoples Forum and the State in the fight on drugs, crime and HIV</p>		
39.	<p><b>THE IMPLEMENTATION OF HEALTH CARE PLUS MODEL IN KOGI STATE.</b></p> <p><b>HONOURABLE COMMISSIONER</b></p>	<p>The Purpose of this Memo is to inform the Council of the implementation of Health Care Plus Model in Kogi State.</p> <p>Background:</p> <p>Health Care plus is a Maternal and Newborn Health Intervention Programme designed to end preventable</p>	<p>The council is invited to note that:</p> <p>i. The implementation of Health Care Plus model is a priority for the State in reducing Maternal and Newborn mortalities to &lt;100/100,000 live births</p>		

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	<b>FOR HEALTH, KOGI STATE</b>  <b>NCH/61/003AJ</b>	<p>Maternal and Newborn Deaths in Kogi State in a political dispensation under the able leadership of His Excellency, Alhaji Yahaya Bello the Executive Governor of Kogi State.</p> <p>Health Care Plus was approved by the State Executive Council on 25<sup>th</sup> July 2016 and officially flagged off by His Excellency, Alhaji Yahaya Bello the Executive Governor of Kogi State on 25<sup>TH</sup> January 2018 and unveiling of Health Care Plus logo by the Honourable Minister of Health, Prof. Isaac Adewole.</p> <p>Content:</p> <p>Health Care Plus is built on a strong political will to end preventable Maternal and Newborn Deaths through:</p> <ol style="list-style-type: none"> <li>1. Renovation, remodeling and equipping of 12 selected Primary Health Care centers in Kogi State (4 per senatorial district) which provides all the centers with a functional PHC that operates 24 hours in a day.</li> <li>2. Bridging of man power gap in those selected PHCs by the recruitment of 4 Midwives and NYSC doctor trained on Basic Emergency Obstetric and Newborn Care to ensure quality skilled birth attendance.</li> <li>3. Provision of free Maternal and Newborn care services visa viz Antenatal care services, labour, delivery and post-natal care services.</li> <li>4. Provision of free basic laboratory tests which includes HIV testing, Hepatitis B and C, Urinalysis, Blood glucose, RDT, Hemoglobin genotype and Blood</li> </ol>	<p>and &lt;10/1000 live births respectively in 2019 as contained in our New Direction Blue print for the Health sector.</p> <p>ii. Health Care Plus model is impacting on lives and helping to reduce Maternal and Newborn Mortalities in Kogi State.</p> <p>Council is further invited to approve:</p> <p>i. The replication of Health Care plus Model in all the States of the Federation and FCT.</p>		

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		<p>grouping in every registered pregnancy.</p> <ol style="list-style-type: none"> <li>Effective 2 way referral system from PHC to Secondary and Tertiary Health facilities for advanced care with Hospital bills of those referred patients fully paid by the State Government to ensure referred patients go to those referral centers with a view to reducing Maternal and Newborn mortality.</li> <li>Community linkage through Health rangers who are Community Health Extension Workers and Social workers selected to follow up on registered Pregnant women to ensure they access the Health facilities as at when due and during emergencies.</li> <li>Free Treatment for Newborn in the first month of life to reduce Newborn deaths in Kogi State.</li> <li>Electronic data capturing and tracking system to ensure prompt monitoring and supervision of the selected PHCs by the supervising Consultant Obstetrician attached to each Hospital.</li> <li>Pre-implementation plan towards a Sustainable Social Health Insurance Scheme.</li> </ol> <p>Observation:</p> <p>We noticed that since the commencement of Health Care Plus, antenatal registration and hospital deliveries have increased considerably in those Health Facilities due to the free Maternal and Newborn Health Care Services in those centers and with a strong 2-way referral system set up operative deliveries in the referral centers have remarkably reduced Maternal mortality to an extent.</p>			

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40.	<p><b>APPEARANCE IN COURT OF PHYSICIAN (HEALTH CARE DELIVERER) IN LITIGATION THAT REQUIRES INPUTS OF A MEDICAL EXPERT TO AID JUDGEMENT</b></p> <p><b>HONOURABLE COMMISSIONER FOR HEALTH, OGUN STATE</b></p> <p><b>NCH/61/003AK</b></p>	<p>To examine the duty (Physician) Health Care Service Deliverer beyond the scope of health facility and Medical jurisdiction. Especially Civil obligation to testify in Court, to assist judiciary in giving judgement, but has no relationship with the management of the health of the personality in health sector.</p> <p><b>INTRODUCTION</b> It is an established fact that the primary obligations of health care service deliverer are preventive, curative and rehabilitation. In the course of these assignments issues of communicable and non-communicable diseases in the likes of injuries – self-inflicted, professional hazard, social conflict, domestic and public accidents are involved. It is also a known fact that some of these cases go to the judiciary to address some social imbalance beyond health sector purview, for one reason or the other.</p> <p>A physician (Health Care Deliverer) who had rendered his/her primary obligation of provision of relief and restoration of health to clients are sometimes called upon to give a brief or testify in court to help the judiciary to deliver judgement, which has no effect in management of the patient health condition but judicial. The physician time and intellectual resources are exploited without any specified legal remuneration/compensation.</p> <p><b>ISSUE AND JUSTIFICATION</b> The issue here are exploitation of time and intellectual resources of the health care deliverer outside his/her primary assignment. The physician (health care deliverer) has</p>	<p><b>PRAYERS</b></p> <ol style="list-style-type: none"> <li>1. That the Council review the situation and submit the outcome for an enduring policy. <ol style="list-style-type: none"> <li>a. That the physician journey to and from the court and intellectual opinion be catered for.</li> </ol> </li> <li>2. That such summon should give enough time to arrange for the above.</li> </ol>		

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		<p>completed his services and obligations of health care delivery, sometimes even issued Medical Certificate or report on the services rendered. The judiciary in the course of delivery judgement sometimes summon the physician (health care deliverer) to court to testify on the service rendered, without consideration of the financial effect on the schedule of duty of the physician or the effect on the facility where the physician is employed or working.</p> <p>This type of summon leads to cancellation of elective procedure stop/halts service delivery and even closure of the facility for service emergency where there are shortage of personnel which is a common phenomenon in Nigeria health Sector.</p>			
41.	<p><b>THE NEED TO ESTABLISH VESICO VAGINAL FISTULA CENTRE IN IBADAN, OYO STATE.</b></p> <p><b>HONOURABLE COMMISSIONER FOR HEALTH, OYO STATE</b></p> <p><b>NCH/61/003AL</b></p>	<p>The purpose of this memo is to seek the approval of the council to establish South West National Obstetric Fistula Centre in Ibadan, Oyo State.</p> <p><u>Introduction</u></p> <p>Vesico Vaginal Fistula (VVF) is a major public health issue in Nigeria, causing severe morbidity and social rejection.</p> <p>According to Federal Ministry of Health, between 500,000 to 1,000,000 women/girls are living with VVF with an estimate of 80,000 new cases annually.</p> <p>The following factors have been attributed to increased incidence of OVVF in Nigeria, these include poverty, lack of education, culture and tradition and poor access to appropriate health care services.</p> <p>Currently, Nigeria National Fistula Program is one of the</p>	<p><u>Prayers</u></p> <p>Council is invited to note that:</p> <ol style="list-style-type: none"> <li>There is need to have South West National Obstetric Fistula Centre in Ibadan, Oyo State</li> <li>Oyo state Government has allocated a structure for the proposed Centre for Vesico Vaginal Fistula in Ibadan, Oyo State.</li> <li>For year 2016, over 50 VVF effective repairs have been done in the State, while more than 20 are still on the waiting list.</li> </ol> <p>Council is further invited to approve:</p> <ol style="list-style-type: none"> <li>That, the South West National Obstetric</li> </ol>		

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		<p>largest fistula repair and surgeon training program in the world. There are 9 sites in Nigeria serving the entire population. There is none at present in South West Nigeria, with resultant effect of sufferers traveling to far distant zones to access care.</p> <p>The increasing incidence of VVF has justified the reason to have a regional Centre in Ibadan to take care of the large population of South West region of the country.</p> <p><u>Observation</u></p> <p>Ibadan, the capital of Oyo State was the former capital of South West and is easily accessible to all the States in the South West.</p> <p>Oyo State Government has a strong political will to support the establishment of VVF Centre in the State and has provided a site for the commencement of the program.</p> <p>University College Hospital Ibadan, is internationally recognized training Centre for surgeons in the treatment of VVF. The Centre has produced manpower for other zones in the country, this implies that Oyo State can boast of enough surgeon to man the South West zonal Centre if sited in Ibadan.</p> <p>The Centre will serve as treatment, training and research Centre for the entire country with strong support from University College Hospital, Ibadan.</p> <p>The Centre will restore dignity, hope as well as promote the health of women which is crucial for national development.</p>	<p>Fistula Centre be established in Ibadan, Oyo State.</p> <p>b) That, the Honourable Minister of Health recommends to the President to approve the establishment of National Obstetric Fistula Centre in Ibadan, Oyo State.</p>		



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42.	<p><b>TO LAY-OUT A FEASIBLE IMPLEMENTATION PLAN FOR THE INTEGRATION OF MENTAL HEALTH INTO PRIMARY CARE</b></p> <p><b>HONOURABLE COMMISSIONER FOR HEALTH, OYO STATE</b></p> <p><b>NCH/61/003AM</b></p>	<p>The purpose of this memorandum is to seek Council's approval for the adoption of a feasible implementation plan for the effective integration of mental health into primary health care in Nigeria.</p> <p><u>Background</u></p> <p>Mental health was adopted as the 9<sup>th</sup> pillar of primary health care in 1991 during the tenure of Professor Olikoye Ransome Kuti, who was a tireless advocate of primary care. Furthermore, the first national mental health policy of Nigeria was also passed in 1991 and revised in 2013; with both documents adopting the successful integration of mental health into primary care, as the feasible mechanism for improving access to mental health care services in the country.</p> <p>However, the World Mental Health Surveys conducted by the World Health Organization (WHO) in 2006 across all the regions of the world including in Nigeria, showed that there was a huge treatment gap for mental health services in low and middle income countries (LMICs) such as Nigeria. The treatment gap was estimated at 80% for Nigeria, meaning that only 2 out of every 10 Nigerians with mental illness was able to access care in the preceding 12 months before the study. This huge treatment gap is worsened by the very small numbers of mental health professionals, unequal distribution across the country and even within states as well as the associated stigma and superstitious beliefs about the aetiology of mental illness. Thus, they are more likely to be taken to traditional healers or prayer houses where they will</p>	<p>The Council is invited to note as follows:</p> <ol style="list-style-type: none"> <li>I. Mental health is already an integral component of primary care (9<sup>th</sup> pillar) since 1991.</li> <li>II. The National Mental Health Policy of 1991 and revised in 2013 recommends integration into primary care using a task – shifting approach</li> <li>III. The WHO mhGAP-IG manual has been adapted for Nigeria and successfully piloted in Osun, Oyo, Benue and Lagos States.</li> <li>IV. The national implementation plan for the mhGAP-IG was adopted by the 56<sup>th</sup> National Council on Health (NCH) meeting in August 2013 as item 7, article xviii of the communique.</li> <li>V. The combination of the Mental Health Policy Document as well as the adapted mhGAP-IG for Nigeria provides the necessary tools for the successful implementation of this policy to reduce the huge treatment gap and the untold suffering of persons (and their families) with mental illness.</li> <li>VI. The successful integration of mental health into primary care and thus, a reduction in the treatment gap for persons with mental illness can only occur with the commitment of all States.</li> </ol>		

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		<p>be chained and their human rights frequently violated. In almost every city in the country, it is not usual to find vagrant psychotics roaming the streets, naked or grossly unkempt.</p> <p>The WHO in 2008, launched a Mental Health Gap Action Programme (mhGAP) to reduce this huge treatment gap for mental disorders through the adoption of integration into primary and community care, using the principle of task-shifting. A manual was produced, mhGAP Intervention Guide (mhGAP-IG) for the training of non-specialists to screen for, identify and provide basic interventions for common mental disorders. Nigeria was the first country to contextualize and adapt this manual for use, with a team led by Professor Oye Gureje, in collaboration with the FMOH, WHO and the NPHCDA in 2011. The adapted manual was successfully piloted as a demonstration project in Osun State to train primary health care (PHC) workers (Medical Officers of Health, Nurses, Community Health Officers, and Community Health Extension Workers).</p> <p>While pockets of activity are ongoing in some states using the mhGAP-IG to train PHC workers in Lagos and Benue States, The Oyo State Ministry of Health, through the State Primary Health Care Board, has adopted a cascade model of training primary care workers to successfully implement the integration of mental health into primary care in the State. It is imperative that this approach is adopted to ensure that the 9<sup>th</sup> pillar of primary care is not neglected and relegated to the background, but that citizens suffering from mental disorders have access to quality care that is devoid of human rights</p>	<p>Council is further invited to approve:</p> <ol style="list-style-type: none"> <li>The adoption of a cascade model of training as the feasible implementation plan for the effective integration of mental health into primary care in all the 36 states of the Federation and the Federal Capital Territory (FCT).</li> <li>The adoption of the contextualized mhGAP-IG manual as the instrument for the implementation of this policy using task-shifting approach by all the states of the Federation and the FCT, as previously ratified by the 56<sup>th</sup> NCH in 2013.</li> </ol>		

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		<p>abuses. This can best be achieved through the successful integration into primary care using a task-shifting approach, with the instrumentality of the mhGAP-IG.</p> <p><u>Content</u></p> <ul style="list-style-type: none"> <li>I. In Oyo State thus far, 40 senior primary care workers were selected and trained to become trainers (Training of Trainers -ToT workshop) on the mhGAP-IG, with their breakdown as follows: <ul style="list-style-type: none"> <li>a. 5 Doctors</li> <li>b. 22 Nurse/midwives</li> <li>c. 7 Community Health Officers</li> <li>d. 6 Senior Community Health Extension Workers</li> </ul> </li> <li>I. A total of 198 frontline PHC workers across 4 local government areas in the first phase have been trained on the mhGAP-IG, to focus on screening women attending antenatal clinics for perinatal depression</li> <li>I. This was organized as a series of 2-days training workshops with 20-25 participants each</li> <li>V. Each training was conducted by 2 trainers with a master trainer sitting in the background to provide support. The Master Trainers were psychiatrists from the Department of Psychiatry of the University College Hospital, Ibadan, led by Professor Oye Gureje.</li> <li>V. A total of 2989 pregnant women have been screened since commencement in 2017, with about 218 being identified as having perinatal depression (7.2% prevalence rate).</li> <li>I. The trained PHC workers also now routinely provide</li> </ul>			

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		interventions for the women diagnosed as having depression (psychosocial and pharmacological interventions – with an emphasis on psychosocial approach); while the Medical Officers of Health and the Psychiatrists provide supportive supervision.			
43.	<p><b>ESTABLISHING A NATIONAL RECORD/COMPILATION OF APPROVED MEMOS, COMMUNIQUEs AND DIRECTIVES OF COUNCIL IN THE LAST TEN YEARS; A COMPENDIUM WHICH SHOULD BE CONVENTIONALLY UPDATED EVERY DECADE</b></p> <p><b>HONOURABLE COMMISSIONER FOR HEALTH, RIVERS STATE</b></p> <p><b>NCH/61/003AN</b></p>	<p>The purpose of this memo is to seek the Council's approval to enable the Federal Ministry of Health, "to produce an official compilation or compendium of approved memos, communiques and directives of Council in the last ten years; a compendium which should be conventionally updated every decade, for record purposes and disseminated to stakeholders."</p> <p><b>BACKGROUND</b></p> <p>The National Council on Health is responsible for the formulation of policies and measures necessary for protection, promotion, improvement and maintenance of the health of the citizens of the country. The Council offers advice to the Government of the Federation, through the Minister, on matters relating to the development of national guidelines on health and the implementation and administration of the National Health Policy. NCH issues, and promotes adherence to, norms and standards, and provide guidelines on health matters, and any other matter that affects the health status of the people. NCH identifies health goals and priorities for the nation as a whole and monitors the progress of their implementation.</p> <p>These functions are carried out routinely by statutory council</p>	<p>The Council is hereby invited to approve:</p> <p>i.) the Federal Ministry of Health to publish a ten-year compilation of directives of Council and approved memos for record purposes in order to strengthen the institutional memory of the Health Care sector.</p> <p>that the publishing of this compendium be carried out every ten years and should include where necessary the current state of implementation of the decisions approved</p>		

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		<p>representatives from all States through council sessions and advised by technical sessions, leading to approvals and directives in the overall interest of the health of the citizens of the nation. The key members of Council ensure that these directives are seen through, to conclusive implementation.</p> <p>Unfortunately, the key members of Council are rarely permanent, they are often subject to attrition issues at State and national level. This leaves a need for proper record keeping, a compendium of approvals and directives as a means of strengthening the institutional memory, at the State and National levels in order to ensure evidence-based continuity.</p> <p>JUSTIFICATION</p> <p>I. There is a need to have strengthened institutional records by producing an official compilation or ten-year compendium/report of all Council approvals and directives of the 50-60<sup>th</sup> council for State records and referencing in every day implementation of health services</p> <p>II. There are commonly, new members of council yearly, at every Council meeting. It is envisaged that Council members will be better equipped for making contributions and further recommendations if they have a compendium of official records on the previous position of Council on topical issues for deliberations.</p>			

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		<p>III. A record of proceedings and approvals will make a good reference for the States and key stakeholders to rely on in making everyday decisions for the progress of the Health Care delivery sector.</p> <p>IV. A record of approved memos in booklet will be easier to disseminate widely to various stakeholders who rely on them for policy changes, operations and implementation.</p>			
44.	<p><b>THE ESTABLISHMENT OF FUNCTIONALLY EQUIPPED AND FULLY RESOURCED STATE PUBLIC HEALTH EMERGENCY OPERATIONS CENTRE (PHEOC) WITH LABORATORY, CONFERENCE AND COMMUNICATION SERVICES IN EVERY STATE OF THE FEDERATION</b></p> <p><b>HONOURABLE COMMISSIONER FOR HEALTH, RIVERS STATE</b></p> <p><b>NCH/61/003AO</b></p>	<p>The purpose of this memorandum is to seek the approval of the Council on Health to enable the States supported by the Federal Government, “strengthen emergency preparedness and response systems by the allocation of physical space as a Public Health Emergency Operations Centre (PHEOC), fully equipped, with requisite infrastructure including laboratory, Conference Centre and communication systems for effective coordination in line with recommendations of the World Health Organisation”.</p> <p>INTRODUCTION</p> <p>Over the past few years, Nigeria has seen recurrent episodes of diseases outbreaks with higher morbidity patterns that have claimed human lives despite concerted control measures. In week 13 ending 1<sup>st</sup> of April, 2018, there were 337 suspected cases of Cholera reported from eight LGAs in seven States, 19 suspected cases of Lassa fever were reported from ten LGAs in eight States and 255 suspected</p>			

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		<p>cases of Cerebrospinal Meningitis (CSM) reported from 73 LGAs in 15 States. Containment requires early diagnosis, isolation/treatment and monitoring of exposed contacts in addition to mitigation measures for effective control.</p> <p>Emergency operations Centres (EOC) of various States, either physical or virtual, are largely responsible for the coordination efforts in containing most Public Health Emergencies. The World Health Organization, recommends that the member States should establish PHEOCs in order to respond promptly and effectively to public Health risks and Emergencies. (WHO, Framework for Public Health Emergencies, November, 2015). Notably, the EOCs of Lagos and Rivers State in the period of Ebola outbreak were instrumental to effective coordination and response. Yet, quite a number of States are yet to designate a physical, functionally equipped and fully resourced PHEOC. The need is now more apparent and can be made more realistic by a resolution/directive of council.</p> <p>Indeed, there is no guarantee that these outbreaks will ever cease. In fact, with increasing international trade systems, urban migration and accelerated travel systems, the world has come to be a global village. Transmission of contagious disease across borders can occur more frequently these days and dangerously challenge the local health care systems except there is an adequate baseline preparedness and response mechanism to contain routine outbreaks.</p> <p>Whilst awaiting the passage of the bill on the establishment of National Centre for Disease Control, it may be imperative</p>			

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		<p>in the interim to direct by order of Council, for all States to dedicate and physically designate a Centre for Emergency Preparedness and Response popularly referred to as the PHEOC to coordinate and harmonize the outbreak mitigation and response processes in all States.</p> <p>JUSTIFICATION</p> <p>Apart from the recommendations of WHO to member States, International Health Regulations of 2005 require that State Parties develop capacity to handle public health emergencies and adverse health events.</p> <p>Consequently, there is need for a standard building to be designated as an EOC in every State, fully equipped with communication gadget, conference room, laboratory, vehicles and staff, fully resourced for mitigation and control.</p> <p>The EOC will function as a strong arm of the epidemiology department of the State Ministry for Health. It will be responsible for enhancing readiness, stockpiling necessary resources, planning and risk assessment. The PHEOC will assist in supervising and enforcing hospital infection prevention and control processes and conduct routine drills in preparedness for untoward health events. A functional PHEOC encourages volunteerism and can increase the pool of human resource for health.</p> <p>The approval of the Council in this direction will not only help States establish the PHEOC, it will also enable collective engagement of organisations for partnership and encourage</p>			



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		the Federal Government to prioritize and commit resources to each State PHEOC plan, in order to reach the target of having a 'physical' EOC functional in every State.			
45.	<p><b>THE STATE'S INITIATIVE IN ENGAGING THE PRIVATE SECTOR IN A PUBLIC PRIVATE PARTNERSHIP IN HEALTH-CARE WASTE MANAGEMENT.</b></p> <p><b>HONOURABLE COMMISSIONER FOR HEALTH, RIVERS STATE</b></p> <p><b>NCH/61/003AP</b></p>	<p>The purpose of this memorandum is to inform and seek the Council's approval on the state's initiative in engaging the Private Sector in a Public Private Partnership in Health-Care Waste Management.</p> <p><u>INTRODUCTION</u></p> <p>Public Private Partnership (PPP) essentially defines the various types of relationships developed between public institutions and the private sector often with the aim of introducing the expertise and resources available to the private sector in order to provide and deliver effective public assets and services for the interest of the parties.</p> <p>Healthcare activities generate peculiar waste which may pose grave dangers to healthcare practitioners, the environment, waste handlers, patients and the community if not properly managed. The choice of methods of healthcare waste management may itself result in risks to health from exposure to infectious agents. Contaminated syringes and needles pose particular danger as they are easily scavenged from general waste dumps sites and reused. Types of Health-care waste include:</p> <ul style="list-style-type: none"> <li>• Pathological wastes, body parts and body fluids</li> <li>• Pharmaceutical and chemical waste</li> <li>• Radioactive and cytotoxic waste</li> <li>• Infectious waste which are sharp disposable needles</li> </ul>	<p>PRAYERS</p> <p>Council is hereby invited to note:</p> <ol style="list-style-type: none"> <li>That Council's Resolution on Health-care Waste Management at the 50th NCH is yet to be fully complied with by healthcare institutions in the country;</li> <li>The benefits and need for proper management of Health-care Waste in the country.</li> </ol> <p>Council is further invited to approve:</p> <ol style="list-style-type: none"> <li>The creation of an enabling environment for States and the Federal Government for organised private sector to be involved in Health-care waste management;</li> <li>The inclusion of proper management of Health-care waste as a criteria for registration of institutions where Health-care wastes are generated by all agencies charged with that responsibility.</li> </ol>		

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		<p>and syringes etc. These account for greater percentage of Health-care waste.</p> <p>JUSTIFICATION.</p> <p>At the 50th National Council on Health (NCH) meeting held in Abuja, Council approved the National Policy on Injection Safety and Health-care Waste Management. Council also resolved to take steps to tackle the problems associated with Health-care waste management in the country. It does not appear that much has been done in this direction. Following this, the Rivers State Government installed two dual fuel capacity (gas and liquid) incinerators each capable of treating 1 tonne per hour of Health-care waste.</p> <p>Cognisant of the potentially beneficial resources which abound within the private sector, the State Ministry of Health entered into a PPP agreement with private sector operators who are experienced in the management of Health-care waste to:</p> <ul style="list-style-type: none"> <li>• Train healthcare workers on handling of wastes within the facilities where they are generated</li> <li>• Collect and transport the wastes and treat at the incinerators site</li> <li>• Manage, operate and maintain the incinerators</li> </ul> <p>OBSERVATION</p> <p>1. Over 90% of Health-care facilities dispose of generated Health-care waste in the same manner as other waste without recourse to the dangers posed to the health care delivery system and the environment.</p>			

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		2. Evidence of proper disposal of Health-care waste has been included as a criterion for renewing the license of Health-care facilities to operate in Rivers State.			
46.	<p><b>STRENGTHEN INFECTION PREVENTION AND CONTROL (IPC) PRACTICES BY ADVOCATING FOR THE MANDATORY IDENTIFICATION OF AN IPC FOCAL PERSON IN ALL SECONDARY AND TERTIARY FACILITIES IN EVERY STATE AS CONTAINED IN THE NATIONAL POLICY ON INFECTION PREVENTION &amp; CONTROL</b></p> <p><b>HONOURABLE COMMISSIONER FOR HEALTH, RIVERS STATE</b></p> <p><b>NCH/61/003AQ</b></p>	<p>The purpose of this memorandum is to seek Council's approval in order to enable the States "strengthen infection control efforts in all secondary and tertiary health care facilities by the mandatory identification of a "change agent"- an infection prevention and control focal person to take charge and coordinate the IPC services in the health care facility.</p> <p>BACKGROUND</p> <p>"The commonest question following the death of a health care worker due to hospital acquired hemorrhagic infection is: Could it have been averted with better oversight and triage systems within the facility? Was the principle of Infection Prevention and Control in the facility sufficiently followed?" A response is desired.</p> <p>Infection Prevention and Control refers to policies and procedures that reduce the occurrence and minimize the risk of spreading infections, especially in hospitals. The global standard and indeed the technical guidelines for IPC requires the <u>establishment of an Infection Prevention and Control Committee and the appointment of a Hospital Infection Prevention Officer/Focal Person whose primary duty is to ensure that best standards for infection prevention are complied with</u> in the interest and safety of health care</p>	<p>PRAYERS:</p> <p>The Council is hereby invited to approve:</p> <p>i.) the identification and designation of an Infection, Prevention and Control Focal Person as mandatory in all Secondary and Tertiary facilities as contained within the IPC policy of the Country as an important strategy which will strengthen early detection and control of infectious disease transmission in health care settings in order to safe guard the lives of all health care workers in course of their routine assignments.</p>		

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		<p>workers and the patients alike.</p> <p>Incidentally, the recent outbreaks of Lassa Fever across the county has been quite challenging with worrisome mortality rates amongst health care workers in the country. In the first quarter of 2018, between weeks 1 and 13 (2018), 698 suspected Lassa fever cases with 182 laboratory confirmed cases and 53 deaths (CFR, 7.59%) from 123 LGAs (28 States) were reported compared with 231 suspected cases with 57 laboratory confirmed cases and 43 deaths (CFR, 18.62%) from 44 LGAs (16 States) during the same period in 2017 (NCDC weekly reports - <a href="http://ncdc.gov.ng/reports/weekly">http://ncdc.gov.ng/reports/weekly</a>, 20<sup>th</sup> April, 2018). It is reported that at least 17 health care workers have been affected since the onset of the outbreak in six states - Ebonyi (9), Nasarawa (1), Kogi (2), Benue (1), Ondo (1) and Edo (3) with four deaths in Ebonyi (3) and Kogi (1) - <a href="http://www.pulse.ng/news/local/86-confirmed-killed-in-2018-lassa-fever-outbreak-ncdc-id8141054.html">http://www.pulse.ng/news/local/86-confirmed-killed-in-2018-lassa-fever-outbreak-ncdc-id8141054.html</a> - published 20<sup>th</sup> March, 2018.</p> <p>The high transmission/mortality rate amongst unsuspecting health care workers in the course of their routine duties, puts a question on early identification systems and triage mechanism that govern clinical engagement. It creates a genuine need to ensure that in all high volume facilities an infection prevention control focal person is identified and trained to carefully and routinely oversee, recognize, enforce and strengthen the minimum standard necessary to maintain the safety of health care workers in the facility especially with</p>			

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		<p>the recent turn of events.</p> <p>JUSTIFICATION</p> <p>i.) There is rising health care worker mortality from Haemorrhagic (especially Lassa) Fevers occurring often as occupational hazards in health care settings. These are usually at high volume facilities where physicians and other health care workers are often very busy and fully engrossed with technicality of saving lives in their respective fields.</p> <p>ii.) The National Policy on Infection Prevention and control clearly recommends for the identification of an infection Prevention Focal Person/Officer and the establishment of IPC Committee amongst other strategies. The domestication and implementation in various States and facilities seems quite weak and unacceptable (See AIDSFREE assessment of IPC and Health Care Waste Management – 2016 available at <a href="http://aidsfree.usaid.gov">www.http://aidsfree.usaid.gov</a>).</p> <p>iii.) There is need for every facility especially secondary and tertiary facility to have an Infection Prevention and Control Committee with a focal person who should see to everyday implementation of the decisions of the committee and ensure that housekeeping practices are up to date and compliance to simple triage systems as a primary duty.</p>			

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		<p>iv.) Such a focal person should be trained to meet the evolving challenges posed by endemic infectious diseases with notorious effect in health care settings. The officer will be able to supervise patient entry and exit triage systems, referral networks, availability of standard operating procedures, enforce simple hand washing compliance, ensure that guidelines are conspicuously available and where possible conduct routine drills to strengthen hospital response systems.</p> <p>The focal person serves as an immediate reminder on the need to have a high index of suspicion and the pro-active necessity for barrier nursing of suspected cases. Once a case is identified, the officer can be reached easily to coordinate further engagement, isolation, reporting, decontamination and medical evacuation in liaison with the Disease Surveillance and Notification Officer of the respective Local Government Area. This will in no small measure boost the confidence of Health Care workers in their routine service delivery.</p>			
47.	<p><b>THE ESTABLISHMENT OF OCCUPATIONAL THERAPY AND YOUTH DEVELOPMENT CENTRE SOKOTO</b></p> <p><b>HONOURABLE COMMISSIONER FOR HEALTH, SOKOTO STATE</b></p>	<p>The purpose of this memorandum is to inform the Council on the steps taken by the Sokoto State Government for completing circle of rehabilitating and integrating the drug victims in the communities through management and training on skills.</p> <p><u>2. BACKGROUND:</u> Drugs abuse is one of the major Global Health problems that has done a lot of damages to the teeming populace especially in the developing World, Nigeria inclusive. The</p>	<p>Council is invited to note as follows:</p> <ul style="list-style-type: none"> <li>i. There is an established Centre for completing the circle of rehabilitation and integration of drugs addict in the State</li> <li>ii. The Centre was established through close collaboration with NDLEA and Federal Neuro Psychiatric Hospital, Sokoto</li> </ul>		

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	NCH/61/003AR	<p>menace of drug abuse has eaten deep into the fabrics of our society. Many of our Youths and even married women who are supposed to be productive have become societal problem with no hope of becoming useful members of the society. The abuse of drugs by adolescents has become one of the most disturbing health related phenomena in Nigeria and other parts of the world. Several school going adolescents experience mental health programme, either temporarily or for a long period of time. Some become insane, maladjusted to school situations and eventually drop out of school.</p> <p>Observations</p> <ul style="list-style-type: none"> <li>Addiction has expanded beyond use of psychoactive substances and indulging in harmful habits like gambling to involve wrong use of technology, use of unconventional substances and self-submission to attack by animal (e.g. "scorpion stings)."</li> <li>Addiction is primarily a disease of the brain and not a disease of morality.</li> <li>Lobbying/advertisement by addiction industries, weak law on addiction, poor parenting, bad peer influence, poverty, psycho-trauma and decaying social values are some of the factors responsible rise in addiction prevalence.</li> <li>It is currently observed that there is adulteration of common practice medications like 'kayanmata' (i.e. traditional female aphrodisiac) and non-addictive drinks (e.g. "zobo", tea, etc.) with addictive substances.</li> </ul>	<p>Council is further invited to approve:</p> <ol style="list-style-type: none"> <li>The Establishment of Occupational and Therapy Centre in each State of Nigeria</li> </ol>		

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		Considering the dangers of the above, the Federal Government of Nigeria decided to ban Cough syrups containing codeine in all communities of Nigeria reported on 5/2/2018. The Sokoto State Government on the other hand decided to take the next steps for rehabilitating the victims of drugs abuse by establishing the Occupational Therapy and Youths Development Centre in the State. This is not only aiming at treating the patients but also training them on various skills to enable them link up and re-join the society. The Centre comprises of offices, Laboratories, Dormitories (Male and Female), Diagnostic unit, Neurological Psychiatric unit, Parks/Sports recreational facilities etc			
	<b>STRATEGIC PILLAR TWO: INCREASED UTILIZATION OF ESSENTIAL PACKAGE OF HEALTH CARE SERVICES</b>				
48.	<b>INTEGRATION OF CLIMATE CHANGE INTO THE TRAINING CURRICULUM OF ALL MEDICAL AND HEALTH INSTITUTIONS IN NIGERIA</b>  <b>HONOURABLE MINISTER OF HEALTH</b>  <b>NCH/61/004</b>	<p>The purpose of this memorandum is to notify on the progress made by the United Nation's Framework Convention on Climate Change (UNFCCC) and Inter-governmental Panel on Climate Change (IPCC) to include health related issues in climate change negotiations and in order to build on the progress, seek Council's approval for the integration of climate change issues into training curricula of all Medical and Health institutions in Nigeria.</p> <p><u>Background</u></p> <p>2. There is no doubt today that climate change caused by the emission and accumulation of greenhouse gases (GHGs) in the atmosphere is already affecting virtually all sectors in Nigeria, posing grave and dangerous unprecedented threats to our health. Its impact will continue</p>	<p>Council is hereby invited to note:</p> <ul style="list-style-type: none"> <li>i. The progress made by UNFCCC and IPCC to include 'health' in climate change negotiations; and</li> <li>ii. How that it is time to build on the progress made in Paris (2015) and COP 23 (2017).</li> </ul> <p>Council is further invited to approve: The integration of climate change issues into all training curricula of medical and health institutions in Nigeria and teach same to all upcoming medical and health professionals.</p>		



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		<p>unless we urgently engage in meaningful interventions.</p> <p>3. In 1992, Countries agreed on an international treaty - the United Nations Framework Convention on Climate Change (UNFCCC) to cooperatively consider what they could do to limit global temperature rise and cope with the inevitable impact of climate change. The UNFCCC is the highest decision-making body for climate agreements working in close association with the Inter-governmental Panel on Climate Change (IPCC). The UNFCCC works to achieve stabilization of greenhouse gas concentrations in the atmosphere at a level that would prevent dangerous anthropogenic interference with the climate system.</p> <p>4. The IPCC is the only leading international body established to provide the world with clear scientific views on the current state of knowledge in climate change. The IPCC has reported that climate change impact is far more rapid and dangerous than earlier thought. A chapter on health was included in its 5th IPCC assessment report (chapter 8, November 2014) indicating that health aspects of climate change should be taken more seriously.</p> <p>5. In the past, climate change and health were often considered independently but now, in a bid to tackle climate change more holistically, the need for public health actions to anticipate, manage and ameliorate the health burdens it imposes are receiving more attention during negotiations.</p> <p>6. There are two links between climate change and health. The first is that in the process of addressing climate change and emission reduction, we prevent worsening health conditions such as those caused by air pollution. The second</p>			

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		<p>is that by improving on adaptation and ensuring food security and water safety, we are actually improving health conditions. Therefore, addressing climate change has co-benefits for health.</p> <p>7. At the Conference of Parties (COP 21) meeting in Paris, participants took some decisions called 'the Paris Agreement 2015'. It was the first time, that Parties under the UNFCCC made unified, bold commitment to catalyze transition to a decarbonized economy while protecting human well-being. The Paris Agreement marked the beginning of a new era in the global response to climate change and significantly facilitated progress with individual Country's public health response to climate change because it states that 'the right to health will be central to the actions taken'.</p> <p>8. Furthermore, with the Paris Agreement, Parties were asked to develop their climate priorities. These priorities were called 'Intended Nationally Determined Contributions' (INDCs now known as 'Nationally Determined Contributions'- NDCs) and came into force in Nov 4, 2016. With this, Countries committed to keep global warming below 2°C while pursuing a target of 1.5°C and strengthen adaptation which includes implementing plans that should protect human health from the worst impacts of climate change such as heat waves.</p> <p>9. During the annual Global Climate and Health Summit at COP 23 in Bonn, Germany, 2017 the health community agreed that it was about time climate change issues were integrated into all medical and health training curricula to prepare the health workforce to respond to climate change.</p>			

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		<p><u>Justification</u></p> <p>10. The aim of the health sector in any Country is to continually provide and improve wellbeing, deliver high quality care now and for future generations and reduce to the barest minimum the wasting of human lives.</p> <p>11. There is no climate change impact that does not affect health. Therefore, these impacts have to be linked to health in a health-in-all policy approach.</p> <p>12. Partly due to the population, heavy burden of diseases, gas flaring and socio-economic factors, Nigeria as a developing country is one of the most vulnerable to impacts of Climate Change.</p> <p>13. In Nigeria, Climate change will worsen the main health problems of vulnerable populations by increasing malnutrition, reducing access to safe water and adequate hygiene and sanitation, deteriorate air quality and increase exposure to vector-borne diseases, emerging and re-emerging infectious diseases, loss of livelihoods and displacement of communities which impose costs, increase poverty and vulnerability.</p> <p>14. Some climate related health indicators correlate with sustainable development goals. Thus, Climate Change has cross-cutting issues of significance relevant to attainment of the highest possible level of health.</p> <p>15. Nigeria is a signatory to the UNFCCC, has ratified the Paris Agreement and is therefore expected to be supportive of and aligned to global and regional Treaties, Conventions, Protocols, Agreements and efforts related to climate change.</p>			

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		<p>16. The relevance of the health sector in contributing to response to climate change is becoming a recurring decimal in climate change negotiations.</p> <p>17. Medical and health professionals in training have to influence how vulnerable communities will survive in the coming decades. They therefore need to be well informed because they will eventually work with policymakers on issues such as sustainable energy, urban planning, transport and migration and need to infuse public health perspectives to solutions offered to shape a sustainable future. Therefore, training the next and future generations of medical and health professionals to mainstream climate change into all health decisions, planning, budgeting etc is pertinent.</p> <p>18. Some of the advantages of the proposed integration are that it will enable the health sector to contribute immensely to the national response to climate change and sustainable development since the training will include how to tackle emerging public health issues caused by climate change.</p> <p>19. The Paris Agreement (2015) and deliberations by the health sector at COP 23 (2017), necessitate moving forward. The first step in this movement is through education and training.</p> <p>20. The process of addressing the risks caused by climate change avail opportunities which should be used to establish healthy communities resilient to climate change.</p> <p>21. Integration of climate change into medical and health training curricula will help sustain Universal Health Coverage.</p>			

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49.	<p><b>PROGRESS MADE IN THE NIGERIAN POLIO ERADICATION INITIATIVE</b></p> <p><b>HONOURABLE MINISTER OF HEALTH</b></p> <p><b>NCH/61/004A</b></p>	<p>The purpose of this memorandum is to inform Council Members on the progress made in the Polio Eradication Initiative (PEI) following the resurgence of Wild Polio Virus (WPV) in 2016, after almost two years of interrupting transmission.</p> <p><u>2. BACKGROUND:</u></p> <p>Since the robust Outbreak Response campaigns that were conducted between August 2016 and January 2017, seven quality polio campaigns were conducted in 2017 two of which were Nation-wide. In addition, one (1) National Immunization Plus Day (NIPD) and two (2) Sub-National Immunization Plus Days (SIPDs) have been implemented between January and April 2018. In February, 2018, various review meetings were conducted including the orientation meeting for reactivated National Polio Expert Committee (NPEC), National Certification Committee (NCC), and Adverse Events Following Immunization (AEFI) committee. One meeting of the Expert Review Committee on Polio Eradication and Routine Immunization (ERC) was held in March 2018. During the ERC meeting, the country was commended for sustaining the interruption of poliovirus transmission through innovative approaches to improve population immunity; special efforts to reach trapped populations in insecure areas; and the commitment of the Federal government of Nigeria to the polio eradication drive.</p> <p><u>3. CONTENT:</u></p>	<p>Council is invited to note as follows:</p> <ol style="list-style-type: none"> <li>I. To ensure that no other part of the country is re-infected by the Polio virus, many innovative Strategies were implemented.</li> <li>II. Environmental surveillance sites were expanded to 70 sites in 18 states + FCT compared to 57 sites in 2016.</li> <li>III. Continued oversight function and support in appropriating adequate funds for Polio eradication and routine immunization to enable the programme sustain its high impact interventions.</li> <li>IV. To interface with States and Chairmen of LGAs with identified low commitment.</li> </ol>		

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		<p>Sustained High Quality Campaigns</p> <p>Through the unwavering efforts of Government and partners, the country has been able to halt the spread of the poliovirus in Borno state to neighbouring States and other parts of the country. So far we have gone 22 months without a case of WPV. This is the result of the sustained high-quality polio campaigns and your commitments in your respective States.</p> <p>In 2018, the overall goal of the program will be to;</p> <ul style="list-style-type: none"> <li>• Sustain the interruption of poliovirus transmission through sustaining a polio-free (WPV, cVDPV) status by Sustaining resilience.</li> <li>• Enhance SIA quality in prioritized vulnerable areas</li> <li>• Increase access to vaccination in security challenged areas and IDPs (particularly in Borno, Yobe and Lake Chad islands)</li> <li>• Ensure robust Outbreak Response across all states</li> <li>• Enhance routine immunization in polio high risk LGAs</li> <li>• Intensify surveillance</li> <li>• Strengthen cross-border collaboration</li> </ul> <p>In furtherance of our efforts to ensure that no other part of the country is re-infected by the poliovirus, many innovative strategies were implemented. These included peer review of surveillance data; temperature tracking using temperature log tags to track transported stool samples; and expansion of environmental sampling. Environmental surveillance sites were expanded to 70 sites in 18 states + FCT compared to 57 sites in 2016. In 2018, we intend to add 2 more States</p>			

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		<p>(Anambra and Enugu) and 6 more sites. A one-time sewage collection from potential environmental sites identified from security compromised areas in Borno state was also conducted. Furthermore, children in internally displaced persons (IDPs) camps and from recently accessible areas are being tracked and vaccinated.</p> <p>Remaining Challenges</p> <p>Insecurity in the Northeast zone, especially in Borno, Yobe and Adamawa States has continued to be a major challenge to the programme as some communities remain inaccessible to vaccination teams, and evolving security incidents in areas outside the north east relating to kidnapping, armed robbery and clashes between herdsmen and farmers. However, the programme has continued to explore innovative ways to address immunity gaps and protect the children in most of the security challenged communities. These include: vaccinating children in internally displaced persons (IDPs) camps; active engagement of military and civilian Joint Task Force to escort teams and vaccinate children in partially accessible areas; Reaching Every Settlement (RES) intervention; Reaching Inaccessible Children (RIC) intervention.</p> <p>Government released its 2017 financial contribution to the program in order to address the funding gap. Government is committed to increasing its financial commitment in view of the GPEI funding ramp down. Also, non-release of States and LGA counterpart funds by some high-risk States and frequent health workers' strike constitute a threat to the programme.</p>			
50.	<b>PUBLIC ENLIGHTENMENT</b>	The purpose of this Memorandum is to seek approval of the	Council is invited to note that:		

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	<p><b>CAMPAIGNS AGAINST THE USE OF CALCIUM CARBIDE FOR FRUIT RIPENING AND THE DEVELOPMENT OF A NATIONAL CODE OF PRACTICE ON ARTIFICIAL RIPENING OF FRUITS</b></p> <p><b>HONOURABLE MINISTER OF HEALTH</b></p> <p><b>NCH/61/004B</b></p>	<p>Council for coordinated, extensive and sustained public enlightenment campaigns to be carried out by all relevant MDAs at Federal, State and Local Government levels against the use of calcium carbide for fruit ripening and the development of a National Code of Practice (NCP) on Artificial Ripening of fruits.</p> <p>1. BACKGROUND:</p> <p>Fruits are consumed as essential component of food to provide micronutrients that improve immunity and prevent diseases. Fruit ripening is a unique aspect of plant development which makes the fruit edible, softer, sweeter, more palatable, nutritious and attractive. During ripening, there is enzymatic breakdown of insoluble polysaccharides (starch) to water soluble saccharides such as fructose, sucrose and glucose. Ripening also changes the skin colour of fruit from green to yellow, red, etc due to the degradation of the chlorophyll and softer due to conversion of pectin into soluble form.</p> <p>Ripening has been categorized as either 'climacteric' or 'non-climacteric'. Climacteric fruits continue to ripen after being harvested e.g mangoes, bananas, guavas, pears, papaya, apple, melon, etc while non-climacteric have shorter shelf life and do not ripe after being harvested, e.g grapes, pineapple, strawberry, citrus fruits, etc.</p> <p>The demand for fruits as component of daily diet is growing in Nigeria due to increased nutrition consciousness. As a result, fruits merchants device various ways of fast tracking fruit ripening including the use of calcium carbide.</p> <p>Natural Ripening agents:</p>	<p>i. Fruit ripening is a unique aspect of plant development which makes the fruit edible, softer, sweeter, more palatable, nutritious and attractive.</p> <p>ii. The demand for fruits as component of daily diet is growing in Nigeria due to increased nutrition consciousness. As a result, fruits merchants device various ways of fast tracking fruit ripening using artificial fruit ripening agents.</p> <p>i. That organoleptic properties of artificially ripened fruits are lost considerably; hence they are less juicy, do not give the natural aroma and flavour, not very tasty, difficult to cut and have comparatively short shelf life.</p> <p>v. The artificial ripening agents in use include Calcium Carbide ethylene gas, Ethephon, ethanol, methanol and ethylene glycol.</p> <p>v. That Calcium Carbide is the most widely used artificial ripening agent in Nigeria, Africa and South Asia.</p> <p>i. Calcium Carbide is not an acceptable ripening agent due to its health hazards.</p> <p>ii. Ethylene Gas, Ethephon, Ethanol, Methanol and Ethylene Glycol are less harmful as ripening agents.</p> <p>i. Calcium Carbide generally contains impurities of arsenic, lead particles and phosphorus that pose a number of health problems e.g. frequent thirst, irritation in mouth and nose, weakness, permanent skin damage, difficulty</p>		



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		<p>Ethylene is the main natural ripening agent. Ethylene is a naturally occurring hormone that is emitted from fresh fruit, vegetables, and floral items. Ethylene gas is necessary in initiating the ripening process. There is increased production of ethylene during ripening of fruits. Artificial ripening agents are sometimes used to produce ethylene.</p> <p>Artificial ripening agents: Modern farms as well as fruit industry use ethylene gas to ripen fruits for the following reasons:</p> <ul style="list-style-type: none"> <li>▪ Ripening agents speed up the ripening process.</li> <li>▪ To meet high demand and overcome transportation damage thereby attracting high profit.</li> <li>▪ Allow many matured fruits to be picked prior to full ripening and then ripened at the final destination.</li> </ul> <p>The following are the most common artificial ripening agents in use:</p> <ul style="list-style-type: none"> <li>▪ Smoke from hay which contains ethylene gas.</li> <li>▪ Artificial sources of ethylene gas which can be generated from many sources. This is an acceptable practice worldwide.</li> <li>▪ Calcium Carbide is the most common and widely used artificial ripening agent, especially in Africa and South Asia, mainly as a result of ignorance of its harmful effects. Acetylene gas produced by Calcium Carbide when it comes in contact with water behaves like ethylene and is used for fruit ripening.</li> <li>▪ Ethephon, although mainly used as an insecticide, is another commonly used artificial agent and is assumed</li> </ul>	<p>in swallowing, vomiting, skin ulcer, kidney problems and possibly cancer.</p> <p>The Agency on realising the danger posed by the use of this Chemical on fruits, placed Calcium Carbide under restriction; hence any importer of Calcium Carbide is required to obtain from the Agency Permits to Import and to Clear a certain justifiable quantity in a year. Also End User certificate must be obtained from Office of National Security Adviser by importers.</p> <p>Preliminary investigation has identified smuggling, ignorance on the part of the bulk fruit merchants and retailers as well as Artisans who use Calcium Carbide for welding purposes as the major hindrance to the control of the chemical.</p> <p>Arising from the incessant use of Calcium Carbide for fruit ripening, the Office of the National Security Adviser (ONSA) called the attention of the Honourable Minister of Health to the problem posed by this practice and requested that measures be put in place to protect consumers from the effect of consuming fruits ripened with Calcium Carbide. Consequent upon this, the Hon. Minister in a memo ref: NCD/5537/11 of 14/12/2017 requested NAFDAC to put in place measures to protect consumers from</p>		

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		<p>as better than calcium carbide.</p> <ul style="list-style-type: none"> <li>Others include ethanol, methanol and ethylene glycol.</li> </ul> <p>Effect of artificial ripening on fruit quality</p> <ul style="list-style-type: none"> <li>Organoleptic properties are lost considerably.</li> <li>It does not give the natural aroma and flavour to the fruits.</li> <li>Artificially ripened fruits are less juicy.</li> <li>These fruits have uniform colour than when ripened naturally.</li> <li>Artificially ripened fruits are not very tasty and are difficult to cut.</li> <li>They have recorded weight loss and have comparatively short shelf life.</li> </ul> <p>2. <u>CONTENT:</u></p> <p>i. Calcium Carbide when sprayed with water reacts chemically to produce acetylene which acts like ethylene and ripens fruits by a similar process. Calcium carbide generally contains impurities of arsenic, lead particles and phosphorus that pose a number of health problems.</p> <ul style="list-style-type: none"> <li>These impurities may cause serious health hazards when workers come in direct contact with these chemicals while applying the ripening agents.</li> <li>Acetylene produced by Calcium Carbide affects the neurological system and reduces oxygen supply to the brain and further induces prolonged hypoxia.</li> <li>Consuming such artificially ripened fruits could result in sleeping disorders, mouth ulcers, skin rashes, kidney problems and possibly even cancer.</li> <li>It is hazardous to pregnant women and children and</li> </ul>	<p>the effect of consuming fruits ripened with calcium carbide. In addition, the Federal Ministry of Health wrote to all the State Commissioners to take necessary action in a letter titled 'Looming health hazard over indiscriminate use of carbide by fruit and vegetable vendors' in January 2018 and copies of the letter from ONSA were attached to all.</p> <p>Council is further invited to:</p> <ol style="list-style-type: none"> <li>1. Approve coordinated, extensive and sustained public enlightenment campaigns against the use of Calcium Carbide for ripening of fruits.</li> <li>2. Approve that the campaign against the use of Calcium Carbide for ripening of fruits be driven by the Federal Ministry of Agriculture and Rural Development (FMA&amp;RD), Federal Ministry of Health (FMoH), State Ministries of Health and Agriculture, Local Government Departments of Health and Agriculture, Agencies and Parastatals including NAFDAC, Standard Organisation of Nigeria (SON), Nigeria Agricultural Quarantine Service (NAQS), Consumer Protection Council (CPC) as well as</li> </ol>		

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		<p>may lead to headache, dizziness, mood disturbances, mental confusion, memory loss, cerebral oedema (swelling in the brain caused by excessive fluids), sleepiness, seizure etc.</p> <ul style="list-style-type: none"> <li>▪ Higher exposure may cause undesired fluid build-up in lungs (pulmonary oedema).</li> <li>▪ They may cause frequent thirst, irritation in mouth and nose, weakness, permanent skin damage, difficulty in swallowing, vomiting, skin ulcer etc.</li> <li>▪ Calcium Carbide is alkaline in nature and erodes the mucosal tissue in the abdominal region and disrupts intestinal functions. Cases of stomach upset after eating carbide ripened mangoes have been reported recently.</li> <li>▪ Apart from these, symptoms of poisoning include diarrhoea (with or without blood), burning or tingling sensation in abdomen and chest, difficulty in swallowing, irritation in eyes/skin, sore throat, cough, shortness of breathing, numbness etc</li> </ul> <p>ii. In November 2014, the Agency conducted a nationwide survey on calcium carbide to ascertain its use for fruit ripening. The result of the survey showed that Calcium Carbide is widely used in Nigeria as a fruit ripening agent.</p> <ul style="list-style-type: none"> <li>▪ Realizing the danger posed by the use of this chemical on fruits, the Agency placed it under restriction. Any importer of Calcium carbide is required to obtain from the Agency Permits to Import and to Clear a certain justifiable quantity in a year. He is also, if not an end user, expected to obtain a Local Purchase Order (LPO) from a verified end user. The Office of the National Security Adviser also issues End User Certificates to</li> </ul>	<p>NGOs, Faith Based Organisations and Traditional Rulers.</p> <p>3. Encourage the Federal Ministry of Agriculture and Rural Development to develop a National Code of Practice for Artificial Ripening of Fruits in line with global best practices.</p> <p>4. Encourage the Standards Organization of Nigeria (SON) in conjunction with relevant MDAs to develop Nigerian Industrial Standards on Fresh Fruits and Vegetables where maximum levels of contaminants will be specified.</p>		

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		<p>importers of calcium carbide.</p> <ul style="list-style-type: none"> <li>▪ NAFDAC inspects warehouses for storage of chemicals and monitors the distribution and sale of chemicals. The extent of the monitoring is from the importer down to the chemical marketers. Some quantities of Calcium Carbide are sold to artisans such as welders and panel beaters by chemical marketers. Preliminary investigation reveals that it is likely this chemical leak from this low level of use to those misusing it for agricultural purposes.</li> <li>iii. The Agency has on several occasions organised Workshops/Seminars for Chemical Marketers, Importers and End Users on the proper use and disposal of Chemicals including calcium carbide.</li> <li>iv. The Agency also uses text messages to educate the populace on the dangers of using calcium carbide to ripen fruits.</li> <li>v. Arising from the incessant use of calcium carbide for fruit ripening, the Office of the National Security Adviser, in a memo ref: NSA/INT/333 of 13<sup>th</sup> September, 2017 called the attention of the Honourable Minister of Health to the problems posed by this practice. Consequent upon this, the Hon. Minister in a memo ref: NCD/5537/11 of 14/12/2017 requested NAFDAC to put in place measures to protect consumers from the effect of consuming fruits ripened with calcium carbide.</li> </ul> <p>Thus, there is urgent need to put in place measures to protect consumers from the effect of consuming fruits ripened</p>			

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		with Calcium Carbide.			
51.	<p><b>SCALE UP OF THE IMPLEMENTATION OF MATERNAL AND PERINATAL DEATHS SURVEILLANCE AND RESPONSE (MPDSR) IN NIGERIA.</b></p> <p><b>HONOURABLE MINISTER OF HEALTH</b></p> <p><b>NCH/61/004C</b></p>	<p>The purpose of this memorandum is to seek the National Council on Health (NCH) approval for the scale up implementation of Maternal and Perinatal Deaths Surveillance and Response (MPDSR) and the use of electronic platform for data management from 8 pilot States to 36 States and the Federal Capital Territory (FCT) in Nigeria.</p> <p><b>BACKGROUND</b></p> <p>The current maternal and neonatal mortality ratios of 576/100,000 and 37/1000 live births (NDHS 2013) respectively are unacceptable. Therefore, there is need for all stakeholders to sustain the ongoing efforts to accelerate reduction of maternal and neonatal mortality through effective implementation of Maternal and Perinatal Deaths Surveillance and Response in the 36 States and FCT.</p> <p>The National Council on Health (NCH) at its 57<sup>th</sup> meeting approved the implementation of Maternal and Perinatal Deaths Surveillance and Response in Nigeria. Adopting the Maternal and Perinatal Deaths Surveillance and Response (MPDSR) process, which is a veritable tool and process of identifying both direct and indirect causal factors of the deaths, enhance the efforts at preventing further deaths and provide more credible data for health planning effective and efficient budgeting. The goal of this initiative is to eliminate preventable maternal and perinatal deaths.</p> <p>Significant reduction of maternal and perinatal mortality in countries will require counting every case and collection of</p>	<p>Council is therefore invited to approve:</p> <ol style="list-style-type: none"> <li>1. The scale up of the implementation of MPDSR in the Private Health Facilities and Communities in line with Universal Coverage with the reviewed Training Manual, Guideline and Tools.</li> <li>2. Adoption and scale up in 36 states and FCT, the use of the electronic platform for data entering, notification, quantification, analysis and reporting from 8 states to 36 States and FCT.</li> </ol>		

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		<p>routine information to permit an effective response that prevents future deaths. This is in keeping with Sustainable Development Goal 3 (SDG).</p> <p>A number of activities have been implemented. These include:</p> <ul style="list-style-type: none"> <li>(i) Quarterly National MPDSR Steering Committee meeting</li> <li>(ii) Advocacy and Resource Mobilization and Monitoring and Evaluation.</li> <li>(iii) Training of key officers of all the States MPDSR Committees</li> <li>(iv) Development of the Federal and State implementation Plan.</li> <li>(v) Inauguration of MPDSR Steering Committees.</li> </ul> <p>Other important activities implemented include:</p> <ul style="list-style-type: none"> <li>• Collaboration with Integrated Disease Surveillance and Response (IDSR): Civil Registration and Vital Statistics and National Health Management Information System (NHMIS).</li> <li>• Training of States Surveillance and M&amp;E (IDSR) Officers (April 2017). Training of Trainers (TOT) for the States MPDSR and IDSR Officers (May 2017).</li> <li>• Training of Population Registrar of Birth on the registration component of Civil Registration and Vital Statistics on MPDSR (February 2017).</li> <li>• Collaboration with Rotary International to develop electronic platform web-based data capturing for MPDSR. (This was fully funded by Rotary International in July 2017). Eight States (Anambra, Enugu, Ebonyi, Osun, Ondo, Kano, Kaduna and FCT) with 20 Secondary Health Facilities each</li> </ul>			

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		<p>were fully trained, connected and have been reporting regularly using the electronic platform for data capturing.</p> <p>Furthermore, the planned activities for 2018 include:</p> <ul style="list-style-type: none"> <li>(i) Quarterly National MPDSR Steering Committee meeting. (April, June, September and November 2018 supported by MNCH2);</li> <li>(ii) Collaboration of MPDSR with NFELTP on Surveillance and Response;</li> <li>(iii) The Biannual Supervision and Monitoring of States on MPDSR (June and November 2018);</li> <li>(iv) Training of Health Personnel in Tertiary Health Institution on MPDSR implementation.</li> <li>(v) Development of Private Health Facilities Guidelines and tools on implementation of MPDSR.</li> <li>(vi) MPDSR Annual review meeting;</li> <li>(vii) Review of Public Health Facility and Community MPDSR Guidelines and Tools;</li> <li>(viii) Training of the States MPDSR on the formation and Conducting Community MPDSR;</li> <li>(ix) Review of Facilitators Training Manual on MPDSR and Development of Participants Training Manual on MPDSR.</li> </ul> <p>Meanwhile, there are challenges that have been hampering the implementation in some States which already have MPDSR Steering Committee:</p> <ul style="list-style-type: none"> <li>a) Lack of budgetary allocation to MPDSR Steering Committee to implement activities in the costed implementation plan to reduce maternal and neonatal mortality.</li> <li>b) Lack of commitment from existing structures to support MPDSR at State, LGAs and Community levels is a</li> </ul>			

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		<p>major setback.</p> <p>c) Data Management for MPDSR Steering Committees activities at all levels in the 36 States + FCT.</p> <p>d) Resistance to change by health workers for the implementation of MPDSR in Health Facilities.</p> <p>e) Human resources for implementation not readily available.</p> <p>f) Private Sector and Community not reporting yet which has led to low coverage.</p> <p>g) Discipline of Medical Officers who treated patients by employer where 'No Name No Blame' is not adhere to.</p> <p>h) Community acceptability</p> <p>As we have challenges so also there are lesson learnt from the implementation of MPDSR activities so far. The lessons learnt are:</p> <ol style="list-style-type: none"> <li>1. Regular stakeholders meeting enhance performance through monitoring of activities.</li> <li>2. Collaboration with existing structure is cost effective and efficient in the implementation of MPDSR in Nigeria.</li> <li>3. Electronic Data Management is prompt and efficient than hard copy data management</li> <li>4. Capacity building, Advocacy and Supervision are important components of activities for the success of MPDSR.</li> <li>5. Review meetings on all Maternal and Perinatal deaths are keys to prevent future occurrence.</li> <li>6. MPDSR is a veritable tool for health planning development and budgeting.</li> </ol>			
52.	<b>FEDERAL GOVERNMENT INTERVENTION FOR HEALTHCARE DELIVERY FOR PERSONS WITH ALBINISM –</b>	The purpose of this memo is to seek the approval of Council for the sustainability of the Free Skin Cancer Treatment for Persons with Albinism in at least six designated Federal Teaching Hospitals across the six Geopolitical zones and the	<p>Council is invited to note as follows:</p> <ol style="list-style-type: none"> <li>i. That all persons have the right to life, especially the vulnerable groups</li> <li>ii. That skin cancer remains the biggest</li> </ol>		



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	<p><b>SUSTAINING THE FREE SKIN CANCER TREATMENT IN NIGERIA</b></p> <p><b>HONOURABLE MINISTER OF HEALTH</b></p> <p><b>NCH/61/004D</b></p>	<p>National Hospital.</p> <p>2. INTRODUCTION/BACKGROUND</p> <p>Albinism is a global phenomenon that affects all race and gender. People living with albinism exist across all strata of humanity, and the common term used for persons affected with albinism is "albino."</p> <p>People with albinism have absence or reduced pigment in their eyes, skin or hair. This is as a result of the absence of a pigment called melanin which is essential for the full development of the retina. Reduction in the production of melanin is also responsible for partial development of the retina which is the primary cause of visual impairment in people with albinism. The general health of a child and an adult with albinism is normal and the reduction in melanin pigment in the skin, hair and eyes does not affect the brain, the cardiovascular systems of the lungs, immune system or other parts of the body.</p> <p>It is estimated that about one in seventy (70) people carry recessive gene for albinism and about 1 in every 17,000 people have albinism disorder. Nigeria is estimated to have one of the highest prevalence rates of persons with albinism in the world.</p> <p>According to a study carried out by the Albino Foundation on the knowledge, attitude and practices on the education of children with albinism in Nigeria supported by UNICEF, it is estimated that there are about two million persons with</p>	<p>challenge confronting persons with albinism in Nigeria due to high intensity of the sun rays</p> <p>i. That most persons with albinism cannot afford skin cancer treatment</p> <p>v. That only the National Hospital Abuja provides free skin cancer treatment for persons with albinism in Nigeria</p> <p>v. The need for the decentralisation of free skin cancer treatment to six designated teaching hospitals across the six geopolitical zones as (ABUTH, UMTN, JUTH, UNTH, UPTH, UCH and NHA)</p> <p>i. The need to increase awareness on skin cancer prevention, and all states and FCT to provide desk officers for Albino awareness campaign.</p> <p>i. The need to include Sunscreen lotion in National Drug Requirement List</p> <p>i. Persons with albinism should be included in accessing services under the Basic Health Care Provision Fund.</p> <p>k. A Desk to be established in the Specialty Division of the Hospital Services Department of the Federal Ministry of Health for Albinism Healthcare interventions 'projects and programmes.</p> <p>k. Albinism Healthcare interventions 'projects and programmes to receive funding through budgetary allocations from the Federal and</p>		

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		<p>albinism living in Nigeria.</p> <p>Living with albinism can be very challenging. Persons with albinism are susceptible to specific health conditions, principally dermatological and ophthalmic vulnerabilities, requiring higher levels of care and attention. Because of their delicate skin (low melanin) type, 99.9% of persons with albinism are susceptible to skin cancer; thus, skin cancer is the highest health risk persons with albinism face. Increased unprotected exposure to the sun enhances the possibilities of skin cancer and other skin related diseases in persons with albinism. Unfortunately, as a result of ignorant, poverty and discrimination persons with albinism especially those in the rural areas find it difficult to access preventive measures that will reduce their prevalent rate of acquiring skin cancer related diseases. Even where facilities are available persons with albinism hardly afford the high cost of treatment resulting to many of these patients to look up to God until the time of their death. Even when the money is there for treatment, some hardly have the knowledge on where to access medical interventions.</p> <p>3. CONTENT</p> <p>The provision of free skin cancer to persons with albinism in Nigeria is informed on the need for Universal Access to Health Coverage by World Health Organisation (WHO) especially to the vulnerable groups. The specific objectives are:</p>	<p>State Ministries of Health, other MDAs and interested corporate bodies, Civil Society Organisations, International Development Partners etc.</p> <p>Council is further invited to approve:</p> <p>i. The decentralisation and sustainability of the Free Skin Cancer Treatment for Persons with Albinism in the following designated Federal Teaching Hospitals across the six Geopolitical zones in Nigeria and FCT (ABUTH, UMTN, JUTH, UNTH, UPTH, UCH and NHA).</p> <p>ii. The notes in para 4 (I – x) above.</p>		

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		<ul style="list-style-type: none"> <li>a. To reduce the high rise of skin cancer among persons with albinism in Nigeria</li> <li>b. To reduce the financial burden of paying for cancer treatment by persons with albinism and their families</li> <li>c. To increase treatment and rehabilitation rate and overall number of treated persons diagnosed with skin cancer</li> <li>d. To increase access to specialized tertiary healthcare by persons with albinism.</li> </ul>			
53.	<p><b>THE IMPACT OF NATIONAL HOME-GROWN SCHOOL FEEDING PROGRAMME (NHGSFP) ON THE HEALTH AND NUTRITION OF CHILDREN AND WOMEN IN NIGERIA.</b></p> <p><b>HONOURABLE MINISTER OF HEALTH</b></p> <p><b>NCH/61/004E</b></p>	<p>The purpose of this memo is to inform Council on the impact of the NHGSF programme and the role of the Federal Ministry of Health.</p> <p><b>1.0. Background</b></p> <p>The Nigerian HGSP programme aims to deliver a government-led, cost-effective school feeding programme with a specific focus on the development of smallholder farmers and local procurement to spur growth in the local economy. Whilst focused on providing food to children, this food-based safety net programme will indirectly also help improve food security in the beneficiary households. The intended benefits of HGSP will accrue to a wide range of stakeholders.</p> <p>The main objectives of the HGSP programme are as follows:</p> <ul style="list-style-type: none"> <li>1. School Enrolment and Completion: The programme aims to improve the enrolment of primary school children in Nigeria and reduce the current dropout rates from primary school which is estimated at 30%.</li> <li>2. Child Nutrition and Health: The programme aims to address the poor nutrition and health status of many</li> </ul>	<p>5.0 Council is invited to note the following:</p> <ul style="list-style-type: none"> <li>l. Home-Grown School Feeding (HGSP) is a school feeding programme that provides food produced and purchased locally within the country to school children to address child hunger and malnutrition".</li> <li>l. Children under 15 make 45% of Nigeria's population, 24% of children under 15 yrs. are malnourished</li> <li>l. 110 Million Nigerians live below poverty line due to high unemployment.</li> <li>/. Because of poverty many children have poor nutrition and health status, which affects learning outcomes</li> <li>/. That the Federal Ministry of Health should have a dedicated team with dedicated budgetary allocation for the implementation and monitoring of the health services of the NHGSFP. Some of the core departments include, Family Health (School health and Nutrition), Public health, Food Safety, and Neglected tropical diseases</li> <li>l. That the Federal Ministry of health should collaborate with Federal Ministry of Education/ UBEC to ensure healthy school environment</li> </ul>		

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		<p>children and thereby also improve learning outcomes.</p> <p>3. Local Agricultural Production: Linking the programme to local agricultural production has direct economic benefits and can potentially benefit the entire community as well as the children. The programme aims to stimulate local agricultural production and boost the income of farmers by creating a viable and ready market via the school feeding programme.</p> <p>4. Creating Jobs and Improving Family and State Economy: The programme aims to create jobs along the value chain and provide a multiplier effect for economic growth and development.</p> <p>Total target beneficiary population- the programme is targeted to reach 12.8 million pupils in Primary one to three by the end of academic year 2018/19. The cost of feeding per child is at an agreed cost of ₦70 (\$0.33) per day, an annual budget of ₦93billion (\$295million) was approved within the ₦500billion (\$1.59billion) Social Investment Fund.</p> <p>Initially two states from each geopolitical zone were selected for a pilot school feeding programme based on the multi-dimensional poverty index. The multi-dimensional poverty Index (MPI) is a measure of acute poverty. It identifies deprivations across health, education and living standards. However, the enrolment of the States selected to the pilot programme was further based on the states commitment to the programme.</p> <p><b>2.0.</b> Collaboration with Health sector in Nigeria.</p> <p>In collaboration with other partners and stakeholders the health sector is responsible for ensuring effective links</p>	<p>I. That the Federal Ministry of health should collaborate with the NHGSF program to provide WASH facilities and Deworming drugs to pupils in public primary schools benefitting on the programme.</p> <p>II. That the Federal Ministry of health and the State counterparts should ensure the health status of the cooks on the program- medical screening, trainings on food hygiene and safety as well as Health Insurance</p> <p>K. The need to begin discussions around providing health insurance for the pupils and the cooks working collaboratively with the community, NHIS and NPHCDA.</p>		

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		<p>between the Primary health care delivery and state school feeding programmes are created. The Ministry provides guidance on menu guidelines, standards for hygiene and food handling and implementation of integrated health interventions using the platform of the school feeding programme. Others include:</p> <p>Ensuring Healthy environment:</p> <ul style="list-style-type: none"> <li>• Lack of information</li> <li>• Food safety and hygiene</li> <li>• Food and nutrition standards</li> <li>• Linkage to PHCs</li> </ul> <p>Tailoring basic health care packages on the school platform</p> <ul style="list-style-type: none"> <li>• e.g. deworming activities</li> <li>• micronutrient supplementation,</li> </ul> <p>Hygiene and Health seeking behaviour</p> <ul style="list-style-type: none"> <li>• Wash programs</li> <li>• Food vendor training manual</li> <li>• Menu standardisation</li> <li>• Health insurance for pupils and cooks</li> </ul> <p><b>3.0. STATUS OF NHGSFP.</b></p> <ul style="list-style-type: none"> <li>• The NHGSFP is currently been implemented in 24 states in Nigeria. Currently a total of 8228383 pupils are being fed by 85,332 cooks in about 40,252 public primary schools (Abia, Anambra, Enugu, Ebonyi and</li> </ul>			

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		<p>Imo (South East); Akwa Ibom, Cross River and Delta (South South); Ondo, Osun, Oyo and Ogun (South West); Benue, Niger and Plateau (North Central); Kaduna, Jigawa, Kano, and Zamfara, Niger (North West); Bauchi and Borno (North East).</p> <ul style="list-style-type: none"> <li>De-worming has been concluded in collaboration with the NTD unit of the FMOH in 6 States (Bauchi, Jigawa, Abia, Ogun, Plateau and Osun) and second round will commence in May 2018 so far 2,737,553 pupils.</li> <li>The FMOH supported with developing the training manual and the training of the 85,332 cooks on the program.</li> <li>NHGSFP leverages on the institutional structures within the states to implement the programme. The State have signed an agreement with the FGN to be responsible for the cost for operational activities, logistics of recruiting cooks and delivery of meals as well as monitoring and evaluation of the programme.</li> </ul> <p>4.0 Challenges on Programme</p> <p>As much as the NHGSFP leverages on the institutional structures within the FGN and the states to implement the programme. Challenges has been encountered with this collaboration. One of such is the need to ensure standards are adhered to in terms of Health and Hygiene, the Programme has been able to mitigate these issues by working closely with the NHEALTH volunteers on the Job creation cluster of the National Social Investment</p>			

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		<p>Programme.</p> <p>Some of the Basic Roles and responsibilities of the Ministry OF Health Include</p> <ul style="list-style-type: none"> <li>• Ensure that all schools comply with the standards of providing school health services-, The ministry is leveraging on the M and E activities of the Programme, to measure weight and height measurements of the pupils</li> <li>• Provision of manuals of implementation / observation training manual – The Ministry had some challenges in delivering on this task because of the unbudgeted activities, however the FMOH partnered with a private sector Organization to deliver on the food safety and Hygiene Standards of the programme. The organization HEBRON Limited has technically and Financially supported the Trainings and is to deliver on the trainer manuals.</li> <li>• Provision of essential drugs- the Provision of drugs has also been stalled by the lack of funding. Funding to ensure the service is delivered and monitored, The FMOH leveraged on the activities and funding of the NHGSF programme and State Government to roll out the first-round school-based deworming programme. The second round is pending.</li> <li>• At the State ministry of health(s) are to monitor the implementation of programme and to water and sanitation facility in the schools in collaboration with the Ministry of water resources and environment.</li> </ul>			
54.	<b>INCREASED UTILIZATION OF ESSENTIAL PACKAGE OF CARE THROUGH PARTNERSHIP WITH</b>	The purpose of this memorandum is to inform Council that collaborating with traditional birth attendants can increase ante natal clinic attendance and delivery in the hospitals.	<p>PRAYERS:</p> <p>The council is hereby invited to note that working closely with the TBAs with much supervision can</p>		

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	<p><b>TRADITIONAL BIRTH ATTENDANTS FOR IMPROVED ANTE NATAL CLINIC ATTENDANCE</b></p> <p><b>HONOURABLE COMMISSIONER FOR HEALTH, AKWA IBOM STATE</b></p> <p><b>NCH/61/004F</b></p>	<p><b>BACKGROUND:</b> A Traditional Birth Attendant (TBA) according to the World Health Organization (WHO) is defined "as a person who assists the mother during childbirth and who initially acquired her skills by delivering babies herself or through an apprenticeship from other TBAs". They are often not formally trained but are usually respected elderly persons (mostly women) in their communities. Accordingly, to the Akwalbom State Strategic Health Development Plan I, 67% of our women attend ante natal clinic and only 44% go back to the facility for delivery.</p> <p><b>CONTENT:</b> The various TBAs were registered through the help of their association with technical support from Management Science for Health (MSH). Lectures were organized for the TBAs and the curriculum included basic anatomy of the reproductive system, physiology, Health Education and Promotional ante natal and post-natal activities etc. This lasted for six (6) weeks. Thereafter, the TBAs were placed on attachment at the ante natal clinic, labour ward and post-natal clinic at the three general hospitals of Eket, IkotEkpene and Anua. This on-the-job training lasted for six weeks. At the end of the training, a passing out ceremony was organized where the trainees were kitted by MSH</p>	<p>have a positive impact on ante natal clinic attendance and deliveries in the health facilities.</p>		
55.	<p><b>ESTABLISHMENT OF NEONATAL UNIT AT JUMMAI BABANGIDA ALIYU MATERNAL AND NEONATAL HOSPITAL, MINNA</b></p>	<p>The purpose of this memorandum is to inform the Council of the establishment of a neonatal unit at Jummai Babangida Aliyu Maternal and Neonatal Hospital, Minna, and the efforts of Niger State Government towards improving the survival of</p>	<p><b>PRAYERS</b> Council is hereby invited to note that: i) an ultramodern neonatal unit was established on 27<sup>th</sup> April, 2017, at Jummai Babangid aAliyu</p>		



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	<b>HONOURABLE COMMISSIONER FOR HEALTH, NIGER STATE</b>  <b>NCH/61/004</b>	<p>premature and low birth weight babies so as to lower neonatal mortality rate in Nigeria.</p> <p><b>BACKGROUND</b> Niger State, with a population of over 5 million people, does not have a well-equipped neonatal care services Centre to serve this category of patients. The nearest Centre is University of Abuja Teaching Hospital, Gwagwalada, which is about 3 hours away from Minna. It is also a recognized fact that neonatal mortality contributes the largest chunk to the under-5 mortality rate in Nigeria. Premature babies are at increased risk of mortality. It is also known that well managed low birth weight babies under regulated conditions have lower incidence of neurological defects. It is for these reasons that Niger State considered it a worthy investment to establish a multi-million-naira, ultra-modern neonatal Centre which took off on 27<sup>th</sup> April, 2017.</p> <p>Towards the success of this 40 bed Centre, a dedicated block of several rooms was opened in this Hospital. It was equipped with all gadgets necessary to make it the best in the country.</p> <p>Towards sustainability, a world-renowned organization headed by a Nigerian professor and specializing in the provision, training and maintenance of these equipment has been contracted to give regular trouble shooting visits to the Centre. The partnership is governed by a memorandum of understanding with Niger State Government.</p> <p>In terms of logistics, the Centre enjoys 24 hours power supply, through a combination of public mains, generator and solar power banked system. It also enjoys 24 hours</p>	<p>Maternal and Neonatal Hospital, Minna, to increase the survival of preterm and other low birth weight babies.</p> <p>ii) full complements of staff including neonatologists, medical officers, nurses and maintenance staff were trained to guarantee sustainable positive outcome at the Centre.</p> <p>iii) regular support for clinical services and maintenance of equipment has been taken into consideration through signing of agreements/memorandum of understanding with specialists and with a world-renowned organization in this filed.</p> <p>iv) early results are indicative of positive outcome which this kind of investment brings- thousands have being treated and survival improving.</p> <p>v) current challenges (high running costs and inadequate personnel) and future challenges (collaboration with neurologists and ophthalmologists to provide more complete care) are being looked into.</p> <p>Council is further invited to note the efforts of Niger State Government towards improving under-5 mortality rates by establishing an ultramodern unit to cater for pre-term and other low birth weight babies and to urge all states to emulate this.</p>		

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		<p>dedicated water supply. Services rendered in this facility are divided into in-born and out born units and neonatal outpatient clinics.</p> <p><b>SUCCESSIONS</b> Although the time of 5 months of this facility is too short for objective report of the achievements at this Centre, hospital data shows that Nigerlites now have easy access to this specialized care. 2000 patients have been treated at the Centre, 1,300 as inpatients. Survival is also improving. A dedicated research team has however been set up to give a picture of what is achieved over time.</p> <p><b>CHALLENGES</b> Despite all these, current challenges are high running costs, and in adequate staffing to cover all the required shifts. Future challenges would be how to bring about required specialists to cater for conditions expected among survivors such as eye diseases and neurological challenges.</p>			
56.	<p><b>THE IMPROVED INFORMATION AND TECHNOLOGY IN DATA CAPTURE SYSTEMS FOLLOWING STATE INTERVENTION.</b></p> <p><b>HONOURABLE COMMISSIONER FOR HEALTH, RIVERS STATE</b></p> <p><b>NCH/61/004H</b></p>	<p>The purpose of this memo is to share the experience of the State in use of ICT for data capture to improve data quality and its use in decision making in the Health Sector.</p> <p><b>BACKGROUND:</b></p> <p>In line with World Health Organization recommendations, Nigeria has adopted District Health Information Software (DHIS2) as part of the National Health Management Information System. The DHIS2 and the family planning (FP) dashboard were introduced in Rivers State, in 2014 and 2015 respectively, to improve data management, demand and use in the health system. Subsequently, a lot of investments have</p>	Council is invited to note that there is considerable improvement in the use of information technology for data capturing following state interventions and that States are encouraged to make use of it.		

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		<p>also been made in capacity building, deployment of electronic devices, and Internet subscriptions for data capturing.</p> <p>JUSTIFICATION:</p> <p>There was a preliminary situation analysis of the experiences and perceptions of the health workers who use the electronic tools and the effect of electronic data management on data demand. Thus a study of 56 participants made of Family Planning providers and HIOs at the State, LGA and health facility levels was conducted on the use of technology to manage health data in Rivers State. The study done was to provide information that may lead to an improvement in data quality, demand, and use by stakeholders. This research was funded by United States Agency for International Development (USAID) through the MEASURE Evaluation project. The major findings of the study were;</p> <ul style="list-style-type: none"> <li>i) faulty Information and Communication Technology (ICT) equipment.</li> <li>ii) low levels of ICT skills.</li> <li>iii) Inconsistencies between the electronic forms, in DHIS 2, and the paper-based forms, owing to missing data elements on the electronic forms, and the existence of parallel FP reporting lines.</li> <li>iv) Insufficient data demand and use culture at all three levels of the healthcare system.</li> <li>v) Adequate interest and ownership of the electronic platforms by the users.</li> </ul> <p>Subsequently the State in conjunction with her partners</p>			

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		<p>inclusive of African Field Epidemiological Network (AFNET) and USAID carried out the following interventions:</p> <ul style="list-style-type: none"> <li>i) Trained the M&amp;E officers on data management through ICT.</li> <li>ii) Instituted regular data quality assurance meetings.</li> <li>iii) Purchase of ICT equipment including Open Data Kit (ODK) phones and solar computers.</li> <li>iv) Funding for internet services</li> </ul> <p>These processes were carried out and co-funded by partners and the State in focused collaboration.</p> <p>These have resulted to:</p> <ul style="list-style-type: none"> <li>i) Improved data capturing from 56.5% in 2016 to 79.3% in 2017 as seen in the National Health Management Information System (NHMIS) monthly summary.</li> <li>ii) Timely reporting from 49.4% in 2016 to 65.4% in 2017 (NHMIS)</li> <li>iii) Better quality reporting data as reported by data quality assurance meetings.</li> </ul> <p>Increased number of facilities reporting.</p>			
57.	<p><b>THE TARABA STATE/ROCHE HEPATITIS TREATMENT ACCESS PROJECT</b></p> <p><b>HONOURABLE COMMISSIONER FOR HEALTH, TARABA STATE</b></p>	<p>The purpose of this memorandum is to inform Council of the collaboration of the State and Roche Limited aimed at increasing access to viral hepatitis diagnosis and treatment services in the State.</p> <p><u>Background</u></p> <p>Viral hepatitis, particularly Hepatitis B and Hepatitis C have</p>	<p><u>Prayers</u></p> <p>Council is hereby invited to: -</p> <p>1. Note the modest effort of the Taraba State government to address the high burden of viral hepatitis in the State in collaboration with Roche Limited.</p>		

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	NCH/61/004I	<p>since been recognized as diseases of serious public health importance, causing significant morbidity and mortality. The prevalence of these diseases in Nigeria is about 11% for hepatitis B and 2% for hepatitis C. However local studies in Taraba state indicates that the prevalence of hepatitis could be much higher. Over the past years, there has been significant awareness about viral hepatitis with screening campaigns conducted by various Non-governmental organisations. This has led to a demand for treatment services which unfortunately was not easily available in the State.</p> <p>3. <u>Issues and Justification</u></p> <p>Treatment of viral hepatitis is very expensive and often not available in the state. Many unscrupulous individuals have taken advantage of this situation to exploit citizens without providing any benefits whatsoever. This is why the State government has resolved to provide access to prevention and treatment services for free. Roche Limited, a major pharmaceutical company and a leader in the provision of diagnostics and treatment products for viral hepatitis has offered to partner the State on this project. This collaborative proposal was submitted to government in 2011 but an MOU and project agreement was only signed in 2016.</p> <p>The Hepatitis Treatment Access Programme agreement with Roche Products is for a period of five-years. It is estimated that 50,000 individuals would be screened for the viral hepatitis out of which an estimated 2,450 eligible positive patients will benefit from free treatment during the course of the project. An estimated 44,500 of persons screened will be</p>	<p>2. Recommend that other States in the country take similar measures to prevent, diagnose hepatitis and make treatment services accessible to their citizens.</p>		

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		<p>negative for hepatitis B and will receive vaccination with the hepatitis B vaccine.</p> <p>Government has committed to spend 1.326 billion naira over the five years to cover for 50% of the cost of the drugs, 30% of the cost of the viral load testing required, cost of other supportive laboratory test during the course of the treatment and the cost of the screening test and hepatitis B vaccines. Roche will cover for 50% of the cost of the drugs and 70% of the cost of viral load testing amounting to nine hundred and ninety-four million naira (N994, 000,000). In addition, Roche further supported with training of health care workers, awareness creation, and has made available to the State, state-of-the-art supportive diagnostic equipment. Government has since approved and released the sum of 100 million for the first phase of the implementation to kick start the project.</p> <p>The Hepatitis Treatment Access project offers services to all citizens of the State. However, the services for now are offered in only one location in each of the 3 senatorial zones in the State. The services will gradually be scaled-up to other health facilities to increase access.</p> <p>iv) Implementation began in earnest in December 2017 following a flag-off of the project by the Executive Governor of Taraba State, Arch. Darius Dickson Ishaku. Treatment for now is offered for only Hepatitis B using Pegylated Interferon (Pegasys®). The Ministry is aware that treatment guidelines have now changed since the Project document was submitted and already discussions</p>			

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		are ongoing with Roche to modify the agreement in the second year of implementation to include treatment for Hepatitis C (and also for Hepatitis B) using the new antiviral drugs now available.			
<b>STRATEGIC PILLAR THREE: STRENGTHENED HEALTH SYSTEM FOR DELIVERY OF PACKAGE OF ESSENTIAL HEALTH CARE SERVICES</b>					
58.	<b>PROMPT RELEASE OF FUND FOR OPERATIONALIZATION OF THE LOGISTICS MANAGEMENT COORDINATING UNIT (LMCU) OF THE STATE MINISTRIES OF HEALTH</b>  <b>HONOURABLE MINISTER OF HEALTH</b>  <b>NCH/61/005</b>	<p>The purpose of this memo is to update Council on the achievements of the Logistics Management Coordinating Unit (LMCU), and the status of implementation of the approved Nigeria Supply Chain Policy for Pharmaceuticals and other Health care products, and to seek for the approval and release of funds for the LMCU for effective implementation of supply chain activities in the States and for sustainability.</p> <p>1. BACKGROUND AND JUSTIFICATION:</p> <p>1.1 The Logistics Management Coordinating Unit is an established unit domiciled in the Directorate of Pharmaceutical Services in the State Ministry of Health</p> <p>1.2 The core mandate of the LMCU is to coordinate, align and synchronize all supply chain activities across all the public health programmes, donor and implementing partners to ensure uninterrupted availability of medicines and other healthcare products, reduce stock out rate, minimize wastages through damages and expires, avoid duplication of effort by supply chain stakeholders, improve effective utilization of scarce</p>	<p>3. Council is invited to note that:</p> <p>i. The LMCUs have been institutionalized in the 36 states and FCT;</p> <p>ii. Budget line have been created for LMCUs in 28 States (75%) while only 4% of the total amount budgeted by these States were released for LMCU activities; and</p> <p>iii. There is dire need for creation of budget line for the remaining States and release of fund by the States for LMCU activities.</p> <p>Council is further invited to approve:</p> <p>i. The creation of budget line for the States LMCUs by states that are yet to do so; and</p> <p>ii. Prompt release of fund for LMCUs by the States.</p>		

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		<p>resource, ensure data visibility for informed decision making and demonstrate value for money that translate to improved health outcomes.</p> <p><b>1.3</b> The Nigeria Supply Chain Policy for Pharmaceuticals and other Health care products was approved and adopted at the 58<sup>th</sup> NCH meeting in 2016.</p> <p><b>1.4</b> The implementation of the policy is ongoing; amongst other things achieved are: operationalization of LMCUs, harmonization of Logistics Management Information System (LMIS) across public health programmes, upgrading of six zonal warehouses to Pharma-grade standard for public private partnership (PPP) initiative, development of Supply chain related Standard Operating Procedures (SOPs), guidelines and framework to aid effective implementation.</p> <p><b>2. CONTENT</b></p> <p><b>2.1</b> All the States have institutionalized and operationalized LMCU in line with the approval of the Council in 2014. This was achieved with the Support of the National Product Supply Chain Management programme of the Federal Ministry of Health through its Nigeria Supply Chain Integration Project (NSCIP).</p> <p><b>2.2</b> The State Ministries have also supported the LMCU by the provision of office, equipment, human resource and political will.</p>			



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		<p><b>2.3</b> However, in view of the tremendous achievements recorded by the LMCUs in providing supply chain leadership through improved partners and stakeholders' coordination, alignment of supply chain activities, improved reporting rate and data cum commodity visibility which were mostly achieved through partners' support, nevertheless there still remain some challenges.</p> <p><b>2.4</b> The analysis of the LMCU report for 2017 showed that 75% of the states have created budget line for LMCUs while only 4% of the total amount budgeted by these states were released for LMCU activities.</p> <p><b>2.5</b> This result is of great concern and threat to the supply chain system of the country as it is currently evident that funding from donors and implementing partners is tapering and there is need for ownership and sustainability of our supply chain management system in the country. Thus, the need for release of fund to the LMCU for effective and efficient implementation of supply chain activities cannot be over emphasized.</p>			
59.	<p><b>THE NIGERIA HIV/AIDS INDICATOR AND IMPACT SURVEY (NAIIS)</b></p> <p><b>HONOURABLE MINISTER OF HEALTH</b></p>	<p>The purpose of this memorandum is to inform and solicit the support of Council for the successful conduct of the Nigeria HIV/AIDS Indicator and Impact Survey (NAIIS).</p> <p>INTRODUCTION</p> <p>HIV was first found in Nigeria in 1985 and reported at the International AIDS Conference in Paris the following year.</p>	<p>Council is invited to note that:</p> <p>I. Despite progress made in reducing the prevalence of HIV in Nigeria, challenges remain in terms of low treatment coverage, and slow decline in new HIV infections;</p>		

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	NCH/61/005A	<p>However, it was in 1991 that the results from the first antenatal sero-prevalence sentinel survey among pregnant women (popularly called ANC Sentinel Survey) showed that the estimated prevalence of HIV was 5.8%. Over the years however, subsequent surveys showed the prevalence have reduced steadily to 3.0% in 2014. This progress is as a result of concerted efforts of the Government of Nigeria in collaboration with the United States (U.S.) President's Emergency Plan for AIDS Relief (PEPFAR), The Global Fund and other stakeholders.</p> <p>Considering the importance of ensuring that the country is able to report on the 90-90-90 UNAIDS target for termination of transmission of HIV; and especially to account for the massive resources that has been expended to achieve this target, The Federal Government of Nigeria through the leadership of the Federal Ministry of Health and in collaboration with the National Agency for the Control of AIDS (NACA), PEPFAR, the Global Fund and other stakeholders have made a commitment to define the Nigerian HIV epidemic through the conduct of the Nigeria HIV/AIDS Indicator and Impact Survey (NAIIS). An implementing Partner, University of Maryland, Baltimore (UMB) is the</p>	<p>II. Nigeria has joined other nations to endorse the UNAIDS 90-90-90 targets as a commitment towards ending HIV by 2020 guided by the National Strategic Frameworks 2017-2021;</p> <p>III. Nigeria will implement a Nigeria HIV/AIDS Indicator and Impact (NAIIS) as a tool to monitor progress towards the UNAIDS 90-90-90 targets as well as to account for the massive resources that has been invested in the process; and</p> <p>IV. The roles of States and FCT in the implementation of the National HIV/AIDS Indicator and Impact Survey (NAIIS) as described above are very important and central to the successful implementation of the Survey.</p>		

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		<p>technical partner for the survey.</p> <p>CONTENT</p> <p>The NAHS will be conducted in the 36 States of Nigeria and the FCT. The goals of this survey are to determine the national and state level prevalence of HIV in Nigeria, the prevalence of Hepatitis B and C at the National level, to assess the coverage and impact of HIV intervention services, and to measure HIV-related risk behaviours using a nationally representative sample. It will also estimate HIV incidence, Viral Load Suppression among HIV-positive individuals, and pediatric HIV prevalence. Other HIV-related measures, such as CD4 T-cell count, prevalence of detectable ARVs Metabolite and HIV Drug Resistance will also be assessed to characterize the HIV epidemic in Nigeria and provide greater clarity on the impact of the national HIV program. In addition, the survey will collect information on uptake of and access to HIV-related services and will estimate the prevalence of selected behaviours typically associated with HIV acquisition and/or transmission, and on common HIV co-morbidities and other health conditions. Conducting such a survey requires collaboration and buy-in</p>			

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		<p>from all stakeholders especially the State governments through the leadership of the Ministries of Health and their equivalent in the Federal Capital Territory Administration (FCTA). As primary stakeholders in the successful conduct of the NAHS, State Ministries of Health and the FCT Health and Human Services Secretariat are expected to:</p> <ol style="list-style-type: none"> <li>1. Participate actively in the implementation of the NAHS: <ol style="list-style-type: none"> <li>a. For the Honorable Commissioners, through the instrument of the NCH; and</li> <li>b. For Permanent Secretary, Directors of Public Health, Director Planning, research and statistics, Director Laboratory services, SAPCs, Executive secretary/DGs SACAs, through the Stakeholders Committee;</li> </ol> </li> <li>2. Support community engagement and other survey communication initiatives that is currently being carried out in their areas of jurisdiction in order to sensitize the populace about the study and secure their buy-in;</li> <li>3. Facilitate and support the use of laboratories in their states that has been selected for the survey following a capacity assessment that has been conducted in preparation for the</li> </ol>			

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		<p>survey;</p> <p>4. Provide any other support to the team that will be assigned to conduct the survey in their states as may be necessary for successful implementation.</p> <p>Below is a summary of some project milestones that has been achieved in different thematic areas in the implementation of NAIIS:</p> <p><b>A. Governance:</b></p> <ul style="list-style-type: none"> <li>• The setting-up of Survey Steering Committee (SSC) and Survey Technical Committee by the Honourable Minister of Health to oversee the implementation of the Survey. The setting-up of State Survey Teams.</li> <li>• The signing of Memorandum of Understanding (MOU) between the Federal Government (FGN) and United States Government and University of Maryland Baltimore (the Implementing Partner for NAIIS). The Hon Minister, DG NACA and US Ambassador signed the MoU.</li> <li>• Receipt of all ethical approval from both the Nigeria Health research Ethics Committee and the CDC and UMB Institutional Review Boards.</li> </ul>			

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		<p><b>B. Field Implementation</b></p> <ul style="list-style-type: none"> <li>• Training of all field, laboratory and community mobilization staff have been concluded</li> <li>• Pilot testing has been concluded and all findings are currently being incorporated</li> </ul> <p>1. The advocacy visits to the states to reached out to the following groups:</p> <p>i. CAN, SASCP, NOA, CISHAN, NEPWHAN, SMoH, NURTW, NAPTIP, Chief Imams, Traditional council, State chapter of the Vigilante groups in Nigeria</p> <p><b>C. Funding</b></p> <p>This survey will be funded by the President's Emergency Plan for AIDS Relief (PEPFAR) through US Center for Disease Control and the Global Fund to Fight HIV/AIDS, Malaria and Tuberculosis.</p>			
60.	<b>THE USE OF NATIONAL YOUTH SERVICE CORPS (NYSC) MEDICAL TEAM TO BRIDGE THE HUMAN RESOURCE FOR HEALTH CHALLENGE AND IMPROVE SERVICE DELIVERY FOR UNIVERSAL HEALTH COVERAGE.</b>	<p>The purpose of this memo is to inform the Council on the use of NYSC Medical Team to improve the human resources capacity for Universal Health Coverage.</p> <p><u>BACKGROUND:</u></p> <p>The NYSC Scheme provides yearly trained human resources for Health, who have completed their professional training and are made available for the mandatory service to the Nation. Most Health facilities have the challenge of</p>	<p>Council is invited to note that:</p> <p>i. Borno State is providing human resource capacity support to Health facilities through NYSC Medical Team for improve service delivery and provide for Universal Health Coverage; and</p> <p>ii. This practice has been on for the past two years in the State and the impact</p>		

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	<b>HONOURABLE COMMISSIONER FOR HEALTH, BORNO STATE</b>  <b>NCH/61/005B</b>	<p>proper and adequate personnel to man the facilities for Universal Health Coverage. The availability of certain cadre of staff such as Medical Doctors, Nurse/Midwives, Pharmacists, Laboratory Scientists at the Health Facility is critical to the overall improvement of the services delivery in line with HUMAN RESOURCES FOR HEALTH, priority area three, in the Strategic Health Development Plan.</p> <p><u>CONTENT:</u></p> <p>His Excellency, The Executive Governor of Borno State visited the Borno State NYSC Orientation camp at Bauchi in 2016 and requested for more NYSC Medical personnel to the State for improved Health Care service delivery.</p> <p>In order to provide comprehensive health care services to the populace, Government has provided monthly allowance of N100,000 and N50,000 to Doctors and other health professionals respectively as Stipend.</p> <p>Government has also provided well-furnished accommodation and buses to transport them to various health facilities.</p> <p>State Hospital Management Board has set up a monitoring team to ensure the presence of Medical team in their various stations and Checklists are provided to enable them submit activity reports each month.</p> <p>So far about 250 NYSC Medical personnel were posted to various Health facilities especially secondary Health facilities to improve service delivery.</p>	<p>on the health care delivery has been tremendous.</p>		

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61.	<p><b>THE SUCCESSFUL ACTIVATION OF DR -TB TREATMENT CENTRE AT INFECTIOUS DISEASE HOSPITAL (IDH) ZAMBUK.</b></p> <p><b>COMMISSIONER FOR HEALTH, GOMBE STATE</b></p> <p><b>NCH/61/005C</b></p>	<p>The purpose of this memo is to inform the council on the monumental milestone of activating the DR - TB Treatment Centre in Zambuk.</p> <p>BACKGROUND:</p> <p>The treatment Centre in IDH Zambuk was build and handed over to the State Ministry of Health by Agbami Partners in 2014. This was followed by some strategic renovations by Institute of Human Virology Nigeria (IHVN), after signing Memorandum of Understanding with the sole aim of setting an ideal DR- TB Treatment Centre model. IHVN also provided equipments and human resource training to Doctors, Nurses, Pharmacists and Social workers who will provide care to DR - TB from the State and other neighbouring States in the zone.</p> <p>ACHIEVEMENTS:</p> <ul style="list-style-type: none"> <li>• Successful activation and enrollment of new DRTB Patients.</li> <li>• IHVN provides logistic support for feeding and daily maintenance of the facility.</li> <li>• Received referrals from neighboring States; Yobe, Adamawa States respectively</li> <li>• State Government drilled a functional bore hole with an overhead tank powered by solar panels</li> <li>• Security units were deployed to the Centre by the State Government.</li> </ul> <p>CHALLENGES:</p> <ul style="list-style-type: none"> <li>• Security post was abandoned during the renovation</li> </ul>	<p>Council is invited to note:</p> <ol style="list-style-type: none"> <li>1. The existence of an established DR - TB Treatment Centre in Gombe State which will support the care of all DR TB patients in the State and the entire zone at large,</li> <li>2. The fact that other States may wish to copy from this good practice, especially with the peculiarities of insurgency in the North East</li> </ol>		



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		<p>process.</p> <ul style="list-style-type: none"> <li>• Constant erratic power supply to the facility.</li> <li>• Establish a separate ART site within the unit, as co-infected patients are also admitted in the Centre.</li> <li>• A catering unit within the Centre will help minimize the transit time of transporting food from outside the domain of hospital.</li> </ul> <p>A sustainability plan is being work upon considering the dwindling support from foreign donors.</p>			
62.	<p><b>BOOSTING ROUTINE IMMUNIZATION THROUGH THE CONDUCT OF STATE OUTREACH DAYS (SODs)</b></p> <p><b>HONOURABLE COMMISSIONER FOR HEALTH, JIGAWA STATE</b></p> <p><b>NCH/61/005D</b></p>	<p>The purpose of this memorandum is to seek Council's approval to note and encourage states to conduct the State Outreach Days to rapidly increase routine immunization coverage.</p> <p><u>2. BACKGROUND:</u></p> <p>Routine immunization has remained the corner stone of primary health care. More than 80% of childhood morbidity and mortality in Nigeria is due to vaccine preventable diseases. Most states in the northern parts of the country have single digit immunization coverages. Low RI coverage has been observed to be due to a number of factors including inadequately trained front-line service providers, poor quality Reaching Every Ward (REW) micro-plans, gaps in vaccine supply chain management, inadequate data tools, as well as lack of effective engagement of communities leading to poor health seeking behaviour by the household heads and caregivers to mention but a few.</p> <p>The current fixed sessions at health facilities and outreach</p>	<p>The council is hereby invited to note that the conduct of SODs can rapidly increase coverage of immunization services and that states should be encouraged to follow suit.</p>		

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		<p>services are not adequately conducted and generally speaking, are currently too slow and insufficient to provide the platform for a rapid scale up.</p> <p>In order to fast track the uptake of RI in the Jigawa state, State Outreach Days (Ranar Lamba) was launched in September 2017. During this period (5 days monthly) all health workers who are licensed to give injections, except for a critical mass that remained at the health facilities, were mobilized to the field to provide RI services at community level and issue immunization cards. So far seven rounds were conducted, and it is interesting to note that the percentage of children that were fully immunized rose from the SMART 2017 value of 7%, to WHO LQAS value of 46% in April 2018. The RI processes are also being carried out in which an in-between-round plan is implemented tracking defaulters and immunizing them as well as continued social mobilization activities at the community levels.</p> <p>3. <u>CONTENT:</u></p> <p>SOD Components</p> <p>The SOD strategy is a quick-win intervention that is used in addressing low immunization coverage in Jigawa state. It involves the following steps.</p> <ol style="list-style-type: none"> <li>Community mapping and health worker allocation</li> <li>Trainings at state, LGA and ward levels</li> <li>Cold chain logistics</li> <li>Mobilization of tools and supervisors</li> </ol>			

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		e. Community mobilization activities f. Conduct of the SOD g. Post implementation review meetings • During each cycle, health workers move from village to village to provide RI. Before the arrival of the health workers, the community is informed through the community focal person who ensures the mobilization of eligible children to the vaccination point. The data is entered into the local health facility register while a line list of all the RI eligible children with their vaccination status is left with the community focal person.			
63.	<b>THE INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS (IMCI) IN KOGI STATE.</b>  <b>HONOURABLE COMMISSIONER FOR HEALTH, KOGI STATE</b>  <b>NCH/61/005E</b>	<p>The purpose of this memorandum is to inform Council on the Integrated Management of Childhood Illness (IMCI) strategy in Kogi State.</p> <p>Background / Introduction            The Integrated Management of Childhood Illness (IMCI) strategy was launched in 1995 by the World health Organization (WHO) and United Nations Children's Fund (UNICEF) as a key strategy for improving child survival. IMCI has already been introduced in more than 75 countries around the world, including Nigeria.</p> <p>According to UNICEF, every single day, Nigeria loses about 2,300 under-five year olds. This makes the country the second largest contributor to the under-five (U5) mortality rate in the world. To address this concern of the burden of U5 mortality in the country, Nigeria National Council on Health in 1997 ratified the implementation of the IMCI strategy as the</p>	<p>Council is invited to note that:</p> <ol style="list-style-type: none"> <li>1. IMCI strategy is a proven intervention which reduces U5 morbidity and mortality.</li> <li>2. the coverage of IMCI intervention in Kogi State is still low despite donor support.</li> </ol> <p>Council is further invited to Approve:            All States in the Federation to adopt the IMCI strategy as the main thrust of her child survival program to reduce the frequency and severity of childhood illnesses and reduce child mortality.</p>		

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		<p>main thrust of the nation's child survival strategy. The IMCI strategy aims to reduce under-five (U5) mortality and morbidity in developing countries by combining improved management of common childhood illnesses with proper nutrition and immunization. About 70% of these deaths are due to one or a combination of major childhood killer diseases - Malaria, acute respiratory infections especially pneumonia, diarrhea, measles, malnutrition, HIV/AIDs and neonatal conditions - addressed by the Integrated Management of Childhood Illness (IMCI) strategy.</p> <p>Content</p> <p>Sick children in the developing world often suffer from more than one disease condition, making the traditional disease-specific approach to illness less effective. The IMCI strategy has numerous advantages, as it provides the means of detecting more than one problem in a child during the same consultation and managing those problems through an integrated approach. In the health facilities, it promotes the accurate identification of childhood illnesses in outpatient settings, ensures appropriate combined treatment of all major illnesses, strengthens the counseling of caregivers, promotes rational use of drugs, and speeds up the referral of severely ill children. In the home setting, it promotes appropriate care seeking behaviours, improved nutrition and preventative care, and appropriate home care based on prescription in health facilities. The strategy also focuses on the health of the mother, thus establishing a child care-maternal care linkage, as well as increase opportunity for immunization by</p>			

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		<p>screening for immunization status of all sick children seen. This represents one of the added values of IMCI to existing national immunization programme (NPI) activities. The results of WHO Multi-Country Evaluation of the impact, cost and effectiveness of the IMCI strategy in Brazil, Bangladesh, Peru, Uganda and the United Republic of Tanzania indicate that:</p> <ul style="list-style-type: none"> <li>• IMCI improves health worker performance and their quality of care</li> <li>• IMCI can reduce U5 mortality and improve nutritional status, if well implemented.</li> <li>• IMCI is worth the investment, as it costs up to six times less per child correctly managed than current care;</li> <li>• Child survival programmes require more attention to activities that improve family and community behaviour;</li> <li>• A significant reduction in under-five mortality will not be attained unless large-scale intervention coverage is achieved.</li> </ul> <p>OBSERVATION The Maternal and Child Survival Program (MCSP) currently supports implementation of the IMCI strategy in six local government areas in Kogi State. The LGAs are Idah, Dekina, Lokoja, Ijumu, Okene, and Okehi. MCSP has supported the training of 110 PHC workers in 55 public PHC facilities on IMCI / PSBI as part of its mandate to improve the quality of</p>			

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		facility-based child health services in the state. However, this training figure represents about 10% of the total number of Community Health Extension Workers/Community Health Workers in the 1072 public PHC facilities in Kogi state. It is recommended that at least 60% of all clinical staff in PHCs be trained to achieve a critical mass for effective coverage of IMCI interventions.			
64.	<b>THE USE OF HEALTH RANGERS IN THE REDUCTION OF MATERNAL MORTALITY IN KOGI STATE UNDER THE HEALTH CARE PLUS PROJECT</b>  <b>HONOURABLE COMMISSIONER FOR HEALTH, KOGI STATE</b>  <b>NCH/61/005F</b>	<p>The purpose of this Memo is to inform the Council of the use of Health Rangers in the reduction of maternal Mortality in Kogi State under the Health Care plus Project</p> <p><u>Introduction:</u></p> <p>Health Care plus is a Maternal and New born Health Intervention Programme designed to end Preventable Maternal and new-born Deaths in Kogi State in a political dispensation.</p> <p><u>Background:</u></p> <p>The Persistently High maternal and New born Mortality in Kogi state which stand at 576/100,000 live births and 37/1000 live births respectively (NDHS 2013) have necessitated the need to use Health Rangers in the reduction of Maternal Mortality.</p> <p>Health Rangers are community Health Extension Worker and social workers trained to follow up on registered pregnant women under the health Care Plus Project</p>	<p>Council is invited to note that:</p> <ol style="list-style-type: none"> <li>Health Care Plus was approved by the state Executive Council on 25<sup>th</sup> July 2016 and officially flagged off by the Honourable Minister of Health, Prof Issac Adewole on 25<sup>th</sup> January, 2018</li> <li>Since the flag off Health Care plus Project, we have commenced implementation on February 13 , 2018 in 2 Primary Health Care Centres (PHCs) and so far so good 500 Pregnant women have registered in the 2 Centres with 64 spontaneous vaginal deliveries and 28 Caesarean section with no Maternal Mortality.</li> <li>With the successes we have recorded so far, 10 other PHCs will be activated by June 2018 to cut across the state so as to tackle our persistently High Maternal Mortality.</li> </ol>		

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		<p>They serve a link in rural communities between pregnant women and the Health facilities.</p> <p>Once a pregnant women registers under the Health care plus Project, she is attached to a Health Ranger who immediately obtains the contact numbers and address of the women in order to trace her to her place of residence of the physical verification. They also carry out periodic visitation to the residence of the Pregnant woman to monitor her wellbeing and respond to calls from any registered pregnant woman who need urgent medical attention and make emergency arrangement for the transfer of the client to the Health Facility whenever the need arises which has significantly reduced the second delay with respect to maternal mortality</p> <p>Furthermore, Health rangers also follow referred pregnant women to the referral Hospitals and Provides social supports needed.</p>	<p>Council is further invited to approve:</p> <ul style="list-style-type: none"> <li>i. The use of Health Rangers as a link in rural communities between pregnant women and Health facilities in the reduction of maternal Mortality in Nigeria</li> <li>ii. That all states of the Federation to adopt the use of Health Rangers as a measure for the reduction of Maternal Mortality in Nigeria using the Health care Plus Model of Kogi State.</li> </ul>		
65	<p><b>IMPROVING IMMUNIZATION COVERAGE IN SOKOTO STATE</b></p> <p><b>HONOURABLE COMMISSIONER FOR HEALTH, SOKOTO STATE</b></p> <p><b>NCH/61/005G</b></p>	<p>The purpose of this memorandum is to seek Council's approval for the adoption and implementation of the Sokoto State model for improving Immunization.</p> <p><u>2. BACKGROUND:</u> According to NDHIS survey of 2013, Sokoto State has the lowest coverage on DPT1 (3.2%) DPT3 (2.3 %.), Measles 3.3% while other States were having 92.2%, 85.2% and 75.8% respectively. This is disturbing and unacceptable considering the huge investment by Government and partners in the sector. This will also expose the children to Poliomyelitis, Measles, Tetanus, and Tuberculosis, blood</p>	<p>The Council is invited to note as follows:</p> <p>1. The Progress recorded in immunization in Sokoto State as a result of the following measures taken:</p> <ul style="list-style-type: none"> <li>- Introduction of newborn tracking and registration by traditional leaders</li> <li>- Traditional Barbers (Wanzamai) engagement in tracking and referring newborns for immunization</li> <li>- Jumuat mosques engagement for routine immunization and other health issues</li> <li>- Full involvement of traditional and religious</li> </ul>		

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		<p>infection, diphtheria, ear infection, Hepatitis, Pertusis etc.</p> <p>In order to raise the coverage of Immunization in Sokoto State, various measures were taken which included the following:</p> <ul style="list-style-type: none"> <li>- Introduction of newborn tracking and registration by traditional leaders</li> <li>- Traditional Barbers (Wanzamai) engagement in tracking and referring newborns for immunization</li> <li>- Jumuat mosques engagement for routine immunization and other health issues</li> <li>- Full involvement of traditional and religious leaders in resolving noncompliance to Routine and Supplementary Immunization Activities</li> <li>- Expansion of Health Facilities offering RI in the state</li> <li>- Signing MoU with Private Health Facilities for RI service provision</li> <li>- Increasing budgetary provision of SPHCDA</li> <li>- Establishment of SERIEC within the SPHCDA</li> <li>- Increase awareness creation using media, IEC materials</li> <li>- Training and re-training at all levels</li> <li>- Constitution of RI Task force committee headed by the State Deputy Governor</li> <li>- Strengthening of zonal cold stores for vaccine safety</li> </ul> <p>As a result of the above activities, the coverage on Immunization in Sokoto State has improved to 43% according to Q2 LQAS 2018 survey</p>	<p>leaders in resolving noncompliance to Routine and Supplementary Immunization Activities</p> <ul style="list-style-type: none"> <li>- Expansion of Health Facilities offering RI in the state</li> <li>- MoU with Private Health Facilities for RI service provision</li> <li>- Increasing budgetary provision of SPHCDA</li> <li>- Establishment of SERIEC within the SPHCDA</li> <li>- Increase awareness creation using media, IEC materials</li> <li>- Training and re-training at all levels</li> <li>- Constitution of RI Task force committee headed by the State Deputy Governor</li> <li>- Strengthening of zonal cold stores for vaccine safety</li> </ul> <p>2. Bilgate and Dangote visited PHC Sifawa and conducted Integrated Supportive Supervision for an hour. They are satisfied and later sent a commendation letter to the State and in particular PHC Sifawa.</p>		



S/N	TOPICS/ORIGINATOR(S) FEDERAL AND STATES	ISSUES RAISED	NOTES/PRAYERS	NCH TECHNICAL COMMITTEE'S RECOMMENDATION	COUNCIL DECISION
<b>STRATEGIC PILLAR FOUR: PROTECTION FROM HEALTH EMERGENCIES AND RISKS</b>					
66.	<p><b>THE HEALTH SECTOR HUMANITARIAN EMERGENCIES IN NIGERIA</b></p> <p><b>HONOURABLE MINISTER OF HEALTH</b></p> <p><b>NCH/61/006</b></p>	<p>The purpose of this memo is to inform and seek Council's approval for the Development of a National Framework for Health Sector Response to Humanitarian Crisis in the Nigeria</p> <p>2. Nigeria over the years has combated different humanitarian crisis, be it as a result of conflicts, insurgencies or migration. Amongst these, the Boko-Haram insurgency is recognized to have wreaked the most debilitating humanitarian crisis with an almost complete destruction of the health architecture in the North East with Borno State as the epicenter. As at June 2017, it was estimated that there are 1,825,321 Internally Displaced Persons (330,680 households) across Adamawa, Bauchi, Borno, Gombe, Taraba, and Yobe States (Displacement Tracking Matrix June 2017). Considering all the conflicts in Nigeria with the North East being the most affected the Honourable Minister of Health directed the establishment of a stepwise coordination structure to efficiently and effectively midwife the process of repositioning the Humanitarian crisis affected regions in Nigeria but with emphasis on the ravaging</p>	<p>Council is invited to note the following:</p> <ul style="list-style-type: none"> <li>i. The protracted insurgency in the North East and increased complexities of humanitarian crisis in Nigeria warrants a more systemic approach.</li> <li>ii. There are various on-going humanitarian crisis in Nigeria such as such the pastoralist and farmers clashes in the middle belt and in agrarian communities, violent campaigns of secessionist in the south east, and the health crisis in oil producing communities in the south-south region</li> <li>iii. In response to the Humanitarian crisis in the North East, a North East Health Sector Humanitarian Crisis Response Strategic Plan (NEHSHRSP) was developed and subsequently domesticated to state specific operational plans for the six (6) North</li> </ul>		

S/N	TOPICS/ORIGINATOR(S) FEDERAL AND STATES	ISSUES RAISED	NOTES/PRAYERS	NCH TECHNICAL COMMITTEE'S RECOMMENDATION	COUNCIL DECISION
		instance in the North East. Through exceptional leadership portrayed by the HMH, diligence of the Special project department and support from relevant stakeholders notably WHO, PCNI, VSF, UNICEF and other UN subsidiary agencies, a North East Health Sector Humanitarian Crisis Response Strategic Plan (NEHSHRSP) was developed and subsequently domesticated to State Specific Operational Plans for the six (6) North East states. Juxtapose to this response, there was a reported decline in the health and nutritional status of the populace in the Humanitarian crisis epicenter "Borno state" resulting in a declaration of an emergency within the on-going emergency. This retrogression in health status warranted the deployment of a rapid response team by the Honourable Minister of Health to assess the situation and develop a comprehensive Health and Nutrition Emergency Response Plan for Borno state. In accordance to the set Terms of Reference a Health and Nutrition Emergency Response in Borno State Project (HNERIBS) was collaboratively developed with state actors and development partners and implemented over a period of one (1) year in two phases of six (6) months each. A total of N4.3 billion was expended in the first phase and N380,	<p>East states to address the health dilapidation and reposition the health system in the North East.</p> <p>iv. An emergency within an emergency was declared in Borno state warranting the development of a Health and Nutrition Emergency Response in Borno State which has been implemented over a period of one (1) year, in two (2) phases of six (6) months each with an expenditure of N4.3 billion and N380,000,000 respectively.</p> <p>v. Through this project, access to quality health care has increased in Borno State.</p> <p>vi. Finalization of the development of the North East Health system strengthening comprehensive plan and 2018 operational plan.</p> <p>vii. Benue State was supported with medicines and health related supplies</p>		

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		<p>000,000 in the second phase of the project. Over N2 billion was utilized in procuring and distributing medicines and health related supplies (Large cache of medicines still remaining at the central medical stores) other components of this project were the procurement of logistics trucks for distribution, ambulances for referrals and logistic vehicles for monitoring and evaluation as well as outreach programmes by ad-hoc staff. The summit of this project was the engagement and deployment of 375 ad-hoc staff in groups of thirteen (13) members to 25 LGAs in Borno state to provide day to day Nutritional care, treatment of communicable and non-communicable diseases, mental health and psychosocial support services (MHPSS), Obstetric and family health care.</p> <p>3. In addition to the on-going Humanitarian crisis in the North East, There have been a myriad of on-going reoccurring crisis in other parts of the country such as the pastoralist and farmers clashes in the middle belt and in agrarian communities, violent campaigns of secessionist in the south east, and the health crisis in oil producing communities in the south south region. In recent times, the FMOH has supported Benue state in responding to the flooding disaster by providing medicines and Health related</p>	<p>during the flooding incident in the state.</p> <p>viii. A total of 2,000 Nigerian migrants from Libya have been provided with comprehensive health care and psychosocial support during repatriation exercise funded by the Federal Government.</p> <p>ix. The FMOH has developed and submitted a comprehensive plan for the provision of comprehensive health care and psychosocial support to an expected 91,000 Nigerian returnees from Cameroun.</p> <p>Council is further invited to approve:</p> <p>i. The Development of a National Framework for the Health Sector Response to Humanitarian Crisis in Nigeria.</p> <p>ii. The institutionalization of a coordination office for health sector response to humanitarian crisis in all State Ministries of Health and</p>		

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		<p>supplies to the affected communities and has provided support to 2,000 Nigerian returnees from Libya and is to be replicated for the upcoming repatriation exercise of 91,000 returnees from Cameroun</p> <p>4. Mindful of the complexity and evolutionary pattern of Humanitarian crisis, it is pertinent to establish a National Humanitarian crisis response Framework to effectively and efficiently respond to all variants of hazards and humanitarian situations in the Country and the following: -</p> <p>a. The institutionalization of an office for health humanitarian crisis intervention in all State Ministry of Health.</p> <p>b. To strengthen the National office for coordinating Health sector response to Humanitarian crisis.</p>	<p>iii. The strengthening of the extant National coordination office on health sector response to humanitarian crisis.</p>		
67.	<p><b>THE ESTABLISHMENT AND OPERATIONALIZATION OF THE PUBLIC HEALTH EMERGENCY OPERATIONS CENTRE (PHEOC) IN THE STATE</b></p> <p><b>HONOURABLE COMMISSIONER FOR HEALTH, BORNO STATE</b></p>	<p>The purpose of this memo is to inform the Council on the Establishment and Operationalization of the Public Health Emergency Operation Center (PHEOC) in the State in response to the health and humanitarian crisis.</p> <p><u>BACKGROUND:</u></p> <p>Borno State Ministry of Health has established a Public Health Emergency Operations Center (PHEOC) to enhance coordination of information and resource for managing public health emergencies such as infectious diseases, floods, fires, landslides, drought, structural collapse, utility failure,</p>	<p>Council is invited to note that the Borno State Ministry of Health in collaboration with WHO has established a functional &amp; effective Public Health Emergency Operation Center; first of its kind in the country.</p> <p>Council is also invited to urge other States to emulate this best experience.</p>		

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	NCH/61/006A	<p>terrorism, internal conflicts, road carnage and chemical, biological, nuclear, radiological &amp; explosives, among others.</p> <p>The concept of operation of the PHEOC is heavily inclined to Incident Management System (IMS) which is the common and globally recommended model for executive, strategic, operational, and tactical management of all hazards. It provides structures and organization of response and highlights key responsibilities of PHOEC staff as well as designated response agencies. The framework establishing the PHEOC outlines key concepts and essential standards to ensure that the PHEOC achieves its objectives, some of which include:</p> <p>Real-time information for timely decision-making;</p> <ul style="list-style-type: none"> <li>○ Time and coordinated acquisition &amp; deployment of key personnel;</li> <li>○ Communication and coordination with response partners;</li> <li>○ Collection, analysis and dissemination of information and data; and</li> <li>○ Factual and reliable communication with the public and media.</li> </ul> <p>The Center is located at Maiduguri Eye Hospital, off Damboa road The Center has been furnished with monitoring and surveillance equipment, including computers installed with appropriate systems, conference facility and other emergency coordination tools. It has adequate security for data, personnel and equipment and is manned by technical personnel with various professional skills in public health,</p>			

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		<p>disaster management, information technology, resource mobilization and communication.</p> <p><u>CONTENT:</u></p> <p>Twenty-two (22) Development Partners in Health sector, Nigeria Center for Disease Control (NCDC), Federal Ministry of Health are in the Center.</p> <p>There is a weekly Health Bulletin for Health awareness and enlightenment of general public.</p> <p>The Center serves as capacity building and training ground for health professionals.</p> <p>It is well equipped with modern ICT materials such as video conferencing, surveillance system</p> <p>Coordination of meetings with Development partners and other stakeholders twice every month.</p> <p>The State has supported the Center with venue in collaboration with W.H.O.</p> <p>A M.o.U agrees that W.H.O. should run the Center for one (1) year and then hand it over to the State Government.</p> <p><u>ACHIVEMENTS SO FAR:</u></p> <p>The Center has successfully managed Viral Hemorrhagic Fever (suspected lassa fever in 2017).</p> <p>Managing outbreak of Hepatitis E across the State in places like Monguno, Kala-balge and Damasak.</p> <p>It has also managed the outbreak of Cholera in five (5) LGAs of the State.</p> <p>Managing another Cholera outbreak in Kukawa.</p>			

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68.	<b>PROTECTION FROM HEALTH EMERGENCIES AND RISK</b>  <b>HONOURABLE COMMISSIONER FOR HEALTH, LAGOS STATE</b>  <b>NCH/61/006B</b>	<p>The purpose of this memorandum is to inform Council on the efforts of Lagos State Government through collaboration with the Global Partnership Programme (GPP) Canada in establishing a biosafety Laboratory and further seek Council's approval for the development of a national policy, national framework on health security, including biosecurity, bio-banking and community engagement.</p> <p>INTRODUCTION</p> <p>Health emergencies are the health consequences of infectious diseases, natural disasters or man-made disasters. Public health emergencies caused by highly infectious diseases have the potential to kill thousands or millions of people. These threats can emerge naturally as outbreaks or pandemics, such as the Ebola virus disease, Lassa fever (seasonal), influenza (pandemic and seasonal), severe acute respiratory syndrome (SARS), extremely-drug resistant (XDR) tuberculosis, antibiotic-resistant bacterial infections; or they can emerge deliberately through bioterrorism.</p> <p>BACKGROUND</p> <p>Health security is the protection against health emergencies and other risks. It is a part of general human security. All human security threats have one thing in common and that is the centrality of people. With the Ebola outbreak, it is apt to say that the world is only as safe as the most fragile States. Therefore, safeguarding individual and collective health security depends on the ability of governments and</p>	<p>Council is hereby invited to note the efforts of Lagos State Government through collaboration with the Global Partnership Programme (GPP) Canada in establishing a biosafety Laboratory.</p> <p>Council is further invited to approve the development of a national policy, national framework on health security, including biosecurity, bio-banking and community engagement</p>		

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		<p>international institutions to set priorities and allocate resources to control and mitigate the effects of disease outbreaks. Building resilient public health surveillance systems and infrastructure is crucial to combat threats from infectious diseases.</p> <p>In 2014, the Global Health Security Agenda (GHSA) was launched to accelerate global capability and strengthen collective health security through country and inter country capacities to prevent, detect and respond to infectious disease threats both naturally occurring and intentionally released. GHSA targets are Prevention, Detection and Response. Biosecurity and biosafety are part of strategies for protection against health emergency and risks. The main focus of a BSL laboratory is to find ways to control the emerging infectious diseases, strengthening national disease surveillance and strengthening prevention, control and response systems.</p> <p>ESTABLISHMENT OF LAGOS STATE BIOSAFETY LABORATORY</p> <p>Following the Ebola virus disease outbreak of 2014, Lagos State Government with a view to prepare against emerging and re-emerging biological threats of local or international concern established a committee on Emerging Infectious Diseases. One of the strategic interventions designed for prevention and control of EIDs in the State is the establishment of a high consequence bio-safety and bio-containment Laboratory in collaboration with Global</p>			



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		<p>Partnership Programme (GPP) Canada. The design and construction of the laboratory have been completed, and the Laboratory has been shipped to Lagos, Nigeria. Installation is ongoing.</p> <p>The facility would afford the State the opportunity to promptly diagnose diseases of public health importance during routine surveillance activities and during outbreaks of emerging highly pathogenic infectious diseases or incidents of environmental toxicity towards effective clinical management.</p> <p>In addition, bio-samples would be stored in the biobank section of the BSL laboratory for medical research and international collaboration to fast track research and discovery.</p> <p><b>CHALLENGES</b></p> <p>Challenges faced in providing protection from health emergencies and risks include, Weak health systems, Irregular Supply of Drugs and other Essential Life Saving Commodities., Migration and High financial burden.</p> <p><b>RECOMMENDATIONS</b></p> <p>In order to mitigate the numerous challenges faced in executing a robust bio-security and bio-banking facility, it is essential to execute high resource mobilisation drive, improved political and financial investments, implementation of Universal Healthcare Coverage (UHC), review public health regulations, regulate international migration and</p>			

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		promote health security and health education. The media can be engaged to improve the knowledge of the public on understanding of infectious diseases. These will empower individuals to adopt appropriate preventive behaviours and pre-empting migration. Community perceptions, human behaviour, willingness to report, and compliance with control measures are all key factors in effective disease control.			
69.	<p><b>CONTAINING DISEASE OUTBREAKS IN CONGREGATE SETTINGS: A CASE TO STRENGTHEN MEDICAL SERVICES AT YOUTH CORP CAMPS AND PRISONS.</b></p> <p><b>HONOURABLE COMMISSIONER FOR HEALTH, RIVERS STATE</b></p> <p><b>NCH/61/006C</b></p>	<p>The purpose of this memorandum is to seek approval of the Council on Health, to direct relevant agencies to reinforce early diagnosis and effective containment of infectious disease outbreaks in congregate settings in the country: A case for the strengthening of medical services at National Youth Service Corp camps and Nigeria Prisons.</p> <p><u>INTRODUCTION</u></p> <p>The recent outbreaks of infectious diseases across the country despite concerted effort at control and the associated morbidity and mortality has continued to be a source of worry. More troublesome has been cases of Viral Hemorrhagic disease and Monkey Pox Virus infections in the Southern part of the country. Studies suggest an estimated 300,000-500,000 Lassa infections/year whilst very few are actually detected. Following the first index case in Bayelsa, the country reports an estimated 205 cases of suspected Monkey Pox Virus with 80 cases confirmed across 24 States with three deaths as at 2<sup>nd</sup> February 2018. Within the same period, in Rivers State, following the identification of an index case in October, 2017, there has been about twenty-seven laboratory confirmed cases of monkey pox.</p> <p>Incidentally there were five cases of Monkey Pox infections in</p>	<p>PRAYERS:</p> <p>Council is humbly requested to note:</p> <p>i.) Congregate settings should have a minimum of a medical clinic, with a trained medical officer who has capacity to identify and institute early containment measures in infectious diseases conditions.</p> <p>ii.) In addition, the medical Centre in all camps and prison facilities should be sufficiently equipped for exit and entry triage processes for detecting infectious disease manifestations and must have a private or holding bay for keeping in case of scenarios where suspected cases are identified.</p> <p>iii.) The consequences of a poorly managed outbreak in a congregate setting and the attendant media resonance of an outbreak in these settings is not in the interest of the health care delivery system at this time when vigorous</p>		

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		<p>Port Harcourt Prisons and two cases of Monkey Pox infections in National Youth Service Corp camp in December, 2017 which were effectively contained. These cases posed very significant challenges to control in settings beyond the ordinary. Despite being congregate settings, which could make transmissions easier, these settings have commonly observable poor medical capability for triage and early containment. They seemed significantly overcrowded and the standards of cohabitation made interruption of transmission herculean as toilets were shared and no preparation was made for isolation of cases considered as infectious. Areas for decontamination were open ended and the line listed contacts which required monitoring was significantly lengthy. The situation appears to be similar across same settings around the country. These challenges are also observable in temporary religious and social camps.</p> <p>All congregate settings with residential status should have the capacity for identifying, triage and isolation before they are set up.</p> <p><u>JUSTIFICATION</u></p> <p>Preparedness is key to controlling infectious diseases of public health significance. Indeed, congregate settings of the Prisons and Youth Corp camps in the country are hot spots and high risk areas for transmission of infectious diseases with persons of diverse background travelling across peculiar localities with specific disease preferences only to converge in a single locality to share common social amenities.</p> <p>Most of these facilities are overcrowded, poorly maintained</p>	<p>attempt at restoring confidence of the people in our health delivery systems is most desired.</p> <p>iv.) It is therefore imperative to ensure that minimum medical standards are met in the Corp camps and Nigeria Prisons which incidentally are all federal institutions.</p> <p>Council is further invited to:</p> <p>I.) Approve that all congregate settings including the Corp camps, Religious camps, Social camps and Prisons, should consciously maintain the minimum standard necessary for Infection Prevention and Control, especially entry and exit triage systems as recommended in the National Policy.</p> <p>II.) Direct the relevant agencies in charge of Youth Corp camps and Prisons in the country to ensure that there is a fully functional clinic with a holding bay for identified cases of infectious diseases in order to guarantee the interruption of transmission of infectious diseases where necessary and safeguard lives of campers and inmates.</p>		

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		with poor medical triage and response systems. Whilst the regular inmates and Corp members may be confined, it is important to note that the staff of these facilities return home to general public off-duty periods and can establish a transmission link with the general public whenever there is an outbreak in the setting.			
<b>STRATEGIC PILLAR FIVE: PREDICTABLE FINANCING AND RISK PROTECTION</b>					
70.	<b>THE COMPLETION OF THE NATIONAL HEALTH ACCOUNTS STUDY 2010-2016 AND COMMENCEMENT OF THE 2017 NHA STUDY</b>  <b>HONOURABLE MINISTER OF HEALTH</b>  <b>NCH/61/007</b>	<p>This memo is to inform the National Council on Health of the completion the National Health Account Health study 2010 - 2016 and commencement of National Health Accounts Study 2017.</p> <p>Background</p> <p>The Federal Ministry of Health of Nigeria (FMOH) has conducted National Health Account studies for the periods 1998 – 2002, 2003 – 2005, 2006 – 2009, 2010-2014, and currently finalized the 2015-2016 NHA study. This became necessary in order to close the gap in Nigeria's conduct of NHA studies and to put Nigeria on the global map of NHA front-runners.</p> <p>Findings from the studies will be used by policy makers, researchers, and other health stakeholders in informing health policy and practice in Nigeria and beyond. Additionally, results from the NHA study will provide essential baselines for Nigeria's UHC Agenda and will be pivotal for major decisions in resource mobilization, allocation, reprioritization as well as utilization within the health sector at</p>	<p>Council is invited to note that:</p> <p>NHA 2017 is planned to commence in the month of August and this will be cascaded to the States; and as such maximum cooperation is requested from all stakeholders.</p>		

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		<p>all levels.</p> <p>The NHA 2010-2016 is the first of its kind in Nigeria, as it not only deployed the newly introduced System of Health Accounts (2011), it is in addition the first to be conducted in all the 36 States and FCT. We hope that skills acquired and built during the process will make Nigeria a hub for the learning of strategies for conducting NHA studies in the sub-region in the coming years and most importantly in the conduct of the sub-national (state) Health Accounts (SHA).</p> <p>Findings from the NHA 2010 -2016 reveal a weak performance of the healthcare financing system as follows;</p> <ul style="list-style-type: none"> <li>• Total health expenditure to GDP ratio averaged 3.6% for the period, still below the target range of 4-5%.</li> <li>• Government health expenditure to total government expenditure increased from 2.8% in 2010 to 5.1% in 2016 but remains far below the Abuja declaration target of 15%.</li> <li>• Out-of-Pocket household spending was very high at average of 69.7% of THE compared to the benchmark of 30-40%. This portends both elevated levels of exposure of households to catastrophic health spending and high welfare losses as more than 99% of OOP is spent on curative care, leaving no room for preventive care.</li> <li>• Social health insurance as a proportion of THE remained very low at 1.6%, compared to the UHC target of 90%</li> <li>• These findings will contribute immensely to resource</li> </ul>			

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		<p>mobilization, allocation and overall decision making in the health sector especially as we are currently working towards revitalizing and strengthening our health system.</p> <p>As part of efforts towards strengthening our health system, strategies have being articulated towards institutionalizing the NHA in Nigeria, proactive efforts are being made to conduct routine NHA in the FMOH and State Ministries of Health. Although the challenges of conducting routine NHA are enormous, ranging from inadequate technical capacity and structures to manage NHA, unavailability of data, poor priority setting by policymakers, and poor funding, the importance of establishing sustainable mechanisms to surmount these would not be over-emphasized. At the moment, plans have commenced to jettison the very episodic, periodic and non-efficient practice of NHA and embrace routine conduct of the study that will ensure provision of real-time evidence for health planning and resource mobilization in the health sector.</p> <p>To this end, the NHA 2017 is being planned and will commence in the coming weeks. We solicit your usual cooperation with the provision of relevant information to our NHA officers and data collectors whenever they come around.</p>			
71.	<b>UPDATE ON THE OPERATIONALIZATION OF THE BASIC HEALTHCARE PROVISION FUND (BHCPF) AND DEVELOPMENT OF AN</b>	The purpose of this memo is to formally update Council on the status of operationalizing the Basic Healthcare Provisions Fund in line with the provisions of the National Health Act - 2014 and to seek Council's approval for the adoption of the operations manual as the blueprint to implement the BHCPF.	<p>Council is invited to note:</p> <ol style="list-style-type: none"> <li>I. The NHAAct -2014 provides for a basic healthcare provision fund.</li> <li>I. To fast track the operationalization of the provisions of the Act, a basic minimum</li> </ol>		

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	<p><b>OPERATION MANUAL</b></p> <p><b>HONOURABLE MINISTER OF HEALTH</b></p> <p><b>NCH/61/007A</b></p>	<p>2. BACKGROUND</p> <p>2.1. Nigeria's Commitment to Universal Health Coverage was heralded by a Presidential commitment following a Universal Health Coverage summit in 2014. This was further symbolized with the enactment of the National Health Act in 2014 which serves as a legal framework for galvanizing the activities of all stakeholders in the health sector as well as providing an additional stream of predictable financing for health. Part one, section eleven of the Act established a BHCPF for the provision of a basic minimum package of healthcare services as defined by the Honourable Minister of Health for all Nigerians. The Funds will be sourced from an at least 1% of the consolidated revenue funds, grants from international donors and funds from any other sources. The funds shall be disbursed through three gateways – National Health Insurance Scheme (NHIS), National Primary Health Care Development Agency (NPHCDA) and the Emergency Medical Treatment (EMT) gateways in ratio 50%, 45% and 5% respectively.</p> <p>2.2. As part of strategies to operationalize the provisions of the Act, a benefit package has been defined by the Honourable Minister of health and an Operations Manual which outlines the governance structures, disbursement pathways including monitoring and evaluation strategies as well as a complaints and redress mechanism has been jointly developed by the FMOH, NHIS and the NPHCDA. The Operations Manual also established a National Steering Committee to provide oversight for the implementation of the BHCPF in line with Section 60 of the National Health Act,</p>	<p>package of healthcare services has been defined by the Minister as stipulated in the Act.</p> <p>i. To guide the administration, disbursement and ensure accountability and transparency in utilization of the Fund, an operations manual has been developed.</p> <p>ii. The start-up phase for the operationalization of the Act will be funded by donor contributions – BMGF, WB and GFF.</p> <p>Council is further invited to approve:</p> <p>The Operations manual which has been jointly developed by the FMOH, NHIS and NPHCDA technical teams for the implementation of the BHCPF Start-up phase.</p>		

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		<p>2014.</p> <p>2.3. The Federal Government, since the enactment of the Act has been unable to finance the implementation of the BHCPF. In the absence of Government's commitment to finance the BHCPF, some development partners (the World Bank, Bill and Melinda Gates Foundation and the Global Financing Facility for RMNCAH+N) have decided to support the Federal Ministry of Health to operationalize the BHCPF through a proof of concept in three states. However, there are some conditions precedents to accessing the funds.</p> <p>2.4. Conditions precedent as stipulated by the donor partners include but not limited to; conducting an environmental safeguard, posting of a project accountant from the Office of accountant general of the federation's office, developing clear strategies for capacity building for the states, a robust operations manual that outlines the governance and funds disbursement pathway in a transparent and accountable manner. To coordinate the implementation process, a National Steering Committee for the BHCPF has been constituted by the Minister as mandated by the Act. Membership of the NSC comprises of the HMH, HMSH, PSH, ES-NHIS, ED-NPHCDA, Chairman Committee of Commissioners of Health, Representative of the CSO community, Development Partners contributing to the fund, and an independent observer.</p> <p>2.5. To kick-start the implementation of the BHCPF, three start-up states have been selected for the initial phase which will facilitate the generation of evidence for the final roll out of the BHCPF in the 36+1 States. Niger, Osun, and Abia</p>			



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		<p>States will be used for the start-up phase. As part of the evidence generation for the start-up phase, baseline assessment of selected health facilities in a number of Local government areas in the States are currently on-going.</p> <p>2.6. The BHCPF as an instrument for accelerating Universal Health Coverage in Nigeria forms a basis for a national health insurance program that aggregates premiums from the informal sector to build a national social insurance scheme. It will complement the larger National Social Safety as well as facilitate our PHC strengthening for service delivery readiness. It will further address access to quality care for the poor while preventing them from falling into financial catastrophe and package of health services may be reviewed at intervals as defined by the Minister.</p>			
72.	<p><b>UPDATE ON IMPLEMENTATION OF THE STATE SOCIALHEALTH INSURANCE INITIATIVE</b></p> <p><b>HONOURABLE MINISTER OF HEALTH</b></p> <p><b>NCH/61/007B</b></p>	<p>This memorandum seeks to formally update Council on the status of implementation of the State Social Health Insurance Initiative by the NHIS in Nigeria. The Guidelines was presented at the special NHC in March 2015 as part of efforts by the NHIS to consolidate coverage expansion and attainment of Universal Health Coverage in Nigeria.</p> <p>2.0 BACKGROUND</p> <p>2.1 Universal health coverage represents a sustainable development goal for health. Empirical evidence abounds of the correlation of health population health with development. A healthy population implies higher labour productivity and higher returns to households from labour participation. According to the World Health Organization, universal health coverage (UHC) not only guarantees every citizen access to acceptable and quality healthcare, it also provides financial</p>	<p>Council is hereby invited to note the following:</p> <ul style="list-style-type: none"> <li>i. That NHIS decentralization policy is on course and has been adopted by many states towards the attainment of UHC in Nigeria.</li> <li>ii. The SSHIS will be the platforms for implementing the NHIS Gateway of the BHCPF</li> <li>iii. Thirty- Five states have legal frameworks in place; Seventeen states have laws passed and Twelve states have their bills signed into law. Thirteen States have their Agencies in place and Seven states have commenced population coverage.</li> </ul>		

S/N	TOPICS/ORIGINATOR(S) FEDERAL AND STATES	ISSUES RAISED	NOTES/PRAYERS	NCH TECHNICAL COMMITTEE'S RECOMMENDATION	COUNCIL DECISION
		<p>protection to them, thus cushioning them from the impoverishing effects of ill health and the costs thereof. Universal access to healthcare improves health system's outcomes, improves productivity and positively correlates with economic development.</p> <p>2.2 Nigeria's efforts towards UHC have been tremendous and clearly visible. The establishment of the National Health Insurance Scheme as the institutional framework with the mandate for UHC goal attainment; the hosting of the Presidential Summit on UHC in 2014; the signing into law of the National Health Act (2014) and current efforts at operationalization of the Basic Healthcare Provision Fund (BHCPF), all highlight a choice and seriousness of the government of Nigeria in pursuit of this lofty goal.</p> <p>2.3 The National Health Insurance Scheme (NHIS), having identified several constraints militating against a scale up of coverage in Nigeria commenced the decentralization of NHIS implementation to the States through the State Social Health Insurance (SSHI) Initiative. This takes cognizance of the important roles that states could play in the achievement of UHC, given their importance in issues relating to health as enshrined in the 1999 constitutional.</p> <p>2.4 In recognition of the important role of states, the NHIS has adopted the SSHI structure as the framework for the implementation of its 50% share of the BHCPF as enshrined in section 11 of the National Health Act, 2014. All states are therefore encouraged to work towards establishing their respective SSHIS structures.</p>	<p>See annexure for details.</p> <p>iv. The State health insurance Schemes are urged to create ICT systems that can interconnect with the NHIS system. Council is hereby invited to encourage all states to adopt and expedite efforts to establish SSHIS as a cost effective, transparent and sustainable platform for achieving their health systems' goals and for implementing the NHIS Gateway of the BHCPF</p>		

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		<p>3.0 STATUS REPORT OF IMPLEMENTATION OF SSHIP IN NIGERIA.</p> <p>3.1 Following the presentation and adoption of the Council memo in March, 2015, many states commenced activities aimed at implementing mandatory health insurance schemes in their domains. The summary of the implementation status is as summarized below:</p> <ul style="list-style-type: none"> <li>• Thirty-Five (35) States have developed their legal frameworks.</li> <li>• Seventeen (17) states have passed their bills.</li> <li>• Twelve (12) States have their laws signed.</li> <li>• Thirteen (13) states have their Agencies in place.</li> <li>• Seven (7) states have started enrolling their populations.</li> </ul> <p>The NHIS and Partners have provided support to the states in various areas.</p> <p>3.2 Since NHIS plans to use the SSHIS structure to implement the NHIS Gateway of the BHCPF, it is imperative that a seamless exchange of data between NHIS and the SSHIAs exist. Therefore, SSHIAs are urged to ensure that their ICT system demonstrate interconnectivity with the NHIS system for operational ease.</p> <p>3.3 The overall objective of the policy is to ensure:</p> <ul style="list-style-type: none"> <li>i. Transparency</li> <li>ii. Equity</li> <li>iii. Accountability</li> </ul>			

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		iv Accessibility  v. Aggregation of pools to deal with the dangers of fragmentation as currently evident in the system.			
73.	<b>NIGERIA STATE HEALTH INVESTMENT PROJECT (NSHIP)</b>  <b>HONOURABLE MINISTER OF HEALTH</b>  <b>NCH/61/007C</b>	<p>The purpose of this memorandum is to provide a progress report to the National Council on Health (NCH) on the implementation of Nigeria State Health Investment Project (NSHIP) a Performance Based Financing (PBF) project in Nigeria with extension to additional five North- Eastern states of Bauchi, Borno, Gombe, Taraba and Yobe.</p> <p>Background</p> <p>The Nigeria State Health Investment Project (NSHIP) is a performance based financing health intervention designed to improve primary health care in the project states with a focus on maternal and child health services; strengthening participating institutions at federal, state and LGA levels; Strengthening information management; and capacity building. The project has been implemented in three states: Adamawa, Ondo and Nasarawa since 2011 as a pilot in some Local Government Areas (LGAs) and later extended to all LGAs in these states in early 2015. The Midline Impact Evaluation of the project was done in collaboration with the</p>	<p>Council is invited to note:</p> <ul style="list-style-type: none"> <li>i. that NSHIP is a performance-based financing intervention aimed at improving the quality and quantity of health services;</li> <li>ii. the potential benefits of the project and its extension to the five additional states in the North East to rapidly restore health services in emergency situations;</li> <li>iii. that non-state actors hold great potential for service delivery and this has been incorporated into the design of AF-NSHIP;</li> <li>iv. the capacity of PBF to transform the health system and the need for states to explore opportunities to pilot PBF in at least one LGA;</li> <li>v. that the AF-NSHIP became effective in February, 2017 and is being scaled up in the states;</li> <li>vi. that the NPHCDA has developed sufficient technical capacity to support any State that</li> </ul>		

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		<p>National Bureau of Statistics, National Population Commission and the World Bank. The preliminary analysis of the data showed marked improvement in both quantity and quality of services provided compared to non-NSHIP states. The outcome which was presented at the Mid Term Review (MTR) of the project in November 2017 revealed remarkable progress on all five Project Development Objectives (PDO) indicators—on total project beneficiaries, number of curative visits by children under-five and, number and proportion of (i) children immunized and (ii) births attended by skilled personnel. In addition, the health facilities in Project states have seen an impressive increase in quality of care, and the patients have seen a significant decrease in out-of-pocket spending.</p> <p>In keeping with the Presidential mandate to re-establish health care services provision in the North East, the NSHIP building on observed positive results in the existing NSHIP states, especially in Adamawa, has been expanded to the remaining five North East states of Borno, Yobe, Taraba, Gombe and Bauchi. This expansion is made possible through an additional financing (AF) credit from the World Bank of \$125 million and a Global Financing Facility grant of</p>	<p>i. desires piloting PBF; that the PBF approach institutionalises health worker motivation and is a likely panacea for the frequent strikes seen across the country.</p>		

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		<p>\$20 million.</p> <p>The AF is adapted to the specific conditions in the NE by: (a) reinforcing health service delivery using Performance-Based Financing (PBF); (b) promoting contracting of indigenous non-state actors to strengthen local capacity for service delivery; (c) application of special strategies including mobile clinics to provide 'hit and run' services as well as temporary structures for health service delivery, community nutritional rehabilitation and psychosocial support.</p> <p>The project became effective on 27th February 2017. The pilot of the Performance-Based Financing (PBF) Project has started with success in one selected pilot LGA in Bauchi, Taraba and Gombe and 2 selected LGAs in Borno and Yobe states. The NPHCDA, as part of her technical assistance to support the project states and LGAs on implementation, has engaged the services of two Performance-Based Financing (PBF) Technical Experts and 5 Verifiers to conduct monthly quantity verification, coaching and mentoring of health facilities. The PBF verifiers and the Technical Experts have resumed work in their respective states. The details of the implementation are attached as appendix.</p>			

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74.	<p><b>THE IMPORTANCE OF PARTNERS' CONTRIBUTION TO THE STATE HEALTH ACCOUNT</b></p> <p><b>HONOURABLE COMMISSIONER FOR HEALTH, ADAMAWA STATE</b></p> <p><b>NCH/61/007D</b></p>	<p>The purpose of this memorandum is to seek council's approval to compel Partners to declare their health expenditures to states.</p> <p><b>BACKGROUND</b></p> <p>National Health Account is a means of tracking the sources and uses of funds in the health sector over a specific period of time. It accounts for how money from the state, private sector and donor agencies are spent on health. It is useful in measuring health indicators such as: total health expenditure (THE) as a proportion of GDP and proportion of expenditure made on the different areas of health such as preventive and curative medicines.</p> <p><b>CONTENT</b></p> <p>Estimating National or state health account involves accounting for all inflow of funds into the health system. Knowing how much Partners spend on health is therefore crucial in estimating the health account of a state. Unfortunately most implementing partners are not willing to declare their health expenditures to the states.</p>	<p><b>PRAYERS</b></p> <p>Council is invited to note as follows:</p> <ul style="list-style-type: none"> <li>i. The estimation of state health account is important in tracking health expenditure over a given period of time.</li> <li>i. Resolutions No xvii-xx of the 60<sup>th</sup> National Council on Health encourages states to estimate their Health account.</li> <li>i. Most Implementing Partners do not declare their health expenditure to states thereby making health account estimation difficult.</li> <li>/ Council is further invited to approve:</li> </ul> <p>Compel Partners to declare their annual health expenditure to their states</p>		
75.	<p><b>IMPLEMENTATION OF THE 60<sup>TH</sup> NCH RESOLUTION ON INSTITUTIONALIZING ANNUAL STATE HEALTH ACCOUNT (SHA) STUDIES BY CONDUCTING THE FIRST-EVER ANAMBRA STATE HEALTH ACCOUNT (SHA) 2010-</b></p>	<p>The purpose of this memo is to inform the Council of the successful completion of the Anambra State Health Account (ASHA) 2010-2017 study, and strategies already instituted for routine annual conduct of subsequent SHA study.</p> <p><b>Background:</b></p> <p>An effective robust Health System is an evidence of</p>	<p>The Council is invited to note that:</p> <ul style="list-style-type: none"> <li>i. Anambra State has successfully completed the State Health Account study from 2010—2017, with technical support from the World Health Organization (WHO) and funding from the European Union under “Strengthening the</li> </ul>		

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	<b>2017 STUDY</b>  <b>HONOURABLE COMMISSIONER FOR HEALTH, ANAMBRA STATE</b>  <b>NCH/61/007E</b>	<p>availability of accurate and timely health data, including information on financial expenditure and flows in the Health sector. The State Health Accounts (SHA) offers a comprehensive review of all expenditures on health in a given economy. It tracks the flow of funds from financing sources through health financing schemes and healthcare providers to beneficiaries.</p> <p>Anambra is the most populous state in South-East Nigeria, with projected population of 5.5 million in 2016, and home to majority indigenous Igbo ethnic group (98%) and a minority Igala enclave in the North-west part of the state (2%). The state is divided into 3 senatorial districts which are further subdivided into 21 Local Government Areas, 235 districts and 330 political wards. The State has adopted the National Health Act (NHAct), the National Health Policy (NHP) in 2016/2017 respectfully, and has developed the State Strategic Health Development Plan (SSHDP II).</p> <p>The state's Gross Domestic Product (GDP) was valued at N3.8 trillion in 2016, equivalent of 3.8% of Nigeria's GDP of N101.5 trillion in the same year. With estimated population of 5.5 million, GDP per capita was N688,495 in 2016, which exceeded the national average of N542,761. Overall, the economy is a service economy, with tertiary activities accounting for nearly two-thirds (65.3%) of GDP in 2016.</p> <p>Considering the current priority accorded to health by the government of Chief (Dr) Willy Obiano towards achieving UHC, there is a need to provide key baseline health financing data to benchmark progress towards UHC in State especially</p>	<p>Nigerian Health Systems for Primary Healthcare Delivery" Project.</p> <p>ii. That prior to the conduct of the SHA 2010-2017, the State Ministry of Health</p> <p>a. Established the State Health Financing Equity and Investment (HCFE&amp;I) Unit in DHPR&amp;S, SMOH;</p> <p>b. Established the State Health Financing Equity and Investment Technical Working Group (TWG)</p> <p>c. Trained the HCFE&amp;I Unit, the TWG, and key Policy Makers in the SMOH on Health Financing and Management including Systems of Health Account</p> <p>ii. With the completion of the SHA 2010 – 2017, Anambra is the very first State in Nigeria to comply with the 60<sup>th</sup> NCH Resolution on Institutionalizing State Health Accounts Study and close the gap in providing verifiable baseline health financing evidence for ongoing tracking of progress towards UHC.</p> <p>v. The Anambra State Ministry of Health has completed plans to validate the SHA 2010-2017 report with stakeholders and use ensuing evidence for the development of the State Health Financing Policy and Strategy towards UHC in the State.</p> <p>Council is further invited to:</p>		



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		<p>as the State Health Insurance Scheme has been established.</p> <p><u>Goal:</u> The main goal of the 2010-2017 ASSHA is to demonstrate how Anambra state's health resources are spent, on what services, which providers, who pays for them and through which schemes. ASSHA will be used for monitoring health expenditure patterns in implementation phase of the 2<sup>nd</sup> Anambra State Strategic Health Development Plan (ASSHDP II) and to provide requisite information to improve the capacity of decision-makers to identify health system problems and improve health system performance towards UHC in the State.</p> <p><u>Methodology:</u></p> <p>This exercise was conducted in six phases with technical support from the World Health Organization (WHO) and funding from the European Union under "Strengthening the Nigerian Health Systems for Primary Healthcare Delivery" Project.</p> <ul style="list-style-type: none"> <li>i. Establishment of the State Health Financing Equity and Investment (HCFE&amp;I) Unit in DHP&amp;S, SMOH;</li> <li>ii. Establishment of the State Health Financing Equity and Investment Technical Working Group (TWG)</li> <li>iii. Training of the HCFE&amp;I Unit, the TWG, and key Policy Makers in the SMOH on Health Financing and Management including Systems of Health Account</li> <li>iv. Data collection in six main aspects of health accounts namely Government, Household, Enterprises, Donor, and NGO in collaboration with, SPHCDA, ASHIA,</li> </ul>	<ul style="list-style-type: none"> <li>i. Encourage other States and FCT to follow the example of Anambra State in establishing sustainable mechanisms for the conduct of annual State Health Accounts studies in line with the 60<sup>th</sup> NCH resolution to support implementation of the SSHDP II.</li> </ul>		

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		<p>Federal Ministry of Health, State Bureau of Statistics (SBS), and Centre for Health Economics and Development (CHECOD).</p> <p>v. Data entry, mapping into the Health Accounts Production Tool (HAPT), and final analysis over a period of Eight years on healthcare expenditure in the State.</p> <p><u>Major Results from the Study include</u></p> <ul style="list-style-type: none"> <li>• Total health expenditure to GDP ratio averaged 3.2% for the period, still below the target range of 4-5%, but THE per capita exceeded the established targets for health financing resource mobilization.</li> <li>• Generally Out-of-Pocket household spending was very high at average of 91.4% of THE compared to the benchmark of 30-40%. This portends both elevated levels of exposure of households to catastrophic health spending and high welfare losses.</li> <li>• Among providers, an average of 84.1% of CHE was spent in hospitals (including specialist hospitals and PHCs). Of these, secondary hospitals which are 97% owned and operated privately accounted for a dominant share of 77.8%.</li> <li>• Curative care services are the dominant function on which health expenditures are spent, accounting for an average of 82.7% of CHE. An average of 57.0% of expenditure on curative care was spent on outpatient services.</li> <li>• Service delivery indices are very high and health</li> </ul>			

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		<p>outcomes are competitive.</p> <ul style="list-style-type: none"> <li>The State still rely highly on donor contributions</li> </ul> <p>Based on the above results, the following are hereby recommended. There is a need to</p> <ol style="list-style-type: none"> <li>Continue engagement of the Ministries of Finance and Economic Planning, Budget and development in the state for increase in Government expenditure on health to meet up with Abuja declaration</li> <li>Develop innovative domestic resource mobilization for health in Anambra State and reduce dependence on donors for critical health interventions</li> <li>Urgently reduce the very high OOPE by accelerating coverage on the Anambra State Health Insurance Scheme</li> <li>Re-focus expenditure to PHC in the State as Nigeria as a whole is revitalizing PHCs as a means of achieving UHC</li> <li>Subsequently conduct annual State Health Accounts (SHA) with support from the NHA Core Team in FMOH, WHO, and development partners, to show the trend and progress towards UHC and for consolidation to produce the annual National Health Accounts (NHA).</li> <li>Use the SHA results to inform development of Anambra State Health Financing Policy and Strategy to re-position the State for efficient and sustainable financing of UHC in the State.</li> <li>Finalize and publish the State Health Accounts Manual.</li> </ol> <p>Encourage other States and FCT to follow the example of</p>			

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		Anambra State in establishing sustainable mechanisms for the conduct of annual State Health Accounts studies in line with the 60 <sup>th</sup> NCH resolution.			
76.	<p><b>STATE GOVERNMENT'S EFFORTS IN IMPROVING HEALTH FINANCING IN BAUCHI STATE.</b></p> <p><b>HONOURABLE COMMISSIONER FOR HEALTH, BAUCHI STATE</b></p> <p><b>NCH/61/007F</b></p>	<p>The purpose of the memorandum is to inform the Council on Bauchi State Government's effort in improving Health Financing in the State.</p> <p><b>INTRODUCTION</b></p> <p>The availability of financial resources to provide equitable and quality care is key to Bauchi state's achievement of Universal Health Coverage. In an effort to explore additional sources of revenue for the state to improve its health sector performance and also provide health insurance coverage to its population through the state contributory healthcare scheme, the SMoH with the support of USAID-HFG Project conducted a fiscal space analysis of the state.</p> <p><b>ISSUES AND JUSTIFICATION</b></p> <p>The fiscal space analysis reveals many potential sources of revenue as follows: -</p> <ul style="list-style-type: none"> <li>(i) The 2015 figures show that raising the proportion of health expenditure as a share of total government expenditure from the current 8.7% to 15% will potentially bring in additional 5.3 billion naira to the health sector.</li> <li>(ii) A second prospective source of additional revenue for Bauchi state is the earmarked funds for health. The principal source of funds for the state contributory healthcare scheme Equity Fund is 1% state Consolidated Revenue Fund (CRF). Therefore, once the scheme takes off the state will</li> </ul>	<p>Council is hereby invited to note as follows:</p> <ol style="list-style-type: none"> <li>1. Bauchi State Government has made Improving Funding to Health Sector through Innovative financing mechanisms, accountability and transparency as one of the 5point Health Agenda of the Currents Administration Lafiya Garkuwa.</li> <li>2. The State Government in the years 2016, 2017 and 2018 has consistently allocated 15-16% of the States Total Annual Budget to Health Sector in line with 2001 Abuja Declaration, and that efforts are on-going to ensure that the budgetary release match the allocation.</li> <li>3. The Government has also passed a law to provide for the establishment of Bauchi State Health Trust Fund charged with the responsibility for collection of certain percentage of the States Internally Generated Revenue (IGR) managing and disbursing the funds to Public Health Institutions in the State. This is aimed at improving budgetary release.</li> <li>4. The Bauchi State Government has reached advanced stage in the establishment of the State Health Insurance Scheme tagged Bauchi State Health Contributory Scheme to</li> </ol>		

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		<p>potentially have an additional 785 million naira for health insurance in 2018.</p> <p>(iii) Similarly, State Health Trust Fund will be getting 1% LGA Total Revenue Fund monthly in addition to 5% state IGR. Following the assent to the bill, the fund would potentially generate an additional 661 million naira.</p> <p>(iv) Bauchi state has a dedicated fund which has been established to cater for orphans and vulnerable children, and there have been ongoing discussions to earmark 15% of the fund for the purchase of services through the state contributory healthcare scheme. If this is realized, it is estimated to bring in additional 46.4 million naira.</p> <p>(v) On the other hand, Internally Generated Revenue (IGR) formed 8.3% of Bauchi state's total revenue in 2015, one of the lowest in the country. However, the state is making efforts to increase its IGR; based on the 2015 figures, raising IGR to 15% of total revenue will bring an additional 3.1 billion naira to the state coffers, part of which can be channeled to the health sector.</p> <p>(vi) Bauchi state has had two tranches of debt relief in 2017, which totals 13.7 billion naira. If the state considers dedicating 15% of the discretionary fund, which forms 25% of the total, to the health sector, it will bring in an additional 513.7 million naira.</p> <p>(vii) Finally, Federal statutory allocations to Bauchi state have historically been above 50 billion naira.</p>	<p>be managed by Bauchi State Health Contributory Management Agency. The Executive bill that initiated the scheme was passed by Bauchi State House of Assembly and signed into Law by the Executive Governor. The State has also finalized the development and costing of the Minimum Service Package for the scheme. Establishment of the Agency has reached an advanced stage and is expected to be operational by 1<sup>st</sup> week of July 2018.</p> <p>5. The State Ministry of Health has formed a Health sector Donors Forum which includes Heads of State Health MDAs, State Program Officers, Representative of All International Donors &amp; Partners and Civil society Organizations working in the Health Sector, State planning Commission and all relevant Stakeholders. The forum meets on quarterly basis and is aimed at improving efficiency and cost effectiveness for services through integration and harmonization of programs to reduce duplications and wastes of time, money and energy.</p> <p>6. There is also in place, the Bauchi State Standing Committee on Corporate Social Responsibility (CSR) for the health sector that will mobilize more resources into the health Sector from Private establishments like</p>		

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		<p>However, the economic slowdown experienced by the country lowered the state's allocation to about 40 billion naira. With ongoing implementation of the Economy Recovery and Growth Plan, the allocation could rise to pre-economic crisis level, which will bring additional 10 billion naira revenue to the state. At 16% allocation to health, there is a potential for additional 1.6 billion naira for health.</p> <p>Bauchi state's fiscal space analysis shows the state has the potential to generate the total sum of about 9 billion naira for health which could be used to fill identified gaps in the state's Health sector</p> <p>CONCLUSION</p> <p>It was based on the above fiscal space analysis outcome the Bauchi State Government decided to come up with strategies that will Improve the Public Sector spending on health, mobilize extra-resources from Private Sector as part their corporate social responsibilities to the people of the state, reduce the out of pocket expenditure to the barest minimum and ensure judicious utilization of international Donor support. These strategies are expected to improve financing of Health Care Services in Bauchi State as well as improve the health Indices of the State.</p> <p>i.</p>	<p>Banks, Communication Companies, Oil &amp; Gas organizations, Philanthropists etc.</p> <p>7. The Bauchi State Ministry of Health has also established a State Health Financing Working Group with membership from all relevant stakeholders that broadly review periodically all aspects of Health Financing in Bauchi State and advise appropriately.</p>		
77.	ADOPTION OF THE NATIONAL POLICY FOR STRENGTHENED	The purpose of this memo is to inform the Council on Health Care Services financing and how utilization is becoming	PRAYER:		

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	<p><b>HEALTH SYSTEM FOR DELIVERY OF PACKAGES OF ESSENTIAL HEALTH CARE SERVICES: THE NEED FOR IMPROVED HEALTH CARE FINANCING AND INCREASED UTILIZATION OF QUALITY SKILLED HEALTH CARE PROFESSIONALS</b></p> <p><b>HONOURABLE COMMISSIONER FOR HEALTH, ENUGU STATE</b></p> <p><b>NCH/61/007G</b></p>	<p>increasingly difficult for individual citizens of the country because of high cost of drugs and consumables as well as the cost of engaging skilled health professionals such as doctors and nurses.</p> <p>Consequently, there is underutilization of skilled manpower in the delivery of essential health care packages necessary for strengthened health system.</p> <p><b>BACKGROUND</b></p> <p>Health care financing through health insurance scheme appears to be a very viable option in Nigeria. The experience in all states particularly during recession and high inflationary trends suggests that the cost of health care services burden on individuals in the face of high cost of drugs and consumables is catastrophic and pervasive.</p> <p>Moreover, there is high cost of living and maintaining health professionals highly needed to provide essential packages of health care services. Many health care facilities are dysfunctional because of acute shortage of these health professionals' especially doctors, nurses and midwives, pharmacists, etc. many are unemployed, searching for jobs obviously available but cannot be engaged principally because of funding constraints.</p> <p><b>JUSTIFICATION</b></p> <p>Poor health indices such as high maternal mortality rate in Nigeria currently noted by Hon. Minister of Health to be 576 per 1000 live births in Nigeria clearly demand for strengthening Health Care delivery system. Apart from facility upgrading, the case challenges focus on bringing down the cost of health care service to individuals and family through adoption of Health insurance schemes at States and Local government levels to enhance access to health care service to majority of Nigerians. The challenges of providing</p>	<p>Council is invited to note that:</p> <ol style="list-style-type: none"> <li>1) The States should establish mandatory Health Insurance Scheme for her citizens. National Health Insurance Scheme should be strengthened and more citizen uptake of scheme advocate</li> <li>2) Reintroduction of midwives' service scheme to involve nurses and doctors for rural posting s especially in primary Health care centers to curtail available deaths from obstetric emergencies and other childhood illness</li> </ol> <p>Increased manpower development by opening up more schools of midwifery, Nursing and departments of nursing in Nigeria universities.</p>		

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		essential packages of health care services in the face of growing demands necessitates the imperative of engaging unemployed qualified skilled health professionals in the existing facilities especially in rural settings . The focus using semi-skilled and less competent health care service practitioners like CHEWS is not an alternative. To strengthened Health Care Service System, the right personnel must be engaged.			
78.	<b>THE NEED FOR SUSTAINING AND FUNDING THE LMCU CONCEPT BY THE STATES</b>  <b>HONOURABLE COMMISSIONER FOR HEALTH, KANO STATE</b>  <b>NCH/61/007H</b>	<p>The purpose of this memorandum is to seek Council's approval for sustaining and funding of LMCUs by the States in the event of the cessation of NSCIP project.</p> <p>BACKGROUND:</p> <p>Nigeria has been facing Procurement and Supply Management (PSM) challenges. These include but not limited to: commodity stock-outs, wastage through expiries, poor visibility of PSM resource mobilization and low stakeholders' confidence in supply chain management, hence the introduction of the LMCU concept by Nigeria Supply Chain Integration Project (NSCIP) under the National Product Supply Chain Management Program (NPSCMP) of the Department of Food and Drugs Services (FDS), of the Federal Ministry of Health (FMOH).</p> <p>The goal of NSCIP is to establish and institutionalize Logistics Management Coordination Units (LMCUs) at the state level among other goals.</p> <p>The concept was later extended to cover local governments, with the introduction of the LGA-LMCUs.</p>	<p>PRAYERS</p> <p>The Council is kindly invited to note as follows:</p> <ol style="list-style-type: none"> <li>Kano was among the first states in the country to inaugurate its LGA-LMCUs in all the 44 LGAs of the state in collaboration with a partner from the state (MNCH2).</li> <li>Kano was among the first states in the country to train its LGA-LMCUs on integrated supply chain management in all the 44 LGAs of the state in collaboration with Sustainable Drug Supply System Committee.</li> <li>Kano State has created a budget line for LMCU activities worth N10.3 million.</li> <li>Capturing of LMCU activities in the 5-year State Strategic Health Development Plan (SSHDP), State Annual Operational Plan (AOP) and LGA AOP.</li> <li>Kano State LMCU has scouted for Alternative Financing to support routine LMCU activities.</li> <li>Kano State LMCU has adopted the NSCIP's model for integration, to integrate the FMCNH</li> </ol>		



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		<p>The LMCU concept was first piloted in 14 focal states in Nigeria, but later extended to cover the remaining states.</p> <p>CONTENT:</p> <p>Kano State has immensely benefited from the LMCU concept. Some of the achievements derived through the LMCU include:</p> <ul style="list-style-type: none"> <li>➤ Kano State has constructed a new LMCU office at DMCSA.</li> <li>➤ LMCU has been able to achieve product integration with respect to warehousing for the 4 major supply chain systems (TB, Malaria, Reproductive Health &amp; FMNCH commodities. Vaccines are stored separately because of special need, and ARVs are supplied from the Zonal Hubs directly to the facilities.</li> <li>➤ So far, LMCU has a total of 28 staff, with 11 residing within its office confines (including partners, the SDSS Desk Officer &amp; Volunteer Pharmacist).</li> <li>➤ Kano was among the first states in the country to inaugurate its LGA-LMCUs in all the 44 LGAs of the state in collaboration with a partner from the state (MNCH2).</li> <li>➤ Kano was among the first states in the country to train its LGA-LMCUs on integrated supply chain management in all the 44 LGAs of the state in collaboration with Sustainable Drug Supply System Committee.</li> <li>➤ Kano State has created a budget line for LMCU activities worth N10.3 million.</li> </ul>	<p>commodities' supply into the Deferral &amp; Exemption component of Drug Revolving Fund scheme.</p> <p>Council is further invited to approve:</p> <ol style="list-style-type: none"> <li>i. The sustaining and funding of LMCUs by the States in the event of the cessation of NSCIP project.</li> <li>ii. The creation of budget line for LMCU activities in all the states.</li> <li>iii. For all the state LMCUs to source for Alternative Financing to support routine LMCU activities.</li> </ol>		

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		<ul style="list-style-type: none"> <li>➤ Capturing of LMCU activities in the 5-year State Strategic Health Development Plan (SSHDP), State Annual Operational Plan (AOP) and LGA AOP.</li> <li>➤ Kano State LMCU has scouted for Alternative Financing to support routine LMCU activities. <ul style="list-style-type: none"> <li>○ Prime sources included SDSSC (more than 4.5M), DMCSA, MNCH2, GHSC-PSM and Child Health MoU.</li> <li>○ The NSCIP donated Generator set is being fueled and maintained by DMCSA.</li> </ul> </li> <li>➤ Kano State LMCU has conducted advocacy to relevant stakeholders on the need for office expansion, additional Data entry Clerks and the need to capture LMCU activities on SDSSC mark up.</li> <li>➤ Kano State LMCU has conducted advocacy to DMCSA on the need to tap from their customers' Corporate Social Responsibilities for project vehicle.</li> <li>➤ Kano State LMCU has driven the process for the review of EML &amp; STG.</li> </ul> <p>Kano State LMCU has adopted the NSCIP's model for integration, to integrate the FMCNH commodities' supply into the Deferral &amp; Exemption component of Drug Revolving Fund scheme.</p>			
79.	<b>THE INTEGRATION OF VERTICAL PROGRAMMES ON THE LAGOS STATE HEALTH SCHEME</b>  <b>HONOURABLE COMMISSIONER FOR HEALTH, LAGOS STATE</b>	<p>The purpose of this memorandum is to inform the Council on the integration of vertical Programmes within Lagos State Health Scheme.</p> <p><u>Introduction:</u></p> <p>The Lagos State Health Scheme (LSHS) was established by</p>	<p>Council is hereby invited to note</p> <ol style="list-style-type: none"> <li>1. That Lagos State's effort in integrating vertical programmes into its State Health Insurance Scheme (LSHS)</li> <li>2. The need as a nation to reduce dependency on donor funding and begin to develop and</li> </ol>		

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	NCH/61/007	<p>law in May 2015, and is a major health financing reform targeted at ensuring that all residents of the State have access to quality, affordable and equitable health care. This will lead to improved health outcomes for all residents of Lagos State and target improving Maternal and child mortality amongst other health indices.</p> <p>The LSHS was established as part of Government's strategy to attain Universal health coverage. The sole aim being to improve access, provide quality health services and ensure that no person has to undergo financial hardship in order to access services for their health. As part of the LSHS Strategy, the State set up a fund called the equity fund that comprises of 1% of the Consolidated Revenue Fund (CRF) to cover the premiums for the poor and vulnerable and also provided funds to subsidize 75% of the premium of the Civil Servants.</p> <p><u>Background:</u></p> <p>Nationally, there has been a heavy reliance on external funding for the provision and delivery of some health programmes such as HIV services, TB services, malaria and family planning. There has been heavy dependence on international donor funding with very little or no counterpart funding from government.</p> <p>It is expected that with the implementation of the Lagos State Health Scheme, there would be increased population demand for and access to health care services specifically those on the benefit package. This triggered the need to</p>	<p>adapt strategies to increase Government funding for health services.</p> <p>3. And consider for adoption, the initiative as a national policy for all State's implementing State Health Insurance Scheme.</p>		

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		<p>address the issue of vertical programme and the feasibility of including them in the benefit package to be accessed under the LSHS.</p> <p><u>Content</u></p> <p>The Lagos State Ministry of Health with the support of implementing partners developed an implementation framework for the integration of vertical programs into the LSHS. This framework focused on providing answers to these critical questions:</p> <ol style="list-style-type: none"> <li>1. What are the operational requirements for achieving a seamless delivery of HIV/AIDS and other vertical programme services onto the LSHS?</li> <li>2. What is the technical capacity of the LSHS provider network to deliver these services.</li> <li>3. What is the financial impact on the premium of adding HIV/AIDS services to the LSHS benefits package?</li> </ol> <p>The framework looks at two approaches:</p> <ol style="list-style-type: none"> <li>1. Integration of the donor funded vertical programmes into the LSHS benefit package</li> <li>2. For sustainability purposes, the absorption of these programmes into the premium for the LSHS.</li> </ol> <p>The process for the development of the framework was multipronged and included:</p> <ol style="list-style-type: none"> <li>1. Active engagement of the partners involved in the</li> </ol>			

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		<p>delivery of vertical programmes to jointly explore the feasibility of the transition of these programmes into the LSHS benefit package and further include in the LSHS premium,</p> <ol style="list-style-type: none"> <li>2. Service availability mapping to determine the facilities on the LSHS provider network or around these facilities who already offer one or more of the donor funded health care services in order to develop a cluster of health care facilities that can provide care for those on the LSHS who require such services</li> <li>3. Actuarial analysis to actually cost some of these services specifically HIV/AIDs and TB to determine the needed fund in the premium needed to cover the integration of this services into the LSHS.</li> <li>4. Development of an integrated implementation plan phased into immediate and medium term has been developed to address identified issues around the delivery of commodities and supplies, diagnostics and service delivery, monitoring and evaluation, capacity building, provider payment and service quality assurance.</li> </ol> <p>In the immediate term, the State Government has made some funds available for the procurement of commodities for vertical programmes such as tuberculosis, family planning and malaria so that this would be at no extra cost to the empaneled providers.</p>			
80.	<b>THE ESTABLISHMENT OF THE CONTRIBUTORY HEALTH COMMISSION</b>	The purpose of this memorandum is to inform the Council on the progress made so far on the establishment of Contributory Health Scheme towards achieving Universal	<p>PRAYERS</p> <p>Council is hereby invited to note that;</p>		

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	<b>HONOURABLE COMMISSIONER FOR HEALTH, ONDO STATE</b>  <b>NCH/61/007J</b>	<p>Health Coverage.</p> <p><u>BACKGROUND/INTRODUCTION</u></p> <p>In a bid to provide accessible, affordable, quality health care to the citizens and achieve Universal Health Coverage, the Ondo State Government set up a committee to look into health service delivery and financing. The committee was saddled with the responsibility for bringing up a bill on the establishment and implementation of the contributory health scheme in Ondo State. The bill was designed to provide a framework for financial risk protection to the residents in the state by reducing out of pocket expenditure (OOPE) and cushion the impoverish effects of ill health and their cost.</p> <p>There were several advocacy meetings held to sensitize stakeholders on the need for a Contributory Health Scheme. The first stakeholders meeting was held in October 2017 with the Nigeria Labour Congress, Trade Unions, Various Professional bodies, Religious Societies, Schools, Civil Society Organizations, service providers, NHIS, UNICEF etc.</p> <p>In December 2017, a memo on the establishment of the Contributory Health Scheme was read at the State Executive Council meeting and subsequently forwarded to the House of Assembly. In January 2018, an advocacy visit, and subsequently, a public hearing was done at the House of Assembly complex.</p> <p>Furthermore a seminar was organized for members of the House of Assembly in January 2018 to intimate them on the best practices as it relates to health insurance and a sustainable financial model for optional health care delivery</p>	<ol style="list-style-type: none"> <li>1) The Executive Governor of Ondo State signed into law the bill to establish the Contributory Health Commission to institute the Ondo State Contributory Health Scheme for all residents of Ondo State and connected purposes on the 6<sup>th</sup> February 2018;</li> <li>2) A study tour was sponsored by UNICEF in January 2018 to Asaba, Delta State Contributory Health Commission to understudy their operation and eventual implementation in the state</li> <li>3) Series of advocacy and sensitization meetings have commenced since signing the bill. Meetings were held with Labour Union Leaders, health care providers both in public and private health facilities, traditional rulers, heads of Ministries Department and Agencies;</li> <li>4) There is continuous advocacy, engagement, dialogue and sensitization meetings with relevant stakeholders for the successful implementation of the scheme</li> <li>5) Ondo State is making effort to achieve Universal Health Coverage for its residents through the implementation of the Ondo State Contributory Health Scheme which will commence before the end of year 2018.</li> </ol>		

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		<p>in Ondo State for subsequent political and legislative buy in.</p> <p>Also as part of the efforts for insight and capacity building on the contributory health scheme, a study tour was sponsored by UNICEF in January 2018 to Asaba Delta State Contributory Health Commission to understudy their operations. The study tour created an avenue for participants to tap into the wealth of experience Delta State has gathered through the process of conception and implementation of the scheme.</p> <p>The Executive Governor of Ondo State signed into law the bill to establish the Contributory Health Commission to institute the Ondo State Contributory Health Scheme for all residents of Ondo State and connected purposes on the 6<sup>th</sup> February 2018. This law is mandatory and is expected to reduce out of pocket expenditure (OOPE) on health among residents of Ondo State. Series of advocacy and sensitization meetings have commenced since signing the bill into law. Meetings have been held with Labour Union Leaders, health care providers both in public and private health facilities, traditional rulers, heads of Ministries Department and Agencies.</p> <p>FUTURE PLANS FOR ITS COMMENCEMENT</p> <ul style="list-style-type: none"> <li>➤ Appointment of a General Manager for the Commission</li> <li>➤ Appointment of critical key staffs to drive the process</li> <li>➤ Functional temporary office for the Ondo State Contributory Health Scheme</li> <li>➤ Conduct a baseline assessment for the implementation of the Ondo State Contributory Health Scheme</li> <li>➤ Conduct an actuarial study to determine the premium</li> </ul>			

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		<ul style="list-style-type: none"> <li>➤ Development of operational guidelines with technical partners like UNICEF, WHO, NHIS, WORLD BANK.</li> <li>➤ Develop Monitoring &amp; Evaluation Framework</li> <li>➤ Define and Prioritize coverage population</li> <li>➤ Continuous Advocacy &amp; Sensitization</li> </ul>			
81.	<p><b>SPONSORSHIP/SUBSIDIZING OF RENAL DIALYSIS; A MEANS OF ENSURING UNIVERSAL ACCESS TO TREATMENT FOR CHRONIC KIDNEY DISEASE PATIENTS</b></p> <p><b>HONOURABLE COMMISSIONER FOR HEALTH, PLATEAU STATE</b></p> <p><b>NCH/61/007K</b></p>	<p>The purpose of this Memo is to seek Council's approval for sponsorship/subsidizing of renal dialysis as a means of ensuring universal access to treatment for Chronic Kidney Disease (CKD) patients</p> <p>INTRODUCTION/BACKGROUND:</p> <p>Many reforms have been declared in the health system to achieve Universal Health Coverage with the ultimate goal of promoting population health by ensuring universal access to high quality health care and improving quality in health across socioeconomic groups.</p> <p>On a global level, it is estimated that one (1) in every Twenty (20) people have Chronic Kidney Disease (CKD), end stage renal disease, the last and critical stage is a growing problem in most countries. The disease is common in Nigeria and sub-Saharan Africa with a prevalence rate of as high as 13.9% of hospital admissions according to some studies. Majority of the patients present late to hospital (85.6% in one study) with up to 50% requiring urgent kidney dialysis.</p> <p>Since treatment of chronic kidney disease can have catastrophically high costs for patients and their families (a session of dialysis costs between ₦20,000.00 - ₦60,000.00) government should consider programmes that can subsidize</p>	<p>PRAYERS:</p> <p>Council is hereby invited to note that:</p> <ol style="list-style-type: none"> <li>There is a high prevalence of chronic kidney disease in Nigeria with most of the patients presenting late to hospital and requiring urgent renal dialysis.</li> <li>Treatment of the disease has catastrophically high costs for the patients and their families</li> <li>There is need to ensure universal access to high quality health care and improve equity in health across socioeconomic groups.</li> </ol> <p>Council is therefore invited to approve:</p> <ol style="list-style-type: none"> <li>Budget provision for sponsorship/subsidizing of kidney dialysis for patients.</li> <li>Introduction of an insurance programme for chronic kidney disease patients to cover kidney dialysis (peritoneal dialysis or haemodialysis)</li> </ol>		



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		<p>CKD patients' costs to a certain extent.</p> <p>ISSUES AND JUSTIFICATION:</p> <ol style="list-style-type: none"> <li>1. There is a high prevalence of chronic kidney disease in Nigeria with late hospital presentation the norm with up to 50% of such patients requiring urgent kidney dialysis.</li> <li>2. Treatment of the disease has catastrophically high costs for patients and their families ranging between Twenty to Sixty Thousand Naira (<del>₦20,000.00</del> -<del>₦60,000.00</del>) per session of dialysis.</li> <li>3. To ensure universal access to high quality health care and improve equity in health across socioeconomic groups, there is the need for government to consider programmes that can subsidize CKDs patient' cost to a certain extent.</li> </ol>			