



NATIONAL STRATEGIC HEALTH DEVELOPMENT PLAN 2010 - 2015

NATIONAL STRATEGIC HEALTH DEVELOPMENT PLAN

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PREFACE

Successive Governments have strived to improve the health of Nigerians, through a series of national development plans and annual budgets. And modest progress has been made, at least in the past. However there has been a major reversal of health gains over the past decade. Childhood immunization plummeted and life expectancy reportedly dropped to mid 40-years and has not improved much since then. The country is largely not on course in achieving the Millennium Development Goals by 2015.

Starting with the beginning of a new decade, and under the leadership of the Federal Ministry of Health, the health sector is poised to reposition itself to implement and deliver on RESULTS within the context of the MDG and national targets as enshrined in the National Vision 20:2020, and a new National Health Plan.

In an unprecedented collaborative and fully participatory national process all the key stakeholders in health – Federal, States, LGAs, partners both international and domestic, civil society organizations, etc, - have evolved a uniform national health development framework and have used this to put the first ever truly National Health Plan in place with an associated Results (Targets/Indicators) Framework, that is consistent and elaborate on the Vision 20:2020 Human Capital development aspirations, against which to measure progress from 2010 to 2015, in the first instance, and beyond, as we march towards Vision 20:2020.

The National Strategic Health Development Plan (NSHDP) - or for short, the National Health Plan - reflects our shared aspiration to strengthen the national health system and to vastly improve the health status of Nigerians. The Plan is the overarching reference health development document for all actors towards delivery on a shared Results Framework, to which each and everyone will be held

accountable for achieving the goals and targets as contained in the Results Framework. The Health Plan, which was also developed in tandem to the guidelines of the National Planning Commission – Vision 20:2020 process (including the V20:2020 Implementation Plan), is the compass or reference for the health sector Medium Term Sector Strategy (MTSS) and annual operational plans and budgets at all levels.

The development of NSHDP involved inputs from a vast number of people and agencies. Public health experts from Government and academia took the lead in preparing evidence-based background studies for the work of the NSHDP Technical Working Group (TWG) in drafting a framework for the plan's focus areas and objectives. The NSHDP Steering Committee provided guidance to steer the process. The Department of Health Planning, Research & Statistics at the Federal Ministry of Health in conjunction with the NSHDP Reference Group expertly managed the process. However, and most importantly the success of this effort is due to the overwhelming and enthusiastic engagement through the nationwide consultation and contribution by people in every State and in person through several consultative public meetings.

The knowledge, commitment, and collaboration of these groups combined to produce, in the first instance, the NSHDP Framework, which was formalized by the National Council on Health (the highest policy advisory body in Nigeria) for use, to develop the National Health Plan and its Results Framework. The emerging plan is more comprehensive than previous attempts. There are Eight (8) Priority Areas of Focus for the National Health Plan, divided into goals (8); strategic objectives/programs (33); strategic interventions (70); and translation into various activities for implementation by different levels of stakeholders, including partners, thus making the National Health Plan 2010 – 2015 an encyclopedic compilation of health investments and improvement opportunities over the next

intermediate period, and beyond, addressing the noble ideals of National Vision 20:2020.

Our national health-demographics suggests that we are faced with several epidemiological profiles: massive but preventable communicable infectious disease, side-by-side a growing life-style induced worsening health conditions, with excessive mortality at younger ages, and impacting negatively on the average life expectancy of Nigerians. There is also a staggering health inequalities and disparities among different groups, hence the need to take measures to eliminate these disparities. So, for the first time a set of shared health indicators in the NSHDP Results Framework are aimed to help all actors to focus on the required actions to improve health in Nigeria.

On behalf of the Federal Ministry of Health, I appreciate and congratulate all the numerous individuals, institutions, and our health partners that have worked so hard together to create this National Health Plan document. But this is just the beginning of our match towards delivering on RESULTS to change our national health fortune for better health in Nigeria. I implore us all, including our development partners, to remain guided by this plan in meeting the aspirations of the health component of the National Vision 20:2020 to achieve better health in Nigeria.

Professor Babatunde Osotimehin, OON
Minister of Health

ACKNOWLEDGEMENT

The National Strategic Health Development Plan – NSHDP - has emerged as a Federal Ministry of Health lead process, mandated by the National Council on Health, to develop a National Health Plan, which later formed part of an elaboration of the health component of the National Vision20:2020.

The Plan was prepared through an elaborate collaborative process involving all major stakeholders; Federal Government agencies and individuals from the Federal Ministry of Health, National Planning Commission, Federal Ministry of Finance, the Budget Office of the Federation; the National Assembly Senate and House Committees on Health, and other relevant Sub-Committees of the National Assembly, such as the House and Senate Sub-Committees on MDGs; all the States Ministries of Health and the FCT Department of Health Services and Local Governments Health Departments; academia and public experts, development partners, including the UN agencies HHA (Harmonization for Health in Africa) partnership – WHO, UNICEF, UNFPA, UNAIDS, African Development Bank, the World Bank; USAID, IHP+ partnership such as DFID or UKAID through PATHS2, CIDA, JICA, and many other Bilateral organizations; Civil Society organizations, etc.

Managerially, the production of the Plan was coordinated by the Department of Health Planning, Research & Statistics of the Federal Ministry of Health in close collaboration with the NSHDP Reference Group, the NSHDP Technical Working Group (TWG) and the health sector Vision20:2020 National Technical Working Group.

Finally, commendation must go to the National Council on Health for its foresight in mandating the preparation of this ONE Health Plan for the country and to Mr. President and the State Governors for adopting a Declaration on Mutual Accountability for Measurable Results based on the implementation of the National Health Plan.

ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ARI	Acute Respiratory Infections
ART	Anti-Retroviral Therapy
AU	African Union
B-EOC	Basic Emergency Obstetric Care
CBN	Central Bank of Nigeria
CBSHIP	Community-Based Social Health Insurance Programme
CCTs	Conditional Cash Transfers
C-EOC	Comprehensive Emergency Obstetric Care
CHO	Community Health Officer
CHW	Community Health Worker
CSO	Civil Society Organization
DHS	Demographic and Health Survey
DOTS	Directly Observed Treatment Short-course
DP	Development Partner
DPRS	Department of Planning Research and Statistics
DRG	Debt Relief Gains
FCT	Federal Capital Territory
FIRS	Federal Inland Revenue Service
FMF	Federal Ministry of Finance
FMOH	Federal Ministry of Health
FP	Family Planning
FRSC	Federal Road Safety Commission
GDP	Gross Domestic Product
HDCC	Health Data Consultative Committee
HF	Health Facility
HHA	Harmonization for Health, Africa
HHHE	House-hold Health Expenditure
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HMB	Hospital Management Board
HRH	Human Resources for Health
ICT	Information Communications Technology
IHP+	International Health Partnerships
IMCI	Integrated Management of Childhood Illnesses
IPTp	Intermittent Preventive Treatment
ISS	Integrated Supportive Supervision
ITN	Insecticide Treated Net
LGA	Local Government Area
LGHE	Local Government Health Expenditure
MCH	Maternal and Child Health
MDA	Ministries, Departments and Agencies
MDGs	Millennium Development Goals
MDR	Multi Drug Resistant

M&E	Monitoring and Evaluation
MICS	Multiple Indicator Cluster Survey
MRCN	Medical Research Council of Nigeria
MTSS	Medium Term Sector Strategy
NACA	National Action for Control of AIDs
NAFDAC	National Agency for Food and Drug Administration and Control
NARHS	National AIDS and Reproductive Health Survey
NCDs	Non-Communicable Diseases
NCH	National Council on Health
NDHS	National Demographic and Health Survey
NDP	National Development Plan
NGO	Non-Governmental Organization
NHA	National Health Accounts
NHIS	National Health Insurance Scheme
NHMIS	National Health Management Information System
NIMR	Nigeria Institute for Medical Research
NIPRD	National Institute for Pharmaceutical Research and Development
NPHCDA	National Primary Healthcare Development Agency
NSHDP	National Strategic Health Development Plan
NSTDA	National Science and Technology Development Agency
ODA	Official Development Assistance
OOPE	Out-Of-Pocket Expenditure
OPS	Organised Private Sector
ORT	Oral Rehydration Therapy
OSSAP	Office of the Senior Special Assistant to the President
PBF	Performance Based Financing
PERs	Public Expenditure Reviews
PHC	Primary Health Care
PITC	Provider Initiated Testing and Counseling
PMTCT	Preventing Mother to Child Transmission
PPP	Public Private Partnerships
P/PROM	Preterm/Prelabour Rupture of Membrane
QALY	Quality Adjusted Life Years
RBF	Results Based Financing
SHDP	Strategic Health Development Plan
SHI	Social Health Insurance
SMOH	State Ministry of Health
SSA	Sub-Saharan Africa
SGHE	State Government Health Expenditure
STHE	State Total Health Expenditure
STI	Sexually Transmitted Infection
TA	Technical Assistance
TB	Tuberculosis
TGHE	Total Government Health Expenditure
THE	Total Health Expenditure
USD	United State Dollars

VAT	Value Added Tax
VLBW	Very Low Birth Weight
VOC	Vote-Of-Charge
VPD	Vaccine Preventable Diseases
WDI	World Development Index
WHO	World Health Organization

**NATIONAL PARTNERSHIP ON HEALTH: DECLARATION ON MUTUAL ACCOUNTABILITY FOR IMPROVED AND MEASURABLE HEALTH RESULTS IN NIGERIA BY THE PRESIDENT OF THE FEDERAL REPUBLIC OF NIGERIA, EXECUTIVE GOVERNORS OF THE 36 STATES AND FCT MINISTER AT THE PRESIDENTIAL SUMMIT ON HEALTH IN NIGERIA: IMPLEMENTING THE HEALTH SECTOR COMPONENT OF VISION 20:2020
ABUJA, 10th November 2009**

WE, the President, Vice-President, Executive Governors and FCT Minister of the Federal Republic of Nigeria, met in Abuja this 10th day of November 2009 on the occasion of the first Presidential Summit on Health Care in Nigeria, held under the theme ***“Accepting collective responsibility for improving our health in Nigeria”***;

2. **RECOGNIZING** that a healthy and economically productive population that is growing at a sustainable pace, supported by a health care system that caters for all, sustains a life expectancy of not less 70 years and reduces to the barest minimum the burden of infectious and other debilitating diseases, and emphasizing that the Nigerian health sector is vital to sustainable socio-economic development for achieving the goal of Vision 20:2020;
3. **DEEPLY CONCERNED** that Nigeria is not on track towards significant improvement in meeting the health expectations of its people, inclusive of achieving the health MDGs;
4. **RECOGNIZING** that the key challenges for achieving national health objectives are related to the weak health system characterized by constrained governance systems and structures, low levels of health care financing and poor predictability and release of funds with inadequate financial protection for the poor, shortage and mal-distribution of human resources for health, poor quality service delivery, inadequate and untimely availability of quality health commodities, lack of routine health services data, low levels of research for health, weak partnership and coordination, as well as poor community participation and poor utilization of health services, particularly child and maternal services, to mention a few;
5. **RE-AFFIRMING** the principles of health as a basic human right and the leadership role of government in the health of its people;
6. **AWARE** of the cross-cutting nature of health and the importance of inter-sectoral collaboration in the achievement of improved health outcomes through equitable access to health services;
7. **WELCOMING** the significant progress made towards the interruption of wild polio virus transmission following renewed commitments to the Abuja declaration to eradicate poliomyelitis and engagement of political, traditional and religious leadership with stakeholders; believing that such levels of commitments would be sustained, increased and deployed to other health interventions at community, LGA and State levels.
8. **APPRECIATING** the support of all partners active in the Nigerian health sector, civil society organizations, particularly women and youth focused groups, Private Sector, Traditional and

Religious Institutions, and the communities inclusive of multilateral and bilateral organizations;

WE HEREBY COMMIT OURSELVES TO SIGNIFICANTLY IMPROVE THE HEALTH STATUS OF NIGERIANS THROUGH THE DEVELOPMENT OF A STRENGTHENED AND SUSTAINABLE PRIMARY HEALTH CARE DELIVERY SYSTEM BY:

9. **ESTABLISHING** National and State level Partnerships led by Mr. President and the Governors respectively for accelerating the annual progress towards improvement of health outcomes for Nigerians irrespective of location, gender, age, or socio-economic status;
10. **COMMITTING** to the results oriented National Strategic Health Development Plan, State Strategic Health Development Plan and their attendant annual operational plans with appropriate costs and budgets as part of the continued implementation of the health sector component of Vision 20:2020;
11. **LAUNCHING** with a call to action at state and LGA levels, the State Strategic Health Development Plans (SHDPs) in our respective states for timely and integrated implementation of interventions and activities, as well as laying emphasis on achieving improved health results;
12. **REAFFIRMING** our commitment to the Primary Health Care (PHC) approach and henceforth adopting effective governance and coordination including establishment of state primary health care agencies/ boards or its equivalent;
13. **INCREASING** budget allocations to health at federal, state and LGAs from present levels by at least 25% each year towards achieving the Abuja Declaration target of 15%; committing to at least 90% budget release and 100% utilization by the end of the year;
14. **ESTABLISHING** pro-poor financial protection systems, including provider incentives to implement fee exemptions for the poor and vulnerable groups and appropriate risk pooling mechanism such as social and community health insurance;
15. **COMMITTING to** effective implementation of integrated, high impact interventions, and to deliver for our respective states on the following results and targets:
 - a. Reducing infant and under-five mortality from present levels (75/1,000 Live-Births and 157/1,000 Live-Births respectively) by half by 2015;
 - b. To have decreased prevalence of underweight children under 5 years of age to 18% by 2015;
 - c. Interrupt wild polio virus transmission by 2010
 - d. Increase percentage of Children aged 12-23 months who are fully immunized by at least 25% annually and to have attained 80% by 2015
 - e. Achieve 80% of 1 year olds immunized against measles by 2015

- f. Reducing Maternal mortality ratio by a third from present level (800/100,000 Live-Births) by 2015;
 - g. Increase by at least 10% annually (from present level of 37%), the proportion of births attended by skilled health personnel and to have achieved at least 80% Nationally by 2015;
 - h. Increase by at least 10% annually the percentage of pregnant women with four antenatal care visits by 2015;
 - i. Achieve universal access to reproductive health by 2015;
 - j. To have halted by 2015 and begun to reverse the spread of HIV/AIDS;
 - k. To have halted by 2015 and begun to reverse incidence of malaria and other diseases;
 - l. To have reduced the prevalence of Malaria in children under the age of five (5) years by at least 25% annually from present level (198/10,000) and to achieve 75% reduction by 2015 using an integrated approach;
16. **ADDRESSING** all the human resources for health challenges, including incentives-based deployment to rural and underserved locations, direct implementation of the Midwifery Services Scheme, as well as scaling up the production of human resources for health;
17. **IMPROVING** infrastructure planning and investments targeted at underserved populations, inclusive of maintenance and operational costs;
18. **ESTABLISHING AND STRENGTHENING** partnerships with the private sector and other health service providers such as non governmental organizations, military, etc towards improved access and service coverage;
19. **ACHIEVING** timely availability of quality health commodities and supplies at all levels within federal, state and Local Government owned facilities, as applicable;
20. **DIRECTING** our principal officers at federal, state and Local Government levels to forge inter-sectoral collaborations for an integrated, well-coordinated and comprehensive response to the health challenges of our state and the nation, including events that may constitute public health emergencies of national and international concerns, such as Human Influenza and other diseases that have potential to spread rapidly across international boundaries;
21. **ENSURING** effective coordination and collaboration with development partners in the health sector at federal, State and Local Government levels, as well as private sector, CSOs, Traditional and Religious Institutions, and the communities, particularly on demand creation for health services;

22. **COMMITTING** to strengthening the National Health Information System to serve as the backbone for managing for results;
23. **ENDORISING** the establishment of a joint monitoring mechanism based on the National Monitoring and Evaluation/Results Framework, with an enabling Fund, database and scorecard, to chart the progress of implementation on a regular basis (annual, semi-annual, and quarterly for federal, state and LGA respectively) of the decisions reflected in this declaration and as stated within the National and State Strategic Health Development Plans;
24. **ENSURING** the provision of periodic reports on the status of implementation to the National Economic Council and the hosting of an annual review of performance by Federal, States and Local Government Areas along the benchmarks set out in our state and national plans' results indicators framework; and
25. **IMPLEMENTING** the decisions and recommendations of this first Presidential Summit on Health Care in Nigeria.

SIGNED in Abuja, Nigeria on 10th November 2009 BY

S/N	DESIGNATION	NAME	SIGNATURE
1	President of the Federal Republic of Nigeria	Alhaji Umaru Musa Ya'ardua GCFR	
2	Vice President of the Federal Republic of Nigeria	Dr. Goodluck Jonathan GCON	
3	Executive Governor, Abia State		
4	Executive Governor, Adamawa State		
5	Executive Governor, Akwa Ibom State		
6	Executive Governor, Anambra State		
7	Executive Governor, Bauchi State		
8	Executive Governor, Bayelsa State		
9	Executive Governor, Benue State		
10	Executive Governor, Borno State		
11	Executive Governor, Cross River State		
12	Executive Governor, Delta State		
13	Executive Governor, Ebonyi State		

14	Executive Governor, Edo State		
15	Executive Governor, Ekiti State		
16	Executive Governor, Enugu State		
17	Executive Governor, Gombe State		
18	Executive Governor, Imo State		
19	Executive Governor, Jigawa State		
20	Executive Governor, Kaduna State		
21	Executive Governor, Kano State		
22	Executive Governor, Katsina State		
23	Executive Governor, Kebbi State		
24	Executive Governor, Kogi State		
25	Executive Governor, Kwara State		
26	Executive Governor, Lagos State		
27	Executive Governor, Nasarawa State		
28	Executive Governor, Niger State		
29	Executive Governor, Ogun State		
30	Executive Governor, Ondo State		
31	Executive Governor, Osun State		
32	Executive Governor, Oyo State		
33	Executive Governor, Plateau State		
34	Executive Governor, Rivers State		
35	Executive Governor, Sokoto State		
36	Executive Governor, Taraba State		
37	Executive Governor, Yobe State		

38	Executive Governor, Zamfara State		
39	Honourable Minister, FCT Abuja		

EXECUTIVE SUMMARY

Vision

“To reduce the morbidity and mortality rates due to communicable diseases to the barest minimum; reverse the increasing prevalence of non-communicable diseases; meet global targets on the elimination and eradication of diseases; and significantly increase the life expectancy and quality of life of Nigerians”.

Mission Statement

“To develop and implement appropriate policies and programmes as well as undertake other necessary actions that will strengthen the National Health System to be able to deliver effective, quality and affordable health”.

The overarching goal of the NSHDP is “to significantly improve the health status of Nigerians through the development of a strengthened and sustainable health care delivery system”.

CHAPTER 1

1.0 BACKGROUND

1.1 Geography and Demography

Nigeria is a country on the West Coast of Africa; lying 5° North of the Equator and between 3° and 4° East of the Greenwich Meridian. It is bordered on the South by the Bight of Benin and the Atlantic Ocean, on the North by the Republics of Niger and Chad, on the East by the Republic of Cameroon and on the West by the Republic of Benin. Nigeria has a land mass of 923,768 Km² and a projected 2009 population of 149,107,132 million¹, making it the most populous black country in the world.

1.2 Political Administration

Nigeria operates a Federal System of Government with three levels; the Federal, the State and the Local Government Areas/Councils (LGAs). There are 774 LGAs within 36 states and the Federal Capital Territory (FCT) Abuja. The states and FCT are grouped into six geo-political zones, namely: the South-South, the South-East, the South-West, the North-East, the North-West and the North Central zones.

1.3 National Development Initiatives

Nigeria is endowed with relatively good access to skills, capital and technology, fertile land, mineral resources and a favourable geographic location and recent improvements in development policy and performance also mean that the country now benefits from a positive medium-term economic outlook. Despite these signs of progress, however, Nigeria's dependence on oil and gas – and its wider social, political and economic ramifications - have contributed to significant development shortfalls: for example, the country is presently on track towards achieving, in part or in whole, only targets for three out of the eight MDGs, namely, basic education, HIV/AIDS prevalence and the global partnership for development.¹ The Federal Government, in particular, is keenly aware of this challenge and is developing the policy framework to address key shortfalls. The main point of reference is the 7-Point Agenda which will be implemented through two main instruments: the Vision 20:2020 document, focused on

¹ Nigeria. Office of the Senior Special Adviser on MDGs. Mid-Point Assessment of the Millennium Development Goals in Nigeria 2000-2007. Accessed [02/02/2009]. Available online [<http://www.ng.undp.org/mdgs/Mid-Point%20Assessment2000-7.pdf>]

transforming Nigeria into one of the top 20 global economies by 2020, and the National Development Plan (NDP).

1.4 National Health Development Initiative(s)

The importance of human capital development, with health, being one of the cardinal factors, has been underscored in the Vision20:2020, and the National Development Plan. However, Nigeria is said to shoulder 10% of the global disease burden due to high disease burdens and its relative large population in the continent. For example, Nigeria is making slow progress towards achieving the 2015 targets for the Health Related MDGs, especially goals 4, 5 and the targets for Malaria, and Tuberculosis in MDG 6. The health indicators in Nigeria have remained below country targets and internationally-set benchmarks including the MDGs, which have recorded very slow progress over the years. Currently, the health sector is characterized by lack of effective stewardship role of government, fragmented health service delivery, inadequate and inefficient financing, weak health infrastructure, mal-distribution of health work force and poor coordination amongst key players. To improve the health and wellbeing of Nigerians so they are able to contribute towards the actualization of the goals of these development agendas including the MDGs. The Federal Government of Nigeria through the Federal Ministry of Health (FMOH) has recognized the need, and undertaken to ensure that health services are scaled-up, health systems are strengthened, and additional financing for health secured at all levels; building and strengthening the Primary Health Care System in the process, in line with the principles in the Ouagadougou and Abuja declarations.²

The Federal Government of Nigeria, through the Federal Ministry of Health is convinced that a National Strategic Health Investment Plan is best suited to provide the context and will serve as the tool to articulate a health development agenda geared towards improving the performance of the Nigerian Health Care Delivery System to achieve the goals of the local and international health development agendas. The process for developing a National Strategic Health Investment Plan were initiated in 2007 and endorsed by the National Council on Health (NCH) in November 2007. However, considering the need to align the initiatives of the Federal Ministry of Health, with the National Development initiatives including the 7 point agenda, Vision20:2020,

² Ouagadougou Declaration on Primary Health Care And Health Systems In Africa: Achieving Better Health For Africa In The New Millennium. Available at http://www.afro.who.int/en/divisions-a-programmes/dsd/health-policy-a-service-delivery/hps-publications/doc_details/2135-ouagadougou-declaration-on-primaire-health-care-and-health-system-in-africa-2008.html. Accessed [03/02/2010]

and National Development Plan, the NSHIP was expanded and later developed into a National Strategic Health Development Plan.

The National Strategic Health Development Plan is the first of its kind in the history of the development of the Nigerian Health Care Delivery System which will serve as THE overarching, all encompassing, reference document for actions in health by all stakeholders to ensure transparency, mutual accountability for results in the health sector. It is a developed using a participatory bottom-up approach to ensure ownership by all the three tiers of government. In developing the NSHDP, studies in 10 different thematic areas were commissioned to provide the evidence base for the context of the plan. A framework to guide the development of the SHDPs at the different levels of government (through a participatory consultative process and approved by an emergency NCH in 2009) was developed; a toolkit that will guide the development of the plans was also developed, which serves as a log frame and template to ensure uniformity of Federal, State, FCT and LGA plans. Capacity building for States and Federal technical officers to apply the framework to develop their SHDPs was built.

The NSHDP has eight strategic priority areas including Leadership and Governance for Health; Health Service Delivery; Human Resources for Health; Financing for Health; National Health Management Information System; Partnerships for Health; Community Participation and Ownership; and Research for Health. It is within these areas that the Federal, State and LGAs will develop and implement strategic activities aimed at achieving the goals and objectives of each priority area.

1.5 Linkages with IHP+ and HHA Partners Strategic Orientations

Nigeria is a signatory to the International Health Partnerships Global Compact in May 28, 2008, and is committed to the achievement of the principles of the Paris Declaration on Aids Effectiveness. The NSHDP development process has received tremendous support from all the Harmonization for Health, Africa (HHA) partners in Nigeria. The country is committed to signing a country IHP+ compact which will have the NSHDP as its basis. This will facilitate the achievement of the goals of the Global IHP+ compact and the Paris declaration in the Country. The collaboration and support of the HHA partners in the development of the NSHDP has already been applauded as a best practice example in the region.

The successful implementation of the NSHDP will require the commitment of all the responsible agencies at the three tiers of government; Federal, State and LGAs; development partners, civil society organizations and communities.

CHAPTER 2

SITUATION ANALYSIS

Health Status of the Population

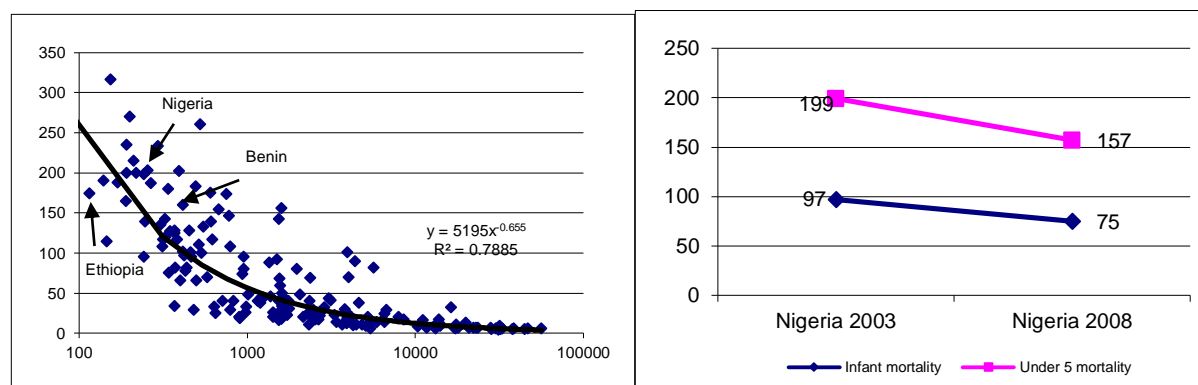
The health status indicators for Nigeria are among the worst in the world. On average, the health status of the population has declined, compared with the indicators of a decade earlier. Some of the Nigerian health indicators also fare poorly when compared to other countries with similar income per capita. Inequalities in health outcomes also exist between rural and urban areas, between northern and southern regions, and across income groups. These poor outcomes are not only due to large increases in poverty but also to weaknesses in the health sector, especially in primary health care services such as immunization. Nevertheless, some care interventions have been resilient to the general deterioration of the system. Some even improved during the last decade, such as certain nutritional programs and child health services such as treatment of diarrhea and ARI symptoms. Maternal, newborn, child mortality as well as malnutrition rates remain high in the country, indeed the latter has remained relatively unchanged and rate of wasting has actually increased especially in the northern regions of the country as evidenced in the DHS2008.

The life expectancy at birth declined to 44 years according to the 2009 UNICEF State of the World's Children report. This figure is below the Sub-Saharan Africa average of 46 years and below the least developed countries (LDC)' average of 53 years. The disability adjusted life expectancy at birth is 38.3years; vaccine-preventable diseases and infectious and parasitic diseases continue to exact their toll on health and survival of Nigerians, remaining the leading causes of morbidity and mortality. Nigeria has the highest number of HIV infected persons in the African continent and the fourth highest TB burden in the world. In the face of these, non communicable diseases are increasingly becoming public health problems, especially among the affluent urban population.

Infant and child mortality rates are high, though decreasing. At present, one out of every 7 to 8 children dies before his first birthday and one out of almost every five before his fifth. As seen in Figure, the level of child mortality in the country is slightly higher than what its income per capita would suggest. In the case of infant mortality, however, it is still lower than many countries with similar income. In the last decade, many SSA countries have experienced improvements in both infant and under five mortality rates³.

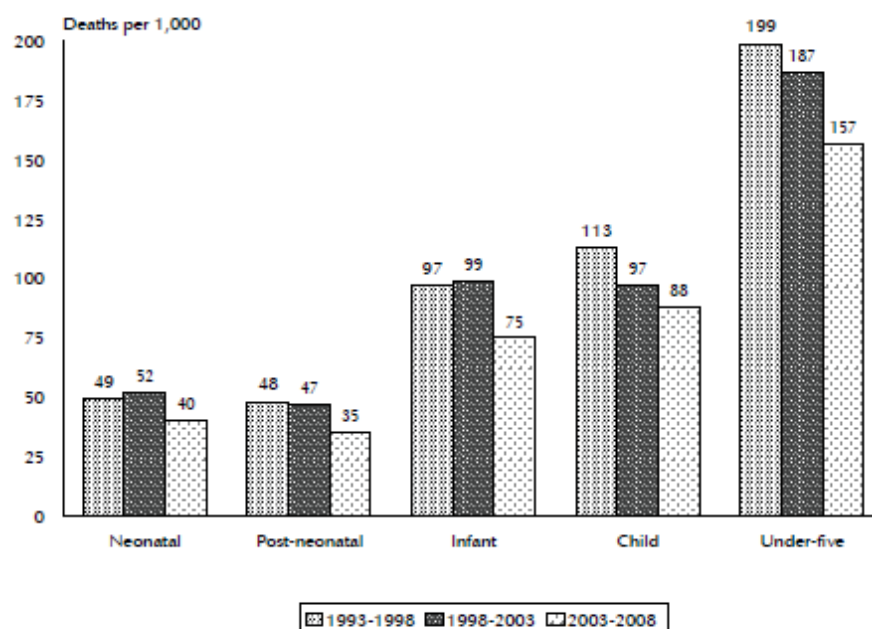
³ Among the countries with two years of DHS data on infant mortality, Benin, Ghana, Malawi, Mali, Niger, and Togo experienced a decrease in this indicator. Most of the countries that saw this indicator increase have high HIV/AIDS infection rates or experienced conflicts such as Cameroon, Kenya, Rwanda, Tanzania, Uganda, Zambia, and Zimbabwe.

Figure : World Tendency in Child Mortality and GDP per capita and trends in infant and child mortality in the last decade



Source: WDI and NDHS 2003 and 2008.

Figure : Mortality trends



Source: NDHS, 2008

There are also large differences in infant and child mortality rates across population sub-groups and zones. The 2008 NDHS give reliable data on infant and child mortality disaggregated across regions, income groups, or type of residence. These indicators present a rather bleak picture of the situation. Poor children, children living in rural areas, and children living in the north are more likely to die before they reach their fifth birthday than their richer, urban, and southern counterparts. Infants and children under five years are more likely to die in the northern region of the country than in the southern region, in the rural more than urban areas and trend has remained unchanged in the past decade. Children and infants among the poorest 20% of the population are about three times more likely to die than those among the richest

20%. The poor living in rural areas and in the Northern regions, fare considerably worse than the rest of the population. The disparity is even greater for under five mortality where the mortality rate is 87 per 1,000 among the wealthiest population and a staggering 219 per 1,000 amongst the poorest (DHS 2008). In Nigeria therefore, the poor have more than twice more under-five children dying than the rich.

Table : Childhood mortality rates by socio-economic characteristics

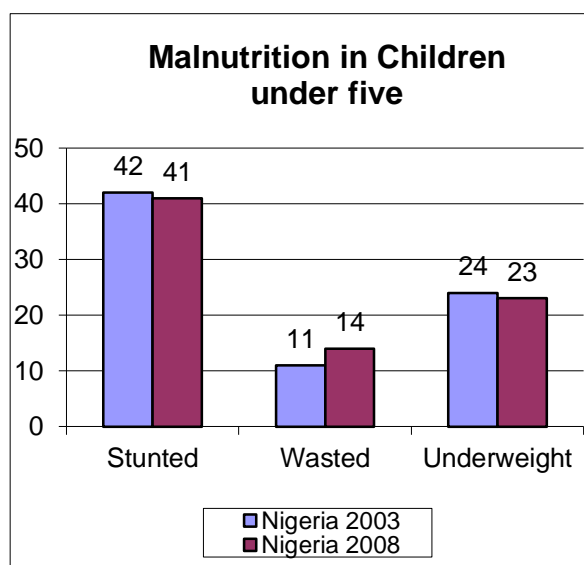
Neonatal, post-neonatal, infant, child, and under-five mortality rates for the 10-year period preceding the survey, by background characteristic, Nigeria 2008					
Background characteristic	Neonatal mortality (NN)	Post-neonatal mortality ¹ (PNN)	Infant mortality (Iq)	Child mortality (Cq)	Under-five mortality (Uq)
Residence					
Urban	38	29	67	58	121
Rural	49	46	95	106	191
Zone					
North Central	41	37	77	62	135
North East	53	56	109	126	222
North West	47	44	91	139	217
South East	51	44	95	64	153
South South	48	37	84	58	138
South West	37	22	59	32	89
Mother's education					
No education	49	49	97	124	209
Primary	48	40	89	77	159
Secondary	40	30	70	49	116
More than secondary	33	15	48	22	68
Wealth quintile					
Lowest	50	49	100	132	219
Second	51	52	103	121	212
Middle	45	40	86	87	165
Fourth	40	34	73	60	129
Highest	39	20	58	31	87
Total	46	41	87	92	171

Note: Estimates are for deaths per 1,000 live births except for child mortality, which is deaths per 1,000 children age 12-59 months.
¹ Computed as the difference between the infant and neonatal mortality rates

Source: NDHS, 2008

With the current estimated maternal mortality ratio of 545 per 100,000 live births (DHS 2008), Nigeria still has one of the highest rates in the world. With the new 2008 DHS information, about 4 maternal deaths occur in Nigeria per hour, 90 per day, and 2,800 per month totaling about 34,000 deaths annually, with wide regional and local variations. It is also estimated that for every maternal death, at least 30 women suffer short to long term disabilities such as vesico-vaginal fistula (VVF). Each year some 50,000-100,000 women in Nigeria sustain obstetric fistulae. Over 600,000 induced abortions are also estimated to be taking place in Nigeria annually. Abortions take place often under unsafe conditions, with an estimated 40% performed in privately owned health facilities.

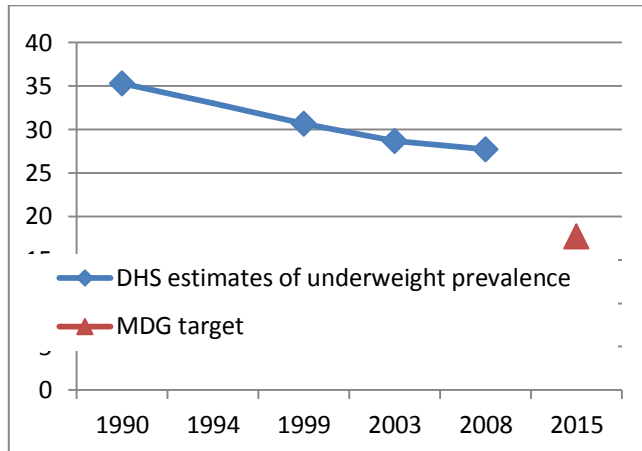
Similarly, the nutritional status of Nigerian children is poor, showing little improvement compared to 2003. The 2008 NDHS found that 41% of under-five children suffer from chronic malnutrition (stunting) and 14% from acute malnutrition (wasting), rates which are consistent with other poor countries in Sub-Saharan Africa. In addition, women and children among the poorest 20% are about three times more likely to be stunted and underweight than children among the richest 20%.



Large regional and rural/urban differences in children's malnutrition persist. There is also wide geographical variation, with rates highest in the dry savannah areas of the northern part of the country; and lowest in the humid forest areas of the South as shown in the figures above. Similarly, the figures are also higher in the rural than urban areas. Children in the North are therefore more likely to be undernourished.

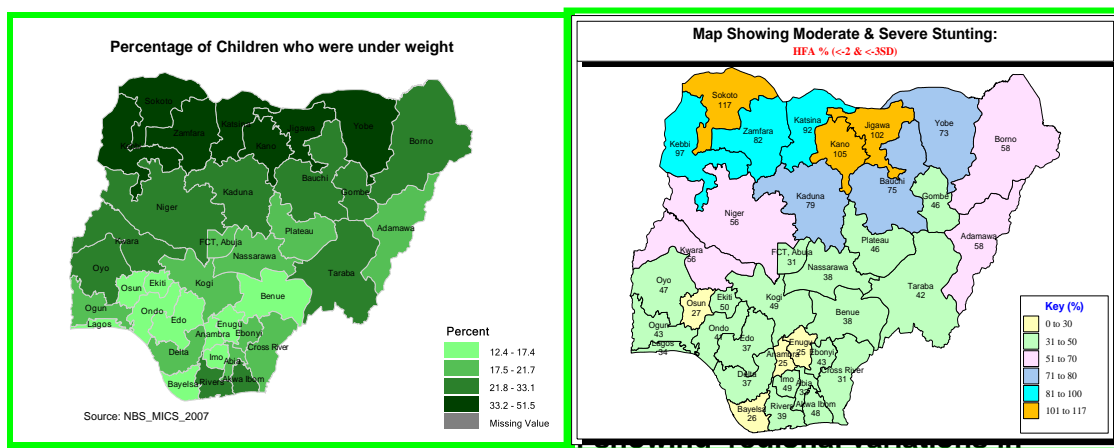
According to the NDHS report of 2008, there has not been any significant improvements in the overall prevalence of stunting or chronic under-nutrition (height for age) among Nigerian children under-5 years in the past decade and indication that there may have been little or no action taken to address this. Similarly, prevalence of underweight has dropped insignificantly from 35% in 1990 to 23% in 2008, keeping the country of track in achieving the MDG target 1 of goal 4 by 2015.

Underweight trends & MDG target



There is also wide geographical variation, with rates highest in the dry savannah areas of the northern part of the country; and lowest in the humid forest areas of the South as shown in the figures below. Similarly, the figures are also higher in the rural than urban areas. Children in the North are therefore more likely to be undernourished and suffer from its multiple, often irreversible, consequences to physical and mental development.

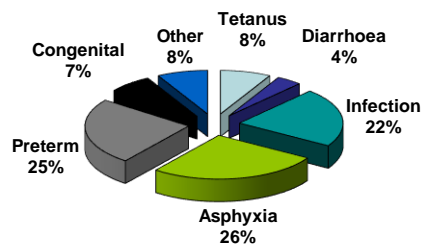
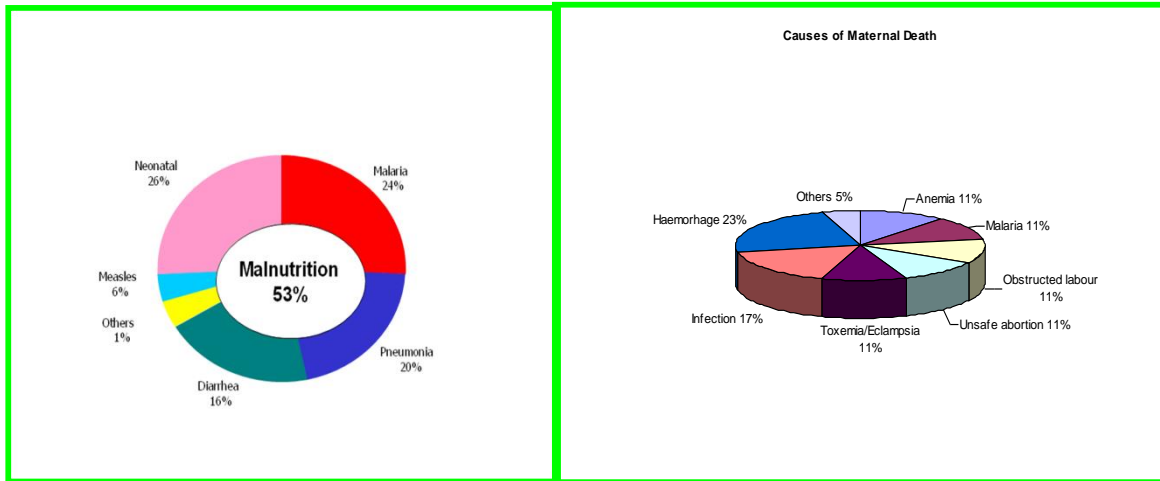
Figure...: Regional variation in under weight & stunting



Although the regional desegregations in the two years of the data (NDHS 2003 and 2008) are not comparable, in general, there are more malnourished children living in the northern areas of the country than in the southern ones. Similarly, although the percentage of malnourished children decreased in both rural and urban areas the difference between the two remained the same. Children in rural areas are 1.2 times more likely to be underweight than children living in the cities.

Nigeria is still in the first stages of the epidemiological transition; communicable diseases are the major causes of mortality and morbidity in the country. In children, the major causes of mortality and morbidity are malaria, diarrhea, acute respiratory infections (ARI), measles and other vaccine preventable diseases (VPD), and the exacerbating effect of children's malnutrition. These diseases, though, are preventable and/or can be treated at small cost.

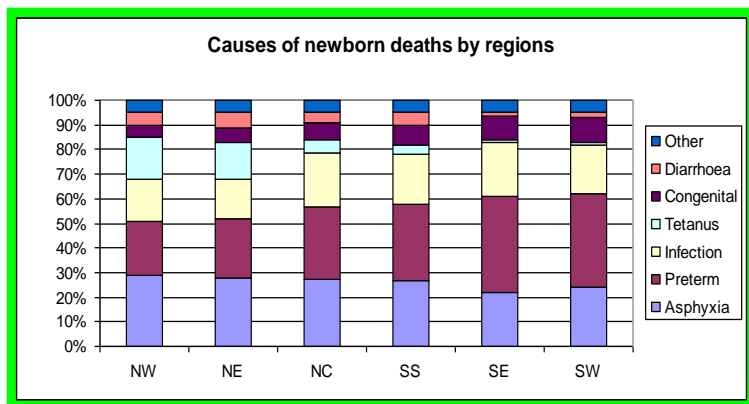
Causes of under five, maternal and newborn mortality



Malaria is a leading cause of death of children under five years in Nigeria. Chronic repeated malaria also contributes to anaemia in children. Diarrhoea and pneumonia cause almost 400,000 child deaths annually in Nigeria. Diarrhoea is also a major cause of child morbidity, and is both a cause and an effect of malnutrition, and can lead to linear growth retardation, causing more than 176,000 deaths of children under five in the country. Pneumonia, the most serious acute respiratory infection (ARI), is another major cause of mortality among children; responsible for an estimated 200,000 deaths each year. Many of these deaths can be avoided, as both diarrhoea and ARI like malaria can be treated at low cost, yet these conditions continue to cause under five mortality, mainly due to very poor response at the household level and poor quality health services at the facility level.

Birth asphyxia or intrapartum-related neonatal deaths remain a major cause of newborn deaths and disability in Nigeria, constituting more than one quarter of all causes. For each asphyxia-related newborn death, many more babies are left with permanent disabilities. Low birth weight and preterm babies also form another bulk of babies who lose their lives daily. Infections including neonatal tetanus, diarrhoea and pneumonia account for 34% although contributions by each of these vary by region.(fig 6). The World Health Organization (WHO) estimates stillbirth rate for the year 2000 as 30 per 1,000 total births for Nigeria, resulting in an estimated 183,000 stillborn babies each year.

Causes of newborn deaths by region



Adult HIV prevalence is estimated at 5%, so that Nigeria has the third highest number of infected people in the world – an estimated 3.5 million. A 2008 NDHS survey found that adult HIV prevalence was 5%. This is partially encouraging, since it is an apparent decrease from the 2001 estimate of 5.8%, but the data are not sufficient to conclude that the epidemic has stabilized. Estimated prevalence in 1992 was 1.8%. State-level estimates from the 2008 NDHS survey do show a broad regional pattern.

Nigeria has the fourth highest number of tuberculosis (TB) cases in the world, while other infectious diseases, such as meningitis, also represent a considerable health burden. Estimated annual TB incidence is 293 new cases per 100,000 persons; estimated prevalence

(both new and old cases) of 546 per 100,000 implies that over 700,000 people have TB in the country. Nigeria experiences periodic epidemics of meningitis and suffers from numerous other endemic communicable diseases.

Although communicable diseases are major causes of mortality and morbidity in the country, there are reasons to believe that non-communicable diseases (NCDs) represent an increasing share of Nigerians' burden of disease. Major NCDs in Nigeria include: hypertension, diabetes mellitus, coronary heart disease, sickle cell disease, cancers, G6PD deficiency anemia, mental health, road traffic injuries and violence, oral health, blindness, rheumatic heart disease, stroke, osteoporosis.

As at 2007, Nigeria ranked second on the weighted scale of countries with very high road traffic crashes. (WHO Nigeria publication on Road safety 2008). Similarly, according to data from the Federal Road Safety Commission (FRSC), over 7,000 Nigerians die every year from road traffic crashes, while over 26,000 injuries are recorded.

HEALTH SERVICES Provision and Utilization

Despite considerable investment in the health sector over the years, available evidence suggests that health services throughout Nigeria are delivered through a weak health care system. The latter is characterized by inequitable distribution of resources, decaying infrastructure, poor management of human resources for health, negative attitude of health care providers, weak referral systems; poor coverage with high impact cost-effective interventions, lack of integration and poor supportive supervision.

Consequently the health care system is unable to provide basic, cost-effective services for the prevention and management of common health problems especially at the LGA and Ward levels. For example, the proportion of PHC facilities providing immunisation services range from 0.5% in the North-West zone to 90% in the South West and South East Zones. Also the capacity to provide basic emergency obstetric services is very limited as only 20% of facilities are able to provide this service⁴. This limited coverage of basic health services, which results from poor access to information and services results in under utilisation of services. Only 58% of women receive antenatal care from a professional, with coverage levels ranging from 31% to 87%, and deliveries under the supervision of a trained birth attendant ranging from 9.8% to 81.8%. The lowest figures are from the North East and North West zones¹⁰.

Availability and distribution of functional health facilities and other health infrastructure are variable across the country. And many new PHC facilities being built are wrongly sited. Majority of the public health facilities especially PHC centres are in a state of disrepair. Although every State currently has at least one tertiary health facility, nonetheless most are not functioning at optimal capacities in the provision of quality specialist care.

⁴ FMOH/UNFPA study on essential obstetric care in Nigeria (2002-2003)

*Most public health facilities across the country are poorly equipped as indicated in findings from a 2001 survey of public PHC facilities*⁵. The report shows that only a quarter of health facilities had more than 50% of the minimum equipment package and 40% had less than a quarter. However, in the past few years a significant level of capital investment has been made to improve the medical equipment and infrastructure of a cohort of federal teaching hospitals and 350 model PHC facilities have been constructed and equipped.

The Essential Drugs Programme, including the first national essential drug list in the country was developed in 1988. The Bamako Initiative aimed at strengthening PHC through ensuring sustainable quality drug supply systems was re-invigorated in all LGAs in 1998 under the Petroleum Trust Fund. These initiatives are now moribund due to poor commitment to the establishment of systemic procurement systems for health commodities resulting in loss of confidence and decreased utilization of public sector health facilities due to drug stock-outs. One of the consequences of these is the proliferation of patent medicine vendors and drug hawkers which is compounding the problem of irrational drug use. In relation to this, the market is replete with substandard and fake drugs. However, there is a perception of increased confidence in the drug regulatory framework operated by NAFDAC in recent years.

Most services provided by private and public providers are clinic-based, with minimal outreach, home and community-based services. The services are fragmented, with many vertical disease control programs. Referral systems are weak and even tertiary facilities are used for provision of primary care thus diminishing the continuum of care and making the system inefficient. Also, despite the private sector delivering 60% of health care in the country, private-public partnership is very weak.

The NPHCDA has defined a ward health care minimum package for PHC, but dissemination and implementation remain very limited. At higher levels, except for a few disease control programs, like PMTCT, TB, Malaria, Family planning and Essential Obstetric care, there are no standard operating procedures and treatment protocols. These lead to provider-initiated rather than client-centered delivery of care.

Other confounding factors that further limit quality of care include dearth in the skills and, quantity of available human resources for health with poor attitude of health care providers. In addition the country is confronted with lack of emergency preparedness to respond to epidemics.

To improve the functionality, quality of care and utilization of services so as to positively impact the health status of the population, universal access to a package of cost-effective and evidence-based interventions is needed. This would of necessity require interventions that transform the way the health care system is resourced, organized, managed and services delivered

⁵ Adeniyi. J, Ejembi CL, et al (2001) The Status of Primary Health Care in Nigeria: Report of a Needs Assessment Survey. National Primary Health Care Development Agency.

Key Issues and Challenges

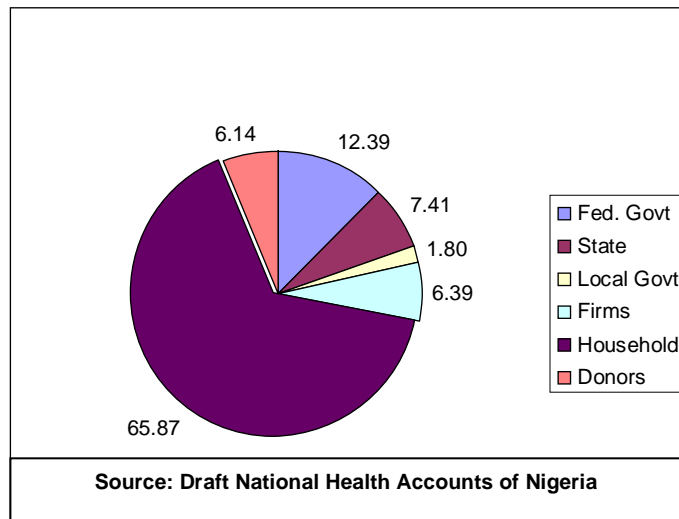
Health Care Financing

The poor performance of Nigeria's health system can be primarily attributed to poor management. After many years of neglect, the health system fails to deliver even the most basic health services with immunization coverage among the lowest in the world. The bulk of the nation's resources come from oil revenues, which are deposited into the federation account. This is shared among federal, state and local governments according to an allocation formula. However, transfers to the state and local governments are not earmarked, meaning that the federal government does not outline and enforce how state and local governments spend their allocated funds. They are not required to provide budget and expenditure reports to the federal government. The federal government is consequently unable to monitor the expenditure of funds allocated for secondary and primary health services. Local and state governments also demonstrate a critical lack of accountability, as local governments allocate funds with little influence from the states. A National Health Bill, said to have been passed by the 2 houses of the National Assembly, but yet to be signed into law by the President of the Federal Republic of Nigeria is expected to help streamline the responsibilities of the different levels of care and enhance health care financing, especially at the PHC level. The bill proposed that two percent of the national budget should contribute towards a PHC Fund, which will finance MNCH and other PHC activities through the National Primary Health Care Development Agency (NPHCDA). The bill states that the management and accountability of this fund should be completely transparent. However, the extent to which it will effect changes in implementation of community based programming will need to be seen.

Budget Allocation and financing for health

Experience has shown that in Nigeria, health care is predominantly financed from out-of pocket payments. A work on the national health account estimation(1998 – 2002) reveals that the bulk of health funding in Nigeria is borne by households, making out of pocket payment for health care regressive.

Sources of health financing 2002



Household expenditure as a proportion of the total health expenditure (THE) varied between 60.35% recorded in 2000 to 69.21 in 1999 with a mean of 64.59% over the period with massive implications for access and scaling up of maternal and child nutrition & health services.

It is noteworthy that Federal budgetary component of this expenditure increased marginally from 1999 actual spending of N16 billion (1.7% of the federal budget) to N63.2 billion (6.4%) in the 2002 actual expenditures. The projected federal figure for 2006 is about N106, 940 billion (5.6% of the budget proposal) representing a forty percent increase. It is thus likely that national health expenditure would have significantly increased in the year 2003 to date. The 2006 appropriations also include N21bn Virtual Poverty fund (VPF) resources deployed to achieving the Health related MDGs from the Debt Relief Gains. This shows that health budgetary allocation is far below the 15% Abuja declaration and signed by the Nigerian government. National Health Accounts reveals that the bulk of Nigeria's health spending is on curative care, which utilizes 74 percent of THE. Preventive care is a distant second, consuming only 1 percent of THE in 2002. However, health expenditure data are not broken down according to the type of services rendered and spending is not broken down into patient sub-groups. It is therefore impossible to determine the proportion of THE spent on child or newborn health according to the available data.

National Health Insurance Scheme

The Government of Nigeria (GON) has, made concerted efforts to improve access to quality of health for the Nigerian people. In 1999, the government established the National Health Insurance Scheme (NHIS) which is a federally funded social health insurance scheme. The scheme is designed to facilitate fair financing of health care costs through risk pooling and cost-sharing arrangements for individuals. The scheme was officially launched in 2005 and to date; over 1.2 million identity cards have been issued.

Given that alternative mechanisms for health care financing such as user fees, have failed to meet desired goals, the option of health insurance seems to be a promising alternative. Through risk pooling and transferring unforeseeable healthcare costs to fixed premiums, there is the

possibility of improving poor people's access to healthcare that is of acceptable quality. Several attempts in the past have focused on community-based schemes that were unsustainable. The challenge is to emphasize large scale implementation that can reach a significant proportion of the poor. The focus should be overall population coverage by a multiple of schemes looking at those same issues as those of more sophisticated social and private health insurance schemes– building up adequate reserves, health plans being informed purchasers, consumer education, re-insurance etc...

The programs of the NHIS seek to cover those in the formal and informal sectors and additional special needs groups. The majority of the coverage however for now reaches mainly individuals working in the formal sector leaving large gaps among the poor and informally employed. For most people living in poor rural or urban slums in Nigeria, ill health still represents a permanent threat to their ability to earn income and continues to impoverish them. Apart from the direct cost for treatment and drugs, indirect costs such as loss of productive man-hours, and transport still have to be borne by the households.

Community health insurance scheme

In an effort to address some of the remaining gaps in coverage and improve Nigeria's health indicators by addressing the health financing side, Pharm Access, in collaboration with the Health Insurance Fund (HIF) and Hygeia Health Maintenance Organization, has sought to increase access to health care through private risk sharing arrangements. The pilot program, Hygeia Community Health Plan (HCHP) subsidizes insurance premiums for low income previously uninsured people and targets approximately 75,000 farmers in Kwara State and 40,000 local market women in Lagos have been recruited. As a follow on to this and in an attempt to improve access of the poor to health service, the national Health Insurance Scheme, has been funded to pilot community health insurance scheme in six states in the country, states selected due to their poor mortality and morbidity indices and poor communities.

Human resources for Health

Although human Resources are no panacea for poor health situation in any country, no health intervention can be successful without an effective workforce. Every country should therefore have a national workforce plan to build sustainable health systems to address national health needs. These plans should aim to provide access of every family to a motivated, skilled and supported health worker. To optimize health system performance, workers should be recruited from, accountable to and supported for work in their community where feasible. The main categories of human resource in the Nigerian health care system are doctors, nurses, midwives, laboratory staff, public health nurses, public health nutritionists and the community health and nutrition workers (community health officers, community health extension workers and community health assistants – etc.). Government health workers are employed and paid by the level of government responsible for their facilities. That means federal for tertiary hospitals, states for secondary hospitals and local government authorities for PHC facility staff. However, there are a few exceptions, in some states, professionals working in PHC facilities may be employed by the state government, while some skilled health staff employed by the federal

parastatals or vertical programmes may also work at the secondary and primary levels. As at 2006, health manpower status in the country is as indicated below;

Some Categories of Health Workers in Nigeria 2006

Staff Type	Number of Staff	No. of Staff /100,000 pop
Doctors	39,210	30
Nurses	124,626	100
Midwives	88,796	68
Dentist	2,773	2
Pharmacist	12,072	11
Medical Lab. Scientist	3,059	3
Com Health Practitioners	117,568	91
Physiotherapist	769	0.62
Radiographers	519	0.42
Health Record Officers	820	0.66

Source; IMNCH Strategy FMOH 2007

On the account of 1997 registration, the number of nurses and midwives trained were 95,000 and 70,000 respectively (NPC and UNICEF,2001).There are more doctors per capita in the

south than in the north, however, there is no large regional differences in numbers of nurses. Most doctors and nurses work in higher level and private practices. 88% of 26,361 doctors practising in the country work in hospitals, most of them (74%) in private hospitals. Only about 12% of practising doctors work in private or public sector PHC services⁶.

Table8; Human resources available as at 2008

Doctors	Increases from new graduates
In the public sector 10%	Doctors – 16.5%
In residency programmes 9.1%	Nurses – 1.14%
In private hospitals 55%	CHOs /CHEWs – 3.25%
Abroad 18%	Attrition Rate
Outside the profession 7.9%	Doctors – 2.34%
	Nurses - 1.43%
	CHO/CHEWs – 1.44%

Source; FMOH 2008

This is a particularly unique feature of Nigeria’s health system rarely seen in other countries. It does imply that improving health and nutrition outcomes will need to recognise this peculiarity and explore options for increasing government stewardship of this sub sector. Also the human resources to adequately address nutrition issues need to be strengthened and the course on malnutrition needs to be fully incorporated into all health training institution curricula. Data from a survey of 202 LGAs representing the 6 geopolitical zones in 2001 revealed 0.4 medical doctors working in PHC facilities per 100,000 population, this does not compare well to the overall ratio of 24 practising doctors to 100,000 population. Similarly, there were 7.9 nurses/midwives practising in PHC services per 100,000, which again does not compare with overall ratio of 126 nurse/midwives per 100,000 populations.

Although available information is limited, there are indications that better working conditions and remuneration draw skilled health personnel to urban areas and the private sector. Irregular or non payment of staff salaries were described as reasons why many health workers have a second source of income, sell drugs privately or provide services outside the facilities. Also, lack

⁶ Dare et al,

of supplies and equipment, poor remunerations, lack of training and supervision and lack of transportation are common reasons adduced for poor performance.

GOING FORWARD

One of the main issues that needs to be addressed in the Nigerian health system is the weakness of government's primary health care services. This weakness is one of the causes of the stagnation and even deterioration of some of the population's health outcomes. As will be detailed in the following sections, the available data indicate that public PHC facilities: (a) have inadequate stocks of pharmaceuticals and support services, (b) are not properly maintained, (c) do not regularly pay their staff's salaries, and (d) have inadequate record-keeping. As a consequence, PHC services are often bypassed in favor of higher level care facilities in both the public and the private sector that offer both preventive and first level curative care. The services offered by public higher level facilities and the private sector ensured the availability of certain care interventions such as ORT. However, this was not the case for all preventive and curative activities, and many of them such as immunization declined.

Organization and management difficulties that affect the entire health system are behind the weakness in the government's PHC services. Some of these difficulties, such as an unclear division of responsibilities, a fragmented and uncoordinated system, and weak governance are discussed below as well as one of the major opportunities the system counts with: the dynamic private sector.

Lack of clarity in the division of responsibilities across different levels of government. The current (1999) Constitution mentions health only with regard to the responsibilities of local governments, implying that responsibility for health services is shared between the State and local levels.⁷ In practice, the division of responsibilities is based on the 1979 Constitution, where health services were on the "concurrent list" of responsibilities shared between the Federal and State governments, and reflects a body of Federal directives, policies, and laws relating to the health sector. The diffusion of responsibility is particularly evident at the primary level, where services are managed by Local Governments, under the nominal supervision of the States, and involving Federal Ministry of Health (FMOH) Departments and Federal parastatals concerned with particular programs and diseases. In many ways, this seems to have led to a situation where government primary health care services are perceived as the responsibility of everyone and of no-one. The new National Health Act, currently under discussion, seeks to address this problem.

⁷ The 1999 Constitution states: "The functions of a local government council shall include participation of such council in the Government of a State as respects the following matters: (a) the provision and maintenance of primary, adult and vocational education; (b) the development of agriculture and natural resources, other than the exploitation of minerals; (c) the provision and maintenance of health services; and (d) such other functions as may be conferred on local government councils by the House of Assembly of the State."

The health system is highly fragmented and the linkages across the different levels of government and stakeholders is weak. The health system is highly decentralized with the three levels of government having roles in the sector that are not well coordinated. Furthermore, the tendency to bypass both federal and state health ministries through the creation of large numbers of parastatal organizations to implement programs and manage services have added to the fragmentation of the system. For instance, at the Federal government level alone there are more than eighty of these parastatal organizations. There are some coordination structures in place such as the National Health Council and State Health Councils but they meet infrequently and irregularly and the available information indicates that they have been found to be generally ineffective.

A requirement for effective decentralization is that the lower-level political units have the capacity to meet their new responsibilities. In most cases, this requirement was not met when responsibility for primary health care services was transferred from the States to Local Governments in the late 1980s, while some of the newly-created States also found themselves with insufficient capacity to manage their responsibility for secondary-level facilities.

Underlying many of the organizational problems described above are inadequate governance and accountability at all levels of the health system. A major justification for decentralizing responsibilities is to improve governance by bringing control of health services closer to the communities they serve. However, this was done in Nigeria in the context of a military government attempting to balance regional and ethnic divisions at the same time as retaining as much power centrally as possible. Since governments at all levels were poorly accountable to the population during this period, decentralization of the health system likely had little benefit in terms of improving governance. Fulfilling the promise of decentralization will now depend on the consolidation of democracy in Nigeria, particularly at the State and Local levels. Moreover, although accountability problems affect all levels of government, at the local level they presents a particular challenge and would entail improvements in commitment, governance, accountability, and institutional capacity.

A dynamic private sector offers an opportunity to fill part of the gap left by a weak PHC system. The private sector represents an important share of the health care provision in Nigeria. This sector includes pharmacists and patent medicine dealers, outpatient clinics, private doctors, and hospitals. Despite their large numbers, these providers are not particularly available to the rural poor.

Despite the large role of the private sector in the provision of health care, information on their performance is very scarce. At present, little is known on the efficiency of these providers, their quality, their affordability, the type of services they offer, the characteristics of their health staff, their sources of financing, or whether these providers face any constraints in their development. An analysis of the characteristics of this sector will help identify strategies to ensure appropriate service standards and build better public/private partnerships in the provision of health care.

Chapter 3 Priority Areas for revitalization of the Nigerian Health system

Preamble

A Framework has been developed to serve as a guide to federal, state and LGAs in the selection of evidenced-based priority interventions that would contribute to achieving the desired health outcomes for Nigerians. Federal, States and LGAs have used this framework to respectively develop their costed plans through participatory approaches to reflect their context and prevailing issues.

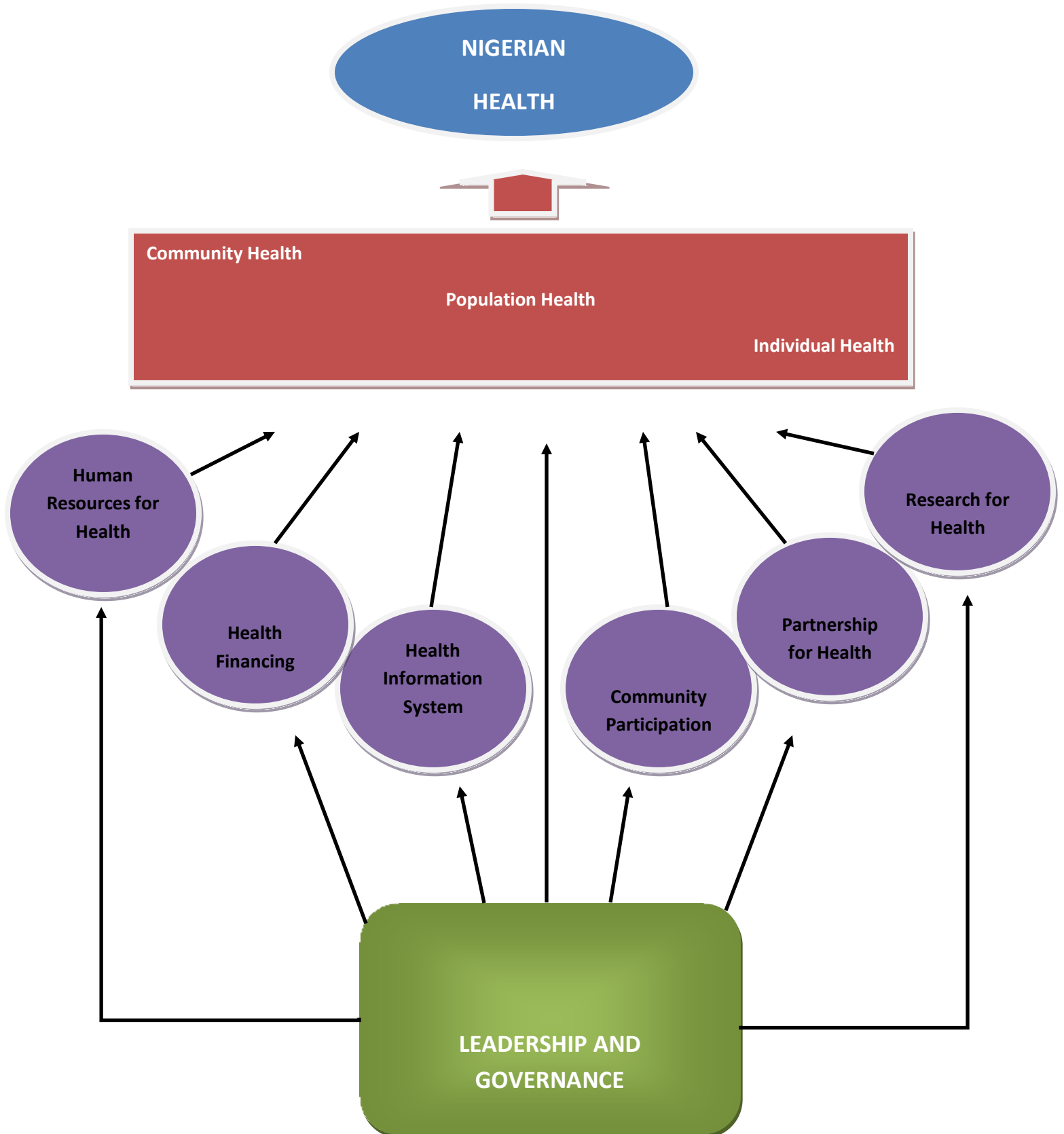
What is presented below are National Strategic Health Objectives and Interventions based on the harmonization of the different Federal, States and FCT plans.

Eight evidenced-based priority areas have been identified to improve the performance of the health sector, through a holistic approach at federal, state and LGA levels. They are: leadership and governance, service delivery, human resources for health, health financing, health information system, community participation and ownership, partnerships for health and research for health.

These serve as the basis for collective ownership, adequate resource allocation, inter-sectoral collaboration, decentralization, equity, harmonization, alignment, and mutual accountability in Nigeria.

Goals with strategic objectives, interventions and activities have been developed for each priority areas. A Framework inclusive of detailed activities is available in annex XXXXX

**PRORITY AREAS TO BE STRENGTHENED FOR
A REVITALIZATION OF NIGERIAN HEALTH SYSTEM**



PRIORITY AREA: LEADERSHIP AND GOVERNANCE FOR HEALTH

This priority area seeks to streamline and empower the Ministries of Health at the Federal and State levels as well as LGA Health Departments to reposition their organisational and management systems to provide the strategic and tactical leadership and governance for health. It equally recommends interventions to enhance mutual accountability and transparency in the use of health development resources, particularly through results-based management approaches.

Strategic Objectives and Interventions for 2010 – 2015

LEADERSHIP AND GOVERNANCE FOR HEALTH	
Goal: To create and sustain an enabling environment for the delivery of quality health care and development in Nigeria	
To provide clear policy directions for health development	<ul style="list-style-type: none">▪ Improved Strategic Planning at Federal and State levels
To facilitate legislation and a regulatory framework for health development	<ul style="list-style-type: none">▪ Strengthen regulatory functions of government
To strengthen accountability, transparency and responsiveness of the national health system	<ul style="list-style-type: none">▪ To improve accountability and transparency.
To enhance the performance of the national health system	<ul style="list-style-type: none">▪ Improving and maintaining Sectoral Information base to enhance performance ork will contribute to achieving this intervention.

PRIORITY AREA: HEALTH SERVICE DELIVERY

Health care services are activities geared towards the provision of a comprehensive package of integrated care to beneficiaries through the primary, secondary and tertiary levels. This includes increasing both demand and supply of services with the goal of expanding coverage for improving the health status of the citizenry. It is recognized that health care services in Nigeria are provided by a multiplicity of health care providers - public, private including for profit and not-for-profit, patent medicine vendors and the traditional health care providers.

The NPHCDA has defined a ward health care minimum package for PHC, but dissemination and implementation remain very limited. At higher levels, except for a few disease control programs, like PMTCT, TB, Malaria, Family planning and Essential Obstetric care, there are no standard operating procedures and treatment protocols. These lead to provider-initiated rather than client-centered delivery of care.

To improve the functionality, quality of care and utilization of services so as to positively impact the health status of the population, universal access to a package of cost-effective and evidence-based interventions is needed. This would of necessity require interventions that transform the way the health care system is resourced, organized, managed and services delivered

Strategic Objectives and Interventions for 2010 – 2015

HEALTH SERVICE DELIVERY	
Goal: To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare	
To ensure universal access to an essential package of care	<ul style="list-style-type: none"> ▪ To review, cost, disseminate and implement the minimum package of care in an integrated manner
To increase access to health care services	<ul style="list-style-type: none"> ▪ To improve geographical equity and access to health services ▪ To ensure availability of drugs and equipment at all levels ▪ To establish a system for the maintenance of equipment at all levels ▪ To strengthen referral system ▪ To foster collaboration with the private sector
To improve the quality of health care services	<ul style="list-style-type: none"> ▪ To strengthen professional regulatory bodies and institutions ▪ To develop and institutionalize quality assurance models ▪ To institutionalize Health Management and Integrated Supportive Supervision (ISS) mechanisms
To increase demand for health care services	<ul style="list-style-type: none"> ▪ To create effective demand for services
To provide financial access especially for the vulnerable groups	<ul style="list-style-type: none"> ▪ To improve financial access especially for the vulnerable groups

Essential Package of care to be delivered through Nigerian Health System

FAMILY/COMMUNITY ORIENTED SERVICES	POPULATION ORIENTED/OUTREACHES/SCHEDULABLE SERVICES
Insecticide Treated Mosquito Nets for children under 5	Family planning
Insecticide Treated Mosquito Nets for pregnant women	Condom use for HIV prevention
Household water treatment	Antenatal Care
Access to improved water source	Tetanus immunization
Use of sanitary latrines	Deworming in pregnancy
Hand washing with soap	Detection and treatment of asymptomatic bacteriuria
Clean delivery and cord care	Detection and management of syphilis in pregnancy
Initiation of breastfeeding within 1st hr. and temp management	Prevention and treatment of iron deficiency anemia in pregnancy
Condoms for HIV prevention	Intermittent preventive treatment (IPTp) for malaria in pregnancy
Universal extra community-based care of LBW infants	Preventing mother to child transmission (PMTCT)
Exclusive Breastfeeding for children 0-5 mo.	Provider Initiated Testing and Counseling (PITC)
Continued Breastfeeding for children 6-11 months	Condom use for HIV prevention
Adequate and safe complementary feeding	Cotrimoxazole prophylaxis for HIV+ mothers
Supplementary feeding for malnourished children	Cotrimoxazole prophylaxis for HIV+ adults
Oral Rehydration Therapy	Cotrimoxazole prophylaxis for children of HIV+ mothers
Zinc for diarrhea management	Measles immunization
Vitamin A - Treatment for measles	BCG immunization
Artemisinin-based Combination Therapy for children	OPV immunization
Artemisinin-based Combination Therapy for	DPT immunization

pregnant women		
Artemisinin-based Combination Therapy for adults		Pentavalent (DPT-HiB-Hepatitis b) immunization
Antibiotics for U5 pneumonia		Hib immunization
Community based management of neonatal sepsis		Hepatitis B immunization
Follow up Management of Severe Acute Malnutrition		Yellow fever immunization
Routine postnatal care (healthy practices and illness detection)		Meningitis immunization
		Vitamin A - supplementation for U5
INDIVIDUAL/CLINICAL ORIENTED SERVICES		
Family Planning	Artemisinin-based Combination Therapy for children	TB case detection and treatment with DOTS
Normal delivery by skilled attendant	Artemisinin-based Combination Therapy for pregnant women	Re-treatment of TB patients
Basic emergency obstetric care (B-EOC)	Artemisinin-based Combination Therapy for adults	Management of multidrug resistant TB (MDR)
Resuscitation of asphyctic newborns at birth	Management of complicated malaria (2nd line drug)	Management of Severe Acute Malnutrition
Antenatal steroids for preterm labor	Detection and management of STI	Comprehensive emergency obstetric care (C-EOC)
Antibiotics for Preterm/Prelabour Rupture of Membrane (P/PROM)	Management of opportunistic infections in AIDS	
Detection and management of (pre)ecclampsia (Mg Sulphate)	Male circumcision	Management of severely sick children (Clinical IMCI)
Management of neonatal infections	First line ART for children with HIV/AIDS	Management of neonatal infections
Antibiotics for U5 pneumonia	First-line ART for pregnant women with HIV/AIDS	Clinical management of neonatal jaundice
Antibiotics for dysentery and enteric fevers	First-line ART for adults with AIDS	Universal emergency neonatal care (asphyxia aftercare, management of serious infections, management of the

		VLBW infant)
Vitamin A - Treatment for measles	Second line ART for children with HIV/AIDS	Other emergency acute care
Zinc for diarrhea management	Second-line ART for pregnant women with HIV/AIDS	Management of complicated AIDS
ORT for diarrhea management	Second-line ART for adults with AIDS	

PRIORITY AREA: HUMAN RESOURCES FOR HEALTH

Human Resources for Health (HRH) comprise of trained health personnel in the public and private sector (doctors, nurses/midwives, pharmacists, relevant technicians, and community health workers e.t.c.), untrained informal health workers, including community-based health care providers e.g. herbalists, traditional birth attendants and volunteers, who play complementary roles in health care service delivery. Human Resources for Health (HRH) plays an important role in improving health system performance and should reflect the right number, mix, distribution and appropriate skills set (experience & qualifications) to provide the services required.

To respond to the weak HRH performance, in 2006, the FMOH through a participatory approach developed a comprehensive National Human Resources for Health Policy⁸ and its corresponding Strategic Plan for 2008 to 2012⁹. Interventions contained therein guide investments and decision making in the planning, management and development of human resources for health at the federal, state, LGA and institutional levels. The HRH policy and Strategic plans are therefore valuable tools in rationalizing production, distribution and utilization of health workforce in the country. It is also noted that currently, few States have adapted the National HRH policy.

⁸ Federal Ministry of Health. (2006) *National Human Resources for Health Policy*

⁹ Federal Ministry of Health. (2008) *National Human Resources for Health Strategic Plan (2008 – 2012)*

Strategic Objectives and Interventions for 2010 – 2015

HUMAN RESOURCES FOR HEALTH	
Goal: To plan and implement strategies to address the human resources for health needs in order to enhance its availability as well as ensure equity and quality of health care	
To formulate comprehensive policies and plans for HRH for health development	<ul style="list-style-type: none"> • To develop and institutionalize the Human Resources Policy framework
To provide a framework for objective analysis, implementation and monitoring of HRH performance	<ul style="list-style-type: none"> • To reappraise the principles of health workforce requirements and recruitment at all levels
Strengthen the institutional framework for human resources management practices in the health sector	<ul style="list-style-type: none"> • To establish and strengthen the HRH Units
To strengthen the capacity of training institutions to scale up the production of a critical mass of quality, multipurpose, multi skilled, gender sensitive and mid-level health workers	<ul style="list-style-type: none"> • To review and adapt relevant training programmes for the production of adequate nb of CHW based on national priorities • To strengthen health workforce training capacity and output based on service demand
To improve organizational and performance-based management systems for human resources for health	<ul style="list-style-type: none"> • To achieve equitable distribution, right mix of the right quality and quantity of human resources for health • To establish mechanisms to strengthen and monitor performance of health workers at all levels
To foster partnerships and networks of stakeholders to harness contributions for human resource for health agenda	<ul style="list-style-type: none"> • To strengthen communication, cooperation and collaboration between health professional associations and regulatory bodies on professional issues that have significant implications for the health system

PRIORITY AREA: HEALTH FINANCING

Poor utilisation of modern health services leading to poor health outcomes for majority of the citizens of Nigeria is not only influenced by lack of knowledge and negative perception but also by health care costs that include cost of services, travel to health facilities and opportunity costs. Poverty level is therefore a major factor responsible for individual and household decision making on utilization of health services.

In order to achieve the level of funding required for meeting the health needs of the whole population, the country has to put in place mechanisms for increased funding both in absolute terms and as a proportion of the total budget. In addition, there is a need to coordinate all the resources available to the sector from all sources. The Draft National Health Bill, when enacted into law will assure significant improvement in health care financing in the country as it earmarks 2% of the consolidated federal revenue for health, with a large proportion of it assigned for PHC.

In the recent past, a range of potential measures are being established, including the National Health Insurance Scheme (NHIS) that incorporates programmes covering formal sector workers; community-based health insurance; social health protection models targeted at the poor and vulnerable groups such as free maternal and child health (MCH) services, voucher schemes, health cards and exemptions; and private health insurance. However, none of these options have been scaled up to the point of providing adequate financial risk protection for majority of people in Nigeria¹⁰.

Strategic Objectives and Interventions for 2010 – 2015

FINANCING FOR HEALTH	
Goal: To ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and consumption at Local, State and Federal levels	
To develop and implement health financing strategies at Federal, State and Local levels consistent with the National Health Financing Policy	<ul style="list-style-type: none"> • To develop and implement evidence-based, costed health financing strategic plans at LGA, State and Federal levels in line with the National Health Financing Policy
To ensure that people are protected from financial catastrophe and impoverishment as a result of using health services	<ul style="list-style-type: none"> • To strengthen systems for financial risk health protection
To secure a level of funding needed to achieve desired health development goals	<ul style="list-style-type: none"> • To improve coordination of donor funding mechanisms

¹⁰ National Health Insurance Scheme. (2008). *Blueprint for the Implementation of Social Health Insurance Programme in Nigeria*. Abuja: National Health Insurance Scheme

and objectives at all levels in a sustainable manner	<ul style="list-style-type: none"> • To improve financing of the Health Sector
To ensure efficiency and equity in the allocation and use of health sector resources at all levels	<ul style="list-style-type: none"> ▪ To improve Health Budget execution, monitoring and reporting ▪ To strengthen financial management skills

PRIORITY AREA: NATIONAL HEALTH INFORMATION SYSTEM

A Health Data Consultative Committee (HDCC) comprising of government and partners was established at federal level to coordinate and harvest population based data and other data from surveys and with a mandate to meet quarterly and with similar structures at State and LGA level. To meet the resource requirement to strengthen the NHMIS, in 1995, the National Council on Health adopted a resolution to allocate funding to the NHMIS based on an identified vote-of-charge (VOC) consisting of 0.5% to 1.0% of the annual capital (health) budget.

Strategic Objectives and Interventions for 2010 – 2015

NATIONAL HEALTH INFORMATION SYSTEM	
Goal: To provide an effective National Health Management Information System (NHMIS) by all the governments of the Federation to be used as a management tool for informed decision-making at all levels and improved health care	
To improve data collection and transmission	<ul style="list-style-type: none"> • To ensure that NHMIS forms are available at all health service delivery points at all levels • To periodically review of NHMIS data collection forms • To coordinate data collection from vertical programmes • To build capacity of health workers for data management • To provide a legal framework for activities of the NHMIS programme • To improve coverage of data collection • To ensure supportive supervision of data collection at all levels
To provide infrastructural support and ICT of health databases and staff training	<ul style="list-style-type: none"> • To strengthen the use of information technology in HIS • To provide HMIS Minimum Package at the different levels (FMOH, SMOH, LGA) of data

	management
To strengthen sub-systems in the Health Information System	<ul style="list-style-type: none"> • To strengthen the Hospital Information System • To strengthen the Disease Surveillance System
To monitor and evaluate the NHMIS	<ul style="list-style-type: none"> • To establish monitoring protocol for NHMIS programme implementation at all levels in line with stated activities and expected outputs • To strengthen data transmission
To strengthen analysis of data and dissemination of health information	<ul style="list-style-type: none"> • To institutionalize data analysis and dissemination at all levels

PRIORITY AREA: COMMUNITY PARTICIPATION AND OWNERSHIP

Traditional self help and community efforts in health development through community safety nets and other support mechanisms have been part of the history of communities in Nigeria. These efforts at community participation have however been limited in scope, organization and impact. Lack of clear policy framework to empower the community as the draft Community Development Policy is yet to be finalized may be contributory. National efforts at promoting community participation in health began with the introduction of PHC in the country in 1986. National guidelines were developed for PHC planning and implementation, including those for community participation. They included very prescriptive guidelines for setting up village health committees across the country with definitions of the size, composition and functions, which resulted in little or no efforts in the identification and strengthening of existing local social organizations, thereby pre-empting a crisis of legitimacy.

There is minimal constructive engagement of communities in needs identification, planning and implementation of health programmes. To many, community participation was synonymous with provision of building for government to staff and provide curative services. Largely, communities remain reliant on government. Inadequate community participation has also resulted in inappropriate siting of PHC facilities in inaccessible or unacceptable locations and also, gross underutilization of the services rendered.

Strategic Objectives and Interventions for 2010 – 2015

COMMUNITY PARTICIPATION AND OWNERSHIP	
Goal: To attain effective community participation in health development and management, as well as community ownership of sustainable health outcomes	
To strengthen community participation in health development	<ul style="list-style-type: none"> • To provide an enabling policy framework for community participation • To provide an enabling implementation framework and environment for community participation
To empower communities with skills for positive health actions	<ul style="list-style-type: none"> ▪ To build capacity within communities to 'own' their health services.
To strengthen the community - health services linkages	<ul style="list-style-type: none"> ▪ To restructure and strengthen the interface between the community and the health services delivery points
To increase national capacity for integrated multisectoral health promotion	<ul style="list-style-type: none"> ▪ To develop and implement multisectoral policies and actions that facilitate community involvement in health development
To strengthen evidence-based community participation and ownership efforts in health activities through researches	<ul style="list-style-type: none"> ▪ To develop and implement systematic measurement of community involvement

PRIORITY AREA: PARTNERSHIPS FOR HEALTH

Health is a multidimensional issue and government alone cannot meet the all the health needs of the people in Nigeria. Partnership with the private sector, non-governmental organisations, communities and development partners (donors) as well as other social and economic sectors is essential to deliver health services that can meet the needs of the population on a sustainable basis.

Strategic Objectives and Interventions for 2010 - 2015

PARTNERSHIPS FOR HEALTH	
Goal: To enhance harmonized implementation of essential health services in line with national health policy goals	

<p>To ensure that collaborative mechanisms are put in place for involving all partners in the development and sustenance of the health sector</p>	<ul style="list-style-type: none"> • To promote Public Private Partnerships (PPP) • To institutionalize a framework for coordination of Development Partners • To facilitate inter-sectoral collaboration • To engage professional groups • To engage with communities • To engage with traditional health practitioners
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PRIORITY AREA: RESEARCH FOR HEALTH

Over the years successive government have introduced various initiatives to promote research for health in Nigeria. In particular, the Medical Research Council of Nigeria (MRCN) was established by Decree No 1 of 1972 and inaugurated in January 1973. In 1977 the National Science and Technology Development Agency (NSTDA) was established. The Nigeria Institute for Medical Research (NIMR) was initially an agency under the NSTDA, which transmuted into the Federal Ministry of Science and Technology until it was transferred to the FMOH. In 1988, the reorganization of civil service by Federal Government for effective, efficient and productive service created the Department of Planning, Research and Statistics (DPRS) in all ministries. One of the responsibilities of the department is to co-ordinate research activities as well as spear-head planning. Consequently, there is now a Department of Planning and Research at the Ministries of Health at the Federal and State government levels. To conduct research in the area of Pharmaceutical commodities, the National Institute for Pharmaceutical Research was established under the oversight of the Federal Ministry of Health. A draft National Health Research Policy as well as National Health Research Priorities were produced in 2001, both document have been reviewed and merged in 2006. A Country report on status of health research was also produced by the FMOH in 2006.

There is currently no legal framework mandating a depository of researches and output of databases in the country. Linking research for health with policies and decision making on health care in a country is imperative to provide decision-makers with empirically-based and scientifically-valid information on service delivery.

Strategic Objectives and Interventions for 2010 - 2015

RESEARCH FOR HEALTH	
Goal: To utilize research to inform policy, programming, improve health, achieve nationally and internationally health-related development goals and contribute to the global knowledge platform	
To strengthen the stewardship role of governments at all levels for research and knowledge management systems	<ul style="list-style-type: none"> • To finalize the Health Research Policy at Federal level and develop health research policies at State levels and health research strategies at State and LGA levels • To establish and or strengthen mechanisms for health research at all levels • To institutionalize processes for setting health research agenda and priorities • To promote cooperation and collaboration between Ministries of Health and LGA health authorities with Universities, communities, CSOs, OPS, NIMR, NIPRD, development partners and other sectors • To mobilize adequate financial resources to support health research at all levels • To establish ethical standards and practice codes for health research at all levels
To build institutional capacities to promote, undertake and utilize research for evidence-based policy making in health at all levels	<ul style="list-style-type: none"> • To strengthen identified health research institutions at all levels • To create a critical mass of health researchers at all levels • To develop transparent approaches for using research findings to aid evidence-based policy making at all levels • To undertake research on identified critical priority areas
To develop a comprehensive repository for health research at all levels (including both public and non-public sectors)	<ul style="list-style-type: none"> ▪ To develop strategies for getting research findings into strategies and practices ▪ To enshrine mechanisms to ensure that funded researches produce new knowledge required to improve the health system
To develop, implement and institutionalize health research communication strategies at all levels	<ul style="list-style-type: none"> ▪ To create a framework for sharing research knowledge and its applications ▪ To establish channels for sharing of research findings between researchers, policy makers and development practitioners

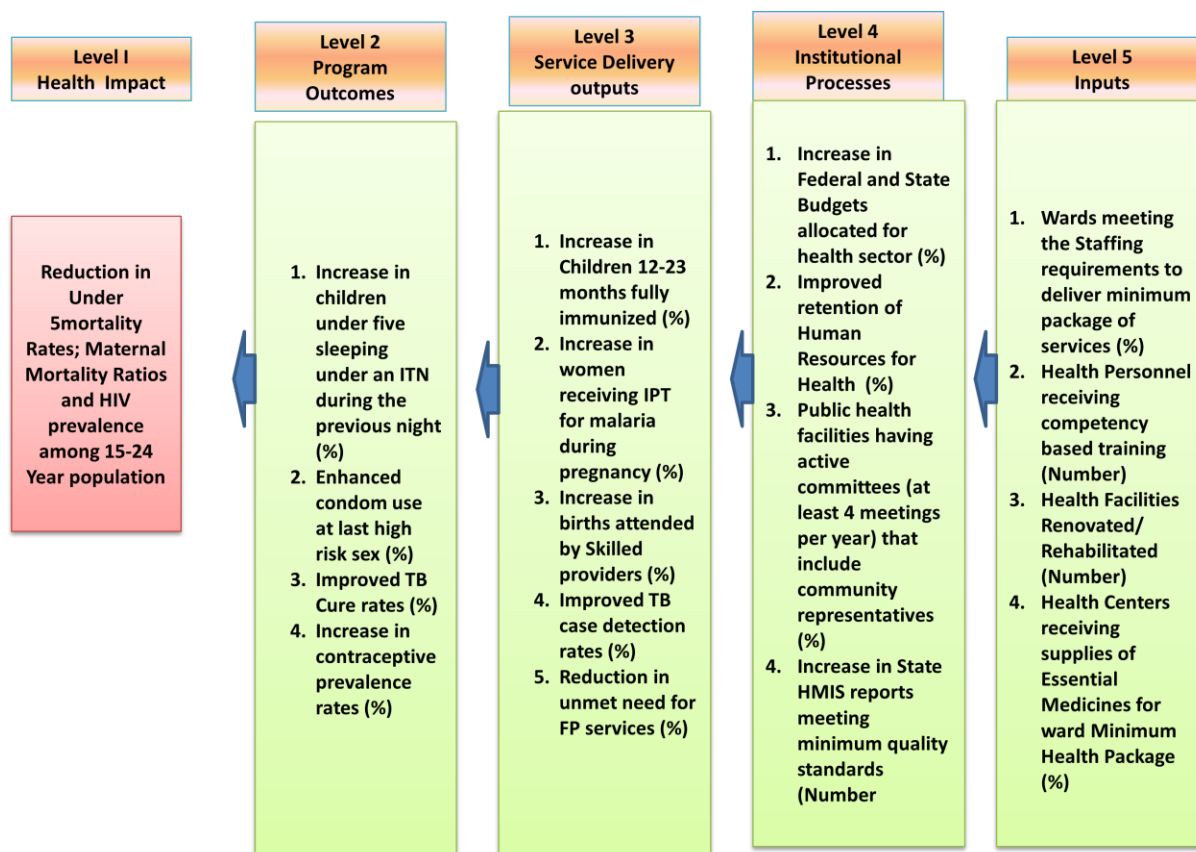
Chapter 4. Results Matrix and Monitoring and Evaluation

The NHSDP recognizes the criticality of improving health indicators in Nigeria to achieve national targets and global MDGs and importance of reducing inequities within the country to accelerate progress towards achieving NHSDP goals and MDGs.

4.1 Results Matrix:

The NHSDP Results Matrix provides an excellent summary of key performance indicators to assess the progress of the National Plan. It has a total of 52 indicators covering a good combination of indicators on impact, outputs, process and inputs. Some of these indicators require population based data while others require facility based information collected by surveys, quantifiable supervision checklists and Health Management Information System (HMIS) and data from published reports and records. All indicators included in the National Results Matrix are clearly defined and baselines are available for most of them. Performance targets for each of these indicators have been established through a consultative process involving key stakeholders. The attached figure presents logical flow of the indicators from inputs to health impacts while the detailed list of indicators by each of the eight NSHDP strategic areas is presented as Annex ??

Fig 1. The NSHDP Results Chain with selected indicators



4.2 Monitoring and Evaluation Systems:

The main purpose of the proposed Monitoring and Evaluation (M&E) System is to provide accurate, reliable and timely information on progress made by the NHSDP regularly reporting on the performance indicators listed in the results matrix. The proposed M&E system will have to meet this important reporting requirement and should ensure that the core principles of a good M&E system (listed below) are addressed.

1. Providing data with adequate disaggregation meeting the reporting requirements of NHSDP and development partners;
2. Identifying sub groups that are consistently missing out services to promote equitable access;
3. Using 3rd party assessments for evaluations to allow independence
4. Having clearly defined roles and responsibilities for M&E data collection, analysis and use to ensure accountability; and
5. Providing performance data for innovative financing instruments such as Results Based Financing, Conditional Cash Transfers and Contracting which require more precision in measuring results
6. Identifying appropriate tools and methods covering both supply and demand side issues for providing accurate data and
7. Widely disseminating M&E results using approaches such report cards to enable better informed program decisions

4.3 Approaches for Data Collection:

The main focus of the proposed M&E system will be therefore on collecting accurate, reliable and timely data on the NHSDP results at the prescribed intervals using appropriate tools providing data both from population and health facilities. A combination of approaches are proposed to operationalize M&E systems to update the NSHDP results matrix at the required periodicity. The proposed M&E systems will ensure adequate independence in information provided and will focus on building national capacities for data collection and analysis. A comprehensive table providing details of data collection instruments, frequency and responsibility is provided in annex???. The attached table summarizes different M&E methods proposed, types of information provided by each of them and frequency of data reporting during the NSHDP implementation period.

4.4 Proposed M&E tools and methods for collecting data on NHSDP Results Matrix

M&E Method	Information Provided	Year-wise M&E outputs					
		2010	2011	2012	2013	2014	2015
National Demographic and Health Survey (NDHS)	Population based data 26 Indicators covering Mortality, Fertility and Utilization of services		? Mini DHS		NDHS 5		? Mini DHS
Multiple Indicator Cluster Survey (MICS)	Population based data on on maternal and child health indicators covering mortality and utilization of services	MICS 3		MICS4		MICS5	
National AIDS and Reproductive Health Survey (NARHS)	Population based data on HIV AIDS and reproductive health behaviours and use of services		NRHS 4		NRHS5		NRHS6
Facility Surveys	Facility based data on use of services, availability of inputs and quality of services	Pilots under HSDP	Round 1	Round 2	Round 3	Round 4	Round 5
Health Watch Group Reports	Data on community perceptions about health systems based on visits and community contacts in all 6 zones of the country	Annual Reports	Annual Reports	Annual Reports	Annual Reports	Annual Reports	Annual Reports
Quatifiable Supervision Checklist	Facility based data on inputs, provider competency and quality of services	Pilots under HSDP	Quarterly Reports	Quarterly Reports	Quarterly Reports	Quarterly Reports	Quarterly Reports
National Health Management Information System (NHMIS)	Data reported by health facilities on availability of inputs, use of services covering both public and private sectors including information on Surveillance of Communicable diseases	Quarterly Reports	Quarterly Reports	Quarterly Reports	Quarterly Reports	Quarterly Reports	Quarterly Reports
Human Resources in Health Database	Data on Human Resources including availability, skill mix and projected demands	Annual Reports	Annual Reports	Annual Reports	Annual Reports	Annual Reports	Annual Reports
Gezettes, Audits and Reports from Federal Ministry of Health and State Departments of Health	Data on Government notifications, budget allocation and execution, appropriate use and implementation progress of respective plans	Annual Reports	Annual Reports	Annual Reports	Annual Reports	Annual Reports	Annual Reports

4.5 Strategy:

The Federal Ministry of Health based on extensive consultations with states proposes to introduce more frequent household surveys in between the planned rounds of Demographic and Health Survey (DHS) and Multi Indicator Cluster Survey (MICs) rounds which are currently planned once every five and three years respectively. The focus will be on providing more disaggregated data at the state level. The feasibility of mini DHS and MICs rounds in between

DHS as being done in some countries will be explored and if this is not possible, special surveys will be planned. At present, the next DHS round will be due on 2013 and two rounds of MICs will be due in 2010 and 2013 respectively. If these surveys are complemented by two rounds of mini DHS in 2011 and 2015 and three rounds of MICs (instead of 2 rounds planned) in 2010, 2012 and 2014, Nigeria will have one robust household survey following internationally accepted protocols every year during the next 5 years.

The Federal Ministry of Health will be supporting development of standardized tools and protocols for undertaking facility surveys and will also assist the states in developing and using quantifiable supervision checklists. Towards this, workshops and trainers training programs are planned during April-May 2010. The states will actively participate in this process and will also identify appropriate institutions including schools of public health, nursing/midwifery schools etc for capacity building to undertake facility surveys on a sustained basis.

The FMOH has constituted a technical committee to facilitate this process and this committee will closely interact with all key stakeholder including states and development partners to ensure that the proposed strategy meets their reporting requirements fully.

Chapter 5: Resource Requirements

The resources required to fulfill the NSHDP is partly depended on the current efficiency of the health service delivery and partly on the magnitude of ambitions to scale up the services during the next 6 years. It is beyond doubt a potential for increasing efficiency in the current system. But without a comprehensive assessment to this important issue it is difficult to estimate resource requirements. Estimates on resource requirements must therefore remain crude based on available data. Efforts will be made to improve the basis for future analysis of the efficiency of the health service in the country.

5.1 Human resources

While Nigeria has one of the largest stocks of human resources for health in Africa, it is probably still inadequate to meet the country's needs. The ability of Nigerian health service to meet its health goals depends largely on the knowledge, skills, motivation and distribution of the HRH. The planning and management of HRH still poses a major challenge to health development in the country for several reasons. These include migration within and outside the country, mal-distribution, poor skill mix and limited production capacity. In addition, poor motivation, differential conditions of service, remuneration and work environment; negative attitude to work and poor supervision are added challenges. Given the targets in the NHSDP it is evident that future availability of HRH is critical. There are about 39,210 doctors and 124,629 nurses registered in the country, which translates into about 30 doctors and 100 nurses per 100,000 populations (table x). This compares to a Sub-Sahara African average of 15 doctors and 72 nurses per 100,000 populations (WHO 2006).

The figures presented in Table X¹¹ are for some health professional categories registered by Nigeria's professional medical/health regulatory bodies as in 2006. They include health workers in both the private and public health sectors, and, very likely, health professionals who are not practising in the country or may not be practising health care at all.

¹¹ Source HRH Strategic Plan 2008 2012

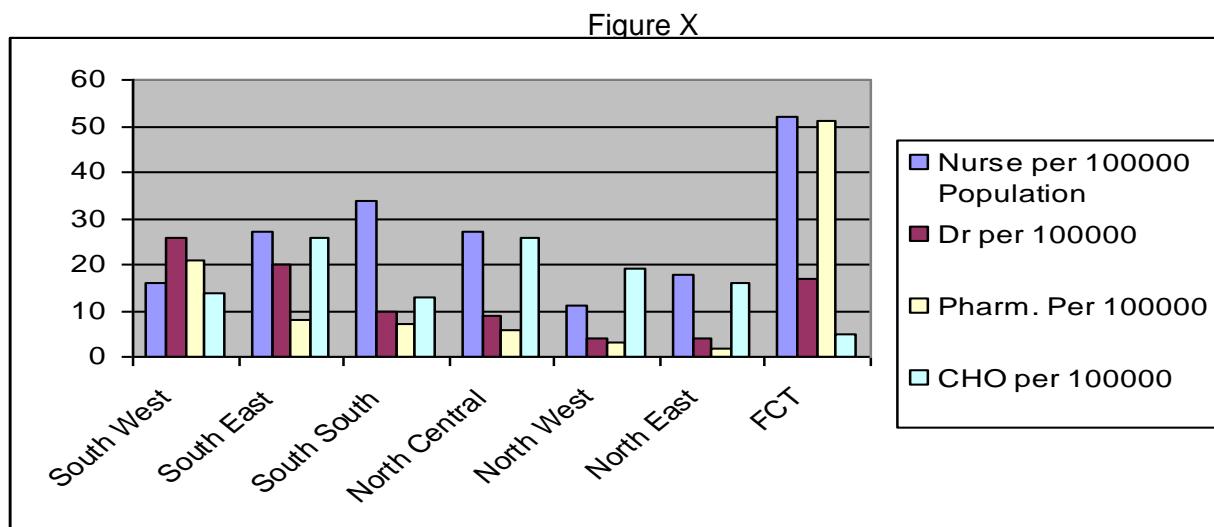
Table X

Staff Type	Number of Staff current situation 2006	No. of Staff/100,000 population
Doctors	39,21	30
Nurses	124,629	100
Midwives	88796	68
Dentists	2,773	2
Pharmacists	12,072	11
Medical Lab. Scientists	12,86	12
Community Health Practitioners	117,568	19
Physiotherapists	769	0.62
Radiographers	519	0.42
Health Record Officers	820	0.66
Environmental Health Officers	3441	3
Dental Therapists	872	0.69

There is no recommended density of each category of health workers per population, and it is not possible to establish the number of personnel necessary to deliver the essential package of care. Such approach would not take into account any other variables, aside from population size, which are known to play a part in determining the impact of health workforce performance on health outcomes in a given context. Even though there is unemployment among some certain health workers in certain areas, the targeted level of activity in the NSHDP will require a significant increase in education and training of all types of health workers. The net supply of health personnel must increase to scale up service delivery according to the NSHDP. The implementation of a national HRH policy must be lead by an continuous monitoring and evaluation process.

About an average of 2,500 doctors, 5,500 nurses and 800 pharmacists graduate and enter the health sector every year. Except for nurses and midwives, there appears to be a positive net gain when rate of inflow of fresh graduates are compared with attrition rates. Intakes into health training institutions are not influenced by evidence-based predetermined staff requirements. Consequently, many of the health training institutions over-produce some cadres of staff who do not readily find employment within the state yet are not employed by other states where needs

exist. At the same time, there is gross under-production of other cadres who are critically needed in the states.



There is a geographical mal-distribution of HRH varying between rural and urban areas. Figure X¹² above shows that availability of various staff category per 100,000 population vary from one zone to the other. Whilst the national average for doctor per 100,000 population is estimated at 12, some zones notably North West and North East have as low as 4. Whereas the national nurse/midwife per 100,000 population stands at 21, the South West, North West and North East zones have 16, 11, 18 respectively. This suggests that any strategy to ensure equitable distribution of doctors and nurse-midwives must be sensitive to the needs of the affected zones.

The Federal government is committed to implement the comprehensive National HRH policies to meet the aggregate demands for health personnel in the country. It is expected that these will be adopted by all states and LGAs by end of 2015

5.2 Physical/materials

In 2005 FMOH estimated a total of 23,640 health facilities in Nigeria of which 85,5% are primary health care facilities, 14% secondary and 0,2 tertiary. 38% of these facilities are owned by the private sector. Physical facilities are often decaying, equipment are obsolete. In order to sustain healthcare service delivery, increase access, ensure geographical spread and equity measures will be taken by the states. The State Plans envisages serious investments in physical

¹² Source HRH Strategic Plan 2008 2012

structures and infrastructure through new buildings and renovations of existing health facilities. New hospitals and PHCs in under-served areas are planned. In addition facilities will be equipped in line with minimum requirements and upgraded during the 6-year strategic period. A comprehensive assessment of the status of equipment and supplies of medical consumables in the States is not currently available. Mapping of existing resources on each health health facility has started in two states and will be strengthened to improve the basis for future planning.

As well as investments in health facilities there is need for procurement of logistics, essential drugs, commodities and medical equipment for the successful implementation of the state and federal strategic plans

5.3 Estimated costs of the strategic orientations

The total estimated costs of the NSHDP for the six year period 2010 / 2015 is USD 26.653.107.239. This gives an annual cost per capita of USD 31,63¹³. The estimated costs of the different strategic orientations reflects the challenges faced by the states in providing quality and available health service . See table below

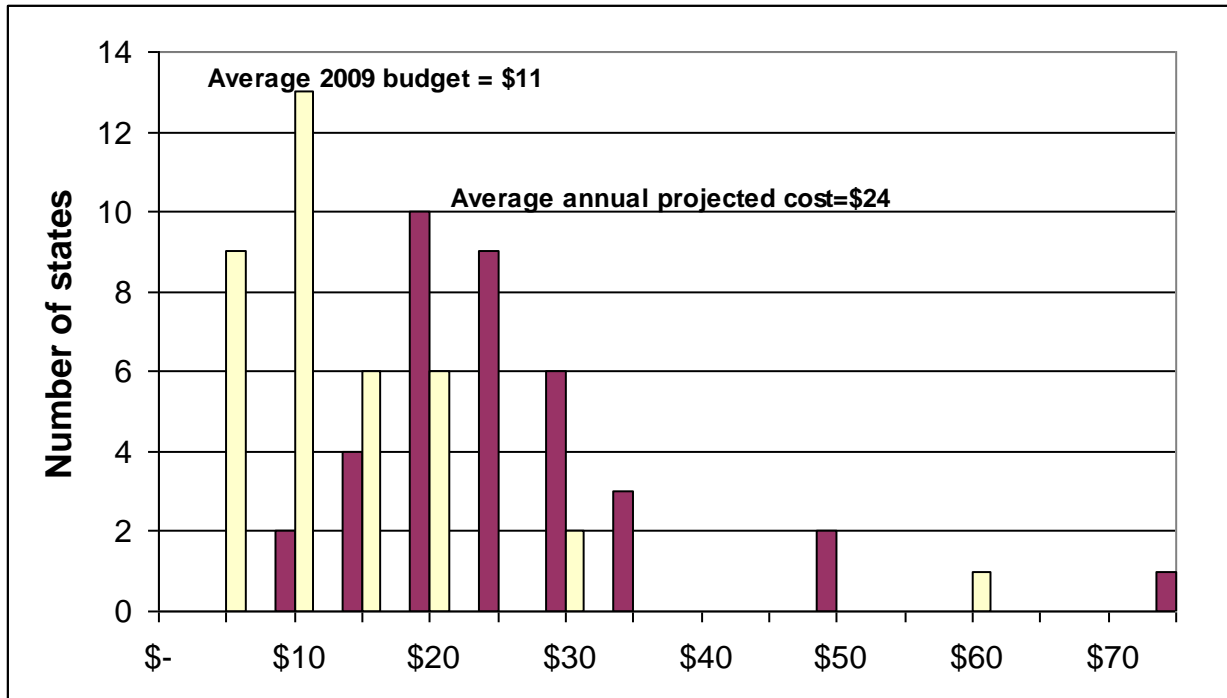
By priority area:		
LEADERSHIP AND GOVERNANCE FOR HEALTH	183 914 685	1 %
HEALTH SERVICE DELIVERY	12 975 047 689	49 %
HUMAN RESOURCES FOR HEALTH	11 097 841 997	42 %
FINANCING FOR HEALTH	1 459 843 402	5 %
NATIONAL HEALTH INFORMATION SYSTEM	277 367 996	1 %
COMMUNITY PARTICIPATION AND OWNERSHIP	159 420 543	1 %
PARTNERSHIPS FOR HEALTH	170 016 518	1 %
RESEARCH FOR HEALTH	329 654 407	1 %
SUM	26 653 107 239	100 %

The national costs of USD 31,63(included Federal plan) is at the level of recommended expenses to attain a basic package of care(reference?). The NSHDP seems therefore to be consistence with this recommendation.

At the state level the average state current per-capita budget for 2009 was around N1,700 (\$11.50) with each state weighted equally. The average projected annual per capita expenditure

¹³ Source; Costing workshop january Abuja??

for the state level is around N3,600 (\$24) per capita (roughly doubling of costs). There is however a very large range in the current budgets and projected costs. See figure below.



Cost distribution according to The National Chart of Accounts was dominated by costs associated with salary and wages (19%), materials and supplies (22%) and capital investments(20%). See table below for more details.

Column1	Column2	Column3
By National Chart of Accounts	\$	Percent
1100010 - SALARY & WAGES - GENERAL	10 327 230 277	39 %
1200020 - BENEFITS AND ALLOWANCES – GENERAL	930 177 788	3 %
1300030 - SOCIAL CONTRIBUTION	288 821 294	1 %
2050110 - TRAVELS & TRANSPORT – GENERAL	156 164 159	1 %
2060120 - TRAVELS & TRANSPORT (TRAINING) – GENERAL	73 407 286	0 %
2100200 - UTILITIES – GENERAL	284 859 218	1 %
2150300 - MATERIALS & SUPPLIES – GENERAL	5 080 520 971	19 %
2200400 - MAINTENANCE SERVICES – GENERAL	1 020 768 042	4 %
2250500 - TRAINING – GENERAL	571 320 969	2 %
2300600 - OTHER SERVICES – GENERAL	11 693 212	0 %
2350700 - CONSULTING AND PROFESSIONAL SERVICES – GENERAL	83 998 352	0 %
2400800 - FINANCIAL – GENERAL	1 149 602 138	4 %
2450900 - FUEL & LUBRICANTS – GENERAL	23 839 675	0 %
2501000 – MISCELLANEOUS	1 049 819 462	4 %
3001100 - LOANS & ADVANCES – GENERAL	1 504 656	0 %

4001200 - GRANTS & CONTRIBUTION – GENERAL	161 542 841	1 %
20000000 - CAPITAL INVESTMENT	5 437 836 897	20 %
SUM	26 653 107 239	100 %

Chapter 6: Financing the NSHDP (or Financial sustainability plan?)

This chapter presents the current health expenditure trends in Nigeria and estimates the resource needs for achieving the goals and targets of NSHDP. Taking in to consideration the all potential sources for financing the health sector, the financing gap is estimated and strategic options for meeting the resource gap are presented towards the end of the chapter.

6.1. Health Expenditure Trends in Nigeria:

The National Health Accounts (NHA) for Nigeria over the period 2003 to 2005¹⁴ estimate that the Total Health Expenditure (THE) in Nigeria has grown from N661.662 billion in 2003 to N976.69 billion in 2005. While the THE has grown in absolute terms by nearly a third during this period, THE as a share of Gross Domestic Product (GDP) has actually declined from 12.25% in 2003 to 8.56% in 2005. Federal government health expenditure was estimated to have grown three fold from N47.02 billion in 2003 to N130.76 billion in 2005, while the estimated expenditures for the same period by states grew from N48 billion to N78.8 billion and that of LGAs nearly doubled from N28.63 billion to N44.64 billion.

This trend is supported by figures from the Central Bank of Nigeria which reveals that the proportion of federal government's total expenditure on the social sector between 2001 and 2005 ranged between 12% and 19%¹⁵. The other sources also confirm that absolute expenditure on health over the period 2001 – 2005, has increased by more than 150%.¹⁶

Household out of pocket expenditure remains by far the largest source of health expenditure in Nigeria (about 69%) and in absolute terms increased from N489.79 billion in 2003 to N656.55 billion in 2005. The estimated health expenditure of private firms grew from N20.32 billion in 2003 to N29.67 billion in 2005. The contributions from the development partners to health sector in Nigeria is estimated to increase from N48.02 billion in 2003 to N78.78 billion in 2005.

In terms of contribution from different levels of Government, the NHA 2003-05 estimates that the Federal government contributes to above a tenth (12.1%), State government around 7.6%, and LGA about 4.5%. The Household Out-Of-Pocket Expenditure (OOPE) by far remains the largest source contributing to over two thirds (68.6%) and the remaining contributed by Private Firms (3.1%) and Development Partners (4.1%) as illustrated in Fig 1 below¹⁷

¹⁴ 2003 – 2005 NHA Estimation, Final Report, 2009

¹⁵ CBN Report 2006

¹⁶ Macroeconomics and Health background study, commissioned by the FMOH, 2009

¹⁷ 2003 – 2003 NHA Estimation, Final Report, 2009

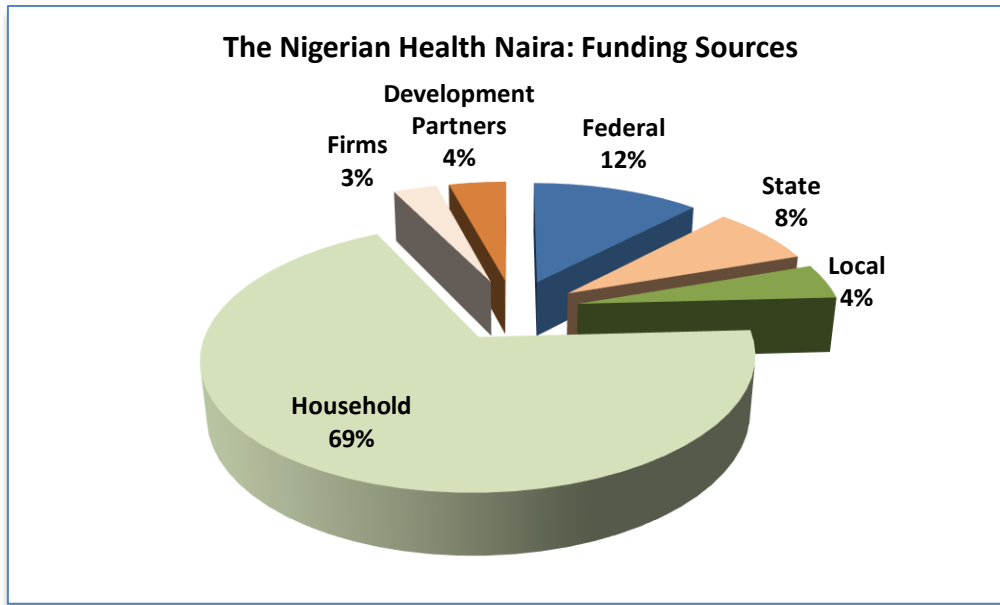


Fig 1: Funding Sources in the Nigerian Health system, 2003 - 2005

It appears that the share of OOPE has been steadily increasing and stands around 68.6% of THE by the recent NHA(2003-05) indicating an increase from the 64.25% estimated over the period 1998 to 2002. There are however notable differences in share of OOPE across the states and with some states in the northern zones estimated to have household share as high as 86%. This underscores the huge economic burden of health care expenditure on households, especially the poorer households. The responsibility to lessen this burden therefore rests with the Government playing a stewardship role to ensure provision of quality and affordable health services to Nigerians.

6.2. Public Expenditure on Health:

Average share of Total Government Health Expenditure (THE) over the period 2003 to 2005 was about a quarter of THE (24.1%). This has increased from an average of about a fifth of THE (20.65%) over the period 1998 to 2002. State level analysis shows that the contribution of state and local governments to STHE is generally very low. State Government Health Expenditure (SGHE) as a proportion of STHE averaged less than 10% over the study period. The contribution of LGHE during the same period averaged less than 7%.¹⁸ However, it is gratifying to note that all levels of government have the capacity to subsidize health expenditure of poor families through social health insurance, incentives or cash transfer approaches. This is currently true of the formal sector, where employees receive medical re-imbursements within specified rates, or are enrolled in the formal sector National Health Insurance Scheme. Some of the recent initiatives by states to reduce OOPE include the establishment of targeted exemption schemes or free health services for vulnerable populations such as pregnant women, children under five years, elderly, etc.

¹⁸ 2003 – 2005 Nigeria NHA Estimation, Final Report, 2009

The financing agents of health care in Nigeria, through which funds are channeled to providers include public agents (Federal ministries and agencies, SMOHs, Hospital management boards, LGA health departments), National Health Insurance for the formal sector and pilot community health insurance schemes, NGOs and Faith based organizations, private firms' medical units and direct expenditure by households. Their financing contribution to providers is as illustrated in Fig 2 below.

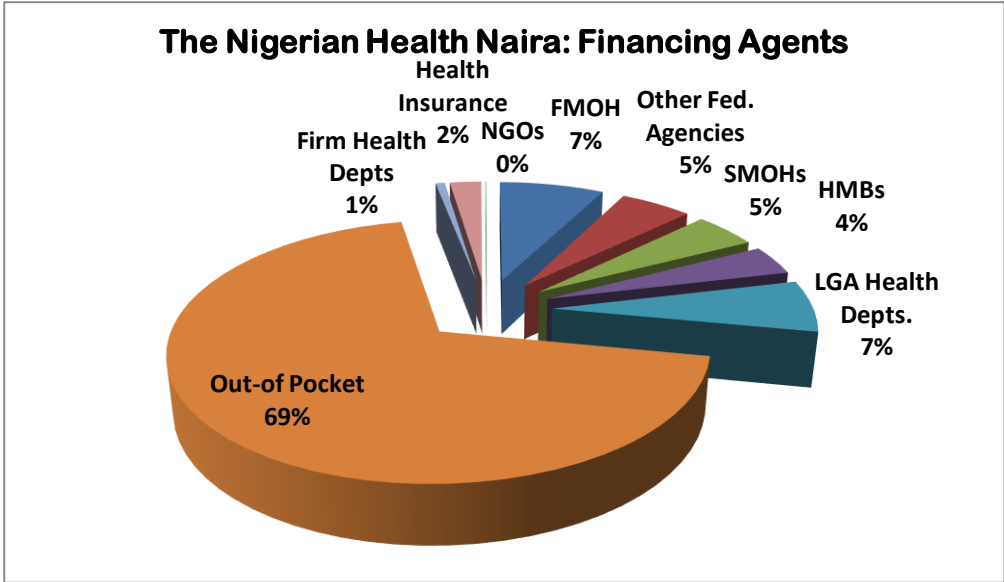


Fig 2: Financing Agents in the Nigerian health system

The interplay between the funding sources and financing agents in the Nigerian health system is critical to ensure adequate and timely resourcing of the National Strategic Health Development Plan for the delivery of high impact and cost effective health services within an enabling environment that promotes universal access to the services. The strategic planning process for the development of the NSHDP has identified specific areas for key investments required for achieving the MDGs and health targets in Nigeria’s Vision 20: 2020 blueprint for economic transition.

The financial plan of the NSHDP is therefore developed based on the careful review of estimated costs, available and potential sources of resources, financing strategies relevant to the Nigerian context and with a focus on allocation of funds towards achieving measurable results.

6.3 Assessment of the available and projected funds

The findings from the NHA 2003 – 2005, highlight the criticality of government contributions to promote equitable access to essential health services for the poor. With limited external aid, the onus lies on government to provide the bulk of resources required for the implementation of the 6 year NSHDP.

The available funding from government is estimated using the retrospective review of the NHA data due to paucity of administrative data on budgetary allocations, releases and expenditures on a routine basis.

The National Strategic Health Development Plan (2010 – 2015) projects significant resource needs for each of the eight (8) priority areas, underscoring the importance of predictable and sufficient investments to achieve the targeted measurable results. In total, an investment of N2.863 trillion (\$26.653billion) is required over the six year period of the NSHDP with an annual cost requirement of N477.084 billion (\$4.442billion). The specific earmarks by priority area and national chart of accounts are as detailed in section 5.3.

To compute the available and projected funding therefore, the per capita health expenditure data from the recent NHA 2003 – 2005 has been considered as the most reliable TGHE to estimate available funds for the sector from government and development partners. Based on the NHA (2003-05), projections for public expenditure on health including development partner support for the health sector have been made for 2010 in the first instance and would apply for the subsequent years marked up with inflation factors as the cost projections for the NSHDP are in constant 2009 USD rate.

The NHA reveals a steep increase in Federal Government expenditure from 2003 to 2004 (From USD 2.82 per capita to USD 6.52 per capita), and to ensure realistic projections, the data from 2004 and 2005 have been used for making the following projections. It is important to note that the projection is therefore limited by the fact that it is based only on two data points and assumes a linear growth.

Estimated expenditure on Health (USD/Capita)			
Sources of Financing	2003	2004	2005
Total Health Expenditure (THE)	39.76	44.67	54.61
Federal	2.82	6.52	7.32
State	2.90	3.22	4.42
LGA	1.71	2.05	2.51
Development Partners	1.67	2.05	2.02

Table 1: Estimated health expenditure from the NHA 2003 – 2005

The parameters applied in the computation are population of 128,568,961.362 with an Exchange rate of N129.7 to \$1 for 2003; 132,272,975.171 with an Exchange rate of N133.5 to \$1 for 2004; and 136,082,929.853 with an Exchange rate of N131.43 to \$1 for 2005.

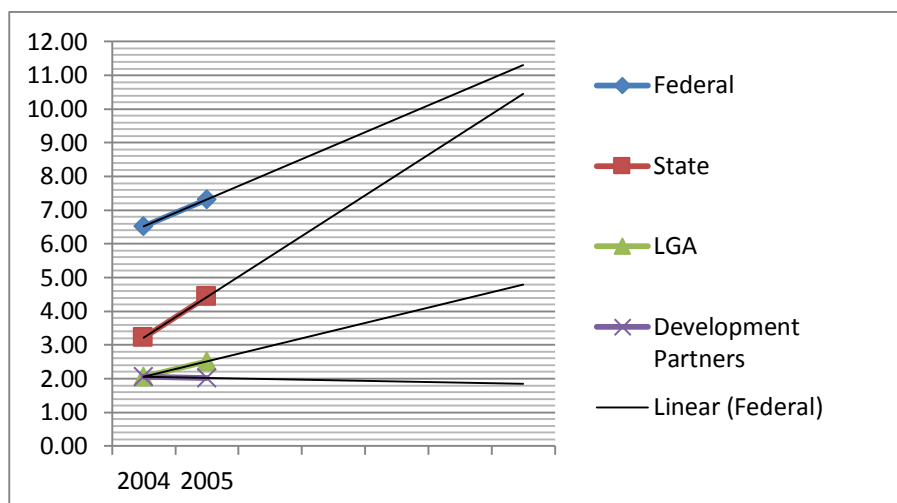


Fig 3: 2004 – 2005 Trend of funding

6.4 Financing gap

The estimated per capita cost for delivering the evidence based plans prepared by the states and Federal Government for the year 2010 is USD 31.6. This is fairly close to the costs estimated by Commission for Macroeconomics in Health for delivering an essential health care package (USD 34) and it can be assumed that this is the minimum annual requirement to ensure provision of essential health services for all Nigerians.

A review of the National Health Accounts data indicates a linear growth for the years 2003 – 2005 and assuming that the current trends in public expenditure by all three levels of Government will continue to grow in this linear fashion until the year 2010 and support from the development partners is sustained, the resource envelope available for delivering the essential health care package would be about USD 28.1 per capita, leaving a financing gap of USD 3.5 per capita needed for implementing the NHSDP for the specified year. In absolute terms this will translate to a short fall of nearly USD 500 million per annum, applying a population of about 142,857,142.857.

Projected Public Expenditure on Health in 2010 (USD/Capita)	
Federal	11.1
State	10.4
LGA	4.8
Development Partners	1.8
TOTAL	28.1

Table 2: Projected funds for 2010

These financial projections take into consideration a focus on the allocation of such funds for the implementation of the Strategic priorities within the NSHDP with a primary focus on high impact

and cost effective delivery of essential health services and operation of the federal health facilities at their current levels. The estimated costs also take into consideration the marginal increase in resources required for addressing the identified bottlenecks in service delivery to optimize the public expenditure on delivery of essential health services. Another assumption is that the funds would be deployed with strong results focus for such additional investments in the health sector, from both domestic as well as support from external partners. Finally, it is important to note that demographic transition is taking place in Nigeria and disease pattern is also gradually changing. Increasing burden of non-communicable diseases, injuries and accidents will require additional investments as well as effective social health insurance schemes to safeguard against financial barriers to health services and risk pooling mechanisms to ensure value for huge out of pocket expenditures being incurred by Nigerian households. It is therefore important to note that the funding projections and estimated funding gaps do not cater for huge capital investments in health infrastructure.

6.3 Financing the plan: Strategic Investment plan

As highlighted in previous sub-sections of this Chapter, strategy for financing the NSHDP is not solely dependent on increases in federal, state and LGA government spending, as it also requires actions by all actors in the health sector - DPs, CSOs, private sector and philanthropists to make the best of all available resources to the sector. The strategic investment plan underwrites the effective implementation of the NSHDP towards achieving measurable results by providing a clear guidance on financing. The expenditure targets will only be achieved if resource commitments are met. While on an annual basis, expenditure plans and budgets need to match available resources to meet the priorities identified by the annual operational plans to reach NHSDP targets. It is important to ensure flexibility of government funding and untied aid by development partners to the health sector on an yearly basis to allow for necessary budget reviews that may require tradeoffs, trimmings, re-prioritization of earmarked funds, etc.

In resourcing the NSHDP therefore, three core principles are considered as platforms for leveraging funds from the various sources within and outside the Nigerian health system;

1. Optimizing the effectiveness of existing investments in the health sector spending by Federal, State and LGA governments
2. Ensuring all additional investments in the health sector - from governments and development partners - have strong results focus and support the achievement of NHSDP results framework.
3. Ensuring better value for expenditures being incurred by households through promoting effective social health insurance and risk pooling mechanisms

Optimizing the effectiveness of existing investments in the health sector spending by Federal, State and LGA governments

Efficiency of spending in the sector will be determined if healthcare resources are being utilized to get the best value for money. Efficiency in the Nigerian health system will therefore be concerned with the relationship between resource inputs (costs, in the form of labour, capital, or equipment) and intermediate outputs (numbers treated, waiting time, etc) and final health outcomes (lives saved, life years gained, quality adjusted life years (QALYs). In adopting the criterion of economic efficiency, it is implied that the Nigerian society will make choices which maximize the health outcomes gained from the resources allocated to healthcare and this would be substantiated by evidence-based data. Inefficiency in the system will exist when resources could have been reallocated in a way which would increase the health outcomes produced but they are not, as may be true of the current situation. Efforts must therefore be made to achieve Technical efficiency by ensuring that the available resources are deployed to maximum advantage; while ensuring productive efficiency with different combinations of resources in the system in a manner to achieve the maximum health benefit at the given minimal costs. Equally, the system needs to be reviewed to ensure that Allocative efficiency is achieved through the funding of a right mixture of healthcare programmes in order to maximize the health of the Nigerian society. State specific mix of interventions using existing health infrastructure towards addressing identified specific bottlenecks have been analyzed to show marked reductions in the effect of the bottlenecks, while indicating possible impact levels results from such efficiencies.

The THE in Nigeria was put at an estimated \$44.67 per capita for the period 2003 – 2005 and when compared with other developing countries in Africa, though Nigeria’s per capita expenditure ranks higher, some of the countries that have achieved improved health system performance for their populations^{19,20}.

Table 3: Per capita expenditure and health systems performance

Countries	per capita health expd (US \$)	% of GDP	WHO Health system ranking 2000
Ghana (2002)	13.6	4.24	135
Nigeria (2004)	44.67	7.96	187
Egypt (2001/2002)	71.26	6	63
Rwanda (2006)	33.93	11	172
South Africa (1998)	709.22	7.5	175
Malawi (1998)	33.3	7.2	185
Mozambique (1998)	31.51	4	184

¹⁹ 2003 – 2005 Nigeria NHA Estimation, Final Report, 2009.

²⁰ WHO 2000 Health system performance country ranking

As Nigeria is not an aid dependent country, the core operating government budgets at federal, state and LGA for all MDAs therefore needs to be utilized to optimal efficiency levels. By so doing, specific government financial commitments to annual operational budgets and available funds allocated from the federation account to the health sector will be fully optimized. The level of funding determined by policy makers in the FMOH, FMF, Budget office of the federation and accountant general's office, as well as members of the legislative arms of government – the National assembly need to be appropriated and released timely, though in accordance to the national due process procedures and guidelines. Allocation of funds to prioritized areas within the NSHDP to ensure the delivery of high impact cost effective interventions is required with a shift to financing for results, as a pre-requisite for success.

Increased funding of Primary Health Care (PHC) is arguably the most important financing goal for the current Government. Its commitment to the PHC approach and support of the ward health system must be backed up with sufficient financial resources. To explore recent funding and expenditure patterns in this area it is necessary to investigate allocations to different levels of care within the public health care system. The NHA 2003 – 2005 revealed a skewed allocation to curative services (74.2%) rather than public health prevention (12.8%) and to capital investments rather than to service delivery related spending. Such re-allocations need to be effected for currently available funds.

The MDG Debt Relief Gains Virtual Fund, is another important additional source for financing the health sector in Nigeria since 2005, when the Paris Club group of government creditors wrote off about US\$18 billion of Nigeria's debt. The MDG Debt Relief Gains (DRG) for health interventions should be allocated to deliver measurable results. The Virtual Poverty Fund managed by the Office of the Senior Special Assistant to the President on the MDGs (OSSAP,MDGs) disburses the DRG to various government ministries, agencies and departments for projects that are directly pro-poor and can improve the performance of the country towards achieving the MDGs. The table below presents the disbursements for 2006 and 2007.

Table 3: Top-up Revenue Allocated to MDAs from the Debt Relief Gains (billion naira)

Ministry	2007			2006		
	Allocation	Appropriated	% appropriated	Allocation	Appropriated	% appropriated
Education	18.00	15.35	85.29	20.79	18.22	87.65
Health	15.00	15.35	102.32	20.79	21.29	102.4
Agriculture	15.00	15.00	100.00	9.90	9.40	94.95
Water Resources	10.86	13.85	127.51	19.80	19.02	96.04
Power and Steel	10.00	10.11	101.09	14.85	16.96	114.22
Housing	3.00	3.00	100.00	0.50	0.50	100
FCT	2.00	1.80	90.00	-	-	
Youth	1.00	1.00	100.00		0.99	
Women Affairs	1.00	1.02	101.50	0.99	1.00	101.01
NACA	1.00	1.00	100.00	-	-	
WORKS				9.90	9.86	99.55

Environment				1.49	1.49	100
Conditional Grants	22.00	20.00	90.91			
Safety Nets	10.00	10.00	100.00			
Monitoring and Evaluation	2.00	2.00	100.00	1.00	1.00	100
Total	110.86	109.47	98.75	100.00	99.71	99.71

Recently, the DRG funds have been allocated for Community Based Health Insurance Schemes in 12 states (selected facilities and catchment populations in 3 LGAs per state) targeting maternal, newborn and child health services, health system strengthening initiatives and the Midwives Services Scheme. The continued allocation of the DRG funds in support of the National Results framework is critical.

A key resource platform for the NSHDP implementation is the National Health Bill already passed by both the House of Representatives and the Senate and awaiting Presidential Assent. The National Health Bill proposes a major paradigm shift in health financing in Nigeria through the establishment of a Fund to be known as the National Primary Health Care Development Fund. The Fund would be financed from the consolidated fund of the Federation, at an amount not less than 2% of its value; grants by international donor partners; and funds from any other source.

The fund would be allocated as (a) 50% of the fund for the provision of basic minimum package of health services to all citizens, in primary health care facilities through the National Health Insurance Scheme (NHIS); (b) 25% of the fund for essential drugs for primary healthcare services; (c) 15% for the provision and maintenance of facilities, equipment and transport for primary healthcare; and (d) 10 per cent for the development of Human Resources for Primary Health Care services.

The National Primary Health Care Development Agency shall disburse the funds for items b, c, d above totalling 50% through State Primary Health Care Boards for distribution to Local Government Health Authorities. Specific criteria have been detailed for State and LGAs to quality for the funds as grants, inclusive of payment of counterpart funds (LGA – 5% and State 10%)

The National Primary Health Care Development Agency is mandated by the Health Bill to develop appropriate guidelines for the administration, disbursement and monitoring of the fund accruing to the NPHCD fund.

Ensuring that all additional investments in the health sector - from governments and development partners - will have a strong results focus and support the achievement of NHSDP results framework.

Nigeria's National Partnership on Health emerging from the First Presidential Summit on Health by the President and State Governors, is a potential source of additional funding for the sector with the commitment of increasing budget allocations to health at federal, state and LGAs from present levels by at least 25% each year towards meeting the Abuja 2001 Declaration of 15%

national budget allocation to health. In addition, the National Partnership commits to at least 90% budget release and 100% utilization by the end of year in the health sector. This increase in government allocations will ensure the utilization of available fiscal space within the public system at federal, state and LGAs. In applying the funds, it is important that a results focus in support of the NSDHP is achieved.

Another source of finance for the health sector in Nigeria is Official Development Assistance (ODA) from development partners and donors. Between 1999 and 2007, Nigerian received more than N6 billion in both credits and grants from development partners. Out of this, \$3.2 billion were credit while \$2.8 billion were grants. Although the sectoral and zonal distribution of the grants was uneven, the health sector had been the largest recipient. Figure 4 shows the share of donor support to various social sectors.

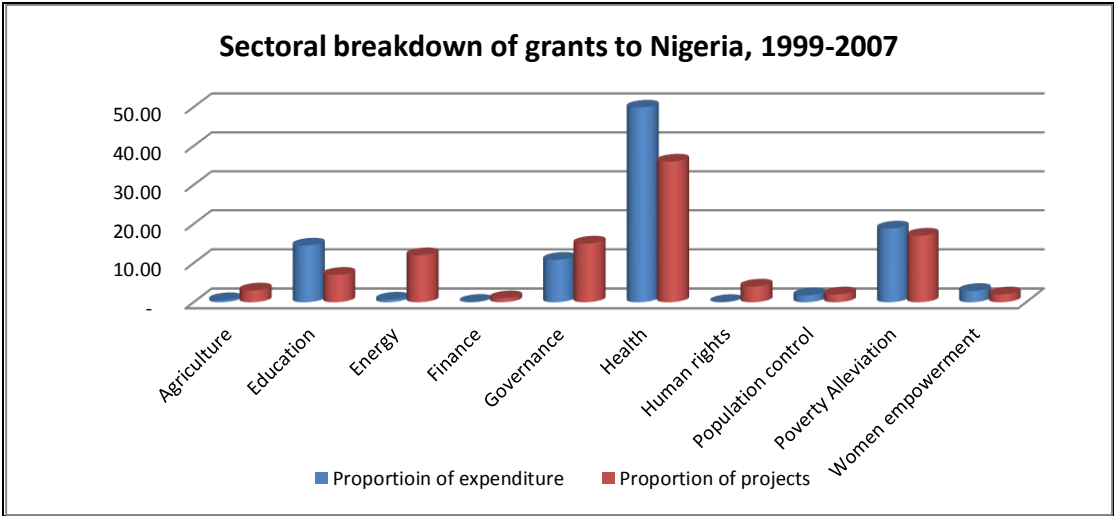


Fig 4: Proportion of donor ODA to sectors in the Nigerian economy

The proposed Country Compact with Development partners in health will provide the enabling platform to sustain present levels of ODA to health and also leverage additional predictable funding for the NSHSP towards achieving measureable health results. In Nigeria, a donor matrix outlining the Development partners’ contribution to the health sector has been developed and serves to be a veritable tool for negotiations of priority areas of the NSHDP to be supported by DPs.

In ensuring that funding opportunities are optimally utilized through the platform of the country compact, considerations need to be given to issues of ensuring the availability of Financial Absorptive capacities for the potential increase in aid. Good governance, sound macroeconomic management, effective public administration all creates absorptive capacities, together with improvement in financial position and effective fiscal management. These are required by each level of government in order to absorb the potential increase in aid flow in the Nigerian health sector in response to the NSHDP. It is also noteworthy that to achieve the desired levels of absorptive capacity, technical assistance from the development partners must be instrumental.

Equally, fiduciary arrangements would need to be strengthened in the event that government and development partners in response to the NSHDP and the country compact explore opportunities for pooled funding arrangements.

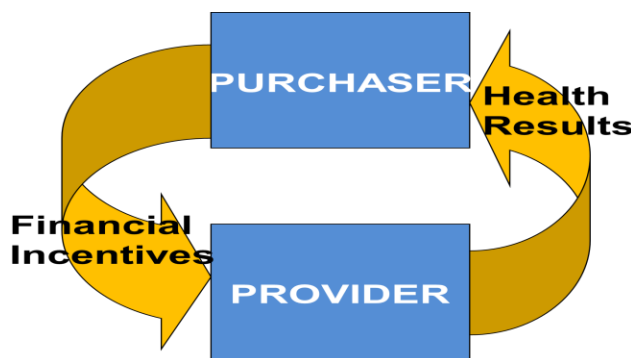
Another platform for ensuring that all additional investments in the health sector have a strong results focus and support the achievement of NHSDP results frameworks is **Innovative Financing Mechanisms**.

The initial approach will include the innovative financing mechanism being pursued by government in mobilizing and channeling additional funds to health through VAT deductions. There is an ongoing collaboration between the Federal Ministry of Health (FMOH), Federal Inland Revenue Service (FIRS), Federal Ministry of Finance (FMF), etc, in these areas while efforts are at advanced levels to strengthening Public Private sector Partnerships (PPP). These additional funding would also be tied to health results.

However, the recent developments have further broadened the scope of innovative financing mechanisms that explicitly link funding to results through mechanisms such as Results Based Financing (RBF), Conditional Cash Transfers (CCTs) and Performance based contracting for health.

The planning process for the NSHDP has highlighted a number of priorities and new ways of resourcing the plan. Linking additional investments in health to results, is a core principle recently adopted by the federal and state ministries of health. Government has indicated its willingness to pilot projects of RBF, CCTs and performance based contracting for health in selected locations that will be determined by technical criteria.

The Performance or results based financing pilots will entail the transfer of money or material goods conditional to implementing a measurable health related action or achieving a predetermined performance target. PBF/RBF is considered a strong financial mechanism which can change the Nigerian health systems by providing performance incentives at health facility level with autonomy to address bottlenecks.



The essential elements for the initiation of PBF include: Performance contract for HF defining rules of the game of PBF; Focus on public health and preventative services conditional on quality of services; Significant and regular incentives to reach health workers based on

performance; ensured autonomy to manage (e.g. finances, resource allocation) for results; Transparent governance systems to manage, verify performance and oversee transparent use of funds. In addition, technical support will be required to establish a good RBF/PBF system and ensure set up of appropriate governance structures and verification systems.

Conditional cash transfers will provide incentives to beneficiaries of health services as a reward to increasing access to and utilization of basic health services, while at the same time creating incentives for behavioural change. In principle, government will transfer cash to poor families in response to the pre-specified actions and will in the short term support the household. In the mid-term the CCTs may accumulate and possibly break the inter-generational trends of poverty. It is important to note that CCTs are only effective when the supply side of the health services is available, reachable and affordable by the families and there are no negative consequences from the health action from one health indicator on another.

Evaluation data and findings from the pilot schemes would guide and inform implementation of these schemes at a larger scale.

Promoting effective risk pooling mechanisms:

Social Health Insurance and Risk pooling mechanism will ensure that users of health services, especially households get better value for the substantive money spent on health with exemption schemes established and strengthened for vulnerable groups (children under five, pregnant women, elderly, poor, etc)

This is underscored by the fact that OOPe contribution to Total Health Expenditure (THE) is estimated at about 69%, indicating the health seeking behaviors and willingness to pay for health services. The need to ensure alternative means of financing the NSHDP towards ensuring universal access to quality and affordable health services is therefore critical to prevent catastrophic burdens and further impoverishment of already poor families.

Though the contribution of health insurance to health financing in Nigeria is still low, it has a high potential of making impact. Over the period of 2003 – 2005, there was a significant increase in health insurance expenditure from one year to the other, even though its contribution to THE, was relatively constant at 2% over the three years. The estimated expenditure on health insurance has increased from about N15.66 billion in 2003 to N21.34 billion in 2005. However, state level analysis shows that health insurance is limited to a few states. Even where they exist, except in Lagos State, it accounts for just 1 to 2% of STHE. The fact that health insurance is growing even if minimally and the fact that households are paying for their health as evidenced by the high share of HHHE in both SGHE and STHE, suggests the importance of effective risk pooling. The social health insurance (SHI) introduced recently in the formal sector has a high potential for expansion to the informal sector. Accordingly, SHI needs to be made inclusive by extending it to the informal sector. The NHIS in early 2009 developed the blueprint for implementing the Community-based Social Health Insurance Programme (CBSHIP) in the informal sector, which is currently being piloted in 12 states of the country with plans to scale up to the entire country by end of 2011.

In summary, these three core principles provide tremendous means of leveraging resources to finance the NSHDP and are consistent with the principles and provisions of the National Health Financing Policy²¹. However, considering the limited financial resources, financing the NSHDP may require a phased approach in line with the M&E results matrix for the periods (i) 2010 – 2011; (ii) 2012 – 2013 and (iii) 2014 – 2015. The availability of funding would be consequent upon predictable, sustainable and sufficient financial resources mobilized from both domestic and external sources. Prioritized areas for action should receive priority funding using the phased approach.

6.4 Financial monitoring and economic evaluations

There is a wide spatial disparity in health care expenditure and its delivery across Nigeria, highlighting the concerns of equity. The spatial differences involve contributions and roles of government and the private sector both in funding health care and in health care delivery in the country. This issue highlighted in Chapter 5 requires action in addressing the equity gaps by the application and allocation of additional funding and investments to health. In general, households dominate in funding health care across the country however; there were some states in the north where the burden was much higher than the average. This showed that poor households in these states would be mostly vulnerable for health shocks. Governments at all levels therefore needs to direct efforts at minimizing these disparities in health financing and in the provision of health services by working towards equitable access to health financing and health care delivery.

Budget monitoring and expenditure tracking during the implementation phase of NSHDP and institutionalization of NHAs, PERs, and economic evaluations including Public Expenditure Tracking Studies will provide routine and survey data and information on key data variables required to support governance actions, transparency and accountability in the sector, while informing further revision of the financial plan to address equity, amongst other issues.

A Health financing task force comprising of government and representatives of development partners, the private sector and CSOs bodies with requisite technical expertise and experience is proposed to be established to function as a think tank and guide the efforts to ensure effective resourcing of the NSHDP and regularly advice government, and DPs accordingly. This is akin to such bodies that advice the G8, the international donor community, the AU and some national governments in Africa. The main task of the team would be to ensure predictable and adequate levels of resources for the implementation of the NSHDP. The team would be required to work in close collaboration with M&E teams to ensure value for money in the utilization of the resources towards achieving measurable results.

²¹ Federal Ministry of Health, Nigeria National Health Financing Policy, 2006

Chapter 7: Implementation Modalities

The NSHDP provides strategic direction for collective action by the Nigerian health system partners to achieve the vision and goal of the health sector to promote and protect health for all, eliminate health disparities, and transform the Nigerian health system. It is a flexible, living document designed to address the national health and system priorities.

The NSHDP is linked to the Vision 20:2020 which represents the national priorities, strategies and implementation framework for the whole national economy. The NSHDP is an expanded version of the Vision 20:2020 chapter on health and presents a more detailed analysis of the existing situation, sector priorities, proposed strategies and expected outputs. It will serve as the tool for implementing the health component of the Vision document. The Vision 20:2020 implementation plan (which contains the National Health Objectives, the National Health Policy Targets, the Vision 20:2020 Medium Term Plan for Health, as well as detailed description of programmes and projects) coupled with the Medium Term Sector Strategy (MTSS) will serve as important tools for implementing the NSHDP through annual operational plans for all planning entities at all levels of care, federal, states, LGAs and development partners (in the IHP+ compact process).

The implementation of the NSHDP is the responsibility of the authorities at the three different levels of the health care delivery system – Federal, State and LGA, in collaboration with all the stakeholders in health including the private sector, development partner agencies, NGOs in health, civil society groups, faith based organisations and communities.

Coordination of the Implementation

The leadership for the Implementation of the NSHDP at each level will be provided by the responsible authority – Federal Ministry of Health at Federal Level, State Ministry of Health at the State Level, and Local Government Health Authority at the Local Government Level.

An SHDP implementation steering committee will be established at the Federal and State levels to monitor the implementation of the plan accordingly. The steering committee will be chaired the Permanent Secretary, Health at the Federal Ministry of Health, the Honourable Commissioner for Health at the State Level and the Chairman of the Local Health Management Team at the LGA level. It shall have representatives from the relevant departments/Units at the FMOH, SMOH and LGA Health Management Team, representatives of Planning Commission Ministries at all levels, and relevant development partner agencies. The committee will be responsible for catalysing the implementation of the plans at each of the levels; mobilising government support for implementation through advocacy planning and implementation; resource mobilisation, awareness creation and engagement of all stakeholders that are crucial to the implementation of the plans

Operational Plans

Based on peculiar priorities, the Federal, State and LGAs will extract strategic activities from their SHDPs, to develop their MTSS and annual operational plans. These plans will show

detailed activities that are linked to key deliverables towards the achievement of the targets of the plans. Technical assistance will be provided to the Federal, State and LGAs to develop plans with realistic costing and stakeholder participation to facilitate implementation. It is the responsibility of the Departments of Planning Research and Statistics at all levels to ensure that these plans are developed annually and to monitor their implementation using a suitable tool that ties deliverables to the results/targets of their respective SHDPs. To this effect, the FMOH will prepare and disseminate specific guidelines on how to operationalize the NSHDP into MTSS and annual operational plans.

Resources

The NSHDP will have a direct influence on resource requirements, mobilization and allocation to the health sector. The implementation of the SHDP at all levels requires committed human and financial resources. Dedicated resources are required to facilitate the meetings of the steering committee; strengthen the DPRS at all levels in planning, monitoring and reporting on progress and implementation of the M&E plan. A core technical staff will be identified in the DPRS at each level, who will be empowered with necessary skills in planning, monitoring and evaluation and tools to facilitate their work. The SHDP implementation steering committee is responsible for identifying resource needs and mobilisation from governments and development partner agencies. Resource mobilization and allocation will be directed towards addressing the health sector priority interventions to achieve the vision and goal of the NSHDP.

Managing implementation

The SHDP implementation steering committee and the DPRS at each level will be responsible for managing the implementation of the SHDPs. Managing implementation of the SHDPs will require provision of TA for development of operational plans; orientation of all stakeholders on the plan and required actions and responsibilities for achieving the targets of the plan; progress review and feedback.

Global progress review and feedback

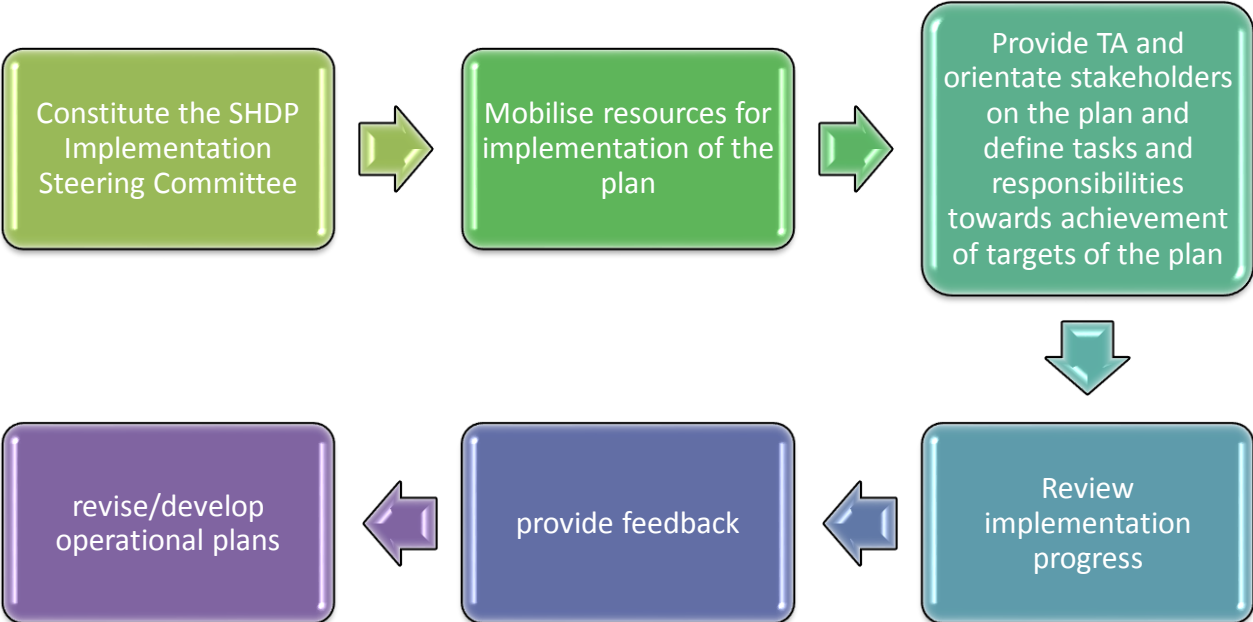
The FMOH will review overall progress of the implementation of the NSHDP periodically and will provide feedback to all the states highlighting their progress towards achievement of the targets in the Presidential Health Summit Declaration. Since all governments have signed onto this declaration, which has committed them to delivering on key results and targets of the NSHDP, this activity will facilitate accountability and provide information that will enable healthy competition among the States. The development partner agencies, CSOs and media will be closely involved in this process.

Development Partner Agencies

The Country Compact on the NSHDP requires development partner agencies to align with and support the implementation of the NSHDP at all levels. In line with this compact therefore, development partner agencies are important and key stakeholders in the implementation of the NSHDP, and the SHDPs at the Federal, State and LGA.

All development partner agencies in health will engage with the responsible authority at the Federal, and State levels to support the implementation of the SHDPs, especially in providing technical support and building the capacity of the implementation teams at all levels in planning, progress monitoring and evaluation among others. They will provide financial support for the implementation of the SHDPs within the limits of their resources and extant financial policies.

Key Steps



Annexes