

WE ARE ON TRACK TO REACH OUR DESTINATION

MAKING NIGERIANS HEALTHY

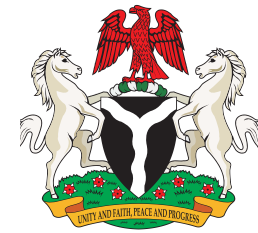


WE ARE ACHIEVING OUR GOALS

- GOAL ONE**
More vaccines are being purchased; new vaccines are being introduced and better coverage of routine immunisation activities
- GOAL TWO**
More health centres are being refurbished, equipped and staffed
- GOAL THREE**
More frontline health workers, midwives and Community Health Workers are being trained
- GOAL FOUR**
Better processes and procedures are being implemented
- GOAL FIVE**
More equipment, facilities and training are being provided to help staff deliver effective results
- GOAL SIX**
Better partnerships are being forged with international organisations and NGOs
- GOAL SEVEN**
Engaging traditional and religious leaders as well as Ward Committees in better and more effective ways



ACTIVITY AND PROGRESS REPORT OF THE NATIONAL PRIMARY HEALTH CARE DEVELOPMENT AGENCY



Federal Republic of Nigeria



National Primary Health Care Development Agency

GOAL 5 CREATE A HIGH PERFORMANCE AND EMPOWERED WORKFORCE 		GOAL 7 ENGAGE COMMUNITIES 		GOAL 1 CONTROL PREVENTABLE DISEASES
		GOAL 2 IMPROVE ACCESS 		
	GOAL 6 STRENGTHEN PARTNERSHIPS 			
GOAL 3 IMPROVE QUALITY 				GOAL 4 STRENGTHEN INSTITUTIONS

PRIMARY HEALTH CARE IN FOCUS 2012

Primary Health Care in Focus 2012

Activity and Progress Report of the National Primary Health Care Development Agency

An official publication of the National Primary Health Care Development Agency

Primary Health Care in Focus 2012

Activity and Progress Report of the National Primary
Health Care Development Agency

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This is a publication of the National Primary Health Care Development Agency to serve as a review of its work in the year 2012 under the leadership of Dr. Ado J G Muhammad. Dr Ado J G Muhammad was appointed Executive Director/CEO of the National Primary Health Care Development Agency (NPHCDA) on the 1st November 2011. Prior to his Appointment, Dr Ado J G Muhammad served as a Special Assistant in the State House, Abuja.

Dr. Ado J G Muhammad comes to the NPHCDA with a wealth of experience spanning over 20 years in the Health and Public Service Sectors; having also worked in the capacity of the Senior Technical Adviser (Health Sector) in the Office of the Senior Assistant to the President on MDGs and as National Health Adviser for the Bamako Initiative Programme of the Petroleum Trust Fund amongst other top management positions. Dr. Ado J G Muhammad is a former Staff of the defunct National Programme on Immunization (NPI), which was merged, with the NPHCDA in 2007.

Dr. Ado J G Muhammad is a graduate of the School of Medicine, University of Ilorin Nigeria and also possesses a Masters in Public Health from University of Wales, United Kingdom; amongst other professional certification.

"We have made extraordinary progress in improving access to primary health care in recent years. Through increased funding, political commitment and a clear strategy, we are taking the next great strides towards making Nigerians healthy."

Dr Ado Jimada Gana Muhammad

Executive Director, NPHCDA



HIS EXCELLENCY

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PRESIDENT, COMMANDER IN CHIEF OF THE ARMED FORCES
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DR ADO JIMADA GANA MUHAMMAD

THE EXECUTIVE DIRECTOR NATIONAL PRIMARY HEALTH CARE DEVELOPMENT AGENCY

Glossary

AFP – Acute Flaccid Paralysis

ALGON – Association of Local Government Organizations of Nigeria

BMGF – Bill and Melinda Gates Foundation

CBO – Community Based Organizations

CBHI(S) – Community Based Health Insurance (Scheme)

CDC – Centers for Disease Control

CHAI – Clinton Health Access Initiative

CHSD – Community Health Services Department

CMD – Centre for Management Development

CSO – Community Service Organization

CSM – Cerebro Spinal Meningitis

ERC – Expert Review Committee

ERP – Enterprise Resource Planning

ESRI – Economic and Social Research Institute

FBOs – Faith Based Organizations

FCT – Federal Capital Territory

FMOH – Federal Ministry of Health

FOMWAN – Federation of Muslim Women's Associations in Nigeria

GAVI – Global Alliance for Vaccines and Immunisation

GIS – Geographic Information System

G(PEI) – (Global) Polio Eradication Initiative

GPS – Global Positioning System

GSM – Global System for Mobile Communications

HC – Health Centre

HLS – Health Life Style

HRH – Human Resources for Health

ICC – Inter-Agency Coordination Committee

ICM – International Confederation of Midwives

ICCM – Integrated Community Case Management

IDA – International Development Association

IPD – Immunization Plus Day

KM – Knowledge Management

LGA – Local Government Association

MCH – Maternal and Child Health

MDG – Millennium Development Goals

MLMT – Mid-Level Management Training (Programme)

MNT – Maternal and Neonatal Tetanus

MNCHW – Maternal, Newborn and Child Health Week

MOU – Memorandum of Understanding

MSS – Midwives Services Scheme

NACA – National Agency for the Control of AIDS

NAFDAC – National Agency for Food and Drug Administration and Control

NGO – Non-Governmental Organization

NHIS – National Health Insurance Scheme

NIFAA – Nigeria Interfaith Action Association

NMCP – National Malaria Control Programme

NPHCDA – National Primary Health Care
Development Agency

NYSC – National Youth Service Corps

ORS – Oral Rehydration Salts

OHCSF – Office of the Head of Civil Service of the
Federation

PBF – Performance-Based Financing

PBM – Pharmaceutical Benefit Management

PEI – Polio Eradication Initiative

PHC – Primary Health Care / Centre

PHCSD – Primary Health Care Systems Development
(Department)

PSSHIP – Public Sector Social Health Insurance
Programme

PSRHN – Private Sector Roundtable on Health in
Nigeria

PTFoPE – Presidential Task Force on Polio Eradication

QoC – Quality of Care

RI – Routine Immunization

SIA – State Inter-agency

STF – State Task Force

SIACC – State Inter-agency Coordination Committee

SURE-P – Subsidy Reinvestment Programme

SIADs – Short Interval Additional Dose strategy

SIPD – Strategic Immunization Plus Day

SOP – Standard Operating Procedure

STF/SIACC – State Task Force/State Inter-agency
Coordination Committee

SURE-P – Subsidy Reinvestment Programme on
Maternal and Child Health

TMC – Top Management Committee

TMM – Top Management Meeting

UNICEF – United Nations Children’s Fund

VCM – Volunteer Community Mobilizers

VDC – Village Development Committees

WDC – Ward Development Committees

WHO – World Health Organisation

WMHCP – Ward Minimum Health Care Plan

WPV – Wild Polio Virus

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Introduction

“We have made extraordinary progress in improving access to primary health care in recent years. Through increased funding, political commitment and a clear strategy, we are taking the next great strides towards making Nigerians healthy.”

Achieving our aim requires a focused, coordinated approach. In 2011 we identified seven strategic goals. They are the critical paths to success, and our blueprint for making Nigerians healthy.

In April 2012, the NPHCDA top management team met to review progress and revise the milestones that would bring us closer to achieving each individual goal. This booklet is a record of our progress against each of the goals during 2012.

Our efforts in respect of *Goal 1: Control preventable diseases* have been as intense as they have been widespread. Coordinated health promotion and social mobilization activities, combined with improved operational effectiveness and strong accountability measures, have driven our progress towards interrupting the spread of polio. And in distributing the MenAfriVac vaccine we have protected the lives of 17 million children.

Improving access to primary health care is the focus of Goal 2. The success of the Midwives Services Scheme has clearly demonstrated how we can transform services within Nigeria, and change lives as a result. Yet Goal 2 takes us further, working to make affordable health care available for all through CBHIS. Through performance-based financing we are establishing a new basis for health care in Nigeria that provides funds based on real, tangible results.

We believe it is not enough to improve access to health care without also improving the quality. Goal 3 details our work to recruit, train and retain doctors and midwives, and ensure their skills are accessible across the country.

Improving the structure and technology of our intra-Agency communications and infrastructure





Minister of State for Health, Dr Ali-Pate and the Executive Director, Dr Ado J G Muhammad at a polio torch event.

makes a difference to health workers on the ground in remote areas. It also improves the level of cross-Agency understanding and knowledge management. *Goal 4 – Strengthen Institutions* examines our work to improve the health infrastructure so we can better serve our communities.

Creating a high performance and empowered workforce is about more than training. From orientation to pay and promotion, *Goal 5* examines the progress we have made in developing an environment in which people want to work.

Partnerships are at the heart of our work to make Nigerians healthy. Many of the local, national and international organizations with whom we are working feature prominently throughout this booklet. *Goal 6 – Strengthen partnerships* focuses on the impact our relationships have, particularly with regard to Saving One Million Lives.

Our final goal is, in many ways, the one that binds the others together. Unless Nigeria's key influencers speak as one we cannot make the progress we need.

Thankfully, our efforts to engage communities have resulted in a unified, common approach amongst Ward Development Committees, traditional and religious leaders, LGA chairmen, health workers, and volunteers. From the Walk 4 Life to the ongoing success of Maternal, Newborn and Child Health Week, we are ensuring that we are reaching and engaging with Nigerians, wherever they are.

This booklet serves as a milestone in its own right. It is recognition of the fact that although we have come so far, we still have more to do. 2012 was a year when the NPHCDA embedded principles of recruitment, retention, performance pay, procurement, partnerships, community insurance and more that will serve us well for the future. In 2013, we will do more.

Dr Ado Jimada Gana Muhammad
Executive Director, NPHCDA

“Nigeria has made extraordinary progress in improving access to vaccination in recent years.”



So says the World Pneumonia Day Organisation, yet their comments are valid for far more than pneumonia.

According to WHO/UNICEF estimates, we more than doubled diphtheria, tetanus and pertussis coverage from 29% to 69% between 2000 and 2010. We have reduced measles mortality by 98%, with incidences dropping from 18,000 per million to 1.8 per million.

Despite a recent increase in polio cases, we should feel proud that the measures we have taken have reduced polio to a fraction of historic levels. We can do more. We must do more. That is why the NCHCDA continues to work with its partners to put more funding in place and more qualified health workers on the ground – especially in remote areas. It is why we have improved logistics to improve the efficiency and effectiveness of cold chains.

It is also why we work ceaselessly to promote the value of vaccination. With the help of health workers, government, traditional leaders, aid partners and the media, our recent vaccination campaigns prove those messages are reaching the people who need to hear them.

About a quarter of the children who die in Nigeria each year do so as a result of vaccine-preventable diseases. Yet if a disease is vaccine-preventable, surely it is our duty to prevent it.

Dr Emmanuel Abanida

Director, Immunization and Disease Control

Goal 1 Milestones

Interrupt Polio 2012

Stop exportation

Accountability

New innovations

Enhanced surveillance

Fix logistics

Conduct 1, 2, 3 Strategy

Vaccine availability

Engaging the private providers

Health promotion/social mobilization

Cerebro Spinal Meningitis

Control of Men A serotype

Reduce burden of PBM by 10%

Health promotion

Strengthen lab of surveillance

Cholera

Health education targeted at communities

Support states/LGA with case management



Eradicate polio and control vaccine-preventable, communicable and non-communicable diseases using immunization, health promotion, biological control and other proven interventions.

Goal 1

Interrupt Polio 2012

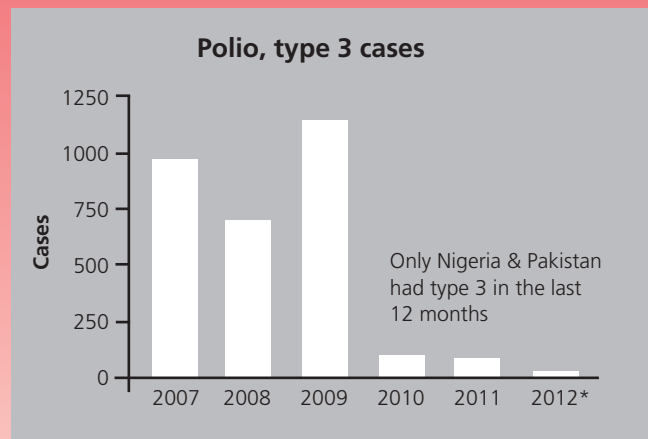
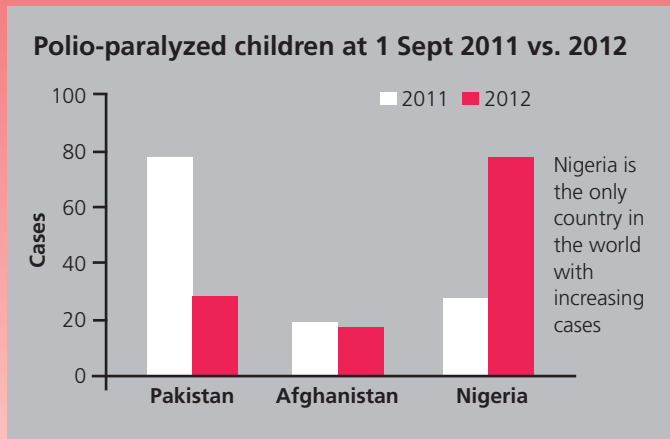
Stop exportation and transmission of WPV

Polio in Nigeria – a recent history

2006
1200 cases of polio are reported

2010
Reported cases drop further – by 95% compared to 2009 figures

2009
Case numbers drop significantly



* 1 Sept 2012: Nigeria = 16 cases; Pakistan = 2 cases

2012

Only one case of mutagenus (Type 2) poliovirus is recorded compared to 35 cases in 2011

- Since 2009, Nigeria has not recorded more than double digit numbers of WPV cases
- 70% of States and 94% of LGAs have been polio free for the past two years
- Population immunity across all states continues to increase (2010 – 73%; 2011 – 78%; 2012 – 80%)

2011

Despite best efforts, transmission of all three serotypes of poliovirus increases. Numbers increase again in 2012

Virus transmission levels remain historically low and are not comparable to the multiple hundreds of cases reported prior to 2010. Additionally, cases are largely localised. 60% of cases have been reported from just three states, yet we must meet any increase with the resolve to do more.



The Vice President of the Federal Republic of Nigeria, Namadi Sambo flags-off the National Polio Free Campaign.

Nigeria's National Emergency Plan - interrupting poliovirus transmission

The setback we experienced in polio eradication over the past two years is being treated as an emergency by the Nigerian national authorities.

With the support of Global Polio Eradication Initiative (GPEI) partners and the NPHCDA, the Federal Government developed a Polio Eradication Emergency Plan, the main aim of which was to achieve interruption of poliovirus transmission by the end of 2012.

Additionally, the Plan seeks to ensure that:

- The number of children who miss vaccination is dramatically reduced through new micro-planning techniques applied by well-skilled, well-motivated and well-led NPHCDA vaccinators and supervisors

- The work of traditional leaders in overcoming resistance to vaccination is sustained
- Strong advocacy delivers increased and continuing support from policy makers and opinion moulders
- Local religious clerics are systematically engaged in responding to rumours and misinformation
- A revisit strategy is established for missed children, migrants and nomadic children
- Surveillance reviews are rapid and recommendations are implemented
- Nigeria delivers full advantage from proven innovations/interventions
- Accountability at every level of activity increases, ensuring those hired to assist in the polio eradication programme do so

Eradication activities

The NPHCDA's actions have been driven by the requirements of the Emergency Plan and the

Presidential Task Force on Polio Eradication's (PTFoPE) five-prong approach to eradicating polio.

This five-pronged approach encompasses:

- Political commitment
- Coordination
- Accountability
- Ensuring operational effectiveness
- Finance

Political commitment

Our continued advocacy in support of the Presidential Task Force on Polio Eradication and the Honourable Minister of State for Health is aimed at sustaining the improvements in ownership secured under the Abuja Commitments.

Measures include:

- Written feedback to all states
- High level advocacy visits to specific states
- Timely meetings of PEI Task Forces
- Timely release of funds

At the Presidential Task Force meeting in Abuja during July 2012, the President of Nigeria urged Governors of high risk states to double their efforts towards polio eradication within their respective domains. He added that members of the Northern Traditional Leaders' Committee should mobilize and encourage their respective communities to immunize children against the poliovirus.

The NCHPDA's Executive Director/CEO reinforced this message in his discussions with Governors.

Coordination

LGA Chairmen are being encouraged to hold Task Force meetings 7–10 days before every 'Immunization Plus Day' and conduct in-between round activities e.g. routine immunization outreaches.

Governors are being similarly encouraged to make LGA Chairmen accountable for eradicating polio from their LGAs.

Governors across the country have worked closely with the NPHCDA to promote – and become actively involved in – immunization activities within their states.

Ensuring operational effectiveness

Repeat vaccinations:

We continue to focus repeat vaccinations on 219 wards identified as having the greatest vulnerability or highest incidences of polio. Already such revaccinations using the Short Interval Additional Dose strategy (SIADs) have been conducted in nomadic populations of Katsina, Kaduna, Yobe, Borno and Sokoto States.

Additional support:

High risk states are receiving additional personnel at Ward and LGA level from partners including WHO, UNICEF, Rotary, BMGF and CDC. They are also receiving increased technical support from senior NPHCDA staff, WHO staff and WHO medical officers from India.

Improving performance:

Teams are being restructured to deliver continuously improving performance.

Improved micro-planning:

The quality of our micro-planning is improving through the use of Geographic Information Systems (GIS) and becoming more strongly linked to performance and accountability.

Better remuneration:

Vaccination teams are better remunerated. Rewarding success is helping to drive further improvements.

Finance

The World Bank announced its Board approval of an International Development Association (IDA) credit of US\$95 million for the Nigeria Polio Eradication Support Project, which will help the country achieve and sustain at least 80% polio immunization across all states, supporting the eventual eradication of the disease from Nigeria.

The project will finance roughly 655 million doses of oral polio vaccine for children under age five across Nigeria, with a special focus on the northern states where polio is endemic.

For our part, the NCHPDA is releasing funds 14 days prior to implementation, ensuring immunization activities have the timely financial support they need.

Accountability

National level

The Presidential Task Force on Polio Eradication (PTFoPE)

The PTFoPE was officially inaugurated by His Excellency President Goodluck Jonathan on 1 March 2012. The PTFoPE has the overall objective of providing leadership support to Nigeria's efforts to accelerate interruption of poliovirus transmission by end of 2012.

The PTFoPE is chaired by the Honourable Minister of State for Health and has membership drawn from the National Assembly (Chairman of the Senate Committee on Health, Chairman of the House Committee on Health), National Primary Health Care Development Agency, Federal Ministry of Health, polio high risk and polio-free states, Northern Traditional Leaders Committee on Primary Health Care, Nigeria Inter-Faith Group, Nigeria Governors Forum and GPEI Partners.

The PTFoPE meets monthly to review the progress in polio eradication with specific attention being given to the status of implementation of the 2012 PEI emergency plan.

Key areas reviewed during PTFoPE monthly meetings include:

- Reports on the Abuja Commitments
- Status of funding for priority PEI activities including timing of funding release
- Quality of PEI activities (SIA, Surveillance, RI), particularly in the highest risk areas
- Actions undertaken to address sub-optimal programme performance
- Monthly reports on the national accountability framework from all 36 states and FCT

Following their meetings, the PTFoPE is expected to:

- Provide reports to Mr President with recommendations for improvement actions





Presidential Task Force on Polio Eradication, 2nd July, 2012.

- Provide feedback to Governors and Chairs of State PEI Task Forces
- Plan high level advocacy visits to areas with particular challenges
- Organize periodic meetings with State PEI Task Forces

Inter-Agency Coordination Committee (ICC)

The ICC is chaired by the Honourable Minister of Health and oversees all immunization activities in the country including polio eradication.

Membership of the ICC is from the Federal Ministry of Health, National Primary Health Care Development Agency, NAFDAC and Partner Agencies including ALGON.

The ICC ensures seamless coordination of polio eradication activities with the broader immunization and PHC agenda in Nigeria. The ICC is expected to meet at least once monthly.

Core Group and ICC Working Groups

The Core Group is chaired by the CEO/ED of NPHCDA with members from NPHCDA, relevant ministries, international organizations, donors and civil society.

Working groups – including in the areas of operations, vaccines, logistics, monitoring and evaluation, routine immunization and social mobilization – support the Core Group.

Responsibilities of the Core Group include:

- **Monitoring:** the Core Group ensures monitoring of implementation of the 2012 PEI emergency plan as well as monthly monitoring of the State and LGA Accountability Framework
- **Reporting:** the Core Group (a) ensures the necessary reports, including a report on the State and LGA Accountability Framework, are prepared for the Secretariat to transmit to the Presidential Task Force in a timely fashion; and (b) provides summary updates from each meeting to the Task Force Chairman
- **Advisory:** the Core Group identifies specific challenges to polio eradication and recommends practical solutions to the Task Force
- **Implementation:** the Core Group facilitates the implementation and follow-up of Task Force decisions
- **Feedback and Information sharing:** the Core Group ensures information sharing mechanisms, including email lists, distribute pertinent and timely information about polio eradication to the National Task Force and relevant partners

State level

State Task Force/State Inter-agency Coordination Committee (STF/SIACC)

The STF/SIACC are established under the auspices of the Governor and include membership from State Ministries, Departments and Agencies including Local Government, Health, Women's Affairs, Education, Local Government Commission, National Orientation Agency; and Civil Society including Traditional and Religious Leaders as well as partners.

Similar to the PTFoPE, the STF/SIACC is expected to meet at least once monthly to review the overall status of polio eradication in the state with particular attention being given to the status of implementation of the 2012 PEI Emergency Plan in the highest risk areas.

Key areas reviewed during the monthly meetings of STF/SIACC include:

- Status of implementation of the Abuja Commitments
- Status of funding for priority PEI activities, including timing of funding release
- Quality of PEI activities (SIA, Surveillance, RI) particularly in the highest risk LGAs and wards
- Actions undertaken to address sub-optimal programme performance
- Monthly reports on the national accountability framework from all LGAs in the state

The STF/SIACC is expected to support the functioning of LGA Task Forces and provide required technical and/or advocacy support to LGAs with persistent sub-optimal performance. The State Task Forces are also expected to maintain a close functional relationship with the PTFoPE.

SIPD monitoring, September 2012.





*Polio Free Torch Campaign in Kano State
22nd and 23rd December, 2011.*

Local Government Area level

LGA Task Force

The LGA Task Force is chaired by the LGA Chairman with members drawn from senior members of the Local Government Council, councillors for health, District Heads and members of the LGA Technical Team.

The LGA Task Force is responsible for ensuring that priority activities required to ensure high quality implementation of PEI activities in the LGA are fully implemented as recommended.

LGA Task Forces are expected to provide regular feedback to the State Task Force. Wherever required, the State Task Forces will organize capacity building for LGA Task Forces.

The Accountability Framework

The Accountability Framework (see Appendix 1) is a tool to help raise population immunity to above the critical threshold required to achieve interruption of persistent transmission in infected, high-risk and vulnerable LGAs. The Framework aids the identification of critical barriers and solutions to improved quality of PEI activities. It also helps to hold individuals responsible for delivering rapid improvement so that polio transmission can be stopped in Nigeria.

Principles of the accountability framework include:

- **Promoting individual accountability at every level:** People have been hired to achieve specific terms of reference for the polio eradication programme. The framework helps to identify those

who are performing and those who are not, and to consider rewards and consequences accordingly

- **Rewards for strong performance:** The individuals who demonstrate strong performance should be recognized through a new reward programme. The programme will develop a standardized reward scheme to recognize top performers in wards, LGAs and states. Rewards can include public recognition, a congratulatory meeting with a senior leader, an award certificate, a mention in the media, enrolment in training of choice, etc
- **Consequences for weak performance:** All weak performance will be documented and reported to appropriate policy makers and stake-holders. Demonstrated weak performance will be sanctioned. Weak performance at the individual level will be accompanied by sanctions including warnings, withholding of allowances and/or disengagement from the programme
- **Evidence based decision making:** Assessments of critical impediments, their solutions, staff performance and progress will be evidence based
- **Independent assessments every month:** The programme will conduct random independent assessments of critical impediments, solutions and performance at LGA and state levels throughout the year
- **Feedback to all levels:** Constant feedback loops between wards, LGAs, state, Core Group and Presidential Task Force are critical to ensure a coordinated response and common understanding of challenges and progress

New innovations

New methods, strategies and technologies are helping the NPHCDA in our mission to interrupt the spread of WPV.

Among these improvements are:

- **Improved micro-planning:** This helps to identify settlements, including nomadic populations, which have not been traditionally easy to access
- **Improved immunization strategies:** Organisational and strategic change is helping vaccination teams deliver a better service
- **Improved technology:** The Geographic Information System (GIS) aids team-tracking and settlement identification. Satellite imagery through

GIS will be used to geo-code settlements, helping vaccination teams plan their work

- Revised team selection and training is producing more well-trained and supervised vaccinator teams
- Vaccination teams are receiving the vaccines, vaccine carriers and transportation they need to carry out their duties

Enhanced surveillance

We have enhanced our surveillance of acute flaccid paralysis (AFP), the most common indicator of Wild Polio Virus. Detecting it requires a rigorous and comprehensive surveillance regime.

Surveillance activities this year have included:

- Priority surveillance training for clinicians and nurses
- Deployment of more community informants in all high risk LGAs
- Advocacy to states to ensure provision of funds for surveillance
- Rapid surveillance reviews in response to any 'orphan' virus
- Monitoring of quarterly implementation of rapid surveillance assessment recommendations

While the surveillance indicators have systematically improved, there is evidence from genetic sequencing that we still have gaps in our ability to detect outbreaks of WPVs in some areas.

We aim to ensure that 90% of LGAs meet their main surveillance indicators.

The NPHCDA is helping LGAs meet those indicators by:

- Establishing a toll-free number for AFP reporting to the NPHCDA
- Conducting a national/international surveillance review in conjunction with WHO
- Increasing community informers in border and high risk areas
- Ensuring the full functioning of secondary and tertiary hospitals in the surveillance network

Fix logistics

Providing our vaccination teams with adequate vaccines, vaccine carriers and transportation is key to ensuring that they are able to effectively perform their required functions.

During 2012 the Federal Government spent N6 billion on vaccine procurement, distribution, cold chain infrastructure and logistics. The expenditure meant that the Federal Government had fully met the projected vaccine needs for the country.

We have devoted particular attention to teams operating in hard-to-reach and border areas that have hitherto not been very well covered.

32 border vaccinating posts were established in various parts of the country to prevent cross-border transmission of polio from neighbouring countries.

Vaccine availability

The N6 billion investment in vaccine procurement, distribution, cold chain infrastructure and logistics means sufficient vaccines have been available to meet projected needs. What has also been required is commitment and engagement within local areas to ensure vaccines reach their targets.

Driving vaccination among LGAs

Evidence of the effectiveness of the NPHCDA's advocacy work came in July, when the Governor of Katsina state, Barrister Ibrahim Shema, and the Emir of Daura in Katsina state got tough on polio at their polio flag-off exercise.

Barrister Shema suggested that any Local Chairman who allowed a child in his Local Government Council to be attacked by the poliovirus would also be attacked by polio of a political kind.

He warned that the state government would not entertain any laxity or inaction by any responsible authority charged with providing services to the people.

Speaking at a flag-off exercise at Karkarku ward of Sandam Local Government Council of the State, the Emir of Daura, Alhaji Faruk Umar, said village heads, community leaders and religious Leaders in his domain would risk sanctions if he received any confirmed reports of rejection or any undoing of the polio vaccination exercise.

At the flag-off event, Dr Ado J G Muhammad said the Federal Government had done what it was supposed to do by releasing adequate funds for the purchase of vaccine.

He applauded the President of Nigeria, Dr Goodluck Jonathan, for being the only leader among the current countries of the world battling to eradicate

the disease by solely financing the purchase of its vaccine need, unlike others who depend on donors.

Engaging private providers

Building public—private partnerships is about harnessing more of the skills, resources and technology we need to aid our fight against polio. Just one example of how private providers have contributed to the polio eradication initiative in 2012 can be seen in the collaboration with the Economic and Social Research Institute (ESRI) and telecommunications service provider Etisalat.

The collaboration harnessed the power of smartphones to monitor real-time performance of

SIPD monitoring, September 2012.





World Pneumonia Day.

vaccination teams as they carried out door-to-door campaigns. A bespoke Android application used GPS data to map communities in high-risk areas, and for the first time allowed the quality and coverage of campaigns to be monitored in real-time.

Areas of northern Nigeria were selected for the first phase of full deployment, which saw global GPS transmitters attached to vaccine carrier bags. As vaccination teams successfully covered their designated areas, their progress was uploaded to dedicated servers. The resulting 'risk maps' showed which areas had been successfully covered, and which still posed a threat.

The information provided vital real-time micro-planning data for polio teams, programme managers and communities, helping them make immediate adjustments to make sure they reached – and vaccinate – more children.

The initiative was funded by the Bill and Melinda Gates Foundation.

Social mobilization

The NPHCDA is working with the Federation of Muslim Women's Associations in Nigeria (FOMWAN) and other NGOs/CSOs to scale up involvement, with members deployed to states to provide support to the vaccination teams.

The NPHCDA is working with and grateful for the support of HIZBAH and other religious groups to improve compliance with vaccination in local communities.

Almost 2,000 Volunteer Community Mobilizers (VCM) have been deployed to areas of greatest need to ensure no children are missed during Immunization Plus Days.

Health promotion

At every level, communications have centred on raising awareness and increasing support for immunization activities.

From policy makers and opinion moulders to local communities, activities have aimed to:

- Counter resistance and/or non-compliance
- Engage and mobilize religious leaders (imams, madrassa headmasters, etc.) in high risk areas. The major cause of non-compliance has been religious belief. See Goal 7 for more on engaging religious leaders
- Build awareness and political support of LGA Chairmen in collaboration with ALGON
- Strengthen the engagement and involvement of faith-based and community-based organizations in mobilizing communities, particularly in the highest risk areas. See Goal 7 for more on this
- Establish national advocacy teams to visit high risk states for advocacy to State Governors, members of national and state legislatures and other top government officers

Awareness campaigns

Kano State Governor, Engr. Rabiu Musa Kwankwaso launched the polio eradication awareness campaign in Kano in November 2011.

During the event he stressed that women had a vital role to play, being the guardians of children who are the target in the fight against the disease in Nigeria.

He called on women to take the crusade seriously so as to ensure a total eradication of the disease in Kano state.

The event, supported by the NPHCDA, included an interactive session with women journalists. At the session, NPHCDA Executive Director, Dr Ado J G Muhammad disclosed that of the 41 cases of WPV recorded in Nigeria, 16 were in Kano and seven in Jigawa.

Dr Muhammad said he was in Kano with his team to create awareness of polio issues and appeal for the active participation of women and women journalists in the fight against the disease.



SIPD monitoring, September 2012.

Dr Muhammad recalled that the Governors' Forum in July this year dedicated November 12 of every year as Polio Awareness Day and the theme of this year's day would be 'Women Against Polio'.

Kano has the highest number of polio cases and is therefore a vital territory in the campaign to wipe out the disease.

Dr Muhammad appealed to women journalists in the state to support the state government in its drive to eradicate polio.

Blazing a trail – the Polio Free Torch Campaign

Launched in September 2011, the Polio Free Torch Campaign seeks to 'help Nigeria achieve its goal of eradicating polio' by:

- Driving the growth in volunteer community mobilizers in 200 high-priority settlements. These volunteers are being trained and equipped to carry out door-to-door health education sessions with caregivers
- Overcoming resistance to polio immunization and mobilizing wide support from a variety of stakeholders at national and state levels for the last lap of the polio eradication efforts in Nigeria
- As Vice-President Namadi Sambo put it at the Presidential flag-off at Maitama General Hospital: "[Serving] as a reminder that a healthy Nigerian child can grow up to be an Olympian and win laurels for the country."

During 2012 the Polio Free Torch continued its journey from state to state driving awareness and engagement in polio eradication activities.

The Torch has travelled from state to state engaging governors, LGA chairmen and key influencers in the north to support the Polio Eradication Initiative.

Each Polio Free Torch event featured a lighting of the torch by the state's governor, symbolising that state's commitment to eradicating polio.

Governors then decorated a number of key influencers as "Polio Ambassadors" with polio-free lapels.

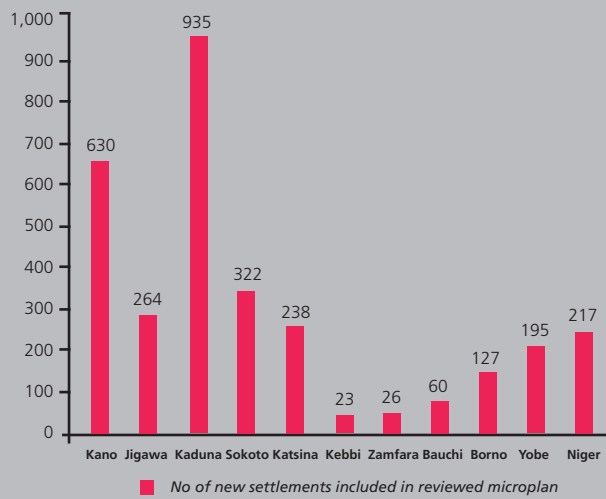
Every Polio Free Torch event has been supported by an intensive publicity campaign through radio, television, and print.



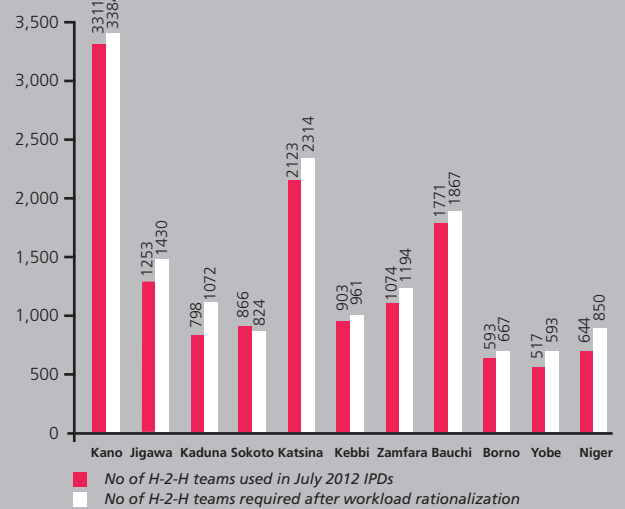
Polio Free Torch events.

Achievements

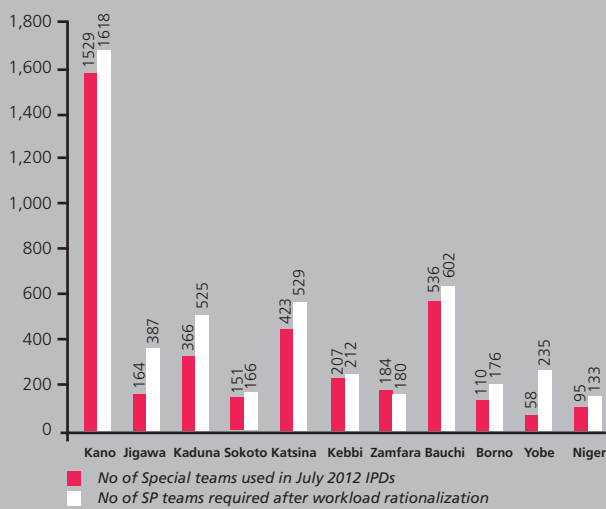
No of new settlements included in reviewed microplan



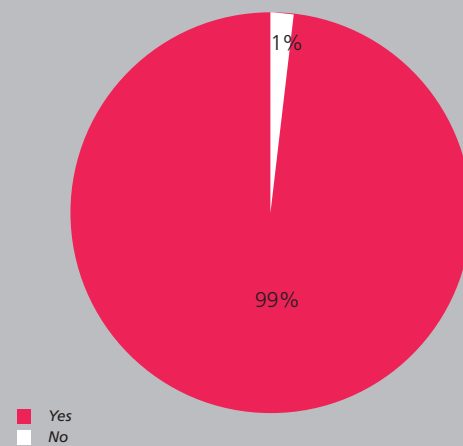
No of House to House teams after workload rationalization



No of Special teams after workload rationalization



If a vaccination team comes to your community, will you allow your child to be vaccinated? (n=1,189)



Cerebro Spinal Meningitis

Control of Men A serotype

In December 2011, Chad, Cameroon, and Nigeria became the latest countries to introduce a new vaccine against meningitis A: MenAfriVac.

The new vaccine will protect Nigerians against the A strain which is responsible for 90% of all meningitis epidemics.

The first phase of the vaccination campaign is now complete and was delivered to around 17 million Nigerians in the five northern states most affected by the disease (Zamfara, Katsina, Jigawa, Bauchi and Gombe).

A second phase, heralded by the MenAfriVac Phase II Stakeholders' meeting in Abuja in September 2012, focuses on 14 more states. By 2013, we aim to have achieved a vaccination target of 79.5 million people between the ages of 1 and 29.

Spreading the word

As with so many of our campaigns over recent years, promoting MenAfriVac required the involvement of stakeholders from mothers to health workers to traditional leaders.

We began communications early, involving teachers, imams and the media. We even used motorcyclists with megaphones to engage communities, mobilize them, and inform them of their immunization dates and locations.

Pneumococcal Summit, 25th November, 2011.





Reaching the targets

Although the campaign was short, at only 10 days, the planning for it took eight months. Resolving logistical issues was our greatest challenge. Our cold chain assessment resulted in the installation of new cold rooms, and the transport of vaccine via lorry from national to state stores.

In the most difficult to reach areas we used motorcycles and bicycles to transport materials and personnel.

We also deployed 200 logistics officers and 25 media monitors to supervise and monitor the implementation of the campaign in the five states.

Administering the vaccine

In addition to the health facilities that already exist, we established temporary vaccination posts in schools, markets and hard-to-reach settlements.

Many Emirs and other traditional leaders gave us use of their palaces, while others went into towns and villages to encourage people towards their nearest vaccination point.

17 million successes

In some areas, the 10-day campaign ran longer than expected due to the numbers of people still presenting themselves for immunization.

Reaching our target was a challenge – and one that was only made possible through the efforts of all stakeholders – but thanks to those efforts 17 million people in five states are now immunized against meningitis A.





Cholera

Health education targeted at communities

We recognise the need to educate communities about cholera, providing the information and good hygiene practices that can save lives.

NPHCDA partner UNICEF has provided safe excreta disposal and family kits for 30,000 cholera-affected people in addition to promoting hand-washing practices in cholera-prone states.

Support states/LGA with case management

When cholera outbreaks occur, the NPHCDA is committed to helping states and LGAs manage outbreaks and prevent spread.

An example of this was November's cholera outbreak in the Ede North and South Local Government Areas of Osun.

By coordinating the efforts of the Rural Water Environment and Sanitation Agency, and the Ministries of Health, and Environment and Sanitation, the situation was brought under control.

In another outbreak in Katsina in September, additional medical workers were deployed to complement the staff at the village health centre. This enabled the emergency to be dealt with and ensured all required preventive measures were taken.

“The quality of our health care systems is nothing without the ability for all Nigerians to access them.”



Ensuring we establish the Ward Minimum Health Care Package in every area of the country, including rural, remote areas and in displaced communities, is a core part of our work.

Yet when we talk about ‘improving access’ we mean more than geography. Access to healthcare is about more than having a primary health facility or health worker close by, vital as that is.

The Primary Health Care Systems Development (PHCSD) Department is responsible for making basic health services available and accessible to Nigerians and ensuring that those health facilities and services are within reach.

Yet we must also ensure that Nigerians are financially protected against ill health, build the capacity of our human resources and provide essential logistics support for the implementation of primary health care at the Ward level.

We are ensuring our arrangements for delivering health care through partner agencies, suppliers and employees are robust and financially rigorous. Performance based financing ensures we are investing in success. It will help us deliver greater access to a better service.

Dr MJ Abdulahi

Director, PHC Systems Development

Goal 2 Milestones

Physical access

Update existing PHC data mapping including GIS mapping. This will guide in knowing where there are gaps
 Advocacy to state/LGA to complete renovation of non-functional HCs, expand PHC infrastructure based on evidence from mapping study
 NPHCDA to complete abandoned HCs
 Set minimum standards – all facilities must be based on minimum standards (HR, equipment, essential drugs)

Implementation of WMHCP (basic essential HS and MSS)

Advocacy to states to implement
 Provision of necessary guidelines – handbooks, standards, guide, protocol
 Revise and disseminate these guidelines
 Build capacity of state/LGA/HF workers to support implementation
 Supportive supervision (M and E) to ensure the package is properly implemented

Collaborate with NHIS to implement community based health

Advocacy to NHIS on collaboration areas for community health financing
 Joint training of various stakeholders
 Monitoring and supervision of implementation

Performance based financing

Follow-up ongoing piloting by World Bank in three states
 Evaluate impact using standard methodologies
 Advocate for adoption of performance based financing based on lessons learnt

Implement conditional cash transfer (SURE-P)

Identify beneficiaries
 Institute payment mechanisms (NPHCDA, State, Communities)
 Monitor implementation through proper data management and field visits (NPHCDA, State, Community)



Supporting state and local governments to improve access to essential health care services in communities



Goal 2

Physical access

Geographic Information System (GIS) mapping

Establishing a map of existing PHC coverage will identify gaps in that coverage. In 2012, the Geographic Information System (GIS) was used to improve polio immunization microplans and aid teams in tracking implementation.

Satellite imagery through GIS was employed in eight states beginning with the geo-coding of settlements in Jigawa in February and Kano in March.

The activity demonstrated the wider applicability of the technology for use in other public health projects including primary care coverage.

Improvement of physical access to primary health care facilities through expansion of PHC infrastructures

Construction of new facilities

Model Primary Health Centres are being constructed or are planned for designated political wards. Previously only one such facility existed across all thirty-six states and FCT. Primary care facilities are receiving more basic equipment in the form of government funded equipment and Global Alliance for Vaccines and Immunisation (GAVI) supplies (see below and Appendix 2).

Rehabilitation/renovation of existing facilities

With support from the Global Fund and GAVI, 499

centres nationwide have benefitted from renovation and/or additional equipment over the past year.

Appendix 1 details a sample of the activity across primary care centres.

In the above instances, Ward Development Committees (WDCs) were formed to enhance community ownership through greater involvement of community representatives in the running of the health facilities and in the decision making processes.

Implementation of WMHCP

The Ward Minimum Health Care Plan (WMHCP) is a priority set of health interventions which should be provided in PHC centres on a daily basis at all times and at little or no cost to clients through the government financing mechanism.

The CHSD

The Community Health Services Department (CHSD), part of NPHCDA, is the body responsible for creating community demand for WMHCP and ensuring packages are available at community levels across the country.

The package includes:

- Health promotion and community mobilization
- Maternal, newborn and child health care services
- Nutrition





- Control of communicable and non-communicable diseases
- Sexual and reproductive health services

The Midwives Services Scheme

The 2009 Appropriation Act tasked the NPHCDA with establishing the Midwives Service Scheme.

The MSS mobilizes midwives for deployment to primary health care facilities in rural communities, allowing pregnant women to deliver safely with skilled birth attendants in designated MSS facilities. One year's MSS service is mandatory for newly graduated midwives, as part of their being fully licensed to practice midwifery in Nigeria.

The NPHCDA receives updates and reviews progress to provide strategic direction, support and guidance for the implementation of the MSS. The scheme uses a cluster model. Each cluster is formed of four Primary Health Centres (PHC) around a general hospital. A total of 1,000 PHC facilities and 250 designated referral general hospitals comprise the 250 clusters.

Advocacy to states and provision of necessary guidelines

Key to the success of the MSS programme was a memorandum of understanding created by the NPHCDA, which provided a framework of responsibilities for local, state and federal government in their implementation of MSS.



Federal responsibilities

The MOU establishes that federal government will provide the following:

- Basic health insurance cover for all midwives
- Midwifery kits for each participating PHC facility and each midwife
- A personal health record booklet
- Basic maternal and child health equipment, drugs, registers, and monitoring tools

The federal government also supports LGAs in implementing, supervising, monitoring, and evaluating MSS.

State responsibilities

The MOU clarifies that state governments will support MSS by allowing general hospitals to be used as referral facilities.

States are also required to upgrade hospitals to provide the following where not already offered:

- Comprehensive emergency obstetric and newborn care
- Equipment and supplies such as drugs and other consumables, ambulance services, constant electricity and a potable water supply, stationery
- Security for health workers and equipment

State governments monitor and supervise the programme within their jurisdiction and coordinate the provision by LGAs of free, decent accommodation in the host communities.

Dr Abdullahi, Dr Ali-Pate and Dr Muhammad.



Collaboration with NHIS to implement community based health

The NHIS is a sustainable healthcare financing strategy with a remit to enable universal health insurance coverage for all Nigerians. The Public Sector Social Health Insurance Programme (PSSHIP), a core part of the national health insurance plan, launched formally in June 2005 and has over 2 million enrollees.

The Community Based Health Insurance Scheme (CBHS) allows communities to organize a pooling arrangement to finance their health care needs. We believe it is an essential element in expanding affordable healthcare to more Nigerians.

Piloting CBHI

In collaboration with the NHIS, a nationwide inventory of existing civil society organizations, community-based organizations, cooperative societies, existing community-based health insurance schemes and occupation-based groups has been identified.

The NHIS will select about 50 groups to serve as viable entry points for piloting CBHI. Viable groups will continue to be identified, in partnership with all stakeholders, to allow the Scheme to be scaled up.

The programme was flagged off at Isanlu in Yagba East Local Government Area of Kogi State on 17 December 2011 and developments have continued throughout 2012.

Health insurance for midwives

The NPHCDA and NHIS are also collaborating on a method for providing health insurance cover for MSS midwives.

Midwives have already started accessing care under the NHIS and the supporting Act has gone through its second reading at the Federal House of Representatives.

The scheme is expected to achieve universal coverage by 2015.



Mama Kits.

Performance based financing

Performance-Based Financing (PBF) at health facilities is an approach that provides incentives to health workers based on the quality and quantity of services provided to clients.

In April, the World Bank Board approved financing of US\$150 million for the Nigeria State Health Investment Project. The funding was agreed on a PBF basis, rewarding health workers and institutions that perform well, boosting performance management and accountability, and encouraging innovation.

Three states led the way in performance management techniques during 2012: Adamawa, Nasarawa and Ondo. Together they demonstrated how performance management techniques and increased incentives can boost the quality and uptake of health services.

Marie Françoise Marie-Nelly, World Bank Country Director for Nigeria, said, "I hope that these states will show how public money can be invested more smartly to get closer to the Millennium Development Goals, especially those related to the survival and health of mothers and children."

Using their own resources, the three states had initiated pilot activities to jumpstart the reforms. Under PBF, health facilities in these states are now paid based on the verifiable results they achieve (e.g. the number of children immunized, number of mothers delivering safely, etc).

Evaluating the impact

This 'Results-Based Financing' approach is being evaluated to assess its effect and wider applicability in Nigeria.

"We have a huge gap to cover in terms of achieving the health outcomes we desire for our people," said Dr Muhammad Ali-Pate, Nigeria's Minister of State for Health. "The Results-Based Financing approach will enable us to focus on those outcomes, because in the end it is not the process or the inputs that matter; it's whether or not you are getting people to

be healthier, or women surviving childbirth, or children surviving till the age of five."

Implement conditional cash transfer (SURE-P)

The partial removal of the petroleum subsidy released funds for further improving health care.

The NPHCDA is charged with judiciously spending these Federal Government funds to increase country-wide access to primary health care.

In September, the Subsidy Reinvestment Programme on Maternal and Child Health delivered over two thousand health workers to rural primary health care facilities nationwide.

Comprising retired and unemployed midwives, female nurses and community health extension

Midwives representative of the SURE-P maternal and child health project, south-east zone.



workers, the SURE-P workers trained for their new roles during September and are now supporting the rapidly expanding Midwives Services Scheme. The investment made so far in the maternal and child health component of the SURE-P programme clearly demonstrates the NPHCDA's and Federal Government's commitment to reducing maternal mortality.

Improving access, making a difference

MSS and SURE-P are making a difference to the lives of women and children across Nigeria. The NPHCDA's commitment to do more has encouraged midwives who have retired or otherwise left the profession to return.

Some have been practicing in private hospitals, but through SURE-P they have seen that the government is serious about the incentives that can make a real difference to the lives of mothers, babies and the professionals who care for them.

Some joined SURE-P because they believe it makes doing a job they love financially worthwhile.

Others have recognised the efforts made by the government and NPHCDA and want to do their part.

But of all the reasons midwives have joined or rejoined SURE-P and the MSS, there is one overriding consideration: a passion for saving lives and making a difference.

“Trained, skilled people, in the areas where they are needed most, with the equipment they need to carry out their duties.”



The Department of Community Health Services has a commitment to improving the quality of care received by the people of Nigeria.

It is a commitment that remains valid wherever people are. As a result we are working with states and LGAs to improve the equitable spread of health workers.

We are recruiting more, training more and retaining more.

The result is an improving picture of health coverage across Nigeria. It is a picture we aim to improve still further.

Dr Nnenna Ihebuzor

Director, Community Health Services

Goal 3 Milestones

Mapping PHC facilities (location, human resources for health capacity)

Advocacy for recruitment, deployment, retention of health workers, quality of health facilities (structure, water etc)

Provision of equipment, logistics and supply

Training of health workers

Needs assessment

Assemble/develop training manuals/job aids

Training based on needs assessment (cascaded)

Integrated service delivery, SOP (Standard

Operating Procedure), QoC (Quality of Care), etc.

Monitoring and supervision

Monitor and track QoC (planned vs implemented)

Monthly supervision of states, LGAs, Health,

Finance



Ensuring essential health care services are people oriented and delivered according to established quality standards and protocols.

Goal 3



HR for health capacity

Nigeria has one of the largest stocks of human resources for health (HRH) in Africa but densities of nurses, midwives and doctors remain below optimum levels.

In recent years we have reduced the level of migration of health workers to foreign countries. The primary challenges that remain are to produce more of the health workers we need and ensure their distribution matches the needs of communities across Nigeria.

Key objectives of the HRH policy include:

- Providing a framework for objective analysis
- Measuring for implementation and monitoring

- Aligning health worker supply with health sector needs
- Applying best practices in HRH management and development to promote, fairly distribute and retain the optimum quality and quantity of HRH
- Institutionalizing performance incentives and management systems (including recognition for those working in deprived or unpopular locations)
- Fostering collaboration between public sector, non-government providers and other HRH stakeholders
- Strengthening HRH management practices

The highest profile HRH success story is the Midwives Services Scheme, an NPHCDA initiative which mobilizes unemployed, retired and newly qualified

midwives, placing them in rural communities for one year of community service.

The MSS

In 2009, the NPHCDA established plans to expand women's access to skilled health care workers in rural and suburban regions with the Midwives Services Scheme (MSS).

By 2011 2,488 midwives had been dispersed to 652 primary health care centres linked to 163 general hospitals across all 36 states of Nigeria. The programme reaches a population of over 10,700,000 people, roughly 15% of the total population.

NPHCDA Executive Director Dr Ado J G Muhammad has said: "A major cause of maternal mortality is women not being delivered by skilled attendants and a significant proportion of that is being tackled now."

Thanks to MSS and improved equipment (see below) around 1,000 facilities now have midwives running 24-hour services.

By the end of 2012, the MSS should have delivered around 6,000 midwives to facilities nationwide since its inception, together with 1,000 community health officers, 1,000 community decision workers and about 6,000 village health workers.

The National HRH Forum Steering Committee

NPHCDA members also form part of the The National HRH Forum Steering Committee, a body established to address the constitutional provision for HRH; provision, absorption and distribution of staff; and retention levels of health workers.

Advocacy for recruitment and retention

Recruiting midwives

Achieving sufficient numbers of appropriately trained staff is key to the NPHCDA's strategy for delivering health care services in Nigeria.

An initial nationwide recruitment exercise resulted in

2,608 successful MSS midwives being deployed to 652 designated PHCs in the 36 states and FCT.

45% of recruits were previously unemployed midwives, 44% were probationary midwives completing their mandatory pre-registration community service year, and 11% were retired midwives.

The success of MSS recruitment is a measure of the advocacy activities carried out throughout 2011 and 2012 to drive up the number of skilled birth attendants, especially in rural communities.

Recruiting HRH specialists

We aim to improve female participation in the health workforce, increase the number of women health workers, and retain more of them.

Recruitment of HRH specialists is providing expertise in health worker recruitment and retention. The knowledge of the HRH specialists is assisting in the design and implementation of long and short-term retention schemes and recruitment strategies, and improving advocacy and job seeking - especially amongst midwives in rural areas.

Specialists are also responsible for:

- Formulating cost effective and sustainable mechanisms to ensure improved regulation of health teaching facilities and providers in Nigeria
- Enhanced staff management and leadership development
- Supporting the overall management process related to improving HRH management at decentralized levels

Recruitment at LGA level

Local councils are being encouraged to review deployment of health workers and recruit accordingly.

In Enugu State, for example, baseline assessments revealed 50% of the skilled medical and nursing workforce was in tertiary hospitals. The rest were split between the secondary and primary healthcare facilities.

Results from this analysis showed that some LGAs in the state required more health workers. Others were identified as needing to strengthen their monitoring and supervision systems, especially in the primary health centres.

As a result, in 2012 (to date) 300 new health workers have been recruited in Enugu, with local councils reiterating their commitment to tackling 'lopsidedness' in staffing.

Providing equipment

Rural areas which lack adequate vaccine service delivery are particularly vulnerable to maternal and neonatal tetanus (MNT). In addition to increasing the numbers and geographical spread of available health workers, the NPHCDA has been working to deliver the equipment and sterile tools which, together with clean delivery surfaces and hands, are crucial in preventing MNT.

The use of sterilized tools to sever the umbilical cord during delivery could, for example, help reduce instances of MNT. Reducing this risk of infection is the purpose of the 'mama kit'.

Midwives are equipped with mama kits, which include a stethoscope, razor blade, essential medicines, weighing scales, blood pressure indicator and mobile registration system. Midwives then distribute kits to pregnant women.

The mama kits have proved effective in encouraging pregnant women to attend antenatal facilities, and they remove any complaint that, as Dr Ado J G Muhammad puts it, "My husband has not provided me with a mama kit for safe delivery."

Dr Muhammad added that facilities that used to witness three births per month now record 40 – and some many more.

Mama kits, in conjunction with MSS, have helped renew confidence in the health system. More women now attend antenatal care and can expect the services of skilled, equipped attendants.

Training of health workers

Standards of Practice

The NPHCDA is committed to continually improving standards of healthcare. During 2012 we have worked to develop, refresh and update the skills of our health professionals.

In 2011 we developed new Standards of Practice for Community Health Workers. Training in the use of the Standards has continued during 2012.

Training doctors

In August 2012 a new initiative to train medical doctors in comprehensive emergency obstetric care began at the Enugu State Teaching Hospital.

The initiative, part of the MSS, aimed to increase obstetrics knowledge and reduce the number of deaths among women during childbirth.

Although levels of medical assistance to states have improved through general hospitals, other factors including inability to access medical health facilities on time, complications and bleeding have been identified as major causes of deaths during childbirth.

Dr Damaris Onwuka, NPHCDA Zonal Coordinator, South-East Zone, said at the launch: "We want doctors to gain more knowledge on direct obstetrics and how to get skills to treat these cases so that these women don't die during childbirth."

The course also sought to address the attitudinal issues among doctors and health workers that can cause delay. Delay in transportation in rural areas, and further delay when women arrive at hospital, can increase the risk of maternal death.

"The major thing here is the delay in attending to the cases – delay in even knowing that they require attention," explained Dr Onwuka. "Sometimes [women] will have their antenatal, but during child delivery, you can't even see them in hospitals. Some go to the native doctors, churches and so on. These are the issues we are tackling."

Training based on needs assessment

Continued training for MSS midwives

MSS midwives are selected and trained to the International Confederation of Midwives (ICM) global standards for midwifery education.

All MSS midwives are expected to take part in quarterly development activities which include a quarterly review, life saving skills and management of childhood illness.

Training sessions are conducted at schools of midwifery in each state. Each course lasts six days, with class sizes varying between 24 and 32 people. Programme content includes interactive theoretical and illustrative lectures with skills demonstration and practical sessions. Initial practical sessions use dummies, and as the course progresses attendees progress to working with consenting patients. All recruited midwives are eligible for participation in the training programme.

The Mid-Level Management Training Programme (MLMT) is building the management capacity of the PHC system in Nigeria and acting as a catalyst to improve health outcomes and attainment of the health related MDGs.

MLMT for primary health care has been established by the NPHCDA in collaboration with the Federal Ministry of Health (FMOH), Office of the Head of Civil Service of the Federation (OHCSF) and Centre for Management Development (CMD) with technical support from Duke University (USA). The office of Senior Special Assistant to the President on MDGs provided funding support for the project.

MLMT Objectives

The goals of the MLMT programme are:

- To establish a PHC management training programme within Nigeria
- To strengthen the technical and general management skills of frontline health managers to improve execution of maternal, neonatal and child health programmes

- To develop a mechanism for coaching, mentoring and evaluating health sector management with the aim of improving service delivery

Course design

The programme is an in-service continuing professional development course. It consists of six residential seasons, each of one week duration, which take part within a six month period of practical, on-the-job exercise and field project work.

As part of the course, the trainees work in teams to deliver a project related to their area of current employment. Students are expected to implement their project recommendations during and after the course.

Assessment is based on a combination of in-course performance and formal examination conducted at end of the training period. Successful candidates are awarded a certificate.

Curriculum and content

The course covers the following modules:

Policy:

- MDGs
- National health policy
- Public service reform

Leadership Skills:

- Strategy
- Human resources management
- Team building
- Negotiation
- Decision making
- Communication skills
- Integrated PHC services
- Project management
- Supply chain management
- Monitoring and evaluation

Analytical Skills:

- Financial management
- Statistics
- Epidemiology
- Computer skills
- Health economic quality
- Health Management Information Systems

“Supporting healthcare with the resources our health workers need.”



From improved environments to improved technology, the advances we wish to see in healthcare provision require estates, budgets and contracts that are aligned with our goals.

Our healthcare interventions and actions need to be responsive and flexible to cope with changing demands. In such an environment our institutions must be similarly responsive and flexible.

That is why we are ensuring our zonal structures, state representation, internal communications, health management information systems, procurement and financial management systems are fit for the purpose of supporting our healthcare goals.

Dr Ibrahim Alhaji Umar

Head of Procurement

Mr Billy Asogbon

Director, Finance and Accounts

Goal 4 Milestones

Office automation

Enterprise Resource Planning

Finance and Accounts

Human Resources and Administration

Contract

Provision of conducive office accommodation

Deciding approval level

Creation of service delivery contract

Strengthen zonal structure

Strengthening representation at the states

Provide offices

Post high ranking officers

Approval of concept

Implementation

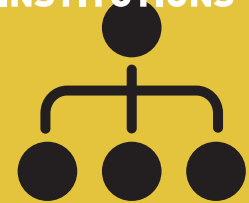
Review of communication strategy

Strengthening monitoring and evaluation

Creation of awareness of the divisions and units within the agency

Review of budget structures

GOAL 4
STRENGTHEN
INSTITUTIONS



Strengthening zonal structures, state representation, internal communications, health management information systems, procurement and the financial management system.

Goal 4



Sensitization of the Management Staff, 6th August, 2012.

Office automation

Throughout 2012 work has continued to streamline office processes, contracts and human resources to deliver greater value for money by harnessing the latest technology.

ERP

Enterprise Resource Planning enables organisations to streamline key processes and gain improved oversight of financial operations.

People become more productive and more empowered as role-specific information is made available instantly.

Provision of conducive office accommodation

Good office accommodation and a conducive working environment does more than make a workplace an appealing place to be. It also helps increase productivity and efficiency.

So said NPHCDA South-East Zonal Co-ordinator Dr Dahiru Onwuka in August as he welcomed dignitaries to the commissioning of the agency's south-east zonal office.

Work is ongoing across the country to create better office accommodation for health workers.

Ogun State – a case study

When the NPHCDA invited the media to tour 47 newly refurbished PHC centres in Ogun State recently, the response was impressive.

The Guardian said the improvement works “showed the tremendous upgrade in the areas of better qualified workers; efforts in the elimination of the frequent drug and vaccine shortages; and provision of equipment such as bedding and delivery apparatuses.”

The newspaper went on to say, “The centres now also have a regular water supply from boreholes and generator power backups. These efforts have upped patronage...”.

Our work continues across states to improve the fabric of health facilities, utility supply, and the supplies and equipment needed to increase access to PHC.

Improvement activities

Across the country the NPHCDA has invested in the improvement and renovation of health facilities and the procurement of new equipment.

These are some of the improvement activities of the past year:

- Purchase of additional project vehicles – we have purchased 13 new vehicles this year, with more due next year subject to budgetary provision
- Ongoing repair and maintenance of cold stores at the national and zonal offices
- Improved communications systems for MSS mid wives
- Renovation of office complexes
- Tagging of agency assets
- Improved security at NPHCDA HQ and zonal offices
- Provision of office equipment
- Provision of internet services

Creation of service delivery contract

A contract has been developed. This now needs disseminating.

Strengthening zonal structure

The NPHCDA's remit to support and oversee state and LGA primary health care is augmented by the work of zonal offices in each of Nigeria's six geo-political zones. In 2012 the NPHCDA approved the concept of strengthening the zonal structure.

Already efforts have been made to ensure resources are available. Work has included:

- Strategically managed staff deployment to ensure we place 'square pegs in square holes'
- Improved ICT, building the quality and frequency of communications between zones and the centre
- Greater access to improved equipment and environments

Review of communications

Effective communications are far more than a 'nice to have.' They improve health outcomes, linking facility with facility, health worker with health worker. They improve the management of resource, and they improve the support, motivation and performance of our people.

Top Management meeting.



Joined up, effective communications are how we share our common goals, values and progress. They are fundamental to creating a high performance, empowered workforce.

Improving communications – a case study

Midwives across Nigeria are being connected with other health workers and administrative units to improve the management and reporting of maternal and neonatal care.

Currently the initiative connects the NPHCDA headquarters with six regional offices, the central health supplies store and 40 clusters.

A dedicated voice communication system and website is already operational, allowing midwives to consult colleagues and upload reports and data. The dedicated communications system takes advantage of new technologies such as GSM to give midwives the support they need to make them more effective.

Internal communications

We are working to improve the quantity and quality of information that passes laterally and vertically through the NPHCDA.





In pursuit of that goal we have:

- Issued departmental circulars
- Held departmental and divisional meetings
- Held and disseminated the outcomes of TMM and TMC meetings
- Developed a quarterly newsletter circulated to all zonal offices

Creation of awareness of the divisions and units within the agency

Understanding the roles and responsibilities of the divisions and units which make up the NPHCDA enables quicker decision making, reduces duplicated work and ensures new policies and strategies are 'joined up'.

By creating understanding of the work of individual divisions, and harmonising activities across all NPHCDA departments, we stand to improve inter-departmental working, improve transparency, and deliver better, more consistent results for the people of Nigeria.

Awareness activities have included:

- Roles and responsibilities
- Levels of care
- Span of control
- Support and supervision
- Managerial authority and accountability
- Practical systems and procedures for implementing PHC services

Managing knowledge effectively

A harmonised NPHCDA is one which shares effectively the knowledge and information of its departments and partners.

Knowledge Management (KM) is a tool we are implementing to deliver the following benefits:

- To create systems and mechanisms for learning, sharing and transferring information
- To provide a roadmap for evidence based solutions
- To enable delivery of organizational goals
- To provide organizational direction

KM Strategy

We are applying the principles of KM to the following cross-departmental strategic goals:

- Institutional reform
- Updating and repositioning of the library under the Department of Planning and Statistics
- Capacity building (intensive training and mentoring of staff)
- Creating intersectoral capacity
- Rebranding the research activity (e.g. developing a research framework)
- Improving access to internet in the agencies
- Subscribing to feedback journals and publications
- Developing a KM framework and policy (practical application)
- Guiding effective KM application to NPHCDA departments and programmes

“Our people are our greatest asset in delivering improved primary health care across Nigeria.”



Our challenge to make Nigerians healthy begins with our staff. Their skills, knowledge and commitment are what drive us closer to achieving our Millennium Development Goals.

Day by day, in every PCH facility in every ward in every state, the work of our staff is making a real and growing difference to our nation's health.

At the Department of Administration and Human Resources we understand that the responsibility to deliver a well-trained, caring and able staff is also a responsibility to the people of Nigeria.

Already we have made massive efforts in respect of our human capital development. 80% of staff have undergone some form of training during the past year. We must continue to ensure our workers possess the skills they need to perform their roles effectively.

We must ensure all staff understand the importance of their role. We must train individuals and teams to the highest standards and reinforce that training with ongoing skills development. And we must empower our staff, because achieving the swift results we need demands the willingness, capability and authority to make the right decisions.

Mrs Lami Abubakar

Director, Administration and Human Resources

Goal 5 Milestones

Schedule of duties

Staff promotion – 2012

Scheme of service

Conditions of service

Staff re-deployment

Staff training (local and foreign)

Pension verification exercise

Remuneration for medical officers and of the non-clinical allowance for staff

Renovation of the annex office

Provision of internet service in annex office

Resuscitation of TMC and other meetings

Ensure moves of the SS2 to a new office accommodation

Landscaping and erosion control SE2

Purchase of additional office equipment/furniture for SE2

Purchase of additional project vehicles

Tagging of agency assets

Performance management and evaluation

Guidelines on the engagement of consultants/contract staff

Instituting a reward and sanction system

GOAL 5
CREATE A HIGH
PERFORMANCE
AND EMPOWERED
WORKFORCE



Create a strong, productive, dynamic and result-oriented workforce by enforcing discipline, implementing a robust welfare package, encouraging attitudinal change, support training and introduce a performance management system.

Goal 5



Top Management Retreat in Minna Niger State, 14th April, 2012.

Actioning milestones

Training equips our staff with the skills to carry out their roles effectively. Yet training in isolation cannot deliver results. We recognize that our people must also be happy, motivated and prepared to give all they have to achieve the goals of the NPHCDA.

Codifying and detailing what is required of our people is fundamental to the understanding of their roles and to the development of effective performance management systems.

During 2012, the Department of Administration and Human Resources has made the following progress in respect of:

Schedule of duties

This has been prepared and distributed with a view to improving the effectiveness of our performance management measures. Key performance indicators have been identified.

Scheme of service

At time of writing, the scheme is awaiting final approval from the office of the Head of Service.

Conditions of service

Produced and awaiting final approval.

Staff training

Achieving our health goals requires us to deliver training to improve:

- Staff orientation
- Skills – providing the technical, organizational and interpersonal training to improve the skills of the health workers involved in administering primary health care in Nigeria
- The capacity of our mid-level managers to organize and deploy human, material and financial resources to achieve optimal results

Orientation training

We are equipping our people with the personal skills development to allow them to perform their roles more effectively.

Measures include lectures, seminars and workshops on:

- Attitude to work
- Change management
- Crisis management
- Leadership

Developing managerial competence

Strong managerial skills give our health improvement activities the greatest chance of success. We have identified effective mid-level management as being crucial to the implementation of NPHCDA strategy.

Staff redeployment

We are working to ensure that staff changes improve the situation within facilities, are handled sensitively, and are successful in delivering the right people to the right posts at the right time.

Any redeployment is carried out with the aim of meeting the needs of health care facilities, communities and individuals. In particular, we



Top Management Retreat in Minna Niger State, 14th April, 2012.

recognize that placing 'square pegs into square holes' smoothes transition and improves motivation.

Reinforcing the right actions: performance management, rewards and sanctions

Performance management and evaluation

We believe an effective appraisal system is the key driver of positive actions.

On the spot assessment of PHC Services by Management, 15th February, 2012.





Sensitization of the Management Staff, 6th August, 2012.

It identifies and reinforces good work, reveals knowledge gaps and training needs, and provides the correct environment for imposing sanctions where necessary.

All annual performance assessments are evidence based.

Performance evaluations are complete for 2011, and those for 2012 will be completed this December.

Implementing a reward/sanction system

We believe we should recognize the contribution of individuals who demonstrate strong performance, and sanction poor performance. That is why the NPHCDA is working towards implementing a programme of rewards and sanctions.

The programme will be a standardized reward scheme that will recognize top performers in wards, LGAs and states. Rewards may include public recognition, a congratulatory meeting with a senior leader, an award certificate, a mention in the media or enrolment in training of the individual's choice.

Demonstrably weak performance will be sanctioned with measures including warnings, withholding of allowances (in accordance with public sector reforms) and/or disengagement from the programme.

Welfare – promotion, pay and pensions

Promotion

The opportunity to progress and develop is a powerful motivational tool and one that has previously been hindered through promotion backlogs and arrears.

During the past year we have cleared all such backlogs.

Pay

It is widely recognized that pay is rarely a motivational factor in its own right, but it is a 'hygiene factor' which, left unaddressed, can reduce morale. During 2011 we have agreed remuneration for medical officers, signed-off on the non-clinical allowance for staff, and made payment of both.

Pensions

The pensions verification exercise was scheduled for November 2012.

Improvement activities

Across the country the NPHCDA has invested in, and the Department of Administration and Human Resources has co-ordinated, the improvement, and renovation of health facilities and the procurement of new equipment.

These are some of the improvement activities of the past year:

- Purchase of additional project vehicles – we have purchased 13 new vehicles this year, with more due next year subject to budgetary provision
- Ongoing repair and maintenance of cold stores at the national and zonal offices
- Improved communications systems for MSS midwives
- Renovation of office complexes
- Tagging of agency assets
- Improved security at NPHCDA HQ and zonal offices

- Provision of office equipment
- Provision of internet services



“Together we are stronger.”



When departments, states and LGAs work effectively together we achieve more.

When we pool our indigenous expertise with that of our external partners such as WHO, UNICEF, Rotary, BMGF and CDC, those achievements are even greater.

And when our partnerships allow us to harness the latest technology, they make real and lasting contributions towards the achievement of our health goals.

Partnerships – interdepartmental, inter-organizational and international – are documented throughout this booklet. They are improving the health of all Nigerians. I am working to foster, co-ordinate and expand those relationships.

Dr Emmanuel Odu

Director, Planning, Research and Development

Goal 6 Milestones

Inter-departmental partnerships strengthened

Identification of core programme components and assignment to appropriate units/department/zone

Planning/Review meetings

Advocacy to states for PHC Boards

State capacity building for PHC Boards

Comprehensive listing/identifying

CSOs/engagement

Increase in number of organizations partnering with NPHCDA (effectiveness of partnership)

Identification of resource mobilization opportunities

Enhancement of resource mobilization for established partnerships on an on-going basis

Review of framework for monitoring partnership activities

Enhancement/strengthening partnership with other health agencies (NHIS, NAFDAC, NACA, NMCP etc)

Identification/Listing and increase private sector engagement for PHC programmes/activities

Assessment of PHC services by private providers

GOAL 6
STRENGTHEN
PARTNERSHIPS



To mobilise and coordinate stakeholders such as ministries, departments, agencies, development partners and the media to support the implementation of primary healthcare.

Goal 6

Strengthening partnerships, mobilizing resources and Saving One Million Lives

In pursuit of our Millennium Development Goal of reducing childhood mortality the NPHCDA has led the development of an Integrated Community Case Management (ICCM) programme to treat childhood illnesses.

The programme includes improving access to zinc, ORS and other commodities within communities.

In October 2012, Nigeria took the next step in its pursuit of the MDGs by announcing its commitment to save one million lives by 2015.

The launch of Saving One Million Lives, held in Abuja, was attended by Ministers, Governors, traditional leaders, Nigeria's private sector health

alliance, the Nigeria Development Partners' Group on Health, UN agency representatives, Chelsea Clinton as a board member of the Clinton Health Access Initiative (CHAI), and the people on the front line of saving Nigerian women and children: Nigerian midwives.

The campaign launch raised the level of advocacy for – and provision of – essential childhood medicines.

The work built on efforts made earlier in the year, supported by the NPHCDA and CHAI, to scale up zinc and ORS. The National Essential Medicines Scale-up Strategy specified national coverage targets and prioritized key actions over a three year period.

“Nigeria is on the verge of a historic breakthrough toward reducing the number of children who die from diarrheal every year,” said Chelsea Clinton. “The leadership, commitment, and diverse coalition of partners supporting this initiative is extraordinary,

Senate Committee Members on Health 24th January, 2012.





Send Forth for UNICEF Country Representative, 18th July, 2012.

and CHAI is proud to be a part of it. Nigeria is an example for other countries facing similar challenges.”

Strengthening partnerships and monitoring activities

Prior to the launch, Abuja hosted a meeting attended by President Jonathan and Norwegian Prime Minister Jens Stoltenberg (the Chairs), Vice-Chairs from UNFPA and UNICEF, and Commissioners of the UN Commission on Essential and Life-Saving Commodities for Women and Children.

The meeting was a follow-up to the report launch in New York the previous month, and was also attended by representatives from Ethiopia, the Democratic Republic of Congo, Uganda, Senegal, Sierra Leone and the United Republic of Tanzania.

The meeting was asked to review draft implementation plans and develop milestones, targets and global progress monitoring measures.

Increasing the range of partnerships

The Saving One Million Lives launch also saw leaders from across Nigeria’s public and private sectors support our national scale-up efforts.

At an event hosted by the Nigerian Government, CHAI, MDG Health Alliance, the Wellbeing Foundation and the UN Foundation, a broad coalition of partners was announced. Each partner supported the need for collective action from the government, NGOs, private companies, civil society and key partners.

The partners signed a ‘Pledge to Eliminate Child Diarrheal Deaths in Nigeria’ at the event, and committed to support three key enablers of success:

- Building demand among health workers for ORS and zinc
- Ensuring widespread availability of affordable and high-quality ORS and zinc
- Mobilizing resources to support scale-up of zinc and ORS



Ted Turner's visit to Nigeria.

Many other organizations also made significant and welcome commitments to support the reduction of diarrhea mortality among Nigeria's children. They included:

- Bates Cosse
- CHI Pharmaceuticals
- Fidson Healthcare PLC
- McCann Health
- Micronutrient Initiative
- National Association of Proprietary Patent Medicine Dealers (NAPPMED)
- Nigerian German Chemicals
- Nigerian Inter-Faith Action Association (NIFAA)
- Olpharm
- OMD
- Partnership for Transforming Health Systems Phase II (PATHS2)
- Society for Family Health (SFH)
- Strengthening Health Outcomes through the Private Sector (SHOPS)

- Unilever
- WellBeing Foundation Africa

Increasing private sector engagement

In June 2012 Minister of State for Health, Muhammad Ali-Pate announced that the Federal Government, through the Federal Ministry of Health (FMOH), had established a Private Sector Roundtable on Health in Nigeria (PSRHN). The PSRHN was charged with conducting “a rapid diagnostic of the private health sector” in order to reduce ongoing losses to medical tourism.

The NPHCDA hosts the secretariat for the PSRHN.

Speaking at the inaugural private health sector summit in Lagos, Minister Ali-Pate revealed that up to N 81 billion leaves Nigeria yearly in the form of foreign hospital treatment.

Nigeria's private health sector had the fundamentals, he said, to make it the envy of the world. "Imagine if we created an enabling environment for local vaccine manufacturing, pharmaceutical companies, hospital chains, diagnostic centres and Health Maintenance Organisations (HMOs). This would enable us to better harness the resources and expertise of our medical personnel in diaspora."

Identifying resource mobilization opportunities

As a first step to understanding the extent of the problem, the Minister commissioned a study in collaboration with the International Finance Corporation (IFC) and World Bank. The study was a diagnostic of the private health sector involving interviews with around 100 stakeholders, including FMOH senior officials and private sector chief executives.

The following PSRHN aimed to identify and mobilize eminent and influential private sector leaders with the intention of galvanising resources to accelerate progress towards achieving the MDGs.

Unlocking market potential

The Minister identified two key challenges to realising the Nigerian private healthcare market's potential.

First was the challenge healthcare providers face in accessing finance, although the Minister pointed to a recent study by the Groupe Agence Française de Développement which identified the difficulties financial institutions are also having finding suitable healthcare investments.

"These market failures are significant and may necessitate government intervention," he said. "I am aware that some pilot programmes are in place, but it's time to scale these up."

WHO representative visits new ED CEO, 15th November, 2011.



“Engaging communities is about giving groups the resources (financial and otherwise) to improve their situation. It is about having the tools to make the right choices – and encouraging people to make those choices.”



To successfully engage our communities, the Department of Community Health Services works through key audiences to ensure community mobilization and buy-in for all Primary Health Care issues.

Our engagement work begins with large scale media campaigns such as Maternal Newborn and Child Health Week, and ends at the doors of individual houses in individual communities.

We champion capacity building for state, local government and health facility staff for the integration of AIDS, TB, and Malaria (ATM) issues. The department has also implemented the Global Fund Health System Strengthening grant and through this has supported the refurbishing of PHC health facilities.

Our work is necessarily carried out in the full media spotlight. It has resulted in successful partnerships with the Northern Traditional Leaders Committee on PHC Development, Nigerian Inter-Faith Action Association, Nigeria Governors Forum (NGF) and the Association of Local Governments of Nigeria (ALGON). Yet it is also the less high profile – but just as vital – engagement work carried out by Ward and Village Development Committees, health workers and volunteers across the country that is helping to make Nigerians healthy.

Dr Nnenna Ihebuzor

Director, Community Health Services

Goal 7 Milestones

WDCs establishment

Reactivation in at least two per ward/LGA

Quarterly community advocacy to ensure sustainability

LGA chairmen sensitization (in zonal groups)

Engagement of CBOs/FBOs/CSOs with MOUs (e.g. FOMWAN, NIFAA, CHAI, CWO etc)

Engagement of traditional and religious leaders nationwide

Intensification and expansion of the intensified ward communication strategy (IWCS) for PHC including NCDs:

- Community dialogues
- Community radio station messaging
- Community edutainment (e.g. Majigi)

Engagement and scale-up of volunteer community mobilizers (VCM) and village health workers (VHWs)

Orientation of NYSC members as community change agents for “Facts of Life” for KHHP (Key House Hold Practices)

Walk 4 Life – NPHCDA HLS Program

Engagement of schools in select communities as “Model Health Lifestyle Friendly Schools”



To promote community participation, ownership and responsibility for health (through ward development committees and communication programmes etc)

Goal 7

WDC establishment

WDCs and VDCs are the administrative link between health facility services and communities across Nigeria.

By allowing communities to participate in planning and monitoring the health and other social services in their localities, the NPHCDA is empowering communities, promoting health issues, mobilizing action and increasing demand for services.

WDCs are being encouraged to:

- Coordinate all components of primary health care programmes in their respective wards (including management of health facilities, maternal and

child health care, immunization programmes, family planning)

- Supervise, monitor and evaluate the success of health activities within their locality
- Keep accurate records and information on the implementation of health and vaccination programmes
- Coordinate the distribution of equipment, drugs and consumables
- Manage their community-based services and contribute to the sustainability of local primary health care initiatives

VDCs and WDC members have commended the NPHCDA for helping to bring the people and government closer together, and for renovating health facilities within WDCs and VDCs.





Polio mobilisation.

Tools for the job

The NPHCDA is working with PHC units to ensure WDCs are provided with health care packages which include:

- Control of communicable diseases
- Child immunization
- Nutrition
- Maternal and newborn care
- Non-communicable diseases
- Health education and community mobilization

Supporting midwives

The NPHCDA has ensured that midwives of the MSS are heavily involved in the establishment of WDCs.

Midwives attend WDC meetings to update the WDC on activities. They outline any areas of concern and brief the WDC on their upcoming work within the community.

The midwives aid the WDCs by acting as change agents, helping mobilize health care action within communities and carrying out home visits. They are key advocates in promoting women and child health issues.

The NPHCDA is encouraging WDCs to support their midwives by ensuring their security and accommodation, and arranging transportation of pregnant women and neonates in cases of emergency.

Popular support for WDCs and VDCs

The NPHCDA has received widespread support from ward representatives, traditional rulers, women's groups and other stakeholders as it continues to work towards establishing two WDCs per ward/LGA.

Developing the role of the WDC and VDC

The implementation of WDCs across Nigeria has made a significant contribution to driving up vaccination rates, engaging communities and coordinating resources.

There is much to be positive about, yet there remains more to do to sustain and develop the recent advances. We must:

- Look critically at the operation of each WDC and VDC to enhance operational effectiveness
- Put in place mechanisms to learn from mistakes so as to ensure each WDC and VDC is better able to carry out its duties
- Fully involve stakeholders in the selection and implementation of projects
- Build consensus and support by ensuring the NPHCDA, all tiers of government and traditional leaders engage, consult and work together
- Ensure WDCs 'own' every project they execute, so that each is protected, nurtured and developed for the long term

Engagement of traditional and religious leaders nationwide

The fight for a healthier Nigeria begins with communication. Throughout the year the NPHCDA has continued to work closely with traditional and religious leaders to ensure that those in positions of greatest influence are assisting in immunization and health awareness campaigns, and supporting local WDCs.

Northern traditional leaders

Our partnership arrangement with religious leaders under the platform of Northern Traditional Leaders Committee was formed by the Sultan of Sokoto. Presently, it is led by his representative, the Shehu

of Burma. During 2012 we have deepened that relationship.

In July, a meeting in Zamfara with northern traditional leaders revealed strong support for the programme in terms of planning, supervision and resolving issues during campaigns.

Traditional leaders have been instrumental in resolving non-compliance issues. District and village heads followed health teams, and also attended each day's evening review meetings to help resolve issues.

At a regional conference in Abuja, Dr Ado J G Muhammad was able to convince the Izalla sect of the importance of vaccination. Members of the sect began sending messages to their members to accept vaccines.

Sensitization meeting, Enugu, July 2012

During the sensitization meeting with south-eastern traditional leaders, Dr Ado J G Muhammad told the attendees that despite the stoppage of polio in the area for over two years, it could re-surface if not eradicated in other regions.

The meeting was well attended by traditional leaders and officials of the south-east zone of the NPHCDA. Dr Muhammad added that the agency had the required doses of polio vaccine and other materials needed to continue the fight against the disease in the northern part of the country where the disease is endemic.

"Having understood the nature of the disease, we urge traditional and religious leaders to continue the good work of enlightening the people on the significance of the vaccine to our children," he said.

Sensitization meeting with Traditional Rulers South East, 26th July, 2012.





Meeting of Northern Traditional Leaders.

Eze Cletus Ilomuaya, traditional ruler of Obinugwu Autonomous Community described the stoppage of polio in the south east for over two years as a “great feat and achievement”.

He added that traditional institutions would not rest until polio is eradicated totally from the country.

The traditional rulers commended the Federal Government for providing the NPHCDA with necessary facilities and adequate funding for the purchase of vaccines and all that is needed to eradicate polio.

Results of engagement activities

Engaging with traditional and religious leaders has resulted in a number of high profile and helpful announcements.

Sheikh Dahiru Usman Bauchi

In March 2012, for example, Sheikh Dahiru Usman Bauchi, celebrated Muslim scholar and spiritual leader, called on all Muslims to ensure their children were vaccinated against poliomyelitis.

Sheikh Dahiru Bauchi made this call while speaking at the Polio Free Torch Campaign, organized at Bauchi Government House, Bauchi by the NPHCDA (see Goal 1).

“The Prophet Muhammad (SAW) says: ‘Prevention is better than cure’” the Sheikh submitted, adding that this was why he was urging “all and sundry to please allow the vaccinators access to their house so as to vaccinate their children against poliomyelitis.”

He recalled with great delight past efforts by the World Health Organization (WHO) which led to the eradication of similar diseases, hitherto believed to be incurable.

Sheikh Dahiru Bauchi said that Nigeria, as one of the countries still battling with polio, required the support of all patriotic citizens to make the country polio free.

The Emir of Daura

Speaking at a flag-off exercise at Karkarku Ward of Sandam Local Government Council of the State, The Emir of Daura, Alhaji Faruk Umar, lamented the attitude of anyone employed as a vaccinator who

didn't carry out their assignment, believing it to be ungodly.

The Emir said village heads, community leaders and religious leaders in his domain would risk sanctions if he received any confirmed reports of rejection or any undoing of the polio vaccination exercise.

The Wakili of Dagaro Ward

Sheikh Ahmed Abdullahi commended the introduction of WDCs and VDCs. As the Patron of the Dagaro Ward Development Committee, he said the programme would strengthen health care delivery in the area.

The traditional ruler stated that fully implementing the policy as planned across all states would reduce the difficulties faced by people in rural communities in trying to access health care delivery.

LGA chairmen sensitization

The 2012 Polio Eradication Emergency Plan listed building awareness and the political support of LGA

Chairmen as a key factor in ensuring oversight of the program at the highest level.

LGA Chairmen are required to participate in supervision of SIAs and RI, coordination and physical attendance of review meetings during implementation, and the releasing of funds for activities.

Yet the role of LGA Chairmen stretches beyond polio, to wider health issues including supporting WDCs. The NPHCDA has been working with ALGON chairmen to engage and support them.

One example of this came in November's workshop in Kano, attended by the National Orientation Agency, Ministry of Health Directors and ALGON chairmen in the affected states.



Signing of the MOU with the National Orientation Agency.



Engaging FOMWAN and NIAA

FOMWAN

When members of the Federation of Muslim Women's Associations in Nigeria (FOMWAN) and other NGOs/CSOs become part of vaccination teams there is a positive effect on local awareness and mobilization rates.

The NPHCDA has worked with FOMWAN to scale up their involvement and fully realise the benefits they can bring, especially in remote and difficult to reach areas, and areas of traditionally high non-compliance.

NIAA

During the year the NPHCDA has developed its partnership with the Nigeria Interfaith Action Association (NIAA).

As a result, November saw NIAA challenge stakeholders in the health sector to collaborate with the Federal Government in fighting pneumonia infection in children.

The association made the call in Abuja at the National Summit on Pneumonia, organised by the NPHCDA.

The co-chairmen of NIAA, the Sultan of Sokoto, Alhaji Sa'ad Abubakar, and the President of the Christian Association of Nigeria (CAN), who was represented by the Executive Director of NIAA, Bishop Sunday Onouha, said because pneumonia "is a deadly disease that kills thousands of children yearly in the country," there was the need for everybody to join hands with government to reduce the ugly trend.

"It is our children that are dying, and when they die, they either die as Muslims or Christians," he said. "They die as human beings with blood. This is why we must care for their health. Parents should therefore bring out their children to get the vaccine against pneumonia during immunization."



Polio QTR Awareness Campaign in Kano State.

Engagement and scale-up of volunteer community mobilizers

Almost 2,000 Volunteer Community Mobilizers (VCMs) have been deployed to areas of greatest need to ensure no children are missed during Immunization Plus Days. The work of VCMs raises the level of local knowledge and understanding and drives engagement within local communities.

In the first phase, VCMs worked in 557 settlements in Kano, 200 in Kebbi and 200 in Sokoto to reduce the number of missed children through targeted house-to-house interventions, generating demand for and acceptance of the oral polio vaccine.

The first training-of-trainers sessions took place in Kebbi and Kano in early March with follow-up cascade training for settlement volunteers to ensure high levels of mobilization in the earliest stages of the initiative.

Selected from their settlement, the VCMs continue to act as 'change agents' in their respective communities. They are responsible for resolving

non-compliance, tracking unimmunized children in their own high risk settlement and carrying out door-to-door communication interventions with caregivers on issues related to immunization and key household practices.

The fact that the volunteers will also provide information to the community on key household practices such as nutrition, basic sanitation and hygiene is important to counter 'polio fatigue' at the community level. The volunteers also disseminate information on existing health services and explain the need for timely utilization of health services.

"Several pilot projects which have engaged and empowered community volunteers in the efforts to reduce missed children and non-compliance have shown encouraging results in the country. These volunteers are expected to be a fountainhead of community participation in health programmes in Nigeria," said Dr Ado J G Muhammad, Executive Director of the NPHCDA.

Maternal Newborn and Child Health Week

The NPHCDA's Department of Community Health Services leads the planning and implementation of the annual Maternal, Newborn and Child Health Week (MNCHW), a strategy endorsed by the National Council on Health which aims to improve coverage of key interventions targeted at reducing maternal, newborn and child morbidity and mortality.

MNCHW began in March 2010, as a major part of our strategy to achieve the Millennium Development Goal of reducing maternal and child mortality.

Since 2010 there have been five MNCHWs, each delivering improvements on the last. Each week sees events take place in every state at which health



Dr Ado J G Muhammad.

workers administer Oral Polio Vaccine, Vitamin A supplement and mosquito nets.

The NPHCDA will continue to support states and local governments to ensure quality implementation of each MNCH week.

Orientation of NYSC members as community change agents

In June 2012 the NPHCDA met the National Youth Service Corps (NYSC) with a view to strengthening the health care system at the grassroots. The result was the establishment of the Primary Health Care Corps, a collaboration between NPHCDA and NYSC.

Speaking at the National Stakeholders' Meeting on Primary Health Care Under One Roof (PHCUOR), NPHCDA Executive Director Dr Ado J G Muhammad said the nation's health system had remained disjointed at the sub-national level with straight delivery programmes failing to achieve desired results.

"There is therefore the need to create new strategies that will bring the health system on track, hence the need for the PHC Corps," he said.



“The NPHCDA is working towards the re-birth of PHC. To achieve this goal, we are providing a platform for actualisation of the Saving One Million Lives strategy, which is a home grown strategy.”

Represented by Dr Muhammad Jibril Abdullahi, the Director, Primary Health Care System Development, the executive director said PHCUOR aims to bring managerial, planning, implementation and monitoring “under one roof.”

In his address, the Minister of State for Health, Dr Mohammed Ali-Pate, represented by his Special Assistant, Dr Ibrahim Labaran, said the nation’s health system had been faced with structural limitations through the decentralised system of government.

He called for a paradigm shift from inputs and processing to result driven programmes that would improve the health sector at all levels.

Walk 4 Life – NPHCDA HLS Programme

During 2012, the NPHCDA worked to ensure that other government Ministries, Departments and Agencies (MDAs) established health promotion desks to ensure a healthy workforce.

A key part of the initiative was the ‘Walk 4 Life’, a health promotion designed by the agency to awaken Nigerians to the immense advantages of physical exercise to prevent diseases and ensure healthy living.

According to Executive Director Dr Ado J G Muhammad, a healthy workforce is paramount to attainment of the transformation agenda of the present administration and the Millennium Development Goals (MDGs).

“Through regular exercise people will be able to prevent non-communicable diseases like diabetes and hypertension. People will be healthy and more effective and efficient to put in their bests in their work place.

People don’t need to come out every time for exercise. They can do it in their homes before going to work every day,” he said.



Walk 4 Life Programme.

Appendix 1: Accountability framework

STEP	ACTION
1	The first step is for the state team to direct a full strategic assessment of the high-risk LGAs.
2	<p>The LGA teams should conduct this assessment, and based on evidence (IPDs, RI and surveillance data) and experience, determine the specific impediments to achieving high population immunity. These impediments may include:</p> <ul style="list-style-type: none"> • Leadership issues such as low involvement of the LGA Chairman, District and Village Heads or Ward Development Committees in planning and review • Funding issues such as the timely release of sufficient funds at every level • Personnel issues such as the quality of ward focal persons, supervisors and monitors; the selection of vaccinators; the seniority of community leaders • Population demographic issues such as low population immunity in neighbouring LGAs with heavy transport and trade routes, seasonal population movements; hard to reach areas • Operations issues such as quality of microplans, the completeness of settlement lists, the implementation of social mobilization and communication activities to address community concerns; the efforts to line-list and return to vaccinate non-compliant and absent children; the rationality of vaccinator workloads; logistics and transport; the quality of the cold chain; the quality of afternoon and evening review meetings, etc.
3	The LGA teams should identify up to four core impediments.
4	The LGA teams should identify concrete, specific solutions to each impediment.
5	The LGA Teams should identify the individual responsible to implement each solution along with a timeline for implementation. Note the individual may be a government, traditional leader or other.

Appendix 2:

Summary of GAVI renovated health facilities and medical equipment inspected

S/N	State	LGA	WARDS	SELECTED HF
1	ABIA	UMUNNEOCHI	Amauba/Umugbuele	
			Amorie	
			Amuda	Umucha PHC
			Aroikpa	
			Eziama-Agbor	
			Eziamaugwu	
			Ezingodo	Ezingodo PHC
			Lekwesi	
			Leru	Leru HC
			Lokpanta	Lokpanta BHC
			Lokpaukwu	Umuchieze PHC
			Mbaala/Achara	Mbala PHC
			Obinolou/Obiagu/Lomara	Lamora Maternity
			Obinulo/Umugbokocha	
			Ubaha/Akawa	
			Umuaku 1	Umuaku HC
			Umuaku 2	
			Umudim/Umuloghu	
			Umuobasi	Umuobasi PHC
2	AKWA-IBOM	NSIT IBOM	ASANG 1	Mbiokporo 1 Model PHC
			ASANG 2	
			ASANG 3	
			ASANG 4	Oboetim Ikot Ekong PHC
			ASANG 5	
			MBIASO 1	Afaha Offiong PHC
			MBIASO 2	Afia Nsit Udua Nko PHC
			MBIASO 3	Afaha Abia PHC
			MBIASO 4	
			MBIASO 5	Mbiaso PHC
3	ANAMBRA	ORUMBA NORTH	Ajalli	Ajalli ward 2 PHC
			Amaetiti	Amaetiti Phc Centre
			Amaokpala	Amaokpala Phc Centre

S/N	State	LGA	WARDS	SELECTED HF
3	ANAMBRA	ORUMBA NORTH	Awa	Awa Phc Centre
			Awgbu I	Awgbu Ward I Phc Centre
			Awgbu II	Awgbu Ward II Phc Centre
			Nanka I	Nanka Ward 1 Phc Centre
			Nanka II	Nanka Ward 2 Phc Centre
			Ndikelionwu	Ndikelionwu Phc Centre
			Ndiokolo	Ndiokolo Phc Centre
			Ndiokpaleke	Ndiokpaleke Phc Centre
			Ndiokpaleze	Ndiokpaleze Phc Centre
			Ndiowu	Ndiowu Phc Centre
			Ndiukwuenu	
			Oko I	Oko Ward I Phc Centre
			Oko II	Oko Ward II Phc Centre
			Okpeze	Okpeze/Ndiukwelu PHC
			Omogho	Omogho Phc Centre
			Ufuma I	Ufuma Ward1 Phc Centre
			Ufuma II	Ufuma Ward 2 Phc Centre
4			CROSS RIVER	OBUBRA
	Apiapum	Staff Qtrs		
	Iyami	Okumuretet		
	Obubra Urban	Ogada 1		
	Ochon	Isabang		
	Ofat	Ofat HC		
	Ofodua	Ofodua HC		
	Ofumbongha-Yala	Yala HC		
	Osopong 1	Apiapumtet		
	Osopong 2	Ohannaeda		
	Ovonum	Ofatdua HC		
5	DELTA	ISOKO NORTH		
			Emevor	Emevor PHC
			Iyede(1)	Otor-Iyede PHCC
			Iyede(2)	Iwride PHCC

S/N	State	LGA	WARDS	SELECTED HF
5	DELTA	ISOKO NORTH	Ofagbe	Ofagbe
			Okpe-Isoko	Okpe-Isoko
			Owhe(1)	Owhe Ologbo PHC
			Owhe(2)	Akiewhe PHC
			Owhe(3)	Otiblo PHC
			Oyede	Bethel PHC
6	EBONYI	IZZI	AMUZU	Amuzu Health Post
			AZUABE	ENYIBUCHIRI H/C
			EZZA INYIMAGU WARD II	Ette Model PHC
			MGBALUKWU WARD 1	Iboko staff clinic
			IGBHUPHU WARD I	Ezzaofu Health Clinic
			IGWELEDOHA	NDINWAGBA H/P
			Izenyi	NDUENYIM H/P
			EZZA INYIMAGU WARD IV	Iziogu Health Centre
			MGBABELUZOR	Ndiegu Obovu Health Post
			MGBO & AGUBATA	NGBO AGBAJA H/P
			NDIABOISHIAGU	NDIABIOISHIAGU H/C
			NDIBOKOTE	
			NDIEZA	Izhokoma Health Centre
			NDIMBAM	
			MGBALUKWU WARD 1	Ndingele Health Post
			NDINKWUDA	NDINKWUDA H/C
			NDIORUTA	-
			NDUBIA	Ndubia HC
			NWANU	-
	NWOFE	NWOFE H/C		
7	EDO	OVIA SOUTH	IGUOBAZUWA EAST	Iguobazuwa HC
			IGUOBAZUWA WEST	Okokpon Health Centre
			NIKROGHA	Jamaigbe Health Centre
			OFUNAMA	Ofunama health Centre
			ORA	Ora Health centre
			SILUKO	Izide Health Centre
			UDOO	Urhenzen Health Centre
			UGBOGUI	Aden Health Centre
			UMAZA	Iguelaiho Health Centre
			USEN	Okha Health Centre
8	EKITI	IKERE	AFAO/KAJOLA	Afaoko Kajola HC
			AGBADO OYO	Agbaado Oyo PHC
			ARE/ARAROMI	Are-Araromi HC
			ATIBA AAFIN	Ikoyi Health Centre
			IDEMO	Idemo Health Centre
			IJAO ILAPETU	Oke-Ikere PHC
			ODOSE	Odose Health Centre
			OGBONJANA	Ogbonjana Health Centre
			OKE-OSUN	Oke - Osun II
9	ENUGU	ISI UZO	Eha Amufu 1	Isu Model Primary HC
			Eha Amufu 2	Umuhu PHC
			Eha Amufu 3	Abor Health Post
			Eha Amufu 4	Amede health Post
			Ikem 1	Ikem PHC
			Ikem 2	Ikem Nkwo Health Post
			Mbu 1	Agudene health Post
			Mbu 2	Akpuoga Health Post
			Neke 1	Neke Health Post
			Neke 2	Neke PHC
			Umualor	Umalor PHC

S/N	State	LGA	WARDS	SELECTED HF
10	IMO	IKEDURU	Eziama Ward	Iziama Health Clinic
			Okwu /Ugirike	Ugurike Health Clinic
			Akabo	Akabo Health Clinic
			Amaimo	Amaimo Health Clinic
			Amakohia ward	
			Amatta	
			Atta I	Atta Health Clinic
			Atta II	
			Avuvu	Avuvu Health Centre
			Ebikoro	Ebikoro Health Clinic
			Iho	Infant Welfare Clinic
			Inyishi	Inyishi Health Clinic
			Ngugo-Ikembra	Ikembra Health Centre
			Umudim	Umudim Health Clinic
			Umuri	Uwuri Health Clinic
			Uzoagba	
11			LAGOS	OSODI/SOLO
	Aigbaka			
	Ailegun	Ejiagbo Maternity		
	Ajao Estate	Ajao HC		
	Akingbaye			
	Alagbeji	LSDPC HC		
	Apena			
	Ewutuntun	Ewutitun PHC		
	Fadu	Ejiabo PHC		
	Ifoshin	Omiyale		
	Igbehinadun	Oshodi PHC		
	Ilamoshe	Abule Igbira		
	Ilasamaja	Iliasa PHC		
	Ishagba/Ire-Akarin	Com. Health Centre		
	Mafolokun	Branco PHC		
	Ogunolokun	-		
	Oke-Afa	Jakande PHC		
	OKOTA	Openia		
	OLUYEYE	Mafolokun PHC		
	SHOGUNLE	Shogunle PHC		
12	OGUN	ABEOKUTA NORTH	Iberekodo 1	Iberekodo Health Clinic
			Iberekodo 2	
			Iberekodo 3	
			Iberekodo 4	
			Idiya	
			Ierekodo 5	Ibereku Health Clinic
			Ikereku 1	Ibara Orile Health Clinic
			Ikereku 2	Fagbenro Health Clinic
			Imala	Anigbado Health Clinic
			Olorunda	Olorunda Health Clinic
			Sabo 1	Sabo Health Clinic
			Sabo 2	
			Totoro 1	Igosun Health Clinic
			Totoro 2	Totoro health Clinic
			Totoro 3	Ikeye Health Clinic
			Totoro 4	Lafenwa Health Clinic

S/N	State	LGA	W ARDS	SELECTED HF
13	ONDO	AKOKO	AGBA	Agba PHC
			AKUNGBA I	Ilale street, Akungba PHC
			AKUNGBA II	Araromi PHC
			AYEGUNLE	Ayegunle PHC
			IBAKA	
			IKANMU	Ikanmu PHC
			IKESE	Family support Ikese market
		SOUTH WEST	IKUN	Ikun PHC
			OBA I	Oba PHC
			OBA II	
			Oka-Odo	Oka Odo PHC
			Okia	Okia - Oka PHC
			Owalusi	Owalusi PHC
			Supare I	Supare Model PHC
Supare II	Idofun Supare maternity			
14	OYO		Oke Adu	Oke Ibadan HC & Maternity
			Oranyan	
	EKITI		Okeruku	Okereku Health Centre
			Ugele/Arokun	Ayede Health Centre
OSUN		Alusekere	Agodo PHC	
15	OSUN	EDE NORTH	Apaso	Apaso PHC
			Asunmo	Asunmo PHC
			Bara-Ejemu	
			Buari Isibo	Oju TimimPHC
			Oloba/Atapara	Isale Oyeku HC
			Ologun/Agbaakin	Ologun-Agba-Akin PHC
			Olusokun	Olusokun PHC
			Sabo Agbengbe1	Osun Agbeni PHC
			Sabo Agbengbe11	Oke Gada PHC
			Sagba/Abogunde	Sagba PHC
			16	OYO
Alafara	Alafara PHC			
Aperin	Arema Health Centre			
Atipe				
Basorun	Okeke-oloronbo H C			
NORTH EAST	Irefin			
	Ode Aje	Ode Aje Health Post		
	Odo-Osun			
	Oja-Gbo			
	Oje			
		Oke Ibadan HC & Maternity		
		Oranyan		
17	RIVERS	OBIO AKPOR	ObWard1	Eleozo Maternity HC
			ObWard2	Eriebe HC
			ObWard3	Rumuokwusi HCM
			ObWard4	Rumuodumaya HP
			ObWard5	Eledenwo Family support
			ObWard6	Obio HC
			ObWard7	St Jude HP

S/N	State	LGA	WARDS	SELECTED HF		
			ObWard8			
			ObWard9	Rumuekprikom HC		
18	RIVERS	OBIO AKPOR	ObWard10	Cohtech HC		
			ObWard11			
			ObWard12	Rumuigbo HC		
			ObWard13			
			ObWard14	Eneke Basic HC		
			ObWard15	Rumuekini PHC		
			ObWard16	Akpor HC		
			ObWard17	Rumuolumini HC		
19			BAYELSA	KOLOKUMA/OPOKUMA	IGBEDI	Igbedi Health Centre
					KAIAMA	
	KAIAMA/OLOBIRI					
	ODI CENTRAL	Odi Central Health Centre				
	ODI NORTH					
	ODI SOUTH					
	OKOLOBA	Okoloba Health Centre				
	OPOKUMA NORTH	Opokuma North HC				
	OPOKUMA SOUTH					
	SAGREIA	Sabagreia Health Centre				
	SAMPOU/KALAMA	Sampou Health Centre				



Staff of the NPHCDA at the inaugural Walk for Life programme