



NIGERIA

MDG ACCELERATION FRAMEWORK

A COMMITMENT TO IMPROVED MATERNAL HEALTH



MDG ACCELERATION FRAMEWORK:

A COMMITMENT TO IMPROVED MATERNAL HEALTH

August 2013

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AUGUST 2013

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FOREWORD

The Government of Nigeria recognizes the enormous impact of the achievement of the health-related millennium development goals (MDGs) on the overall success of all of the MDGs in Nigeria. For this reason, I am particularly delighted that *Nigeria's MDGs Acceleration Framework and Action Plan for Maternal Health (MDG 5)* has been meticulously prepared in order to be implemented and meet the MDGs by 2015 or shortly thereafter. It is worth reiterating that no woman should die from preventable causes while giving birth. This is the *raison d'être* for the *Saving One Million Lives Initiative* that this Administration has been vigorously promoting.

Over the years, the issue of improving maternal health has been of particular interest to President Goodluck Ebele Jonathan in his former role of Chairman of the Economic Community of West African States (ECOWAS) and as current Co-chairman of the United Nations Commission on Life-Saving Commodities for Women and Children. He successfully mobilized other African Heads of State and Government to give a fresh impetus to the Campaign for the Accelerated Reduction of Maternal Mortality in Africa (CARMMA). This is one area where we cannot afford to fail if we want to ensure human development and greater wellbeing.

Consequently, the Government is doing everything possible to steadily build on the progress achieved in our country in maternal mortality reduction. To this end, we have continued to pursue a multifaceted approach by improving health facilities, public sanitation, education and communication. There is still need for greater commitment to increasing access to essential life-saving commodities designed to save millions of lives of our women. I therefore call on all relevant health professionals to prioritize ongoing efforts in saving the lives of all pregnant women, a task that must be transmitted to future generations.

I also call on our international development partners, the private sector, national and international humanitarian agencies, philanthropic individuals and organizations, civil society organizations, and community and faith-based organizations to continue their cooperation with our Administration in order to drastically reduce maternal mortality in our country. It is therefore my singular honour and privilege to present *Nigeria's MDGs Acceleration Framework: A commitment to improve maternal health* to be implemented by three tiers of government.

Finally, I commend the Office of the Senior Special Assistant to the President on Millennium Development Goals (OSSAP-MDGs), the Federal Ministry of Health and its agencies, the United Nations Country Team, and the UK Department for International Development (DFID) for their collaborative efforts in producing this important document.



Professor C.O. Onyebushi Chukwu
Honourable Minister of Health

PREFACE

Since Nigeria signed the Millennium Deceleration in 2000, it has invested substantially in the Millennium Development Goals (MDGs) through its establishment of Presidential Committee on MDGs, conducting the MDG Costing and Countdown Strategy; establishing and continuously implementing the debt relief gain (DRG) funds, including the Conditional Grants Scheme (CGS) and conditional cash transfers (CCTs); mainstreaming the MDGs into Vision 2020 and the Transformational Agenda; and preparing an MDG acceleration priority action plan for maternal health, among others. With less than three years remaining until the MDG 2015 deadline, Nigeria is on track on some targets and is making progress on many others, but is off-track on several others. As at 2012, Nigeria has achieved three targets: (i) Halving the proportion of population undernourished; (ii) gender parity in primary and secondary school enrolments; and (iii) reversing the trend on HIV/AIDS and malaria. Reducing maternal mortality is among the targets that have recorded appreciable progress between 1990 and 2012: it declined from 1,100 per 100,000 live births in 1990 to 350 in 2012. However, although this trend is encouraging, the rate of decline is inadequate for reducing the maternal mortality ratio (MMR) to 250 maternal deaths per 100,000 live births by 2015. Accelerated attention is required, therefore, for further improvement. Given the country's large population, Nigeria's attainment of the MMR target will significantly improve the maternal health outcomes in Africa as a whole.

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

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

The Country Action Plan (CAP) is firmly anchored on feasible, cost-effective, high-impact interventions in place that have the highest potential to accelerate progress. The MAF is not aimed at inventing new interventions or replacing nationally owned planning processes and frameworks; rather, it complements and reinforces them by identifying interventions and actors that have worked effectively to overcome bottlenecks. There is a need to sustain the high level of political commitment, adequate funding and dedicated administrative support from federal, state and local government levels. It is our considered belief that an effective and focused implementation of the MAF Action Plan will help redouble efforts and enhance the effectiveness of resources utilization towards significantly reducing maternal mortality in Nigeria – an achievement that all national actors and partners alike will look back on proudly.

Finally, we wish to restate our collective commitment in providing the high-level support required for the successful implementation of the MAF. This political commitment was stressed by the Vice President during the stakeholders' workshop on the MAF in Nigeria organized by the OSSAP-MDGs in collaboration with international development partners (IDPs) on 17 January 2013 in Abuja and through the endorsement of the report by the Presidential Committee on the MDGs during its March 2013 meeting. In the same vein, we would like to appeal to all public and private health professionals, development partners and other stakeholders to provide the maximum support needed for the achievement of maternal health targets.



Dr. Precious Gbeneol
Senior Special Assistant
to the President on MDGs



Daouda Toure
United Nations Resident Coordinator and
UNDP Resident Representative

ACKNOWLEDGEMENT

As the organizing agency for the preparation of *Nigeria's MDGs Acceleration Framework and Action Plan for Maternal Health* (MDG 5), the Office of the Senior Special Assistant to the President on MDGs (OSSAP-MDGs) wishes to express its sincere gratitude to President Goodluck Ebele Jonathan, GCFR, for providing the energizing force that fast-tracked the roll-out of the United Nations MDG Acceleration Framework (MAF) in Nigeria. The support of the Presidency in providing the necessary political support and guidance for the effective implementation of the MDGs in Nigeria cannot be overemphasized. In this regard, the OSSAP-MDGs is most grateful to the Vice-President Arch. Mohammed Namadi Sambo, GCON, for declaring open the high-level stakeholders' briefing on the application of MAF in Nigeria.

The support of the National Assembly on the preparation of MAF was very encouraging. Special thanks go to the Senator Mohammed Ali Ndume, Chairman, Senate Committee on MDGs for making useful contributions at the commencement stage of the preparation of MAF. The OSSAP-MDGs is also grateful to the Chairman House of Representatives Committee on the MDGs, Hon. Alhassan Ado Doguwa, for his unflinching support in the implementation of the MDGs.

The preparation and completion of MAF on MDG 5 would not have been possible without the collaborative effort and technical lead of the Federal Ministry of Health. The OSSAP-MDGs is deeply grateful for the immense cooperation of the Honourable Minister of Health, Prof. Onyebuchi Chukwu, and of the entire staff of the Ministry and its parastatals, especially, the National Primary Health Care Development Agency (NPHCDA). We are also grateful to National Agency for the Control of AIDS (NACA), who worked tirelessly to provide the necessary data.

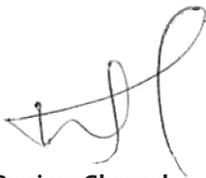
The OSSAP-MDGs deeply appreciates the wonderful contributions made by our technical partners. The technical backstopping provided by UNDP was outstanding because it brought in international experts from both New York and Ghana to support a team of national consultants. The Office expresses its special thanks to Daouda Toure, United Nations Resident Coordinator, Nigeria, Ade Mammonyane Lekoetje, UNDP Nigeria Country Director, Kamil K. Kamaluddeen, UNDP Ghana Country Director, Colleen Zamba, UNDP Economic Advisor, Nigeria, and Victor Oboh, UNDP National Economist, Nigeria, for their tireless efforts in making the preparation and roll-out of MAF possible. The technical support, oversight and quality assurance on the MAF preparation process by Dr Ayodele Odusola, the MDG Adviser to UNDP Regional Bureau for Africa are deeply appreciated. We also appreciate the editorial role of Barbara Hall and logistic support from Jonas Mantey and Yechi Bekele.

The OSSAP-MDGs is extremely grateful to DFID for funding support towards the realization of this very important project. The organization of the technical stakeholder and validation workshops, the hiring of three out of the four national consultants, *inter alia*, were supported by DFID. The Office is grateful to the following people for relentlessly ensuring that the preparation and roll-out of MAF was a huge success: Richard Montgomery, Head of DFID in Nigeria; Dr. Joe Abah, National Programme Manager of DFID-SPARC; Hadiza Elayo, Programme Manager Federal workstream, DFID-SPARC; Virtuous Igbodika, Senior Technical Officer, Federal workstream, DFID-SPARC; and Chioma Itodo, Senior Technical Officer, Federal Workstream, DFID-SPARC.

To all members of the Technical Working Group (TWG) that coordinated the entire process, OSSAP-MDGs cannot thank you enough. In addition to UNDP and DFID, these members include Pharm. Yahaya Hamza (Chairman of TWG), Dr. Ngozi Azodoh, P.A. Akinfemide, Dr. Ifeolu Joseph Falegan, Dr. Seifa F. Brisibe, Barrister Chinedu Eze, Lola Olaopa, Tom Northover, Dr. Andrew L. Mbewe (WHO), Dr. Esther Obinya (UNICEF), Olunfunke Baruwa, Adigun Philip, J.O. Gillis Harry from the FMoH and NPHCDA and Barrister Paul Gbeneol, Secretary. The contributions of Barth Feese and other costing experts who joined the team at the advanced stage of the MAF process are deeply appreciated.

The OSSAP-MDGs gratefully acknowledges the immense assistance received from experts from some other United Nations agencies such as the World Health Organization (WHO), United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF), Joint United Nations Programme on HIV/AIDS (UNAIDS) and UN Women. The participation of all stakeholders across the country at both the technical and validation workshops is well appreciated because their contributions reflected the various perspectives and consequently enriched the diversity and quality of the MAF process.

OSSAP-MDGs is also grateful to the lead consultant Prof. Ode Ojowu, and other consultants, namely Prof. Eric Eboh, Prof. Isaac Obasi and Dr. Muhammed Lecky for their patriotic zeal and commitment in the preparation of *Nigeria's MDGs Acceleration Framework and Action Plan for Maternal Health*.



Dr. Precious Gbeneol

Senior Special Assistant to the President on MDGS

August 2013

ACRONYMS AND ABBREVIATIONS

| | |
|-----------------|--|
| ANC | Antenatal care |
| BEmONC | Basic emergency obstetric and newborn care |
| BEOC | Basic emergency obstetric care |
| BFH | Baby-friendly hospital |
| BFI | Baby-friendly initiative |
| CAP | Country Action Plan |
| CBMNC | Community-based maternal and newborn care |
| CBNC | Community-based newborn care |
| CBO | Community-based organizations |
| CDS | Countdown strategy |
| CEmONC | Comprehensive emergency obstetric and newborn care |
| CEOC | Comprehensive emergency obstetric care |
| CGS | Conditional Grants Scheme |
| CHEW | Community health extension worker |
| CHW | Community health worker |
| CSO | Civil society organization |
| DFID | Department for International Development |
| ELSS | Expanded life-saving skills |
| EmONC | Emergency obstetric and newborn care |
| ETAT | Emergency triage and treatment |
| FANC | Focused antenatal care |
| FBO | Faith-based organization |
| FCT | Federal Capital Territory |
| FMoE | Federal Ministry of Education |
| FMoH | Federal Ministry of Health |
| FP | Family planning |
| GDP | Gross domestic product |
| GSM | Global system for mobile communication |
| HDI | Human Development Index |
| HF | Health facility |
| HIV/AIDS | Human immunodeficiency virus/acquired immune deficiency syndrome |
| ICT | Information and communication technology |
| IDP | International development partner |
| IEC | Information, Education and Communication |
| LGA | Local government area |
| LSS | Life-saving skills |
| MAF | MDG Acceleration Framework |
| MDA | Ministries, departments and agencies |

| | |
|----------------|---|
| MDG | Millennium Development Goal |
| M&E | Monitoring and evaluation |
| MICS | Multiple Indicator Cluster Survey |
| MLSS | Modified life-saving skills |
| MMR | Maternal mortality ratio |
| MNCH | Maternal, newborn and child health |
| MSS | Midwives Service Scheme |
| NACA | National Agency for the Control of AIDS |
| NBS | National Bureau of Statistics |
| NCC | National Communications Commission |
| NCCGS | National Committee on Conditional Grants Scheme |
| NDHS | Nigerian Demographic and Health Survey |
| NGN | Nigerian Naira |
| NGO | Non-governmental organization |
| NHIS | National health insurance scheme |
| NPC | National Planning Commission |
| NPHCDA | National Primary Health Care Development Agency |
| NSHDP | National Strategic Health Development Plan |
| NURTW | National Union of Road Transport Workers |
| NYSC | National Youth Service Scheme |
| ODA | Overseas development assistance |
| PHC | Primary health centre |
| PMTCT | Prevention of mother-to-child transmission |
| PPFN | Planned Parenthood Federation of Nigeria |
| RH | Reproductive health |
| SBA | Skilled birth attendant |
| SMoH | State Ministry of Health |
| SOP | Standard operating procedures |
| SPARC | State Partnership for Accountability, Responsiveness and Capability |
| SSAP | Senior Special Assistant to the President |
| STI | Sexually transmitted infection |
| TBA | Traditional birth attendant |
| ToT | Training of trainers |
| TT | Tetanus toxoid |
| TWG | Technical working group |
| UNDP | United Nations Development Programmes |
| UNFPA | United Nations Population Fund |
| UNGASS | United Nations General Assembly Special Session |
| UNICEF | United Nations Children's Fund |
| UNO | United Nations Organization |
| VHW | Village health worker |
| VPF | Virtual Poverty Fund |
| WDC | Ward development committees |
| WHO | World Health Organization |
| YFHS | Youth-friendly health services |

EXECUTIVE SUMMARY

In September 2010, at a United Nations General Assembly Special Session (UNGASS), the United Nations Organization (UNO) provided a platform for a comprehensive review of the progress made during the last decade in achieving the Millennium Development Goals (MDGs). This review afforded participating nations the opportunity to peer review progress towards achieving the MDGs and to confirm their commitment to realizing them by 2015.

Like other nations, the Federal Republic of Nigeria presented its five-year countdown strategy (CDS) at the UNGASS. The overarching objective was to outline a roadmap for accelerating progress towards achievement of the MDGs by 2015. However, due to a variety of factors, implementation of the CDS did not gain the expected momentum, and as a result, the promising progress being made on some MDGs has suffered setbacks.

The MDG Acceleration Framework (MAF), a key outcome of the MDG+10 review, is a process that involves the preparation of a focused, agreed upon Action Plan to address specific MDGs where progress is lagging. This plan also requires the cooperation and support of all stakeholders, including governments, development partners, civil society organizations (CSOs) and the private sector in providing the resources and other services needed to advance key policy reforms and overcome the identified constraints to achieving a given MDG target.

The key strategy of MAF is to:

- identify and prioritize **interventions** that have the potential to deliver the highest impact;
- analyse and prioritize **bottlenecks** hindering the success of interventions;
- identify **solutions** and their sequencing.

Based on these three steps, an accelerated action plan, together with an implementation and monitoring plan, is then developed. Given both the overwhelming evidence of the synergies that progress in improved maternal health engenders for other MDGs and overall economic progress, Nigeria has chosen MDG 5 for the MAF.

The goals, targets and indicators of MDG 5 that the MAF will focus on are presented in Table 1.

MDG Acceleration Framework (MAF) process methodology

The roll-out of the MAF clearly involves a rigorous process, all the more so in a populous federal country like Nigeria. This process received the highest level of political endorsement from the Presidency through a stakeholder forum. Three key decisions that established the methodological point of departure were:

- the setting up of the institutional framework for effective coordination of the MAF process. This was jointly driven by the Office of the Senior Special Assistant to the President on MDGs (OSSAP-MDGs), the Federal Ministry of Health (FMoH) and international development partners (IDPs);

TABLE 1:

MDG ACCELERATION FRAMEWORK (MAF) – FOCUS ON MGD 5

| MDG | Target | Indicators |
|-------------------------|--|--|
| Improve maternal health | Target 5.A: Between 1990 and 2015, reduce by three-quarters the maternal mortality ratio | 1. Maternal mortality ratio 2. Proportion of births attended by skilled health personnel |
| | Target 5.B: Achieve, by 2015, universal access to reproductive health | 3. Contraceptive prevalence rate 4. Adolescent birth rate 5. Antenatal care coverage (at least one visit and at least four visits) 6. Unmet need for family planning (FP) |

- the engagement of consultants to drive the technical process;
- the planning and organization of the stakeholders' consultation technical workshop in which the FMOH played a catalytic role.

The preparation of a comprehensive desk review provided the main input for the stakeholders' technical workshop. Participants were carefully selected to cover not only a geographical spread, but also different levels of professionals in the medical fields with hands-on experience in achieving MDG 5 (refer to the list of participants in Appendix 1). The participants discussed and chose five prioritized interventions and identified the prioritized bottlenecks through an elaborate process. Subsequently, a two-day intensive bilateral meeting was held between the consultants and key policy drivers and implementers, with support from IDPs. This meeting developed the suggested solution indicators, targets, timelines, the costing of MAF, and the assignment of responsibilities for the implementation of the solutions contained in the MAF Action Plan. The preparation of the final report benefitted further from the validation workshop organized for critical policy makers, stakeholders and supporting IDPs.

Prioritization of key interventions

Following consultations with stakeholders to accelerate the achievement of MDG 5, the following five key priority areas were selected from a list of over 20 major interventions without prejudice to state-level preferences in re-ordering the priorities:

- Family planning
- Skilled birth attendants (SBAs)
- Emergency obstetric and newborn care (EmONC)
- Universal coverage of antenatal care (ANC) and post-natal care (PC)
- An improved referral system.

Bottleneck analysis and prioritization

The bottlenecks that impede the success of prioritized interventions were identified, as shown in the tabulation below. The tabulation shows two broad types of bottlenecks – **sector-specific** and **cross-cutting**. Sector-specific bottlenecks are under the responsibility of the Federal and State Ministries of Health and local government health departments or affiliated agencies. Cross-cutting bottlenecks are inter-sector and economy-wide problems that affect

the results-based achievement of the MDG 5 interventions (see Table 2).

| TABLE 2 : | | BOTTLENECKS IMPEDING PRIORITIZED INTERVENTIONS | | | | |
|---|----------------------------|---|--|---|--|-----------------------------------|
| Prioritized bottleneck | Bottleneck category | Prioritized interventions | | | | |
| | | Family Planning (FP) services | Skilled birth attendants (SBAs) | Emergency obstetric and newborn care (EmONC) | Universal coverage of ANC and PNC | Improved referral services |
| Socio-cultural religious barrier | Cross-cutting and systemic | | | | | |
| Inadequately trained personnel | Service delivery | | | | | |
| Low male involvement/uptake | Systemic | | | | | |
| Inadequate SBAs | Service delivery | | | | | |
| Uneven distribution of available SBAs | Service delivery | | | | | |
| Inadequate referral training for SBAs | Service delivery | | | | | |
| Lack of functional equipment and facilities | Service delivery | | | | | |
| Poor incentives especially in rural areas | Budget and financing | | | | | |
| Shortage of skilled health personnel | Service delivery | | | | | |
| Inadequate equipment and supplies | Service delivery | | | | | |
| Delay in accessing care services | Service use | | | | | |
| Inadequate political will | Cross-cutting | | | | | |
| Poor access to health facilities in rural areas | Service use | | | | | |
| Poor attitude of health workers | Service delivery | | | | | |
| Lack of legislation | Policy and planning | | | | | |
| Inadequate ambulance services | Service delivery | | | | | |
| Poor communication and feedback system | Service delivery | | | | | |
| System delay | Service delivery | | | | | |

Acceleration solutions

With due regard to cultural sensitivities, the acceleration solutions proposed for each of the five prioritized interventions and their numerous bottlenecks are, *inter alia*:

Family Planning interventions:

- Scale up sensitization of traditional leaders, religious leaders, community-based organizations (CBO), faith-based organizations (FBOs) through appropriate media.
- Focus on teaching of family life education in secondary schools curriculum.
- Establish more functional youth-friendly centres.
- Raise awareness and mobilize men to take leadership in health matters.

SBA interventions:

- Recruit, train and re-train more SBAs.
- Shift/share tasks for SBAs.
- Scale up supply of basic equipment for SBAs.
- Strengthen, re-activate and form ward development committees (WDCs).

EmONBC interventions:

- Provide additional incentives for health workers in hard-to-reach areas/difficult terrain/rural areas.
- Scale up in-service training and implementation of life-savings skills (LSS) and community-based newborn care (CBNC).
- Incorporate LSSCBNC into the pre-service curriculum of SBAs.
- Regularly maintain adequate EmONC equipment and services.

Universal coverage of antenatal and post-natal care interventions:

- Train identified interest groups and civil society organizations (CSOs) to demand their rights.
- Ensure that CSOs pursue implementation of the rights of vulnerable groups.
- Bring outreach activities closer to the people.

Improved referral system interventions:

- Decentralize ambulance services to rural areas.
- Improvise functional ambulance services, such as tricycles, donkeys, speedboats, cows and camels.
- Collaborate with members of the National Union of Road Transport Workers (NURTW) or any community member for a reward.
- Develop an effective two-way referral system.

Budget

Details of the recommended accelerated solutions to each of the identified bottlenecks are contained in the later part of this report. It is estimated that the costs of these acceleration solutions and constituent activities would be NGN65,521,997,572 (equal to US\$420,632,968.941 million).¹ The mobilization of this amount is crucial to the successful implementation of the MAF Accelerated Action Plan.

1. At the January 2013 exchange rate of N155.77 to the US dollar.

Monitoring and evaluation (M&E) plan

A well functioning, results-based M&E system established as an integral element of implementation management is central to the success of the MAF Action Plan. The M&E plan recommended for MAF has three main thrusts:

- To provide programme managers and stakeholders with data and information on the pace, nature and levels of progress in service delivery and service use.
- To supply a credible evidence base for management responses in bridging gaps, correcting weaknesses and consolidating gains in the implementation of the agreed solutions and actions.
- To deliver a reporting and feedback system for tracking progress on MDG 5 through 2015 based on the MAF results chain – inputs, outputs, outcomes and impacts – with respect to MDG 5.

Key recommendations

An emergency meeting of the Presidential Committee for the MDGs should be convened to deliberate on the budget and commitments. Additionally, it should confirm the allocation of responsibilities to various tiers and agencies of the Government for the implementation of the MAF Action Plan, as detailed in the report. The IDPs are requested to make specific commitments to the implementation of the MAF Action Plan. With respect to achievement of the overall MDGs, it is recommended, among other things, that the attainment of the MDGs be made the central focus of the ongoing Centennial celebration.





I. INTRODUCTION

Photo: OSSAP

BACKGROUND

In 2010, a remarkable push was made in the global drive towards fast-tracking the achievement of the MDGs when the United Nations Organization provided a platform for a comprehensive review of the progress made to date. This global platform was the UNGASS on MDGs+10 that took place in September 2010. The decade's stocktaking event came on the heels of new challenges and realities, such as the global economic and financial crises and climate change as well as new evidence and innovations that needed to be factored into the MDGs' achievement trajectory. The MDGs+10 was an epoch-making event. It afforded the different nations the opportunity to reiterate their commitment to the MDGs, peer review progress and redouble their efforts towards meeting the goals by 2015, given the new risks and challenges.

The Federal Republic of Nigeria was among the nations that presented a five-year Countdown Strategy (CDS) at the UNGASS on MDGs+10. The overarching objective of the CDS was to outline a roadmap for accelerating progress towards the achievement of the MDGs by 2015. The specific objectives of the CDS were as follows:

- Identify the most effective mechanisms and interventions that have made progress against the MDGs.
- Highlight the roles and responsibilities of all agencies, stakeholders, and each tier of government.
- Guide the institutional improvements, policies and human resources required.
- Chart the trajectory of the MDGs' financing and investment to 2015.
- Interface with Nigeria Vision 20:2020 and the Seven-Point Agenda.

The CDS was designed to identify the gaps and detail the policy actions, investments and

milestones that would help Nigeria scale up its successes and remedy any weaknesses. The CDS acknowledged the progress made to 2010, including a notable success story, the Conditional Grant Scheme (CGS). It also addressed the critical challenges and gaps that accounted for the overall average or slow rate of achievement for the eight MDGs. In addition to the strategic initiatives that the Government would introduce to tackle the highlighted challenges, sharply focused strategies for scaling up the achievement of the eight goals or a combination thereof were spelled out in the CDS.

In its review of the Government's investment plans, priorities and choices, the CDS highlighted the integration of the MDGs into the implementation plans for Nigeria Vision 20:2020. It stresses the imperative of nurturing a combination of public and private investments to ensure to accelerate progress towards achieving the MDGs by 2015. Furthermore, it re-examined the costs assessment for achieving the MDGs. The review highlighted the need for a new financing strategy, which would involve all three levels of government, as well as the respective branches of government and all relevant stakeholders.

Further, it also highlighted a need for a solid commitment, through a national partnership and fiscal compact, to achieve the MDGs within the next five years. Finally, a roadmap for coordination and M&E is provided a *matrix of actions, lead responsibilities and time frames for the Countdown Strategy* (covering only 2010 and 2011) leaving room for any refinements and modifications that a new administration might decide to introduce after presidential and legislative elections in 2011.

To date, for a variety of factors, implementation of the CDS has not gained adequate momentum to deliver the envisaged progress; rather, some MDGs that showed promising achievements

have suffered setbacks. The MAF offers another avenue to resume and accelerate progress. It enables nations to:

- assess and identify their interventions with the aim of scaling up those with a higher impact;
- analyse and prioritize bottlenecks hindering the success of other interventions;
- identify solutions and their sequencing;
- develop an accelerated action plan, together with an implementation and monitoring plan.

At present, the MAF has become the fastest tool that any nation can adopt to make its MDGs achievement strategy operational. In the case of Nigeria, the MAF will also make its CDS operational. The MAF helps countries to:

- analyse why they are lagging behind on specific MDGs;
- prioritize the bottlenecks to progress;
- identify collaborative solutions involving governments and all relevant development stakeholders.

It could also help to address new challenges related to meeting the MDGs in a particular country context. It could integrate new evidence, such as the strategic importance of energy and technology, the centrality of gender equality, and women's empowerment in relation to specific MDGs targets and indicators. It could also include any innovations in national and sub-national efforts to accelerate and sustain progress towards the MDGs. In countries where the rates of progress vary sharply across geographic regions and/or population groups, the MAF can help in understanding the reasons behind such differences in progress and thereby address them through tailored solutions.

The MAF results in the preparation of a focused, agreed upon accelerated action plan to address the specific MDGs. Such a plan will rally the efforts of governments and their partners, including civil society and the private sector, in providing the

investments and services needed to advance key policy reform and overcome identified constraints.

The Office of Senior Special Assistant to the President on MDGs (OSSAP-MDGs), in collaboration with the FMOH and the IDPs – notably the United Nations Development Programme (UNDP), the State Partnership for Accountability, Responsiveness and Capability (SPARC) supported by the United Kingdom's Department for International Development (DFID), and other United Nations bodies – established a technical working group (TWG) for applying the MAF to make the CDS operational.

In line with the Federal Government's recognition of the multiplier effects of the MDGs' health goals on the overall success of the entire MDGs in Nigeria, and given the enormous amount of time and resources involved in the application of the MAF exercise, the OSSAP-MDGs selected MDG 5 – Improve maternal health – for a special focus in the acceleration efforts. It is against this background that the OSSAP-MDGs, the United Nations Country Team in Nigeria, DFID and other IDPs are collaborating in the application of the MAF to MDG Goal 5. More specifically, the assignment seeks to develop, in close collaboration with the Expert Technical Working Group, a Country Action Plan (CAP) to accelerate the achievement of MDG 5. This involves:

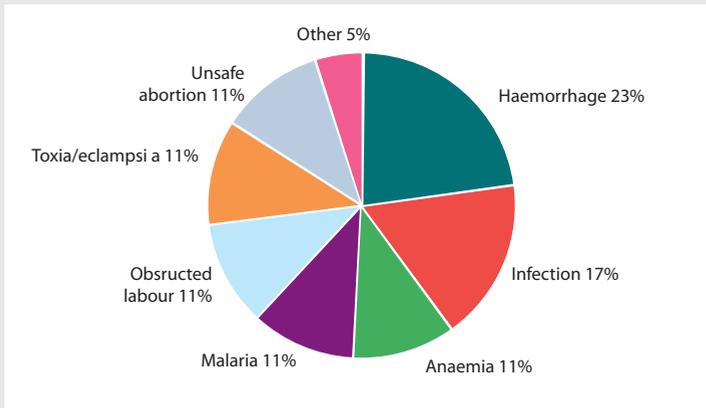
- partnering with relevant sector agencies and other stakeholders to identify and prioritize the require high- impact interventions;
- conducting research, gathering data and holding workshops to ascertain the bottlenecks to achieving MDG 5 and consequently, to propose solutions to overcome them;
- developing a comprehensive MAF Action Plan, including an implementation and monitoring plan to accelerate the achievement of MDG 5;
- producing recommendations on the next steps with the remaining seven goals.

BOX 1 :

OVERVIEW OF THE MATERNAL MORTALITY RATIO IN NIGERIA WITH RESPECT TO MDG 5

With the current estimated maternal mortality ratio (MMR) of 545 per 100,000 live births (NPC, 2009), Nigeria still has one of the highest MMR in the world. It is estimated that about four maternal deaths occur in Nigeria per hour, 90 per day and 2,800 per month – a total of about 34,000 deaths annually; however, there are wide regional and local variations. Just over one half (57.7 per cent) of pregnant women aged 15–49 receive antenatal care (ANC) from skilled birth providers. The proportion of births at which skilled birth attendants (SBAs) are present remains low, at 39 per cent. Again, there is great variation in this proportion. For example, in Imo State, 98 per cent of births are attended by an SBA, whereas in Jigawa State, the proportion is only 5 per cent. The available data show that 35 per cent of deliveries occurs in health facilities, whereas an estimated 62.1 per cent occur at home deliveries, which underscores the need for improved access to and use of maternal health services within health facilities. It is also estimated that for every maternal death, at least 30 women suffer short-to long-term disabilities, such as vesicovaginal fistula (VVF). Each year, some 50,000 to 100,000 women in Nigeria suffer from obstetric fistulae. Over 600,000 induced abortions are also estimated to take place in Nigeria annually. These are often performed under unsafe conditions, with an estimated 40 per cent performed in privately owned health facilities.

As illustrated in following figure, the major causes of maternal deaths are: haemorrhage, infections, malaria, toxemia/eclampsia, obstructed labour, anaemia and unsafe abortions.



| MDG 5 | Target | Indicators |
|-------------------------|--|--|
| Improve maternal health | Target 5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio. | Maternal mortality ratio Proportion of births attended by skilled health personnel |
| | Target 5.B: Achieve, by 2015, universal access to reproductive health | Contraceptive prevalence rate Adolescent birth rate Ante-natal care coverage (at least one visit and at least four visits) Unmet need for family planning |

Nigeria's country profile

The Federal Republic of Nigeria is located in the West African sub-region and is composed of 36 states and the Federal Capital Territory (FCT), Abuja. The 36 states are further divided into 774 local governments, which are regarded as grassroots-level government. For political purposes and also convenience, Nigeria is divided into six geopolitical zones, which are used in allocating some political appointments at the federal level. With a total land area of 923,768 km², Nigeria shares boundaries with the Republic of Niger to the north, Chad to the northeast, Cameroon to the east and southeast, Benin to the west and the Gulf of Guinea to the south. According to the 2006 Population Census, with a population at 140 million and a projected population of approximately 168 million for 2011 (National Population Commission, 2011), Nigeria is the most populous country in Africa and has 20 per cent of the world's black population. At a conservative growth rate of 3.2 per cent, Nigeria's projected population by 2020 is estimated to reach 221 million. Of the latest population projection of 168 million, it is estimated that the females constitute 82 million, while males account for 85 million. The 2011 projected figure represents a shift away from the nearly 50:50 male-female ratio of the population census of 2006.

Socially, Nigeria is multi-ethnic nation with over 250 different ethnic groups. Politically, Nigeria has been running an uninterrupted presidential democracy since 1999. This is a significant departure from decades of military dictatorship, which had led to a grossly underdeveloped democratic culture.

Economically, Nigeria had a gross national product (GNP) of about US\$195 billion in 2007; this rose to US\$353.2 billion in 2009. The gross domestic product (GDP) per capita from the 2010 estimate is US\$1,324, and the real GDP per

capita at purchasing power parity is estimated at US\$2,289. Crude oil is the main source of revenue, accounting for about 63 per cent of government revenue and about 97 per cent of export income. In addition to crude oil, there are other fairly large deposits of natural gas and coal, tin, columbite, iron ore, limestone, lead and zinc. The main non-oil exports include cocoa beans, palm oil, rubber, textiles, hides and skins.

Nigeria has an adult literacy rate of 72 per cent and an average life expectancy of 48.4 years, which has dropped from 51 over a decade ago. Nigeria's rank in the UNDP's Human Development Index (HDI) has been disappointingly low over the years: in the Human Development Report it dropped from 141st in 1997 to 159th in 2006, and subsequently rose to 142nd in 2010. In 2010, however, Nigeria's HDI of 0.423 placed it above the sub-Saharan regional average of 0.389. In 2008, the inequality-adjusted HDI was 0.246, and the extent of the deprivation or lack of basic social amenities (the intensity of deprivation) of the multi-dimensionally poor was 57.3 per cent, and 68 per cent of the population were living below the poverty line. The governance and development challenges facing Nigeria remain enormous.

High-level endorsement of the MDG Acceleration Framework (MAF)

Given the multiple levels of government involved in achieving the MDGs in Nigeria, any effort to accelerate achievement of the MDGs not only requires the support of the Federal Government, but also that of the state and local governments. Other critical stakeholders, such as the IDPs, the private sector, CSOs, CBOs and FBOs are also involved. Indeed, in countries where there has been a successful application of the MAF to the MDGs, there has been high-level endorsement by their governments and critical stakeholders. Thus, a stakeholders' briefing on the application of MAF

in Nigeria was organized by the OSSAP-MDGs in collaboration with IDPs on 17 January 2013 at the Transcorp Hilton Hotel, Abuja. The event was declared open by His Excellency, Architect Namadi Sambo, Grand Commander of the Order of the Niger (GCON) and Vice-President of the Federal Republic of Nigeria. Architect Sambo re-stated the commitment of the Federal Government to fast-track the achievement of the MDGs. He stated that the Federal Government welcomed the application of MAF to fast-track the progress of the MDGs and in particular MDG 5. Also, the National Assembly, through the Chairman of the Senate Committee on MDGs, Senator Mohammed Ali Ndume, re-stated the commitment of its members to offer the necessary assistance in the application of MAF. Indeed, Senator Ndume made a case for a special allocation towards the MDGs in order to achieve the acceleration, since, as he rightly noted, Nigeria started five years behind schedule in commencing the implementation plans. The Honourable Minister of Health Professor Onyebuchi Chukwu meticulously chronicled the key interventions in the health sector in general, and in MDG 5 – Improving maternal health – specifically in Nigeria.

In her welcome address, the Senior Special Assistant to the President on SSAP-MDGs, Dr. Precious Gbeneol explained the rationale for holding a stakeholders' briefing, saying that the application of MAF was carried out in collaboration with the United Nations System in Nigeria and the DFID. Dr. Gbeneol pointed out that the need to identify bottlenecks and barriers that impede progress against the MDGs has made the application of MAF necessary. She also added that with less than 1,000 days from the MDG 2015 deadline, there is evidence that the MAF presents a proven strategy that has the potential to address regional disparities and large in-country variations in progress in Nigeria.

During the stakeholders' briefing, the Nigeria Governors Forum, the United Nations System

in Nigeria, DFID, FMoH, the Federal Ministry of Finance, the Federal Ministry of Education (FMoE) and the Federal Ministry of Women Affairs (FMoWA) re-stated their commitments to the acceleration efforts. Also, the presence of the Minister of Water Resources, Sarah Ochekepe, and the Minister for Housing, Land and Urban Development, Ama Pepple, as well as the heads of parastatals under the FMoH and a host of other development partners was an encouraging demonstration of their support in the application of MAF in Nigeria.

Institutional frameworks for achievement of the MDGs in Nigeria

Institutional structures at the federal level

Nigeria established and maintains robust institutional frameworks for the achievement of the MDGs. At the federal level, the executive and legislative arms of government have institutional mechanisms that work jointly towards the achievement of the MDGs. Unlike the situation in some other countries, the Federal Government established an MDG office in 2005 and appointed a Senior Special Assistant to the President (SSAP) to head it. The establishment of the OSSAP-MDGs, which was aimed to give MDGs both priority and visibility, demonstrated the Government's commitment to the achievement of the MDGs. In addition, the Government established a Presidential Committee for the Assessment and Monitoring of the MDGs (PCAM-MDGs). The members of the Presidential Committee, which is chaired by the President, include representatives of the State Governors, the National Planning Commission (NPC), local and international non-governmental organizations (NGOs) and ministers of implementing agencies of the debt relief gains (DRG) programmes and projects. The OSSAP serves as the Secretariat of the Committee. Furthermore, some ministries, departments and agencies (MDAs) were designated for achieving

the MDGs thus becoming bodies through which the OSSAP-MDGs channelled funds to this end.

In order to give life to this institutional framework, MDG achievement was given an enormous boost when the Government pledged to apply the savings accruable from the Debt Relief Deal with the Paris Club of Creditors in September 2005 (Debt Relief Gains or DRGs) to pro-poor programmes and projects that would enhance the prospects of achieving the MDGs. To this end, a Virtual Poverty Fund (VPF)² was adopted in the Federal Government of Nigeria's budget to report on the nature of debt relief expenditures. The reporting platform was provided by the Office of the Accountant General of the Federation through the Accounting Transaction Recording and Reporting System. In concrete terms, the VPF tracks the portion of Federal Government

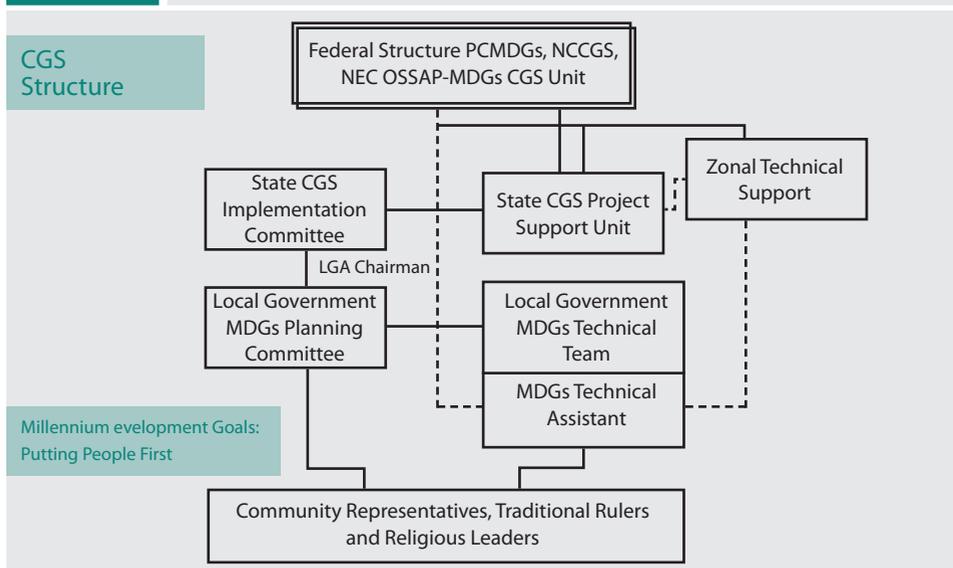
expenditures dedicated to supporting poverty-reducing activities.

In the National Assembly, both the Senate and the House of Representatives established MDGs committees that have been working in collaboration with the OSSAP-MDGs and relevant MDAs to fast-track the achievement of the MDGs.

Inter-governmental institutional arrangements

At the inter-governmental level, the Federal Government, through the OSSAP-MDGs, established structures for setting up the Conditional Grants Scheme (CGS), which is one of the MDGs' intervention achievements. The CGS operates through specific federal, state and local government structures, as shown in Figure 1.

FIGURE 1 : CONDITIONAL GRANTS SCHEME (CGS) IMPLEMENTATION STRUCTURES



Source: CGS Implementation Manual, revised edition, OSSAP-MDGs, 2012

2. The VPF is a coding system within an existing budget classification structure that enables the tagging and tracking of MDGs spending including on poverty-reducing initiatives.

The following structures are briefly described:

- The PCAM-MDGs is chaired by the President. Membership of the Committee is drawn from the public and private sectors, civil society and the IDPs. It assesses and monitors the progress of CGS projects towards the achievement of the MDGs in Nigeria.
- The National Committee on Conditional Grants Scheme (NCCGS) is chaired by the Minister of Finance. Its membership is composed of the Minister of the NPC, the Ministers of key MDG line ministries, the Director General of the Budget Office of the Federation, the Accountant General of the Federation and the SSAP on the MDGs.
- The OSSAP-MDGs serves as the Secretariat to the PCAM-MDGs and NCCGS.
- State government structures include:
 - o the State CGS Implementation Committee;
 - o the State CGS Project Support Unit;
 - o relevant state MDAs.
- Local government structures include:
 - o local government area (LGA) MDGs Planning Committee;
 - o LGA MDGs Technical Team;
 - o community, traditional and faith-based institutions and organizations;
 - o CSOs.

Objectives of the MDGs Acceleration Framework (MAF)

A critical assessment of the operational effectiveness of these structures in the achievement of MDG 5 in the past decade is key to the application of MAF. Some important questions need to be examined to understand why critical interventions failed in many states and local governments. For example, to what extent were the structures at both the state and local government levels sufficiently empowered and enabled to perform their responsibilities?

Second, to what extent did the lack of effective collaboration between the state and their local governments impede the achievement of MDG 5? Third, are grassroots structures for achieving MDG 5 merely symbolic rather than substantive? Since the successful achievement of MDG 5 depends largely on the effectiveness of structures at the primary health care level, these questions are critical in the implementation of Nigeria's MAF Action Plan.

The overarching objective of MAF is to build partnerships around maternal health issues in Nigeria between the various tiers of government (federal, state and local governments) and MDAs, CSOs, the private sector, the United Nations agencies and other development partners working on neonatal and maternal health in the country. Primarily, it seeks to:

- provide a deeper understanding of the key bottlenecks to the implementation of maternal health interventions in the country;
- collectively identify key local solutions;
- develop an action plan that can help to reduce the risks impeding progress on maternal health in the country.

Specifically, the MAF seeks to:

- assess past and present maternal health policies and interventions;
- identify the key bottlenecks and gaps in the implementation plans leading to attainment of MDG 5;
- develop feasible and cost-effective solutions that can accelerate progress towards maternal health in the country;
- prepare an action plan for implementing collectively identified interventions, monitor and evaluate progress.

Methodology of MDGs Acceleration Framework preparation and roll-out

The preparation of MAF in a federal and populous country like Nigeria necessarily entails a complex methodological framework of operations. The sheer complexity of planning and of the organizational requirements for such a large and heterogeneous country no doubt require a multi-faceted methodological approach that can maximize the goals in the MAF preparation and its eventual roll-out. Accordingly, three key decisions established the methodological point of departure:

- the setting up of an institutional framework for the effective coordination of the MAF process jointly driven by OSSAP-MDGs and IDPs;
- the recruitment of four national consultants to drive the technical and consultation processes;
- the planning and organization of the stakeholders' consultation technical workshop in which the FMoH played the role of catalyst.

The Technical Working Committee was initially composed of members from OSSAP-MDGS, UNDP and DFID-SPARC, and was subsequently enlarged to involve the FMoH when MDG 5 became the main focus, as well as other development partners. The Technical Working Committee was one of the approaches of the three-pronged methodology aimed at ensuring quality assurance in the MAF preparation process. The second approach was the actual engagement of four national consultants with wide-ranging expertise on the MDGs in Nigeria to manage the technical process. The third approach was the hosting of the MAF stakeholders' workshop for wide consultative and participatory engagements.

The management of the technical process by the consultants began with a desk review of an array of relevant national and international policy documents and reports made available by OSSAP-MDGs, the FMoH, UNDP, DFID-SPARC and other key United Nations agencies, as well as documents and reports collected by the consultants. The completion of the desk review paved the way for the organization of the stakeholders' technical workshop.

The technical ground work for the workshop began when Dr. Ayodele Odusola (MDG Advisor, Regional Bureau for Africa, UNDP) met with the consultants. Subsequently a tripartite meeting of OSSAP-MDGs, UNDP and DFID-SPARC was called for further brainstorming with Dr. Odusola and the consultants. This meeting, hosted by DFID-SPARC, turned out to be one of the most fruitful meetings at the commencement of the MAF process in Nigeria. Here, a careful and detailed selection was carried out of stakeholders for the workshop.

The selection of the stakeholders for the workshop involved a complex set of criteria designed to ensure representativeness of the major voices that needed to be heard on issues relating to the improvement of maternal health. The selection of key stakeholders in the health sector took into consideration the following:

- a wide geographical spread and geopolitical zones (all 36 states and the FCT);
- occupational sub-sectors (doctors, nurses, midwives, community health extension workers (CHEWs) and traditional birth attendants);
- tiers of government (federal, state and local governments);
- professional associations (Nigerian Medical Association, and Nurses and Midwives Association);

- grassroots representatives and CSOs (the Planned Parenthood Federation of Nigeria PPFN and the Society for Family Health representing the marginalized interests);
- key policy makers and executors in the MDGs line ministries, parastatal organizations, OSSAP-MDGs and the National Assembly; IDPs including UNDP, DFID, DFID-SPARC; the DFID Partnership for Reviving Routine Immunisation in Northern Nigeria/Maternal, Newborn and Child Health initiative (PRRINN-MNCH), World Health Organization (WHO), United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF), University of Nebraska Medical Center, UN Women, One UN, World Bank, European Union, and the United States Agency for International Development USAID.

A matrix showing the criteria for the selection of key stakeholders from all the states and those representing the diverse interests listed above can be found in Appendix 1 of this report.

The data-gathering instruments for the MAF stakeholders' workshop were adapted from the *MDG Acceleration Framework-Operational Note* developed by the United Nations and made available to the consultants by Dr. Odusola, MDG Advisor. Four main instruments, in line with the four stages involved in the preparation of MAF, were developed based on the United Nations generic templates. The first instrument for Step 1 of the MAF process relates to the Priority Intervention on Maternal Health as well as the Intervention Selection Guidelines. Key selection guidelines are incremental outputs and outcomes, beneficiary population, impact ratio, speed of impact and evidence of impact, all of which were geared towards the objectivity of the selection process. The second instrument for Step 2 of the MAF process focused on the identification and prioritization of the bottlenecks, while the third set of instruments

was for Step 3 of the process. These three instruments provided:

- the Guidelines on Solution Impact Evaluation,;
- the Guidelines on Feasibility Evaluation;
- the Solution Prioritization Scorecard.

The fourth instrument is a template for the MAF Action Plan.

This stakeholders' technical workshop was held successfully on 20–21 February 2013 and represented a major milestone in the preparation of MAF in Nigeria. There was high-level participation from Federal Government officials and the United Nations System. High-level participants included the representative of the Honourable Minister of Health, the SSAP on the MDGs, the Resident Coordinator of the United Nations in Nigeria, the representative of the Head of DFID in Nigeria, the Country Director of UNDP in Nigeria, and the Country Director of UNDP in Ghana, among others.

Participants at the workshop identified a list of all the key interventions on maternal health and identified five of them as prioritized interventions. Additionally, they identified all the bottlenecks impeding success and prioritized five of them, and identified a list of acceleration solutions.

The next major activity was the hosting of a two-day intensive Bilateral Discussion meeting on 27–28 February 2013. The participants principally involved the consultants and the key policy drivers and implementers in the FMOH and its parastatal organizations, as well as representatives from WHO. Planning for the Bilateral Discussion meeting was coordinated by OSSAP-MDGs, which was hosted by DFID-SPARC. The UNDP provided the technical backstopping, while the FMOH played the major role of mobilizing the participants for the discussions.

Based on the identified acceleration solutions, participants at the Bilateral Discussion meeting proceeded to identify the solution indicators, targets, timelines and responsible partners that would be involved in implementing the solutions and the action plan. It was at these meetings that the costing parameters emerged and costing experts who were in attendance commenced work immediately.

The MAF validation workshop, held on 12 March 2013, was another milestone in the application of MAF to MDG 5 in Nigeria. Like the stakeholders' workshop, it also attracted high-level participation, including the Honourable Minister of Health, the SSAP on the MDGs, the Honourable Minister/Vice Chairman of NPC, the Honourable Minister of State for Health, the Resident Coordinator of the United Nations in Nigeria, the Head of DFID in Nigeria and the Executive Director and CEO of the National Primary Health Care Development Agency (NPHCDA), among others.



Photo: OSSAP



II. STATUS OF NIGERIA'S MDGS: AN OVERVIEW WITH A FOCUS ON MILLENNIUM DEVELOPMENT GOAL (MDG) 5

Photo: OSSAP

OVERVIEW

Since the MDGs were mainstreamed in national planning and budgeting, there have been successive country-level assessment and monitoring reviews by MDGs Status Reports 2004, 2005, 2006, 2007 and 2010. The reports show the progress, trends and challenges in the march toward the MDGs' 2015 targets. This overview of the status of Nigeria's MDGs, therefore, draws from the cumulative and collective assessments of these reports, supplemented with updates based on recent statistics and with a special focus on the reasons for choosing MDG 5 for MAF.

Overall, Nigeria's progress towards achieving the MDGs is mixed, especially when comparison is made across the different sub-national jurisdictions, as well as between urban and rural populations.

MDG 1 – Eradicate extreme poverty and hunger – Recent statistics show that, nationally, the incidence of poverty increased from 54.4 per cent in 2004 to 69.0 per cent in 2010. Against the background of a rapidly rising population, this percentage translates into 112.47 million people living in poverty in the country. In terms of differences between zones, the incidence of poverty varies from 59 per cent in the southwest to 78 per cent in the northwest. It is significant to note that the incidence of poverty, whether by zone or rural comparison, well exceeds 50 per cent. With respect to the hunger dimension of MDG 1, recent statistics estimated that 24.0 per cent of children under five were underweight in 2011.³ This suggests that a reduction of at least 2 per cent per year is required to meet the 2015 target of 17.85 per cent. If current trends continue, Nigeria is likely to achieve this target employing strategies that are sensitive to the

sharp differences between geopolitical zones and between states within a zone.

MDG 2 – Achieve universal basic education – This goal has also experienced staggered progress. The net enrolment ratio in primary education, which improved from 80 per cent in 2004 to 90 per cent in 2007, has experienced a steady decline since then to a low of 70.1 per cent in 2010.⁴ It has thus receded from the target of 100 per cent set for 2015.

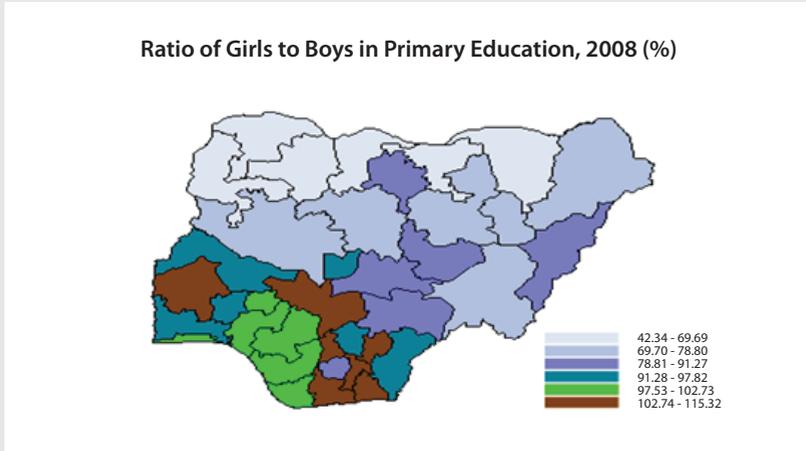
Similarly, both the "ratio of pupils starting primary 1 who reach primary 5", which was well over 90 per cent in 2001, dropped to 72.3 per cent by 2008, while the "primary 6 completion rate", which rose to 80 per cent in 2004, also declined, to 67.5 per cent in 2008. Both have continued to suffer setbacks since then. In terms of differences between zones and states, while the net enrolment in primary education is as high as 87 per cent in Ekiti State in the southwest and 83 per cent in Abia State in the southeast, it is as low as 21 per cent in Borno State in the northeast, and drops to 18 per cent in Zamfara State in the northwest of Nigeria.

MDG 3 – Promote gender equality and empower women – Nigeria is currently on track and has bright prospects of meeting MDG 3 with regard to the ratio of girls to boys in primary education as well as the ratio of girls to boys in secondary education. There were 90 girls per 100 boys in primary schools in 2010,⁵ as against the baseline of 70 girls per 100 boys in 1990. Similarly, there were 93 girls per 100 boys in secondary schools in 2010, against the baseline of 75 girls per 100 boys in 1990. On these two indicators, consistent progress has been sustained over the years. There continue to be high disparities across zones and states

3. *Multiple Indicator Cluster Survey (MICS) 2011.*

4. *Nigeria DHS EdData Survey 2010.*

5. *Nigeria DHS EdData Survey 2010*

FIGURE 2 :**RATIO OF GIRLS TO BOYS IN PRIMARY EDUCATION, 2008 (%)**

Source: Nigeria MDGs Report, 2010.

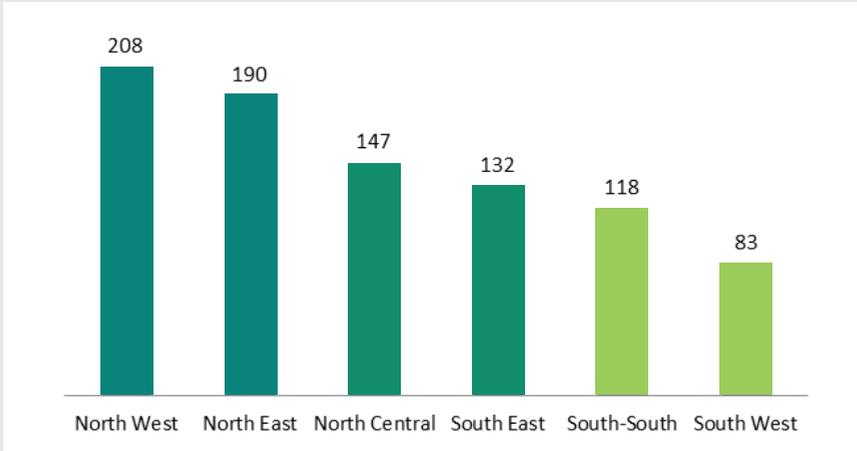
on progress toward MDG 3. For example, gender parity in primary school has been achieved in Ekiti, Delta, Abia and Imo States, but disparity persists in Sokoto, Jigawa, Katsina and Kebbi States. These patterns are shown in Figure 2.

MDG 4 – Reduce child mortality – Progress towards this goal is uneven between zones and states similar to progress towards the other MDGs. Recent statistics⁶ estimated the mortality rate for children under five at about 158 per 1,000 live births in 2011, against the 2015 target of 64 per 1,000 live births. The most recent estimate for the infant mortality rate was 97 per 1,000 live births in 2011 against the 2015 target of 30 per 1,000 live births. The wide differences between zones are illustrated in Figures 3 and 4.

6. Multiple Indicator Cluster Survey (MICS) 2011.

FIGURE 3 :

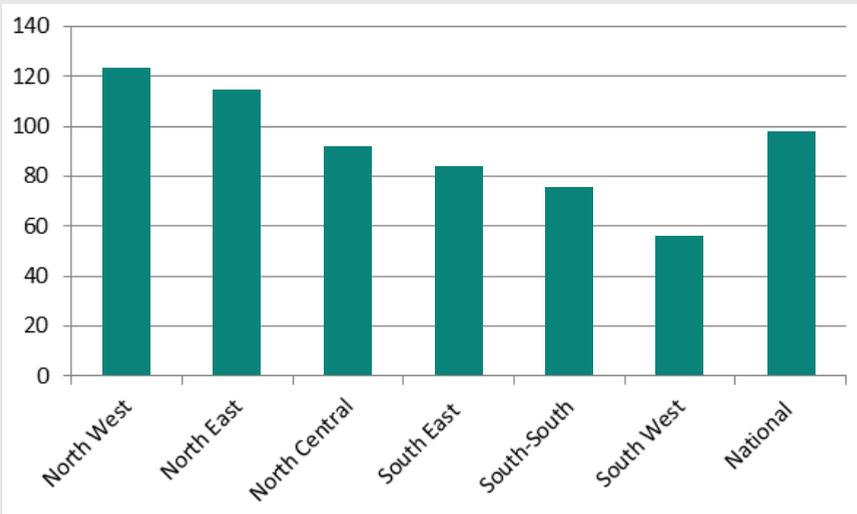
CHILDREN UNDER FIVE MORTALITY RATE BY GEOPOLITICAL ZONE, NIGERIA 2011



Source: Based on data in NBS Multiple Indicator Cluster Survey Report, 2011

FIGURE 4 :

INFANT MORTALITY RATE PER 1,000 LIVE BIRTHS BY GEOPOLITICAL ZONE, NIGERIA, 2011



Source: Based on data contained in NBS Multiple Indicator Cluster Survey Report, 2011

MDG 6 – Combat HIV/AIDS, malaria and other diseases – Nigeria is on track towards meeting this goal, particularly with regard to the target ‘halt and reverse the spread of HIV/AIDS’. The most recent statistics of 2008, although old, show that the country is making good progress with this MDG and will likely achieve the target if current trends continue. The HIV/AIDS prevalence rate declined from about 5.4 per cent in 2000 to about 4.1 per cent in 2008. However, critical challenges persist with regard to access to treatment for persons living with HIV/AIDS (PLWHA) who currently are receiving treatment, and prevention of mother-to-child transmission (PMTCT). Currently, only one out of three PLWHA receives treatment against the target of universal coverage. Regarding the PMTCT, the country currently achieves a meagre 16 per cent against the 2015 target of 90 per cent. Nigeria is also on track with respect to reducing the prevalence of malaria, given that this has declined by 42.8 per cent – from 2,024 per 100,000 in 2000, to 1,157 per 100,000 in 2004.

MDG 7 – Ensure environmental sustainability – Progress towards this goal diverges widely across the respective constituent indicators. On the one hand, there is modest progress towards the 2015 target of halving the proportion of the population without sustainable access to safe drinking water and basic sanitation. About 58.5 per cent of Nigerians had access to improved drinking water source in 2010,⁷ as against the 2015 target of 77 per cent. Similarly, about 42.6 per cent of Nigerians had access to improved toilet/latrines facilities in 2010,⁸ as against the 2015 target of 70 per cent. On the other hand, however, the situation is not satisfactory with respect to halting deforestation and gas flaring. Only about 10 per cent of the gas produced is used domestically, primarily for power generation,

whereas 24 per cent is flared.⁹ Gas flaring from joint venture oil companies represents roughly 60 per cent of all emissions from Nigeria’s oil and gas sector. Similarly, tackling the growing tide of slum dwellings will become even more challenging amidst the wave of urbanization sweeping across the country. It is estimated that Nigeria’s urban population will rise to about 60 per cent by 2025, given the current growth rate of 5.8 per cent per annum.

MDG 8 – Develop a Global Partnership for Development – Nigeria has succeeded in achieving this goal, as evidenced by the Paris Club debt relief as the primary source of funding of the MDGs in Nigeria. However, overseas development assistance (ODA) has been lagging behind the levels desired to meet the MDGs. ODA to Nigeria increased from US\$4.49 per person in 2004 to US\$81.67 per person in 2006 and 2007, but much of this increase came from debt relief rather than from additional ODA from IDPs. Estimates show that per capita ODA was US\$8.53 in 2008, but still falls short of the volume of funds required to make appreciable progress on the MDGs.

Nigeria’s progress in access to information and communication technology (ICT) has been rising sharply, fuelled by the deregulation of the telecommunications sub-sector and the entry of private sector global system for mobile communication (GSM) operators into the market. In 1990, there were only 0.3 telephone lines per 100 people in Nigeria. The number of GSM lines increased from 0.27 million in 2001 to over 1.57 million in 2002 and approximately 32 million in 2006. Thus, access to cellular phones increased from just two out of 100 persons in Nigeria in 2000 to nearly 42 per 100 in 2008. As of October 2012, Nigeria had a total 109,499,882 active

7. *Nigeria Malaria Indicator Survey (NMIS), 2010.*

8. *Nigeria Malaria Indicator Survey (NMIS), 2010.*

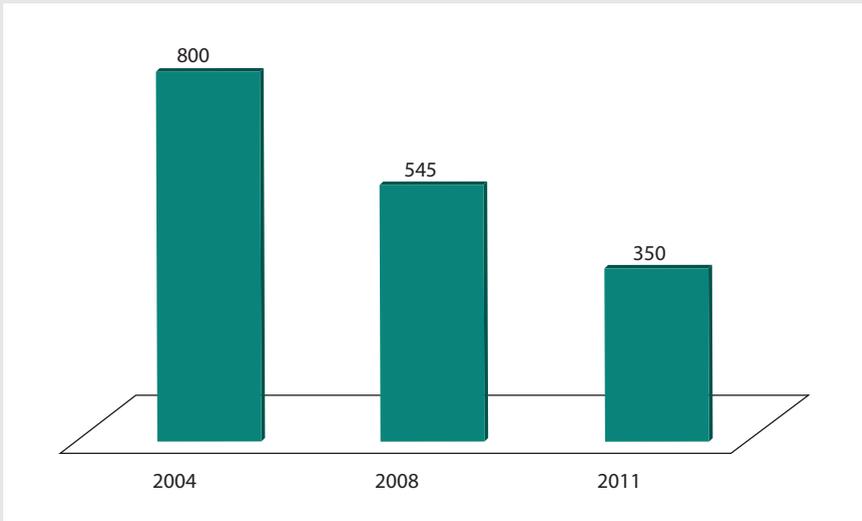
9. NNPC, 2010.

telephone lines (GSM, mobile code division multiple access and fixed wired/wireless), representing a telephone density of 78.21 per cent, up from the 1.89 per cent of 2002. However, Internet access lags far behind the growth of

telephone lines. Internet users per 100 persons increased from 0.32 in 2002 to 15.86 in 2009. Despite this increase, access to Internet remains low, indicating that there is a large scope for improvement.

FIGURE 5 :

MATERNAL MORTALITY RATE PER 100,000 LIVE BIRTHS BY GEOPOLITICAL ZONE, 2011



Source: Berived based on data from NBS MDGs 2012 Survey Report

Improvement in maternal health is another area where the country has made appreciable progress. The data in Figure 5 show that maternal mortality has been reducing steadily – from 800 per 100,000 live births in 2004 to 545 per 100,000 live births in 2008 and to 350 per 100,000 live births in 2012. Thus, there was a 56.2 per cent drop between 2004 and 2012, and a 35.8 per cent reduction between 2008 and 2012. To

achieve the 2015 benchmark, a further reduction in the 2012 figure of approximately 28.6 per cent is needed.

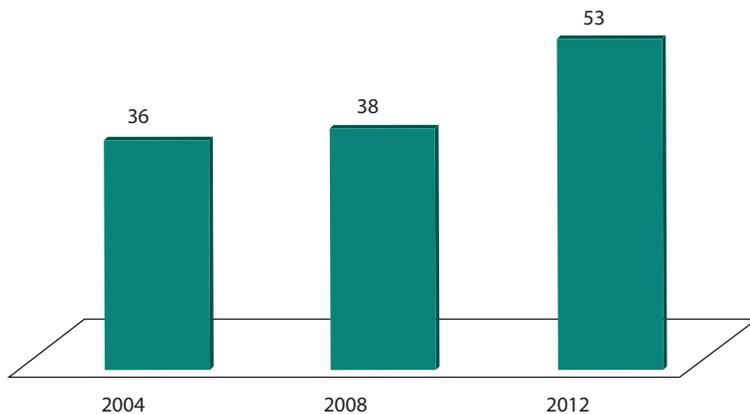
Focus on MDG 5: Improve Maternal Health

The 35.8 per cent decline in the number of women who died in child birth between 2008 and 2012 is partly attributable to the increase in the number of births attended by skilled health personnel in the country (Figure 6). A skilled health professional – doctor, nurse, midwife/

auxiliary midwife or community health worker – can intervene to prevent or manage life-threatening complications during child births. In Nigeria, the proportion of deliveries attended by skilled health personnel increased from 36.3 per cent in 2004 to 38.9 per cent in 2008. It further rose to 53.6 per cent in 2012.

FIGURE 6 :

PERCENTAGE OF BIRTHS ATTENDED BY SKILLED HEALTH PERSONNEL



Source: Based on data from NBS MDGs 2012 Survey Report

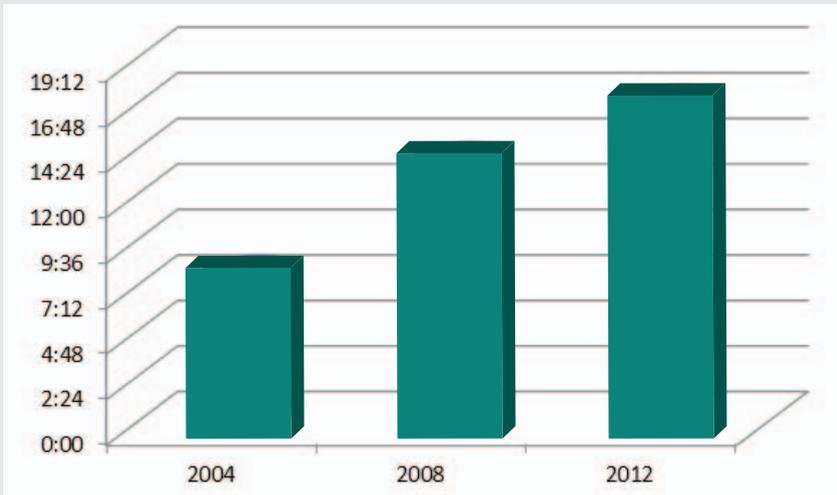
Increased access to safe, affordable and effective methods of contraception is providing individuals with more choices and opportunities for responsible decision making in reproductive matters. In addition, contraceptive use has contributed to improvements in maternal and infant health by serving to prevent unintended or closely spaced pregnancies. Contraceptive prevalence increased rapidly from 8.2 per cent in 2004 to 14.6 per cent in 2008 and later rose

to 17.3 per cent in 2012 (Figure 7). There is still room for improvement given that various unmet FP needs have been progressively rising since 2004. This need expresses the percentage of women aged 15 to 49, married or in a union, who report the desire to delay or avoid pregnancy but are not using any form of contraception. It rose from 17.0 per cent in 2004 to 21.5 per cent in 2012 (Figure 8). There is an urgent need to reverse this trend.

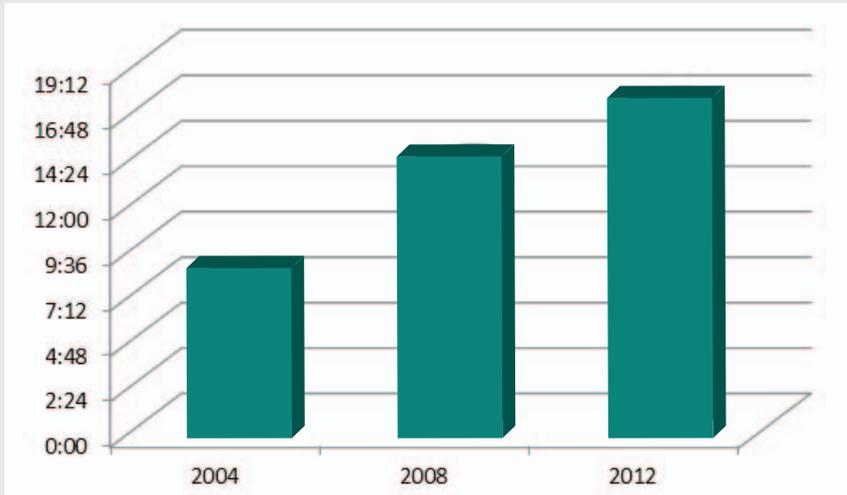
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FIGURE 7 : CONTRACEPTIVE PREVALENCE RATE



Source: Based on data from NBS MDGs 2012 Survey Report

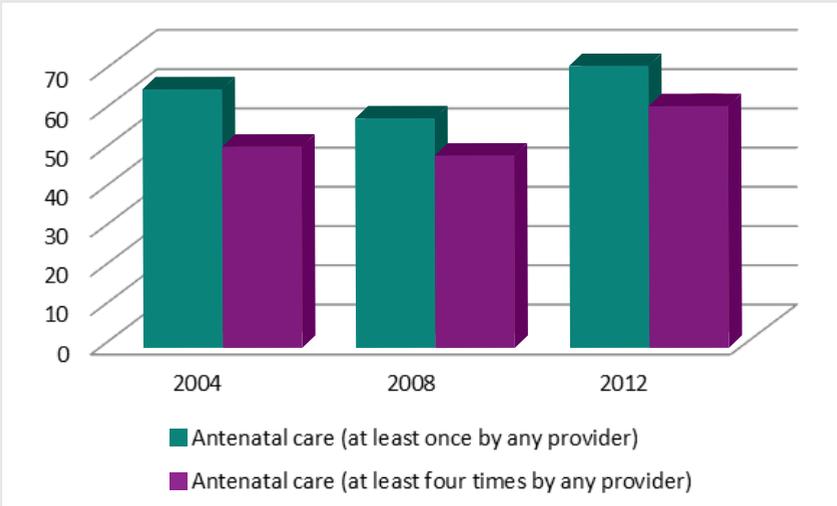
FIGURE 8 :**PERCENTAGE OF UNMET FAMILY PLANNING NEEDS OF NIGERIAN WOMEN**

Antenatal care is one of the health interventions that help to reduce maternal deaths. It is critically important to reach women with timely interventions and information that promote health, wellbeing and measures for the survival of mothers and their babies. Coverage (at least one visit) by a skilled health worker decreased from 61 per cent in 2004 to 54.5 per cent in 2008, but then increased to 67.7 per cent in 2012. The 2012 figure represents a 6.7 per cent increase over the 2004 figure and a 12.8 per cent increase over the 2008 figure. In addition, in 2012 antenatal coverage of at least four visits rose to about 57.6 per cent. This represented an increase of 10.6 per cent over the 2004 figure and 12.8 per cent over the 2008 figure; there had been a 2.8 per cent decline between 2004 and 2008 (Figure 9). However, this spectacular success is skewed towards the urban areas. As with other

indicators, the rural areas are also lagging in antenatal coverage. The coverage rate in the rural areas is about 56.5 per cent for at least one visit and 47.7 per cent for four visits.

The unmet need for FP remains persistently high. In 2004, the figure was about 17 per cent. It increased to 20.2 per cent in 2008 and 21.55 in 2012. It should be noted that the rate of increase in the need slowed between 2008 and 2012.

As can be deduced from the overview in this chapter, there are a number of clear justifications for the choice of MDG 5 for Nigeria's MAF:

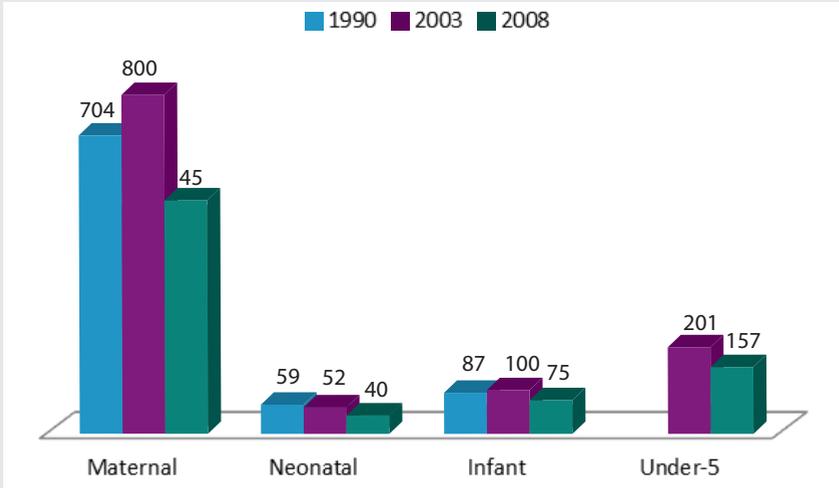
FIGURE 9 :**PERCENTAGE OF NEW MOTHERS RECEIVING ANTENATAL COVERAGE (ANC)**

- **Focusing on MDG 5 is consistent with the Government's transformation agenda.** Right from the start, the present Administration launched an agenda for addressing the most pressing development challenges facing the country. The agenda identified, *inter alia*, healthcare as a key development and policy challenge. In the gamut of health challenges, poor maternal health is emblematic. For the Government, the underpinning policy for the inputs toward achieving the human capital development goal of the Vision 20:2020 Strategy is the National Strategic Health Development Plan (NSHDP). The NSHDP is the vehicle for actions at all levels of the health care service delivery system, which seeks to foster the achievement of the MDGs and other local and international targets and declaration commitments.
- **The choice of MDG 5 for MAF will address persistent disparities in health outcomes between zones.** Disparities abound in the achievement of the MDGs across states and between the six geopolitical zones of the country. Indeed, these are much more dramatic with respect to MDG 5, especially given its immediate impact on human lives. Whereas the South West zone had, on its own, virtually met the target, even as early as at 2008, others, especially the North West and North East, showed performances far below the national average. By focusing on MDG 5, lessons from regions with good outcomes can be used in areas of poor outcomes.

- ***Sustaining and improving progress on MDG 5.*** As indicated, on average, some progress has been made on all the three maternal health indicators between 2003 and 2008. On the basis of this development, and factoring in what appeared to be good prospects for achieving MDG 5, the 2010 MDGs+10 Report suggested that MDG 5 could be a candidate for realization if the momentum was sustained. In his Foreword to the 2010 MDG+10 Report, President Goodluck Jonathan declared the achievement in MDG 5 up to 2008 as “unprecedented”.
- ***If the average performance on MDG 5 is sustained, the target would be met by 2015*** (Figure 10). This performance-based projection was the basis for the official optimism that was shared with the rest of the world by President Jonathan in September 2010. The CDS provided a roadmap and targeted investment and the ingredients of effective partnerships, which helped to sustain the observed trend in the implementation during the three years to 2008 and which formed the basis for the optimistic projection of meeting the target by 2015. For several reasons associated with transition in administration, the implementation of the CDS was delayed. A number of otherwise laudable initiatives, such as the Midwives Service Scheme (MSS) programme, were not anchored effectively to the roadmap of the CDS. Even with the latest National Bureau of Statistics (NBS) data showing an MMR of 350 as a national average, there are still wide differences within the least performing zones. The political commitment and the associated resources devoted to the attainment of MDG 5 still remain a matter of great concern. Violence and the resulting social and economic instability have contributed to a loss of momentum towards the attainment of MDG 5 in some parts of the country. The healthcare initiatives that aimed at raising the national average performance on MDG 5 – MSS, routine immunization programme, Roll Back Malaria Programme Maternal and child health (MCH) programme, HIV/AIDS Control Programme, Health Systems Strengthening, and even the Subsidy Reinvestment and Empowerment Programme (SURE-P) – appear overwhelmed by insecurity in parts of the county where their operations are needed most for the achievement of the health MDGs and in particular for MDG 5.
- ***MDG 5 is an approximate measure of progress of other MDGs.*** Maternal health is closely linked to other MDGs, such as child health, gender and women empowerment, and poverty reduction. Accordingly, accelerating progress on MDG 5 could lead to gaining some mileage with the other MDGs in which progress is currently slow. A healthier mother is better able to work, earn a living, participate in household decision making and better provide for a child. Available data demonstrate this correlation. For example, the national MMR declined from 800 deaths per 100,000 live births in 2003 to 545 deaths in 2008, which correlated with declines in infants and under-five mortality rates, as illustrated in Figure 10. The focus on MDG 5 is therefore expected to have salutary effects on the performance of other goals, especially MDG 4. Hence, for the good health of Nigerian women in the vibrant age group between 18 and 45, and for political accountability, the choice of the MDG 5 for MAF is considered appropriate and timely.

FIGURE 10 :

**TRENDS IN MATERNAL AND CHILD MORTALITY RATES
(PER 100,000), 1990–2008**



Source: Chart adapted from *The Health MDGs (4, 5 and 6): Achievements and Lessons Learnt. OSSAP-MDGs (2012)*



III. KEY INTERVENTIONS TO ACCELERATE MDG5 IN NIGERIA

Photo: SPARC

In Nigeria, MDG5 specific interventions are being delivered using the principles of integration of services along a continuum of life stages of care starting with the pre-pregnancy period, passing through the pregnancy and intra-partum periods (delivery) and ending with the post-natal period. Over the years, a series of Health-MDG response frameworks and plans have been produced in concerted efforts to rise to the challenge of meeting the MDG targets by 2015.¹⁰ The packages of interventions that have been identified and implemented to meet the target for MDG 5 are described below:

- Providing of – and facilitating demand for – basic and sometimes comprehensive essential obstetric care services in health facilities to treat pregnancy and delivery-related complications, such as eclampsia, haemorrhage, obstructed labour, sepsis, abortion-related cases, and the other causes of maternal mortality identified earlier. The Government and its development partners have stepped up initiatives to increase the availability of basic emergency obstetric and newborn care (BEmONC) intervention projects across the country. These initiatives currently address at least three well-known delays *inter alia*:
 - the delay in making a decision to seek treatment;
 - the delay between making a decision and reaching a health facility;
 - the delay between arriving at the health facility and receiving appropriate treatment.
- Putting in place a number of interventions that respond to these delays and address the demand-side of these challenges to the reproductive health services. For example, the Maternal and Child Health Integrated Programme addresses the delays that result in

maternal and newborn deaths by seeking to improve household and care-seeking practices and by empowering the community to create and maintain an enabling environment for the increased use of maternal and newborn care services wherever they are available. The main thrust is the improvement of EmONC services, which recognizes that response to potential pregnancy and child delivery complications starts in the antenatal period and continues through childbirth into the post-natal period.

- Developing and implementing a coordinated behavioural change communication strategy to promote essential newborn care practices at the community level through women's groups, religious organizations and other community mobilization structures. This includes an increased use of trained household counsellors, who, in several northern states:
 - educate women and their families about the danger signs in pregnancy and during and after childbirth;
 - promote the increased the use of trained male birth spacing motivators to educate men about the benefits of healthy timing and spacing of births;
 - encourage the use of long-acting contraceptive methods;
 - implement community systems which in the event of complications respond with immediate referrals to primary health clinics and hospitals.
- Equipping community health workers (CHWs) with kits to be used when they visit pregnant women at home to counsel them. The kits inform the women on:
 - ANC;
 - danger signs in pregnancy, delivery and after delivery for both mother and baby;

10. FMOH (2004b); FMOH (2005); FMOH (2010b); and NPC-OSSAP (2010).

- birth preparedness for the family, including the various preparations for facilitating delivery such as planning transportation and having the delivery with an SBA present;
- the importance of saving for emergencies;
- birth spacing and appropriate referrals.

As part of the Community-based Maternal and Newborn Care (CBMNC) programme, these CHWs support women during labour at the pre-arranged facility and make home visits to support the new mother and baby. They treat or in the case of the mother or baby needing care that they cannot render promptly - make referrals. They counsel on and support appropriate feeding practices and encourage exclusive breastfeeding. The CBMNC aims at:

- ***improving access to quality essential obstetric care services.*** Health facilities providing maternal and reproductive health services are few and unevenly distributed across the country. Not only are facilities insufficient, but also the majority of those available do not have the minimum required health staff (doctors, nurses, midwives, CHEWs, junior community health extension workers, etc.), equipment and LSS to function properly and respond to patient's needs and expectations, especially during emergencies;
- ***establishing mentoring linkages between tertiary and primary care facilities and health workers to improve the quality of obstetrics and newborn care;***
- ***improving reproductive health and family planning services and use.*** The lack of ready access, affordability and use of reproductive health services, such as FP, is largely attributed to poverty and the lack of funds to procure these services. Interventions addressing these deficiencies improve the use of reproductive/FP services and significantly improve maternal

health and reduce maternal mortality;

- ***improving financial access for vulnerable groups, especially women.*** This has involved the implementation of various models of financial protection schemes, notably, conditional cash-transfer schemes for pregnant women and the national health insurance scheme (NHIS) to address and ameliorate women's access to financial services;
- ***improving access through improved geographic equity in access to health care services.*** The Federal Government, through the NPHCDA, has been involved in expanding the construction of new primary health centre (PHC) facilities. A number of state governments have also launched various forms of initiatives, including free health care to targeted groups in addressing expansion and access to health care services;
- ***developing a network of PHCs linked to secondary referral health facilities that are well-equipped and staffed to facilitate access to emergency obstetric care facilities;***
- ***renovating health facilities with a focus on areas such as antenatal clinics, labour wards and general maternity sections, and providing basic drugs and commodities,*** including equipment for the treatment of common MNCH illnesses to improve the delivery of MNCH services;
- ***constructing boreholes for the provision of a potable water supply to improve the quality of care in health facilities;***
- ***providing pregnancy period interventions,*** consisting of focused antenatal care (FANC) and the PMTCT of HIV. The goals of FANC are to promote maternal and newborn health and survival through the early detection and

treatment of problems and complications, prevention of complications and diseases, birth preparedness and complication readiness, and health promotion;

- **strengthening referrals through the identification and capacity building of referral systems**, including focal persons in the community and in health centres to effectively refer clients to the appropriate health facility level;
- **providing adolescent/pre-pregnancy interventions** including FP services, prevention of unsafe abortions and post-abortion care, prevention and management of sexually transmitted infections and prevention of cancer of the cervix;
- **mitigating PMTCT of HIV**. Nigeria accounts for about 30 per cent of the global burden of mother-to-child transmission of HIV. The risk of transmission of HIV through heterosexual contact is higher during pregnancy. HIV can be transmitted to the unborn child during pregnancy, labour and delivery, and through breastfeeding. Compliance with the recent WHO guidelines on antiretroviral prophylaxis provided during pregnancy and in the post-natal period through breastfeeding can reduce transmission to below 5 per cent and accelerate the elimination of mother-to-child transmission of HIV. Nigeria has a plan for the elimination of mother-to-child transmission of HIV;
- **preventing cervical cancer**. Cervical cancer is the most common type of cancer and the leading cause of cancer mortality among women in developing countries, accounting for approximately 270,000 deaths of women annually. Of these, 85 per cent occur in resource-poor settings due to late diagnosis and to being present when the disease is

at advanced stages. In Nigeria, WHO has estimated that about 14,550 new cases occurred in 2008, eight out of ten of which present an advanced stage of the disease, a mortality rate of about 23 per cent. It is believed that human papilloma virus (HPV) types 16 and 18 are responsible for most cases in Nigeria and other countries. Other risk factors may include tobacco use, lack of screening and adequate treatment of pre-cancerous lesions, and HPV and HIV co-infection. The national cervical cancer control policy, centred on a public health approach, uses a combination of vaccination, education, screening, treatment and linkages with other programmes. Primary prevention include the use of bivalent vaccine, which acts against genotypes 16 and 18. Cervarix (GlaxoSmithKline) is recommended for girls aged nine to 15. This is delivered through the schools, health centres and community outreach programmes. Secondary prevention consists of screening for pre-cancerous lesions and early diagnosis followed by adequate treatment and visual inspection with acetic acid/Lugol's iodine (VIA/VILI). Over 1,000 service providers (doctors and midwives) have been trained on VIA/VILI. The focus is to integrate VIA into sexual and reproductive health and HIV services at the PHC level.

- **providing intra-partum (delivery) care intervention**, consisting of the access to and use of SBAs, EmONC and referral;
- **providing post-natal care interventions**, consisting of FP, prevention and management of post-partum sepsis and anaemia. A large percentage of maternal and neonatal deaths occur during the first 24 hours after delivery. Thus, prompt PNC is important for both the mother and the child to treat complications arising from the delivery, as well as to provide the mother with important information

on how to care for herself and her child. It is recommended that all women receive a health check within three days of giving birth. According to the 2008 Nigeria Demographic and Health Survey (NDHS), 56 per cent of women did not receive PNC up to six weeks after delivery. This intervention needs to be scaled up to avert maternal deaths occurring during the first 24 hours;

- **improving access to health facilities for women and children in the community** by training volunteer drivers to transport them to health facilities during emergencies (the Emergency Transport Scheme);
- **developing and distributing service delivery protocols and job aids to health facilities and training health workers to manage MNCH conditions according to standard protocols;**
- **setting up and building the capacity of facility health committees (FHCs) to hold health facilities accountable for the quality of care delivered to the community and to participate in improving the community's response to the facility's needs and care seeking.** These committees should include community members and health providers;
- **continuing the Midwives Service Scheme (MSS).** Some 2,488 midwives were deployed and 2,323 retrained as of April 2010. This is seen as an excellent initiative, which promises to produce good results if kept on track;
- **continuing the community health insurance scheme.** This is an excellent initiative targeting women and children, and removing the financial barriers to accessing health services;

- **holding bi-annual maternal, newborn and child health weeks throughout the country to improve the coverage of selected high-impact interventions and promote key MNCH household and community practices.**

The current coverage for all high-impact interventions falls short of expected levels. With the exception of the South West zone, with a MMR of 165/100,000, which is below the MDG 5 target of 250/100,000 for Nigeria, other zones have substantial burdens of maternal mortality. The three tiers of government need to scale up interventions on ANC, skilled birth attendant, EmONC and PMTCT.

Prioritization of key interventions

Following stakeholders consultations to accelerate the achievement of MDG 5, the following areas of intervention have been identified as the key priority areas of work (Table 3):

- Family planning
- Skilled birth attendance
- Emergency obstetric and newborn care
- Universal coverage of antenatal and post-natal care
- Improved referral system.

TABLE 3 :

MDG 5 OVERVIEW

| MDG 5 | Target | Indicators | MAF Key Intervention Area |
|-------------------------|---|---|--|
| Improve maternal health | Target 5A. Between 1990 and 2015, reduce by three-quarters the maternal mortality ratio (MMR) | 1. MMR 2. Proportion of births attended by skilled health personnel | Emergency obstetric and newborn care (EmONC) Skilled birth attendant (SBA) Improving the referral system |
| | Target 5B. Achieve, by 2015, universal access to reproductive health | 3. Contraceptive prevalence rate 4. Adolescent birth rate 5. Antenatal coverage (ANC) (at least one visit and at least four visits) 6. Unmet need for Family Planning (FP) | FP FP Focused antenatal care (FANC) FP |

Family planning. Family planning (FP) is defined as the use of modern contraception and other methods of birth control to regulate the number, timing and spacing of human births. FP is one of the fundamental pillars of safe motherhood and one of the quick wins in addressing maternal morbidity and mortality. Studies have shown that an effective FP programme will reduce maternal deaths by 30 per cent and child deaths by 20 per cent. Currently, use of FP is low, with a contraceptive prevalence rate (CPR) of 17.3 per cent (MICS, 2012) and an unmet need for FP of 21.5 per cent (MICS, 2012). FP addresses high-risk pregnancies, which constitute about two-thirds of all pregnancies.

Prevention of unsafe abortions and post-abortion care consists of health care services, FP counselling and referral services offered to unmarried adolescents to prevent unwanted pregnancies and to women who have experienced a complication arising from an induced or spontaneous abortion that could be inevitable, incomplete or septic. Unsafe abortion

accounts for 11 per cent of maternal deaths in Nigeria, where abortion is legally restricted to life-threatening conditions affecting the mother; approximately 610,000 abortions occur annually and 80 per cent of patients with abortion complications are adolescents. Currently, post-abortion care services are being provided only in 12 states.

Effective FP plays a pivotal role in delaying the first pregnancy, child-spacing and the prevention of sexually transmitted infections (STIs), including HIV. Delaying first pregnancy requires provision of adequate adolescent reproductive health information, including FP, to all adolescents or young adults (15-24 years), preferably prior to marriage. Nigeria has a high total fertility rate of 5.7, with rates as high as 6.3 in the rural areas. Nigeria also has a high rate of early marriage and a low rate of modern contraceptive use. Only 17.3 per cent of married women report using modern contraceptives. Over 20 per cent of Nigerian women have an unmet need for FP, 15 per cent for spacing

births and 5 per cent for limiting pregnancies. Children born too soon after a previous birth, especially if the interval between the births is less than two years, have an increased risk of sickness and death at an early age. Yet, 8 per cent of births are less than 18 months apart and 24 per cent have an interval of less than two years. The government has approved a policy for the distribution of free contraceptive commodities in all public health facilities to eliminate financial barriers to services. This is in addition to an annual counterpart contribution of US\$3 million from 2011 to support the free distribution of contraceptive commodities. At the 2012 London Summit on Family Planning, the Government made a commitment to provide an additional US\$8.35 million annually for the next four years in a dedicated budget line item for the United Nations Commission life-saving commodities for women. This significantly increases Nigeria's total commitment for the next four years from US\$12 million to US\$45.4 million. The Government has further approved the integration of FP commodities in the NHIS package.

Skilled birth attendants (SBAs). The SBA intervention refers to the process by which a pregnant woman and her infants are provided with adequate care during labour, birth and the post-natal period by an accredited health professional. This professional has the knowledge, and cognitive and practical skills to enable him or her provide safe and effective health care during childbirth to women and their infants in the home, health centre and hospital settings. SBAs include midwives, doctors and nurses with midwifery skills and LSS. This WHO definition excludes traditional birth attendants, whether trained or not. In order for this process to take place, the SBA must have the necessary expanded LSS (doctors), LSS (midwives) or modified LSS (CHEWs). Additionally, they must be supported by an enabling environment at various levels of the health care system,

including a supportive policy and regulatory framework, adequate supplies, equipment and infrastructure. EmONC services ensure that care is provided by SBAs to pregnant women with obstetrics complications and to their newborn. Generally, 85 per cent of women will have a safe delivery without complication, with just 15 per cent experiencing obstetric complications. It is this latter share that contributes to the high MMR. According to the WHO, emergency obstetric care can be divided into basic and comprehensive emergency obstetric care (CEOC). The six basic emergency obstetric care services to be provided at the PHCs are:

- administration of parenteral antibiotics;
- administration of uterotonic drugs (i.e. parenteral oxytocin);
- administration of parenteral anti-convulsants for pre-eclampsia and eclampsia (magnesium sulphate);
- the manual removal of the placenta;
- the removal of retained products (e.g. manual vacuum aspiration, dilation and curettage);
- assistance in vaginal delivery (e.g. vacuum extraction, forceps delivery).

In addition to the six functions of basic emergency obstetric care, CEOC services are:

- surgery, e.g. Caesarean sections;
- blood transfusion services.

Currently, there are no data in NDHS 2008 that capture the percentage of facilities that provide basic and comprehensive emergency obstetric services.

To date, the MSS represents the most visible response from the Government to address the issue of making SBAs available to pregnant women. The innovation was launched in 2009 to reduce the high rates of maternal and child mortality. Significant changes together with attendant challenges have become apparent since launching the scheme. Within the

programme, key health systems issues are also being addressed, such as the availability of essential health care commodities and the redistribution of skilled human resources to remote rural areas to address some of the inequities in the health system.

The MSS specifically addresses the human resource needs for SBAs in rural primary care. Evidence shows that when the number of SBAs increases, use of the services increases, women's satisfaction with care improves, and maternal and newborn mortality decrease.

The MSS hires three categories of midwives – the newly graduated, the unemployed and the retired but able. They are posted for one year (renewable subject to satisfactory performance) to selected PHCs in rural communities. The scheme is the largest of its kind in Africa. It has increased the coverage of SBAs by recruiting 4,000 midwives and 1,000 CHWs as frontline workers for providing MNCH services including FP. The scheme is being further expanded with an additional 3,426 midwives/CHEWs under the 2012 Subsidy Reinvestment and Empowerment Programme (SURE-P) of the Federal Government.

Despite making good progress towards achieving its objectives, the scheme has encountered several challenges. Currently, there is the need to fill gaps with respect to midwives, particularly in the North East and North West zones, mainly because of the inadequate number of midwives trained in the two zones and the recent security challenges in these zones. The specific objectives of the Scheme are to:

- Increase the percentage of primary health care facilities manned by midwives offering 24 hour service by 80 per cent in the MSS target areas by December 2015.
- Ensure that all midwives recruited under MSS are trained in LSS.

- Increase the percentage of primary health care facilities providing BEmONC in MSS target areas by 60 per cent by December 2015.
- Increase the percentage of pregnant women receiving FANC in MSS facilities by 80 per cent by December 2015.
- Increase the percentage of deliveries attended to by SBAs in MSS target areas by 72.6 per cent by December 2015.
- Increase FP attendance in MSS target areas by 50 per cent by 2015.
- Reduce maternal, newborn and child mortality by 60 per cent in the MSS target areas by December 2015.

Operationally, the MSS adopts a Cluster Model or a 'hub and spoke' structure wherein four selected PHCs with the capacity to provide basic emergency obstetric care (BEOC) are clustered around a general hospital with the capacity to provide CEOC, which serves as the referral facility (Figure 11). Presently, there are 250 clusters comprising 1,000 PHCs and 250 general hospitals. This needs to be considerably scaled up.

FIGURE 11 :**THE MIDWIVES SERVICE SCHEME (MSS) CLUSTER MODEL**

Each of the PHC facilities within the cluster has a complement of four midwives providing 24-hour coverage. The midwives and CHWs provide facility and community-based MNCH services, including outreach, in rural hard-to-reach areas. In the existing MSS response, the CHWs are deployed in the North East and North West zones and some hard-to-reach facilities in the North Central zone, where the mortality burden is highest. This serves to complement the services of the midwives in the communities.

As an intervention, the MSS has made tremendous progress since its inception and is now beginning to show benefits to the women and families in rural communities in Nigeria:

- It has engendered a better nationwide coordinated response, resulting in the Governors of the 36 States and the FCT signing a Memorandum of Understanding (MoU) with the Federal Government to support and sustain the MSS by providing accommodation and supplementing the allowances paid to

the midwives in the scheme. The scheme is having its share of successes and challenges in states across the country; the successes are encouraging the states to replicate the scheme in other rural PHC facilities. This will enable sustainability and make the scheme's services available to communities in rural areas.

- It has fostered the emergence of viable WDCs established in all MSS facilities in order to engender community participation and ownership, which is an important component of the scheme. The committees also have the responsibility of monitoring the presence of the midwives in the communities and providing them with accommodation, security and an enabling environment in which to provide services for their communities.
- It has led to the provision of essential commodities as incentives to pregnant women and as supports for the smooth running of the facilities. These include the provision of Mama and midwifery kits, drugs,

basic equipment such as blood pressure apparatus, stethoscopes, weighing scales, facility/community registers, protocols and service guidelines to all PHC facilities under the scheme. For example, 588,000 doses of misoprostol tablets with other relevant materials were distributed to all MSS facilities nationwide. This ensured the availability of the drug in the MSS facilities.

- It has piloted the use of ICT innovations in 160 MSS PHC facilities and 40 referral general hospitals. These facilities and institutions are now connected with ICT, such as voice-over rural telephony, data transmission and internet/video conferencing and remote training and mentoring. In addition, the scheme uses a mobile health technology, the Mobile Application Data Exchange System, for the collection of data from rural MSS facilities and onward transmission to a centre for collation, analysis and reporting.
- It has resulted in quarterly cluster monitoring of the MSS facilities and midwives/CHWs, and in bi-annual integrated supportive supervision to mentor and support the midwives in the field.
- It has trained 4,000 midwives on emergency LSS to enhance the quality of care provided to the communities.
- It has conducted expanded LSS (ELSS) for Medical Officers from the designated referral general hospitals in the 36 States and the FCT thus strengthening their capacity for CEOC.
- It has hired 1,000 CHWs and trained them on essential basic obstetric and newborn care they have been deployed to rural and hard to reach communities in the North East, North West and part of the North Central zones. All training was carried out in partnership with the

Schools of Midwifery and Health Technology in the 36 States and FCT of Nigeria.

- It has trained 94 tutors from 37 Schools of Midwifery nationwide on the use of misoprostol. The training of trainers (ToT) was followed by the training of midwives from 1,000 MSS facilities to enhance the effective management of post-partum haemorrhage at the community and PHC levels using misoprostol.
- It has provided ToT on quality improvement (QI) for 161 midwife tutors from the 37 schools of midwifery by establishing a critical mass of quality improvement trainers nationwide and strengthening institutions on QI with its multiplying effect. QI champions were established nationwide and the facilitation skills of participants were sharpened.
- It has trained 1,000 officers in-charge and 4,000 midwives from the 1,000 MSS facilities on QI to enhance the quality of service delivery at the facility level. Each facility currently has a functional QI team in place.
- It has introduced routine maternal death reviews or audits in MSS facilities and/or communities. The exercise was designed to determine the root causes of maternal mortality in a supportive environment and provide evidence for local decision making on the appropriate interventions needed to reduce maternal mortality.

MSS outcomes: Baseline data were established on December 2009 before the MSS started. A comparison of information obtained from MSS facilities in December 2012 with this baseline information provides evidence of progress towards achieving the objectives of the MSS. The outcomes confirm significant improvements in the core indicators (Figure 12).

FIGURE 12 :

OVERVIEW OF MSS PROGRESS AFTER THREE YEARS OF OPERATION

Summary of the progress Midwives Service Scheme has delivered within three years of implementation

| | | | | |
|---|---------|---------|---|-------|
| ANC attendance | 240,489 | 489,834 | ↑ | +104% |
| Deliveries | 27,877 | 69,641 | ↑ | +150% |
| Maternal Deaths | 316 | 257 | ↓ | -19% |
| Neonatal Deaths | 281 | 267 | ↓ | -5% |
| Family Planning attendance | 24,816 | 72,995 | ↑ | +234% |
| Maternal deaths is compared for 2011 and 2012 | 2009 | 2012 | | |

The MSS remains a strategic intervention because of the recognition that improving the skills of birth attendants in areas with the greatest needs is achievable within a short period. The strategic redistribution of these health workers potentially serves as a model of an effective, realistic and efficient response. It can be adapted to suit the local situation to ensure successful implementation. Some of these adaptations would include the signing of a MoU with all State Governors detailing their responsibilities, and the setting up of a Ward Development Committee where each of the 1,000 MSS facilities is located. The benefits of the scheme also include raised awareness of the use of SBAs at delivery as a human resource intervention. It has created a platform for the effective implementation of other health interventions, particularly in the rural areas. In addition, the scheme adopted the approach of task shifting in areas where there are issues concerning the retention of the midwives.

This was achieved by engaging CHWs resident in these areas to overcome these challenges. The scheme has also fostered partnerships, working with states and local governments as well as development partners to ensure synergy in implementation.

Emergency obstetric and newborn care (EmONC)

Globally, 15 per cent of all pregnant women develop obstetric complications, most of which are unpredictable. Therefore, services for emergency care must be available in order to prevent maternal and/or neonatal deaths and disabilities. Certain critical services or signal functions have been identified as essential for the treatment of obstetric complications and reducing maternal deaths. These signal functions provide a basis for assessing, training, equipping and monitoring obstetric services.

A basic EmONC (BEmONC) facility can administer parenteral antibiotics, oxytocics and anti-convulsants. It can perform the manual removal of the placenta and retained products, as well as assisted childbirth. A comprehensive EmONC (CEmONC) facility, in contrast, can perform all BEmONC functions in addition to performing surgery (e.g. Caesarean section) and safe blood transfusions. The Nigerian BEmONC standard includes two additional signal functions in the guidelines: 24-hour service coverage and a minimum of four midwives per facility. Neonatal resuscitation has been incorporated as an additional signal function to save newborn lives as part of basic and comprehensive care at the global level, which explains the renaming as BEmONC and CEmONC.

WHO recommends that for every 500,000 people, the minimum acceptable level is five EmONC facilities, at least one of which must provide comprehensive care. According to the FMoH/UNFPA EmONC survey of 2003, only Lagos State met the standard of four BEmONC facilities per 500,000 people, counting both public and private healthcare providers. If counting public facilities alone, only seven states met the standard of "one CEmONC facility per 500,000 people". In all states surveyed, a higher percentage of private facilities met the EmONC standard compared with the public health facilities, but both fell below the recommended EmONC levels. Many facilities in Nigeria do not meet the national staffing standard for BEmONC. While all tertiary facilities in 12 surveyed states provide 24-hour coverage, only 90 per cent of secondary facilities provide the same service. Not only is there almost no 24-hour coverage in PHCs, which are often the closest facilities for pregnant women, but also, many do not have a qualified midwife present. One nation-wide survey found that only one PHC facility (in Lagos State) met the national BEmONC standard of a minimum of four midwives per facility with 24-hour service coverage. Generally,

many health facilities lack adequate material resources, as well as basic infrastructure, such as water and electricity supplies. This has a significant impact on the ability of health facilities to offer quality obstetric care. As one primary healthcare worker in the EmONC survey stated, "There is a lack of drugs and equipment, no suction machine, no water, no power supply. We deliver babies using light from lanterns and candles, and also do vaginal exams with them as well." The same EmONC survey shows that 21 per cent of secondary health facilities and most PHCs have no functional equipment to measure blood pressure in the labour wards. This was the situation prior to the launching of the MSS programme in 2009.

The estimated percentage of between 5 and 15 per cent of women will experience complications requiring a Caesarean section. The prevalence of women who give birth by Caesarean section can serve as an indicator of whether EmONC facilities meet women's needs when they are presented with obstetric emergencies. While a high Caesarean section rate can also reflect poor services, Nigeria does not even meet the low threshold, since only around 2 per cent of babies are delivered using this procedure, and some zones are recording coverage of as low as 0.4 per cent.

Universal coverage of antenatal and post-natal care

Women are advised to attend at least four antenatal visits, during which they should receive evidence-based examinations and screenings. These services are offered through a package referred to as 'focused ANC'. The purpose of focused ANC is to provide better care for pregnant women with a goal-oriented approach, which emphasizes the content rather than the sheer number of ANC visits. The content of ANC is an essential component of the quality of services. Focused ANC hinges on the principle that every pregnancy is at risk of complications and should be monitored. According to NDHS 2008 87 per cent of Nigerian mothers who attend ANC have their weight measured 85 per cent have their blood pressure taken; 74 per cent have a blood sample taken; three-quarters have a urine sample taken; 54 per cent receive iron tablets, and 61 per cent are informed of signs of pregnancy complications. Overall, recent evidence shows that 67.7 per cent of Nigerian mothers made at least one ANC contact and 57.6 per cent made four or more ANC visits (MICS, 2012), with significant disparities between urban and rural mothers. Just over two-thirds of urban women made four or more ANC visits compared with only 34 per cent of rural women.

It is important that women attend ANC at the early stages of pregnancy in order to benefit from interventions that require early or repeat visits. Among all women who receive ANC in Nigeria, only 16 per cent make their first ANC visit during the first three months of pregnancy. One survey of safe motherhood in northern Nigeria found that more than half of the women (53 per cent) who attended ANC made their first visit from the sixth month of pregnancy. Culturally, it is common for Nigerian woman not to disclose their pregnancy early for fear of evil spirits.

A multi-country randomized control trial by WHO and a systematic review showed that essential interventions can be provided over four visits at specified intervals, at least for healthy women with no underlying medical problems. This evidence has prompted WHO to define a new model of ANC based on four goal-oriented visits. The Nigerian National Policy Guidelines for Reproductive Health recommended a minimum of four ANC visits, as follows:

- Visit 1: before 16 weeks of pregnancy
- Visit 2: between 20 and 24 weeks of pregnancy
- Visit 3: between 28 and 32 weeks
- Visit 4: at 36 weeks or later.

Two key interventions administered during FANC are intermittent preventive treatment (IPT) for malaria using sulphadoxine pyrimethamine (SP) and administration of tetanus toxoid (TT). The implementation of the FANC is based on the WHO guidance of 2006, which recommends that countries should eliminate the traditional four-week check-ups of pregnant women. However, women with complications, special needs, or conditions beyond the scope of basic care may require additional visits.

Improved referral system

Effective referral systems are considered critical for reducing maternal mortality, since they ensure ready and timely access to appropriate case management, especially for pregnancy-related and newborn complications. Some of the critical action steps in an effective referral system include:

- engaging the community to develop an effective community transport system for referral purposes;
- encouraging adequate awareness creation on birth preparedness to limit delays as much as possible in cases of emergency;
- providing ambulances and other transport evacuation arrangements to health facilities and their maintenance and sustainability;
- enabling two-way communication between the community, PHC facilities and referral centres, including through the use of mobile phones;
- facilitating pre-payment schemes (such as the NHIS and other community mechanisms) for transport to a referral facility;
- putting in place functional triage systems to minimize delays at health facilities;
- ensuring 24-hour availability of maternity services at all health facilities.



IV. ANALYSIS AND PRIORITIZATION OF BOTTLENECKS TO THE ACHIEVEMENT OF MDG 5

Photo: SPARC

Maternal mortality in perspective

In spite of successive policies and interventions to curb maternal mortality and promote maternal health in Nigeria, there are gaps between the current status and the MDGs targets for 2015 on several maternal mortality indicators. Recent estimates indicate that up to one million women and children die every year in Nigeria largely from preventable causes.¹¹ About 33,000 women are estimated to die from pregnancy-related causes and approximately 946,000 children under five years of age die, of whom 241,000 are newborns. The preventable causes of morbidity and mortality among women include pregnancy, anaemia due to malaria, intra- and post-partum haemorrhage, post-partum sepsis, eclampsia and complications from obstructed labour.

The fact that many indicators lag behind the 2015 targets reveal the scale and intensity of the challenges associated with accelerating progress on maternal health (MDG 5). Additionally, the sharp disparity in maternal health between sub-national units (geopolitical zones and states) constitutes an important dimension of the maternal mortality burden in the country. A related dimension of the inequality is access to maternal healthcare services. The wealthiest quintile is eight times more likely to have an SBA at delivery than the poorest quintile. Similarly, the difference in full immunization coverage between the wealthiest and poorest quintiles is almost ten-fold. Coverage of key interventions is low, quality of care is inadequate, and the most basic services do not reach the poorest segments.

Evidence of the gaps

Recent statistics on the MMR point to improved progress towards the 2015 target. The MMR has declined from 545 per 100,000 in 2008 to 350 per 100,000 in 2012; the 2015 target is 250 per 100,000. Similarly, the percentage of births attended by an SBA improved from 38.9 per cent in 2008 to 53.6 per cent in 2012, which still falls far short of the target of 100 per cent by 2015. The percentage of pregnant mothers attending ANC at least four times has improved from 44.8 per cent in 2008 to 57.6 per cent in 2012, which still falls short of the target of 100 per cent by 2015. There is a lack of progress regarding the unmet need for FP; the indicator has barely improved from 20.6 per cent in 2008 to 21.5 per cent in 2012. Moreover, more than two-thirds¹² of maternal deaths occur during childbirth and are closely linked to intra-partum stillbirths and early neonatal deaths.

Bottlenecks to implementation

To date, MDG 5 interventions are making slower than desired progress towards the 2015 targets. The problems stem from wide-ranging bottlenecks that impede implementation. There are two broad types of bottlenecks, sector-specific and cross-cutting. Sector-specific bottlenecks lie entirely within the ambit of the Federal and State Ministries of Health and local government health departments or affiliated agencies. Cross-cutting bottlenecks do not fall under the responsibility of the Federal and State Ministries of Health and local government health departments; they are inter-sector and economy-wide problems that affect the results-based implementation of the MDG 5 interventions.

11. *Saving One Million Lives Initiative 2012.*

12. *Integrated Maternal, Neonatal and Child Health Strategy Paper 2011.*

Sector-specific bottlenecks can be reclassified to one of the following four categories: policy and planning, budget and financing, service delivery (supply-side) and service use (demand-side). Monitoring and assessment reports and MDG documentation have identified several bottlenecks militating against the achievement of targets.

Policy and planning

Policy coordination difficulties: Like other development sectors, the Nigerian health system is underpinned by policy and fiscal decentralization, and concurrent responsibilities between the three tiers of government – federal, state and local. While responsibility sharing, in principle, could promote accountability, the lack of adequate coordination and synergy in the provision and management of health care across the three levels of governmental authority have tended to distort service delivery, reduce the coherence of actions and diminish the collective impacts of interventions. While local governments have critical mandates in primary health care, including maternal health, they lack the requisite institutional and human capacity and resources to effectively discharge their responsibilities. Consequently, there is often a significant fragmentation of efforts and a suboptimal coordination and focus on inputs and processes (e.g. the Saving One Million Lives Initiative) rather than on outcomes and results that matter.

Inadequate engagement of the private sector: The private sector, which provides at least half of the health services, is fragmented, poorly regulated, poorly understood and practically with no or limited partnership with the public health sector, especially at the primary care level.

Inadequate strategy for dealing with inequalities: The persistence of sub-national (geopolitical

zone, state, rural/urban) disparities in maternal healthcare services and the resultant sharp variations in MMR reveal the ineffectiveness of the current strategy and approach to solving the imbalances.

Inadequate monitoring and shortage of good quality tracking data: Effective monitoring of service delivery (performance of personnel, availability and quality of services, availability and use of commodities) for the reshuffling of resources and realignment of efforts require good quality data. The data should, ideally, mirror intervention pathways (including minor difficulties) from inputs/activities through outputs and outcomes. However, the data system for tracking the maternal healthcare results chain – from inputs through outputs and outcomes – is largely undeveloped, piecemeal and not institutionalized. Hence, the effectiveness of spending money to achieve outputs and outcomes is not clearly delineated across the three tiers of government, thereby leaving ample room for ambiguity and anonymity in the attribution of outcomes. Moreover, the lack of reliable and consistent maternal health service delivery and service use data makes it difficult for troubleshooting and benchmarking against baselines and targets. The situation hampers the ability of managers and operators of the maternal health care system to implement the needed responses in a precise and timely manner.

Financing and budgeting

Despite improved public spending on health in recent years, up to three-quarters of the total health expenditure is borne by households through out-of-pocket payments for healthcare. The cost of care, particularly in the case of obstetric emergency, is one of the most important barriers to healthcare use.

Service delivery (supply side)

In order to realize the targets for maternal healthcare, there is need for adequate and well-motivated health personnel, sufficient supplies/inputs and key logistics that work towards good quality and are highly responsive and readily available. The implementation pathways of the MDG 5 interventions are beset with difficulties. As detailed in available documents, these difficulties and gaps include:

- a shortage of skilled health personnel particularly in rural areas;
- irregularity of attendance of skilled health personnel in rural primary health care centres;
- delays between patient arrival and getting treatment;
- scarcity of emergency obstetric care services;
- a lack of adequate kits for TBAs;
- shortage of critical supplies in PHCs;
- a lack of adequate attention to special (disadvantaged) groups of mothers.

Other often-mentioned bottlenecks include the lack of FP services, delayed completion of PHCs and in supplying complementary inputs, and sometimes inappropriate project selection or location. For example, it was specifically reported that most of the 23,000 frontline primary health care facilities often lack skilled practitioners, and a large percentage of the facilities do not have basic pharmaceuticals and commodities consistently in-stock.

Service use (demand side)

Services cannot be said to be successfully delivered until they are used beneficially by the intended persons or groups. The manner and extent of use of maternal health care services is a final outcome that signals the effectiveness of the entire intervention chain. Available reports show that the use of maternal health care services lags far behind what is required to

achieve MDG 5. Pregnant mothers are not able to use maternal health care services because of a number of bottlenecks in availability, access (physical and financial) and regularity, lack of information about what to do in emergency cases, delays in the decision to seek treatment, the time lapse between the decision to seek assistance and reaching a health facility, and the inability of the poor to afford maternal health care services. Other user-related impediments to maternal health care are socio-cultural and traditional beliefs, practices and attitudes.

Cross-cutting bottlenecks pertain to low public accountability, inadequate value for public spending, corruption, shortage of infrastructure (power and roads/transport), particularly in rural areas, negative attitudes towards serving in rural areas, lack of rigorous project appraisal and insecurity.

Analysis and prioritization of the bottlenecks

Specific bottlenecks against the prioritized interventions: The identified bottlenecks have been analysed with respect to the prioritized interventions. The match between prioritized bottlenecks and the prioritized interventions is provided in Table 4.

TABLE 4 :

BOTTLENECKS AFFECTING THE PRIORITIZED INTERVENTIONS

| Prioritized bottleneck | Bottleneck category | Prioritized Interventions | | | | |
|---|----------------------------|---------------------------|-------------------------------|---|---|----------------------------|
| | | Family Planning services | Skilled Birth Attendant (SBA) | Emerg-ency obstetric and newborn care (EmONC) | Universal coverage of antenatal and post-natal care | Improved referral services |
| Socio-cultural religious barrier | Cross-cutting and systemic | | | | | |
| Inadequately trained personnel | Service delivery | | | | | |
| Low male involvement/uptake | Systemic | | | | | |
| Inadequate SBAs | Service delivery | | | | | |
| Uneven distribution of available (SBAs) | Service delivery | | | | | |
| Inadequate referral training for (SBAs) | Service delivery | | | | | |
| Lack of functional equipment and facilities | Service delivery | | | | | |
| Poor incentives especially in rural areas | Budget and financing | | | | | |
| Shortage of skilled health personnel | Service delivery | | | | | |
| Inadequate equipment and supplies | Service delivery | | | | | |
| Delay in accessing care services | Service use | | | | | |
| Inadequate political will | Cross-cutting | | | | | |
| Poor access to health facilities in rural areas | Service use | | | | | |
| Poor attitude of health workers | Service delivery | | | | | |
| Lack of legislation | Policy and planning | | | | | |
| Inadequate ambulance services | Service delivery | | | | | |
| Poor communication and feedback system | Service delivery | | | | | |
| System delay | Service delivery | | | | | |

Indications from matching bottlenecks against prioritized interventions: The matching of bottlenecks against the prioritized interventions reveals some critical points. *The majority of the prioritized bottlenecks are in the service delivery category.* They include: an inadequate number of skilled health workers; inadequate training of health personnel; irregular services at care centres; an uneven distribution of health professionals; an uneven distribution of commodities; and poor attitudes of health workers. Unsupportive socio-cultural and traditional beliefs, attitudes and practices cut across the prioritized interventions. The quantity and quality of funding are both underlying and direct forms of bottlenecks for the prioritized interventions: underlying in terms of inadequate budget/funds for logistics, personnel incentives, infrastructure and commodities, and direct in terms of poor quality of spending, which lead to a low value for the money spent. The service delivery-related bottlenecks are based on a systemic failure of the supervision and monitoring system, as a result of which service readjustments are either non-existent or too slow to bring about positive results.

Prioritized bottlenecks: analysis of 'potential impact' and 'solution feasibility'

Further analysis on the bottlenecks was carried out by assessing the 'potential impact' and 'feasibility' of removing the specific bottleneck. The 'potential impact' relates to the extent to which removal of the bottleneck will accelerate achievement of the MDGs 2015 target for reducing the MMR. In contrast, 'feasibility' refers to the prospects for solving the bottleneck in the near term, i.e. by 2015. Using this framework, the bottlenecks were assessed, as shown in Tables 5 and 6.

| TABLE 5: | | BOTTLENECK ASSESSMENT SCORECARD | |
|--------------------|-------------------------------------|--|--|
| Colour code | Potential impact | Amenability to near-term solution | |
| | Achieves acceleration | Very amenable | |
| | Potentially achieves acceleration | Moderately amenable | |
| | Probably does not help acceleration | Marginally amenable | |
| | Does not help acceleration | Not amenable | |

TABLE 6 :
THE POTENTIAL IMPACT AND FEASIBILITY OF THE PRIORITIZED BOTTLENECKS

| Prioritized interventions | Identified bottlenecks | Potential impact | Amenability to near-term solution | Overall acceleration potential |
|---|---|------------------|-----------------------------------|--------------------------------|
| Family Planning services | Socio-cultural religious barrier | Green | Red | Not likely |
| | Inadequately trained personnel | Green | Green | Yes |
| | Inadequate male involvement | Light Green | Light Green | Likely |
| Skilled Birth Attendant (SBA) | Inadequately trained personnel | Green | Yellow | Likely |
| | Uneven distribution of available SBAs | Green | Green | Yes |
| | Inadequate referential training for SBAs | Green | Green | Yes |
| | Lack of functional equipment and facilities | Green | Green | Yes |
| | Poor incentives, especially in rural areas | Green | Green | Yes |
| Emergency obstetric and newborn care (EmONC) | Shortage of skilled health personnel | Green | Yellow | Likely |
| | Inadequate equipment and supplies | Green | Green | Yes |
| | Delay in accessing care | Yellow | Light Green | Not likely |
| Universal coverage of antenatal and post-natal care | Socio-cultural and religious barrier | Green | Red | Not Likely |
| | Inadequate political will | Green | Red | Not likely |
| | Poor access to health facilities, especially in rural areas | Green | Light Green | Likely |
| | Poor attitude of health workers | Light Green | Green | Likely |
| | Lack of legislation | Green | Red | |
| Improved referral services | Inadequate ambulance services | Green | Green | Yes |
| | Poor communication and feedback systems | Green | Light Green | Likely |
| | System delays | Green | Green | Yes |



V. ACCELERATION SOLUTIONS



Photo: SPARC

INTRODUCTION

Following the identification of the prioritized interventions and the prioritized bottlenecks in the two preceding chapters, the focus of Chapter 5 is on the presentation of the acceleration solutions. The United Nations' MAF Operational Notes define a solution as *"a single action or package of actions taken to resolve an intervention bottleneck in the near term to produce quick impact on the ground."* Consequently, in order to obtain the right solution, a solution analysis was carried out during the stakeholders' technical workshop. The workshop participants developed a comprehensive list of bottleneck solutions and after critical examination, they came up with a list of prioritized solutions that ultimately constitute the acceleration solutions for MDG 5.

Basis for selecting the acceleration solutions

Participants at the stakeholders' workshop evaluated a solution on the basis of two dimensions – **impact and feasibility**. Accordingly, four criteria were used to assess an impact:

- magnitude – defined as the extent of the solution's impact on solving the bottleneck, including its impact on the priority MDG target, its indirect spill-over impact and its impact on equity;
- speed of impact – described as the length of time to realize the solution's impact;
- sustainability of impact;
- adverse impact – described as the magnitude of the negative impact, within or outside the sector.

The feasibility dimension of solutions is also evaluated on the basis of four criteria:

- Governance – seen in terms of rule of law, transparency and accountability mechanisms to implement the solution;

- Capacity – seen in terms of the ability to plan, implement and monitor the solution;
- Funding availability – seen as the availability of funds to cover the solution's cost
- Additional factors – seen in terms of additional factors that may impede the solution.

The analysis of the impact and feasibility of a solution formed the basis for the final list of acceleration solutions. The rest of this chapter is a presentation of the acceleration solutions to the prioritized bottlenecks.

Family planning

Solutions to socio-cultural religious barrier

- Scaling up of sensitization of traditional leaders, religious leaders, CBOs and FBOs through appropriate media.
- Focus on the teaching of family life education in the secondary school curriculum.
- Establishment of more functional youth-friendly centres.

Solutions to inadequate trained personnel

- Recruitment of more trained personnel.
- Intensification of training and re-training of health workers including community-based resource persons.

Solution to poor/inadequate male involvement

- Sensitization and mobilization of the men to take leadership in health matters.

Skilled birth attendants

Solutions to inadequate SBAs

- Recruitment of more SBAs.
- Training and re-training of SBAs.
- Mandatory posting of National Youth Service Scheme (NYSC) SBAs to rural areas.
- Mandatory one-year internship posting in rural areas.
- Task shifting/sharing for SBAs.

Solutions to uneven distribution of available SBAs

- Additional incentives for rural posting.
- Doctors at tertiary hospitals to mentor SBAs in rural areas.

Solutions to inadequate referential training for SBAs

- More refresher courses for SBAs in EmONC skills.
- Regular support supervision for SBAs.

Solutions to lack of functional equipment and facilities

- Scaling up of supply of basic equipment for SBAs.
- Regular maintenance of facilities, structure, equipment and supplies.

Solutions to poor incentives in rural areas

- Provision of allowances for rural posting.
- Provision of accommodation for rural posting.
- Strengthening, reactivating or forming of WDCs.

Emergency obstetric and newborn care

Solutions to shortage of skilled health personnel

- Recruitment of more SBAs
- Additional incentives for health workers in hard-to-reach areas/difficult terrain/rural areas.
- Scaling up of in-service training and implementation of LSS and CBMNC
- Incorporation of the LSS and CBMNC into the pre-service SBA curriculum.

Solutions to inadequate equipment and supplies

- Provision of adequate EmONC equipment and services
- Regular maintenance of adequate EmONC equipment and services
- Equitable and effective distribution of EmONC equipment and supplies.

Solutions to delay in accessing care services

- Awareness and sensitization campaigns on (EmONC) services and issues using appropriate media
- Promotion of key household and community service packages
- Promotion of mobile phone communication system (GSM) services between clients and SBAs on EmONC as has been successfully demonstrated through the Abiye Project in Ondo State
- Reduction of the delay at the health facilities by using standard operating procedures (SOP) for EmONC
- Establishment of emergency triage and treatment (ETAT) for EmONC at health facilities.

Universal coverage of antenatal and post-natal care

Solution to socio-cultural and religious barriers

- Carrying out an advocacy campaign to traditional, community and religious leaders.

Solutions to inadequate political will

- Training of identified interest groups/civil society organizations to demand their rights
- Assistance by CSOs to vulnerable groups to demand their rights.

Solutions to poor access to health facilities especially in rural areas

- Creation of outreach sites closer to the people
- Community involvement in ownership and monitoring the use of health services
- Scaling up and strengthening of regular mobile health services.

Solutions to poor attitude of health workers

- Re-orientation of health workers to imbue them with appropriate values
- Appropriate staffing ratio of health workers to patients
- Recognition of health workers based on merit

- Effective, regular supervision and coordination
- Enforcement of discipline.

Solution to the lack of legislation

- Support to the accelerated passage of the health care bill.

Improved referral system

Solutions inadequate ambulance services

- Decentralization of ambulance service to rural areas
- Improvisation of functional ambulance services, such as. tricycles, donkeys, speedboats, cows and camels
- Collaboration with NURTW members or any community member for a reward
- Regular revision of referral directory
- An effective two-way referral system
- Regulation against and discipline for the wrongful use of ambulances.

Solutions to poor communication network and feedback system

- Provisions of phones
- Provision of toll-free lines by telecommunications companies.

Solutions to system delay

- Adherence to SOPs
- Integration of ambulances in the handing-over process.



VI. THE IMPLEMENTATION STRATEGY

Photo: OSSAP

Four pertinent issues are raised in this chapter – the financial implications of the priority action plan, the partnership for implementation, the monitoring and evaluation framework and some key success factors; the essence of each is provided below.

The financial implications of the priority action plan

The overall resource allocation for the acceleration plan for the 2013–2017 period is N65,521,997,572 (about US\$436,813,317). Given the federal nature of the country, which involves three tiers of government, and based on the annual budgetary allocation to the health sector, this seems to be a moderate amount. Because the interventions *skill birth attendants* involved the construction of PHC facilities (not less than 1,000) and recruitment of 7,000 midwives and 4,200 CHEWS by 2017, it constitutes the largest

share (75.3%) of the financial implication of the strategy. This is followed by *universal coverage of antenatal and post-natal care, family planning and emergency obstetric and newborn care* (see Table 7 and Figure 13 for more information).

Figure 14 provides the annual distribution of the financial outlay for the implementation of the various interventions. The allocation in 2013 are mostly influenced by the awareness and sensitization campaigns needed to kick-start the initiative, while those of 2015 and 2016 are influenced by the recruitment of a large number of SBAs. To ensure effective implementation and quality service, a modest 1.00 per cent was allocated to monitoring and evaluation.

Appendix 2 provides a comprehensive breakdown of the budget provisions for the various near-term solutions and activities.

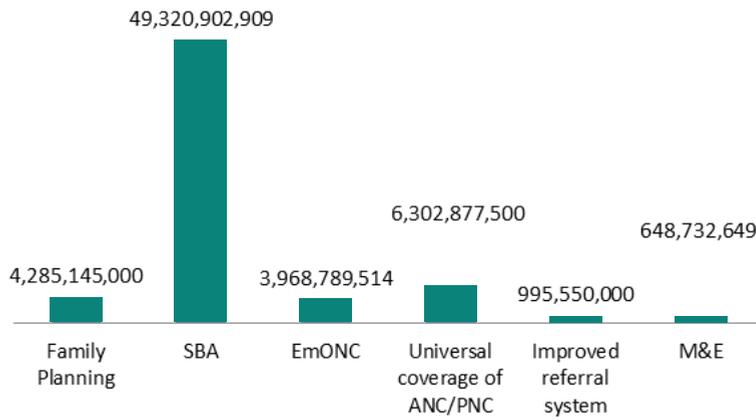
| Intervention areas | Budget (naira) | | | | | |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| | 2013 | 2014 | 2015 | 2016 | 2017 | Total |
| 1. Family Planning | 2,636,745,000 | 491,100,000 | 474,100,000 | 474,100,000 | 209,100,000 | 4,285,145,000 |
| 2. Skilled birth attendants | 6,352,304,002 | 9,226,641,382 | 11,101,641,382 | 12,404,641,382 | 10,235,674,760 | 49,320,902,909 |
| 3. Emergency obstetric and newborn care | 1,707,017,500 | 896,092,014 | 1,066,590,000 | 247,090,000 | 52,000,000 | 3,968,789,514 |
| 4. Universal coverage of antenatal and post-natal care | 2,341,120,500 | 1,026,720,500 | 1,189,220,500 | 1,351,720,500 | 394,095,500 | 6,302,877,500 |
| 5. Improved referral system | 376,800,000 | 192,250,000 | 197,500,000 | 202,750,000 | 26,250,000 | 995,550,000 |
| 6. Monitoring and evaluation | 129,746,530 | 129,746,530 | 129,746,530 | 129,746,530 | 129,746,530 | 648,732,649 |
| Total (naira) | 13,543,733,532 | 11,962,550,426 | 14,158,798,412 | 14,810,048,412 | 11,046,866,790 | 65,521,997,572 |
| Total (US\$) | 90,291,557 | 79,750,336 | 94,391,989 | 98,733,656 | 73,645,778 | 436,813,317 |

Note: The average official exchange rate dollar for the US dollarexchange rate is N150 per \$1.00.

Source: Compiled from Appendix 2

FIGURE 13:

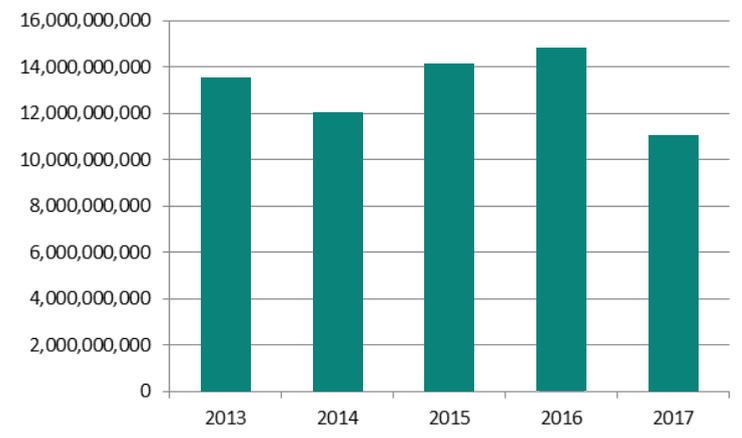
SUMMARY OF FINANCIAL ALLOCATION TO PRIORITY INTERVENTIONS (NAIRA)



Source: Compiled from Appendix 2.

FIGURE 14:

BUDGETARY ALLOCATION, 2013 TO 2017



Source: Compiled from Appendix 2.

Partnership for effective implementation

A strong collaboration is required between and among various actors in the health sector. Nigeria is a federal state with over 812 government entities comprising one federal government, one federal capital territory, 36 state governments and 774 local governments (excluding development council areas). It therefore requires horizontal and vertical collaboration among the various tiers of government. The implementation of Conditional Grant Scheme and Conditional Cash Transfers, which have been promoting partnership between the state and federal governments, should be strengthened. Collaboration within the tiers of government is also a critical element in achieving the targets. All areas of current collaboration across the various tiers and units of government need to be strengthened.

The private sector constitutes a critical part of Nigeria's health system. However, the current level of partnership is too weak to achieve these priority interventions. It is important for the Ministry of Health (in the three tiers of government) to strengthen the current partnership arrangement between the Government and the private sector in improving maternal health in the country. This requires the organization of regular stakeholders' meetings between the private and the public sectors to discuss pertinent issues concerning public health in general, and maternal and newborn health in Nigeria. The CSOs also play a significant role in accelerating progress.

The partnership on maternal health will be incomplete without an effective and strong collaboration with development partners. Both bilateral and multilateral institutions have their role to play here. United Nations institutions such as UNFPA, UNICEF and WHO as well as the World Bank are key in the implementation of this strategy. The UNDP and the National Planning Commission are also key in the monitoring and evaluation of the MAF.

Table 8 provides detailed information about relevant stakeholders needed in the implementation of this priority action plan.

TABLE 8: MAF PRIORITIZED SOLUTIONS AND RESPONSIBILITIES

| PRIORITIZED INTERVENTIONS | PRIORITIZED BOTTLENECKS |
|---------------------------|--|
| Family Planning | 1) Socio-cultural and religious barriers |
| | 2) Inadequately trained personnel |
| | 3) Poor/inadequate male involvement |
| SBAs | 1) Inadequate number of SBAs |
| | 2) Uneven distribution of available SBAs |
| | 3) Inadequate referential training for SBA |
| | 4) Lack of functional equipment and facilities |
| | 5) Poor incentives especially in rural area |

| | ACCELERATION SOLUTIONS | RESPONSIBLE PARTNERS |
|--|---|---|
| | a) Scaling up of the sensitization of traditional leaders, religious leaders, CBOs and faith-based organizations (FBOs) through appropriate media | Federal Ministry of Health (FMoH), Office of the Senior Special Assistant to the President (OSSAP)/ National Youth Service Scheme (NYSC), UN Women, National Orientation Agency (NOA) |
| | b) Focus on the teaching of family life education in the secondary school curriculum | Federal Ministry of Women Affairs (FMoWA), Federal Ministry of Youth Development (FMYD), National Primary Health Care Development Agency, (NPHCDA) |
| | c) Establishment of more functional youth- friendly centres | FMoWA/Youth Development, United Nations Population Fund (UNFPA), OSSAP, National Agency for the Control of AIDS (NACA) |
| | a) Recruitment of more trained personnel | State Ministry of Health (SMoH), FMoH, UNFPA |
| | b) Intensification of training and re-training of health workers including community-based resource persons | FMoH, SMoH, UNFPA, OSSAP, NPHCDA |
| | a) Awareness raising and mobilization of the men to take leadership in health matters | FMoH, OSSAP-MDGs, UN Women, NOA |
| | a) Recruitment of more SBAs | NPHCDA and partners |
| | b) Training and re-training of SBAs | NPHCDA and partners, NACA |
| | c) Mandatory posting of NYSC SBAs to rural areas | NYSC, local government areas LGAs, SMoH |
| | d) Mandatory one-year internship posting in rural areas | FMoH |
| | e) Shifting and sharing of tasks for SBAs | NPHCDA/ State Primary Health Care Development Agency SPHCDA |
| | a) Provision of additional incentives for rural posting | FMoH, NPHCDA, SPHCDA, SMoH, MLA |
| | b) Doctors at tertiary hospitals to mentor SBAs in rural areas. | FMoH, SMoH |
| | a) Provision of more refresher courses for SBAs in EmONC skills | FMoH, SMoH, NPHCDA |
| | b) Provision of regular support supervision for SBAs. | FMoH, SMoH, NPHCDA |
| | a) Scaling up of the supply of basic equipment and supplies for SBAs. | FMoH, SMoH, NPHCDA, OSSAP and partners. |
| | b) Regular maintenance of facilities, structures, equipment and supplies | SMoH, LGAs and partners |
| | a) Provision of allowances for rural postings | SPHCDA, SMoH, NPHCDA |
| | b) Provision of accommodation for rural postings | SPHCDA, SMoH, NPHCDA |
| | c) Strengthening, re-activating and setting up of Ward Development Committees (WDCs) | SPHCDA, SMoH, National Primary Health Care Development Agency (NPHCDA) and the Ministry of Local Government Affairs, (MLGA) |

| PRIORITIZED INTERVENTIONS | PRIORITIZED BOTTLENECKS |
|--|--|
| <p>Emergency obstetric and newborn care</p> | <p>1) Shortage of skilled health personnel</p> |
| | <p>2) Inadequate equipment and supplies</p> |
| | <p>3) Delay in accessing care services</p> |

| | ACCELERATION SOLUTIONS | RESPONSIBLE PARTNERS |
|--|---|--|
| | a) Recruitment of more SBAs | LGAs, SMoH, NPHCDA |
| | b) Provision of additional incentives for health workers in hard-to-reach/difficult terrain/rural areas | LGAs, SMoH, NPHCDA |
| | c) Scaling up of in-service training and implementation of life-saving skills (LSS) and CBMNC | LGAs, SMoH, NPHCDA |
| | d) Incorporation of LSS and CBMNC into the pre-service curriculum for SBAs | FMoH, Nursing and Midwifery Council of Nigeria (NMCoN), Community Health Directors |
| | a) Provision of adequate EmONC equipment and services | FMoH, SMoH, OSSAP, NPHCDA and partners |
| | b) Regular maintenance of adequate EmONC equipment and services | LGAs and partners |
| | c) Equitable and effective distribution of EmONC equipment and supplies | LGAs, SMoH and partners |
| | a) Awareness creation and sensitization campaign for EmONC services and issues using appropriate media | LGAs, SPHCDA, SMoH, FMoH |
| | b) Promotion of key household and community service packages | NPHCDA, SMoH and partners |
| | c) Provision of GSM services (communication) between clients and SBAs on EmONC | NCC, FMoH and partners |
| | d) Reduction of delays at the health facilities through the use of standard operating procedures (SOPs) for EmONC | FMoH, SMoH and stakeholders |
| | e) Establishment of emergency triage and treatment (ETAT) for EmONC at health facilities | FMoH, SMoH and partners |

| PRIORITIZED INTERVENTIONS | PRIORITIZED BOTTLENECKS |
|--|--|
| Universal coverage of antenatal and post-natal care | 1) Socio-cultural and religious barriers |
| | 2) Inadequate political will |
| | 3) Poor access to health facilities, especially in rural areas |
| | 4) Poor attitude of health workers. |
| | 5) Lack of legislation |

| | ACCELERATION SOLUTIONS | RESPONSIBLE PARTNERS |
|--|--|--|
| | a) Carrying out of an advocacy campaign for traditional, community and religious leaders | FMoH, OSSAP/NYSC, UN Women, NOA |
| | b) Training of identified interest groups/civil society organizations (CSOs) to demand for their rights. | FMoH, NHRC, NOA |
| | c) Assistance of CSOs to vulnerable groups in demanding their rights. | NGOs, CSOs, NOAs, FMoH, NHRC |
| | a) Creation of outreach sites closer to the people. | LGAs, WDC |
| | b) Strengthened community involvement in ownership and monitoring of the use of health services | LGAs, NYSC, NPHCDA/SPHCDA, SMoH |
| | c) Scaling up and strengthening of the regular mobile health services | LGAs, SMoH, SPHCDA. |
| | a) Re-orientation of health workers to imbue them with appropriate values | Federal and state regulatory agencies |
| | b) An appropriate staffing ratio of health workers to patients | SPHCDA, SMoH, FMoH, LGAs |
| | c) Recognition of health workers on the basis of merit | Employers/management |
| | d) Effective regular supervision and coordination | LGAs, SMoH, FMoH, NPHCDA |
| | e) Enforcement of discipline | Management/regulatory bodies |
| | a) Support for the accelerated passage of the health care bill | CSOs, NGOs, development partners, SMoH, FMoH |

| PRIORITIZED INTERVENTIONS | PRIORITIZED BOTTLENECKS |
|---------------------------------|--|
| Improved referral system | 1) Inadequate ambulance services |
| | 2) Poor communication network and feedback systems |
| | 3) System delays |

| | ACCELERATION SOLUTIONS | RESPONSIBLE PARTNERS |
|--|---|--|
| | a) Decentralization of ambulance services to rural areas | FMoH, SMoH, SPHCDA |
| | b) Improvisation of functional ambulance services, such as tricycles, donkeys, speedboats, cows and camels | LGAs, SMoH |
| | c) Collaboration with National Union of Road Transport Workers (NURTW) members or any person in the community | LGAs, NURTW, management |
| | d) Regular revision of the referral directory | FMoH |
| | e) An effective two-way referral system in place | SPHCDA, LGAs, FMoH |
| | f) A law in force against the wrongful use of ambulances | FMoH, SMoH, LGAs |
| | a) Provision of phones | NCC, FMoH, GSM/Telecommunication service providers |
| | b) Provision of toll-free lines by telecommunication companies | NCC, GSM/Telecom service providers |
| | a) Adherence to SOPs | FMoH, SMoH, LGAs |
| | b) Integration of ambulances in the handing-over process | SMoH, LGAs |

Monitoring and Evaluation Plan

A well-functioning, results-based monitoring and feedback system, established as an integral element of implementation management, is central to the success of the MAF Action Plan. While M&E processes are usually built into national and sub-national plans and programmes, lessons learned show that the critical challenges lie in faithfully implementing them to achieve the intended effects. Moreover, the unique, action-oriented nature of MAF solutions requires a strong M&E mechanism.

For the purpose of the MAF, the monitoring system will involve collecting, analysing, reporting and using data and information to gauge the implementation of solutions and results (outputs, outcomes and impact). Specifically, the MAF M&E system will perform the following functions:

- Provide programme managers and stakeholders with data and information about the pace, nature and degree of progress in service delivery and service use.
- Supply a credible evidence base for management responses in bridging gaps, correcting weaknesses and consolidating gains in the implementation of the agreed solutions and actions.
- Deliver a reporting and feedback system for tracking progress on MDG 5 through to 2015 based on the MAF results chain – inputs, outputs, outcomes and impacts.

Scope and nature of the M&E

The monitoring of the MAF Action Plan will cover multiple, successive levels of the results chain spanning inputs, outputs, outcomes and impacts:

- Input-level monitoring will cover the tracking of funds/spending, staff deployments and material resources used in implementing the

respective MAF solutions and actions.

- Output level monitoring will be directed at tracking completed activities combined with the first-level results achieved through these activities – e.g. the number of health staff trained, the number of new midwives recruited, the amount of supplies delivered and the quantity of equipment acquired.
- Outcome-level monitoring will focus on the delivery and use of services (for example, FP, SBAs and EmONC).
- At the highest level, the impact monitoring pertains to the achievement of a reduction in maternal mortality.

The MAF M&E will be operated based on best practice principles and approaches that have eluded many of the past plans and programmes. The M&E will be conducted and organized to be timely, inclusive, participatory, credible, useful and evidence-based.

Framework of M&E indicators

The MAF M&E system will measure and track the progress of the implementation and the achievement of results based on the framework of indicators given in the implementation and action plans. As provided for in the action plan, there are a set of indicators for every prioritized acceleration solution. For the respective indicators, the tracking exercise will benchmark the progress of the implementation and achievement of results against the targets set in the action plan, in order to detect gaps/ deviations and design corrective responses.

M&E resources

The MAF M&E will apply standard quality assurance methods and tools to track implementation and results, as follows:

a) *Calendar of milestones*: The MAF Action Plan will be further distilled into an operational 'Calendar of milestones' to gauge actual versus expected results. The milestones represent landmark achievements in service delivery and service use en route to 2015. These pre-identified landmarks serve as scheduled 'checkpoints' to assess whether service delivery and use are still on track.

b) *Monitoring and evaluation scorecard*: The M&E scorecard will report metrics showing the trajectory of progress, quantify observed deviations and determine whether the implementation and impact of solutions (reduction in maternal deaths) are on track. It describes the extent to which the removal of bottlenecks by applying the prioritized solutions is leading to targeted reductions in maternal mortality. It is a target-oriented measurement tool.

c) *Reporting requirements*: The M&E system will involve periodic reports to track and document solution outputs and outcomes (service provision and use). The reporting will entail successive levels of tracking starting from LGAs, state-wide through national coverage. The reports will contain point-of-service monitoring data on maternal healthcare service delivery and use in the local governments, aggregated at the state and national levels. Within the framework of the reporting system for the MDGs, the MAF M&E reports will include:

- i. Quarterly progress reports – describing the progress on implementation and outputs in the reference three-month period. Primarily, these reports will focus on the facility-level (i.e. service-level) data from the various local communities aggregated at the state and national levels;
- ii. Semi-annual progress reports – describing the achievement of outcomes and impacts

- iii. MAF completion report – giving the final status of outcomes and impacts achieved based on the acceleration solutions.

Sourcing and managing data

To effectively bring about the desired information and feedback, monitoring will be based on timely, relevant, accurate and useable data. The sources of data will include administrative records and periodic sample surveys. The administrative data will be collected at the facility level (service delivery points) in local communities and will be collated by the SMOHs for onward transmission to the FMOH. The data will constitute live evidence of the status and progress of maternal health services throughout the country and provide timely information for management decision making. Additionally, sample surveys will be carried out by the NBS as part of the data tracking mechanism. Data will cover critical variables, including funding levels and spending patterns, staffing and human resources, supplies and equipment, logistics, service delivery, service use and maternal deaths.

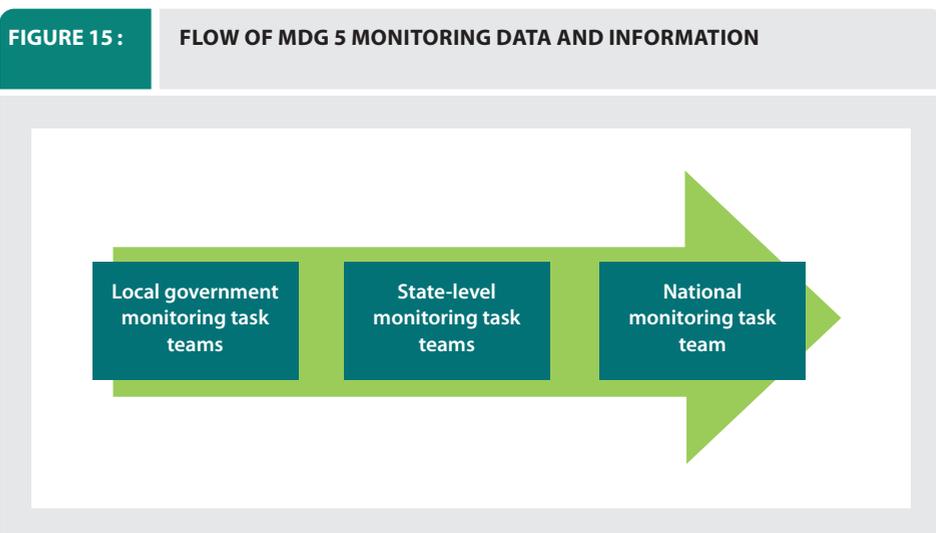
Execution of the M&E plan

To avoid the pitfalls of past M&E systems in national plans and programmes, the MAF M&E will follow a clear and focused agenda executed by dedicated task teams underpinned by an unequivocal division of roles between the federal and state levels. The organization of the MAF M&E process will be tripartite, involving local governments, state governments and the federal government. Monitoring task teams (MTTs) will be constituted from among relevant agencies at the three levels of government. Local government task teams will include local health departments and community representatives, while state-level task teams will include the SMOH, MDGs desk officers, health sector

professional associations and state-level civil society representatives. Similarly, federal-level task teams will include MDGs Officers, FMoH (and affiliated agencies), the NPC and national civil society representatives, such as national level health sector professional associations. In line with this tripartite organization, the monitoring

data will flow successively from local task teams through the state task teams to the federal M&E task teams.

The flow of data and information along the monitoring chain from local level to national level will be organized as shown in Figure 15.



Making use of monitoring data

Drawing on lessons learned, the MAF M&E system will incorporate key enablers that promote effective monitoring as the basis for feedback on improved implementation. There will be central coordination of the M&E by OSSAP-MDGs in collaboration with the NPC. The MAF Management Information System will be structured to transmit monitoring data to the decision-making mechanisms of the service providing implementing line agencies. The feedback information is useful for programme realignment and the redistribution of services and supplies. In addition to providing relevant forecasting data, the supply chain data from

local healthcare facilities will serve as a guide to design responses in underperforming situations. To give substance to the feedback value of the monitoring data, OSSAP-MDGs will build and coordinate appropriate management response mechanisms that address observed implementation problems. The M&E calendar is contained in Table 9.

TABLE 9 :

MAF MONITORING AND EVALUATION CALENDAR

| M&E Activity | Time Schedule | | | | | | | | | | | |
|---|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---|
| | Qtr 2 2013 | Qtr 3 2013 | Qtr 4 2013 | Qtr 1 2014 | Qtr 2 2014 | Qtr 3 2014 | Qtr 4 2014 | Qtr 1 2015 | Qtr 2 2015 | Qtr 3 2015 | Qtr 4 2015 | |
| Formation of monitoring task teams (MTTs) at the federal and state levels | █ | | | | | | | | | | | |
| M&E indicators rendered operational at the federal and state levels | | | | | | | | | | | | |
| Preparation of the Calendar of Milestones tool | █ | | | | | | | | | | | |
| Application of the Calendar of Milestones tool | | | █ | | █ | | █ | | █ | | | |
| Preparation of the M&E Scorecard tool | █ | | | | | | | | | | | |
| Application of the M&E Scorecard tool | | | | █ | | | █ | | | █ | | |
| Data flow from local government to national level | | █ | | █ | | █ | | █ | | █ | | |
| Quarterly reports (focused on milestones) | █ | █ | █ | █ | █ | █ | █ | █ | █ | █ | | |
| Bi-annual reports (focused on Scorecard) | | | █ | | █ | | █ | | █ | | | |
| MAF Completion Report | | | | | | | | | | | | █ |

Key Success Factors

Key success factors for the implementation of this priority action plan should be as follows:

- An Emergency Presidential Committee on the MDGs should be convened to deliberate on the budget and commitments, and to confirm the responsibilities of the various tiers and agencies of Government for the implementation of the MAF Action Plan.
- Through the auspices of the National Planning Commission and other relevant agencies of government, the IDPs should be requested to make their specific commitments to the implementation of MAF Action Plan.
- The OSSAP-MDGs should be required to work out a detailed MAF implementation plan that is sensitive to the status of MDGs in the various geopolitical zones and states. In this regard, special consideration should be given to the North East and North West geopolitical zones in order for Nigeria to achieve MDG 5. For this assignment, OSSAP-MDGs can seek technical assistance from the FMoH and IDPs.
- The OSSAP-MDGs, the State MoH, and relevant actors should embark on a strong mobilization campaign and consult with state governments and key development actors on the immediate adoption and implementation of this MAF.
- The OSSAP-MDGs should render the MAF monitoring and feedback mechanism operational by coordinating and facilitating establishment of the relevant indicators (together with the baseline and milestones) for periodically measuring and reporting on the results chain – inputs, outputs, outcomes and impacts. The monitoring and feedback mechanism should be able to answer the question: has MAF made any difference to the attainment of the MDG 5 targets by 2015?

Key success factors for accelerating all the MDG targets in Nigeria include:

- The governance and accountability environment should be continuously improved.
- Efforts should be intensified to ensure the availability and harmonization of adequate and reliable data, and in particular, the coordination of data generation on the MDGs by the National Population Commission and NPC (NBS).
- There should be enhanced up-to-date performance tracking of the MDGs investments in all MDAs and reporting of the impact to the Presidential Committee on MDGs on quarterly basis.
- The achievement of the MDGs should be a key element of the performance contract for ministers.
- The ongoing Centennial Celebration should focus primarily on achieving the MDGs.
- The State Governors and local government chairs should be recognized and honoured on the basis of their contributions to the achievement of the MDGs.
- The Federal Government should provide incentives to the best performing and most improving states towards achieving the MDGs based on objective criteria.

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APPENDIX 1 :
PARTICIPANTS AT THE TECHNICAL WORKSHOP, BY STATE AND CATEGORY

| States | Nurses and midwives (14) | Doctors (6) | HMIS (Medical records) (3) | CHEWs/VHWs (18) | TBAs (10) | Private sector (6) | NGOs(6) | Directors of Health (4)/ HODs of health/PHC Coordinators at LGA level(5) | |
|-------------|--------------------------|-------------|----------------------------|-----------------|-----------|---|---|--|---|
| Abia | 1 | | | | | | | 1 Head of Department (HOD) at Local Government Area (LGA) | 2 |
| Adamawa | | | | 1 | 1 | | | | 2 |
| Akwa-Ibom | 1 | | | | | | | 1 Department of Public Health (DPH) | 2 |
| Anambra | | | 1 | | | 1 Pharmaceutical Society of Nigeria (PSN) | | | 2 |
| Bauchi | | | | 1 | | | 1 Federation of Muslim Women's Associations in Nigeria (FOMWAN) | | 2 |
| Bayelsa | | | | 1 | 1 | | | | 2 |
| Benue | 1 | | | | | | | 1 HOD at LGA | 2 |
| Borno | | 1 | | 1 | | | | | 2 |
| Cross-River | | 1 | | | | | 1 TULSI CHANGALIER | | 2 |
| Delta | 1 | | | | 1 | | | 1 HOD at LGA | 2 |
| Ebonyi | | | | 1 | | | | | 2 |
| Edo | 1 | | | | | 1 NMA Nigeria Medical Association (NMA) | | | 2 |
| Ekiti | 1 | | | | | | | 1 HOD at LGA | 2 |
| Enugu | 1 | | | | | | | 1 DPH | 2 |
| Gombe | | | | 1 | 1 | | | | 2 |

| States | Nurses and midwives (14) | Doctors (6) | HMIS (Medical records) (3) | CHEWs/MHWs (18) | TBAs (10) | Private sector (6) | NGOs(6) | Directors of Health (4)/ HODs of health/PHC Coordinators at LGA level(5) | |
|----------|--------------------------|-------------|----------------------------|-----------------|-----------|--------------------|---|--|---|
| Imo | 1 | | | | | | 1 National Council Of Women's Societies Nigeria (NCWS) | | 2 |
| Jigawa | | | 1 | 1 | | | | | 2 |
| Kaduna | | 1 | | | 1 | | | | 2 |
| Kano | 1 | | | | | 1 NANM | | | 2 |
| Katsina | | 1 | | 1 | | | | | 2 |
| Kebbi | | | | 1 | | | | 1 Department of Public Health (DPH) | 2 |
| Kogi | 1 | | | | | | | 1 DPH | 2 |
| Kwara | 1 | | | | | | 1 Society for Family Health (SFH) | | 2 |
| Lagos | | | | | | PSN | | | 2 |
| Nasarawa | | | | 1 | | | | 1 State Primary Health care Development Agency (SPHCDB) | 2 |
| Niger | 1 | | | | | | | 1 SPHCDB | 2 |
| Ogun | 1 | | | | | | 1 Planned Parenthood Federation of Nigeria (PPFN) | | 2 |
| Ondo | 1 | | | | | | | 1 DPH | 2 |
| Osun | | | | 1 | | | 1 Association for Reproductive and Family Health (ARFH) | | 3 |

| States | Nurses and midwives (14) | Doctors (6) | HMIS (Medical records) (3) | CHEWs/VHWs (18) | TBAs (10) | Private sector (6) | NGOs (6) | Directors of Health (4)/ HODs of health/PHC Coordinators at LGA level(5) | |
|---------------------------------------|--------------------------|-------------|----------------------------|-----------------|-----------|--------------------|--|--|----|
| Oyo | | 1 | | | | | 1 Centre for Health Sciences Training, Research and Development (CHESTRAD) | 2 | |
| Plataeu | | | | 1 | | NANM | | 2 | |
| Rivers | 1 | | | | 1 | | | 2 | |
| Sokoto | | | | 1 | 1 | | | 2 | |
| Taraba | | | | 1 | 1 | | | 2 | |
| Yobe | | | | 1 | 1 | | | 2 | |
| Zamfara | | | | 1 | 1 | | | 2 | |
| Abuja Federal Capital Territory (FCT) | | | | 1 | | NMA | 1Health Reform Foundation of Nigeria (HERFON) | 3 | |
| Total | 15 | 6 | 2 | 17 | 10 | 6 | 8 | 11 | 76 |

APPENDIX 2: MDG 5 MAF ACTION PLAN (IN NAIRA)

| ACCELERATION SOLUTIONS | TARGETS | ACTIVITIES | INDICATORS | |
|---|--|--|---|--|
| FAMILY PLANNING | | | | |
| 1. Scaling up of sensitization of traditional leaders, religious leaders, CBOs and FBOs through appropriate media | Provide universal access to reproductive health by 2015 | 1) Preparation and launching of FP logo/ IEC/BCC materials | | |
| | Substantially reduce unmet needs for FP, adolescent birth rate, by 2017 | 1a) Review or development of the FP logo and IEC/BCC materials (including jingles and consultations) | a) No. of review meetings held b) No. of materials developed | |
| | | 1b) Printing and distribution of IEC/BCC materials | | |
| | | 1c) Airing of jingles | c) No. of jingles aired | |
| | 2. Commitment and awareness raising of traditional and religious leaders, CBOs/FBOs | | | |
| | | 2a) Stakeholder identification and mapping | | |
| | 2b) Sensitization/ awareness creation meetings and signing reproductive health (RH) compact with traditional and religious leaders, CBOs,/FBOs | | d) No. of people reached | |
| 2. Focus on the teaching of family life education in the curriculum of secondary schools | | Ministry of Education | | |

| TIMELINE AND ANNUAL COST | | | | | | | |
|--------------------------|---------------|------|------|------|------|------------------|--|
| | 2013 | 2014 | 2015 | 2016 | 2017 | TOTAL COST (NGN) | NOTES |
| FAMILY PLANNING | | | | | | | |
| | | | | | | | |
| | 25,000,000 | | | | | 25,000,000 | |
| | 1,500,000,000 | | | | | 1,500,000,000 | Nationwide |
| | 3,120,000 | | | | | 3,120,000 | Nationwide |
| | | | | | | | |
| | 3,500,000 | | | | | 3,500,000 | |
| | 98,400,000 | | | | | 98,400,000 | Six zone meetings and community dialogue meetings (five communities in each of 774 LGAs) |
| | | | | | | | |

| ACCELERATION SOLUTIONS | TARGETS | ACTIVITIES | INDICATORS |
|--|---|---|--|
| 3. Integration of Youth-Friendly Health Services (YFHS) into existing functional PHC, secondary health facilities (HFs) and tertiary hospitals | 1. Provide YHFS to young people | Integration of YFHS into PHC facilities (within the MSS clusters) and secondary HFs | No. of PHC and secondary HFs providing YFHS and no. of health care providers trained to provide YFHS |
| | | Training of health care providers to provide YFHS | No. of health care providers trained to provide YFHS |
| | Provision of basic equipment for the take-off of the youth-friendly facilities (television sets, tables, BCC materials, indoor sports facilities, internet facilities, etc. | No. of PHC and secondary HFs with basic equipment for the provision of YFHS | |
| | regular monitoring and provision of supportive supervision | No. of PHC and secondary HFs implementing YFHS | |
| | | Two-day finalization meeting for the minimum package of service and standards for YFHS | Finalization meeting conducted |
| | | | Printing and dissemination of minimum package of service and standards for YFHS in Nigeria |
| No. of HFs in the states that have integrated YFHS | | | |
| | | Printing and dissemination of National Guidelines for integrating YFHS to PHCs in Nigeria | No. of copies printed on national guidelines for integrating YFHS |
| | | | No. of HFs with guidelines for integrating YFHS |

| | TIMELINE AND ANNUAL COST | | | | | | |
|--|--------------------------|------------|------------|------------|------------|------------------|--|
| | 2013 | 2014 | 2015 | 2016 | 2017 | TOTAL COST (NGN) | NOTES |
| | 78,000,000 | 78,000,000 | 78,000,000 | 78,000,000 | 78,000,000 | 390,000,000 | Target for now is the MSS facilities (3125HF) |
| | | | | | | | |
| | 31,250,000 | 31,250,000 | 31,250,000 | 31,250,000 | 31,250,000 | 156,250,000 | 50,000/HF |
| | | | | | | | |
| | 21,850,000 | 21,850,000 | 21,850,000 | 21,850,000 | 21,850,000 | 109,250,000 | 20% of project cost – training and equipping facilities |
| | | | | | | | |
| | 3,500,000 | | | | | 3,500,000 | |
| | | | | | | | |
| | 51,125,000 | | | | | 51,125,000 | Total no. of primary and secondary HFs in Nigeria in 2011 was 34,090 |
| | | | | | | | |
| | | | | | | - | |
| | | | | | | | |
| | 36,000,000 | | | | | 36,000,000 | |
| | | | | | | | |
| | | | | | | - | |

| ACCELERATION SOLUTIONS | TARGETS | ACTIVITIES | INDICATORS |
|---|---------|--|--|
| | | Six zone-based ToTs on how to build capacity of health care providers in YFHS in 10/state | No. of ToTs conducted |
| | | | No. of providers with increased capacity on YFHS per state |
| | | Needs assessment and training of service provider on YFHS at state and LGA levels – its planning is to be led by the state and LGA | |
| 4. Intensification of training and retraining of health workers, including community-based resource persons | | 1. Meetings to develop/adapt FP manual for CHEWs | No. of review meetings held |
| | | 2. Printing of manual | No. of manuals printed |
| | | 3. Conduction of six zone-based ToTs on contraceptive technology update (4 per/state, 5 m per ToT) | No. of trainers trained |
| | | 4. Training on contraceptive technology for 6,250 CHEWs from MSS HF | No. of CHEWs trained |
| | | 5. One week's training for 240 clinical service providers on CLMS/ state | No. of clinical service providers trained on CLMS |
| 5. Awareness raising and mobilization of men to take leadership roles in health matters | | State-based activity | No. of IEC/BCC materials developed |
| | | Meetings to develop IEC/BCC materials | No. of dialogue meetings held |
| | | Dissemination of IEC/BCC materials | |
| Sub-total | | | |

| | TIMELINE AND ANNUAL COST | | | | | | |
|--|--------------------------|-------------|-------------|-------------|-------------|------------------|---|
| | 2013 | 2014 | 2015 | 2016 | 2017 | TOTAL COST (NGN) | NOTES |
| | 54,000,000 | - | | | | 54,000,000 | |
| | | | | | | - | |
| | 20,000,000 | 17,000,000 | | | | 37,000,000 | |
| | 7,000,000 | | | | | 7,000,000 | 2 meetings at N3.5m each |
| | 9,000,000 | | | | | 9,000,000 | |
| | 30,000,000 | | | | | 30,000,000 | |
| | 78,000,000 | 78,000,000 | 78,000,000 | 78,000,000 | 78,000,000 | 390,000,000 | |
| | 500,000,000 | 250,000,000 | 250,000,000 | 250,000,000 | | 1,250,000,000 | |
| | | | | | | | |
| | 7,000,000 | | | | | 7,000,000 | 2 meetings at 3.5 m/meeting |
| | 30,000,000 | 15,000,000 | 15,000,000 | 15,000,000 | | 75,000,000 | Target men in the community and WDC members (200 men per community) |
| | 2,636,745,000 | 491,100,000 | 474,100,000 | 474,100,000 | 209,100,000 | 4,285,145,000 | |

| ACCELERATION SOLUTIONS | TARGETS | ACTIVITIES | INDICATORS |
|--|--|--|--|
| SKILLED BIRTH ATTENDANTS | | | |
| 1. Recruitment of more SBAs | Target 2,500 PHC facilities by 2017 | Increase in PHC facilities by 1,000 and recruit 7,000 midwives and 4,200 CHEWS by 2017 | Recruitment of 7,000 midwives Recruitment of 4,200 CHEWS |
| 2. Training and re-training of SBAs | Train 4,200 CHEWS, 7,000 midwives and 375 doctors by 2017 | Scaling up of training on LSS and EmONC for SBAs (1) | No. of copies of the document printed |
| | | Printing and dissemination of finalized LSS manuals (MLSS, LSS and ELSS) | |
| | | (2) Capacity building of service providers on LSS nurses and midwives) in the six geopolitical zones in the country | No. of service providers trained on LSS per state |
| | | | Share of state training teams with full copies of the document |
| | | | Share of LSS centres with copies of reviewed LSS manual |
| | | | Capacity building of service providers on ELSS (doctors) in 6 geopolitical zones |
| | Capacity building of service providers on MLSS – CHEWs in six geopolitical zones | No. of service providers trained on MLSS per state | |
| 3. Mandatory posting of NYSC SBAs to rural areas | | Dialogue meetings with NYSC for the deployment of SBAs to rural areas | No. of dialogue meetings held |
| | | | Consensus built for the deployment of SBAs to rural areas |
| | | Orientation and awareness raising of NYSC SBA (doctors and BSc nurses and midwives) on EmONC in the six geopolitical zones | No. of sensitization meetings held in NYSC camps with NYSC SBAs |

| | TIMELINE AND ANNUAL COST | | | | | | |
|---------------------------------|--------------------------|---------------|---------------|-------------|------|------------------|--|
| | 2013 | 2014 | 2015 | 2016 | 2017 | TOTAL COST (NGN) | NOTES |
| SKILLED BIRTH ATTENDANTS | | | | | | | |
| | 1,144,000,000 | 1,144,000,000 | 1,144,000,000 | 572,000,000 | | 4,004,000,000 | |
| | 470,400,000 | 392,000,000 | 392,000,000 | 392,000,000 | | 1,646,400,000 | |
| | 4,507,125 | 4,507,125 | 4,507,125 | 4,507,125 | | 18,028,500 | |
| | 306,250,000 | 306,250,000 | 306,250,000 | 306,250,000 | | 1,225,000,000 | |
| | | | | | | | |
| | | | | | | | |
| | 2,460,281 | 2,460,281 | 2,460,281 | | | 9,841,124 | |
| | 114,151,800 | 114,151,800 | 114,151,800 | | | 456,607,200 | |
| | 300,000 | | | | | 300,000 | 100,000 per dialogue meeting at federal level x three meetings |
| | | | | | | - | |
| | 1,850,000 | | | | | 1,850,000 | 50,000 per meeting x 37 state camps |

| ACCELERATION SOLUTIONS | TARGETS | ACTIVITIES | INDICATORS |
|--|--|--|---|
| | | Mapping and listing of NYSC SBAs (doctors and BSC nurses and midwives) in the orientation camps for the six geopolitical zones | Comprehensive listing of NYSC SBAs |
| | | Capacity building on ELSS for NYSC SBAs (doctors) in six geopolitical zones | No. of NYSC doctors trained on ELSS per state |
| | | Capacity building on LSS for NYSC SBAs (nurses) in six geopolitical zones | No. of NYSC nurses trained on LSS per state |
| 4. Task shifting and sharing for SBA | | Dialogue meeting with stakeholders on task shifting and sharing | No. of meetings |
| | | Meetings to review the pre-service curriculum on EmONC for CHEWs | No. of meetings |
| 5. Additional incentives for rural posting for the MSS | Hire 10,000 midwives (four per 2,500 MSS facilities) | A rural posting allowance paid to 10,000 midwives in addition to their current salary (Currently, there are 10,000 midwives and there is an expected scale-up) | No. of midwives paid rural posting allowance |

| | TIMELINE AND ANNUAL COST | | | | | | TOTAL COST (NGN) | NOTES |
|--|--------------------------|---------------|---------------|---------------|---------------|--|------------------|---|
| | 2013 | 2014 | 2015 | 2016 | 2017 | | | |
| | 1,850,000 | | | | | | 1,850,000 | |
| | 370,000,000 | 740,000,000 | 740,000,000 | 740,000,000 | 740,000,000 | | 3,330,000,000 | Target: an average of 30 doctors per state. This entails two ToTs per state per batch. 2 x 37 x NGN5,000,000 |
| | 60,337,380 | 120,674,760 | 120,674,760 | 120,674,760 | 120,674,760 | | 543,036,420 | One batch for 2013 and two batches for the remaining years |
| | 14,000,000 | | | | | | 14,000,000 | Two meetings |
| | 7,000,000 | | | | | | 7,000,000 | Two meetings (a smaller meeting) There is already an ongoing process on task shifting and sharing in EmONC for CHEWs by Jpheigo |
| | 1,200,000,000 | 3,600,000,000 | 4,800,000,000 | 6,000,000,000 | 6,000,000,000 | | 21,600,000,000 | Rural posting allowance of NGN50,000 per midwife *2013 calculated as for July to Dec. |

| ACCELERATION SOLUTIONS | TARGETS | ACTIVITIES | INDICATORS |
|---|---|---|--|
| | Hire 5,000 CHEWs (two per 2,500 MSS facilities) | A rural posting allowance paid to 5,000 CHEWs in addition to their existing salary (5,000 is the current no. of CHEWs and it is expected to be scaled-up) | No. of CHEWs paid rural posting allowance |
| 6. Tertiary hospitals to adopt primary health centres (PHCs) in rural areas | | Orientation and sensitization meeting for Chief Medical Director (CMDs) of tertiary institutions on the adoption of PHCs | Orientation and sensitization meeting held with Chief Medical Director (CMDs) of tertiary institutions |
| | | | No. of PHCs adopted by tertiary hospitals |
| | | | No. of tertiary hospitals identified with current rural PHC posting programmes |
| 7. More refresher courses for SBA in EmONC skills | 10,000 midwives, 625 doctors | Training of doctors, nurses and midwives on five-day refresher competency-based training on EmONC in the six geopolitical zone 15 service providers /LGA using the Liverpool School of Tropical Medicine Protocol for the evaluation of epidemiological surveillance systems | a) No. of doctors, nurses and midwives trained per state b) No. of refresher courses held |
| Institution-alization of mentoring programme | | Dialogue meeting with professional bodies – Society of Obstetricians & Gynaecology of Nigeria, Paediatric Association of Nigeria (SOGON), Association of Public Health Physicians of Nigeria and experienced and retired midwives identified by SMOH to establish the mentoring programme | No. of dialogue meetings conducted |
| | | | No. of professional bodies participating in the mentoring programme |
| | | Mapping of PHCs and linkage with mentoring team | Comprehensive lists of PHCs linked to mentoring teams available |

| | TIMELINE AND ANNUAL COST | | | | | | |
|--|--------------------------|-------------|---------------|---------------|---------------|------------------|---|
| | 2013 | 2014 | 2015 | 2016 | 2017 | TOTAL COST (NGN) | NOTES |
| | 300,000,000 | 900,000,000 | 1,200,000,000 | 1,500,000,000 | 1,500,000,000 | 5,400,000,000 | Rural posting allowance NGN25,000 per CHEWs 2013 calculated as for July to Dec. |
| | 7,000,000 | | | | | 7,000,000 | One meeting |
| | | | | | | - | |
| | | | | | | - | |
| | 425,000,000 | 212,500,000 | 212,500,000 | 212,500,000 | | 1,062,500,000 | Based on projected no. of doctors, nurses and midwives required for each year |
| | 7,000,000 | | | | | 7,000,000 | One meeting |
| | | | | | | - | |
| | 3,500,000 | | | | | 3,500,000 | |

| ACCELERATION SOLUTIONS | TARGETS | ACTIVITIES | INDICATORS |
|--|--|---|---|
| 1. Regular support and supervision for SBAs | 10,000 midwives, 625 doctors | Supportive supervisory visits | No. of supervisory visits conducted |
| 2. Scaled-up supply of basic equipment and supplies for SBAs | | Provision of 2,500 midwifery kits and 250,000 Mama kits | |
| | | Needs assessment of essential MNCH medicines and supplies – oxytocin, mgso4 and misoprostol, anti-shock garments and blood loss estimating drapes, injectable antibiotics for the newborn and chlohexidine needed in the six geopolitical zones | Share of states that have conducted a needs assessment on the availability of essential medicines on the United Nations list of essential life-saving commodities |
| | | Procurement and distribution of MNCH medicines and supplies to the MSS facilities | Share of facilities with stocks of medicines on the UN list of essential life-saving commodities |
| 3. Provision of accommodation for rural postings | Assumption of responsibility by the LGAs | | |
| 4. Strengthening, reactivation and forming of WDCs | Scale up to 2,500 (currently 1,000 WDCs in line with MSS facilities) | Participatory learning and action approach for the formation of WDCs for the upcoming 1,500 MSS facilities | No. of WDCs formed |
| Sub-total | | | |

| | TIMELINE AND ANNUAL COST | | | | | | |
|--|--------------------------|---------------|----------------|----------------|----------------|------------------|--|
| | 2013 | 2014 | 2015 | 2016 | 2017 | TOTAL COST (NGN) | NOTES |
| | 137,697,416 | 137,697,416 | 137,697,416 | 137,697,416 | | 550,789,665 | |
| | 525,000,000 | | | | | 525,000,000 | Midwifery kit NGN10,000 & Mama kit- N2,000 |
| | 500,000,000 | 250,000,000 | 250,000,000 | 250,000,000 | | 1,250,000,000 | |
| | 750,000,000 | 1,125,000,000 | 1,500,000,000 | 1,875,000,000 | 1,875,000,000 | 7,125,000,000 | 750,000 per facility |
| | | | | | | | LGAs should take responsibility and build appropriate hostels, etc. |
| | | 177,400,000 | 177,400,000 | 177,400,000 | | 532,200,000 | |
| | 6,352,304,002 | 9,226,641,382 | 11,101,641,382 | 12,404,641,382 | 10,235,674,760 | 49,320,902,909 | |

| ACCELERATION SOLUTIONS | TARGETS | ACTIVITIES | INDICATORS |
|--|--|---|---|
| EMERGENCY OBSTETRIC AND NEWBORN CARE | | | |
| 1 CBNC | Train 5,000 CHEWs | 1. A rapid assessment of key neonatal interventions in communities in selected LGAs in the state | Share of communities that have carried out a rapid assessment for CBNC |
| | | 2. Six zone- based ToTs on CBNC | No. of ToTs conducted on CBNC |
| | | 3. Provision of state step-down training of CHEWs on CBNC | No. of CHEWs |
| | | 4. Procurement of toolkit for CBNC (bag, timer, weighing scale thermometer and pictorial counselling cards, etc.) | Share of CHEWs equipped with CBNC toolkits |
| | | 5. Follow-up/ supportive supervision of trained CHEWs | No. of follow-up visits conducted |
| 2. Establishment of baby- friendly HFs | 1. Increase the number of mothers who breastfeed within 30 minutes of delivery from 38% to 80% in 2015 | 1) Five-day review/ pre-test of BFI/WHO tool | 1. Share of HFs designated baby-friendly compliant in the past one year |
| | 2. Increase the number of mothers who exclusively breastfeed their infants from 13% to 22.3% by 2015 (annual rate of 3.1%) | 2) Five-day assessment of HFs and communities for BFI in the existing 1,000 MSS | 2. The number of designated BFHs trained with a focus on the ten steps in the past one year |
| | 3. Increase the number of hospitals/ operational HFs in Nigeria designated baby- friendly from 4.6% in 1991 to 10% by 2015 | 3) Five-day training on integrated infant and young child feeding (IYCF) of the designated BFH | |
| 4) Designation of HFs and communities as baby-friendly | | | |
| 5) Supportive supervision of BFHs | | 5. No. of supportive supervisions conducted at the BFHs in the past one year | |

| TIMELINE AND ANNUAL COST | | | | | | | |
|---|-------------|-------------|-------------|------------|------|------------------|-------|
| | 2013 | 2014 | 2015 | 2016 | 2017 | TOTAL COST (NGN) | NOTES |
| EMERGENCY OBSTETRIC AND NEWBORN CARE | | | | | | | |
| | 625,000,000 | | | | | 625,000,000 | |
| | 15,000,000 | 2,014 | | | | 15,002,014 | |
| | 124,500,000 | 63,000,000 | 63,000,000 | 63,000,000 | | 313,500,000 | |
| | 10,000,000 | 2,500,000 | 2,500,000 | 2,500,000 | | 17,500,000 | |
| | 150,000,000 | 300,000,000 | 375,000,000 | | | 825,000,000 | |
| | 7,000,000 | | | | | 7,000,000 | |
| | 15,000,000 | | | | | 15,000,000 | |
| | 62,500,000 | 31,250,000 | 31,250,000 | 31,250,000 | | 156,250,000 | |
| | 5,000,000 | | | | | 5,000,000 | |
| | 30,000,000 | 60,000,000 | 75,000,000 | | | 165,000,000 | |

| ACCELERATION SOLUTIONS | TARGETS | ACTIVITIES | INDICATORS |
|---|--|---|---|
| 4. Provision of adequate EmONC equipment and services | Provide more anti-shock garments and blood loss estimation drapes in all the PHC facilities | Procurement of 2,500 anti-shock garments and blood loss estimation drapes | No. of MSS PHCs with anti-shock garments and blood loss estimation drapes |
| | | Distribution of anti-shock garments and blood loss estimation drapes | |
| 5. Awareness creation and sensitization campaign on EmONC services and issues using appropriate media | All stake-holders should participate in awareness creation. Establish radio talk shows and community jingles | Safe Motherhood Day celebration at the national and state level on 22 May every year | Share of states having implemented Safe Motherhood (SMH) Day celebration |
| | | Commemoration of bi-annual MNCH week by state | Share of states having implemented the MNCH commemoration |
| | | Development of advocacy materials on RH issues | No. of meetings held. No. of advocacy material/kits printed |
| | Promote key household and community service package | Involvement of women's groups at community level on RH issues. To be implemented by the state and local governments | No. of women groups informed |
| | | ToT on key household practices (KHHP) | |
| | | Step-down training of the Community-based Poverty Reduction Project (CPRPS) on key household practices (KHHP) | |
| 6. Promotion of key household and community service packages | | Supervision of Community-based Poverty Reduction project (CPRPS) on community-based information system | |

| | TIMELINE AND ANNUAL COST | | | | | | |
|--|--------------------------|-------------|-------------|------------|------------|------------------|---|
| | 2013 | 2014 | 2015 | 2016 | 2017 | TOTAL COST (NGN) | NOTES |
| | 18,800,000 | 19,400,000 | 24,400,000 | 29,400,000 | | 92,000,000 | |
| | 1,880,000 | 1,940,000 | 2,440,000 | 2,940,000 | | 9,200,000 | |
| | 39,000,000 | 39,000,000 | 39,000,000 | 39,000,000 | 39,000,000 | 195,000,000 | |
| | 13,000,000 | 13,000,000 | 13,000,000 | 13,000,000 | 13,000,000 | 65,000,000 | Fully funded by NPHCDA |
| | 7,000,000 | | | | | 7,000,000 | |
| | 98,400,000 | | | | | 98,400,000 | Six zone-based meetings and community dialogue meetings (five communities for each 774 LGA) |
| | 15,000,000 | | | | | 15,000,000 | |
| | 124,500,000 | 63,000,000 | 63,000,000 | 63,000,000 | | 313,500,000 | |
| | 150,000,000 | 300,000,000 | 375,000,000 | | | 825,000,000 | |

| ACCELERATION SOLUTIONS | TARGETS | ACTIVITIES | INDICATORS |
|--|-------------------------------------|---|----------------------------------|
| 7. Promotion of GSM services (communication) between clients and SBAs on EmONC | Provide PHC facilities | Provision of toll-free phone lines kept at the facilities | No. of HFs with toll-free phones |
| 8. Reduction of delay at the HF by using SOPs for EmONC | | Meeting to review/ update SOPs for EmONC | |
| | | Printing of SOPs | |
| | | Distribution of SOPs | |
| 9. Establishment of emergency triage and treatment (ETAT) for EmONC at HFs. | Target 2,500 PHC facilities by 2017 | ToT on ETAT | |
| | | Step-down training | |
| Sub-total | | | |

UNIVERSAL COVERAGE OF ANTENATAL AND POST-NATAL CARE

| | | | |
|---|--|--|--|
| 1. Carrying out of an advocacy campaign to traditional, community and religious leaders | Ensure the assumption of responsibility by LGAs and CBOs | 1. Development of advocacy material for conducting community engagement for FANC and PNC including printing and distribution | Percentage of newborns and mothers visited within 48 hours of delivery by a skilled health care provider |
| | | | ANC coverage four visits |
| | | | Advocacy Kit developed on FANC and PNC |
| | | 2. Identification and mapping of key traditional, community and religious leader | Listing of key traditional, community and religious leader available per state/community |
| | | 3. Planning and carrying out community engagement of traditional, community and religious leaders on FANC and PNC | No. of meetings held with key traditional, community and religious leaders on FANC and PNC |

| | TIMELINE AND ANNUAL COST | | | | | | NOTES |
|--|--------------------------|-------------|---------------|-------------|------------|------------------|-------|
| | 2013 | 2014 | 2015 | 2016 | 2017 | TOTAL COST (NGN) | |
| | 6,000,000 | 3,000,000 | 3,000,000 | 3,000,000 | | 15,000,000 | |
| | 7,000,000 | | | | | 7,000,000 | |
| | 30,000,000 | | | | | 30,000,000 | |
| | 7,500,000 | | | | | 7,500,000 | |
| | 27,750,000 | | | | | 27,750,000 | |
| | 117,187,500 | | | | | 117,187,500 | |
| | 1,707,017,500 | 896,092,014 | 1,066,590,000 | 247,090,000 | 52,000,000 | 3,968,789,514 | |

UNIVERSAL COVERAGE OF ANTENATAL AND POST-NATAL CARE

| | | | | | | | |
|--|---------------|--|--|--|--|---------------|--|
| | 1,525,000,000 | | | | | 1,525,000,000 | |
| | | | | | | - | |
| | | | | | | - | |
| | 3,500,000 | | | | | 3,500,000 | |
| | 98,400,000 | | | | | 98,400,000 | |

| ACCELERATION SOLUTIONS | TARGETS | ACTIVITIES | INDICATORS |
|---|--|---|------------|
| 2. Assistance by CSOs to vulnerable groups to demand their rights | Train CSOs, FBOs, NGOs and comm.-unity | 1. Identification of interest groups/ CSOs and host community dialogue or focus group discussion | |
| 3. Provision of outreach units closer to the people | WDCs | Provision of outreach by the WDCs based facilities | |
| | | Scale-up and strengthen regular mobile health services | |
| 4. Reorientation of health workers and encouraging them to imbibe right attitudes and values | | Training on quality of care | |
| Sub-total | | | |
| IMPROVED REFERRAL SYSTEM | | | |
| 1. Decentralization of ambulances to rural areas | | Identification of HFs without functional ambulance services | |
| 2. Improvisation of functional ambulance services, e.g. tricycles, donkeys, speedboats, cows and camels | | Procurement of cost-effective need-specific alternatives to vehicular ambulance and distribute to referral clusters (1) Procurement of three speedboats (Bayelsa and Rivers) | |
| | | (2) Procurement of tricycles (Keke Napep) for MSS facilities | |

| | TIMELINE AND ANNUAL COST | | | | | | |
|--------------------------|--------------------------|---------------|---------------|---------------|-------------|------------------|-------|
| | 2013 | 2014 | 2015 | 2016 | 2017 | TOTAL COST (NGN) | NOTES |
| | 145,125,000 | 145,125,000 | 145,125,000 | 145,125,000 | | 580,500,000 | |
| | 25000000 | 37500000 | 50000000 | 62500000 | | 175,000,000 | |
| | 150,000,000 | 450,000,000 | 600,000,000 | 750,000,000 | | 1,950,000,000 | |
| | 394,095,500 | 394,095,500 | 394,095,500 | 394,095,500 | 394,095,500 | 1,970,477,500 | |
| | 2,341,120,500 | 1,026,720,500 | 1,189,220,500 | 1,351,720,500 | 394,095,500 | 6,302,877,500 | |
| IMPROVED REFERRAL SYSTEM | | | | | | | |
| | 7,000,000 | | | | | 7,000,000 | |
| | 4,800,000 | | | | | 4,800,000 | |
| | 350,000,000 | 175,000,000 | 175,000,000 | 175,000,000 | | 875,000,000 | |

| ACCELERATION SOLUTIONS | TARGETS | ACTIVITIES | INDICATORS |
|--|---|---|--|
| 3. Collaboration with National Union of Road Transport Workers (NURTW) members or any community volunteer to strengthen referral | | Collaboration with NURTW members or any community members to strengthen referral services | |
| 4. An effective two-way referral system | | Procurement and distribution of telephones to referral clusters in the state | |
| | | Printing and distribution of two-way referral forms | |
| Sub-total | | | |
| MDG coordination, monitoring and tracking of the MAF implementation | Facilitate implementation and reporting of the MAF implementation process | Coordination, monitoring and tracking of the MAF implementation by the FMOH and NPHCDA in line with international best practice | Bi-annual overall progress/status reports produced |
| Total | | | |

| | TIMELINE AND ANNUAL COST | | | | | | NOTES |
|--|--------------------------|----------------|----------------|----------------|----------------|------------------|---|
| | 2013 | 2014 | 2015 | 2016 | 2017 | TOTAL COST (NGN) | |
| | 10,500,000 | 15,750,000 | 21,000,000 | 26,250,000 | 26,250,000 | 99,750,000 | |
| | 1,500,000 | | | | | 1,500,000 | |
| | 3,000,000 | 1,500,000 | 1,500,000 | 1,500,000 | | 7,500,000 | |
| | 376,800,000 | 192,250,000 | 197,500,000 | 202,750,000 | 26,250,000 | 995,550,000 | |
| | 129,746,530 | 129,746,530 | 129,746,530 | 129,746,530 | 129,746,530 | 648,732,649 | 1% of total programme implementation cost |
| | 13,543,733,532 | 11,962,550,426 | 14,158,798,412 | 14,810,048,412 | 11,046,866,790 | 65,521,997,572 | |

APPENDIX 3 :
OPERATIONAL RESULTS-LEVEL M&E INDICATORS

| Level of results | Indicator | Baseline | Milestones | | | | | Means of verification |
|--|-----------|----------|------------|------|------|------|------|-----------------------|
| | | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | |
| Impact | | | | | | | | |
| Maternal mortality reduced | | | | | | | | Annual |
| Outcomes | | | | | | | | |
| FP services enhanced | | | | | | | | |
| SBA upscaled and improved | | | | | | | | |
| EmONC enhanced | | | | | | | | |
| Universal coverage of antenatal and post-natal care achieved | | | | | | | | |
| Referral system improved | | | | | | | | |
| Outputs (goods/ services produced) | | | | | | | | |
| FP | | | | | | | | |
| SBA | | | | | | | | |
| EmONC | | | | | | | | |
| Universal coverage of antenatal and post-natal care | | | | | | | | |
| Referral system | | | | | | | | |

