WHO COUNTRY COOPERATION STRATEGY

2014 - 2019

World Health Organization
REGIONAL OFFICE FOR Africa

NIGERIA

AFRO Library Cataloguing-in-Publication Data

WHO Country Cooperation Strategy 2014–2019 - Nigeria

1. Health planning
2. Health plan Implementation
3. Health Priorities
4. International cooperation
I. World Health Organization. Regional Office for Africa

ISBN: 978 92 9 023207 0 (NLM Classification: WA 540 HE8)

Designed in the WHO Country Office in Nigeria,
and Printed in Nigeria

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ACRONYMS

ADB	African Development Bank
AFP	Acute Flaccid Paralysis
ANC	Ante-Natal Care
APIN	AIDS Prevention Initiative in Nigeria
ARFH	Association for Reproductive and Family Health
ART	Anti-Retroviral Therapy
ATM	AIDS, Tuberculosis and Malaria
AU	African Union
BMGF	Bill & Melinda Gates Foundation
CCA	Common Country Assessment
CCS	Country Cooperation Strategy
CDC	Centers for Disease Control
CHAI	Clinton Health Aid Initiative
CHIP	Copenhagen HIV Programme
CND	Canadian Dollar
CSM	Cerebro-Spinal Meningitis
CSO	Civil Society Organizations
DALY	Disability Adjusted Life Year
DFATD	Department of Foreign Affairs Trade and Development (Canada)
DOTs	Directly-Observed Treatment short-course
DPG	Development Partners' Group
DPT	Diphteria Pertussis Tetanus
ECOWAS	Economic Community of West African States
EPI	Expanded Programme of Immunization
EWARN	Early Warning and Response Network
FAO	Food and Agriculture Organization
FCT	Federal Capital Territory
FHI	Family Health International
FMoH	Federal Ministry of Health
FRSC	Federal Road Safety Committee
FTC	Framework on Tobacco Control
GATS	Global Adult Tobacco Survey
GDP	Gross Domestic Product

GSM	Global System Management
HDCC	Health Data Consultative Committee
HHA	Harmonization for Health in Africa
HIV	Human Immuno Deficiency Virus
HMIS	Health Management Information System
HPCC	Health Partners Coordination Committee
HRH	Human Resources for Health
HSS	Health Systems Strengthening
ICC	Interagency Coordination Committee
ICCM	Integrated Community Case Management
IDSR	Integrated Disease Surveillance and Response
IHP	International Health Partnership
IHR	International Health Regulations
IHVN	Institute of Human Virology Nigeria
IMNCH	Integrated Maternal, Newborn and Child Health
IPV	Inactivated Polio Vaccine
IST	Intercountry Support Team
ITN	Insecticide Treaded Nets
JICA	Japanese International Cooperation Agency
KFW	German Development Bank
M&E	Monitoring and Evaluation
MDG	Millennium Development Goal
mhGAP	Mental Health GAP Action Programme
MMR	Maternal Mortality Ratio
MNCH	Maternal, Newborn and Child Health
MNS	Mental, Neurological and Substance-use disorders
MTR	Mid-Term Review
NARHS	National Reproductive Health Survey
NBS	National Bureau of Statistics
NCD	Noncommunicable Diseases
NCH	National Council on Health
NEEDS	National Economic Empowerment and Development Strategy
NEMA	National Emergency Management Agency
NGO	Non-Governmental Organization

NHA	National Health Assembly
NHMIS	National Health Information Management System
NIGEP	Nigeria Guinea Worm Eradication Programme
NORAD	Norwegian Agency for Development Cooperation
NPC	National Planning Commission
NPHCDA	National Primary Health Care Development Agency
NSHDP	National Strategic Health Development Plan
NSHIP	National Strategic Health Investment Plan
NTBLCP	National Tuberculosis and Leprosy Control Programme
NTD	Neglected Tropical Disease
ODA	Overseas Development Assistance
OOPE	Out Of Pocket Expenditure
OPV	Oral Polio Vaccine
ORS	Oral Rehyation Salt
OSSAP-MDGs	Office of the Senior Special Assistant to the President on MDGs
PA	Priority Area
PCAMMDGs	Presidential Committee on the Assessment and Monitoring of the MDGs
PCRP	Presidential Comprehensive Response Plan
PEI	Polio Eradication Initiative
PEPFAR	US President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PMTCT	Prevention of Mother-To-Child Transmission of HIV
RC	Regional Committee
RH	Reproductive Health
RHCS	Reproductive Health Commodity Security
RPM	Regional Programme Meeting
RTA	Road Traffic Accidents
SARA	Service Availability and Readiness Assessment
SCD	Sickle Cell Disease
SDH	Social Determinants of Health
SEEDS	State Economic Empowerment and Development Strategy
SFH	Society for Family Health
SMoH	State Ministry of Health
SO	Strategic Objective

SOML	Saving One Million Lives
SP	Sulfadoxine-Pyrimethamine
SSHDP	State Strategic Health Development Plan
TB	Tuberculosis
UHC	Universal Health Coverage
UN	United Nations
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNFPA	United Nations Population Fund
UNH4+	UNFPA, WHO, UNICEF, World Bank, & UNAIDS Health Project on MNCH
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
YLL	Years of Life Lost
WCO	WHO Country Office
WFP	World Food Programme
WHA	World Health Assembly
WHO	World Health Organization
WPV	Wild PolioVirus
WR	WHO Country Representative

PREFACE

The WHO Third Generation Country Cooperation Strategy (CCS) crystallizes the major reform agenda adopted by the World Health Assembly with a view to strengthen WHO capacity and make its deliverables more responsive to country needs. It reflects the WHO Twelfth General Programme of Work at country level, it aims at achieving greater relevance of WHO's technical cooperation with Member States and focuses on identification of priorities and efficiency measures in the implementation of the WHO Programme Budget. It takes into consideration the role of different partners including non-state actors in providing support to Governments and communities.

The Third Generation CCS draws on lessons from the implementation of the first and second generation CCS, the country's strategy focus (policies, plans strategies and priorities), and the United Nations Development Assistance Framework. The CCSs are also in line with the global health context and the move towards Universal Health Coverage, integrating the principles of alignment, harmonization, effectiveness, as formulated in the Rome (2003), Paris (2005), Accra (2008), and Busan (2011) declarations on Aid Effectiveness. Also taken into account are the principles underlying the "Harmonization for Health in Africa" (HHA) and "International Health Partnership Plus" (IHP+) initiatives, reflecting the policy of decentralization and enhancing the decision-making capacity of Governments to improve the quality of public health programmes and interventions.

The document has been developed in a consultative manner with key health stakeholders in the country and highlights the expectations of the work of WHO secretariat. In line with the renewed country focus strategy, the CCS is to be used to communicate WHO's involvement in the country; formulate the WHO country work plan; advocate, mobilise resources and coordinate with partners; and shape the health dimension of the UNDAF and other health partnership platforms in the country.

I commend the efficient and effective leadership role played by the Government in the conduct of this important exercise of developing WHO's CCS. I also request the entire WHO staff, particularly WHO Country Representative to double their efforts to ensure effective implementation of the programmatic orientations of this document for improved health outcomes that contribute to health and development in Africa.

Dr Matshidiso Moeti
WHO Regional Director for Africa

EXECUTIVE SUMMARY

For Nigeria, various health indicators have shown steady, albeit slow, improvement. In 2013, Nigeria was certified free of indigenous transmission of Guinea Worm. Transmission of wild poliovirus was interrupted in the southern states and only two cases of the disease were reported nationwide in the first four months of 2014. Polio immunization coverage improved even in security-compromised areas. But success is tempered by challenges from communicable diseases. The use of insecticide-treated bed nets increased from 8% in 2008 to 50% in 2013, but malaria is still responsible for 30% of childhood mortality. AIDS, lower respiratory tract infections and diarrhoeal diseases are among the leading factors in years of life lost. Malnutrition is very common and the stunting level has stagnated at 40%. The increasing burden of noncommunicable diseases – including hypertension, diabetes and neurological disorders and road traffic injuries present a novel challenge for the health system. Alcohol consumption and tobacco use are exceptionally high.

Progress towards achieving the Millennium Development Goals (MDGs) in Nigeria is mixed. Poverty is still pervasive in the country with recent figures indicating that 68% of the population lives on less than US$ 1.25 a day. The goals on child and maternal mortality (MDGs 4 and 5) will also require augmented efforts. The most recent figures for maternal and under-five mortality are 350 per 100 000 live births and 94 per 1000 live births, respectively. The Government of Nigeria took a major step to accelerate reduction in maternal mortality with the creation of the Midwives Service Scheme to increase the proportion of births with skilled attendants. Nigeria is on track to achieve in whole or in part three out of the eight MDGs by 2015, namely, the goals on basic education, HIV prevalence reduction and global partnership for development.

Great disparities in health status exist in Nigeria across states and geopolitical zones. Disease etiology is linked to social determinants of health such as socioeconomic status, education, gender, access to water and sanitation, and hygiene levels.

The second WHO Country Cooperation Strategy (CCS II) expired in 2013 and a new one was developed to cover the next six years starting in 2014. Its last five years will be synchronized with the planning cycle of the next National Strategic Health Development Plan (NSHDP) and the State Strategic Health Development Plans (SSHDPs). In preparing CCS III, external and internal reviews of CCS II were conducted between October 2013 and January 2014 and validated through a stakeholder consultation workshop.

CCS III, covering 2014–2019, will focus on the specific elements where WHO contribution is judged to be most beneficial in view of its comparative advantage and core functions. The five strategic objectives of CCS III and their main focus areas are:

- **Strengthen health systems based on the primary health care (PHC) approach**:

– Leadership, governance and stewardship;
– Evidence-based policy formulation and strategic planning in the health sector;
– People-centred integrated services based on PHC and universal health coverage (UHC) principles;
– Access to medicines and health technology and strengthening of regulatory capacity; and
– Health systems information and evidence.

- **Promote health and scale up priority interventions through the life-course**:

– Contribute to the reduction of maternal, neonatal and child morbidity and mortality rates;
– Build capacity for the implementation of the health-in-all policies approach, intersectoral action and social participation to address the social determinants of health;
– Support mainstreaming of the social determinants of health and health promotion in all programmes;
– Support promotion of healthy lifestyles and healthy living;
– Support intersectoral collaboration in addressing the social determinants of health;
– Support the promotion of equity and gender mainstreaming in health programmes; and
– Strengthen the capacity of the government to assess health risks and to develop and implement policies, strategies and regulations for prevention, mitigation and management of health impacts of environmental risks.

- **Scale up evidence-based priority interventions for communicable and noncommunicable diseases towards universal health coverage**:

– Support the government in prevention and control of HIV/AIDS, tuberculosis and malaria in line with international guidelines;
– Support strengthening of the national capacity for the control, elimination and eradication of neglected tropical diseases (NTDs);
– Support the updating and implementation of the strategic plan for noncommunicable diseases (NCDs) including mental health in line with the global NCD strategy; and

– Support routine immunization for preventable childhood diseases.

- **Scale up national capacity for preparedness for and response to public health emergencies including polio eradication and crisis management**:

– Support strengthening of capacity for integrated disease surveillance and response at all levels of the government for effective disease surveillance and response to emergencies, including disaster management; and
– Support eradication of polio and response to epidemic-prone diseases.

- **Promote partnership coordination and resource mobilization in alignment with national, regional and global priorities**:

– Partnership coordination based on the principles of harmonization and aid effectiveness in the health sector;
– Resource mobilization and assistance with monitoring of the impact of health resources on developmental goals;
– National capacity to translate, adopt and implement regional and global resolutions on priority health issues such as the resolutions of the World Health Assembly (WHA), regional planning meetings, United Nations, African Union, Economic Community of West African States (ECOWAS) and others related to health;
– Advocacy for Nigeria's involvement in regional and global health diplomacy and policy-making; and
– Capacity building for the WHO country office staff to promote and facilitate the work of WHO in Nigeria.

CCS III priorities can be mapped onto the priority areas of NSHDP, the outcomes in the United Nations Development Assistance Framework **(UNDAF II) and the WHO Twelfth General Programme of Work.**

The WHO Nigeria country office will disseminate the CCS III document to the Federal Ministry of Health and partners and use it for advocacy, resource allocation and operational planning. A close working relationship between the country office and relevant technical units at the WHO Regional Office for Africa and WHO headquarters will add value to the work of WHO in Nigeria.

The division of the WHO country office activities into clusters will aid the implementation of the CCS. In addition, the country office has staff in the Federal Capital Territory and all the 36 states of the federation mainly responsible for polio eradication. CCS III will be monitored and reviewed periodically to accommodate changes and emerging national, regional and global health priorities and approaches. In particular mid-term and final reviews will establish and share lessons learned.

SECTION 1: INTRODUCTION

1.1 Country context

Nigeria finds itself at a critical juncture in regard to its citizen's health as we stand on the brink of the Millennium Development Goals (MDG) target year 2015, but with a number of promising developments. Thanks to the commitment, focus and hard work of all partners such as the World Health Organization (WHO), between 2007 and 2012[1,2] some hard-won but fragile gains were made in health indices such as the under-five and neonatal mortality rates, maternal mortality ratio and HIV prevalence. On the other hand, progress has not been on track for several MDG health goals.

The Nigerian government should be commended for these achievements, but great care should be taken to ensure that the gains are maintained, consolidated and improved upon through well-aligned strategies, tactical clarity and integrated approaches. This is the basis for WHO's assumption of the responsibility to develop the third WHO Country Cooperation Strategy for Nigeria (CCS III). This strategy is designed to support Nigerian efforts to preserve and amplify the health gains over the next six years.

CCS III serves several purposes:

- It is a medium-term vision for Nigeria's technical cooperation with other Member States in support of its national health policy, strategy and plan;
- It is WHO's key instrument to guide efficient and effective planning, budgeting and resource allocation for WHO work in and with the country; and
- It is the main instrument for harmonizing WHO cooperation with the country and other United Nations (UN) agencies and development partners.

1.2 Policy framework and development plan for the cooperation strategy

WHO institutionalized the country cooperation strategy approach in 2000 to:

- Articulate the WHO strategic agenda in each country as the umbrella within which all WHO work in a country takes place;
- Foster strategic thinking and internal coherence across the organization; and
- Use the cooperation strategy process to put into practice new ways of working that strengthen WHO corporate performance at the country level.

WHO developed the first (2002–2007) and second (2008–2013) cooperation strategies for Nigeria to guide its work through December 2013. The third cooperation strategy will cover 2014–2019.

1.3 Values and principles underpinning CCS III

CCS III is founded on the core values of WHO, where health is seen as "a state of complete physical, mental and social well-being". The WHO Constitution identifies the "enjoyment of the highest attainable standard of health" as "one of the fundamental rights of every human being without distinction".

CCS III is based on the following principles[3]:

- WHO sees a close connection between health and the core values of justice and security. A crucial part of justice in human relations is promoting equitable access to health-enabling conditions, which is one of the reasons behind WHO's drive for universal health coverage (UHC).
- The threat of old and new infections demands new forms of cooperation between security and public health, a situation clearly evident in Nigeria.
- Population health crucially contributes to economic and social development, as reflected by the importance accorded to health issues in the MDGs. The health MDG goals are thus central to the WHO agenda. Health is both a goal in itself and a key ingredient in the achievement other goals.
- Collaboration across political and sectoral boundaries is considered vital.

1.4 Methodology for developing CCS III

Development of CCS III began in November 2013 and comprised external and internal reviews and key retreats and stakeholder meetings conducted by the CCS team between October 2013 and January 2014. A detailed account of the review process can be found in Annex-2. The findings are reported in Section 4.

CCS III development was led by the WHO Country Representative, with extensive consultation and strategic dialogue with the Nigerian Federal Ministry of Health and other stakeholders, including UN agencies, bilateral cooperators and NGOs. The process consisted of four main elements:

- Use of an inclusive questionnaire with WHO staff and a cross-section of stakeholders and partners to assess the progress made against the second CCS agenda and to determine the relevance of that strategy's objectives given the dynamic national, regional and global contexts.
- Aligning actions for CCS III with those outlined in the key strategic documents:

  – The UN Country Common Assessment and the United Nations Development Assistance Framework 2014–2017 **(**UNDAF III) for Nigeria;
  – The NSHDP (National Strategic Health Development Plan) medium-term review results and recommendations;
  – The WHO biennial plan 2014–2015 and beyond;
  – The MDG progress report for Nigeria 2013;
  – The Nigeria plan for accelerating progress of the health MDGs;
  – The Save One Million Lives Initiative's documents and other relevant developments.
- Ensuring the alignment and consistency of CCS III with UNDAF III for Nigeria.
- Developing the CCS III document as an operational priority to be launched and disseminated locally in 2014

.

CCS III consistently aligns with UNDAF III for Nigeria, which responds to strategic national priorities as highlighted in the simplified 2012 UN Common Country Assessment (CCA). That assessment highlighted the key challenges and critical issues for sustainable development in governance, service quality, equitable social service delivery, accountability and human security (see Section 3).

SECTION 2: HEALTH AND DEVELOPMENT

2.1 Macroeconomic, political and social context

A selection of key statistics for Nigeria is provided on Annex-1.

Demographic profile

Nigeria, the most populous country in Africa, had an estimated population of about 169 million[4] in 2012, 41.8% of whom were younger than 15 years and 3.2% older than 65 years. There are more than 250 different ethnic groups speaking over 500 different languages and dialects. English is Nigeria's official language, with Hausa, Igbo and Yoruba as the three dominant indigenous languages. The north is predominantly Muslim, the south Christian.

The country is experiencing rapid urbanization with slum development due to high – and predominantly youth – rural-to-urban migration, especially in Lagos, Kano and Ibadan.

Politics and governance

The Federal Republic of Nigeria comprises 36 states and the Federal Capital Territory with Abuja as the capital. The states are divided into 774 local governments and 9565 wards. The six geopolitical zones are North-West, North-Central, North-East, South-West, South-East and South-South.

Since 1999 Nigeria has enjoyed an uninterrupted presidential democracy and has held three successful elections at both the federal and state levels of government. However, the country has known a turbulent history to which extreme discrepancies in wealth and development across the geopolitical zones and cultural and religious differences have contributed. Since 2009 the Boko Haram group has led an insurgency that has seen thousands killed, in particular in the North-East. In 2011 a bomb blast on the UN building in Abuja killed 26 people, including WHO staff. Schools are frequently targeted and health workers have been among the victims. A state of emergency is in force in Borno, Yobe and Adamawa states in the North-East. An upsurge in violent attacks has been seen in 2014 with abductions, shooting sprays and bomb blasts, including several devastating incidents in the capital Abuja. Security will remain an important issue in the coming years[5].

The National Planning Commission of Nigeria has the core responsibility of formulating the medium and long-term economic and development plans for the nation. Nigeria's Vision 20:2020 is intended to make the country one of the top 20 economies by 2020. The vision has three pillars:

- Guaranteeing the well-being and productivity of the people
- Optimizing the key sources of economic growth
- Fostering sustainable social and economic development.

Strategic planning efforts led by the Federal Government include the National Economic Empowerment and Development Strategy (NEEDS I and II), Nigeria's Strategy for Attaining the Millennium Development Goals and the "Seven Point Agenda".

NEEDS is Nigeria's poverty reduction strategy that derives from the country's long-term goals of poverty reduction, wealth creation, employment generation and value re-orientation. It is a nationally coordinated framework of action involving close collaboration with state and local

governments. State Economic Empowerment and Development Strategies (SEEDS) have been developed to complement NEEDS.
The Seven Point Agenda was launched by the late President Umaru Musa Yar'Adua. Its fifth point deals with education and human capital development, including health objectives such as strengthening the National Primary Health Care Development Agency (NPHCDA) and re-emphasizing primary health care.

As a signatory to the Millennium Declaration, Nigeria continues to respond in various ways to the global push towards achievement of MDGs. Actions have included incorporating MDG targets in development plans starting with NEEDS in 2004 and subsequently in the various state-level economic empowerment and development strategies. MDG targets and programmes have been mainstreamed into successive development plans, strategies and sector-specific policies, including the Seven Point Agenda in 2007, the Economic Transformation Agenda, and the Nigeria Vision 20:2020's First Implementation Plan, 2010–2013. Some states have made significant progress with MDG-based planning with the support of the Federal Government and international development partners.

2.2 Socioeconomic factors

Nigeria's economy is currently the largest in Africa, with crude oil revenues dominating the fiscal profile and public finance. However, agriculture remains the dominant economic sector, accounting for about 40% of GDP, more than 60% of total employment and the most recent economic growth in the country.

Over the past three decades or so, economic development has led to rapid urbanization accompanied by unemployment, which reached 23.9% in January 2012[4]. Youth unemployment, at 37.7%, is one of the highest in sub-Saharan Africa[4]. Lifestyle and behaviour changes associated with industrialization, globalization and unemployment are factors in the new health risks.

Income distribution and poverty

There is a stark contrast in economic success and wealth accumulation between the rich few and the large majority who bear the huge burden of poverty. Absolute poverty affects 62.6% (100 million people) and relative poverty 69% of the population. The gap between the poorest and the richest is widening. Furthermore, there are large poverty disparities across geopolitical zones, states and rural versus urban areas, which reflects the heterogeneous economic and social circumstances at the subnational level[4].

Education

Net primary school enrolment increased slowly from 68% in 1990 to 88.8% in 2008, and the primary school completion rate grew from 58% in 1990 to 87.7% in 2012. The literacy rate for youths aged 15–24 has risen progressively, going from 60.1% in 2000 to 80% in 2008[4]. However, girls, especially in the rural areas, are still the most disadvantaged with literacy rates of 56.6% compared with 87% for urban areas. Literacy rates among women in the North-East and North-West ranged between 7.2% and 55.7% compared with 90.1% to 96.4%[1,2] in the South-East, South-West and South-South zones, punctuating the great difference between the north and the south.

Gender

The ratios of girls to boys in primary, secondary and tertiary education institutions have increased in recent years due to specific efforts in the education sector. However, the share of women in wage employment remains stagnant, standing at 7.7% in 2012[4]. In addition, Nigeria is far from achieving gender parity in political representation in parliament, ranking 118 out of 192 countries[6]. Marriage before the age of 15 is common and domestic violence is rampant[6]. These are just a few of the reasons that many Nigerian women do not come even close to achieving their potential to participate fully in the society.

Nutrition and food safety

Combating malnutrition still remains a challenge especially among children. There was little change in the overall prevalence of underweight children between 2003 and 2011, but there was a noticeable increase in the prevalence of severely underweight children in the north, an indication of the presence of acute starvation. The prevalence of moderate to severe underweight children stands at 24.2%, for stunting at 35.8% and for wasting at 10.2%. Some 10.2% of the mothers practice exclusive breast feeding for less than 6 months while 79.3% breast feed for at least 1 year. Mothers in the poorest quintile, at only 10.3%, are less likely to exclusively breast feed than mothers in the richest quintile, at 21.6%.[13]

Water and sanitation

Despite some level of progress in urban areas, availability of safe drinking water and basic sanitation is not consistent with the level of economic development. According to the multiple indicator cluster survey of 2011, 58.5% of the population have access to improved drinking water sources, 4.1% to treated water, 31% to improved sanitation, 52.3% to safe disposal of children's waste, 48% to hand-washing facilities and 61.5% to soap. Nigeria is far behind in progress to achieve the water and sanitation MDG targets by 2015.

Road safety

Data from the Federal Road Safety Commission show that road traffic accidents account for over 26 000 injuries and 7000 deaths annually. Despite the noticeable reduction in traffic accidents following a campaign by the commission, in 2011 road traffic injuries per day were estimated at 49. Traffic injuries contribute an economic cost of 3 billion naira annually, or 3% of the GNP[7].

Emergencies and disasters

The country is prone to disasters including droughts in the north and floods in other areas. A two–year (2014–2016) National Emergency Response Plan was developed by the National Emergency Management Agency in collaboration with nine humanitarian sectors and key partners. The plan targets 8.3 million out of the 9.5 million people requiring humanitarian assistance in 2014.

Alcohol consumption and tobacco use are high in Nigeria. The prevalence of tobacco use ranges from 2.6% to 6.2% among the youth[8], while for adults the levels are 9% for males and 0.2% for females[9]. The alcohol use level was 32.03 litres per user per year, which is above the regional average. The overall share of deaths attributable to alcohol was 3.5%, while the alcohol-attributable burden of disease (2013) was 2.8%[10]. Nevertheless, there are many Nigerians who abstain from alcohol.

2.3 Health status of the population

Burden of disease

The Global Burden of Disease Study of 2010[11] determined for Nigeria a list of the top 25 causes of years of life lost (YLL), a statistic that quantifies premature mortality by weighting younger deaths more than older deaths (Table 1).

Table 1: Top 25 causes of years of life lost in Nigeria in 1990 and 2010.

Rank	1990	% of total YLL	Rank	2010	% of total YLL
1	Malaria	15.7	1	Malaria	23.2
2	Diarrhoeal diseases	13.8	2	HIV/AIDS	8.3
3	Lower respiratory infections	10.8	3	Lower respiratory infections	7.8
4	Measles	6.9	4	Neonatal sepsis	6.4
5	Protein-energy malnutrition	6	5	Diarrhoeal diseases	5.7
6	Neonatal sepsis	5.5	6	Road injury	4.3
7	Meningitis	3.7	7	Preterm birth complications	4.3
8	Preterm birth complications	3.7	8	Protein-energy malnutrition	4.2
9	Neonatal encephalopathy	3.7	9	Meningitis	3.6
10	Tuberculosis	2.2	10	Neonatal encephalopathy	3.1
11	Road injury	2.1	11	Fire	1.9
12	Fire	1.7	12	Tuberculosis	1.8
13	Stroke	1.2	13	Maternal disorders	1.3
14	Congenital anomalies	1.1		Congenital anomalies	1.2
15	Tetanus	1.3	15	Stroke	1.2
16	Falls	1.1	16	Falls	1
17	Maternal disorders	0.9	17	Interpersonal violence	0.9
18	Iron-deficiency anaemia	0.9	18	Syphilis	0.9
19	Syphilis	0.9	19	Epilepsy	1.1
20	Ischemic heart disease	0.8	20	Ischemic heart disease	0.8
21	Epilepsy	0.9	21	Cirrhosis	0.8
22	Interpersonal violence	0.7	22	Measles	0.7
23	Cirrhosis	0.5	23	Diabetes	0.5
24	COPD	0.5	24	Iron-deficiency anaemia	0.5
25	Asthma	0.4	25	Drowning	0.4

Source: Global burden of diseases, injuries, and risk factors study 2010 Profile Nigeria. Institute for Health Metrics and Evaluation 2301 Fifth Ave., Seattle, USA (www.healthmetricsandevaluation.org).

Key: Communicable, maternal, neonatal and nutritional causes of death
Noncommunicable diseases
Injuries

Malaria ranked first in both years, with 23.2% of YLL, and was responsible for even more YLL in 2010 than in 1990. YLL from diarrhoeal diseases fell from 13.8% in 1990 to 5.7% in 2010, and measles, which ranked fourth in 1990, dropped to the twenty-second position in 2010. New diseases in the top 10 in 2010 were HIV/AIDS and road injuries. The three risk factors that accounted for most of the disease burden in Nigeria were being underweight in childhood, household air pollution from solid fuels and alcohol use.

Child health

The infant and under-five mortality ratios declined consistently by about 4.5% annually over the last decade (Fig. 1)[16] , dropping from 75 and 153 per 1000 live births, respectively, in 2008 to 65 and 128 per 1000 live births, respectively, in 2013 according to Nigeria Demographic and Health Surveys of 2008 and 2013 These rates continue to decline, but challenges in meeting MDG 4 targets will remain unless the pace of mortality reduction is accelerated.
The main data sources used (Fig 1) were the Nigeria Demographic Health Surveys (DHS) 2003,

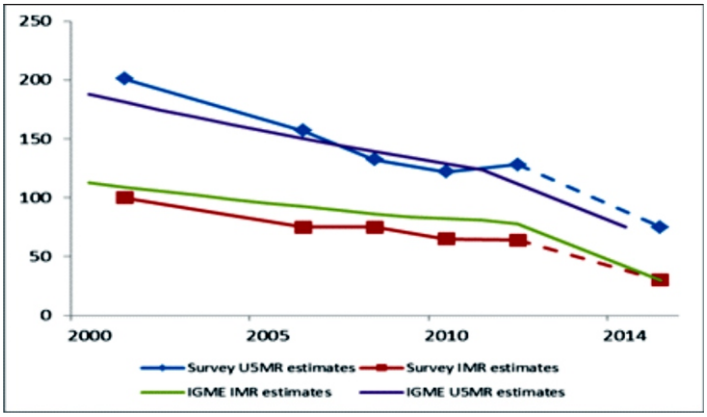

Figure 1: Under-five and infant mortality per 1,000 live births, survey data

2008, and 2013, the National Aids and Reproductive Health Survey (NARHS) 2012 and mortality estimates from the Inter-agency Working Group for Child Mortality Estimation (IGME) cited in the Combined 2012 Health Sector Performance Report and 2013 Mid-Term Review[16].

The improvement in child health indicators is overshadowed by the conspicuous inequities. Fig. 2 shows under-five equity gaps among zones, between urban and rural areas, and among wealth quintiles.

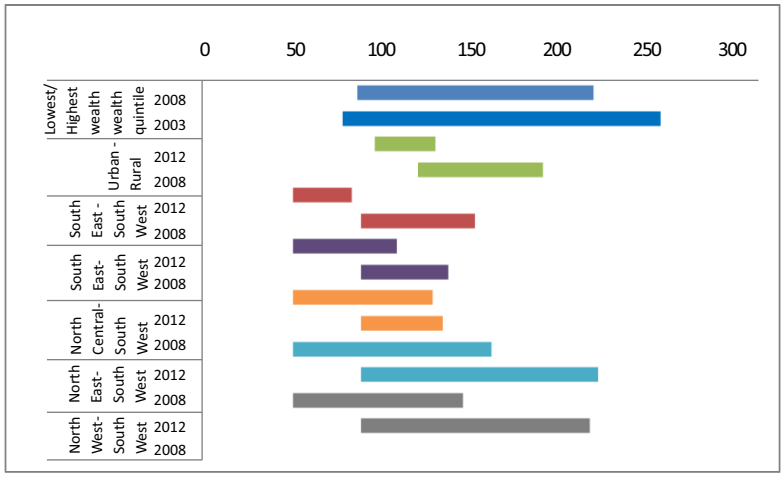

Figure 2 : Under-f ive mortality rate equity gap by zone, urban or rural area and wealth quintile

The surveys used for zonal and urban-rural comparison (Fig 2)[16] are the Nigeria Demographic Health Surveys (DHS) 2003, 2008, and 2013, the National Aids and Reproductive Health Survey (NARHS) 2012. The longer the bar, the greater the mortality gap between the zone of interest

compared to the Southwest Zone. The Northwest and Northeast zones have the largest mortality gap when compared with the Southwest zone. However, there has been some improvement in equity in mortality across all the zones. This can be seen by the bars for 2012 are all a little narrower than the bars for 2008.

Similar trends were observed in infant mortality. Neonatal deaths, pneumonia, diarrhoeal diseases and malaria are the major causes of under-five deaths (Fig. 3)[16]

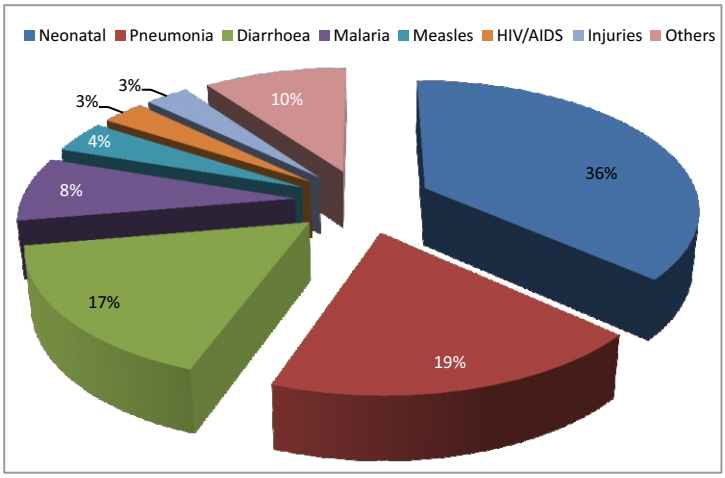

Figure 3: Major causes of under-five deaths in Nigeria

Maternal health

Maternal mortality ratio (MMR) data for Nigeria present a major challenge as they differ vastly depending on the source[11]. The National Demographic and Health Survey 2008 shows a baseline MMR of 545 per 100 000 live births, which was thought to be consistent with other surveys around that period. The MDG Performance Tracking Survey of 2013 reports the ratio as 350, while the report from National Reproductive Health Survey of 2013 shows 224 (Fig. 4).

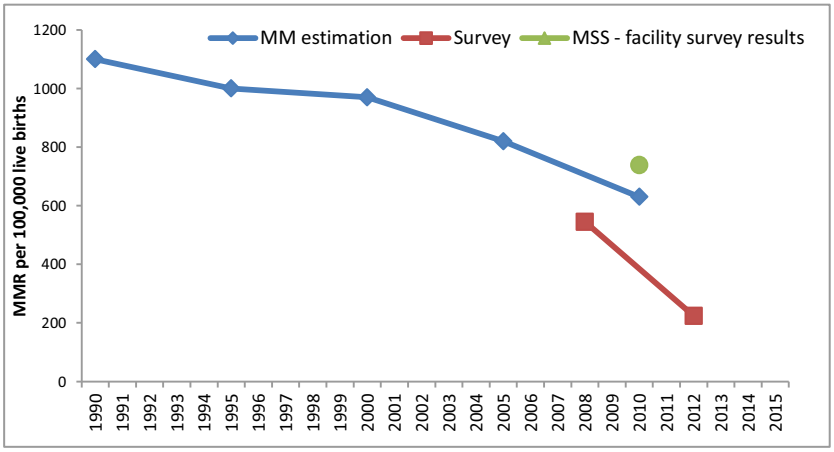

Figure 4 : Maternal Mortality Ratio trends from surveys and estimates by the Maternal Mortality Estimation Inter-Agency Group; MM=Maternal Mortality, MSS = Midwives Service Scheme (2010)

There seems to have been good progress in the reduction of MMR. If the data hold and the current annual rate of decrease is maintained, Nigeria should reach its target of 136 deaths per 100 000 live births. However, just as in child health and so many other areas, geographical inequities are evident, with northern zones having higher MMR than southern zones. The South-East Zone's MMR of 313 was the lowest. Taking the South-East Zone as a reference (Fig. 5), the zone with the largest gap was North-Central with an MMR of 1463 per 100 000 live births.

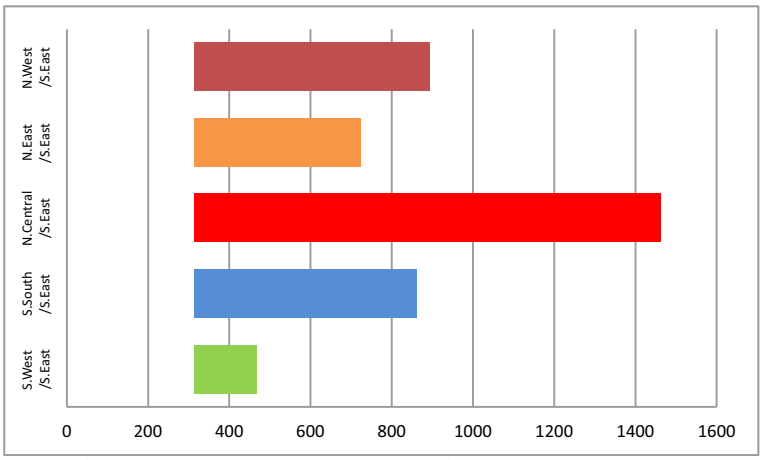

Figure 5 : Maternal Mortality Ratiozonal equity gap, 2010

Source: Midwives Service Scheme baseline survey report.[12]

Levels of unmet needs for family planning services rose slowly from 17% in 2004 to reach 21.5% in 2012. There has been progress in the proportion of women attended by skilled birth attendants during delivery, which rose from 36% in 2004 to 54% in 2012. The overall contraceptive use prevalence among all women is 17.5%. It will take determined efforts to reach the contraceptive use goal of 30% set in the NSHDP.[12,22]

The portion of pregnant women who had at least one antenatal visit with a skilled health worker increased from 61% in 2004 to 67.7% in 2012 and at least four visits from 47% in 2004 to 57.6% in 2012.

Communicable diseases

Despite progress in the control of communicable diseases, they remain the major cause of death throughout the course of the life−cycle, especially in childhood. The control of communicable diseases through various national programmes remains a priority, and accelerating progress in this goal can significantly improve the health status of populations in Nigeria. The country is on course to eliminate the transmission of malaria, wild poliovirus, measles and some neglected tropical diseases. For example Nigeria has recently been certificated as Guinea Worm free.

Childhood immunization against communicable diseases

Even though about 40% of under-five deaths still are due to vaccine-preventable diseases, children are getting better protected. Overall, more children are being immunized at the right age, a broader range of antigens has been introduced, and the incidence of cases of vaccine-preventable diseases has been reduced. DPT3 coverage increased from 52% in 2008 to 83% in 2013[13].

Nationally, the proportion of fully immunized children aged 12–23 months is 23%, ranging from 4.7% in the North-West Zone to 40.7%[4] in the South-West Zone. Coverage in rural areas was 13.4% compared with 32.6% in urban areas. Nigeria is facing difficulties in progress towards achieving the measles vaccination target of 95% by 2015, and large equity gaps persist among zones and between urban and rural areas.[12]

Concerted efforts led to significant decreases in new infections from wild poliovirus, which fell from 388 in 2009 to 21 in 2010. But this was followed by a gradual increase in cases to 63 in 2011 and 122 in 2012. Another decline started in 2013 with 53 cases. By week 28 of 2014, only five cases had been recorded and only in two states, compared with 36 cases in nine states in the same period in 2013, an 86% reduction. There has not been any case of wild poliovirus Type 3 since November 2012.

Increasing the proportion of children sleeping under insecticide-treated bednets (ITNs) to 60% by 2015 is challenging. In fact, there was a drop in under-five ITN use between 2010 and 2012, especially in the northern zones.[4]

HIV/AIDS and TB

The national HIV prevalence in 2012 was 3.4%, an estimated 3.4 million people were living with HIV and there were 270 000 new HIV infections. The estimated AIDS-related deaths in the same year were 250 000 (Spectrum modelling, 2012)[14]. The multisectoral national response to HIV/AIDS led to the stabilization of the epidemic in 2011 and annual declines in new infections of 7.1% between 2008 and 2010 and 5.6% between 2010 and 2012[15].

Nigeria is responsible for 29% of the global gap in reaching 90% of pregnant women living with HIV who need antiretroviral therapy for prevention of mother-to-child transmission (PMTCT) of the virus. About 5% of maternal and under-five deaths in Nigeria can be attributed to HIV/AIDS, according to the 2013 National Maternal and Child Health Strategy[16]. The much-needed progress in expanding PMTCT services is gathering momentum.

The 2010 National Tuberculosis and Leprosy Control Programme's annual report shows a decrease in prevalence of TB from 15.74 per 100 000 in 2000 to 5 per 100 000 in 2012. However, the WHO supported population-based TB prevalence survey of 2012 shows much higher levels of 318 (95% CI of 225–412) for smear-positive and 524 (95% CI of 378–670) for bacteriologically confirmed cases in the adult population. The DOTS strategy for TB currently is implemented in 3931 facilities across the country[17] and had coverage of 68% in 2011. Improved access to services has resulted in improved notification and treatment success of TB cases, but the rate of progress has slowed down and programme outcome indicators have stagnated in the last 3 years.

Neglected Tropical Diseases (NTDs)

The NTD programme in Nigeria currently deals with lymphatic filariasis, onchocerciasis, schistosomiaisis, soil-transmitted helminths, trachoma, leprosy, buruli ulcer, human African Trypanosomiasis and Guinea Worm disease. The strategic goal of the programme is to progressively reduce morbidity, disability and mortality due to NTDs using integrated and cost-effective approaches, with a view to eliminating these diseases in Nigeria by 2020. The NTD programme is an integrated package of existing NTD disease-specific programmes, but each programme maintains its specific focus goal, objectives and strategies, with the understanding that

achieving its goals will contribute to the achievement of the overall national NTD goal[18].

Noncommunicable diseases

Nigeria is undergoing a demographic transition with a concomitant increase in risk factors for noncommunicable diseases (NCDs). Though current data are lacking, the most recent national survey conducted in 1990–1992 showed that among adults aged 15 and above the prevalence of hypertension was 11.2% (4.3 million people) and of diabetes mellitus 2.7% (1.05 million people).

Using the current high blood pressure cut-off level of 140/90 mmHg as the base, it is estimated that the prevalence of hypertension should have exceeded 20% (8 million) by now. In the absence of appropriate interventions, the projected cumulative annual economic loss from deaths due to heart diseases, stroke and diabetes for the period 2005–2015 is estimated at US$ 0.8 billion (128 billion Naira)[19].

Sickle cell disease is the most common genetic disorder in Nigeria, estimated to affect 0.5% of the population. The sickle cell trait affects up to 23.04% of the population. Sickle cell disease causes 100 000 deaths among infants annually or 8% of infant mortality in the country.

Mental, neurological and substance-use disorders together contribute up to 25% years of potential life lost due to premature mortality and years of productive life lost due to disability (DALYs) in Nigeria[7]. A large community study[20] in the country estimated that one in five persons deal with a significant mental health problem in his or her lifetime requiring treatment. The proportion of people receiving any mental health treatment, orthodox or otherwise, within a 12-month period was about 10%. As a result of their high prevalence, relatively low mortality and identification rates, and the poor use of treatment on them, mental, neurological and substance-use disorders are the largest single group of noncommunicable diseases contributing to disability in the population.[7]

2.4 National response to health challenges

Health policies, strategies and plans

A Federal Government reform of the national health care delivery system was undertaken in 2003–2007 in the context of NEEDS and SEEDS. It also captured elements from the President's Seven Point Agenda, Vision 20:2020, the MDG agenda and the National Strategic Health Investment Plan 2007/2008, which facilitated:

- revision of the national health policy
- definition of a framework for achieving the MDGs in Nigeria
- drafting of the National Health Bill
- revitalization of the National Council on Health
- formal launching of the National Health Insurance Scheme
- formulation of policies and plans for several subsectors for both health systems and health programmes

The National Council on Health endorsed the development of the NSHDP 2010–2015 and adopted it in 2010. The NSHDP aligns national health development with international developments, including those related to the MDGs, the Ouagadougou Declaration, the Paris Declaration on Aid

Effectiveness and the Accra Agenda for Action. It guides formulation of state and local government plans, serving as a reference document for actions in health by all stakeholders to ensure transparency and mutual accountability in the sector. NSHDP focuses on eight priority areas:

- leadership and governance
- health service delivery
- human resources for health
- financing for health
- national health management information system
- partnerships for health
- community participation and ownership
- research for health

A national compact agreement involving federal and state governments and key development partners coordinates the implementation of NSHDP and SSHDPs. Ongoing initiatives and approaches in the implementation of the NSHDP include:

- The Save One Million Lives Initiative of the UN Commission on Life Saving Commodities for Women and Children, launched by His excellency, the President in 2012;
- The Presidential Committee on the Assessment and Monitoring of the MDGs and the Office of the Senior Special Assistant to the President on MDGs;
- The Presidential Comprehensive Response Plan, which seeks to mobilize resources to achieve the targets of MDGs 4, 5 and 6;
- The Midwives Service Scheme coordinated by NPHCDA;
- The UNH4+ Project 2010–2015, which is a joint effort of four UN agencies funded by Canada's Department of Foreign Affairs, Trade and Development (DFATD) and coordinated via UNICEF; and
- The national monitoring and evaluation system.

Nigeria has recently passed into law the National Health Bill 2014. This Bill provides a framework for development and management of the health system focusing on:

- responsibility for health provision, eligibility for health services and establishment of a national health system
- health establishments and technology
- rights and obligations of users and health care personnel
- the national health research and information system
- human resources for health
- control of the use in humans of blood, blood products, tissue and gametes
- regulations and miscellaneous provisions

The Bill promotes primary health care and seeks to provide health care insurance for all Nigerians, including deprived people. It also defines the responsibilities and limitations of professional bodies in the health sector[21].

2.5 Health systems and services

Health service delivery

A mix of public and private groups is involved in providing health services. As at December 2011, the Directory of Health Facilities in Nigeria had listed 34 173 health facilities from the 36 states and the Federal Capital Territory (Table 2). Of these, 30 098 (88%) provided primary health care, 3992 (12%) secondary care, and 83 (1%) tertiary care. More than 66% of the facilities are government owned. On the average, there were 22 health facilities per 100 000 population, with a range of 8 to 42 for the states. Similar disparities exist among local government areas within the states.

The Federal Ministry of Health provides public sector policies and the framework for the delivery of services by federal health institutions, parastatals and health programmes at the national level while state and local governments have responsibility for delivering health care to the population. As part of the emphasis on integrated primary health care, NPHCDA is responsible for coordinating delivery of basic essential health care services. Maximizing synergies between public and private health care providers to enhance performance is still a challenge despite the huge potential in the private sector.

Table 2: Health facilities in Nigeria by type and ownership, 2011

Type	Ownership		Total
	Public	Private	
Primary	21 808	8 290	30 098
Secondary	969	3 023	3 992
Tertiary	73	10	83
Total	22 850	11 323	34 173

Source: A directory of health facilities in Nigeria, 2011, FMoH

Organizational and management deficiencies in primary heath care services related to weak, fragmented and inconsistent linkages across the different levels of the government and stakeholders form a major challenge in developing health services in Nigeria. The division of responsibilities in the different levels of the government is not clear. This is accompanied by inadequate accountability and low capacities at the operational level. The new National Health Bill seeks to address these problems[22].

Health financing

Estimates from the WHO Global Health Expenditure Database show that the total health expenditure for Nigeria rose from 1919.2 billion Naira (US$ 12.8 billion) in 2010 to 2497.5 billion Naira (US$ 15.9 billion) in 2012. This translated into a per capita expenditure of US$ 80 in 2010 and US$ 94 in 2012. As at 2012, 31% of the total health expenditure came from general government expenditure, 69% from private sources[23].

Household out-of-pocket expenditure remains the largest source of health expenditure in Nigeria, standing at 66% of the total in 2012. This demonstrates the huge effort needed from the government to make progress towards achieving universal health coverage and highlights the importance of the commitments made in this regard in the Presidential Summit on Universal Health Coverage.

As part of the efforts towards providing universal health coverage, the Government of Nigeria established the federally funded National Health Insurance Scheme in 1999. This risk pooling and cost-sharing prepayment mechanism was launched in 2005 and had a registered membership of over 1.2 million by 2010, mainly from the formal sector. The insurance scheme seeks to cover the informal sector as well, which contains the majority of the needy populations. Community-based insurance schemes are currently being piloted by both the public and the private sectors in states selected for their poor health indices.

The 2014 Presidential Summit on Universal Health Care recommended that the Government of Nigeria work towards instituting mandatory health insurance, with contributions from income earners providing special funds to cover the poor. Another recommendation was that a standard benefit package of essential health services addressing priority health care needs of all Nigerians be defined.

Human resources for health

The most recent information on the numbers and density of health workers is from the "Nigeria health workers profile as of December 2012" published in 2013, whose data were drawn from the various health professionals' registries. Unfortunately, huge discrepancies exist between the total numbers in the registries and the numbers of professionals "in good standing", which are far more likely to reflect the staff in the various cadres actively practising in Nigeria. As at December 2012, some 20 284 medical doctors were in good standing. The density per 100 000 population ranged from 50.5 in the Federal Capital Territory to 1.9 in Yobe State. Sokoto was the "median state" with 8.9 doctors per 100 000 people. Information on nurses and midwives in good standing was not available, but state data showed densities of nurses and midwives taken together ranging from 5.9 per 100 000 population in Zamfara State to 96.5 in Imo State. Niger State, with 24.7, was the median State.

These "medians" are not strict statistical values but simply health worker densities in the states that appeared in the middle of a curve in a graph of health workforce densities in the 36 states and the Federal Capital Territory arranged in the order of magnitude. Combining the median densities and nurse and midwife ratios for these median states gives 0.336 as the number of health workers per 1000 population, which is almost an order of magnitude lower than the absolute minimum level of 2.28 workers required per 1000 people as stated in the 2006 World Health Report. This is of great concern.

To make things worse, the growth in a number of cadres, in particular nurses and midwives, is not keeping pace with population growth. This has partly been attributed to massive external migration of medical doctors and nurses, which topped between 2002 and 2007. Migration since then has diminished drastically, but still in 2012 it represented 38% of the medical doctors that had to be trained to fill the gap of emigrants. The seemingly negative trend in the number of medical doctors in good standing depicted in the records was attributed to delays in updating the registries.

To respond to these issues, the national Human Resources for Health Policy of 2007 and the strategic plan for 2008–2012 are being revised. Additionally, a National Human Resources for Health Forum has been constituted with subcommittees and technical working groups to advise on health workforce issues such as human resources information, task shifting and strategic planning. The establishment of an electronic national health workforce registry that is under way is expected to enhance tracking of and accounting for all health workers in the country and to improve planning and management of human resources for health.

Health information

The National Health Management Information System (NHMIS) has undergone progressive improvements since its inception in 1992, culminating in the development of a policy in 2006. NHMIS is led by the Federal Ministry of Health and is linked to relevant federal ministries and departments, state NHMIS's, and local government departments' primary health care monitoring and evaluation units. The National Bureau of Statistics also generates valuable health information. NHMIS is facing several key challenges, especially at the subnational level:

- The health management information is not used for governmental programme planning, monitoring and evaluation or strategic decision-making at any level. This is probably attributed to the poor funding and performance of NHMIS at all levels.
- Although the rates of reporting improved in 2012 for some states, systematic routine analysis of submitted health management information data and feedback to health institutions are still lacking.
- The excessive reviews of data collection tools at the federal level and the absence of refresher training have left NHMIS personnel at the subnational level with inadequate skills and capacity.
- Many states have created "vertical" monitoring and evaluation processes with donor funding or have projects implemented by other departments of the state ministries of health. Some of the health projects at the federal level also utilize alternative means to access routine health performance data.
- Although the NHMIS policy provides clear coordination structures with assigned roles and responsibilities at the federal and subnational levels, the coordinating forum, that is, the Health Data Consultative Committee, is largely nonfunctional in many states.

Essential medicines and technology[24]

In accordance with the Saving One Million Lives Initiative launched in October 2012, a country implementation plan for essential life-saving commodities for women and children was developed. This is part of Nigeria's effort to deliver basic health services and to enhance access to life-saving commodities for women and children, with a focus on saving lives. The overall objective of the implementation plan is to provide a road map for activities and targets that will ensure availability and use of the priority life-saving commodities by women and children. These commodities cover the reproductive, maternal, neonatal and child health continuum and include:

- Reproductive and maternal health commodities such as Oxytocin, Misoprostol, magnesium sulfate, female condoms, emergency contraceptives, contraceptive implants, intrauterine contraceptive devices and Sulfadoxine-Pyrimethamine;
- Neonatal health commodities such as Chlorhexidine, injectable antibiotics, antenatal corticosteroids and neonatal resuscitation devices;
- Child health commodities such as oral rehyation therapy, zinc and Amoxicillin.

Based on identified needs and existing commitments by the government and donors, Nigeria received US$ 10 million from the Reproductive, Maternal, Newborn and Child Health Fund of the UN Commission on Life-Saving Commodities for Women and Children to kickstart its reproductive, maternal, neonatal and child health efforts and for work through 31 December 2014. Of this US$ 7 million went to WHO for neonatal and child health commodities, and US$ 3 million to the United Nations Population Fund (UNFPA) for reproductive health commodities.

Poverty reduction strategies

Reducing poverty, hunger and unemployment remains an underlying development challenge for Nigeria. Over the years, governments at both national and subnational levels have tackled these intertwined problems within the contexts of MDG interventions and wider frameworks of economic and social policies, development plans and programme interventions. The improved economic performance in the last decade resulting from better macroeconomic and fiscal management and the growth in the non-oil sector has not translated into a reduction in poverty.

The increased policy attention to inclusive growth with a focus on agriculture and the informal sector gives hope for progressive reduction in unemployment and poverty. Tackling poverty also requires innovative targeting of action to address the sharp subnational and rural–urban disparities. Policies addressing population growth and promoting social protection are also essential in reducing poverty.

2.6 Nigeria's contribution to the global health agenda

Nigeria has contributed to global health in several significant ways, including:

- Eradication of Guinea Worm disease (declared in 2013 by the WHO International Certification Commission on Dracunculiasis Eradication);
- Improvement in the under-five mortality rate;
- Increased iodization of common salt to control and reduce goitre cases. Nigeria and South Africa are the only countries in the African Region to have developed dietary guidelines[25];
- Reduction in the number of wild poliovirus cases.

With the implementation of the Save One Million Lives Initiative, coverage of health services has been extended to all parts of the country. The government's commitment to universal health coverage was demonstrated through the organization of the Presidential Summit in March 2014. With the sheer size of the country, these steps are bound to generally improve health in Africa and globally.

Nigeria is an active member of the African Union and the United Nations and a signatory to International Health Regulations (IHR 2005), the MDGs and the WHO Framework Convention on Tobacco Control. The country is a regular contributor to the Global Fund for AIDS, Tuberculosis and Malaria, giving US$ 10 million yearly.

Like many other African countries, Nigeria has recorded some progress in the attainment of the MDGs, but considerable efforts will have to be made to achieve the targets by 2015. Most African countries are still facing a high burden of communicable diseases like HIV/AIDS, TB and malaria and vaccine-preventable diseases. Nigeria and Cameroon remain the only countries in Africa reporting polio cases. The burden of noncommunicable diseases as well as their risk factors is also growing in the country just like in some other African countries[26].

Another unfortunate feature common among African countries is the low level of investment in health. In 2011 per capita expenditure on health (US$ at average exchange rate) ranged from US$ 12 in Eritrea to US$ 404 in Botswana. In the same year per capita health expenditure was US$ 64 in

Cameroon, US$ 25 in Chad, US$ 39 in Burkina Faso and US$ 34 in Benin. Despite the vast resources available in Nigeria, per capita expenditure on health was only US$ 85 in 2011. More investment in health will be required to address health challenges for better outcomes.

Nigeria accounts for about 35% (about 45% at the regional level) of the global population without access to preventive chemotherapy required for the control and elimination of neglected tropical diseases amenable to this intervention. Efforts to scale up this intervention need to be accelerated for national, regional and global attainment of the road map goals for these diseases by the 2020 strategic milestone. In 2014, the Federal Ministry of Health launched a joint implementation plan for elimination of malaria and lymphatic filariasis. While it is too early to report on outputs from this initiative, the collaboration represents an innovative and exemplary integrated approach to eliminating these diseases through synergistic intervention strategies, monitoring and evaluation.

SECTION 3: DEVELOPMENT COOPERATION AND PARTNERSHIPS

3.1 Aid environment in the country

Official development assistance per capita has doubled since the early 2000s and debt service as a proportion of exports of goods and services has declined remarkably. Unfortunately, the debt relief fund that is being used under the MDGs to fund health activities, including those associated with the health-related MDGs, will be exhausted in 2015.[1] Several discussions have been aimed at developing modalities to increase local financing for development programmes, including the engagement of the private sector and public–private partnerships.

Nigeria is a signatory to the various global and regional declarations relating to aid effectiveness and harmonization. For that reason NSHDP 2010–2015 is fully compliant with the principles of the Paris Declaration on Aid Effectiveness and the International Health Partnership (IHP+). Accordingly, NSHDP has created an enabling environment for the Federal Ministry of Health to collaborate with the many development partners in the health sector.

3.2 Stakeholder analysis

Development partners demonstrated their commitment to support the implementation of NSHDP through signing of the Country Compact. These partners operate in many states and work in diverse areas of health. While some of them derive the programmes they support directly from NSHDP, others have programmes that are not necessarily from the strategic plan.

The key health development partners of Nigeria include USAID, the US government, DFID, the EU Delegation, DFATD, the Japan International Cooperation Agency (JICA), Germany, Italy, Spain, Norway, Russia, the Korea Foundation, the World Bank, the African Development Bank (ADB), the Centres for Disease Control (CDC), NORAD, KFW, UN Foundation, the Bill & Melinda Gates Foundation, the Global Fund to fight AIDS Tuberculosis and Malaria (GFATM), and the GAVI Alliance.

International and national NGOs are also important in the health sector, supporting service delivery. They include Save the Children, Management Science for Health, Capacity Plus, Clinton's Health Access Initiative, the Population Council, the Malaria Consortium, the Health Reform Foundation of Nigeria, the Association for Reproductive and Family Health, and the Society for Family Health. Several other implementing partners have transitioned into national NGOs such as the Institute of Human Virology Nigeria, the US President's Emergency Plan for AIDS Relief, FHI 360, the AIDS Prevention Initiative in Nigeria, and the Copenhagen HIV Programme, all working mainly in HIV/AIDS. Among the UN country teams, UNAIDS, UNICEF, UNFPA, UNHCR, IOM and WHO are active in the health sector.

Both for-profit and not-for-profit components of the private sector are important players in health service delivery but their efforts are yet to be appropriately harnessed. The Federal Ministry of Health plans to create an appropriate engagement mechanism to ensure inclusion of private health care service providers under an overall coordination structure of the health sector[27].

Through the Health Partners Coordination Committee (HPCC), the Federal Ministry of Health has embarked on computer-based mapping of technical and financial contributions of development partners at all levels of the health sector.

The presence of many development partners at national and subnational levels presents several opportunities for WHO collaboration during CCS III implementation.

3.3 Aid coordination and effectiveness

The National Health Policy recognizes the National Council on Health as the highest health sector coordinating body in Nigeria. The Council is chaired by the Minister of Health and its membership is made up of Commissioners of health from all the states and the Federal Capital Territory. The Council meets once a year. States are expected to have a Council of health to coordinate health activities. The NSHDP focus on "One plan, one M&E framework and one coordination" resulted in the creation of the NSHDP Reference Group and its subcommittees.

HPCC is an umbrella coordination structure for engaging stakeholders in the health sector. Its wide ranging membership is drawn from the directorates and agencies of the Federal Ministry of Health, NGOs and development partners. It is chaired by the Minister of Health to ensure coordination of government and partner programmes. Efforts have been made to make HPCC effective and aligned with NSHDP, since some of its responsibilities overlap with those of the NSHDP Reference Group.

The Development Partners in Health Group (DPG/DPH) functions as the technical arm of HPCC. The National Planning Commission is responsible for coordinating all development assistance in Nigeria. It initiated the creation of a development assistance database in 2010–2011. There are several other coordination structures within the health sector, including:

- The Country Coordinating Mechanism for the Global Fund for HIV, TB and Malaria
- The Development Partners' Group on HIV/AIDS, Nigeria
- The AIDS, Tuberculosis and Malaria Task Force
- The Interagency Coordinating Committee on Polio Eradication and Immunization
- The Reproductive Health Commodity Security Steering Committee
- The Core Technical Committee on Integrated Maternal, Newborn and Child Health
- The Presidential Task Force on Polio Eradication
- The Saving One Million Lives Steering Committee

Other coordination platforms operate along similar programmatic lines, many of which are not necessary aligned with or linked to HPCC. However, development partners, including WHO, are obliged to actively participate in many of these policy fora.

The sheer number of federal health agencies, stakeholders and parastatal organizations; the multiple comprehensive planning instruments; the overlapping coordination platforms and the many redundant systems constitute an exceptionally complex and highly fragmented health policy environment. It is often difficult to link responsibilities of organizations with the areas of authority of these myriad stakeholders, policies, plans or programmes, with their often slightly different, somewhat overlapping or relatively "siloed" focuses. The general opacity in their mandate stifles coordination and encourages intense inter- and intra-agency competition for information and the scarce resources. The complexity increases when one considers that many federal structures are partly or wholly duplicated by some or all of the 36 states. Specific state priorities also may change depending on the state governor.

The government is committed to improving coordination structures and functions to ensure that all health sector interventions work together for the benefit of the health of Nigerians. A recent review of the existing coordination structures[28] suggested their streamlining and proposed a framework (Fig. 6) to ensure management effectiveness in the health sector in line with NSHDP. The review suggested in addition that leadership of the coordination mechanism be improved to ensure that all health interventions work for the benefit of the health of Nigerians. WHO is well positioned to contribute to the strengthening of the coordination structures and functions during CCS III.

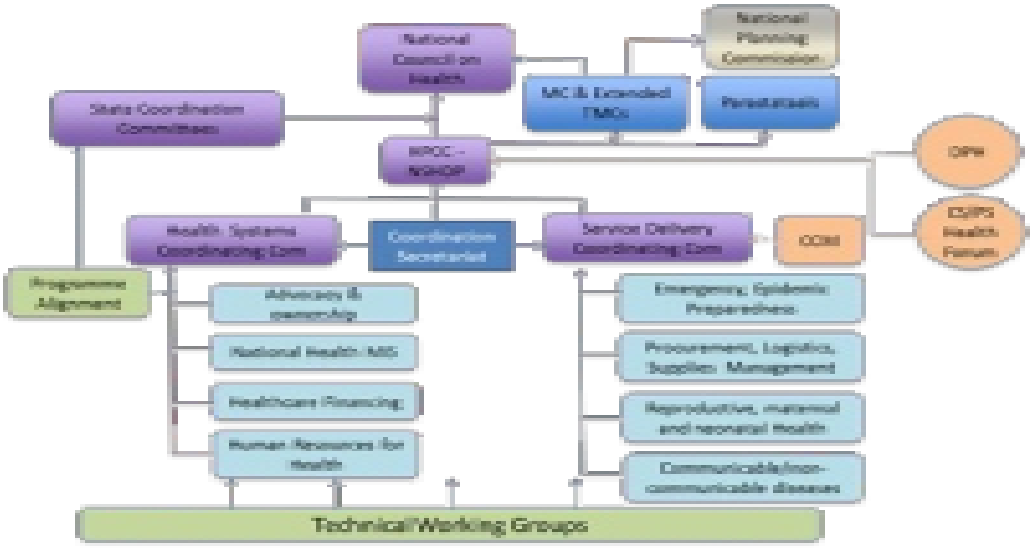

Figure 6: Proposed revised health sector coordination mechanism

Source: A Review of Coordination and Aid Harmonization in the Nigerian Health Sector: Summary Report, FMoH & PATHS2, Abuja, July 2012.

CCM = Country Coordination Mechanism (linked to Global fund for Malaria, AIDS and Tuberculosis)
DPH = Development Partners in Health, also referred to as DPG (Development Partners' Group)
HPCC-NHSDP = Health Partners Coordination Committee- National Strategic Health Development Plan
CS/PS = Civil Society and Private Sector

3.4 UN and UNDAF

UNDAF is the strategic structure for the collective work of the 18 UN organizations in Nigeria responding to the national development priorities. UNDAF III implementation is aligned with the planning cycle of the second National Implementation Plan of Nigeria's Vision 20:2020 and, as such, with the eight priorities of NSHDP. It provides a unique opportunity for the UN system in Nigeria to operationalize the "Delivery as one" principles by working through one office, one fund and one leader to improve programme coherence, relevance and impact in the country. UNDAF III focuses on four results areas: good governance, social capital development, sustainable and equitable economic growth, and human security and risk management.

WHO actively participated in the development of UNDAF III and ensured the inclusion of UNDAF III priorities in CCS III. WHO will contribute specifically to outcomes 2, 3 and 4 under "social capital development" and outcomes 1 and 3 under "human security and risk management[29]," as well as to the good governance results area.

3.5 Health achievements, opportunities and challenges

Nigeria's health sector has seen some important health outcomes but success has been affected by factors mostly related to the structural makeup of the sector, as summarized below:

- **Achievements**

– Stakeholder participation in the development of National Strategic Health Development Plan (NSHDP), State Strategic Health Development Plan (SSHDP) and Federal Capital Strategic Health Development Plan (FCSHDP);
– Joint planning, implementation and review of the NSHDP;
– Harmonized support for the Polio Eradication Initiative and routine immunization under the National Primary Health Care Development Agency.

- **Challenges**

– Extensive and widespread fragmentation and duplication, especially at the subnational level because coordination mechanisms are non-functional;
– Multiple stakeholders, policies, plans and programmes resulting in poor coordination;
– Inadequate capacity for effective coordination of action at all levels.

- **Opportunities**

– Commitment of the government to improve stewardship and governance in the health sector;
– Presence of a large number of development partners that are willing to collaborate with the government and other partners in the health sector;
– UNDAF III (2014–2017) with commitment to "Deliver as one".

SECTION 4: WHO IMPLEMENTATION OF CSS II

The CCS II review process included internal and external reviews, a one-day retreat and stakeholder consultations, as described in Annex 2. The following sections describe the findings.

4.1 Alignment of the WHO 2008–2013 biennial workplans with CCS II

The strategic agenda of CCS II was closely aligned with the strategic objectives of WHO as shown in Table 3. Alignment with the National Strategic Health Development Plan 2010-2015, which was developed after CCS II will be shown in Section 5 Strategic Agenda for CCS III, Table 8.

Table 3: Alignment of CCS II priorities with WHO strategic objectives

CCS II strategic agenda	WHO strategic objectives' focus
Improving stewardship and governance	SO 10: Governance, health systems strengthening
Strengthening health systems within the context of primary health care	SO 10: Governance, health systems strengthening SO 11: Improved access to quality medical products and technology
Scaling up priority interventions	SO 1: Communicable diseases SO 2: HIV/AIDS, TB and malaria SO 3: Noncommunicable diseases SO 4: Maternal, newborn and child health SO 9: Nutrition and food safety
Adessing the social determinants of health	SO 6: Health promotion/risk reduction SO 7: Social and economic determinants of health SO 8: Healthier environment/influence policies in all sectors
Coordinating partnerships and mobilizing resources	SO 10: Governance, health systems strengthening SO 12 : Leadership, governance and partnerships

4.2 Human resources

WHO continued to operate a decentralized office structure with one central WHO County Office in Abuja; and an office in each of the 36 states and one more in the Federal Capital Territory (Table 4). The six state offices in Bauchi, Enugu, Ibadan, Kano, Minna and Port Harcourt also function as WHO offices for the respective zones having a zonal coordinator. The number of technical staff increased from 212 at the end of the first biennium to 271 at the end of the third biennium, with most of these in temporary cadres in the North-West, North-East and North-Central zones to combat the continuing polio transmission.

Table 4: Distribution of WHO staff by location of office and biennium during the CCS II period

	Zonal office location	No. of offices	Number of staff			
			2008–2009	2010–2011	2012–2013	
					Regular	EPI surge staff
Federal Capital Territory	Abuja	2	104	95	122	–
North-Central	Minna	6	66	62	76	183
North-East	Bauchi	6	77	71	95	505
North-West	Kano	7	115	103	148	1352
South-East	Enugu	5	28	29	31	5
South-South	Port Harcourt	6	33	32	37	10
South-West	Ibadan	6	74	69	75	6
Total		**38**	**497**	**461**	**584**	**2061**

4.3 Financial resources for CCS II

Total funding increased significantly during CCS II, going from US$ 116 878 606 for 2010–2011 to US$ 279 209 969 during 2012–2013. The WHO country office mobilized a considerable amount of these resources (Table 5).

Table 5: Summary of resources mobilized during 2010 – 2013 by source*

Source of funding	2010–2011	2012–2013	Total	Proportion (%)
Assessed contributions	4 064 975	4 511 645	8 576 620	2
External resources health systems strengthening (voluntary contributions from WHO country office)	22 235 983	52 802 649	75 038 632	18
External resources mobilized (voluntary contributions from WHO African Regional Office and WHO HQ)	90 577 648	221 895 675	312 473 323	79
Grand total	**116 878 606**	**279 209 969**	**396 088 575**	100

*Information for 2008–2009 is not available from the Global System Management

Assessed contributions were distributed across all the 13 strategic objectives based on priorities and workplans. The voluntary contributors allocated over 90% of their resources to communicable diseases. Some strategic objectives did not receive any funds. This indicates inconsistency between CCS II and the workplans emanating from it and may have been due in part to the fact that most of the resources for CCS II were earmarked.

Additionally, CCS II had anticipated that polio transmission in Nigeria would be interrupted. This was not achieved and resources continued to be allocated to that goal, leading to a mismatch between CCS II priorities and the actual implementation of activities. Further, competencies within WHO during CCS II were determined based on availability of resources. Table 6 shows the distribution of resources by strategic objectives and source of funding. There is need for CCS III to ensure that resources are mobilized for all priority areas.

Table 6 : Distribution of financial resources by strategic agenda, objectives and source of funding for first CCS II biennia

CCS II agenda	Strategic objectives	2010–2011		2012–2013	
		Assessed contribution (%)	Voluntary contribution (%)	Assessed contribution (%)	Voluntary contribution (%)
Scaling up priority interventions	1. Communicable diseases	5.9	94.0	13.5	93.7
	2. HIV/AIDS, TB and malaria	11.1	3.6	4.5	3.8
	3. Noncommunicable diseases	3.5	0.1	6.0	0.1
	4. Maternal, newborn and child health	2.4	1.8	10.9	1.8
	5. Emergencies and disasters	3.4	0.1	2.1	0.3
Social determinants of health	6. Health promotion/risk reduction	2.7	–	5.1	0
	7. Social/economic determinants of health	11.4	–	3.5	–
	8. Healthier environment/influence policies in all sectors	4.0	–	3.2	–
Scaling up priority interventions	9. Improve nutrition and food safety	4.5	–	2.3	0
Partnership and resource mobilization Strengthening health systems Improving stewardship and governance	10. Governance, Health systems strengthening	5.8	0.4	12	0.2
Strengthening health systems	11. Improved access to quality medical products and technology	3.2	0.1	2.7	0.1
Partnership and resource mobilization	12. Leadership governance and partnerships	26.5	–	15.0	–
	13. WHO country presence	15.6		19.2	
Total		**100**	**100**	**100**	**100**

4.4 Consistency between CCS II and UNDAF II

CCS II was developed aligned with UNDAF II (2009–2012), which provided a unique opportunity for WHO to work with other UN agencies active in the health sector such as UNICEF, UNFPA and UNAIDS. WHO collaborated in the development of UNDAF II with the UN country team to ensure that the relevant CCS II priorities were adequately addressed. Those priorities were appropriately situated within the third priority of UNDAF II, "transforming social service delivery". In the context of "Deliver as One", WHO and other UN country team members planned and implemented joint programmes on HIV/AIDS. The UNH4+ joint programme on maternal newborn and child health involving WHO, UNICEF and UNFPA aimed at reducing maternal, newborn and childhood morbidity and mortality in 15 states.

4.5 CCS II and achievement of national health goals

Improve stewardship and governance for health at all levels

WHO continued to support the country during the CCS II period in line with its mandate. The main focus under the priority of improving stewardship and governance was to assist the Federal Ministry of Health in developing management tools, policies and legislation and building capacity for development of medium-term plans and expenditure frameworks. Other issues addressed related to collaboration with other sectors, advocacy to government, improvement of health security and management of emergencies. The key achievements under this priority area include:

- Co-signing of the Country Compact by the government and partners in support of NSHDP (2010–2015) that resulted in an enhanced enabling environment for NSHDP and CCS II implementation;
- Development and adoption of programmatic policies and guidelines – including those for malaria; maternal, newborn and child health as well as reproductive health (MNCH/RH); HIV/AIDS; neglected tropical diseases; Expanded Programme on Immunization including routine immunization – and of accountability frameworks;
- Strengthened health sector coordination structures and mechanisms resulting in regular meetings of government and partner coordination forums. These fora included the Development Partners Group, HPCC and the Interagency Coordination Committee; and
- Strengthened capacity to manage health emergencies through the implementation of the Early Warning and Response Network activities in the 15 states affected by the 2012 flood.

Strengthen health systems within the context of PHC

WHO followed its mandate and objective to focus on health systems strengthening in accordance with its eleventh General Programme of Work, and regional and national priorities aimed at improving health services. Primary health care revitalization, the goal of universal health coverage and the MDGs were among the main drivers of WHO support for health systems strengthening during CCS II implementation. Under this priority, WHO worked with partners to support the Federal Ministry of Health to develop NSHDP, evaluate implementation of the national health policy, build capacity for health policy formulation and provide technical support to important federal and state policy organs.

Health workforce planning and management systems and capacity were strengthened. Further, policies and strategies were developed to improve availability of quality essential medicines and health technology. Technical assistance was provided to strengthen health information systems and research and for instituting expenditure tracking in the health sector, particularly for health accounts at national and state levels, the national strategic health financing policy, and health insurance schemes. The key achievements under the health systems strengthening priority area included:

- Development and implementation of the first NSHDP under the leadership of the Federal Ministry of Health with the support of WHO and partners, as well as the development of the strategic health development plans for the 36 states and the Federal Capital Territory;
- Institutionalization of and support for mechanisms for monitoring and evaluating strategic health development plans at all levels of the government, including joint annual and mid-term reviews;

- Strengthening of systems and capacity for planning and management of health human resources through creation of human resource desks at the federal and state levels, complemented with training of focal points for human resource functions. In addition, a health workforce situation analysis was conducted to provide evidence for the development of a new health human resources strategic plan for 2014 and beyond;
- Facilitation by WHO in collaboration with the Federal Ministry of Health, CDC and other stakeholders of studies to determine data elements, processes and functions required for the creation of a computerized registry to track all health workers in the country. WHO also supported the development of capacity and strategies for the adoption and implementation of the use such a registry;
- Strengthening by WHO of partnership coordination mechanisms for health resources, including the establishment of the National Health Human Resources Forum under which key partners meet regularly to share experiences and take joint action in support of health workers in Nigeria. Two national conferences were held in 2011 and 2013 to advocate for policy-level and stakeholder support for the health workforce in the effort to achieve universal health coverage;
- Support by WHO in collaboration with partners for the Federal Ministry of Health to conduct two rounds (2003–2005 and 2006–2009) of national health accounts during the CCS II period, with sub-accounts for reproductive and child health included in the 2006–2009 round. In addition, three states and the Federal Capital Territory received support to establish community health insurance schemes;
- Harmonization of data-collection tools for the health management information system, integrated disease surveillance and reporting, and capacity building for health information management. Resource mobilization is going on and preparations are under way to support a countrywide assessment of the availability and readiness of surveillance and reporting services;
- Revision of the national essential drugs list, and development of standard treatment guidelines and distribution of 30 000 copies of the guidelines to health workers in both the public and private sectors by the health ministry with leadership and support of WHO. Capacity at the Drug Regulatory Body was strengthened, and the National Drug Laboratory and five local drug manufacturers were provided technical support for WHO prequalification accreditation.

Scale up priority interventions to improve health

This priority area aims at increasing availability of and access to evidence-based health interventions to improve the health of all Nigerians. The focus of WHO support in this area is the expansion of interventions in polio eradication, routine immunization, HIV/AIDS, TB and malaria, as well as on integrated family, reproductive, maternal, newborn and child health. WHO also continued to intensify strategies for the prevention and control of communicable, noncommunicable and neglected tropical diseases. Support was provided to build national capacity for integrated disease surveillance and epidemic preparedness. The following are the key achievements under this priority area:[4,16,30,31]

- Interruption of wild poliovirus transmission in the southern states since 2009. In addition, support for the timely containment of new cases of the virus resulted in a 59% reduction in the number of cases reported in 2013;

- Expansion in national coverage of DPT3 from 52% in 2008 to 83% in 2013 and reduction in unimmunized children by 69%;
- Certification of Nigeria as free of indigenous transmission of Guinea-Worm by the International Certification Commission on Dracunculiasis Eradication, as a result of WHO support to the Nigeria Guinea-Worm Eradication Programme, working with other partners;
- Increase in DOTS centres from 2742 in 2008 to 4642 in 2013, as well as in TB microscopic diagnostic centres, which grew from 900 in 2008 to 1341 in 2013, improving access to quality TB services;
- Expanded availability of evidence-based interventions for HIV/AIDS, malaria and TB, and reproductive, maternal, newborn and child health through both institutional and human capacity building for provision of quality services at all levels. This involved development of treatment guidelines for HIV (both antiretroviral therapy and PMTCT interventions); malaria; TB; and integrated community case management; and reproductive, maternal, newborn and child health, hand in hand with training of front-line health workers to enable effective implementation of these interventions;
- Capacity improvement for health workers in 15 states and the Federal Capital Territory to provide quality maternal, newborn and child health services by training and sensitization of 150 community members on family and community practices through a partnership of WHO, UNICEF and UNFPA under the UNH4+ project. This project also supports development and monitoring of the states' annual operational plans based on their strategic health development plans;
- National capacity enhanced for parasite-based diagnosis of malaria and development and piloting of integrated community case management of childhood illnesses, working in collaboration with partners;
- Generation of evidence for the development of priority interventions with WHO support and facilitation, including through undertaking a national HIV drug resistance survey and the first ever national survey to establish the true status of TB in the country. WHO provided technical support and grants for implementation research on maternal, newborn and child health;
- Conducting by the Government of Nigeria with WHO support of the first Global Adult Tobacco Survey (GATS) in the African Region in 2012 as part of global tobacco surveillance. GATS results provide evidence for tobacco control interventions;
- Enhancement of the national capacity for disease prevention and control through training and retraining surveillance officers, harmonizing and expanding IDSR (integrated disease surveillance and reporting) tools to include other diseases, and improving the capacity of the national public health laboratory for diagnosing influenza, cholera and cerebral spinal meningitis through provision of equipment and supplies and training;
- Attention to noncommunicable diseases, including support to develop a national policy and strategic plan of action. A pilot Mental Health Gap Action Programme (mhGAP) was implemented in Osun State with European Union funding, building national capacity for effective management of mental disorders at the primary health care level. The Osun project led to the adoption by the Federal Ministry of Health of mhGAP as the basis for scaling up mental health services in the country. Consequently, an mhGAP implementation plan was adopted by the National Council of Health and was recently commissioned in the six geopolitical zones;
- Financial and technical support by WHO for staging of national and regional events that brought together policy-makers, partners and other stakeholders to review and make

decisions on priority health interventions, including the Abuja Vaccine Summit in April 2012 and the Abuja +12 Summit of the African Union on HIV/AIDS, Tuberculosis and Malaria in July 2013. The Abuja +12 Summit resulted in renewed commitment of African Union leaders through the declaration Abuja Actions toward the Elimination of HIV and AIDS, Tuberculosis and Malaria in Africa by 2030. The 2013 HIV treatment guidelines were disseminated during that event.

Address the social determinants of health

During the CCS II period, WHO continued to provide support under this priority area in line with its mandate. The WHO focus was on health promotion and its integration into disease control programmes and on supporting the Federal Ministry of Health to promote intersectoral collaboration.

WHO worked in close collaboration with the government and partners to monitor progress in the health MDGs, as well as to provide support for poverty reduction strategies and for priority health programmes on rights-based and gender dimensions. Some of the achievements under this priority area include:

- Integration of health promotion messages into disease control and community health programme activities of WHO at all levels for health services demand creation;
- Development of health education and media campaign messages and their airing on radio and television with WHO support;
- Organization of a quarterly social mobilization meeting for states and its replication at the local government levels.

The absence of technical staff at the WHO country office focusing on this priority area during most of the CCS II period resulted in inadequate implementation of planned interventions.

Improve partnership coordination and resource mobilization

WHO supported the Federal Ministry of Health in improving partnerships and their coordination in the health sector, based on NSHDP requirements, to ensure that collaborative mechanisms are put in place for involving all partners in the development and sustenance of health sector programmes. WHO focused on promoting the principles of international partnership and aid effectiveness as recommended in the Paris Declaration, IHP+ and other related initiatives such as Harmonization for Health in Africa.

Technical support was provided to the Federal Ministry of Health and partners to review health sector coordination mechanisms and to facilitate partners' fora that meet regularly to share experiences and make joint decisions in support of the health development agenda. The Development Partners Group and HPCC are examples of such fora. Moreover, given its mandate and comparative advantage, WHO continued to play an active role in the UN country team and in implementation and evaluation of UNDAF II. WHO was involved in the development of UNDAF III, which commenced in 2014.

As part of its advocacy role, WHO supported the government and relevant institutions at all levels in conducting situational analyses and in generating and using evidence on the burden of disease to

facilitate partnerships with the GAVI Alliance, GFATM, the Bill & Melinda Gates Foundation and others. These partnerships increased resources and expanded priority interventions such as polio eradication and combating of HIV/AIDS, TB and malaria, as well as strengthening the health system. The key achievements under this priority area include:

- WHO supported, actively participated in and facilitated meetings of bilateral, multilateral, UN and NGO partners, including assuming co-chairing roles and serving as secretariat, working through the Development Partners Group. WHO also participated in and supported HPCC and the National Council of Health. WHO used these fora for sharing information on global strategies and on its resolutions and those of member countries and partners, including the World Health Assembly and the Regional Committee for Africa;
- WHO undertook regular advocacy among policy-makers and key donors to mobilize support for NSHDP implementation and development of the health agenda in the country;
- WHO provided technical support for the generation and use of evidence to develop fundable proposals and to negotiate access to donor funds and other resources required for scaling up priority health interventions;
- The effective communication skills and capacity of WHO technical staff helped increase the resources mobilized by the WHO country office from donors, including the GAVI Alliance, GFATM, the Bill & Melinda Gates Foundation, EU, DFATD, USAID and DFID.

4.6 Facilitating factors, constraints and lessons from CCS II

Major facilitating factors

- The IHP+ Compact signed by partners and the government, which created an enabling environment for WHO's joint work with these parties;
- WHO's comparative advantage of having a close working relationship with the Federal Ministry of Health, state health ministries and partners working in the health sector as well as with the UN country team;
- The recognition of WHO's leadership role in providing technical support to the health sector;
- WHO success in resource mobilization, which enhanced implementation of CCS II; and
- Support from the Intercountry Support Team, the Regional Office for Africa and WHO headquarters, which enabled provision of expanded technical support, bringing both regional and global perspectives to bear on the national initiatives.

Constraints

- Widespread fragmentation of initiatives and programmes;
- Inadequate funding, which compromised implementation of activities for all the five priority areas;
- The insurgency, which was directly responsible for the bomb blast of the UN building in August 2011, killing and wounding staff, shutting down operations for several months and forcing relocation of the country office to a temporary and suboptimal space;

- Insecurity, especially in the northern states of Borno and Yobe, which led to the resurgence of polio and impeded the interruption of polio transmission and implementation of other interventions; and
- Inadequate technical staff support from the WHO country office during the CCS II period, e.g. the unavailability of a health promotion officer and staff required to provide needed support to the government, especially for HIV/AIDS, malaria and the health information system.

Lessons learned

- Inadequate consultation during the development of CCS II may have led to the poor levels of awareness of its programmes observed among both WHO staff and stakeholders;
- WHO needs to ensure that each of the five strategic priority areas of CCS III is given adequate advocacy attention to ensure that appropriate resources can be mobilized to support implementation of the programmes; and
- Technical capacity within the states and the lessons from the Polio Eradication Initiative can be leveraged in scaling up priority interventions in support of the work to achieve universal health coverage.

4.7 Recommendations for WHO action during CCS III

During the stakeholder consultations (Annex 2) recommendations were made for WHO focus during CCS III for Nigeria as follows:

Strengthening health systems within the context of PHC

- Complete the unfinished business from CCS II, that is, engage in advocacy for commitment to implementation of NSHDP at all levels;
- Support strengthening and implementation of accountability frameworks at all levels;
- Support capacity development for joint operational planning using NSHDP and SSHPD at all levels;
- Support national capacity building for use of harmonized health management information systems for evidence-based decision-making at all levels especially at facility and local government levels;
- Support national initiatives on human resources for health aimed at addressing health workforce challenges nationally through the establishment of a national health workforce registry;
- Provide support to ensure availability of quality medicines and medical products, and strengthen the drug regulatory body;
- Support the government to produce a coherent and realistic strategy for health financing in support of the Presidential Declaration on Universal Health Coverage, and engage in dialogue with the government and partners to focus on approaches that are feasible in the Nigerian context.

Addressing the social determinants of health and health promotion

- Support national capacity development on the social determinants of health;
- Continuously share information on best practices on social determinants of health with policy-makers and partners;
- Support incorporation of health promotion in health plans and advocate for the inclusion of health in various sectoral plans;
- Support the development and implementation of government accountability and monitoring frameworks for the social determinants of health;
- Support the government to undertake cost–benefit analyses on investments in social determinants of health;
- Strengthen the capacity at the WHO country office through recruitment of qualified technical staff to support the implementation of priority interventions related to the social determinants of health.

Scaling up evidence-based priority interventions towards universal health coverage

- Continue to support national efforts to interrupt polio transmission and to improve routine immunization;
- Support the country's effort to accelerate achievement of the health-related MDGs;
- Extend the lessons from the Polio Eradication Initiative to maternal, newborn and child health and to support the government's initiative on universal health coverage, focusing on AIDS, TB, malaria, neglected tropical diseases and road traffic accidents;
- Support institutional and individual capacity building using innovative methods that facilitate training of large numbers to meet the needs of the country;
- Support integration of health services and promotion of the concept of primary health care under one roof.

Partnership coordination and resource mobilization

- Support institutionalization of structured stakeholder fora in NSHDP and SSHDPs;
- Conduct evidence-based advocacy to increase awareness on the need for community involvement in and ownership of health interventions included in NSHDP and SSHDP;
- Support advocacy to mobilize local resources to support the implementation of NSHDP and SSHDP, including exploration of local private sector financing options for public health care;
- Support strengthening of the institutional capacity of federal and state health ministries to mobilize resources;
- Support implementation of the National Health Bill.

Linking WHO Nigeria with national, regional and global initiatives

- Support the implementation of regional and global resolutions and initiatives at national and state levels;
- Utilize the presence of WHO staff at the state level to implement regional and global initiatives.

SECTION 5: STRATEGIC AGENDA FOR WHO–NIGERIA COOPERATION

CCS III will focus on the specific elements where WHO contribution may be most beneficial based on its comparative advantage and factoring in Nigeria's socioeconomic development trends and evolving health priorities. Overall, the collaboration will be related to WHO's six core functions:

- providing global health leadership
- setting norms and standards
- shaping the research agenda
- articulating policy options
- providing technical support
- monitoring health trends

The strategic agenda and priorities for CCS III described in this section are supported by an analysis of the country situation as described in sections 1–3 and build upon the results and lessons from CCS II (Section 4). The evidence base for CCS III priorities is reinforced by other relevant analyses among which are the NSHDP mid-term review conducted in 2013 and the country's MDG progress report of 2013. In addition, CCS III priorities consider Nigeria's international commitments as described in the resolutions of the World Health Assembly and the WHO Regional Committee for the Africa. Both the national and WHO capacity have to be considered before embarking on the five proposed strategic objectives summarized below:

- Strengthen health systems within the context of primary health care and universal health coverage;
- Promote health and scale up priority interventions through the life-course;
- Scale up priority interventions for communicable and noncommunicable diseases, towards universal health coverage;
- Scale-up national capacity for preparedness and response to public health emergencies, including polio eradication and crisis management; and
- Promote partnership coordination and resource mobilization in alignment with national, regional and global priorities.

Table 7 provides details on the focus areas for WHO within each strategic objective of CCS III and shows how the objectives are aligned to WHO's twelfth General Programme of Work, NSHDP and UNDAF III.

Table 7: The CCS III strategic agenda

Strategic objective 1: Strengthen health systems based on the primary health care approach	
Focus area	**Strategic approach**
Leadership, governance and stewardship	• Support strengthening of Nigeria's capacity for leadership, governance and stewardship in the health sector to facilitate clear policy direction in health development: - Support leadership and managerial capacities (skills and competencies) development for policy and decision-making at various levels of the health sector; - Provide technical assistance for the review of health sector organizational structures and coordination mechanisms at federal, state and local government levels of the health system and also for partnerships between the various players in the health sector, such as government private partnerships, government civil society partners etc. • Strengthen government capacity to develop and use accountability and regulatory frameworks at all levels of the health system:

5.1. Strategic objective 1: Strengthen health systems based on the primary health care approach	
Focus area	**Strategic approach**
	- Improve the health sector information base and the use of evidence to monitor and enhance performance of the national health systems; - Support the government's regulatory functions, including strengthening capacity for and advocacy on the National Health Bill.
Evidence-based policy formulation and strategic planning in the health sector	• Advocacy and policy dialogue to support Nigeria to develop comprehensive national health policies, strategies and plans: - Facilitate the review, development and implementation of a one-country health strategic plan in line with the IHP+ and development effectiveness principles; - Advocate for and support high-level national and local policy dialogue for health systems development to support universal health coverage. • Strengthen the country's capacity to develop and implement legislative, regulatory and financial frameworks by generation and use of evidence, norms, standards and robust monitoring and evaluation tools: - Provide technical support and strengthen national capacity to (a) monitor and evaluate progress towards UHC, (b) monitor progress in health MDGs and implement the post-2015 development agenda, and (c) design, undertake and report on joint annual and mid-term sector reviews.
People-centred integrated services based on PHC and UHC principles	• Provide policy options, tools and technical support for equitable, people-centred, integrated service delivery and strengthening of public health approaches: - Strengthen capacity of the Federal Ministry of Health and the states to enable adaptation and implementation of the WHO global strategy on integrated people-centred service delivery; - Review and harmonize the minimum integrated package of health care services; - Develop guidelines and institutionalize mechanisms for a functional referral system at all levels of health service provision; and - Promote at national and local levels approaches based on public health principles in order to reduce inequalities, prevent disease, protect health and promote well-being. • Strengthen capacity to enable planning for and implementation of strategies that are in line with WHO's regional and global strategies and guidelines on health workforce, towards achieving UHC, particularly capacity for: - Formulation, review and increased use of evidence-based human resource policies, strategies and plans that also respond to the country's needs; - Transformation and scaling up of heath workforce education and accreditation to increase availability of qualified front-line health workers; - Establishment of a functional human resource information system and a national health workforce registry; - Effective deployment, management and retaining of health workers who have an adequate skills mix, and equitable distribution of the available workers; and - Improved partnerships and coordination for mobilizing sustainable health workforce resources in Nigeria. • Guidelines, tools and technical support for improved patient safety and quality of services, and for patient empowerment: - Support national capacity strengthening needs and raising of the quality and safety of the health services. • Support development and implementation of a health financing strategy that expands

5.1. Strategic objective 1: Strengthen health systems based on the primary health care approach	
Focus area	**Strategic approach**
	financial risk protection for all Nigerians irrespective of their labour force status, by supporting coherent and realistic policies to bring the entire population under financial risk protection, especially the poor and other vulnerable groups: - Support policy, analysis and advocacy to encourage movement towards financing mechanisms that are predominantly funded through compulsory contributions; - Support health authorities to dialogue effectively with finance authorities at all levels of government to align the level of public funding for health with the government's stated commitment to UHC and the Abuja targets, as well as to explore innovative financing approaches; - Support the establishment of functional systems for expenditure tracking, including for national and subnational health accounts.
Access to medicines and health technology and strengthening of regulatory capacity	• Support the development, updating, implementation, monitoring and evaluation of national policies that aim for better access to health technology and to strengthen evidence-based selection and rational use of health technology: - Provide technical assistance to revise and implement national policies for medicines, procurement, management of the supply chain, and pricing of health technology. • Strengthen national regulatory authorities; support development of norms, standards and guidelines for medical products; and ensure quality, safety and efficacy of health technology through prequalification. • Support systems and strategies for improved access to affordable and quality-assured essential medicines at all levels of the health care service.
Health systems information and evidence	• Support comprehensive monitoring of the global, regional and country health situation, trends and determinants using global standards, and provide leadership in new data generation and analysis of health priorities: - Support strategies and capacity building at federal and state levels to ensure that the health information management system is functional and that reliable health data are available; - Promote national and state capacity building for generation, analysis, management and use of health data; and - Support studies, including health facility surveys, for monitoring service availability and use, such as service readiness assessments. • Provide support to develop policy options and tools, to define and promote research priorities and to address priority ethical issues related to public health and research for health: - Review the national health research policy and priorities; - Establish and support a national health research forum. • Build national and institutional capacity for undertaking health sector reform and using research evidence in policy decisions.

5.2. Strategic objective 2: Promote health and scale up priority interventions through the life -course	
Focus area	**Strategic approach**
Contribute to the reduction of maternal, neonatal and child morbidity and mortality rates	Provide technical support for the development and implementation of policies, strategies and plans for integrated maternal, neonatal and child health. • Support the government to increase accessibility to and availability of integrated maternal, neonatal and child health services at all levels of health care.
Build capacity for implementing health-in-all policies and for fostering intersectoral action and social participation to address social determinants of health	• Provide evidence-based information on social determinants of health to help policy-makers in decision-making. • Provide technical support for the development of advocacy kits and information, education and communication materials.
Support the mainstreaming of social determinants of health and health promotion in all programmes	• Facilitate integration of health promotion into disease control and community health programmes. • Facilitate the inclusion of health promotion and social determinants of health in training curricula in schools. • Support the government to develop accountability and monitoring frameworks for social determinants of health. • Support the government to undertake cost–benefit analyses for investments in social determinants of health.
Support the promotion of healthy lifestyles and healthy living	• Support the Federal Ministry of Health in its healthy cities, healthy villages and healthy workplace programmes and health-promoting school initiatives. • Support the health ministry in its promotion of intersectoral collaboration and public–private partnerships, including those involving the civil society, the media and communities in order to improve the use of health services. • Support high level advocacy to increase funding for health interventions and passage of bills that aim to reduce exposure to major risk factors like tobacco • Support the health ministry to develop and implement a national health promotion communication strategy based on the national health promotion policy.
Support inter-sectoral collaboration in addressing social determinants of health	• Support appropriate inter-sectoral action and mechanisms relating to the economic, social, demographic, nutritional, cultural and environmental determinants of health, including climate change. • Work with UN agencies such as UNICEF, the World Food Programme and the Food and Agricultural Organization and other partners to implement requisite food safety and food security interventions, including those aimed at ensuring adequate nutrition, and monitor the progress and impact. • Support institutionalization and strengthening of mechanisms for inter-sectoral interventions on social determinants of health.
Support the promotion of equity and gender mainstreaming	• Support the health dimension of poverty reduction and the rights-based and gender dimensions of priority health programmes. • Support the health sector at all levels to adopt an organization-wide gender equality policy and gender mainstreaming strategies, and advocate for mainstreaming of gender into activities of other ministries and agencies.

5.2. Strategic objective 2: Promote health and scale up priority interventions through the life	
Focus area	**Strategic approach**
Strengthen the capacity of the government to asses health risk and develop and implement policies, strategies and regulations for prevention, mitigation and management of health impacts of environmental risks	• Strengthen the national capacity to assess and manage the health impacts of environmental risks through health impact assessment • Support the strengthening of the national capacity for preparedness for and response to environmental emergencies related to climate, water, sanitation, chemicals, air pollution and radiation. • Support the development of national policies and plans on environmental health and sustainable development. • Convene partners for policy dialogue on improving preparedness for and mitigation and management of health impacts of environmental risks and emergencies.

5.3. Strategic objective 3: Scale up priority interventions for communicable and noncommunicable diseases, towards universal health coverage	
Focus area	**Strategic approach**
Support the government in the prevention and control of HIV/AIDS, TB and malaria in line with international guidelines	• Provide technical and policy support to develop or adapt guidelines for scaling up programmes for the control of HIV/AIDS, TB and malaria. • Provide technical support and build national capacity at all levels for implementation of plans and policies and adoption of standard operating procedures, guidelines and protocols for the management of HIV/AIDS, TB and malaria. • Provide technical support to monitor trends in HIV/AIDS, TB and malaria to achieve the MDG targets and implement post-2015 strategies.
Support the strengthening of national capacity for the control, elimination and eradication of neglected tropical diseases	• Facilitate the development of policy guidelines, plans and budgets at all government levels for the control of neglected tropical diseases • Provide technical support and build capacity for disease mapping, surveillance and monitoring, aiming to reach the disease control, elimination and eradication targets. • Support the implementation and monitoring of the WHO road map for neglected tropical diseases. • Support the building of partnerships for the control of neglected tropical diseases.
Support the updating and implementation of the strategic plan for non-communicable diseases including mental health, in line with global NCD strategy	• Provide technical support for updating and implementing the national strategic plan for chronic NCDs. • Promote prevention of NCDs through diet, physical activity and avoidance of harmful risk factors. • Provide technical support for integration of NCD and mental health services at the primary health care level. • Provide technical support to conduct a comprehensive assessment of the burden of road traffic accidents in Nigeria. • Support the country in the collection, analysis, dissemination and use of national disability data for policy development, programming and monitoring.
Support routine immunization for preventable childhood diseases	• Provide technical support to increase coverage of routine childhood and maternal immunization, including the supplement immunization activities.

5.4. Strategic objective 4: Scale up national capacity for preparedness and response to public health emergencies, including polio eradication and crisis management	
Focus area	**Strategic approach**
Support strengthening of capacity for integrated disease surveillance and response at all levels of the government for effective disease surveillance and response to emergencies, including disaster management	• Provide policy documents and technical guidance to implement integrated disease surveillance and reporting at all levels, including the communities. • Provide technical support to build staff capacity at all levels to carry out routine disease surveillance and respond to emergencies. • Support capacity building for all stakeholders for implementation of the WHO emergency response framework.
Support eradiation of polio and response to epidemic-prone diseases	• Strengthen support for interruption of polio transmission • Provide technical support for surveillance of active acute flaccid paralysis in the country. • Support capacity building for public health laboratories staff to participate in control efforts for epidemic-prone diseases such cholera, Lassa fever, measles and meningitis.

5.5. Strategic objective 5: Promote partnership coordination and resource mobilization in alignment with national, regional and global priorities	
Focus area	**Strategic approach**
Partnership coordination based on the principles of harmonization and aid effectiveness in the **health sector**	• Support the health sector to institutionalize, review and strengthen collaboration mechanisms for involving partners in the development and sustenance of the health sector's policies and strategies: - Support the review of the health sector's coordination mechanisms and structures and provide guidance on partnerships and aid effectiveness, based on guidelines from regional and global initiatives such as IHP+, Harmonization for Health in Africa, Sector Wide Approaches (SWAPs) etc. • Advocate for, facilitate and support partnership forums, including for: - Bilateral and multilateral donors, local and international NGOs, civil society organizations and the private sector; - Coordination of the government and partners, the Health Partners Coordination Committee, the Development Partners' Group, the Interagency Coordination Committee, the Country Coordinating Mechanism, etc. • Common country assessment, UNDAF and joint UN programmes.
Resource mobilization and assistance with monitoring of the impact of health resources on developmental goals	• Work with other partners to continue to support federal and state health ministries in advocacy for increased resources and investment in health from both local and external sources to meet the Abuja Declaration targets: - Support institutional capacity building for federal and state health ministries to develop fundable proposals and mobilize additional resources for priority health programmes from bilateral development partners, GFATM, GAVI Alliance, Bill & Melinda Gates Foundation, etc. • Support generation of evidence on the economic burden of diseases and for assessment of MDG needs, and assist Nigerian policy- and decision-makers in using such evidence for advocacy and negotiation of increases in resources for the attainment of MDG targets, post-2015 agenda goals and UHC targets: - Build capacity in federal and state health ministries for MDG and UHC needs assessment and regular tracking of progress in achievement of health goals. - Support institutionalization of structured mechanisms for implementation of SSHDP and NSHDP:

5.5. Strategic objective 5: Promote partnership coordination and resource mobilization in alignment with national, regional and global priorities	
Focus area	**Strategic approach**
	- Conduct evidence-based advocacy activities to increase awareness on the need for community involvement in and ownership of the health interventions defined in NSHDP and SSHDP; and - Support the role of the private sector in health and explore other domestic financing options for health, to attain UHC. • Develop communication and negotiation skills among key WHO country office technical and administrative staff for effective partnerships and increased resource mobilization.
National capacity to translate, adopt and implement regional and global resolutions on priority health issues, such as resolutions from WHA, regional planning meetings, UN, AU and ECOWAS	• Provide leadership on matters critical to health and engage policy-makers, partners and civil society organizations where joint action is needed to follow up on and implement regional and global resolutions. Support preparation for and active participation of Nigerian government officials in relevant regional and global fora such as the World Health Assembly, the Regional Committee for Africa, and regional planning meetings: - Support the strengthening of government capacity for translating and implementing regional and global health resolutions that require actions by member countries.
Advocacy for Nigeria's involvement in regional and global health diplomacy and policy-making	• Promote engagement of health authorities with other key sectors like the ministries of finance, trade and investment to influence global discourse on key issues like UHC, the post-2015 development agenda, etc.
Capacity building for WHO country office staff to promote and facilitate WHO work in Nigeria	• Take advantage of the presence of WHO staff at federal and state levels to implement regional and global initiatives and also expand WHO support in all priority areas.

Table 8: Linking CCS III strategic priorities with WHO GPW, NSHDP and UNDAF III

CCS III strategic priorities	12th GPW categories	NSHDP priority areas	UNDAF III outcomes
Strengthen the health system based on a primary health care approach	Health systems: • Supporting the strengthening of health systems with a focus on the organization of integrated service delivery; • Financing to achieve universal health coverage; • Strengthening human resources for health; • Health information systems; • Facilitating transfer of technologies; • Promoting access to affordable, quality, safe and efficacious health technologies;	• Leadership and governance; • Service delivery; • Human resources for health; • Health financing; • NHMIS; • Research for health development.	• Strong and well-coordinated health systems; • Capacities strengthened to deal with various issues.

CCS III strategic priorities	12th GPW categories	NSHDP priority areas	UNDAF III outcomes
	• Promoting health systems research.		

Promote health and scale up priority interventions through the life-course	Promoting health through the life-course:
	• Reducing morbidity and mortality and improving health during pregnancy, childbirth, the neonatal period, childhood and adolescence;
	• Improving sexual and reproductive health;
	• Promoting active and healthy ageing, taking into account the need to address determinants of health and internationally agreed development goals, in particular the health-related MDGs.
		Service delivery
		• Community participation and ownership, health promotion and demand creation:
		  • To ensure universal access to an essential package of care;
		  • Increasing access to health care services.
			• Human rights and gender equality;
			• Water Sanitation and Health (WASH);
			• Nutrition;
			• Employment;
			• Protection of the environment.

Scale up priority interventions for communicable and noncommunicable diseases, towards universal health coverage	Communicable diseases: • Reducing the burden of communicable diseases, including HIV/AIDS, tuberculosis, malaria and neglected tropical diseases. Noncommunicable diseases: • Reducing the burden of noncommunicable diseases through health promotion, risk reduction, and prevention, treatment and monitoring of noncommunicable diseases and their risk factors.	Service delivery • Ensure universal access to an essential package of care; • Increase access to health care services; • Improve data collection and transmission; • Utilize research for evidence-based policy.	• Health related MDGs; • Reducing HIV transmission.
Scale up national capacity for preparedness and response to public health emergencies, including polio eradication and crisis management	Preparedness, surveillance and response: • Supporting the preparedness, surveillance and effective response to disease outbreaks and acute public health emergencies, and the effective management of health-related aspects of humanitarian disasters to contribute to health security.	Service delivery	Disaster and emergency responses • Conflict and violence.
Partnership coordination and resource mobilization in alignment with national, regional and global priorities	Greater coherence in global health with WHO leadership: • Enabling different actors to play an active and effective role in contributing to the health of all people; • Organizational leadership and corporate services that are required to maintain the integrity and efficient functioning of WHO.	• Leadership and governance; • Partnerships; • Community participation and ownership.	• National coordination mechanisms and partnerships; • Green technology; • South-South collaboration.

SECTION 6: IMPLEMENTING THE STRATEGIC AGENDA

6.1 Implementation process for CCS III

Despite the substantial health progress in Africa, serious challenges still remain. Nigeria, like other African countries, must be prepared to address the rapidly changing global and regional health needs and the new threats to health. Security matters, cross-boarder migration and associated importation of communicable diseases, climate change and other related trends need to be taken into consideration as WHO moves forward to launch and implement the third country cooperation strategy for Nigeria.

CCS III will be reviewed periodically to accommodate changes and emerging national, regional and global health priorities and approaches. The division of the WHO country office into clusters will aid the implementation of CCS III at the country level. The six clusters are:

- AIDS, TB and malaria
- Disease prevention and control
- Expanded programme on immunization and polio eradication
- Health systems strengthening
- Family and reproductive health and maternal and child health
- Administration and finances

Each cluster is responsible for implementing one or more of the CCS III strategic objectives.

WHO Nigeria has personnel in the Federal Capital Territory and all the 36 states working at Ward, LGA and State levels. Large proportions of personnel are recruited by the Polio Programme and support other key public health interventions such as surveillance and state level outbreak response.

The staffing structure, composition and competencies at the WHO country office will be reviewed from time to time to optimize efficiencies and equip the office for effective implementation of CCS III, giving attention to all priority areas beyond polio eradication. The skills of existing staff will be carefully assessed and where necessary and possible lateral transfers will be effected. The normative functions will be strengthened and efforts made to mobilize additional funding for recruitment of professional staff to support priority areas that currently are either unstaffed or understaffed, including health promotion and health information systems.

CCS III will guide the WHO work in Nigeria at all levels from 2014 to 2019 and support the Federal Ministry of Health to achieve the health goals for the country. CCS III priorities and those of the Twelfth General Programme of Work will be used to guide future workplans.

The responsibilities of the WHO country office will include:

- Disseminating the CCS III document to the Ministry of Health, UN agencies and other partners;
- Using CCS III to guide WHO support to the Ministry of Health of Nigeria;
- Accommodating emerging health issues during the CCS III implementation period;
- Using CCS III priorities to guide the development of the next two biennial workplans; and

- Using CCS III for advocacy and resource mobilization for health in Nigeria.

The strategic priorities of CCS III require a range of technical expertise that is available at the Regional Office for Africa and WHO headquarters. A close working relationship between the country office and relevant technical units at those two locations will add value to the work of WHO in Nigeria. The roles of the Intercountry Support Team (IST) for West Africa, the Regional Office and the headquarters include:

- Circulating the CCS III document and brief among all WHO departments and divisions, and other relevant partners and stakeholders;
- Ensuring that technical interactions between the WHO Nigeria country office and the Nigerian government are consistent and based on CCS III priorities;
- Ensuring that CCS III priorities are used as the basis for the preparation of strategic and operational plans, including budgets and resource allocation; and
- Using CCS III for advocacy and resource mobilization for WHO work in Nigeria.

6.2 Monitoring and evaluation of CCS III

CCS III is a strategic document and not a plan, so it will have no direct indicators or monitoring log frame. Emphasis will be put on aligning the plans of action with the CCS III strategic agenda and on routine monitoring of achievement of indicators in the plan of action using existing tools such as biennial monitoring and annual and biennial evaluation frameworks.

This country cooperation strategy will be executed through three consecutive biennial programme budgets and workplans with a results-based framework for the periods 2014–2015, 2016–2017 and 2018–2019. These plans contain clear indicators and targets for inputs, outputs and outcomes for the identified strategic priorities. WHO will monitor programme implementation using established procedures. Efforts will be made to align the monitoring of the priority programmes with the agreed-upon processes for their oversight, performance and accountability throughout the six years. CCS III monitoring will be aligned with the requirements of the WHO monitoring and evaluation system. The strategic agenda will be used to develop the biennial plans of action, which will be monitored using existing tools for generating semi-annual monitoring reports and annual and biennial evaluation reports. To evaluate its impact, CCS III will undergo a mid-term review in December 2016 after three years of implementation and a final review shortly before the end of the implementation period in December 2019. Monitoring and evaluation will, therefore, play a crucial role in assessing the progress made throughout the six years.

The formative evaluation results will be used to redirect CCS III workplans if necessary. Both the formative and summative evaluations will also assess adherence to the strategic agenda and the similarity of the outcomes with the positive and negative programme results from biennial workplans and office reports. The summative evaluation will provide lessons from the implementation of the CCS. Evaluation will involve both internal and external exercises, and results will be disseminated to the Ministry of Health and partners as well being used to foster effective engagement where appropriate.

The findings and lessons from the mid-term and final evaluations will be used as an input in the development of the next WHO country cooperation strategy for Nigeria and shared with other countries and partners.

Annex 1. Nigeria Key statistics

Table 9: Key statistics from Nigeria WHO CCS at Glance May 2009

Key Statistics	Achievement
Total population (2007)[1]	140 431 000 (male: 71 345; female: 69 086 000)
GDP per capita (2006)[2]	US$ 1852
Life expectancy at birth (2007)[3]	51.9 years
Under-five mortality rate (2007)[3]	*189 per 1000 live births*
Neonatal mortality rate (2004)[3]	47 per 1000 live births
Maternal mortality ratio (2005)[4]	800 per 100 000 live births
Adult (age 15 and older) literacy rate (2006)[2]	71%
HIV prevalence rate (2008) [1]	4.6%
Children (0–5 years) underweight for age (2006)[2]	29 %
Human development index[2]	0.499 (154th out of 179 countries with data)

Sources:

1. National Population Commission
2. UNDP Human Development Report 2008
3. http://uniceforg/infobycountry/nigeriastatistics/html
4. World Health Statistics 2006

Table 10: Key statistics from Nigeria WHO CCS at Glance May 2013

Key Statistics	Achievement
Total population (2012)[1]	171 470 000
GDP per capita (2011)[2]	US$ 2203
Life expectancy at birth (2011)[2]	51.9 years
Under-five mortality rate (2011)[6]	158 per 1000 live births
Neonatal mortality rate (2008)[4]	40 per 1000 live births
Infant mortality rate (2011)[6]	97 per 1000 live births
Maternal mortality ratio (2010)[3]	545 per 100 000 live births
Adult (age 15 and older) literacy rate (2011)[2]	60.8 %
Population with access to improved inking water sources (2011)[6]	58.5%
Population with access to improved sanitation (2011)[6]	31%
HIV prevalence rate (2010)[5]	3.4%
Children (0 -5 years) underweight for age (2008)[4]	23 %
Total expenditure on health as percentage of GDP (2011)[7]	5.3%
General government expenditure on health as percentage of general government expenditure (2011)[7]	7.5%
Human development index (2011)[2]	0.459 (156th out of 187 countries with data)

Sources

1. National Population Commission
2. UNDP Human Development Report 2011
3. FMoH Health Related MDG Report for Nigeria Sept. 2010
4. NDHS 2008
5. National Agency for the Control of AIDS
6. Nigeria Multiple Indicator Cluster Survey 2011 (Main report , NBS, UNICEF, UNFPA April 2013)

Annex 2. CCS III development process

Internal Review

An internal review determined the extent of CCS II implementation and adherence to its priorities and used the relevant achievements, challenges and lessons to inform CCS III. The exercise included desk reviews of biennial workplans and annual and programme reports. A semi-structured matrix survey on the five strategic agenda items was administered among all WHO technical staff for feedback on implementation, achievements, constraints and unfinished business. A total of 182 technical staff from the WHO country office, zonal offices and state offices completed the questionnaire.

External Review

The external component of the CCS II review aimed at assessing stakeholder knowledge and perception of the work of WHO as demonstrated through the implementation of CCS II. Semi-structured questionnaires designed specifically for each category of external stakeholders were administered via interviews conducted between 21 November 2013 and 15 January 2014. Six states, one from each geopolitical zone, were selected for face-to-face interviews. Twenty-eight states received the questionnaire through WHO state coordinators. All the selected states were visited except Borno and Yobe, which due to security challenges sent representatives to Abuja for the interview. Forty-one of the 51 (80%) targeted stakeholders were interviewed and eight of the 28 (28%) states returned completed questionnaires.

One-day retreat

A one-day internal retreat was organized by the WHO country office on 24 January 2014 to present the preliminary results of the internal and external reviews of CCS II and agree on the main findings and recommendations for the stakeholders meeting. The retreat was attended by the WHO Country Representative, the CCS team, cluster leaders and key technical and administrative staff from the country Office selected based on their experience and geographic representation. The suggestions from the meeting were incorporated into the findings.

Stakeholder consultation

A one-day stakeholders' meeting was organized by the WHO country office on 30 January 2014 to share the findings of the external and internal reviews of CCS II. The stakeholders included key officials from the Nigerian Federal Ministry of Health, the National Primary Health Care Agency, Commissioners of health of all 36 states, development partners, the UN country team, the civil society, the media, and the WHO zonal, country and regional offices, and the Intercountry Support Team[33].

During this meeting, participants were randomly assigned to one of five thematic groups to develop recommendations for CCS III based on lessons from CCS II and the emerging national, regional and global health development priorities. Following this comprehensive exercise, the participants' consensus was that the five strategic objectives of CCS II were still relevant for CCS III. As such, the WHO Country Cooperation Strategy 2014–2019 will focus on the same strategic agenda and key priorities as CCS II, which are detailed in sections 4 and 5.

Stakeholders consulted

WHO staff participating in the review included the country office staff, all cluster leaders and state coordinators, who consulted their staff when responding to the questionnaire prepared for the purpose. Virtually all 2345 staff can be considered having been consulted. Table 11 shows the organizations that were represented in the external review of CCS II.

Table 11: Organizations that participated in the external review of CCS-II

Agency	No. of interviewees
Federal Ministry of Health	15
National Primary Health Care Development Agency GAVI Alliance Desk	12
National Agency for Food and Drug Administration and Control (NAFDAC)	14
National Agency for the Control of AIDS (NACA)	1
National Emergency Management Agency (NEMA)	5
National Health Insurance Scheme (NHIS)	3
National Planning Commission (NPC)	1
National Population Commission (NPOPC)	2
National Bureau of Statistics (NBS)	2
MDG office	1
Ministry of Agriculture	1
Federal Road Safety Corporation	1
Federal Ministry of Finance	–
Country Coordination Mechanism	2
EU Delegation	2
Japanese International Corporation Agency	2
DFATD	2
Bill & Melinda Gates Foundation	1
CDC	7
USAID	6
World Bank	1
African Development Bank	–
PATHS 2	5
DFID	1
Save the Children	–
Australian Embassy	–
Clinton's Health Initiative	3
Malaria Consortium	1
UNAIDS	2
UNDP	1
UNICEF	2
UNFPA	7
Nigerian Medical and Dental Council	1
Nigerian Nursing and Midwifery Council	–
Pharmacy Council of Nigeria	–
Community Health Practitioners Practice Board	2
Medical Laboratory Science	
Association for Reproductive and Family Health	2
Society for Family Health	3
Rotary International	–
Enugu Ministry of Health	1
Gombe (could not be visited)	–
Lagos	–
Niger PHC Board	2

Agency	No. of interviewees
Niger MoH Public Health Department	1
Rivers PHC Board	1
Sokoto Ministry of Health **Sokoto PHC Agency** **FOMWAN** **Religious leader**	7 1 2 1
Borno Hon Commissioner for Health **Borno PHC Agency**	1 1
Yobe PHC Management Board	2
FCT Health and Human Services **FCT PHC Board**	3 1
Media AIT ***This Day* Newspaper** **FRCN**	1 1 1
Total	138

Table 12: Participants in the one-day stakeholders' meeting, Abuja 30th January 2014

Name	Organization and Designation	Base location
Rui Gama Vaz	WR, WHO/Nigeria	WHO/Abuja
Eileen Petit-Mshana	HSS Cluster Leader WHO Nigeria	Abuja
Rex Mpazanje	ATM Cluster Leader WHO Nigeria	Abuja
Andrew Mbewe	CAH Cluster Leader, WHO Nigeria	Abuja
Emmanuel Musa	DPC Cluster Leader WHO Nigeria	Abuja
Pascal Mkanda	Team Leader EPI WHO Nigeria	Abuja
Koffi Agblewonu	Budget & Finance Officer WHO Nigeria	Abuja
Lucy Idoko	CCS National Consultant	Abuja
Alieu Wadda	Operational Officer (OO), WHO/Nigeria	WHO/Abuja
Adeniyi Ogundiran	WHO	Abuja
Bola Murele	WHO	Abuja
Joy Ufere	WHO	Abuja
Jeevan Makam	WHO Nigeria - EPI	Abuja
Charity Warigon	WHO Nigeria Communication Officer	Abuja
Anthony Onimisi	WHO Nigeria EPI	Abuja
Mary Stephen	WHO Nigeria NCD	Abuja
Ogori Taylor	WHO Nigeria, EDM	Abuja
Taiwo Oyelade	WHO Nigeria, RH	Abuja
Stephen Nurse-Findlay	WHO Nigeria, RHMNCH	WHO/Abuja
Ayodele Awe	WHO TB Programme	Abuja
Omar Sam	WHO, IST/WA	Ougadougou
S. Abdullahi	WHO/Coordinator/NWZ	Kano
Onyibe Rosemary	WHO/Zonal Coordinator	Enugu
Fadinding Manneh	WHO/Zonal Coordinator	Minna
A. I. Ningi	WHO/Zonal Coordinator ai/NEZ	Bauchi
Igbu Tom	WHO/Zonal Coordinator/SSZ	Port Harcourt
Wapada Balami	Director Family Health, FMoH, Representing Honourable Minister of Health, Professor Onyebuchi Chukwu	FMoH Abuja
U. Bajoga	FCT PHCDB	Abuja

Name	Organization and Designation	Base location
Agalasi Ehigie	FMoH	Abuja
Ekandem A. E.	FMoH	Abuja
Bolaji Oladejo	FMoH	Abuja
Lawal M. O	FMoH	Abuja
Lawal M.M.	FMoH	FCT
Oloyede y. A.	FMoH	FCT
Anyaike Chukwuma	FMoH	FCT
A. O. Etta	FMoH	FCT
Tomowo Faduyile	FMoH CHD	Abuja
Ononose J. V.	FMoH FH	Abuja
Ofaka E. C.	FMoH HAD	Abuja
Segilola Araoye	FMoH NASCP	Abuja
Ibokpum C. O.	FMoH/ Dep Dir.	Abuja
Deborah Odoh	FMoH/Asst Dir HIV/AIDs Div.	FMoH
Omoru A. E.	FMoH/DD MNCH	Abuja
Ajagun David O.	FMoH/DD/ASH	Abuja
U.M. Ene-Obong	FMoH/Dir Climate Change (Repres.)	Abuja
Tinvola Taylor	FMoH/Director	Abuja
Adeniran	FMoH/FHD/Head RH	Abuja
O. J Alaka	FMoH/HRH	Abuja
Franca Okafor	FMoH/NASCP	Abuja
Ima John Dada	FMoH/NASCP	Abuja
Ombugadu O. B. Adiah	FMoH/NASCP	Abuja
W. I. Balami	FMoH/Representative of HMH	Abuja
Edward Ihejirika	HC SMoH ImoState	Owerri
Aderemi Azeez	Head HMIS FMoH	Abuja
Shakuri Kadiri	Head of Unit HRH/FMoH	Abuja
Emem Abose Bassey	MoH	Akwa Ibom
Eghe Ase	MoH	Benin
Orduen Abunka	MoH	Benue
Butawa Nuhu	MoH	Kaduna
Babale U. Yanru	MoH	Kebbbi
Kayode Ogunniyi	MoH	Oshogbo/Osun
Okeji A. C.	MoH	Owerri
Oliver Wubon	MoH	Taraba
Mohammed Kabiru Janya	MoH	Zamfara
Douiye Aganaba	MoH (Rep of Hon.Commissioner)	Bayelsa
Abaita Emmanuel	NASCP/FMoH	Abuja
Francis Onyeangbule		Imo
C. J. Okoye	Anambra HCH	Awka
Fabusinwa Festus	Director PHC	Akure
Ossai P. O.	DPHS/Rep of HC	Enugu

Name	Organization and Designation	Base location
Tafida A	HC Jigawa	Dutse
Mustapha Abdullahi I.	Hon. State Commissioner of Health	Kwara
Ibrahim B. Sule	Hon. State Commissioner of Health	Minna
O. Soyinka	Hon. State Commissioner of Health	Ogun
Salma Anas-Kolo	Hon. State Commissioner of Health	Borno
E. A. Akabe	Hon. State Commissioner of Health	Nasarawa
Tanimola Latifah M.	Lagos State MoH, RHO	LAGOS
Tosin Oso	MoH Ado-Ekiti	Ado-E / Lokoja
R. Alhasan	MoH Sokoto	Sokoto
O. S. Ogah	MoH Umahia	Umuchi
Ado Zakari	MoH/DPH	Kaduna
N. V. Onyekwere	MoH/Rep of the HC	Rivers
Aliyu Yabaga Shehu	NIGER SOHCDA	Niger
Mohammed Bello Mustapha	PHDA/DPHC	Bauchi
Abubakar M. Feteh	SMoH Bauchi	Bauchi
Ma Awuya Aliu	SPHCDA	Katsina
Shahu Usman Abdullahi	SPHCMB ES	Abuja
Muhammad Lawan Gana	Yobe S MoH	Damaturu
S. A. Bennibor	Community Health Practitioners Registration Board of Nigeria	Abuja
Ohenmwen Dickson Ehima	DFH Office	Abuja
Ayeke Anthony	EU/Health Advisor	Abuja
Jinga Felicity	FHOM PMLS	Abuja
A. S. Iyamah	FRSC	Abuja
Chie Shin Opara	JICA	FCT
Kolawole Maxwell	Malaria Consortium/ Country Director	Abuja
Anthony Emerise	MLSCN	Abuja
Adaola Awosike	NACA	Abuja
Ali Ibrahim	NAFDAC	Abuja
Kenneth Onu	NAFDAC/Tech Services	Abuja
Oni, O. O.	National. Population. Commission./Dir.	Abuja
I. A. Jegede Abiya	NIPRO	Abuja
P. E. Uhomoihai	NMEP Director	Abuja
Dapo Oyewole	NPC	Abuja
Daughter Sample	Nursing & Midwifery Council	Abuja
Anthony Idoko	PCN	Abuja
A. William	Save the Children	Abuja
Chukwumalu Kingsley	SC	Abuja
Koffi Kouane	UNFPA	Abuja
Adelakin	UNFPA/NPO	Abuja
Ndel Chisaka	World Bank	Abuja

MEDIA		
Name	**Organization**	**Location Base**
Lawal Mohammed	Kapital FM	Abuja
Abiemiowense Moru	NAN	Abuja
Bamalli Abbas	Peoples Daily	Abuja
Winifred Ogbeso	Leadership	Abuja
Aisha Uba A. I.	NTA News24	Abuja
Nurudeen Muhammed	Daily Trust	Abuja
Modupe Aduloju	FRCN	Abuja
Vincent Ikuomola	The Nation	Abuja
Paul Obi	THISDAY	Abuja
Rafatu Salami	VON	Abuja
Grace Edet	Aso Radio	Abuja
Sheila Obi	AIT	Abuja
Binta Bukar	AIT	Abuja

Annex 3: CCS team and other contributors

The CCS review team was formulated by the WHO Country Representative in consultation with cluster leaders and programme managers. The main team consisted of members from the WHO Country Office in Nigeria, representing each cluster or programme, and one national consultant. In addition, co-opted members included officials and staff from the WHO Intra-Country Support Team for West Africa, WHO Regional Office for Africa CCS Steering Group, as well as WHO Head Quarters Department of Country Cooperation and Collaboration with the UN System. Federal Ministry of Health inputs were coordinated by the Directorate of Health Planning Research and Statistic (DHPR/FMoH). Inputs were also received from the State Ministries of Health, health development partners and other stakeholders as shown in tables 11 and 12. Key CCS team members are listed below.

WHO country office CCS Team Members

- Rui Gama Vaz, WHO Country Representative (CCS team chair and leader)
- Eileen Petit-Mshana, HSS adviser and cluster leader (CCS team coordinator)
- Stephen Nurse-Findlay, Technical Officer, Maternal Newborn and Child Health (deputy team coordinator)
- Anthony Onimisi, NPO/EPI (representing EPI/PEI team)
- Mary Stephens, NPO/NCD (representing DPC team)
- Phillips Patrobas, NPO/TUB (representing the AIDS, TB and malaria cluster)
- Oleji Oba, Programme Assistant, Health Systems Strengthening
- Paul Idehen, Assistant, CCS team
- Lucy Idoko, Consultant for CCS external review

Other WHO colleagues who provided technical inpus and commented on the CCS III draft:

- Chris Ngenda Mwikisa, Coordinator, AF/RGO/ORD/CAS
- Rufaro Chatora, CCS Steering Group, Regional Office for Africa
- Patrick C. Kabore, Technical Officer (Strategic Planning), AF/RGO/D/PBM
- Sam Omar, IST West Africa, Health Systems Strengthening
- Daniel Lopez Acuna, Director, Department of Country Cooperation and Collaboration with the UN System, WHO headquarters
- Funke Elizabeth Bolujoko, Department of Country Cooperation and Collaboration with the UN System, WHO headquarters
- WHO Nigeria Cluster Leaders and Programme Officers including:
- Rex Mpazanje, Cluster Leader ATM
- Emmanuel Musa, Cluster Leader DPC
- Paschal Mkanda, Team Leader EPI/PEI,
- Andrew Mbewe, Cluster Leader FRH/MNCH,
- Alieu Wadda Head of Operations (OO)
- Ogori Taylor NPO/EDM, HSS Cluster
- Ogochukwu Chukwujekwu NPO/HEC, HSS Cluster
- Koffi Agbblewonu Budget & Finance Officer BFO

- Other WHO Country Office Staff , States and Zonal Coordinators also contributed considerably
- Various other departments at WHO headquarters, including the health financing policy and IHP+ teams.

Federal Ministry of Health was represented by heads of departments and other key officials in the review and stakeholders' meeting coordinated by the Director of Department of Health Planning, Research and Statistics (DHPRS/FMOH) Mrs. Ansa Boco Ogu.

Role of CCS chair and leader

- To provide oversight and leadership for the entire CCS III development process
- To approve all budgets and final documents for the CCS III development effort
- To moderate and chair the debriefing workshop

Role of CCS coordinator (programme manager)

- To provide day-to-day management of the CCS III development process
- To provide leadership for the CCS III writing team
- To assist the chair in running the debriefing workshop

CCS II review team's terms of reference

- Provide oversight and leadership for the entire CCS II review and CCS III development process
- Provide all required logistic and administrative services
- Be familiar with the relevant CCS literature
- Review, compile and analyse data and prepare a report on the internal review findings
- Work with the consultants to develop the external feedback guide
- Review and approve the report on the external review findings
- Develop the agenda and structure for the debriefing workshop
- Develop CCS III as described above

Consultants' terms of reference

- Provide support and key technical inputs to the CCS team
- Be completely conversant with the relevant CCS literature
- Lead the development of the external feedback guide
- Conduct face-to-face interviews with key external informants in the six states and the Federal Capital Territory
- Compile the results of the external review
- Provide technical input for the design and agenda of the debriefing workshop
- Facilitate in the debriefing workshop in collaboration with the WHO Country Representative and the CCS team
- Lead the writing of the CCS II review report after the debriefing workshop
- Lead the compilation of recommendations for CCS III after the debriefing workshop

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