



# THIRD GENERATION COUNTRY COOPERATION STRATEGY

2018 - 2022



FEDERAL REPUBLIC OF NIGERIA



# THIRD GENERATION COUNTRY COOPERATION STRATEGY

**FEDERAL REPUBLIC OF NIGERIA**

2018 - 2022





AFRO Library Cataloguing-in-Publication Data

WHO Country Cooperation Strategy 2018–2022 - 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)

© WHO Regional Office for Africa, 2018

Publications of the World Health Organization enjoy copyright protection in accordance with the provisions of Protocol 2 of the Universal Copyright Convention. All rights reserved. Copies of this publication may be obtained from the Library, WHO Regional Office for Africa, P.O. Box 6, Brazzaville, Republic of Congo (Tel: +4724139100; Fax: +4724139507; E-mail: afrobooks@afro.who.int). Requests for permission to reproduce or translate this publication, whether for sale or for non-commercial distribution, should be sent to the same address. The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement. The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters. All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either express or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization or its Regional Office for Africa be liable for damages arising from its use.

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

MAP OF NIGERIA	05
ACRONYMS	06
PREFACE	07
EXECUTIVE SUMMARY	08
<b>CHAPTER 1: INTRODUCTION</b>	<b>10</b>
1.1 Overview of WHO Policy Framework	10
1.2 Country Policy Framework and WHO Country Cooperation Strategy	11
<b>CHAPTER 2: HEALTH AND DEVELOPMENT SITUATION</b>	<b>12</b>
2.1 Political, Social and Macroeconomic Context	12
2.2 Health Status of the Population (Burden of Disease)	13
2.3 Health Systems Response	15
2.4 Gender, Equity and Human Rights	19
2.5 Development Partners' Environment	20
2.6 Mid Term Review of the WHO Nigeria CCSIII (2014-2019) and Key Achievements.	22
<b>CHAPTER 3: SETTING THE STRATEGIC AGENDA FOR WHO – NIGERIA COOPERATION</b>	<b>26</b>
<b>CHAPTER 4: THE REVISED STRATEGIC AGENDA: Implications for the Secretariat</b>	<b>32</b>
<b>CHAPTER 5: MONITORING AND EVALUATION OF THE REVISED CCS III</b>	<b>35</b>
5.1 Participation in CCS III monitoring and evaluation	35
5.2 Monitoring	35
5.3 Evaluation	36
5.3.1 Mid Term Review	36
5.3.2 Final Evaluation	36

# Map of Nigeria



# Acronyms

AIDS	Acquire Immune Deficiency Syndrome	NHA	National Health Act
BHCPF	Basic Health Care Provision Fund	NHMIS	Nigeria Health Management Information System
CCS	Country Cooperation Strategy	NHRHP	National Human Resources for Health Policy
CSO	Civil Society Organizations	NHRHSP	National Human Resources for Health Strategic Plan
DPG	Development Partners' Group	NPC	National Planning Commission
DPT	Diphtheria Pertussis Tetanus	NPHCDA	National Primary Health Care Development Agency
EPI	Expanded Programme on Immunization	NSHDP II	National Strategic Health Development Plan II
ERGP	Economic Recovery and Growth Plan	NTD	Neglected Tropical Disease
EWARS	Emergency Disease Surveillance System	OOPE	Out-of-Pocket Expenditure
FCT	Federal Capital Territory	OPV	Oral Polio Vaccine
FMoH	Federal Ministry of Health	PEI	Polio Eradication Initiative
GDP	Gross Domestic Product	PHC	Primary Health Care
GPEI	Global Polio Eradication Initiative	PHEOC	Public Health Emergency Operations Centre
GPWI3	Thirteenth General Programme of Work	SDG	Sustainable Development Goals
HIS	Health Information System	SDH	Social Determinants of Health
HIV	Human Immuno-deficiency Virus	SHIS	State Health Insurance Scheme
HPCC	Health Partners Coordination Committee	SOML	Saving One Million Lives
HRH	Human Resources for Health	TB	Tuberculosis
HSS	Health Systems Strengthening	THE	Total Health Expenditure
ICCM	Integrated Community Case Management	UHC	Universal Health Coverage
IDSR	Integrated Disease Surveillance and Response	UN	United Nations
IHP	International Health Partnership	UNDAF	United Nations Development Assistance Framework
IHR	International Health Regulations	UNICEF	United Nations Children's Fund
IMNCH	Integrated Maternal, Newborn and Child Health	UNSDPF	United Nations Sustainable Development Partnership Framework
IPV	Inactivated Polio Vaccine	WCO	WHO Country Office
IST	Intercountry Support Team	WHO	World Health Organization
LGA	Local Government Area	WMHCP	Ward Minimum Health Care Package
MDG	Millennium Development Goal		
MMR	Maternal Mortality Ratio		
MNCH	Maternal, Newborn and Child Health		
MTR	Mid-Term Review		
NCD	Non-communicable Diseases		
NCH	National Council on Health		
NGO	Non-Governmental Organizations		



## Preface

The revised World Health Organization (WHO) Third Generation Country Cooperation Strategy (CCS) crystallizes the major reform agenda adopted by the World Health Assembly with a view to strengthening WHO's capacity and make its deliverables more responsive to country needs. It reflects the WHO's Twelfth General Programme of Work, the Africa Regional Office (AFRO) Transformation Agenda as well as the key principles of the Thirteen 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's Programme Budget. It takes into consideration the role of different partners including non-state actors in providing support to Governments and communities.

The revised Third Generation CCS draws on lessons from the implementation of the first, second and part of the third-generation Country Cooperation Strategies, the country's strategy focus (policies, plans strategies and priorities), and the United Nations Sustainable Development Partnership Framework (UNSDPF). This CCS is also aligned with the global health context and the move towards Universal Health Coverage (UHC); integrating the core principles of alignment, harmonization, and 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), "International Health Partnership Plus" (IHP+) initiatives and the Key Performance Indicators of the AFRO Transformation Agenda (2015-2020), reflecting the policy of decentralization and enhancing the decision-making capacity of Governments to improve the quality and equity of public health programmes.

This document has been revised through a consultative process following the mid-term review and highlights the expectations of the work of WHO Secretariat. In line with the renewed country focus strategy, and the Second National Strategic Health Development Plan (NSHDP II), the CCS is to be used to communicate WHO's support to Nigeria; formulate the WHO country work plan; advocate for and mobilise resources; shape the health dimension of the UNSDPF; and coordinate sustainable partnerships towards UHC in the country.

I commend the efficient and effective leadership role played by the Government of Nigeria in the conduct of this important exercise of revising the CCSIII. I hereby request the entire WHO staff; particularly WHO Country Representative, to double their efforts to ensure effective implementation of the programmes outlined in this document for improved health outcomes that contribute to health and development of Africa.

**Dr Matshidiso Moeti**  
WHO Regional Director for Africa





Nigeria, the most populous country in the African continent, has shown its commitment towards achieving universal health coverage (UHC) through the introduction of the Primary Health Care (PHC) Revitalization Programme in 2016 as its strategic vehicle towards achieving the Health Sustainable Development Goal (SDG) Goal 3. Although the various health indicators have shown slow improvement in recent years;

Nigeria was certified free of indigenous transmission of Guinea Worm in 2013 and transmission of wild poliovirus was curtailed with only four cases of wild poliovirus reported nationwide in 2016. Polio vaccination coverage improved even in security-compromised areas with Nigeria and working very closely with WHO, humanitarian response in the North East, especially the newly liberated areas, has been

<sup>1</sup>WHO: World Malaria Report 2017

<sup>2</sup>WHO: World Health Statistics 2017

<sup>3</sup>WHO: World Health Statistics 2017

## EXECUTIVE SUMMARY

strengthened although success is mitigated by challenges from communicable diseases. The use of insecticide-treated bed nets (ITN) increased from 8% in 2008 to 50% in 2013 while 78.0 million ITNs were delivered in Nigeria between 2014 and 2016. Malaria incidence per 1000 population at risk in 2015 still stood at 380.8; much higher than the African regional average of 244.9 and diarrhoeal diseases, HIV/AIDS and lower respiratory tract infections were among the leading causes of death in 2016. Malnutrition is very common and the prevalence of stunting among children under five years of age from 2005 to 2016 is 32.9%. The increasing burden of non-communicable 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 at 9.1% in 2015 and 17.4% in 2016 respectively while mortality rate attributed to household and ambient air pollution was 99.0 per 100,000 population. Poverty is still pervasive in the country with recent figures indicating that 53.5% of the population lives on less than US\$ 1.90 a day.

Nigeria has embarked on the domestication of the SDGs with various states trying to contextualize the actions, however the pace of progress varies amongst the different states. The achievement of the SDG targets on maternal and child mortality (SDGs 3.1 and 3.2) will require augmented efforts with the most

recent figures for maternal and under-five mortality ratios being 814 (596-1180) per 100 000 live births and 108.8 per 1000 live births, respectively. The Government of Nigeria has commendably taken 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, developing the MNCH quality of care strategy and standards and developing a costed road map for accelerated maternal mortality reduction in six high burden states. Nigeria is equally working towards achieving other health related-SDG targets such as the goals SDG 4.1 and 4.2 on basic education and SDG 17 on global partnership for development.

The priority areas of the revised CCS III focus on the specific elements where WHO's contribution is judged to be the most beneficial, and build upon the results and lessons from the mid-term review of the CCS III. These priority areas, which are based on the GPW13 and aligns with the NSHDP II are summarized below:

#### **I. All Nigerians are covered on essential package of health services**

- Improved access to quality essential health services
- Improved financial risk protection for health towards UHC
- Improved availability of essential medicines, vaccine, diagnostics, devices, and appropriate health technologies for PHC

#### **2. All Nigerians (men, women, children and marginalized or underserved communities) are better protected from public health threats**

- Better protect Nigerians from public health threats
- Reduce the risk and burden of public health emergencies
- All affected Nigerians have access to lifesaving health services

#### **3. All Nigerians enjoy better health and wellbeing**

- Better health and well-being for every Nigerians, ensuring no-one is left behind, by addressing social determinants of health (SDH)
- Reduction of morbidity and mortality from non-communicable diseases (NCD) and underlying risk factors through prevention and treatment
- Health and well-being realized through health in all policies and healthy settings interventions

#### **4. Nigeria has improved integrated and sustainable health information system**

- Strengthen health systems information and evidence generation for effective monitoring of health systems performance in Nigeria

This revised CCS III will be monitored and

reviewed periodically to track implementation progress and accommodate emerging national, regional and global health priorities. Lessons learned during the period of implementation will be appropriately documented and shared.

<sup>4</sup> World Bank: Poverty and Equity Data Portal 2016

<sup>5</sup> WHO: World Health Statistics 2017



## CHAPTER I:

# INTRODUCTION

---

## 1.1 Overview of WHO Policy Framework

The year 2015 saw the introduction of the sustainable development goals (SDG) following the completion of the timeline for the millennium development goals (MDG). The SDG seek to build on the achievements of the MDG and reinforce the improvements on the root causes of the slow progress in some parts of the world. Particularly for health, The 2030 SDG Agenda views health as vital for the future of our world. SDG 3 calls on all stakeholders to "Ensure healthy lives and promote well-being for all at all ages." The World Health Organization (WHO) leads efforts on health in the SDG.

WHO's 13<sup>th</sup> General Programme of Work (GPW 13) is based on the SDG and reiterates the call for action by all countries – low, middle and high income – to cooperate to end all forms of poverty, fight inequalities and tackle climate change while ensuring that no one is left behind. The GPW 13 sets out WHO's strategic direction, provides a framework to measure progress, and outlines how WHO will implement the GPW 13. GPW 13 is structured around three strategic priorities (i.e. what WHO will do) – healthy lives, universal health coverage and health emergencies.

Within the African region, The Transformation Agenda sets a commitment to positive change and acceleration of the implementation of the WHO reform within the African region. The objective of the five-year agenda is to ensure that the WHO remains the primary leader in health development in Africa and the reliable and effective protector of Africa's health stock. The Transformation Agenda has four focus areas, namely: pro-results values, smart technical focus, responsive strategic operations, and effective communications and partnerships.

## 1.2 Country Policy Framework and WHO Country Cooperation Strategy

Nigeria's health sector strategic focus is guided by Vision 20: 2020, the Medium Term Economic Recovery and Growth Plan, and the National Health Act (NHA) that guarantees the right to health of all Nigerians. The National Strategic Health Development Plan II (NSHDP II) provides the health sector medium term implementation roadmap towards the accomplishment of national health policy goals and objectives. The NSHDP II has 5 strategic pillars which are further decomposed into 15 priority areas and strategic objectives.

WHO institutionalized the country cooperation strategy approach in 2000 with the aim 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,
- Use the cooperation strategy process to put into practice new ways of working that strengthen WHO corporate performance at the country level.

In Nigeria, three successive WHO Country Cooperation Strategy (CCS) documents have been developed; CCS I – 2002 to 2007, CCS II – 2008 to 2013, and CCS III – 2014 to 2019. While the third cooperation strategy was developed to cover the period 2014–2019, the emergence of new global, regional and national health priorities necessitated the revision of the current version and extension of the period under consideration leading to a **“revised third cooperation strategy: 2018-2022”**. Specifically, the emerging health priorities include; universal health coverage, health security, equity (leaving no one behind), and promoting health along the life course and ensuring continuum of care.

The revised WHO CCS III (2018-2022) serves three main purposes namely; as

- I. WHO's medium-term strategy in supporting Nigeria through implementation of her national health policy, strategies and plans,
- II. WHO's key instrument in guiding efficient and effective planning, budgeting and resource allocation for WHO's work in and with the country; and
- III. The main instrument for harmonizing WHO's cooperation with the country and other United Nations (UN) agencies and

other United Nations (UN) agencies and development partners through the United Nations Sustainable Development Partnership Framework (UNSDPF) 2018-2022

The revised CCS III is a product of extensive consultation and strategic dialogue across different stakeholders including; Federal Ministry of Health (FMoH), UN and bilateral agencies, civil society and non-governmental organizations (NGO). The consultative process consisted of the following elements, namely:

- Application of a semi-structured interview guide across a cross-section of WHO staff, stakeholders and partners to assess the relevance, responsiveness and the progress made in the CCS III
- Aligning actions for CCS III with those outlined in the key national and global strategic documents. such as;
  - a. UN Country Common Assessment and the UNSDPF 2018–2022 for Nigeria;
  - b. National Health Policy (2016-2021 and NSHDP II (2018-2022) strategic pillars and priority areas;
  - c. WHO biennial plan 2018–2019 and beyond;
  - d. Saving One Million Lives (SOML) Initiative's documents; and
  - e. Priorities of the AFRO Transformation Agenda (2015-2020); the Strategic Priorities of the WHO 13<sup>th</sup> General Programme of Work and other relevant documents.

The key users of the revised WHO CCS III will include WHO, Federal Ministry of Health, government partners in health, and all others who are interested in knowing how WHO will support Nigeria in matters of health.

## CHAPTER 2:

# HEALTH AND DEVELOPMENT SITUATION

## 2.1 Political, Social and Macroeconomic Context

Nigeria had an estimated population of 192 million in 2017, with relatively similar distribution by sex (49% females and 51% males). The population is predominantly young (41.8% younger than 15 years) with only 3.2% being older than 65 years. The life expectancy at birth in 2016 was 54.5 years, an increase of 7.5 years from the value of 47.2 years in 2007. This increase however, is below the World Bank income group average of 66, the regional average of 58 and the global average of 71 years.

Nigeria is a federation with three tiers of Government: Federal, State, and Local Government Areas (LGA). She has 36 States spread across six geo political zones and the Federal Capital Territory (FCT) which is the capital City. There are 774 LGA, and more than 250 ethnic groups speaking over 500 languages with Hausa, Igbo and Yoruba being the dominant dialects. English is Nigeria's official language, while Islam and Christianity are the predominant religions with the three northern zones largely Muslim and the southern zones being predominantly Christians.

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, and more than 60% of total employment.



The rebound in oil prices towards the end of 2017 ushered Nigeria out of recession to register a 0.8% growth in 2017. With the continued upward trend in oil prices, Nigeria is projected to register 2018 GDP growth of 3.5%. There are however, continued strong calls for continued economic diversification and increased investment in human capital in order to anchor the Nigerian economy over the long term. The country's developmental agenda, the Vision 20:2020, is intended to make the country one of the top 20 economies by 2020, guided by the Economic Recovery and

Growth Plan (ERGP) 2017-2021. Income inequality however still remains a major challenge with 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 North East insurgency though weakened remains a challenge. Recent incidents of kidnapping and voluntary return of over 100 school girls is pointing at the insurgency's high residual capacity to

<sup>6</sup>World Health Organization (WHO 2016). World Health Statistics 2016. Monitoring health for the Sustainable Development Goals (SDGs). WHO. Geneva.

continue and maintain a state of insecurity in the region. A humanitarian crisis in Northeast (NE) Nigeria has been ongoing for nine years with the three most-affected states being Borno, Adamawa and Yobe. The region has experienced destruction of public infrastructure, a collapse of livelihoods, widespread displacement. As at November 2017, 1.6 million people remained displaced and 7.7 million people in the 3 states depend on humanitarian assistance for their survival. Though the insurgency is largely weakened, it remains a challenge as there continues to be sporadic attacks.

Through delicate balancing, the country's South Eastern region's agitation for secession and restructuring is so far being contained. Similarly, the Niger Delta insurgency has been contained following resumption of the amnesty programme. The country also continues to experience periodic deadly tribal clashes between pastoralists and farmers in the North-central zone of the country.

## 2.2 Health Status of the Population (Burden of Disease)

Over the years, Nigeria has recorded some improvement in its health indicators. However, the health status of its populace across the life course persist as one of the lowest in the world evidenced by a low life expectancy at birth. Analysis of the health indices reveals regional, rural, socio-economic, gender and sub-population disparities. The country is saddled with the burden of communicable and non-communicable diseases, vaccine preventable diseases, and maternal and child morbidity and mortality. Diseases of public health emergencies such as lassa fever; environmental health diseases and humanitarian crisis are fast becoming significant health problems which constitutes major barriers to the country's achievement of its human development potentials. Poverty, low level of education and unemployment are underlying issues giving rise to the risk factors of child malnutrition, unsafe water, poor sanitation, unsafe sex and household air pollution from solid fuels, which in turn drives mortality and disabilities among the populace<sup>8</sup>.

### Communicable and Non Communicable Diseases.

In Nigeria, 80% of the burden of diseases are due to communicable diseases. The country contributes a significant proportion to the global disease burden bearing the highest, second

highest and fourth highest burden of malaria, HIV/AIDS and Tuberculosis diseases respectively. Despite a decline in the Malaria prevalence rate of 42% in 2010 to 27% in 2015 the disease remains the leading cause of death among the populace especially among children under the age of five. Similarly, Human Immuno-deficiency Virus and Acquire Immune Deficiency Syndrome (HIV/AIDS) which had a decline from a prevalence rate of 3.4 % in 2010 to 3.0 in 2014, remains the third leading cause of death. Females and children remains disproportionately affected as they respectively account for 54% and 7% of the estimated 3.2 million people living with HIV.

At an estimated incidence rate of 219 per 100,000 population and mortality rate of 62 per 100,000 populations (excluding HIV+tuberculosis (TB)), Nigeria remains a high burden country for TB, TB/HIV and multi-drug resistant TB and account for 15% of all missing TB cases. Childhood TB notification rates remains low as only 13% of the estimated TB cases among children were notified in 2017. The prevalence of viral hepatitis diseases is one of the highest in the world at a rate of 11.0% and 2.2% for Hepatitis B and C respectively. The country experiences sporadic outbreaks of Hepatitis A and E. Nigeria reports at least 13 types of neglected tropical diseases (NTD) and accounts for about 50% of the global burden. These diseases which includes onchocerciasis, lymphatic filariasis, trachoma, soil

<sup>8</sup> Nigeria Multiple Indicator Cluster Survey (MICS), 2017

<sup>9</sup> Global burden of diseases, injuries, and risk factors study 2016; Institute for Health Metrics and Evaluation

transmitted helminthiasis, schistosomiasis, yaws, leishmaniasis, leprosy and buruli ulcer are endemic across the states and continues to be a major cause of morbidity and disability especially among poor rural dwellers.

Cancers, diabetes, cardiovascular and chronic respiratory diseases constitute major causes of deaths and illnesses. Mental health issues are beginning to take prominence as suicides, homicides and gender based violence becomes rampant. Tobacco and alcohol use continue being major risk factors for diseases and untimely death.

**Table 1: Top 12 causes of death in 2016 and percent change, 2005 – 2016, all ages, number**

Rank	2005	Rank	2016	Percentage change 2005-2016
1	Malaria	1	Malaria	-15.3%
2	Diarrheal diseases	2	Diarrheal diseases	-33.5%
3	HIV/AIDS	3	HIV/AIDS	-32.0%
4	Lower respiratory infections	4	Lower respiratory infections	-8.3%
5	Neonatal encephalopathy	5	Neonatal encephalopathy	-0.5%
6	Measles	6	Neonatal preterm birth	-2.7%
7	Tuberculosis	7	Ischemic heart disease	7.2%
8	Neonatal preterm birth	8	Congenital defects	15.0%
9	Ischemic heart disease	9	Meningitis	14.0%
10	Congenital defects	10	Neonatal sepsis	7.5%
11	Neonatal sepsis	11	Tuberculosis	-39.0%
12	Meningitis	12	Measles	-82.6%

Source: Global burden of diseases, injuries, and risk factors study 2016; Institute for Health Metrics and Evaluation

### Maternal, Child and Adolescent Health:

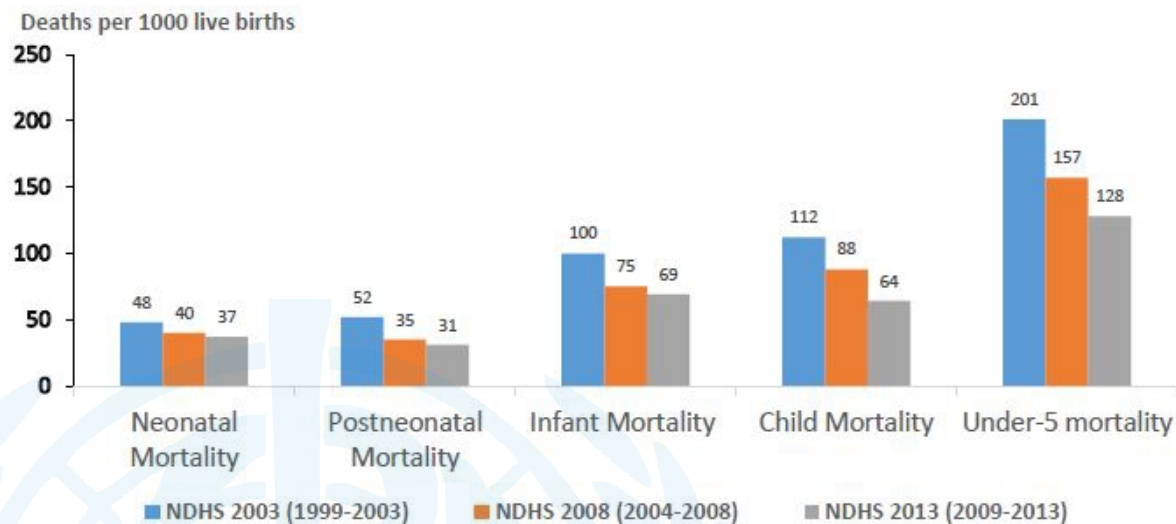
Maternal, infant and under five mortality rates have declined over the years, however at an estimated 33,000 annual maternal deaths and a maternal mortality ratio of 576 per 100,000 live births, maternal deaths due to medical causes such as pre and post-delivery bleeding, obstructed labor, infections and hypertension, remains unacceptably high. These deaths account for 32% of all deaths among women in the reproductive age group. Similarly, infant and under five mortality at a rate of 64 per 1000 live births and 128/1000 live births respectively remains high with diarrhoea diseases, pneumonia, malaria, malnutrition and neonatal illnesses being the most common causes of death. Key interventions coverage for children remains abysmally low with only about one quarter of children aged 12 – 23 months fully immunized. Based on the 2016 National Immunization Coverage Survey the Diphtheria Pertussis Tetanus (DPT) 3 containing antigen cumulative coverage was 33%, ranging from 3% to 80%. Modern contraceptive prevalence rate was 10% and only 38% of women were delivered by skilled birth attendants.

There is meagre information on adolescent health status, however with adolescent health becoming a flagship programme in countries in the region; efforts are being made to improve the health status of this group. Adolescent childbearing rate has been static at 121 per 1,000 live births in 2008 and





## Trends in Early Childhood Mortality 1999-2013



122 per 1,000 live births in 2013 respectively. Likewise, the proportion of young people (15-24 years) that had begun childbearing barely changed from 22.9% in 2008 and 22.4% in 2013.

### Polio Eradication Initiative.

- Nigeria is among the three remaining endemic countries for polio. The last wild polio virus (WPV1) was reported in September 2016 in Borno State. Significant efforts at the international and national level to eradicate polio through the Global Polio Eradication Initiative (GPEI) end game and strategic plan. Supplemental immunization activities and routine immunization intensification activities continue to be implemented to mitigate outbreaks. However recent outbreaks of circulating vaccine derived virus detected in Jigawa and Sokoto with spread to four other states, again underlines the suboptimal population immunity and vulnerability of northern Nigeria populace to poliovirus transmission;

### 2.3 Health Systems Response

Indicators of Nigeria's health outcomes and coverage of basic health services show under-performance as indicated in earlier sections. Revitalization of the health system is vital to achieving desired health outcomes. This will involve revitalisation of the health system to provide equitable services to the population in attainment of UHC in Nigeria.

#### Governance and Stewardship

The health sector in Nigeria is governed along the three tiers of government, federal, state, and local government. Policy and legal frameworks are in place to provide overarching strategic direction including the NHA 2014, National Health Policy 2016 aligned to SDGs, and 2<sup>nd</sup> National Strategic Health Development Plan 2018-2022 (NSHDP II). Policy and strategy documents including guidelines have also been developed in various areas of health such as the Primary Healthcare Under One Roof (PHCUOR), PHC revitalization, HIV/AIDS, Reproductive, Maternal, Neonatal, Child, and Adolescent Health (RMNCAH), Nutrition, etc. Implementation of these policies and guidelines is the mandate of key arms of the ministries of health,



departments, regulatory bodies or agencies. To strengthen harmony and coordination along the tiers of government in health, the National Council on Health (NCH) has been established. This serves as the highest decision making body in Nigeria on health. As development partners are numerous, the Health Partners Coordinating Committee (HPCC) provides a functional coordinating platform. In addition, a strong network of Civil Society Organizations (CSO) exist in Nigeria to mainstream citizens' voice and ensure accountability in health. Despite the existence of the above structures and platforms, the health sector continues to face several challenges such as delayed or poor implementation of policies and plans; suboptimal regulation and standardization of services and practice provided by the public, private sector, including traditional medical practice; weak inter and intra sectoral collaboration leading to programmes fragmentation; and poor management capacity at the frontline of care.

### Health Financing

Health financing is pivotal to the performance of the health system. Government prioritization of health is assessed by its expenditure on health relative to overall expenditure in a given year. From the National Health Account 2010-2016, the total health expenditure to Gross Domestic Product (GDP) ratio was 3.8% in 2016, below UHC benchmark of 4 to 5%. Government health expenditure to total government expenditure increased from 2.8% in 2010 to 5.1% in 2016 but remains far below the Abuja declaration target of 15%. Out-of-pocket

household expenditure (OOPE) was very high at 71.5% of the total health expenditure (THE) in 2016 compared to the UHC benchmark of 30 to 40%. This portends both elevated levels of exposure of households to catastrophic health spending and high welfare losses as more than 99% of OOPE was spent on curative care. Health insurance as a proportion of THE remained very low at 1.5% in 2016 with about 4.4% of Nigerians covered on social and voluntary private insurances. Per-capita THE was \$81 in 2010 rising to \$112 in 2014 before declining to \$77.

To ensure appropriate health financing for UHC in Nigeria effort will be made to strengthen health financing governance, while providing evidence to make a case for improved funding for health. Proper implementation of the Basic Health Care Provision Fund (BHCPF) will support PHC revitalization at the State levels with a potential to increasing the number of Nigerians covered on a basic minimum package of health services. Scaling up insurance coverage through States Health Insurance Schemes (SHIS) will reduce the huge OOPE for health and efficient management of resources can be achieved through performance based financing mechanisms.

### Human Resources for Health

Health workforce densities and skill-mix affect health system performance. Nigeria has one of the highest stock of skilled workers in Africa with a skilled health professional density of 18.3 per 100,000 population from 2005 to 2015 ranging from 50.5 per 100,000 in the Federal Capital Territory to

1.9 per 100,000 in Yobe State. Health worker distribution was skewed towards the south, urban areas and tertiary health care services.

Deployment and retention of health workforce in rural areas remains major challenges, as appropriate incentives to get people to work in rural areas are not in place. A government embargo on employment across the country has compounded the problem further especially in the rural areas. Emigration of skilled workforce is a major problem with the country accounting for about 80% of total health workforce export from Africa.

Government in response revised the NHA 2014, providing the appropriate legislation for HRH development in the country. Additionally, the National Human Resources for Health Policy (NHRHP) 2015, National Human Resources for Health Strategic Plan (NHRHSP) (2016 – 2020) and the National Task Shifting and Task Sharing (TSS) Policy were developed to guide implementation at the national and sub-national levels. In line with the policy provisions, states, are expected to establish human Resources for Health units in their respective ministries of health, however only about one third have done so.

### Health Information

The Nigeria Health Management Information System (NHMIS) has undergone progressive improvements since its inception in 1992 culminating in the development of a policy in 2006. The revised Health Information System (HIS) Policy

<sup>11</sup> FMOH 2017: NHA report 2009 -2016

<sup>12</sup> WHO 2006. The World Health Report 2006: working together for health

provides the framework for comprehensive, inter-sectoral, and integrated structure for collection, collation, storage, analysis, dissemination and use of health data. Subsequent development of the HIS strategic plan (2014-2018) was done to guide implementation of the revised policy. Although a monitoring and evaluation framework was developed 2012 to track the implementation of the first National Strategic Health Development Plan, it was only partially implemented due to the absence of an investment plan. There has been a general dissatisfaction from stakeholders about poor performance of the NHMIS and its inability to provide comprehensive good quality health information when needed to guide evidence-based decisions. Systems for periodic reviews and feedback on health sector performance are functioning sub-optimally at all levels and thus health information is not routinely used for programme planning and decision-making at all levels.

### **Essential medicines and technology**

Availability of affordable good quality drugs and products increases the credibility of any health system.

Some challenges have hindered effective health products management & supply chain in Nigeria. These have included weak capacity at sub-national levels to leverage on the existing national policies and guidelines, lack of transparency and accountability in commodities utilization; inefficient supply chain system; limited skilled personnel at all levels of the supply chain and lack of effective control

systems with indiscriminate influx of donated medicines, vaccines and other technologies leading to expiries and wastages.

In accordance with the SOML launched in October 2012, the 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.

Various strategies have been developed towards pharmaceutical development including the establishment of the National Institute for Pharmaceutical Research and Development; the National Agency for Food and Drug Administration and Control (NAFDAC) providing appropriate guidelines and regulations; attainment of WHO Good Manufacturing Practices certification of four Nigerian Pharmaceutical companies; establishment of the National Product Supply Chain Management Programme ; ratification of the National Quality Assurance Policy for Medicines and other Health Products (2016) and the Nigeria Supply Chain Policy for Pharmaceuticals and other Healthcare Products (2016).

### **Service Delivery**

The Federal Government of Nigeria has selected PHC revitalization as one of its recovery pillars in attaining UHC and enhancing access to quality health services by the population. Government seeks to holistically implement the Ward Minimum Health Care Package (WMHCP). The WMHCP consist of 6 interventions; (1) control of communicable diseases

(malaria, sexually transmitted infections, HIV/AIDS), (2) child survival, (3) maternal and new-born Care, (4) nutrition, (5) non-communicable diseases prevention, (6) health education and community mobilization. Subsequently the Minimum Standard for Primary Health Care in Nigeria which defined standards for health infrastructure, human resource for health and service provisions was developed.

The challenges to a well-functioning PHC is worse in North East Nigeria due to insurgency which has caused widespread devastation which has endangered and partially reversed the modest gains made in the recent past toward improving maternal, new born and child health services. Nigeria intends to improve on her health indicators through adequate service delivery by: (i) implementing an integrated people centred health service delivery model; (ii) institute acceptable norms and standards quality of care; (iii) design an effective facility-community interface; and (iv) review and establish an appropriate referral system anchored by functional secondary and tertiary facilities.



## 2.4. Gender, Equity and Human Rights

The impact of Nigeria's efforts to improve the health status of its populace across the life course is further limited by the prevalence of regional, socio-economic, gender and sub-population disparities. Several initiatives were launched over the past years to reduce those inequities. This included increasing focus on PHC, strengthening community action and promoting the concept of ward development committees. Nonetheless, Nigeria's health indices show the persistence of wide gaps in access to health care services and coverage across the zones and states of the federation, between rural and urban areas and by educational, social status and gender. Promoting gender equality, equity and human rights-based approaches to health is critical to effectively address those barriers and ensure the health and well-being of all Nigerians.

### Gender

With only 15% of Nigerian women owning a house or land (40% for men), 49.7% of adult females being literate (69.2% for males), and 36% of Nigerian women in the adult workforce, Nigeria ranks 152 out of 188 countries on the gender-related development index.<sup>14</sup>

These gender inequalities and the related socio-cultural determinants that influence it have an important impact of the health conditions women and their children are susceptible to. In 2013, the

under-five mortality among children born to mothers with no education (180 deaths per 1,000 live births) was almost twice that of children born to mothers with secondary education (91 deaths per 1,000 live births) and three times that of children born to mothers with more than secondary education (62 deaths per 1,000 live births)<sup>12</sup>. Those gender determinants also influence access to and uptake of health services. For instance, immunization coverage was shown to increase with mother's education; 64% of children whose mothers have more than secondary education were fully vaccinated, compared with 7% of children whose mothers have no education. Sociocultural barriers such as the need to seek permission from gatekeepers result in more than 50% of the Nigerian women having problems accessing health care for themselves while only about 40% of married women participate in decisions about their own health<sup>12</sup>.

This situation is worsened by the prevalence of gender based violence with nearly 30% of women having experienced physical violence since age 15. Additionally, in the context of the humanitarian crisis in the North East, 40,000 people are estimated to be at risk of sexual violence in 2018 and will require clinical management of rape services.

The capacity of Nigeria to address this gender gap and empower women in taking control of their health is hampered by the limited role women play in shaping those policies in the first place. As of 2017, Nigerian women held less than 6% of the seats in national parliaments with Nigeria ranking as the

176th country in the world in terms of female representation in the parliaments.

### Equity

In addition to gender inequalities, Nigeria's health indices show the persistence of broader inequities in access to health care services and health outcomes across the country. Data notably shows gross regional inequities in maternal mortality with rate of North East and North West zones of the country being almost 10 and 6 times higher than that of the South West zone of the country (the zone with the lowest rate) respectively. Similar fluctuations are noted in relation to early childhood mortality with rates in the North West zone of the country (83 deaths per 1,000 children) being four times higher than in the South South (21 deaths per 1,000 children).

In addition to regional inequities, those discrepancies in health indices are also influenced by inequalities in health between rural and urban settings. Knowledge about HIV is higher among women and men in urban areas (64% and 77% respectively) than in rural areas (47% and 64%). While more than 60% of births occur at home nationally, home births are more common in rural areas (77%) than urban areas (37%)<sup>12</sup>. This illustrates the important fluctuations in health seeking behavior, uptake of modern health practices and access to care by place of residence.

Differences in fertility and attendance of skilled attendants at birth also show the impact of the

education and economic determinants. Fertility increases as the wealth of the respondent's household decreases. Women from the poorest households, in general, have three children more than women who live in the wealthiest households (7.0 versus 3.9 children per woman)<sup>12</sup>. Skilled birth attendance was more than 4 times higher among women with a high level of education (92%) than with no education (22%), and 7 times higher among the richest women (84%) than the poorest (12%)<sup>17</sup>.

### Human Rights

These gender inequities and inequalities affect the rights of Nigerians to the highest attainable standard of health. More particularly, it deters their right to control their own health through a system of health protection that gives everyone an equal opportunity.

This is compounded by the current humanitarian crisis in the North-east and the related insurgency that affect the health of more than 6.9 million people. Of these, 5.4 million people are the most vulnerable and in need of humanitarian life-saving and life-sustaining health services in 2018. This includes internally displaced populations, children under 5, females of reproductive health age, the elderly and the host community population under the poverty level. This population remains at significant risk of epidemic-prone diseases. In addition to malaria, respiratory infections and watery diarrhea are the two other leading causes of illness among internally displaced populations along with severe acute

malnutrition. Reproductive, maternal, new-born, child and adolescent health are also particular challenges with approx. 320,000 live births and 50,000 women facing pregnancy-related complications and requiring emergency obstetric care services expected within 12 months<sup>14</sup>.

## 2.5 Development Partners' Environment

### 2.5.1 Partnership and development cooperation

Nigeria is a signatory to the various global and regional declarations relating to aid effectiveness and harmonization. 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.

The NSHDP II is fully compliant with the principles of the Paris Declaration on Aid Effectiveness and the International Health Partnership Plus and has created an enabling environment for the FMOH to collaborate with the many development partners in the health sector.

Development partners demonstrated their commitment to support the implementation of the NSHDP II through the signing of the Country Compact. These partners operate in many states and work in diverse areas of health.

### Aid coordination and effectiveness

The National Planning Commission is responsible for coordinating all development assistance in

Nigeria. Several stakeholder groups support the planning commission in achievement of its mandate namely;

- **The NCH**, chaired by the Minister of Health, and with the membership of Commissioners of Health from all the states and the Federal Capital Territory is the highest health sector coordinating body in Nigeria.
- **HPCC**, chaired by the Minister of Health, 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 FMOH NGO and development partners.
- **The Development Partners in Health Group (DPG/DPH)** functions as the technical arm of HPCC.

WHO actively participates in the these and other disease specific coordinating groups exist such as 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 and the SOML Steering Committee.

The existence of these numerous and sometimes overlapping coordination platforms makes it difficult to clearly delineate the role of each, which further stifles coordination and encourages intense inter- and intra-agency competition for information and the scarce resources.

### **2.5.2 Collaboration with the United Nations system at country level**

There are 18 UN organizations in Nigeria. The United Nations Development Assistance Framework (UNDAF) is the strategic structure for the collective work of the UN system in responding to national development priorities. The UN System, in collaboration with the government recently developed the UNSDPF which serves as a collective support and response of the UN System to the national development initiatives of the Government regarding the ERGP, the SDG, and other internationally agreed declarations.

Its implementation is aligned with the planning cycle of the second National Implementation Plan of Nigeria's Vision 20:2020 and, as such, with the priorities of NSHDP II. The UNSDPF aims 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. UNSDPF (2018-2022) focuses on three results areas: governance, human rights, Peace and Security; Equitable Quality Basic Services and Sustainable and Inclusive Growth & Development. WHO actively participated in the development of UNSDPF 2018-2022 and has ensured inclusion of UNSDPF priorities in the revised CCS III. WHO is the leading UN Agency in the implementation of the UNSDPF 2018-2022 in Bauchi State and will contribute specifically to outcomes 3, 4, 5 and 6 under “Equitable Quality Basic Services” and outcome 2 under “Governance, Human Rights, Peace & Security” results areas.

### **2.5.3 Nigeria's contribution to the global health agenda**

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

Like many other African countries, Nigeria is already making progress in the implementation of the SDG by domesticating the goals, mainstreaming the targets into the national, state and LGA plans and also developing an accountability framework for effective monitoring and reporting the implementation and attainment of the targets.

Similar to many African countries, Nigeria's level of investment in health remains low despite being endowed with vast resources. The 2011 per capita expenditure on health (US\$ at average exchange rate) was US \$85, with countries ranging from US\$ 12 in Eritrea to US\$ 404 in Botswana. More investment in health will be required to address health challenges for better outcomes.



## 2.6. Mid-Term Review of the WHO Nigeria CCSIII (2014-2019) and Key Achievements.

### Development Process Ownership and Use

The development of the CCSIII followed a participatory approach with wide stakeholder consultations and input from both Federal and State levels, agencies, development partners, NGO, the media and within all levels of WHO. The use of the document was immediate within the WHO country office, with update of the 2014/2015 biennial work plans and use of the third CCSIII agenda to inform the 2016/2017 and the 2018/2019 programme budgets and work plans.

Consultations during the mid-term review of the CCSIII however noted a limited level of knowledge of the document and its contents both internally within WHO and externally among WHO's partners.

Within WHO, majority of the staff with the exception of the cluster leads had minimal awareness of or appreciation of the importance of it. It was rather largely considered as HSS cluster's document, which was only used during the biennium planning.

Externally, awareness was equally low especially among the ministries of health and donors. This is despite the CCS's participatory development process, official launching and extensive dissemination in 2014. This low awareness could

especially among the donor community, who usually serve in a duty station for a short and fixed period of time.

WHO's visibility and pro-active interventions within the health sector have been mostly noticed by partners in disease control measures cum containment of public health emergencies such as polio, ebola, meningitis, cholera, tuberculosis, HIV/AIDS and malaria as well as in MNCH.

### Alignment with Current National, Regional and Global Health Development Frameworks

The CCS agenda was informed by key national and international documents at the time such as the UNDAF II (2009-2012), the NSHDP I (2010-2015), the MDGs and the Strategic Objectives of the WHO Medium Term Strategic Plan (2008-2013). As such, all the strategic priorities, focus areas and strategic approaches defined during the third CCS process were found to be still relevant to the health needs of the Nigerian population and consistent with the principles and priorities of the above documents.

### Progress and Achievements.

The progress attained in the implementation of the CCS agenda was ranked during the internal review exercise on a Scale of 0 to 5 (0-Not started; 1-Far Behind; 2-Behind; 3-As anticipated; 4-Advanced; 5-Completed). The table below highlights implementation progress of the 3<sup>rd</sup> CCS.

**Table 2: CCS III Implementation progress**

Status	Number	Percentage
Not started	1	4%
Far behind	2	9%
Behind	5	22%
Normal progress	12	52%
Advanced	3	13%
Completed	0	0%
<b>Total</b>	<b>23</b>	<b>100%</b>

Majority (52%) of the priority areas were progressing normally though none was completed and 8 (35%) were either behind, far behind or not started.

Some key achievements recorded by the country office under each of the Strategic priorities include:

### Strategic priority I: Strengthening the Health System based on the PHC approach

Facilitation of the renewal/development of key national policies, strategies and guidelines (NHP, BHCPE, NSHDP, ask shifting policy and plans, Essential Drug List, Health Policy and Finance Strategy), Development of National Health Accounts 2006-2016, accreditation of nine training institutions to produce additional frontline health workforce (approx. 1,000) and staff audit for two states; Preparation of National Agency for Food Administration and Control laboratory towards WHO prequalification and development of country's Anti-microbial Resistance Plan, Strengthening laboratory services network, health and human resource information systems.



### Strategic Priority 2: Promoting health and scale up priority interventions through the life-course.

Harmonization of RMNCH, Adolescent Health and Nutrition Strategy with the National Health Policy and NSHDP II, Development of MNCH quality of care strategy and standards, Update of training materials for key child survival interventions (essential newborn care, integrated management of childhood illnesses and integrated community case management) ICCM).

### Strategic Priority 3: Scaling up evidence-based priority interventions for communicable and non-communicable diseases towards UHC

Provision of technical and resource mobilization support for the prevention, control and management of HIV/AIDS, malaria burden re-estimation, implementation of North east malaria control and support towards implementation of iCCM in two states, adaptation of WHO End TB strategy (plans & tools), directly observed treatments expansion, mapping of NTD burden in LGAs, supply of NTD mass drug administration drugs, national viral hepatitis strategic plan, state funded plans. Introduction of new vaccines (pneumococcal vaccine and Inactivated Poliovirus Vaccine ) nationally, and implementation of accelerated disease control initiatives for measles elimination, yellow fever control and maternal and neonatal Tetanus Elimination through supplementary immunization activities of national and sub national scope.

Strategic priority 4: Scaling up national capacity for preparedness for and response to public health emergencies including polio eradication and crisis management

Establishment and operationalization of the Emergency Disease Surveillance System (EWARS) and the Public Health Emergency Operations Centre (PHEOC) and coordination of 22 health sector partners. Strengthening integrated disease surveillance response, outbreak preparedness and response to key public health emergencies such as lassa fever, cholera, ebola and meningitis while training/engagement of 113 mobile health teams across 3 North east focus states for provision of basic health services in hard to reach areas as well as 780 community oriented resource persons to provide iCCM interventions in communities to children under five years while providing supplies and medicines to nutrition stabilization centres for treatment of estimated 400,000 severe acute malnourished children and conducting IHR Joint external evaluation; cholera, meningitis, monkeypox and lassa fever after action reviews.

Facilitation of robust outbreak response activities and several polio supplementary immunization activities with varying scopes synchronized with other countries for greater impact; expanded environmental surveillance from three to 18 states plus FCT; Establishment of polio transit vaccination sites (in markets, motor parks, border points), implementation of innovative mechanisms to

immunise children in insecure settlements; implementation of innovative monitoring and surveillance using mobile technology; use of polio infrastructure to support broader disease surveillance and outbreak response.

### Strategic Priority 5: Promoting partnership coordination and resource mobilization in alignment with national, regional and global priorities.

Provision of technical support to country to mobilize resources for HIV/AIDS, TB and Malaria control through the GFATM, resource mobilisation for polio eradication while giving support to the FMoH to coordinate partner activities through the HPCC and participation in sectoral coordinating committees.

### Distribution of Resources to CCS III Strategic Priorities (2014 -2017)

Table 7 shows that about 83% of the \$676.5million in contributions available to the WHO country office between 2014-2017 were spent on only one of the five strategic priorities (3.4) which is on scaling up national capacity for preparedness and response to public health emergencies including polio eradication and crisis management, nearly all of this was spent on polio eradication majority (83%) of the 681 country office personnel were allocated

The improved allocation in the program budget of

29% of the \$259.8 million to all the other four strategic priorities including the non-communicable diseases and health emergencies in the 2018/2019 biennium is commendable. It is also hoped that some of the WCO's polio capacity will be transitioned towards these other four strategic priorities in the 2018/2019 biennium and beyond to enhance the implementation of the revised CCS III strategic agenda, particularly the health system strengthening.

**Table 3: Proportion of human and financial resources to CCS III strategic priorities**

CCS Strategic Priorities	Cluster/ Category	2014-2017		2018-2019
		Percentage of Sum of Total Funding Available \$	Percentage allocated of human resources	% of Allocated Program Budget \$
<b>3.1 Facilitating the achievement of Universal Health Coverage through a revitalised primary health care approach and sustainable service delivery through strengthening of health system.</b>	HSS	2.5%	1.5%	4.9%
<b>3.2. Promoting health and scale up priority interventions through the life-course.</b>	RH	2.3%	0.6%	4.2%
<b>3.3. Scaling up evidence-based priority interventions for communicable and non-communicable diseases towards universal health coverage.</b>	CND	11.4%	4.1%	17.0%
<b>3.4 Scaling up national capacity for preparedness for and response to public health emergencies including polio eradication and crisis management</b>	EPI	82.9%	82.7%	71.0%
	WHE	0.3%	8.5%	2.1%
<b>3.5 Promoting partnership coordination and resource mobilization in alignment with national, regional and global priorities.</b>	WR's Office	0.9%	2.6%	0.9%

Suggested focus areas for WHO from partners WHO was urged to:

- Be bold and less diplomatic in promoting the establishment of a peer-review mechanism of the Nigeria health sector with only about 10 objectively selected standard indicators that have ripple effects which would be monitored combined with benchmarking of services for communicating performance on a regular basis to inform the population about the status of the health delivery services and health outcomes.
- Proactively engage in high level evidence-based advocacies at Federal and state level with the bigger picture of health in mind to mobilize political support and material resources for health.
- Undertake a systematic sharing of international best practices on different aspects of health with ministries of health at national and sub-national levels for improved performance.
- Actively promote multi-sectoral approach to health, focusing particularly on mainstreaming health into all policies within the context of the SDG.
- Proactively promote partnership for health to reduce fragmentation and promote mutual accountability as well as strengthen the capacity of national and state ministries of health to effectively engage partners through guidelines and establishment of donor mapping at state and federal levels.



## CHAPTER 3: SETTING THE STRATEGIC AGENDA FOR WHO–NIGERIA COOPERATION

This chapter focuses on the specific elements where WHO contribution may be most beneficial, factoring in Nigeria's socioeconomic development trends, environmental conditions and evolving health priorities and assists in addressing the country's developmental and humanitarian challenges, leveraging on WHO's leadership and comparative advantages. Overall, the collaboration will be related to WHO's six core functions which are: 1. Providing global health leadership; 2. Setting norms and Standards; 3. Shaping the research agenda; 4. Articulating policy options; 5. providing technical support and 6. Monitoring health trends.

The priority areas of the CCS III described in this chapter are supported by an analysis of the country situation as described in chapters 1 and 2 and build upon the results and lessons from the Mid-term review of the CCS III (Chapter 2). These priority areas, which are based on the GPW13 and aligns with the NSHDP II are summarized below:

- All Nigerians are covered on essential package of health services
- All Nigerians (men, women, children and marginalized or underserved communities) are better protected from public health threats
- All Nigerians enjoy better health and wellbeing
- Nigeria has improved integrated and sustainable health information system

Table 4 provides details of the priority areas, strategic actions, and key results.



Table 4: CCS III Priority Areas, Strategic Actions and Key Results

S/N	CCS Priority Areas	Ranking	Strategic Actions	Key Results	Key Indicators
3.1	<b>All Nigerians are covered on essential package of health services</b>				
3.1.1	<b>Improved access to quality essential health services</b>	<b>High</b>	<ol style="list-style-type: none"> <li>1) Strengthen health sector governance and stewardship including legal and regulatory frameworks 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</li> <li>2) Strengthen capacity of the FMOH, it's agencies and States 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</li> <li>3) Ensure good quality people-centred health services and use of health technologies while improving equity in their distribution for UHC</li> <li>4) Strengthen prevention, control, elimination, and eradication of diseases while establishing institutional mechanisms for defining package of health services</li> <li>5) Improve inter-sectoral governance and empower communities to share responsibilities for shaping and improving health services towards universal health coverage</li> </ol>	<ol style="list-style-type: none"> <li>1) Functional health coordination mechanisms including policy and regulatory frameworks developed at all levels</li> <li>2) Appropriate health workforce produced, motivated and retained for UHC</li> <li>3) Technical support, structures, guidelines, and tools are provided for improved patient safety and provision of equitable quality health services</li> <li>4) Package of Essential Health services are defined based on the needs of Nigerian people.</li> <li>5) Communication and collaboration between health and other sectors including communities are strengthened for improved performance and accountability towards UHC</li> </ol>	<ol style="list-style-type: none"> <li>1) % of population in the poorest wealth quintile reached with essential health services,</li> <li>2) Contraceptive Prevalence Rate,</li> <li>3) % of deliveries supervised by skilled birth attendants,</li> <li>4) Measles immunization coverage,</li> <li>5) DPT-HepB+Hib3 immunization coverage</li> <li>6) TB case detection rate,</li> <li>7) Malaria prevalence in the general population,</li> <li>8) % of diagnosed persons living with HIV/AIDS receiving HIV treatment services,</li> <li>9) % of persons with mental illness treated,</li> <li>10) % Premature NCD-related mortality reduce</li> </ol>

**Table 4: CCS III Priority Areas, Strategic Actions and Key Results**

S/N	CCS Priority Areas	Ranking	Strategic Actions	Key Results	Key Indicators
3.1	<b>All Nigerians are covered on essential package of health services</b>				
3.1.2	Improved Financial Risk protection for health towards UHC	<b>High</b>	<ol style="list-style-type: none"> <li>1) Strengthen Health Financing governance and coordination in 36 States and FCT</li> <li>2) Ensure adequate revenue generation for health from public and private sources</li> <li>3) Expand effective pooling of fund and coverage of Nigerians on prepayment schemes to reduce high out-of-pocket expenditure</li> <li>4) Improve value for money and strategic purchasing of essential health services</li> </ol>	<ol style="list-style-type: none"> <li>1) Health Financing Equity and Investment coordination mechanisms and Health Financing Policy &amp; Strategy at Federal, 36 States, and FCT established</li> <li>2) Business and Investment Case for UHC priorities at Federal, 36 States, and FCT developed</li> <li>3) Systems for health financing evidence generation and management at Federal, 36 States, and FCT established</li> <li>4) Phased implementation of the BHCPF coordinated</li> <li>5) Sustainable systems for training of health personnel on health financing and management established</li> <li>6) Domestic resource mobilization strategy including Sin Taxes, Telecom Taxes, VAT, Aviation Taxes, etc. developed and implemented</li> <li>7) State Health Insurance and contributory Schemes established and expanded in 36 States &amp; FCT</li> <li>8) Value for money expanded through results based financing</li> </ol>	<ol style="list-style-type: none"> <li>1) Number of States and FCT with approved Health Financing Policy &amp; Strategy</li> <li>2) FMOH and SMOH have institutionalized routine Health Account studies</li> <li>3) Number of personnel trained on health financing and management</li> <li>4) % of population covered by BHCPF</li> <li>5) GHE as % of GGE</li> <li>6) % of Nigerian population covered by any risk protection mechanisms</li> <li>7) Number of states that have established State Health Insurance and contributory Schemes</li> <li>8) Nigeria quality and HTA Agency established</li> <li>9) Number of States with functional PFM Systems</li> <li>10) % of health fund spent through PBF</li> </ol>
3.1.3	Improved availability of essential medicines, vaccines, diagnostics, devices, and appropriate health technologies for Primary Health Care.	<b>High</b>	<ol style="list-style-type: none"> <li>1) Improved governance and stewardship of pharmaceutical services and other health technologies</li> <li>2) Strengthened intellectual property protection and leveraging on trade-related intellectual property flexibilities</li> <li>3) Improved rational dispensing, prescribing and use of medicines and other health technologies</li> <li>4) Strengthened policies and systems for tackling antimicrobial resistance</li> <li>5) Improved availability, affordability of medicines and other health technologies (i.e., efficient procurement and supply chain, pricing, etc)</li> <li>6) Increased local production of quality assured medicines, vaccines and diagnostics</li> </ol>	<ol style="list-style-type: none"> <li>1) National Guidelines and Policy documents on health technologies and their rational use developed</li> <li>2) National mechanisms for procurement and supply chain management including pricing of health technology established</li> <li>3) Antimicrobial resistance policy, strategy and plan developed, and capacity built on its implementation</li> </ol>	<ol style="list-style-type: none"> <li>1) National Guidelines and Policy documents on health technologies and their rational use developed</li> <li>2) % of Health facilities that report stock out of anti-malarial commodities, diagnostic kits lasting more than one week in the past three months,</li> <li>3) % of patients prescribed antibiotics in public health facilities,</li> <li>4) % of federal tertiary institution with functional antimicrobial stewardship program,</li> <li>5) National Medicines regulatory authority (NAFDAC) achieves WHO prequalification by the year 2020,</li> <li>6) % of blood donation collected in the country that is reported by NBTS,</li> <li>7) % of voluntary non-remunerated blood donation in the country</li> </ol>

**Table 4: CCS III Priority Areas, Strategic Actions and Key Results**

S/N	CCS Priority Areas	Ranking	Strategic Actions	Key Results	Key Indicators
3.2	<b>All Nigerians (men, women, children and marginalised or underserved communities) are better protected from public health threats</b>				
3.2.1	Better protect Nigerians from public health threats	High	<ol style="list-style-type: none"> <li>1) Strengthen all-hazards emergency preparedness including IHR core capacities</li> <li>2) Establish minimum core capacities for emergency preparedness and disaster risk management</li> <li>3) Institute operational readiness to manage risks and vulnerabilities</li> <li>4) Develop risk profiling and vulnerability mapping conducted, and multi-hazard plan developed</li> </ol>	<ol style="list-style-type: none"> <li>1) National action plan for health security, Multi-hazard plan, and National/state emergency and response plans developed and implemented</li> <li>2) Risk profiling and vulnerability mapping conducted</li> <li>3) Operational studies and research on alternative preventive options on public health threats conducted</li> <li>4) Preposition emergency contingency stocks procured and multi-sectoral RRTs established</li> <li>5) iSimulations in selected states, AARs, and review preparedness plans conducted</li> </ol>	<ol style="list-style-type: none"> <li>1) IHR core capacities strengthened</li> <li>2) % of health emergencies, investigated and contained within nationally/ internationally accepted standards</li> <li>3) Proportion of LGAs and States that provide timely and complete surveillance reports to the Federal level</li> <li>4) Availability of multi-hazard plan informed through risk profiling and vulnerability mapping</li> </ol>
3.2.2	Reduce the risk and burden of public health emergencies	High	<ol style="list-style-type: none"> <li>1) Assess and monitor drivers for epidemics and pandemics</li> <li>2) Strengthen research and development for infectious hazard management</li> <li>3) Scale up prevention of epidemic-prone diseases</li> <li>4) Reduce the re-emergence of high-threat infectious pathogens</li> <li>5) Improve the capacity to control epidemics or other disease outbreaks</li> </ol>	<ol style="list-style-type: none"> <li>1) Risk assessment and situation analysis conducted</li> <li>2) Timely response to epidemics or other disease outbreaks provided ensured through strengthened outbreak response capacities and coordination mechanism (e.g. Emergency Operation Centres) strengthened</li> <li>3) Public health laboratory network developed and strengthened</li> <li>4) Research on emerging and re-emerging pathogens conducted</li> <li>5) Health systems post epidemics strengthened and built back better</li> <li>6) Wild Polio Virus interrupted</li> </ol>	<ol style="list-style-type: none"> <li>1) Morbidity and mortality rate of public health emergencies maintained below emergency thresholds</li> <li>2) Number of public health emergencies and events</li> <li>3) Number of research studies undertaken</li> <li>4) Number of public health events controlled</li> <li>5) Number of high-threat infectious pathogens controlled</li> <li>6) Number of epidemics controlled</li> <li>7) Number of wild polio viruses</li> </ol>
3.2.3	All affected Nigerians have access to lifesaving health services	High	<ol style="list-style-type: none"> <li>1) Strengthen rapid detection and risk assessment for potential health emergencies capacities</li> <li>2) Establish and improve rapid response to acute health emergencies</li> <li>3) Provide essential health services for vulnerable conflict affected communities</li> <li>4) Establish minimum Health package for humanitarian response</li> </ol>	<ol style="list-style-type: none"> <li>1) Humanitarian assessments and partner coordination/mapping conducted</li> <li>2) Early warning systems and surveillance established</li> <li>3) Provision of basic health services and minimum health package for humanitarian response ensured</li> </ol>	<ol style="list-style-type: none"> <li>1) % Coverage of health services by area and target population</li> <li>2) Number of people assisted by lifesaving health interventions</li> <li>3) % of public health events detected within 48 hours</li> <li>4) Coverage and timeliness of the Early Warning Alert and Response System (EWARS), Number of emergencies responded to within 72 hours</li> <li>5) Number and percentage of health facilities that are fully functional</li> <li>6) Number of people reached with basic health services</li> <li>7) Number and percentage of health facilities providing an essential package of health services</li> <li>8) Availability of essential medicines and medical supplies</li> <li>9) Number of trained healthcare workers</li> <li>10) Number of health facilities implementing the basic packages</li> </ol>



**Table 4: CCS III Priority Areas, Strategic Actions and Key Results**

S/N	CCS Priority Areas	Ranking	Strategic Actions	Key Results	Key Indicators
<b>3.3.</b>	<b>Enable all Nigerians to enjoy better health and wellbeing</b>				
<b>3.3.1</b>	Better health and well-being for every Nigerians, ensuring no-one is left behind, by addressing social determinants of health	<b>High</b>	<ol style="list-style-type: none"> <li>1) Improve health and well-being of marginalized or underserved populations</li> <li>2) Strengthen inter-sectoral governance and investment in health</li> <li>3) Analyse impact of social and economic health challenges across sectors</li> <li>4) Strengthen health inequality monitoring</li> <li>5) Ensure safer environmental conditions</li> </ol>	<ol style="list-style-type: none"> <li>1) Approaches on social determinants of health, incl. equity, gender and health promotion implemented and mainstreamed</li> <li>2) Sex-disaggregated data available and gender lens to needs analysis and programme design implemented</li> <li>3) Nutrition plans improving new-borns, children, adolescents and adults' health developed and implemented</li> <li>4) Maternal, neonatal and child morbidity and mortality reduced</li> <li>5) Intersectoral platform for engagement of partners and other relevant sectors to facilitate actions that address the SDH established</li> <li>6) Maternal, neonatal, child and Adolescent morbidity and mortality reduced</li> </ol>	<ol style="list-style-type: none"> <li>1. Number of Nigerians enjoying health and well-being</li> <li>2. Mortality from climate-sensitive diseases</li> <li>3. % wasting among children</li> <li>4. % women making informed reproductive health decisions, etc</li> <li>5. % maternal mortality</li> <li>6. % neonatal mortality</li> <li>7. % infant mortality</li> <li>8. % adolescent mortality rate</li> <li>9. % Adolescent fertility rate</li> <li>10. % number of stunted children &lt;5</li> <li>11. % increase equitable access to healthcare</li> <li>12. % access to safe drinking water</li> <li>13. % access to safe sanitation for all Nigerians</li> <li>14. Sex- and age disaggregated data available</li> <li>15. % children developmentally on track in health</li> <li>16. % children subject to violence</li> <li>17. % intimate partner violence</li> </ol>
<b>3.3.2</b>	Reduction of morbidity and mortality from Non-Communicable Diseases (NCDs) and underlying risk factors through prevention and treatment	<b>High</b>	<ol style="list-style-type: none"> <li>1) Support enactment of policies, legislation, regulations for reduction of risk factors</li> <li>2) Improve people's participation and engagement for reducing risk factors through health promotion and rights literacy</li> <li>3) Engage non-state actors and sectors outside health on risk factor reduction</li> <li>4) Generate evidence for cost-effective multisectoral policies and actions</li> </ol>	<ol style="list-style-type: none"> <li>1) Effective NCD multisectoral mechanism established</li> <li>2) Health system strengthened to include systematic management of NCDs</li> <li>3) Cost-effective WHO best-buy interventions implemented</li> <li>4) Whole-of-government and whole-of-society approach implemented</li> </ol>	<ol style="list-style-type: none"> <li>1) % tobacco use</li> <li>2) % harmful use of alcohol</li> <li>3) % salt/sodium intake</li> <li>4) % raised blood pressure</li> <li>5) Amount of industrially produced trans fats</li> <li>6) % childhood overweight and obesity</li> <li>7) Level of insufficient physical</li> </ol>
<b>3.3.3</b>	Health and well-being realized through Health in all policies and healthy settings interventions	<b>High</b>	<ol style="list-style-type: none"> <li>1) Support the strengthening of policy, legislation and regulatory frameworks on inter-sectoral coordination</li> <li>2) Improve leadership in health development</li> <li>3) Build evidence, innovation and scientific research</li> <li>4) Address the changing landscape through Whole-of-government approach, Health in all policies/strategies and Healthy setting approaches to health promotion</li> </ol>	<ol style="list-style-type: none"> <li>1) Policy dialogue with inter-sectoral partners having high influence on policies, equity and health outcomes established</li> <li>2) Evidence-based advocacy and strategic support to develop systems of the future implemented</li> <li>3) Mainstreaming of health issues into all sector policies facilitated and monitored</li> <li>4) Use of research findings in policy formulation and programming institutionalized</li> <li>5) Collection of disaggregated data at national and sub-national levels to monitor inequalities and inequities strengthened</li> </ol>	<ol style="list-style-type: none"> <li>1) Maternal mortality rate</li> <li>2) % of deliveries assisted by Skilled attendants</li> <li>3) Under-five mortality rate Suicide deaths per 100,000 populations in a specified period</li> <li>4) Mortality rate attributable to unsafe water, unsafe sanitation and lack of hygiene</li> <li>5) % of intersectoral coordination platforms at national and subnational levels established/functional</li> <li>6) % of policies and programmes from other sectors addressing the determinants of health for all population groups.</li> <li>7) % sectoral researches responsive to social determinants of health priorities/agenda.</li> <li>8) % of national policies that address at least two priority determinants of health (and involve at least two sectors) in target populations</li> </ol>

**Table 4: CCS III Priority Areas, Strategic Actions and Key Results**

S/N	CCS Priority Areas	Ranking	Strategic Actions	Key Results	Key Indicators
3.4	<b>Nigeria has improved integrated and sustainable health information system</b>				
3.4.1	Strengthen Health Systems Information and evidence generation for effective monitoring of health systems performance in Nigeria	High	<ol style="list-style-type: none"> <li>1) 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:</li> <li>2) 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;</li> <li>3) Promote national and state capacity building for generation, analysis, management and use of health data; and</li> <li>4) Support studies, including health facility surveys, for monitoring service availability and use, such as service readiness assessments.</li> <li>5) Harmonize health information for all health interventions in one platform</li> <li>6) Strengthened national statistical capacities</li> <li>7) Improved use of data at all level</li> <li>8) Improved data quality</li> <li>9) 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:</li> <li>10) Review the national health research policy and priorities;</li> <li>11) Establish and support a national health research forum.</li> <li>12) Build national and institutional capacity for undertaking health sector reform and</li> </ol>	<ol style="list-style-type: none"> <li>1) Data and tools harmonized for all health indicators</li> <li>2) Capacity developed at both state and federal level to monitor, analyse and generate high quality, evidence-based reports on health systems performance</li> <li>3) Quality health data are available and all levels of health management use data for decision making</li> <li>4) Research policy/tools developed by December 2018</li> <li>5) Systems and capacities strengthened for generation and use of data for decision making and making a case for health at Federal and state level</li> <li>6)</li> </ol>	<ol style="list-style-type: none"> <li>1) % of States and health institutions with functional management information system</li> <li>2) % of health facilities with functional district health information system for health information</li> <li>3) Number of monthly/quarterly feedback on data analysis from federal, State, and LGAs</li> <li>4) Proportion of consistent data sets in health information system</li> </ol>



## CHAPTER 4:

# THE REVISED STRATEGIC AGENDA: Implications for the Secretariat

## Implementation process for the revised CCS III

The Successful implementation of the revised CCSIII, is contingent upon the WCO rapidly adapting its roles, capacities and presence based on the strategic directions of GPWI3, to address the evolving health development processes and challenges in Nigeria. The protracted humanitarian crisis in the North East, the global rump down of the GPEI and the Nigerian Governments' drive for PHC revitalization as a means to achieving UHC will have implications for WHO's role and presence in achieving the strategic priorities of the revised CCSIII. In addition, the WCO will promptly address the impact and implications of global and regional health threats and priorities to public health and wellbeing of Nigerians. The impact of climate change, cross boarder migration, precipitated by regional security risks and associated importation of communicable diseases will be tackled within the Government's commitment to achievement of health related SDGs targets.

The WCO will be responsible for the overall implementation of the revised CCSIII, while drawing on backstopping from the regional and headquarters level whenever required.

The revised CCSIII will inform the programming, sequencing and delivery of all the WCO results through implementation of biennial operational plans. The revised CCSIII will guide engagement with national counterparts, partnerships and resource mobilization required for its implementation.

### WHO Country Office Core capacity

The current WCO core capacity (staffing, financial and infrastructure) which is skewed towards addressing Polio and Emergencies, will have to be reviewed, re-profiled and strengthened so as to effectively deliver WHO's responsibilities for achievement of the revised CCSIII strategic priorities. The anticipated rump down of the current GPEI workforce, present in all the 36 states and FCT, that have hitherto been leveraged by other programs, further underlines the need this rapid transformation in the WCO core capacity.

The WCO has commissioned the development of a business case that will inter-alia mitigate the impact of the anticipated downsizing of the GPEI

Through these processes' the human resource capacity and skill mix, at the WCO will be strengthened to match the technical support roles across all programmes of the revised CCSIII in a 'fit for purpose' manner. This will involve initially re-assignment of the current staff and recruitment of additional staff for the following currently understaffed and new programme areas: health systems, environmental health, social determinants of health; NCD risk factors and health promotion in all policies and settings.

The capacity of staff to provide quality technical support in line with the evolving advances in knowledge and requisite expertise for the strategic priorities of the revised CCSIII, will be enhanced by effective enforcement of the staff development and learning program to constantly upgrade their skills and competences. Reorganization of the WCO structure and working methods to foster cross cluster collaboration and synergies that address the revised CCSIII strategies, as well as the new way of working to strengthen the humanitarian development nexus will be undertaken. This will be particularly important at sub national level offices, where staff tend to disproportionately address specific programmes with minimal support to areas considered to be outside their primary responsibility.

The WCO has developed a resource mobilization strategy to secure additional flexible funding for poorly resourced programs and particularly the new CCSIII strategic priority areas. Furthermore, the available Polio and Emergency funds shall be leveraged through the new ways of working towards supporting other strategic priority areas.

The operational and enabling capacity of the administrative functions of the WCO will be strengthened to foster the effective implementation of the revised CCS. The WCO will secure the necessary Information, Communication Technology (ICT) infrastructure, equipment and supplies as well as bolster its logistics, procurement and human resources management capacity to match the increased staffing capacity in line with the revised CCSIII strategic priorities. More emphasis will be placed for the sub-national offices that require improvement of their ICT capacity, transport, office space and residential facilities to ensure that they comply with the Minimum Operating Security Standards of the UN system.

#### **WHO Country Office Strategic shifts**

The WCO will address the strategic shifts of GPWI3 by strengthening its normative functions, emphasising provision of up-stream policy dialogue and strategic support, while maintaining the necessary technical assistance and service delivery operations required to effectively address

polio eradication, recurrent disease outbreaks and the humanitarian crisis in the North East. Regular policy dialogue and collaborative work to strengthen systems will be maintained with national counterparts. Capacity of government counterparts and partners will be built to progressively take over operational activities that are hitherto directly implemented by the WCO, while maintaining an optimal balance of the operational aspects of WHO actions that are critical for emergency response and polio free certification status count down. Deliberate effort will be made to ensure WCO provides leadership and synthesizes the necessary evidence to advocate for health issues in as many forum's as possible at all levels of government and amongst partners. Institutionalization of systematic technical and administrative backstopping from the country office to sub-national offices will be done to foster effectiveness in WCO support to the State Ministry of Health and partners at that level.

#### **WHO Regional Office for Africa**

In addition, the WCO will work with the other levels of the organization to ensure more structured and predictable technical and administrative backstopping towards implementation of the revised CCSIII. A close working relationship between the WCO and relevant technical units at the other levels of the Organization will be

maintained. The WCO will regularly draw on AFRO's technical and administrative support, especially in programming for the new strategic priority areas as well as biannual planning, implementation, monitoring and evaluation of the revised CCS. Guidance will also be sought for implementation of regional commitments and agenda; cross-country experience sharing and South to South cooperation to tackle common regional challenges. Furthermore, the WCO will engage AFRO in resource mobilization and leveraging regional partnerships.

#### **WHO Headquarters**

WHO headquarters (WHO-HQ) guidance and technical assistance towards implementation of the global agenda and particularly translation and adaptation of the GPWI3, will be sought by the WCO. In addition, the WCO will proactively engage the WHO-HQ to leverage global partnerships and ensure that the WCO benefits from global resources.

#### **Partnerships**

While the WCO will limit its support to WHO's core functions and comparative advantage in implementing the revised CCS, efforts will be made to leverage other partner's resources to ensure synergy and convergence towards achievement of the overall national health goals. The UNSDPF, the Humanitarian Cluster Coordination mechanisms and other relevant

national and sub national coordination mechanisms shall be used to foster partnerships towards realizing revised CCSIII outcomes. Multi-sectoral collaboration and coordination will be strengthened to foster, the attainment of health related national SDGs targets.

#### **Risk Management**

The WCO has developed a risk register which will be regularly updated to address all the internal and external risks that may arise during the implementation of the revised CCS. The WCO business continuity plan aligned to the risk register will be used to mitigate the impact of any adverse events, minimising as much as possible disruptions of the WCO operations during the implementation of the revised CCS.

## CHAPTER 5: SETTING THE STRATEGIC AGENDA FOR WHO–NIGERIA COOPERATION

### 5.1 Participation in CCS III monitoring and evaluation

The revised CCS III is a strategic document with identified key milestones as demanded by partners during the mid-term review exercise for accountability purposes. These key milestones will be used to monitor and evaluate the implementation of CCS priority areas. 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. The country office – under the leadership of the World representative (WR), with the support of AFRO and HQ, and with the full participation of and in coordination with the ministry of health, other ministries, national stakeholders and other partners that participated in the CCS formulation will monitor and evaluate the CCS. This is the first step towards assessing WHO's performance in the country.

#### Timing

The CCS is monitored regularly during implementation, evaluated mid term, and again towards the end of the CCS cycle, coinciding with other national review processes. These exercises should be linked with the biennial work plan.

#### 5.2 Monitoring

The progress of the CCS' implementation will be monitored through internal mechanisms involving quarterly and semi-annual monitoring. This revised CCS will be executed through three consecutive biennial programme budgets and work plans with a results-based framework for the periods 2018–2019, 2020–2021 and 2022–2023. 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. The 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.

The purpose of the regular monitoring are to identify:

1. **The country's WHO biennial workplans against the CCS Strategic Agenda to ensure consistency;** - each cluster will conduct a quarterly monitoring on the status of the implementation of the various strategic action under the CCSIII priority areas which they are responsible with. At the CCS III working group level under the leadership of the WR the priority areas will be monitored semi-annually in line with the biennial work plan and produce a report with mitigation plan.
2. Core capacity of the country office against the CCS strategic priorities to ensure consistency; - making sure the required human resource for delivery of the strategic priorities are available and tracked every quarter. During the semi-annual monitoring of the CCSIII the report should include on the availability of these human resources, the mitigation plan should also address on how to fill the gap identified.

### 5.3 Evaluation

To evaluate its impact, the revised CCS III will undergo a mid-term review and a final review

#### 5.3.1. Mid Term review

The mid-term review will be conducted half-way into the strategic plan's period in December 2020 after three years of implementation using a

after three years of implementation using a formative evaluation method. The various instruments used to collect the data will be questionnaires, surveys, interviews, and observations. It should be carefully designed and executed to ensure the data is accurate and valid.

The focus of the mid-term evaluation will be:-

1. To determine the progress in focus areas (whether the expected achievement(s) is/are on track);
2. To identify impediments and potential risks that may require changes to the strategic priorities or focus areas;
3. To identify actions required to improve progress during the second half of the CCS cycle.

The mid-term evaluation is a risk management tool to alert the country office to focus areas that might require special attention, corrective action (including revised guidance for country-level programme budget and resource allocation), or revision of the strategic priorities to which they contribute. A major emergency or significant change to the country context may require review, revision and renewal of the CCS.

The WR will designate CCS evaluation team to undertake mid-term evaluation and the regional office, headquarters and other stakeholders could be invited to be in the group.

#### 5.3.2. Final evaluation

Shortly before the end of the implementation period in December 2022 the final evaluation will be done using summative evaluation method. The final evaluation is a more comprehensive assessment than the mid-term review. The focus is:

1. To measure the achievement of selected national SDG targets linked to the CCS Strategic Agenda;
2. To identify achievements and gaps in implementing the CCS Strategic Agenda and in relation to the multilateral organization performance assessment network (MOPAN) performance areas
3. To determine the extent to which the CCS strategic priorities were incorporated into or influenced the NHSDP II and UNSDPF and affected the work in country of other development partners towards achieving the SDGs;
4. To identify the critical success factors and impediments;
5. To identify the lessons to be applied in the next CCS cycle.

The final evaluation document should describe the achievements, gaps, challenges, lessons learnt and recommendations. The framework for the final evaluation should be harmonized with other monitoring and evaluation processes, such as the UNSDPF evaluation. The draft document should be shared for comments with the AFRO and HQ. Lessons learnt from CCS evaluations should be shared with the government and other partners.



**World Health  
Organization**

---

**Nigeria**