“Saving one million lives initiative”

A framework for national leadership and accountability for women and children’s health

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Federal Ministry of Health, Nigeria

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Agenda

- Background
  - Key interventions and results
  - A new approach to delivery
  - Contribution to Global Strategy Goals
Nigeria is a federation of 167 million people

Region/state map of Nigeria
Population in mn

- Administratively divided into
  - 6 geopolitical zones
  - 36 states plus 1 Federal Capital Territory
  - 774 Local Government Authorities (LGAs)
  - 9,565 wards

There are
- 31 million women of child bearing age
- 28 million children under the age of five
- An estimated 6.0 million births annually

SOURCE: Nigeria Population Census 2006, FMOH
Weak health system has contributed to suboptimal health outcomes especially for women and children

<table>
<thead>
<tr>
<th><strong>Weak health system has contributed to suboptimal health outcomes especially for women and children</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Maternal mortality</strong> rate is 545/100,000 live births = 33,000 women each year — 1 in 9 maternal deaths worldwide, the 2nd highest global total</td>
</tr>
<tr>
<td><strong>~23,000 health facilities</strong> (estimated 14,000 PHCs) but with different levels of functionality</td>
</tr>
</tbody>
</table>
| **Infant mortality** rate is 75/1,000
| **8% of the global total,**
| **An estimated 70% of these deaths are preventable** |
| **Supply challenges**
| — Inadequate power or water supply
| — Commodity stock-outs
| — Equipment inadequacy
| — Weak Quality standards |
| **Child mortality rate** is 157/1,000 = ~1 million deaths per year
| — ~10% of the global total, |
| **Demand for critical services very low**, e.g.
| — 38% of women have skilled births
| — 58% have ANC
| — ~130 births / PHC vs. ~750 capacity |

*SOURCE: Nigeria Demographic and Health Survey, 2008*
Equity matters: There was also significant inequity in access to basic services by socioeconomic status

The poorest 20% of Nigerian women have significantly less access to maternal and child health services than richer women

- Multiple antenatal care (ANC) visits
  - % of pregnant women
  - Poorest 20%: 31%
  - Richest 20%: 91%
  - Increase: +196%

- Skilled attendant at birth
  - % of live births
  - Poorest 20%: 13%
  - Richest 20%: 85%
  - Increase: +555%

- Contraceptive prevalence
  - % of women of reproductive age
  - Poorest 20%: 4%
  - Richest 20%: 21%
  - Increase: +469%

SOURCE: World Bank: Socio-economic Differences in Health, Nutrition, and Population within Developing Countries
Despite improvements in recent years, progress needs to be accelerated to meet MDG targets e.g. U5MR reduction from 4% to 13% per year.

Under-five mortality decline in Nigeria 1990 - 2035
Per 1000 live births

- Nigeria must reduce its under-five child mortality rate at a rate of up to 13% p.a. in order to achieve the target of reaching one-third of the 1990 under five mortality rate by 2015.

- Although Nigeria has achieved 4.8% p.a. reductions in mortality in recent years, it needs to accelerate to the rates of the fastest African countries.

*Over a five-year period prior to latest survey.

Sources: U.N. Millennium Development Goals; WHO Country Report, NDHS 2008; World Bank
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A lot has happened in the past year

**Policy**
- Highest level political commitment: President, Senate, House of representatives
- NSHDP as the health sector strategy for transformation agenda
- Economic Management Implementation Team: SOML in KPI

**Financial**
- Federal budgetary allocation to health – 4th largest
- Subsidy reform program
- Additional financing for Immunization
- The National Health Bill for sustainable financing in progress

**Advocacy**
- Involvement of the WDCs
- Traditional and religious leaders and Civil society
- Events: Nutrition summit, Vaccine Summit, SOML, FP and Dev conference this month

**Operational**
- MOUs with Governors
- Involvement of the Nigeria Governor’s forum
- Support (technically and operationally) using data for performance management
Some of the implemented interventions aimed at improving the health of women and children include the following

**MSS Program**
- Described as one of the largest Public-Sector led HRH intervention schemes in Africa
- 4,000 Midwives deployed to 1,000 PHCs in most needy areas
- Additional 1,000 Community Health Workers were deployed to close persisting gaps in under-served areas without midwives

**SURE-P MCH**
- Builds on the MSS program by expanding the interventions
- Introduction of demand side interventions e.g. CCT
- Pilots of financing mechanisms for referrals and EmOC

**MNCH Weeks**
- High-impact, low-cost interventions targeted at newborns, U5 children, breast feeding mothers and women of reproductive age in conformity with continuum of care approach.

**Family Planning**
- Integrated within overarching narrative on population, demographics and development as well as maternal and child survival
- Commitment by Mr. President to increase allocation of additional $8.35m p.a. for procurement of RH commodities over the next four years, through UNFPA on the platform of an existing agreement.
The Midwives Service Scheme has delivered visible results within two years of implementation

<table>
<thead>
<tr>
<th>Category</th>
<th>2009</th>
<th>2011</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal mortality ratio</td>
<td>789</td>
<td>584</td>
<td>-26%</td>
</tr>
<tr>
<td>Neonatal mortality ratio</td>
<td>11</td>
<td>9</td>
<td>-22%</td>
</tr>
<tr>
<td>Pregnant women with focused ANC</td>
<td>41%</td>
<td>50%</td>
<td>+22%</td>
</tr>
<tr>
<td>Skilled attendant at birth</td>
<td>12%</td>
<td>16%</td>
<td>+33%</td>
</tr>
<tr>
<td>Use of family planning methods</td>
<td>1%</td>
<td>2%</td>
<td>+100%</td>
</tr>
</tbody>
</table>

SOURCE: Midwives Service Scheme evaluation report
Additional resources have been mobilised under the SURE-P MCH programme to build on the impact of MSS through supply and demand-side interventions along the continuum of care.

<table>
<thead>
<tr>
<th>Supply Inputs</th>
<th>Demand Inputs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human Resources for Health</td>
<td>Conditional Cash Transfer</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Recruitment</th>
<th>Deployment</th>
<th>Training</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Midwives and CHWs recruited from school or unemployment database, VHWs from communities</td>
<td>▪ Midwives and CHWs deployed after enrolment, VHWs deployed after training</td>
<td>▪ All cadres receive a one-week training</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Continuum of care</th>
<th>Payment</th>
<th>Conditions</th>
<th>Identification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antenatal visit 1</td>
<td>▪ Women who meet conditions are paid a set incentive value</td>
<td>▪ Women are encouraged to meet programme conditions (i.e. to access MCH services at PHCs)</td>
<td>▪ Pregnant women in the community identified by VHW, CHW, or midwife</td>
</tr>
<tr>
<td>Antenatal visit 4</td>
<td>Skilled attendant at birth</td>
<td>Postnatal care</td>
<td></td>
</tr>
<tr>
<td>Family Planning</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SOURCE: PIU team
The supply-side intervention will dramatically scale up the number of health workers

<table>
<thead>
<tr>
<th>Description</th>
<th>Scale-up from 2011-15</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Midwives</strong></td>
<td>Thousands of workers</td>
</tr>
<tr>
<td>Midwives provide care for women during pregnancy, labour, and the postpartum period, and also provide care for newborns</td>
<td>4.0 2.0 0.8 0.6 2.0 9.4</td>
</tr>
<tr>
<td><strong>Community health workers (CHW), MSS</strong></td>
<td></td>
</tr>
<tr>
<td>Health workers hired by the MSS programme specifically to offer MCH services to communities</td>
<td>1.0 1.0 0.4 0.3 1.0 3.7</td>
</tr>
<tr>
<td><strong>Community health workers (CHW), non-MSS</strong></td>
<td></td>
</tr>
<tr>
<td>Health workers not hired under the MSS programme who provide a wide range of health services within their community, but to be trained on MCH by MSS</td>
<td>0 12.0 12.0 12.0 12.0 48.0</td>
</tr>
<tr>
<td><strong>Village health workers (VHW)</strong></td>
<td></td>
</tr>
<tr>
<td>Workers within the community trained on basic health care services and household practices</td>
<td>0 9.0 1.2 0.9 3.0 14.1</td>
</tr>
<tr>
<td>Primary role is to stimulate demand for health services</td>
<td>2011 12 13 14 2015 Total</td>
</tr>
</tbody>
</table>

**SOURCE:** World Health Organization, PIU team
These health workers will reach deeper into target communities with the help of the ward development committees

- **WDCs** play important roles in this system:
  - Ensure beneficiaries are aware of the programme and receive the benefits
  - Monitor implementation within the community

- **Hospitals** key for providing services for complicated births

- **SURE-P** to provide health commodities to the PHCs and health workers in each community

**SOURCE:** PIU team
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The Government has launched the “saving one million lives” initiative, to accelerate access to basic service delivery with a focus on results.
The PHCs will provide a strong primary care platform and existing vertical programs will be integrated into it.

Theory of change

Car 2: Other interventions

Car 1: Maternal, newborn & child health

The engine: Basic supply components

Components

- Other HIV
- Malaria
- TB
- ORS/Zinc
- Antibiotics, Etc.

- ANC
- Skilled birth attendance
- Post-natal care
- Family planning
- eMTCT
- Immunization

- Human Resources
- Infrastructure & equipment
- Quality: patient safety, experience, etc.
- Supply chain

Integrated interventions aimed at improving maternal, newborn and child health are the lead interventions in this approach.

SOURCE: Midwives Service Scheme, Discussions with Minister of State for Health
There are three factors critical for implementing the initiative:

<table>
<thead>
<tr>
<th>Rationale</th>
<th>Intervention</th>
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<tbody>
<tr>
<td><strong>I</strong> Reliable and available data flow</td>
<td>▪ For determining number of lives saved&lt;br▪ Current data systems suboptimal</td>
</tr>
<tr>
<td><strong>II</strong> Coordination and alignment of programs</td>
<td>▪ Multiple programs exist within the country that contribute to lives saved&lt;br▪ Poor coordination among partners and programs</td>
</tr>
<tr>
<td><strong>III</strong> Delivery structure/team</td>
<td>▪ History of challenges in successfully delivering on projects&lt;br▪ Capabilities and capacity currently lacking within the system</td>
</tr>
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</table>
The Performance management framework will be underpinned by a four-step monthly performance cycle

**Implementation process**
- Targets and milestones established
- Problems escalated and more closely monitored
- Delivery Unit ensures corrective action is taken and provides targeted support
- Plans adjusted as required
- Progress reviewed during monthly Steering Committee meetings
- Implementation constraints and bottlenecks highlighted and corrective action proposed

**Plans and performance agreements**

**Final delivery**
- Data collected at the facilities, using standardized templates
- Delivery unit receives and collates the data

**Monthly performance cycle**

**Corrective action**

**Review**

**Report**

**SOURCE: Team analysis**
A steering committee comprising government departments, civil society and development partners will ensure accountability for results.

**Diagram Description:**
- **Presidency**
- **Minister (Chair)**
- **Nigeria Governor’s Forum**
- **Economic Management Implementation Team**
- **Project Delivery Unit**
- **FMOH Departments**
  - FCH
  - DPRS
  - PH
  - FDS
- **Health sector parastatals**
  - NACA
  - NHIS
  - NPHCDA
- **Development Partners**
  - Bilateral agencies
  - Multilateral agencies
  - Other partners
  - UN
- **Private sector**
- **Civil Society**
  - NGOs
  - Trad & Religious leaders

**Institutions and Organizations:**
- **NHIS**
- **NACA**
- **NPSHA**
- **UN**
- **FCH**
- **DPRS**
- **PH**
- **FDS**
- **NPHCDA**
- **NPHCDA**
- **NGOs**
- **Trad & Religious leaders**
The PDU will be structured around providing strong content and data management support to program implementation.

- Liaise with state data agents to pursue, collect and review weekly data
- Analyze data with support from content specialists
- Prepare & disseminate monthly reports to Delivery Unit secretariat
- Procurement adviser
- Supply chain advisor

Local funding agent

- Malaria
- Essential medicines
- Routine Immunization
- eMTCT
- Nutrition
- MCH

State Data Agents
- Pursue facility data
- Maintain mobile # database of facilities

Intervention area specialists
- Provide on-demand problem-solving expertise to regional data coordinates or state liaison officers
- Engage with relevant focus-area partners to ensure alignment with targets
- Support regional data coordinates in preparing monthly reports
- Prepare quarterly reports for Steering Committee

Regional data coordinators

Steering committee
PDU Secretariat

NW
SW
NE
SE
NC
SS
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Key elements of the Global strategy are being addressed in the country

<table>
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<tr>
<th>Element</th>
<th>Description</th>
<th>Country actions</th>
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</table>
| More Health for the Money| ▪ Increasing effectiveness through integration  
 ▪ Using innovation to increase efficiency and impact  
 ▪ Making funding channels more efficient | ▪ New approach centres on integrating interventions at PHC level  
 ▪ ICT collaboration with MHealth Alliance and GSMA; Role of NPSHA  
 ▪ Predictable resource flow committed for four years and targeted at cost effective interventions in areas most in need |
| More Money for Health    | ▪ Investing to scale up efforts  
 ▪ Bridging the financing gap | ▪ Unprecedented increase in funding for high impact interventions including $500m over four years from SURE-P  
 ▪ National health bill making its way through congress |
| Holding ourselves accountable | ▪ Focus on national leadership. Govt to develop national plans  
 ▪ Strengthening Monitoring and Evaluation capacity | ▪ NSHDP as overarching strategic document for the health sector in Nigeria  
 ▪ SOML focuses on results and performance management |
Thank you
The first SURE-P baby, Hamza Abdulsalaam, born to Fatima Abdulsalaam on the 24th April, 2012 at Kuje Primary Health Center.