FEDERAL MINISTRY OF
HEALTH & SOCIAL WELFARE

The Nigeria **Child Survival Action Plan**

2025-2029

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Foreword

The rates of child mortality have declined globally in the last two decades, however, children in lower-middle-income countries, fragile and conflict-affected situations, and poor households all remain particularly vulnerable to premature and preventable deaths. The tragedy of our times is that almost all of these childhood deaths could be avoided with well-known, tested and cost-effective interventions. Unfortunately, Nigeria with an annual death of 850,000 of children is the highest contributor to the overall global burden of under-five mortality. If these child mortality trends persist, Nigeria may struggle to meet the Sustainable Development Goal (SDG) child mortality targets of reducing neonatal mortality to at least as low as 12 per 1000 livebirths and under-5 mortality to at least as low as 25 per 1000 livebirths by SDG endline in 2030.

At the 75th World Health Assembly, the Panel of Ministers of Health and other global health leaders agreed on the immediate need for urgent evidence- based action in 54 target countries including Nigeria to tackle the unfinished business of child survival. The aim is to accelerate under-five mortality reduction in these target countries by prioritizing programmatic and health system challenges that hamper progress on child survival.

Children have no voice, and their health needs are overshadowed by other conflicting priorities. It is imperative to note that investments aimed at improving their health outcomes is beneficial for a sustained economic and social development. This comes at the determination to give them a voice and the commitment to place child health high on the political, economic and development agendas through resource mobilization, stronger health outcome orientation, advocacy and monitoring that addresses the existing limitations in human and financial resources that currently prevent optimizing the delivery of life-saving interventions to improve child survival at the subnational level irrespective of the location and social status.

The renewed commitment and emphasis on childhood mortality reduction in line with the SDG 3.2 target warrants an accelerated plan that accommodates the most important life-saving interventions that will lead to childhood mortality reduction in Nigeria. I am pleased to present this plan, which highlights the collaborative effort of various stakeholders in the child health space under the oversight of the Federal Ministry of Health and Social Welfare in the development of the NCSAP. By implementing the accelerated actions highlighted, national and subnational can redress the major health system barriers and amplify the facilitators and enablers for scaling up quality integrated child-centred services and accelerating progress towards sustainable development goals for children. The NCSAP complements the Ending Preventable Maternal Mortality and Every Newborn Action Plan (ENAP-EPMM) as well as other child survival programs along the life course in articulating evidence-based interventions rooted in the principles of primary health care, at reducing the high burden of under-five killer diseases, eliminating the high prevalence of acute malnutrition and zero dose, child rights act, and equity geared towards a strengthened primary health care and universal health coverage for an accelerated reduction in child morbidity and mortality at the subnational level.

Thus, with the collective commitment to the shared principle of leaving no child behind in the mist of glaring and persistent disparities in under-five mortality of the Sector Wide Approach (SWAp), coordinated action across multiple sectors is required to address all the determinants of inequitable and unequal distribution of child health outcomes for every child. Therefore, it is our responsibilities as stakeholders in the field of child health to change the course of actions by transforming policy parameters into tangible

and measurable actions that improve the health and well-being of Nigerian children along the continuum of care and life course.

I recommend this Nigerian Child Survival Action Plan to all stakeholders at all levels of care for immediate implementation so that together we can combat child mortality and reduce it to the barest minimum.

Prof. Muhammed Ali Pate, CON
Coordinating Minister of Health and Social Welfare

Acknowledgement

The Federal Ministry of Health recognizes and appreciates the laudable contributions of all stakeholders who participated in the development of the National Child Survival Action Plan 2025-2029.

I also recognize the outstanding contributions of the Ministries (Particularly the Federal Ministry of Women Affairs and the Federal Ministry of Humanitarian Affairs and Poverty Alleviation), Departments and other Agencies of Government, particularly National Primary Health Care Development Agency (NPHCDA).

I also appreciate the erudite contribution of members of the Child Survival Sub-Committee of the National Child Health Technical Working Group, Academia, the Paediatric Association of Nigeria (PAN), the Society of Family Physicians of Nigeria (SOFPON), the Association of Public Health Physicians of Nigeria and the Nutrition Society of Nigeria.

My special than.ks go to our development partners, WHO, UNICEF, USAID, JPIEGHO/MCGL, Nutrition International, Save the Children, IHP and the Global Child Survival Action Group for their active participation and contribution to the development of the Action Plan.

On behalf of the Ministry, I acknowledge with special appreciation, the commitment of Professor Alice Nte, Chairperson of the Child Survival Sub-committee of the National Child Health Technical Working Group and the three Consultants, Prof Robinson D. Wammanda, Mrs. Tinu Taylor and Ufon Udofia for their tireless effort to develop a quality document.

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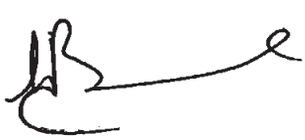

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Abbreviations/Acronyms

AIDS	Acquired Immune Deficiency Syndrome
AOP	Annual Operation Plan
AQ+SP	Amodiaquine plus sulfadoxine-pyrimethamine
ARI	Acute Respiratory Infection
BCG	Bacillus Calmette-Guérin
BFHI	Baby -Friendly Hospital Initiative
BFI	Baby Friendly Initiative
BHCPF	Basic Health Care Provision Fund
CBO	Community Based Organisations
CHIPS	Community Health Influencers, Promoters and Services
CHWs	Community Health Workers
CME	Continuous Medical Education
CRA	Child's Right Act
CRVS	Civil Registration and Vital Statistics
CSA	Child Survival Action
CSO	Civil Society Organisations
ECD	Early Childhood Development
DHIS2	District Health Information System 2
ENAP-EPMM	Ending Preventable Maternal Mortality and Every Newborn Action Plan
ENCC	Essential Newborn Care Course
EPMM	Ending Preventable Maternal Mortality
EPTB	Extra Pulmonary Tuberculosis
DOTS	Directly Observed Treatment Short course
DT Amoxicillin	Dispersible Tablet-Amoxicillin
FCT	Federal Capital Territory
FGN	Federal Government of Nigeria
FMoH	Federal Ministry of Health
FMoHSW	Federal Ministry of Health and Social Welfare
GFF	Global Funding Facility
GIS	Geographic Information System
HBV	Hepatitis B vaccine
HCWs	Health Care Workers
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRH	Human Resource for Health
HSSB	Health Sector Strategic Blueprint
iCCM	Integrated Community Case Management of Childhood Illness
IGME	Interagency
IMAM	Integrated Management of Acute Malnutrition
IMCI	Integrate Management of Childhood Illness
IMNCH	Integrated Maternal, Newborn and Child Health
IMNCI	Integrated Management of Newborn and Childhood Illness
IMCI FP	Integrated Management of Childhood Illness Focal Person
IPC	Infection Prevention and Control
IPV	Inactivate Polio Vaccine
ITN	Insecticide Treated Net

KIR	Key Indicator Report of the NDHS 2023-24
LGA	Local Government Area
LGHA	Local Government Health Authority
LLITN	Long-Lasting Insecticide-Treated Net
LMCU	Logistic Management Coordinating Unit
LMIS	Logistics Management Information System
LQAS	Lot Quality Assurance Sampling
MUAC	Mid Upper Arm Circumference
MDAs	Ministries, Departments and Agencies
MDGs	Millennium Development Goals
M&E	Monitoring and Evaluation
MEAL	Monitoring, Evaluation, Accountability and Learning
MICS	Multiple Indicator Cluster Survey
MIS	Management Information Systems
MIYCN	Maternal, Infant and Young Child Nutrition
MNH	Maternal and Newborn Health
MoH	Ministry of Health
MOSV	Missed Opportunity for Simultaneous Vaccination
MPCDSR	Maternal Perinatal and Child Death Surveillance & Response
MSH	Management Sciences for Health
MSP	Minimum Service Package
MSS	Midwives' Service Scheme
MTR	Mid Term Review
NACA	National Agency for the Control of AIDS
NAFDAC	National Agency for Food and Medicines Administration and Control
NBS	National Bureau of Statistics
NCDC	Nigeria Centre for Disease Control
NCSAP	Nigeria Child Survival Action Plan
NDHS	Nigeria Demographic and Health Survey
NFCMS	National Food Consumption and. Micronutrient Survey
NHIA	National Health Insurance Authority
NICS	National Immunisation Coverage Survey
NiENAP	Nigeria Every Newborn Action Plan
NMCP	National Malaria Control Programme
NFM4	New Funding Model IV (NFM4)
NHRHIS	National Database of Human Resource for Health Information System
NHSRII	Nigerian Health Sector Renewal Investment Initiative
NNHS	National Nutrition and Health Survey
NPHCDA	National Primary Health Care Development Agency
NPC	National Population Commission
NTBLCP	National TB Leprosy and Buruli Ulcer Control Programme
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
PAN	Paediatric Association of Nigeria
PCV	Pneumococcal Vaccine
PCR	Polymerase Chain Reaction
PENTA	Pentavalent Vaccine
PHC	Primary Health Care
PMP	Performance Monitoring Plan

PPP	Public- Private Partnership
QOC	Quality of Care
RDT	Rapid diagnostic test for malaria
RMNCAEH+N	Reproductive, Maternal, Newborn, Child, Adolescent and Elderly Health plus Nutrition
ROTA	Rotavirus Vaccine
RUTF	Ready-to-Use Therapeutic Food
SBCC	Social and. Behaviour Change Communication
SCD	Sickle Cell Disease
SDGs	Sustainable Development Goals
SMoH	State Ministry of Health
SOML	Saving One Million Lives
SOP	Standard Operating Procedures
SORMAS	Surveillance Outbreak Response Management and Analysis System
SPHCDB	State Primary Health Care Development Board
Sure-P MCH	Subsidy Reinvestment and Empowerment Programme MCH
SRMH	Sexual Reproductive and Maternal Health
SSHIS	State Social Health Insurance Scheme
SWAp	Sector Wide Approach
TB	Tuberculosis
ToR	Terms of Reference
TWG	Technical Working Group
U5MR	Under-5 Mortality Rate
UN	United Nations
UNICEF	United Nations Children's Fund
VASA	Verbal Autopsy and Social Autopsy-Survey
VDC	Village Development Committee
WASH	Water Sanitation and Hygiene
WASHNORM	Water, Sanitation and Hygiene National Outcome Routine Mapping
WB	World Bank
WDC	Ward Development Committee
WHO	World Health Organisation
WMHCP	Ward Minimum Health Care Package

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Executive Summary

Nigeria, the most populous nation in Africa has an estimated population of 214,000,000 as of 2024 with children under the age of five (0- 59 months) making up 19% of the population. Over the past two decades, Nigeria has made significant progress in reducing child mortality but unfortunately, the country was unable to achieve Millennium Development Goal 4 (MDG 4) for child survival and still grapples with unacceptably high under-five mortality rates. The 2023-24 Nigeria Demographic and Health Survey (NDHS) showed that the under-5 mortality rate for the 5-year period preceding each survey rose from 193 deaths per 1,000 live births in the 1990 NDHS to 201 deaths per 1,000 live births in the 2003 NDHS and has since generally decreased, to 110 deaths per 1,000 live births in the 2023–24 NDHS. This reduction in the under-five mortality rate in Nigeria is significantly slower than what is needed to achieve the Sustainable Development Goals (SDGs) target of reducing child mortality to at least as low as 25 deaths per 1,000 live births and neonatal mortality to at least as low as 12 deaths per 1,000 live births by the year 2030. In 2022, Nigeria was listed among the 54 target countries in the world that need to take immediate urgent evidence-based actions to tackle the unfinished agenda of child survival if the SDG 3 2030 target of reducing child mortality to at least as low as 25 deaths per 1000 live births is to be realised. If the country wants to achieve the global averages a further reduction of 66% is needed. Nigeria will have to accelerate action to achieve the global SDG 3.2.1 target by 2030.

In response to the call to action by Child Survival Action (CSA) initiative for all partners to join hands with national governments, civic and traditional leaders, as well as communities, to address the programmatic and health system challenges that hamper progress in child survival, especially in the countries that are not on track to meet their SDG 3 2030 targets, the Federal Ministry of Health and Social Welfare (FMoHSW), through the National Child Health Technical Working Group and Partners initiated the process of developing a Nigerian Child Survival Action Plan (NCSAP) (2025-2029) to identify opportunities and actions that will accelerate the implementation of policies and investments towards reaching all children with life-saving interventions. The process of developing this national plan was participatory and driven by available evidence and documented best practices.

The NCSAP developed along the theory of change for child survival, thriving, and transforming is aligned with and complements regional framework for strengthening integrated child-centered services which is situated within the context of reorienting health systems to a primary health care approach, and universal health coverage. It emphasizes alignment across health programmes, service delivery levels and providers, and health systems support. It advocates empowerment of people and communities and highlights priority areas for multisectoral action and efforts that promote the continuum of care along the life course. The plan lays out priority strategies for children 1-59 months and underlying health system issues to be strengthened with measurable outputs to achieve the desired outcome – focusing on primary health care approach and eliminate equity gaps to ensure universal health coverage for the accelerated reduction in child morbidity and mortality.

The 2019 Verbal and Social Autopsy Study (2019 VASA) showed that infectious diseases dominated the causes of deaths of children under the age of five. For children age 1-59 months, malaria and diarrhea were the top two causes of death while pneumonia and meningitis were other major causes. These death rates in children varied greatly by zone. Child deaths aged 1-4 years were highest in the North-West (117 per 1000 births), high in the North-East (65 per 1000 births) and much lower in the other zones (20-39 per 1000 births).

As it became obvious that the rate of decline of under-five mortality was slower than needed for Nigeria to achieve MDG 4 in 2015, a number of policies, strategies, programmes, and activities to improve un der-five survival either directly or through improving maternal health were introduced while ensuring integration across other programme areas such as immunization, WASH, nutrition, Air pollution, early childhood development were considered. With the SDG in mind, other policies, strategies and programmes have been developed.

Applying the process of the bottleneck analysis guided by the child survival action toolkit with inputs from relevant stakeholders, critical systems issues hindering acceleration of child survival in Nigeria were identified. The bottleneck analysis also identified context-specific challenges and barriers hindering effective utilization of high-impact interventions for accelerated reduction in child mortality.

The Nigerian Child Survival Action Plan is based on a set of guiding principles within the context of primary healthcare. These principles are the moral and ethical compass that will guide the actions, decisions, and strategies to ensure that the plan's objectives are met.

The vision of the NCSAP is a Nigeria in which there are no preventable deaths of children aged 1 to 59 months and where the health, rights, development and well-being of this priority group are ensured to enable them survive and reach their full potentials with the mission to promote integration of relevant Reproductive, Maternal, Newborn, Child, Adolescent and Elderly Health plus Nutrition services and programmes along the continuum of care, as well as provide a framework for the equitable delivery of high-quality priority child survival interventions across the life course. The overall goal of the plan is to accelerate the reduction of preventable deaths of children 1-59 months of age in Nigeria.

The Strategic Approaches for the implementation of the NCSAP included engagement with the Leadership for effective governance, ppartnership and coordination for the implementation of quality priority interventions and monitoring for equitable coverage, improving quality of care, increase access to healthcare for vulnerable population, community engagement, data-driven approach for evidence based decisions, track progress and Stakeholders' accountability at all levels and mobilisation and equitable distribution of resources.

To maximise the impact of the Plan, the NCSAP has prioritised States and tailored their key activities based on their performance levels. The States are categorised into low, mid, or high performing states. One Hundred and Seventy Two (172) LGAs were identified as LGAs with poorest child mortality in the country based on triangulation analysis from these data sources (routine DHIS 2; NDHS 2018, Nigerian Malaria Indicator Survey 2022, Health Facility Assessment 2023).

Recognizing that efficient coordination and the delineation of roles and responsibilities among stakeholders are critical for the successful imlementation of the NCSAP., For effective management of the Plan, roles and responsibilities have been identified and assigned to the various levels of government and key stakeholders.

In alignment with the principles guiding the Monitoring and Evaluation of the HSSB and SWAp of the HMH's agenda, the RMNCAEH+N, which serves as the primary reference resource for developing the NCSAP, has established a comprehensive M&E framework. This framework provides guidance, indicators, and targets for child survival, serving as the foundation for the NCSAP's MEAL component.

Using a customized tool which incorporated relevant elements from the One Health Tool, the estimated cost for implementing the NCSAP 2024 -2029 was computed. The under-five population was identified as a

key factor in determining intervention costs. The 2029 projected population figures were used to compute intervention costs for all under-five child health indicators. Seven indicators (ITN use, malaria, ARI, diarrhoea, vaccination, nutrition, and WASH) from NDHS 2024, MICS 2023, and WASHNORM 2021 were used to calculate under-five child health intervention costs, focusing on specific health risks and basic hygiene needs.

Chapter **1**

Introduction

Nigeria, located in West Africa is the most populous nation on the African continent and the seventh in the world with an estimated population of 214,000,000 as of 2024.[1] Children under the age of five (0- 59 months) make up 19% of Nigeria's population. Nigeria is vibrant with diversity and rich in culture. However, amid this tapestry of life, there lies a profound and pressing challenge ensuring the survival and well-being of children.

In the past two decades, Nigeria has made significant progress in reducing child mortality.[2] However, the country was unable to achieve Millennium Development Goal 4 (MDG 4) for child survival and still grapples with unacceptably high under-five mortality rates. The Key indicator report of 2023-24 Nigeria Demographic and Health Survey (NDHS) showed that the under-five mortality rate (U5MR) for the 5-year period preceding each survey rose from 193 deaths per 1,000 live births in the 1990 NDHS to 201 deaths per 1,000 live births in the 2003 NDHS and has since generally decreased, to 110 deaths per 1,000 live births in the 2023–24 NDHS (NDHS 2023-24).[2] However, the neonatal mortality over the same period declined from 48 deaths per 1,000 live births in the 2003 NDHS to 39 deaths per 1,000 live births in 2018 NDHS and rose again to 41 deaths per 1,000 live births in 2023-24. This reduction in the under-five mortality rate in Nigeria is significantly slower than what is needed to achieve the Sustainable Development Goals (SDGs) target of reducing child mortality to at least as low as 25 deaths per 1,000 live births and neonatal mortality to at least as low as 12 deaths per 1,000 live births by the year 2030.[3] Nigeria is not on track in achieving the SDG 3.2 2030 targets for under-five and neonatal mortality. With its population growth rate of 2.5%, Nigeria has the most under-five deaths each year in the world.

The Nigeria Child Survival Action Plan (NCSAP) is a demonstration of the country's unwavering commitment to addressing this challenge, advocating for a brighter future, and embracing its shared responsibility. The theme is 'Advancing Child Survival in Nigeria: A Vision for a Healthier Tomorrow'.

1.1 Development of the Nigeria Child Survival Action Plan

In 2022, Nigeria was listed among the 59 target countries in the world that need to take immediate urgent evidence-based actions to tackle the unfinished agenda of child survival if the SDG 3 2030 target of reducing child mortality to at least as low as 25 deaths per 1000 live births is to be realised.[4]

The Child Survival Action (CSA) initiative is a renewed call to all partners to join hands with national governments, civic and traditional leaders, as well as communities, to address the programmatic and health system challenges that hamper progress in child survival, especially in the countries that are not on track to meet their SDG 3 2030 targets. Efforts in the development of the NCSAP are situated within the global context of child survival and public health. While Nigeria possesses a distinct identity, we recognize that child mortality is a universal challenge that transcends borders. It is a global issue that requires a united and determined response from all.

In response to this Call to Action, the Federal Ministry of Health and Social Welfare (FMoHSW), through the National Child Health Technical Working Group and Partners initiated the process of developing a NCSAP to identify opportunities and actions that will accelerate the implementation of policies and investments

towards reaching all children with life-saving interventions. The Plan underscores the Government's determination to realize SDG 3, which aims to ensure healthy lives and promote well-being for all and at all ages. It is developed in the context of a shared responsibility of bridging inequity that transcends political, cultural, and geographical boundaries aligning it to the revised Reproductive, Maternal, Newborn, Child, Adolescent and Elderly Health plus Nutrition (RMNCAEH+N) strategy 2024-2028 and the Nigerian Health Sector Renewal Investment Initiative (NHSRII) (2023-2027)

The process of developing this national plan was participatory and driven by available evidence and documented best practices. It involved consultations with experts drawn from several government Ministries, Departments and Agencies, academia and professional groups, Non-Governmental Organisations, Civil Society Organisations (CSOs), International Development Partners and Independent Experts.

1.2 Overview of the Nigeria Child Survival Action Plan (NCSAP)

The NCSAP is a roadmap to ending preventable deaths among children 1-59 months of age. This comprehensive, evidence-based plan is rooted in the principles of public health, child rights, and equity geared towards the best interest of the child. The plan emphasizes the need for strong collaboration among all stakeholders in order to ensure that no child is left behind.

The NCSAP is developed along the theory of change for child survival. The plan lays out priority strategies for children 1-59 months and underlying health system issues to be strengthened with measurable outputs to achieve the desired outcome – strengthening primary health care and eliminate equity gaps to ensure universal health coverage for the accelerated reduction in child morbidity and mortality.

The NCSAP is aligned with and complements the Ending Preventable Maternal Mortality and Every Newborn Action Plan (ENAP-EPMM) acceleration plan, as well as other child survival programs and efforts that promote the continuum of care along the life course, such as programs focusing on strengthening routine immunization and reaching the unreached and zero-dose children, maternal infant and young child nutrition in Nigeria. The NCSAP elevates child survival in Nigeria to the highest level to accelerate the reduction of the unacceptably high child mortality. It will serve as a framework for Nigeria's 36 States and the Federal Capital Territory (FCT) to develop -specific action plans and to track progress towards the desired outcomes.

Chapter **2**

The Health Status of Under-Five Children in Nigeria

2.1 Under-five Mortality Trends and Equity Gap

Globally, there has been a substantial decrease in under-five deaths since the 1990s. However, there still exists an estimated five million deaths of under-fives 5 which is still unacceptably high. A great number of children are not reached by effective interventions at the appropriate time due to inequitable distribution of services occasioned by inadequate investment in primary health care. Highest rates of child mortality are in the sub-Saharan Africa particularly West and Central Africa.[5]

Nigeria recorded about 835,000 under-five deaths in 2022, contributing to 17% of total global deaths of under-fives[4], ranking first on the list of countries with the highest burden of child mortality. This implies that 1 in every 9 children born in Nigeria dies before his/her fifth birthday.

The under-5 mortality rate for the 5-year period preceding each NDHS has shown significant decline from 1990 to 2023-24 data with a decline from 193 deaths per 1,000 live births to 110 deaths per 1,000 live births. The infant mortality rate has also decline from 87 deaths per 1,000 live births to 63 deaths per 1,000 live births. The Neonatal mortality rate however, has not shown any significant reduction from 1990 to 2023-24 which still remains at 41 deaths per 1,000 live births [2]. (Figure 1)

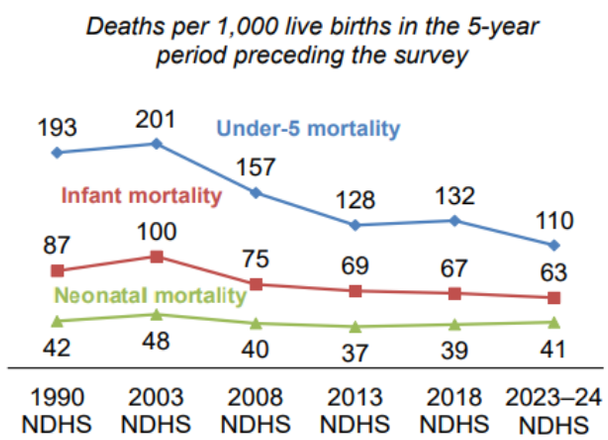


Figure 1: Trends in Childhood Mortalities in Nigeria (1990-2023-24)[2]

These death rates in children varied greatly by geopolitical zones of the country with subnational inequities being the major drivers of the observed differences in the mortality rates. The Northwest zone has the highest under-five mortality rate at 140 per 1000 live births, and the Southwest zone is lowest, at 42 per 1000 live births.[2] Among the states, Under-5 mortality rate is highest in Jigawa, Northwest (161 deaths/1000 live births) and lowest in Kwara, North central (14 deaths/1000 live birth) while neonatal mortality rate is highest in Kano, Northwest (59 deaths/1000 live births) and lowest in Ondo, South-West (3 deaths/1000 live births).

Nigeria is among the countries in the world that are not on track to achieve the 2030 SDG target for under-five mortality rate of at least as low as 25 deaths per 1,000 live births. There is a wide gap between the annual reduction of under-five mortality required to achieve the 2030 SDG target and the current rate of reduction of under-five mortality in Nigeria. Achieving the 2030 SDG target for U5MR in Nigeria would save nearly 3.6 million children's lives, but that would require an increase in the reduction of U5MR from the current estimate of 2% per year to 16% per year. [3]

There is some improvement in immunization coverage over the years in Nigeria from 29% in 1990 to 39% in 2023-24 for children age 12-23 months who received all basic vaccinations. Similarly, percentage of children who received none of the basic vaccinations declined from 36% to 31% during the same period.2 However, 37.1% of children still remain zero dose by status. The NDHS 2023-24 report showed wide disparity in coverage by states, with coverage highest in Cross-river state (94.6%) South-south zone and lowest in Sokoto (10.9%) Northwest zone. This trend is far short of SDG 3 target of more than 90% coverage of all basic immunizations among children age 12-23 months.

The proportion of missed opportunity for simultaneous vaccination (MOSV) was highest in Northwest (35.8%) and lowest in Southwest (18.6%). At state level, the MOSV was highest in Sokoto (50.0%) (46.9%) and lowest in Lagos (10.4%).[7]

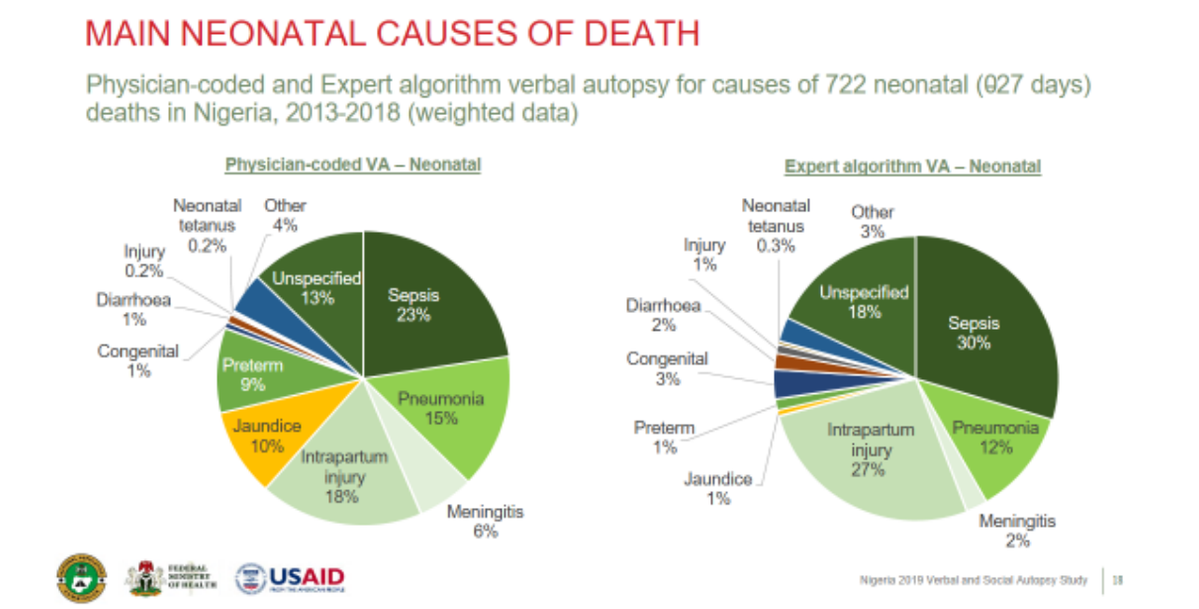
In addition, there is a significant disparity in access to some essential health services. According to the NDHS 2023-24, skilled birth attendance was highest in the Southeast, 88.1% and lowest in the Northwest 25.6%, with a national average of 45.7%. Penta 3 coverage was highest in South-south, 78.7% and lowest in the northwest, 39.6% with a national average of 53.3%. Percentage of children with diarrhea given ORS, Zinc and advised on continued feeding was highest in the Northeast 23.3%, and lowest in Southeast 7.6%, with a national average of 16.3%. Percentage for whom advice was sought for ARI at National level was 60.1%.

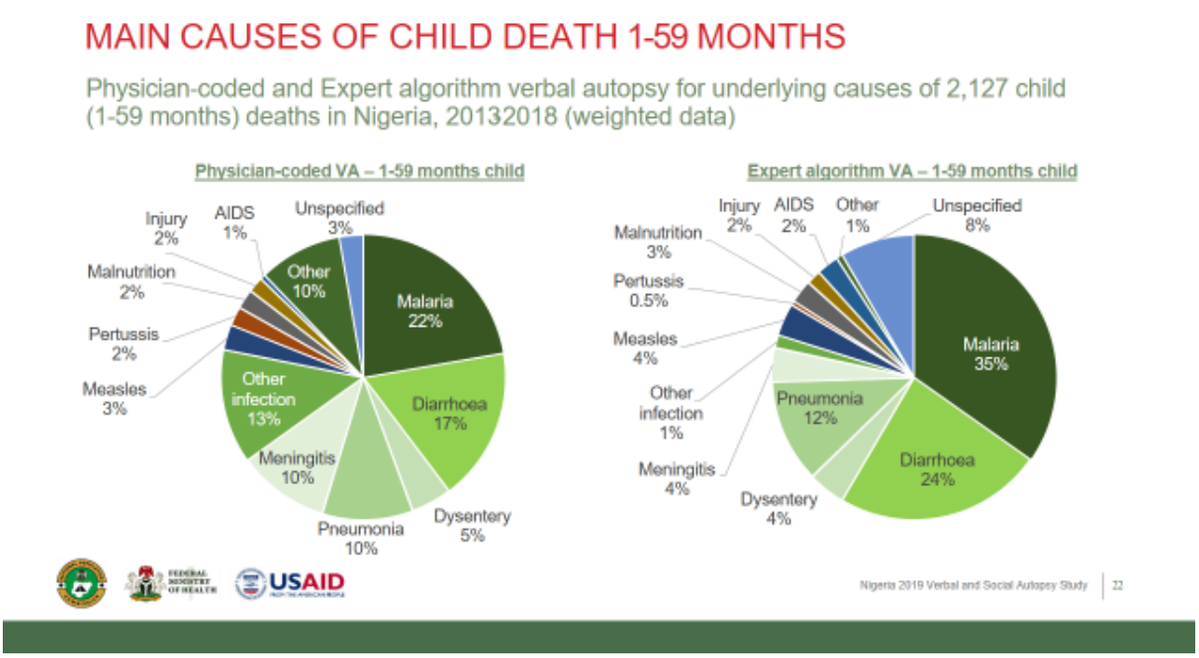
2.2 Causes of Under-five Mortality

The 2019 Verbal and Social Autopsy Study (2019 VASA) showed that infectious diseases dominated the causes of deaths of children under the age of five.6 In children aged 1-59 months, malaria and diarrhea were the top two causes of death while pneumonia and meningitis were other major causes. Malnutrition is a major underlying contributor in almost all cases of death in these age-group and was also identified as the major risk factor for Tuberculosis (TB) in Nigeria. [8]

In the neonates, infections (sepsis, pneumonia and meningitis) were the leading causes of death followed by intrapartum injuries (birth asphyxia, birth trauma) as well as jaundice and prematurity. In this group of under-five children, prematurity and/or low birth weight were significant contributing factors. Most of these disease conditions are either preventable and/or treatable.

Nigeria's high neonatal and child mortality rates in comparison to other countries in Africa are not due to different diseases but to higher rates of deaths from the same diseases. Figure 4 below depict the commonest cause of deaths in Under-fives in Nigeria.





Many other conditions are less common, including both other infections and several non-infectious causes (e.g. injuries, sickle cell disease).

Figure 4 Cause of under 5 mortality

Death rates in children varied greatly by zone. Child deaths aged 1-4 years were highest in the Northwest (117 per 1000 births), high in the Northeast (65 per 1000 births) and much lower in the other zones (20-39 per 1000 births). Malaria, diarrhoea and pneumonia were the top three causes of deaths in children aged 1-59 months by physician-coded and expert algorithm verbal autopsy methods. This was similar to the 2014 VASA and global models of child mortality. Furthermore, most of the remaining deaths in this age group were also from infections. Signs of malnutrition were common in the VASA study, but this was mostly treated as an underlying contributor rather than as a cause of death.6 The WHO estimates that malnutrition contributes to 45% of under-five deaths.[8]

2.3 The Continuum of Care along the life course (Maternal, Newborn, Child and Adolescent Health)

The NCSAP aims to ensure the integrated implementation of evidence-based interventions for child health. It involves strengthening the health system to ensure the delivery of essential interventions along the continuum of care. The continuum for maternal, newborn, child and adolescent health refers to continuity of individual care with two dimensions – the maternal, newborn, child health (MNCH) continuum of care and the household to hospital continuum of care (HHCC). This encompasses a continuum of essential interventions that should be accessible throughout the lifecycle (adolescence, pregnancy, childbirth, the postnatal period, and childhood) and between places of caregiving (including households and communities, outpatient and outreach services, and clinical-care settings). Figure 5.

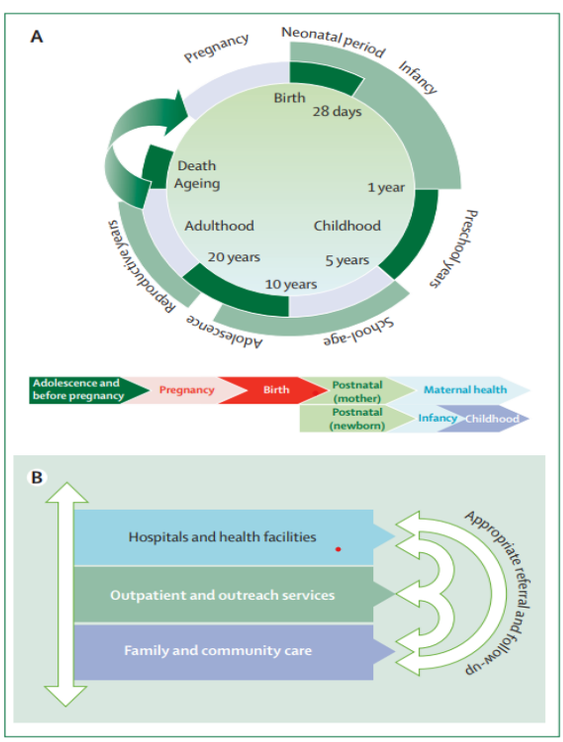


Figure 5: Continuum of care connecting care during the lifecycle (A) and at places of care (B). Adapted from Partnership for Maternal, Newborn, Child and Adolescent Health

Saving lives for under-five depends on high coverage and quality of integrated service-delivery packages throughout the continuum, with functional linkages between levels of care in the health system and service-delivery packages, such that the care provided at each time and place contributes to the effectiveness of all the linked packages. The packages are delivered through clinical care, outpatient, and outreach services as well as through integrated family and community care throughout the lifecycle.

Nigeria has made systematic efforts to integrate family and community package with other levels of care. Building the continuum of care for maternal, newborn, and child health with these packages has led to policy support for integration; investment to strengthen health systems; results-based operational management, especially at subnational level and review/update of existing policy documents on MNCH to promote continuum of care. This includes the implementation of the national health policy, Health Sector Strategic blue print (2023-2027) which will be actualized using the Sector Wide Approach (SWAp) as well as the Reproductive, Maternal, Newborn, Child, Adolescent and Elderly Health plus Nutrition (RMNCAEH + N) Strategy to shape responses at all levels of care.

2.4 Country Policies, Strategies and Programmes to promote the Health and Survival of Under-five Children in Nigeria

National policies, strategies and programmes exist in Nigeria for all areas of RMNCAEH+N issues at all levels of care. As it became obvious that the rate of decline of under-five mortality was slower than needed for Nigeria to achieve MDG 4 in 2015,6 a number of policies, strategies, programmes, and activities to improve under-five survival either directly or through improving maternal health were introduced. With the SDG in mind, other policies, strategies and programmes have been developed. Table 1 shows policies/strategies, programmes and activities to promote under-five health and survival.

Table 1. Policies, Strategies, Programmes and Activities to promote the Health and Survival of Under-five Children in Nigeria

Policies	When	Purpose/Description
The National Child Rights Act	2003	In line with the UN Convention of the Rights of the Child, aimed at up-holding the best interests of a child to be of paramount consideration in all actions taken in the care provided to children.
National Policy for Integrated Early Childhood Development in Nigeria	2007	To expand, universalize and integrate interventions from various sectors in early childhood development for efective implementation and coordination of programmes that will, optimize development for children age 0-5 years in Nigeria
National Health Act	2014	To provide a framework for the regulation, development and management of the national health system and sets standards for rendering health services in Nigeria.
National Task Shifting and Task Sharing Policy	2014	To promote rational redistribution of tasks among existing health workforce cadres and allow for moving speciic tasks, where appropriate, from highly qualiied health workers to health workers with shorter training and fewer qualiications in order to make more e cient use of the available health workers to improve access to services for the Nigerian people.
National Health Policy	2016	To accommodate emerging trends and to attain Universal Health Coverage and other health-related Sustainable Development Goals, the FMoH revised the National Health Policy.
National Health Promotion Policy	2019	This seeks to improve the health and wellbeing of Nigerians' through promotion of healthy lifestyle'. It provides guidance for the empowerment of individuals, families, households, groups and communities, with appropriate information on helpful habits, steps and behaviours to maintain good health and reduce the burden of communicable and non-communicable diseases, but also inform on the negative impact of certain practices.
National Child Health Policy	2022	To provide framework for planning, management, delivery and supervision of services to address the critical problems afecting childcare in the target group .
National Policy on Maternal, Infant and Young Child Nutrition	2022	Aims to improve the health outcomes of pregnant women, infants, and young children by promoting optimal nutrition practices. The policy includes strategies such as promoting exclusive breastfeeding, providing access to nutritious foods and supplements, and improving healthcare services. The goal is to reduce malnutrition, enhance maternal and child health, and overall well-being in Nigeria.

Policies	When	Purpose/Description
Strategies		
Integrated Management of Childhood Illness (IMCI)	1997 revised 2024	To improve the quality of care for children under ive years of age. It focuses on training healthcare providers in the integrated management of common childhood illnesses, promoting preventive measures, and strengthening the health system. The goal is to reduce child mortality and improve the overall health and well-being of children in Nigeria.
Integrated Maternal, Newborn and Child Health (IMNCH) Strategy	2007	To provide policy direction and guidance to the diferent levels of government to formulate more in-depth operational/implementation plans for an Integrated Maternal, Neonatal and Child Health (IMNCH) Programme.
National Guideline for "The Maternal, Perinatal and Child Death Surveillance and Response"	2015	To eliminate preventable maternal and perinatal deaths by enhancing accountability for maternal and perinatal health through active surveillance and speedy response to Maternal and Perinatal deaths.
Essential Newborn Care Course	2016 revised 2019	To provide an Essential Newborn Care Course (ENCC) with a combination of documented evidences about newborn health in Nigeria and global best practices to ensure provision of a full range of updated, evidence-based interventions and standards that will enable health care workers to give high quality care during childbirth and postnatal period considering the needs of the newborn baby. The ENCC conveys the national recommended standards for use at all levels of health care delivery.
Nigeria Every Newborn Action Plan (NiENAP)	2016 revised 2023	To accelerate progress and scale up evidence-based high-impact and cost-efective interventions to end preventable stillbirths and newborn deaths.
National Strategy for Scale up of Chlorhexidine in Nigeria	2016	To lead national scale-up eforts and overcome key barriers in realising widespread coverage of Chlorhexidine gel in Nigeria by integrating Chlorhexidine gel use into existing health programmes and supporting the scaleup of other products for mothers and children in Nigeria.
Integrated Community Case Management of Childhood Illness (iCCM)	2016	It enables the assessment, classiication, treatment, and referral of cases of the main causes of mortality among children under the age of ive years in Nigeria: pneumonia, diarrhea, and malaria.
National Guidelines for Maternal and Perinatal Deaths Surveillance and Response in Nigeria (2017)	2017	To provide a standardized approach to monitoring and investigating maternal and newborn deaths. By following these guidelines, healthcare providers and policymakers can identify the causes and contributing factors to these deaths, implement interventions to prevent future deaths, and ultimately improve the quality and safety of maternity care services. The goal is to reduce the incidence of preventable deaths and improve outcomes for pregnant women and newborns.

Policies	When	Purpose/Description
Strategies		
Reproductive Maternal Newborn Child Adolescent and Elderly Health plus Nutrition (RMNCHAEH+N)	2018	Aligns with the global strategy, the SDGs, as well as Nigeria's National Health Policy and the National Strategic Health Development Plan. It is also in tandem with Nigeria's Health Sector Renewal Initiative towards a Healthy and Prosperous Nigeria, and seeks to promote survival and healthy development of women, children, and adolescents.
National Guidelines on integration of TB care into RMNCAH+N services	2018	To promote integration of TB care into RMNCAH+N services towards improving prevention, diagnosis and treatment of TB in children and adolescents
National Pneumonia Control Strategy and Implementation Plan (2019)	2019	To reduce newborn and child morbidity and mortality caused by pneumonia, aligned with and supportive of the integrated health goals of the FGN. Within SDG 3.2 to end under-ive preventable deaths, the GAPPD target is to reduce newborn and child pneumonia deaths to less than 3 per 1,000 live births by 2030.
National Essential Medicines List	2020	To streamline the medicines to be deployed in the healthcare delivery system of the country by providing a reference standard for all levels of health care towards ensuring good medicine supply management as all listed medicines are to be procured by the public health facilities for the enhancement of quality of health care services.
National guideline on self-care for SR and Maternal health (2020)	2020	To standardize guidance on self-care for SRMH including creating an enabling environment for the implementation across Nigeria, based on WHO's Consolidated Guideline on Self-Care Interventions for SRHR.
National Strategy for Maternal, Infant and Young Child Nutrition (MIYCN) in Nigeria	2021	The overall goal of the National Strategy for Maternal Infant and Young Child Nutrition is to ensure the optimal nutrition of adolescent girls, pregnant and lactating women, and children aged zero to 59months to contribute to the prevention and management of malnutrition among them.
National Guidelines on Maternal, Infant and Young Child Nutrition, 2022	2022	To guide health workers, public health practitioners, and caregivers, as well as interested members of the general public on how to improve the nutritional status of Mothers, infants and young children including children and women in exceptionally difficult circumstances.
National Guidelines for Integrated Management of Acute Malnutrition	2022	Aimed at standardising the identiication, treatment and management of acute malnutrition among children; and pooling adequate resources for management of malnutrition. Also provide guidance for the special circumstances of the conditions of chronic illnesses including HIV and emergency settings.

Policies	When	Purpose/Description
Strategies		
Counselling Guide on key Household practices	2022	The guide aims to empower individuals and families to create a supportive and nurturing home environment that promotes well-being and happiness.
Desk Guide for Prevention, Diagnosis and Treatment of Tuberculosis in Children and Adolescents in Nigeria	2023	To improve the management of TB in children and adolescents by addressing early and accurate diagnosis of pulmonary and extra-pulmonary TB (EPTB); contact investigation and TPT; management of childhood and adolescent TB in special situation; treatment outcomes; and management of presumed or conirmed drug -resistant TB (DR-TB).
Programmes		
Community Health Inluencers, Promoters and Services (CHIPS) programme	2022	CHIPS was initiated in a bid to reposition and strengthen PHC and community-based interventions in the country. It aims to improve access to, and equitable coverage for essential health services, especially those related to maternal and child survival in rural and urban communities.

Chapter **3**

Bottleneck Analysis

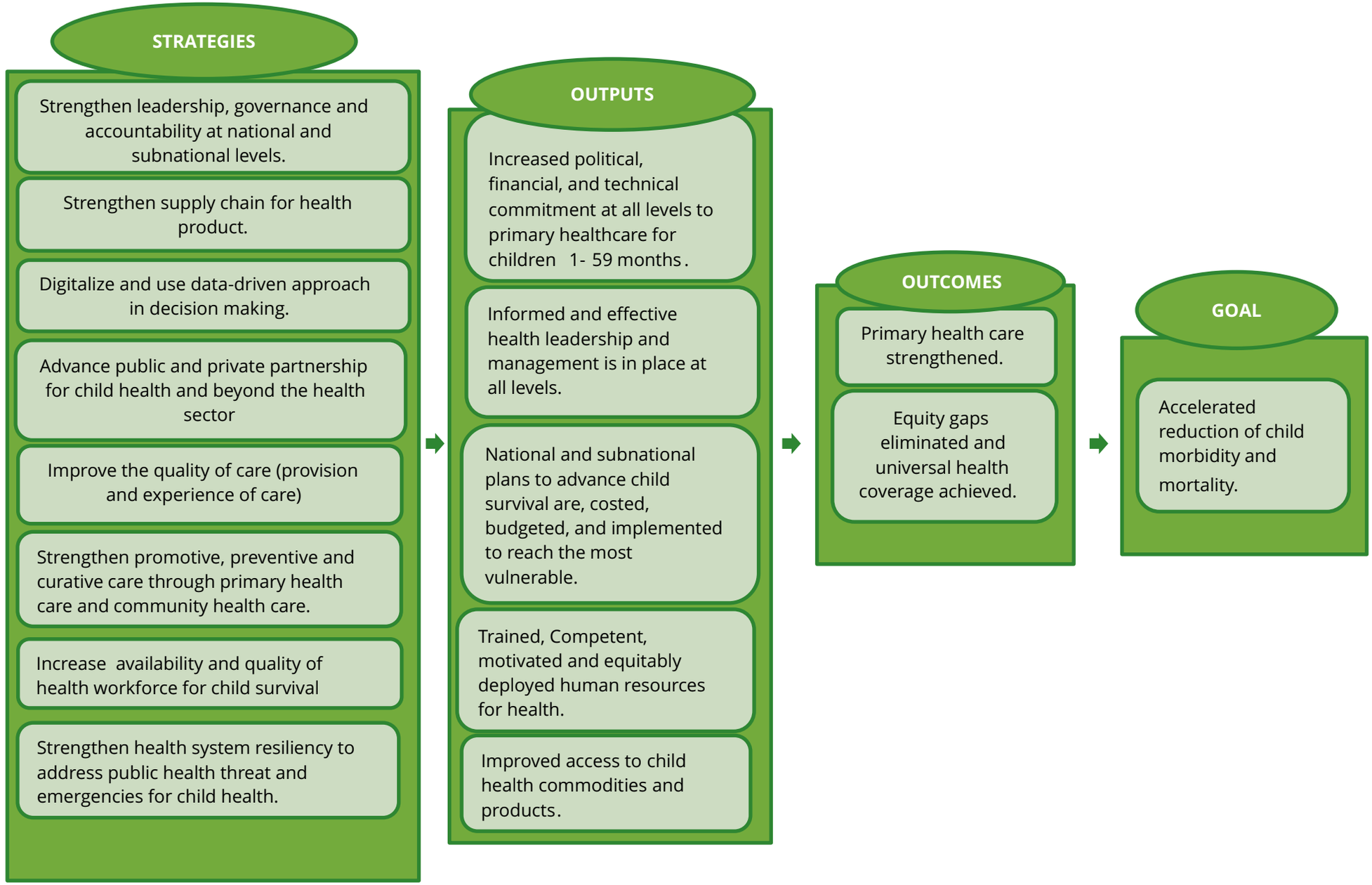
In September 2023, a bottleneck analysis was conducted by stakeholders to identify critical systems issues hindering acceleration of child survival in Nigeria. The process of the bottleneck analysis guided by the child survival action toolkit with inputs from relevant stakeholders informed identification of context-specific challenges and barriers hindering effective utilization of high-impact interventions for accelerated reduction in child mortality.

Table 2 shows the major bottlenecks identified for priority child health interventions

Health system building block	Key bottlenecks and challenges
Leadership and Governance	Weak child health leadership and accountability
Health financing	Poor optimization of funding opportunities Poor utilization of funding for health
Health workforce	Inadequate and maldistribution of health workforce Weakness in health workers capacities
Medical products	Stockout or unavailability of essential child health commodities
Health Services delivery	Poor adherence to norms, standards and guidelines Poor/Inadequate referral systems between community, primary and secondary health facilities Poor/Inadequate quality of care in facilities
Health Information system	Poor accountability and oversight on quality data report and use
Community Ownership and partnership	Poor institutionalization of Community Health Workers Poor community engagement

3.1 Theory of Change

The findings from the bottleneck analysis and the vision for the health sector strategic blueprint informed the theory of change for detailing the strategies, outputs and outcomes needed to reach the goal and vision of this plan (Figure 6 below).


STRATEGIES
Strengthen leadership, governance and accountability at national and subnational levels.
Strengthen supply chain for health product.
Digitalize and use data-driven approach in decision making.
Advance public and private partnership for child health and beyond the health sector
Improve the quality of care (provision and experience of care)
Strengthen promotive, preventive and curative care through primary health care and community health care.
Increase availability and quality of health workforce for child survival
Strengthen health system resiliency to address public health threat and emergencies for child health.
OUTPUTS
Increased political, financial, and technical commitment at all levels to primary healthcare for children 1- 59 months.
Informed and effective health leadership and management is in place at all levels.
National and subnational plans to advance child survival are, costed, budgeted, and implemented to reach the most vulnerable.
Trained, Competent, motivated and equitably deployed human resources for health.
Improved access to child health commodities and products.
OUTCOMES
Primary health care strengthened.
Equity gaps eliminated and universal health coverage achieved.
GOAL
Accelerated reduction of child morbidity and mortality.

3.2 Guiding Principles and Theory of Change

Guiding Principles

The Nigeria Child Survival Action Plan (NCSAP) is based on a set of guiding principles within the context of primary healthcare. These principles are the moral and ethical compass that will guide the actions, decisions, and strategies to ensure that the plan's objectives are met. These include:

Country Leadership: Leadership for the implementation of the NCSAP at each level will be provided by the responsible authority – the MoH at the Federal and, State level and the Local Government Health Authorities (including the Ward Development Committees at the Ward and Community) levels.

Integration: NCSAP recognises that child survival is a shared responsibility. Implementation will be done within the context of continuum of care as against vertical programming. All components relevant to the target age group 1-59 months will be integrated across all health service delivery levels. This will foster partnerships and collaborations with government, professional associations, academia, implementing partners, development partners, civil society, the private sector, and communities. These collaborations will promote synergy, maximize resources and amplify impact.

Accountability: Strengthening accountability mechanisms is crucial and the responsibility of all stakeholders as it enables tracking of resources and outcomes, ensuring efficiency, transparency, and quality of care. It is firmly rooted in the principles of evidence-based decision-making.

Equity and Inclusivity: The NCSAP places emphasis on determining and implementing strategies that ensure all population groups are reached with high-impact interventions, with special focus on vulnerable and marginalised groups (including children with special needs) to bridge existing disparities and ensure that no child is left behind.

Child Rights: The Child Right Act (CRA) and other relevant human rights documents will be at the core of NCSAP. It is committed to protecting the rights of children and ensuring that gender equality is promoted. It addresses gender disparities and promote the empowerment of women as a fundamental aspect of child survival as every child has the right to live, survive, thrive and develop to full potential.

Innovation, Adaptability and Research: The NCSAP will remain adaptable and open to innovation, continuously evolving strategies to address emerging challenges and harness new opportunities. It will embrace creative and innovative approaches to maximise impact. While a number of global best practices are available to increase coverage with evidence-based interventions, more innovative approaches and research can help improve outcomes. Some practices include active involvement of all stakeholders, use of effective interventions, expansion to scale taking into account equity issues, and documentation to assess quality of care and outcomes.

Community Engagement and Empowerment: Communities play a pivotal role in child survival. It is believed that empowered communities are better equipped to support child health, demand quality services, and actively participate in promoting the health and well-being of the children. Family centered approach with male involvement will be promoted. The NCSAP will actively engage and empower communities to take ownership of child health initiatives.

Sustainability and Long-Term Impacts: The NCSAP aims to create sustainable solutions that will have long-term impacts on child survival. The Plan will invest not only to save lives today but also ensure that future generations of children thrive and grow in good health.

Data-Driven Approach: Data will be at the core of the NCSAP's improvement process and will be used to continually assess, track progress and monitor for evidenced-based decision making and multi-stakeholder accountability. Monitoring and evaluation will guide our efforts for continuous improvement.

Chapter **4**

Nigeria Child Survival Action Plan

4.1 Vision, Mission, Goal, Objectives and Targets

4.1.1 Vision

A Nigeria in which there are no preventable deaths of children aged 1 to 59 months and where the health, rights, development and well-being of this priority group are ensured to enable them survive and reach their full potentials.

4.1.2 Mission

To promote integration of relevant Reproductive, Maternal, Newborn, Child, Adolescent and Elderly Health plus Nutrition services and programmes along the continuum of care, as well as provide a framework for the equitable delivery of high-quality priority child survival interventions across the life course.

4.1.3 Goal

To accelerate the reduction of preventable deaths of children 1-59 months of age in Nigeria.

4.1.4 Objectives:

- To accelerate the reduction of morbidity and mortality from major causes of deaths in children 1-59 months
- To prevent child vulnerability and ensure vulnerable children survive, thrive and attain their full potential.

4.1.5 Targets

1. Reduce Under-five mortality rate (deaths among children under -five per 1000 live births) from 110 per 1000 live birth in 2023-24 to 70 per 1000 live birth by 2029
2. Increase the average national coverage of penta 3 from 53% in 2023-24 to 84% by 2029
3. Reduce zero dose children from 37% in 2023-24 to 5% by 2029
4. Increase the proportion of children under-five with fever who received ACT from 56.9% in 2023-24 by 25% by 2029
5. Increase percentage of children with diarrhoea who received both ORS, zinc and counsel on continued feeding from 16.3% in 2023-24 to 56.8% by 2029
6. Increase the percentage of children under-five with symptoms of ARI for whom advice or treatment was sought from 60.1% in 2023-24 to 80% by 2029
7. Increase percentage of health facilities with health workers trained on IMCI from 10% in 2019 to 60% by 2029
8. Increase exclusive breastfeeding rate from 28.8% (NDHS 2023-24) to 50% by 2029
9. Increase the percentage of children aged 6-23 months who were fed foods and beverages from at least 5 out of 8 defined food groups from 12.4% in 2023-24 to 40% by 2029
10. Reduce childhood wasting from 8% in 2023-24 to 5% by 2029

4.2 Strategic Approaches

4.2.1 Engagement with the Leadership for Effective Governance

Engage the leadership and stakeholders across sectors at all levels as defined in the National Child Health Policy (2022), on the need for effective governance and accountability for child health.

Ensure the commitment of governments at all levels for the implementation of multi-sectoral and integrated child health packages for child survival.

Leverage on existing coordination mechanism to facilitate the acceleration of results.

4.2.2 Partnerships and Coordination for the implementation of quality priority interventions and monitoring for equitable coverage

Delivery of inclusive, comprehensive, and quality services for children requires innovative partnerships within the public and private health sectors for the effective implementation of the RMNCAEH+N services and programmes. The Plan leverages on the existing RMNCAEH+N Multi-Stakeholders Partnership Coordination Platform (MSPCP) to facilitate effective partnership for child survival.

Ensure that scheduled National Child Health Technical Working Group Meetings and Child Survival Subcommittee meetings are held with effective participation of relevant stakeholders.

Partnerships between government and relevant development partners and donors for child survival would be strengthened.

4.2.3 Improving Quality of Care

Children aged 1-59 months should have access to family centred high-quality, evidence-based, safe, effective, timely, efficient, equitable, and appropriate care for their age and stage of development.

Prioritise the implementation of IMCI and iCCM trainings for primary healthcare workers and communities respectively and strengthen capacity of health workers at referral levels of care (public and private).

Ensure efficient and effective context-specific referral system linking communities and facilities.

4.2.4 Increase access to healthcare for vulnerable population

Most child deaths in Nigeria occur in the poorest population and the rural settings. To respond to this disparity, scale up quality essential services and reduce out-of-pocket expenditure for the poor.

Invest in and strengthen the functionality of primary health care, with a clearly defined referral mechanism that uses locally available resources for emergency communication and transportation access to support community-led referral system.

In emergencies and humanitarian Settings, with conflict and displacement, NCSAP will adapt its interventions to provide immediate and life-saving care for children and mothers. This includes setting up mobile clinics, distributing essential supplies, and collaborating with humanitarian organizations to ensure that children's health needs are met, even in challenging circumstances.

4.2.5 Community engagement

Community engagement helps ensure that care is centred around the needs of the child and its family so that it is inclusive, accessible, supportive, affordable, accountable, and fully meets their needs. Active

engagement with community groups through social accountability mechanisms in planning and implementation ensures services that respond to their social and cultural contexts are provided.

4.2.6 Data-driven approach for Evidence Based Decisions

Data-driven approaches play a critical role in routine program monitoring, evidence-based decision-making, and multi-stakeholder accountability mechanisms. An effective system to maximize generation, dissemination and application of data should be put in place for decision making. The monitoring framework should align with the country's one M&E plan of the Health Sector Strategic Blueprint as well as reflect the approaches and strategies identified to reach defined vulnerable groups. This will be used to identify inequities in outcomes and reach the most vulnerable families and children. Investments in data systems, knowledge management and digital health should be prioritized in the resource mobilization plan.

4.2.7 Track progress and Stakeholders' accountability at all levels

Tracking progress requires developing, deploying, and implementing a monitoring and accountability framework. The NCSAP provides milestones and proposed indicators to facilitate the tracking of progress. Locally available data from multiple sources, including health information systems, health facility assessments, population-level surveys, periodic in-depth studies and score cards (facility and community based) would be leveraged for effective accountability.

4.2.8 Mobilisation and Equitable Distribution of Resources

Inadequate and inefficient utilisation of resources limits the implementation of effective child survival interventions. This Plan will mobilise and ensure an equitable and effective distribution of resources at all levels.

4.3 The Intervention Packages

The Nigeria Child Survival Action Plan (NCSAP) is committed to accelerating the implementation of comprehensive intervention packages designed to address the multifaceted challenges that impact child survival towards the attainment of universal health coverage and SDG targets.

The Plan is embedded within the context of the Primary Health Care aligned to the Child Survival Wheel. To realise the goal of this Plan, the following key packages are outlined:

- Integrated Management of Childhood Illness (IMCI).
- Integrated Community Case Management of Childhood Illness (iCCM).
- Maternal, Infant, and Young Child Nutrition (MIYCN).
- Integrated Management of Acute Malnutrition (IMAM)
- Routine immunisation including Zero Dose Children.
- Water Sanitation and Hygiene (WASH)
- Infection Prevention and Control (IPC)
- Early Childhood Development (ECD)
- Preventive, diagnostic and treatment services for HIV, TB, Malaria at referral levels.

Table 3. Priority intervention packages for NCSAP

S/N	Dimension	Intervention	Levels of Delivery		
			Community	PHC facility	Referral facility
1	**Promote**	Capacity building for frontline health workers on IMCI case Management course		X	
		IMCI Follow-up after training courses		X	
		Introduction and use of modern electronic training tools such as IMCI training and adaptation tools (ICATT)/Smart-IMCI		X	X
		Early Initiation of breastfeeding within 1 hour of birth	X	X	X
		Exclusive breastfeeding for 6 months	X	X	X
		Complementary feeding from 6 months and Continued breastfeeding up to 36months	X	X	X
		Strengthen and scale up the Baby Friendly Initiative (BFI) • Baby-Friendly Hospital Initiative • Baby-Friendly Community Initiative • Baby-Friendly Workplace Initiative	X	X	X
		Use of Long-Lasting Insecticide-Treated Net (LLITN)	X	X	X
		Growth Monitoring and Promotion (including nutrition screening and Counselling)	X	X	X
		Care seeking for treatment of ARI and fever	X		
		Capacity building on iCCM/Community IMCI for Community based Health Workers	X	X	
		Public-private partnerships to ensure sustainable Nutrition Commodities Logistics Management System (NUT-CLMS)		X	X

S/N	Dimension	Intervention	Levels of Delivery		
			Community	PHC facility	Referral facility
		Integrated campaigns for child survival.	X	X	X
		Early Childhood Development	X	X	X
		WASH/IPC programme implementation	X	X	X
		Provision of Routine childhood immunization (BCG, HBV, OPV, PENTA, IPV, Measles, PCV, ROTA, Yellow Fever, Meningitis,)	X	X	X
		Eliminate **Zero Dose** children	X	X	X
		HIV prophylaxis for HIV-exposed infants		X	X
		Early infant diagnosis for HIV		X	X
		Polymerase Chain Reaction (PCR) at 6 weeks	X	X	X
		Cotrimoxazole prophylaxis for *Pneumocystis Jiroveci Pneumonia*		X	X
		Amodiaquine plus sulfadoxine-pyrimethamine (AQ+SP) chemoprevention for seasonal malaria chemoprophylaxis	X	X	X
		Screening for sickle cell disease			X
		Home fortiication using Multiple Micronutrient Powder/SQ-LNS	X	X	X
		Promote Key household practices	X		
		Vitamin A supplementation from 6 -59 months of age	X	X	X
		Deworming for children from 12 to 59 months	X	X	X
		Folate supplementation for Sickle Cell Disease (SCD)	X	X	X
		Integrate diagnostic services for HIV and TB		X	X

S/N	Dimension	Intervention	Levels of Delivery		
			Community	PHC facility	Referral facility
	Treat	Rapid diagnostic test (RDT) and appropriate Antimalarial treatment	X	X	X
		Case management of childhood pneumonia (DT Amoxicillin)	X	X	X
		Case management of diarrhea (Low Osmolar ORS + Zinc tabs)	X	X	X
		Case management of children infected with Tuberculosis		X	X
		Case management of children infected with or exposed to HIV with Antiretrovirals		X	X
		Pulse oximetry		X	X
		Follow up visit after treatment		X	X
		Facilitated Referral	X	X	X
		Screening and treatment of acute malnutrition using MUAC tape	X	X	X
		Ready to Use Therapeutic Food (RUTF) for Acute malnourished children	X	X	X
		Scale-up Outpatient Treatment Centres for acute malnutrition		X	
		Scale up Oral Rehydration Therapy (ORT) corners for managing dehydration		X	X
		Integrate treatment services for HIV and TB	X	X	X

S/N	Dimension	Intervention	Levels of Delivery		
			Community	PHC facility	Referral facility
	Crosscutting	Birth Registration	X	X	X
		Home visits	X	X	X
		Quality Supplies and medicines	X	X	X
		Integrated supportive supervision	X	X	X
		Gender mainstreaming	X	X	X
		Monitoring, Evaluation and Learning	X	X	X
		Food systems (Food security)	X	X	X

4.4 State prioritisation and State specific key activities (Low, Mid and High)

The Nigeria Child Survival Action Plan (NCSAP) recognises that the health needs and performance levels of States within the country vary significantly. To maximise the impact of the Plan, the NCSAP has prioritised States and tailored their key activities based on their performance levels. The States are categorised into low, mid, or high performing states.

Table 4. State categorisation and suggested key activities ref NDHS 2023-24 (see table at appendix)

Category	Criteria	States	Suggested key activities
Low-performing states	Under-five mortality >70 deaths per 1000 live births	Kogi Nasarawa Plateau Adamawa Bauchi Gombe Borno Yobe Taraba Jigawa Kaduna Kano Kastina Sokoto Kebbi Zamfara Imo Akwaibom Anambra Bayelsa	**Capacity Building**: Focus will be on: • Building and strengthening healthcare capacity. • Recruiting and orientating healthcare workers, • Improving healthcare infrastructure • Ensuring the availability of essential medical equipment and supplies.
			Strengthen immunisation Drives: Implement intensive immunisation campaigns to ensure that all children receive their vaccines. • Mobile clinics and outreach programmes to address the problem of zero dose children.
			Advocacy, Community and Social Mobilisation: • Engage communities actively in maternal, neonatal and child health initiatives. • Raise awareness about the importance of healthcare services. • Advocacy to Stakeholders • Encourage community participation in healthcare decision-making.

Category	Criteria	States	Suggested key activities
			Data collection and Analysis: Establish robust data collection and analysis systems to monitor progress and identify areas that require targeted intervention. • Strengthen community dashboard/score cards e.g data quality assessment. • Use real-time data to make informed decisions.
			Emergency Response Planning: • Develop/update and implement plans for responding to emergencies, such as disease outbreaks or natural disasters, to ensure the continuity of essential healthcare services.
Mid-Performing States	Under-five mortality 25 - 70 deaths per 1000 live births	Ekiti Lagos Ogun Osun Cross river Delta Rivers Enugu Niger Benue FCT Abia Ebonyi	**Quality Improvement**: • Focus on enhancing the quality of healthcare services Implement measures to ensure that healthcare facilities meet national standards • Stimulate healthcare workers to provide high-quality care.
			Outreach and Awareness: • Conduct outreach programs to reach marginalized communities and underserved areas. • Raise awareness about maternal, newborn and child health • Ensure that communities are informed about available services.
			Capacity Enhancement: • Build on existing healthcare capacity by recruiting additional healthcare workers, particularly in areas with healthcare workforce shortages.

Category	Criteria	States	Suggested key activities
			Equity Promotion: • Address disparities in access to healthcare services and health outcomes. • Implement policies and strategies to bridge the equity gap • Ensure that healthcare services are distributed equitably.
			Data Utilisation: Enhance data utilisation by: • Using data for informed decision-making and programme improvement, • Identifying areas where additional support is needed.
High-Performing States	Under-five mortality < 25 deaths per 1000 live births	Ondo Oyo Edo Kwara	**Sustainability and Innovation**: • Focus on sustaining the achievements and innovating to further improve maternal, newborn and child health outcomes. • Encourage innovative approaches • Strengthen partnerships to maximise impact.
			Research and Development: Invest in research and development to identify best practices, new technologies, and evidence-based interventions that can be adapted in other States.
			Resource Sharing: Collaborate with low and mid-performing States to share resources, expertise, and best practices. • Act as mentors and role models to facilitate improvements in other regions. • Peer to peer learning from other high performing States

Category	Criteria	States	Suggested key activities
			Emergency Preparedness: Strengthening the existing emergency services and providing support during emergencies in neighboring States or at the national level.
			Policy Advocacy: Advocate for policies at the national level that support newborn, child survival and maternal health initiatives. • Share successful policy models with other States.

4.5 Nigeria Child Survival Action Plan: Strategies, Aaction Points and Timeline

Strategy	Action	Timeline				
		2025	2026	2027	2028	2029
Strategic objective 1: To accelerate the reduction of morbidity and mortality from major causes of deaths in children 1-59months						
Strengthen leadership, governance and accountability at national and subnational levels	Set-up or re-activate Child health technical working group at the State and LGHA level with other programmes (e.g., Nutrition, Immunization, WASH, TB, Malaria, HIV, Planning) and other sectors (Education, women afairs, humanitarian, information, budgeting and planning and partners.	X	X	X	X	X
	Hold quarterly meetings of the Child Health Technical Working Group to track progress at National, State level, LGAs and Community. (Physical or Virtual)	X	X	X	X	X
	Designate IMCI focal person at State/LGA where not in existence with clear ToR for Child Health programmes	X	X	X	X	X
	Integrate Child Survival Action Plan into the National, State and LGAs Annual Operational Plans based on context speciic issues	X	X	X	X	X
	Conduct targeted advocacy to key stakeholders for resource mobilization to support one budget.	X	X	X	X	X
	Identify and empower high level National and State champions for child health	X	X	X	X	X
Strengthen supply chain for child health commodities and health products	National child health programme to engage with the national supply chain for forecast and quantiication for child survival commodities	X	X	X	X	X
	procurement and distribution of child commodities and products at state levels	X	X	X	X	X
	Advocate for review/update and dissemination of essential medicines list and promote state domestication.	X	X	X	X	X

Strategy	Action	Timeline				
		2025	2026	2027	2028	2029
	Designate IMCI focal person to collaborate with logistic management coordinating unit (LMCU) focal person at the state level for last-mile efective distribution to health facilities	X	X	X	X	X
	Training on logistic management system for the state, LGAs, health facilities and ward development committee (WDC) for accountability	X	X	X	X	X
	Advocate the introduction of an electronic monitoring system to capture data for prompt quantiication of essential commodities.	X	X	X	X	X
	Conduct quarterly onsite monitoring and veriication of reporting for quality assurance and accountability.	X	X	X	X	X
	Conduct orientation for LGA pharmacists & partners on service delivery system serving a catchment area.	X	X	X	X	X
Increase the availability and quality of the health workforce for child health programme	Advocate for recruitment, equitable deployment and retention of health workforce for child health interventions	X	X	X	X	X
	Training of 60% of frontline health workers on IMCI on in-service	X	X	X	X	X
	Training of communities on community-based interventions including iCCM and C-IMCI	X	X	X	X	
	Collaboration with Nutrition programme to ensure that critical mass of health workers on MIYCN, Integrated management of Acute Malnutrition, in- patient management of severe acute malnutrition with complications	X	X	X	X	X
	Training on case management of severe pneumonia, malaria, diarrhoea at referral heath facilities	X	X	X	X	X
	Conduct follow-up and supportive supervision and mentorship	X	X	X	X	X

Strategy	Action	Timeline				
		2025	2026	2027	2028	2029
	Strengthen pre-service education of IMCI and Nutrition (where applicable)	X	X	X	X	X
	Advocate for and track the implementation of the Essential Health Service Package (EHSP) for PHCs sta ng	X	X	X	X	X
	Review, update and standardise training packages for child health interventions, and develop a comprehensive training plan	X	X	X	X	X
Improve quality of care	Domesticate the national RMNCAEH QOC strategy at the state level	X	X	X	X	X
	Scale-up MPCDSR (Maternal Perinatal and Child Death Surveillance & Response) at the state level	X	X	X	X	X
	Advocacy to key policy makers to secure adequate funding to strengthen routine integrated competency-based supportive supervision and mentoring at the state and health facilities level	X	X	X	X	X
	Update, Print and distribute job aids and SOPs for child health interventions at the health facilities	X	X	X	X	X
	Conduct capacity building for quality improvement team at all levels	X	X	X	X	X
	Scale up infection prevention and control measures	X	X	X	X	X
	Develop a standardized mentoring guide to be adapted at all levels	X	X	X	X	X
	Conduct periodic integrated supportive supervision for quality performance review	X	X	X	X	X
	Advocate and leverage on existing emergency transport scheme for children for referral	X	X	X	X	X

Strategy	Action	Timeline				
		2025	2026	2027	2028	2029
	Print and distribute 2-way referral tools to health facilities and community level	X	X	X	X	X
	Advocate, scale up and leverage on existing community score card for experience of care for child health.	X	X	X	X	X
	Develop and use scorecards to track and assess performance of HCWs against QOC	X	X	X	X	X
Strengthen integrated service delivery at PHCs and community levels	Strengthen functionality of Ward development committee at ward level	X	X	X	X	X
	Strengthen routine immunization	X	X	X	X	X
	Community mobilizes for campaign for child surveillance intervention such as zero- dose	X	X	X	X	X
	Advocate for early childhood development	X	X	X	X	X
	Identify and refer children with presumptive Tuberculosis	X	X	X	X	X
	Identify and engage community champions for child survival	X	X	X	X	X
	Support integrated service provision by CBO/CSO in childcare at the community level	X	X	X	X	X
	Scale up engagement of CBO/CSO in child health care at the community level especially in hard-to-reach communities	X	X	X	X	X
Digitalize and use data- driven approach in decision making	Collaborate with relevant departments to include child health data elements in the digital platforms	X	X	X	X	X
	Adapt/adopt relevant on-line digital training package for pre-service/ in-service	X	X	X	X	X
	Strengthen the use of dashboard for data reporting for child survival	X	X	X	X	X

Strategy	Action	Timeline				
		2025	2026	2027	2028	2029
	Conduct quarterly review of child health during TWG meetings at state level	X	X	X	X	X
	Conduct annual performance review at national level	X	X	X	X	X
	Mid-term review	X	X	X	X	X
	End-term evaluation	X	X	X	X	X
Advance public and private partnership for child health and beyond health	Involve private sector as member of the TWGs at state level	X	X	X	X	X
	Advocate to private sectors for increase data reporting for child survival	X	X	X	X	X
	Strengthen referral between the public and private health care providers and diferent levels of care on child health interventions	X	X	X	X	X
	Partner with telecommunication companies for toll-free child health key messages and data transmission	X	X	X	X	X
	Engage the media for efective communication and dissemination for information for improved child health programs	X	X	X	X	X
	Collaborate with relevant sector for WASH	X	X	X	X	X
		X	X	X	X	X

Strategy	Action	Timeline				
		2025	2026	2027	2028	2029
Objective 2: To prevent child vulnerability and ensure vulnerable children survive						
Strengthen health system resilience to address public health threat and emergencies for child health	Advocate to policy makers for community-based health insurance scheme implementation	X	X	X	X	X
	Conduct outreach and mobile clinics for child health services to hard-to-reach communities	X	X	X	X	X
	Advocate for the update of the RMNCAEH continuity plan on emergencies to include children in humanitarian settings	X	X	X	X	X
	Advocate for integration of RMNCAEH+N into the national humanitarian preparedness and response plan	X	X	X	X	X

Chapter **5**

Management of NCSAP
(Roles and Responsibilities at all levels)

Efficient coordination and the delineation of roles and responsibilities among stakeholders are critical for the successful execution of the Nigeria Child Survival Action Plan (NCSAP). The NCSAP acknowledges the multi-faceted nature of child survival and maternal health and recognizes the importance of multi-sectoral collaboration among all stakeholders.

List of NCSAP Stakeholders

For the purpose of this Plan, the key stakeholders are as follows:

- Federal Government Ministries, Departments, and Agencies
  - Ministries of Health and Social Welfare, Education, Agriculture and Food Security, Information and National Orientation, Budget and Economic Planning, Humanitarian and Poverty Reduction, Environment, Women Affairs, Water Resources and Sanitation, National Primary Health Care Development Agency, National Centre for Disease Control, National Population Commission, National Health Insurance Authority, National Agency for Food Drug Administration and Control, National Agency for the Control of AIDS, National Bureau of Statistics.
- National Assembly, State Assembly & Judiciary
- State Governments, Ministries, Departments, and Agencies
- Nigerian Governors' forum
- Nigerian Governors' Spouse Forum
- State Health Commissioners forum
- Local Government Departments
- Universities and Research Institutions
- Professional Associations
- Development Partners
- Regulatory Bodies
- Organised Private Sector
- Civil Society Organisations
- Communities
- Mothers and Caregivers
- Media
- Religious Leaders
- Traditional Leaders

5.1 National Level

1. **Federal Ministry of Health and Social Welfare (FMOHSW):**
   The FMOHSW plays a pivotal role in plan formulation, development of guidelines and the overall oversight of NCSAP. Its responsibilities include setting the national child health agenda, mobilizing resources, and establishing/fostering partnerships with international organizations. The NCSAP

Coordination Unit (Child Survival Branch) is a branch of Child Health Division of Family Health Department of the FMoHSW, and serve as the central hub for the planning, implementation, and monitoring of the action plan. It is responsible for managing and overseeing all aspects of NCSAP, including resource mobilization, monitoring and evaluation, and communication.

- Shall act as the principal coordinator of all the interventions aimed at achieving the goal and objectives of the Plan.
- Disseminate and monitor the operationalisation of the NCSAP at all levels.
- Lead the monitoring and evaluation of all NCSAP activities including use of data for policy formulation and decision making.
- Provide technical support to State and Local Governments for advocacy, resource mobilization and orientation on NCSAP, in collaboration with relevant stakeholders.
- Promote inter-agency relationship on Child Health interventions.

2. **National Primary Healthcare Development Agency (NPHCDA):**
NPHCDA is responsible for the coordination of primary healthcare activities. It plays a crucial role in ensuring that child survival interventions are integrated into primary healthcare services.

- Provide technical support to State primary health care development agencies, LGA primary health care departments and communities on roll out of NCSAP.
- Facilitate capacity building of Health Workers on relevant NCSAP activities at PHC level.
- Facilitate community engagement through Ward Development Committees (WDC) on NCSAP activities.
- Mobilize supply of essential Child Health commodities and equipment through the SPHCBs to the health facilities.
- Conduct monitoring and supportive supervisions with feedback on NCSAP at PHCs
- Facilitate the establishment and revitalisation of Child Health interventions and strategies in primary health facilities.
- Facilitate the integration of NCSAP services in routine PHC delivery
- Ensure strengthened supply chain for Child Health interventions commodities and equipment to support NCSAP.

5.2 State Level

1. **State Ministries of Health (SMoH)**
    - The SMoH shall act as the principal coordinator of all the interventions aimed at achieving the goal and objectives of NCSAP by adapting the NCSAP based on state specific needs.
    - Ensure adequate resource mobilization and allocation for implementation of the plan.
    - Ensure effective implementation of state specific child survival plan in collaboration with relevant MDAs, professional associations, private sector, and development partners.
    - Coordinate the implementation of NCSAP activities leveraging on existing coordination platforms including the joint review meeting.
    - Facilitate the training and re-training of health care workers on relevant child survival training packages.
    - Ensure that the NCSAP is reflected in the State AOP
    - Develop, Print and disseminate the annual operational plan, guidelines, SOP and SBCC materials for standardized and quality services for child survival.
    - Monitor and track progress of implementation and keep stakeholders updated as reflected in the Workplan for accountability.

- Strengthen the Logistics Management Cordination Unit (LMCU) to ensure regular and timely distribution of quality medicine, supplies and medical equipment.
- Participate in the National annual review meeting on child survival program.
- Collaborate with relevant State MDAs to strengthen service provision at secondary health facilities.

2. **State Primary Healthcare Development Agencies (SPHCDAs)/ State Primary Health Care Development Boards (SPHCDB):**
    - Coordinate primary healthcare activities in the State and ensure that NCSAP interventions are integrated into primary health care services.
    - Provide technical support to Local Governments and communities for advocacy and social mobilization for the implementation of child survival activities in collaboration with other stakeholders.
    - Facilitate the training and re-training of health care workers on relevant child survival training packages [IMCI, cIMCI, iCCM, MIYCN, CMAM, WASH etc].
    - Facilitate community engagement through Ward Development Committees (WDC) on child health activities.
    - Conduct monitoring and supportive supervisions with feedback on AOP
    - Ensure strengthened supply chain for the replacement of commodities, supplies, and equipment to support AOP.

5.3 Local Government Level

- Oversee the implementation of child survival interventions at the LGA and community levels.
- Ensure the functionality of primary health care centres, and engage with communities to promote child survival interventions.
- Provide budgetary allocation and ensure the timely release of funds for the implementation of child survival programmes.
- Establish/Strengthen Local Government Committees on Health to coordinate child survival interventions.
- Collaborate with private sectors on implementation of child survival interventions
- Build capacity of PHC workers on IMCI, cIMCI and iCCM training packages etc.
- Monitor, evaluate and supervise the implementation of child survival interventions at LGA and PHC facilities.

5.4 Community Level

1. **Community Leaders:**
    - Mobilize and advocate for child health and ensure that community members are aware of available services.
    - Collaborate with PHCs through the WDCs/VDCs to ensure that the community has access to functional health services.
    - Create an enabling environment, support, and promote the implementation of the plan in their communities.
    - Advocate to relevant stakeholders for the establishment of community-based health insurance scheme.
    - Promote emergency transport services for referral
    - Support the implementation of the community health programmes
    - Institutionalise the use of Community Score Cards for decision making in collaboration with health facilities

2. **Community members:**
    - Participate in determining community child health needs and relevant interventions as well as the planning for and the implementation of these interventions.
    - Take appropriate steps to contribute to and utilize available healthcare services for children.
    - Make themselves available for enrolment and participation in the community-based insurance schemes.
    - Promote care- seeking behaviour and support the implementation of key household practices.
    - Support the identification of children at the household level who are sick or require special attention.

3. **Mothers and Caregivers:**
    - Serve as primary caregivers for the well-being of children
    - Ensure prompt and appropriate care seeking for sick children
    - Advocates for the health and well-being of children.
    - Practise all components of Key Household and Community Practices.

4. **Community-based healthcare workers:**
    - Promote and offer iCCM services for children under-5 and support PHCs at the community level.
    - Promote the implementation of key household and community practices.
    - Conduct home visits and follow up of under-5 children under their care.
    - Provide health education, counselling, and create demand for child health services.
    - Refer under-5 children with care needs to health facilities.
    - Collect data and transmit same to the Community Health Management Information System.
    - Facilitate community surveillance of childhood diseases.
    - Mobilise the community for participation in child health outreaches and integrated campaigns.
    - Identify zero-dose children and those who have missed immunization and ensure they are immunised

5.5 Healthcare Workers

1. **Healthcare Workers (Doctors, Nurses, Midwives, and community health workers):**
    - Provide quality child health services using IMCI and other relevant documents or guidelines.
    - Ensure quality data collection and entry in the respective dashboards, registers and use data for decision making.
    - Participate in continuing educational programmes, trainings and re-training on Childhealth programmes and stepdown to other healthcare workers.
    - Facilitate peer-to-peer mentoring of child health care workers
    - Conduct outreach health services for children including those in hard-to-reach communities, emergency and humanitarian settings.
    - Participate in research in child health programmes.
    - Identify zero-dose children and those who have missed immunization and ensure they are immunized

2. **Pharmacists and Pharmacy technicians:**
    - Ensure appropriate forecasting, quantification and inventory management of essential medicines, supplies and diagnostics.
    - Practise appropriate dispensing of medicines.
    - Dispose expired medicines according to the guideline.
    - Participate in continuing educational programmes, trainings and re-training on Child health programmes and stepdown as appropriate.
    - Document pharmacovigilance cases

3. **Medical Laboratory Scientists/Technicians**
    - Adhere to gold standards for all laboratory test according to the guidelines
    - Promote infection control and appropriate medical waste management
    - Conduct routine internal quality assurance

4. **Other cadre of healthcare workers**
    - Promote and support the implementation of child survival intervention according to their various SOPs and guidelines

5. **Health facility management team/Ward Development Committees:**
    - Ensure the provision of quality child health services on routine and emergency basis.
    - Ensure availability and appropriate utilization of child health recording and reporting tools.
    - Ensure regular supply and effective management of child health commodities and supplies
    - Ensure access and effective utilization of funds and other resources for child health interventions.
    - Ensure regular facility review meetings on quality of care with supervision from MDAs
    - Ensure prompt referral where necessary and strengthen the two-way referral system.
    - Ensure effective integrated disease surveillance and response.
    - Ensure availability of appropriate mix of health workforce for child health.
    - Ensure child health quality improvement activities are integrated into quality improvement plan with support from National and subnational levels.
    - Support the community in demand generation on Child health interventions
    - Institutionalize planned preventive maintenance of critical health infrastructure and equipment

5.6 Development Partners

- Provide technical and financial supports for the implementation of the NCSAP and AOP
- Support evidence generation for decision making and policy formulation
- Support resource mobilisation and partnership for child survival
- Act as advocate for child survival

Chapter **6**

Monitoring, Evaluation, Research and Learning

In alignment with the principles guiding the Monitoring and Evaluation of the Health Sector Strategic Blueprint (HSSB) and Sector Wide Approach (SWAp) of the HMH's agenda, the RMNCAEH+N, which serves as the primary reference resource for developing the NCSAP, has established a comprehensive M&E framework. This framework provides guidance, indicators, and targets for child survival, serving as the foundation for the NCSAP's MEAL component.

This NSCAP framework is designed to:

i. **Verify Implementation:** Ensure NCSAP Strategic activities and interventions are implemented as planned, promoting accountability and timely problem-solving.
ii. **Track Progress and Achievements:** Monitor the progress and outcomes of NCSAP implementation and demonstrate results.
iii. **Coordinate Data Management:** Coordinate the collection, collation, processing, analysis, and dissemination of NCSAP-related data in Nigeria.
iv. **Assess Performance:** Evaluate performance against agreed strategic objectives linked to specific interventions.
v. **Document Lessons Learned:** Facilitate the documentation of implementation challenges, lessons learned, and innovations.
vi. **Inform Decision-Making:** Provide timely feedback to the FMoH and stakeholders to enable evidence-informed decisions and identify areas for improvement.

Implementation efficiency is paramount for the success of the NCSAP; therefore, efficient implementation of the MEAL component will contribute to:

i. **Transparency:** Open and clear communication about the NCSAP's activities.
ii. **Accountability:** Responsibility for achieving the NCSAP's goals.
iii. **Evidence-based decision-making:** Informed choices based on data and analysis.

The NCSAP's M&E framework is guided by the following key concepts:

i. **Efficiency:** Ensuring activities are conducted as planned, promoting accountability, and enabling timely issue resolution.
ii. **Tracking Progress:** Regularly monitoring the NCSAP's implementation and achievements.
iii. Data Management: Collecting, organizing, processing, analyzing, and sharing data related to the NCSAP.
iv. **Evaluating Performance:** Assessing the NCSAP's performance against strategic objectives and targets.
v. **Documenting Lessons Learned:** Capturing challenges, insights, and innovative solutions.
vi. **Providing Feedback:** Sharing timely feedback with stakeholders to inform decision-making and identify areas for improvement.

Through M&E, NCSAP program results at all levels (impact, outcome, output, process, and input) will be measured to inform decision-making. The M&E plan is designed to support governments and other

stakeholders in tracking progress and achievements based on Results-Based Management (RBM) principles.

Key Performance Indicators: A number of outcome measures of success have been identified in the NCSAP M&E log frame, with indicators linked to each strategic objective or result. These indicators align with the HSSB/SWAp, as well as the health-related SDGs.

Data Sources and Management: Various data sources will be used to monitor NCSAP Strategy progress. The sources include

i. **NHMIS:** Primary source of routine data from community, primary, secondary, and tertiary health services.
ii. **Surveys:** MICS, NDHS, MIS, NNHS, NFCMS, health facility surveys
iii. **Surveillance:** MPCDSR, SORMAS
iv. **NHRHIS:** Provides records of active health professionals.
v. **LMIS:** Provides data on the supply and use of medicines and health commodities.
vi. **GIS:** Analyzes coverage of services in relation to need and infrastructure.
vii. Data Collection and Analysis

Routine data collection for the health sector is done using DHIS2, an open-source web-based software. Progress on service delivery will be tracked through routine data, supervision visits, health facility assessments, and implementation research. Impact and outcome-level indicators will be tracked using periodic national surveys and CRVS data.

Data Quality: Data quality measures will follow NHMIS procedures. The FMoH will conduct regular data quality assessments to identify gaps and improve NCSAP services and utilization.

Performance Review: Monthly, quarterly, and annual reports will be produced and disseminated. NCSAP implementation review meetings will be held quarterly at national, state, and local government levels. NCSAP scorecards will be used to visually highlight performance and identify bottlenecks.
Performance Monitoring Plan (PMP). This PMP, aligned with RMNCAEH+N M&E, will measure immediate and intermediate results, and inform decision-making. Key success measures and indicators have been identified for each strategic objective of the NCSAP to guide the results measurement.

Evaluation: A mid-term review will be conducted at the end of the second year to assess achievements, lessons learned, and challenges. An independent end-of-term evaluation will be conducted at the end of the fifth year to assess the impact of the plan against set targets and guide future planning.

Table 5: NCSAP Logical Framework

	NCSAP Summary	Indicators	Means of Verifications	Risks & Assumptions
Goal	Accelerated reduction of child morbidity and mortality.	Under-5 mortality rate per 1,000 live births Child mortality rate	Survey Reports (NDHS, MICS/NICS, LQAS, and others)	There is demonstrated political commitment towards operationalization of the SWAp at all levels Adequate health financing particularly at the sub national level Active community involvement in community health care initiatives
Outcomes	Primary Health Care Strengthened	Proportion of health facilities with essential medicines and supplies for under 5 health care needs	HMIS LMCU reports Facility reports	There is demonstrated political commitment towards operationalization of the SWAp at all levels Availability of HRH Medicines, equipment and other supplies are available
		Proportion of health workers trained in integrated management of childhood illness (IMCI)	HMIS Surveys and Assessments (NDHS, HRH audit)	
		Number of health workers per 1,000 under 5 population	Surveys and Assessments (NDHS, HRH audit)	
		Proportion of health facilities with access to clean water and sanitation	WASHNORM report	

	NCSAP Summary	Indicators	Means of Verifications	Risks & Assumptions
	Equity health gaps eliminated, and universal health coverage achieved	Percentage of the under 5 with access to primary health care services within 5km distance or 30 minutes walk time	Survey Reports (NDHS, MICS/NICS, LQAS, and others)	
		Percentage of the under 5 receiving essential health services	Survey Reports (NDHS, MICS/NICS, LQAS, and others)	
		Percentage of under-fives with access to health services when needed, disaggregated by parents' socioeconomic status, gender, and other relevant factors.	Survey Reports (NDHS, MICS/NICS, LQAS, and others)	
		Proportion of under-fives protected from catastrophic health expenditure	Health accounts report	
Outputs	Increased number of children with diarrhoea who received Lo-Osmolar ORS and zinc	Proportion of children with diarrhoea receiving Lo-Osmolar ORS and zinc	HMIS data	Sustained community mobilizations. Sustained supply of medicines, commodities, equipment and supplies. Availability of skilled staff.
	Increased number of children treated with antibiotics for pneumonia and dysentery	Proportion of children treated with antibiotics for pneumonia and dysentery	Survey Reports (NDHS, MICS/NICS, LQAS, and others)	Sustained community mobilizations. Sustained supply of commodities, equipment and supplies.
		Children 12 to 23 months fully	HMIS data	

	NCSAP Summary	Indicators	Means of Verifications	Risks & Assumptions
		immunized (all basic vaccines)		Availability of skilled staff.
		Malaria prevalence among children 6 to 59 months		
	Increased number of children 1-59 months with severe acute malnutrition receiving treatment.	Proportion of children 1-59 months with severe acute malnutrition (wasting).		
	Increased availability of effective child health interventions	Proportion of health facilities providing IMCI	HMIS data	Skilled staff, equipment and supplies available.
		ITN coverage among children (under 5 years)	MIS, NDHS	
	Scale up provision of quality IMCI services at facility and community.	Coverage of IMCI services	HMIS data	Funds available
	Increase coverage of Integrated outreach services, especially in hard-to-reach areas.	Integrated outreach conducted, especially in hard-to-reach areas	Activity report	

Table 6: NCSAP, 2025-2029 Strategic Results Framework

ITEM	INDICATOR		BASELINE							
			Baseline Value	Year	Source	2025	2026	2027	2028	Target 2029
Goal										
Impact	Reduced under-5 mortality rate in Nigeria									
Outcome	Primary Health Care Strengthen Equity Gaps Eliminated and Universal Health Coverage Achieved									
Goal	Accelerated reduction of child morbidity and mortality.									
Accelerated reduction of preventable deaths of children 1-59 months of age Nigeria.	1	Under Five Mortality Rate	110 per 1000 live births)	2023-2024	NDHS	105	100	90	80	70
OBJECTIVE 1										
To accelerate the reduction of morbidity and mortality from major causes of deaths in children 1-59months	1.1	To reduce Under-ive mortality rate (deaths among children under year 5 per 1000 live births) from 132 per 1000 live birth in 2018 to 70 per 1000 live birth in 2028	110	2023-2024	NDHS	105	100	90	80	70
	1.2	Increase in average National coverage penta 3 from 53% in 2023-24 to 84% in 2029	53	2023-2024	NDHS	78	80	82	84	84

ITEM	INDICATOR		BASELINE							
			Baseline Value	Year	Source	2025	2026	2027	2028	Target 2029
	1.3	Reduce zero dose children from 37% in 2023-24 to 5% in 2029	30	2023-2024	NDHS	20	15	10	5	5
	1.4	Increase the proportion of children under-ive with fever who received ACT from 56.9% in 2023-24 by 25% in 2029	56.9	2023-2024	NDHS	59.5	62.2	64.8	67.5	70
	1.5	Increased percentage of children with diarrhoea who received both ORS, zinc and counsel on continued feeding from 16.3% in 2023-24 to 56.8% in 2029	16.3	2023-2024	NDHS	24.3	32.3	40.3	48.3	56.8
	1.6	Increase the percentage of children under-ive with symptoms of ARI for whom advice or treatment was sought from 60.1% in 2023-24 to 80% in 2029	60.1	2023-2024	NDHS	62	65	70	75	80

ITEM	INDICATOR		BASELINE							
			Baseline Value	Year	Source	2025	2026	2027	2028	Target 2029
OBJECTIVE 2										
To prevent child vulnerability and ensure vulnerable children survive, thrive and transform to their full potential.	2.1	Increase exclusive breastfeeding rate from 28.8% (NDHS 2023-24) to 50% by 2029	28.8	2023-2024	NDHS	30	35	40	45	50
	2.2	Reduce childhood wasting from 87% in 2023-2024 to 5 % in 2029;	87	2023-2024	NDHS					5
	2.3	Increase the percentage of children aged 6-23 months who were fed foods and beverages from at least 5 out of 8 deined food groups from 12.4% in 2023-24 to 40% by 2029.	12.4	2023-24	NDHS	17.4	22.4	27.4	32.4	40
		Increase the percentage of children aged 6-23 months who were fed foods and beverages from at least 5 out of 8 deined food groups from 12.4% in 2023-24 to 40% by 2029	12.4	2023-24	NHDS	17.4	22.4	27.4	32.4	40

ITEM	INDICATOR		BASELINE							
			Baseline Value	Year	Source	2025	2026	2027	2028	Target 2029
	2.4	Reduce childhood wasting from 8% in 2023-24 to 5% in 2029.	8	2023-2024	NDHS	7.5	7	6.5	5.5	5
	2.5	Increase percentage of health facilities with HW trained on IMCI from 10% in 2019 to 60.5% in 2029	39.4	2023	National Health Facility Survey	20	30	40	50	60

Table 7 Performance Monitoring Plan

Actions		Outputs (Targets) – cumulative and yearly accordingly	Verifiable Indicator	Data source	Data collection method	Reporting Timelines	Responsibility DAPs
Objective 1			**To accelerate the reduction of morbidity and mortality from major causes of deaths in children 1-59months**				
Strategy 1			**Strengthen leadership governance and accountability at national and subnational levels**				
1.1.1	Set-up or re-activate Child health technical working group and hold quarterly meeting at the State and LGHA level with other programmes (e.g., Nutrition, Immunization, WASH, TB, Malaria, HIV, Planning) and other sectors (Education, women affairs, humanitarian, information, budgeting and planning and partners.	By 2029- 37 Child health TWG are operational	% of states/LGHAs with IMCI FP	Implementation Report	Review	Quarterly	Child Health Focal Person
1.1.2	Hold quarterly meetings of the Child health technical working group to track process at state level, LGAs and Community. (Physical or Virtual)	Quarterly child health TWG meeting convened by 38 states plus FCT and national	% of states who held quarterly child health TWG meetings Number of low and mid-performing states who held quarterly child health TWG meetings	Implementation Report	Review	Quarterly	Child Health Focal Person
1.1.3	Designate IMCI focal person at State/LGHA where not in existence with clear TOR for Child Survival programmes	IMCI FP designate functional at states/LGHAs	% of states/LGHAs with IMCI FP Number of low and mid performing states with IMCI FP	Implementation Report	Review	Quarterly	Child Health Focal Person

Actions		Outputs (Targets) – cumulative and yearly accordingly	Verifiable Indicator	Data source	Data collection method	Reporting Timelines	Responsibility DAPs
1.1.4	Develop a costed annual plan with targets and timeline clearly defined for Child survival program at State and LGAs .	38 states plus FCT have AOPs	Number of states and LGAs with developed costed child survival AOP Number of states with developed costed child survival AOP integrated into State Health AOP	Copy of costed AOP Implementation Report State AOP report	Review	Quarterly Annually	Child Health Focal Person
1.1.5	Conduct periodic targeted advocacy to key policy makers for resource mobilization to support one budget.	Advocacy conducted to key policy makers at national, state and local government level	Number of child health issue-based advocacy to policy makers conducted per state (further distributed by low and mid performing states)	Implementation Report Activity report	Review Budget Tracking	Quarterly Annually	Child Health Focal Person
1.1.6	Identify and empower high level National and State champions for child health	Child Health National Champions operational across the 37 states plus FCT	Number of active child health champions per geo-political region and per key Nigerian Languages	Copy of ToR Implementation Report Social media/social listening Reports	Review	Quarterly Annually	Child Health Focal Person
Strategy 2			**Strengthen supply chain for child health commodities and health products**				
1.2.1	National child health program to engage with the national supply chain for forecast and quantiication for child survival commodities	Forecast and quantification for child health essential medicines and supplies available for states with all facilities in 37 states plus FCT captured	Number of states with comprehensive child health essential medicine forecasted and quantified % of facilities across states reporting stockout of essential medicines and supplies for child health	Implementation Report LMIS report	Review	Quarterly Annually	Child Health Focal Person
1.2.2	Advocate for review/update and dissemination of essential medicines list and promote state domestication.	Advocacy conducted for review/update and dissemination of essential medicines list and promote state domestication.	Number of advocacy meetings held with relevant stakeholders at National, state and LG level	Implementation Report Activity report	Review	Quarterly Annually	Child Health Focal Person

Actions		Outputs (Targets) – cumulative and yearly accordingly	Verifiable Indicator	Data source	Data collection method	Reporting Timelines	Responsibility DAPs
1.2.3	Designate IMCI focal person to collaborate with logistic management coordinating unit (LMCU) focal person at the state level for last-mile effective distribution to health facilities	IMCI focal person operational across all states and the FCT	% of states/LGHAs with IMCI LMCU FP Number of low and mid-performing states with IMCI LMCU FP	Implementation Report	Review	Quarterly Annually	Child Health Focal Person
1.2.4	Training in logistic management system for the state, LGAs, health facilities and ward development committee (WDC) for accountability	Increased capacity of state, LGA, health facility, and WDC staff in logistic management system.	Number of participants trained at each level (state, LGA, health facility, WDC)	Activity report	Review	Quarterly Annually	Child Health Focal Person
1.2.5	Advocate for the introduction of an electronic monitoring system to capture data for prompt quantification of essential commodities.	Child health data integrated into the electronic monitoring system to capture data on essential commodity quantification operational at national, state and LG level	Number of advocacy meetings held with relevant stakeholders at National, state and LG level	Implementation Report Activity report	Review	Quarterly Annually	Child Health Focal Person
1.2.6	Conduct quarterly onsite monitoring and verification of reporting for quality assurance and accountability.	Quarterly onsite monitoring and verification of reporting for quality assurance and accountability conducted across the 36 states plus FCT and the national	Number of On-Site Monitoring Visits Conducted % reported Data Verified % of states adhering to the NCSAP desegregated by low, high and mid performing states	Reports	Review	Monthly Quarterly Annually	Child Health Focal Person
1.2.7	Conduct orientation for LGA pharmacists & partners on service delivery system serving a catchment area.	100% of pharmacists and partners at the LGA level mobilized for the orientation	Number of partnerships established or strengthened with pharmacists or other partners at the LGA level	Reports	Review	Monthly Quarterly Annually	Child Health Focal Person

Actions		Outputs (Targets) – cumulative and yearly accordingly	Verifiable Indicator	Data source	Data collection method	Reporting Timelines	Responsibility DAPs
Strategy 3			**Increase availability and quality health workforce for child health program**				
1.3.1	Advocate for recruitment, equitable deployment and retention of health workforce for child health interventions	Advocacy conducted to key policy makers at national, state and local government level Increased number of health workers with specialty in child health	Percentage increase in the number of health workers per 10,000 0-59 child population in target areas.	Facility staff Nominal role Human Resource for health report	Reviews HRH audit	Annually	Child Health Focal Person
1.3.2	Training of 60% of frontline health workers on IMCI on in-service	In-Service training conducted for frontline health workers trained on IMCI	% of frontline health workers trained by facility level and per state, per LGA	Training report Training Curriculum	Review	Monthly Quarterly Annually	Child Health Focal Person
1.3.3	Training of communities on community-based interventions including ICCM and C-IMCI	Increased Community Awareness and Knowledge on child health issues	Number of communities trained in community-based interventions including ICCM and C-IMCI % of communities in low and mid-performing states trained on community-based interventions including ICCM and C-IMCI	Training report Training Curriculum Training materials	Review	Monthly Quarterly Annually	Child Health Focal Person
1.3.4	Collaboration with Nutrition program to ensure that critical mass of health workers on MIYCN, Integrated management of Acute Malnutrition, in-patient management of severe acute malnutrition with complications	Enhance collaboration and coordination between the health and nutrition programs.	Percentage of health facilities with integrated nutrition and health services across the 37 states plus FCT further desegregated by low and mid performing states	Program reports	Review	Monthly Quarterly Annually	Child Health Focal Person
1.3.5	Training on case management of severe pneumonia,	Health workers across levels in the 37 states and FCT trained on case management of severe	Number of healthcare workers trained	Training report Training Curriculum	Review	Monthly Quarterly	Child Health Focal Person

Actions		Outputs (Targets) – cumulative and yearly accordingly	Verifiable Indicator	Data source	Data collection method	Reporting Timelines	Responsibility DAPs
	Malaria, diarrohea, at referral heath facilities	pneumonia, Malaria, diarrohea, at referral heath facilities	Percentage of health workers trained desegregated by facility level and, low and mid performing states	Training materials List of healthcare workers trained with their job titles and facilities		Annually	
1.3.6	Conduct follow-up and supportive supervision and mentorship	Supervision Visits Conducted: Mentorship Sessions Held	Number of follow-up and supportive supervision visits conducted. Number of mentorship sessions held	Activity report Supervision visits logs Attendance records.	Review	Monthly Quarterly Annually	Child Health Focal Person
1.3.7	Strengthen pre-service education of IMCI and Nutrition (where applicable)	Relevant institutions engaged with agree on revision of pre-service education of IMCI and Nutrition	Number of educational institutions with updated IMCI and nutrition curricula.	Developed curriculum	Review	Annually	Child Health Focal Person
1.3.8	Advocate for and track the implementation of the Minimum Service Package (MSP) for PHCs staffing	Advocacy conducted for review/update and dissemination of essential medicines list and promote state domestication. Revised pre-service curriculum for healthcare professionals incorporating MSP content.	Number of advocacy meetings held with relevant stakeholders at National, state and LG level Number of pre-service training programs updated to include MSP content. Percentage of pre-service trainees who successfully complete MSP-related modules by state categorization – low and mid performing states	Activity Report Developed curriculum	Review	Annually	Child Health Focal Person
1.3.9	Review, update and standardize training packages for child health interventions, and develop a comprehensive training plan	Training packages for child health interventions reviewed, updated, and standardized	Number of training packages reviewed and updated Percentage of training packages that meet the established standards (e.g., content accuracy, clarity, and visual appeal) Number of training materials developed or revised	Developed curriculum Training plan Developed training materials	Review	Annually	Child Health Focal Person

Actions		Outputs (Targets) – cumulative and yearly accordingly	Verifiable Indicator	Data source	Data collection method	Reporting Timelines	Responsibility DAPs
Strategy 4			**Improve quality of care**				
1.4.1	Domesticate the national RMNCAEH QOC strategy at the state level	RMNCAEH QOC Strategy domesticated across 37 states plus the FCT with detailed plan outlining steps, timelines, and resources required for implementation	Number of states with domesticated RMNCAEH QOC Strategy % of low and mid-performing states with domesticated RMNCAEH QOC Strategy	Activity report Copy of state-level RMNCAEH QOC strategy document	Review	Annually	Child Health Focal Person
1.4.2	Scale-up MPCDSR (Maternal Perinatal and Child Death Surveillance & Response) at the state level	Improved Data Quality and Timeliness in all 37 states, the FCT and national	Number of states with Increased completeness and accuracy of maternal, neonatal, and child death records. Timely reporting of maternal, neonatal, and child deaths to the state-level health authorities. Regular child health data quality audits and validation processes.	All relevant routine data reporting platforms	Review	Monthly Quarterly Annually	Child Health Focal Person
1.4.3	Advocacy to key policy makers to secure adequate funding to strengthen routine integrated competency-based supportive supervision and mentoring at the state and health facilities level	Consultations with key policy makers at national, state and local government level to secure adequate funding to strengthen routine integrated competency-based supportive supervision and mentoring at the state and health facilities level	Number of consultative meetings held with key policymakers and stakeholders across states	Activity Report	Review	Quarterly Annually	Child Health Focal Person
1.4.4	Update, Print and distribute job aids and SOPs for child health interventions at the health facilities	Job aids and SOPs for child health interventions are printed and distributed to health facilities.	Number of job aids and SOPs printed. Number of health facilities that received the materials. Percentage of health facilities that confirmed receipt.	Activity Report Copies of job aids and SOPs.	Review	Quarterly Annually	Child Health Focal Person

Actions		Outputs (Targets) – cumulative and yearly accordingly	Verifiable Indicator	Data source	Data collection method	Reporting Timelines	Responsibility DAPs
1.4.5	Conduct trainings in capacity building for quality of care at all levels	QoC training in child health with emphasis on conducted in all levels of care across the 37 states and FCT	Number of healthcare providers trained at various levels (e.g., doctors, nurses, community health workers) per state and FCT further desegregated by low and high performing states	Training curriculum Activity report Attendance	Review	Quarterly Annually	Child Health Focal Person
1.4.6	Scale up infection prevention and control measures	CME for healthcare workers on IPC principles and practices held across facilities in all 37 states, FCT and federal facilities	Number of CME conducted. % of healthcare workers who participated in the IPC principles and practices CME further desegregated by low and mid performing states	IPC curriculum Activity report Attendance	Review	Quarterly Annually	Child Health Focal Person
1.4.7	Develop a standardized mentoring guide to be adapted at all levels	Comprehensive and standardized Child Health Mentoring Guide developed and operationalized	% of states implementing the program Number of child health mentors and mentees signed up for the program across states and the FCT	Copy of the mentorship guide List of mentors List of mentees	Review	Quarterly Annually	Child Health Focal Person
1.4.8	Conduct periodic integrated supportive supervision for quality performance review	Integrated Supportive Supervision for Quality Performance Review for child health service delivery conducted across States and the FCT Improved performance and technical development of supervised staff	Number of integrated supportive supervision visits conducted. Number of quality performance review meetings held with health facility staff. % of health facilities supervised % of health workers with improved performance and technical skills	Monitoring report Visit logs	Review	Quarterly Annually	Child Health Focal Person
1.4.9	Advocate and leverage on existing emergency transport scheme for children for referral	Advocacy meetings held with stakeholders to reinforce the emergency transport scheme for children for referral.	Number of advocacy meetings held with stakeholders to promote the emergency transport scheme. Number of partnerships established with transport providers, communities and health facilities.	Activity reports MoU	Review	Quarterly Annually	Child Health Focal Person

Actions		Outputs (Targets) – cumulative and yearly accordingly	Verifiable Indicator	Data source	Data collection method	Reporting Timelines	Responsibility DAPs
1.4.10	Print and distribute 2-way referral tools to health facilities and community level	Referral Tools Developed, printed and distributed	Number of referral tools printed Number of referral tools distributed to health facilities and community levels. % of facilities with referral tools	Copies of the printed referral tool Distribution logs	Supervision visits Review	Quarterly Annually	Child Health Focal Person
1.4.11	Advocate, scale up and leverage on existing community score card for experience of care for child health at relevant facilities	Advocacy engagements conducted to key stakeholders	Number of advocacy engagements done with key stakeholders	Activity reports	Reviews Supportive supervisions	Monthly Quarterly Annually	Child Health Focal Person
1.4.12	Develop and use scorecards to track and assess performance of HCWs against QOC	Community Scorecard Implementation and Scaled up Standardized scorecards to measure HCW performance against QOC standards developed and implemented	Number of communities trained in community scorecard methodology Number of health facilities involved in the scorecard process Number of stakeholders engaged in the scorecard process	Copies of completed community scorecards	Reviews Supportive supervisions	Monthly Quarterly Annually	Child Health Focal Person
Strategy 5		**Strengthen integrated service delivery at PHCs and community levels**					
1.5.1	Strengthen functionality of Ward development committee at ward level	WDCs operational at ward levels across the 36 states and FCT.	% of WDCs operational/activated further desegregated by low and mid performing states Number WDCs trained Number of regular WDC meetings conducted Number of community projects initiated and completed by WDCs	Activities reports Minutes of meeting	Reviews Supportive supervisions	Monthly Quarterly Annually	Child Health Focal Person

Actions		Outputs (Targets) – cumulative and yearly accordingly	Verifiable Indicator	Data source	Data collection method	Reporting Timelines	Responsibility DAPs
1.5.2	Strengthen routine immunization	Increased Immunization Coverage	Number of training sessions held for healthcare workers on immunization practices. Number of community outreach programs conducted to raise awareness about the importance of immunization. Number of cold chain equipment (e.g., refrigerators, vaccine carriers) distributed to health facilities. Number of children immunized according to the national immunization schedule.	Activity reports Distribution logs Immunization registers, health facility records.	Reviews Supportive supervisions	Monthly Quarterly Annually	Child Health Focal Person
1.5.3	Community mobilization for campaign for child surveillance	Communities across the 774 LGAs activated for community mobilization campaign	Number of communities activated for community mobilization campaign for child surveillance interventions	Activity reports Community health worker reports	Reviews Supportive supervisions	Monthly Quarterly Annually	Child Health Focal Person
	intervention such as zero- dose	for child surveillance interventions	further desegregated by low and mid performing states Number of community campaigns surveillance intervention held further desegregated by low and mid performing states % of zero-dose children identified and referred for immunization desegregated by low and mid performing states	Health facility records			
1.5.4	Advocate for early childhood development	Advocacy meetings held with key stakeholders	Number of advocacy meetings held with key stakeholders, including policymakers, community leaders, and parents.	Activity report	Reviews	Quarterly Annually	Child Health Focal Person

Actions		Outputs (Targets) – cumulative and yearly accordingly	Verifiable Indicator	Data source	Data collection method	Reporting Timelines	Responsibility DAPs
1.5.5	Identify and refer children with presumptive Tuberculosis	TB screening interventions held across all levels	Number of community awareness campaigns conducted to educate about TB symptoms and the importance of early referral. Number of screening sessions conducted to identify children with presumptive TB. Number of children screened for TB symptoms. Number of children with presumptive TB referred to health facilities for further evaluation and treatment.	Activity reports Outreach records	Reviews Supportive supervisions	Monthly Quarterly Annually	Child Health Focal Person
1.5.6	Identify and engage community champions for child survival	**Link to 1.1.6**					
1.5.7	Support integrated service provision by CBO/CSO in childcare at the community level	Increased number of CBO/CSO involved in or providing integrated childcare services at the community level	Number of joint activities or projects implemented by CBO/CSO and health facilities and communities Number of children benefiting from integrated childcare programs	Activity reports Outreach records	Reviews	Monthly Quarterly Annually	Child Health Focal Person
1.5.8	Scale up engagement of CBO/CSO in child health care at the community level especially in hard-to-reach communities	Link to 1.5.7					

Actions		Outputs (Targets) – cumulative and yearly accordingly	Verifiable Indicator	Data source	Data collection method	Reporting Timelines	Responsibility DAPs
Strategy 6			**Digitalize and use data- driven approach in decision making**				
1.6.1	Collaborate with relevant departments to include child health data elements in the digital platforms	Comprehensive child health data elements incorporated into the FMoH digital platforms	Number of meetings held with relevant departments and stakeholders to discuss data integration. Number of training sessions held for relevant staff on the use of updated digital platforms.	Meeting reports Lists of identified data element Screen shots of digital platform showing child health data elements	Reviews	Annual	Child Health Focal Person
1.6.2	Adapt/adopt relevant on-line digital training package for pre-service/ in-service	Relevant online digital training packages on comprehensive child health revised and adapted or adopted and operationalized	Number of training modules developed Number of pre-service and in-service participants trained.	Activity report Web link to the training packages	Reviews	Annual	Child Health Focal Person
1.6.3	Strengthen the use of dashboard for data reporting for child survival	**Link to 1.6.1**					
1.6.4	Conduct quarterly review of the NCSAP during TWGs at state level	NCSAP implementation Quarterly Review Meetings Conducted across all states and the FCT	Number of NCSAP implementation quarterly review meetings held by the TWGs across states and the FCT desegregated by low and mid performing states Number of recommendations implemented by health facilities desegregated by low and mid performing states	Review reports Review template	Reviews Supportive supervisions	Monthly Quarterly Annually	Child Health Focal Person
1.6.5	Conduct annual performance review of the NCSAP at national level	Annual performance review of the NCSAP conducted	Number of annual performance review meetings conducted % of recommendations from the review meetings implemented by relevant departments and agencies.	Review reports Review template	Reviews Supportive supervisions	Annually	Child Health Focal Person

Actions		Outputs (Targets) – cumulative and yearly accordingly	Verifiable Indicator	Data source	Data collection method	Reporting Timelines	Responsibility DAPs
1.6.6	Conduct Mid-term review of the NCSAP	Updated NCSAP document incorporating lessons learned and evolving global/national priorities.	Number of key stakeholders consulted during the review process across all levels % of recommendations from the MTR implemented by relevant departments and agencies. % of low and mid-level states incorporated into the MTR	Review reports Review template	Reviews Supportive supervisions	Mid Term Annually Quarterly Monthly	Child Health Focal Person
1.6.7	Conduct End-term evaluation of the NCSAP	NCSAP ETR conducted	Number of key stakeholders consulted during the evaluation process. Number of technical reports and data sources used for the assessment. % of low and mid-level states incorporated into the MTR	Review reports Review template	Reviews Supportive supervisions	End Term	Child Health Focal Person
Strategy 7			**Advance public and private partnership for child health and beyond health**				
1.7.1	Involve private sector as member of the TWGs at state level	The organized private sector incorporated into the child health TWG at state level	Number of private sector representatives identified and invited. % of private sector representatives actively participating in TWG meetings Percentage of collaborations implemented as a result of private sector involvement.	Activity reports TWG meeting minutes	Reviews Supportive supervisions	End Term	Child Health Focal Person
1.7.2	Advocate to private sectors for increase data reporting for child survival	Advocacy meetings held with stakeholders involved in child health services	Number of advocacy meetings held with private sector stakeholders to discuss the importance of data reporting for child survival. Number of training sessions held for private sector partners on data reporting standards and practices.	Activity reports	Review DHIS	Quarterly Annually	Child Health Focal Person

Actions		Outputs (Targets) – cumulative and yearly accordingly	Verifiable Indicator	Data source	Data collection method	Reporting Timelines	Responsibility DAPs
			% of private sector entities involved with child health with improved data reporting rate				
1.7.3	Strengthen referral between the public and private health care providers and different levels of care on child health interventions	Referral between the public and private health care providers reviewed and operationalized	Number of healthcare facilities provided access to referral protocols % of private health care providers abiding with the referral protocol % of referrals made guided by the referral protocol	Activity report Referral protocol Facility registers	Reviews Supportive supervisions	End Term	Child Health Focal Person
1.7.4	Partner with telecommunication for toll-free child health key messages and data transmission	Toll-Free Number for free child health key messages and data transmission activated	Number of telecommunication companies engaged in the partnership Number of toll-free numbers launched Percentage of community members aware of the toll-free services desegregated by low and mid performing states.	Reports (program and telco)	Reviews Supportive supervisions	Monthly Quarterly Annually	Child Health Focal Person
1.7.5	Engage the media for effective communication and dissemination for information for improved child health programs	Media outlets engaged for effective communication and dissemination for information for improved child health programs	Percentage of media professionals trained on child health issues. Percentage of health professionals trained on media communication. Number of news articles, radio broadcasts, television segments, and social media posts featuring child health programs by type Number of social media posts promoting child health programs.	Activity reports Reach and engagement metrics Reports	Social listening Reviews Supportive supervisions	Monthly Quarterly Annually	Child Health Focal Person

Actions		Outputs (Targets) – cumulative and yearly accordingly	Verifiable Indicator	Data source	Data collection method	Reporting Timelines	Responsibility DAPs
1.7.6	Collaborate with relevant sector for WASH	WASH projects or program development and implementation integrates child health WASH needs	Number of integrated WASH programs developed and implemented at facilitate and community level further desegregated by low and mid performing states	WASHNORM report NCSAP review reports	Reviews Supportive supervisions Survey	Monthly Quarterly Annually	Child Health Focal Person
Objective 2			**To prevent child vulnerability and ensure vulnerable children survive**				
Strategy 1			**Strengthen health system resilience to address public health**				
2.1.1	Advocate to policy makers for community-based health insurance scheme implementation	Meetings on CBHIS conducted with relevant policymakers and stakeholders at all levels	Number of meetings held with key policymakers % allocated resources for community-based health insurance further desegregated by low and mid-performing states % of community driven community-based health insurance further desegregated by low and mid performing states	Health account reports Activity reports	Reviews Supportive supervisions Budget tracking	Monthly Quarterly Annually	Child Health Focal Person
2.1.2	Conduct outreach and mobile clinics for child health services to hard-to-reach communities	Mobile clinic units equipped with necessary medical supplies and personnel Implementation plan developed and operationalized	Number of mobile clinic units established and operational Number of health workers deployed to conduct outreach and provide services at mobile clinics. % of hard-to-reach communities serviced by mobile clinics further desegregated by services/treatment/supplies provided and, low and mid performing states % of children in targeted communities reach with required services	Reports Consultation schedules	Reviews Supportive supervisions	Monthly Quarterly Annually	Child Health Focal Person

Actions		Outputs (Targets) – cumulative and yearly accordingly	Verifiable Indicator	Data source	Data collection method	Reporting Timelines	Responsibility DAPs
2.1.3	Advocate for the update of the RMNCAEH continuity plan on emergencies to include children in humanitarian settings	Advocacy actions targeting relevant stakeholders/entities conducted	Number of stakeholder/entity consultations conducted % of states hosting humanitarian settings targeted % of under 5 children in humanitarian settings reach with child health interventions	Updated RMNCAEH plan Health care delivery reports	Reviews Supportive supervisions	Monthly Quarterly Annually	Child Health Focal Person
2.1.4	Advocate for integration of RMNCAEH+N into the national humanitarian preparedness and response plan	Refer to 2.1.3					

Chapter 7

Cost for implementing the National Child Survival Action Plan

7.1 Overview

The estimated cost for implementing the NCSAP 2025-2029 was arrived at using a customized tool which incorporated relevant elements from the One Health Tool and the MSH/UNICEF Community Health Service Delivery Tool. The tool enhanced the computation, projections, estimation and management of the costing process for programme activities, medicines and medical supplies for the plan.

7.2 Cost Parameters for the NCSAP 2025-2029

7.2.1 Population:

The under-five population was identified as a key factor in determining intervention costs. Using the 2006 population figures as the baseline and the growth rate provided by the National Population Commission (NPC), the population was projected annually from 2025 to 2029 for each state, and the Federal Capital Territory (FCT). The 2029 projected population figures were specifically used to compute the cost for all under-five child health interventions.

7.2.2 Indicators Considered

Seven indicators (ITN use, malaria, ARI, diarrhoea, vaccination, nutrition, and WASH) from NDHS 2024, MICS 2023, and WASHNORM 2021 were used to calculate under-five child health intervention costs, focusing on specific health risks and basic hygiene needs.

i. Malaria Prevalence: Proportion of children with fever in the two weeks before the survey (NDHS 2024).
ii. ARI Symptoms: Proportion of children with acute respiratory infection symptoms in the past two weeks (MICS 2023, used as an alternative to NDHS due to limited state-level data).
iii. Diarrhoea Episodes: Proportion of children experiencing diarrhoea in the last two weeks (MICS 2023).
iv. Vaccination Coverage: Proportion of children with no vaccinations (NDHS 2024).
v. Nutrition: Proportion of children classified as underweight based on weight-for-age z-scores below -2SD (NDHS 2024).
vi. ITN Usage: Proportion of children not sleeping under an Insecticide-Treated Net (NDHS 2024).
vii. WASH: Proportion of the population lacking access to basic hygiene services, used as a proxy for safe water access (WASHNORM 2021). Costs were limited to water guard and hand sanitizers for mothers.

7.2.3 Population in Need of intervention:

The population of under-five children requiring intervention was estimated using the projected 2029 population and the prevalence rate of each child health indicator. The formula used was:

$$\textit{Population in need} = \left(\frac{\textit{Chil health indicator}}{100}\right) \textit{x 2029 projected under 5 population}$$

This calculation determined the number of children affected by each health issue, guiding the intervention planning for a five-year period (2025–2029).

7.2.4 Intervention Cost:

The cost was calculated based on the unit cost of medicines and medical supplies per child, while medical equipment and other logistics were budgeted per health facility, including Primary Health Care Centers (PHCs), secondary, and tertiary facilities.

7.2.5 Programme Cost:

Ingredient costing was utilized for costing programs governance, coordinating, monitoring, evaluating and learning for attainment of the NCSAP's goal by 2029. The costs were categorized by levels and stakeholders targeted.

The scope of the costing did not however, include health system inputs such as human resources and general infrastructure.

7.3 Challenges and Limitations

i. **Data quality and availability:** Accurate and timely data are essential for effective costing.
ii. **Unforeseen costs:** Unexpected challenges can arise, such as natural disasters or economic downturns.
iii. **Political and economic instability:** Can disrupt program implementation and increase costs.

7.4 Estimated Cost of NCSAP 2025-2029

Overall, the five-year child health intervention plan totals ₦2.9 Trillion, with the largest allocations for nutrition (₦1.6 Trillion) and vaccination (₦6.4 billion). Costs vary by year, peaking in 2025, 2026, and 2028. Program activities consistently cost ₦5.7 billion annually.

Cost Categories:

a. **Medications and Supplies:** Significant costs are attributed to consumables (₦96.4 Billion), malaria treatment (₦38.1 Billion), and ITN distribution (₦62.3 Billion).
b. **Specific Interventions:** Vaccination (₦639.7 Billion) and nutrition (₦1.1 Trillion) account for the largest portions of the overall cost.
c. **Equipment and Logistics:** Equipment costs total ₦10.5 Billion, while WASH and ARI interventions contribute ₦23.7 Billion and ₦7.8 Billion, respectively.
d. **Programme Activities:** Consistent annual expenditure of ₦5.7Billion contributes to a total of ₦28.5 Billion over five years.

Yearly Trends: Costs are distributed unevenly, with higher expenditures in 2025, 2026, 2028, and slightly reduced costs in 2027 and 2029. Nutrition and vaccination consistently dominate annual budgets, followed by diarrhoea treatment and ITN distribution.

To address financial constraints, the implementation of intervention plans was adjusted as follows:

i. **2025 and 2026:** 25% of the plans will be executed in each year, prioritizing consistent resource allocation.
ii. **2027:** Implementation will be reduced to 15%, reflecting budget adjustments.
iii. **2028:** Implementation returns to 25%, matching the earlier years.
iv. **2029:** Implementation is limited to 10%, possibly to wind down the intervention or align with reduced funding.

This phased approach ensures a manageable distribution of resources over the five-year period.

Overall breakdown of Cost for the NCSAP

costed Items	Overall Cost (in Million) (period of 5 years)	Implementation years				
		Yr 2025	Yr 2026	Yr 2027	Yr 2028	Yr 2029
Other Medications	₦401	₦100	₦100	₦60	₦100	₦40
Consumables	₦96,397	₦24,099	₦24,099	₦14,460	₦24,099	₦9,640
Equipment	₦10,480	₦2,620	₦2,620	₦1,572	₦2,620	₦1,048
Malaria	₦38,052	₦9,513	₦9,513	₦5,708	₦9,513	₦3,805
ITN	₦62,338	₦15,584	₦15,584	₦9,351	₦15,584	₦6,234
WASH	₦23,716	₦5,929	₦5,929	₦3,557	₦5,929	₦2,372
ARI	₦7,764	₦1,941	₦1,941	₦1,165	₦1,941	₦776
Diarrhoea	₦394,070	₦98,518	₦98,518	₦59,111	₦98,518	₦39,407
Vaccination	₦639,653	₦159,913	₦159,913	₦95,948	₦159,913	₦63,965
Nutrition	₦1,603,061	₦400,765	₦400,765	₦240,459	₦400,765	₦160,306
Intervention Total Cost	₦2,875,932	₦718,983	₦718,983	₦431,390	₦718,983	₦287,593
Programme Activities Total Cost	₦28,452.07	₦5,690.41	₦5,690.41	₦5,690.41	₦5,690.41	₦5,690.41

Figure 1: Breakdown of Cost (in Million) of interventions and Programs Per Year

Overall Per Capita Cost: Total intervention cost per capita over five years is ₦72,027.12, with program activities adding ₦712.58, making a combined per capita cost of ₦72,739.70.

Per capita costs for each intervention category over a five-year period, highlighting the financial distribution across various child health needs:

1. **Major Cost Drivers:**
    a. **Nutrition:** The highest per capita cost at ₦40,148.32, reflecting its critical role in addressing underweight children.
    b. **Vaccination:** The second-largest per capita cost at ₦16,019.97, emphasizing its importance in preventive health measures.
    c. **Diarrhoea:** Costs ₦9,869.41 per capita, indicating the significant burden of diarrhoeal diseases among under-five children.

2. **Moderate Cost Categories:**
    a. **Consumables:** At ₦2,414.24 per capita, this category supports essential supplies.
    b. **ITN and Malaria:** Combined costs of ₦1,561.24 (ITN) and ₦953.00 (Malaria) highlight the emphasis on combating malaria.

3. **Lower Cost Categories:**
    a. **WASH:** Costs ₦593.97 per capita, targeting hygiene and safe water access.
    b. **ARI:** Accounts for ₦194.45 per capita, reflecting a lower financial burden compared to other health challenges.
    c. **Other Medications:** The lowest at ₦10.05 per capita.

4. **Program Activities:**
    a. The per capita cost of program activities is ₦712.58, ensuring operational support for the interventions.

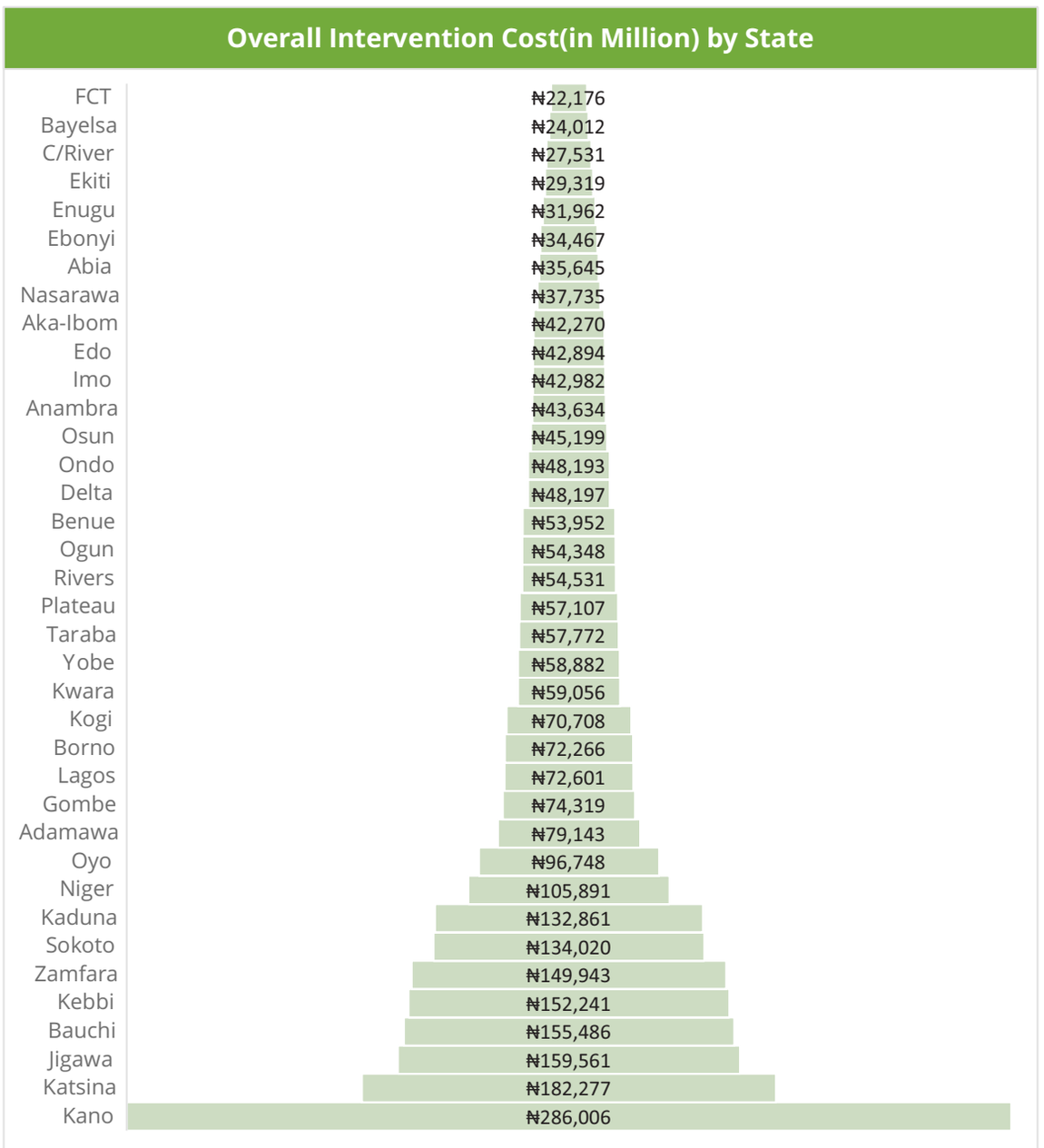


Figure 2: Overall cost of intervention (in millions) Per State

The chart displays the **overall cost of intervention (in millions)** for under-five health programs across 36 states and the FCT over a five-year period. Below are the key observations:

Highest Costs: Kano leads with ₦286,006M, followed by **Katsina** (₦182,277M) and **Jigawa** (₦159,561M), reflecting higher child populations or health needs.
Moderate Costs: States like **Bauchi** (₦155,486M), **Kebbi** (₦152,241M), and **Zamfara** (₦149,943M) are also significant contributors to overall costs.

Lowest Costs: Bayelsa (₦24,012M) and **FCT** (₦22,176M) show the lowest costs, likely due to smaller target populations.

Regional Trends: Northern states generally have higher costs, reflecting larger populations or greater intervention needs compared to southern states.

Table 8 Overall Cost by State Per Year

Percentage Cost of Implementation	100%	25%	25%	15%	25%	10%	
State	Overall Cost (in Million) (period of 5 years)	Yr 2025	Yr 2026	Yr 2027	Yr 2028	Yr 2029	Per Capita
Abia	₦35,645	₦8,911	₦8,911	₦5,347	₦8,911	₦3,564	₦44,870
Adamawa	₦79,143	₦19,786	₦19,786	₦11,871	₦19,786	₦7,914	₦79,973
Aka-Ibom	₦42,273	₦10,568	₦10,568	₦6,341	₦10,568	₦4,227	₦57,677
Anambra	₦43,634	₦10,909	₦10,909	₦6,545	₦10,909	₦4,363	₦41,721
Bauchi	₦155,486	₦38,871	₦38,871	₦23,323	₦38,871	₦15,549	₦84,214
Bayelsa	₦24,012	₦6,003	₦6,003	₦3,602	₦6,003	₦2,401	₦60,710
Benue	₦53,952	₦13,488	₦13,488	₦8,093	₦13,488	₦5,395	₦52,929
Borno	₦72,266	₦18,066	₦18,066	₦10,840	₦18,066	₦7,227	₦69,269
C/River	₦27,531	₦6,883	₦6,883	₦4,130	₦6,883	₦2,753	₦44,791
Delta	₦48,197	₦12,049	₦12,049	₦7,230	₦12,049	₦4,820	₦49,522
Ebonyi	₦34,467	₦8,617	₦8,617	₦5,170	₦8,617	₦3,447	₦53,072
Edo	₦42,894	₦10,724	₦10,724	₦6,434	₦10,724	₦4,289	₦50,990
Ekiti	₦29,319	₦7,330	₦7,330	₦4,398	₦7,330	₦2,932	₦46,208
Enugu	₦31,962	₦7,990	₦7,990	₦4,794	₦7,990	₦3,196	₦37,386
Gombe	₦74,319	₦18,580	₦18,580	₦11,148	₦18,580	₦7,432	₦89,842
Imo	₦42,982	₦10,745	₦10,745	₦6,447	₦10,745	₦4,298	₦46,248
Jigawa	₦159,561	₦39,890	₦39,890	₦23,934	₦39,890	₦15,956	₦92,861
Kaduna	₦132,861	₦33,215	₦33,215	₦19,929	₦33,215	₦13,286	₦73,553
Kano	₦286,006	₦71,501	₦71,501	₦42,901	₦71,501	₦28,601	₦93,222
Katsina	₦182,277	₦45,569	₦45,569	₦27,342	₦45,569	₦18,228	₦74,819
Kebbi	₦152,241	₦38,060	₦38,060	₦22,836	₦38,060	₦15,224	₦120,215
Kogi	₦70,708	₦17,677	₦17,677	₦10,606	₦17,677	₦7,071	₦81,500
Kwara	₦59,056	₦14,764	₦14,764	₦8,858	₦14,764	₦5,906	₦82,768
Lagos	₦72,601	₦18,150	₦18,150	₦10,890	₦18,150	₦7,260	₦41,769
Nasarawa	₦37,735	₦9,434	₦9,434	₦5,660	₦9,434	₦3,774	₦63,298
Niger	₦105,891	₦26,473	₦26,473	₦15,884	₦26,473	₦10,589	₦81,134
Ogun	₦54,348	₦13,587	₦13,587	₦8,152	₦13,587	₦5,435	₦61,330
Ondo	₦48,193	₦12,048	₦12,048	₦7,229	₦12,048	₦4,819	₦57,154
Osun	₦45,199	₦11,300	₦11,300	₦6,780	₦11,300	₦4,520	₦65,795
Oyo	₦96,748	₦24,187	₦24,187	₦14,512	₦24,187	₦9,675	₦72,427
Plateau	₦57,107	₦14,277	₦14,277	₦8,566	₦14,277	₦5,711	₦67,236
Rivers	₦54,531	₦13,633	₦13,633	₦8,180	₦13,633	₦5,453	₦47,207

Percentage Cost of Implementation	100%	25%	25%	15%	25%	10%

State	Overall Cost (in Million) (period of 5 years)	Yr 2025	Yr 2026	Yr 2027	Yr 2028	Yr 2029	Per Capita
Sokoto	₦134,020	₦33,505	₦33,505	₦20,103	₦33,505	₦13,402	₦100,196
Taraba	₦57,772	₦14,443	₦14,443	₦8,666	₦14,443	₦5,777	₦83,206
Yobe	₦58,882	₦14,721	₦14,721	₦8,832	₦14,721	₦5,888	₦85,457
Zamfara	₦149,943	₦37,486	₦37,486	₦22,491	₦37,486	₦14,994	₦124,355
FCT	₦22,176	₦5,544	₦5,544	₦3,326	₦5,544	₦2,218	₦41,251
National	₦2,875,935	₦718,984	₦718,984	₦431,390	₦718,984	₦287,593	₦72,027

Summary Tables for Interventions, Other Medicines, Consumables, Equipment Per State

State	Other Medications	Consummables	Equipment	Malaria	ITN	WASH	ARI	Diarrhea	Vaccination	Nutrition	Overall
Abia	₦12,304,838	₦2,955,137,115	₦321,282,150	₦1,304,124,470	₦1,618,348,766	₦528,375,605	₦94,330,801	₦8,103,180,161	₦578,842,844	₦20,128,801,285	₦35,644,728,034
Adamawa	₦9,368,221	₦2,249,877,501	₦244,606,410	₦593,603,835	₦1,321,204,707	₦643,307,505	₦235,023,298	₦9,926,401,155	₦13,922,538,720	₦49,996,668,419	₦79,142,599,771
Aka-Ibom	₦7,693,109	₦1,847,581,524	₦200,868,840	₦1,915,858,909	₦1,401,074,748	₦462,767,852	₦29,010,135	₦7,824,559,233	₦2,834,548,505	₦25,748,754,895	₦42,272,717,751
Anambra	₦12,067,013	₦2,898,021,020	₦315,072,495	₦825,441,572	₦1,688,403,216	₦567,303,481	₦10,349,108	₦11,082,485,752	₦5,099,965,027	₦21,135,099,142	₦43,634,207,827
Bauchi	₦12,976,951	₦3,116,552,168	₦338,831,175	₦1,363,942,504	₦2,341,934,244	₦ 1,051,836,002	₦602,907,552	₦17,369,856,612	₦33,425,995,038	₦95,860,851,107	₦155,485,683,352
Bayelsa	₦3,133,081	₦752,442,476	₦81,805,455	₦646,813,420	₦662,851,591	₦240,653,642	₦46,966,380	₦4,133,005,346	₦3,303,217,319	₦14,141,377,189	₦24,012,265,897
Benue	₦16,678,743	₦4,005,576,611	₦435,485,805	₦547,055,355	₦1,083,976,186	₦692,595,483	₦40,345,855	₦10,985,866,178	₦14,911,607,915	₦21,232,530,598	₦53,951,718,729
Borno	₦4,415,265	₦1,060,372,730	₦115,283,595	₦665,298,954	₦1,614,699,466	₦702,126,934	₦474,875,628	₦9,661,260,190	₦12,396,610,276	₦45,570,773,354	₦72,265,716,390
C/River	₦12,149,735	₦2,917,887,488	₦317,232,375	₦780,070,459	₦765,479,104	₦309,152,754	₦231,125,548	₦6,221,001,430	₦689,031,998	₦15,287,707,657	₦27,530,838,548
Delta	₦8,489,304	₦2,038,796,279	₦221,657,685	₦694,388,393	₦1,508,824,336	₦455,290,861	₦9,630,539	₦10,224,851,127	₦3,382,106,812	₦29,652,730,655	₦48,196,765,990
Ebonyi	₦7,434,604	₦1,785,498,812	₦194,119,215	₦934,912,724	₦1,138,286,596	₦456,180,002	₦12,852,654	₦6,668,505,575	₦655,209,746	₦22,613,555,643	₦34,466,555,570
Edo	₦12,739,126	₦3,059,436,072	₦332,621,520	₦706,437,426	₦1,823,692,944	₦591,514,591	₦33,297,270	₦8,914,211,110	₦10,420,437,484	₦17,000,043,114	₦42,894,430,656
Ekiti	₦5,532,007	₦1,328,570,048	₦144,441,975	₦428,663,886	₦1,364,125,654	₦436,129,994	₦6,278,555	₦6,802,493,039	₦2,133,811,198	₦16,668,803,843	₦29,318,850,199
Enugu	₦10,722,787	₦2,575,190,915	₦279,974,445	₦496,607,608	₦1,899,345,337	₦559,419,637	₦186,112,183	₦8,923,628,259	₦6,133,482,509	₦10,897,427,933	₦31,961,911,614
Gombe	₦7,124,398	₦1,710,999,557	₦186,019,665	₦1,008,048,430	₦1,013,237,563	₦534,768,980	₦73,670,426	₦8,325,510,204	₦11,823,223,229	₦49,635,911,934	₦74,318,514,385
Imo	₦12,377,219	₦2,972,520,275	₦323,172,045	₦1,314,455,450	₦2,112,422,426	₦580,808,998	₦91,965,394	₦10,142,847,483	₦2,604,590,655	₦22,826,511,897	₦42,981,671,842
Jigawa	₦8,375,562	₦2,011,479,885	₦218,687,850	₦1,616,527,921	₦1,972,578,306	₦773,004,124	₦255,043,808	₦14,881,386,116	₦25,907,221,752	₦111,916,875,538	₦159,561,180,861
Kaduna	₦14,683,084	₦3,526,298,070	₦383,378,700	₦3,911,991,461	₦2,605,982,347	₦865,760,103	₦268,115,313	₦17,505,017,563	₦34,423,443,775	₦69,356,208,517	₦132,860,878,935
Kano	₦15,365,537	₦3,690,196,431	₦401,197,710	₦4,978,426,390	₦2,555,063,066	₦1,959,143,742	₦1,305,431,250	₦26,918,179,035	₦61,046,242,893	₦183,136,455,065	₦286,005,701,119
Katsina	₦20,111,689	₦4,830,035,033	₦525,120,825	₦1,984,341,764	₦3,389,892,208	₦1,214,867,447	₦1,566,991,720	₦20,685,833,942	₦46,564,266,062	₦101,495,355,446	₦182,276,816,135
Kebbi	₦9,812,850	₦2,356,659,767	₦256,215,765	₦1,351,340,889	₦1,538,210,783	₦654,226,358	₦288,225,653	₦10,423,117,463	₦55,437,146,460	₦79,926,143,605	₦152,241,099,592
Kogi	₦12,821,848	₦3,079,302,540	₦334,781,400	₦755,953,435	₦1,627,370,113	₦598,214,139	₦8,585,044	₦9,478,252,623	₦26,356,447,055	₦28,456,601,090	₦70,708,329,288
Kwara	₦10,278,159	₦2,468,408,649	₦268,365,090	₦153,173,943	₦1,599,828,113	₦449,487,707	₦70,604,528	₦7,625,406,090	₦19,236,350,050	₦27,174,193,977	₦59,056,096,305
Lagos	₦22,707,079	₦5,453,345,466	₦592,887,060	₦1,327,934,202	₦3,598,834,238	₦823,099,712	₦17,199,577	₦19,107,128,496	₦3,020,122,095	₦38,637,750,701	₦72,601,008,626
Nasarawa	₦10,836,530	₦2,602,507,308	₦282,944,280	₦726,467,743	₦956,296,697	₦314,814,095	₦35,394,588	₦5,736,710,843	₦5,847,479,331	₦21,221,648,687	₦37,735,100,101
Niger	₦16,182,413	₦3,886,377,803	₦422,526,525	₦840,544,477	₦1,725,716,793	₦825,936,084	₦103,318,263	₦12,899,110,967	₦37,088,571,546	₦48,083,213,566	₦105,891,498,435
Ogun	₦12,480,621	₦2,997,353,360	₦325,871,895	₦693,811,591	₦2,027,825,691	₦585,594,277	₦8,768,927	₦9,149,549,520	₦5,761,684,526	₦32,785,471,586	₦54,348,411,994
Ondo	₦8,520,325	₦2,046,246,204	₦222,467,640	₦266,200,925	₦1,480,094,426	₦568,096,973	₦8,343,843	₦9,154,680,047	₦11,106,546,469	₦23,331,581,065	₦48,192,777,917
Osun	₦11,074,354	₦2,659,623,404	₦289,153,935	₦485,798,175	₦1,059,726,133	₦386,923,263	₦6,797,738	₦7,271,675,255	₦3,234,363,023	₦29,793,853,101	₦45,198,988,382
Oyo	₦15,293,156	₦3,672,813,272	₦399,307,815	₦438,579,332	₦2,481,659,089	₦885,592,882	₦105,745,376	₦14,411,949,343	₦20,140,429,082	₦54,196,337,401	₦96,747,706,748
Plateau	₦13,907,569	₦3,340,049,933	₦363,129,825	₦488,016,047	₦1,680,232,217	₦561,876,618	₦201,711,442	₦7,644,425,411	₦12,710,879,237	₦30,103,165,758	₦57,107,394,056
Rivers	₦6,059,357	₦1,455,218,781	₦158,211,210	₦758,531,857	₦2,261,482,029	₦517,180,812	₦11,430,548	₦12,292,871,658	₦13,726,125,558	₦23,343,633,192	₦54,530,745,001
Sokoto	₦8,654,747	₦2,078,529,215	₦225,977,445	₦532,061,203	₦2,766,010,817	₦929,955,458	₦132,357,216	₦12,447,377,717	₦63,125,488,923	₦51,773,199,224	₦134,019,611,965
Taraba	₦9,761,149	₦2,344,243,224	₦254,865,840	₦223,581,037	₦1,021,259,192	₦483,229,959	₦103,058,219	₦6,948,676,012	₦12,492,272,313	₦33,890,583,797	₦57,771,530,741
Yobe	₦5,376,904	₦1,291,320,420	₦140,392,200	₦1,144,182,950	₦670,938,350	₦392,534,247	₦368,179,891	₦6,552,454,551	₦6,758,485,594	₦41,558,136,100	₦58,882,001,207
Zamfara	₦7,724,129	₦1,855,031,450	₦201,678,795	₦700,415,679	₦1,087,601,985	₦808,903,977	₦656,231,848	₦11,985,262,648	₦49,606,171,704	₦83,034,078,487	₦149,943,100,702
FCT	₦6,162,759	₦1,480,051,866	₦160,911,060	₦448,040,651	₦873,357,478	₦305,482,262	₦63,833,891	₦5,641,677,166	₦1,747,604,292	₦11,448,502,099	₦22,175,623,525
National	₦401,396,224	₦96,399,552,662	₦10,480,547,715	₦38,051,645,065	₦62,337,866,958	₦23,716,156,560	₦7,764,110,010	₦394,070,405,319	₦639,652,561,014	₦1,603,060,536,665	₦2,875,934,778,191

Figure 3: Summary Tables for Interventions, Other Medicines, Consumables, Equipment Per State

SN	State	PHC	Secondary	Tertiary	Total	Other Medications	Consummables	Equipment	Cost PHC	Other Medications	Consummables	Equipment	Cost Secondary	Other Medications	Consummables	Equipment	Cost for Tertiary	state	Other Medications	Consummables	Equipment
1	Abia	938	245	7	1,190	₦9,699,108	₦2,329,343,373	₦253,245,930	₦2,592,288,411	₦2,533,349	₦608,410,583	₦66,146,325	₦677,090,257	₦72,381	₦17,383,160	₦1,889,895	₦19,345,436	Abia	₦12,304,838	₦2,955,137,115	₦321,282,150
2	Adamawa	862	43	1	906	₦8,913,252	₦2,140,611,927	₦232,727,070	₦2,382,252,249	₦444,629	₦106,782,266	₦11,609,355	₦118,836,249	₦10,340	₦2,483,309	₦269,985	₦2,763,634	Adamawa	₦9,368,221	₦2,249,877,501	₦244,606,410
3	Aka-Ibom	535	208	1	743	₦5,532,007	₦1,328,570,048	₦144,441,975	₦1,478,544,030	₦2,150,762	₦516,528,168	₦56,156,880	₦574,835,810	₦10,340	₦2,483,309	₦269,985	₦2,763,634	Aka-Ibom	₦7,693,109	₦1,847,581,524	₦200,868,840
4	Anambra	728	436	3	1,167	₦7,527,666	₦1,807,848,588	₦196,549,080	₦2,011,925,334	₦4,508,327	₦1,082,722,506	₦117,713,460	₦1,204,944,293	₦31,021	₦7,449,926	₦809,955	₦8,290,901	Anambra	₦12,067,013	₦2,898,021,020	₦315,072,495
5	Bauchi	1,188	61	6	1,255	₦12,284,158	₦2,950,170,498	₦320,742,180	₦3,283,196,836	₦630,752	₦151,481,819	₦16,469,085	₦168,581,656	₦62,041	₦14,899,851	₦1,619,910	₦16,581,802	Bauchi	₦12,976,951	₦3,116,552,168	₦338,831,175
6	Bayelsa	225	74	4	303	₦2,326,545	₦58,744,413	₦60,746,625	₦621,817,583	₦765,175	₦183,764,829	₦19,978,890	₦204,508,894	₦41,361	₦9,933,234	₦1,079,940	₦11,054,535	Bayelsa	₦3,133,081	₦752,442,476	₦81,805,455
7	Benue	1,489	121	3	1,613	₦15,396,558	₦3,697,646,357	₦402,007,665	₦4,115,050,579	₦1,251,164	₦300,480,329	₦32,668,185	₦334,399,678	₦31,021	₦7,449,926	₦809,955	₦8,290,901	Benue	₦16,678,743	₦4,005,576,611	₦435,485,805
8	Borno	370	55	2	427	₦3,825,874	₦18,824,145	₦99,894,450	₦1,022,544,469	₦568,711	₦136,581,968	₦14,849,175	₦151,999,854	₦20,680	₦4,966,617	₦539,970	₦5,527,267	Borno	₦4,415,265	₦1,060,372,730	₦115,283,595
9	C/River	1,035	137	3	1,175	₦10,702,107	₦2,570,224,298	₦279,434,475	₦2,860,360,880	₦1,416,607	₦340,213,265	₦36,987,945	₦378,617,817	₦31,021	₦7,449,926	₦809,955	₦8,290,901	C/River	₦12,149,735	₦2,917,887,488	₦317,232,375
10	Delta	648	171	2	821	₦6,700,450	₦1,609,183,908	₦174,950,280	₦1,790,834,638	₦1,768,174	₦424,645,754	₦46,167,435	₦472,581,363	₦20,680	₦4,966,617	₦539,970	₦5,527,267	Delta	₦8,489,304	₦2,038,796,279	₦221,657,685
11	Ebonyi	657	59	3	719	₦6,793,511	₦1,631,533,685	₦177,380,145	₦1,815,707,341	₦610,072	₦146,515,202	₦15,929,115	₦163,054,388	₦31,021	₦7,449,926	₦809,955	₦8,290,901	Ebonyi	₦7,434,604	₦1,785,498,812	₦194,119,215
12	Edo	927	294	11	1,232	₦9,585,365	₦2,302,026,980	₦250,276,095	₦2,561,888,440	₦3,040,019	₦730,092,699	₦79,375,590	₦812,508,308	₦113,742	₦27,316,394	₦2,969,835	₦30,399,971	Edo	₦12,739,126	₦3,059,436,072	₦332,621,520
13	Ekiti	431	101	3	535	₦4,456,626	₦1,070,305,964	₦116,363,535	₦1,191,126,125	₦1,044,360	₦250,814,159	₦27,268,485	₦279,127,004	₦31,021	₦7,449,926	₦809,955	₦8,290,901	Ekiti	₦5,532,007	₦1,328,570,048	₦144,441,975
14	Enugu	678	353	6	1,037	₦7,010,656	₦1,683,683,163	₦183,049,830	₦1,873,743,649	₦3,650,091	₦876,607,901	₦95,304,705	₦975,562,696	₦62,041	₦14,899,851	₦1,619,910	₦16,581,802	Enugu	₦10,722,787	₦2,575,190,915	₦279,974,445
15	Gombe	637	51	1	689	₦6,586,707	₦1,581,867,515	₦171,980,445	₦1,760,434,667	₦527,350	₦126,648,734	₦13,769,235	₦140,945,319	₦10,340	₦2,483,309	₦269,985	₦2,763,634	Gombe	₦7,124,398	₦1,710,999,557	₦186,019,665
16	Imo	822	373	2	1,197	₦8,499,644	₦2,041,279,587	₦221,927,670	₦2,271,706,901	₦3,856,895	₦926,274,071	₦100,704,405	₦1,030,835,370	₦20,680	₦4,966,617	₦539,970	₦5,527,267	Imo	₦12,377,219	₦2,972,520,275	₦323,172,045
17	Jigawa	775	34	1	810	₦8,013,655	₦1,924,564,088	₦209,238,375	₦2,141,816,118	₦351,567	₦84,432,489	₦9,179,490	₦93,963,546	₦10,340	₦2,483,309	₦269,985	₦2,763,634	Jigawa	₦8,375,562	₦2,011,479,885	₦218,687,850
18	Kaduna	1,276	124	20	1,420	₦13,194,095	₦3,168,701,646	₦344,500,860	₦3,526,396,601	₦1,282,185	₦307,930,254	₦33,478,140	₦342,690,579	₦206,804	₦49,666,170	₦5,399,700	₦55,272,674	Kaduna	₦14,683,084	₦3,526,298,070	₦383,378,700
19	Kano	1,344	136	6	1,486	₦13,897,229	₦3,337,566,624	₦362,859,840	₦3,714,323,693	₦1,406,267	₦337,729,956	₦36,717,960	₦375,854,183	₦62,041	₦14,899,851	₦1,619,910	₦16,581,802	Kano	₦15,365,537	₦3,690,196,431	₦401,197,710
20	Katsina	1,902	40	3	1,945	₦19,667,060	₦4,723,252,767	₦513,511,470	₦5,256,431,297	₦413,608	₦99,332,340	₦10,799,400	₦110,545,348	₦31,021	₦7,449,926	₦809,955	₦8,290,901	Katsina	₦20,111,689	₦4,830,035,033	₦525,120,825
21	Kebbi	887	60	2	949	₦9,171,757	₦2,202,694,640	₦239,476,695	₦2,451,343,092	₦620,412	₦148,998,510	₦16,199,100	₦165,818,022	₦20,680	₦4,966,617	₦539,970	₦5,527,267	Kebbi	₦9,812,850	₦2,356,659,767	₦256,215,765
22	Kogi	1,083	153	4	1,240	₦11,198,437	₦2,689,423,106	₦292,393,755	₦2,993,015,297	₦1,582,051	₦379,946,201	₦41,307,705	₦422,835,956	₦41,361	₦9,933,234	₦1,079,940	₦11,054,535	Kogi	₦12,821,848	₦3,079,302,540	₦334,781,400
23	Kwara	782	209	3	994	₦8,086,036	₦1,941,947,247	₦211,128,270	₦2,161,161,553	₦2,161,102	₦519,011,477	₦56,426,865	₦577,599,443	₦31,021	₦7,449,926	₦809,955	₦8,290,901	Kwara	₦10,278,159	₦2,468,408,649	₦268,365,090
24	Lagos	1,475	714	7	2,196	₦15,251,795	₦3,662,880,038	₦398,227,875	₦4,076,359,708	₦7,382,903	₦1,773,082,269	₦192,769,290	₦1,973,234,462	₦72,381	₦17,383,160	₦1,889,895	₦19,345,436	Lagos	₦22,707,079	₦5,453,345,466	₦592,887,060
25	Nasarawa	999	47	2	1,048	₦10,329,860	₦2,480,825,192	₦269,715,015	₦2,760,870,066	₦485,989	₦116,715,500	₦12,689,295	₦129,890,784	₦20,680	₦4,966,617	₦539,970	₦5,527,267	Nasarawa	₦10,836,530	₦2,602,507,308	₦282,944,280
26	Niger	1,498	64	3	1,565	₦15,489,620	₦3,719,996,133	₦404,437,530	₦4,139,923,283	₦661,773	₦158,931,744	₦17,279,040	₦176,872,557	₦31,021	₦7,449,926	₦809,955	₦8,290,901	Niger	₦16,182,413	₦3,886,377,803	₦422,526,525
27	Ogun	1,000	205	2	1,207	₦10,340,200	₦2,483,308,500	₦269,985,000	₦2,763,633,700	₦2,119,741	₦509,078,243	₦55,346,925	₦566,544,909	₦20,680	₦4,966,617	₦539,970	₦5,527,267	Ogun	₦12,480,621	₦2,997,353,360	₦325,871,895
28	Ondo	722	98	4	824	₦7,465,624	₦1,792,948,737	₦194,929,170	₦1,995,343,531	₦1,013,340	₦243,364,233	₦26,458,530	₦270,836,103	₦41,361	₦9,933,234	₦1,079,940	₦11,054,535	Ondo	₦8,520,325	₦2,046,246,204	₦222,467,640
29	Osun	1,010	55	6	1,071	₦10,443,602	₦2,508,141,585	₦272,684,850	₦2,791,270,037	₦568,711	₦136,581,968	₦14,849,175	₦151,999,854	₦62,041	₦14,899,851	₦1,619,910	₦16,581,802	Osun	₦11,074,354	₦2,659,623,404	₦289,153,935
30	Oyo	901	568	10	1,479	₦9,316,520	₦2,237,460,959	₦243,256,485	₦2,490,033,964	₦5,873,234	₦1,410,519,228	₦153,351,480	₦1,569,743,942	₦103,402	₦24,833,085	₦2,699,850	₦27,636,337	Oyo	₦15,293,156	₦3,672,813,272	₦399,307,815
31	Plateau	1,248	94	3	1,345	₦12,904,570	₦3,099,169,008	₦336,941,280	₦3,449,014,858	₦971,979	₦233,430,999	₦25,378,590	₦259,781,568	₦31,021	₦7,449,926	₦809,955	₦8,290,901	Plateau	₦13,907,569	₦3,340,049,933	₦363,129,825
32	Rivers	460	120	6	586	₦4,756,492	₦1,142,321,910	₦124,193,100	₦1,271,271,502	₦1,240,824	₦297,997,020	₦32,398,200	₦331,636,044	₦62,041	₦14,899,851	₦1,619,910	₦16,581,802	Rivers	₦6,059,357	₦1,455,218,781	₦158,211,210
33	Sokoto	797	37	3	837	₦8,241,139	₦1,979,196,875	₦215,178,045	₦2,202,616,059	₦382,587	₦91,882,415	₦9,989,445	₦102,254,447	₦31,021	₦7,449,926	₦809,955	₦8,290,901	Sokoto	₦8,654,747	₦2,078,529,215	₦225,977,445
34	Taraba	903	40	1	944	₦9,337,201	₦2,242,427,576	₦243,796,455	₦2,495,561,231	₦413,608	₦99,332,340	₦10,799,400	₦110,545,348	₦10,340	₦2,483,309	₦269,985	₦2,763,634	Taraba	₦9,761,149	₦2,344,243,224	₦254,865,840
35	Yobe	488	30	2	520	₦5,046,018	₦1,211,854,548	₦131,752,680	₦1,348,653,246	₦310,206	₦74,499,255	₦8,099,550	₦82,909,011	₦20,680	₦4,966,617	₦539,970	₦5,527,267	Yobe	₦5,376,904	₦1,291,320,420	₦140,392,200
36	Zamfara	708	36	3	747	₦7,320,862	₦1,758,182,418	₦191,149,380	₦1,956,652,660	₦372,247	₦89,399,106	₦9,719,460	₦99,490,813	₦31,021	₦7,449,926	₦809,955	₦8,290,901	Zamfara	₦7,724,129	₦1,855,031,450	₦201,678,795
37	FCT	487	101	8	596	₦5,035,677	₦1,209,371,240	₦131,482,695	₦1,345,889,612	₦1,044,360	₦250,814,159	₦27,268,485	₦279,127,004	₦82,722	₦19,866,468	₦2,159,880	₦22,109,070	FCT	₦6,162,759	₦1,480,051,866	₦160,911,060
	TOTAL	**32,915**	**5747**	**157**	**38,818**	₦340,347,683	₦81,738,099,278	₦8,886,556,275	₦90,965,003,236	₦59,425,129	₦14,271,573,950	₦1,551,603,795	₦15,882,602,874	₦1,623,411	₦389,879,435	₦42,387,645	₦433,890,491		₦401,396,224	₦96,399,552,662	₦10,480,547,715

Figure 4: Cost Per Facility

	2025	2026	2027	2028	2029	GRAND TOTAL
Grand Total	**5,690,414,000.00**	**5,690,414,000.00**	**5,690,414,000.00**	**5,690,414,000.00**	**5,690,414,000.00**	**28,452,070,000.00**
1. Strategic objective 1: To accelerate the reduction of morbidity and mortality from major causes of deaths in children 1-59months	**5,685,514,000.00**	**5,685,514,000.00**	**5,685,514,000.00**	**5,685,514,000.00**	**5,685,514,000.00**	**28,427,570,000.00**
Strategic Intervention 1.1: Strengthen leadership governance and accountability at national and subnational levels	*2,038,028,000.00*	*2,038,028,000.00*	*2,038,028,000.00*	*2,038,028,000.00*	*2,038,028,000.00*	*10,190,140,000.00*
Strategic Intervention 1.2: Strengthen supply chain for child health commodities and health products	*6,460,000.00*	*6,460,000.00*	*6,460,000.00*	*6,460,000.00*	*6,460,000.00*	*32,300,000.00*
Strategic Intervention 1.3: Increase availability and quality health workforce for child health programme	*3,633,446,000.00*	*3,633,446,000.00*	*3,633,446,000.00*	*3,633,446,000.00*	*3,633,446,000.00*	*18,167,230,000.00*
Strategic Intervention 1.4: Improve quality of care	*1,680,000.00*	*1,680,000.00*	*1,680,000.00*	*1,680,000.00*	*1,680,000.00*	*8,400,000.00*
Strategic Intervention 1.7: Advance public and private partnership for child health and beyond health	*5,900,000.00*	*5,900,000.00*	*5,900,000.00*	*5,900,000.00*	*5,900,000.00*	*29,500,000.00*
2. Strategic Objective 2: To prevent child vulnerability and ensure vulnerable children survive	**4,900,000.00**	**4,900,000.00**	**4,900,000.00**	**4,900,000.00**	**4,900,000.00**	**24,500,000.00**
Strategic Intervention 2.1: Strengthen health system resilience to address public health threat and emergencies for child health	*4,900,000.00*	*4,900,000.00*	*4,900,000.00*	*4,900,000.00*	*4,900,000.00*	*24,500,000.00*

	2025	2026	2027	2028	2029	GRAND TOTAL
National	17,260,000.00	17,260,000.00	17,260,000.00	17,260,000.00	17,260,000.00	86,300,000.00
State	5,357,902,000.00	5,357,902,000.00	5,357,902,000.00	5,357,902,000.00	5,357,902,000.00	26,789,510,000.00
LGA	315,252,000.00	315,252,000.00	315,252,000.00	315,252,000.00	315,252,000.00	1,576,260,000.00
	5,690,414,000.00	**5,690,414,000.00**	**5,690,414,000.00**	**5,690,414,000.00**	**5,690,414,000.00**	**28,452,070,000.00**

	2025	2026	2027	2028	2029	GRAND TOTAL
Facility Health Worker	5,630,122,000.00	5,630,122,000.00	5,630,122,000.00	5,630,122,000.00	5,630,122,000.00	28,150,610,000.00
Legislators	1,680,000.00	1,680,000.00	1,680,000.00	1,680,000.00	1,680,000.00	8,400,000.00
Others	58,612,000.00	58,612,000.00	58,612,000.00	58,612,000.00	58,612,000.00	293,060,000.00
	5,690,414,000.00	**5,690,414,000.00**	**5,690,414,000.00**	**5,690,414,000.00**	**5,690,414,000.00**	**28,452,070,000.00**

Figure 5: Programme Cost

7.5 Resource Mobilization

Healthcare services in Nigeria is financed from numerous sources. These include the government budgets (federal, state and LGA), donor partners, private sector contributions, health insurance schemes and out-of-pocket payments. Nigeria still relies heavily on foreign aids to fund the health sector as the country is yet to implement the recommendation of the Abuja Declaration which seeks to commit a minimum of 15% of the national budget of each African member state to her health sector.

The only predictable government source of funding for the NCSAP 2025-2029 programme as at the time of the development of this Plan is the allocation from the Primary Health Care gateway of the Basic Health Care Provision Fund (BHCPF). Donor support occurs in isolated instances and does not go beyond the scope and timelines of the project. Projections for predictable financing have been significantly limited by the paucity of relevant data from the development partners and government sources.

In 2023, cumulatively, all 36 states allocated N2.3tn to the health sector but spent N1.4tn, representing a 58.2% budget performance. On the purchase of medical equipment, an aggregate of N35.7bn was spent; however, nine states had no record of expenses for this purchase in their 2023 budget implementation reports. Those states include Edo, Ekiti, Katsina, Ogun, Ondo, Osun, Oyo, Yobe and Zamfara. Furthermore, N104.3bn was spent on constructing and rehabilitating hospitals and clinics across the sub-nationals. On the purchase of medicines and medical supplies, a combined amount of N15.3bn was spent, excluding Delta, Ebonyi and Niger states, which had no records. Investments in health care are still very far from the ideal and need to be prioritized.10 With the current SWAp arrangement to deliver and implement the HSSB, the expectation is that funds and other resources will be made available to expedite implementation of the NCSAP.

To improve financing for implementation of the NCSAP, all the resource mobilization strategies suggested below should be followed through to mobilize expected resources to fill the funding gap highlighted above.

a. **Increased budgetary allocation to NCSAP 2025-2029 Programme and commitment to efficiently manage BHCPF:** Targeted high-level advocacy to decision makers at the federal and state levels for prompt release of BHCPF and the state counterpart fund. The federal, state and local governments should also commit additional budgetary allocation to NCSAP 2025-2029 programme as an essential component of Primary Health Care. Additionally, utilization of the available and prospective resources to achieve programmatic efficiency should be emphasized.

b. **State Social Health Insurance Scheme (SSHIS):** The NCSAP 2025-2029 programme and NCSAP 2025-2029 Agents should be integrated into the basic health care packages of the SSHIS of the implementing states to allow the beneficiaries and communities to leverage on the resources of the schemes. Payment of stipends for NCSAP 2025-2029 agents or supervisors involved in the continuum of care of insured clients will help fill some of the financing gaps.

c. **Domestic financing:** Aside from allocating sufficient funds from national budgets, there is an urgent need to ramp up Public-Private Partnerships to leverage additional resources and expertise to improve health services for the cohort planned for. Additionally, consistent and active community engagement and involvement in decision-making and resource mobilization can enhance ownership and sustainability of planned interventions.

d. **International Aid:** Government and CSOs should be encouraged to seek support from donor agencies and international organizations. To bolster confidence from potential donors, transparency in aid allocation and spending have to be demonstrated by all actors.

7.6 Sustainability

By prioritizing the strategies below, the actions set out to significantly reduce under-five mortality rates and improve the health and well-being of under five children in Nigeria will be sustained reduction in under five mortality rates in Nigeria.

1. **Strong Leadership and Ownership:**
    - **Engaging Stakeholders:** Involvement of key stakeholders such as government officials, healthcare providers, community leaders, and parents in planning and implementation of the Plan.
    - **Empowering Communities:** Encourage communities to take ownership of child health initiatives, fostering responsibility and engagement.
    - **Capacity Building:** Provide training and support to healthcare workers to enhance their skills and knowledge in managing child health issues.

2. **Robust Data Systems:**
    - **Monitoring and Evaluation:** Intentional operationalization of existing comprehensive system for collecting, analyzing, and using data to track progress and identify areas for improvement of the plan's implementation.
    - **Evidence-Based Decision Making/Course Correction:** Utilize data to inform decisions and allocate resources effectively, ensuring targeted and impactful interventions.

3. **Sustainable Financing:**
    - **Diversified Funding Sources:** Source for sustainable funding from various sources, aside from government budgets and donor agencies e.g. community support, PPP.
    - **Cost-Effective Interventions:** Prioritize high-impact, cost-effective interventions to maximize resource utilization.

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