National Primary Healthcare Development Agency

Overview of the Integrated Measles – Rubella Campaign

September , 2025

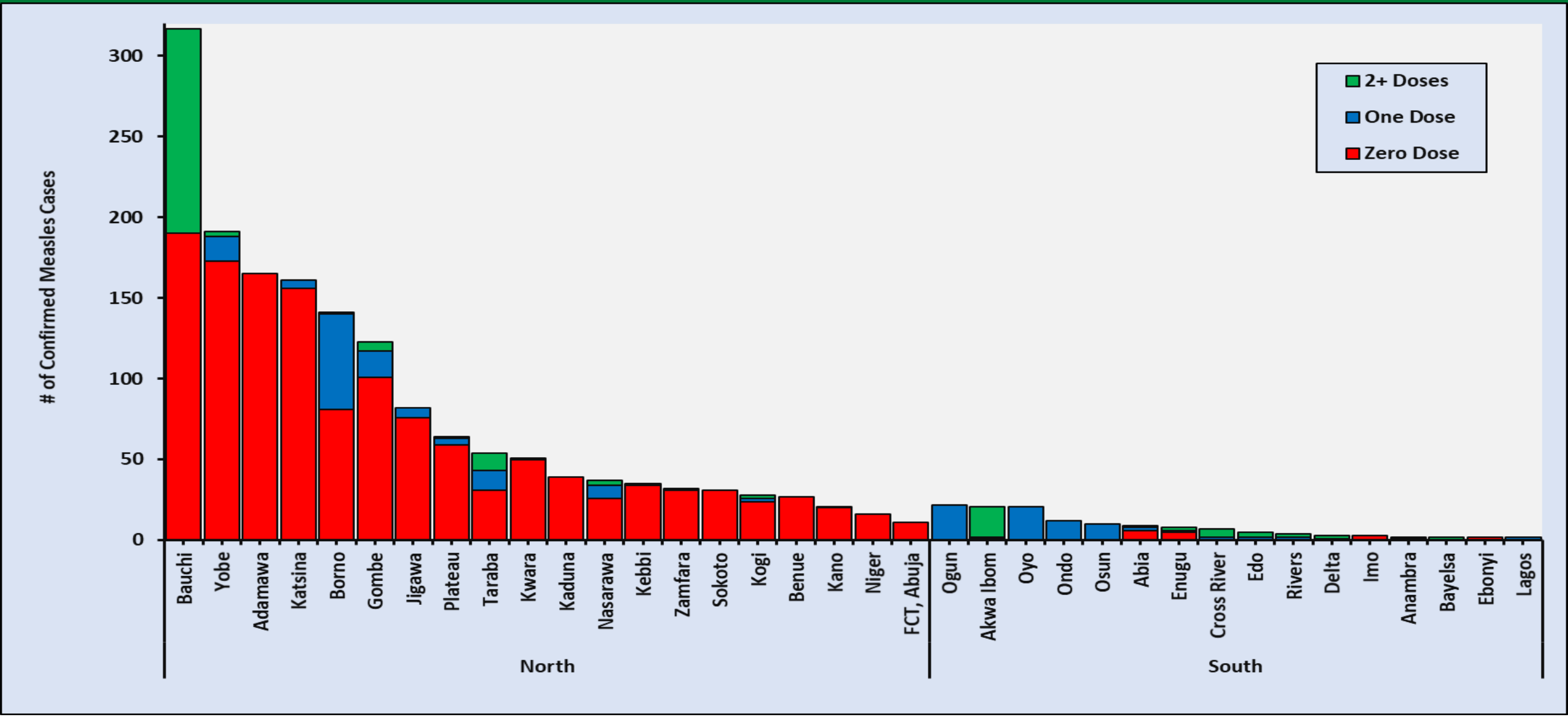
Outline

- Introduction
- Rationale for the Campaign
- Aims and Objectives of integrated Measles-Rubella Vaccination campaign
- Scope and Phasing of the integrated Campaign
- Where we are
- Key Ask from Executive Secretaries

Introduction

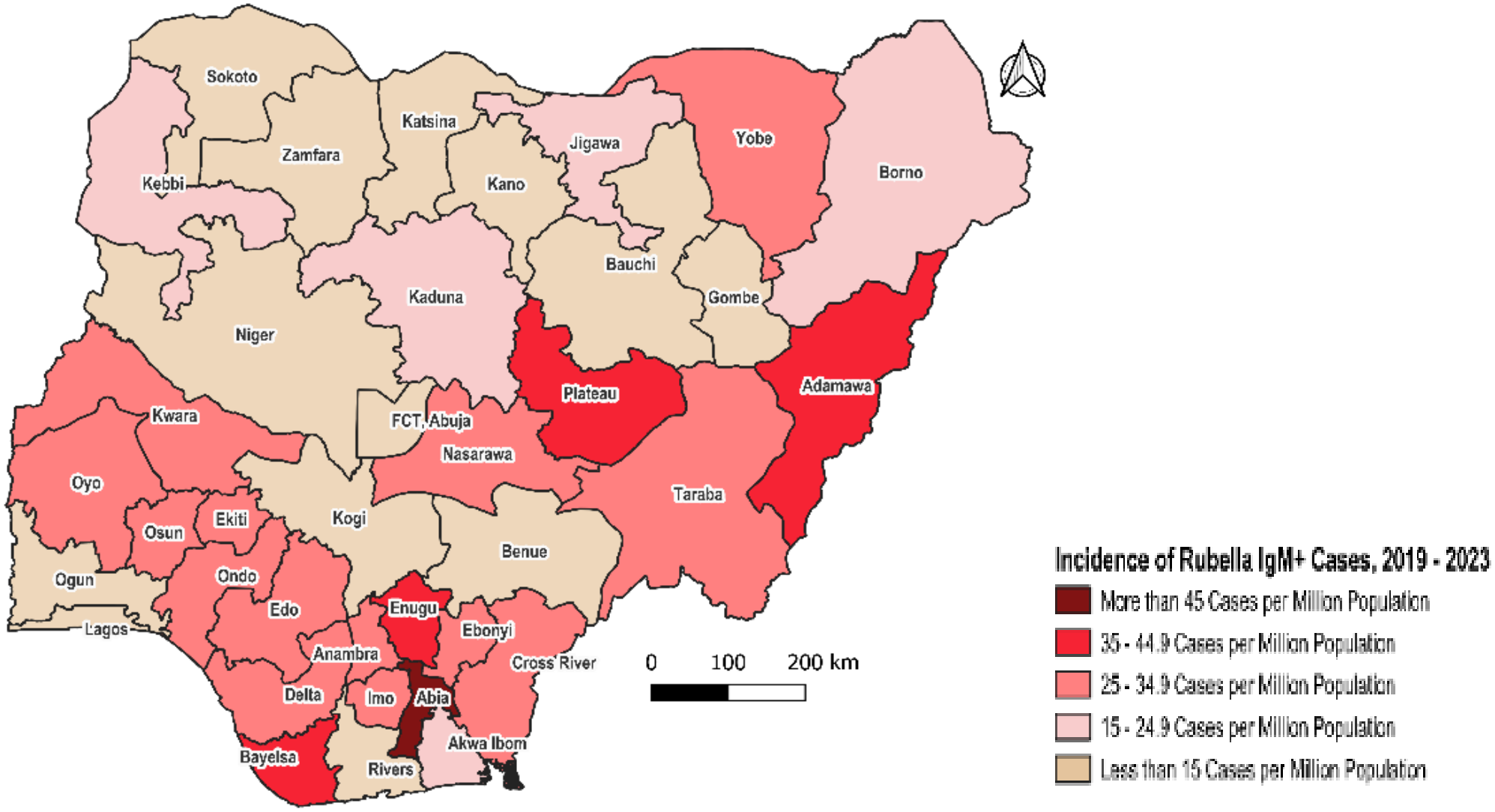
- Measles infection remains a threat to an infection free Nigeria. In 2024, all 37 states and 725 LGAs in these states reported an outbreak of measles.
- The measles vaccine has been part of the immunization schedule since 1976 but over 75% of the measles cases have never received a single dose of the measles vaccine with this being more prominent in Northern Nigeria.
- Overall, there still remain challenges achieving high immunization coverage as the country has never reached the 95% coverage to eliminate transmission and the outbreaks interrupts the health system and diverts resources.
- Rubella infection (also known as German Measles), though grossly underreported, is a present problem and causes birth defect in unborn children of infected mothers. The rubella infection is often mistaken for Measles (have similar features)
- The measles-rubella vaccine has been in use since the 1960s and the current vaccine since 1979.
- The vaccine will be introduced starting with a Mass vaccination campaigns, to deliver the vaccines to large populations and ensure adequate immunity and reduce outbreaks

Vaccination status of confirmed measles cases by States/Regions in Nigeria: Epi-week 01-25, 2025



Average Incidence of Rubella IgM+ Cases by States, 2019 - 2023

- Rubella incidence in majority (19) of States is **>/= 25 cases/ million pop**
- Incidence is higher in South compared to Northern States



Why we are introducing the Measles Rubella Vaccine in Nigeria

- Nigeria contributes significantly to the burden of measles, rubella and cVPV2 globally(in Africa, 54% for polio, second highest for measles after DRC)
- The campaign is being implemented to:
  - **Close immunity gaps**
    - MR vaccine has a better seroconversion than measles-only vaccine - >90% VS 85%
    - Protect a large cohort (9 months -14 years) and bridge the gaps in those who have never received Rubella vaccine
    - Starts the drive towards reducing the incidence of Congenital rubella syndrome (CRS)
  - **Interrupt transmission of Polio, Measles and Rubella infections**
  - **Strengthen Routine Immunisation**
    - Second Year of Life (2YL) activities and integration into broader PHC interventions for healthier communities.
    - Addressing vaccine inequities
    - Strive towards elimination

Aim and Objectives of the Integrated MR Campaign

AIM:

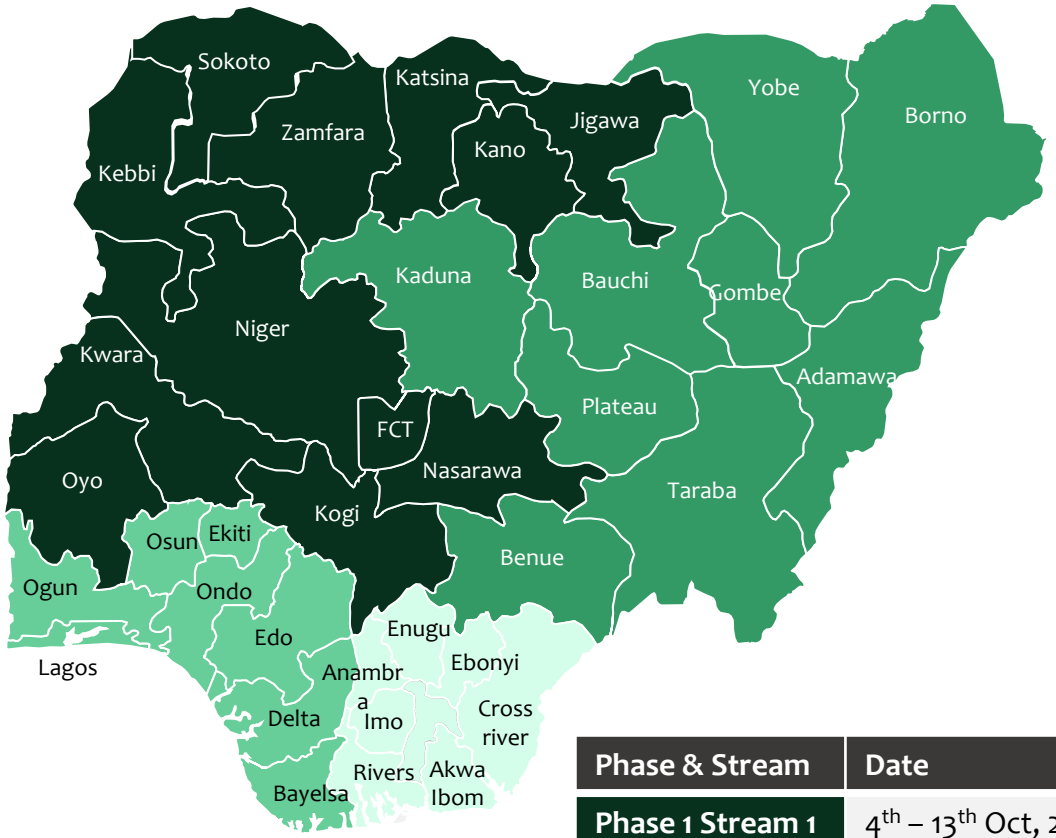
To contribute to the reduction of measles and rubella incidence in Nigeria to < 5 cases/million by 2026 and 1 case/million in 2030 by increasing population immunity through vaccination

OBJECTIVES

- Achieve 95% measles-rubella vaccination post campaign coverage among children aged 9 months – <15years in all implementing states
- Achieve 95% coverage with nOPV2 in states conducting polio campaign
- Strengthen the immunisation system by using the 2025/2026 SIA to improve RI performance, 2YL and strengthen AEFI surveillance
- Reduce zero dose children by 15% in the identified LGAs

Different services will be delivered during the integrated campaign across the implementing states

Map showing the scope and schedule for the upcoming national integrated campaign



Phase & Stream	Date	Target
Phase 1 Stream 1	4th – 13th Oct, 2025	**63M**
Phase 1 Stream 2	18th – 27th Oct, 2025	
Phase 2 Stream 1	20th – 29th Jan, 2026	**43M**
Phase 2 Stram 2	4th – 13th Feb, 2026	

Services	States	Scope
Measles -Rubella	All 36 States + FCT	State wide
Polio (nOPV2)	21 phase 1 states	State wide
Routine Immunization + HPV	All 36 States + FCT	State wide
Onchocerciasis (Ivermectin)	Kano	6 LGAs (≥5 years)
Lymphatic Filariasis (Albendazole & Ivermectin)	Oyo	2 LGAs
Trachoma (Azithromycin + Tetracycline ointment)	Yobe	3 LGAs
Malaria (SMC) (Sufadoxine-Pyrimethamine + Amodiaquine)	Kano, Yobe	All LGAs

Source: Team analysis

Where we are

Thematic Area	Activities
Planning and Coordination	*-All working groups activated, meeting regularly with operational plans and costed budgets* *- Integrated coordination meetings (polio, MR, NTD, Malaria) holding weekly*
Logistics and Health Commodities	-Dry storage, Cold chain (slow and fast) storage capacities assessed & mitigation plan to breach gaps developed, costed and already being implemented - Delivery of MR vaccines and Devices have begun in Phase 1 states.
Training	- *All Microplan training have been completed for all 36 states +FCT* - *Implementation NToT for Phase 1 states scheduled for 3rd week of September 2025.*

Where we are

Thematic Area	Activities
Advocacy, communication and Social Mobilization	*- Several High level advocacies have been conducted (traditional rulers, faith/religious groups, etc.* - *Social media campaign, regular polling and social listening ongoing.* - *Training of State Health Education Officers for Phase 1 states ongoing*
Data Management	- Dashboard has been deployed both at National and for Phase 1 states (deployment for phase 2 in November 2025) - Data tools for implementation being delivered (phase 1 states- 16 states have received) - Microplan Verification being concluded this week in Phase 1 states.

Our Key Ask of the Executive Secretaries

- ***To ensure the success of the Campaign and vaccine introduction we require the following from your leadership***

  - Organize and Participate in coordination meetings including advocacy for State Task Force meeting. (it is an avenue to review and update the dashboard, plans and mitigate)
  - Funding for State Flag-off and State Supervision
  - Advocacy to State Governors, executive and legislative arms of the state and other key influential persons to support the campaign and routine immunization
  - Follow up your team to ensure they are on track for the campaign.

Q3 and Q4 2025 DCI Department Priorities

S/N	Activities	Scope
1	Mini BCU (mBCU)-	**40 LGAs across 10 states**- Bauchi, Borno, Yobe, Jigawa, Kaduna, Kano, Katsina, Sokoto, Lagos, Plateau. The target age group is **24-59 months.**
2	Optimised Outreach Strategy (OOS) – normal outreach	**RI providing HFs from 139 LGAs across 6 + 1 States** - Bayelsa, Kaduna, Kano, Kebbi, Sokoto, Zamfara + FCT. The target age group is **0-23 months**
3	RI intensification	**60 LGAs (all wards) across 12 states** - Bauchi, Borno, Gombe, Yobe, Jigawa, Kaduna, Kano, Katsina, Sokoto, Lagos, Edo, Imo. The target age group is **0-23 months** (the cohort of 24 – 59 months will also be vaccinated).
4	Integrated Campaign (MR, Polio, RI, HPV, NTD, Malaria)	36 states + FCT (**Phase 1 in northern states + Oyo in Oct. 2025**, while **Phase 2 in southern states in Jan & Feb 2026**). The target age group is **9 months – 14 years**
5	Green Ember (HPV vaccination)	**209 LGAs** (25% low performing LGAs) across 36+1 States – **30% of the wards** will be targeted. The target age group is **9-year-old** girls.
6	HPV integration during MNCH Week	**209 LGAs** (25% low performing LGAs) across 36+1 States – **30% of the wards** will be targeted. The target age group is **9-year-old** girls. These LGAs are different from those prioritized during "Green Ember"
7	Mpox Vaccination – 2nd Dose	**12 high-risk states-** Akwa Ibom, Edo, Delta, Bayelsa, Cross River, Benue, Plateau, Rivers, Imo , Ondo, Ogun**,** Kaduna
8	Expansion of IE implementation	**8 states-** Kwara, Niger, Kogi, Plateau, FCT, Nasarawa, Kaduna & Bauchi
9	PCV switch (4 dose vial to 5 dose vial)	**Nationwide**


NATIONAL PRIMARY HEALTHCARE
DEVELOPMENT AGENCY
Partnership for Service

THANK YOU

Redesigned Community-Based Health Worker (CBHW) Program

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Director, PHCSD
03/09/25

Context

- Nigeria has, over the years, implemented many community-based health programs, including those of vertical programs like Polio, malaria, HIV/AIDS, Nutrition, etc.
- The Community Health Influencers and Providers Services (CHIPS) Program was launched by President Muhammadu Buhari in 2018 to harmonise and integrate all existing Community-based health structures in the PHC space
- Demand creation for PHC services, health promotion and disease prevention as well as integrated community case management of malaria, diarrhoea and Acute Respiratory Tract Infections among children under 5, were the major roles of CHIPS Agents

Context

- By 2023, all states of the Federation had commenced implementation at some level, but coverage was suboptimal, and the program was fraught with many challenges
- About 18,559 CHIPS Agents and 3,493 Community Engagement Focal Persons (CEFPs) had been trained, with 12,986 CHIPS Agents providing services across 1, 796 wards (20.3%) in the country.
- The following challenges contributed to the sub-optimal performance of CHIPS:
  - Poor ownership at the subnational level and thus grossly inadequate funding
  - Poor remuneration and motivation of the CHIPS personnel
  - Gaps in the supply chain for commodities
  - Inadequate supportive supervision systems
  - Weak data management and use
  - Sub-optimal coverage

Rationale and Objectives of the Current CBHW Program Redesign

Imperative for redesign of CHW program

We cannot achieve UHC goal of making quality basic health services accessible for ALL Nigerians without an effective community health program

- Though NPHCDA and States have begun a nationwide PHC revitalisation effort to improve access to quality healthcare, gaps remain in the delivery of integrated and quality healthcare in Nigeria:
- We are unlikely to reach 100% of Nigerians through PHCs, as some communities still do not have HFs
- CHIPS Agents are not adequately integrated with the formal health care system
- CHIPS Program and other CBHW programs face challenges in ownership at the subnational levels
- Volunteerism and poor renumeration = high turn over

Hence, the need to build a strong, integrated community-based health program

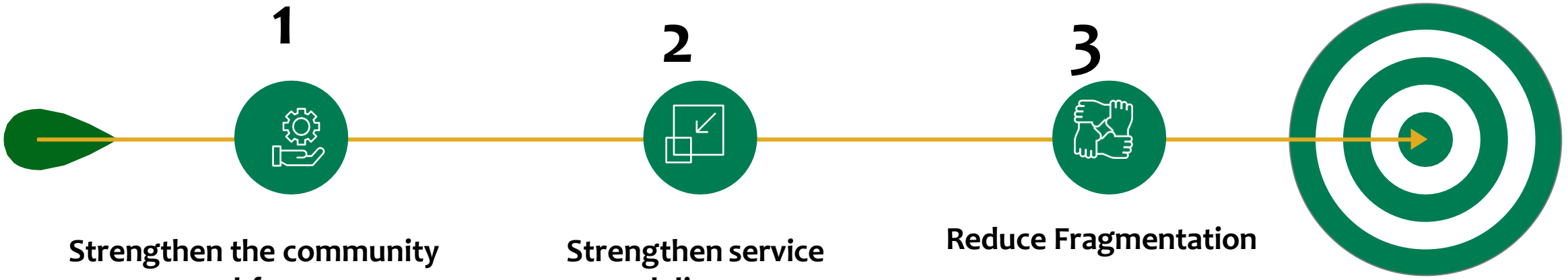
Aim of the redesign

To achieve this, we have redesigned the community health programme into **a blended model comprising JCHEWs and Assistant Community Based Health Workers** who will **provide more relevant services delivered by professionalized and better renumerated** community health workers **integrated into the formal sector** who can improve the range of services in the community.

The objectives of the redesign are:

- **Strengthen service delivery**- including trained JCHEWs
- **Strengthen the community workforce**- integrated with the PHC facilities & formal health sysyem
- **Reduce fragmentation in the health system-** reduce verticalization, broaden service coverage through harmonization and training

The redesigned Community-based Health Program is set to achieve 3 key objectives:



Strengthen the community workforce.

Ensure the community health workers are **integrated** into the formal health system, are **well-trained, remunerated** and **supervised** to ensure quality and **retention**

Strengthen service delivery

Ensure that CBHWs are well positioned to deliver a **range of basic to expanded services, which cover promotion, prevention, diagnosis and basic treatment services** and ensure strong referrals to facilities

Reduce Fragmentation

Ensures a coordinated approach across state and local governments, as well as development partners to **reduce fragmentation and duplication**

1 Applicable for community delivery

Key components of the redesigned program include (1/3)

Dimension	From	To
1. Roles, profiles, responsibilities	 **Deployment of CHIPS and CEFPs** (auxiliary CBHW) to provide **simple services**	**Leveraging a mix of Assistant CBHW and JCHEW Cadres to provide a complement of simple and intermediate services, respectively**
2. Supportive Supervision	 **Overburdened facility HCWs are** also expected to supervise and mentor the CHIPS Agents. Supervision is time-consuming due to manual, paper-based processes.	**Mentorship, supervision and performance management** to be done by **facility personnel** for **JCHEWs,** and by **JCHEWs** for **ACBHWs.** **Community issues and feedback are incorporated into performance management** and shared with supervisors. **Incentives** (stipends and transport), **digital** record-keeping and performance tracking**, supervision for supervisors**, and **supervisor training** to be leveraged to enhance the effectiveness of supervision.
3. Supplies	 **Commodity supply gaps** and **lack of integration** of community health worker commodities into the state and facility supply chain system	**Commodity supply planning is integrated into facilities.** Initial annual procurement based on **target population and incidence of target disease** – continuous procurement is based on **utilisation**
4. Remunerations and incentives	 **Inconsistent and low compensation due to limited funding availability**	**Monthly salaries above minimum wage and in alignment with state salary structures,** including eligible incentives like enlistment into national health insurance Provide other **non-monetary incentives** e.g., scholarships; venture creation opportunities such as stipends for enrolling populations into NHIA, distribution of ancillary health products; public recognition for service etc

1. CBHWPRB: Community Health Practitioners Registration Board of Nigeria
2. SPHCB: State Primary Healthcare Board

Key components of the redesigned program include (1/3)

Dimension	From	To
5. Training 	Cascade training with **extensive NTOT and STOT capacity building (12 days)**	For the ACBHW cadre, **institutionalize pre-service** training by using **pre-selected, trained trainers** who have had **streamlined and** cascaded training for NTOTs and STOTs (5 days each). For all CBHWs, conduct refresher training and **leverage digital e-learning**
6. Accreditation 	**No accreditation required** as roles were not formalized or salaried	**JCHEWs** remain accredited by **CHPRB**[1], while **ACBHWS will be r**egistered by the **State Primary Health Care Boards** following a *1-month* pre-service training and a 3-month intensive mentorship
7. Recruitment and placement 	**NPHCDA led and coordinated recruitment process**	**States and LGAs** to lead and coordinate the end-to-end **recruitment and placement** process in collaboration with nominations from communities NPHCDA and CHPRBN to support in validating JCHEW qualifications
8. Career advancement 	**Lack of well-defined** and **performance-based career advancement opportunities** for CBHWs in the system	Opportunities to be provided for **ACBHWs to become JCHEWs** and **JCHEWs to progress to CHEWs** through **full-time educational programs** and potentially through **flexible advancement that accounts for their work experience.**
9. Governance 	Inadequate **buy-in** from sub-national governance stakeholders	**Clearly defined and communicated roles for states and LGAs to enhance their buy-in** before programme implementation. **Ministry of Health** sets strategy, **NPHCDA** handles high-level coordination and implementation, while **state/lLGAs** oversee community-level implementation and resources.

1. CBHWPRB: Community Health Practitioners Board
2. SHCB: State Primary Healthcare Board

Key components of the redesigned program include (3/3)

Dimension	From	To
10. Data collection & evaluation 	**Paper-based data** collections; multiple data sources resulting in an unclear single source of truth	Household, demographic and patient data to be collected digitally on a **single platform and integrated to the health system** (DHIS2). Data to be communicated at **state-and LGA levels** through regular meetings and digital dashboards so that **states and LGAs** can track programme performance and initiate interventions / support where required.
11. Digital 	**Proliferation of over 11 different tools- primarily manual-for the CBHWs**	**Integrated and interoperable eCHIS** to facilitate data collection, workflow management, decision support, and communication with patients, peers and facilities. **Digital also supports supervision and performance management.**
12. M&E 	Outcome KPIs hav**e no baseline** to track shifts attributable the programme; with limited **state access to KPIs** required to make data-driven changes	**Baseline data will be obtained from NDHS 2023 and the DHIS2 platform** **DHIS2 platform and the data from eCHIS** will be utilized to review ongoing progress and address program challenges The **Federal, State and LGAs will have access to evaluate and use data for decision making** using dashboards and other performance management mechanisms **Data from NDHS will be used to evaluate the impact** of the CBHW program

1. CBHWPRB: Community Health Practitioners Board
2. SHCB: State Primary Healthcare Board

1 Both Assistant CBHW and JCHEWs will be professionalized and salaried positions

Dimension	Assistant CBHW	JCHEW Cadre
Training and accreditation 	• Literate even though not professionally qualified • May not have received in-service training • Should have minimum of secondary school education,	• Professionally trained in a School of health technology and other in-service training • Should have a valid certificate and license from a formal accredited health training institution
Roles 	• Provide simple interventions across the key areas, which cover all health promotion, and awareness creation services, most assessment/diagnostic aspects, and some preventive and basic curative treatment	• Provide intermediate services which includes all basic services and additional services that may be more complex interventions across the key service areas
Renumeration 	• Salaries and compensation commensurate with training workload	

2 Assistant CBHWs, would work alongside experienced JCHEWs to deliver a spectrum of community health services subject to state circumstances

ILLUSTRATIVE DETAILED SERVICE PACKAGE IN APPENDIX

Services	**Promotion**	**Prevention**	**Diagnosis & assessment**	**Treatment**
Location of service delivery	All can be delivered in communities (e.g., Promote contraceptives and use of condoms to prevent STIs and unwanted pregnancies)	Selected services will be delivered in communities (e.g., iCCM of priority childhood illnesses, detecting and referring of danger signs in pregnancy and childhood; Managing childhood illness).		Referred to facilities in the ideal case Minimal delivery of treatment within communities (e.g., Administer HPV vaccination)
Expertise	Minimal expertise requirements	Expertise required, supplemented by in-service training		Expertise of a trained professional required
Profile	Auxiliary CBHWs	←	→	JCHEWs
Depth of expertise				

States can employ a mix of ACBHWs and JCHEWS based on their starting point

It is critical that all CBHWs are salaried, and enablers are in place for them to perform (e.g., eCHIS, supervision, etc.)

3 Service Package by CBHW Cadre & Service Delivery Point

Priority Area	Basic Package (ACBHW\JCHEW)	Additional Services (JCHEW only)
Reproductive Health	Counselling, refills of OCP, distribution of condoms	Provision of Family planning services- injectables, Implants
Maternal Health	Identification, line-listing, counselling and referral of pregnant women for antenatal, delivery & postnatal services Distribution of misoprostol. Community IPT	Rectal misoprostol & outreach ANC services
Newborn Health	Counselling of mothers on good breastfeeding practices & essential newborn care. Distribution of chlorhexidine for cord care, KMC	Provision of treatment for severe bacterial infection if facility treatment is not possible, monitor AEFIs
Child Health	HE, Counselling, screening for malnutrition, identification & referral for other child health services. Provision of iCCM. food demonstrations & replenishment of RUTF	Provision of outreach immunization services,
Adolescent Health	Counsel on adolescent nutrition, risky behaviours, general and menstrual hygiene practices	Provision of outreach HPV vaccination
Other Household Services	Health Education, Counsel on WASH, disease prevention, nutrition, NCDs, CDs & care of the aged and the disabled. Distribute LLINs. Provide first aid	Screening for diabetes and hypertension, support sputum collection & DOTS for TB, HIV Testing and Counselling, Provision of PMTCT
Community based surveillance	Identify and report maternal, perinatal and child deaths. Participate in community MPDSR activities. Report suspected cases of diseases of public health importance, contact tracing	
Community Mobilisation	Awareness creation, mobilization for campaigns, outreaches and health facility and support services	

4 A comprehensive supervision, mentorship and performance management process will be leveraged for both JCHEWs and ACBHWs

	JCHEW	ACBHW
Mentors / supervisors / performance managers:	**Facility personnel (CHEWs, nurses, midwives)**	**JCHEWs**
Ratio of supervisors to CBHWs:	**1:3**	**1:3**
Mentorship:	• **2 x one-one-one** household visitations per CBHW per month (3 households per visit) • **2 x group** visitations per month (3 households per visit)	
Supervision:	**Monthly household visitations:** • 6 scheduled and observed visit p.a. (2 households per visit) • 6 unscheduled and unobserved 'spot checks' p.a. (3 households per visit)	**Monthly household visitations:** • All household visitations are observed (3 households per visit) but 6 visitations per year are scheduled and 6 visitations per year are unscheduled spot checks
Performance management:	• **Target setting** at the beginning of every year • **Performance review** after every household visitation (visitations and target population served vs target) • **Quarterly WDC meetings** for summary feedback on how CBHWs • **Year-end performance evaluation** and awards / sanctions	
Workload management measures for supervisors:	Only half of the monthly supervisory household visitations conducted per year will be in-depth sessions requiring observation of care	A lighter caseload will be given to JCHEWs vs ACBHWs to account for the supervision responsibilities of JCHEWs

Adoption measures: **(i) Incentives** (Stipend and Transport), **(ii) Digital record-keeping and tracking of KPIs, (iii) Oversight for Supervisors and (iv) Supervisor Training**

5 A combination of monetary, non-monetary, and hybrid incentives would be required to enhance CBHW retention

PRELIMINARY

Minimum renumeration and incentives package

Renumeration and incentive type	Viable options to provide to CBHWs	Description	Responsible entity
Monetary incentives	Salaries	Monthly salaries above minimum wage, aligned with state salary structures, disbursed through a standardized payroll system	State Treasury
	Transport stipend	Advance disbursement of transport stipends to facilitate CBHW commute to and from patient locations, paid alongside salaries	State Treasury
Hybrid	National Health Insurance	Mass enrollment of CBHWs in the National Health Insurance once they are onboarded onto the state payroll	SPHCDA and SHIA
	Venture creation	Opportunities for CBHWs to earn commissions by enrolling populations in NHIA or distributing healthcare adjacent products (e.g., mosquito nets), enhancing their income streams	SPHCDA and SHIA for national insurance PVAC for mosquito net distribution
	Scholarships	Financial assistance for the **top 5% of CBHWs** seeking advanced training and professional development to be deployed by NPHCDA	NPHCDA
Non-monetary incentives	Public recognition	Public recognition for top CBHW performers, with their images displayed in PHCDA offices at local, state, and national levels	SPHCDA

Considerations

Clear guidelines and strong monitoring are essential to prevent adverse behaviors from monetary and in-between incentives, such as prioritizing venture creation over community health service delivery e.g.,

- Adjustment of transport stipend based on average visitation rates
- Roll-off venture creation arrangements if minimum visitation and service delivery is not achieved

Community based health workers will play a pivotal role in the MAMII initiative

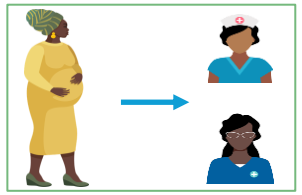
The MAMI initiative will ensure every woman gets the support she needs on her journey from pregnancy to childbirth and beyond

1 Identify all pregnant women in facilities and communities

In PHC: Use ANC registers to find women in facilities

In the community: Use CBHWs to find women in communities

2 Link woman to a dedicated 'care team' of CBHW and/or SBA



Refer to mapped PHC

3 Ensure the woman has the correct information and ability to seek care

CBHWs conduct house-to-house visits to provide health education, promotion, counselling and basic services and develop **birth plans**

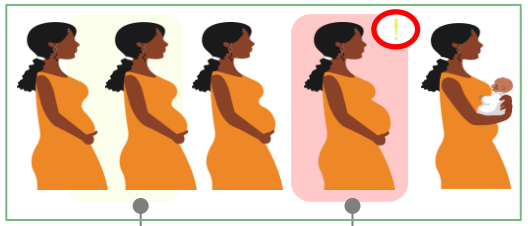
Woman has transport support to access basic and emergency services at the facility

4 Provide needed services directly to the woman (at facility or in community)

1 Facility/Ward

- Routine ANC diagnostics including ultrasound
- Preventive antenatal therapies
- Commodities at no cost
- 24hrs access to care by SBA
- Delivery, emergency obstetric and newborn care

5 Follow woman at every stage of pregnancy to ensure smooth delivery



Track every woman. In case of a drop out, trace and return to care

In the event of complications, refer to mapped CEmONC center for **emergency obstetric care** at no cost to the woman

A Phased Implementation Approach is recommended for the redesigned Program

- The National CBHW implementation strategy targets coverage across all the 8, 856 wards of the country within a 5-year period.
- The national coverage of community health worker stood at 21,375 with a baseline of 20.0% in 2024.
- Thus, an incremental rate of 25% in the following 2 years and 15% increase in the remaining 2 years is proposed.
- The strategy prioritizes coverage in the early periods in rural areas to address the differential burden of diseases and cater for the unmet needs in the underserved areas

National Population targeted by CBHW services	Roadmap for CBHW Scale-up				
	2024	2025	2026	2027	2028
Rural areas (%)	30.0	60.0	85.0	100.0	100.0
Urban areas (%)	10.0	30.0	55.0	70.0	100.0
Total (%)	19.3.0	43.8	68.9	83.9	100.0

- The recommended model involves a mix of JCHEW and Assistant CBHWs at an average of 50:50 ratio, depending on the availability of JCHEWs and possible resource constraints
- States can begin with an appropriate mix starting from their current point and build to an optimum of having a predominantly JCHEW led program within 5 years
- States may also decide to prioritise MAMMII LGAs and gradually expand

To effectively implement the program, collaboration between & across strategic stakeholders is required

FMoH / NPHCDA

- Set overall **program strategy** and **guidelines** for implementation
- Mobilize resources to **incentivize states** to implement the CBHWP
- Co-ordinate states and partners for maximal efficiency and to **minimize fragmentation** of community health activities
- Gather and disseminate learnings

States and LGAs

- States to oversee the implementation of CBHW program in collaboration with LGAs
- **States and LGAs to recruit, deploy and renumerate** 70k CBHWs.

Development/ Implementation partners

- DPs to **complement resourcing** in line with national strategy and priorities (SWAP)
- **DPs and IPs** to provide Technical Assistance and implementation support in collaboration with NPHCDA

Cross cutting roles

- All parties to participate in governance to foster accountability in implementation
- All parties to actively contribute to financing the community health program through a collaborative and sustainable approach

A sustainable funding model that gives states some ownership from the outset is required to address the funding gap

Key Questions	Implementation Approaches
Who hires?	• **FMoH to officially classify Assistant CBHWs as government employees**, for enrolment into formal payroll systems • **States will recruit CBHWs directly,** with SPHCBs and CHPRBN validating credentials.
Who pays?	• **States to fund salaries (and other routine costs) with support from DPs. DP contribution to taper down gradually,** facilitating a smooth transition from DP to state funding over time (4-year proposal)
How would funds be paid and accounted for?	• **Fund transfer:** Funding to be disbursed (via NPHCDA) into existing state mechanisms i.e., directly into State accounts • **Reconciliation and audits:** 3rd party to validate CBHWs are qualified, employed and paid
How to ensure successful transition to state over time?	• **States to contribute to CBHWP costs from the outset, e.g., cover recruiting and onboarding costs from year 1** • **States expected to meet their annual contribution** to salaries post year 1 such that **DPs would not cover shortfalls** • **Link contributions to incentives/consequences e.g.** access to DLI funding and additional support from DP on CBHW and/or related areas • **Ensure continuous buy in** through continuous engagement with State governors (NGF), State health commissioners, FMoH and FMoF

UPDATE ON IMPLEMENTATION OF THE CBHW PROGRAM

National CBHW Workplan

Phase	Key Milestones	Activities	Responsible	Remarks
Phase 1: Pre-implementation & planning	Project Initiation	Policy review (National level)	NPHCDA & Partners	Done
		Review & share the National Strategy & Program Guide for adoption/adaptation by the states	DPHCSD	Done
		National Stakeholders Engagemnet Meeting	NPHCDA & PHCSD	Done
		Develop & share a generic implementation plan template with states for adoption/adaptation	NPHCDA & Partners	To be shared with states to standardize the program
		Program Initiation Meeting with States (Virtual)	PHCSD.	Done
		Weekly engagemnet with states & partners	PHCSD	Commenced
		Establish national and state coordination platforms	PHCSD	Done. States to replicate
		States to share adapted/adopted Strategies/Program Guide with National.	PHCSD	Follow-up with states, and provide technical support, where necessary
		States to share implementation plan with national for review & finalization	PHCSD	To be submitted alongside adopted/adapted Strategy/Program Guide, letter of interest. NPHCDA & Partners to provide TA to states to fast-track submission.
		Formal Indication of Interest by states	PHCSD	States to include this formal letter when submitting adopted/adapted Strategy/Program Guide.
	Operational readiness	Review & finalization of state adopted/adapted Strategies/Program Guide, and Implementation Plans	PHCSD	Running concurrently with states' submission of adopted/adapted strategy
		Define objectives & methodology of the readiness assessment for states	NPHCDA & CHAI	Done
		Develop state readiness assessment tool		Done
		Recruit and assign assesors to respective states		Done
		Onboard and train assessors on the assessment tools and methodology		Done
		Deploy, and collect CBHW data from state readiness assessment tool		Done
		Validate & triangulate data from states' readiness assessment		CHAI to provide daily feedback to secretariat
		Disseminate readiness assessment report		After review by ED - NPHCDA
		Select states for pilot using the readiness tracker tool	ED & DPHCSD	Criteria for selection (indication of interest; submission of adopted/adapted strategy; completion of readiness assessment; resource mapping; political will etc.)
		Develop/Update/Finalize program implementation tools & documents (training materials - job aids, flip books, manuals, data tools, supervision tools & checklists, SOPs, community engagement tools, reporting forms, peformance management tools & checklists, logistics mgt. tools, M&E tools, peformance management plan & tools, etc.	NPHCDA & Partners	

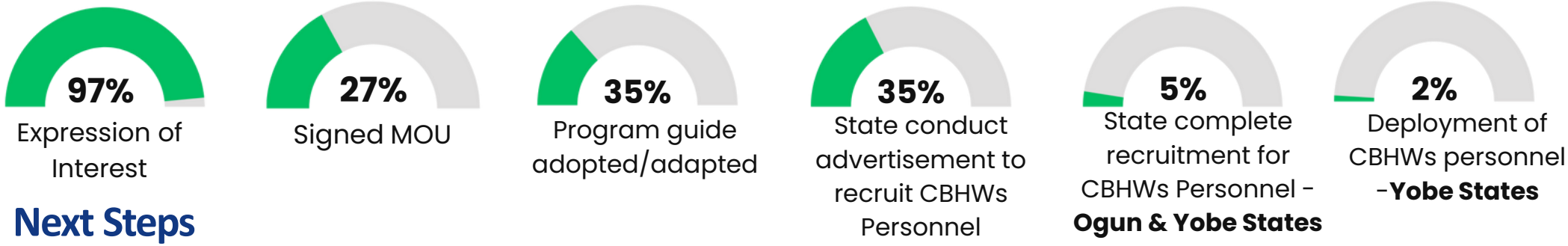
Phase	Key Milestones	Activities	Responsible	Remarks
		Branding & printing of the Programme Guide and revised tools	NPHCDA	
		National Launch	NPHCDA & Partners	
		Identification & deployment of trainers for cascaded training	DPHCSD & DCHS	Identify trainers from various levels from exisiting database, leve CHIPS master trainers, CHPRBN, College of HT, NMCN, Training Institutions, Partners, etc
	Institutute systems for supply chain & logistics management, supportive supervision, performance management, etc	Review/update exisiting commodity and drug supply chain system; Review & update monitoring systems to track resource usage, stock levels, flag potential shortages or overstock situations, etc	PHCSD, CHS, Logistics & Procurement	
		Assess commodity needs and establish minimum stock levels for CBHWs	Logistics, PHCSD, CHS	
		Procurement of essential medicines, consumables, electronic tablets, PPEs and other commodities, (July 2025)	PHCSD & Procurement	
	Advocacy & Sensitization	Advocacy & sensitization visits to states	FMoH, NPHCDA & Partners	Continuous activity (July - Dec)
		Advocacy & sensitization visits to NGF & ALGON	HCMH & SW, ED NPHCDA, etc	Continuous activity (July - Dec)
		Media engagement by Minister & ED NPHCDA	PHCSD, PRU & Advocacy & Comms	Continuous activity (July - Dec)
		Social media engagemnet & publicity	PHCSD, PRU, Advocacy & Comms	Continuous activity (July - Dec)
	Community Engagement	Engage community leaders, influencers, and stakeholders	FMoH/NPHCDA/States/LGAs/Private sector/Partners	continuous activity (July - Dec)
		Support states & LGAs to engage/sensitize community memebers using jingles, etc	FMoH/NPHCDA/Partners	continuous activity (July - Dec)
		Support states & LGAs to reactivate and sensitize WDCs on the redesigned CBHW Program	NPHCDA/Partners	continuous activity (July - Dec)
		Monitor community response and adapt engagement efforts as needed	NPHCDA/SPHCDA/LGAs	continuous activity (July - Dec)
	Baseline Assessment & Situation Analysis	conduct baseline assessment in each state to generate information for planning and monitoring on program progress	NPHCDA, SPHCDA, LGHA	Collect data on community health needs, existing workforce capa service coverage. Leverage BIRCH Readiness assessment as base situation analysis.
	Recritment & Deployment	Support states to advertise, screen, recruit & deploy CBHWs	FMoH/NPHCDA/Partners	continuous activity (August - Dec)
		Support orientation, onboarding & documentation of CBHWs	FMoH/NPHCDA/Partners	continuous activity (August - Dec)
	KEY			
	Completed			
	On-going			

CBHWs Program Status update

Achieved Milestones

1. Guidiance provided to all States for the roll-out of CBHWS program
2. MOUs signed with 10 States
3. Partnership Letters development. To be disseminated to Non MOU States
4. National Community-based Health Workforce Strategy finalised and disseminated to all States
5. Governance and coordination platforms set-up and hold weekly engagement (States cordination platforms also set up for some States)
6. Development of critical documents for CBHW program commenced (5 days workshop to develop CBHW training manuals and data tools ongoing at Johnwood Hotels Abuja).

State Progress



Next Steps

- Support States through the recruitment SOP to commence and/or complete the recruitment and deployment of CBHWs (JCHEWS/ ACBHWs)
- Conduct the national program launch and official kick-Start roll-out
- Continue to provide periodic program and implement all phases of the program (ongoing)

CBHWS States update

Breakdown of progress for Top performers - 35% State

Milestone/States	Edo	Bayelsa	Adamawa	Ogun	Yobe	Imo	Ebonyi	Oyo	Kaduna	Borno	Benue	Zamfara	Kwara
NPHCDA provides guidiance to State/ Distribute redesigned CBHWs program guide to State	■	■	■	■	■	■	■	■	■	■	■	■	■
State submits expression of Interest	■	■	■	■	■	■	■	■	■	■	■	■	■
States Adopt/Adapt CBHWS program guide	■	■	■	■	■								
States advertise for the recruitment of CBHWs (JCHEWs/ACBHWs)			■	■	■	■	■	■	■	■	■	■	■
Shortlist CBHWS (JCHEWs/ACBHWs) candidates				■	■								
Deployment of CBHWS (JCHEWs/ACBHWs) candidates					■								

NPHCDA

National Primary Health Care Development Agency

NPHCDA
National Primary Health Care Development Agency

Maternal and Newborn Mortality Reduction Innovations Initiative

Overview and Status of Implementation

OVERVIEW OF MAMII

Nigeria's Health Sector Renewal Investment Initiative (NSHRII) aims to improve the health system

"In addressing Nigeria's perennial health challenges to provide quality health care and improve health outcomes, there's no fence sitting. It requires whole-of-government and whole-of-society"

SOURCE: HCMH&SW, FMOH&SW SWAp Coordinating Office

In line with the NHAct Cooperate Governance, the NHSRII Compact was signed between Federal and State Governments and DPs

COMMITTING to the redesign of the Basic Health Care Provision Fund, comprising at least 1% of the Consolidated Revenue Fund, provided by the National Health Act (2014)

COMMITTING all State Governments and FCT to complement the Federal Government by undertaking the following key policy actions

SOURCE: HCMH&SW, FMOH&SW SWAp Coordinating Office

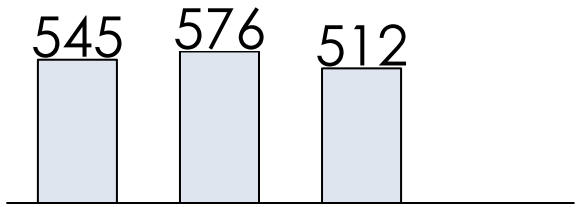
The CMoHSW launched the Maternal and Neonatal Mortality Reduction Innovation Initiative

MAMII is focused on using SWAp Principles to catalyse crashing Maternal Mortality in Nigeria

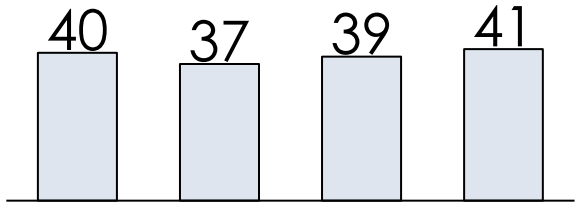
Maternal and Child mortality rates in Nigeria have remained high over the years

Mortality Indices

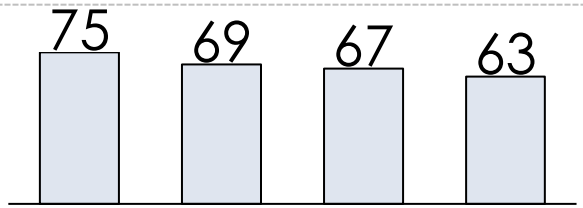
Maternal Mortality Rate *(per 100,000 live births)*



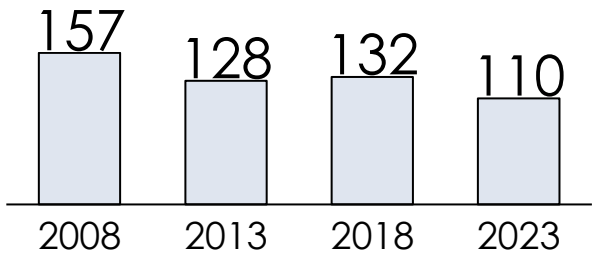
Neonatal Mortality Rate *(per 1,000 live births)*



Infant Mortality Rate *(per 1,000 live births)*

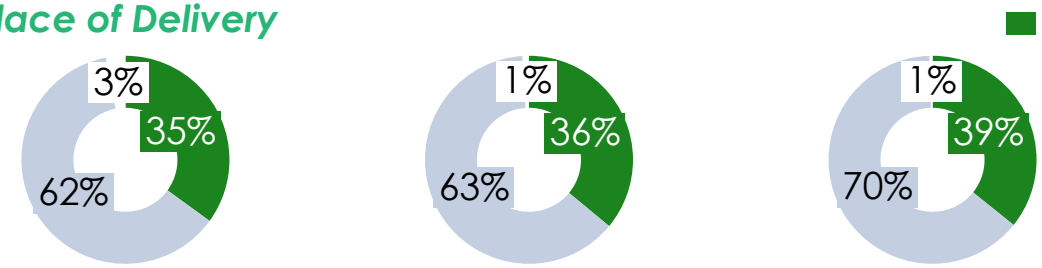


Under 5 Mortality Rate *(per 1,000 live births)*

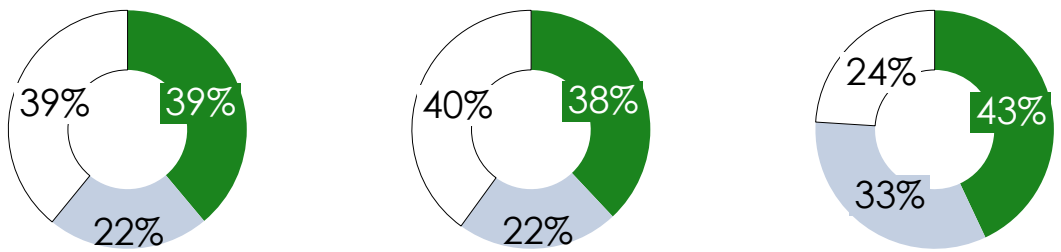


Delivery Care

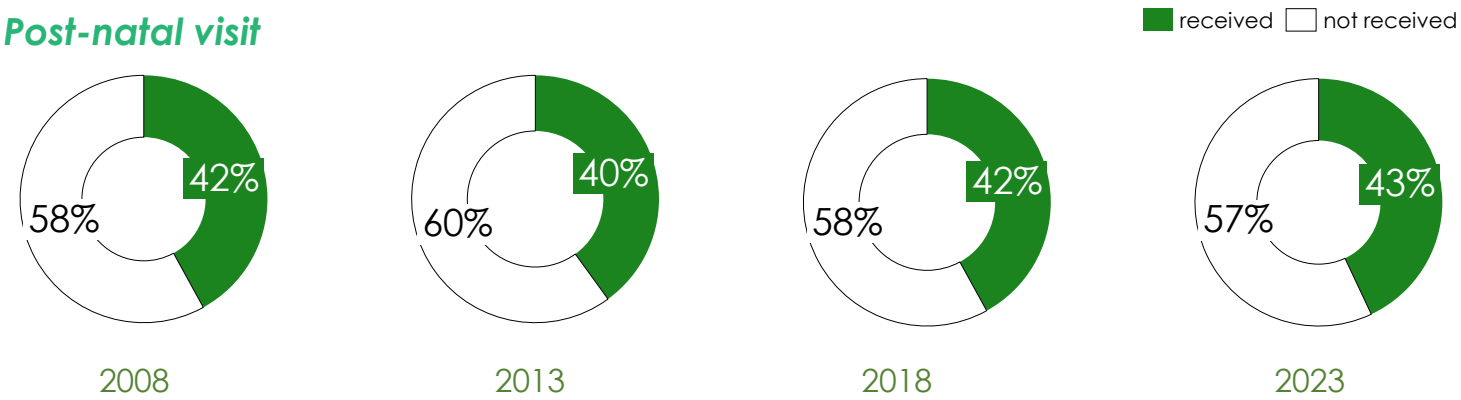
Place of Delivery



Assistance during delivery



Post-natal visit



To achieve SDG 2030, there is a pressing need to identify priority areas where maternal mortality is high

SOURCE: 1. Nigeria Demographic Health Survey 2008 to 2023

Improvements in Maternal and Child mortality rates in Nigeria is paramount

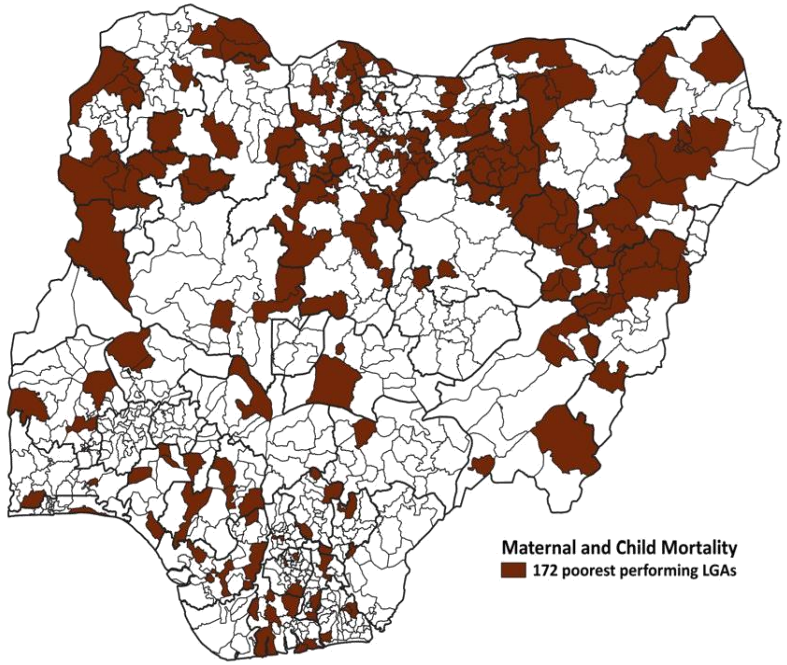
Results		
Maternal Mortality Rate *(per 100,000 live births)*	***National[1]***	**512**
Neonatal Mortality Rate *(per 1,000 live births)*	***National[2]***	**41**
Infant Mortality Rate *(per 1,000 live births)*	***National[2]***	**63**
Under 5 Mortality Rate *(per 1,000 live births)*	***National[2]***	**110**

Causes		
Demand for and capability to seek services		• **Limited access to the right information** to access care on time • **Inability to pay** for health services - less than 5% of total population have access to health insurance • **Lack of affordable transport services** to health facilities, particularly for antenatal visits, emergencies and referrals
Supply	**Services**	• **Suboptimal planning and resourcing** for maternal MNCH services e.g. funding for outreaches is inadequate • **Poor client satisfaction** on quality of care at health facilities e.g., long waiting times
	Facilities and Frontline health workers	• **Limited access** to functional health facilities *(only 20% of surveyed PHCs were functional[3])* • Shortage of Skilled birth attendants and community health workers
	Commodities	• Frequent stockout of essential MNCH commodities driven by limitations in last mile delivery, and weaknesses in last-mile stock visibility e.g. NHLMIS only tracks some drugs
Enablers	**M&E**	• Poor data quality, with insufficient use of data for action – including maternal and perinatal death surveillance data
	Financing	• Limited financing for PHCs

1. Nigeria Demographic Health Survey 2018 | 2. Nigeria Demographic Health Survey 2018 | 3. NPHCDA PHC Assessment 2024 - survey of 8435 BHCPF facilities

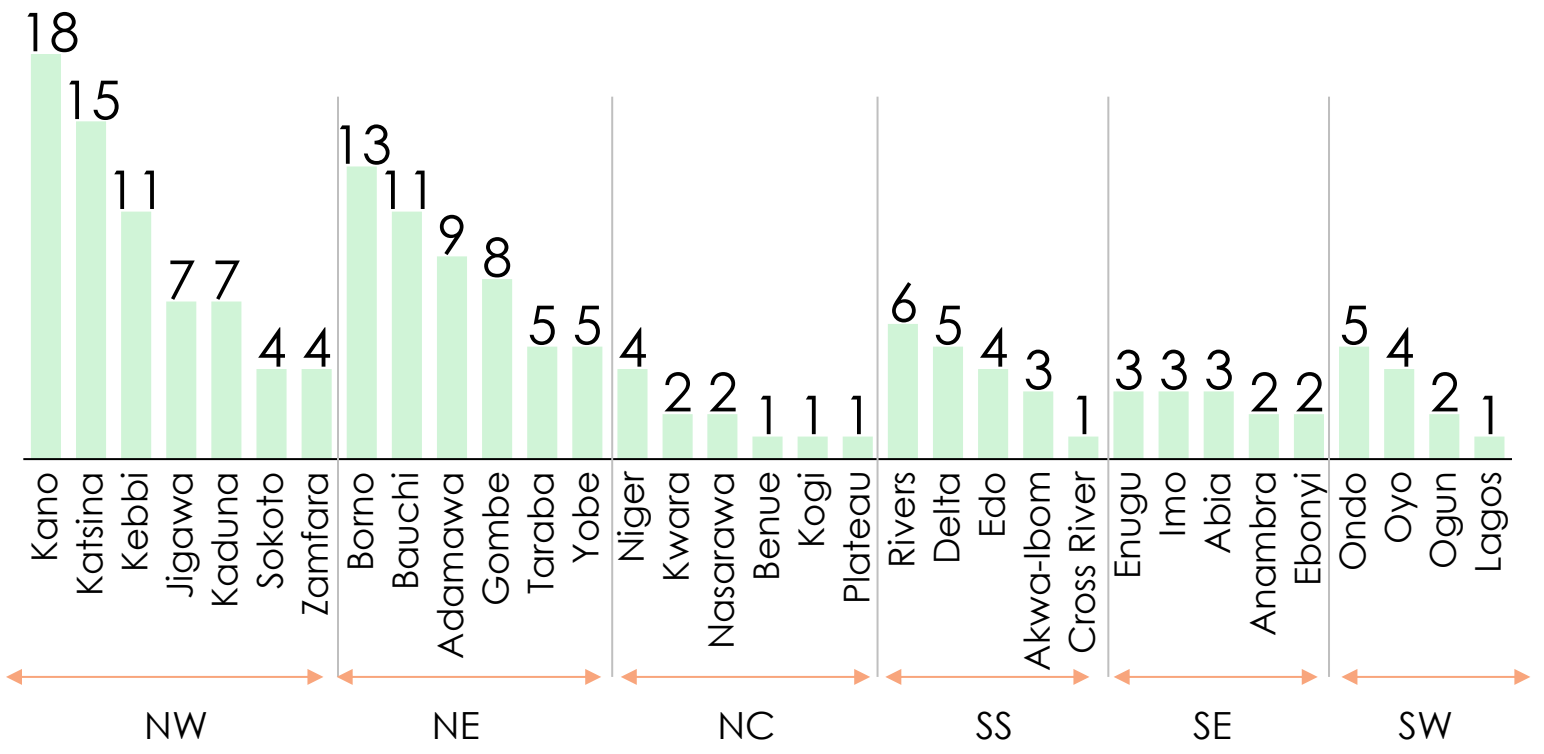
MAMII will start in 172 LGAs with the highest maternal mortality rates

Map showing distribution of priority LGAs across the country



Distribution of priority LGAs by Geopolitical zones with proposed phasing

(n=number of LGAs)



These LGAs have been selected for Phase 1 implementation of MAMII to strengthen maternal health service delivery, increase financial protections for women, and generate insights that will guide expansion to the next phase of LGAs

*** 19 states contribute to 84% of the MMR burden across prioritized states (145 LGAs)

SOURCE: NPHCDA and modelling team analysis

MAMII aims to address the five delays towards crashing maternal and neonatal mortality

- **Delay in seeking care**
- **Delay in reaching care**
- **Delay in receiving care**
- **Delay in taking responsibility**
- **Delay in Coordination**

MAMII Strategic Framework

Physical and Financial Access

Facilitate emergency transport and financial protection to access FREE services at health facilities using climate-friendly options

Surveillance and Monitoring

Strengthen MPDSR. Data availability, Quality and use for decision making using data

Management and Coordination Principles aligned with the Sector-Wide Approach

Strengthen structures to ensure One plan, One budget, One report and One conversation across levels

Community engagement, Stewardship & Services

Identify all pregnant women; Deliver culturally-appropriate information and basic services; Facilitate referral & facility linkage in collaboration with community structures; Catalyze behavior change

Facility and Service readiness

Adequately staff and equip health facility with competent birth attendants, adequate lifesaving commodities; and conducive infrastructure

Enablers

Provide an enabling environment for sustained maternal mortality reduction through:
Health financing; Digital solutions; Performance management; Incentives; and Strategic communication

MAMII will implement comprehensive interventions aimed at reducing maternal mortality, with each state MAMII consultant playing a key role in supporting their execution

Governance & accountability system: Aligning Management Principle with SWAp
(1) State: PHC/SD/MNCH TWG (2) Federal: RMNCH TWG

Delay in Coordination

| Coordinating agency
Theme/Pillar
Causes of delays in care

Delay in receiving care: *Poor infrastructure; HR gaps; low QoC; Commodity shortages; weak regulation*

Delays in seeking care

- *Lack of trust in the health system*
- *Limited knowledge and awareness*
- *Sociocultural norms and birth traditions*
- *Low tendency to seek healthcare*

Generate demand at community level

A. Improve knowledge and trust

- **Ensure health promotion and demand generation** including birth preparedness
- **Connect communities with health facilities & facilitate referral** using existing **community structures including TBAs & faith homes**
- **Provide Financial protection *(via the Vulnerable Group Fund)***

| NPHCDA, NHIA

Improve readiness and quality of skilled services and facilities

Primary Health Centres & SHFs

B1. Improve facility readiness and workforce

- **Upgrade PHCs and** empanel them for **BEmONC** services
- **Recruit, train and retain healthcare workers (Skilled birth attendants)**

| NPHCDA

B2.Strengthen Commodities Supply chain; introduce innovation

- **Optimize procurement and delivery of commodities** to the last mile
- **Implement (MNH) innovations,** such as PPH bundles, MMS, calibrated drapes, and ITNs

| NPHCDA

B3. Improve service delivery

- **Provide quality integrated RMNCAH + N services** & optimize treatment protocol
- **Strengthen linkages and referrals to upgraded CEmONC** sites for obstetric emergencies
- Provide free caesarean sections and manage obstetric complications

| NPHCDA, NHIA

Delay in reaching care

C. Climate Friendly Emergency transport services - *Free ambulance services; Emergency help lines*

- C1. From Communities to PHC
- C2. From PHCs to CEmONC sites

| NEMSAS

D. Strengthen Maternal Perinatal and Child Disease Surveillance and Response (MPCDSR) & Quality of Care | FMoHSW

Poor financing & performance management

E. Sustainable financing: (1) BHCPF 2.0-enhanced (2) DFF (3) Enrolling women on health insurance and reducing OOPE | NHIA

F. M&E & performance management; Mini DHS, DHIS-2 scorecards, incentives; digital technology & communication | FMoHSW

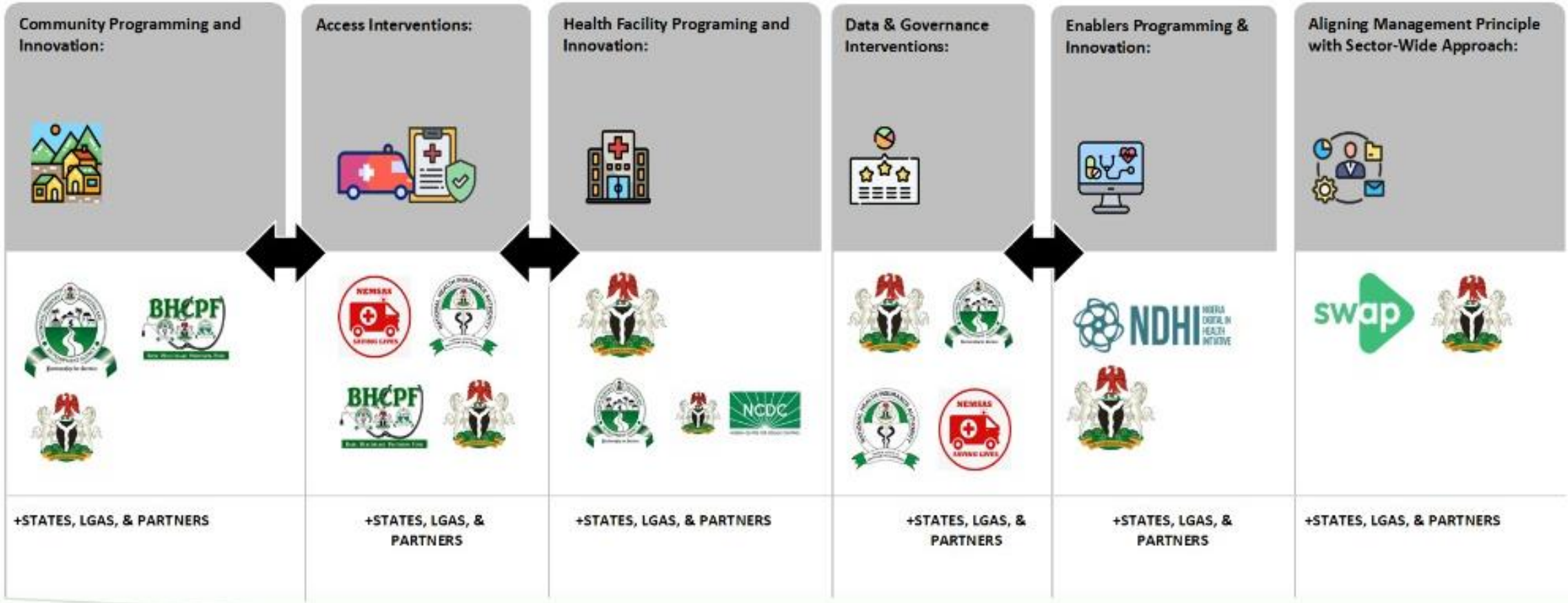
NPHCDA - National Primary Health Care Development Agency; NEMSAS - National Emergency Medical Service And Ambulance System; NHIA - National Health Insurance Authority; B/CEMoNC – Basic/ Comprehensive Emergency Obstretric Maternal and newborn care; SHFs – Secondary Health Facilities; PPH Bundle includes Oxytocin (+ carbetocin), Tranexamic acid, IV fluids, Massage care, and Examination; MMS- Multiple micronutrient supplementation; ITNs- Insecticide treated bed nets

Source: MAMII strategy document, FMoHSW and NPHCDA analysis

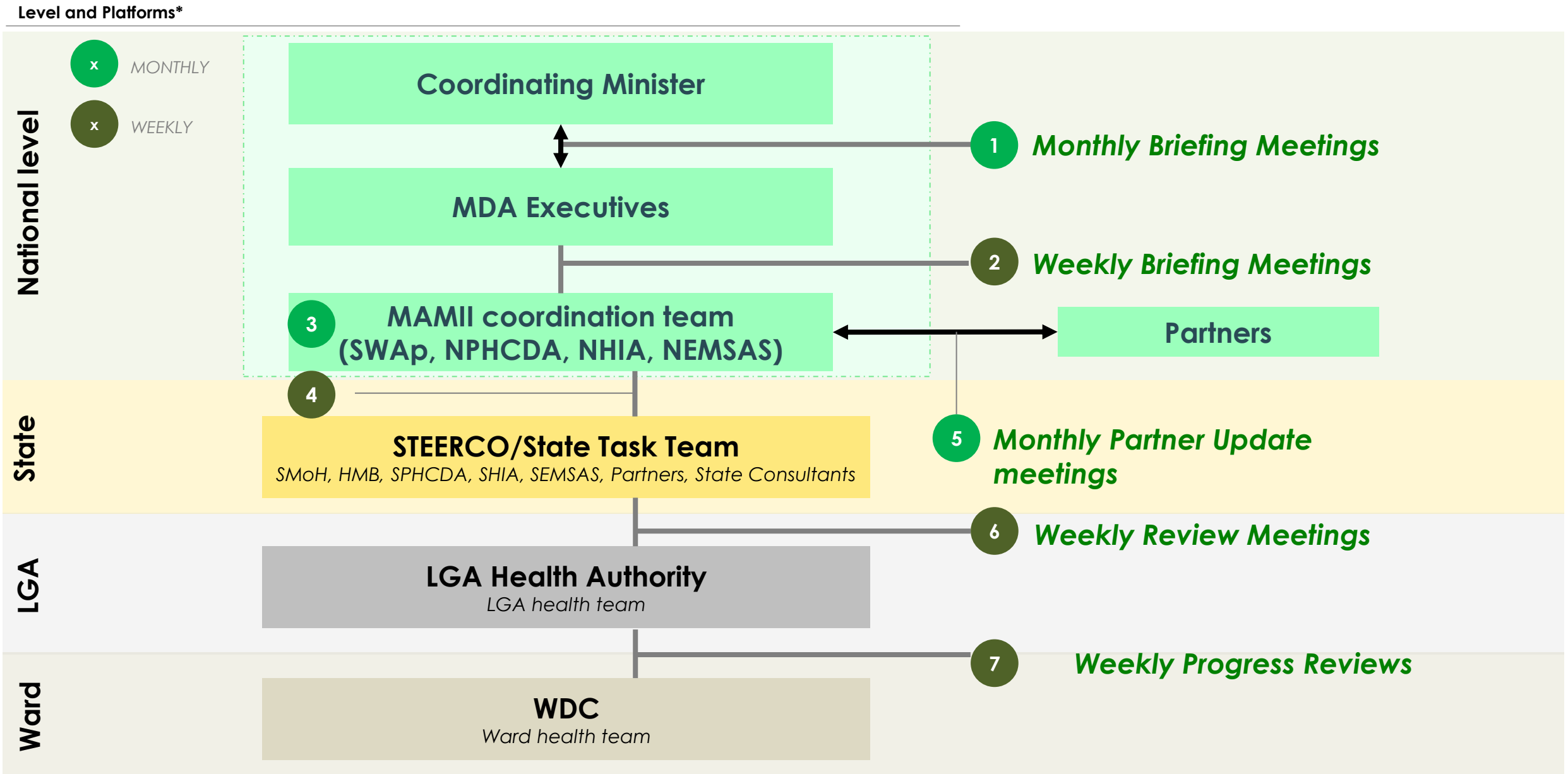
The implementation framework addresses five critical delays driving maternal mortality using a six-pronged strategic approach

Strategic Priority	Proposed Interventions to crash maternal and neonatal mortality in the states
1. Community engagement Stewardship & Services	a) Map women with financial constrain b) Identify transport hubs that will transport women to HFs at no cost c) Develop and distribute transport vouchers for women d) Link transport voucher scheme to community transport scheme (ETS) for sustainability
2. Facility and Service readiness	a) Invest in standardizing and renovating healthcare facilities to create a safe, welcoming, and functional environment for patients b) Provide a reliable and clean water supply in healthcare facilities to meet hygiene c) rain and utilize health care workers to deliver integrated services and education within hard-to-reach areas d) Recruitment of health workers including SBAs e) Regular training and retraining of health workers f) Provision of a succession plan for health workers g) Good and competitive renumeration to health workers and other welfare incentives such as accommodation h) incentives for health workers posted to rural areas i) Provide seed stock for the prioritized MNCH commodities to the facilities j) Activate DRF committee k) Implement a system to track commodities and provide visibility
3. Physical and Financial Access	a) Domestication of NEMSAS emergency response system i. Full operationalization and support for SEMSAS ii. Provision of more ambulance vehicles and equipment iii. Partnership with NURTW, ETS and community volunteer drivers iv. Regular road maintenance b) Subsidized transport for pregnant women and Children U5
4. Data Intelligence, Surveillance and Monitoring	a) Provision of conducive ICT infrastructure and data to secondary health facilities b) Provision of Android/SMART phones and data for more effective communication/reporting by CRGs
5. Enablers programming and innovation	a) Upgrading/provision of conducive ICT infrastructure b) Strengthen quarterly Integrated Mentoring and Supportive Supervision program c) Build capacity of senior and top management of health sector on QI approaches
6. Aligning management principle with SWAp	a) Strengthening health sector coordination b) *Reactivate the state multi-sectoral TWG to ensure comprehensive representation of relevant stakeholders c) *Strengthen the MPCDSR structure in the state

Various stakeholders will need to play crucial role towards crashing maternal mortality



Coordination structures for MAMII



Source: MAMII Coordination Team Brainstroming Sessions; MAMII Implementation Manual; Team analysis

The strategy deploys a direct client-centered service delivery approach

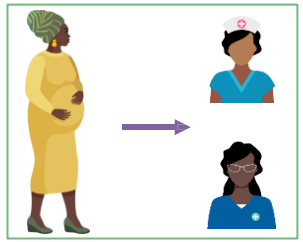
MAMII will ensure every woman and her child gets the support they need through their journey from pregnancy to childbirth and beyond

1 Identify all pregnant women in facilities and communities

In PHC: Use ANC registers to find women in facilities

In the community: Use CHWs to find women in communities

2 Link woman to a dedicated 'care team' of CHW and/or SBA



Refer to mapped PHC

3 Ensure the woman has the correct information and ability to seek care

CHWs conduct house-to-house visits to provide health education, promotion, counselling and basic services; develop **birth plans**

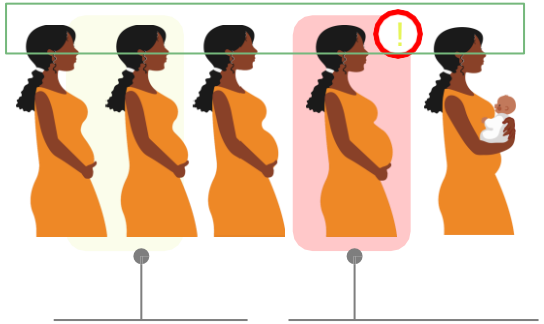
Woman has transport support to access basic and emergency services at the facility

4 Provide needed services directly to the woman (at facility or in community)

1 Facility/Ward

- Routine ANC diagnostics including ultrasound and preventive ANC therapies
- Commodities at no cost
- 24hrs access to care by SBA
- Delivery, BEmONC and CEmONC
- Access to care by SBAs
- SRH

5 Follow woman at every stage of pregnancy to ensure smooth delivery



Track every woman. In case of a drop out, trace and return to care

In the event of complications, refer to mapped CEmONC center for **emergency obstetric & newborn care** at no cost to the woman

5b Provide post natal care (birth spacing, contraception & immunization)

In the event of death, ensure every death is notified, investigated and responded to

Significant support will be required from lead partners toward driving MAMII implementation

Who is a Lead partner?

1

State presence

- Partner implementing within the priority states

2

Last mile support (HFs/ward)

- Has resources (HR) at grass root level (health facility, LGA and/or ward level)

3

Service provision

- Provides direct service delivery support for MNCH program

4

State-investment

- Has an active investment within the state

Key responsibilities of service delivery partners

Lead partners will coordinate activities of all service delivery partners in the state to implement MAMII

a) Support execution of MAMII task team routines (convene meetings, tracking progress and reporting)

b) Map other partners across priority LGAs and coordinate other partners to drive implementation at grass root level

All service delivery partners will be assigned priority LGAs to support implementation activities, including but not limited to…

a) Lead the enumeration of pregnant women at HFs and communities (Mapping resources to commence enumeration)

b) Facilitate service delivery via facility mapping and linking enumerated pregnant women at communities to health facilities- *including MPCDSR implementation*

c) Oversee the training and sensitization of community health workers (CHWs) and health facility staff to enhance service delivery

d) Provide support in distribution and monitoring utilization of commodities across HFs

e) Track status of women and ensure QOC received by all pregnant women through out the maternal journey

f) Support in monitoring and tracking results

Source: Team analysis

Roles and Responsibilities of Service Delivery Partner

All service delivery partners will support implementation activities in priority LGAs, including but not limited to:

Enrolment of pregnant women	▪ Work with states to map and share CRGs (CBHW) report ▪ Facilitate enumeration of pregnant women at community level ▪ Prospective enrolment of pregnant women at HF level *(weekly visits to HFs to monitor and collate weekly enrolment data)*
Tracking and referral of pregnant women	▪ Facilitate service delivery via facility mapping and linking enumerated pregnant women at communities to health facilities ▪ Facilitate mapping and establishment of referral networks (for ANC and delivery) within priority LGAs ▪ Facilitate the enrolment of pregnant women into an insurance scheme
Service Delivery	▪ Facilitate mapping of HFs and referral networks ▪ Provide support in distribution and monitoring of the utilization of commodities across HFs in priority MAMII LGAs ▪ Track status of women and ensure continuous care is received throughout the maternal journey
Training and capacity building	▪ Support states in the recruitment and deployment of community health workers and SBAs to priority LGAs ▪ Work with the state to train and sensitize community health workers (based on a pre-defined module) and SBAs (including BEMONC and MNH innovations)
Coordination, Monitoring & reporting	▪ Facilitate implementation of MPCDSR at HF and community level ▪ Participate in meetings with NPHCDA to share periodic updates/report while problem solving challenges

SOURCE: ToR for Service delivery partner

IMPLEMENTATION STATUS

Status of implementation

Implementation Status	State Activation	Identifying and Enumerating Pregnant Women	Service Delivery
Details →	**Kick off design/Activation** workshop with all stakeholders	A total of **411,210 pregnant women were** identified across MAMII LGAs in 6 States.	A **total 30, 587 pregnant** women linked to care in **in 5 LGAs**
Conducted	Kano, Bauchi, Kaduna, Ogun, Borno, Gombe, Katsina, Ondo, Kebbi, Zamfara, Yobe, Nasarawa, Kwara, Akwa Ibom & Adamawa	Jigawa, Kano, Katsina, Kebbi, Sokoto, and Zamfara States	Kano, Katsina, Kebbi, Sokoto, and Jigawa States
Ongoing	Abia, Ebonyi,, Imo, Jigawa, Plateau, Niger,	-	Zamfara State
Next Batch	Anambra, Cross Rivers, Delta, Edo, Sokoto, Taraba. Benue, Enugu, Oyo, Rivers, Kogi, Lagos.	Bauchi, FCT, Kaduna, Kwara, Kogi, Nasarawa, Niger, Plateau	Borno, Bauchi, Ebonyi, Gombe, Kaduna, Niger, Ogun, Plateau, and Yobe States

- **99.000 pieces of Mama Kits and 3,300** delivery kits distributed to the 33 MAMII States. States at varying levels of delivery to high-volume PHC facilities
- A mechanism for tracking the delivery and utilization of commodities is being operationalized.
- MAMII State TA Consultants engaged for 33 MAMII states

Updates on MAMII implementation: Service Delivery

Focus	Details
Facility and Community Enumeration	▪ **411,210 pregnant women were** identified across MAMII LGAs in 6 States - ***Kano, Katsina****, Jigawa, Sokoto, Kebbi, and* ***Zamfara*** ▪ Pregnant women **(1,833**) receiving ANC services were enumerated for service utilization monitoring in five (5) MAMII LGAs across 5 states – ***Kano, Katsina****, Jigawa, Sokoto, and Kebbi*
PHC Facility Mapping	▪ 102 facilities mapped as providing MNH services across the 5 MAMII LGAs across 5 states – **Kano, Katsina**, Jigawa, Sokoto, and Kebbi
Service Delivery Model Design	▪ End-to-end service delivery piloted in 5 states with IEV data - Kano, Katsina, Jigawa, Sokoto, and Kebbi ▪ Engagement of MAMII Technical Assistants across 33 states to support the acceleration of service delivery
Service Provision	▪ Commencement of community level follow up and linkage of pregnant women (29,307) in five (5) MAMII LGAs across 5 states – **Kano, Katsina**, Jigawa, Sokoto, and Kebbi

Updates on MAMII implementation (2/2)

Focus	Details
Training	▪ Phase II integrated frontline health workers training (PHC services, PPH bundle, BEmONC and MMS) has commenced in Zamfara, Plateau, Borno, Bauchi, Yobe, and Kaduna ▪ 200 videos were produced in preparation to the lunch of e-learning platform
SBAs & CBHWs Recruitment	▪ NPHCDA signed MoUs with nine states (**Borno, Ebonyi, Bauchi, Kaduna, Katsina, Niger, Yobe, Plateau and Zamfara**), we are working towards getting Kano State which is the only outstanding to sign soon ▪ Seven states (Kaduna, Zamfara, Borno, Yobe, Niger, Plateau and Katsina) have commenced recruitment process for SBAs and CBHWs ▪ Kaduna has finished recruitment ▪ Zamfara has conducted prescreening of applicants ▪ Borno, Plateau and Yobe have placed recruitment advert ▪ 39 MAMII State Consultants were recruited and deployed to the states to support implementation of MAMII including recruitment and deployment of SBAs and CBHWs
Commodities	▪ NPHCDA has received the deliveries of 13 out of 21 MNH commodities with the deliveries of additional 6 commodities expected on or before August 18th, 2025 ▪ NPHCDA to align with Lead IPs and service delivery partners this week on distribution plan

Roles of Executive Secretaries

The ESs will play a critical leadership role in the co-creation and execution of the initiative

As the co-chairs of the State Task Team

- Support the HCH in providing strategic leadership in establishing the overall state implementation framework and management structure.
- Support the HCH in administration of the activities of the Task Team:
- Coordinate the DAPs and partner roles in the execution of the Initiative
- Facilitate resource mobilisation for the overall implementation of the various interventions

As the Chief Executives of the Institution responsible for service delivery

- Oversee alignment of the activities of the SPHCDB with the key interventions of the initiative
- Ensure resource allocation and effective use for the interventions within the SPHCD-wide resource mobilisation and expenditure structure.
- Provide tactical managerial guidance and oversight to the responsible department and senior program officers for the day to day implementation
- Oversee effective implementation of result oriented performance management strategy for the Initiative to achieve the desired outcomes of the interventions

Conclusion

Duration: 5 minutes

By: Director CHS, NPHCDA
Dr. Nana Sandah - Abubakar

Summary of the National Stakeholders' Engagement and Status of Implementation of Community-Based Health Workers Program

The Stakeholders' Engagement held in two segments:

1. Meeting with Honourable Commissioners of Health, Executive Secretaries, Partners, ALGON and CSOs on the 20th May 2025
2. Meeting with State Directors in charge of community Health workforce development, LGA Health Secretaries and ALGON on the 22nd May 2025.

Objectives of the Stakeholders' Engagement

- To socialize key stakeholders on the redesigned CBHW program
- To secure sub-national buy-in, support and ownership for effective implementation of the CBHW program
- To gather feedback from stakeholders to further strengthen the CBHW program and accelerate the roll out of CBHW in alignment with the implementation timelines of related initiatives like the MAMI program

Participants

The first meeting had broad representation from key health sector partners, including:

World Health Organization (WHO), Global Fund, Clinton Health Access Initiative (CHAI), UNICEF, Pathfinder International, Health Sector Reforms Coalition, Nigeria Red Cross Society, Norwegian Refugee Council, Association of Local Governments of Nigeria (ALGON), Mastercard Foundation, Community Health Practitioners Registration Board of Nigeria (CHPRBN), Nursing and Midwifery Council of Nigeria, Nigeria Governors' Forum (NGF), Management Sciences for Health (MSH), SWAp Coordination Office, SOLINA, and various Civil Society Organizations (CSOs), Honourable Commissioners of Health of the State Ministry of Health, Executive Secretaries of the State Primary Health Care Boards, Directors and other Staff of the NPHCDA, Gentlemen of the Press, etc.

While the second meeting had broad representation from key health sector partners, including: the Directors of Community Health Service from 24 States and FCT, CHAI, Africa CDC, Health Sector Reforms (Prof. Clara Ejembi), Vaccine Network (Dr. Chika Offor), and World Bank (Dr. Onoriode). State representatives introduced themselves, with participation from Abia, Adamawa, Akwa Ibom, Anambra, Bayelsa, Bauchi, Borno, Gombe, Sokoto, Ekiti, Kaduna, Imo, Zamfara, Rivers, Cross River, Oyo, Niger, Yobe, Nasarawa, Kogi, Lagos, Ogun, and Kebbi.

National Stakeholders' Engagement Outcomes

- Stakeholder endorsement of the Program Re-design and Strategy.
- Consensus on dropping the designation 'Auxiliary' as it connotes quackery.
- Most of the States preferred to use only JCHEWs
- Some States suggested use of other trained categories of Health Workers eg (Environmental Health Officers and Health Attendants) apart from JCHEWs instead of lay persons.
- Five states (Kaduna, Bauchi, Zamfara, Ogun, Kebbi) committed to immediate recruitment of CBHW.
- SWAp office has requested prioritization of the following 11 States for MAMII roll-out (**Bauchi, Borno, Gombe, Kaduna, Kano, Katsina, Kebbi, Sokoto, Jigawa, Zamfara, and Ogun**)

Status of Implementation of Community-Based Health Workers Program

Stage	Activity	Status
Pre-implementation /Planning	Policy review and adaptation	Done
	Stakeholder engagement and consensus building with national and subnational state actors and partners	Done
	Strategy finalization	Done
	Financing and resource mobilization	On-going
	Development/revision of Program Guide, training materials and data tools	On-going
	State Readiness Assessment	On-going
	Development of operational work plans/roadmaps at national and subnational levels	On-going
	Establishing a commodity and drug supply chain system	On-going
	Printing of Program guide and training materials	Not done
	Branding of the Programme	Not done
	Procurement of training materials and commodities, drugs and supplies	Not done
	Development of a communication strategy	Not done
	Launch	Not done

Status of Implementation of Community-Based Health Workers Program

Implementation	National Stakeholders' Engagement	Done
	State/community engagement/entry	Not done
	Establishing governance and coordination platforms	Not done
	Selection of the JCHEWs and ACHWs and identification of supervisors	Not done
	Capacity Building (Onboarding/Training)	Not done
	Accreditation of the CHWs	Not done
	Deployment of the JCHEWs and ACHWs	Not done
	Service delivery	Not done
	Integrated supportive supervision	Not done
	Capacity Building (mentoring and continuous learning)	Not done
	Commodity and drugs supply and replenishment	Not done
	Performance management	Not done
	Operations and implementation research	Not done

Status of Implementation of Community-Based Health Workers Program

Monitoring, Evaluation and Research	Routine monitoring	Not done
	Mid-year review	Not done
	Annual reviews	Not done
	Periodic evaluation	Not done

Next Steps from the Stakeholders' Engagement Meeting

S/N	Action Points	Timeline	Status
1	CHW Data Collection: States to submit data on existing community health workers (CHWs) using the template shared with the Directors in charge of community health services.	May-June 2025	On-going
2	State Commitment: States should formally indicate their interest and commitment to implementing the redesigned community health workforce model.	June 2025	On-going
3	Readiness Assessment: CHAI to commence readiness assessments in 11 priority states and other States.	June 2025	On-going
4	Strategy Adaptation: States should review, adapt, adopt and share the national strategy document with NPHCDA, tracking all changes in red for clarity.	June 2025	On-going
5	Implementation Plan: States to develop State-specific implementation plan and share with National.	June 2025	On-going


NATIONAL PRIMARY HEALTHCARE
DEVELOPMENT AGENCY
Partnership for Service

Thank you!

National Primary Health Care Development Agency

Overview of the Refresher Training Programme for 120,000 Frontline Health Care Workers in Nigeria

Dr. Ngozi Nwosu
Director, Department of Primary Health Care System Development
NPHCDA.

September, 2025

Outline

1. Introduction/Context
2. Purpose and Specific Objectives
3. Priority Service Areas
4. Training Methodologies
5. Targeted Participants
6. Eligibility Criteria for Participant Selection
7. Organization of the Training
8. Selection of national and State Facilitators
9. Electronic Learning System
10. Supportive Supervision, Coaching and Mentoring
11 Performance Monitoring, Reporting and Evaluation
12. Key Performance Indicators
13. Benefits of the Training to Participants

Context

- As part of the **Nigeria Health Sector Renewal Investment Initiative** (NHSRII), one of the goals of the health sector is the **refresher training of frontline health workers** on integrated service delivery to provide quality health services for Nigerians and improve health outcomes
- **120,000+** health workers comprising doctors, nurses, midwives, CHEWs and JCHEWs providing clinical services in government-owned PHCs across the country were proposed for training across the 36 states + FCT and 774 LGAs
- The Phase-1 training comprised 1. **ten days of classroom training including two days of practical sessions; 2. subsequent training on E-learning platform** using Low Dose High-Frequency Approach; 3. **Mentoring, Coaching and Supportive Supervision;** and **Post Training Evaluation**
- Many Donors/Partners and sister Health MDAs like NACA,NCDC,NHIA supported with technical support
- About 40-50% of HCW nominated for training were found to be volunteers **leading to advocacy by ED and Ministers to NGF and Governors for recruitment of additional health workers starting from qualified Volunteers.**

Purpose and Specific Objectives

Purpose:

The aim of the *Refresher Training Programme* is to strengthen the capacity of Frontline Health Workers working in **publicly-owned PHC** facilities to provide quality health services and improve health outcomes in Nigeria**.**

Specific Objectives:

- To increase the competency and skills of 120,000 FHWs across the country.
- To enhance quality service delivery in primary health care facilities
- To improve health outcomes and accelerate progress towards achieving UHC
- To improve adherence for the use of SOPs and guidelines by FHWs

Priority Service Areas

The Refresher Training focuses on critical service areas:

- Principles of Integrated PHC Service delivery
- AIDS, Tuberculosis and Malaria (ATM)
- Maternal and Child Health;
- Adolescent Sexual and Reproductive Health
- Nutrition
- Communicable and Non-Communicable Diseases
- Vaccine Preventable Diseases & IMCI
- Care of the Elderly Water Sanitation and Hygiene (WASH)
- Health Security & Infection Prevention and Control at the PHC Level
- Mental Health
- Management of Emergencies at the PHC Level
- Essential Drugs and Commodities Management ; Rational Use of Drugs
- Financial Management at the PHC level, including BHCPF
- Communication, Attitude and Ethics
- PHC Managerial Structures: WDC, VDC,etc

Components of the Training

1. Classroom training- formerly 10 days but now 13 days because of expansion of BEmONC, PPH and MMS
2. Electronic Learning System
3. Coaching, mentoring and supportive supervision
4. Evaluation

Incentives for the Trainees

- **Financial incentives**- stipends to cover transport and meals
- **Professional development opportunity**- continuing through the Electronic LS
- **Recognition and Awards**- certificates of participation, public recognition and awards which can enhance the HWs credentials and career advancement prospects
- **Networking opportunities** – network forums where HWs can connect with peers
- **Access to support services** like mentorship, coaching and counselling
- **Access to exclusive resources** like training materials and tools for further learning and practice
- **Feedback and inputs**- HWs can send and receive feedback to organizers to ensure the training meets participants' needs and expectations.

Training Dashboard for Phase 1

S/N	State	FHWs Training Progress Report											
		Shortlisted FHWs	Trained FHWs	Disaggregated by cadre (professional qualification)									
				Doctors	Nurses	Midwives	Nurse/ Midves	CHOs	CHEWs	JCHEW	Volunteers	Others	TOTAL
	NTOT												223
	STOT												3930
1	Katsina	4,413	4,406	2	61	157	10	44	1670	678	0	1,784	4,406
2	Kebbi	1,998	1,625	1	5	1	2	33	731	288	1	563	1,625
3	Sokoto	2,001	1,956	0	34	38	5	35	1397	299	0	148	1956
4	Zamfara	581	587	0	1	2	0	53	418	78	0	35	587
5	Jigawa	1,796	1171	0	20	131	0	31	714	260	0	15	1171
6	Kaduna	2,932	2,932	0	182	196	53	313	1641	361	0	186	2932
7	Kano	4,538	4,269	0	53	119	7	87	2631	290	0	1,082	4269
8	Bauchi	1,934	1,901	0	41	68	16	200	1125	219	0	232	1901
9	Borno	867	878	0	60	40	6	27	480	253	0	12	878
10	Gombe	1,029	1,103	0	16	44	15	80	702	225	0	21	1103
11	Taraba	1,392	1280	0	20	13	0	14	943	284	0	6	1280
12	Adamawa	1,656	1776	0	21	14	0	8	956	772	0	5	1776
13	Yobe	989	930	4	12	76	10	22	426	337	0	43	930
14	Akwaibom	1,454	1,558	0	161	2	65	72	701	173	0	384	1558
15	Bayelsa	643	673	1	81	6	1	59	326	88	18	93	673
16	Cross River	1,603	1,533	0	7	6	14	325	931	198	0	52	1533
17	Delta	10,221	956	7	134	49	191	64	409	82	0	20	956
18	Edo	800	900	16	43	42	146	124	430	48	9	42	900

Training Dashboard contd.

19	Rivers	1,295	1,275	55	16	9	97	242	600	193	0	63	1275
20	FCT	843	858	7	30	9	17	82	559	108	0	46	858
21	Kwara	1,290	1,100	2	63	17	93	89	727	90		19	1100
22	Kogi	1,158	1,132	5	22	7	43	38	773	236	0	8	1132
23	Nasarawa	1,347	1,498	0	24	81	3	33	1139	211	0	7	1498
24	Niger	2,835	2,452	1	48	44	14	124	1640	579	0	1	2451
25	Plateau	2,010	2,030	0	56	1	17	84	1285	247	0	340	2030
26	Benue	1,035	1,029	23	29	14	145	32	636	140	0	10	1029
27	Abia	1,445	1,490	3	55	13	107	28	881	117	0	286	1490
28	Anambra	1,318	1,714	53	156	88	250	106	746	205	0	110	1714
29	Ebonyi	632	730	0	6	6	9	18	586	94	0	11	730
30	Enugu	1,114	1,123	1	2	0	57	8	871	177	0	7	1123
31	Imo	1,694	1,704	4	84	0	53	55	792	209	0	507	1704
32	Ekiti	890	589	0	5	16	3	83	437	19	0	26	589
33	Lagos	1,698	1,447	36	343	31	36	162	533	18	0	288	1447
34	Ogun	1,356	1,450	0	224	46	0	132	877	166	0	5	1450
35	Ondo	991	1,073	12	110	20	26	290	552	49	0	14	1073
36	Osun	1,762	1,794	0	135	25	22	244	1034	200	0	134	1794
37	Oyo	1,354	1396	1	49	32	49	184	489	109	0	483	1396
	TOTAL			**234**	**2409**	**1463**	**1582**	**3625**	**31788**	**8100**	**28**	**7088**	**60,470**

A total of 60,470 Health Workers were trained at the National, State and Health facility levels (phase 1)

Activity	Duration	# Trained
National Training of Trainers (NTOT)	*5 days*	*223*
State Training of Trainers (STOT)	*5 days*	*3,930*
Health Facility level Training	*10 days*	*56,317*
Total		***60,470***

SUMMARY

All 36 States + FCT have completed the phase 1 Training of Frontline Health Workers

Phase II implementation.

Objectives of Phase-2 Training

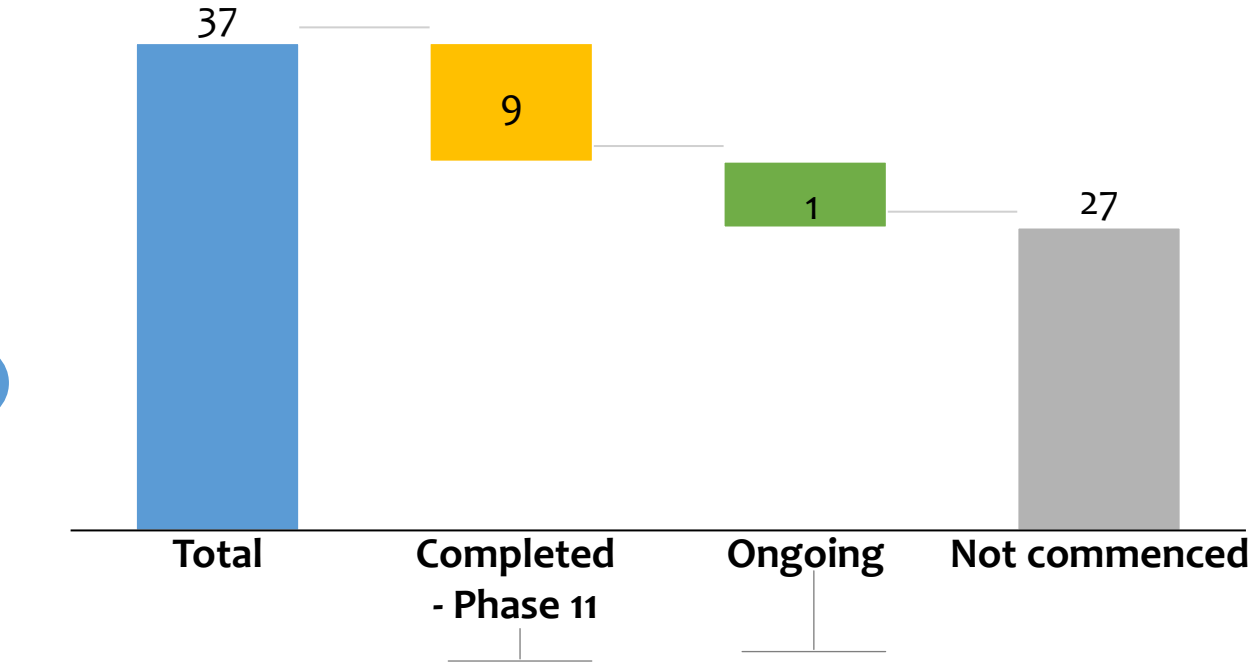
- To consolidate on the successes of Phase-1 training
- To expand the training to include newly recruited health workers and all FLHWs not trained in phase-1
- Introduction of addenda to the Integrated training package:
  - BEmONC (Basic Emergency Obstetric and Newborn Care)
  - PPH (Prevention and Management of Postpartum Haemorrhage)
  - MMS (Multiple Macronutrient Supplementation)

Operational Changes to Phase II Implementation

Training participants	• SBAs: Doctors, Nurses, Midwives, CHOs, CHEWS, • Non-SBAs: JCHEWS
Training days: thirteen (13) days:	•**SBAs and Non-SBAs:** 6 days joint classroom & 1 day practical on integrated PHC •**SBAs:** Additional 5 days classroom & one (1) day practicals on BEmONC, PPH and MMS
Facilitators Selection (7)	• **Integrated Training:** 3 LG Programme Officers, 1 Health Training Institution, 1 state facilitator • **BEmONC/PPH/MMS**: 2 Master trainers
Training tools	• **Integrated Training:** Existing national integrated PHC manuals • **BEmONC/PPH/MMS**: Addenda developed, printed and being distributed ton states • **Other training materials** also being distributed

Progress with Phase-2 training ….

A total of **8,902** been trained across nine states: Plateau, Bauchi, Borno, Kaduna, Zamfara, Taraba, Ekiti, Yobe & Akwa Ibom states.
Niger- ongoing



Challenges and mitigating actions

Challenges	Mitigating actions
Non submission of List of eligible trainees from some states (6) for resource mapping *(Ebonyi, Kogi, Delta, Cross River, Enugu & Kwara states)*	Consistent follow up and support to states for generation of list of eligible training participants
Incomplete database of trained FLHWs for phase I and II	Identification of gaps and support states to maintain an accurate database of trained FLHWs
Resource mobilization	Continuous engagement with donors and partners for resource pooling for phase II implementation
Conflicting activities in states	Early engagement with states to determine suitable schedules with minimal disruptions

Next Steps

Training to continue across states as resources become available

Commencement of the Evaluation of phase 1 training

Roll-out of e-learning platform

Requests from Executive Secretaries/States

- Follow up with State Team to finalise and submit comprehensive database for phase-1 and phase-2
- Follow up with identification of submission of lists of eligible trainees for Phase-2 as per Concept- training to include newly recruited health workers and all FLHWs not trained in phase-1
- Warehousing and security of training materials and tools
- Support planning, facilitation, monitoring and supportive supervision
- Logistic and other support where possible

THANK YOU