MAMII:

Maternal and Neonatal Mortality Reduction Innovation Initiative

A Comprehensive Guide

OCTOBER 2025

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OCTOBER 2025

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Foreword

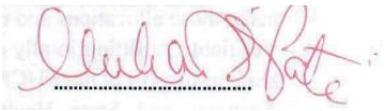
This guide is a comprehensive resource designed to support policy makers and critical stakeholders of the Nigeria health system in delivering a set of targeted, evidence-based, high-quality, and respectful care to women and their newborns with the goal to crash maternal and neonatal mortality in Nigeria.

Al coThe Federal Ministry of Health and Social Welfare through the Nigeria Health Sector Renewal Investment Initiative has curated the Maternal and Newborn Mortality Reduction Innovation Initiative (MAMII) set of programs for the best possible experience and outcome for every mother and newborn in Nigeria. This guide integrates key programs across multiple responsible entities within the health sector in Nigeria and demonstrates the interconnectedness of these programs and actions toward crashing maternal and newborn mortality while also setting renewed targets for maternal and newborn care.

We are committed to the vision where every woman and newborn, regardless of socioeconomic status or geographic location, has unfettered access to the best quality care. We believe the MAMII approach will have a crucial positive short- and long-term impact on the health of mothers and neonates in Nigeria. This guide provides the framework for shared understanding and clear communication of approach, providing essential information to all policymakers and relevant stakeholders within the Nigerian health system.

The MAMII guide is a living document that will evolve with new evidence and our collective learning from the implementation of the prioritised initiatives. I encourage all users of this manual to take into account the prioritised initiatives under MAMII and implement these reforms in a manner that builds public trust and serves our great country, Nigeria, with distinction.

Thank you for your dedication to this vital work.



Professor Muhammad Ali Pate

Contents

Abbreviations

ANC	Antenatal Care
AOP	Annual Operational Plan
BEmONC	Basic Emergency Obstetric and New-born Care
BHCPF	Basic Healthcare Provision Funds
CAPs	Community Action Plans
CBHMIS	Community Based Health Management Information System
CBHW	Community-Based Health Workers
CEmONC	Comprehensive Emergency Obstetric and New-born Care
CEMTTO	Community Emergency Medical Transport Triage Officer
CHEW	Community Health Extension Workers
CHOs	Community Health Officers
CHW	Community Health Worker
CMHSW	Coordinating Minister of Health and Social Welfare
CSR	Cooperate Social Responsibility
CUG	Closed User Group
DFH	Division of Family Health
DIME	Development Impact Evaluation
DPRS	Department of Planning, Research and Statistics
DRF	Drug Revolving Funds
ECA	Emergency Care Assistant
EmONC	Emergency Obstetric and New-born Care
EMS	Emergency Medical Services
ETO	Emergency Transport Operator
FF	Finish-to-Finish
FG	Funding Gap
FGA	Funding Gap Analysis
FMOH	Federal Ministry of Health
FMOHSW	Federal Ministry of Health and Social Welfare
FPIC	Free, Prior and Informed Consent
FS	Finish-to-Start
GESI	Gender and Social Inclusion
GRM	Grievance Redress Mechanism
HCD	Human Capital Development
HF	Health Facility
HFMC	Health Facility Management Committee
HIV	Human Immunodeficiency Virus
HOPE	Health Sector Renewal Investment Initiative (Project name)
HRH	Human Resources for Health
HSP	Health Service Provider
ICF	International Consulting Firm
ICT	Information and Communication Technology
IEV	Identify Every Village (immunization strategy)
IP	Implementing Partner
JCHEW	Junior Community Health Extension Workers
JHDTAF	Joint Health Development Technical Assistance Fund
KPI	Key Performance Indicator
LGA	Local Government Area

LGHAs	Local Government Health Authorities
LMIC	Low-and-Middle Income Countries
M&E	Monitoring and Evaluation
MDSR	Maternal Death Surveillance and Response
MERL	Monitoring, Evaluation, Research and Learning
MMR	Maternal Mortality Rate
MMS	Misoprostol, Mifepristone, and other medical Supplies
MNCH	Maternal, Newborn and Child Health
MNH	Maternal and Newborn Health
MoU	Memorandum of Understanding
MPCDSR	Maternal, Perinatal, and Child Death Surveillance and Response
MSS	Minimum Service Standards
NDHI	Nigeria Digital Health Initiative
NDHS	National Demographic and Health Survey
NEMSAS	National Emergency Medical Service and Amulance System
NFFP	NHIA Fistula Free Programme
NHF	National Health Fellow
NHIA	National Health Insurance Authority
NHMIS	National Health Management Information System
NHSRII	Nigeria Health Sector Renewal Investments Initiative
NICU	Neonatal Intensive Care Unit
NMR	Neonatal Mortality Rate
NPC	National Population Commission
NPHCDA	National Primary Healthcare Development Agency
NSC	National Steering Committee
PFI	Partner Funded Intervention
PHC	Primary Healthcare
PHCUOR	Primary Healthcare Under One Roof
PMU	Program Management Unit
PoCUS	Point-of-Service Ultrasound
PPH	Post-Partum Hemorrhage
PPP	Public Private Partnership
QA	Quality Assurance
QI	Quality Improvement
RBF	Result-Based Financing
RBM	Result-Based Monitoring
RBM&E	Result-Based Monitoring and Evaluation
RESMAT	Rural Emergency Service and Medical Transport
RMNCAEH	Reproductive, Maternal, Newborn, Child, Adolescent and Elderly Health
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
RMNCH	Reproductive, Maternal, Newborn and Child Health
RRA	Realistic Resource Allocation
SBA	Skilled-Birth Attendant
SCBU	Special Care Baby Unit
SCO	SWAp Coordinating Office
SDG	Sustainable Development Goal

SDP	Service Delivery Point
SEMSAS	State Emergency Medical Service and Ambulance System
SF	Start-to-Finish
SGF	State Government-Funded Intervention
SMoH	State Ministry of Health
SMOH	State Ministry of Health
SPHCB	State Primary Healthcare Board
SPHCDA	State Primary Healthcare Development Agency
SS	Start-to-Start
SW	Social Welfare
SWAp	Sector-Wide Approach
TA	Technical Assistance
TBA	Traditional Birth Attendants
ToR	Terms of Reference
TWG	Technical Working Group
UHC	Universal Health Coverage
UNICEF	United Nation International Children's Emergency Fund
USSD	Unstructured Supplementary Service Data
VA	Verbal Autopsy
VGF	Voucher Guarantee Fund
VVF	Vesicovaginal Fistula
WDC	Ward Development Committee
WHO	World Health Organizations
WRA	Women of Reproductive Age
YSSH	Yobe State Specialist Hospital

Figures and Tables

CHAPTER ONE

Introduction

1. Introduction

1.1 Background and Rationale

Globally about 800 women die from complications related to pregnancy and childbirth each day[1]. Most of these deaths (99%) occur in low-and-middle income countries (LMICs). Nigeria contributes approximately 20% of these maternal deaths. The maternal mortality ratio (MMR) in Nigeria is estimated at over 1,000 deaths per 100,000 live births compared to the global average of 223 per 100,000 live births, indicating Nigeria's significantly higher burden. The neonatal mortality rate (NMR) in Nigeria has also increased from 39 per 1,000 live births in 2018 to 41 per 1,000 live births in 2023-24[2,3]

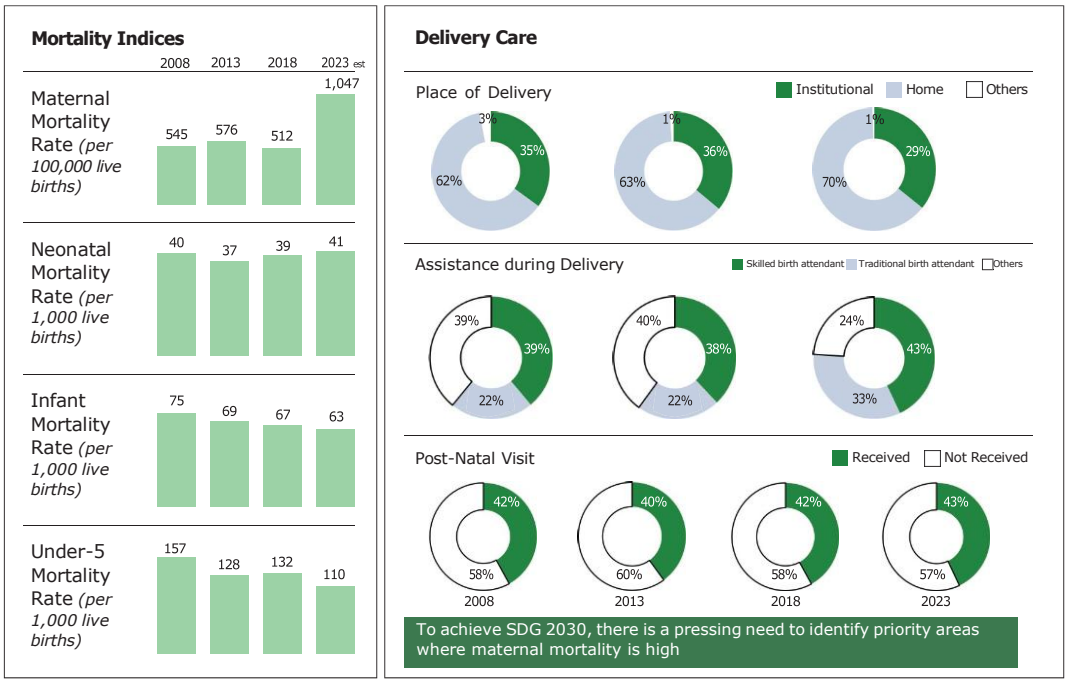


Fig. 1.1 Graphical representation of MMR rate in Nigeria from 2018 - 2023

In Nigeria, there are maternal mortality disparities existing across regions, geographical locations, and socio-economic class. The Nigerian health sector is faced with numerous challenges including a weak reform environment especially at the subnational level, inadequate financing, poor infrastructure, shortage of healthcare workforce, and limited access to services for the majority of the population. These challenges contribute to the poor health outcomes including high maternal and newborn mortality.

In Nigeria, major causes of maternal mortality include haemorrhage, hypertensive disorders (eclampsia), infection/sepsis, obstructed labour, and unsafe abortion, with additional contributions from anaemia and HIV as indirect factors; most of these causes are considered preventable or treatable under timely and quality obstetric care[4].

Some risk factors that worsen maternal and neonatal mortality within the Nigeria health environment include limited healthcare infrastructure, lack of skilled birth attendants, inadequate emergency services, and socio-cultural practices - including the preference of traditional birth attendants over skilled professionals.

1. World Health Organization. (n.d.). Maternal mortality (Fact sheet). https://apps.who.int/iris/bitstream/handle/10665/112318/WHO_RHR_14.06_eng.pdf
2. National Population Commission (NPC) [Nigeria], & ICF. (2019). Nigeria Demographic and Health Survey 2018. NPC & ICF
3. Federal Ministry of Health and Social Welfare (FMoHSW), National Population Commission (NPC) [Nigeria], & ICF. (2024). Nigeria Demographic and Health Survey 2023–24: Key Indicators Report. NPC & ICF.

1.2 The Maternal and Neonatal Mortality Reduction Innovation Initiative (MAMII)

To address this crisis, the Maternal and Neonatal Mortality Reduction Innovation Initiative (MAMII) was launched by the Federal Government of Nigeria in November 2024 under the leadership of the Coordinating Minister of Health and Social Welfare (CMHSW), Prof. Muhammad Ali Pate CON. MAMII is a targeted, data-driven initiative designed to drastically reduce maternal and neonatal mortality by 30% and 20% respectively. This applies particularly to areas where mortality rates exceed 1,000 maternal deaths per 100,000 live births and where there is increased health facility utilization by 60% in the selected MAMII (172) LGAs mentioned below by 2028. The initiative adopts a context-specific approach, ensuring that interventions are tailored to the unique challenges of each state.

MAMII's core objectives include:

- Increasing facility utilization for maternal and newborn health services.
- Enhancing the proportion of births attended by skilled providers.
- Significantly reducing maternal and neonatal mortality rates.

MAMII is structured around the Sector-Wide Approach (SWAp) principles, ensuring alignment with national and state health strategies while fostering coordinated action among government agencies, development partners, and community stakeholders. The initiative aims to achieve 50% rollout across the 172-priority local government areas (LGAs) by December 2025. These LGAs contribute 55% of the national maternal mortality burden and 18% of under-five mortality[5].

Prior to MAMII's launch, extensive data analytics and maternal health assessments were conducted to identify intervention priority areas. The findings highlighted 172 high-burden LGAs across Nigeria's six geopolitical zones:

- 51 LGAs in the Northeast
- 66 LGAs in the Northwest
- 11 LGAs in the North-Central
- 13 LGAs in the Southeast
- 19 LGAs in the South-South
- 12 LGAs in the Southwest

The assessments revealed systemic challenges such as facility readiness gaps, quality of care deficiencies, geographic and financial barriers, as well as socio-cultural influences on maternal health-seeking behaviours. MAMII directly addresses these challenges through tailored intervention suites, ensuring a comprehensive, sustainable, and high-impact response to maternal mortality reduction in Nigeria. To address the challenges associated with the risk factors for increase maternal mortality under the Renewed Hope's Initiative Nigeria Health Sector Renewal Investment Initiative (NHSRII), the Maternal Mortality Reduction Innovation Initiative (MAMII), seeks to understand the specific drivers of maternal deaths in communities, and provide context-specific solutions. MAMII is designed to address five critical delays that contribute to maternal deaths including delays in seeking medical care, reaching a health facility, receiving adequate care, taking responsibility for mortality reviews, and coordinating sector-wide interventions. MAMII aligns and fosters collaboration, ensuring a more focused and unified strategy to tackle the causes of maternal death in communities.

4. Olamijulo, J. A., Olorunfemi, G., & Okunola, H. (2022). Trends and causes of maternal death at the Lagos University Teaching Hospital, Lagos, Nigeria (2007–2019). BMC Pregnancy and Childbirth, 22, Article 360. https://doi.org/10.1186/s12884-022-04649-4
5. National Population Commission (NPC) [Nigeria], & ICF. (2019). Nigeria Demographic and Health Survey 2018. NPC & IC

In some communities, women prefer to deliver under the care of Traditional Birth Attendants (TBAs) whom they perceive to show more concern and compassion to pregnant women. This highlights the importance of the attitude of healthcare workers to access and utilization of PHC services.

1.3 MAMII Strategic Framework

The key pillars of MAMII make up the strategic framework of the intervention. These pillars rest on the earlier defined delays that contribute to maternal deaths.

The MAMII Strategic Framework outlines a multi-faceted approach to reducing maternal and newborn mortality by integrating governance, intervention strategies, and enabling mechanisms.

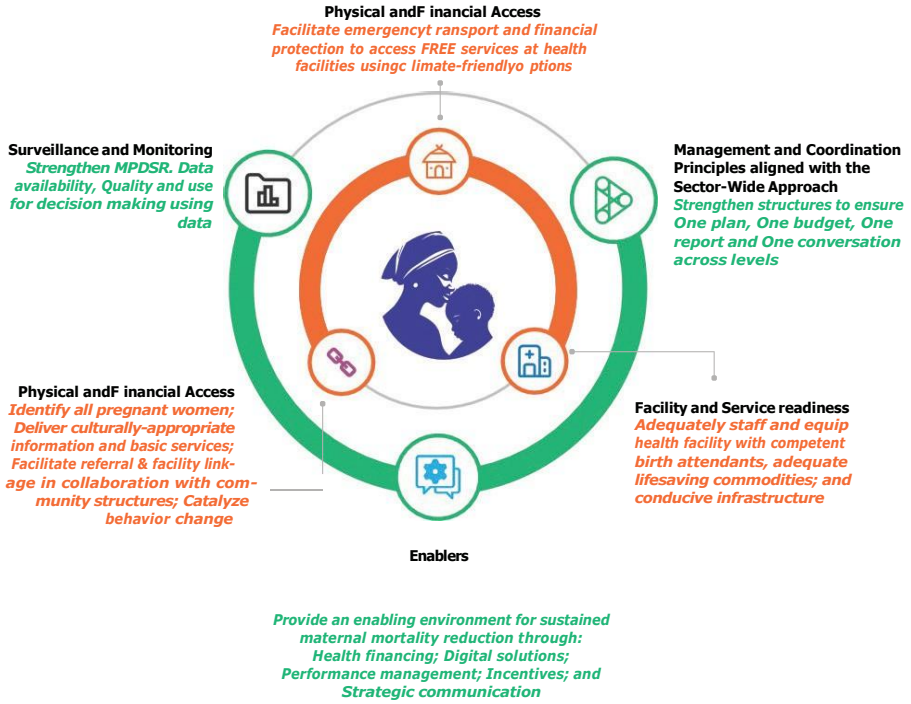


Fig. 1.2 MAMII Strategic Framework

Key components include:

1. Community Programming & Innovation – Enhancing health literacy and demand generation, deploying Community based Health workers (CBHWs) for demand generation, follow-up and referrals, engaging traditional birth attendants (TBAs) and faith-based organizations to link clients to healthcare facilities and utilizing community leadership structures to improve maternal and newborn health.
2. Access Interventions – Addressing financial and physical barriers to care through mechanisms such as Voucher Guarantee Fund (VGF) Coverage, Emergency Evacuation Systems, and Climate-Resilient Health Services.
3. Health Facility Programming & Innovation – Strengthening Basic Emergency Obstetric and Newborn Care (BEMONC) and Comprehensive Emergency Obstetric and Newborn Care (CEMONC) facilities, ensuring availability of essential commodities, optimizing treatment protocols, and training healthcare workers
4. Data & Governance Interventions – Establishing an M&E Framework, Scorecard, and Incentive System to track progress and enhance accountability.
5. Enablers – Leveraging digital technology, communication strategies, and incentives to

improve maternal and child health outcomes.

6. Aligning Management with the Sector-Wide Approach (SWAp) – Ensuring that maternal health interventions align with national and sub- national health policies. This involves harmonising institutions across the tiers of government (vertically and horizontally) and coordinating resources and technical assistance to a holistic nation-wide implementation process.

1.4 Objectives of the MAMII Initiative

Under the NHSRII, MAMII has the following core objectives:

1. Strengthening the health system by improving access of women and children to quality health
2. Improve knowledge and skill of health providers, thereby increasing quality of care provided
3. Improve health-seeking behaviour among pregnant women in the community
4. Significantly reduce (crash) maternal and newborn mortality rates
5. Scale-up the uptake of the practices in maternal and perinatal death surveillance and response (MPDSR)

1.5 Alignment with National and Global Health Goals (SDGs, U4C, NHSRII)

The Sustainable Development Goals (SDGs) are adopted by all United Nations Member States as a blueprint for peace and prosperity for people and the planet. There are 17 SDGs of which the third goal "Good Health and Well-being" falls within the operational context of MAMII. This goal ensures healthy lives and promotes well-being for all. The first target of SDG 3 is "By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births." Member countries have united behind this target to facilitate the decline of maternal mortality by 2030. In the same vein, the SDGs, specifically SDG 3.2, aim to end preventable deaths of newborns and children under 5 years of age by 2030. This includes reducing neonatal mortality (deaths within the first 28 days of life) to at least 12 deaths per 1,000 live births and under-5 mortality to at least 25 deaths per 1,000 live births[6].

Improving maternal and newborn health is one of the key priorities of MAMII. MAMII's activities will work to contribute to the reduction of maternal mortality by enhancing surveillance and research evidence, strengthening the capacity of the health workforce and facilities, mobilizing communities to adopt healthy practices in relation to maternal and newborn health, and implementing effective programme policies.

Universal Health Coverage (UHC) means that all people have access to the quality health services they need, when and where they need them (including during emergencies), without the risk of financial hardship. In addition to committing to achieving the SDGs by 2030, many world leaders have committed to achieving UHC. This covers essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care. The lack of access to quality care and the inability to afford them are some of the reasons why pregnant women in most rural communities in Nigeria do not use skilled professionals during childbirth.

MAMII's objective to accelerate access to healthcare services to pregnant women in the

community aligns with the UHC movement to promote access to essential health services for everyone, especially the most vulnerable members of society.

To reform Nigeria's health system and improve access to healthcare, the Federal Government launched the Nigeria Health Sector Renewal Investment Initiative (NHSRII). This initiative supports the goal of Universal Health Coverage (UHC) and adopts a Sector-Wide Approach (SWAp) to manage the health sector. It integrates key components such as the Basic Healthcare Provision Fund (BHCPF), the Nigerian Healthcare Industrialization Program, and various initiatives carried out in partnership with subnational governments and development partners. NHSRII is specifically designed to address geographic disparities and improve health outcomes among vulnerable populations. Its core objectives are to save lives, reduce physical and financial suffering, and ensure the well-being of all Nigerians. The goals of the MAMII initiative align with NHSRII by focusing on improving access to healthcare for pregnant women and reducing maternal mortality.

1.6 Expected Outcomes and Key Targets

Establishing clear outcomes and targets is essential in ensuring the effectiveness of MAMII. These outcomes will serve as measurable indicators of progress and a guide to intervention activities. In further chapters, the monitoring and evaluation mechanisms for project indicators will be explored. Below are some of the expected outcomes for MAMII programs which will be reported in the annual health report for the health sector and published by the SWAp coordinating office.

Expected Outcome	Key Targets Measurement Framework
Reduction in maternal and neonatal mortality rate	30% Decrease in maternal deaths per 100,000 live births by year 2028 20% Decrease in neonatal deaths per 1,000 live births by 2028
Improved access to maternal healthcare	Increase in average antenatal care visits per woman to 4 by 2028 40% Increase in the Quality of Care (QoC) for postnatal services received by mothers Increase in births attended by skilled birth attendants to at least 80% by 2028 Increase in PHCs fully equipped with the minimum service complement to at least one per ward by 2028
Increased awareness and behavioural change amongst community members on all aspects of maternal and child health	Increase in healthcare facility births to 80% by 2028 Increase in health facility utilization to 60% by 2028

Table 1.1 Expected Outcomes and Key Targets of MAMII Intervention

6. United Nations. (2023). Metadata for Sustainable Development Goal 3.2: End preventable deaths of newborns and children <5 years of age. United Nations. Retrieved June 20, 2025, from https://metadata.un.org/sdg/3.2?lang=en

CHAPTER TWO

Maternal and Child Mortality in Nigeria: Situational Analysis

2. Maternal and Child Mortality in Nigeria: Situational Analysis

2.1 Current Maternal and Neonatal Mortality Trends

Maternal and newborn mortality remains a critical public health challenge in Nigeria, with the country accounting for one of the highest maternal and newborn death rates globally. Nigeria contributes approximately 20% of global maternal deaths (WHO/UNICEF). The maternal mortality ratio (MMR) in Nigeria is estimated at 512 deaths per 100,000 live births, while the neonatal mortality rate (NMR) increases from 39 in 2018 to 41 in 2023-24 deaths per 1,000 live births[7]. In comparison, the global average maternal mortality rate is 223 per 100,000 live births, indicating Nigeria's significantly higher burden[8].

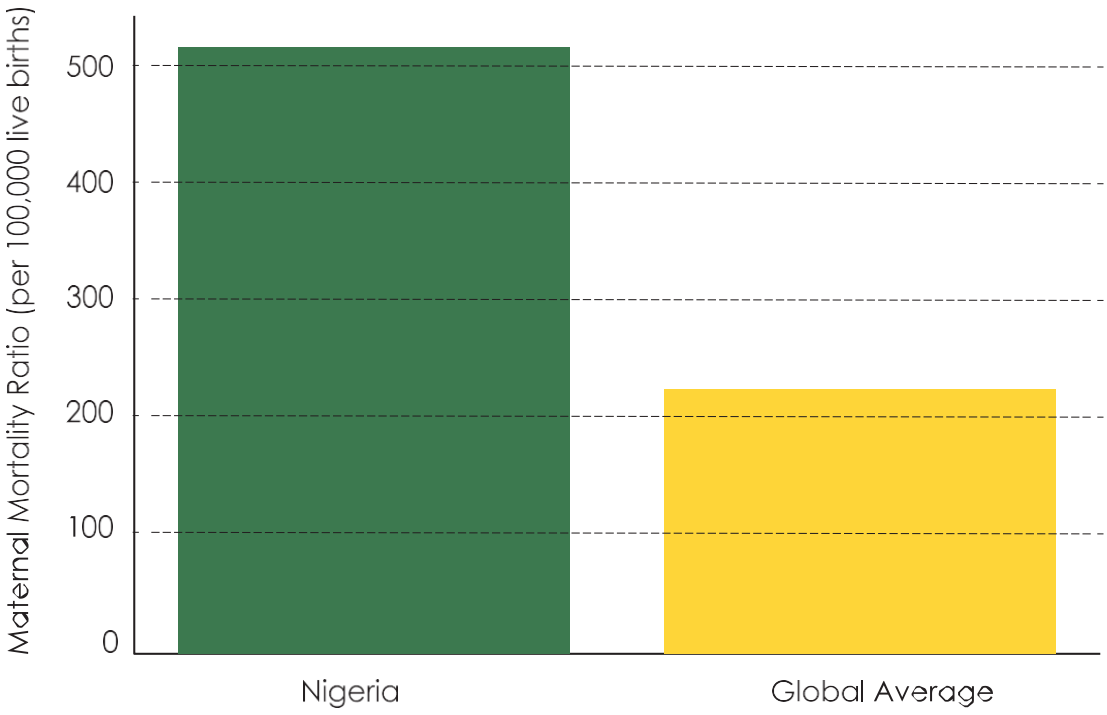


Fig. 2.1 Data Representation of Maternal Mortality Ratio of Nigeria and Global Average

Addressing these challenges requires urgent and sustained efforts from both government and stakeholders to improve healthcare access, ensure equitable distribution of maternal health services, and strengthen healthcare policies aimed at reducing maternal and newborn mortality. Greater financial investments, enhanced data-driven policy decisions, and stronger community engagement are necessary to drive meaningful progress and reduce the burden of maternal and newborn mortality in Nigeria. Fig. 2.2 Data Representation of Neonatal Mortality Ratio of Nigeria from 2018 to 2023.

7. UNICEF. Nigeria Country Profile, 2024 available at https://open.unicef.org/country/Nigeria?cid=3210
8. WHO. Maternal Mortality available at https://www.who.int/news-room/fact-sheets/detail/maternal-mortality

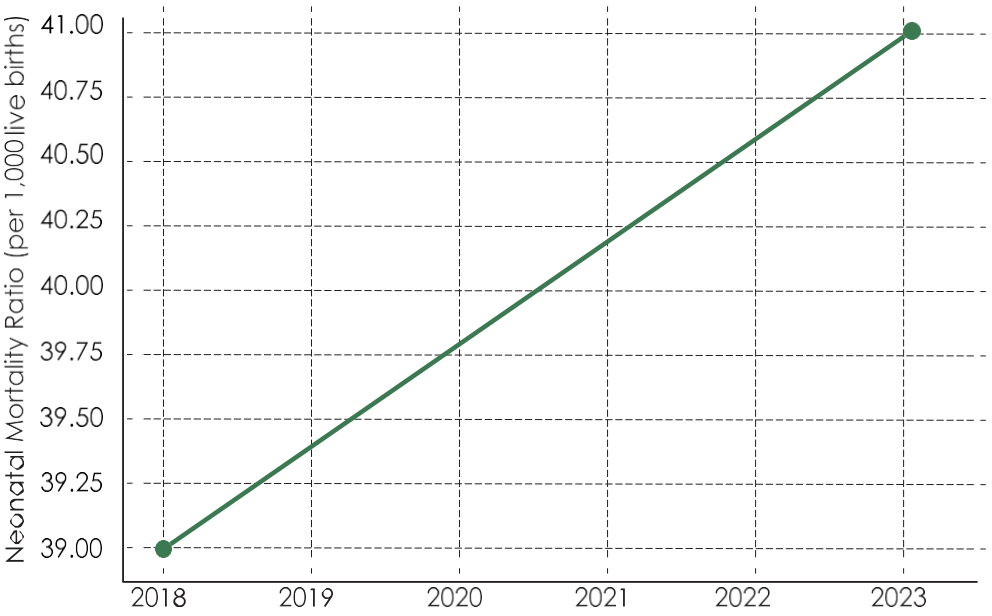


Fig. 2.2 Data Representation of Neonatal Mortality Ratio of Nigeria from 2018 to 2023

2.2 Disparities in Maternal Health Outcomes Across States and LGAs

Significant disparities in maternal and newborn health outcomes exist across Nigeria, particularly between Northern and Southern states. Regional disparities in maternal mortality persist in Nigeria, with Northern states experiencing higher rates than their Southern counterparts. This trend is supported by a 2023 analysis of NDHS data published in the African Journal of Reproductive Health1. States in Northern Nigeria (e.g., Zamfara, Yobe, Borno) record the highest maternal mortality rates. This is driven by socio-cultural practices, inadequate healthcare infrastructure, low antenatal care (ANC) uptake, and security challenges. In contrast, Southern states (e.g., Lagos, Rivers) generally report better maternal and newborn health outcomes due to higher facility-based deliveries and greater access to skilled birth attendants.

The disparities are further exacerbated by the urban-rural divide, where rural communities suffer from inadequate healthcare facilities, a shortage of trained healthcare providers, difficulties in accessing emergency obstetric care and interference due to socio-cultural beliefs. Many women in remote areas are forced to rely on traditional birth attendants due to the lack of nearby healthcare facilities, which increases the risk of complications during childbirth. Moreover, poverty and illiteracy play significant roles in healthcare accessibility, as women in lower- income households often lack the financial resources and knowledge to seek timely medical interventions.

To bridge these gaps, the Sector-Wide Approach (SWAp) under the Nigeria Health Sector Renewal Investment Initiative (NHSRII) aims to streamline resource allocation and strengthen healthcare infrastructure for a more equitable distribution of maternal health services. Additionally, evidence suggests that a significant proportion of maternal deaths in Nigeria are concentrated in specific high-burden LGAs within identified states. A study focusing on Jigawa State in Northern Nigeria found that in certain LGAs, such as Sule Tankarkar, Gwiwa, and Kiyawa, approximately 29.2% of deaths among women of reproductive age were related to pregnancy and childbirth. Furthermore, recent data highlights that 172 high-burden LGAs account for about 55% of Nigeria's maternal mortality. By targeting additional interventions to these high-burden areas, national maternal and newborn mortality rates can be substantially reduced, accelerating progress toward achieving global health targets.

It is also crucial to address systemic weaknesses in healthcare service delivery, including the shortage of skilled birth attendants, inadequate referral systems, and inconsistent supply chains for essential maternal and newborn medicines. Strengthening healthcare systems at the primary healthcare level, increasing the availability of midwives and trained birth attendants, and improving community-based health education initiatives can significantly improve maternal and newborn health outcomes. Additionally, leveraging technology and digital health interventions, such as telemedicine and mobile Health applications can help bridge gaps in service delivery and improve accessibility in underserved regions.

Efforts to close these disparities must be multi-sectoral, involving government agencies, international organizations, and community-based initiatives to ensure a comprehensive and sustainable approach to reducing maternal and newborn mortality across Nigeria.

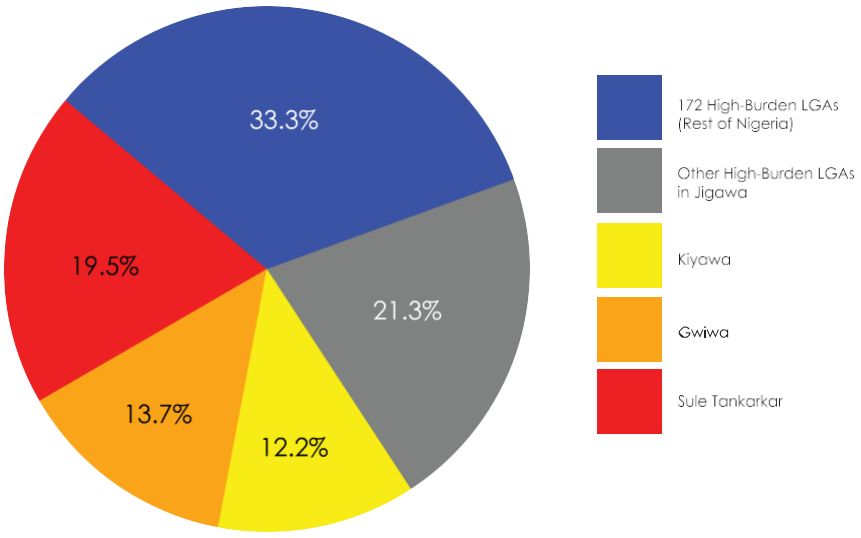


Fig. 2.3 Graphical Data representation of Maternal Deaths in High Burden LGAs in Jigawa State

Maternal Death Hotspots: Insights from Jigawa State

A study conducted in Jigawa State, Northern Nigeria, offers a stark illustration of the localized burden of maternal mortality in rural regions. Using the indirect Sisterhood Method, researchers surveyed over 7,000 women aged 15–49 across 96 clusters in 24 Local Government Areas (LGAs). These women provided information on nearly 11,000 sisters who had reached reproductive age. The findings were sobering: 29.2% of all reported deaths among these sisters were related to pregnancy or childbirth.

The study estimated a maternal mortality ratio (MMR) of 1,012 deaths per 100,000 live births—almost double the national average at the time—indicating a lifetime risk of maternal death of 6.6%. Notably, in some LGAs such as Sule Tankarkar, Gwiwa, and Kiyawa, maternal-related deaths accounted for over half of all female deaths among women of reproductive age. For example, in Kiyawa, 20 out of 37 sister deaths (54.1%) were pregnancy-related, while in Gwiwa and Sule Tankarkar, the figures were 55.6% and 50.0%, respectively.

These findings underscore the urgent need for targeted maternal health interventions in high-burden LGAs. The study's insights reveal how geographically concentrated maternal mortality can be and highlight the importance of disaggregated data to inform local health planning and resource allocation. Addressing such stark inequities will be critical to achieving national and global maternal health goals.

Source: Sharma, V., Brown, W., Kainuwa, M. A., Leight, J., & Björkman Nyqvist, M. (2017). High maternal mortality in Jigawa State, Northern Nigeria estimated using the sisterhood method. BMC Pregnancy and Childbirth, 17, 163. DOI:10.1186/s12884-017-1341-5

CHAPTER THREE

Understanding the Causes of Sustained Maternal and Neonatal Mortality in Nigeria

3. Understanding the Causes of Sustained Maternal and Neonatal Mortality in Nigeria

Despite ongoingmaternal and neonatal health interventions in Nigeria, the indicators remains unacceptably high. A key framework for examining the primary barriers faced by women is the Delays Model..

3.1 The Four Delays

The Delays Model identifies specific stages where obstacles to timely and effective maternal care can result in preventable deaths:

1. Delay in Seeking Appropriate Medical Care

Many women delay seeking care due to cultural norms favoring home births or reliance on traditional birth attendants. Factors such as lack of awareness about danger signs, financial constraints, and limited decision-making autonomy in households also contribute.

2. Delay in Reaching an Appropriate Health Facility

Even when women decide to seek , challenges like poor roads, long distances to health centers, high transportation costs, and insecurity can delay their arrival at a facility..

3. Delay in Receiving Adequate Care at the Facility

Once at a facility, systemic issues such as staff shortages, insufficient skilled birth attendants, absence of essential supplies, and inefficient admission or referral processes often result in further delays in receiving lifesaving interventions.

4. Delay in Taking Responsibility for Maternal Deaths

Inadequate accountability systems contribute to inadequate responses to maternal deaths. Mechanisms like the Maternal Death Surveillance and Response (MDSR) system are often underutilized, and lessons from maternal deaths are not always translated into improvements in service delivery or policy.

These four delays are widely recognized in global literature and have been used extensively to understand and address maternal mortality (Thaddeus & Maine, 1994; WHO, 2015).

Fig. 3.1 Five delays in accessing care

3.1.1 The Fifth Delay: Coordination of Interventions

Building on the traditional delays framework, the Maternal and Neonatal Mortality Reduction Innovation Initiative (MAMII) introduces a Fifth Delay—the delay in coordinating interventions

for effective response—as a critical systems-level barrier contributing to maternal mortality in Nigeria.

While the first four delays focus on individual behavior, facility-level readiness, and accountability, the Fifth Delay shifts attention to how well health interventions and actors are aligned, sequenced, and managed within the broader maternal health system. This delay draws attention to the systemic weaknesses in governance, program harmonization, and cross-sector collaboration that hinder sustainable progress.

MAMII's introduction of the Fifth Delay is grounded in its work across Nigerian states under the Health Sector-Wide Approach (SWAp) platform, where the lack of programmatic and institutional coordination repeatedly emerged as a bottleneck. Key issues include:

- Fragmentation of maternal and neonatal health efforts across multiple donors, agencies, and programs.
- Limited government ownership and leadership, with technical assistance often donor-driven.
- Weak multisectoral engagement, especially with transport, education, water, and finance sectors.
- Inadequate data integration and joint planning mechanisms, leading to duplication and inefficiency.

By framing the Fifth Delay, MAMII emphasizes the urgent need for systems thinking and strategic governance reform to complement clinical and service delivery improvements.

Addressing this delay involves:

- Establishing national and subnational coordination mechanisms with strong leadership from the Ministry of Health.
- Promoting a common results framework for maternal and nenonatal health programming.
- Strengthening the role of state-level coordination platforms to drive harmonized planning, resource allocation, and accountability.
- Building multisectoral coalitions that recognize maternal and neonatal health as a shared responsibility beyond the health sector.

The Fifth Delay thus broadens the understanding of maternal and neonantal mortality to include the interdependencies and institutional dynamics that determine whether women receive timely, quality, and continuous care across their reproductive journey.

3.2 Factors Fuelling the Five Delays

The persistence of maternal mortality in Nigeria is not only a result of the five delays but is also driven by structural, social, and behavioural factors that exacerbate these delays. Addressing these underlying causes is critical to improving maternal and neonatal health outcomes in the country.

3.2.1 Structural Factors

3.2.1.1 Weak Primary Healthcare (PHC) System and Infrastructure

The Nigerian healthcare system is characterized by an underdeveloped Primary Healthcare (PHC) system, which serves as the first point of contact for maternal health services. Many PHC centers lack the necessary infrastructure, medical equipment, and skilled personnel to provide

adequate maternal and newborn healthcare. Rural communities, in particular, are affected by poorly equipped PHC facilities, leading to a reliance on secondary and tertiary hospitals, which are often overcrowded and difficult to access in emergencies.

3.2.1.2 Inadequate Human Resources for Health (HRH)

There is a critical shortage of skilled birth attendants (SBA) , including obstetricians, gynecologists, midwives, and nurses. Many trained health workers prefer to work in urban areas or migrate abroad due to better job opportunities and working conditions. The inadequate staffing of health facilities results in long waiting times, burnout among available healthcare providers, and suboptimal maternal health outcomes.

3.2.1.3 Gaps in Emergency Obstetric and Neonatal Care (EmONC)

Emergency obstetric and neonatal care services, including Basic and Comprehensive Emergency Obstetric and Neonatal Care (BEmONC and CEmONC), are not available in sufficient quantity or equitable distribution across healthcare facilities. This shortage poses a critical challenge, leading to preventable maternal deaths. Key issues include:

- Limited Availability: Many healthcare centers lack the necessary emergency units to manage life-threatening obstetric complications such as hemorrhage, sepsis, and eclampsia.
- Unequal Distribution: Even where BEmONC and CEmONC services exist, they are often concentrated in urban areas, leaving rural and underserved regions without adequate care.
- Delayed Access to Care: Women experiencing complications during labor frequently travel long distances to reach life-saving interventions, increasing the risk of negative outcomes.
- To improve maternal and neonatal health outcomes, there is an urgent need to expand both the availability and equitable distribution of BEmONC and CEmONC services, ensuring timely and effective emergency care for all women.

3.2.1.4 Poor Supply Chain and Logistics for Essential Maternal and Child Health (MCH) Services

The supply chain and logistics for essential MCH services face significant challenges, including:

- Fragmented Supply Chain Systems: Multiple procurement structures and mechanisms at the national and state levels lead to inefficiencies and a lack of coordination.
- Logistics Challenges: Inadequate transportation infrastructure, particularly in rural areas, hinders the timely delivery of essential MCH commodities and vaccines.
- Limited Data Visibility and Management: Insufficient data management systems and a lack of real-time visibility into inventory levels and commodity movement contribute to stockouts and overstocking.
- Inadequate Cold Chain Storage: Limited cold chain infrastructure and inadequate storage facilities compromise the quality and availability of temperature-sensitive MCH commodities, such as vaccines and oxytocin.

These challenges result in:

- Frequent Shortages: Critical MCH commodities and vaccines are often in short supply across health facilities, compromising the delivery of life-saving interventions.
- Limited Access: Remote and underserved areas are disproportionately affected, with limited access to essential MCH services and commodities.

Addressing these supply chain and logistics challenges is crucial to ensuring the availability and accessibility of essential MCH services, particularly in underserved areas.

3.2.2 Social and Behavioural Factors

3.2.2.1 Cultural Beliefs and Preferences for Home Deliveries/TBAs

In many communities, especially in rural areas, home births and traditional birth attendants (TBAs) remain the preferred choice for childbirth due to long-standing cultural practices. Many families believe that giving birth at home is more natural, while others rely on TBAs due to trust, familiarity, and affordability. However, TBAs often lack the training and equipment to handle birth complications, increasing the risk of maternal mortality.

3.2.2.2 Low Health Literacy and Awareness on Maternal and Neonatal Health

A significant proportion of Nigerian women, particularly those in rural areas, have low awareness of maternal and neonatal health risks. Many do not recognize danger signs during pregnancy or understand the importance of antenatal and postnatal care. Myths and misconceptions about hospital deliveries, vaccines, and medical interventions further discourage facility-based childbirth.

3.2.2.3 Financial Barriers and Out-of-Pocket Expenditures

Despite some states offering free maternal and newborn health programs, women often face high out-of-pocket costs for critical services like caesarean sections and blood transfusions. Limited health insurance coverage exacerbates financial burdens, particularly among rural and informally employed women.

3.2.2.4 Gender and Socioeconomic Determinants

In many Nigerian households, men are the primary decision-makers regarding healthcare access. Some women require permission from their husbands or in-laws before seeking care, leading to delays in accessing timely maternal health services. Additionally, gender inequality in education and employment limits women's financial independence, making it difficult for them to afford quality maternal healthcare services.

Delay	Intervention	Responsible Stakeholders	Expected Outcome	Timeline for Implementation
Delay in Seeking Appropriate Medical Care	1. Conduct awareness campaigns on maternal health and danger signs.	State Ministry of Health, NGOs, Community Health Workers	Increased community awareness and early healthcare seeking.	Ongoing (Quarterly campaigns)
	2. Train community health workers to identify danger signs and educate women.	State Ministry of Health, Training Institutions	Empowered community health workers are able to guide women effectively.	6 months to 1 year
	3. Strengthen health insurance schemes to reduce financial barriers.	State Ministry of Health, Private Insurers	Reduced financial barriers for maternal healthcare access.	1 year
Delay in Reaching an Appropriate Health Facility	1. Improve road infrastructure to increase access to health centres in rural areas.	State Ministry of Works, Local Government Authorities	Improved access to health facilities, especially in rural areas.	1-3 years
	2. Provide subsidized or free transportation for pregnant women in remote areas.	State Ministry of Health, Local Transport Agencies	Reduced delays in reaching health facilities for care.	6 months
	3. Create a mobile health unit for remote areas.	State Ministry of Health, NGOs, Local Health Authorities	Increased healthcare access in hard-to-reach areas.	1 year

Delay in Receiving Adequate Care at the Facility	1. Increase the recruitment and training of skilled health personnel.	State Ministry of Health, Training Institutions	Improved quality of maternal healthcare at health facilities.	1-2 years
	2. Improve healthcare facility infrastructure and supply chains.	State Ministry of Health, Donors, Local Governments	Well-equipped and functional healthcare facilities.	1-2 years
	3. Strengthen referral and admission systems to reduce waiting times.	State Ministry of Health, Healthcare Facilities	Streamlined care delivery and reduced delays at facilities.	6 months
Delay in Taking Responsibility for Maternal Deaths	1. Strengthen Maternal Death Surveillance and Response (MDSR) system.	State Ministry of Health, Local Health Authorities	More responsive and proactive health systems.	6 months
	2. Implement accountability frameworks and regular audits of maternal deaths.	State Ministry of Health, Civil Society Organizations	Improved learning from maternal deaths to prevent future occurrences.	6 months to 1 year
	3. Establish a state-level coordination committee for maternal health programs.	State Ministry of Health, Local Governments, Donors	Coordinated and harmonized maternal health interventions.	6 months to 1 year
Delay in Coordination of Interventions	1. Establish clear roles and responsibilities among stakeholders at the state level.	State Ministry of Health, Local Governments, NGOs	Better coordination and efficient use of resources.	6 months
	2. Develop a unified results framework to guide maternal health programming.	State Ministry of Health, Donors, Technical Partners	Alignment and coherence of maternal health interventions.	6 months
	3. Foster multisectoral partnerships, involving sectors like education, transport, and water.	State Ministry of Health, State Ministries (Education, Water, Transport)	Broader approach to maternal health, addressing underlying factors.	1 year

Table 3.1: Intervention plan designed to address the delays

CHAPTER FOUR

Repositioning Maternal and Child Care Using MAMII

4. Repositioning Maternal and Newborn Care Using MAMII

4.1 MAMII's Theory of Change

The Maternal and Newborn Health Innovation Initiative (MAMII) Theory of Change offers a strategic blueprint for reducing maternal mortality in Nigeria, with a targeted focus on 172 high-burden LGAs.

The framework begins with foundational inputs, including funding from the Nigerian government and development partners, alongside technical assistance. These resources support key interventions across several areas: community engagement (e.g., training community health workers), access improvements (e.g., transport schemes), facility upgrades (e.g., better equipment), and strengthened data systems through digital tracking and reporting.

These efforts are designed to yield tangible outputs such as trained health personnel, increased maternal and neonatal health awareness, enhanced facility readiness, and wider adoption of mobile health solutions. These outputs are expected to drive key outcomes, including higher antenatal care (ANC) attendance, more facility-based deliveries, timely access to skilled birth attendants, reduced financial barriers, and improved data-informed decision-making.

Together, these outcomes contribute to the ultimate impact: reduced maternal and neonatal mortality, improved community trust, equitable access to care, and a more responsive and coordinated health system. The success of this model depends on key assumptions—chiefly, sustained political will and reliable digital infrastructure.

MAMII's overall goal: to crash maternal mortality rate by 30% and neonatal rate by 20% by 2027

Specific objectives include:

- Improve access to MNH services by 80% across MAMII LGAs by 2027. Improve quality MNH service utilization by 60% across MAMII LGAs by 2027. Improve coordination and alignment among relevant agencies and partners. MAMII is structured around the Sector-Wide Approach (SWAp) principles, ensuring alignment with national and state health strategies while fostering coordinated action among government agencies, development partners, and community stakeholders. The initiative aims to achieve 50% rollout across the 172 priority local government areas (LGAs) by December 2025. These LGAs contribute 55% of the national maternal mortality burden and 18% of under-five mortality (NDHS 2018).

Prior to MAMII's launch, extensive data analytics and maternal and neonatal health assessments were conducted to identify intervention priority areas. The findings highlighted 172 high-burden LGAs across Nigeria's six geopolitical zones:

- 51 LGAs in the Northeast
- 66 LGAs in the Northwest
- 11 LGAs in the North-Central
- 13 LGAs in the Southeast
- 19 LGAs in the South-South
- 12 LGAs in the Southwest

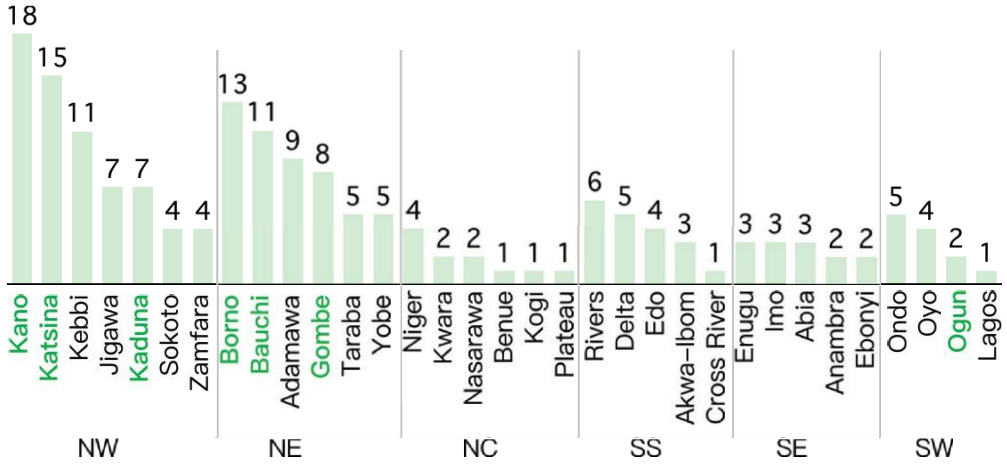


Fig. 4.1 Distribution of LGAs that contributed to the 55% of MMR in Nigeria

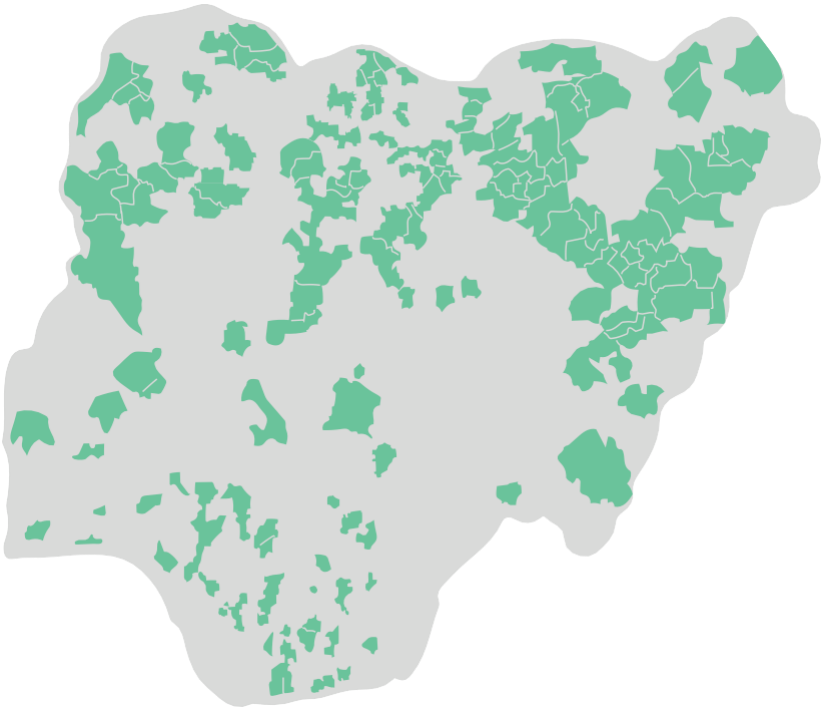


Fig. 4.2 Geospatial representation of LGAs that contributed to the 55% of MMR in Nigeria

The assessments revealed systemic challenges such as facility readiness gaps, quality of care deficiencies, geographic and financial barriers, and socio-cultural influences on maternalhealth-seeking behaviours. MAMII directly addresses these issues through tailored intervention suites, ensuring a comprehensive, sustainable, and high-impact response to maternal and neonatal mortality reduction in Nigeria.

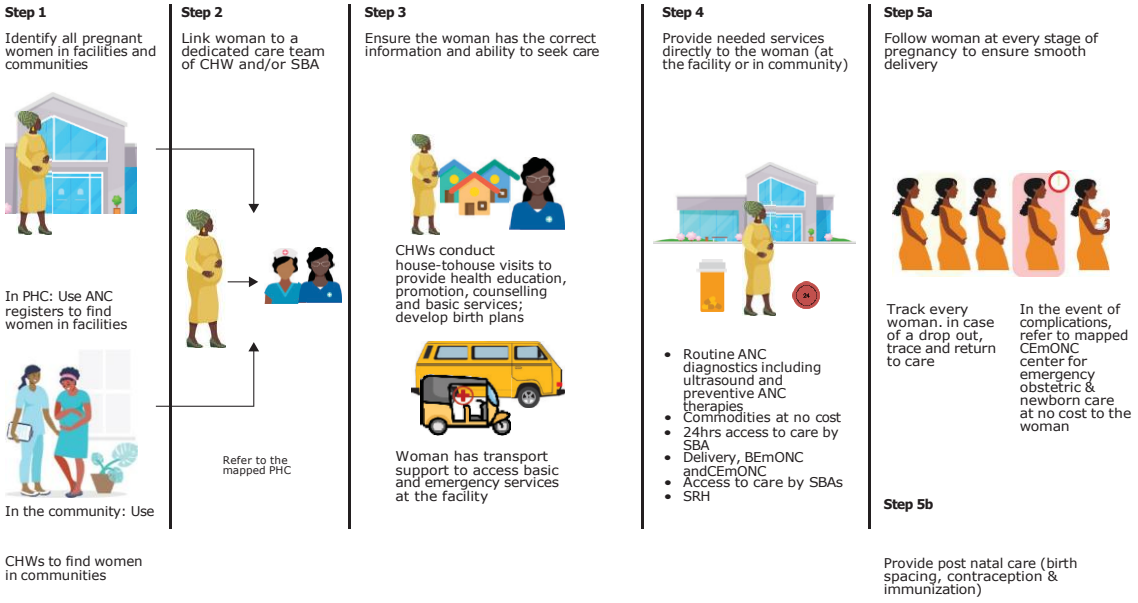


Fig 4.3 MAMII strategy to crashing maternal mortality in Nigeria

Focus		Opportunities
Demand & Access		Access to information: Leverage community institutions to ensure women have access to information on health services, how to access the services with messaging tailored to local beliefs and norms Ability to pay: Ensure women have access to health insurance (via NHIA) to increase ability to pay Access to facilities: Provide affordable services to take women from their homes to facilities for ANC and Delivery in the case of emergency (emergency transport)
Supply	Service Optimization	Line list pregnant women in facilities and minimize drop offs between pregnancy to childbirth to ensure safe delivery Line list pregnant women in communities and ensure they get access to skilled care either in facility and/or in community Strengthen community institutions and facilities to identify, record and determine cause of death
	Facility Revitalization	Provide 24/7 power supply at PHC facilities and close infrastructure gaps and equip facilities Empanel CEmONC sites for referrals for emergency obstetric care
	Human Resources	Recruit, train and deploy skilled birth attendants (midwives, nurses, and CHEWs) to ensure facilities have at least 4 Recruit, train and deploy Community based health workers to provide a range of services in community including referrals
	Commodities	Provide maternal and newborn commodities including MNH Innovations (PPH bundles, Calibrated drapes, MMS) at no cost to the woman
Enablers	M&E	Assess performance using mini DHS
	Financing	Disburse performance linked funding to PHCs as part of BHCPF 2.0

Fig 4.4 MAMII Program Opportunities

This framework underscores MAMII's integrated, data-driven, and community-focused approach to maternal and newborn mortality reduction in Nigeria.

Component	Key Functions	Key Actors
1. Access Interventions	- Remove financial barriers through insurance - Enable emergency evacuation - Ensure climate and BEmONC/CEmONC readiness - Build emergency transport systems	Government (NHIS, LGAs), Health Facilities, Emergency Services
2. Community Programming	- Conduct health literacy campaigns - Deploy CHWs and incentivize TBAs - Link communities to facilities - Support risk stratification and transport	CHWs, TBAs, Community Leaders, Ward Development Committees, NGOs

3. Health Facility Programming	- Conduct outreach and demand creation - Ensure staff training and protocol standardization - Maintain commodity supply - Strengthen referrals	Facility Managers, State MoH, Facility Staff, Professional Associations
4. Data & Governance	- Use MPCDSR and scorecards for learning - Identify underserved areas using CBHMIS - Improve accountability and tracking systems	SMoH, NPHCDA, M&E Units, Development Partners
5. Digital Technology	- Send SMS/USSD reminders - Use chatbots and profiling tools - Coordinate transport and referrals digitally - Provide telemedicine support	HealthTech Providers, MoH ICT Units, Telecom Operators
6. Strategic Communications	- Launch mass/social media campaigns - Drive care-seeking behavior	MoH Comms Teams, Civil Society, Media Agencies, Religious & Traditional Leaders
7. Incentives	- Provide financial and non-financial incentives - Motivate CHWs, TBAs, and health workers - Improve service quality and referral rates	LGAs, MoH, Development Partners, Community Influencers
8. Learning & Implementation Science	- Document and codify lessons - Track implementation environment - Generate evidence for policy and scale-up	Researchers, Academia, Program Managers, Donors

Table 4.1 MAMII Key Actors' Network

4.2 MAMII's Core Strategy: Context-Specific Co-Creation

The Maternal and Newborn Mortality Reduction Initiative (MAMII) is built on a context-specific, co-creation approach that ensures interventions are locally driven, evidence-based, and sustainable. Unlike traditional top- down programs, MAMII is not a 'done-for-you' initiative but a 'done-with- you' strategy, designed to significantly reduce maternal and neonatal mortality with a heightened focus on high-burden states and LGAs.

At the heart of MAMII's approach is co-creation, a collaborative process that brings together government agencies, healthcare providers, local communities, NGOs, and private sector partners to jointly design and implement tailored solutions. This inclusive and participatory model ensures that interventions are culturally relevant, responsive to state-specific challenges, and integrated into existing health structures.

By actively engaging all stakeholders in the planning, decision-making, and implementation phases, MAMII fosters ownership, encourages innovation, and enhances the effectiveness of maternal and neonatal health interventions. This approach not only ensures the long-term sustainability of interventions but also maximizes their impact, leading to meaningful reductions in maternal and newborn mortality across Nigeria.

MAMII's co-creation process is structured into three distinct yet interconnected phases, each comprising specific, well-defined activities that collectively drive the successful design and implementation of maternal and neonatal health innovative interventions.

1. Pre-Co-Creation workshop Phase
2. During Co-Creation workshop Phase
3. Post Co-Creation workshop Phase

Each phase consists of clear activities to ensure the seamless design, adoption, and implementation of tailored maternal and neonatal health interventions

4.2.1 Pre-Co-Creation Workshop Phase

This phase focuses on preparatory activities ahead of the co-creation workshop. It ensures

that all necessary stakeholders are engaged and logistical requirements are in place. Key activities should include:

1. Pre-Co-Creation Phase

Components	Objective	Key Activities	Expected Outcomes
1 State Engagement	Ensure state ownership and high-level commitment	●Advocacy visits, ●Stakeholder mapping ●strategic sessions, ●MoU development, ●community leader engagement	State buy-in, policy support, grassroots involvement
MAMII Partners' Forum	Partner support and resource mobilization	stakeholder meeting, ●intervention mapping, ●TWG setup, ●communication strategy	Aligned partner support, technical synergy, ongoing dialogue
3 Analysis of State AOP	Align MAMII with existing plans	●Identify MNH gaps, ●assess previous programs, ●align budgets	Integrated planning, gap closure
4 Logistics & Planning	Ensure seamless workshop organization	●Venue, ●logistics, ●material preparation	Workshop readiness
5 Identification of Focal Persons	Assign key actors for coordination	●Appoint state and ●community reps	

4.2.1.1 During Co-Creation Phase

This phase is the core of MAMII's strategy development process. It involves hosting the co-creation workshop where stakeholders collaboratively design tailored interventions.

Objective: The co-creation workshop serves as the core platform for designing MAMII interventions at state level, ensuring that program strategies are evidence-based, context- specific, and community-driven. It leverages available data, insights from field visits, and stakeholder expertise to develop actionable maternal and neonatal health interventions tailored to the focus state.

Key Activities

4.2.1.1 a Hosting the Co-Creation Workshop

- Official opening with keynote speeches from the State Commissioner for Health and MAMII Lead.
- Presentation of state-specific maternal health data, challenges, and opportunities.
- Breakout sessions for group discussions and brainstorming.
- Interactive sessions where community representatives share on-the-ground maternal health experiences.
- Facilitation of discussions on gender-sensitive interventions and cultural practices affecting maternal health.

4.2.1.1 b Facilitating Workshop Activities

- Establish clear role assignments among participants (e.g., moderators, facilitators, and rapporteurs).
- Ensure effective coordination of presentations, field visits, and group work.
- Guide the development of evidence-based, culturally relevant maternal health interventions.
- Document stakeholder commitments and resource allocations.
- Use real-life case studies to generate practical solutions to identified challenges.

4.2.1.1 c Conducting Field Visits

Objective:

The primary objective of field visits is to conduct deep dives into the drivers of maternal mortality in the focus state through verbal and social autopsies. These visits will provide critical insights into maternal deaths by identifying key delays and systemic gaps, ensuring that MAMII interventions are context-specific and data-driven.

i. Organizing Site Visits

- Identify high-burden LGAs and facilities (PHCs, referral hospitals, and community birthing homes) where maternal deaths have been recorded.
- Develop a visit schedule in coordination with the State Ministry of Health (SMoH), State Primary Healthcare Board (SPHCB), and LGHAs.
- Engage health facility managers, frontline health workers, and community representatives to facilitate access and information-sharing.

ii. Conducting Verbal and Social Autopsies

- Verbal Autopsy:
  - Interview family members and caregivers of deceased mothers to understand the sequence of events leading to maternal death.
  - Document delays in seeking care, reaching care, and receiving quality care at health facilities.
  - Identify social, cultural, and financial factors that influenced health-seeking behaviour.
- Social Autopsy:
  - Conduct community-based discussions with traditional rulers, religious leaders, TBAs, and women's groups to gather collective insights on maternal deaths.
  - Analyze community perceptions of maternal healthcare, including trust in health facilities, common birth practices, and emergency response challenges.
  - Identify community-driven solutions that could enhance maternal health outcomes.

iii. Identifying Key Systemic Barriers

- Assess accessibility of healthcare services, including distance to facilities and emergency transport availability.
- Examine health facility readiness, particularly the availability of skilled birth attendants, essential medicines, and emergency obstetric care.
- Evaluate the effectiveness of the referral system between PHCs and referral hospitals.

iv. Documentation and Reporting

- Compile case-specific findings on maternal deaths and categorize them under the five-delay model:
  1. Delay in seeking care (awareness, cultural beliefs, financial constraints).
  2. Delay in reaching care (transport, geography, road conditions).
  3. Delay in receiving care (health facility preparedness, staffing, medical supplies).
  4. Delay in taking responsibility for maternal deaths (accountability and quality

improvement mechanisms).

5. Delay in coordinating interventions for effective response (fragmentation of maternal health programs).

- Each team should given time at a plenary session to present their findings.
- Collate field findings to inform intervention designs.

By systematically conducting these field visits, MAMII ensures that maternal health interventions are based on real-life challenges and community realities, making the initiative more effective and impactful.

4.2.1.1 d Intervention Design

Intervention design should be guided by the MAMII framework, ensuring that all strategies are holistic, evidence-based, and aligned with the broader health system approach. Interventions must be structured under the following key pillars:

- Community Programming & Innovation – Strengthening community-led initiatives, increasing health literacy, and integrating traditional birth attendants (TBAs) into the formal health system.
- Access Interventions – Addressing financial, geographic, and socio-cultural barriers to maternal healthcare, including emergency transport systems and health insurance coverage.
- Health Facility Programming & Innovation – Enhancing service delivery at PHCs and referral hospitals through staffing, infrastructure improvements, and capacity building for healthcare workers.
- Data & Governance Interventions – Improving accountability, data systems, and maternal death surveillance to drive informed decision-making and policy adjustments.
- Enablers – Leveraging technology, partnerships, and incentives to enhance the efficiency and sustainability of maternal health interventions.
- Aligning Management with the Sector-Wide Approach (SWAp) – Ensuring coordination across government agencies, development partners, and community structures for unified planning, resource allocation, and program execution.

i. Evidence-Based Intervention Design

- Present findings from maternal mortality data analytics, verbal and social autopsies, and facility assessments conducted in the focus state.
- Review key drivers of maternal mortality identified during field visits, categorized under the five-delay model (seeking, reaching, receiving care, accountability, and coordination).
- Align with existing state health policies and programs to avoid duplication and enhance integration.
- Engage technical experts, policymakers, and health system managers to validate and refine proposed interventions.

ii. Designing Tailored Maternal Health Interventions

- Develop intervention prototypes that address service delivery gaps, community health behaviours, and systemic challenges in the focus state.
- Categorize interventions into:

- Community-Led Solutions (health education, male engagement, traditional birth attendant integration).
- Health Facility Strengthening (staffing, equipment, emergency transport).
- Governance and Accountability (data systems, referral tracking, maternal death reviews).
- Financing and Sustainability (health insurance, donor partnerships, public-private collaboration).

- Establish a multi-stakeholder technical working group (TWG) to oversee intervention implementation and adaptation.

4.2.1.1 e Documentation and Next Steps

- Consolidate workshop outcomes into a MAMII intervention blueprint for the focus state.
- Develop a timeline and action plan for piloting and scaling interventions.
- Assign responsibilities to key actors, including government agencies, development partners, and community stakeholders.
- Schedule periodic review meetings to assess implementation progress and make necessary adjustments.

4.2.1.1 f Documentation of Workshop Proceedings

- Assign a documentation team to record all discussions, recommendations, and resolutions.
- Compile a co-creation report detailing key interventions and action plans.
- Validate the report with stakeholders before finalization.
- Disseminate findings through digital platforms and print media to ensure transparency.

4.2.1.1g Establishment of State MAMII Task Force

The State MAMII Task Force is a multi-stakeholder coordination and execution platform responsible for leading the implementation of MAMII interventions across prioritized LGAs. It brings together key actors from the health sector and beyond—including SMOH, SPHCDA, SEMSAS, SHIA, LGHAs, development partners, and non-health stakeholders—to ensure the successful roll-out and scale-up of MAMII.

i. Composition

The Task Force should include senior representatives from the following bodies:

1. State Ministry of Health (SMOH)
2. State Primary Health Care Development Agency (SPHCDA)
3. State Emergency Medical Services and Ambulance System (SEMSAS)
4. State Health Insurance Agency (SHIA)
5. Local Government Health Authorities (LGHAs)
6. Development Partners
7. Civil Society Organizations
8. Traditional and Religious Leaders
9. Relevant Non-Health Ministries and Agencies

ii. Key Responsibilities and Functions

S/N	Focus Area	Key Tasks/Steps
1	Program Management & Execution	• Lead day-to-day execution of MAMII across facilities and communities in priority LGAs. • Conduct line-listing of pregnant women. • Train and upskill SBAs, CHEWs, and CHWs. • Adapt service delivery models to ensure access to skilled care including referral to CEmONC sites. • Drive maternal and neonatal health commodity distribution. • Implement MPCDSR, track women's maternal journey, and coordinate state-level stakeholders.
2	Stakeholder Coordination	• Serve as the primary point of contact for MAMII in the state. • Establish or strengthen coordination platforms between state, LGA, PHC, and community stakeholders. • Hold weekly review/problem-solving sessions. • Institute accountability mechanisms, including reward and sanction systems per civil service rules.
3	Monitoring, Evaluation & Reporting	• Track progress on MAMII KPIs. • Monitor overall program implementation. • Implement accountability tools and performance reviews.
4	Capacity Building	• Collate training needs for health workers and CHWs. • Organize training sessions and continuous mentoring on maternal and child health service delivery.
5	Resource Management	• Oversee procurement and distribution of digital tools, maternal and neonatal commodities, and equipment.
6	Community Engagement & Advocacy	• Develop locally tailored interventions to address cultural and belief-based barriers. • Lead advocacy (in collaboration with the Commissioner for Health) to secure funding and political support for MAMII.

iii. Reporting Structure

The Task Force shall report to the State Honourable Commissioner for Health, with periodic briefings to the SCO National Program Coordinator to ensure alignment with national objectives and escalation of systemic issues requiring federal support.

POST-CO-CREATION WORKSHOP PHASE		
Objective: Transition to implementation and monitoring.		
Activity	Sub-Activities	Expected Outcomes
Retrofit into AOP	- Integrate interventions into state health plans	Sustainable alignment with state systems; unified resource allocation.
	- Adopt "One Plan" approach	
Funding Gap Analysis	- Match resources to priorities	Transparent financing; gaps addressed through collaboration.
	- Identify state/partner funding streams (• State-funded, • Partner-funded, • SWAp)	
Work Plan Development and Implementation	Define activities	Clear timeline with dependencies; visual progress tracking.
	Define time lines	
	Identify responsible actors	
	Costing	
Implementation Tracking	- Set up M&E system	Accountability; adaptive management for continuous improvement.
	- Regular progress reviews	

RETROFITTING IN MAMII

MAMII retrofitting refers to the systematic integration of newly designed MAMII interventions into existing state health plans and policies, ensuring seamless alignment with the Annual Operational Plan (AOP). This process is grounded in the One-Plan principle of the Sector-Wide Approach (SWAp) Strategy, fostering a coordinated, efficient, and unified implementation framework under the Federal Government's health sector strategy.

4.2.2 Intervention - Funding Gap Analysis (FGA) and Realistic Resource Allocation

Identify gaps between state-planned maternal and neonatal health interventions and MAMII's co-created interventions.

CONDUCTING INTERVENTION-FUNDING GAP ANALYSIS

A Funding Gap Analysis is a systematic approach to identifying financial shortfalls in maternal and newborn health interventions, ensuring that resource mobilization efforts are strategically targeted. The process involves:

1. Identifying Total Financial Need
    - Review the Annual Operational Plan (AOP), which includes both state-planned maternal and neonatal health interventions and newly integrated MAMII interventions.
    - Establish the total financial requirement for implementing all planned interventions for the fiscal year.
2. Determining Existing Funding Contributions
    - Sum up the State Government-funded interventions (SGF) based on the state health budget.
    - Identify and quantify partner-funded interventions (PFI), including contributions from NGOs, donor agencies, and private sector partners.
3. Calculating the Funding Gap (FG)

The funding gap (FG) is calculated as follows:

$FG = AOPi - (GFi+PFi)$

Where:

- FG = Funding Gap
- AOPi = Total number of interventions planned in the AOP (including retrofitted MAMII interventions)
- GFi = Government-Funded Interventions
- PFi = Partner-Funded Interventions

4. Interpreting the Funding Gap
    - A positive FG value indicates a shortfall in funding, necessitating resource mobilization from additional sources.
    - A zero or negative FG value suggests that all interventions have been sufficiently funded.

ii. Conduct a Realistic Resource Allocation (RRA) exercise based on available budget.

REALISTIC RESOURCE ALLOCATION (RRA)

Realistic Resource Allocation (RRA) is a budgeting and planning approach that ensures the optimal use of available resources by aligning financial commitments with prioritized interventions. In the context of MAMII, conducting an RRA exercise involves:

- Assessing Available Funds – Reviewing the state budget, partner contributions, and donor funding to determine the actual financial resources available for maternal and neonatal health interventions.
- Determining the available budget for Maternal and child health for the fiscal year from the state
- Realign Partners plans and budget – The state should engage with partners to ascertain their plan for the fiscal year and determine which interventions they intend to fund from the state AOP (engagement with partners should be based on the AOP version that has MAMII interventions retrofitted).
- Prioritizing Interventions – Identifying high-impact, cost-effective maternal and newborn health interventions that the state can realistically fund given the limit of available budget for the year after eliminating interventions that partners intend to fund from the list interventions in the AOP.

NOTE: It is crucial for the state to allow partners to select their activities first before finalizing the state-funded interventions list. This approach is recommended because partners often operate within fixed donor mandates and pre- approved implementation plans, which may limit their flexibility in adjusting priorities. By allowing partners to take the lead in choosing their interventions, the state can:

- Maximize Partner Contributions – Ensuring that partners fully commit their available resources to maternal and neonatal health interventions within their scope.
- Avoid Redundancy – Preventing duplication of efforts and ensuring a complementary distribution of interventions between state and partner-funded activities.
- Enhance Resource Efficiency – Allowing the state to strategically allocate its resources to fill critical gaps left by partners, leading to a more balanced and comprehensive intervention plan.

By following this structured approach, the state can optimize collaboration, ensure alignment with donor requirements, and enhance the overall impact of maternal and newborn health programs under MAMII.

- Strategic Allocation – Distributing state budget based on urgency, feasibility, and alignment with state health goals, ensuring essential services receive adequate funding based on what the state budget can realistically fund.
- Monitoring and Adjustments – Regularly tracking expenditures and intervention effectiveness to make real-time adjustments for efficiency and sustainability.

This approach ensures that funding is directed where it has the greatest impact, maximizing the effectiveness of maternal health interventions under MAMII.

iii. Addressing Funding Gaps Identified by States Under MAMII - Resource Mobilisation

Once a funding gap is identified through the Intervention-Funding Gap Analysis, states are responsible for mobilizing additional resources in collaboration with key stakeholders. The

approach includes the following steps:

1. Engaging the SWAp Office and Federal MDAs
    - States must work closely with the Sector-Wide Approach (SWAp) office and relevant Federal Ministries, Departments, and Agencies (MDAs) to explore available funding opportunities.
2. Strengthening Resource Mobilization Strategies
    - Advocacy & Policy Engagement: Engage state policymakers, legislators, and budget officers to secure increased allocations for maternal and newborn health interventions in subsequent budget cycles.
    - Public-Private Partnerships (PPPs): Partner with corporate organizations, private healthcare investors, and philanthropic foundations to secure additional funding.
    - Development Partner Engagement: Leverage partnerships with international donors, NGOs, and bilateral/multilateral agencies to close financial gaps through grants and technical assistance.
    - Community-Based Resource Mobilization: Encourage local funding initiatives, such as community health trusts and corporate social responsibility (CSR) contributions from local businesses.
3. Aligning Funding Efforts with National Health Priorities
    - Ensure that additional resources are channelled in line with the One Plan principle under the SWAp framework, avoiding duplication of efforts.
    - Align state maternal health funding requests with national maternal and child health priorities to enhance eligibility for federal grants and funding streams.
4. Tracking and Accountability for Mobilized Funds
    - Establish transparent financial tracking mechanisms in accordance with the agreed standards to monitor how mobilized funds are allocated and utilized.
    - Strengthen reporting structures to ensure that all funds are accounted for and used effectively for their intended purpose.

By actively mobilizing resources in partnership with the SWAp office and Federal MDAs, states can bridge funding gaps under MAMII, ensuring that critical maternal and newborn health interventions are implemented effectively and sustainably.

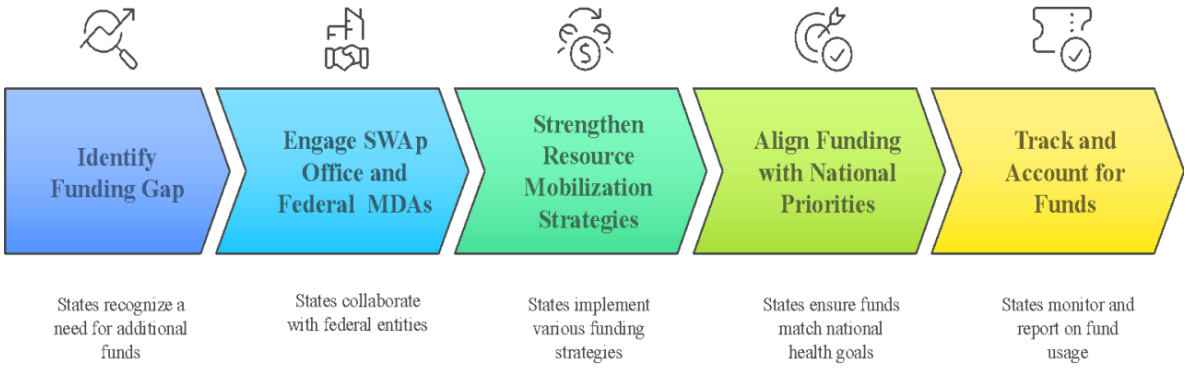


Fig 4.5 Resource Mobilization Process for Maternal Health

4.2.3 Implementation/Work Plan Development

- Stage 1: Define the Project Scope & Objectives
    - Clearly outline what MAMII aims to achieve in the state.
    - Identify key deliverables, milestones, and timelines.
- Stage 2: List all interventions from the AOP including the retrofitted interventions from MAMII co-creation workshop
    - Categorize interventions as follows:
    - Category A = Interventions to be funded by the state budget.
    - Category B = Interventions to be funded by partners.
    - Category C = Interventions to be resourced (through collaboration with SWAp and Federal MDAs.)
- Stage 3: Establish Intervention Dependencies
    - Identify which interventions depend on others before they can start (e.g., intervention B starts only after intervention A is completed).
    - Use Finish-to-Start (FS), Start-to-Start (SS), Finish-to-Finish (FF), or Start-to-Finish (SF) relationships.
- Stage 4: Assign Duration to Each intervention
    - Estimate the time required to complete each intervention (days, weeks, or months or ongoing).
    - Consider factors like resource availability and potential delays.
    - Based on dependencies and durations, set the start and end dates for each intervention.
    - Ensure logical sequencing to avoid overlap, duplication, or unnecessary delays.
- Stage 5: Create a Gantt Chart to illustrate interventions, timeliness, and responsible parties.
    - Step 1: Display tasks as horizontal bars, with lengths representing durations as follows:
        - Green Line: Funded by the state budget.
        - Blue Line: Funded by partners.
        - Red Line: To be resourced through collaboration with SWAp and Federal MDAs.
        - Show dependencies with arrows or connectors.
        - Allocate people or organisations/partners, equipment, and budget to interventions
    - Step 2: Mark key dates or achievements (e.g., project kick-off, phase completion, approvals)

4.2.4 Implementation Tracking System

- Step 1: Develop a robust system for monitoring and evaluating the implementation of interventions.
- Step 2: Regularly update stakeholders on progress and challenges.

4.2.5 Cross-Cutting Activities

- Documentation: MAMII is a new initiative with significant learning opportunities that

can inform future implementations. Therefore, it is essential for implementing states to ensure comprehensive documentation across all phases. This includes maintaining detailed records of meetings, decisions, actions taken, and key lessons learned. Proper documentation will not only support continuous improvement and knowledge sharing but also enhance accountability, transparency, and the ability to scale successful interventions effectively.

- Communication: Maintain open lines of communication with all stakeholders to foster collaboration and trust.
- Develop a reporting template or use reporting template provided by SWAp Coordinating Office (SCO) for periodic updates to MAMII's national coordination office.
- Set up a state-level MAMII dashboard for real-time intervention and result tracking.
- Feedback Loops: Establish mechanisms for continuous feedback to refine strategies and improve outcomes.

CHAPTER FIVE

Institutional and Financing Arrangements for MAMII

5. Institutional and Financing Arrangement for MAMII

The MAMII institutional arrangements are aligned to the Basic Healthcare Provision Program (BHCPP) relying on the broader Nigeria Health Sector Renewal Investment Initiative (NHSRII). The MAMII governance and accountability system specifically addresses the key challenges with crashing maternal mortality and identifies key responsible MDAs for their resolution.

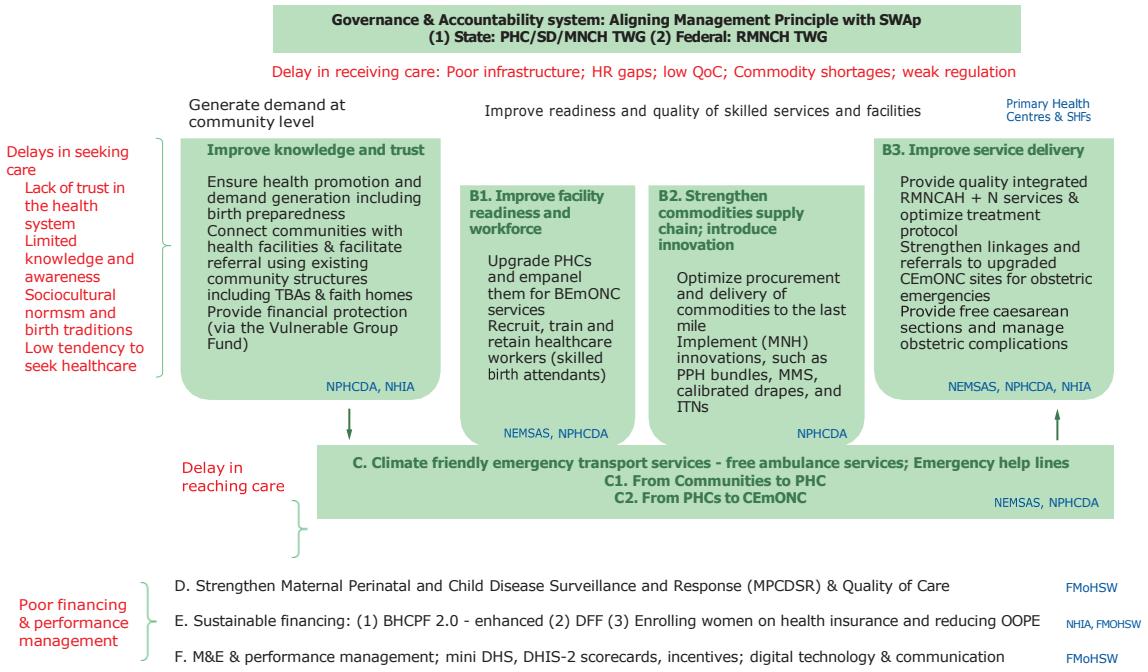


Fig 5.1 MAMII Governance and Accountability System

The MAMII program implementation is informed by the following principles:

- National and state-level priorities for improved maternal and child health outcomes as reflected in the Annual Operational Plans (AOP)
- Support an ambitious, expansive, and fundamentally new approach to crashing maternal and newborn mortality
- Leverage on existing institutions and the immediate need to strengthen them
- Recognize the complexity of Nigeria's federal context, which presents unique challenges concerning the allocation of roles and responsibilities in the health sector
- Incorporate lessons from previous and current health system strengthening reform efforts to inform innovation

5.1. Governance and Coordination Mechanism

The Government of Nigeria is adopting a sector-wide approach to implement the Nigeria Health Sector Renewal Investment Initiative (NHSRII) in its totality including MAMII, requiring all stakeholders to contribute to improving citizens' health by aligning with one national plan, one national budget and one set of results. The implementation and governance arrangement is presented in the schema below (refer to HOPE PHC POM for additional information)

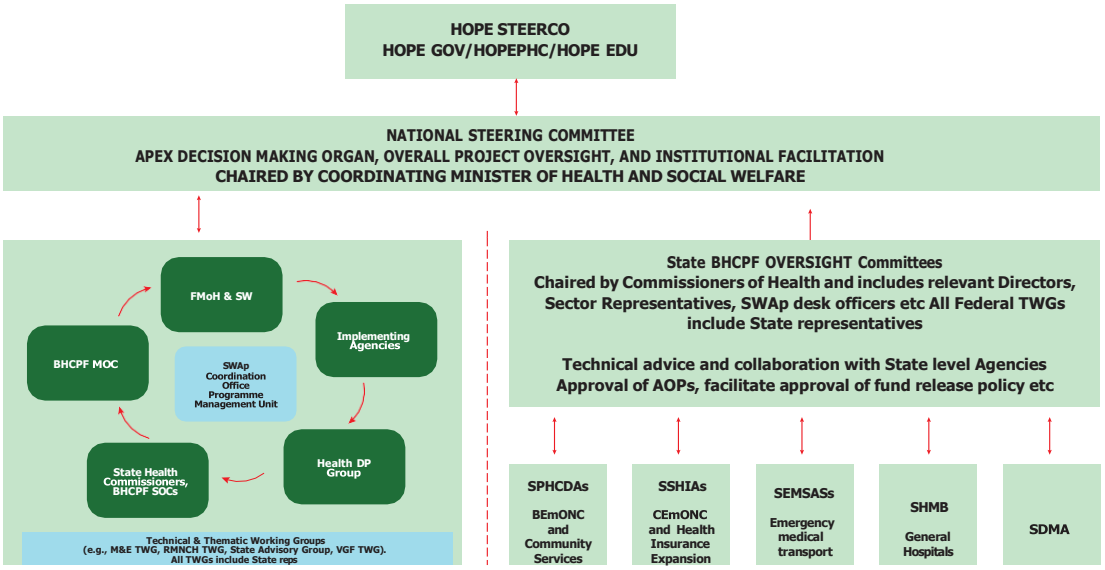


Fig. 5.2 MAMII Implementation and Governance Arrangement

RESPONSIBLE ENTITY	COMPOSITION	ROLES AND RESPONSIBILITIES	ACCOUNTABILITIES
NATIONAL STEERING COMMITTEE (NSC) "Joint inter-ministerial steering committee at the federal level {the "National Steering Committee" (NSC)}	• Co-chaired by Coordinating Minister of Health & Social Welfare, Minister of Budget & Economic Planning, and Minister of Education. • Also include the minister responsible for finance and any other relevant ministries, departments, agencies, and organizations as decided by the co-chairs.	• Responsible for providing high-level guidance, advice, and strategic oversight on the HOPE series of operations, with functions as further detailed in the Operations Manual. • Guardian of rules for the HOPE SOP. • Adoption of government-wide Human Capital Development (HCD) policies. • Setting and achieving of HCD reforms agenda.	• Realization of HOPE Standard Operating Procedures (ISOPs) contribution to the HCD vision of the Government of Nigeria.
NATIONAL SWAP STEERING COMMITTEE "Steering committee at the federal level (the National SWAp Steering Committee, NSC) responsible for providing strategic sectoral oversigh	• NSC will be chaired by the Coordinating Minister of Health and Social Welfare (CMHSW) Members shall comprise the following: • the Honourable Minister of State for Health (HMSH), • the Permanent Secretary for Health (PSH), • Representatives of Ministry of Finance & Ministry of Budget and Economic Planning, • Relevant heads of agencies of the FMOH&SW (NPHCDA, NHIA, NCDC, Secretary BHCPF Ministerial Oversight Committee (MOC), Chair NEMT),	A. PROGRAM OVERSIGHT AND POLICY GUIDANCE: a. Provide oversight and policy guidance for achieving NHSRII objectives b. Oversee program coordination and implementation progress of the SWAp NHSRII indicators c. Approve the annual work plans and procurement plans of the NHSRII Programs d. Review submissions/ requests from relevant stakeholders, e.g. from subnational entities and LGAs	• The investments and other project programs are aligned with national priorities and state demands as articulated in the NHSRII

	• Directors at the Federal Ministry of Health including family health, public health, planning, research, and statistics, hospital services, • Chair of the committee of health commissioners in the federation, • Representative of the SPHCDA/B, • Representative of the SSHIAs, • Members of the Development Partners Group for Health (DPG-Health) who have contributed financial resources to the SWAp • Others as nominated by the CMHSW. • The NPCU National Coordinator shall be the Secretary of the NSC	B. ADHERENCE TO SWAP Behaviours & TWG CODE OF CONDUCT: e. Oversee alignment to SWAp principles. f. Oversee governance charter of all TWGs, formalising their role and commitment as part of a SWAp TWGs g. Provide formal approval for changes in TWG mandate, TORs, or membership h. Review TWG attendance and progress against work plan output i. Review /approve content of TWG output to inform policy direction C. FINANCIAL / FIDUCIARY REVIEW AND MANAGEMENT: j. Provide approval for any budgetary and TA needs k. Review technical and financial/ audit performance	
SCO Coordination unit for the NHSRII operation	• A National Coordinator shall head the NPCU • Include specialists in program management, procurement, financial management, environmental and social matters, communications, and other specialists all with qualifications, experience and ethics, and subject to the terms of reference acceptable to the World Bank	• Day-to-day operations and overall coordination of the project • Planning, budgeting, and reporting. • Serving as the secretariat of the SWAp Steering Committee (SSC) • Monitoring and coordinating program implementation in line with guidance from the SSC • Implementing the project with responsibilities including but not limited to financial management, procurement, environmental and social, monitoring and evaluation, and communications	• Attaining the PDO-level and intermediate-level indicators
STATE BHCPF OVERSIGHT COMMITTEE. Based on a revised terms of reference and composition of the State BHCPF Oversight Committee (the State Oversight Committee or SOC) will accommodate membership from the State Ministry of Finance; Budget and Planning; office of the state accountant General and any other entity.	• Chaired by the Commissioner of Health responsible for the state health system and co-chaired by Commissioners of Finance and Budget & Planning • Membership includes technical experts from relevant state departments • Includes state-based DPG members • Meets at least quarterly	• Coordination between state government and SCO. • Technical approval for State AOPs. • Responsible for providing technical oversight and implementation monitoring to ensure that critical actions are on track towards the achieving of the DLIs in participating states as applicable, all as further specified in institutional arrangement section of the BHCPF manual • Day-to-day operations and overall coordination of the project • Planning, budgeting, and reporting	• Ensuring that the investments conform to national standards. • Monitoring and evaluation of project indicators

Table 5.1 Responsible Entities and their Roles and Responsibilities

5.2. Funding Mechanism

Technical assistance needs would be documented across the health sector, scopes of work developed for the technical assistance needs and presentations made to the Technical Advisory Committee. External development assistance in Nigeria has risen over the years, now accounting for about 10 percent of Nigeria's total health spending. However, its impact represents less than the sum of its contributions due to significant fragmentation, inefficiencies, and parallel procedures. There are many multilateral, bilateral, and philanthropic development partners in the health sector, with a complex array of inputs (financing, technical assistance (TA), and commodities), geographical distribution (focus states and federal government), sectoral priorities, and institutional arrangements (monitoring and evaluation (M&E) frameworks, financial management (FM) practices, and authorizing structures).

This fragmented approach has undermined the impact of this significant financing in the sector. Under the management of the SCO, a joint health development technical assistance fund (JHDTAF) will be hosted. The governance arrangement for JHDTAF is described in fig 5.3.

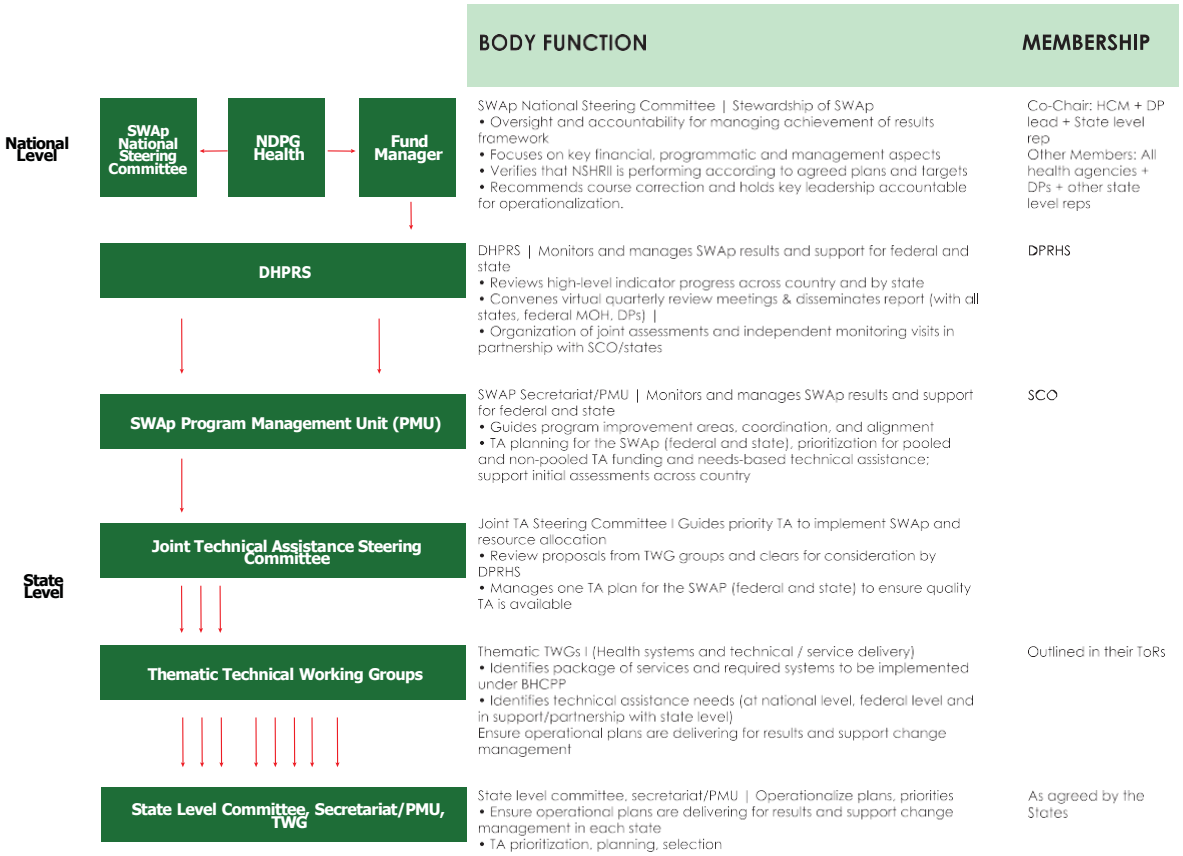


Fig. 5.3 Governance Arrangement for JHDTAF

Specifically, for the MAMII programs all partners are invited to contribute to the implementation support plans, taking into account the possible implementation support and financing arrangements described in the pooling options below.

Requests to the JHDTAF will cover the needs of all public health sector actors, including Federal Ministry of Health Directorates and Units, all Federal and National Agencies, and all States. Procedures will be established to:

- Set up databases of prospective TA to institutions defined under MAMII that are "pre-vetted" and can rapidly be deployed

- Determine eligibility criteria and other factors for "approval" of requests for support and the use of such resources
- Conduct performance monitoring and quality control of deployed technical assistance

5.3. Donor Coordination for MAMII

Currently, multiple development partners provide Technical Assistance (TA), but these efforts are uncoordinated. To enable faster deployment, greater transparency, and improved accountability, pooling or virtual alignment of technical assistance under the NHSRII will apply to the MAMII group of programs. This approach aims to harmonize technical assistance mechanisms and procedures, reducing fragmentation in externally funded development activities and minimizing the burden on health sector leadership and management.

The SCO National Steering Committee, under the leadership of the CMHSW, will mobilize all development partners (including those under the SWAp TWGs) on the opportunity to provide continuous implementation support in the context of the MAMII program in alignment with the overall pooling. The technical assistance will address the TA needs of national and subnational implementing entities to ensure alignment of efforts and the successful execution of all BHCPP/MAMII interventions.

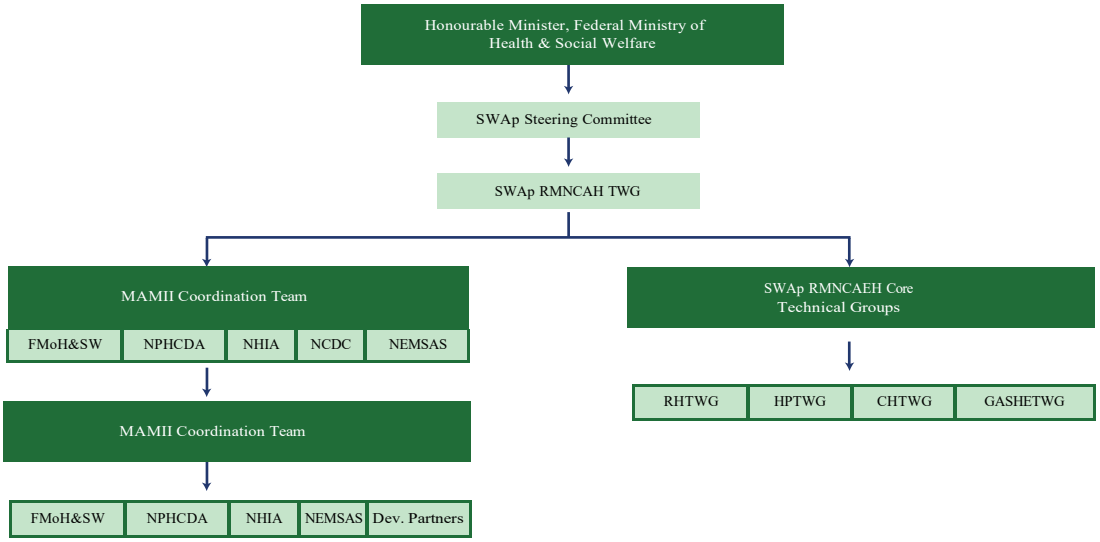


Fig. 5.4 Steering Committee for MAMII Program Approval and Funding

RHTWG - Reproductive Health Technical Working Group

HPTWG - Health Promotion Technical Working Group

CHTWG - Child Health Technical Working Group

GASHETWG - Gender, Adolescent, School Health and Elderly Technical Working Group

RMNCAEH - Reproductive, Maternal, Newborn, Child, Adolescent, and Elderly Health

The support provided through the pooled TA mechanism aims to facilitate coordination, monitor progress and outcomes, help identify and resolve roadblocks, strengthen performance management, improve equity, and enhance overall administrative efficiency for the NHSRII. In doing so, partners are invited to communicate interests and core areas of strength to provide implementation support. The SCO will collate all expressed interest, share this with the CMHSW, and publish a report of all expressed interest on its website every six months.

The SCO is also expected to develop an annual implementation support report on all activities implemented that year and how the health SWAp has aligned the sector resources with the NHSRII.

CHAPTER SIX

SWAp Coordination Office (SCO) Interventions for the MAMII LGAs

6. SWAp Coordination Office (SCO) Interventions for the MAMII LGAs

Under MAMII, the SWAp Coordination Office (SCO) in addition to being the secretariat will administer a couple of special interventions which do not directly fit under the purview of any MDA within the health system. These interventions will be coordinated and financed at the central level; however, they require significant State or LGA level operationalization. The interventions described in this guide are not exhaustive, and the SCO may design or develop new programs based on data/evidence-based feedback toward crashing the maternal mortality in Nigeria. The sub-sections of the chapter below describe some of the interventions which have been prioritized to be centrally managed at the SCO.

6.1 Priming the Pump: Incentivizing State-Led CEmONC Revitalization

Through the Sector-Wide Approach (SWAp), the government is incentivizing states to revitalize key health infrastructure. A primary focus of this initiative is the upgrade of secondary and tertiary health facilities to the standard of Comprehensive Emergency Obstetric and Neonatal Care (CEmONC). This revitalization is a cornerstone of the nation's renewed hope agenda, designed to restore public trust and foster cooperation between communities and the government by improving the function and performance of previously neglected facilities.

The SWAp Coordination Office (SCO) will collaborate with State Governments to prioritize one facility per Local Government Area (LGA) for CEmONC revitalization. This effort will concentrate on LGAs prioritized under the MAMII program, especially those with high poverty levels. The selection process is strategic, mapping facilities that can serve as the primary referral point for the Basic Emergency Obstetric and Neonatal Care (BEmONC) services offered at Primary Health Centers (PHCs). All upgrades will adhere to the Minimum Service Standards (MSS) for CEmONC care as defined by the National Health Insurance Authority (NHIA). (See Appendix … - Empanelment Criteria for CEmONC Facilities)

This initiative institutionalizes a robust, bottom-up referral system. The goal is to educate both health workers and the populace to view PHCs that provide BEmONC services as the first point of contact. CEmONC facilities are then reserved for complicated deliveries requiring services like caesarean sections or blood transfusions. This structured approach ensures patients receive care at the appropriate level, which improves triaging and prevents the overburdening of secondary and tertiary hospitals, leading to a more efficient and resilient health system.

The revitalization will involve practical steps, including the construction and equipping of the prioritized facilities to meet CEmONC standards. Essential medical supplies will also be provided to ensure these centers are immediately operational upon completion. By upgrading these crucial facilities and integrating them into a functional referral network, this effort aims to improve health outcomes and foster a positive, lasting change in how communities utilize health services.

NHIA CEmONC Facility Empanelment Criteria	
1. Identified as a potential facility for the program	All federal facilities, nominated state facilities, and private (+ faith based) facilities with high volumes of live births and maternal and neonatal deaths
2. Meets accreditation criteria	Provide full CEmONC signal functions; must have the necessary infrastructure, equipment, and supplies, including oxygen, adult resuscitation/CPR, and equipment for newborn care; skilled healthcare providers and trained support staff available 24/7;

3. Meets other empanelment requirements	Legal and administrative requirements operations; adherence to NHIA reporting standards; CQI efforts; Acceptance of NHIA rates and billing requirements; Ability to receive referrals or further refer patients; Geographic and physical accessibility; Data management system
4. Passes facility readiness assessment (FRA) conducted by NHIA	Validate the capacity to capture patient encounter and service delivery data; Demonstrates empanelment requirement during scoping visit
5. Completes MOU signing	MoU signing between the facility, TPA and NHIA

Table 6.1 NHIA CEmONC Facility Empanelment Criteria

6.2 Initiatives Addressing Social Factors Affecting Maternal and newborn Outcomes

Like other health indicators, maternal and newborn health outcomes are socio-culturally influenced by prevailing factors where the targeted populations exist. Such factors include gender inequality, cultural beliefs, poverty, and the lack of education. Part of the MAMII implementation activities aimed at reducing maternal mortality in such communities involves developing strategies to address these factors, turning them from barriers to opportunities. The SCO will support the funding of these programs from pooled grants, and the implementing entities will provide periodic reports documenting implementation progress and impact to the SCO. The underlisted initiatives will be developed with the NPHCDA and SPHCDAs to deploy following the operationalization of MAMII at the state level.

6.2.1 Programs Addressing Gender Inequality and Cultural Biases

Numerous localities across Nigeria remain traditionally patriarchal communities where women and girls are often dominated and discriminated against. In these societies, women are most times not permitted to partake in decision-making, especially on issues that affect them. The SCO will support States to launch local orientation and behavioral change campaigns to address issues and empower women by increasing their capacity to make decisions within their households and in the communities. States will be expected to develop proposals on planned campaigns with a clear implementation strategy, which will be submitted to the SCO for review.

Health education and promotive interventions for maternal and childcare will be encouraged. The SCO will consider activities that promote healthy pregnancy habits, as well as positive health-seeking behaviour in rural communities. Programs that address cultural biases, especially those that correct the perception of delivery through caesarean section as a taboo, will also be favored. States will be encouraged to incorporate TBAs into their advocacy programs, as they are often custodians of tradition and often closer to the populace. Approaches must acknowledge the cultural and social acceptability of their roles and encourage acceptance of all MAMII interventions among community members.

The SCO reserves the right to approve and finance state advocacy programs addressing gender inequality and targeted behavioural change communication to create a mind shift among residents in the states. The SCO will also prioritize proposals that have strong maternal and childcare elements as part of the strategy towards crashing maternal and neonatal mortality in Nigeria. Calls for proposals will be advertised and communicated to states through available platforms for coordination of state health programs

CHAPTER SEVEN

National Primary Healthcare Development Agency (NPHCDA) Initiatives

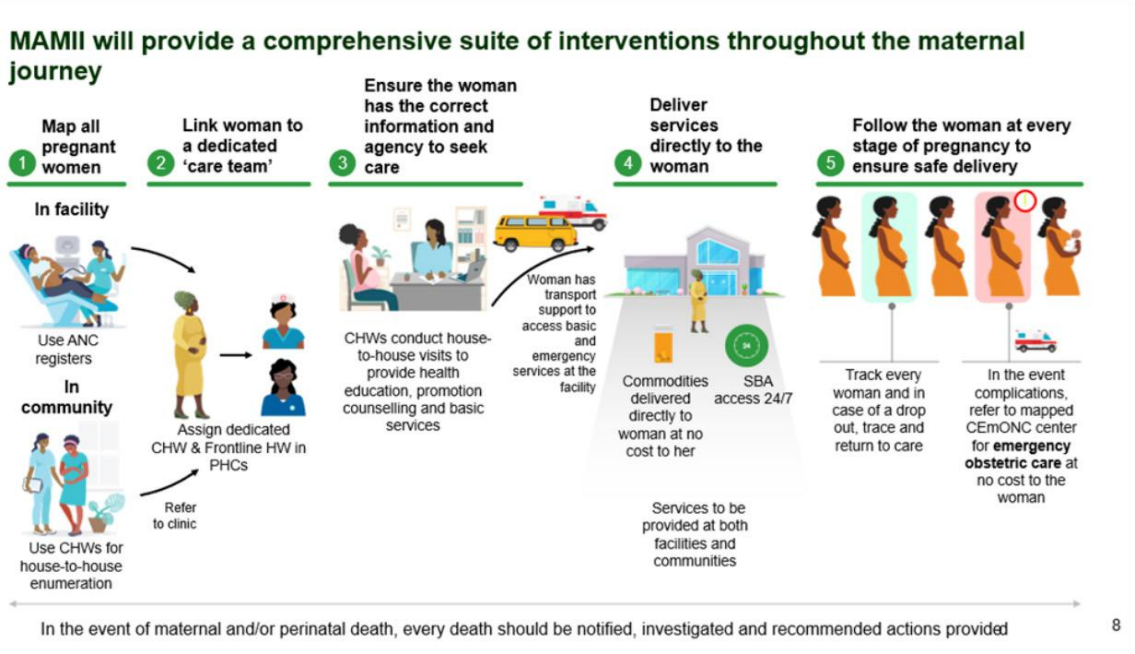
7. National Primary Healthcare Development Agency (NPHCDA) Initiatives

The National Primary Healthcare Development Agency (NPHCDA) is the entity responsible for primary healthcare administration in Nigeria. Crashing maternal and newborn mortality requires significant primary healthcare focused investments to improve access and quality of primary healthcare services that can zero preventable maternal morbidity and mortality.

Crashing maternal and newborn mortality requires a direct client-centered service delivery model, with complementary investments in systems strengthening to ensure all women and children are identified and reached with a full bouquet of services.

7.1 MAMII Service Delivery Strategic Approach

The NPHCDA implementation strategy deploys a direct client-centred service delivery approach to ensure every woman, and her child gets the support they need through their journey from pregnancy to childbirth and beyond. See schema below).



This is an opportunity to take an integrated approach to optimize performance by leveraging ongoing investments across all the Primary health system building blocks. To achieve MAMII objectives,additional resources and key success factors have been identified. These include recruitment, training and deployment of Community-Based Health Workers (CBHWs), bridgingthe existing skilled birth attendants (SBAs) gaps, revitalization of PHCs, procurement and supply of essential commodities and MNH innovations to BHCPF facilities.

For the successful implementation, the commitment of every stakeholder including government (at the federal, state and LGA,)partners, prvate sector, CSOs, etc should play critical roles and work together to achieve results. The implementation roles cut across oversight and coordination, service provision, commodities and supply chain, facility revitalization, human resources for health, emergency transport services, citizen engagement, monitoring and supervision,documentation, performance management and accountability, etc

7.2 How-to-guide: Crashing maternal and newborn mortality (MAMII)

A. Demand

S/N	Key Activity	Steps	Responsible
1.	Secure community buy in	Map community stakeholders and secure buy-in on the MAMII individual-centred approach	SPHCDB/A, LGA and IPs
		Conduct ongoing/periodic engagement with community stakeholders leveraging existing community structures	IPs
2.	Address LGA specific barriers to service utilization	Engage stakeholders (pregnant women and those who influence them, health workers) to identify LGA-specific barriers to demand generation for maternal and newborn services	IPs
		Co-create and roll out LGA specific solutions which will generate demand for maternal health care services e.g male engagement, TBA referrals etc	IPs

B. Supply: Service Optimization

S/N	Key Activity	Steps	Responsible
1.	Map all facilities that provide MNH services	Identify all PHC facilities (Public and private) that provide MNCH services	SPHCDB/A, LGA
		Map services provided by each health facility, service hours and population served	SPHCDB/A, LGA
		Establish linkages from communities to BEmONC, and BEmONC to CEmONC sites	SMOH
2.	Enumerate pregnant women in facilities	Enumerate pregnant women in the listed health facilities within the priority LGAs leveraging existing ANC registers and other sources - Utilize the line listing tool - eCHIS app (see appendix)	SPHCDB/A, LGA and IPs
3.	Enumerate pregnant women in the communities	Map all communities, settlements and households in the LGAs	SPHCDB/A, LGA
		Assign households to CBHWs to commence house to house enumeration	SPHCDB/A, LGHA
		CBHW to line list all pregnant women in their assigned households. Utilize the eCHIS app (see appendix)	SPHCDB/A, LGHA
4.a	Ensure retention in care along the MNH care cascade amongst pregnant women attending PHCs	Engage health workers and pregnant women to identify reasons for poor retention in care/drop offs	SPHCDB/A, LGA and IPs
		Design and implement plans to prevent drop offs	SPHCDB/A, LGA and IPs
		Track the implementation plan to ensure retention in careof line listed women	SPHCDB/A, LGHA
4. b	Ensure unbooked pregnant women are linked to skilled maternal care	Engage women and other community members to identify reasons for not seeking maternal health services	SPHCDB/A, LGHA and IPs
		Develop community specific service delivery plans for reaching unbooked pregnant women e.g Mobile clinics, community outreaches, house to house visits, TBA referrals etc	SPHCDB/A, LGHA and IPs
		Implement community specific service delivery plans utilizing SBAs, community health workers, TBAs, other community resource groups etc	SPHCDB/A, LGHA and IPs
		CHWs to track drop offs among line listed women and directly contact them to bring them back to the facility	IPs and CBHWs
5.	Improve ability to pay	Enroll all line listed women into National Health Insurance Scheme	SPHCDB/A, SSSHIA, LGHA & Partners
6.	Eliminate transport barriers	Determine community- specific reimbursement interventions	SPHCDB/A, SSSHIA, LGHA & Partners

7.	Ensure pregnant women with complications can access advanced care	● Link CEmONC sites to PHCs/communities (within and across LGAs) ● Develop referral notification and tracking mechanism from community-to-PHCs-to-CEMONC (referral tokens to facilitate community-to-facility visits, help lines and call centers etc) ● Deploy emergency transport services across all LGAs/ HF for ETS notification in collaboration with NEMSAS	SPHCDB/A, SSSHIA, LGHA & Partners
8.	Ensure services are provided according to standards and protocols	● Distribute SOPs and protocols for ANC and other MNH services in each PHC ●Monitor health workers adherence to protocols through quality improvement activities ●Provide on-the-job support to ensure adherence to protocols	SPHCDB/A, LGHA, FMC
	Ensure continuous quality assessment and improvement	●Conduct quarterly quality of care assessments and biannual client satisfaction surveys ●Identify quality gaps related to HF structure, infrastructure, equipment functionality and commodity availability using QA findings ●Identify quality gaps related to clients experience and satisfaction using data from QA and community satisfaction survey ●Develop and implement Quarterly QI plans to improve identified gaps	SSHIA

B. Supply: HRH - Skilled Birth Attendants

S/N	Key Activity	Steps	Responsible
1.	Validate number of SBAs to be recruited	Validate number of skilled birth attendants required (Min of 4 SBAs per health facility) in the identified facilities providing MNH services	SPHCDB/A, LGHA
	Launch state-led recruitment process	Engage SPHCBs on recruitment of SBAs	NPHCDA
		Conduct recruitment in line with state processes	SPHCDB/A
		●Employ successful candidates and ensure inclusion in the Government's payroll ●Deploy SBAs to the Health Facilities with gaps-prioritizing high volume facilities	SPHCDB/A
2.	Deploy and onboard healthcare workers	Deploy SBAs to the Health Facilities with gaps-prioritizing high volume facilities	S
		Orient SBAs on Life Saving Skills and Modified Life Saving Skills as applicable, integrated maternal and child health guidelines, and job descriptions	S
		Initiate monthly capacity building and mentoring visits, gather data on SBA performance, and conduct feedback surveys	S

B. Supply: HRH - Community Based Health Workers

S/N	Key Activity	Steps	Responsible
1.	Recruit and Deploy community-based healthcare workers	Quantify CBHW requirement in mapped settlement areas using a 1:250 CBHW/household ratio	S
		Identify available LGA staff who can be be deployed to be community based health workers	S
		Train, kit and deploy CBHWs to households and communities for service provision	S
		Link CBHWs to BHCPF facilities (ward focal PHC) within the ward	S
2.	Ensure community based health workers are equipped with tools commodities and equipment	Quantify commodities and medicines required in the community based on the target population	S
		Procure commodities to meet target population attending PHCs and to be served in the communities	NPHCDA, S
		Distribute commodities and kit to community based health workers	NPHCDA, SPHCDB/A, LGHA and IPs

3.	Supervision	Assign and link CBHWs to technical supervisors	S
		Integrate community level service delivery into routine PHC supportive supervision	S
		Establish framework for non WDCs and CBOs	NPHCDA, SPHCDB/A, LGHA and IPs
		Track implementation of supervision framework	NPHCDA, SPHCDB/A, LGHA, Ward focal persons

B. Supply: HRH: Training

S/N	Key Activity	Steps	Responsible
1	Develop training plan	Adopt National training methodology and curriculum (for skilled birth attendants and community based health workers)	SPHCDB/A,
		Develop state specific training plans	SPHCDB/A
2.	Conduct SBAs trainings	Conduct SBA training and mentoring	SPHCDB/A
		Monitor and evaluate training/mentoring of SBAs	NPHCDA

B. Service delivery: Commodities

S/N	Key Activity	Steps	Responsible
1.	Deploy MNH commodities to the last mile	Forecast/ quantify requiremennts for prioritized MNH commodities to be provided at no cost to the woman	NPHCDA, SPHCDB/A
		Supply and distribute MNH commodities to facilities	NPHCDA, SPHCDA, 3PL & IPs
		Deploy digital solutions for real-time stock tracking and monitoring at facility and community level	NPHCDA, SPHCDB/A and IPs
		Validate stock levels in facilities	NPHCDA, SPHCDB/A and IPs
2.	Improve transparency and access to MNH commodities	Communicate to facilities, health workers and patients that MNH innovations/commodities will be provided free	IPs
		Establish a feedback mechanism and periodic check that will ensure that MNH innovations/commodities are provided at no cost	IPs

B. Service delivery: MPCDSR

S/N	Key Activity	Steps	Responsible
1.	Ensure all maternal and perinatal deaths are identified and reported	Establish/activate facility/comunity MPCDSR/QoC Committees in all wards	NPHCDA, SPHCDB/A and IPs
		Identify and train CBHWs and facility HCWs to track and report maternal and perinatal deaths	NPHCDA, SPHCDB/A and IPs
		Support CBHWs and facility HCWs to track and report maternal and perinatal deaths in the communities according to the standards	NPHCDA, SPHCDB/A and IPs
2.	Ensure cause of maternal and newborn deaths is known and documented	●Conduct verbal autopsy (VA) at the community level by designated member of facility QI team ●Support conduct of deaths review during the monthly FMC/QIT ●Identify and train Medical Officers in secondary facilities for assignment of medical cause(s) of the deaths using ICD 11 from reports of VA ●Conduct social autopsy by representatives of WDC and facility QI teams and develop community action points to address the contributory factors identified	Facility QIT, WDC, LGA DSNO, IPs
		Upload the autopsy reports onto the Nigeria Obstetric Quality Assurance platform	LGA DSNO
3.	Develop a response plan to prevent future deaths	●Identify individual, family and community level factors that contributed to the deathss at the community levelss ●Identify the service delivery gaps which resulted in the death ●Identify which gaps can be addressed at community level, facility level, state level, and national level ●Develop and implement plans to address the gaps ●Monitor and report on progress to community, LGA and state representatives	•HF management committee, IPs, WDC, LGHA, SPHCDB/A, IPs

B. Supply: Facility Revitalization

S/N	Key Activity	Steps	Responsible
1.	Close infrastructure gaps in facility	Identify infrastructure gaps in mapped facilities	NPHCDA, SPHCDB/A
		Revitalize BEmONC and empanel CEmONC sites	NPHCDA, NHIA

1. IEV implementation: identification and enumeration

S/N	Key Activity	Steps	Responsible
1	Standardize the IEV checklist and tool	●Review existing tools and guidelines for identifying zero-dose and under-immunized children ●Develop a standardized checklist and user-friendly tools based on best practices ●Pilot the tools in selected areas and incorporate feedback ●Distribute the finalized tools to all relevant stakeholders	SPHCDB/A, LGA, AND IP
2	Identify and train enumerators	●Identify eligible community health workers, volunteers, and local leaders as potential enumerators ●Develop a training curriculum focused on the use of IEV tools and data collection techniques ●Conduct training workshops to build capacity and ensure standardization ●Monitor and evaluate the performance of enumerators during initial field activities	IP
3	Conduct enumeration of zero-dose and other vaccine-eligible children	●Map high-risk areas and plan door-to-door surveys based on geographic and demographic data ●Deploy trained enumerators to systematically collect data on zero-dose and vaccine-eligible children ●Use digital platforms for data entry to enable real-time monitoring and reporting ●Validate collected data through supervisory visits and cross-checks with existing records	IP

1. IEV implementation:vaccination

S/N	Key Activity	Steps	Responsible
1	Analyze enumeration data	Consolidate data from enumeration activities into a central database Conduct a detailed analysis to identify trends, high-risk areas, and unvaccinated groups Generate summary reports to inform strategy development Share findings with stakeholders for joint planning	SPHCDB/A, LGA, AND IP
2	Define strategies to reach the identified zero dose and under-immunized children	Identify barriers to immunization, such as geographical, cultural, or logistical challenges Develop targeted solutions, including tailored outreach for hard-to-reach populations Integrate immunization services into routine health system activities for sustainability Prioritize interventions based on available resources and population needs	IP
3	Develop microplan	Use analyzed data to prepare microplans detailing resource allocation, staff deployment and logistics Engage local health teams and community leaders in the microplanning process Review and finalize microplans for each target area Disseminate microplans and train health workers on their implementation	IP
4	Commence vaccination	Roll out fixed-site, outreach, and mobile immunization sessions based on microplans Ensure vaccines, supplies, and trained staff are in place for each session Implement defaulter tracking systems to follow up on partially vaccinated children Monitor immunization activities and address operational challenges in real time	IP

1. IEV implementation: : community engagement and advocacy

S/N	Key Activity	Steps	Responsible
1	Analyze enumeration data	●Review existing tools and guidelines for identifying zero-dose and under-immunized children ●Develop a standardized checklist and user-friendly tools based on best practices ●Pilot the tools in selected areas and incorporate feedback ●Distribute the finalized tools to all relevant stakeholders	SPHCDB/A, LGA, AND IP
2	Engage local stakeholders	●Identify eligible community health workers, volunteers, and local leaders as potential enumerators ●Develop a training curriculum focused on the use of IEV tools and data collection techniques ●Conduct training workshops to build capacity and ensure standardization ●Monitor and evaluate the performance of enumerators during initial field activities	IP
3	Establish feedback channels	Establish multiple feedback mechanisms, including hotlines, suggestion boxes, and community forums Train staff to manage feedback channels and respond promptly to concerns Analyze feedback to identify recurring challenges and gaps in service delivery Use feedback insights to inform continuous improvement efforts	IP

CHAPTER EIGHT

National Health Insurance Authority (NHIA) Initiatives

8. National Health Insurance Authority (NHIA) Initiatives

Like many LMICs, Nigeria adopted health insurance as its way to ensure UHC. This pathway ensures that everyone has access to healthcare without financial burden or barriers. Although there are various health insurance schemes, the National Health Insurance Authority (NHIA) Act of 2022 was passed to regulate the provision of health insurance and ensure its alignment with global health goals. It is focused on expanding health insurance coverage for all regardless of their socio-economic status, promoting fairness and equity for healthcare access, enhancing healthcare quality, and creating value through sustainable strategies.

The NHIA has launched several initiatives to reduce maternal mortality by focusing on subsidised health insurance for women under the Vulnerable Group Fund (VGF) i.e., the BHCPF, and other special intervention initiatives, which are:

- NHIA Fistula Free Programme (NFFP)
- NHIA—Financing Access to Comprehensive Emergency Obstetric and Neonatal Care (CEmONC) for maternal and newborn complications.

8.1 NHIA—Financing Access to CEmONC

The NHIA financing access to CEmONC programme will directly impact the reduction of maternal mortality rate by ensuring the provision of life-saving emergency care for women and newborns, particularly in underserved areas with challenges in financial access to quality healthcare. The program provides coverage for critical maternal health conditions, including sepsis, ectopic pregnancy, antepartum and postpartum haemorrhage (APH/PPH), pre-eclampsia/eclampsia, prolonged obstructed labour, preterm/pre-labour rupture of membranes (P/PROM), and post-abortion complications and services such as emergency caesarean section.

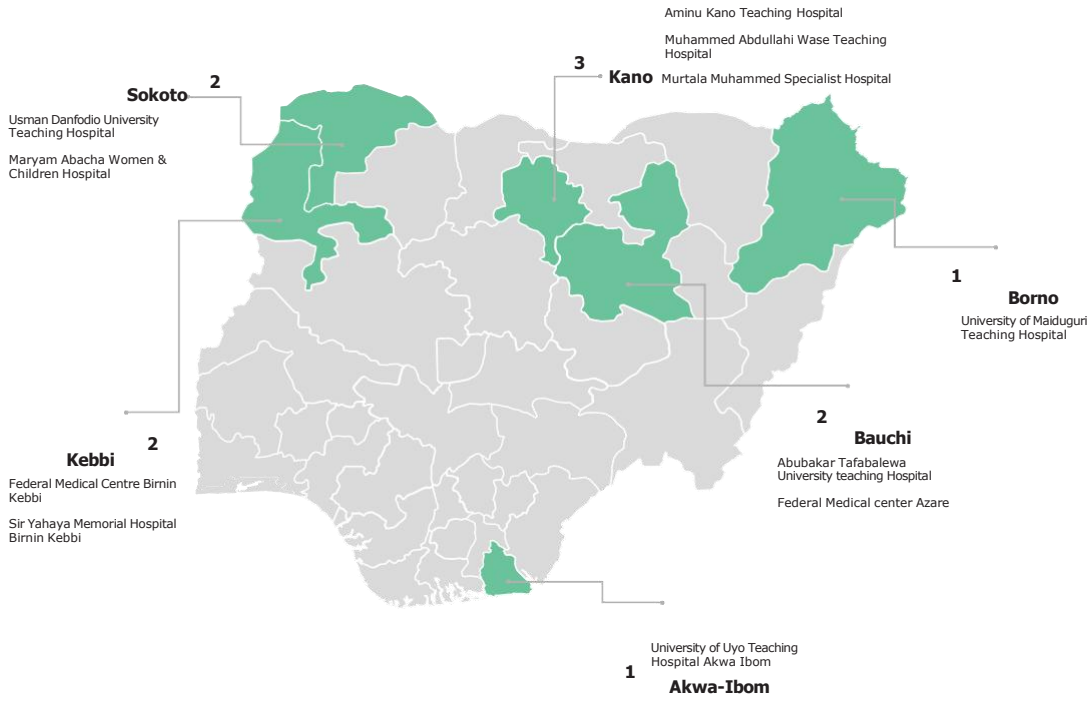


Fig 8.1 NHIA accredited facility list for the National VVF surgery program

***(the list is dynamic as NHIA shall continuously update and publish the list of the facilities)

The list of accredited health service providers (public and private) for CEmONC services shall be updated and published regularly by the NHIA. The updated list shall be made available to PHCs/ BEmONC service providers, traditional birth attendants (TBAs), Emergency Transport/Ambulance Services Providers, and the public to ensure widespread knowledge of where to transfer patients in case of emergencies. The NHIA will also finance on a fee-for-service basis the use of essential CEmONC in these approved facilities. This approach will increase awareness for the program, improve decision making timeline for the use of CEmONC services as necessary, and establish public trust in the initiative through referrals by stakeholders in the community. A copy of the current NHIA guideline for CEmONC care will be provided as annex to this guide.

8.2 NHIA Fistula Free Program (NFFP)

The NHIA has developed a national program that enables eligible women across the country to access obstretic fistula repair without financial obstacles. Obstetric fistula is a condition that disproportionately affects women in rural areas where there is limited access to quality healthcare.. The affected women deal with the social stigma of urinary or faecal incontinence, recurrent UTIs and reduced quality of life.

Under the program, the NHIA will cover all cost of management including the cost of feeding, transportation, insurance enrolment, post-care follow- ups, and sustained access to healthcare services.

CHAPTER NINE

National Emergency Medical Service and Ambulance System (NEMSAS) Initiatives

9. National Emergency Medical Service and Ambulance System (NEMSAS) Initiatives

9.1 Indications for Referral and Referral Management in Nigeria

Studies have shown that over 70% of deliveries in Nigeria happen at homes limiting access to live saving maternal and newborn care leading to high maternal and newborn mortalities in communities. To reduce these mortalities, a comprehensive emergency referral system needs to be established to move pregnant women and newborn with complications to primary and secondary healthcare facilities to access emergency care.

In maternal and neonatal health, referral indications also encompass conditions requiring specialized care beyond the capabilities of the primary facility, while referral management ensures timely and effective transfer of care. Common indications include prolonged labor, preeclampsia/eclampsia, ante and postpartum hemorrhage, obstructed labor and neonatal emergencies, , necessitating immediate referral to a higher-level facility. Strengthening referral systems to improve its efficiency and effectiveness by strengthening communication, training, and resource availability. This will include signaling functions such as an effective communication, triage, and emergency transport system including protocols for moving pregnant women and neonates to the appropriate health facility making both BEmONC and CEmONC services accessible to those who need them. The Emergency Medical Treatment Gateway of the BHCPF is saddled with this responsibility through its operational arm; the National Emergency Medical Service and Ambulance System (NEMSAS). For MAMII, NEMSAS has introduced the Rural Emergency Service and Maternal Transport (RESMAT) program to combat delays predisposing to maternal mortality especially in rural communities in the 172 LGAs where more than 50 percent of all maternal maternity occur in Nigeria.

9.2 Rural Emergency Service and Maternal Transport (RESMAT)

9.2.1 Background

Nearly one-half of Nigeria's population of 213 million reside in rural areas where poverty is widespread, and access to quality health care is limited. Well over 40 percent of the country's population is under the age of 15, with children under five accounting for roughly 20 percent. Geography and physical challenges, including remote and hard-to-reach villages with poor infrastructure and limited transportation options, the requirement for financial resources, as well as considerations of family preferences all combine to hinder access to healthcare services among rural populations.

The lack of properly equipped ambulances, adequately trained staff, reliable communication equipment, and poorly coordinated response between incidents and healthcare facilities present major shortcomings to the country's health systems. Coordinated and well-equipped ambulance services are therefore crucial for improving health outcomes and reducing preventable deaths in Nigeria's rural areas.

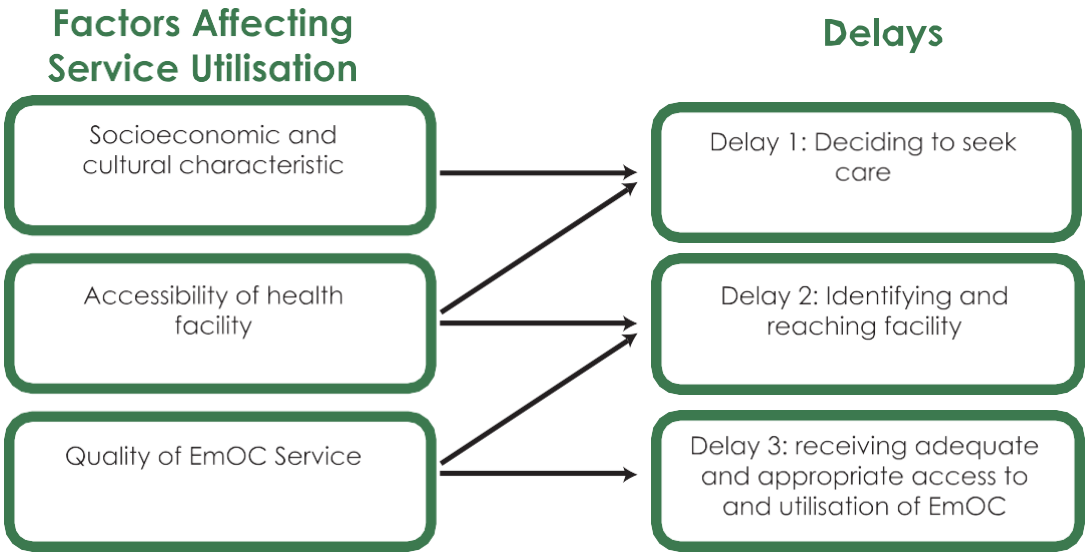


Figure 9.1: Factors Affecting Access to Essential Healthcare

9.2.2 Reducing Maternal Mortality by Addressing "The Second Delay"

Nigeria's high MMR pose significant challenges to achieving the SDGs. Most of the maternal deaths (80-85 percent) can be attributed to direct obstetric causes (hemorrhage, sepsis, complications of abortion, hypertensive disorders). A major factor implicated in maternal mortality in Nigeria is the delay in reaching the point of care and delay in receiving quality care at the health facility. The "three delays model" concept has proven to be a practical and widely accepted framework to account for the delay in management for obstetric emergencies and its role in maternal mortality.

The model allows for evaluating the circumstances surrounding maternal deaths, which has proven useful in examining constraints to obstetric care and helping to understand ways to prevent maternal mortality (See Figure 9.1). The model explores what, why, and how maternal deaths occur and comprises the delay in deciding to seek appropriate care by individuals, family, or both (Delay 1), delay in reaching an adequate health care facility (Delay 2) and delay in receiving adequate care when a facility is reached (Delay 3).

The application of the Three Delays Model to analyse maternal mortality highlights the considerable obstacles faced in accessing appropriate healthcare. Transportation barriers in rural Nigeria have profound implications on maternal and child health. Proximity to health care services and access to affordable public transport for pregnant women are fundamental factors needed to solve type 2 delays. Addressing type 2 delays provides a strong justification for the availability of an ambulance service and having well-maintained roads. Some of the hurdles that have been identified with Delay 2 include

- the absence of healthcare facilities in the immediate area which is being resolved under the BHCPF
- long travel times from home to a healthcare facility, often requiring more than one hour to reach healthcare facility
- the cost of transportation services
- poor road condition or terrain; and
- visits to a traditional healer or traditional birth attendant first.

Access to health facilities, including the distance to such facilities, is a critical factor influencing

maternal, neonatal, and child health outcomes asserts that the strengthening and establishment and support for the implementation of an emergency transport scheme to convey pregnant women from their homes to health facilities for emergency obstetric care is necessary to address the second delay in Nigeria. In many settings, women must pay out-of-pocket fees, resulting in delays in accessing care. In the prioritized LGAs where 50% of maternal mortality occur in Nigeria, there are significant gaps in services and access to first medical care.

Furthermore, some of the delays recognized under Delay 3 include delays in the necessary referrals of mothers from one healthcare facility to another due to the lack of emergency transport. For instance, the use of an ambulance might be constrained by fuel shortages or instances where ambulances are used for non-emergency purposes. Strengthening the referral network to ensure that women with complications are promptly transferred from the community or health center to an appropriate level of care and for follow-up, particularly of mother/baby pairs through supporting referral services is therefore also crucial.

The Rural Emergency Service and Maternal Transport (RESMAT) provides a low-cost model that leverages existing resources within the community for improving maternal health outcomes. RESMAT builds upon local networks of volunteers trained to provide basic first aid, and health centers to connect laypersons (such as commercial transport drivers) and medical first responders using the local cellular telephone network to communicate and coordinate in emergency situations.

9.2.3 Strategic Objectives

1. To reduce maternal and neonatal mortality by providing emergency care and transportation within the golden hour.
2. To extend universal access Emergency Obstetric and Newborn Care to rural populations in Nigeria
3. To demonstrate National Emergency Medical Services and Ambulance System (NEMSAS), State and local government collaboration mechanisms for strengthening Rural EMS delivery in selected LGAs in Nigeria.

9.2.4. Relevance to Higher Level Objectives:

i. RESMAT is fully aligned with the principles and procedures for operationalizing the National Health Sector Renewal Investment Initiative.

ii. The implementation of the RESMAT will be prioritized for addressing rural emergencies and maternal transport during pregnancy thus driving:

   a. Reduction of crude mortality rates arising for absence of effective, efficient, and timely medical emergency transport

   b. Reduction in maternal mortality from 2nd delays i.e., delays in transportation and referral of obstetric cases and emergencies in the communities.

9.2.5 Governance and Implementation Framework

RESMAT shall be coordinated through the State Emergency Medical Service and Ambulance system (SEMSAS) at the state level through Local Government EMSAS (LEMSAS) officers deployed from the Local Government Health Authority. At the community level the Ward Development Committee (WDC) shall oversee governance and operations within the communities of its jurisdiction.

9.2.6 Operations Model

9.2.6.1 LGA-Wide Rural Ambulance Service Model:

The model describes an arrangement where ambulance service is purchased from a private sector operator to cover a catchment population. The operator will provide tricycle ambulances that can be deployed quickly, at low cost, with high safety standards. The ambulances will be equipped with basic life-saving equipment, and trained staff to provide emergency care service packages and manage emergencies during patient transportation. For operational purposes, each PHC will have 1 tricycle ambulances and a motorcycle for deployment of Community Emergency Responders.

9.2.6.2 Rural Transport for Maternity Services

The rural transport for maternity services model is a low-cost Transport service utilized for maternity patients leveraging existing resources within the community. Usually, laypersons who are Community members, particularly commercial transport drivers, are required to pool their vehicles. The selected individuals are also trained to provide basic first aid intervention. This model is driven by community participation. Using the existing HRH in the PHCs, all pregnant women in the community are identified and enrolled in the scheme.

9.2.6.3 Decentralized Community-based Model

The model is a hybrid of the LGA-wide Rural Ambulance Model and the Rural transport for maternity services. Services are Outsourced to Emergency Transport Operators (ETO) both public and private and Commercial transport operators National union of Road Transport Workers (NURTW) for maternity services depending on location and catchment population.

In this Model, the use of appropriate vehicles to transport patients and the need for care during transportation is a significant decision factor. Services are purchased from operators based on the available capacity to provide emergency services.

9.2.7 Operations Flow

Using the decentralized community-based model, emergency medical service and medical transport for obstetrics and neonatal emergencies shall be provided using a toll free voice call, SMS and USSD dispatch notification system to establish communication linkages between public and private emergency transport operators, Health Facilities and clients during obstetric and neonatal emergencies

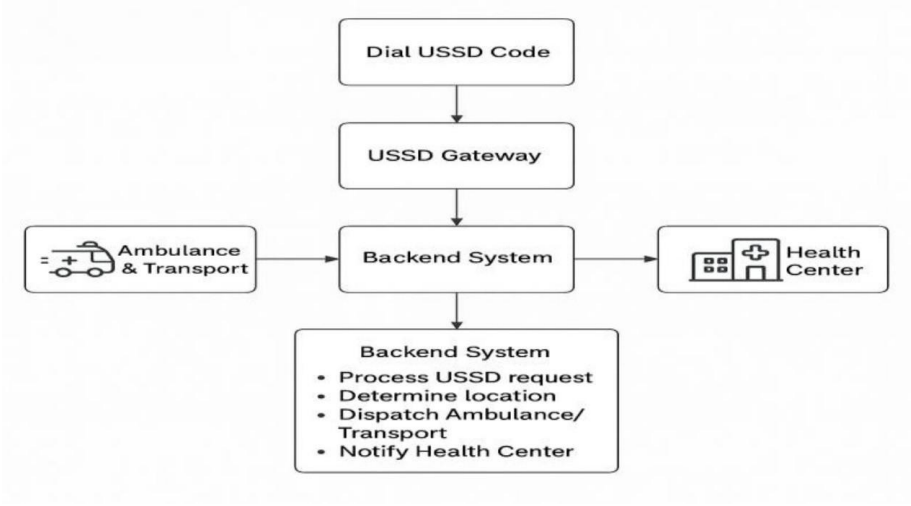


Figure 9.2: SAVEMAMA Operational Flow

9.2.8 Inter Facility Transfer

This level of response should be reserved for those circumstances when a BEMONC facilities are unable to provide the necessitated quality and standard of Emergency care, Facilities then notifies CEMTTO to deploy an Emergency Transport Provider to transport client to the appropriate health facility.

9.2.9 Dispatch, Communications, And Information Systems

Delivering effective emergency medical services (EMS) in rural areas presents unique challenges due to limited resources, infrastructure, and connectivity. Establishing efficient dispatch, communication, and information systems tailored to these contexts is critical for ensuring timely responses to emergencies and improving patient outcomes.

A Community Emergency Medical Transport Triage officers (CEMTTO) will serve as the nerve center for coordinating emergency responses. The CEMTTO shall be a woman (consider basic medical knowledge) selected by the WDC to serve this purpose and she must be resident in the community, Rural areas suffer from poor and unavailable communication technologies, hindering seamless communication between dispatch centers and responders. To address this, feature phones will be used for implementation.

Process Flow for Emergency Transport Operations

Step 1: Initiation of Request

A beneficiary or their representative initiates a request for emergency transportation by calling a toll-free number or dialing a USSD code.

Step 2: Callback from Central Emergency Medical Transport and Triage Office (CEMTTO)

The backend system alerts the CEMTTO of the incoming request. CEMTTO immediately places a return call to assess and validate the emergency.

Step 3: Dispatch Notification to Emergency Transport Operators (ETOs)

Once validated, CEMTTO broadcasts a dispatch alert to all registered ETOs within the relevant ward.

Step 4: Notification of Treatment Centre

CEMTTO concurrently notifies the appropriate healthcare facility— either a Basic Emergency Obstetric and Newborn Care (BEmONC) or a Comprehensive Emergency Obstetric and Newborn Care (CEmONC) center—based on the nature of the case.

Step 5: Transportation and Arrival Confirmation

The selected ETO transports the patient to the designated health facility. Upon arrival, the facility confirms the patient's drop-off by sending a toll-free SMS.

Step 6: Dispatch Code Generation and Forwarding

Upon confirmation of drop-off, an auto-generated dispatch code is sent to the health facility's focal person.

Step 7: Dispatch Code Handover to ETO

The focal person then provides the dispatch code to the ETO as proof of completed service.

Step 8: Reimbursement

The ETO uses the dispatch code to redeem their reimbursement via the USSD platform.

9.2.10 Reporting and Record keeping

The officer in charge of PHCs shall maintain accurate records of emergency responses, including patient information, interventions performed, and transportation details. They ensure thorough documentation for each case, adhering to reporting protocols and conveying essential information to dispatch centers and healthcare facilities.

CHAPTER TEN

The Federal Ministry of Health and Social Welfare (FMOH&SW) Initiatives

10. The Federal Ministry of Health and Social Welfare (FMOH&SW) Initiatives

The Federal Ministry of Health and Social Welfare (FMOHSW) will anchor a set of interventions under MAMII that are crucial to crash maternal and neonatal mortality in Nigeria. The focus of the ministry will be on strengthening local administrative structures and appropriate messaging and social behavioural change for improved maternal and newborn health. The FMOHSW provides oversight functions to the relevant agencies in the implementation of MAMII.

10.1 The Role of FMOH&SW in MAMII

The role of FMOH&SW in MAMII are

- Coordination
- Policy formulation and National Guidelines
- Resource Mobilization and partner Engagement
- Commodity Security
- Capacity Development
- Monitoring Evaluation and Research
- Data Intelligence

10.1.1 Coordination

The FMOHSW will support and strengthen establishment of coordination platforms for implementation of MAMII at sub-national level

10.1.2 Policy formulation and development of National Guidelines

FMOHSW will ensure an enabling policy environment for implementation of MAMII through roll-out of appropriate policies, guidelines, plans, Standard Operating Procedures (SOPs) etc. This will be achieved by supporting the adoption / adaptation of Nigeria Every Newborn Action Plan (NiENAP), Nigeria Child Survival Action Plan at the sub-national level.

10.1.3 Resource Mobilization and Partner Engagement

FMOHSW will continue to support state implementation in-line with the Nigeria Health Sector Renewal Compact which is a unified funding arrangement aimed at improving the health system.

MAMII will:

- Leverage the Basic Health Care Provision Fund (BHCPF) to finance maternal and neonatal services.
- Collaborate with the National Health Insurance Authority (NHIA) to integrate maternal and newborn health services into covered benefits.
- Prioritize high-burden LGAs for intervention scale-up and funding allocation in AOPs.

10.1.4 Commodity Security

FMOHSW to support forecasting, quantification and procuring of MNCH commodities including FP for MAMII implementation across states

10.1.5 Capacity Development

Health Workforce Capacity Development: FMOHSW will support capacity building for health workforce to enhance the skills and processes to provide quality maternal and newborn services, to achieve the MAMII objectives.

The SMOH will consider the underlisted strategies for ensuring workers development:

- Health Workforce Recruitment and Retention:
- Improving working conditions by providing equipment and commodities
- Encouraging professional development opportunities
- Conducting performance evaluations
- Incentivization, such as bonuses

FMOHSW will support the states to establish/ strengthen of:

- ANC, facility delivery and Postnatal services including FP
- Management of post-partum
- Newborn Care Corners/Simulation Corners at Primary Health Care (PHC) facilities, equipped with essential resuscitation and newborn support tools.
- Special Care Baby Units (SCBU) and Neonatal Intensive Care Units (NICU) in secondary and tertiary facilities, including infrastructure for immediate Kangaroo Mother Care (iKMC).
- Standardized neonatal care practices including early breastfeeding, Vitamin K1 administration, eye care, skin-to-skin contact, and chlorhexidine cord care.
- Neonatal resuscitation using bag-and-mask ventilation, CPAP, and oxygen therapy.

Action Point: Establish a national SCBU/NICU accreditation framework under MAMII to ensure adherence to equipment, staffing, and infection control standards.

10.1.6 Community-Based Interventions

Community-level programming will involve:

Facilitation of the training of CHWs and TBAs in

- Strengthening referral systems for danger signs and emergency neonatal conditions.
- Community emergency transport systems
- Equipping ambulances with neonatal transport incubators and training paramedics.

10.1.7 Integration with Monitoring and Evaluation Systems

All maternal and newborn health interventions under MAMII shall be:

- Tracked using updated Health Management Information Systems (HMIS).
- Aligned with Maternal, Perinatal, and Child Death Surveillance and Response (MPCDSR) systems.

- Aligned with MNCH Quality of care using scorecards, digital tools, and annual household surveys.
- Integrated into supportive supervision and Joint Annual Review

10.1.8 Digital Intelligence

FMOHSW to coordinate the digitization, implementation and scale up of the use of health records, training manuals, and all other processes and approaches in the conduct of the implementation of MAMII.

10.2 Service Readiness

- In recognition of inadequate emphasis on the development of critical clinical skills for EmONC during pre- and in-service education, and poor retention of those skills over time, and to improve the quality of intrapartum care, the MAMII program will deploy a novel evidence-based health systems strengthening approach – the MAMII Bundle of Care (MBC) in ALL MAMII LGAs to address the key drivers of maternal, perinatal, neonatal, and child deaths.
- A bundle is defined as 'A small set of evidence-based interventions for a defined patient segment/population and care setting that, when implemented together, will result in significantly better outcomes than when implemented individually'. MAMII Bundle of Care is a bundle incorporating various maternal, newborn and child care bundles adapted to the Nigeria context (see figures 6 and 7 below).
- The roll out will be phased in line with facilities which meet the minimum criteria for introducing MBC. The number of LGAs beyond the MAMII LGAs will be scaled over time as effectiveness and scalability are demonstrated and as feasible, in consultation with state governments.
- The training delivery platforms will be Safer Birth Bundle of Care (SBBC) for primary and secondary care levels (tertiary level if PROMPT is not available) and PROMPT for secondary and tertiary care levels.

The PROMPT (Practical Obstetric Multi-Professional Training) program is a multidisciplinary, team-based training package aimed at strengthening the safety and quality of maternity care. It equips entire maternity teams, including midwives, obstetricians, anaesthetists, and support staff—with the knowledge, practical skills, and teamwork needed to respond swiftly and effectively to obstetric emergencies such as postpartum haemorrhage and eclampsia. A key feature of PROMPT is its use of in-situ simulation, where training takes place in the actual clinical setting with the same equipment, workflows, and team structures used during real emergencies. This approach ensures learning is directly applicable, highlights system gaps in real time, and allows teams to practice under realistic conditions. The curriculum combines concise, evidence-based teaching with practical drills and structured debriefs, building both technical expertise and essential non-technical skills such as communication, leadership, and situational awareness.

The Safer Births Bundle of Care (SBBC) is a proven, scalable approach that aims to significantly reduce maternal and newborn deaths by integrating lifesaving tools, simulation-based training, and continuous quality improvement into routine health services. Over more than a decade, SBBC has been co-developed with frontline clinicians, making it a model grounded in real-world practice and responsive to the urgent challenges faced in maternity care.

Across many facilities, health workers encounter life-threatening obstetric and newborn

emergencies without timely recognition, coordinated teamwork, or access to reliable equipment. Traditional off-site training workshops, often delivered sporadically, do little to prepare staff for such high-pressure situations. SBBC addresses this gap by introducing low-dose, high-frequency simulation training conducted directly in delivery rooms. This approach allows staff to practice critical skills in their actual work environment, with the same equipment and alongside the same colleagues they rely on when emergencies arise.

Training is led by local champions, ensuring ownership and sustainability. Each session is followed by structured debriefs, where teams reflect on performance, identify system weaknesses, and co-create practical solutions. This process not only strengthens individual competence but also builds collective confidence, resilience, and collaboration within health teams.

At the heart of SBBC is the integration of innovative clinical and training tools, particularly those supporting labour management and newborn resuscitation—with robust strategies for continuous quality improvement. The result is a culture of ongoing learning, problem-solving, and accountability that drives better care for mothers and babies.

By embedding these practices directly into health facilities, SBBC moves beyond short-term skill-building to deliver sustainable, system-wide improvements. Its unique combination of simple tools, locally led training, and team-based learning makes it a transformative model for saving lives and strengthening health systems.

10.3 Deployment of Point of Care Ultrasound (POCUS) to all Women in Mamii LGAs:

To enhance antenatal care quality and responsiveness, Point of Care Ultrasound (POCUS) will be deployed as a diagnostic aid to improve the early identification and referral of obstetric complications at the primary healthcare and community levels within MAMII LGAs. Key components and activities of POCUS deployment include Health Worker Training and Certification, Technology Access and Infrastructure, Integration with Antenatal Care (ANC) Protocols, Referral System Strengthening, and Monitoring, Learning, and Adaptation

CHAPTER ELEVEN

Monitoring, Evaluation, and Performance Management Framework

11. Monitoring, Evaluation, and Performance Management Framework

11.1 Result-Based Monitoring and Evaluation (RBM&E) System

This chapter of the guide will provide MAMII set of intercalated programs with a systematic process that evaluates selected innovations and programs outputs and outcomes toward evaluating performance. The MAMII RBM&E system will assess the several interrelated program efficiencies against set objectives in human development to determine progress identifying areas in need of improvement or more action, and provide data to be used in decision-making processes. This RBM&E approach will be done throughout the life cycle of this initiative as an effective way to ensure desired results are being achieved all around. This system enables all stakeholders and implementing entities the avenue to re-strategize their efforts when they identify a problem in their program. It also allows for a more strategic approach to allocation of resources for the forestalling of maternal and newborn mortality in Nigeria. For MAMII, the RBM&E reporting systems will answer the following questions:

- What are the goals and objectives of the initiative?
- Are these goals and objectives being achieved?
- How can this achievement be proven?

11.1.1 The Need for RBM&E in MAMII

The RBM&E approach allows for accurate and effective progress tracking of MAMII initiative, creating an avenue to identify issues that may develop at the early stages of implementation or successes from such action. This is necessary as the MAMII compiles a group of intercalated initiatives required for the crashing of maternal mortality in Nigeria. This system provides data from tracking changes and circumstances, providing measurable parameters that enable us to be more strategic on how best to achieve the MAMII objectives. The data from RBM&E in MAMII will allow us to focus resources to priority areas that may be revealed in the results, allowing for effectiveness and success in the implementation of the initiative. The RBM&E will focus on indicators that are meaningful and linked to outcomes and impacts. It improves the efficiency of service delivery, the program quality, and the policy implementation process. Indicators that will be tracked under the RBM&E system for MAMII are described in Table 11.1.

11.1.2 7-Step Model for MAMII RBM&E System

The MAMI RBM&E model will work with all implementing entities to define the following assessment. This model differs from other national M&E systems in the country because it specifies steps in building, maintaining, and sustaining the RBM&E system.

1. Readiness Assessment: To develop a working research-based monitoring and evaluation system, the SCO will review and publish the existing political, cultural, and organizational environment of the implementing entities and recipient states and LGAs. This report will also include a scoring for the readiness assuming that implementing entities and subnational governments at these levels need to have an M&E system in place and assesses if such governments are ready to have and sustain this system.
2. Selecting and Agreeing on Outcome Indicators: Short- and medium-term outcome targets, spanning one, two, and three years_ will be established in collaboration with implementing entities to define what success looks like across all MAMII programs. These

targets will be tied to clear, measurable indicators that serve as reliable tools for tracking progress. The selected indicators will meet the SMART criteria: Specific, Measurable, Achievable, Relevant, and Time-bound, ensuring they are cost-effective, appropriate, and feasible to monitor. For MAMII programs, outcome indicators will align closely with program objectives and reflect both short-term outputs and medium-term impact results.

a. Setting Baseline on Indicators: This step establishes the current standing of the program in relation to the outcomes to be achieved. The MAMII programs will adopt the 2023 Nigeria Demographic and Health Survey (NDHS) and other available institutional desk records where applicable as baseline. The SCO will ensure baseline data is gathered on all MAMII programs to a reasonable depth which allows the program to be measurable.

b. Establishing Targets on Indicators: The desired level of performance to be achieved within each MAMII program must be designed to be SMART within the means and resources available. The targets must also be applicable to the time-frame of the implementation of the program and agreeable to both the implementing entity and the SCO.

3. Monitoring for Results: The implementing entities will be responsible for the tracking of the direction, pace, and magnitude of change on all MAMII programs. The implementing entities are expected to report periodically to the SCO on the progress, gaps and mitigation strategy. The periodic reporting arrangement will be mutually agreeable to the SCO and the implementing entity and results will feed into SCO M&E briefs and annual reviews of the health sector.

4. Reporting Findings: The central purpose of this report is to deliver the message. This step is critical because such findings can be used as evidence to convince stakeholders to invest, to demonstrate accountability, to explore organizational learning, and to promote understanding. MAMII progress reports will be presented in SCO briefs and bulleting and the national joint annual review to all stakeholders. Citizen's versions of all reports and briefs will also be provided for all Nigerians with data in simplified and comprehensive format.

5. Evaluations: This is an assessment of an intervention, regardless of its cycle, to determine its impact, relevance, effectiveness, and sustainability. The evaluations will be led by the implementing entities, SCO, and the World Bank DIME team. These evaluations will provide information on strategy (rationale), operations (effectiveness in outcomes, efficiency in using resources), and learning (alternatives, lessons learned) The specific types of evaluation relevant to MAMII include:

   - Performance Logic Chain Assessment: This is used to determine the strength and logic behind the program model. This is the model that addresses sequencing of activities, resources, and initiatives in MAMII. This evaluation will assess the feasibility of achieving desired change based on past efforts.
   - Pre-Implementation Assessment: This approach ensures that program failure is not programmed from the beginning of implementation efforts. This approach addresses three standards that check the following factors; well defined objectives, coherent implementation plan, and clear rationale for resource allocation.
   - Process Implementation Evaluation: This focuses on implementation details like planned processes that were or were not implemented, unanticipated outputs, and differences in what was intended and what actually happened.

- Rapid Appraisal: This is a multi-method approach to evaluation. Since M&E are continuous tools, this type of evaluation is invaluable. It allows for quick assessment with immediate feedback on program progress. Some of such methods are interviews, observation, and surveys.

Outcome Evaluation

- Impact Evaluation: This identifies the changes and what parts of the document these changes can be attributed to or what other events may have influenced these changes. It usually comes at the end of interventions. The aim of this approach is to attribute documented change.

6. Using Findings and Sustaining RBM&E: The report generated from the M&E process is used to improve performance and inform reform priority for reproductive, maternal, and child health in Nigeria. The use of findings will also promote knowledge development in implementing entities, planning future initiatives, and ensuring the health system's utility. The findings can also provide useful information to finance ministries, legislatives, and other orders of government and public administration in Nigeria on the far-reaching implication of health programs.

11.2 Tracking Key Performance Indicators (KPIs) for MAMII

The Key Performance Indicators (KPIs) selected for MAMII will be used to monitor the achievement of performance objectives. The selected KPIs have been selected to be unambiguous, consistent, and specified. The following are the key indicators related to the project development objectives:

Purpose: Monitor and evaluate Nigeria's Maternal Mortality Reduction Innovation Initiative (MAMII)

Framework Area	Focus	Key Measures
Facility & Service Readiness	Healthy facility capacity	BEmONC/CEmONC availability, PCH upgrades
Community Engagement	Community involvement	Stewardship, community-level interventions
Physical & Financial Access	Service availability	Geographic/economic barrier reduction
Surveillance & Monitoring	Tracking systems	Maternal health outcome monitoring
Digital Health & Enablers	Supporting infrastructure	Technology, enabling factors
Management & Coordination	Governance (SWAp aligned)	Multi-stakeholder coordination

Table 11.1 Strategic Framework Structure

11.2.1 Key Implementation Points

- Evidence-Based Decisions: Use KPIs for facility-level improvements and policy development
- Multi-Level Monitoring: Support decisions from facility to national levels
- Accountability: Demonstrate impact to stakeholders and funding partners
- Sustainability: Built on existing data systems to reduce collection burden
- Scalability: Identify successful interventions for expansion

11.2.2 Quick Reference Guide

11.2.2.1 For Programme Managers:

1. Monthly indicators provide real-time performance insights
2. Quarterly reviews enable comprehensive programme adjustments
3. Annual data supports strategic planning and resource allocation

11.2.2.2 For Data Collectors:

1. Detailed specifications available in Annex [X]
2. Each indicator includes numerator/denominator definitions
3. Clear institutional responsibilities assigned

11.2.2.3 For Evaluators:

1. Framework supports both process and outcome evaluation
2. Disaggregation requirements specified for equity analysis
3. Alignment with SDGs and national health strategies

11.2.3 Expected Outcomes

1. Reduced maternal mortality through evidence-based interventions
2. Reduced
3. Strengthened health system monitoring capacity
4. Improved accountability and transparency in maternal health programming
5. Enhanced coordination across multiple implementing partners

Table 11.2 below shows a reporting template for key indicators that will be provided to key implementing entities for the implementation of MAMII programs.

Indicator		Baseline	Actual	Target	% Achievement
Number of births in health facilities (disaggregated by the level of care)	Value				
	Date				
	Comment				
Perceived quality of care	Value				
	Date				
	Comment				

Table 11.2 Reporting Template for Indicators

11.3 Maternal and Perinatal Death Surveillance and Response (MPDSR) System

The MPCDSR system is a continuous surveillance and response mechanism that links the health information system with quality improvement processes at all levels—community, facility, state, and national. Its structure involves the routine identification and notification of all deaths, case reviews, data analysis, development and implementation of responses, and monitoring and evaluation of interventions.

The system ensures that information on deaths is translated into timely actions aimed at preventing future maternal, perinatal, and child deaths. Its primary goal is to eliminate preventable

mortality by systematically gathering relevant data, conducting death audits and using findings to guide immediate and long-term public health actions, and monitoring their impact.

Leadership of the MPCDSR lies with the Family Health Department of the Federal Ministry of Health and Social Welfare (FMoHSW), with support from NPHCDA for community and primary health care components in collaboration with stakeholders at the State and LGA levels. Findings will also be presented in the SCO Bulletin/Briefs for MAMII.

At its core, the MPCDSR system is a continuous action cycle:

- Identify deaths and their causes/contributory factors;
- Recommend actions to prevent recurrence;
- Assign responsibilities and timelines;
- Monitor implementation of actions;
- Use results to design effective, data-driven interventions.

11.3.1 Surveillance Components in the MPDSR

11.3.1.2 Identification and Notification

The first step is the systematic identification and notification of every maternal, perinatal, and child death. This active surveillance process helps uncover modifiable risk factors that can be addressed to prevent recurrence. Unlike passive reporting, active surveillance involves targeted case-finding, which provides more timely and reliable data.

Key benefits include:

- Timely notification and verification of deaths.
- Heightened awareness and advocacy.
- Greater accountability for health services, policymakers, and civil society.

Capturing community-based deaths is particularly critical, as they constitute the majority but are often missed due to weak reporting systems. Data collected include both the death event and surrounding circumstances.

11.3.1.2 Maternal, Perinatal and Child Death Review

This is an in-depth, confidential, qualitative investigation into the medical and non-medical factors surrounding maternal, perinatal, or child deaths. Information is gathered through facility records, staff interviews, and, at community level, verbal and social autopsies with families and community members.

Objectives:

- Identify avoidable and remediable factors.
- Reconstruct the events leading to death.
- Improve the quality of care in health facilities and communities.
- Generate recommendations for preventing future deaths.

A medical officer assigns the probable cause of death, while data are coded and analyzed to guide interventions.

11.3.2 Analysis: Data Aggregation and Interpretation

Collected data are translated into meaningful information for decision-makers and

stakeholders. Both qualitative and quantitative methods are applied to:

- Identify causes of death and high-risk groups;
- Highlight contributing factors and emerging trends;
- Prioritize public health problems and guide responses.

Indicators may include:

1. Magnitude of deaths.
2. Cause-specific mortality rates.
3. Measures of preventability.

This step ensures reliable indicators that can be cross-referenced with other health information systems.

11.3.3 Response

Findings from reviews and analysis should lead to immediate and long-term actions to prevent recurrence. Responses must be culturally appropriate and targeted to the specific problems identified.

Types of responses:

- Immediate Response: Quick corrective action at facility or community level without waiting for aggregated data.
- Periodic Response: Broader interventions at monthly, quarterly, or semi-annual intervals, addressing systemic issues across facilities, LGA, States and National.

Responses may include health worker training, community education, infrastructure improvements, or policy adjustments

11.3.4 Dissemination of Results, Recommendations, and Responses

To ensure accountability, the FMOHSW will disseminate national-level findings, while states will share sub-national reports. Dissemination should be transparent, regular, and focused on actionable insights for stakeholders.

11.3.5 Monitoring and Evaluation (M&E) for MPDSR System

M&E ensures that all steps in the MPCDSR cycle are functioning effectively. A monitoring framework with specific indicators should be established and regularly reviewed.

The evaluation process should assess:

- Efficiency: quality and timeliness of identification, review, and analysis.
- Effectiveness: implementation of recommendations and impact on mortality reduction.

If actions are not implemented or outcomes are not achieved, system gaps must be identified and corrected. Maternal, perinatal, and child health indicators will serve as benchmarks for assessing performance.

CHAPTER TWELVE

Research Agenda

12. Research Agenda

The MAMII has a robust research agenda which will be executed by the SCO and Implementing entities with support from the World Bank Development Impact Evaluation (DIME) team. Stakeholders including development partners and the academia are invited to identify research areas under the MAMII. The prioritized research areas under MAMII are discussed in section 12.1.

12.1 Priority Areas for Research on Maternal and Neonatal Mortality

The priority areas of research have been carefully identified as areas where developmental research may influence programming and policy reform. The list below describes priority areas and subthemes to encourage researchers to align their research topics to those underlisted below:

12.1.1 Strengthening Healthcare Systems and Service Delivery

12.1.1.1 Access to Quality Care

Investigate enablers and barriers to accessing antenatal, delivery services, essential and comprehensive newborn care as well as postnatal care, including financial, geographical, and cultural factors

12.1.1.2 Human Resource for Health

Research is needed to generate evidence on strategies to attract and retain skilled health workers, particularly in remote areas with an emphasis on MAMII-prioritized LGAs.t Assess the primary health systems' readiness to identify and transfer obstetric emergencies to where comprehensive care can be sought

12.1.1.3 Health Facility Infrastructure

Under the health facility infrastructure, the research priority is to evaluate the adequacy and functionality of health facilities. The focus should be on the service menu and capacity across all levels, equipment, supplies, infrastructure , and climate resilience

12.1.1.4 Community Health Structures

Explore strategies to optimize community health structures in improving maternal and newborn health outcomes

12.1.1.5 Data Collection and Monitoring

For data collection and monitoring, it is crucial to evaluate the M&E systems including MPCDSR for collecting and analyzing data on maternal, newborn and child health outcomes, including maternal mortality, morbidity, Newborn and child health indicators

12.1.2 Addressing Gender Equality and Social Inclusion Priorities

12.1.2.1 Socio-Cultural Factors

Investigate how cultural beliefs, practices, and norms influence maternal and child health behaviors and outcomes

12.1.2.2 Poverty and Inequality

Explore the impact of poverty, socioeconomic status, incentives & rewards, and other social determinants on maternal and child health

12.1.2.3 Access to Education and Empowerment

Research the role of women and their partners' education and empowerment in improving maternal and child health outcomes

12.1.2.4 Specific Populations

Focus on the needs of marginalized populations, including those living in rural and underserved areas and the prioritized MAMII LGAs, ethnic minorities, and people with disabilities

12.1.3 Promoting Evidence-Based Interventions

12.1.3.1 Nutrition

Investigate the effectiveness of nutrition interventions, such as micronutrient supplementation and food fortification, in improving maternal and child health outcomes

12.1.3.2 Family Planning

Research the effectiveness of family planning programs and financing in reducing unintended pregnancies and improving maternal and child health

12.1.3.3 Infectious Diseases

Investigate the prevalence and impact of infectious diseases, such as HIV/AIDS, malaria, and tuberculosis, on maternal and child health

12.1.3.4 Maternal Mental Health

Explore the prevalence and impact of maternal mental health conditions, such as depression and anxiety, on maternal, Newborn and child health

12.1.3.5 Perinatal Care

Focus on improving the quality and coverage of perinatal care for mothers and newborns, including ANC, delivery services, and postnatal care.

Generate evidence on prevalence and effective interventions to address drivers of maternal mortality including PPH, pre-eclampsia, eclampsia, anemia, etc

12.1.3.6 Newborn Health

Conduct implementation research to assess effectiveness of new and emerging interventions for addressing key drivers of newborn morbidity and mortality

12.1.3.7 `Childhood Illnesses

Research the causes, prevention, and treatment of common childhood illnesses, such as pneumonia, diarrhoea, and measles

12.2 Leveraging Digital Innovations for Maternal, Newborn and Child Health Monitoring

Under MAMII, the SCO will ensure the better analysis of large microeconomic and social data sets, improve digital and computing power for more sophisticated modelling, experimentation, and econometric examination of micro and social policy impacts. The use of digital innovations will yield improvements in the ability of public systems to identify and quantify causal relationships.

With the NHMIS and data from other sources, there is a challenge to ensure that the analytical tools and evidentiary practices appropriately serve contemporary use of data, and

that the institutional framework is sufficiently robust to ensure transparent and independent evaluation of the evidence. The SCO and implementing entities will ensure analysis of all data at a scale that was previously unimaginable, to ensure government policies work without wasting resources.

12.3 Strengthening Evidence-Based Policy Formulation

Evidence-based policy-making is a process that transparently uses rigorous and tested evidence in the design, implementation, and refinement of policy to meet designated policy objectives. For MAMII, evidence for policy change must address the following characteristics that seem emblematic of the present interest of the Government of Nigeria across all levels:

- evidence should be broad, tested, rigorous, and ideally capable of replication
- evidence should be robust and avoid common methodological pitfalls; and
- the entire process should be transparent and contestable.

The best available evidence should underpin policy decisions. The research agenda will be used to inform policy programs on both demand and supply- side of healthcare. The number of complex policy challenges on the horizon puts a premium on ensuring rigorous assessment of policy choices and evaluation of existing programs. For instance, in the human capital sphere there is often little settled evidence about what policy measures work best and there can be long lead times before results are fully evident making policy mistakes come at a significant cost.

This broader view recognises that evidence and evaluation are relevant at every stage of the policy cycle, from identifying the policy problem, through assessing policy options, to ex-post evaluation (figure 12.1). Moreover, it can encompass an array of evidence and research methods (figure 12.2).

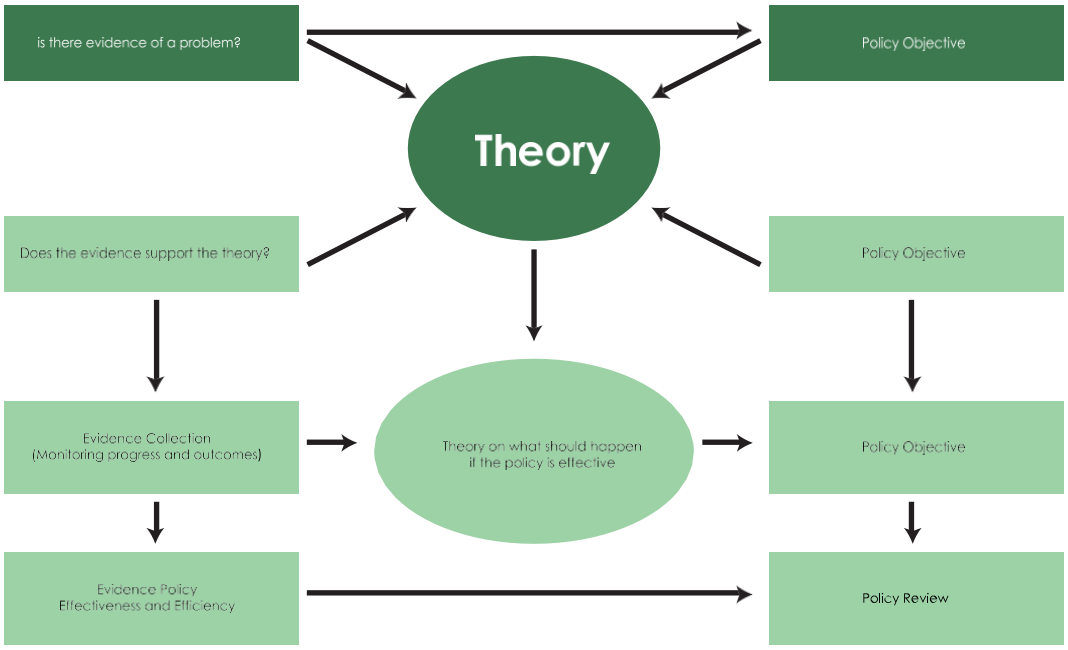


Figure 11.1: The role of Evidence in Policy Cycle

Figure 12.2 The types of evidence in evidence-based policy making

Under this view, what matters for public policy development is not only what works, but also how does it work, what are the broader ramifications, at what cost, and who benefits or loses? Fundamentally, evidence-based policy is about assessing whether a policy improves community wellbeing. To strengthen evidence-based policy formulation, the SCO will foster a culture of evidence use, build capacity for data collection and analysis, and ensure that policy decisions are informed by rigorous research and data.

As part of its duty, the SCO will perform the following functions to ensure evidence-based policy making is institutionalized at the centerstage of high- level decision making:

12.3.1. Fostering a Culture of Evidence Use

Leadership Commitment

Strong leadership from the center of government and pressure on relevant government MDAs crucial to embed evidence-informed approaches in policy-making

Performance-Driven Approach

Leverage performance-driven resource allocation to incentivize the use of evidence

Cross-Cutting Missions

Establish high-profile committees and networks with a cross-cutting mission to promote evidence use

Capacity Building

Invest in capacity building initiatives that embed evaluation from the beginning to inform implementation and support continuous learning

Reduce Knowledge Gaps

Assess what initiatives effectively foster evidence use and find ways to measure their impact

12.3.2 Building Capacity for Data Collection and Analysis

Data Infrastructure

Invest in robust data infrastructure to collect, store, and analyze relevant data

Data Literacy

Train policymakers and staff on data literacy and analytical skills

Collaboration

Foster collaboration between researchers, policymakers, and other stakeholders to ensure that research is relevant and actionable

12.3.3 Ensuring Evidence-Informed Decision-Making

Policy Process

Integrate evidence-informed approaches into the policy process, from problem identification to implementation and evaluation

Evidence Synthesis

Use systematic reviews and other evidence synthesis methods to identify and evaluate the best available evidence

Transparency

Ensure transparency in the use of evidence by making data and research findings publicly available

Accountability

Support policymakers' accountability for using evidence to inform their decisions

Sustainability

Embed evidence-informed approaches within organizational structures and strategies to enable sustainable and long-term change

12.3.4 Addressing Barriers to Evidence Use

Political Factors

Understand and address the politics of evidence-informed policy-making, particularly the incentives facing policymakers to support the use of evidence

Resource Constraints

Allocate sufficient resources to support evidence-informed policy-making

Lack of Capacity

Address capacity gaps in data collection, analysis, and interpretation

Lack of Trust

Build trust between researchers, policymakers, and the public

CHAPTER THIRTEEN

Environmental and Social Safeguards in MAMII Implementation

13. Environmental and Social Safeguards in MAMII Implementation

Safeguards are measures taken to avoid or minimise the negative impacts of aid activities on people and the environment. For MAMII program, the following safeguard principles shall be adhered to:

Principle 1: Do no harm

Protect the rights, health, safety, and livelihoods of people including, children, women, ethnic minorities, and other vulnerable or disadvantaged groups while maintaining the health, diversity, and productivity of the environment.

Principle 2: Identify, assess, and manage environmental and social impacts

- Identify and assess plausible environmental and social risks and impacts early to ensure that they are adequately addressed and managed in the MAMII program concepts, designs, and implementation

Principle 3: Engage with stakeholders and working effectively with partners

- Ensure transparency about project activities, risks, and impacts in a timely, accessible, culturally, and socially acceptable manner for affected groups
- Early and continuous engagement with relevant stakeholders in identifying and managing risks and impacts
- Ensuring consultations with stakeholders are inclusive, free of external manipulation, interference, coercion, or intimidation, and allow for meaningful participation
- Provide accessible and appropriate grievance redress mechanisms, ensuring that grievances are handled promptly and transparently
- Work with multilateral, bilateral, NGO and private sector implementing partners to ensure environmental and social impacts are properly managed

Principle 4: Promote improved environmental and social outcomes

- Comply with Nigerian safeguard laws and policies
- Integrating eco-friendly strategies into MAMII program implementation Social Safeguards

13.1 Community Engagement and Rights-Based Approaches

All MAMII programs should take community engagement as a strategic and inclusive process of working in collaboration with local communities based on principles that uphold their right to be informed, consulted, involved, and empowered to meaningfully participate in MAMII and positively influence lives. Communities should be engaged through dialogue, and town hall meetings to foster trust which is a crucial element for long term co-creation, ownership and impact.

13.1.1 3C's of Community Engagement

The community engagement strategy for MAMII program will rest on the following (3Cs):

Cooperation: All MAMII programs will seek cooperative alliances with relevant

implementing entities, including international organisations to work towards a common goal. A cooperative and participatory approach will secure greater understanding and commitment to implementation. Cooperation with relevant partners will ensure flexibility to adjust with the unseen challenges and rapid responsiveness to adaptive learning through pooling of technical knowledge and experiences.

Collaboration: Collaborating with local authorities who are trusted within the community, enjoy credibility, are looked up to with confidence and 'have a voice' will be sought as MAMII programs are designed and implemented. These could be local administration, religious leaders, local elders, and opinion leaders.

Communication: Communicating in a clear, coherent, and consistent manner which is significant in avoiding misinformation from different sources. A set of mutually agreed key messages would help to earn trust and confidence. The SCO will also support all programs in the overall messaging for MAMII.

The following core principles of the MAMII programs community engagement process will be adhered to:

1. Communities will be approached in collaboration and be made aware of the project's purpose and potential benefits to participating communities. They will be informed of their choice to opt out of participating in the proposed activities
2. Project beneficiaries, regardless of their ethnic group or social status, shall be engaged in a culturally relevant way on the basis of a Free, Prior, and Informed Consent (FPIC) aimed at establishing broad-based and sustainable community support for the project
3. An account of ethnic differentiation will be taken into consideration in the community engagement process to ensure that project implementation is inclusive and carried out in the appropriate languages. Communication during the project cycle will use appropriate information, education, and communication (IEC) materials to respond to issues of language and ethnicity, literacy/illiteracy, gender, and social vulnerability
4. All project stakeholders will have the opportunity to participate and benefit from the project through participation in the preparation and implementation of Community Action Plans (CAPs)

13.1.2 Community Engagement Process Stages

Community consent will be obtained during main project stages to ensure that the community is fully involved in decision making at each stage and is fully aware of activities during project implementation. The community engagement process consists of 4 stages:

Stage 1: Field team formation and selection of participating villages

In this stage, recruitment, formation, and orientation of the technical team involved in this process will the executed. This stage will also involve the identification of participating villages following a set of eligibility criteria.

Stage 2: Community awareness and initiating FPIC process

This stage will involve project disclosure to communities and input their consultation on project plans, initiating free, prior, and informed consent process.

Stage 3: Participatory planning, including consultations, consensus, and agreement

This stage will cover Community Action Plans (CAP) between the community, and private companies and private service providers and authorities.

Stage 4: Implementation

This stage will cover the implementation of all plans and agreements, and implementation of grievance mechanism, and monitoring and evaluation consisting participatory monitoring and project monitoring.

13.1.3 Rights-based approach

A rights-based approach to development provides a framework for human development using human rights standards and principles. Using these human rights principles to the development process make up the core of a rights-based approach. The approach installs marginalised and discriminated people who do not realise their rights as citizens, at the very centre of a development programme. A rights-based approach enables communities and individuals to develop the capacity to reflect and analyse their current situation to identify solutions and claim their rights. The following safeguards must be considered by all MAMII programs when identifying and managing rights of beneficiaries and stakeholders for potential environmental and social impacts:

- Do No Harm – Ensure no intervention exacerbates existing inequalities or creates new vulnerabilities, or harm human rights, livelihoods, or well being of affected communities.
- Free, Prior, and Informed Consent (FPIC) – Obtain meaningful consent from affected communities, particularly Indigenous Peoples and marginalized groups. Before initiating activities, ensuring consultations are transparent, inclusive and free from coercion
- Gender-Responsive Measures – Integrate and address the specific needs and rights of women and girls in all program designs.
- Monitoring & Grievance Mechanisms – Implement systems to track rights violations and provide accessible, transparent and appropriate channels for complaints and remedies ensuring prompt and fair resolution

13.1.3.1 Health and social impacts: gender equality, rights, and equity

This standard recognises that essential parts of MAMII's implementation can increase community exposure and vulnerabilities to social and health- related risks and impacts. The activities involved in procuring health- related materials, its storage, transportation, use, and disposal may harm human health or cause social distress. Transparency about these health and social risks and their repercussions is a complex societal, moral, and ethical commitment of MAMII. This standard emphasises the protection of communities and individuals from these unsafe environmental and social issues, while avoiding adverse impacts to other standards including human rights and gender equality. This standard also aims to assess the various risks that MAMII imposes on the health and social safety of diverse groups within the community. Additionally, it proposes measures to minimise and prevent the identified risks and impact.

13.1.3.2 Resource efficiency, pollution prevention, and health care waste management

Activities involving health delivery services that are mismanaged can result in large quantity of waste and environmental pollution, consumption of resources, and the threatening of communities and individual safety. These activities include managing radiological and biological materials, infrastructure development, sanitation practices, and chemical usage. MAMII facilitates processes to avoid or minimize contamination from activities under its responsibility through addressing health and safety concerns of waste handlers and preventing this hazardous waste from contaminating the environment.

13.1.3.3 Labour and working conditions

The achievement of MAMII's goals, through the execution of its planned activities, requires the protection of workers' rights, fair treatment, and safe working conditions. The requirements

regarding labour and working conditions apply to all workers on projects and programs executed in implementing MAMII policies. These standards rests on the following principles:

1. Equal Opportunity and Non-Discrimination

Ensure equal opportunity and treatment in all aspects of employment, including recruitment, working conditions, training, job assignments, promotions, termination, retirement, and disciplinary practices, without discrimination based on any grounds.

2. 2.Prohibition of Exploitative Practices

Strictly prohibit forced labour, child labour, and all forms of slavery or human trafficking in any MAMII-related activities.

3. 3.Safe and Respectful Workplace

Protect the health, safety, and well-being of all workers, fostering an environment where employees feel valued, respected, and supported.

4. 4.Support for Health Care Personnel

Safeguard the rights and well-being of personnel involved in formulating and delivering health care activities and services, ensuring their contributions are recognized and protected.

These standards promote a fair, inclusive, and safe workplace, aligning with MAMII's commitment to ethical labour practices and employee well-being.

13.1.3.4. Children, vulnerable and disadvantaged groups

MAMII activities are proposed to benefit people and communities. In project implementation plans, the development needs of vulnerable and disadvantaged groups must be considered. MAMII seeks to protect vulnerable groups from any forms of sexual exploitation, abuse, and harassment in any of its activities. These vulnerable groups include women, children, people living with disabilities, the poor, the elderly, ethnic and religious minorities. MAMII will engage, in a relevant way, with the interests of these affected groups while avoiding or mitigating negative impacts on these disadvantaged groups.

13.1.4 Benefits of Using a Rights-Based Approach in MAMII

Consistency and efficiency: The objectives of many community projects established to alleviate disadvantage and hardship are likely to be underpinned by human rights principles. Organisations are bound to improve efficiency by articulating their functions within a human rights framework. By focusing and articulating all areas of operation within a human rights-based approach, MAMII processes will be streamlined and simplified, thereby reducing costs that arise from unnecessary duplication.

Quality of Service Delivery: The following are key benefits of a human rights-based approach in the context of healthcare:

- Improved quality of health services
- Person-centred design and delivery of health services
- Reduced risk of complaints and litigation
- Improved overall decision-making
- More effective handling of uncomfortable or complex issues involving people's rights

Active Stakeholder Engagement: Using a rights-based approach in MAMII can help earn the trust of communities and groups thereby allowing for the smooth implementation of the project and added benefits including setting a solid foundation for long-term operational security, facilitating valuable partnerships with a range of stakeholders, and mitigating the risk

of spurious allegations against the organisation.

Other benefits include:

- Improving the ease and quality of decision-making
- Ensuring a bigger and more sustainable project impact by putting the rights of the most vulnerable front and centre in our goal to change norms, structural policies, and practices
- Facilitating dialogue between citizens and authorities
- Increasing transparency and accountability towards targeted communities, partners, donors, and collaborators.

Worker Productivity, Retention and Motivation: Workers that are treated fairly, with dignity and respect tend to be productive. When organisations uphold their employees' human rights, it builds staff confidence, morale, and loyalty. Employees and volunteers who feel valued and well-treated are more likely to maximise their contribution to the implementation of MAMII.

13.1.5 Rights-holders and Duty-bearers

Every human being is a rights-holder and for every human right there is a corresponding duty-bearer. Duty bearers are those whose responsibility it is to respect, protect, promote, and fulfil those rights. In MAMII, the rights-holders we refer to are individuals, groups, communities, movements, and organisations of marginalised people.

The rights-holder is entitled to rights, claim rights, hold the duty-bearer accountable, and respect the rights of others. On the other hand, the duty-bearers can be members of the government and actors such as private companies and employers, traditional authorities, and parents who hold power and duties with regard to rights. Duty-bearers have the obligation to

- respect the rights of rights-holders; refrain from actions depriving people of their right
- protect the rights of rights-holders; enacting laws and creating mechanisms to prevent the violation of rights, and
- fulfil the rights of rights-holders; taking active steps to enable people to enjoy their right.

Table 13.1 describes the institutional strategies for managing right holders and duty bearers under MAMII.

ACTORS	STRATEGIES IN RELATION TO THESE ACTORS
Rights-holders (Individuals, groups, communities, movements and organisations of marginalised people)	Addressing basic needs while also empowering rights-holders
	Raising rights awareness and consciousness about why rights-holders are economically or socially disadvantaged
	Organising and mobilising rights-holders
	Organising and mobilising rights-holders
	Building organisational and leadership capacity of rights-holder organisations
	Supporting rights-holder mobilisation in advocacy actions and campaigns
	Supporting social movements
	Building alliances and networking with partners
Duty-bearers (Governments, traditional leaders, etc.)	Creating pilot projects in cooperation with duty-bearers, covering basic needs and raising awareness about rights, entitlements, and their obligations to fulfil them
	Capacity building with service providers and state actors
	Collaborative pilot projects, such as including community monitoring mechanisms in service provision
	Holding duty-bearers accountable
	Convincing duty-bearers to accept their responsibility
	Exposing duty-bearers' inactions or violation of human
	Rights

Table 13.1 Strategies towards rights-holders and duty-bearers

13.2 Addressing Gender and Social Inclusion (GESI) Concerns

Community engagement in MAMII's environmental and social safeguards involves communication with representatives of all social groups in the community. It is also about ensuring that women and vulnerable groups are given opportunities to participate. MAMII's project objectives cannot be achieved without proper attention to the needs, interests, priorities, and roles of these groups. MAMII recognises the health risks facilitated by gender inequality and pervasive harmful gender norms. In addition, disability inclusion is an essential aspect of providing the highest standard of health for every human being. People living with disabilities experience a range of health inequities including stigma, discrimination, denial of life-saving care in emergencies, use of derogatory language, and involuntary seclusion or restraint.

MAMII, through the available national will ensure that disability inclusion is mainstreamed in the MAMII implementation process. This includes ensuring that disability inclusion is systematically integrated in all programme areas and operations by ensuring that persons with disabilities are consulted with the process and how the barriers interfere with their access, like communication barrier, attitudinal barrier, infrastructural barrier and environmental barriers. This entails providing support to incorporate a disability-sensitive and inclusive approach in accessing quality health services. In addition, disability inclusion is an essential aspect of providing the highest standard of health for every human being. People living with disabilities experience a range of health inequities including stigma, discrimination, denial of life-saving care in emergencies, use of derogatory language, and involuntary seclusion or restraint.

MAMII, through the available national policies and structures will ensure that disability inclusion is addressed meaningfully in the MAMII implementation process. This entails ensuring that disability considerations are systematically integrated in all programme areas and operations. This entails providing support to incorporate a disability-sensitive and inclusive approach in accessing quality health services.

Women often face greater barriers to access health information and services including restrictions on mobility, discriminatory attitudes of both the communities and HSPs, minimal knowledge of specific health needs and challenges of women and girls by HSPs and health systems.

Gender equality is a fundamental human right and a necessity for a sustainable world. However, gender inequality and discrimination faced by women and girls puts their health and well-being at risk. Unequal power dynamics in gender roles, norms, and relations, are reasons why this group is historically discriminated against, marginalized or disadvantaged. Addressing gender inequality and discrimination is key in the execution of MAMII activities. The Convention on the Elimination of All Forms of Discrimination Against Women, acknowledges that extensive discrimination against women continues to exist and emphasizes that such discrimination violates the principles of equality of rights and respect for human dignity.

Through progressive frameworks, MAMII programs will ensure that plans and approaches are gender-responsive, and that discriminated groups are actively involved in decision-making processes and leadership. To address and ensure the equality of women, ethnic groups, people living with disabilities, the poor, and other marginalised groups' right to participate, MAMII programs will take the following actions:

1. Build basic understanding of GESI among team members: For the importance of GESI to be appreciated and understood, all relevant team members will be sensitised on what gender and social inclusion is, why it is important, and what it means to apply GESI in implementation. This will include provisional training by a GESI expert at the early

stages of implementation

2. Consider GESI at all levels: GESI is frequently seen as a sub-category of a project that only pertains to a section of the project despite the fact that women and the vulnerable frequently face many challenges. In MAMII, the application of GESI will consider affected groups of individuals across all levels and all sections of the project
3. Mapping of GESI structures at the community level and engagement: During conceptualisation of implementation activities for each community, women's groups and organisations representing marginalised groups will be identified and engaged with to provide their perspective. This stakeholder identification will be inclusive to ensure equitable benefits
4. Develop GESI targeted interventions as part of overall program design: MAMII will take advantage of opportunities to conduct stand-alone interventions that address gender barriers that inhibit the full participation of women and vulnerable groups.

13.3 Ensuring Sustainability and Scalability of MAMII Interventions

Scalability is the ability of a health intervention that has proven its efficacy on a small scale or under controlled conditions to be expanded to reach a greater proportion of an eligible population, while maintaining its effectiveness. Sustainability is the extent which an intervention can be continued beyond its initial implementation without changing resource needs. In order to ensure the achievement and sustainability of MAMII programs, implementing entities will prioritize the following:

1. Aligning intervention with stakeholder needs: An important way to ensure the scalability and sustainability of MAMII is to align project activities with the expectations and needs of the primary and secondary stakeholders throughout the intervention process. This means that they must be involved in the process, engaged meaningfully to understand their perspectives and preferences, and implement their feedback into MAMII's project design. This will give the stakeholders a sense of ownership and commitment to the project, ensuring its relevance.
2. Establish a sustainability and scalability framework: Having a realistic plan that outlines the rationale, objectives, and strategies for sustainability and scalability of this project is important. This framework should contain an analysis of the factors that affect MAMII's scalability and sustainability. Monitoring and evaluation systems that track the sustainability and scalability of this project must also be included to view project progression and status.
3. Capacity building: Stakeholders must be provided with necessary skills, knowledge, and tools to enable them use, engage, and expand the project even after intervention activities have been ended. There is also a need to foster lasting relationships with stakeholders to leverage their strength and resources, ensuring mutual benefits.
4. Communicate project results: Project results need to be communicated and widely disseminated to create visibility for MAMII and also create awareness of the results of the intervention. This entails identifying the right audience and channels to disseminate project results, while highlighting the value, impact, and successes of the project.

Figure 13.1. Scalability Assessment Process

13.4 Grievance Redress Mechanisms

Grievances and concerns may be raised by project-affected parties related to the environmental and social performance and implementation of the project. For this reason, all MAMII programs will set up a grievance mechanism which will rest on the following principles:

- That the rights and interests of project participants are protected. Ensuring concerns are respected and prioritized
- That concerns raised by participants relating to the project implementation process are adequately and promptly addressed to maintain trust and mitigate negative impacts
- That entitlements or livelihood support for project participants are provided on time
- That project participants are aware of their rights to access grievance procedures at no cost, ensuring transparency and ease of use
- •That this grievance mechanism will be in line with existing policies, strategies, and regulations on grievances

The MAMII programs grievance redress mechanism would be:

1. Legitimate: enabling trust among stakeholder groups by ensuring accountable, fair and impartial management of grievance
2. Accessible: Ensure the Mechanism is widely known to all stakeholder groups, providing

adequate support and assistance to overcome accessibility barriers, enabling inclusive participation

3. Predictable: providing a clear and known procedure with an indicative time-frame for each stage, and possible outcomes
4. Equitable: seeking to ensure that aggrieved parties have reasonable access to sources of information, advice, and expertise necessary to engage effectively in the grievance process
5. Transparent: keep all parties informed about grievances, while enhancing confidence in the mechanisms' effectiveness
6. Rights-based: ensuring that outcomes and remedies accord with internationally recognized human rights standards, ensuring fairness and dignity

The SCO, in addition to implementing the GR system, will primarily be responsible for addressing, managing, and resolving project-related concerns or grievances submitted by participant groups. The unit will have a grievance officer who will receive complaints, respond, and, where necessary, escalate them to the national program coordinator of the SCO for review and prompt response. The SCO shall resolve issues that may arise within 15 days of receiving the complaint. When issues are escalated, the grievance officer shall inform the complainants of the actions to be taken and the likely timeline.

13.5 Environmental Safeguards

Resource efficiency, pollution prevention, and health care waste management.

Activities involving health delivery services that are mismanaged can result in large quantities of waste and environmental pollution, consumption of resources, and the threatening of communities and individual safety. These activities include managing radiological and biological materials, infrastructure development, sanitation practices, and chemical usage. MAMII facilitates processes to avoid or minimize contamination from activities under its responsibility through addressing health and safety concerns of waste handlers and preventing this hazardous waste from contaminating the environment.

13.6 Safe Medical Waste Management

- Categorization & Segregation: Use color-coded bins (e.g., black for general, yellow/red for infectious, brown for pharmaceuticals, specialized sharps containers)
- Treatment & Disposal: Develop protocols for on-site treatment or safe off-site transfer in compliance with National guidelines
- Infection Control: Form an infection control team responsible for PPE, SOPs, and staff training.

13.7 WASH Standards in Facilities

- Provide potable water, adequate hand-washing stations, and sanitation facilities in clinics and outreach settings.
- Regular WASH assessments to prevent waterborne infections

CHAPTER FOURTEEN

Climate and Maternal-Newborn Health in the Context of Mamii

14. Climate and Maternal-Newborn Health in the Context of MAMII

14.1 Why Climate Matters for MAMII

Nigeria's maternal mortality burden is among the highest globally, driven by causes such as hemorrhage, eclampsia, sepsis, malaria, and anemia. These drivers are closely linked to climate hazards including extreme heat, flooding, vector-borne diseases, food insecurity, and poor air and water quality. Climate change compounds existing health system challenges and amplifies the well-documented Five Delays (in seeking care, reaching care, receiving care, accountability, and coordination) that contribute to maternal and newborn mortality. MAMII, as a strategic initiative to reduce maternal deaths, must integrate climate resilience to ensure interventions remain effective in the face of increasing climate risks.

14.2 Climate Hazards, Maternal Mechanisms, and Mortality Drivers in Nigeria

Climate Hazard	Mechanism	Maternal/Neonatal Mortality Driver	Affected MAMII Indicators
Extreme heat	Hypertensive disorders, reduced placental blood flow	Eclampsia, stillbirth	Maternal mortality ratio, neonatal mortality rate
	Displacement, blocked access to care	Hemorrhage, obstructed labor	Percentage of skilled birth attendance, Percentage of facility deliveries
Malaria	Maternal anemia, IUGR, hemorrhage	Malaria-related maternal death, IUGR stillbirth	Maternal and neonatal mortality rates
Food insecurity	Malnutrition leading to anemia	Hemorrhage, perinatal mortality	Maternal mortality rate
Water insecurity	Infections during pregnancy	Sepsis, low birthweight, perinatal mortality	Maternal and neonatal mortality rates
Poor air quality	Low birth weight, IUGR, stillbirth	Stillbirth	Neonatal mortality rate

Table 14.1 Climate hazards, maternal mechanisms, and mortality drivers in Nigeria

14.3 Climate-Sensitive MAMII Interventions

Sustainable Quality of Care

- Climate-adapted PHCs: Design and retrofit PHC facilities for flood resistance, passive cooling, and solar power to ensure service continuity during climate events.
- Resilient health workforce: Continuous training on climate-sensitive maternal care, including management of heat-related hypertensive disorders, malaria, and malnutrition.
- Sustainable supply chains: Ensure steady availability of maternal health commodities (e.g., oxytocin, magnesium sulfate, bed nets) despite climate shocks.
- Integrated service delivery: Align emergency obstetric care readiness with climate disaster preparedness plans.

Social Prescribing for Maternal Resilience

- Link pregnant women to community-based support structures (e.g., women's groups, traditional leaders, agricultural programs) for nutrition, protection, and emergency preparedness.
- Prescribe access to climate-adapted safe spaces for pregnant women (e.g., shelters during floods).
- Use social networks and faith-based channels for climate-health messaging.
- Encourage community participation in local environmental actions (e.g., tree planting to reduce heat island effects).
- Empower CHWs as frontline agents of climate-informed maternal health: delivering risk communication, early warning alerts, home-based services, and referrals to climate-adapted community supports

Climate-Resilient Health Systems Strengthening

- Disaster-ready service delivery protocols: Develop standard operating procedures (SOPs) for maternal health services during floods, heatwaves, or disease outbreaks linked to climate.
- Flexible service models: Deploy mobile clinics or outreach teams that can reach pregnant women during climate shocks (e.g. flood season, extreme heat days).
- Supply chain continuity planning: Pre-position maternal health commodities (e.g. oxytocin, magnesium sulfate, clean delivery kits) in climate-vulnerable areas ahead of known hazard seasons.

Early Warning and Risk Mapping Integration

- Link maternal programs to national climate early warning systems (e.g. from NIMET): Use forecasts (floods, heatwaves, malaria transmission seasons) to trigger preparedness actions (e.g. alert health workers, pre-position supplies, adjust ANC schedules).
- Develop maternal-climate risk maps: Overlay maternal mortality hotspots with climate vulnerability zones to inform prioritization of interventions.

Community and Multisectoral Engagement

- Strengthen collaboration with disaster management agencies (NEMA, State Emergency Management Agencies): Ensure maternal health is embedded in disaster response plans and simulations.
- Engage agricultural, water, and environmental sectors: Promote interventions that reduce maternal vulnerability to climate risks (e.g. clean water supply, local food security initiatives that target pregnant women).

Digital Innovation for Climate-Responsive Maternal Care

- Use mobile platforms for climate-health messaging: Send tailored alerts to pregnant women and families about heatwaves, malaria peaks, flood warnings, with actionable advice.
- Digital monitoring tools: Enable real-time tracking of facility functionality during climate events.

Environmental Health Co-benefits

- Promote clean energy and sustainable technologies at PHCs: Solar power, clean cooking solutions, and waste management improvements that reduce indoor air pollution and make facilities more climate-resilient.
- Greening of PHC compounds: Community tree planting and shaded waiting areas to reduce heat exposure.

14.4 Climate-Sensitive Indicators Aligned with MAMII Key Activities

MAMII Key Activity	Climate-Sensitive Indicator Suggestion
Community-level interventions	Percentage of outreach including climate-health messages (such as heat risk, flood preparedness for pregnant women) Percentage of birth plans addressing climate risk (e.g. safe shelter during flood)
Improve access to services	Percentage of emergency transport climate-adapted (e.g. flood prone routes covered); Percentage of PHCs climate-resilient (flood-proofing, cooling)
Strengthen PHC & referral systems	Percentage of PHCs maintaining service during climate events (measured during /after flood/heat season); Percentage of with climate protocols for maternal care
Digital health & communication	Percentage of mobile messages with climate maternal advisories (like heat precautions for pregnant women)
Coordination through SWAp	Inclusive for climate risk in maternal death reviews (MPCDSR reports that document climate factor where relevant). Number of coordination meetings where climate risk for maternal health was discussed. Percentage of maternal death reviews documenting climate hazard involvement

Table 14.2 Climate-sensitive indicators aligned with MAMII key activities

14.5 CHWs as a Bridge Between Climate and Maternal-Newborn Health

Why CHWs are key in climate-health integration

- CHWs are the first point of contact for pregnant women in many rural and underserved areas, especially during climate emergencies.
- They provide continuous care, health education, and support at community level where facility access may be compromised by climate hazards.
- They can act as sentinels for early warning signs, reporting emerging climate-related healththreats (e.g. malaria surges, heat-related illnesses)

CHW Role	Climate-Health Action	Example
Health education & counselling	Provide climate-informed ANC education	Advice on heat safety, hydration, flood preparedness, malaria prevention during high-risk seasons
Community surveillance	Report climate-linked maternal health risks	Early reports on access barriers due to floods, heat illness cases, vector outbreaks
Social prescribing	Link women to climate-adapted community support	Referrals to shelters during floods, food assistance during droughts, local support groups

Service continuity	Deliver essential services during climate events	Home-based ANC, distribution of clean delivery kits when PHCs are inaccessible
Roles CHWs can play in linking climate and maternal-newborn health		

Table 14.3 CHWs as a bridge between climate and meternal-newborn health

14.6 Data, Governance, and Financing

- Integrate climate data into MPDSR: maternal death reviews should capture climate hazard contexts.
- Partner with NIMET, NEMA, NPHCDA for maternal health risk mapping and disaster planning.
- Advocate for climate adaptation funding to support resilient maternal health services.

14.7 Monitoring and Evaluation

MAMII does not currently include climate-sensitive M&E. This chapter proposes suggestions to integrate climate considerations into existing monitoring systems without creating parallel indicators. These enhancements will help track how climate hazards affect maternal health outcomes and program performance. Climate-sensitive M&E can fit within MAMII's Theory of Change by strengthening documentation and responsiveness at each key activity level:

- MPDSR reviews: Record climate hazards contributing to maternal deaths.
- PHC assessments: Track percentage of PHCs with climate-resilient infrastructure.
- Service delivery records: Track percentage of maternal clients receiving climate-informed care.
- Social prescribing referrals: Document percentage of linked to community climate supports.

Embedding these suggestions ensures that MAMII's interventions remain effective and adaptive in the face of climate change.

- Percentage of maternal deaths linked to climate hazards
- Percentage of PHCs adapted for climate resilience
- Percentage of maternal clients receiving climate-informed services
- Percentage of uptake of social prescribing interventions

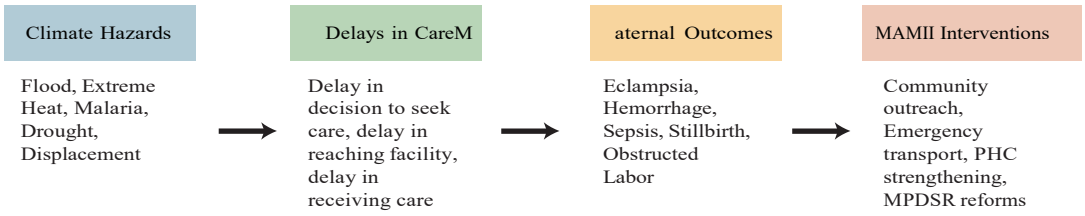


Figure 14.1. Flowchart Showing Climate Hazards to MAMII Intervention

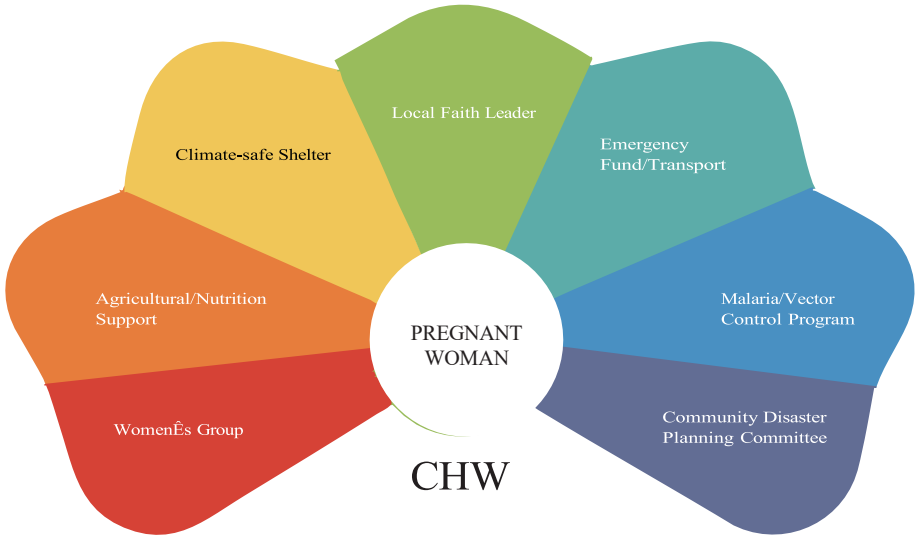


Figure 14.2. Social Prescribing for Climate-Resilient Maternal Care

Diagram 4: Climate-Sensitive M&E Across MAMII Activities

MAMII Key Activity	Suggested Climate-Sensitive Indicator
Community engagement	% outreach including flood/heat messaging
Access to services	% transport functioning during climate events
PHC strengthening	% PHCs assessed for climate resilience
MPDSR & surveillance	% reviews citing climate hazard
Digital health	% alerts issued during extreme weather

Table 14.4 Mapping MAMII Activities to Climate-Sensitive Monitoring Indicators

14.8 Conclusion

Sustaining maternal mortality reduction in Nigeria under climate change demands integrating climate resilience into MAMII's quality of care, infrastructure, workforce capacity, and community engagement strategies. Social prescribing offers an essential complement, linking women to the social and environmental supports they need to survive and thrive during climate shocks. By building climate-resilient maternal health systems, MAMII can ensure equitable, high-quality care that endures in the face of future climate threats.

Diagram 3: Map Overlay – Maternal Mortality and Climate Risk Zones

Title: Geographic Overlay of Maternal Mortality and Climate Vulnerability in Nigeria

Purpose: To visualize where maternal mortality hotspots and climate hazards intersect — guiding resource prioritization.

Structure:

A map of Nigeria showing:

1. LGAs or states with highest maternal mortality (shaded in red)
2. Flood-prone areas (blue overlay)
3. Malaria-endemic zones (green dots or cross-hatching)
4. Extreme heat zones (orange areas or icons)

Design Tip: Use layering or transparency to show overlaps. Label sample LGAs. Include a small legend and compass.

Annex

CEmONC facilities to be empanelled by NPHCDA and NHIA

S/N	STATE	NAME OF FACILITY
1	Kano	Aminu Kano Teaching Hospital
2	Kano	Murtala Mohammed Specialist Hospital
3	Kano	Mohammed Abdullahi Wase Specialist Hospital
4	Akwa Ibom	University of Uyo Teaching Hospital Uyo,
5	Kebbi	Sir Yahaya Memorial Specialist Hospital Birnin Kebbi
6	Kebbi	Federal Teaching Hospital Birnin Kebbi (FMC Birnin Kebbi)
7	Sokoto	Maryam Abacha Women and Children Hospital Sokoto
8	Sokoto	Usmanu Danfodio University Teaching Hospital Sokoto
9	Bauchi	Abubakar Tafawa Balewa University Teaching Hospital Bauchi
10	Bauchi	Federal University of Health Sciences Teaching Hospital Azare
11	Borno	University of Maiduguri Teaching Hospital Maiduguri
12	Ekiti	Federal Teaching Hospital, Ido-Ekiti
13	Ekiti	Federal Medical Centre, Ikole-Ekiti
14	Ekiti	Ekiti State University Teaching Hospital Ado-Ekiti
15	FCT	University of Abuja Teaching Hospital Gwagwalda
16	Jigawa	Federal Medical Centre Birnin Kudu
17	Niger	Federal Medical Centre Bida,
18	Cross River	University of Calabar Teaching Hospital Calabar,
19	Ebonyi	NOFIC, Abakaliki,
20	Ebonyi	David Umahi University Teaching Hospital, Uburu
21	Ebonyi	Alex Ekwueme Federal University Teaching Hospital, Abakaliki
22	Anambra	Nnamdi Azikiwe Teaching Hospital, Nnewi,
23	Enugu	University of Nigeria Teaching Hospital, Enugu,
24	Edo	Irrua Specialist Teaching Hospital, Irrua,
25	Edo	University of Benin Teaching Hospital Benin
26	Edo	Mother and child Hospital, National Orthop. Hospital Benin-City
27	Yobe	Federal Medical Centre, Nguru,
28	Osun	Obafemi Awolowo University Teaching Hospital, Ile-Ife,
29	Benue	Federal Medical Centre, Makurdi,
30	Plateau	University of Jos Teaching Hospital, Jos,
31	Nasarawa	Federal University Teaching Hospital, Lafia,
32	Nasarawa	Federal Medical Centre, Keffi
33	Gombe	Federal Teaching Hospital, Gombe,
34	Ogun	Federal Medical Centre, Abeokuta,
35	Oyo	University College Hospital, Ibadan,
36	Jigawa	Rasheed Shekoni Federal University Teaching Hospital, Dutse,
37	Abia	Federal Medical Centre, Umuahia,
38	Bayelsa	Federal Medical Centre, Yenagoa,
39	Zamfara	Federal Medical Center Gusau
40	Anambra	Federal Medical Center Onitsha,
41	Rivers	University of Port-Hacourt Teaching Hospital,
42	Katsina	Federal Teaching Hospital Katsina,

43	Abia	Federal Medial Center Umuahia,
44	Adamawa	Madibbo Adama University Teaching Hospital Yola,
45	Kwara	University of Ilorin Teching Hospital Ilorin,
46	Anambra	Chukwu Emeka Odumegwu Ojukwu Teching Hospital Awka,
47	Benue	FederalUniversity of Health Sciences Teaching Hospital Otupko
48	Lagos	Federal Medical Centre, Epe
49	Lagos	Federal Medical centre Ebute Metta,
50	Kwara	Kwara State University Teaching Hospital Ilorin,
51	Adamawa	Federal Medical Centre Mubi,
52	Adamawa	Federal Medical Centre Hong,
53	Taraba	Federal Medical Center Jalingo,
54	Ekiti	ABUAD Multisystem Hospital Ado-Ekiti,
55	Ondo	Federal Medical Centre Owo,
56	Ondo	University of Medical Sciences Teaching Hospital Akure,
57	Ondo	University of Medical Sciences Teaching Hospital Ondo
58	Katsina	Nationl Obstetric Fistula Centre Katsina,
59	Taraba	Federal Teaching Hospital Wukari,
60	Delta	Federal Medical Centre Asaba,
61	Anambra	Enugu State University Teaching Hospital Enugu,
62	Yobe	Yobe State University Teaching Hospital Damaturu,
63	Abia	Abia State University Teaching Hospital, Aba ,
64	Benue	Benue State University Teaching Hospital Makurdi,
65	Kaduna	Ahmadu Bello University Teaching Hospital Shika, Zaria
	Secondary Health Facilities	
66	AKWA IBOM	General Hospital Ikot Ekpene
67		Immanuel General Hospital Eket
68		St Luke's Hospital Anua
69	ANAMBRA	Immaculate Heart of Mary Specialist Hospital Nkpor
70		Rock foundation Hospital and Maternity
71		Gozie Specialist Hospital
72		Iyi-enu Mission Hospital, Ogidi
73	BAUCHI	Bauchi Specialist Hospital
74		General Hospital Toro
75		General Hospital Itas
76		General Hospital Misau
77	BAYELSA	Diete Koki Mem.Hospital,
78		General Hospital Otuasege
79		General Hospital Amassoma
80		General Hospital Sagbama
81	CROSS RIVER	General Hospital Calabar
82		Holy Family Hospital Ikom
83		General hospital Ogoja
84		Obudu Sacred Heart Hospital
85	EBONYI	General Hospital Edda
86		General Hospital Onueke
87		St. Patrick Hospital Mile Four Abakaliki

88	GOMBE	General Hospital Dukku
89		Zainab Bulkachuwa Women & Children Hospital Gombe
90		General Hospital Kaltungo
91		General Hospital Bajoga
92		Gombe State Specialist Hospital
93	JIGAWA	General Hospital Dutse
94		General Hospital Gumel
95		General Hospital Hadejia
96		General Hospital kazaure
97	KADUNA	Hajiya Gambo Sawaba Gen Hospital Zaria
98		Yusuf Dan Tsoho Memorial Hospital Kaduna
99		General Hospital Sabon Tasha Kaduna
100		Sir Patrick Yakowa Memorial Hospital Kafanchan
101		St Gerard's Catholic Hospital Kakuri, Kaduna
102	KANO	General Hospital Rano
103		General Hospital Gwarzo
104		Waziri Shehu General Hospital, Bachirawa, Kano
105		Sabo Bakin Zuwo Maternity Hospital Jakara, Kano
106	KEBBI	General Hospital Argungu
107		General Hospital Yauri
108		Martha Bamaiyi General Hospital Zuru
109		General Hospital Kamba
110	KWARA	Aisha Buhari Mother & Child Hospital Eiyenkorin
111		General Hospital Offa (Specialist Hospital)
112		General Hospital Kaima
113	NIGER	General Hospital Mokwa
114		General Hospital Kuta
115		General Hospital Tungan Magaji
116		Jummai Babangida Aliu Maternal &Neonatal Hospital
117		General Hospital Suleja
118	OGUN	State Hospital Abeokuta ijaye
119		Oba Ademola II Maternity Hospital Abeokuta
120		State Hospital Ijebu Ode
121		State Hospital Ilaro
122	ONDO	State Specialist Hospital Ikare
123		State Specialist Hospital Oke-Aro
124		State Specialist Hospital Okitipupa
125	RIVERS	Zonal Hospital Ahoada
126		Zonal Hospital Okirika
127		General Hospital Nchia-Eleme
128	SOKOTO	Sokoto Specialist Hospital
129		Illela General Hospital Illela
130		General Hospital Tambuwal
131	TARABA	First Referral Hospital Donga
132		General Hospital Gembu
133		Specialist Hospital Jalingo

134	ZAMFARA	General Hospital Tsafe
135		General Hospital Kaura Namoda
136		General Hospital Shinkafi
137		General Hospital Gummi
138	ENUGU	General Hospital Nsukka
139		General Hospital Awgu
140		Poly General Hospital Enugu
141		General Hospital Uwani
142	EKITI	State Specialist Hospital, Ikere-Ekiti
143		Oba Adejugbe General Hospital, Ado-Ekiti
144		General Hospital, Omuo-Ekiti
145		General Hospital, Aramoko-Ekiti
146	YOBE	Yobe State Specialist Hospital (YSSH), Potiskum
147		Yobe State Specialist Hospital (YSSH), Damaturu
148		Yobe State Specialist Hospital (YSSH), Gashua
149		Yobe State University Teaching Hospital Damaturu
150	FCT	Nyanya General Hospital
151		Kubwa General Hospital
152		Kuje General Hospital
153		Gwarimpa General Hospital
154		Abaji General Hospital

Note: This list of CEmONC facilities is continuously reviewed and updated. Users are advised to verify with the appropriate authority for the latest approved list.

Commodity list for Reproductive Health

S/N	Products	Quantity (Forecasting Unit)	Brand Name	Pack size	No of Packs	Unit Price of packs + margin
		Family Planing				
1	Male Condom (Latex) Lubricated, No Logo, 53 mm, 1 Each	3,284,363.99	DKT	3.00	821,091.00	279.72
2	Levonorgestrel/Ethinyl Estradiol 150/30 mcg + Fe 75 mg, 28 Tablets/ Cycle (PS), 1 Cycle	300,103.28	DKT	1.00	225,077.46	1,890.00
3	Progestin Only (Levonorgestrel 30 mcg 35 Tablets/Cycle, 1 Cycle or Lynestrenol 0.5mg 3	178,358.77	OKT	1.00	133,769.08	362.49
4	Levonorgestrel 75 mg/Rod w/ Trocar, 3 Year Efficacy, 2 Rod Implant, 1 Each	47,941.77	DKT	1.00	35,956.33	9,240.00
5	Levonorgestrel 75 mg/Rod w/ Trocar, 5 Year Efficacy, 2 Rod Implant, 1 Each	197,653.92	DKT	1.00	148,240.44	3,360.00
6	Levonorgestrel-Releasing Intrauterine Device 52 mg w/ Inserter, 1 Each	16,007.79	Mirena	1.00	12,005.84	182,000.00
7	Copper TCu380A Intrauterine Device, 1 Each	68,564.46	DKT	1.00	51,423.34	2,100.00
8	Medroxyprogesterone Acetate 104 mg/0.65 ml, SC Injection (Uniject Device), 1 Device	520,668.99	DKT	1.00	390,501.74	1,820.00
9	Levonorgestrel 1.5mg (Emergency contraceptive)	114,370.48	DKT	1.00	85,777.86	3,150.00
	Sub-total {NJ					
	Uterotonics for PPH and PAC					
11	Oxytocin lOIU ampoules	1,109,216.21	Juhel	10.00	83,191.22	347.20
12	Carbetocin (HSC) 100 mcg/ml amp	212,868.77		10.00	15,965.16	5,292.00
13	Tranexamic Acid (TXA) lg/lOML	45,939.18	Prexam	5.00	6,890.88	8,421.00
14	Ergomethrine O.Smg/ml ampoules	844,799.21	Swiss	10.00	63,359.94	3,187.80
15	Misoprostol 200 mcg tablets	414,382.05	DKT	10.00	31,078.65	2,450.00
	Sub-total {NJ					
	Ant1-1ntect1ves tor””- andSTI Management					
16	Doxycycline, 100mg	3,816,291.93	Generic	10.00	286,221.89	350.00
17	Azithromycin 250mg tablet	3,461,993.10	Generic	6.00	432,749.14	2,744.00
18	Metronidazole 400mg tablet	7,654,575.95	Generic	10.00	574,093.20	266.00
19	Amoxicillin plus clavulanic acid 625mg	206,848.49	Generic	1.00	155,136.36	3,850.00
20	Ceftriaxone	937,680.95	Generic	1.00	703,260.72	1,215.20
21	Gentamycine	625,120.64	Generic	10.00	46,884.05	1,204.00
22	Clotrimazole Vaginal Tablet 100mg	2,055,556.82	Mycotem	6.00	256,944.60	3,187.80
	Sub-total {NJ					
	HBP m Pregnancy/Pre-ecIamps1a/EcIamps1a					
23	Magnesium Sulphate	351,648.55	Juhel	10.00	26,373.64	6,993.00

24	Diazepam 10mg tablet	7,509.86	Univval	10.00	563.24	22,636.60

MNH Commodity List

S/No	MNH Commodities
1	Calibrateddrape
2	Injectionoxytocin
3	Injectiontranexamicacid
4	PPH trolley/carrycase
5	Anti-shockgarment
6	Multiplemicronutrient supplement
7	Injectionheat-stablecarbetocin
8	Tabs misoprostol
9	lnj.magnesiumsulphate
10	Ambuba
11	Face mask (pre-termand term babysizes)
12	4g{)chlorhexidinegel
13	O.Sguerythromycineye ointment
14	VitaminKl injection
15	Penguinsuction
16	InjectionPhenobarbitone
17	lnj./tabsmetronidazole
18	Injectiongentamicin
19	Tabsamoxicillin/clavulanicacid
20	Pulseoximeter

Drugs and Consumable List

S/N	Drugs and Consumable
1	Acetylsalicylic Acid Tablet
2	Ampicillin Caps.
3	Ampicillin Syrup
4	Ascorbic Acid Tablet
5	Benzyl Benzoate Emulsion
6	Calamine Lotion
7	Chloramphenicol Eye Drop
8	Artemethen Lumefantrine.
9	Promethazine Syrup
10	Chlorpheniramine Tablet
11	Chlorpromazine Hydrochloride Injection
12	Cotrimazole Cream
13	Cotrimazole Syrup
14	Cotrimazole Tablet
15	Cough Syrup
16	Diazepam Amp.
17	Ferrous Sulphate Tablets
18	Folic Acid Tablet
19	Ampiclox caps
20	Ampiclox suspension
21	Glucose in Saline
22	Glucose in Water
23	Hyoscine N. Butyl Bromide (TAB)
24	Iodine Solution
25	Magnesium TrisiIicate Tablet
26	Methylated Spirit Liquid
27	Metronidazole Tablet
28	Mist Magnesium TrisiIicate
29	Multivitamin Syrup
30	Multivitamin Tablet
31	Paracetamol Syrup
32	Paracetamol Tablet
33	PyranteI Palmoate Suspension
34	Normal Saline (500mls)
35	Lofaramide (LamotiI)
36	Tetracycline Capsule
37	Vitamin B-Complex Tabs.
38	Vitamin B-Complex Syrup
39	Vitamin B-Complex Injection
40	Flavoured ORS
41	Zinc
42	Chlorhexidine
43	Magnesium Sulphate 5g Injection
44	Misoprostol Tablets
45	Charcoal tablet
46	Salbutamol tab
47	Water for Injection
48	Cotton Wool
49	Disposable Syringes
50	Disposable Syringes
51	Gauze Plain
52	Chloramphenicol Eye Ointment
53	Metronidazole Susp.
54	Gentian Vialet
55	Scalp Vein Needle 20G
56	Scalp Vein Needle 24G
57	Plaster 4”
58	Bandage 4”
59	Bandage 2”
60	Promethazine Injection
61	I.V. giving Set
62	FolIev Catherter Size 16
63	Folley Catherter Size18
64	Hyoscine N. Butyl Bromide Injection (Buscopan)

Equipment List for PHCs

S/N	Equipment	Qty per	Qty Procured
1	Angle poised lamp	2	1,000
2	Anti-shock garment	2	1,000
3	Artery forceps	3	1,500
4	Bed pan	2	1,000
5	Bed sheet & pillow case	6	3,000
6	Cusco vaginal speculum	2	1,000
7	Baby weighing scale	2	1,000
8	Binocular microscope	1	500
9	Bowls (stainless steel) with stand	2	1,000
10	Dressing tray	2	1,000
11	Calibrated drapes	6	3,000
12	Centrifuge with tube	1	500
13	Clinical thermometer{Axillary)	4	2,000
14	Dressing scissors	2	1,000
15	Delivery bed	2	1,000
16	Diagnostic set	1	500
17	Dissecting forceps	3	1,500
18	Episiotomy scissors	2	1,000
19	Dry heat oven	1	500
20	Drip stand	2	1,000
21	Fetal doppler	1	500
22	Fetoscope	2	1,000
23	Fire extinguisher {9kg)	2	1,000
24	Forceps jar	3	1,500
25	Gallipot(medium)	4	2,000
26	Heamatocrit.reader for pvc	1	500
27	Insertion and removal kits for IUD	2	1,000
28	Kidney dish{big)	4	2,000
29	Kidney dish{medium)	4	2,000
30	Kidney dish{small)	4	2,000
31	Korcher's forceps	2	1,000
32	Mackintosh yard	4	2,000
33	Microscope cover slide(pack of 1oo)	2	1,000
34	Length measure for babies	4	
35	Medicine cabinets & shelves	1	500
36	Mid-upper arm circumference tape	4	2,000
37	Newborn bag and mask	2	1,000
38	Stethoscope	2	1,000
39	Patient bed with mattress	6	3,000
40	Portable incubator	1	500
41	Portable ultrasound with fetal dopper	1	510
42	Sims Vaginal speculums	2	1,000
43	Stainless instrument tray	2	1,000
44	Sterilizing drums (set of 3)	1	500

45	Needle holding forceps	3	1,500
46	Veronica bucket with tap	2	1,000
47	Work surface for resuscitating of	1	500
48	Uterine sound	1	500
49	Wall clock	1	500
50	Partograph booklet	5	2,500
51	Manual vacuum aspirator	2	1,000
52	Suction machine/apparatus	2	1,000
53	Ward screens (four folder)	3	1,500
54	Insertion and removal kits for Implants	2	1,000
55	Autoclave		1,500
56	Weighing scale		1,500
57	Pulse oximeter		1,500

Maternal and Neonatal Mortality
Reduction Innovation Initiative