



FEDERAL MINISTRY  
OF HEALTH

# NIGERIA'S CALL TO ACTION TO SAVE NEWBORN LIVES



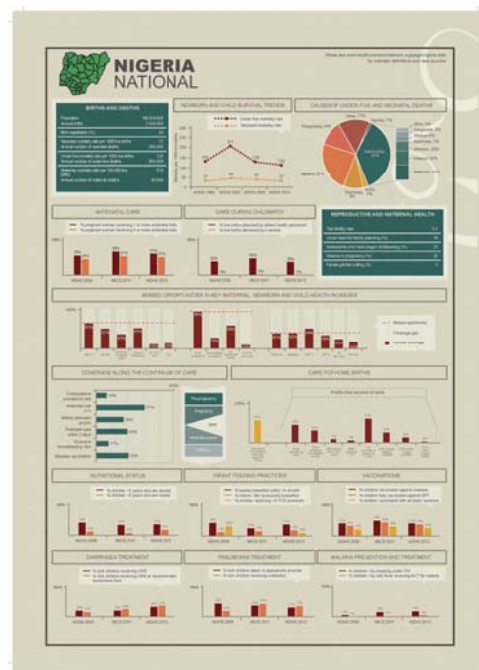
**Nigeria is committed to end preventable newborn deaths,  
making life-saving interventions available to all mothers  
and babies who need them.**

# SITUATION ANALYSIS | Maternal and Newborn Survival in Nigeria

Nigeria is Africa's most populous nation and accounts for nearly one-quarter of the continent's maternal and newborn deaths, and is one of ten countries that contributes to two-thirds of all newborn deaths worldwide.<sup>1</sup> While mortality rates are decreasing for mothers and children, progress is slow, especially for newborns. Nigeria's rate of neonatal mortality reduction was an estimated 1.83% per year from 2000 – 2012, while under-five mortality for this same period was nearly twice as fast at 3.47%<sup>2</sup> and maternal mortality declined at 4.1% from 2000 to 2013.<sup>3</sup> Of the 7 million babies born in Nigeria every year, over 260,000 die within their first month of life and nearly 300,000 are stillborn.<sup>4</sup> With nearly 90,000 deaths in the first 24 hours of life, Nigeria has the second highest burden of first day deaths in the world or 9% of the global total.<sup>5</sup> In addition, 40,000 women die from pregnancy and childbirth complications each year.<sup>6</sup>

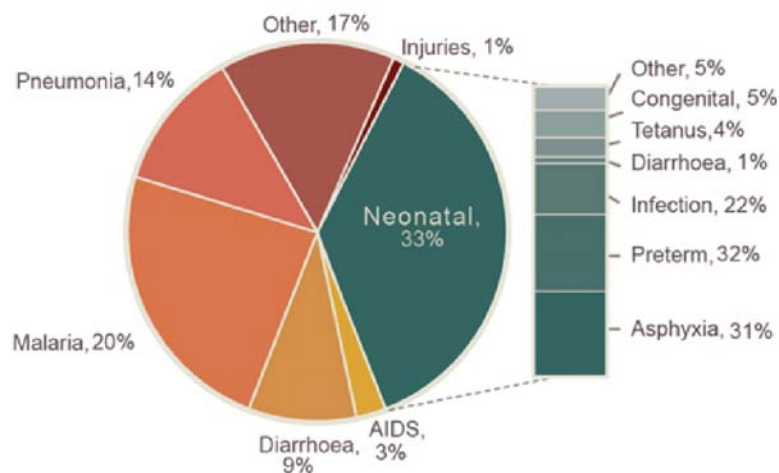
31% (see Figure 1).<sup>7</sup> Babies born too early or too small are at greater risk of infection and other complications. In Nigeria, 16% of newborns are low birth weight<sup>8</sup> and 12% are born premature.<sup>9</sup>

Box 1: Nigeria data profiles provide national and state maternal, newborn and child data to promote and inform policies and programmes. To view the data profiles visit: [www.healthynewbornnetwork.org/page/nigeria-data](http://www.healthynewbornnetwork.org/page/nigeria-data).



The vast majority of newborn deaths in Nigeria are a result of prematurity (33%) and infections (33%) followed by intrapartum complications at

Fig. 1: Causes of neonatal and under-five mortality in Nigeria.



Data source: UNICEF and WHO. 2014. Countdown to 2015: Fulfilling the Health Agenda for Women and Children. Geneva: World Health Organization.

## Policies Guiding Maternal and Newborn Health

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Since 2007 maternal, newborn, and child health (MNCH) in Nigeria have been guided by the Integrated Maternal, Newborn and Child Health (IMNCH) Strategy. This groundbreaking strategy resulted in the Federal Ministry of Health's (FMOH) formation of the Core Technical Committee for IMNCH, intended to move the IMNCH agenda forward at national and state levels and to serve as a consensus-building and decision-making forum. The committee is comprised of development partners, professional associations, research institutions, and civil society organizations. An official subgroup on newborn care was formed in 2014.

In October 2012, Nigeria's President launched the government's *Saving One Million Lives* (SOML) Initiative, which serves as an organizing framework for government efforts to accelerate improvements in health outcomes for women, newborns and children. The framework sets clear, ambitious targets to strengthen basic health services before 2015. It also creates an opportunity to scale up implementation of intervention packages towards the attainment of MNCH goals. The initiative also calls for upgrading health facilities, training and equipping facility staff to resuscitate babies and practice thermal care, expanding the use of chlorhexidine gel for cord care, accelerating the practice of Kangaroo Mother Care to manage preterm and low birth weight babies, and improving management of neonatal jaundice.

The FMOH has in the past year revised the IMNCH strategy and the Child Health Policy, both of which have prioritized newborn health. Civil society organizations continue to actively advocate for the National Health Bill to be signed into law by the President.

In 2014, the national newborn care task team reviewed standards for newborn care, including ways to improve the skills and supervision of frontline health workers and to provide the appropriate equipment, quality drugs and supplies needed at each level of the health system. The 2013 World Health Organization (WHO) postnatal care guideline<sup>10</sup> is yet to be implemented at sub-national level, despite reference to it in policy and strategy documents. Interventions for the prevention of stillbirths and neonatal deaths are also being integrated into existing training materials and guidelines.

The Midwives Service Scheme (MSS) and the Subsidy Reinvestment and Empowerment Programme for Maternal and Child Health (SURE-P MCH) have led to a considerable increase in human resources for maternal and newborn health in rural health facilities. The focus has been on care during the time of birth and the immediate postpartum period – a critical period for both the mother and baby. In addition, a community based cadre, the Village Health Worker (VHW) has been rolled out in SURE-P MCH clusters.

The MNCH pillar of SOML coordinates interventions through the Federal Government's flagship programs – the MSS and the SURE-P MCH programs as well as activities led by states and development partners. These programs aim to increase access to MNCH services through the continuum of care for pregnant women and their newborns. The MSS and SURE-P MCH programs collectively serve a combined target population of about 10 million women of reproductive age.

## Maternal and Newborn Care in Nigeria

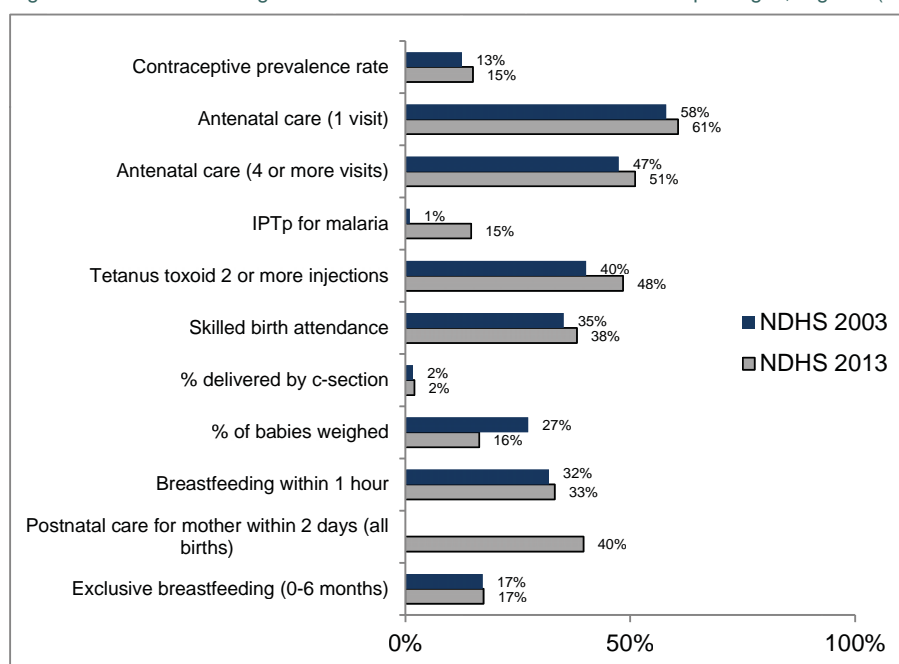
Key interventions that could prevent over two-thirds of newborn deaths in Nigeria have been identified, but coverage is very low. No intervention along the continuum of care reaches up to two-thirds of Nigerian women and children (see Figure 2). The proportion of women not receiving any antenatal care (ANC) is high, especially in the northern zones.

Inequities in coverage and quality of care at birth are extreme. Of the 36 states and Federal Capital Territory (FCT) of Abuja, six states have over 90% of births in health facilities, while in 10 states less than 25% of women give birth in a health facility (see Box 1).<sup>11</sup> In three states, nearly one-third of women give birth alone. Even where the majority of births take place in a facility and with a skilled attendant, the quality of care remains low and outcomes for mothers and babies are poor. Overall, only 38% of women across Nigeria deliver in a health facility, and a similar proportion received a postnatal care (PNC) check in the two days

after birth whilst only a quarter of women report that they initiated breastfeeding within the first hour after birth. Exclusive breastfeeding rates are low and showing no signs of improvement. Rural and less educated women are less likely than others to attend ANC, have assistance from a skilled health provider during delivery and to give birth in a health facility.<sup>12</sup>



Figure 2: Trends in coverage data for newborn-related interventions and packages, Nigeria (2003–2013)



Data sources: Nigeria Demographic Health Surveys

# ACTION NEEDED TO OVERCOME BOTTLENECKS TO SERVICE DELIVERY

Following Nigeria's participation at a regional consultation meeting in Dakar in August 2013, a two-day national consultation was held in Abuja in September 2013 to engage key stakeholders in conducting an analysis of the bottlenecks hindering the implementation of newborn health interventions. The meeting also allowed for discussions on the *Every Newborn Action Plan* (ENAP) as well as stimulated national dialogue to promote coordinated efforts to scale-up evidenced

based interventions to address preventable newborn deaths. Using the generic ENAP Bottleneck Analysis Tool, and in very interactive sessions, Nigerian maternal and newborn stakeholders reviewed and analyzed several newborn interventions along seven building blocks of the health system. Table 1 outlines the major bottlenecks identified by stakeholders and their recommended actions to enable the effective delivery of newborn health interventions at scale.

Table 1: Summary of health system bottlenecks and solutions to scale-up newborn care

SUMMARY OF PRIORITY BOTTLENECKS BY HEALTH SYSTEM BUILDING BLOCK	STRATEGIES AND ACTIONS NEEDED TO ADDRESS IDENTIFIED BOTTLENECKS
<b>LEADERSHIP AND GOVERNANCE</b>	
<ul style="list-style-type: none"> <li>No focal person or responsible person at state and local government authority (LGA) levels</li> <li>Birth registration policy exists but not enforced</li> </ul>	<ul style="list-style-type: none"> <li>Develop and strengthen the capacity of MCH focal persons at the State and LGA levels to take on newborn health</li> <li>Increase advocacy for newborn health at all levels of government</li> <li>Strengthen birth registration and include provision of certificates</li> <li>Include vital registration as part of the national conditional cash transfer programme</li> </ul>
<b>HEALTH FINANCE</b>	
<ul style="list-style-type: none"> <li>Very low coverage of health financing schemes</li> <li>No specific line item for tracking financial resources for maternal and newborn health at all levels</li> </ul>	<ul style="list-style-type: none"> <li>Global backing to support signing of the National Health Bill by the President and implementation at all levels to ensure adequate resources for implementation of MNH interventions at primary health care (PHC) level</li> <li>High level advocacy to improve financial access to MNH services</li> <li>Establish government budget line for maternal and newborn health</li> <li>Appropriate legislative bodies to support MOH to track expenditure, to ensure prompt fund release and strengthen accountability on health expenditures</li> <li>State government to expand community-based health insurance schemes</li> </ul>
<b>HEALTH WORKFORCE</b>	
<ul style="list-style-type: none"> <li>Inequitable distribution and poor retention of health workers when posted to remote and security challenged areas</li> <li>Poor remuneration of health workers</li> <li>Health worker skill gap for management of newborn conditions</li> </ul>	<ul style="list-style-type: none"> <li>Train and deploy skilled health workers and expand the MSS to cover more PHC centers</li> <li>Provide incentives for health workers in remote and unsafe areas</li> <li>Maintain health worker skills up to date through quality pre-service and in-service training</li> </ul>
<b>ESSENTIAL MEDICAL PRODUCTS AND TECHNOLOGIES</b>	
<ul style="list-style-type: none"> <li>Ineffective coordination for purchase and distribution of supplies and equipment</li> </ul>	<ul style="list-style-type: none"> <li>Integrate all existing procurement systems</li> </ul>
<b>HEALTH SERVICE DELIVERY</b>	
<ul style="list-style-type: none"> <li>Inadequate funding</li> <li>Supervision not regular at sub-national level</li> </ul>	<ul style="list-style-type: none"> <li>Make funding available for supervision at all levels of the health system</li> <li>Ensure regular integrated supportive supervision (ISS) is conducted</li> <li>Link Information from ISS with PHC reviews</li> </ul>
<b>HEALTH INFORMATION SYSTEMS</b>	
<ul style="list-style-type: none"> <li>Ineffective engagement of the private sector</li> <li>Weak reporting mechanisms</li> <li>Socio-cultural issues prevent reporting of deaths</li> <li>Poor use of data for action</li> <li>Stillbirths and newborn deaths not counted</li> </ul>	<ul style="list-style-type: none"> <li>Provide incentives for private sector reporting</li> <li>Implement Public-Private Partnership policy</li> <li>Increase supervision of private sector</li> <li>Use HMIS tools to capture MNH indicators at community level</li> <li>Improve Behavior change communication (BCC) strategies around making newborns count</li> </ul>
<b>COMMUNITY OWNERSHIP AND PARTICIPATION</b>	
<ul style="list-style-type: none"> <li>Sub-optimal engagement of community structures (ward development committees, women's groups, community based associations etc.)</li> </ul>	<ul style="list-style-type: none"> <li>Establish sustainable system for engaging and strengthening existing community structures</li> </ul>

# GOVERNMENT'S COMMITMENT TO ENDING PREVENTABLE NEWBORN DEATHS

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We reaffirm our commitments to A Promise Renewed and the *Every Woman Every Child* including the endorsement of the Secretary General's *Global Strategy for Women's and Children's Health* and commitment to achieving the goal of a contraceptive prevalence rate of 36% by 2018. We commit to develop the Nigerian *Every Newborn* Action Plan that will build on post 2015 goals and link with previous government commitments.

Nigeria has witnessed significant progress in improving the health of children under-five years and the health of their mothers. Unfortunately, progress in newborn health has been limited. In fact, recent data shows that newborn deaths account for a growing proportion of deaths among under-five Nigerian children, and more babies are stillborn. The present circumstance informs that if we do not reorient to arrest the current trend, Nigeria will not attain Millennium Development Goal 4 for child survival.

The periods of greatest risk for morbidity and mortality for women and children are the hours during and immediately after birth, with risks established during pregnancy and earlier. We know the key evidence-based interventions, the service delivery channels, as well as approaches to extend coverage and accelerate progress in reducing newborn morbidity and mortality. Newborn health continues to be a sensitive indicator of national development. Hence, there is a need to adopt focused strategies which are evidence-based and reflect best practices for the accelerated reduction of neonatal morbidity and mortality in Nigeria.

Through the SOML Initiative, Nigeria aims to save one million lives of mothers, newborns and children by 2015 through ambitious and comprehensive scale-up of effective MNCH interventions. Progress at state level has varied

with some states making good progress whilst others continue to lag behind. For instance, national coverage by Skilled Birth Attendants is 38% with a wide range of 5.2% in Sokoto State to 96.5% in Osun State.<sup>13</sup> There are also great disparities between rural and urban, lowest and highest wealth quintiles and women with higher education compared to women with no formal education. The government therefore commits to ensuring that states review their individual state profiles and commit to working towards ending preventable maternal and newborn deaths, using data for planning and accountability purposes. The FMOH therefore strongly advocates to states and LGAs to prioritize resources to improve coverage of MNH interventions.

One of the major barriers to accessing essential health care services in Nigeria is the dearth of skilled manpower. The majority of health care workers are in urban areas in Southern Nigeria. Very few work in Northern Nigeria and in rural areas, hindering the delivery of services where they are most needed. To address this challenge, a new Task Shifting policy has been developed with the aim of increasing access to skilled attendance for pregnant women and newborns in hard-to-reach areas.

The Nigerian President serves as the co-Chair of the United Nations Commission on Life Saving Commodities at the global level with the

Prime Minister of Norway. Under this initiative, Nigeria has adopted the 13 UN lifesaving and essential commodities and is poised to ensure that they are available to every mother, newborn and child under five years through the active involvement of States and LGAs. For example, Chlorhexidine gel, a proven and cost-effective way to prevent newborn infections and one of the 13 commodities, has recently been introduced and local production has begun.

The Essential Medicines and Equipment List (EML) has been reviewed to appropriately reflect neonatal commodities and the national EML review committee has granted a provisional approval of the updated EML. The use of multiple Chlorhexidine gel application for cord care has been approved for all levels of care including placement as an over-the-counter commodity.

The National Agency for Food and Drug Control (NAFDAC) has developed a manufacturing guide to accelerate considerations for Chlorhexidine product registration.

Key messages and production of advocacy materials for neonatal commodities have also been developed, field tested and await finalization and subsequent printing.

Nigeria is also implementing other strategies to prevent neonatal infection, including tetanus toxoid immunization, and the promotion of clean delivery, hand washing, breastfeeding, and hygiene. In addition, Nigeria is home to 3 of the sites in the African Neonatal Sepsis Trial (AFRINEST), which tested simplified antibiotic regimens for treating newborns with possible serious bacterial infection in situations where it is not feasible to access in-patient hospital care. Results of this important study will inform the standard of care provided to the nation's

and the region's sick newborns. Improving access to neonatal infection diagnosis and treatment as close to home as possible will be a key activity and requires support for testing simplified models of care, including outpatient treatment linked to community health extension workers.

Nigeria is also initiating maternal death reviews and surveillance. Efforts are underway to include perinatal death reviews at the facility level in order to count deaths and identify avoidable factors that can be addressed and lead to improved quality of care.

Finally, in some of our communities, stillbirths and newborn deaths are neither recognized nor counted and most often women are blamed for the loss of their babies. This silence surrounding stillbirths and newborn deaths hides the problem and impedes positive action. Stigma and blame add to prolong parents' grief. As part of our efforts to end preventable maternal and newborn deaths, we will work with communities to change these norms that hinder progress, empowering families with knowledge and capacity to adopt optimal newborn care practices, seek care promptly, and demand quality care. We will also work to strengthen the linkages between communities and health facilities.

Overall, we are committed to a supportive partnership for innovation in health care delivery that ensures Nigeria can end preventable maternal and newborn deaths through scaling-up evidence-based approaches that generate positive results for the health of our families and communities.



## References

1. Save the Children. *Surviving the First Day State of the World's Mothers 2013*. May 2013
2. The UN Inter-agency Group for Child Mortality Estimation, 2014. [www.childmortality.org](http://www.childmortality.org)
3. WHO. 2014. *Levels and Trends for Maternal Mortality: 1990 to 2013*. Geneva: World Health Organization
4. Lawn JE, Blencowe H, Oza S, You D, Lee A CC, Waiswa P, Lalli M, Bhutta Z, Barros A, Christian P, Mathers C, Cousens SN. 2014. *Every Newborn: Progress, priorities, and potential beyond survival*, *The Lancet*, 384(9938): 189 - 205.
5. Save the Children. *Surviving the First Day State of the World's Mothers 2013*. May 2013
6. WHO. 2014. *Levels and Trends for Maternal Mortality: 1990 to 2013*. Geneva: World Health Organization
7. UNICEF and WHO. 2014. *Countdown to 2015: Fulfilling the Health Agenda for Women and Children*. Geneva: World Health Organization
8. National Population Commission (NPC) [Nigeria] and ICF International. 2014. *Nigeria Demographic and Health Survey 2013*. Abuja, Nigeria, and Rockville, Maryland, USA: NPC and ICF International.
9. UNICEF and WHO. 2014. *Countdown to 2015: Fulfilling the Health Agenda for Women and Children*. Geneva: World Health Organization
10. World Health Organization. *WHO recommendations for postnatal care of the mother and newborn*. ISBN 978 92 4 150664 9. October 2013.
11. National Population Commission (NPC) [Nigeria] and ICF International. 2014. *Nigeria Demographic and Health Survey 2013*. Abuja, Nigeria, and Rockville, Maryland, USA: NPC and ICF International.
12. National Population Commission (NPC) [Nigeria] and ICF International. 2014. *Nigeria Demographic and Health Survey 2013*. Abuja, Nigeria, and Rockville, Maryland, USA: NPC and ICF International.
13. National Population Commission (NPC) [Nigeria] and ICF International. 2014. *Nigeria Demographic and Health Survey 2013*. Abuja, Nigeria, and Rockville, Maryland, USA: NPC and ICF International.

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