Nigeria's Collaborative Action Strategy (N-CAS) for Health Campaign Effectiveness

NATIONAL PRIMARY HEALTHCARE DEVELOPMENT AGENCY
Partnership for Service

FEDERAL MINISTRY OF HEALTH

HEALTH CAMPAIGN EFFECTIVENESS COALITION
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Nigeria - Collaborative Action Strategy (N-CAS)
For Health Campaign Effectiveness

Table of Contents

Glossary

Acronym	Meaning
ACSM	Advocacy, Communication, and Social Mobilisation
AHOA	Afri-health Optonet Association
BHCPF	Basic Health Care Provision Fund
BMGF	Bill and Melinda Gates Foundation (now Gates Foundation)
CAS	Collaborative Action Strategy
CDC	Center of Disease and Control
CHAI	Clinton Health Access Initiative
FOMWAN	Federation of Muslim Women's Associations of Nigeria
GAVI	Global Alliance for Vaccines and Immunisation
GF	Global Fund
GPEI	Global Polio Eradication Initiative
HCE	Health Campaign Effectiveness
ICC	Inter-agency Coordination Committee
LF	Lymphatic Filariasis
LGA	Local Government Authority
LMIC	Lower and Middle Income Country
MERLA	Monitoring, Evaluation, Research, Learning and Adaptation
MNCH	Maternal, Newborn and Child Health
MoH	Ministry of Health
MWHUN	Medical and Health Workers Union
NACHPN	National Association of Community Health Practitioners
NANNM	National Association of Nigeria Nurses and Midwives
N-CAS	Nigerian Collaborative Action Strategy
NCWS	National Council of Women Societies
NMA	Nigerian Medical Association
NMS	Nigeria Military School
NNMC	Nigerian Nurses and Midwives Council
NNNGO	Nigeria Network of Non-Governmental Organisations
NPHCDA	National Primary HealthCare Development Agency
NTDs	Neglected Tropical Diseases
NTD-NGDOC	Neglected Tropical Diseases Non-Governmental Development Organisation Coalition
NTLC	Northern Traditional Leaders Committee on Primary Health Care
PATH	Program for Appropriate Technology in Health
PHC	Primary Health Care
PPMV	Patent and proprietary medicine vendors

PPSN	Parasitology and Public Health Society of Nigeria
PSN	Pharmaceutical Society of Nigeria
SBC	Social and Behaviour Change
SDGs	Sustainable Development Goals
SIA	Supplementary Immunisation Activities
S-MoH	State Ministry of Health
S-PHCDA	State Primary HealthCare Agency
STH	Soil-transmitted helminth
SWAp	Sector-Wide Approach
TA	Technical Assistance
ToRs	Terms of Reference
TWG	Technical Working Group
UKAID	United Kingdom Agency for International Development
UN	United Nations
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VDC	Village Development Committee
WB	World Bank
WDC	Ward Development Committee
WHO	World Health Organisation

Introduction

The **Nigerian Collaborative Action Strategy (N-CAS) for Health Campaign Effectiveness** is designed to guide the Nigerian government, global health organisations active in Nigeria, and health campaign programs to a future state where health campaign[1] programs collaborate effectively with each other and corresponding health services to maximise the effectiveness of all health campaigns on health outcomes in the short- medium- and long-term . In addition, the N-CAS aims to catalyse a stronger, more resilient, and Nigeria-led health system that provides high quality, sustainable and equitable health services for all people.

Over the next five years, the N-CAS will also inform the work of the various health campaign partners in Nigeria including the Federal Ministry of Health (FMOH), National Primary Healthcare Development Agency (NPHCDA), state-level stakeholders, global and regional organisations, campaign funders, and implementing partners[2]) .

Background on Nigeria and the CAS

Background on the HCE Coalition and the CAS

Health programs for immunisations (including polio), neglected tropical diseases (NTDs), malaria, and nutrition, depend in part – or at times almost entirely – on large-scale campaigns to reach under-resourced populations, and to achieve disease elimination and impact goals, such as the UN Sustainable Development Goals (SDGs). There are many settings where these campaigns serve as an essential part of the delivery approach to supplement ongoing primary health care services. However, health campaigns are often carried out with little communication or collaboration across disease domains and stakeholders, and inadequate coordination with national health systems. This leads to strategic and operational inefficiencies and inequities that can strain those health systems, burden healthcare workers, and limit the effectiveness of health campaigns. The institutions and individuals leading and implementing health campaigns have felt these acute needs and challenges and have called for increased collaboration and alignment to improve the efficiencies and effectiveness of campaigns.

To address these challenges, a diverse set of global and country stakeholders came together in 2020 to form the Health Campaign Effectiveness (HCE) Coalition with the aim of transforming health campaigns into more effective, equitable, efficient interventions that work in concert with primary health care (PHC) services, freeing up resources for other critical needs. Its members envision a future where health systems have been strengthened thereby lessening the need for multiple, individual campaign interventions, and supporting countries to achieve and sustain health-development goals for all people.

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[1] Campaigns are time-bound, intermittent activities which are deployed to address specific epidemiologic challenges expediently to fill delivery gaps or provide surge coverage for health interventions. They can be used to respond to disease outbreaks, eliminate targeted diseases as a public health problem, eradicate disease altogether, or achieve other health goals.

[2] Implementing partners (or implementers) refers to all stakeholders involved in the implementation of health campaigns (government, local and international non-governmental organisations (NGOs), Civil Society Organisations, public or private entities…). This document understands "implementation" as defined in Remme et al.'s *Defining Research to Improve Health Systems*: implementation "aims to develop strategies for available or new health interventions in order to improve access to, and the use of, these interventions by the populations in need."

In 2023, the HCE Coalition developed the **Collaborative Action Strategy (CAS) for Campaign Effectiveness** with over 50 partners from both global and country-level settings, representing more than 20 organizations, and collectively covering all five major health campaign domains: immunisations, polio, neglected tropical diseases (NTDs), malaria and nutrition/Vitamin A supplementation.

The CAS is a first-of-its-kind commitment by the global health community to work with countries to plan, implement, evaluate, and finance campaigns in a fundamentally different way. It is designed to add practical but transformative value to countries' existing efforts to develop approaches to improve effectiveness, efficiency and equity while strengthening core health system functions. Through the adaptation and implementation of the CAS, countries will:

- Decrease fragmentation, improve the timely release of donor funds, and better harmonise planning, financing, coordination, and timing across programs via stronger collaboration amongst campaign partners (e.g., MoH, implementers, funders, sub-national & community stakeholders) & with PHC services
- Create more effective, efficient, and equitable campaigns -- including integration and co-delivery of campaign interventions when and where appropriate (to decrease the number of single intervention or single antigen health campaigns), to optimise financial, technical, and human resources and reach underserved, never treated, or zero-dose communities
- Streamline approaches to measurement, monitoring, evaluation, and learning while fostering sharing of information about the effectiveness of interventions and missed populations among the different programs
- Harmonise funding processes and streams from campaign donors to decrease the burden on countries and support integrated and cost-sharing approaches
- Align and ultimately mainstream health campaigns with and into the government's health care system

Nigeria Commitment

During the HCE Coalition CAS planning meeting, held in Addis Ababa January 30 – February 1st, 2024, Nigeria (and Ethiopia) opted-in to the CAS and developed a preliminary CAS customization work plan. Commitment to the CAS was reinforced by Dr. Saidu Ahmed at the behest of Professor Muhammad Ali Pate, Coordinating Minister of Health and Social Welfare. Nigerian representatives from the F-MoH and NPHCDA aligned with the processes for CAS implementation, as set out by the HCE Coalition.

The N-CAS is the result of a process that included:

- an in-depth feasibility assessment to evaluate current campaigns, including challenges and opportunities to strengthen their effectiveness (and collaboration / integration) through the adaptation and implementation of CAS recommendations;
- the establishment of a Technical Working Group (TWG) to oversee the customisation of the CAS to reflect the Nigerian context;
- the establishment of three TWG subgroups to specifically focus on customisation and implementation of CAS recommendations related to campaign planning and implementation, MERLA and campaign financing. The work and outputs from the TWG and its three subgroups informed the development of the N-CAS.

Problem Statement – What are the campaign-related challenges in Nigeria and how will the CAS solve them?

Overview of campaigns and campaign integration in Nigeria

There is a steady number of health campaigns undertaken in Nigeria. Collecting data is challenging but on average Nigeria conducted 25 campaigns per year between 2019 and 2023. Campaign burden is a country-wide phenomenon with about a third of campaigns that are nationwide (55 out of 172 conducted between 2019 and 2023). **Northern States** (e.g. Sokoto, Borno, Zamfara) and **Kwara** are where the greatest number of state-specific campaigns occur.

The greatest number of identified campaigns between 2019 and 2026 were for **Polio** and **NTDs** (e.g., lymphatic filariasis- LF, soil-transmitted helminths-STH, Schistosomiasis). Malaria, Measles, Yellow Fever and Nutrition campaigns are regularly undertaken as well and while **integrated campaigns do already occur in Nigeria,** they can likely be increased (see Figure 1 below).

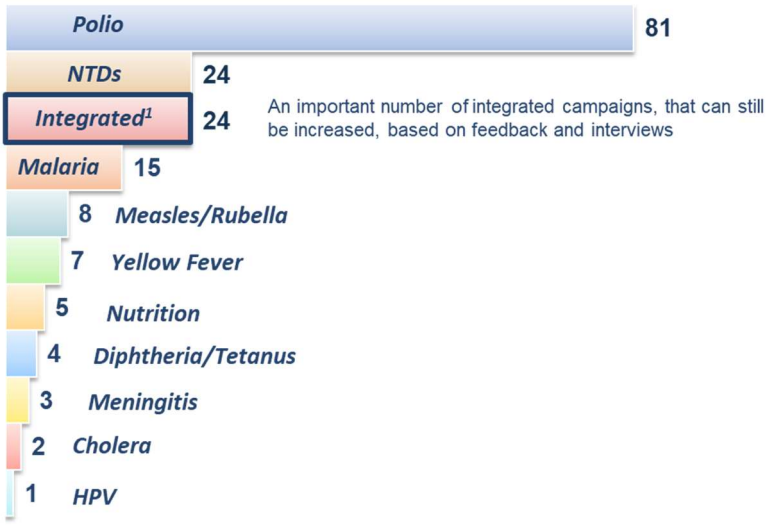

Figure 1 Number of health campaigns (realised or planned as of 2024) by type in Nigeria 2019-2026 (n=172)

There are many public health coordinating bodies including campaign donors/partners & national stakeholders that can be involved in campaign integration. These bodies are tasked with coordinating public health matters at a strategic level and **are not campaign focused** *(except for the Non-Polio SIAs Division of NPHCDA)*. **Domain-specific coordinating bodies are many and limit collaboration bandwidth** dedicated to improved campaign effectiveness.

Challenges created by campaigns

The large number of health campaigns in Nigeria creates five major challenges that were identified during the drafting of the N-CAS:

1. **Intervention and campaign fatigue:** A high number of campaigns leads to fatigue from campaign planning and implementation teams and the communities and populations that the campaigns

seek to serve. Teams are burdened by additional work and reporting requirements, which can hinder campaign quality (e.g., poor demand creation). Communities and populations are also burdened by a high number of campaigns, which can result in lower acceptance of new antigens and scepticism about additional interventions

2. **Suboptimal planning and related inefficiencies:** The large number of campaigns can lead to inadequate planning, which can negatively impact campaign quality and effectiveness
3. **Disruptions to the primary healthcare system:** Campaigns regularly rely on the same teams of health workers from the primary healthcare system to plan and implement health campaigns. This negatively impacts the primary healthcare system because health workers must leave their fixed posts to work on campaigns. The high number of campaigns also results in resource fragmentation, which leads to the same areas being regular outbreak or low coverage sites
4. **Capital intensive/Inefficient use of resources:** Campaigns are expensive to run. Funding that is used for campaigns could be used for other MoH priorities including strengthening the primary healthcare system
5. **Limited accountability/Lack of available data:** Poor data quality within campaigns is leading to waste and a lack of ownership and data-driven action from stakeholders. Additionally, there is a lack of a clear and enforced accountability framework for all campaign implementing levels.

It is also important to note that campaigns themselves face many challenges in Nigeria:

- **Inadequate intra and inter-agency collaboration and coordination**: Inadequate communication, collaboration, and coordination among various partners and programs within Ministries, Departments, and Agencies (MDAs), as well as across different MDAs, and between federal, state, and local health authorities, leads to fragmented and inefficient healthcare service and campaign delivery.
- **Inadequate human resources:** Insufficient number of skilled personnel, staff attrition, competing programs and demands due to poor coordination, and commitment of personnel to data collection/use at sub-national level lead to poorly resourced campaigns from a staffing perspective.
- **Funding** constraints:
    - Funds released at the national and sub-national levels are often inadequate and not timely. B
    - At the state level, funds are often not available for collection and distribution of health commodities and devices, maintaining cold stores and conducting supportive supervision .
    - A costed-MERLA plan is not typically embedded in budgets (e.g., lack of funding to print data forms or surveys).
    - At the local government area (LGA) level, lack of autonomy as LGA funds are often domiciled with the State Assembly, State Primary Health Care Development Agency/Boards (S-PHCDA/Bs) and State Ministries of Health (SMoH) and LGA (note: this challenge should have been mitigated with new system implemented this year)
    - At the health facility level, no budget lines exist to cover crucial activities from available funding source (Basic Health Care Provision Fund, etc.). Furthermore, payment systems are not harmonised across all campaigns. For example, the NPHCDA has worked over the

past three years to harmonise the payment system across different levels but challenges still exist in terms of how payments are disbursed and the timeliness of disbursements, especially for NTD campaigns that have a very different funding system than immunization campaigns.
    - At the community level, support is not mobilised adequately and beneficiaries are not clearly demarcated.
- **Gaps in data management and sharing:** Several challenges exist related to data management and sharing, including: unintegrated health information systems and data sources; unleveraged technology and innovation needed to enhance data collection, analysis, and use; and lack of comprehensive and timely data to address inclusivity and equity challenges, particularly for vulnerable and hard to reach populations. **Suboptimal community demand** for campaign interventions due to poor awareness resulting from inadequate analysis, communication and feedback of available social data.

Nigeria is at a crossroads and commits to solving these challenges created and experienced by health campaigns. However, mitigation of these challenges can be impeded by:

- **Bandwidth Constraints:** Teams are overburdened at all levels (e.g., national and subnational). Additional bandwidth must be freed by rationalising and leveraging existing structures in implementing CAS (e.g., merging working groups or limiting duplication).
- **Collaboration Disincentives:** While stakeholders at all levels describe fatigue resulting from numerous campaigns, there are disincentives to collaboration and integration that must be overcome (e.g., siloed internal and external working structure, disparate per-diem practices, apprehension towards a perceived decrease in funding or efficiency).
- **Polio Integration:** Almost half of all identified campaigns in 2019-2026 are polio campaigns. However, integration efforts have so far rarely included Polio because of different priorities, workforces, campaign methods, etc. Identifying ways of collaborating more with the Polio campaigns is critical to CAS success.

Primary Aim and Anticipated Outcomes of the CAS

The CAS is designed to deliver tangible added value across several key areas to solve the challenges presented above. Critically, the strategy aims to serve the political momentum initiated with the recent adoption of the Sector-Wide Approach (SWAp)[3] in Nigeria and to achieve higher health outcomes leveraging:

- **Political Commitment:** There is clear commitment at all political levels and within partners in the country towards fewer campaigns, increased campaign efficiency, and integration into the PHC system.
- **Institutional Knowledge:** Nigeria can leverage on its wide government infrastructure, history of improving government collaboration (e.g., PHC Under One Roof), and history of integration. The country has already demonstrated its potential for campaign integration (e.g. Maternal Newborn

[3] For more information see: What Does Nigeria's Sector-Wide Approach Mean for the Health Sector? - Nigeria Health Watch

and Child Health Week; 2022 COVID/Measles/Yellow Fever/Vitamin A/Birth registration campaign).

- **Near-Term Momentum:** Intra- and inter-department norms are changing. A clear first step is to align with the SWAp and foster information sharing (specifically within the NPHCDA).

Anticipated outcomes of the CAS that will bring significant added value to Nigeria include, but are not limited to, the following:

- reducing fragmentation of public health programs by improving effectiveness, collaboration and coordination amongst partners (e.g., MOH, NPHCDA implementers, funders, subnational and community stakeholders) during the planning and implementation phases
- creating more efficient, targeted and integrated campaigns – including co-delivery when and where appropriate – that optimise financial, technical and human resources, and reach underserved or zero-dose communities
- streamlining approaches to measurement, monitoring, evaluation, and learning while fostering information sharing on the effectiveness of interventions and missed populations among the different programs
- harmonising funding processes and streams to decrease the burden on Nigeria, mitigate health program fragmentation, support integrated and cost-sharing approaches and reprogram cost savings for other activities, and improving the timely release of funds to countries
- strengthening and integrating selected functions of health campaigns into the PHC system over the short-term (e.g. supply chain logistics, HMIS and surveillance, financing, health workforce)
- transitioning health campaign interventions to the PHC system in the long-term
- achieving global health goals, including SDG 3, UHC2030 and goals laid out in the Immunisation Agenda 2030, A Road Map for NTDs 2021-2030, Global Technical Strategy for Malaria, the Global Polio Eradication Initiative strategy, the Global Task Force on Cholera Control's Roadmap 2030, and by the Global Alliance for Vitamin A
- accelerating progress toward closing public health gaps in the wake of the COVID-19 pandemic
- aligning partners around an expanded definition of campaign effectiveness
- increasing equitable campaign coverage and genuine community engagement at all levels and phases of health campaigns.

Overview of Recommendations to Improve Health Campaign Effectiveness in Nigeria

The sections below present the 11 recommendations[4] that form the foundation of the N-CAS and its vision for deeper collaboration and increased effectiveness at all levels, resulting in greater impact at the country level, including improved health outcomes and strengthened health systems. The

[4] The coalition-wide CAS includes 12 recommendations, 11 of which aim to be customised to country contexts and one (recommendation 2c – "At the global level, develop a Learning Platform and a MERLA framework as a practical guidance to countries and global stakeholders") being addressed by the HCE Coalition itself

recommendations are organised around three key topics (i.e., campaign planning & implementation; MERLA[5]; campaign financing) and are primarily intended to:

1) support the implementation of increased coordination/integration and reduce fragmentation by outlining the value, key steps, and actors
2) maximise the efficiency of campaigns and resources to address country health gaps and priorities, and optimally serve target populations and communities
3) deepen information gathering on coordination/integration benefits and opportunities across campaigns
4) foster timely, harmonized funding processes and streams so countries are better able to implement effective campaigns
5) support the transition of health campaign interventions to the PHC system in the long-term
6) deliver high-quality, equitable, accessible and people-centred health services that meet multiple health needs.

Presented below is a high-level summary of the N-CAS recommendations followed by each recommendation in detail:

Table 2 High-level summary of the 11 recommendations adopted for the N-CAS

List of Recommendations for Improved Campaign Effectiveness	
1. Planning & Implementation	
1a	Establish, or leverage an existing multi-sectoral, cross-campaign National Coordination Body
1b	Identify campaigns and domains for collaboration and integration
1c	Develop a multi-year, cross-campaign workplan and schedule for campaigns
1d	Harmonize tools and operations (e.g., logistics, supply chain, microplanning) across campaigns
1e	Develop a coordinated and effective approach to enable active community engagement at all levels and phases
2. Monitoring, Evaluation, Research, Learning and Adaptation (MERLA)	
2a	Within countries, develop a coordinated and collaborative cross-campaign MERLA strategy
2b	Aligned with the coordinated country MERLA strategy, improve the ability of campaign implementers and partners to identify, measure, utilize, and share data on campaign effectiveness
3. Campaign Financing	
3a	Create a comprehensive view of campaign financing at the country level
3b	Take incremental steps toward harmonizing and aligning campaign financing
3c	Harmonize and align incentive payment modalities and rates across campaigns
3d	Advance government role in campaign financing

1. Campaign Planning and Implementation Recommendations

Overview: At national and subnational levels, campaign planning and implementing phases are often fraught with challenges, including limited coordination between multiple campaigns, limited long-term

[5] Monitoring, evaluation, research, learning, and adaptation

and flexible planning, limited early engagement with communities, lack of inclusion of key stakeholders, uncoordinated operations (e.g., supply and logistics) processes, and different priorities from disease-specific initiatives. Highly coordinated, integrated and effective campaigns necessitate new ways of working. The recommendations below aim to overcome these challenges and support the achievement of health system objectives through highly effective, coordinated, and equitable use of campaigns.

Recommendation 1a: Establish a multi-sectoral, cross-campaign National Coordination Body to oversee CAS activities

A multisectoral and well-supported cross-campaign national coordinating and decision-making body, that includes national leadership (and subnational structures, where applicable and appropriate). This national body, mandated to increase coordination amongst relevant campaign departments within the F-MoH and NPHCDA, as well as partner organizations, will streamline national campaign-related efforts and leverage existing resources more efficiently to sustainably accelerate achievement of health-related development goals.

How would this recommendation benefit or be of service to Nigeria?

A functional cross-campaign coordination body will offer Nigeria highly coordinated and streamlined campaign oversight, including collaboration and integration.

Which stakeholders should act on this recommendation?

The national coordinating body must ensure that the relevant department heads, and key partners and stakeholders involved in planning and implementation are included. The committee should call for nomination of skill programme officers who would contribute to the success of CAS. It is critical to ensure a strong link between ICC & IGCO for coordination purposes.

What are the specific tasks of the actor(s) and related stakeholders (e.g., activities and actions)?

The recommendation will require the following activities to be undertaken:

- Identify and develop Terms of References (ToRs) and inaugurate the Coordinating Body, including an inaugural meeting and orientation for NCM members (F-MoH/NPHCDA)
- Oversee all CAS recommendations, campaigns, and cross-campaign integration as well as formation of all technical working groups required to execute the recommendations (e.g., budget, logistics/supply chain, MERLA, community engagement)
- Draft guidelines for States to establish their own State-Coordination Body and send an official letter to States inviting them to initiate a Coordination Body with a similar structure to the National one
- Manage cross-campaign strategies, budget, procedures and supportive oversight
- Develop and implement a communication and advocacy plan

What is the estimated timeline and what are the key milestones for this recommendation?

The ToR and composition of the national coordination body should be developed in parallel to CAS implementation plan development. Within 2 months of CAS development, the National Coordinating Body should hold its first meeting.

Recommendation 1b: Identify campaigns for collaboration and integration (including the plan to transitioning them to the PHC system)

How would this recommendation benefit or be of service to Nigeria?

Certain campaigns and contexts are better placed than others to benefit from increased and improved collaboration and integration. A proper assessment of collaboration and integration opportunities and overlap can facilitate better understanding of when and how to integrate campaigns and improve overall efficiency in the management and utilization of resources for campaigns

The implementation of the recommendation will allow for a clear and dynamic view of campaigns suited for such integration, and ultimately improve the primary health care system

Which stakeholders should act on this recommendation?

Given the nature of this recommendation, it will be essential that all campaign-related departments in the F-MoH and NPHCDA participate in supplying campaign-related data (to develop a common understanding of current and future campaigns) as well as to develop a standard criterion for campaign integration. The following groups / departments (non-exhaustive list; additional partners should be included) should take part in this process and develop internal processes, where relevant, to continually update a shared campaign calendar: Non-polio SIAs, Polio EOC, NPSIA (YF PMVC, MSIA, Meningitis vaccination, OCV, outbreak response vaccination), Diphtheria OBR, CHS (MNCHW, RMNCAEH+N), Family planning, NCDs, NTDs, Malaria (SMC, ITN), and partners (WHO, UNICEF, The Carter Center, BMGF, CDC, NTD-NGDO Coalition, etc),

What are the specific tasks of the actor(s) and related stakeholders (e.g., activities and actions)?

The committee (or TWG) should ensure the following at both national and subnational levels (though this group would need to meet more than quarterly in order to identify campaigns for integration)

Some of activities below need to be updated / occur regularly:

- Map all campaigns (every relevant department identify their campaigns for the next 3 years)
- Develop a template or platform for mapping campaigns (and update it regularly)
- Develop criteria for integration (e.g., timing, target, availability of antigens, medicines, Test-Kits, funding schedules)
- Identify campaigns that have been missed (i.e., integration) over the past 5 years
- Identify campaigns for integration
- *When relevant,* Develop a plan for specific campaigns to be transitioned into the Primary Healthcare System

What is the estimated timeline and what are the key milestones for this recommendation?

- Develop a template to capture campaigns and domains, and map out plans for integrated coordination and implementation – *3 months*
- Use the tool in an integrated monitoring and supervision plan as per recommendation 2a – *1 year*
- Reporting and dissemination should be done on quarterly basis – *Every three months*

Recommendation 1c: Develop a multi-year, cross-campaign workplan and schedule for campaigns

Develop a multi-year (a 3 year plan), comprehensive, integrated, and inclusive, cross-campaign plan and schedule for campaigns that is less reactive/more proactive, more dynamic, and better leverages opportunities for impactful collaboration and integration

How would this recommendation benefit or be of service to Nigeria?

Collaborative, proactive cross-campaign planning and schedule development will allow campaigns, the PHC system, and funders to better anticipate the required level of effort and improve the management and timely utilisation of local human and financial resources. Furthermore, countries will be able to adapt the plan periodically when facing more reactive needs, leveraging the resources outlined in the plan.

Which stakeholders should act on this recommendation?

This recommendation should be implemented by the coordinating body as per recommendation 2a and be adapted at the subnational level by committees set up at state level. Programme managers from different campaigns/ domains should be consulted from the start and involved throughout the planning process.

What are the specific tasks of the actor(s) and related stakeholders (e.g., activities and actions)?

The recommendation will mandate the following activities:

- *Coordinating body, in collaboration with program managers:* Organise an initial discussion amongst relevant program managers to discuss and develop a workplan and schedule template (coordinating body, in collaboration with program managers)
- *Departments planning campaigns:* Quarterly submit preliminary workplans to the coordinating body
- *Coordinating body, in collaboration with program managers:* Harmonise workplans
    - Technical Assistance might be initially needed for the first collection and harmonisation of workplans
    - The campaign mapping developed as part of recommendation 1b should be leveraged
    - Each relevant department should assign a focal person to update content on a shared dashboard

What is the estimated timeline and what are the key milestones for this recommendation?

- Established committees should develop a multi-year plan within the 1st year of CAS implementation.
- Either the 1st quarter or the last quarter of every year should be set for submission of individual campaign plans and harmonisation

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Recommendation 1d: Harmonise tools and operations (e.g., logistics, supply chain, microplanning) across campaigns

Develop a detailed (integrated planning tool) plan for harmonising tools, logistics, data management, and supply chains across campaigns, using topic-specific cross-campaign technical working groups.

This will include (but not be limited to) harmonised daily data summary for call-in as well as integrated logistics, health commodities and Supply/Cold Chain plans.

How would this recommendation benefit or be of service to Nigeria?

Harmonisation of tools and operations can improve efficiency and save planning and implementation time and resources, reduce strain on the primary health care system, and allow for better transparency across campaigns.

Which stakeholders should act on this recommendation?

This recommendation touches on a wide array of activities. Harmonisation of certain tools and templates will take a set of stakeholders unique from supply chain harmonisation. That said, the national coordination body should identify the critical organisations (e.g., FMoH/NPHCDA) departments and partners, based on their expertise and a mapping exercise to decide which components of campaigns can be integrated. Most likely, the harmonisation will take place at the federal, the state , and the LGA levels depending on the tool, template, or activity to be harmonised. Certain partners (e.g.., UNICEF) will be critical to include given campaign-related logistics are very depending on partners

What are the specific tasks of the actor(s) and related stakeholders (e.g., activities and actions)?

In order to implement the recommendation, the following activities will need to be undertaken:

- Within campaigns identified for integration, map which elements (i.e. data tools, templates, supply chains) should be integrated
- Identify the stakeholders who should be engaged for harmonising these campaign components based on the mapping above
- Develop time limited working groups or task teams where needed to integrate or harmonise some of the most challenging components
- Develop a workplan that identifies which components can be integrated in the short, medium, and long term (as well as risks to harmonisation)
- Within this recommendation, two critical components were identified for integration:
    - Digitise primary data so as to efficiently integrate all data during integrated campaigns[6]
    - Integrate post campaign surveys (n.b., for many campaigns this is done by NBS, which could be the common coordinated mechanism, as independent body on statistics for campaigns. That said not all campaigns (e.g., malaria uses this process).

What is the estimated timeline and what are the key milestones for this recommendation?

[6] At the date of drafting of this strategy, primary data is integrated at the campaign posts – without digitisation.

Within the first year of CAS implementation, all tools should be collated, analysed and a decision reached on harmonising them. Where feasible, and based on a strong workplan, components of campaigns (e.g., tools, templates, logistics) should be harmonized.

Recommendation 1e: Develop a coordinated and effective approach to enable active community engagement at all levels and phases

Develop a coordinated and effective approach to engage communities at all levels and phases building on existing community structures

Develop a cross-campaign coordinated approach that fosters purposeful engagement of communities at all levels through all stages and phases of campaign planning and implementation, integration, and post-campaign (e.g., learning, adaptation), that builds on existing approaches and increases credibility

How would this recommendation benefit or be of service to Nigeria?

Decisions made in a participatory manner and validated by stakeholders at all levels (e.g., government, indigenous communities) will foster sustained participation of the local communities and increase the effectiveness and acceptance of proposed interventions. Multicultural, community-based, and interdisciplinary approaches to campaign implementation maintain the potential to unlock understanding of problems and provide greater possibilities for solutions

Which stakeholders should act on this recommendation?

This recommendation should largely be led by the Health Promotion Department at the federal level to support the development of SBC materials. Although, there should be engagement of ACSM units of various campaigns expected to work with health promotion units during the development of these SBC materials. The tools upon development are send down to the state and LGA for feedback / input (based on interaction from community members) then English language updated tool is sent to local level for transfer into local languages

At the community level, it can build on existing community structures of the VDC, WDC and LGA health committees, faith-based communities, NTLC, STLC, CSOs (NNNGOs, AHOA), influential women groups (FOMWAN, NCWS etc) and professional bodies (NMA, PPMV, PSN, NAMN, NMS, NACHPN, PPSN, academia etc.)

What are the specific tasks of the actor(s) and related stakeholders (e.g., activities and actions)?

- Identify existing strategies within each department at the federal level (via ACSM units), as well as partners. In addition, access what strategies have been implemented
- Develop a unified strategy and workplan for harmonisation at both the federal and subnational level
- Harmonise and develop a sustainable coordination structure at Federal Level (MoH & NPHCDA) leveraging the ACSM units
- As there is significant overlap amongst community engagement strategies already, harmonise materials that already exist. Integrate engagement tools and SBC materials (community tools that are rightly updated and accurate)

What is the estimated timeline and what are the key milestones for this recommendation?

This should be done within the first year of CAS implementation, with a sustainable process developed to renew the material/strategy on a semi-regular basis

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2. Campaign Monitoring and Evaluation Recommendations

Overview: Currently, measuring the quality and impact of inherently complex health campaigns accurately and comprehensively represents a significant challenge for campaign decision-makers, managers and implementers. Because of this challenge, funders, decision-makers, campaign managers and health workers are often unable to adjust campaign delivery, strategies and practices to: i) optimize the benefits of their public health interventions; ii) reach the full target population, especially those who have never been reached; and iii) strengthen the broader country health system to deliver interventions sustainably and with country ownership. Furthermore, some campaign partners suggest that "coverage" is an essential but an insufficient proxy measure of overall health campaign effectiveness[7] and could be adequately expanded through additional indicators.

What is campaign effectiveness?

Traditionally, campaign effectiveness is measured through coverage with indicators that primarily measure targets, prevention, detection, treatment and results/outcomes.

Given the desire for an expanded definition beyond coverage, it can also be understood as a combination of additional parameters, including: efficiency, equity, availability, access, service quality (including timeliness), clinical outcomes, resilience, responsiveness, community acceptance and engagement. Indicators to measure these additional parameters are suggested in the appendix of this strategy (see appendix F for additional information).

Recommendation 2a: Develop a coordinated and collaborative cross-campaign MERLA strategy in Nigeria

This recommendation aims to bring together different health campaigns, program implementation actors and stakeholders within Nigeria to develop a unified MERLA strategy. This strategy will facilitate the sharing of resources, expertise, and knowledge, enabling a more efficient and effective approach to monitoring, evaluation, research, learning, and adaptation.

How would this recommendation benefit or be of service to Nigeria?

At the national level, all health campaigns will have the same monitoring and evaluation framework for tracking and monitoring campaign effectiveness endorsed by the Federal Ministry of Health and Social Welfare, NPHCDA and other partners. At the subnational levels, there will be fewer parallel structures

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[7] Beyond Coverage: Measuring Vitamin A Supplementation Program Effectiveness in Mauritania and Sierra Leone Defining Health Campaigns and Health Campaign Effectiveness https://campaigneffectiveness.org/publications/measuring-and-assessing-effectiveness-in-preventive-nutrition-and-public-health-programmes-a-closer-look-at-the-global-vitamin-a-supplementation-programme/ ; Measuring and Assessing Effectiveness in Preventive Nutrition and Public Health Programmes: A closer look at the global vitamin A supplementation programme

and campaigns, as well as a reduction in the proliferation of data tools. There should also be more resources for planning effective campaigns for better health outcomes. The effectiveness of campaigns will be better understood and measured. Ministries of Health will appreciate how campaigns contribute to the attainment of their broader goals and where coordination and collaboration is relevant to them based on synergy. Overall, the cross-campaign MERLA strategy should help Nigeria boost its healthcare system, achieve better health results, build stronger partnerships, and increase efficient use of resources.

Which stakeholders should act on this recommendation?

The Federal Ministry of Health and Social Welfare (FMOHSW) as the coordinating body will lead the development of the cross-campaign MERLA strategy in consultation with relevant stakeholders. The Ministries of Health at the national, state and LGA levels with the implementing partners will play important roles within their mandate. Essentially, all the underlisted bodies through the coordination of FMOHSW will contribute to the development of the cross-campaign MERLA strategy:

- *Nigeria government:* FMoH, Federal Ministries of Education, Environment, Water Resources, NPHCDA,
- *State governments:* SMoHs, SPHCDAs/Bs, LGHAs,
- *Partners*:
    - WHO, UNICEF, BMGF, GAVI, CDC, WB, UKAID, PATH, Sydani, JSI, CHAI etc., for technical & financial support, CSOs, NGOs, CBOs,
    - Professional Associations; NMA, NNMC, PPSN etc., Academia and Research Institutions for evidence-based research and technical support to inform the development and implementation of the MERLA strategy

What are the specific tasks of the actor(s) and related stakeholders (e.g., activities and actions)?

1. Federal Ministry of Health (FMoH): As the lead agency for healthcare, FMoH would spearhead the development and implementation of the MERLA strategy. The SWAp at the FMoH will have oversight functions. A focal person for MERLA needs to be identified from MoH and NPHCDA.

2. The CAS Coordinators from the FMoH and the NPHCDA will plan, coordinate, monitor and supervise the MERLA strategy. Persons to be nominated.

3. State Ministries of Health (SMoH) and State Primary Health Care Agencies/Boards: SMoHs and SPHCAs should collaborate with FMoH and NPHCDA to adapt and implement the MERLA strategy in their respective states.

4. Local Government Health Authorities (LGHAs): LGHAs should work with S-MoHs/S-PHCA/Board to ensure effective implementation at the service delivery level.

5. Development Partners (DPs) at national and state levels: provide technical and financial support to the government to develop and implement the MERLA strategy.

6. Civil Society Organisations (CSOs): CSOs, including non-governmental Development Organizations (NGDOs) and Community-Based Organisations (CBOs), would contribute in the development and implementation of the strategy to ensure community participation and ownership.

7. Professional Associations: Professional associations, such as the Nigerian Medical Association (NMA) and the Nigerian Nurses and Midwives Council (NNMC), Medical and Health workers union(MWHUN) Parasitology and Public Health Society of Nigeria (PPSN), would contribute their expertise and support to the development and implementation of the MERLA strategy.

8. Academic and Research Institutions: Academia and research institutions would provide evidence-based research, learning and technical support to inform the development and implementation of the MERLA strategy. They would also support advancement of knowledge sharing and dissemination through the writing and publications in reputable journals.

What is the estimated timeline and what are the key milestones for this recommendation?

2 – 3 months from CAS Launch in Nigeria

Key activities include:

- Stakeholder engagement and sensitization of coordinated MERLA concept and planned approach at all levels to be done by the MERLA subgroup
- Establish a cross-campaign MERLA working group, comprising representatives from different health campaigns, government agencies, and other relevant stakeholders at all levels (sync stakeholder list with master list)
- Identify existing MERLA initiatives, gaps, and opportunities for collaboration from the different government programs for all campaigns
- Develop a coordinated MERLA framework from existing MERLA frameworks of individual programs for the country for all campaigns (Note: framework includes approach, indicators, etc.)
- Develop a costed MERLA implementation strategy and mobilise resources to ensure sustainable funding
- Share costed MERLA strategy with CAS Coordinator to secure approval via agreed upon process(es) (TBD)
- Validate the strategy through surveys or online consultations and pilot testing or simulation exercises.

3 – 6 months: Implementation of the strategy which involves the rollout of the strategy across states and LGAs

Key activities include:

- Establish shared data hub for easy collection, analysis, and sharing of data across different campaigns and health services
- Develop and install a dashboard for decision-makers at the national and sub-national levels
- Develop a joint research plan that focuses on studies on the effectiveness of integrated health campaigns with primary health care systems
- Develop a learning and adaptation system that enables the sharing of best practices, lessons learned, and innovative solutions that can be used across different health campaigns and services
- Establish an intra-campaign M&E system to track progress, conduct regular review meetings to assess implementation, and provide feedback.

6 – 12 months

Key activity includes:

- Conduct regular review meetings (e.g., quarterly or bi-annually) to assess implementation, provide feedback, foster learning and adapt strategies as needed.

Recommendation 2b: Aligned with the coordinated country MERLA strategy, improve the ability of campaign implementers and partners to identify, measure, utilise and share data on campaign effectiveness

The recommendation for Nigeria is to align with the coordinated country MERLA strategy in order to improve the ability of campaign implementers and partners to identify, measure, utilise and share data on the effectiveness of campaigns. This will help to track progress and make informed decisions to improve the impact of campaigns in the country.

How would this recommendation benefit or be of service to Nigeria?

This recommendation will benefit Nigeria by improving the success and impact of campaigns using data and metrics. It will also align with the country's MERLA strategy and improve the coordination and communication between campaign implementers and partners. By identifying, measuring, utilising, and sharing data on campaign effectiveness, this recommendation will ultimately lead to more targeted and efficient campaigns, resulting in positive outcomes for the country.

Which stakeholders should act on this recommendation?

This recommendation should be acted upon by the Federal Ministry of Health, NPHCDA, State Ministries of Health and FCT Health and Human Services Secretariat, and Local Government Health Authorities, as well as campaign funders, implementers and technical partners who are involved in the country's MERLA strategy (e.g., GPEI, GF, CDC, UNICEF, USAID, WHO, CHAI, NTD-NGDO Coalition, etc). These stakeholders will work in collaboration to improve their ability to identify, measure, utilise, and share data for decision-making to aid campaign effectiveness, in alignment with the country's coordinated MERLA strategy; the one source of truth/one report initiative of the Sector Wide Approach (SWAp) of the ministry. Compare with 2A above.

What are the specific tasks of the actor(s) and related stakeholders (e.g., activities and actions)?

The specific tasks to be conducted may include harmonisation of M&E processes and tools across the campaign in-country, conducting regular evaluations of campaign effectiveness, collecting and analysing data on campaign impact to identify key metrics for measuring campaign effectiveness, sharing this data with partners and stakeholders, and utilising this data to inform and improve campaign implementation strategies. Additionally, there would be collaboration with local communities and organisations to gather data on campaign reach and effectiveness and work with government agencies to ensure that policies and strategies align with campaign goals. Other activities may include training and capacity-building for campaign implementers and partners to effectively measure, utilise and share campaign data.

What is the estimated timeline and what are the key milestones for this recommendation?

The estimated timeline for this recommendation is to be aligned with the coordinated country MERLA strategy.

The key milestones include:

2 – 3 months from effective CAS Launch in Nigeria

- Conduct a thorough assessment of existing campaign data in Nigeria as a baseline, in order to create a comprehensive map. The developed map should provide a detailed overview of the various campaigns, their objectives, target population, implementation strategies, reviews all parameters currently used for measuring impacts and review overall impact of campaigns.

6 – 12 months

- Conduct in-depth analysis on the current information sharing practices and identify gaps and areas of improvements.
- Work closely with relevant stakeholders to develop a comprehensive strategy that will facilitate the effective use of existing information and implement updated sharing mechanisms with the guideline of data-sharing policies in the country. This will help to streamline processes, eliminate duplication of efforts and ensure efficient use of resources, ultimately benefiting all parties involved.

In the longer time:

- Improve the ability of campaign implementers and partners to identify, measure, utilise, and share data on campaign effectiveness in Nigeria. This includes implementing strategies to gather and analyse data, as well as ensuring effective communication and collaboration among all stakeholders involved in the campaign. Ultimately, the goal is to continuously improve and optimise the effectiveness of campaigns in Nigeria through the sharing, use of data and collaboration for synergistic outcomes.

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3. Campaign Financing Recommendations

Overview: Campaigns have historically been organised within disease-specific (vertical) programs, which are often funded, planned, and implemented independently from one another and from routinely offered primary health care (PHC) services. Over the last three decades, there has been a growth of disease-specific financing, which has contributed to the proliferation of disease-specific campaigns, with little coordination between programs and among campaigns. As a result, campaign financing is often vertical and fragmented with disjointed practices, procedures and timelines for funding health campaigns.

This fragmented financial system results in high transaction costs for countries as they manage and report on each investment.

Furthermore, it is challenging for countries to increase collaboration and promote integration across campaigns as there are few incentives for integrating campaign functions, as the improved efficiencies or cost savings are not accrued back to the programs or communities. In addition, variation in the type and amount of financial and non-financial incentives provided to campaign workers (e.g. community health workers), can serve as a disincentive to campaign coordination or integration.

Many LMICs rely partially or fully on partner support and extra-governmental funding to cover the costs of health campaigns. Reliance on extra-governmental funding poses challenges to sustain funding for campaigns when countries transition from external funder support. The level of government contribution to campaigns is often unknown.

The recommendations below aim to contribute to better alignment and coordination of health campaign funding to support integrated planning and joint interventions. This will be accomplished through:

- more holistic mapping of external funder and government funding of campaigns
- better coordinating funding flows amongst external funders and countries
- harmonization of payment rates and modalities to campaign workers
- governments further planning and budgeting their own contributions to campaign financing as part of their strategic and operational planning processes

These recommendations aim to contribute to better harmonized and integrated campaigns that will reflect a more efficient use of resources. Improvements in campaign effectiveness could allow funders and countries to do more with existing resources and/or reprogram cost savings for other activities (e.g., PHC strengthening).

Recommendation 3a: Create a comprehensive view of campaign financing at the country level

Map out the health campaign funding across all health programs as well as their funders to generate a comprehensive view of the funding landscape from the government and partners.

How would this recommendation benefit or be of service to Nigeria?

A comprehensive view of past and planned campaign funding information in Nigeria will have the following positive impacts in the country:

- Improved planning and budgeting for healthcare
- Better identification of redundancies and gaps in campaign funding
- Better alignment of government and partner funding policies, strengthening health campaign financing and the primary healthcare system
- Better awareness of differences in payment systems between campaigns (e.g. variation from a standardized rate for stipends, health campaign workers compensation and incentives to Community Directed Distributors CDDs)
- Improve the overall cost-effectiveness of campaigns through a reduction in duplicated funding
- More equitable use of scarce funding resources

Which stakeholders should act on this recommendation?

This recommendation is targeted to three types of stakeholders:

- *Nigerian government / Ministry of Health*: NPHCDA, Department of Public Health under the Health Sector-Wide Approach (Swap), coordinated through a National Coordinating Body led by the Director of Public Health and the Executive Director of NPHCDA
- *Funders and implementing partners*: GAVI, Gates Foundation, CDC, USAID, Global Fund, World Bank, Malaria Consortium, NTD-NGDO Coalition (The Carter Center, Sightsavers, RTI etc)
- *United Nations Agencies*: WHO, UNICEF, UNITAID, UNFPA etc.

What are the specific tasks of the actor(s) and related stakeholders (e.g., activities and actions)?

A finance working group (including representative focal points from the NPHCDA Finance committee, NTD officers from selected states, Malaria financing) within the national coordinating body should develop a funding information repository and a template to be shared with each funder and agencies involved in health campaigns. This exercise should be undertaken in close coordination with the SWAp mapping exercise and be based on an initial assessment of existing funding data and their format.

Funders and government agencies should fill the template on an annual basis to share the following information:

- *Program managers/financing and accounting units within the Ministry of Health and NPHCDA:* campaigns funded; policies guiding campaign funding; budgeting and funding cycles; funding and geographic scope; partners
- *Ministry of Budget and Economic Planning*: registered funders and implementers; elements funded; geographic scope
- *Ministry of Finance*: government funding allocated to health campaigns ; other sources of funding (e.g. private sector, donors, local NGDOs, etc.)

What is the estimated timeline and what are the key milestones for this recommendation?

Once the finance working group is set up, the development of the information sharing template should be operational in 6 months:

- Initial data collection – *3 months*
- Data analysis and development of the template and data repository with focal points – *2 months*
- Dissemination of the template to country stakeholders and global partner – *1 month*

Recommendation 3b: Take incremental steps toward harmonising and aligning campaign financing

Using (periodically updated) information from the finance mapping developed in line with recommendation 3a, identify campaigns whose funding can be harmonised (e.g.: similar scope, required resources, budget available).

For those pre-identified campaigns, analyse implementing partners, funding streams, amounts available, elements funded, funding sources and identify gaps and duplications.

Then, develop a harmonisation framework describing aspects that can be harmonised making economic sense (e.g. adjusted payment rates, accountability frameworks).

How would this recommendation benefit or be of service to Nigeria?

Implementing this recommendation in Nigeria will strengthen the country's funding mechanisms for health campaigns and increase resources dedicated to end users.

It will improve the visibility, accountability and quality of campaigns while strengthening a sustainable health system.

Beyond Nigeria, it will contribute to the harmonisation of country applications for health campaigns funding/grants globally.

Which stakeholders should act on this recommendation?

The analysis of financing data and the development of a harmonisation framework will need to be undertaken by a finance working group under the national coordinating body.

The following stakeholders will need to be engaged and involved in validating and implementing the framework:

- *Nigerian Ministries:* Ministry of Health (MoH-NMEP, NPHCDA, NCDC, NAFDAC); Ministry of Finance; Ministry of Planning and Budget
- *Coordinating bodies:* Health Sector Partnership Coordination Committee; Development partners group for health
- *Subnational stakeholders:* Nigeria Governors Forum, State governments (e.g. S-MoH; SPHCDA)
- Campaign funders and implementers: GAVI, Gates Foundation, CDC, USAID, Global Fund, World Bank, Malaria Consortium, NGDOs (The Carter Center, Sightsavers, RTI etc)
- *United Nations Agencies:* WHO, UNICEF, UNITAID, UNFPA etc.

What are the specific tasks of the actor(s) and related stakeholders (e.g., activities and actions)?

A proposition of a harmonisation framework should be developed by a working group under the national coordinating body.

This working group should include representatives from the Ministry of Finance, Ministry of Health (MoH-NMEP, NTDs, NPHCDA, NCDCD, NAFDAC), Ministry of Planning and Budget and the Health Sector Partnership Coordination Committee.

It should start with complementarities and harmonisation for immunisation activities (given that they are mainly funded by one partner: GAVI), and develop an integration 'atlas' (e.g. timeline, milestones for financial integration) aligned with the SWAp and other related government priorities (e.g. leveraging the SWAp for pooled funding).

Funders and partners (e.g. members of the development partners group for health) should support the development of the framework by sharing policies and norms around integration.

The harmonisation framework will need to be endorsed by the Governors Forum and implemented (and monitored) by funders and partners, together with state-level stakeholders (state government and relevant bodies).

What is the estimated timeline and what are the key milestones for this recommendation?

- Constitute a relevant working group – *1 month*
- Collect relevant data (e.g. funding policies) – *3 months*
- Analyse data and identify complementarities – *2 months*
- Develop a harmonisation framework – *4 months*
- Engage stakeholders and initiate implementation – *6 months*

Recommendation 3c: Harmonise and align incentive payment modalities and rates across campaigns

This recommendation will consist in developing a harmonised system for payment across health programs and campaigns (i.e. immunisation, NTD, polio, NMEP, NTBLCP, etc.).

This will mean onboarding and aligning other incentive payment modalities (especially NTD drug distribution system) to the NPHCDA harmonisation efforts (see contextual elements below).

Outbreak campaigns may differ in payment modalities but across cadres, payment rates will be harmonised.

How would this recommendation benefit or be of service to Nigeria?

The implementation of the recommendation will reduce the turnaround time for payments to healthcare workers, and reduce financial incentives towards participants to one programme vs. others.

Harmonised payment practices will facilitate integration and collaboration between simultaneously run campaigns (e.g. net distribution and MDA). They will likely lead to cost-savings that can be reallocated to underfunded programs.

Which stakeholders should act on this recommendation?

This recommendation will be implemented by the following stakeholders:

- *Nigeria Ministries/government agencies*: Ministry of Health (MoH-NMEP, NPHCDA)
- *State governments*: State ministries of health and health commissioners
- *Campaign funders and implementers*: GAVI, Gates Foundation, CDC, USAID, Global Fund, World Bank, Malaria Consortium, NGDOs (The Carter Center, Sightsavers, RTI, MITOSATH, Evidence Action, CMB, HANDS, HKI, Amen Foundation etc)
- *United Nations Agencies*: WHO, UNICEF, UNITAID, UNFPA etc.

What are the specific tasks of the actor(s) and related stakeholders (e.g., activities and actions)?

A finance dedicated working group will need to define categories of campaigns for harmonisation of payment rates/modalities:

- For example, injectable campaigns administered by trained healthcare workers will have different payment rates than drug distribution campaigns using volunteers
- Volunteers for NTD campaigns need to be categorised by level and training (e.g. teachers are engaged for Schisto campaigns, and other volunteers are from communities).

The working group will then need to use these categories to draft a comprehensive framework (steps, cadres, workers involved from planning to implementation – including supervisors) to harmonise rates across campaigns. Federal MoH and State-MoH (especially Health Commissioners) will need to lead discussions and determine fair rates for each category of campaigns.

Funders and implementers will need to endorse and adhere to the guideline so that payment modalities are effectively harmonised.

NTD (and other) campaign implementing partners will need to adjust their fiscal year budget to accommodate for new rates, and they will therefore need to be engaged early in the process.

What is the estimated timeline and what are the key milestones for this recommendation?

The development of the harmonisation framework can follow the timeline of recommendation 3b above:

- Constitute a relevant working group – *1 month*
- Collect relevant data (e.g. list of payment practices) – *3 months*
- Analyse data and identify discrepancies– *2 months*
- Develop a harmonisation framework – *4 month*
- Engage stakeholders and initiate implementation – *6 months*

The eventual implementation of this recommendation will need to be timed according to the different fiscal year calendars of donors. It will need an official letter from the government stating the recommendation, reasons backing it as well as the effect date to allow donors to revise their budgets.

Recommendation 3d: Advance government role in campaign financing – gradually transition campaigns into the PHC system

Develop a roadmap for eventual transition of campaigns into the PHC system, starting with increased integration among interventions.

Where campaigns remain needed, develop an investment case showing how direct government funding will help existing policies.

The investment case will be structured along federal, state and LGA needs and their budgeting processes and describe existing funding sources and how they affect government contributions. It will also describe how the Basic Health Care Provision Fund (BHCPF) can eventually address campaign needs.

How would this recommendation benefit or be of service to Nigeria?

Implementing the recommendation will improve the sustainability of health campaign funding and increase Nigerian ownership of campaign priorities.

By contributing to a transition into the PHC system and direct government funding, the recommendation will lead to better planning and evaluating of campaign funding, through a reduction in funding streams.

The centralisation of funding implied by an increased government role will also contribute to a faster response to health emergencies and the possibility of having a pool of resources to respond to emergencies.

Which stakeholders should act on this recommendation?

This recommendation will be implemented by the following stakeholders:

- *Nigerian government*: Ministry of Health (MoH-NMEP, NPHCDA) – in a One Health Approach, Ministry of Finance; Ministry of Budget and Planning
- *Campaign funders*: GAVI, Gates Foundation, CDC, USAID, Global Fund, The Carter Center, NTD-NGDO Coalition, etc.
- *United Nations Agencies*: WHO, UNICEF

What are the specific tasks of the actor(s) and related stakeholders (e.g., activities and actions)?

A dedicated working group with key ministerial staff will need to:

- Collect and analyse campaign financing data (e.g. through the implementation of rec. 3a) to understand the current level of funding provided by/to government to support health campaigns
    - A deep dive into the basic health care provision fund should be undertaken as part of that analysis
- Build an Investment Case to support domestic investment in health campaigns and determine the best place to include campaign financing in government budgets
    - this investment case will be prepared by government counterparts in collaboration with key funders to be used in policy dialogue with relevant stakeholders
    - it should include transition plans where possible for campaigns to be progressively part of the primary healthcare system
- Advocate for the resources and commitment necessary to increase domestic funding for health campaigns

At a global level, health campaign funders will need to develop funding policies or mechanisms to facilitate greater government co-financing and inputs into campaign financing to ensure the implementation of the recommendation.

What is the estimated timeline and what are the key milestones for this recommendation?

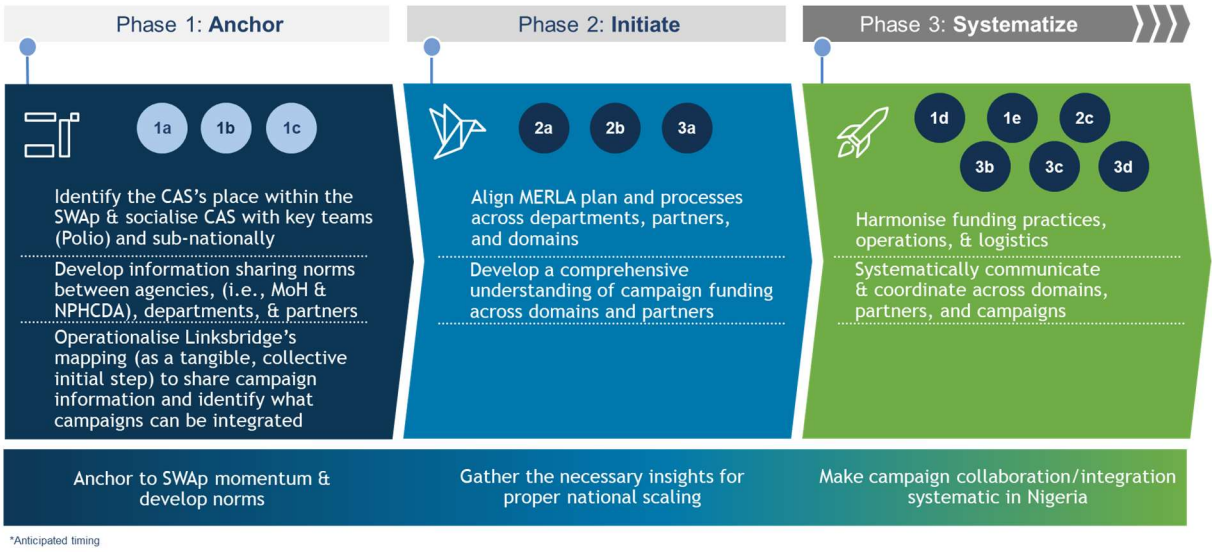
- Collection and analysis of campaign financing data – *6 months*
- Development of an Investment Case – *6-12 months*
- Implementation of the Investment Case – *6-12 months (taking into account campaign cycles and annual operational plans of states)*

CAS Implementation in Nigeria

The recommendations outlined above are meant to be implemented progressively and in parallel. The overall implementation of the CAS will likely happen in three distinct phases:

1. Anchor to the SWAp;

2. Develop norms and gather necessary insights;
3. Systematise collaboration/integration in the country



An implementation plan was developed by the end of 2024 to precisely outline all practical next steps for CAS implementation, including target dates, milestones, cost/resources needed and source(s) of funding, roles and responsibilities and measures of success.

Annexes

In the sections below are compiled the following annexes:

A. SWOT Matrix identified during the feasibility assessment

	STRENGTHS
Political commitment	• The **highest level of decision making** (the Hon. Prof. Pate, the National Council on Health) has **committed** to increase collaboration and integration. This commitment is reflected in the **Sector Wide Approach (SWAp)** and its "One Programme, One Budget, One Report, One Conversation" objective. • **All stakeholders interviewed** agree that the high number of campaigns is a burden on the Nigerian health system and **see the value in the CAS / increased integration and their willingness** to participate in additional integration (incl. Polio stakeholders).
Existing Infrastructure for Improved Effectiveness	• Nigeria has **long-standing priorities that align with** the integration and increased efficiency goals of **the CAS**. for example, Nigeria **increased its efforts** towards PHC strengthening and rationalisation with the **PHC Under One Roof**, the **Health Provision Fund** and the **multiyear plan on immunization**.

	• While bandwidth is limited, NPHCDA and F-MoH have **highly motivated & dedicated staff** focused on improving health outcomes.
Integration Experience	• Nigeria maintains **well established integration practices** including the Maternal, Newborn and Child Health Week (**MNCH Week**), on which to lean for increased integration in the country. • Multiple integrated campaigns have happened in the country at an **increasing pace since COVID-19** (e.g., a COVID/Measles/Yellow Fever/Vitamin A/Birth registration campaign was conducted in 2022)
	WEAKNESSES
Decentralised and fragmented ecosystem	• Nigeria is characterised by a **multiplicity of actors at all levels** (national, zonal, state, LGA) and **decentralised decision making**. • States have **strong agency** and **disparate structures** that necessitate tailor-made plans for socialization / advocacy and campaign implementation. • Campaign stakeholders are **strongly fragmented** and sometimes duplicative (e.g., there are Nutrition depts in F-MoH & NPHCDA).
No systemic approach	• **While campaign integration occurs, it is not systematised,** and many opportunities are missed. When it occurs, it happens opportunistically or at the grassroot level, with **little consistency**. • Most programmes **work in siloes**, including within the same organisation (e.g. 3 teams manage campaigns in the disease control unit of NPHCDA). They develop **different ways of working** (planning, implementation methods, reporting templates) which result in a high number of working groups, parallel processes and funding flows. • **Information is seldom shared** with other departments.
Limited resources (HR & Financial)	• Teams and **health workers are overburdened** by numerous campaigns. This affects routine services and limits available bandwidth to initiate integration efforts, all within an HR environment with recruitment/retention difficulties. • **Campaign funding remains limited**, especially at the state level when several international programmes request counterpart funding.
	OPPORTUNITIES
Sector-Wide Approach momentum	• The **political momentum** created by the SWAp is recognised by all actors, creating a **unique opportunity for action** towards increased collaboration and integration at all levels. • CAS should be nested as a **SWAp working group,** liaising with the 4 that can directly contribute to it (i.e., Resource Mobilisation, Health Financing, M&E, HR).
Institutional Memory to leverage	• Key **moments are clearly identified** as "integration moments": MNCH Week, Nutrition week. They are clear opportunities to lean on and expand for increased integration. • Institutional knowledge fostered in the **coordination structures put in place in past years** can also be leveraged to benefit the CAS (e.g., PHC Under One Roof approach, Health Provision Fund, Health Promotion media calendar).
Optimal Timing to increase integration	• Numerous and fragmented campaigns have led to **widespread campaign fatigue** in the country: for example, 8 vaccination campaigns happened in Kano in Sept-Dec 2023.

	• The **moment** is **prone to increased integration** and there is "low hanging fruit" to seize[1]. • All programmes state interest, **including Polio** which has an ambitious end of 2024 eradication target.
	THREATS
Limited Financial Incentives	• Multiple stakeholders depend on the **important funding for campaigns** (e.g., federal and state-level public agents, NGOs) and are apprehensive of meaningful change. • **Grassroot-level workers** compensated through **per-diems** have incentives to continue the status quo.
Perception of a potential decrease in efficiency	• **Stakeholders are concerned and protective of their scope** and have **conflicting priorities** (e.g., Polio's eradication target). This can lead to a **perceived fear** that increased integration will lead to **underperformance** & a reduced effectiveness. • **Trust and transparency is not institutionalised** among teams, limiting willingness to collaborate and awareness of common targets.
Difficulty mobilising resources	• **Mechanisms pushing for change (e.g., SWAp) are in their infancy,** while strong initial efforts will be needed. • Skilled human resources (e.g., trained vaccinators, project managers) are hard to hire and retain. It **will be challenging for limited teams to find the time additional integration will mandate**. • International donors have shown limited appetite for basket funding for campaigns and can have **limited flexibility**. • States have difficulty releasing **counterpart funding** which can cause delays and limit integration.

N-CAS

Implementation Plan & Financing Policy Brief Overview

vNov JAR 2025

Federal Ministry of Health & Social Welfare

HEALTH CAMPAIGN EFFECTIVENESS COALITION
Strengthen Systems. Maximize Impact.

N-CAS: Nigeria's Collaborative Action Strategy for Health Campaign Effectiveness

- A 5-year strategy that aims to catalyze global, regional, and country-level partners to take action to **enhance campaign effectiveness and build a more effective and coordinated health system**
- The N-CAS was **developed through a co-creation process across departments** (e.g., malaria, NTDs, non-polio SIAs, polio, RI, nutrition) and key partner stakeholders (e.g., WHO, UNICEF, The Carter Center, Gates Foundation). It is a unified and timely strategy to **institutionalize campaign coordination & integration**
- The CAS should **lead to better acceptability, cost savings, overall improved program efficiencies**[1]

N-CAS: 11 Customized Recommendations to Enhance Campaign Impact & Coordination in Nigeria

In 2024, CAS recommendations were customized to the Nigerian context, and piloted in 2025/2026 in 4 states (Akwa Ibom, Kano, Oyo, Yobe)

Planning & Implementation

Rec #1a

Establish a multi-sectoral, cross-campaign National Coordination Body to oversee CAS activities

Rec #1b

Identify campaigns for collaboration and integration (including plan to transitioning them to the PHC system)

Rec #1c

Develop a multi-year, cross-campaign workplan and schedule for campaigns

Rec #1d

Harmonize tools and operations (e.g., logistics, supply chain, microplanning) across campaigns

Rec #1e

Develop a coordinated and effective approach to enable active community engagement at all levels and phases

M&E/MERLA[1]

Rec #2a

Develop a coordinated and collaborative cross-campaign MERLA strategy in Nigeria

Rec #2b

Aligned with the coordinated country MERLA strategy, improve the ability of campaign implementers and partners to identify, measure, utilize and share data on campaign effectiveness

Campaign Financing

Rec #3a

Create a comprehensive view of campaign financing at the country level

Rec #3b

Take incremental steps toward harmonizing and aligning campaign financing (as articulated in the Health Campaign Finance Policy Brief)

Rec #3c

Harmonize and align incentive payment modalities and rates across campaigns

Rec #3d

Advance government role in campaign financing – gradually transition campaigns into the PHC system

1. Monitoring, evaluation, research, leaning, and adaption
2. The coalition-wide CAS includes 12 recommendations, 11 of which aim to be customized to country contexts and one (recommendation 2c – "At the global level, develop a Learning Platform and a MERLA framework as a practical guidance to countries and global stakeholders") being addressed by the HCE Coalition itself

N-CAS Plan for Implementation

The CAS TWG formalized specific steps for each recommendation in a comprehensive Implementation Plan. The immediate next steps (i.e., 2025 and early 2026) are summarized in the following slides

Planning & Implementation Next Steps

The CAS TWG formalized next steps for 2025 and early 2026 within the planning and implementation section of the N-CAS

1a

Establish a multi-sectoral, cross-campaign National Coordination Body to oversee CAS activities

- Identify **NCB members**
- Organize an **inaugural meeting** and **orientation workshop**
- **[TA]** Support **development of ToRs**, **guidelines** and orientation materials
- **Support States** in setting up their own campaign Coordination Body (send official letter, guidelines and support their inaugural meeting with refreshments)

1b

Identify campaigns for collaboration, integration and eventual transition into the PHC system

- **Transition** current campaign **dashboard prototype into a Nigeria-owned tool**
- Support the population and **update of a campaign calendar for all campaigns in Nigeria across domains**
- Identify criteria to select **campaigns to integrate**, or transition into the PHC system and **draft transition plans** for specifically mature campaigns

1c

Develop a multi-year, cross-campaign workplan and schedule for campaigns

- Develop a cross-campaign 3-year workplan **template**
- Organise a **workshop** with program managers and department heads **to fill the template** into a cross-campaign 3-year workplan

1d **1e**

Harmonise tools and operations across campaigns

- **Map out existing tools and practices** used by different campaigns (e.g., planning, logistics, team selection, community engagement, monitoring tools)
- **Identify elements that can be harmonised** or shared and initiate harmonisation process

M&E/MERLA[1] Next Steps Overview

The CAS TWG formalized next steps for 2025 and early 2026 within the MERLA section of the N-CAS

2a

Develop a coordinated and collaborative cross-campaign MERLA strategy in Nigeria

- Engage and facilitate a cross-campaign **MERLA working group**
- **Identify MERLA initiatives, gaps and opportunities** for collaboration and more information sharing
- Develop a **comprehensive strategy** to facilitate the effective use of existing information
- Develop a **coordinated MERLA framework** from existing MERLA frameworks

2b

Improve the collection and use of health campaign data

- Establish a **single database for action**, a shared data hub for collection, analysis and sharing of health campaign data
- Develop, install, pilot test and refine a **CAS dashboard** (national and subnational levels)
- Develop and implement a **data management plan** to measure campaign effectiveness tracking KPIs
- Publish **regular campaign reports**

1. Monitoring, evaluation, research, learning, and adaption

Campaign Financing Next Steps Overview[1]

The CAS TWG formalized next steps for 2025 and early 2026 within the Financing section of the N-CAS

3a

Create a comprehensive view of campaign financing at country level

- Conduct **3-day solutioning meeting** based on evidence generated from a **campaign finance and finalize a policy assessment** to develop recommendations for policy changes on campaign finance efficiency
- **Develop a visibility dashboard** tracking and monitoring funding sources and allocations and integrate it with MERLA and P&I dashboards

3b

Take incremental steps towards harmonising and aligning campaign financing

- Engage MoH, NPHCDA, implementers and donors to **include integrated campaigns in their workplans** and flexibility on timing of disbursements
- **Develop a harmonization strategy** with co-created solutions on improving harmonizing funding (in the format of a policy brief)
- **Pilot harmonization framework** nationally and/or in selected states

3c

Harmonise and align incentive payment modalities and rates across campaigns

- **Review data on payment rates and modalities** across partners and MoH/NPHCDA programs, and identify discrepancies
- **Develop recommendations for task-based standardized payment rate** for field implementers engaged in integrated campaigns
- **Formally agree** on an end-to-end payment modality for field implementers engaged for integrated campaigns (e.g., payment, process, and type)

1. Activities supporting Recommendation 3d are likely to occur in 2026 / 27 and are not included in this summary

Rec 1b. Identify Campaigns for Collaboration & Integration

Identifying Campaign Components for Integration

As noted in the implementation plan, a critical initial steps in CAS implementation is to align on which campaigns and their components can be integrated. As the initial first step, the CAS TWG developed a campaign component matrix and a 4-step process

i

Compile campaign characteristics for each domain (Immunization; Malaria, Nutrition)

i.e., for each campaign domain list targets, implementation modalities, teams, funding, microplanning practices

ii

Identify **commonalities and similar practices,** as well as major differences

e.g., are different campaigns using the same training processes?

iii

Identify **overarching integration opportunities** for all campaigns

i.e., what tools can be harmonized across all campaign domains, regardless of their target population, geography or timing

iv

Identify **co-delivery opportunities** and specific campaigns to fully integrate

i.e., what campaigns should be co-delivered to lower the burden on populations

The next pages present this exercise (i – iv), summarizing the campaign component matrix and identified co-delivery and integration opportunities[1]

1. Nutrition campaigns are not on this matrix yet for lack of representatives during the Implementation Plan workshop. They will be included in future iterations

Nigeria Component & Opportunities Matrix

Most campaign domains have similar practices & clear collaboration opportunities can be identified

Key
- Similar campaign practice
- Collaboration opportunity

	Non-polio SIAs	Polio	Malaria ITNs	Malaria SCN	NTDs
Target pop.	9 months – 49 years	0-59 months	Total population	3-59 months	Total population
Geography	Nationwide	Nationwide	Nationwide	Sahel/Savannah regions	Nationwide
Frequency	Once a year	-	Every 3-4 years	Annual	Annual
Seasonality	Yes (Measles: Q3-Q4)	No	No	July-October/November	No
Point of delivery	Temporary Fixed posts	House to house	Fixed or house to house	House to house	Fixed or house to house
Mode of delivery	Injectables	Oral antigen	N/A	Oral treatment	Oral treatment
Pharmaceuticals	Vaccines	nOPV	Nets	SPAQ	Multiple specific drugs
Supplies/logistics	Cold chain, syringes	State to LGA cold stores	State warehouses to facilities	State warehouses to delivery point	Federal, state, LGA, facility/community stores
Team composition	HEW, supervisor, crowd control, recorder	Supervisor, vaccinator, recorder	HEW, supervisor crowd control, recorder	Facility manager, supervisor, distributor	Distributors in pairs
Training	N&S TOT, LGA, Ward	N&S TOT, LGA, Ward	N&S TOT, LGA, Ward	N&S TOT, LGA, Ward	State, LGA, Com training
Job aids	1 pager information	Documentation	SOP, flip chart	SOP, flip chart	Manuals, SOP, flip chart
Census/registration	Microplanning	Microplanning	Net cards	ICT4D	Annual census update
Communication	Media, town announcers	Media, town announcers	Media, town announcers	Media, town announcers	Media, town announcers
Supervision	ODK, RCM, Tally sheet	National, state, LGA	Nat., State, LGA, ICT4D	Nat., State, LGA, Facility	State, LGA, Facility
Data collection/ Monitoring	Forms, data dashboard	Summary forms	ICT 4D	ICT4D, Surveys	Forms, ComCare, LMIS
Transportation	Trucks and cars	Trucks and cars	Trucks and cars	Trucks and cars	Trucks and cars
Stakeholders	Govt and partners	Govt and partners	Govt and partners	Govt and partners	Govt and NGDOs
Funding	Govt – GAVI	Govt – GPEI – BMGF	Govt – Global Fund	Govt – Global Fund	Govt – NGDOs – Com.
Microplanning	Template; ward summary	Microplans templates	Ward maps, route maps	ICT4D tools	No NTD integrated tools

Integration & Co-Delivery Opportunities in Nigeria

Based on the matrix, CAS TWG members discussed & analysed what can be integrated among health campaigns in Nigeria, with a goal to apply these criteria in 2025

1 **4 overarching areas** were identified as integration opportunities **for all campaigns:**

- ***Microplanning*** *(esp. team availability)*
- ***Advocacy, Communication & Social Mobilization***
- ***Training***
- ***Transportation***

2 **5 cumulative criteria** can be analysed to identify **campaigns that can be co-delivered:**

- ***Geography***
- ***Target population***
- ***Timing***
- ***Drug compatibility***
- ***Timely availability of resources*** *(commodities, Human Resources, funds)*

Federal Ministry of Health & Social Welfare

swap

Rec 3a. Create a comprehensive view of campaign financing at country level (Health Campaign Financing in Nigeria *Policy Brief)*

Health Campaign Financing Assessment & Policy Brief

To address health campaign financing challenges, a landscape assessment was commissioned, leading to objective findings and concrete recommendations

Objectives

Between August and November 2024, a **national health campaign financing assessment** was conducted aimed at:

- Identifying **structural and operational challenges** in current campaign financing mechanisms
- Examine opportunities to **align campaign financing with routine health system financing**
- Recommend **strategic actions** to promote sustainable, integrated, and equitable financing of health campaigns

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Mixed Methods

- The **WHO Health Financing Progress Matrix was adapted** to assess the country's health financing system through mixed methods:

Key Informant Interviews	Policy Desk Review	Solutioning Meeting
74 KIIs were conducted with NPHCDA, FMOH, Implementing Partners, Donors, State Representatives (e.g., Kwara State)	A desk review of existing policies, financial reports, and key literature was conducted to create a knowledge baseline	Stakeholders were convened to review assessment findings over a 3-day Solutioning meeting. Recommendations were refined and evidence translated into strategies to strengthen Nigeria's health campaign financing aligned with national priorities and the CAS framework.

Slide 13

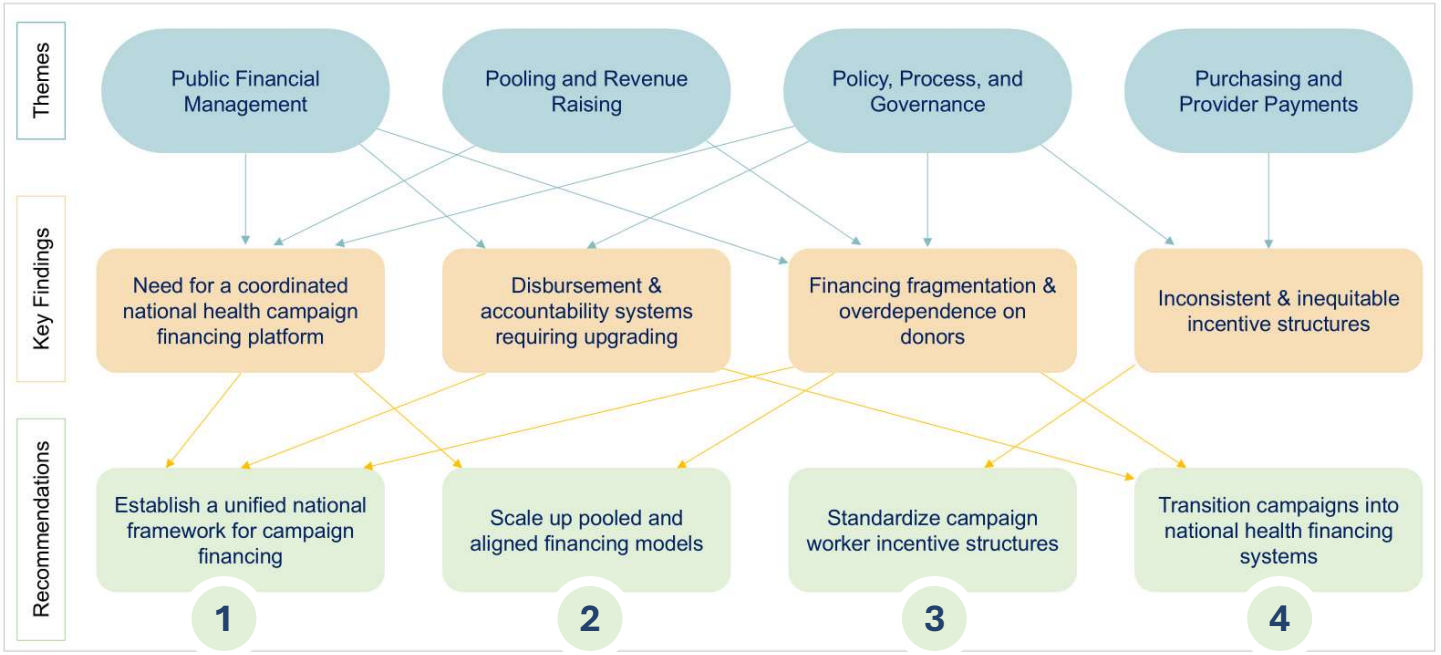
CA1 can we split this slide into 2 separate slides. I think the information is too condensed and it loses the impact. I think the last section with the matrix should go on a separate slide.

Chi Chi Amadi, 2025-10-28T18:49:01.167

Health Campaign Financing Assessment and Policy Brief

*The landscape assessment for Nigeria revealed **system barriers** to sustainable and integrated health campaign financing in Nigeria*

In response to the finance assessment, ***4 key recommendations are suggested*** *for implementation*



Health Campaign Financing Policy Brief Recommendations

To strengthen health campaign effectiveness and ensure long-term sustainability in Nigeria, the following strategic actions are recommended

	Title	Recommendation
1	**Establish a Unified National Framework for Campaign Financing**	▪ **Update the terms of reference** for the national multi-sectoral finance working group. ▪ Use this platform to **bring together** funders, implementers, and key stakeholders to create a **unified, country-level approach to health campaign financing**.
2	**Scale Up Pooled and Aligned Financing Models**	▪ Promote the adoption of **pooled funding models**, such as basket funds, through **targeted advocacy** via the Nigeria Governors' Forum. ▪ Provide **technical assistance** to support states in implementing Sector-Wide Approach (SWAp) financing policies that align campaign funding with routine primary healthcare efforts.
3	**Standardize Campaign Worker Incentive Structures**	▪ Develop and enforce **national guidelines on payment** rates and modalities for campaign workers to ensure fairness and transparency. ▪ Strengthen **digital payment systems** and introduce **feedback mechanisms** to improve accountability and consistency.
4	**Transition Campaigns into National Health Financing Systems**	▪ Gradually embed campaign financing into **national and state health budgets and Annual Operational Plans**. ▪ **Harmonize coordination forums** across disease areas to improve collaboration and reduce overlap. ▪ Adopt a **national health campaign financing policy** to guide this transition and enhance use of digital systems for real-time tracking and timely disbursement of funds.