

Good afternoon. Let me first thank the organizers for giving us the opportunity to share what we are doing in Nigeria. And what I'm going to discuss is an achievable goal that we believe is possible in Nigeria, to save a million lives. And I don't have a bigger projector, but I believe some of you who are close to the podium might be able to follow the discussion.

Now, I will share with you – OK, now, let's see. OK, I'll share with you approach, giving you a case study of what we have started to do and how we would like to partner with all willing partners in Nigeria to achieve that achievable goal of saving 1 million lives in our country. OK, sorry, the technology is failing me here.

But this is our country, a country of 36 states, federal capital territory and 167 million people. The diversity within this country in terms of health outcomes is significant. It reminds me of the physician who went into the ward and asked for the average temperature of the patients in the ward. Now, in our country, the health outcomes are also equally diverse in terms of geographical areas, rural/urban, socioeconomic areas within the country.

And the health system challenges that we face in terms of the poor outcomes, poor maternal health outcomes – although it's improving – we've got 545 per hundred thousand maternal deaths per year according to 2008 demographic and health survey. That's the true situation of the problem as of 2008, infant mortality of 75 per thousand live births, which is also according to the DHS of 2008.

We've got child mortality ratio of 157 per thousand live births, which is roughly 10 percent of the global total. And we've got in terms of health system infrastructure almost 23,000 health facilities all over Nigeria, of which 14,000 are primary health care facilities located in rural areas.

The supply challenges that we have include the infrastructure that has evaporated over time, commodity stock outs and equipment inadequacies. This is the reality that we have in our country. And demand for critical services is weak.

For example, only 38 percent of our women have skilled births and 58 percent attend antenatal care. Specifically, in order to meet the MDG, Nigeria needs to accelerate its progress in reducing under 5 (year old) mortality rate by 13 percent per year. That's the under 5 (year old) mortality rate to achieve the MDG goal four.

At the moment, from the slide that we have there which is copied from The Economist, we're achieving at 4.8 percent annual reduction in terms of under 5 (year old) mortality in Nigeria. Although we are achieving this, we need to significantly accelerate the progress that we have in achieving the mortality reduction in our country.

In summary, even though we've actually the most fairly consistent reduction in child mortality over the last few years, the current trajectory challenges us to achieve the MDGs by 2015. It's almost impossible. But we do believe that the path we are taking, the curve like was mentioned by Mr. Tedros, can be altered. The majority of the causes of child mortality are preventable and easily managed.

However, several factors, including poor access to essential primary health care services, remain a challenge. The government of Nigeria has made a significant stride in tackling this problem politically as well as financially. However, there's an opportunity to rapidly reduce newborn and under 5 (year old) mortality by fully implementing key high impact evidence-based interventions.

What have we done? As government, the government of Nigeria has initiated some interventions as we observe our own commitment to achieving the MDG goals. First, the essential medicines scale-up plan, a national scale-up plan for essential medicines was recently developed and fully endorsed by the government and partners focusing on the leading causes of under 5 (year old) deaths: pneumonia, diarrhea and malaria using ACT's – (inaudible) – for diarrhea and antibiotics for pneumonia.

If fully scaled up, this will save estimated 221,000 lives by 2013 – by the end of 2013, and an additional 500,000 lives by 2015. Second area is long-lasting insecticide-treated nets. The LLINs began to be distributed in 2009 and as of 2012 April, 46 million nets have been distributed in 36 states of our federation. The demonstrable impact on child mortality is estimated that 178,000 child lives have been saved by this intervention.

And collaboration with private sector players is beginning to be galvanized in cooperation with the MDG Health Alliance. We have established our own domestic private sector health alliance in collaboration with our key corporate leaders in Nigeria. Immunization is another area. Although – (inaudible) – has mentioned area, I will not dwell on that.

Routine immunization has gone from 42 percent to 67 percent. Measles immunization has been fully integrated into the primary health care services, reaching almost 70 percent of coverage in 2010 under routine immunization system. And an introduction of new vaccine, the pentavalent vaccine with support of GAVI which was introduced in the last one week protect our children against haemophilus influenza alongside the other antigens in the pentavalent vaccine.

And plans are underway for pneumococcal vaccine to be introduced in 2013. The government has already paid up its counterpart contribution for all these vaccines. Nutrition – the committee to manage nutrition was started in two states in 2009 and has been scaled up to 11 states and 67 local governments by 2011.

And annual admissions have increased from 6,900 in 2009 to 44,000 in 2010 and 141,000 children in 2011 with a cure rate of 61 percent. We have also introduce biannual maternal newborn and child health weeks which deliver high impact, low cost interventions targeted to newborns, under 5 (year old) children, breastfeeding mothers and women of reproductive age in conformity with the continuum of care approach.

Then finally, we started a program which is the midwifery service scheme which is one of the largest public sector-led human resources for health intervention schemes in Africa. We've deployed 4,000 midwives in a thousand primary health care centers all over rural Nigeria

in all the states. But going forward, we are anchoring our efforts on a target to save a million lives mostly through enhancing access to basic primary health care interventions.

The pillars of this effort are the maternal newborn and child health interventions, the elimination of mother-to-child transmission, strengthened routine immunization, scaling up of the essential medicines as well as other interventions.

We will strengthen our primary health care system through human resource deployment to the front lines, performance management, improving the quality of care and ensuring availability of medicines and supplies as well as generating demand. This is going to be revitalizing our primary health care system.

The PHCs, which are the front line – the retail outlets, so to speak, of health care service in our country will provide a strong platform and existing vertical programs can then build on it and integrate within that context.

The engine of this train that we've demonstrated here has the human resources, which is the front-line health workers, village health workers, community health workers, midwives, nurses and doctors in health facilities in the rural areas, the infrastructure and equipment, the quality aspect which includes the patients' safety and other aspects of the quality of care and the supply chain.

And then the programmatic aspects, the incidence of care, skilled birth attendance, postnatal family planning, PMT and immunization as a first coach of this maternal and child health training. Other interventions can ride on the back of this platform, like the HIV/AIDS interventions, the malaria, tuberculosis, ORS and zinc as well as antibiotics for pneumonia. We aspire to scale up to 3,000 modern primary health care centers that deliver outstanding primary health care.

At the moment, we have a thousand primary health care centers which were built basically and refurbished, deployed with human resources from 2009 to 2011. Our goal is to get to 3,000. And by 2015, we expect that at least 3,000 subset of the primary health care centers will be staffed, upgraded and resourced to deliver quality basic services to millions of Nigerians.

Eight thousand trained midwives should be deployed. Four thousand trained community health workers and 12,000 village health workers promoting maternal and neonatal health in the villages will be staffing those facilities. We expect to upgrade the infrastructure, provide equipment such as very adapted to the rural context and to have adequate supplies of commodities and to ensure that this quality program, that the standards of care that are being offered in those facilities are actually those that will save lives.

On our demand side, we expect and are already finding additional cash transfer system built on what has been done in India and other countries like Mexico to see how we can incentivize mothers to attend facilities, to attend and have scalable attendance. I give you an example of what we did in the midwifery service scheme which I mentioned in terms of reduction of maternal outcomes.

We've reduced over the two-year period of the midwifery service scheme maternal mortality has gone down by 26 percent. Neonatal mortality in areas where this scheme has been implemented by 22 percent and focus A&C attendance has increased by 22 percent while skilled birth attendance has increased by 33 percent in those particular facilities. This is a scheme that we are expanding as a way of scaling up access to basic services and saving the million lives.

And additional resources have been mobilized under the subsidy investment program to build on the impact of the midwifery service scheme through both supply side as well as demand side interventions along the continuum of care. So on the supply side inputs, I've mentioned them. And on the demand side, it's mostly in the conditional cash transfer side of the equation. And this gives you a sense of the targets we have.

I'm running out of time. So I'm not going to go through them. But I've already discussed the deployments that we will have over the period to come. But the model is a hub-and-spoke model whereby rural facilities are selected around general hospitals with a referral system between them with acute facilities and trained human resources to deliver services to the population.

So in terms of the approach to partnership, obviously we cannot achieve this as a government alone. We need a coalition of willing partners to join hand with us in country to manifest this ambition of saving a million lives. And that coalition of partners comprises both public as well as private sector players.

We need to have a multisector collaboration, a good understanding of the local context which government not only at the federal level but also at the subnational level actually have with clear accountability mechanisms to ensure that what we commit to we actually delivering on those commitments together.

And I present to you here a pictorial of the coalition which is both public as well as private sector coalition that we have in the country to achieve this objective. In essence, to save the lives that we anticipate we will, will take a coalition and a social movement, so to speak, that will galvanize the country towards reduction of child morbidity and mortality alongside the mothers also of those children.

So we are very committed to this effort. And I want to thank you once again for giving us the opportunity to share this vision that we have. (Applause.) Thank you.