

2Jl8 - 2fi22

## MINISTRY OF HEALTH

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**ACRONYMS**

AIDS Acquired Immune Deficiency Syndrome ANC Ante Natal Care

AOPs Annual Operational Plans ART Anti-Retroviral Therapy

APYIN Association of Positive Youth in Nigeria

ARFH Association for Reproductive and Family Health BCC Behaviour Change Communication

BHCPF Basic Health Care Provision Fund BMHB Basic Minimum Health Benefit BSG Breastfeeding Support Group

CAP Common African Position

CBO Community Based Organisation CDC Community Development Committee

CEMOC Comprehensive Emergency Obstetric Care CHAI Clinton Health Access Initiative

CHIPS Community Health Influencers/Promoters & Service CHIS Community Based Insurance Scheme

CISHAN Civil Society for HIV and AIDS in Nigeria CHX Chlorhexidine

CSOs Civil Society Organizations

CMAM Community-based Management of Acute Malnutrition CTC Core Technical Committee

CPR Cardiopulmonary Resuscitation CVHW Community Volunteers Health Workers DHIS District Health Information System

DHMIS District Health Management Information System DOTS Direct Observation Treatment Short-course

DP Development Partner

DPRS Department of Planning, Research & Statistics DQA Data Quality Assurance

DQA Data Quality Assessment

DRF Drug Revolving Fund

DSA Daily Subsistence Allowance

DSNO Disease Surveillance & Notification Officer EBF Exclusive Breast Feeding

EHO Environmental Health Officer

EID Early Infant Diagnosis EmOC Emergency Obstetric Care EMR Electronic Medical Record

EMS Emergency Medical Service ENBC Essential Newborn Care

ENCC Essential Newborn Care Course EOC Emergency Operation Centre

ETE End Term Evaluation

ERGO Economic Growth Recovery Plan FANC Focused Antenatal Care

FBO Faith-Based Organisation FHI360 Family Health International FMCP Free Medical Care Programme FMOH Federal Ministry of Health

FRSC Federal Road Safety Commission FTCs Facility Technical Committees

GBV Gender-Based Violence

GDP Gross Domestic Product

GHW Global Health Watch

GIS Geographic Information System

HAI Heartland Alliance International

HBFI Hospital Baby Friendly Initiative

HBB Helping Babies Breathe

HBC Home-Based Care

HCT HIV Counselling & Testing

HCW Health Care Workers

HDCC Health Data Consultative Committee HDGC Health Data Governing Council

HDI Human Development Index

HE Health Education

HFs Health Facilities

HFG Health Finance and Governance

HFU Health Finance Unit

HIO Health Information Officer

HIS Health Information System

HIS Health Information Services

HIV Human Immuno-Deficiency Virus

HMIS Health Management Information System HPCC Health Partners Coordinating Committees HR Health Regulations

HRH Human Resources for Health HRHIS Human Resource Health Information

HSDF Health Strategy and Delivery Foundation HTP Harmful Traditional Practices

HTS HIV Testing Services

HW Health Worker

IDSR Integrated Disease Surveillance & Response IDU Intravenous Drug Users

IEC Information, Education, Communication Materials IHR International Health Regulation

IMCI Integrated Management of Childhood Illnesses IPC Infection, Prevention and Control

IPC Interpersonal Communication

IPSM Integrated Procurement & Supply Chain Management

IPSMTWG Integrated Procurement Technical Working Group IPT Intermittent Preventive Treatment

##### IRS Internal Revenue Service

ISS Independent Supportive System

IVM Integrated Vector Management

IYCF Infant & Young Child Feeding

JAR Joint Annual Review

JCCR Joint Consultative Committee on Referral LAC Long Acting Contraceptive

LARC Long Acting Reversible Contraceptive LGA Local Government Area

LLIN Long Lasting Insecticide Net

LMCU Logistics Management Coordinating Unit LMD Last Mile Distribution

LMIC Low and Middle-Income Countries

LMIS Logistic Management Information Officer M&E Monitoring & Evaluation

MDA Ministry, Department and Agency MFOC Fund Oversight Committee MHAs Mutual Health Associations MICS Multiple Indicator Cluster Survey MNCH Maternal Neonatal & Child Health

MPPI Minimum Package Preventive Intervention MTR Mid-Term Review

NAFDAC National Agency for Food and Drug Administration and Control NBTS National Blood Transfusion Services

NASCP National AIDS/STDs Control Programme NCD Non-Communicable Diseases

NCH National Council on Health

NDDC Niger Delta Development Commission NDHS Nigeria Demographic & Health Survey NEPWHAN Network of People Living with HIV/AIDS NHRHP National Human Resources for Health Policy

NHRH SIP National Human Resources for Health Strategic Implementation Plan NHRHSP National Human Resources for Health Strategic Plan

NPHCDA National Primary Health Care Development Agency NPMCN National Postgraduate Medical College of Nigeria NPopC National Population Commission

NPPB National Programme for Prevention of Blindness NSPAN National Strategic Plan of Action for Nutrition NTD Neglected Tropical Diseases

OB Obstetrics

OB Van Outside Broadcasting Van OF Obstetric Fistula

ODK Open Data Kit

OHT One Health Tool

ORS Oral Rehydration Solution

OVC Orphan and Vulnerable Child

PBF Performance-Based Financing

PHC Primary Health Care

PHE Public Health Emergency

PFM Public Finance Management PHCUOR Primary Health Care Under One Roof PHL Public Health Laboratory

PHALGA Port Harcourt Local Government Area PM Programme Manager

PMS Performance Monitoring System

PMTCT Prevention of Mother-to Child Transmission of HIV PMV Patent Medicine Vendors

PPE Personal Protective equipment

PPP Public Private Partnership PPM Providers Payment Mechanism PTA Parents Teachers Association

QA Quality Assurance

R&D Research and Development

REW Reach Every Ward

RI Routine Immunisation

RIFO Routine Immunisation Focal Officer

RIVCHPP Rivers State Contributory Health Protection Programme RIVSACA Rivers State Agency for Control of AIDS

RIWG Routine Immunisation Working Group

RMNCAH Reproductive health, Maternal &Newborn, Child & Adolescent Health RMNCAH+N Reproductive, Maternal, Newborn, Child Health and Nutrition RSPHCMB Primary Health Care Management Board

RSHMB Rivers State Hospitals Management Board RUTF Ready to Use Therapeutic Food

SAM Severe Acute Malnutrition SASCP State AIDS & STI Control Program SCCO State Cold Chain Officer

SCH State Council on Health

SCM Supply Chain Management SDGs Sustainable Development Goals SFA State Fund Administrator

SFH Society for Family Health

SHIS Social Health Insurance Scheme SHREC State Health Research Ethics Committee SMO Social Mobilization Officer

SMOH State Ministry of Health

SOGON Society of Gynaecology and Obstetrics of Nigeria SOP Standard Operating Procedure

SOT Standards of Training

SP Sulphadoxine Pyrimethamine

SPDC Shell Petroleum Development Company SPT State Planning Team

SSHDP II State Strategic Health Development Plan II STG Standard Treatment Guideline

STM State Team Members SWAPS Sector –Wide Approaches

SWOT Strengths, Weaknesses, Opportunities and Threats TBAs Traditional Birth Attendants

TBLS Tuberculosis & Leprosy Supervisors TMB Traditional Medicine Board

TOT Training of Trainer

TSTS Task Shifting/Task Sharing TWG Technical Working Group

UHC Universal Health Coverage UNICEF United Nations Children's Fund

UPTH University of Port Harcourt Teaching Hospital USAID United States Agency for International Development VDCs Village Development Committees

VHC Village Health Committees

VHF Viral Haemorrhagic Fever

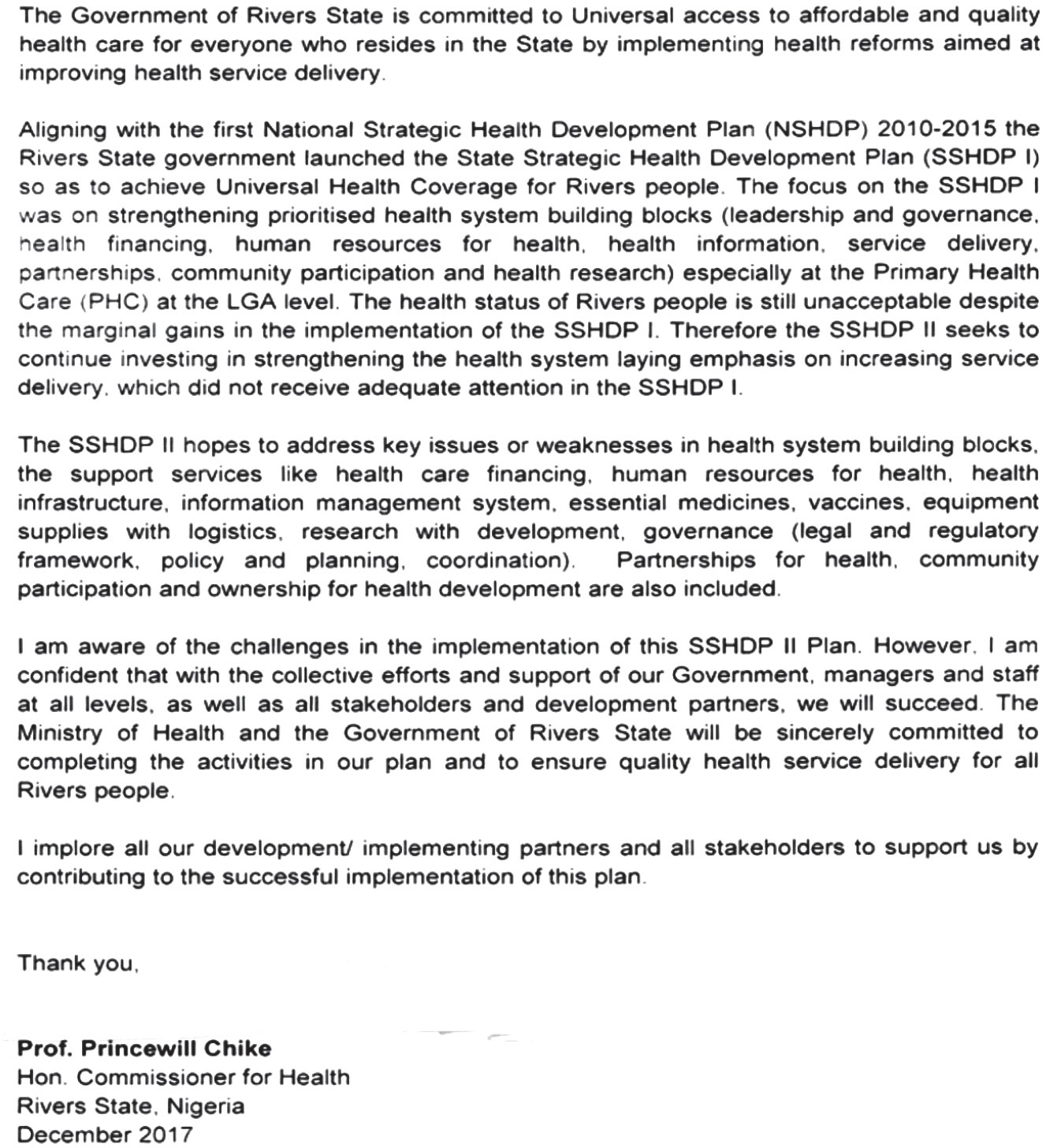
WACP West African College of Physicians WATSAN Water & Sanitation

WASH Water, Sanitation and Hygiene WB World Bank

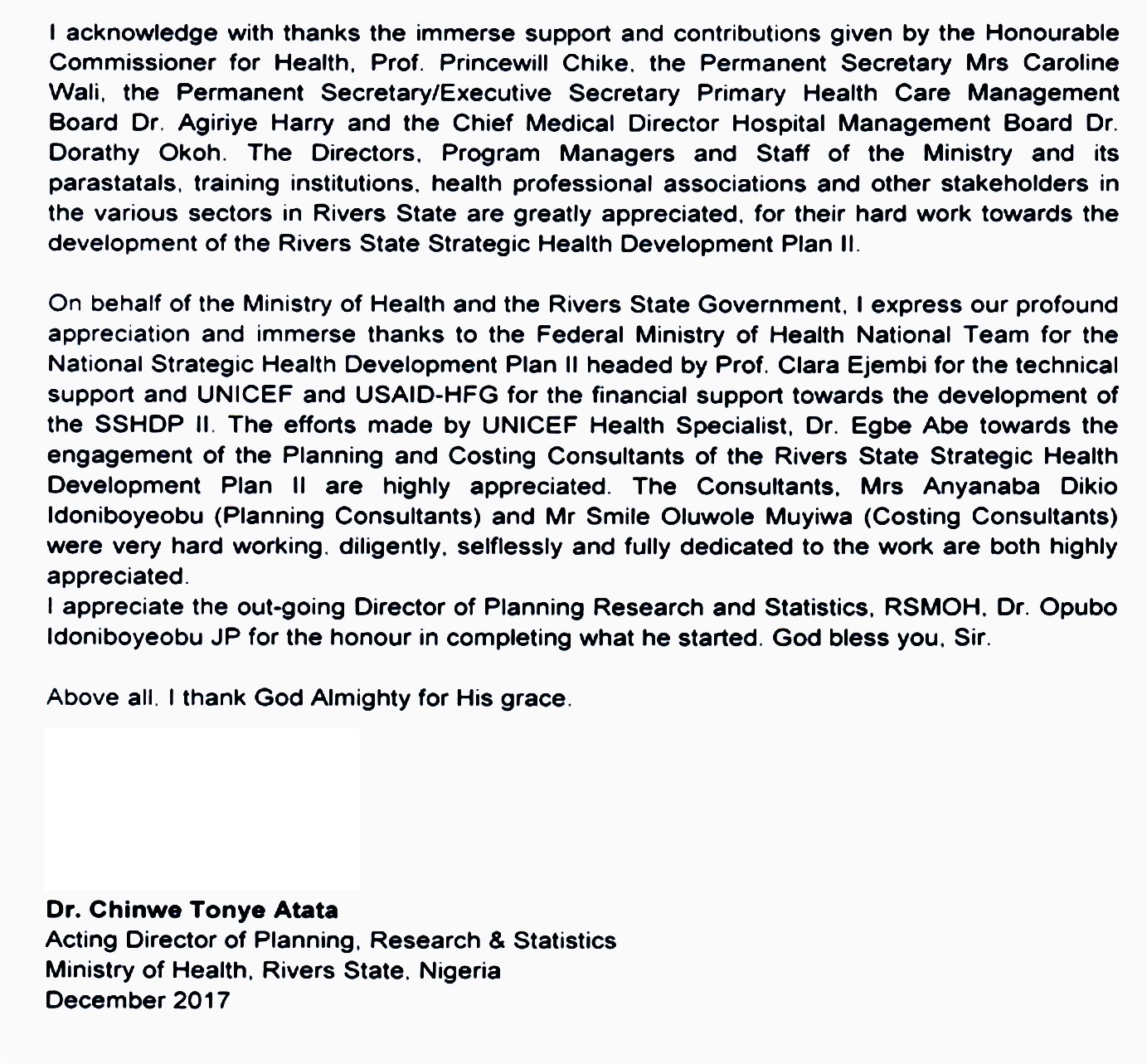
WDC Ward Development Committee WHO World Health Organization

WRAG Women of Reproductive Age Group.

## FOREWORD



## ACKNOWLEDGMENT



**EXECUTIVE SUMMARY**

Rivers State is located in the oil rich Niger Delta region in the South-South geopolitical zone and is made up of 23 Local Government Areas and 319 political wards, with Port Harcourt as the State capital. Rivers State vegetation is characterized by mangrove forest and thick rain forest with arable land. Over one third of the State is occupied by water even Port Harcourt still has communities/settlements that can only be accessed by the use of canoes and small motorized boats. This terrain makes service delivery difficult for the health workforce in the state but despite this there are 408 Public health facilities (385 Primary, 18 secondary and 5 tertiary facilities) spread across the State.

Rivers State health status indicators are still unacceptable. Rivers State has a high prevalence rate of HIV/AIDS of 5.8% and is among the 12+1 states sharing 70% of the national disease burden. The maternal mortality ratio of 338.1 per 100,000 live births (DHIS 2) was low as against the National maternal mortality ratio of 576/100,000. The other health status indicators: under-five mortality rate of 58/1000, infant mortality rate of 41/1000 and child mortality rate (18/1000). The life expectancies for male, 52.6 years and female, 53.8 years are still low compared to 54 and 57 years (2008) respectively, and the national 54.5 years and global average of 71.4 years. The indices of health in the State are still below acceptable limits. Expansion of access to quality health care services is necessary if Rivers State is to attain the Social Development Goal 3 target of universal access of all to health care services. This access to quality health care and prevention is also vital for poverty reduction and economic growth, which is key to the attainment of her Vision 2020.

The NSHDP II Framework, was used by Rivers State along with other States, to develop the SSHDP II. The plan was prepared within the framework of Vision 2020, the Economic Recovery and Growth Plan (2017 2020), and the 2016 revised National Health Policy. It was also being guided by all relevant extant policies and legislations, notably the National Health Act and international declarations, majorly the UN-Social Development Goals (SDGs). The end product is the harmonized National Strategic Health Development Plan with its appropriate costing, will thereafter serve as the basis for collective ownership, adequate resource allocation, inter-sectoral collaboration, decentralization, equity, harmonization, alignment, and mutual accountability in Nigeria. It would also stipulate requirements for future health investments towards achieving sustainable universal access and coverage within the planned period of 2018 - 2022.

Unlike, the SSHDP I with priority concern on improving the Rivers State health service delivery system. The services to be delivered were not given adequate attention, so the SSHDP II includes the technical health service programmes in its plan. These health service programmes, which are being proposed as the essential health care package, and derived from the national health policy comprises:

Reproductive, maternal, newborn, child health and nutrition–related programmes; Control of communicable diseases (malaria, tuberculosis, HIV/AIDS, hepatitis and neglected tropical diseases);

Control of non-communicable diseases;

Mental health;

Care of the elderly;

Public health emergencies;

Oral health;

Eye health;

Environmental health (water and sanitation, food safety, snakebites and chemical programme);

General and emergency hospital services;

Health promotion.

This framework provides the context, goals, strategic objectives, and recommended evidence- based and cost-effective interventions required to deliver improved performance of the health system and health outcomes for Rivers people for each prioritized health system area. The areas given high priority in the SSHDP II are:

Ensuring effective leadership and governance with emphasis on increasing resource mobilization and aligning funding to UHC;

Reducing geographic and socioeconomic barriers to access, strengthening coordination of different levels of the health care system and also among various stakeholders and strengthening regulatory institutions to ensure effective functionality; and Improving human resource management through effective performance appraisals and reward systems based on performance;

Review financing mechanisms to ensure functionality, allocative efficiency and rapid expansion of social health insurance so as to increase risk protection and increased funding, including government's increased funding to the health sector in line with Abuja Declaration;

Strengthen PHC and other levels of the health care system by defining and approving an

essential health care package for all Rivers people;

Strengthening LGA/primary health care services and community systems to ensure resilience and guarantee health security;

Develop standards of practice at different levels of the health care system, referral guidelines and ensure functionality of the referral system;

Reduce medical tourism by improvement in quality of care and enforcements of standards. Increase investments in health promotion and disease prevention;

Redress human resource gaps, promote industrial harmony and reduce strikes within the sector, and invest in health research and innovations.

The overall purpose of the plan is to reduce disease burden from all causes of ill health in Rivers State, and reduce disparities by increasing access to a comprehensive package of appropriate, affordable, quality, equitable and integrated essential health care services within the context of a strengthened health care system, aligning resources in relation to needs. The entry point for the delivery of the essential package of health care services will be the strengthened LGA and ward primary health care system and appropriate referral pathways to other levels of care.

In order to strengthen the health system to deliver the essential health package five Strategic Pillars with fifteen evidence-based Priority Areas have been identified to improve the performance of the health sector, through a holistic approach at all levels of healthcare delivery. For each of these priority areas, there is a goal with strategic objective, interventions and activities.

These activities have targets and verifiable indicators. The strategic pillars & priority areas are:

Strategic Pillar One: Enabled environment for attainment of sectoral goal

Priority Area 1: Leadership and Governance Priority Area 2: Community Participation Priority Area 3: Partnerships for Health

Strategic Pillar Two: Provision of essential package of health care services

Priority Area 4: Reproductive, Maternal, Newborn, Child and Adolescent Health Plus Nutrition Priority Area 5: Communicable Diseases (Malaria, TB, Leprosy, HIV/AIDS) and Neglected

Tropical Diseases

Priority Area 6: Non-Communicable Disease, Care of the Elderly, Mental Health, Oral Health, Eye Healthcare

Priority Area 7: Emergency Medical Services and Hospital Care Priority Area 8: Health Promotion and Environmental Health **Strategic Pillar Three: Health system support**

Priority Area 9: Human Resource for Health Priority Area 10: Health Infrastructure

Priority Area 11: Medicines, Vaccines, Health Technologies and Supplies Priority Area 12: Health Information

Priority Area 13: Health Research

**Strategic Pillar Four: Protection from Public Health Emergencies and Risks** Priority Area 14: Public Health Emergencies: Preparedness and Response **Strategic Pillars Five: Health Financing**

Priority Area 15: Health Financing

The preferred policy option for Rivers SSHDP II (2018-2022)was the Essential Service Moderate Scenario with an estimated Cost of Two Hundred and Twenty Billion, One Hundred and Eighty- Nine Million Naira (? 220,189,000,000)for the 5-year plan.

The Rivers State Ministry of Health (RSMOH), under the leadership of the Honourable Commissioner, the Chief Executive and the Permanent Secretary, the Chief Administrative Officer of the Ministry is responsible for formulating the State health policy and ensuring its implementations. The RSMOH has parastatals, agencies and training institutions with their administrative heads that provide manpower needs for the secondary and tertiary health facilities. All these would make sure the SSHDP II is put into proper practice and the various programmes actualized.

Monitoring and Evaluation will be done by the implementing departments and special units (inbuilt M & E) and a central M & E Unit in the PRS Department. It is important to monitor and evaluate the plan's operational elements (the required activities) that are essential ingredients in ensuring the successful implementation of the plan and it is equally important to monitor and evaluate programme outputs and impacts for measurable variables and changes in the health status of the population and the health services as a consequence of the implementation of the SHDP also the health prevention and utilization indicators. The major categories of indicators that are relevant for monitoring and evaluating the State SHDP include the policy and socioeconomic indicators.

# CHAPTER 1

### INTRODUCTION

* 1. BACKGROUND
     1. **Purpose:**

The first five-year Rivers State Strategic Health Development Plan 2010-2015 was aimed at engendering significant improvement in the health care delivery system to enable the state in line with the National meet the relevant Millennium Development Goals, (MDGs) by 2015, improve the well-being of Rivers indigenes, as well as Nigeria's ranking in the global human development index (HDI).

Although Rivers State has made significant improvements in the health sector, the health status of her citizens is still unacceptable. The disease burden of the State is mostly due to preventable diseases including malaria, upper respiratory tract infection, diarrhoea etc. Poverty is the major cause of the high disease burden in the State. Other contributory factors to the poor health status include militancy, youth restiveness, kidnapping, difficult geographical terrain making it almost impossible for health workers to reach the riverine communities in the State. Furthermore, environmental degradation occasioned by the exploration of oil and gas, Lassa fever, HIV/AIDS, Ebola and most recently the high atmospheric soot deposits due to menace of artisanal refining of stolen crude oil and uncontrolled emission of hydro carbon by oil exploration companies in the State are of great concern.

The End Term Evaluation of the SSHDP I revealed that progress was made but the achievements were lower than expected. The 2015 targets were largely unmet for most of the indicators. The Rivers State Strategic Health Development Plan (RSSHDP) 2018 – 2022 is the second state health plan being designed within the context of placing health at the centre of socioeconomic development and presents a clear shift in the role of health in the State and national development framework.

* + 1. National and State Context:

The Federal Ministry of Health (FMOH) in collaboration with Development Partners, commenced the process of developing the second National Strategic Health Development Plan (NSHDP II) 2018-2022. The validated framework was used by both Federal and States Ministry of Health to develop their specific plans. Rivers State has used the validated framework to develop their own Strategic Health Development Plan (SSHDP II), which will be harmonized with those of other states and the Federal into ONE NATIONAL PLAN for implementation over a period of 5 years. The Parastatals, agencies and health institutions under the Rivers State Ministries of Health including Local Government health authorities and the private health care providers are all responsible for healthcare in the State.

1 National Strategic Health Development Plan ( NSHDP II) framework

2 State Strategic Health Development Plan (SSHDP 2010-2015)

3 Joint Annual Review/ Mid-term Review 2012 (JAR/MTR)

At the national level, the health Sector in the State is expected to contribute to the attainment of the Nigeria's Development Agenda; Vision 20:2020 through ensuring a healthy, vibrant and productive labour force. The long-term goal is for Nigeria becoming one of the twenty largest economies in the world by the year 2020. Nigeria also has a medium-term plan; Economic Growth Recovery Plan (EGRP) 2017-2020, that has three broad strategic objectives, which are; restoring growth; investing in our people, and building a globally competitive economy.

The EGRP sets 10 policy objectives for the health sector as follows: Improve the availability, accessibility, affordability and quality of health services; Expand healthcare coverage to all Local Governments; Provide sustainable financing for the health care sector; Revitalize 10,000 Primary health care centres and establish at least one functional Primary Health Centre (PHC) in each ward to improve access to health care; Fully implement the primary health care refinancing programme to mobilize domestic resources; Drive progress to meet United Nations Strategic Development Goals (UN SDGs) health targets; Reduce infant and maternal mortality rates; Roll out universal health coverage (NHIS); Strengthen delivery beyond the primary health care system; Reduce under-five mortality rates.

These policy goals have been considered in the development of the NHSDP II accordingly. The national aligns with both the policies made at the Regional level; like the Abuja 2001 Declaration and Abuja+12 Declaration which committed the African Union Member States to allocate at least 15% of their annual national budget to health and the Common African Position (CAP) on the Post 2015 Agenda (African Union 2014)which seeks to achieve universal and equitable access to quality health care on the continent, prioritizing improvement in MNCH, enhanced access to sexual and reproductive health and family planning, with special focus on vulnerable groups, including youths, unemployed, children, elderly and people with disabilities; reduction in incidence of communicable diseases (HIV/AIDS, malaria and TB), and NCDs including mental health and emerging diseases; as well as strengthening health systems, including health financing, improved hygiene and sanitation and improving monitoring and evaluation and quality assurance systems.

The attainment of Sustainable Development Goals 2016-2030 (SDGs) especially SDG three is a priority in the health sector. SDG 3 focuses on health and has as a goal to '*Ensure healthy lives and wellbeing for all ages'* with 13 targets that include the “unfinished Millennium Development Goal agenda” from MDG. New targets to address the other health threats and challenges that cover the means of implementation are also addressed. It is worthy to note that the lack of universal health coverage and financing gaps were identified as the major factors militating against the attainment of health-related MDGs in low and Middle-Income Countries (LMIC). The need to address the on- going public health challenges of acute epidemic diseases, disasters and conflict situations, the burgeoning epidemic of non-communicable diseases, including mental health disorders are also incorporated in the NSHDPII.

4 National Bureau of Statistics (2010). Nigeria Vision 20: 2020 Abridged Version (Online) Availablefr[om:http://www.nigerians](http://www.nigerianstat.gov.ng/pdfuploads/Abridged_Version_of_Nigeria)t[at.gov.ng/pdfuploads/Abridged\_V](http://www.nigerianstat.gov.ng/pdfuploads/Abridged_Version_of_Nigeria)er[sion\_of\_Nigeria%20](http://www.nigerianstat.gov.ng/pdfuploads/Abridged_Version_of_Nigeria) Vision %202020.pdf (Accessed 27th June 2017)

*5 African Union 2014*

*6 Sustainable Development Goals (SDGs)*

* + 1. Policy Environment:

In line with the revised National Health policy, the SSHDP II (2018-2022) aims to promote universal access to essential health care services by strengthening and expanding access to primary health care, redress inequity and ensure financial risk protection by expanding coverage with social health insurance. The various policies used included: National policy on the health and development of National Health Management Information System (2006); Primary Health Care (launched in Nigeria in 1988); National Health Policy (2016); National Health Insurance Scheme (1999); National Health Act (2014); etc. The SSHDP, 2018-2022 aims to address issues that will ensure achieving the Sustainable Development Goals (SDGs). The Health Policy direction of Rivers State is Universal access to affordable and quality health care for everyone who resides in the State (Table 1).

***Table 1: Policy thrust in Rivers State***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **SN** | **Policies** | **Year** | **Key Provisions/Purpose** | |
| 1 | Free Medical Care | 2000 | o Aimed at free medical care for children less than 6 years and adult above 60 years of age in all State government  hospitals. | |
|  |  | 2010 | * Free Caesarean Sections for adolescents. * Treatment of medical emergencies and accident victims for the first 24 hours. * Made universal to all residents in the State. | |
| 2 | Primary Health Care Management Boards Law | 2011 | This law seeks to make primary health care facilities should be autonomous through the establishment of Boards and the direct funding of these facilities. | |
| 3 | Rivers State Agency for the Control of AIDS |  | Aimed at strengthening coordination mechanisms for HIV/AIDS prevention and control across all sectors state. | of the |
| 4 | Rivers State Government’**s**  health policy of “60 **-**  60**-** 60” Project | 2010-  2012 | The 60 -60-60 project was commissioned to deliver 60 PHC to 60 communities in 60 days so that over 100 new PHC centres were been built and fully equipped.  To address these inadequacies, the State Government  adopted a health policy that gave priority to | |
|  |  |  | strengthening of the primary health care system with a view to improving the performance of the health sector. The Government’s objective was to provide good quality, efficient effective and affordable essential health  services across the state. | |
| 5 | Public Private Partnership |  | In a bid to strengthen the referral system, a 120 bed Kelsey Harrison Hospital was built and equipped.  The building of six other zonal referral hospitals in the State.  In addition, a new dental and maxilla -facial hospital has also been constructed. | |
| 6 | Rivers State Contributory Health  Protection | 2017 | * The aim is to prevent the financial hardship experienced by families and move toward health insurance scheme. * The (RIVCHPP) draft bill has been sent to the State Executive Council for approval and onward transmission to the Rivers State House of Assembly for public hearing and signing into law. * Is yet to become operational | |
|  | (RIVCHPP)  Programme draft Bill |  |

* 1. State Profile

Rivers State, one of the thirty-six states in Nigeria, is located in the southern part of the country and is embedded in the Niger delta region. It was created on May 27, 1967 and, on 1st October 1996, Bayelsa State was carved out of Rivers State2. The present Rivers State is made up of 23 Local Government Areas and 319 political wards, with Port Harcourt as the State capital.

There are 385 Primary health care Centres spread across the 319 political wards while at the Secondary health care level there are 36 general hospitals spread across the 23 LGAs in the state with only 18 functional.

Rivers State is located in the oil rich Niger Delta region in the South-South geopolitical zone. It occupies an area of about 37,000 square kilometres and is bounded on the south by the Atlantic Ocean, to the North by Imo and Abia States, to the East by Akwa Ibom State and to the West by Bayelsa and Delta States. Its shores form part of the West African Coastline 2.

The vegetation of Rivers State is characterized by mangrove forest in the south while the northern part has thick rain forest with arable land. Rainfall is heavy throughout the year, but decreases from 430 cm to 342 cm towards the north. The dry season usually lasts from November to April, interrupted occasionally by sporadic downpour.

The inhabitants of the State are of different ethnic groups with cultural diversity expressed in language, beliefs, dress codes and music. They are mainly Christians, though a few Muslims and traditional worshipers exist. They include the Abuans, Andonis, Ekpeyes, Engenis, Etches, Ikwerres, Kalabaris, Ogba-Egbema-NdoniOgonis, the Wakrikes, amongst others. The waterways are vital transport system within the State. The major rivers in the State include: River Niger, River Sombreiro, River Orashi, New Calabar River, Bonny River and Andoni River, etc.

Demographically, Rivers State has a population of 7,244,152 based on the projected population of 2016 (2006 Nat. Provisional Result at Population Growth Rate of 3.4%), adults and adolescents aged 15 to 64 years accounted for 61% of the population in the state. Children below the age of 15 accounted for 36% of the population and those aged 65 years and above, another 3%. The population of Rivers State was 4% of the population of Nigeria based on the National Bureau of Statistics projection.

Rivers State is the second largest economy in Nigeria after Lagos State2. It has a GDP of 21.1 million USD8 which is larger than most national GDPs in the African continent. The State has two major refineries, two major seaports and airports and various industrial estates spread across the State particularly in the state capital 2. The State has a per capita income of 4 USD. While the State's economy is still largely dependent on oil, the declining oil price, ongoing security challenges in the Niger Delta and the subsequent recession has caused a steady decline in the economy of the State.

* + 1. Literacy Rate

There is a relationship between female literacy levels and rate of change in maternal

7 National Provisional Result, National Population Commission (2010). 2006 Population and Housing Census:Abuja: NPC*, p9*

8 National Bureau of Statistics (NBS 2017).

mortality ratios. The female literacy rate is about 98.1%9 in Rivers State women (Table 1) which is relatively high despite the poor health indices. We know that literate women care for the health of their family especially their children. They are more likely to complete the immunization schedule than others.

* + 1. Transportation

Over one third of the State is occupied by water with a low land stretching from Bonny in the South to Ndoni in the North. A network of creeks spans the riverine South, stretching into the Atlantic Ocean through Bonny, Opobo, etc. In terms of terrain the core riverine LGAs are Bonny, Andoni, Opobo- Nkoro, Okrika, Ogu-Bolo, Asari Toru, Akuku Toru and Degema LGAs. The upland LGAs are Port Harcourt City, Khana, Obio-Akpor, Eleme, Oyibo, Tai, Omuma, Etche, Emohua and Ikwerre. LGAs with mixed terrain are Ogba–Egbema-Ndoni, Ahoada East, Ahoada West and Abua–Odual2. However, LGAs like Khana, Gokana, Omuma, Emohua and Port Harcourt still have communities/settlements that can only be accessed by the use of hand pulled canoes and small motorized boats. The terrain makes service delivery difficult for the health workforce. The Task shifting and sharing policy embarked upon would help to alleviate this problem.

* 1. Methodology for Developing the SSHDP II

The SSHDP, (2018-2022) adopts a comprehensive, inclusive and holistic approach organized along three parts in line with the NSHDP II; Service delivery; which covers Reproductive Health, Maternal Newborn, Chilld and Adolescent Health (RMNCAH), Communicable and Non- Communicable diseases, Mental Health, Care of the Elderly, NTD's etc. The Health Systems component which focuses on the nine thrusts of the National Health Policy, 2016; governance, human resources, financing, health information system, medicines, vaccines and other technologies, research etc., and the M&E component which cuts across all the programmes.

The SSHDP, 2018-2022 anchors on five Strategic Pillars using 15 Priority Areas1 to achieve equitably reduced morbidity and mortality and improved socioeconomic wellbeing that will aid in '*Ensuring healthy lives and promoting well-being of the Rivers populace at all ages*'.

At the National level the NSHDP II Framework was developed. Then there was wide-stakeholder consultations with key actors at Federal, State and LGA levels. This was followed by Stakeholder validation workshops; and dissemination of the framework to Federal and the States, to guide the formulation of their respective plans. These state plans and FCT would be harmonized into

NSHDP II.

The process for the development of the Rivers State SHDP comprised of the following steps:

1. State Planning and Costing Consultants were engaged and trained by the Federal Ministry of Health to support the work at the State.
2. A State Planning Team (SPT) was inaugurated by the Permanent Secretary and comprised of Directors and Programme Managers from the SMOH, RSPHCMB, RSHMB and health training institutions and Development Partners
3. A Technical Working Group (TWG), was inaugurated by the Permanent Secretary, with the Director PRS as the Chairman, reviewed the first SSHDP; and supported the development of the second SSHDP;
4. An end-term evaluation of the first SSHDP was conducted to determine level of implementation, outcomes, challenges and lessons learned;
5. Members of the SPT & TWGs were trained on the NSHDP Framework and planning process at the State level;
6. Using the NSHDP Framework, State policies, national and international documents and declarations, the SPT developed the costed draft of the second SSHDP;
7. The draft plan was reviewed by the TWG;
8. The final draft of the plan was validated, produced and disseminated to all stakeholders in the State.
   1. Structure of the National and SSHDP II

This NSHDP II, (2018-2022) is divided into 10 chapters. Chapter One describes the purpose and as well as national and the state contexts of development of the NSHDP II. The health sector policy environment, methodology and structure are enumerated. Chapter Two is the situation analysis. It provides the current health status of the State with the key issues and challenges and the Implementation Status of the SSHDP I and the future prospects for the present SSHDP II.

Chapters Three to Seven highlights the 5 Strategic Pillars and its 15 Priority Areas, many Strategic Goals, Strategic Objectives, Strategic Interventions and Activities.

Strategic Pillar 1 is Enabled Environment for Attainment of Sectoral Goal. Within this are Priority Areas: Priority Area 1 – Leadership and Governance; Priority Area 2 – Community Participation and Priority Area 3 – Partnership for Health.

Strategic Pillar 2 is Provision of Essential Package of Health Care Services. It has Priority Area 4 – Reproductive, Maternal, Newborn, Child and Adolescent Health Plus Nutrition; Priority Area 5 – communicable Diseases (Malaria, TB, Leprosy, HIV/AIDS) and Neglected Tropical Diseases; Priority Area 6 – Non-communicable Diseases, Care of the Elderly, Mental Health, Oral Health, Eye Healthcare; Priority Area 7 – General and Emergency Hospital Services; Priority 8 – Health Promotion and Environmental Health.

Strategic Pillar 3 highlights the Health System Support. Under this are Priority Areas 9 – Human Resource for Health; Priority 10 – Health Infrastructure; Priority Area 11 – Medicines, Vaccines, Health Technologies and Supplies; Priority Area 12 - Health Information; Priority Area 13 – Health Research.

Strategic Pillar 4 is Protection from Public Health Emergencies and Risks with Priority Area 14 - Public Health Emergencies: Preparedness and Response.

Strategic Pillar 5 is on Health Financing and has Priority 15 - Health Financing. States including Rivers State are expected to include their activities in the strategic interventions in order to achieve its goal. For each of the Strategic Objectives there are Output Indicators showing level of implementations, stakeholders/Key responsible entity and years of expected implementation (2018-2022). This is followed by the costing of each planned strategic activity for each of the 5 years.

Chapter Eight and Nine discusses the human and financial resources while chapter 10 is for the financial plan.

# CHAPTER 2

### SITUATION ANALYSIS

* 1. Socioeconomic context
     1. **Agriculture and Natural Resources**

Most inhabitants of the State are engaged in fishing, farming and petty trading except for those in metropolitan cities like Port Harcourt, Obio-Akpo and Oyigbo who are either civil servants or employees of a multinational company.

Despite its rich economy and high adult literacy rates of over 80%9 the present health status of citizens of State is unacceptable. Disease burden in the State is mostly due to preventable diseases including malaria, upper respiratory tract infection, diarrhoea etc. They account for high morbidity and mortality in the state.

Environmental degradation occasioned by the exploration of oil and gas, improper disposal of effluents and gas flaring are the causes of the high prevalence of respiratory diseases and non- communicable diseases (NCD) such as hypertensive heart disease and other non-communicable diseases.2

* + 1. Poverty

Poverty which is a major cause of high disease burden in the State adversely affects access to care in health facilities and is responsible for low productivity as well as school absenteeism and loss of man-hours at work places. A large proportion of the population especially in the rural areas patronized the unregulated and unregistered traditional practitioners and patent medicine vendors. The Free Medical Care Programme (FMCP) that was of immerse benefit to the state, was later suspended due to poor funding and overwhelming pressure on the health facilities. The quality of service delivery also dropped. With the improvement in infrastructure came other structural problems like the maintenance of infrastructure and equipment. There was also loss of consumer confidence and low utilization of services, low staff morale, poor health indices and eventually near collapse of primary health care. Presently the construction of the four Zonal hospitals is in progress as well as the renovation of existing General hospitals.

* + 1. Unemployment

The Joint Annual/Mid-Term Reviews (JAR/MTR) of the Rivers State Strategic Health Framework (2010-2015) revealed an unemployment rate that is higher than the national average and that approximately 50% of the population are 'poor.'3The high level of unemployment is correlated with poor health status and increased mortality. Young persons and especially young graduates are worst affected by unemployment. In recent times militancy, youth restiveness and kidnapping of health workers have become the norm. This is made worse by the difficult geographical terrain of the communities, inadequate funds for health care delivery and skilled manpower. Lassa fever, Monkey pox, HIV/AIDS, Ebola and most recently the soot pollution scare are of major concern.

* + 1. Water and Sanitation

According to the NDHS 2013, the households with improved source of drinking water showed an improvement from 26% to 71.3%9 and households with improved sanitary facilities (not shared)

also improved from 10% to 28% in 2008 to 2013 respectively. The Multiple Indicator Cluster Survey (MICS) 2016-17 report, 83.5%9 of the people of State had access to improved sources of drinking water, while 38.7% were using improved sanitation facilities, It is expected that this plan would articulate various strategies of increasing access to improved sources of drinking water and sanitation.

* + 1. Lifestyle Determinants

The leading preventable risk factor of disease and death is the use of tobacco products11. It causes premature deaths. Up to half of all tobacco users will die of tobacco-related causes11. There is a national law prohibiting tobacco smoking in public places11. The MICS (2016-17) report has shown that in State, the use of any tobacco product among men is much higher 22.9% when compared to women (3.3%)9. The percentage of women taking any tobacco product appears to be high in the State, when compared with that of South-South zone of 2.4%. The use of alcohol within the last one month was high in women 15-59 years at 20.9 which is close to the SS average of 21.7% while that of men was 47% for Rivers State and 48.8% for South-South zone.

* 1. Health Status of the Population

The State health status indicators are still unacceptable. Rivers State has a high prevalence of HIV/AIDS of 5.8% and is among the 12+1 states sharing 70% of the national disease burden. The maternal mortality ratio from DHIS2 for Rivers State was 338.1 per 100,000 live births as against the maternal mortality ratio for Nigeria is 576/100,0001. The other health status indicators: under-five mortality rate of 58/1000 live births (MICS 2016)9 as against 90/1000 in NDHS 2008, infant mortality rate of 41/1000 live births and child mortality rate (18/1000) live births. The life expectancies for male, 52.6 years and female, 53.8 years are still low compared to 54 and 57(2008) respectively and the national 54.5 years and global average of 71.4 years. The indices of health in the State are still below acceptable limits.

The health status indicators for Rivers State are summarized in Table 2 below.

***Table 2: Rivers State Health Indicators***

|  |  |  |
| --- | --- | --- |
| **POPULATION** | **2006 census** | **2016**  **Projected** |
| **Total population** | **5,198,716** | **7,244,152** |
| Under 5 years (20% of Pop) | 618,384 | 1,448,830 |
| Adolescents age 10-24 years (1/3 of pop) | 1,763,506 | 2,414,717 |
| Women of child bearing age 15-49 years (22% of total population) | 1,402,749 | 1,593,713 |
| **INDICATORS** | **NDHS (%) 2008** | **MICS(%) 2016/2017** |
| Literacy rate (female) | 95 | 98.1 |
| Literacy rate (male) | 84 | 94.7 |
| Households with improved source of drinking water | 26 | 83.5 |
| Households with improved sanitary facilities (not shared) | 10 | 38.7 |
| Households with electricity | 32 | 80.9 |
| Employment status (currently)/ female | 65.6 | 77.1 NDHS2013 |

11 FGN (2015). National Tobacco Act Control, 2016. Official Gazette No.70 Vol. 102. Lagos, Nigeria: FGN; A179- 208

12 WHO (2012).WHO global report: mortality attributable to tobacco. Geneva: World Health Organization

|  |  |  |
| --- | --- | --- |
| Employment status (currently)/ male | 68.0 | 81.3 NDHS 2013 |
| Total Fertility rate | 4.3 | 3.3 |
| Use of FP modern method by married women 15-49 | 14 | 11 |
| Antenatal Care provided by skilled Health worker | 67 | 87.6 |
| Skilled attendants at birth | 64 | 83.7 |
| Delivery in health facility | 48 | 80 |
| Children 12-23 months with full immunization coverage | 37 | 45 |
| Children 12-23 months with no immunization | 10 | 11 |
| Stunting in under 5 children | 29 | 10.9 |
| Wasting in under 5 children | 5.0 | 5.0 |
| Diarrhoea in children | 3.8 | 3.4 |
| ITN ownership | 12 | 27.8 |
| ITN utilization (children) | 10 | 64.4 |
| ITN utilization (pregnant women) | 9 | 12.3 NDHS 2013 |
| Children under 5 with fever receiving malaria treatment | 21 | 49 |
| Pregnant women receiving IPT | 5 | 9.5 NDHS 2013 |
| Comprehensive knowledge of HIV (female) | 17 | 45.9 |
| Comprehensive Knowledge of HIV (male) | 36 | 71.7 |

Source: SSHDP 2010-2015, NDHS 2013, MICS 2016/2017

In health service delivery and quality of care, about37% of children aged 12 – 23 months were fully immunized in 2008, it rose to 55.5%9 in 2013 but reduced to 45% in the recent 2016-2017 MICS report. Those with no immunization within this same age at 10% reduced to 7.4% in NDHS 2013 and back to 11% in 2016 MICS survey. There was an increase in the proportion of women who received antenatal care from a skilled provider from 67% in 2008 to 87.6% in 2016 and births assisted by a skilled provider from 64% in 2008 to 83.7% in 2016. Births in a health facility also went up to 80% in 2016 from 48% in 2008. Modern contraceptive prevalence rate amongst married women aged 15 – 49 years went down to 11% from 14% in 2008 (Table 2).

* 1. Overview of the State Health System
     1. **Structures and Key Actors**

Rivers State has the Public and Private Sectors both providing orthodox health care services in the State. The Public Health Sector under the Rivers State Ministry of Health, provides tertiary, secondary and primary health care. The tertiary health care is managed by the Federal government, the State government manages the secondary care and the local government, the primary care. The National Health Act 2014 assigned these roles to the different levels of administration in the nation. There are four State-owned Specialist Hospitals providing tertiary care to the citizenry. The Private Health Sector is also a key player in healthcare delivery. It is made up of multiple players; those for- profit and those not for-profit, across the State. These include, the Non- Governmental Organizations (NGOs), Community Based Organizations (CBOs) and Faith Based Organizations (FBOs). Others are the informal sector such as the Patent Medicine Vendors, Pharmacies and Traditional health care practitioners and all contribute to Private health care in the State.

There are two parastatals of the Rivers State Ministry of Health; the Rivers State Hospital Management Board (RSHMB) that oversees the secondary health care system and the Rivers State Primary Care Management Board (RSPHCMB) which manages and control the human resources, finance and infrastructures in line with the National Strategy of 'Bringing PHC under one Roof' (PHCUOR) project. The RSPHCMB was established in 2011 in line with the NPHCDA policy. The Rivers State Agency for Control of AIDS (RIVSACA) oversees the implementation of non- health sector interventions for HIV/AIDS control, while the health sector response is coordinated by the State AIDS and STI Control Program (SASCP). The Rivers State HIV/AIDS Programme was established in 1988 as a State arm of the National AIDS/STDs Control Programme (NASCP) in response to the HIV/AIDS pandemic.

Key Stakeholders in Health Sector comprises of the Ministry of Health under the Honourable Commissioner for Health as the Chief Executive Officer, while the Permanent Secretary is the accounting Officer. Other stakeholders include the Permanent/ Executive Secretary of RSPHCMB, Chief Medical Director RSHMB, head of agencies and medical institutions and their key officers. The State health related MDA through specific activities collaborate effectively with health-related Federal institutions like the University of Port Harcourt Teaching Hospital (UPTH), FMOH and National Agency for Food and Drug Administration and Control (NAFDAC), State Assembly, Civil Society(s), Research institutes, development partners. Informal actors include PSO, WDC, Faith based organization, professional bodies and Philanthropists.

* + 1. Human Resource for Health

The Rivers State Human Resource for Health Strategic Implementation Plan (HRH SIP 2015-2019) was developed to address the problems of HRH management such as shortage and mal- distribution through increased funding, relocation of staff for optimum utilization, matching demand and supply, building new training institutions and ensuring accreditation of existing ones, expanding student intake and further involving the private sector in training health workers, among others. The National Task Shifting/Task Sharing Policy has been adopted and validated but it is considered only as an interim measure which is applied to improve healthcare delivery in the State.

The total number of skilled health workers in the State is 14,631 spread across the different cadre (1792 doctors and 3329 nurses & midwives etc).13The total number of health personnel by professional category as at 2015 is shown in Table 3.

The following five tertiary referral health facilities, four of which are state-owned; Rivers State University Teaching Hospital (old Braithwaite Memorial Teaching Hospital), Professor Kelsey Harrison Hospital, Neuro-psychiatric Hospital, Dental & Maxillo-facial Hospital and University of Port Harcourt Teaching Hospital (Federal-owned) provide advanced manpower for the health sector. While University of Port Harcourt, Madonna University (private-owned), Schools of Nursing, Midwifery, Public Health Nursing and College of Health Science and Technology all contribute immensely to the high cadre Health workforce in the State.

The following departments have accreditation in Rivers State University Teaching Hospital (RSUTH) for Residency training by both the West African College of Physicians (WACP) and the National Postgraduate Medical College of Nigeria (NPMCN); departments of Family Medicine, Paediatrics and Obstetrics & Gynaecology. Accredited programmes are run by the various schools in Rivers College of Health Sciences and Technology. These are School of Dental Technology/Technician, School of Pharmacy, School of Medical Laboratory and Community

Health. Recruitment of Health Manpower has been ongoing in order to run the existing and newly built health facilities. This is remarkable despite the fact that embargo on employment of workforce has been in place for a long time.

Rivers State has leveraged on the National Human Resources for Health Policy (NHRHP) and National Human Resources for Health Strategic Plan (NHRHSP)1templates and developed her Human Resources for Health Strategic and Implementation Plan 2015-2019. In line with these policy provisions, Rivers state, has established a HRH unit in the Department of Planning, Research and Statistics in the Ministries of Health (SMOH). The Departments of Planning, Research and Statistics provides the institutional hub for HRH policy formulation, planning and management.

In line with the National, a Rivers State Workforce Registry project was established in the State in collaboration with Capacity Plus but the project was not completed before their contract was over.

***Table 3: Health Manpower in Rivers State***

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **S/N** | **Profession** | **UPTH (30**  **level)** | **RSHMB**  **(20 level)** | **SMOH (HQ)\*** | **RSPHCMB (PHC)** | **Private Hospitals** | **Private- Public**  **Hospitals** | **Total** |
| 1 | Doctors  & dentists | 800 | 233 | 80**\*** | 245 | 399 | 35 | 1792 |
| 2 | Nurses &  Midwives | 700 | 1308 | 240**\*** | 500 | 549 | 32 | 3329 |
| 3 | pharmacist | 80 | 28 | 4 | 36 | 36 | 2 | 186 |
| 4 | Pharm.  Tech/asst | 0 | 73 | 6 | 251 | 77 | 18 | 425 |
| 5 | Chews | 0 | 0 | 47 | 2719 | 0 | 0 | 2766 |
| 6 | Comm.Hlth  Officers | 0 | 0 | 94**\*** | 265 | 0 | 0 | 359 |
| 7 | Env.Hlth  Officers | 0 | 1 | 70 | 690 | 0 | 0 | 761 |
| 8 | Hlthedu  Officers | 0 | 0 | 8 | 0 | 0 | 0 | 8 |
| 9 | Hlth rec.  Offers/ him | 0 | 46 | 1 | 652 | 0 | 0 | 699 |
| 10 | Nutrition  Officer | 0 | 3 | 10 | 0 | 0 | 0 | 13 |
| 11 | Catering officer | 0 | 22 | 3 | 0 | 0 | 0 | 25 |
| 12 | Scientific officer | 0 | 3 | 24**\*** | 0 | 0 | 0 | 27 |
| 13 | Med. Lab Science | 100 | 34 | 13**\*** | 97 | 0 | 0 | 244 |
| 14 | Med. Lab Tech | 0 | 89 | 12 | 612 | 113 | 4 | 830 |
| 15 | Planning officer | 0 | 0 | 1 | 0 | 0 | 0 | 1 |
| 16 | Statistics  Officers | 0 | 0 | 4 | 0 | 0 | 0 | 4 |
| 17 | Research  Officers | 0 | 0 | 1 | 0 | 0 | 0 | 1 |
| 18 | Tutors | 0 | 0 | 93**\*** | 0 | 0 | 0 | 93 |
| 19 | Admin officers | 0 | 128 | 86**\*** | 0 | 0 | 32 | 246 |
| 20 | Accounts  Officers | 0 | 48 | 38**\*** | 0 | 0 | 0 | 86 |
| 21 | Optometry | 0 | 0 | 10 | 0 | 0 | 0 | 10 |
| 22 | Dental Tech | 0 | 8 | 0 | 275 | 0 | 0 | 283 |
| 23 | physiotherapists | 0 | 7 | 0 | 0 | 0 | 0 | 7 |
| 24 | Physiotherapist  Asst. | 0 | 16 | 0 | 0 | 0 | 0 | 16 |
| 25 | Radiographer | 0 | 3 | 0 | 0 | 0 | 2 | 5 |
| 26 | Socio-welfare  Officer | 0 | 7 | 0 | 0 | 0 | 0 | 7 |
| 27 | Ophthalmologist | 0 | 1 | 0 | 0 | 0 | 0 | 1 |
| 28 | Dental therapist | 0 | 5 | 0 | 0 | 0 | 2 | 7 |
| 29 | Dental surgical | 12 | 9 | 0 | 0 | 0 | 12 | 33 |
| 30 | Anaesthetic  Tech/asst. | 0 | 28 | 0 | 0 | 0 | 0 | 28 |
| 31 | X-ray tech | 0 | 34 | 0 | 0 | 0 | 0 | 34 |

Source: Rivers State HRH Strategic and Implementation Plan 2015-2019

**\***Deployed to various health facilities**.**

13 Rivers State Human Resources for Health Strategic and Implementation Plan 2015-2019 pg 15

* + 1. Financing for Health

Health insurance is a key form of sustainable healthcare financing, to ensure that Rivers people have access to needed quality of health services without the risk of financial ruin linked to out-of- pocket payment for health care services.

The Rivers State Government, through the Ministry of Health, and in collaboration with USAID- Health Finance and Governance (USAID-HFG) Project, has commenced a robust process of reforming the State's healthcare financing landscape by moving away from the unsustainable “Free Medical Care Programme (FMCP) towards a new era of sustainable “contributory” healthcare financing programme through the proposed establishment of a Rivers State Contributory Health Protection Programme (RIVCHPP) for the attainment of Universal Health Coverage (UHC), healthier citizenry and improved social development.

The FMCP which was established on May 5, 2000 to provide Free Medical Care for children less than 6 years and adults above 60 years of age in all the State government hospitals across the 23 local government areas and later extended to all citizens in the State but it was not sustainable. The Draft bill for Rivers State Contributory Health Protection program (RIVCHPP) has been sent to Rivers State Executive Council. Health financing Core diagnostics carried out to generate evidence. Activities to strengthen institutional and legislative RIVCHPP framework/capacities like. Stakeholders' engagement, sensitization and enlightenment, process of developing Basic minimum healthcare package and actuarial studies are on-going.

**Table 4: Health Financing Indicators in Rivers State**

|  |  |
| --- | --- |
| **Health financing and universal coverage indicators** | |
| **Percentage of GDP devoted to healthcare** | Less than 2.5%of GDP instead of the WHO benchmark of at least 4%- 5%; |
| **Out-of-pocket spending** | More than94.6% of total health expenditure instead of the WHO recommended 30-40%; |
| **Level of financial risk protection** | Less than 2% of the population is covered by pre-payment and risk pooling schemes instead of the WHO recommended 90%. |
| **Catastrophic health spending in Nig** | **Eria** |
| **Proportion of catastrophic health expenditure** | 14.8% (Onoka et al, 2011) and 22.0% (Onwujekweet al, 2012), 50.3  (RSMOH, 2017) |
| **2.3.4 Research for Health** | |

There are several institutions involved in health research at both the academic level and government research levels. The institutions are faced with challenges like gross under funding, leadership and governance issues, non-commercialization of research findings and weak linkages between health research institutes, the private sector and community needs.

Research and Development is the backbone of innovative and sustainable development of the

health sector. Research findings enhance evidence-based policy and decision making at all levels of government and ensure more targeted health

interventions that have a higher impact on reduction of the country's diseases burden.

Funding for health research in Nigeria is meager with evidence indicating at most only 0.08% of the health expenditure at the federal level with hardly any funding at lower levels. This is contrary to the 2% allocation to research for health prescribed by African Health Ministers and agreed to by the National Council on Health. The paucity of these allocations to the Health Sector had affected the quality and depth of health research in particular. The Malaria Elimination Project has thrown up areas of Research in areas like Integrated Vector management. There has been capacity building of RSPHCMB staff on conducting research studies and data analysis. There is also partnership with academic institutions in the State for collaborative research studies. The research team of the public Health department is conducting trend analysis on the soot haze in Rivers State.

* + 1. Partnership for Health

Partnership with the private sector, non-governmental organizations, communities and development partners (donors) is presently on-going in the State. The SMOH is also involved in coordination of activities of development partners and engages communities, other professional groups, Traditional Birth Attendants (TBAs)/ Patent Medicine Vendors (PMVs) in service delivery.

Public-Private Partnership programmes in the State include:

* + - 1. The RSUTH mortuary is managed by a private company on a Public Private Partnership basis.
      2. The Prof. Kelsey Harrison Hospital was built on the grounds of the former Niger Hospital, Emenike Street, Diobu. This 120 bed hospital, was completed in 2009 and presently in use and the Dental and Maxillofacial Hospital at Garrison for specialist care.
      3. The Ministry partnered with FHI 360 in the development of Human Resources for Health Strategic Policy and Plan for implementation (2015-2019).
      4. An Auto-disable Syringe factory, which also manufactures intravenous fluids, exists with technical partnership from Pan African Health Foundation. This has been expanded to serve the total syringe needs of the country and West Africa.

The Public-Private Partnership programmes have benefited the Rivers people greatly especially when there is a strike in the health sector, these facilities bridge the gap during this period. The services are expensive and available only to a limited cadre of individuals.

* + 1. Community participation and ownership

Community participation ensures we engage communities to participate in key activities through the Ward Development Committees (WDCs), Village/voluntary, Civil Societies Organizations (CSOs) and Community Based Organizations (CBOs). This ensures the underserved are reached also enlightening and empowering communities through IEC and media helps to promote health up to the grassroot.

There is also the Community Based Insurance Scheme (CHIS) initiated at Obio Health care facility in partnership with Shell to provide comprehensive care to indigenes and also residents of Rumuomasi who voluntarily contribute to the Scheme. This CHIS has been a success story and it led to the establishment of another, the Rumukwurushi Community Based Insurance Scheme in Rumukwurushi, Rivers State.

* + 1. Health information system

The State's Health Information System (HIS) remains weak and fragmented with numerous vertical programmes, which are mostly donor driven. Despite significant past investments aimed at improving the State's HIS, the sub-sector remains challenged due to duplications and lack of a common investment framework. There are multiplicity of data collection tools. The District Health Information System (DHIS) suffers from the use of poorly defined non-standardized indicators. Also, some of the Development Partners and the programmes they support are reluctant to utilize national tools. Monitoring and evaluation of programs and carrying out integrated supportive supervision through field visits and review meetings cannot be overemphasized. Recent innovation are the use of District Health Information System (DHIS) and technologies such as Open Data Kit (ODK) phones for data gathering and supervision by the RSPHCMB with provision of infrastructural support and ICT to ensure improved data collection and transmission. There is also the introduction of Online Phone calls for supervision and monitoring by RSPHCMB and the establishment of a health databank for the Ministry of Health. The Ministry of Health also established a website: [www.riversstatemoh.gov.ng](http://www.riversstatemoh.gov.ng/) .The Ministry has also initiated moves to commence a pilot project on e- health in the State.

* 1. Health services provision and utilization
     1. **Scope, Coverage, Quality & Equity**

The public health care facilities are 408: 385 PHC centres, 18 functional secondary health facilities and 5 tertiary care facilities14 while there are 147 registered private facilities. Rivers state has 8 training institutions for the health workforce and five tertiary referral health facilities, four of which are state- owned. They provide tertiary training for the health workforce.

In addition to the health facilities below, other facilities are the Government House Clinic and Civil Servant Clinic.

Utilization of Services

Rivers State has made significant improvements in health, housing, and others. These improvements in health include an increase in the use of family planning methods by married women 15-49 years which rose from 14% in 20082 (NDHS 2008) to 17.5% NDHS 20139 but however, declined to 11%in the MICS 2016.. Antenatal care (ANC) provided by skilled health worker improved from 67% to 87.6%, children 12-23months with full immunization coverage also increased from 37% to 45%, while households with improved source of drinking water leaped from 26 to 83.5% and households with improved sanitary facilities (not shared) rose from 10% to 38.7%. The State government has focused on making health care accessible and affordable to its citizenry hence the construction and renovation of facilities both at the primary, secondary and tertiary level of health care. In order to reduce financial burden most health services are provided free of change at point of use for children and elderly persons at the Primary Health Care (PHC) level.

***Table 5: Health Indicators in Service Delivery***

|  |  |  |  |
| --- | --- | --- | --- |
|  | Health Indicators | Value (%) | Source |
| 1. | Service Coverage:  % that booked for ANC:   1. % that had at least 4 visits 2. Delivery by Skilled birth Attendants 3. Facility based delivery rate 4. Modern contraceptive prevalence rate 5. Unmet needs |  |  |
|  | 85.8 | MICS 2016/2017 |
|  | 83.7 | MICS 2016 |
|  | 80.0 | MICS 2016 |
|  | 83.7 | MICS 2016 |
|  | 27.7 | MICS 2016 |
| 2. | Vaccination Rate   1. BCG 2. Penta 3 3. Measles 4. Fully immunized 5. Partial immunized 6. Not immunized | 82  66  71  45  61  11 | MICS 2016  MICS 2016  MICS 2016  MICS 2016  MICS 2016  MICS 2016 |
| 3. | Exclusive Breastfeeding Rate Under 5 malnourished   1. Stunted 2. Underweight 3. Wasted | 0.5 | MICS 2016/2017 |
|  | 10.9 | MICS 2016 |
|  | 7.6 | MICS 2016 |
|  | 5.0 | MICS 2016 |
| 4. | TB cure Rate | 79 | ETE |
|  | ITN | 40 | NDHS 2013 |
|  | Persons on Antiretroviral | 37000 | Program Data |
|  | Coverage with IMCI | 0.32 | Monthly statistics |
|  | PMTCT coverage & persons on treatment |  |  |
|  |  | 25 | Program Data |
| 5. | Communicable Disease TB Prevalence Rate Hepatitis  Malaria among under 5 | 350/100,000  0.00091  49 | National statistics IDSR  MICS 2016 |
| 6. | Facility Type: |  |  |
|  | State: Primary, Secondary, Tertiary | 408: 385,36, 4 | DHIS2 |
|  | Federal: Tertiary | 1 |  |
|  | Private: Secondary, Tertiary | 147,1 |  |

***Table 5: Some health status indicator changes observed after the SSHDP I***

* 1. Implementation of the Rivers State Strategic Health Development Plan I

The RSSHDP I (2010-2015) was formally launched in 2011 and its goal *was to* significantly improve the health status of Rivers People through the development of a strengthened and sustainable health care delivery system. This was in accordance with the NSHDP, in order to have an integrated Health Plan for the nation. The RSSHDP I was to serve as a framework where operational plan would be developed for all stakeholders in the health sector in Rivers State. It provided a road map for accelerated development of a sustainable, cost-effective and efficient health system that improves the health status of the population on a continuing basis. The RSSHDP I was implemented to varying degrees by the Ministry of Health, as evident from the Joint Annual Review (JAR), Mid-Term Review (MTR) and End-Term Evaluation (ETE). The directors in the Ministry and heads of agencies were expected to monitor the SSHDP I implementation since there was no reference committee for that purpose.

It was noticed that the RSSHDP I was not being referred to for operational planning since the staff in the Ministry were not familiar with the existence of the RSSHDP.I The State Commissioner for Health had however taken steps to ensure its utilization for future planning processes. The RSSHDP I focused on eight strategic priority areas: Leadership and Governance for Health; Health Service Delivery; Human Resources for Health; Financing for Health; National Health Management Information System; Partnerships for Health; Community Participation and Ownership; and, Research for Health. These strategic areas broadly cover the globally recognised building blocks of the health system as defined by the World Health Organisation.

There was high performance in some areas such as human resource for health, provision of minimum health care package and some areas had poor output e.g. number of children fully immunized, access to anti-retroviral prophylaxis and treatment and community engagement. These performance findings include:

The persistence of governance and accountability weaknesses and poor coordination

across levels of government, departments and programs.

There was poor awareness of the existence of strategic plans by some key actors and failure to use the plans for operational plans;

There was no existing data on the percentage of wards with functioning public health facility providing minimum health care package however there were HMIS records of the total number of Primary Health Care facilities (not wards) that provide the minimum health care package and this showed a marked improvement between 2011 and 2012; 49.6% and 72.4% respectively.

There was an increase in the number of registered medical doctors and nurses in the State

by 2010-2012, with current ratios of: 1:2000 (Nurses) and 1:3500 (Doctors) exceeding the State target of 1: 5000 by 2013.

Health insurance coverage remains low as out-of-pocket spending still remains the dominant method of health care financing. We note that the proportion of the State 2012 budget allocated to health was approximately 5.8% (SSHDP: JAR/MTR 2012) an increase from previous year's allocation as recorded in the 2011 JAR report which ranged between 4.6 to 4.9%. A significant proportion of this (over 95%) was allocated to capital projects and personnel cost.

There was failure to meet targets for most of the indicators, including coverage indicators. The percentage of disease surveillance reports that were submitted timely was 82.6%, an improvement from the baseline and 2011 values of approximately 70% (HMIS Annual Reports). This was due to the efforts made to strengthen HMIS in the State by training of Records Officers, procurement of ICT equipment and strengthening of supervision particularly in the LGAs.

Research for health was also weak in the State with only about 0.02% of the budget spent on research in 2012 (JAR/MTR 2012).

There was poor engagement of consumers in most PHC facilities since there was no documentation of community participation in facility management despite having active committees (at least 4 meetings per year).

*14 WHO (2007), World Health Organization, 2007*

There were eight PPP initiatives that were launched in 2012. The registration and accreditation of private providers is being monitored by the PRS and Medical Services department of the State Ministry of Health. However, many private hospitals remain unregistered.

Annual and quarterly review meetings were conducted within the Ministry of Health at both policy and implementation levels which has helped to improve accountability and responsiveness to emerging health-related issues but this was not strictly oriented towards assessing the progress towards achieving the targets of the RSSHDP I.

Proper monitoring and evaluation of the plan would have facilitated evidence-based decision making and highlighted areas for research and/or intervention. Hence strengthen the HMIS data management systems and improve funding for research in the State.

* 1. **SWOT Analysis**

***Table 6: SWOT Analysis***

|  |  |
| --- | --- |
| **STRENGTHS**   * The SMOH has demonstrated strong commitment to address leadership in health sector. * Improvement in health infrastructure * Clear Health policies available at the State level. * Existence of skilled staff in the health sector to manage policies, program planning and implementation for decision making. * Existence of agencies that support various roles in the health sector. * Existence of procedures and guidelines for leadership and governance. * Job Security for health care work force. * Presence of PPP prevents disruption of healthcare services during industrial action. * Standard and mechanism for graded. accreditation of Private facilities available. * harmonized implementation of services only at program level | **OPPORTUNITIES**   * The political will to address Leadership and governance in health which is in the National Health Act (2014). * Relative peace between major players in the health sector. * Commitment of SMOH to community participation in health. * Increased inter -sectorial collaboration in emergency services * The development partners to key into the activities of the SSHDP II. * Increased collaboration of SMOH with stakeholders and donor. * Proper implementation of PPP guidelines at various levels. * Saving one million lives is an avenue to improve the state’s health indicators. * Task Shifting/Sharing Policy would improve skills of health workers in the communities. * Enlightenment of Populace on health insurance and its benefits. |
| **WEAKNESSES**   * Constraints in funding in the MOH affects implementation of programs. * leadership and accountability is weak * Poor engagement of consumers in most PHC facilities even with regular meetings taking place. * Many private hospitals remain unregistered. * Publishing of health sector performance was not done. * Poor documentation of management meeting with community representation present. * Bureaucracy in the civil service affects efficiency. * Lack of Resources. * Poor inter-sectorial collaboration. * Persistent industrial actions in health sector. * Poor data tools**.** * Weak monitoring and evaluation. * Weak enforcement of policies. * Poorly observed protocols. * HMIS data is not used for decision making despite improvement from baseline reporting. * Dwindling donor funds. | **THREATS**   * Lack of electricity for vaccines * Inadequate/ lack of funds for health from the state budget. * Poor attitude of health workers. * High out -of-pocket expenses for health care services reducing access to health services. * High staff attrition due to high level of insecurity. * Poor enrolment in health insurance. * Incessant outbreaks of communicable diseases and other health emergencies. |

* 1. Key issues and challenges

The health Sector continues to encounter various challenges despite all efforts by the Rivers State Government to implement the Sustainable Development Goal (SDG) activities. The most important of these challenges are the incessant youth restiveness, kidnapping and militancy in the area. Despite the recent grant of amnesty to the militants by the State government, these activities have continued unabated with kidnapping becoming a lucrative source of income to criminals in the State. Health workers find it difficult to get to hard to reach areas with lifesaving interventions as a result of the security risks involved and coupled the difficult terrain of the State. There is limited or absence of response to medical emergencies in these areas where health facilities are far from the community or in trouble zones. The SWOT analysis show the different weakness, strengths and in the health sector and opportunities to be leveraged on.

There is poor data reporting at service delivery points; NCDs had little or no data on diabetes Mellitus and hypertension despite the high morbidity and mortality rate from NCDs. The High out- of-pocket expenses on health in the State is catastrophic and detrimental to the economy of the populace. The RIVCHPP, if signed into law and operational will help alleviate this debilitating effect on the finances of the Rivers people and also enhance the quality health care accessible to the people at point of need. The dwindling funds of the Development /Implementing Partners would adversely affect the State's health indicators.

* 1. Future Prospects for SSHDP II (Recommendation)

In other to address the gaps identified in the RSSHDP I implementation, the RSSHDP II should be the 'road map' for the health sector. The goal of the RSSHDP II is to improve the health status of Rivers citizens through the development of a strengthened and sustainable health care delivery system. This Plan would serve as a framework and a reference document for all stakeholders in the health sector, to ensure transparency and mutual accountability for the results.

Therefore, widespread dissemination and deeper knowledge of its contents are required by the major actors.

Advocacy for development partners and bilateral agencies to key into the SSHDP II Plans

rather than producing parallel plans is imperative.

The harmonization and effective utilization of Monitoring and Evaluation (M&E) data at both LGA and state levels for strategic implementation and periodic supportive supervision and reviews at both State and L.G.As, to address frontline issues that may pose a challenge to the implementation plan should be pursued vigorously.

There should also be a system of sharing data between all relevant agencies in the health sector.

The FMOH should ensure that core health indicators in the National results matrix are

addressed in this SSHDP II to help synergize efforts towards achieving national goals and establish mechanisms for tracking progress in States.

Monitoring and Evaluation must be strengthened in all health programmes like Saving One Million Lives Result for Performance (SOMLPforR) so as to achieve improvement of the state indices.

The SSHDP II would be a tool for the state actors to source for 'more money for health and more health for money'.

These funds could be from Health insurance (RIVCHPP), donors; locally or internationally

and 'sin taxes'.

Efforts at influencing the political leadership to continue to support the health sector should be sustained. Funds should be sourced and made available for relevant research and proper program monitoring and evaluation.

Active Community engagement and Civil Society Organizations should be encouraged to participate in program planning, implementation and evaluation.

# CHAPTER 3

### STRATEGIC DIRECTIONS OF THE PLAN

* 1. **Vision:** The overarching goal of the SSHDP II is “to ensure healthy lives and promote the wellbeing of all Rivers citizens through enhancing access to quality, affordable, cost- effective, preventive, curative, rehabilitative and promotive healthcare delivery'. The Vision is to guarantee a healthy and productive State.
  2. **Mission**: Is to ensure that the Rivers populace have universal access to comprehensive, appropriate, affordable, efficient, equitable, and quality essential health care through a strengthened health system”.
  3. The Core Values and Principles of the SSHDP II

The development of the plan was based on some core values and principles which include: Accountability Equity-driven

Alignment Multi-sectorial collaboration Ethics and respect for human rights Efficiency and effectiveness Industrial harmony Teamwork Innovativeness

Community participation Sustainability

Evidence-based measures Transparency

Quality of care Partnership(s)

People-centred Gender-sensitivity

These core values and principles have been reflected across the strategies and approaches in the State Strategic Health Development Plan II.

* 1. Strategic Themes and Strategic Results
     1. SSHDP II Strategic Objectives

The central strategic objectives of the SHDP II are as outlined in this section.

1. Promote an enabling environment for attainment of sector goals:

i. Strengthen coordination at all levels

1. Ensure harmonization and alignment within the sector
2. Strengthen regulatory systems and processes
3. Enhance multi-sectorial collaboration
4. **Equitably Increase coverage with packages of quality essential health care services** The essential health care services package comprises (a) reproductive, maternal, newborn, child and adolescent health plus nutrition, (b) prevention and control of communicable diseases, ( c) prevention and control of non-communicable diseases, (d) health promotion and environmental health):

i. Increase access to package of essential health care services

1. Create demand for essential health care services
2. Improve quality of essential health care services.
3. Strengthen health system for delivery of packages of essential health care services:
4. Equitably improve the quantity, skill mix, motivation and distribution of health workforce
5. Increase funding to the health sector and allocative and technical efficiencies
6. Improve sustained availability of medicines, vaccines, commodities and health technologies
7. Improve availability and distribution of functional infrastructure for health services delivery
8. Strengthen the health information system for timely evidence-based decision-making
9. Improve protection for health emergencies and risks:
10. Strengthen national surveillance system and early warning mechanisms
11. Strengthen mechanisms for timely response to public health emergencies
12. Enhance healthcare financial risk protection:

**i.** Increase coverage with social health insurance

* + 1. SSHDP Health Sector Priorities

The priorities of the SSHDP II articulated for the plan period 2018 to 2022, as stated in the succeeding sections, are designed to address indicated contextual gaps in service delivery (scope and quality), improve on the systems for delivery of health care services, as well as promote reporting and use of evidence in planning and for improvements of plans and implementation.

* + 1. Health Service Delivery Priorities:

1. RMNCAH+ Nutrition
2. Communicable diseases, including environmental health, health emergencies and preparedness response, and neglected tropic diseases (NTDs)
3. Non- communicable Diseases, including mental health, injuries, and care of the elderly
   * 1. Health System Strengthening Priorities

Given major weaknesses in all domains of the health system, the plan provides for strengthening of health financing, human resources for health, health infrastructure, information management system. In addition, improvements in partnerships for health, and community participation and ownership for health development were included.

1. Leadership and governance: Emphasis will be on strengthening coordination

of regulatory institutions and processes aimed at reducing geographic and socio-economic barriers to access;

1. Community Participation and Ownership; The focus will be on deepening community participation and ownership
2. Partnerships for Health; The emphasis will be on *building and strengthening* collaborative mechanisms for involving all partners in the development and sustenance of the health sector
3. Reproductive, Maternal, Newborn, Child, Adolescent Health Services & Nutrition
4. Communicable Diseases (Malaria, TB, Leprosy, HIV/AIDS) And Neglected Tropical Diseases
5. Non-Communicable Disease, Care of the Elderly, Mental Health, Oral Health, Eye Healthcare
6. General and Emergency Health Services
7. Health Promotion & Social Determinants for Health (Environmental Health)
8. Health Human Resources: The emphasis will be to ensure availability and equitable distribution of productive, highly motivated, customer-centred health workers, with the right skills and in the right mix;
9. Health Infrastructure
10. Medicines, Vaccines, and other Health Technologies and Supplies: The focus will be on increasing access to safe, affordable and quality essential medicines vaccines equipment supplies through the building and maintaining of an integrated supply chain system.
11. Health Information System: Emphasis will be on ensuring that the National Health Information System promotes evidence-based decision making.
12. Research and Development
13. Public Health Emergencies: Preparedness and Response
14. Health financing: The focus will be on increasing resource mobilization and public sector funding in line with the Abuja Declaration of improving equity and efficiency in resource allocation and utilization; improving PFM; increasing financial risk protection to reduce out of pocket expenditure and rapid expansion of social health insurance coverage

Monitoring and Evaluation

Monitoring and Evaluation of this plan during the plan period shall focus on generating quality evidence for informed decision making across the health sector, and to track progress against targets as set in the SSHDP II. A separate volume on the M&E of the SSHDP II has been developed.

* + 1. The Results Framework of the SSHDP II

The SSDHP II is hinged on five strategic pillars namely:

Strategic Pillar One: Enabled environment for attainment of sectoral goal

Strategic Pillar Two: Provision of essential package of health care services

Strategic Pillar Three: Health system support

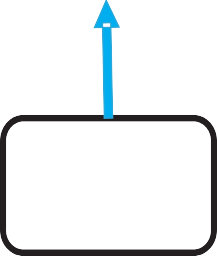
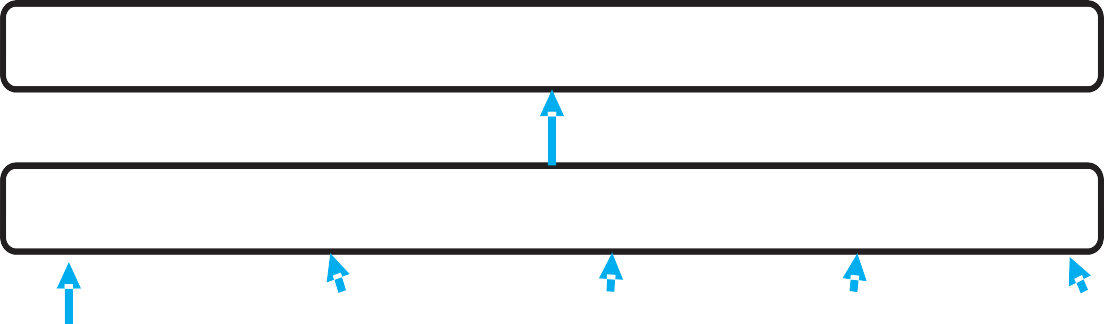
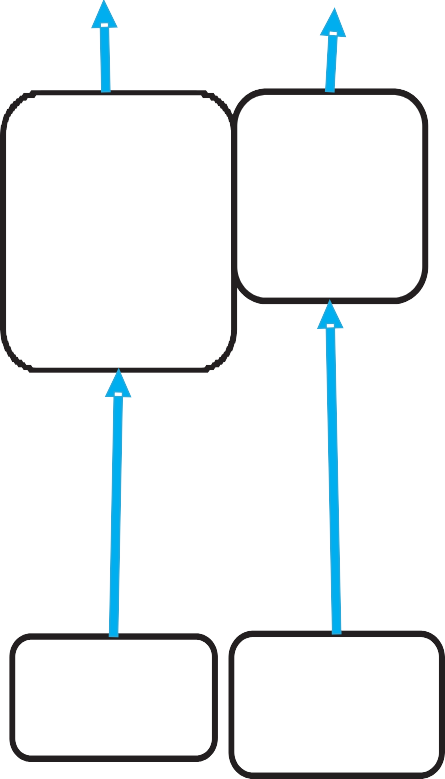
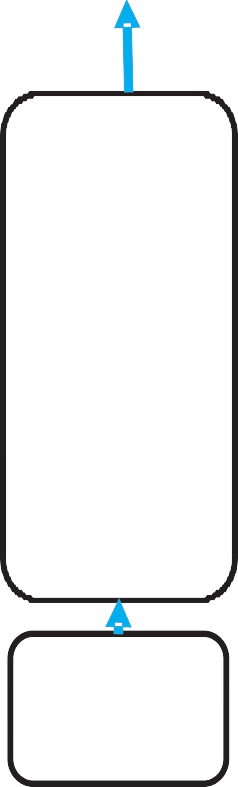
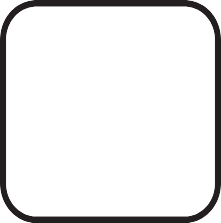
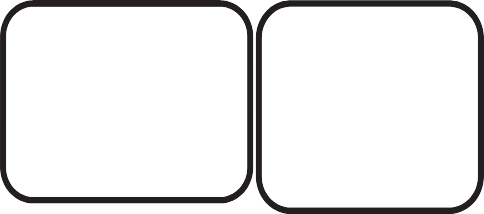
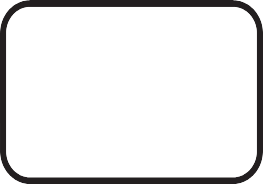
Strategic Pillar Four: Protection from public health emergencies and risks

Strategic Pillars Five: Health Financing

As indicated in the Results Framework (figure 1), for each pillar, the prioritized areas were identified and for each prioritized area, the core interventions were developed targeting specific outcomes and an ultimate goal to 'Ensure healthy lives and promote well-being of the Rivers people of all ages'.

The context and core interventions for each strategic pillar have been elaborated in specific sections of this plan to provide overall guidance for Local Government level planning activities by the Primary Health Care Management Board.

**Figure 1: The Results Framework of the SSHDP II**



**Overall Goal:** Ensure healthy lives and promote well -being of the Rivers State populace at all ages

**Overall Result:** Equitably reduced morbidity and mortality and improved socioeconomic wellbeing

**Strategic Pillar**

**One:**Enabled environment for attainment of

comes

**Strategic Pillar Two**:

Provision of essential package of health care services

**Strategic Pillar**

**Three:**Healthh system support

**Strategic Pillar**

**Four:** Protection from public health emergencies& risks and risks

**Strategic Pillar**

**Five:** Health Financing

**Priority**

**Areas (3):**

1.)

Leadership & Governance 2.)

Community Participation 3.)

Partnership for Health

**Priority Areas**

**(4):**

9.) Human Resource for Health

10.) Health Infrastructure 11.) Medicines, Vaccines and Other Health Technologies and Supplies

12.) Health Information System

**Priority Area (1):**

14.) Protection from health emergencies and risks

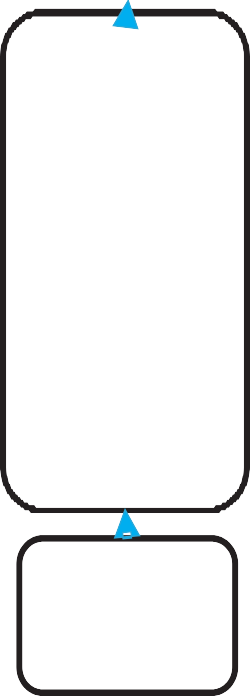
**Priority Area**

**(1):**

15.) Health Financing

1. **Outcomes:**
2. **Key Interventions:**
3. **Outcomes:**
4. **Key Interventions:**
5. **Outcomes:**
6. **Key Interventions:**
7. **Outcomes:**
8. **Key Interventions:**

**Strategic Pillars**



**Priority Areas (5):**

4.) RMNCAH &

Nutrition

5.) Communicable Disease

6.) Non-

Communicable Disease

7.) General & Emergency Hospital Services 8.) Health Promotion and Social determinants

1. **Outcomes:**
2. **Key Interventions:**

***(Guide for the Development and Alignment of Strategies for Operational Plans and for the Monitoring and Evaluation of the SSHDP II)***

# CHAPTER 4

### STRATEGIC PILLAR 1 - ENABLED ENVIRONMENT FOR ATTAINMENT OF SECTORAL GOALS

Priority Area: 1 Leadership & Governance Context

Health is on the concurrent legislative list, which implies that the State government can legislate on health services. The National Health Act 2014 assigns specific responsibility areas; tertiary, secondary and primary healthcare delivery to Federal, States and Local governments respectively. Rivers State health system is beset by several challenges such low budgetary allocation, frequent change in leadership of the SMOH, ineffective coordination and weak governance and partnership structures among others.

The State has over the years made efforts to create the right policy environment to strengthen partnership in the delivery of health services by adopting Public-Private-Partnership for Health policy developed in 2005. Additionally, there has been an increased effort to include other stakeholders, such as the private sector and civil society in policy and planning processes for health care delivery.

There has been considerable progress in multi-sectoral collaboration as exemplified by the comprehensive response to epidemics and disasters and the HIV programme in River State. However, a lot still needs to be done to strengthen inter-sectoral collaboration.

The Nigeria Public Finance Management (PFM) system is often characterised by breach of established due processes and accountability; and ineffective monitoring and supervisory roles, among others.

In an attempt to address these bottlenecks, and to significantly impact governance by strengthening coordination in the health system, the government has initiated coordination platforms such as State Council on Health meetings and adopted innovative strategies initiated by the Federal Government such as Health Accounts: Primary Health Care Under One Roof: PHC revitalization and much needed legislation in the form of the National Health Act 2014, among others.

* + 1. Strategic Goal

Provide effective leadership and an enabling policy environment that ensures adequate oversight and accountability for the delivery of quality health care for sustainable development of the national health system.

* + 1. Strategic objectives

Provide clear policies, plans, legislative and regulatory frameworks for the health sector.

**Targets**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Target | Baseline | **2018** | **2019** | **2020** | **2021** | **2022** | **National** |
| Percentage of coordination organs at national and subnational levels (NCH & SCH, WDC, HPCC) that are established  and are functional | TBD | 45% | 50% | 55% | 60% | 65% | 70% |
| Number of LGAs and SMOH that have  developed operational plans from the SHDP II | 0 | 0 | 35 | 35 | 35 | 35 | 38 |
| Number of LGAs and SMOH that have developed their annual health budget  from annual operational plans | 0 | 0 | 35 | 35 | 35 | 35 | 38 |
| State undertake annual review of the SSHDP II implementation? | 0 | 0 | 35 | 35 | 35 | 35 | 38 |
| State undertake regulatory and standardization visits to public and private health facilities in the State | 0 | 0 | 35 | 35 | 35 | 35 | 38 |
| State conducting JAR of implementation of SHDP II | 0 | 0 | 35 | 35 | 35 | 35 | 38 |
| **Strengthen transparency and accountability in planning, budgeting and procurement**  **Processes** | | | | | | |  |
| Has state increased annual budget implementation rate by 25% |  | 0 | 2 | 5 | 7 | 10 | Increased by 25% |
| Does state produce and disseminating annual progress reports including financial reports? |  | 20 | 25 | 30 | 35 | 35 | 38 |
| **Improve health sector performance through regular integrated reviews and reports** | | | | | | |  |
| SMOH and proportion of MDAs that publish annual and state of health reports increase by 50% of baseline | TBD | 5% | 8% | 10% | 12% | 15% | Increased by 50% from baseline |
| **Strengthen coordination, harmonization and alignment at all levels** | | | | | | |  |
| Percentage of PHCs with functional ward development committees increase  by 50% of baseline | TBD | 10% | 12% | 14% | 16% | 18% | Increased by 50% from  baseline |
| Percentage of WDCs carrying out health activities increased to 50% of baseline | TBD | 10 | 12 | 14 | 16 | 18 | Increased by 50% from  baseline |
| Percentage of funding of health from partners (development partners and private sector) that is aligned to the  State Strategic Health Plan by 2022. | TBD | 10 | 12 | 14 | 16 | 18 | 30% |

Interventions

* + - 1. Promote review and development of polices and laws as necessary. Key actions include: Strengthen Planning, Research & Statistics Department of the SMOH to coordinate meetings for policy activities at all levels; Advocacy to the Commissioner of Health and House of Assembly on the need to pass a bill for regular conduct of State Council on Health in the State; Conduct State Council on Health (SCH) meetings to review and develop policies, adapt the guidelines on essential package of health care services for Nigeria & define norms and standards of practice at different levels of the health care system, from community level; Participate in National Council on Health (NCH) meetings; Track and monitor compliance on existing guidelines and regulations.
      2. Scale-up strategic and operational planning at all levels. Key actions include Organize workshops to develop SSHDP II with technical assistance from FMOH; Organize workshops to develop LGSHDP II with technical assistance from FMOH; Organize workshops to develop SMOH Operational Plan; Organize workshops to develop PHC Operational Plan; Develop Mid Term Sector Strategy (MTSS) and support MTEF from the strategic plan.
    1. Strengthen transparency and accountability in planning, budgeting and procurement process

Interventions

* + - 1. Strengthen Public Finance Management system including oversight in Fund disbursement and utilization at all levels. Key actions include; adapt existing national guidelines, laws and regulations on fiscal policies and public finance management; Build capacity of all relevant staff in fiscal policies and public financial management; Conduct Joint Annual Review (JAR) of the implementation of SSHDP II; Coordinate the development of annual budget at all levels and tracking; Publish SHDP II financial implementation review in the health bulletin and website and distribute same to the public.
      2. Strengthen the linkages between various planning and budgeting process (MTEF/MTSS). Key actions include Adopt Medium-Term Sector Strategy (MTSS) and Medium-Term Expenditure Framework (MTEF) in the allocation and management of public sector health expenditure at State; Put in place a framework for regular evaluation of benefits and costs of interventions and technologies to ensure optimal choices; Train all key officers responsible for budgeting and planning in the SMOH, RSPHCMB & RSHMB on budget and planning; Create Platform for the planning and budget officers to work together to optimize the synergy; Harmonize the cost circular of various Planning with the budget process.
      3. Strengthen voice and accountability, including community participation and CSO engagement. Key actions include Develop a framework to monitor implementation of all the strategic plans and annual operational plans in the health sector in the state; SMOH to ensure that all its MDAs produce disseminate annual report of their activities in both print and electronic media; Constitute an audit team, comprising of independent assessors, including CSOs to monitoring the budgeting process, fund disbursements and utilization; and also produce and disseminate annual audit reports; Develop a platform for deepening community involvements in planning and implementation of health programmes and projects.
    1. Improve health sector performance through regular integrated reviews and reports

Interventions

* + - 1. Strengthen annual operational/work-plan for the health sector. Key actions here include: Develop and implement an effective reporting system; Conduct quarterly review of the implementation of the Annual Operational Plans (AOP)/Budget; Disseminate findings of implementation reviews to stakeholders annually and publish same in the state bulletin and MOH website.
      2. Improve information generation and sectorial information base for decision-making to enhance sectorial performance. Key actions include; develop a health management information base, including a website and a data management office for harmonization and standardization of information management; Institutionalize quarterly inter-sectorial review meetings to analyse available data / results and strategize ways for further development; Integrate submission of data into conditions for re-accreditation of private health facilities; Build capacity of relevant staff for data management, including data demand and data use
      3. Institutionalize the mechanism for sector progress status and performance review. Key actions include; Establishment of Central Monitoring Unit at the SMOH to monitor & evaluate State & PHC programmes in the state and LGAs/Operating cost for engaging and supervising the contractor to equip the unit; Set up a Monitoring & Evaluation Team and monitor all health activities; Develop tools to monitor all programmes and activities; Operating cost for engaging and supervising the contractor to purchase vehicles for M & E; Conduct periodic review of plan activities performance in the State & the 23 LGAs/Review and update monitoring tools annually.
      4. Disseminate sector performance reports and score cards in compliance with NHAct 2014 and other channels. Key actions include; Annual production and dissemination of sector performance reports and score cards.
      5. Design and institutionalize an incentivization and reward system for the efficient performance of the health sector at all levels. Key actions include; Institute annual incentives/reward for the best performance at LGAs and GHs.
    1. Strengthen coordination, harmonization and alignment at all levels Interventions
       1. Strengthen governance structures, rules and processes at all levels. Key actions include; Coordinate activities of State Primary Health Care Management Board and other organs of health in the State by the SMOH; Fund coordinating meetings of Boards and relevant bodies of MDAs; Establish/strengthening functional coordinating structures for professional bodies- government interface, development partners, intersectoral collaboration etc; Review/Formulate and implement policies and guidelines to regulate private Health practice in the state;
       2. Strengthen development and review of sectorial polices and plans. Key actions include; Build capacity of DPRS of SMoH for policy analysis and briefs.
       3. Strengthen inter-sectorial collaboration at all levels. Key actions include; create a functional platform for engagement of other sectors (related to social determinants of health) and stakeholders in the planning of health programmes and interventions; Institute quarterly inter departmental meetings at LGA level to discuss health issues.
       4. Improve partnership with professional groups and other relevant stakeholder for effective service delivery and industrial harmony. Key actions include; develop MoU with relevant professional bodies (e.g. SOGON) and other key stakeholders’ e.g FBOs, to promote participation of the professional bodies to enhance health care service delivery quality and coverage.
       5. Strengthen implementation of Health Service Charters at all levels. Key actions include; Empower health service charters at all levels in the State.
       6. Strengthen coordinating mechanism of health development partners (Development Partners and Private Sector Partners). Key actions include; Establish and strengthen Donor Coordination Forum and ensure functionality through regular meetings; Harmonize of Donor interventions and resources for optimal performance of the health sector; Harmonize

reporting formats for all health interventions in the state and ensure partners key into state reporting systems;Develop framework to ensure alignment of donor programmes with the State's workplan. ***Priority Area 2: Community Participation***

Effective partnership between government and rural communities in improving health care service delivery remains critical for the achievement of universal health coverage in the state. Community participation ensures that the underserved population are reached, community capacity to manage their health challenges is built and health promotion gets to the grassroots. Entrenchment of ownership enables individuals, families and communities to get more involved and take greater control over their health; thereby engendering resilience and program sustainability.

In order to strengthen community participation and ownership, the state government had taken some giant strides in the establishment of health committees in the recent past. These efforts include the formation of Ward Development Committees in more than 319 political wards, the creation and strengthening of Rivers State Primary Health Care Boards (RSPHCMB) and Local Government Health Authorities (LGHAs) to support Community Health Committees (WDCs & VDCs) initiative and the adoption of the national guidelines for community participation. It also includes the adoption of the prescriptive guidelines for setting up Village Health Committees (VHC) across the LGAs with definitions on size, composition and functions**.** These have resulted in significant improvement in community mobilization and ensured community representations at high level health management through participation in Primary Health Care and Hospital management Committees**.**

Government will continue to promote community participation in the planning, implementation, utilization, monitoring and evaluation of health services, through the PHC, to ensure optimal maximization of healthcare benefits arising from increased self-reliance and community control on their health issues. In this respect, government intends to strengthen existing structures and infrastructure for effective collaboration and partnership between communities and government at all levels that will translate into better health outcomes for the rural communities.

* + 1. Strategic Goal

To promote community engagement for sustainable health development.

* + 1. Strategic objectives

To strengthen community level coordination mechanisms and capacities for health planning.

**Targets**

**Community Participation and Ownership**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Targets | Baseline | **2018** | **2019** | **2020** | **2021** | **2022** | **National** |
| Percentage of PHCs with functional Ward Development Committees increase by 50% of baseline | TBD | 10% | 12% | 14% | 16% | 18% | Increase by 50%  from baseline |
| Percentage of wards with functional CHIPs programme | TBD | 10 | 12 | 14 | 16 | 18 | 0 |
| Percentage of WDCs carrying out health activities increased to 50% | TBD | 10 | 12 | 14 | 16 | 18 | Increase by 50% from  baseline |

Interventions

* + - 1. Strengthen institutional and coordinating mechanisms for promotion of community participation. Key actions include; Setup/reactivate Ward Development Committees (WDCs) in the 23 LGAs; Produce and disseminate guidelines for the functioning of community coordinating structures; Conduct advocacy and sensitization to community leaders for effective collaboration; Conduct capacity building for Ward Development Committee on community participation.
      2. Strengthen financial management systems at the community levels. Key actions include; Institute a system for financial monitoring and auditing at community level; Build capacity of community committees and structures (CBOs, FBOs, WDCs, etc) on resource mobilization, financial management system and accountability at the community level.
      3. Strengthen capacities of communities to participate in the planning of health interventions at all levels. Key actions include Engage WDCs to participate in the planning of health interventions; Strengthen community and ward development committees to respond appropriately in times of emergencies; Build capacity of community structures in participatory appraisal of needs, planning and implementation of health interventions; Conduct advocacy and community mobilization for increase community resources support and private sectors investment in health program planning and implementation.
    1. To strengthen community engagement in the implementation, monitoring and evaluation of health programs

**Targets**

At least 80% of PHC are implementing MSP

Interventions

* + - 1. Strengthen capacities of communities to facilitate the implementation of community and facility level minimum service package (MSP) Key actions include; develop/adopt community mobilization and IPC manual and job aides on minimum service package areas; Conduct training workshop for WDCs on community utilization of Minimum Service Package (MSP); Develop a reward system to motivate community volunteers, CDDs, WDCs, CBOs to conduct community mobilization.
      2. Strengthen mechanisms for data collection, analysis, storage, utilization and accountability at community level Key actions include; develop/adapt and harmonise existing M & E mechanism & tools for M&E and community based evaluation programme; Operating cost for engaging and supervising the contractor to provide equipment to strengthen M&E Unit at LGA levels and enhance data collection, analysis & dissemination.

Priority Area 3: Partnerships in Health

Health is a multidimensional issue and government alone cannot secure the health of the people of Rivers State. Partnership with the private sector, non-governmental organisations, communities and development partners (donors) as well as other social and economic sectors is essential to deliver health services that can meet the needs of the population on a sustainable basis.

The public-private partnership (PPP) is undertaken to leverage additional resources and managerial approaches from the private sector with the social orientation of the public sector in order to improve the delivery of health services.

Surveys have shown that there is a higher utilization of private facilities, than public ones due to the perceived better quality of care (Health Reform Foundation of Nigeria, 2007). Despite the high costs, the poor represent a significant proportion of beneficiaries of varied forms of private health care. Although effectively priced out of the health care market, but poorly regulated, private sector providers (ranging from private hospitals, clinics, to pharmaceutical stores, patent medicine stores and traditional healers) are increasingly being used by growing numbers of people to access health services. Most of such facilities are unregistered; employ unqualified health workers and dispense counterfeit drugs despite the regulatory framework provided by the National Agency for Food and Drugs Administration and Control (NAFDAC Report, 2005).

There are numerous active non-governmental organisations providing health care in Rivers State and significant among these are faith-based organizations (*private not for profit*). Their services are generally perceived to be of better quality and more accessible to the poor, however, unlike other African countries, in Nigeria, this sub-sector has received little government and external support. Judicious and focused support to this sub-sector could in areas of need secure improved health benefits to the poor and the vulnerable.

There has been a lack of a harmonized framework for coordination between the FMOH and health development partners. As a result, effective coordination has been poor with donors working separately through various departments and agencies within the sector. The lack of an overarching framework specifying priority needs has allowed for donor driven aid deployed in sub-optimal areas of need or non -geographical spread. The Health Sector Reform Programme (2004 – 2007) in recognition of this captured improved donor coordination as essential to increasing the effectiveness of aid resources.

Presently, there is little or no inter-sectoral collaboration with key relevant Ministries such as Finance (adequate budgetary allocation and prompt release of funds); Education (school health and health promotion, girl-child education); Agriculture (food security, adequate and proper nutrition); Water Resources (adequate and safe, clean water); Environment (pollution and vector control); Industry (production of critical inputs such as food and drugs and occupational health); Planning Commissions (Economic development and Poverty Reduction Strategies) to mention a few. For a holistic approach to health, all sectors must be mobilized through good governance, strong political will and commitment to galvanize all stakeholders towards a common purpose – better health for all.

Health professionals and health workers require strong, integrated health systems at both national and local levels to support the delivery of universal care and services. These professionals' groups include those for Doctors (Nigerian Medical Association and its affiliates), Nurses and Midwifery (NANNM), Pharmacists (PSN), Medical Lab Technician and other professional bodies. Health professional associations and societies have vital roles to play in ensuring that health professionals are well equipped to deliver their important roles in improving health outcomes. Households are the main consumers of health care at the facility levels in most communities. Health authorities should be accountable to the community for the course of events as it affects their health.

* 1. Strategic Goal

Enhance harmonized implementation of essential health services in line with national health policy goals.

* + 1. Strategic objectives

Ensure that collaborative mechanisms are put in place for involving all partners in the development and sustenance of the health sector.

**Partnerships for Health**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Targets | Baseline | **2018** | **2019** | **2020** | **2021** | **2022** | **National** |
| Percentage of funding of health from partners (development partners and private sector) that is aligned to the State  Strategic Health Plan by 2022. | TBD | 10 | 12 | 14 | 16 | 18 | 30% |
| Proportion of public health institutions and government programmes having partnerships with the private sector. | TBD | 20 | 25 | 30 | 35 | 40 | Increase to 50% from  baseline |
| Does State have common basket funding model by 2022? | TBD | 0 | 10 | 12 | 14 | 16 | Increase to 50% from baseline |

Interventions

* + - 1. Promote the adoption and utilization of national policies and guidelines on PPP. Key actions include; Domesticate the national PPP policy; Establish/empower Health Partners Coordination Committee (HPCC) to promote, oversee and monitor PPP initiative in the state; Conduct periodic meeting to deliberate & review all PPP activities in the State; Conduct mass media edutainment on the need for adoption and utilization of national policies and guidelines on PPP.
      2. Strengthen legal and coordinating framework for PPP at all levels. Key actions include; Strengthen / develop existing PPP coordinating structures & feedback mechanisms.
      3. Establish a single Development Partners Forum at federal and state levels, which comprises of only health development partners. Key actions include; develop/adapt & circulate guidelines that regulates Development Partners' activities in the state; Establish Development Partners Forum comprising only health development partners at State level as single entry points for engaging partners in the State; Conduct periodic meeting Development Partners Forum to deliberate & review all PPP activities in the State.
      4. Strengthen mechanisms for the implementation of PPP (e.g. contracting or out-sourcing, leases, concessions, social marketing and franchising mechanism). Key actions include; Explore the feasibility of different models of implementation of health programmes including Performance- Based Financing (PBF); Engage in PPP collaboration with interested bodies.
      5. Scale-up PPP in planning and implementation of health programmes. Key actions include; Engage the private sector in the development of strategic plan and AOPs.
      6. Promote joint (public and private sector) monitoring and evaluation of health programs. Key actions include; Establish & strengthen a joint public-private sector monitoring team; Engage the private sector in regular reviews of health programs.
      7. Scale up resource mobilization interventions (funding skills e.g. managerial approaches) targeting the private sector. Key actions include; Conduct advocacy meeting with private sector for increase funding of health intervention;

Build & strengthen capacity of key officers from the public sector, CSOs & NGOs on resource mobilization; Develop innovative ways of resource mobilization (fund raising) targeting the private sector.

* + - 1. Establish mechanisms for resource coordination through common basket funding models such as Joint Funding Agreement, Sector Wide Approaches, and sectorial multi-donor budget support. Key actions include; Adapt/adopt the existing policy on basket fund and develop guidelines for its implementation; Establish a common basket funding through options such as joint funding agreements, Sector-Wide Approaches (SWAps) and sectoral multi-donor budget support etc that will be coordinated by Health Partners Coordinating Committee (HPCC) which serves as government coordinating body with other development partners at the State level.
      2. Promote the establishment of an inter-sectorial ministerial forum at all levels to facilitate inter-sectorial collaboration, involving all relevant MDAs directly engaged in the implementation of specific health programmes. Key action include; Revamp the inter-sectorial ministerial forum at State level to facilitate inter-sectorial collaboration, involving all relevant MDAs directly engaged in the implementation of specific health programmes; Organise regular meetings with all relevant MDAs; Disseminate information and reports of meetings and develop a feedback mechanism.
      3. Promote effective partnership with professional groups and other relevant stakeholders through jointly setting standards of training by health institutions, subsequent practice and professional competency assessments. Key actions include; engagement of private sector, professional groups, training institutions & traditional medicine practitioners by health institutions to set Standards of Training (SOT); Periodic assessment of professional competence.
      4. Strengthen collaboration between government and professional groups including Nigerian health professionals in diaspora to advocate for increased coverage of essential interventions, particularly increased funding. Key actions include; Establish a forum of professional groups and partners to advocate for increased funding; Organize Conferences, Seminars or exhibitions for health practitioners from the diaspora, traditional medicine practitioners, private/religious health providers.
      5. Leverage human resources for health from partners, health professionals, other levels of government to optimize resource use and improve service delivery. Key actions include; Partner with medical training institutions abroad or outsource units where expertise is lacking; Secure technical assistance by Development Partners to provide on-the-Job mentorship for public officers in the health sector.
      6. Promote linkages with academic institutions to undertake research, education and monitoring through existing networks. Key actions involved here include; create/establish a functional forum for all of training and research institutions and stakeholders in the state for developing a research and implementing training and research linkage interventions/activities; Mobilize technical assistance from research bodies to build the capacity of relevant officers in the state on health research; Conduct research on Quality & Inconsistent Services availability & challenge in Rivers State in collaboration with World Bank (WB); Conduct research on Achieving Population-Level Behaviour Change in collaboration with WB.
      7. Promote partnerships with communities to address felt needs of the communities. Key actions involved here include; establish and strengthen a forum for interaction between Government, partners and the communities; Collaborate with WDCs in the state regularly.
      8. Strengthen implementation of Health Service Charters at all levels, with Civil Society Organizations, traditional and religious institutions to promote the concept of citizen's rights and entitlement to quality, accessible basic health services. Key actions involved are; Develop & implement health service charters for CSOs, communities, service providers (PPMVs, traditional, private & public), government and partners; Establish a joint monitoring group to assess level of compliance with health service charters; Put in place community health perception index (e.g. opinion posts) at every Ward.

# CHAPTER 5

### STRATEGIC PILLAR TWO: PROVISION OF ESSENTIAL PACKAGE OF HEALTH CARE SERVICES

The proposed Essential Package intended for delivery within the plan period comprises of:

* + - * 1. Reproductive, maternal, neonatal, child, adolescent health and nutrition (including Focused antenatal care; Skilled delivery and emergency obstetric care; Obstetrics fistula care; Sexual and reproductive health services, including family planning; Newborn and child health care (essential newborn care, IMCI and C-IMCI and Nutrition)
        2. Control of communicable diseases and neglected tropical diseases (malaria, tuberculosis, HIV/AIDS, hepatitis, and NTD)
        3. Control of non-communicable diseases (cardiovascular diseases, diabetes, cancers, sickle cell disease)
        4. Mental health
        5. Oral health
        6. Eye Health
        7. Care of the elderly
        8. Public health emergencies
        9. Environmental health (water and sanitation, food safety, chemicals and snake bites
        10. Essential medical and emergency services

Priority Area 4: Reproductive, Maternal, Newborn, Child and Adolescent Health Plus Nutrition

**Context**

The Reproductive, Maternal, Newborn, Child and Adolescent Health *plus* Nutrition (RMNCAH + N) program aims to promote health through the life course. It is a strategy to integrate an existing range of interventions, improve the use of resources and greatly expand health care coverage to improve access to quality health services for women, newborns, children and adolescents along the continuum of care. Covered in this thematic area are reproductive, maternal, newborn, child and adolescent health as well as nutrition programmes. The RMNCAH+N services are organized in different components and are described along their programmatic areas. To this end, national policies and associated strategic plans addressing RMNCAH + N are in place to provide direction to programming.

Globally, significant strides have been made in improving maternal and child health outcomes due to investments in MDGs 4 and 5. Preventable child deaths are down by more than half; and maternal mortality is down by almost as much. Despite these global achievements Rivers State has made very little progress in improving RMNCAH + N outcomes. The Health indicators for RMNCAH

+N indicators are as in table 5.

Strategic Goal

* + 1. Promote universal access to comprehensive quality sexual and reproductive health services throughout life cycle and reduce maternal, neonatal, child and adolescent morbidity and mortality in Rivers State.

Strategic Objective

* + 1. Reduce maternal mortality and morbidity through the provision of timely, safe, appropriate and effective healthcare services before, during and after child birth.

**Reproductive, Maternal, Newborn, Child, and Adolescent Health Plus Nutrition**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Targets | Baseline | **2018** | **2019** | **2020** | **2021** | **2022** | **National** |
| Maternal Mortality Ratio  reduced from 576/100,000 to 374/100,000 | 576/100,000 | 576/  100,  000 | 550/  100,  000 | 500/  100,00  0 | 400/  100,  000 | 374/100,0  00 | 374/  100,000 |
| Proportion of women having Essential ANC (formerly focused ANC) increased from 49% to 74% | 47.6% | 50 | 55 | 60 | 65 | 70 | Increase to 74% from baseline |
| Percentage of deliveries supervised by skilled birth attendants increase from 43%  to 57% | 79% | 84% | 86% | 88% | 90% | 92% | Increase to 5 7% from  baseline |
| % of primary/Ward Health primary healthcare facilities providing basic emergency obstetric and neonatal care services disaggregated by  level of care increase to 80% | 45 | 47% | 49% | 51% | 53% | 55% | Increase to 80% from baseline |
| Proportion of pregnant women who have received PMTCT services | 10% | 15% | 20% | 25% | 30% | 35% | 66% |

Interventions

* + - 1. Improve access to focused Antenatal and Postnatal Care. Key actions include; conduct meetings by Maternal Newborn& Child Health Core Technical Committee to map out Wards with Service Delivery Points for RMNCAH including ANC in the State; Conduct ANC outreaches; Conduct Integrated Supportive Supervision (ISS) for Primary, Secondary & Private HFs on focused Antenatal plus essential newborn and PNC; Provide routine drugs (Folic Acid & Fesolate) for Primary & Secondary) HFs for ANC & PNC mothers and Sulphadoxine Pyrimethamine (SP) for Intermittent Preventive Treatment (IPT) of malaria for pregnant mothers for Primary & Secondary HFs in the state; Conduct at least one abdominal scan (before 24 weeks of gestation).
      2. Expand coverage of skilled delivery services. Key actions include; Employ personnel to strengthen at least one PHC per ward to provide skilled delivery services; Conduct Elongated Life Saving Skills (ELSS) training for Medical Doctors; Conduct Life Saving Skills (LSS) training for Nurses/Midwives; Conduct Modified Life Saving Skills (MLSS) training for CHOs/CHEWs; Revamp Home-Based Care (HBC) and Midwifery Service Scheme in the state.
      3. Promote advocacy, community Mobilization and Behaviour Change Communication for Safe Motherhood Services. Key actions include;- Conduct advocacy visits to stakeholders (House of assembly, Wife of Governor, Line Ministries e.t.c) on Safe motherhood services (Conduct advocacy to Community Chiefs & Religious Leaders in the 23 LGAs on Safe Motherhood to encourage delivery in health facilities & improve the proportion of delivery by skilled birth attendance; Identify, build capacity of HWs and provide support to CBOs and community structures and CBOs to promote uptake of safe motherhood interventions by WRAG; Conduct Education & Sensitization meetings for commnunity members on safe motherhood practices in the 23 LGAs; Flag-off Safe Motherhood Week at state/LGA levels to increase sensitization, awareness,

practice &utilization of Safe Motherhood services in health facilities; Strengthen male involvement in reproductive health services and information by training male advocate on safe motherhood in the communities.

* + - 1. Increase access to Basic and Comprehensive Emergency Obstetric Services. Key actions include; Upgrade one hospital per LGA to provide comprehensive obstetrics care services (Basic EmOC plus blood transfusion plus C/S); Procure & distribute Obstetrics Emergency drugs (Misoprostol, Oxytocin, Ergometrine, Magnesium Sulphate, IV Fluids: Ringer Lactate, N/Saline, D/Saline, D/Water. Antibiotics, Anticonvulsants, Metronidazole) for 393 health facilities (Primary & Secondary) in the state; Strengthen/Establish emergency transport system for obstetric emergencies; Conduct training workshops for HWs (Doctors, Nurse/Midwives & CHOs/CHEWs on Essential Newborn Care (ENBC) & Helping Babies Breath(HBB); Train community-based workers in Life Saving Skills at community level using the adapted WHO manual.
      2. Improve quality of care for safe motherhood services. Key actions include; develop Standard operating procedures (SOPs) and job aids on reproductive health, maternal, new born, child and adolescent health (RMNCAH) care; Adopt and implement WHO Standards of Care for improving quality of maternal and newborn care in health facilities; Advocacy visits to community institutions for community mobilization and Behavioural Change Communication on Safe Motherhood Services; Conduct orientation training for HWs on IPC skills; Strengthen maternal and perinatal death surveillance and response (MPDSR) through adequate monitoring & evaluation to ensure coordinated referral system in the state.
      3. Strengthen referral and feedback mechanisms. Key actions include; to revamp the Joint Consultative Committee on Referral (JCCR) to oversee referral activities in the state; Operating cost for engaging and supervising the contractors to equip two model referral systems in a predominantly riverine and upland communities in the State. For 2-way referrals; Orientation of facility staff on updated 2-way Referral System Forms and its importance and conduct training on ambulatory services; Design, print and distribute 2-way Referral Forms; Operating cost for engaging and supervising the contractor to provide logistics including functional communication system for referral services and transport services.
      4. Expand access to life saving commodities. Key actions include; Operating cost for engaging and supervising the contractor to procure and distribute life-saving commodities (Anti-shock Garments, Suction Machines, Self-Inflating Ambu Bags, Chlorhexidine Gels, Oxygen cylinders etc) to all 350 HFs in the State; Train Health Workers (HWs) on use of procured equipment and commodities; Operating cost for engaging and supervising the contractor to provide logistics (vehicle) to strengthen the supply chain management for the life-saving commodities.
    1. **Strengthen prevention, treatment and rehabilitation services for fistula care in Rivers State**

**Target**

**Obstetrics Fistula**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Targets | Baseline | **2018** | **2019** | **2020** | **2021** | **2022** | **National** |
| Incidence of obstetrics fistula | TBD | 5% | 4% | 3% | 2% | 1% | 50% |
| Percentage of treated obstetric fistula cases re -integrated into their communities | TBD | 50% | 60% | 70% | 80% | 90% | Increase by 50% from baseline |
| Reduce backlog of obstetric fistula cases by 30% (from 150,000 to  105,000) | TBD | 5% | 10% | 15% | 20% | 25% | Reduced by 30% |

Interventions

* + - 1. Promote Obstetric Fistula (OF) preventive interventions. Key actions include; train health workers on catheterization in prolonged obstructed labour. Collaboration meetings with other sectors to address the determinants of obstetrics fistula. Monitor and enforce use of catheterization in prolonged obstructed labour.
      2. Strengthen/expand services for treatment of obstetric fistula. Key actions include; advocacy visit to the Governor for free treatment and management of OF patients; Regular supply of commodities to strengthen existing Obstetric Fistula treatment centre in the state.
      3. Foster community participation for the rehabilitation and re-integration of fistula patients. Key actions include; Meetings to develop an OF mitigation and rehabilitation plan; Advocacy to integrate counselling into the continuum of OF patient management; Build capacity of CBOs to conduct OF rehabilitation interventions; Collaboration meeting with NGOs, social workers and other stakeholders/sectors in OF rehabilitation.
    1. Promote demand and increase access to comprehensive and integrated reproductive health services (including family planning services and management of unsafe abortion)

**Target**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Targets | Baseline **2018** | | **2019** | **2020** | **2021** | **2022** | **National** |
| Contraceptive prevalence rate increased from 15% to 23%from baseline by 2022 | TBD | 84% | 85% | 86% | 87% | 88% | Increase by 23% from  baseline |
| Proportion of women of reproductive age (15 -49) who have their needs of FP satisfied with modern methods increased 3-7%  from baseline. | TBD | 84% | 85% | 86% | 87% | 88% | Increase by 7% from baseline |

Interventions

* + - 1. Scale up sexual and reproductive health services. Key actions include;- Establish/strengthen and promote uptake of RH cancer screening services (cervical cancer, breast cancer and prostrate); Operating cost for engaging and supervising the contractor to provide logistics (vehicle) to scale up screening and treatment of STIs to PHC level;

Advocacy meetings to integrate HIV screening into STI management; Provide gender-based violence counseling and treatment services.

* + - 1. Increase demand for Reproductive health services. Key actions include Conduct advocacy for enabling legislations, policies and funding for RH; Develop communication materials for BCC; Conduct BCC interventions at all levels (from community to health facility, etc, including use of media); Sensitization meetings with community stakeholders (WDCs, Chiefs, Elders, CDC, Religious groups, Youth leaders, Women group, market women, male groups (including Muslim youths) at the local Government level on Family Planning Services; Sensitization meeting with stakeholders to get involved in RH interventions at state level.
      2. Expand access to comprehensive, quality family planning services. Key actions include; Increase number of FP services delivery points, including outreaches, and community-based distribution, Observe World Contraceptive Day, Implement task shifting in FP service provision by training and using CHEWs for long lasting FP methods and community volunteers; Conduct training of health care providers in comprehensive FP services provision, including LARC; Operating cost for engaging and supervising the contractor to provide logistics to ensure sustainable FP commodity supply chain management in the State.
      3. Strengthen and integrate Family Planning and Post Abortion Care services at all levels. Key actions include Conduct training & re-training workshops for Family Planning providers to provide Family Planning & Post Abortion Care services; Provide counseling and family planning services for post- abortion care clients in all Model Primary Health Care Centres & Secondary Health Facilities in the State; Conduct training workshops for Private Sector on Long Acting Reversible Contraceptive (LARC); Conduct public enlightenment and community engagement interventions.
      4. Promote prevention of harmful traditional practices and gender-based violence. Key actions include; Conduct public education and community sensitization on HTP and GBV.
      5. Scale up Prevention, counseling and treatment of rape and other gender-based violence such as Rape, intimate partner violence etc. Key actions include; Develop training manuals, treatment guidelines and job aids for HTP and GBV; Train health care providers in the detection and management of GBV and rape/intimate partner violence; Establish treatment and reporting protocols; Establish linkages between health care providers, law enforcement agencies, social services etc for comprehensive service provision for GBV.
    1. Reduce neonatal and childhood mortality and promote optimal growth, protection and development of all newborns and children under five years of age.

**Target**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Targets | Baseline | **2018** | **2019** | **2020** | **2021** | **2022** | **National** |
| Neonatal mortality reduced by 50% | TBD | 18/ | 17/ | 16/ | 15/ | 14/ | 24/1000 |
| from 18/1000 live births to 14/1000 |  | 1000 | 1000 | 1000 | 1000 | 1000 |  |
| live births by 2022 |  |  |  |  |  |  |  |
| Infant mortality reduced by 50% | TBD | 41/ | 41/ | 40/ | 39/ | 38/ | 48/1000 |
| from 41/1000 live births to 38/1000 |  | 1000 | 1000 | 1000 | 1000 | 1000 |  |
| live births by 2022 |  |  |  |  |  |  |  |
| Under-five mortality reduced by | 58/1000 | 52/ | 44/ | 40/ | 35/ | 30/ | 85/1000 |
| 50% from 58/1000 live births to |  | 1000 | 1000 | 1000 | 1000 | 1000 |  |
| 30/1000 live births by 2022 |  |  |  |  |  |  |  |

Interventions

* + - 1. Strengthen postnatal and newborn care. Key actions include: Conduct training for Midwives in all HFs on follow up care of Post-natal mothers within the first 24 hrs, and 3rd and 7th day after delivery; Print & distribute posters on Danger signs of heavy bleeding, smelly discharge per vaginum, fever, weakness & dizziness to all HFs to create awareness; Procure & distribute 4% chlorhexidine gel (CHX) for cord care to all 385 HFs for prevention of cord infection; Conduct sensitization meetings for HWs on proper use of Chlorhexidine gel for Cord care for prevention of neonatal sepsis and provide essential newborn care in all delivery service points (thermal care, including kangaroo mother care, neonatal resuscitation).
      2. Strengthen emergency obstetric, newborn and childhood care. Key actions include; Develop and implement emergency obstetrics, newborn and child health treatment guidelines and protocols along the different levels of care, from community level, including effective referral systems; Upgrade special care baby units for emergency newborn care in LGA general hospitals to include CEmOC; Conduct training and re-training workshops for HWs on Essential Maternal Newborn Care and Helping Babies Breathe (HBB); Procure and supply Emergency Obstetric and Neonatal drug and commodities to all HFs in the state.
      3. Intensify the promotion of exclusive breastfeeding for the first six months of life and appropriate complimentary feeding. Key actions include; Promote early initiation of breastfeeding including promotion of Hospital Baby Friendly Initiative (HBFI), so that every maternity home practices the 10 steps to successful breast feeding; Intensify mass media edutainment and community engagement/sensitization on Exclusive Breast Feeding (EBF); Develop, print and distribute IEC materials on EBF.
      4. Strengthen routine child immunization including new antigens. Key actions include; Conduct advocacy visit for RI Focal Officers (RIFO) to the 23 Local Government Chairmen for timely release of RI funding for the LGAs; Procure and supply cold room kit for SCCO to conduct the temperature mapping; Develop and implement MOU on accountability for RI (with all stakeholders, including Private Sector) and re-active Routine Immunisation task force; Conduct RI in all HFs to ensure vaccination of newborn with BCG, HBV & OPV at birth before discharge; Initiate and implement Community Health Influencers/Promoters and Service (CHIPS) Program for demand creation.
      5. Improve quality of newborn and child healthcare services. Key actions include; develop/adapt and produce newborn and child health treatment guidelines and protocols for different levels of care; Strengthen capacity of health care providers and facilities to provide quality newborn care; Develop and disseminate messages in local dialects through multiple media channels (Print and electronic media) on ENCC & chlorhexidine gel use for cord care; Orientate Private HFs, PPMVs/Pharmacies on Newborn Care including cord care with CHX.
      6. Promote advocacy, community mobilization and behavioural change communication for newborn and child healthcare services. Key actions include; advocate to policy makers and legislators for enabling policies, funding and prioritization of newborn and child health; Engage and train WDC/Community volunteers on community sensitization and education for public promotion and uptake of newborn and child health services; Develop and distribute newborn and child health communication materials.

5.4.4.8 Expand coverage of IMCI (Community-IMCI, Community Case Management (ICCM) & IMCI). Key actions include; scale-up implementation of Community Case Management of Childhood Illness (CIMCI) using national protocols at all PHC facilities in all LGAs; Scale up implementation of Community IMCI (promotion of key household practices for child survival and development); Train health care providers IMCI (case management) and community-based health care providers and CHEWs on IMCI and CIMCI); Build capacity of community structures (WDC) in planning and implementation of CIMCI and IMCI interventions.

* + 1. Improve access to adolescent health and young people information and services Target

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Targets | Baseline | **2018** | **2019** | **2020** | **2021** | **2022** | **National** |
| Adolescent birth rate per 1000 women aged 10 to 19 years  decreased from 18/1000 to 14/1000 | TBD | 18/1000 | 17/1000 | 16/1000 | 15/1000 | 14/1000 | 60/1000 |

**Interventions**

* + - 1. Intensify advocacy, social mobilization and behaviour change communication for positive adolescent behaviour. Key actions include; set up Core Technical Committee (CTC) with membership from all adolescent related services (SMOH, Women Affairs, Youth & Empowerment, Sports, Finance, Chieftaincy, Justice, Agriculture, Media, CBOs, FBOs etc) to ensure positive adolescent behaviour; Advocate for revival of Peer To Peer Health Education; Conduct advocacy visits to relevant stakeholders e.g SMOH, SMOE, PHCMB, Women Affairs, Youth & Empowerment, Sports, NDLEA, FRSC etc to mobilize them to support promotion of positive adolescent behaviour change in Schools; Conduct sensitization/advocacy visits to schools on positive adolescent behaviour change; Engage media advocacy and sensitization to promote positive adolescent behaviour change.
      2. Expand access to quality adolescent reproductive health services. Key actions include; Conduct comprehensive sexual and reproductive health education for in- and out-of school adolescents; Provide Family Planning Services in secondary schools (include HPV vaccine & TT immunization); Give Health Education on Family Life Education, Nutrition, Sex Education, Gender equality e.t.c in schools; Provide Career Counseling, Integrate Youth friendly ARHS into Primary Health Centre.
      3. Strengthen prevention, detection, and management of HIV and STIs among adolescents. Key actions include; Conduct sensitization meetings with MOY, MOE, CBOs, FBOs, YBOs for support in prevention, detection & management of HIV & STIs among adolescents; Conduct TOT for secondary school (JS1 - SS3) teachers in the 23 LGAs on prevention, detection & management of HIV & STIs among adolescents; Train JSS1 - SS3 students on prevention, detection & management of HIV & STIs among adolescents; Train female secondary students in the 23 LGAs on cervical cancer prevention & awareness creation; Conduct identification exercise in schools in the state.
      4. Promote menstrual hygiene among adolescents. Key actions include;– Conduct TOT for Health Educators and councilors from concerned NGOs on menstrual hygiene in the LGA/State; Conduct Health Education for secondary school girls in the state on Menstrual hygiene among adolescents; Conduct peer to peer education in girls schools in the 23 LGAs; Purchase & distribute toiletries & sanitary pad to secondary school females in the 23 LGA.
      5. Scale-up implementation of adolescent sexual and reproductive health education in the school curriculum. Key actions include; – Advocate for inclusion of adolescent sexual reproductive health in the school curriculum; Operating cost for engaging and supervising the contractor to purchase vehicle (Hilux & Bus) for supervision & monitoring of sex education in primary & secondary schools; Conduct periodic supportive supervision & monitoring of implementation of adolescent sexual and reproductive health education in schools in the state.
      6. Scale up screening and management of drug use, internet addiction, self-harm, mental health, nutrition disorders and other leading adolescent health problems. Key actions include; – Conduct Training of Trainers (TOT) workshops for teachers on identification of substance use, internet addiction, self, mental health, nutrition disorders & other leading adolescent health problems & management in schools; Conduct training of Doctors, Nurses, Psychologists, Counsellors etc on Drug Demand Reduction in the 23 LGAs; Operating cost for engaging and supervising the contractor to establish drug treatment/rehabilitation centre for males & females in the state. Provide skill acquisition centres for paint making, tailoring, shoe making, computer training & fabrication; Operating cost for engaging and supervising the contractor to equip drug treatment/rehabilitation centre for males & females in the state; Advocacy for integration of adolescent drug addiction into mental health.
      7. Promote school health services including de worming. Key actions include; – Conduct biannual deworming of school age children; Purchase & distribute worm expellant to schools in the state according to target population; Conduct orientation workshop for secondary school students & PTA Chairmen on the importance of deworming in children and adolescents; Conduct media (Radio & Television) talks on deworming exercise in schools during MNCH Week; Operating cost for engaging and supervising the contractor to provide vehicle for School Health activities in the LGAs.
    1. Improve the nutritional status of Rivers people throughout their life cycle with a particular focus on vulnerable groups especially children under five years, adolescents, women of reproductive age and the elderly.

**Target**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Targets | Baseline | **2018** | **2019** | **2020** | **2021** | **2022** | **National** |
| Exclusive breastfeeding rate in the first six months of life increased to 42% by 2022 | 19.8% | 34% | 36% | 38% | 40% | 42% | 60% |
| Incidence of low birth weight reduced to 5% | 23% | 25% | 20% | 15% | 10% | 5% | 10% |
| Prevalence of childhood wasting reduced from 8% to less than 4% by 2022 | TBD | 8% | 7% | 6% | 5% | 4% | 10% |
| Prevalence of stunting in under-  Fives reduced from 11% to less than 7% | TBD | 11% | 10% | 9% | 8% | 7% | 20% |
| Incidence of anaemia among  women of reproductive age reduced to 6% | TBD | 10% | 9% | 8% | 7% | 6% |  |
| Prevalence of childhood overweight  reduced to 1%. | TBD | 5% | 4% | 3% | 2% | 1% |  |
| Prevalence of malnutrition among women of reproductive age reduced from 11% to less than 7% by 2022 | TBD | 11% | 10% | 9% | 8% | 7% | 5% |
| Malnutrition among the elderly reduced 7% by 2022 | TBD | 11% | 10% | 9% | 8% | 7% |  |

Interventions

* + - 1. Promote hospital baby friendly initiative. Key actions include; – Print & distribute posters on baby friendly initiative to promote awareness on IYCF in all health facilities (PHC centres, ANC clinics, OTP and CMAM sites, and child welfare clinics); Conduct periodic campaigns through the media to the general public to promote baby friendly hospitals.
      2. Promote exclusive breastfeeding for the first six months of life. Key actions include; - Ensure initiation of breastfeeding within 30 minutes of delivery; Give health talk on exclusive breastfeeding to pregnant women and parents of infants under 6months of age pregnant/lactation women, adolescents & women of reproductive age at the health facilities in the 23 LGAs; Conduct advocacy meeting with high level stakeholders (Traditional ruler, Legislators, Health Workers e.t.c) to promote, support & protect exclusive breast feeding at state & LGA levels; Observe World Breast Feeding Week at the state & LGA levels; Establishment of Breastfeeding Support Group (BSG) during Breastfeeding Week at the LGA level.
      3. Scale-up continued breastfeeding and appropriate complementary feeding from six months. Key actions include; – Media awareness campaign on the importance of continued breastfeeding & complementary feeding; Advocacy to workplace for provision of crèche in work environment to enable working nursing mothers continue breastfeeding; Health Education (HE) to promote adoption of principles of FADUS (frequency, adequacy, density, utilization and safety) of complementary feeds and counseling on complimentary feeding promotion to parents of infants from 6 months & pregnant women routinely at the primary, secondary & tertiary levels; Conduct routine food demonstration at the health facilities on provision & preparation of nutrient dense complimentary food to pregnant women & parents of infants from 6months at LGA & State levels; Conduct training and re-training for Community Counselor on Infant & Young Child Feeding (IYCF).
      4. Expand coverage with micronutrient powder supplementation. Key actions include; - Introduce & distribute Multi Micronutrient Powder for fortification of home feeds for children aged 6 to 23 months; Provide biannual doses of Vitamin A for children aged 6 - 59 months, integrate distribution with measles campaign, RI and in CWC; Provide Zinc supplements as routine constituent of diarrhoea management for children aged 6 - 59 months; Conduct demonstration of the use of micronutrients powders for in-home fortification of complimentary foods to parents of infants & children of 6-23months of age at the health facilities routinely.
      5. Scale-up prevention, detection, control and management of acute malnutrition. Key actions include; - Sensitize mothers/caregivers within communities on adequate nutrition for infants and young children; Mass media (special regular nutrition programmes on radio and TV) and ICT platforms to provide general information on Community-Based Management of Acute Malnutrition (CMAM); Observe Nutrition Week and conduct active community screening of children for signs of undernutrition; Establish CMAM sites in Primary and Secondary health facilities to increase access to CMAM services; Procure and distribute to all Primary and Secondary health care facilities, essential drugs for the management of malnutrition and nutrition commodities for management of severe acute malnutrition including Ready to Use Therapeutic Foods (RUTF).
      6. Scale up nutrition for children with special nutritional needs including children born to HIV positive mothers; infants and young children in emergencies with persistent diarrhoea etc. key actions include; - Adhere to national guidelines in the management of nutritional needs of children in

difficult situations; Give health talk to HIV positive mothers and caregivers of under-fives on the use of zinc supplement as part diarrhoea management in all facilities routinely; Conduct demonstration on the use of micronutrients powders for in-home fortification of complimentary foods to parents of HIV positive under-five children in all health facilities in the state routinely.

* + - 1. Promote implementation of school feeding programme. Key actions include; – Conduct advocacy meetings with Ministry of Education on promotion and implementation of school feeding; Train Primary School Teachers on salt testing for presence of Iodine; Community outreaches through the media to promote hand washing and sanitation.
      2. Foster Iron and Folic Acid supplementation in pregnant women; and Vitamin A supplementation in lactating women. Key actions include; – Integrate provision of iron, folic acid and vitamin A supplementation into ANC package and vit A for lactating mothers --- Link to ANC; Conduct media campaign on the importance and use of iron-folic acid in pregnancy & vitamin A supplementation in lactating women.
      3. Promote optimal nutrition of adolescents and Women of Reproductive Age (WRA). Key actions include; – Conduct dietary counseling sessions to adolescents & WRA at the health facilities on promotion & importance of good nutrition during pregnancy & lactation; Conduct sensitization training on Improved Nutrition for Adolescent Girls for Secondary Schools girls in the 23 LGAs; Conduct seminar on nutrition education and the importance of adequate nutrition to adolescents & Women of Reproductive Age (WRA) in Faith Based Organizations (FBOs), CBOs & the general public to promote women nutritional status; Observe International Women's Day (IWD) celebration; Baseline survey on nutritional status of Adolescent girls in secondary and tertiary institutions in the State.
      4. Promote healthy diets for the elderly. Key actions include - Baseline Survey on number and health/nutritional status of elderly men/women in 319 wards of the State; Development of Guidelines / SOP on the Nutritional care of the elderly; Build capacity of LGA Nutrition Officers and State officers on Geriatric nutrition and care; Train Volunteer Health Workers per ward on Nutritional Care of the elderly; Conduct quarterly orientation/sensitization per senatorial zone for the Elderly on healthy choice of foods for improved life.

Priority Area 5: Communicable Disease ((Malaria, TB, Leprosy, HIV/AIDS) and Neglected Tropical Diseases)

**Context**

Communicable diseases continue to pose major challenges to the global community accounting for over 60% of all causes of deaths in 2015*(World Health Organization, 2015).* In Nigeria, communicable diseases (HIV/AIDS, Viral Hepatitis, Malaria, Tuberculosis, Leprosy and neglected tropical diseases (filariasis, onchocerciasis, trachoma, worm infestation, and schistosomiasis), account for 66% of the total burden of morbidity. However, with advances in medicine, most of these diseases are now treatable (HIV, Viral Hepatitis B) and curable (Tuberculosis, Malaria and Viral Hepatitis C and NTDs). The SDG 3, Target 3.3, explicitly seeks to end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases (filariasis, onchocerciasis, trachoma, worm infestation, schistosomiasis, leprosy etc.) and combat hepatitis, waterborne diseases and other communicable diseases by 2030 *(https://sustainabledevelopment.un.org*). These diseases have also been listed as priority concerns in the National Health Policy.

Strategic Goal

* + 1. To improve prevention, case detection and coordinated response for the prevention, control and management of communicable diseases and NTDs.

Strategic objectives

* + 1. **Reduce significantly morbidity and mortality due to malaria and move towards pre-elimination levels.**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Targets | Baseline | **2018** | **2019** | **2020** | **2021** | **2022** | **National** |
| % of children with suspected malaria tested with mRDT or microscopy increased from  55% to 75% | TBD | 55% | 60% | 65% | 70% | 75% | 80% |
| Prevalence of malaria in children under -five reduced from 13% to 8% (80% reduction based on mRDT) | 13% | 12% | 11% | 10% | 9% | 8% | 9% |
| % of children <5yrs sleeping under an ITN increased from  29.5% to 50% | 29.5% | 30% | 35% | 40% | 45% | 50% | 80% |
| % of pregnant women sleeping under an ITN  increased from 30% to 70% | TBD | 30% | 40% | 50% | 60% | 70% | 70% |
| % of pregnant women who receive IPT from 17% to 60% | 17% | 20% | 30% | 40% | 50% | 60% | 80% |

**Interventions**

* + - 1. Expand access to integrated vector control interventions. Key actions include;- Conduct micro plan for LLIN mass campaign; Procure and distribute LLIN/L, Larvicides, IRS for health facilities (Primary & Secondary); Conduct indoor residual spray in Port Harcourt watersides & high density areas and the 23 LGAs Headquarters; Produce and air jingles in electronic media on malaria prevention and vector control; Operating cost for engaging and supervising the contractor to construct and mount Bill boards on Malaria prevention and vector control.
      2. Strengthen laboratory services for diagnosis of malaria at all levels. Key actions include; – Upgrade Ward Health Centres for laboratory services; Procure & distribute microscopes for 319 Ward Health Centre laboratories; Procure and distribute malaria RDT Kits to Primary & Secondary Health facilities; Procure consumables for Ward Health Centres laboratories; Conduct parasitological diagnosis.
      3. Build capacity of personnel in public and private health facilities for parasitological confirmation of malaria. Key actions include; – Conduct re-training workshops for Med. Lab scientists, Technicians and Assistants on malaria parasitological confirmation; Conduct trainings for laboratory microscopists on basic malaria microscopy for deployment to Ward Health Centres; Conduct a training/retraining for Malaria Focal persons and State Team Members on the use of RDTs for malaria diagnosis; Distribute SOPs on parasitological confirmation to Health Facilities; Hold Stakeholders' Annual Review Meetings on National Guidelines for laboratory diagnosis of malaria.

5.5.1.5 Improve availability of and access to commodities and supplies for treatment of uncomplicated and severe malaria. Key actions include; – Strengthen malaria treatment by purchasing and distributing ACT and artesunate injections and ensuring successful treatment using approved protocol; Procure and distribute hand gloves to Primary & Secondary Health facilities for effective Lab use; Conduct trainings for RBM manager, State Malaria logistics officer and 23 MFPs on commodity management.

5.1.6 Expand use of IPTp among pregnant women attending ANC. Key actions include; – Strengthen malaria prevention among pregnant women attending ANC by providing and distributing SP to all Primary & Secondary Health Facilities in the State; Production and distribution of malaria IEC materials (posters & flyers) on IPT annually to all Primary and Secondary Health Facilities.

5.5.1.7 Promote active community participation in malaria control initiative. Key actions include; – Conduct workshops with community stakeholders to plan malaria control programmes; Conduct community dialogue meetings in the 23 LGAs; Increase advocacy visits to community chiefs & compound heads for initiating community sensitizations; Conduct quarterly meetings to review M&E conducted; Observe World Malaria Day Celebration.

* + 1. Ensure universal access to high quality, client-centred TB/Leprosy diagnosis and treatment services for the reduction in the incidence and prevalence of tuberculosis/leprosy in Rivers State.

**Target**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Targets | Baseline | **2018** | **2019** | **2020** | **2021** | **2022** | **National** |
| To increase TB case detection from 30% to 38% | 26% | 30% | 32% | 34% | 36% | 38% | 50% |
| To reduce TB prevalence by 25% from 171 /100,000 to 126/100,000 | 171/  100,000 | 162/  100,000 | 153/10  0,000 | 144/10  0,000 | 135/100,  000 | 126/100,0  00 | 244/  100,000 |
| Decrease the incidence of TB by 60% from 300/100,000 to 156/100,000 | TBD | 300/100,  000 | 264/10  0,000 | 228/10  0,000 | 192/100,  000 | 156/100,0  00 | 129/  100,000 |
| To increase TB treatment success rate from 74% to  90% | 70% | 74% | 78% | 82% | 86% | 90% | 100% |

**Interventions**

* + - 1. Strengthen TB case detection, diagnostic capacity and access to quality treatment services. Key actions include; - Strengthen and scale up diagnostic capacity strategically, focusing on high- burden areas and areas of poor coverage and maintain quality throughout the laboratory network; Engage all health facilities in intensified case finding through presumptive and referral to ensure universal access to TB services.
      2. Promote demand for TB services. Key actions include; – Conduct mass media edutainment to create awareness on how to access TB services, get cured and what their rights and responsibilities are to support demand for universal access to services; Advocacy visits to Government & Development Partners to provide/increase funding of the TB programs at all levels; Observe world TB day in the state & 23 LGAs annually.
      3. Expand access to TB diagnosis and treatment services for persons co-infected by TB and HIV. Key actions include; – Operating cost for engaging and supervising the contractor to procure TB equipment to upgrade health facilities for TB microscopy in the 23 LGAs; conduct trainings for Health workers on HCT in new Dots sites; Provide HIV services in all DOTs sites in the state to enhance patient-centred treatment (one stop shop).
      4. Scale up paediatric TB diagnosis and treatment services. Key actions include;- Implement active TB case finding in specific vulnerable populations (e.g. contacts to active TB cases, migrants, prisoners and slum dwellers); Conduct advocacy to paediatric related bodies (Paediatric associations, department of IMCI, thoracic associations, UNICEF and other bi- and multilateral agencies) on integration of TB services into other child survival strategies.
      5. Increase access to diagnosis and management services for DR-TB. Key actions include; - Operating cost for engaging and supervising the contractor to establish a robust DR-TB diagnosis, treatment and care services.
      6. Strengthen collaboration with and capacity of CBOs to support TB programming. Key actions include; – Engage patent medicine vendors and community pharmacists, traditional healers, religious leaders and other first-points-of-contact in identification of people with TB symptoms and referral for evaluation; Engage FBO health facilities and private health facilities in providing TB diagnostic services; Conduct trainings to increase capacity of CBOs for PMV in the 23 LGAs; Conduct re-training for PMV and Health providers in the 23 LGAs; Hold Education & Sensitization meetings for community members on TB programming in the 23 LGAs.
      7. Strengthen mechanism for coordination of TB/HIV collaborative activities at all levels of health care. Key actions include; – Upgrade the existing Monitoring and Evaluation system to be more robust and be able to meet up with the increasing demand for the TBL programme at all level; Build the capacity of health care workers to deliver integrated TB/HIV services; Conduct periodic review meetings for coordination of TB/HIV collaborative activities at all levels.
      8. Promote innovative advocacy, social mobilization and behaviour change intervention for the prevention and control of TB. Key actions include; – Develop an effective advocacy, communication and social mobilization system to ensure prevention and control of TB; Conduct advocacy visit to Chiefs, Elders, Community leaders on TB & Leprosy sensitization; Conduct trainings for GHW on M&E and ICT Data management.
      9. Build capacity of all cadres of health staff (GHW, Physicians, and specialist) and community members on Leprosy case finding and case management. Key actions include; – Conduct training for medical officers on TB, Leprosy, Buruli Ulcer case finding and management in the 23 LGA; Conduct trainings for GHW on case finding and management in the 23 LGA.
      10. Promote community based TB/Leprosy control initiatives. Key actions include; - Conduct consensus building meetings for TBL Officers on community TB / Leprosy control; Conduct trainings for community volunteers on TB management.
      11. Strengthen physical and socio-economic rehabilitation for leprosy. Key actions include; – Operating cost for engaging and supervising the contractor to provide & equip leprosy rehabilitation centre in the state.
    1. Significantly reduce the incidence and prevalence of HIV/AIDS in Rivers State by 2022.

**Target**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Targets | Baseline | **2018** | **2019** | **2020** | **2021** | **2022** | **National** |
| Incidence of HIV among key and general population (disaggregated by age and  sex) reduced by 70% | TBD | 15% | 12% | 10% | 8% | 6% | Reduced by 70% of baseline |
| Prevalence of HIV among the general adult population reduced from 10% by 70% to  2% | TBD | 10% | 8% | 6% | 4% | 2% | 1% |
| Increase coverage of HIV HTS from 20% to 40% | TBD | 20% | 25% | 30% | 35% | 40% | 60% |
| Incidence of mother -to-child  transmission of HIV from 11% to 0% | TBD | 11% | 8% | 5% | 3% | 0% | 0% |
| % of HIV positive persons receiving HIV treatment services increased from 20%  to 60% | 10% | 20% | 30% | 40% | 50% | 60% | 90% |
| % of the population age 15 - 49 years tested for HIV (VCT and collected result) from 30% to 50% | TBD | 30% | 35% | 40% | 45% | 50% | 60% |
| % of HIV positive pregnant  women who received ART | 10% | 20% | 30% | 40% | 50% | 60% | 66% |

Interventions

* + - 1. Expand access to Minimum Package of Preventive Interventions (MPPI) for HIV targeting key and general populations. Key actions include; - Conduct HTS/ PMTCT in PHC facilities at ANC clinics in 23 LGAs; Engage TBA / private health facilities to provide PMTCT/HTS services in 23 LGAs; Conduct HTS in communities in 23 LGAs; Carry out advocacy visit to CBO to link with health facilities to promote client tracking in all PHC.
      2. Expand access of people living with HIV and AIDS to ART and co-infection management services. Key actions include; - Activate inactive ART sites in PHC facilities in 23 LGAs and train Health workers; Activate inactive PMTCT/HTS sites & train Health workers; Conduct supportive supervisory visits to PHC facilities in 23 LGAs; Conduct DQA to PMTCT/HTS/ART in PHC in 23 LGAs.
      3. Promote universal access to quality PMTCT services. Key actions include; –Train/build capacity of health workers on the implementation of HTS / PMTCT (Paediatric diagnosis (EID); Conduct trainings/capacity building for HIV Desk officers in 23 LGAs; Conduct regular review meetings of HIV desk officers and stakeholders on data harmonization in the state (Expand access of pregnant women to testing and ART for pregnant women exposed infants to diagnosis); Conduct enlightenment and orientation activities on PMTCT in ANCs (Testing of pregnant women); Conduct HIV awareness campaign for adolescents in secondary schools in 23 LGAs.
      4. Strengthen referral and linkages between HIV/AIDS services and other health and social services. Key actions include; – Engage TBA / private health facilities to provide PMTCT service or make referral to PHC; Supervise testing and link HIV positive infants to treatment in 23 LGAs; Engage expert clients/ volunteers to track HIV positive mothers.
      5. Improve access to safe blood and blood products. Key actions include; – Train Health Workers in PHC facilities in the state to improve access to safe blood products; Provide blood banking services in 2 facilities each for 23 LGAs.
      6. Promote injection safety and health care waste management practices. Key actions include; – Train HWs in PHC facilities on Safety and Waste management practices; Train CBOs and private health workers in the 23 LGA on injection safety & healthcare waste management practices.
      7. Strengthen community systems to support HIV/AIDS programming for key and general populations. Key actions include; – Engage WDC to support HIV/AIDs Programme mobilization in 23 LGAs; Conduct community outreach programmes on HIV in the 23 LGAs.
      8. Improve the logistics and supply chain management for all HIVAIDS- related drugs and commodities. Key actions include – Procure and distribute Rapid test kits pack in the 23 LGAs; Procure and distribute ART Drugs for positive client in the 23 LGAs; Print and distribution PMTCT collection tools to Secondary & PHC facilities in the State.
    1. Reduce morbidity, disability and mortality due to targeted Neglected Tropical Diseases (NTDs) and improve quality of life of those affected.

**Target**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Targets | Baseline | **2018** | **2019** | **2020** | **2021** | **2022** | **National** |
| State implement integrated vector management for targeted NTDs? | TBD | 0% | 5% | 10% | 20% | 30% | Increased to 70% of baseline |
| Attain 50% coverage in preventive chemotherapy for  selected neglected tropical diseases (NTDs) by 2022 | TBD | 10% | 20% | 30% | 40% | 50% | Increased to 50% of baseline |
| Prevalence of targeted NTDs reduced to 32% by 2022 | TBD | 40% | 38% | 36% | 34% | 32% | Reduced  to 60% of baseline |
| Attain 50% coverage in preventive chemotherapy for selected neglected tropical  diseases (NTDs) | TBD | 10% | 20% | 30% | 40% | 50% | Increased to 50% |

**Interventions**

* + - 1. Strengthen advocacy, social mobilization and behaviour change communication for NTDs. Key actions include; – Conduct advocacy visit to community institutions on Community Mobilization on NTDs recognition, reporting and control in the 23 LGAs; Conduct advocacy visit to the Commissioner of Education for inclusion of all NTDs control in curricula of health training schools; Design, print and distribute IEC materials and advocacy kits; Engage media advocacy and sensitization : Press briefing, talk shows on NTDs (TV & Radio); Production of newsletter on NTDs.
      2. Scale up delivery of integrated preventive chemotherapy packages and other packages. Key actions include; – Collection of FMOH allocation of medicine from CMS, Oshodi, Lagos State; Conduct trainings for state & 23 LGA Officers on Logistic Management Information System; Conduct delivery of chemotherapy packages and others to LGAs, communities and schools and retrieval of left over.
      3. Strengthen integrated vector and management and activities for health education, access to clean water, sanitation, and environmental improvement for targeted NTDs. Key actions include;

– Conduct advocacy visit to Ministry of Environment for increased coverage of safe water supply and sanitation; Set up intersectoral collaboration forum for water supply in the state; Conduct periodic meetings for intersectoral collaboration forum for water supply; Conduct advocacy meetings with WDC to mobilize communities to undertake IVM measures.

* + - 1. Increase access to integrated case management for NTDs (Buruli Ulcer, Leishmaniasis, Trypanosomiasis, Loasis, Schistosomiasis, Zoonosis, soil-transmitted helminthic infections, onchocerciasis, and filariasis). Key actions include; – Awareness creation through jingles, town announcers and other channels of communication on NTDs.
      2. Strengthen capacity for NTD programming and implementation. Key actions include – Sponsor state NTD Coordinator on disease programme management short courses; Sponsor NTDs Desk Officers on their respective Desk Disease Management short courses; Sponsor state and LGAs NTD teams on Data Management short courses; Operating cost for engaging and supervising the contractor to equip State and 23 LGA NTD offices; Operating cost for engaging and supervising the contractor to procure a Hilux and a Bus for the State office, and a bike each for the 23 LGAs with annual fund for fueling and maintenance.
      3. Strengthen the integration and linkages of NTD programme and financial plans into sector- wide and national budgetary and financing mechanisms. Key actions include; – Establish/Inaugurate NTD Advisory Committee; Develop annual NTD Work plans with inputs from partners; Strengthen collaboration with other community based health programs like RBM, EPI, School Feeding programs, WASH, Sanitation Authority, Ministry of Environment; Conduct sensitization meetings with policy makers, line ministries, and other stakeholders on the beneficial synergy of integration at the state, LGAs and community levels (including Village health Committees); Conduct periodic meetings for NTDs programmes managers and all stakeholders.

Priority Area 6: Non-Communicable Disease, Care of Elderly, Mental Health, Oral Health, Eye Healthcare.

**Context**

Nigeria is experiencing a rapid epidemiological and demographic transition from communicable diseases to Non-Communicable Diseases (NCDs), thus resulting in double burden of diseases. In Rivers State, NCDs contribute significantly to adult mortality and morbidity. They impose a heavy economic burden on individuals, societies and health system as they affect the highly productive population. The major NCDs in the State include; cardiovascular diseases (hypertension, stroke, and coronary heart disease), diabetes mellitus, cancers, sickle cell disease and chronic obstructive airway diseases including asthma. Others include mental health disorders, violence, road traffic injuries and oral health. Although there is dearth of data on NCDs in the State, as the last national survey on NCD was in 1992, the prevalence of NCDs is predicted to rise even more in the coming decades.

The modifiable shared risk factors for NCDs include- tobacco use, harmful use of alcohol, physical inactivity and unhealthy diets such as excessive consumption of red meat, salt, saturated fat, refined sugars in foods and drinks. Others include exposure to outdoor and indoor smoke from solid fuels, harmful radiation (domestic or industrial) contribute to an emerging increase in NCDs. The above risk factors are fueled by increasing globalization, urbanization and industrialization in

the last few years that imposed new lifestyle on the population with ascendancy in the occurrence of related chronic conditions.

Strategic Goal:

* + - 1. To reduce the burden of morbidity, mortality and disability due to non-communicable diseases.

Strategic Objectives

* + - 1. Reduce morbidity and mortality due to NCDs (Cancers, Cardiovascular Diseases, Chronic Obstructive Airway Diseases, Diabetes and Sickle Cell Disease).

**Targets***:*

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Targets | Baseline | **2018** | **2019** | **2020** | **2021** | **2022** | **National** |
| Reduce overall mortality from NCDs (cardiovascular diseases, cancer, diabetes, sickle cell diseases or chronic  respiratory diseases.) | TBD | 56% | 54% | 52% | 50% | 48% | Reduced by 20% |
| Reduce the prevalence of |  |  |  |  |  |  |  |
| modifiable risk factors for |  |  |  |  |  |  |  |
| NCDs in Nigeria from current |  |  |  |  |  |  |  |
| levels by: |  |  |  |  |  |  |  |
| a.Tobacco use (current |  |  |  |  |  |  | Reduced by |
| prevalence rate is 5.6% | TBD | 6% | 5% | 4% | 3% | 1% | 30% of |
| among adults) |  |  |  |  |  |  | baseline |
| b.Insufficient physical activity | TBD | 80% | 70% | 60% | 50% | 40% | Reduced by |
|  |  |  |  |  |  |  | 30% of |
| c.Mean adult (aged ≥18) population salt intake, with aim |  |  |  |  |  |  | baseline |
| of achieving recommended | TBD | 80% | 70% | 60% | 50% | 40% | Reduced by |
| level of <5g per day. |  |  |  |  |  |  | 30% of |
|  |  |  |  |  |  |  | baseline |
| Increase in uptake of vaccines for carcinogenic viruses (HBV, high risk HPV serotypes and pneumococcal vaccination  among children) | TBD | 10% | 20% | 30% | 40% | 50% | Increase to50% |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Targets | Baseline | **2018** | **2019** | **2020** | **2021** | **2022** | **National** |
| Increase proportion of adults  who are aware of their genotype to 30% | TBD | 5% | 10% | 20% | 25% | 30% | Increase to 50% |
| Increase in proportion of eligible population screened for early detection and management of NCDs (These include mammography for breast cancer, Pap smear for cancer o f the cervix, PSA for cancer of the prostate; and screening for diabetes mellitus, hypertension and  Sickle cell disease). | TBD | 10% | 20% | 30% | 40% | 50% | Increase to 50% |
| Access to quality treatment facilities for persons with  NCDs | TBD | 10% | 20% | 30% | 40% | 50% | Increase to 50% |

Interventions

* + - 1. Promote generation of evidence for decision-making for planning and implementation of NCD interventions. Key actions involved here include; – Conduct sensitization meetings with DSNOs on collection and collation of NCDs data; Operating Cost for engaging and supervising the contractor to establish a population-based cancer registry for the state in collaboration with FMOH; Initiate continued active case search of NCDs cases in the state; Report accurately with use of appropriate tools on NCDs prevalence/incidence in the state to FMOH for planning and control; Implement surveillance activities in all health sectors (public and private).
      2. Intensify advocacy, legislation, social mobilization and behaviour change communication for NCD prevention and control: Key actions include; – Setting up an NCD stirring/Cancer Control committees to carry out advocacy on NCDs prevention & control; Conduct sensitization on NCDs for all HWs in the state; Observe Global days marked for celebration ie World Hypertension day, World Heart Day, World Cancer Day, World Diabetes Day, World NO Tobacco Day, World Sickle cell Day, World Breast and Cervical Cancer Month & World Bronchial Asthma Month for highlighting problem associated with these disease.
      3. Promote healthy lifestyles and behaviour for the prevention of NCDs. Key action include; – Establish public awareness programmes to promote healthy lifestyles and increase physical activities including advertisement to discourage and prohibit tobacco amongst the populace; Conduct screening programmes for clinical breast examination, 2 yearly mammogram examination, 3 yearly PAP examination in the target population, women of reproductive age; Produce & distribute approved health posters by State Ministry of Health for NCDs; Establish programmes to address NCD risk factors such as physical inactivity, unhealthy diet, tobacco use and harmful use of alcohol in schools, religious places, etc.
      4. Expand access (geographic and financial etc.) to NCD prevention, screening, control and treatment services. Key actions include; – Identify facilities rendering NCD services in the state, both public and private for monitoring and supervision; Develop SOPs for NCDs in all Health facilities in the state; Provide screening tools such as VIAs, Mammogram, Accu-check metres, Sphygmomanometers etc; Operating cost for engaging and supervising the contractor to establish comprehensive NCD treatment/Cancer treatment/Radiotherapy centres.
      5. Increase the quality of life affected by NCDs. Key actions include; – Establishment of a multidisciplinary management team for prevention and control of NCDs; Provide psychotherapy and vocational rehabilitation to all patients undergoing diagnosis, treatment and rehabilitation; Expand the availability of drugs in the essential drug list such as drugs used for palliative care and treatment of NCDs; Provide prosthetic aides for patients affected by NCD complications.
      6. Build capacity of health care providers, especially at lower levels (PHC) in prevention and screening for NCDs: Key actions include; – Develop & disseminate guides lines and SOPs for the management of NCDs at all health care levels; Train & Re-train Community Health workers on prevention & screening for NCDs; Periodic review and update of Community health workers and standing orders to include current trends in the management of major NCDs; Conduct capacity building for NCD focal points in Health Facilities on programme management; Promotion of educational activities: conferences, workshops, seminars etc. for health care personnel in the management of NCDs especially pre-diabetes and diabetes mellitus.
      7. Promote demand for NCD services: Key actions include; – Conduct campaign in key sectors of the communities community, schools (including primary, secondary and tertiary institutions), Health facilities, Workplaces, Unions, Trade Unions, Market women, etc. on available of NCD services in the state; Provide free NCD screening services at five designated centres in the state. Centres - PH., Bori, Ahoada, Oyigbo, Abua central.

**5.6.2 Promote the health and wellbeing of the elderly in Rivers State**

**Targets**:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Targets | Baseline | **2018** | **2019** | **2020** | **2021** | **2022** | **National** |
| To increase access to basic and long term care of the elderly by 50% of baseline | TBD | 4% | 6% | 8% | 10% | 20% | Increase to 50% from  baseline |

*I*nterventions

* + - 1. Promote generation of evidence for planning, implementation and monitoring of geriatric services: Key actions include; – To carry out community survey in the 23 LGAs to ascertain the proportion of the elderly requiring geriatric care in the State; Report accurately with use of appropriate tools on geriatric population in the state to SMOH/FMOH for planning, implementation, monitoring of geriatric services; Initiate continued active case search of geriatrics in the state in other to determine their health problems; Collaborate with Geriatric Association of Nigeria to provide adequate care to the elderly.
      2. Promote enabling policy environment for programming for the elderly: Key actions include; – Propose bill to Government on policy/ law that protect the rights and privileges of the elderly; Advocacy visit to Chiefs and Traditional rulers in the community to intimate them on roles and responsibilities they need to play to create enabling environment for implementation of elderly programmes; Establish a multi-sectoral State / Local Government task force on prevention and control of elderly abuse.
      3. Promote community participation and partnerships for sustainability of health programmes for the elderly: Key actions include Conduct trainings& re-training for HWs in the 23 LGAs on Interpersonal Communication Skill (IPCS) for the care of the elderly.
    1. **Promote optimal oral health in Rivers State. Target:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Targets | **Baseline** | **2018** | **2019** | **2020** | **2021** | **2022** | **National** |
| Percent decrease in the prevalence of oral diseases (e.g. dental caries,  gingivitis, cancrum oris etc.) | TBD | 5 | 10 | 20 | 30 | 40 | Decrease by 40% |
| Percent Increase in the proportion of PHCs providing basic package of oral  care by 60% of baseline | TBD | 10 | 20 | 30 | 40 | 50 | Increase to 60% |
| Percent of Rivers residents who have  adequate access to oral health care by 2022 | TBD | 5 | 10 | 15 | 20 | 25 | 50% |
| Percent of PHCs providing basic  package of oral care by 2022 | 0 | 10 | 20 | 30 | 40 | 50 | 50% |
| Percent of secondary level health care facilities are providing oral health care  appropriate for that | TBD | 10 | 20 | 30 | 40 | 50 | 60% |

Interventions

* + - 1. Scale-up BCC for oral health promotion, disease prevention and early care seeking for oral diseases. Key actions include; – Develop and implement an oral health prevention and promotion strategy; Develop and distribute Information Education and Communication (IEC) materials for oral health awareness creation among the general population; Conduct advocacy to integrate oral health education into school curricula; Integrate oral health education into health education activities at PHC level; Institutionalize Oral week to promote good oral health habits.
      2. Expand access to oral health care services by integrating oral health into the mainstream of service delivery at all levels of the health care system. Key actions include; – Develop/adapt norms and standards for oral health at different levels of the health care system; Integrate oral health care at all levels of the health care system, from primary level in line with defined norms and standards; Strengthen the capacity of the health facilities to provide dental care services as appropriate for the level of care (Dental clinic from level of General hospital with at least one Dental unit per LGA). Establish/strengthen regional oral health referral centres; Advocate for inclusion of dental health into NHIS, including CBHIS.
      3. Strengthen capacity of health workers at all levels to deliver oral health care services. Key actions include –Conduct train & re-train workshops for health workers at State & LGA levels on oral health.
    1. Eliminate avoidable blindness, and reduce the burden of various visual impairment conditions.

Target: 70% of blind and visually impaired persons have adequate access to eye treatment and rehabilitative services by 2022.

30% of health facilities in the country have capacity to deliver appropriate quality eye care services by 2022.

50% of blind and visually impaired needing rehabilitation have access to required services by 2022

Prevalence of avoidable visual impairment in the country reduced to 25% by 2022.

Interventions

* + - 1. Improve coordination of eye care services. Key actions include; – Conduct meeting for National Programme for Prevention of Blindness (NPPB) committee to assess the present state of coordination of eye services in Primary, Secondary and Tertiary health facilities in the state; Conduct periodic trainings& re-training workshops for eye care personnel of eye care services.
      2. Promote the development of health plans and policies at all levels to be in consonance with the WHO Global Eye Health Action Plan 2014 – 2019. Key actions include; – Conduct workshops to develop eye plans & policies for all levels in consonance with the WHO Global Eye Health Action Plan 2014-2019; Conduct periodic meetings of the NPPB committee to assess implementation of the WHO Global Eye Health Action Plan 2014 – 2019.
      3. Strengthen eye health focused research and information system. Key actions

Include; – Set up research team in major eye care facilities (RSUTH & UPTH) with focus on eye health & information system; Hold periodic meetings to review research articles and adopt innovations in eye management.

* + - 1. Strengthen advocacy, social mobilization and behaviour change communication on eye health. Key actions include; – Conduct advocacy visits to the Government for provision of affordable, accessible and adequate eye care delivery services in the state; Conduct advocacy visits to community institutions (WDCs) in the 23 LGAs to increase public awareness of available eye care services; Public enlightenment through multi-media approach to enhance positive behaviour change and improved uptake eye care services by the communities.

Priority Area 7: Emergency Medical Services and Hospital Care Context

The health care delivery system is divided into the Primary, Secondary and Tertiary sub-systems. The primary and secondary sub-systems are under the supervision of the Local and State governments respectively and they are the weakest links. In many States, they are non-functional, and this has severely weakened referral services. Most Rivers people have lost confidence in these two sub-systems and usually bypass them in their quest to access medical services. The result is that the tertiary system is over burdened with minor ailments which tend to distract health workers at that level from their other core mandates of training of health workers and health research.

The tertiary health care delivery sub-system is operated by the Federal Ministry of Health and there are fifty-four (54) institutions providing services in this sub-system. They are under the direct supervision of the Department of Hospital Services of the Ministry. In the Rivers State there are6 tertiary health facilities with 4 state-owned and the other one is run by the federal government (UPTH) while the last one is privately owned (Table 5). Most of the hospitals have adequate manpower and some level of equipment to deliver reasonable services but this is not usually the case as a result of poor attitude of health workers, inter-professional wrangling, incessant strike actions, conflict of interest, poor housekeeping and unregulated labour Unionism etc. The result is that more people are fast losing confidence in this level of care and those who can afford it go outside the country to access care, which in some cases may not be up to the standard obtainable in the country. It has been estimated that Nigeria loses up to USD 1billion to medical tourism annually.

Strategic Goal:

* + 1. **Improve health outcomes through prompt and effective response to medical emergencies.**

**Strategic objectives:**

* + 1. **Strengthen Emergency Medical Services (EMS)**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Targets | Baseline | **2018** | **2019** | **2020** | **2021** | **2022** | **National** |
| Does state have EMS policies, plans and services in place by 2022 | TBD | 5% | 10% | 20% | 30% | 40% | 50% |

**Interventions:**

* + - 1. Promote the development/adaptation and implementation of regulatory framework, policy and plans for Emergency Medical Services (EMS) across all levels of care. Key actions include; – Adapt national EMS policies, plans and guidelines on EMS services with support from FMOH; Revamp the coordinating framework for EMS and ETS at state level; Strengthen institutional structures for the implementation of the EMS and ETS services; Mobilize resources (Financial, human, infrastructure etc.) for the functioning of the EMS and ETS services.
      2. Build capacity of health care providers for emergency medical services including training for first responders and ambulance drivers. The key actions include; - Conduct a needs assessment with to identify HR gaps on EMS and ETS services; Develop and implement training programmes for EMS (Training of paramedics in basic and advanced life support, ETS drivers, EMS Doctors, Nurses and other relevant health care workers).
      3. Create/Strengthen coordination of various emergency medical services (NEMA/SEMA, Police, Public, Private etc). Key activities here are – Establish a coordinating framework for harmonization, integration and alignment of all public sector medical emergency services; Promote PPP in EMS and ETS services.
      4. Promote demand for appropriate use of medical services. Key activities include; - Public enlightenment through multi-media approach on use of emergency and trauma care services.

###### Increase provision and access to quality, affordable & integrated Emergency Medical Services

**Targets**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Targets | Baseline | **2018** | **2019** | **2020** | **2021** | **2022** | **National** |
| Does state have dedicated centres for integrated emergency medical service | TBD | 1% | 10% | 20% | 30% | 40% | 80% |

Interventions:

* + - 1. Ensure provision and access to emergency medical services. Key actions include; – Provide reliable community-based transport system in emergencies in all HFs; Operating cost for engaging and supervising the contractors to provide standard ambulance.
      2. Build capacity (human and institutional) of emergency medical services units/departments of receiving health facilities. Key actions include; – Training of staff on services and advance CPR; Operating cost for engaging and supervising the contractor to procure emergency equipment e.g. oxygen, defibrillator and life-saving equipment; Build capacity of disease surveillance officers for disease outbreak control; Conduct review meetings with stakeholders on improvement of comprehensive emergency and trauma care.
      3. Strengthen coordinated and integrated emergency transport system (ETS). Key actions include; – Evaluate the existing integrated transport system for emergencies and trauma; Operating cost for engaging and supervising the contractor for maintenance of ambulance and repairs; Procure drugs and consumables for the ambulance for three senatorial zones.
    1. Improve provision, access, quality and responsiveness of ambulatory (OPD) services at all levels of health care system

**Target:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Baseline | **2018** | **2019** | **2020** | **2021** | **2022** | **National** |
| 70% of states have coordinated functional ambulance services | TBD | 5% | 10% | 20% | 30% | 40% | 70% |
| Case fatality rates reduced by 30% by 2022 | TBD | 10 | 10 | 15 | 20 | 25 | 30 |

**Interventions:**

* + - 1. Promote the development of practice standards and guidelines for ambulatory services. Key actions include; - Revive Joint Consultative Committee on Referral (JCCR); Develop guidelines for ambulatory services by the JCCR; Train staff on developed guidelines.
      2. Scale-up functional and integrated ambulatory services (general, and specialized) in all facilities according to standards. Key actions include; – Monitor and Evaluate ambulatory services activities by the central M&E unit and make report available to all stakeholders; Employ and deploy health professionals to all facilities in the state; Train and re-train staff on integrated ambulatory services in all Hfs.
      3. Promote & enhance capacity (human and institutional) for continuous quality improvement of Outpatient services. Key actions include; – Train health care providers on Triage and Lean Approach to health care service; Monthly review meetings on implementation of Triage and Lean; Provide directional signs and tagging of Departments and Units in all HFs to shorten time spent by clients; Training of diseases surveillance officers for active case search; Prompt treatment of clients on arrival to health facilities.

Strategic objectives:

* + 1. **Strengthen the provision of health services at public and private health facilities that are appropriate, accessible and meet minimum quality and safety standard for optimized health outcomes.**

**Interventions:**

* + - 1. Promote the development and implementation of policies, plans, legislations, regulations and clinical standards for safety and quality improvement of medical services across levels of care. Key actions include; – Set up committee to pay advocacy visit to Legislative/executive bodies in Government as well as Partners Agencies( NGOs, Public Health Institutions, Companies and other Parastatals) for safety and quality improvement of medical services; Conduct workshops to develop policy guidelines ( Standard Operating Procedures) for Management of Common Medical conditions, Infection Prevention and Control and Quality of Care; Print and distribute guideline and SOPS and ensure implementation; Orientation/Interactive sessions with Stakeholders on new Policy Documents across all levels of care; Training of Trainers Workshops on the new policy on Quality of Care in General Hospital and Primary Health Care Facilities.
      2. Scale up provision of accessible medical services. The key actions include; - Mapping, categorizing and establishing Geographic Information System (GIS) for all HFs & ensure networking between PHC Board and all PHC HFs and SMOH and all secondary health facilities; Operating cost for engaging and supervising the contractors to construct & equip General Hospitals in LGAs without any (Obio/Akpor, Oyigbo& Tai); Operating cost for engaging and supervising the contractor to provide ambulances for SMOH and LGAs for emergency response; Operating cost for engaging and supervising the contractor to provide vehicles ( Hilux and buses) for State and LGAs for Monitoring and Supervision; Operating cost for engaging and supervising the contractor to purchase and install ultrasound scan in all General Hospitals in the State.
      3. Intensify continuous quality improvement in medical service provision at all levels. Key activities here are; – Conduct continuous training of Secondary and Primary healthcare staff on the SOPS on Quality of Care, Infection Prevention and Control, Management of common medical conditions; Operating cost for engaging and supervising the contractor to maintain equipment at all levels; Periodic training of staff on management and maintenance of equipment & supplies; Printing of private health institutions registration/renewal certificate.
      4. Build capacity of health care providers for emergency medical services. Key actions are – Build capacity of Health workers on quality medical services; Employ Health care professionals; Training of HWs on current emerging health challenges at all levels; Trainings on the use of ultrasound scan.
      5. Promote demand for appropriate use of medical services. Key actions are – Public enlightenment through multi-media approach on use of medical services
      6. Strengthen Infection, Prevention and Control (IPC) practices in health care settings. Key actions are – Train HWs on universal precaution; Regular update of guidelines on universal precaution; Procurement of Personal Protective Equipment (PPE) for use at all levels; Provision of IEC materials on infection control; Operating cost for engaging and supervising the contractor to provide incinerator in the state for hazardous hospital wastes.

Strategic Objectives

* + - 1. Promote the provision of and access to palliative and End-of-life care services at public and private health facilities that meet defined minimum quality and safety standards

###### Targets

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Targets | Baseline | **2018** | **2019** | **2020** | **2021** | **2022** | **National** |
| Client satisfaction level improved by  35 % by 2022 | TBD | 15% | 20% | 25% | 30% | 35% | 50% |
| Adherence to quality measures improved by 25% by 2022 | TBD | 5% | 10% | 15% | 20% | 25% | 50% |

Interventions

* + - 1. Promote the development and implementation of policies, plans, legislations, regulations and clinical standards for palliative and end-of -life care services. Key actions include; – Adopt existing policies and develop protocols and guidelines for Palliative and End of Life Care services; Conduct advocacy visits to policy makers on establishing Palliative and End of Life services; Conduct need assessment for the Palliative /End of Life Care by DPRS, SMOH; Print & disseminate guideline; Create awareness on availability care.
      2. Build capacity (human and institutional) for continuous quality improvement of palliative and End-of-life care services. Key actions include; – Operating cost for engaging and supervising the contractor to purchase, supply and maintain equipment for End-of-life care services; Procure commodities for End-of-life care services; Build capacity of staff on protocols and guidelines; Institute referral linkage.
      3. Strengthen community systems to support Palliative and End-of-life care services. Key actions include; - Train Community Care Givers on End-of-Life guidelines; Train Religious leaders, WDCs, CDCs and VDCs on their roles and responsibilities.
      4. Promote appropriate disposal of dead bodies. Key actions include;– Advocacy for PPP collaboration in provision of mortuary services at primary & secondary levels; Training on infection prevention and control of all health workers in Primary and Secondary facilities; Procure and distribute personnel protective equipment; Training of the mortuary attendants and Environmental Health Officers (EHOs); Print and distribute tools on capturing dead bodies.

Priority Area 8: Health Promotion and Environmental Health Context

Health promotion is defined as 'the process of enabling people to increase control over and to improve their health' (WHO 1986). It comprises actions aimed at fostering good health and wellbeing, focusing on populations within the context of their everyday lives. It is aimed at promoting health and preventing disease. It addresses many factors that influence health such as Individual factors-(biological, socio-demographic and lifestyle and health care seeking behaviour); and Environmental factors (cultural, social, economic, physical, etc.). These are the social determinants of health.

Strategic Goals:

* + 1. Improve the well-being, safety and quality of life of Rivers people through health promotion and healthy environment.

###### Strategic objective:

* + 1. **Promote the wellbeing of individuals and communities through protection from health risks, and promotion of healthy lifestyle and environment.**

**Target:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Targets | Baseline | **2018** | **2019** | **2020** | **2021** | **2022** | **National** |
| % of communities that have capacity for health promotion increased by 25% of baseline  (TBD) by 2022 | TBD | 20 | 10 | 15 | 20 | 25 | Increase by 25% of  baseline |
| % of community members making healthy life style choices increased by 40% of baseline  (TBD) by 2022 | TBD | 20 | 30 | 40 | 50 | 60 | Increase by 40% of  baseline |

Interventions:

* + - 1. Promote the development and implementation of policies, plans, legislation and regulations that prevent health risks and ensures healthy life styles. Key actions are; – Conduct advocacy to policy makers to enact laws that will promote healthy life style; Conduct situation analysis on the risky health behaviours, Conduct stakeholders' meetings to Identify and review existing policies; Design & print posters on healthy living and distribute to every community and schools in the 23 LGAs of the state; Legislate standard of establishment of private schools.
      2. Strengthen community capacity for responses and ownership of health promotion. Key actions include; - Conduct meetings with the different groups in the community to sensitize them on the risky health behaviours and consequences; Orientate and re-orientate WDCs, CBOs on promotion of healthy life style; Conduct outreaches and town hall meetings on promotion of healthy life style and environment.
      3. Strengthen health promotion coordination mechanisms at all levels. Key actions are; - Public enlightenment on risky health behaviours through production and airing of jingles; Conduct stakeholders' meetings at the state level to disseminate information on promotion of healthy living; Conduct stakeholders' meetings at the LGA level to disseminate information on promotion of healthy living; Support zonal meetings with WDC Chairman to disseminate information on promotion of healthy living.
      4. Scale-up health promotion activities at all levels. Key actions include; – Integrate Reach Every Ward (REW) strategy with components of all health interventions at state & LGA levels; Conduct zonal hygiene promotion debate and quiz amongst schools in the state, Celebration of world hand washing day in the state & 23 LGAs, Establish environmental health clubs in schools; Monitoring of activities of environmental health clubs.
      5. Promote the inclusion of health promotion in workplace health programs. Key actions are; – Conduct advocacy visit to the Head of Service by Environmental Health Officers (EHOs) for inclusion of health promotion (violence at work, smoking at work place, harassment and bullying at work place, consumption of alcohol and substance abuse at work place) in workplace health programmes; Operating cost for engaging and supervising the contractor to construct sanitary convenience in workplaces; Procure and distribute dust bins & buckets at workplace; Institutionalize weekly environmental sanitation in workplace; Orientation of public servants on hygiene promotion in workplace.
      6. Promote the inclusion of health promotion in school curricula at all levels. Key actions are; - Conduct advocacy visit to the Commissioner of Education by EHOs for inclusion of health promotion in school curricula at all levels; Institutionalize health promotion activities in school curricula at all levels; Conduct quiz and debates on healthy living.
      7. Intensify multi-sectorial and intra-sectorial collaboration and partnerships in planning, implementation and health promotion activities. Key activities are; – Hold periodic stakeholders' meetings with line ministries and MDAs to review implementation of planned activities; Periodic monitoring and supervision of health promotion activities in schools in collaboration with line ministries and MDAs; Monitoring of citing of public conveniences and borehole by environmental health workers.
    1. **Promote food hygiene and safety for the reduction of illnesses associated with unwholesome food.**

**Targets:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Targets | Baseline | **2018** | **2019** | **2020** | **2021** | **2022** | **National** |
| Designated sentinel site  established and equipped to report on foodborne illnesses | TBD | 0 | 1 | 3 | 3 | 3 |  |

Interventions:

* + - 1. Strengthen system for food and water safety surveillance. Key actions are; - Organize periodic trainings for food handlers from 23 LGAs in the state on food handling; Conduct workshop for EHOs to ensure that the food which the public consumes are safe, wholesome and nutritious; Conduct sensitization workshops for food handlers on food hygiene and other practices; Conduct sensitization trainings for butchers and meat handlers from 23 LGAs on practice of meat handling; Conduct training workshops for water and sanitation (WATSAN) officers and zonal EHOs from 23 LGAs for promotion of potable water supply in the state.
      2. Strengthen the legal, and regulatory framework for food safety in line with international guidelines. Key actions include; – Engage a Consultant to review and adapt the National Policy on Food and Nutrition and any other policy on Food Safety; Review /Adaptation of the existing National policies on Food/Nutrition; Food Safety etc, in line with national guidelines; Organize meetings with State Assembly on the adopted policies on Food safety; Validation and printing of the policy document on Food /Nutrition and food Safety; Dissemination of the adopted Food/Nutrition Policy and Food safety policy to relevant stakeholders in the state.
      3. Intensify awareness and sensitization on food safety and quality particularly at the rural community level. Key actions include; – Engage the media (both electronic and print) on awareness creation and sensitization of the populace on food safety and quality; Orientation of members of the State Committee on Food and nutrition on Food safety and quality; Inauguration of LGA Committees on Food and Nutrition in the 23 LGAs of the state; Orientation of members of 23 LGA Committees on Food and Nutrition on Food safety and quality; Training of community volunteers on Food Safety and Quality.
      4. Scale up the training of food inspectors that will ensure that foods sold within the State are in compliance with current standards and regulations. Key actions are; - Mapping of the Food inspectors in the state; Development of SOP on Food Safety and Quality; Training of Food Inspectors on Food Safety and quality; Review meetings for Food Inspectors and members of the Food/Nutrition committee.
      5. **:** Promote the practice of food safety across the food production pipe lines from farms to the table. Key actions are; - Collaborate with the relevant Ministries and Parastatals in the state to promote the practice of Food Safety and quality e.g. Ministry of Agriculture, ADP, Ministry of Education etc.; Collaboration with Ministry of Agriculture and ADP on food safety practices during production and processing of foods from farms to the table; Training for farmers on food safety practices during production and processing of foods from farms to the table.
    1. Promote universal access to safe drinking water and acceptable sanitation

**Targets:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Targets | Baseline | **2018** | **2019** | **2020** | **2021** | **2022** | **National** |
| % of mortality rate attributable to unsafe water, unsafe sanitation and lack of hygiene (WASH) | TBD | 75 | 70 | 65 | 60 | 55 | Reduced by 50% from baseline |

**Interventions:**

* + - 1. Promote the development and the implementation of policies, plans and legislation and regulation for the provision of safe water supply and promotion of environmental health. Key actions are - Establish WASH committees at all levels to ensure implementation of policy, plan etc and hold quarterly meeting; Review of existing policies and regulations on safe water supply and promotion of environmental health; Advocacy visits to the 23 LGAs Chairmen & Traditional Rulers on the need to provide potable water in accordance to WHO standard; Training of community members (WDCs) on regulation guiding safe water supply; Create awareness on hand washing at appropriate times using print, electronic and social media platforms.
      2. Promote preventive and curative healthcare for water and sewage borne diseases. Key actions are; – Conduct training workshops for waste management desk officers in the 23 LGA; Conduct community sensitization in the 23 LGAs on the prevention of water & sewage borne diseases; Conduct workshops for all registered commercial table water in 23 LGAs on proper standard of water safety, to prevent water & sewage borne diseases; Organize orientation for commercial water producers on proper standard of water safety; Public enlightenment of the populace through production and airing of jingles & print/distribution of posters/fliers on WASH.
      3. Strengthen behavioural change communication, social mobilization and advocacy for the promotion of safe water and sanitation. Key activities are; – Conduct advocacy visits to policy makers at the State for the provision of functional safe water points in the State; Develop, print and distribute IEC materials on promotion of safe water and sanitation; Community sensitization on safe water and sanitation using WDC monthly meetings; Orientation of health workers on effective hand washing and sanitation; Production and airing safe water and sanitation jingles.
      4. Strengthen the regulatory and supervisory frame work for production of commercial water to ensure water safety. The key actions are – Establish in collaboration with NAFDAC a regulation enforcement committee for commercial water producer; Produce and distribute regulation for production of commercial water supply; Monitoring and supervision of construction of commercial water points.
    1. Reduce morbidity and mortality from snake bites in Rivers State Target:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Targets | Baseline | **2018** | **2019** | **2020** | **2021** | **2022** | **National** |
| **Reduction in the incidence of snakebites by 2022** | TBD | 12% | 14% | 16% | 18% | 20% | Reduced by 50%  from baseline |

**Interventions:**

* + - 1. Promote the development and the implementation of policies, plans, legislations and regulations for the reduction of snake bites in the State. Key activities are; – Identify qualified members for a TWG on Anti-snake bites; and conduct a meeting to inaugurate the Anti-snake bite TWG with terms of reference; Conduct workshops to review and adapt policies, plans, legislations and regulations for snake bite reduction in Rivers State.

Draw up Work plan and budget for anti-snake bite programme. Identify all potential sources of funding and partnership; Conduct advocacy visits to incorporate policies and regulations into the State Legislative system by TWG; Print and disseminate anti snakebite policies to all parastatals.

* + - 1. Scale up sustainable supply of anti-snake venom in Rivers State, including local production. Key activities are; - Conduct review of existing sources of supply of anti-snake venom and identify institutions and companies involved with snake venom research for local production; Support procurement and distribution of anti-venoms and complimentary items (analgesics, TT and antisera, parenteral fluids, wound care consumables etc.); Conduct resource mobilization activities for implementation: advocacy visits to identified sources of funding.
      2. Build capacity of health care workers on snakebite management at all levels. Key activities are; – Conduct TOT of state officers on snakebite management; Conduct trainings of health workers on appropriate snakebite management at State level, including on data management on snakebites; Conduct training of all levels of health workers on appropriate snakebite management at LG level, including on data management on snakebites.
      3. Promote partnerships for national snakebite response. Key actions are; – Identify NGOs, FBOs, CBOs and related partners for partnership on national snakebite response; Conduct advocacies to identified partners for partnership negotiations.
      4. Scale up generation of local evidence to inform more responsive snakebite programming. Key activities are: Conduct periodic data quality assessments of snakebite programmes; Initiate surveillance and reporting systems for snakebite and conduct regular surveillance. Data to be used for resource allocation and distribution.
      5. Promote snakebite prevention and Control interventions. Key actions include;- Produce and distribute educational posters and leaflets across communities in the state; Support research into snakebite prevention and control for regular improvements; Advocate for incorporation of modern management of snakebites into the schools' curriculums of medical personnel; Conduct supervision and monitoring of health centres and facilities for snakebite prevention and control.
    1. Protect human health, environment and infrastructure from chemical hazard, medical & Bio waste and poisoning.

**Targets:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Target | Baseline | **2018** | **2019** | **2020** | **2021** | **2022** | **National** |
| Mortality associated with hazardous chemicals and poisons reduced | TBD | 0% | 5% | 10% | 15% | 20% | Reduced by 30% from baseline |

**Interventions:**

* + - 1. Strengthen legal, regulatory framework, policies and plans for chemical hazards and poisoning, medical and Bio waste and climate change. Key actions are; - adapt, print and disseminate relevant policies and regulations for chemical hazards & poising, medical & Bio waste & climate change; Develop health protection policy for children; Conduct stakeholders' meetings on legal framework for chemical hazards and poisoning; Conduct advocacy visits to government officials and other stakeholders on the need to mitigate the effects chemical hazards on climate change on health.
      2. Scale-up advocacy, community sensitization and education on chemical wastes and poisoning, medical and Bio waste and climate change. Key activities are; - Conduct advocacy visits to the stakeholders, to sensitize them on the possible effect of chemical wastes, medical and bio waste and chemical change; Advocacy and social mobilization to communities (319 wards) to sensitize them on climate effects on health; Periodic town hall meetings with communities living in an industrial area; Conduct public enlightenment campaigns in state media houses on the effect of chemical hazards.
      3. Build capacity of health workers for effective management of medical and Bio waste and hazardous chemicals at all levels of the health care system. Key actions are; - Conduct training of health workers on the management of medical and bio waste at all level; Conduct training for Environmental Health Officers on risk assessment.
      4. Build capacity to appropriately respond to health effects of climate change. Key activities are; – Establish a committee made up of weather experts, Develop and implement climate and health adaptation plan; Conduct training of health workers on climate impacts and how to assess vulnerabilities; Hold training for State Climate Change Disk officers, Civil Society Organizations and 23 LGA climate change Desk officer on emergency Response.
      5. Deepen collaboration with relevant stakeholders on Chemicals Management, medical & Bio waste management and climate change. Key actions are - Conduct risk assessment for hazardous chemicals and poisoning; Hold Bi-Annual Stakeholders review meetings on effects of climate change in the state.
      6. Improve systems for data collection, management and utilization for chemical hazards and poisons, medical and Bio wastes and climate change. Key actions are; –

Develop surveillance and reporting systems for data collection, management and utilization for chemical hazards and poisons, medical and Bio wastes and climate change; Conduct quarterly data quality assessments; Review of activities of climate change desk officers yearly.

Specific Objectives

* + 1. **Promote optimal health and safety of workers in their work environment Target**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Targets | Baseline | **2018** | **2019** | **2020** | **2021** | **2022** | **National** |
| Proportion of health workers that have access to occupational health services increased | TBD | 5% | 10% | 15% | 20% | 25% | Increase from 25% From baseline |

**Interventions:**

* + - 1. Promote health and safety in the workplace. Key activities are; - Establishing an occupational health unit in the SMOH; Sensitization of workforce on the use of safety protective devices in the work place; create awareness on any existing & emerging risks using print, electronic and social media platforms.
      2. Promote collaboration between the key stakeholders (Ministry of Health, Ministry of Labour and the private sector). Key activities are – Setup/Inaugurate an occupational health committee in the State Ministry of Health; Hold quarterly collaboration meetings.

# CHAPTER 6

### STRATEGIC PILLAR THREE: HEALTH SYSTEM SUPPORT

Priority Area 9: Human Resources for Health (HRH) Context

The performance of a health system and its impact on health outcomes is influenced significantly by the size, distribution, and skill mix of its health workforce. Nigeria has one of the largest stocks of human resources for health in Africa whilst Rivers State has one of the largest supply of human resources for health in the South-South geopolitical zone, with 14,631 skilled health workers. Doctor per population ratio for Rivers State as at 2017 is 27/100,000 and the figure for the Nurse/Midwife per population ratio 64/100,000. For example, the doctor population ratio in Nigeria is 38.9/100,000 compared to the sub-Saharan African ratio of 15/100,000 while the nurse/midwife ratio is 148/100,000 in the country while the average in the region is 72/100,000. However, the quantity is inadequate to meet the country health needs.

In line with the policy provisions, Rivers state, has established a HRH unit in the Department of Planning, Research and Statistics in the Ministries of Health (SMOH). The Departments of Planning, Research and Statistics provides the institutional hub for HRH policy formulation, planning and management. The National Task Shifting and Task Sharing (TSS) Policies have been adopted and validated by the State.

Strategic Goal:

* 1. To have in place the right number, skill mix of competent, motivated, productive and equitably distributed health work force for the provision of optimal and quality health care services in the State.

Strategic Objectives:

* + 1. **Ensure coordination and partnership for aligning investment of current and future needs and institutional strengthening for HRH agenda.**

**Target:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Targets | Baseline | **2018** | **2019** | **2020** | **2021** | **2022** | **National** |
| % of LGAs that are implementing HRH policy and strategic plans increased | TBD | 30 | 40 | 50 | 60 | 70 | 100% |
| % of health training institutions accredited by the relevant  regulatory bodies each year | TBD | 65 | 70 | 75 | 80 | 85 | 90% |

**Interventions:**

* + - 1. Strengthen institutional capacities of HRH coordinating structures. The actions are; Build capacity to strengthen HRH units at state level to enhance performance; Set up committee to assess the state of health training institutions (College of Health Science & Technology, School of Nursing, School of Midwifery & School of Public Health) and establish a multi-sectoral coordinating body including Ministry of Health, Education, finance, NGOs, professional bodies such as associations and licensing councils, training

institutions, universities, etc. to coordinate human resource activities in the state; Operating cost for engaging and supervising the contractor to equip the practical demonstration rooms of School of Midwifery and School of Public Health; Operating costs for engaging and supervising the contractor to renovate School of Nursing classroom; Conduct workshops on staff training and development for academic staff, Senior Non Academic staff and Junior Non Academic staff for College of Health Science & Technology.

* + - 1. Strengthen coordination of public, private, regulatory, Health workforce association and development partners at all levels. Key activities are; - Update a state comprehensive HRH database.
      2. Enhance funding for HRH development for the current and future needs. Key activities are;

- Advocacy for allocation a minimum of 15% of the health budget to development of human resources. (NHP 2004); Advocate to private sector for adequate funding for HRH using HRH plan as an advocacy tool; Conduct resource mobilization activities for HRH, including craftsmanship, proposal development, fund raising activities etc.

* + 1. Ensure the production of adequate numbers of qualified health workers Target:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Targets | Baseline | **2018** | **2019** | **2020** | **2021** | **2022** | **National** |
| % of health workers who have received in-service training (all forms) based on performance assessments, task analysis, or development needs at least once every 2-3 years, by cadre, location,  and type of training increased to 50% of baseline | TBD | 10 | 15 | 20 | 25 | 30 | 50 |

**Interventions:**

* + - 1. Strengthen the quality assurance for HRH training institutions especially for producing frontline health workers. Key actions are; - Assess training needs of health training institutions; Review and revise training curricula in line with current market needs; Develop continuing professional development programmes targeting HR trainers; Develop and implement a quality assurance framework for health training institutions; Monitor and evaluate training programmes.
      2. Strengthen the platform between HRH training institutions, regulatory bodies and other stakeholders to increase health workforce production. Key action is; Establish evidence-based staffing norms for all levels of human resources for health based on workload analysis; Deploy/redeploy/recruit qualified personnel (Clinical and Non Clinical Staff) based on needs and established gaps; Train and retrain healthcare personnel for effective and efficient staff utilization according to training needs (e.g. Train SPHCDA staff on IMCI and Community IMCI, LSS, MLSS etc); Conduct periodic Integrated Supportive Supervision (ISS) to all health cadre and facilities by the multi-sectoral coordinating body.
      3. Improve gender sensitivity in the production of health work force for all cadres at all levels. Key actions are; - Establish/ update annually a database disaggregated by gender to track gender disparities in training of healthcare workers.
    1. **Strengthen monitoring and evaluation for HRH including systems for HRHMIS and Registry.**

**Target:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Targets | Baseline | **2018** | **2019** | **2020** | **2021** | **2022** | **National** |
| Number of LGAs with functional HRHIS? | TBD | 10% | 15% | 20% | 25% | 30% | 38% |
| Percent of health workers who have received supportive supervision in last six months and  left copy of the checklist | TBD | 20 | 25 | 30 | 35 | 40 | 50% |

Interventions:

* + - 1. Strengthen/establish HRHIS at state and federal levels. The key actions are;- Establish

/Strengthen Human Resource Health Information System (HRHIS); Establish a performance management system (performance of individual workers using job aids, job descriptions, scheme of service and work plans); Conduct periodic facility-based and health workers' performance assessment, monitoring and supervision.

* + - 1. Establish mechanisms for annual HRH reviews and reporting for evidence and decision making at the State and LGA levels. The key actions are; - Conduct joint annual reviews to assess progress made in implementing HRH action plans by thematic areas; Conduct mid-term and final evaluation of HRH strategic plan implementation.
      2. Improve the production of HRH research evidence through monitoring and evaluation mechanisms. The key actions are; - Promote and build capacity for HRH research; Conduct relevant research to improve the production and utilization of relevant professional cadres and skill mix required for a responsive health system; Create a platform for translating HRH research findings to action (evidence to action).
    1. Ensure effective health workforce management through retention, deployment, work condition, motivation and performance management

**Target:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Targets | Baseline | **2018** | **2019** | **2020** | **2021** | **2022** | **National** |
| % of health facilities at all levels with the appropriate skill mix of health providers | TBD | 40 | 45 | 50 | 55 | 60 | 50 |

**Interventions:**

* + - 1. Strengthen mechanisms for deployment and retention of HRH at all levels. Key actions include; – Review of existing HRH recruitment and deployment policies to remove barriers/embargo to competitive recruitment, deployment and retention of appropriate health workforce; Create an enabling work and living environment to promote health worker recruitment and retention; Sustain incentives in the hiring of rural health workers in order to attract qualified staff from urban areas to work in the rural areas; Introduce performance based reward systems. Identify best performers from each department in SMOH, RSHMB and RSPHCMB annually; Institutionalize the Midwifery Service Scheme (MSS) and other flagship interventions to increase HRH availability especially in hard to reach areas.
      2. Improve HRH performance management systems at all levels. Key action are; - Review and implement system for measuring performance of health workers in line with the civil service Performance Monitoring System (PMS).
      3. Strengthen the Task Shifting/ Task Sharing implementation with required guidelines. Key activities are; - Submit draft report of Task Shifting /Task Sharing (TSTS) training to Hon. Commissioner for Health; Produce final copies of TSTS Policy and distribute to relevant Stakeholders; Conduct advocacy meetings with Key Stakeholders to sensitize them on TSTS Implementation with guidelines; Hold meetings with Stakeholders, Professional Bodies, Health Institutions on TSTS implementation guidelines; Commence TSTS training for all cadre of HWs in line with the guidelines.

###### Strengthen Health workforce planning for effective management Target:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Targets | Baseline | **2018** | **2019** | **2020** | **2021** | **2022** | **National** |
| Number of LGAs with harmonized HRH Annual Operational Plan | TBD | 30% | 40% | 45% | 50% | 55% | 50% |

Strategic Interventions:

* + - 1. Improve capacity for HRH planning at all levels. Key activities are; - Provide IT tools to enable HRH unit plan HRH needs across all levels; Train HRH Personnel to improve HRH planning at state, LGAs Health Facilities.
      2. Strengthen mechanisms for HRH joint planning at primary, secondary and tertiary levels. Key action is; Organise workshops for primary, secondary & tertiary levels to develop harmonised HRH plan.

Priority Area 10: Health Infrastructure Context

Health Infrastructure comprises buildings - both medical & non-medical; equipment - medical equipment, furniture and hospital plant; communications (ICT equipment); and ambulatory systems (ambulances, cars, pick-up vans, trucks, etc.) as required for healthcare delivery at different levels.

The Federal Government of Nigeria planned to have one functional Primary Healthcare (PHC) centre per ward in the country. The reason for this is to facilitate the provision of universal health coverage to over its 180 million citizens. The functionality referred to in the definition of a functional PHC is one that meets the minimum standards, which are for effective planning and continuous development of PHC in terms of infrastructure, human resources, availability of health commodities and service provision. However, the standards do not include building of new facilities but limited to infrastructural upgrade (Facility renovation, power supply, toilets and water amenities).

Strategic Goal

6.10.0 To improve the availability and functionality of health infrastructure required to optimize service delivery at all levels and ensure equitable access to effective and responsive health services throughout the country.

Strategic Objective

6.10.1- To improve availability and functionality of health infrastructure required to optimize service delivery at all levels.

Targets

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Targets | Baseline | **2018** | **2019** | **2020** | **2021** | **2022** | **National** |
| 80% of Wards in the country has at least one fully functional PHC centre with capacity to provide comprehensive primary health care  services by 2022. | TBD | 55 | 60 | 65 | 70 | 75 | 80% |
| 50% of the LGAs have functional  general hospitals for referral from PHCs. | TBD | 50 | 60 | 70 | 80 | 90 | 50% |
| 80% of health facilities at all levels of the health system has fully functional health infrastructure (related to medical equipment; water supply; electricity supply; roads; waste disposal; ICT; and security) needed for supporting and facilitating health service  Deliv b ery, by 2022. | TBD | 55 | 60 | 65 | 70 | 75 | 80% |

**Interventions**

* + - 1. : Strengthen legal, policy and institutional frameworks and coordinating mechanisms for health infrastructure planning and maintenance in Rivers State. The activities include; - Set up functional health infrastructure coordinating committees at different levels; Review/adapt policies, laws and guidelines on health infrastructure, equipment maintenance and management; Develop a state strategic health infrastructure plan; Build capacity of health infrastructure unit at state level.
      2. : Promote the establishment of norms and standards for health infrastructure for all levels of the health care system in the State. The activities include; - Establish norms and standards for health infrastructure (Physical facilities including laboratory services and municipal services e.g. water, sanitation, electricity facilities), ICT, communication, equipment, transport, etc including critical infrastructure (e.g. blood banks, energy supply systems, laboratories, etc) at all levels of the healthcare system; Convene meetings of key stakeholders in the public and private sector to review and adopt the norms.
      3. : Ensure availability of equipment and other health infrastructure in line with established norms and standards for the different levels of health care and other health institutions. The activities include;- Conduct facility assessment of equipment in all secondary and & PHC health facilities in the state by infrastructure coordinating committee; Conduct periodic monitoring and evaluation of provision & distribution of hospital equipment to all functional secondary & primary health facilities in the State & LGA as planned by the various departments; Establish a system for procurements of health infrastructure (e.g. vehicle, ICT, communication, equipment etc) in partnership with the private sector; Cost of engaging and supervising the contractor to provide equipment and infrastructure in primary and secondary HFs in the state; Advocate for dedicated funds for health infrastructure development and management in Rivers State.
      4. : Strengthen the monitoring of health infrastructure including inventories and performance. The activities include; - Conduct monitoring of health infrastructures, including inventories & performance at State & LGA levels; Ensure inclusion of health infrastructures into the Electronic Medical Record (EMR) framework for all health facilities.
      5. : Strengthen capacities and partnerships for health infrastructure maintenance and management. The activities include; - Establish a plan and system for maintenance of all health infrastructure; Develop and implement MoUs with private suppliers in the post-supply of health infrastructure maintenance and training of providers in use and maintenance; Establish PPP platform on health infrastructure procurement, service provision and maintenance (e.g. Build and maintain, outsource, contract, concession etc); Mobilize resources from development partners, philanthropists, and communities on health infrastructure development, management and maintenance; Train human resource in the use and maintenance of the health infrastructure.
      6. : Promote partnerships between Equipment Manufactures/Suppliers and government at all levels for technology transfer/training/maintenance agreements. The activities include; -Identify and provide platform for engagement of major equipment manufacturers/suppliers for technology transfer/training/ maintenance of infrastructure; Develop and implement MoUs for production, training, and maintenance of health infrastructure; Advocate for an enabling fiscal policy to create an enabling environment for PPP on health infrastructure e.g. exemption or reduction on import tariffs.
      7. : Scale up training of Biomedical Engineers and health infrastructure equipment maintenance officers, in order to increase stock availability. The key actions include; - Training and retraining of Biomedical Engineers, Technicians and Health Maintenance Officers with major equipment manufacturers.
      8. : Accelerate the revitalization of primary health infrastructure for improved access to health services. The activities include; - Set up committees to assess the state of existing PHC facilities as well mapping out areas for siting new ones in the 23 LGAs; Operating costs for engaging and supervising contractors to rehabilitate 50 PHC facilities in the 23 LGAs; Operating costs for engaging and supervising contractors to renovate the Rivers State Primary Health Care Management Board (RSPHCMB) office complex (Waterlines Building); Operating cost for engaging and supervising contractors to equip Rivers State Primary Health Care Management Board (RSPHCMB) office complex (Waterlines Building); Strengthen at least 1 PHC per Ward to provide the Essential Service Package (ESP) of care including BEmOC.
      9. : Improve Secondary and Tertiary levels infrastructure to support for referrals systems. The key activities include; - Operating costs for engaging and supervising contractors to renovate all General & Specialist Hospitals in the State; Operating costs for engaging and supervising contractors to establish/strengthen logistics support including transportation and communication systems to aid referral; Establish standard diagnostic centres in all senatorial zones of the State that are WHO certified.

Priority Area 11: Medicines, Vaccines, Health Technologies and Supplies Context

Access to essential medicines is critical to achieving universal health coverage. It is one of the WHO key building blocks of a strong health system.

The primary goal is to ensure commodity security. This is a situation where essential medicines are available, affordable, and people are able to choose, obtain and use high quality medicines and medical supplies, as at when needed. The supply chain activities include; product selection, quantification, procurement, warehousing, transportation, storage and rational use, among others. Supply chain management of commodity-related tasks is a crosscutting issue that requires inter- sectoral and inter-governmental collaboration to ensure that commodities are available to support the health sector goal and objectives. The Nigerian government is aware that optimal management of Nigeria's essential drugs and commodities supply chain, requires the development of an effective information system for facilitation and coordination of these interrelated functions at the three tiers of government as well as, efficient procurement procedures and controls.

To this effect, the Nigerian government has continued to make concerted effort towards ensuring availability of essential drugs and commodities in the country through formulation of policies and issuance of guidelines. A major achievement, in this respect, was the establishment of the National Pharmaceutical Research Centre, with the mandate to research into drugs and pharmaceuticals. In addition, local manufacturing of drugs is being promoted and currently four out of eleven Nigerian Pharmaceutical Companies that applied for have received WHO certification for Good Manufacturing Practices (GMP). The National Agency for Food and Drug Administration and Control (NAFDAC) has provided, appropriate guidelines and regulations that ensured compliance with Good Manufacturing Practices; and has continued to make efforts to check the prevalence of fake and substandard medicines, vaccines and products. The Central Medical Stores in Rivers State has been re-organized and runs a drug revolving fund account resulting in regular availability of drugs and consumables. The CMS is a distributor for most major Pharmaceutical Manufacturers and Companies leading to a reduction in the cost of drugs and consumables.

Strategic Goal

* + 1. : To ensure that quality medicines, vaccines and other health commodities and technologies are available, affordable and accessible to all Rivers people.

Strategic Objective

* + 1. : To strengthen the availability and use of affordable, accessible and quality medicines, vaccines, health technologies and supplies at all levels.

**Targets**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Targets | Baseline | **2018** | **2019** | **2020** | **2021** | **2022** | **National** |
| Increase local production of quality medicines, vaccines and other commodities from 5% to 40%, | TBD | 0 | 5% | 5% | 10% | 10% | 40% |
| Increase local production of simple active pharmaceutical ingredient to  70% | TBD | 0 | 7% | 8% | 9% | 10% | 70% |
| Proportion of LGAs with functional logistics management coordinating  units increased to 50% | TBD | 10% | 20% | 30% | 40% | 50% | 80% |
| Percentage of health facilities with no stock-out of tracer drugs or vaccines within the last three  months | TBD | 35% | 40% | 50% | 55% | 60% |  |
| Number of LGAs having a medicine  and therapeutic committee at the state and facility levels | TBD | 5% | 10% | 15% | 20% | 25% |  |

Interventions

* + - 1. : Strengthening the development and implementation of legal, regulatory framework, policies and plans for drugs, vaccines, commodities and health technologies at all levels. The Key actions; - Adapt the National Public Health Supply Chain Policy and implement enabling legal and regulatory frameworks, policies, guidelines; Develop & disseminate SOPs for medicines, vaccines, laboratory supplies, equipment and other health commodities; Establish Logistics Management Coordinating Unit (LMCU) in SMOH & RSPHCMB and develop annual work plan and ensure implementation; Set up state Integrated Procurement and Supply Chain Management Technical Working Group (IPSM TWG) for supply chain decisions at the highest level and coordinate the activities; Conduct an integrated State stock status of public health commodities meetings at State and LGA levels.
      2. : Strengthen effective coordination of structures that ensures accessibility of medicines, vaccines, commodities and other technologies at all levels and at all times. The activities include; - Conduct advocacy to governments for the establishment of funding streams and explore PPP and outsourcing to competent companies on appropriate supply chain functions; Hold monthly meetings at State & LG levels for data collection and validation, to ensure quality data that will guide the state in supply planning for health commodities distribution & redistribution; Periodic and random sampling of medicines using true scan machines in the three senatorial zone of the state to ascertain for quality assurance; Conduct quarterly partners forum of all implementing and developing partners in the State; Monitor the Last mile distribution to health facilities (HFs).in the state and reconcile Proof of deliveries (PoDs) with Last Mile Distribution Matrix (LMDs).
      3. : Enhance production and use of locally manufactured medicines and vaccines that meet global standards. The key activities include; - Institutionalize the Systems for Public Private Partnership for Production and Sourcing of Medicines and others Health Commodities and equipment for affordable service delivery to the citizens.
      4. : Strengthen effective procurement systems (forecasting, orders, procurement) to ensure (40% local content) and commodity security for on a sustainable basis at all levels, The activities include; - Review existing procurement system by the Rivers State Procurement Bureau to ensure accelerated procurement of goods, works and services following due process including product dissemination, review and feedback; Conduct workshops to develop Procurement Plan & Budget; Capacity building of all officers responsible for procurement decisions & implementations in the State including forecasting, quantification and usage; Establish/update monthly a database of consumers and clients, consumption patterns and cost implication; Strengthen stores and storage conditions (e.g. power supply, cooling facilities, metal shelves, pallets etc).
      5. : Strengthen integrated supply chain management system and quality assurance models for medicines, vaccines, commodities and other technologies with a functional logistics management information system (LMIS). The key actions include; - Establish Supply Chain coordination structures in line with national policy, guidelines and international best practices; Create and sustain a viable distribution networks which supports effective and efficient systems and ensures timely delivery of supplies; Integrated Supply Chain Management (ISCM) step down training at the State level for Logistics Management Coordinating Unit (LMCU) members; Conduct LMIS Report collection of HIV, TB, Malaria, Reproductive health and Vaccine programs and
      6. - Strengthen rational drug use and antimicrobial stewardship at all levels. The key actions include; - Produce and disseminate standard treatment guidelines (STGs); Provide continuing education to product users (e.g. clinicians, patients, general population, and technicians) on appropriate product use and conduct community sensitization and education especially in rural areas to increase understanding and capacity on product use; Make products available and affordable at the lowest tier of service delivery; Employ, train and deploy staff knowledgeable in appropriate product use; Establish a quality system for pharmacovigilance, that will cover organizational structure, responsibilities, procedures, processes and resources as well as appropriate resource, compliance and record management.
      7. - Strengthen existing systems for the management of biological and non-biological wastes including expiries of medicines, vaccines and other commodities at all levels. The key actions include - Conduct annual quantification of expiries of medicines and other commodities at Health facilities in the State; Implement an effective safe health commodities waste management system in the State; Provision and distribution of sharp boxes and consumables to all Health facilities in the State.
      8. - Strengthen the development of traditional medicine in Rivers State. The key actions include; - Establish a Traditional Medicine Board (TMB) and hold periodic meetings to ensure the implementation of the Traditional Medicine Policy guidelines in the State & LGAs; Conduct advocacy to the government for allocation of adequate funds for the operation of traditional medicine programmes and activities in the State & LGAs; Capacity building for traditional medicine practitioners in the State; Establish a regulatory agency for the registration, regulation, standardization and training with respect to traditional practice; Promote research and development (R&D) of traditional medicine.

Priority Area 12: Health Information System (HIS) Context

The revised HIS policy provides the framework for inter-sectoral, comprehensive and integral structure for collection, collation, analysis, storage, dissemination and use of health and health- related data and information. The development of the HIS Strategic Plan 2014-2018 was guided by the HIS Policy.

The country's Health Information System (HIS) remains weak and fragmented with numerous vertical programmes, which are mostly donor driven. Despite significant past investments aimed at improving the nation's HIS, the sub-sector remains challenged due to duplications and lack of a common investment framework. There are multiplicity of data collection tools and DHIS instances resulting from the use of poorly defined non-standardized indicators. Also, some of the Development Partners and the programmes they support (including programmes within the FMOH) are reluctant to utilize national tools. Routine data completion rate and timeliness is still low at 63%(National DHIS 2016).

Although the private sector provides 60% of healthcare services in the country, there is very limited capture of their data into the HMIS. Other data subsystems perform sub-optimally such as vital statistics, survey and implementation of research for health. Overall, poor data quality still persists at all levels. In addition, there is an absence of a systematic process of routine analysis of submitted HMIS data and feedback to health institutions. This inadequacy has limited the use of HMIS data as a management tool for health planning and improvement of health outcomes. Other challenges include; weak mechanism for coordination of M&E at all levels; poor human resource capacity and lack of material resources especially at the sub-national levels.

Strategic Goal

* + 1. - To institutionalize an integrated and sustainable health information system for decision- making at all levels in Rivers State.

Strategic Objective

* + 1. - To improve the health status of Rivers people through the provision of timely, appropriate and reliable health information services at all levels, for evidenced based decision making.

**Targets**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Targets | Baseline | **2018** | **2019** | **2020** | **2021** | **2022** | **National** |
| % of health facilities (public and private) generating and  transmitting routine HMIS data | 60% | 60 | 65 | 70 | 75 | 80 | 50% |
| % of timeliness, completeness and accuracy of reporting from facilities (reporting rate) for each  LGA/State | TBD | 50 | 55 | 60 | 65 | 70 | 30% |
| % improvement in in data quality using standard DQA  tools | TBD | 25 | 30 | 35 | 40 | 45 | 50% |

Interventions

* + - 1. - Strengthen institutional framework and coordination for HIS at all levels. The key actions include; - Inaugurate a committee to develop the terms of reference (TOR) for the HDGC, review the TOR of the HDCC and disseminate the roles and responsibilities to all stakeholders; Revise/adapt the national policy, guidelines and tools on HMIS; Collaboration with State Bureau of Statistics to utilize annual population figures disaggregated by State, LGA and Ward to encourage evidence- informed planning; Support the broad stakeholder consultative forum on data management and use to ensure cross-institutional relationships that foster sharing of data and knowledge between the different members of the HDGC and HDCC; Support monthly review/coordinating meetings of HMIS and M&E officers.
      2. - Strengthen the capacity to generate, transmit, analyze and utilize routine health data from all the health facilities, including private health facilities. The key activities include; - Review, harmonize, update, print and distribute DHIS indicators and tools, guidelines, SOPs, including ISS and DQA checklist; Develop electronic media for continuous training of HMIS officers and other HIS users and mainstream gender in data generation and analysis (disaggregate data by gender); Print and disseminate widely the 2013 version of the harmonized data collection tools and the national indicator definition/ reference sheets; Training and retraining of HIO's (SMOH & RSPHCMB) across the 23 LGA's on data collection tools and train State HMIS and M&E Officers on the administration of the DHIS; Support Recruitment and deployment of HMIS and M&E officer for health programmes at the state and LGA levels.
      3. - Improve integration of existing surveillance systems and diseases registries into the overall health information system. The key actions include; - Develop and continuously review compendium of all health indicators from all health related programmes in the State; Interoperation/Integration of DHIS2, EMRs and other health systems information sub-systems and disease registers by the development of common data architectures.
      4. - Improve the mechanism of an integrated data repository for data sharing amongst stakeholders at all levels. The key activities include; - Establish and maintain comprehensive, accessible data bank for all health data in the State; Establish multi-sectoral data collaborative forum drawing from all relevant MDAs.
      5. - Strengthen monitoring of the sub-sector performance. The key activities include – Conduct Data Quality Assurance exercises; Conduct regular supportive supervisory visits; Develop a dashboard to monitor data entry and quality of data entered; Institute a mechanism for pooling resources from MDAs and Partners for HMIS activities; Institutionalize performance plan for monitoring the budget allocated and released by MDAs for HMIS activities.

Priority Area 13: Research for Health

Context

Research and Development is the backbone of innovative and sustainable development of the health sector. Research findings enhance evidence-based policy and decision making at all levels of government and ensure more targeted health interventions that have a higher impact on reduction of the State's diseases burden.

There is also an internationally accepted guideline that donor agencies should provide 5% of Aid to research which is not complied with. The overall goal is to ensure that research is informing effective health policy and programming, and contributing to the advancement of global health knowledge.

Strategic Goal

I. To utilize research to inform policy and programming for improved performance of the health sector and better health outcomes; and also contribute to global health knowledge production.

**Strategic Objectives**

**6.13.1 To significantly contribute to the overall improvement of the performance of the Rivers State health system.**

**Targets**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Targets | Baseline | **2018** | **2019** | **2020** | **2021** | **2022** | **National** |
| State has health/ research institution with functional ethics review committees | TBD | 25 | 30 | 40 | 45 | 50 | 100% |
| Percent of health institutions at various levels of government that spend at least 2% of their health budget for research/ State health MDAs and training institutions allocate 2% of their health budget to research | TBD | 1 | 2 | 3 | 4 | 5 | 40% |
| Percent of health research outputs that is responsive/aligned to jointly set national health priorities/agenda. | TBD | 5 | 10 | 15 | 20 | 25 | 50% |

Interventions

* + - 1. Strengthen coordination and regulatory mechanisms for health research and development by all relevant stakeholders, in line with the National Health Act 2014. Key actions include - Strengthen the Research Unit of the Planning, Research, and Statistics Department (SMOH, RSPHCMB & RSHMB) to provide stewardship on research, and harness research findings for decision-making; Strengthen State Health Research Ethics Committee at the RSHMB to coordinate research activities in the state; Adapt National Health Act 2014; Build capacity of all relevant stakeholders on health research; Establish a platform for linking the academia with the health sector, thus linking research to national/state priorities and translating research to action.
      2. Strengthen the development and implementation of the national research agenda. Key actions include; - Develop a State research agenda (including criteria for identifying health research priorities, conduct and dissemination of research findings); Establish a platform for collaborative research; Train researchers to strengthen their competencies on both quantitative and qualitative research approaches; Promote PPP in Research and Development (R&D); Carry out actual studies to determine the costs premiums& capitation rates / willingness and ability to pay etc.
      3. Increase resource mobilization and allocation for research activities at all levels in line with agreed international declarations, especially the Algiers Declaration on Health Research. Key actions include; - Conduct advocacy meetings to policy makers to inform on the Algiers Declaration and solicit their commitment to increase budgetary allocations to research; Ensure Government support for the development of collaborative research proposals and their implementations between governments and public and private health research organisations; Build capacity for resource mobilization for health research (e.g. proposal writing, craftsmanship, fund-raising etc); Build institutional capacities of the research institutes for research.
      4. Strengthen the national health research institutions (the National Institute of Medical Research and the National Institute of Pharmaceutical Research and Development) to contribute to evidence-based decision making and R&D. Key activity include; - Advocate for increased funding for research institutions in the country.
      5. Strengthen institutions and systems at all levels for the promotion, regulation and ethical oversight of essential national health research. Key actions include; - Empower RSHMB to oversee, monitor & review implementation of approved health research on human subjects across all levels; Conduct training for SHREC members; Develop/strengthen infrastructure in health research institutions; Foster strategic partnerships at national and international levels for improved quality health research output.
      6. Enhance strategic partnerships at the State and international levels for the promotion and timely dissemination of research findings. Key actions include; - Conduct meetings for PPP committee to develop Memorandum of Understanding with national and international partners to promote research activities; Map existing and potential health research entities at State level and maintain a database; Conduct sensitization workshops for policy makers, health care providers and other target audiences to share research findings and appraise them on policy and practice implications.
      7. Strengthen the utilization of research findings to inform policy, programming and practice. Key actions include; - Develop communication strategy for dissemination of research findings to different target audiences in the State (e.g. policy makers, politicians, practitioners, consumers, development partners and the general public); Create and support a platform for regular dialogue between researchers and policy makers for evidence-based decisions; Develop a platform to promote commercialization of research findings; Engage media on dissemination of research findings to the public.
      8. Facilitate the development of a repository for the collation and archiving of health-related research findings for improved knowledge management. Key actions include; - Operating cost for engaging and supervising a contractor to establish health research library in the in the state with assess to printed and electronic research materials; Subscribe to relevant national and international health journals; Build capacity of the data managers and web masters on handling and processing of research documents; Create a mechanism for harvesting, collating, documenting and uploading of health researches on the website; Annual subscription for website.

# CHAPTER 7

### STRATEGIC PILLAR FOUR: PROTECTION FROM PUBLIC HEALTH EMERGENCIES AND RISKS

Priority Area 14: Public Health Emergencies: Preparedness and Response Context

The Country has developing systems and institutions for containment of public health emergencies that require strengthening across all tiers of the health care system. The overall goal of the planned interventions is to significantly reduce the incidence and impact of public health emergencies in Rivers State.

Strategic Goal

* 1. Significantly reduce the incidence and impact of public health emergencies.

Strategic Objectives

* + 1. **Reduce incidence and impact of public health emergencies in Rivers State Targets**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Targets | Baseline | **2018** | **2019** | **2020** | **2021** | **2022** | **National** |
| Morbidity and mortality from public health emergencies reduced by 20% | TBD | 10% | 10% | 15% | 20% | 20% | Reduced by 50% of baseline |
| % of all health facilities in the State participate in disease surveillance and reporting using IDSR tools. | TBD | 85% | 87% | 89% | 90% | 93% | At least 50% |
| % of the population covered with surveillance alert systems | TBD | 30% | 40% | 50% | 60% | 70% | At least 75% |
| Proportion of responses to all confirmed epidemics that fall within  the 24 – 48-hour window | TBD | 20% | 30% | 40% | 50% | 60% | Increased to 80% |
| Proportion of road traffic accidents that fall within the 1-hour window  (golden hour). | TBD | 5% | 10% | 15% | 20% | 25% | Increase to 50% |

Interventions

* + - 1. Promote the development and implementation of legal, regulatory framework, policies and plans for emergency preparedness at all levels. Key actions include - Strengthen Epidemic Prepared and Response Committees at state and LGA levels to coordinate rapid response epidemiological services; Conduct continuous advocacy to policy and decision makers for resource mobilization and provision of adequate funding to support Integrated Disease Surveillance and Response (IDSR) activities; Ensure that a legal framework is in place for the compliance with International Health Regulation (IHR); Update IDSR Epidemic Management Protocol and Standard Operating Procedures (SOPs) and make them available to health personnel at all levels; Review laws and policies for outbreak and surveillance activities as it relates to isolation and quarantine.
      2. Promote an integrated national disease surveillance system in line with the International Health Regulation (IHR) and IDSR. Key actions include; -Strengthen the Epidemiology Unit of the SMOH to review all existing IHRs and IDSR protocols and domesticate them to suite the circumstance of the state as well as integrate and harmonize all vertical surveillance systems into IDSR including digitization of the surveillance system; Dissemination of health information at the state level as well as provision of functional communication gadgets to all levels of IDSR system, from the community level for IDRS timely reporting and response; Establish sentinel surveillance sites for active surveillance and more robust analysis for targeted diseases of public health importance, e.g. VHF, cholera, measles, monkey pox; Supervisory visits and distribution of IDSR data tools to strengthen data collection using IDSR tools at all levels of health care and ensure availability of IDSR tools at all health service delivery points at all levels; Conduct sensitization workshops for clinicians and heads of health bodies and the private sector on IDSR to enlist their participation in IDSR implementation (case detection, timely and complete case reporting and appropriate management of cases).
      3. Expand/strengthen a network of public health laboratories in Rivers State. Key actions include; - Adopt standards and guidelines for the operation of the public health labs at all levels, including MoU with network of PHL in the country; Cost for engaging and supervising the contractor to build and equip a standard public health laboratory in the state. Strengthen for confirmation of special pathogens and also act as quality control for State laboratories and Infection Control Practices; Strengthen BMSH Laboratory to handle public health investigations including VHFs; Strengthen the system for sustainable laboratory reagents procurement and supplies including VHF reagent pack for the virology lab.; Establish a system for communication with the LGA and adequate transportation of the samples from health facilities/LGAs to the PHLs.
      4. Scale-up public education and awareness creation on public health emergencies. Key actions include; - Advocacy/sensitization meetings with the Key Stakeholders- NMA, NANNAM, AGPMPN, NLC, MHWU, Pharmaceutical Society of Nigeria, MWAN, Traditional Rulers, Religious leaders, women leaders, Media Executives, (NUJ, NAWOJ, RATTAWU, NOA, Rotary Club, Red Cross, Lions Club, Market Women leaders) on public health emergencies; Design, print and distribute materials on public health emergencies for public education (IEC materials, posters, flyers, jingles etc.); Conduct mass edutainment on Lassa Fever, Dengue fever, cholera, monkey pox and other infectious diseases; Social mobilization activities with OB Vans (rallies, campaigns), Video Shows;
      5. Promote access to comprehensive services for the prevention, treatment and impact mitigation of public health emergencies. Key actions include; – Cost for engaging and supervising the contractor to provide ambulances at the EOC and Infectious Disease Treatment centres; Cost for engaging and supervising the contractor to provide isolation wards or holding areas for infectious patients at all health care facilities; Cost for engaging and supervising the contractor to build quarantine centres for infectious diseases; Cost for engaging and supervising the contractor for equipping of quarantine centres for infectious diseases in the state; Develop/Review a state emergency resilience and response plan for Public Health Emergencies (PHE).
      6. Promote integration of disease surveillance activities at all levels of the health care system. Key actions include; - Integrate all vertical surveillance systems (addressed in 14.1.2); Monitor and evaluate IDSR at all levels and establishment of monitoring protocol.
      7. Build human resource capacity and equitably distribute them for appropriate and optimal response to public health emergencies. Key actions include; - Adapt WHO generic materials/adopt national training materials for disease surveillance, laboratory diagnosis and public health emergencies and response; Training and retraining/deployment of Public health laboratory personnel on response to public health emergencies; Training of clinicians, EHOs and Nurses at all levels to handle infectious diseases; Training of DSNOs, EHOs, CHEWs, SMOs, Media, CBOs NOA, Volunteer Health workers, informants, Ward Health Committees, Traditional Rulers, CDC chairmen, CAN, and Muslim group on response to public health emergencies; Training and retraining of DSNOs and Data management team at state level on use of ICT in IDSR.
      8. Strengthen coordination mechanisms for public health emergencies at all levels. Key actions include; - Develop a road map and commence implementation of Global Health Security Agenda; Cost for engaging and supervising the contractor to renovate and upgrade the Infectious Disease Treatment Centre at Emohua to serve as zonal centre for management of Viral Haemorrhagic Fevers (VHFs); Cost for engaging and supervising the contractor for provision of logistics for emergency response (vehicles, motorcycles, drugs and other materials/consumables - PPEs, Hand gloves- latex and thick rubber, body bags, digital thermometers, Thermoscan, hand sanitizers, bleach, chlorine, coverall, face masks, N95 Respirators, Ribavirin, stationaries etc.) at all health care levels; Conduct periodic meetings for EOC and Emergency Preparedness and Response Committee.
      9. Promote community participation in disease surveillance activities. Key actions include; - Advocacy visits to the gatekeepers (Council Chairmen and Councilors of health, Traditional rulers, CDC chairmen) on community participation in disease surveillance; Sensitization and training meetings with the Community health workers, volunteer health workers, ward health committee, focal persons and informants.; Conduct periodic feedback and review meetings for the DSNOs; also hold integrated review meetings with stakeholders at all health care levels.

# CHAPTER 8

### STRATEGIC PILLAR FIVE: HEALTH FINANCING

Priority Area 15: Health Financing Context

Health financing is the foundation of the health care system. The availability and quality of health care services are contingent on adequate funding. Optimal utilization of the health care services is influenced by the financing mechanism put in place that removes financial barriers to access. The low demand for health care services in Rivers State leading to poor health outcomes is not only due to poor health care seeking behavior but also, unaffordability of the services.

Government's prioritization of health care is seen from the amount it spends on health relative to its overall expenditure outlay. According to the USAID Health Finance and Governance (HFG) Project survey the general government expenditure on health in Rivers State as a proportion of total government expenditure was estimated at 6.5% in 2015. This represents only a 0.5% increment from its value in 2014. Although there has been an increment in the share of general government expenditure to health, this is far below the Abuja Declaration target of 15% (Organization of African Unity, 2001).The country’s out-of-pocket expenditure on health remains high. Overall, out-of- pocket expenditure (OOPE), as a proportion of total health expenditure is high, ranging from 78% in 2010 to 73% in 2014 (Federal Ministry of Health, 2017) while for Rivers State its 94.6% in 2016. The high level in OOPE poses a barrier to accessing health services, thereby fueling inequity in health outcomes and further exposing the already poor to impoverishment and financial catastrophe and only 1.7% of the Rivers State population is covered by any form of health insurance.

Strategic Goal

* + 1. Ensure all residents of Rivers State have access to health services without any financial barriers or impediments at the point of accessing care.

Strategic Objectives

* + 1. **Strengthened Governance and Coordination for actualizing stewardship and ownership of Health Financing reforms**

**Targets**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Targets | Baseline | **2018** | **2019** | **2020** | **2021** | **2022** | **National** |
| State with approved health financing policy and strategy | 0 | 5% | 10% | 20% | 30% | 40% | 70% |
| SMOH with institutionalized routine SHA | 0 | 5% | 10% | 20% | 25% | 30% | 70% |

Interventions

* + - 1. Strengthen Health Financing Equity and Investment Units in the State. Key actions include; - Inaugurate & train Technical Working Group (TWG) members on the Health Care Financing Reforms; Conduct advocacy to the Commissioner & Permanent Secretary MOH on State Health Insurance and the need for creating Health Financing Equity & Investment Unit (HFU) as recommended by the FMOH; Cost for engaging and supervising the contractor to equip Health Financing Equity & Investment Unit to analyse equity and efficiency of different healthcare financing mechanisms; Train & re-train of personnel on current Health Care Financing (HCF) reforms; Operational cost for engaging and supervising the contractor to provide vehicles for the operations of the unit.
      2. Strengthen Coordination Frameworks and TWGs for health financing in the State. Key actions include; - Empower Technical Working Group (TWG) to hold periodic meetings; Advocate for the implementation of Health Financing Equity framework/guidelines at all levels and MDAs; Support the design and development of HCF implementation strategies; Conduct capacity building workshops for TWG members.
      3. Develop Health Financing Policy & Strategy and Investment case in the State. Key actions include; -Adopt Health Financing (HF) Policy document in the state; Organise workshops to develop Health Financing & Strategy and Investment case; Print & disseminate copies of the Health Financing & Strategy and Investment case in the State & LGAs; Advocate for favourable fiscal policies (e.g. tariffs for importation of drugs, free health services, customs clearance etc.); Strengthening drug revolving funds (DRF) at all levels.
      4. Establish systems for health financing evidence generation and management in the State. Key actions include; - Establish/strengthen institutional capacity for integrated financial management system development for all health financing functions (resource mobilization, pooling and purchase of services); Establish mechanisms for fostering inter-sectorial collaborations, public-private partnerships, and collaboration with community members, CSOs, and Development Partners to ensure improvement and coordination of health financing functions; Update information system for resource mapping for revenue generation; Develop tools for collecting, analysing & dissemination of HF data; Establish a platform RIVCHPP and PHCMB.
    1. Increase sustainable and predictable revenue for health Targets

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Targets | Baseline | **2018** | **2019** | **2020** | **2021** | **2022** | **National** |
| % Budgetary allocation to Primary Health Care increased  from 3% to 20% | TBD | 3% | 5% | 10% | 15% | 20% | 35% |

***I*nterventions**

**8.15.2.1** Alignment of health allocations to national priorities. Key activities include;- Advocacy to the Governor for allocation of at least 15% of State and LGAs budgets to health in compliance with Abuja declaration; Include state health priorities into MTEF and align all LGAs, MDAs and donors to it; Conduct evidence-based advocacy to increase domestic revenue for health using innovative financing strategies.

* + - 1. Advocate for increase in government annual budget and spending on health. Key actions include; - Conduct advocacy to the Government at all levels (State and Local Government) to make financial provisions for poor and vulnerable groups in the form of direct payments, subsidies, paying for insurance contributions or any other methods. Make special provision for diseases of public health significance such as Malaria, HIV/AIDS, TB, Leprosy, Monkey pox, vaccine preventable diseases and others; Develop and implement advocacy strategy for increased and timely release of health budgets; Support health advocacy committee to advocate for increase in health budget, timely budgetary releases and adequate expenditure tracking.
      2. Strengthen legal and coordinating framework for PPP at the State levels. Key actions include; - Review and domesticate Legal & Coordinating framework for PPP for the State; Conduct periodic trainings for PPP committee for update in PPP policy changes; Produce copies of Rivers State Legal Framework & disseminate to all stakeholders in Public and Private sectors; Advocate for PPP legal backing in health Agencies laws and implementation of PPP policy at all levels.
      3. Develop and implement resource mobilization strategy and guideline including Sin Taxes, Telecom Taxes, VAT, Aviation Taxes, etc. Key actions include; - Develop resource mobilization strategies and guidelines; Engage telecommunication companies for telecom tax; Advocacy to Board of Internal Revenue service (BIR) for establishment of SIN, Telecom, VAT, Aviation Taxes; Engage BIR for tax reform review and audits.
    1. Enhance financial risk protection through pooled funds at federal and state levels

**Targets**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Targets | Baseline | **2018** | **2019** | **2020** | **2021** | **2022** | **National** |
| Increased % of Rivers State population covered by any risk  protection mechanism increased to 20% | TBD | 2% | 5% | 10% | 15% | 20% | 30% |

**Interventions**

* + - 1. Engage Stakeholders to increase enrolment and contribution to Health Insurance. Key actions include; - Commission Third Party Associators (TPAs) to register and enroll beneficiaries; Conduct sensitization workshops for engaging employers of labour to key into health insurance for their employees; Engage philanthropists and community influencers to enroll community members and support vulnerable groups; Engage the media in promoting health insurance as well as produce and disseminate IEC materials on health Insurance; Engage communities and NGOs on financial risk protection benefit of Health insurance.
      2. Strengthen Laws and regulations for the implementation of the State health Insurance Scheme. Key actions include; - Advocacy to the Executive Governor/ House of Assembly to facilitate passage of Rivers State Contributory Health Protection Programme (RIVCHPP) bill; Develop memos for public hearing of the RIVCHPP bill; Development of Basic Minimum Benefit Package (BMHP), operational guidelines and SOPs; Develop Framework for consolidation of fund pools at state levels; Conduct advocacy for laws to establish/enforce SHIS and scale up Community Health Insurance Scheme in Primary/Secondary Health Facilities across the State.
      3. Strengthen technical capacity of health personnel on health insurance and contributory schemes. Key actions include; - Training of staff on basic Health Insurance strategies and principle; Routine training & re-training of health human resources in private and public health facilities.
      4. Establish and expand Mandatory State Health Insurance and contributory Schemes in the State. Key actions include; - Establish an Agency for RIVCHPP/Deploy relevant qualified staff to occupy the offices in the established agency; Establish 23 LGA desk offices and appoint desk officers; Training and retraining of desk officers; Review all existing programmes in the states with the aim of integrating them into a single pool; Engage NHIS, to decide on how to collapse schemes into one single pool.
    1. Enhance transparency and accountability in strategic purchasing of Health Services

**Targets**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Targets | Baseline | **2018** | **2019** | **2020** | **2021** | **2022** | **National** |
| No of LGAs with functional health insurance/ contributory schemes | TBD | 5% | 10% | 15% | 20% | 25% |  |
| % of health facilities operating any form of Results Based Financing  (RBF) | TBD | 5% | 10% | 15% | 20% | 25% | 30% |

**Interventions**

* + - 1. Review Provider Payment Mechanisms in the Rivers State health sector to focus on PPM. Key actions include; - Conduct workshops to develop Provider Payment Mechanism (PPM); Conduct workshop to validate the PPM; Print and disseminate to stakeholders the developed PPM.
      2. Develop Framework for competition between public and private sector providers in the allocation of new resources for healthcare. Key actions include; - Develop a framework for competition between public and private sector providers; Develop/publish a financial health bulletin for feedback/disseminate to eligible public and private providers; Regular monitoring of adherence to SOPs for Service delivery; Empowerment/provision of incentives to enhance performance.
      3. Institutionalize routine NHA and expenditure tracking mechanisms at the State and LGA levels. Key action includes; - Conduct periodic health expenditure resource tracking; Conduct Household Surveys; Institutionalize annual SHA; Conduct Annual State Health Account data collection in accordance with the establish sub National health Account guidelines and disseminate to stakeholders; Monitor budget execution.
      4. Institute Public Finance Management (PFM) reforms at the State and LGA levels. Key action include; - Establish financial management systems; Engage stakeholders on public finance management reforms; Train accounting staff on financial management and International Public Sector Accounting Standard (IPSAS) system of accounting; Conduct financial Audit of all health facilities.

# CHAPTER 9

### RESOURCE REQUIREMENTS

* 1. Human

Currently, the State has the following manpower in the tertiary, secondary and primary levels of health care service delivery who are trained with skills needed to function in their various capacities; Doctors, Nurses, Pharmacists etc. (Table 3).

The categories of workers are as follows:

* + 1. The professionals such as doctors, nurses, pharmacists / technicians / assistants, radiologists /radiographers /X-ray technicians, dentists / technicians / assistants, nutritionists (dieticians)
    2. Management personnel such as administrators, planning officers
    3. Community health workers
    4. Clerical officers
    5. Ancillary personnel
    6. Traditional practitioners

The professional are usually officers with urban background and have had high formal education, while the community health workers are usually officers with rural background with minimum education. These workers enumerated above have had basic education in their respective professions and therefore are equipped with the basic skills required to execute their functions. But with the ever-increasing demand for health care and introduction of new technology in the system, the skills acquired become inadequate or obsolete rendering them ineffective and unproductive. The adverse effect of this is deterioration in the provision of health care to the citizenry, which leads to increase in mortality and morbidity rates in the State.

* 1. Physical/Materials

There are currently 408 public health facilities in Rivers State that are distributed in the 23 LGAs made up as follows; 5 Tertiary, 18 functional Secondary health facilities and 385 Public Primary health facilities. There are also numerous private health facilities with majority located in Port Harcourt. There are over 1000 private health care facilities in Rivers State but only 147 of them are registered with the SMOH (DHIS 2).

The material resource needs include upgrades and refurbished health facilities in the State to meet the expectations of the populace. However, infrastructural developments that have attracted the attention of the government include; the Construction of four (4) Zonal Hospitals, Renovation of 13 General Hospitals, Construction of Doctors Quarters at RSUTH, Construction of Mother and Child Hospital, the purchase of Gene Xpert Assay for diagnosis of Tuberculosis, PCR Machine for viral Load Count for HIV for RSUTH and presently operational.

* 1. Financial

The sources of funding for the healthcare delivery include;

Federal Government of Nigeria

Rivers State Government

LGA

Social contribution for Health insurance

Development partners, include:

* The World Bank
* World Health Organization (WHO)
* Family Health International (FHI360) a National and International USAIDs funded project in collaboration with SIDHAS and Deloitte Consortium work in the area of Health Systems Strengthening and Organizational Capacity Development including HIV/AIDS, and PMTCT services.
* Society for Family Health (SFH) a National NGO with funding from USAID, focuses on Female Sex Workers (FSWs) Brothel based and Non-Brothel based, Intravenous Drug Users (IDUs).
* Heathland Alliance International (HAI) focuses on Men Who Have Sex with Men (MSM) and FSWs.
* Association for Reproductive and Family Health (ARFH) also a USAID funded project concentrates on Orphan and Vulnerable Children (OVC). This organization works with identified Community Based Organization (CBOs) in the state.
* Health Strategy and Delivery Foundation (HSDF) supports Early Infant Diagnosis (EID) services a subset of PMTCT.
* USAID/Health Finance and Governance (HFG), funded by DFID focuses on strengthening systems and providing technical assistance in Domestic Resource Mobilization for Sustainability of Health sector response.
* Civil Society Coordination in the form of Constituent Coordinating Entities (CCEs) which includes Civil Society Network for HIV and AIDS in Nigeria (CiSHAN) and Network of People Living with HIV/AIDS (NEPWHAN), Association of Positive Youths in Nigeria (APYIN), Association of Positive Women in Nigeria (ASWAN).
* United Nations International Children Education Fund (UNICEF) also a USAID driven organization responsible for neonatal, children and maternal health.
* European Union-Sign supporting immunization in the LGAs
* Africare, supporting malaria elimination in the state funded by world bank
* National Primary Health Care Development Agency
* Intra Health funded USAID to register health work force in the state
* Clinton Health Access Initiative (CHAI) are into HIVAIDS and Health Financing,
* Global Fund Round 9, funded by USAIDs to combat HIVAIDS

Others are NDDC, AGIP, Shell Petroleum, Non- Governmental Organizations.

# CHAPTER 10

### FINANCING PLAN

* 1. Introduction to the SSHDP Costing

Rivers State SHDP II cost estimates and resources available for its implementation are both vital preconditions to ensure realistic levels of ambition for the strategy. This will leverage the prioritization of planned investments and the design of appropriate measures to finance the emerging resource gaps. This section outlines the methodology used in costing the Rivers State SHDP II (2018-2022), and the estimates of available resource commitments within the State over the strategy period. With both the Total Cost of the Plan and resource commitments estimated; recommendations have also been presented to bridge the emerging financing gap in the strategy

* 1. SSHDP Costing Methodology

Cost estimates of the Rivers SSHDP II (2018-2022), has been determined using the One Health tool, a unified costing template that estimates the overall cost of delivering the package of health services identified in the strategy. The total cost of the strategy presented in this section takes into consideration the cost of programme management activities to be carried out and the health system inputs required to be in place to achieve the desired coverage targets and impact goals.

The Rivers SSHDP II (2018-2022) costing exercise is the result of a consultative and iterative process of data collection, targets setting and quality assurance to ensure alignment with Government's health policy thrust and accuracy of estimates. The costing process entailed the following steps:

* + 1. Inauguration of the core group/Technical Working Group (TWG);
    2. Orientation/capacity building of State planning team on the costing methodology;
    3. Collection of high Impact interventions coverage baselines and System inputs required for calibrating the One Health tool;
    4. Development of strategies and costing of key actions and;
    5. The modeling of the costing and impact facilitated by the Zonal Costing Consultant with the OHT.

In addition to the Total Cost of the strategy, impact estimates are presented for different cost scenarios in this chapter. Three policy scenarios have been modelled for costs and impact to guide stakeholders in arriving at the more cost-effective investment pathway for improving the health status of the State, within limits of available resources. While a more detailed description of each of the three scenarios is discussed in the next section, other assumptions considered in arriving at the total Cost of the National Strategy include the following:

The population estimate for the three scenarios was based on NpopC projections, and

currency rate is set at N305/US$. 2016 was adopted as the base year, in accordance with the national council of health (NCH) resolution stipulating 2018-2022 as the duration of the plan.

Baseline mortality ratios for maternal, neo-natal and under-five were obtained from DHS2013, MCIS 2015 and UNDP/NBS published 2014 HDI reports.

Apparently, many of the health service coverage baselines were not provided for 2016. To address this gaps survey data from MICS 2015 and DHS 2013 were applied. For MNCH data gap not found in the references listed above, studies on the relationship between coverage of skilled birth attended deliveries and other childbirth interventions guided the estimation of some of the missing MNCH baselines.

Similarly, with the coverage baselines of the SSHDP II scenarios derived mainly from population-based surveys such as DHS 2013 and MICS 2015, it is assumed that SSHDP II services modeled with these baselines address health services delivered at both public and private facilities.

Baseline estimates for Health Infrastructure were calculated using the inputs submitted by the Department of Planning, Research and Statistics of the Ministry of Health.

Costs for medicine and supply management was yet another category affected by the

paucity of data at all levels. While the unit costs of each medicine and supply was obtained from global price lists, in-country investments required for warehousing, handling, and last mile distribution to the points of care, was determined through historical estimates and expert opinion. As recommended by in-country experts, the cost of warehousing, handling, and distribution was set at 30% of the total amount allocated to Procurement and Supply Management.

HR costs were based on State Specific HR data, especially for the baseline scenario.

However, existing capacities skilled staff (i.e., Doctors, Nurses, and Midwives) were scaled- up to meet the demand of the Scaled SSHDP II scenarios. This HSS investment is crucial for delivering the health service targets of the strategy, particularly as the projections for staffing was not provided.

As part of the SSHDP II governance activities, allocations were provided to strengthen

private sector involvement; these funds were to cater for effective regulations and capacitation of care providers, for improved quality and collection of service data.

Government estimates for the resource analysis were derived from the 2017 budget and

projected using population growth while partners funds were collected using the resource mapping tool.

For many of the Programs, SSHDP II is expected to guide the development of their Strategy,

i.e., Immunization. However, for the Programs with existing country strategies such as RMNCAH, Family Planning and HIV, efforts were made to align the intervention targets of SSHDP II with those of the country strategy.

Although measures were put in place to mitigate the effects of the challenges encountered during

the costing process, it is noteworthy to highlight some of these setbacks as the Rivers SSHDP II cost outputs are interpreted. Across the required inputs data for costing, access to community and health facility information top the list of challenges, as-well-as the paucity of HSS information to guide the scenario modeling process. Others have been listed below:

* The dearth of service coverage baselines across many of the health program areas, particularly NCD, NTD, and TB. Using expert opinion, service coverage for these interventions were set at 10% for the base year.

Treatment inputs required for estimating intervention cost for the plan was not provided for 22%

of the SSHDP II interventions modelled. All attempts by the costing team to assess this information was unsuccessful within the planning period.

* As for Health System cost inputs, information provided for HR, Logistic and Infrastructure were insufficient. While some inputs were provided for Infrastructure and HR, no information was provided for the management and distribution of medicine and supplies. Logistics was estimated as a share of the total cost of Medical commodity procurement and Distribution.
* Similarly, access to State-specific unit cost for building and equipping of health facilities (primary, secondary and tertiary) was challenging. This gap was addressed using harmonized estimates across states.
* Accessing data on resource commitments from development partners for financial sustain ability analysis was very challenging; no data on dev. partners' financial commitments was provided.
  1. Costing Scenarios and Assumptions for SSHDP II

Impact and cost estimates for the Rivers State SHDP II was modeled for the period 2018-2022. This target was derived from the State's model towards the attainment of the global mortality targets for Maternal, New-born, and Under-five by 2030. With the 2022 mortality ratio agreed upon, coverage parameters for high impact health services were iteratively scaled until the desired targets to yield the mortality ratios were achieved. Guided by this approach, three SHDP II Policy Scenarios have been modeled in response to the high causes of mortality for the State. The three scenarios proposed to estimate the cost of the strategic plan are as follows:

Baseline – with no coverage scale up and no significant change in HSS investment across the horizon of the plan.

Essential Service Moderate Scenario – scale-up of essential services and HSS investments required for implementation of the Primary Health Revitalization Agenda.

Essential Service Aggressive Scenario – scale-up of Health Service and HSS investments aimed at achieving universal health coverage while implementing components of the primary health care revitalization agenda contained in the Moderate Scenario.

Overview of Baseline Scenario

Rivers State SHDP II baseline scenario is one of the three policy scenarios modelled for the state health sector strategy. For this scenario, Service coverage between the base and target year remained unchanged across all health service areas. Consequently, targets for MMR, NMR, and U- 5MR remained unchanged over the horizon of the strategy. Although the coverage profile for this scenario was modeled as “baseline,” measures were put in place to sustain the quality of existing health services. Some of which include allocation of fund for programme management activities aimed at sustaining the quality of services provided. Investment in HSS was limited to routine current expenditure. For infrastructure, allocations were provided to maintain office buildings and health facilities. While for HR, key staff added to maintain the same quality of service are; Medical Doctors-138%, Nurses-921%, and Midwives-100%.

Overview of Essential Service Moderate Scenario

Rivers State Essential Service moderate scenario is one of the two scaled scenarios aimed at implementing Government's primary health revitalization agenda. By increasing access to the package of essential services at this level of care, this policy scenario targets the reduction of mortality outcome. For this policy scenario, a year-on-year exponential interpolate profile has been proposed, while the baseline coverage for health services were increased by a mean value of 17.5%. Some of the Programme and interventions scaled as part of this scenario include but not limited to the following; Maternal & child health- Anti-Natal Care Services, Skilled Delivery including EmOC Services, Immunization, Malaria- Prevention and Case Management, Nutrition-MAM and SAM, NCDs, Mental health, and NTDs.

Of the 289 interventions modeled for this scenario, a different policy assumption was adopted

for two – Family Planning-CPR and HIV-ART treatment. For CPR, target was scaled by 7.5%, while HIV- ART coverage treatment for both Male and Female was scaled to 90%. CPR was scaled based on historical trends while HIV treatment scale-up was guided by the recently adopted 90-90-90 policy. For HSS, investments have been planned to increase access to primary health care and to improve the existing PHC facilities. Referral systems have equally been targeted for strengthening. With a 17.5% average increase in service coverage, sufficient allocation was provided to address the associated health system's demands. Skilled provider density has been scaled-up to meet the demands for frontline health workers. The number of additional key health providers required for this scenario include Medical Doctors-138%, Nurses- 921%, and Midwives-100%. Other assumptions upon which the moderate scenario was modeled

include the attainment of the Family Planning Modern method mix of 79% from a baseline 61.1%.

With the investment proposed for this scenario, the following mortality outcomes are anticipated.

MMR reduction from 576/100,000 to 498/100,000 Live Birth representing a 14% reduction towards the attainment of global target,

NMR reduction from 27/1,000 to 25/1,000 Live Birth representing a 7% reduction towards the attainment of global target,

U-5MR reduction from 58/1,000 to 47/1,000 Live Birth representing a 19% reduction towards the attainment of global target.

Overview of Essential Service Aggressive Scenario

Rivers State Essential Service Aggressive Scenario is the third policy scenario modelled for SSHDP II. In this instance, the coverage of essential services has been scaled optimally towards the attainment of Universal Health Coverage while implementing components of the primary health revitalization agenda modelled in the moderate scenario. A year-on-year front loaded interpolate profile was implemented to arrive at 30% coverage increase across interventions for this scenario. Examples of Programme and Interventions modelled for the aggressive scenario include; Maternal & child health- Anti-Natal Care Services, Skilled Delivery including EmOC Services, Immunization, Malaria- Prevention and Case Management, Nutrition-MAM and SAM, NCDs, Mental health, and NTDs. Unlike the moderate scenario, Family Planning-CPR coverage was increased by 10%, which is 2.5% more than the estimates of moderate scenario. More so, the HSS investment proposed for Aggressive scenario cuts across all the three levels of care: Primary, Secondary and Tertiary levels of Care. To this end, human resource and infrastructure capacities were scaled to accommodate the HSS requirements for service delivery.

Specifically, for HR, frontline health workers were scaled as followed Medical Doctor- 168%, Nurses-1219%, and Midwives-100% to guarantee skilled staff adequacy, while additional 7%- health facilities were planned to cater for the increased volume of in-patient days and Out-patient visits associated with this policy profile. As programme management investments the following activities were planned; in-service refresher training, supportive supervisory visits, data collection and coordination meeting, etc., to ensure optimal quality in service provision. Funds were allocated to strengthen the referral systems including the capacity of the secondary and tertiary health to support referral process. It is premised on these assumptions, that the Aggressive scenario has been modelled to achieve the following mortality outcomes.

* MMR reduction from 576/100,000 to 462/100,000 Live Birth representing a 20% reduction towards the attainment of global target
* NMR reduction from 27/1,000 to 24/1,000 Live Birth representing a 11% reduction towards the attainment of global target
* U-5MR reduction from 58/1,000 to 42/1,000 Live Birth representing a 26% reduction towards the attainment of global target.
  1. Costs and Impact of Scaling-up

The Rivers SHDP II 2018-2022 was estimated at a total cost of ? 282.686b, ? 220.189b and ? 150.655b across the three scenarios; Essential Package Aggressive Scale-up, Essential Package Moderate Scale-up Scenario and Baseline respectively over the five-year period of the plan. With the mean cost per capita for each scenario estimated at $ 40, $ 31 and $ 22 for Essential Package Aggressive Scale-up, Essential Package Moderate Scale-up Scenario and Baseline respectively. See table 7 below.

***Table 7: Total Cost of Rivers SSHDP II 2018-2022by Scenarios, in Million (*? *)***

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Total Cost of Rivers SSHDP II 2017 -2021 by Scenarios, in Million (**?** ) | | | | | | | **Mean Cost Per Capita** |
| **SSHDP II**  **Policy Scenarios** | **2018** | **2019** | **2020** | **2021** | **2022** | **TOTAL** |
| SSHDP II  Essential Package Aggressive Scale-up  Scenario | **?**  **42,343M** | **?**  **52,780M** | **?**  **57,402M** | **?**  **62,868M** | **?**  **67,291M** | **?**  **282,686M** | **$ 41** |
| SSHDP II  Essential Package Moderate Scale-up  Scenario | **?**  **33,573M** | **?**  **38,628M** | **?**  **44,542M** | **?**  **49,328M** | **?**  **54,118M** | **?**  **220,189M** | **$ 32** |
| SSHDP II  Baseline Scenario | **?**  **29,541M** | **?**  **29,541M** | **?**  **30,741M** | **?**  **30,496M** | **?**  **30,372M** | **? 150,655M** | **$ 22** |

* + 1. **SSHDP II Essential Package Moderate Scale-up Scenario cost outputs**

***Table 8: Summary costs by Programme area of Rivers SSHDP II 2018-2022 Essential Package Moderate Scale-up Scenario, in Million (*? *)***

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Summary costs by Programme area of Rivers S SHDP II 2018 - 2022 Essential**  **Package Moderate Scale - up Scenario, in Million (? )** | | | | | | | | **% of**  **Total Cost** |
| **SHDP II 2017 -**  **2021**  **Programme Areas** | **201 8** | | **201 9** | **2020** | **202 1** | **202 2** | **Total** |
| **Maternal/newborn and reproductive**  **health** | | ? 903M | ? 918M | ? 926M | ? 938M | ? 948M | ? 4,632M | **21.0%** |
| **Child health** | | ? 593M | ? 613M | ? 629M | ? 642M | ? 649M | ? 3,127M | **14.2%** |
| **Immunization** | | ? 123M | ? 139M | ? 155M | ? 170M | ? 184M | ? 769M | **3.5%** |
| **Malaria** | | ? 162M | ? 140M | ? 241M | ? 215M | ? 195M | ? 951M | **4.3%** |
| **TB** | | ? 476M | ? 616M | ? 752M | ? 891M | ? 1,028M | ? 3,762M | **17.1%** |
| **HIV/AIDS** | | ? 355M | ? 402M | ? 446M | ? 489M | ? 529M | ? 2,221M | **10.1%** |
| **Nutrition** | | ? 179M | ? 230M | ? 279M | ? 328M | ? 375M | ? 1,391M | **6.3%** |
| **WASH** | | ? 52M | ? 64M | ? 70M | ? 78M | ? 85M | ? 349M | **1.6%** |
| **Non-**  **communicable diseases** | | ? 385M | ? 552M | ? 724M | ? 907M | ? 1,100M | ? 3,668M | **16.7%** |
| **Mental,**  **neurological, and substance use**  **disorders** | | ? 49M | ? 61M | ? 73M | ? 85M | ? 98M | ? 367M | **1.7%** |
| **Adolescent**  **health** | | ? 78M | ? 114M | ? 146M | ? 178M | ? 209M | ? 724M | **3.3%** |
| **Neglected**  **tropical diseases** | | ? 1M | ? 2M | ? 2M | ? 2M | ? 2M | ? 9M | **0.0%** |
| **Health**  **Promotions and Social Determinant** | | ? 0.20M | ? 7M | ? 7M | ? 7M | ? 7M | ? 27M | **0.1%** |
| **General and Emergency**  **Hospital Services** | | ? 0.70M | ? 5M | ? 5M | ? 4M | ? 4M | ? 19M | **0.1%** |
| **Public Health**  **Emergencies,**  **Preparedness and Response** | | ? 0.1M | ? 0.4M | ? 0.3M | ? 0.4M | ? 0.3M | ? 1.5M | **0.0%** |
| **SHDP II Total Cost** | | **?**  **33,573M** | **?**  **38,628M** | **?**  **44,542M** | **?**  **49,328M** | **? 54,118M** | **?**  **220,189M** |  |

***Table 9: Summary costs of Rivers SSHDP II 2018-2022 Essential Package Moderate Scale-up Scenario, in Million (N)***

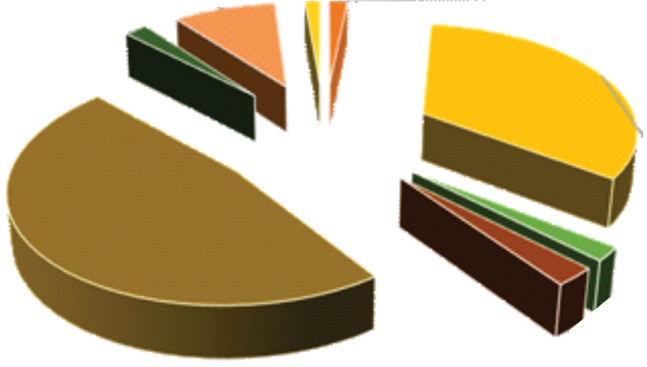
|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Summary costs of Rivers SSHDP II 201 Scenario, in Million (? )** | | | | **8- 202 2 Essential Package Moderate Scale - up** | | | | | | | **% of Total Cost** |
| **HSS Cost**  **Categories** | **201 8** | | **201 9** | | **2020** | | **202 1** | **202 2** | **Total** | |
| **Programme**  **Activity Costs** | ? | 359M | ? | 679M | ? | 626M | ? 632M | ? 627M | ? | 2,923M | **1.3%** |
| **Human Resources** | ? | 13,525M | ? | 14,856M | ? | 16,174M | ?  17,651M | ?  19,088M | ? | 81,294M | **36.9%** |
| **Infrastructure** | ? | 753M | ? | 753M | ? | 752M | ? 752M | ? 753M | ? | 3,764M | **1.7%** |
| **Logistics** | ? | 5,658M | ? | 6,675M | ? | 8,080M | ? 9,069M | ?  10,078M | ? | 39,560M | **18.0%** |
| **Medicines,**  **commodities, and supplies** | ? | 13,180M | ? | 15,507M | ? | 18,798M | ?  21,108M | ?  23,464M | ? | 92,057M | **41.8%** |
| **Health**  **Financing** | ? | 1M | ? | 26M | ? | 18M | ? 18M | ? 16M | ? | 79M | **0.0%** |
| **Health**  **Information Systems** | ? | 43M | ? | 43M | ? 36M | | ? 36M | ? 36M | ? | 194M | **0.1%** |
| **Governance** | ? | 54M | ? | 88M | ? | 58M | ? 61M | ? 56M | ? | 318M | **0.1%** |
| **SHDP II Total Cost** | **?** | **33,573M** | **?** | **38,628M** | **?** | **44,542M** | **?**  **49,328M** | **?**  **54,118M** | **?**  **220,189M** | |  |

***Figure 2: Distribution of Program Activity Cost for Rivers S SHDP II 2018 -2022 Essential Service Moderate Scenario***

###### Distribution of program Activity Cost for Rivers SHDP II 2017.

**2021 Essential Moderate Scenario**

**General Programme Management 9.1%**



**1.3% of SSHDP II**

**Total Cost**

**Advocacy, 2.1%**

**Communication, Media & Outreach, 47.4%**

**Items<1% of Total Cost, 1.4%**

**Programme-Specific Human Resources, 1.6%**

**Training, 33.6%**

**Monitoring and Evaluation, 2.0%**

**Transport, 2.7%**

* + 1. **N/SHDP II Essential Package Aggressive Scale-up Scenario cost outputs**

***Table 10 : Summary costs by Programme area of Rivers SHDP II 2018-2022 Essential Package Aggressive Scale-up Scenario, in Million(*? *)***

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Summary costs by Programme area of RIVERS SSHDP II 2018-2022**  **Essential Package Aggressive Scale-up Scenario, in Million (? )** | | | | | | | **% of**  **Total Cost** |
| **SHDP II 2017 -**  **2021**  **Programme Areas** | **2018** | **2019** | **2020** | **2021** | **2022** | **Total** |
| **Maternal/newborn and reproductive**  **health** | **?**  8,980M | **?**  9,776M | **?**  9,268M | **?**  9,547M | **?**  9,732M | **?**  47,303M | **16.7%** |
| **Child health** | **?**  7,023M | **?**  7,687M | **?**  7,591M | **?**  7,901M | **?**  8,094M | **?**  38,296M | **13.5%** |
| **Immunization** | **?**  1,449M | **?**  1,700M | **?**  1,873M | **?**  2,020M | **?**  2,138M | ? 9,179M | **3.2%** |
| **Malaria** | **?**  1,847M | **?**  1,719M | **?**  2,745M | **?**  2,600M | **?**  2,395M | **?**  11,306M | **4.0%** |
| **TB** | **?**  7,244M | **?**  9,838M | **?**  10,988M | **?**  12,358M | **?**  13,459M | **?**  53,887M | **19.1%** |
| **HIV/AIDS** | **?**  3,893M | **?**  4,646M | **?**  5,050M | **?**  5,504M | **?**  5,856M | **?**  24,949M | **8.8%** |
| **Nutrition** | **?**  2,604M | **?**  3,591M | **?**  3,962M | **?**  4,471M | **?**  4,861M | **?**  19,489M | **6.9%** |
| **WASH** | ? 583M | ? 818M | ? 857M | ? 968M | ?  1,062M | ? 4,288M | **1.5%** |
| **Non-**  **communicable diseases** | **?**  6,451M | **?**  9,572M | **?**  11,107M | **?**  13,067M | **?**  14,832M | **?**  55,028M | **19.5%** |
| **Mental, neurological, and substance**  **use disorders** | ? 675M | ? 932M | **?**  1,070M | **?**  1,218M | **?**  1,377M | ? 5,271M | **1.9%** |
| **Adolescent health** | **?**  1,555M | **?**  2,266M | **?**  2,660M | **?**  2,989M | **?**  3,258M | **?**  12,728M | **4.5%** |
| **Neglected**  **tropical diseases** | ? 26M | ? 34M | ? 34M | ? 34M | ? 34M | ? 160M | **0.1%** |
| **Health Promotions and**  **Social Determinant** | ? 3M | ? 104M | ? 107M | ? 107M | ? 107M | ? 428M | **0.2%** |
| **General And**  **Emergency Hospital Services** | ? 10M | ? 91M | ? 86M | ? 78M | ? 81M | ? 346M | **0.1%** |
| **Public Health Emergencies,**  **Preparedness and Response** | ? 1M | ? 7M | ? 5M | ? 7M | ? 6M | ? 27M | **0.0%** |
| **SHDP II Total Cost** | **?**  **42,343M** | **?**  **52,780M** | **?**  **57,402M** | **?**  **62,868M** | **?**  **67,291M** | **?**  **282,686M** |  |

***Table 11: Summary costs of Rivers SHDP II 2018-2022 Essential Package Aggressive Scale- up Scenario, in Million (?)***

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Summary costs of Rivers SSHDP II 201 8- 202 2 Essential Package Aggressive Scale - up Scenario, in Million(? )** | | | | | | | **% of Total Cost** |
| **HSS Cost**  **Categories** | **201 8** | **201 9** | **2020** | **202 1** | **202 2** | **Total** |
| **Programme Activity Costs** | ? 652M | ?  1,196M | ?  1,088M | ?  1,079M | ?  1,084M | ? 5,099M | **1.8%** |
| **Human Resources** | ?  15,687M | ?  17,521M | ?  19,242M | ?  20,625M | ?  21,920M | ?  94,996M | **33.6%** |
| **Infrastructure** | ? 769M | ?  3,169M | ? 767M | ?  1,503M | ?  1,868M | ? 8,077M | **2.9%** |
| **Logistics** | ?  7,533M | ?  9,228M | ?  10,869M | ?  11,874M | ?  12,705M | ?  52,210M | **18.5%** |
| **Medicines,**  **commodities, and supplies** | ?  17,557M | ?  21,424M | ?  25,264M | ?  27,610M | ?  29,547M | ?  121,401M | **42.9%** |
| **Health Financing** | ? 2M | ? 46M | ? 33M | ? 33M | ? 30M | ? 144M | **0.1%** |
| **Health**  **Information Systems** | ? 48M | ? 48M | ? 40M | ? 40M | ? 40M | ? 215M | **0.1%** |
| **Governance** | ? 95M | ? 148M | ? 99M | ? 104M | ? 97M | ? 543M | **0.2%** |
| **SHDP II Total Cost** | **?**  **42,340M** | **?**  **52,780M** | **?**  **57,400M** | **?**  **62,870M** | **?**  **67,290M** | **?**  **282,690M** |  |

***Figure 3: Distribution of Program Activity Cost for Rivers SSHDP II 2018 -2022 Essential Service Aggressive Scenario***

Distribution of Program Activity Cost for Rivers SHDP II 2017 - 2021 Essential Service Aggressive Scenario

**General Programme Management, 7.9%**

**1.8% of SSHDP II**

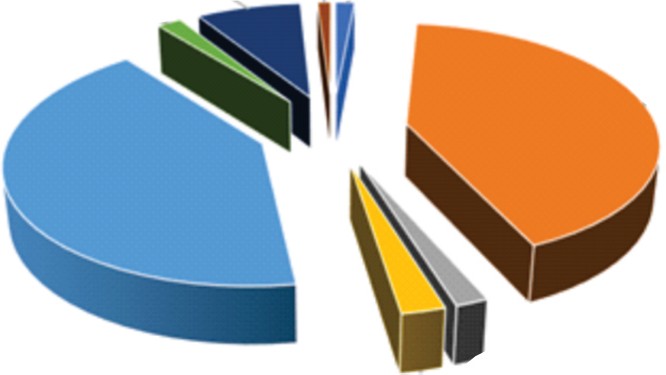
**Total Cost**

**Advocacy, 1.8%**

**Items<1% of Total Cost,1.0%**

**Programme-Specific Human Resources, 1.5%**

**Training, 42.0%**

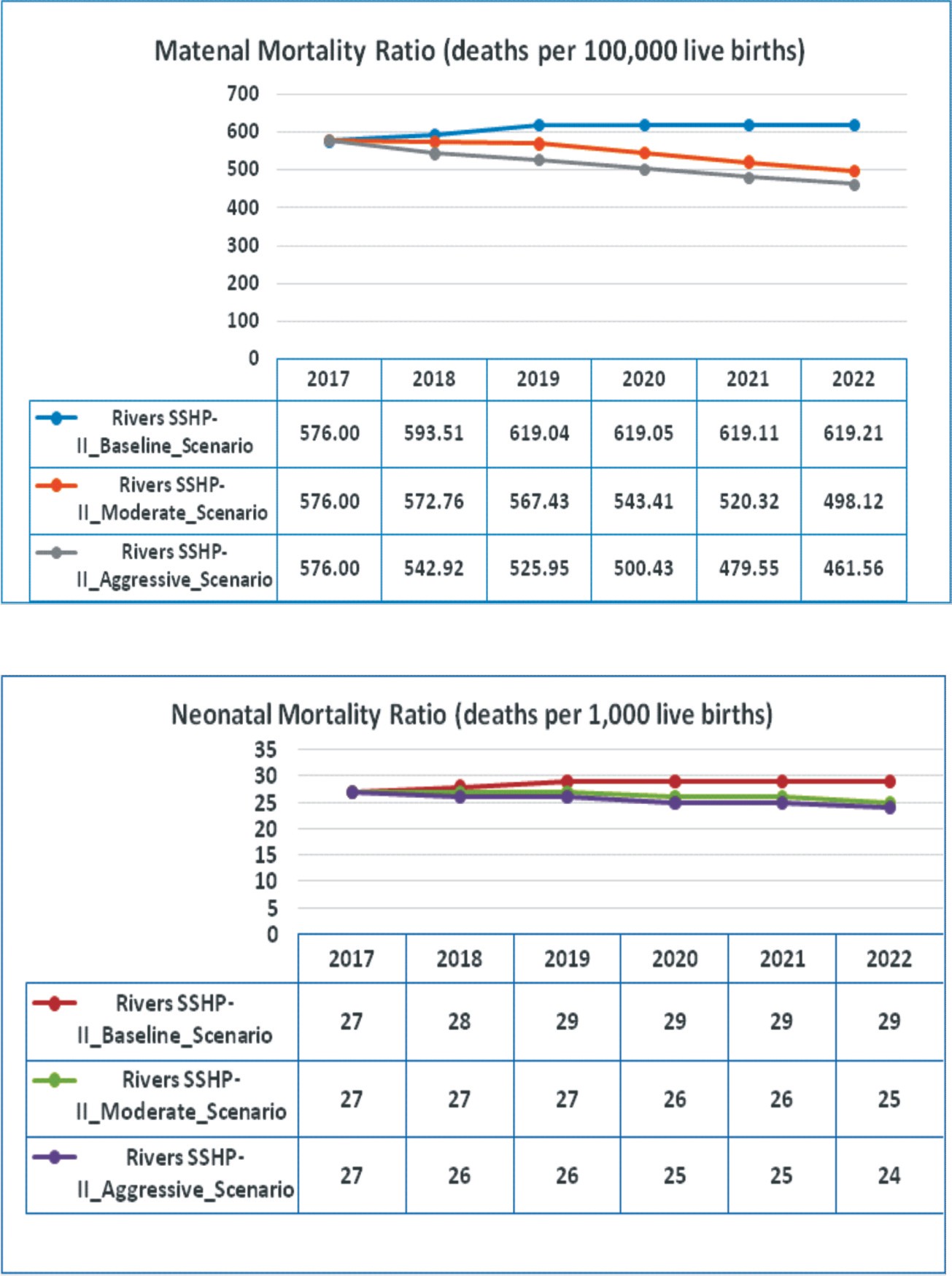


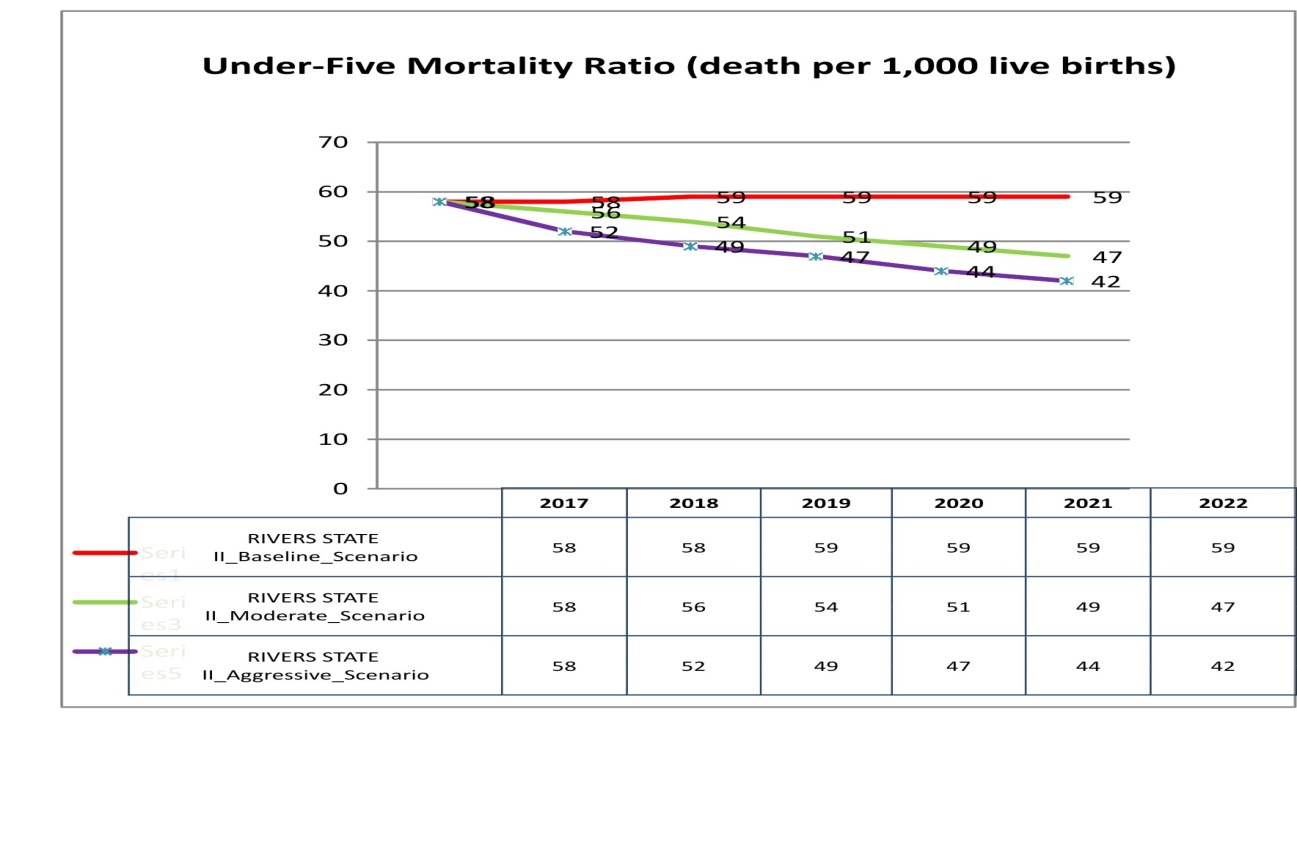
**Communication, Media & Outreach, 41.7%**

**Transport, 2.4%**

**Monitoring and Evaluation, 1.8%**

* + 1. **SSHDP II Impact outputs across the three scenarios**





* 1. Health System Capacity/Utilization Analysis

Even though the Rivers SSHDP II Total Cost was calculated based on the required health system capacity, it is crucial to highlight the limitations of implementing the strategy with existing HSS capacity. While it is desirable for the SSHDP II policy goals to target ambitious service coverages, ensuring HSS capacities are sufficient to deliver on these targets remains pertinent, particularly skilled care providers and infrastructure capacities required to cater for clients' need. Without due consideration of the required HSS demands, effective and/or comprehensive implementation of the strategy will not be possible. Consequently, the anticipated SSHDP II outcomes would not be realized. In support of advocacy effort for HSS policy reform in the State, existing HR and Infrastructure have been assessed against the HSS capacity utilization of the SSHDP II scenarios. For HR, the key assumption considered in the analysis is the average daily work-time of skilled frontline providers (Doctors, Nurse, and Midwives); this has been set at 8hours per day, over a period of 260days annually. Available staff time for the specified staff types was compared against the proposed staff time required for service delivery for each of the SSHDP scenario.

Results of the analysis presented in table12, below illustrate the percentage capacity utilization for each of the specified staff type currently in service. And where gaps were identified, estimates including costs for the additional Staff required to achieve the desired service and impact targets has been provided. Similar capacity assessment has been conducted for health infrastructure; measuring the current bed day capacity against the need for each scenario. As we review the outputs in the table below, it should be noted that not all health services provided by the Health System were modelled in the One Health tool. For example, a large share of health workers time, may be spent on addressing care seeking for conditions not addressed within the projections, e.g., ear infection and general injuries were not modelled. As a result, the Staff time needs captured in the table below underestimates the gap and should be considered as the minimum requirement. Another vital component of the health System, though not captured in the capacity assessment is the staff time of the private care provider. While this analysis is focused on public sector, it is important to highlight the contributions of the private sector to service delivery in the State. With the client uptake ratio across both Public and Private reported as in DHS 2013, engaging contribution of private sector remains imperative.

***Table 12: Analysis of HSS Capacity Utilization across the three Scenarios***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **HSS Capacity Utilization for Key Staffs and Bed days** | | | | | | |
| **NSHDP II**  **Scenari o** | **Cost of Plan without HSS**  **Scale - up** | **HSS Capacity utilization**  **(end year) (%)** | **mortality rate**  **(end year)** | **Additional HSS Capacity Required for Service delivery (%)** | **Cost of**  **Plan with HSS**  **Scale - up (end**  **year)** | **Additiona l Cost required**  **with HSS Scale - up** |
| Moderat e | ? 176,213M | A.) Doctor - 225% B.) Nurses – 1021% C.) Midwives - \*\*nil D.) Bed days -86% | MMR: 498/100,000  U-5MR: 47/1,000 | A.) Doctor -125% B.) Nurses – 921% C.) Midwives -100% D.) Bed days - NA | ? 220,189M | ? 43,976M |
| Aggress ive | ? 220,864M | A.) Doctor - 268% B.) Nurses – 1319% C.) Midwives -\*\*nil D.) Bed days -107% | MMR: 462/100,000  U-5MR: 42/1,000 | A.) Doctor - 168% B.) Nurses – 1219% C.) Midwives -100% D.) Bed days -7% | ? 282,686M | ? 61,821M |

\*NA: No scale-up required; \*\*nil: no baseline information was provided

From the information provided in table 6 above, the staff capacity utilization of the key frontline staff at end year shows that the number of doctors and nurses provided have exceeded their capacity to deliver the required service needs of the base, moderate and aggressive scenarios. To attain the 17.5% average increase in service coverage across all interventions, and the attended 14% reduction in maternal mortality modelled in the moderate scenario, an addition of 125% doctors, 921% nurses and 100% midwives would be required. Based on the existing capacity of bed spaces spread across the primary, secondary, and tertiary health facilities, only 86% bed days utilization would be achieved at the end year. Hence, no additional infrastructure would be required to achieve the service needs of the plan. The addition to Human Resources needed to provide service would

require an additional investment of ? 43.976b, bringing the total cost of the Rivers State SHDP II Essential Service Moderate Scenario to ? 220.189b.

To realize the 30% average increase in coverage across all interventions proposed by the

aggressive scenario, a significant increase in HSS would be required without which the 20% reduction in maternal mortality cannot be achieved. An addition of 168% doctors, 1219% nurses, and 100% midwives. There would also be a need to add 7% to the number of healthcare facilities.

This increase in HSS requires an addition of ? 61.821b bringing the total cost of the Rivers State SHDP II Essential Service Aggressive Scenario to ? 282.686b.

* 1. Sustain ability / Financing Gap Analysis

In this section, the two scaled scenarios of Rivers SHDP II plan are subjected to a financial sustain ability analysis to compare the costs and the available of funding; and, to assess the afford ability of the plan given available sources. This assessment will enable Rivers state government to decide on which scenario to adopt and determine whether there is need to scale down the adopted scenario. More so, at what point in the planning horizon this should be done.

In Rivers state, health care is resourced by the following actors, government, Dev. Partners contributions, private sector and out-of-pocket. With Government's commitments established, a 5 year forward looking resource mapping was undertaken. This exercise covered actors across the entire health sector with particular emphasis on funding commitment from the following sources; Bilateral, Multilateral and Development Partners. Data was collected on resources available for a minimum of 3years; 2018 to 2020.

Limitations of the resource mapping including the following:

1. No data on the financial commitments of the dev. partners operating within Rivers State was provided.
2. Data on the resource contributions of faith-based organisations and other Non- Governmental Organisation actors were not collated.

***Table 13: Financial Sustainability Analysis of Rivers SSHDP II 2017-2021 Essential Package Moderate Scale-up Scenario, in Million ($)***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Financial Sustainability Analysis of Rivers SHDP**  **II 201 8- 202 2 Essential Package Moderate Scale-up Scenario, in Million ($)** | | | | | | |
| **Sources of Funds** | **201 8** | **201 9** | **2020** | **202 1** | **202 2** | **TOTAL** |
| **Govt.**  **Allocations** | $ 45.7M | $ 46.4M | $ 47.1M | $ 47.8M | $ 48.4M | $ 235.4M |
| **Dev Partner** | - | - | - | - | - | - |
|  | - | - | - | - | - | - |
| **Total Available Funds** | **$ 45.7M** | **$ 46.4M** | **$ 47.1M** | **$ 47.8M** | **$ 48.4M** | **$ 235.4M** |
| **Cost of N/SHDP**  **II Plan Moderate Scenario** | **$ 110.1M** | **$ 126.6M** | **$ 146.0M** | **$ 161.7M** | **$ 177.4M** | **$ 721.9M** |
| **Resource Gap** | **$ 64M** | **$ 80M** | **$ 99M** | **$ 114M** | **$ 129M** | **$ 487M** |
| *% of Resource Gap* | 58.5% | 63.4% | 67.8% | 70.5% | 72.7% | **67.4%** |

***Table 14: Financial Sustainability Analysis of Rivers SSHDP II 2018-2022 Essential Package Aggressive Scale-up Scenario, in Million ($)***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Summary costs of Rivers SHDP II 201 8- 2022 Essential Package Aggressive Scale - up scenario, in Million (? )** | | | | | | |
| **Sources of**  **Funds** | **201 8** | **201 9** | **2020** | **202 1** | **202 2** | **TOTAL** |
| **Govt.**  **Allocations** | $ 45.7M | $ 46.4M | $ 47.1M | $ 47.9M | $ 48.6M | $ 235.7M |
| **Dev Partner** | - | - | - | - | - | - |
|  | - | - | - | - | - | - |
| **Total Available Funds** | **$ 45.7M** | **$ 46.4M** | **$ 47.1M** | **$ 47.9M** | **$ 48.6M** | **$ 235.7M** |
| **Cost of N/SHDP II Plan Aggressive**  **Scenario** | **$ 138.8M** | **$ 173.1M** | **$ 188.2M** | **$ 206.1M** | **$ 220.6M** | **$ 926.8M** |
| **Resource Gap** | **$ 93M** | **$ 127M** | **$ 141M** | **$ 158M** | **$ 172M** | **$ 691M** |
| *% of Resource Gap* | 67.1% | 73.2% | 75.0% | 76.8% | 78.0% | **74.6%** |

From the tables above, the available funds indicate a resource gap of 67.4% for Moderate Scenario and 74.6% for Aggressive Scenario with all the funds being provided coming from government alone. This indicates that financial appropriations sourced from government allocations even when increased from 2% to 6% by 2022 cannot fund the plan. Other sources of health financing have to be explored in order to bridge the gap one of which is to explore ways of increasing SHIS subscriber base to significantly reduce the gap. Taking into consideration the cost of plan and resource gaps in both scenarios, the Rivers SSHDP II Essential Service Moderate Scenario has been proposed and adopted as the most feasible scenario for the Rivers State government.

* 1. Bridging the Resource Gap

With the adoption of the Moderate scenario as the cost of the strategy, mobilizing sufficient resources for its implementation becomes imperative. A starting point would be to advocate for an increase in the State's government's allocation to health which currently stands at 2% towards the attainment of the 15% benchmark. While it is understood that government's allocation may not sufficiently address the funding need of the strategy, the large share of out-of-pocket payments reported for the national and sub-national health accounts is equally unacceptable, especially as it exacerbates the financial risk of beneficiaries to health services. Consequently, adopting pooled and prepaid private financing presents the much-desired opportunity to mobilize adequate resource, as well as reduce the burden of the out-of-pocket payments to finance the strategy. As states undertake to implement the SSHDP II plan, additional resource can be mobilized from the social health insurance scheme. States are expected to contribute between 0.5 - 1% of their Consolidated Revenue Fund (CRF) as statutory allocation to the State Health Insurance/Contributory Scheme, while growing the subscriber base. Another domestic resource, potentially available to the 36 States and FCT is the allocation from the basic healthcare provision fund (BHCPF) of the National Health Act (NHAct) when implemented. As stipulated in the National Health Act, the Federal Government is expected allocated at least 1% of the Federal Consolidated Revenue Fund (CRF) for coverage of basic minimum package of health services, and PHC operational costs (HRH, medicines, infrastructure, transport), and public emergency services.

**Scenario one**: (***attaining 10% Health Insurance Subscribers base****)*, in this instance, available resources to bridge the gap have been estimated by computing (1.) the contribution of existing partner commitments, (2.) the State's Government's Allocation to Health increased to 6% by 2022,

(3.) the estimated annual allocation through NHIS and NPHCDA amounting to ? 1.6 billion from the basic health provision funds, (4.) annual deduction from state's consolidated revenue and finally

(5.) the state health insurance scheme, with the premium set at ? 12,000 per annum as the scheme approaches 10% subscribers base by 2022.

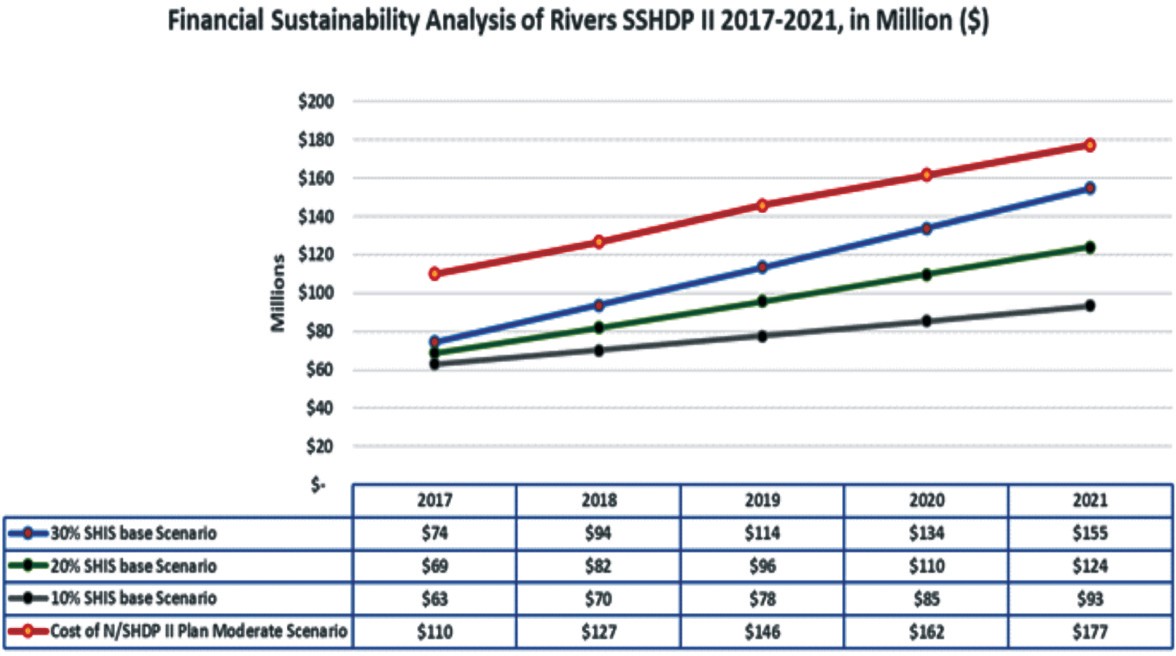
**Scenario two**: (***attaining20% Health Insurance Subscribers base****)*, similarly, this scenario estimates the available resources by computing (1.) the contribution of existing partner commitment, (2.) the State's Government's allocation to 6% by 2022, (3.) the estimated annual

allocation through NHIS and NPHCDA in the sum of ? 1.6billion from the basic health provision funds, (4.) annual deduction from state's consolidated revenue and (5.) the state health insurance scheme, with premium set at ? 12,000 per annum while the scheme is scaled to 20% subscribers based by 2022.

**Scenario three**(***attaining 30% Health Insurance Subscribers base****)*, estimates for available funds have been determined by computing (1.) the contribution of existing partner commitment, (2.) the State's Government's allocation to health increased to 6% by 2022, (3.) the estimated annual

allocation through NHIS and NPHCDA in the sum of ? 1.6 billion from the basic health provision funds, (4.) annual deduction of state's consolidated revenue (5.) the state health insurance scheme with premium set at ? 12,000 per annum while the scheme is scaled to 30% subscribers based by 2022.

***Figure 4: Financial sustainability of RIVERS SSHDP II 2018-2022, in Millions ($)***



From the information provided in the graph above, it is evident that even an achievement of 30% subscriber base through the SHIS, and increasing the Rivers State Government's allocation to health to 6% by 2022, there would still be a cumulative funding gap of $146m through the duration of the plan. It should be pertinent to note that this graph may not present an accurate representation of the health financing need for the Rivers SSHDP II, as funds sourced from dev. partners operating within the state were not captured.

* 1. Conclusions and Recommendations:

Two Scenarios were proposed for the Rivers SSHDP II, the Essential Service Moderate and the Essential Service Aggressive. Both scenarios scaled-up service coverage across all interventions averagely by 17.5% and 30% respectively.

The Essential Service Moderate Scenario proposes a scale-up of HR which will increase the key front line staff and add ? 43.979b to the salaries of existing staff over the duration of the plan, bringing the total cost of plan to $ 721.9m. Projecting Governments allocation in addition to the declared Dev. Partner funding, the total funds available stands at $ 235.4m, with a resource gap of $

487m.

The Essential Service aggressive Scenario scaled-up HSS, adding key frontline staff to existing staff strength and added 7% to the existing infrastructure which was provided for by the addition of ? 61.821m to the existing cost of HSS. The total cost of plan stands at $ 926.8m Resources from projected Government allocations and Dev. Partner commitments provides $ 235.4m, with a

resource gap of $ 691m.

The Rivers SSHDP II 2018-2022 Essential Service Moderate Scenario was considered the preferred policy option, with an estimated Total Cost of plan of $ 721.9m. The plan is expected to have the following impact at the end year, 2022:

Decline in neonatal mortality from 27 per 1,000 live births (2016) to 25 per 1,000 live births (2022),

Decline in under-five mortality from 58 per 1,000 (2016) to 47 per 1,000 (2022,

Decline in maternal mortality from 576 per 100,000 live births (2016) to 498 per 100,000 live births (2022).

SHIS was explored as an avenue for bridging the resource gap. 3 scenarios were proposed; 1. Increasing the SHIS subscriber base by 10%, 2. Increasing the SHIS subscriber base by 20%. 3. Increasing the SHIS subscriber base by 30%. All three Scenarios were not sufficient to bridge the gap in the moderate scenario. However, with a more concise picture of dev. Partner contributions to the Rivers State health sector and stronger fiscal disciple, the plan could be sufficiently funded.

It is therefore recommended to

1. Conduct state-specific core analytics for health financing including health accounts, fiscal space analysis, and cost of illness studies.
2. Effort should be made to conduct regular health facility and inventory assessments to have real-time access to such data when needed in the state.
3. States should be proactive in expanding the network of officers with the knowledge and expertise of conducting costing and prioritization of health strategies.
4. State and Federal Ministries of health to develop costing guidelines and benchmarks for health services.

# CHAPTER 11

## IMPLEMENTING FRAMEWORK

Rivers State Ministry of Health (SMOH) is under the leadership of the Honourable Commissioner, who is also the Chief Executive Officer. The Permanent Secretary is the Chief Administrative Officer of the Ministry and is in charge of all administrative procedures of the various sections. The Ministry is made up of eight departments and other special units with Directors and various cadres of staff. The physical structure of the SMOH, made up of four floors with many offices and rooms, is situated at the State Secretariat complex. The SMOH is responsible for formulating the State health policy and ensuring its implementation.

The Primary Health Care Management Board controls and manages all human resources, infrastructure, programmes and activities of Primary Health Care. The Permanent / Executive Secretary, is the administrative head of the Board and is responsible for the day-to-day running of the Board and implements decisions made by the Board of Trustees. There are eight departments in the Board, each headed by a Director. These departments are responsible for the implementation of various PHC programmes and activities. The 23 LGAs oversee the implementation of PHC activities in their LGAs. The Medical Officer of Health serves as the secretary of the Local Government Primary Health Care Authority. The Board advises the Honourable Commissioner for Health and Local Governments in all matters concerning PHC activities.

Under the Rivers State Hospitals Management Board are the secondary and tertiary health facilities, also with their own different cadres of healthcare providers and administrative officers. There are the eight training institutions that provide the varied health manpower needs of the State. All these make sure that the SHDP is put into proper practice and the various programmes actualized.

Apart from the statutory composition of the SMOH, there are other development partners that help with the implementation of the SSHDP II. There are various development partners, international and national agencies and corporations such as the UNICEF, WHO, USAID, CHAI, FHI360, SPDC, NDDC, etc. These organizations provide financial, technological and manpower needs for the actualization of the SSHDP II. Also involved are the Non-Governmental Organizations (NGOs) and Faith Based Organizations (FBOs) of various types and interests. Individuals and philanthropists are not excluded as they also take an active part in healthcare delivery in Rivers State. They provide financial and other resources for the implementation of the SSHDP II. All these individuals, households, groups and organizations are interrelated in their functions and they all work towards the common goal of providing optimum health for the people of Rivers State within the resources that are made available.

The SSHDPII implementation steering committee headed by the Honourable Commissioner for Health and the DPRS at each level will be responsible for managing the implementation of the SSHDPII. Managing implementation of the SHDPII will require provision of technical assistance (TA) for development of operational plans where necessary.

# CHAPTER 12

## MONITORING AND EVALUATION

* 1. Proposed mechanism for monitoring and evaluation

Plans will be monitored and evaluated by the implementing departments and special units (inbuilt M & E) and a central M & E Unit (Planning Division, PRS Department).

There are two perspectives to monitoring and evaluation in the context of the SSHDP II and its implementation process. First, it is important to monitor and evaluate the plan's operational elements (in this case, the required activities) that are essential ingredients in ensuring the successful implementation of the plan. Secondly, it is equally essential to monitor and evaluate programme outputs and impacts. The latter concerns measurable variables and changes in the health status of the population and the health services as a consequence of the implementation of the SHDP II. The detailed SSHDP II M&E Plan is a free stand-alone document while this section is an overview.

The major categories of indicators that are relevant for monitoring and evaluating the State SHDP II include the policy and socioeconomic indicators as well as the health prevention and utilization indicators.

Types and sources of data

The sources of data for the monitoring and evaluation of the state of health of the population and the health system are:

* + 1. disease and related reporting mechanisms
    2. vital statistics, e.g. from the National Population Commission
    3. sentinel surveillance, focusing on the monitoring of key health indicators in the general population or in special population
    4. registries – mostly for monitoring the public health impact of non-acute diseases, e.g. exposure and work related registries may be particularly useful in tracking the health protection objectives
    5. surveys – health demographic surveys
    6. administrative and routine service data collection system

Categories of data

The four major categories of data are:

1. Input database

Input refers to resources and requirements to create and enable the success of health programmes. They are the precedent actions that must be taken (invested) for the health system. They are not limited to physical inputs, but may also include provision of appropriate institutional arrangements, policy instruments and legislation.

1. Process database

Process refers to a set of activities that must be undertaken or actions and rules and regulations that are required to take place. This may include for instance protocols for immunization, for collecting, storing, processing and making available health data, etc.

1. Output database

Output database will concern itself to keeping the time-series data on activities completed in relation to set targets. An example is interval data on immunization status of children under 5 years of age. Another example is the efficiency of health intervention programmes, e.g. the eradication of poliomyelitis and the control of tuberculosis.

1. Outcome or impact database

These are concerned with health status measures or indicators. An example is the level of morbidity and mortality for a given condition and specific target population,

e.g. under-5 mortality rate, maternal mortality rate and prevalence of HIV/AIDS.

Overall statutory responsibility for monitoring, evaluating and reporting on SSHDP is vested in the Department of Planning, Research and Statistics (DPRS). Health priority areas implementing agencies shall work in concert with the DPRS to establish a simple flexible and acceptable monitoring and evaluation protocols.

* 1. **Costing the monitoring and evaluation component and plan**

The central M & E unit of the SMOH oversees the entire monitoring and evaluation activities in the State. Each department and unit of the SMOH, its Parastatals and the 23 LGAs also have their M & E units. The money budgeted for the central M & E unit for the 5-year period is 2% of the total sum for the SSHDP II.

# CHAPTER 13

**CONCLUSION**

The Rivers State Strategic Health Development Plan II for the period 2018 to 2022 was successfully produced with wide stakeholder participation involving a cross section of State Ministry of Health officials and its parastatals, local government officials, and representatives of various development partners, professional groups and individuals that are directly or indirectly involved with healthcare delivery in the State. The final draft was obtained after the harmonization of the 23 LGA Strategic Health Development Plans. The tools that were used included the following:

1. FMOH – NSHDP Framework (2018 – 2022)
2. State Strategic Health Development Plan (2010 – 2015)
3. Current National Policies of all health related programmes
4. Rivers State Approved Capital Budget Estimates

The five pillars and fifteen priority areas were strictly adhered to and activities mapped out according to the stipulated guidelines. Certain activities that are specific to the State were duly adopted with appropriate costing. The Rivers State Strategic Health Development Plan II for the year 2018 - 2022 was also produced from the framework and appropriate budgeting carried out. Future monitoring and evaluation of the plan was taken care of making use of various health indicators for definite areas of the plan.

It is hoped that if the Strategic Health Development Plan of the State is strictly adhered to, the health situation which is presently unacceptable in the area will be greatly improved, and the Sustainable Development Goals, especially those that concern health, one more likely to be achieved.

### APPENDICES

**Appendix1 for the Costing Chapter**

NSHPII Services & System Components Costed by the One Health Tool

* **Health Services Component**
  + RMNCH+Nutrition, Adolescent Health
  + Communicable Disease/NTDs
  + NCDs, Mental Health
  + Emergency & Epidemic Preparedness
  + General And Emergency Hospital Services
* HSS Component
  + HR (Admin and Service Delivery)
  + Logistics
  + Infrastructure including Blood Safety, Labs
  + Governance
  + Health Financing
* Overview of the Essential Services Package modelled for NSHDP II
  + **Maternal, Newborn, Child and Adolescent Health plus Nutrition (RMNCHA+N)**

Pre-pregnancy, Labour and Delivery, Postpartum (Mothers) Initiate within 48 hours of delivery

* + Child Health

Essential and emergency Newborn Care, Community IMCI,

* + Sexual and Reproductive Health

Family Planning, Screening for Cervical & Prostate Cancer, GBV,

Education, counselling and treatment of rape

* + Adolescent Health

Comprehensive sexual and reproductive health education, Tetanus immunization, School health Services, Menstrual hygiene promotion, prevention & management of STI, Post abortion care for post-abortion cases

* + Nutrition

Nutritional education and exercise promotion, Micronutrient supplementation, Management of SAM & MAM in children

* + Communicable Diseases (prevention & treatment)

Malaria, Hepatitis, Tuberculosis/Leprosy, HIV/AIDS

* + Non-Communicable Diseases

Cardiovascular diseases, Diabetes, Cancers-(cervix, breast, liver, prostrate), Sickle Cell Disease, Oral Health, Eye health, Care for the Elderly

* + Emergency Medical and Hospital Services

In -patient care - treatment, surgery and critical care, OPD, Rehabilitation,

Ambulatory Services, Emergency preparedness

* + Health Promotion, WASH, Social Determinants of Health

**Appendix 2: List of Contributors**

* Federal Ministry of Health (FMOH)
* Rivers State Ministry of Health (RSMOH)
* Rivers State Primary Healthcare Management Board (RSPHCMB)
* Rivers State Hospital Management Board (RSHMB)
* University of Port Harcourt Teaching Hospital (UPTH)
* Rivers State University Teaching Hospital
* Rivers State Agency for The Control of AIDS (RIVSACA)
* College of Health Science & Technology (RSCOHST)
* School of Nursing & School of Midwifery
* National Health Insurance Scheme (NHIS)
* Development Partners; UNICEF, USAID-HFG, SOMLPforR, FHI360, CHAI, Society for Family Health, Afenet.
* Planning Consultant
* Costing Consultant, FMOH
* Zonal Consultant, FMOH
* Ministry of Works
* Ministry of Information
* Ministry of Environment
* Ministry of Women Affairs
* Ministry of Finance
* Ministry of Budget and Economic Planning
* Professional bodies; Nigeria Medical Association (NMA), National Association of Nigeria Nurses And Midwives (NANNM), Joint Health Sector Unions (JOHESU), Association of General And Private Medical Practitioners of Nigeria (AGPMPN), Pharmaceutical Society of Nigeria (PSN)
* Civil Society Organization; CHISHAN
* Unions; Nigeria Union of Local Government Employees (NULGE)
* Institutions; Ken Saro-Wiwa Polytechnic (KEMPOLY)

**Appendix 3**

**Annex 1: Detailed activities for Rivers State Strategic Health Development Plan**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **RIVERS STATE STRATEGIC HEALTH DEVELOPMENT PLAN II** | | | | | | | |
| **Priority Areas or Sub domain** | | | | | | | |
| **Goals** | | | | | **BASELINE YEAR 2016** | **Risks And Assumptions** | **Cost inputs/Assumptions (Sub-activities)** |
|  | **Strategic Objectives** | | | | |
|  | | **Interventions** | | | **Output Indicators** |
|  | | | **Activities** | | |
| **Strategic Pillar One: Enabled environment for attainment of sectoral goal** | | | | | | | |
| **1.Leadership and Governance** | | | | | | | |
| **1. Provide effective leadership and an enabling policy environment that ensures adequate oversight and accountability for the delivery of quality health care for sustainable development of the national health system** | | | | | | | |
|  | **1.1** | **Provide clear policy, plans, legislative and regulatory framework for the health sector** | | | | | |
|  | | 1.1.1 | Promote review and development of polices and laws as necessary | | * State Council on Health meeting held annually • State participate in National Council on Health meeting annually * Guidelines & Regulations tracked &   monitored |  |  |
|  | | | 1.1.1.a | Strengthen Planning, Research & Statistics Department of the SMOH to coordinate meetings for policy activities at all levels | | Lack of funds | Convene coordination meetings |
| 1.1.1.b | Advocacy to the Commissioner of Health and House of Assembly on the need to pass a bill for regular conduct of State Council on Health in the State | | Lack of funds & Political Will | Conduct advocacy visit |
| 1.1.1.c | Conduct State Council on Health (SCH) meeting to review and develop policies, adapt the guidelines on essential package of health care services for Nigeria & define norms and standards of practice for at different levels of the health care system, from community level | | Lack of funds | Conduct SCH meeting |
| 1.1.1.d | Participate in National Council on Health (NCH) meeting | | Lack of funds | Participate in NCH meeting |
| 1.1.1.e | Track and monitor compliance on existing guidelines and regulations | | Lack of funds | Costed in 1.3.3b |
|  | | 1.1.2 | Scale-up strategic and operational planning at all levels | | * State Strategic Health Development Plan II & Operational Plan developed * Local Government Strategic Health Development Plans & Operational Plans developed * SMOH/PHC Operational Plans developed |  |  |
|  | | | 1.1.2.a | Organize workshops to develop SSHDP II with technical assistance from FMOH | | Lack of funds | Organize SSHDP II workshop |
| 1.1.2.b | Organize workshops to develop LGSHDP II with technical assistance from FMOH | | Lack of funds, commitment, security & difficult terrain | Organize LGSHDP II workshop |
| 1.1.2.c | Organize workshop to develop SMOH Operational Plan | | Lack of funds | Organize SMOH Operational Plan workshop |
| 1.1.2.d | Organize workshop to develop PHC Operational Plan | | Lack of funds | Organize PHC Operational Plan workshop |
| 1.1.2.e | Develop Mid Term Sector Strategy (MTSS) and support MTEF from the strategic plan | | Lack of funds | Organize MTSS workshop |

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| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **1.2** | **Strengthen transparency and accountability in planning, budgeting and procurement process** | | | | |  |
|  | | 1.2.1 | Strengthen Public Finance Management system including oversight in Fund disbursement and utilization at all levels | | * At least 10 staff trained on fiscal policies and public financial management * Guidelines and regulations on procurement for medicines, consumables and other commodities implemented * Disbursements and funds utilization monitored |  |  |
|  | | | 1.2.1.a | Adapt existing national guidelines, laws and regulations on fiscal policies and public finance management | | Lack of funds | Convene coordination meetings |
| 1.2.1.b | Build capacity of all relevant staff in fiscal policies and public financial management | | Lack of funds | Train staff |
| 1.2.1.c | Conduct Joint Annual Review (JAR) of the implementation of SSHDP II | | Lack of funds | Conduct JAR |
| 1.2.1.d | Coordinate the development of annual budget at all levels and tracking | | Lack of funds | Conduct budget tracking |
| 1.2.1.e | Publish SHDP II financial implementation review in the health bulletin and website and  distribute same to the public | | Lack of funds | Publish health bulletin |
|  | | 1.2.2 | Strengthen the linkages between various planning and budgeting process(MTEF/MTSS | | * Medium-Term Sector Strategy (MTSS) and Medium Term Expenditure Framework (MTEF) developed * Platform for the planning and budget officers to work together put in place * Cost circular of various planning with   budget process harmonized |  |  |
|  | | | 1.2.2.a | Adopt Medium-Term Sector Strategy (MTSS) and Medium-Term Expenditure Framework (MTEF) in the allocation and management of public sector health expenditure at State | | Lack of funds | Adopt Medium-Term Sector Strategy (MTSS) and Medium-Term Expenditure  Framework (MTEF) |
| 1.2.2.b | Put in place a framework for regular evaluation of benefits and costs of interventions and technologies to ensure optimal choices | | Lack of funds | Put in place evaluation framework |
| 1.2.2.c | Train all key officers responsible for budgeting and planning in the SMOH, RSPHCMB & RSHMB on budget and planning | | Lack of funds | Train all key officers |
| 1.2.2.d | Create Platform for the planning and budget officers to work together to optimize the  synergy | | Lack of funds | Create Platform for the  planning and budget |
| 1.2.2.e | Harmonize the cost circular of various Planning with the budget process | | Lack of funds | Harmonize cost circular |
|  | | 1.2.3 | Strengthen voice and accountability, including community participation, CSO engagement. | | * Framework to monitor implementation of all the strategic plans and annual operational plans developed * SMOH & MDAs annual reports submitted * Audit Team constituted |  |  |
|  | | | 1.2.3.a | Develop a framework to monitor implementation of all the strategic plans and annual  operational plans in the health sector in the state | | Lack of funds | Develop a framework for  monitoring |
| 1.2.3.b | SMOH to ensure that all its MDAs produce & disseminate annual report of their activities in both print and electronic media. | | Lack of funds | Produce & disseminate annual report |
| 1.2.3.c | Constitute an audit team, comprising of independent assessors, including CSOs to monitoring the budgeting process, fund disbursements and utilization; and also produce and disseminate annual audit reports. | | Lack of funds | Produce and disseminate annual audit reports |
| 1.2.3.d | Develop a platform for deepening community involvements in planning and implementation of health programmes and projects | | Lack of funds | Develop a platform for deepening community involvements |

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| --- | --- | --- | --- | --- | --- | --- |
| **1.3** | **Improve health sector performance through regular integrated reviews and reports** | | | | |  |
|  | 1.3.1 | Strengthen annual operational/work-plan for the health sector | | * Annual operational/work plan reporting system developed and used * Operational Plan reviewed quarterly and findings disseminated   • |  |  |
|  | | 1.3.1.a | Develop and implement an effective reporting system | | Lack of funds | No cost |
| 1.3.1.b | Conduct quarterly review of the implementation of the Annual Operational Plans (AOP)  /Budget | | Lack of funds | Conduct quarterly review meeting |
| 1.3.1.c | Disseminate findings of implementation reviews to stakeholders annually and publish  same in the state bulletin and MOH website | | Lack of funds | Disseminate findings |
|  | 1.3.2 | Improve information generation and sectoral information base for decision-making to enhance sectoral performance | | * Health management information base and website developed * Submission of data as conditions for re- accreditation of private health facilities in place * 250 staff trained on data management |  |  |
|  | | 1.3.2.a | Develop a health management information base, including a website and a data management office for harmonization and standardization of information management. | | Lack of funds | Develop a health management information base |
| 1.3.2.b | Institutionalize quarterly inter-sectoral review meetings to analyze available data / results and strategize ways for further development. | | Lack of funds | Convene quarterly inter- sectoral review meetings |
| 1.3.2.c | Integrate submission of data into conditions for re-accreditation of private health facilities | | Lack of funds | Integrate submission |
| 1.3.2.d | Build capacity of relevant staff for data management, including data demand and data use | | Lack of funds | Build capacity of relevant staff |
|  | 1.3.3 | Institutionalize the mechanism for sector progress status and performance review | | * Central Monitoring Unit established in the SMOH and equipped * Monitoring & Evaluation Team set up and periodic review of plan conducted * Monitoring tools developed |  |  |
|  | | 1.3.3.a | Establishment of Central Monitoring Unit at the SMOH to monitor & evaluate State & PHC programmes in the state and LGAs /Operating cost for engaging and supervising the contractor to equip the unit | | Lack of funds | Establish & equip Central M&E unit |
| 1.3.3.b | Set up a Monitoring & Evaluation Team and monitor all health activities | | Lack of funds | No cost |
| 1.3.3.c | Develop tools to monitor all programmes and activities | | Lack of funds | Develop monitoring tools |
| 1.3.3.d | Operating cost for engaging and supervising the contractor to purchase vehicles for M & E | | Lack of funds | Operating cost for  engaging and supervising the contractor |
| 1.3.3.e | Conduct periodic review of plan activities performance in the State & the 23 LGAs/Review  and update monitoring tools annually | | Lack of funds | Conduct meeting to review  plan performance |
|  | 1.3.4 | Disseminate sector performance reports and score cards in compliance with NH Act and other channels | | * Sector performance reports and score cards developed and disseminated |  |  |
|  | | 1.3.4.a | Annual production and dissemination of sector performance reports and score cards | | Lack of funds | Production & dissemination of sector performance reports |
|  | 1.3.5 | Design and institutionalize an incentivization and reward system for the efficient performance of the health sector at all levels | | * Health workers' performance and rewarding system in place   •  • |  |  |
|  | | 1.3.5.a | Institute annual incentives/reward for the best performance at LGAs and GHs | | Lack of funds | Annual incentives and annual performance based reward exercise |

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| --- | --- | --- | --- | --- | --- | --- |
| **1.4** | **Strengthen coordination, harmonization and alignment at all levels** | | | | |  |
|  | 1.4.1 | Strengthen governance structures, rules and processes at all levels | | * Activities of all health organs in the state coordinated by the SMOH and meetings funded * Coordinating structures for professional bodies-government interface, development partners, intersectoral collaboration etc in place and functional * Policies and guidelines to regulate private Health practice in the state reviewed & implemented |  |  |
|  | | 1.4.1.a | Coordinate activities of State Primary Health Care Management Board and other organs of health in the State by the SMOH | | Lack of funds | No cost |
| 1.4.1.b | Fund coordinating meetings of Boards and relevant bodies of MDAs | | Lack of funds | Fund coordinating  meetings |
| 1.4.1.c | Establish/strengthening functional coordinating structures for professional bodies-  government interface, development partners, intersectoral collaboration etc. | | Lack of funds | No cost |
| 1.4.1.d | Review/Formulate and implement policies and guidelines to regulate private Health practice  in the state | | Lack of funds | Convene quarterly review  meeting |
|  | 1.4.2 | Strengthen development and review of sectoral polices and plans | | * At least 5 DPRS staff of SMOH trained on policy analysis   •  • |  |  |
|  | | 1.4.2.a | Build capacity of DPRS of SMOH for policy analysis and briefs | | Lack of funds | Build capacity of DPRS of  SMOH |
|  | 1.4.3 | Strengthen inter-sectoral collaboration at all levels. | | * Platform for engagement of other sectors created and functional * Inter departmental meetings at LGA level held   • |  |  |
|  | | 1.4.3.a | Create a functional platform for engagement of other sectors (related to social determinants  of health) and stakeholders in the planning of health programmes and interventions | | Lack of funds | Create a functional platform |
| 1.4.3.b | Institute quarterly inter departmental meetings at LGA level to discuss health issues | | Lack of funds | Convene quarterly meeting |
|  | 1.4.4 | Improve partnership with professional groups and other relevant stakeholder for effective service delivery and industrial harmony. | | * Professional bodies participate in health care delivery   •  • |  |  |
|  | | 1.4.4.a | Develop MoU with relevant professional bodies (e.g. SOGON) and other key stakeholders  e.g FBOs, to promote participation of the professional bodies to enhance health care service delivery quality and coverage | | Lack of funds | No cost |
|  | 1.4.5 | Strengthen implementation of Health Service Charters at all levels | | * Health service charters functional at all levels   •  • |  |  |
|  | | 1.4.5.a | Empower health service charters at all levels in the State | | Lack of funds | Convene bi-annual meeting |
|  | 1.4.6 | Strengthen coordinating mechanism of health development partners (Development Partners and Private Sector Partners) | | * Donor Coordination Forum established and regular meetings held * Reporting formats for all health interventions in the state harmonized & donor programme aligned with state work plan * Tracking and evaluation of donor support done |  |  |
|  | | 1.4.6.a | Establish and strengthen Donor Coordination Forum and ensure functionality through  regular meetings | | Lack of funds | Convene monthly meeting |
| 1.4.6.b | Harmonize Donor interventions and resources for optimal performance of the health sector | | Lack of funds | Costed in 1.4.6c |
| 1.4.6.c | Harmonize reporting formats for all health interventions in the state and ensure partners key  into state reporting systems | | Lack of funds | Harmonize reporting  formats |
| 1.4.6.d | Develop platform for tracking and evaluation of donor support | | Lack of funds | Conduct meeting |
| 1.4.6.e | Develop framework to ensure alignment of donors programme with State's work plan | | Lack of funds | Develop framework |

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| **2.Community Participation** | | | | | | | |
| **2.To promote community engagement for sustainable health development** | | | | | | | |
|  | **2.1** | **To strengthen community level coordination mechanisms and capacities for health planning.** | | | |  |  |
|  | | 2.1.1 | Strengthen institutional and coordinating mechanisms for promotion of community participation | | * WDC set up in at least 200 wards * Advocacy and sensitization of community leaders done * Orientation of at least 200 WDCs on community participation done |  | |
|  | | | 2.1.1.a | Setup/reactivate Ward Development Committees (WDCs) in the 23 LGAs | | Lack of funds | Convene meeting |
| 2.1.1.b | Produce and disseminate guidelines for the functioning of community coordinating structures | | Lack of funds | Produce and disseminate guidelines |
| 2.1.1.c | Conduct advocacy and sensitization to community leaders for effective collaboration | | Lack of funds, commitment, security &  difficult terrain | Conduct advocacy and sensitization |
| 2.1.1.d | Conduct capacity building for Ward Development Committee on community participation | | Lack of funds,  commitment, security & | Capacity building |
|  | | 2.1.2 | Strengthen financial management systems at the community levels | | * 200 WDCs trained on financial management   •  • | difficult terrain |  |
|  | | | 2.1.2.a | Institute a system for financial monitoring and auditing at community level | | Lack of funds, commitment, security &  difficult terrain | Institute a system |
| 2.1.2.b | Build capacity of community committees and structures (CBOs, FBOs, WDCs, etc.) on resource mobilization, financial management system and accountability at the community  level | | Lack of funds, commitment, security & difficult terrain | Build capacity |
|  | | 2.1.3 | Strengthen capacities of communities to participate in the planning of health interventions at all levels. | | * At least 200 WDCs trained and participated in the planning of health interventions   •  • |  |  |
|  | | | 2.1.3.a | Engage WDCs to participate in the planning of health interventions | | Lack of funds, commitment, inadequate collaboration, security & | Conduct workshop |
| 2.1.3.b | Strengthen community and ward development committees to respond appropriately in times of emergencies | | difficult terrain commitment, inadequate collaboration, security & | Conduct workshop |
| 2.1.3.c | Build capacity of community structures in participatory appraisal of needs, planning and  implementation of health interventions | | Lack of funds, commitment, security & | Build capacity |
| 2.1.3.d | Conduct advocacy and community mobilization for increase community resources support  and private sectors investment in health program planning and implementation | | Lack of funds, commitment, inadequate | Conduct advocacy |

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|  | **2.2** | **To strengthen community engagement in the implementation, monitoring and evaluation of health programs** | | | |  |  |
|  | | 2.2.1 | Strengthen capacities of communities to facilitate the implementation of community and facility level minimum service package(MSP) | | •At least 200 WDCs trained on community utilization of Minimum Service Package (MSP)   * At least 300 community volunteers, CDDs, WDCs, CBOs motivated and participated in community mobilization   • |  |  |
|  | | | 2.2.1.a | Develop/adopt community mobilization and IPC manual and job aides on minimum service package areas | | Lack of funds | Develop/adopt community mobilization and IPC  manual |
| 2.2.1.b | Conduct training workshop for WDCs on community utilization of Minimum Service Package (MSP) | | Lack of funds, commitment, security &  difficult terrain | Conduct training workshop |
| 2.2.1.c | Develop a reward system to motivate community volunteers, CDDs, WDCs, CBOs to conduct community mobilization | | Lack of funds | Develop a reward system |
|  | | 2.2.2 | Strengthen mechanisms for data collection, analysis, storage, utilization and accountability at community level | | * M & E mechanism & tools for M&E and community based evaluation programme developed and harmonized   •M&E Unit at LGA levels equipped and  functional |  |  |
|  | | | 2.2.2.a | Develop/adapt and harmonize existing M & E mechanism & tools for M&E and community based evaluation programme | | Lack of funds | Convene meeting |
| 2.2.2.b | Operating cost for engaging and supervising the contractor to provide equipment to  strengthen M&E Unit at LGA levels and enhance data collection, analysis & dissemination. | | Lack of funds | Costed in 1.3.3a |
| **3.Partnerships for Health** | | | | | | | |
| **3. Enhance harmonized implementation of essential health services in line with national health policy goals.** | | | | | | | |
|  | **3.1** | **Ensure that collaborative mechanisms are put in place for involving all partners in the development and sustenance of the health sector** | | | |  |  |
|  | | 3.1.1 | Promote the adoption and utilization of national policies and guidelines on PPP | | * Health Partners Coordination Committee established and National PPP policy domesticated * PPP quarterly meetings held * At least 6 slots of jingles, TV broadcast & phone in programmes carried out annually |  |  |
|  | | | 3.1.1.a | Domesticate the national PPP policy | | Lack of funds | Domesticate PPP Policy |
| 3.1.1.b | Establish/empower Health Partners Coordination Committee (HPCC) to promote, oversee and monitor PPP initiative in the state | | Lack of funds | Establish PPP committee |
| 3.1.1.c | Conduct periodic meeting to deliberate & review all PPP activities in the State | | Lack of funds | Conduct meeting |
| 3.1.1.d | Conduct mass media edutainment on the need for adoption and utilization of national policies and guidelines on PPP | | Lack of funds | Create awareness through media |
|  | | 3.1.2 | Strengthen legal and coordinating framework for PPP at all levels | | * PPP coordinating structures & feedback mechanisms functional   • |  |  |
|  | | | 3.1.2.a | Strengthen/develop existing PPP coordinating structures & feedback mechanisms | | Lack of funds | Conduct meeting |
|  | | 3.1.3 | Establish a single Development Partners Forum at federal and state levels, which comprises of only health development partners; | | * Guidelines that regulates Development Partners' activities developed and adopted * Development Partners Forum established * Development Partners Forum quarterly meeting held |  |  |
|  | | | 3.1.3.a | Develop/Adapt & circulate guidelines that regulates Development Partners' activities in the state | | Lack of funds | Develop/Adapt & circulate guidelines |
| 3.1.3.b | Establish Development Partners Forum comprising only health development partners at State level as single entry points for engaging partners in the State | | Lack of funds & Political Will | Establish Development Partners Forum |
| 3.1.3.c | Conduct periodic meeting Development Partners Forum to deliberate & review all PPP  activities in the State | | Lack of funds | Conduct meeting |
|  | | 3.1.4 | Strengthen mechanisms for the implementation of PPP (e.g. contracting or out-sourcing, leases, concessions, social marketing, franchising mechanism) | | * Feasibility of different models of implementation of health programmes explored * PPP engaged in collaboration with interested bodies   • |  |  |
|  | | | 3.1.4.a | Explore the feasibility of different models of implementation of health programmes including Performance-Based Financing (PBF) | | Lack of funds | Conduct meeting |
| 3.1.4.b | Engage in PPP collaboration with interested bodies | | Lack of funds & collaboration | Engage in PPP |

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| 3.1.5 | Scale-up PPP in planning and implementation of health programmes | | * Private sector engaged in the development of strategic plan and AOPs & performance reviewed   • |  |  |
|  | 3.1.5.a | •  Engage the private sector in the development of strategic plan and AOPs | | Lack of funds & collaboration | Conduct meeting |
| 3.1.6 | Promote joint (public and private sector) monitoring and evaluation of health programs | | * Joint public-private sector monitoring team established * Health programmes reviewed quarterly   • |  |  |
|  | 3.1.6.a | Establish & strengthen a joint public-private sector monitoring team | | Lack of funds & collaboration | Conduct meeting |
| 3.1.6.b | Engage the private sector in regular reviews of health programs | | Lack of funds & collaboration | Conduct meeting |
| 3.1.7 | Scale up resource mobilization interventions(funding, skills - e.g. managerial approaches) targeting the private sector | | * Advocacy meeting with private sector held & funding from the private sector increased * 50 key officers from the public sector, CSOs & NGOs trained on resource   mobilization |  |  |
|  | 3.1.7.a | Conduct advocacy meeting with private sector for increase funding of health intervention | | Lack of funds & Political Will | Conduct advocacy |
| 3.1.7.b | Build & strengthen capacity of key officers from the public sector, CSOs & NGOs on  resource mobilization | | Lack of funds | Build & strengthen capacity |
| 3.1.7.c | Develop innovative ways of resource mobilization (fund raising) targeting the private sector | | Lack of funds | No cost |
| 3.1.8 | Establish mechanisms for resource coordination through common basket funding models such as Joint funding Agreement, Sector Wide Approaches, and sectoral multi-donor budget support. | | * Policy on basket fund adopted, guidelines developed and implemented * Common basket funding established & coordinated by HPCC   • |  |  |
|  | 3.1.8.a | Adapt/adopt the existing policy on basket fund and develop guidelines for its implementation | | Lack of funds | Adapt/adopt policy and develop guidelines |
| 3.1.8.b | Establish a common basket funding through options such as joint funding agreements, Sector-Wide Approaches (SWAps) and sectoral multi-donor budget support etc. that will be coordinated by Health Partners Coordinating Committee (HPCC) which serves as government coordinating body with other development partners at the State level | | Lack of funds & Political Will | Conduct advocacy meeting |
| 3.1.9 | Promote the establishment of an inter-sectoral ministerial forum at all levels to facilitate inter-sectoral collaboration, involving all relevant MDAs directly engaged in the implementation of specific health programmes | | * Inter-sectoral ministerial forum revamped & functional * Quarterly meeting held and reports disseminated   • |  |  |
|  | 3.1.9.a | Revamp the inter-sectoral ministerial forum at State level to facilitate inter-sectoral collaboration, involving all relevant MDAs directly engaged in the implementation of specific health programmes | | Lack of funds & collaboration | Revamp the inter-sectoral ministerial forum |
| 3.1.9.b | Organize regular meetings with all relevant MDAs | | Lack of funds &  collaboration | Organize regular meetings |
| 3.1.9.c | Disseminate information and reports of meetings and develop a feedback mechanism | | Lack of funds | No cost |
| 3.1.10 | Promote effective partnership with professional groups and other relevant stakeholders through jointly setting standards of training by health institutions, subsequent practice and professional competency assessments; | | * SOT set by health institutions through partnership with private sector, professional groups & other relevant stakeholders * Professional competence assessed annually   • |  |  |
|  | 3.1.10.a | Engagement of private sector, professional groups, training institutions & traditional medicine practitioners by health institutions to set Standards of Training (SOT) | | Lack of funds & collaboration | Convene meeting |
| 3.1.10.b | Periodic assessment of professional competence | | Lack of funds | Periodic assessment |
| 3.1.11 | Strengthen collaboration between government and professional groups including Nigerian health professionals in diaspora to advocate for increased coverage of essential interventions, particularly increased funding; | | * Forum of professional groups and partners established * Conferences, Seminars or exhibitions organized   • |  |  |
|  | 3.1.11.a | Establish a forum of professional groups and partners to advocate for increased funding | | Lack of funds &  collaboration | Establish forum to  advocate |
| 3.1.11.b | Organize Conferences, Seminars or exhibitions for health practitioners from the diaspora,  traditional medicine practitioners, private/religious health providers | | Lack of funds | Organize Conferences and  Seminars |
| 3.1.12 | Leverage human resources for health from partners, health professionals, other levels of government to optimize resource use and improve service delivery | | * Partnership established with medical training institutions abroad * Technical assistance by Development Partners on-the-Job mentorship obtained |  |  |

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| 3.1.12.a | Partner with medical training institutions abroad or outsource units where expertise is lacking | | Lack of funds & collaboration | Costed in 3.1.1 b |
| 3.1.12.b | Secure technical assistance by Development Partners to provide on-the-Job mentorship for public officers in the health sector | | Lack of funds & collaboration | No cost |
| Promote linkages with academic institutions to undertake research, education and monitoring through existing networks; and | | * Forum for training and research institutions and stakeholders created and functional * Research on Quality & Inconsistent Services Availability & Challenge conducted in collaboration with WB * Research on Achieving Population-Level   Behaviour Change conducted in collaboration with WB |  |  |
| 3.1.13.a | Create/establish a functional forum for all of training and research institutions and stakeholders in the state for developing a research and implementing training and research linkage interventions/activities | | Lack of funds & collaboration | Create/establish a functional forum |
| 3.1.13.b | Mobilize technical assistance from research bodies to build the capacity of relevant officers in the state on health research | | Lack of funds & collaboration | Costed in 3.1.13a |
| 3.1.13.c | Conduct research on Quality & Inconsistent Services availability & challenge in Rivers State in collaboration with World Bank (WB) | | Lack of funds | Costed in 3.1.13a |
| 3.1.13.d | Conduct research on Achieving Population-Level Behaviour Change in collaboration with WB | | Lack of funds | Costed in 3.1.13a |
| Promote partnerships with communities to address felt needs of the communities | | * Forum for interaction between Government, partners and the communities established * Regular collaboration with WDC established |  |  |
| 3.1.14.a | Establish and strengthen a forum for interaction between Government, partners and the communities | | Lack of funds, Political Will & collaboration | Establish forum for interaction |
| 3.1.14.b | Collaborate with WDCs in the state regularly | | Lack of funds &  collaboration | Costed in 2.1.3d |
| Strengthen implementation of Health Service Charters at all levels, with Civil Society Organisations, traditional and religious institutions to promote the concept of citizen’s rights and entitlement to quality, accessible basic health services; and | | * Health service charters implemented * Joint monitoring group established * Community health perception index in place |  |  |
| 3.1.15.a | Develop & implement health service charters for CSOs, communities, service providers (PPMVs, traditional, private & public), government and partners | | Lack of funds & collaboration | Costed in 3.1.14a |
| 3.1.15.b | Establish a joint monitoring group to assess level of compliance with health service charters | | Lack of funds &  collaboration | Costed in 1.3.3b |
| 3.1.15.c | Put in place community health perception index (e.g. opinion posts) at every Ward | | Lack of funds &  collaboration | Put in place community  opinion posts |

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| **Strategic Pillar Two: Provision of essential package of health care services** | | | | | | | |
| **4.Reproductive, Maternal, Newborn, Child and Adolescent Health Plus Nutrition** | | | | | | | |
| **4. Promote universal access to comprehensive quality sexual and reproductive health services throughout life cycle and reduce maternal, neonatal, child and** | | | | | | | |
|  | **4.1** | **adolescent morbidity and mortality in Nigeria**  **Reduce maternal mortality and morbidity through the provision of timely, safe, appropriate and effective healthcare services before, during and after child birth.** | | | |  |  |
|  | | 4.1.1 | Improve access to focused Antenatal and Postnatal Care | | * ANC outreaches carried out * Routine drugs provided * At least one abdominal scan conducted before 24 weeks of gestation |  |  |
|  | | | 4.1.1.a | Conduct meeting for Maternal Newborn & Child Health Core Technical Committee to map out Wards with Service Delivery Points for RMNCAH including ANC in the State | | Lack of funds | Conduct meetings for Maternal Newborn & Child Health Core Technical Committee |
| 4.1.1.b | Conduct ANC outreaches | | Lack of funds, security & difficult terrain | Conduct ANC outreaches |
| 4.1.1.c | Conduct Integrated Supportive Supervision (ISS) for Primary, Secondary & Private HFs on focused Antenatal plus essential newborn and PNC | | Lack of funds, security & difficult terrain | Conduct Integrated Supportive Supervision for Primary, Secondary &  Private HF |
| 4.1.1.d | Provide routine drugs (Folic Acid & Fesolate) for Primary & Secondary) HFs for ANC & PNC mothers and Sulphadoxine Pyrimethamine (SP) for Intermittent Preventive Treatment (IPT) of malaria for pregnant mothers for Primary & Secondary HFs in the state | | Lack of funds, security & difficult terrain | Costed in OHT |
| 4.1.1.e | Conduct at least one abdominal scan (before 24 weeks of gestation) | | Lack of funds | No cost |
|  | | 4.1.2 | Expand coverage of skilled delivery services | | * At least 200 skilled personnel employed * ELSS, LSS & MLSS trainings conducted * Home-Based Care & Midwifery Service Scheme revamped |  |  |
|  | | | 4.1.2.a | Employ personnel to strengthen at least one PHC per ward to provide skilled delivery services | | Lack of funds | Costed in OHT |
| 4.1.2.b | Conduct Elongated Life Saving Skills (ELSS) training for Medical Doctors | | Lack of funds | Conduct ELSS training for Medical Doctors |
| 4.1.2.c | Conduct Life Saving Skills (LSS) training for Nurses/Midwives | | Lack of funds | Conduct LSS training for Nurses/Midwives |
| 4.1.2.d | Conduct Modified Life Saving Skills (MLSS) training for CHOs/CHEWs | | Lack of funds | Conduct MLSS training for  CHOs/CHEWs |
| 4.1.2.e | Revamp Home-Based Care (HBC) and Midwifery Service Scheme in the state | | Lack of funds & difficult terrain | Revamp HBC and MSS |
|  | | 4.1.3 | Promote advocacy, community Mobilization and Behaviour Change Communication for Safe Motherhood Services | | * Uptake of safe motherhood interventions promoted by CBOs * Education & Sensitization meeting on safe motherhood practices held in the 23 LGAs * Safe Motherhood Week celebrated annually * Males trained and involved in reproductive health services and information in the communities |  |  |
|  | | | 4.1.3.a | Conduct advocacy to stakeholders (House of assembly, Wife of Governor, Line Ministries etc.) on Safe motherhood services (Conduct advocacy to Community Chiefs & Religious Leaders in the 23 LGAs on Safe Motherhood to encourage delivery in health facilities &  improve the proportion of delivery by skilled birth attendance | | Lack of funds & Political Will | Conduct advocacy to stakeholders on Safe Motherhood |
| 4.1.3.b | **Identify, build capacity of HWs and provide support to CBOs and community structures and CBOs to promote uptake of safe motherhood interventions by Women of Reproductive Age** (WRAG) | | Lack of funds | Develop IEC materials on safe motherhood |
| Lack of funds | Conduct meeting for community members on  safe motherhood practices |
| 4.1.3.c | Conduct Education & Sensitization meeting for community members on safe motherhood  practices in the 23 LGAs | |
| 4.1.3.d | Flag-off Safe Motherhood Week at state/LGA levels to increase sensitization, awareness, practice & utilization of Safe Motherhood services in health facilities | | Lack of funds | Observe Safe Motherhood Week |
| 4.1.3.e | Strengthen male involvement in reproductive health services and information by training male advocate on safe motherhood in the communities | | Lack of funds | Training male advocate |

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| 4.1.4 | Increase access to basic and comprehensive Emergency Obstetric Services | | * At least 23 hospitals upgraded * Obstetrics Emergency drugs procured and distributed to all HFs quarterly * Emergency transport system strengthened * At least 150 HWs trained on ENBC & HBB * At least 200 community-based workers trained on LSS |  |  |
|  | 4.1.4.a | Upgrade one hospital per LGA to provide comprehensive obstetrics care services (Basic EmOC plus blood transfusion plus C/S) | | Lack of funds | Upgrade hospitals |
| 4.1.4.b | Procure & distribute Obstetrics Emergency drugs (Misoprostol, Oxytocin, Ergometrine, Magnesium Sulphate, IV Fluids: Ringer Lactate, N/Saline, D/Saline, D/Water. Antibiotics, Anticonvulsants, Metronidazole) for 393 health facilities (Primary & Secondary) in the state | | Lack of funds | Costed in OHT |
| 4.1.4.c | Strengthen/Establish emergency transport system for obstetric emergencies | | Lack of funds | Strengthen/Establish emergency transport system |
| 4.1.4.d | Conduct training workshop for HWs (Doctors, Nurse/Midwives & CHOs/CHEWs on  Essential Newborn Care (ENBC) & Helping Babies Breath(HBB) | | Lack of funds | Costed in OHT |
| 4.1.4.e | Train community-based workers in Life Saving Skills (LSS) at community level using adapted WHO manual | | Lack of funds | Train community-based workers |
| 4.1.5 | Improve quality of care for safe motherhood services | | * SOPs developed * WHO Standards of Care for improving quality of maternal and newborn care adopted & implemented * At least 300 HWs trained on IPC skill |  |  |
|  | 4.1.5.a | Develop Standard operating procedures (SOPs) and job aids on reproductive health, maternal, new born, child and adolescent health (RMNCAH) care | | Lack of funds | Develop SOPs |
| 4.1.5.b | Adopt and implement WHO Standards of Care for improving quality of maternal and newborn care in health facilities | | Lack of funds | No cost |
| 4.1.5.c | Advocacy to community institutions for community mobilization and Behavioural Change  Communication on Safe Motherhood Services | | Lack of funds | Advocacy to community  institutions |
| 4.1.5.d | Conduct orientation training for HWs on IPC skills | | Lack of funds | Conduct orientation training |
| 4.1.5.e | Strengthen maternal and perinatal death surveillance and response (MPDSR) through adequate monitoring & evaluation to ensure coordinated referral system in the state | | Lack of funds | Quarterly monitoring & evaluation |
| 4.1.7 | Strengthen referral and feedback mechanisms | | * Joint Consultative Committee on Referral (JCCR) revamped & functional * Two model referral systems in riverine and upland communities equipped & functional * At least 100 facility staff trained on Referral Forms * At least 50% logistics provided for referral services |  |  |
|  | 4.1.7.a | Revamp Joint Consultative Committee on Referral (JCCR) to oversee referral activities in the state | | Lack of funds | Revamp JCCR |
| 4.1.7.b | Operating cost for engaging and supervising the contractor to equip two model referral systems in a predominantly riverine and upland communities in the State. For 2 way referrals | | Lack of funds | Costed in OHT |
| 4.1.7.c | Orientation of facility staff on updated 2-way Referral System Forms and its importance and conduct training on ambulatory services | | Lack of funds | Orientation & training of staff on referral forms/ambulatory services |
| 4.1.7.d | Design, print and distribute 2-way Referral Forms | | Lack of funds | Print & distribute |
| 4.1.7.e | Operating cost for engaging and supervising the contractor to provide logistics including functional communication system for referral services and transport services | | Lack of funds | Costed in OHT |
| 4.1.8 | Expand access to life saving commodities | | * Lifesaving commodities procured & distributed to all HFs annually * At least 300 HWs trained   • |  |  |
|  | 4.1.8.a | Operating cost for engaging and supervising the contractor to procure and distribute lifesaving commodities (Anti-shock Garments, Suction Machines, Self-Inflating Ambu Bags, Chlorhexidine Gels, Oxygen cylinders etc.) to all 350 HFs in the State | | Lack of funds | Costed in OHT |
| 4.1.8.b | Train Health Workers (HWs) on use of procured equipment and commodities | | Lack of funds | Train HWs |
| 4.1.8.c | Operating cost for engaging and supervising the contractor to provide logistics (vehicle) to  strengthen the supply chain management for the lifesaving commodities | | Lack of funds | Costed in OHT |

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| **4.2** | **Strengthen prevention, treatment and rehabilitation services for fistula care in Nigeria** | | | |  |  |
|  | 4.2.1 | Promote Obstetric Fistula preventive interventions | | * At least 360 HWs trained on catheterization in prolonged obstructed labour & the use of catheterization in prolonged labour enforced   •  • |  |  |
|  | | 4.2.1.a | Train health workers on catheterization in prolonged obstructed labour | | Lack of funds | Conduct quarterly meeting |
| 4.2.1.b | Collaboration meeting with other sectors to address the determinants of obstetrics fistula | | Lack of funds | Collaboration meeting |
| 4.2.1.c | Monitor and enforce use of catheterization in prolonged obstructed labour | | Lack of funds | Monthly visit |
|  | 4.2.2 | Strengthen /expand services for treatment of obstetric fistula | | * Advocacy visit to the Governor for free treatment and management of OF patients done * Regular supply of commodities to OF treatment centre done   • |  |  |
|  | | 4.2.2.a | Advocacy visit to the Governor for free treatment and management of OF patients | | Lack of funds | Advocacy visit |
| 4.2.2.b | Regular supply of commodities to strengthen existing Obstetric Fistula (OF) treatment centre in the state | | Lack of funds | Costed in OHT |
|  | 4.2.3 | Foster community participation for the rehabilitation and re-integration of fistula patients | | * OF mitigation and rehabilitation plan developed * Advocacy to integrate counseling into the continuum of OF patient management done * At least 20 CBOs trained to conduct OF rehabilitation interventions |  |  |
|  | | 4.2.3.a | Meeting to develop an OF mitigation and rehabilitation plan | | Lack of funds | Costed in 4.2.1b |
| 4.2.3.b | Advocacy to integrate counseling into the continuum of OF patient management | | Lack of funds | Advocacy meeting |
| 4.2.3.c | Build capacity of CBOs to conduct OF rehabilitation interventions | | Lack of funds | Train CBOs |
| 4.2.3.d | Collaboration meeting with NGOs, social workers and other stakeholders/sectors in OF  rehabilitation | | Lack of funds | Collaboration meeting |
| **4.3** | **Promote demand for and increase access to comprehensive and integrated reproductive health services (including family planning services and management of unsafe abortion** | | | |  |  |
|  | 4.3.1 | Scale up sexual and reproductive health services | | * RH cancer screening services established * 1 Hilux & 1 bus purchased * Advocacy meeting to integrate HIV screening into STI management done * Gender-based violence counseling and   treatment services provided |  |  |
|  | | 4.3.1.a | Establish/strengthen and promote uptake of RH cancer screening services (cervical cancer, breast cancer and prostrate) | | Lack of funds | Promote uptake of RH cancer screening services |
| 4.3.1.b | Operating cost for engaging and supervising the contractor to provide logistics (vehicle) to scale up screening and treatment of STIs to PHC level | | Lack of funds | Provide logistics for STIs screening at PHC level |
| 4.3.1.c | Advocacy meeting to integrate HIV screening into STI management | | Lack of funds | Advocacy meeting |
| 4.3.1.d | Provide gender-based violence counselling and treatment services | | Lack of funds | Provide counseling & treatment services |
|  | 4.3.2 | Increase demand for Reproductive health services | | * Advocacy for enabling legislations, policies and funding for RH done * Sensitization meeting with community stakeholders on Family Planning Services held * Sensitization meeting with stakeholders to get involved in RH interventions held |  |  |
|  | | 4.3.2.a | Conduct advocacy for enabling legislations, policies and funding for RH | | Lack of funds | No cost |
| 4.3.2.b | Develop communication materials for BCC | | Lack of funds | Print communication materials |
| 4.3.2.c | Conduct BCC interventions at all levels (from community to health facility, etc, including use of media) | | Lack of funds | Radio jingles @12,000x6 slot  TV N20,000x3 |
| 4.3.2.d | Sensitization meeting with community stakeholders (WDCs, Chiefs, Elders, CDC, Religious groups, Youth leaders, Women group, market women, male groups (Muslim community) at the local Government level on Family Planning Services | | Lack of funds | Sensitization meeting at LG level |
| 4.3.2.e | Sensitization meeting with stakeholders to get involved in RH interventions at state level | | Lack of funds | Sensitization meeting at State level |

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|  | 4.3.3 | Expand access to comprehensive, quality family planning services | | * At least 5 new FP service points provided * Task shifting in FP implemented & at least 40 unemployed SCHEWs trained on long lasting FP methods and functional * At least 120 Health care providers trained on comprehensive FP services provision, including LAC & functional |  |  |
|  | | 4.3.3.a | Increase number of FP services delivery points, including outreaches, and community- based distribution | | Lack of funds | Increase FP services delivery points & outreaches |
| 4.3.3.b | Observe World Contraceptive Day | | Lack of funds | Observe World Contraceptive Day |
| 4.3.3.c | Implement task shifting in FP service provision by training and using CHEWs for long lasting FP methods and community volunteers | | Lack of funds | Train CHEWs |
| 4.3.3.d | Conduct training of health care providers in comprehensive FP services provision, including  LARC | | Lack of funds | Train HWs |
| 4.3.3.e | Operating cost for engaging and supervising the contractor to provide logistics to ensure sustainable FP commodity supply chain management in the State | | Lack of funds | Costed in OHT |
|  | 4.3.4 | Strengthen and integrate Family Planning and Post Abortion Care services at all levels | | * At least 120 FP providers trained to provide counselling & FP & Post Abortion Care services * Counselling & FP services for Post Abortion Care in place and utilized * 50 persons from the Private Sector trained   on LARC and providing the service |  |  |
|  | | 4.3.4.a | Conduct training & re-training workshop for Family Planning providers to provide counselling & Family Planning Services for Post Abortion Care | | Lack of funds | Training workshop |
| 4.3.4.b | Provide counselling and family planning services for post-abortion care clients in all Model Primary Health Care Centres & Secondary Health Facilities in the State | | Lack of funds | Provide counselling & Family Planning Services for Post-Abortion Care  client |
| 4.3.4.c | Conduct training workshop for Private Sector on Long Acting Reversible Contraceptive (LARC) | | Lack of funds | Conduct training workshops for LARC |
| 4.3.4.d | Conduct public enlightenment and community engagement interventions | | Lack of funds | Conduct public  enlightenment |
|  | 4.3.5 | Promote prevention of harmful traditional practices and gender-based violence | | * Public education and community sensitization on HTP and GBV carried out   •  • |  |  |
|  | | 4.3.5.a | Conduct public education and community sensitization on HTP and GBV | | Lack of funds | Conduct public education |
|  | 4.3.6 | Scale up Prevention, counseling and treatment of rape and other gender based violence such as Rape, intimate partner violence etc. | | * At least 360 health care providers trained on detection and management of GBV and rape/intimate partner violence * Treatment and reporting protocols HTP & GBV established |  |  |
|  | | 4.3.6.a | Develop training manuals, treatment guidelines and job aids for HTP and GBV | | Lack of funds | Develop training manuals |
| 4.3.6.b | Train health care providers in the detection and management of GBV and rape/intimate  partner violence | | Lack of funds | Train Health care providers |
| 4.3.6.c | Establish treatment and reporting protocols | | Lack of funds | No cost |
| 4.3.6.d | Establish linkages between health care providers, law enforcement agencies, social  services etc for comprehensive service provision for GBV | | Lack of funds | No cost |
| **4.4** | **Reduce neonatal and childhood mortality and promote optimal growth, protection and development of all newborns and children under five years of age.** | | | |  |  |
|  | 4.4.1 | Strengthen postnatal and newborn care | | * At least 385 Midwives trained on follow up care of Postnatal mothers * 4% chlorhexidine gel procured & distributed to 385 HFs * 200 HWs trained on proper use of Chlorhexidine gel for Cord care and prevention of neonatal sepsis RI conducted in all HFs annually |  |  |

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|  | 4.4.1.a | Conduct training for Midwives in all HFs on follow up care of Postnatal mothers within the  first 24 hrs, then 3rd and 7th day after delivery | | Lack of funds | Conduct training |
| 4.4.1.b | Print & distribute posters on Danger signs of heavy bleeding, smelly discharge per vagina, fever, weakness & dizziness to all HFs to create awareness | | Lack of funds | Print & distribute posters |
| 4.4.1.c | Procure & distribute 4% chlorhexidine gel (CHX) for cord care to all 385 HFs for prevention of  cord infection | | Lack of funds | Costed in OHT |
| 4.4.1.d | Conduct sensitization meeting for HWs on proper use of Chlorhexidine gel for Cord care for prevention of neonatal sepsis and provide essential newborn care in all delivery service points (thermal care, including kangaroo mother care, neonatal resuscitation) | | Lack of funds | No cost |
| 4.4.2 | Strengthen emergency obstetric, newborn and childhood care. | | * Special care baby units for emergency newborn care in LGA general hospitals upgraded to include CEmOC * 300 HWs trained on Essential Maternal Newborn Care and Helping Babies Breathe (HBB) * Emergency Obstetric and Neonatal drug and commodities procured & supplied |  |  |
|  | 4.4.2.a | Develop and implement emergency obstetrics, newborn and child health treatment guidelines and protocols along the different levels of care, from community level, including effective referral systems | | Lack of funds | Develop/implement guideline |
| 4.4.2.b | Upgrade special care baby units for emergency newborn care in LGA general hospitals to include CEmOC | | Lack of funds | Costed in OHT |
| 4.4.2.c | Conduct training and re-training workshop for HWs on Essential Maternal Newborn Care and Helping Babies Breathe (HBB) | | Lack of funds | Train HWs on Essential Maternal/Newborn Care & HBB |
| 4.4.2.d | Procure and supply Emergency Obstetric and Neonatal drug and commodities to all HFs in the state | | Lack of funds | Costed in OHT |
| 4.4.3 | Intensify the promotion of exclusive breastfeeding for the first six months of life and appropriate complimentary feeding | | * The 10 steps to successful breast feeding initiated in every maternity home practices * Mass media edutainment and community engagement/sensitization on Exclusive Breast Feeding (EBF) intensified * At least 750 copies of IEC materials on EBF developed, printed & distributed |  |  |
|  | 4.4.3.a | Promote early initiation of breastfeeding including promotion of Hospital Baby Friendly Initiative (HBFI), so that every maternity home practices the 10 steps to successful breast feeding | | Lack of funds | No cost |
| 4.4.3.b | Intensify mass media edutainment and community engagement/sensitization on Exclusive  Breast Feeding (EBF) | | Lack of funds | Public education |
| 4.4.3.c | Develop, print and distribute IEC materials on EBF | | Lack of funds | Print IEC materials |
| 4.4.4 | Strengthen routine child immunization including new antigens | | * 60 cold room kit procured & supplied * Routine Immunisation task force in place & MOU on accountability developed & implemented * RI carried out in all HFs * CHIPS Programme initiated and implemented |  |  |
|  | 4.4.4.a | Conduct advocacy visit for RI Focal Officers (RIFO) to the 23 Local Government Chairmen  for timely release of RI funding for the LGAs | | Lack of funds | Conduct advocacy visit |
| 4.4.4.b | Procure and supply cold room kit for SCCO to conduct the temperature mapping. | | Lack of funds | Costed in OHT |
| 4.4.4.c | Develop and implement MOU on accountability for RI (with all stakeholders, including Private Sector) and re-active Routine Immunisation task force | | Lack of funds | Develop and implement MOU |
| 4.4.4.d | Conduct RI in all HFs to ensure vaccination of newborn with BCG, HBV & OPV at birth before discharge | | Lack of funds | No cost |
| 4.4.4.e | Initiate and implement Community Health Influencers/Promoters and Service (CHIPS)  Program for demand creation | | Lack of funds | No cost |
| 4.4.5 | Improve quality of newborn and child healthcare services | | * 300 HWs trained on updated ENCC packages * Local dialects messages on ENCC & Chlorhexidine disseminated through multiple media channels * Orientation for Private HFs, PPMVs/Pharmacies on Newborn Care including cord care with CHX implemented |  |  |

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|  | 4.4.5.a | Develop/adapt and produce newborn and child health treatment guidelines and protocols  for different levels of care | | Lack of funds | Develop/adapt treatment  guidelines and protocols |
| 4.4.5.b | Strengthen capacity of health care providers and facilities to provide quality newborn care | | Lack of funds | Train HWs |
| 4.4.5.c | Develop and disseminate messages in local dialects through multiple media channels (Print and electronic media) on ENCC & chlorhexidine gel use for cord care | | Lack of funds | Develop and disseminate messages |
| 4.4.5.d | Orientate Private HFs, PPMVs/Pharmacies on Newborn Care including cord care with CHX | | Lack of funds | Conduct orientation |
| 4.4.6 | Promote advocacy, community mobilisation and behavioural change communication for newborn and child healthcare services | | * Advocate to policy makers and legislators done * At least 300 WDC/Community volunteers engaged and trained * Newborn and child health communication materials developed and distributed |  |  |
|  | 4.4.6.a | Advocate to policy makers and legislators for enabling policies, funding and prioritization of newborn and child health | | Lack of funds | Advocacy visit |
| 4.4.6.b | Engage and train WDC/Community volunteers on community sensitization and education for public promotion of and uptake of newborn and child health services | | Lack of funds | Train WDC/Community volunteers |
| 4.4.6.c | Develop and distribute newborn and child health communication materials | | Lack of funds | Print communication materials |
| 4.4.8 | Expand coverage of IMCI (Community-IMCI, Community Case Management (ICCM) & IMCI) | | * Community Case Management of Childhood Illness (CIMCI) done * Community IMCI implemented * At least 560 health care providers trained on IMCI and CIMCI |  |  |
|  | 4.4.8.a | Scale-up implementation of Community Case Management of Childhood Illness (CIMCI) using national protocols at all PHC facilities in all LGAs | | Lack of funds | Implement CIMCI |
| 4.4.8.b | Scale up implementation of Community IMCI (promotion of key household practices for child survival and development) | | Lack of funds | Costed in OHT |
| 4.4.8.c | Train health care providers IMCI (case management) and community-based health care providers and CHEWs on IMCI and CIMCI) | | Lack of funds | Train Health care providers |
| 4.4.8.d | Build capacity of community structures (WDC) in planning and implementation of CIMCI and IMCI interventions | | Lack of funds | No cost |
| **Improve access to adolescent health and young people information and services** | | | |  |  |
| 4.5.1 | Intensify advocacy, social mobilization and behavior change communication for positive adolescent behaviour. | | * Adolescent Core Technical Committee (CTC) set up * Peer To Peer Health Education revived * Advocacy visits to stakeholders & schools carried out * Media engaged to promote positive adolescent behaviour change |  |  |
|  | 4.5.1.a | Set up Core Technical Committee (CTC) with membership from all adolescent related services (SMOH, Women Affairs, Youth & Empowerment, Sports, Finance, Chieftaincy, Justice, Agriculture, Media, CBOs, FBOs etc.) to ensure positive adolescent behaviour. | | Lack of funds | No cost |
| 4.5.1.b | Advocate for revival of Peer To Peer Health Education | | Lack of funds | Advocate for revival |
| 4.5.1.c | Conduct advocacy visits to relevant stakeholders e.g. SMOH, SMOE, PHCMB, Women Affairs, Youth & Empowerment, Sports, NDLEA, FRSC etc. to mobilize them to support promotion of positive adolescent behaviour change in Schools | | Lack of funds | Conduct advocacy visits |
| 4.5.1.d | Conduct sensitization/advocacy visits to schools on positive adolescent behaviour change | | Lack of funds | Conduct  sensitization/advocacy visits |
| 4.5.1.e | Engage media advocacy and sensitization to promote positive adolescent behaviour change | | Lack of funds | Engage media advocacy and sensitization |

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| 4.5.2 | Expand access to quality adolescent reproductive health services | | * Comprehensive sexual and reproductive health education for adolescents conducted * Family Planning Services, Health Education on Family Life Education, Nutrition, Sex Education, Gender equality etc. & Career Counselling provided in at least 10 secondary schools per LGA * Youth friendly ARHS integrated into Primary Health Centre |  |  |
|  | 4.5.2.a | Conduct comprehensive sexual and reproductive health education for in- and out-of school adolescents | | Lack of funds | Conduct health education |
| 4.5.2.b | Provide Family Planning Services in secondary schools (Include HPV vaccine & TT immunization) | | Lack of funds | Provide Family Planning Services |
| 4.5.2.c | Give Health Education on Family Life Education, Nutrition, Sex Education, Gender equality etc. in schools | | Lack of funds | Costed in 4.5.2b |
| 4.5.2.d | Provide Career Counselling | | Lack of funds | Costed in 4.5.2b |
| 4.5.2.e | Integrate Youth friendly ARHS into Primary Health Centre | | Lack of funds | No cost |
| 4.5.3 | Strengthen prevention, detection, and management of HIV and STIs among adolescents | | * At least 50 teachers (TOT) & 2,300 students trained on prevention, detection & management of HIV & STIs among adolescents   •At least 500 female secondary students in the 23 LGAs on cervical cancer prevention & awareness creation   * Identification exercise conducted |  |  |
|  | 4.5.3.a | Conduct sensitization meeting with MOY, MOE, CBOs, FBOs, YBOs for support in prevention, detection & management of HIV & STIs among adolescents | | Lack of funds | Conduct sensitization meeting |
| 4.5.3.b | Conduct TOT for secondary school (JS1 - SS3) teachers in the 23 LGAs on prevention, detection & management of HIV & STIs among adolescents | | Lack of funds | Conduct TOT |
| 4.5.3.c | Train JSS1 - SS3 students on prevention, detection & management of HIV & STIs among  adolescents | | Lack of funds | Train JSS1 - SS3 students |
| 4.5.3.d | Train female secondary students in the 23 LGAs on cervical cancer prevention & awareness creation | | Lack of funds | Train female secondary students |
| 4.5.3.e | Conduct identification exercise in schools in the state | | Lack of funds | Costed in 4.5.3c |
| 4.5.4 | Promote Menstrual hygiene among adolescents | | * At least 100 Health Educators & Counselors trained on menstrual hygiene   •Health Education & Peer to Peer education implemented   * 500 toiletries & 500 sanitary pad purchased & distributed |  |  |
|  | 4.5.4.a | Conduct TOT for Health Educators and counselors from concerned NGOs on menstrual  hygiene in the LGA/State | | Lack of funds | Conduct TOT |
| 4.5.4.b | Conduct Health Education for secondary school girls in the state on Menstrual hygiene  among adolescents | | Lack of funds | Costed in 4.5.3d |
| 4.5.4.c | Conduct peer to peer education in girls’ schools in the 23 LGAs | | Lack of funds | Costed in 4.5.3d |
| 4.5.4.d | Purchase & distribute toiletries & sanitary pad to secondary school females in the 23 LGA | | Lack of funds | Purchase & distribute toiletries & sanitary pads |
| 4.5.5 | Scale-up implementation of adolescent sexual and reproductive health education in the school curriculum | | * Adolescent sexual and reproductive health education included in school curriculum and implemented * ! Hilux & 1 bus purchased   • |  |  |
|  | 4.5.5.a | Advocate for inclusion of adolescent sexual reproductive health in the school curriculum | | Lack of funds | Costed in 4.5.1c |
| 4.5.5.b | Operating cost for engaging and supervising the contractor to purchase vehicle (Hilux & Bus) for supervision & monitoring of sex education in primary & secondary schools. | | Lack of funds | Operating cost |
| 4.5.5.c | Conduct periodic supportive supervision & monitoring of implementation of adolescent  sexual and reproductive health education in schools in the state | | Lack of funds | Conduct supportive visits |
| 4.5.6 | Scale up screening and management of drug use, internet addiction, self-harm, mental health, nutrition disorders and other leading adolescent health problems | | * 1,200 teachers trained on identification & management of adolescent health problems * 150 HWs trained on Drug Demand Reduction * Drug rehabilitation centre established * Youth clubs set up in at least 50 schools per LGAs & Peer to peer education done |  |  |

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|  | 4.5.6.a | Conduct Training of Trainers (TOT) workshop for teachers on identification of substance use, internet addiction, self, mental health, nutrition disorders & other leading adolescent health problems & management in schools | | Lack of funds | Training of Trainers |
| 4.5.6.b | Conduct training Doctors, Nurses, Psychologists, Counsellors etc. on Drug Demand Reduction in the 23 LGAs | | Lack of funds | Conduct 1wk training for 150 persons |
| 4.5.6.c | Operating cost for engaging and supervising the contractor to establish drug treatment/rehabilitation centre for males & females in the state. Provide skill acquisition centres for; paint making, tailoring, shoe making, computer training & fabrication. | | Lack of funds | Operating cost. Costed in OHT |
| 4.5.6.d | Operating cost for engaging and supervising the contractor to equip drug treatment/rehabilitation centre for males & females in the state | | Lack of funds | Operating cost. Costed in OHT |
| 4.5.6.e | Advocacy for integration of adolescent drug addiction into mental health | | Lack of funds | Advocacy for integration |
| 4.5.7 | Promote school health services including deworming | | * Biannual deworming of school age children conducted & at least 100 cartons of worm expellant to schools purchased & distributed * Orientation workshop on the importance of deworming done * Media talk implemented * 1 bus purchased |  |  |
|  | 4.5.7.a | Conduct biannual deworming of school age children | | Lack of funds | No cost |
| 4.5.7.b | Purchase & distribute worm expellant to schools in the state according to target population | | Lack of funds | Purchase/distribute worm expellant |
| 4.5.7.c | Conduct orientation workshop for secondary school students & PTA Chairmen on the importance of deworming in children and adolescents | | Lack of funds | Conduct workshop |
| 4.5.7.d | Conduct media (Radio & Television) talk on deworming exercise in schools during MNCH Week | | Lack of funds | Conduct media talk |
| 4.5.7.e | Operating cost for engaging and supervising the contractor to provide vehicle for School  Health activities in the LGAs | | Lack of funds | Operating cost. Costed in  OHT |
| **Improve the nutritional status of Nigerians throughout their life cycle with a particular focus on vulnerable groups especially children under five years, adolescents, women of reproductive age and the elderly** | | | |  |  |
| 4.6.1 | Promote hospital baby friendly initiative | | * At least 744 posters printed & distributed * Campaigns through media implemented   • |  |  |
|  | 4.6.1.a | Print & distribute posters on baby friendly initiative to promote awareness on IYCF in all health facilities (PHC centres, ANC clinics, OTP and CMAM sites, and child welfare clinics) | | Lack of funds | Print & distribute posters |
| 4.6.1.b | Conduct periodic campaigns through the media to the general public to promote baby friendly hospitals | | Lack of funds | Conduct campaigns |
| 4.6.2 | Promote exclusive breastfeeding for the first six months of life | | * Breastfeeding within 30 minutes of delivery initiated in all HFs * Health talk on exclusive breastfeeding given in all health facilities in the 23 LGAs * World Breast Feeding Week at the state & LGA levels observed   + Breastfeeding Support Group (BSG)   established |  |  |
|  | 4.6.2.a | Ensure initiation of breastfeeding within 30 minutes of delivery | | Lack of funds | No Cost |
| 4.6.2.b | Give health talk on exclusive breastfeeding to pregnant women and parents of infants under 6months of age pregnant/lactation women, adolescents & women of reproductive age at the  health facilities in the 23 LGAs | | Lack of funds | No cost |
| 4.6.2.c | Conduct advocacy meeting with high level stakeholders (Traditional ruler, Legislators, Health Workers etc.) to promote, support & protect exclusive breast feeding at state & LGA levels | | Lack of funds | No cost |
| 4.6.2.d | Observe World Breast Feeding Week at the state & LGA levels | | Lack of funds | Observe World Breast Feeding Week |
| 4.6.2.e | Establishment of Breastfeeding Support Group (BSG) during Breastfeeding Week at LGA level | | Lack of funds | No Cost |
| 4.6.3 | Scale-up continued breastfeeding and appropriate complementary feeding from six months | | * Advocacy visit to workplace for provision of crèche in work environment done * Health Education (HE) to promote adoption of principles of FADUS given in at least 385 HFs * At least 100 Community Counselors trained on Infant & Young Child Feeding |  |  |

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|  | 4.6.3.a | Media awareness campaign on the importance of continued breastfeeding & complementary feeding | | Lack of funds | Media campaign |
| 4.6.3.b | Advocacy to workplace for provision of crèche in work environment to enable working nursing mothers continue breastfeeding | | Lack of funds | Advocacy visit |
| 4.6.3.c | Health Education (HE) to promote adoption of principles of FADUS (frequency, adequacy, density, utilization and safety) of complementary feeds and counselling on complimentary feeding promotion to parents of infants from 6 months & pregnant women routinely at the  primary, secondary & tertiary levels | | Lack of funds | No cost |
| 4.6.3.d | Conduct routine food demonstration at the health facilities on provision & preparation of nutrient dense complimentary food to pregnant women & parents of infants from 6months at LGA & State levels | | Lack of funds | No cost |
| 4.6.3.e | Conduct training and re-training for Community Counselor on Infant & Young Child Feeding (IYCF) | | Lack of funds | Conduct training |
| 4.6.4 | Expand coverage with micronutrient powder supplementation | | * Multi Micronutrient powders for fortification of home feeds for children aged 6- 23months introduced & distributed * Doses of Vitamin A for children aged 6 - 59 months, integrated distributed with measles campaign, RI and in CWC * Zinc supplements provided as routine constituent of diarrhea management for children aged 6 - 59 months |  |  |
|  | 4.6.4.a | Introduce & distribute Multi Micronutrient Powder for fortification of home feeds for children aged 6 to 23 months | | Lack of funds | No cost |
| 4.6.4.b | Provide biannual doses of Vitamin A for children aged 6 - 59 months, integrate distribution with measles campaign, RI and in CWC | | Lack of funds | Costed in OHT |
| 4.6.4.c | Provide Zinc supplements as routine constituent of diarrhea management for children aged 6 - 59 months | | Lack of funds | No cost |
| 4.6.4.d | Conduct demonstration of the use of micronutrients powders for in-home fortification of  complimentary foods to parents of infants & children of 6-23months of age at the health  facilities routinely | | Lack of funds | No cost |
| 4.6.5 | Scale-up prevention, detection, control and management of acute malnutrition | | * Mothers/caregivers within communities sensitized on adequate nutrition for infants and young children * CMAM sites established in primary and secondary health facilities * Essential drugs & food for the management of malnutrition procured and distributed to primary & secondary HFs |  |  |
|  | 4.6.5.a | Sensitize mothers/caregivers within communities on adequate nutrition for infants and young children | | Lack of funds | Sensitize mothers |
| 4.6.5.b | Mass media (special regular nutrition programmes on radio and TV) and ICT platforms to provide general information on Community-Based Management of Acute Malnutrition (CMAM) | | Lack of funds | Mass media campaign |
| 4.6.5.c | Observe Nutrition Week and conduct active community screening of children for signs of undernutrition | | Lack of funds | Observe Nutrition Week |
| 4.6.5.d | Establish CMAM sites in primary and secondary health facilities to increase access to CMAM services | | Lack of funds | No Cost |
| 4.6.5.e | Procure and distribute to all primary and secondary health care facilities, essential drugs for the management of malnutrition and nutrition commodities for management of severe acute malnutrition including Ready to Use Therapeutic Foods (RUTF) | | Lack of funds | Costed in OHT |
| 4.6.6 | Scale up nutrition for children with special nutritional needs including (children born to HIV positive mothers; infants and young children in emergencies with persistent diarrhoea etc. | | * Health talk on the use of zinc supplement for diarrhoea management given in HFs * 100 mothers trained on use of micronutrients powder * Demonstration on the use of micronutrients powders carried out |  |  |
|  | 4.6.6.a | Adhere to national guidelines in the management of nutritional needs of children in difficult situations | | Lack of funds | No Cost |
| 4.6.6.b | Give health talk to HIV positive mothers and caregivers of under-fives on the use of zinc supplement as part diarrhoea management in all facilities routinely | | Lack of funds | No Cost |
| 4.6.6.c | Conduct demonstration on the use of micronutrients powders for in-home fortification of complimentary foods to parents of HIV positive under-five children in all health facilities in the state routinely | | Lack of funds | No cost |

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| 4.6.7 | Promote implementation of school feeding programme | | * Advocacy meeting with Ministry of Education on promotion and implementation of school feeding done * At least 500 teachers trained on salt for presence of Iodine * Media engaged to promote handwashing   and sanitation |  |  |
|  | 4.6.7.a | Conduct advocacy meeting with Ministry of Education on promotion and implementation of school feeding | | Lack of funds | Conduct advocacy visit |
| 4.6.7.b | Train Primary School Teachers on salt testing for presence of Iodine | | Lack of funds | Conduct training |
| 4.6.7.c | Community outreaches through the media to promote handwashing and sanitation | | Lack of funds | Media outreach |
| 4.6.8 | Foster Iron and Folic Acid supplementation in pregnant women; and Vit A supplementation in lactating women. | | * Provision of iron, folic acid and vitamin A supplementation integrated into ANC package including vit. A for lactating mothers * Media campaign on the importance and use of iron-folic acid in pregnancy & vitamin A supplementation in lactating   women conducted |  |  |
|  | 4.6.8.a | Integrate provision of iron, folic acid and vitamin• supplementation into ANC package and  A  vit A for lactating mothers --- Link to ANC | | Lack of funds | No cost |
| 4.6.8.b | Conduct media campaign on the importance and use of iron-folic acid in pregnancy & vitamin A supplementation in lactating women | | Lack of funds | Conduct media campaign |
| 4.6.9 | Promote optimal nutrition of adolescents and Women of Reproductive Age (WRA) | | * Dietary counselling sessions for adolescent & WRA conducted in at least 50% of HFs * At least 600 girls trained in 6 schools (100 per school) annually on Improved Nutrition for Adolescent Girls * Seminar on nutrition education done |  |  |
|  | 4.6.9.a | Conduct dietary counselling sessions to adolescents & WRA at the health facilities on promotion & importance of good nutrition during pregnancy & lactation | | Lack of funds | No Cost |
| 4.6.9.b | Conduct sensitization training on Improved Nutrition for Adolescent Girls for Secondary Schools girls in the 23 LGAs | | Lack of funds | Conduct training |
| 4.6.9.c | Conduct seminar on nutrition education and the importance of adequate nutrition to adolescents & Women of Reproductive Age (WRA) in Faith Based Organisations (FBOs), CBOs & the general public to promote women nutritional status | | Lack of funds | 1 day seminar foe 50 persons |
| 4.6.9.d | Observe International Women's Day (IWD) celebration | | Lack of funds | Observe IWD celebration |
| 4.6.9.e | Baseline survey on nutritional status of Adolescent girls in secondary and tertiary institutions  in the State. | | Lack of funds | Conduct baseline survey |
| 4.6.10 | Promote healthy diets for the elderly | | * Guidelines / SOP on the Nutritional care of the elderly developed * At least 23 LGA Nutrition Officers and State officers trained on Geriatric nutrition and care. * 200 Volunteer Health Workers trained on Nutritional Care of the elderly. * Orientation/Sensitization on healthy choice of foods for the elderly carried out quarterly |  |  |
|  | 4.6.10.a | Baseline Survey on number and health/nutritional status of elderly men/women in 319 wards of the State | | Lack of funds | Conduct baseline survey |
| 4.6.10.b | Development of Guidelines / SOP on the Nutritional care of the elderly | | Lack of funds | Develop SOP |
| 4.6.10.c | Build capacity of LGA Nutrition Officers and State officers on Geriatric nutrition and care. | | Lack of funds | Build capacity |
| 4.6.10.d | Train Volunteer Health Workers per ward on Nutritional Care of the elderly. | | Lack of funds | Train Volunteer Health  Workers |
| 4.6.10.e | Conduct quarterly orientation/sensitization per senatorial zone for the Elderly on healthy  choice of foods for improved life | | Lack of funds | Conduct orientation |

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| **5.Communicable Diseases (Malaria, TB, Leprosy, HIV/AIDS) And Neglected Tropical Diseases** | | | | | | | |
| **5. To improve prevention, case detection and coordinated response for the prevention, control and management of communicable diseases and NTDs** | | | | | | | |
|  | **5.1** | **Reduce significantly morbidity and mortality due to Malaria and move towards pre-elimination levels** | | | |  |  |
|  | | 5.1.1 | Expand access to integrated vector control interventions | | * LLIN/L, Larvicides & IRS procured & distributed to primary & secondary HFs * Indoor residual spray conducted in Port Harcourt watersides, high density areas & 23 LGA HQs * Jingles in electronic media on malaria prevention and vector control produced & aired * Bill boards on Malaria prevention and vector control mounted |  |  |
|  | | | 5.1.1.a | Conduct micro plan for LLIN mass campaign | | Lack of funds | Costed in OHT |
| 5.1.1.b | Procure and distribute LLIN/L, Larvicides, IRS for health facilities (Primary & Secondary) | | Lack of funds | Costed in OHT |
| 5.1.1.c | Conduct indoor residual spray in Port Harcourt watersides & high density areas and the 23 LGAs Headquarters | | Lack of funds | Costed in OHT |
| 5.1.1.d | Produce and air jingles in electronic media on malaria prevention and vector control | | Lack of funds | Media campaign |
| 5.1.1.e | Operating cost for engaging and supervising the contractor to construct and mount Bill boards on Malaria prevention and vector control | | Lack of funds | Costed in OHT |
|  | | 5.1.2 | Strengthen laboratory services for diagnosis of malaria at all levels | | * At least 200 Ward Health Centres upgraded for laboratory services * Microscopes & consumables procured and distributed to at least 200 Ward Health Centre laboratories * Malaria RDT Kits procured & distributed to at least 200 Primary & Secondary Health facilities |  |  |
|  | | | 5.1.2.a | Upgrade Ward Health Centres for laboratory services | | Lack of funds | Upgrade Ward Health Centres |
| 5.1.2.b | Procure & distribute microscopes for 319 Ward Health Centre laboratories | | Lack of funds | Procure/distribute microscopes. Costed in OHT |
| 5.1.2.c | Procure and distribute malaria RDT Kits to Primary & Secondary Health facilities | | Lack of funds | Procure and distribute Malaria RDT Kits. Costed |
| 5.1.2.d | Procure consumables for Ward Health Centres laboratories | | Lack of funds | iPnroPcHuTre & distribute  Malaria consumables. Costed in OHT |
| 5.1.2.e | Conduct parasitological diagnosis | | Lack of funds | No cost |
|  | | 5.1.3 | Build capacity of personnel in public and private health facilities for parasitological confirmation of malaria. | | * At least 50 Med. Lab scientists, Technicians and Assistants re-trained on malaria parasitological confirmation. * At least 200 laboratory miscroscopists trained on basic malaria microscopy & deployed to 200 Ward Health Centres * At least 30 Malaria Focal persons and State Team Members trained & re-trained   on the use of RDTs for malaria diagnosis |  |  |
|  | | | 5.1.3.a | Conduct re-training workshop for Med. Lab scientists, Technicians and Assistants on malaria parasitological confirmation. | | Lack of funds | Conduct workshop |
| 5.1.3.b | Conduct training for laboratory microscopists on basic malaria microscopy for deployment to Ward Health Centres | | Lack of funds | Costed in 5.1.3a |
| 5.1.3.c | Conduct a training/retraining for Malaria Focal persons and State Team Members on the use of RDTs for malaria diagnosis | | Lack of funds | Conduct training/re-training |
| 5.1.3.d | Distribute SOPs on parasitological confirmation to Health Facilities | | Lack of funds | Distribute SOPs |
| 5.1.3.e | Distribute SOPs on parasitological confirmation to Health Facilities | | Lack of funds | Stakeholders' Review Meeting |
|  | | 5.1.5 | Improve availability of and access to commodities and supplies for treatment of uncomplicated and severe malaria | | * ACT and artesunate injections purchased & distributed to 407 primary & secondary HFs * Hand gloves procured & distributed to 407 Primary & Secondary Health facilities * RBM manager, State Malaria logistics   officer and 23 MFPs trained on commodity management |  |  |

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|  | 5.1.5.a | Strengthen malaria treatment by purchasing and distributing ACT and artesunate injections and ensuring successful treatment using approved protocol. | | Lack of funds | Procure and distribute ACT. Costed in OHT |
| 5.1.5.b | Procure and distribute hand gloves to Primary & Secondary Health facilities for effective  Lab use | | Lack of funds | Procure and distribute hand  gloves. Costed in OHT |
| 5.1.5.c | Conduct training for RBM manager, State Malaria logistics officer and 23 MFPs on  commodity management | | Lack of funds | Conduct training |
| 5.1.6 | Expand use of IPTp among pregnant women attending ANC | | * SP provided & distributed to 407 primary & secondary HFs * Malaria posters & flyers on IPT produced & distributed to 407 primary & secondary HFs |  |  |
|  | 5.1.6.a | •  Strengthen malaria prevention among pregnant women attending ANC by providing and distributing SP to all Primary & Secondary Health Facilities in the State. | | Lack of funds | Procure and distribute SP Anti-Malaria drugs |
| 5.1.6.b | Production and distribution of malaria IEC materials (posters & flyers) on IPT annually to all primary and secondary health facilities. | | Lack of funds | Produce and distribute IEC |
| 5.1.8 | Promote active community participation in malaria control initiative | | * Workshop with community stakeholders to plan malaria control programmes done * Community dialogue meeting conducted in the 23 LGAs * World Malaria Day Celebration observed |  |  |
|  | 5.1.8.a | Increase advocacy visits to community chiefs & compound heads for initiating community sensitizations malaria | | Lack of funds | Conduct workshop |
| 5.1.8.b | Conduct community dialogue meetings in the 23 LGAs | | Lack of funds | Conduct meetings |
| 5.1.8.c | Increase advocacy visits to community chiefs & compound heads for initiating community sensitizations | | Lack of funds | Advocacy visits |
| 5.1.8.d | Conduct quarterly meetings to review M&E conducted | | Lack of funds | Conduct meetings |
| 5.1.8.e | Observe World Malaria Day Celebration | | Lack of funds | World Malaria Day Celebration |
| **Ensure universal access to high quality, client-centred TB/Leprosy diagnosis and treatment services for the reduction in the incidence and prevalence of tuberculosis/leprosy in Nigeria.** | | | |  |  |
| 5.2.1 | Strengthen TB case detection, diagnostic capacity and access to quality treatment services . | | * Diagnostic capacity scaled up in at least 50 HFs * TB case finding through presumptive and referral intensified in at least 50 HFs   • |  |  |
|  | 5.2.1.a | Strengthen and scale up diagnostic capacity strategically, focusing on high-burden areas and areas of poor coverage and maintain quality throughout the laboratory network | | Lack of funds | Strengthen and scale up diagnostic capacity |
| 5.2.1.b | Engage all health facilities in intensified case finding through presumptive and referral to ensure universal access to TB services | | Lack of funds | Engage all health facilities |
| 5.2.2 | Promote demand for TB services | | * Mass media edutainment on how to access TB services conducted * Advocacy visits to Government & Development Partners to provide/increase funding of the TB programs done * World TB day observed in the state & 23   LGAs |  |  |

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|  | 5.2.2.a | Conduct mass media edutainment to create awareness on how to access TB services, get cured and what their rights and responsibilities are to support demand for universal access to services | | Lack of funds | Conduct mass media edutainment |
| 5.2.2.b | Conduct mass media edutainment to create awareness on how to access TB services, get cured and what their rights and responsibilities are to support demand for universal access to services | | Lack of funds | Advocacy visits |
| 5.2.2.c | Observe world TB day in the state & 23 LGAs annually | | Lack of funds | Observe world TB day |
| 5.2.3 | Expand access to TB diagnosis and treatment services for persons co-infected by TB and HIV | | * TB equipment purchased & distributed to upgrade at least 50 health facilities for TB microscopy in the 23 LGAs * At least 100 Health workers trained on HCT in new Dots sites * HIV services provided in at least 50% of   DOTs sites |  |  |
|  | 5.2.3.a | Operating cost for engaging and supervising the contractor to procure TB equipment to upgrade health facilities for TB microscopy in the 23 LGAs | | Lack of funds | Costed in OHT |
| 5.2.3.b | Conduct training for Health workers on HCT in new Dots sites | | Lack of funds | Conduct training |
| 5.2.3.c | Provide HIV services in all DOTs sites in the state to enhance patient-centred treatment (one stop shop) | | Lack of funds | Provide HIV services |
| 5.2.4 | Scale up paediatric TB diagnosis and treatment services | | * Active TB case finding implemented in at least 50% of specific vulnerable populations * Advocacy conducted to at least 80% paediatric related bodies   • |  |  |
|  | 5.2.4.a | Implement active TB case finding in specific vulnerable populations (e.g. contacts to active TB cases, migrants, prisoners and slum dwellers ) | | Lack of funds | Implement active TB case finding |
| 5.2.4.b | Conduct advocacy to paediatric related bodies (Paediatric associations, department of IMCI, thoracic associations, UNICEF and other bi- and multilateral agencies) on integration of TB services into other child survival strategies | | Lack of funds | Conduct advocacy |
| 5.2.5 | Increase access to diagnosis and management services for DR-TB | | * Robust DR-TB diagnosis, treatment and care services established   • |  |  |
|  | 5.2.5.a | Operating cost for engaging and supervising the contractor to establish a robust DR-TB diagnosis, treatment and care services | | Lack of funds | Costed in OHT |
| 5.2.6 | Strengthen collaboration with and capacity of CBOs to support TB programming. | | * CBOs engaged & trained on identification of people with TB symptoms and referral * FBO health facilities and private health facilities engaged in providing TB diagnostic services * Education & Sensitization meeting for community members on TB programming held in the 23 LGAs |  |  |
|  | 5.2.6.a | Engage patent medicine vendors and community pharmacists, traditional healers, religious leaders and other first-points-of-contact in identification of people with TB symptoms and referral for evaluation | | Lack of funds | No cost |
| 5.2.6.b | Engage FBO health facilities and private health facilities in providing TB diagnostic services | | Lack of funds | No cost |
| 5.2.6.c | Conduct training to increase capacity of CBOs for PMV in the 23 LGAs | | Lack of funds | Conduct training |
| 5.2.6.d | Conduct re-training for PMV and Health providers in the 23 LGAs | | Lack of funds | Conduct training |
| 5.2.6.e | Hold Education & Sensitization meeting for community members on TB programming in the 23 LGAs | | Lack of funds | Conduct meeting |

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| 5.2.7 | Strengthen mechanism for coordination of TB/HIV collaborative activities at all levels of health care. | | * Existing Monitoring and Evaluation system upgraded to meet demand for TBL programmes * At least 100 health care workers trained to deliver integrated TB/HIV services   • |  |  |
|  | 5.2.7.a | Upgrade the existing Monitoring and Evaluation system to be more robust and be able to meet up with the increasing demand for the TBL programme at all level | | Lack of funds | Upgrade Monitoring and Evaluation system |
| 5.2.7.b | Build the capacity of health care workers to deliver integrated TB/HIV services | | Lack of funds | Train HWs |
| 5.2.7.c | Conduct periodic review meetings for coordination of TB/HIV collaborative activities at all levels | | Lack of funds | Conduct review meeting |
| 5.2.8 | Promote innovative advocacy, social mobilization and behaviour change intervention for the prevention and control of TB | | * Effective advocacy, communication and social mobilization system for prevention and control of TB developed & implemented   •  • |  |  |
|  | 5.2.8.a | Develop an effective advocacy, communication and social mobilization system to ensure  prevention and control of TB | | Lack of funds | Develop effective system |
| 5.2.8.b | Conduct advocacy visit to Chiefs, Elders, Community leaders on TB & Leprosy sensitization | | Lack of funds | Conduct advocacy visit |
| 5.2.8.c | Conduct training for GHW on M&E and ICT Data management | | Lack of funds | Conduct training |
| 5.2.10 | Build capacity of all cadres of health staff (GHW, Physicians, and specialist) and community members on Leprosy case finding and case management | | * At least 50 Medical officers trained on TB, Leprosy, Buruli Ulcer case finding and management * At least 100 GHW trained on case finding and management   • |  |  |
|  | 5.2.10.a | Conduct training for medical officers on TB, Leprosy, Buruli Ulcer case finding and management in the 23 LGA. | | Lack of funds | Conduct training |
| 5.2.10.b | Conduct training for GHW on case finding and management in the 23 LGA | | Lack of funds | Conduct training |
| 5.2.12 | Promote community based TB/Leprosy control initiatives | | * Consensus building meeting for TBL Officers on community TB / Leprosy control held   • |  |  |
|  | 5.2.12.a | Conduct consensus building meeting for TBL Officers on community TB / Leprosy control | | Lack of funds | Conduct training |
| 5.2.12.b | Conduct training for community volunteers on TB management | | Lack of funds | Conduct meeting |
| 5.2.13 | Strengthen physical and socio-economic rehabilitation for leprosy | | * Leprosy rehabilitation center provided & equipped   • |  |  |
|  | 5.2.13.a | Operating cost for engaging and supervising the contractor to provide & equip leprosy rehabilitation center in the state. | | Lack of funds | Costed in OHT |
| **Significantly reduce the incidence and prevalence of HIV/AIDS in Nigeria by 2022** | | | |  |  |
| 5.3.1 | Expand access to Minimum Package of Preventive Interventions (MPPI) for HIV targeting key and general populations | | * At least 80% of PHC facilities conduct HTS   / PMTCT at ANC clinics   * At least 50 TBA/private health facilities engaged to provide PMTCT / HTS services * HTS is carried out in at least 350   communities in 23 LGAs |  |  |

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|  | | 5.3.1.a | Conduct HTS / PMTCT in PHC facilities at ANC clinics in 23 LGAs | | Lack of funds | No cost |
| 5.3.1.b | Engage TBA / private health facilities to provide PMTCT / HTS services in 23 LGAs | | Lack of funds | Engage TBA / private health facilities |
| 5.3.1.c | Conduct HTS in communities in 23 LGAs | | Lack of funds | Conduct HTS |
| 5.3.1.d | Carry out advocacy visit to CBO to link with health facilities to promote client tracking in all  PHC | | Lack of funds | Conduct advocacy visit |
|  | 5.3.2 | Expand access of people living with HIV and AIDS to ART and co-infection management services. | | * Inactive ART sites in PHC facilities in 23 LGAs activated and 250 HWs trained * Inactive PMTCT/HTS sites activated & at least 250 HWs trained   • |  |  |
|  | | 5.3.2.a | Activate inactive ART sites in PHC facilities in 23 LGAs and train Health workers | | Lack of funds | Conduct training |
| 5.3.2.b | Activate inactive PMTCT/HTS sites & train Health workers | | Lack of funds | Conduct training |
| 5.3.2.c | Conduct supportive supervisory visits to PHC facilities in 23 LGAs | | Lack of funds | Conduct supportive supervisory visits |
| 5.3.2.d | Conduct DQA to PMTCT/HTS/ART in PHC in 23 LGAs | | Lack of funds | Conduct DQA |
|  | 5.3.3 | Promote universal access to quality PMTCT services | | * At least 250 HWs trained on the implementation of HTS / PMTCT (Paediatric diagnosis (EID) * At least 23 HIV Desk officers trained   • |  |  |
|  | | 5.3.3.a | Train/build capacity of health workers on the implementation of HTS / PMTCT (Paediatric diagnosis (EID) | | Lack of funds | Train health workers |
| 5.3.3.b | Conduct training/capacity building for HIV Desk officers in 23 LGAs | | Lack of funds | Conduct training |
| 5.3.3.c | Conduct regular review meeting of HIV desk officers and stakeholders on data harmonization in the state (Expand access of pregnant women to testing and ART for  pregnant women exposed infants to diagnosis) | | Lack of funds | Conduct meeting |
| 5.3.3.d | Conduct enlightenment and orientation activities on PMTCT in ANCs (Testing of pregnant women) | | Lack of funds | Conduct enlightenment |
| 5.3.3.e | Conduct HIV awareness campaign for adolescents in secondary schools in 23 LGAs | | Lack of funds | Conduct awareness campaign |
|  | 5.3.4 | Strengthen referral and linkages between HIV/AIDS services and other health and social services | | * TBA / private health facilities engaged to provide PMTCT service or make referral to PHC * HIV testing supervises and positive infants linked to treatment in the 23 LGAs * Expert clients/ volunteers engaged to track HIV positive mothers |  |  |
|  | | 5.3.4.a | Engage TBA / private health facilities to provide PMTCT service or make referral to PHC | | Lack of funds | Provide PMTCT service |
| 5.3.4.b | Supervise testing and link HIV positive infants to treatment in 23 LGAs | | Lack of funds | Supervise testing |
| 5.3.4.c | Engage expert clients/ volunteers to track HIV positive mothers | | Lack of funds | Engage expert clients/ volunteers |
|  | 5.3.5 | Improve access to safe blood and blood products | | * At least 250 Health Workers in PHC facilities trained to improve access to safe blood products * Blood banking services provided in at least 46 facilities   • |  |  |
|  | | 5.3.5.a | Train Health Workers in PHC facilities in the state to improve access to safe blood products | | Lack of funds | Training HWs |
| 5.3.5.b | Provide blood banking services in 2 facilities each for 23 LGAs | | Lack of funds | Provide blood banking  services |
|  | 5.3.6 | Promote injection safety and health care waste management practices | | * At least 250 HWs in PHC facilities trained annually on Safety and Waste management practices * At least 20 CBOs and private health workers trained on injection safety & healthcare waste management practices annually |  |  |

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|  | 5.3.6.a | Train HWs in PHC facilities on Safety and Waste management practices | | Lack of funds | Train HWs |
| 5.3.6.b | Train CBOs and private health workers in the 23 LGA on injection safety & healthcare waste management practices | | Lack of funds | Train CBOs & private HWs |
| 5.3.7 | Strengthen community systems to support HIV/AIDS programming for key and general populations | | * At least 200 WDCs engaged to support HIV/AIDs Program mobilization * Community outreach program on HIV done   • |  |  |
|  | 5.3.7.a | Engage WDC to support HIV/AIDs Programme mobilization in 23 LGAs | | Lack of funds | Engage WDC |
| 5.3.7.b | Conduct community outreach programmes on HIV in the 23 LGAs | | Lack of funds | Conduct community outreach |
| 5.3.8 | Improve the logistics and supply chain management for all HIVAIDS- related drugs and commodities. | | * At least 1000 Rapid test kits pack procured & distributed quarterly * At least 1,000,000 ART Drugs for positive client procured & distributed quarterly * PMTCT collection tools printed &   distributed to at least 200 Secondary & PHC facilities |  |  |
|  | 5.3.8.a | Procure and distribute Rapid test kits pack in the 23 LGAs | | Lack of funds | Procure and distribute Rapid test kits (OHT) |
| 5.3.8.b | Procure and distribute ART Drugs for positive client in the 23 LGAs. | | Lack of funds | Procure and distribute ART Drugs (OHT) |
| 5.3.8.c | Print and distribution PMTCT collection tools to Secondary & PHC facilities in the State. | | Lack of funds | Print and distribution  PMTCT collection tools |
| **Reduce morbidity, disability and mortality due to targeted Neglected Tropical Diseases (NTDs) and**  **improve quality of life of those affected.** | | | |  |  |
| 5.5.1 | Strengthen advocacy, social mobilization and behaviour change communication for NTDs | | * Advocacy visit to community institutions on Community Mobilization on NTDs recognition, reporting and control done * Advocacy visit to the Commissioner of Education for inclusion of all NTDs control in curricula of health training schools done * At least 850 IEC materials and 407 advocacy kits distributed * Media advocacy and sensitization on   NTDs done |  |  |
|  | 5.5.1.a | Conduct advocacy visit to community institutions on Community Mobilization on NTDs recognition, reporting and control in the 23 LGAs | | Lack of funds | Conduct advocacy visit |
| 5.5.1.b | Conduct advocacy visit to the Commissioner of Education for inclusion of all NTDs control in curricula of health training schools | | Lack of funds | Conduct advocacy visit |
| 5.5.1.c | Design, print and distribute IEC materials and advocacy kits | | Lack of funds | Design, print & distribute IEC materials |
| 5.5.1.d | Engage media advocacy and sensitization : Press briefing, talk shows on NTDs (TV & Radio) | | Lack of funds | Engage media advocacy |
| 5.5.1.e | Production of newsletter on NTDs | | Lack of funds | Produce newsletter |
| 5.5.2 | Scale up delivery of integrated preventive chemotherapy packages and other packages. | | * FMOH allocation of medicine collected & delivery of chemotherapy packages and others done bi-annually * State & 23 LGA Officers trained on Logistic Management Information System   • |  |  |
|  | 5.5.2.a | Collection of FMOH allocation of medicine from CMS, Oshodi, Lagos State | | Lack of funds | Collect allocation |
| 5.5.2.b | Conduct training for state & 23 LGA Officers on Logistic Management Information System | | Lack of funds | Conduct training |
| 5.5.2.c | Conduct delivery of chemotherapy packages and others to LGAs, communities and schools  and retrieval of left over | | Lack of funds | Conduct delivery of  medicine |
| 5.5.3 | Strengthen integrated vector and management and activities for health education, access to clean water, sanitation, and environmental improvement for targeted NTDs. | | * Advocacy visit to Ministry of Environment for increased coverage of safe water supply and sanitation done * Meeting for intersectoral collaboration forum for water supply done * Meeting with WDC to mobilize communities to undertake IVM measures done |  |  |

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|  | 5.5.3.a | Conduct advocacy visit to Ministry of Environment for increased coverage of safe water supply and sanitation | | Lack of funds | Conduct advocacy visit |
| 5.5.3.b | Set up intersectoral collaboration forum for water supply in the state | | Lack of funds | Set up intersectoral collaboration forum |
| 5.5.3.c | Conduct periodic meeting for intersectoral collaboration forum for water supply | | Lack of funds | Conduct meeting |
| 5.5.3.d | Conduct advocacy meeting with WDC to mobilize communities to undertake IVM measures | | Lack of funds | Conduct advocacy meeting |
| 5.5.4 | Increase access to integrated case management for NTDs (Buruli Ulce, Leishmaniasis, Trypanosomiasis, Loasis, Schistosomiasis, Zoonosis , soil-transmitted helminthic infections, onchocerciasis, filariasis) | | * Jingles, town announcers and other channels of communication on NTDs done   •  • |  |  |
|  | 5.5.4.a | Awareness creation through jingles, town announcers and other channels of communication on NTDs | | Lack of funds | Create awareness |
| 5.5.5 | Strengthen capacity for NTD programming and implementation. | | * At least 5 state NTD coordinators trained on disease program management * At least 10 NTDs Desk Officers trained on their respective Desk Disease Management * At least 28 state and LGAs NTD teams trained on Data Management |  |  |
|  | 5.5.5.a | Sponsor state NTD Coordinator on disease programme management short courses | | Lack of funds | Sponsor State NTD Coordinator |
| 5.5.5.b | Sponsor NTDs Desk Officers on their respective Desk Disease Management short courses | | Lack of funds | Sponsor State NTD Desk  Officer |
| 5.5.5.c | Sponsor state and LGAs NTD teams on Data Management short courses | | Lack of funds | Sponsor State and LGA  NTD Team |
| 5.5.5.d | Operating cost for engaging and supervising the contractor to equip State and 23 LGA NTD State office | | Lack of funds | Costed in OHT |
| 5.5.5.e | Operating cost for engaging and supervising the contractor to procure a Hilux and a Bus for the State office, and a bike each for the 23 LGAs with annual fund for fueling and maintenance | | Lack of funds | Costed in OHT |
| 5.5.6 | Strengthen the integration and linkages of NTD programme and financial plans into sector-wide and national budgetary and financing mechanisms. | | * NTD Work plans developed   •  • |  |  |
|  | 5.5.6.a | Establish/Inaugurate NTD Advisory Committee | | Lack of funds | Establish/Inaugurate Committee |
| 5.5.6.b | Develop annual NTD Work plans with inputs from partners | | Lack of funds | Develop work plans |
| 5.5.6.c | Strengthen collaboration with other community based health programs like RBM, EPI, School Feeding programs, WASH, Sanitation Authority, and Ministry of Environment. | | Lack of funds | No cost |
| 5.5.6.d | Conduct sensitization meetings with policy makers, line ministries, and other stakeholders on the beneficial synergy of integration at the state, LGAs and community levels (including  Village health Committees) | | Lack of funds | Conduct meeting |
| 5.5.6.e | Conduct periodic meeting for NTDs programmes managers and all stakeholders | | Lack of funds | Conduct meeting |

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| **6.Non-Communicable Disease, Care of The Elderly, Mental Health, Oral Health, Eye Healthcare** | | | | | | | |
| **6. To reduce the burden of morbidity, mortality and disability due to non-communicable diseases** | | | | | | | |
|  | **6.1** | **Reduce morbidity and mortality due to NCDs (Cancers, Cardiovascular Diseases, Chronic Obstructive Airway Diseases, Diabetes and Sickle Cell Disease)** | | | |  |  |
|  | | 6.1.1 | Promote generation of evidence for decision-making for planning and implementation of NCD interventions | | * Population-based cancer registry established * Continued active case search of NCDs initiated * Accurate report on NCDs prevalence/incidence given * Surveillance activities in public and private health sectors |  | |
|  | | | 6.1.1.a | Conduct sensitization meeting with DSNOs on collection and collation of NCDs data. | | Lack of funds | Conduct sensitization meeting |
| 6.1.1.b | Operating Cost for engaging and supervising the contractor to establish a population-based cancer registry for the state in collaboration with FMOH. | | Lack of funds | Costed in OHT |
| 6.1.1.c | Initiate continued active case search of NCDs cases in the state. | | Lack of funds | Initiate active case search |
| 6.1.1.d | Report accurately with use of appropriate tools on NCDs prevalence/incidence in the state to FMOH for planning and control. | | Lack of funds | No cost |
| 6.1.1.e | Implement surveillance activities in all health sectors (public and private). | | Lack of funds | Implement surveillance activities |
|  | | 6.1.2 | Intensify advocacy, legislation, social mobilization and behaviour change communication for NCD prevention and control | | * Advocacy on NCDs prevention & control done * Sensitization on NCDs for all HWs in the state done * World celebration of the various NCD Days observed |  | |
|  | | | 6.1.2.a | Setting up an NCD stirring/Cancer Control committees to carry out advocacy on NCDs prevention & control | | Lack of funds | Setting up NCD committees |
| 6.1.2.b | Conduct sensitization on NCDs for all HWs in the state | | Lack of funds | Conduct sensitization |
| 6.1.2.c | Observe Global days marked for celebration ie World Hypertension day, World Heart Day, World Cancer Day, World Diabetes Day, World NO Tobacco Day, World Sickle cell Day, World Breast and Cervical Cancer Month & World Bronchial Asthma Month for highlighting problem associated with these disease. | | Lack of funds | Observe Global days |
|  | | 6.1.3 | Promote healthy lifestyles and behaviors for the prevention of NCDs | | * Public awareness programmes to promote healthy lifestyles and increase physical activities established * Screening programmes for clinical breast & PAP examination done * Approved health posters distributed * Programmes to address NCD risk factors established |  |  |
|  | | | 6.1.3.a | Establish public awareness programmes to promote healthy lifestyles and increase physical activities including advertisement to discourage and prohibit tobacco amongst the populace | | Lack of funds | Establish public awareness programmes |
| 6.1.3.b | Conduct screening programmes for clinical breast examination, 2 yearly mammogram examination, 3 yearly PAP examination in the target population, women of reproductive age | | Lack of funds | Conduct screening programmes |
| 6.1.3.c | Produce & distribute approved health posters by Federal Ministry of Health for NCDs | | Lack of funds | Produce & distribute posters |
| 6.1.3.d | Establish programmes to address NCD risk factors such as physical inactivity, unhealthy diet, tobacco use and harmful use of alcohol in schools, religious places, etc. | | Lack of funds | Establish programmes |

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| 6.1.4 | Expand access (geographic and financial etc. ) to NCD prevention, screening, control and treatment services | | * Facilities rendering NCD services in the state, both public and private identified * SOPs for NCDs in all Health facilities developed * Screening tools for NCDs provided * At least 1 Comprehensive NCD treatment/Cancer treatment/Radiotherapy |  |  |
|  | 6.1.4.a | center established  Identify facilities rendering NCD services in the state, both public and private for monitoring and supervision | | Lack of funds | Identify and conduct monitoring and supervision |
| 6.1.4.b | Develop SOPs for NCDs in all Health facilities in the state. | | Lack of funds | Develop SOPs for NCDs |
| 6.1.4.c | Provide screening tools such as VIAs, Mammogram, Accu check metres, Sphygmomanometers etc. | | Lack of funds | Provide screening tools (Costed in OHT) |
| 6.1.4.d | Operating cost for engaging and supervising the contractor to establish comprehensive NCD treatment/Cancer treatment/Radiotherapy centers. | | Lack of funds | Costed in OHT |
| 6.1.5 | Increase the quality of life of those affected by NCDs | | * Multidisciplinary management team for prevention and control of NCDs established * Psychotherapy and vocational rehabilitation provided * Prosthetic aides provided |  |  |
|  | 6.1.5.a | Establishment of a multidisciplinary management team for prevention and control of NCDs. | | Lack of funds | Establish management team |
| 6.1.5.b | Provide psychotherapy and vocational rehabilitation to all patients undergoing diagnosis, treatment and rehabilitation. | | Lack of funds | Provide treatment and rehabilitation centre (Costed in OHT) |
| 6.1.5.c | Expand the availability of drugs in the essential drug list such as drugs used for palliative care and treatment of NCDs. | | Lack of funds | Expand the availability of drugs |
| 6.1.5.d | Provide prosthetic aides for patients affected by NCD complications. | | Lack of funds | Provide prosthetic aides |
| 6.1.6 | Build capacity of health care providers, especially at lower levels (PHC) in prevention and screening for NCDs | | * Guides lines and SOPs for the management of NCDs developed & disseminated * At least 130 Community Health workers trained & re-trained on prevention & screening for NCDs and provided with regularly updated Standing Orders   • |  |  |
|  | 6.1.6.a | Develop & disseminate guides lines and SOPs for the management of NCDs at all health care levels | | Lack of funds | Develop & disseminate guides lines |
| 6.1.6.b | Train & Re-train Community Health workers on prevention & screening for NCDs | | Lack of funds | Train & Re-train Community Health workers |
| 6.1.6.c | Periodic review and update of Community health workers and standing orders to include current trends in the management of major NCDs. | | Lack of funds | Periodic review |
| 6.1.6.d | Conduct capacity building for NCD focal points in Health Facilities on programme management. | | Lack of funds | Conduct capacity building |
| 6.1.6.e | Promotion of educational activities: conferences, workshops, seminars etc. for health care personnel in the management of NCDs especially pre-diabetes and diabetes mellitus. | | Lack of funds | Promotion of educational activities |
| 6.1.7 | Promote demand for NCD services | | * Campaign in key sectors of the communities on available NCD services done * Free NCD screening services provided at five designated centres |  |  |
|  | 6.1.7.a | Conduct campaign in key sectors of the communities community, schools (including primary, secondary and tertiary institutions), Health facilities, Workplaces, Unions, Trade Unions, Market women, etc. on available of NCD services in the state. | | Lack of funds | Conduct campaign |
| 6.1.7.b | Provide free NCD screening services at five designated centres in theState. Centres - PH., Bori, Ahoada, Oyigbo, Abua central. | | Lack of funds | Provide free NCD |

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| **6.2** | **Promote the health and wellbeing of the elderly in Nigeria** | | | |  | |
|  | 6.2.1 | Promote generation of evidence for planning, implementation and monitoring of geriatric services | | * Community survey in 23 LGAs to ascertain the proportion of geriatrics in the State carried out and reported planning, implementation and monitoring of geriatric services   • |  |  |
|  | | 6.2.1.a | Carry out community survey in 23 LGAs to ascertain the proportion of geriatrics in the  State. | | Lack of funds | Carry out community survey |
| 6.2.1.b | Report accurately with use of appropriate tools on geriatric population in the state to SMOH/FMOH for planning, implementation, monitoring of geriatric services. | | Lack of funds | Report with the use of appropriate tools |
| 6.2.1.c | Initiate continued active case search of geriatrics in the state in other to determine their  health problems. | | Lack of funds | Initiate active case search |
| 6.2.1.d | Collaborate with Geriatric Association of Nigeria to provide adequate care to the elderly. | | Lack of funds | Collaborate with Geriatric Association of Nigeria |
|  | 6.2.2 | Promote enabling policy environment for programming for the elderly | | * Bill submitted to Government * Advocacy visit to Chiefs and Traditional rulers done * Multi-sectoral State/Local Government task force on prevention and control of elderly abuse established |  |  |
|  | | 6.2.2.a | Propose bill to Government on policy/ law that protect the rights and privileges of the elderly. | | Lack of funds | Propose Bill to Government |
| 6.2.2.b | Advocacy visit to Chiefs and Traditional rulers in the community to intimate them on roles and responsibilities they need to play to create enabling environment for implementation of elderly programmes. | | Lack of funds | Advocacy visit |
| 6.2.2.c | Establish a multi-sectoral State / Local Government task force on prevention and control of elderly abuse. | | Lack of funds | Establish Task force |
|  | 6.2.6 | Promote community participation and partnerships for sustainability of health programmes for the elderly | | * At least 250 HWs trained & re-trained on Interpersonal Communication Skill (IPCS) for the care of the elderly   •  • |  |  |
|  | | 6.2.6.a | Conduct training & re-training for HWs in the 23 LGAs on Interpersonal Communication Skill (IPCS) for the care of the elderly | | Lack of funds | Conduct training |
| **6.4** | **Promote optimal oral health in Nigeria.** | | | |  | |
|  | 6.4.1 | Scale-up BCC for oral health promotion, disease prevention and early care seeking for oral diseases | | * Oral health prevention and promotion strategy developed and implemented * IEC materials for oral health awareness creation among the general population developed & distributed * Oral health education integrated into school curricula HE activities at PHC level |  |  |
|  | | 6.4.1.a | Develop and implement an oral health prevention and promotion strategy | | Lack of funds | Develop and implement an oral health |
| 6.4.1.b | Develop and distribute Information Education and Communication (IEC) materials for oral health awareness creation among the general population | | Lack of funds | Develop and distribute IEC materials |
| 6.4.1.c | Conduct advocacy to integrate oral health education into school curricula | | Lack of funds | No cost |
| 6.4.1.d | Integrate oral health education into health education activities at PHC level | | Lack of funds | No cost |
| 6.4.1.e | Institutionalize Oral week to promote good oral health habits | | Lack of funds | No cost |

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|  | 6.4.2 | Expand access to oral health care services by integrating oral health into the mainstream of service delivery at all levels of the health care system | | * Oral health care at all levels integrated into   the health care system, from primary level with defined norms & standards   * Capacity of at least 50% of health facilities strengthened to provide dental care services * Advocacy for inclusion of dental health into NHIS, including CBHIS done |  |  |
|  | | 6.4.2.a | Develop/adapt norms and standards for oral health at different levels of the health care system | | Lack of funds | Develop/adapt norms and standards |
| 6.4.2.b | Integrate oral health care at all levels of the health care system, from primary level in line with defined norms and standards | | Lack of funds | No cost |
| 6.4.2.c | Strengthen the capacity of the health facilities to provide dental care services as appropriate for the level of care (dental clinic from level of general hospital with at least one dental unit per LGA ) | | Lack of funds | Strengthen the capacity |
| 6.4.2.d | Establish/strengthen regional oral health referral centres | | Lack of funds | Establish/strengthen referral centres |
| 6.4.2.e | Advocate for inclusion of dental health into NHIS, including CBHIS | | Lack of funds | Advocate for inclusion |
|  | 6.4.3 | Strengthen capacity of health workers at all levels to deliver oral health care services | | * At least 250 training & re-training workshop for health workers at State & LGA levels on oral health   • |  |  |
|  | | 6.4.3.a | •  Conduct train & re-train workshop for health workers at State & LGA levels on oral health | | Lack of funds | Conduct training workshop |
| **6.5** | **Eliminate avoidable blindness, and reduce the burden of various visual impairment conditions.** | | | |  | |
|  | 6.5.1 | Improve coordination of eye care services | | * Present state of coordination of eye services in primary, secondary and tertiary health facilities in the state assessed by NPPB committee |  |  |
|  | | 6.5.1.a | •  Conduct meeting for National Programme for Prevention of Blindness (NPPB) committee  to assess the present state of coordination of eye services in primary, secondary and tertiary health facilities in the state | | Lack of funds | Conduct meeting |
| 6.5.1.b | Conduct periodic training & re-training workshops for eye care personnel of eye care services | | Lack of funds | Conduct training workshop |
|  | 6.5.2 | Promote the development of health plans and policies at all levels to be in consonance with the WHO Global Eye Health Action Plan 2014 - 2019 | | * Eye plans & policies developed for all levels   •  • |  |  |
|  | | 6.5.2.a | Conduct workshop to develop eye plans & policies for all levels in consonance with the WHO Global Eye Health Action Plan 2014-2019 | | Lack of funds | Conduct workshop |
| 6.5.2.b | Conduct periodic meetings of the NPPB committee to assess implementation of the WHO Global Eye Health Action Plan 2014 - 2019 | | Lack of funds | Conduct quarterly meeting for 5persons |
|  | 6.5.3 | Strengthen eye health focused research and information system; | | * Research team set up system in major eye care facilities (BMSH & UPTH) * Research articles and innovations in eye management adopted   • |  |  |
|  | | 6.5.3.a | Set up research team in major eye care facilities (BMSH & UPTH) with focus on eye health & information system | | Lack of funds | Conduct 1day meeting for 4 persons |
| 6.5.3.b | Hold periodic meeting to review research articles and adopt innovations in eye management | | Lack of funds | Hold periodic meeting |
|  | 6.5.4 | Strengthen advocacy, social mobilization and behaviour change communication on eye health | | * Advocacy visit to the Government for provision of affordable, accessible and adequate eye care delivery services in the state done * Advocacy visit to community institutions (WDCs) in the 23 LGAs to increase public awareness of available eye care services done * Public enlightenment through multi-media approach to enhance positive behaviour change and improved uptake eye care   services by the communities done |  |  |

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|  | | | 6.5.4.a | Conduct advocacy visit to the Government for provision of affordable, accessible and adequate eye care delivery services in the state | | Lack of funds | Conduct advocacy visit |
| 6.5.4.b | Conduct advocacy visit to community institutions (WDCs) in the 23 LGAs to increase public awareness of available eye care services | | Lack of funds | Conduct advocacy visit |
| 6.5.4.c | Public enlightenment through multi-media approach to enhance positive behaviour change and improved uptake eye care services by the communities | | Lack of funds | Public enlightenment |
| **7. Emergency Medical Services and Hospital Care** | | | | | | | |
| **7. Improve health outcomes through prompt and effective response to medical emergencies** | | | | | | | |
|  | **7.1** | **Strengthen emergency medical services (EMS)** | | | |  |  |
|  | | 7.1.1 | Promote the development/adaptation and implementation of regulatory framework, policy and plans for Emergency Medical Services (EMS) across all levels of care | | * EMS policy, plans and guideline adapted * EMS functional   • |  |  |
|  | | | 7.1.1a | Adapt national EMS policy, plans and guidelines on EMS services with support from FMOH | | Lack of funds | Conduct workshop |
| 7.1.1.b | Revamp the coordinating framework for EMS and ETS at state level | | Lack of funds | Conduct meeting |
| 7.1.1.c | Strengthen institutional structures for the implementation of the EMS and ETS services | | Lack of funds | Costed in OHT |
| 7.1.1.d | Mobilize resources (Financial, human, infrastructure etc.) for the functioning of the EMS and ETS services | | Lack of funds | Costed in OHT |
|  | | 7.1.2 | Build capacity of health care providers for emergency medical services including training for first responders and ambulance drivers | | * EMS needs assessment done * EMS manpower trained   • |  |  |
|  | | | 7.1.2.a | Conduct a needs assessment with the view to identify HR gaps on EMS and ETS services | | Lack of funds | Conduct need assessment |
| 7.1.2.b | Develop and implement training programmes for EMS (Training of paramedics in basic and advanced life support, ETS drivers, EMS Doctors, Nurses and other relevant health care  workers) | | Lack of funds | Train health workers |
|  | | 7.1.3 | Create/Strengthen coordination of various emergency medical services (NEMA/SEMA, FRSC, Police, Public, Private etc.) | | * Public sector medical emergency service harmonized, integrated and aligned * PPP involved in EMS and ETS services   • |  |  |
|  | | | 7.1.3.a | Establish a coordinating framework for harmonization, integration and alignment of all public sector medical emergency services | | Lack of funds | Costed in 7.1.1 b |
| 7.1.3.b | Promote PPP in EMS and ETS services | | Lack of funds | Awareness campaign |
|  | | 7.1.5 | Promote demand for appropriate use of medical services | | * Public enlightenment on emergency and trauma services carried out   •  • |  |  |
|  | | | 7.1.5.a | Public enlightenment through multi-media approach on use of emergency and trauma care services | | Lack of funds | Public enlightenment |

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|  | **7.2** | **Increase provision and access to quality, affordable & integrated emergency medical services** | | | |  | |
|  | | 7.2.1 | Ensure provision and access to emergency medical services | | * Reliable community-based transport system in emergencies available in at least 50% of HFs in the state |  |  |
|  | | | 7.2.1.a | Provide reliable community-based transport system in emergencies in all HFs | | Lack of funds | Provide reliable (Costed in  OHT) |
| 7.2.1.b | Operating cost for engaging and supervising the contractor to provide standard ambulance | | Lack of funds | Costed in OHT |
|  | | 7.2.2 | Build capacity (human and institutional) of emergency medical services units/departments of receiving health facilities | | * At least 814 HWs trained on services and advance CPR * Emergency equipment procured & distributed * At least 23 disease surveillance officers trained for disease outbreak control |  |  |
|  | | | 7.2.2.a | Training of staff on services and advance CPR | | Lack of funds | Training of staff |
| 7.2.2.b | Operating cost for engaging and supervising the contractor to procure emergency equipment e.g. oxygen, defibrillator and lifesaving equipment | | Lack of funds | Costed in OHT |
| 7.2.2.c | Build capacity of disease surveillance officers for disease outbreak control | | Lack of funds | Build capacity |
| 7.2.2.d | Conduct review meeting with stakeholders on improvement of comprehensive emergency  and trauma care | | Lack of funds | Conduct review meeting |
|  | | 7.2.3 | Strengthen coordinated and integrated emergency transport system (ETS) | | * Ambulances maintained * Emergency drugs available   • |  |  |
|  | | | 7.2.3.a | Evaluate the existing integrated transport system for emergencies and trauma | | Lack of funds | Conduct meeting |
| 7.2.3.b | Operating cost for engaging and supervising the contractor for maintenance of ambulance and repairs | | Lack of funds | Costed in OHT |
| 7.2.3.c | Procure drugs and consumables for the ambulance for three senatorial zones | | Lack of funds | Costed in OHT |
|  | **7.3** | **Improve provision, access, quality and responsiveness of Ambulatory (outpatient) Services at all levels of health care** | | | |  | |
|  | | 7.3.1 | Promote the development of practice standards and guidelines for ambulatory services | | * Guidelines for ambulatory services available * At least 407 staff trained on guidelines |  |  |
|  | | | 7.3.1.a | Revive Joint Consultative Committee on Referral (JCCR) | | Lack of funds | Conduct quarterly meeting |
| 7.3.1.b | Develop guidelines for ambulatory services by the JCCR | | Lack of funds | Develop guidelines |
| 7.3.1.c | Train staff on developed guidelines | | Lack of funds | Train staff |
|  | | 7.3.2 | Scale-up functional and integrated ambulatory services (general, and specialized) in all facilities according to standards | | * At least 814 health professionals employed and deployed to all facilities in the state * At least 814 staff trained on integrated ambulatory services in all HFs |  |  |
|  | | | 7.3.2.a | Monitor and Evaluate ambulatory services activities by the central M&E unit and make  report available to all stakeholders | | Lack of funds | Monitor and Evaluate |
| 7.3.2.b | Employ and deploy health professionals to all facilities in the state | | Lack of funds | Costed in OHT |
| 7.3.2.c | Train and re-train staff on integrated ambulatory services in all HFs | | Lack of funds | Train and re-train |

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|  | 7.3.3 | Promote & enhance capacity (human and institutional) for continuous quality improvement of Outpatient services | | * At least 814 health care providers trained on Triage and Lean Approach to health care service * Directional signs and tagging of Department and Units provided in all HFs * Prompt treatment of clients on arrival to health facilities done |  |  |
|  | | 7.3.3.a | Train health care providers on Triage and Lean Approach to health care service | | Lack of funds | Train health care providers |
| 7.3.3.b | Monthly review meeting on implementation of Triage and Lean | | Lack of funds | Monthly review meeting |
| 7.3.3.c | Provide directional signs and tagging of Departments and Units in all HFs to shorten time  spent by clients | | Lack of funds | Costed in OHT |
| 7.3.3.d | Training of diseases surveillance officers for active case search | | Lack of funds | Training of diseases  surveillance |
| 7.3.3.e | Prompt treatment of clients on arrival to health facilities | | Lack of funds | No cost |
| **7.4** | **Strengthen the provision of health services at public and private health facilities that are appropriate, accessible, and meet the minimum quality and safety standards for optimized health outcomes** | | | |  | |
|  | 7.4.1 | Promote the development and implementation of policies, plans, legislations, regulations and clinical standards for safety and quality improvement of Medical Services across all levels of care | | * Policy guidelines ( SOPs) developed, printed, distributed and implementation monitored * Orientation/Interactive sessions done * Training of Trainers Workshop done |  |  |
|  | | 7.4.1.a | Set up committee to pay advocacy visit to Legislative/executive bodies in Government as  well as Partners Agencies( NGOs, Public Health Institutions, Companies and other Parastatals) for safety and quality improvement of medical services. | | Lack of funds | Conduct advocacy visit |
| 7.4.1.b | Conduct workshop to develop policy guidelines ( Standard Operating Procedures) for Management of Common Medical conditions, Infection Prevention and Control and Quality  of Care . | | Lack of funds | Conduct workshop |
| 7.4.1.c | Print and distribute guideline and SOPS and ensure implementation | | Lack of funds | Print and distribute  guideline |
| 7.4.1.d | Orientation/Interactive sessions with Stakeholders on new Policy Documents across all  levels of care | | Lack of funds | Orientation/Interactive  sessions |
| 7.4.1.e | Training of Trainers Workshop on the new policy on Quality of Care in General Hospital and  Primary Health Care Facilities | | Lack of funds | Training of Trainers  Worship |
|  | 7.4.2 | Scale up provision of accessible medical services | | * GIS established in the state * General Hospitals constructed & equipped in Obio/Akpor, Oyigbo & Tai LGAs * At least 3 ambulances purchased and distributed * Ultrasound scan purchased & installed in all General Hospitals |  |  |
|  | | 7.4.2.a | Mapping, categorizing and establishing Geographic Information System (GIS) for all HFs & ensure networking between PHC Board and all PHC HFs and SMOH and all secondary health facilities | | Lack of funds | Conduct meeting |
| 7.4.2.b | Operating cost for engaging and supervising the contractor to construct & equip General Hospitals in LGAs without any (Obio/Akpor, Oyigbo & Tai) | | Lack of funds | Costed in OHT |
| 7.4.2.c | Operating cost for engaging and supervising the contractor to provide ambulances for  SMOH and LGAs for emergency response | | Lack of funds | Costed in OHT |
| 7.4.2.d | Operating cost for engaging and supervising the contractor to provide vehicles ( hilux and  buses) for State and LGAs for Monitoring and Supervision | | Lack of funds | Costed in OHT |
| 7.4.2.e | Operating cost for engaging and supervising the contractor to purchase and install  ultrasound scan in all General Hospitals in the State | | Lack of funds | Costed in OHT |
|  | 7.4.3 | Intensify continuous quality improvement in medical service provision at all levels | | * Continuous training done * Private health institutions registration/renewal certificate done annually |  |  |

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|  | | 7.4.3.a | Conduct continuous training of secondary and primary healthcare staff on the SOPS on  Quality of Care, Infection Prevention and Control, Management of common medical conditions | | Lack of funds | Conduct training |
| 7.4.3.b | Operating cost for engaging and supervising the contractor to maintain equipment at all  levels | | Lack of funds | Maintenance of equipment |
| 7.4.3.c | Periodic training of staff on management and maintenance of equipment & supplies | | Lack of funds | Train staff |
| 7.4.3.d | Printing of private health institutions registration/renewal certificate | | Lack of funds | Print certificate |
|  | 7.4.4 | Build capacity of health care providers for quality medical services | | * At least 814 Health workers trained on quality medical services * At least 814 HWs trained on current emerging health challenges at all levels * At least 1 doctor trained on the use of ultrasound scan in all General Hospitals |  |  |
|  | | 7.4.4.a | Build capacity of Health workers on quality medical services | | Lack of funds | Build capacity |
| 7.4.4.b | Employ Health care professionals | | Lack of funds | Employ health care  professional |
| 7.4.4.c | Training of HWs on current emerging health challenges at all levels | | Lack of funds | Train HWs |
| 7.4.4.d | Training on the use of ultrasound scan | | Lack of funds | Costed in OHT |
|  | 7.4.5 | Promote demand for appropriate use of medical services | | * Public enlightenment through multi-media approach on use of medical services done   •  • |  |  |
|  | | 7.4.5.a | Public enlightenment through multi-media approach on use of medical services | | Lack of funds | Public enlightenment |
|  | 7.4.6 | Strengthen Infection, Prevention and Control (IPC) practices in health care settings. | | * At least 814 HWs on universal precaution * Guidelines on universal precaution updated regularly * Incinerator in the state for hazardous hospital wastes |  |  |
|  | | 7.4.6.a | Train HWs on universal precaution | | Lack of funds | Train HWs |
| 7.4.6.b | Regular update of guidelines on universal precaution | | Lack of funds | Update of IPC guideline |
| 7.4.6.c | Procurement of Personal Protective Equipment (PPE) for use at all levels | | Lack of funds | PPE (Costed in OHT) |
| 7.4.6.d | Provision of IEC materials on infection control | | Lack of funds | Provide IEC materials on  infection control |
| 7.4.6.e | Operating cost for engaging and supervising the contractor to provide incinerator in the  state for hazardous hospital wastes | | Lack of funds | Provision of incinerator  (Costed in OHT) |
| **7.6** | **Promote the provision of and access to palliative and End-of-life care services at public and private health facilities that meet defined minimum quality and safety standards.** | | | |  | |
|  | 7.5.1 | Promote the development and implementation of policies, plans, legislations, regulations and clinical standards for palliative and end-of -life care services | | * Policy of Palliative /End of Life Care adapted & protocols/ for services developed, printed & disseminated * Advocacy visits to policy makers on establishing Palliative and End of Life services done * Awareness created on availability care |  |  |
|  | | 7.6.1.a | Adopt existing policies and develop protocols and guidelines for Palliative and End of Life  Care services | | Lack of funds | Adopt existing policies |
| 7.6.1.b | Conduct advocacy visits to policy makers on establishing Palliative and End of Life services | | Lack of funds | Conduct advocacy |
| 7.6.1.c | Conduct need assessment for the Palliative /End of Life Care by DPRS, SMOH | | Lack of funds | Conduct need assessment |
| 7.6.1.d | Print & disseminate guideline | | Lack of funds | Print & disseminate |
| 7.6.1.e | Create awareness on availability care | | Lack of funds | Create awareness on |

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|  | | 7.6.2 | Build capacity (human and institutional) for continuous quality improvement of palliative and End-of-life care services | | * Equipment for End-of-life care services purchased, supplied & maintained * Commodities for End-of-life care services procured and supplied * Staff trained on protocols and guidelines |  |  |
|  | | | 7.6.2.a | Operating cost for engaging and supervising the contractor to purchase, supply and  maintain equipment for End-of-life care services | | Lack of funds | Costed in OHT |
| 7.6.2.b | Procure commodities for End-of-life care services | | Lack of funds | Costed in OHT |
| 7.6.2.c | Build capacity of staff on protocols and guidelines | | Lack of funds | Build capacity |
| 7.6.2.d | Institute referral linkage | | Lack of funds | Institute referral |
|  | | 7.6.3 | Strengthen community systems to support Palliative and End-of-life care services | | * Community Care Givers trained on End-of-life guidelines * Religious leaders, WDCs, CDCs and VDCs trained   on their roles and responsibilities  • |  |  |
|  | | | 7.6.3.a | Train Community Care Givers on End-of-life guidelines | | Lack of funds | Train Community Care  Givers |
| 7.6.3.b | Train Religious leaders, WDCs, CDCs and VDCs on their roles and responsibilities | | Lack of funds | Train Religious leaders |
|  | | 7.6.4 | Promote appropriate disposal of dead bodies | | * Health workers in Primary and Secondary facilities trained on infection prevention and control * Personnel protective equipment procured & distributed * Mortuary attendants and Environmental Health Officers (EHOs) trained |  |  |
|  | | | 7.6.4.a | Advocacy for PPP collaboration in provision of mortuary services at primary & secondary  levels | | Lack of funds | Advocacy for PPP  collaboration |
| 7.6.4.b | Training on infection prevention and control of all health workers in Primary and Secondary  facilities | | Lack of funds | Training on infection  prevention |
| 7.6.4.c | Procure and distribute personnel protective equipment | | Lack of funds | Costed in OHT |
| 7.6.4.d | Training of the mortuary attendants and Environmental Health Officers (EHOs) | | Lack of funds | Training of mortuary  attendants |
| 7.6.4.e | Print and distribute tools on capturing dead bodies | | Lack of funds | Print and distribute tools |
| **8.Health Promotion And Environmental Health** | | | | | | | |
| **8. Improve the wellbeing, safety and quality of life of Nigerians through health promotion and healthy environment** | | | | | | | |
|  | **8.1** | **Promote the wellbeing of individuals and communities through protection from health risks, and promotion of healthy lifestyle and environment** | | | |  |  |
|  | | 8.1.1 | Promote the development and and implementation of policies, plans, legislation and regulations that prevent health risks and ensures healthy life styles | | * Advocacy to policy makers to enact laws that will promote healthy life style done * Existing policies on risky health behaviours identified & reviewed * Posters on healthy living designed, printed   & distributed to every community and schools in the 23 LGAs |  |  |
|  | | | 8.1.1.a | Conduct advocacy to policy makers to enact laws that will promote healthy life style | | Lack of funds | Conduct advocacy |
| 8.1.1.b | Conduct situation analysis on the risky health behaviours | | Lack of funds | Conduct situation analysis |
| 8.1.1.c | Conduct stakeholders meeting to Identify and review existing policies | | Lack of funds | Conduct stakeholders  meeting |
| 8.1.1.d | Design & print posters on healthy living and distribute to every community and schools in the 23 LGAs of the state | | Lack of funds | Design & print posters |
| 8.1.1.e | Legislate standard of establishment of private schools | | Lack of funds | No cost |
|  | | 8.1.2 | Strengthen community capacity for responses and ownership of health promotion. | | * Community sensitized on the risky health behaviours and consequences * Orientation and re-orientation of WDCs, CBOs etc. on promotion of healthy life style done * Outreaches and town hall meetings on   promotion of healthy life style and environment done |  |  |
|  | | | 8.1.2.a | Conduct meetings with the different groups in the community to sensitize them on the risky health behaviours and consequences | | Lack of funds | Conduct meetings |
| 8.1.2.b | Orientate and re-orientate WDCs, CBOs etc. on promotion of healthy life style | | Lack of funds | Orientate and re-orientate |
| 8.1.2.c | Conduct outreaches and town hall meetings on promotion of healthy life style and  environment | | Lack of funds | Conduct outreaches |
|  | | 8.1.3 | Strengthen health promotion coordination mechanisms at all levels | | * Public enlightenment on risky health behaviours through production and airing of jingles done * Stakeholders meeting to disseminate information on promotion of healthy living done at state & LGA levels * Zonal meeting with WDC Chairman to   disseminate information on promotion of healthy living held |  |  |

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|  | | 8.1.3.a | Public enlightenment on risky health behaviours through production and airing of jingles | | Lack of funds | Public enlightenment |
| 8.1.3.b | Conduct stakeholders meeting at the state level to disseminate information on promotion of  healthy living | | Lack of funds | Conduct stakeholders  meeting |
| 8.1.3.c | Conduct stakeholders meeting at the LGA level to disseminate information on promotion of  healthy living | | Lack of funds | Conduct stakeholders  meeting |
| 8.1.3.d | Support zonal meeting with WDC Chairman to disseminate information on promotion of  Healthy living. | | Lack of funds | Support zonal meeting |
|  | 8.1.4 | Scale-up health promotion activities at all levels. | | * Reach Every Ward (REW) strategy with components of all health interventions integrated at state & LGA levels * Celebration of World Handwashing Day in the state done * Environmental health club established in   schools at all levels |  |  |
|  | | 8.1.4.a | Integrate Reach Every Ward (REW) strategy with components of all health interventions at state & LGA levels | | Lack of funds | Integrate Reach Every Ward |
| 8.1.4.b | Conduct zonal hygiene promotion debate and quiz amongst schools in the state | | Lack of funds | Conduct zonal hygiene promotion |
| 8.1.4.c | Celebration of World Handwashing Day in the state & 23 LGAs | | Lack of funds | Celebration of world handwashing day |
| 8.1.4.d | Establish environmental health club in schools at all levels | | Lack of funds | Establish environmental |
| 8.1.4.e | Monitoring of activities of environmental health club | | Lack of funds | Monitoring of activities |
|  | 8.1.5 | Promote the inclusion of health promotion in workplace health programs | | * Advocacy visit to the Head of Service for inclusion of health promotion in workplace health programmes done * Sanitary convenience in workplaces constructed & dust bins & buckets procured & distributed * Weekly environmental sanitation in workplace institutionalized |  |  |
|  | | 8.1.5.a | Conduct advocacy visit to the Head of Service by Environmental Health Officers (EHOs) for inclusion of health promotion (violence at work, smoking at work place, harassment and  bullying at work place, consumption of alcohol and substance abuse at work place) in workplace health programmes | | Lack of funds | Advocacy visit |
| 8.1.5.b | Operating cost for engaging and supervising the contractor to construct sanitary  convenience in workplaces | | Lack of funds | Costed in OHT |
| 8.1.5.c | Procure and distribute dust bins & buckets at workplace | | Lack of funds | Procure and distribute dust  bin |
| 8.1.5.d | Institutionalize weekly environmental sanitation in workplace | | Lack of funds | No cost |
| 8.1.5.e | Orientation of public servants on hygiene promotion in workplace | | Lack of funds | Orientation of public  servants |
|  | 8.1.6 | Promote the inclusion of health promotion in school curricula at all levels | | * Advocacy visit to the Commissioner of Education by EHOs for inclusion of health promotion in school curricula at all levels done * Health promotion activities in school curricula at all levels institutionalized |  |  |
|  | | 8.1.6.a | Conduct advocacy visit to the Commissioner of Education by EHOs for inclusion of health  promotion in school curricula at all levels | | Lack of funds | Conduct advocacy visit |
| 8.1.6.b | Institutionalize health promotion activities in school curricula at all levels | | Lack of funds | Institute health promotion |
| 8.1.6.c | Conduct quiz and debate on healthy living | | Lack of funds | Conduct quiz |
|  | 8.1.7 | Intensify multi-sectoral and intra-sectoral collaboration and partnerships in planning, implementation and health promotion activities | | * Quarterly stakeholders meeting with line ministries and MDAs to review implementation of planned activities held * Quarterly monitoring and supervision of health promotion activities in schools in collaboration with line ministries and MDAs. held * Citing of public conveniences and   borehole by environmental health workers |  |  |
|  | | 8.1.7.a | Hold periodic stakeholders meeting with line ministries and MDAs to review implementation  of planned activities. | | Lack of funds | Hold meeting |
| 8.1.7.b | Periodic monitoring and supervision of health promotion activities in schools in collaboration with line ministries and MDAs. | | Lack of funds | Quarterly monitoring and supervision |
| 8.1.7.c | Monitoring of citing of public conveniences and borehole by environmental health workers | | Lack of funds | Monitoring of citing |
| **8.2** | **Promote food hygiene and safety for the reduction of illnesses associated with unwholesome food.** | | | |  | |
|  | 8.2.1 | Strengthen system for food and water safety surveillance. | | * Food handlers from 23 LGAs in the state trained. * Workshop for EHOs done * Butchers and meat handlers from 23 LGAs trained * WATSAN officers and zonal EHOs from   23 LGAs trained. |  |  |
|  | | 8.2.1.a | Organise periodic training for food handlers from 23 LGAs in the state on food handling. | | Lack of funds | Organise periodic training |
| 8.2.1.b | Conduct workshop for EHOs to ensure that public consumes are safe, wholesome and nutritious food. | | Lack of funds | Conduct workshop |
| 8.2.1.c | Conduct sensitization workshop for food handlers on food hygiene and other practices | | Lack of funds | Conduct sensitization workshop |
| 8.2.1.d | Conduct sensitization training for butchers and meat handlers from 23 LGAs on practice of  meat handling | | Lack of funds | Conduct sensitization  training |
| 8.2.1.e | Conduct training workshop for water and sanitation (WATSAN) officers and zonal EHOs from 23 LGAs for promotion of potable water supply in the state. | | Lack of funds | Conduct training workshop |
|  | 8.2.2 | Strengthen the legal, and regulatory framework for food safety in line with international guidelines. | | * Existing National policies on Food/Nutrition; Food Safety etc., reviewed & adapted in line with national guidelines. * Policy document on Food /Nutrition and food Safety validated, printed & disseminated |  |  |

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|  | | 8.2.2.a | Engage a Consultant to review and adapt the national policy on Food and Nutrition and any  other policy on Food Safety. | | Lack of funds | Engage a Consultant |
| 8.2.2.b | Review /Adaptation of the existing National policies on Food/Nutrition; Food Safety etc., in line with national guidelines. | | Lack of funds | Review /Adaptation |
| 8.2.2.c | Organise meeting with State Assembly on the adopted policies on Food safety. | | Lack of funds | Organize meeting |
| 8.2.2.d | Validation and printing of the policy document on Food /Nutrition and food Safety | | Lack of funds | Validation and Printing |
| 8.2.2.e | Dissemination of the adopted Food/Nutrition Policy and Food safety policy to relevant  stakeholders in the state. | | Lack of funds | Dissemination of the  adopted |
|  | 8.2.3 | Intensify awareness and sensitization on food safety and quality particularly at the rural community level. | | * Electronic and print media engaged. * Orientation of Members of Committees done * Community Volunteers trained on Food Safety and quality. |  |  |
|  | | 8.2.3.a | Engage the media (both electronic and print) on awareness creation and sensitization of the populace on food safety and quality. | | Lack of funds | Engage the media |
| 8.2.3.b | Orientation of members of the State Committee on Food and nutrition on Food safety and quality. | | Lack of funds | Orientation of members |
| 8.2.3.c | Inauguration of LGA Committee on Food and Nutrition in the 23 LGAs of the state. | | Lack of funds | Inauguration of LGA  Committee |
| 8.2.3.d | Orientation of members of 23 LGA Committees on Food and Nutrition on Food safety and  quality. | | Lack of funds | Orientation of members |
| 8.2.3.e | Training of community volunteers on Food Safety and Quality. | | Lack of funds | Training of community  volunteers |
|  | 8.2.4 | Scale up the training of food inspectors that will ensure that foods sold within the country are in compliance with current standards and regulations. | | * SOP on Food Safety and Quality developed * Food Inspectors on Food Safety and quality trained * Review meeting of the Food Inspectors |  |  |
|  | | 8.2.4.a | Mapping of the Food inspectors in the State. | | Lack of funds | Conduct mapping |
| 8.2.4.b | Development of SOP on Food Safety and Quality | | Lack of funds | Development of SOP |
| 8.2.4.c | Training of Food Inspectors on Food Safety and quality. | | Lack of funds | Training of Food Inspectors |
| 8.2.4.d | Review meeting for Food Inspectors and members of the Food/Nutrition committee. | | Lack of funds | Review meeting |
|  | 8.2.5 | Promote the practice of food safety across the food production pipe line from farm to the table. | | * Collaboration with the relevant Ministries and Parastatals in the state done * Collaboration with Ministry of Agriculture and ADP done * Farmers trained |  |  |
|  | | 8.2.5.a | Collaborate with the relevant Ministries and Parastatals in the state to promote the practice of Food Safety and quality e.g. Ministry of Agriculture, ADP, Ministry of Education, etc. | | Lack of funds | Collaborate with the relevant Ministries |
| 8.2.5.b | Collaboration with Ministry of Agriculture and ADP on food safety practice during production and processing of foods from farm to the table. | | Lack of funds | Costed in 8..2.5a |
| 8.2.5.c | Training for farmers on food safety practice during production and processing of foods from  farm to the table. | | Lack of funds | Training for Farmers |
| **8.3** | **Promote universal access to safe drinking water and acceptable sanitation** | | | |  | |
|  | 8.3.1 | Promote the development and the implementation of policies, plans and legislation and regulation for the provision of safe water supply and promotion of environmental health | | * WASH committee established, quarterly meeting held and existing policies and regulations on safe water supply and promotion of environmental health reviewed and adopted * Advocacy to the 23 LGAs Chairmen & Traditional Rulers done * Community members(WDCs) trained * Awareness creation done |  |  |
|  | | 8.3.1.a | Establish WASH committee at all levels to ensure implementation of policy, plan etc. and hold quarterly meeting | | Lack of funds | Establish WASH committee |
| 8.3.1.b | Review of existing policies and regulations on safe water supply and promotion of environmental health | | Lack of funds | Review of existing policies |
| 8.3.1.c | Advocacy visit to the 23 LGAs Chairmen & Traditional Rulers on the need to provide potable water in accordance to WHO standard | | Lack of funds | Advocacy visit |
| 8.3.1.d | Training of community members (WDCs) on regulation guiding safe water supply. | | Lack of funds | Training of community members |
| 8.3.1.e | Create awareness on hand washing at appropriate times using print, electronic and social  media platforms | | Lack of funds | Create awareness |
|  | 8.3.2 | Promote preventive and curative healthcare for water and sewage borne diseases | | * Waste management desk officers in the 23 LGA trained * Community sensitization in the 23 LGAs on the prevention of water & sewage borne diseases done * Registered commercial table water in 23 LGAs trained on prevention of water & sewage borne diseases * Public enlightenment of the populace through production and airing of jingles & print/distribution of posters/fliers on WASH   done |  |  |

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|  | | 8.3.2.a | Conduct training workshop for waste management desk officers in the 23 LGA | | Lack of funds | Conduct workshop |
| 8.3.2.b | Conduct community sensitization in the 23 LGAs on the prevention of water & sewage borne diseases | | Lack of funds | Conduct sensitization meeting |
| 8.3.2.c | Conduct workshop for all registered commercial table water in 23 LGAs on proper standard of water safety to prevent water & sewage borne diseases | | Lack of funds | Conduct workshop |
| 8.3.2.d | Organize orientation for commercial water producers on proper standard of water safety | | Lack of funds | Organize orientation |
| 8.3.2.e | Public enlightenment of the populace through production and airing of jingles &  print/distribution of posters/fliers on WASH | | Lack of funds | Public enlightenment |
|  | 8.3.3 | Strengthen behavioural change communication, social mobilization and advocacy for the promotion of safe water and sanitation. | | * Advocacy to policy makers at the State for provision of functional safe water points in the State * Orientation of health workers on effective   hand washing and sanitation done |  |  |
|  | | 8.3.3.a | Conduct advocacy to policy makers at the State•for provision of functional safe water points  in the State | | Lack of funds | Costed in 8.1.1a |
| 8.3.3.b | Develop, print and distribute IEC materials on promotion of safe water and sanitation | | Lack of funds | Develop, print and  distribute |
| 8.3.3.c | Community sensitization on safe water and sanitation using WDC monthly meetings | | Lack of funds | Conduct sensitization |
| 8.3.3.d | Orientation of health workers on effective hand washing and sanitation | | Lack of funds | Orientation of health  workers |
| 8.3.3.e | Production and airing safe water and sanitation jingles | | Lack of funds | Production and airing |
|  | 8.3.4 | Strengthen the regulatory and supervisory frame work for production of commercial water to ensure water safety | | * Monitoring and supervision of construction of commercial water points done * Regulation for production of commercial water supply produced and distributed * Monitoring and supervision of construction of commercial water points carried out |  |  |
|  | | 8.3.4.a | Establish in collaboration with NAFDAC a regulation enforcement committee for commercial  water producer | | Lack of funds | Establish in collaboration |
| 8.3.4.b | Produce and distribute regulation for production of commercial water supply | | Lack of funds | Produce and distribute |
| 8.3.4.c | Monitoring and supervision of construction of commercial water points | | Lack of funds | Monitoring and supervision |
| **8.4** | **Reduce morbidity and mortality from snake bites in Nigeria** | | | |  | |
|  | 8.4.1 | Promote the development and the implementation of policies, plans, legislations and regulations for the reduction of snake bites in Nigeria. | | * Anti-snake bite TWG inaugurated quarterly meetings held * Policies, plans, legislations and regulations for snake bite reduction in Rivers State adapted, printed & disseminated, Work plan for programme & all potential sources of funding identified * Advocacy visits to incorporate policies and regulations into the State Legislative system   done |  |  |
|  | | 8.4.1.a | Identify qualified members for a TWG on Anti-snake bites; and conduct a meeting to inaugurate the Anti-snake bite TWG with terms of reference | | Lack of funds | Conduct a meeting |
| 8.4.1.b | Conduct workshop to review and adapt policies, plans, legislations and regulations for snake bite reduction in Rivers State. Draw up Work plan and budget for snake bite  programme. Identify all potential sources of funding and partnership | | Lack of funds | Conduct workshop |
| 8.4.1.c | Conduct advocacy visits to incorporate policies and regulations into the State Legislative  system by TWG. | | Lack of funds | Conduct advocacy visits |
| 8.4.1.d | Print and disseminate anti snakebite policies to all parastatals | | Lack of funds | Print and disseminate |
|  | 8.4.2 | Scale up sustainable supply of anti-snake venom in Nigeria, including local production | | * Existing sources of supply of anti-snake venom reviewed and institutions and companies involved with snake venom research for local production identified * Anti-snake venoms and complimentary items procured & distributed   • |  |  |
|  | | 8.4.2.a | Conduct review of existing sources of supply of anti-snake venom and identify institutions  and companies involved with snake venom research for local production. | | Lack of funds | Conduct review |
| 8.4.2.b | Support procurement and distribution of antivenoms and complimentary items (analgesics, TT and antisera, parenteral fluids, wound care consumables etc.) | | Lack of funds | Support procurement and  distribution |
| 8.4.2.c | Conduct resource mobilization activities for implementation: advocacy visits to identified  sources of funding | | Lack of funds | Conduct resource  mobilization |
|  | 8.4.3 | Build capacity of health care workers on snakebite management at all levels. | | * TOT of state officers on snakebite management done * Health workers on appropriate snakebite management at State & LG levels, including on data management on snakebites trained   • |  |  |
|  | | 8.4.3.a | Conduct TOT of state officers on snakebite management | | Lack of funds | Conduct TOT |
| 8.4.3.b | Conduct trainings of health workers on appropriate snakebite management at State level, including on data management on snakebites | | Lack of funds | Conduct trainings |
| 8.4.3.c | Conduct training of all levels of health workers on appropriate snakebite management at LG level, including on data management on snakebites | | Lack of funds | Conduct training |

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|  | 8.4.4 | Promote partnerships for national snakebite response | | * NGOs, FBOs, CBOs and related partners for partnership on national snakebite response identified * Advocacies to identified partners for partnership negotiations done   • |  |  |
|  | | 8.4.4.a | Identify NGOs, FBOs, CBOs and related partners for partnership on national snakebite  response | | Lack of funds | Costed in 8.4.2c |
| 8.4.4.b | Conduct advocacies to identified partners for partnership negotiations | | Lack of funds | Costed in 8.4.2c |
|  | 8.4.5 | Scale up generation of local evidence to inform more responsive snakebite programming | | * Quarterly data quality assessments of snakebite programmes done * Monthly surveillance held and reporting systems for data developed & data used for resource allocation and distribution |  |  |
|  | | 8.4.5.a | Conduct periodic data quality assessments of snakebite programmes | | Lack of funds | Conduct data assessments |
| 8.4.5.b | Initiate surveillance and reporting systems for snakebite and conduct regular surveillance.  Data to be used for resource allocation and distribution | | Lack of funds | Initiate surveillance |
|  | 8.4.6 | Promote snakebite prevention and Control interventions. | | * Educational posters and leaflets produced & distributed across communities in the state * Advocate for incorporation of modern management of snakebites into the schools' curriculums of medical personnel done * Supervision and monitoring of health   centers and facilities for snakebite prevention and control done |  |  |
|  | | 8.4.6.a | Produce and distribute educational posters and leaflets across communities in the state | | Lack of funds | Produce and distribute |
| 8.4.6.b | Support research into snakebite prevention and control for regular improvements | | Lack of funds | Support research |
| 8.4.6.c | Advocate for incorporation of modern management of snakebites into the schools'  curriculums of medical personnel | | Lack of funds | Advocate for incorporation |
| 8.4.6.d | Conduct supervision and monitoring of health centres and facilities for snakebite prevention  and control | | Lack of funds | Conduct supervision |
| **8.5** | **Protect human health, environment and infrastructure from chemical hazard, medical & Bio waste and poisoning** | | | |  | |
|  | 8.5.1 | Strengthen legal, regulatory framework, policies and plans for chemical hazards and poisoning, medical and Bio waste and climate change | | * Policies and regulations for chemical hazards & poisoning, medical & Bio waste & climate change adapted, printed & disseminated * Stakeholders meeting on legal framework for chemical hazards and poisoning held regularly * Advocacy to government officials and other stakeholders on the need to mitigate   the effects chemical hazards on climate |  |  |
|  | | 8.5.1.a | Adapt, print and disseminate relevant policies and regulations for chemical chemical hazards & poising, medical & Bio waste & climate change | | Lack of funds | Adapt, print and disseminate |
| 8.5.1.b | Develop health protection policy for children | | Lack of funds | Develop health protection  policy |
| 8.5.1.c | Conduct stakeholders meeting on legal framework for chemical hazards and poisoning | | Lack of funds | Conduct stakeholders  meeting |
| 8.5.1.d | Conduct advocacy to government officials and other stakeholders on the need to mitigate  the effects chemical hazards on climate change on health | | Lack of funds | Conduct advocacy |
|  | 8.5.2 | Scale-up advocacy, community sensitization and education on chemical wastes and poisoning, medical and Bio waste and climate change | | •Advocacy to stakeholder to sensitize them on the possible effect of chemical waste medical and bio waste and chemical change done  •Periodic town hall meeting with communities living in an industrial area held   * Public enlightenment in state media   houses on the effect of chemical hazards |  |  |
|  | | 8.5.2.a | Conduct advocacy to stakeholder to sensitize them on the possible effect of chemical  waste, medical and bio waste and chemical change | | Lack of funds | Costed in 8.5.1d |
| 8.5.2.b | Advocacy and social mobilization to communities (319 wards) to sensitize them on climate effects on health | | Lack of funds | Advocacy and social mobilization |
| 8.5.2.c | Periodic town hall meeting with communities living in an industrial area | | Lack of funds | Periodic town hall meeting |
| 8.5.2.d | Conduct public enlightenment in state media houses on the effect of chemical hazards | | Lack of funds | Conduct public  enlightenment |
|  | 8.5.3 | Build capacity of health workers for effective management of medical and Bio waste and hazardous chemicals at all levels of the health care system | | * Health workers trained on the management of medical and bio waste at all level * Environmental Health Officers trained on   risk assessment |  |  |
|  | | 8.5.3.a | Conduct training of health workers on the mana•gement of medical and bio waste at all  level | | Lack of funds | Conduct training for HWs |
| 8.5.3.b | Conduct training for Environmental Health Officers on risk assessment | | Lack of funds | Conduct training for EHOs |

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|  | 8.5.4 | Build capacity to appropriately respond to health effects of climate change | | * Health workers trained on climate impacts and how to assess vulnerabilities * State Climate Change Disk officers, Civil Society Organizations and 23 LGA climate change Desk officer trained on emergency   Response |  |  |
|  | | 8.5.4.a | Develop and implement climate and health adaptation plan | | Lack of funds | Develop and implement |
| 8.5.4.b | Conduct training of health workers on climate impacts and how to assess vulnerabilities | | Lack of funds | Costed in 8.5.3a |
| 8.5.4.c | Hold training for State Climate Change Disk officers, Civil Society Organizations and 23  LGA climate change Desk officer on emergency Response | | Lack of funds | Hold training |
|  | 8.5.5 | Deepen collaboration with relevant stakeholders on Chemicals Management, medical & Bio waste management and climate change | | * Bi-annual stakeholders review meeting on effects of climate change in the state held   •  • |  |  |
|  | | 8.5.5.a | Conduct risk assessment for hazardous chemicals and poisoning | | Lack of funds | Costed in 8.5.4b |
| 8.5.5.b | Hold bi-annual stakeholders review meeting on effects of climate change in the state | | Lack of funds | Hold review meetings |
|  | 8.5.6 | Improve systems for data collection, management and utilization for chemical hazards and poisons, medical and Bio waste and climate change | | * Surveillance and reporting systems for data collection, management and utilization for chemical hazards and poisons, medical and Bio waste and climate change developed * Quarterly data quality assessments done * Activities of climate change desk officer reviewed annually |  |  |
|  | | 8.5.6.a | Develop surveillance and reporting systems for data collection, management and utilization for chemical hazards and poisons, medical and Bio waste and climate change | | Lack of funds | Costed in 8.5.4b |
| 8.5.6.b | Conduct quarterly data quality assessments | | Lack of funds | Conduct assessments |
| 8.5.6.c | Review of activities of climate change desk officer yearly | | Lack of funds | Costed in 8.5.5b |
| **8.6** | **Promote optimal health and safety of workers in their work environment** | | | |  | |
|  | 8.6.6 | Promote health and safety in the workplace | | * Occupational health unit established in the SMOH * Sensitization of workforce on the use of safety protective devices in the work place done * Awareness on any existing & emerging risk using print, electronic and social media platforms created |  |  |
|  | | 8.6.6.a | Establishing occupational health unit in the SMOH | | Lack of funds | Establishing occupational health unit |
| 8.6.6.b | Sensitization of workforce on the use of safety protective devices in the work place | | Lack of funds | Sensitization of workforce |
| 8.6.6.c | Create awareness on any existing & emerging risk using print, electronic and social media  platforms | | Lack of funds | Create awareness |
|  | 8.6.7 | Promote collaboration between the key stakeholders (Ministry of Health, Ministry of Labour and the private sector) | | * Occupational health committee set up in the State Ministry of Health and inaugurated * Quarterly collaboration meeting held   • |  |  |
|  | | 8.6.7.a | Setup/Inaugurate occupational health committee in the State Ministry of Health | | Lack of funds | Setup/Inaugurate |
| 8.6.7.b | Hold quarterly collaboration meeting | | Lack of funds | Hold meeting |

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| **Strategic Pillar Three: Health system support** | | | | | | | |
| **9.Human Resource for Health** | | | | | | | |
| **9. To have in place the right number, skill mix of competent, motivated, productive and equitably distributed health work force for optimal and quality health care** | | | | | | | |
|  | **9.1** | **services provision.**  **Ensure coordination and partnership for aligning investment of current and future needs and institutional strengthening for HRH agenda** | | | |  |  |
|  | | 9.1.1 | Strengthen institutional capacities of HRH coordinating structures | | * Practical demonstration rooms of School of Midwifery and School of Public Health equipped * School of Nursing classroom renovated * College of Health Science & Technology Academic Staff, Senior Non Academic Staff and Junior Non Academic Staff trained |  |  |
|  | | | 9.1.1.a | Build capacity to strengthen HRH units at state level to enhance performance | | Lack of funds | Build capacity |
| 9.1.1.b | Set up committee to assess the state of health training institutions (College of Health Science & Technology, School of Nursing, School of Midwifery & School of Public Health) and establish a multi-sectoral coordinating body including Ministry of Health, Education, finance, NGOs, professional bodies such as associations and licensing councils, training institutions, universities, etc. to coordinate human resource activities in the state | | Lack of funds | Set up committee & conduct meeting |
| 9.1.1.c | Operating cost for engaging and supervising the contractor to equip the practical demonstration rooms of School of Midwifery and School of Public Health | | Lack of funds | Costed in OHT |
| 9.1.1.d | Operating cost for engaging and supervising the contractor to renovate School of Nursing classroom | | Lack of funds | Costed in OHT |
| 9.1.1.e | Conduct workshops on staff training and development for academic staff, Senior Non Academic Staff and Junior Non Academic Staff for College of Health Science & Technology | | Lack of funds | Conduct training |
|  | | 9.1.2 | Strengthen coordination of public , private , regulatory, Health workforce association and development partners at all levels | | * State comprehensive HRH database updated   • |  |  |
|  | | | 9.1.2.a | Update a state comprehensive HRH database | | Lack of funds | Update HRH database |
|  | | 9.1.3 | Enhance funding for HRH development for the current and future needs | | * Advocacy for allocation a minimum of 15% of the health budget to development of HR done * Advocate to private sector for adequate funding for HRH done * Resource mobilization activities for HRH, including craftsmanship, proposal   development, fund raising activities etc. |  |  |
|  | | | 9.1.3.a | Advocacy for allocation a minimum of 15% of the health budget to development of human resources. (NHP 2004) | | Lack of funds | Advocacy for allocation |
| 9.1.3.b | Advocate to private sector for adequate funding for HRH using HRH plan as an advocacy  tool | | Lack of funds | Advocacy visits |
| 9.1.3.c | Conduct resource mobilization activities for HRH, including craftsmanship, proposal  development, fund raising activities etc. | | Lack of funds | Resource mobilization |
|  | **9.2** | **Ensure the production of adequate numbers of qualified health workers** | | | |  | |
|  | | 9.2.1 | Strengthen the quality assurance for HRH training institutions esp. for producing frontline health workers | | * Training needs of health training institutions assessed * Training curricula revised in line with current market needs and continuing professional development programs targeting HR trainers developed * Quality assurance framework for health   training institutions developed and implemented |  |  |

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|  | | 9.2.1.a | Assess training needs of health training institutions | | Lack of funds | Assess needs |
| 9.2.1.b | Review and revise training curricula in line with current market needs | | Lack of funds | Review and revise training |
| 9.2.1.c | Develop continuing professional development programmes targeting HR trainers | | Lack of funds | Develop programmes |
| 9.2.1.d | Develop and implement a quality assurance framework for health training institutions | | Lack of funds | Develop and implement |
| 9.2.1.e | Monitor and evaluate training programs | | Lack of funds | Monitor and evaluate  training |
|  | 9.2.2 | Strengthen the platform between HRH training institutions, regulatory bodies and other stakeholders to increase health workforce production | | * Evidence-based staffing norms for all levels of human resources for health based on workload analysis established * Healthcare personnel trained for effective and efficient staff utilization according to training needs * Integrated supportive supervision (ISS) to all health cadre and facilities by the multi- sectoral coordinating body done |  |  |
|  | | 9.2.2.a | Establish evidence-based staffing norms for all levels of human resources for health based  on workload analysis | | Lack of funds | No cost |
| 9.2.2.b | Deploy/redeploy/recruit qualified personnel(Clinical and Non Clinical Staff) based on needs and established gaps | | Lack of funds | Costed in OHT |
| 9.2.2.c | Train and retrain healthcare personnel for effective and efficient staff utilization according to  training needs (e.g. Train SPHCDA staff on IMCI and Community IMCI, LSS, MLSS etc.) | | Lack of funds | Train and re-train |
| 9.2.2.d | Conduct periodic integrated supportive supervision (ISS) to all health cadre and facilities by the multi-sectoral coordinating body. | | Lack of funds | Conduct Integrated Supportive Supervision |
|  | 9.2.3 | Improve gender sensitivity in the production of health work force for all cadres at all levels | | * Database disaggregated by gender done |  |  |
|  | | 9.2.3.a | Establish/ update annually a database disaggregated by gender to track gender disparities in training of healthcare workers | | Lack of funds | Establish/ update database |
| **9.3** | **Strengthen monitoring and evaluation of HRH including systems for HRHMIS and Registry** | | | |  | |
|  | 9.3.1 | Strengthen/establish HRHIS at state and federal levels | | * Human Resource Health information System (HRHIS) established in the state   • |  |  |
|  | | 9.3.1.a | Establish/strengthen Human Resource Health information System (HRHIS) | | Lack of funds | Establish/strengthen  HRHIS |
| 9.3.1.b | Establish a performance management system (performance of individual workers using job aids, job descriptions, scheme of service and work plans) | | Lack of funds | Establish a performance management system |
| 9.3.1.c | Conduct periodic facility-based and health workers' performance assessment, monitoring an  supervision | | Lack of funds | Conduct facility-based  assessment |
|  | 9.3.2 | Establish mechanisms for annual HRH reviews and reporting for evidence and decision making at the Federal and State levels | | * Joint annual reviews to assess progress made in implementing HRH done * Mid-term and final evaluation of HRH strategic plan implementation done   • |  |  |
|  | | 9.3.2.a | Conduct joint annual reviews to assess progress made in implementing HRH action plans  by thematic area | | Lack of funds | Conduct joint annual  reviews |
| 9.3.2.b | Conduct mid-term and final evaluation of HRH strategic plan implementation | | Lack of funds | Conduct mid-term  evaluation |
|  | 9.3.3 | Improve the production of HRH research evidence through monitoring and evaluation mechanisms | | * Capacity building for HRH research done * Research to improve the production and utilization of relevant professional cadres and skill mix done * Platform for translating HRH research findings to action created |  |  |
|  | | 9.3.3.a | Promote and build capacity for HRH research | | Lack of funds | Promote and build capacity |
| 9.3.3.b | Conduct relevant research to improve the production and utilization of relevant professional cadres and skill mix required for a responsive health system | | Lack of funds | Conduct research |
| 9.3.3.c | Create a platform for translating HRH research findings to action (evidence to action) | | Lack of funds | Costed in 9.3.3b |
| **9.4** | **Ensure effective health workforce management through retention, deployment, work condition, motivation and performance management** | | | |  | |

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|  | 9.4.1 | Strengthen mechanism for deployment and retention of HRH at all levels | | * Existing HRH recruitment and deployment policies reviewed to remove barriers/embargo * Enabling work and living environment created * Incentives in the hiring of rural health   workers sustained |  |  |
|  | | 9.4.1.a | Review existing HRH recruitment and deployment policies to remove barriers/embargo to competitive recruitment, deployment and retention of appropriate health workforce | | Lack of funds | Review existing HRH |
| 9.4.1.b | Create an enabling work and living environment to promote health worker recruitment and  retention | | Lack of funds | No cost |
| 9.4.1.c | Sustain incentives in the hiring of rural health workers in order to attract qualified staff from  urban areas to work in the rural areas. | | Lack of funds | Costed in OHT Human  Resource |
| 9.4.1.d | Introduce performance based reward systems. Best performance from each department in  SMOH and RSPHCMB annually | | Lack of funds | Introduce performance  based reward |
| 9.4.1.e | Institutionalize the Midwifery Service Scheme (MSS) and other flagship interventions to  increase HRH availability especially in hard to reach areas | | Lack of funds | Monthly allowance |
|  | 9.4.2 | Improve HRH performance management systems at all levels | | * System for measuring performance of health workers reviewed and implemented |  |  |
|  | | 9.4.2.a | Review and implement system for measuring performance of health workers in line with the  Civil Service Performance Monitoring System (PMS) | | Lack of funds | Promotion activities |
|  | 9.4.3 | Strengthen the task shifting and task sharing implementation with required guidelines. | | * TSTS Policy produced and distribute to relevant Stakeholders * Advocacy meeting with Key Stakeholders to sensitize them on TSTS Implementation with guidelines done * TSTS training for all cadre of HWs   commenced |  |  |
|  | | 9.4.3.a | Submit draft report of Task Shifting /Sharing (TSTS) training to Hon. Commissioner for  Health | | Lack of funds | No cost |
| 9.4.3.b | Produce final copies of TSTS Policy and distribute to relevant Stakeholders | | Lack of funds | Print and Distribute copies  of TSTS policy |
| 9.4.3.c | Conduct advocacy meeting with Key Stakeholders to sensitize them on TSTS  Implementation with guidelines | | Lack of funds | Conduct meeting |
| 9.4.3.d | Hold meeting with Stakeholders, Professional Bodies, Health Institutions on TSTS  implementation guidelines. | | Lack of funds | Conduct meeting |
| 9.4.3.e | Commence TSTS training for all cadre of HWs in line with the guidelines | | Lack of funds | Commence TSTS training |
| **9.5** | **Strengthen Health workforce planning for effective management** | | | |  | |
|  | 9.5.1 | Improve capacity for HRH planning at all levels | | * IT tools to enable HRH unit plan for HRH needs across all levels provided * HRH Personnel trained   • |  |  |
|  | | 9.5.1.a | Provide IT tools to enable HRH unit plan for HRH needs across all levels | | Lack of funds | Provide IT tools |
| 9.5.1.b | Train HRH Personnel to improve HRH planning at state, LGAs Health Facilities | | Lack of funds | Training HRH Personnel |
|  | 9.5.2 | Strengthen mechanisms for HRH joint planning at primary, secondary and tertiary levels | | * Workshop organized, HRH plan developed and harmonized |  |  |
|  | | 9.5.2.a | Organize workshop for primary, secondary & tertiary levels to develop harmonized HRH  plan | | Lack of funds | Organize workshop |

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| **10.Health Infrastructure** | | | | | | | |
| **10. To improve availability and functionality of health infrastructure required to optimize service delivery at all levels and ensure equitable access to effective and** | | | | | | | |
|  |  | **responsive health services throughout the country.** | | | | | |
|  | **10.1** | **To improve availability and functionality of health infrastructure required to optimize service delivery**  **at all levels** | | | |  |  |
|  | | 10.1.1 | Strengthen legal, policy and institutional framework and coordinating mechanism for health infrastructure planning and maintenance in Nigeria | | * Policies, laws and guidelines on health infrastructure, equipment maintenance and management reviewed and adapted * State strategic health infrastructure plan developed * Capacity of health infrastructure unit staff   at state level built |  |  |
|  | | | 10.1.1.a | Set up a functional health infrastructure coordinating committees at different levels | | Lack of funds | Set up coordinating  committees |
| 10.1.1.b | Review/adapt policies, laws and guidelines on health infrastructure, equipment maintenance  and management | | Lack of funds | Review/adapt policies |
| 10.1.1.c | Develop a state strategic health infrastructure plan | | Lack of funds | Develop a State Strategic |
| 10.1.1.d | Build capacity of health infrastructure unit at state level | | Lack of funds | Build capacity |
|  | | 10.1.2 | Promote the establishment of norms and standards for health infrastructure for all levels of the health care system in the country | | * Norms and standards for health infrastructure established * Meeting of key stakeholders in the public and private sector convened   • |  |  |
|  | | | 10.1.2.a | Establish norms and standards for health infrastructure (Physical facilities including laboratory services and municipal services e.g. water, sanitation, electricity facilities), ICT, Communication, equipment, transport, etc. including critical infrastructure (e.g. blood banks, energy supply systems, laboratories, etc.) at all levels of the healthcare system | | Lack of funds | Establish norms |
| 10.1.2.b | Convene meeting of key stakeholders in the public and private sector to review and adopt  the norms | | Lack of funds | Convene meeting |
|  | | 10.1.3 | Ensure availability of equipment and other health infrastructure in line with established norms and standards for the different levels of health care and other health institutions | | * Facility assessment of equipment in all secondary and & PHC health facilities done * System for procurement of health infrastructure established |  |  |
|  | | | 10.1.3.a | Conduct facility assessment of equipment in all secondary and & PHC health facilities in the  state by infrastructure coordinating committee | | Lack of funds | Conduct assessment |
| 10.1.3.b | Conduct periodic monitoring and evaluation of provision & distribution of hospital equipment  to all functional secondary & primary health facilities in the State & LGA as planned by the various departments | | Lack of funds | Conduct periodic meeting |
| 10.1.3.c | Establish a system for procurements of health infrastructure (e.g. vehicle, ICT, communication, equipment etc.) in partnership with the private sector | | Lack of funds | Establish a system |
| 10.1.3.d | Cost of engaging and supervising the contractor to provide equipment and infrastructure in primary and secondary HFs in the state | | Lack of funds | Costed in OHT |
| 10.1.3.e | Advocate for dedicated funds for health infrastructure development and management in  Nigeria | | Lack of funds | Advocate for dedicated  fund |
|  | | 10.1.4 | Strengthen the monitoring of health infrastructure, including inventories and performance | | * Monitoring of health infrastructures, including inventories & performance done * Health infrastructures included into the EMR framework |  |  |
|  | | | 10.1.4.a | Conduct monitoring of health infrastructures, in • ding inventories & performance at State &  clu  LGA levels LGA levels | | Lack of funds | Conduct monitoring |
| 10.1.4.b | Ensure inclusion of health infrastructures into the Electronic Medical Record EMR framework for all health facilities | | Lack of funds | Costed in 9.1.2a |
|  | | 10.1.5 | Strengthen capacities and partnerships for health infrastructure Maintenance and management | | * MoUs with private suppliers in the post- supply of health infrastructure maintenance and training of providers in use and maintenance established * Resources from development partners, philanthropists, and communities on health infrastructure development, management and maintenance mobilized * Human resource rained in the use and maintenance of the health infrastructure |  |  |



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|  | 10.1.5.a | Establish a plan and system for maintenance of all health infrastructure | | Lack of funds | No cost |
| 10.1.5.b | Establish MoUs with private suppliers in the post-supply of health infrastructure maintenance and training of providers in use and maintenance | | Lack of funds | Establish MoU |
| 10.1.5.c | Establish PPP platform on health infrastructure procurement, service provision and  maintenance (e.g. Build and maintain, outsource, contract, concession etc.) | | Lack of funds | Fueling of vehicle |
| 10.1.5.d | Mobilize resources from development partners, philanthropists, and communities on health  infrastructure development, management and maintenance | | Lack of funds | Community visit |
| 10.1.5.e | Train human resource in the use and maintenance of the health infrastructure | | Lack of funds | Train human resource |
| 10.1.6 | Promote partnerships between Equipment Manufacturers/ Suppliers and government at all levels for technology transfer/training/ maintenance agreements. | | * Platform for engagement of major equipment manufacturers/suppliers for technology transfer/training/ maintenance of infrastructure identified and provided * MoUs for production, training, and maintenance of health infrastructure developed and implemented * Advocate an enabling fiscal policy to create an enabling environment for PPP done |  |  |
|  | 10.1.6.a | Identify and provide platform for engagement of major equipment manufacturers/suppliers  for technology transfer/training/ maintenance of infrastructure | | Lack of funds | Costed in 10.1.5b |
| 10.1.6.b | Develop and implement MoUs for production, training, and maintenance of health  infrastructure | | Lack of funds | Costed in 10.1.5b |
| 10.1.6.c | Advocate an enabling fiscal policy to create an enabling environment for PPP on health  infrastructure e.g. exemption or reduction on import tariffs | | Lack of funds | Costed in 10.1.3e |
| 10.1.7 | Scale up training of Biomedical Engineers and health infrastructure equipment maintenance officers, in order to increase stock availability. | | * Biomedical Engineers, technicians and health maintenance officers with major equipment manufacturers trained   •  • |  |  |
|  | 10.1.7.a | Training and retraining of Biomedical Engineers, technicians and health maintenance  officers with major equipment manufacturers | | Lack of funds | Training and retraining |
| 10.1.8 | Accelerate the revitalization of primary health infrastructure for improved access to health service | | * At least 50 PHC facilities in the 23 LGAs rehabilitated. * RSPHCMB office complex (Waterlines Building) renovated & equipped * ESP of care including BEmOC provided in the 319 Wards |  |  |
|  | 10.1.8.a | Set up committee to assess the state of existing PHC facilities as well mapping out areas  for new siting in the 23 LGAs | | Lack of funds | Set up committee |
| 10.1.8.b | Operating cost for engaging and supervising contractor to Rehabilitate 50 PHC facilities in the 23 LGAs. | | Lack of funds | Costed in OHT |
| 10.1.8.c | Operating cost for engaging and supervising contractor to renovate Rivers State Primary Health Care Management Board (RSPHCMB) office complex (Waterlines Building). | | Lack of funds | Costed in OHT |
| 10.1.8.d | Operating cost for engaging and supervising contractor to equip Rivers State Primary Health Care Management Board (RSPHCMB) office complex (Waterlines Building). | | Lack of funds | Costed in OHT |
| 10.1.8.e | Strengthen at least 1 PHC per ward to provide the package of essential service package (ESP) of care including BEmOC | | Lack of funds | Strengthen at least 1 PHC |
| 10.1.9 | Improve Secondary and Tertiary levels infrastructure to support for referrals systems | | * General & Specialist Hospitals in the State renovated * Logistics support including transportation and communication systems established and strengthened |  |  |
|  | 10.1.9.a | Operating cost for engaging and supervising contractor to renovate all General & Specialist  Hospitals in the State. | | Lack of funds | Costed in OHT |
| 10.1.9.b | Operating cost for engaging and supervising contractor to establish/strengthen logistics support including transportation and communication systems to aid referral | | Lack of funds | Costed in OHT |
| 10.1.9.c | Establish standard diagnostic centers at all senatorial zones of the State that are WHO certified | | Lack of funds | Establish standard diagnostic centers |

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| **11.Medicines, Vaccines, Health Technologies and Supplies** | | | | | | | |
| **11. To ensure that quality medicines, vaccines, and other health commodities and technologies are available, affordable and accessible to all Nigerians** | | | | | | | |
|  | **11.1** | **Strengthen the availability and use of affordable, accessible and quality medicines, vaccines, and other health commodities and technologies at all levels.** | | | |  |  |
|  | | 11.1.1 | Strengthen the development and implementation of legal, regulatory framework, policies and plans for drugs, vaccines , commodities and health technologies at all levels | | * National Public Health Supply Chain Policy adapted and implemented * Annual work plan developed and implemented * IPSM TWG set up |  |  |
|  | | | 11.1.1.a | Adapt the National Public Health Supply Chain Policy and implement enabling legal and regulatory frameworks, policies, guidelines | | Lack of funds | No cost |
| 11.1.1.b | Develop & disseminate SOPs for medicines, vaccines, laboratory supplies, equipment and other health commodities | | Lack of funds | Develop & disseminate SOPs |
| 11.1.1.c | Establish Logistics Management Coordinating Unit (LMCU) in SMOH & RSPHCMB and develop annual work plan and ensure implementation | | Lack of funds | Establish Logistics Management Coordinating |
| 11.1.1.d | Set up state Integrated Procurement and Supply Chain Management Technical Working Group (IPSM TWG) for supply chain decisions at the highest level and coordinate the  activities | | Lack of funds | Set up state IPSM & TWG |
| 11.1.1.e | Conduct an integrated State stock status of public health commodities meeting at State and  LGA levels | | Lack of funds | Conduct meeting |
|  | | 11.1.2 | Strengthen effective coordination of structures that ensures accessibility of medicines, vaccines, commodities and other technologies at all levels and at all times | | * Advocacy to state & LGs for the establishment of funding streams and explore PPP * Quality data generated that will guide the state in supply planning for health commodities distribution & redistribution. * Last Mile distribution to health facilities (HFs) in the state done and Proof of   Deliveries (PoDs) reconciled with Last Mile |  |  |
|  | | | 11.1.2.a | Conduct advocacy to governments for the establishment of funding streams and explore PPP and outsourcing to competent companies on appropriate supply chain functions | | Lack of funds | No cost |
| 11.1.2.b | Hold monthly meeting at State & LG levels for data collection / validation, to ensure quality  data that will guide the state in supply planning for health commodities distribution & redistribution. | | Lack of funds | Hold monthly meeting |
| 11.1.2.c | Periodic and random sampling of medicines using true scan machines in the three  senatorial zone of the state to ascertain for quality assurance | | Lack of funds | Periodic and random  sampling |
| 11.1.2.d | Conduct quarterly partners’ forum of all implementing and developing partners in the State. | | Lack of funds | Conduct partners forum |
| 11.1.2.e | Monitor the Last mile distribution to health facilities (HFs).in the state and reconcile Proof of deliveries (PoDs) with Last Mile Distribution Matrix (LMDs) | | Lack of funds | Costed in 1.3.3b |
|  | | 11.1.3 | Enhance production and use of locally manufactured medicines and vaccines that meet global standards | | * System for Public Private Partnership for Production and Sourcing of Medicines and others Health Commodities and equipment institutionalized   • |  |  |
|  | | | 11.1.3.a | Institutionalize System for Public Private Partnership for Production and Sourcing of Medicines and others Health Commodities and equipment for affordable service delivery to  the citizens. | | Inadequate collaboration | No cost |
|  | | 11.1.4 | Strengthen effective procurement systems (forecasting, orders, and procurement) to ensure (40% local content) and commodity security for on a sustainable basis at all levels. | | * Existing procurement system reviewed and procurement plan & budget developed * Officers responsible for procurement decisions & implementations in the State trained * Stores and storage conditions |  |  |
|  | | | 11.1.4.a | Review existing procurement system by the Rivers State Procurement Bureau to ensure  accelerated procurement of goods, works and services following due process including product dissemination, review and feedback | | Lack of funds | Review existing procurement |
| 11.1.4.b | Conduct workshop to develop Procurement Plan & Budget | | Lack of funds | Conduct workshop |
| 11.1.4.c | Capacity building of all officers responsible for procurement decisions & implementations in  the State including forecasting, quantification and usage. | | Lack of funds | Capacity building |
| 11.1.4.d | Establish/update monthly a database of consumers and clients, consumption patterns and  cost implication | | Lack of funds | Costed in 1.3.3b |
| 11.1.4.e | Strengthen stores and storage conditions (e.g. power supply, cooling facilities, metal  shelves, pallets etc.) | | Lack of funds | Costed in OHT |
|  | | 11.1.5 | Strengthen integrated supply chain management system and quality assurance models for medicines, vaccines, commodities and other technologies with a functional logistics management information system (LMIS) | | * Supply Chain coordination structures established * Integrated Supply Chain Management   (ISCM) step down training at the State level done   * LMIS Report collection of HIV, TB, Malaria, Reproductive health and Vaccine   programs available |  |  |

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|  | 11.1.5.a | Establish Supply Chain coordination structures in line with national policy, guidelines and international best practices. | | Lack of funds | No cost |
| 11.1.5.b | Create and sustain a viable distribution network which supports effective and efficient systems and ensures timely delivery of supplies | | Lack of funds | No cost |
| 11.1.5.c | Integrated Supply Chain Management (ISCM) step down training at the State level for Logistics Management Coordinating Unit (LMCU) members | | Lack of funds | Step down training |
| 11.1.5.d | Conduct LMIS Report collection of HIV, TB, Malaria, Reproductive health and Vaccine programs and validation at the state and LGAs | | Lack of funds | No cost |
| 11.1.5.e | Conduct monitoring and supportive supervision to health facilities | | Lack of funds | Conduct monitoring |
| 11.1.6 | Strengthen rational drug use and antimicrobial stewardship at all levels | | * STGs produced & disseminated * Products available and affordable at the lowest tier of service delivery * Staff knowledgeable in appropriate product use employed & trained |  |  |
|  | 11.1.6.a | Produce and disseminate standard treatment guidelines (STGs) | | Lack of funds | Produce and disseminate |
| 11.1.6.b | Provide continuing education to product users (e.g. clinicians, patients, general population, and technicians) on appropriate product use and conduct community sensitization and education especially in rural areas to increase understanding and capacity on product use | | Lack of funds | Provide continuing education |
| 11.1.6.c | Make products available and affordable at the lowest tier of service delivery | | Lack of funds | No cost |
| 11.1.6.d | Employ, train and deploy staff knowledgeable in appropriate product use | | Lack of funds | Costed in OHT |
| 11.1.6.e | Establish a quality system for pharmacovigilance, which will cover organizational structure, responsibilities, procedures, processes and resources as well as appropriate resource, compliance and record management. | | Lack of funds | No cost |
| 11.1.7 | Strengthen existing systems for the management of biological and non-biological wastes including expiries of medicines, vaccines and other commodities at all levels | | * Quantification of expired medicines and other commodities at Health facilities done * Safe health commodities waste management system in the State implemented * Sharp boxes and consumables provided   and distributed to all Health facilities |  |  |
|  | 11.1.7.a | Conduct annual quantification of expiries of medicines and other commodities at Health  Facilities in the State. | | Lack of funds | No cost |
| 11.1.7.b | Implement an effective safe health commodities waste management system in the State | | Lack of funds | No cost |
| 11.1.7.c | Provision and distribution of sharp boxes and consumables to all Health facilities in the State | | Lack of funds | Costed in OHT |
| 11.1.8 | Strengthen the development of traditional medicine in Nigeria | | * Traditional Medicine Board revived and periodic meeting held * Traditional medicine practitioners in the State trained * Regulatory agency established |  |  |
|  | 11.1.8.a | Revive Traditional Medicine Board (TMB) and hold periodic meeting to ensure the implementation of the Traditional Medicine Policy guidelines in the State & LGAs | | Lack of funds | Revive Traditional Medicine Board |
| 11.1.8.b | Conduct advocacy to the government for allocation of adequate funds for the operation of traditional medicine programmes and activities in the State & LGAs | | Lack of funds | Conduct advocacy |
| 11.1.8.c | Capacity building for traditional medicine practitioners in the State | | Lack of funds | Capacity building |
| 11.1.8.d | Establish a regulatory agency for the registration, regulation, standardization and training  with respect to traditional practice. | | Lack of funds | Costed in 11.1.8a |
| 11.1.8.e | Promote research and development (R&D) of traditional medicine | | Lack of funds | Create awareness |

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| **12.Health Information** | | | | | | | |
| **12. To institutionalize an integrated and sustainable health information system for decision-making at all levels in Nigeria** | | | | | | | |
|  | **12.1** | **Improve the health status of Nigerians through the provision of timely, appropriate and reliable health information services at all levels, for evidenced based decision making.** | | | |  |  |
|  | | 12.1.1 | Strengthen institutional framework and coordination for HIS at all levels | | * National policy, guidelines and tools on HMIS revised & adapted   •Collaboration with State Bureau of Statistics done   * Stakeholder consultative forum on data management and use supported |  |  |
|  | | | 12.1.1.a | Inaugurate committee to develop terms of reference for the HDGC, review that of the HDCC and disseminate the roles and responsibilities to all stakeholders | | Lack of funds | Inaugurate committee |
| 12.1.1.b | Revise/adapt national policy, guidelines and tools on HMIS | | Lack of funds | Costed in 12..1.1a |
| 12.1.1.c | Collaboration with State Bureau of Statistics to develop a process for providing annual population figures disaggregated by State, LGA and Ward by the first month of each year to the SMOH to encourage evidence-informed planning | | Lack of funds | No cost |
| 12.1.1.d | Support the broad stakeholder consultative forum on data management and use to ensure cross-institutional relationships that foster sharing of data and knowledge between the different members of the HDGC and HDCC | | Lack of funds | Support stakeholder consultative forum |
| 12.1.1.e | Support monthly review/coordinating meetings of HMIS and M&E officers | | Lack of funds | Support  review/coordinating |
|  | | 12.1.2 | Strengthen capacity to generate, transmit, analyze and utilize routine health data, from all health facilities, including private health facilities. | | * DHIS indicators and tools, guidelines, SOPs, including ISS and DQA checklist reviewed, harmonized, updated, printed & distributed   •HIO's (SMOH & RSPHCMB) across the 23 LGAs and State HMIS & M&E Officers trained   * Recruitment and deployment of HMIS and |  |  |
|  | | | 12.1.2.a | Review, harmonize, update, print and distribute DHIS indicators and tools, guidelines, SOPs, including ISS and DQA checklist | | Lack of funds | Review, print and distribute DHIS indicators and tools |
| 12.1.2.b | Develop electronic media for continuous training of HMIS officers and other HIS users and mainstream gender in data generation and analysis (disaggregate data by gender) | | Lack of funds | Develop electronic media |
| 12.1.2.c | Print and disseminate widely the 2013 version of the harmonized data collection tools and the national indicator definition/ reference sheets | | Lack of funds | Print and disseminate |
| 12.1.2.d | Training and retraining of HIO's (SMOH & RSPHCMB) across the 23 LGA's on data collection tools and train State HMIS and M&E Officers on the administration of the DHIS | | Lack of funds | Training and retraining of HIO's |
| 12.1.2.e | Support Recruitment and deployment of HMIS and M&E officer for health programmes at the state and LGA levels. | | Lack of funds | Costed in 9.2.2b |
|  | | 12.1.3 | Improve integration of existing surveillance systems and diseases registries into the overall health information system | | * Compendium of all health indicators from all health related programmes for the state developed and continuously reviewed   •DHIS2, EMRs and other health systems information sub-systems and disease registers integrated |  |  |
|  | | | 12.1.3.a | •  Develop and continuously review compendium of all health indicators from all health related programmes for the state | | Lack of funds | Costed in 1.3.3b |
| 12.1.3.b | Interoperation/Integration of DHIS2, EMRs and other health systems information sub- systems and disease registers by the development of common data architectures | | Lack of funds | Costed in 12.1.2a |
|  | | 12.1.4 | Improve the mechanize of an integrated data repository for data sharing amongst stakeholders at all levels | | * Comprehensive & accessible data bank for all health data in the state established & maintained   •Multi-sectoral data collaborative forum  drawing from all relevant MDAs established |  |  |
|  | | | 12.1.4.a | Establish and maintain comprehensive, accessible data bank for all health data in the state | | Lack of funds | Costed in 1.3.3b |
| 12.1.4.b | Establish multi-sectoral data collaborative forum drawing from all relevant MDAs | | Lack of funds | Costed in 12.1.1d |
|  | | 12.1.5 | Strengthen monitoring of the sub-sector performance | | * Data Quality Assessment exercises done   •Regular supportive supervisory visits done  •Dashboard to monitor data entry and quality of data entered developed |  |  |
|  | | | 12.1.5.a | Conduct Data Quality Assessment exercises | | Lack of funds | Conduct Data Quality Assessment |
| 12.1.5.b | Conduct regular supportive supervisory visits | | Lack of funds | Conduct supportive supervisory visits |
| 12.1.5.c | Develop a dashboard to monitor data entry and quality of data entered | | Lack of funds | No cost |
| 12.1.5.d | Institute a mechanism for pooling resources from MDAs and Partners for HMIS activities | | Lack of funds | No cost |
| 12.1.5.e | Institutionalize performance plan for monitoring the budget allocated and released by MDAs  for HMIS activities | | Lack of funds | Production & distribution |

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| **13. Health Research** | | | | | | | |
| **13. To utilize research to inform policy and programming for improved performance of the health sector and better health outcomes; and to contribute to global health knowledge production** | | | | | | | |
|  | **13.1** | **To significantly contribute to the overall improvement of the performance of the Nigerian health system** | | | |  |  |
|  | | 13.1.1 | Strengthen coordination and regulatory mechanisms for health research and development by all relevant stakeholders, in line with the National Health Act 2014 | | * State Health Research Committee strengthened   •National Health Act 2014 adapted   * Capacity of all relevant stakeholders on health research built * Platform for linking academia with the health sector established |  |  |
|  | | | 13.1.1.a | Strengthen the Research Unit of the Planning, Research, and Statistics Department (SMOH, RSPHCMB & RSHMB) to provide stewardship on research, and harness research findings for decision-making | | Lack of funds | Strengthen the Research Unit |
| 13.1.1.b | Strengthen State Health Research Ethics Committee at RSHMB to coordinate research  activities in the state | | Lack of funds | Strengthen Committee |
| 13.1.1.c | Adapt National Health Act 2014 | | Lack of funds | Costed in 13.1.1b |
| 13.1.1.d | Build capacity of all relevant stakeholders on health research | | Lack of funds | Costed in OHT |
| 13.1.1.e | Establish a platform for linking academia with the health sector on linking research to  national/state priorities and translating research to action | | Lack of funds | Costed in 3.1.1c |
|  | | 13.1.2 | Strengthen the development and implementation of the national research agenda | | * State research agenda developed & platform for collaborative research established   •Researchers trained on both quantitative and qualitative research annually   * Promotion of PPP in R&D done |  |  |
|  | | | 13.1.2.a | Develop a State research agenda (including criteria for identifying health research priorities, conduct and dissemination of research findings) | | Lack of funds | Costed in 13.1.1b |
| 13.1.2.b | Establish a platform for collaborative research | | Lack of funds | Costed in 13.1.1b |
| 13.1.2.c | Train researchers to strengthen their competencies on both quantitative and qualitative  research | | Lack of funds | Costed in OHT |
| 13.1.2.d | Promote PPP in Research and Development (R&D) | | Lack of funds | No cost |
| 13.1.2.e | Carry out actual studies to determine costs premium & capitation / willingness & ability to pay | | Lack of funds | Carry out studies |
|  | | 13.1.3 | Increase resource mobilization and allocation for research activities at all levels in line with agreed international declarations, especially Algiers Declaration on Health Research | | * Advocacy meeting to policy makers to inform on the Algiers Declaration and solicit their commitment to increase budgetary allocation research done * Government support for the development of collaborative research proposals and their implementation achieved * Capacity for resource mobilization for health research built |  |  |
|  | | | 13.1.3.a | Conduct advocacy meeting to policy makers to inform on the Algiers Declaration and solicit  their commitment to increase budgetary allocation to research | | Lack of funds | Conduct advocacy meeting |
| 13.1.3.b | Ensure Government support for the development of collaborative research proposals and their implementation between governments and public and private health research organisations | | Lack of funds | Ensure Government support |
| 13.1.3.c | Build capacity for resource mobilization for health research (e.g. proposal writing, grantsmanship, fund-raising etc). | | Lack of funds | Costed in OHT |
| 13.1.3.d | Build institutional capacities of the research institutes for research | | Lack of funds | Costed in OHT |
|  | | 13.1.4 | Strengthen the national health research institutions (the National Institute of Medical Research and the National Institute of Pharmaceutical Research and Development) to contribute to evidence-based decision making and R&D | | * Advocate for increased funding for research institutions in the country done   •  • |  |  |
|  | | | 13.1.4.a | Advocate for increased funding for research institutions in the country | | Lack of funds | No cost |
|  | | 13.1.5 | Strengthen institutions and systems at all levels for the promotion, regulation and ethical oversight of essential national health research | | * SHREC empowered * SHREC members trained * Infrastructure in health research institutions developed & strengthened |  |  |
|  | | | 13.1.5.a | Empower RSHMB to oversee, monitor & review implementation of approved health research on human subjects across all levels | | Lack of funds | Empower RSHMB |
| 13.1.5.b | Conduct training for SHREC members | | Lack of funds | Conduct training |
| 13.1.5.c | Develop/strengthen infrastructure in health research institutions | | Lack of funds | Costed in OHT |
| 13.1.5.d | Foster strategic partnerships at national and international levels for improved quality health  research output | | Lack of funds | Costed in 3.1.3b |

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| 13.1.6 | Enhance strategic partnerships at the national and international levels for the promotion and timely dissemination of research findings | | * Memorandum of Understanding with national and international partners to promote research activities developed * Existing and potential health research entities at national and international levels mapped * Sensitization workshops for policy makers, health care providers and other target audiences done |  |  |
|  | 13.1.6.a | Conduct meeting for PPP committee to develop Memorandum of Understanding with national and international partners to promote research activities | | Lack of funds | Costed in 3.1.1c |
| 13.1.6.b | Map existing and potential health research entities at national and international level and  maintain a database | | Lack of funds | Costed in 13.1.5a |
| 13.1.6.c | Conduct sensitization workshops for policy makers, health care providers and other target  audiences to share research findings and appraise them on policy and practice implications | | Lack of funds | Conduct sensitization  workshop |
| 13.1.7 | Strengthen the utilization of research findings to inform policy, programming and practice | | * Communication strategy for dissemination of research findings developed & strengthened * Platform for regular dialogue between researchers and policy makers created & supported * Platform for research findings developed * Engagement of media on dissemination of research findings to the public done |  |  |
|  | 13.1.7.a | Develop communication strategy for dissemination of research findings to different target audiences (e.g. policy makers, politicians, practitioners, consumers, development partners and the general public) | | Lack of funds | Develop communication strategy |
| 13.1.7.b | Create and support a platform for regular dialogue between researchers and policy makers for evidence-based decisions | | Lack of funds | Costed in 13.1.7a |
| 13.1.7.c | Develop a platform to promote commercialization of research findings | | Lack of funds | Costed in 13.1.7a |
| 13.1.7.d | Engage media on dissemination of research findings to the public | | Lack of funds | Engage media |
| 13.1.8 | Facilitate the development of a repository for he collation and archiving of health-related research findings for improved knowledge management | | * Health research library established in the in the state * Build capacity of the data managers and web masters on handling and processing of research documents done * Website created and subscription done annually done |  |  |
|  | 13.1.8.a | Operating cost for engaging and supervising the contractor to establish health research library in the in the state with assess to printed and electronic research materials | | Lack of funds | Costed in OHT |
| 13.1.8.b | Subscribe to relevant national and international health journals | | Lack of funds | Subscribe |
| 13.1.8.c | Build capacity of the data managers and web masters on handling and processing of  research documents | | Lack of funds | Costed in OHT |
| 13.1.8.d | Create a mechanism for harvesting, collating, documenting and uploading of health  researches on the website | | Lack of funds | Create mechanism |
| 13.1.8.e | Annual subscription for website | | Lack of funds | Annual subscription |

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| **Strategic Pillar Four: Protection from Public Health Emergencies and Risks** | | | | | | | |
| **14.Public Health Emergencies: Preparedness and Response** | | | | | | | |
| **14. Significantly reduce the incidence and impact of public health emergencies** | | | | | | | |
|  | **14.1** | **Reduce incidence and impact of public health emergencies in Nigeria** | | | |  |  |
|  | | 14.1.1 | Promote the development and implementation of legal, regulatory framework, policies and plans for emergency preparedness at all levels | | * Legal framework for compliance with IHR in place   •Updated IDSR epidemic management protocol and SOPs available   * Laws and policies for outbreak and surveillance activities as it related to   isolation and quarantine reviewed |  |  |
|  | | | 14.1.1.a | Strengthen Epidemic Prepared and Response Committees at state and LGA levels to coordinate rapid response epidemiological services | | Lack of funds | Strengthen Epidemic Preparedness |
| 14.1.1.b | Conduct continuous advocacy to policy and decision makers for resource mobilization and provision of adequate funding to support Integrated Disease Surveillance and Response (IDSR) activities | | Lack of funds | No cost |
| 14.1.1.c | Ensure legal framework is in place for compliance with International Health Regulation (IHR) | | Lack of funds | Costed in 14.1.1a |
| 14.1.1.d | Update IDSR epidemic management protocol and Standard Operating Procedures (SOPs) and make available to health personnel at all levels. | | Lack of funds | Costed in 14.1.1d |
| 14.1.1.e | Review laws and policies for outbreak and surveillance activities as it related to isolation and quarantine | | Lack of funds | Costed in 14.1.1d |
|  | | 14.1.2 | Promote an integrated national disease surveillance system in line with International Health Regulation (IHR) and IDSR | | * Epidemiology unit of the SMOH strengthened to review all existing IHR and IDSR * Provision of infrastructural support, ICT for   health databases & IDSR data tools at all health service delivery points done   * Sentinel surveillance sites established |  |  |
|  | | | 14.1.2.a | Strengthen the epidemiology unit of the SMOH to review all existing IHR and IDSR and domesticate to suite the circumstance of the state as well as integrate and harmonize all vertical surveillance systems into IDSR including digitization of the surveillance system | | Lack of funds | Costed in OHT |
| 14.1.2.b | Dissemination of health information at the state level as well as provision of functional communication gadgets to all levels of IDSR system, from community level for IDRS timely reporting and response | | Lack of funds | No cost |
| 14.1.2.c | Establish sentinel surveillance sites for active surveillance and more robust analysis for targeted diseases of public health importance, e.g. VHF, cholera, measles, monkey pox | | Lack of funds | No cost |
| 14.1.2.d | Supervisory visits and distribution of IDSR data tools to strengthen data collection using IDSR tools at all levels of health care and ensure availability of IDSR tools at all health service delivery points at all levels | | Lack of funds | Supervisory visits |
| 14.1.2.e | Conduct sensitization workshops for clinicians and heads of health bodies and the private sector on IDSR to enlist their participation in IDSR implementation (case detection, timely and complete case reporting and appropriate management of cases) | | Lack of funds | Conduct sensitization |
|  | | 14.1.3 | Expand/strengthen a network of public health laboratories in Nigeria | | * Standards and guidelines for the operation of the public health labs at all levels adopted   •Standard public health laboratory built & equipped and BMSH laboratory strengthened   * System for laboratory reagents procurement and supplies strengthened   •System for communication with the LGA |  |  |
|  | | | 14.1.3.a | Adopt standards and guidelines for the operation of the public health labs at all levels, including MoU with network of PHL in the country | | Lack of funds | Costed in 14.1.1a |
| 14.1.3.b | Cost for engaging and supervising the contractor to build and equip a standard public health laboratory in the state. Strengthen for confirmation of special pathogens and also act as quality control for State laboratories and Infection Control Practices | | Lack of funds | Costed in OHT |
| 14.1.3.c | Strengthen BMSH Laboratory to handle public health investigations including VHFs | | Lack of funds | Costed in OHT |
| 14.1.3.d | Strengthen the system for sustainable laboratory reagents procurement and supplies including VHF reagent pack for the virology lab. | | Lack of funds | Costed in OHT |
| 14.1.3.e | Establish a system for communication with the LGA and adequate transportation of the samples from health facilities/LGAs to the PHLs | | Lack of funds | Establish system |
|  | | 14.1.4 | Scale-up public education and awareness creation on public health emergencies | | * Materials on public health emergencies designed, printed & distributed   •Mass edutainment on Lassa Fever, Dengue fever, cholera, monkey pox and other infectious diseases done   * Social mobilization activities with OB Van   (rallies, campaigns), Video Show done |  |  |

and adequate transportation of the samples

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|  | 14.1.4.a | Advocacy/sensitization meetings with the Key Stakeholders- NMA, NANNAM, AGMPPH, NLC, MHWU, Pharmaceutical Society of Nigeria, MWAN, Traditional rulers, Religious leaders, women leaders, Media Executives NUJ, NAWOJ, RATTAWU, NOA, Rotary Club, Red Cross, Lions Club, Market Women leaders on public health emergencies | | Lack of funds | Advocacy/sensitization meeting |
| 14.1.4.b | Design, print and distribute materials on public health emergencies for public education (IEC materials, posters, flyers, jingles etc.) | | Lack of funds | Design, print and distribute |
| 14.1.4.c | Conduct mass edutainment on Lassa Fever, Dengue fever, cholera, monkey pox and other infectious diseases | | Lack of funds | Conduct mass edutainment |
| 14.1.4.d | Social mobilization activities with OB Van (rallies, campaigns), Video Show | | Lack of funds | Social mobilization |
| 14.1.5 | Promote access to comprehensive services for the prevention, treatment and impact mitigation of public health emergencies | | * Ambulances stationed at the EOC and Infectious Disease Treatment centres * Isolation wards or holding areas for infectious patients provided in at least 5 HFs in each of the 23 LGAs * Quarantine centres for infectious diseases built and equipped |  |  |
|  | 14.1.5.a | Cost for engaging and supervising the contractor to provide stationed ambulances at the EOC and Infectious Disease Treatment centres | | Lack of funds | Costed in OHT |
| 14.1.5.b | Cost for engaging and supervising the contractor to provide isolation wards or holding areas for infectious patients at all health care facilities | | Lack of funds | Costed in OHT |
| 14.1.5.c | Cost for engaging and supervising the contractor to build quarantine centres for infectious diseases | | Lack of funds | Costed in OHT |
| 14.1.5.d | Cost for engaging and supervising the contractor for equipping of quarantine centres for infectious diseases in the state | | Lack of funds | Costed in OHT |
| 14.1.5.e | Develop/Review a state emergency resilience and response plan for Public Health Emergency (PHE) | | Lack of funds | Costed in 14.1.1a |
| 14.1.6 | Promote integration of disease surveillance activities at all levels of the health care system | | * Integrate all vertical surveillance systems done * Monitor and evaluate IDSR at all levels |  |  |
|  | 14.1.6.a | Integrate all vertical surveillance systems (addressed in 14.1.2) | | Lack of funds | No cost |
| 14.1.6.b | Monitor and evaluate IDSR at all levels and establishment of monitoring protocol | | Lack of funds | Costed in 1.3.3b |
| 14.1.7 | Build human resource capacity and equitably distribute them for appropriate and optimal response to public health emergencies | | * Adapt WHO generic materials/adopt national training materials for disease surveillance done * Public health laboratory personnel trained & re-trained on response to public health emergencies and equitably distributed * DSNOs and Data management team at   state level trained & re-trained on use of ICT in IDSR & equitably distributed |  |  |
|  | 14.1.7.a | Adapt WHO generic materials/adopt national training materials for disease surveillance, laboratory diagnosis and public health emergencies and response | | Lack of funds | Costed in 14.1.1a |
| 14.1.7.b | Training and retraining/deployment of Public health laboratory personnel on response to  public health emergencies | | Lack of funds | Training and retraining |
| 14.1.7.c | Training of clinicians, EHOs and Nurses at all levels to handle infectious diseases | | Lack of funds | Training of clinicians |
| 14.1.7.d | Training of DSNOs, EHOs, CHEWs, SMOs, Media, CBOs NOA, Volunteer Health workers,  Informants, Ward Health Committees, Traditional Rulers, CDC chairmen, CAN, and Muslim group on response to public health emergencies. | | Lack of funds | Training of DSNOs, EHOs |
| 14.1.7.e | Training and retraining of DSNOs and Data management team at state level on use of ICT  in IDSR | | Lack of funds | Training and retraining |
| 14.1.8 | Strengthen coordination mechanisms for public health emergencies at all levels | | * •Infectious Disease Treatment Centre at Emohua renovated and upgraded * logistics for emergency response provided |  |  |
|  | 14.1.8.a | Develop a road map and commence implementation of Global Health Security Agenda | | Lack of funds | No cost |
| 14.1.8.b | Cost for engaging and supervising the contractor to renovate and upgrade the Infectious Disease Treatment Centre at Emohua to serve as zonal centre for management of Viral Haemorrhagic Fevers (VHFs). | | Lack of funds | Costed in OHT |
| 14.1.8.c | Cost for engaging and supervising the contractor for provision of logistics for emergency response (vehicles, motorcycles, drugs and other materials/consumables - PPEs, Hand gloves- latex and thick rubber, body bags, digital thermometers, Thermoscan, hand sanitizers, bleach, chlorine, coverall, face masks, N95 Respirators, Ribavirin, stationaries etc.) at all health care levels | | Lack of funds | Costed in OHT |
| 14.1.8.d | Conduct periodic meetings for EOC and Emergency Preparedness and Response Committee | | Lack of funds | Conduct periodic meetings |

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|  | | 14.1.9 | Promote community participation in disease surveillance activities | | * Advocacy visits to the gatekeepers on community participation in disease surveillance done * Community health workers, volunteer health workers, ward health committee, focal persons and informants trained and sensitized * Quarterly review meeting for DSNOs held |  |  |
|  | | | 14.1.9.a | Advocacy visits to the gatekeepers (Council Chairmen and Councilors of health, Traditional rulers, CDC chairmen) on community participation in disease surveillance | | Lack of funds | Advocacy visits |
| 14.1.9.b | Sensitization and training meetings with the Community health workers, volunteer health workers, ward health committee, focal persons and informants. | | Lack of funds | Sensitization meetings |
| 14.1.9.c | Conduct periodic feedback and review meetings for the DSNOs; also hold integrated review meetings with stakeholders at all health care levels | | Lack of funds | Conduct periodic feedback |
| **Strategic Pillar Five: Health Financing** | | | | | | | |
| **15.Health Financing** | | | | | | | |
| **15. Ensure all Nigerians have access to health services without any financial barriers or impediments at the point of accessing care** | | | | | | | |
|  | **15.1** | **Strengthened Governance and Coordination for actualizing stewardship and ownership of Health Financing reforms** | | | |  |  |
|  | | 15.1.1 | Strengthen Health Financing Equity and Investment Units at Federal, 36 States, and FCT | | * TWG inaugurated and members trained on the Health Care Financing Reforms * Health Financing Equity & Investment Unit created and equipped * Personnel trained and re-trained on   current Health Care Financing (HCF) reform |  |  |
|  | | | 15.1.1.a | Inaugurate & train Technical Working Group (TWG) members on the Health Care Financing Reforms | | Lack of funds | Inaugurate & train |
| 15.1.1.b | Conduct advocacy to the Commissioner & Permanent Secretary MOH on State Health Insurance & the need for creating Health Financing Equity & Investment Unit (HFU) as recommended by the FMOH | | Lack of funds | Conduct advocacy |
| 15.1.1.c | Cost for engaging and supervising the contractor to equip Health Financing Equity &  Investment Unit to analyzing equity and efficiency of different healthcare financing mechanisms. | | Lack of funds | Costed in OHT |
| 15.1.1.d | Train & re-train personnel on current Health Care Financing (HCF) reforms | | Lack of funds | Train & re-train |
| 15.1.1.e | Operational cost for engaging and supervising the contractor to provide vehicles for the  operations of the unit | | Lack of funds | Costed in OHT |
|  | | 15.1.2 | Strengthen Coordination Frameworks and TWGs for health financing at Federal, 36 States, and FCT | | * Advocate for the implementation of Health Financing Equity framework/guidelines done * HCF implementation strategies designed and developed * TWG members trained |  |  |
|  | | | 15.1.2.a | Empower Technical Working Group (TWG) to hold periodic meetings | | Lack of funds | Hold periodic meetings |
| 15.1.2.b | Advocate for the implementation of Health Financing Equity framework/guidelines at all  levels and MDAs | | Lack of funds | Advocate for the implementation |
| 15.1.2.c | Support the design and development of HCF implementation strategies | | Lack of funds | No cost |
| 15.1.2.d | Conduct capacity building workshop for TWG members | | Lack of funds | Conduct workshop |
|  | | 15.1.3 | Develop Health Financing Policy & Strategy and Investment case at Federal, 36 States, and FCT | | * Health Financing (HF) Policy document adopted and Health Financing & Strategy and Investment case developed, printed and disseminated * Advocate for favourable fiscal policies |  |  |
|  | | | 15.1.3.a | Adopt Health Financing (HF) Policy document in the state | | Lack of funds | Adopt Health Financing |
| 15.1.3.b | Organise workshop to develop Health Financing & Strategy and Investment case | | Lack of funds | Organise workshop |
| 15.1.3.c | Print & disseminate copies of the Health Financing & Strategy and Investment case in the  State & LGAs | | Lack of funds | Print & disseminate |
| 15.1.3.d | Advocate for favourable fiscal policies (e.g. tariffs for importation of drugs, free health services, customs clearance etc.) | | Lack of funds | No cost |
| 15.1.3.e | Strengthening drug revolving funds (DRF) at all levels | | Lack of funds | No cost |
|  | | 15.1.4 | Establish systems for health financing evidence generation and management at Federal, 36 States, and FCT | | * Institutional capacity for integrated financial management system development strengthened * Information system for resource mapping for revenue generation updated * Tools for collecting, analysing &   dissemination of HF data developed |  |  |
|  | | | 15.1.4.a | Establish/strengthen institutional capacity for integrated financial management system  development for all health financing functions (resource mobilization, pooling and purchase of services) | | Lack of funds | Establish/strengthen institutional capacity |
| 15.1.4.b | Establish mechanisms for fostering inter-sectorial collaborations, public-private partnerships, and collaboration with community members, CSOs, and Development Partners to ensure improvement and coordination of health financing functions | | Lack of funds | Costed in 3.1.1b |
| 15.1.4.c | Update information system for resource mapping for revenue generation. | | Lack of funds | No cost |
| 15.1.4.d | Develop tools for collecting, analysing & dissemination of HF data | | Lack of funds | Develop tools |
| 15.1.4.e | Establish a platform for strategic collaborative linkages between NHIS and state health insurance schemes as well as NPHCDA and SPHCDAs | | Lack of funds | No cost |

done

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| **15.2** | **Increase sustainable and predictable revenue for health** | | | |  | |
|  | 15.2.1 | Alignment of health allocations to national priorities | | •Advocacy on allocation of at least 15% of State and LGAs budgets done  •State health priorities included into MTEF  and all LGAs, MDAs and donors aligned to it.   * Advocacy to increase domestic revenue for health done |  |  |
|  | | 15.2.1.a | Advocacy to the Governor for allocation of at least 15% of State and LGAs budgets to  health in compliance with Abuja declaration. | | Lack of funds | Costed in 9.1..3a |
| 15.2.1.b | Include state health priorities into MTEF and align all LGAs, MDAs and donors to it. | | Lack of funds | No cost |
| 15.2.1.c | Conduct evidence-based advocacy to increase health revenue for health using innovative  financing strategies | | Lack of funds | Conduct advocacy |
|  | 15.2.3 | Advocate for increase in government annual budget and spending on health | | * Advocacy to make financial provisions for poor and vulnerable groups & diseases of public health significance done   •Advocacy strategy for increased and timely release of health budgets developed and implemented   * Health advocacy committee supported to advocate for increase in health budget |  |  |
|  | | 15.2.3.a | Conduct advocacy to the Government at all levels (State and Local Government) to make financial provisions for poor and vulnerable groups in the form of direct payments, subsidies, paying for insurance contributions or any other methods. Make special provision for diseases of public health significance such as Malaria, HIV/AIDS, TB, Leprosy, Monkey pox, vaccine preventable diseases and others | | Lack of funds | Conduct advocacy |
| 15.2.3.b | Develop and implement advocacy strategy for increased and timely release of health budgets | | Lack of funds | No cost |
| 15.2.3.c | Support health advocacy committee to advocate for increase in health budget, timely budgetary releases and adequate expenditure tracking. | | Lack of funds | No cost |
|  | 15.2.4 | Strengthen legal and coordinating framework for PPP at Federal and State levels | | * Legal & Coordinating framework for PPP reviewed and domesticated   •PPP committee updated in PPP policy changes   * Rivers State Legal Framework produced |  |  |
|  | | 15.2.4.a | and disseminated  Review & domesticate Legal & Coordinating framework for PPP for the state | | Lack of funds | Review & domesticate |
| 15.2.4.b | Conduct periodic training for PPP committee for update in PPP policy changes | | Lack of funds | Conduct periodic training  for PPP |
| 15.2.4.c | Produce copies of Rivers State Legal Framework & disseminate to all stakeholders in the  Public & Private sectors | | Lack of funds | Produce & disseminate |
| 15.2.4.d | Advocate for PPP legal backing in health Agencies laws and implementation of PPP policy  at all levels | | Lack of funds | No cost |
|  | 15.2.5 | Develop and implement resource mobilization strategy and guideline including Sin Taxes, Telecom Taxes, VAT, Aviation Taxes, etc. | | * Resource mobilization strategy and guideline developed and implemented   •  • |  |  |
|  | | 15.2.5.a | Develop resource mobilization strategy and guideline | | Lack of funds | Costed in 15.1.3b |
| 15.2.5.b | Engage telecommunication companies for telecom tax | | Lack of funds | Engage telecommunication |
| 15.2.5.c | Advocacy to Board of Internal Revenue ( BIR) for establishment of SIN, Telecom, VAT, Aviation Taxes | | Lack of funds | Advocacy to BIR |
| 15.2.5.d | Engage BIR for tax reform review and audits | | Lack of funds | Engage BIR |
| **15.3** | **Enhance financial risk protection through pooled funds at federal and state levels** | | | |  | |
|  | 15.3.1 | Engage Stakeholders to increase enrolment and contribution to Health Insurance | | * Third Party Association (TPAs) commissioned   •Employers of labour sensitized to key into health insurance for their employers   * Philanthropists and community influencers   engaged to enroll community members and support vulnerable groups |  |  |
|  | | 15.3.1.a | Commission Third Party Associators (TPAs) to register and enroll beneficiaries | | Lack of commitment | No cost |
| 15.3.1.b | Conduct sensitization workshops for engaging employers of labour to key into health insurance for their employees | | Lack of funds | Conduct sensitization workshop |
| 15.3.1.c | Engage philanthropists and community influencers to enroll community members and support vulnerable groups | | Lack of funds | Engage philanthropists |
| 15.3.1.d | Engage the media in promoting health insurance as well as produce and disseminate IEC materials on Health Insurance | | Lack of funds | Engage the media |
| 15.3.1.e | Engage communities and NGOs on financial risk protection benefit of Health insurance | | Lack of funds | Engage communities |

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|  | 15.3.2 | Strengthen Laws and regulations for the implementation of the NHIS | | •Advocacy to the Executive Governor / House of Assembly to facilitate passage of RIVCHPP bill done   * BMHB package, operational guidelines and SOPs developed * Advocacy for laws to establish/enforce SHIS done |  |  |
|  | | 15.3.2.a | Advocacy to the Executive Governor / House of Assembly to facilitate passage of Rivers State Contributory Health Protection Programme (RIVCHPP) bill | | Lack of Political Will | No cost |
| 15.3.2.b | Develop memo for public hearing and passage of RIVCHPP bill. | | Lack of funds | Develop memo |
| 15.3.2.c | Development of Basic Minimum Health Benefit (BMHB) package, operational guidelines and SOPs | | Lack of funds | Costed in 15.1.3b |
| 15.3.2.d | Develop Framework for consolidation of fund pools at state levels | | Lack of funds | No cost |
| 15.3.2.e | Conduct advocacy for laws to establish/enforce SHIS and scale up Community Health Insurance Scheme in Primary/Secondary Health Facilities across the State. | | Lack of funds | No cost |
|  | 15.3.3 | Strengthen technical capacity of health personnel on health insurance and contributory schemes | | * Staff trained on basic Health Insurance strategy and principle   •Health human resources in private and public health facilities trained & re-trained on health insurance & contributory schemes  • |  |  |
|  | | 15.3.3.a | Training of staff on basic Health Insurance strategy and principle | | Lack of funds | Training of staff |
| 15.3.3.b | Routine training & re-training of health human resources in private and public health facilities | | Lack of funds | Routine training & re- training |
|  | 15.3.4 | Establish and expand Mandatory State Health Insurance and contributory Schemes in 36 States & FCT | | * Agency for RIVCHPP established and relevant qualified staff deployed   •23 LGA desk offices established and desk officers appointed   * Desk officers trained and re-trained |  |  |
|  | | 15.3.4.a | Establish an Agency for RIVCHPP/Deploy relevant qualified staff to occupy the offices in the established agency | | Lack of funds | No cost |
| 15.3.4.b | Establish 23 LGA desk offices and appoint desk officers | | Lack of funds | No cost |
| 15.3.4.c | Training and retraining of desk officers | | Lack of funds | Train and re-train |
| 15.3.4.d | Review all existing programmes in the states with the aim of integrating them into a single pool | | Lack of funds | Review all existing programmes |
| 15.3.4.e | Engage NHIS, to decide on how to collapse schemes into one single pool | | Lack of funds | No cost |
| **15.4** | **Enhance transparency and accountability in strategic purchasing of Health Services** | | | |  | |
|  | 15.4.1 | Review Provider Payment mechanisms in the Nigerian health sector to focus on RBF | | * PPM developed, validated and disseminated to stakeholders   •  • |  |  |
|  | | 15.4.1.a | Conduct workshop to develop Provider Payment Mechanism (PPM) | | Lack of funds | Conduct workshop |
| 15.4.1.b | Conduct workshop to validate the PPM | | Lack of funds | Costed in 15.1.1a |
| 15.4.1.c | Print and disseminate to stakeholders the developed PPM | | Lack of funds | Print and disseminate |
|  | 15.4.2 | Develop Framework for competition between public and private sector providers in the allocation of new resources for healthcare | | * Framework for competition between public and private sector providers developed   •Financial health bulletin developed and published   * Empowerment/provision of incentives to enhance performance done |  |  |
|  | | 15.4.2.a | Develop framework for competition between public and private sector providers | | Lack of funds | Develop framework |
| 15.4.2.b | Develop/publish financial health bulletin for feedback/disseminate to eligible public and  private providers | | Lack of funds | Develop/publish |
| 15.4.2.c | Regular monitoring on adherence to SOPs for Service delivery | | Lack of funds | Regular monitoring |
| 15.4.2.d | Empowerment/provision of incentives to enhance performance | | Lack of funds | No cost |

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|  | 15.4.4 | Institutionalize routine NHA and expenditure tracking mechanisms at State and Federal levels | | * Periodic health expenditure resource tracking done * Annual State Health Account data collected * Budget execution monitored |  |  |
|  | | 15.4.4.a | Conduct periodic health expenditure resource tracking | | Lack of funds | No cost |
| 15.4.4.b | Conduct Household Surveys | | Lack of funds | Conduct Household Surveys |
| 15.4.4.c | Institutionalize annual SHA | | Lack of funds | Institutionalize SHA |
| 15.4.4.d | Conduct Annual State Health Account data collection in accordance with the establish sub National health Account guidelines and disseminate to stakeholders | | Lack of funds | Conduct State Health Account data |
| 15.4.4.e | Monitor budget execution | | Lack of funds | No cost |
|  | 15.4.5 | Institute Public Finance Management (PFM) reforms at the Federal and State levels | | * Financial management systems established & stakeholders engaged in PFM reforms * Accounting staff trained on financial management and IPSAS system of accounting * Financial Audit done in all health facilities |  |  |
|  | | 15.4.5.a | Establish financial management systems | | Lack of funds | Establish financial management systems |
| 15.4.5.b | Engage stakeholders on public finance management reforms | | Lack of funds &  commitment | No cost |
| 15.4.5.c | Train accounting staff on financial management and International Public Sector Accounting Standard (IPSAS) system of accounting | | Lack of funds | Train accounting staff |
| 15.4.5.d | Conduct financial Audit of all health facilities | | Lack of funds | Conduct financial Audit |