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## Acronyms

AIDS Acquired Immune Deficiency Syndrome

AOPs Annual Operational Plans

ART Anti-Retroviral Therapy

ACTs Artemisinin Combination Therapy

BCC Behaviour Change Communication

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

CBO Community Based Organisation

CBHIS Community Based Health Insurance Scheme CTC Core Technical Committee

CEMOC Comprehensive Emergency Obstetric Care CHX Chlorhexidine

CIMCI Community Case Management of Childhood illnesses CHIPS Community Health Influencers/Promoters & Service CMAM Community-based Management of Acute Malnutrition DHIS District Health Information System

DPRS Department of Planning, Research & Statistics DRF Drug Revolving Fund

DQA Data Quality Assurance

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

ENCC Essential Newborn Care Course

EOC Emergency Operation Centre

ETS Emergency Transport System

FBO Faith-Based Organisation

FMOH Federal Ministry of Health

GBV Gender-Based Violence

GHW Global Health Watch

HBFI Hospital Baby Friendly Initiative

HBB Helping Babies Breathe

HBC Home-Based Care

HCT HIV Counselling & Testing

HCF Health Care Financing

HCW Health Care Workers

HDCC Health Data Consultative Committee

HDGC Health Data Governing Council

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

HRH Human Resources for Health HRHIS Human Resource Health Information HTS HIV Testing Services

HW Health Worker

IDSR Integrated Disease Surveillance & Response

IEC Information, Education, Communication Materials

IHR International Health Regulation

IMCI Integrated Management of Childhood Illnesses

IPCS Interpersonal Communication Skills

IPSM Integrated Procurement & Supply Chain Management IPSMTWG Integrated Procurement Technical Working Group IPT Intermittent Preventive Treatment

ISCM Integrated Supply Chain Management

ISS Integrated Supportive System

IVM Integrated Vector Management

JAR Joint Annual Review

JCCR Joint Consultative Committee on Referral LGA Local Government Area

LGHA Local Government Health Account

LLIN Long Lasting Insecticide Net

LMIS Logistic Management Information Officer

LSS Life-Saving Skills

M&E Monitoring & Evaluation

MDA Ministry, Department and Agency

MICS Multiple Indicator Cluster Survey

MNCH Maternal Neonatal & Child Health

MPPI Minimum Package Preventive Intervention

MSP Minimum Service Package

MTR Mid-Term Review

NHA National Health Accounts

NASCP National AIDS/STDs Control Programme NCH National Council on Health

NDHS Nigeria Demographic & Health Survey

NGOs Non-Governmental Organization

NHRHSP National Human Resources for Health Strategic Plan

NNRIMS Nigerian National Response Information Management System NPHCDA National Primary Health Care Development Agency

NSHDP National Strategic Health Development Plan NTD Neglected Tropical Diseases

OF Obstetric Fistula

PHC Primary Health Care

PFM Public Finance Management PHCUOR Primary Health Care Under One Roof PMS Performance Monitoring System

PMV Patent Medicine Vendors

POD Proof of Deliveries

PPP Public Private Partnership

QA Quality Assurance

R&D Research and Development

RIVSACA Rivers State Agency for Control of AIDS RSPHCMB Primary Health Care Management Board RSHMB Rivers State Hospitals Management Board SAM Severe Acute Malnutrition

SASCP State AIDS & STI Control Program SCH State Council on Health

SCM Supply Chain Management

SDGs Sustainable Development Goals

SHIS Social Health Insurance Scheme

SMOH State Ministry of Health

SOP Standard Operating Procedure

SOT Standards of Training

SPT State Planning Team

SPHCDA - State Primary Health Care Development Agency SSHDP II State Strategic Health Development Plan II TBLS Tuberculosis & Leprosy Supervisors

TOT Training of Trainer

TWG Technical Working Group

UPTH University of Port Harcourt Teaching Hospital VDCs Village Development Committees

WASH Water, Sanitation and Hygiene

WDC Ward Development Committee

WHO World Health Organization

WRAG Women of Reproductive Age Group

## Operational Definition of Terms

**Data Management:** comprises all processes related to data collection, analysis, synthesis and dissemination.

**Data Use:** Data is said to be used when actions/decisions or policy are made based on the data.

**Data Quality Assurance:** The process of profiling data to discover inconsistencies, and other anomalies in the data cleansing activities (e.g. removing outliers, missing data interpolation) to improve the data quality

**Evaluation:** The rigorous, science-based collection of information about program activities, characteristics, outcomes and impact that determines the merit or worth of a specific program or intervention.

**Impact:** Fundamental intended or unintended changes in the conditions of the target group, population, system or organization.

**Indicator:** a variable that measures the performance level of one aspect of a program/project.

**Knowledge Management:** Is a set of principles, tools and practices that enable people to create knowledge, and to share, translate and apply what they know to create value and improve effectiveness.

**Monitoring:** The routine tracking and reporting of priority information about a program and its intended outputs and outcomes.

**Monitoring & Evaluation Plan:** Is an integral part of the component of the national health strategy that addresses all the monitoring and evaluation activities of the strategy.

**Monitoring & Evaluation Framework:** Refers to the performance based framework for monitoring and evaluation of health systems strengthening.

**Outcome:** Actual or intended changes in use, satisfaction levels or behaviour that a planned intervention seeks to support.

**Performance:** The extent to which relevance, effectiveness, efficiency, economy, sustainability and impact (expected and unexpected) are achieved by an initiative, programme or policy.

**Performance measurement:** The ongoing monitoring and evaluation of the results of an initiative, programme or policy, and in particular, progress towards pre-established goals.

**Performance management:** Reflects the extent to which the implementing institution has control, or manageable interest, over a particular initiative, programme or policy.

**Review:** Is an assessment of performance or progress of a policy, sector, institution, programme or project, periodically or on an ad hoc basis. Reviews tend to emphasize operational aspects and are therefore closely linked to the monitoring function.

## Executive Summary

The Monitoring & Evaluation plan is a key component of the SSHDP II that portrays the clear cut role of the M&E component of the first SSHDPII document and it will increase performance of the outcome of the desired results. M&E is crucial to the successful implementation of various programs aimed at meeting the SDG goals. It tracks what is being done and the interventions undertaken, making different assessment necessary to ensure the close gap between program planning and implementation.

The M&E systems will ensure alignment and that the best quality data are collected and shared across the various stakeholders. The documents consist of core indicators which were shared from the FMOH and program specific indicators. Quarterly M&E TWG meeting will be held to ensure exchange of information and experience between stakeholders. An annual performance review will be put in place to enable systemic review of the document. The review meeting will bring all stakeholders to discern progress and the way forward, make recommendations and agree on decisions for better implementations and performance. The state M&E team are to hold quarterly meetings to harmonize and analyse the data collected and discuss the progress made in implementing the SSHDP II M&E plan and to address whatever challenges that may have arisen.

The development of Monitoring and Evaluation (M&E) plan is for stakeholders in the State health sector to achieve the set goals and objectives of the SSHDP II. This document outlines the roles and responsibilities regarding the monitoring and evaluation of the planned activities and also depicts the quality data usage, data collection, collation, and analysis.

It also proceeds to consider the indicators and their matrix to track the various activities in the planned document. The document ensures guided activities of the M&E team in the quest to provide accurate, reliable and timely information on progress made by the SSHDP II and provide regular reporting on the performance of the indicator listed.

The role of various actors and stakeholders in ensuring the success of the plan is also clearly expounded in order to ensure ownership, sustainability and accountability. The report of the finding shall also be disseminated to aid audience-based decision making by all stakeholders in the health sector.

## 1. Introduction

#### Purpose and Use of M&E Plan

The purpose of M& E is for monitoring, evaluation and supervision of programmes thereby allowing our organizations to work more effectively and efficiently towards achieving our programme, goals and objectives.

M & E is a communication tool that outlines various roles and responsibilities regarding monitoring and evaluation for a project or organization.

It also organizes plans for data collection, analysis, use, and data quality. This can be done using Data Quality Assurance (DQA) checklist (indicator /requirement and progress report of the state).

It outlines specific strategies and tools to encourage informed decision making by carrying out a needs assessment of the hospital's information system (public health facilities).

This M & E Plan organizes the numerous M&E activities that must take place for M&E to be truly successful in our places or work.

A wider body of people in an organization are engaged so that M&E is integrated into part of everyone's' job.

It strengthens to generate, transmit, analyse and utilize routine health data from all health facilities including private health facilities.

Improves the mechanism for an integrated data repository for data sharing amongst stakeholders at all levels.

#### Background of Organization

The Health Sector is headed by the Rivers State Ministry of Health (RSMOH). The Ministry of Health has eight departments, four Special programmes, two Parastatals, four training institutions and Agencies.

Statutorily, the Honourable Commissioner is the Chief Executive Officer of the Rivers State Ministry of Health while the Permanent Secretary is the Accounting Officer.

Within the Parastatals, the Executive / Permanent Secretary heads the Rivers State Primary Health Care Management Board (RSPHCMB) while the Chief Medical Director heads the Rivers State Hospital Management Board (RSHMB). The four institutions have the task of providing skilled level manpower; College of Health Sciences and Technology headed by a Provost, School of Nursing, School of Midwifery and School of Public Health are headed by Principals who report to the Ministry of Health.

The various departments of the Ministry of Health are headed by Directors who report to the Permanent Secretary. The departments are as follows: Administration, Finance and Accounts, Planning, Research and Statistics, Pharmaceutical Services, Nursing Services, Public Health, Medical Services and Department of Special Programmes.

The two parastatals of the Rivers State Ministry of Health; the Rivers State Hospital Management Board (RSHMB) which oversees the secondary health care system and the Rivers State Primary Care Management Board (RSPHCMB) which manages and control all PHC programmes and activities, human resources, finance and infrastructures in line with the 'Bringing PHC under one Roof' (PHCUOR) policy of one management, one plan and one monitoring and evaluation plan. 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.

#### Process of Development of the SSHDP II M&E Plan

The SSHDP II M&E Plan is in line with the National Health Policy thrust of having the M&E component which cuts across all the programmes. The goal of the M&E Plan is to significantly improve the health status of Rivers people through the development of a strengthened and sustainable health care delivery system.

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

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

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

1. A Technical Working Group (TWG), drawn from the SPT, which was inaugurated by the Permanent Secretary, with Director PRS as the Chairman, who reviewed the first SSHDP; and support the development of the second SSHDP;
2. An end-term evaluation of the first SSHDP was conducted to determine the level of implementation, outcomes, challenges and lessons learned;
3. Members of the SPT & TWGs were trained on the NSHDP Framework and planning process at the State level during a sensitization training workshop on the development of the SSHDP II 2018-2022 workshop on 10thAugust, 2017;
4. Using the NSHDP Framework, State policies, national and international documents and declarations, the SPT developed the costed draft of the second SSHDP and selection of the indicators for the M&E template. The finalization and validation workshop on the development of SSHDP Plan II was held on 23rd October 2017. The draft plan was reviewed by the TWG;
5. A stakeholder's review of the SSHDP II 2018-2022 and M&E workshop was held on the 16th and17th November, 2017. This was to complete the Template for the M&E II Plan
6. The final draft of the Plan was validated, produced and disseminated to all stakeholders in the State.

# 2. Description of SSHDP II

#### Rationale for SSHDP II

Rivers 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 of 338.1 per 100,000 live births (DHIS2) as against the National maternal mortality ratio of 576/100,000 (NDHS 2013). The other health status indicators: the under-five mortality rate of 58/1000 (MICS 2016) compared to 90/1000 in NDHS 2008 and infant mortality rate of 41/1000 and child mortality rate 18/1000 (MICS 2016). 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 the global average of 71.4 years 8. 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 Sustainable Development Goal (SDG) 3 target of universal access to all 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 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 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 referrals pathways to other levels of care.

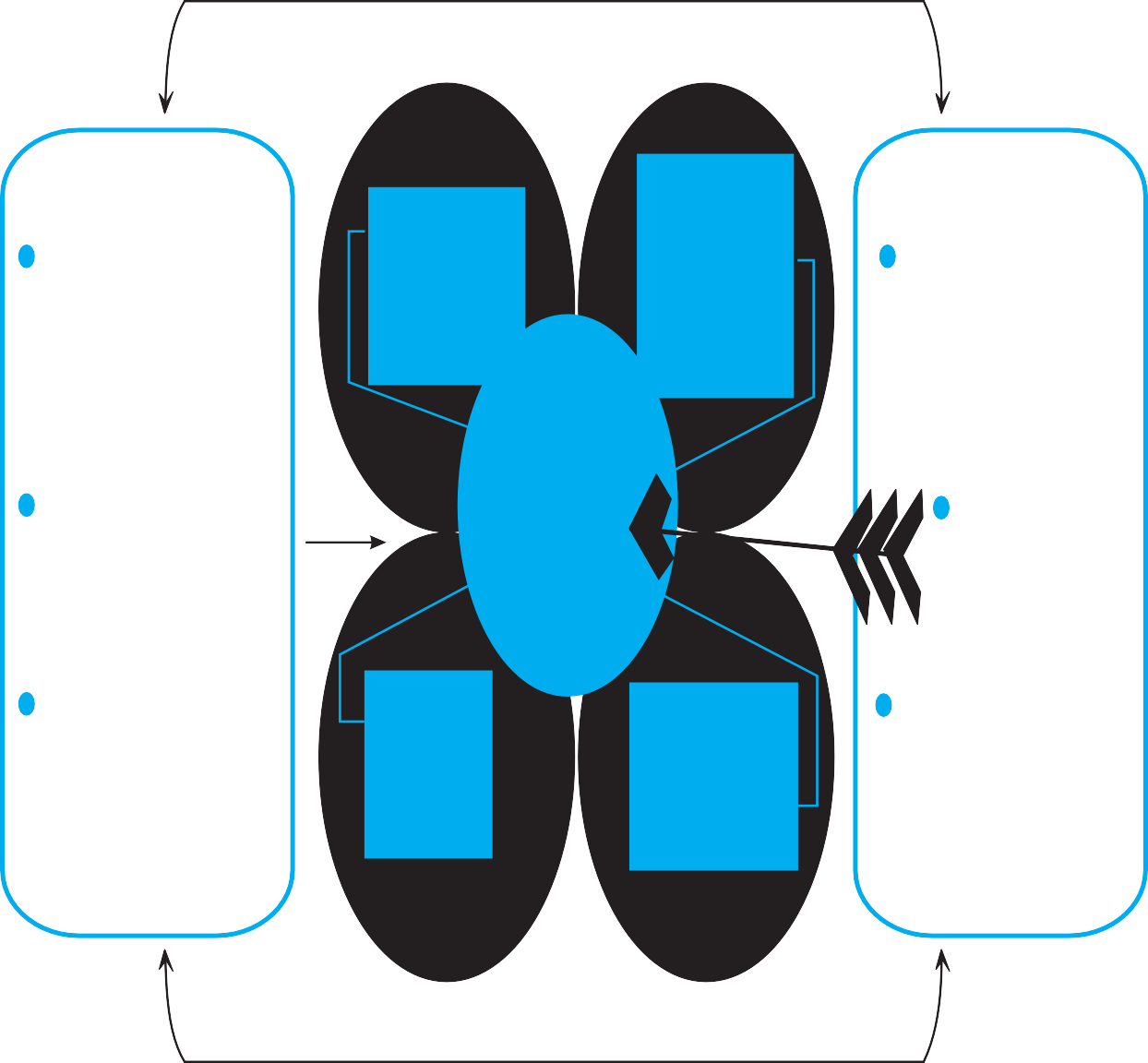
Monitoring and Evaluation will be done by the implementing departments and special units (inbuilt M & E) and a central M & E Unit in the PRS Department. It is important to monitor and evaluate the plan's operational elements (the required activities) that are essential ingredients in ensuring the successful 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 SSHDP also the health prevention and utilization indicators. The major categories of indicators that are relevant for monitoring and evaluating the SSHDP include the policy and socioeconomic indicators.

#### The SSHDP II (2018 – 2022) Conceptual Framework

The overall development of the plan was guided by the agreed conceptual framework as depicted in figure 1.

#### Figure 1: The Conceptual framework of the SSHSDP II

CONCEPTUAL FRAMEWORK FOR NSHDP II



**AT ALL LEVELS...**

**Accountable,**

**Effective and**

**Transparent &**

**Adequate & functional**

**infrastructure, medical equipment & other technologies.**

**Efficient**

**Participatory**

**Health Service**

**Governance**

**Effective Partnership**

**and Community participation.**

**Delivery.**

**Systems.**

**Healthy**

**Lives and**

**Efficient, accessible &**

**affordable laboratory services.**

**Improved**

**Well Being**

**Revitalization of**

**Primary Health Care**

**Adequate, affordable,**

**quality medicines, vaccines & others commodities**

**Adequate &**

**Sustainable,**

**Quality**

**Predictable &**

**Human**

**Equitable**

**Capital.**

**An integrated,**

**comprehensive and reliable information system.**

**Financing.**

#### Implications of Monitoring and Evaluation in the SSHDP II

The Monitoring and Evaluation in the SSHDP II are for tracking the progress of the SSHDP II implementation and it is based on the global M&E operational framework. This global M&E Operational Framework links inputs to intended results, ensuring that considerations are made for influencing and facilitating factor.

#### Figure 2: The SSHDP II Progress Tracking Indicator Flow

**GOAL**

**OVERALL GOALS**

**ENSURE A HEALTHY AND PRODUCTIVE RIVERS CITIZEN**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Strategic Pillar One**  Goals Impact indicators | **Strategic Pillar Two**  Goals Impact indicators | **Strategic Pillar Three**  Goals Impact indicators | **Strategic Pillar Four Goal**  Impact indicator | **Strategic Pillar Five Goal**  Impact indicator |
|  | | |  | |
| **Priority Areas 1, 2**  **& 3**  Strategic objectives Outcome indicators | **Priority Areas 4, 5,**  **6, 7 & 8**  Strategic objectives Outcome indicators | **Priority Areas 9, 10,**  **11, 12 & 13**  Strategic objectives Outcome indicators | **Priority Area 14**  Strategic objectives Outcome indicators | **Priority Area 15**  Strategic objectives Outcome indicators |
|  | | |  | |
| **Interventions**  Output indicators | **Interventions**  Output indicators | **Interventions**  Output indicators | **Interventions**  Output indicators | **Interventions**  Output indicators |
|  |  |  |  |  |
| **Activities**  Process indicators | **Activities**  Process indicators | **Activities**  Process indicators | **Activities**  Process indicators | **Activities**  Process indicators |

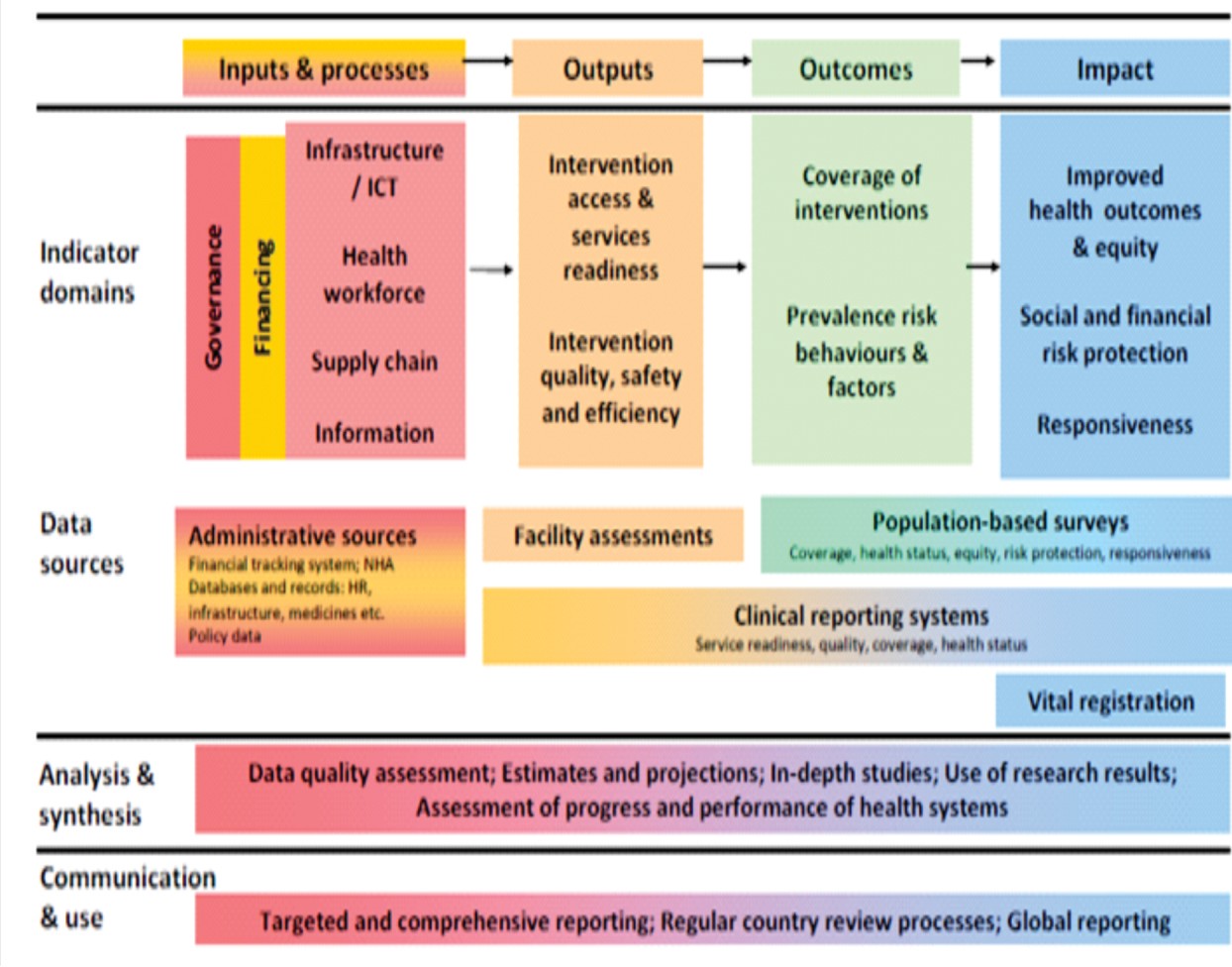
1. **Monitoring and Evaluation Mechanism of the SSHDP II**

#### The General M&E Framework:

The M&E framework are for tracking progress of the SSHDP II implementation is based on the national M&E operational framework which links inputs to intended results, ensuring that considerations are made for influencing and facilitating factors. The general M&E framework is illustrated in the figure below:

**Figure 3: The General M & E Framework**

**Monitoring & Evaluation of health systems reform / strengthening**



#### Indicators

Indicators could be at the levels of inputs, process, output, outcome and impact in a programme. The framework consists of 76 indicators selected because of commitment to their achievements and they measure performance outcomes or impacts in the 15Priority Areas agreed for the State Strategic Health Development Plan II (SSHDP II).

15

Cyan Magenta Yellow Black

#### PERFORMANCE INDICATORS

Performance and result indicators included in the state M/E strategy. Here, inequity and demonstrating improvements in health in line with the national targets are generally not possible without having information about health status, health determinants, service utilization and the effects of services on the health of the population at sub-national state and local levels. Therefore, the information on all of the service coverage, outcome and impact indicators will be appropriately disaggregated. The following indicators will be disaggregated in order to examine whether there are any discrepancies in the utilization of the minimum health package as defined by the National Primary Health Care Development Agency between genders or levels of poverty.

1. Deliveries by skilled health personnel
2. Fully immunized children under one year
3. Prevalence of underweight children
4. Out-Patient Department utilization
5. Clients satisfied with services.

#### Core SSHDP II Indicators

State Modified National Matrix

|  |  |
| --- | --- |
| 1.1 | * % of coordination organs at national and subnational levels(NCH, SCH, WDC, Health Partners Coordination Committee) that are established/functional |
| 1.2 | % of LGAs that increased annual budget implementation rate by 25 percent |
| 1.3 | Proportion of State Level MDAs and 23 LGA publish annual state of health report |
| 2.1 | * % of PHCs with functional Ward Development Committees; |
| 3.1 | * % of the funding of health from partners (development partners and private sector) that is aligned with the National Health Policy and National Strategic Health Plan by 2021 |
| 4.1 | * Maternal mortality ratio |
|  | * % of deliveries by Skilled attendance |
|  | * % of Primary/Ward Health Centers providing basic Emergency Obstetric and neonatal care services disaggregated by Level of care |
| 4.2 | * Incidence rate of obstetrics fistula |
|  | * % of treated obstetrics fistula cases reintegrated into their communities |
| 4.3 | * Contraceptive prevalence rate |
|  | * Proportion of women of reproductive age (15 -49 years) who have their needs for family planning satisfied with modern methods |
| 4.4 | * Neonatal mortality rate |
|  | * Infant mortality rate |

|  |  |
| --- | --- |
|  | * Under-five mortality rate |
| 4.5 | * Adolescent birth rate per 1000 women aged 10 - 19 years |
| 4.6 | * Exclusive breastfeeding rate in the first six months of life |
|  | * Incidence of low birth weight |
|  | * Prevalence of malnutrition in children aged 0 - 59 months |
|  | * Prevalence of wasting among under-fives |
|  | * Prevalence rate of stunting in under-fives |
|  | * Proportion (%) of women of reproductive age with anaemia |
|  | * Prevalence of overweight among under-five |
|  | * % of care seeking persons with suspected malaria that are tested using RDT or microscopy |
|  | * Malaria incidence per 1000 population |
|  | * Prevalence of malaria in pregnancy and children |
| 5.1 | * % of health facilities reported stock-out of diagnostic kits and ACTs lasting more than one week in the past three months |
|  | * TB incidence per 1000 population |
|  | * TB prevalence rate |
| 5.2 | * TB mortality rate |
|  | Treatment Success rate for MDR-TB |
|  | * Incidence of HIV infections by age and sex among the key and general populations |

|  |  |
| --- | --- |
|  | * Coverage of HIV testing Services |
| 5.3 | * Incidence of Mother-to-child transmission of HIV |
|  | * % of diagnosed PLHIV receiving quality HIV treatment services |
|  | * % of diagnosed PLHIV on ARV who achieve sustained virological suppression |
| 5.4 | * Prevalence of vaccine-preventable viral hepatitis |
|  | * Incidence of viral hepatitis B per 100,000 population |
| 5.5 | * Prevalence of targeted NTDs |
| 6.1 | * Mortality from NCDs (cardiovascular diseases, cancer, diabetes, sickle cell diseases or chronic respiratory diseases.) |
| 6.2 | * % of the elderly in Nigeria accessing basic and long term care |
| 6.3 | Incidence of mental illness in Rivers State |
|  | Harmful use of alcohol in terms per capita consumption among adults (persons aged 15 years and above) per annum in liters of pure alcohol |
| 6.4 | Coverage of treatment interventions (pharmacological, psychosocial, rehabilitation and aftercare services) for substance use disorders |
|  | * Incidence of oral diseases (e.g. dental caries, gingivitis, cancrum oris etc.) |
|  | * % of PHCs providing a basic package of oral care |
| 6.5 | * % of blind and visually impaired persons who have adequate access to eye treatment and rehabilitative services |
| 7.1 | * Health facility Case fatality rates |
|  | * Client satisfaction level rates |

|  |  |
| --- | --- |
| 7.2 | % of LGAs with dedicated centres for specific medical and laboratory service (emergency, trauma care, ambulatory, blood, etc) |
|  | * % of Secondary and Tertiary hospitals with functional ambulance services |
| 8.2 | % of designated sentinel sites across the state established and equipped to collect, collate and transmit foodborne illness data to the State Centre for Disease Control by end of 2019 |
| 8.3 | Mortality rate attributable to unsafe water, unsafe sanitation and lack of hygiene (WASH) |
| 8.4 | * Incidence of snakebites |
| 9.1 | Proportion of LGAs that are implementing HRH policies and strategic plans |
| 9.2 | * % of health training institutions that are accredited by the relevant regulatory institution |
|  | * Proportion of health professionals graduating from health training institutions |
| 9.5 | * Health worker density and distribution |
|  | % of Wards in the state with at least one fully functional PHC centre providing comprehensive primary health care services |
| 10.1 | * % of health facilities at all levels of the health system with fully functional health infrastructure   (related to:- medical equipment; water supply; electricity supply; roads; waste disposal; ICT; and security) |
|  | * % Increase in local production of quality medicines, vaccines and other commodities |
| 11.1 | Proportion of State Level MDAs and 23 LGAs with functional logistic management coordinating Unit |
|  | * Proportion of the population with access to affordable medicines and vaccines on a sustainable basis |
| 12.1 | * % of Facilities reporting by timeliness and completeness on the DHIS |
|  | % of data platforms interoperable with the DHIS |
| 13.1 | % of state and LG health research institutions with functional ethical review committee |

|  |  |
| --- | --- |
| 14.1 | * Case Fatality Rate of public health emergencies |
|  | Death rate due to RTA |
| 15.1 | Proportion of the State Level MDAs and LGs with approved Health Financing Policy & Strategy |
|  | Proportion of the State Level MDAs and LGs institutionalized routine SHA and LGHA |
| 15.2 | * % Budgetary Allocation to PHC |
| 15.3 | % of Rivers State population covered by any risk protection mechanism |
|  | % of LGAs with functional PFM Systems |

* + 1. **Program Specific Indicators**

|  |  |  |
| --- | --- | --- |
|  | **Strategic Interventions** | **Output Indicators** |
| 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 |
| 1.1.2 | 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 |
| 1.2.1 | 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 |
| 1.2.2 | 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 |

|  |  |  |
| --- | --- | --- |
| 1.2.3 | 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 co nstituted |
| 1.3.1 | Strengthen annual operational/work - plan for the health sector | * Annual operational / workplan reporting system developed and used * Operational Plan reviewed quarterly and findings   disseminated |
| 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 |
| 1.3.3 | 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 |
| 1.3.4 | Disseminate sector performance reports and score cards in compliance with NHAct and other channels | * Sector performance reports and score cards developed and disseminated |
| 1.3.5 | Design and institutionalize an incentive and reward system for the efficient performance of the health sector at all levels | * Health workers' performance and rewarding system in place |
| 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 i n the state reviewed & implemented |
| 1.4.2 | Strengthen development and review of sectoral policies and plans | * At least 5 DPRS staff of SMOH trained on policy analysis |
| 1.4.3 | Strengthen inter -sectoral collaboration at all levels. | * Platform for engagement t of other sectors created and functional * Inter departmental meetings at LGA level held |
| 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 |

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| 1.4.5 | Strengthen implementation of Health Service Charters at all levels | * Health service charters functional at all levels |
| 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 workplan * Tracking and evaluation of donor support |
| 2.1.1 | Strengthen institutional and coordinating mechanisms for the promotion of community participation | * WDC set up in at least 200 wards and trained on community participation * Advocacy and sensitization of community leaders" * Orientation of at lea st 200 WDCs on community participation done |
| 2.1.2 | Strengthen financial management systems at the community levels | * 200 WDCs trained in financial management |
| 2.1.3 | Strengthen capacities of communities to participate in the planning of health intervention s at all levels | * At least 200 WDCs trained and participated in the planning of health interventions |
| 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• " |
| 2.2.2 | Strengthen mechanisms for data collection, analysis, storage, utilization and accountability at the 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 |
| 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 |
| 3.1.2 | Strengthen legal and coordinating framework for PPP at all levels | * PPP coordinating structures & feedback mechanisms functional |
| 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 |
| 3.1.4 | Strengthen mechanisms for the implementation of PPP (e.g. contracting o r 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 |
| 3.1.5 | Scale-up PPP in the planning and  implementation of health programmes | Private sector engaged in the development of strategic plan and AOPs & performance reviewed |
| 3.1.6 | Promote joint (public and private sector) monitoring and evaluation of health programs | * Joint public-private sector monitoring team established * Health programmes regularly reviewed |

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| 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 |
| 3.1.8 | 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 |
| 3.1.9 | 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 |
| 3.1.10 | 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 a partnership with the private sector, professional groups & other relevant stakeholders * Professional competence assessed annually |
| 3.1.11 | Strengthen collaboration between government and professional groups including Nigerian health professionals in the diaspora to advocate for increased coverage of essential interventions, particularly increased funding; | * Forum of professional groups and partners established * Conferences, Seminars or exhibitions organized |
| 3.1.12 | Leverage human resources for health from partners, health professionals, other levels of government to optimize resource use and improve service delivery | * Partnership with medical training institutions abroad * Technical assistance by Development Partners on-the-Job mentorship obtained |
| 3.1.13 | Promote linkages with academic institutions to undertake research, education and monitoring through existing networks; and | * Forum for all of 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" |
| 3.1.14 | 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 " |
| 3.1.15 | 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 |
| 4.1.1 | Improve access to focused Antenatal and Postnatal Care | * ANC outreaches carried out * Routine drugs provided |

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| 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 |
| 4.1.3 | 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 |
| 4.1.4 | 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/established * At least 150 HWs trained on ENBC & HBB * At least 200 community-based workers trained on LSS |
| 4.1.5 | Improve the quality of care for safe motherhood services | * SOPs developed * WHO Standards of Care for improving the quality of maternal and newborn care adopted & implemented * At least 300 HWs trained on IPC skill |
| 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 |
| 4.1.8 | Expand access to life saving commodities | * Life saving commodities procured & distributed to all HFs annually * At least 300 HWs trained |
| 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 |
| 4.2.2 | Strengthen /expand services for treatment of obstetric fistula | * Advocacy visit to the Governor for free treatment and management of patients * Regular supply of commodities to OF treatment centre |
| 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 * At least 20 CBOs trained to conduct OF rehabilitation interventions |

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| 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 * Gender -based violence counseling and treatment services provided |
| 4.3.2 | Increase demand for Reproductive health services | * Advocacy for enabling legislations, policies and funding for RH * Sensitization meeting with community stakeholders on Family Planning Services held * Sensitization meeting with stakeholders to get in volved in RH interventions held |
| 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 |
| 4.3.4 | 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 |
| 4.3.5 | Promote prevention of harmful traditional practices and gender-based violence | * Public education and community sensitization on HTP and GBV carried out |
| 4.3.6 | Scale up Prevention, counseling and treatment of rape and other gender based violence such as Rape, intimate partner violence e.t.c | * 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 |
| 4.4.1 | Strengthen postnatal and newborn care | * At least 3 85 Midwives trained on follow up care of Postnatal mothers * 4% chlohexidine gel procured & distributed to 385 HFs * 200 HWs trained on proper use of Chlohexidine gel for Cord   care and prevention of neonatal sepsis RI conducted in all HFs annually |
| 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 |

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| 4.4.3 | Intensify the promotion of exclusive breastfeeding for the first six month s 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 |
| 4.4.4 | Strengthen routine child immunization including new antigens | * 60 cold room kit procured & supplied * Routine Immunization task force in place & MOU on accountability developed & implemented * RI carried out in all HFs * CHIPS Programme initiated and implemented |
| 4.4.5. | Improve the quality of newborn and child healthcare services | * 300 HWs trained on updated ENCC packages * Local dialects messages on ENCC & Chlohexidine disseminated through multiple media channels * Orientation for Private HFs, PPMVs/Pharmacies on Newborn Care including cord care with CHX implemented |
| 4.4.6 | Promote advocacy, community mobilisation and behavioural change communication for newborn and child healthcare services | * Advocate to policy makers and legislators * At least 300 WDC/Community volunteers engaged and trained * Newborn and child health communication materials developed and distributed |
| 4.4.8 | Expand coverage of IMCI (Community-IMCI, Community Case Management (ICCM) & IMCI) | * Community Case Management of Childhood Illness (CIMCI) * Community IMCI implemented * At least 560 health care providers trained on IMCI and CIMCI |
| 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 |
| 4.5.2 | 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 Counseling provided in at least 10 secondary schools per LGA * Youth friendly ARHS integrated into Primary Health Centre |

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| 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 |
| 4.5.4 | 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" |
| 4.5.5 | Scale-up implementation of adolescent sexual and reproductive health education in the school curriculum | * Adolescent sexual and reproductive health education included in the school curriculum and implemented * ! Hilux & 1 bus purchased |
| 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 LGA s & Peer to peer education |
| 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 * Media talk implemented * 1 bus purchased |
| 4.6.1 | Promote hospital baby friendly initiative | * At least 744 posters printed & distributed * Campaigns through media implemented |
| 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 breast feeding given in all health facilities in the 23 LGAs * World Breast Feeding Week at the state & LGA levels observed   + Breastfeeding Support Group (BSG) established |
| 4.6.3 | Scale-up continued breastfeeding and appropriate complementary feeding from six months | * Advocacy visit to the workplace for provision of crèche in work environment * Health Education (HE) to promote adoption of principles of FADUS given in at least 385HFs * At least 100 Community Counselors trained on Infant & Young Child Feeding |

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| 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 a routine constituent of diarrhea management for children aged 6 - 59 months |
| 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 |
| 4.6.6 | 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 |
| 4.6.7 | Promote implementation of school feeding programme | * Advocacy meeting with the Ministry of Education on promotion and implementation of school feeding done * At least 500 teachers trained on salt for the presence of Iodine * Media engaged to promote hand washing and sanitation |
| 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 Vits A for lactating mothers * Media campaign on the importance and use of iron-folic acid in pregnancy & vitamin A supple mentation in lactating women conducted |
| 4.6.9 | Promote optimal nutrition of adolescents and Women of Reproductive Age (WRA) | * Dietary counseling 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 |
| 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 in Geriatric nutrition and care. * 200 Volunteer Health Workers trained on Nutritional Care of the elderly. * Orientation/Sensitization on the healthy choice of foods for the elderly carried out quarterly |

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| 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 |
| 5.1.2 | 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 K its procured & distributed to at least 200 Primary & Secondary Health facilities |
| 5.1.3 | Build the 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 microscopists 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 |
| 5.1.5 | 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 |
| 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 |
| 5.1.8 | Promote active community participation in malaria control initiative | * Workshop with community stakeholders to plan malaria control programmes * Community dialogue meeting conducted in the 23 LGAs * World Malaria Day Celebration observed |
| 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 |
| 5.2.2 | 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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| 5.2.3 | 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 |
| 5.2.4 | 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 |
| 5.2.5 | Increase access to diagnosis and management services for DR-TB | * Robust DR -TB diagnosis, treatment and care services established |
| 5.2.6 | Strengthen collaboration with and capacity of CBOs to support TB programming. | * CBOs engaged & trained on the 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 |
| 5.2.7 | Strengthen mechanism for coordination of TB/HIV collaborative activities at all levels of health care. | * Existing Monitoring and Evaluation system upgraded to meet the demand for TBL programmes * At least 100 health care workers trained to deliver integrated TB/HIV services |
| 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 |
| 5.2.10 | 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 |
| 5.2.12 | Promote community based TB/Leprosy control initiatives | * Consensus building meeting for TBL Officers on community TB / Leprosy control held |
| 5.2.13 | Strengthen physical and socio -economic rehabilitation for leprosy | * Leprosy rehabilitation center provided & equipped |
| 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 |
| 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 |
| 5.3.3 | 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 |

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| 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 a 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 |
| 5.3.5 | 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 |
| 5.3.6 | 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 & health care waste management practices annually |
| 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 Programme mobilization * Community outreach programme on HIV |
| 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 |
| 5.5.1 | Strengthen advocacy, social mobilization and behaviour change communication for NTDs | * Advocacy visit to community institutions on Community Mobilization on NTDs recognition, reporting and control * 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 372 advocacy kits distributed * Media advocacy and sensitization on NTDs |
| 5.5.2 | Scale up delivery o f 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 |
| 5.5.3 | 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 * Meeting for inter-sectoral collaboration forum for water supply * Meeting with WDC to mobilize communities to undertake IVM measures done |

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| 5.5.4 | Increase access to integrated case management for NTDs (Buruli Ulcer, Leishmaniosis, Trypanosomiasis, Loasis, Schistosomiasis, Zoonosis , soil-transmitted helminthic infections,  onchocerciasis, filariasis) | * Jingles, town announcers and other channels of communication on NTDs |
| 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 |
| 5.5.6 | Strengthen the integration and linkages of NTD programme and financial plans into sector-wide and national budgetary and financing mechanisms. | * NTD Work plans developed |
| 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 |
| 6.1.2 | Intensify advocacy, legislation, social mobilization and behaviour change communication for NCD prevention and control | * Advocacy on NCDs prevention & control * Sensitization on NCDs for all HWs in the state * World celebration of the various NCD Days observed |
| 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 |
| 6.1.4 | Expand access (geographic and financial etc.) to NCD prevention, screening, control and treatment services | * Facilities rendering NCD services in the st ate, 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 center established |
| 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 |

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| 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 |
| 6.1.7 | 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 |
| 6.2.1 | 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 |
| 6.2.2 | 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 the prevention and control of elderly abuse established |
| 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 |
| 6.4.1 | 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 |
| 6.4.2 | 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 the 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 |
| 6.4.3 | Strengthen the capacity of health workers at all levels to deliver oral health care services | * At least 25 0 training& re-training workshop for health workers at State & LGA levels on oral health |
| 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 |
| 6.5.2 | 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   • |

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| 6.5.3 | Strengthen eye health focused research and information system; | * Research team set up system in major eye care facilities (RSUTH & UPTH) * Research articles and innovations in eye management adopted |
| 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 * Advocacy visit 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 |
| 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 |
| 7.1.2 | Build capacity of health care providers for emergency medical services including training  for first responders and ambulance drivers | * EMS needs assessment * EMS manpower trained |
| 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 |
| 7.1.5 | Promote demand for appropriate use of medical services | * Public enlightenment on emergency and trauma services carried out |
| 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 |
| 7.2.2 | Build capacity (human and institutional) of emergency medical services units/departments of receiving health facilities | * At least 814 HWs trained in services and advance CPR * Emergency equipment procured & distributed * At lease 23 disease surveillance officers trained for disease outbreak control |
| 7.2.3 | Strengthen coordinated and integrated emergency transport system (ETS) | ••Ambulances maintained   * Emergency drugs available |
| 7.3.1 | Promote the development of practice standards and guidelines for ambulatory services | * Guidelines for ambulatory services available * At least 350 staff trained on guidelines |
| 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 |

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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 |
| 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 levels of  care | * Policy guidelines (SOPs) developed, printed, distributed and implementation monitored * Orientation/Interactive sessions * Training of Trainers Workshop |
| 7.4.2 | Scale up the 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 |
| 7.4.3 | Intensify continuous quality improvement in medical service provision at all levels | * Continuous training * Private health insti tutions registration/renewal certificate done annually |
| 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 |
| 7.4.5 | Promote demand for appropriate use of medical services | * Public enlightenment through a multi-media approach on the use of medical services |
| 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 |
| 7.6.1 | 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 * Awareness created on availability care |
| 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 |

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| 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 |
| 7.6.4 | 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 |
| 8.1.1 | Promote the development 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 * Existing policies on risky health behaviour identified & reviewed * Posters on healthy living designed, printed & distributed to every community and schools in the 23 LGAs |
| 8.1.2 | Strengthen community capacity for responses and ownership of health promotion. | * Community sensitized on the risky health behaviour and consequences * Orientation and re -orientation of WDCs, CBOs etc on the promotion of healthy life style * Outreaches and town hall meetings on promotion of healthy life style and environment |
| 8.1.3 | Strengthen health promotion coordination mechanisms at all levels | * Public enlightenment on risky health behaviour through production and airing of jingles * Stakeholders meeting to disseminate information on promotion of healthy living done at state & LGA levels the * Zonal meeting with WDC Chairman to disseminate information on the promotion of healthy living held |
| 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 Hand Washing Day in the state done * Environmental health club established in schools at all levels |
| 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 * Sanitary convenience in workplaces constructed & dust bins & buckets procured & distributed * Weekly environmental sanitation in workplace institutionalized |
| 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 the inclusion of health promotion in school curricula at all levels * Health promotion activities in school curricula at all levels institutionalized |

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| 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 the 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 monitored |
| 8.2.1 | Strengthen system for food and water safety surveillance. | * Food handlers from 23 LGAs in the state training. * Workshop for EHOs done * Butchers and meat handlers from 23 LGAs trained * WATSAN officers and zonal EHOs from 23 LGAs trained. |
| 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 |
| 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 * Community Volunteers trained on Food Safety and quality. |
| 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 and members of the Food/Nutrition committee |
| 8.2.5 | Promote the practice of food safety across the food production pipe line from the farm to the table. | * Collaboration with the relevant Ministries and Parastatals in the state * Collaboration with the Ministry of Agriculture and ADP * Farmers trained |
| 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 * Community members(WDCs) trained * Awareness creation |

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| 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 th rough production and airing of jingles & print/distribution of posters/fliers on WASH   done |
| 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 the provision of functional safe water points in the State * Orientation of health workers on effective hand washing and sanitation |
| 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 * Regulation for production of commercial water supply produced and distributed * Monitoring and supervision of construction of commercial water points carried out |
| 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 |
| 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 |
| 8.4.3 | Build capacity of health care workers on snakebite management at all levels. | * TOT of state officers on snakebite management * Health workers on appropriate snakebite management at State & LG levels, including on data management on   snakebites trained |
| 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 |

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| 8.4.5 | Scale up generation of local evidence to inform more responsive snakebite programming | * Quarterly data quality assessments of snakebite programmes * Monthly surveillance held and reporting systems for data developed & data used for resource allocation and distribution |
| 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 |
| 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 the 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 change on health done |
| 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 * Periodic town hall meeting with communities living in an industrial area held * Public enlightenment in state media houses on the effect of chemical hazards |
| 8.5.3 | 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 in the management of medical and bio waste at all level * Environmental Health Officers trained in risk assessment |
| 8.5.4 | Build capacity to appropriately respond to health effects of climate change | * Health workers trained in 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 |
| 8.5.5 | Deepen collaboration with relevant stakeholders on Chemicals Management, medical & Bio waste management and climate change | * Bi -annual stakeholders review meeting on effec ts of climate change in the state held |

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| 8.5.6 | Improve systems for data collection, management and utilization of chemical hazards and poisons, medical and Bio waste and climate change | * Surveillance and reporting systems for data collection, management and utilization of chemical hazards and poisons, medical and Bio waste and climate change developed * Quarterly data quality assessments * Activities of climate change desk officer reviewed annually |
| 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 * Awareness on any existing & emerging risk using print, electronic and social media platforms created |
| 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 |
| 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 |
| 9.1.2 | Strengthen coordination of public, private, regulatory, Health workforce association and development partners at all levels | * State comprehensive HRH database updated |
| 9.1.3 | Enhance funding for HRH development for the current and future needs | * Advocacy for the allocation of a minimum of 15% of the health budget to development of HR * Advocate to the private sector for adequate funding for HRH done * Resource mobilization activities for HRH, including grantsmanship, proposal development, fund raising activities   etc |
| 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 |
| 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 |

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| 9.2.3 | Improve gender sensitivity in the production of health work force for all cadres at all levels | * Database disaggregated by gender |
| 9.3.1 | Strengthen/establish HRHIS at state and federal levels | * Human Resource Health Information System (HRHIS) established in the state |
| 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 " |
| 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 |
| 9.4.1 | 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 * Performance based reward systems introduced |
| 9.4.2 | Improve HRH performance management systems at all levels | * System for measuring performance of health workers reviewed and implemented" |
| 9.4,3 | Strengthen the Task Shifting and Task Sharing (TSTS) 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 * TSTS training for all cadre of HWs commenced |
| 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 |
| 9.5.2 | Strengthen mechanisms for HRH joint planning at primary, secondary and tertiary levels | * Workshop organised, HRH plan developed and harmonized |
| 10.1.1 | Strengthen the 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 |
| 10.1.2 | 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 |
| 10.1.3 | 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 |

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| 10.1.4 | Strengthen the monitoring of health infrastructure, including inventories and performance | * Monitoring of health infrastructures, including inventories & performance * Health infrastructures included in the EMR framework |
| 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 |
| 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 |
| 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 tra ined |
| 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 |
| 10.1.9 | Improve Secondary and Tertiary levels infrastructure to support for the referrals systems | * General & Specialist Hospitals in the State renovated * General Hospitals constructed & equipped at Obio/Akpor , Oyigbo & Tai LGAs. * Logistics support including transportation and communication systems established and strengthened |
| 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 workplan developed and implemented * IPSM TWG set up |
| 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 Distribution Matrix (LMDs) |

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| 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 |
| 11.1.4 | Strengthen effective procurement systems (forecasting, orders, 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 strengthened |
| 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 * LMIS Report collection of HIV, TB, Malaria, Reproductive health and Vaccine programs available |
| 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" |
| 11.1.7 | 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 * Safe health commodities waste management system in the State implemented * Sharp boxes and consumables provided and distributed to all Health facilities |
| 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 |
| 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 * Stakeholder consultative forum on data management and use supported |
| 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 M&E officers don e |

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| 12.1.3 | Improve integration of existing surveillance systems and diseases registries into the over all 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 |
| 12.1.4 | Improve the mechanism 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 " |
| 12.1.5 | Strengthen monitoring of the sub-sector performance | * Data Quality Assessment exercises * Regular supportive supervisory visits * Dashboard to monitor data entry and quality of data entered developed |
| 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 |
| 13.1.2 | Strengthen the development and implementation of the national research agenda | * State research agenda developed & platform for collaborative research established * Researchers trained in both quantitative and qualitative research annually * Promotion of PPP in R&D |
| 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 * Government support for the development of collaborative research proposals and their implementation achieved * Capacity for resource mobilization for health research built |
| 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 |

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| 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 |
| 13.1.6 | Enhance strategic partnerships at the national and international levels for the promotion and timely dissemination of research findings | * Memorandum of Understanding (MOU) both 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 |
| 3.1.7 | 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 |
| 13.1.8 | 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 * Website created and subscription done annually |
| 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 |
| 14.1.2 | 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 |

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| 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 RSUTH laboratory strengthened * System for laboratory reagents procurement and supplies strengthened * System for communication with the LGA and adequate transportation of the samples established |
| 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 |
| 14.1.5 | Promote access t o 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 |
| 14.1.6 | 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 done |
| 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 |
| 14.1.8 | Strengthen coordination mechanisms for public health emergencies at all levels | * Infectious Disease Treatment Centre at Emohua renovated and upgraded * logistics for emergency response provided |
| 14.1.9 | 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 held |
| 15.1.1 | Strengthen Health Financing Equity and Investment Units at Federal, 36 States, and FCT | * TWG inaugurated and members trained in 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 |

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| 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 * HCF implementation strategies designed and developed * TWG members trained |
| 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 * DRF strengthened at all levels |
| 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, analyzing& dissemination of HF data developed |
| 15.2.1 | Alignment of health allocations to national priorities | * Advocacy for the allocation of at least 15% of State and LGAs budgets * State health priorities included into MTEF and all LGAs, MDAs and donors aligned with it. * Advocacy to increase domestic revenue for health done |
| 15.2.3 | Advocate for an increase in government annual budget and spending on health | * Advocacy to make financial provisions for poor and vulnerable groups & diseases of public health significance * Advocacy strategy for the increased and timely release of health budgets developed and implemented * Health advocacy committee supported to advocate for an increase in health budget |
| 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 and disseminated |
| 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 |
| 15.3.1 | Engage Stakeholders to increase enrolment and contribution to Health Insurance | * Third Party Associations(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 |
| 15.3.2 | Strengthen Laws and regulations for the implementation of the NHIS | * Advocacy to the Executive Governor / House of Assembly to facilitate passage of RIVCHPP bill * BMHB package, operational guidelines and SOPs developed * Advocacy for laws to establish/enforce SHIS |

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| 15.3.3 | Strengthen the technical capacity of health personnel on health insurance and contributory schemes | * Staff trained in basic Health Insurance strategy and principle * Health human resources in private and public health facilities   trained & re -trained on health insurance & contributory schemes |
| 15.3.4 | 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 |
| 15.4.1 | Review of Provider Payment mechanisms in the Nigerian health sector to focus on RBF | * PPM developed, validated and disseminated to stakeholders |
| 15.4.2 | Develop a 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 |
| 15.4.4 | Institutionalize routine NHA and expenditure tracking mechanisms at State and Federal levels | * Periodic health expenditure resource tracking * Annual State Health Account data collected * Budget execution monitored |
| 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 in financial management and IPSAS system of accounting * Financial Audit done in all health facilities |

* + 1. **Indicator Matrix**

**Table 1**

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| **S/N** | **Strategic Objective** | **Indicator** | **Definition of indicator** | **Method/Data Source** | **Frequency/ Schedule of data collection** | **Organisation/Institution Responsible** | **Decision Points/ Comments** |
|  |  | a)The 23 LGAs M/E |  |  |  |  |  |
|  | Strengthen | officers and HIOs |  |  |  |
| 1 | institutional  framework and coordination for | consistently transmit  data to DHIS platform  b) Availability of NHMIS | a) Primary and Secondary sources | Monthly | DPRS MOH/RSPHCMB/RSHMB |
|  | HIS at all levels | Data tools to all |  |  |  |
|  |  | Facilities at all levels |  |  |  |
|  |  | a) Supportive |  |  |  |  |  |
|  | Strengthen | Supervision |  |  |  |
| 2 | monitoring of the  sub-sector | Of Monitoring and  Evaluation officers | a) Primary Data | Monthly | DPRS MOH/RSPHCMB/RSHMB |
|  | performance | Reporting on DHIS |  |  |  |
|  |  | platform |  |  |  |
|  | Strengthen | a)Training and Retraining of Data officers at all levels from the Public and Private Health Care Facilities on NHMIS Data Tools b)Availability of Internet Facilities   1. Availability of annual Statistical Bulletin 2. Rectification of non-Reporting Facilities on DHIS Platform |  |  |  |  |  |
|  | capacity to |  |  |  |
|  | generate, |  |  |  |
| 3 | transmit, analyze  and utilize routine health data, from | a) Primary and Secondary sources | Monthly | MOH in Collaboration with RSHMB/RSHMB/Partners |
|  | all health facilities, |  |  |  |
|  | including private |  |  |  |
|  | health facilities. |  |  |  |
|  | Improve |  |  |  |  |  |  |
|  | integration of |  |  |  |  |
|  | existing |  |  |  |  |
|  | surveillance | a)All programme units |  |  |  |
| 4 | systems and  diseases | Platform should be  made to link with the | a) Secondary | Monthly | DPRS FMOH |
|  | registries into the | DHIS Platform |  |  |  |
|  | overall health |  |  |  |  |
|  | information |  |  |  |  |
|  | system |  |  |  |  |
|  | Improve the | 1. meeting with HDCC member to update   them with the generated data   1. Brief to development Partners on the   outcome of the Data   1. inform management of the data generated for decision making |  |  |  |  |  |
|  | mechanism of an |  |  |  |
|  | integrated data |  |  |  |
| 5 | repository for data | a) Secondary | Monthly | DPRS MOH |
|  | sharing amongst |  |  |  |
|  | stakeholders at all |  |  |  |
|  | levels |  |  |  |
|  | **Process** | | | | | |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  | **Output** | | | | | |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  | **Outcome** | | | | | |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  | **Impact** | | | | | |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

#### Data Collection Plan and Management

* + 1. **Sources of Data for Health Sector Monitoring**

In order for the State M/E System to function, two (2) core data sources that feed into the HMIS have been identified. They are:

* + - 1. Data sources for routine (output) indicators and data set: These are routine data and reports from various levels (Primary, Secondary, and Tertiary). They include the routine data from health facilities and NGOs at lower levels of the health system.
      2. Data sources for impact and outcome assessment such as the periodic population based national and state surveys like national demographic and health survey, population census, special studies such as operational research, health facility surveys.

The health sector in the state utilizes a wide range of data sources at the health facility and programme levels such as immunization, roll-back malaria, tuberculosis and leprosy control. The ministry of health will use GPS devices and questionnaires to allow mapping of results, rapid data processing and report production that shall be integrated with the District Health Information System.

#### Data Collection Methods and Tools

Methods of Data Collection include:

* + - 1. Questionnaires, measurement and analysis
      2. Before and After surveys
      3. Central Data Source e.g DHIS Platform
      4. Departmental, Agency reports and Statistical records
      5. Field observation visits
      6. Stakeholders meetings
      7. Timelines
      8. Stakeholders meetings Sources of data in Health

1. Routine health information
2. Vital registration
3. Population census
4. Disease Surveillance
5. Surveys
6. National Health Accounts

#### Data Storage

The method of Data storage is by District Health Information System (DHIS) and it includes backups and data archiving on the computer.

**DATA FLOW AND USE**



**HMB**

**SMOH**

**MOH**

**RSPHCMB**

**FM**

**PARTNERS**

**DHIS**

**LGA M&E**

**LGA M&E**

**Primary Health Centers**

**BMSH**

**Private Health Facilities**

**Teaching Hospitals**

**General Hospitals**

#### 3.3.4.1 Data Flow

**Table 2**

**VHW.CORPS. CHIPPS**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Source** | **Collection** | **Collation and Storage** | **Analysis** | **Reporting** | **Use** |
| Health | Health Record | a) Data is | a)Provision of | The M/E officer, | Issues arising from the |
| Management | Officers(HIOs) from | aggregated | computers | who factored same | analysed data will be |
| Data | the service delivery | monthly from the | b) Uninterrupted | to DHIS Platform | forwarded to the |
|  | Point (Facilities | different Health | power supply |  | relevant authority for |
|  | Level) with the | Facilities. using | c)Training and |  | decision making |
|  | NHMIS Data Tool, | the various | Retraining of Staff |  | a) Planning |
|  | Daily | NHMIS Data |  |  | b)Research |
|  |  | Tool |  |  | c) Disease |
|  |  | b) At the Health |  |  | Surveillance |
|  |  | Facility Data is |  |  |  |
|  |  | stored in the |  |  |  |
|  |  | NHMIS Monthly |  |  |  |
|  |  | Summary |  |  |  |
|  |  |  |  |  |  |

#### 3.3.4.2. Data Use Plan Table 3

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***Decision Maker*** | ***Decision*** | ***Frequency of the Decision*** | ***Type of Information needed for the***  ***decision*** | ***Time in which the information will be***  ***produced*** |
| Facility/Institution: | | | | |
| Program officers, Chairman H/F Committee | Community sensitization, mobilization and  participation | Monthly | Level of patients patronage in the H/F | Monthly |
|  |  |  |  |  |
| LGA: | | | | |
|  |  |  |  |  |
| LGA Chairman, LGA Teams eg MOH, LIO, M&E  officer, ACCED, Health Educator. | Staffs strength, quality of care provided for the patient  (PCQA). | Regularly | Health facility Report, feedback from the patients and community members | Regularly |
| State: | | | | |
| Commissioner for Health,  Permanent Secretary, Director PRS, NHMIS Officer. | Human resources, drug and equipment, DQA. Etc. | Monthly, quarterly, mid- year and annually. | Report on data generated from the facilities via the LGA M&E Officers. | Monthly. |

* + 1. **Data Quality Management Plan**

All reports submitted to the Resource Centre and QAD will be reviewed for accuracy and clarification sought where necessary. Even where there is no need for clarification acknowledgement of receipt of reports will be provided before the due date for the subsequent report. Data quality assurance processes will include periodic Data Quality Audits (DQA) of recorded data by supervisors; regular training of staff, and provision of routine feedback to staff at all levels on completeness, reliability and validity of data; and data quality assessment and adjustment which will be carried out periodically. The objective of data validation is to ensure that the data used by the health sector to make decisions is sound and accurate. Specific efforts will be made to undertake data validity including:-application of the computed validation/data accuracy index into district annual reports; specific support for outliers; routine (quarterly) data checks on a sample of districts. Regular data quality assurance for facility based data including regular review and verification for accuracy and completeness will be carried out monthly by the health facility in- charges at all levels. All periodic reports should be checked and endorsed before submission to the relevant stakeholders. Periodic data validation, training and provision of feedback on the validity of health facility data will be carried out by the MoH, RC. DQA will be carried out at points of data collection, collation and analysis by the technical staff of the RC for districts and by the District

Statistician within districts. Standardized DQA tools will be developed for application at all levels. The Assistant Commissioner in charge of the RC will be responsible for the overall implementation of the activities on behalf of the sector. The RC will carry out regular training of staff, and provision of routine feedback on completeness, reliability and validity of data. DQA for sector evaluation studies shall be carried out using agreed formats by the MoH M&E.

**Table 4: Data Quality Management Plan**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Indicator** | **Data Quality Issues** | **Actions Taken or Planned to Address this Limitation** | **Additional Comments** |
| NHMIS Tool | Data Quality Assurance | Supportive Supervision | Use of checklist |

* + 1. **Data Use and Dissemination Plan 3.3.6.1Data Use**

**Table 5: Data Use and Dissemination Plan**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Indicator** | **Uses** | **Stakeholders** | **Mechanism** | **Format** | **Next Steps** |
| NHMIS  Data | 1. Health Planning 2. Research activities 3. Monitoring & Evaluation of Health system 4. Decision making by Management | 1. FMOH 2. SMOH 3. RSHMB 4. RSPHCMB 5. Development Partners 6. Health Data Consultative Committee 7. Data providers   & Users | The information is communicated through:   1. Meetings 2. Training 3. Data transmission to FMOH using the DHIS Platform | Through DHIS  Platform | 1. Monitoring of programs 2. Supportive supervision to Health workers 3. Follow up visit to check the progress made |

## 3.3.6.2 Dissemination Plan

Data is translated into information relevant for decision-making. Data will be packaged and disseminated in formats that are determined by management at the various levels. Service delivery data shall be packaged and displayed at the various health facilities using the HMIS formats already provided. The timing of information dissemination should fit in the planning cycles and needs of the users.

**Annual Health Statistical Report**

This report will be compiled from the periodic statistical reports submitted through the District Health Information System (HMIS). The annual health statistical report provides ample attention to data quality issues, including timeliness, completeness and accuracy of reporting, as well as adjustments and their rationale. The RC will be responsible for compiling and disseminating this report. Detailed data should also be available on the web.

**Quarterly Performance Review Reports**

Quarterly sector performance review reports will be presented by the various sector technical working groups and central level institutions during the sector quarterly review meetings. Quarterly district performance (Quarterly District League Table) will also be disseminated and discussed at this forum. At sub-national level (RRHs, LG, projects), quarterly assessment reports will be presented and discussed at the quarterly review meetings attended by the key implementers.

## 4. The SSHDP Governance, Monitoring and Review Process

### State Mechanism and Action

The functions of the Health Data Consultative Committee (HDCC) include:

1. Development of a harmonized data and comprehensive template to capture the various data generated at all levels of healthcare delivery; from the Primary, Secondary and Tertiary Health Facilities, and also from various programmes such as Malaria Eradication, Tuberculosis/Leprosy control, HIV/AIDS control, Emergency Medical Services, Immunization etc
2. Collection and aggregation of all relevant health data and information from all Local Government Areas within the State and stored at a central pool (i.e. the Health Data Bank in the Department of Planning, Research and Statistics of the Ministry of Health) in a uniform platform.
3. Timely forwarding/sharing of data to and with relevant departments, agencies and programmes operating at the State level.
4. Timely distribution of data tools to facilities providing healthcare in Primary, Secondary and Tertiary levels.
5. Immediate submission of data in epidemic diseases to the Epidemiology Division of the Department of Public Health of the Federal Ministry of Health
6. Preparation of a yearly State Health Profile for decision making, dissemination and feedback.
7. Addressing other critical issues in the State Health Data System, and
8. Suggestion of ways of improving data collection, collation, analysis and dissemination in all the health structures of the State.

The Health Data Governance Council (HDGC) is yet to be inaugurated in the State.

#### Performance Monitoring and Review at State level

The State usually holds monthly M&E coordination meeting where routine health data generated at facility/ LGA levels are analysed after collation.

It serves as a forum for providing feedback to head of facilities, state program managers and other key stakeholders collaborating with the ministry.

It also serves as a means of showcasing the importance of generating complete, quality data and provide timely submission of data to aid objective decision making on health programs and interventions.

### Performance Monitoring and Review at LGA level

A monthly data validation meeting with Health Information Officers in charge of Health Facilities, LGA level Programme Managers & Medical Officers of Health.

The RSPHCMB holds monthly PHC data record meeting with Partners, Board M&E Officers, LGA M&E Officers at the State level

### Performance monitoring and Review at Ward Level

The ward focal persons are to hold monthly ward technical review meeting where facility data are expected to be audited and necessary correction effected before transmitting to another level.

* 1. **Linkage between Health Sector Reviews, Disease Programs Specific Reviews and Global Reporting**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Number of presumptive TB cases identified  Number of bacteriologically confirmed TB cases  Number of bacteriologically confirmed TB cases that turns –**ve** at the end of the 2nd month of treatment  Number of clinically diagnosed TB cases  Number of diagnosed TB cases commenced on treatment  Number of under 6 contacts of bacteriologically confirmed TB patients placed on INH  Number of TB / HIV on CPT  Number of TB / HIV on ART  Number of drug resistant TB cases diagnosed  Number successfully enrolled for treatment | | Report | NTBLCP SMOH | 2nd week of every quarter |
| **A.** | **Disease Surveillance** |  |  |  |
| Number of AFP cases seen  Number of FRI cases | | Report | FMOH WHO | 1st week of the following  month |

## 5. SSHDP II Evaluation

SHDP II Evaluation is a process that critically examines the program. It involves collecting and analysing information about a program's activities, characteristics, and outcomes. Its purpose is to make judgments about a program, to improve its effectiveness, and/or to inform programming decisions.

In order to review the progress of SHDP II, the State will conduct mid and end term programme evaluation. This will be an avenue to get additional information such as activity outcomes and the quality of services provided.

End of SHDP II project evaluation will be used to judge the success of the programme activities and provides accountability to those that fund projects. It will also allow the programme to repeat activities that have been demonstrated to work and improve on them and let go of activities that do not work.

Evaluation of SHDP II will be conducted before, during and after the intervention to be able to make judgments about the intervention's effectiveness. However, for proper evaluation of SHDP II, the following activities will be done;

* Data Collection
* Data Analysis
* Data Interpretation
* Report writing
* Report dissemination

Activities that are currently being implemented and the evaluation questions they are addressing is tabulated below.

#### Table 6: Evaluation Activities Implemented

|  |  |  |  |
| --- | --- | --- | --- |
| **S/n** | **Implemented Activities** | **Programme** | **Evaluation Questions** |
| 1. | Quarterly Statistic Review  Meeting (TB) | TB | Programme Performance |
| 2. | Quarterly AOP Review Meeting | Malaria | Programme performance |
| 3. | Mid-Year AOP Review Meeting | Malaria | Programme performance |
| 4. | Quarterly FP Coordination  Meeting | Reproductive  Health | Programme Coordination |
| 5. | Quarterly RMNCH Core  Technical Committee Meeting | Reproductive  Health | Programme monitoring |
| 6. | End-of-year Review of Malaria  Operational Plan | Malaria | Programme performance |
| 7. | End-of-year Review Meeting | SASCP | Programme performance |

1. **Reporting Plan**

**Table 7**

The table below shows the data elements the State has been collecting, to whom it is submitted and time line for submission.

#### Table 7: Reporting Plan

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Data element** | | **Information Product** | **Recipient** | **Date** |
| (what you’ve been collecting) | | ***(specific*** | ***(SMOH,*** | ***(date*** |
|  | | ***report(s) based on a data element or grouping of data***  ***elements,*** | ***RSPHCMB, RSHMB, SACA, SASCP,***  ***developme*** | ***each report is due)*** |
|  | | ***indicators)*** | ***nt partner(s), implementi***  ***ng*** |  |
|  | |  | ***stakeholde***  ***r(s)*** |  |
| **1.** | **Immunization** |  |  |  |
| Number of Children Immunized for each RI antigen | | DVD-MT, DHIS |  | 3rd |
| Number of pregnant women vaccinated with TT | | DVD-MT, DHIS | RSPHCMB, | Week of the |
| Number of Vaccines supplied / used for each RI antigen | | DVD-MT | RSHMB, EU PRIME, WHO,  UNICEF | following month |
| **2. Reproductive Health** | | | | |
| Number of deliveries (Live & still Births) | | State type of report |  | 3rd |
|  | |  | SMOH | Week of |
| Number of Referrals | | RH Data, DHIS | RSPHCMB,  RSHMB, | the  following |
| Number of maternal deaths | |  | Partners | month |
|  | | RH Data, DHIS |  |  |
| Number of teenage pregnancies | |  |  |  |
|  | | RH Data, DHIS |  |  |
| Number of women accessing PNC | |  |  |  |
|  | | RH Data, DHIS |  |  |
| Number of persons accessing modern contraceptives | | RH Data, DHIS |  |  |
|  | | RH Data, DHIS |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **1. HIV/AIDS** | | | |
| Number of individuals counselled tested, and received results for HIV. | ENMRRNS |  |  |
| Number of individual who tested +ve for HIV | ENMRRNS |  |  |
| Number of New ANC booking | ENNMIRS |  |  |
| Number of pregnant women tested for HIV | ENNMIRS |  |  |
| Number of pregnant women who tested +ve for HIV  Number of +ve women who received prophylaxis | ENNMIRS  ENNMIRS ENNMIRS | SASCP SMOH, RSPHCMB, RSHMB,  Partners | 3rdweek of the following month |
| Number of Live Birth | ENNMIRS |  |  |
| Number of exposed babies who received ARV drugs. | ENNMIRS |  |  |
| Number of persons newly enrolled into care | ENNMIRS |  |  |
|  | ENNMIRS |  |  |
| Number of persons who started ART |  |  |  |
| Number of persons currently on ARV drugs |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **1. Malaria** |  |  |  |
| Number of pregnant women who received at least 2 doses of SP for  IPT | DHIS |  |  |
| Number of pregnant women who received LLINs during ANC visit  Number of under 5 children who received LLIN at the completion of Immunization  Number of persons presenting at the facility with fever who received a diagnostic test (RDT or Microscopy) for Malaria | DHIS  DHIS  DHIS  DHIS | SMOH SMEP RSPHCMB RSHMB  Partners/ Stakeholder s | 3rdweek of the following month |
| Number of persons that tested +ve for malaria (uncomplicated or severe) that received malaria treatment according to National Treatment Guidelines | DHIS  DHIS |  |  |
| Number of under 5 that tested +ve for malaria (uncomplicated or severe) that received malaria treatment according to National Treatment Guidelines | DHIS |  |  |
| Number of above 5 tested +ve for malaria (uncomplicated or severe) that received malaria treatment according to National Treatment Guidelines | DHIS |  |  |
| Number of facilities with stock out of ACT lasting more than 1 week Number of secondary facilities with stock out of Injectable Artesunate lasting more than 1 week |  |  |  |
|  | DHIS |  |  |
| Number of facilities with stock out of  RDT lasting more than 1 week |  |  |  |
|  | DHIS |  |  |
| Number of facilities with stock out of  LLIN lasting more than 1 week |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **1. TUBERCULOSIS** |  |  |  |
| Number of presumptive TB cases identified  Number of bacteriologically confirmed TB cases  Number of bacteriologically confirmed TB cases that turns –ve at the end of the 2nd month of treatment  Number of clinically diagnosed TB cases  Number of diagnosed TB cases commenced on treatment  Number of under 6 contacts of bacteriologically confirmed TB patients placed on INH  Number of TB / HIV on CPT  Number of TB / HIV on ART  Number of drug resistant TB cases diagnosed  Number successfully enrolled for treatment | Report | STBLCP SMOH RSPHCMB | 3rdweek of every quarter |
| **2. Disease Surveillance** |  |  |  |
| Number of AFP cases seen  Number of FRI cases | Report | SMOH RSPHCMB FMOH  WHO | 3rd week of every month |
| **3. DATA SETS AS STATED IN NHMIS DATA TOOLS** | DHIS | SMOH, RSPHCMB RSHMB SACA, SASCP,  developme nt partners  etc. | 3rd week of every month |

**Strategic objectives:**

* 1. To provide health sector-wide framework for tracking progress and demonstrating results of the SSHDP II over a period.

Activities for this objective may include:

* + - Develop an M&E plan for the SSHDP II
    - Develop M&E plan for MDAs and other health-related institutions.
  1. To facilitate effective and functional M&E system through the empowering of governance structures

Activities for this objective could include:

* + - The setting of M&E processes and structures such as TWGs, Technical Tasks Teams, etc.
  1. Build capacity of SMOH, MDAs, SPHCDA/B to be able to effectively track progress of the implementation of their SHDP

Activities to be carried out could include:

* + - Training and retraining of Health records workers on data management
    - Development training packages on M&E
    - Development of tools and indicator harmonization
  1. To facilitate learning and knowledge management Activities could include:
     + Development of information products
     + Conduct technical review meetings
     + Conduct data demand and use trainings
     + Carry out documentation and knowledge sharing
     + To generate bulletins for all levels of health care delivery
  2. To promote stakeholders' participation in the management of health data and support evidence based programming
     + Hold meetings to agree on roles and responsibilities.
     + Conduct advocacy and other activities that will lead to increased awareness, transparency and accountability.

## SSHDP 11 M &E Plan Implementation Arrangement

* 1. **Key SSPDP II M&E Plan Implementation Tasks**

The monitoring and evaluation (M/E) framework provides the strategy and guidelines to persons employed to monitor and evaluate the SSHDP and the key and priority areas. The framework includes all the indicators in the state result matrix and indicators for monitoring the HP+ country compact.

The M/E Plan is a written proposal that serves as a guide for carrying out a monitoring and evaluation exercise. It provides information and instructions to enable a complete and valid execution of the M/E activity, whether monitoring of activities and results or valuation of outcomes and impacts. It is the document that bears the terms of reference for the questions and the methodology proposed for the data collection, processing and reporting.

For the monitoring and evaluation of the SSHDP, the M/E plan should outline the following basic 6 sections:

* + 1. Background information on the programme to be executed in terms of its context within which it operates and a situational project description of its resources, activities and result obtained so far on the key performance indicators.
    2. Objectives of M/E are written as statements of purposes of the M/E and the specific key M/E questions that outline why the particular M/E event is being carried out and the answers it seeks with evidence on which the conclusions and recommendations in the M/E report will be based.
    3. Methodology and framework of the M/E design that outlines how the data collection and reporting will be done during the M/E exercise. This M/E design framework enables the development of data collection tools that are appropriate and relevant to the collection of data for the M/E indicators and variables
    4. M/E Team membership responsibilities, schedule of itinerary and timelines and as well as deliverables and deadlines for completion of the M/E exercise and submission and dissemination of the report.

Annex of data collection tools

* + 1. A guideline or template for preparing a full M/E plan.
  1. **Roles and Responsibilities**

The planning and review committee shall be the body responsible for organizing and implementing the quarterly and annual review meeting. The committee will be responsible for implementing strategies designed for the review, coordinating all meetings and ensuring the system of feedback is established between State level, National and other partners. The committee will also establish the costs of the review and source for funding products and use of the data for decision making and programming.

Monitoring and evaluation are most successful when stakeholders have an established role in M&E. To help initiate this process, setting up an M&E Team will be helpful in integrating key concepts of M&E, such as data use and data quality.

The table below shows the various stakeholders and their responsibilities:

#### Table 8: Stakeholders and Their Responsibilities

|  |  |  |
| --- | --- | --- |
| **Sn** | **Players** | **Responsibilities** |
| 1. | Honourable Commissioner for Health | Head / Policy decision maker |
| 2. | Permanent Secretary, MOH | Technical Head / Chief Accounting  Officer |
|  | Permanent Secretary/Executive  Secretary, RSPHCMB | Technical Head / Chief Accounting  Officer |
| 3. | DPRS (MOH, RSHMB, RSPHCMB) | Operational Heads |
| 4. | DPH ( MOH), DCHS, DDCS, DE OHS  (RSPHCMB) | Operational Heads |
| 5. | Program Managers (Malaria, TB, SASCP, Immunization, Nutrition, Reproductive Health, Eye Care &  Food Hygiene, MCH | Data quality and management |
| 6. | Monitoring and Evaluation Officers  (SMOH, RSHMB, RSPHCMB) | Data Quality Assurance and Data  Management & Capturing |
| 7. | Facility Data Managers | Data collection and capturing from  facilities |

1. **SSHDP II Costed M&E Workplan**

**Table 9: SSHDP II Costed M&E Workplan**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ***S/N*** | ***Activity Description*** | ***Timeline*** | ***Cost*** | ***Responsible*** | ***Assumption***  ***/Remarks*** |
| 1 | M&E Technical working Group | Monthly |  | DPRS (SMOH) | Mid-term and End term of the strategic  plan |
| 2 | M&E activities | Monthly |  | DPRS (SMOH, RSHMB,  RSPHCMB) | Review the monitoring/  evaluation plan |
| 3 | Monitoring and Supervision | Monthly or Quarterly |  | DPRS (SMOH, RSHMB, RSPHCMB) | To carry out M/E on NHMIS data entry |
| 4 | Data quality Assessment | Monthly |  | DPRS/ HDCC  (SMOH, RSHMB, RSPHCMB) | To assess the quality of data: Primary, Secondary,  Tertiary |

Cyan Yellow Black

**Appendices**

## SSHDP II M&E KEY INDICATORS

***A. Matrix of Key Indicators***

**SSHDP II M&E KEY INDICATORS**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **N/SSHDP II Framework** | | | **National Indicators** | **State Modified National Indicators** | **Indic ator Level** | **Indicat or Type** | **Nati onal Bas elin e 201**  **6** | **State/LGA Baseline & Target** | | | | | | **National Target 2022** | **Remark**  **/ Comme nts** |
| **Goals (Priority Areas)** | **NSHDP II Strategic Objectives** | | **17** | **18** | **19** | **20** | **21** | **22** |
|  |  |  | * % of | * % of |  |  |  |  |  |  |  |  |  |  |  |
|  |  | Provide | coordination | coordination |  |  |  |  |  |  |  |  |  |  |
|  |  | clear | organs at | organs at |  |  |  |  |  |  |  |  |  |  |
|  |  | policy, | national and | national and |  |  |  |  |  |  |  |  |  |  |
|  |  | plans, a | subnational | subnational |  |  |  |  |  |  |  |  |  |  |
| 1. Provide | 1.1 | legislativ e and regulator  y | levels (NCH, SCH, WDC,  Health  Partners | levels (NCH, SCH, WDC,  Health  Partners | **Outc ome** | **Global Indicat ors** | **TBD** | **45%** | **50%** | **55%** | **60%** | **65%** | **70%** | **70%** |
| effective |  | framewor | Coordination | Coordination |  |  |  |  |  |  |  |  |  |  |
| leadership |  | k for the | Committee) | Committee) |  |  |  |  |  |  |  |  |  |  |
| and an |  | health | that are | that are |  |  |  |  |  |  |  |  |  |  |
| enabling |  | sector | established/f | established/f |  |  |  |  |  |  |  |  |  |  |
| policy |  |  | unctional | unctional |  |  |  |  |  |  |  |  |  |  |
| environment |  | Strength en transpare ncy and accounta bility in planning, budgetin g and procurem ent  process |  | % of LGAs that increased annual budget implementati on rate by 25 percent |  | ***Key Perfor mance Indicat or*** |  |  |  |  |  |  |  |  |  |
| that ensures |  |  |  |  |  |  |  |  |  |  |  |
| adequate |  |  |  |  |  |  |  |  |  |  |  |
| oversight |  | * % of States' |  |  |  |  |  |  |  |  |  |
| and |  | that |  |  |  |  |  |  |  |  |  |
| accountabilit |  | increased |  |  |  |  |  |  |  |  |  |
| y for the  delivery of | 1.2 | annual  budget | **Outc**  **ome** | **TBD** | **0%** | **0%** | **2%** | **5%** | **7%** | **10%** | **25%** |
| quality |  | implementati |  |  |  |  |  |  |  |  |  |
| health care |  | on rate by 25 |  |  |  |  |  |  |  |  |  |
| for the |  | percentage |  |  |  |  |  |  |  |  |  |
| sustainable |  |  |  |  |  |  |  |  |  |  |  |
| development |  |  |  |  |  |  |  |  |  |  |  |
| of the |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| national |  | Improve |  | Proportion |  |  |  |  |  |  |  |  |  |  |
| health |  | health | * Proportion | of State |  |  |  |  |  |  |  |  |  |  |
| system |  | sector | of Federal | Level MDAs |  |  |  |  |  |  |  |  |  |  |
|  |  | performa | Level MDAs | and 23 LGA |  | ***Key*** |  |  |  |  |  |  |  |  |
|  | 1.3 | nce  through regular | and 36 SMOH+ FCT  HSS publish | publish  annual state of health | **Outc ome** | ***Perfor***  ***mance Indicat*** | **TBD** | **5%** | **5%** | **8%** | **10%** | **12%** | **15%** | **decrease**  **by 50% of Baseline** |
|  |  | integrate | annual state | report |  | ***or*** |  |  |  |  |  |  |  |  |
|  |  | d reviews | of health |  |  |  |  |  |  |  |  |  |  |  |
|  |  | and | report. |  |  |  |  |  |  |  |  |  |  |  |
|  |  | reports |  |  |  |  |  |  |  |  |  |  |  |  |

Cyan Magenta Yellow Black 66

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1.4 | Strengthe n coordinati on, harmoniza tion and alignment at all  levels |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Same indicator as 1.1 | Same indicator as 1.1 |  |  |  | **45%** | **50%** | **55%** | **60%** | **65%** | **70%** |  |  |
| 2.1 | To strengthen communit y level coordinati on mechanis ms and capacities for health  planning. | * % of PHCs with functional Ward Development Committees; | * % of PHCs with functional Ward Development Committees; | **Outco me** | ***Key Perform ance Indicato r*** | **TBD** | **7%** | **10%** | **12%** | **14%** | **16%** | **18%** | **decrease by 50% of Baseline** |  |
| 2.2 | To strengthen communit y engageme nt in the implement ation, monitoring and evaluation of health  programs |  |  |  |  |  | **TBD** | **10%** | **12%** | **14%** | **16%** | **18%** | **Increase by 50% from baseline** |  |
| 3.1 | Ensure that collaborati ve mechanis ms are put in place for involving all partners in the developm ent and sustenanc e of the health  sector | * % of the funding of health from partners (development partners and private sector) that is aligned with the National Health Policy and National Strategic Health Plan by 2022 | * % of the funding of health from partners (development partners and private sector) that is aligned with the National Health Policy and National Strategic Health Plan by 2022 | **Outco me** | **Global Indicato rs** | **TBD** | **10%** | **10%** | **12%** | **14%** | **16%** | **18%** | **30%** |  |
| 1.4 | Strengthen coordinatio n, harmonizati on and alignment  at all levels | Same indicator as 1.1 | Same indicator as 1.1 |  |  |  | **45%** | **50%** | **55%** | **60%** | **65%** | **70%** |  |  |

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|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 2.To  promote community engagement for sustainable health development | 2.1 | To strengthe n communi ty level coordinat ion mechanis ms and capacitie s for health  planning. | * % of PHCs with functional Ward Development Committees; | * % of PHCs with functional Ward Developmen t Committees; | **Outc ome** | ***Key Perfor mance Indicat or*** | **TBD** | **7%** | **10%** | **12%** | **14%** | **16%** | **18%** | **decrease by 50% of Baseline** |  |
| 2.2 | To strengthe n communi ty engagem ent in the impleme ntation, monitorin g and evaluatio n of health  programs |  |  |  |  |  | **TBD** | **10%** | **12%** | **14%** | **16%** | **18%** | **Increase by 50% from baseline** |  |
| 3. Enhance harmonized implementati on of essential health services in line with national health policy goals. | 3.1 | Ensure that collabora tive mechanis ms are put in place for involving all partners in the develop ment and sustenan ce of the health  sector | * % of the funding of health from partners (development partners and private sector) that is aligned with the National Health Policy and National Strategic Health Plan by 2022 | * % of the funding of health from partners (developmen t partners and private sector) that is aligned with the National Health Policy and National Strategic Health Plan by 2022 | **Outc ome** | **Global Indicat ors** | **TBD** | **10%** | **10%** | **12%** | **14%** | **16%** | **18%** | **30%** |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 4. Promote universal access to comprehensi ve quality sexual and reproductive health services throughout the life cycle and reduce maternal, neonatal, child and adolescent morbidity and mortality in Nigeria | 4.1 | Reduce maternal mortality and morbidity through the provision of timely, safe, appropria te and effective healthcar e services before, during and after child birth. | * Maternal mortality ratio | * Maternal   mortality ratio | **Impa ct** | **Global**  **Indicat ors** | **576/**  **100,**  **000** | **576/100**  **,000** | **576/100**  **,000** | **550/100**  **,000** | **500/100**  **,000** | **450/100**  **,000** | **374/100**  **,000** | **374/**  **100,000** |  |
| * % of deliveries by Skilled attendance | * % of deliveries by Skilled attendance | **Outc ome** | ***Key Perfor mance Indicat***  ***or*** | **38%** | **79%** | **84%** | **85%** | **86%** | **90%** | **92%** | **57%** |  |
| * % of Primary/War d Health Centers providing basic Emergency Obstetric and neonatal care services disaggregate d by Level of care | * % of Primary/War d Health Centers providing basic Emergency Obstetric and neonatal care services disaggregate d by Level of   care | **Outp ut** | ***Key Perfor mance Indicat or*** | **TBD** | **45%** | **47%** | **49%** | **51%** | **53%** | **55%** | **80%** |  |
| 4.2 | Strength en preventio n, treatment and rehabilita tion services for fistula care in  Nigeria | * Incidence rate of obstetrics fistula | * Incidence rate of obstetrics fistula | **Impa ct** | ***Key Perfor mance Indicat***  ***or*** | **TBD** | **5%** | **4%** | **3%** | **2%** | **1%** | **1%** | **decrease by 50% of Baseline** |  |
| * % of treated obstetrics fistula cases reintegrated into their communities | * % of treated obstetrics fistula cases reintegrated into their communities | **Outc ome** | ***Key Perfor mance Indicat or*** | **TBD** | **50%** | **50%** | **60%** | **70%** | **80%** | **90%** | **75%** |  |
| 4.3 | Promote demand and increase access to sexual and reproduct ive health services (familly planning and post abortion care) | • Contraceptiv e prevalence rate | • Contraceptiv e prevalence rate | **Outc ome** | ***Key Perfor mance Indicat***  ***or*** | **15%** | **84%** | **85%** | **86%** | **87%** | **88%** | **89%** | **23%** |  |
| * Proportion of women of reproductive age (15 -49 years) who have their needs for family planning satisfied with modern   methods | * Proportion of women of reproductive age (15 -49 years) who have their needs for family planning satisfied with modern   methods | **Outp ut** | **Global Indicat ors** | **3%** | **84%** | **85%** | **86%** | **87%** | **88%** | **89%** | **7%** |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Reduce neonatal and | * Neonatal mortality rate | * Neonatal mortality rate | **Impac t** | **Global Indicato rs** | **37/10**  **00** | **18** | **17** | **16** | **15** | **14** | **13** | **18/1000** |  |
|  | childhood mortality and  promote | * Infant mortality rate | * Infant mortality rate | **Impac t** | **Global Indicato rs** | **75/10**  **00** | **41** | **40** | **39** | **38** | **37** | **36** | **38/1001** |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | optimal |  |  |  |  |  |  |  |  |  |  |  |  |
|  | growth, |  |  |  |  |  |  |  |  |  |  |  |  |
| 4.4 | protection |  |  |  |  |  |  |  |  |  |  |  |  |
|  | and |  |  |  |  |  |  |  |  |  |  |  |  |
|  | developm ent of all newborns  and | * Under-five mortality rate | * Under-five mortality rate | **Impac t** | **Global Indicato rs** | **128/1**  **000** | **56** | **55** | **54** | **53** | **52** | **51** | **64/1000** |
|  | children |  |  |  |  |  |  |  |  |  |  |  |  |
|  | under five |  |  |  |  |  |  |  |  |  |  |  |  |
|  | years of |  |  |  |  |  |  |  |  |  |  |  |  |
|  | age. |  |  |  |  |  |  |  |  |  |  |  |  |
| 4.5 | Improve access to adolescen t health and young people | * Adolescent birth rate per 1000 women aged 10 - 19 | * Adolescent birth rate per 1000 women aged 10 - 19 | **Outco me** | **Global Indicato rs** | **TBD** | **18%** | **17%** | **16%** | **15%** | **14%** | **13%** | **decrease by 50% of Baseline** |  |
|  | informatio n and  services | years | years |  |  |  |  |  |  |  |  |  |  |
|  | Improve the nutritional status of  Nigerians | * Exclusive breastfeeding rate in the first six months of   life | * Exclusive breastfeeding rate in the first six months of   life | **Outco me** | ***Key Perform ance Indicato***  ***r*** | **TBD** | **32%** | **34%** | **36%** | **38%** | **40%** | **42%** | **increase by 60% of Baseline** |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | throughout |  |  |  | ***Key*** |  |  |  |  |  |  |  |  |
|  | their life cycle with  a | * Incidence of   low birth weight | * Incidence of   low birth weight | **Impac t** | ***Perform***  ***ance Indicato*** | **TBD** | **30%** | **25%** | **20%** | **15%** | **10%** | **5%** | **decrease**  **by 50% of Baseline** |
|  | particular |  |  |  | ***r*** |  |  |  |  |  |  |  |  |
| 4.6 | focus on vulnerable groups especially children  under five | * Prevalence of malnutrition in children aged 0 - 59   months | * Prevalence of malnutrition in children aged   0 - 59 months | **Impac t** | **Global Indicato rs** | **18%** | **8%** | **7%** | **6%** | **5%** | **4%** | **3%** | **10%** |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | years, adolescen ts, women of | * Prevalence of wasting among under-   fives | * Prevalence of wasting among under-   fives | **Impac t** | **Global Indicato rs** | **18%** | **5%** | **5%** | **4%** | **4%** | **3%** | **3%** | **10%** |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | reproducti | * Proportion | * Proportion (%) of women of reproductive age with   anaemia |  | ***Key*** |  |  |  |  |  |  |  |  |  |
|  | ve age  and the elderly | (%) of women of reproductive  age with | **Outco me** | ***Perform***  ***ance Indicato*** | **TBD** | **10%** | **9%** | **8%** | **7%** | **6%** | **5%** | **decrease by 15% of**  **Baseline** |
|  |  | anaemia |  | ***r*** |  |  |  |  |  |  |  |  |
|  |  | * Prevalence of overweight among under- five | * Prevalence of overweight among under- five | **Outco me** | **Global Indicato rs** | **TBD** | **3%** | **3%** | **2%** | **2%** | **1%** | **1%** | **decrease by 50% of Baseline** |  |
|  |  | Reduce significantl y morbidity and mortality due to Malaria and move towards pre- elimination levels | * % of care | * % of care |  |  |  |  |  |  |  |  |  |  |  |
| 5. To improve prevention,  case detection |  | seeking persons with suspected  malaria that | seeking persons with suspected  malaria that | **Outco me** | **Other custom indicato** | **TBD** | **80%** | **75%** | **70%** | **65%** | **60%** | **55%** | **80%** |
| and |  | are tested | are tested |  | **rs** |  |  |  |  |  |  |  |  |
| coordinated response for |  | using RDT or  microscopy | using RDT or  microscopy |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| the prevention, control and  management | 5.1 | * Malaria   incidence per 1000  population | * Malaria   incidence per 1000  population | **Impac t** | **Global Indicato rs** | **TBD** | **60%** | **59%** | **58%** | **57%** | **56%** | **55%** | **decrease by 80% of Baseline** |
| of communicable diseases and NTDs |  | * Prevalence of malaria in pregnancy and children | * Prevalence of malaria in pregnancy and children | **Outco me** | ***Key Perform ance Indicato***  ***r*** | **TBD** | **20%** | **18%** | **16%** | **14%** | **12%** | **8%** | **decrease by 80% of Baseline** |  |
|  |  | Reduce significantl y morbidity and mortality due to Malaria and move towards pre- elimination levels | * % of care | * % of care |  |  |  |  |  |  |  |  |  |  |  |
|  |  | seeking | seeking |  |  |  |  |  |  |  |  |  |  |
|  |  | persons with | persons with |  | **Other** |  |  |  |  |  |  |  |  |
|  |  | suspected  malaria that | suspected  malaria that | **Outco**  **me** | **custom**  **indicato** | **TBD** | **80%** | **75%** | **70%** | **65%** | **60%** | **55%** | **80%** |
|  |  | are tested | are tested |  | **rs** |  |  |  |  |  |  |  |  |
|  |  | using RDT or | using RDT or |  |  |  |  |  |  |  |  |  |  |
|  |  | microscopy | microscopy |  |  |  |  |  |  |  |  |  |  |
|  |  | * Malaria incidence per 1000 population | * Malaria incidence per 1000 population | **Impac t** | **Global Indicato rs** | **TBD** | **60%** | **59%** | **58%** | **57%** | **56%** | **55%** | **decrease by 80% of Baseline** |  |
|  | 5.1 | * Prevalence of malaria in pregnancy and children | * Prevalence of malaria in pregnancy and children | **Outco me** | ***Key Perform ance Indicato***  ***r*** | **TBD** | **20%** | **18%** | **16%** | **14%** | **12%** | **8%** | **decrease by 80% of Baseline** |  |
|  |  | * % of health | * % of health |  | ***Key Perform ance Indicato r*** |  |  |  |  |  |  |  |  |  |
|  |  | facilities | facilities |  |  |  |  |  |  |  |  |  |
|  |  | reported | reported |  |  |  |  |  |  |  |  |  |
|  |  | stockout of | stockout of |  |  |  |  |  |  |  |  |  |
|  |  | diagnostic kits  and ACTs | diagnostic kits  and ACTs | **Outpu**  **t** | **TBD** | **5%** | **4%** | **3%** | **2%** | **1%** | **0%** | **<10%** |
|  |  | lasting more | lasting more |  |  |  |  |  |  |  |  |  |
|  |  | than one week | than one week |  |  |  |  |  |  |  |  |  |
|  |  | in the past | in the past |  |  |  |  |  |  |  |  |  |
|  |  | three months | three months |  |  |  |  |  |  |  |  |  |

5.2

Ensure universal access to high quality, client- centred TB/Lepros y diagnosis and treatment services for the reduction in the incidence and prevalenc e of tuberculos is/leprosy in Nigeria.

* TB incidence per 1000 population
* TB prevalence rate
* TB mortality rate

Treatment Success rate for MDR-TB

* Incidence of HIV infections by age and sex among the key and general populations
* TB incidence per 1000 population
* TB prevalence rate
* TB mortality rate

Treatment Success rate for MDR-TB

* Incidence of HIV infections by age and sex among the key and general populations

**Outco me**

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**Global Indicato rs**

***Key Perform ance***

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| ***Indicato***  ***r*** |  |  | | | | | |
| ***Key*** |  |
| ***Perform***  ***ance*** | **TBD** | **10%** | **9%** | **8%** | **7%** | **6%** | **5%** |
| ***Indicato*** |  |  |  |  |  |  |  |
| ***r*** |  |  |  |  |  |  |  |
| ***Key*** |  |  |  |  |  |  |  |
| ***Perform*** |  |  |  |  |  |  |  |
| ***ance*** | **TBD** | **79%** | **80%** | **81%** | **82%** | **83%** | **85%** |
| ***Indicato*** |  |  |  |  |  |  |  |
| ***r*** |  |  |  |  |  |  |  |

**Global Indicato rs**

**TBD**

**TBD**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **23,000/1** | **23,000/1** | **23,000/1** | **23,000/1** | **23,000/1** | **23,000/1** | **decrease by** |
| **00,000** | **00,000** | **00,000** | **00,000** | **00,000** | **00,000** | **60% of Baseline** |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **21,000/1** | **21,000/1** | **21,000/1** | **21,000/1** | **21,000/1** | **21,000/1** |
| **00,000** | **00,000** | **00,000** | **00,000** | **00,000** | **00,000** |

**TBD 6%**

**6% 5%**

**5% 4%**

**decrease by 60% of Baseline**

**decrease by 50% of Baseline**

**100%**

**decrease**

**4% by 70% of Baseline**

5.3

Significant ly reduce the incidence and prevalenc e of HIV/AIDS

in Nigeria by 2021

* Coverage of HIV testing Services
* Incidence of Mother-to-child transmission of HIV
* % of diagnosed PLHIV receiving quality HIV treatment services
* Coverage of HIV testing Services
* Incidence of Mother-to- child transmission of HIV
* % of diagnosed PLHIV receiving quality HIV treatment services

**Outco me**

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***Key Perform ance Indicato r***

**30%**

**TBD**

**TBD**

**79%**

**18%**

**10%**

**80%**

**17%**

**15%**

**81%**

**16%**

**20%**

**82%**

**15%**

**25%**

**83%**

**14%**

**30%**

**84%**

**13%**

**35%**

**60%**

**0%**

**90%**

5.4

5.5

Reduce the incidence, morbidity and mortality due to viral hepatitis.

Reduce morbidity, disability and mortality

due to

targeted Neglected Tropical Diseases (NTDs) and improve the

quality of life

of those affected

* % of diagnosed PLHIV on ARV who achieve sustained virological suppression
* Prevalence of vaccine- preventable viral hepatitis
* Incidence of viral hepatitis B per 100,000 population
* Prevalence of targeted NTDs
  + % of diagnosed PLHIV on ARV who achieve sustained virological suppression
  + Prevalence of vaccine- preventable viral hepatitis
  + Incidence of viral hepatitis B per 100,000 population
  + Prevalence of targeted NTDs

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**TBD**

**TBD**

**20%**

**40%**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **60%** | **55%** | **50%** | **45%** | **40%** | **35%** |
| **250/100,** | **240/100,** | **230/100,** | **220/100,** | **210/100,** | **200/100,** |
| **00** | **000** | **000** | **000** | **000** | **000** |

**25%**

**38%**

**30%**

**36%**

**35%**

**34%**

**40%**

**32%**

**45%**

**30%**

**90%**

**decrease by 50% of Baseline**

**decrease by 50% of Baseline**

**decrease by 60% of Baseline**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | Reduce | * Mortality from NCDs (cardiovascul ar diseases, cancer, diabetes, sickle cell diseases or chronic respiratory diseases.) | * Mortality from NCDs (cardiovascu lar diseases, cancer, diabetes, sickle cell diseases or chronic respiratory diseases.) |  |  |  |  |  |  |  |  |  |  |  |
|  |  | morbidity |  |  |  |  |  |  |  |  |  |  |
|  |  | and |  |  |  |  |  |  |  |  |  |  |
|  |  | mortality |  |  |  |  |  |  |  |  |  |  |
|  |  | due to |  |  |  |  |  |  |  |  |  |  |
|  |  | NCDs |  |  |  |  |  |  |  |  |  |  |
|  |  | (Cancers |  |  |  |  |  |  |  |  |  |  |
|  |  | , |  |  |  |  |  |  |  |  |  |  |
|  |  | Cardiova |  |  |  |  |  |  |  |  |  |  |
|  | 6.1 | scular Diseases  , Chronic  Obstructi | **Impa ct** | **Global Indicat ors** | **TBD** | **58%** | **56%** | **54%** | **52%** | **50%** | **48%** | **decrease by 20% of Baseline** |
|  |  | ve |  |  |  |  |  |  |  |  |  |  |
|  |  | Airway |  |  |  |  |  |  |  |  |  |  |
|  |  | Diseases |  |  |  |  |  |  |  |  |  |  |
|  |  | , |  |  |  |  |  |  |  |  |  |  |
|  |  | Diabetes |  |  |  |  |  |  |  |  |  |  |
|  |  | and |  |  |  |  |  |  |  |  |  |  |
|  |  | Sickle |  |  |  |  |  |  |  |  |  |  |
| 6. To reduce the |  | Cell  Disease) |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  | ***Key Perfor mance Indicat or*** |  |  |  |  |  |  |  |  |  |
| burden of |  | Promote | * % of the | * % of the |  |  |  |  |  |  |  |  |  |
| morbidity, |  | the | elderly in | elderly in |  |  |  |  |  |  |  |  |  |
| mortality and |  | health | Nigeria | Nigeria |  |  |  |  |  |  |  |  |  |
| disability  due to | 6.2 | and  wellbeing | accessing  basic and | accessing  basic and | **Outc**  **ome** | **TBD** | **5%** | **5%** | **10%** | **20%** | **30%** | **40%** | **50%** |
| noncommuni |  | of the | long term | long term |  |  |  |  |  |  |  |  |  |
| cable |  | elderly in | care | care |  |  |  |  |  |  |  |  |  |
| diseases |  | Nigeria |  |  |  |  |  |  |  |  |  |  |  |
|  |  | To improve the mental health | * Incidence of mental illnesses in Nigeria | Incidence of mental illness in Rivers State | **Impa ct** | ***Key Perfor mance Indicat***  ***or*** | **TBD** | **40%** | **38%** | **36%** | **34%** | **32%** | **30%** | **decrease by 20% of Baseline** |  |
|  | Harmful use of alcohol in terms per capita consumption among adults (persons aged 15 years and above) per annum in litres of pure  alcohol |  |  |  |  |  |  |  |  |  |  | *Need to get an operatio nal definitio n of national context of harmful alcohol use* |
|  |  | and |  |  |  |  |  |  |  |  |  |  |  |
|  |  | psychoso | Harmful use |  |  |  |  |  |  |  |  |  |  |
|  |  | cial | of alcohol in |  |  |  |  |  |  |  |  |  |  |
|  |  | wellbeing | terms per |  |  |  |  |  |  |  |  |  |  |
|  | 6.3 | of | capita |  |  |  |  |  |  |  |  |  |  |
|  |  | Nigerian | consumption |  |  |  |  |  |  |  |  |  |  |
|  |  | populace by  reducing | among adults  (persons aged 15 | **Outc ome** | **Global**  **Indicat ors** | **TBD** | **70%** | **68%** | **66%** | **64%** | **62%** | **60%** | **60%** |
|  |  | the | years and |  |  |  |  |  |  |  |  |  |  |
|  |  | prevalen | above) per |  |  |  |  |  |  |  |  |  |  |
|  |  | ce of | annum in |  |  |  |  |  |  |  |  |  |  |
|  |  | serious, | litres of pure |  |  |  |  |  |  |  |  |  |  |
|  |  | moderate | alcohol |  |  |  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 7. Ensure equitable, safe, appropriate, quality, and effective medical and laboratory services to meet current and future needs |  | and mild mental illnesses and substance use disorders. | Coverage of treatment interventions (pharmacologi cal, psychosocial, rehabilitation and aftercare services) for substance use  disorders | Coverage of treatment interventions (pharmacologi cal, psychosocial, rehabilitation and aftercare services) for substance use  disorders | **Outpu t** | **Global Indicato rs** | **TBD** | **5%** | **15%** | **20%** | **25%** | **30%** | **35%** | **60%** |  |
| 6.4 | Promote optimal oral health in Nigeria. | * Incidence of oral diseases (e.g. dental caries, gingivitis, cancrum oris   etc.) | * Incidence of oral diseases (e.g. dental caries, gingivitis, cancrum oris   etc.) | **Impac t** | ***Key Perform ance Indicato r*** | **TBD** | **70%** | **65%** | **60%** | **55%** | **50%** | **54%** | **decrease by 40% of Baseline** |  |
| * % of PHCs providing basic package of oral care | * % of PHCs providing basic package of oral care | **Outpu t** | ***Key Perform ance Indicato r*** | **TBD** | **10%** | **10%** | **20%** | **30%** | **40%** | **50%** | **60%** |  |
| 6.5 | Eliminate avoidable blindness, and reduce the burden of various visual impairmen t  conditions. | * % of blind and visually impaired persons who have adequate access to eye treatment and rehabilitative services | * % of blind and visually impaired persons who have adequate access to eye treatment and rehabilitative services | **Outco me** | ***Key Perform ance Indicato r*** | **TBD** | **30%** | **35%** | **40%** | **45%** | **50%** | **55%** | **70%** |  |
| 7.1 | Strenght en the provision of health services at public and private health facilities that are appropria te, accessibl e and meet minimum quality and safety standard for optimized health outcome  s | * Health facility Case fatality rates | * Health facility Case fatality rates | **Outc ome** | ***Key Perfor mance Indicat***  ***or*** | **TBD** | **40%** | **38%** | **36%** | **34%** | **32%** | **30%** | **30%** |  |
| * Client satisfaction level rates | * Client satisfaction level rates | **Outc ome** | **Other custo m indicat ors** | **TBD** | **10%** | **15%** | **20%** | **25%** | **30%** | **35%** | **50%** | *(Measur ement through exit intervie ws)* |
| 7.2 | Increase provision and access to quality, affordabl e & integrate d emergen cy and trauma care | * % of States with dedicated centres for specific medical and laboratory service (emergency, trauma care, ambulatory,   blood, etc) | % of LGAs with dedicated centres for specific medical and laboratory service (emergency, trauma care, ambulatory,  blood, etc) | **Outc ome** | **Other custo m indicat ors** | **TBD** | **10%** | **10%** | **20%** | **30%** | **40%** | **50%** | **80%** |  |
| * % of Secondary and Tertiary hospitals with functional ambulance services | * % of Secondary and Tertiary hospitals with functional ambulance   services | **Outp ut** | **Other custo m indicat ors** | **TBD** | **40%** | **45%** | **50%** | **55%** | **60%** | **65%** | **70%** |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 7.3 | Improve provision, access, quality and responsiv eness of Ambulator y (outpatient  ) Services at all levels of health  care |  |  |  |  | **TBD** | **5%** | **5%** | **10%** | **20%** | **30%** | **40%** | **70%** |  |
| 7.4 | Promote the provision of and access to effective, safe blood and blood products at appropriat e levels of health  care.. | * % of blood collection and utilisation centres that meet the minimum quality standards |  | **Outpu t** | **Other custom indicato rs** | **TBD** |  |  |  |  |  |  | **100%** |  |
| 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. |  |  |  | **Other custom indicato rs** |  |  |  |  |  |  |  |  |  |

Yellow Black

75

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 8. Improve the wellbeing, safety and quality of life of Nigerians through health promotion and healthy environment | 8.1 | Promote the wellbeing of individual s and communi ties through protectio n from health risks, and promotio n of healthy lifestyle and environm  ent |  |  |  | **Other custo m indicat ors** |  |  |  |  |  |  |  |  |  |
| 8.2 | Promote food hygiene and safety for the reduction of illnesses assococi ated with unwholes ome food. | * % of designated sentinel sites across the federation established and equipped to collect, collate and transmit foodborne illness data to the National Centre for Disease Control by   end of 2018. | % of designated sentinel sites across the state established and equipped to collect, collate and transmit foodborne illness data to the State Centre for Disease Control by  end of 2018 | **Outp ut** | **Other custo m indicat ors** | **TBD** | **0%** | **1%** | **60%** | **60%** | **60%** | **60%** | **60%** |  |
| 8.3 | Promote universal access to safe drinking water and acceptabl e  sanitation | Mortality rate attributable to unsafe water, unsafe sanitation and lack of hygiene (WASH) | Mortality rate attributable to unsafe water, unsafe sanitation and lack of hygiene  (WASH) | **Impa ct** | **Global Indicat ors** | **TBD** | **80%** | **75%** | **70%** | **65%** | **60%** | **55%** | **50%** |  |
| 8.4 | Reduce morbidity and mortality from snake bites in  Nigeria | * Incidence of snakebites | * Incidence of snakebites | **Outc ome** | ***Key Perfor mance Indicat or*** | **TBD** | **10%** | **12%** | **14%** | **16%** | **18%** | **20%** | **decrease by 50% of Baseline** |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | 8.5 | Protect the human health, environme nt and infrastruct ure from the chemical hazard, medical & Bio waste and  poisoning |  |  |  | **Other custom indicato rs** | **TBD** |  |  |  |  |  |  | **decrease by 30% of Baseline** |  |
|  |  | Promote optimal health and safety of workers in their work environme  nt |  |  |  | **Other** |  |  |  |  |  |  |  |  |  |
|  | 8.6 | **custom**  **indicato** |
|  |  | **rs** |
|  |  |  | * Proportion of states that are implementing HRH policies and strategic plans | Proportion of |  |  |  |  |  |  |  |  |  |  |  |
|  |  | Ensure | LGAs that are |  |  |  |  |  |  |  |  |  |  |
|  |  | coordinati | implementing |  |  |  |  |  |  |  |  |  |  |
|  |  | on and | HRH policies |  |  |  |  |  |  |  |  |  |  |
|  |  | partnershi | and strategic |  |  |  |  |  |  |  |  |  |  |
|  |  | p for | plans |  |  |  |  |  |  |  |  |  |  |
| 9. To have in  place | 9.1 | aligning investmen t of current and future  needs and |  | **Proce ss** | **Other custom indicato rs** | **TBD** | **60%** | **65%** | **70%** | **75%** | **80%** | **85%** | **100%** |
| the right |  | institutiona  l |  |  |  |  |  |  |  |  |  |  |  |
| number, |  | strengthen  ing for |  |  |  |  |  |  |  |  |  |  |  |
| skill mix |  | HRH |  |  |  |  |  |  |  |  |  |  |  |
| of |  | agenda |  |  |  |  |  |  |  |  |  |  |  |
|  | Ensure the production of adequate numbers of qualified health workers |  | * % of health training institutions that are accredited by the relevant regulatory   institution |  |  |  |  |  |  |  |  |  |  |  |
| compet |  | * % of health |  |  |  |  |  |  |  |  |  |  |
| ent, |  | training |  | **Other** |  |  |  |  |  |  |  |  |
| motivate |  | institutions that  are accredited | **Outpu**  **t** | **custom**  **indicato** | **TBD** | **60%** | **65%** | **70%** | **75%** | **80%** | **85%** | **90%** |
| d, |  | by the relevant  regulatory |  | **rs** |  |  |  |  |  |  |  |  |
| producti | 9.2 | institution |  |  |  |  |  |  |  |  |  |  |
| ve and |  | * Proportion of health professionals graduating from health   training institutions |  |  |  |  |  |  |  |  |  |  |  |  |
| equitable |  | * Proportion of health professionals graduating   from health | **Outpu t** | **Other custom indicato rs** | **TBD** | **60%** | **65%** | **70%** | **75%** | **80%** | **85%** | **70%** |
|  |  | training institutions |  |  |  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | 9.3 | Ensure the developm ent of monitoring and evaluation for HRH including systems for HRHMIS  and Registry |  |  |  | **Other custom indicato rs** |  |  |  |  |  |  |  |  |  |
|  | 9.4 | Ensure effective health workforce managem ent through retention, deployme nt, work condition, motivation and performan ce managem  ent |  |  |  | **Other custom indicato rs** |  |  |  |  |  |  |  |  |  |
|  | 9.5 | Strengthe n Health workforce planning for effective managem  ent | * Health worker density and distribution | * Health worker density and distribution | **Outco me** | **Global Indicato rs** | **TBD** | **40%** | **45%** | **50%** | **55%** | **60%** | **65%** | **100%** |  |
| 10. To improve availability and functionality of health infrastructur e required to optimize service delivery at all levels and ensure equitable access to effective and responsive health services throughout the country. | #### | To improve availabilit y and functional ity of health infrastruc ture required to optimize service delivery at all levels | * % of Wards in the country with at least one fully functional PHC centre providing comprehensi ve primary health care   services | % of Wards in the state with at least one fully functional PHC centre providing comprehensi ve primary health care  services | **Outp ut** | **Other custo m indicat ors** | **TBD** | **50%** | **55%** | **60%** | **65%** | **70%** | **75%** | **80%** |  |
| * % of health facilities at all levels of the health system with fully functional health infrastructure (related to: medical equipment; water supply; electricity supply; roads; waste disposal; ICT; and security) | * % of health facilities at all levels of the health system with fully functional health infrastructure (related to: medical equipment; water supply; electricity supply; roads; waste disposal; ICT; and   security) | **Outp ut** | **Other custo m indicat ors** | **TBD** | **50%** | **55%** | **60%** | **65%** | **70%** | **75%** | **80%** |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  | * % Increase | * % Increase |  | **Other custo m indicat ors** |  |  |  |  |  |  |  |  |  |
|  |  |  | in local | in local |  |  |  |  |  |  |  |  |  |
|  |  |  | production of | production of |  |  |  |  |  |  |  |  |  |
|  |  |  | quality  medicines, | quality  medicines, | **Outp**  **ut** | **TBD** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **40%** |
|  |  | Strength | vaccines and | vaccines and |  |  |  |  |  |  |  |  |  |
| 11. To |  | en the | other | other |  |  |  |  |  |  |  |  |  |
| ensure that |  | availabilit | commodities | commodities |  |  |  |  |  |  |  |  |  |
| quality |  | y and | * Proportion of Federal Level MDAs, 36 States and FCT with functional logistic management coordinating   Unit. | Proportion of State Level MDAs and 23 LGAs  with functional logistic management coordinating  Unit |  |  |  |  |  |  |  |  |  |  |  |
| medicines, |  | use of |  |  |  |  |  |  |  |  |  |  |
| vaccines, |  | affordabl |  |  |  |  |  |  |  |  |  |  |
| and other |  | e, |  | **Other** |  |  |  |  |  |  |  |  |
| health commodities  and | #### | accessibl e and  quality | **Outp ut** | **custo**  **m indicat** | **TBD** | **0%** | **10%** | **15%** | **20%** | **25%** | **30%** | **80%** |
| technologies |  | medicine |  | **ors** |  |  |  |  |  |  |  |  |
| are |  | s, |  |  |  |  |  |  |  |  |  |  |
| available, |  | vaccines, |  |  |  |  |  |  |  |  |  |  |
| affordable |  | and other |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| and |  | health | * Proportion | * Proportion |  |  |  |  |  |  |  |  |  |  |
| accessible |  | commodi | of the | of the |  |  |  |  |  |  |  |  |  |  |
| to all |  | ties and | population | population |  |  |  |  |  |  |  |  |  |  |
| Nigerians |  | technolo  gies at all levels. | with access to affordable medicines  and vaccines | with access to affordable medicines  and vaccines | **Outc ome** | **Global Indicat ors** | **TBD** | **10%** | **15%** | **20%** | **25%** | **30%** | **35%** | **50%** |
|  |  |  | on a | on a |  |  |  |  |  |  |  |  |  |  |
|  |  |  | sustainable | sustainable |  |  |  |  |  |  |  |  |  |  |
|  |  |  | basis | basis |  |  |  |  |  |  |  |  |  |  |
| 12. To institutionaliz e an integrated and sustainable health information system for decision- making at all levels in Nigeria | #### | Improve the health status of Nigerians through the provision of timely, appropria te and reliable health informati on services at all levels, for evidence d based decision  making. | * % of Facilities reporting by timeliness and completenes s on the   DHIS | * % of Facilities reporting by timeliness and completenes s on the   DHIS | **Outp ut** | ***Key Perfor mance Indicat or*** | **TBD** | **70%** | **75%** | **80%** | **85%** | **90%** | **95%** | **30%** |  |
| % of data platforms interoperable with the DHIS | % of data platforms interoperable with the DHIS | **Outp ut** | ***Key Perfor mance Indicat or*** | **TBD** | **5%** | **10%** | **15%** | **20%** | **25%** | **30%** | **50%** |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 13. To utilize research to inform policy and programmin g for improved performance of the health sector and better health outcomes; and also contribute to global health knowledge production | #### | Strength en health research and develop ment to significan tly contribut e to the overall improve ment of Nigeria's health system performa  nce. | * % of federal and State health research institutions with functional ethical review committees | % of state and LG health research institutions with functional ethical review committee | **Outp ut** | ***Key Perfor mance Indicat or*** | **TBD** | **20%** | **25%** | **30%** | **40%** | **45%** | **50%** | **60%** |  |
| 14.  Significantly reduce the incidence and impact of public health emergencies | #### | Reduce incidence and impact of public health emergen cies in Nigeria | * Case Fatality Rate of public health emergencies | * Case Fatality Rate of public health emergencies | **Impa ct** | ***Key Perfor mance Indicat or*** | **TBD** | **5%** | **10%** | **10%** | **15%** | **20%** | **20%** | **50%** |  |
| Death rate due to RTA | Death rate due to RTA | **Impa ct** | **Global Indicat ors** | **TBD** | **20%** | **18%** | **16%** | **14%** | **12%** | **10%** | **70%** |  |
| 15. Ensure all Nigerians have access to health services without any financial barriers or impediments at the point of accessing care) | #### | Strength ened Governa nce and Coordina tion for actualizin g stewards hip and ownershi p of Health Financin g reforms | * Proportion of the Federal Level MDAs; States and FCT with approved Health Financing Policy &   Strategy | Proportion of the State Level MDAs and LGs with approved Health Financing Policy & Strategy | **Outc ome** | **Other custo m indicat ors** | **TBD** | **0%** | **0%** | **1%** | **5%** | **10%** | **15%** | **70%** |  |
| * Proportion of Federal Level MDAs, SMOH, & FCT institutionaliz ed routine NHA and   SHA | Proportion of the State Level MDAs and LGs institutionaliz ed routine SHA and LGHA | **Outc ome** | **Other custo m indicat ors** | **TBD** | **1%** | **2%** | **3%** | **4%** | **5%** | **6%** | **70%** |  |
|  | #### | Increase sustainab le and predictab le revenue  for health | * % Budgetary Allocation to PHC | * % Budgetary Allocation to PHC | **Outc ome** | **Other custo m indicat ors** |  | **3%** | **3%** | **5%** | **10%** | **15%** | **20%** | **35%** |  |
| #### | Enhance financial risk protectio n  through pooled funds at federal and state  levels | * % of Nigerian population covered by any risk protection mechanisms | % of Rivers State population covered by any risk protection mechanism | **Outc ome** | **Global Indicat ors** | **TBD** | **1%** | **2%** | **5%** | **10%** | **15%** | **20%** | **30%** |  |
| #### | Enhance transpare ncy and accounta bility in strategic purchasi ng of Health Services | % of Health Facilities operating any form of RBF | % of Health Facilities operating any form of  RBF | **Outp ut** | **Other custo m indicat**  **ors** |  | **0%** | **5%** | **10%** | **15%** | **20%** | **25%** | **30%** |  |
| * % of States with functional PFM   Systems | % of LGAs with functional PFM  Systems | **Outp ut** | **Other custo m indicat**  **ors** |  | **0%** | **0%** | **1%** | **2%** | **3%** | **4%** |  |  |

## Key Tools for Data Collection and Reporting

Data collection strategy for the routine State essential indicators and data sets at facility, LGA and State levels has already been developed and is being rolled out through the District Health Information System (DHIS).

This strategy entails data collection from the community, health facility (Public and Private), LGA and State levels involving monthly and quarterly progress report coming from health facilities mostly private and public.

The M/E unit co-ordinate future capacity building and the training programs in the M/E at all levels especially in the areas of data collection, analysis, interpretation, production of information products and use of the data for decision making and programming. The key tools for data collection and reporting on NHMIS data

1. Daily General Attendance Register
2. Nutrition and Growth Monitoring Register
3. In-Patient Care Register
4. Out-Patient Department Register
5. Family Planning Register
6. PMTCT Register for pregnant women
7. Tetanus Toxoid Register for women of child bearing age
8. Child Immunization Register
9. Immunization Summary
10. Immunization Tally
11. Health Facility and Post-Natal Register.

## Implementing Framework

For the State to effectively track the progress of implementation of SHDP II using the M & E plan, the following tabulated activities will be conducted;

|  |  |  |
| --- | --- | --- |
| **Sn** | **Objectives** | **Activities** |
| 1. | To provide health sector-wide framework for tracking progress and demonstrating results of the SHDP II  **(201 8 – 202 2 )** | Develop an M&E plan for the SHDP II |
| Print and disseminate M & E plan for SHDP II to stakeholders |
| 2. | To facilitate effective and functional  M&E system through the empowering of governance structures | Identify a State person in DPRS to be  responsible for tracking the progress of implementation of SHDP II |
|  |  | Develop a dashboard/reporting tool for monitoring SHDP II implementation by  the identified State Office |

* Engage 2 consultants for both Mid and End Term Evaluation
* Conduct Mid-term review meeting of the SHDP II
* Constitute and inaugurate M&E TWG
* Conduct Quarterly Joint M&E TWG meeting
* Dissemination of quarterly M&E report for SHDP II using fact sheets
* Conduct Annual Review of SHDP II by M&E Technical Working Group
* Dissemination of quarterly M&E report for SHDP II
* Purchase of 2 Hilux pickups for DPRS to improve M&E activities
* Purchase of 3 laptops, 3 printers and a projector for SHDP II

1. **Build capacity of MDAs(SMOH, HMB, PHCMB) to be able to effectively track the progress of the implementation of their SHDP II activities**
   * Development of training packages on SHDP II M&E plan
   * Development of tools and indicator harmonisation
   * Training and retraining of M&E / Health records Officers on data management
   * Conduct Quarterly ISS
   * Purchase of monthly data subscription for health facilities
   * Monthly Communication and Data purchased for key State officers

***Iv****.*

**To facilitate learning and knowledge management**

* Generate quarterly fact sheet and annual health bulletin for all levels of health care delivery
* Annual dissemination meetings of M & E report