RIVERS STATE GOVERNMENT

STRATEGIC HEALTH DEVELOPMENT PLAN

2010 – 2015

Rivers State Ministry of Health

March 2010

Table of Contents

Acknowledgement 5
Executive Summary 6
Chapter 1: Background 9
1.1 Introduction 9
Chapter 2: Situation Analysis 10
2.1 Socio-economic context 10
2.2 Health status of the population 11
2.3 Health services provision and utilization 13
2.3.3 Key issues and challenges 20
Chapter 3: Strategic Health Priorities 21
3.1 Strategic Orientations 21
3.2 High Impact Services 21
Chapter 4: Resource Requirements 24
4.1 Human 24
4.2 Physical/Materials 24
4.3 Financial 24
Chapter 5: Financing Plan 26
5.1 Estimated cost of the strategic orientation 26
5.2 Assessment of the available and projected funds 26
5.3 Determination of the financing gap 27
5.4 Descriptions of ways of closing the financial gap 27
Chapter 6: Implementation Framework 28
Chapter 7: Monitoring and Evaluation 29
7.1 Proposed mechanism for monitoring and evaluation 29
7.2 Costing the monitoring and evaluation component and plan 30
Chapter 8: Conclusion 31
Annex 1: Detailed activities for Rivers Strategic Health Development Plan 32
Annex 2: Results/M&E Matrix for Rivers Strategic Health Development Plan 57

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ALGON	Association of Local Government Chairmen of Nigeria
BCC	Behaviour Change Communication
BEOC	Basic Emergency Obstetric Services
CEOC	Comprehensive Emergency Obstetric Services
CIDA	Canadian International Development Agency
CORPs	Community oriented resource persons
CPD	Continuing professional development
CSO	Community Service Organization
DFID	Department for International Development
DFID	Department for International Development
DHS	Nigeria Demographic and Health Survey
DP	Development Partners
DPRS	Department of Planning, Research and Statistics
DRF	Drug Revolving Fund
ENCC	Emergency, Neonate Child Care
EU	European Union
FMOH	Federal Ministry of Health
GDP	Gross Domestic Product
HDCC	Health Data Consultative Committee
HF	Health Facilities/Health Facility
HIS	Health Management Information System
HIV	Human Immuno Deficiency Virus/
HRH	Human Resources for Health
HRH	Human Resources for Health
HW	Health worker
HW	Health worker
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illness
IMCI	Integrated management of Childhood Illnesses
IMNCH	Integrated Maternal, Newborn and Child Health
IPC	Interpersonal Communication skills
ISS	Integrated Supportive Supervision
ISS	Integrated supportive supervision
ITNs	Insecticide treated nets
IYCF	Infants, Young Children Feeding
JFA	Joint Funding Agreement
JICA	Japan International Development Agency
LGA	Local Government Area
LSS	Life Saving Skills

M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDAs	Ministries, Departments and Agencies
MDGs	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MLSS	Modified Life Saving Skills
MNCH	Maternal and Newborn Child Health
MRCN	Medical Research Council of Nigeria
MSS	Midwifery Service Scheme
NAFDAC	National Agency for Food Drugs Administration and Control
NBS	National Bureau of Statistics
NDHS	Nigeria Demographic and Health Survey
NGOs	Non-Governmental Organizations
NHA	National Health Accounts
NHIS	National Health Insurance Scheme
NHMIS	National Health Management Information System
NMSP	National Malaria Strategic Plan
NPHCDA	National Primary Health Care Development Agency
NPHCDA	National Primary Health Care Development Agency
NSHDP	National Strategic Health Development Plan
NSHDPf	National Strategic Health Development Plan Framework
NYSC	National Youth Service Corps
OPS	Organized Private Sector
PERs	Public Expenditure Reviews
PHC	Primary health Care
PHC	Primary Health Care
PPP	Public Private Partnerships
QA	Quality Assurance
QAR	Quality Assurance Recognition
RDBs	Research data banks
SESN	Socio-Economic Survey in Nigeria
SHAs	State Health Accounts
SMoH	State Ministry of Health
SMOH	State Ministry of Health
SWAPs	Sector-Wide Approaches
TB	Tuberculosis
TBAs	Traditional birth attendants
TBD	To be determined
UNDP	United Nations Development Programme
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Fund for Children
USAID	United States Agency for International Development

VHW	Village health workers
WHO	World Health Organization

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Executive Summary

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

Rivers State has always occupied a strategic position nationally and internationally. It contributes immensely towards the wealth of nations and empires. The area was formerly known as the oil rivers and played a vital role in the oil industrial revolution of the 19th century in England by providing vegetable oil which served multiple purposes as raw material and lubricant for industries' machinery. Today, with crude oil taking over as the mainstay of modern technology Rivers State continues to supply, in same way, crude Oil to the world community. More than 50% of Nigeria's crude oil comes from the State.

The State has a population of 5,522,575 based on the 2006 National Population Commission figures. The inhabitants of the State are of different ethnic groups with cultural diversity expressed in language, beliefs and music. They are mainly Christians, though a few Muslims and traditional worshipers exist. The ethnic groups include the Ekpeyes, Kalabaris, Ogonis, Ikwerres, the Okrikans, Engenis, the Ogba-Egbema-Ndoni people, the Etches, Abuans, amongst others. Most are engaged in fishing, farming and petty trading except for those in metropolitan cities like Port Harcourt who are either civil servants or employees of one or the other multinational company.

Rivers State occupies an area of about 37,000 square kilometers. It is bounded in the south by the Atlantic Ocean, to the north by Imo and Abia States, to the east by Akwa Ibom State and to the west by Bayelsa and Delta States. Its shores form part of the West African coastline. Over one third of the State is occupied by water with a low land stretching from Bonny in the South to Ndoni in the north. A network of creeks spans the riverine south, stretching into the Atlantic Ocean through Bonny, Opobo, etc. The vegetation of Rivers State is characterized by mangrove forest in the south while the northern part has thick rain forest with arable land. Rainfall is heavy throughout the year, but decreases from 430 cm to 342 cm towards the north.

Rivers State is the second largest economy in Nigeria after Lagos State. It has a GDP of 21,073,410,422 USD which is larger than most national GDPs in the African continent. The State has two major refineries, two major seaports and airports and various industrial estates spread across the State particularly in the state capital.

The present health status of citizens of Rivers State is unacceptable. The disease burden in the State is mostly due to preventable diseases such as malaria, upper respiratory tract

infection, diarrhoea etc. These account for high morbidity and premature deaths in the State. They have adverse effects on agricultural and industrial productivity as well as school absenteeism and man-hour-loss at work places.

Poverty is a major cause of the high disease burden in the State. Other contributory factors include the environmental degradation occasioned by the exploration of oil and gas, improper disposal of effluents and gas flaring. The maternal mortality ratio of 889 per 100,000 live births is one of the highest in the country. The other health status indicators: under-five mortality rate (90/1000) and general mortality rate (60/1000) are higher than average. HIV prevalence rate as at 2008 was 5.4%. The life expectancies for male, 54 years and female, 57 years are very low. The indices of health in the State are still not within acceptable limits.

The Primary Health Care system consists of 353 health care centres spread across the 319 political wards. The primary and secondary health care systems are well developed and functional, though not optimally due to dilapidated infrastructure and under-staffing. However, the state government is addressing the challenge of decay in the PHC infrastructure by constructing model prototype primary health care facilities in all the LGAs in the State.

The State minimum health care package will include the following health interventions:

1. Control of communicable diseases such as malaria, STI, HIV/AIDS, and TB
2. Child survival
3. Maternal and new born cares,
4. Nutrition
5. Non communicable diseases prevention
6. Health education and community mobilisation.

In other to implement these interventions communities will be mobilised using IEC/BCC strategies. Functional health infrastructure, human resources /manpower and financial shall also be provided to support health service delivery at all levels.

In order to strengthen the health system to deliver the essential health package eight evidence-based priority areas have been identified to improve the performance of the health sector, through a holistic approach at all levels of health care delivery. For each of these priority areas, there is a goal with strategic objectives, interventions and activities. These activities have targets and verifiable indicators. The strategic orientations or priority areas are:

Priority Area 1: Leadership and governance for health.
Priority Area 2: Health service delivery.

Priority Area 3: Human resource for health.
Priority Area 4: Financing for health.
Priority Area 5: Health information system.
Priority Area 6: Community participation and ownership.
Priority Area 7: Partnerships for health.
Priority Area 8: Research for health.

The estimated cost of the strategic orientation in Nigerian Naira (₦) for the 6-year plan period (2010 – 2015) is **One Hundred and Sixty Three Billion, One Hundred and Twenty Four Million, Three Hundred and Fifty Two Thousand, Seven Hundred and Eighty Eight Naira (₦ 163,124,352,788).**

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

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

The SSHDP will be monitored and evaluated by the implementing departments and special units (inbuilt M & E) and a central M & E Unit in the PRS Department. There are two perspectives to monitoring and evaluation in the context of the SSHDP and its implementation process. First, it is important to monitor and evaluate the plan's operational elements (in this case, the required activities) that are essential ingredients in ensuring the successful implementation of the plan. Secondly, it is equally essential to monitor and evaluate programme outputs and impacts. The latter concerns measurable variables and changes in the health status of the population and the health services as a consequence of the implementation of the SHDP as well as the health prevention and utilization indicators. The major categories of indicators that are relevant for monitoring and evaluating the State SHDP include the policy and socioeconomic indicators.

Chapter 1: Background

1.1 Introduction

The Rivers State Strategic Health Development Plan (RSSHDP) is being designed within the context of placing health at the centre of socio-economic development and presents a clear shift in the role of health in the State and national development framework. This is based on the recognition that health is not only a basic right issue, but also a key driver to achieving sustainable development.

The health status of citizens of Rivers State is in a deplorable condition. The disease burden in the State is mostly due to preventable diseases including malaria, upper respiratory tract infection, diarrhoea etc. Poverty is the major cause of the high disease burden in the State. Other contributory factors include the environmental degradation occasioned by the exploration of oil and gas, improper disposal of effluents and gas flaring.

The RSSHDP adopts an approach that addresses the building blocks for sustainable health development. It focuses on service delivery including essential medicine, supplies and health equipment, health management information system, health financing and private sector and inter-sectoral collaboration. The Plan further places governance as an important element for effectively steering the health system towards achieving the health sector objectives. It also ensures access to quality health interventions for preventing common diseases and injuries, as well as for restoring the health of the sick and disabled. In that regard, the Plan aims to provide comprehensive health care services comprising promotive, preventive, curative and rehabilitative services.

Chapter 2: Situation Analysis

2.1 Socio-economic context

People:

The inhabitants of the State are of different ethnic groups with cultural diversity expressed in language, beliefs, dress codes and music. They are mainly Christians, though a few Muslims and traditional worshipers exist. They include the Ekpeyes, Kalabaris, Ogonis, Ikwerres, the Okrikans, Engenis, the Ogba-Egbema-Ndoni people, the Etches, Abuans, amongst others. Most are engaged in fishing farming and petty trading except for those in metropolitan cities like Port Harcourt and Obio Akpo and Oyigbo who are either civil servants or employees of one or the other multinational company.

Geography:

Rivers State occupies an area of about 37,000 square kilometers. It is bounded on the south by the Atlantic Ocean, to the north by Imo and Abia States, to the east by Akwa Ibom State and to the west by Bayelsa and Delta States. Its shores form part of the West African Coastline.

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

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

The waterways are vital transport system within the State. The major rivers in the State include:

- River Niger
- River Sombreiro
- River Orashi
- New Calabar River
- Bonny River

- Andoni River, etc

Economy:
Rivers State is the second largest economy in Nigeria after Lagos State which is the first. It has a total GDP of 21,073,410,422 USD which is larger than most national GDPs in the African continent. The State has two major refineries, two major seaports, airports and various industrial estates spread across the state particularly in the state capital. The per capita is 3,965 USD.
The natural resources obtainable from the State include petroleum, natural gas, palm oil, sand and clay, etc.

2.2 Health status of the population

The present health status of citizens of Rivers State is unacceptable. The disease burden in the State is mostly due to preventable diseases including malaria, upper respiratory tract infection, diarrhoea etc. They account for high morbidity and premature deaths in the state. They have adverse effects on agricultural and industrial productivity as well as school absenteeism and lost man-hours in work places. Poverty is the major cause of the high disease burden in the State. Other contributory factors include the environmental degradation occasioned by the exploration of oil and gas, improper disposal of effluents and gas flaring. The maternal mortality ratio of 889 per 100,000 live births is one of the highest in the world. The other health status indicators: under-five mortality rate (90/1000) and general mortality rate (60/1000) are higher than average. HIV prevalence rate as at 2008 was 5.4%. The malaria prevalence among under5 was 21%. Households with at least one insecticide-treated net (ITN) was 12%.The life expectancies for male, 54 years and female, 57 years are very low. The indices of health in the State are still below acceptable limits.

The prevalence of diseases of industrialization such as hypertensive heart disease and other non-communicable diseases are high in the state. These stress-related diseases result from rapid urbanization which is evident in the city of Port Harcourt and its environs, coupled with the fact that the economically productive age group has changed its life style and consumption pattern.

In the aspect of health service delivery and quality of care, routine immunization of about 70% is at an all time low while only 37% of children aged 12 – 23 months were fully immunized. Women who gave birth in the last 5 years who received antenatal care from a skilled provider was 67% while births assisted by a skilled provider was 64% and births delivered in a health facility was 48%. Modern contraceptive prevalence rate amongst married women aged 15 – 49 years was 14%. A high number of public health facilities serve only about 5-10% of their potential work load. In addition, secondary health facilities are in prostrate conditions, with dilapidated infrastructure and inadequate health

personnel. Furthermore, the referral system between various tiers of the health system is non-functional or ineffective. Healthcare delivery in Rivers State is therefore facing a lot of challenges to all persons involved in it at all levels. The health status indicators selected from the NDHS 2008 for Rivers State are summarised in the table below.

POPULATION (2006 Census)	RIVERS
Total population	**5,198,716**
female	2,525,690
male	2,673,026
Under 5 years (20% of Total Pop)	618,384
Adolescents (10 – 24 years)	1,763,506
Women of child bearing age (15-49 years)	1,402,749
INDICATORS	**NDHS 2008**
Literacy rate (female)	95%
Literacy rate (male)	84%
Households with improved source of drinking water	26%
Households with improved sanitary facilities (not shared)	10%
Households with electricity	32%
Employment status (currently)/ female	65.6%
Employment status (currently)/ male	68.0%
Total Fertility Rate	4.3
Use of FP modern method by married women 15-49	14%
Ante Natal Care provided by skilled Health worker	67%
Skilled attendants at birth	64%
Delivery in Health Facility	48%
Children 12-23 months with full immunization coverage	37%
Children 12-23 months with no immunization	10%
Stunting in Under 5 children	29%
Wasting in Under 5 children	5%
Diarrhea in children	3.8
ITN ownership	12%
ITN utilization (children)	10%
ITN utilization (pregnant women)	9%
children under 5 with fever receiving malaria treatment	21%
Pregnant women receiving IPT	5%
Comprehensive knowledge of HIV (female)	17%
Comprehensive knowledge of HIV (male)	36%
Knowledge of TB (female)	68.5%
Knowledge of TB (male)	81.3%

Despite the dismal performance of the health system in Rivers State, there are certain strengths on which a better and more functional health system can be built upon. Notable

among these are: a new political administration committed to improving the performance of the sector; a growing and identifiable number of healthcare providers, health facilities, partners, and other stakeholders – both public and private; a good government revenue base and other potential sources of funding – oil companies, Niger Delta Development Corporation (NDDC), private sector; and existence of demand for good quality services in most communities.

But there are also enormous challenges relating to uncoordinated service delivery, structural problems, underfunding and managerial weakness. These problems have resulted in poor quality of service, loss of consumer confidence, low utilization of services, low staff morale, poor health indices, near collapse of primary health care and little prospect of achieving the MDGs in Rivers State.

2.3 Health services provision and utilization

There are 36 general hospitals spread across the 23 LGAs of the State. There are also the Government House Clinic, Dental and Maxillo-facial Clinic as well as the Civil Servant Clinic, all of which are operational to date. The State has one tertiary referral center, University of Port Harcourt Teaching Hospital (UPTH).

The Primary Health Care system consists of 353 health care centres spread across the 319 political wards. The primary and secondary health care systems are well developed and functional, though not optimally due to dilapidated infrastructure and under staffing. However the state government is addressing the challenge of decay in the PHC infrastructure by constructing model prototype primary health care facilities in all the political wards in the state.

Ministry of Health

The Ministry of Health has eight departments, four special programmes/units, four training institutions and one parastatal. The departments are Administration, Finance & Accounts, Planning, Research & Statistics, Medical Services, Pharmaceutical Services, Public Health Services, and Primary Health Care. The special programmes/units are Free Medical Care, Emergency Medical Services, HIV/AIDS Control and Works/Project Unit. The training institutions are School of Nursing, School of Midwifery, School of Public Health Nursing, College of Health Science and Technology and Rivers State University of Science and Technology. The parastatal is the Hospital Management Board.

Other Programmes of the Ministry include:

1. National Programme on Immunization.
2. State Malaria Control Programme.
3. HIV/AIDS Control Programme.
4. Free Medical Care Programme.

5. Rivers State Health Insurance Scheme.
6. Avian Influenza Control Programme.
7. Emergency Medical Services.
8. Schools of Nursing/Midwifery.

Statutorily, the Honourable Commissioner is the chief executive officer, while the Permanent Secretary is the accounting officer.

The various departments of the Ministry of Health and their functions are as follows.

1. Administration:
   - To coordinate the functions of the Ministry.
   - To develop and motivate human resources through manpower training, promotion and staff welfare.
   - To supply and maintain industrial harmony for the achievement of the goals and objectives of the State Health Policy.

2. Finance and Accounts:
   - To pay roll.
   - Other charges.

3. Planning, Research and Statistics:
   - To draw up development plans (rolling, medium and perspective).
   - To monitor and evaluate programmes and projects in the Ministry.
   - To act as secretariat of the Ministry Tenders Board.
   - To follow up and implement the National and State Health Policies and programmes.
   - To conduct State Council on Health meetings.
   - To coordinate the State's participation in the National Council on Health meetings.
   - To carry out regular collection and processing of health data and statistics and forwarding same to the Federal Ministry of Health.
   - To produce the Ministry's annual/progress reports.
   - To manage the Ministry's records and information resources (data bank, computer services and library).
   - To provide State health data on request to government agencies and private bodies.
   - To coordinate health and developmental committees.
   - To supervise the World Bank assisted Health Systems Development Project (HSDP-II) which is located in the department.

4. Pharmaceutical Services:
   - To coordinate/implement all drug activities in the State.

5. Nursing Services:
    - To ensure a high standard of nursing education and practice in the State.

6. Department of Public Health:
    - To supervise public health activities in the State for the State Ministry of Health.
    - To brief the Hon. Commissioner and the Permanent Secretary on the activities of the department.
    - To coordinate projects for international partners such as WHO, UNICEF, World Bank, AFRICARE and NGOs that are of public health importance and significance.
    - To represent the State Ministry in national public health programmes and to delegate staff where necessary.
    - To implement public health programmes of the National Council on Health of the FMOH.
    - To be in charge of implementing programmes on Public Health Information Services.
    - To issue extracts of births and deaths, exhumation and cremation.
    - To be responsible for disease surveillance in the State.
    - To plan, direct and supervise the control of communicable diseases, epidemic and endemic.
    - To be responsible for the control of non-communicable and communicable diseases in the State.

7. Department of Medical Services:
    - To train and regulate the training of medical and para-medical staff
    - To register and supervise the private medical and other health practitioners.
    - To recommend, process and facilitate government sponsorship of overseas and local treatment of patients.
    - To carry out the Ministry's supervision of the Hospital Management Board and screening of healthcare facilities in the State to ascertain status and standard of facilities.
    - To screen and determine the medical claims and eligibility of all sick government employees to remain in service.
    - To statutorily represent the State Ministry of Health in the Boards, Councils and Institutions such as the Medical and Dental Council on Health, RSHMB, the Emergency Medical Services, etc.
    - To procure, distribute and install medical equipment.
    - To ensure adequate and acceptable standard of medical care in all medical institutions in the State.

- To ensure adequate referral system in the State.

8. Primary Health Care:
   - To develop, implement and monitor/supervise the primary health care facilities in the 23 local government areas of the State.
   - To immunize the vulnerable groups.
   - To conduct family planning services.
   - To supervise, monitor and evaluate primary health care activities.
   - To conduct mental health services.
   - To overlook the tuberculosis and leprosy control.
   - To supervise nutrition.
   - To coordinate the activities of the UN agencies such as UNICEF. and other international NGOs on Maternal and Child Health.
   - In summary, to ensure effective primary health care delivery in the State.

Special Programmes and Units:

i. Free Medical Care Programme

This was established on May 5, 2000 to provide free medical care for children that are less than 6 years and adults above 60 years of age in the State government hospitals. The service was later extended to provide free C/S for adolescents and treatment of medical emergencies and accident victims for the first 24 hours. It currently covers 40 health facilities (35 general/cottage hospitals and 5 comprehensive health centres) spread over the 23 local government areas of the State. The main functions of the programme, apart from coordination and execution of all free medical care programmes in the State are:

- Treatment of beneficiaries.
- Registration of new cases.
- Mobilization.
- Supervision and monitoring.

ii. Emergency Medical Services Programme:

This programme was established on September 22 2001. It is designed to assist victims of road traffic accidents and other medical emergencies with a view to reducing mortality attributable to the aforementioned causes. The functions of this programme are:

- To resuscitate and evaluate victims of accident and other medical emergencies and convey them to the base hospitals (BMH, Ahoada, Bori and Omoku) for further medical treatment.
- To manage major disasters in conjunction with other relevant affiliate bodies.

iii. HIV/AIDS Control Programme:

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. Its duties are

- To create awareness and mobilize prevention, treatment, care and support of all people living with HIV/AIDS (PLWHA) in the State.
- To carry out blood safety practices and laboratory testing for HIV by way of regular screening and CD4 counts.
- To conduct surveillance by means of
    a. The National Sero-prevalence Survey
    b. The State Sero-prevalence Survey
    c. Routine AIDS case reporting
- To monitor and evaluate the programme.

iv. Parastatal

Rivers State Hospital Management Board

- To manage, control, staff and effect discipline in all government hospitals in the State

Achievements

The achievements of the Rivers State Ministry of Health are numerous. Those to be improved include:

a. Infrastructure - Completed

- Construction of 150 bed Prof. Kelsey Harrison (Niger) Hospital.
- Construction of Modular theatre in BMSH, Port Harcourt.
- Collaboration with Clinotech Group Canada in specialist manpower development in BMSH. Radiologists are being trained in the use of MRI, CT Scan, Mammography, Fluorography equipment use and maintenance.
- Upgrade of BMSH Laboratory to a reference Laboratory.
- Construction of Model Primary Health Centre at Okochiri and Okrika.
- Construction of Model Primary Health Centre, Churchill Road, Port Harcourt.
- Construction of Model Primary Health Centre, Okija Street Diobu, Port Harcourt.
- Construction and Equipment of new mortuary for BMSH.
- Construction of Ndoni Primary Health Centre.
- Construction of Model Primary Health Centre Elekahia
- Renovation of two buildings at Admin section of Former UPTH for relocation of Ports Johnson Polyclinics, Port Harcourt.
- Renovation of one building as temporary Zonal Drug Store for South-south TBL Programme.

- Renovation of the Mortuary Foster at Okrika General Hospital.
- Demolition work at the former UPTH site and evacuation of debris.
- Renovation work at Bodo General Hospital.
- Completion of New Mortuary at BMSH.
- Upgrading and conversion of General Hospital Okrika to specialist burns centre.
- Upgrading of General Hospital Isiokpo to Trauma Centre

Infrastructure – On-going

- 5 storey Ultra Modern Dental Hospital near completion
- Construction of 160 Model Primary Health Centres.
- Construction of Justice Karibi Whyte Specialist Hospital in collaboration with Clinotech group Canada to put a stop to overseas
- Commencement of processes of construction of 250 bed Women and Children's Specialist Hospital at site of former UPTH.
- Commissioned the Auto-Disabled Syringe Factory, which has the capacity to produce 1 million syringes annually. Plans are on the way to increase the production capacity to 180 million.

Training

- Sponsorship of Medical mission by Accensure of USA (Internship training programme for House Officers, Dental Surgeons, Optometrists, Laboratory Scientists
- Employment and training of health manpower to man all the Primary Health Centres.

Equipping and Supplies:

- Supply of furniture to Ndoni Comprehensive Health Centre

Treatment:

- 1st Phase Total Knee replacement surgeries for Rivers people at the Braithwaite Memorial Specialist Hospital Port Harcourt in collaboration with Mathrx orthopaedic Group, Belgium/Switzerland.

Counterpart Funding:

- Incorporation of Special Purpose vehicle and payment of Counterpart Funding for Clinorly Specialist hospital and Leisure Limited Project.

Others:

- Accreditation of BMSH by Radiographers Registration Board for internship training.
- Established strong Development Partnership Forum.

- Relocation of EMS Services from BMSH and expanding its scope to include marine and Air.
- Re-organization of Rural Posting of Doctors.
- Re-organization of the Central Medical Stores resulting in efficiency in drug distribution (no more out of stock).

Malaria Control:

- Concluded all rounds of the National Immunization Programme.
- Distribution of Long Lasting Insecticide (LLINs)Treated Bed Nets
- Distribution of Anti Malaria Drugs.
- Purchased vehicles for monitoring and supervision.
- Training of Programme officers is on-going.

HIV/AIDS:

- Purchased Anti Retroviral drugs (HIV/AIDS).
- Purchased 2 vehicles (1 Hilux and 15-seater Bus) (HIV/AIDS).
- Trained 55 Persons on testing procedures (HIV/AIDS).

Strengths:

a. Strong Political Will.
b. Availability of health facilities.
c. Skilled manpower.
d. Free Medical Care Services.

Weaknesses:

a. Inadequate funds.
b. Inadequate manpower.
c. Poor referral system.
d. Uncoordinated monitoring and evaluation.
e. Uncoordinated donor programmes and partnership.

Opportunities:

a. Federal government programmes.
b. Strong political will.
c. Donor agencies.
d. Development partners.

Threats:

a. Security challenges.
b. Environmental degradation by hydrocarbon related industries.
c. High migration rate.

d. High inflation, indiscipline and corruption.
e. High HIV/AIDS prevalence.
f. Underdeveloped agriculture.
g. Bloated bureaucracy.
h. Lack of maintenance culture, etc.

2.3.3 Key issues and challenges

In the quest to execute the Millennium Development Goal (MDG) activities, the Rivers State government continues to encounter some challenges. The most important are the incessant youth restiveness, kidnapping and militancy in the area. A positive impact is however expected from the recent federal government granting of amnesty to the militants who are ready to disarm and be engaged in legitimate activities. This will make it possible for the areas that have hitherto been unreached with healthcare delivery as a result of the security risk to be done so.

Other challenges are as follows:

- High morbidity and mortality rates from both communicable and non-communicable diseases.
- Difficult geographical terrain.
- Inadequate funds / late release of funds for healthcare delivery.
- Inadequate skilled manpower.
- Inadequate level of capacity building.
- Ignorance / poor orientation of the community members.
- Low patronage of some public health facilities in the community.
- Inability to provide logistic support in some areas.
- Poor funding of some projects, but the international donor agencies are coming to the rescue now.
- High rate of unemployment arising from discriminatory policies against indigenes.
- Inadequate power generation and distribution.
- Co-ownership of companies with Bayelsa State government.

Chapter 3: Strategic Health Priorities

3.1 Strategic Orientations

Eight evidence-based priority areas have been identified to improve the performance of the health sector, through a holistic approach at all levels of health care delivery. For each of these priority areas, there is a goal with strategic objectives, interventions and activities. These activities have targets and verifiable indicators. The strategic orientations or priority areas are:

Priority Area 1: Leadership and governance for health.
Priority Area 2: Health service delivery.
Priority Area 3: Human resource for health.
Priority Area 4: Financing for health.
Priority Area 5: Health information system.
Priority Area 6: Community participation and ownership.
Priority Area 7: Partnerships for health.
Priority Area 8: Research for health.

3.2 High Impact Services

However, the following list reflects the priority high impact interventions to be delivered in the State - as part of the Essential Package of Health Services for Rivers State.

3.2A. Family/Community Oriented Services
These include: ● Insecticide Treated Mosquito Nets for children under 5.
● Insecticide Treated Mosquito Nets for pregnant women
● Household water treatment.
● Access to improved water source.
● Use of sanitary latrines.
● Hand washing with soap.
● Clean delivery and cord care.
● Initiation of breastfeeding within 1st hr. and temperature management.
● Condoms for HIV prevention.
● Universal extra community-based care of LBW infants.
● Exclusive Breastfeeding for children 0-5 months.
● Continued Breastfeeding for children 6-11 months
● Adequate and safe complementary feeding.
● Supplementary feeding for malnourished children.
● Oral Rehydration Therapy.
● Zinc for diarrhea management.
● Vitamin A - Treatment for measles.
● Artemisinin-based Combination Therapy for children.
● Artemisinin-based Combination Therapy for pregnant women.
● Artemisinin-based Combination Therapy for adults.
● Antibiotics for U5 pneumonia.
● Community based management of neonatal sepsis.

• Follow up Management of Severe Acute Malnutrition.
• Routine postnatal care (healthy practices and illness detection).
3.2B. Population Oriented/Outreaches/Schedulable Services These include:
• Family planning
• Condom use for HIV prevention
• Antenatal Care
• Tetanus immunization
• Deworming in pregnancy
• Detection and treatment of asymptomatic bacteriuria
• Detection and management of syphilis in pregnancy
• Prevention and treatment of iron deficiency anaemia in pregnancy
• Intermittent preventive treatment (IPTp) for malaria in pregnancy
• Preventing mother to child transmission (PMTCT)
• Provider Initiated Testing and Counseling (PITC)
• Condom use for HIV prevention
• Cotrimoxazole prophylaxis for HIV+ mothers
• Cotrimoxazole prophylaxis for HIV+ adults
• Cotrimoxazole prophylaxis for children of HIV+ mothers
• Measles immunization
• BCG immunization
• OPV immunization
• DPT immunization
• Pentavalent (DPT-HiB-Hepatitis b) immunization
• Hib immunization
• Hepatitis B immunization
• Yellow fever immunization
• Meningitis immunization
• Vitamin A - supplementation for U5

3.2C. Individual/Clinical Oriented Services **These include:**
Family Planning
Normal delivery by skilled attendant
Basic emergency obstetric care (B-EOC)
Resuscitation of asphyctic newborns at birth
Antenatal steroids for preterm labor
Antibiotics for Preterm/Prelabour Rupture of Membrane (P/PROM)
Detection and management of (pre)ecclampsia (Mg Sulphate)
Management of neonatal infections
Antibiotics for U5 pneumonia
Antibiotics for dysentery and enteric fevers
Vitamin A - Treatment for measles
Zinc for diarrhea management
ORT for diarrhea management
Artemisinin-based Combination Therapy for children
Artemisinin-based Combination Therapy for pregnant women
Artemisinin-based Combination Therapy for adults
Management of complicated malaria (2nd line drug)
Detection and management of STI
Management of opportunistic infections in AIDS
Male circumcision
First line ART for children with HIV/AIDS
First-line ART for pregnant women with HIV/AIDS
First-line ART for adults with AIDS
Second line ART for children with HIV/AIDS
Second-line ART for pregnant women with HIV/AIDS
Second-line ART for adults with AIDS
TB case detection and treatment with DOTS

Re-treatment of TB patients
Management of multidrug resistant TB (MDR)
Management of Severe Acute Malnutrition
Comprehensive emergency obstetric care (C-EOC)
Management of severely sick children (Clinical IMCI)
Management of neonatal infections
Clinical management of neonatal jaundice
Universal emergency neonatal care (asphyxia aftercare, management of serious infections, management of the VLBW infant)
Other emergency acute care
Management of complicated AIDS

Chapter 4: Resource Requirements

4.1 Human

Manpower in the health sector ranges from the high-level modern technology trained doctors to the community-oriented appropriate technology-based health workers and traditional practitioners. Each is endowed with skills required to operate in his jurisdiction.

The categories of workers are as follows:

a. The professional such as doctors, nurses, pharmacists/technicians/ assistants, radiologists/radiographers/X-ray technicians, dentists/ technicians/assistants, nutritionists (dieticians)
b. Management personnel such as administrators, planning officers
c. Community health workers
d. Clerical officers
e. Ancillary personnel
f. Traditional practitioners

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

4.2 Physical/Materials

Rivers State has both primary and secondary health facilities that are distributed in the 23 LGAs. According to the 2004 figures, there are 377 public health facilities, 335 of which are primary health facilities and the remaining 42 secondary health care facilities. There are also 467 private health care facilities with majority located in Port Harcourt, the State capital.

4.3 Financial

The capital budget expenditure allocated to Rivers State Ministry of Health was 3.1% of the total State budget for the year 2005. Other sources of funds for healthcare delivery

include

- Federal Government of Nigeria
- Rivers State Government
- LGA
- Social contribution for free medical care
- Development partners, e.g.
    - The World Bank
    - UNICEF
    - WHO

Chapter 5: Financing Plan

5.1 Estimated cost of the strategic orientation

The strategic orientations and their estimated cost in Nigerian Naira (₦) for the 6-year plan period (2010 – 2015) are presented in the Table below.

Table 1: Estimated cost of the Rivers State SHDP (2010 – 2015)

S/No.	Priority Area	Estimated Cost
1.	Leadership and governance for health	616,237,500
2.	Health service delivery	83,715,283,600
3.	Human resources for health	70,475,906,688
4.	Financing for health	6,442,915,000
5.	National health information system	742,765,000
6.	Community participation and ownership	39,165,000
7.	Partnerships for health	300,500,000
8.	Research for health	791,580,000
	Total	**163,124,352,788**

5.2 Assessment of the available and projected funds

The Rivers State 2009 capital budget appropriation was 20,600,000,000 (NGN). The projected figures for 2010 to 2015 using 1% appropriation rate are as follows:

Table 2: Rivers State projected capital budget appropriation (2010 – 2015)

S/No.	Year	Projected Figure
1.	2010	20,806,000,000
2.	2011	21,014,060,000
3.	2012	21,224,200,600
4.	2013	21,463,442,606
5.	2014	21,650,807,032
6.	2015	21,867,315,102

5.3 Determination of the financing gap

- The projected figure for the six-year plan period (2010 – 2015) is **127,998,825,340** Nigerian Naira.
- Budgeted figure for the six-year plan period (2010 – 2015) using the Rivers State SHDP is **163,124,352,788** Nigerian Naira
- Therefore, the financial gap is **35,125,527,448** Nigerian Naira.

5.4 Descriptions of ways of closing the financial gap

The financial gap that exists, being the difference between the SSHDP budgeted amount and the projected figure for the six-year plan period (2010 – 2015) will be closed by the following:

- Federal Government of Nigeria
- Rivers State Government
- Local Government Councils
- Donor partners:
    - International organizations –
        - World Bank
        - World Health Organization
        - UNICEF
    - Local organizations/corporations –
        - Niger Delta Development Corporation (NDDC)
        - Shell Petroleum Company
        - AGIP
        - CHEVRON
        - Non Governmental Organizations
- Social contributions for the free medical care (This is not taxation although the money will be deducted from source)
- Individuals in communities (philanthropic)

Chapter 6: Implementation Framework

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

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

The 23 local government (LG) councils in Rivers State are under the leadership of the Chairmen of the LGs. Each has its health department with various cadres of health workers and ancillary staff who provide and implement the various services that are stipulated for this level of care. They have various types of primary health care facilities with different types of healthcare givers.

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

Chapter 7: Monitoring and Evaluation

7.1 Proposed mechanism for monitoring and evaluation

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

There are two perspectives to monitoring and evaluation in the context of the SSHDP and its implementation process. First, it is important to monitor and evaluate the plan's operational elements (in this case, the required activities) that are essential ingredients in ensuring the successful implementation of the plan. Secondly, it is equally essential to monitor and evaluate programme outputs and impacts. The latter concerns measurable variables and changes in the health status of the population and the health services as a consequence of the implementation of the SHDP.

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

Types and sources of data

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

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

Categories of data

The four major categories of data are:

1. Input database

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

2. Process database

Process refers to a set of activities that must be undertaken or actions and rules and

regulations that are required to take place. This may include for instance protocols for immunization, for collecting, storing, processing and making available health data, etc.

3. Output database

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

4. Outcome or impact database

These are concerned with health status measures or indicators. An example is the level of morbidity and mortality for a given condition and specific target population, e.g. under-5 mortality rate, maternal mortality rate and prevalence of HIV/AIDS.

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

7.2 Costing the monitoring and evaluation component and plan

The central M & E unit of the SMOH oversees the entire monitoring and evaluation activities in the State. Each department and unit of the SMOH and the 23 LGAs also have their M & E units. The money allocated to the central M & E unit for the year 2010 is 520,000,000 Nigerian Naira.

Chapter 8: Conclusion

The Rivers State Strategic Health Development Plan for the period 2010 to 2015 was successfully produced with wide stakeholder participation involving a cross section of State Ministry of Health officials, local government officials, and representatives of various development partners, professional groups and individuals that are directly or indirectly involved with healthcare delivery in the State. The final draft was obtained after the harmonization of the 23 LGA Strategic Health Development Plans. The tools that were used included the following:

1. FMOH – NSHDP Framework (2010 – 2015)
2. Current State Health Plan
3. Current State Health Policy
4. Tenure Strategic Plan
5. Rivers State Approved Capital Budget Estimates

The eight priority areas were strictly adhered to and activities mapped out according to the stipulated guidelines. Certain activities that are specific to the State were duly adopted with appropriate costing. The Rivers State Strategic Health Development Plan for the year 2010 was also produced from the framework and appropriate budgeting carried out. Future monitoring and evaluation of the plan was taken care of making use of various health indicators for definite areas of the plan.

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

Annex 1: Detailed activities for Rivers Strategic Health Development Plan

RIVERS STATE STRATEGIC HEALTH DEVELOPMENT PLAN						
Priority Area						
Goals				**Baseline Year 2009**	**Risks And Assumptions**	**Estimated costs in NGN (2010-2015)**
	Strategic Objectives			**Targets**		
		Interventions		**Indicators**		
			Activities	**None**		
LEADERSHIP AND GOVERNANCE FOR HEALTH						
1. To create and sustain an enabling environment for the delivery of quality health care and development in Nigeria						**641,525,000**
	1.1	**To provide clear policy directions for health development**		**All stakeholders are informed regarding health development policy directives by 2011**		**607,900,000**
		1.1.1	Review of existing Health Policy to be in line with the Federal Policy on Health			**565,550,000**
			1.1.1.1 Establish & maintain PHC Management Board	50% of PHC activities and programmes implemented by the PHC Management Board by end of 2010	PHC Board set up by 2nd quarter 2010.	451,800,000
			1.1.1.2 Set up & maintain a traditional medicine practice regulatory body to adapt & implement the National policy on Traditional Medicine.	25% LGAs enforce traditional medical practice by-laws end of first quarter of 2011 & 50% 2013	Traditional Medicine Practice regulatory body set up by 2nd quarter 2011.	113,750,000
		1.1.2	Improved Strategic Planning at State level			**15,200,000**
			1.1.2.1 Workshops to develope SHDP for the State, including activities that will impact positively on the citizenry	% stakeholders constituencies playing their assigned roles in the SSHDP (disaggregated by stakeholder constituencies)	Lack of funds	15,200,000
		1.1.3	Coordination of the development of LGA SHDP			**27,150,000**
			1.1.3.1 Workshop to coordinate the development of LGAs SHDP	90% of LGAs have developed their SHDP by end of 2010 & 100% by end of 2011	Lack of interest by the LGA Chairmen	27,150,000
	1.2	**To facilitate legislation and a regulatory framework for health development**		**Health Bill signed into law by end of 2010**		**18,500,000**
		1.2.1	To strengthen regulatory functions of government			**18,500,000**
			1.2.1.1 Organize periodic workshops to review, update and enforce Public Health Acts and align with the National Health Bill.	National Health Bill implemented by second quarter of 2011	Lack of funds	18,500,000
	1.3	**To strengthen accountability, transparency and responsiveness of the national health system**		**80% of State and LGAs have an active health sector 'watch dog' by 2013**		**15,125,000**
		1.3.1	To improve accountability and transparency			**15,125,000**
			1.3.1.1 Establish a Health Watch Group in the 23 LGAs	Health Watch Group established in 25% of LGAs by end of 2011 & 50% by end of 2013	Lack of funds	15,125,000
HEALTH SERVICE DELIVERY						
2. To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare						**88,154,483,600**

	2.1	**To ensure universal access to an essential package of care**			**Essential Package of Care adopted by all States by 2011**		**60,488,853,600**
		2.1.1	To review, cost, disseminate and implement the minimum package of care in an integrated manner				**4,160,075,000**
			2.1.1.1	Review, cost, disseminate and implement the minimum health care package.	**% of LGAs with functioning public health facility providing minimum health care package raised to 12.50% by 2010, 25% by 2011 & 50% by 2013.** **% health facilities implementing the complete package of essential health care raised to 37.50% by 2010, 50% by 2011 & 75% by 2013.** **% of the population having access to an essential care package raised to 40% by 2011 & 75% by 2013.**	**Lack of funds**	1,682,675,000
			2.1.1.2	Strenghten family planning in all health facilities	**Contraceptive Prevelence Rate (traditional & modern) increased to 2.5% by 2010, 5% by 2011 & 7.50% by 2013.** **New users of modern contraceptive method (male/female) raised to 2.5% by 2010, 5% by 2011 & 7.5% by 2013.** **New users of modern contraceptive type (male/female) raised to 10% by 2011 & 15% by 2013**	**Lack of funds**	27,600,000
			2.1.1.3	Provide family planning commodities in all familiy planning units	**Service delivery points without stock out of family plannig commodities raised to 10% by 2011 & 20% by 2013**	**Lack of funds**	2,000,600,000
			2.1.1.4	Strenghten IMCH at State & LGA levels including the Private Health facilities	**Delivery in health facility raised to 58% by 2011 & 68% by 2013. Pregnant women with 4 ANC visits raised to 71% by 2011 & 75% by 2013.** **Proportion of births attended by skilled health personnel raised to 68% by 2011 & 75% by 2013.** **Children exclusively breastfed 0-6months raised to 10% by 2011 & 15% by 2013.** **Children under 5years stunted (height for age under 2 SD) reduced to 25% by 2011 & 21% by 2013**	**Lack of funds**	224,600,000

			2.1.1.5	Strenghten EmOC in the State & LGAs Public & Private Health facilities	**% of women with complications trated in an EmOC facility (Basic &/or comprehensive) raised to 15% by 2011 & 25% by 2013. Caesarean section rate raised to 6% by 2011 & 10% by 2013. Case fatality rate among women with obstetric complications in EmOC facilities reduced to 30% by 2011 & 25% by 2013. Perinatal mortality rate reduced to 45/1000LBs by 2011 & 40/1000LBs by 2013. % of women who receive postnatal care based on standards within 48hr after delivery raised to 10% by 2011 & 15% by 2013**	**Lack of funds & difficult terrain**	224,600,000
		2.1.2	To strengthen specific communicable and non communicable disease control programmes				**52,917,850,000**
			2.1.2.1	Strengthen malaria prevention by providing ITNs, reduce malaria vector by indoor residual spraying, intensify community awareness and mobilization campaigns, M & E of programme	**% of ITN utilization amongst children and pregnant women raised to 34% and 29% respectively in 2013 and to 46% and 39% respectively in 2015.**	**Lack of funds**	24,023,970,000
			2.1.2.2	Strengthen malaria treatment by providing ACT and ensuring successful treatment using approved protocol and IPT for malaria during pregnancy.	**% of under 5 with fever receiving malaria treatment and pregnant women receiving IPT raised to 41% and 21% respectively in 2013 and to 46% and 29% respectively in 2015.**	**Lack of commitment**	12,017,970,000
			2.1.2.3	Expand the Health sector response to HIV/AIDS & TBL control programmes e.g. conduct needs assessment for HIV/AIDS & TBL in 23 LGAs, training of staff, provision of nutritional supplements, consumables, test kits, treatment manuals, itensified community awarenes and mobilization campaigns etc, M & E of programmes	**% of female population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS raised to 27% by 2011 and 37% by 2013.** **% of male population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS raised to 46% by 2011 and 56% by 2013.** **% of Female with knowledge of TB raise to 73% by 2011 & 77% by 2013.** **% of male with knowledge of TB raised to 85% by 2011 and 89% by 2013**	**Lack of commitment**	2,423,970,000
			2.1.2.4	Expand the Health sector response to diarrhoeal diseases/acute respiratory tract infections/integrated management of neonatal and childhood infections control programmes e.g. training of LGA IMNCI programme officers on management of DDs, ensuring regular supply of materials and ORS to 23 LGAs, intensified community	**Proportion of diarrhoea in children reduced to 2% in 2013 and to 1% in 2015.**	**Lack of funds and commitment**	2,423,970,000

				awareness and mobilisation campaigns, M & E of programme			
			2.1.2.5	Expand the Health sector response to swine flu and avian influenza control project e.g. training of staff, organization of State and LGAs stakeholders forum, regular meetings with organized/private sectors on surveillance, conduct surveillance activities in all focal health facilities, disinfection and decontamination of infected sites, identification, quarantine and isolation of suspected cases, provision of project vehicles, office equipment, provision of anti-retroviral drug Tamiflu for at least 25% of State population, ICT materials, intensified community awareness and mobilisation campaigns	**80% of health facilities supplied with ICT materials on swine flu & influenza by end of 2nd quarter of 2010**	**Lackof funs and commitment**	12,027,970,000
		2.1.3	To make Standard Operating procedures (SOPs) and guidelines available for delivery of services at all levels				**-**
		2.1.4	To strengthen routine immunization and run campaigns for control of communicable diseases				**3,016,193,600**
			2.1.4.1	Recruit and train staff for routine immunizatin, implementation of IMNCH strategy, house numbering, M&E	**Proportion of 12-23 months-old children fully immunized raised to 41% by 2011, 45% by 2013 49% in 2015.**	**Questionnable vaccine potency**	2,096,493,600
			2.1.4.2	Provide materials and equipment, logistics for mobilization and implementation of IMNCH strategy, vaccine distribution and supervision		**Lack of funds**	687,000,000
			2.1.4.3	Run campaigns for control of communicable diseases e.g. poliomyelitis, measles		**Lack of funds and commitment**	216,400,000
			2.1.4.4	Train community members on key household health promotion practices		**Lack of funds and commitment**	16,300,000
		2.1.5	To stregthen noncommunicable disease control				**394,735,000**
			2.1.5.1	Train resource persons (DPHS, NCD officer, M&E officer, NTD officer, PHC health workers)	**80% of resource persons trained by end of 2011**	**Lack of funds**	68,700,000
			2.1.5.2	Purchase training equipments / materials for NCDs and print and distribute approved health posters by FMOH	**All health facilities display health posters by end of 2011**	**Lack of funds**	289,575,000
			2.1.5.3	Introduce NCDs into regular disease surveillance	**NCDs introduced into disease surveilance by 1st quarter of 2010**	**Lack of funds and commitment**	110,000
			2.1.5.4	Carry out field surveillance and data gathering on NCDs	**80% if NCD surveillance carried out by end of 2013**	**Lack of funds and commitment**	36,350,000
	2.2	**To increase access to health care services**			**50% of the population is within 30mins walk or 5km of a health service by end 2011**		**23,513,515,000**
		2.2.1	To improve geographical equity and access to health services				**21,002,917,500**
			2.2.1.1	Periodic mapping of health facilities and meetings to develop criteria for siting of new health facilities at State and LGA levels	**All health facilities mapped by 3rd quarter of 2010**	**Lack of funds**	2,917,500

			2.2.1.2	Construction, completion and equipping of 160 model health facilities, secondary health facilities, School of Basic Midwifery, College of Health Sciences and Technology.	**40% of health facilities upgraded and refurbished by 2011 & 50% by 2013 & School of Basic Midwifery established by 3rd quarter of 2013. Delivery in health facility raised to 58% by 2011 & 68% by 2013. Pregnant women with 4 ANC visits raised to 71% by 2011 & 75% by 2013. Proportion of births attended by skilled health personnel raised to 68% by 2011 & 75% by 2013 40% of the population have access to essential care package by 2011 & 75% by 2013**	**Lack of funds and political will**	21,000,000,000
		2.2.2	To ensure availability of drugs and equipment at all levels				**417,425,000**
			2.2.2.1	Strengthen Essential Drugs Management Committee to meet regularly, to assess performance and to review the essential drugs list at different levels of health facilities in line with the essential package of care	**Biannual meeting of Essential Drugs Management Committee by end of 2010**	**Lack of commitment by Committee members**	2,040,000
			2.2.2.2	Procure and distribute essential drugs on a sustainable basis at State and LGA levels based on need, including satellite pharmacies for 4 General Hospitals and BMSH	**% of health facilities with all essential drugs available at all times raised to 50% by 2011, 70% by 2013 and 90% by 2015**	**Lack of funds & fake/expired drugs syndrome**	207,935,000
			2.2.2.3	Recruit, train and re-train Pharmacists/Pharmacy Technicians and others and establish School of Pharmacy in Rivers State University of Science and Technology	**Pharmacists/Pharmacy technicians & others recruited, trained & retrained and School of Pharmacy established in Rivers State University of Science and Technology by end of 2014**	**Lack of funds and political will**	203,750,000
			2.2.2.4	Strengthen the Pharmaceutical Inspectorate Unit of the MOH to conduct periodic monitoring, evaluation and inspection of essentials drugs and equipment at State and LGA levels	**% of health facilities with all essential drugs available at all times raised to 70% by 2013 and 90% by 2015**	**Lack of funds**	3,300,000
			2.2.2.5	Establish Drug Abuse Control and Drug Information Unit in MOH	**Drug Abuse Control and Drug Information Unit in MOH established by end of 2011**	**Lack of political will**	400,000
		2.2.3	To establish a system for the maintenance of equipment at all levels				**2,033,975,000**
			2.2.3.1	Review and maintain equipment and furniture at different levels of health facilities in line with the essential package of care and the National Health Equipment Policy, and establish mechanism to procure and distribute them on a sustainable basis at State and LGA levels based on need	% of health institutions with basic medical equipment and functional logistic system appropriate to their levels raised to 35% by 2011, 55% by 2013 and 75% by 2015.	Lack of funds, Political Will & commitment of staff	1,202,455,000
			2.2.3.2	Establish medical equipment and hospital furniture maintenance workshops at State and LGA levels	"	Lack of funds & Political Will	230,000,000
			2.2.3.3	Periodic maintenance of medical equipment and hospital furniture at State and LGA facilities	"	Lack of funds	600,000,000

			2.2.3.4	Establish collaboration with the private sector in maintaining medical equipment and hospital furniture	Private sector collaboration established by end of 2010	Lack of commitment	1,520,000
		2.2.4	To strengthen referral system				**33,812,500**
			2.2.4.1	Establish a Joint Consultative Committee on Referral to map out network linkages for two-way referrals in the State and LGAs	**Network linkages for two-way referrals mapped out by 2nd quarter of 2010**	**Lack of funds & commitment**	1,862,500
			2.2.4.2	Design, print and distribute a model referral form to all health facilities in the State and LGAs	**Model referral forms available in all health facilities by 3rd quarter of 2010 & distributed quarterly**	**Lack of funds, commitment, security & difficult terrain**	2,200,000
			2.2.4.3	Set up two model referral systems in a predominanatly riverrine and upland communities in the State	**2 model referral systems set up in 1 predominantly riverine & upland communities by 3rd quarter of 2010**	**Lack of funds, commitment, security & difficult terrain**	800,000
			2.2.4.4	Provide logistics (transportation, communication etc) for referrals in the State and LGAs	**Logistics provided for referrals by 2nd quarter of 2010**	**Lack of funds**	6,700,000
			2.2.4.5	Monitor referral outcomes in the State and LGAs	**Referral outcome of monitored by end of 2011 & thereafter annually**	**Lack of funds, commitment, security & difficult terrain**	22,250,000
		2.2.5	To foster collaboration with the private sector				**25,385,000**
			2.2.5.1	Establish a Public Private Partnership Committee on Health	**Public Private Partnership Committe inaugurated and functional by 1st quarter of 2011**	Lack of funds & commitment of members	835,000
			2.2.5.2	Review the list of all categories of private health care providers by operational level and location	**List of all categories of private health care providers reviewed by 3rd quarter of 2011 & therafter annually**	Lack of funds	17,375,000
			2.2.5.3	Develop guidelines (for partnership, training and outsourcing of services) as well as standards for regulation of PPP practice and registration	**Availability of PPP guidelines & standards for regulation of practice by the 3rd quarter of 2011**	**Lack of funds and commitment of committee members**	1,000,000
			2.2.5.4	Develop and implement joint performance monitoring mechanism for the private sector	**Collaboration with the private sector in performance monitoring established by end of 2011**	**Lack of funds, commitment, security & difficult terrain**	3,600,000
			2.2.5.5	Adapt and implement the National Policy on Traditional Medicine	**Implementation of the National Policy on Traditional Medicine by 1st quarter of 2013**	**Lack of funds & professional conflict**	2,575,000
	2.3	**To improve the quality of health care services**			**50% of health facilities participate in a Quality Improvement programme by end of 2012**		**51,050,000**
		2.3.1	To strengthen professional regulatory bodies and institutions				**41,350,000**
			2.3.1.1	Review, update and implement operational guideline of all regulatory bodies (PHC Board, RSHMB) in the State	Reviewed 0perational guidelines for PHC Board & RSHMB implemented by end of 2011	Lack of funds & Political Will	8,650,000
			2.3.1.2	Periodic training of regulatory staff to monitor compliance of providers to the regulatory guidelines	80% of staff trained to monitor coplaince of providers to regulatory guidlines by end of 1st quarter of 2012	Lack of funds & Political Will	32,700,000

			2.3.1.3	Provide the necessary security to enhance monitoring exercises with appropriate documentation and feedback	Monitoring exercises documentation and feedback system put in place by end of 2012	Lack of funds	-
		2.3.2	To develop and institutionalise quality assurance models				**9,700,000**
			2.3.2.1	Review existing models of quality assurance at all levels of healthcare delivery in the State	Models of quality assurance reviewed in the State & LGA levels by 1st quarter of 2014	Lack of funds	2,575,000
			2.3.2.2	Institutionalise and implement quality assurance and improvement initiatives at the State and LGA levels	Quality assurance and improvement initiatives institutionalised at the State and LGA levels by 2nd quarter of 2014	Lack of funds and political will	2,575,000
			2.3.2.3	Strengthen existing mechanism to monitor the implementation of quality of care	Implementation of quality of care monitored by third quarter of 2014	Lack of funds	4,550,000
		2.3.3	To institutionalize Health Management and Integrated Supportive Supervision (ISS) mechanisms				**-**
			2.3.3.1	Establish Integrated Supportive Supervision (ISS) mechanisms at the State and LGA health facilities	Integrated Supportive Supervision (ISS) mechanisms exist in 80% of State and LGA health facilities by end of 2015	Lack of funds & Political Will	-
	2.4	**To increase demand for health care services**			**Average demand rises to 2 visits per person per annum by end 2011**		**89,570,000**
		2.4.1	To create effective demand for services				**89,570,000**
			2.4.1.1	Disseminate and implement a national health promotion communication strategy based on the National Health Promotion Policy	80% of health facilities imlement the National health promotion communication strategy based on the National Health Promotion Policy by end of 1st quarter of 2015	Lack of funds & Political Will	1,070,000
			2.4.1.2	Create awareness and mobilise community for behavioural change in order to promote positive lifestyles for disease prevention and increased demand for health services	80% of communities in the state & LGAa live a positive lifestyles for disease prevention and demand health services by 1st quarter of 2014	Lack of funds, commitment, security & difficult terrain	81,900,000
			2.4.1.3	Monitor and evaluate activities periodically	M & E report available by end of 2011 & thereafter annually	Lack of funds, commitment, security & difficult terrain	6,600,000
	2.5	**To provide financial access especially for the vulnerable groups**			**1. Vulnerable groups identified and quantified by end 2010 2. Vulnerable people access services free by end 2015**		**4,011,495,000**
		2.5.1	To improve financial access especially for the vulnerable groups				**4,011,495,000**
			2.5.1.1	Review existing models for financial protection for the vulnerable groups (free medical care programme [FMCP]) e.g. pregnant women, under fives, adolescents, the aged etc	Existing financial protection model for the vulnerable groups FMCP reviewed by 1st quarter of 2013	Lack of funds & commitment	2,575,000
			2.5.1.2	Enact law on FMCP for sustainability by the RSHA	Law on FMCP sustainability enacted by end of 2010	Lack of funds & Political Will	720,000

			2.5.1.3	Treat beneficiaries of FMCP in the State & LGAs	Beneficiaries of FMCP in the State & LGAs treated by end of 2015	Lack of funds & insincerity of workers	4,000,000,000
			2.5.1.4	Register new cases	80% of new cases registered by 3rd quarter of 2011	Lack of commitment & awareness	2,400,000
			2.5.1.5	Supervise, monitor and evaluate FMCP process	FCMB process supervised, monitored and evaluated by end of 2010 thereafter annually	Lack of funds, commitment, security & difficult terrain	5,800,000
HUMAN RESOURCES FOR HEALTH							
3. To plan and implement strategies to address the human resources for health needs in order to enhance its availability as well as ensure equity and quality of health care							**64,121,206,688**
	3.1	**To formulate comprehensive policies and plans for HRH for health development**			**All States and LGAs are actively using adaptations of the National HRH policy and Plan by end of 2015**		**14,847,000,000**
		3.1.1	To develop and institutionalize the Human Resources Policy framework				**14,847,000,000**
			3.1.1.1	Implement State HRH Policy and strategic plan on training and recruitment of health personnel to be non-restrictive and non-discriminatory irrespective of LGA origin and/or gender	% of wards that have appropriate HRH complement as per service delivery norm (urban/rural) increased to 38% by 2011, 54% by 2013 and 70% by 2015.	Lack of funds & political influence	14,847,000,000
			3.1.5.5				-
	3.2	**To provide a framework for objective analysis, implementation and monitoring of HRH performance**			**The HR for Health Crisis in the country has stabilised and begun to improve by end of 2012**		**57,000,000**
		3.2.1	To reappraise the principles of health workforce requirements and recruitment at all levels				**57,000,000**
			3.2.1.1	Implement training programmes aimed at producing adequate cadre of health professionals in critical areas of need (Specialist)	Stock (and density) of HRH per 10,000 pop for Qualified registered Midwives(or Nurses) 1:7000 by 2011 & 1:5000 by 2013, Dr. & Dentists 1:7000 by 2011 & 1:5000 by 2013, CHEWs 1:3500 by 2011 & 1:2500 by 2013, Pharmasist (per 20,000 pop) 1:17500 by 2011 & 1:12500 by 2013	Lack of funds & collaboration	57,000,000
	3.3	**Strengthen the institutional framework for human resources management practices in the health sector**			**1. 50% of States have functional HRH Units by end 2010 2. 10% of LGAs have functional HRH Units by end 2010**		**42,190,000**
		3.3.1	To establish and strengthen the HRH Units				**42,190,000**
			3.3.1.1	Create and strengthen HRH units at State and LGA levels to perform HRH functions	HRH units created & strengthened in the State & 80% of the LGAs by end of 2013 & in all the LGAs by end of 2015	Lack of funds & commitment	21,590,000
			3.3.1.2	Establish training programmes for HRH managers on human resource for health planning and management at State and LGA levels	Training programmes for HRH managers on planning and management established at State 80% of the LGAs & 100% end of 2015	Lack of funds & commitment	20,600,000

	3.4	**To strengthen the capacity of training institutions to scale up the production of a critical mass of quality, multipurpose, multi skilled, gender sensitive and mid-level health workers**			**One major training institution per Zone producing health workforce graduates with multipurpose skills and mid-level health workers by 2015**		**14,078,820,000**
		3.4.1	To review and adapt relevant training programmes for the production of adequate number of community health oriented professionals based on national priorities				**64,000,000**
			3.4.1.1	Expand training of community health workers and other cadres of supportive personnel, incorporating continuous assessments and appropriate curricula and programmes to reflect task shifting requirements	CHEW/10,000 population density improved from 1:4000 pop in 2010 to 1:2500 by 2013 then 1:1500 by 2015	Lack of funds	39,250,000
			3.4.1.2	Promote the National Midwives Service Scheme and the Community Midwifery Programme and recruit.	Qualified registered midwives per 10,000 population density improved from 1:8000 pop in 2010 to 1:5000 by 2013 then 1:3000 by 2015	Lack of funds	24,750,000
		3.4.2	To strengthen health workforce training capacity and output based on service demand				**14,014,820,000**
			3.4.2.1	Conduct periodic upgrading of teaching and learning materials, infrastructure and financial support as incentives for retention of staff	Teaching and learning materials, infrastructure and financial support as incentives for retention of staff upgraded at the end of 2012 & 2015	Lack of funds & inadequate motivation	8,002,200,000
			3.4.2.2	Establish quality assurance and education review units in all training institutions	Quality assurance and education review units established in all training institutions by 2nd quarter of 2012	Lack of funds	5,000,000
			3.4.2.3	Review periodically the curricula of training institutions to reflect the disease burden situation of the State	Institutions' training curricula reviewed annually to reflect disease burden situation of the State by end of 2010	Lack of funds	7,620,000
			3.4.2.4	Promote and coordinate human capital capacity building and continuous professional development (CPD) by the State to discourage migration across States and outside the country	Well coordinated human capital capacity building and continuous professional development (CPD) put in place by end of 2011	Lack of funds	6,000,000,000
	3.5	**To improve organizational and performance-based management systems for human resources for health**			**50% of States have implemented performance management systems by end 2012**		**35,093,196,688**
		3.5.1	To achieve equitable distribution, right mix of the right quality and quantity of human resources for health				**34,961,886,688**
			3.5.1.1	Create a database of HRH including job descriptions and specifications for all categories of health workers	Database of HRH for all categories of health workers available by end of 2010	Lack of funds	2,100,000
			3.5.1.2	Redeploy staff equitably between rural and urban areas at the different levels of the healthcare system in relation to needs, paying attention to staff mix, in collaboration with federal institutions in the State to ensure service coverage and quality	Equitably distributed workforce in the rural and urban areas in place by 3rd quarter of 2011	Political influence & non- compliance	100,000
			3.5.1.3	Promote mandatory rotation of health workers to underserved rural areas e.g. through NYSC scheme	Mandatory rotation of health workers to underserved rural areas e.g. through NYSC scheme put in place by 1st quarter of 2011	Political influence & non- compliance	100,000

			3.5.1.4	Create an enabling (hazard free) environment for staff motivation and establish performance based incentives	Hazard free environment & well motivated staff established by end of 2013	Lack of funds, security & difficult terrain	12,000,000
			3.5.1.5	Personnel cost - SMOH - RSHMB	Salary of all health personnel paid montly	Lack of funds	34,947,586,688
		3.5.2	To establish mechanisms to strengthen and monitor performance of health workers at all levels				**131,310,000**
			3.5.2.1	Promote and conduct routine re-orientation of health workforce on attitudinal change including training and re-training in Interpersonal Communication (IPC) skills and work ethics	20% of health workforce trained & re-trained on Interpersonal Communication (IPC) skills and work ethics by end of 2011	Lack of funds & resistance	126,610,000
			3.5.2.2	Strengthen the system of recognition, reward and sanctions in the State and LGAs	20% of the workforce in the State & LGAs well rewarded and disciplined by end of 2011	Lack of funds & interest	3,000,000
			3.5.2.3	Strengthen integrated supportive supervision and monitoring of health workers' performance including use of client feedback (exit interviews) in the State and LGAs	Health workers' performance supervised & monitored in 20% of facilities in the State and LGAs by end of 2011	Lack of funds, security & difficult terrain	1,700,000
	3.6	**To foster partnerships and networks of stakeholders to harness contributions for human resource for health agenda**			**50% of States have regular HRH stakeholder forums by end 2011**		**3,000,000**
		3.6.1	To strengthen communication, cooperation and collaboration between health professional associations and regulatory bodies on professional issues that have significant implications for the health system				**3,000,000**
			3.6.1.1	Establish effective dialogue and complaints channels between management and staff of public and private sectors, as well as HRH regulatory bodies and associations	Effective dialogue and complaints channels established in 20% of public & private sectors by mid 2013	Resistance	3,000,000
FINANCING FOR HEALTH							
4. To ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and consumption at Local, State and Federal levels							**6,481,697,500**
	4.1	**To develop and implement health financing strategies at Federal, State and Local levels consistent with the National Health Financing Policy**			**50% of States have a documented Health Financing Strategy by end 2012**		**1,020,000**
		4.1.1	To develop and implement evidence-based, costed health financing strategic plans at LGA and State levels in line with the National Health Financing Policy				**1,020,000**
			4.1.1.1	Set up technical working groups to ensure the implementation of state specific safety nets at the State and LGAs.	% of LGAs implementing state specifice safety nets raised to 25% by 2011 & 40% by 2013	Lack of funds & commitment of members & difficult terrain	1,020,000
			4.1.1.2		State & LGA Strategic Plans developed & implemented by 1st quarter of 2010	Lack of funds	-
	4.2	**To ensure that people are protected from financial catastrophe and impoverishment as a result of using health services**			**NHIS protects all Nigerians by end 2015**		**6,024,352,500**
		4.2.1	To strengthen systems for financial risk health protection				**6,024,352,500**
			4.2.1.1	Establish a law to provide legislative backing for Rivers State Social Health Protection Agency (RSSHPA)	The capacity of NHIS strenghtened by the end of 2010	Lack of funds	1,220,000

			4.2.1.2	Strenghten and sustain Free Medical Care Programme (FCMP) in the State (Provide subsidy for vulnerable groups including children <5yrs, adult >60yrs, pregnant mothers etc)	Free Medical Care Programme (FCMP) in the State streghtened by 1 quarter of 2011. Out of pocket expenditure as a % of total health expenditure reduced to 60% by 2011 & 50% by 2013	Lack of funds & Political Will	6,023,132,500
	4.3	**To secure a level of funding needed to achieve desired health development goals and objectives at all levels in a sustainable manner**			**Allocated Federal, State and LGA health funding increased by an average of 5% pa every year until 2015**		**121,385,000**
		4.3.1	To improve financing of the Health Sector				**99,425,000**
			4.3.1.1	Establish PHC Managent Board to get State & Local Governments to increase the allocation of public resources to the health sector to 15% of total budget in line with Abuja declaration & to assist in the effective & effecient use of these resources	State & Local Governments' allocation of public resources to the health sector increased to 15% of total budget by end of 2011. % of LGA budget allocated to the health sector raised to 10% by 2011 & 20% by 2013	Lack of funds & Political Will	99,425,000
		4.3.2	To improve coordination of donor funding mechanisms				**21,960,000**
			4.3.2.1	To establish common basket funding through options such as joint funding agreements, sector-wide approaches (SWAps) and sectoral multi-donor budget support etc that will be coordinated by Health Partners Coordinating Committee (HPCC) which serves as government coordinating body with other development partners at the State level	Common basket funding established by 3rd quarter of 2013	Lack of funds & Political Will	21,960,000
	4.4	**To ensure efficiency and equity in the allocation and use of health sector resources at all levels**			**1. Federal, 60% States and LGA levels have transparent budgeting and financial management systems in place by end of 2015** **2. 60% of States and LGAs have supportive supervision and monitoring systems developed and operational by Dec 2012**		**334,940,000**
		4.4.1	To improve Health Budget execution, monitoring and reporting				**15,650,000**
			4.4.1.1	Develop costed, annual operational State & LGA plans with technical assistance from the FMOH	% of LGAs which allocate costed fund to fully implement essential care package at N5,000/capita (US$34) raised to 10% by 2011 & 15% by 2013. LGAs health budget fully alligned to support state health goals and policies raised to 40% by 2011 & 50% by 2013	Lack of funds	13,600,000
			4.4.1.2	Build additional capacity for proper internal recording to ensure that accounting of expenditures are maintained and that timely and detailed financial management reports are produced periodically.	Proportion of State & LGAs having transparent budgeting & financial management systems	Lack of funds & Political Will	1,800,000

					raised to 25% by 2011 & 40% by 2013		
			4.4.1.3	Develop State and LGA Health Accounts (SHA & LGHAs), Public Expenditure Reviews (PERs) and tracking of health budgets to increase financial transparency	% of LGAs having operational supportive supervision and monitoring systems raised to 25% by 2011 & 40% by 2013	Lack of funds	250,000
		4.4.2	To strengthen financial management skills				**319,290,000**
			4.4.2.1	Conduct hands – on training and competency transfer to enable the State and LGAs manage their financial systems	State & LGA financial management systems adequately managed by 2nd quarter of 2011	Lack of funds	15,210,000
			4.4.2.2	Establish the Rivers State Social Health Protection Agency to implement the Rivers State Social Health Protection Programme	Decrease proportion of informal payments within the public health care system within each LGA to 75% by 2011 & 70% by 2013	Lack of funds & Political Will	4,080,000
			4.4.2.3	Establish Rivers State Primary Health Care Development Fund to ensure the sustainability of PHC provision in the State & LGAs	Rivers State Primary Health Care Development Fund established by end of 2010	Lack of funds & Political Will	300,000,000
NATIONAL HEALTH INFORMATION SYSTEM							
5. To provide an effective National Health Management Information System (NHMIS) by all the governments of the Federation to be used as a management tool for informed decision-making at all levels and improved health care							**2,722,415,000**
	5.1	**To improve data collection and transmission**			**1. 50% of LGAs making routine NHMIS returns to State level by end 2010 2. 60% of States making routine NHMIS returns to Federal level by end 2010**		**2,543,165,000**
		5.1.1	To ensure that NHMIS forms are available at all health service delivery points at all levels				**30,000,000**
			5.1.1.1	Print and distribute data collection forms regularly	% of LGAs making routine NHMIS returns to State raised to 50% by 2011, 70% by 2013 and 90% by 2015	**Lack of funds**	30,000,000
		5.1.2	To periodically review of NHMIS data collection forms				**-**
		5.1.3	To coordinate data collection from vertical programmes				**16,560,000**
			5.1.3.1	Revitalize Health Data Consultative Committee in the State in collaboration with partners and other government agencies to streamline and strenghten data collection systems	**Availability of accurate data in the State and LGAs end of 2010**	**Lack of funds & collaboration**	15,360,000
			5.1.3.2	Establish & strengthen linkages and harmonized data collection mechanism in the State & LGA levels	**Availability of accurate data in the State and LGAs end of 2010**	**Lack of funds & difficult terrain**	1,200,000
		5.1.4	To build capacity of health workers for data management				**2,269,380,000**
			5.1.4.1	Conduct comprehensive training & re-training of service providers on data collection tools, analysis and utilization of data for action in health programminig and policy formulation	% of health facility staff trained to use the NHMIS infrastructure raised to 50% by 2011, 70% by 2013 and 90% by 2015.	Lack of funds	17,880,000
			5.1.4.2	Recruit health information personnel where grossly inadequate to support the system	Availability of accurate data in the State and LGAs end of 2010	Lack of funds & Political Will	2,250,000,000

			5.1.4.3	Procure & maintain materials & equipment for data management	Availability of accurate data in the State and LGAs end of 2010	Lack of funds	1,500,000
		5.1.5	To provide a legal framework for activities of the NHMIS programme				**16,665,000**
			5.1.5.1	Set up a committee to adopt and enforce the sanction of private care providers that fail to submit health data to the relevant health authorities in the State and LGAs proposed in the National Health Bill	Regular submission of data by 80% of private care providers by the end of 2011		9,265,000
			5.1.5.2	Systematic advocacy to the State Assembly by the SMOH to make them understand the value and usefulness of data as well as promulgate an enabling law and bye laws to make it mandatory	Enabling law and bye laws promulgated by 2nd quarter of 2010	**Lack of Political Will**	320,000
			5.1.5.3	Review and equip existing vital registration mechanism in view of strenghtening it and establish Data Bank at the SMOH	Data Bank established at the SMOH by end of 2011	**Lack of funds**	7,080,000
		5.1.6	To improve coverage of data collection				**3,510,000**
			5.1.6.1	Re-enforce data submission by tieing it to registration of private health facilities and giving of imprest to public health facilities	60% increase of data submission by private health facilities by the end 2011	Lack of Political Will	2,160,000
			5.1.6.2	Review and improve the method of community based data collection	Availability of accurate data in the State and LGAs end of 2010	Lack of funds & difficult terrain	1,350,000
		5.1.7	To ensure supportive supervision of data collection at all levels				**207,050,000**
			5.1.7.1	Carry out supportive supervision of data collection at the State and LGA levels	% of health facilities benefiting from HMIS supervisory visits from SMOH raised to 30% by 2011, 50% by 2013 and 70% by 2015.	Lack of funds & difficult terrain	1,050,000
			5.1.7.2	Provide timely logistics materials (vehicles or motorcycles or sea boats) for officers to supervise data collection & facilitate use of NHMIS field monitoring instruments at State & LGA levels	80% logistics provided for data supervision & collection at lower levels by 1st quarter of 2010	Lack of funds & Political Will	206,000,000
	5.2	**To provide infrastructural support and ICT of health databases and staff training**			**ICT infrastructure and staff capable of using HMIS in 50% of States by 2012**		**34,400,000**
		5.2.1	To strengthen the use of information technology in HIS				**29,400,000**
			5.2.1.1	Promote software-based systems for data collection and analysis, and strengthen the use of information technology on HIS	% of HMIS operators at the LGA level trained in analysis of data using the operational manual raised to 50% by 2011, 70% by 2013 and 90% by 2015	Lack of funds	6,000,000
			5.2.1.2	Strengthen public-private partnerships in the management of data, as well as mechanisms to enhance the wide use of e-health data, such as electronic Management Intelligence Information System, websites, patient information system, etc	80% utilization of available data by 2nd quarter of 2011	Lack of funds & collaboration	23,400,000
		5.2.2	To provide HMIS Minimum Package at the different levels (FMOH, SMOH, LGA) of data management				**5,000,000**

			5.2.2.1				-
			5.2.2.1	Monitor the use of computer hardware systems	20% use of computer hardware systems monitored by end of 2011	Lack of funds	950,000
			5.2.2.2	Train and re-train relevant staff on the use of computer database systems	20% of relevant staff trained & re-trained on the use of computer database systems by end of 2011	Lack of funds	4,050,000
	5.3	**To strengthen sub-systems in the Health Information System**			**1. NHMIS modules strengthened by end 2010 2. NHMIS annually reviewed and new versions released**		**92,700,000**
		5.3.1	To strengthen the Hospital Information System				**82,200,000**
			5.3.1.1	Establish and strenghten patient information systems as well as systems for mapping disease	Patient information systems & systems for mapping disease established & strenghtened by end of 2011	Lack of funds	82,200,000
		5.3.2	To strengthen the Disease Surveillance System				**10,500,000**
			5.3.2.1	Conduct advocacy meetings for policy makers to support surveillance	Polical support in surveillance achieved by end of 2011	Lack of Political Will	900,000
			5.3.2.2	Ensure regular reporting of notifiable diseases by all health facilities and strengthen community based surveillance	80% of notifiable diseases reported by 80% health facilities by end of 2011	Lack of funds & difficult terrain	9,600,000
			5.3.2.3				-
	5.4	**To monitor and evaluate the NHMIS**			**NHMIS evaluated annually**		**26,200,000**
		5.4.1	To establish monitoring protocol for NHMIS programme implementation at all levels in line with stated activities and expected outputs				**18,900,000**
			5.4.1.1				-
			5.4.1.1	Empower a central M & E unit in the Department of Planning, Research and Statistics to monitor & evaluate all health activities at the State and LGA levels to ensure data and information quality as well as conduct process of impact evaluation of all activities in PHC & State facilities	% of health facilities benefiting from HMIS supervisory visits from SMOH raised to 50% by 2013 and 70% by 2015. The process to evaluate all activities in PHC & State facilities commenced by end of 2010	Lack of funds and political will	18,900,000
		5.4.2	To strengthen data transmission				**7,300,000**
			5.4.2.1	Build institutional and human capacities for timely and complete transmission of data in line with relevant guidelines	Timely and complete transmission 80% of data achieved by end 2013	Lack of funds & difficult terrain	7,300,000
	5.5	**To strengthen analysis of data and dissemination of health information**			**1. 50% of States have Units capable of analysing health information by end 2010 2. All States disseminate available results regularly**		**25,950,000**
		5.5.1	To institutionalize data analysis and dissemination at all levels				**25,950,000**

			5.5.1.1	Strenghten institutional and human capacity for appropriate data analysis and dissemination of information and data to inform decision making and programming	% of LGAs receiving feedback on NHMIS from SMOH raised to 50% by 2011, 70% by 2013 and 90% by 2015. % of LGA plans using the HMIS data raised to 30% by 2011, 50% by 2013 & 70% by 2015	Lack of funds	3,000,000
			5.5.1.2	Strenghten production & dissemination of periodic health data, bulletin and annual reports by Department of Planning, Research and Statistics at the State & LGAs levels	% of LGAs publishing annual HMIS reports raised to 30% by 2011, 50% by 2013 and 70% by 2015.	Lack of funds and commitment	21,500,000
			5.5.1.3	Train LGA PHC Coordinators in data dissemination	% of LGA PHC Coordinators trained in data dissemination raised to 60% by 2011, 80% by 2013 and 100% by 2015	Lack of funds and commitment	1,450,000
COMMUNITY PARTICIPATION AND OWNERSHIP							
6. To attain effective community participation in health development and management, as well as community ownership of sustainable health outcomes							**87,925,000**
	6.1	**To strengthen community participation in health development**			**All States have at least annual Fora to engage community leaders and CBOs on health matters by end 2012**		**6,675,000**
		6.1.1	To provide an enabling policy framework for community participation				**2,060,000**
			6.1.1.1	Create an enabling policy environment to foster effective community participation in health actions through the appropriate revision of community participation section of the State Health Policy	% of wards holding quarterly health committee meetings raised to 25% by 2011 & 50% by 2013	Lack of funds	2,060,000
		6.1.2	To provide an enabling implementation framework and environment for community participation				**4,615,000**
			6.1.2.1	Implement existing guidlines establishing community participation.	20% of existing guideline establishing community participation implemented by 2011	Lack of funds	2,040,000
			6.1.2.2	Establish inter-sectoral stakeholder committee involving community representatives at State and LGA levels to enhance collaborattion	Proprotion of public health facilities having active committees that include community representatives (with meeting reports and actions recommended) raised to 40% by 2013 and 50% by 2015.	Lack of funds & inadequate collaboration	2,575,000
	6.2	**To empower communities with skills for positive health actions**			**All States offer training to FBOs/CBOs and community leaders on engagement with the health system by end 2012**		**61,600,000**
		6.2.1	To build capacity within communities to 'own' their health services				**61,600,000**
			6.2.1.1	Train Health Development Committee members on their roles and responsibilities in community mobilization.	% of Health Development Committee members trained in community mobilization raised to 40% by 2011, 60% by 2013 and 80% by 2015.	Lack of funds and political will.	3,400,000
							-

			6.2.1.2	Enlighten and empower communities for positive action through information, education and communication (IEC) activities and media	% of LGAs implementing an integrated Health Communication Plan raised to 25% by 2011, 35% by 2013 and 45% by 2015	Lack of funds and political will.	58,200,000
	6.3	**To strengthen the community - health services linkages**			**50% of public health facilities in all States have active Committees that include community representatives by end 2011**		**6,350,000**
		6.3.1	To restructure and strengthen the interface between the community and the health services delivery points				**6,350,000**
			6.3.1.1	Review and assess the level of linkages of the existing health delivery structures with the community	Level of linkages of 80% of existing health delivery structures with the community reviewed and assessed by end of 2013		3,850,000
			6.3.1.2	Promote exchange of experiences between community development committees to strenghten interface between health services delivery points and communities.	% of health actions jointly implemented with HDCs and other related committees raised to 25& by 2011, 35% by 2013 and 45% by 2015.	Lack of funds & Political Will	2,500,000
	6.4	**To increase national capacity for integrated multisectoral health promotion**			**50% of States have active intersectoral committees with other Ministries and private sector by end 2011**		**9,800,000**
		6.4.1	To develop and implement multisectoral policies and actions that facilitate community involvement in health development				**9,800,000**
							-
			6.4.1.1	Develop and implement community health development programmes	Community health development programmes developed & 20% implemented by end of 2011	Lack of funds	6,000,000
			6.4.1.2	Give support to various levels to link health with other sectors using the health promotion guidelines	Health with other sectors linked by the end of 2011	Lack of funds collaboration	3,800,000
			6.4.1.5				-
	6.5	**To strengthen evidence-based community participation and ownership efforts in health activities through researches**			**Health research policy adapted to include evidence-based community involvement guidelines by end 2010**		**3,500,000**
		6.5.1	To develop and implement systematic measurement of community involvement				**3,500,000**
			6.5.1.1	Use locally adapted models to establish simple mechanisms to support communities to measure impact and document lessons learnt and best practices from specific community-level approaches, methods and initiatives	Communities supported to measure impact in 20% of the 23 LGAs by end of 2011	Lack of funds	1,400,000
			6.5.1.2	Disseminate findings to enhance knowledge sharing amongst stakeholders	20% of stakeholders in the 23 LGAs informed by end of 2011	Lack of funds	2,100,000
PARTNERSHIPS FOR HEALTH							
7. To enhance harmonized implementation of essential health services in line with national health policy goals							**256,370,000**

	7.1	**To ensure that collaborative mechanisms are put in place for involving all partners in the development and sustenance of the health sector**			**1. FMOH has an active ICC with Donor Partners that meets at least quarterly by end 2010 2. FMOH has an active PPP forum that meets quarterly by end 2010 3. All States have similar active committees by end 2011**		**256,370,000**
		7.1.1	To promote Public Private Partnerships (PPP)				**157,150,000**
			7.1.1.1	Implement existing PPP Policy in line with the reviewed National PPP policy.	New PPP initiatives per year per LGA raised to 20% by 2011, 30% by 2013 and 40% by end of 2015.	Lack of funds	10,150,000
			7.1.1.2	Establish PPP units at State and LGA levels to promote, oversee and monitor PPP initiatives		Lack of funds	25,100,000
			7.1.1.3	Strenghten existing PPP collaboration (e.g. funding, service delivery, training, survey/research community mobilization, awareness creation, Health Education etc)		Lack of funds	114,300,000
			7.1.1.4	Establish PPP collaboration in security, Free Medical Service, Laboratory and Mortuary, Referrals, Health Statistics etc			7,600,000
		7.1.2	To institutionalize a framework for coordination of Development Partners				**3,630,000**
			7.1.2.1	Establish Development Partners Forum comprising only health development partners at State level as single entery points for engaging partners	% of LGAs holding annual multisectoral development partner meetings raised to 20% by 2011, 30% by 2013 & 40% by 2015.	Lack of funds & Pilitical Will	3,630,000
		7.1.3	To facilitate inter-sectoral collaboration				**2,700,000**
			7.1.3.1	Establish an inter-sectoral ministerial forum at State and LGA levels to facilitate inter-sectoral collaboration, involving all relevant MDAs directly engaged in the implementation of specific health programmes – such as Environment in Malaria control and prevention, Agriculture in Nutrition programmes, Water Resources in control of water borne or related diseases, Women Affairs in Maternel, Newborn and Child Health and Information in Behaviour Change Communication (BCC) programmes	Intersectoral ministerial forum established at State & LGAs by end of 2011	Lack of funds & collaboration	2,700,000
		7.1.4	To engage professional groups				**11,125,000**
			7.1.4.1	Promote effective partnership with professional groups through jointly setting standards of training by health institutions, subsequent practice and professional competency assessments	Effective partnership with professional groups established by end of 2011	Professional conflict	2,525,000
			7.1.4.2	Engage professional groups in planning, implementation, monitoring and evaluation of health plans and programmes and promote effective communication to facilitate relationships between professional groups and Ministry of Health	Professional groups engaged in planning health plans and programmes by end of 2010	Lack of collaboration	2,650,000

			7.1.4.3	Strengthen collaboration between government and professional groups to advocate for increased coverage of essential interventions, particularly increased funding and convene public lectures through a coordinated approach by professional associations to enhance the provision of skilled care by health professionals	20% collaboration between government and professional groups established & 30% of skilled care by health professionals provided by end of 2011	Lack of funds	2,650,000
			7.1.4.4	Promote linkages with academic institutions to undertake research, education and monitoring through existing networks	Linkages with academic institutions to undertake research, education and monitoring established by end of 2013	Lack of funds	1,650,000
			7.1.4.5	Influence regulation and legislation to allow for competency-based practice by all types of health professionals according to the principles of "continuum of care"	Competency-based practice by all types of health professionals established by end of 2013	Lack of Political Will	1,650,000
		7.1.5	To engage with communities				**32,100,000**
			7.1.5.1	Improve availability of information to communities, in a form that is readily accessible and useful through proper culturally approriate and gender sensitive dissemination channels	80% community access information by end of 2011	Lack of funds	2,300,000
			7.1.5.2	Include rights of beneficiaries, means of accessing care at health facilities and minimum standards of quality health services in information packages for community consumption	Information packages for community consumption produced by end of 2015	Lack of funds	2,300,000
			7.1.5.3	Establish and empower 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	Health Service Charters established at State & LGA levels by end of 2015	Lack of funds & collaboration	2,300,000
			7.1.5.4	Build the capacity of communities to prevent and manage priority health conditions through appropriate self-mediated mechanisms such as Behaviour Change Communication (BCC), Social marketing, Public Awareness Campaign, Information, Education and Communication resources (IEC), etc.	Positive behavioural change in 50% of communities in the State by end of 2013	Lack of funds	25,200,000
		7.1.6	To engage with traditional health practitioners				**49,665,000**
			7.1.6.1	Organise traditional medicine practitioners into bodies/organisations that are easy to regulate and actually regulate their practice	Traditional medicine practitioners bodies/organisations regulated by end of 2012	Lack of funds & conflict of interest	4,320,000
			7.1.6.2	Adopt traditional practices and technologies of proven value into State health care system and discourage those that are harmful	Traditional practices and technologies of proven value adopted into State health care system & those that are harmful discouraged by end of 2012	Lack of funds & suspision	4,320,000
			7.1.6.3	Train traditional health practitioners to improve their skills, to know their limitations and ensure their use of the referral system and discourage them from advertising themselves and making false claims in the public media	80% of traditional health practitioners trained to improve their skills by end of 2013	Lack of funds	36,705,000

			7.1.6.4	Seek the cooperation of traditional practitioners in promoting health programmes in such priority areas as nutrition, environmental sanitation, personal hygiene, immunisation and family planning	Health programmes promoted by end of 2015	Lack of collaboration	4,320,000
RESEARCH FOR HEALTH							
8. To utilize research to inform policy, programming, improve health, achieve nationally and internationally health-related development goals and contribute to the global knowledge platform							**658,730,000**
	8.1	**To strengthen the stewardship role of governments at all levels for research and knowledge management systems**			**1. ENHR Committee established by end 2009 to guide health research priorities 2. FMOH publishes an Essential Health Research agenda annually from 2010**		**175,400,000**
		8.1.1	To finalise the Health Research Policy at Federal level and develop health research policies at State levels and health research strategies at State and LGA levels				**12,200,000**
			8.1.1.1	Establish Health research steering committees at State and LGA levels to shepherd research activities at the levels (Such as ensuring coordinated implementation of the Essential National Health Research (ENHR) guidelines, establishing close liaison and linkages between research users (e.g. policy makers, development partners) and researchers, identify research capacity gaps & weaknesses and address them etc)	% of LGAs partnering with researchers raised to 5% by 2011, 15% 2013 and 25% by 2015.	Lack of funds & commitment.	12,200,000
		8.1.2	To establish and or strengthen mechanisms for health research at all levels				**100,000,000**
			8.1.2.1	Strenghten the Departments of Planning Research and Statistics (DPRS) in the SMOH and research units in the LGA to undertake operations research in critical priority areas and other research-related activities (topical areas such as estimating the burden of different diseases biennially, biennial Human Resources for Health studies on health system governance (HSG), health delivery systems, financial risk protection, equity, efficiency and value of different health financing mechanisms etc) as may be determined by policy makers and other key stakeholders	% of State health budget spent on health research and evaluation 1% by 2013 and 2% by 2015.	Lack of funds	100,000,000
		8.1.3	To institutionalize processes for setting health research agenda and priorities				**51,700,000**
			8.1.3.1	Strenghten functional institutional structures for research	50% research activities conducted by end of 2015	Lack of funds	50,000,000
			8.1.3.2	Expand health research agenda to include broad and multidimensional determinants of health and ensure cross-linkages with areas beyond traditional boundaries and categories	Health research agenda expanded by end of 2014	Lack of funds	1,700,000
		8.1.4	To promote cooperation and collaboration between Ministries of Health and LGA health authorities with Universities, communities, CSOs, OPS, NIMR, NIPRD, development partners and other sectors				**8,200,000**
			8.1.4.1	Conven annually multi-stakeholders forum to identify research priorities and harmonize research efforts	Annual meeting of multi-stakeholders conducted by end of 2011	Lack of funds	7,200,000

			8.1.4.2	Ensure Government support for the development of collaborative research proposals and their implementation between governments and public and private health research organisations	Collaborative research proposals developed and 80% implemented by end of 2015	Lack of Political Will	1,000,000
		8.1.5	To mobilise adequate financial resources to support health research at all levels				**3,300,000**
			8.1.5.1				-
			8.1.5.1	Explore opportunities for accessing funds from bilateral and multilateral organizations, research funding agencies (private sector, foundations & individuals) and through north-south and south-south collaboration	20% increase in funds for research activities by end of 2015	Lack of funds & collaboration	3,300,000
			8.1.5.4	Establish a credible and transparent independent national research funding agency to attract additional funds	Credible and transparent independent national research funding agency established by 1st quarter of 2011	Lack of funds, commitment of members, awareness, difficult terrain, Pilitical Will	-
		8.1.6	To establish ethical standards and practise codes for health research at all levels				**-**
	8.2	**To build institutional capacities to promote, undertake and utilise research for evidence-based policy making in health at all levels**			**FMOH has an active forum with all medical schools and research agencies by end 2010**		**219,750,000**
		8.2.1	To strengthen identified health research institutions at all levels				**4,950,000**
			8.2.1.1	Take an inventory of all public and private institutions and organizations undertaking health research at State and LGA levels & strenghten them	50% of public and private health institutions and organizations undertaking health research at State and LGA levels identified by end of 2011	Lack of funds & difficult terrain	850,000
			8.2.1.2	Conduct periodic capacity assessment of health research organizations and institutions	Capacity assessment conducted in 80% of health research organizations and institutions by end of 2015	Lack of funds	4,100,000
		8.2.2	To create a critical mass of health researchers at all levels				**201,000,000**
			8.2.2.1	Create a critical mass of researchers in conjunction with training institutions while developing appropriate training interventions for research, based on the identified needs of the State and LGAs	Training based on the identified needs at State and LG levels conducted by end of 2011 thereafter annually	Lack of funds	1,000,000
							-
			8.2.2.2	Motivate increased PhD training in health in tertiary institutions through award of PhD studentship scholarships by State and Local Governments	Scholarship awarded for 50% PhD training in health in tertiary institutions by end of 2013 and thereafter annually	Lack of funds	200,000,000
		8.2.3	To develop transparent approaches for using research findings to aid evidence-based policy making at all levels				**13,800,000**
							-
			8.2.3.2	Involve a wide range of actors including research producers in policy-making consultations	80% of actors involved in policy-making consultations by end of 2015		13,800,000
		8.2.4	To undertake research on identified critical priority areas				**-**

	8.3	**To develop a comprehensive repository for health research at all levels (including both public and non-public sectors)**			**1. All States have a Health Research Unit by end 2010 2. FMOH and State Health Research Units manage an accessible repository by end 2012**		**31,380,000**
		8.3.1	To develop strategies for getting research findings into strategies and practices				**22,980,000**
			8.3.1.1	Establish getting research into strategies (GRISP) units in the State and LGAs and instituting bi-annual Health Research-Policy forums in the State and LGAs	GRISP units established in the State & 80% LGAs by end 2010 & meeting held bi-annually thereafter	Lack of funds	22,980,000
		8.3.2	To enshrine mechanisms to ensure that funded researches produce new knowledge required to improve the health system				**8,400,000**
			8.3.2.1	Conduct needs assessment to identify required health research gaps in the State and LGAs	Needs assessment conducted in the State and LGAs by 3rd quarter of 2011	Lack of funds & security & difficult terrain	8,400,000
	8.4	**To develop, implement and institutionalize health research communication strategies at all levels**			**A national health research communication strategy is in place by end 2012**		**232,200,000**
		8.4.1	To create a framework for sharing research knowledge and its applications				**220,200,000**
			8.4.1.1	Publish research findings in selected national and State journals and also disseminate to all stakeholders in the state and LGAs	% of health research in LGAs available in the state health research depository raised to 30% by 2011, 50% by 2013 and 70% by 2015.	Lack of funds	2,200,000
			8.4.1.2	Convene annual health conferences, seminars and workshops in the State and LGA levels on key thematic areas (financing, human resources, MDGs, health research, etc)	Health conferences, seminars and workshops conducted annually in State and 10% LGAs levels by end of 2012	Lack of funds	200,000,000
			8.4.1.3	Ensure participation in national and international conferences on health and mainstream best practices in the State and LGAs	Regular State & LGAs participation in 80% of national and international conferences by 1st quarter of 2010	Lack of funds	18,000,000
		8.4.2	To establish channels for sharing of research findings between researchers, policy makers and development practitioners				**12,000,000**
			8.4.2.1	Develop capacity of researchers to effectively produce policy briefs targeted at informing policy-makers, as well as the broad scientific and non-scientific audiences	Policy briefs for policy-makers, scientific and non-scientific audiences developed by end of 1st quarter of 2011	Lack of funds	12,000,000
							163,124,352,788

Annex 2: Results/M&E Matrix for Rivers Strategic Health Development Plan

OVERARCHING GOAL: To significantly improve the health status of Nigerians through the development of a strengthened and sustainable health care delivery system						
OUTPUTS	**INDICATORS**	**SOURCES OF DATA**	**Baseline**	**Milestone**	**Milestone**	**Target**
			2008/9	**2011**	**2013**	**2015**
PRIORITY AREA 1: LEADERSHIP AND GOVERNANCE FOR HEALTH						
NSHDP Goal: To create and sustain an enabling environment for the delivery of quality health care and development in Nigeria						
OUTCOME: 1. Improved strategic health plans implemented at Federal and State levels						
OUTCOME 2. Transparent and accountable health systems management						
1. Improved Policy Direction for Health Development	1. % of LGAs with Operational Plans consistent with the state strategic health development plan (SSHDP) and priorities	LGA s Operational Plans	0	100%	100%	100%
	2. % stakeholders constituencies playing their assigned roles in the SSHDP (disaggregated by stakeholder constituencies)	SSHDP Annual Review Report		100%	100%	100%
2. Improved Legislative and Regulatory Frameworks for Health Development	3. State implementing the National Health Bill? (Yes)	SMOH		100%	100%	100%
	4. % of LGAs enforcing traditional medical practice by-laws	LGA Annual Report	TBD	25%	50%	75%
3. Strengthened accountability, transparency and responsiveness of the State health system	5. % of LGAs which have established a Health Watch Group		0	25%	50%	75%
STRATEGIC AREA 2: HEALTH SERVICES DELIVERY						
NSHDP GOAL: To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare						
Outcome 3: Universal availability and access to an essential package of primary health care services focusing in particular on vulnerable socio-economic groups and geographic areas						
Outcome 4: Improved quality of primary health care services						
Outcome 5: Increased use of primary health care services						
5. Improved access to essential package of Health care	6. % of LGAs with a functioning public health facility providing minimum health care package	NPHCDA Survey Report	TBD	25%	50%	75%
	7. % health facilities implementing the complete package of essential health care	NPHCDA Survey Report	TBD	50	75	100%
	8. % of the population having access to an essential care package	MICS/NDHS	TBD	40	75	100%
	9. Contraceptive prevalence rate (traditional and modern)	NDHS	2.10%	5%	7.50%	10%
	10. % increase of new users of modern contraceptive methods (male/female)	NDHS/HMIS	TBD	10%	15%	25%
	11. % of new users of modern contraceptive methods by type (male/female)	NDHS/HMIS	TBD	10%	15%	25%
	12. % service delivery points without stock out of family planning	Health facility Survey	TBD	10%	20%	50%

	commodities in the last three months					
	13. % of facilities providing Youth Friendly RH services	Health facility Survey	TBD	20%	30%	40%
	14.% of delivery in health facility	NDHS/MICS	48%	58%	68%	78%
	15. % of pregnant women with 4 ANC visits performed according to standards	NDHS	67%	71%	75%	79%
	16. Proportion of births attended by skilled health personnel	NDHS	64%	68.00%	75%	80%
	17. Proportion of women with complications treated in an EmOC facility (Basic and/or comprehensive)	EmOC Sentinel Survey and Health Facility Survey	TBD	15%	25%	40%
	18. Caesarean section rate	EmOC Sentinel Survey and Health Facility Survey	4.60%	6%	10%	15%
	19. Case fatality rate among women with obstretic complications in EmOC facilities	HMIS	TBD	30%	25%	15%
	20. Perinatal mortality rate	HMIS	50/1000LBs	45/1000LBs	40/1000LBs	35/1000 LBs
	21. % of women who received postnatal care based on standards within 48hr after delivery	MICS	5%	10%	15%	25%
	22. % of children exclusively breastfed 0-6 months	NDHS/MICS	2.30%	5%	15%	25%
	23. Proportion of 12-23 months-old children fully immunized	NDHS/MICS	37.00%	41%	45%	49%
	24. % children <5 years stunted (height for age <2 SD)	NDHSMICS	29.00%	25%	21%	17%
	25. % of under-five that slept under LLINs the previous night	NDHS/MICS	10.00%	22%	34%	46%
	26. % of pregnant women that sleep under ITN		9.00%	19%	29%	39%
	27. % of under-five children receiving appropriate malaria treatment within 24 hours	NDHS/MICS	21%	31%	41%	51%
	28. % of women who received intermittent preventive treatment for malaria during pregnancy	NDHS/MICS	5%	13%	21%	29%
	29. Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS (female)	NDHS/MICS	17%	27%	37%	47%
	30. Proportion of population aged 15-24 years with	NDHS/MICS	36%	46%	56%	66%

	comprehensive correct knowledge of HIV/AIDS (male)					
	31. Proportion of female with knowledge of TB		69%	73%	77%	81%
	32. Proportion of male with knowledge of TB		81%	85%	89%	93%
	33. Propotion of diarrhoea in children	NARHS	3.80%	2.80%	2%	1.00%
	34.No of health facilities upgraded & refurbished	NMIS		40%	50%	60%
Output 6. Improved quality of Health care services	35. % of health facilities with all essential drugs available at all times	Facility Survey Report	TBD	50%	70%	90%
	36. % of health institutions with basic medical equipment and functional logistic system appropriate to their levels	Facility Survey Report	TBD	35%	55%	75%
PRIORITY AREA 3: HUMAN RESOURCES FOR HEALTH						
NSHDP GOAL: To plan and implement strategies to address the human resources for health needs in order to ensure its availability as well as ensure equity and quality of health care						
Outcome 6. The Federal government implements comprehensive HRH policies and plans for health development						
Outcome 7.All States and LGAs are actively using adaptations of the National HRH policy and plan for health development by end of 2015						
Output 8. Improved policies and Plans and strategies for HRH	37. % of wards that have appropriate HRH complement as per service delivery norm (urban/rural).	Facility Survey Report	TBD	38%	54%	70%
Output 8: Improved framework for objective analysis, implementation and monitoring of HRH performance	38. CHEW/10,000 population density	MICS	TBD	1:3500 pop	1:2500 pop	1:1500 pop
	39. Nurse density/10,000 population	MICS	TBD	1:7000 pop	1:5000 pop	1:3000 pop
	40. Qualified registered midwives density per 10,000 population and per geographic area	NHIS/Facility survey report/EmOC Needs Assessment	TBD	1:7000 pop	1:5000 pop	1:3000 pop
	41. Medical doctor & Dentist density per 10,000 population	MICS	TBD	1:7000 pop	1:5000 pop	1:3000 pop
	42. Pharmacist per 20,000 population		TBD	1:17500 pop	1:12500 pop	1:7500 pop
PRIORITY AREA 4: FINANCING FOR HEALTH						
Outcome 8. Health financing strategies implemented at Federal, State and Local levels consistent with the National Health Financing Policy						
Output 11: Improved protection from financial catastrophy and impoversihment as a result of using health services in the State	43. % of LGAs implementing state specific safety nets	SSHDP review report	TBD	25%	40%	75%
	44. Decreased proportion of informal payments within the public health care system within each LGA	MICS	80%	75%	70%	65%
	45. % of LGAs which allocate costed fund to fully implement essential care	State and LGA Budgets	TBD	10%	15%	20%

	package at N5,000/capita (US$34)					
	46. LGAs allocating health funding increased by average of 5% every year	State and LGA Budgets	TBD	15%	25	40%
Output 12: Improved efficiency and equity in the allocation and use of Health resources at State and LGA levels	47. LGAs health budgets fully alligned to support state health goals and policies	State and LGA Budgets	TBD	40%	50%	75%
	48.Out-of pocket expenditure as a % of total health expenditure	National Health Accounts 2003 - 2005	70%	60%	50%	40%
	49. % of LGA budget allocated to the health sector.	National Health Accounts 2003 - 2005	2%	10%	20%	30%
	50. Proportion of LGAs having transparent budgeting and finacial management systems	SSHDP review report	TBD	25%	40%	60%
	51. % of LGAs having operational supportive supervision and monitoring systems	SSHDP review report	TBD	25%	40	50%
PRIORITY AREA 5: NATIONAL HEALTH INFORMATION SYSTEM						
Outcome 10. National health management information system and sub-systems provides public and private sector data to inform health plan development and implementation						
Outcome 11. National health management information system and sub-systems provide public and private sector data to inform health plan development and implementation at Federal, State and LGA levels						
Output 13: Improved Health Data Collection, Analysis, Dissemination, Monitoring and Evaluation	52. % of LGAs making routine NHMIS returns to states	NHMIS Report January to June 2008; March 2009	30%	50%	70%	90%
	53. % of LGAs receiving feedback on NHMIS from SMOH		TBD	50%	70%	90%
	54. % of health facility staff trained to use the NHMIS infrastructure	Training Reports	TBD	50%	70%	90%
	55. % of health facilities benefitting from HMIS supervisory visits from SMOH	NHMIS Report	TBD	30%	50%	70%
	56.% of HMIS operators at the LGA level trained in analysis of data using the operational manual	Training Reports	TBD	50%	70%	90%
	57. % of LGA PHC Coordinator trained in data dissemination	Training Reports	TBD	60%	80%	100%
	58. % of LGAs publishing annual HMIS reports	HMIS Reports	TBD	30%	50%	70%
	59. % of LGA plans using the HMIS data	NHMIS Report	TBD	30%	50%	70%
PRIORITY AREA 6: COMMUNITY PARTICIPATION AND OWNERSHIP						
Outcome 12. Strengthened community participation in health development						
Outcome 13. Increased capacity for integrated multi-sectoral health promotion						
Output 14: Strengthened Community	60. Proportion of public health facilities having active committees that	SSHDP review report	TBD	30%	40%	50%

Participation in Health Development	include community representatives (with meeting reports and actions recommended)					
	61. % of wards holding quarterly health committee meetings	HDC Reports	TBD	25%	50%	75%
	62. % HDCs whose members have had training in community mobilization	HDC Reports	TBD	40%	60%	80%
	63. % of health actions jointly implemented with HDCs and other related committees	HDC Reports	TBD	25%	35%	45%
	64. % of LGAs implementing an Integrated Health Communication Plan	HPC Reports	TBD	25%	35%	45%
PRIORITY AREA 7: PARTNERSHIPS FOR HEALTH						
Outcome 14. Functional multi partner and multi-sectoral participatory mechanisms at Federal and State levels contribute to achievement of the goals and objectives of the SHDP						
Output 15: Improved Health Sector Partners' Collaboration and Coordination	65. Increased number of new PPP initiatives per year per LGA	SSHDP Report	TBD	20%	30%	40%
	66. % LGAs holding annual multi-sectoral development partner meetings	SSHDP Report	TBD	20%	30%	40%
PRIORITY AREA 8: RESEARCH FOR HEALTH						
Outcome 15. Research and evaluation create knowledge base to inform health policy and programming.						
Output 16: Strengthened stewardship role of government for research and knowledge management systems	67. % of LGAs partnering with researchers	Research Reports	TBD	5%	15%	25%
	68. % of State health budget spent on health research and evaluation	State budget	TBD	1%	1.00%	2%
	69. % of health research in LGAs available in the state health research depository	State Health Reseach Depository	TBD	30%	50%	70%