FEDERAL CAPITAL TERRITORY ADMINISTRATION

STRATEGIC HEALTH DEVELOPMENT PLAN

(2010-2015)

FCT Health & Human Services Secretariat

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ACRONYMS

BCC	Behaviour Change Communication
CIDA	Canadian International Development Agency
CORPs	Community oriented resource persons
CPD	Continuing professional development
CSO	Community Service Organization
DFID	Department for International Development
DHS	Nigeria Demographic and Health Survey
DP	Development Partners
DPRS	Department of Planning, Research and Statistics
FCT	Federal Capital Territory
FMOH	Federal Ministry of Health
GDP	Gross Domestic Product
GIS	Geographic Information System
GTZ	Gesellschaft für Technische Zusammenarbeit (German NGO)
HDCC	Health Data Consultative Committee
HF	Health Facility
HIS	Health Management Information System
HIV/AIDS	Human Immuno Deficiency Virus/Acquired Immune Deficiency Syndrome
HLM	High Level Ministerial Meeting on Health Research
HPCC	Health Partners Coordinating Committee
HRH	Human Resources for Health
HW	Health worker
IEC	Information, Education and Communication
IMCI	Integrated management of Childhood Illnesses
IMNCH	Integrated Maternal, Newborn and Child Health
IPC	Interpersonal Communication skills
ISS	Integrated supportive supervision
ITNs	Insecticide treated nets
JFA	Joint Funding Agreement
JICA	Japan International Development Agency
LGA	Local Government Area
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDAs	Ministries, Departments and Agencies
MDCN	Medical and Dental Council of Nigeria,
MDGs	Millennium Development Goals
MNCH	Maternal and Newborn Child Health
MRCN	Medical Research Council of Nigeria
NAFDAC	National Agency for Food Drugs Administration and Control
NGOs	Non-Governmental Organizations
NHA	National Health Accounts
NHIS	National Health Insurance Scheme
NHMIS	National Health Management Information System
NHREC	National Health Research Committee
NIMR	Nigerian Institute for Medical Research
NIPRD	National Institute for Pharmaceutical Research and Development
NMSP	National Malaria Strategic Plan
NPHCDA	National Primary Health Care Development Agency

NSHDP	National Strategic Health Development Plan
NSHDPF	National Strategic Health Development Plan Framework
NSTDA	National Science and Technology Development Agency
NYSC	National Youth Service Corps
OAU	Organisation of African Unity
ODA	Oversea Development Assistance
OPS	Organised Private Sector
PEPFAR	President's Emergency Plan for AIDS Relief
PERs	Public Expenditure Reviews
PHC	Primary Health Care
PHCMIS	Primary Health Care Management Information System
PPP	Public Private Partnerships
QA	Quality Assurance
RDBs	Research data banks
SHAs	State Health Accounts
SMOH	State Ministry of Health
SWAPs	Sector-Wide Approaches
TB	Tuberculosis
TBAs	Traditional birth attendants
TWG	Technical Working Group
UN-System	United Nations-System
VAT	Value Added Tax
VHW	Village health workers
VOC	Vote-of-charge
WHO	World Health Organization

PREFACE

The health indicators in FCT have remained below country targets and internationally-set benchmarks including the MDGs, which have recorded very slow progress over the years. Currently, the health sector is characterized by lack of effective stewardship role of government, inadequate and inefficient financing, weak health infrastructure, mal-distribution of health work force and poor coordination amongst key players.

To address these, the federal government implemented the Health Sector Reform Program (HSRP) from 2004-2007, which addressed seven strategic thrusts revolving around government's stewardship role; management of the national health system; the burden of disease; mobilization and utilization of health resources; health service delivery; consumer awareness and community involvement; partnership, collaboration and coordination. The HSRP recorded a number of policy and legislative initiatives, notable among which are the National Health Policy review, the National Health Bill and strengthening the National Health Insurance Scheme. In addition, efforts were directed at strengthening disease programmes and improving the quality of care in tertiary health facilities. Despite these initiatives, much of the underlying weaknesses and constraints of the health sector persist.

Consequently, the Federal Ministry of Health has articulated this framework, as an overarching guide for the development of the National Strategic Health Development Plan (NSHDP) with its appropriate costing. The NSHDP would result from the harmonization of Federal, States' and local governments' health plans, thereafter serving as the basis for national ownership, resource mobilisation/allocation and mutual accountability by all stakeholders – government, development partners, civil society, private sector, communities, etc. The framework is based on the principles of the Four Ones: one health policy, one national plan, one budget, and one monitoring and evaluation framework for all levels of government. It also provides the template to concretize the health sector development component of the 7-point Agenda, Vision 2020 and a platform for achieving the MDGs.

Based on a multidimensional assessment of the health sector, the framework identifies eight priority areas for improving the national health systems with specific goals and strategic objectives. They are leadership and governance for health; health service delivery; human resources for health; health financing; health information systems; community ownership and participation; partnerships for health development; and research for health.

This report is the outcome of many workshops and interactions among the stakeholders in the FCT and its six area Councils in the Health sector. As directed by the FMOH, the plan is a reflection of priority concerns peculiar to the FCT.

EXECUTIVE SUMMARY

The Federal Capital Territory (FCT) is centrally located and serves as the administrative seat of the Federal Republic of Nigeria. FCT covers an area of a little less than 8,000 square kilometres, with the Federal Capital City of Abuja occupying 250 square kilometres. FCT is bigger in land mass than eight states: Enugu, Akwa Ibom, Ebonyi, Ekiti, Imo, Abia, Anambra and Lagos. It has boundaries in the North by Kaduna State, in the West by Niger State, in the East and South by Nassarawa and Kogi states respectively. It is estimated that more than 70% of the population is rural.

The FCT is a multi-cultural society and centre of unity. The different indigenous cultures found in Abuja today have their origin from numerous ethnic groups within the territory. Before Abuja was created, there were pockets of various ethnic nationalities living in the land. For instance, in Abaji Area Council, there are the Igbirra, Gbagyi, Ganagana, Nupe, Bassa, Hausa and Fulani. Gbagyi, Koro, Fulani and Hausa people are predominant in Bwari Area Council. In addition, prominent tribes who live in Kuje include Gade, Gwandara, Bassa, Gbagyi, Hausa and Fulani. Kwali Area Council which borders Kuje has the same ethnic groups. The most populous tribes in Kwali Area Council are the Gbagyis followed by Ganagana and Nupe people. In the Municipal Area Council, the indigenous groups are the Gbagyi, Gwandara, Gade, Bassa, Hausa and Fulani. Virtually all tribes use Hausa and English for commercial and educational activities.

The key economic driver in the FCT is the Government supported by Hospitality industries, construction companies and the banking industries.

The FCT being the seat of the government of an emerging national economy experiences an influx of people which boosts the annual population growth rate to 9.3%, a level considerably above the national level of 3.2%. With an official 1.4 million population (1,406,239 (673,067 females; 733,172 males) [1], children under 5 years make up 20% and Women of child bearing age 26.7 % of the total population, the 2006 National Population and Housing Census indicated that about 56.4% of the population aged 6 years and above were literate with 77% of women and 89% men being literate. Life expectancy in the FCT, which is put at an average of 52 years for both male and female, is higher than other states of the federation. According to the FEEDS I review report, residents of FCT have improved access to healthcare and education services. About 60% (65%) [1]of FCT residents have access to clean water defined as borehole and pipe borne water.

The indigenes of Abuja are mainly subsistence farmers. The major food crops include yam, maize, guinea corn, beans and millet. Fishing activities are also prominent among the Bassa people and villagers along rivers of Usamma, Jabi and Gurara. Besides farming, wood and craft work was and still a notable occupation of the people of the territory especially the Gbagyis. Products derived from wood work include mortars, pestles and tobacco pipes of various dimensions, masks, musical instruments and other household utensils. The Ganagana are renowned in iron works. They produce such items as knives, hoes, dane guns, arrows and ornaments. Cloth weaving is practised by women who weave heavy and closely patterned materials of different colours. A predominantly civil service dominated environment, there are few notable industries in the Territory.

[1] NDHS2008

Malaria and diarrhoea are the leading causes of morbidity while malnutrition and measles (a VPD) contribute to children mortality. Significantly, the FCT records an unacceptable high number of fatalities of road accidents. HIV&AIDS surpassed malaria as the leading cause of mortality. In the area of immunization, high rates were recorded for vaccine preventable diseases thus suggesting that the majority of FCT children were protected against these diseases.

Health services provision and utilization data at the secondary level show that the types and numbers of health professionals at the site level appear to be adequate. However, there are challenges with their development and motivation. From available data on the number of available health facilities, it is obvious that private sector participation is quite high in the FCT. Private facilities outnumber the public health facilities. This suggests that a more robust mechanism for partnership with the private sector shall impact positively on HSD. This is further confirmed by the high and increasing numbers of private pharmacies and patent medicine stores.

The bed complement in the public secondary health care in FCT is about 500. When added to the number at the National Hospital and Gwagwalada Hospital, the territory boasts of 1,200 beds at the secondary and tertiary levels. The referral system is adjudged extremely weak and deserves serious attention in the strategic plan.

The issues and challenges of the system have been documented from the environmental scoping exercise as;

1) Lack of overarching strategy to improve, monitor and evaluate service delivery
2) Poor health indices
3) Weak PHC system
4) Inadequate funding
5) Manpower inadequacy, distribution, training
6) Health expenditure has been erratic and characterized by poor implementation of the health budget e.g. 74% of budgetary allocation was released in 2006 as against 20% in 2007

The weak state of the overall PHC system impinges on the rural Area Councils of the FCT while the enlightened populace of the urban Area Councils demands quality, specialized secondary healthcare services. While there still exists sporadic outbreaks of diseases of public health importance; the prevalence malaria, tuberculosis, HIV & AIDS and non-communicable diseases remain a significant concern. Other challenges as detailed in the draft health policy document are: high child and maternal mortality rates, low immunization coverage, malnutrition, quality of care, weak PHC system, etc.

The FCT minimum health care package includes health interventions and/or services that address health and health related problems that result in substantial health gains at low cost. In defining this package, a number of considerations were made; disease patterns, economic considerations (e.g. cost of services) and proportion of population affected/benefiting from health services. This package targets the grass root level through the delivery of a minimum set of interventions needed to meet the basic health requirement of the people hence contributing to achieving the global target of Health For All and the attainment of the Millennium Development Goals (MDGs). Technically, this

package comprises of cost-effective interventions known to promote health and development and reduce mortality and morbidity from major/common illnesses.

The Minimum Health Care Package will include the following health interventions Control of Communicable Diseases (*Malaria, STI/HIV/AIDS, TB*), Child survival, Maternal and Newborn Care, Nutrition, Non Communicable Disease Prevention, Health Education and Community Mobilization

In order to implement this set of interventions, communities will be mobilized using appropriate IEC/BCC strategies. Functional health infrastructure, human resources/manpower and financial resources would also be provided to support health service delivery at the ward level. Therefore, the following services are required; Provision of Essential Drug, Human Resources for Health and Health Infrastructure Development. These packages of care would be delivered using the three delivery modes which are family and community oriented services, population/ schedulable services and individual oriented clinical services. Available evidence has shown these delivery modes help to strengthen the health system in the long run.

The strategic plan in line with the national frame work has eight priority areas with interventions designed to meet the observed gap in health. These priorities and their strategic thrusts are as follows;

Leadership and governance

Major strategic thrust in FCT plan include; development/review of FCT specific guidelines consistent with provisions of national health policies and plans; new health legislation, creation of database, convocation of statutory or coordination of meetings such as FCT Council of Health, Partners forum, as well as Budget monitoring and Performance management.

Health service delivery

Major strategic thrusts include; Implementation of FCT Minimum Health Care Package inclusive of disease control strategies, Construction and equipping of infectious disease hospital, Construction and equipping of public health laboratory, Construction and equipping of primary and secondary health facilities in underserved areas.

Human resource for health

Major strategic thrusts include; establishment of HRH units at HHSS and Area Councils, recruitment, orientation, managerial and technical capacity building of health workers establish and implement a performance management and reward system, construction and equipping of a school of Health Technology, engage professional associations and regulatory authorities.

Financing for health

Major strategic thrusts include; Implementation of community based social health insurance, advocate for greater public funding of the health sector through evidence, rigorously engage the

private sector. Reinforce SHC concessioning, Improve financial management system through FM manuals and accounting software. Build health finance personnel capacity.

Health management information system (HMIS):

Major strategic thrusts include; provision of HMIS minimum packages at FCT and Area Council levels, Procurement of HIS software for SHC facilities, Establishment of a resource centre with electronic library and ICT facilities.

Community participation and ownership

Major strategic thrusts include Reactivation of ward and village health committees, Training of PHC health workers on community health management, Support participation of traditional/religious leaders and opinion leaders in community health management.

Partnerships for Health

Major strategic thrusts include**,** Institution of joint planning, monitoring and evaluation of programmes and projects**,** Exploring PPP opportunities such as concession.

Research for health

Major strategic thrusts include**;** Provision of a budget line annually for research**,** Collaboration with the academia and research institutions in identification and implementation of research interventions.

Implementation is going to be carried out by FCT Administration, relevant Institutions, strategic partners, civil society, individuals, households and other actors which includes Parliament, CSOs, WHO, UNICEF, UNFPA, UNDP, WORLD BANK, AFDB, USAID, DFID, CIDA, EU, JICA, Private Health Care Providers, CIDA, FMOH, MRCN, NAFDAC, ODA, PEPFAR, NIPRD, NIMR, NHIS, NHMIS, TBA, Ward Focal Person, LGA Health Educators, Reps of VHCs & WHDCs and GM SERVICOM

Proposed mechanism for monitoring and evaluation of all the activities in the priority areas will be through an internal mechanism of all relevant M&E officers (HHSS and Area councils), donor partners and key stakeholders. This will be done routinely for the period of the six years plan.

CHAPTER 1: BACKGROUND AND ACHIEVEMENTS

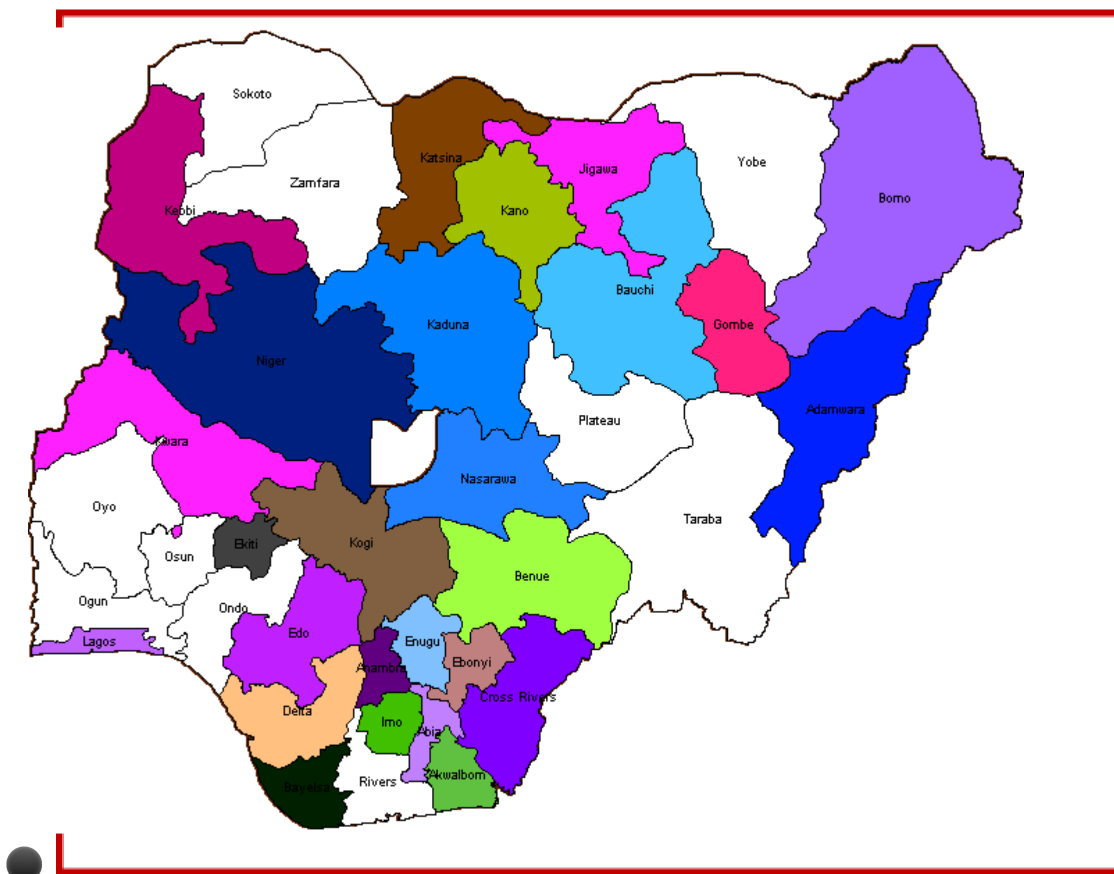
1.1 Background

Administration

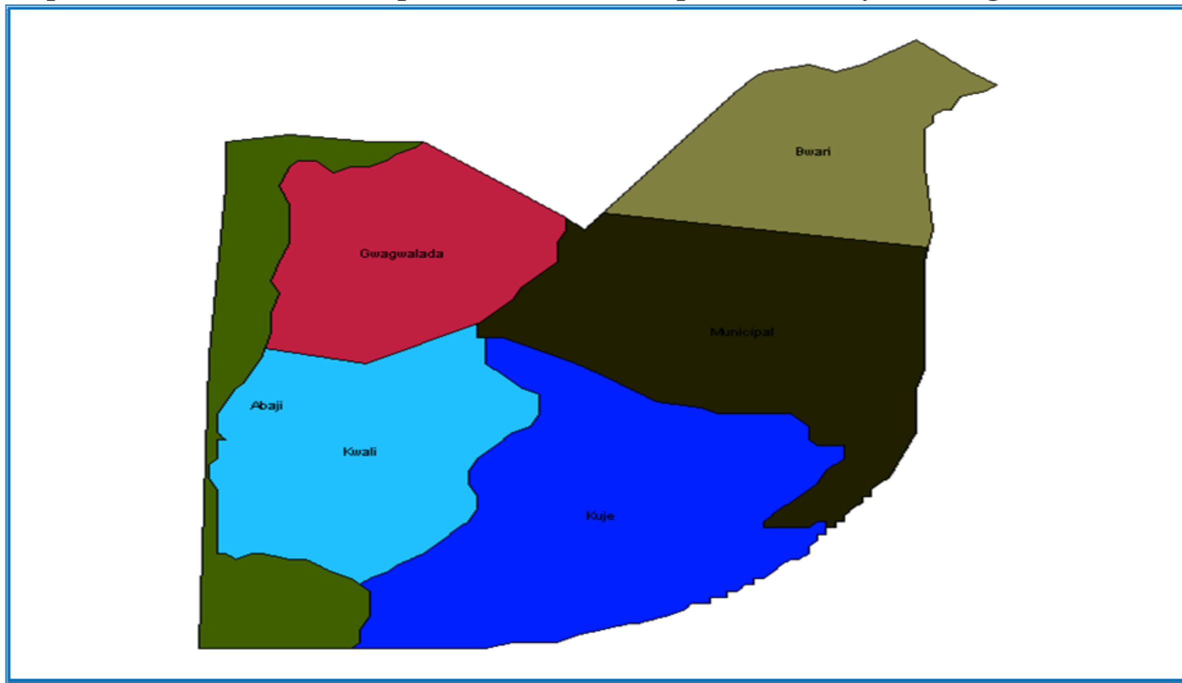
Federal Capital Territory (FCT) is located in the Nigerian geographical centre and also in the North Central geopolitical zone of Nigeria (Map 1). The Territory hosts the capital city of Nigeria, Abuja. The FCT is divided administratively into 6 Area Councils: Abuja Municipal Area Council (AMAC), Bwari, Gwagwalada, Kuje, Kwali and Abaji (Map 2).

According to sections 299 and 302 of the 199 constitution, the President is the "Governor" of FCT. The President by right could delegate powers to the Minister of the FCT in the Presidency. Constitutionally, FCT has one (1) senatorial seat, two (2) House of Representatives Constituencies and six (6) Area Councils.

Map 1: Administrative Map of Nigeria showing the Federal Capital Territory (red ringed)



Map 2: Administrative Map of the Federal Capital Territory showing the 6 Area Councils



1.2 Achievements

Achievements

The proportion of the FCT budget allocated to health has been sustained and increasing beyond 5% over the last 4 years. The Territory arguably has the best constructed and equipped secondary healthcare facilities in the country. The health population: professional ratios for various cadres are far above national averages.

CHAPTER 2: SITUATION ANALYSIS

2.1 Socio-economic context

The FCT being the seat of the government of an emerging national economy experiences an influx of people which boosts the population growth rate to 9.3%, a level considerably above the national level of 3.2%. With an official 1.4 million population consisting of the native Gwari, Gede, Ganagana and Koro people, the home of the nation's capital is also home to practically all the ethnic groups in the country. The Federal Capital Territory has a land area of 8,000 square kilometers. It falls within the Savannah zone vegetation of the West African sub-region but patches of rain forest, however, occur in the Gwagwa plains that form one of the surviving northern-most occurrences of the mature forest vegetation in Nigeria.

The indigenes of Abuja are chiefly subsistence farmers. The major food crops include yam, maize, guinea corn, beans and millet. Fishing activities are also prominent among the Bassa people and villagers along rivers of Usamma, Jabi and Gurara. Besides farming, wood and craft work was and still a notable occupation of the people of the territory especially the Gbagyis. Products derived from wood work include mortars, pestles and tobacco pipes of various dimensions, masks, musical instruments and other household utensils. The Ganagana are renowned in iron works. They produce such items as knives, hoes, dane guns, arrows and ornaments. Cloth weaving is practised by women who weave heavy and closely patterned materials of different colours. A predominantly civil service dominated environment, there are few notable industries in the Territory.

2.2 Health status of the population

Malaria and diarrhoea are the leading causes of morbidity while malnutrition and measles (a VPD) contribute to children mortality (Table 1). Significantly, the FCT records an unacceptable high number of fatalities of road accidents. HIV&AIDS surpassed malaria as the leading cause of mortality (Table 2). In the area of immunization, high rates were recorded for vaccine preventable diseases thus suggesting that the majority of FCT children were protected against these diseases[2].

Table 1: Disease Burden in the FCTA.

S/No	Area Council	Diseases						
		Measles	Malaria	Diarrhoea	Malnutrition	Accident	Pneumonia	Others
1	ABAJI	1	2,062	920	119	241	355	886
2	BWARI	30	7,616	1,377	80	452	673	2,420
3	GWAGWALADA	1	2,191	641	106	137	264	796
4	KUJE	1	3,683	958	138	445	530	1,358
5	KWALI	0	3,119	820	81	278	191	853
6	AMAC	28	3,609	706	62	245	503	1,012
	TOTAL	61	22,280	5,422	586	1,798	2,516	7,325

Source: FCT Health Bulletin (2008)

[2] Annex 2: Routine immunization returns in the FCT

Table 2: FCT Health statistics (selected indices)

Indicator	***Value***	
% of New Born with Low Birth Weight	*24%*	
Crude Birth Rate	*60/1,000*	
Crude Death Rate	*1/1,000*	
Total Fertility Rate	*4.0*[3]	
% of children age 12-23mts who have received all basic immunization	*55%*[3]	
% of children under the age of 5 who are stunted	*30%*[3]	
% of married women age 15-49 who use a modern Family planning method	*21%*[3]	
% of women who received ANC care from a skilled provider	*89%*[3]	
% of women who received delivery care from skilled provider	*64%*[3]	
% of Households with an improved source of drinking water	*65%*[3]	
% of Households with access to electricity	*73%*[3]	
% of Households with at least one ITN	*10%*[3]	
% of children under 5 who sleep under ITN the night before the survey	*8%*[3]	
***Leading Causes of Morbidity and Mortality in FCT*.**		
Communicable Diseases:[4]	*Morbidity*	*Mortality*
HIV/AIDS	*1.5%*	*27%*
Malaria	*94%*	*22%*
Tuberculosis	*0.8%*	*3%*
Others	*3.7%*	*48%*
Non Communicable Diseases:		
Accident	*9.7%*	*7%*
Hypertension	*44.9%*	*5%*
Diabetes Mellitus	*27.2%*	*2%*
Sickle Cell	*1.3%*	*1%*
Others	16.9%	85%
The above indicators were determined based on statistics from the public health facilities (HHSS & Area Councils) in FCT, therefore the indices only showed the mirror health status of the Territory.		
Child Mortality rates North Central Average		
Under 5 mortality rate	*135/1000 live births*[5]	
Infant mortality rate	*77/1000 live births* [5]	
Neonatal mortality rate	*41/1000 live births* [5]	
Child mortality rate	*62/1000 live births* [5]	
Maternal mortality ratio National average	*547/100,000 live births* [5]	

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[3] Source: NDHS 2008

[4] Source: FCT Health Facilities Data

[5] NDHS 2008

2.3 Health services provision and utilization

Health services provision and utilisation data at the secondary level show that the types and numbers of health professionals at the site level appear to be adequate[6]. However, there are challenges with their development and motivation. From available data on the number of available health facilities, it is obvious that private sector participation is quite high in the FCT. Private facilities outnumber the public health facilities (table 3). This suggests that a more robust mechanism for partnership with the private sector shall impact positively on HSD. This is further confirmed by the high and increasing numbers of private pharmacies and patent medicine stores (table 4).

Table 3: 2008 Summary of Health Facilities in Abuja FCT by Area Councils and Ownership

S/N	LGA (No. of Facilities)	Ownership	Total No. of Health Facilities	Primary Health Care	Secondary Health Care	Tertiary
1	Municipal **(Total = 375; 52.7%)**	Private	330	234	96	-
		Public	45	35	9	1
2	Abaji **(Total = 37; 5.2%)**	Private	9	4	5	-
		Public	28	27	1	-
3	Bwari **(Total = 115; 16.2%)**	Private	84	48	36	-
		Public	31	29	2	-
4	Kuje **(Total = 55; 7.7%)**	Private	12	10	2	-
		Public	43	41	2	-
5	Kwali **(Total = 46; 6.5%)**	Private	6	4	2	-
		Public	40	39	1	-
6	Gwagwalada **(Total = 83; 11.7 %)**	Private	52	37	15	-
		Public	31	30	-	1
TOTAL			**711**	**538**	**171**	**2**

Source: FCT Health Bulletin (2008)

Table 4: Distribution of Pharmacy Shops and Patent Medical Stores in the FCT

S/N	Area Council	No. of Pharmaceutical Shops (%)	No. of Patent Medicine Stores (%)
1	Kwali Area Council	2	14
2	Abaji Area Council	Nil	7
3	Gwagwalada Area Council	20	79
4	Municipal Area Council	300	95

[6] Annex 3: Health manpower availability and distribution in the FCT (2007)

5	Bwari Area Council	43	77
6	Kuje Area Council	8	3
	TOTAL	**373**	**275**

The total public bed complement in the FCT is about 500. When added to the number at the National Hospital and Gwagwalada Hospital, the territory boasts of 1,200 beds at the secondary level. The referral system is adjudged extremely weak and deserves serious attention in the strategic plan.

2.4 Key issues and challenges

Challenges of the Health System

The issues and challenges of the system have been documented from the environmental scoping exercise:

1) Lack of overarching strategy to improve, monitor and evaluate service delivery
2) Poor health indices
3) Weak PHC system
4) Inadequate funding
5) Manpower adequacy, distribution, training
6) Health expenditure has been erratic and characterized by poor implementation of the health budget eg. 74% of budgetary allocation was released in 2006 as against 20% in 2007.

The weak state of the overall PHC system impinges on the rural Area Councils of the FCT while the enlightened populace of the urban Area Councils demands quality, specialized secondary healthcare services. While there still exists sporadic outbreaks of diseases of public health importance; the prevalence malaria, tuberculosis, HIV & AIDS and non-communicable diseases remain a significant concern. Other challenges as detailed in the draft health policy document are: high child and maternal mortality rates, low immunization coverage, malnutrition, quality of care, weak PHC system, etc.

Government's response is defined by its political will; resource mobilization potential; and the policy, organization and management of its health services. The new health leadership points the way forward for injecting fresh ideas into policy formulation, planning and delivery of healthcare services for all citizens of the Territory. This strategic planning exercise represents a demonstration of that intention.

CHAPTER 3: STRATEGIC HEALTH PRIORITIES

The strategic priorities are based on the eight nationally identified priority areas which was adopted by the FCT. The interventions and major thrusts were chosen after an expanded stakeholders meeting had looked at the health profile and the challenges of improving the health system of the FCT and area councils.

3.1. Leadership and Governance for Health

3.1.1 Context

Frequent changes in leadership at all levels, lack of accountability and transparency characterize poor leadership systems and crises in governance structures in the FCT's health system. Because transparency and honesty in governance will invariably translate to development, it will be important to ensure trust between the different actors. For all these to happen, the FCT will develop the leadership capacity of key actors in the health sector to lead and manage the implementation of the health plan as a performance improvement and reform process.

3.1.2 Goal

To create and sustain an enabling environment for the delivery of quality health care and development in Nigeria

3.1.3 Interventions

To provide clear policy directions for policy directions for health development

3.1.3.1 Improve capacity for health development
3.1.3.2 Improve strategic planning at State and Local Government level

To facilitate legislation and a regulatory framework for health development

3.1.3.3 Strengthen regulatory functions of government

To strengthen accountability, transparency and responsiveness of the national health system

3.1.3.4 Improve accountability and transparency

To enhance the performance of the national health system

3.1.3.5 Improving and maintaining sectoral information base to enhance performance
3.1.3.6 Develop leadership for health at the FCT state and area council levels

3.2 Health Service delivery

3.2.1 Context

The FCT health system is characterized by inequitable distribution of resources, decaying infrastructure, poor management of human resources for health, weak referral systems; poor coverage with high impact cost-effective interventions, lack of integration and poor supportive supervision. Interventions recommended include strengthening specific communicable and non communicable disease control programmes including the establishment of infectious disease control committee in each SH and TH facilities, as well as the construction of an infectious disease diseases hospital. There is also the plan to strengthen the capacity of the FCTA hospitals by completely overhauling the accident and emergency units of the hospitals. Other activities planned include, developing guidelines on equipment procurement and maintenance, carry out need assessment of drugs and equipment as well as identity and collaborate with companies with interests in health care as their corporate social responsibility.

Please see tables 3& 4 above for Health facilities by ownership in the FCT and Private sector participation at Area Council level and also table in annex 4 for 2007 staff complement in Area Councils health facilities by categories).

3.2.2 Goal

To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare

3.2.3 Interventions

To ensure universal access to an essential package of care

3.2.3.1 Essential health service package

A minimum package of care will be guaranteed for every individual. This will be made possible through the review of the requisite minimum that every facility will be required to implement in an integrated manner. This minimum package will be costed and standard operating procedures made available for its implementation. For effective delivery of these services, case management guidelines for MNCH, priority diseases and other priority health conditions will be put in place. The capacity of programme officers of non-communicable and communicable disease to manage and coordinate the provision of effective interventions for these programmes will be improved through trainings. A major thrust of health care interventions in the territory will be the allocation of community health workers to a predetermined population size in order to ensure that personalized health care services is provided in the context of the FCT health care reform. The table below show the components for essential package of care.

Table 3: Please see table below for FCT essential package of care.

HIGH IMPACT SERVICES
FAMILY/COMMUNITY ORIENTED SERVICES
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 mo.
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)

B. POPULATION ORIENTED/OUTREACHES/SCHEDULABLE SERVICES
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 anemia 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

C. INDIVIDUAL/CLINICAL ORIENTED SERVICES
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

3.2.1 Goal

To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare

Interventions

To increase access to health care services

3.2.1.1 Improve geographical equity and access to health services
3.2.1.2 To ensure availability of drugs and equipment at all levels
3.2.1.3 To establish a system for the maintenance of equipment at all levels
3.2.1.4 To strengthen referral system
3.2.1.5 To foster collaboration with the private sector

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To improve the quality of health care services

3.2.1.6 To strengthen professional regulatory bodies and institutions
3.2.1.7 To develop and institutionalize quality assurance models
3.2.1.8 To institutionalize health management and integrated supportive supervision
3.2.1.9 To improve health infrastructure development

To increase demand for health services

3.2.1.10 To create effective demand for health services
3.2.1.11 Promoting positive lifestyles for disease prevention

To provide financial access especially for the vulnerable groups

3.2.1.12 To improve financial access especially for the vulnerable groups
3.2.1.13 Strengthen specific communicable and non-communicable disease control programmes
including Neglected Tropical Diseases (NTDs)
3.2.1.14 Establish mechanism for continuum of care

To increase access to health care services

3.2.1.15 Improve geographical equity and access to health services
3.2.1.16 To ensure availability of drugs and equipment at all levels
3.2.1.17 To establish a system for the maintenance of equipment at all levels
3.2.1.18 To strengthen referral system
3.2.1.19 To foster collaboration with the private sector

To improve the quality of health care services

3.2.1.20 To strengthen professional regulatory bodies and institutions
3.2.1.21 To develop and institutionalize quality assurance models
3.2.1.22 To institutionalize health management and integrated supportive supervision
3.2.1.23 To improve health infrastructure development

To increase demand for health services

3.2.1.24 To create effective demand for health services
3.2.1.25 Promoting positive lifestyles for disease prevention

To provide financial access especially for the vulnerable groups

3.2.1.26 To improve financial access especially for the vulnerable groups

3.3 Human Resources for Health

3.3.1 Context

The quality, quantity and mix of health care workers is poor with a skewed distribution towards the FCT to the detriment of the six area councils. Vital areas to be developed include broadening the scope of available manpower through implementing the policy that integrates paramilitary and voluntary agencies into the health care delivery service pool as well as undertake the annual recruitment of staff based on clearly defined parameters that match the professional skills of the applicants with gaps derived from a need assessment survey based on merit and geo-political representation.

Please see tables in annexes 3, 4, 6 and 7 for summary tables describing the human resources available and requirements. (Annex 2-Routine immunization returns in the FCT, annex 3- Health power manpower availability and distribution in the FCT, annex 4- 2007 staff complement in the Area Council Health facilities by category, annex 5 bed component for secondary facilities, annex 6-7 - resource requirements gap assessment)

3.3.2 Goal

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

To foster partnerships and networks of stakeholders to harness contributions for human resource for health agenda

3.3.3 Interventions

To formulate comprehensive policies and plans for HRH for health development

3.3.3.1 To develop and institutionalize the human resources framework
3.3.3.2 Strengthen the PHC Development Agency in the FCT

To provide a framework for objective analysis, implementation and monitoring of HRH performance

3.3.3.3 To reappraise the principles of health workforce requirements and recruitment at all levels

Strengthen the institutional framework for human resources management practices in the health sector

3.3.3.4 To establish and strengthen the HRH Units

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

3.3.3.5 To review and adapt relevant training programmes for the production of adequate number of community health oriented professionals based on national priorities
3.3.3.6 To strengthen health workforce training capacity and output based on service demand.
3.3.3.7 Strengthening of Quality assurance

To improve organizational and performance-based management systems for human resources for health

3.3.3.8 To achieve equitable distribution, right mix of the right quality and quantity of human resources for health
3.3.3.9 To establish mechanisms to strengthen and monitor performance of health workers at all levels

To foster partnerships and networks of stakeholders to harness contributions for human resource for health agenda

3.3.3.9.1 To strengthen communication, cooperation and collaboration between health professional associations and regulatory bodies on professional issues that have significant implications for the health system
3.3.3.9.2 Strengthening communication, cooperation between health professional associations and health users

3.4 Financing for Health

3.4.1 Context

Due to an estimated per capita health expenditure of $10 and about 70% Out-Of-Pocket Expenditure, health financing in FCT has remained insufficient and uncoordinated. It has also made it difficult for the poor and the vulnerable populations to have access to health care. Some vital issues that need to be undertaken include the production of a technical brief for policy makers in the FCT on fund raising and how to provide or procure services. There is also the need to establish the FCT steering committee on microeconomics and health as well as scale up the NHIS and FHSS schemes in the FCT by sensitizing the communities in the Area Councils.

Please see tables 3 and 4 (table 3 health allocation as percentage of total FCT budget, table 4 Health budget versus health expenditure)

3.4.2 Goal

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

3.4.3 Interventions

To develop and implement health financing strategies at Federal, State and Local levels consistent with the National Health Financing Policy

3.4.3.1 To develop and implement evidence-based, costed health financing strategic plans for the FCT and area councils in line with the National Health Financing Policy

3.4.3.2 Creating mechanism for the development and use of evidence-based costed health financing strategic plans at the FCT and area council levels.

To ensure that people are protected from financial catastrophe and impoverishment as a result of using health services

3.4.3.3 To strengthen systems for financial risk health protection
3.4.3.4 Exploring innovative social health protection approaches

To secure a level of funding needed to achieve desired health development goals and objectives at all levels in a sustainable manner

3.4.3.5 To improve financing of the Health Sector

3.4.3.6 To improve coordination of donor funding mechanisms

3.4.3.7 To improve government allocation of public resources to the health sector

To ensure efficiency and equity in the allocation and use of health sector resources at all levels

3.4.3.8 To improve health budget execution, monitoring and reporting

3.4.3.9 To strengthen financial management skills

3.5 Health Management Information System (HMIS)

3.5.1 Context

Often the information generated by health workers have no bearing on the task they perform with the result that vital information becomes archival documents. The health information system is vital to health systems improvement yet it is majorly data driven and fragmented rather than being action-driven and tools for effective management decisions. There exists many health programmes with competing information needs and enormous data that must be collected. Our surveillance systems are also not sensitive or efficient enough for an evidence based pubic health response. In view of the weak state of the FCT HIS it was recommended that a needs assessment survey be conducted to be followed by the production and distribution of NHMIS forms and registers. In addition, staff of the FCT Health department will be trained on the use of these documents. It was also suggested that regular meetings of FCT Health Data Consultative Committee (HDCC) be organized to ensure revitalization of HDCC among other interventions.

3.5.2 Goal

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.

3.5.3. Interventions

To improve data collection and transmission

3.5.3.1 To ensure that NHMIS forms are available at all health service delivery points at all levels
3.5.3.2 To periodically review of NHMIS data collection forms
3.5.3.3 To coordinate data collection from vertical programmes
3.5.3.4 To build capacity of health workers for data management
3.5.3.5 To provide a legal framework for activities of the NHMIS programme
3.5.3.6 To improve coverage of data collection
3.5.3.7 To ensure supportive supervision of data collection at all levels

To provide infrastructural support and ICT of health databases and staff training

3.5.3.8 To strengthen the use of information technology in HIS

3.5.3.9 To provide HMIS Minimum Package at the different levels of data management

To strengthen sub-systems in the Health Information System

3.5.3.10 To strengthen the Hospital Information System

3.5.3.11 To strengthen the Disease Surveillance System

To monitor and evaluate the NHMIS

3.5.3.12 To establish monitoring protocol for NHMIS programme implementation at all l evels in line with stated activities and expected outputs

3.5.3.13 To strengthen data transmission

To strengthen analysis of data and dissemination of health information

3.5.3.14 To institutionalize data analysis and dissemination at all levels

3.6 Community participation and ownership

3.6.1 Context

Although in the FCT and the six Area Councils, there are existing structures for community participation but the concept of community ownership is not yet assimilated by the health consumers. Also the various community or facility committees for health actions are confusing and create community fatigue to participation. Persons tend to be involved in plethora of activities (that are not remunerated) all the time, while the pattern of volunteerism defer from one committee to another; thus producing unnecessary insinuation especially about finance. Thirdly there is poor supervision and monitoring of the committees by policy makers and health managers at both local and state government levels. These challenges produce a weakening of the committees and poor sustainability of existing programmes.

Since Community participation and ownership is central to the sustainability of the FCT health system, it is important to empower and engage the communities. This will include, conducting media campaign to sensitize communities on the policy on community participation, reactivating the Village Health committee and Ward Health Development Committee in accordance with National guideline, as well as build capacity within communities to 'own' their health services.

3.6.2 Goal

To attain effective community participation in health development and management, as well as community ownership of sustainable health outcomes

3.6.3 Interventions

To strengthen community participation in health development

3.6.3.1 To provide an enabling policy framework for community participation

3.6.3.2 To provide an enabling implementation framework and environment for community participation

3.6.3.3 Create information platform between health care provider and the community
3.6.3.4 Strengthen community voluntary participation and support for health services

To empower communities with skills for positive health actions

3.6.3.5 To build capacity within communities to 'own' their health services
3.6.3.6 Coordinating existing traditional, faith based health care providers and private health providers
3.6.3.7 Establish and strengthen existing structures for community dialogue on health

To strengthen the community - health services linkages

3.6.3.8 To restructure and strengthen the interface between the community and the health services delivery points
3.6.3.9 Engaging local human resources for health service delivery
3.6.3.10 To strengthen the capacity of civil society organizations (CSOs) to improve linkages between communities and health service delivery points

To increase national capacity for integrated multisectoral health promotion

3.6.3.11 To develop and implement multisectoral policies and actions that facilitate community involvement in health development

To strengthen evidence-based community participation and ownership efforts in health activities through researches

3.6.3.12 To develop and implement systematic measurement of community involvement
3.6.3.13 Involvement of community in information management and evidence based decision making

3.7 PARTNERSHIPS FOR HEALTH

3.7.1 Context

This is a veritable avenue for improving the performance of the FCT health system and addressing the social determinants of health. Critical areas include the review and formulation of policy on partnership as well as the production and distribution of this policy to various stakeholders. Also important is the need to conduct media campaign to sensitize communities on effective Public Private Partnerships, coordination mechanisms with health development partners, including multilaterals, bilateral and the civil society; equally partnerships with professional groups and traditional care providers.

Health development cannot be implemented without the active participation of major stakeholders. Government alone cannot do it and as such partnerships that cut across all areas of human endevaour needs to be identified. These partnerships must be such that will be mutually beneficial and take into consideration the developmental priorities of government and the aspirations of the citizenry.

3.7.2 Goal

To enhance harmonized implementation of essential health services in line with national health policy goals

3.7.3 Interventions

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

3.7.4.1 To promote Public Private Partnerships (PPP)
3.7.4.2 To institutionalize a framework for coordination of Development Partners
3.7.4.3 To facilitate inter-sectoral collaboration
3.7.4.4 To engage professional groups
3.7.4.5 To engage with communities
3.7.4.6 To engage with traditional health practitioners

3.8 Research for health

3.8.1 Context

This is another very poorly implemented important area in health service delivery not only in Nigeria but also in the FCT. Interventions recommended include the training and retraining of research personnel in operations research, the need to acquire, produce and distribute copies of essential National Health Research guidelines and also link researchers by creating communities through information and resource sharing.

3.8.2 Goal

To utilize research to inform policy, programming, improve health, achieve nationally and internationally health-related development goals and contribute to the global knowledge platform

3.8.3 Interventions

To strengthen the stewardship role of governments at all levels for research and knowledge management systems

3.8.3.1 To develop health research policies at FCT level and health research strategies at FCT and Area Council levels

3.8.3.2 To establish and or strengthen mechanisms for health research at all levels

3.8 3.3 To institutionalize processes for setting health research agenda and priorities

3.8 3.4 To promote cooperation and collaboration between Ministries of Health and LGA health authorities with research institutions, communities, CSOs, NIMR, development partners and other sectors

3.8.3.5 To mobilise adequate financial resources to support health research at all levels

3.8.3.6 To establish ethical standards and practice codes for health research at all levels

To build institutional capacities to promote, undertake and utilise research for evidence-based policy making in health at all levels

3.8.3.7 To strengthen identified health research institutions at state level

3.8.3.8 To create a critical mass of health researchers at all levels

3.8.3.9 To develop transparent approaches for using research findings to aid evidence-based policy making at all levels

3.8.3.10 To undertake research on identified critical priority areas

To develop a comprehensive repository for health research at all levels (including both public and non-public sectors)

3.8.3.11 To develop strategies for getting research findings into strategies and practices

3.8.3.12 To enshrine mechanisms to ensure that funded researches produce new knowledge required to improve the health system

To develop, implement and institutionalize health research communication strategies at all levels

3.8.3.13 To create a framework for sharing research knowledge and its applications

3.8.3.14 To establish channels for sharing of research findings between researchers, policy makers and development practitioners

CHAPTER 4: RESOURCE REQUIREMENTS

4.1 Human Resources

A needs assessment of human resources in the FCT has just been concluded. A training needs assessment was also concluded in the same study. The plan would draw on the findings of these studies. Nevertheless, the HR complement produced below is judged adequate for current requirements at the SHC level.

Table 4: Statistics of Core Health Professionals in FCT Health & Human Services Secretariat, 2008

S/No	Health Professionals	M	F	Total
1	Medical Consultants	23	9	32
2	Medical Doctors	167	59	226
3	Dentists	9	4	13
4	Nurses	187	636	823
5	Midwives	0	685	685
6	Pharmacist	64	39	103
7	Medical Laboratory Scientist	38	39	77
8	Medical Records Officers	41	58	99
9	Community Health Officers	35	55	90
11	Radiographers	4	3	7
12	Optometrists	4	11	15
13	Nurse Tutors	10	6	16
14	Midwive Tutors	0	7	7
15	Pharmacy Technicians	20	10	30
16	Medical Laboratory Technicians	11	17	28
17	Community Health Workers	62	76	138
19	Dental Technologists	4	2	6
20	Dental Therapists	6	6	12
21	Dieticians/Nutritionists	1	19	20
22	X- Ray Technicians	2	0	2
	Total	**688**	**1,741**	**2,429**

Source: FCT Health Bulletin (2008)

4.2 Physical/Material Resources

See 4.1 above

A needs assessment of physical / material resources in the FCT has just been concluded. The plan would draw on the findings of these studies.

- Construction and equipping of infectious disease hospital
- Construction and equipping of public health laboratory
- Construction and equipping of primary and secondary health facilities in underserved areas
- Recruitment, orientation, managerial and technical capacity building of health workers
- Construction and equipping of a school of Health Technology
- Provision of HMIS minimum packages at FCT and Area Council levels
- Procurement of HIS software for SHC facilities
- Resource centre
- Procurement of Vehicles

4.3 Financial Resources

The financial resources required to effectively run the FCT health care service delivery system are enormous. There is paucity of systematically collected data in form of State Health Accounts or Public Expenditure Reviews to effectively track the health expenditure in the FCTA and its Area Councils. Available administrative data however shows increasing trend in allocation of resources by 25% from 15bn in 2003 to 59bn in 2007(table 5). However budget implementation performance was varied over the same period (table 6). This highlights the importance for the FCTA HHSS to ensure that mechanisms are put in place to ensure efficient utilization of the funds allocated for the implementation of this SHDP.

Table 5: Health Allocation as Percentage of Total FCT Budget, 2003 – 2007

YEAR	*TOTAL FCT BUDGET (N)*	*TOTAL HEALTH ALLOCATION (N)*	*PERCENTAGE*
2003	15,000,000,000	1,613,777,755.90	10.70%
2004	22,875,727,413	924,000,000	4.04%
2005	52,880,190,000	2,093,000,000	4.04%
2006	52,581,143,442	2,662,000,000	5.06%
2007	59,634,355,784	4,117,901,299	6.91%

Source: FCT Health Bulletin (2008)

Table 6 Health Budget Versus Health Expenditure in the FCT, 2003-2007

Year	*Approved Capital Allocation (N)*	*Approved Recurrent Allocation*	*Total Health Budget (N)*	*Actual Capital Expenditure*	*Actual Recurrent Expenditure (N)*	*Total Expenditure (N)*
2003	90,000,000		1,613,777,755.90	17,836,028.01	1,523,777,755.90	1,541,613,783.91
2004	871,000,000	53,700,000	924,200,000	212,979,706.75	20,493,490.88	233,473,197.63
2005			2,093,000,000			
2006	1,962,000,000	700,000,000	2,662,000,000	1,957,067,616.34	608,217,998.00	2,565,285,614.34
2007	1,505,500,000	2,612,401,299	4,117,901,299	798,852,791.51	340,210,771.91	1,139,063,563.42

Source: FCT Health Bulletin (2008)

CHAPTER 5: FINANCING PLAN

5.1 Estimated cost of the strategic orientations

The estimated cost of the 8 priority areas of the FCT SHDP for the period 2010-2015 is **N62,291,322,482.** This is presented according to each of the priority areas in the table below:

PRIORITY AREA	COST (NGN) (2010-2015)
LEADERSHIP AND GOVERNANCE FOR HEALTH	334,490,799
HEALTH SERVICE DELIVERY	21,427,957,136
HUMAN RESOURCES FOR HEALTH	36,689,729,441
FINANCING FOR HEALTH	1,415,894,234
FCT HEALTH INFORMATION SYSTEM	1,024,117,708
COMMUNITY PARTICIPATION AND OWNERSHIP	94,261,016
PARTNERSHIPS FOR HEALTH	124,272,123
RESEARCH FOR HEALTH	1,180,600,024
Total	62,291,322,482

5.2 Assessment of the available and projected funds

If we take a simple trend of the allocations from table 5 and add 12.5% inflation, it is estimated that on conservatively, the FCT administration may allocate an un-weighted average of N 51,960,217,656.21 billion for entire government activities for the period 2010-2015. Taking an un-weighted average of 6% annual allocation to the health sector, it is estimated that the FCT would allocated the sum of NGN 3,117,613,059.37 annually, and a total of NGN18,705,678,356.24 for the period 2010-2015.

Financing gap is the difference between the estimated funding requirements, NGN 62,291,322,482 and available/projected funds NGN18,705,678,356.24, which is NGN 43,585,644,125.70

5.3 Descriptions of ways of closing the financing gap

1. More government funding;
   a. Annual Budget
   b. MDGs
   c. National Primary Healthcare Development Agency Fund
2. UN organizations
   a. WHO

    b. UNICEF
    c. UNDP
    d. UNFPA
3. Bilateral Developmental Partners
    a. DFID
    b. USAID
    c. JICA
    d. GDA
    e. GLP
    f. Netherlands Foundation.

CHAPTER 6: IMPLEMENTATION FRAMEWORK

6.1 Structures, Institutions, strategic partners, civil society, individuals, households and other actors should be identified as well as their roles and their inter relations. The major implementation partners include the following:

FCTA, Parliament, HHSS, DPS, HMB, CSOS, WHO, UNICEF, UNFPA, UNDP, WORLD BANK, AFDB, USAID, DFID, CIDA, EU, JICA, Private Health Care Providers, CIDA, FMOH, MRCN, NAFDAC, ODA, PEPFAR, NIPRD, NIMR, NHIS, NHMIS, TBA, PM,HSDP,DPRS, DFA, DM&D, DPH, DNS, GMHMB, DRF, Registrar PHERM, Legal Adviser HHSS, DD PHC, Ward Focal Person, LGA Health Educators, FCT M&E, Reps of VHCs & WHDCs, GM SERVICOM, Dir. Budget & Economic Plan. Dept.

(Please see Excel Toolkit in the Annex for their individual responsibilities)

CHAPTER 7: MONITORING AND EVALUATION

The implementation of the FCT SHDP will be monitored and evaluated periodically and at least biennially. Two main categories of the SHDP will be monitored and evaluated: the processes put in place to strengthen the health system; and the performance of the health system in terms of progress made in improving health status indicators. The M&E unit of the FCTA HHSS will have the primary mandate for the M&E of the FCT SHDP. It will develop and implement together with all stakeholders a suitable M&E plan that is well aligned to help monitor progress towards achieving the goals and objectives of the SHDP as detailed in the M&E/Results matrix in annex 8.

It is estimated that implementation of the M&E plan will cost 5% of the total cost of the SHDP which is NGN 3,114,566,124.

CHAPTER 8: CONCLUSION

As stated earlier, this document is a reflection of the priority concerns and peculiarity of the FCT Health Delivery System. The ownership of the plan therefore resides with the officials of the FCT HHSS.

In view of the need to ensure accessibility of health facilities to as many members of the FCT community as possible, primary health care is the centre piece of the plan.

And since health care delivery is a multi disciplinary project, apart from putting a lot of responsibilities on the respective Health Managers in the FCT and the six Area Councils, the document has also identified other key players whose support would be needed in actualizing the good intentions of the plan.

In addition, funding has been given an important attention whereby the operating expenditure, as well as possible sources of funding has been enumerated.

It is hoped that this plan will go a long way in improving the health care delivery not only in the FCT but in Nigeria as a whole.

Annexure

Annex 1: Estimated Cost of the FCT Strategic Health Development Plan (2010-20150

FCT STRATEGIC HEALTH DEVELOPMENT PLAN							
Priority Areas							
Goals					**Baseline Year 2009**	**Risks and Assumptions**	**Estimated Cost (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 FCT							**334,490,799**
	1	**To provide clear policy directions for health development**			**All stakeholders are informed regarding health development policy directives by 2011**		40,502,966
		1.1.1	Improved Strategic Planning at Federal and State levels		Number of Policies developed.		14,424,582
			1.1.1.1	Review present Organizational structure (Organogram), Printing and dissemination.			1,066,770
			1.1.1.2	Review of strategic plan			1,685,740
			1.1.1.3	New Health Policies Development, Review, Printing and Dissemination			1,226,870
			1.1.1.4	Conduct Management Training for health managers.			10,445,203
		1.1.2	Improved coordination of health at all levels		Number of FCT Council of Health Meetings Held.		2,474,795
			1.1.2.1	Attend statutory meetings that enhance coordination eg FCTCH, NCH, HDCC, etc			2,474,795
		1.1.3	Generated evidence to improve planning and management		Number of Health Assessment Documents produced		23,603,589
			1.1.3.1	Conduct of health service delivery assessment			21,241,082
			1.1.3.2	Develop prioritised list of areas requiring further/advanced analytical work for outsourcing			2,362,507
	1	**To facilitate legislation and a regulatory framework for health development**			**Health Bill signed into law by end of 2009**		8,571,210
		1.2.1	Strengthen regulatory functions of government		Number of Standard Operating Procedures Produced.		8,571,210
			1.2.1.1	Develop Standard Operating Procedures and Guidelines for all policies implementation.			1,257,938
			1.2.1.2	Develop/Review Regulatory framework			686,534

			1.2.1.3	Organize workshop for stakeholders to disseminate regulatory framework			6,626,737
	1	**To strengthen accountability, transparency and responsiveness of the national health system**			**80% of States and the Federal level have an active health sector 'watch dog' by 2013**		17,027,322
		1.3.1	To improve accountability and transparency		Proportion of Funds released to FCT Health Secretariat from Budgetry appropriation		17,027,322
			1.3.1.1	Review present Budget preparation, fund allocations and releases to identify gaps			805,008
			1.3.1.2	Institute a framework through advocacy to strengthen the autonomy of the Boards and Agencies			2,527,397
			1.3.1.3	Constitute Budget Monitoring groups that include stakeholders and the Community			13,694,917
	1	**To enhance the performance of the national health system**			**1. 50% of States (and their LGAs) updating SHDP annually** **2. 50% of States (and LGAs) with costed SHDP by end 2011**	**Various levels of government have capacity to update sectoral SHDP** **States may not respond in a uniform and timely manner**	268,389,301
		1.4.1	Improving and maintaining Sectoral Information base to enhance performance		Resource Centre set up .		268,389,301
			1.4.1.1	Review existing data gathering/processing framework to identify gaps			2,900,329
			1.4.1.2	Build, Equip and Provide software for Resource Centre			215,624,658
			1.4.1.3	Conduct ICT Training for Top Management Personnel			49,864,315
HEALTH SERVICE DELIVERY							
2. To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare							**21,427,957,136**
	2	**To ensure universal access to an essential package of care**			**Essential Package of Care adopted by FCT by 2011**		1,406,578,865
		2.1.1	To review, cost, disseminate and implement the minimum package of care in an integrated manner		Guidelines on Minimum Package available at Health Facilities		2,995,010
			2.1.1.1	Develop minimum health care package for primary and secondary level.			564,456
			2.1.1.2	Production, Formal presentation and distribution of implementation Guidelines to Health facilities and Key Stakeholders			2,430,554
		2.1.2	To strengthen specific communicable and non communicable disease control programmes		Availability of 1 HCT Centre at Area Council Level		1,264,520,431

			2.1.2.1	Formulate/Review Guidelines on Disease control programmes			1,837,898
			2.1.2.2	Production and distribution of Guidelines			4,951,010
			2.1.2.3	Develop and Disseminate Health Education Packages on Disease Control to Communities			46,105,461
			2.1.2.4	Training of Health workers involved in Disease control			46,616,738
			2.1.2.5	Conduct meetings with Partners with interest in Disease Control Programmes			528,967
			2.1.2.6	Establish Infectious Disease Control Committee in each SH and TH Facilities			17,532,963
			2.1.2.7	Construct Infectious Diseases Hospital state-of- the- Art adequately equipped Public Health Laboratory			1,146,947,395
		2.1.3	To make Standard Operating procedures (SOPs) and guidelines available for delivery of services at all levels		Availability of SOP in one remote PHC in each Area Council		26,411,474
			2.1.3.1	Review/Develop SOPs and Guidelines			1,688,531
			2.1.3.2	Produce and Distribute SOPs and Guidelines			24,722,943
		2.1.4	To strenghten the capacity of the FCTA hospitals		A&E units established in the hospitals		112,651,949
			2.1.4.1	Complete overhauling of the Accident and Emergency units in order to improve emrgency medical services in FCT hospitals.			112,651,949
	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**		18,742,223,039
		2.2.1	To improve geographical equity and access to health services		Presence of a Health post in a remote community		11,927,044,400
			2.2.1.1	Review and update the GIS on Health facilities to determine the siting of new ones			174,325
			2.2.1.2	Identify the Health Facilities that need upgrading and renovation			678,875
			2.2.1.3	Upgrading and renovation of Health Facilities			382,321,925
	#		2.2.1.4	Construction and equipping of new Health facilities in underserved areas			7,721,243,138
			2.2.1.5	Construction and equipping of 4 cottage hospitals in Nyanya, Gwagwalada, Deidei and Lugbe			3,822,448,754
			2.2.1.6	Develop, Distribute and implement guidelines for outreach services			177,383
		2.2.2	To ensure availability of drugs and equipment at all levels		Availability of ACT in a remote PHC in each Area Council		5,965,388,294
			2.2.2.1	Review guidelines on drugs and formulate guidelines on equipment			211,020
			2.2.2.2	Carry out Needs assesment of drugs and equipment			2,039,631

			2.2.2.3	Procurement of drugs/consumables and equipment			5,962,963,318
			2.2.2.4	Distribution of drugs and equipment			174,325
		2.2.3	To establish a system for the maintenance of equipment at all levels		Budget for equipment maintenance available		124,027,660
			2.2.3.1	Develop guidelines on equipment procurement and maintenance			174,325
			2.2.3.2	Carry out survey of available equipment			1,091,689
			2.2.3.3	Employ Biomedical engineers/Technicians			174,325
			2.2.3.4	Upgrade existing Maintenance unit and Establish and adequtely equip maintenance workshops			114,844,748
			2.2.3.5	Train and re-train biomedical engineers/technicians			7,742,573
		2.2.4	To strengthen referral system		Availability of functional ambulance service in a remote Comprehensive Healthcare Centre in each Area Council		723,508,966
			2.2.4.1	Formulate/ review existing documents and guidelines on referral system at all levels			155,423
			2.2.4.2	Conduct needs assessment to determine gaps			1,311,301
			2.2.4.3	Improve communication like Radio/Telephone and Internet Facilities			644,021,235
			2.2.4.4	Procure 2 ambulances per Area Council			46,293,994
			2.2.4.5	Undertake Training of health care personnel in referral system management			31,727,013
		2.2.5	To foster collaboration with the private sector				2,253,719
			2.2.5.1	Review guideline on PPP with special emphasis on Health Services			388,518
			2.2.5.2	Map Private healthcare providers based on operational level and location			582,777
			2.2.5.3	Identify Companies with interest in Health care as their corporate social reponsibility			84,343
			2.2.5.4	Develop and implement performance monitoring mechanism for Private Healthcare providers			362,788
			2.2.5.5	Develop and implement Guidelines on traditional medicine			835,293
	2	**To improve the quality of health care services**			**50% of health facilities participate in a Quality Improvement programme by end of 2012**		1,216,877,775

		2.3.1	To strengthen professional regulatory bodies and institutions		Availability of Practicing Licenses in two randomly selected hospitals, pharmacies & patent medicine stores in each Area Council		1,704,201
			2.3.1.1	Develop and distribute operational guidelines of all regulatory bodies			1,277,324
			2.3.1.2	Organise regular meetings with regulatory bodies such as NAFDAC			426,878
		2.3.2	To develop and institutionalise quality assurance models		Availability of Quality Assurance Model in one Secondary Facility in each Area Council		954,278
			2.3.2.1	Develop quality assurance model			174,519
			2.3.2.2	Produce and distribute the models to end users			779,759
		2.3.3	To institutionalize Health Management and Integrated Supportive Supervision (ISS) mechanisms		Healthworkers in remote Health facility trained on ISS		12,760,724
			2.3.3.1	Develop framework and ISS toolkit for Health Management and ISS mechanism with partners			513,922
			2.3.3.2	Produce and distribute the framework and the ISS Toolkits to Health Facilities			779,759
			2.3.3.3	Train workers involved in carrying out ISS and staff of Facilities			11,467,042
		2.3.4	To strengthen the capacity to improve Malaria Control Programme		Increase the ownership of ITN to at least 80% for Under-5yrs and pregnant women by end 2012		270,866,829
			2.3.4.1	Procurement and distribution of ITNs to pregnant women and children U5			1,528,939
			2.3.4.2	Procurement and distribution of Artemisin-based combination therapy for chidlren, pregnant women and adults			7,644,695
			2.3.4.3	Provision of intermittent preventive treatment for malaria in pregnancy			3,822,347
			2.3.4.4	Procurement and distribution of second line drugs for the management of complicated malaria			91,736,338
			2.3.4.5	Mass social mobilization of communities for awareness on LLINs			17,062,959
			2.3.4.6	Indoor residential spray/space spray of areas of high mosquito density			91,736,338
			2.3.4.7	Conduct a survey in the communities on the utilization of LLINs			45,868,169
			2.3.4.8	Train health workers, RMM, PMVon general malaria control			11,467,042

		2.3.5	To strengthen the capacity to improve Maternal and Newborn Care		At least two trained midwives in Ward BEOC Centre by end of 2012		310,882,220
			2.3.5.1	Procurement and distribution of BEOC packages to selected health facilities			91,736,338
			2.3.5.2	Provision of ANC packages (folic acid, lab testing, SP, TT) to pregnant women at health facilities			169,712,226
			2.3.5.3	Training of birth attendants in obstetric care, resuscitation of asphytic newborns and community based management of neonatal sepsis and other infections			3,822,347
			2.3.5.4	Procurement and distribution of midwifery kits neonatal			5,351,286
			2.3.5.5	Training of TBAs/Health Assistants			6,134,103
			2.3.5.6	Advocacy visits to AC chairmen, Traditional & Religious Leaders.			-
			2.3.5.7	Carry out supportive supervision			4,586,817
			2.3.5.8	Provision of outreach with services to the under served community			22,934,085
			2.3.5.9	Midwives service scheme (64 midwives to be engaged)			6,605,016
		2.3.6	To strengthen the capacity to improve Child Health		DPT3 coverage increased from 50% to 80% by 2015		72,483,939
			2.3.6.1	Develop, disseminate and implement guidelines for outreach healthcare services			9,173,634
			2.3.6.2	Develop, disseminate and implement strategic plan (involving but not limited to IEC materials and media programmes on clean cord delivery, cord care, etc. in English & local language) for managing childhood illnesses			12,231,512
			2.3.6.3	Strengthen breastfeeding, infant & young child feeding practices			1,528,939
			2.3.6.4	Increase the up-take of routine and supplementary immunization, Vit A Supplementation & zinc prevention			2,293,408
			2.3.6.5	Promote and strengthen detection & management of childhood illnesses			1,911,174
			2.3.6.6	Training of health workers, community resource persons and care givers			29,291,413
			2.3.6.7	Monitoring of supervision follow up of health workers and corps trained on IMCI			16,053,859
		2.3.7	To strengthen the capacity to improve HIV/AIDS Control				381,993,171
			2.3.7.1	Training of 35 health care workers from 7 district Hospitals and Parklane on risk reduction, universal precaution and medical waste management.			95,558,686
			2.3.7.2	Conduct 2 days community engagement advocacy for 50 stakeholders, inorder to enhance male involvement and increase demand for PMTCT services in each of the 6 Area Councils			3,822,347

			2.3.7.3	Build the capacity of 30 Health care workers on the PMTCT of HIV			2,293,408
			2.3.7.4	To establish 3 counselling and testing sites per LGA in the state			68,802,254
			2.3.7.5	To build the capcity of 30 M&E officers on NNRIMS and LHPMIP data MIS			65,274,992
			2.3.7.6	Build the capacity of 30 health workers from ART sites on PLWHA treatment literacy and adherence			46,927,724
			2.3.7.7	Training of doctors, pharmacists, nurses and lab scientists on HIV community logistics management system (CLMS)			46,767,185
			2.3.7.8	Conduct quarterly treatment partners technical review forum for 25 stakeholders			46,767,185
				Strenghten monthly M&E statistical meeting and supportive supervisory visits to HIV sites			5,779,389
		2.3.8	To strengthen the capacity to improve Toberculosis Control				64,472,435
			2.3.8.1	Procurement and Distribution of First Line Anti-Toberculusis Drugs			9,173,634
			2.3.8.2	To equip the MDR Laboratory for Diagnosis			35,165,596
			2.3.8.3	To strengthen TB/HIV collaborative activities			4,586,817
			2.3.8.4	Strengthen logistic and funding support for supervision			4,586,817
			2.3.8.5	To strengthen PPM-DOTs activities			4,586,817
			2.3.8.6	To strengthen community TB care activities			4,586,817
			2.3.8.7	Conduct advocacy, social mobilization to 6 Area Councils			1,785,937
		2.3.9	To Strengthen School Health Services by provision of quality Health Services in FCT schools				67,123,322
			2.3.9.1	Production and distribution of IEC materials to boost reproductive health services for adolescent in the FCT schools			12,231,512
			2.3.9.2	Advocacy visit to the principals of schools/head teachers in FCT			4,454,522
			2.3.9.3	Training of the school food vendors			46,614,941
			2.3.9.4	Supervision of the schools (Monitoring of the implementation)			3,822,347
		2.3.1 0	To promote Gender Health Services				33,636,657
			2.3.10. 1	To create awareness on the hazard of female genital mutilation in FCT communities			3,822,347
			2.3.10. 2	To orientate the male folk on the importance of meeting the health needs of their families and the dangers of female circumcission.			3,057,878
			2.3.10. 3	Celebration of international day of zero tolerance of female genital mutilation			3,822,347
			2.3.10. 4	Creation of awareness of the hazard of female genital mutilation in secondary schools			7,644,695

			2.3.10.5	To promote and sustain women's health through the ward development committee of gender based violence			3,822,347
			2.3.10.6	To develop capacities and competences of men in the FCT for active participation in all reproductive health issues.			3,822,347
			2.3.10.7	Establishment of female functional literacy in FCT			7,644,695
	2	**To increase demand for health care services**			**Average demand rises to 2 visits per person per annum by end 2011**		50,801,731
		2.4.1	To create effective demand for services		Increase in OPD attendance/ANC		50,801,731
			2.4.1.1	Develop Health Promotion Guidelines and Monitoring tools			478,453
			2.4.1.2	Pay advocacy visits to Legislators to push for established Budget line for Health Promotion			212,062
			2.4.1.3	Establish Drug Information centres in all the SHFs			23,526,548
			2.4.1.4	Conduct community mobilisation to promote Healthy life styles.			3,554,260
			2.4.1.5	Train Health Educators on IEC development and design			23,030,408
	3	**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**		11,475,726
		2.5.1	To improve financial access especially for the vulnerable groups		Provision of free Maternity services for pregnant women in one remote PHC in each Area Council		11,475,726
			2.5.1.1	Sensitize the community about Free ANC and Under Five Health programmes			3,250,139
			2.5.1.2	Costing the financial requirement for providing free health services for other Vulnerable groups (Accident Victims, the Aged, etc.)			7,700,904
			2.5.1.3	A feasibility study to be carried out to guide the expansion of health insurance scheme to the communities			524,683
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							**36,689,729,441**
	3	**To formulate comprehensive policies and plans for HRH for health development**			**HHSS actively using adaptations of the National HRH policy and Plan by end of 2015**		1,998,445
		3.1.1	To develop and institutionalize the Human Resources Policy framework		Adapted HRH document available by June 2010		1,998,445

			3.1.1.1	Review the National Human Resources for Health Strategic Plan for adaptation for FCT framework and guidelines			569,336
			3.1.1.2	Develop and annually update database of all health care professionals (including non-government) capturing contact details, location (LGA), profession and experience, specialty, current engagements, and availability for ad-hoc assignments.			1,429,110
	3	**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**		2,033,439,459
		3.2.1	To reappraise the principles of health workforce requirements and recruitment at all levels		Manpower projection and Need Assessment tool to be in use by September 2010		2,033,439,459
			3.2.1.1	Develop an 10-year annualised projection of HRH requirement in each professional, administrative and technical cadre needed for the implementation of the projected level of health service delivery.		The data will guide the planning for requisite manpower	1,003,521
			3.2.1.2	Develop Need-Assessment tools for determining gaps in the critical health professionals needed per health facility:			553,938
	#		3.2.1.3	Undertake annual recruitment of staff based on clearly defined parameters that match the professional skills of the applicants with the gaps derived from 3.2.1.1 and 3.2.1.2 above and based on merit, non-discrimination and geo-political representation			2,031,882,000
			3.2.1.4				-
	3	**Strengthen the institutional framework for human resources management practices in the health sector**			**HHSS and 2 Area Councils functional HRH Units by end 2010**		6,004,850,342
		3.3.1	To establish and strengthen the HRH Units in HHSS		FCT HRH unit established by September 2010		6,004,850,342
			3.3.1.1	Transform the Personnel Admin unit within the DFA into HRH Unit in line with Federal policy, cascading from the HHSS to all levels.			304,110
			3.3.1.2	Organise training workshops for middle level management HRH staff to understand and internalise the principles and practice of HRH			4,546,233
			3.3.1.3	Provide over head cost for the running of the Health system			6,000,000,000
	3	**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**			**HHSS to produce health workforce graduates with multipurpose skills and mid-level health workers by 2015**		3,946,586,151

		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		Report of training programmes assessment available by July 2010		385,336
			3.4.1.1	Assess the programmes available for the training middle-level manpower (CHO, CHEW, Pharmacy Technicians, Laboratory Technicians) with a view to addressing their adequacy (quality and quantity) for the projected level of health services delivery up to 2020.			385,336
		3.4.2	To strengthen health workforce training capacity and output based on service demand		School of Health Technology established and accredited by end 2011		3,946,200,815
			3.4.2.1	Initiate the establishment of a School of Health Technology for the training of middle-level manpower			485,336
	#		3.4.2.2	Construct School of Health Technology			2,605,588,870
	#		3.4.2.3	Equip School of Health Technology			480,148,870
			3.4.2.4	Renovate and/or increase number of classrooms, practical demonstration rooms, conference room, auditorium, hostel blocks to make the School of Nursing and School of Midwifery accreditation-compliant for increased student intake.			800,148,870
			3.4.2.5	Procure laboratory equipment, library books, computers, furniture, office equipment, Internet access facility, air-conditioners and 30-seater buses for the schools.			59,828,870
	4	**To improve organizational and performance-based management systems for human resources for health**			**15% implemented performance management systems by end 2012**		24,697,250,797
		3.5.1	To achieve equitable distribution, right mix of the right quality and quantity of human resources for health		Number and mix of staff at General Hospital, Rubochi		24,027,728,934
			3.5.1.1	Design and publicise a transparent system for staff deployment (at staff entry point and other in-service points) on rotational posting to underserved and difficult to reach non-urban health facilities; system will be developed based on inputs of concerns and expectations from staff and other intesrest groups (NMA, NANM, etc) and service delivery expectations			363,144
			3.5.1.2	Review/Establish incentive scheme that offers differential remuneration for HRH serving in underserved and difficult to reach non-urban locations			173,260

			3.5.1.3	In line with policy framework in 3.1.1.1 above, design a system linked to the database envisaged in 3.1.1.3 above to systematically deploy volunteer teams (from retirees, diaspora professionals, para-military agencies, NGOs) on scheduled duty tours of hard to access communities guided by evidence-based needs of those communities.			7,014,986
			3.5.1.4	Salaries and wages for personel			24,020,177,544
		3.5.2	To establish mechanisms to strengthen and monitor performance of health workers at all levels		Number of staff attended training programmes each year		669,521,863
			3.5.2.1	Organise/sponsor staff to skill enhancement training and patient-friendly attitude training for all categories of HRH professionals			324,831,863
			3.5.2.2	Sponsor HRH professionals for post-graduate studies to meet the improved manpower quality levels projected for health sevices delivery up to 2020 in line with 3.2.1.1 above			184,770,000
			3.5.2.3	Organaise managerial training for senior and middle-level officers (to strengthen Health Systems Management) and appropriate IT training for all cadres of staff to enhance information management in health services delivery.			159,920,000
			3.5.2.4	Develop guidelines for recognising and rewarding initiatives, quality of service, hard work and exemplary performance of duty.			-
			3.5.2.5	Design performance management system for health service managers and HRH professionals			-
	4	**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**		5,604,247
		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		One Stakeholders' Get-Together Forum held every year		5,604,247
			3.6.1.1	Establish interactive stakeholder forums to bring together professional associations, regulatory authorities, HRH professionals and health managers to promote team work, understanding of professional roles, inter-professional respect, appreciation of common obligation to the health of the citizen and multi-diciplinary contribution of solutions to health problems.			5,604,247
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							**1,415,894,234**
	4	**To develop and implement health financing strategies at Federal, State and Local levels consistent with the National Health Financing Policy**			**FCT has a documented Health Financing**		8,048,404

					Strategy by end 2012		
		4.1.1	To develop and implement evidence-based, costed health financing strategic plans at LGA, State and Federal levels in line with the National Health Financing Policy		Health Financing Strategic Plan Developed		8,048,404
			4.1.1.1	Development and Review of Health Financing Strategy			3,101,219
			4.1.1.2	Develop Technical brief for policy makers in the FCT, Policy formulation on Fund rainsing, pool and how to provide or procure services.			2,462,719
			4.1.1.3	Establishment and meeting of FCT steering committee on microeconomics and health			2,411,966
			4.1.1.4	Presentation of steering committees' reports to the FCT Exco			72,500
	4	**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**		585,560,660
		4.2.1	To strengthen systems for financial risk health protection		Number of Area Councils Operating Community Based Social Health Insurance Scheme		559,427,400
			4.2.1.1	Advocacy and sensitization of all stakeholders in the informal sectors.			45,537,000
			4.2.1.2	Develop a regulatory framework for social health insurance			475,000
			4.2.1.3	Provide Seed Funds to initiate Community Based Social Health Insurance Scheme.			513,415,400
		4.2.2	To strengthen the Social Insurance for Health in Vulnerable Groups		Number of Vulnerable Groups Accessing Health Care Services		26,133,260
			4.2.2.1	Conduct Identification Study and Needs Assessment of Vulnerable Groups			24,287,671
			4.2.2.2	Develop Guidelines for Exemption of Vulnerable Groups from Payment for Heath Care Services.			1,845,589
	4	**To secure a level of funding needed to achieve desired health development goals and objectives at all levels in a sustainable manner**			**Allocated FCT and Area Councils Health funding increased by an average of 5% pa every year until 2015**		777,924,734
		4.3.1	To improve financing of the Health Sector		Proportion of Increase in Health Budget Yearly		9,863,692
			4.3.1.1	Preparation of Annual Operating Plan and Budget			9,277,397
			4.3.1.2	Pay Advocacy visits to the National Assembly to Promote Increased Budgetary Allocation			586,295
		4.3.2	To improve coordination of donor funding mechanisms		FCT Health Accounts Template Developed		1,093,795
			4.3.2.1	Develop FCT Health Accounts Template			1,093,795

		4.3.3	To improve on health care services through donor fund		Proportion of Disease Control Programs Supported through Donor Fund		2,407,248
			4.3.3.1	Conduct Needs Assessment of Health System			1,715,308
			4.3.3.2	Organise Meetings to Discuss and Advocate for Budgetary Support			691,940
		4.3.4	To strenghten Health Care Delivery in PHCs using Donor Fund		Number of Primary Health Care Facilities Equiped through Donor Fund		764,560,000
			4.3.4.1	Purchase of medical Equipment for the PHCs			240,000,000
			4.3.4.2	Rehabilitation and Renovation of the PHCs			480,000,000
			4.3.4.3	Training of Health workers in the PHCs			44,560,000
	4	**To ensure efficiency and equity in the allocation and use of health sector resources at all levels**			**1. FCT and Area Councils have transparent budgeting and financial management systems in place by end of 2015** **2. FCT and Area Councils have supportive supervision and monitoring systems developed and operational by Dec 2012**		44,360,436
		4.4.1	To improve Health Budget execution, monitoring and reporting		Health Budget Execution Improved		13,174,175
			4.4.1.1	Develop/Review of FCT Health Accounts (FHAs) and Public Expenditure Reviews (PERs) Framework.			1,093,795
			4.4.1.2	Establishment and Meetings of FCT Budget Monitoring Team			987,436
			4.4.1.4	Training and re-training of staff in Budgeting, Planning, Accounting, Auditing and M&E			11,092,945
		4.4.2	To strengthen financial management skills		No of Finance Staff with Improved Skills		31,186,260
			4.4.2.1	Training of the Accounting Personnel on Financial Management Skills			15,000,000
			4.4.2.2	Development/Review of Financial Management Manual			1,093,795
			4.4.2.3	Provision of Financial Tools (Software and other related applications)			15,092,466
FCT HEALTH INFORMATION SYSTEM							
5. To provide an effective FCT Health Management Information System (FCT-HMIS) by all the Agencies and Area Councils to be used as a management tool for informed decision-making at all levels and improved health care							**1,024,117,708**

	5	**To improve data collection and transmission**			**Atleast 5 Area Councils making accurate and timely routine NHMIS returns to FCT level by end 2010**		1,271,969,950
		5.1.1	To ensure that NHMIS forms are available at all health service delivery points at all levels		Availablity of NHMIS forms at a Remote Hospital		105,123,925
			5.1.1.1	Conduct Needs Assessment Survey			430,607
			5.1.1.2	Production and Distribution of NHMIS Forms/Registers			104,693,318
		5.1.2	To periodically review the NHMIS data collection forms		Number of new data collection forms produced.		5,600,987
			5.1.2.1	Organise meetings with stakeholders			1,955,104
			5.1.2.2	Monitoring for proper utilization of NHMIS Forms			3,645,883
		5.1.3	To coordinate data collection from vertical programmes		Number of meetings of HDCC held in a year		4,587,707
			5.1.3.1	Conduct regular meetings of FCT Health Data Consultative Committee (HDCC)			1,955,104
			5.1.3.2	Integration of the current HIS with M&E system in the territory.			80,425
			5.1.3.3	Advocacy visits to strengthen existing linkages for harmonized data collection mechanism at State and Area Councis levels.			2,552,178
		5.1.4	To build capacity of health workers for data management		Number of Personnel Trained on HMIS		115,616,864
			5.1.4.1	Training Needs Assessment Survey of Health Information Personnel			53,397
			5.1.4.2	Trainings of Staff on the use of NHMIS Forms/Registers			27,097,138
			5.1.4.3	Training of Staff on Data Management			88,466,329
		5.1.5	To provide a legal framework for activities of the NHMIS programme		Legal Framework Developed.		688,340
			5.1.5.1	Develop/Review Legal Framework for FCT HMIS			565,274
			5.1.5.2	Advocacy visits to National Assembly for enactment of Legal Framework into Law.			123,066
		5.1.6	To improve coverage of data collection		Proportion of Private Health Facilities making Data returns		1,269,801
			5.1.6.1	Establish Monitoring & Evaluation Desk at PHERMC specific for Data Collection in all private health facilities			38,527
			5.1.6.2	Conduct a survey to assess the availabity of health Information personnel in private health facilities			1,231,274
			5.1.6.3				-

		5.1.7	To ensure supportive supervision of data collection at all levels		Number of Supportive Supervision Vist Conducted		14,964,619
			5.1.7.1	Provision of Vehicles for State HMIS Officer, PHC M&E Officer for data collection			12,545,616
			5.1.7.2	Conduct monitoring Visits to health facilities			2,419,003
	5	**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**		699,912,260
		5.2.1	To strengthen the use of information technology in HIS		Proportion of HIS Personnel that are ICT Trained		198,640,411
			5.2.1.1	Training of Health Information Managers at all levels on Information & Communication Technology (ICT)			92,709,589
			5.2.1.2	Procure HIS Hardware and Software for the 3 FCTA City Hospitals and HMB			105,930,822
		5.2.2	To provide HMIS Minimum Package at the different levels (FCT-HHSS, Area Councils) of data management		Availability of HMIS Minimum Package at Area Councils.		501,271,849
			5.2.2.1	Provision/Maintenance of Computer Hardware with accessories & comsumbles for HMIS programme at FCT and Area Councils Level			501,271,849
	5	**To strengthen sub-systems in the Health Information System**			**1. NHMIS modules strengthened by end 2010** **2. NHMIS annually reviewed and new versions released**		42,375,055
		5.3.1	To strengthen the Hospital Information System		Availability of Qualified Medical Records Personnel at hospital level		16,171,863
			5.3.1.1	Production and Dissemination of Hospital Patient Data Forms			133,151
			5.3.1.2	Procurement of International Classification of Diseases (ICD) & Surgical books and Training			4,022,411
			5.3.1.3	Printing of Coding & Indexing Forms			583,151
			5.3.1.4	Provision of Computers & Software			11,433,151
		5.3.2	Strengthen Disease Surveillance		IDSR Cases Reported timely.		26,203,192
			5.3.2.1	Provision of Integrated Disease Surveillance & Response (IDSR) Forms			1,357,397
			5.3.2.2	Training of Disease Surveillance Notification Officers (DSNOs)			5,689,397
			5.3.2.3	Communities Awareness on IDSR Reporting System			19,156,397

	5	**To monitor and evaluate the FCT-HMIS**			**FCT-HMIS evaluated annually**		13,777,466
		5.4.1	To establish monitoring protocol for NHMIS programme implementation at all levels in line with stated activities and expected outputs		Availability of NHMIS monitoring protocol		757,397
			5.4.1.1	Bi-annual review meetings of M&E and Disease Surveillance Notification Officers			757,397
		5.4.2	Strengthen Data Transmission		Timely Response		12,603,973
			5.4.2.1	Advocacy for timely reporting			10,326,575
			5.4.2.2	Provision of logistic (Motorcycles) for effective M&E at Ward level	See Costing		2,277,397
		5.4.3	To Assess the Progress made in the various activities & to identify problem area & proffer solutions		Provisionof Project Performance indicators		416,096
			5.4.3.1	Monitoring & Evaluation Consultancy			46,233
			5.4.3.2	Design/Production of Questionnaires and Adequate Supervision Visits			369,863
	6	**To strengthen analysis of data and dissemination of health information**			**1. 50% of Area Councils have Units capable of analysing health information by end of 2010** **2. FCT disseminates available results regularly**		20,200,685
		5.5.1	To institutionalize data analysis and dissemination at all levels		Availability of Health Data Bulletin		20,200,685
			5.5.1.1	Conduct Analysis of NHMIS Quarterly Returns			1,331,507
			5.5.1.2	Publication of Annual Health Data Bulletin			18,684,247
			5.5.1.3	Production of Annual Health Bulletin			184,932
COMMUNITY PARTICIPATION AND OWNERSHIP							
6. To attain effective community participation in health development and management, as well as community ownership of sustainable health outcomes							**94,261,016**
	6	**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**		10,445,736
		6.1.1	To provide an enabling policy framework for community participation		Policy framework on community participation developed		1,817,900
			6.1.1.1	Review/formulate policy on Community participation			709,804
			6.1.1.2	Print & disseminate policy document to all stakeholders			808,096
			6.1.1.3	Conduct media campaign to sensitize communities on the policy on community participation			300,000

		6.1.2	To provide an enabling implementation framework and environment for community participation		Number of WHDCs meeting quarterly		8,627,836
			6.1.2.1	Reactivate or establish the Village Health Committee(VHC) & Ward Health Development Committee(WHDC) in accordance with National guideline			1,984,000
			6.1.2.2	Coordinate & fund the development of workplan for VHC & WHDC			6,643,836
	6	**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**		33,063,808
		6.2.1	To build capacity within communities to 'own' their health services		Number of community health project initiated by communities		33,063,808
			6.2.1.1	Community assessment of capacity needs and available healthcare services			1,800,000
			6.2.1.2	Training of VHCs & WHDCs on PHC management			14,756,795
			6.2.1.3	Production & distribution of IEC materials			3,759,151
			6.2.1.4	Conduct community dialogues			12,747,863
	6	**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**		46,116,055
		6.3.1	To restructure and strengthen the interface between the community and the health services delivery points		Number of home visits conducted at Area Council level		46,116,055
			6.3.1.1	Monthly meetings of service providers & development committees			11,160,000
			6.3.1.2	Develop guidelines for monitoring activities at every level and for each intervention			108,055
			6.3.1.3	Conduct regular home visits			12,528,000
			6.3.1.4	Community mobilization and sensitization meetings			22,320,000
	6	**To increase national capacity for integrated multisectoral health promotion**			**FCT/Area Councils has active intersectoral committee with other Secretariats and private sector by end 2011**		524,432
		6.4.1	To develop and implement multisectoral policies and actions that facilitate community involvement in health development		Number of meetings of inter-sectoral committee held annually		524,432

			6.4.1.1	Inaugurate and organize meetings of Health Secretariat and other mandate Secretariats			524,432
	7	**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**		4,110,986
		6.5.1	To develop and implement systematic measurement of community involvement		Level of community participation determined by survey/evaluation report		4,110,986
			6.5.1.1	Conduct community involvement surveys			992,877
			6.4.1.2	Monitor & Supervise the activities of the VHCs/WHDCs			3,118,110
PARTNERSHIPS FOR HEALTH							
7. To enhance harmonized implementation of essential health services in line with national health policy goals							**124,272,123**
	7	**To ensure that collaborative mechanisms are put in place for involving all partners in the development and sustenance of the health sector**			**1. FCT has an active ICC with Donor Partners that meets at least quarterly by end 2010** **2. FCT has an active PPP forum that meets quarterly by end 2010**		124,272,123
		7.1.1	To promote Public Private Partnerships (PPP)		Number of PPP Initiatives implemented		38,153,219
			7.1.1.1	Review the existing FCT policy on PPP			1,425,822
			7.1.1.2	Sensitization meeting with private organisations & other stakeholders in healthcare industry			5,954,795
			7.1.1.3	Joint monitoring of public and private health facilities			30,772,603
		7.1.2	To institutionalize a framework for coordination of Development Partners		Number of Development Partners that are operating in accordance with signed MOU		19,517,486
			7.1.2.1	Review/update the database of FCT health partners			4,178,630
			7.1.2.2	Conduct quarterly HHSS development partners forum meetings			2,919,863
			7.1.2.3	Jointly develop review & sign MOUs with partners			556,664
			7.1.2.4	Jointly conduct end of project assessment /evaluation of donor supported activities			11,862,329
		7.1.3	To facilitate inter-sectoral collaboration		Number of non-health sector		1,173,000

					institutions identified		
			7.1.3.1	Establish and inaugurate the FCT inter-sectoral health forum			189,000
			7.1.3.2	Hold periodic inter-sectoral health forum meeting			984,000
		7.1.4	To engage professional groups		Number of professional bodies participating and implementing the FCT Health councils' resolutions		11,015,260
			7.1.4.1	Conduct annual meeting of the FCT Council on Health			4,468,932
			7.1.4.2	Organise annual retreat for Guild of medical directors & Other Professional Health Associations			6,546,329
		7.1.5	To engage with communities		Number of community members trained & participating in health promoting activities		52,906,527
			7.1.5.1	Training of Community Resource Persons (CORPs) on key household practices(KHHPs)			8,110,466
			7.1.5.2	Training of town announcers on key health messages			2,110,466
			7.1.5.3	Erection of community health information boards			31,000,000
			7.1.5.4	Training of Community Data Collectors			7,916,918
			7.1.5.5	Conduct Monthly social mobilisation committee meetings at FCT & Area councils			3,768,678
		7.1.6	To engage with traditional health practitioners		Number of Meetings Held with Traditional Health Practioners Forum Yearly		1,506,630
			7.1.6.1	Establish and inaugurate the FCT Traditional Health Practitioners forum			215,233
			7.1.6.2	Hold periodic Traditional Health Practitioners forum meetings			1,291,397
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							**1,180,600,024**
	8	**To strengthen the stewardship role of governments at FCT for research and knowledge management systems**			**1. FCT ENHR Committee established by end 2009 to guide health research priorities** **2. FCT publishes an Essential Health Research agenda annually from 2010**		365,445,852

		8.1.1	To finalise the Health Research Policy at Federal level and develop health research policies and health research strategies at FCT and Area Council levels		Technical Committee established by 1st quarter of 2010 to develop FCT health research policy.		1,713,127
			8.1.1.1	Carry out study visits to FMOH and two identified high-performing States to review and build capacity on health policy formulation and strategy development			802,252
			8.1.1.2	Develop/Review FCT health research policy, implementation strategy and guidelines			497,626
			8.1.1.3	Production and dissemination of health research policy & strategy documents and guidelines			413,249
		8.1.2	To establish and or strengthen mechanisms for health research at FCT		2 Libraries furnished per year		345,014,519
			8.1.2.1	Training of health research workers in operations research			3,523,400
			8.1.2.2	Establish and equip research units/libraries at FCT and Area Council levels			340,072,132
			8.1.2.3	Advocate to NASS for a budget line for health research funding			1,418,986
		8.1.3	To institutionalize processes for setting health research agenda and priorities		Establish Multidisciplinary And Multisectoral Research Steering And Scientific Committees By 2010		13,377,555
			8.1.3.1	Develop and disseminate FCT essential health research strategic plan to stakeholders			13,377,555
		8.1.4	To promote cooperation and collaboration between HHSS,FCTA and LGA health authorities with Universities, communities, CSOs, OPS, NIMR, NIPRD, development partners and other sectors		Regular Meetings among Partners		1,297,158
			8.1.4.1	Inaugurate and organize meetings of Expert Committee on Health Research to identify and evaluate research proposals			1,297,158
		8.1.5	To mobilise adequate financial resources to support health research at FCT		Quantum of funds mobilized annually for health research		551,096
			8.1.5.1	Advocate to NASS for a budget line for health research funding	See 8.1.2.3 for Costing		551,096
		8.1.6	To establish ethical standards and practice codes for health research at FCT		Number of Staff trained in ethical standards and practice code for health research		3,492,397
			8.1.6.1	Establish and organize meetings of FCT Ethical Standards and Practice Codes board			1,544,548
			8.1.6.2	Develop and disseminate FCT health research ethical standards and practice codes guidelines/protocols to stakeholders			1,947,849
	8	**To build institutional capacities to promote, undertake and utilise research for evidence-based policy making in health at FCT**			**FCT has an active forum with all health research stakeholders by end 2010**		582,736,268

		8.2.1	To strengthen identified health research institutions at FCT		Health research institution established at FCT		303,185,041
			8.2.1.1	Establish committee to carry out feasibility and design of FCT Institute of Medical Research (FIMR)	Consulting firm; year 3		2,018,123
			8.2.1.2	Build, equip and recruit personnel for FIMR	Build year 4, equip/recruit personnel, year 5		301,166,918
		8.2.2	To create a critical mass of health researchers at FCT		No of Health Researchers Created		176,233,562
			8.2.2.1	Conduct research methodology and reporting training for health managers			12,402,740
			8.2.2.2	Advocate for budget line to provide seed funds for implementing identified health research			163,830,822
		8.2.3	To develop transparent approaches for using research findings to aid evidence-based policy making at FCT		Proportion of Policies Created through Research Findings		1,199,967
			8.2.3.1	Conduct bi-annual conference of health research policy makers and development partners			1,199,967
		8.2.4	To undertake research on identified critical priority areas		Priority areas for research identified		102,117,699
			8.2.4.1	Establish and organize meetings of Committee to identify critical areas of health research			1,980,849
			8.2.4.2	Conduct research on identified critical areas			100,136,849
	8	**To develop a comprehensive repository for health research at FCT (including both public and non-public sectors)**			**To strengthen the capacity of FCTA Health Research Unit to manage an accessible repository by end 2015**		24,199,774
		8.3.1	To develop strategies for getting research findings into strategies and practices		Proportion of Practices from Research Findings		1,982,699
			8.3.1.1	Inaugurate and organize meetings of Health Research-Policy Forum			1,982,699
		8.3.2	To enshrine mechanisms to ensure that funded researches produce new knowledge required to improve the health system		Operations research conducted		22,217,075
			8.3.2.2	Conduct operations research in collaboration with public and non-public research institutions to identify gaps in health research capacities			21,323,630
			8.3.2.3	Monitoring of health research			893,445
	8	**To develop, implement and institutionalize health research communication strategies at all levels**			**A national health research communication strategy is in place by end 2012**		208,218,130
		8.4.1	To create a framework for sharing research knowledge and its applications		Number of FCT health research findings published		58,218,130

					in reputable journals		
			8.4.1.1	Print and Disseminate FCT Health Research Journal/Bulletin			4,024,110
			8.4.1.2	Publication of FCT health research findings in local and international journals			3,230,137
			8.4.1.3	Conduct of seminars and workshops on health research			1,615,281
			8.4.1.4	Attendance of FCT health personnel at local and international health research conferences			49,348,603
		8.4.2	To establish channels for sharing of research findings between researchers, policy makers and development practitioners		No of Research Findings Shares among Partners		150,000,000
			8.4.2.1	Construct and equip an ICT resource center in DHPR, FCT			150,000,000
							62,291,322,482

Annex 2: Routine immunization returns in the FCT (2007)

S/N	Area Council	Infants Monthly	Proportion To FCT	Annual Target Population	FCT Routine Immunization coverage for children 0<11Months										
					CUMULATIVE PERFORMANCE										
		Target	Population		BCG	OPV1	OPV3	DPT1	DPT3	HBV1	HBV3	Measle	YF	TT1	**TT2+**
1	ABAJI	215	4.8%	2580	1137 (44%)	2130 (83%)	1956 (76%)	2381 (92%)	1950 (76%)	2137 (83%)	1609 (53%)	1946 (76%)	1103 (43%	699 (27%	**1445 (56%**
2	AMAC	2352	52.8%	28224	1922 (68%)	22141 (78%)	19692 (70%)	20881 (74%)	17845 (63%)	21696 (77%)	16810 (53%)	19161 (68%)	7271 (26%	11042 (39%	**14830 (53%**
3	BWARI	621	14%	7452	6330 (85%)	6370 (85%)	7356 (99%)	6989 (94%)	6419 (86%)	8549 (115%	7022 (83%)	6722 (90%)	2961 (40%	2585 (35%	**3471 (47%**
4	G/LADA	513	11.5%	6156	7430 (121%	7285 (118%	7010 (114%	6000 (97%)	5334 (87%)	6630 (106%	4534 (77%)	6971 (113%	2970 (48%	2460 (40%	**3285 (53%**
5	KUJE	462	10.4%	5544	3474 (63%)	3898 (70%)	3951 (71%)	3275 (59%)	3008 (54%)	3340 (60%)	2823 (48%)	4657 (84%)	1859 (34%	1733 (31%	**2453 (44%**
6	KWALI	288	6.5%	3456	3011 (87%)	3933 (114%	3988 (115%	3553 (103%	3351 (97%)	3694 107%)	2742 (90%)	4671 (135%	1440 (42%	1478 (43%	**2350 (68%**
7	**TOTAL**	**4451**	**100%**	**53412**	**23304 (76%)**	**(86%) 45757**	**(82%) 43953**	**(81%) 43079**	**(71%) 37907**	**(86%) 46046**	**(62%) 35540**	**(83%) 44128**	**(33% 17604**	**(37% 19997**	**(52% 27834**

Annex 3: Health manpower availability and distribution in the FCT

	Consultants	Doctors	Pharmacist	Nurses	Medical Lab Scientist	Medical Records	CHEWS	Radiographers	Pysiotherapist	Dieticians	Assistant	Attendants
	2	7	11	8	5	2	-	-	-	-	2	1
	2	12	9	6	2	5	-	-	-	-	-	2
	-	-	1	-	-	-	-	-	-	-	-	-
	1	7	6	75	3	2	181	-	-	-	1	6
ing ery	-	-	1	39	2	1	1	-	-	-	1	9
l	8	27	16	151	19	26	1	2	2	4	14	8
al	9	37	17	146	18	17	3	2	2	2	11	12
	7	30	14	166	13	21	5	3	3	6	11	12
tal	-	11	5	54	3	11	1	-	-	2	5	3
	-	11	9	55	4	10	3	-	-	1	5	3
	-	7	6	43	3	5	2	-	-	-	2	3
	-	4	4	18	2	1	1	-	-	-	-	8
	-	8	5	43	4	5	-	-	-	-	2	3

	-	7	5	21	3	5	-	-	-	-	2	4
	-	10	11	59	8	10	-	-	-	-	6	4
	-	8	6	52	2	4	2	-	-	-	5	-
wn	-	3	2	7	-	-	-	-	-	1	-	1
	29	***189***	***128***	***943***	***91***	***125***	***200***	***7***	***7***	***16***	***67***	***79***

Source: FCT Health Bulletin (2008)

Annex 4: 2007 Staff Complement in Area Council Health Facilities by Category

S/NO	CATEGORY OF STAFF	AREA COUNCILS						
		Abaji	**Amac**	**Bwari**	**G/Lada**	**Kuje**	**Kwali**	**Total**
1	**Doctor**	2	2	1	1	2	1	**9**
2	**Pharmacist**	0	0	1	0	0	0	**1**
3	**Community Health Officer**	2	18	8	6	6	3	**43**
4	**Nurse**	3	10	1	4	5	5	**28**
5	**Midwife**	7	1	7	4	5	5	**29**
6	**SCHEW**	39	41	27	26	44	34	**211**
7	**JCHEW**	7	8	9	5	15	7	**51**
8	**CH Aide**	4	0	0	0	0	0	**4**
9	**Lab Scientist**	1	0	2	0	1	4	**8**
10	**Record Officer**	0	2	0	0	1	0	**3**
11	**Pharm Technician/Assistants**	1	3	0	0	1	1	**6**
12	**Lab Technician**	6	1	0	0	0	0	**7**
13	**Ward Attendant/Assistants**	59	30	37	20	35	41	**222**
14	**Environmental Health Officer**	1	9	2	0	0	3	**15**
15	**Environmental Technicians**	0	0	4	0	0	2	**6**
16	**Nutritionist**	1	0	0	0	2	0	**3**
17	**Health Assistant**	9	0	0	0	0	0	**9**
	TOTAL	**142**	**125**	**99**	**66**	**117**	**106**	**655**

Annex 5: Bed Component for Secondary Health Facilities

S/No.	SHC	Bed Component
1	Abaji General Hospital	20
2	Asokoro District Hospital	63
3	Bwari General Hospital	39
4	Gwarinpa General Hospital	35
5	Karshi General Hospital	30
6	Kubwa General Hospital	30
7	Kuje General Hospital	40
8	Kwali general Hospital	31
9	Maitama District Hospital	92
10	Nyanya General Hospital	26
11	Wuse General Hospital	120
	TOTAL	**496**

Annex 6 Human Resource Requirements

S/NO	Departments/Hospitals	Consultants	Doctors	Pharmacist	Nurses	Medical Lab Scientist	Medical Records	CHEWS	Radiographers	Pysiotherapist	Dieticis
1	**HQTR'S**	2	7	11	8	5	2	-	-	-	-
2	**HMB**	2	12	9	6	2	5	-	-	-	-
3	**HSDP II**	-	-	1	-	-	-	-	-	-	-
4	**Public Health**	1	7	6	75	3	2	181	-	-	-
5	**School of Nursing & Midwifery Gwagwalada**	-	-	1	39	2	1	1	-	-	-
6	**Asokoro Hospital**	8	27	16	151	19	26	1	2	2	4
7	**Maitama Hospital**	9	37	17	146	18	17	3	2	2	2
8	**Wuse Hospital**	7	30	14	166	13	21	5	3	3	6
9	**Gwarinpa Hospital**	-	11	5	54	3	11	1	-	-	2
10	**Kubwa Hospital**	-	11	9	55	4	10	3	-	-	1
11	**Kuje Hospital**	-	7	6	43	3	5	2	-	-	-

12	**Abaji Hospital**	-	4	4	18	2	1	1	-	-	-
13	**Kwali Hospital**	-	8	5	43	4	5	-	-	-	-
14	**Karshi Hospital**	-	7	5	21	3	5	-	-	-	-
15	**Nyanya Hospital**	-	10	11	59	8	10	-	-	-	-
16	**Bwari Hospital**	-	8	6	52	2	4	2	-	-	-
17	**Gwagwalada Town Clinic/Karu Children Home**	-	3	2	7	-	-	-	-	-	1
	TOTAL	***29***	***189***	***128***	***943***	***91***	***125***	***200***	***7***	***7***	***16***

Annex 7: Resource Requirements (Gap Assessment)

Profession	Requirement	Available	Gap	Percentage
Consults	50	29	21	**42%**
Doctors	300	189	111	**37%**
Pharmacists	200	128	72	**36%**
Nurses	1,300	943	357	**27%**
Medical Lab Scientists	120	91	29	**24%**
Medical Records	200	125	75	**37.5%**
CHEWS	**400**	**200**	**200**	**50%**

Annex 8: Results/M&E Matrix for the FCT Strategic Health Development Plan

FCT STRATEGIC HEALTH DEVELOPMENT PLAN RESULT MATRIX						
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 ACs with Operational Plans consistent with the state strategic health development plan (SSHDP) and priorities	AC s Operational Plans	0	33.3	66.6	100%
	2. % stakeholders constituencies playing their assigned roles in the FCT,SHDP (disaggregated by stakeholder constituencies)	FCT,SHDP Annual Review Report	0	25	50	75%
	3. % of ACs enforcing traditional medical practice by-laws	AC Annual Report	0	17%	34%	66%
3. Strengthened accountability, transparency and responsiveness of the State health system	4. % of ACs which have established a Health Watch Group	AC Annual Report	0	33.50%	67	100
	5. % of recommendations from health watch groups being implemented	Health Watch Groups' Reports	0	17	34	66%
	6. % ACs aligning their health programmes to the FCTSHDP	ACs Annual Report	0	33.30%	66.60%	100
	7. % DPs aligning their health programmes to the FCT SHDP at the AC level	AC Annual Report	0	25	50	75
	8. Number of AC Health Watch Reports published	Health Watch Report	0	33.3	66.6	100
4. Enhanced performance of the State health system	9. % AC public health facilities using the essential drug list	Facility Survey Report	40	60	80	100%
	10. % of ACs public sector institutions implementing the drug procurement policy	Facility Survey Report	40	60	80	100%
	11. % ofACs implementing a performance based budgeting system	Facility Survey Report	TBD	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		**SOURCES OF DATA**	**Baseline**	**Milestone**	**Milestone**	**Target**
5. Improved access to essential package of Health care	12. % of facilities in ACs with a functioning public health facility providing minimum health care	NPHCDA Survey Report	30%	50%	60%	75%

	package according to quality of care standards.					
	13. % health facilities implementing the complete package of essential health care	NPHCDA Survey Report	30%	50%	65%	80%
	14. Contraceptive prevalence rate	NDHS	10.50%	20%	30%	40%
	15. % of facilities providing Youth Friendly RH services	Health facility Survey	20%	30	40	60
	16. Proportion of births attended by skilled health personnel	HMIS	64.30%	70	85	100%
	17. Proportion of 12-23 months-old children fully immunized	NDHS/MICS	55.00%	65%	75%	85%
	18. % children <5 years stunted (height for age <2 SD)	NDHSMICS	30.00%	25%	15	5%
	19. % of women who received intermittent preventive treatment for malaria during pregnancy	NDHS/MICS	9%	15%	30%	45%
	20. Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS	NDHS/MICS	67.50%	70%	80%	90%
Output 6. Improved quality of Health care services	21. % of staff with skills to deliver quality health care appropriate for their categories	Facility Survey Report	89%	90%	95%	100%
	22. % of facilities with capacity to deliver quality health care	Facility Survey Report	50%	55%	70%	90%
	23. % of health facilities with all essential drugs available at all times	Facility Survey Report	45%	57%	63%	75%
	24. % of health institutions with basic medical equipment and functional logistic system appropriate to their levels	Facility Survey Report	30%	48%	56%	65%
Output 7. Increased demand for health services	25. Proportion of the population utilizing essential services package	MICS	30%	45%	50%	60%
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**						
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	26. % of wards that have appropriate HRH complement as per service delivery norm (urban/rural).	Facility Survey Report	30%	50%	70%	90%
	27. % ACs actively using adaptations of National/State HRH policy and plans	HR survey Report	0	33.30%	66.60%	100%
Output 8: Improved framework for objective analysis, implementation and monitoring of HRH performance	28. %ACs making availabile consistent flow of HRH information	NHMIS	80%	90%	95%	100%
PRIORITY AREA 4: FINANCING FOR HEALTH **NSHDP GOAL 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**						

NSHDP GOAL 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						
Outcome 8. Health financing strategies implemented at Federal, State and Local levels consistent with the National Health Financing Policy						
Outcome 9. The Nigerian people, particularly the most vulnerable socio-economic population groups, are protected from financial catastrophe and impoverishment as a result of using health services						
Output 11: Improved protection from financial catastrophy and imposerishment as a result of using health services in the State	28. % of ACs implementing state specific safety nets	SSHDP review report	0%	33.30%	66.60%	100%
Output 12: Improved efficiency and equity in the allocation and use of Health resources at State and LGA levels	29. ACs health budgets fully alligned to support state health goals and policies	State and ACs Budgets	0%	33.30%	66.60%	100%
	30.Out-of pocket expenditure as a % of total health expenditure	National Health Accounts 2003 - 2005	95%	90%	80%	70%
	31. % Increase in budget allocated to the health sector both at FCT and Acs levels.	National Health Accounts 2003 - 2005	3%	5%	7%	8%
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	32. % of ACs making routine NHMIS returns to states	NHMIS Report January to June 2008; March 2009	50%	67%	83%	100%
	33. % of ACs receiving feedback on NHMIS from SMOH		0	50	75	100
	34. % of health facility staff trained to use the NHMIS infrastructure	Training Reports	50	60	70	100
	35. % of health facilities benefitting from HMIS supervisory visits from HHSS	NHMIS Report	0	50	65	80
	36.% of HMIS operators at the AC level trained in analysis of data using the operational manual	Training Reports	40%	63%	77%	85%
	37. % of AC PHC Coordinator trained in data dissemination	Training Reports	30	40%	75%	100%
	38. % of ACs publishing annual HMIS reports	HMIS Reports	0	25%	50%	75%
	39. % of AC plans using the HMIS data	NHMIS Report	30	50%	75%	100%
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 Participation in Health Development	40. Proportion of public health facilities having active committees that include community representatives (with meeting reports and actions recommended)	SSHDP review report	0	25%	50%	75%
	41. % of wards holding quarterly health committee meetings	HDC Reports	0	25%	50%	75%
	42. % increase in community health actions	HDC Reports	0	10%	25%	50%
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						
Output 15: Improved Health Sector Partners' Collaboration and Coordination	43. Increased number of new PPP initiatives per year per AC	SSHDP Report	0	25%	40%	60%
	44. % ACs holding annual multi-sectoral development partner meetings	SSHDP Report	0	25%	50%	75%
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	45. % of ACs partnering with researchers	Research Reports	0	33%	50%	67%
	46. % of State health budget spent on health research and evaluation	State budget	0	1%	1.50%	2%
Output 17: Health research communication strategies developed and implemented	47. % ACs aware of state health research communication strategy	Health Research Communication Strategy	0	33%	67%	100%