# *KEBBI STATE STRATEGIC HEALTH DEVELOPMENT PLAN 2010 TO 2016 AND OPERATIONAL PLAN 2010*


**OCTOBER, 2009**

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## LIST OF ACRONYMS AND ABBREVIATIONS

| | |
|---|---|
| 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 |
| 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 |
| UNFPA | United Nations Population Fund |
| UNICEF | United Nations Children Fund |
| UN-System | United Nations-System |
| VAT | Value Added Tax |
| VHW | Village health workers |
| VOC | Vote-of-charge |
| WHO | World Health Organization |

## PREFACE

Nigeria's overall health system performance was ranked 187th position among 191 member States by the World Health Organization (WHO) in 2000. Primary Health Care (PHC), which forms the bedrock of the national health system, remains in a prostrate state due to gross under funding, mismanagement and lack of capacity at the LGA level. The 2003 NDHS indicators demonstrating the performance of the health system indicate an immunization coverage of 23%; 6% of under-fives sleeping under insecticide treated nets (ITNs) with only a third of children with fever appropriately treated with antimalarials at home and less than half of deliveries attended to by skilled health personnel. It is noted that wide variations of these indicators exist in different geographical zones, states and rural/urban locations.

Recognizing that recent improvement in Nigeria's macroeconomic performance have not translated into discernable improvement in the health system and quality of life of Nigerians, the Federal Government's 7-Point Development Agenda has underscored human capital development as the bedrock of this national agenda with explicit reference to the health sector. Access to quality health care and prevention services are therefore considered vital for poverty reduction and economic growth, particularly as Nigeria is lagging behind in attaining the health-related MDGs.

In order to meet the challenges of achieving improved health status particularly for its poorest and most vulnerable population, the health system must be strengthened; proven cost-effective interventions must be scaled up and gains in health must be sustained and expanded. The Federal Ministry of Health (FMOH) appreciates that this can best be done within the context of a costed National Strategic Health Development Plan (NSHDP), which is aimed at providing an overarching framework for sustained health development in the country. The NSHDP is to be developed in accordance with extant national health policies and legislation, and international declarations and goals to which Nigeria is a signatory to, namely; MDGs, Ouagadougou Declaration on PHC and the Paris Declaration on Aid Effectiveness.

As a prelude to the development of the NSHDP, a generic Framework has been developed to serve as a guide to federal, states and LGAs in the selection of evidenced-based priority interventions that would contribute to achieving the desired health outcomes for Nigerians. It is expected therefore, that in using this Framework, the Federal, States and LGAs would respectively develop their respective costed plans

through participatory approaches to reflect their context and prevailing issues. The end product being a harmonized National Strategic Health Development Plan with its appropriate costing will thereafter serve as the basis for collective ownership, adequate resource allocation, inter-sectoral collaboration, decentralization, equity, harmonization, alignment, and mutual accountability in Nigeria. It would also stipulate requirements for future health investments towards achieving sustainable universal access and coverage within the planned period of 2009 - 2015.

Major steps adopted in the development of the NSHDP Framework included the conduct of 10 background studies; inauguration of a steering committee and technical working group comprising of government, development partners, CSOs, private sector, academicians and experts in development planning. Through the review of technical resource materials, wide consultations and participatory techniques, eight priority areas of concern to improve the Nigerian health system were identified namely: leadership and governance, service delivery, health financing, human resources for health, health information system, community participation and ownership, partnerships for health development and research for health. For each of the priority areas, this framework details the context, goals, strategic objectives, and recommended evidence-based and cost-effective interventions required to deliver improved performance of the health system and health outcomes for Nigerians.

Immunization is one of the most successful and cost-effective health interventions ever. It has eradicated small-pox, lowered the global incidence of polio so far by 99% and achieved dramatic reductions in illness, disability and death from diphtheria, tetanus, whooping cough and measles. In 2003 alone, it is estimated that immunization averted more than 2 million deaths.

Immunization services are increasingly used to deliver other important health interventions, making them a strong pillar of health systems.

Immunization will help to achieve the Millennium Development Goals on reducing child mortality, improving maternal health and combating diseases, eventually including malaria and HIV/AIDS.

In spite of its undisputed past success and promising future, however, immunization remains an unfinished agenda.

It is alarming that globally and in some regions immunization coverage has increased only marginally since the early 1990s.

Approximately 2.5 million children under five years of age die every year as a result of diseases that can be prevented by vaccination using currently available or new vaccines. Together we can and will change these sobering statistics.

Global Immunization Vision and Strategy guides countries on how to immunize more people against more diseases; introduce newly available life-saving vaccines and technologies; and provide other critical health interventions (e.g. nutrition and malaria control) at immunization contacts.

Global interdependence has increased the vulnerability of people everywhere to the uncontrolled spread of diseases through epidemics. The mounting threat of an influenza pandemic highlights the need to strengthen international solidarity, mutual support and work through partnerships to contribute to improving global health and security.

## EXECUTIVE SUMMARY

The Strategic Health Development Plan (2010-2015) with a costed estimate of 123 Billion Naira has the eight basic components affecting quality and effective provision of health services. The 2010 operational plan is estimated at 20.5 Billion Naira.

The primary healthcare facilities in Kebbi state are grossly dilapidated, have poor equipment base, lack adequate funding for primary healthcare services at local government level – undermining repair, maintenance and services such as laboratories, ambulances, maintenance of water supply and environmental sanitation, leading to serious customer dissatisfaction with exodus of patients to secondary healthcare centres. Kebbi State Primary Healthcare Development Agency (KBSPHCDA) bill is currently with the State House of Assembly. The bill when passed will provide framework for effective PHC services. The need to employ doctors and midwives at PHC is imperative. While progress has been made in the employment of doctors, nurses and midwives for the 14 general hospitals, there are still unmet gaps. This is particularly evident with Radiographer, Pharmacists, Lab Scientists and technicians.

Furthermore, the plan to retrain female CHEWS in life saving techniques has since commenced at the School of Health Technology Jega. This will no doubt augment the services of midwives that have been employed by the State government and 96 midwives have been employed under the Midwives Service Scheme.

The distribution of nursing staff in all the general hospitals poses a very unusual picture in which up to 75% of all nurses in Kebbi State are in the higher cadre. This administrative cadre of nurses is not very effective in bed-side nursing. The problem can be addressed by employing younger, active nurses. The School of Nursing in Birnin Kebbi is fully accredited by Nursing and Midwifery Council of Nigeria and can produce 20-25 nurses/year and 15-20 midwives. The products of this school can be engaged to redress this anomaly.

With regards to the consultant cadre, the situation in Kebbi State has changed little since 1991 with only 7 Consultants/Specialist in the State's service in 2009.

There is dearth of qualified pharmacists (8 only), and laboratory scientists in the State's hospital.

Arising from the recommendations of the Committee on Health all our existing general hospitals have been rehabilitated with monthly cash allocation releases ranging from N250,000.00 to N3,000,000 depending on the size of the hospital.

The equipment base of all the general hospital have been improved significantly with the procurement of over N1.6 billion Naira worth of equipment.

The two-way referral has been changed for the better with the procurement of 24 number ambulances.

Furthermore, salaries and allowances are promptly paid and welfare package is generally good. The other positive aspect is the good immunization coverage in Kebbi State – which is due to effective maintenance of the cold chain which include the use of solar refrigerators. Training on these should be arranged and maintenance agreement with the supplier should be concluded to protect this investment in child health.

The poverty alleviation programmes of the Kebbi State is laudable – the free drug policy for pregnant women and under-fives and subsidized surgical consumables should be sustained, and need monitoring and evaluation.

The public-private partnership with Hafsat Eye Centre is laudable. Similar areas of cooperation in PPP should be explored.

The central regulatory role of the Kebbi State Ministry of Health has been strengthened with the establishment of Inspectorate Department to monitors and evaluates health related Millennium Development Goals (MDGs) and protect the heavy investment in healthcare delivery of the State.

A Unit of Public Private Partnership in KBSMOH could be established with the aim of coordinating public private partnership in various areas of healthcare.

Public health measures against malaria, HIV/AIDS, TB should continue to be intensified. Insecticide treated nets, ITN could be provided to vulnerable groups and isolated communities like the Fulani and fishermen communities within the riverine areas. The epidemiological unit has been empowered to undertake the necessary action on the control of epidemic and endemic diseases; with monthly cash release of N200,000 for its running cost and provision of essential supplies such as drugs.

Intersectoral cooperation between Kebbi State Ministry of Health and other relevant ministries should be supported.

Community participation in health care delivery system is very low. Government should empower the PHC Department of KBSMOH to begin urgently the process of creating ward health system which will form the basis of community participation in health care. The proposed plan of action on this issue should be given urgent consideration.

All the programmes at the School of Health Technology Jega which had problems with regards to professional accreditation have been resolved. The deficiencies in these programmes are being corrected as a matter of urgency.

Mental health care is very poor in Kebbi State. Implementing the short, medium and long term recommendations on improvement of mental health in Kebbi State should be given urgent consideration.

There is not a single hospital accredited for housemanship or internship in Kebbi State. The recommendation on Sir Yahaya Memorial Hospital should be implemented so that professional bodies can be invited to accredit the hospital. This will improve manpower development for doctors, pharmacists and medical lab scientists.

Tertiary health care is weak in Kebbi State. Consequently, a new 200 bed Specialist Hospital is currently under construction to address tertiary healthcare needs of the State.

The capacity to handle epidemic should be improved, it is recommended that an Infectious Diseases Hospital (IDH) should be built within the state capital on the outskirts.

In addition, the roles of stakeholders are misaligned and coordination systems are weak. These are further compounded by the dearth of data which renders evidence based planning, policy formulation and health systems management weak. The need to address these challenges is therefore imperative.

## VISSION AND MISSION

### Vision

"To reduce the morbidity and mortality rates due to communicable diseases to the barest minimum; reverse the increasing prevalence of non-communicable diseases; meet global targets on the elimination and eradication of diseases; and significantly increase the life expectancy and quality of life of Kebbi State indigenes in particular and Nigerians in general".

**Mission Statement**

"To develop and implement appropriate policies and programmes as well as undertake other necessary actions that will strengthen the Kebbi State Health System to be able to deliver effective, quality and affordable health.

The overarching goal of the Kebbi State SHDP is to significantly improve the health status in Kebbi States through the development of a strengthened and sustainable health care delivery system.

# CHAPTER 1

## BACKGROUND AND ACHIEVEMENTS

### 1.1 Background

Kebbi state was created in 1991, it has a population of 3,238,628 in the 2006 census. There are 21 LGA's, and 225 political wards spread into 4 Emirate Councils (Argungu Emirate, Gwandu Emirate, Yauri Emirate and Zuru Emirate)

The predominant activities of the people in the state is farming and trading, while major tribes include Hausas, Fulani, Kabawa, Dakarkari, Fakkawa, Gungawa and Kambarawa. The State shares international border with Niger republic in the North and Benin republic in the North western part, while in the South it shares borders with Niger state and in the east Sokoto and Zamfara states.

The health facilities in the state include 1 tertiary hospital, 32 secondary health facilities and 124 PHC and 584 clinics. The state also has a Public health laboratory and 6 other laboratories, with 1 referral laboratories.

### 1.2 Achievements

Over the years, since the creation of Kebbi State 17 years ago, successive governments of the state have made tremendous efforts to improve the healthcare delivery system. Progress has been made in provision of infrastructural facilities with fairly equitable distribution across the whole state including coverage of areas that have been, hitherto, underserved.

Adoption of the Ward Health System as a deliberate policy to ensure community participation in PHC delivery which is in line with the current National Health Policy to improve and ensure sustainable health services with full and active participation of people at the grass root level.

In the last 17 years efforts have been made to alleviate the poverty level in the general population and improve the health care delivery to the poor.

Many different programmes targeted at improving the health status of the population had been initiated (Ahmed 2007). The scheme that provides free drugs to all pregnant women and children under 5 years is one of such initiatives.

Surgical consumables are subsidized by government for all patients, while drug dispensing under the DRF programme includes provision of waivers for a variety of patients-including the paupers.

Furthermore, some special treatments are free. These include treatments for HIV/AIDS, TB & leprosy.

It is also worth noting that free catering service is extended to the paupers in some general hospitals-particularly Sir Yahaya Memorial Hospital, Birnin Kebbi.

# CHAPTER 2

## SITUATION ANALYSIS

### 2.1 Socio-economic context

There has been a downward trend in health performance and development since 1993. Preventable diseases accounts for most of Nigeria's disease burden and poverty is a major cause of these problems.

70% of total health expenditure is born mostly out of pocket expenses despite the endemic nature of poverty.

Our maternal mortality rate about one mother die in every one hundred births is one of the highest in the world and most of these women deliver at home either unattended to or by Traditional Birth Attendants (TBAs).

Under 5's mortality rate and adult mortality rates are higher than average for most of the states in Nigeria and increasing poverty in general coupled with the current economic melt down compounds the situation.

### 2.2 Health status of the population

Disease programs such as HIV/AIDs, TB, Malaria, Reproductive health care etc are being implemented within a weak health system and little or no impact is being made.

Routine immunization coverage is low below 25% for most of the antigens used as proxy indicator such as DPT3 and Measles.

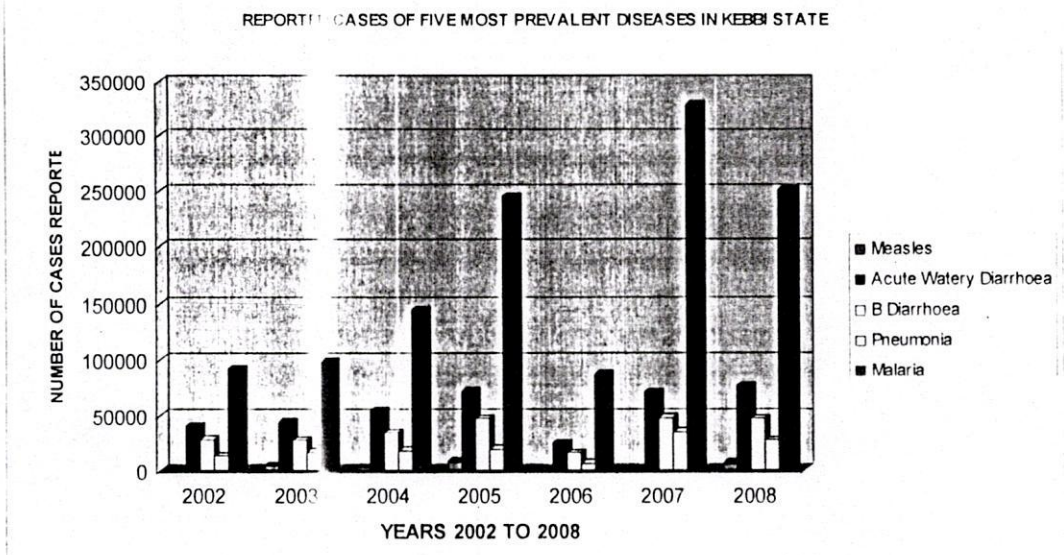
Many of the primary health care (PHC) facilities serve only 5-10% population of their capacities or potential patients load due to loss of confidence in PHC facilities as such the secondary and tertiary facilities are used more or less as primary health care facilities.

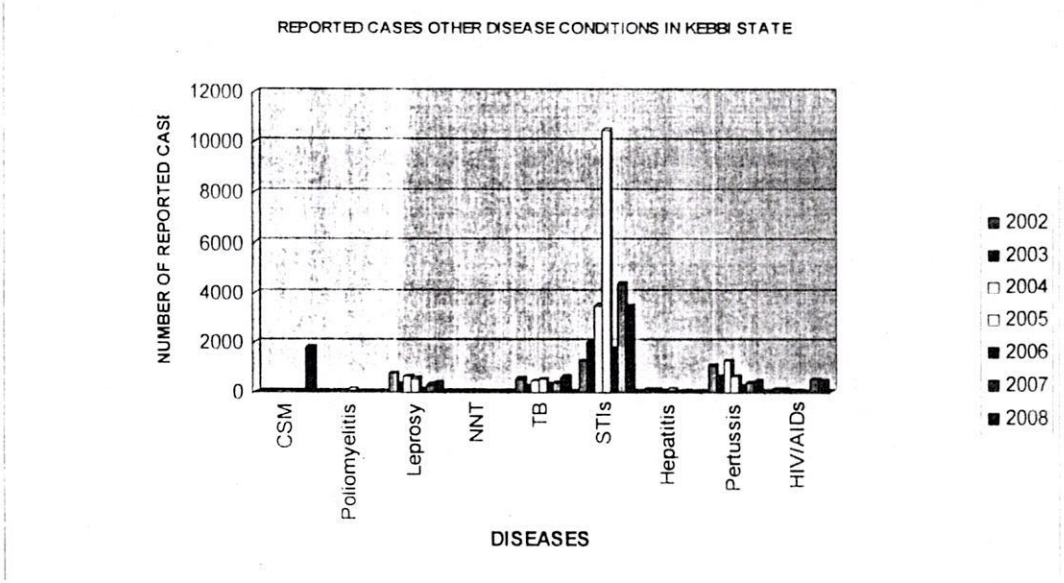
The referral system between the various levels of health care is inefficient and virtually non existent. Until 2008 when deliberate efforts have been to reverse the situation, in this regard twenty four ambulances procured were distributed to the 15 general hospitals. Furthermore, 15 call duty vehicles have also been procured and distributed. In addition, one ambulance vehicle has also been procured by each LGA in the State. These will no doubt impact positively on the patient care generally and referral system in particular.

ID PRIORITY DISEASES IN KEBBI STATE 2002 TO 2008

| | 2002 | 003 | 2004 | 2005 | 2006 | 2007 | 2008 | |
|---|---|---|---|---|---|---|---|---|
| DISEASES | CASES | SES | CASES | CASES | CASES | CASES | CASES | |
| CSM | 39 | 34 | 49 | 36 | 70 | 25 | 1770 | 13 |
| Measles | 784 | 4087 | 3171 | 7591 | 162 | 740 | 6413 | 7 |
| Poliomyelitis | 1 | 38 | 36 | 86 | 3 | 8 | 9 | 15 |
| Leprosy | 728 | 270 | 635 | 519 | 132 | 269 | 358 | 8 |
| NNT | 76 | 57 | 78 | 51 | 18 | 14 | 3 | 14 |
| Acute Watery Diarrhoea | 39792 | 43205 | 53664 | 71095 | 24497 | 70636 | 75904 | 2 |
| B Diarrhoea | 27443 | 26627 | 33675 | 46938 | 15250 | 47567 | 47086 | 3 |
| Pneumonia | 12933 | 16144 | 17947 | 18912 | 6279 | 34781 | 26702 | 4 |
| TB | 530 | 245 | 445 | 494 | 307 | 367 | 591 | 10 |
| STIs | 1228 | 1973 | 3446 | 10484 | 1713 | 4316 | 3382 | 6 |
| Hepatitis | 101 | 84 | 69 | 95 | 14 | 31 | 0 | 12 |
| Malaria | 92118 | 98151 | 143788 | 243792 | 86755 | 328066 | 250359 | 1 |
| Pertussis | 1048 | 616 | 1220 | 630 | 216 | 364 | 393 | 9 |
| HIV/AIDs | 140 | 82 | 49 | 62 | 17 | 477 | 424 | 11 |

KBER=Kebbi State Epidemiologist Report (State Ministry of Health)

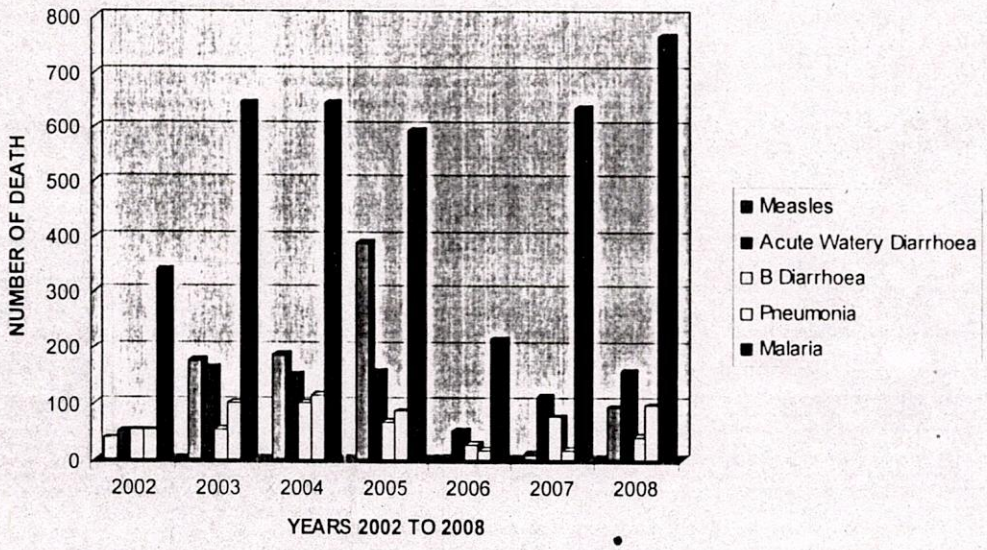




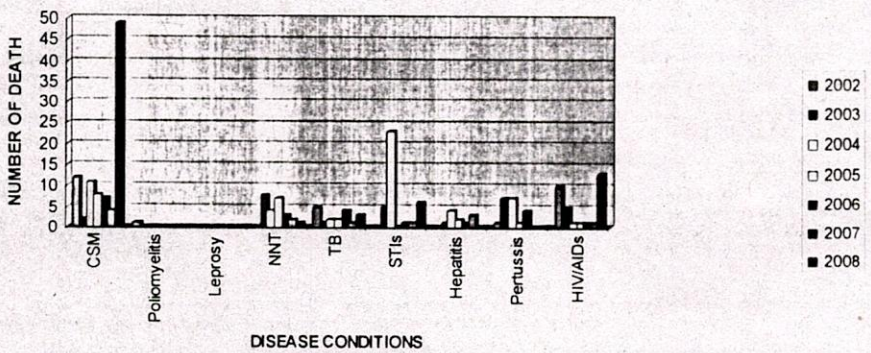

**IDS PRIORITY DISEASES IN KEBBI STATE 2002 TO 2008**

| | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 |
|---|---|---|---|---|---|---|---|
| DISEASES | DEATHS | DEATHS | DEATHS | DEATHS | DEATHS | DEATHS | DEATHS |
| CSM | 12 | 2 | 11 | 8 | 7 | 4 | 49 |
| Measles | 40 | 177 | 186 | 389 | 4 | 11 | 94 |
| Poliomyelitis | 1 | 0 | 0 | 0 | 0 | 0 | 0 |
| Leprosy | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| NNT | 0 | 8 | 4 | 7 | 3 | 2 | 1 |
| Acute Watery Diarrhoea | 51 | 165 | 150 | 157 | 51 | 113 | 156 |
| B Diarrhoea | 53 | 56 | 103 | 68 | 27 | 77 | 41 |
| Pneumonia | 53 | 103 | 116 | 87 | 19 | 18 | 97 |
| TB | 5 | 1 | 2 | 2 | 4 | 1 | 3 |
| STIs | 0 | 5 | 23 | 0 | 1 | 1 | 6 |
| Hepatitis | 0 | 1 | 4 | 2 | 1 | 3 | 0 |
| Malaria | 340 | 645 | 644 | 592 | 216 | 634 | 764 |
| Pertussis | 1 | 7 | 7 | 1 | 4 | 0 | 0 |
| HIV/AIDs | 10 | 5 | 1 | 1 | 1 | 1 | 13 |

DEATHS FROM FIVE MOST PREVALENT DISEASE CONDITIONS IN KEBBI STATE




DEATHS FROM OTHER DISEASE CONDITIONS IN KEBBI STATE



## 2.3 Health services provision and utilization

### Maternal and Child Health Indicators

| Percentage with antenatal care from a health professional1 | Percentage whose last live birth was protected against neonatal tetanus2 | Number of women | Percentage delivered by a health professional | Percentage delivered in a health facility | Number of births |
|---|---|---|---|---|---|
| 12.3 | 11.7 | 442 | 6.2 | 4.8 | 708 |

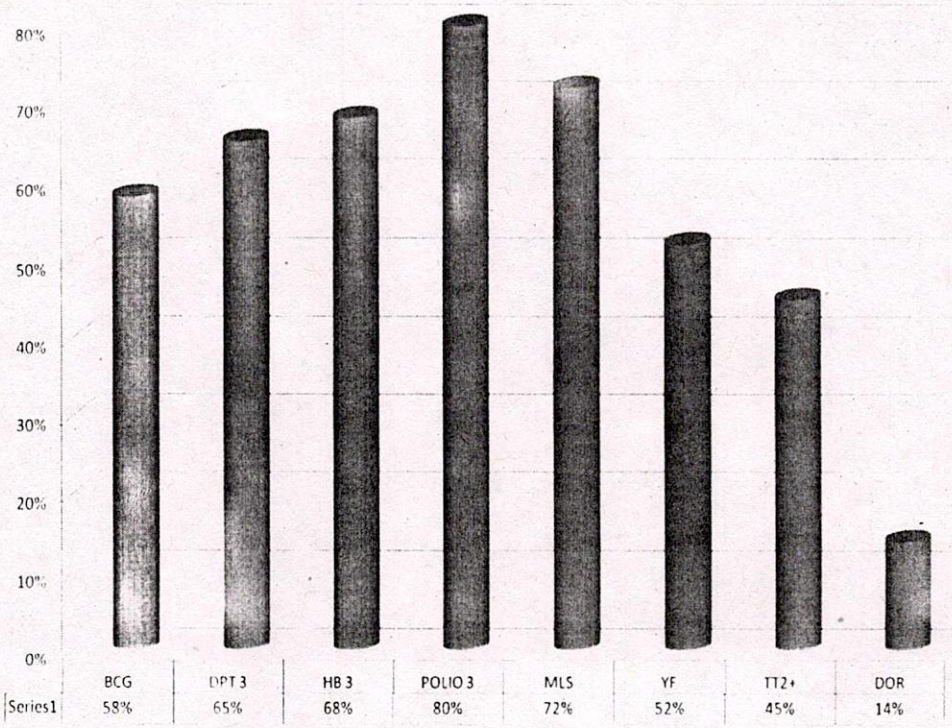
**Source: NDHS 2008 Draft**

Percentage of children age 12-23 months who received specific vaccines at any time before the survey (according to a vaccination card or the mother's report), and percentage with a vaccination card seen, by background characteristics, Nigeria 2008

Background Characteristic

| | |
|---|---|
| BCG | 15.1 |
| DPT 1 | 26.5 |
| DPT 2 | 19.9 |
| DPT 3 | 7.2 |
| POLIO 0 | 12.7 |
| POLIO 1 | 48.8 |
| POLIO 2 | 42.2 |
| POLIO 3 | 28.3 |
| Measles | 21.1 |
| All | 4.8 |
| No Vaccination | 50.6 |
| Percentage with a vaccination card | 4.2 |
| Number of children | 126 |

**Source: NDHS 2008 Draft**




The 2009 Jan to Sept. Routine Immunization coverage by antigens however shows much higher coverage (BCG 58%, DPT3 65%, HB3 68%, Polio3 80%, Measles 72%, TT2+ 45%) as indicated from state data on Routine Immunization (RI) than reported on the NDHS 2008 draft (BCG 15.1%, DPT3 7.2%, Polio3 28.3 and Measles 21.1%

**2.4 Key issues and challenges**

Significant progress have been made in the rehabilitation of physical infrastructure. The challenges of health manpower need to be address frontally. The disparity in the manpower disposition between urban and rural areas needs to be addressed. Accordingly health indicators in rural areas are worse than in urban areas. For example, 26% of women in rural areas deliver with a doctor, nurse, or midwife compared with 59% of women in urban areas (NDHS 2003).

Nigeria with an estimated infant mortality rate of 75 per 1000 live births, child mortality rate of 88 per 1,000 live births, under 5 mortality rate of 157 per 1,000 live births[1] and a maternal mortality ratio of 800 per 100,000 live births, contributes a disproportionate 10% to the global burden of maternal and also infant mortality[2]. Infant and child mortality in the North West zone of the country is generally twice the rate in the southern zones while the maternal mortality in the North West is 9 times the rate of 165/100, 000 recorded in the South West Zone[7].

There is need to focus on high-impact health interventions, including tackling the deteriorating primary healthcare facilities, widen the scope of the Ministry of Health, consolidate the gains of poverty alleviation programmes and the public-private partnership, mount and sustain vigorous monitoring and evaluation programme-including the component of reliable data gathering, concentrate on enforcing attitudinal change of the health staff and involve the community at all levels of healthcare delivery as well as poor coordination of donors and development partners.

### 3.1.1 General Observations on Primary Health Care Facilities

#### 3.1.1.1 The Need to improve PHC facilities

The general consensus that improvement of the secondary and tertiary health care facilities without, parri passu, improving the primary health care, will continue to aggravate the current situation whereby, the communities lose confidence in primary health care facilities, and flock to the secondary and tertiary centres – rendering the latter overcrowded and also ineffective.

#### 3.1.1.2 General Deterioration of Facilities

While some primary health centres (e.g. Gwandu, Besse, Ambursa) have solid building structures and may even have a doctor (usually from NYSC), the vast majority of the facilities –including the rural dispensaries are grossly dilapidated and all suffer from non-functional utilities – poor water supply and non-functional power generating plants.

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[1] National Population Commission (2008) *National Demographic and Health Survey* Abuja: National Population Commission

[2] Federal Ministry of Health (2008) *Integrated Maternal, Newborn and Childhealth Strategy.* Federal Ministry of Health, Abuja

### 3.1.1.3 Lack of Running Cost

Except for the Model Primary Health Centre in Besse, and the one in Bagudo which are given N10,000 per month, most of the PHCs have not received any funding for running the facilities – since 2002. Where generators exist, the plants lie dormant due to lack of fuel.

### 3.1.1.4 Poor Equipment Base

The equipment base of most of the primary health care facilities is extremely poor, the laboratories are either virtually non-existent or are very rudimentary – below the WHO standard for provision of basic laboratory investigations recommended for the developing countries.

### 3.1.1.5 Staffing Situation/Paucity of Qualified Midwives

There is paucity of qualified midwives to handle deliveries in maternal and child health clinics until recently (MCH's). Consequently, with the arrival of 96 midwives under the Midwives Service Scheme (MSS), the staffing situation will greatly improve at the LGAs.

### 3.1.1.6 Poor Attitude to Work

The attitude of both the clinical and administrative staff to work is very poor. This leads to loss of confidence of the community in utilizing the health care facilities.

### 3.1.1.7 Some Positive Aspects

The immunization coverage is very good – thanks to availability of functional solar refrigerators in all the PHCs and MCHs-ensuring the maintenance of the cold chain. However, training of staff on the use and maintenance of these refrigerators is an issue that has not been addressed. The other commendable aspect is that salaries of all staff are regularly paid, although some PHCs have problems with payments of call duty and shift duty allowances.

### 3.1.1.8 Community Participation

Community involvement in health care delivery, in the maintenance of facilities and in decision making is not well developed. Consequently, some of the facilities are grossly neglected and have fallen into total disuse. This poor attitude is particularly more glaring with regards to rural dispensaries, where for instance, some dispensary buildings (e.g. at Gulmare) have completely collapsed, with no signs of any intension of rehabilitation.

### 3.1.1.9 Drug Revolving Fund/Bamako-Initiative Variant

The Drug Revolving Fund does not exist in the PHC facilities. Drugs are often purchased by the pharmacy technician in charge with personal resources and sold to the public at prices dictated by the owner of the drugs, but sold in the public facilities.

### 3.1.1.10 Poverty Alleviation Programme/Free Drug Scheme

The free-drug scheme of the State Government has not been extended to the PHC facilities which mainly serve the rural populace-whose poverty is known to be more severe than in urban population. Method of payment for drugs and consumables at the primary health care is predominantly an out-of-pocket basis. This form of health care financing is considered the most regressive form of health care financing, because the poor's burden of payments for health care is not shared by the richer segments of the society.

Poor Referral System: None of the 33 PHCs has a functional ambulance service. Hence referral of critically ill patients is very problematic – leading deaths that are potentially avoidable.

Treatment Protocols: Of the 33 PHCs only the model PHC in Besse has written treatment protocols (which were also outdated). Basic literature for primary health care is not widely available. Standard tests, such as WHO guidelines on immunization techniques, district laboratory manuals, IMCI protocols, posters on BFHI, code of ethnics of marketing BMS are not available in any of the primary health care facilities.

Other Primary Health Care activities of the promotive/preventive aspects of primary health care. Growth monitoring is the least practiced. Appropriate scales are rarely available

# CHAPTER 3

## STRATEGIC HEALTH PRIORITIES
## 3.1 PRIORITY AREA 1: LEADERSHIP AND GOVERNANCE FOR HEALTH

### 3.1.1 Strategic orientations

Nigeria has adopted 5 successive national and over 24 sectoral health policies since 1960, when the country gained political independence. The first 4 policies were incorporated into various national development plans formulated between 1960 and 1985. The initial guiding philosophy of pre- 1985 policies was based on the assumption that improving the health of the population was essentially dependent upon the availability of health providers and access to health facilities[3].

In 1988 a PHC focused health policy was adopted by the Federation with the latest review in 2004. This policy was the first to provide direction hinged on the concepts and principles of primary health care (PHC) based on the evidence of the health needs and problems of the nation including the disease burden. Apart from a few places where health is mentioned, the current constitution of Nigeria (1999) is largely silent on matters concerning health.[4] Nonetheless, an overarching law – The National Health Bill (May 2008)[5] – which is currently in the process of being enacted attempts to clarify the structure, roles and responsibilities of the different levels of government.

The poor performance of the health system is not helped by the lack of clearly defined roles and responsibilities which results in duplication of efforts. This is compounded by inadequate political commitment especially at lower levels, poor coordination, lack of communication between various actors, lack of transparency and poor accountability. In addition, the private sector, a major contributor to health care delivery in the country, is poorly regulated due to weak capacity of State governments to set standards and ensure compliance. All these factors have led to the lack of strategic direction and an inefficient and ineffective health care delivery system. Nonetheless, there have been successive attempts including the Health Sector Reform Programme (2004-2007), and past health policies and programmes aimed at enhancing leadership and governance for health.

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[3] Health Reform Foundation of Nigeria (2006) *Nigeria Health Review* Abuja: Health Reform Foundation of Nigeria

[4] 1999 Constitutions of the Federal Republic of Nigeria

[5] Draft Nigeria National Health Bill, May 2008

This priority area of the NSHDP Framework seeks to streamline and empower the Ministries of Health at the Federal and State levels as well as LGA Health Departments to reposition their organisational and management systems to provide the strategic and tactical leadership and governance for health. It equally recommends interventions to enhance mutual accountability and transparency in the use of health development resources, particularly through results-based management approaches.

### 3.1.2 Conceptual Definitions

**Stewardship:** The WHO Health Report 2000 refers to stewardship as "function of a government responsible for the welfare of the population, and concerned about the trust and legitimacy with which its activities are viewed by the citizenry"[6] The concept of the stewardship role of government in health as stated above means: the way in which governments mobilize and spend revenues and make regulations and policies that deal with the issue of accountability and transparency in the health system, with specific regard to: (i) Oversight (ii) Financing (iii) Human and Physical Resources (Development and Utilization) (iv) Improvement of Performance (v) Promotion of the Health of the People (vi) Leverage of Health Program Implementation and Outcomes.

**Governance:** Governance for health is the exercise of economic, political and administrative authority to manage the country's health affairs at all levels – Federal, States and LGAs; as well as mechanisms, processes and institutions, through which citizens and groups articulate their interests, exercise their legal rights, meet their obligations and mediate their differences[7]. It includes formulation of national health policy and health strategic plans (defining the vision and directions), exerting influence through regulations and advocacy, collecting and using information, and accountability[8].

**Leadership:** Leadership in health includes providing direction and the enabling environment for the various stakeholders to articulate the complex social processes which impact on the healthcare delivery system at their level in a participatory way, allowing people's viewpoints and assumptions about their local health system and

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[6] WHO (2000) *World Health Report 2000: Health Systems - Improving Performance*. Geneva: World Health Organization, Geneva.

[7] Governance For Sustainable Human Development: A UNDP Policy Document 10-12-2008

[8] Frame work for implementation of the Ouagadougou declaration on PHC and health system in Africa: 2008

economy to be brought to light, challenged and tested and jointly developing a mechanism for achieving positive change. It is imperative for strategic oversight to be provided through collaboration and coordination mechanisms across sectors within and outside government including civil society. Leadership will influence action on key health determinants and access to health services while ensuring accountability. Leadership ensures that policy formulation is deliberately structured and linked to programme planning, project selection and task implementation arising from a common shared vision.

### 3.1.2 Goals, strategic objectives, interventions, activities, targets and indicators

#### 3.1.2.1Goal

Create and sustain an enabling environment for responsive health development in Nigeria

#### 3.1.2.2 Strategic Objectives.

3.1.2.2.1 To provide clear policy directions for health development

3.1.2.2.2 To facilitate legislation and a regulatory framework for health development

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

3.1.2.2.4 To enhance the performance of the national health system

#### 3.1.2.3 Interventions

*To provide clear policy directions for health development:*

**3.1.2.3.1 Improve Strategic Planning at Federal and State levels**

In order to provide clear policy direction for health development in the country, the policy and strategic leadership of the FMoH will be strengthened through an integrated organizational change and development programme, which will incorporate the re-orientation and strengthening of the human resource capacities. Increased emphasis will be placed on effective implementation of agreed plans and this will include advocacy at State level in support of policy development and implementation. The highest priority will be to support States in the development of evidence-based, costed, and prioritized strategic health plans for the sector. The development of strategic health plans will be undertaken in such a way as to optimize the contribution of the wider stakeholders at each level.

*To facilitate legislation and a regulatory framework for health development*

**3.1.2.3.2 Strengthen Regulatory Functions of government**

The private health sector is a major contributor to healthcare delivery in most parts of Nigeria and is often the first point of contact with the health system for the majority of people. Quality of service delivery is extremely variable and the capacity of State governments to set standards and ensure compliance needs to be strengthened. The FMoH will support the development of public/private partnership policies and plans in States in line with the national policy on PPP. States will also be offered opportunities for technical support on implementation of their strategic plans to ensure that the regulatory function of government is strengthened and agreed quality standards are set, monitored, and delivered. The public sector (government) will also collaborate with the private sector to improve their health delivery system, for example through joint continuous professional development, supportive supervision and generation of public health information and intelligence. Arrangements under which State governments may wish to outsource some components of health service delivery to the private sector will be explored and supported.

Similarly, to strengthen regulatory framework through legislation, efforts will be channeled into reviewing, updating and enforcing Public Health Acts and Laws as well as revising and streamlining roles and responsibilities of regulatory institutions to align with the National Health Bill that is due to be passed into law. In this regard, the various tiers of government will prioritise the review of public health legislations to ensure that gaps are filled in areas which need improvement, and relevant laws enacted through National and State Assemblies. Review committees will be set up to review and align laws of regulatory bodies.

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

**3.1.2.3.3 Improve Accountability and Transparency**

Demand for accountability, transparency and responsiveness of the national health system will be institutionalized through effective decentralization of the decision making process in the health sector. The FMoH will support the States and the LGAs to institute stakeholders' dialogue and feedback forum for enlisting input into health sector decision

making. This will also involve creating platforms for interaction and collaboration with health sector advocacy groups, empowering beneficiary communities through sensitization to manage and oversee their health projects and programmes, as well as promoting the emergence of independent health sector 'watch dogs'. The FMoH will lead a process for improved access to information required for yearly joint review of the health sector and put such information in the public domain and on demand by stakeholders.

*To enhance the performance of the national health system*

**3.1.2.3.4 Improving and maintaining Sectoral Information base to enhance performance**

There is a need to deepen and expand the analytical work at both Federal and State Government levels, which is required to understand health sector performance and to drive improvements and reform. In conjunction with development partners a prioritised list of areas for further analytical work will be outsourced to Universities, private sector research firms and research institutes. An example is the Nigeria Demographic and Health Survey (DHS) which is conducted on a five yearly cycle and presently outsourced to Macro International with funding from several donors. Linkage with the relevant activities in the research and health information system priority areas of this framework will contribute to achieving this intervention.

**3.1.2.4 Indicators**

3.1.2.4.1 At least 3 Health Development Policies directives adapted by Kebbi State by 1st qtr 2010.

3.1.2.4.2 Percentage of regulatory bodies functioning and the number of policies implemented by 4th quarter 2010

3.1.2.4.3 Number of Guidelines and Reporting Procedures Institutionalized by 4th quarter 2010

3.1.2.4.4 percentage of timely quarterly fund released in 2010

3.1.2.4.5 Number of Health Information System to be strengthened by 2010.

3.1.2.4.6 Number of Indicators identified by 1st Quarter 2010.

### 3.1.2.5 Targets

3.1.2.5.1 All stakeholders are informed regarding health development policy directives by 2011

3.1.2.5.2 Health Bill signed into law by end of 2009

3.1.2.5.3 80% of States and the Federal level have an active health sector 'watch dog' by 2013

3.1.2.5.4 1. 50% of States (and their LGAs) updating SHDP annually

2. 50% of States (and LGAs) with costed SHDP by end 2011

## *3.2 PRIORITY AREA 2: HEALTH SERVICE DELIVERY*

### 3.2.1 Strategic orientation

Health care services are activities geared towards the provision of a comprehensive package of integrated care to beneficiaries through the primary, secondary and tertiary levels. This includes increasing both demand and supply of services with the goal of expanding coverage for improving the health status of the citizenry. It is recognized that health care services in Nigeria are provided by a multiplicity of health care providers - public, private including for profit and not-for-profit, patent medicine vendors and the traditional health care providers.

Despite considerable investment in the health sector over the years, available evidence suggests that health services throughout Nigeria are delivered through a weak health care system. Consequently it is unable to provide basic, cost-effective services for the prevention and management of common health problems especially at the LGA and Ward levels. For example, the proportion of PHC facilities providing immunisation services range from 0.5% in the North-West zone to 90% in the South West and South East Zones. Also the capacity to provide basic emergency obstetric services is very limited as only 20% of facilities are able to provide this service[9]. This limited coverage of basic health services, which results from poor access to information and services results in under utilisation of services. For example, only 58% of women receive antenatal care from a professional, with coverage levels range from 31% to 87%, and deliveries under the supervision of a trained birth attendant ranging from 9.8% to 81.8%. The lowest figures are from the North East and North West zones[10].

[9] FMOH/UNFPA study on essential obstetric care in Nigeria (2002-2003)

Availability and distribution of functional health facilities and other health infrastructure are variable across the country. And many new PHC facilities being built are wrongly sited. Majority of the public health facilities especially PHC centres are in a state of disrepair. Although every State currently has at least one tertiary health facility, nonetheless most are not functioning at optimal capacities in the provision of quality specialist care.

Most public health facilities across the country are poorly equipped as indicated in findings from a 2001 survey of public PHC facilities[10]. The report shows that only a quarter of health facilities had more than 50% of the minimum equipment package and 40% had less than a quarter. However, in the past few years a significant level of capital investment has been made to improve the medical equipment and infrastructure of a cohort of federal teaching hospitals and 350 model PHC facilities have been constructed and equipped.

The Essential Drugs Programme, including the first national essential drug list in the country was developed in 1988. The Bamako Initiative aimed at strengthening PHC through ensuring sustainable quality drug supply systems was re-invigorated in all LGAs in 1998 under the Petroleum Trust Fund. These initiatives are now moribund due to poor commitment to the establishment of systemic procurement systems for health commodities resulting in loss of confidence and decreased utilization of public sector health facilities due to drug stock-outs. One of the consequences of these is the proliferation of patent medicine vendors and drug hawkers which is compounding the problem of irrational drug use. In relation to this, the market is replete with substandard and fake drugs. However, there is a perception of increased confidence in the drug regulatory framework operated by NAFDAC in recent years.

Most services provided by private and public providers are clinic-based, with minimal outreach, home and community-based services. The services are fragmented, with many vertical disease control programs. Referral systems are weak and even tertiary facilities are used for provision of primary care thus diminishing the continuum of care and making the system inefficient. Also, despite the private sector delivering 60% of health care in the country, private-public partnership is very weak.

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[10] Adeniyi. J, Ejembi CL, et al (2001) The Status of Primary Health Care in Nigeria: Report of a Needs Assessment Survey. National Primary Health Care Development Agency.

The NPHCDA has defined a ward health care minimum package for PHC, but dissemination and implementation remain very limited. At higher levels, except for a few disease control programs, like PMTCT, TB, Malaria, Family planning and Essential Obstetric care, there are no standard operating procedures and treatment protocols. These lead to provider-initiated rather than client-centered delivery of care.

Other confounding factors that further limit quality of care include dearth in the skills and, quantity of available human resources for health with poor attitude of health care providers. In addition the country is confronted with lack of emergency preparedness to respond to epidemics.

To improve the functionality, quality of care and utilization of services so as to positively impact the health status of the population, universal access to a package of cost-effective and evidence-based interventions is needed. This would of necessity require interventions that transform the way the health care system is resourced, organized, managed and services delivered

### 3.2.2 Goal

Revitalize integrated service delivery towards a quality, equitable and sustainable healthcare.

### 3.2.3 Strategic Objectives

3.2.3.1 To ensure universal access to an essential package of care

3.2.3.2 To increase access to health care services

3.2.3.3 To improve the quality of health care services

3.2.3.4 To increase demand for health care services

3.2.3.5 To provide financial access especially for the vulnerable groups

### 3.2.4 Interventions

*To ensure universal access to an essential package of care*

#### 3.2.4.1 Essential Health Service Package

To provide package of essential care, there is a need to review, cost, disseminate and implement the minimum package of care in an integrated manner and also, strengthen specific communicable and non communicable disease control programmes. Standard Operating procedures (SOPs) and guidelines are to be made available for delivery of services at all levels

*To increase access to health care services*

**3.2.4.2 Improve geographical equity and access to health services**

Improving geographical equity and access to quality care will involve mapping of health facilities, establishing GIS for all health facilities in the country as well as developing criteria for siting of new health facilities at all levels. In addition there will be the need to upgrade and refurbish all substandard facilities especially at PHC level. In doing these, effort should be made to ensure adherence to guidelines that stipulate standards for access and linkages of the different levels of care. Guidelines for outreach services will be developed and implemented, budget lines for the maintenance of health facilities provided and guidelines for task shifting established and implemented. The use of telemedicine will be strengthened.

**3.2.4.3 Ensure availability of drugs and equipment at all levels**

Another intervention to increase access to quality health care services will entail ensuring availability of drugs and equipment at all levels. This would involve a review of the essential drugs list and establishing a system to ensure procurement and distribution of essential drugs on a sustainable basis at all levels. Furthermore, there will be the need to develop/review an equipment list for different levels of health facilities in line with the essential package of care and ultimately procure and distribute equipment based on need.

**3.2.4.4 Establish a system for the maintenance of health facilities and equipment at all levels**

Availability of equipment is critical to service delivery. Therefore, there is a need to aadapt, disseminate and implement the National Health Equipment Policy; also create budget lines for the maintenance of equipment and furniture at all levels. The optimal performance and longevity of equipment will be assured by establishing medical equipment and hospital furniture maintenance workshops across the country as well as exploring public private partnership in maintenance of medical equipment and hospital furniture.

**3.2.4.5 Strengthen referral system**

Another key intervention is to strengthen referral systems. This can be done by mappihg network linkages for two-way referral systems in line with national standards, with implementation guidelines for all cases such as emergency obstetric care, complicated malaria, road traffic accidents, etc; Transportation, communication and other logistics for referrals need to be put in place to ensure effective referrals and a system put in place to monitor referral outcomes.

### 3.2.4.6. Foster collaboration with the private sector

The private sector plays a key role in provision of health services in the country. Therefore, collaboration with the private sector health care providers will be fostered. Specific action to promote this will include the mapping of all categories of private health care providers by operational level and location, development of guidelines and standards for regulation of their practice and their registration. For the full potential of the private sector to be realised, guidelines for partnership, training and outsourcing of services will be developed. In addition joint performance monitoring mechanism for the private sector will be developed and implemented. Also, the national policy on traditional medicine will be adapted and implemented at all levels.

### 3.2.4.7 Strengthen professional regulatory bodies and institutions

The need to standardise and regulate practice cannot be over emphasised. To this end regulatory bodies and institutions will be strengthened through the following potential actions: review, update and implement operational guidelines of all regulatory bodies at all levels and build capacity of regulatory staff to monitor compliance of providers to the regulatory guidelines. Budget lines are to be created and necessary resources provided. Regular monitoring exercises with appropriate documentation and feedback will be strengthened and regulators empowered through the provision of necessary security.

### 3.2.4.8 Develop and institutionalise quality assurance models

Another intervention is the development and institutionalisation of quality assuarance models. This will be done by reviewing available models and building consensus on the models to adopt. Furthermore, quality assurance training modules will be developed to build capacity of both public and private health care providers, training of trainers (TOT) conducted and cascaded to other health workers. Thereafter, quality assurance and improvement initiatives will be institutionalised and implemented at all levels. The quality of service delivery can be further assured by entrenching the ideals of SERVICOM at all levels of care. This will be achieved through the development of SERVICOM guidelines, building institutional capacity and training staff for its implementation at all levels. Strategies will be put in place for monitoring implementation of quality of care.

### 3.2.4.9 Institutionalize Health Management and Integrated Supportive Supervision (ISS) mechanisms

Integrated supportive supervision is an important strategy for ensuring that health workers are adequately supported in the process of providing health care services. This concept is predicated on the fact that many problems occur in the health facilities of which providers will not have immediate solutions. This helps in boosting the moral of the workers in their health facilities setting. To achieve comprehensive integrated supportive supervision the management capabilities of health managers and health teams especially at the LGA and Ward Levels will be strengthened through team building and leadership development programmes, institutionalization of comprehensive ISS at all levels, development of capacities of programme managers at all levels on the ISS mechanism; and development of ISS tools and guidelines specifying modalities and frequencies of the ISS visits at all levels.

*To increase demand for health care services*

### 3.2.4.10 Creating effective demand for services

In order to promote positive lifestyles for disease prevention and increase demand for health services, it is necessary to develop, disseminate and implement a national health promotion communication strategy based on the National Health Promotion Policy, and its corresponding adaptation to reflect local realities. To actualise the above intervention, budget lines for health promotion through Behavioural Change Communication (BCC) will be provided at all levels and a programme monitoring and evaluation system put in place. *This intervention is further explored under Priority Area 7 of this framework.*

*To provide financial access especially for the vulnerable groups*

### 3.2.4.11 Improving financial access especially for the vulnerable groups

The costs associated with health care can be a barrier to accessing health services especially for the vulnerable groups. Models for financial protection for the vulnerable groups ( e.g. Pregnant women, under fives, orphans and the aged) such as exemption schemes vouchers, health cards, pre payment schemes will be explored and existing financial protection schemes scaled up.

*This intervention is further explored under Priority Area 4 of this framework.*

### 3.2.5 Indicators

3.2.5.1 Number of LGAs delivery service using the Minimum Healthcare Package by 4th qtr 2011.

3.2.5.2 Number of communicable and non communicable disease programmes strengthened by 2nd qtr 2010

3.2.5.3 Percentage of health facilities delivering services in accordance with SOPs and guidelines 4th quarter 2010 to 2015

3.2.5.4 Increase by 30% number of communities accessing services within 5km in LGAs by the 4th Quarter 2010.

3.2.5.5 1. System established to procure and distribute essential drugs by 2nd quarter 2010 2. Equipments procured and distributed in line with essential care package by 4th quarter 2010

3.2.5.6 Number of LGAs in the state implementing the National Health Equipment Policy by 3rd quarter of 2010.

3.2.5.6 1. Network linkages mapped for 2 way referral systems by 3rd quarter 2010

2. Percentage of health facilitis within the LGAs monitored on referral outcomes by 4th quarter 2010.

3.2.5.7 Number of meetings held and reports submitted per quarter 3rd quarter 2010 to 4th quarter 2015

3.2.5.8 Percentage of health facilities and institutions accessed using quality improvement criteria by 2012

3.2.5.9 Number of quality assurance models adopted and institutionalized by 4th Quarter 2010

3.2.5.10 Percentage of LGAs applying Health Management and Integrated Supportive Supervision Skills by 4th quarter 2010

3.2.5.11 Number of communities with functional WDCs and VDCs by 1st quarter 2011

3.2.5.12 1. Percentage of LGAs providing free healthcare services to Vunerable groups by 4th quarter 2010.

2. Number of LGAs with established Health financing technical working groups by 3rd quarter 2011.

3.2.6 Targets

*3.2.6.1 Essential Package of Care adopted by all States by 2011*

3.2.6.2 50% of the population is within 30mins walk or 5km of a health service by end 2011

3.2.6.3 50% of health facilities participate in a Quality Improvement programme by end of 2012

3.2.6.4 Average demand rises to 2 visits per person per annum by end 2011

3.2.6.5 1. Vulnerable groups identified and quantified by end 2010

2. Vulnerable people access services free by end 2015

## *3.3 PRIORITY AREA 3: HUMAN RESOURCES FOR HEALTH*

### 3.3.1 Strategic orientation

Human Resources for Health (HRH) comprise of trained health personnel in the public and private sector (doctors, nurses/midwives, pharmacists, relevant technicians, and community health workers e.t.c.), untrained informal health workers, including community-based health care providers e.g. herbalists, traditional birth attendants and volunteers, who play complementary roles in health care service delivery. Human Resources for Health (HRH) plays an important role in improving health system performance and should reflect the right number, mix, distribution and appropriate skills set (experience & qualifications) to provide the services required.

While Nigeria has one of the largest stocks of human resources for health in Africa, it is still inadequate to meet the country's needs. In 2006, an inventory of health care personnel indicated 39,210 doctors (0.3 doctors /1,000population), 124,629 nurses (1.03 nurses/1000 population), 88,796 midwives (0.67 midwives/1000 population), 2,482 Dentists (0.02 dentists/1000 population), and 12,072 Pharmacists (0.05 pharmacists/1000 population) for the year 2004[11]. The planning and management of HRH still poses a major challenge to health development in the country as evidenced by absence of a human resource plan, especially at lower levels, lack of coordination, alignment and harmonization of HRH needs at all levels of government. In addition, dearth of skills, problems with HRH mix, poor motivation, differential conditions of service, remuneration and work environment; negative attitude to work and poor supervision are

[11] Health Reform Foundation of Nigeria (2007) *Nigerian Health Review* Abuja: Health Reform Foundation of Nigeria p.55

added challenges, some of which contribute to inequitable distribution to the disadvantage of lower levels of care, rural areas and northern parts of the country, and high attrition rates observed. Also, entry qualifications and the ceilings placed on enrolment to schools of midwifery and nursing by their regulating body are limitations to addressing the very critical HRH challenges in the some parts of the country.

There are presently 14 professional regulatory bodies charged with the responsibility of regulating and maintaining standards of training and practice for various health professionals. However, they are limited by weak structures and institutional capacities to carry out statutory functions of effective monitoring and accreditation of training institution programmes.

To respond to the weak HRH performance, in 2006, the FMOH through a participatory approach developed a comprehensive National Human Resources for Health Policy[12] and its corresponding Strategic Plan for 2008 to 2012[13]. Interventions contained therein guide investments and decision making in the planning, management and development of human resources for health at the federal, state, LGA and institutional levels. The HRH policy and Strategic plans are therefore valuable tools in rationalizing production, distribution and utilization of health workforce in the country. It is also noted that currently, few States have adapted the National HRH policy.

### 3.3.2 Goal

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.

### 3.3.3 Strategic Objectives

3.3.3.1 To formulate comprehensive policies and plans for HRH for health development

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

3.3.3.3 To strengthen the institutional frameworks for human resources management practices in the health sector

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[12] Federal Ministry of Health. (2006) *National Human Resources for Health Policy*

[13] Federal Ministry of Health. (2008) *National Human Resources for Health Strategic Plan (2008 – 2012)*

3.3.3.4 To strengthen the capacity of training institutions to scale up the production of a critical mass of quality, multipurpose, multi skilled, gender sensitive and mid-level health workers

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

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

### 3.3.4 Interventions

*To formulate comprehensive policies and plans for human resource for health development*

#### 3.3.4.1 Development and Institutionalization of the Human Resources Policy framework

States are to domesticate the National HRH Policy and Strategic Plan to guide human resource development at all levels. Policies on training and recruitment of health personnel are to be updated across the country to make them non-restrictive and ensure non-discriminatory processes irrespective of states of origin and/or gender. A policy framework to guide existence of private and public practitioners at all levels of health service delivery is to be developed; also develop and implement guidelines on task shifting and establish a fora for public-private practitioners to institutionalize HRH policy reviews, supervisory and monitoring frameworks.

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

#### 3.3.4.2 Reappraisal of the principles of health workforce recruitment at all levels

Career pathways for all groups of health professionals critically needed to foster demand and supply creation in the health sector are to be developed and streamlined. To guide HRH planning, it is necessary to develop, introduce and utilize staffing norms based on workload, service availability and health sector priorities. It is also necessary to establish coordinating mechanisms for consistency in HRH planning and budgeting by Ministries of Health, Finance, Education, Civil Service Commission, Regulatory bodies, Private Sector Providers, NGOs in health, and other institutions. State and LGA capacities will be strengthened to access and implement federal government circulars, guidelines and policies related to HRH. Entry criteria and admission quotas of prospective health care providers into training institutions are to be reviewed.

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

**3.3.4.3 Establishment and strengthening of the HRH Units**

HRH units will be created / strengthened at all levels to perform HRH functions. Training programmes in human resource for health planning and management at all levels will be established to enhance the HRH managers.

*To strengthen the capacity of training institutions to scale up the production of a critical mass of multipurpose and mid-level health workers*

**3.3.4.4. Review and adaptation of relevant training programmes for the production of adequate number of community health oriented professionals based on national priorities**

Training programmes of health related institutions in HRH will be reviewed in line with national priorities. Special training programmes aimed at producing adequate cadres of health professionals in critical areas of need will be designed and implemented. Similarly, training for community health workers and other cadres of supportive personnel will also be established or expanded. In addition, the national Midwives Service Scheme and the Community Midwifery Programme will be promoted. Furthermore, admission criteria for relevant disciplines in response to the HRH crisis in disadvantaged areas of the country will be reviewed, while adequate production of qualified health professionals through appropriate accreditation and regulatory bodies will be strengthened. Continuous assessments of training institutions and programmes will be institutionalised and curricula and programmes to reflect task shifting requirements will be developed and implemented. Regular review of functions and mandates of HRH regulatory bodies will be conducted and public private partnership in HRH development and management strengthened.

**3.3.4.5 Strengthening of health workforce training capacity and output based on service demand**

To set up and strengthen training institutions for production of health care providers there is need to provide minimum levels as well as ensure the periodic upgrading of teaching and learning materials, infrastructure and financial support as incentives for retention of staff. Quality assurance units and education review units are to be established in all

training institutions with incentives for satisfactory performance. Training curricula of identified training institutions will be reviewed to reflect the disease burden situation of the country. Accreditation systems for training institutions to ensure professional standards of health personnel will be strengthened and accreditation of eligible private sector health facilities to increase training opportunities for internship and post-basic training for all sector health professionals facilitated.

Human capital capacity building and continuing professional development (CPD) by government and healthcare provider institutions will be promoted and coordination with professional regulatory bodies to link sponsorship to bonding of healthcare providers to mitigate migration across states and outside the country established.

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

**3.3.4.6 Equitable distribution, right mix and retention of the right quality and quantity of HRH**

To achieve the objective of recruitment, selection and deployment of competent and capable staff to reflect organizational objectives and needs, attention needs to be paid to deployment processes that are equitable in terms of mix, needs and geographical space. It is crucial to create a database of HRH, and to develop and provide job descriptions and specifications for all categories of health workers. Redeploy staff equitably between rural and urban areas and at the different levels of the health care system in relation to needs, paying attention to staff mix. States MoH are to collaborate with Federal institutions located in their states to leverage available human resource so as to expand service coverage and quality. Mandatory rotation of health workers to underserved rural areas, e. g through NYSC scheme for doctors, pharmacists and appropriate scheme for midwives and nurses is to be promoted. The National Health Bill makes provision for a primary healthcare fund from the federation account; 10% of this fund should be deployed equitably for HRH. Retention strategies including management of migration, through bilateral and multilateral agreements are to be developed and implemented to reverse and contain the crises. The pool of professionals in Diaspora and the capacities of retired trained health professionals will be leveraged to strengthen the human resource availability in the country and meet HRH gaps respectively. Use of intra or extra mural private practice services to improve services in underserved areas as well as provision of incentives for health workers in underserved areas will be instituted.

Mechanisms to minimize work place hazards through management of physical risks and mental stress, with full compliance with prevention and protection guidelines will be strengthened so as to create an enabling environment that motivates staff. Performance-based incentives will be established.

**3.3.4.7 Establishment of mechanisms to strengthen and monitor performance of health workers at all levels**

Routine re-orientation of health workforce on attitudinal change including training and retraining in Interpersonal Communication (IPC) skills and work ethics are to be conducted for the promotion of client satisfaction and improvement of quality of care. A system of recognition, reward and sanctions will be instituted. It is also vital to establish and institutionalize a framework for an integrated supportive supervision with adequate committed resources for all types and levels of care providers across public and private sectors. Mechanisms will be established to monitor health worker performance, including use of client feedback (exit interviews).

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

**3.3.4.8 Strengthening communication, cooperation and collaboration between health professional associations and regulatory bodies on professional issues that have significant implications for the health system**

The HRH policy (2007) states that government shall promote intra and inter-professional respect, harmony and team work among all disciplines of health care workers for optimum health service delivery. This can be achieved through establishing effective dialogue and complaints channels between management and staff of public and private sectors as well as HRH regulatory bodies and associations. Also, involvement of workers and professional groups in management teams, design and monitoring of services is proposed to enhance cooperation amongst all actors.

### 3.3.5 Indicators

3.3.5.1 1. State adaptation and implementation of HRH Policy and Plans by 2nd Qaurter 2011

2. Percentage of LGAs that have adapted and institutionalized HRH policy and plan by 3rd Quarter 2011.

3.3.5.2 Recruitment mechanism for HRH planning and budgetting established by 1st quarter 2010.

3.3.5.3 1. Establishment of HRH Unit by SMOH Planning Dept. by 1st Quarter 2010

2. Percentage of LGAs with established HRH Units by 3rd quarter 2010.

3.3.5.4 1. Number of facilities with adequately trained health personnel at LGA levels by 2012.

3.3.5.5 At least 50% of workforce adequately traind/re-trained based on service demand by 4th quarter of 2011.

3.3.5.6 1. Number of facilities with adequately trained health personnel at State and LGA levels by 3rd quarter 2012.

3.3.5.7 Percentage of communities with increased access to Healthcare delivery and feedback by 4th quarter 2011.

3.3.5.8 Percentage of LGAs with established HRH stakeholders forum by 2nd quarter 2011.

### 3.3.6 Targets

3.3.6.1 All States and LGAs are actively using adaptations of the National HRH policy and Plan by end of 2015

3.3.6.2 The HR for Health Crisis in the country has stabilised and begun to improve by end of 2012

3.3.6.3 1. 50% of States have functional HRH Units by end 2010

2. 10% of LGAs have functional HRH Units by end 2010

3.3.6.4 One major training institution per Zone producing health workforce graduates with multipurpose skills and mid-level health workers by 2015

3.3.6.5 50% of States have implemented performance management systems by end 2012

3.3.6.6 50% of States have regular HRH stakeholder forums by end 2011

## 3.4 PRIORITY AREA 4: HEALTH FINANCING

### 3.4.1 Strategic orientation

Poor utilisation of modern health services leading to poor health outcomes for majority of the citizens of Nigeria is not only influenced by lack of knowledge and negative perception but also by health care costs that include cost of services, travel to health facilities and opportunity costs. Poverty level is therefore a major factor responsible for individual and household decision making on utilization of health services.

The Commission for Macroeconomics and Health estimates a cost of about US$34 per person per year (per capita) to deliver an essential package of interventions to meet the Millennium Development Goals (MDGs)[14]. In Nigeria the total per capita health expenditure is estimated at between $10 at average exchange rates with private out of pocket expenditure (OOPE) accounting for 70%[15]. It is also recognized that the poor spend a disproportionately higher percentage of disposable household income on healthcare and in the absence of social protection mechanisms (health insurance, social security or credible exemptions), this population face challenges of financial barriers to health care at the time of need. This no doubt deters the poor from seeking health care on time or deepens their impoverishment when they are compelled to make health expenditure.

African leaders at a special session of the OAU in Abuja in 2001, in consideration of the dismal situation of health care delivery with its poor level of funding recommended the allocation of 15% of total national budget to health. Though Nigeria committed to meeting this declaration, between 1999 and 2008 the average allocation to the health sector was recorded to be about 5% of the total national budget.

Currently, healthcare is financed in Nigeria from a mixture of budgetary allocations from the Federal, States and LGAs, private out-of-pocket expenditure, external development

[14] Commission for Macroeconomics and Health (2001) *Macroeconomics and Health: Investing in Health for Economic Development*. Geneva: World Health Organisation

[15] Federal Ministry of Health (2004) Health Sector Reform Program: Strategic Thrusts and Logframe

funding, grants from corporations and charities and a small but growing social health insurance contributions. Lately, many States have also commenced programmes aimed at protecting vulnerable groups from the financial risk of ill-health, such as free maternal and child health services. Nonetheless, in order to achieve the level of funding required for meeting the health needs of the whole population, the country has to put in place mechanisms for increased funding both in absolute terms and as a proportion of the total budget. In addition, there is a need to coordinate all the resources available to the sector from all sources. The Draft National Health Bill, when enacted into law will assure significant improvement in health care financing in the country as it earmarks 2% of the consolidated federal revenue for health, with a large proportion of it assigned for PHC.

In the recent past, a range of potential measures are being established, including the National Health Insurance Scheme (NHIS) that incorporates programmes covering formal sector workers; community-based health insurance; social health protection models targeted at the poor and vulnerable groups such as free maternal and child health (MCH) services, voucher schemes, health cards and exemptions; and private health insurance. However, none of these options have been scaled up to the point of providing adequate financial risk protection for majority of people in Nigeria[16].

### 3.4.2 Goal

Ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and consumption at LGA, State and Federal levels

### 3.4.3 Strategic Objectives

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

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

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[16] National Health Insurance Scheme. (2008). *Blueprint for the Implementation of Social Health Insurance Programme in Nigeria*. Abuja: National Health Insurance Scheme

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

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

### 3.4.4 Interventions

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

#### 3.4.4.1 Strategic Health Financing Plans

The first intervention of the health financing strategic framework is 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. This will require the setting up of technical working groups for health financing at each tier of government and capacity building for the development and implementation of the Strategic Plans at all levels. There may be a need for the Federal Ministry of Health to provide technical assistance to support this process.

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

#### 3.4.4.2 Strengthen System for Financial Risk Health Protection

A large proportion of the people in Nigeria have little protection against economic costs of catastrophic illness. States and LGAs will be supported to explore existing and innovative social health protection approaches – social health insurance, other pre-paid schemes, community-based health insurance schemes, etc - for sustainable health financing with protective measures against the financial risks associated with ill health. Technical support will be provided to States and LGAs to rapidly scale up successful approaches to achieve wider population coverage. The capacity of the NHIS needs to be strengthened to provide effective regulatory framework for social health Insurance and protection programmes in the country. This will require the review and amendment of the current law establishing the NHIS to provide the legislative backing for its regulatory authority.

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

### 3.4.4.3 Improving Financing of the Health Sector

The level of public sector finance available within Nigeria for funding health care at all levels – Federal, States and LGAs, is insufficient when compared with the scale of health needs. Mechanisms will be put in place to get governments at all levels to increase the allocation of public resources to the health sector (apportion 15% of total budget on health in line with Abuja Declaration) and to assist them in the effective and efficient use of these resources. States and LGAs will be supported by the FMoH to test and implement strategies for attracting alternative financial flows to the health sector and to share lessons learnt. Existing and potential financing strategies that will be considered include pre-payment schemes, and health insurance schemes, grants from the Federal Government, proportion of Value Added Tax (VAT), "sin tax" from alcohol and cigarette and donations from corporations and charities. Special funds for chronic and emerging diseases (e.g. mental health, cancers, diabetics etc.) may also need to be established. In all cases, the establishment of alternative financing sources will include careful consideration of the impact on poverty and gender and financing safety nets will be established to protect the interests of the poor and vulnerable groups.

### 3.4.4.4 Donor Coordination of Funding Mechanisms

The coordination of the activities of government and donor health programmes is relatively weak at both Federal and State levels in Nigeria. The FMoH in collaboration with Development Partners will conduct a detailed assessment of coordination structures and functions which exist in the country and appropriate models for more effective coordination will be established on a State by State basis and at the Federal level. Mechanisms for coordinating donor resources with that of government for health development are expected to take the form of common basket funding through options such as joint funding agreements, sector-wide approaches (SWAps) and sectoral multi-donor budget support etc. The implementation of Paris declaration on aid effectiveness with a follow up of the Accra agenda will be promoted.

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

**3.4.4.5 Health Budget Execution, Monitoring and Reporting**

Systems for monitoring budget execution at all levels are grossly inadequate more so, with existing wide gaps between annual budgetary allocation and budget outturn. The FMoH will provide technical assistance to aid States and LGAs in developing costed, annual operational plans. Additional capacity will be built to ensure that proper internal recording and accounting of expenditures are maintained and that timely and detailed financial management reports are produced periodically. Credible mechanisms will be put in place to increase financial transparency through the development of National and State Health Accounts (NHA and SHAs) and Public Expenditure Reviews (PERs) and tracking of health budgets.

**3.4.4.6 Strengthening Financial Management Skills**

Competencies at all levels but especially at the State Ministries of Health and LGA Health Departments in critical areas such as budgeting, planning, accounting, auditing, monitoring and evaluation are in short supply. It will be very difficult to undertake effective transparent budgeting and management of the financial systems in the sector if practical steps are not taken to bridge the skills gap. Consequently, hands-on training and competency transfer will be conducted to enable the States and LGAs manage their financial management systems.

**3.4.5 Indicators**

3.4.5.1 Technical working group for health financing established by State and LGAs by 2nd quarter 2010.

3.4.5.2 1. State keys into NHIS and other Health Insurance Schemes by 4th Quarter 2010. 2. Number of Health facilities registered to provide services to enrollees 2010 to 2015

3.4.5.3 1. State health sector funding increased by at least 5% per annum from 2010 to 2015. 2. Number of LGAs with increased funding by at least 5% per annum from 2010 to 2015.

3.4.5.4 Coordination structures and functions in collaboration with development partners established by 4th quarter 2010.

3.4.5.5 Availability of audited annual reports at State and LGA levels by 4th quarter 2010 to 2015.

3.4.5.6 Percentage of personnel trained on financial management at State and LGA level by 3rd quarter 2011.

**3.4.6 Targets**

3.4.6.1 50% of States have a documented Health Financing Strategy by end 2012

3.4.6.2 NHIS protects all Nigerians by end 2015

3.4.6.3Allocated Federal, State and LGA health funding increased by an average of 5% pa every year until 2015

3.4.6.4 1. Federal, 60% States and LGA levels have transparent budgeting and financial management systems in place by end of 2015

2. 60% of States and LGAs have supportive supervision and monitoring systems developed and operational by Dec 2012

## *3.5 PRIORITY AREA 5: NATIONAL HEALTH INFORMATION SYSTEM*

**2.5.1 Strategic orientation**

In 1988, Decree 43 of the Federal Government of Nigeria created national M&E units to provide necessary mechanisms for tracking government budget and performance. This was followed by the establishment of Primary Health Care Management Information system (PHCMIS) in 1990 with a review in 2001. Equally, an integrated National Health Management Information System (NHMIS) was formally developed in Nigeria in 1993, following previous attempts at vertical data collection, collation and analysis systems. Recently in 2006, eventual harmonization of vertical M&E tools and systems culminated in the incorporation of key programmatic indicators in the health sector into the NHMIS and as captured in the current NHMIS Policy (2006). The NHMIS is equipped to improve data capture, storage analysis and report generation for health data in Nigeria. Also in existence is the National Bureau of Statistics which is backed by law and responsible for collecting as well as collating socio-economic indicators to inform decision making.

A Health Data Consultative Committee (HDCC) comprising of government and partners was established at federal level to coordinate and harvest population based data and other data from surveys and with a mandate to meet quarterly and with similar structures at State and LGA level. To meet the resource requirement to strengthen the NHMIS, in

1995, the National Council on Health adopted a resolution to allocate funding to the NHMIS based on an identified vote-of-charge (VOC) consisting of 0.5% to 1.0% of the annual capital (health) budget.

The NHMIS/M&E remains weak and fragmented with numerous vertical programmes and systems, which are mostly donor driven. In addition, there are multiplicity of data collection tools, too many indicators, and reluctance of developmental partners and the vertical programmes which they support (including programmes within the FMoH), to utilise national tools. Furthermore, there is no national M&E policy, framework and plan and there is lack of integration between the NHMIS and M&E systems. Even though the private sector provides 60% of healthcare in the country, there is very limited capture of their data into the NHMIS. Other major problems include lack of forms; incomplete, untimely, and largely incorrect reporting of data; grossly inadequate capacity to analyse and utilise data for decision making at all levels; and poor feedback mechanisms.

### 3.5.1.1 Conceptual Definitions

**Health Information System** is defined as a set of components and procedures organized with the objective of generating information which will improve health care management decisions at all levels of the health system.

**Monitoring and Evaluation**: **Monitoring** is a systematic process of collection and analysis of data to track project implementation and use of the information in project management and decision making. **Evaluation** on the other hand is a systematic process of collecting and analyzing information to assess the effectiveness of the programme organization in the achievement of its stated goals.

**Disease surveillance:** The ongoing systematic collection, collation, analysis, and dissemination of information to all those people who need to take action for the prevention and control of disease. In Nigeria, the surveillance system in place Integrated Disease Surveillance and Response (IDSR) is for communicable diseases.

### 3.5.2 Goal

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 Proposed Strategic Objectives

3.5.3.1 To improve data collection and transmission

3.5.3.2 To provide Infrastructural Support and ICT on Health Databases and Staff Training

3.5.3.3 To strengthen sub-systems in Health Information System

3.5.3.4 To Monitor and Evaluate the NHMIS

3.5.3.5 To strengthen analysis of data and dissemination of health information

### 3.5.4 Interventions

To strengthen data collection using nationally standardised forms

#### 3.5.4.1 Ensure availability of NHMIS tools at all health service delivery points at all levels

One key constraint to implementation of effective NHMIS is lack of tools for data collection. States and LGAs will make forms available by providing adequate budget and ensuring that funds are released for printing of the data collection forms. Moreover, the forms will be distributed to appropriate facilities to ensure their utilisation. Forms will be produced 6 monthly.

#### 3.5.4.2 Periodic review of NHMIS data collection forms

NHMIS data collection forms will be reviewed periodically by FMOH in consultation with all stakeholders. The health managers at States and LGAs will create mechanisms to ensure regular feedback from the field on the appropriateness and user friendliness of data collection tools and establish mechanisms for annual review.

#### 3.5.4.3 Coordinate data collection from vertical programmes

The Health Data Consultative Committee at Federal and State levels in collaboration with partners and other government agencies will be revitalised to streamline and strengthen data collection systems. The FMoH will integrate the current HIS with M&E system in the country to ensure coherence and complementarity. Linkages and harmonized data collection mechanism at State and LGA levels will be established and strengthened.

#### 3.5.4.4 Build capacity of health workers for data management

Comprehensive training and re-training of service providers on data collection tools, analysis and utilisation of data for action in health programming and policy formulation will be conducted. Adequate monitoring systems at Federal and State levels to ensure data quality will be established, and recruitment of health information personnel, where grossly inadequate, to support the system will be undertaken.

#### 3.5.4.5 Provide legal framework for activities of the NHMIS programme

In order to make data collection and utilisation mandatory, the draft National Health Bill proposes sanction of private care providers that fail to submit health data to the relevant health authorities. Mechanisms to enforce these sanctions will be put established. Additional legal framework for activities of the NHMIS programme will be put in place at State and LGA levels. Systemic advocacy will be embarked upon to policy makers to make them understand the value and usefulness of data as well as promulgate an enabling law and bye laws to make this mandatory. The FMoH and SMoH will spearhead this advocacy both to the top government functionaries as well as National and State Assembly. The vital registration system in the country will also be strengthened.

#### 3.5.4.6 Improve coverage of data collection

In order to have good database the national data collection process and coverage will be improved. States will be encouraged to develop innovative strategies to collect data from all public and private health facilities and equally improve the collection of community based data. In addition, the National Population Commission will be supported to strengthen vital statistics of birth and death registration both by the federal and state government. This will only be feasible if there are adequate data collection tools and follow up on defaulting facilities.

#### 3.5.4.7 Supportive supervision of data collection at all levels

Supportive supervision of data collection at all levels will be carried out and provision for adequate logistics for officials to supervise data collection at lower levels will be ensured.

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

### 3.5.4.8 Strengthen the use of Information technology in HIS

Use of information technology on HIS will be strengthened, and decentralized software-based systems for data collection and analysis will be promoted public-private partnerships in the management of data warehouses will be established as well as mechanisms to enhance the wide use of e-health data, such as through electronic Management Intelligence Information System, websites, Patient information system, etc.

### 3.5.4.9 Provision of HIS Minimum Package at the different levels (FMOH, SMOH, and LGA) of data management

An HIS Minimum Package at the different levels (FMoH, SMoH, and LGA) of data management will be defined. Subsequently, adequate and timely availability of the NHMIS Minimum Package at federal, state and LGA levels for data management, inclusive of basic infrastructure for data storage, analysis and transmission systems (computers, power supply, and internet) will be provided. Appropriate use of computers hardware systems will be monitored while acquisition systems for database software at all levels will also be deployed. Finally, capacity of relevant staff on the database will be built.

*To strengthen sub-systems in Health Information System*

### 3.5.4.10 Strengthen Hospital Information System

The Federal and State ministries of health will establish and strengthen patient information systems as well as systems for mapping disease.

### 3.5.4.11 Strengthen Disease Surveillance

The Federal, State and LGAs will also ensure that regular reporting of notifiable diseases by all health facilities is carried out, as well as initiate and strengthen community based surveillance to strengthen disease Surveillance System.

3.5.4.12 **Establishment of monitoring protocol for NHMIS programme implementation at all levels in line with stated activities and expected outputs**

Timely availability of logistics materials (vehicles or motorcycles) will be provided and use of NHMIS field monitoring instruments at all levels facilitated. HIS Quality Assurance (QA) manual (Handbook) will be used at each level of health care delivery, while quarterly HIS review meetings at LGA level, bi-annual review meetings at State level and annual meetings at National level instituted.

3.5.4.13 **Strengthen data transmission**

Institutional and human capacities for timely and complete transmission of data in line with relevant guidelines will be built.

*To strengthen analysis of data and dissemination of health information*

3.5.4.14 **Institutionalize data analysis and dissemination at all levels**

Institutional and human capacities for appropriate data analysis and dissemination of information and data to inform decision making and programming will be strengthened. Production of periodic health data bulletin and annual reports by Departments of Planning Research and Statistic at the Federal and States levels will be instituted.

3.5.5 **Indicators**

3.5.5.1 Number and types of NHMIS forms available at health service delivery point by 1st Quarter 2010.

3.5.5.2 Stakeholder's forum/technical working group established at state level to recommend review of NHMIS management tools by 1sr quarter 2010.

3.5.5.3 Availability of harmonized data through integrated HIS and M&E at state and LGA level by 4th quarter 2010.

3.5.5.4 Percentage of Health workers trained on Data Management at State and LGA levels from 2010 to 2015.

3.5.5.5 Legal framework of NHMIS programme adapted and implemented by State and LGAs from 1st quarter 2010 to 2015.

3.5.5.6 1. Percentage of facilities submitting timely and complete reports to LGAs from 3rd quarter 2010 to 2015.

2. Percentage of LGAs submitting timely and complete reports to State from 2010 to 2015.

3.5.5.7 1. Timely submission of complete monthly and quarterly reports by LGAs by 3rd quarter of 2010

2. Availability of completed supervisory checklist for all visits by 4th quarter 2010

3.5.5.8 Percentage of health institutions at LGAs and State level using Health Information Technology by 4th Quarter 2011.

3.5.5.9 Percentage of health facilities operating minimum package of HMIS by 2nd quarter 2011.

3.5.5.10 Percentage of hospitals in the state utilising Hospital Information System for informed decision by 4th quarter 2011

3.5.5.11 Number of LGAs and Health Facilities submitting timely and completed weekly/monthly surveillance reports from 1st quarter 2010 to 2015

3.5.5.12 HMIS monitoring protocol established at all levels and minutes/reports of all meetings/ monitoring visits available from 1st quarter 2010 to 2015

3.5.5.13 1. Percentage of facilities within the LGA submitting complete report on time to the LGA. 2. Number of LGA submitting complete reports on time to the State from 2010 to 2015

3.5.5.14 Number of bulletins, periodicals and annual reports produced yearly by the State from 2010 to 2015

**3.5.6 Targets**

3.5.6.1 1. 50% of LGAs making routine NHMIS returns to State level by end 2010

2. 60% of States making routine NHMIS returns to Federal level by end 2010

3.5.6.2 ICT infrastructure and staff capable of using HMIS in 50% of States by 2012

3.5.6.3 1. NHMIS modules strengthened by end 2010

2. NHMIS annually reviewed and new versions released

3.5.6.4 NHMIS evaluated annually

3.5.6.5 1. 50% of States have Units capable of analysing health information by end 2010

2. All States disseminate available results regularly

## 3.6 PRIORITY AREA 6: COMMUNITY PARTICIPATION AND OWNERSHIP

### 3.6.1 Strategic orientation

Traditional self help and community efforts in health development through community safety nets and other support mechanisms have been part of the history of communities in Nigeria. These efforts at community participation have however been limited in scope, organization and impact. Lack of clear policy framework to empower the community as the draft Community Development Policy is yet to be finalized may be contributory. National efforts at promoting community participation in health began with the introduction of PHC in the country in 1986. National guidelines were developed for PHC planning and implementation, including those for community participation. They included very prescriptive guidelines for setting up village health committees across the country with definitions of the size, composition and functions, which resulted in little or no efforts in the identification and strengthening of existing local social organizations, thereby pre-empting a crisis of legitimacy.

The introduction of PHC in the country also witnessed the development of training curricula for traditional birth attendant (TBAs) and village health workers (VHWs). The TBAs were to assist in home deliveries while the VHWs were to provide basic curative care and health education. While there were guidelines for linking this cadre of health care providers to the formal health sector, they were never implemented. The system for replenishing their health commodities were similarly not implemented as was the

mechanism for their supervision, leading to the collapse of the programme. However, other programs have continued to train and support this cadre of workers, albeit on a limited scale. More recently, many programmes have successfully introduced the training programmes of different cadres of community-based health care providers like community drug distributors of ivermectin for onchocerciasis, community-based distribution agents for family planning commodities, vaccinators for polio eradication campaigns, community oriented resource persons (CORPs) for Integrated Management of Childhood Illness (IMCI), community volunteers for the community-based TB programme, home-based care providers for home management of HIV/AIDS and role model mothers for home-based malaria treatment and control.

The Bamako Initiative (BI) which began in Nigeria in 1987 was a major effort to introduce the concept of community co-management and co-financing of essential drugs as a strategy for improving maternal and child health through the improvement of quality of services in PHC facilities. By 1998, the programme was scaled -up and consolidated through the PTF to cover all the LGAs in the country. A nationwide evaluation of BI by NPHCDA in 2001 showed a massive decapitalization of the funds and minimal evidence of community participation in the management of the drugs[17]. The introduction of the National Health Insurance Scheme has also opened another window of opportunity to foster community participation in health care through the community-based social health insurance scheme for the informal sector, which constitutes 70% of the population in the country. Currently, this sector pays for services through out-of-pocket expenditure; thus limiting access to health services.

There is minimal constructive engagement of communities in needs identification, planning and implementation of health programmes. To many, community participation was synonymous with provision of building for government to staff and provide curative services. Largely, communities remain reliant on government. Inadequate community participation has also resulted in inappropriate sitting of PHC facilities in inaccessible or unacceptable locations and also, gross underutilization of the services rendered.

[17] National Primary Health Care Development Agency. (2001) *Evaluation of the Bamako Initiative.* NPHCDA, Abuja

### 3.6.1.1 Conceptual Definitions

**Community Participation**

Community participation has been defined as the process of enabling individuals, families and communities to take greater control over their health, on health promotion interventions to prevent disease, and take actions in the event of ill health on what to do and when and where to seek health care. It seeks to establish a partnership between government and local communities in the planning, implementation, utilization, monitoring and evaluation of services so that the community can benefit from increased self-reliance and social control over the infrastructure and technology of PHC. Community participation in health is therefore considered a fundamental human right as individuals and families have a right to participate in decisions affecting their health and are known as "right holders". The Alma Ata declaration identified community participation as a key principle of PHC and central to the attainment of the goal of Health for All.

### 3.6.2 Goal

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

### 3.6.3. Strategic Objectives

3.6.3.1. To strengthen community participation in health development

3.6.3.2. To empower communities with skills for positive health actions

3.6.3.3. To strengthen the community-health services linkages

3.6.3.4. To increase national capacity for integrated multi-sectoral health promotion

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

### 3.6.4 Interventions

*To strengthen community participation in health development*

#### 3.6.4.1 Provide an enabling policy framework for community participation

The importance of community participation in health outcomes is recognized by stakeholders. While there are guidelines for engaging communities, a policy that gives direction is lacking. There is the need to create an enabling policy environment to foster

effective community participation in health actions through the appropriate revision of community participation section of the National Health Policy and finalization of the Community Development Policy.

### 3.6.4.2 Provide an enabling implementation framework for community participation

Communities have some level of organization which enables them carry out activities that protect their common interests and foster achievement of common goals. However, where available, the guidelines for establishing community structures for health development activities have been highly prescriptive. Therefore, existing guidelines for establishing community development are to be updated and adapted and participatory tools and approaches to enhance community involvement in planning, management, monitoring and evaluation of health interventions developed and utilised. There is need to establish inter-sectoral stakeholder committees involving community representatives at all levels so as to enhance collaboration.

*To empower communities with skills for positive health actions*

### 3.6.4.3 Building community capacity

To enable communities to actively participate in health actions, they need to be empowered with health knowledge and capacity in management, implementation, as well as basic interpretation of health data. The key roles and functions of community stakeholders and structures will be defined. To actualize the intervention, various processes will be followed, which starts with the development, upgrading or modification of existing participatory tools for mobilising communities in planning and management. Follow up actions to this will entail the identification and mapping out of key community stakeholders and resources with community assessment of capacity needs. Community development committees and community-based health care providers will be re-oriented on their roles and responsibilities and resources mobilized and allocated for funding for community level activities. Community dialogue between communities and government structures for maximum impact will be established and information, education and communication (IEC) activities and media used to enlighten and empower communities for positive action. Communities will be involved at all levels in program planning, implementation and monitoring of health activities.

*To strengthen the community-health services linkages*

**3.6.4.4 Restructure and strengthen the linkages between the community and health services delivery points**

Across the country, the isolated and piecemeal approach to community participation for health services (when they exist) has resulted in the fragmentation and limited success recorded for community participation efforts. A major intervention will be jumpstarted by a review and assessment of the level of linkages of the existing health delivery structures with the community. Technical guidance and support will be provided to community stakeholders for the development of guidelines for strengthening the community-health services linkage and there will be restructuring of health delivery structures to ensure adequate promotion of community participation in health development. In addition facilitation of exchange of experiences between community development committees will be promoted.

*To increase national capacity for integrated multi-sectoral health promotion*

**3.6.4.5 Develop and implement multi-sectoral policies and actions that facilitates community involvement in health development**

Community involvement in health development is hinged on the utilization of approved and acceptable approaches, people and systems. Advocacy to community gatekeepers to increase their awareness on community participation and health promotion will be undertaken and community health development programmes developed and implemented. Action plans to facilitate the development of health promotion capacities at community levels will be formulated and support given to various levels to link health with other sectors using the health promotion guidelines.

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

**3.6.4.6 To develop and implement systematic measurement of community involvement**

The framework for measurement of community involvement efforts (methods, and impact, which showcases the various models that have been adopted, and opportunities to learn lessons) has been seriously lacking. Locally adapted models will be used to

establish simple mechanisms to support communities to measure impact and document lessons learnt and best practices from specific community-level approaches, methods and initiatives and the findings from such efforts disseminated to enhance knowledge sharing amongst stakeholders.

### 3.6.5 Indicators

**3.6.5.1** 1. Percentage of communities with community development committees (CDC) within the LGAs in the State 1st quarter 2010 2. Minutes of meetings held from 2010 to 2015.

**3.6.5.2** 1. Percentage of communities with community development committes (CDC) within the LGAs 1st quarter 2010

2. Minutes of meetings held from 2010 to 2015.

**3.6.5.3** Percentage of WDCs/CDCs/FBOs/CBOs and VDCs trained and type of training conducted from 2010 to 2015

**3.6.5.4** Number of health facilities development community meetings held and minutes of meetings available from 1st quarter 2010 to 2015.

**3.6.5.5** Percentage of communities with inter-sectoral committees and minutes of meetings held from 1st quarter 2010 to 2011.

**3.6.5.6** Percentage of communities with documented impact assessment and lessons learnt by 4th quarter 2010 to 2015.

### 3.6.6 Targets

**3.6.6.1** All States have at least annual Fora to engage community leaders and CBOs on health matters by end 2012

**3.6.6.2** All States offer training to FBOs/CBOs and community leaders on engagement with the health system by end 2012

**3.6.6.3** 50% of public health facilities in all States have active Committees that include community representatives by end 2011

**3.6.6.4** 50% of States have active intersectoral committees with other Ministries and private sector by end 2011

**3.6.6.5** Health research policy adapted to include evidence-based community involvement guidelines by end 2010

## *3.7 PRIORITY AREA 7: PARTNERSHIPS FOR HEALTH*

### 3.7.1 Strategic orientation

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

***Private for profit Health Care Providers***

There is a growing, but poorly regulated, private sector and a plethora of private sector providers ranging from private hospitals, clinics, to pharmaceutical stores, patent medicine stores and traditional healers used increasingly by growing numbers of people to access health services. Most of such facilities are unregistered; employ unqualified health workers and dispense counterfeit drugs despite the regulatory framework provided by the National Agency for Food and Drugs Administration and Control (NAFDAC).[18] It has been shown that there is a higher utilization of the private sector health facilities than public ones in Nigeria[19]. Perceived better quality care was identified as a factor and despite the high costs, the poor represent a significant proportion of beneficiaries of varied forms of private health care, although effectively priced out of the health care market.

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[18] NAFDAC Baseline Study of the Nigeria Medicines Situation conducted in 2005 by the World Health Organisation, and funded by the UK Department for International Development (DFID)

[19] Health Reform Foundation of Nigeria (2007) *Nigeria Health Review* Abuja: Health Reform Foundation of Nigeria

*Private Not for Profit*

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

***Health Development Partners (DP)***

The coordination of international and national based health development partners including Multilaterals, Bilaterals, NGOs, etc is the responsibility of the Departments of Planning and Planning Commissions at federal and state levels. Within the health sector, there currently exists some coordinating mechanism such as inter-agency coordinating committee (ICC) for immunization, Country Coordinating Mechanism (CCM) for the Global Fund and the Roll Back Malaria (RBM) partnership, Health Partners Coordination Committee and Health Systems Forum. However, there has been a lack of a harmonized framework for coordination between the FMOH and health development partners. As a result, effective coordination has been poor with donors working separately through various departments and agencies within the sector. The lack of an overarching framework specifying priority needs has allowed for donor driven aid deployed inefficiently and inequitably with the programmes not aligned or harmonized with government plans.

The Health Sector Reform Programme (2004 – 2007) in recognition of this captured improved donor coordination as essential to increasing the effectiveness of aid resources. There is some work in progress in the development of a Joint Funding Agreement (JFA) under the guidance of Federal government agencies such as NACA. The increasing focus on implementing the principles of the Paris Declaration on Aid Effectiveness towards achieving the MDGs is a propelling force to improve harmonization amongst donors and the subsequent alignment to national priorities.

*Other Sectoral Ministries, Department and Agencies (MDA)*

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

*Professional groups*

Health care is a labour intensive sector dominated by various professionals that necessarily have to work in collaboration with one another and with all health authorities. Health professionals and health workers require strong, integrated health systems at both national and local levels to support the delivery of universal care and services. Proven, affordable interventions implemented in collaboration with professional groups within an integrated network of care, from community to referral centers have recorded success. Throughout the cycle of life, individuals and communities rely on health professionals to not only save lives, but to maintain and promote well being. These professionals groups include those for Doctors (Nigerian Medical Association and its affiliates), Nurses and Midwives (NANNM), Pharmacists (PSN), Community Health Workers (ACHPN), Medical Lab Scientists, anesthetists and other professional bodies. Health professional associations and societies therefore have vital roles to play in ensuring that health professionals are well equipped to deliver their important roles in improving health outcomes. Failure of cooperation among these professional groups to achieve broader health sector objectives such as better patient outcome has in part contributed to the poor performance of the health system.

*Communities*

Significant healthcare is undertaken by households at the family and community levels and households are also the main consumers of health care at facility level. Health

facilities are located in communities and are expected to respond to their needs. However, there is poor engagement of the community by State and LGA health authorities. 'Community empowerment' has been an overused word that has become a mere rhetoric for health planners. Community/Village Health Committees where in existence have very limited role in determining the course of events as they affect the health of the community. Consequently, duty bearers (health authorities) are presently not accountable to the right holders (the community) resulting in lack of ownership by the communities.

### 3.7.2 Goal

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

### 3.7.3 Strategic Objectives

3.7.3.1 To ensure that collaborative mechanisms are put in place for involving all partners in the development and sustenance of the health sector by 2011.

### 3.7.4 Interventions

A description of some activities that could contribute to the achievement of each specific objective and intervention are presented below for consideration at Federal, State and LGA levels. It is expected that the identification of appropriate activities would be based on the stewardship role and mandate of each level.

*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 Public Private Partnerships (PPP)

While the private sector is the major provider of health care provision in the country, public-private partnership remains weak. Public-private partnership in health should not be seen as privatization, which involves complete transfer of public assets to private owners. The existing national PPP policy for the country will be updated with a view to leveraging technical and financial resources alongside improved management approaches for improved delivery of health care services. Strategies for implementing PPP initiatives in line with this national policy will be developed and PPP units at all levels to promote, oversee and monitor PPP initiatives will be established. Mechanisms for

engaging the private sector – such as contracting or out-sourcing, leases, concessions, social marketing, franchising mechanism and provision incentives (e.g health commodities, or technical support at no cost) will be undertaken. In addition, other options that encourage the private sector set up health facilities in rural and under-served areas will be explored. Also, joint monitoring visits by public and private care providers with adequate feedback are to be established.

### 3.7.4.2 Coordination of Development Partners

At present most of the activities of international development agencies are not coordinated with that of the country health programmes. A framework for the harmonization and alignment of development partner's support will be institutionalized at all levels. One key activity will be the establishment of *Development Partners Forum* comprising only health development partners at Federal and State levels as single entry points for engaging with partners. The Health Partners Coordinating Committee (HPCC) as a government coordinating body with all other health development partners will be strengthened and similar mechanisms will be established at state level. In addition, mechanisms for resource coordination through common basket funding models such as Joint funding Agreement, Sector Wide Approaches, and sectoral multi-donor budget support will be established.

### 3.7.4.3 Inter-Sectoral Collaboration

In order for the country to attain the level of health status required, other social and economic sectors, other than health, have to take specific actions within their spheres of influence that would synergize the key health specific actions that could in turn bring about health gains for the entire population. To facilitate this, an inter-sectoral ministerial forum at all levels to facilitate inter-sectoral collaboration, involving all relevant MDAs directly engaged in the implementation of specific health programmes – such as Environment in Malaria control and prevention, Agriculture in nutrition programmes, Water Resources in control of water borne or related diseases, Women Affairs[1] in Maternal, Newborn and Child Health, and Information in Behaviour Change Communication (BCC) programmes will be established.

### 3.7.4.4 Engaging Professional Groups

The following suggested activities would ensure that the concept of team-based collaborative work approach is entrenched in order to achieve better integration of care and prevent fragmentation of in service delivery: (i) Promote effective partnership with professional groups through jointly setting standards of training by health institutions, subsequent practice and professional competency assessments; (ii) engage professional groups in planning, implementation, monitoring and evaluation of health plans and programmes; (iii) Promote effective communication to facilitate relationships between professional groups and Ministries of Health; (iv) strengthen collaboration between government and professional groups to advocate for increased coverage of essential interventions, particularly increased funding; (v) convene public lectures through a coordinated approach by professional associations to enhance the provision of skilled care by health professionals; (vi) Promote linkages with academic institutions to undertake research, education and monitoring through existing networks; and (vii) influence regulation and legislation to allow for competency-based practice by all types of health professionals according to the principles of "continuum of care".

### 3.7.4.5 Engaging Communities

One pre-requisite for citizen's empowerment is improved availability of information, in a form that is accessible and useful. Suggested activities to achieve this intervention include: (i) Improve availability of information to communities, in a form that is readily accessible and useful through proper culturally appropriate and gender sensitive dissemination channels; (ii) Information packages for community consumption should include rights of beneficiaries, means of accessing care at health facilities and minimum standards of quality health services; (iii) develop indicators on health system performance at States, LGAs and facilities to improve transparency and accountability of the government to its citizens; (iv) institute mechanisms for competition between States, LGAs and facilities for satisfactory performance in delivery of community support programmes for health; (v) establish and empower Health Service Charters at all levels, with Civil Society Organisations, traditional and religious institutions to promote the concept of citizen's rights and entitlement to quality, accessible basic health services; and (vi) build the capacity of communities to prevent and manage priority health conditions through appropriate self-mediated mechanisms such as Behaviour Change Communication (BCC), Social marketing, Public Awareness Campaign, Information, Education and Communication resources (IEC), etc.

### 3.7.4.6 Traditional health practitioners

Despite the availability of modern medical care and improvement in literacy levels, many people still patronize the services of traditional health care providers. This may not be unconnected with the belief system inherent in the country. While many traditional medical approaches may seem to be useful, many others are of no effect and some may indeed be harmful. Therefore, there is a need to find out what works and what does not and find ways in which both approaches can be integrated where necessary. The following are some suggested activities for working with traditional health practitioners: (i) Seek to have better understanding of traditional health practices and support research activities to gain more insight and evaluate them; (ii) organise traditional medicine practitioners into bodies/organisations that are easy to regulate and actually regulate their practice; (iii) adopt traditional practices and technologies of proven value into State health care system and discourage those that are harmful; (iv) train traditional health practitioners to improve their skills, to know their limitations and ensure their use of the referral system; (v) where applicable seek the cooperation of traditional practitioners in promoting health programmes in such priority areas as nutrition, environmental sanitation, personal hygiene, immunisation and family planning; and (vi) discourage traditional health practitioners from advertising themselves and making false claims in the public media.

### 3.7.5 Indicators

**3.7.5.1** 1. Availability of adapted PPP Policy at State level by 4th quarter 2010..

2. Number of MOUs signed 1st quarter 2010 to 2015

3. Availability of minutes of meetings held from 1st quarter 2010 to 2015

**3.7.5.2** Development Partners Coordination Committee established by 1st Quarter 2010.

**3.7.5.3** Inter-Sectoral Committee established by 1st Quarter 2010.

**3.7.5.4** Number and types of Services provided by professional groups from 2010 to 2015.

**3.7.5.5** 1. Number of IEC materials made available, media engagement, community dialogues, sensitization meetings by 4th quarter 2010.

2. Number of community development project undertaken from 2010 to 2015.

**3.7.5.6** 1. Number and types of trainings conducted for traditional health practitioners from 3rd quarter 2010 to 2015.

2. Number of meetings held with traditional health practitioners from 2010 to 2015.

### 3.7.6 Targets

**3.7.6.1** 1. FMOH has an active ICC with Donor Partners that meets at least quarterly by end 2010

2. FMOH has an active PPP forum that meets quarterly by end 2010

3. All States have similar active committees by end 2011

## *3.8 PRIORITY AREA 8: RESEARCH FOR HEALTH*

### 3.8.1 Strategic orientation

Over the years successive government have introduced various initiatives to promote research for health in Nigeria. In particular, the Medical Research Council of Nigeria (MRCN) was established by Decree No 1 of 1972 and inaugurated in January 1973. In 1977 the National Science and Technology Development Agency (NSTDA) was established. The Nigeria Institute for Medical Research (NIMR) was initially an agency under the NSTDA, which transmuted into the Federal Ministry of Science and Technology until it was transferred to the FMOH. In 1988, the reorganization of civil service by Federal Government for effective, efficient and productive service created the Department of Planning, Research and Statistics (DPRS) in all ministries.One of the responsibilities of the department is to co-ordinate research activities as well as spear-head planning. Consequently, there is now a Department of Planning and Research at the Ministries of Health at the Federal and State government levels. To conduct research in the area of Pharmaceutical commodities, the National Institute for Pharmaceutical Research was established under the oversight of the Federal Ministry of Health. A draft National Health Research Policy as well as National Health Research Priorities were produced in 2001, both document have been reviewed and merged in 2006. A Country report on status of health research was also produced by the FMOH in 2006.

Funding for health research in Nigeria is meager with evidence indicating at most 0.08% of health expenditure at the federal level with hardly any funding at lower levels. This is contrary to the 2% allocation to research for health prescribed by African Health Ministers and agreed to by the National Council on Health. The paucity of these allocations to the Health Sector had affected the quality and depth of health research in particular[20]. There is also an internationally accepted guideline that Donor agencies provide 5% of Aid to research.

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20 The10/90 Report on Health Research 2003-2004. Global Forum for Health, 2006

Potential researchers are produced annually from the various tertiary institutions with high attrition rates resulting from lack of mentorship programmes and weak enabling environment in the country to sustain their research interests. It is important to note that the present trend in the communication of health research findings is that of translating or 'repackaging' technical or scientific information into a more user friendly format that will increase the uptake of the research. The National Research and Knowledge Enterprise Committee of the Federal Ministry of Health require strengthening to translate and summarise research findings for use by policy makers, implementing partners or local communities. Even where such findings have been carefully documented and published, dissemination of such findings has been very poor at all levels, explaining the weak impact of research at all levels.

The factors responsible for the inadequacies in health research in Nigeria are lack of coordination in research, lack of regular fora to discuss health research, poor linkage between research and policy, as well as between international and national research agenda. Equally contributory are inadequate research priority setting, dearth of research infrastructure, sub-optimal capacity building strategies, ineffectual documentation and publication. The National Ethical Research committee though in place at the Federal level; there is poor adherence to ethical guidelines in medical research resulting possibly from absence of ethical review boards in most states and higher institutions. Also, monitoring and evaluation of research is limited and researchers are not adequately motivated.

There is currently no legal framework mandating a depository of researches and output of databases in the country. Linking research for health with policies and decision making on health care in a country is imperative to provide decision-makers with empirically-based and scientifically-valid information on service delivery.

#### 3.8.1.1 Conceptual Definition

**Research for health** is defined as the generation of knowledge that can be used to promote, restore, maintain, protect monitor or conduct surveillance of health of populations. Health research is the systematic generation of new knowledge in the field of medical, natural, social, economic and behavioral science and its use to improve the health of individuals or Group.

### 3.8.2 Goal:

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. Strategic Objectives.

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

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

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

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

### 3.8.4 Interventions

Some possible activities that could contribute to the achievement of each specific objective and intervention are presented below for consideration at Federal, State and LGA levels. It is expected that the identification of appropriate activities would be based on the stewardship role and mandate of each level.

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

**3.8.4.1 Finalise Health Research Policy at Federal level and develop health research policies and strategies at state and LGA levels.**

There is need to finalize the National Health Research Policy at Federal level and develop states' health research policy. In addition health research strategies will be developed at all levels. These interventions can be facilitated by convening Technical working groups to finalise or develop health research policies and strategies at all levels. There will also be the establishment of Health research steering committees at all levels to shepherd research activities at all levels.

**3.8.4.2 Establish and or strengthen mechanisms for health research at all levels**

The capacities of health research divisions and units at all levels to coordinate and encourage research efforts are to be strengthened, linking researchers and creating communities of practice. Departments of Planning Research and Statistics (DPRS) at all levels are also to be similarly strengthened in addition to the creation of active research units in FMOH, SMOH and LGA to undertake operations research and other research-related activities.The coordinated implementation of the Essential National Health Research (ENHR) guidelines are to be ensured.

**3.8.4.3 Institutionalize processes for setting health research agenda and priorities**

Currently there are no systematic mechanisms for setting health research agenda at all levels. Research agenda are mostly driven by availability of research grants from outside the country. To redress this trend, functional institutional structures for research are to be established and or strengthened. The health research agenda will be expanded to include broad and multidimensional determinants of health and ensure cross-linkages with areas beyond traditional boundaries and categories. Guidelines for collaborative health research agenda are to be developed at all levels.

**3.8.4.4 Promote cooperation and collaboration between Ministries of Health and LGA health authorities with Universities, communities, CSOs, OPS, NIMR, NIPRD, Development partners and other sectors**

For research to thrive and to be used to inform health development efforts, strong links will be established between the users of research such as policy makers and the producers of research such as universities. Hence, governments at all levels will establish a forum of health research officers at the FMOH and SMOH plus LGA. There will be annual convening of multi-stakeholders forum to identify research priorities and harmonize research efforts. Governments at all levels will have to support the development of collaborative research proposals and their implementation between governments and public and private health research organisations.

**3.8.4.5 Mobilisation of adequate financial resources to support health research at all levels**

Lack of adequate financial resources is a major bane of health research. To address this and) in line with the recommendation of African governments, at least 2% of health budget will be allocated for health research at all levels. Similarly funds for health

research will be deployed in a targeted manner while expanding beneficiaries of funding to researchers from both public and non-public health research organizations and individuals. Opportunities for accessing funds from bilateral and multilateral organizations, research funding agencies and through north-south and south-south collaboration will be explored. To attract additional funds, a credible and transparent independent national research funding agency will be established.

**3.8.4.6 Establish ethical standards and practice codes for health research at all levels**

In order to respond effectively in this regard, health research ethical mechanisms, guidelines and ethical review committees at federal and state levels will be established and or strengthened. Relatedly, similar mechanisms in tertiary health and education institutions will be strengthened as well as monitoring and evaluation system to regulate research and use of research findings at all levels also established.

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

**3.8.4.7 Strengthen identified health research institutions at all levels**

Most of the research institutions in Nigeria are weak and do not produce research outputs that are relevant for policy making. To mitigate this, Governments at all levels should strengthen identified health research institutions identified by inventory of all public and private institutions and organizations undertaking health research. Periodic capacity assessment of health research organizations and institutions will be conducted. Governments at all levels and development partners in conjunction with health research organizations/institutions are to develop and implement measures to address identified research capacity gaps and weaknesses. The development and implementation of resource mobilization strategies targeting the private sector, foundations and individuals for health research are to be ensured.

**3.8.4.8 Create a critical mass of health researchers at all levels**

Adequate and qualified human resources for health research are required at all levels to produce high quality and relevant research outputs. In this regard a critical mass of researchers in conjunction with training institutions will be created while developing appropriate training interventions for research, based on the identified needs at all level.

Governments will regularly provide competitive research grants for prospective researchers while motivating increased PhD training in health in tertiary institutions through award of PhD studentship scholarships.

**3.8.4.9 Develop transparent approaches for using research findings to aid evidence-based policy making at all levels**

To achieve evidence-based policy formulation, mechanisms for translating research findings into policies will be evolved. Further to this, close liaison and linkages between research users (e.g. policy makers, development partners) and researchers will be established. A wide range of actors including research producers will be involved in policy-making consultations.

**3.8.4.10 Undertake research on critical areas already identified in different forums**

To immediately strengthen the health system, systematical researches on a number of topical areas such as estimating the burden of different diseases biennially, undertaking biennial Human Resources for Health studies; studies on health system governance (HSG); biennial studies on health delivery systems; studies on financial risk protection, equity, efficiency and value of different health financing mechanisms biennially, etc as may be determined by policy makers and other key stakeholders will be undertaken.

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

**3.8.4.11 Develop strategies for getting research findings into strategies and practices**

Deliberate efforts will be made to utilize research outputs in the short to medium term to improve strategies and practices in the health sector by establishing getting research into strategies (GRISP) units at all levels and instituting bi-annual Health Research-Policy forums at all levels.

**3.8.4.12 Enshrine mechanisms to ensure that funded researches produce new knowledge required to improve the health system**

This will entail conducting needs assessment to identify required health research gaps at all levels as well as undertaking operations research by all government Health Ministries, Departments and Agencies at all levels. Public and non-public research organizations/institutes will be contracted to collaborate with government in the conduct of operations research thereby addressing gaps in research capacity in government institutions.

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

**3.8.4.13 Create a framework for sharing research knowledge and its applications:** Knowledge is power and health system program implementation should not wallow in ignorance in the face of research evidence. However, the research outputs must be communicated to large audiences for them to be meaningful. Doing this will in addition to publishing the research findings in academic journals, involve the development of a framework for sharing research knowledge at all levels. Annual health conferences, seminars and workshops at Federal and State levels on key thematic areas (financing, human resources, MDGs, health research, etc) will be convened. Also, opportunities for international collaboration on national research agenda, both in terms of ensuring research findings from Nigeria are published and presented in other countries and that Nigerians receive research updates from other countries will be pursued. Participation in international conferences on health and mainstream best practices at National, State and LGAs will be ensured.

**3.8.4.14 Establish channels for sharing of research findings between researchers, policy makers and development practitioners**

Governments and donors will develop the capacity of researchers to effectively produce policy briefs targeted at informing policy-makers, as well as the broad scientific and non-scientific audiences. Also an inventory of national journals according to areas of focus will be conducted. This is in addition to selection of national journals to be supported on the basis of their ability to address issues related to Essential National Health Research (ENHR) principles. Governments and donors will support the publication of high quality national journals, following a review of editorial boards, establishing appropriate linkages between editors of national journals and reputable publishers (especially online, free web-based access publishers) and international collaborators, to improve the quality of national journals. Wide dissemination of selected national journals to all stakeholders at federal, state and LGA levels will be vigorously pursued.

### 3.8.5 Indicators

**3.8.5.1** Availability of State health research policy by 2nd quarter 2010.

**3.8.5.2** 1. A Research Unit established in DPRS of SMOH by 2011. 2. Availability of research guidelines by 4th quarter 2010.

**3.8.5.3** 1. Guidelines for collaborative health research developed by 1st quarter 2011.

2. Number of researches supported by 4th quarter 2011.

**3.8.5.4** 1. Health Research Officer's Forum established and report of research findings from 4th quarter 2010 to 2015.

**3.8.5.5** 1. Percentage of fund allocated to research from 2010 to 2015.

2. Number of researches funded by organizations, agencies and individuals from 2010 to 2015.

**3.8.5.6** Ethical Review Committee established and availability of research guidelines by 1st quarter 2011.

**3.8.5.7** Number of health research institutions supported by the State from 4th quarter 2010 to 2015.

**3.8.5.8** Number of individual and health personnel trained on health research from 2011 to 2015.

**3.8.5.9** Number of health policies formulated based on research findings from 2010 to 2015.

**3.8.5.10** Number and types of priorities health researches conducted from 2010 to 2015.

**3.8.5.11** 1. GRISP established by 4th quarter 2010 2. Percentage of research findings translated into strategic plan from 2010 to 2015.

**3.8.5.12** Number of needs assessment, operations research and impact assessment conducted 1st quarter 2011 to 4th quarter 2015.

**3.8.5.13** 1. Framework for sharing research findings/knowledge established and number of reports shared with stakeholders by 4th quarter 2011. 2. Number of confrences and workshops organized and attended from 2nd quarter 2011 to 4th quarter 2015.

**3.8.5.14** Research Dissemination Committee (RDC) established by 3rd quarter 2010.

### 3.8.6 Targets

**3.8.6.1** 1. ENHR Committee established by end 2009 to guide health research priorities

2. FMOH publishes an Essential Health Research agenda annually from 2010

**3.8.6.2** FMOH has an active forum with all medical schools and research agencies by end 2010

**3.8.6.3** 1. All States have a Health Research Unit by end 2010

2. FMOH and State Health Research Units manage an accessible repository by end 2012

**3.8.6.4** A national health research communication strategy is in place by end 2012

# CHAPTER 4

## RESOURCE REQUIREMENTS

### 4.1 Human

Kebbi State has an existing human resource policy, plan to meet the human resource needs and other identified critical issues especially by implementing the recommendations of the technical team report on health.

### NUMBER OF HEALTH PERSONNEL BY TYPE.

**Distribution of Doctors in 14 General Hospital, Kebbi State, April 2008**

| General Hospital | Consultant | PMO/ CMO | Doctors >10yrs post-qualification | Other Doctors | Total | Short fall |
|---|---|---|---|---|---|---|
| Argungu | Nil | 1 | 2 | 3 + 1 Dentist | 6 | - |
| Aliero | Nil | 1 | 1 | 3 | 5 | 1 |
| Zauro-Ambursa | Nil | 1 | - | 1 | 2 | 2 |
| Dirin Daji | Nil | 1 | - | - | 1 | 3 |
| Illo | Nil | 1 | 0 | - | 1 | 4 |
| Jega | Nil | 1 | - | 3 | 4 | 5 |
| Kamba | Nil | 1 | - | 3 | 4 | 2 |
| Koko | Nil | 1 | - | 3 | 4 | 2 |
| Maiyama | Nil | 1 | - | 1 | 2 | 2 |
| Senchi | 1 | - | - | - | 1 | 3 |
| Wasagu | Nil | 1 | - | - | 1 | 2 |
| Wara | Nil | 1 | - | 1 | 2 | 3 |
| Yauri | Nil | 1 | 2 | 2 | 5 | 3 |
| Zuru | Nil | 1 | 1 | 3 | 5 | 4 |
| **Total** | **1** | **12** | **6** | **23** | **43** | **50** |

FINDINGS ON HUMAN RESOURCES : KEBBI STATE, APRIL, 2008 Secondary Health Care

DISTRIBUTION OF NURSING STAFF IN GENERAL HOSPITALS & MOH

| General Hospital | CNO | ACNO | PNO | SNO | NO I | NO II | Mid wives | Total |
|---|---|---|---|---|---|---|---|---|
| Sir Yahaya Mem. Hosp. | 38 | 10 | 2 | 2 | 3 | 31 | 8 | 93 |
| Gen. Hospital Argungu | 3 | 2 | 6 | 2 | 1 | 10 | 2 | 6 |
| Gen. Hospital Am/Zauro | 7 | 1 | 1 | - | - | 2 | - | 11 |
| Gen. Hospital Aliero | 5 | 1 | 2 | 2 | - | 7 | - | 17 |
| Gen. Hospital Bena | 3 | - | 2 | 2 | - | 1 | 1 | 9 |
| Gen. Hospital Dirin Daji | 1 | 2 | 4 | - | - | 2 | 1 | 10 |
| Gen. Hospital Illo | 2 | - | 1 | - | 1 | 2 | 1 | 7 |
| Gen. Hospital Jega | 10 | 3 | - | 1 | 1 | 5 | 1 | 21 |
| Gen. Hospital Kamba | 5 | 2 | 1 | 1 | 1 | 2 | 1 | 13 |
| Gen. Hospital Koko | 19 | 1 | 3 | 6 | 2 | 6 | - | 37 |
| Gen. Hospital Maiyama | 2 | 2 | 2 | - | - | 3 | 2 | 11 |
| Gen. Hospital Senchi | 2 | - | 1 | 2 | - | 1 | - | 6 |
| Gen. Hospital Wasagu | 4 | 1 | 3 | 1 | - | 1 | - | 10 |
| Gen. Hospital Warra | 3 | 1 | 2 | - | 1 | 3 | - | 10 |
| Gen. Hospital Yauri | 21 | 2 | 4 | 1 | 5 | 8 | 2 | 43 |
| Gen. Hospital Zuru | 28 | 2 | 15 | 5 | 3 | 8 | 2 | 63 |
| V.V.F Centre | 8 | - | 3 | 1 | 2 | 1 | 2 | 15 |
| TOTAL | 185 | 30 | 44 | 23 | 18 | 85 | 16 | 412 |

**MOH**

DNS - 1

DDNS - 2

ADNS - 2

CNO - 2

7

The staffing situation in all the PHC facilities is grossly inadequate.

Table gives detailed distribution of the various cadres of personnel in all the PHCs visited. It is obvious that:

1. Except 3 NYSC doctors, none of the remaining 124 PHCs have a doctor.
2. Overall, the total number of CHOs is 17, which is half of what is required to cover the existing PHC's.
3. The situation with regards to midwives is particularly precarious-as there are only 3 qualified midwives for the 33 PHCs in the services of the LGAs. However, 96 midwives have been deployed under the MSS.

### 3.2.1.6 Staffing in secondary health Care facilities in Kebbi State

The staffing situation is not only grossly inadequate, but has the following undesirable peculiar characteristics:

(a) *Doctors*: There are only 7 consultant/specialist in general hospitals in Kebbi State. There is also grossly inadequate medical manpower to handle general hospitals.

(b) *Nurses*: in all the general hospitals the top-level cadre of nursing staff (ACNO's, CNO's) is blown out of proportion to the lower level cadre – with the result that the quality of nursing care in most general hospitals has deteriorated, since the CNO's and ACNO's do not usually run duty shifts. The few junior nurses that do most of the bedside nursing are often overworked and rendered inefficient.

KEBBI STATE MINISTRY OF HEALTH

Department of Pharmaceutical Services

STAFF DISPOSITION

| S/N | Name of Facility | No. of Pharmacists | No. of Pharm. Tech. |
|---|---|---|---|
| 1. | Headquarters | 2 | 3 |
| 2. | State Medical Stores | 1 | 5 |
| 3. | Gen. Hospital Argungu | 2 | 9 |
| 4. | Gen. Hospital Koko | - | 5 |
| 5. | Gen. Hospital Jega | 1 | 4 |
| 6. | Gen. Hospital Senchi | - | 3 |
| 7. | Gen. Hospital Aliero | - | 4 |
| 8. | Gen. Hospital Wasagu | - | 1 |
| 9. | Gen. Hospital Maiyama | - | 2 |
| 10. | Gen. Hospital Wara | - | 3 |
| 11. | Gen. Hospital Yauri | 3 | 6 |
| 12. | Gen. Hospital Illo | - | 2 |
| 13. | Gen. Hospital Kamba | - | 8 |
| 14. | Gen. Hospital Dirin Daji | - | 1 |
| 15. | Gen. Hospital Zauro/Ambursa | - | 5 |
| 16. | Gen. Hospital Zuru | 2 | 8 |
| 17. | Gen. Hospital Bena | 1 | 1 |
| 18. | V.V.F. Centre | - | 5 |
| **TOTAL** | | **12** | **75** |

*(c) Pharmacists:*

DISTRIBUTION OF PHARMACY STAFF IN GENERAL HOSPITALS KEBBI STATE, APRIL, 2008 Secondary Health Care

| General Hospital | Pharmacists | Pharmacy Technicians | Total |
|---|---|---|---|
| Sir Yahaya Mem. Hosp. | 3 | 15 | 15 |
| Gen. Hospital Argungu | 2 | 8 | 10 |
| Gen. Hospital Aliero | - | 5 | 5 |
| Gen. Hospital Ambursa/Zauro | - | 6 | 6 |
| Gen. Hospital Dirin Daji | - | 2 | 2 |
| Gen. Hospital Illo | - | 3 | 3 |
| Gen. Hospital Jega | - | 5 | 5 |
| Gen. Hospital Kamba | - | 7 | 7 |
| Gen. Hospital Koko | - | 4 | 4 |
| Gen. Hospital Maiyama | - | 2 | 2 |
| Gen. Hospital Senchi | - | 2 | 2 |
| Gen. Hospital Wasagu | - | 2 | 2 |
| Gen. Hospital Warra | - | 3 | 3 |
| Gen. Hospital Yauri | 3 | 5 | 8 |
| Gen. Hospital Zuru | 2 | 9 | 11 |
| Gen. Hospital Bena | 1 | 2 | 3 |
| SMS | 1 | 6 | 7 |
| TOTAL | | | 95 |

There is dearth of qualified pharmacists. 12 pharmacy units in general hospitals of Kebbi State are manned mainly by pharmacy technicians. There are only 8 pharmacists practicing in the general hospitals in the State. Overall, currently there are only 10 trainee pharmacists of Kebbi State origin, distributed in only 2 pharmacy faculties in Nigerian Universities (3 in ABU Zaria, and 7 in the newly created Faculty of Pharmacy in UDUS). Trained pharmacists of Kebbi State origin do not readily take up appointment with Kebbi State, and if they do, they rarely remain in the State. This is because they are poorly motivated and poorly remunerated. The remunerations are not attractive. A starting grade level – 9 (Hatiss 8) for a pharmacy graduate – who trained for 8 years (6 years in the University, 1 year as pharmacy intern and 1 year as NYSC pharmacist) is not attractive. The Kebbi State Government has not yet implemented the recommended Salary Grade Level 10 as the entry – point for pharmacists.

(d) *Laboratory Staff*: There is gross inadequacy of qualified laboratory scientists in the State with histopathology worst affected. There is not a single histopathology lab scientist in the State. Coupled with total absence of a consultant histopathologist, the manpower in this important aspect of lab medicine is virtually non-existent, so are the services.

(e) *Other Supporting Staff*:

FINDINGS ON HUMAN RESOURCES Secondary Health Care
DISTRIBUTION OF LABORATORY STAFF IN GENERAL HOSPITALS:

KEBBI STATE, APRIL, 2008

| General Hospital | Laboratory Staff | | | | | Total |
|---|---|---|---|---|---|---|
| | Consultant Specialist | Lab Scientist | Lab Technicians | Lab Assistant | Non-Registrable Lab Staff | |
| Sir Yahaya Mem. Hosp. | - | 6 | 30 | | 7 | 36 |
| Gen. Hospital Argungu | - | 1 | 18 | | | 19 |
| Gen. Hospital Amb/Zauro | - | - | 3 | | | 3 |
| Gen. Hospital Aliero | - | - | 4 | | | 4 |
| Gen. Hospital Dirin Daji | - | - | 5 | | | 5 |
| Gen. Hospital Illo | - | - | 1 | | | 1 |
| Gen. Hospital Jega | - | 1 | 11 | | | 12 |
| Gen. Hospital Kamba | - | 1 | 4 | | | 5 |
| Gen. Hospital Koko | - | 1 | 10 | | | 11 |
| Gen. Hospital Maiyama | - | - | 3 | | | 3 |
| Gen. Hospital Senchi | - | - | 3 | | | 3 |
| Gen. Hospital Wasagu | - | - | 9 | | | 9 |
| Gen. Hospital Yauri | - | 1 | 9 | | | 10 |
| Gen. Hospital Zuru | - | 1 | 15 | | 2 | 16 |
| Gen. Hospital Wara | - | - | 2 | | | 2 |
| **TOTAL** | | **8** | **97** | | **9** | **139** |

DISTRIBUTION OF MEDICAL RECORD OFFICER AT HEALTH FACILITIES

| S/N | Facilities | No. of Officers |
|---|---|---|
| 1. | Ministry of Health Headquarters | 22 |
| 2. | Gen. Hospital Yauri | 6 |
| 3. | Gen. Hospital Argungu | 18 |
| 4. | Gen. Hospital Koko | 11 |
| 5. | Gen. Hospital Zuru | 14 |
| 6. | Gen. Hospital Jega | 4 |
| 7. | Gen. Hospital Aliero | 3 |
| 8. | Gen. Hospital Bunza | 4 |
| 9. | Gen. Hospital Illo | 3 |
| 10. | Gen. Hospital Wara | 3 |
| 11. | Gen. Hospital Senchi | 2 |
| 12. | Gen. Hospital Kamba | 7 |
| 13. | Gen. Hospital Maiyama | 3 |
| 14. | Gen. Hospital Zauro/Ambursa | 3 |
| 15. | Sir Yahaya Memorial Hospital | 15 |
| 16. | Gen. Hospital D/Daji | 2 |
| 17. | Hafsat Eye Centre | 9 |
| 18. | V.V.F. Centre | 5 |
| 19. | Gen. Hospital Gwandu | 2 |
| 20. | Gen. Hospital Bagudo | 3 |
| 21. | Gen. Hospital K/Giwa | 2 |
| 22. | Gen. Hospital Bena | 3 |
| 23. | Gesse Clinic | 6 |
| 24. | M.C.H. B/Kebbi | 1 |
| 25. | M.C.H. Yauri | 1 |
| 26. | ZHO Argungu | 2 |
| 27. | ZHO Yauri | 1 |
| 28. | ZHO Zuru | 1 |
| 29. | ZHO Bunza | 3 |
| 30. | ZHO Jega | 1 |
| 31. | S.H.T. Jega | 5 |
| 32. | Epid Unit | 1 |

DISTRIBUTION OF TECHNICAL & SUPPORTING STAFF IN GENERAL HOSPITALS: KEBBI STATE, APRIL, 2008

| General Hospital | Radiographers | Radiography Technicians | Physiotherapists |
|---|---|---|---|
| Sir Yahaya Mem. Hosp. | - | 1 | 1 |
| Gen. Hospital Argungu | - | 1 | |
| Gen. Hospital Aliero | - | - | |
| Gen. Hospital Ambursa/Zauro | - | - | |
| Gen. Hospital Dirin Daji | - | - | |
| Gen. Hospital Illo | - | - | |
| Gen. Hospital Jega | - | - | |
| Gen. Hospital Kamba | - | - | |
| Gen. Hospital Koko | - | - | |
| Gen. Hospital Maiyama | - | - | |
| Gen. Hospital Senchi | - | - | |
| Gen. Hospital Wasagu | - | 1 | |
| Gen. Hospital Warra | - | - | |
| Gen. Hospital Yauri | - | 1 | |
| Gen. Hospital Zuru | - | 1 | |

On training X-ray Tech. 14

The number of ward assistants/maids and cleaners in all general hospitals is inadequate. Casual labourers perform the jobs of this cadre of staff, but these labourers are paid through the meagre allocation from the overhead costs.

(f) *Continuing Medical Education*: Facilities for continuing medical education are virtually non-existent in all the general hospitals. Good medical practice entails some form of continuing education for doctors, nurses and all other health care staff. No general hospital in the state has stock of books and journals (no matter how small) and this is unacceptable. In-house seminars are rarely conducted in general hospitals. Sponsorship for seminars, workshops and conferences is rare.

3.2.8 Human Resources

Doctors

The distribution of doctors in the 14 general hospitals is shown in Table 3.2(a).

Nurses

The distribution of nursing staff in 15 general hospitals (including SYMH) is shown on - Page. 78

Laboratory Staff

There are only 8 qualified, registered Lab. Scientists in the whole state. This is grossly inadequate. The 97 Lab. Technicians cannot function as lab scientist, since they cannot handle the equipment to be procured, and they cannot delivery the services needed.

Pharmacy Staff

There are only 7 pharmacists practising in the state-owned general hospitals. This is grossly inadequate. Meanwhile there are 76 pharmacy technicians. These cannot replace the qualified pharmacists in general hospitals. Unfortunately except for the 1st and 2nd generation hospitals (S.Y.M.H., Argungu, Zuru, Yauri), all the pharmacy unit in other hospitals are manned by pharmacy technicians-who are not qualified to work in general hospitals.

Radiographers (Table 3.2e)

The situation with radiographers is the worst. There is no single radiographer in any of the state's hospitals including SYMH. This is unacceptable in modern medical practice-bearing in mind the large number of patients seen in the hospitals-and the vital role of x-rays in diagnosis.

Physiotherapists

There is only one physiotherapist in the whole state in S.Y.M.H.

## 3.5 FINDINGS ON SCHOOL OF NURSING AND MIDWIFERY, KEBBI STATE

Established 2003

Accredited 5th February 2007

by Nursing and Midwifery Council of Nigeria – full accreditation.

3.5.1 Programmes

1. Nursing
2. Midwifery

} Both accredited 5th February 2007

Facilities

Generally good.

Major problems of the school;

1. Hostel accommodation is inadequate
2. Allocation of ₦500,000.00 inadequate for running cost

## 3.6 FINDINGS ON SCHOOL OF HEALTH TECHNOLOGY, JEGA

3.6.1 Introduction

The School was established in 1978 in Former Sokoto State.

3.6.2 Programmes

It runs 5 professional programmes as follows:

| | Programme | Professional Accreditation Body | Accreditation Status/Date Visited |
|---|---|---|---|
| (A) | Medical Lab. Technician programme | MLSCN | Visited December 2007. Not yet accredited |
| (B) | Health Information Technician programme (new programme stated 6/Oct./2007 | HRORBW | Not yet visited expected visit on 5/5/2006. Not yet fully accredited. Programme started with permission of Board |

| | | | |
|---|---|---|---|
| (C) | Pharmacy Technician programme | PCN | Visited June 2007. Provisional accreditation in August 2007. |
| (D) | CHEW programme stopped since 2006 | CHPRB | Programme has been stopped school asked not to admit new students |
| (E) | Environmental Health | WAHEB EHORECON | Never visited. Not yet accredited. Major programme – lack of Environmental design ground |

3.6.3 Staffing situation

(A) Medical Lab. Technician programme

| | | Available | | | Comment on qualification |
|---|---|---|---|---|---|
| | Minimum Council Requirement | Full Time | Part time | Total | |
| Con/Chemical Pathologies | 1 | 1 | 1 | 2 | Qualified $ licensed |
| Con/Haematologists | 1 | 1 | 0 | 1 | Licensed |
| Con/Microbiologists | 1 | 3 | 0 | 3 | Licensed |
| Deficient Histopthalogists | 1 | 0 | 0 | 0 | Nil |
| Deficient Virologists | 1 | 0 | 1 | ½ | Licensed |

HOD Qualified.

- Secretariat Staff. 3 for the whole school. Inadequate.
- Stand-by generator for the School – not available.
- Library needs more stock of books

**A Comparison of the Current Situation on Consultant/Specialist Cadre with that of 1991 at Sir Yahaya Memorial Hospital, Birnin Kebbi**

| S/No | SPECIALITY | NOVEMBER 1991 | APRIL 2008 |
|---|---|---|---|
| 1 | Consultant Surgeon | 1 | 3 |
| 2 | Consultant ENT Surgeon | Nil | 1 |
| 3 | Consultant Physician | Nil | 2 |
| 4 | Consultant Opthalmologist | Nil | 1 |
| 5 | Consultant Dental Surgeon | 1 | Nil |
| 6 | Consultant Paediatrician | Nil | 1 |
| 7 | Consultant Gynaecologist | Nil | 1 |
| 8 | Consultant Pathologist | Nil | Nil |
| 9 | Consultant Haematologist | Nil | Nil |
| 10 | Consultant Orthopaedic Surgeon | Nil | Nil |
| 11 | Consultant Medical Microbiologist | Nil | Nil |
| 12 | Consultant Chemical Pathologist | Nil | Nil |
| 13 | Consultant Public Health | Nil | Nil |
| 14 | Consultant Demochologist | Nil | 1 |
| | | 3 | 10 |

**4.2 Physical/Materials**

**3.1.3 Status of Equipment in Primary Health Care Facilities**

The status of equipment in terms of adequacy, for antenatal care, out patient clinics, in-patient care, labour room and laboratories is extremely poor. In 15(45%) of the 124 Primary Health Care Centres visited, the remaining 18 (55%) PHCs have been adequately equipped by the Federal Government of Nigeria through the NPHCDA.

The 18 PHCs that need no extra equipment at the moment are as follows:

| Location | | LGA |
|---|---|---|
| Augie | - | Augie |
| Libata | - | Ngaski |
| Mahuta | - | Fakai |
| Kaliel | - | Bagudo |
| Besse | - | Koko-Besse |
| Felande | - | Argungu |
| Aljannare | - | Suru |

| | | |
|---|---|---|
| Raha | - | Bunza |
| Kare | - | Arewa |
| Dalijan | - | Gwandu |
| Makuku | - | Sakaba |
| Zamare | - | Yauri |
| Tungan Zazzagawa | - | Argungu |
| Bayawa | - | Augie |
| Digi | - | Kalgo |
| Raha | - | Shanga |
| Bui | - | Arewa |
| Ayu | - | Danko-Wassagu |

These PHCs however need boreholes and generators which are supposed to be put in place bys the State Government.

The estimated cost of construction of the boreholes and installation of the 25KVA generators has been given in Volume II of this report.

The remaining 15 PHCs irrespective of what is currently available in terms of equipment, urgently need improved in the equipment status to enable them provide the minimum standards of care required at the community level.

The standard equipment list required for Primary Health Care Centre is given in chapter 4 (see table 4.1).

### 3.1.4 Drugs and other Consumables

As has been mentioned under section 3.1.1.9, the DRF at the Primary Health Care facilities has collapsed. Furthermore, essential drug list (of the Federal Government of Nigeria or that of Kebbi State Ministry of Health) was not available in most of the Primary Health Care facilities.

**Specific Findings on General Hospitals in Kebbi State**

**Equity in Distribution**

All the general hospitals under Kebbi State Ministry of Health can be categorized into 4 groups based on year establishment.

Group I: Sir Yahaya Memorial Hospital – the oldest and the Premier Hospital established 1952 – the only general hospital owned by the State Government serving as a Specialist Hospital and offering both secondary and some level of tertiary care.

Group II: Five General Hospitals termed 'second generation' established in the 1980's-1990's.

Distributed – one per Emirate.
Argungu General Hospital (Argungu Emirate)
Koko General Hospital (Gwandu Emirate)
Yauri General Hospital (Yauri Emirate)
Zuru General Hospital (Zuru Emirate)

Group III: Third generation: (1990's-2000's)

Distributed as follows:

| | | |
|---|---|---|
| Argungu Emirate | - | 1 |
| Gwandu Emirate | - | 5 |
| Yauri Emirate | - | 1 |
| Zuru Emirate | - | 3 |

One of these in Zuru (Senchi) is part of public private partnership.

The 15 General Hospitals including Sir Yahaya Memorial Hospital are listed in Table 3.2 (a) – 3.2 (d)

Group IV: Primary Healthcare (PHC) recently upgraded to General Hospitals/ Construction of new ones.

These are 14 in number – with the following distribution:

| | | |
|---|---|---|
| Argungu | - | 2 |
| Gwandu | - | 8 |
| Yauri | - | 1 |
| Zuru | - | 3 |

Therefore, the overall distribution of general hospitals in the State (excluding Sir Yahaya Memorial Hospital) according to Emirates and LGA's is as follows:

Distribution of General Hospital in Kebbi State

| Emirate | LGA | 2nd Generation | 3rd Generation | New upgraded | Total |
|---|---|---|---|---|---|
| Argungu | 4 | 1 | 1 | 2 | 4 (12.9%) |
| Gwandu | 9 | 1 | 8 | 8 | 17 (54%) |
| Zuru | 5 | 1 | 3 | 3 | 7 (22.6%) |
| Yauri | 3 | 1 | 1 | 1 | 3 (9.7%) |

From this distribution, based on No of LGA's and Emirates, there is a fairly equitable distribution of general hospitals in the State.

## 3.2 FINDINGS ON SECONDARY HEALTH CARE FACILITIES

### 3.2.1 General Observations on 14 General Hospitals in Kebbi State (Nov., 2009)–(Sir Yahaya Memorial Hosp. Excluded)

#### 3.2.1.1 Nomenclature

General hospitals are meant to provide secondary health care to the community. This care is supposed to be of general clinical nature – covering at least, the 4 major clinical medical disciplines of medicine, surgery, obstetrics and gynaecology and paediatrics. In a general hospital set-up these 4 departments must be established, and they are all equally essential for the alleviation of the distress of patients and for saving lives. For such departments to be optimally functional they must be supported by hospital non-clinical support services and facilities (such as water and sanitation, security and safety, reliable electricity supply, adequate laundry service) and other essential supporting units, including laboratory and radiology services. The manpower needs of the hospitals have been addressed following the Technical Committee Report recommendations. All the hospitals have been rehabilitated at a total cost of about N200 million. Equipment and instrument worth N1.6 billion have been procured and delivered. A 24 number ambulances, 15 call duty vehicles and 15 mortuary vans have been procured and delivered. Furthermore, 12 numbers Toyota Hilux have been procured for monitoring and supervision services.

**3.2.1.2 Paediatric Care**: The situation up to April 2008 is as follows:-

Except for General Hospital Zuru, reasonable paediatric care at the secondary level is non-existent. Paediatric wards are a rare phenomenon. In a few hospitals where such wards exist, they are empty-devoid of patients and/or the necessary facilities. In a few hospitals that admit children, these sick children are forced to share the wards with sick adult females. Considering that children in our environment are most vulnerable to mortality and morbidity, and that they constitute 45% of the entire population and more than 50% of the outpatient and inpatient load, this trend is unacceptable and is contrary to the MDG on child health. Secondary health care facilities are supposed to be equipped to handle not only curative aspects of paediatric care, at a level higher than what is obtainable at the primary health care facilities, but also preventive and promotive aspects of child (similar to what is obtainable at the primary health care centres). The near – total neglect of provision of child health care facilities, as observed in 1991 in the general hospitals in Kebbi State by both the Task Force on Health and the Sub-Committee on Health for the Blue print of Development of the newly created Kebbi State, has virtually remained un addressed in the last 17 years. There is no Special Care Baby Unit (SCBU) in any of the State – owned hospitals. The implication is that many babies die of treatable conditions. Following the Technical Committee Report recommendation, the issues raised above have been addressed by the Implementation Committee on Health

3.2.1.3 **Surgical Care** April, 2008

The provision of surgical care in all the general hospitals is very poor. Surgeons in Kebbi State general hospitals are doing their best, but operate under extremely difficult circumstances – with inadequate theatre facilities, obsolete or improvised operating tables and no properly functional theatre lamps. The issues have now been addressed and required equipment procured and delivered.

3.2.1.4 **Utilities: Water Supply**

Following the Technical Committee Report recommendation, all the boreholes and electric generating sets have been rehabilitated and put to use. Furthermore, the monthly cash allocation has been increased from N50,000/N800,000 to N250,000/N3,000,00.

3.2.1.5 **Electric Power Supply**

All the 14 general hospitals are connected to PHCN. There are also 19 standby generators of various capacities. Five of the general hospital i.e. Argungu, Kamba, Koko, Wara and Wassagu have two generators each while the remaining 9 hospitals have one generator each. All the malfunctioning generators have been repaired and put to use at a total cost of N6,3007,010.00

3.2.1.7 **Laboratories**

Following the Technical Committee Report recommendation, all the laboratories have been rehabilitated and equipped with equipment procured at a total cost of N790 million Naira.

3.2.1.8 **Radiology**

Following the Technical Committee Report recommendation, 4 static and 15 mobile X-ray machines have been procured, supplied and installed at 15 general hospitals. The X-ray Technicians that we have and doctors have been trained by the suppliers on the use and maintenance of the machines.

3.2.1.9 **Central Centralizing Supply Department (CCSD)**

Following the Technical Committee Report recommendation, equipment for CCSD has been procured to allow for sterilization at the department.

3.2.1.10 **Drug Revolving Fund**

In all the general hospitals the Drug Revolving Fund has been rendered ineffective, mainly due to accumulation of unrefunded exemption bills. Following the Technical Committee Report recommendation, efforts are being made to pay the bills and recapitalize the scheme.

### 3.2.1.11 The Free Drug Policy for Pregnant Women and Children under 5 years

This programme is commendable. In the year 2009 drugs and medical supplies worth N561 million Naira have been procured and delivered, items have already been distributed to the 15 general hospitals.

### 3.2.1.12 Ambulance Service

The State Government has procured 24 number ambulances for our referral services. Ina addition, 15 number call duty vehicles have also been procured.

### 3.2.1.13 Running Costs

The monthly allocation given to the PMO's to run the hospitals have been increased significantly. The current monthly allocation ranges from N250,000 to N3,000,000 as against the previous allocation of N50,000 to N800,000.

### 3.2.1.14 Safety

None of the general hospitals has clear written evacuation and fire policies. Most general hospitals have no fire extinguishers

### 3.2.1.15 Rubbish Disposal

Most general hospitals have sent staff for short training on rubbish disposal, but no general hospital has clearly written cleaning policies or written policies on disposal of various types of rubbish. The method of rubbish disposal in most general hospitals in inadequate.

### 3.2.1.16 Mortuary Facilities

The State Government has procured and installed new chilling units at the 15 general hospitals at a total cost of N194 Million Naira.

### 3.2.1.17 Housemanship and Internship

There is not a single hospital in the State (SYMH inclusive) that is accredited for either housemanship (for new medical graduates) or internship (for intern-pharmacists and lab-scientists). The Technical Committee's inspection of facilities and staffing revealed that no hospital has satisfied the minimum standards of the accreditation bodies – i.e. the Medical & Dental Council of Nigeria MDCN- (for doctors), the Pharmacy Council of Nigeria – PCN (for pharmacists) and the Medical Laboratory Council of Nigeria – MLCN (for medical lab scientist) up to April 2008. However, following the procurement of equipment and employment of needed manpower, the PCN has accredited Sir Yahaya and is hoped that soon the MDCN will follow as well.

### 3.2.1.18 Lack of computers/Poor Record Keeping:

Except for Sir Yahaya Memorial Hospital, there is no general hospital with a single desk-top computer for use in the office and in Medical Record Dept. Even manual record keeping is very poor, generally. The International Classification of Diseases (ICD) manuals (2 volumes) are not available in any of the hospitals including S.Y.M.H. Manual or electric type writers are also not available. All the typing needed in these hospitals are done outside the hospital in commercial outfits. However, since the report was submitted, arrangement has been concluded to procure 79 units of desktop computers for hospitals.

### 3.2.3 Equipment base of the 14 General Hospitals (Group II & II Hospitals)

The equipment base of these hospitals adequate. This was as a result of the N1.6 Billion Naira worth of equipment for laboratories, pharmacist and X-ray procured.

### 3.2.4 Building Infrastructure

The 14 general hospitals have all been rehabilitated at a total cost of N200 Million Naira.

### 3.2.5 Utilities: Electricity

The problem with electricity supply in each of the 14 general hospitals have been addressed. All the generators have been repaired.

### 3.2.6 Utilities: Water Supply

There are 17 boreholes in 14 general hospitals, all the boreholes that were not functioning up to April 2008, have all been provided with the needed spare parts and are now functioning properly.

## 3.3 FINDINGS ON SIR YAHAYA MEMORIAL HOSPITAL, BIRNIN KEBBI

### 3.3.1 General Observations on Sir Yahaya Memorial Hospital

The hospital was established in 1952 and is the premier hospital in the state.

#### 3.3.1.1 Clinical Scope and Facilities

Sir Yahaya Memorial Hospital has been supplied clinical equipment worth N100 million. It has a total of 43 doctors out of which seven (7) are Consultants. There are 91 Nurses and Midwives in the hospital, 33 of which are midwives. The hospital has also some facilities for tertiary healthcare, e.g. some special laboratory investigations e.g. $CD_4$ cell count for management of HIV/AIDS, renal dialysis unit, ophthalmological, urological, dental surgery and ENT units and some equipment for special care baby unit (e.g. baby incubators).

#### 3.3.1.2 Management

The hospital-under the leadership of Dr. S. M. Kaoje the Permanent Secretary/Chief Consultant Surgeon/CMD. All the Departmental Heads of the hospital wish the CMD constitute the management.

#### 3.3.1.3 The Need for Accreditation of the Hospital for Housemanship and Internship

The facilities of this hospital has improved to enable the hospital achieve accreditation for training of house officers, pharmacy interns and medical lab scientists interns. Achievement of accreditation for training of these professional groups will greatly contribute to the manpower development of this important cadre of healthcare workers in Kebbi State. However, the hospital is deficient in a number of areas, and these deficiencies should be corrected before the hospital could gain accreditation from the various professional regulatory bodies e.g. Medical and Dental Council of Nigeria (for housemanship), Pharmacy Council of Nigeria (for pharmacy-internship) and Medical Laboratory Council of Nigeria (medical laboratory science-internship). Areas needing attention are highlighted under specific findings.

### 3.3.2 Specific Findings on Sir Yahaya Memorial Hospital With regards to Hospital Non-clinical Support Services and Facilities.

#### 3.3.2.1 Administrative facilities

Office rooms available are well furnished. However, some senior officers still share offices. More offices are needed.

#### 3.3.2.2 Office equipment/facilities

This is the best equipped hospital in terms of office equipment, with TV and satellite system, fridge, ACs and 3 laptop computers. More laptops, printers, internet access, scanner and file cabinets are needed.

3.3.2.3 Safety

Communication system within hospital is poor. The intercom machine got burned and needs replacement. A few fire extinguishers are available. More fire extinguishers are needed.

3.3.2.4 Utilities

Sir Yahaya Memorial Hospital has the best water supply system among all the state hospitals. It is connected to the municipal water supply system and has two functional boreholes, with an overhead tank. An underground tank is needed in addition to one borehole for the maternity ward. The electricity supply is fair. There are 4 stand-by generators: two 250KVA generators, one 187KVA Rolls Royce generator (which is >30years old, with unavailable spare parts) and one 30KVA generator. The Rolls Royce generator needs replacement.

3.3.2.5 Laundry Services

The industrial washing machines have broken down. The pressor is not functioning. There are no driers. Supply of more clean beddings, towels and washable blankets is urgently needed. However, the issue is being addressed by the Implementation Committee.

3.3.2.6 Cleaning Services

The little amount of overhead funds is also used to employ casual labourers-making maintenance of cleanliness inadequate. Equipment cleaning and cleaning of toilets is fair but more ward assistants (servants) are needed. However, the increased cash allocation from N800,000 to N3,000,00 tangible improvement would soon be realized.

3.3.2.7 Rubbish Disposal

Inadequate incinerators. Needle destroyers not available.

3.3.2.8 Facility and Utility Maintenance Service

Maintenance unit is functional and maintained on contract for maintenance of buildings, utilities, equipment and sewage system. There is no Biomedical Engineering Unit for maintenance of hospital equipment.

3.3.2.9 Pottering Service

Few wheel chairs available. More needed.

3.3.2.10 Catering Services

Free feeding for some patients. Service doest not cater for special diets for those requiring them.

3.3.2.11 Ambulance Services

Three ambulances available. A call duty vehicle, utility vehicle and mortuary van have been supplied to the hospitals.

3.3.2.12 Mortuary Facility

A 12-body capacity chilling unit available, functioning well. Additional chilling unit with 6 body capacity has been installed

3.3.2.13 CSSD

No CSSD at all and no trained staff. However, contract has been awarded worth N7.5 million to supply the CSSD to the four premier hospitals.

3.3.2.14 Physiotherapy

The unit is very narrow and needs expansion for equipment procured.

3.3.2.15 Support Services of Special Significance for Housemanship/Internship

There are no library facilities, books, journals or internet services. Similarly there are no side laboratories for the clinical departments. However, 28 houses that were under construction have been completed. These will no doubt facilitate housemanship/internship at the hospital.

### 3.3.3 FINDINGS ON CLINICAL EQUIPMENT AND FACILITIES Nov., 2009.

This is the best equipped hospital owed by Kebbi State Government. The level of equipment in both quality and quantity-particularly in the general surgical and urological specialists is good.

Medicine: Basic equipment such thermometers, sphygmomanometers and sunction machines are available. Oxygen concentrators and ambu-bags are available. Indeed all the need equipment were supplied early 2009.

Surgical Bed: There are no orthopaedic beds adequate basic equipment. There are two theatres 2 operating tables, but ceiling lamps need replacement. There is only one Boyle's anaesthetic machine. A good supply of basic surgical instruments, specialized instruments for Urology, Opthamologist, ENT Dental Surgery have been made early 2009.

O&G: Theatre available and its facilities are generally good. Basic equipment available, additional supply of equipment was made early 2009.

Paediatrics: No Special Care Baby Unit though incubators (3) available but the functional status is not known. This is the most poorly equipped at clinical department. However, needed equipment have been supplied equipped early 2009.

Other Clinical Unit: Intensive Care Unit is not available. Physiotherapy, Dental Unit, ENT, Ophthalmology have been properly equipped early 2009.

3.3.4 Clinical Support Departments

- The pharmacy dept is fairly equipped with excellent cooling system. There is room for improvement.
- The x-ray department has been equipped with a state of the art

- Static x-ray machines and a mobile unit.
- The laboratory is the best in the State and should be maintained. However histopathological investigations are not available. Facilities and expertise for these are also not available. This is a very serious problem for a hospital of this status.

3.3.5 Staff Compliment: Details on staff compliment with regards to doctors is shown in table 3.3.5.
There are only 7 Consultants/Specialists skewed to surgical sub-specialists with consultant physician offering clinical services in the hospital. The number of junior doctors is 27. This will affect delivery of services. Considering a minimum number of 6 junior doctors attached to one consultant (i.e. 2 non-consultant senior doctors and 4 non-consultant junior doctor) and a PMO needs 3 doctors attached to him/her, the shortfall on number of doctors is up to 36. Furthermore, consultants will be needed as shown in table 3.3.5(b) which shows that in 1991 when Kebbi State was created there were 3 consultants (2 clinicians and 1 public health specialist). The picture has changed by about 50% as shown in table 3.36, as against the table 3.3.5(b).

3.3.6 Building Infrastructure
The hospital is overcrowded with buildings and there is no room for future expansion.

## 3.4 FINDINGS ON SPECIALISED HEALTH CENTRES

3.4.0 Findings on Hafsat Eye Centre, Birnin Kebbi

3.4.1 Background Information
Cataract out-reached programme was first initiated in May 1997 by the State Government in collaboration with Sight Savers International, during which all the local governments were visited by the team and over 2,509 patients were screened. Eight hundred and eighty three patients (883) were treated of minor eye ailments while six hundred and twenty six (626) patients awaited major surgeries. This was however not possible due to some logistics problems.
Cataract out-reached programme became a reality only when the ten Governor of Kebbi State Alh. Muhammad Adamu Aliero approved the take-up of the programme. Four eye camps were organized and conducted in collaboration with Sight Savers International. T he first Eye Camp was organized and conducted in September 1999, second in December 2000 respectively. During the period, two hundred and four (204) patients were successfully operated upon and sights restored.

3.4.2 An Excellent Example of Public Private-Partnership
As a result of these achievements recorded by Kebbi State Government in collaboration with Sight Savers International in eye Care Programme, the TULSI CHANRAI FOUNDATION, an NGO from India also join in partnership with Kebbi State Government to provide Eye Care service to the people within and outside Kebbi State. Government in partnership with Tulsi Chanrai Foundation started to implement a Community Eye Care Programme in the year 2002 when

804 surgeries were successfully conducted and vision was restored to these needy patients. T he State Government seeing the success of the Eye Camp embarked on a new project of setting up a permanent Eye Centre in the state in partnership with the Tulsi Chanrai Foundation.

3.4.3 Scope and Clinical Services offered to the Community

Hafsat Eye Centre started as a permanent eye centre in the State in August 2004, and was officially commissioned on s10th December 2004, by His Excellency, the Vice President of the Federal Republic of Nigeria Alh. Abubakar Atiku (Turakin Adamawa). The Centre has so far conducted cataract surgeries to 1600 patients who are now able to see the colours of life once again with their own eyes. Thus in total the State Government in partnership with Tulsi Chanrai Foundation was able to restored sight to about 14,000 patients.

The Eye Care Programme run by the State Government and Tulsi Chanrai Foundation is unique in the sense that it served patients not only from Kebbi State, but also from various nearly states and neighbouring countries like Niger and Benin Republic. The cataract surgery was done in such away that no patient is charged a kobo as the state government in partnership with Tulsi Chanrai Foundation takes the responsibility of the cost i.e. it is done FREE OF CHARGE. Since its inception to date and the programme will continue to be free.

3.4.4 Achievement of the Centre

Hafsat Eye Centre was established in 2004. Since its inception it has successfully performed 14,000 surgeries. The centre is also serving as a raining institution for doctors and nurses. Furthermore, it has applied for accreditation visitation from the West African College of Surgeons and therefore needs to upgrade its facilities and improve infrastructure. Equipment for the centre has been ordered.

3.4b Vesico Vaginal Fistula (VVF) Centre, Birnin Kebbi

The Vesico Vaginal Fistula (VVF) Centre was established in 1993 but was moved to the new complex at Gesse Phase I in the year 2005. The Centre has 50-bed capacity and is patronised by patients from far and near. All the services including drugs are free at the Centre. Over 200 patients have successfully been operated.

Furthermore, the Centre is being managed by both the Ministry of Health and that of Women Affairs.

Facilities/Equipment

Most of the facilities are functional. Some of the facilities were provided by Non Governmental Organizations (NGOs). There are no mortuary facilities at the Centre.

Funding

The Centre has a monthly allocation of N150,000.00 as running cost.

Feeding of the Patients

The Centre receives N300,000.00 for feeding patients. This is a commendable gesture of the government, considering the fact that most of these patients of this nature are among the poorest. This is an important component of poverty alleviation and is in the spirit of Kebbi SEEDs.

Staff Situation

The Centre has two doctors and one NYSC doctor. The number of nurses and midwives is adequate, but there are not enough labourers to clean the wards on 24 hours basis.

Clinic within the Centre

The centre shares accommodation with Gesse Basic Health Clinic. This has been a source of friction between the management of both health facilities.

### 4.3 Financial

### 4.3.0 Health Financing

The major sources of health financing in Kebbi State are as follows:

FMOH

Ministry of Finance

FMOH MDGs

FGN MDGs

Local Government

Developmental Partners

Donors

Firms

Households

The State budget for health represents the Primary and major source of health financing especially for the Secondary Health Facilities while the Ministry of Local Government & Chieftaincy Affairs bears the cost for health at the LGAs.

The trends for total health expenditure as percentage of State budget is still difficult to arrive at because not all health expenditure has been captured. However, total health budget by State Ministry of Health as against Kebbi State Budget using 2008 and 2009 budgets is about 11%

| | **EXPENDITURE** | **SMOH BUD. (NIARA) 2008** | **2009** |
|---|---|---|---|
| | CAPITAL | 5.619 Billion | 5.24 Billion |
| | RECURRENT | 1.04 Billion | 1.432 Billion |
| **TOTAL** | | 6.659 Billion | 6.672 Billion |
| **STATE BUD. (NAIRA)** | | 61 Billion | 59.909 Billion |
| **HEALTH EXP.AS %AGE OF STATE BUD.** | | **10.92%** | **11.14%** |
| | | | |

### 4.3.1 Public Funding

Public expenditures budgeted and actual (recurrent) for 2008/2009. Find below breakdown according to major line items.

| S/Head | Details of Expenses | Estimates 2008 | Actual Expenditure Jan-Dec. 2008 | Estimates 2009 |
|---|---|---|---|---|
| 101 | Salaries and Allowances | 978, 000, 000.00 | 968, 737, 503.00 | 1, 215, 054, 038.00 |
| 102 | Transport and travelling | 5, 000, 000.00 | 5, 164, 200.00 | 20, 000, 000.00 |
| 103 | Utility Services | 800, 000.00 | 764, 750.00 | 1, 000, 000.00 |
| 104 | Telephone Services | 580, 000.00 | 388, 500.00 | 590, 000.00 |
| 105 | Stationaries | 1, 000, 000.00 | 890, 000.00 | 3, 000, 000.00 |
| 106 | Maint. of furniture/Equip | 1, 000, 000.00 | 3, 383, 250.00 | 20, 000, 000.00 |
| 107 | Maint of veh and C/assets | 2, 500, 000.00 | 4, 337, 750.00 | 10, 000, 000.00 |
| 108 | Consultancy Services | 0.00 | 0.00 | 0.00 |
| 109 | Grant and Contributions | 60, 000.00 | 0.00 | 60, 000.00 |
| 110 | Training and Staff Dev. | 2, 000, 000.00 | 1, 006, 000.00 | 13, 000, 000.00 |
| 111 | Entertainment and Hosp. | 60, 000.00 | 0.00 | 2, 000, 000.00 |
| 112 | Miscellaneous Expenses | 2, 000, 000.00 | 1, 483, 000.00 | 2, 000, 000.00 |
| 113 | Bicycle Advance | 0.00 | 0.00 | 0.00 |
| 114 | Seminars and Workshops | 200, 000.00 | 99, 000.00 | 5, 000, 000.00 |
| 115 | Replacement of Hosp Equip | 200, 000.00 | 97, 000.00 | 500, 000.00 |
| 116 | Contribution to Int. Org. | 50, 000.00 | 0.00 | 50, 000.00 |
| 117 | Medical Treatment Overseas | 40, 000, 000.00 | 79, 530, 536.00 | 80, 000, 000 |
| 118 | Drug and Dressing | 1, 000, 000.00 | 815, 000.00 | 1, 000, 000.00 |
| 119 | Vaccinations | 500, 000.00 | 431, 000.00 | 500, 000.00 |
| 120 | N.P.I and O.R.T | 25, 000, 000.00 | 24, 015, 050.00 | 25, 000, 000.00 |
| 121 | Health Education | 200, 000.00 | 0.00 | 1, 000, 000.00 |
| 122 | Medical Treat. In Nigeria | 17, 400, 000.00 | 20, 629, 500.00 | 17, 400, 000.00 |
| 123 | Drug abuse contr prog | 30, 000.00 | 0.00 | 30, 000.00 |
| 124 | Aid Contr. Prog | 500, 000.00 | 486, 000.00 | 500, 000.00 |
| 125 | Feeding of Patient | 5, 000, 000.00 | 3, 300, 000.00 | 5, 000, 000.00 |
| 126 | Print of medical records | 1, 000, 000.00 | 691, 500.00 | 1, 000, 000.00 |

| | | | | |
|---|---|---|---|---|
| 127 | Maint. of Generators | 2, 000, 000.00 | 0.00 | 2, 000, 000.00 |
| 128 | Cont Education | 0.00 | 0.00 | 0.00 |
| 129 | Out break of Disease | 3, 700, 000.00 | 1, 605, 000.00 | 4, 000, 000.00 |
| 130 | Health Information syst. | 500, 000.00 | 90, 000.00 | 500, 000.00 |
| 131 | Nurse Uniforms (student) | 1, 000, 000.00 | 1, 000, 000.00 | 1, 000, 000.00 |
| 132 | UNICEF Contr prog | 2, 000, 000.00 | 0.00 | 0.00 |
| | | **1, 093, 280, 000.00** | **1, 118, 944, 539.00** | **1, 431, 984, 038.00** |
| | SUMMARY OF RECURRENT EXPENDITURE | | | |
| 1 | Basic Salary | 593, 248, 399.00 | | |
| 2 | Leave Grant | 59, 324, 839.90 | | |
| 3 | Allowances | 272, 426, 761.10 | | |
| | **Personnel Cost Total** | **925, 000, 000.00** | | **1, 215, 054, 038.00** |
| 4 | Overhead Cost | 115, 280, 000.00 | | 216, 430, 000.00 |
| | **GRAND TOTAL** | **1, 040, 280, 000.00** | | **1, 431, 484, 038.00** |

Find details attached as annex

Government policy on user fees in public facilities, recovery rate and existence and effectiveness of exemption policies are on.

Population coverage of social health insurance (mandatory and pay roll deductions) is yet to be implemented.

Funds provided by donor agencies in form of project support

Resource allocation and budgeting mechanism used is Medium Term Expenditure Framework (MTEF).

### 4.3.2 Private funding

Private health expenditures (households, firms, NGOs, private health insurance, community financing schemese.g. Community based Poverty Alleviation Project (CPRP).

These have not been captured adequately because of non availability of appropriate mechanism and data collection tools.

### 4.3.3 External Funding

Major development agencies active in the health sector and their key programmes are listed below

- World Health Organization (WHO) - Immunization (RI/IPDs), Surveillance (AFP/Measles/YF) and Logistics
- United Nations Children Education Fund (UNICEF) – Immunization, Social Mobilization, Logistic management, Reproductive health (MCH)
- United Nations Population Fund (UNFPA) – reproductive health, operations surveys
- Tulsi Chanrai Foundation (NGO) - Eye Care
- Management Sciences for Health (MSH) – HIV/AIDs
- AQUIRE Project – VVF
- Global Health and AIDs Initiative in Nigeria (GHAIN) – HIV/AIDs
- SAMI TRUST – HIV/AIDs
- Sight Savers International – Eye Care

**ESTIMATES OF SUPPORT TO KEBBI STATE**

WHO (JAN-OCT 2009) – =N= 212, 439, 967.00 ANNEX--------

FMOH (DRUGS) – 200 Million Naira

FMOH MDG PROJECTS 18 clinics at 45M (12 completed) – 810 Million Naira

FGN MDGs 70 Clinics – 800 Million Naira plus 1 (one) Billion Naira Kebbi State

UNICEF----------

UNFPA ----------

Others 500 Million

# CHAPTER 5

## FINANCING PLAN

### 5.1 Estimated cost of the strategic orientations

Estimates for each component of Kebbi State SHDP

| | | |
|---|---|---|
| Leadership and Governance for Health | =N= | 841, 254, 500.00 |
| Service Delivery | =N= | 8, 446, 540, 500.00 |
| Human Resources for health | =N= | 6, 257, 670, 831.00 |
| Health Financing | =N= | 1, 610, 922, 000.00 |
| Health Information Systems | =N= | 537, 499, 666.00 |
| Community Ownership and participation | =N= | 292, 585, 005.00 |
| Partnership for health development | =N= | 757, 040, 000.00 |
| Research for Health | =N= | 1, 760, 339, 000.00 |
| Total cost of the Strategic Orientation | =N= | 20, 503, 851, 502.00 X 6 years |
| | =N= | 123, 023, 109012.00 (approx. 123 Billion Naira). |

### 5.2 Assessment of the available and projected funds

Available funds are from the sources below:

- Ministry of Finance (SMOH budget) which is approximately 6.7 Billion Naira per year
- Kebbi State Government (matching grants) approx. 2.0 Billion Naira per year
- Developmental partners approximately 2.0 Billion Naira per year
- FMOH which is approximately 500 Million Naira per year
- MDGs approximately 2.5 Billion Naira per year
- Donors and community approx. 700 Million per year

**TOTAL available and projected funds is 14.4 Billion Naira per year for Kebbi State**

For strategic plan 14.4 Billion Naira X 6 years = 86.4 Billion Naira

### 5.3 Determination of the financing gap

Financing gap = 5.1 – 5.2 (123 billion Naira minus86.4 Billion Naira) = 36.6 Billion Naira

### 5.4 Descriptions of ways of closing the financing gap

Ways of closing the gap includes resource mobilization strategies

- Influencing government and policy makers to increase allocation to health sector
- Attracting more development partners to Kebbi state
- Capacity building of the roles of all stakeholders towards buying and keying in into the SHDP
- Implement health programmes beneficial to communities and identify multilateral and bilateral agencies with special interest in such programmes
- Access and make effective and efficient use of health insurance schemes
- Sensitize philanthropists and communities to own and drive specific health programmes
- Generate funds through luncheons or involvement of companies and other groups operating within the State
- Training of Stakeholders on resource mobilization strategies.

# CHAPTER 6

## IMPLEMENTATION FRAMEWORK

### 6.1 REFERRAL SYSTEM

**Medical referrals in Kebbi State are basically of 3 types:**

(1)Referral within the health care delivery system in Kebbi State.

(2) Referral to other health facilities outside Kebbi, within the Nigerian borders

(3) Referral of patients for medical treatment abroad.

#### 6.1.1 Referral within the Healthcare Delivery System in Kebbi State

In Kebbi State there is one Tertiary Health Institution owned by the Federal Government (FMC, Birnin Kebbi) and one Specialist Hospital (SYMH) in the State Capital both hospitals provide secondary healthcare and some level of Tertiary Healthcare. In addition in Birnin Kebbi there are also2 specialised health institutions;

The Hafsat Eye Centre offers ophthalmologist care and the VVF Centre.

In addition there are 14 established general hospitals and 14 new hospitals under construction, indeed three have been completed. Additionally there are 124 PHCS and over 700 rural clinics.

Facilities exist to provide primary, secondary and tertiary care within the health delivery system in Kebbi State.

However, the referral system from one level of care to the next and the two-way referral systems are inefficient. The major challenges against efficient referral system are:

(1) At the primary healthcare level, the facilities are poorly funded leading to poor services and customer dissatisfaction resulting in massive self referral of patients to secondary and tertiary centres-converting the latter into primary healthcare facilities and rendering them less efficient.

(2) Most of the Primary Healthcares (PHCs) have no functional ambulances. Therefore referral care for delivery complications – a determinant of maternal mortality is least available to the poor in rural areas. The Ministry for Local Government and Chieftaincy Affairs has just procured 21 number Ambulances for referral services at the LGAs.

(3) The 14 well established secondary healthcare facilities have been supplied with equipment worth N50 million Naira each only. Furthermore, each of the hospitals have been supplied with an Ambulance, call duty vehicle and a mortuary van. Additional staff have also been recruited, under the MDG, 96 midwives have also been deployed to Kebbi State. With these huge investment it is hoped will translate into positive outcomes.

(4) Two-way referrals are rare partly due to poor ambulance services at LGAs and also attitude of both the patients and the healthcare providers. The secondary healthcare provider, after treating the patient from the rural areas rarely has the confidence to refer the patient to a rural facility of the patient's abode, because of lack of confidence in the ability of the rural health post to deliver proper treatment.

(5) Referrals between private providers of healthcare and the public institutions are rare due to the rivalry between the two groups of healthcare providers.

6.12 To improve the referral system and save lives, the following measures would be taken by the Government;

(i) Expediate action on the refurbishing of the Primary Healthcare (PHC) facilities through the KBSPHCDA and make these centres efficient.

(ii) Expediate action on the implementation of the recommendation of the Committee on equipping, rehabilitating and staffing of the PHCs and clinics in the LGAs.

(iii) Supervise the Local Governments through the KBSPHCDA

(iv) Encourage cooperation and collaboration between the for-project providers of health and the Kebbi State Ministry of Health through the public-private partnership programme.

(v) Continue to give assistance to the Federal Medical Centre, Birnin Kebbi.

### 6.1.3 Referral of Patients Outside Kebbi State to other Nigerian Health Institutions

In some cases patients will have to be referred from the health institution of Kebbi State to other Centres in Nigeria where highly specialized facilities and expertise are available for treatment of such cases. Improvement of facilities in Kebbi state will minimize unnecessary, costly and risky referrals to distant places. An efficient ambulance system is again necessary for such referrals, especially in precarious circumstances. The 24 ambulances should be put to use.

### 6.1.4 Medical Referrals Abroad

With regards to medical referrals abroad it should be borne in mind that:

(1) With regards to Civil Servants, approval for journeys outside Nigeria for medical treatment will only be given by the Ministry of Establishment on the recommendations of the Chief Medical adviser and will be confined to serious cases where a patient's life is in danger or where the examination is necessary for diagnosis of difficult cases, or to ensure that a patient is fully recovered to undertake the duties of his office (FGN, 1974).

(2) In the last 2 decades indigenous medical expertise has been allowed to drain elsewhere abroad, especially to the Middle East, Europe and North America and sometimes, even elsewhere in Africa, where facilities are provided and remunerations are attractive. Consequently, medical or surgical procedures that could be performed in Nigeria more than 30 years ago in Nigeria, by Nigerians such as open heart surgery, are no longer easily available in the country, because of deteriorating infrastructure and the exodus of experts to greater pastures (Ahmed H, 1996).

(3) There are, it seems, good reasons for occasional referrals abroad for a few selected patients who can afford the cost (Ahmed H, 1996).

It is recommended that:

(i) Government should intensify efforts to curtail those referrals that are unnecessary and ensure strict enforcement of relevant civil service rules.

(ii) Provision of conducive atmosphere and facilities in our health institutions will minimize needless and often risky trips for medical treatment abroad.

(iii) The modest allocation of N40 million for medical treatment abroad and N80 million for medical treatment in Nigeria (outside Kebi State) can be retained.

## 6.2 COMMUNITY PARTICIPATION AND INVOLVEMENT IN HEALTH CARE DELIVERY

### 6.2.1 Primary Health Care Level

The Committee recommends that the State Government adopts the Ward Health System as a deliberate policy to ensure community participation in PHC delivery. This is in line with the current National Health Policy.

The Ward Health System is based on the WHO review team of 1992 which noted that "Community mobilization would greatly be assisted if the boundaries of the health district are the same as the electoral ward (20,000 to 30,000 people) which elects a councillor to the LGA. The LGA – District/Village" structure, therefore gave way to the LGA-Ward Community/Village structure. The goal of the ward health system is to improve and ensure sustainable health services with full and active participation of people at the grass root level.

In order to make the WHS functional, there shall be established in each ward where a PHC health facility exists, a Ward Development Committee (WDC) selected by the community and headed by the elected councillor or the ward head with other influential member of the community as member and the head of the health facility in the ward as member/secretary.

6.2.1 Membership of the Ward Development Committee

1. Elected Councillor or Ward Head (Chairman)
2. Influential members of the Community (a minimum of 5 members)
3. Head of PHC facility – Secretary/member

6.2.2 Functions of the Ward Development Committee

1. Mobilizes and motivates active participation of the people.
2. Identifies health and social needs of the ward and plans for their solution.
3. Mobilizes local resources to meet the health needs of community.
4. Supports and monitors the implementation of work plans including activities of the community-based workers and health facility staff.
5. Forwards all health development plan to the LGA.
6. Provides feedback regularly to the communities
7. Serves as the linkage between communities and government/other parties.

There shall also be established Village Development Committees that have similar functions and operational guidelines to that of the Ward Development Committee but are limited to their respective communities/villages.

It is believed that if this system is implemented, it will improve and ensure sustainable health services with full and active participation of people at the grass root level. This is exactly the principle behind Primary Health Care.

6.2.3 SECONDARY HEALTH CARE

At this level, the hospital management committee being proposed should include in its membership, the most senior community leader in the area. This could be the Emir, District Head or Village Head as the case may be.

Inclusion of the Community leader in these management committee is expected to empower the communities to be part of the hospital management, recognize and take positive action, ensure resource mobilization for the success of the hospital in their domain.

6.2.4 Role of the Kebbi State Ministry of Health (KBMOH) in Community Mobilization for effective participation of the Community in Health Care

The Directorate of Primary Health Care of the KBMOH should be empowered, as a matter of urgency, to enable it collaborate with the relevant local governments department and other stakeholders to ensure mobilization of the local communities to form the ward and village development committees. Plan of action attached as annex.

It should be borne in mind that the process of mobilization and monitoring the progress of the ward health system are continuous and deserve regular monthly allocation of funds to make it effectives.

**6.3 PUBLIC – PRIVATE PARTNERSHIP**

There are various reports that indicate that in Nigeria the private sector contributes substantially to the health service delivery system (World Bank Reports 2005). The revised National Health Policy (2003) recognizes the importance of the private health care sector. This new policy also recognizes the need to develop public-private partnership in provision of health service delivery system that makes optimal utilization of resources, covers more people and improves the quality of care.

Collaboration with private health care sector already exists to a limited extent on some health issues including a few disease control areas and in delivery of some services in a few states in Nigeria including Kebbi State. The general consensus is that there is an opportunity to build on the good experiences and expand this public-private partnership.

The Committee made use of the recent classification of the private health care providers in Nigeria (World Bank Report No. 34177NG of 2005) as it applies to provision of private health care in Kebbi State. Similar to what obtains in other Nigerian states; private health care providers in Kebbi State are varied and consist of Patent Medicine Vendors (PMVs), private pharmacies, private hospitals and clinics, numerous drug hawkers, practitioners of traditional medicine and traditional birth attendants. The Committee mainly addressed areas of possible collaboration with organized private sector of health care provision.

6.3.1 Private health care providers

Private health care providers in Kebbi State consist of 2 main groups:

a) The for-profit providers
b) The non-profit providers

6.3.1.1 For-Profit Providers

For-profit providers include registered Patent Medicine Vendors (PMVs), registered pharmacy shops and registered private hospitals and clinics. There are 663 registered PMVs distributed across the whole state, 8 registered private pharmacy shops distributed thus: 3 in Birnin Kebbi, 2 in Yauri and 3 in Zuru. There are also 20 private accredited private hospitals and clinics offering services of general clinical nature.

Constraints in the Provision of Clinical and Preventive Services by For-Profit Private Hospitals and Clinics

1. Water Supply:

Assessment of for-profit private hospitals and clinics in Kebbi State revealed that most of them have serious problems regarding water supply. Even the biggest and best equipped of the hospitals (Godiya Hospital, Birnin Kebbi) has no borehole. Connection to municipal water supply is poor and the water supply is erratic. Similar to many hospitals in the State, the private hospitals and clinics also rely on water vendors for their supply.

2. Hospital Waste Disposal:

Furthermore, all the clinical hospitals have serious problems with regards to hospital waste disposal. It is commendable that Godiya Hospital –the best organized private, for-profit facility-has sent one pharmacist for training on hospital waste disposal. However, the waste from this hospital and from other private clinics is dumped in available open spaces on the outskirts of the towns. This method exposes the public (including children) to the hazards of hospital waste including infections and injuries form contaminated sharp objects.

3. Scope of Clinical and Preventive Services Offered:

A wide range of curative services are provided in the for-profit health facilities with little attention to preventive services. The equipment base of all the hospitals is very poor and often below the standard for provision of acceptable primary

health care. Although in many of such hospitals some secondary health care activities including major surgical operations (eg. Caesarean Section) do take place, the operating theatres are in poor condition and the equipment is rudimentary.

4. Neglect of Primary Health Care activities:

In some of the hospitals that conduct deliveries infant weighing scales are available, but there are no weighing scales for children. Therefore, basic primary health care activities such as growth monitoring – are not conducted. Other primary health care activities e.g. promotion of breast feeding, free immunization of children, free treatment of malaria for children and pregnant women and free treatment of tuberculosis cannot be conducted in private clinics because they attract no profit and will constitute a drain on the resources of the private providers – in both money and time. For similar reasons free voluntary HIV testing and counselling is not provided in the profit-driven practice.

5. Poor Referral System:

Private practitioners in Kebbi State tend to opt for small scale facilities. It is not surprising that they do not offer diagnostic services like x-ray and laboratory investigations (except for the most basic types). Therefore, these private facilities tend to rely on outsourcing or referral to public hospitals for radiological and laboratory investigations. In Kebbi State, these referral in the light of 19 X-rays machines procured will make it a lot easier. Within the state with good equipoment base of over N1.6 million, X-ray machine (19) procured at a total cost of N339 million, procured of 24 number ambulances, the referral system will be greatly enhanced.

6. Lack of Continuing Medical Education:

In-house training and continuing medical education is rarely available to private practitioners in Kebbi State. This professional isolation also compromises quality of services provided. Although the Medical and Dental Council of Nigeria has planned a programme of recertification in which evidence of continuing medical education will be required from all practitioners before the annual practising licence is issued, the council has not yet enforced this programme.

7. Other Peculiarities:

There is a general consensus (as has been shown in other states in Nigeria) that the main source of contraception is the private sector followed by the public sector and other sources in that order. Users of pills and male condoms tend to patronize the private sector, where as users of indictable and intrauterine devices tend to patronize the government owned health facilities. This peculiarity can be exploited by government to enhance family planning, HIV/AIDS prevention and other reproductive health measures.

6.3.1.2 The Private Non-Profit Providers

With regards to the private non-profit providers there are a few of such facilities in Kebbi State. The most prominent of these are the Sundu Bamaiyi Memorial Hospital, in Senchi, the Hafsat Eye Centre in B/Kebbi and some faith-based NGO clinics – the most conspicuous of which is the Muslim Umma Health Organization (MUHO).

6.3.1.2.1 Sundu Bamaiyi Memorial Hospital

This hospital was built and equipped by the Bamaiyi family. The State government has provided support with regards to staffing (including payment of salaries of the staff) and running costs of N400,000/month. The hospital in turn provides free curative and preventive services to the community.

6.3.1.2.2 Hafsat Eye Centre

This is an excellent example of public-private partnership in the provision of health care to the community and this centre has been covered in details in chapters 2,3 and 4 of the main report.

6.3.1.2.3 Muslim Umma Health Organization

This is a faith based NGO and provides non-profit curative and preventive services, and functions like other faith-based providers of health care such as the Christian Health Association of Nigeria (CHAN), which is the umbrella organization for church – sponsored health care programs in Nigeria. Faith-based NGOs as providers of health care play a less prominent role in Kebbi State than in other states – such as Enugu where the Christian mission facilities provide the majority of health care services (PATHS 2004). It has been reported that CHAN institutions collaborate with Muslim Organizations in some areas of health care e.g. interfaith forum on HIV/AIDS and sexual and reproductive health of which Federation of Muslim Women of Nigeria (FOMWAN) is also a member. There is evidence that some assistance from KBSMOH is rendered to Muslim Umma Health Organization in the provision of HIV testing and counselling of patients.

6.3.2 Contribution from Philanthropists

There is evidence from the public in Kebbi State that some rich individuals who want to contribute funds or facilities for improvement of health care in the state are not sure of the correct approach of doing this.

6.3.3.Private Pharmacies and PMVs

These are adequately regulated by the Kebbi State Ministry of Health.

### 6.3.4 The Role of the Ministry of Health

Similar to other Ministries of Health in Nigeria (World Bank Reports 2005) and those in many developing countries (e.g. Indonesia – WHO 2003, Middle Eastern Countries WHO 2004), the Kebbi State Ministry of Health traditionally focuses on government owned (public) hospitals and clinics. It is observed that while the Kebbi State Ministry of Health (KBSMOH) can give direct instructions and budgetary allocations to the public sector system including its public health components, which it completely controls, when it engages with other sectors and non-governmental providers it cannot give direct orders on every aspect of provision of health care. It is true that the Ministry can influence the conduct of these providers by various forms of regulatory actions – such as restrictive licensing, positive accreditation or outright closure of the health facility. This limited scope of the ministry seems to hinder collaboration with for-profit private provider of health care not only in Kebbi State but in many other Nigerian states. Furthermore the public-based providers and the for-profit private providers do not cooperate very well in the provision of health care for the populace – as the for-profit providers regard the public sector as rival competing for patronage of patients. Because of this rivalry, cross referral between the private and public sector is not common and is mainly dependent on personal relationships.

The Ministry of Health, similarly, cannot give direct instructions to public agencies in other sectors vital to improved health status of the population and achievement of the MDG, such as education, agriculture and nutrition sectors and water supply and sanitation along with provision of improved economic opportunities. The main function it can perform in such cases is mainly advocacy on intersectoral collaboration relevant to health issues of the population. The Committee observed that the Kebbi State Ministry of Health is ready to widen its scope if supported by government.

#### 6.3.4.1 Increase the Central Role of Kebbi State Ministry of Health

Public-private partnership can be enhanced and expanded by increasing collaboration of the Kebbi State Ministry of Health with private – providers of health care. It is essential that the Kebbi State Ministry of Health should take a wider view of its responsibilities than is traditional. A new strategy is urgently needed. This strategy should enhance the capability and cooperation of the private providers of health to participate in government's programmes that are aimed at improving health care of the population within the Kebbi State SEEDs plan aimed at achieving the MDGs. This public –private partnership should be extended beyond the regulatory role of the Ministry and should involve collaborative agreements on areas beneficial to the Ministry and the private providers of health care.

The Kebbi State Ministry of Health should also be involved in active intersectoral collaboration with relevant public sectors in areas that can significantly improve the health status of the community (e.g water supply, education & school health, environmental sanitation, agriculture etc).

6.3.4.1 Engagement of the Kebbi State Ministry of Health with Non-Governmental providers of Medical Care in specific areas

It is recommended that public-private partnership can be worked out in the following areas.

a) Child Immunization

The private facilities should be encouraged to offer free immunizations to children by supplying free vaccines bundled to the facilities.

b) Incentives to Private-Providers

With regards to other health related MDGs and other incentives to be given to the private providers that comply with Kebbi SEEDs should be considered-including waving or reduction of taxes.

KBSMOH could also assist the private-providers (who participate in its programmes) with regards to water supply, rubbish disposal and concessional consideration in electricity supply by PHCN.

**Disease Control Programmes**

Modalities could be worked out on how to involve private providers in disease control programmes by providing not only vaccines for child immunizations but also anti TB drugs free of charge to private providers who want to participate in the programs; as has been done in some States of the Federation.

**Involvement of Non-Profit Providers in the Free Drug Scheme of the State Government**

The non-profit providers of health care should be encouraged to participate in the free drug scheme of the State Government (Sundu Bamaiyi Memorial Hospital, Faith-based NGOs). The allocation of N400,000.00 to Sundu Bamaiyi Memorial Hospital have been increased to from N250,000 and is commendable.

**Assistance to Hafsat Eye Centre**

The Hafsat Eye Centre's requirements should be addressed urgently (these have been highlighted in the relevant sections)

**Creation of a Unit of Public-Private Partnership**

A unit of public private partnership could be established in the KBSMOH with the aim of coordinating public-private partnership in various areas of health care. The unit should be equipped to carry out advocacy on this partnership and invite the public to participate. Philanthropists interested in participation in the partnership should know who to approach and what areas of priority exist for this partnership.

## 6.4 DRUG REVOLVING FUND (DRF)

### 6.4.1 Initial Seed Stock

The Drug Revolving Fund started with initial seed stock money of N1,000,000.00 provided by the Federal Government in 1990 (Former Sokoto State). Furthermore the former Sokoto Health Project purchased drugs worth N30,000,000.00. Following the creation of Kebbi State in 1991 the share for Kebbi State was one third of the total (the sharing formular after Kebbi State creation). The total drug seed stock for Kebbi State came to about N10,400,000.00.

### 6.4.2 The Problem of Lack of Refund of Waivers/Exemptions

From the seed stock, drugs worth over N5,000,000.00 were supplied to the 16 local government in 1991 – 1994 (as they were then), out of this few Local Government have shown to make some payments. And as at April 2007, the local government had an outstanding balance of N4,260,659.48 to be paid to the DRF account (see table below). Unpaid exemption bills from various hospitals Epidemic Control, Boarding School, Hajj Camp Operation, Fishing Festivals etc in the state amounted to N8,692,129.80 as at 2002/2003. Therefore the current unpaid money due to accrue to the DRF account is N12,952,789.20. This shows that exempted cases has eaten deep into DRF capital.

### 6.4.3 OUTSTANDING PAYMENTS AGAINST LGAS IN THE STATE

| S/No | Local Govt. | Outstanding Amount |
|---|---|---|
| 1. | Jega | 289,319.95 |
| 2. | Arewa | 241,553.95 |
| 3. | Argungu | 250,192.30 |
| 4. | Bagudo | 431,2421.01 |
| 5. | Birnin Kebbi | 335,389.38 |
| 6. | Bunza | 337,001.41 |
| 7. | Dandi | 241,680.99 |
| 8. | Wasagu | 299,653.80 |
| 9. | Zuru | 5,892.85 |

| | | |
|---|---|---|
| 10. | Gwandu | 282,026.75 |
| 11. | Koko/Besse | 90,920.98 |
| 12. | Maiyama | 291,123.84 |
| 13. | Ngaski | 369,292.64 |
| 14. | Sakaba | 217,166.90 |
| 15. | Yauri | 336,983.50 |
| 16. | Suru | 243,219.26 |
| **TOTAL** | | **N4,260,659.50** |

6.4.4 Procurement Method of DRF

The procurement method of the DRF is usually by contract method at ministerial level. This method is not cost effective and counter productive since contractors are bound by profit making. This makes the final drug cost to the patient exorbitant. This negates the very fundamental principles of DRF – which is to ensure steady supply of good quality drug at affordable price.

6.4.5 Unpaid Exemption Bills

The Committee recommends the urgent refund of exemption bill amounting to N8,694,129.80 to the DRF account.

6.4.6 Local Government's Unpaid Drug Supplies

The Local Governments should be directed to pay N4,260,659.48 to the DRF account which is a fall out from drug supplies made to them by the State Government from DRF stock.

6.4.7 Regular Refund of Exemptions to DRF

Exemption bills should be paid at least quarterly to prevent accumulation and depletion of the DRF account. Exemption policy should be reviewed.

**6.4.8 Facilitating Monitoring of DRF Operations**

A four-wheel drive vehicle should be made available to DRF unit for close monitoring of the DRF operations.

**6.4.9 The Need for Additional Seed Stock**

In addition to the unpaid balance, N20,000,000.00 should be urgently added to the seed stock of the DRF to enable it operate efficiently.

**6.4.10 Improvement on Procurement Method for DRF**

The Committee strongly recommends for the procurement of drug meant for DRF to be by direct purchase from manufacturers not by contract. This, in the opinion of the Committee, will make final cost to the patient affordable.

Furthermore, there are many other advantages of this method of drug procurement: Drug source directly from manufacturers are standard, qualitative,

effective and manufactured according to official specification of NAFDAC and other regulatory bodies and are therefore devoid of faking; Direct procurement is cheaper and cost effective since the issue of middlemen/distributors does not arise; it ensures drugs with long shelf life are delivered to the State. Experts are involved in manufacture, transport, handling up to the State Medical Store thereby eliminating degradation of the active constituents due to ignorance of the supplier who is not an expert in the field.

## 6.5 FREE DRUG SCHEME TO PREGNANT WOMEN AND CHILDREN UNDER 5 YEARS OF STATE GOVERNMENT

**6.5.1** The free drug or Health Service to pregnant women and children under five years was started in the year 2000 by the State Government. And it appears Kebbi State was the first to start the programme after which others copied. This poverty alleviation programme may have been informed by high cost of drugs and medical supplies, and the low capacity of the population to pay for these drugs due to extreme poverty. This good gesture from the government will prevent catastrophic household health expenditure (Xu et al, 2003, World Bank Reports, 2005, Ahmed, 2007)

As at 2006 drug worth about N500,000,000.00 have been invested in the programme. The impact can be seen in various hospitals. In year 2009 drugs and medical supplies worth N561 billion have been procured.

### 6.5.2 Scope of the Scheme

The programme is restricted to state government hospitals only, which are mostly in the urban centres.

The scheme covers pregnant women and children under 5 years.

### 6.5.3 Procurement Method of Drug under the Free Drug Scheme

This is usually by contract method to various individuals, companies and sometimes to individual who have no knowledge of pharmaceuticals.

6.5.3.1 Wider Coverage

The scheme should continue and be extended to local government health institutions in the state where poverty is at its worst level. Local Government should be encouraged to contribute funds to the scheme.

6.5.3.2 Customized Contract Procurement

It is recommended that drug procurement under this scheme should be by customized contract manufacturing with inscription "Property of Kebbi State Government" on the drugs. This will minimize pilfering and stealing of the drugs. Since manufacturers are involved, drug delivery can be staggered as and when due.

6.5.3.3 Cost of Drugs for 1year

The population of Kebbi State is projected to be about 3.4 million (2006). Children under 5years constitute one quarter of a given population; this is also true of women of child bearing age. Therefore, about half the population is expected to benefit. The Committee, after due consideration of the population, drug quantification, and studies of the Kebbi State Health System Development Project II (2005) have come up with N500,000,000.00 to be set aside for the programme for 1year.

6.5.3.4 Subsidized Surgical Material (50% Subsidy)

This programme is laudable and should be continued. However, the subsidy should be sustained to prevent depletion of the stock. Otherwise after 4 rounds of supply and purchase, the funds will be completely exhausted. Therefore the funds should be replenished after every purchase.

## 6.6 STATE MEDICAL STORES

The State Medical Stores was constructed immediately after Kebbi State creation. The store is meant to keep all drugs and related materials in good condition. The store consists of 3 big stores and a small store meant for thermolabile products. Attached to the store is a small drug quality control laboratory meant for on the-spot quality test of drugs coming into the stores.

The 3 big stores are marked store A, B. & C. Store A for storage of infusion, syrups capsules and ointments while store B is for tables and injections. And store C meant for storing surgical consumables.

**Condition of the Structure**

The structure is solid but needs rehabilitation as the roof is leaking. The store has now been rehabilitated with three giant industrial Air Conditions installed to each.

**Equipment of Quality Control Laboratory**

The equipment are in deplorable condition, old and obsolete. The equipment for the slide laboratory have now been procured and supplied.

**Cooling System**

The cooling system is inadequate as there are only 15 fans and air conditions available to provide the required temperature for drug store conducive. No thermometer for monitoring the temperature of the stores.

**Store Vehicles**

The two vehicles are grounded.

**Fire Extinguishers**

There are only 2 fire extinguishers for the whole structure.

**Book Keeping**
Ledgers tally cards, S.I.V. & SRV's are all kept and updated.

**Staffing**
At least more pharmacists and one technicians are recommended to be employed for the store.

**6.7 National Health Insurance Scheme (NHIS)**
Currently, health financing in most developing countries-including Nigeria relies predominantly on out of pocket payments (OPP) by individuals at the time of treatment. Although a National Health Insurance Scheme has recently been introduced in Nigeria (Airede LR, 2003), the scheme is still in its initial stages of implementation and has not yet covered all Nigerians including the poor, unemployed and the rural populace. Another consequence of OPP is what is currently termed catastrophic health costs (CHC) or catastrophic health expenditure (CHHE). CHHE is defined as spending 40% or more of household income on health problems after meeting subsistence needs. Nigeria's rate of CHHE is within the high range (i.e. more than 5% of the population may be affected by CHHE – Ahmed, 2007). This is so because all the three components leading to CHHE are prevalent in the country – i.e. services requiring payments, low capacity to pay and lack of repayment or health insurance.
Out of pocket payments account for 68% of total health financing in Nigeria (World Bank reports 2005). Out of pocket payments by the poor are considered the most regressive form of healthcare financing because the poor's burden of payments for health services and catastrophic health expenditures are not shared by the richer segments of society (World Bank, 2005).

There are currently six programmes of the NHIS (NHIS Handbook 2002).

1- The Formal Sector Social Insurance Health Programme – is expected to cover formal sector employees-made up or public sector employees and those of the organised private sector (OPS). Only OPS members of 10 or more employees are qualified to participate in this programme. The contribution rate is 15% of the employee's basic salary with the employer paying 10% and the employee 5% to make up the total. The beneficiaries are the contributor, one spouse and up to 4 children under 18years. Benefit package covers wide range of healthcare, except malignancies and ARV drugs.

2- Rural Community Based Social Health Insurance Programme.

3- Urban Self-Employed Social Health Insurance Programme.

4- The Children Under-Five Social Health Insurance Programme. This is wholly funded by the Federal Government of Nigeria and administered by National Health Insurance Scheme.

5- The Permanently Disabled Persons Social Insurance Programme-again wholly sponsored by Federal Government of Nigeria.

6- The Prison Inmates Social Health Insurance Programme also paid for by the Federal Government of Nigeria and administered by National Health Insurance Scheme.

There is evidence that all the 6 schemes have now commenced at various levels of operation in various parts of the country. In Kebbi State, it seems only the employees of Federal Government of Nigeria are currently involved in the scheme (Scheme No 1).

The Kebbi State Government has not yet been involved in any of the schemes. It is, however, worth noting that the free drug scheme of the Kebbi State Government for the under-5 and pregnant women is a form of an insurance against OPP for these most vulnerable groups of patients.

It is recommended that the Kebbi State Ministry of Health should dialogue with the National Health Insurance Scheme officials on how the State Government can fit into the scheme for the benefit of Kebbi citizens.

The following documents should be available to Kebbi State Ministry of Health officials for perusal.

1. National Health Insurance Scheme: Handbook. Heritage Press, 2002.
2. National Health Insurance Scheme: Operational Guidelines, Abuja. Heritage Press 2002.
3. National Health Insurance Scheme: Rules and regulations Abuja. Heritage Press 2002.

## 6.8 SCHOOL HEALTH SYSTEM

This important aspect of health care is virtually non existent in the vast majority of boarding in the State. Even the best school with regards to school health programme, scored below the minimum acceptable standard based on recognized scoring system for this aspect of paediatric care. It is therefore recommended that attention should be paid to the following three components of the school health programme:

1. Health Care Services:
   In most of the schools there is no health care personal of any type to supervise the health programme. It is advised that a health supervisor e.g. health educator, nutritionist, nurse/midwife/doctor should be involved in provision of health care services in boarding schools.
2. Time allotted to health institution should be increased to a minimum of 2 periods/week, and the scope/conduct of health education curriculum should conform with the one suggested in appendix viii of this report.
3. Attention should be paid to healthful school environment-by improving water supply and access to safe water, refuse disposal, sewage disposal, adequacy of toilets (minimum of 1:20 pupils) and ensuring safety of buildings in the school.
4. The school health programme should be resuscitated urgently and should form part of responsibilities of the Inspectorate Division of the KBSMOH.

**6.9 Health Services Management Board/Hospital Management Committee**

In 1996 Kebbi State established Hospital Management Committees for each hospital. T here is an edict on this. At the same time the law in Kebbi State, also provides for a Hospital Management Board. Both edicts are still in the laws of Kebbi State.

Currently, however it is the Hospital Management Committees that are operational. There are arguments against and for both systems. The Health Services Management Board is highly centralized and delegates little financial responsibilities to the hospital management. With the Hospital Management Committees hospital staff and the local community are delegated to mange the hospital with supervision from the Ministry. The Hospital Management Committees can be effective if funding is for running costs is adequate, otherwise collapse of the system is eminent. For Hospital Management Committee to function effectively, proper funding is needed.

It is recommended that Health Management Committees system be continued. M & E from the Inspectorate Dept. should be able to assess the efficiency of this system within 2 years. Funding the hospital on running cost should be increased as recommended.

**6.10 MENTAL HEALHT CARE**

The Committee accepts the expert report from Professor Obembe a renewed psychiatrist who physically inspected the facilities of the mental home in Jega. Recommendations attached are endorsed by the Committee for implementation by Government.

The Rehabilitation Centre was established in 1997 by Col. S.B. Chema under the supervision of Ministry of Women Affairs and Social Development. It has 20 beds with capacity for additional 20 beds. The bed occupancy rate is one hundred percent (100%) and records average of 3 new psychiatric cases weekly. A Consultant Psychiatrist visits the centre once every fortnight.

Averagely a patient on admission takes two (2) months to improve. The Ministry for Women Affairs and Social Development takes complete care of the patient's needs including feeding, accommodation and medication. The nurses dispense and administer prescribed medication and when such drugs are not available at the Centre, patients have to travel to Birnin Kebbi to purchase them. There is no single pharmacy shop in Jega. Water is available as there is a functional bore-hole system. The only available source of light is from the Power Holding. There is no stand-by generator.

STAFF SITUATION

Staff compliments as on 10th April 2008:

| S/N | Designation | Rank | No. |
|---|---|---|---|
| 1. | Officer-in-charge Social Worker | Principal (SWO) | 1 |
| 2. | SWO | SWO I | 1 |
| 3. | Messenger | - | 1 |
| 4. | Attendant | - | 3 |
| 5. | Security Officer | - | 1 |
| 6. | Cooks | - | 2 |
| 7. | Chief Nursing Officers (from Min. of Health) | - | 2 |
| 8. | Community Health Extension Workers | - | 4 |

The Centre was formerly a lodging facility and has suffered neglect and is completely in a state of disrepair. The wards have no ceiling, the walls have cracked and virtually there is no kitchen. Food is being prepared in the open. I was privileged to meet the visiting consultant psychiatrist consulting under a tree shade. Three rooms are fully equipped each with carpentry tools, sewing and knitting and computers. These were donated by the British High Commission as vocational tools. These tools are yet to be utilized since installations.

The World Health Organization proposes that community-based mental health services should be developed through integration of mental health into existing Primary Health Care system and mobilization of community resources. This system is more accessible, affordable, efficient and effective. It is important to develop a culturally-sensitive approaches and models that can be adapted to the Kebbi State situation. It must be accessible, comprehensive and equitable. Important obstacle has been lack of human resources and the difficulty retaining staff especially in the rural areas. In order to facilitate detection, referral and rehabilitation of persons with mental disorders, it is necessary to collaborate with traditional leaders and spiritual leaders. The community is also important in providing a base of local expertise upon which mental health care might be built. The community needs to be sensitized regarding mental disorders and anti-stigma campaigns. The absolute necessity of a reliable supply of essential medications and need for transport facilities for outreach and attending to the logistical aspects of providing care are important.

For a population of about 3.239 million, Kebbi State needs 14 psychiatrists (recommended: 1 psychiatrist to 250,000). It is being proposed that the State Government should deliberately seek out its indigenes who are interested in Psychiatry, and there are quite a lot of them in the medical school (UDUS). Two (2) at a time can be sent to Jega as corpers. At the end of service year they should be encouraged to have the Diploma in Mental Health being coordinated by the Faculty of Psychiatry of the West African College of Physicians at the Department of Mental Health, Obafemi Awolowo University, Ile-Ife as a short term measure. It is one (1) year programme leading to a Diploma of the College. On return they should be sponsored to any of the accredited University Departments of Psychiatry or one of the eight (8) Psychiatric Hospitals in the Country for a four (4) year Fellowship training programme in Psychiatry as a long term measure. This could be worked out for other members of the "psychiatric team".

- Clinical Psychologists
- Psychiatric Nurses
- Psychiatric Social Workers
- Occupational Therapists

The Federal Ministry of Health runs programmes at the Psychiatric Hospital, Yaba, Lagos in Occupational Therapy and Psychiatric – Social Work. A training school exists in Sokoto for psychiatric nurses.

The School of Health Technology in Jega should be strengthened to train sufficient Community Health Extension Workers with appropriate exposure to mental health care. Also needed are the community health officers and the importance of linkage with educational system and the judiciary.

All the staffs should be encouraged and supported in attending refresher courses and short courses to keep them in tune with current innovations in mental health care and its adaptation.

In order to avoid turnover of staff which undermines every effort to expand provision of mental health care, there is need for strong support in the field together with adequate remuneration.

The nomenclature of the Centre need to be more appropriate and under a proper ministry. It is proposed that the State should have a psychiatric hospital of its own in the Ministry of Health, with a department of mental health in place. Owing to the peculiar nature of the local government distribution into the senatorial districts, four (4) community-based mental health services integrated into the existing PHC is being suggested along emirate councils.

| Emirate Council | L.G. (Proposed) |
|---|---|
| Argungu | Argungu |
| Yauri | Yauri |
| Zuru | Zuru |

It is expected that these three (3) local governments are central enough in their various emirate council to serve the citizens. Since the responsibility for the finance of the PHC falls on the LG, the LGs in each council should be able to jointly fund the service, possibly deducted by the State Government from source, mutually agreed. Severe mental disorders in these services can then be referred to the State Psychiatric Hospital at Jega.

The State Psychiatric Hospital would need expansion for:

- Administrative block with secretarial staff
- Staff offices
- Ambulance
- Functional kitchen
- Consultation rooms
- Nursing stations on the wards
- Stand-by generator
- Psychiatric nurses
- Psychiatric social workers
- Psychiatric beds
- Regular supply of essential psychotropic drugs
- Refrigerators
- Occupational therapist for vocational/recreational aids especially (tailoring and carpentry)
- Pharmacist and pharmacy technicians.
- Laboratory and other life support systems.

## 6.11 EPIDEMIOLOGICAL UNIT

The Epidemiological Unit should be supported to function effectively. It is recommended that:

1. Distribution of Insecticide Treated Nets (ITN) be extended to isolated communities like the Cattle Fulani and the reverine communities within the State.
2. Residual spraying should be supported including supply of lavaecides.
3. The World Bank Assisted project on malaria control is worth participating in.

## 6.12 REQUEST FOR ASSISTANCE FROM FEDERAL MEDICAL CENTRE, BIRNIN KEBBI: COMMITTEE'S ASSESSMENT AND RECOMMENDATIONS

This Federal tertiary institution is very important in the healthcare delivery system of Kebbi State as it offers secondary and tertiary healthcare to the populace and is an important base for future training of House Officers, Resident Doctors, Pharmacy Interns, Laboratory Interns and Physiotherapy Interns. It compliments the efforts of the State Government in improvement of the health status of the population and attainment of Millennium Development Goals (MDGs).

A memorandum received from the Management of the Hospital requested for assistance from the State Government in the following areas:

1. **Construction of a Paediatric Surgical Ward.** Estimated to cost ₦20 million and equipment worse ₦25 million. Note that list of equipment with quantity and unit cost has not been indicated in the memorandum.

2. **Construction of a Trauma Ward.** Estimated to cost ₦25 million and equipment worse ₦30 million. Note that list of equipment, quantity and unit cost has not been indicated in the memorandum.

3. **Construction of Amenity Ward.** Estimated to cost ₦30 million and equipment worse ₦40 million. Note that list of equipment, quantity and unit cost has not been indicated in the memorandum.

4. **Construction of three (3) block of Classrooms and stock of Library books in School of Optical Dispensing Technology.** Estimated to cost ₦15 million and Optical workshop worse ₦20 million.

   Other observations in the memorandum have been taken into consideration in various parts of the report.

   The estimated cost of projects requested amount to ₦205 million.

It is the view of the Committee that this institution should receive some form of assistance to enable it function effectively. Details on the construction plan and cost of individual equipment is required for guiding the Government on the level of assistance to be provided by the Kebbi State Government.

# CHAPTER 7

## MONITORING AND EVALUATION

7.1 Proposed mechanisms for monitoring and evaluation

7.1.1 The 1991 Report of the Committee on Blue Print for the Development of Kebbi State (Health chapter) recommended that there should be regular inspection of the secondary health institutions. The Task Force Committee on Health (1991) for the newly created Kebbi State recommended the reorganisation of the Kebbi State Ministry of Health according to the then civil service reforms which assigned the role of monitoring and evaluation to the Directorate of Planning Research and Statistics, which replaced the Inspectorate Division that used to carry out the function of monitoring and evaluation.

Over the years, the Inspectorate Division has been virtually dormant due to poor funding of its activities-rendering monitoring and evaluation of programmes and other regulatory functions difficult or impossible to perform.

7.1.2 The Urgent Need for Empowering the Kebbi State Ministry of Health to carry out effective Monitoring and Evaluation.

Currently, the need to create the Inspectorate Department of the Ministry for effective monitoring and evaluation of its programmes is very urgent for the following reasons.

1. Monitoring and evaluation of the health sector is crucial for achieving the objectives of the Kebbi SEEDS with regards to attainment of the health-related MDGs.

2. The traditional regulatory role the ministry can be effective only if there is efficient monitoring and evaluation.

3. With the widening of the scope of the ministry beyond its traditional role, and with its commitment to be involved in collaborative engagement on important health innovations such as public-private partnership and mobilization of the communities for effective community participation in healthcare delivery, the Inspectorate Division together with the Directorate of Primary Healthcare will need to play a central role in monitoring and evaluating the effectiveness of programmes.

4. Having heavily invested in infrastructural rehabilitation of healthcare facilities and the procurement of vast amount of hospital equipment, the Government needs to monitor the availability of the health resources provided, and how effectively these resources are managed.

5. The free drug scheme of the Government for pregnant women and children needs continuous assessment of performance.

6. Other investments of the Government such as procurement of ambulances for improvement of the referral system can be protected by monitoring and evaluation.

7. Through effective monitoring and evaluation, inefficiencies in programmes and public expenditure can be detected and corrected, and transparency, accountability and efficiency will improve.

7.1.3 Facilities and Funding

To enable the Kebbi State Ministry of Health (KBSMOH) carry out its statutory functions, including effective monitoring and evaluation the current monthly allocation ₦700,000 is grossly inadequate.

The State Government has approved N3.5 million monthly cash allocation.

The State Government has procured 1-8 seater bus, 12 Toyota Hilux for monitoring and supervision.

7.2 Costing the monitoring and evaluation component and plan

The monitoring and evaluation plan is on the drawing board and will incorporate all the monitoring and supportive supervision aspects of the Kebbi state SHDP in an integrated manner employing an integrated tool to be designed to capture relevant indicators in the 8 components of Kebbi state SHDP.

# CHAPTER 8

## CONCLUSION

The Strategic Health Development Plan (2010-2015) with a costed estimate of 123 Billion Naira, has the eight basic components affecting quality and effective provision of health services. With the depth and excellent layout of the Strategic plan, implemented with political will by the various levels of government and all stakeholders keying in, will definitely result in Kebbi state health indices improving well above average for the North West zone, Nigeria and Sub- Sahara region as a result of sustainability and universal access. The estimated cost of the 2010 operational plan is 20.5 Billion Naira.

There is need to salute the courage of The Federal Ministry of Health taking the bull by the horn at this point in time to accelerate achieving health indicator goals especially the MDG related goals with the development and hopefully implementation to the later of the National and State Strategic Health Development Plans.

The firm commitment of the Executive Governor of Kebbi State. His Excellency Alh. Sai'idu Usman Dakingari and his health team headed by the Honourable Commissioner of Health is an example to be emulated.

**ACKNOWLEDGEMENT**

The development of Kebbi State Strategic Health Development Plan (KBSSHDP) 2010-2015 had input from various organizations and individuals without whom it would have been impossible to have KBSSHDP.

The support of Kebbi State Government through the State Ministry of Health is worth mentioning for being on the driver seat towards ensuring that everything within their power was done to ensure that Kebbi State Strategic Health Development Plan 2010-2015 and 2010 operational plan were developed and costed.

First and foremost, the United Nations Population Funds (UNFPA) is commended for their support to Kebbi State in the provision of training funds and being responsible for the State Consultant Dr. Peter Edafiogho. The WHO State Coordinator Dr. Isameldine Mirghani and his team of consultants were wonderful in their technical support. The UNICEF consultants cannot be forgotten in a hurry for their contributions and technical support.

The zeal, drive and commitment of the Permanent Secretary Kebbi State Ministry of Health, Alh. Umar J Ahmad who is always supportive and with a listening ear and informed views is acknowledged.

We thank the planning team and the steering team most especially the directors and the secretary to the steering committee.

The secretariat support of Bose Omonisi and the senior driver Shehu are acknowledged.

Finally we thank God for the successful completion and development of KBSSHDP as well as others who have contributed in many ways.