AIDS	Acquired Immune Deficiency Syndrome
ATBLCP	Adamawa State Tuberculosis and Leprosy Control Programme
DLS	*Director Laboratory Services*
DOTS	Directly Observed Treatment Short-Course
FMOH	Federal Ministry of Health
GHCW	General Health Care Worker
HIV	Human Immono-Deficiency Virus
LGA	*Local Government Area*
LGTBLS	Local Government Area Tuberculosis and Leprosy Supervisor
MDG	Millennium Development Goals
MO	Medical Officer
NLR	Netherlands Leprosy Relief
NTBLCP	National Tuberculosis and Leprosy Control
PHC	Primary Health Centre
QCO	Quality Control Officer
STBLS	State Tuberculosis and Leprosy Control
TB	Tuberculosis
TWG	Tuberculosis/HIV-AIDS Working Group
WHO	World Health Organization

TUBERCULOSIS CONTROL

Introduction

Tuberculosis (TB) is a chronic infectious disease caused by bacteria. The most important source of infection is an untreated TB patient suffering from the pulmonary form of the disease. When such a person coughs, sneezes or spits, droplets containing the germ are released; transmission results from inhalation of these droplets.

TB control was launched in 2002 in Adamawa State and the Netherlands Leprosy Relief (NLR) assists the state with the implementation of TB control based on a Memorandum of Understanding (MOU), which covers the period 2006 – 2010 that is based on the framework of the National TB and Leprosy Control Programme (NTBLCP).

The goal of this strategic plan is:

- To reduce mortality, morbidity and disease transmission (while preventing drug resistance) until TB no longer constitutes a public health problem by the end of 2015

While policy guidelines, supervision, monitoring and administrative support will be provided by the Federal Government through the Federal Ministry of Health and NTBLCP, the Adamawa State Government (ADSG) and the Local Government Areas (LGAs) will provide funds including salaries and allowances and maintain Primary Health Centres to support TB control activities.

The production of this document is a welcome development given the rise in the number of TB cases detected in Adamawa State and the challenges the TB control programme faces towards meeting the Millennium Development Goals (MDG). It is hoped that this document will be put to the best use so that we can achieve the targets of TB control within the framework of the MDGs.

Situation Analysis

Adamawa State has an estimated 5,300 TB cases; despite this high number of TB cases notified in the state, the TB control programme only detects 50% of the estimated cases in the state at the end of 2007. Of the 2,623 cases detected in 2007, 1,296 had the most infectious form of the disease (smear positive). It has been estimated that an untreated smear positive TB case transmits the infection to 12 – 15 persons yearly. HIV is the highest known risk factor for the development of TB and with the present high prevalence in Adamawa State (4.2%); there could be more cases of TB than presently estimated.

Figure 1 shows the trends of TB case notification in Adamawa State in the past 6 years; the number of new TB cases has been on the increase for the 3 years, stabilized in the following 2 years and decreased at the end of 2007. However, smear positive case notification has continued to rise gradually.

Table1: Tuberculosis case notifications in Adamawa State; 2002 to 2007.

	2002	2003	2004	2005	2006	2007
Smear Positive	993	1200	1117	1198	1293	1296
Smear Negative	537	1227	1727	1357	1347	1149
Extra-Pulmonary TB	29	58	149	197	209	178
Total	**1559**	**2485**	**2993**	**2752**	**2849**	**2623**

TB mostly affects the most productive age group (15 – 54 years) and if untreated, could result to over 50% mortality. The morbidity it confers on individuals result to loss of physical and economic independence, aggravating poverty and exerting pressure on the already weak health systems of the making it difficult for the few health workers to cope with the challenges of management. This makes TB a serious public health problem in Adamawa State.

Adamawa State Response:

Although the National TB and Leprosy Control Programme (NTBLCP) was launched in 1988, it was in 2002 that Adamawa State launched its TB control. Starting with 6 treatment centres and 6 diagnostic centres in 6 LGAs, the programme expanded to all 21 LGAs by 2004 with an average of 3 treatment centres per LGA. At the end of 2007, there were 98 treatment centres supported by 26 diagnostic centres for TB in the state. This led to a sharp increase in case detection from 2002 to 2004 (figure 1); the number of cases detected stabilized through 2005 and 2006 and declined in 2007. While the detection of smear positive TB was on the increase, the detection of smear negative was on the decline; this could have been due to difficulties in the diagnosis of smear negative TB which is done by Medical Officers (MOs) in secondary or tertiary health facilities; MOs are inadequate in numbers in Adamawa State. Further more, smear negative cases are being lost after diagnosis; this could be because not all secondary health facilities have DOTS centres within their premises. In addition, some of the TB cases are diagnosed in private facilities that have not been engaged in TB control.

In order to reach the WHO set target for TB service coverage, there needs to be 128 TB treatment centres and 32 TB diagnostic centres in the State. These centres must be of high quality if the Millennium Development Goal is to be achieved.

Political commitment:

The Adamawa State Government (ADSG) signed a Memorandum of Understanding (MOU) with the Netherlands Leprosy Relief (NLR) at the commencement of TB control, in the state in 2002. Under the agreement, ADSG will provide yearly counterpart funds to NLR for the running of the TB control programme while NLR assists with training, planning programme activities and provision of logistics and technical assistance in terms of supervision, monitoring and evaluation of the programme.

For the 7 years the TB programme has been running (2002 – 2008), ADSG provided counterpart funds for 4 years. The smooth running of TB control activities are hinged on the timely provision of counterpart funds by ADSG. However, increased support from NLR who are mainly a leprosy based organization, led to improvement in TB control in the state. The TB control programme still requires support from ADSG in order to meet its targets as stated in the Millennium Development Goals.

Main Stake Holders:

The main stake-holders involved in the Adamawa State TB control programme are:

- The States Ministry of Health
- Netherlands Leprosy Relief (NLR)
- World Health Organization (WHO)
- Federal Ministry of Health (FMOH)
- The Adamawa State TB and Leprosy Control Programme
- State Dermatological Hospital Garkida.
- The Department of PHC of all Local Government Areas
- The Department of PHC, Ministry of Local Government and Chieftaincy Affairs
- Community Heads
- Private Medical Practitioners
- TB Patients

GOAL:

- To reduce mortality, morbidity and disease transmission (while preventing drug resistance) until TB no longer constitutes a public health problem

TARGET:

- To detect 70% of estimated smear positive TB cases and treat successfully 85% by the end of 2010

In order to achieve and sustain the goal and target of TB control in Adamawa State, the following activities have been developed:

- To sustain the optimal functioning of TB diagnostic network;
- To Increased effectiveness of case finding and case holding;
- To establish the mechanism for collaboration between TB and HIV/AIDS control programmes;
- To decrease the burden of TB among HIV/AIDS patients;
- To decrease the burden of HIV/AIDS among TB patients;
- To ensure proper Drugs & Supplies management system;
- To improve the quality of supervision at all levels;
- To ensure proper management of the control programme.

Activities:

S/N	Activities	2009	2010	2011	2012	2013	2014	2015	By Whom
1	***To sustain the optimal functioning of TB diagnostic network***								
1.1	Train 20 AFB (TB) microscopists yearly	-	-	-	-	-	-	-	QCO, STBLCO
1.2	Increase TB diagnostic centres from 26 to 40		-	-	-	-	-	-	QCO, STBLCO
1.3	Procure and distribute 20 microscopes to AFB laboratories	-							
1.4	Equipment maintenance	....	....	....	....	....	....	....	QCO
1.5	Quarterly meetings of lab staff, DLS, QCO and TB control staff	----	----	----	----	----	----	----	QCO, STBLCO
1.6	Recording and reporting			....	....	....	....	....	GHCWs/LGTBLS/ QCO
1.7	Monitoring and Evaluation	- -	- -	- -	- -	- -	- -	- -	DLS, QCO, STBLCO
2	***To increase the effectiveness of case finding and case holding***								
2.1	Train 100 GHCWs yearly on TB control	-	-	-	-	-	-	-	State Team
2.2	Train 50 community volunteers yearly on TB control	-	-	-	-	-	-	-	State Team
2.3	Public awareness on TB	....	....	....	....	....	....	....	Sate Team
2.4	Patient and community education on TB	....	....	....	....	....	....	....	LGTBLS/ GHCWs
2.5	Carry out diagnostic	....	....	....	....	....	....	....	GHCWs

	services								
2.6	On-the-job training	……..	……..	……..	……..	……..	……..	……..	State Team/ LGTBLS
2.7	Examination of contacts	……..	……..	……..	……..	……..	……..	……..	GHCWs
2.8	Defaulter retrieval	……..	……..	……..	……..	……..	……..	……..	GHCWs
2.9	Uninterrupted TB services	……..	……..	……..	……..	……..	……..	……..	State Team
2.10	Management of complications	……..	……..	……..	……..	……..	……..	……..	GHCWs/MOs
2.11	Recording and reporting	……..	……..	……..	……..	……..	……..	……..	GHCWs/LGTBLS
2.11	Monitoring and evaluation	- -	- -	- -	- -	- -	- -	- -	State Team
3	***To ensure optimal functioning of the*** *collaborative mechanism between* ***TB and HIV/AIDS control programmes***								
3.1	Quarterly meeting of state TWG	- - - -	- - - -	- - - -	- - - -	- - - -	- - - -	- - - -	STBLCO/SAPC /LGTBLS
3.2	Quarterly meeting of LGA TWG	- - - -	- - - -	- - - -	- - - -	- - - -	- - - -	- - - -	LGTBLS/LACA Chairman
3.3	Advocacy to relevant authorities: SMOH, Min of LGA & Chieftaincy Affairs, HSMB, LGAs, FMC, Faith based organizations: CAN, JNI, CIT, Community Leaders	……..	……..	……..	……..	……..	……..	……..	TWG
3.4	Quarterly Meetings of TB/HIV working	- - - -	- - - -	- - - -	- - - -	- - - -	- - - -	- - - -	STBLCO/TWG

	group, Budget planning & Resource mobilization								
4	***To decrease the burden of TB among HIV/AIDS patients***								
4.1	Training of 21 members of support group on TB (suspect & refer) yearly	-	-	-	-	-	-	-	STBLCO/SAPC
4.2	Training of 100 Counselors from DOTS Facilities on TB/HIV counseling	-	-	-	-				STBLCO/SAPC/ Counselor
4.3	Training of 60 MOs on Management of TB/HIV co infection, STI syndromic management & OIs	-		-		-			STBLCO/SAPC
4.4	Training of 50 Lab personnel on AFB sputum microscopy/HIV testing	-			-				QCO/STBLCO
4.5	Training 10 support Group members/LGA on community DOTS & HBC	………	………	………	………	………	………	………	STBLCO/SAPC
4.6	Management of TB patients among PLWHAs	………	………	………	………	………	………	………	GHCWs
4.7	Set up EQA for HIV testing and improve same for AFB Sputum microscopy	………	………	………	………	………	………	………	QCO/STBLCO

4.8	Procure HIV Test Kits/Sputum microscopy reagents & consumables	....	....	....	....	....	....	....	STBLCO/SAPC
4.9	Provision of storage facilities for HIV test kits/consumables in all DOTS centres	....	....	....	....	....	....	....	STBLCO/SAPC
4.10	Recording and reporting	....	....	....	....	....	....	......	GHCWs/ LGTBLS/STBLS
4.11	Monitoring and evaluation	- -	- -	- -	- -	- -	- -	- -	State Team
5	***To decrease the burden of HIV/AIDS among TB patients***								
5.1	Develop Radio and Television Jingles	-							STBLCO/SAPC
5.2	Broadcast Radio, Television Jingles, Documentaries & drama	....	....	....	....	....	....	....	STBLCO/SAPC
5.3	Advocacy Communication & Social Mobilization (ACSM)	....	....	....	....	....	....	....	TWG
5.4	Procurement and distribution of condoms	....	....	....	....	....	....	....	STBLCO/SAPC
5.5	Integration of VCT centers into DOTS clinics	....	....	....	....	....	....	....	TWG/State Team/LGTBLS
5.6	Provision of ART/DOTS drugs	....	....	....	....	....	....	....	
5.7	Establishment of ART sites in 6 General		-		-		-		SACA/SAPC/ STBLCO

	Hospitals								
5.8	Procurement and distribution of CPT to all DOTS facilities	....	....	....	....	....	....	....	
5.9	Active case finding among Support groups and other PLWHAs, women accessing PMTCT	....	....	....	....	....	....	....	State team/LACA/ LGTBLS/ GHCWs
5.10	Recording and reporting	....	....	....	....	....	....	....	GHCWs
5.11	Monitoring and evaluation	- -	- -	- -	- -	- -	- -	- -	State Team
6	***To ensure proper drug supply and management system***								
6.1	Send quarterly stock reports to FMOH/NLR	- - - -	- - - -	- - - -	- - - -	- - - -	- - - -	- - - -	STBLCO
6.2	Send order timely	- - - -	- - - -	- - - -	- - - -	- - - -	- - - -	- - - -	STBLCO
6.3	Procure anti-TB drugs	....	....	....	....	....	....	....	
6.4	Collect and distribute drugs, reagents and consumables	....	....	....	....	....	....	....	State Team
6.5	Train STBLS on drug & supply management	-							Zonal Store Officer
6.6	Train LGTBLS on drug and supply management	-							State Team
6.7	Supervision and monitoring	....	....	....	....	....	....	....	State Team/LGTBLS
7	***To improve the quality of supervision at all levels***								
7.1	Revise/develop supervisory checklists	-							State Team/ LGTBLS

	where necessary								
7.2	Train LGTBLS on use of checklists	-							State Team
7.3	Monitoring and evaluation	- -	- -	- -	- -	- -	- -	- -	State Team
8	***To ensure proper management of the TB control programme***								
8.1	Send reports timely	- - - -	- - - -	- - - -	- - - -	- - - -	- - - -	- - - -	STBLCO
8.2	Transport, allowances and office management functioning	....	....	....	....	....	....	....	STBLCO
8.3	Quarterly planning sustained	- - - -	- - - -	- - - -	- - - -	- - - -	- - - -	- - - -	STBLCO
8.4	Meeting system functioning	....	....	....	....	....	....	....	STBLCO
8.5	Timely release of funds	- - - -	- - - -	- - - -	- - - -	- - - -	- - - -	- - - -	STBLCO
8.6	Evaluations			-			-		NLR/WHO/FMOH/ SMOH
8.7	Thematic support (HSR, client perspective study)			-			-		NLR/FMOH/SMOH

Budget Breakdown:

S/N	Activities	2009	2010 (2009 + 5%)	2011 (2010 + 5%)	2012 (2011 + 5%)	2013 (2012 + 5%)	2014 (2013 + 5%)	2015 (2014 + 5%)	2016/2018	Total	Responsible Body
1	***To sustain the optimal functioning of TB diagnostic network***										
1.1	Train 21 AFB (TB) microscopists yearly: 28,850*21= N 605,850	605,850	636,145	667,950	701,350	736,420	773,240	811,800	1,817,550	6,750,305	ADSG & Dev. Partner
1.2	Increase TB diagnostic centres from 26 to 44										
1.3	Procure and distribute 25 microscopes to AFB laboratories: 25*250,000 = 6,250,000	6,250,000	-	-	-	-	-	-	18,750,000	25,000,000	ADSG & Dev. Partner
1.4	Equipment maintenance: 5,000/microscope*44 = 220,000.	220,000	231,000	242,550	254,680	267,410	280,780	294,820	660,000	4,431,240	ADSG
1.5	Quarterly meetings of lab staff, DLS, QCO and TB control staff: 12950*47*4 = 2,434,600	2,434,600	2,556,330	2,684,145	2,818,350	2,959,270	3,107,230	3,262,590	7,303,800	65,734,200	ADSG
1.6	Recording and reporting										
1.7	Monitoring and Evaluation: 25,000*3 = 75,000	75,000	78,750	82,690	86,825	91,165	95,720	100,505	225,000	835,655	ADSG
2	***To increase the effectiveness of case finding and case holding***										
2.1	Train 100 GHCWs yearly on TB control: 100*28,850 = 2,885,000	2,885,000	3,029,250	3,180,710	3,339,745	3,506,730	3,682,065	3,866,170	8,655,000	32,144,670	ADSG
2.2	Train 50 community volunteers yearly on TB control: 50*28,850 = 1,442,500	1,442,500	1,514,625	1,590,360	1,669,880	1,753,375	1,841,045	1,933,100	4,327,500	16,072,385	ADSG
2.3	Identify at least 1 PPP/congregate facility per LGA										
2.4	Train 21 GHCWs from identified PPP/congregate facilities: 21*28,850 = N 605,850	605,850	638,140	669,940	703,435	738,605	775,535	814,310	1,817,550	6,763,365	ADSG & Dev. Partner

2.5	Public awareness on TB: Radio: 3,750*365 = 1,368,750	1,368,750	1,437,190	1,509,050	1,584,500	1,663,725	1,746,910	1,834,255	4,106,250	15,250,630	ADSG
	TV:7,500*365 = 2,737,500	2,737,500	2,874,375	3,018,090	3,168,995	3,329,445	3,495,815	3,670,605	8,212,500	30,507,325	ADSG
2.6	Patient and community education on TB	Salaries	Salaries	Salaries	Salaries	Salaries	Salaries	Salaries			
2.7	Carry out diagnostic services	Salaries	Salaries	Salaries	Salaries	Salaries	Salaries	Salaries			
2.8	On-the-job training	Salaries	Salaries	Salaries	Salaries	Salaries	Salaries	Salaries			
2.9	Examination of contacts	Salaries	Salaries	Salaries	Salaries	Salaries	Salaries	Salaries			
2.10	Defaulter retrieval: 10,000/LGA*21	210,000	220,500	231,525	243,100	255,260	268,020	281,420	630,000		ADSG
2.11	Uninterrupted TB services	Salaries	Salaries	Salaries	Salaries	Salaries	Salaries	Salaries			
2.12	Management of complications	Salaries	Salaries	Salaries	Salaries	Salaries	Salaries	Salaries			
2.13	Recording and reporting	Salaries	Salaries	Salaries	Salaries	Salaries	Salaries	Salaries			
2.14	Monitoring and evaluation	- -	- -	- -	- -	- -	- -	- -			
3	***To ensure optimal functioning of the collaborative mechanism between TB and HIV/AIDS control programmes***										
3.1	Quarterly meeting of state TWG: 11,150*12pers = 133,800	133,800	140,490	147,515	154,890	162,635	170,765	179,300	401,400	1,490,795	ADSG
3.2	Quarterly meeting of LGA TWG: 4,150*15 = 62,250	62,250	65,360	68,630	72,060	75,660	79,440	83,410	186,750	693,560	ADSG
3.2	Advocacy to relevant authorities: SMOH, Min of LGA & Chieftaincy Affairs, HSMB, LGAs, FMC, Faith based organizations: CAN, JNI, CIT, Community Leaders: 500per visit*12*4 = 24,000	24,000	25,200	26,460	27,780	29,170	30,630	32,160	72,000	267,400	ADSG
4	***To decrease the burden of TB among HIV/AIDS patients***										
4.1	Training of 21 members of support group on TB (suspect & refer) yearly: 11,150*21 = 234,150	234,150	245,860	258,150	271,060	284,615	298,850	313,780	702,450	2,608,915	ADSG

4.2	Training of 25 GHCWs yearly from DOTS Facilities on TB/HIV counseling: 39,450*25 = 986,250	986,250	1,035,560	1,087,340	1,141,705	1,198,790	1,258,730	1,321,660	2,958,750	10,988,785	ADSG
4.3	Training of 60 MOs on Management of TB/HIV co infection, STI syndromic management & OIs: 28,850*60 = 1,731,000	1,731,000	1,817,550	1,908,430	2,003,850	2,104,045	2,209,250	2,319,710	5,193,000	19,286,835	ADSG
4.4	Training of 50 Lab personnel on AFB sputum microscopy/HIV testing; 28,850*50 = 1,442,500	-			-						
4.5	Training 30 support Group members/LGA on community DOTS & HBC: 18,250*10 = 182,500	182,500		201,205			232,925		547,500	1,164,130	ADSG
4.6	Management of TB patients among PLWHAs	Salaries	Salaries	Salaries	Salaries	Salaries	Salaries	Salaries			
4.7	Set up EQA for HIV testing and improve same for AFB Sputum microscopy	………	………	………	………	………	………	………			
4.8	Procure HIV Test Kits/Sputum microscopy reagents & consumables	………	………	………	………	………	………	………			ADSG & Dev. Partner
4.9	Provision of storage facilities for HIV test kits/consumables in all DOTS centres: 6,000*21 = 126,000		126,000							126,000	ADSG
4.10	Recording and reporting	………	………	………	………	………	………	………			
4.11	Monitoring and evaluation	- -	- -	- -	- -	- -	- -	- -			
5	***To decrease the burden of HIV/AIDS among TB patients***										
5.1	Develop Radio and Television Jingles	50,000							150,000	200,000	ADSG
5.2	Advocacy Communication & Social Mobilization (ACSM)	………	………	………	………	………	………	………			
5.3	Procurement and distribution of condoms	………	………	………	………	………	………	………			ADSG & Dev. Partner

5.4	Integration of VCT centers into DOTS clinics	Salaries	Salaries	Salaries	Salaries	Salaries	Salaries	Salaries			
5.5	Provision of ART/DOTS drugs	………	………	………	………	………	………	………			ADSG & Dev. Partner
5.6	Establishment of ART sites in 6 General Hospitals	Salaries	Salaries	Salaries	Salaries	Salaries	Salaries	Salaries			
5.7	Procurement and distribution of CPT to 4 HFs	………	………	………	………	………	………	………			
5.8	Active case finding among Support groups and other PLWHAs, women accessing PMTCT	Salaries	Salaries	Salaries	Salaries	Salaries	Salaries	Salaries			
5.9	Recording and reporting	………	………	………	………	………	………	………			
5.10	Monitoring and evaluation	- -	- -	- -	- -	- -	- -	- -			
6	***To ensure proper drug supply and management system***										
6.1	Send quarterly stock reports to FMOH/NLR										
6.2	Send order timely										
6.3	Procure anti-TB drugs	………	………	………	………	………	………	………			ADSG & Dev. Partner
6.4	Collect and distribute drugs, reagents and consumables	Salaries	Salaries	Salaries	Salaries	Salaries	Salaries	Salaries			
6.5	Train STBLS on drug & supply management: 12,950*5 = 64750	64,750							194,250	259,000	ADSG
6.6	Train LGTBLS on drug and supply management	-									
6.7	Supervision and monitoring	Salaries	Salaries	Salaries	Salaries	Salaries	Salaries	Salaries			
7	***To improve the quality of supervision at all levels***										
7.1	Revise/develop supervisory checklists where necessary	-									
7.2	Train LGTBLS on use of checklists	-									
7.3	Monitoring and evaluation	- -	- -	- -	- -	- -	- -	- -			
8	***To ensure proper management of the TB control programme***										

8.1	Send timely reports										
8.2	Transport, allowances and office management functioning: Office maintenance@240,000/year	240,000	252,000	264,600	277,830	291,720	306,305	321,620	720,000	2,674,075	ADSG
8.3	Quarterly planning sustained	----	----	----	----	----	----	----			
8.4	Meeting system functioning	………	………	………	………	………	………	………			
8.5	Timely release of funds	----	----	----	----	----	----	----			ADSG
8.6	Evaluations			-			-				
8.7	Thematic support (HSR, client perspective study)			-			-				
	Total									**243,240,270**	

Implementation arrangements:

The Adamawa State Tuberculosis and Leprosy Control Programme is the implementer of this plan. It will be assisted by the Netherlands Leprosy Relief (NLR), who support Leprosy Control activities in the state technically, logistically and through monitoring and evaluation of the programme. NLR had earlier provided 2 vehicles for ATBLCP and 21 motorbikes for the 21 LGAs; these are used for supervision, monitoring and other programme activities.

STBLS from the ATBLCP office will provide supervisory support to the LGTBLS at the LGA level while the LGTBLS would do same to GHCWs in health facilities providing TB control services. The laboratory Quality Control Officer of the ATBLCP will also provide supervision to all TB diagnostic facilities in the State. Statistics and relevant reports will be generated from all TB service provision points by the LGBLS; these will be compiled and collated by the ATBLCP on quarterly basis and will be forwarded to the SMOH, NLR, FMOH and WHO.

A mid-term and end-term evaluation would be carried out by experts from NLR, WHO and FMOH.

MALARIA CONTROL

INTRODUCTION

- Malaria is an illness caused by the bite of an infective female anopheline mosquito which transfers parasites called **Plasmodium;**
- Four Plasmodium parasites exist (Falciparium, Malariae, Vivax and Ovale) but only one (Falciparium) is of very vital importance in disease transmission in Nigeria;
- The vectors of malaria are female Anopheles mosquitoes;
- In Nigeria, these vectors include:
  - ***Anopheles gambiae s.s* – Most efficient**
  - ***Anopheles arabiensis***
  - ***Anopheles malas***
  - ***Anopheles funestus***
- Symptoms of Malaria may vary in individuals, but include fever (most important symptom in children), malaise, body pain, headache and vomiting;
- Malaria represents one of the major causes of ill health and death throughout Nigeria. It also reduces economic productivity due to absenteeism from school and place of work during attacks of malaria

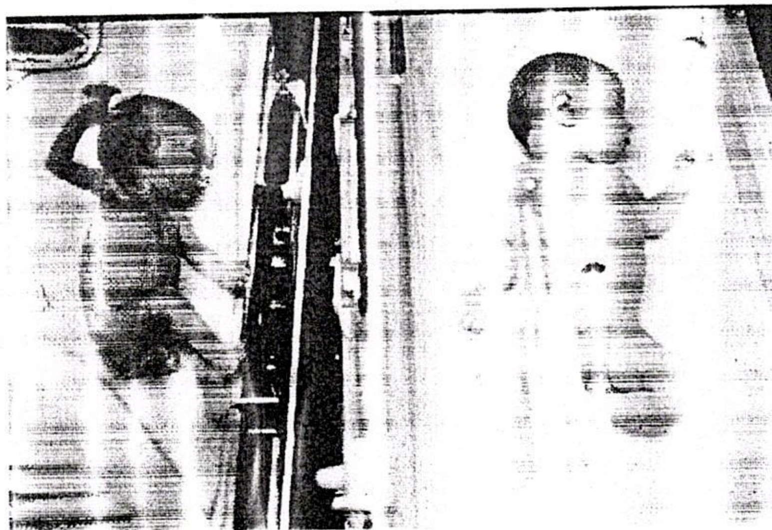
MALARIA BURDEN

- Malaria is the cause of one in four deaths recorded in infants and young children and worse still for every ten women that died around childbirth one death is caused by malaria, in Nigeria;
- Malaria particularly hurts under-five children and pregnant women due to the lessened immunity seen in both groups;
- Nigeria has one of the highest maternal mortality rates (MMR) in the world: about **800 deaths per 100,000 live births**, compared to less than 10 deaths per 100,000 births in developed countries;

- Malaria and Anaemia contributes 11% apiece to this high mortality;
- About half of Nigerian adults have at least one episode of malaria each year while malaria occurs in younger children up to 3-4 times a year;
- It is also the reason for hospital attendance in 7 out of every 10 patients seen in Nigerian hospitals;
- It thereby contributes to both poverty and underdevelopment both for the nation, community, family and individual because people spend a large part of their yearly income on its prevention and treatment;
- Affects five times as many people as AIDS, leprosy, measles, and tuberculosis combined;
- Reducing the burden of malaria is a cost-effective way of promoting development and reducing poverty;
- About 7.5 million Nigerian women are pregnant yearly;
- Malaria is more frequent and serious during pregnancy;
- Malaria during pregnancy may account for;
  - Up to 15% of maternal anemia
  - 5–14% of low birth weight
  - 30% of "preventable" low birth weight
- All pregnant women in malaria-endemic areas are at risk;
- Parasites attack and destroy red blood cells;
- Malaria causes up to 15% of anaemia (low blood) in pregnancy;
- Can cause severe anaemia;
- In Africa, anaemia due to malaria causes up to 10,000 maternal deaths per year;
- 4, 500 maternal deaths yearly in Nigeria.

- Parasites hide in the placenta;
- Parasites interfere with transfer of oxygen and nutrients to the baby, increasing the risk of;
  - Spontaneous abortion
  - Stillbirth
  - Preterm birth

Low birth weight-single greatest risk factor for death during first month of life



Low and **Normal**
Birth-weight infants

WORK PLAN FOR 2009 – 2018 FOR MALARIA CONTROL PROGRAMME

S/N	OBJECTIVE	ACTIVITY	EXPECTED OUT COME	RESPONSIBLE BODY			TIME FRAME	MONTHLY RUNING COST	BUDGET
				STATE	LGA	OTHERS			
1.	Advocacy	Visit to policy makers at State/LGA level	Policy makers support programme	State	-	Others	January – March, 2009	₦200,000.00	₦4,473,000.00
2.	Advocacy	Visit to traditional rules and community leaders	To support programme (activities)	State	LGA	-	January – March, 2009	₦200,000.00	₦5,544,000.00
3.	Advocacy sensitization	Visit to NGOs and private sectors	Support state /LGA during activities	State		Others	April – June, 2009	₦200,000.00	₦3,402,000.00
4.	Formation of group e.g. CBBI, youth group, women group, TBAS and VHW etc.	Orientation	Community behavior change	-	LGA	-	July – September, 2009	₦200,000.00	₦5,544,000.00
5.	Media coverage	Jingles radio paid announcement, documentation and publicity	Create awareness on use of LLIN	State	-	-	April – June, 2009	₦200,000.00	₦200,000.00
6.	TOT	Capacity building for 9 state staff and 3 NGOs	Behavioral change on use of ACTs and LLIN	State	LGA	-	July – September, 2009	₦200,000.00	₦700,000.00
7.	TOT	Local fort training for 20 persons per LGA for 3 zone	Knowledge acquire	State	-	Others	October – December, 2009	₦200,000.00	₦1,000,000.00
8.	Procurement	Purchase 2 4wheel Toyota hillux	2 four wheel Toyota hillux purchased	State	-	-	January – December, 2009	₦200,000.00	₦10,000,000.00

S/N	OBJECTIVE	ACTIVITY	EXPECTED OUT COME	RESPONSIBLE BODY			TIME FRAME	MONTHLY RUNING COST	BUDGET
9.	IRS (spray) chemical and equipment	Procurement of ACT – treatment of cases - IRS spray - knapsack sprayer for mosquito, retreatment kits for LLINs	Mobility and mortality rate reduce	State	-	Others	July – September, 2010	₦200,000.00	₦30,000,000.00
10.	Logistic support	For monthly supervision (vehicle, motor cycle and bicycle)	Effective Control and utilization of ACT/SP	State	LGA	-	January – December, 2010	₦200,000.00	₦4,473,000.00
11.	TOT	Training Of Professional Doctors, Nurses, Midwives (60)	Knowledge acquire	State	-	-	April – June, 2010	₦200,000.00	₦1,000,000.00
12.	Support/ equipment	Compound microscope, slides, surgical blades, forceps, reagents, mask, hand gloves, overall, boots, bowls, buckets and eye goggles etc.	For Effective spraying	State	LGA	-	January – July, 2011	₦200,000.00	₦30,000,000.00
13.	M & E	Monthly supervision and evaluation	Improve efficacy and efficiency of workers	State	-	-	January – December, 2012	₦200,000.00	₦200,000.00
14.	Procurement	Purchase of 105 bicycles for 21 LGAs	105 BICYCLES FOR 21 LGAs purchased	-	LGA	-	2009 -2013	₦200,000.00	₦1,125,000.00
15.	Procurement	Purchasing of 21 motorcycles for 21 LGA	21 motorcycles purchased for 21 LGAs	-	LGA	-	Year 2009 – Year 2013	₦200,000.00	₦2,800,000.00

S/N	OBJECTIVE	ACTIVITY	EXPECTED OUT COME	RESPONSIBLE BODY			TIME FRAME	MONTHLY RUNING COST	BUDGET
16.	Procurement of LLINs	Purchase of LLINs to 168,705 for pregnant women for 21 LGAs	168, 705 for the 21 LGAs purchased	State	LGA	-	January – December, 2014	₦200,000.00	₦404,892,000.00
17.	Procurement of LLINs	Purchase of LLINs for 674,821 for all the 21 LGAs in the state	674, 821 for 21 LGAs to sleep under LLINs	State	LGA	-	January – December, 2014	₦200,000.00	₦1,349,442,000.00

S/N	OBJECTIVE	ACTIVITY	EXPECTED OUT COME	RESPONSIBLE BODY			TIME FRAME	MONTHLY RUNING COST	BUDGET
18.	Effective control of malaria to reduce disease burden	Advocacy and health education to stake holders on provision of ITNs and other malaria activities	Stake holders behavior change on use of ITNs	State	LGA	-	January – March, 2015	₦200,000.00	₦20,000,000.00
19.	Effective control of malaria to reduce disease burden	Distribution and supervision of use of sulphadoxin premethamine & ACTs	Number of malaria attacks reduce	State	LGA	-	January – December, 2015	₦200,000.00	₦5,000,000.00
20.	Effective control of malaria to reduce disease burden	Procurement of residual spray (IRS Chemicals) and capacity building of health workers	Number of IRS chemical distributed and use properly by the communities	State	LGA	-	July – September, 2015	₦200,000.00	₦50,000,000.00
21.	Improve effective treatment of malaria	Training of health workers, community leader on home treatment of malaria with ACTs in 21 LGAs	Numbers, of participants that acquire knowledge on treatment with ACT and SP	State	LGA	-	April – June, 2015	₦200,000.00	₦3,000,000.00
							SUB TOTAL FOR MALARIA CONTROL		₦1,932,795,000.00

BUDGET SUMMARY

	TOTAL (₦)		
	ANNUAL	**4 YEARS**	**10 YEARS**
Primary Health Care	7,887,777,000bn	9,425,596,001bn	56,312,700,000bn
Secondary Health Care	8,150,300,000bn	-	6,887,035,270bn
GRAND TOTAL	**16,038,077,000bn**	**9,425,596,001bn**	**63,199,735,270bn**

CONCLUSION

This report is as a result of in-depth study of the health facilities in the State and some selected States in the Country, as well as consultation with relevant Ministries, Parastatals, Professional Groups, Local Government Councils and Stake Holders in both Preventive and Secondary Health Care Delivery Services.

The situation analysis of the Health Care Delivery in the State shows that a lot need to be done to catch up with the rest of the States in the Country. However, if the recommendations herein are implemented with proper planning and necessary political will, a health revolution could be a reality. No effort is too much to achieve this goal.

We thank His Excellence for the confidence reposed on us by this appointment to contribute toward the development of our dear State.

ANNEXUERS

REPORT OF THE ADAMAWA STATE SUB-COMMITTEE ON HEALTH CARE DEVELOPMENT (10 YEAR) PROGRAMME ON NATIONAL VISIT TO KATSINA STATE, 24TH -27TH AUGUST, 2008.

1.0 **MEMBERSHIP**

(i) DR ZAINAB B. KWONCHI

(ii) DR ADAMU BAKARI GIREI

(iii) MR. GEORGE FARAUTA

(iv) MRS RAMATU D. WILLIAM

2.0 **ARRIVAL**

The Sub-Committee members were received in Katsina State by the Permanent Secretary Katsina State Ministry of Health, Dr. A. T. Gidado on 25th August, 2008.

The Adamawa State Honourable Commissioner of Health Dr. Zainab B. M. Kwonchi who led the sub-committee members briefed the Permanent Secretary about the mission of the Sub-Committee members as indicated in the letter earlier sent to Katsina State through DHL informing them of the visit.

In his response, the Permanent Secretary addressed all the issues related to Katsina State Health care delivery systems and also suggested that for the members of the sub-committee to have a glimpse of the success story of Katsina State Health Care delivery system, visit to some primary care clinics, comprehensive health care centes in a nearby Local Government Area and to other health centres will be done by the sub-committee members.

He thus briefed the sub-committee members on the various issues raised in their letter as follows:-

3.0 MANAGEMENT

That the Health Care delivery in Katsina State operates through a Boards and two Agencies.

i. Health Services Management Board

ii. Primary Health Care Agency

iii. HIV/AIDS, TB and Malaria Agency (Yet to take off) and the Local Governments in charge of H/Posts and dispensaries.

The Administration of these Agencies and Board headed by the Executive Chairman is through Board members and committees who are responsible for the day to day running of activities of the Board and Agencies.

4.0 RENUMERATION

Medical and Health workers wages in Katsina State is paid in such manner that would attract workers to take up appointment in the State. Doctors earn as much as three hundred and fifty thousand Naira (N350,000.00) monthly apart from other allowances. Foreign Doctors having some certain specialities are also employed by the Katsina State Government and FOREX allowance of twenty five thousand Naira (25 000.00) only is paid together with their wages and allowances to attract them.

All other civil servants in the State are on katsina State Salary Scale with allowances negotiable by their respective unions, however, at retirement, benefits are calculated uniformly according to grade levels.

5.0 EQUIPMENT AND DRUGS SUPPLY

The Katsina State Hospital and Health Care centres are well equipped with modern equipments such as x-ray machines, dental and surgical equipments etc. drugs are supplied through Drug Revolving Fund (DRF) and supplied to patient at subsidized rate. The State also have an oxygen plant situated in one of the hospitals, a renal dialysis plant and other life saving units such as intensive care unit.

6.0 ANNUAL BUDGET

Annual Budget for the health sector in Katsina State based on NEEDS Assessment is N1.3b. Capital expenditure is N600m and N250m is for the PHC operations. The capital expenditure takes the lion share of the Budget and to ensure strict implementation of the Budget, monitoring and Evaluation is done at all levels.

Project manager's ware assigned to the various State Ministries and Agencies to ensure strict compliance and implementation of State programmes.

7.0 PRIMARY HEALTH CARE AGENCY

Approval for the take off of the Agency through an Edict was done in 2005 by the former Government of Katsina State, His Excellency,

governor Umaru Musa Yar'adua. The Agency operates in line with the Millennium development Goals (MDGS) of reducing child mortality and improving maternal mortality, Goals 4 & 5. The Long term plan of the Katsina State Government since then is to build (where there is no such structure on ground) and equip one 91) primary health centre and one (1) comprehensive health centre in each of the 34 Local Governments Area of the State. An organ gram of operations of PHCs Agency was drawn to identify the various hierarchy in the operation of the Agency.

On visit to the Agency the Executive Chairman confirmed that the agency is in charge of recruiting and posting of personnel to the PHC under its jurisdiction, while the State Government Constructs, equips and supplies drugs to the PHCs.

8.0 EMERGENCY AMBULANCE SERVICES

The Katsina State Government has six (6) ambulances stationed at strategic locations in the State to render emergency services free of charge to its citizens.

The Sum of eighteen Million Naira (18M) only is released on quarterly basis for the ambulance maintenance and purchase of drugs.

9.0 VISIT TO WOMEN AND CHILDREN HOSPITAL

On arrival at the newly constructed 300 bed women and children hospital in Katsina metropolis the project Manager took us round the entire building which can best be described to be situated in the

heart of London. The yet to be commissioned building was contracted out at the sum of N500m and consists of all that is required of hospital i.e. OPD, ward, theater, laundry, kitchen, Administration offices, x-ray rooms, laboratories, mortuary, staff quarters etc. We learnt that equipments for the hospital has been ordered and that the commissioning of the hospital would take place as soon as all installations of all the equipments have been completed.

The Katsina State Government plans to build such structures one in each of the 3 senatorial zones of the State based on the long term plans of the Government.

10.0 VISIT TO SAFANA LOCAL GOVERNMENT AREA

The National visit on the advise of our hosts took us to one of the Local Governments named Safana Local Government Area situated about 80km from the State headquarters. The comprehensive health centre is a 40 bed hospital. It consists of all hospital components with drugs supplied to the hospital through Drugs Revolving Fund and gives free drugs to pregnant women, children of Ages 0=5 years and Malaria patients. Records of the two drugs administration is kept separately. Order of the drugs is done ahead of time while stock still lasts for 2 weeks to avoid breakdown in supply.

Other activities of interest at the Local Government Area is the life support Ambulance which operates in all the 34 Local Government Areas of the State. The ambulance staff consists of I midwife, I CHEW and I driver. The sum of thirty thousand Naira (N30,000.00)

is budgeted monthly for the ambulance maintenance i.e. N5m per ambulance annually and drugs supplies is free. The mobile Ambulance moves from village to village and renders services to the sick at all locations. At the end of every visit to a village the village head certifies that indeed the ambulance was there.

The Director Primary Health Care of the Local Government also highlighted on their success story of effective delivery of health care to its citizens due to effective monitoring and evaluation in place with 7 zonal offices under the supervision of 1 officer. They also recognized the contributions of the Local Government Area ward and village Development Committees who promptly report all lapses that may arise in the day to day operations of the health workers with the aim of finding immediate solution to the problems. All these services rendered by the development committees is a voluntary service.

The Director primary Health care also informed us that all stake holders are involved during immunization exercises e.g. NGOs, Miyetti Allah, Village heads etc.

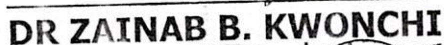
11.0 VISIT TO THE STATE EPIDEMOLOGICAL UNIT

On arrival at the Katsina State Epidemiological unit, the officer $^{1}/_{c}$ explained to us that the unit's power supply is on NPHC and 2 stand bye 35KVA and 75KVA generators to ensure constant power supply for Drugs preservation. The cold room, cold chain and dry stores are well equipped with assorted vaccines drugs and equipments that were being used during monthly routine immunization exercise.

Wastes are properly disposed using locally fabricated incinerators at the EPID Unit. Samples of documents supplied to the Committee as souvenirs by our hosts include:-

1. Architectural drawing of the Women and Children Hospital.
2. Edict for PHC takes off
3. Bill for the emergency clinic
4. Free drugs dispensing record from (Form 02)
5. Monthly PHC drugs stock record (form 01)
6. PHC OPD card
7. Organogramme etc.

The People of Katsina State showed us no small hospitality by warmly receiving us and giving us all the necessary backing to make our assignment a success, they indeed are partners in progress of whom we would recommend that the Adamawa State Government should lias with the Katsina State Government to make our health sector similar to that of Katsina State. Their hospitality is something to be emulated by the entire peoples of Adamawa State most especially those of us who have seen and tasted of their hospitality.

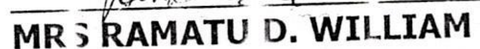


DR ZAINAB B. KWONCHI

DR ADAMU BAKARI GIREI

20/11/03

MR. GEORGE FARAUTA



MRS RAMATU D. WILLIAM

REPORT OF THE SUB-COMMITTEE ON HEALTH DEVELOPMENT (10 YEARS) PROGRAMME THAT VISITED OWERRI, IMO STATE BETWEEN 24TH - 25TH AUGUST, 2008

1. **MEMBERSHIP**

(i)	Dr. Ahmed I. Mustafa	Ex. Chairman	Chairman
(ii)	Barr. H.S. Dudari	Rep. M.O.J.	Member
(iii)	Ahmed I. Bello	HSMB	Secretary

2. **ARRIVAL**

02.1 The team arrived Owerri, the Imo State Capital on Sunday, 24th August, 2008 at about 8:00pm.

02.2 At 9:00am the Committee was at the State Secretariat, but was informed that the Honourable Commissioner Ministry of Health was attending Executive Council meeting, while the Permanent Secretary was expected soon.

02.3 Brief enquiry revealed that the Ministry has received the advance letter notifying them of the visit of the Sub-Committee on Friday 22nd August, 2008.

02.4 At around 10:05 the Committee was told of the unexpected arrival of the Commissioner, but that he could not give us audience and should wait for the Permanent Secretary. She arrived a little after 11:00am and the Committee was ushered in to see her.

02.5 She welcomed us warmly and the Committee Chairman highlighted to her the objective of its visit to Imo State, a state he mentioned as having been identified as excelling in the areas of Primary Health Care activities, Environmental Sanitation and Health Care Delivery Services.

02.6 He explained further, the desire of the Adamawa State Government to share the positive experiences of the Imo State Government towards successfully and effectively designing and implementing (10 year) rolling plan of Health Development Programmes and Environmental Sanitation, which goes hand in hand.

02.7 In response, she thanked the Adamawa State Government for identifying with the successes of her State in the Health and Environment Sector and for finding them worthy of emulation. She promised 100% cooperation and assistance necessary in that direction

02.8 At that point, she invited the Director i/c Public Health and Primary Health Care, also a woman and told her the mission of our Committee to the State and further directed her to assemble all the Concerned Heads of Departments to meet with us and render necessary assistance, including documentary support, where applicable.

02.9 The Committee Chairman thanked her and left in the company of the Public Health Director for the assignment proper.

3. **THE ASSIGNMENT PROPER**

03.1 At the office of the Director, Public Health she assembled the following officials: -

(i) Head of Primary Health Care activities;
(ii) Head of Environmental Sanitation Activities;
(iii) Head of Nutrition;
(iv) Director Public Health; and
(v) Head of HIV/AIDS Control.

03.2 She assured the team that positive contribution from the officials will no doubt provide us with materials to assist Adamawa State in its quest towards improving Health Care Delivery Services to its citizenry.

(A) PRIMARY HEALTH CARE ACTIVITIES

In his contribution, the Head of Primary Health Care activities, confirmed that the Imo State Government pursue policies on immunization activities with an aggressive vigor because of its conviction that prevention is better than cure. Such aggressive policies are particularly directed towards effectively ensuring the potency of all immunization drugs for the fact that application of potent immunization drugs is the backbone of successful immunization exercise. Focal attention areas included: -

(i) Effective Management of Cold Chain System

Under This programme, the Imo State Government ensures adequate provision and equipping of cold chain facilities throughout the nook and cronies of the state for effective storage of immunization drugs. At grassroots areas, where power supply is not available, solar fridges are supplied and areas where power supply is available and fairly steady, its is supplemented by standby generating plants.

(ii) Effective and Sustained Public Mobilization and Awareness Campaign

Target beneficiaries of the programme needs to be adequately mobilized and well enlightened to disabuse their minds from the perceived ills of immunization. These, the Government do through wide and effective media campaign and through traditional rulers and religious leaders. That strategy has worked, rising high the level of immunization coverage and bringing to the barest minimum, incidences of Polio miliatis and the rate of maternal and child mortality among women and children in Imo State.

(iii) Primary Health Care Development Agency

The Director Public Health has revealed that the Ministry identified the need to have a separate agency to coordinate and control Primary Health Care activities in the State, but up to the time of our visit that desire had not been realized. She however, assured that the State Assembly had passed the bill into law and now awaiting assent by the executive. Efforts to secure the draft bill was not successful as the Ministry had no direct access to it. Incidentally the bill has reached similar level in Adamawa State. The Director Public Health was particularly optimistic of the positive role a separate agency will play in the efficient Administration of Primary Health Care activities in the State towards increasing efficiency and sustaining effective Primary Health Care Service delivery to the people of Imo State.

(iv) State Health Policy

On State Health policy, the Director Public Health told members that Imo State has no State health policy.

She however, indicated that during the last National Council on Health Conference, a National Health Policy was adopted and each state is expected to design its health policy within the confines of the National Policy, each however, reflecting its own peculiarities or convenience.

Consequent upon that development the Imo State Government came-up with what it called "the policy thrusts of the new face of Imo Ministry of Health with the thame: - to provide a comprehensive accessible affordable Health Care Delivery System that is attainable and effective for healthy and productive population: the thrusts was armed at: -

(i) Reducing infant mortality and mobility (infants) from 66/100 to 33/100 and under 5 mortality from 1104/1000 to 57/1000 by 2009;

(ii) Reducing the incidences of HIV/AIDS from 3.1% to 0.1 by 2009; reduce incidence of tuberculosis from 842 cases per year to 84 cases per year by 2009;

(iii) Reducing maternal mortality from 600/100,000 to 200/100,000 by 2009;

(iv) Sensitizing/training health personnel on one hand and the people on the other hand on some specific health matters;

(v) Ensuring regular available of essential drugs in all health facilities.

(v) To attain those Goals, the Ministry adopted the Following Strategies: -

(i) Increase routine immunization coverage in the 27 LGAs;
(ii) Establishment of Family Planning Units in all Health Institutions;
(iii) Sensitizing of the population on spread and prevention methods of diseases;
(iv) Procurement and distribution of drugs (for instance, 117,800 anti-retroviral drugs in 2007; 117,600 in 2008 and 189,380 in 2009.

(vi) The Success of the Programme is Assessed Vide the Following Indicators: -

(i) No. of vaccines procured and distributed;
(ii) Percentage increase in routine immunization coverage;
(iii) No. of Family Planning Units established;
(iv) No. of sensitization workshop on methods of infection prevention conducted in 27 LGAs;
(v). No. of health personnel trained per year;
(vi) No. of monitoring visit to health institutions/projects conducted;
(vii) Surveillance outfit for quick identification of presence of epidemic established.

(B) ENVIRONMENTAL SANITATION ACTIVITIES

Members arrived Owerri, the Imo State Capital at night, around 8:00pm, but even at that time, we were impressed with the neatness of the city and greenish environment. The city was really beautiful and attractive. During discussion with the Head of Environmental Activities of the State in the Ministry, he told members that they achieved the feat by the effective implementation of the State new Environmental Policy tagged" Imo State Environmental Transformation Programme" and by the application of the following activities: -

(i) Establishment of Taskforce on Sanitation
(ii) Ban on the Sale of Pure Water in Owerri the State Capital
(iii) Introducing Sanitation Laws Enforcement Officials
(iv) Conducting Statewide Sanitation Activities Last Saturdays of Every Months.

(a) *Establishment of Taskforce on Sanitation*

The Imo State Government has established a high-powered taskforce on sanitation with the responsibility to ensure proper sanitation condition of the state, particularly the state capital under the motto of "Clean and Green". Under that programme, in addition to clean environment, government and citizens were required to plant beautiful fancy trees and weeds along the streets with proper maintenance to beautify the environment and promote healthy habits.

(b) **Ban on Sale of Pure Water**
The sale of pure water has been banned in the State Capital. Under that law, any person caught throwing polythene bags indiscriminately is arrested by the sanitation law enforcement officials and punished by the Mobile Court there and then.

(c) **Introduction of Sanitary Laws Enforcement Officers**
knowing fully well, the attitude of its citizens, government was aware that the sanitation laws will not be fully observed completely free from default. For that reason enforcement officials had to be recruited to effectively enforce the laws. In reality, such officials are deployed at strategic locations and any one found abusing the sanitation laws are reprimanded and handed over to the mobile sanitations courts. That way, sanitation in the State Capital was tremendously achieved.

(d) **Conducting Monthly Sanitation Activities**
Imo State, just like its Adamawa State counterpart, carries out monthly sanitation exercises last Saturday of every month. In the case of Imo State, however, that exercise was effectively implemented by the other three(3) activities highlighted earlier which gave it great impact. Backed by strong political will, effective mobilization and patriotism of the citizenry Owerri, the Imo State capital is wearing a very good sanitary/healthy environment worthy of emulation.

(e) **HIV/AIDS Control Activities**
The officer in charge of this activity area told members that all its control activities are done through the State Aids Control Agency (SACA). In reality, HIV/AIDS control in Imo State is not in any way different from what is obtained in Adamawa State.

(f) **Imo State Health System Development Project II**
The role of the Health System Development Project II, previously World Bank Assisted, is meant to service the health facilities and supply them with needed equipment, appliances and materials.

The Programme Manager welcomed members and observed that the Adamawa State Government acted wisely by selecting Imo State among the States to emulate because his Government has made laudable strides in Health Care Delivery and Environmental Sanitation.

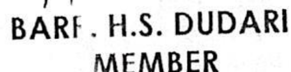
He stated that his programme did wonderfully well in promoting the quality of health Care delivery in the State. The intervention of the programme in the provision of Hospital equipment, appliances, materials and logistics has gone well in improving the effectiveness and quality of health care delivery in Imo State.

Such interventions also extend to the provision of laboratory equipment and training of professionals in that field. In fact, he stated that the intervention does not stop at only the training and retaining of appropriate professionals, for effective and efficient service delivery in the health sector, but also in the provision of suitable residential accommodation for health personnel and Youth Corpers.

He reiterated that in view of the effective intervention of the Health System Development Project II in the roll-back malaria activities, malaria indices for 2006, 2007 and 2008 reduced drastically. In fact, he identified such services as an important dividend of democracy enjoyed by the people of Imo State, which he said will not be attainable under military dispensation.

03.3 Finally, members noted that the activities of the programme is not much different from that of Adamawa State.

DR. AHMED I. MUSTAFA
VICE CHAIRMAN



BARR. H.S. DUDARI
MEMBER

AHMED I. BELLO
SECRETARY

SUB-COMMITTEE REPORT ON THE INTER-STATE VISIT TO KWARA STATE MINISTRY OF HEALTH ON 24TH TO 27TH AUGUST, 2008

01.1 MEMBERSHIP

(1)	Dr. L.C. Barka	DDC	-	M.O.H.
(2)	Mr. Moh'd Nayako	DPHC	-	MLG

02.1 On the 25th of August 2008 we met with the Director of Primary Health Care at the State Level. She apologized that she had immunization problem with un-authorized persons, which resulted into public outcry. So the Governor have directed that no outside visitors will be entertained on Health matters without his authority.

However, we were able to discuss the structure of their Primary Health Care Services. She said there is a strong working relationship between the State Ministry of Health and Local Governments in the implementation of Primary Health Care Services.

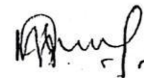
All Local Government Areas in the State have staff of various cadres posted to relevant. However, there are being paid by the State. In turn, the Local Government have their own staff and they pay their salaries.

The other point to note is that they post key officers e.g. midwives to the LGAs so as to improve quality of service. Its obvious from their field activities e.g. IPDS, immunization. Plus days is designed to increase immunization coverage using all the key policy makers of the State participate e.g. Hon.

Commissioner and his directors, legislators and councilors of the LGAs participate. Apparently their strategy seem to works since in most meetings Kwara state stands out in performance, e.g. High immunization coverage and low infant mortality rate.

Their strategy of involving highly skilled state people in implementing Primary Health Care activities has brought into the service highly skilled people at the grassroots level and hence the observed high performance.

(DR. L.C. BARKA)
MEMBER



ALH. MOH'D M. NYAKO
MEMBER

MINUTES OF CONSULTATIVE MEETING WITH LOCAL NGOs HELD AT THE CONFERENCE HALL OF MINISTRY OF HEALTH ON 9TH SEPTEMBER, 2008.

ATTENDANCE

1.	Dr. Zainab M. B. Kwonch:-	Hon. Com. Health	Chairman
2.	Dr. Ahmed I. Mustafa:	Ex. Chairman HSMB	V. Chairman
3.	Dr. L. C Barka	Dir. Disease Control	Member
4.	Dr. A. B. Girei	PSA-H/Excellency	"
5.	Ahmed I. Bello	Dir Admin HSMB	M/Co-opted
6.	Mohmood M. Nyako	DPHC MLG Affairs	"
7.	Ramatu D. William	Rep. ASPC	Secretary

PARTICIPANTS

1.	Mr. Amos Yusuf Sunday	CVIF, Yola
2.	Mal Aminu Buba Chukkol	JNI, Yola
3.	Saratu Yakubu	FOMWAN HQTRS, Yola
4.	Fadimatu Umaru	FOMWAN, Yola North
5.	Zarah M. Bello	FOMWAN, Yola North
6.	Aishatu A. Mustafa	FOMWAN Yola South
7.	Haj. Larai A. K. Idris	FOMWAN HQRS, Yola
8.	Mrs. Ayuka U. Gwalem	DAWA, Yola
9.	Mrs. Farah N. James	SPHS, Yola
10.	Mrs. Blessing Newton James	G&L INTL Yola
11.	Aisha A. Abba	FOMWAN, Yola South.

2.0 OPENING PRAYER/PREAMBLE

2.1 The meeting started at 12:05 with opening prayer from Mal. Aminu B. after which participants and committee members present introduced themselves.

2.2 As a preamble, the chairman after welcoming the participants highlighted on the committee assignment as a means of addressing the deteriorating health care delivery condition of the state by Government. It is expected that at the end of the forum, the participants would arrive at giving some recommendations aimed at improving health care delivery services in the State. The chairman itemized the following health problems for discussion.

They are as follows:-

i. Basic courses of ill health in communities.
ii. High rate maternal and infant mortality.
iii. Prevalence of communicable and non-communicable diseases.
iv. VVF occurrence
v. Infrastructure
vi. Drug supply and other related health problems.

3.0 GENERAL BUSINESS

3.1 In responds the participants identified some of the problems militating against health care services delivery in the State such as inequitable distribution of health facilities, poor community participation, lack of intersectoral collaboration amongst line ministries, bribery and corruption, poor, monitoring and evaluation

of funds released on projects and programmes, inflation of contracts, vaccine diversion, poor roads network making other villages inaccessible, poverty etc.

3.2 The participants also listed some of the problems as follows:-

i. Husbands not allowing their wives to come out to listen to awareness campaigns.

ii. Shortage of manpower, poor remuneration of health and medical workers, lack of employment of trained and qualified health personnel, lack of implementation of health sector annual budget and budget discipline.

iii. Recent pronouncement by Government on the issue of free drug programme to women and children of age 0-5 years, that a clear modus operandi of the programme is not clear and that such drugs are only available in the urban areas, as a result, rural health facilities were deserted by ANC attendees in search of free drugs.

iv. Anti-Retroviral drugs administration centres were not geographically spread and that the name "KANJAMAU" as referred to HIV/AIDS patients and disease is a stigma that needs to changed adoption of the name "SIDA" is welcome.

v. Lack of adherence to prescribed drugs by PLWHA and pregnant women leads to spread of the disease and ill health among pregnant women who refuse to take their dugs (multivite and folic acid, B. Complex). To overcome some of the problems listed above, the participants made the following recommendation.

i. Health facilities in the State to be spread according to need and population to meet up the WHO requirement of 5Km distance apart for health facilities.

ii. Monitoring and evaluation of all Government health related projects and programmes to be done at all levels to ensure implementation, check bribery and corruption, inflation of contract sum through review and monitoring of drug supply.

iii. Training and re-training of health personnel should be done and wages of health workers to be re-viewed upward for effective health care delivery.

iv. Media houses should be involved in awareness campaigns by slotting health issues during public favourite programmes and news time.

v. Annual Budget on health programmes and projects to be strictly adhered to and budget discipline to be adopted by health sector managers.

vi. Religious organizations should educate their followers on the importance of Government programmes e.g. Immunization programmes.

vii. Drugs should be purchased directly from manufacturers to reduce high cost.

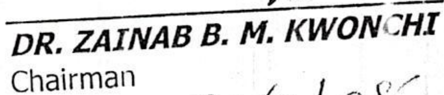
viii. Meeting of stakeholder is to hold monthly to address health issues in the State and promote intersectoral collaboration.

ix. List of free drugs should be published and pasted at all centres of the administration of the free drugs.

x. Community participation at ward, village and Local Government levels should be encouraged by forming community Development Committees to overseer programmes and projects of the communities especially the CBBI programme.

4.0 **CLOSING REMARKS/PRAYER**

In the absence of other discussions, the Chairman thanked the participants for turning up to the meeting and for their contributions that made the meeting a success. The meeting was closed at 2:40pm with a word of prayer said by Haj. Larai A. K.Idris.



DR. ZAINAB B. M. KWONCHI
Chairman
20/11/08

MRS. RAMATU D. WILLIAM
Secretary.

MINUTES OF CONSULTATIVE MEETING WITH REPRESENTATIVES OF LINE MINISTRIES HELD AT THE BOARD ROOM OF HOSPITAL SERVICES MANAGEMENT BOARD, ON 16TH SEPTEMBER, 2008.

ATTENDANCE

1.	Dr. L. C. Barka	Dir. Disease Cont. MOH	Ag. Chairman
2.	Dr. A. B. Girei	PSA H/Excellency	Member
3.	Barr. H. S. Dudari	Rep. MOJ	"
4.	Mr. Farauta George	Rep. MOF	"
5.	Mahmood M. Nyako	DPHC LG/Affairs	Member-Co-opted
6.	Ahmed I Bello	Dir. Admin HSMB	"
7.	Mrs. Ramatu D. William	Rep ASPC	Secretary.

PARTICIPANTS

1.	Mr. Joseph Onyike	Ministry of Environment
2.	James Pukuma	Ministry of WASD
3.	Bajam Umaru	Ministry of Agric.
4.	Babayo Iliyasu	"
5.	Tiku M. Joel	Ministry of LG/Affairs
6.	Afisawa Istifanus	Ministry LG/Affairs.

2.0 **OPENING PRAYER/PREAMBLE**

2.1 The meeting started at 11:05am with opening prayer from Mal. Umaru Bajam after which introduction of participants and the Committee members present was done.

2.2 The Ag. Chairman welcomed participants and highlighted on the Committee assignment and hoped that the participants will contribute positively, towards improving health care delivery in the State. He enumerated some of the factors responsible for non-achievement of the Millennium Development Goals (MDGs), of reducing infant mortality and improving maternal health as follows:-

i. Poverty
ii. Ignorance
iii. Culture and Religion
iv. Poor health care services
v. Substandard infrastructure
vi. Filthy Environment
vii. Lack of clean drinking water
viii. Malnutrition
ix. Lack of drugs.
x. Inadequate manpower, especially the midwives responsible for saving the life of pregnant women and children during labour.

It is expected that at the end of the forum the participants would arrive at giving some recommendations aimed at improving health care delivery services by Government. The following problems were itemized by the Ag. Chairman for discussion. They are as follows:-

i. Infrastructure-General
ii. Drug Supply
iii. Health Staff-Remuneration, Training and shortage
iv. Environment

v. Social Mobilization

vi. Community participation

vii. Local and International Donor participation in health care delivery Assistance in the State,

viii. High rate of infant and maternal mortality due to malnutrition and other factors etc.

3.0 GENERAL BUSINESSES:

3.1 INFRASTRUCTURE

The participants observed that:-

i) The structures built 15 years ago for PHCs were not renovated. Hence there is need for renovation and new ones built to meet up with WHO requirement of 5km distance apart from health facilities.

ii) Uniformity in structures should be adopted by all LGAs for PHCs and staff quarters should be constructed along side structures, to solve staff accommodation problems.

iii) Local Governments should agree on list of basic equipments per type of facility and provide them.

3.2 DRUG SUPPLY

i. Participants discussed on the recent pronouncement by Government on the issue of free drugs for pregnant women and children of ages 0-5, that there is a problem of sustainability and availability of such free drugs for all the pregnant women and children of ages 0-5 years in the State.

ii. They agreed that Local Communities of the State should re-suscitate the CBBI programmes in all LGAs.

3.3 **HEALTH STAFF RENUMERATION, ETC.**

The participants agreed that shortage of manpower can be meet through training and re-training of existing staff and also by employing grandaunts of Health institutions who are jobless and that all Local Governments should sponsor health related courses. Shortage of health staff in Toungo Local Government Area should be addressed by Ministry of Health and that the Government should review salary of health workers upward to stop brain drain and encourage medical doctors to take up appointments in the State.

3.4 **ENVIRONMENT.**

The participants observed that high rate of malaria prevalence can be attributed to blockage of drainages, illegal structures, dumping of refuse in drainages, lack of refuse collection and management which leads to dirty environment etc. they suggested that:-

- Media enlightenment to create awareness on the dangers of dirty environment to a community should be done.
- Households should be involved in refuse management
- Proposal in the annual budget should be in place to contract refuse cleaning and dumping by Government to keep the environment clean and funds should be made available for daily refuse collection.

- A committee on environmental problems should be formed by Government to address the problems.

3.5 **SOCIAL MOBILITATION**

Participants agreed that mobilization of all communities through enlightenment campaigns should be championed by Ministry for women affairs, the media, the Ministry of Environment, Ministry of Agriculture, Planning Commission, Ministry of Commerce, etc to

i.) Provide soft loans for women to reduce poverty

ii.) Discourage early marriage and discourage bad cultures.

iii.) Discourage Tribal Marks which leads to tenanus infection.

iv.) Encourage women participation in commercial activities with the consent of their husbands.

v.) Produce foods that are rich in proteins and vitamins through cultivation of vegetable gardens.

vi.) Encourage women on the need to keep their environment clean.

vii) Publish statistics on infant & maternal mortality and socio-economic statistics of Adamawa State.

viii.) Encourage intersectioral collaboration of all sectors of Government to achieve the MDGs Goals, etc.

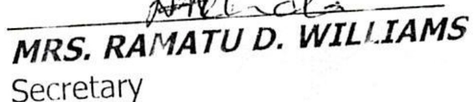
3.6 Participants also agreed that community participation can be improved by forming development committees at ward, village and local Government levels to overseer developmental programmes and projects of the communities and should be a voluntary service.

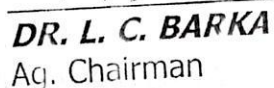
3.7 Assistance towards improvement of Health care delivery in the State by Local and international donor Agencies can be obtained by providing accurate data on situation analysis was the opinion of the participants.

3.8 Participants agreed that all stake holders must be involved in providing effective health care delivery in the State so as to achieve reduction in child mortality and maternal mortality, prevalence of HIV/AIDS, malaria and other diseases and improve the life span of the people of Adamawa State.

4.0 CLOSING REMARKS/PRAYER

In the absence of further discussions, the Ag. Chairman thanked participants for their contribution in the discussion, and declared the meeting closed at 3:40pm with prayers from Mr. James Pukuma





DR. L. C. BARKA
Ag. Chairman

MRS. RAMATU D. WILLIAMS
Secretary

MINUTES OF CONSULTATIVE MEETING WITH PROFESSIONALS HELD AT THE BOARD ROOM OF HOSPITAL SERVICES MANAGEMENT BOARD, ON 17TH SEPTEMBER, 2008.

ATTENDANCE

1.	Dr. L. C. Barka-Director Dis. Cont. MOH	-	Ag. Chairman
2.	Dr. A. B. Girei- PSA H/Excellency	-	Member
3.	Barr. H. S. Dudari Rep. MOJ	-	"
4.	Mr. Farauta George Rep. MOF	-	"
5.	Mahmood M. Nyako- DPHC LG/Affairs	-	Member-Co-opted
6.	Ahmed I. Bello- Dir. Admin	-	"
7.	Ramatu D. Williams (Mrs.)	-	Secretary.

PARTICIPANTS

1.	Andrawus F. Tarfa	-	NUJ
2.	David Molomo	-	NUJ
3.	Philip L. Pulasar	-	Dir. Nursing HSMB
4.	Polycarp L. Salus	-	Chief Pharm. HSMB
5.	Lazarus Gideon	-	Lab Scientist HSMB
6.	Dr. Zira Kumanda	-	Dr. Hospital HSMB

2.0 **OPENING PRAYER/PREAMBLE**

2.1 The meeting started at 12:10am with opening prayer said by Mr. Farauta George after which the participants and committee members present introduced themselves.

2.2 The Ag. Chairman after welcoming the participants highlighted on the committee assignment that it was formed by the State Government with the aim of finding solutions to the deteriorating health care delivery system of the state and to outline developmental plans aimed at improving the system. It was in this regard that as professionals they were invited to make positive contributions aimed at salvaging the system. He itemized some of the problems with the Health care delivery in the state as follows:-

i. Deteriorating health facilities
ii. High rate of infant and maternal mortality
iii. Inadequate number of Health staff.
iv. Poverty, which courses malnutrition
v. Drug supply and other socio-cultural factors.

3.0 **HEALTH FACILITIES**

The participants after deliberation recommended that along term plan of say 5 years should be adopted by Government to renovate the existing health facilities and new ones constructed and equiped to meet up with the WHO 5km distance apart for health facilities. A monitoring and evaluation of all Government Health related projects and programmes is to ensure prudent resources management to be done at all levels of implementation and that contracts for projects is to be awarded after competitive beedings.

4.0 **HIGH MARTERNAL AND INFANT MORTALITY RATE.**

The participants lamented on the activities of private quake medical practitioners whose activities if unchecked would further increase

the rate of maternal mortality and infant mortality in the state. These private operators according to the participants operate under dirty environment and use sub-standard equipments on patients and therefore call on the Government to check activities of these private practitioners to save the lives of especially women and children. A committee should be set in place for supervision and recommend to Government for closure of all private facility that are sub-standard.

5.0 INADEQUATE NUMBER OF HEALTH STAFF

The participants observed with dismay the attitude of some Health personnel who refuse to accept postings to rural areas and thus results in scarcity of services in the rural areas. They suggested that all staff should accept postings in good faith and that recruitment of graduates of health institutions should be done by Government to improve their number.

Training and re-training of health personnel should be embarked on by all L. G. A and HSMB. An upward review of Health workers wages to be approved by Government for effective health care delivery.

6.0 POVERTY AND MALNUTRITION

Participants after deliberation agreed that there is need for intersectoral collaboration of all sectors of Government to educate, enlighten and encourage the people of Adamawa State to find ways of overcoming poverty and malnutrition. The Government should fund the Ministry of information to channel Government activities to the grass roots by use of projectors and other equipments.

The media houses should be patronized by Government as a means for public enlightenment. The Ministry of Health should include in their annual budget media activities for sponsorship of its programmes. The skill acquisition centres should have media coverage to portray commitments of communities to Government programmes. The communities should be educated on the need to produce crops rich in proteins and vitamins to overcome malnutrition.

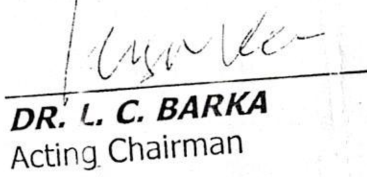
7.0 DRUG SUPPLY

Participants observed that the recent pronouncement by Government to provide free drugs to pregnant women and children of ages 0-5 years is too expensive for implementation because of the population involved and sustainability of the programme and therefore suggested that the Government should purchase drugs directly form manufacturers and sale to patients at subsidized rate and the funds revolved.

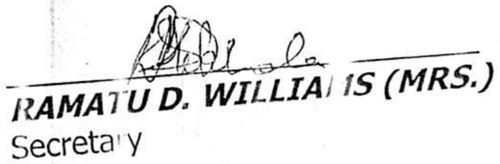
They called on the Government to allow professionals to be properly used their in the field of specialization in order to avoid lapses that may arise in not doing so.

8.0 **CLOSING REMARK/PRAYER**

In the absence of other discussions, the Chairman thanked participants for turning up to the meeting and declared the meeting closed at 3:50pm with a closing prayer from Ahmed I. Bello



DR. L. C. BARKA
Acting Chairman



RAMATU D. WILLIAMS (MRS.)
Secretary

MINUTES OF CONSULTATIVE MEETING WITH ALL ADAMAWA STATE LOCAL GOVERNMENT AREA PHC DIRECTORS AND CBBI REPRESENTATIVES HELD AT THE CONFERENCE HALL OF HOSPITAL SERVICES MANAGEMENT BOARD ON 18TH SEPTEMBER, 2008.

ATTENDANCE

1.	Dr. L. C. Barka	-	Dir. Disease Cont. MOH	-	Ag. Chairman
2.	Dr. A. B. Girei	-	PSA H/Excellency	-	Member
3.	Barr. H. S. Dudari	-	Rep. MOJ	-	"
4.	Mahmood M. NYako	-	DPHC LG/Affairs	-	M/Co-opted
5.	Bashiru Ahmad	-	Executive Chairman ASPC	-	Special Guest
6.	Mrs. Ramatu D. William		Rep. ASPC	-	Secretary.

PARTICIPANTS

1.	Jebu M. Baba	-	DPHC Girei
2.	Rahimatu M. Nyako	-	DPCH Fufore
3.	Jimmy M. Kati	-	Rep. DPHC Numan
4.	Joab H. Salma	-	CBBI Shelleng
5.	Bulus I. Dawango	-	Rep. DPHC Shelleng
6.	Peter Jabasu	-	CBBI Shelleng
7.	Penninah E. Lamu	-	DPHC Demsa
8.	John Hamidu	-	Rep. DPHC Mubi South
9.	Clement Ndolo	-	CBBI Numan
10.	Kenneth N. Sakiyo	-	HOS Demsa
11.	Yakubu N. Nekenjumu		DPHC Yola South
12.	Mohammed Bala Isa		DES Mubi South
13.	Kabiru W. Sadiq		DPHC Gombi L. G. A
14.	Shuaibu Bin Abdu		DPHC Hong L. G. A.
15.	Bala Yuguda Sanda		DPHC Fufore L. G. A
16.	Mohammed Usman L		CBBI Madagali L.G.A

17. Paul Papka DPHC Madagali L. G. A
18. Dauda Inuwa CBBI Hong L. G. A
19. Sajo S. Gayus DPHC Hong L. G. A
20. Grace Danbaki DPHC Lamurde L. G. A.
21. Alh. Yusuf Y. Garba DPHC Mayo-Belwa
22. Abdukarim Bukar DPHC Maiha L. G. A.
23. Abba A. Medugu HOS Guyuk L. G. A.

2.0 **OPENING PRAYER/INTRODUCTION.**

2.1 The meeting started at 11:50am with opening prayer from Mr. John Hamidu, after which the participants and committee members present introduced themselves.

2.2 The Ag. Chairman welcomed participants to the meeting and highlighted on the committee assignment that it was formed by Government of Adamawa State with the aim of studying the deplorable health conditions of the State and to draw a plan with the aim of addressing the problems and enable the state benefit from E. U assistance in health care delivery system of the State. It was in this regard all Adamawa State PHC directors and CBB1 representatives were invited to make positive contributions aimed at improving the health care delivery of the State.

The Acting Chairman listed some of the problems to be discussed at the meeting as follows:-

i. Structures and facilities
ii. High rate of maternal and child mortality
iii. Shortage of staff.
iv. Community participation.
v. Drug supply.
vi. Logistics, etc.

3.0 STRUCTURES AND FACILITES

The participants observed the need for Government to pin down plan for renovation of PHCs and to equip them with simple modern facilities that are easy to maintain.

Uniform structures should be adopted in building PHC facilities by type and should be of the same standard all over the State. The Health facilities should be spread according to need and population to meet up the WHO requirement of 5km distance apart from each Health facility.

Communities should be involved in project planning and execution to enable them co-manage the facility with the Government. Staff quarters should be built alongside the health facility to solve staff accommodation problems.

4.0 HIGH RATE OF MARTERNAL AND CHILD MORTALITY.

Participants agreed that indeed there is high rate of maternal and child mortality and these can be attributed to several factors which can be summarized as poor health care services delivery. On improvement of the health care services delivery, which will take a long time the rate of maternal mortality and child mortality will be reduced. They suggested that more midwives should be trained to meet up with the shortages.

5.0 SHORTAGE OF STAFF

Participants lamented that employment of health workers has not been done in the past 15 years by the Local Government Service Commission. They called on the LGSC to as a matter of urgency lift ban on employment and employ qualified health staff to meet up with the shortages. The staff

should be centrally controlled by the commission and should be posted to the LGAs that don't have enough health staff on ground.

Local Governments should embark on sponsoring indigenes of origin studying health related courses and should employ there after completion of studies.

6.0 COMMUNITY PARTICIPATION

Participants lauded the efforts of various communities in the State in running the CBBI. However, most CBBI activities in the various Local Governments needs to be resuscitated. Development committees are to be constituted at ward, village and Local Government levels to handle developmental programmes and projects of communities and should be voluntary services.

7.0 DRUG SUPPLY

Participants lamented on the attitude of some Health organizations which allow essential drugs to expire and at last destroyed, while some communities are in dear need of such drugs It was agreed, therefore, that health workers should identify such drugs ahead of time and make it available for other users to buy and the money realized from such sales should be saved in Banks for the owners. The activities of CBBI in relation to purchase and sale drugs should be encouraged at community level and should be properly monitored to ensure accountability.

8.0 LOGISTICS

Participants observed that supervision by Directors of PHC is not being done in all the Local Governments. It was agreed that a memo requesting the purchase of A 4 x 4 wheel drive vehicles should be written to His Excellency by the Hon. Commissioner of Health to supply all the 21 Local

Governments Areas in Adamawa State with Primary Health Care Inspection vehicles. Monitoring to ensure on the job training should be done by the DPHCs. A monthly/daily monitoring charts should be used by the directors. The DPHCs should also be involved directly during immunization periods.

9.0 PRESENTATION BY THE EXECUTIVE CHAIRMAN A. S. P. C.

The Executive Chairman, Adamawa State Planning Commission, Bashiru Ahmad, who was a special Guest at the Meeting made a presentation on situation analysis of Primary Health care facilities through a survey report on Primary Health Care, a survey conducted in June, 2008. The survey report revealed that:-

- Survey reported 807 PHC facilities existing and functional across the State.
- Infrastructure
  345 (42.6%) of the facilities are dilapidated
  Only 53 (6.5%) have established basic laboratory
  95% of the facilities are poorly equipped 157 (19.5%) have good toilet facilities 40 (5%) have running tap water.
- Staffing.
  There are a total of 4,315 PHC staff.No LGA has a designate Medical Officer of Health only 29 PHC clinics have trained Midwives (total midwives=48) 3, 923 (66.2%) of the staff are non-medical (attendants/cleaners/watchmen etc).
- Summary of staffing

Doctors	0	(0.0%)
CHEWs/JCHEWs	1,614	(27.2%)
Nurses	162	(2.7%)
Midwives	48	(0.8%)
Laboratory Staff	69	(1.2%)

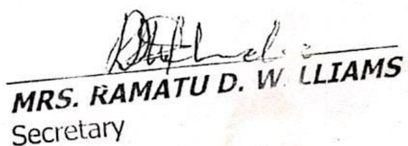
Pharmacy Staff	27	(0.5%)
Storekeeper	19	(0.3%)
Medical Record Staff	67	(1.1%)
Attendants/cleaners	2,249	(37.9%)
Other staff		1,674 (29.2%)
Total staff		4,315 (100.0%)

NB: CHEWs/JCHEWs were only estimated since at least 2 per clinic exist in most situations.

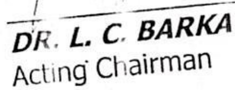
It is in this regard that all stake holders of health care services delivery in the state should put hands on desk to salvage the rather ugly situation and that should be timely done.

10.0 **CLOSING REMARKS/PRAYER**

In the absence of other discussions, the Acting Chairman thanked the Executive Chairman Adamawa State Planning Commission and the participants for honouring their invitation despite short notice and wished them journey mercies to their various destinations. He declared the meeting closed at exactly 3:25pm with a prayer from Haj. Jebu M. Buba.



MRS. RAMATU D. WILLIAMS
Secretary



DR. L. C. BARKA
Acting Chairman