



FEDERAL REPUBLIC OF NIGERIA

FEDERAL MINISTRY OF HEALTH, ABUJA

HEALTH SECTOR REFORM PROGRAMME

**Strategic Thrusts with a Logical Framework and a
Plan of Action, 2004 – 2007**

September 2004

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ACRONYMS and ABBREVIATIONS

AIDS	-	Acquired Immunodeficiency Syndrome	IDRS	-	??
ARI	-	Acute Respiratory Infections	ISC	-	Implementation Steering Committee
ARVs	-	Antiretrovirals	ITNs	-	Insecticide-Treated Nets
BCC	-	Behavioural Change Communication	LEEDS	-	Local Economic Empowerment Development Strategy
BEOC	-	Basic Emergency Obstetric Care	LGA	-	Local Government Area
BOI	-	Bank of Industry	MDGs	-	Millennium Development Goals
CBN	-	Central Bank of Nigeria	M&E	-	Monitoring and Evaluation
CBO	-	Community-Based Organization	MHA	-	Mutual Health Association
CEOC	-	Comprehensive Emergency Obstetric Care	MICS	-	??
CHEWS	-	Community Health Workers	MTEF	-	Medium-Term Expenditure Framework
CITES	-	??	NAFDAC	-	National Agency for Drugs Administration and Control
DFID	-	Department for International Development	NASS	-	National Assembly
DHS	-	Demographic Health Survey	NCH	-	National Council on Health
DOTS	-	Directly Observed Treatment Services	NDHS	-	National Demographic Health Survey
DRFs	-	Drug Revolving Funds	NDLEA	-	National Drugs Law Enforcement Agency
DSA	-	Daily Sustenance Allowance	NEEDS	-	National Economic Empowerment Development Strategy
DTA	-	Daily Travel Allowance	NGO	-	Non-Governmental Organisation
EOC	-	Essential Obstetric Care	NHA	-	National Health Account
FBO	-	Faith Based Organisation	NHIC	-	National Health Insurance Council
FEC	-	Federal Executive Council	NHIF	-	National Health Insurance Fund
FGN	-	Federal Government of Nigeria	NHIS	-	National Health Insurance System
FHIs	-	Federal Health Institutions	NHMIS	-	National Health Management Information System
FMF	-	Federal Ministry Finance	NHP	-	National Health Policy
FMJ	-	Federal Ministry of Justice	NHSA	-	National Hospital Service Agency
FMOH	-	Federal Ministry of Health	NIMR	-	National Institute of Medical Research
FMOH-VAMED	-	??	NIPRD	-	National Institute for Pharmaceutical Research and Development
GAVI	-	Global Alliance for Vaccine Initiative	NITDA	-	National Information Technology Development Agency
GNP	-	Gross National Product	NPHCDA	-	National Primary Health Care Development Agency
HIV	-	Human Immunodeficiency Virus	NPI	-	National Programme on Immunisation
HLF	-	High Level Forum	OHSF	-	Office of Head of Service of the Federation
HMO	-	Health Maintenance Organisation	OPS	-	Organised Private Sector
HSDP	-	Health Systems Development Project	PCN	-	Pharmaceutical Council of Nigeria
HSPA	-	Health Systems Performance Assessment	PHC	-	Primary Health Care
HSR	-	Health Sector Reform	PHIF	-	Private Health Insurance Fund
HRSC	-	Health Sector Reform Committee	PHSA	-	??
HSRP	-	Health Sector Reform Programme	PIGMAN	-	Pharmaceutical Industry Group of Manufacturers Association of Nigeria
ICTs	-	Information and Communication Technologies	PIT	-	Project Implementation Team

POA	-	Plan of Action
PPP	-	Public-Private Partnership
PSN		Pharmaceutical Society of Nigeria
R&D	-	Research and Development
RBM	-	Roll Back Malaria
RMS		??
SEEDS	-	State Economic Empowerment Development Strategy
SHMB		State Health Management Board
SIN		??
SMOH	-	State Ministry of Health

SPHCMB		State Primary Health Care Management Board
STDs	-	Sexually Transmitted Diseases
STIs		Sexually Transmitted Infections
SON	-	Standards Organisation of Nigeria
TB	-	Tuberculosis
TMC	-	Top Management Committee
TORs		Terms of Reference
UNDP		United Nations Development Programme
VVF	-	Vesico Vagina Fistulae
WSDP		??

EXECUTIVE SUMMARY

The Federal Ministry of Health has the responsibility to develop policies, strategies, guidelines, plans and programmes that provide direction for the national health care delivery system. In addition, the Ministry is currently a major provider of tertiary health care services and various other health intervention programmes aimed at promoting, protecting and preventing ill health of Nigerians. The **HEALTH SECTOR REFORM PROGRAMME (HSRP)** establishes a framework, including goals, targets and priorities, that should guide the action and work of the Federal Ministry of Health and, to some extent, State Ministries of Health and our health development partners over the next four years, 2004-2007. The document sets the tempo and direction for strategic reforms and investment in key areas of the national health system, within the context of the overall Government macroeconomic framework, NEEDS – the *New Economic Empowerment and Development Strategy* – which is aimed at re-orienting the values of Nigerians, reforming government and institutions; growing the role of the private sector, and enshrining a social charter on human development with the people of Nigeria.

The health system in Nigeria and the health status of Nigerians are in a deplorable state: Nigeria's overall health system performance was ranked in the 187th position among the 191 Member States by the World Health Organization in 2000. Health status indicators are worse than the average for sub-Saharan Africa. For example, infant mortality rate of 115/1,000, under-5 mortality rate of 205/1,000, and maternal mortality ratio of 948/100,000 (range 339/100,000 to 1,716/100,000) are among the highest in the world.

Disease programmes such as HIV/AIDS, TB and malaria and other programmes, such as reproductive health, are currently being implemented within a weak health system and hence have had little impact. The relatively high routine immunization coverage in early 1990s

has dropped to an all time low and there has been little improvement. Primary health care facilities serve only about 5-10% of their potential load. Public expenditure on health is less than \$10 per capita compared to the \$34 recommended internationally. Private expenditure is estimated to be over 70% of total health expenditure with most of it coming from out-of-pocket expenditures in spite of the endemic nature of poverty in Nigeria. Consumers' health knowledge and awareness of their rights to quality care are low. Partnerships between the public and private sectors are mostly non-existent or ineffective. Donors and other development partners are poorly coordinated.

Constitution: Under the current 1999 Constitution, only vague reference is made to the responsibility of LGAs for health. In Section 45, the Constitution makes provision only for the overriding of individual rights, if it is in the interest of, among other things, public health. The current Constitution, therefore, falls short of specifying what roles the LGAs, State and Federal Governments must play in the national health care delivery system. For the health sector, this is a very serious omission since Nigeria's current health system is built on a three-tier system, with LGAs being the main implementing agents of primary health care.

Population Growth: The rapid population growth in the country has overstretched the social resources. Our past failure to factor in population figures in our planning has also made our health planning unrealistic and it has led to the provision of inadequate facilities for the teeming and increasing population.

Managerial Accountability: One of the biggest constraints to reform remains the rigidity of the civil service. For example, the cost of personnel of the departments within the FMOH is not managed by the FMOH. The Ministry does not recruit some categories of personnel found on the Ministry's payroll. The cumulative effect is that there is little accountability. The annual budget preparation exercise hitherto can be described as a "ritual" and over- expenditure has been rampant. There is a general lack of transparency and fiscal discipline, as well as a complete absence of a

healthcare-financing framework to guide government's rationale for investment, allocation and disbursement of resources.

Health Management Information System: The health management information system is weak and has not been able to provide adequate evidence for policy/programme development and implementation.

Inter-ministerial and State Collaboration: The FMOH is yet to establish regular working relationships with the Federal Ministries of Agriculture and Education and with other health-related Ministries, such as Science and Technology, Water Resources, Housing Works, Transport and Environment. Despite the existence of policy, there is no sense of cohesion between the States and the FMOH. There is no consultation and no cooperation. State authorities perceive the National Health Council which meets once a year for a week as a waste of time, a "talk-shop" where it is alleged that the FMOH tries to get the States to merely rubber-stamp decisions already taken.

Monitoring and Evaluation: Since the FMOH is accountable for the health of the nation, it is imperative that it sets goals for the entire nation and monitors progress. This is not yet happening across much of the nation. There is an ineffective and fragmented information system in place, and information from the private sector is not being captured, thus making comprehensive health planning difficult.

Organizational Structure and Reporting Relationships: The existing system is so complex and has grown out of so many obtuse "needs" that the best approach to reform is to start afresh and plan the system *de novo*.

Health Finance and Expenditure: In the past, the budget was a paper exercise and no one paid any attention to it at all. The real cost of health services is not known, as there is no system for National Health

Accounts (NHA). There are no reliable data or information on the combined Federal, State and LGA expenditures, nor on expenditures from private and donor sources. There is no broad-based health financing strategy, even with the planned commencement of a National Health Insurance Scheme (NHIS).

Pharmaceuticals and Medical Supplies: Fake, sub-standard, adulterated and unregistered drugs are prevalent, in spite of the highly visible and commendable efforts of NAFDAC. Erratic supplies, non-availability of some basic essential and specialized drugs and other health materials as a result of heavy dependence on imported drugs are common. At present, only 40% of pharmaceuticals consumed in the country are produced locally and 100% of the active ingredients for this production is imported. The drug distribution system is chaotic as a result of adherence to current regulations and a lack of update pharmaceutical regulations. Furthermore, the roles and responsibilities of different players are yet to be defined. Efforts aimed at local research and development of pharmaceutical raw materials is yet to yield the desired results due to low funding of research and development.

Management and Management Systems: Management of the limited health resources available is ineffective and inefficient. There is a culture of corruption and the promotion of self-interest.

The Disease Burden: Available information indicates that malaria, ARI, measles, diarrhoea, TB and HIV/AIDS/STIs account for a disproportionate share of ill-health and deaths among Nigerians. They also have adverse effects on socio-economic development and school attendance. These are all preventable diseases. With a well-organized health system and active community participation, the diseases can be controlled to a point where they cease to be of public health importance.

Human Resources for Health: With nearly 50 universities in the country, including University Teaching Hospitals, trained health personnel should not be difficult to find. However, their distribution and skills mix are a source of serious concern. The issue of poor motivation and low remuneration has an adverse effect on the morale of professional health workers. The issue of brain drain also constitutes a problem,

especially where the qualified personnel pursues lucrative jobs beyond the shores of this country.

Vision and Mission of the Federal Ministry of Health

1. **Vision**: To reduce the morbidity and mortality rates due to communicable diseases to the barest minimum; to reverse the increasing prevalence of non-communicable diseases; meet the global targets on the elimination and eradication of diseases; and significantly increase the life expectancy and quality of life of Nigerians.
2. **Mission**: To develop and implement appropriate policies and programmes, as well as undertake other necessary actions that will strengthen the National Health System to be able to deliver effective, quality and affordable health services to all Nigerians.

Health Sector Reform Programme (HSRP)

The preceding account of the existing features and performance of the national health system is unacceptable. The Federal Ministry of Health, with the support of the National Council on Health (NCH), has committed to undertake a sustained process of ***fundamental change*** in policy, regulation, financing, provision of health services, re-organization, management and institutional arrangements, that is led by Government, and designed to improve the performance of the health system to attain a better health status for the Nigerian population.

Content: Seven (7) strategic areas of work have been identified, through a nation-wide consultative process which started during the first term of President Obasanjo's administration. It is within these areas that the Ministry intends to undertake various reform initiatives. The areas of work are:

- Improving the stewardship role of Government;
- Strengthening the national health system and its management;
- Reducing the burden of disease;
- Improving availability of health resources and their management;
- Improving access to quality health services;
- Improving consumers' awareness and community involvement; and,
- Promoting effective partnership, collaboration and coordination.

The cross-cutting areas of work that will also receive focused attention include an effective ***health management information system (monitoring & evaluation)*** and a ***communication strategy*** for mobilizing and sustaining the HSRP.

Within each of the strategic thrusts for the reform programme, a number of priority health sector performance issues have been identified for focused interventions. Their perceived sector-wide catalytic effects inform the choice of issues.

Key Health Sector Reform Performance Issues:

The components of the Health Sector Performance issues addressed by the HSRP are as follows:

- A. **Improving the Stewardship Role of Government**
 - Review of existing health policies and strategies, including existing legislation;
 - Enactment of a National Health Act that re-defines the National Health System as well as the functions of each level of government;
 - Deployment of ICTs; and
 - Development and implementation of 5-year strategic plans and 2-year plans of action by departments of FMOH, State Ministries of Health, Parastatals, Teaching and other Tertiary Health Institutions.
- B. **National Health System & its Management**
 - Redefining the essential public health functions, roles and responsibilities of the FMOH, its parastatals and other agencies;

- Development of an appropriate structural mechanism and procedure in response to the redefined functions, roles and responsibilities;
- Review of the laws setting up all National Health Institutions (NPHCDA, NPI, NHIS, NIMR, NAFDAC & NIPRD) with the aim of streamlining their roles, functions and operations in conformity with the spirit of the national health policy;
- Revitalization of the PHC system; and
- Refurbishing of tertiary health institutions and the standardization of their equipment.

C. Reduction of Disease Burden

- Revitalization of the PHC System to deliver the minimum package of healthcare, including effective routine immunization;
- Development of an appropriate health sector response to HIV-AIDS, Maternal mortality, Malaria, TB and other infectious diseases as specified in the MDGs; and
- Promotion of healthy lifestyles through reduction of risk factors.

D. Improving Availability of Health Resources & their Management

- Construction and institutionalization of a national health account (NHA);
- Development of a comprehensive healthcare financing strategy to include payment mechanisms and arrangements that promote incentives to improve health service delivery, and refocusing of the current strategy for the implementation of NHIS;
- Development of a national strategy for human resources in health, including a performance-based human resource management system, training and skills upgrading within the context of the new public sector reform;
- Development of a maintenance system for physical assets in public health institutions; and

- Stimulating the local production of health inputs, e.g., drugs, including ARVs, vaccines, ITNs and Auto-Disabled Syringes.

E. Improving Access to Quality Health Services

- Establishment of a system for quality assurance/“Certificate of Needs and Standards”.
- Registration and regulation of traditional and alternative healthcare providers.
- Establishment of a reliable system for the procurement, distribution and management of drugs and medical supplies.
- Strengthening regulatory mechanisms, including professional codes of conduct.

F. Improving Consumers Awareness/Community Involvement

- Development of strategies to increase consumers’ knowledge and awareness of personal obligation to better health, their right to quality care and information on health.
- Development of a strategy to enhance community participation in the provision and financing of health services.
- Designing communication programs and building capacity in basic communication skills for health care workers and community-based health providers in priority health conditions.

G. Promoting Effective Partnership/Collaboration & Coordination

- Development of an effective public-private partnership policy.
- Establishment of a mechanism to enhance effective donor coordination

H. Establishing A Communication Strategy for HSR

- Building of consensus support of HSR amongst all stakeholders.
- Clarification of the roles and responsibilities of all stakeholders
- Sustenance of the core HRS issues in the consciousness of Nigerians.

I. HSR: Monitoring & Evaluation

In 1997, the National Health Management Information System (NHMIS) was introduced with a view to making available accurate, reliable and timely health statistics to health data users. When the NHMIS was first reviewed, one of the aims was to streamline the various health data in use. Experience has shown since 1999 that the NHMIS is beset with lots of problems in regard to low return rates, completeness, accuracy and usefulness for decision making. In the context of the HSR, the NHMIS will have to be relied upon as one of the sources of health data for monitoring and evaluation. A stepwise process leading to the development of a strengthened and reformed health information system is proposed, to consist of:

- Technical and resource assistance,
- National consensus-building and coordination,
- Review of the existing NHMIS and an initial implementation of the national plan, and
- Monitoring and evaluation of progress.

The expected results from reforming the NHMIS will include the following:

- Availability of appropriate health data and information for the assessment, monitoring and evaluation of programmes,
- Availability of Health Systems Performance Assessments (HSPAs), and
- Better quality and timely health information.

HSR Implementation Steering Committee (ISC): For the implementation of the Health Sector Reform Programme, it will be desirable to establish an Implementation Steering Committee (ISC). It will monitor progress against agreed benchmarks; assess the continued viability of the health sector reform programme; facilitate inter-sectoral, inter-governmental and inter-agency coordination and collaboration in mobilizing resources, financial and technical assistance for the reforms; and channel policy and organizational issues to relevant government departments and agencies and partners for action.

The ISC will be headed by the Honourable Minister, with other members to include: the Honourable Minister of State for Health; the Permanent Secretary of the Federal Ministry of Health; Members of the Ministerial Consultative Committee of the Federal Ministry of Health; Director of Budget of Federal Ministry of Finance; Representative of the National Planning Commission; 6 Representatives from State Commissioners for Health; 2 Representatives of key donor agencies; Executive Secretary of the Health Reform Foundation; 2 representatives of the Health Sector Change Agents; 1 Representative each of the Nigerian Medical Association, the Pharmaceutical Society of Nigeria, the National Association of Nurses and the Midwives of Nigeria, the Senior Staff Association of University Teaching Hospitals and Research Institutes, the Medical and Health Workers Union of Nigeria, the Association of Medical Laboratory Scientists of Nigeria, the National Union of Pharmacists and Technical Health Workers of Nigeria, the Association of Physiotherapists of Nigeria, the National Association of Community Health Practitioners of Nigeria, a Representative of the House Committee on Health; a Representative of the Senate Committee on Health; Chairman of Chairmen of Boards of Tertiary Health Institutions, and Chairman of the Committee of Chief Medical Directors/Medical Directors.

I. STRATEGIC THRUSTS OF THE HEALTH SECTOR REFORM PROGRAMME

1. INTRODUCTION

1. As part of its essential public health functions, the Federal Ministry of Health has the responsibility to develop policies, strategies, guidelines, plans and programmes that provide direction for the national health care delivery system. In addition, the Ministry is currently a major provider of tertiary health care services and various other health intervention programmes aimed at promoting, protecting and preventing ill health of all Nigerians. This document establishes a framework for the **Health Sector Reform** policy programme, including goals, targets and priorities that should guide the action and work of the Federal Ministry of Health and, to some extent, State Ministries of Health and our health development partners over the next three years, 2004-2007. The document sets the tempo and direction for strategic reforms and investment in key areas of the national health system, within the context of the Government's overall macroeconomic framework, the New Economic Empowerment and Development Strategy, NEEDS (aimed at re-orienting the values of Nigerians, reforming government and institutions, growing the role of the private sector, and enshrining a social charter on human development with the people of Nigeria).
2. The health system in Nigeria and the health status of Nigerians are in a deplorable state: Nigeria's overall health system performance was ranked 187th position among the 191 Member States of the World Health Organization in 2000. Health status indicators are worse than the average for sub-Saharan Africa. For example, infant mortality rate of 115/1,000; under-5 mortality rate of 205/1,000; and maternal mortality ratio of 948/100,000 (range 339/100,000 to 1,716/100,000) is one of the highest in the world.
3. Disease programmes, such as HIV/AIDS, TB and malaria and other programmes, such as reproductive health are currently implemented within a weak health system and hence have had little impact. Routine immunization coverage rate of over 80% in the early 1990s has dropped to less than 25% and is only now beginning to show marginal improvements. Primary health care facilities serve only about 5-10% of the potential load. Public expenditure on health is less than \$10 per capita compared to the \$34 recommended internationally. Private expenditures are estimated to be over 70% of the total national health expenditure with most of it coming from out-of-pocket expenditures, in spite of the endemic nature of poverty in Nigeria. Consumers' health knowledge and awareness of their rights to quality care are low. Partnerships between the public and private sectors are mostly non-existent or ineffective. Donors and other development partners are poorly coordinated.
4. Constitution: Under the current 1999 Constitution, only vague reference is made to the responsibility of LGAs for health. In Section 45, the Constitution makes provision only for the over-riding of individual rights, if it is in the interest of, among other things, public health. The current Constitution, therefore, falls short of specifying what roles the State and Federal Governments must play in the national health care delivery system. For the health sector, this is a very serious omission since Nigeria's current health system is built on a three-tier system, with LGAs being the main implementing agents of primary health care.
5. Population Growth: The rapid population growth in the country has overstretched the social resources. Our past failure to factor in population figures in our planning has also made our health planning unrealistic and it has led to the provision of inadequate facilities for the teeming and increasing population.
6. Managerial Accountability: One of the biggest constraints to reform is the rigidity of the civil service. For example, the cost of personnel of the departments within the FMOH is not managed by the FMOH. The Ministry does not recruit some categories of personnel found on the Ministry's payroll. The cumulative effect is that there is little accountability. The annual budget preparation hitherto can be

described as a “ritual” and over-expenditure has been rampant. There is a general lack of transparency and fiscal discipline, as well as a complete absence of a healthcare-financing framework to guide government’s rationale for investment, allocation and disbursement of resources.

7. Health Management Information System: The health management information system is weak and has not been able to provide adequate evidence for policy/programme development and implementation.
8. Inter-Ministerial and State Collaboration: The FMOH is yet to establish regular working relationships with the Federal Ministries of Agriculture and Education and other health-related Ministries, such as Science and Technology, Water Resources and Environment. Despite the existence of policy, there is no sense of cohesion between the States and the FMOH. There is no consultation and no cooperation. State authorities perceive the National Health Council which meets once a year for a week as a waste of time, a “talk-shop” where it is alleged that the FMOH merely tries to get the States to rubber- stamp decisions already taken.
9. Monitoring and Evaluation: Since the Ministry (FMOH) is accountable for the health of the nation, it is imperative that it sets goals for the entire nation and monitors progress. This is not yet happening across much of the nation. There is an ineffective and fragmented information system in place and information from the private sector is not being captured, thus making comprehensive health planning difficult.
10. Organizational Structure and Reporting Relationships: The system is so complex and has grown out of so many obtuse “needs” that the

best approach to reform is to start afresh and plan the system *de novo*.

11. Health Finance and Expenditure: In the past, the budget was a paper exercise and no one paid any attention to it at all. The truth is that the real cost of health services is not known, as there is no system for National Health Accounts (NHA). There are no reliable data or information on the combined Federal, State and LGA expenditures or on expenditures from private and donor sources. There is no broad-based health financing strategy, even with the planned commencement of a National Health Insurance Scheme (NHIS).
12. Pharmaceuticals and Medical Supplies: Fake, sub-standard, adulterated and unregistered drugs are prevalent, in spite of the highly visible and commendable efforts of NAFDAC. Erratic supplies, non-availability of some basic essential and specialized drugs and other health materials as a result of heavy dependence on imported drugs are common. At present, only 40% of pharmaceuticals consumed in the country are produced locally and 100% of the active ingredients for this production is imported. The drug distribution system is chaotic as a result of adherence to current regulations and a lack of update pharmaceutical regulations. Furthermore, the roles and responsibilities of different players are yet to be defined. Efforts aimed at local research and development of pharmaceutical raw materials are yet to yield the desired results due to low funding of research and development.
13. Management and Management Systems: Management of the limited health resources available is ineffective and inefficient. There is a culture of corruption and the promotion of self-interest.
14. The Disease Burden: Available information indicates that malaria, ARI, measles, diarrhoea, TB and HIV/AIDS/STIs account for a disproportionate share of ill-health and deaths among Nigerians. They also have adverse effects on socio-economic development and school attendance. These are all preventable diseases. With a well-organized health system and active community

participation, the diseases can be controlled to a point where they cease to be of public health importance.

15. Human Resources for Health: With nearly 50 universities in the country, including University Teaching Hospitals, trained health personnel should not be difficult to find. However, their distribution and skills mix is a serious source of concern. The issue of poor motivation and low remuneration has an adverse effect on the morale of professional health workers. The issue of brain drain also constitutes a problem, especially where the qualified personnel pursues lucrative jobs beyond the shores of this country.

Health Sector Reform Programme (HSRP)

16. The preceding account of the existing features and performance of the national health system is unacceptable. Therefore, the Federal Ministry of Health, with the support of the National Council on Health (NCH), has committed to undertake a Health Sector Reform (HSR) i.e. a sustained process of **fundamental change** in policy, regulation, financing, provision of health services, re-organization, management and institutional arrangements, that is led by Government, and designed to improve the performance of the health system to attain a better health status for the Nigerian population.
17. The Ministry has identified seven (7) strategic areas of work within which to undertake various reform initiatives. These are:
- Improving the stewardship role of Government;
 - Strengthening the national health system and its management;
 - Reducing the burden of disease;
 - Improving the availability of health resources and their management;
 - Improving access to quality health services;

- Improving consumers' awareness and community involvement; and,
- Promoting effective partnership, collaboration and coordination.

18. Within each of the strategic thrusts of the reform programme, a number of priority health sector performance issues have been identified for focused intervention. The perceived sector-wide catalytic effects inform the choice of issues.

Vision and Mission of Federal Ministry of Health:

19. Vision: To reduce the morbidity and mortality rates due to communicable diseases to the barest minimum; to 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 Nigerians.
20. Mission: To develop and implement appropriate policies and programmes as well as undertake other necessary actions that will strengthen the National Health System to be able to deliver effective, quality and affordable health.

Underlying Principles/Assumptions:

21. The underlying assumptions and cross-cutting principles for the HSR programme are as follows:
- Ill health is a major determinant of poverty. Thus, addressing the health needs of all Nigerians is an important component of the country's poverty reduction strategy.
 - A large proportion of the excess burden of disease among Nigerians can be attributed to a limited number of health problems.
 - Cost-effective intervention programmes exist to target priority health problems which can have a significant impact on the health outcomes of the population in the short, medium and long term.

- Political will and commitment will enhance the implementation of planned reforms, especially in terms of making necessary resources available for their implementation. The needed resources will come partly from re-allocative efficiencies, in favour of preventive, promotive, and protective health care services.
- Equity and social justice, as enshrined in the Nigerian Constitution, would translate into the reality of providing adequate health care.
- The priority health interventions would be those that are directly **responsive** to the various health needs of Nigerians. Given the nature of the disease burden in the country, it would mean that a greater proportion of the set of interventions should address the predominant health problems in the country, that is, infectious and parasitic diseases, most of which are associated with poverty.
- The planned health systems and services would be such that offer quality health care services and provide protection from risk for the poor against the catastrophic economic effects of illness.
- Reforms would not only enhance the financial and cultural access of the people to health care, particularly the poor, but also their physical access which, in a majority of Nigerian communities, remains a substantial challenge.
- Intervention would be sustainable financially, politically, organizationally and managerially. This objective would be achieved when all stakeholders are actively involved in defining

the required interventions and also when there is committed leadership to implement the interventions.

- The people, particularly the poor, would be closely involved, at the community level, in the design and implementation of the targeted interventions. The involvement of the people in assessing their health needs is vital since they themselves would have an important role to play in the implementation of the interventions in order to ensure that the desired results and outcomes would be achieved.
- Health determinants are numerous and cut across sectors and sometimes even national boundaries or barriers. Therefore, the health sector contributes only part of the inputs that affect the health outcomes of a people, particularly the poor. The health sector must, therefore, work closely with other sectors to ensure collective support for actions that improve health.
- There are a number of risk factors responsible for a high disease burden in the country that would have to be addressed as part of the rationalization, allocation and utilization of relevant resources.

2. IMPROVING THE STEWARDSHIP ROLE OF GOVERNMENT (FEDERAL MINISTRY OF HEALTH)

Background

1. Stewardship is defined as the careful and responsive management of the well being of the population and, thus, the very essence of good governance in health. Stewardship goes beyond the Ministry of Health playing its leadership role in the health sector (stewardship in health) to include focusing on responsibility and tasks for the strategic management of the health system (stewardship of health), as well as the inter-sectoral, socio-political environment within which the health system operates (stewardship for health)¹. There are three basic tasks in stewardship:
 - Setting an explicit health policy development framework, with a clearly defined vision, roles and responsibilities, and performance objectives (deliverables) for short and intermediate periods;
 - Exerting influence and ensuring compliance through regulation; and
 - Generating intelligence, that is, establishing a reliable data and information base for informed decision-making, monitoring, evaluation and performance assessment.
2. The stewardship role of Government *in* the national health system, which is performed by the Ministries of Health, is arguably the most important and fundamental function of the health system. Thus, a diagnostic analysis of the performance, or the lack thereof, of the

¹ WHO/AFRO, Resolution AFR/RC52/12. *Implementation of Health Sector Reforms in the African Region: Enhancing the Stewardship Role of Government* (RC52, 2002).

national health system must necessarily, in our case, look at, if not start with, how well government is performing its stewardship role.

3. Stewardship, as a key element and success factor of health system performance, cuts across all the other functions of the system but, more importantly, is the very essence of governance and a uniquely and, perhaps, an exclusive preserve of Government in ensuring that the national health system achieves its national policy goals. There are other dimensions and actors in stewardship *for* health, such as extra-ministerial and donor actions. However, these other dimensions of stewardship are not discrete areas of health system functions, organizations or structures that matter fundamentally but rather tangentially for health system performance and are, therefore, not the subject of fundamental change as part of health reform. Even where these other dimensions of stewardship are important and do contribute to health systems performance, they do not fundamentally determine its performance. Government, specifically the Ministry of Health, remains the prime mover and must assume central responsibility for the management of the national health system as an overarching public health function in the interest of the public. The lack of performance of our national health system is attributable to the weakness in the leadership/stewardship role of government in health. Thus, to a very large extent, improving the performance of the health system depends on improving the stewardship role of Government in the health system.
4. Good stewardship of the national health system is a requirement to achieve better health for all. In Nigeria, the ultimate responsibility for ensuring the overall performance of the national health system lies with Government, especially the Federal Ministry of Health and all the State Ministries of Health and Local Government Health Authorities. As is currently practised, the stewardship role of Government does not imply or require that Government should be **directly and simultaneously** involved in all the functions of the health system: financing, payments, provisioning, regulating, etc.

5. Stewardship in health is especially the preserve of our Ministries of Health, as this area of stewardship is concerned with ensuring that the primary functions of the health system – financing, the provision of services, resource generation and performance of oversight responsibilities, including regulation and evidence/intelligence – are dully performed. For example, it would be necessary to establish and maintain both organizational and regulatory mechanisms, institutions and processes to ensure adequate financing of health, through defining healthcare financing policies. Other tasks may include health information, purchasing arrangements and human resources for health.

6. A number of constraints and challenges impede the stewardship role of government and these include:

- The poor definition of the roles and responsibilities of key actors. Government has a responsibility, through various statutory instrumentalities and in a coordinated manner, to ensure that all key stakeholders (Federal, State and Local Governments and the wider civil society organizations and development partners) know and play their roles and assume their responsibilities for the management of the health system for overall health development, as well as accept responsibility for the role of the health system in the overall poverty alleviation and macro-economic development of Nigeria;
- The need to strengthen our various Ministries of Health's role and responsibility in their stewardship in health by providing the requisite enabling management and stewardship tools, such as relevant policies, operational health sector strategic development framework, legislation, financing, human and physical resources, etc;
- The challenges of fostering inter-sectoral collaboration with other arms of government and the wider society to ensure that all aspects of our stewardship roles and responsibilities are effectively carried out;

- Poor dissemination and enforcement of health policy implementation;
- Absence of legal and constitutional backing for some major policy thrusts, including the misleading assumption that health is on the concurrent list in the Constitution;
- The fact that current policies are not inclusive of the definitive roles and responsibilities of the private sector;
- The generally depressed state of evidence-based budget and plan management practices; and
- Inadequate funding of the health sector.

7. Presently, our public health sector has fallen far below the expectation of most Nigerians as a result of the constraints and challenges described above. In addition, the system also suffers from:

- Serious confusion regarding the legislative versus functional powers and responsibilities of the three tiers of government. This means that the work that has to be done for legislating, implementing, regulating, monitoring and evaluating health services is not being done;
- A low level of staff awareness and understanding of the internal workings of the Ministries of Health, the civil service rules, the budgets, allocations and expenditure reports, and information regarding health. Those in authority seem able to do what they want with little regard for accountability and transparency;
- The absence of a structured involvement of different stakeholders in the policy development process;
- Rigid interpretation of extant civil service rules, to the effect that Ministries lack flexibility to respond appropriately to uniquely sectoral demands. For example, parastatals and other agencies have emerged as parallel implementing entities within the Federal Ministry of Health, resulting in conflicts of mandates, roles and responsibilities; and
- The absence of an overarching health law, which means that there is no statutory mandate for the present functions of health authorities at all levels. Without such a mandate, there ought not to be any claim to funds.

Performance Issues

On the basis of the analysis presented above, it is obvious that a plethora of problems fall under the stewardship role of Government. However, in the context of the planned reform actions of the Federal Ministry of Health, attention will be focused on four specific stewardship performance issues, over the next several years, as follows:

- (a) The need for reviewing, updating and harmonizing national health policies;
- (b) The need for the enactment of a National Health Act, the objectives of which would be to regulate the national health system and to provide standards in respect of health services across the nation by:
 - (i) establishing a national health system which encompasses public and private providers of health services and provides, in an equitable manner, the population of the Federal Republic with the best possible health services that available resources can afford;
 - (ii) setting out the rights and duties of health care providers, health workers, health establishments and users; and
 - (iii) protecting, respecting, promoting and fulfilling the rights of the people of Nigeria to the progressive realization of access to health care services.
- (c) The need to accelerate the deployment of appropriate ICTs for the transformation and improved productivity and efficiency of the internal workings of the Federal Ministry of Health, as well as its relationships with partners and the outside world.
- (d) The need for the development, implementation and institutionalization of 5-year strategic plans and 2-year plans of action by Departments of the Federal Ministry of Health, State Ministries of Health; Parastatals; Teaching and other tertiary health institutions.

Strategies

Appropriate strategies will be deployed to enhance the stewardship role of Government as a priority area of focus for the Health Sector Reform (HSR) agenda. In the context of the unfolding FMOH-led HSR programme, the stewardship role would start with the FMOH providing leadership in reformulating and refocusing the HSR process, and in ensuring an all-inclusive participation and actual implementation. The specific strategies to enhance Government's stewardship role would be as follows:

- (a) Reviewing, updating and harmonizing the national health policy to set the vision and road map for health development in Nigeria;
- (b) The processing and enactment of a National Health Act;
- (c) The deployment of ICTs in all facets of the business transactions of the Federal Ministry of Health; and
- (d) The preparation and implementation of a credible and effective health sector Medium-Term Economic Framework (MTEF) that reflects articulated priorities (that is, the Health sector component of NEEDS).

Expected Results

The overarching expected result is substantial improvement in the stewardship role of government in protecting the public interest, including combating corruption in the public health sector. Specifically, the following measurable results would be achieved at the end of the period:

- (a) The National health policy reviewed, updated and harmonized;
- (b) A National Health Act enacted that describes the re-defined national health system and the functions of each level of government;
- (c) Establishment of a sector-wide e-health enterprise, resulting in improved access and usage of ICTs in the public health sector, starting with the process and functions of the Federal Ministry of Health; and

- (d) 5-Year strategic plans and 2-year plans of action developed by departments of FMOH, SMOH, Parastatals and other federal health institutions.

M&E Indicators

The monitoring and evaluation indicators for the expected results shall include the following:

- (a) The adoption by the Federal Executive Council of a reviewed, updated and harmonized national health policy;
- (b) The passage by the National Assembly of a National Health Act;
- (c) The degree of deployment of ICTs in the functions and processes of the Federal Ministry of Health; and
- (d) The preparation and implementation of a 5-Year Strategic Plan and 2 –Year Plans of Action (POA) by FMOH departments, SMOH, Parastatals and all Federal Health Institutions (% of departments, States and institutions that have developed and are implementing).

Costs & Sources of Financing

The estimated total cost for the strategies enumerated for improving the stewardship role of Government would be ₦450 million. A detailed

breakdown is provided in the Plan of Action Table. It is envisaged that the HSR Programme would emerge as the fulcrum for investing in the health sector over an intermediate period. Therefore, the major sources for financing the HSR programme would be through the Federal Government treasury and budgetary allocations to the Ministry, from the assistance of development partners in health, and from the contributions of the private sector and civil society, as part of their stewardship for health development in Nigeria.

3. STRENGTHENING THE NATIONAL HEALTH SYSTEM AND ITS MANAGEMENT

Background

1. 'Health system' is defined as comprising all organizations, institutions and resources that are designed to produce health action. A health action is defined as any effort, whether in personal health care, public health services or through inter-sectoral initiatives whose primary purpose is to improve health.²
2. The interest of Government is to have a health system whose performance is optimal in terms of its goals and functions. The goals of the system are as follows:
 - Provision of good health to the population,
 - Responsiveness to the non-medical expectation of the population, such as respect and confidentiality, and
 - Making financial contributions fair.
3. The health system is expected to perform certain functions. Such functions include creating resources, allocation of such resources and the delivery of services. However, the way the health system is organized and managed would, inevitably, influence the extent of achieving its goals.
4. Over the years, in Nigeria, structural organization was created to superintend the delivery of health services and the system. Functional relationships between various institutions in the health system and the management mechanism of the Nigerian health

system have been challenged by a series of issues that have constrained optimal functioning and, thus, the performance of the system. This has been so in spite of the quantum of financial investment in the system. Thus, as part of this health sector reform programme, a restructuring and strengthening of the health system to make it more effective and efficient shall be pursued.

5. In the mid 1980s, in compliance with global and regional consensus, Nigeria adopted the Three-Phase Health Development Scenario. This subsequently stimulated the development of the National Health Policy (1988)³ in which the FMOH was charged with the responsibility of formulating policy, setting standards, issuing guidelines, monitoring and evaluating health programmes. The SMOHs were to offer a secondary level of care, provide technical advice and supervision to the LGAs. The LGAs on their part were charged with PHC implementation at the operational level. Over the years, the roles of the three tiers of government have overlapped considerably, resulting in the FMOH directly implementing programmes at State and LGA levels.
6. In terms of organization, the health system in Nigeria is pluralistic and complex. It includes a wide range of providers, comprising the public and a large and growing private sector made up of private-for-profit and private-not-for-profit providers (NGOs, community-based organizations, religious, spiritual and traditional care providers). Other private health sector actors include the various professional associations, such as the Association of General and Private Medical Practitioners, the Association of Nurses and Midwives, the Community Health Practitioners Association, to mention just a few. Furthermore, the relatively large size of private sector expenditure in

² Health Systems: Improving performance – *The World Health Report 2000*.

³FMOH. *The National Health Policy*. This was revised in 1996.

health has led to the evolvement of private health maintenance organizations operating pre-payment arrangements for health care.

7. Operationally, Ministries of Health were created at both federal and state levels to supervise the bureaucracy required for the day-to-day functioning of the health system. However, like most bureaucracies, the ministries have developed obtuse structures that are dysfunctional, as well as an institutional culture and apparatus that are at least inconsistent with the spirit of the national health policy.
8. Also, within the health system, some parastatals have been created to deal with priority health issues. Generally, the roles of the different parastatals of the public sector have not been well delineated and their activities neither streamlined nor coordinated, thereby creating overlaps in functions and organizational friction.
9. According to the National Health Policy (1988) document, the Federal Government is responsible for policy formulation, strategic guidance, coordination, supervision, monitoring and evaluation of national health policy implementation at all levels. It also has operational responsibility for disease surveillance, essential drugs supply and vaccine management. In addition, it is required to provide specialized health care services at the tertiary health institutions (University Teaching Hospitals and Federal Medical Centres). These facilities serve as referral facilities for the secondary health facilities.
10. Primary Health Care (PHC), whose implementation is dependent on local government authorities, forms the bedrock of the National Health System. Unfortunately, PHC is in a prostrate situation due to poor funding, inadequate skilled human resources and lack of commitment by the local authorities. Since PHC is the gateway to the health system, its poor performance has, inevitably, impacted

negatively on the health of the nation. Its re-invigoration with funds, legislation and political support is imperative for the sustainable recovery of the health care system.

11. At the lower level, the States and the LGAs share responsibility for health care. The States largely operate secondary health facilities providing mostly secondary care and serving as the referral level for the LGA, while the LGAs are to provide essential elements of PHC.
12. However, operationally, the Federal Government has established Federal Medical Centres in the States, which have further created conflict between her regulatory/supervisory role and service provision functions. Furthermore, with the changing macroeconomic milieu in Nigeria resulting in Government's shying away from direct involvement at the operational and delivery level of social and economic services, a review of the FMOH's role in the ownership and direct administration of the teaching hospitals and federal medical centres would seem inevitable. Such a review would free resources which could be deployed to areas of greater externality.

Performance Issues

- The functions, roles and responsibilities of FMOH and other health institutions are not clearly defined.
- National health structures and institutions are not properly streamlined for easy coordination.
- The Federal Ministry of Health has established Federal Medical Centres that are, at best, providing secondary-level of care.
- The primary, secondary and tertiary health institutions are in such deplorable condition that have generally undermined the effectiveness, efficiency and quality of the services that they currently provide.

Strategies

- Redefining the essential public health functions, roles and responsibilities of FMOH, its parastatals and other agencies, and the development and implementation of appropriate structural mechanisms and procedures in response to the redefined functions, roles and responsibilities.
- Enactment of a National Health Act (and review of laws setting up all National Health Institutions (NPHCDA, NPI, NHIS, NIMR, NAFDAC & NIPRD) with the aim of streamlining their roles, functions and operations to be in conformity with the spirit of the national health policy.
- Development and implementation of a blueprint for the Reform and Revitalization of the PHC system.
- Reforming the management and structure of FHIs and the refurbishment of Federal Tertiary Health Institutions (FHIs) and the standardization of their equipment. (Note the ongoing FMOH-VAMED, FHIs refurbishment programme).

Expected Results

- National health institutions re-profiled with well defined roles and responsibilities.
- Structural reform of the Federal Ministry of Health to make its bureaucracy more efficient and effective.
- National Hospital Agency established to enhance effective coordination in terms of policies, standards and performance of tertiary/specialized hospitals.
- Devolution of ownership and/or management of tertiary health institutions.

- Establishment of a National Blood Transfusion System which shall be located at the national level, each of the six geo-political zones, and the military.
- A revitalized /functioning PHC system.
- Teaching Hospitals regaining their status as centres of excellence for the provision of quality tertiary care, training of high quality doctors/nurses, etc., and the conduct of relevant medical/health research whose product will be used.

Monitoring and Evaluation Indicators

- Existence of formally documented functions, structures and relationships of FMOH with other health institutions.
- Organizational restructuring of the Federal Ministry of Health completed.
- National Hospitals Agency Act.
- Decentralization/devolution of the management functions and/or ownership structure of Federal Medical Centres, Teaching and Specialized Hospitals, including making them self-accounting, Budget and Cost Centres.
- Existence of a functioning blood transfusion system.
- Availability and implementation of a PHC blueprint.

Costs and Sources of Financing

It is estimated that the total cost of the strategies enumerated for improving the National Health System and its management within the Health System Reform Programme would be ₦15 billion (fifteen billion naira). It is envisaged that funding for this component of the HSR programme would come from the Government treasury and development partners' contribution.

4. REDUCTION OF THE DISEASE BURDEN

Background

1. The Leading causes of mortality and morbidity in Nigeria include malaria, ARI, measles, diarrhoea diseases, and tuberculosis. The current epidemic of HIV/AIDS ravaging the nation has compounded the poor health situation decreasing life expectancy and threatening economic development of the nation. The rates of maternal and neonatal morbidity and mortality, resulting from pregnancy and birth-related complications, are unacceptably high. The country is also experiencing an increasing burden of non-communicable diseases. Issues of adolescent health and development challenges, mental health disorders, work-related health problems and zoonotic infections are assuming increasing importance. Furthermore, important risk factors, such as road traffic accidents, violent civil disturbances and unhealthy lifestyle practices, such as smoking, alcohol and illicit use of drugs are on the increase.
2. The health system has not been able to cope with these problems. Health infrastructure, including equipment, is in poor status. Public health expenditure is much lower than required to provide a basic package of health services. Routine immunization coverage is very low due to unavailability of the required antigens, lack of logistics/cold chain and absence of community participation and ownership. Widespread poverty impedes the capacity of the citizen to access medical care, particularly as the predominant mode of payment for health services is in form of out-of-pocket expenditure.

Performance Issues

- Improvement of PHC services to ensure a guaranteed minimum package of health care, including effective routine immunization.

- Improvement in the availability, accessibility, affordability and quality of essential obstetric care (EOC) services, as well as promoting their effective utilization to reduce maternal and neonatal morbidity and mortality.
- Development and implementation of appropriate health sector response to HIV/AIDS, and control measures for malaria, TB and other major infectious diseases.
- Reduction of risk factors through health education, with emphasis on promotion of adequate nutrition, healthy lifestyles, food and environmental hygiene, road safety consciousness and safe reproductive health behaviour.

Strategies

- Provision of a federally guaranteed minimum package of PHC health services with particular emphasis on routine immunization.
- Development of a network of PHC centres linked to secondary referral health facilities for emergency obstetric care (EOC), and strengthening the referral mechanism.
- Implementation of Health Sector Response to the HIV/AIDS pandemic.
- Strengthening the implementation of specific disease control and health programmes, such as DOTS and RBM.
- Reduction of risk factors by promoting healthy lifestyles.

Expected Results

- A functional PHC system resulting in increased access to a minimum package of health services in at least 60 % of all LGAs in the country.

- Reduction in morbidity and mortality from pregnancy and birth-related complications.
- Reduction in the rate of new HIV infection.
- Reduction in morbidity and mortality from communicable diseases.
- Reduction in morbidity and mortality from non-communicable diseases.
- Reduction in infant/child mortality rates.

Monitoring and Evaluation Indicators

- Proportion of primary health facilities offering the guaranteed minimum package of services in each state.
- Proportion of the population living within 5km from a health facility.
- Percentage of children 12-23 months fully immunized.
- Incidence and prevalence of malaria.
- Proportion of pregnant women attended to by skilled attendants at delivery.
- Number of basic and comprehensive essential obstetric care (EOC) facilities available per 500,000 population, and their geographical spread.
- HIV seroprevalence rate.
- Proportion of the population who are aware and adopting healthy lifestyle practices (such as exercise, diet, use of seat belts while driving and other injury-prevention practices) and avoiding health-risky lifestyles (such as alcohol and smoking).
- Proportion of the population who are aware and maintaining appropriate level of environmental hygiene, particularly with regards to safe drinking water, and disposal of waste (both liquid and solid) in the home or work environment.
- Proportion of Under-5 children that are malnourished.

Costs and Sources of Financing

The estimated cost of implementing the strategies for reducing the disease burden over a three-year period is ₦10.0 billion. The funding is expected to come from multiple sources, including Federal, State and Local Governments and development partners.

5. IMPROVING AVAILABILITY OF HEALTH RESOURCES AND THEIR MANAGEMENT

Background

1. The delivery of health care in the health system involves three actions: System Inputs, Health Production, and System Output. System inputs include **facilities, personnel, equipment and supplies** that are required for health production by **health providers** who offer health services as System output to **patients**. Low funding at all levels hampers the performance of the health care system, as reflected in poor quality resources and management.
2. After many years of neglect, Nigeria's health system is already failing to deliver even the most basic health services. Inadequate provision of funds and poor management has led to deterioration of equipment and facilities, lack of drugs and poor standards of care.
3. Poor conditions of service and working conditions have left professional staff highly de-motivated. This may have created a situation in which unofficial payments are demanded for services, with the result that fewer people are now benefiting from government health services.
4. The private health care sector is characterized by a general lack of benchmarks in terms of facility standards and quality of services. Private health services have grown markedly during the past two decades, but many of them are still too expensive for most people to use, especially the poor. About 60 per cent of health service expenditure is out-of-pocket and now occurs outside of the public sector on a range of for-profit, not-for-profit, traditional and other practitioners.
5. According to the World Bank, Nigeria's public financing of the social services at 0.3 per cent of GNP is lower in real per capita terms, compared with the late 1970s and early 1980s. The health management information system is weak. There is a paucity of accurate and timely health financial information. Actual records of national health expenditure to capture total spending, contribution to spending from various sources, and claims on spending by different users of funds are not complete and mostly inaccurate. Alternative sources of financing, such as the Drug Revolving Funds that were instituted some years ago, have not been properly implemented and have collapsed in most cases.
6. There is rigidity in the system due to hierarchical bureaucracy and the resultant lack of control by managers over day-to-day operations of their facilities. There are no performance-based incentives for managers of public health facilities. Because of the lack of accountability, the scarce resources available to publicly run hospitals are often ineffectively or inefficiently applied. Services delivered by public providers are unresponsive and unaccountable to users. Quality (clinical and consumer perception) is often a problem with both sectors.
6. Despite the long-standing realization and need of an affordable contributory financing for health care, there has been slow movement towards the implementation of a national health insurance scheme.
7. There is an inadequate and inappropriate mix of personnel. Training of health personnel (continuing medical education and training) has not been properly funded or implemented and even when this is achieved, the continued retention of health personnel is not guaranteed due to poor service conditions and external incentives (brain drain syndrome). This has further compounded the inadequacy of trained and skilled human resources for health.

8. The capacity of managers and operators to effectively and efficiently manage the scarce available resources, in the face of competing needs, is severely limited. Systems for budget preparation and budgetary controls have been weak. The procurement system has been characterized by lack of transparency, economy and efficiency. Security and maintenance of physical assets, as a culture, is poor with the result that the expected life span of such assets is severely compromised while replacement costs cannot be met. The health institutions are, thus, characterized by dilapidated physical structures and broken down equipment. National standards and guidelines in the requirements for primary and secondary health care facilities are not being enforced.

Performance Issues

- Lack of reliable information on the funding of the health sector, in terms of sources and uses of funds.
- Absence of a comprehensive healthcare financing strategy.
- Lack of a performance-based national strategy/policy for human resources in health and low capacity in general and financial management
- Weak maintenance system for physical assets in public health institutions.

Strategies

1. Development of a health financing policy that would involve:
 - Construction and institutionalization of a National Health Account.
 - Introduction of legislation for Special Health Taxes/Funds to finance public health programmes and primary health care.
 - Development of a payments mechanism and arrangements that promote incentives to improve health service delivery.

2. Advocacy for increased budgetary allocations at all levels by providing the minimum financial resources to support the desired change.
3. Implementation of the re-designed National Health Insurance Scheme.
4. Development and implementation of a health human resources development policy and plan.
5. Development of a maintenance system for physical assets in public health institutions.

Expected Results

- National Health Management and Information System (NHMIS) developed.
- Construction and institutionalization of a National Health Account (NHA).
- Development and implementation of a comprehensive health care financing strategy.
- Development of a performance-based human resources management system.
- Establishment of a National Hospital Service Agency for better management of tertiary health institutions.
- Development of a maintenance system for physical assets in public health institutions.
- Staffing guidelines for primary and secondary health facilities.

Monitoring and Evaluation Indicators

- Availability of a National Health Account.
- Adequacy of skilled health personnel and managers as stipulated in guidelines.
- Percentage of facilities conforming to human resource guidelines.
- Annual audited financial accounts of health institutions.

- Number of financing and service provision ventures/initiatives embraced by the private sector.
- Number of maintenance agreements signed.
- Physical and functional state of infrastructure and equipment.

Costs & Sources of Financing

- The estimated total cost for the strategic thrust of improving health resources, including human resources, is ₦8.6 billion. The breakdown of the amount and the expected sources are provided in the Plan of Action table. The major sources of the funds would be the Federal Government, Health Tax, Development Agencies and the private sector.

6. IMPROVING ACCESS TO QUALITY HEALTH SERVICES

Background

1. Nigeria's health indices (as contained in the introductory chapter to this document) rank among the worst in the world. Reasons advanced for this unacceptable situation include, among others, poor access to quality health care services.
2. The factors responsible for this situation include the following:

Facilities: The health system is characterized by inadequate and poorly maintained health facilities, particularly at the primary healthcare level; poor state of infrastructure of existing facilities, i.e. buildings, equipment, material and supplies; and inequitable distribution of available facilities such that in many instances people travel over 5km to access health care services. The location of health facilities is sometimes based on political expediency rather than need. Construction of the facilities sometimes does not take into consideration appropriate cultural and technological peculiarities and the development status of beneficiaries.

Human Resources: There is inadequate and inequitable distribution of health personnel at various levels, especially the rural and hard-to-reach areas. In addition, the provider-client relationship is poor, while incentives with respect to compensation levels and structures are inadequate, thereby exacerbating the brain drain syndrome and refusal of postings to rural areas.

Services: The provision of quality services is poor and mainly unaffordable. There is the dearth of protocols for the standard management of common health problems. Often times, there are unofficial payments by patients. Poor client satisfaction has often led to

loss of confidence in the public health system, leading to patronage of the private health sector and alternative medical providers by over 80 percent of the population.

Supplies: The drug system is characterized by an 'out-of-stock syndrome,' fake, sub-standard, adulterated and spurious drugs, and unaffordability. This has contributed in no small measure to poor client satisfaction.

Consumer Awareness: The vast majority of consumers are unaware of their rights regarding health service delivery due to the absence of a Bill of Rights for consumers and providers.

Performance Issues

It is against this background that there is the need, within the health system reform agenda, to improve access to quality health service by:

- Institutionalizing a system for quality assurance;
- Establishing a system of registration and regulation of alternative and traditional medical practitioners;
- Ensuring that consumption of essential drugs is met mostly from local production;
- Harnessing Nigeria's medicinal plant resources for health care delivery;
- Ensuring that good quality, safe and effective drugs, foods and other regulated products are available in the distribution channels in Nigeria; and
- Developing an effective and efficient system for the procurement, distribution and management of drugs and medical supplies.

Strategies

- Establishment of a system that will regulate the location, practice and quality of human and material resources in both public and private health facilities.
- Professional regulation of the standard and practice of alternative and traditional medical practitioners.
- Facilitating and supporting local production of most of the essential drugs needed, including ARVs.
- Facilitating and ensuring that only qualitative, safe, efficacious and affordable drugs are available in the distribution channels in Nigeria.
- Phasing out open drug markets throughout Nigeria.

Expected Results

- Establishment of facilities on the basis of a Certificate of Health Needs and Standards.
- Law regulating the practice of alternative and traditional medicine.
- Establishment of a management system to guarantee quality drugs and supplies in health facilities.

Monitoring & Evaluation Indicators

- Number of facilities across the country with a Certificate of Health Needs and Standards.
- National Health Act passed with provisions for law regulating alternative and traditional medicine.
- Percentage of alternative and traditional practitioners registered in accordance with the law regulating practice.
- Percentage of facilities with essential drugs at any point in time.

Costs & Sources of Financing

It is estimated that the total cost of the strategies enumerated for improving access to quality health service would be ₦5 billion. It is envisaged that funding for this component of the HSR programme would be sourced from government budgets and development partners' contributions.

7. IMPROVING CONSUMER AWARENESS AND COMMUNITY INVOLVEMENT

Background

1. Consumers, particularly women and key family members, play an important role in providing basic services to their families, especially to children and, given reliable information, they are likely to contribute to improved health outcomes with improved management and prevention of priority health conditions and early referral when indicated. Health care consumers in the country currently have inadequate access to information, either through the mass media, or take-home IEC materials or local alternative media. Communities, from past governmental and non-governmental efforts, have shown a willingness to be involved in health actions which affect them, but the policies, methodologies and the necessary coordination to ensure their effective and efficient participation have either been non-available or weak.
2. The current situation of limited consumer and community involvement in health has resulted in:
 - i. Low level of community involvement in health care management structures and consumers' are isolation from key decision-making and ownership arrangements.
 - ii. Missed opportunities to use traditional communication systems by the public health system to elicit community and personal health empowerment, with the result that effective health mass mobilization has not been achieved to a level necessary to generate desired health behavioural change at both individual and community levels.

Performance Issues

- Communities and health consumers are not sufficiently empowered to demand and advocate for their health rights.
- Limited enabling environment to facilitate enhanced community participation in health.
- Services provided are unresponsive to the demands and expectations of consumers and communities.
- Poorly designed traditional communication strategy has resulted in a low, positive health behavioural change on the parts of both consumers and communities.

STRATEGIES

i. Advocacy and Mobilisation

- Ensure the transmission of information and ideas from the sources to the recipient, through advocacy, for the purposes of achieving the expected results.
- Reach out to key strategic leaders of the communities and consumers, as well as collaborating partners, to enhance consumer awareness and community involvement.

ii. Participation

Ensure the active involvement of all stakeholders through organization of activities, such as meetings, seminars, summits and conferences to enhance participation of all groups in defining the course and implementation of the HSR process.

iii. Coalition

Promote and support organized groups and networks to be built around specific and relevant HSR issues.

iv. Media

Maximize the utilization of both traditional and modern media practices to bring home the vision, focus, and benefits of the HSR to all Nigerian communities and consumers.

Expected Results

- Leaders supporting and promoting the HSR process, through practical activities and involvement.
- Communities participating in the design, implementation, monitoring and evaluation of health care delivery as it affects them.
- Communities and consumers being well informed about their rights to quality health care.
- Communities become co-owners and co-financiers of health care delivery.
- Health consumer protection groups formed and actively engaged on health issues.
- Consumers and communities imbibe practical actions that support healthy lifestyles.

Monitoring and Evaluation

The Monitoring and Evaluation indicators would include:

- The legislation and usage of a Community Health Charter document.
- The production and approval of a Guaranteed Minimum Health Package document.
- The percentage (%) of consumers and communities with increased knowledge of their rights and responsibilities in health care.
- The percentage (%) of communities involved as co-owners and co-financiers of health care.
- The availability and usage of community-focused communication framework.

Costs and Sources of Financing

- The estimated total cost for the strategies proffered for improving consumer awareness and consumer involvement over the period would be ₦1,220 billion (One billion, two hundred and twenty million Naira).
- The major sources of finance would be the Federal Government, the State Governments, the Local Governments, and the development partners.

8. PROMOTING EFFECTIVE PARTNERSHIPS, COLLABORATION AND COORDINATION

Background

1. The national health system is replete with many areas of ill-defined, conflicting and overlapping functions. There is disconnection between the public and other sectors of the system. As a result of the inadequacies of the public sector health care delivery system, there is a parallel system of health care delivery in the private sector of the economy. This parallel system has grown exponentially in the past decade, largely fuelled by the poor financing and poor fiscal cycles, slow moving bureaucracy and general decay in the public health care delivery system. There is no interface or coordination between the activities of the public and private health sectors on one hand, and between health institutions in the public sector on the other.
2. The public health care delivery system faces the challenges of increasing costs, diminishing resource allocations, shortage of resources, and ever-increasing expectations from the public for better services. An over-extended government tries to do too much with too little resources and diminishing capability. The general picture is one of fragmented and uncoordinated care and services. International, local, non-governmental, and private health providers are engaged in a large variety of health activities that are not integrated into the national health system.
3. The activities of international development partners and foreign donors and agencies continue to be an important source of assistance in health care interventions in the country. They usually operate through the Ministries of Health and other multilateral arrangements.
4. Donors generally fund vertical (top-down) projects or work in a particular state or zone. The result is that some segments of the population may be well served while others may be largely neglected.
5. A large number of grants as well as the activities of donors and NGOs have had very little impact on national health indices. This is because the FMOH has not been able to define and enforce partnership relationships in which assistance would be used to support nationally defined policies and strategies to produce improved general health outcomes. At present the practice is to initiate from abroad individually financed health projects with little regard for governmental initiatives.
6. The private sector is also very active in the provision of health care. Indeed, there are indications that this sub-sector is responsible for more than 60% of the national health expenditure. Since there is no integration of services between the public and private health providers, there has not been any strategy to maximize the resources that may be available across both sub-sectors. The involvement of private providers in the delivery of public health services is minimally acknowledged.
7. Private companies, such as pharmaceutical companies and medical equipment manufactures have a big role to play in the production of health-related goods and in making health care more affordable. Such companies when given the right incentives may enter into agreements with the government to produce certain generic drugs and medical items, specifically for selected public health interventions.
8. Long-term global and local partnerships have not been clearly streamlined.

9. Under-utilization of installed capacities in public and private health facilities is common. Intra-mural practice by health consultants and practitioners is neither encouraged nor supported by law.

Performance Issues

- Development of an effective public-private partnership policy.
- Establishment of a mechanism to enhance effective donor coordination

Strategies

- Development of an effective public-private partnership (PPP) policy and capacity to manage PPP initiatives.
- Active promotion of intra-mural practice to enhance quality of service and improve capacity utilization in public and private health facilities.
- Establishment of a mechanism to enhance effective donor coordination.

Expected Results

- Publication of the policy to guide and monitor public-private partnerships.
- Global public-private partnerships with international organizations, corporations and NGOs.
- Domestic public-private partnerships with the commercial sector in the production and distribution of health materials.

- Domestic public-private partnerships with health care providers
- Increased access to private finance for health care.
- Sharing under-utilised public or private health resources.

Monitoring and Evaluation Indicators

- Policy and guidelines on a public/private mix in the health sector.
- Establishment of a sector-wide mechanism for coordinating foreign donor and NGO activities.
- Sustained consultations with development partners, agencies, other ministries and the private sector.
- Collaborative human resources development activities for health.
- Legislation and guidelines for promoting traditional medicine.
- Integrated referral system.
- Out-put/outcome-based contracts with private health facilities for the provision of specific public health services.

Costs and Sources of Financing

The estimated cost of implementing the thrust for promoting effective partnerships, collaboration, and co-ordination would be ₦155 million. The funds would be sourced from development partners, international and local NGOs and the private sector.

9. COMMUNICATION STRATEGY FOR HSR ADVOCACY

Background

1. Much needs to be done to mount an effective communication strategy for HSR advocacy. At the policy level, there is very little effective inter-sectoral communication about health priorities, e.g., among public/private partnerships. Similarly, there is little vertical bi-directional communication within FMOH (or between the FMOH and other ministries), and horizontally between and among line ministries.
2. At the health system level, there is a poor level of effective communication between managers and providers on one hand, and between providers and clients on the other. There has been no training in inter-personal skills for health providers in more than a decade. There are no IEC materials, either for providers or for clients. Job aids do not exist. Community health workers (CHEWs) do not have the training or the materials to carry out their important function of educating their community members about prevention and care for the priority conditions.

Strategies

The following key stakeholders have been identified for HSR Advocacy:

At the socio-political level:

- Legislators at all levels,
- All political parties,
- Executive Councils at all levels, and
- The Business Sector.

At the health systems level:

- Heads of Health Institutions,
- Providers (private and public),
- Trade unions,
- Professional associations,
- NGOs/CSOs, and
- Consumers.

At the community, family and individual level:

- Religious, traditional and community leaders
- NGOs, CBOs and special interest groups, and
- Consumers and individuals

An advocacy strategy has been developed in three phases which synchronize with ongoing technical work on health policy reform and the enactment of the health Bill.

Phase One: Engagement - 'Better Health Begins with You and Me'

The first phase involves the engagement of all key stakeholders through formal institutions, associations, professional groups, and community groups. They will be provided with the essential documents and key issues around HSR (e.g., the draft Bill, the Policy, or POA). Each of the institutions would be responsible for filtering the discussion down through their systems and providing a collated feedback to the HSRC. In this phase, there is no effort to promote mass media involvement in HSR.

Phase One introduces the idea that real change within the health system is possible, but that it needs everyone to get involved. The focus would be on an open invitation to get everyone involved and to voice health concerns at every possible level. The theme for HSR would be **Better Health Begins with You And Me**. (Duration: up to six months)

Phase Two: Capacity Building – ‘Making It Happen’

This phase involves a broader engagement, and embraces the idea of ‘*Making It Happen*’. While substantive feedback reflecting a cross-section of interests is already taking place through institutions, this phase takes the advocacy process to the public at large. The focus would be on the *process* of reform, not on the *results* that such a reform would bring about, though it would still emphasise the benefits of participating in defining health priorities to all stakeholders. This phase strengthens the theme of ‘Better Health Begins with You and Me’, with the message being aimed at the public as individuals, as family members and caregivers, as community members, or as members of larger groups, companies or institutions. The idea is to promote engagement in whatever manner would make sense for the particular person being addressed, and to emphasise that health reform would be only as real as the level of personal engagement. It would not happen on its own; it would require the engagement of everyone.

At this stage, some quick ‘wins’ are highlighted to show that the process is already having small results e.g., traditional leaders are speaking out publicly in support of the health reform process; concrete changes are happening at some health facilities; health providers are being trained in client-focussed approaches; materials for clients about prevention and care for the major preventable diseases are becoming available, etc. (Duration: 9 – 12 months).

Phase Three: ‘Seeing is Believing’

Phase Three shifts the emphasis to the real evidence of improved services and engagement in better health by leaders, health providers and consumers alike. This phase may begin with a roll out in those States which already have SEEDs policies and in which there is clear evidence that better services are in place at community level. This phase solidifies the trust built in the second phase and encourages the continued engagement and responsibility of all

stakeholders to effect change in one’s own environment. (Duration: up to 2007 and beyond)

Expected Results

Phase One:

- Passage of the NHA,
- Finalized Health Policy,
- Consensus in support of HSR, participation among key stakeholders, and
- A full understanding of what reform means within the FMOH.

Process expectations:

- Roles and responsibilities clarified for all stakeholders,
- Engagement of chief executives at all levels, and
- Built-in monitoring and evaluation mechanisms from the outset.

Phase Two:

- Basic services for specific health priority issues are in place.
- Referral systems have been built.
- DRFs are in place at secondary and tertiary level facilities.
- Accessible and affordable services are available, both through public and private facilities.
- Consumers know about their rights and responsibilities.
- Quality services are in place in samples of facilities in some states.
- Providers and systems management have capacity to respond in a client-friendly way.

Support systems for services are in place: drug availability and quality control, logistics, job aids, outreach support and client materials.

Phase Three

- Basic services for specific health priority issues are in place.
- Referral systems have been built.
- DRFs are in place at all levels of public health facilities.
- Quality services are in place in samples of facilities in flagship states.
- Public and private sector partnerships are strong, and provide for efficient and affordable distribution of drugs.
- Public perceptions of public and private services are positive and demand for health services has risen significantly.
- Providers and systems management have capacity to respond in a client-friendly manner. A client-centred approach is normative.
- Support systems for services are in place: drug availability and quality control, logistics, job aids, outreach support and client materials, etc.

Monitoring and Evaluation Indicators

- Passage of the National Health Act.
- Numbers of Federal and State Reform Policies in place and acted upon.
- Adoption and substantial degree of implementation of the 1st-year and 2nd-year POA by Federal, State, Local Governments and parastatals.
- Numbers of private sector health providers involved in HSR process
- Number of Private Sector companies that have employee health schemes in place.
- Quantitative surveys (RMS, DHS, intervention-specific surveys).
- National, State and Local Government allocations and expenditures of appropriate resources in timely fashion.
- Degree/number of stakeholder engagement in the process.
- Level of input by communities and non-public stakeholders to health system priorities at all levels.

Costs and Sources of Funding

For the three Phases of the programme, the estimated cost would be 270 million Naira. Federal, State and Local Governments, the private sector and donors, implementation partners are expected to provide the funds.

10. HSR MONITORING AND EVALUATION

Background

1. Generating an appropriate evidence and information base for the national health system is a cross-cutting HSR issue involving multiple stakeholders. From different producers and users of health information, there are often very competing and conflicting interests.
2. The demand and supply of health information has resulted in the production and use of a variety of data, using different tools, instruments and methods to generate measures of indicators on mortality, morbidity, risk factors, disability, disease outbreaks, determinants of health (nutrition, environment, socio economic status), access, coverage, quality of services, costs and expenditures, health sector reform performance assessment, and equity, etc.
3. Available evidence suggests that the situation is far from optimal. There is over-supply of largely unwanted and unused data, coexisting with large, unmet needs for health information. The policy and programme of the National Health Management Information System (NHMIS) constituted the health sector response to these issues, and more. The NHMIS is weak and fragmented at all levels, and has remained driven by programme and donor demands, despite commendable efforts to integrate the system. There is much overlap and duplication, as resources are wasted. The system still lacks standardization and coherence in terms of the definitions and methods used. Information flows from different parts of the system – from health departments, programmes, public and private health sectors and other sectors – are weak. There is little horizontal information flow among actors and consumers, for example, between communities and facilities. Where information flow exists at all, it has remained exclusively vertical, from the periphery to the centre, with little feedback. Most significantly, at all levels of the system, data are not analysed and converted into information for decision-making.
4. The demand for good quality information is growing as there has been an uptake in both government financial investment in the health sector, especially in 2004, coupled with the demand of global initiatives in the health sector and bilateral development assistance to the national health system. Frequent monitoring of short-term programme outputs, such as improved service provision and the number of people using services, are being required as part of performance-based disbursement systems (e.g., for GAVI, the Global Fund for HIV/AIDS, TB and Malaria). Enhanced reporting of health outcomes, such as improvements in the quality and length of life, is required to monitor progress towards major international goals, such as the Millennium Development Goals (MDGs). However, demands for data emanating from such international, disease-specific initiatives tend to focus on particular indicators and do not necessarily translate into building a robust national health system response to health information as a vital part of the health system.
5. In 1997, the new NHMIS was introduced, with a view to making available accurate, reliable and timely health statistics to health data users. When the NHMIS was first reviewed, one of the aims was to streamline the various health data in use. Experience has since shown, since 1999, that the NHMIS is still beset with lots of problems: low return rates, incompleteness, inaccuracies and unsuitability for use for decision making. In the context of the HSR, the NHMIS would have to be relied upon as a robust source of health data and information for monitoring and evaluation.

Performance Issues

- A coordinated and cohesive health information system is essential as the foundation for sound programme development and implementation and as a prerequisite for strategic decision-making.
- The NHMIS needs to become a functioning system that links different components of the HSR in meaningful and effective ways.
- Programmes and people need to be transformed from collectors of data to generators of knowledge, and practitioners into users of knowledge for action.
- It is important to take advantage of new opportunities stimulated by the use of performance-based disbursement mechanisms, and by increased willingness on the part of governments and donors to invest in systems that would generate better information on which investment decisions in health are based.

Principles

Reform of the National Health Management Information System should be guided by a number of principles and approaches, including the following:

- The NHMIS should be seen as a public good, of value to everyone, at all levels;
- Embedding health information system reform within the broader context of health system development;
- Using a phased process with incremental change, building synergistically on the parts of the system that work well;
- Providing clear policy guidelines and conceptual frameworks for reform;
- Supporting the establishment or strengthening of the NHMIS mechanisms that involve donors and other stakeholders;
- Creating consensus around core indicators and the most cost-effective ways of capturing them;
- Standardising definitions and harmonizing data collection instruments;

- Addressing resource and capacity issues at all levels;
- Introducing new technologies cautiously, bearing in mind that technologies cannot in themselves “cure” an ailing system, but can bring benefits when used appropriately; and
- Developing better ways of disseminating, presenting, and packaging health information in order to enhance recognition of the need for, and increase ownership and use of, health information at all levels.

It is essential to establish a monitoring and evaluation system for the Health Sector Reform Programme, as a continuous process of assessing the programme and its constituent parts, its implementation in accordance with agreed schedules and use of inputs; expected outputs, and the ultimate impact/outcomes of the reform programme. Monitoring the HSR programme would provide feedback on implementation to implementing agents and key stakeholders and, through early detection of actual or potential successes and problems, it would facilitate timely corrective responses to keep the programme processes on course.

Key considerations for the M&E design and processes include: clear statements of measurable HSR performance objectives and associated sub-objectives which have been translated into definable indicators; a set of indicators for performance, inputs, outputs and impact/outcomes; flexible data requirements that can be obtained from currently available data collection systems (e.g., NHMIS, NDHS, etc); establishment of institutional arrangements for assessing the performance of the health system (including joint exercises with donors and other health partners); and clear guidelines and processes for integrating evidence-based findings into the decision-making process (e.g., through joint planning exercises).

Strategies

A stepwise process, leading to the development of a strengthened and reformed health information system, is proposed, to consist of:

- Technical and resource assistance,
- National consensus-building and coordination,
- Revision of the existing NHMIS and an initial implementation of the national plan, including the institutionalization of existing population-based sentinel/survey programmes,
- Building the NHMIS infrastructure, and
- Monitoring and evaluation of progress.

Expected Results

- Availability of health data and information for assessment, and the monitoring and evaluation of programmes,
- Availability of Health Systems Performance Assessment (HSPA), and
- Better quality and timely information on national health indicators, especially on the health-related MDGs.

HSR M&E Indicators

- A number of hierarchical indicators have been identified for the purpose of monitoring and evaluating the Health Sector Reform programme and its performance. These are:
- Key performance indicators: comprising a higher-level set of indicators that measure the attainment of the overarching objective of the performance objective which had been identified for intervention. The success or failure of the HSR programme would be judged essentially by the attainment of the key performance indicators, that is, the cumulative effects of the impacts/outcomes indicators.

Impacts/Outcomes indicators: These indicators measure the attainment of the expected long-term effects of a specific intervention. Evidence of such impacts will come from evaluation of the interventions.

Output indicators: These measure the results from deploying resources (inputs) to undertake activities in the implementation process.

Input indicators: These are measures of whether or not needed resources, e.g., funds, materials personnel, etc., that are required to undertake activities have been provided.

Some of the pertinent indicators are as provided in the Logical Framework section of this document. For each of the interventions, the systematic collection, analysis, interpretation and dissemination of health data and information would be essential for an effective HSR M&E process. There is, therefore, a need to strengthen the system for collecting the various types of data and ensure that the means for verification of indicators are available. The collection and availability of data would require the active cooperation of diverse partners, including donors. In order to improve the health data systems, there is a parallel requirement to review and strengthen the NHMIS as part of the reform process; identify and create, where necessary, additional data sources to measure progress towards the attainment of each of the year 2007 HSR objectives; and implement periodic analysis and publication on progress for all the indicators.

Costs and Sources of Financing

For the three year period the estimated cost would be 300 million naira. Federal, State and Development Partners are expected to provide the funds.

11. STRUCTURE AND MANAGEMENT OF THE REFORM PROCESS

Background

Reform entails dynamic processes. The Federal Ministry of Health has committed itself to substantial reform to re-position the public health sector, necessitating the need for corresponding administrative and institutional arrangements to adequately respond to sustainable management of health reform. Essential principles and elements of such arrangements include: political commitment and endorsement, requisite technical and process know-how (either in-house, or from seconded staff or long-term consultancies/technical assistance from development agencies), evidence-based actions internalising ownership/commitment and accountability within the Ministry, a responsive agenda to people's expectations (promoting debate and providing information), enthusiasm, motivation, etc. The experience from a number of reference countries, such as Ghana, Egypt, Malaysia, South-Africa, Singapore, Zambia and Cambodia, is indicative of national-level approaches to managing health sector reform. The failure of the HSR experience in Zambia clearly demonstrates the need for institutionalization.

Management of the implementation of the Health Sector Reform Programme in Nigeria would involve undertaking the following functions:

- Implementation of a communication strategy to promote a shared vision, cultivating champions and change agents for the reform agenda; mobilizing latent forces in favour of the reform, within and outside the Government;
- Programming the HSR interventions/deliverables through the budgeting process of Government;

- Coordinating the implementation of the HSR programme;
- Initiating policy-level dialogue with partners and undertaking regular production of policy briefs;
- Provisioning and management of the technical direction of the Health Sector Reform agenda, including various committees and special project reports and inputs;
- Development, implementation and sustenance of mechanisms for monitoring and reporting on the progress of the Health Sector Reform programme;
- Identification and mobilization of Technical Assistance (TA) to support sub-national health reforms/SEEDS/LEEDS initiatives;
- Coordination of management development and training activities as they relate to HSR;
- Fostering and maintenance of statutory linkages with government-wide reform efforts, especially the Public Service Reforms Programme of the Office of the Head Service of the Federation, and the National Council on Public Service Reforms; and
- HSR monitoring & evaluation.

Alternative Approaches to Managing the Implementation of the HSRP

The planned HSR is part of an overall Government public service reform programme. Hence, any management arrangement should be evaluated within allowable latitude and in conformity with organizational model. The following structures within government departments/directorates are options for HSR management that would be considered later:

- (a) HSR Unit: One option is to create a Unit within the Office of the Hon. Minister to manage the HSR initiative. In civil service parlance, a Unit is one of the lowest levels in the administrative structure of a Ministry.

Typically, an officer of the equivalent of Grade-Level 15 would head such Unit. However, the head of Unit might not have the necessary clout (power/authority) to meet the requirements for managing the HSR agenda. While it is recognized that the Hon. Minister of Health should be seen to be on top of the agenda, it is, nevertheless, reasoned that creating such a Unit in the Office of the Hon. Minister might be a bit precarious politically and might suffer policy discontinuity in the event of a new administration coming into power. Policy continuity and stability are critical ingredients for the success of any reform programme, such as the HSR.

- (b) HSR Branch: Another option is to consign the management of HSR to a Branch-level functionary. A Branch is a 3rd level structure within a department, and is usually headed by an officer at the level of Assistant Director. Given the management requirements of the HSR processes this option must be balanced against the management functions of the HSR programme.
- (c) HSR Division: Yet another option is to manage the HSR at the level of a Division within a Department in the Ministry. Again, this need to be balanced against the scope of work proposed for the HSR agenda. The envisaged scope of the management functions of the HSR would be far beyond the level and authority of a division within the meaning of existing functions of a typical division within a department.
- (d) HSR Task Force: This is yet another option. However, it might not be adequate, given the magnitude of the management functions contemplated and the very tenuous nature of Task Forces, especially their lack of statutory authority. A Task Force approach is not well suited for managing a change agenda.
- (e) HSR Department: Considering the scope of work to be undertaken, both on a short- and long-term basis (especially given that HSR would be a

continuing/sustained process of ***fundamental change*** in policy, regulation, financing, and provisioning for health services, including re-organization, management and institutional arrangements designed to improve the performance of the health system to attain a better health status for the population), another option is to create a Department of Health Systems Development and Reforms. This has been the approach in a number of countries to give significant statutory policy-level visibility and authority to the management arrangements of their HSR programmes. The examples of Cambodia, Egypt, Ghana, Colombia, and Brazil come readily to mind. It would appear that the wisdom of this approach might have informed the decision of the Office of the Head of Service of the Federation (OHSF) to adopt an implementation arrangement that has led to the establishment of the Directorate of Public Service Reform Programme (PRSP) and the subsequent establishment by Government of a National Council on Public Service Reform.

Implementation Steering Committee (ISC) for the HSR

For the implementation of the Health Sector Reform Programme, it would be desirable to establish an Implementation Steering Committee (ISC). The Committee would monitor progress against agreed benchmarks; assess the continued viability of the health sector reform programme; facilitate inter-sectoral, inter-governmental and inter-agency coordination and collaboration in mobilizing resources, financial and technical assistance for the reforms; and channel policy and organizational issues to relevant government departments and agencies and partners for action. The ISC would be headed by the Honourable Minister, with other members to include: the Honourable Minister of State for Health; the Permanent Secretary of the Federal Ministry of Health; Members of the Ministerial Consultative Committee of the Federal Ministry of Health; Director of Budget of the Federal Ministry of Finance; Representative of the National Planning Commission; 6 Representatives from State Commissioners for Health; 2 Representatives of key donor agencies;

Executive Secretary of the Health Reform Foundation; 2 representatives of the Health Sector Change Agents; 1 Representative each of the Nigerian Medical Association; the Pharmaceutical Society of Nigeria; the National Association of Nurses and Midwives of Nigeria; the Senior Staff Association of University Teaching Hospitals and Research Institutes; the Medical and Health Workers Union of Nigeria; the Association of Medical Laboratory Scientists of Nigeria;

the National Union of Pharmacists and Technical Health Workers of Nigeria; the Association of Physiotherapists of Nigeria; the National Association of Community Health Practitioners of Nigeria; 1 Representative of the House Committee on Health; 1 Representative of the Senate Committee on Health; the Chairman of Chairmen of Boards of Tertiary Health Institutions; and the Chairman of the Committee of Chief Medical Directors/Medical Directors.

II. THE LOGICAL FRAMEWORK

1. IMPROVING THE STEWARDSHIP ROLE OF GOVERNMENT (FEDERAL MINISTRY OF HEALTH)

Logical Framework: Improving the Stewardship Role of Government

Performance Objectives	Narrative	Key Performance Verifiable Indicators	Data Collection Strategy / Report & Means of Verification	Assumption/Risks
To improve government's performance of its stewardship role	Strategic management of the health system; setting direction and exerting influence	Improved stewardship of the health sector (improved performance of the health system and well-being of the population)	Health Systems Performance Assessment Report	<ul style="list-style-type: none"> Stable macroeconomic framework Adoption and implementation of relevant policy and legislative instruments and Medium-Term Economic Framework
Intervention Projects Objectives:				
a) To review, update and harmonize national health policies	Setting the vision of the health sector and redefining roles and responsibilities of stakeholders	Availability of an updated and harmonized National Health Policy	<ul style="list-style-type: none"> Report National Health Policy 	NCH and FEC approval of new National Health Policy
	Impact/Outcome:			
	<ul style="list-style-type: none"> A coordinated national health system 	Health Systems Performance Assessment report	Survey	<ul style="list-style-type: none"> Acceptance and implementation of the new National Health Policy by key stakeholders Adequate funding and release of funds for implementation
	Output:			
	<ul style="list-style-type: none"> Draft new National Health Policy 	Availability of draft National Health Policy	Draft National Health Policy	Availability of inputs/resources
	Activities:	Inputs:		
	<ul style="list-style-type: none"> C'mttee to review NHP Stakeholder Consultation NCH approval FEC approval Seminal dissemination and orientation 	<ul style="list-style-type: none"> Consultants/resource persons Funds for: <ul style="list-style-type: none"> Meetings Logistic/Secretariat support Fees/honoraria DSA/DTA Publications 	Report	Availability of resource requirements
b) To enact a National Health Act				
	The object of a National Health Act is to regulate and provide standards in respect of health services across the nation	Availability of a National Health Act	The Health Bill	<ul style="list-style-type: none"> Endorsement by the National Council on Health Passage of the National Health Act by the NASS and Mr. President
	Outcome/Impact:			
	<ul style="list-style-type: none"> Defined roles for different levels of 	<ul style="list-style-type: none"> Availability of Health Bill 	<ul style="list-style-type: none"> The Health Act document 	NCH and FEC approval plus passage of

Performance Objectives	Narrative	Key Performance Verifiable Indicators	Data Collection Strategy / Report & Means of Verification	Assumption/Risks
	Government	<ul style="list-style-type: none"> Degree of awareness of Health Bill 	<ul style="list-style-type: none"> Awareness report 	Bill by the NASS
	Outputs:			
	<ul style="list-style-type: none"> Development of a draft National Health Bill 	Availability of draft National Health Bill	Draft National Health Bill	Availability of inputs/resources
	Activities	Inputs		
	<ul style="list-style-type: none"> Committee to draft a National Health Bill Stakeholder Consultations NCH approval FEC approval NASS Consultation/Retreat NASS passage of Bill Seminal dissemination and orientation 	<ul style="list-style-type: none"> Consultants/resource persons Funds for: <ul style="list-style-type: none"> Meetings Logistic/Secretariat support Fees/honoraria DSA/DTA Publications 	<ul style="list-style-type: none"> Committee Report NCH Resolution FEC Resolution The Health Act 	NCH and FEC approval plus passage of Bill by the NASS
c) to deploy ICTs for transformation, efficiency and productivity	Harnessing the power of Information & Communication Technologies to transform and improve performance, including transparency and accountability of the Federal Ministry of Health	Degree of ICT deployment in the public health sector	ICTs Project implementation report	Approval and funding by Government/FMOH for the ICTs Project work plan
	Outcome/Impact:			
	Improved access/use of ICTs in the public health sector	Degree of ICTs deployment in FMOH	ICTs project implementation report	Approval and funding by Government/FMOH for the ICTs Project work plan
	Outputs:			
	Development and implementation of ICTs work-plan	Availability of ICTs project document	ICTs project document	Approval and funding by Government/FMOH for the ICTs Project work plan
	Activities	Inputs:		
	<ul style="list-style-type: none"> Preparation of ICTs Project work-program Approval of ICTs work-program by FMOH Computerization/networking functions/processes of FMOH Installation of Intra-net/Internet facilities, including linkages access for SMOHs and FHIs Establish and maintain interactive FMOH Web-site Establish FMOH e-Learning centre 	<ul style="list-style-type: none"> Constitute FMOH-ICTs Work plan Committee Funding support for work of the ICTs Work plan Committee Funds to implement FMOH-ICTs work plan 	<ul style="list-style-type: none"> FMOH-ICTs project document FMOH-ICTs Project implementation report 	<ul style="list-style-type: none"> FMOH approval of ICTs project document Availability of funds to implement ICTs project work plan Availability of human resource for the ICTs deployment

Performance Objectives	Narrative	Key Performance Verifiable Indicators	Data Collection Strategy / Report & Means of Verification	Assumption/Risks
d) Preparation of public health sector MTEF strategic plans	Development of a collaborative public health sector MTEF at all levels, within the framework of NEEDS, SEEDS, and LEEDS to address health goals and priorities and as a co-factor in poverty reduction	Attainment of national/MDG goals in health, including equity, fairness and responsiveness of the health systems	Health Systems Performance Assessment report	<ul style="list-style-type: none"> ▪ Stable macroeconomic framework ▪ Adoption and implementation of relevant policy and legislative instruments and Medium-Term Economic Framework
	Outcome/Impact:			
	A coordinated reform/development of the national health system, providing coherence for goals, objectives and targets	<ul style="list-style-type: none"> ▪ Availability of Health-NEEDS ▪ No. of States with health-SEEDS ▪ % of LGAs with health-LEEDS 	Health-plan documents at all levels	Availability of resources
	Outputs:			
	Development and adoption of health component of NEEDS, SEEDS, and LEEDS	Availability of health-NEEDS/SEEDS/LEEDS	NEEDS/SEEDS/LEEDS documents	Availability of resources
	Activities	Inputs:		
	<ul style="list-style-type: none"> ▪ Est. C'mte on HSR program ▪ Preparation of 5-Year Strategic Plan & 2-Year Rolling Plans ▪ Preparation of health-SEEDS ▪ Preparation of health-LEEDS ▪ Consolidation of Federal/State/LGA health plans ▪ Health systems assessment/M&E ▪ Joint-Annual Review Meeting 	<ul style="list-style-type: none"> ▪ C'mte and working groups inauguration with TORs ▪ Funds to support processes ▪ Human Resource capacity building for HSPA 	<ul style="list-style-type: none"> ▪ Health Systems Performance Assessment report ▪ M& E Report 	<ul style="list-style-type: none"> ▪ Stable macroeconomic framework ▪ Availability of funds for planning and implementation processes, including HSPA/M&E

2. STRENGTHENING THE NATIONAL HEALTH SYSTEM AND ITS MANAGEMENT

Logical Framework: Strengthening the National Health System and Its Management

Performance Objectives	Narrative	Key Performance Verifiable Indicators	Data Collection Strategy / Report & Means of Verification	Assumptions / Risks
To strengthen the national health system and its management	Strategic planning and management of the national health system for delivery of effective, efficient and qualitative health services	Improved performance and management of health system	Health Systems Performance Assessment (HSPA) reports	<ul style="list-style-type: none"> ▪ Strong political commitment ▪ Stable political and macroeconomic environment
Intervention Projects Objectives:				
a) To reposition the Federal Ministry of Health for better performance	Structural reform of the Ministry of Health, in line with redefined roles and responsibilities; and review of health institutions to eliminate duplication of efforts and functioning at cross purposes, and position the Federal Ministry of Health as the Chief Steward and Custodian of the development & management of Nigeria's health care system	Availability of approved reorganization plan	Report	Approval by FEC
	Impact/Outcome:			
	A coordinated efficient and effective system for implementing health policy, plans, programmes and projects	Streamlined and functioning health institutions and structures	Operations, Organization and Management Research (OOMR) Reports	Approval by FEC
	Output:			
	Functions, roles and responsibilities of national health structures redefined	Availability of report defining functions, roles and responsibilities	Report	Availability of resources
	Activities:	Inputs:		
	<ul style="list-style-type: none"> ▪ Develop TOR ▪ Set up Review Committee ▪ Committee meetings ▪ Submission of reports ▪ Approval of recommendations by TMC and FEC ▪ Dissemination of approved report and orientation ▪ Implementation of Recommendations. 	<ul style="list-style-type: none"> ▪ Consultants/resource persons ▪ Funds for: <ul style="list-style-type: none"> ▪ Meetings ▪ Logistic/Secretariat support ▪ Fees/honoraria ▪ DSA/DTA ▪ Publications 	Reports	Availability of resource requirements

Performance Objectives	Narrative	Key Performance Verifiable Indicators	Data Collection Strategy / Report & Means of Verification	Assumptions / Risks
b) To establish a National Hospitals Agency to enhance coordination in terms of policies, standards and performance regulation	Development and maintenance of standard guidelines, and other technical matters regarding organization and distribution of hospitals, including monitoring and control of performance, quality assurance enforcement of compliance and ensuring linkages among tertiary and specialized hospitals across the country	National Hospitals Agency	Government gazette	Approval by FEC
	Impact/Outcome			
	Improved coordination of tertiary and specialized hospitals across the country	Improved efficiency in hospitals management	Technical audit and performance report	Hospital personnel are willing to take advantage of benefits inherent in the establishment of the Agency
	Output			
	National Hospitals Agency established	Statute establishing Agency	Statute	Needs assessment; Approval by FEC
	Activities	Inputs		
	<ul style="list-style-type: none"> ▪ Preparation of FEC Memo ▪ Meetings ▪ Approval of FEC memo ▪ Take-off of Agency ▪ Training 	<ul style="list-style-type: none"> • Funds 	Reports	Passage of Health Act Approval by FEC Release of funds
c) To establish new management structure for FHLs: seeking ways and means to make tertiary health institutions more effective and efficient - including contracting, autonomization, corporatization, and a substantial Government refurbishment/modernization programme	(l) The establishment of committee to seek ways and means of making tertiary hospitals more effective and efficient	Report of committee	Report of committee	Availability of resources
	Impact/Outcome			
	Improved management and service delivery and enhanced capacity for tertiary-level care within the country	Service utilization rate	Monitoring reports Special survey	
	Output			
	<ul style="list-style-type: none"> ▪ Committee on ways and means to make tertiary health institutions effective and efficient established ▪ Reduction in overseas treatment for tertiary-level 	<ul style="list-style-type: none"> ▪ Availability of Report ▪ Data on tertiary-level 	Report	Availability of funds

Performance Objectives	Narrative	Key Performance Verifiable Indicators	Data Collection Strategy / Report & Means of Verification	Assumptions / Risks
	health care services	service statistics/overseas treatment register		
	Activities	Inputs		
	<ul style="list-style-type: none"> ▪ Set up committee ▪ Meetings ▪ Stakeholder consultations ▪ Committee Report & Recommendations ▪ TMC & FEC Approvals ▪ Stakeholders' orientation on approved recommendations and implementation steps ▪ Study-Tour /Change Agents for FHIs ▪ Implementation of recommendations ▪ PPP capacity building 	<ul style="list-style-type: none"> ▪ Consultants/resource persons ▪ Funds for: <ul style="list-style-type: none"> ▪ Meetings ▪ Logistic/Secretariat support ▪ Fees/honoraria ▪ DSA/DTA ▪ Publications 	Minutes of meetings Report	Availability of funds
	(II) The refurbishing of Teaching Hospitals and standardization of their equipment	Inputs <ul style="list-style-type: none"> • Funds for the implementation of the VAMED Engineering Project 		
d) Establishment of a National Blood Transfusion System	<ul style="list-style-type: none"> ▪ A National blood transfusion system which has a national facility, six zonal facilities and an armed forces facility 	<ul style="list-style-type: none"> ▪ Existence and functioning of the blood transfusion facilities 	Record of blood transfusion activities	Approval by FEC and provision of funds
	Impact/Outcome <ul style="list-style-type: none"> ▪ A coordinated system of safe blood and blood products for patient use 	<ul style="list-style-type: none"> ▪ Easy access to safe blood and blood products in every zone of the country and the army 	Report of blood transfusion activities in the country	Political will
	Output <ul style="list-style-type: none"> ▪ Safe blood availability in all parts of the country 	<ul style="list-style-type: none"> ▪ Report of blood transfusion activities in the country 	Report of blood transfusion activities in the country	Availability of resources (human and material)
	Activities <ul style="list-style-type: none"> ▪ Setting up of committee on National Blood Transfusion programme ▪ Approval of committee report ▪ Setting up of the facilities at national, zonal, and military levels./Implementation 	Inputs <ul style="list-style-type: none"> ▪ Consultants and personnel for committee ▪ Logistical inputs for the committee ▪ Qualified personnel and equipment of the facilities Funds: for the setting up of the Zonal Blood Transfusion Centres; the construction and equipping additional 574 model primary health centres in the remaining LGAs for	Reports of committee	Establishment of the blood transfusion centres

Performance Objectives	Narrative	Key Performance Verifiable Indicators	Data Collection Strategy / Report & Means of Verification	Assumptions / Risks
		the implementation of PHC; and for supporting and replicating 'Best Practices' projects with regard to PHC		
e) Blueprint for the Reform and Revitalization of PHC System	The development of a system that will provide sustainable, equitable, accessible and affordable delivery of PHC services			All levels of government, especially the State and Local Governments, would effectively assume their important roles and responsibilities with regard to the implementation of the blueprint for PHC implementation
	Impact/Outcome: <ul style="list-style-type: none"> ▪ Improved PHC services and achievement of Health-Millennium Development Goals ▪ Improved healthy life-styles 			
	Outputs: <ul style="list-style-type: none"> ▪ PHC system reformed and sustained at State/LGA levels ▪ Appropriate/adequate PHC manpower/resources provided 			
	Activities: <ul style="list-style-type: none"> ▪ Set up Committee on PHC Blueprint ▪ Undertake stakeholder consultation on PHC system reform ▪ TMC/FEC Approval of recommendations ▪ Implementation of recommendations + recommendations on FMOH/Parastatals structural reforms ▪ Resource mobilization for PHC implementation <ul style="list-style-type: none"> ○ Coordinated Assistance to State/LGAs on: <ul style="list-style-type: none"> ▪ PHC health workers/community training ▪ M&E progress of performance of PHC services ▪ Donors/FGN resource mobilization/grant program for PHC development including Health Fund; NHMIS; etc. 			

3. REDUCTION OF THE DISEASE BURDEN

Logical Framework: Reduction of the Disease Burden

Performance Objectives	Narrative	Key Performance Indicators	Data Collection Strategy / Report & Means of Verification	Assumptions / Risks
To reduce the burden of disease among the Nigerian population	Evidence-based approach to prioritization and addressing major diseases and health problems	<ul style="list-style-type: none"> ▪ Disability-adjusted life expectancy ▪ MDGs Goal Prevalence-rated major diseases (HIV/Malaria/TB) 	<ul style="list-style-type: none"> ▪ World Health Report ▪ Health in Nigeria Report ▪ Reports of Selected National Health Surveys ▪ IDSR Report 	<ul style="list-style-type: none"> ▪ Political commitment at all levels of government ▪ Availability of sustained funding
Intervention Projects Objectives:				
a) To improve PHC services with emphasis on the provision of a guaranteed minimum health care package	Strengthen PHC services, including routine immunization, HIV, emergency obstetric care to deliver a guaranteed minimum health package	<ul style="list-style-type: none"> ▪ Proportion of health facilities that meet specified national standards for PHC services ▪ Proportion of population living within 5 km of PHC facility ▪ % of clients satisfied with quality of services 	<ul style="list-style-type: none"> ▪ Health Survey Report ▪ Demographic & Health Survey ▪ Multiple Cluster Indicator Survey ▪ PHC Policy document ▪ National Health Act 	LGAs would give necessary political and financial support to PHC system <ul style="list-style-type: none"> • Support of relevant agencies, including international, federal and state agencies, to the PHC system • National Health Bill passed and enacted • NPHCD Funds
	Impact/Outcome:			
	Improved health service delivery for better outcomes	<ul style="list-style-type: none"> ▪ % of health facilities that offer minimum package ▪ % of health facilities with essential drugs available ▪ Establishment of NPHCD Fund. 	Health Facilities Assessment/Survey Reports	<ul style="list-style-type: none"> ▪ Facilities would be provided with relevant human and financial resources ▪ Attitude of staff would be positive and responsive to clients' needs
	Output:			
	Increased accessibility and utilization of health services	<ul style="list-style-type: none"> ▪ Increased proportion of population living within 5 km of PHC facilities ▪ Increased utilization rate of PHC facilities ▪ Increased proportion of infant immunized 	<ul style="list-style-type: none"> ▪ Reports of National Surveys ▪ Attendance Rates at Facilities ▪ Immunisation Coverage Survey Reports ▪ NPI Routine Reports 	<ul style="list-style-type: none"> ▪ Facilities would be provided with relevant human and financial resources ▪ Attitude of staff would be positive and responsive to clients'

Performance Objectives	Narrative	Key Performance Indicators	Verifiable	Data Collection Strategy / Report & Means of Verification	Assumptions / Risks
					<ul style="list-style-type: none"> needs People would use provided facilities and services
	Activities:	Inputs:			
	<ul style="list-style-type: none"> Inventory/needs assessment for PHC health facilities. Provide Grant-leveraged refurbishment/construction & equipping PHC facilities Provide grant-leveraged refurbishment of selected schools of health technologies for PHC manpower development Implement P-P arrangement for supply of drugs and medical consumables (Pilot scheme in 6 States). 	<ul style="list-style-type: none"> Human resources Funding, Equipment, Drugs and medical supplies, MIS forms, Training materials, Service and Management protocols 		<ul style="list-style-type: none"> Needs Assessment Reports Procurement Reports Staff List HMS data Training Reports Stock Cards and Inventory Reports 	<ul style="list-style-type: none"> Political commitment at all levels Financial and other resources would be available on timely basis and well utilized
b) To improve the accessibility, quality and utilization of essential obstetric care (EOC) services	Reduce the maternal and neonatal morbidity and mortality through improved accessibility and utilization of EOC services	<ul style="list-style-type: none"> Proportion of pregnant women attended to by skilled attendants at delivery Number of basic and comprehensive EOC facilities available per 500,000 population Geographical spread of BEOC and CEOC facilities Neonatal morbidity, and mortality rates Obstetric morbidity, including VVF 		<ul style="list-style-type: none"> Demographic and Health Surveys, Hospital statistics Health facility survey 	<ul style="list-style-type: none"> Government's commitment and Political will Readiness of the population to utilize available health facilities
	Impact/Outcome:				
	Increased utilisation of modern health facilities and health professionals for pregnancy, childbirth, post-natal services and related RH services, including family planning and commodity security.	<ul style="list-style-type: none"> Proportion of pregnant women attended to by skilled attendants at delivery Proportion of deliveries that take place in EOC facilities % of pregnancy that occur in women not belonging to high-risk maternal groups 		<ul style="list-style-type: none"> Demographic and Health Surveys, Hospital statistics Hospital Statistics (combined with population census) <p>Demographic and Health Surveys, Hospital statistics</p>	<ul style="list-style-type: none"> Government's commitment and Political will Readiness of the population to utilize available health facilities

Performance Objectives	Narrative	Key Performance Verifiable Indicators	Data Collection Strategy / Report & Means of Verification	Assumptions / Risks
	Output			
	<ul style="list-style-type: none"> ▪ Increased availability and accessibility of basic and comprehensive EOC facilities ▪ Improved quality of maternal health and other reproductive health services ▪ Increased knowledge of individuals, households and communities about pregnancy and related reproductive health issues, including family planning ▪ Increased awareness of benefits of using modern health facilities in pregnancy, childbirth, postnatal and related reproductive health services 	<ul style="list-style-type: none"> ▪ Number of basic and comprehensive EOC facilities available per 500,000 population ▪ Proportion of health facilities meeting the standards for EOC ▪ % of the population with knowledge about warning signs in pregnancy ▪ % of population with knowledge of benefits of child spacing services ▪ % of population preferring modern health facilities for pregnancy-related services 	<ul style="list-style-type: none"> ▪ Health facility survey ▪ Health facility survey, exit interview of clients, review of hospital records ▪ Population-based survey ▪ Population-based survey 	<ul style="list-style-type: none"> ▪ Government's commitment and Political will ▪ Behaviour change communication activities would be effective to ensure improved health knowledge and behaviour
	Activities	Inputs		
	<ul style="list-style-type: none"> ▪ Assess maternal mortality reduction efforts to identify 'best practices' that could be up-scaled ▪ Identify and designate EOC facilities, with input from community stakeholders ▪ Establish an enhanced and effective system of 2-way referrals between facilities ▪ Equip facilities with relevant equipment ▪ Provide drugs and other relevant medical supplies on a continuous and sustainable basis ▪ Train relevant health professionals in life-saving skills ▪ Train, employ and deploy new skilled attendants to service delivery facilities ▪ Conduct behaviour change communication activities at national and community levels ▪ Define relevant standards and protocols, including definition and costing of a minimum RH package as part of a basic PHC package ▪ Monitor compliance of facilities and practitioners with defined standards ▪ Advocacy activities targeting policy makers and community leaders for improvement in maternal health services and status of women ▪ Community mobilisation for maternal mortality reduction activities 	<ul style="list-style-type: none"> ▪ Fund ▪ Human resources ▪ Equipment, Drugs and medical supplies, ▪ Training materials ▪ Service protocols ▪ BCC and advocacy materials ▪ Assessment and Monitoring instruments 	<p>Programme and health services records, including staff roll, training profile, and inventory of drugs and other supplies</p>	<ul style="list-style-type: none"> ▪ Government's commitment and Political will

Performance Objectives	Narrative	Key Performance Verifiable Indicators	Data Collection Strategy / Report & Means of Verification	Assumptions / Risks
c) To establish effective health sector response to HIV/AIDS, and appropriate control measures for malaria, TB and other major communicable diseases	Reduce the health problems and disease burden related to HIV/AIDS, TB and other major communicable diseases	<ul style="list-style-type: none"> ▪ Disease burden attributable to selected health problems ▪ Incidence/prevalence of selected health problems 	National Health Surveys MICS, IDRS and others	<ul style="list-style-type: none"> ▪ Political will ▪ Effectiveness of selected interventions ▪ Availability of required resources
	Impact/Outcome:			
	<ul style="list-style-type: none"> ▪ Improved health and quality of life through reduction in disease burden 	<ul style="list-style-type: none"> ▪ Proportion of population with health problems ▪ Incidence/Prevalence of major diseases among the population 	<ul style="list-style-type: none"> ▪ National Demographic and Health Survey ▪ Multiple Cluster Indicator Survey ▪ Other National Surveys 	<ul style="list-style-type: none"> ▪ Political will ▪ Effectiveness of selected interventions
	Output:			
	<ul style="list-style-type: none"> ▪ Reduce the frequency of disease through effective prevention strategies ▪ Improved health outcome through effective management of problems 	<ul style="list-style-type: none"> ▪ % of children 12-23 months fully immunized ▪ % of children U5 sleeping under an ITN ▪ % of population adopting HIV/AIDS prevention strategies, including abstinence and safer sex practices ▪ % of people with TB on DOTS 	<ul style="list-style-type: none"> ▪ Health Surveys ▪ IDRS Reports ▪ NHMIS 	<ul style="list-style-type: none"> ▪ Political will ▪ Effectiveness of selected interventions ▪ Population would adhere to prevention strategies and follow recommended management
	Activities:	Inputs:		
	<ul style="list-style-type: none"> ▪ Assess the frequency and impact of health problems, health-seeking behaviour, and health professionals' practices ▪ Recruit and train health care providers as necessary ▪ Provide drugs and other medical supplies ▪ Institute client-friendly policies in health facilities, including payment mechanisms ▪ Educate the population on prevention and treatment of health problems ▪ P-P partnership to produce ARV Drugs locally 	<ul style="list-style-type: none"> ▪ Human resources (Consultants, health professionals, survey personnel etc) ▪ Material resources (drugs, medical supplies etc) ▪ Management protocols and service guidelines ▪ Training materials ▪ MIS forms and other health management instruments ▪ Financial resources 	<ul style="list-style-type: none"> ▪ Programme records (procurement, consultancy, monitoring records, etc) ▪ Health facility records ▪ Health facility assessment survey reports ▪ Reports of health-seeking behaviour studies ▪ Establish functional ARV manufacturing plant 	Political will to ensure availability of materials and implementation of programmes and projects
d) Promotion of healthy lifestyles through reduction of risk factors.	Reduction in incidence of preventable diseases through adequate nutrition, adoption of healthier lifestyles, food and environmental hygiene, and injury-	<ul style="list-style-type: none"> ▪ Proportion of the population adopting healthy lifestyles (such as exercise) and 	<ul style="list-style-type: none"> ▪ Health surveys 	<ul style="list-style-type: none"> ▪ Political will ▪ Effective behavioural change Communication

Performance Objectives	Narrative	Key Performance Indicators	Data Collection Strategy / Report & Means of Verification	Assumptions / Risks
	prevention and safe reproductive behaviours	<p>health-promoting practices, such as appropriate diet, food hygiene, environmental sanitation, and injury prevention</p> <ul style="list-style-type: none"> Proportion of the population not indulging in health-risky behaviour (such as alcohol and smoking) 		
	Impact/Outcome:			
	<ul style="list-style-type: none"> Increased adoption of positive, healthy lifestyles and reduction of health-risky behaviour among the population 	<ul style="list-style-type: none"> Prevalence of lifestyle-related health problems Proportion of the population involved in regular exercise % of the population adopting healthy diet lifestyle % of young persons who smoke cigarette % of the population that are aware of the benefits of safe disposal of wastes % of population who drive vehicles who are knowledgeable about the safety provisions of the highway code 	<ul style="list-style-type: none"> Health facilities data Health surveys Population-based survey 	<ul style="list-style-type: none"> Political will Willingness of the population to take to health messages
	Output:			
	<ul style="list-style-type: none"> Increase in the proportion of population with awareness and knowledge of healthy lifestyle Increase in the proportion of the population with access to relevant health services that address health-risky behaviours and promote positive healthy behaviour 	<ul style="list-style-type: none"> Proportion of the population involved in regular exercise % of the population adopting healthy diet lifestyle Proportion of the population that are smokers Proportion of population aware of healthy lifestyles, including safe sex 	<ul style="list-style-type: none"> Health survey Nutritional surveys NDHS, IDRS 	<ul style="list-style-type: none"> Political will Willingness of the population to take to health messages
	Activities:	Inputs:		
	<ul style="list-style-type: none"> Public education on health-promoting behaviour Provision of health services to address health- 	<ul style="list-style-type: none"> Human resources (health educators, counsellors, 	<ul style="list-style-type: none"> Media activity reports Survey of mass media activities log 	<ul style="list-style-type: none"> Political will Effective service

Performance Objectives	Narrative	Key Performance Verifiable Indicators	Data Collection Strategy / Report & Means of Verification	Assumptions / Risks
	<ul style="list-style-type: none"> risky behaviour ▪ Establish regulations/enact health legislation to encourage healthy life behaviours 	<ul style="list-style-type: none"> media professionals, etc) ▪ Behaviour change communication materials ▪ Finance 	<ul style="list-style-type: none"> ▪ Programme accounting records 	<ul style="list-style-type: none"> activities by health educators and other relevant personnel

4. IMPROVING AVAILABILITY OF HEALTH RESOURCES AND THEIR MANAGEMENT

Logical Framework: Health Resources & Management

Performance Objectives	Narrative	Key Performance Verifiable Indicators	Data Collection Strategy / Report & Means of Verification	Assumptions / Risks
To mobilise and effectively and efficiently manage health resources	Establish mechanisms and sustainable systems for effective mobilisation and efficient management of resources	<ul style="list-style-type: none"> ▪ Adequate funding of a Guaranteed Minimum Package of health care ▪ Improved Adequacy of human and physical resources ▪ Improved per capita expenditure in health 	Relevant Documents and Reports <ul style="list-style-type: none"> ▪ Health Management Information System (HMIS) ▪ National Health Account (NHA) ▪ Health Care Financing Strategy ▪ National Strategy for Human Resources ▪ Maintenance System for Physical Assets 	Political Commitment to the implementation of the HSR process
Intervention Projects Objectives:				
a) To develop a comprehensive health care financing strategy and plan	Develop a comprehensive financing strategy to improve availability and efficient allocation of financial resources for effective performance of the health system	Availability of health care financing strategy document	The document	<ul style="list-style-type: none"> ▪ Political commitment ▪ Willingness of relevant stakeholders to take advantage of strategy
	Impact:/Outcome:			
	Broadened Financial Resource Base for Health	Improved per capita expenditure in health	NHA	Stable and improved macroeconomic environment
	Output:			
	Rational use of available resources	Functionality and coverage of National Health Insurance Scheme	<ul style="list-style-type: none"> • National Health Account • National Health Insurance system 	Involvement of Communities and private sector
	Activities:	Inputs:		
	<ul style="list-style-type: none"> ▪ Capacity Building for and Construction of National Health Accounts ▪ Introduction of Special Legislation on Health/Taxes/Funds to finance public health programmes and Guaranteed Minimum PHC services ▪ Development and implementation of payment schemes and arrangements that promote incentives to improve health services delivery ▪ Build managerial capacity to 	<ul style="list-style-type: none"> ▪ Human resources (Consultants, others) ▪ Funds ▪ Capacity building ▪ Reports ▪ Commencement funds for NHMIS 	<ul style="list-style-type: none"> ▪ Contract papers ▪ Programme implementation reports ▪ Policy documents ▪ PHC fund ▪ National Health Insurance Council ▪ Health Insurance Funds ▪ HMOs and MHAs 	<ul style="list-style-type: none"> ▪ Appropriate legislation ▪ Availability of resources. ▪ Dominance of public sector

Performance Objectives	Narrative	Key Performance Verifiable Indicators	Data Collection Strategy / Report & Means of Verification	Assumptions / Risks
	<ul style="list-style-type: none"> implement NHMIS at all levels and Implement a re-Designed NHMIS Implement "HLF" strategies for increased budgetary allocation/donor resource mobilization for the health sector. 			
b) To develop a national strategy for human resources in health	Institute a national strategy to produce better motivated, skilled and efficient workforce	<ul style="list-style-type: none"> Retention rate of health workers 	<ul style="list-style-type: none"> Personnel audit report 	Sector remains attractive to the best talents
	Impact:/Outcome:			
	Enhanced capacity for service delivery	Utilisation rates	Utilisation reports	<ul style="list-style-type: none"> Stable Political Environment Conducive management environment
	Output:			
	Motivated health personnel	Improved service conditions	Policy & Establishment reports	<ul style="list-style-type: none"> Macroeconomic environment stable Political will
	Activities:	Inputs:		
	<ul style="list-style-type: none"> TOR Human resource needs assessment Development of Health Human Resource Policy Implement appropriate management structure for human resources in health (HRH) Institutionalise mechanism for continuous managerial and professional training and development 	<ul style="list-style-type: none"> Consultants Funds Training Consensus meetings 	<ul style="list-style-type: none"> Policy document Training manuals and reports 	Acceptability of reform by health personnel
d) To Develop a maintenance system for physical assets	To rehabilitate, restore and maintain physical assets (buildings & equipment) to functional state	Physical state of assets	Agreements signed	Adequate financial management and human resources
	Impact:/Outcome:			
	Institutionalized acquisition, regulation & regular maintenance schedule for physical assets	All health facilities operating in relatively full functional capacity	Number of closed wards & facilities or unserviceable equipment	Budgetary provisions
	Output:			
	<ul style="list-style-type: none"> Standardized medical equipment nationally Accreditation of health facilities 	<ul style="list-style-type: none"> Spares always available for equipment repairs Maximum utilization of services 	<ul style="list-style-type: none"> Serviceable medical equipment. Maintenance contracts 	Enforcement of Regulations

Performance Objectives	Narrative	Key Performance Verifiable Indicators	Data Collection Strategy / Report & Means of Verification	Assumptions / Risks
	Activities:	Inputs:		
	<ul style="list-style-type: none"> ▪ Audit and classification of assets ▪ Standardization of equipment ▪ Establish a system for coordinated procurement of equipment/physical assets and related supplies ▪ Regulation on appropriate technologies ▪ Training of maintenance staff ▪ Out-sourcing of services and maintenance 	<ul style="list-style-type: none"> ▪ Consultants ▪ Funds for meetings ▪ Resource Personnel ▪ Fees ▪ Funds for training 	Maintenance contracts	Adequacy of management capacity

5. IMPROVING ACCESS TO QUALITY HEALTH SERVICES

Logical Framework: Improving Access to Quality Health Service

Performance Objective	Narrative	Key Performance verifiable indicators	Data Collection Strategy / Report & Means of Verification	Assumptions / Risks
1. To enhance access of Nigerians to quality health care services, particularly PHC	<ul style="list-style-type: none"> ▪ Ensure availability of quality and relevant health facilities and essential drugs and consumables ▪ Ensure public/private mix in health care delivery, including registration and control of traditional and alternative medicine practitioners ▪ Ensure availability of appropriate and quality health human resources 	% of families with access to quality health care services	Survey on facilities (location and utilization)	<ul style="list-style-type: none"> ▪ Political commitment to reform ▪ Stakeholders' interest ▪ Availability of funds
Intervention Objectives Establishment of a system for quality assurance/certificates of needs and standards	<ul style="list-style-type: none"> ▪ The establishment of a system that would regulate the location, practice and quality of human and material resources in health facilities 	Presence of quality health facilities within 5km of every Nigerian	Survey of facilities	<ul style="list-style-type: none"> ▪ Political commitment to reform ▪ Stakeholders' cooperation ▪ Funds
	<u>Impact/Outcome</u>			
	<ul style="list-style-type: none"> ▪ Increased access to quality health facilities 	No. of facilities across the country with certificates of needs and standards	Survey/Report of issuing agency	Agency established and funded
	<u>Output</u>			
	<ul style="list-style-type: none"> ▪ Facilities are established on the basis of certificates of needs and standards 	No. of facilities across the country with certificates of needs and standards	Survey / report of issuing agency	<ul style="list-style-type: none"> ▪ Agency functioning well ▪ Stakeholders cooperation
	<u>Activities</u>	<u>Input:</u>		
	<ul style="list-style-type: none"> ▪ Committee on National Health Bill ▪ Establish NHS Agency; SHMB; SPHCMB ▪ Agencies to publish guidelines on certificates of needs and standards, Stakeholders education ▪ Agencies comply with certificates of needs and standards 	Funds for committee/Agency activities	National Health Act Passed and contains provision for certificates of needs and standards	<ul style="list-style-type: none"> ▪ NASS pass bill ▪ Agencies established and funded
2. To ensure that the consumption of essential drugs is met mostly from local production	Increased local production of essential drugs, including ARVs, through a regime of incentives, import prohibition, tariff measures and boosting of R & D for local sourcing of pharm. raw materials, including pharmaceutical actives and excipients	(i) Qty & value of essential drugs produced as a % of total finished drug products (ii) % Increase in capacity utilisation of local pharm. manufacturers (iii) % Increase in quantity & type of raw materials sourced locally	Survey on finished drug imports and production outputs of local manufacturers	<ul style="list-style-type: none"> ▪ Political commitment on incentives to manufacturers ▪ Availability of funds

Performance Objective	Narrative	Key Performance verifiable indicators	Data Collection Strategy / Report & Means of Verification	Assumptions / Risks
Intervention Objectives a. To boost local production of essential drugs through import prohibition and reduction of tariffs on pharm. raw materials	Implement approved prohibition list and tariff reduction on raw materials	% Increase in qty of prohibited drugs being produced locally Low out-of-stock syndrome in health facilities	<ul style="list-style-type: none"> ▪ Data on local production of essential drugs ▪ Records from health facilities 	<ul style="list-style-type: none"> ▪ Political commitment on incentives ▪ Adequate funding of health facilities for drug procurement
	Impact/Outcome Increased availability of & access to basic essential drugs			
	Activities (i) Liaise with FMF to implement prohibition list and other incentives to manufacturers (ii) Re-equip & reposition Pharm. Mfg.Lab for ARV production (iii) Facilitate access to soft loans through BOI for local pharm. manufacturers	(a) Circular to Customs and other relevant agencies on essential drugs and tariff reduction on raw materials (b) Qty of ARVs produced (c) Funds accessed by local pharm. manufacturers		Provision of funds for rehabilitating the Production Lab
b. To revamp Research & Development to support local pharmaceutical industry thro NIPRD and other research institutions	Establish a Pharmaceutical R & D Fund to increase tempo of research while also facilitating establishment of plants for production of excipients (starch, cellulose) and pharm. actives	% Increase in no. and type of raw materials adopted for local drug manufacture	Report on research outputs	<ul style="list-style-type: none"> ▪ Political commitment ▪ Adequate funding for research
	Impact/Outcome Increase in research outputs and pharm. raw materials			
	Activities (i) Allocate 2% surcharge on drug imports to fund NIPRD's research activities (ii) Complete and equip NIPRD's abandoned 5-storey lab. complex (ii) Woo investors thro incentives to engage in production of excipients (starch, cellulose) (iv) Advocate commercial production of cassava and maize for starch production, lemon grass and Eucalyptus and Ginger for essential oils	Value of funds available <ul style="list-style-type: none"> ▪ No of investors participating in the scheme ▪ Qty and type of excipients produced ▪ Acreage of crops cultivated 	Report on disbursement Report and data on outputs	Political commitment

Performance Objective	Narrative	Key Performance verifiable indicators	Data Collection Strategy / Report & Means of Verification	Assumptions / Risks
	(v) Collaborate with UNDP to establish pilot plant for manufacture of active raw materials from intermediates	No. of plants and qty and types of active raw materials produced		
3. To harness Nigeria's medicinal plant resources for health care delivery	Ensure conservation and sustainable use of medicinal plants	Increased availability of medicinal plants for use in reducing the national disease burden	Report on conservation efforts	Political commitment
Intervention Objectives				
a. To adopt appropriate strategy for the conservation and sustainable use of Nigeria's medicinal flora, especially endangered species	<p>Establish an Inter-Ministerial Committee/Taskforce to promote conservation activities</p> <p><u>Impact/Outcome</u> Preservation of endangered medicinal plant species</p>	Inter-Ministerial Committee functional	Regular Report of Committee's Activities	<ul style="list-style-type: none"> ▪ Political commitment ▪ Adequate funding
	<p>Activities</p> <p>(i) Identification, verification and compilation of medicinal plants used in Nigeria (especially for malaria & HIV management)</p> <p>(ii) Inventorise medicinal plants used both in herbal medicine and the codified traditional system of medicine</p> <p>(iii) Identification of threatened species and develop POA for protection and conservation (including listing on National CITES Legislation, the Endangered Species Act)</p> <p>(iv) Strengthen existing facilities/promote establishment of specific National Botanical Gardens & Medicinal Plant Gene Banks</p>	Inventory of Medicinal plants available for use by interested stakeholders (Traditional Medicine Practitioners, Research Institutions)	Reports	<ul style="list-style-type: none"> ▪ Political commitment ▪ Cooperation by constituent members of Inter-Ministerial Committee
b. To ensure effective regulation of traditional herbal medicines	<p>Establish and enforce Guidelines to ensure safety and efficacy of herbal medicines</p> <p><u>Impact/Outcome</u> Herbal Medicines made safer to consumers</p> <p>Activities</p> <p>(i) Establish and circulate Guidelines</p>	Record of listed/registered herbal medicines available		Adequate funding
	<p>Activities</p> <p>(ii) Educate stakeholders on Guidelines</p> <p>(iii) Implement Guidelines</p> <p>(iv) Establish a Pharmacognosy Laboratory</p>	Herbal Medicines standardized for safety and efficacy	Evaluation reports	<ul style="list-style-type: none"> ▪ Cooperation of practitioners ▪ Adequate funding

Performance Objective	Narrative	Key Performance verifiable indicators	Data Collection Strategy / Report & Means of Verification	Assumptions / Risks
Intervention Objective c. To develop a Nigerian Herbal Pharmacopoeia	A Nigerian Herbal Pharmacopoeia will be a veritable reference manual for the National Traditional Medicine System	Availability of a Nigerian Herbal Pharmacopoeia for reference purposes	Report on documentation	Adequate funding
	<u>Impact/Outcome</u> Identification and utilisation of medicinal plants enhanced			
	Activities (i) Hosting of Meetings of Expert Committee on Pharmacopoeia Development (ii) Documentation & verification of field activities in Research Institutions (Institutes & Universities) (iii) Printing & circulation of Pharmacopoeia	Nigerian Herbal Pharmacopoeia published	Reports	Adequate funding
4. To ensure that only good quality, safe, and effective drugs, foods and other regulated products are available in the distribution channels in Nigeria	Eliminate fake, adulterated, substandard and unregistered drugs and other regulated products from the distribution channels	% Decrease in the level of fake drugs as well as other substandard and unwholesome regulated products in circulation	Survey report	<ul style="list-style-type: none"> ▪ Political commitment sustained ▪ Adequate funding of regulatory agencies
Intervention Objectives a. To strengthen the legislative framework as well as the enforcement capacities of regulatory agencies	Complete the review of Pharmacy and Drug laws and strengthen the enforcement capacities of relevant agencies of government (NAFDAC, NDLEA, PCN, Customs)	% Increase in arrests of smugglers and peddlers in fake/adulterated regulated products	Report	<ul style="list-style-type: none"> ▪ Political commitment sustained ▪ Adequate funding of regulatory agencies
	<u>Impact/Outcome</u> Quality of drugs and other regulated products in circulation assured	Low level of fake/adulterated drugs and other substandard regulated products in circulation	Survey report on incidence of fake/adulterated drugs	

Performance Objective	Narrative	Key Performance verifiable indicators	Data Collection Strategy / Report & Means of Verification	Assumptions / Risks
	<p>Activities</p> <p>(i) Review Pharmacy & Drug Laws involving relevant stakeholders (PCN, PSN, NAFDAC, FMOH, FMJ, NASS)</p> <p>(ii) Establish and equip new laboratories and upgrade existing ones</p> <p>(iii) Undertake regular staff training (PCN, NAFDAC) to enhance performance</p> <p>(iv) Establish baseline data on extent of fake drugs in circulation</p> <p>(v) NAFDAC & PCN intensify inspections at ports, manufacturing, distribution and retail establishments</p>	<p>Revised laws enacted</p> <p>Capacity of NAFDAC to certify quality of regulated products enhanced</p> <p>Staff motivated for increased productivity</p> <p>Empirical data on level of fake drugs available</p> <p>Increase in surveillance and enforcement activities of regulatory agencies</p> <p>Low level of fake/substandard products in circulation</p>	<ul style="list-style-type: none"> ▪ Report ▪ Reports of Product Analyses ▪ Tempo of enforcement and laboratory activities intensified ▪ Published data ▪ Published report 	<ul style="list-style-type: none"> ▪ Commitment of stakeholders ▪ Adequate funding of agencies ▪ Adequate funding ▪ Adequate funding ▪ Political commitment ▪ Judicious prosecution
	<p>Activities:</p> <p>(vi) Institute Regular consultative meetings among the agencies (NAFDAC, NDLEA, SON, Customs & Immigration Services) as well as joint patrols undertaken at ports & border posts</p> <p>(vii) Intensify consumer awareness programme</p>	<ul style="list-style-type: none"> ▪ Increased cooperation among regulatory agencies ▪ Increase in arrests of smugglers and low level of substandard products ▪ Increased consumer awareness of quality of regulated products 	<ul style="list-style-type: none"> ▪ Reports ▪ IEC materials, mass media campaigns 	<ul style="list-style-type: none"> ▪ Commitment of other regulatory agencies ▪ Adequate funding
b. To develop a National Pharmacopoeia for Orthodox Drug Products	<p>A National Pharmacopoeia comprises standards and test methods that are adaptable to less sophisticated analytical equipment to facilitate quality control of medicines. It would be an invaluable reference manual and tool for Nigerian regulatory agencies</p>	<ul style="list-style-type: none"> ▪ Analyses of drug products facilitated 	<ul style="list-style-type: none"> ▪ Validated monographs 	<ul style="list-style-type: none"> ▪ Adequate funding
	<p>Impact/Outcome</p> <p>Quality assessment of drugs facilitated</p>			
	<p>Activities</p> <p>(i) Hosting of Meetings of Expert Committee on Pharmacopoeia Development</p> <p>(ii) Validation of test methods in accredited laboratories</p> <p>(iii) Collation and compilation of verified monographs</p> <p>(iii) Printing & circulation of Pharmacopoeia</p>	<ul style="list-style-type: none"> ▪ National Pharmacopoeia printed 	<ul style="list-style-type: none"> ▪ Validated monographs 	<ul style="list-style-type: none"> ▪ Adequate funding

Performance Objectives	Narrative	Key Performance Verifiable Indicators	Data Collection Strategy / Report & Means of Verification	Assumption / Risks
c. To establish a system of monitoring adverse drug reactions	Monitoring of adverse drug reactions is crucial to assuring drug safety. A pharmaco-vigilance centre is the logical outcome. Impact/Outcome Increased awareness of drug safety issues	Adverse Drug Reaction Reporting System established		
	Activities (i) Ministerial approval to establish a Pharmaco-vigilance Centre (ii) Develop tools for adverse drug reactions (iii) Conduct staff training (iv) Establish a database (v) Organise stakeholders' meetings	Pharmaco-vigilance Centre established and Adverse Drug Reaction Reports institutionalised in health facilities	Reporting Forms	<ul style="list-style-type: none"> ▪ Adequate Funding; ▪ Full cooperation of Health Practitioners to undertake voluntary reporting
5. To sanitise the drug distribution system in Nigeria	Undertake the phasing out of open drug markets In Nigeria	Availability of drugs only in licensed/ authorized distribution channels	Survey report	Political commitment
Intervention Objectives a. To facilitate, on lease basis, access to unutilised/idle govt. medical warehouses by investors in drug distribution network	Ensure provision of facilities to investors in drug distribution as alternative to open drug markets which contribute to the fake drug menace	Number of private sector-managed Drug Distribution Centres established	Report	<ul style="list-style-type: none"> ▪ Political commitment ▪ Adequate funding
	Impact/Outcome Quality of drugs in distribution channels assured	Low level of substandard drug products in circulation	Survey report	
	Activities (i) Undertake a study to identify unused capacity in Govt. Medical Stores across the country (ii) Upgrade & refurbish Fed Govt. Medical Stores and allocate idle spaces to investors in drug distribution (iii) Encourage States to upgrade & refurbish their own facilities and lease out to investors (iv) Complete the Fed. Govt. Premier Medical Stores in Abuja and lease excess space to investors in drug distribution	<ul style="list-style-type: none"> ▪ Study report available ▪ No. of warehouses upgraded and available for leasing ▪ No. of States' warehouses available for leasing 	Report on drug distribution centres functioning	<ul style="list-style-type: none"> ▪ Political commitment ▪ Cooperation of States in the scheme

6. IMPROVING CONSUMER AWARENESS AND COMMUNITY INVOLVEMENT

Logical Framework: Improving Consumer Awareness and Community Involvement

Performance objectives	Narrative	Key Performance Verifiable indicators	Data Collection strategy / report & Means of verification	Assumptions / Risks
Improving consumers' awareness/ Community Involvement	Promote consumer awareness and community participation through advocacy	Consumers and communities are enlightened about their rights and responsibilities for health	Assessment Report	<ul style="list-style-type: none"> ▪ Stable political environment ▪ Sustained policy thrust ▪ Enabling economic environment
Intervention Project Objectives				
(a) Advocacy: Development of strategies to increase consumers' knowledge and awareness of personal obligation to better health, their rights to quality care and information on health	Identify stakeholders and develop framework to enable community-wide awareness on their health rights and their personal obligation to better health, including maternal and child health across the country	Community Health Charter produced clearly outlining stated rights and obligations	Report	<ul style="list-style-type: none"> ▪ Approval by TMC, NCH and FEC ▪ Favorable Economic Environment
	Impact:/Outcome:			
	<ul style="list-style-type: none"> ▪ An empowered community of consumers who understand and advocate and enforce their rights and obligations 	Level of awareness of rights and obligations	Performance survey report	<ul style="list-style-type: none"> ▪ Passage of National Health Act ▪ Sustained advocacy
	Output			
	<ul style="list-style-type: none"> ▪ Document on Community Health Charter approved 	<ul style="list-style-type: none"> ▪ Availability of Community Health Charter and National Health Act 	<ul style="list-style-type: none"> ▪ The Community Health Charter document 	<ul style="list-style-type: none"> ▪ Political support ▪ Legislative support
			Community Reports	<ul style="list-style-type: none"> ▪ Availability of resources
	Activities:	Inputs		
	<ul style="list-style-type: none"> ▪ Identification of stakeholders ▪ TORs developed ▪ Project Implementation Team (PIT) established ▪ Consultations with stakeholders ▪ Consultants appointed ▪ Community Health Charter reviewed by stakeholders ▪ TMC approval ▪ NHC approval ▪ FEC approval ▪ Dissemination and sensitization of key community groups 	<ul style="list-style-type: none"> ▪ Funds for: ▪ Advocacy and mobilization ▪ Meetings ▪ Equipment ▪ Logistics ▪ Secretariat support ▪ Supplies ▪ DSA/DTA ▪ Fees and honoraria ▪ Consultants' fees ▪ Communication ▪ Media activity ▪ Publications 	Community Health Charter	<ul style="list-style-type: none"> ▪ Adequate resource available ▪ Socio-economic stability

Performance objectives	Narrative	Key Performance Verifiable indicators	Data Collection strategy / report & Means of verification	Assumptions / Risks
b) Participation: Develop a strategy to enhance community participation in the provision and financing of health services	Establishment of functional community-based, pre-payment schemes across the country with the active participation of community members in the management of the ward health committees	Community-based pre-payment schemes functional across the country	<ul style="list-style-type: none"> ▪ Programme report ▪ Survey report 	<ul style="list-style-type: none"> ▪ Reviewed National Health Insurance Scheme operational ▪ HSR institutionalized ▪ Acceptance and willingness of community leaders
	Impact:/Outcome			
	<ul style="list-style-type: none"> ▪ Risk protection for poor and vulnerable ▪ Members of the community have access to quality and affordable health services 	Guaranteed minimum health package available to the poor Community becomes co-owners and co-financiers of health care	<ul style="list-style-type: none"> ▪ Service assessment report. 	<ul style="list-style-type: none"> ▪ Reviewed National Health Insurance Scheme operational ▪ HSR institutionalized ▪ Acceptance and willingness of community leaders
	Output			
	<ul style="list-style-type: none"> ▪ Ward and village health committees functional 	Community contributes resources and time to support local health actions	<ul style="list-style-type: none"> ▪ Survey ▪ Community committee reports 	<ul style="list-style-type: none"> ▪ Reviewed National Health Insurance Scheme operational ▪ HSR institutionalized ▪ Acceptance and willingness of community leaders
	Activities	Inputs		
	<ul style="list-style-type: none"> ▪ PIT established ▪ Baseline studies ▪ Identification of key community groups and leaders ▪ Identification of collaborative partners – LGAs, NPHCDA, FMOH, NHMIS, SMOH, NGOs and international agencies ▪ Targeted sensitization and advocacy and mobilization. ▪ Capacity needs assessment of key groups ▪ Capacity building interventions for targeted groups ▪ Support community groups to evolve association-based pre-payment Schemes ▪ Support community dissemination of available services 	<ul style="list-style-type: none"> ▪ Resources:- human, material and funds ▪ Consultants' time ▪ Logistical support ▪ Communication ▪ Community volunteers ▪ Community philanthropic support 	<ul style="list-style-type: none"> ▪ Report ▪ Community committee reports and minutes 	Effective communication and mobilization strategy
c) Designing communication programmes and building capacity in basic communication skills for health care workers and	Comprehensive communication strategy developed and implemented	Effective communication messages developed to capture core problem issues in the communities	<ul style="list-style-type: none"> ▪ Survey report 	<ul style="list-style-type: none"> ▪ Controversies avoided ▪ Local communication needs and channels identified and used effectively

Performance objectives	Narrative	Key Performance Verifiable indicators	Data Collection strategy / report & Means of verification	Assumptions / Risks
community-based health providers in priority health conditions				<ul style="list-style-type: none"> Use of appropriate language and symbols
	Impact./Outcome: <ul style="list-style-type: none"> Consumers and communities imbibe actions that promote healthy lifestyles 			
	Output			
	<ul style="list-style-type: none"> Communities and consumers are well informed about their rights and responsibilities in health 	Community Health Charter developed	Community Health Charter document	<ul style="list-style-type: none"> Community perceptions addressed by communication strategy and outreach Community awareness and acceptance of Community Health Charter
	Activities	Inputs		
	<ul style="list-style-type: none"> Stakeholder analyses Community needs assessment Capacity building to address areas of specific need among targeted members of the community Design and implement communication strategy relevant to the community Review of ongoing communication strategy implementation 	Resources:- <ul style="list-style-type: none"> Funds, material and human resources Community suggestions External support Logistics Communication 	Community reports	<ul style="list-style-type: none"> Presence of an enabling environment for public, private and community interactions Resource availability

7. PROMOTING EFFECTIVE PARTNERSHIPS, COLLABORATION & COORDINATION

Logical Framework: Promoting Effective Partnership and Collaboration

Performance Objectives	Narrative	Key Performance Verifiable Indicators	Means of Verification	Assumptions / Risks
To promote effective Partnerships Collaboration and coordination	Recognising that the public sector alone cannot cope with the demands of the health sector, there is the need to enhance effective collaboration with the private sector, development partners and other actors.	Availability of coordination mechanism	<ul style="list-style-type: none"> ▪ Document ▪ Signed Documents (MOUs) ▪ Annual reports 	<ul style="list-style-type: none"> • Political stability and commitment from public and private sectors • Adoption of mechanism for collaboration • Cooperation of all stakeholders
Intervention Objectives				
a) To develop an effective public-private partnership (PPP) policy and capacity to manage PPP initiatives	Development of a policy document that would guide collaboration between public and private sector actors to enhance partnerships within the national health system	National Health Policy	Policy Document	Acceptance of national health policy
	Impact/Outcome:			
	<ul style="list-style-type: none"> ▪ Expansion and maximization of private sector participation in health system development and management. 	Existence of PPP initiatives	<ul style="list-style-type: none"> ▪ Agreements ▪ No. of PPP projects 	Cooperation of all stakeholders
	Output:			
	<ul style="list-style-type: none"> ▪ Policy and capacity to guide global and local partnerships/ Collaboration 	Policy document available	Policy Document	Private sector and international agencies buy-in
	Activities:	Inputs:		
	<ul style="list-style-type: none"> ▪ Establish a Committee on Guidelines for PPP ▪ Conduct a PHSA ▪ Committee to review PHSA ▪ Stakeholder meetings ▪ PPP capacity building within FMOH ▪ Initiate pilot PPP projects for health services delivery ▪ Establish mechanism for cross-referral system in health care delivery between public and private institutions 	Consultants/Resource persons Funds for: Meetings Logistics Fees/Honorarium DSA/DST Publications	<ul style="list-style-type: none"> • PSHA report • Intramural practice • Seamless referral system between public & private health facilities 	Availability of funds for study and policy development
b) Active promotion of intramural practice to enhance quality of service and improve capacity utilization at public and private health facilities	Too many publicly owned health facilities, such as general hospitals, especially at State/LGA levels are under-utilized, and co-exist side-by-side with poor and low standards in privately owned medical centres/clinics. There is a need to improve utilization of public health facilities by allowing intramural practice, which would in turn raise the standards of private practice for the benefit of the communities they serve.	<ul style="list-style-type: none"> ▪ Proportion of Intramural arrangements completed <i>vis-à-vis</i> numbers of co-existing public-private health facilities 	Reports Signed MOUs	<ul style="list-style-type: none"> ▪ Political will ▪ Cooperation of all parties

Performance Objectives	Narrative	Key Performance Verifiable Indicators	Means of Verification	Assumptions / Risks
	Impact/Outcome: <ul style="list-style-type: none"> Improved quality of health care services to clients 	<ul style="list-style-type: none"> Levels of consumer satisfaction 	<ul style="list-style-type: none"> Survey report Exit interviews 	
	Outputs: <ul style="list-style-type: none"> Improved utilization/vibrancy of publicly owned health facilities Cost-effective public-private health care services in the catchment areas 	<ul style="list-style-type: none"> Utilization/attendance indicators of public health facilities Overall health-care cost index in a given catchment's area 	<ul style="list-style-type: none"> Survey/study reports 	
	Activities: <ul style="list-style-type: none"> Establish Committee to produce Intramural Service protocol and guidelines TMC & FEC approval of Intramural protocol Capacity building in the implementation of protocol Sensitization on the benefits of protocol Enforcement of strict certificates of need and standards for public and private health facilities 	<ul style="list-style-type: none"> Funds to implement activities 	<ul style="list-style-type: none"> Reports 	
c) Establishment of a forum to enhance effective donor coordination	Strengthening the donor coordination mechanism of the Division for Partnership/Collaboration within the FMOH to streamline donor activities with national health objectives and programmes	<ul style="list-style-type: none"> Forum strengthened Division strengthened 	<ul style="list-style-type: none"> Functional secretariat Reports and meetings 	<ul style="list-style-type: none"> Seriousness of purpose and commitment Leadership role of FMOH Re-structuring of FMOH
	Impact/Outcome:			
	A coordinated, effective and efficient integration of donors (local & foreign) into national health system	Number of Bilateral Agreements/MOUs signed	<ul style="list-style-type: none"> Signed Bilateral Agreements/MOUs 	<ul style="list-style-type: none"> Stakeholder Interest
	Output:			
	Bilateral Agreements reviewed and streamlined	Number of Agreements	<ul style="list-style-type: none"> Programmes 	<ul style="list-style-type: none"> Funding
	Activities:	Inputs:		
	<ul style="list-style-type: none"> FMOH restructuring Capacity building for development assistance coordination Establishment of PPP desks at private NGOs Establish protocol for regular/scheduled consultation with key stakeholders 	<ul style="list-style-type: none"> Consultants Training of personnel Funds for: <ul style="list-style-type: none"> Operations DSA/DST Stakeholder meetings Publications 	Functioning Division for collaboration PPP desks established	<ul style="list-style-type: none"> Availability of funds Leadership in FMOH Restructuring of FMOH

8. COMMUNICATION STRATEGY FOR ADVOCACY

Logical Framework: Communication Strategy for advocacy

Performance Objectives	Narrative	Key Performance Verifiable Indicators	Data collection/strategy / report & Means of verification	Assumptions / Risks
Objective 1: Engage different levels of stakeholders in the health sector reform process				
	Facilitate partnerships, coalitions, and consensus-building on the HSR among key stakeholders at socio-political, health systems and community levels	Increase in number of meetings, interactive fora, open dialogue sessions, advocacy visits, briefing sessions, road shows held with key stakeholders	Meeting reports, News editorials, Media releases, public statements, featured articles	<ul style="list-style-type: none"> • People are willing to sit and discuss reform issues • Apathy • Political stability
	Impact/outcome: Enabling environment to facilitate HSR process	<ul style="list-style-type: none"> • Established and functional coalitions and partnerships on HSR • Enactment of National Health Act • Approved National Health Policy • Numbers of Federal and State Reform Policies in place and acted upon 	<ul style="list-style-type: none"> • National Health Act • Approved National Health Policy • Quantitative survey Reports (RMS, DHS, intervention specific surveys) • Media Analysis and reports • News analysis 	<ul style="list-style-type: none"> • People are willing to sit and discuss reform issues • Apathy • Political stability
	Output: Key stakeholders at socio-political, health systems, private sector and community levels are knowledgeable, well informed and actively involve their constituencies in the HSR process	<ul style="list-style-type: none"> • National Health Act passed • Increase in proportion of key stakeholders at socio-political, health systems and community levels who are well informed and engaging their constituencies in the HSR and the roll out process at institutional, state and LGA levels • Increase in reportage on HSR process • Increase in proportion of open discussions/dialogue, media reporting on HSR and related processes 	<ul style="list-style-type: none"> • Records of procedures of HSR Bill Debate • Meeting reports, News editorials, Media releases, public statements, NGO/CBO reports, Faith-based activity reports and releases, Communiqués • No. of radio and TV programmes • Feedback reports from groups 	<ul style="list-style-type: none"> • Political stability and commitment at all levels • Support of development partners in process • Fear of retrenchment • Apathy to government policy and reforms • Endemic corruption
Objective 2: Mobilize communities and individuals to participate in the health sector reform process				

Performance Objectives	Narrative	Key Performance Verifiable Indicators	Data collection/strategy / report & Means of verification	Assumptions / Risks
	Design implement and evaluate multi- media campaign to target specific audiences at socio-political, health systems, private sector and community levels	<p>Increase number of general public with clear understanding of concept of 'Better Heath Begins with You and Me' with emphasis on the fact that reforms are only as real as personal involvement.</p> <ul style="list-style-type: none"> Adoption and degree of implementation of the % -year and 2-year POA by Federal, State, Local and Parastatals No. of radio spots produced and aired No. of TV spots produced and aired No. of print materials available and distributed No. of stakeholders that are taking positive action supportive of HSR No. of stakeholders advocating for improved health services 	<ul style="list-style-type: none"> Surveys Certificates of Broadcast Distribution list Newspaper clippings Reportorials National and State HSR Plans of Action 	<ul style="list-style-type: none"> Suspicion and mistrust Political stability Opposition to ruling party Costs of air time Improved economic status Expanding democratic space.
	Design and implement community mobilization activities	Increase in number of community leaders, organizations, and networks that clearly understand the concept of ' Better Heath Begins with You and Me ' and play a key role in mobilizing their communities for change	<ul style="list-style-type: none"> Meeting reports Community charters and declarations 	<ul style="list-style-type: none"> Suspicion and distrust Lack of funds Poor social capital issues Enhanced community capacity
	Implement interactive consumer-related activities to discuss health and development issues with providers and community leaders	<ul style="list-style-type: none"> Increase in number of communities, CBOs, networks that are openly discussing Health and development issues Degree/number of stakeholder engagement in the process 	<ul style="list-style-type: none"> Meeting reports Community charters and declarations 	<ul style="list-style-type: none"> Suspicion and distrust Lack of funds Poor social capital issues Enhanced community capacity
	Design and Implement a multi media campaign focusing on client education, awareness, rights and responsibilities	<ul style="list-style-type: none"> Increase in number of communities, community leaders, households and individuals that are aware of their roles and responsibilities in health care delivery Increase in number of community leaders, households and individuals that are demanding for better quality health care 	<ul style="list-style-type: none"> NGO/CBO reports Surveys Certificates of Broadcast Newspaper clippings Reportorials Faith-based activity reports and releases No. of radio and TV programmes Feedback reports from groups 	<ul style="list-style-type: none"> Suspicion and mistrust Political instability Opposition to ruling party Costs of air time Expanding democratic space
	Impact/outcome Broader engagement of all stakeholders across sectors and levels	<ul style="list-style-type: none"> Increased resource allocation Increase in proportion of consumer-focused responses Available and standardized protocols 	<ul style="list-style-type: none"> National, State and LGA Health Accounts Employee Health programmes Household Surveys 	<ul style="list-style-type: none"> Political instability Opposition to ruling party Distrust and Suspicion

Performance Objectives	Narrative	Key Performance Verifiable Indicators	Data collection/strategy / report & Means of verification	Assumptions / Risks
		<ul style="list-style-type: none"> on quality issues Improved provider performance Increase in proportion of community leaders, CBOs, FBOs, etc. providing input to local health priorities Increase in % of consumers that are more knowledgeable in health issues and taking action on early prevention Numbers of private sector health providers involved in HSR process 	<ul style="list-style-type: none"> Meeting reports Community charters and declarations 	<ul style="list-style-type: none"> Poor social capital issues
	<p>Outputs Key stakeholders and consumers at all levels are taking supportive actions to show that they clearly understand the 'Better Health Begins with You and Me' campaign</p>	<ul style="list-style-type: none"> Increase in proportion of health facilities offering client-centred services Increase in proportion of Health providers with improved job performance 	<ul style="list-style-type: none"> Facility survey reports Household survey reports 	<ul style="list-style-type: none"> Suspicion and mistrust Political instability Opposition to ruling party
Objective 3: Capacity Building				
	Build capacities of health care providers in interpersonal communication skills and client-focused approaches	<ul style="list-style-type: none"> Proportion of health care providers who begin to understand their rights and responsibilities client and are responding in a client friendly manner Proportion of health care providers who are using client-focused approaches, have materials for clients and participate actively in client education 	<ul style="list-style-type: none"> Performance improvement reports Health facility surveys Demographic and Health Surveys 	<ul style="list-style-type: none"> Suspicion and distrust Political instability Lack of funds
	Build Capacity of media executives and journalists to support the HSR process	Proportion of journalists trained and no. of media houses and journals promoting consumer rights and awareness	<ul style="list-style-type: none"> Training reports Newspaper clippings Reportorials Press releases No. of radio and TV programmes Feedback reports from media and professional groups 	<ul style="list-style-type: none"> Suspicion and distrust Political instability Lack of funds
	Impact/Outcome	<ul style="list-style-type: none"> Healthy and productive workforce that would increase productivity and enhance public image and profit Rights of clients are protected 	<ul style="list-style-type: none"> Newspaper clippings Reportorials Press releases, No. of radio and TV programmes Feedback reports from satisfied communities and individuals 	<ul style="list-style-type: none"> Suspicion and distrust Political instability Lack of funds
Objective 4: Reflect quick wins of the HSR process to all stakeholders				

Performance Objectives	Narrative	Key Performance Verifiable Indicators	Data collection/strategy / report & Means of verification	Assumptions / Risks
	Multi-media campaign targets all levels highlighting quick wins of the HSR process	<ul style="list-style-type: none"> Increased Multi-sectoral support for sustainable health 	<ul style="list-style-type: none"> Reports Surveys Newspaper clippings Spotlight radio/TV programs 	<ul style="list-style-type: none"> Deep mistrust and suspicion Political instability Lack of funds
	Socio-political level	<ul style="list-style-type: none"> Increase in % resource allocation to health National, State and Local Government allocation and expenditure of appropriate resources in timely fashion 	<ul style="list-style-type: none"> Legislative reports Newspaper clippings Reportorials Press releases National, State and LGA Allocations 	<ul style="list-style-type: none"> Deep mistrust and suspicion Political instability Lack of funds
	Health System Level	<ul style="list-style-type: none"> Quality service becomes the norm Increased proportion of health care service delivery sites offering affordable and accessible services 	<ul style="list-style-type: none"> Facility surveys Consumer reports Newspaper clippings Reportorials 	<ul style="list-style-type: none"> Deep mistrust and suspicion Political instability Lack of funds
	Private Sector	<ul style="list-style-type: none"> Increase in number of public/private partnerships for accessible and affordable health services 	<ul style="list-style-type: none"> Surveys Newspaper clippings Reportorials Press releases 	<ul style="list-style-type: none"> Apathy Suspicion
	Communities and Individuals	<ul style="list-style-type: none"> Increase in proportion of community members providing inputs to local health priorities % increase in communities engaged in local health system change 	<ul style="list-style-type: none"> Household surveys Consumer reports Newspaper clippings Reportorials, Fora reports 	<ul style="list-style-type: none"> Apathy Deep mistrust and suspicion Political instability Lack of funds
	Impact/ Outcome	<ul style="list-style-type: none"> Increase in health allocations 	<ul style="list-style-type: none"> National, State and LGA Health Accounts 	<ul style="list-style-type: none"> Apathy Deep mistrust and suspicion Political instability Lack of funds

9. MONITORING AND EVALUATION

Logical Framework: Monitoring and Evaluating HSR

Performance Objectives:	Narrative	Key Performance Verifiable Indicators:	Data Collection Strategy / Report & Means of Verification	Assumptions / Risks
To effectively establish a health data system to support the measurement of the performance and progress of the national health system and reforms	Generating the evidence and information base for periodic assessments of the performance of the health system and decision-making at all levels	Availability of data systems to measure progress and performance of HSR	<ul style="list-style-type: none"> ▪ HSP Assessment Report ▪ M&E Reports 	<ul style="list-style-type: none"> ▪ Revision and strengthening the NHMIS and other health data systems ▪ A shared framework for HSR M&E ▪ Funding M&E for HSR
Intervention Projects Objectives:				
To identify and strengthen health data systems, the NHMIS and capacity building to undertake HSR M&E	Generating the evidence and information base for the HSR	Availability of data systems to measure progress and performance of HSR	<ul style="list-style-type: none"> ▪ HSP Assessment Report ▪ M&E Reports 	<ul style="list-style-type: none"> ▪ Revision and strengthening the NHMIS and other health data systems ▪ A shared framework for HSR M&E ▪ Funding M&E for HSR
	Impact:/Outcome:			
	<ul style="list-style-type: none"> ▪ Improved evidence base and information permitting the assessment of the HSR 	Availability of evidence for HSR	<ul style="list-style-type: none"> ▪ HSP Assessment Report ▪ M&E Reports 	<ul style="list-style-type: none"> ▪ Revision and strengthening the NHMIS and other health data systems ▪ A shared framework for HSR M&E ▪ Funding M&E for HSR
	Outputs			
	<ul style="list-style-type: none"> ▪ Data collection system available to generate information for M&E 	Availability of evidence for HSR	<ul style="list-style-type: none"> ▪ HSP Assessment Report ▪ M&E Reports 	Availability of resources for M&E
	Activities:			
	<ul style="list-style-type: none"> ▪ Reform and strengthen the NHMIS and other data systems ▪ Revise and strengthen the routine health information system ▪ Develop protocol for HSR M&E ▪ Undertake a joint-HSPA with key stakeholders ▪ Build capacity for data analysis within the FMOH ▪ Establish and strengthen a national health data processing centre within FMOH ▪ Build capacity for ICTs within the FMOH, including an E-Learning Centre 	<ul style="list-style-type: none"> ▪ Funds for all the activities identified 	<ul style="list-style-type: none"> ▪ Functioning NHMIS ▪ Functioning national health data centre in FMOH ▪ Staff with capacity for health data analysis 	<ul style="list-style-type: none"> ▪ Availability of resource requirements ▪ Willingness of stakeholders to respond positively

III. THE PLAN OF ACTION

1. IMPROVING THE STEWARDSHIP ROLE OF GOVERNMENT (FEDERAL MINISTRY OF HEALTH)

Plan of Action: Improving the Stewardship Role of Government

Activities	Inputs	Outputs	Time-Frame	M&E Indicators	Responsibility	Est. Budget (Nm)	Source of Funds
Review, Update, Harmonize National Health Policies: <ul style="list-style-type: none"> ▪ Committee to review NHP ▪ Stakeholder Consultation ▪ NCH approval ▪ FEC approval ▪ Seminal dissemination and orientation 	<ul style="list-style-type: none"> ▪ Consultants/resource persons ▪ Funds for: <ul style="list-style-type: none"> ▪ Meetings ▪ Logistic/Secretariat support ▪ Fees/honoraria ▪ DSA/DTA ▪ Publications 	<ul style="list-style-type: none"> ▪ Preparation of new National Health Policy 	June-Aug. 2004	<ul style="list-style-type: none"> ▪ Committee Report ▪ NCH Resolution ▪ FEC Approval ▪ Seminal dissemination of report 	FMOH SMOH Partners	40	FMOH Partners
Enact a National Health Act <ul style="list-style-type: none"> ▪ Committee to draft a National Health Bill ▪ Stakeholder Consultation ▪ NCH approval ▪ FEC approval ▪ NASS Bill ▪ Seminal dissemination and orientation 	<ul style="list-style-type: none"> ▪ Consultants/resource persons ▪ Funds for: <ul style="list-style-type: none"> ▪ Meetings ▪ Logistic/Secretariat support ▪ Fees/honoraria ▪ DSA/DTA ▪ Publications 	<ul style="list-style-type: none"> ▪ Development of a draft National Health Bill 	June – Aug. 2004	<ul style="list-style-type: none"> ▪ Availability of Committee Report ▪ NCH Resolution ▪ FEC Approval ▪ Availability of Health Act 	FMOH NCH FMJ NASS FEC	100	FMOH Partners
Deploy ICTs in the public health sector <ul style="list-style-type: none"> ▪ Preparation of ICTs Project work-program ▪ Approval of ICTs work-program by FMOH ▪ Computerization/ 	<ul style="list-style-type: none"> ▪ Constitute FMOH-ICTs Work plan Committee ▪ Funding support for work of the ICTs Work plan Committee ▪ Funds to implement FMOH- 	<ul style="list-style-type: none"> ▪ Development and implementation of ICTs work plan 	June 2004 – Dec 2005	<ul style="list-style-type: none"> ▪ Availability of ICTs project document ▪ FMOH approval of ICTs work plan ▪ Degree of implementation of ICTs project work-plan. 	FMOH NITDA	160	FMOH W/Bank: HSDP

Activities	Inputs	Outputs	Time-Frame	M&E Indicators	Responsibility	Est. Budget (#m)	Source of Funds
networking functions/processes of FMOH <ul style="list-style-type: none"> ▪ Installation of Intra-net/Internet facilities, including linkages access for SMOHs and FHIs ▪ Establish and maintain interactive FMOH Web-site ▪ Establish FMOH e-Learning centre 	ICTs work plan						
Preparation of health sector MTEF (NEEDS; SEEDS; LEEDS): <ul style="list-style-type: none"> ▪ Est. C'mte on HSR programme ▪ Preparation of 5-Year Strategic Plan & 2-Year Rolling Plans ▪ Preparation of health-SEEDS ▪ Preparation of health-LEEDS ▪ Consolidation of Federal/State/LGA health plans ▪ Health systems assessment/M&E ▪ Joint-Annual Review Meeting 	<ul style="list-style-type: none"> ▪ C'mte and working groups inauguration with TORs ▪ State SEEDS/LEEDS C'mtee inaugurated ▪ Funds to support processes ▪ Human Resource capacity building for HSPA 	<ul style="list-style-type: none"> ▪ Development and adoption of health component of NEEDS, SEEDS, and LEEDS 	June 2004 – June 2005	<ul style="list-style-type: none"> ▪ Availability of health-NEEDS/SEEDS/LEEDS Documents ▪ HSPA report ▪ M&E reports 	FMOH NPC SMOH LGA Partners	150	FMOH SMOH W/Bank: HSDP Partners
Total Budget Est.						₦450 Million	

2. STRENGTHENING THE NATIONAL HEALTH SYSTEM AND ITS MANAGEMENT

Plan of Action: Strengthening the National Health System And Its Management

S/No	Activities	Inputs	Outputs	Time-Frame	M&E Indicators	Responsibility	Est. Budget (Nm)	Source of Funds
A	<p><u>Revise national health structures and institutions within the context of redefined functions, roles and responsibilities</u></p> <ul style="list-style-type: none"> • Develop TORs • Set up Review Committee • Committee meetings • Submission of reports • Approval of recommendations by TMC and FEC • Dissemination of approved report and orientation • Implementation of Recommendations. 	<p>Consultants/resource persons</p> <p>Funds for:</p> <ul style="list-style-type: none"> ▪ Meetings ▪ Logistic/Secretariat support ▪ Fees/honoraria ▪ DSA/DTA ▪ Publications 	<p>Report on the redefined functions, roles and responsibilities of national health structures and responsibilities</p>	<p>June 2004 – Dec 2005</p>	<p>Non-duplication of health institutions' functions, roles and responsibilities</p>	<p>FMOH</p>	<p>30</p>	<p>FMOH Partners</p>
B	<p><u>Establish a National Hospitals Agency to enhance coordination in terms of establishment matters, policies, standards and performance regulation</u></p> <ul style="list-style-type: none"> ▪ Preparation of FEC Memo ▪ Meetings ▪ Approval of FEC memo ▪ Take-off of Agency ▪ Training 	<p>Meetings</p> <p>Funds</p>	<p>National Hospital Agency</p>	<p>July 2004 to June 2005</p>	<p>Improved efficiency in hospitals' management</p>	<p>FMOH</p>	<p>1,000</p>	<p>FMOH Partners</p>

S/No	Activities	Inputs	Outputs	Time-Frame	M&E Indicators	Responsibility	Est. Budget (Nm)	Source of Funds
C	<p><u>Develop ways and means to make tertiary health institutions more effective and efficient</u></p> <ul style="list-style-type: none"> Set up committee Meetings Stakeholder consultations Committee Report & Recommendations TMC & FEC Approvals Stakeholders' orientation on approved recommendations and implementation steps Study-Tour/Change Agents for FHIs Implementation of recommendations PPP capacity building 	<p>(i) The establishment of committees</p> <ul style="list-style-type: none"> Consultants/resource persons Funds for: <ul style="list-style-type: none"> Meetings Logistics and Secretariat support Fees/ honoraria DSA/ DTA Publications <p>(ii) Refurbishing of Teaching Hospitals and standardization of their equipment</p> <p>(iii) Rehabilitation of FMCs and other THIs</p>	Improved patient satisfaction	June – Dec 2004	Service utilization rate	FMOH	15 10,000 8,000	FMOH Partners
D	<p><u>Establish National Blood Transfusion Service</u></p> <ul style="list-style-type: none"> Setting up of committee on National Blood Transfusion programme Approval of report of committee Setting up of blood transfusion facilities at national, zonal, and military levels / implementation 	<p>Consultancy and Funds for logistics</p> <p>Human resources, material resources, blood transfusion vehicles, etc</p>	<p>Report</p> <p>Functioning blood transfusion services</p>	<p>June-Dec. 2004</p> <p>June 2005 – June2007</p>	<p>Report</p> <p>Functioning fixed and mobile blood transfusion facilities</p>	FMOH FMOH	5 3,000	Fed. Budget Fed. Budget, Development partners and the Armed Forces

S/No	Activities	Inputs	Outputs	Time-Frame	M&E Indicators	Responsibility	Est. Budget (Nm)	Source of Funds
E.	<p>Revitalization of PHC System</p> <ul style="list-style-type: none"> • Set up Committee on PHC Blueprint • Undertake stakeholder consultations on PHC system reform • TMC/FEC Approval of recommendations • Implementation of recommendations + recommendations on FMOH/parastatals structural reforms • Resource mobilization for PHC implementation • Coordinated Assistance to States/LGAs on: <ul style="list-style-type: none"> - PHC health workers/community training - M&E progress of performance of PHC services - Donors/FGN resource mobilization/grant programme for PHC development including Health fund; NHMIS; etc. ▪ Construction and equipping of additional 474 model PHC at local government level 							
	Sub-Total						10,000 32,050	

3. REDUCTION OF THE DISEASE BURDEN

Plan of Action: Reduction of the Disease Burden

Intervention Objectives	Activities	Inputs	Outputs	Time-Frame	M&E Indicators	Responsibility	Est. Budget (Nm)	Source of Funds
To revitalize the PHC system to deliver basic minimum health package	<ul style="list-style-type: none"> ▪ Inventory needs assessment for PHC health facilities • Provide Grant-leveraged refurbishment/construction & equipping PHC facilities • Provide grant-leveraged refurbishment of selected schools of health technologies for PHC human resource development ▪ Implement P-P arrangement for supply of drugs and medical consumables (Pilot scheme in 6 states) ▪ Strengthen routine immunization system to increase coverage 	<ul style="list-style-type: none"> ▪ Consultants and other personnel ▪ Funding ▪ Equipment ▪ Drugs and medical supplies ▪ MIS forms ▪ Training materials ▪ Service ▪ Management protocols 	<ul style="list-style-type: none"> ▪ Increased accessibility and utilization of health services 	2005-2007	<ul style="list-style-type: none"> ▪ Increased proportion of population living within 5km of PHC facilities ▪ Increased utilization rate of PHC facilities ▪ Increased proportion of immunization rate among infants & under-5 children 	FMOH NPI NPHCDA SMOH LGA	20,000	FMOH SMOH LGA Partners
To improve the accessibility, quality and utilization of essential obstetric care (EOC) services	<ul style="list-style-type: none"> ▪ Assess maternal mortality reduction efforts to identify best practices that could be up-scaled ▪ Identify and designate EOC facilities, with input from community stakeholders ▪ Establish an enhanced and effective system of 2-way referrals between facilities ▪ Equip facilities with relevant equipment ▪ Provide drugs and other relevant medical supplies on a continuous and sustainable basis ▪ Train relevant health professionals in life saving skills ▪ Train, employ and deploy new skilled attendants to service delivery facilities ▪ Conduct behaviour change communication activities 	<ul style="list-style-type: none"> ▪ Fund ▪ Human resources ▪ Equipment, Drugs and medical supplies ▪ Training materials ▪ Service protocols ▪ BCC and advocacy materials ▪ Monitoring instruments 	<ul style="list-style-type: none"> ▪ Increased utilisation of modern health facilities and health professionals for pregnancy, childbirth, post-natal services and related RH services 	2005 - 2007	<ul style="list-style-type: none"> ▪ Proportion of pregnant women attended to by skilled attendants at delivery ▪ Number of basic and comprehensive essential obstetric care (EOC) facilities available per 500,000 population, and their geographical spread 	FMOH NPHCDA SMOH LGAs Communities & Households	770	FMOH SMOH LGAs Partners

Intervention Objectives	Activities	Inputs	Outputs	Time-Frame	M&E Indicators	Responsibility	Est. Budget (Nm)	Source of Funds
	<ul style="list-style-type: none"> ▪ Define relevant standards and protocols, including definition and costing of minimum RH package as part of a basic PHC package ▪ Monitor compliance of facilities and practitioners with defined standards ▪ Advocacy activities targeting policy makers and community leaders for improvement in maternal health services and status of women ▪ Community mobilisation for maternal mortality reduction activities 							
To establish effective health sector response to HIV/AIDS, and appropriate control measures for malaria, TB and other major communicable diseases	<ul style="list-style-type: none"> ▪ Assess the frequency and impact of health problem, health-seeking behaviour, and health professionals' practices ▪ Recruit and train health care providers as necessary ▪ Provide drugs and other medical supplies ▪ Institute client-friendly policies in health facilities, including payment mechanisms ▪ Educate the population on prevention and treatment of health problems ▪ P-P partnership to produce ARV Drugs locally ▪ Scale up implementation of ARV Treatment Initiative and other strategies for HIV/AIDS centre ▪ Expand DOTS implementation ▪ Scale up the implementation of strategies for implementation of other diseases 	<ul style="list-style-type: none"> ▪ Human resources (Consultants, health professionals, survey personnel, etc) ▪ Material resources (drugs, medical supplies etc) ▪ Management protocols and service guidelines ▪ Training materials ▪ MIS forms and other health management instruments ▪ Financial resources 	<ul style="list-style-type: none"> ▪ Reduce the frequency of disease through effective prevention strategies ▪ Improved health outcome through effective management of health problems 	2004-2007	<ul style="list-style-type: none"> ▪ % of children 12-23 months fully immunized ▪ % of children under 5 sleeping under ITN ▪ % of population adopting HIV/AIDS prevention strategies, including abstinence and safe sex practices ▪ % of people with TB on DOTS 	FMOH SMOH LGA NACA	18,000	FMOH SMOH LGA NACA Partners

Intervention Objectives	Activities	Inputs	Outputs	Time-Frame	M&E Indicators	Responsibility	Est. Budget (Nm)	Source of Funds
Promotion of healthy life styles through reduction of risk factors	<ul style="list-style-type: none"> ▪ Public education on health-promoting behaviour ▪ Provision of services to decrease practice of health-risk behaviour ▪ Establish regulations/enact legislation to encourage healthy life behaviour 	<ul style="list-style-type: none"> ▪ Human resources (health educators, counselors, media professionals etc) ▪ Behaviour change communication materials 	<ul style="list-style-type: none"> ▪ Increase in proportion of population with healthy lifestyles ▪ Decrease in the proportion of population with health-risky lifestyles 	2004-2007	<ul style="list-style-type: none"> ▪ Proportion of the population involved in regular exercise ▪ % Of the population adopting healthy diet lifestyle ▪ Proportion of the population that are smokers ▪ Proportion of population aware of healthy lifestyles ▪ Proportion of population aware of, that practise safe waste disposal ▪ Proportion of the population engaged in driving who are knowledgeable about the safety provisions of the highway code 	FMOH SMOH LGAs Partners	3,000	FMOH SMIH LGAs Partners
Sub-Total							41,770	

4. IMPROVING AVAILABILITY OF HEALTH RESOURCES & THEIR MANAGEMENT

Plan of Action: Improving Availability of Health Resources and their Management

Activities	Input	Output	Time-frame	M & E Indicators	Responsibility	Est. budget (Nm)	Source of Funds
<p><u>Develop Health Care Financing Strategy and Plan</u></p> <ul style="list-style-type: none"> ▪ Capacity building for construction of National Health Accounts ▪ Introduction of Special Legislation on Health/Taxes/Funds to finance public health programmes and Guaranteed Minimum PHC services ▪ Development and implementation of payment schemes and arrangements that promote incentives to improve health services delivery ▪ Build managerial capacity to implement NHMIS at all levels and implement a re-designed NHMIS ▪ Implement "HLF" strategies for increased budgetary allocation/donor resource mobilization for the health sector 	<ul style="list-style-type: none"> ▪ Consultants ▪ Funds ▪ Training ▪ Co census meetings ▪ Commencement fund for NHMIS 	<ul style="list-style-type: none"> ▪ Improved Financial Resource Allocation ▪ NHMIS ▪ Primary Health Care Fund 	2004-2007	<ul style="list-style-type: none"> • Functionality of NHMIS • NHIC, NHIF, PHIF • Formal Sector Scheme • Community Health Schemes • Vulnerable group programmes • Re-insurance • SIN taxes 	<ul style="list-style-type: none"> ▪ FGN, FMOH, International Agencies, NHMIS, HMOs ▪ Private Sector ▪ Communities 	30,000 (including check-off contributions for NHMIS)	National Budget, Check-off from Contributions

Activities	Input	Output	Time-frame	M & E Indicators	Responsibility	Est. budget (\$m)	Source of Funds
<p><u>To develop a national strategy for health human resources</u></p> <ul style="list-style-type: none"> ▪ TOR ▪ Human resource needs assessment ▪ Development of Health Human Resource Policy ▪ Implement appropriate management structure for human resources in health (HRH) ▪ Institutionalise mechanism for continuous managerial and professional training and development 	<ul style="list-style-type: none"> ▪ Human resources (Consultants, others) ▪ Funds ▪ Publications ▪ Reports 	Motivated Health Personnel	June 2004 – Dec 2006	Retention of Health Workers	<ul style="list-style-type: none"> ▪ FMOH, DFID Development partners, Int. agencies 	500	International Agencies and National Budget

Activities	Input	Output	Time-frame	M & E Indicators	Responsibility	Est. budget (#m)	Source of Funds
<u>To develop a maintenance system for physical assets</u> <ul style="list-style-type: none"> ▪ Audit and classification of assets ▪ Stakeholder meetings ▪ Standardization of equipment ▪ Establish a system for coordinated procurement of equipment/physical assets and related supplies ▪ Regulation on appropriate technologies ▪ Training of maintenance staff ▪ Out-sourcing of services and maintenance 	<ul style="list-style-type: none"> ▪ Consultants ▪ Funds for meetings ▪ Resource Personnel ▪ Fees ▪ Funds for training 	Functional Health Facilities	June 2004 – Dec 2005	Maintenance System & Service Contracts for Physical Assets in Health Institutions	FMOH	500	<ul style="list-style-type: none"> ▪ Health Budgets ▪ Contracts
Sub-Total						31,000	

5. IMPROVING ACCESS TO QUALITY HEALTH SERVICES

Plan of Action: Improving Access to Quality Health Services

Activities	Inputs	Outputs	Time Frame	M&E Indicators	Responsibility	Estimated Budget (Nm)	Sources of funds
<p>Establishment of a system for quality assurance/certificate of needs and standards</p> <ul style="list-style-type: none"> • National health act to contain provision for certificates of need and standards • Establishment of NHSA, SHMB to issue certificates of need and standards • Agencies to publish guidelines on certificates of need and standards • Stakeholders education on certificates of need and standards • Agencies implement the issuance of certificates of need and standards 	<ul style="list-style-type: none"> • Committee on National Health Bill • Funds to set up office, recruit staff and put necessary machinery in place • Funds to Agencies (NHSA, NHMB) • Funds to Agencies • Funds: FMOH, State Ministries of Health 	<ul style="list-style-type: none"> • National Health Act passed • NHSA • SHMB • SPHCMB • Guidelines Published • Providers and consumers awareness on certificates of need and standards • Facilities comply with certificates of need and standards 	<p>July – Dec 2004 Jan – Dec. 2005 June 2005 June– Dec 2005 Jun-Dec 2005</p>	<ul style="list-style-type: none"> ▪ Passed National Health Act Contains Provision for certificates of need and Standards ▪ Guidelines available ▪ Survey of providers/consumers awareness ▪ Survey of facilities ▪ Survey of PHC facilities/equipment 	<p>FMOH, NASS FMOH SMOH NHSA SHMB SPHCMB NHSA SHMB SPHCMB NHSA SHMB SPHCMB</p>	<p>10 75 100 200 250</p>	<p>HSDP II HSDP II State Budget State Budget State Budget</p>
<p>Boosting Local Production of Essential Drugs through import prohibition and reduction of tariffs on pharm. raw materials</p>							
<p>(i) Publish Prohibition List of Essential Drugs and other incentives to manufacturers (ii) Re-equip & reposition Pharm. Mfg. Lab for ARV production (iii) Facilitate access to soft loans through BOI for local pharm. manufacturers</p>	<p>FMOH liaising with FMF</p> <p>Funds, FMHousing</p> <p>Funds</p>	<p>Prohibition List and Incentives published</p> <p>Production Lab. Refurbished and re-equipped, ARVs produced</p> <p>Increased production of essential drugs, including ARVs</p>	<p>July –Dec 2004</p> <p>July 2004 – Dec. 2005</p> <p>July 2004 – Dec. 2005</p>	<ul style="list-style-type: none"> ▪ Published circulars ▪ No. of equipment provided, qty of ARVs produced ▪ Amount of funds accessed, Qty of drugs produced 	<p>FMOH, FMF</p> <p>FMOH, FMHousing</p> <p>FMOH, PIGMAN, BOI</p>	<p>500</p> <p>2,000</p>	<p>FG</p> <p>BOI</p>
<p>Revamping Drug Research &</p>							

Activities	Inputs	Outputs	Time Frame	M&E Indicators	Responsibility	Estimated Budget (Nm)	Sources of funds
Development to support local pharmaceutical industry							
(i) Allocate 2% surcharge on drug imports to fund NIPRD's research activities	Funds	Increased tempo of R & D activities	July 2004 – Dec. 2007	<ul style="list-style-type: none"> Amount of funds realized from Surcharge, No. of research products 	FMOH, FMF, NIPRD, CBN	2,000	Import Surcharge
(ii) Complete and equip NIPRD's abandoned 5-storey laboratory complex	Funds, equipment	Increased tempo of R & D activities	July 2004- Dec. 2005	<ul style="list-style-type: none"> Amount of funds provided, research products 	FMOH, FMF, NIPRD, Dev. Partners	750	FG, Dev. Partners
(iii) Woo investors thro incentives to engage in production of excipients (starch, cellulose)	Incentives (i.e. pioneer status- tax relief for 5yrs)	Pharm. excipients available for local industry	Aug. 2004-Dec. 2007	<ul style="list-style-type: none"> No. of establishments producing excipients, No. and qty of pharm. raw materials produced 	FMOH, Private investors		BOI, Private Investors
Revamping Drug Research & Development to support local pharmaceutical industry							
(iv) Collaborate with UNDP to establish pilot plant for manufacture of active raw materials from intermediates	Funds	Plants established, Active raw materials produced	Aug. 2004- Dec. 2006	No. of plants established, Qty of raw materials produced	FMOF, NIPRD, UNDP	\$20 million	UNDP, FG(Counterpart)
(v) Advocate commercial Production of cassava and maize for starch production, lemon grass and eucalyptus and ginger for essential oils	Funds for consultative meetings	Increased production of identified crops	Aug. 2004- Dec. 2007	Acreage of crops cultivated, Qty of starch & essential oils produced	FMOH, FMAgric, Farmers	Agro-project facilities available to farmers at low interests	Nigerian Agric. & Coop & Rural Dev. Bank
Adopting strategies for the conservation and sustainable use of Nigeria's medicinal flora, especially endangered species							
Establish an Inter-Ministerial Committee/Task Force to promote							

Activities	Inputs	Outputs	Time Frame	M&E Indicators	Responsibility	Estimated Budget (Nm)	Sources of funds
conservation activities as follows: (i) Identification, verification and compilation of medicinal plants used in Nigeria (especially for malaria & HIV management) (ii) Inventories of medicinal plants used both in herbal medicine and the codified traditional system of medicine	Funds	Data on medicinal plants for special diseases	July 2004 – June 2005	Published reports	Inter-Ministerial Committee/Task Force	3	FG
	Funds	Data available	Ditto	Published reports	Ditto		
Adopting strategies for the conservation and sustainable use of Nigeria's medicinal flora especially endangered species							
(iii) Identification of threatened species and develop POA for protection and conservation (including listing on National CITES Legislation, the Endangered Species Act) (iv) Strengthen existing facilities/promote establishment of specific National Botanical Gardens & Medicinal Plant Gene Banks	Funds	Plan of action available	July 2004 – June 2005	Published reports	Inter-Ministerial Committee/Task Force	3	
	Funds	Increased production of medicinal plants	July 2004 – Dec. 2006	Acreage of medicinal plants cultivated	Task Force, Interested Investors	150 (6 botanical gardens at 25 million)	FG, OPS, Dev. Partners
Ensure effective regulation of herbal medicines through the following activities							
(i) Develop and circulate Guidelines (ii) Educate stakeholders on Guidelines (iii) Implement Guidelines	Funds	Guidelines produced	June-Dec 2004	No. of copies of Guidelines printed & circulated	FMOH, NAFDAC, other stakeholders	50	FG, Dev. Partners
	Funds	Stakeholders informed	Jan-March 2005	No. of meetings held, No. of stakeholders educated & complying with Guidelines	NAFDAC	2	FG (regular budget)
(iv) Establish a Pharmacognosy Laboratory	Funds and facilities	Compliance with Guidelines,	June-Dec 2005		NAFDAC	5	FG, Dev.

Activities	Inputs	Outputs	Time Frame	M&E Indicators	Responsibility	Estimated Budget (Nm)	Sources of funds
	Funds and facilities	Products listed/registered Well equipped Laboratory	June 2004- Dec. 2005	No. of herbal medicinal products listed/registered Laboratory functioning (no. of herbal products assessed)	NAFDAC	50	Partners FG, Dev Partners
<p>Adopting strategies for the conservation and sustainable use of Nigeria's medicinal flora especially endangered species</p> <p>Developing a National Herbal Pharmacopoeia through (i) Hosting of Meetings of Expert Committee on Pharmacopoeia Dev (ii) Documentation & verification field activities in Research Institutions (Institutes & Universities) (iii) Printing & circulation of Pharmacopoeia</p>	Funds Funds Funds	Pharmacopoeia Developed	July – Nov 2004 July – Dec 2004 Jan-Feb 2005	No. of meetings held No. of medicinal plants documented and validated No. of copies printed and circulated	Expert Committee Expert Committee Expert Committee	5 3 10	FG, Dev Partners FG, Dev Partners FG, Dev Partners
Strengthening the legislative framework as well as the enforcement capacities of regulatory agencies							

Activities	Inputs	Outputs	Time Frame	M&E Indicators	Responsibility	Estimated Budget (Nm)	Sources of funds
Activities (i) Review Pharmacy & Drug Laws involving relevant stakeholders (PCN, PSN, NAFDAC, FMOH, FMJ, Nat. Assembly) (ii) Establish and equip new laboratories and upgrade existing ones (iii) Undertake regular staff training (PCN, NAFDAC) to enhance performance	Funds	Revised laws enacted by NASS	July 2004 – June 2005	Copies of revised laws produced and circulated	FMOH, FMJ, NAFDAC, PCN, PSN, NASS	10	FG, Dev. Partners
	Funds	Well equipped laboratories	Aug. 2004 - June 2006	No. of laboratories established and equipped	FMOH/NAFDAC	500	FG, OPS, Development Partners
	Funds	Enhanced staff expertise and skills	July 2004 – Dec. 2007 (annual)	No. of staff trained, % increase in outputs (measured by No of inspections, lab. Results etc.	NAFDAC, PCN	150	FG, Partners
<u>Strengthening the legislative framework as well as the enforcement capacities of regulatory agencies:-</u>							
(iv) Establish baseline data on extent of fake drugs in circulation (v) NAFDAC & PCN intensify inspection at ports, manufacturing, distribution and retail establishments (vi) Institutionalize regular consultative meetings among the agencies (NAFDAC, NDLEA, SON, Customs & Immigration Services) as well as Joint patrols undertaken @ ports & border posts (vii) Intensify Consumer awareness programme	Funds	Report on level of fake drugs	July 2004 – June 2005	Copies of Report produced & circulated	NAFDAC	80	FG, OPS, Partners
	Funds	Increased tempo of enforcement	July 2004 – Dec. 2007	Low level of fake/ adulterated drugs	NAFDAC	25	FG, OPS, Partners
	Funds	Increased surveillance activities Low level of fake/ substandard regulated products	July 2004 – Dec. 2007 (quarterly)	Increased cooperation among regulatory agencies Increased in arrests of smugglers and low level of substandard products	NAFDAC, PCN, NDLEA, Customs Services	5	FG (regular budget)
	Funds	More enlightened consumers	July 2004 – Dec 2007	% Increase in	NAFDAC,	50	FG, Partners

Activities	Inputs	Outputs	Time Frame	M&E Indicators	Responsibility	Estimated Budget (Nm)	Sources of funds
				voluntary reporting of product violations	Consumers		
(viii) Develop a National Pharmacopoeia for Orthodox Medicines through: (a) Hosting of Meetings of Expert Committee on Pharmacopoeia Dev (b) Validation of test methods in accredited laboratories (c) Collation and compilation of validated monographs (d) Printing & circulation of Pharmacopoeia	Funds	Meetings held	July 2004 – July 2005	No. of meetings held	Expert Committee	5	FG, Partners
	Funds	Monographs accepted	Ditto	No. of monographs accepted	Expert Committee	10	
	Funds	Compiled monographs	Ditto	Total no. of monographs	Expert Committee	0.5	
	Funds	National Pharmacopoeia developed	March –June 2005	No. of copies printed and distributed	Expert Committee	20	
Strengthening the legislative framework as well as the enforcement capacities of regulatory agencies							
(ix) Establishment of a National Pharmaco-vigilance Centre through:- (i) Establishment of Committee & development of guidelines for running the Centre (ii) Establishment of Centre after Minister's Approval (iii) Hold Consultative Meetings with relevant stakeholders (iv) Establishment of Adverse Drug Reaction Review Committee	Funds	Guidelines adopted	May-Sept. 2004	<ul style="list-style-type: none"> ▪ Guidelines available ▪ Equipped Centre available ▪ No. of meetings and ▪ No. of stakeholders attending ▪ No. of reports and regularity of publication 	NAFDAC	2.5	FG
	Funds	Centre Established	May – Dec 2004		FMOH, NAFDAC	15	FG, Partners
	Funds	Stakeholders educated and informed	May – Dec 2004		NAFDAC, Stakeholders	5	FG, Partners
	Funds	Adverse Drug Reaction reports	Jan – Dec 2005 and regularly thereafter		Expert Committee	20	FG, Partners
Sanitising the Drug Distribution System thro Provision of facilities to investors in drug distribution as alternative to open drug markets							
Activities (i) Undertake a study to identify unused capacity in Govt. Medical Stores across	Funds	Report of study	July – Dec 2004	Copies of report	FMOH	10	FG

Activities	Inputs	Outputs	Time Frame	M&E Indicators	Responsibility	Estimated Budget (Nm)	Sources of funds
the country (ii) Upgrade & refurbish Fed Govt. Medical Stores and allocate spaces to investors in drug distribution (iii) Encourage States to upgrade & refurbish their own facilities and lease out to investors (iv) Complete the Fed. Govt. own Premier Medical Stores in Abuja and lease excess space to investors in drug distribution	Funds	Storage facilities available	July 2004- June 2005	produced No. of warehouses refurbished & available for leasing	FMOH,	50	FG
	Funds by states	Storage facilities available	July 2004 – June 2006	No. of warehouses refurbished & available for leasing	Interested states	Variable cost	States
	Funds	Storage facilities available	July 2004 – Dec 2005	No. of warehouses refurbished & available for leasing	FG	200	FG
					No. of warehouses completed & available for leasing		
Sub-Total						7,293 plus \$20m	

6. IMPROVING CONSUMER AWARENESS AND COMMUNITY INVOLVEMENT

Plan of Action: Improving Consumer Awareness and Community Involvement

Activities	Inputs	Outputs	Time Frame	M & E Indicators	Responsibility	Estimated Budget (A/m)	Sources of Funds
Intervention Objectives							
<ul style="list-style-type: none"> • Development of strategies to increase consumers' knowledge and awareness of personal obligations to better health, their rights to quality care and information on health • Constitute Coordinating Committee (PIT) • Stakeholders identification and consultation • TOR developed • Consultants appointed • Community Health Charter draft reviewed by stakeholders • TMC approval • NCH approval • FEC approval • Dissemination and sensitization of key community groups 	<ul style="list-style-type: none"> • Funds for: • Advocacy and mobilization • Meetings • Equipment • Logistics • Secretariat support • Supplies • DSA/DTA • Fees and honoraria • Consultants fees • Communication • Media activity • Publications • Draft Community Health Charter report • Enacted Community Health Charter 	<ul style="list-style-type: none"> • Patient Charter approved • Approved Community Health Charter • Public Launch 	<ul style="list-style-type: none"> July 2004 July-August 2004 July-August 2004 August – November 2004 November 2004-February 2005 Feb-April 2005 April –August 2005 	<ul style="list-style-type: none"> • PIT functional • Stakeholders identified • Draft implementation plan outlined and developed • Consultant agreement signed • Draft Charter developed • Evidence of consultation with various strata of society and relevant interest groups • Draft Community Health Charter report • Community Health Charter submitted for final debate by the NASS • Community Health Charter launched and disseminated 	<ul style="list-style-type: none"> HMH PIT Stakeholders/ PIT PIT Stakeholders FMOH FMOH PIT Community Partners 	<ul style="list-style-type: none"> 5 1 3 8 80 50 50 	<ul style="list-style-type: none"> FMOH FMOH FMOH FMOH Development Partners Communities FMOH Development Partners FMOH Development Partners

Activities	Inputs	Outputs	Time Frame	M & E Indicators	Responsibility	Estimated Budget (Nm)	Sources of Funds
<p>Develop a strategy to enhance community participation in the provision and financing of health services</p> <ul style="list-style-type: none"> Coordination Committee (PIT) established Baseline studies Identification of key community groups and leaders Identification of collaborative partners –LGAs, NPAHDA, FMOH, NHMIS SMOH, NGOs and international agencies Targeted sensitization and advocacy and mobilization Capacity needs assessment of key groups Comprehensive communication strategy developed and implemented Capacity building interventions for targeted groups Support community groups to evolve association-based pre-payments Support community dissemination of available services 	<ul style="list-style-type: none"> Resources: human, material and funds Consultants' time Logistical support Communication Community volunteers Community philanthropic support Discussions on ideas generated from consultation processes Study instruments and tools for accessing needs Consultants Related logistics Plan of Action Consultants Tools and logistics Plan of action for capacity building Plan of Action Service package 	<ul style="list-style-type: none"> Ward and village health committees functional Identification of core issues and options for community participation and financing of health Capacity needs identified and Plan of Action to address capacity needs Communication strategy framework developed Capacity building interventions undertaken Implementation of POA Community involvement in decision making in planning and implementation of services 	<p>August 2004 October 2004- March 2005 April-June 2005 April-June 2005 July – September 2005 July – September 2005 July – September 2005 September 2005-June 2006 October 2005- October 2006 December 2005- December 2006</p>	<ul style="list-style-type: none"> PIT functional Consultants' agreement Consultant report Identified community groups consulted Identified collaborative groups consulted Consensus built around the core issues on community participation and financing. Plan of Action Communication strategy framework Performance Report Report Implementation report 	<p>FMOH PIT Stakeholders NPHCDA FMOH Consultants/PIT PIT NHMIS FMOH PIT FMOH SMOH SMOH LGAs PIT Consultant SMOH LGAs PIT FMOH SMOH LGAs Partners PIT FMOH NPCDA SMOH LGAs Partners PIT NHMIS NPCDA FMOH Partner SMOH LGAs PIT FMOH SMOH LGAs Partners</p>	<p>10 75 25 3 45 250 75 150 100 50</p>	<p>FMOH FMOH Development Partners States FMOH Development Partners States FMOH Development Partners States FMOH Development Partners States FMOH SMOH LGAs Partners FMOH FMOH SMOH LGAs Partners FMOH SMOH Partners Communities FMOH FMOH SMOH LGAs Partners FMOH SMOH LGAs Partners</p>

Activities	Inputs	Outputs	Time Frame	M & E Indicators	Responsibility	Estimated Budget (Nm)	Sources of Funds
Designing communication programmes and building capacity in basic communication skills for health care workers and community-based health providers in priority health conditions							
<ul style="list-style-type: none"> Coordinating Committee (PIT) constituted Stakeholders analysis Community needs assessment Capacity building to address areas of specific need among targeted members of the community 	<ul style="list-style-type: none"> PIT TOR Resources:- Funds, material and human resources Community suggestions External support Consultants' time Communication Logistics Communication Communication framework Capacity plan of action Communication framework 	<ul style="list-style-type: none"> PIT action plan Communities and consumers are well informed about their rights and responsibilities in health Capacity plan of action Capacity interventions Quality communication messages designed and disseminated Performance survey 	<p>June 2004 July –Augt 2004 Aug-Oct 2004 Oct-Dec 2004 Jan-June 2005 June - December 2005</p>	<ul style="list-style-type: none"> PIT functional Report Consultants agreement Report Report Performance Report Report 	<p>HMH PIT Consultants Development partners SMOH LGAs Communities Consultants/PIT FMOH SMOH LGAs Development partners Consultants/PIT FMOH SMOH LGAs Partners Consultants/PIT FMOH</p>	<p>2 18 20 60 100 40</p>	<p>FMOH Community Leaders Development partners FMOH SMOH LGAs Development Partners FMOH SMOH LGAs Partners FMOH SMOH LGAs Partners</p>

Activities	Inputs	Outputs	Time Frame	M & E Indicators	Responsibility	Estimated Budget (₦m)	Sources of Funds
<ul style="list-style-type: none"> Design and implement communication strategy relevant to the community Review of ongoing communication strategy implementation 	<ul style="list-style-type: none"> Performance report Survey report 	<ul style="list-style-type: none"> Identification of emerging issues, lessons and gaps Reprogramming 			SMOH LGAs Partners Consultants/PIT FMOH SMOH LGAs Partners		FMOH FMOH SMOH LGAs Partners FMOH FMOH SMOH LGAs Partners
Sub-Total						1,220	

7. PROMOTING EFFECTIVE PARTNERSHIPS, COLLABORATION & COORDINATION

Plan of Action: Promoting Effective Partnerships' Collaboration and Coordination

Activities	Input	Outputs	Time-Frame	M & E Indicators	Responsibility	Estimated Budget (Am)	Source of Funds
Development of an effective public-private partnership policy <ul style="list-style-type: none"> • TOR • Appointment of consultants • Conduct a PSHA • Committee to review PSHA • Stakeholder meetings • Collation of data • Policy drafting • Stakeholder review • Publication 	Consultants/Resource persons Funds for: <ul style="list-style-type: none"> • Meetings • Logistics • Fees/Honoraria • DSA/DST • Publications 	Policy to Guide Global and local partnerships/Collaboration	July 04 – Jan 05	<ul style="list-style-type: none"> • National Policy on Public/Private collaboration • Signed Documents • Intramural practice 	FGN, FMOH, Private sector	150	FGN, FMOH International Agencies Local NGOs
Promotion of Intramural practice to enhance quality of service and improve capacity <ul style="list-style-type: none"> • Establish committee to produce intramural service protocol and guidelines • TMC&FEC approval of intramural protocol • Capacity building in the implementation of protocol • Sensitization of the benefit of • Enforcement of strict Certificate of Needs and Standards for Public and Private health facilities. 	Funds/Resources for: <ul style="list-style-type: none"> - Committee work - TMC/FEC approval - Training - Draft Certificate of Needs/Structure - Sensitization - etc 	IS protocol produced Certificate of Needs/standards produced	Sept-Dec. 2004 Jan-March 2005	Availability of Intra-Mural Service protocol Availability of Certificate of Needs/Standards	FMOH Partners	25	FMOH Partners
Establishment of a forum			June - Dec 04			5	FMOH

Activities	Input	Outputs	Time-Frame	M & E Indicators	Responsibility	Estimated Budget (Nm)	Source of Funds
to enhance effective donor coordination <ul style="list-style-type: none"> • FMOH restructuring • Capacity building • Review of Existing Bilateral or Multilateral Agreements • Personnel review • Technical Training in Contract Formulation • Review of policy 	Consultants Funds for: <ul style="list-style-type: none"> • Training • Operations • DSA/DST • Stakeholders meetings • Publications • Funding for Department 	Strengthening of department for coordination of collaboration within the FMOH		Bilateral & Multilateral Agreements Regularity and records of meetings	FMOH Ministry of Finance		Private International and local NGOs
						180	

8. COMMUNICATION STRATEGY FOR ADVOCACY

Plan of Action: Communication Strategy for Advocacy

Activities	Inputs	Outputs	Time Frame	M & E Indicators	Responsibility	Est. Budget	Source of Funds
PHASE 1: ENGAGEMENT – 'GETTING ENGAGED'							
Develop draft advocacy pack consisting of background draft documents on the HSR, NHP, NHB and fact sheets on the HSR	Funds for: <ul style="list-style-type: none"> • Technical Consultants • IEC Officers, HSR BCC sub committee members • BCC and HSR background materials 	Comprehensive Advocacy kits, including fact sheets developed, printed and distributed	June –July 2004	Number of advocacy kits developed, produced and distributed	FMOH Development partners HSRC	??	FMOH Dev. Partners
Finalize and produce advocacy package	Ad. Agency Consultants Funds	Advocacy package produced and printed	June 2004	Advocacy package available			FMOH Dev. partners
SOCIO-POLITICAL LEVEL							
LEGISLATIVE HOUSES							
Conduct one-day interactive briefing sessions for members of the House of Reps and Senate Committees on Health	Funds for: <ul style="list-style-type: none"> • Technical Consultants • HSRC Chair, • Hon Minister and FMOH staff • BCC and HSR background materials 	Members of the committees on health at Rep. and Senatorial levels are knowledgeable, well informed and will actively facilitate the passing of the Draft National Health Bill into Act. Will also facilitate support for the HSR, especially in political will and fund commitment	June –July 2004	Proportion of Health committee members who are advocating for the passing of the Draft National Health Bill into act. Time-frame developed to facilitate Draft review and passage Proportion of members advocating for support for the HSR, especially in political will and fund commitment	FMOH Development partners HSRC		FMOH Dev. Partners House committees
Conduct interactive legislative briefing sessions at zonal levels	Funds for: <ul style="list-style-type: none"> • Technical Consultants • Media professionals • BCC and HSR background materials 	Members of committees on Health at Senate and Rep levels inform State and LGA level legislative houses on the National Health Bill and HSR process	July –Aug 2004	Proportion of state level members who are knowledgeable and supporting HSR implementation in their states and LGAS	FMOH Development partners HSRC Consultant		FMOH Dev. Partners House Committees

Activities	Inputs	Outputs	Time Frame	M & E Indicators	Responsibility	Est. Budget	Source of Funds
	<ul style="list-style-type: none"> • Advocacy kits • Audio-Visual Aids 						
Advocacy visits to the executives of major political parties	Funds for: <ul style="list-style-type: none"> • Technical Consultants • HMH • HSRC • Background materials • Advocacy kits 	<ul style="list-style-type: none"> • Political parties begin to show collaborative relationships among themselves • Begin to demonstrate inter/intra party collaboration in support of HSR 	July – September 2004	Number of political parties/chapters and wings at national, state and LGA levels with inter/intra party activities that support the HSR process	FMOH, Party Chairmen, HSRC,	??	FMOH Dev. Partners Secs of political parties
Write letters to all thirty six governors and Minister of FCT on the proposed reforms and discussions at the next National Council	<ul style="list-style-type: none"> • Dispatch Funds • Writing materials • Secretary 	Letters dispatched and governors informed about the HSR process	June 2004	Proportion of state governors acknowledging receipt of letter and taking further action on the HSR process	Chief Press Secretary HSRC Chair/Sec. Consultant		FMOH Dev. partners
Brief all commissioners of health on the HSR at the next National Council on Health Meeting	Briefing Package Sec. Staff	Members of the National Council of Health are knowledgeable, well informed and actively involve their constituencies in the HSR process	May – June 2004	Proportion of members of NCH who are well informed and openly discussing the HSR and the roll out process	Chief Press Secretary HSRC Chair/Sec.		FMOH Dev. partners
Organize an interactive briefing session at the next Governors Forum	Funds for: <ul style="list-style-type: none"> • Technical Consultants • HSR background materials • Advocacy kits • Audio-Visual Aids 	Governors informed, engaged and develop state roll out plans for HSR.	July 2004	Proportion of state governors who are well informed and engaged in the HSR and the roll out process at state and LGA levels	Chief Press Secretary HSRC Chair/Sec. State Commissioners of Health		FMOH HSRC Dev. partners
Conduct zonal stakeholders advocacy briefing sessions in all six zones	Funds for: <ul style="list-style-type: none"> • Technical Consultants • HSR background materials • Advocacy kits • Audio-Visual Aids 	Zonal stakeholders informed on the HSR process	June – Aug 2004	Proportion of identified zonal stakeholders who are well informed and engaging their constituencies in the HSR and the roll out process at institutional, state and LGA levels	Chief Press Secretary HSRC Chair/Sec. Consultant		FMOH Dev. partners

Activities	Inputs	Outputs	Time Frame	M & E Indicators	Responsibility	Est. Budget	Source of Funds
				Proportion of Identified stakeholders who are giving feedback through channels on the HSR and the roll out process at State and LGA levels		??	
Organize interactive briefing sessions with identified key stakeholders, including National Orientation Agency, Civil society Organizations, Nigerian Labour Congress, Media, faith-based groups and community leaders	Funds for: <ul style="list-style-type: none"> • Technical Consultants • HSR background materials • Advocacy kits • Audio-Visual Aids 	<ul style="list-style-type: none"> • External stakeholders are informed and engaged in the HSR process • Identified key stakeholders are knowledgeable, well informed and actively involve their constituencies in the HSR process 	June –Aug 2004	<ul style="list-style-type: none"> • Proportion of identified external stakeholders who are well informed and engaging their constituencies in the HSR and the roll out process at institutional, state and LGA levels • Proportion of Identified key stakeholders who are giving feedback through channels on the HSR and the roll out process at state and LGA levels 	Chief Press Secretary HSRC Chair/Sec. Consultant		FMOH Dev. partners
Health Systems Level							
Conduct one-day interactive briefing sessions for members of the Top Management Committee (TMC) and Senior Management Committee (SMC) of the FMOH	Funds for: <ul style="list-style-type: none"> • Technical Consultants • Media professionals • BCC and HSR background materials • Advocacy kits • Audio-Visual Aids 	Different cadres of staff in the Federal Ministry of Health and its parastatals in the Health Sector Reform process Staff are knowledgeable, well informed and openly discuss the HSR and the roll out process	June – July 2004	Increase in proportion of different cadres of staff in the Federal Ministry of Health and its parastatals who are knowledgeable, well informed and openly discussing the HSR and the roll out process	FMOH Development partners HSRC		FMOH Dev. partners
Establish channels for feedback from the FMOH and parastatals	Feedback officers	Feedback channels identified and functional	June 2004	Proportion of established feedback channels reporting to HSRC	FMOH HSRC/M&E sub-committee		FMOH Dev. partners
Organize Interactive fora for professional groups and associations of private and public health care providers		Professional groups/associations significantly increase in level of cooperation and support for HSR process	July – December 2004	Proportion of professional groups/associations cooperating among themselves and with various tiers of government and private sector on HSR processes	Chairpersons of professional groups, HSRC, FMOH	??	FMOH
Media							

Activities	Inputs	Outputs	Time Frame	M & E Indicators	Responsibility	Est. Budget	Source of Funds
Organize interactive briefing sessions with electronic and print media executives and members of the Guild of Editors on HSR	Funds for: <ul style="list-style-type: none"> • Technical Consultants • Media professionals • BCC and HSR background Materials • Advocacy kits • Audio-Visual Aids 	Journalists and media executives are knowledgeable and well informed on issues related to the Health Sector Reforms and its roll out process	July 2004	Proportion of journalists who are knowledgeable and are accurately reporting and promoting the National Health Bill and HSR process	<ul style="list-style-type: none"> • Chief Press Secretary • Development partners • HSRC • Consultant 		FMOH Development partners
Conduct training for health and related sectors journalists on effective HSR reporting	Funds for: <ul style="list-style-type: none"> • Technical Consultants • Media professionals • BCC and HSR background Materials • Advocacy kits • Audio-Visual Aids 	Identified journalists and media executives are trained and are accurately reporting on issues related to the health sector	June – July 2004	Proportion of media houses (electronic and print) that are actively promoting open dialogue and discussion around the National Health Bill and HSR process	<ul style="list-style-type: none"> • Chief Press Secretary • Development partners • HSRC • Consultant 		FMOH Development partners
Private Sector							
Organize interactive briefing sessions with organized private health and non-health sectors	Funds for: <ul style="list-style-type: none"> • Technical Consultants • Media professionals • BCC and HSR background Materials • Advocacy kits • Audio-Visual Aids 	Leadership of the private sector has a clear understanding of the concept of the HSR process	July-August 2004	Proportion of leaders of the private sector committed to supporting the HSR efforts through the development of implementation structures e.g. system resource allocation	<ul style="list-style-type: none"> • FMOH • HSRC • Consultant 		FMOH Development partners
PHASE 2 – CAPACITY - AND COALITION BUILDING-‘MAKING IT HAPPEN’							
Multi-media Campaign							
Design, implement, and evaluate multi-media campaign to target specific stakeholders	<ul style="list-style-type: none"> • Advocacy Agency • Consultants • Funds • Resource materials 	General public clearly understands concept of ‘Better Health Begins with You and Me’ with emphasis on the fact that reforms are only as real as personal involvement	September 2004 – December 2005	Proportion of states and LGAs with multi-media campaign broadcast	<ul style="list-style-type: none"> • FMOH • Dev. Partners • Media • Ad. agency 		FMOH Dev. partners
Design and implement community mobilization activities	Funds for: <ul style="list-style-type: none"> • HSRC chair/sec. • HSR background Materials • Advocacy kits 	Clear understanding of concept of ‘Better Health Begins with You and Me’ and playing a key role in mobilizing their	September 2004 – December 2005	Proportion of opinion leaders and influentials who are publicly speaking out in support of the process	FMOH SMOH Electronic, print and local media Community leaders	??	Communities Dev. Partners

Activities	Inputs	Outputs	Time Frame	M & E Indicators	Responsibility	Est. Budget	Source of Funds
		communities for change		Community members are	NGOS CBOS FBOS		
Communities and individuals	Funds for: <ul style="list-style-type: none"> • Technical Consultants • Media professionals • Advocacy kits • Support print materials • Mobile vans • Town criers 	Clear understanding of concept of ' Better Health Begins with You and Me ' and playing a key role in mobilizing their households and families for change	September 2004 – December 2005	Proportion of consumers who begin to understand their rights and responsibilities in the health care delivery process	FMOH, FMI, NOA,		Communities Dev. Partners
Health care providers	Funds for: <ul style="list-style-type: none"> • Technical Consultants • Trainers • HSR background Materials • Advocacy kits • Audio-Visual Aids 	Clear understanding of concept of ' Better Health Begins with You and Me ' and responding in client-friendly ways	September 2004 – December 2005	Proportion of health care providers who begin to understand the rights and responsibilities of clients and are responding in a client-friendly manner	FMOH SMOH Private providers Performance improvement teams		/FMOH Dev. Partners
Capacity Building							
Build capacities of health care providers in interpersonal communication skills and client focused approaches	Funds for: <ul style="list-style-type: none"> • Technical Consultants • Trainers • HSR background Materials • Advocacy kits • Job Aids • Support print materials for clients 	Health providers are trained and retrained in client-focused approaches	September 2004 – Dec. 2005	Proportion of health care providers who are using client-focused approaches, have materials for clients and participate actively in client education	FMOH SMOH Private providers Performance improvement teams		FMOH Dev. Partners
Phase Three – 'Seeing is Believing'							
Legislature	Funds for: <ul style="list-style-type: none"> • Technical Consultants • HSR background Materials • Support print materials 	<ul style="list-style-type: none"> • Members of legislative houses monitor national and state level improvements in health system • Openly discuss and highlight changes in 	Dec. 2005	No. of legislators and politicians openly discussing and highlighting improvements in the health system	Media Consultants Partners	??	Media House of Assemblies

Activities	Inputs	Outputs	Time Frame	M & E Indicators	Responsibility	Est. Budget	Source of Funds
		health system					
Health care system	Funds for: <ul style="list-style-type: none"> • Technical Consultants • Ad. Agency • Trainers • HSR background Materials • Advocacy kits • Job Aids • Support print materials for clients 	<ul style="list-style-type: none"> • Basic services for specific health priority issues are in place • Referral systems have been built DRFs are in place at all levels of public health facilities • Support systems for services are in place: drug availability and quality control, logistics, job aids, outreach support and client materials, etc. Health providers are trained and retrained in client-focused approaches 	Dec. 2005	<ul style="list-style-type: none"> • Quality services are in place in sampling of facilities in flagship states • Public and private sector partnerships are strong, and provide for efficient and affordable distribution of drugs • Public perceptions of public and private services are positive and demand has risen significantly. • Providers and systems management have capacity to respond in client-friendly way. 	FMOH SMOH Private providers Performance improvement teams		FMOH Dev. Partners
Mass media campaign focusing on client education on awareness, rights and responsibilities	Funds for: <ul style="list-style-type: none"> • Technical Consultants • Ad. agency • Multi-media campaign • Support print materials for clients 	Communities and Individuals are aware of personal obligation to better health; and begin to demand for their rights to quality health care	From Dec. 2005	Proportion of consumers who are aware of their rights and are demanding for improved quality of health care	Ad agency Media houses FMOH Technical partners		FMOH Dev. Partners
Interactive consumer fora to discuss health and development issues with providers and community leaders	<ul style="list-style-type: none"> • Support BCC materials for clients • Local capacity to facilitate take-off of fora 	Communities, individuals, leaders and providers are actively discussing issues relating to improving performance of health care delivery systems	From September 2005	<ul style="list-style-type: none"> • Number of community for a established and functional • Proportion of community fora implementing decisions and recommendations taken 	Community leaders NGOS CBOS FBOS		FMOH, NOA, FMI, States, Dev. Partners

9. MONITORING AND EVALUATION

Plan of Action: Monitoring and Evaluation

Activities	Inputs	Outputs	Time-Frame	M&E Indicators	Responsibility	Est. Budget (Nm)	Source of Funds
<p>To identify and strengthen health data systems, the NHMIS and capacity building to undertake HSR M&E</p> <ul style="list-style-type: none"> ▪ Reform and strengthen the NHMIS and other data systems ▪ Revise and strengthen the NHMIS and other related health data systems ▪ Develop protocol for HSR M&E ▪ Undertake a joint-HSPA with key stakeholders ▪ Build capacity for data analysis within the FMOH ▪ Establish and strengthen a national health data processing centre within FMOH ▪ Build capacity for ICTs within the FMOH, including an e-Learning Resource Centre 	Funds for all the activities identified	<ul style="list-style-type: none"> ▪ Data collection system available to generate information for M&E 	June-2004 to Dec 2007	<ul style="list-style-type: none"> ▪ Functioning NHMIS ▪ Functioning national health data centre in FMOH • Staff with capacity for health data analysis 	FMOH SMOH Partners (GTZ, W/Bank, AfDB, DFID/PATHS, CIDA, WHO, etc)	300	FMOH Partners
Sub-Total						300.00	