NATIONAL PRIMARY HEALTH CARE DEVELOPMENT AGENCY

FG LOGO

PLOT 681/682 PORTHARCOURT CRESCENT, OFF GIMBIYA STREET
AREA 11, FCT, ABUJA

WARD MINIMUM HEALTH CARE PACKAGE

2007 – 2012

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WHO LOGO *PATHS LOGO*

FOREWORD

At the 16th WHO Regional Programme meeting held in Yaoundé, Cameroon in February 1994, to discuss the acceleration of the attainment of Health For All (HFA) through the PHC approach; the need for the implementation of a Minimum District Health For All Package (MDHFA) by African Countries was recognized.

In August of the same year, Nigeria developed a MDHFA package comprising thirteen (13) components for implementation between 1995 and 2000. Following two National Stakeholders meetings held in 1996 and 1998 with WHO support, the components of the MDHFA package were reduced to four (4). However in 2001, the MDHFA package was again reviewed with a change in nomenclature to the Ward Minimum Health Care Package (WMHCP) and the addition of a fifth component. Furthermore between 2005 and 2007 the National Primary health Care Development Agency (NPHCDA) with the support of the WHO, convened a series of meetings during which a sixth component was added and data collection undertaken to cost the package. The end product is a WMHCP for the plan period 2007-2012. The Partnership for Transforming Health Systems (PATHS) supported the concluding meetings on the package and the finalization of the costing process.

In order to ensure the synergy in government effort to meet the health need of Nigerians, in July 2007, the package was harmonised with the Integrated Maternal Neonatal and Child Health (IMNCH) Strategy document of the Federal Ministry of Health.

The WMHCP consists of a set of health interventions and services that addresses health and health related problems that would result in substantial health gains at low cost to government and its partners. The document outlines key areas of concern in ensuring equitable primary health care delivery, the set of interventions deemed necessary to achieve equity and significant reductions in morbidity and mortality within the general populace and the minimum package of resources required for the implementation of each intervention. In addition, the document outlines the broad strategies to be utilized, the main objectives to be achieved and a time frame for the establishment of the minimum package in wards across the country.

While government at all levels particularly the Local government, would continue to implement and support the implementation of all components of primary health care, it is expected that the WMHCP would provide a standard reference for the setting of priorities and development of plans for the provision of quality PHC with scarce resources. This plan of action requires governments at all levels and its partners to direct all targeted PHC resources towards the establishment and implementation of the WMHCP. It is the expectation of the NPHCDA, that at the end of the current plan period (2007-2012), the WMHCP would have been established in all wards across the country; giving room for a possible upward review of what should constitute the “minimum set of services’ to be provided by the government for all its citizenry.

It must be borne in mind by all stakeholders within the health sector that PHC remains the corner stone of the Nigeria’s health policy and represents a vital component of the nation’s strategy for achieving the Millennium Development Goals (MDGs). Thus the successful implementation of the WMHCP presents a sure avenue for accelerating our achievement of the MDGs. The basic cost required to implement the package has been computed and would be published alongside the package and disseminated.

Mrs T. I. Koleoso-Adelekan
Executive Director, NPH Care Development Agency

Acknowledgement

The Ward Minimum Health Care Package document is the product of close collaboration between the National Primary Health Care Development Agency (NPHCDA) and WHO Nigeria. It is an outcome of a review of the Nigerian country plan of Action for implementing the Minimum District Health Care Package (1995 -2000). The NPHCDA sincerely appreciates the efforts of all contributors to the development of a minimum health care package since its inception in 1994.

The process of reviewing this document would not have been possible without the commitment and support of the top management of the (NPHCDA) in the persons of the Executive Director Mrs. T.I. Koleoso-Adelekan and her team of directors, Mr. P. Ehimwenma, Prof. C.O Akpala; and the immediate past Executive Director Dr S. Mahdi. The invaluable support of the Nigeria WHO office and its Health Systems Development team contributed immensely to the initiation, finalization and the costing of the Ward Minimum Health Care Package. The efforts and contributions of Dr Amos Petu and P. Bozegha, Dr F. Bogunjoko and Dr T. Adegboyega are very much appreciated.

At various stages of the document's development and review, teams of Experts, Consultants and numerous Stakeholders made exceedingly valuable contributions, which is most appreciated. Dr. T. Muhebwa (WHO AFRO Consultant) provided invaluable guidance to the foundation and organization of the document. Similarly, contributions were made by Dr. C. Tobin-West (Affricate) and Dr. N.V.Onyekwere (School of Health Technology Rivers State) who were Consultants at the initial stages, of the document development.

Our profound gratitude also goes to Officers of the various departments of the Federal Ministry of Health who have always honoured our invitation and made constructive inputs into the document. By extension we are grateful to representatives of various State Ministries of Health and LGA PHC departments who also made their input.

The finalization of the WMHCP represents a landmark for the department of Planning, Research and Statistics and our gratitude goes to the department's staff who have repeatedly worked on the document over time; The invaluable contribution of Dr I. Lewis who has been part of the process of developing a minimum health care package since inception to its finalization is highly appreciated. In addition, the effort of Mr T. Marafa at the initial stage of the review and those of Dr. O. Ogbe who was the desk officer and has been working with various teams till the emergence of the final product is also duly acknowledged. The attached list of medical equipment is a product of the assiduous efforts of Mr A. S. Lawal, Dr M.J. Abdullahi and Mr O.A. Amusan; this too is duly acknowledged.

This acknowledgement would not be complete without highlighting the timely intervention of the Partnership for Transforming Health Systems (PATHS) which supported the concluding meetings on the package and the finalization of the costing process. The work of Dr K. Ojo and Dr B. Sagoe of PATHS and Dr A. Jimoh (University of Ilorin) on the costing of the WMHCP is highly commendable and appreciated. The outcome of the costing is being published as an addendum to this document. In addition, the NPHCDA sincerely appreciates the invaluable contributions of the IMNCH Technical Working Group, made up of representatives of UNICEF, WHO, PATHS, USAID and FMOH and their Consultants.

The NPHCDA is profoundly grateful to all afore mentioned, all attendees at the various Stakeholders' meetings, various contributors and many others too numerous to mention.

Prof. C.O Akpala
Director Planning Research and Statistics
NPHCDA, Abuja.

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Executive Summary

The need to ensure equity in the delivery of health care services and improve access, informed the development of the Ward Minimum Health Care Package (WMHCP) in line with the ward health system currently being implemented at the primary health care level in Nigeria. The WMHCP targets the grass root for the delivery of a minimum set of primary health care interventions needed to meet the basic health requirements of a majority of Nigerians, resulting in substantial reduction in morbidity and mortality and contributing significantly to achieving "Health for All" and the MDGs at a cost government and its Partners can afford.

The plan of action for establishing the WMHCP from 2007 to 2012 includes the following six (6) interventions:

- Control of Communicable Diseases (Malaria, STI/HIV/AIDS)
- Child Survival
- Maternal and Newborn Care
- Nutrition
- Non-Communicable Diseases Prevention
- Health Education and Community Mobilization

In recognition of overriding importance of key support services and resources, strategies for their provision and sustenance are outlined in the package. These include:

- Provision of Essential Drugs
- Human Resource for Health
- Health Infrastructure development

Expectedly, successful delivery of the WMHCP would require the cooperation and coordination of government partners at all levels, and a system of continuous and effective monitoring. For each of the interventions, a minimum set of requirements is identified within the document which must be made available in each ward by government and its partners. In addition, areas of thrust and broad time frames have been developed for the implementation of activities for the various interventions. Furthermore, collaborative strategies to ensure the availability of the required support services have also been expanciated within the document. A standardized equipment list for Primary Health Centres and staffing norms for PHC facilities have also been included for comprehensiveness and easy reference.

ACRONYMS

AIDS -	Acquired Immune Deficiency Syndrome
ARI -	Acute Respiratory (tract) Infection
BCC -	Behavioural Change Communication
BCG -	Bacillus Calmette Guerin (vaccine)
BEOC -	Basic Essential Obstetric Care
CBO -	Community Based Organisation
CHEW	Community Health Extension Worker
CHO -	Community Health Officer
DPT -	Diphtheria, Pertusis, Tetanus (vaccine)
EHO -	Environmental Health Officer
FMOE -	Federal Ministry of Environment
FMOH -	Federal Ministry of Health
GDP -	Gross Domestic Product
HIV -	Human Immune Deficiency Virus
IEC -	Information Education Communication
IMCI -	Integrated Management of Childhood Illness.
IMF -	International Monetary Fund
IMNCH	Integrated Maternal, Neonatal and Child Health
LGA -	Local Government Authority (Area)
NASCP	National AIDS and STI Control Programme
NCD -	Non Communicable Disease
NDHS -	National Demography and Health Survey
NGO -	Non Governmental Organisation
NHMIS	National Health Management Information System
NPHCDA	National Primary Health Care Development Agency
NPI -	National Programme on Immunization
OPV -	Oral Polio Virus (vaccine)
PATHS -	Partnership for Transforming Health Systems
PHC -	Primary Health Care
PMTCT	Prevention of Maternal to Child Transmission (of HIV)
RBM -	Roll Back Malaria
SM -	Safe Motherhood
SMOH	State Ministry of Health
STI -	Sexually Transmitted Infection
TB -	Tuberculosis
TBA -	Traditional Birth Attendant
VCT -	Voluntary and Counselling and Testing
VDC -	Village Development Committee
VHW -	Village (Voluntary) Health Worker
WDC -	Ward Development Committee
WHO -	World Health Organisation
WHO AFRO	WHO African Regional Office
WHS -	Ward Health System
WMHCP	Ward Minimum Health Care Package

PART 1 - BACKGROUND INFORMATION

1. INTRODUCTION

1.1 Background

Nigeria is a Federation made up a Federal Capital Territory, Abuja, and 36 States, which are divided into 774 Local Government Areas. The states are grouped into six geo-political zones; namely the North Central, North East, North West, South East, South-South and South West.

The political history of Nigeria dates back to 1914 following the amalgamation of the Northern and Southern protectorates with the colony of Lagos under the British Colonial administration; and its Subsequent independence in 1960.

Administratively, the political structure of Government has three tiers, namely Federal Government, State Government and Local Government Authorities. In the same vein, the public health services are also organized along the same tiers of Government as follows:

- Primary care, which is largely the responsibility of local government area councils, with the support of the State Ministry of Health and the Federal Government;
- Secondary care, which provides specialized services to patients referred from the primary health care level and is the responsibility of the State government; and
- Tertiary care, which provides highly specialized services referred form the primary and secondary levels of care and is the responsibility of the Federal and State Governments.

(Source: Revised National Health Policy, 2004))

In addition to the public health sector, Nigeria has a viable private health sector that provides various health services ranging from primary care to tertiary care services. These include private not for profit sector notably Non Governmental Organizations (including religious organizations), individuals, and the for-profit sector, which is dominated by private hospitals, clinics and registered drug shops. There is substantial community contribution to health care in the country especially at primary care level.

1.1.1 Socio-economic indicators

According to the 2006 census, Nigeria has a population of 140 million people, with a life expectancy of 47 years at birth and a population growth rate estimated at 2.9%. Currently, an estimated 66% of this population live in the rural areas, while the remaining 34% live in the urban areas.

Whereas Nigeria is rich in natural resources, it's GDP per capita is only US$350 putting it among the world poorest countries. The economy is based on agricultural

production meant for export and internal consumption, small industrial sector, a wide range in minerals and export of crude oil being the largest foreign exchange earner. Annual inflation rate in 1999 was estimated at 8.0% and the economic growth rate recorded slight improvement in 2001, with a gross domestic product (GDP) of 3.9% up from 2.7% in 1999 *(NDHS, 2003)*.

In 1986, Nigeria initiated the implementation of the World Bank/IMF structural adjustment programme aimed at stimulating economic growth through privatization of public utilities and introduction of policies aimed at improving welfare of the population. However, the broad objectives of this programme were not realized and instead, led to a decline in living standards and health service delivery *(Report of Needs Assessment Survey, NPHCDA, 2001)*.

Available health indicators show high figures for infant mortality rate of 100 per 1000 live births, maternal mortality of 800 per 100,000 live births *(FMOH, Family Health Division Aggregated data; 2007)*, under-five mortality of 201 per 1000 live births in the 1999-2003 period and a total fertility rate of 5.7 in 2003. These indicators pose a challenge to the health sector resources and infrastructure particularly the distribution and targeting of public subsidy. Besides, using number of births attended to by health workers as a proxy, only 34% of the population could be said to have access to health care *(NDHS, 2003)*.

The current national health expenditure is 0.2% of the total national expenditure and 0.6% of the GNP. This is equivalent to US$ 0.7 per capita *(Through The Eye Of A Needle: The African Debt Report By Jubilee, 2000)*. Based on available information from the Federal Ministry of Health, it is estimated that (a) Federal Ministry of Health receives 5% of the 40% of the Federal Government budget; (b) State Ministries of Health receive 10% - 15% of the 40% of the State Government budget and (c) LGA health expenditure 15% - 20% of the remaining 20%. It is envisaged that with the development and prescription of the minimum health care package for the wards, public sector resources will be directed to this level. In addition, health care financing initiatives will be encouraged as a means of bridging the gap where applicable.

1.1.2 Disease Profile

Nigeria like many Sub-Saharan African countries has a high burden of communicable diseases of public health importance that are responsible for high morbidity and mortality. Notable among these are Malaria (30%), diarrhoea (20%), and ARI (10%) in children aged less than five years. *(NDHS 2003).*Despite recent reduction in the national prevalence of HIV/AIDS, it still remains at epidemic proportions with the current prevalence rate estimated at 4.4% *(NASCP, Sentinel Survey 2005)*. The existence of these disease conditions puts significant pressure on the health care system and requires deliberate measures aimed at improving access to the vulnerable population groups, and availability of services at the lowest level through an extension of the existing health services.

1.1.3 The National Health Policy

The overall objective of a national health policy is to improve accessibility of the population to primary health care as well as to secondary and tertiary care. The

Nigerian *National Health Policy* identified primary health care (PHC) as the main focus for delivering an effective, efficient, quality, accessible and affordable health services, to a wider proportion of the population through four approaches:

- Promotion of community participation in planning, management, monitoring and evaluation of the local government health system i.e. the PHC system;
- Improved inter-sectoral collaboration in primary care delivery;
- Enhancing functional integration at all levels of the health system;
- Strengthening of the managerial process for health development at all levels.

This reviewed National Health Policy recognized the Local Government Area as the operational level for primary health care implementation. In a bid to institutionalize PHC services and ensure sustainability, a decree was promulgated in 1992 *(Decree No 29)* establishing a National Primary Health Care Development Agency (NPHCDA). This Agency has a mandate to; periodically monitor and evaluate the National Health Policy, especially as it relates to primary health care, mobilize resources nationally and internationally for the development of PHC, and most importantly; provide technical support, co-ordinate and develop strategies for the effective implementation of PHC nation-wide.

Despite these developments, the desired outcomes of this policy have not been fully realized. An attempt to develop and implement a National Plan of Action for Implementing a District (LGA) Minimum Health Care Package for the plan period of 1995 to 2000, was constrained by low level of political commitment at all levels of Government. In an attempt to improve access to health care, the NPHCDA has reviewed the flaws in the present primary health care system and developed a ward health system through which a minimum health care package would be delivered.

Description of a Ward

The ward is the smallest political structure, consisting of a geographical area with a population range of 10,000 to 30,000 people. There are on average, ten (10) wards per LGA, each represented by an elected councillor. The main rationale for selecting a ward as an operational area for delivering a minimum health care package was to mobilize political commitment to health service delivery as a requisite for social development.

Structurally, each ward has a Ward Development Committee composed of the following:

- A Ward/Clan Head as Patron
- An elected Chairman
- Secretary,
- Chairmen of village/community development committees,
- Headmaster of school,
- Senior agricultural extension worker,
- Community Development officer,
- Representatives of occupational groups (which includes VHW/TBA, NGO/International Organizations, Religious Groups, Women and Youth

groups, chairmen of patent medicine and store dealers, traditional healers),
- Heads of facilities in the area).

Functionally, each Ward Development Committee is responsible for the following:
- Identification of health and social needs of the Ward and planning solutions.
- Mobilization of resources (human and material)
- Supervision, monitoring and evaluation of health activities in the Ward
- Mobilization for community participation in health, and other health related programmes
- Liaison with Government, NGO and other partners in the implementation of health programmes
- Forwarding plans from villages and the wards to LGA/PHC Development Committee and providing feedback
- Supervision and support to TBA/VHW/CHEWs
- Support the establishment of health facilities and overseeing their functions at ward level

(Source: Operational Training Manual and Guidelines for the Development of Primary Health Care System in Nigeria, NPHCDA, 2004)

As appropriate, it is expected that the Federal Government, State Government and LGA would provide the necessary manpower; infrastructure and logistics to enable the Ward perform its role.

Concept and Development of the Minimum Health Care Package; Historical Perspective

In February 1994, at the 16th WHO Regional Programme Meeting held in Yaoundé, Cameroon, participants from African countries including Nigeria met to discuss issues relating to acceleration of the attainment of Health for all through PHC. The meeting recognized the need for each member country of WHO in the African Region to organize a National Programme Meeting (RPM.16C). This was to serve as a forum for presentation of the Minimum District Health for all Package, which was extensively discussed at that meeting. Strategies for implementing the package were developed. In August 1994, six months after the Yaoundé meeting, the then Hon. Minister of Health and Social Services, in collaboration with the WHO, Nigeria and the National Primary Health Care Development Agency, organized a four day stakeholders meeting aimed at developing a Minimum District Health Care Package for Nigeria for the acceleration of HFA through PHC. A package that came out of that meeting consisted of thirteen (13) components each with objectives and strategies to be implemented between 1995 and 2000. In 1996, each of the 36 States and selected LGAs developed a Plan of Action to implement the package. In January 1998, report of supervisory visits conducted to ascertain level of implementation indicated that most of the selected LGAs had 4 – 5 components in their plan of action; however, level of implementation of MHCP was low. In June 1998, a National Review Meeting to discuss progress report was convened, and a resolution by the meeting, brought the number of components to four namely:

1. Child Survival (IMCI & Routine Immunization)
2. Safe motherhood (ANC, Delivery, Postnatal Care, FP)

3. Control of Communicable diseases of public health importance (Malaria, TB, HIV/AIDS)
4. Health Information, Education and Communication.

At a national review meeting held in Port Harcourt in 2001, an additional component was incorporated into the package, namely: Nutrition. State and LGAs presentations at the review meeting indicated low implementation of components of the package. The meeting re-emphasized the need for government to fund the package in line with the recommendation of WHO AFRO of 1994. It also observed that socio-economic indicators had worsened; level of unemployment was high, while morbidity and mortality statistics were unacceptably high. Cost of health services had gone beyond the reach of majority of Nigerians. The meeting recommended the need to strengthen budgetary allocation to health. The reviewed package was renamed Ward Minimum Health Care Package (WMHCP) in line with the introduction of the Ward Health System (WHS) in 2001. However constraints in costing the package undermined its widespread dissemination and utilization.

In 2005, the NPHCDA in collaboration with WHO convened a meeting to update the WMHCP and adopt instruments for its costing. At this meeting, the Control of Non Communicable diseases was incorporated as the sixth component.

Costing Of Minimum Health Care Package

In November 2005, the NPHCDA in collaboration with WHO, conducted a preliminary field survey in one geopolitical zone to generate data for costing the WMHCP. A Health Economist was engaged for this purpose, and the outcome was presented to a cross-section of stakeholders; who called for additional data collection in the other geo-political zones, prior to the finalization of the costing exercise. Subsequent to this, in March 2007 the NPHCDA with support from PATHS conducted a second survey in 5 geo-political zones. Data generated from these two surveys was analysed and provided the cost for each of the components of the package. The costed package was adopted at a stakeholders' meeting in July 2007

Plan of Action for Implementation of the Ward Minimum Health Care Package

The Ward Minimum Health Care Package describes a priority set of health interventions which should be provided in PHC centres on daily basis at all times and at little or no cost to clients, through government financial mechanism. The operationality of the package requires that government defines minimum health manpower requirement, equipment, drugs, infrastructure and services for the primary health centre. To facilitate this process, the package has been costed. It is to be used as a tool for advocacy to all levels of government and to Partners within the health sector.

This plan of action stipulates that over the plan period i.e. 2007-2012, government at all levels would demonstrate a high level of political commitment and harness all available resources in collaboration with Partners, the private sector and communities to ensure that the proposed package is instituted in all wards by 2012. At the end of the plan period a comprehensive evaluation would be conducted to create the evidence base for a possible review. This plan of action acknowledges that many local government authorities and communities may possess enough resources to provide services based on all the components of PHC.

Overall Goal of delivering the Ward Minimum Health Care Package is to:

Contribute to national socio-economic development.

Purpose:

Reduce morbidity and mortality; in the Nigerian communities.

Objectives:

(a) To define a ward minimum health care package that would be made available at PHC level.
(b) To improve access to quality health care at community level particularly for the rural population.
(b) To address the inequalities between and within wards in health service delivery.
(c) To ensure availability of quality interventions that addresses the health needs of the population.
(d) To strengthen the monitoring and evaluation indicators of the ward health system as part of the National Health Management Information System.
(e) To provide a structure for effective programme integration at ward/primary care level
(f) To provide a minimum health care package as a basis for improved public health expenditure and to guide the investment of all stakeholders.

1.2 IMPLEMENTATION OF THE WARD MINIMUM HEALTH CARE PACKAGE

The minimum health care package includes **health interventions and/or services that address health and health related problems that result in substantial health gains at low cost.** In defining this package, a number of considerations were made; disease patterns, economic considerations (e.g. cost of services) and proportion of population affected/benefiting from health services. This package targets the grass root level through the delivery of a minimum set of interventions needed to meet the basic health requirement of the people hence contributing to achieving the global target of Health For All and the attainment of the Millennium Development Goals (MDGs). Technically, this package comprises of cost-effective interventions known to promote health and development and reduce mortality and morbidity from major/common illnesses. Based on these and other considerations, a package is proposed[1].

During the implementation period of this Plan of Action (2007-2012), the Minimum Health Care Package will include the following health interventions:

- Control of Communicable Diseases (*Malaria, STI/HIV/AIDS, TB*)
- Child survival

[1] A Memorandum to the National Council on Health on the adoption and implementation of the minimum health care package held in June 1998, recommended a set of health interventions for inclusion in the minimum package

- Maternal and Newborn Care
- Nutrition
- Non Communicable Disease Prevention
- Health Education and Community Mobilization

In order to implement this set of interventions, communities will be mobilized using appropriate IEC/BCC strategies. Functional health infrastructure, human resources/manpower and financial resources would also be provided to support health service delivery at the ward level. Therefore, the following services are required:

- Provision of Essential Drugs
- Human Resources for Health
- Health Infrastructure Development

Other Interventions of Public Health Importance:

Certain services have an effect on the health status of the population, though their provision is not entirely confined to the health sector. These include water, sanitation, and emergency and disaster preparedness. This Plan of Action recognizes the role of other sectors in the financing and provision of these services.

Need for Co-ordination and Collaboration:

To ensure effective implementation and optimisation of resources for the delivery of the Minimum Ward Health Care Package, there will be co-ordination among related programmes such as Essential Drugs Programme or Bamako Initiative, Malaria (RBM), CDD/ARI (IMCI) and NASCP. **Co-ordination will take the form of integrated approach to training, service delivery, supervision and monitoring. In addition to programme co-ordination, Development Partners and Agencies will be encouraged to collaborate at various levels of service delivery particularly at the Ward and LGA levels, in the implementation of the Minimum Care Package.**

Monitoring and Evaluation:

The availability of accurate, timely, reliable and relevant health information is the most fundamental step towards informed public health action (Revised NHMIS Policy, 2006). This underscores the fact that Monitoring and Evaluation stands out as an essential component necessary for achieving success in implementing the Ward Minimum Health Package.

It is mandatory that at the Ward level, a Primary health care information system for effective monitoring and evaluation be instituted for routine data collection, collation, analysis and feedback to the communities. Data collected from communities within the ward are sent to the Ward PHC centre where they are analyzed together with facility based data and forwarded to the LGA M&E Office for subsequent transmission to the State and zonal office of the NPHCDA. Data from the State are sent to the Federal Ministry of Health and those from the zonal office of the NPHCDA are sent to its headquarters. At the federal level, the NPHCDA headquarters is expected to forward data to the Department of Health Planning and Research,

FMOH. Furthermore, interaction at Data Users' Forum would enhance comparability, feedback and generate evidence for more integrated planning.

Implementation of the Primary Health Care Information System:

The PHC information system is a sub-set of the NHMIS. It consists of health maps, house numbering, home-based records (child health card, personal card) facility based Family Master Card, the wall chart, health facility/district referral forms, VHW/TBA pictorial and tally sheets, M&E forms and Health Facility Registers etc.

The PHCMIS information system feeds into the LGA health system in order to attain the desired impact. However, other parallel reporting formats such as the Disease Surveillance and Notification (Immediate Notification - DSN001; and Routine (monthly) Notification - DSN002) exist and continue to feed into the relevant reporting systems.

However, it must be emphasized that basic training, retraining, and necessary logistics must be given to the PHC staff at the ward level to be able to collect, analyze and use data for informed decision making and provide a feedback to both the communities and the next level of reporting. This coupled with active supervision is an effective strategy for achieving desired results in the operation of PHC at the Ward level. Regular supervision not only emphasizes management's commitment to an issue but is also supportive. It provides the necessary feedbacks for evidence based decision making, planning and achievement of desired outcome.

PART 2 - COMPONENTS OF THE MINIMUM HEALTH CARE PACKAGE

COMPONENT 1: CONTROL OF COMMUNICABLE DISEASES *(Malaria, TB, STI/HIV/AIDS)*

1.1 Situation Analysis

Like many Sub-Saharan African countries, Nigeria has a high burden of communicable diseases that are of public health importance. These diseases can be classified as (a) diseases targeted for eradication e.g. *leprosy, Guinea worm, Onchocerciasis, Poliomyelitis*; (b) Notifiable diseases e.g. *Meningitis, Cholera, Yellow Fever* (c) Diseases of public health importance e.g. *Malaria, STI/HIV/AIDS, TB (NPHCDA, 2001)*.

Whereas Nigeria has a National Disease Surveillance and Notification (DSN) system for monitoring trends and occurrence of selected communicable diseases, current information on the extent to which these diseases cause morbidity and mortality is not readily available. However, information provided in the *Report on Needs Assessment Survey,* NPHCDA, 2001, points to a high burden of diseases: e.g. malaria (50%), TB, and HIV/AIDS, which has a prevalence rate of 5% (*NASCP, FMOH Sentinel survey, 2004*).A burden of disease study would be beneficial in order to obtain more detailed information. Nonetheless, Government has selected *Malaria, Tuberculosis, and STI/HIV/AIDS* as key disease entities for inclusion in the minimum health care package that should be provided at the lowest level of the health system. Furthermore, about 66% of the Nigerian population live and work in the rural areas where these diseases cause high morbidity and mortality. It is therefore necessary that programmes and services aimed at controlling these disease conditions be provided at the ward/community level.

1.2 Malaria

1.2.1 Description

Malaria is a major cause of morbidity and mortality in Nigeria, especially in children under five and pregnant women. With a prevalence of approximately 50% of the Nigerian population having at least one (1) episode of malaria annually; and 31.6% of children under five years having fever and/or convulsion due to malaria.*(NDHS 2003)*. Consequently, the affected individuals/communities, especially in the rural areas lose productivity, due to loss of man-hours from ill health; contributing to poverty and slow economic development.

Results of a baseline survey conducted by the Federal Ministry of Health show that most facilities do not have guidelines on the management of malaria. First action for appropriate treatment of malaria at the community level was estimated to be 30.6% while 69.4% was inappropriate. Stock out in health facilities for anti-malaria drugs during the week preceding the survey ranged from 15.2% for chloroquine tablets to 8.7% for the injections and 43.5% for sulphadoxine-pyrimethamine etc. In addition, it is to be noted that the current national policy for malaria control, stipulates the use of

Artemisinin based combination therapies (ACTs) as the drug for the treatment for uncomplicated malaria. There are however, no current statistics on the level of utilization of ACTs.

Furthermore, the use-rate for insecticide treated nets (ITN) in 2002 were 2% for households, 1.2% and 1.3% for children under five, and pregnant women respectively *(NDHS, 2003)*. However this has risen to 6.8% in *(National Malaria Situation Analysis, 2005).* It is recommended that relevant training be conducted, drug revolving funds be revitalized using the Bamako initiative and other strategies developed to enhance community marketing of ITNs.

1.2.2 General Objective:

To reduce morbidity and mortality rates from malaria by 50% by 2012.

This objective will be achieved through an application of a number of strategies guided by the national Roll Back Malaria initiatives; with synergistic efforts at the ward level being complementary to national efforts.
Targets: By 2012;

- At least 80% of those suffering from Malaria have access to affordable and appropriate treatment within 24hours of onset.
- Increase the use of ITN from the current 6.8% to at least 80% for high-risk groups particularly under-5yrs and pregnant women within the plan period
- At least 90% of all pregnant women have access to intermittent prevention treatment.
- Create awareness on environmental sanitation as it affects malaria control in 80% of all wards.

1.2.3 Implementation Strategy

The Malaria Control Programme is organized in three tiers, namely the National, State and LGA levels. The National Malaria Control Programme sets policies and co-ordinates national initiatives such as Roll Back Malaria (RBM) to ensure that all levels operationalize these policies.

At the Ward level, development committees will facilitate the availability of anti-malarial drugs, through sustainable drug revolving schemes of the Bamako Initiative; and take responsibility for the distribution and sale of ITNs in rural and urban Communities. The communities would also be empowered to undertake environmental sanitation and promote the use of Insecticide Treated Nets (ITNs). These strategies would be enhanced by limited laboratory diagnosis in health facilities and constant availability of chemicals for re-treatment of the ITNs. In addition, ward development committees, in collaboration with health workers will be responsible for community mobilization, and ensure that health facilities are functional and optimally utilized.

The LGA should ensure effective supervision and provide all necessary logistic support in terms of minimum manpower requirements and equipment. In addition, creating an enabling environment for the institutionalization of mechanisms for

effective environmental sanitation (i.e. provision of receptacles for refuse disposal and enforcement of environmental laws, would significantly enhance malaria control).

1.2.4 Minimum Health Package For malaria:

To this end a minimum health package for the control of malaria is proposed as follows:

1. Availability of Insecticide Treated Nets (ITNs) for all pregnant women and children under five (5) years of age; and insecticide for re-treatment, or long lasting ITNs.
2. Provision and use of Artemisinin based Combination Therapy (ACT) for treatment of uncomplicated malaria.
3. Institutionalizing effective case management of malaria in the community and all health facilities.
4. Provision of Sulphadoxine-Pyrimethamine for Intermittent Preventive Treatment in pregnant women.

In order to facilitate the equitable establishment of the package nation wide, the areas of thrust are identified as outlined in table 1a.

1.3 Tuberculosis

1.3.1 Description

An estimated 100,000 new sputum positive cases occur each year and an estimated annual risk of infection is approximately 2%. Hence, about 200,000 cases of all types of tuberculosis occur annually. As at the year 2001, although treatment success was as high as 79.7% in 21 states, case detection was very low and was 26.2% *(NTBLCP, Annual Report 2002).* With HIV/AIDS on the increase and gaining epidemic proportions, TB is also re-emerging and becoming a major public health problem.

1.3.2 General Objective:

To reduce the prevalence of TB to a level it will no longer constitute a public health problem

To achieve this objective, the work schedule in table 1b describes desirable thrust for implementation by responsible bodies. Targets for the plan period are;

- To increase community awareness on the causes, prevention and treatment of TB to at least 80%.
- To ensure availability of drugs for TB therapy to at least 75% of all primary health facilities.
- Update knowledge and skill of 75% of Health workers on early detection and treatment of cases.

1.3.3 Implementation Strategy

To achieve the targets, the development committees at ward and village levels, together with trained health personnel will be guided by the broader objectives and strategies of the national Tuberculosis/Leprosy Programme.

The role of relevant bodies involved in TB control is outlined in operational schedule (Table 1b). However, it is assumed that the infrastructure, equipment and financial inputs will be provided through the Government disbursement system (i.e. through the local government authorities). Community mobilization and level of awareness has to be raised with the aim of achieving effective management of TB patients through strategies such as contact and default tracing, and implementation of DOTS.

1.3.4 Minimum Health Package for Tuberculosis

To this end a minimum health package for the control of tuberculosis is proposed as follows:

1. Provision of basic laboratory infrastructure and equipment in all ward health centres for case identification of tuberculosis. {microscope, slides and slide covers, stains, swaps, sterile sputum receptacles, disposable gloves} *(also see section on equipment)*
2. Ensure the availability of drugs and infrastructure for Direct Observation Treatment Short Course (DOTS) {Rifampicin, INH, Pyrazinamide, Streptomycin, Ethambutol etc for all identified cases}

1.4 STI/HIV/AIDS

1.4.1 Description

Based on data from sentinel sites in the country, HIV/AIDS prevalence rates have shown an increase over the years. The series of surveys revealed an increase in median prevalence rates from 4.5% in 1995 (21 States), 4.5% in 1999 (36 States and FCT) to 5.8% in 2001 in 36 States and FCT (Human Development Report, UNDP Nigeria 2004). However, the results from the 2004 sentinel survey conducted by the Federal Ministry of Health show a marginal decline in HIV/AIDS prevalence to 5%. Male condom use during high risk sex stands at 46%, while 42.3% and 59.8% of women and men respectively knew at least two ways to prevent HIV/AIDS. In addition, analysis of data from the sentinel sites shows that about 85% of adult infection was attributed to heterosexual transmission of which the most infected age group is 15-49 years. As at 2001, it was estimated that 3.4 million Nigerians were living with HIV. *(NASCP and NDHS 2003.)*.

The socio-economic implication of this epidemic is of concern to policy makers in the country. In this regard, a Presidential Committee on AIDS (PCA) which was transformed into the National Agency for the Control of AIDS was established to develop and co-ordinate a national multi-sectoral approach for controlling HIV/AIDS. To date, this Agency has developed a HIV/AIDS Emergency Action Plan (HEAP) and a set of national indicators (NNIRMS) and has been involved in a number of activities related to HIV/AIDS control and management.

The activities of NACA have been decentralized to States (State Action Committee on AIDS) and LGAs (Local Action Committee on AIDS). It is strongly recommended that this trend continues to the community/ward level to create the needed awareness and make the necessary impact.

1.4.2 General Objectives:

Create awareness on STI/HIV/AIDS transmission and prevention.

The following have been identified as targets for this Plan of Action by 2012:

- To increase public awareness of STI/HIV/AIDS to 95% in 5 years
- To increase condoms availability and use by 80% in all communities
- To establish in at least 60% of the wards, community-based voluntary counselling and home-based care centres
- To Institute the management of STI and opportunistic infection at PHC level in at least 70% of LGAs
- To reduce HIV infection rates by 50%.

1.4.3 Implementation Strategy

The framework developed by the National Agency for the Control of AIDS (NACA) will guide the implementation of an effective STI/HIV/AIDS control programme at the State, LGA and community level. The National AIDS/STI Control Programme *(NASCP)* in close collaboration with the National Primary Health Care Development Agency *(NPHCDA)* is working closely with Ward development committees, relevant health personnel and other stakeholders in implementing control measures.

To this end, the Local Action Committee on AIDS in collaboration with health workers in the wards is implementing, (a) voluntary counselling and testing (VCT), as well as support services for the HIV infected and AIDS patient; (b) home based care (c) management of opportunities infections (d) distribution of condoms. The VCT strategy at the ward level, would immensely contribute to the prevention of mother to child transmission (MTCT) of HIV; through the identification of HIV positive women during antenatal care and effecting appropriate referral. In addition, Counsellors and primary health care workers would be expected to provide relevant information on feeding for HIV positive children. It is therefore recommended that the necessary linkages with other community resources be utilized. Hence extensive community involvement and mobilization is required.

The implementation of this programme will be based on the existing health infrastructure, and will use existing health personnel. This may necessitate the rehabilitation or construction and equipping of the primary level facilities. The focal areas of work are contained in the schedule. (Table 1c).

1.4.4. Minimum Health Package for STI/HIV/AIDS

Based on the implementation strategy, the following minimum is proposed for the control of STI/HIV/AIDS:

1. Availability of Voluntary Counselling and Testing (VCT) services; {i.e trained Counsellors, conducive infrastructure and Rapid Test kits for HIV} in all Wards. Counselling would include safe infant feeding options.
2. Provision of condoms and establishment of logistic mechanisms for their distribution.
3. Treatment of Opportunistic infections {trained staff, appropriate drugs; *{refer: National essential drugs list}*
4. Routine implementation of IEC and BCC activities *{also refer section on health education}*

WORK SCHEDULE: Control of Communicable Diseases

Table 1a
PROGRAMME AREA: Malaria Control

No.	THRUST	Time Frame					Responsible Bodies
		YR 1	YR 2	YR 3	YR 4	YR 5	
1	Capacity building at community and facility levels for effective case management of malaria.						WDC, LGA, SMOH, FMOH, NPHCDA, Partners
2	Extensive community education and mobilization for malaria prevention and control.						WDC, LGA, SMOH, FMOH, NPHCDA, FMOE Partners
3	Promotion of ITN use and Logistic mechanism for ITN and insecticide for re-treatment.						WDC, CBO, Partners, FMOH, SMOH, LGA, NPHCDA, Private Sector
4	Promotion of the use of Intermittent Preventive Treatment of malaria in pregnancy						WDC, CBO, Partners, FMOH, SMOH, LGA, NPHCDA
5	Support the provision of commodities i.e. ITNs SP and ACTs.						WDC, CBO, Partners, FMOH, SMOH, LGA, NPHCDA, Private Sector
5	Implementing an effective National Health Management Information System.						FMOH, NPHCDA, SMOH, LGA, Partners.
6	Conducting operational research at the primary health facility/community						NPHCDA, WDC, SMOH, Partners, LGA

Notes

(1) Case management involves the provision of anti-malarial drugs e.g. ACTs. Capacity building would include training of health worker, Community Resource Persons (CORPs) and other community members
(2) PHC Management Information System is a subset of the National Health Management Information System. .
(3) Where FMOH is indicated as responsible body, the relevant department(s) will be involved in the activity as indicated.

Table 1b
PROGRAMME AREA - Tuberculosis Control

No.	THRUST	Time Frame					Responsible Bodies
		YR 1	YR 2	YR 3	YR 4	YR 5	
01	Capacity building of health workers for early detection and appropriate management of TB						LGA, FMOH, NPHDCA, Partners
02	Establishment of community based treatment and drug collection centres in the community.						WDC, CBOs LGA & SMOH, FMOH
03	Creation of public awareness through appropriate IEC campaigns/strategies						DC, LGA, Partners, FMOH & NPHCDA
04	Development and institutionalization of appropriate systems for contact and defaulter tracing.						DC, LGA, SMOH & NPHCDA

Notes

(1) Appropriate management should be based on direct observation therapy (DOTS).
(2) Drugs for TB treatment will be procured and provided through the National Tuberculosis/Leprosy Programme

Table 1c
PROGRAMME AREA - STIs/HIV/AIDS

S/No.	THRUST	Time Frame					Responsible Bodies
		YR 1	YR 2	YR 3	YR 4	YR 5	
01	Logistics for distribution and promotion of use of condoms in sexually active groups and distribution of opportunistic infection injection kits in health centres.						DC, LGA, SMOH, NASCP, Partners, CBOs
02	Extensive community mobilization through targeted IEC messages						DC, CBO, LGA, SMOH
03	Capacity building of Health workers on syndromic management of STI and opportunistic infections						NACA,NPHCDA, NASCP,SMOH, LGA
04	Establishment of voluntary counselling and testing (VCT) centres in each Ward						NACA, NASCP, SMOH,LGA, NPHCDA
05	Establishment community based support groups on the prevention of STI and HIV/AIDS						NPHCDA, WDC, LGA
06	Establishing community based support groups for home care for PLWHA and PABA						WDC, LGA, NPHCDA, Partners

Notes

(1) Community mobilization involves the promotion of traditional, religious and cultural values that discourage promiscuous behaviour

(2) Voluntary counselling and treatment centres provide basic treatment of AIDS related illnesses (opportunistic infections) and may have to refer those cases that require specialized medical attention

(3) Drugs for the treatment of opportunistic infections and syndromic management should be provided through the appropriate sources (LGA Drug store).

COMPONENT 2: CHILD SURVIVAL

2.1 Situation Analysis

In Nigeria, children under five years of age constitute a significant 20% of the total population. The neo-natal mortality rate (deaths of infants within the first 28days of life) is 48 per 1000 live births (NDHS, 2003). There is also a wide regional variation in the distribution of neo natal mortality. According to NDHS 2003, the highest neo natal rates were observed in the NE and NW regions of the country. The lowest rates were seen in the SE region. 10% of children were born with low birth weight, a condition that plays an important role in new born mortality. Most new born deaths in Nigeria occur within the first week of life, reflecting the intimate link of new born survival to the quality of maternal care (NDHS 2003). Of the neo-natal deaths that occurred in 2003, 37% were due to infection, while preterm birth and asphyxia accounted for 49%.

Common childhood diseases like Malaria, Acute Respiratory Infections (particularly pneumonia), Diarrhoea, Malnutrition and Vaccine Preventable Diseases (VPDs) especially measles are the leading causes of mortality and morbidity in Nigeria. These diseases are estimated to contribute to over 70% of deaths in children less than five years of age. In addition, they are the reasons for three out of four visits to health facilities by sick children. Based on the magnitude of these problems, several child survival programmes on control of diarrhoea diseases and acute respiratory infections, growth monitoring, breast feeding, immunisations etc have been instituted and are currently being implemented in the country. In 1997, the National Council on Health ratified the implementation of Integrated Management of Childhood Illness (IMCI) strategy as a main thrust of these efforts.

Despite all these, our health indicators for this age group have not been impressive. The annual incidence of acute diarrhoea is between 4.3 and 4.9 episodes per child. Nigeria with about 2% of the world population, contributes 8.1% of the global mortality attributable to pneumonia placing second after India. In addition, the NDHS 2003 reports that an estimated fifty-three percent (53%) of preschool children in Nigeria are malnourished.

Although Immunisation against childhood killer diseases (measles, neonatal tetanus, tuberculosis, whooping cough, poliomyelitis and diphtheria) is considered critical to survival of the child, national coverage in the target population fell dismally from 80% in 1991 to 17% in 1999 and 13% as reported by the NDHS 2003. Also, a 2001 report by the Federal Ministry of Health on the implementation of integrated management of childhood illness (IMCI) revealed that only 22% of health facilities visited during IMCI follow up visits provided routine immunization services. However, more recent reports from the FMOH (2006) indicate that over 30 states of the federation are implementing IMCI.

In the absence of documented national studies, a number of reasons have been advanced for this low coverage notably (a) Frequency of NIDs campaigns have resulted in public expectations that all forms of immunisation would be brought to their homes. (b) poor infrastructure for the distribution, storage and maintenance of

the vaccines i.e. cold chain at grass root level (c) higher motivation (in terms of social benefits) for health workers to carry out NIDS compared to routine immunization. (e) Absence of organized supervision, monitoring and evaluation of the routine immunization activities especially at health facility level. Fortunately over the last couple of years there has been significant improvement in logistics for the distribution, storage and maintenance of vaccines.

The summation of the problems highlighted above, is that one out of every five children born alive will not live to celebrate the fifth birthday given the under five mortality rate of 201 per 1000. Similarly, the Infant mortality rate is as high as 100 per 1000 live births *(NDHS 2003*).

2.2 Description

For purposes of the Ward Minimum Health Care Package, child survival consists of IMCI (including neonatal care) with particular emphasis on routine immunization...

(a) Neonatal Care:

Neonatal care (New born care), involves clean delivery of pregnant women, cord and eye care, early breast feeding (within 1 hour), exclusive breast feeding and temperature management. It also consists of community based care of low birth weight infants, including bonding i.e. skin to skin contact. There is need for skilled delivery care, resuscitation of new born with asphyxia, management of neonatal infections and provision of referral and outreach services.

(b) Routine Immunisation

The immunization programme in Nigeria involves provision of vaccines to children and infants to protect them from future illnesses namely tuberculosis, poliomyelitis, diphtheria, whooping cough, tetanus, and measles. This includes BCG, OPV, DPT and measles vaccines. In addition, vaccinations against yellow fever and Hepatitis B have also been included in the routine schedule due to their public health importance.

National immunization programme have been decentralized from national and zonal level, to the state and LGA levels. However, the problem of implementation at state and LGA levels appear to be persistent. For successful coverage, it is crucial that adequate support is provided to these lower tiers of government to enable them uptake their responsibility and functions for routine immunization.. The proposed minimum health care package to be provided at the ward level, would serve as an extreme form of this decentralization and should be handled cautiously as this may require substantial capital inputs. However, the role and confidence of the community in routine immunization would be enhanced. In addition to the re-establishment of routine immunization in health facilities, concrete efforts would be made to strengthen out-reach services to all communities.

(c) Integrated Management of Childhood Illness

The IMCI strategy aims to reduce childhood mortality and morbidity as well as promote the healthy growth and development of children less than five years in a

holistic manner, using cost-effective interventions. A World Bank report (*Investing in Health; 1993)* ranked IMCI among the ten most cost effective and cost beneficial interventions with the greatest potential for reducing the burden of disease in mid and low income countries. IMCI ensures accurate identification and treatment of childhood illnesses, prompt referral of severe cases, strengthening of preventive services such as use of insecticide treated nets (ITN), increasing immunization coverage and other health promotional activities in the homes, communities and health facilities.

IMCI as a strategy targets five major diseases malaria, measles, diarrhoea, acute respiratory infections (in particular pneumonia) and malnutrition that account for about 70% of childhood mortality and morbidity in developing countries. *(Paediatric Association of Nigeria, 1998)*. Further adaptation of the IMCI, has recently included newborn care, HIV/AIDS, birth preparedness and complication readiness.

Following the adoption of IMCI as a main thrust for child survival strategy by the National Council on Health in 1997, efforts were made to ensure the incorporation of IMCI into the curricula of the schools of Nursing, Midwifery and Health Technology. This process has since been completed. Furthermore, to date IMCI has been established in 32 states through the efforts of the federal and state ministries of health and Partners. It is to be noted that IMCI consists of three key components: (a) improving health workers' skills, (b) improving the health system, and (c) improving household and community practices and behaviour.

2.3 General Objectives:

- To reduce morbidity and mortality from childhood illnesses
- To promote healthy growth and development
- To revitalise and increase immunisation coverage

During the Plan period (2007-2012), the following targets will be achieved:

1. 70% reduction in morbidity due to the prevalent childhood diseases
2. 60% reduction in under-five mortality from 201 per 1,000 live births in 2003 to 80 per 1,000 by 2012
3. Increase coverage of health staff trained and number of facilities providing IMCI to at least 60%
4. Improving routine immunization coverage to at least 80% by 2012.
5. Empowering 60% of mothers/households with adequate knowledge for; improving key household and community practices, neonatal and child care.

2.4 Implementation Strategy:

Government will ensure effective case management of childhood diseases both at the health facility and at household level through the implementation of child survival strategies. In addition, promotion of preventive interventions for morbidity reduction, healthy growth and development such as immunization against vaccine preventable diseases, nutrition education e.g. breast-feeding, appropriate complementary feeding

and training of volunteers (CORPS) who would counsel care givers on the identification and management of common childhood ailments would be implemented.

Local government councils will collaborate with others in upgrading PHC facilities to provide quality neonatal and child care. LGAs will also support the sensitization of families and community groups on the care of newborns, infants and older children.

In order to accelerate the revitalization of routine immunization, increase and sustain coverage, the federal, state and local government authorities will ensure regular availability and effective distribution of all vaccines to the ward level. The ward health infrastructure would be positioned to perform this function while complementary efforts would be made to scale up outreach services. In addition, efforts would be made by all tiers of government in collaboration with Partners, relevant agencies and the community, to ensure the maintenance of an effective cold chain system. This will be achieved through adequate logistics, equipment and supplies, infrastructure development, financial and technical support; in order to ensure the potency of vaccines.

At the ward level, the WDC will be responsible for community mobilization, facilitating defaulter tracing and maintaining records of immunized children. In addition, health workers at this level will work closely with the WDC to implement routine immunization as well as maintaining necessary PHCMIS records and regularly make data returns to the LGA as part of the national health information system. In addition routine monitoring and supervision would be ensured at all levels.

2.5 *Minimum Health Package for Child Survival*

Based on the above a minimum package for child survival is proposed:

1. To have at least 60% of Health workers trained on IMCI in each Ward: the training is to pay particular attention to new born care and the need for prompt referral.
2. To have at least 30 trained and functional Community Resources Persons (CORPs) per Ward.
3. Each LGA to have adequate cold chain equipment {Deep freezers, cold boxes, vaccine carriers, ice-packs, constant electricity supply, alternative source of power supply}.
4. All facilities to have vaccine carriers and ice packs
5. Each LGA to have at least a designated motor vehicle or boat as appropriate; and each ward to have designated motorcycle as appropriate for distribution of Vaccines.
6. Every under-five child to be provided with a child health card.
7. Essential drugs including ORT (low osmolar) sachets, Zinc tablets and appropriate antibiotics to be available at all health facilities *{ refer: Essential drug list)*

Table 2a
PROGRAMME AREA - CHILD SURVIVAL

WORK SCHEDULE - Basic Immunization

No.	THRUST	Time Frame					Responsible Bodies
		YR1	YR2	YR3	YR4	YR5	
01	Determination of resources and need for routine immunization at LGA and Ward levels.						LGA, NPHCDA
02	Improvement in community mobilization, awareness and participation in defaulter tracing						WDC, CBO, LGA
03	Ensuring availability of cold chain equipment at all levels						NPI, NPHCDA, SMOH, LGA, WDC.
04	Facilitating adequate logistics for routine immunization						NPI, NPHCDA, SMOH, LGA, WDC.
05	Capacity building of health workers on cold chains maintenance						LGA, NPHCDA
06	Establishment of functional outreach sites						WDC, LGA, NPHCDA
07	Establishing functional primary health care management information system (PHCMIS) at ward level.						WDC, LGA, SMOH, FMOH, NPHCDA
08	Ensuring availability of child health cards						LGA, WDC, Partners

Notes:

1. The PHCMIS is part of the National Health Management Information System. It is an integral part of the monitoring and evaluation of the system.
2. The child health cards are used for growth monitoring, and immunization. Mothers are to be encouraged to keep their child health cards as precious document just the same way they keep their children's birth certificates.
3. The wards have some capacity for immunization. However, areas of deficiency need to be identified and corrective measures implemented before cold chains and outreach services are put in place.
4. An IEC strategy has to be in place while health personnel regularly conduct health/nutrition education in facilities and communities.

Table 2b
WORK SCHEDULE: Integrated Management of Childhood Illness (Including Neonatal care)

No.	THRUST	Time Frame					Responsible Bodies
		YR 1	YR 2	YR 3	YR 4	YR 5	
01	Advocacy and Re-orientation at ward and LGA level.						LGA, NPHCDA
02	Capacity building of Health workers and Community Resource Persons (CORPS): with focus on integrated maternal, newborn and child health care.						WDC, CBO, LGA, FMOH, NPHCDA, UNICEF, WHO
03	Ensuring adequate coordination and logistics mechanism for drugs and supplies						LGA, WDC, FMOH
04	Implementation of IEC strategies						WDC, LGA, FMOH, NPHCDA
05	Regular supervision monitoring and evaluation.						WDC, LGA, FMOH, NPHCDA, UNICEF, WHO

Notes

Capacity building would involve:

(i) Facility based case management
(ii) Supervision skills
(iii) Key household and community practices, for Care givers at household level, community groups (volunteers, teachers, transporters etc) and other community resource persons.

COMPONENT 3: MATERNAL AND NEWBORN CARE

3.1 Situation Analysis

The maternal mortality rate in Nigeria is estimated to be 800 per 100,000 live births, representing approximately 25% of all deaths in women of childbearing age *(MMR Aggregated Data; Family Health Division, FMOH 2005)*. This has been attributed to inadequate number of skilled health providers, low morale and poor utilization of services, poor quality of care, uneven access to emergency obstetric care, weak community support, lack of male involvement, and low status of women, poverty and low literacy levels. Lack of political commitment, inadequate funding of the health sector leading to deterioration of health infrastructures and services, have also been noted as key factors contributing to high maternal mortality in Nigeria. *(FMOH June 2002; NRHSFP)*

An estimated 40% of pregnant women suffer from pregnancy related problems; while 15-20 women suffer from debilitating conditions including pelvic inflammatory diseases, vesico-vaginal fistula and ruptured uterus secondary to obstructed labour etc *(Reproductive health Situation in Nigeria: ENHANCE Project 2005).* In addition, about three-quarters of the maternal deaths had been associated with complications of pregnancy and delivery, particularly haemorrhage, sepsis, abortions, hypertensive disease of pregnancy (pre-eclampsia and eclampsia), to mention but a few.

The National Demographic and Health Survey 2003 revealed that about 60.1% of women received antenatal care from health care professionals, 2.5% received antenatal care from TBA while 36.9% received no antenatal care at all. In addition, about 66.4% of pregnant women delivered at home or outside a health facility, attended by unskilled persons under possibly unclean conditions *(NDHS 2003).*

Closely associated with maternal health, is the family planning programme, which is a cardinal strategy for implementing the National Population Policy. The NDHS 2003 indicated that there was a high level of unmet needs for family planning, and the use of modern family planning was low. Therefore, family planning methods aim at assisting couples on deciding when, how often and at what intervals to have children as a means of deciding on a manageable family size. According to current statistics, Total Fertility Rate (TFR) is 5.7%, the present coverage of family planning services is 13% amongst currently married women with only 8% using modern methods. *(NDHS 2003)*

3.2 Description

Safe motherhood is an important health programme that contributes to the reduction of maternal, peri-natal, and under-five morbidity and mortality. In addition, the family planning programmes enable families to deal with traditional practices of having large families that exert extreme pressure on household income.

Whereas the public sector provides safe motherhood services as part of the public health programme, there exists a significant private sector involvement in this area. This mainly includes the traditional birth attendants, private for-profit maternity homes and NGOs. However, of concern to Government, is the regulation of the private sector

particularly with respect to the quality of care. Adequate maternal nutrition, promotion of breast feeding, improving contraceptive acceptance rates and legislation against harmful traditional practices such as female genital mutilation are essential for a successful safe motherhood programme. The programme also requires multisectoral efforts in the areas of human rights, female empowerment, education and other socio-economic sectors to achieve success. Some of the benefits of providing safe motherhood services at the ward level are to ensure that complications of pregnancy are prevented and where they occur, treatment can be offered or started and prompt referral effected when necessary. Community Resource persons (Teachers, VHW, TBA etc are invaluable in linking the community and families to Primary Health facilities. They provide supportive care during pregnancy labour and post-partum and so can be trained to recognize danger signs and advise women to seek early care at the health facility.

3.3 Objective: To reduce maternal and newborn morbidity and mortality

To achieve this objective, a number of targets have been set for achievement by the year 2012. These include the following:

- Reduce maternal mortality rate by 62.5% from 800 per 100,000 to 500 per 100,000 by 2012
- Reduce incidence of low Birth Weight from 14.5% to 10%;
- Reduce Peri-natal Mortality Rate from 20 per 1000 to 14 per 1,000;
- Increase proportion of pregnant women receiving ante-natal care from 60% to 80%;
- Increase proportion of deliveries attended by skilled birth attendants to 70%
- Expand utilization coverage of family planning services from 13% to 50%
- Eliminate female genital mutilation.

3.4 Implementation Strategy

A number of strategies will be utilized as a means of operationalizing this plan. The programme will adopt appropriate methodologies that would protect and promote the health of mothers and newborns. These would include the integration of priority interventions that would respond to the needs of the mother and the newborn, promote women and children's rights and ensure equity of access to quality care. In addition, there would be strengthening of the health system through capacity building and reduction of barriers to service utilization. Government and Partners at all levels would mobilise resources to support LGAs and Wards for the implementation of an integrated maternal, neonatal and child health service.

Furthermore, it is expected that family planning services would be expanded to cover a wide population.. Collaboration with Faith-based organizations, male involvement and participation will contribute immensely to this expansion. PHC facilities (Ward Health Centres) would be identified and upgraded as necessary for the provision of Basic Essential Obstetric Care (BEOC) which would also serve as a referral centre from other primary health care facilities within the Ward. In addition, an effective and efficient two way referral system would be reinforced between BEOCs (or any other

PHC facility) and secondary facilities. The collaborative efforts of the National Union of Road Transport Workers in the provision of vehicles for transporting referred cases would be invaluable.

To realize these targets, the programme will strengthen the management capabilities of Ward Development Committees. Promotion of safe motherhood and family planning services will be achieved through community mobilization, sensitization and targeted advocacy to community resource persons, traditional birth attendants, traditional and religious leaders, who would be engaged as change agents to promote service utilization and remove socio-cultural barriers and delays that prevent women from seeking prompt health care.

The LGA will be expected to provide adequately trained health personnel and equipment for health facilities. The FMOH will provide policy direction and in collaboration with the NPHCDA, would review and provide manuals, guidelines and curricula on integrated maternal, neonatal and child health as required.

3.5. Minimum Health Package for Maternal and Newborn Care

Based on the above the following minimum package for Safe Motherhood is proposed;

1. The establishment of One (1) Basic Essential Obstetric Care Centres (BEOC) in each Ward.

These centres would be;

- Adequately staffed including four (4) midwives or Nurse/midwife (double qualified) for 24 hours coverage. Basic staff skill would include ability to provide focused antenatal care, perform 'manual removal of placenta and placenta products; provide basic neonatal care and effective post natal care.
- Provided with the all basic obstetric equipments *(refer section on equipments).*
- Provided with adequate stock of Non-Pneumatic Anti-Shock Garment
- Provided with basic obstetric drugs; including oxytocin, misoprostol, sedatives and antibiotics. *(Refer: Essential Drug List)*
- Provided with transportation Facilities for referral.

Table 3
WORK SCHEDULE: MATERNAL AND NEONATAL CARE

No.	THRUST	Time Frame					Responsible Bodies
		YR 1	YR 2	YR 3	YR 4	YR 5	
01	Determination of community and health facilities needs.						LGA, WDC, NPHCDA, FMOH
02	Advocacy and Social Mobilization						LGA, WDC, FMOH
03	Establishing logistics for Supply and ensuring availability of family planning commodities and basic ante-natal/obstetric drugs.						WDC, LGA, SMOH, NPHCDA,FMOH
04	Implementation of a comprehensive IEC campaign						WDC, LGA, NPHCDA
05	Capacity building of health workers on RH, care of the newborn and basic clinical skills for safe delivery and prompt referral and midwives on Life Saving Skills (LSS), MLSS for CHEWs						WDC, LGA, FMOH, NPHCDA
06	Establishment of BOEC centres in LGAs.						LGA, WDC, FMOH
07	Establishment of Basic Voluntary and Counselling Services.						LGA, WDC, NPHCDA, FMOH
08	Establishment of an effective supervision, M&E programme						WDC, LGA

Notes

1. IEC Campaigns will involve (i) social mobilization, (ii) female and community education, (iii) health and nutritional education, (iv) benefits of family planning.
2. Advocacy includes mobilization of traditional, opinion and the religious leaders against adverse traditional practices such as female genital mutilation, early girl child marriage to mention but a few. In addition, LGA and State Executives would be advocated to ensure support and the provision of adequate and sustained budget line, funding and expenditure.
3. The provision of VCT under the minimum package for maternal and neonatal care would be linked to that of the HIV/AIDS programme and serve to provide an opportunity for HIV positive mothers to be referred to appropriate secondary facility for further interventions.
4. Programme officers/health workers in charge of maternal and child health at the wards and LGA level will conduct routine supportive supervision. It is expected to contribute to comprehensive data collection and improved quality of care.

COMPONENT 4: NUTRITION

4.1. Situation Analysis

The nutritional status of the vulnerable groups, notably women and children in Nigeria is poor. Although no current specific surveys have been done to quantify the extent of this problem, information available points to the existence of protein energy malnutrition, deficiencies of iron, iodine and vitamin A as being the leading disorders in the country. In addition, nutritional deficiencies have been found to contribute to high rates of morbidity and mortality in Nigeria, especially amongst infants and young children *(National Planning Commission, UNICEF 2001).* To a large extent, the feeding practices contribute to the prevalence of malnutrition. The Nigerian food consumption and nutrition survey 2003 indicates that 42% of children are stunted, 9% are wasted or thin and 25% are under weight. In addition, the survey revealed micronutrient deficiency in pregnant women to be 48% for iron, 34% for iodine, 19% for vitamin A and 42% for Zinc. For under-five, observed deficiencies were iron 34%, vitamin A 23.2% Zinc 20% and Iodine deficiency disorders (IDD) 27.2%.

Furthermore, recent data *(NDHS, 2003)* show that only 17% of infants below 6 months were exclusively breastfed. Amongst children aged 4-5 months, 36% received complementary food in addition to breast milk. Likewise, 23% of children under two months and 25% of those between 2-3 months drank from a bottle with nipples. Generally, the median breast-feeding duration is about 18.6 months.

For older children, aged 12-13 months, complementary foods were introduced late. About 13% of children received only breast milk or breast milk and water. Similarly, over the same period, for children under three years, stunting increased from 36% to 46% and wasting from 11% to 12%. Underweight children constitute about one third of those aged 12-35 months. In addition, only one fifth of breast fed infants aged between 6-9 months consume fruits and vegetables rich in vitamin A.

Furthermore, short stature secondary to malnutrition in mothers, increases both susceptibility to difficult labour on one hand and low birth weight babies on the other. While the 1999 NDHS reported that 70% of the mothers had short stature (height less than 145 cm), the 2003 NDHS reports some improvement with 64% of women with body mass index (BMI) falling within normal limits (18.5-24.9). However, 15% of women are reported to be overweight and 6% obese, with susceptibility to being overweight or obese increasing with age.

Micronutrient wise, the intake of vitamin A remains low with only about one fifth of women who gave birth between 1999 and 2003 receiving a dose of vitamin A within 2 months of delivery. Similarly 8% of women with recent birth at the time of survey reported experiencing night blindness. Regarding Iron supplementation, 40% of women received no iron at all during pregnancy. However almost all households in Nigeria utilize iodized salt (97%) *(NDHS 2003).* A recent Universal Salt Iodization (USI) Certification indicated a 98% iodization of salt in Nigeria

4.2. Description

In children, malnutrition of whatever form, increases the likelihood of mortality from a number of complications and disease entities. Likewise, micronutrient deficiencies also have implications for maternal health. Vitamin A deficiency increases proness to night blindness. Anaemia secondary to iron, folate and vitamin deficiency could increase risk of premature delivery and low birth weight. (NDHS 2003). Therefore, interventions to reduce malnutrition are important in order to avert maternal and childhood morbidity and mortality.

Nutritional status is intricately linked with availability and access to food. Food production in Nigeria is currently insufficient to meet the demands of a growing population *(population growth rate of 3.2%)*. Worse still, one third of food harvested is lost due to inappropriate processing, storage and poor distribution methods. Even when available, many households do not have the means to purchase enough food to meet the needs of members.

In order to address the disease conditions associated with nutritional deficiency disorders, a comprehensive approach that includes nutritional education, treatment of illness, food supplementation and fortification of commonly consumed food e.g. flour, vegetable oil and sugar; are being implemented. This process would be enhanced through effective collaboration between the health sector, other line Ministries, Agencies and the Private sector.

The interventions aimed at improving the nutritional status of the population are expected to reduce levels of wasting, stunting and underweight among children under five years. In addition, levels of vitamin A deficiency, iodine deficiency disorders and nutritional anaemia among women and children will be reduced. Furthermore, government would implement a behavioural change communication strategy to create awareness on health dietary practices for all age groups.

4.3 Objective: To improve and sustain the nutritional status of the ward population; and combat micronutrient deficiencies.

By the end of the plan period (2007-2012) we should achieve the following targets:

- Increasing exclusive breast-feeding for 0-6 months to 50%;
- Reduction in stunting among under-five from 42% to 20%, wasting from 9% to less than 3% and underweight from 25% to 10%;
- Reducing under-five with preventable blindness secondary to vitamin a deficiency to less than 15%;
- Reduction of protein energy malnutrition (PEM) by 50% in children under five years.
- Increase in the consumption of iodized salt among households to 100%;
- Increase in the proportion of households consuming staple food fortified with vitamin A and other micro-nutrients to 70%;
- Increase in the proportion of mothers/care-givers with knowledge of complementary feeding to 80%.

4.4 Implementation Strategy

To implement a comprehensive and effective nutrition programme in Nigeria, it should be recognized that the role of the other sectors is vital. It is therefore urged that, Government develops a national coordination strategy that will involve all the relevant sectors namely the Federal Ministry of Agriculture and Natural Resources, Federal Ministry of Health, National Food and Drug Administration and Control, and National Planning Commission. With proper coordination, it is expected that integration will be an important strategy at the lower tiers of Government. Improvement in food fortification and integration of vitamin A supplementation in routine health activities would expectedly drastically reduce micronutrient deficiencies.

The strategy of creating community awareness particularly at household level on behaviour that promote nutritional well being remains the cornerstone of this programme. Through a comprehensive ward health programme, effort will be directed to support and strengthen all relevant agencies in food processing, storage, and preservation using local technology. In addition, capacity building through training of VHW, TBA, CHEW, and JCHEW to provide knowledge on child feeding practices, as well as promoting breast-feeding, complementary feeding and nutritional management of sick children will be undertaken. In this regard, health workers will train volunteers and establish community-based growth monitoring centres. With the support of the WDC, strategies will be developed to encourage households to increase food production for consumption, through the use of, home gardens and community farming. Likewise, school authorities would be encouraged to promote the development of school gardens.

Furthermore, the synergistic effect of family and population planning would result in more manageable households and eventually translate to a healthier population.

4.5. Minimum Health Package For Nutrition

Based on the above implementation strategy, the following is proposed as the minimum package for nutrition:

1. Health and Nutritional Educational materials *(Refer: health education section).*
2. Provision of equipments for food demonstration in all wards. {Kitchen and Food demonstration space in designated health facilities, appropriate cooking implements, Appropriate refrigerating apparatus, Food demonstration charts, Plates, spoons etc, Trained health staff.}
3. Establishment of Community Based growth monitoring in all communities by trained volunteers, with appropriate equipment {Mosley scale, Tape rule, Child health Cards} and health facility based growth monitoring.
4. Implementation of food Security programme at household and community levels.

Table 4
WORK SCHEDULE: Nutrition

No.	THRUST	Time Frame					Responsible Bodies
		YR 1	YR 2	YR 3	YR 4	YR 5	
01	Capacity building on nutrition						LGA, WDC, SMOH, NPHCDA, Partners
02	Establishment and revitalization of community based growth monitoring centres; and promotion of clinic based GMP						WDC, CBO, LGA NPHCDA
03	Development and implementation of targeted nutrition IEC campaign						LGA, WDC, SMOH, FMOH
04	Strengthening food security programmes e.g. household gardens and community farming.						WDC, LGA, FMOANR
05	Establishing a nutrition surveillance system at the ward level						WDC, LGA, FMOH, NPHCDA
06	Instituting mechanisms for adequate supplies of food supplements to health facilities/communities						LGA, WDC, FMOH

Notes

1. Capacity building should include training of CHEW, JCHEW, TBAs, VHWs and CORPs on (i) the importance of breastfeeding, (ii) food supplementation, (iii) community based growth monitoring, and (iv) food storage and preservation
2. Growth monitoring centres will be equipped with weighing scales, registers, manuals and other instruments necessary for growth monitoring.
3. IEC strategy will be an integral part of the ward IEC programme and will include such information as (i) exclusive breast-feeding, (ii) food supplementation (iii) nutrition in pregnancy, (iv) nutrition deficiency diseases and (v) food security.
4. Community demonstration gardens will focus on school and home gardens.
5. Integrate vitamin A supplementation into the routine immunization programme.

COMPONENT 4: NON- COMMUNICABLE DISEASES PREVENTION

5.1. Situation Analysis

With progressive urbanization, industrialization and increased consumption of processed food, chronic and non communicable diseases (NCDs) have begun to emerge as an important public health problem in many developing countries, Nigeria inclusive. Although no comprehensive data exist on the prevalence and morbidity from NCDs, the following are noted to be increasing in prevalence in Nigeria; hypertension, coronary heart disease, sickle cell disease, Diabetes Mellitus, smoking related diseases, cancers, oral health and mental Health conditions, occupational related diseases (e.g. asbestosis and silicosis), malnutrition and bronchial asthma.

In an effort to address this trend, the Federal Ministry of Health established a NCD programme in 1989, and inaugurated an expert committee to formulate suitable programmes for the early detection, prompt treatment and effective control of NCDs. Till recent times however, these efforts have been focused on the curative aspects of NCDs and centered around secondary and tertiary health care facilities. Currently efforts are being made globally and nationally towards the promotion of healthy lifestyles through behavioural change communication (BCC) strategies for the prevention and control of NCD. In addition, recent policy thrust of the government of Nigeria towards tackling smoking related diseases has resulted in the ban of public adverts on cigarettes.

5.2. Description

The chronic nature and slow onset of most NCDs causes late clinical presentation by patients. Often, patients present after the manifestation of recognizable complications e.g. stroke/hemiplegia, heart attack, or diabetic coma etc. The prevention of NCDs requires individual to take health action without any ‘apparent’ health problem. Therefore it is necessary that health education is provided with clarity and in a medium that can be easily understood by a majority of the targeted population. In addition, the genetic/familiar nature of some NCDs e.g. Sickle cell disease, hypertension and cardiac problems etc have frequently in the past, led to superstitious beliefs amongst various communities.

It is also essential that a functional two way referral system is established to ensure prompt referral of diagnosed cases and community based management.

5.3. Objective

The objective for the minimum health package for NCDs is to provide preventive measures through comprehensive health education packages, capacity building for healthful living, early diagnosis, prompt referral and management; with the aim of reducing the incidence, prevalence and complications of NCDs.

5.4. Implementation Strategy

The key strategy for implementing the NCD programme shall be through health education, information and communication. The populace would be educated on risk

factors for NCDs and their primary prevention through avoidance. Communities would be educated on adopting healthy life styles and the causes of NCDs, possible symptoms, the 'familiar' (hereditary) nature of some NCDs and available treatment.

To effectively implement this strategy, health workers including TBAs/VHWs would have their capacity built to recognize prevalent NCDs in their communities, create awareness, develop and implement comprehensive health education packages, recognize early symptoms and institute necessary health action. In addition health workers would be required in certain cases to initiate treatment, effect necessary referral and provide community based management and follow up.

At State and federal levels, advocacy, enforcement of regulation, policy development and implementation, would be targeted at relevant manufacturers, corporate entities and advertising agencies regarding the content and quality of their products; as well as health information provided on processed food, cosmetics and related items. In addition, routine monitoring, supervision and regulation of industrial safety measures would be instituted and enforced by government at all levels.

5.5. Minimum Health Package for Non-Communicable Diseases:

Based on the above, the following minimum package on NCDs is proposed at the primary care level:

1. Phased capacity building of health workers for prevention and control of NCDs in all facilities.
2. Availability of IEC materials on NCDs displayed in all Facilities.
3. Provision of basic equipments for screening and early diagnosis of NCDs i.e. Sphygmomanometer, Weighing Scale, Hyetometer, Urine Test Kits etc. (Refer section on equipment)

Table 5
WORK SCHEDULE: Non Communicable Disease

No.	THRUST	Time Frame					Responsible Bodies
		YR 1	YR 2	YR 3	YR 4	YR 5	
01	Advocacy, Awareness creation and social mobilization.						WDC, LGA, SMOH, FMOH NPHCDA
02	Promotion of case management of NCDs at health facility and community level						LGA, NPHCDA
03	Capacity buildings of service providers on early case detection and management						LGA, FMOH, NPHCDA
04	Development and implementation of IEC/BCC strategies.						FMOH, SMOH, NPHCDA, LGA, WDC.

COMPONENT 6: HEALTH EDUCATION AND COMMUNITY MOBILIZATION

6.1 Situation Analysis

The NDHS 2003 indicated that approximately 46.1% females and 30.5% males respectively had received no education. There are also obvious indications that health knowledge and practices are still at a low level of development. In pursuit of achieving higher levels of community mobilization, Government is implementing health education programmes on the different areas of Primary Health Care. This campaign tends to emphasize health talks, mass communication, distribution of pamphlets and posters. However, in spite of these efforts, it has been recognized that most of these activities have been limited to health facilities, and effective community outreach services have been constrained by inadequate resources. Trained health educators are also in short supply at all levels.

6.2 Description

Health seeking behaviour in any population is dependent on a wide range of socio-economic factors that influence knowledge, attitudes and practices. In many cases, morbidity and mortality are the result of either as a result of ignorance, poverty and cultural practices that reduce the scope for independent decision making within the population. In addition, there are many taboos and misconceptions about causes and management of disease or ill health.

The health education programme will provide information on health promotion, disease prevention at community and individual levels. This requires creating awareness, demand and utilization/patronage of health services and programmes. A deliberate effort to improve collaboration and participation will be implemented.

6.3 Objective: To promote community and individual participation and responsibility for health.

Behavioural change in the individual and the community requires the provision of basic information that enables them make informed decision and take appropriate actions in order to practise healthier lifestyles.

By the end of the plan period 2012:

- 80% of the community members will be aware of prevalent health problems, related social causes and how to prevent them;
- 80% of the health facilities/communities will have adequate supply of appropriate and targeted IEC materials.

6.4 Implementation Strategy

This Plan of Action sets out a number of health interventions that will be implemented at the lowest level of the health care system. The main strategy therefore, will include development of integrated and targeted IEC messages, and will require an understanding of the community's health problems.

At ward/community level, the programme will include training all categories of health workers especially health educators and community based health workers (JCHEW, VHW, TBA) on IEC strategies. The health workers at this level will work closely with LGAs, States and other agencies to develop and disseminate relevant health messages.

The WDC together with the health workers and teachers at the ward/community level will conduct school health education programmes as a strategy for reaching the children. Appropriate advocacy methods to elicit support from community leaders will be developed.

6.5 Minimum Package For Health Education And Community Mobilization

Based on the above targets the following minimum package for health education and community mobilization is proposed:

1. At least two (2) Health workers and two (2) members of the VDC/WDC per ward are trained as Health Educators.
2. Every facility to have relevant I.E.C materials conspicuously displayed with cultural acceptable language and graphics.
3. A logistic vehicle or motor cycle with public address system to be available at LGA level for the purpose of health education.

Table 6
WORK SCHEDULE: Health education and Community Mobilisation

No	THRUST	Time Frame					Responsible Bodies
		YR 1	YR 2	YR 3	YR 4	YR 5	
01	Determination of IEC requirements at the community level						LGA, WDC, FMOH, NPHCDA, FMOI, NOA
02	Development and implementation of comprehensive IEC strategies at ward level						WDC, LGA, NPHCDA
03	Production and logistics for dissemination of IEC materials						WDC, LGA, NPHCDA, FMOH
04	Promoting community mobilization through IEC campaigns						LGA, WDC, VHC, NOA, NGO, FBO,
05	Capacity building of Health workers and other stakeholders on health promotion and communication and counselling skills						LGA, FMOH, NPHCDA, NGOs
06	Advocacy						LGA, FMOH, NPHCDA,SMOH

Notes

1. Identification exercise takes into account the prevalent health problems of the target ward or community
2. Comprehensive IEC strategy involves (i) child survival including immunization, (ii) maternal and neonatal care, (iii) STD/HIV/AIDS, (iv) malaria, (v) tuberculosis, (vi) nutrition and (vii) messages on other health interventions of public health importance (water & sanitation, epidemic preparedness). In addition, school health programmes will be included in this activity.
3. Training will be targeted at community health workers, school teachers, and traditional leaders.

PART 3: COMMON SUPPORT SERVICES

Common support services include those services on which the implementation of all the technical components of the wards minimum health cares package is based. For purposes of this Plan of Action, these services include (a) Essential Drugs; (b) Health Manpower or Human Resources; and (c) Health Infrastructure (buildings, equipment etc.)

7.1 ESSENTIAL DRUGS

7.1.1. Situation Analysis

The global recession and the unprecedented fall in oil price of the 1980s, and the introduction of the Structural (economic) Adjustment Programme, led to a significant reduction in public health expenditure. As a result essential health supplies were persistently in short supply. As a means to bridge this gap, User fees were introduced in public health facilities *(NPHCDA, 2001)*.

Drug production and marketing has been dominated by multi-national firms, which has influenced the prescription practices in the country. As such, there was scarcity and irrational use of drugs in the public health sector. Hence government had to rationalize the procurement and prescription of drugs to the most basic ones needed to manage at least 80% of the prevailing disease conditions at all levels. These drugs are referred to as Essential Drugs. In this regard, a comprehensive drug programme was established to improve the quality of drugs, reduce cost, encourage rational use, and improve physical and economic access and use of generic brands. In addition, Drug Revolving Fund (DRF) schemes were introduced and implemented. The Bamako Initiative (BI) is one of such schemes introduced in 1987 to ensure that (a) essential drugs are available at public health facilities and at affordable prices, (b) income accruing from drugs sale is revolved for the replenishment of drug stock for sustainability, (c) enhanced community empowerment to participate in the management of the programme, and (d) surplus income is available to finance health.

In a survey of 202 LGAs in 2001, 79% were found to have a drug revolving fund in place and 73% had essential drug lists available. However, only 27% have all essential drugs available at the time of survey. At the village health system level, only 25% of the 698 sampled communities had a drug revolving fund in place and only 10% had evidence of cash at hand *(Needs Assessment Survey; NPHCDA, 2001).*

7.1.2. Description

Ensuring the availability of essential drugs is a function of Government. Besides, to control and manage health conditions/diseases identified for implementation at the ward level requires a range of essential drugs. As such the aim of this provision in the Plan of Action is to ensure that the ward health system has adequate supply of safe and efficacious essential drugs and other medical sundries required to deliver the Minimum Health Care Package. Where deficiencies can be overcome by community contributions, schemes such as user-charges or drug revolving fund

based on the Bamako Initiative will be implemented. This is to ensure availability, sustainability and efficient management to discourage irrational use of drugs.

7.1.3. Objectives

- To ensure availability and accessibility of safe and efficacious essential drugs and other medical supplies in all ward facilities
- To set up and strengthen the effective management of essential drugs and drug revolving schemes at the primary level of care.

To achieve the above objectives, the following targets are being set for the plan period: 2007 - 2012

- 80% of all health facilities within the ward health system to have adequate, safe and efficacious essential drugs and other medical supplies;
- Establishing drug revolving funds in at least 50% of the wards and ensuring that they are well managed and operational.

7.1.4 Implementation Strategy

Essential drugs are a vital component of medical care. To maintain a constant supply of these inputs, effective public supply and management is important. Therefore, during the plan period, Government will continue to procure and distribute essential drugs and other health supplies. The community will develop effective management systems and storage of these supplies. The role of drug revolving funds on increasing community empowerment and availability of essential drugs is recognized. Therefore, more communities will be encouraged where feasible to implement these schemes within the Ward Health System. To this end, the Ward Development Committee will be responsible for establishing an essential drug supply and management system in close collaboration with the LGA health department.

All these initiatives will be executed in line with NPHCDA guidelines for drug replenishment, drug policies particularly the LGA drug policy, and the recommended LGA Essential Drug list. In addition, there will be institutional development and capacity building especially of health workers in rational use of drugs and drug management. The Ward Development Committee and health workers will promote health initiatives and undertake social mobilization through information, education and communication (IEC) campaigns.

Table 7a
WORK SCHEDULE: Essential Drugs

No.	THRUST	Time Frame					Responsible Bodies
		YR 1	YR 2	YR 3	YR 4	YR 5	
01	Establishment of effective essential drug management system at the ward level						LGA, WDC, NPHCDA
02	Developing and implementing a comprehensive inventory control system						WDC, LGA, NPHCDA
03	Capacity building of health workers on rational use of drugs.						LGA, WDC
04	Monitoring and supervision of health workers on prescription practices						WDC, LGA, NPHCDA
05	Establishment and reactivation of Drug revolving fund schemes at community level.						LGA, Partners, NPHCDA

Notes

1. Effective essential drug management involves procurement (where applicable), storage, and distribution. In wards where storage is lacking, provision has to be made. Other medical/health supplies *(sundries, laboratory reagents, beds, linen)* will be managed similarly.
2. Inventory control system for the ward level will be linked with the LGA, State and FMOH system. This inventory will include the list of essential drugs supplied/procured; stocks in store, daily quantities dispensed (may need to harmonize this with existing)
3. Training programme for health workers includes training on rational use, prescription habits, and management
4. Drug revolving schemes here mainly refer to the Bamako Initiative Strategy. Establishing the system would involve training and re-training of health workers and community members (WDC).

5. ***For the listing of Essentials Drugs; refer to the Essential Drug List (Department of Food and Drugs Federal Ministry of Health, Abuja).

7.2 HUMAN RESOURCES FOR HEALTH

7.2.1 Situation Analysis

Human resources for health in Nigeria are the responsibility of the three tiers of Government, namely the Federal, State and Local Governments. Currently, relevant service commissions have been established for recruitment of personnel. As such, primary health care personnel are the responsibility of the Local Government Service Commission.

The current staffing levels of health facilities in terms of numbers, cadres, and salary scales in the country cannot be established as this varies significantly between the three tiers of service delivery. Although minimum staffing levels are not clearly described, there is available information giving a clear description of the various categories required at the lower primary health care level *(Operational Guidelines for PHC, NPHCDA 2004)* However, Human Resources for Health (HRH) Policy was passed at the National Council on Health (NCH) in January 2007. There is on-going work to develop staffing norms and a costed strategic HRH plan will be invaluable in determining the staffing needs of facilities.

The staff/population ratio for senior PHC staff varies between zones of the country. For instance, for the medical officers of health, the South West zone has a ratio of 1:164,110 compared to the North West zone, which has a ratio of 1:480,313. In the same area, for the PHC health personnel notably the community health officer (CHO), the North Central zone has a ratio of 1:20,494 compared to the South East zone with a ratio of 1:59,679 *(Report of a Needs Assessment Survey, NPHCDA, 2001).* This indicates that staffing levels vary between health cadres. It is noted in the same report that PHC technical support staffs are in short supply. In general it was estimated that less than 50% of the LGAs had laboratory technicians, 40% had medical records officers and 20 dental assistants. The survey concluded that the rural areas had junior and less qualified staff as compared to the urban health facilities, which had high concentration of senior PHC staff.

Current data from the Human Resources for Health Division, Federal Ministry of Health, estimated that although 38,800 medical doctors and dentists of varying qualifications have been registered in the country as at December 2005 only 16,626 appear to be actively practising within the various states of the country; with an approximate doctor- population ratio of 1:8000. The same records also showed that only a total of 19, 268 community health practitioners are operating within the country. Although registered Midwives were estimated at 87, 171 (approximately 1:1,600); there is a disproportionate distribution between the urban and rural areas. In addition, it is recognized that there is 11-16% variation between the actual numbers practicing in the country and registered personnel due to attrition at all levels. This is in part attributed to poor incentive structures and non employment of qualified health workers.

7.2.2 Description

Human resources for health are vital for successful implementation of the Ward Minimum Health Care Package. To ensure that staffing requirements are met, Government established schools of health technology to produce junior community

health extension workers, community health extension workers and other support staff, namely the medical laboratory assistants, pharmacy technicians, medical records officers, and the dental technicians. The medical schools and teaching hospitals in various parts of the country train doctors and community health officers, while the schools of nursing and midwifery train nurses and midwives.

During the implementation of the Ward Minimum Health Care Package, deliberate effort will be made to (a) develop a strategy of improving staff retention, and (b) ensure that the infrastructure development matches the human resource development. This will be done in close collaboration with the LGA.

7.2.3 Objective:

To ensure that the ward health system meets the national minimum staffing standards/requirements to provide appropriate and quality primary health care services.

To achieve this objective, the following targets are recommended:

- At least 80% of PHC facilities should meet the minimum staffing standards by 2012;
- All the health personnel on the payroll should receive their salaries promptly and regularly;
- At least 80% of all health workers receive continuous medical education by 2012
- 80% of the ward population seeking health care should be attended to by trained health personnel
- To establish a school of midwifery in every state of Nigeria.
- To ensure workers in difficult terrain are provide with incentives.

7.2.4 Implementation Strategy

Human resource development requires substantial inputs in terms of training, time and logistics. In addition, personnel costs account for a big proportion of public expenditure at the Federal, State and LGA levels.

This Plan of Action recognises that human resource development costs will be met by levels higher than the ward. The Ward Development Committee in collaboration with health workers would play a crucial role in (a) overseeing the activities of the health workers in terms of attendance, pricing of drugs safety of equipment and materials etc and (b) selection and recommendation of community members for training as community health extension workers, CORPs etc,, and (c) workout appropriate incentives for TBA/VHWs and CORPs.

The LGA, with support from the state, federal and Partners, will be responsible for training and re-training of health workers. There is also a need for the LGAs to improve skills of its health staff through appropriate training. It is expected that an enabling bill would be passed to ensure that LGAs have adequate funds to employ the minimum recommended number/cadre of health staff and pay their salaries on a

sustainable basis. Furthermore, the LGAs would be encouraged to develop or enforce existing performance based evaluation and result oriented management on which staff promotion will be based. States are expected to train and employ more midwives. Relevant policies should be developed to ensure the provision of incentives to health workers in difficult terrains.

7.2.5 Proposed Health Manpower for a PHC Health Centre (Ward Health Facility)

Based on the recommendation of the World Health Organization (1994), the World Bank Publication (1995), Tulsi Chanrai Foundation report of 2001 and findings on PHC from the case studies of three Primary Health Centres in Nigeria, carried out in November 2001, the following is proposed as the minimum health manpower requirement for Primary Health Care: (*Operational Guidelines for PHC; NPHCDA 2004)*

A. Health Post

1 JCHEW

B. Primary Health Clinic

2 Community Health Extension Workers
4 Junior Community Health Extension Workers

C. Primary Health Centre *(Ward Health Centre)*

1 Community Health Officer (CHO)
1 Public Health Nurse (PHN)
3 Community Health Extension Workers (CHEWS)
- 1 CHEW is responsible for statistics
- 1 CHEW is responsible for Drugs
- 1 CHEW is responsible for Equipment

6 JCHEW
4 Nurse/Midwives
1 Medical Assistant (optional)

Where available, a Medical Records Officer, should be in charge of Statistics and a Pharmacy Technician in charge of drugs. .
Notes: Where available a medical officer or an orientated NYSC doctor should work from the ward Health Centre. In addition, at the Ward level there should be an active Ward Councillor and a functional Ward Development Committee.

D. PHC Department (at the LGA Secretariat)

Functional LGA PHC Management Committee
1 MOH as PHC Coordinator/Director.
3 CHOs as Assistant PHC Coordinators.
1 Nurse/Midwife
2 - 3 EHO
2 CHEWs
2 JCHEWS
1 Administrative Officer.

Notes:
In the absence of a Medical Officer of Health, the most Senior CHO will function as LGA PHC Coordinator.

The network of health centres in the local government provides the operational base for implementing the package of activities using a minimum of qualified staff mentioned above. The financial burden is being shared between the clients using the health centres, the communities, government and external partners. The proposed staff strength is expected to improve health care delivery as a foundation for social economic development. LGAs can adapt the profile to their particular circumstances in order to ensure child survival, improved maternal and neonatal care and a healthy work force.

Table 7b
WORK SCHEDULE: Health Manpower for Ward Health System

No	THRUST	Time Frame					Responsible Bodies
		YR1	YR 2	YR 3	YR 4	YR5	
01	Undertaking human resources audit and determine optimal staffing requirements for the ward health system						NPHCDA, FMOH, SMOH, LGA, WDC
02	Establishing an effect monitoring and supervisory system.						WDC, LGA, NPHCDA
03	Developing modalities to encourage the selection of indigenous community members for training as community health workers and their recruitment.						LGA, SMOH, WDC, NPHCDA
04	Facilitating the provision of incentives for volunteer workers.						WDC, LGA

Notes
1. The staffing requirements will be judged against the minimum staffing standards established by the NPHCDA. It is assumed that the Ward Health staffing structure will be defined to guide this process.
2. One of the key functions of the WDC is to collaborate with health workers in supervising some activities within and outside the health facility. The WDC or relevant LGA authority at the ward level will develop guidelines for community health worker appraisal.
3. Community Health Workers here include JCHEW, VHW and TBA

7.3 **HEALTH INFRASTRUCTURE/FACILITIES**

7.3.1 Situation Analysis

Nigeria has a wide range of health facilities distributed all over the country. As at the year 2000, publicly owned facilities in Nigeria included 33 Tertiary hospital; 2,990 Secondary health facilities; and 20,209 Primary health care facilities *(Health facility data Base in Nigeria, FMOH; 2000)*

At the LGA level, Primary Health Care (PHC) facilities are classified into four (IV) types:

Type I: Health Posts, and Dispensaries
Type II: Primary Health Clinics,
Type III: Primary Health Centres
Type IV: Comprehensive Health Centres

Type I: Each community is expected to have one health post or dispensary. However, available information indicates that many communities are underserved *(Report of a Needs Assessment Survey, NPHCDA, 2001)*.

Type II: A group of communities with an approximate population of 2000 people should have a Primary health Clinic.

Type III: The distribution of primary health centres in the LGA is not equitable within and between the various geo-political zones in the country.

Type IV: There is a minimum requirement to have at least one comprehensive health centre/general hospital for each LGA and a number of other health facilities. However, in recent times this requirement is not always met, as most comprehensive health centres are being up-graded to General or Cottage hospitals..

Apart from the public facilities, Nigeria has a large number of private for profit facilities concentrated in the urban areas. These range from private clinics to specialized hospitals.

7.3.2 Description

A Federal policy on health infrastructure development exists and stipulates the number of health facilities by level. The National Health Policy recognises the role and contributions of other government departments namely Ministries of Works, the State and the Local Government Authorities in developing the state master plans of requirements for health facilities. In this regard, the Federal Ministry of Health in collaboration with its parastatals is mandated to review the, staffing, design, equipment, and cost of investments among others.

It is estimated that 40% of people in Nigeria live at least 5 km from a health facility. This level of access is low given the current levels of health facilities in the country. Many studies published and unpublished indicate that there has been deterioration of public health facilities in the last decade. This among other reasons is responsible

for the under utilisation of public sector health facilities compared to private sector facilities.

A health infrastructure development plan at the LGA level taking into account the existing stock and facilities that have to be rehabilitated and equipped needs to be developed. This will enable the wards identify underserved areas and dilapidated ones.

7.3.3 Objectives:

1. Increase physical access to health services from 40% to 60% of households
2. Rehabilitate and equip LGA health facilities in the ward
3. Upgrade at least 50% of primary health care facilities and reorganise services with particular focus on maternal, neonatal and child care.
4. Develop an effective ward health facility maintenance plan

7.3.4 Implementation Strategy

These objectives will be achieved through the constructions of new health facilities, procurement of medical equipment, providing resources for maintenance of existing health facilities and rehabilitation of dilapidated health facilities to full functionality. Whereas the main focus is the Ward Health System, resource inputs for health infrastructure development have to be provided for, from budgetary allocations to the Federal, State and local governments. Community efforts to provide additional health facilities will be supported through the WDC.

The health infrastructure development programme will concentrate on PHC facilities described above. More emphasis will be put on Primary Health Centres, which would serve as a means of improving access to the ward/ communities. However, the development plan should match the human resource availability.

Table 7c
ACTIVITY SCHEDULE: Health Infrastructure Development

No	Activity Description	Time Frame					Responsible Bodies
		YR 1	YR 2	YR 3	YR 4	YR 5	
01	Determining health infrastructure and equipment requirements for the ward health system.						LGA, WDC, FMOH
02	Coordinating and undertaking new construction and rehabilitation of ward facilities and supply of equipment.						LGA, WDC, FMOH
03	Developing and facilitating the implementation a facility maintenance plan						WDC, LGA, NPHCDA
04	Developing modalities for private, public partnership in providing health infrastructure						

Notes

1. Identification of infrastructure includes quantifying the gap and resources needed for new construction and rehabilitation.
2. Maintenance of health facilities requires financial inputs, which should be regularly provided by the LGA through their budgetary allocation to the Ward Health System. It is assumed that LGA allocation for this function will increase as some of the targets for infrastructure development are realized. In addition, Health workers and the WDC would be trained on facility maintenance.
3. Private/community development of health facilities should be properly coordinated. In some instances this development may be in underserved areas where the Wards may not be able to cover. Such initiatives should be supported. Modalities for this support have to be developed.
4. Propagation of the concept of the ward health system at state and LGA levels including within the private health sector.

PART 4: OTHER INTERVENTIONS OF PUBLIC HEALTH IMPORTANCE

8.1 Description

Health and health intervention provision extends beyond the health sector. Several programmes that affect the health status of the people are situated in other departments of Government e.g. agriculture, water resources, education, works and housing. In addition availability of access roads to health facilities significantly influences their utilization.

Interventions of public health importance considered here include (a) water and sanitation (b) emergency preparedness and response. The following section will highlight activities that the Ward Development Committee may undertake as part of community mobilisation, due to the limited role the health sector has in the provision of these services,

8.2 Water Supplies and Sanitation

Clean water is important for improving personal hygiene and reducing transmission of communicable (and parasitic) infections. Similarly, proper disposal of solid and human wastes, contribute significantly to reduction in the transmission of vector diseases. Both contribute to the reduction of morbidity and mortality. This indicates that access to potable drinking water and adequate sanitation facilities are important determinants of health.

The NDHS 2003 estimates that only 42% of Nigerian households have access to potable water supply. About 30% of urban and 20% of rural populations have access to proper and satisfactory excreta disposal systems respectively; with 15% of households utilizing flush toilets, and a majority (57%) using the traditional pit toilets, others have no facility whatsoever.

Water provision and distribution in Nigeria is the function of the three (3) tiers of Government (Federal, State and Local Governments). Bilateral organizations and the private sector also assist in the provision and distribution of water. While the Federal and State governments provide pipe borne water to about 25% of the population, the local governments, bilateral organizations and the private sector organizations provide boreholes and public wells to over 40% of the population. The remaining 35% of the population get water from rivers, dams or ponds. Thus only 4% of rural households use pipe borne water in their residence compared to 24% of urban households. Furthermore, a third (32%) of rural households obtains drinking water from rivers and streams. This situation is expected to improve with the new strategy being implemented by the Water Resources Ministry *(Improved Natural Access to Water supply and Sanitation, June 2000).*

8.2.1 Role of the Ward Development Committee in Water Supply and Sanitation

The role of the WDC includes creating and improving awareness on the importance of safe water and sanitation through community mobilization. Through this campaign,

they are expected to contribute to the realizations of national objectives of access to regular potable water within 1km or 15 minutes of walking distance from a source and implementing proper waste disposal. Furthermore, with effective community mobilization, advocacy and collaboration between intergovernmental departs at LGA, State and Federal level, additional sources of potable water can be established with the wards.

8.3 Emergency Preparedness and Response

Disasters are unforeseen situations with serious and immediate threats to public health (WHO Definition). These could be man-made (e.g. fire, explosions, conflicts) or natural (e.g. flooding, epidemics and earthquakes).
Intra and inter-communal conflicts, civil unrest, oil spillages, flood and kerosene explosion are on the increase in Nigeria, suggesting the need to increase awareness beyond epidemics to other issues of public health concern.

8.3.1 Role of the Ward Development Committee Emergency Preparedness and Response

A National Working Group on Emergency Preparedness and Response (National Emergency Management Agency) exists and was mandated to develop guidelines on emergency response. The involvement of the health sector, particularly at the ward level will supplement these efforts. Therefore, the activities at the ward level would include putting in place adequate contingency plans to contain the effects of disasters, emergencies and epidemics. At the ward and community levels, the strategy is to focus on creating community awareness, mobilization and building the capacity of the community, WDC, and health workers to handle home accidents, disasters and emergencies. The strategy will also be to put in place an early warning systems e.g. DSN to give the WDC and health workers some indication of impending emergency situations, or strengthen communication channels and immediate relief measures in the case of Natural disasters.

NEMA and Federal Ministry of Health would be expected to collaborate with relevant Agencies and personnel at the State and LGA level, to develop necessary capacity, infrastructure and communication channels for emergency preparedness and responses.

Appendix I:

Essential Equipment List for Primary Health Care Centre (Reference: equipment list for model ward health centres)

S/N	Item description	Qty required
	Female ward	
1.	Angle poised lamp	1
2.	Artery forceps (Medium)	4
3.	Bed pan (stainless steel)	2
4.	Bowls stainless steel with stand	2
5.	Ceiling fan	2
6.	Plastic chair (President)	2
7.	Stainless covered bowl for cotton wool	2
8.	Graduated medicine, cup	2
9.	Dissecting forceps	2
10.	Dressing scissors	2
11.	Dressing trolley	1
12.	Drinking mug	2
13.	Dust bin (Pedal)	2
14.	Galipot (median)	1
15.	Gloves, disposable pack of 100	2
16.	Hospital bed and mattress coved with Macintosh	6
17.	Stainless Instrument tray	1
18.	Forceps Jar	1
19.	Kerosene pressure lamp	1
20.	Kidney dishes (large)	4
21.	Length measure for babies	1
22.	Long benches	1
23.	Mackintosh sheet	6
24.	Pump, breast, hand rubber bulb	4
25.	Refrigerator (kerosene)	1
26.	Screen	1
27.	Sphygmomanometer mercurial (Accossons) Table top	1
28.	Stethoscope (Littman)	1
29.	Stitch removal/suture scissors	1
30.	Writing Table	1
31	Tape measure	1
32	Thermometer, oral	2
33	Thermometer rectal	2
34	Tongue depressor	2
35	Vaginal speculum, Sims, set of 3	2
	LABOUR	
1.	Artery forceps (Medium)	4
2.	Bed pan, adult stainless steel	2
3.	Stainless Bowls with stand	1
4.	Ceiling fan	1
5.	Plastic Chairs (president)	1

6.	Covered bowl for cotton wool	1
7.	Delivery couch	2
8.	Dissecting forceps	1
9.	Dressing trolley	1
10.	Dust bin (Pedal)	1
11.	Enema can	2
12.	Episiotomy scissors	2
13.	Foetal stethoscope (Aluminium)	2
14.	Stainless Galipot	1
15.	Gloves, disposable pack, pack of 100	4
16.	Instrument tray	1
17.	Forceps jar	1
18.	Kerosene pressure lamp	1
19.	Kidney dish	2
20.	Length measure for babies	1
21.	Mackintosh sheet	2
22.	Nail scrubbing brush, box of 12	1
23.	Needle holder	2
24.	Scalpel blade, pack of 100, 4 sizes	3
25.	Scalpel handle, set of 2	2
26.	Catheter tray with cover	1
27.	Sphygmomanometer, mercurial (Accosons) Table top	1
28.	Sponge holding forceps	4
29.	Stethoscope (Littman)	1
30.	Suture needle	1
31	Syringes & Needles (100)2cc,	5
32	Syringes & Needles (100) 5cc,	5
33	Syringes & Needles (100) 10cc,	1
34	Thermometer, oral	1
35	Vaginal speculum, Sims set of 3	2
36	Wall clock	1
37	Water container with tap	1
38	Screen	2
39	Soap/disinfectant dispenser	1
40	Scrub brush dispenser	1
41	Nursery costs	1
42	Angle poised lamp	1
43	Vacuum extractor, manual	1
44	Suction pump	1
45	Weighting scale, baby	1
46	Instrument cabinet	1
47	Tape measure	1
48	Thermometer jar	1
49	Urinary catheter	3
50	Umbilical cord clamp, pack of 100	1
51	Drip stand	2
52	Suture kit	1
53	Oro-pharyngeal airway, set of 7	1

54	Plastic apron	10
55	Anvard's speculum	1
1.	**LABORATORY** Kidney dish (medium)	1
2.	Box, microscope slide (x100)	1
3.	Centrifuge, manual	1
4.	Clam, test tube	1
5.	Container, sputum screw capped	50
6.	Container, sputum, snapped on lid	50
7.	Microscope, binocular	1
8.	Refrigerator, kerosene	1
9.	Scalpel handle	1
10.	Slides rack	3
11.	Spirit lamp	1
12.	Stop watch	1
13.	Test tube rack	1
14.	Tray test tube	2
15.	Tray test tube	2
16.	Waste receptacle	1
17.	Microscope cover slides pack of 1000	1
18.	Bunsen burner	1
19.	Tripod stand	1
20.	Wire gauze	1
21.	Laboratory glass ware	1
22.	Blood lancets, pack of 200	1
23.	Tourniquet	1
24	Urine dipstick (multistix)	10
26	Stool specimen bottles, pack of 100	1
27	Urine specimen bottles, pack of 100	1
28	Wall Clock	1
29	Door name plate	1
30	Haemoglobinometer (sliding type)	1
1.	**DRESSING AND INJECTION ROOMS** Artery forceps (medium size)	2
2.	Stainless Bowl with stand	1
3.	Ceiling fan	2
4.	Plastic chairs	2
5.	Stainless covered bowl for cotton wool	1
6.	Dissecting forceps (medium)	2
7.	Dressing scissors	2
8.	Dust bin (pedal bin)	1
9.	Stainless Instrument tray	2
10.	Latex gloves (size 71/2) pack of 100	1
11.	Stainless instrument tray	1
12.	Jar, forceps	1
13.	Kidney dish (medium)	2
14.	Long benches	1
15.	Needle holder	2

16.	Plastic bowls	1
17.	Scalpel blade, pack of 100, 4 sizes	3
18.	Scalpel handle	2
19.	Stainless catheter tray with cover	1
20.	Spencer wells artery forceps	2
21.	Sphygmomanometer, mercurial (Accosons, Table Top)	1
22.	Sponge holding forceps	4
23.	Small sterilizer	1
24.	Stethoscope	1
25.	Stitch removal/suture	2
26.	Stretcher trolley	2
27.	Suture needles	1
28.	Syringes & needles (100) 2cc,	5
	5cc	5
	10cc	1
29.	Table	1
30.	Tape measure	1
31	Thermometer, oral	2
32	Thermometer, rectal	2
33	Tongue depressor	4
34	Scrub brush dispenser	2
35	Weighting scale, adult	1
36	Height measuring stick	1
37	Stainless dressing trolley	2
38	Tourniquet	1
39	Pen torch	1
40	Instrument cabinet	2
41	Medicine cupboard	1
42	Wheel chair	1
43	Angle poised lamp	2
44.	Filling cabinet	1
45.	Suction pump	1
46.	Filling cabinet	1
47.	Refrigerator, kerosene	1
48	Tissue forceps	4
49	Dressing forceps	4
50	Sterilizing forceps	4
51	Bandage scissors	2
52	Soap/disinfectant dispenser	2
53	Examination couch	1
54	Foot step	1
55	Swivel stool	1
56	Incision and Drainage kit	10
57	Suture kit	4
58	Stainless ear syringe	2
59	Wall clock	5
1.	**FAMILY PLANNING** Ceiling fan	1

2.	Plastic chairs (president)	2
3.	Stainless covered bowl for cotton wool	1
4.	Dissecting forceps	1
5.	Stainless gallipot (medium)	1
6.	Gloves, disposable pack, box of 100	1
7.	Instrument tray	1
8.	Stainless kidney dish (medium)	1
9.	Sphygmomanometer, mercurial (Accosons, Table Top)	1
10.	Small size sterilizer	1
11.	Syringes & needles	100
12.	Table	1
13.	Thermometer, oral	1
16.	Swivel stool	1
17.	Foot step	1
18.	Screen	1
19.	Stethoscope (Littman)	1
20.	Angle poised lamp	1
21.	IUD Kit	1
22.	Pedal bin	1
23.	Thermometer jar	1
24.	Bowls stainless steel with stand	1
25.	Stainless instrument trolley	1
26.	Gynae couch	1
27.	Auvards speculum	1
28.	Tenaculum forceps	1
29.	Kick about	1
30.	Wall clock	1
31	Door name plate	1
	INFANT AND CHILD WELFARE	
1.	Basket with lid for ORS	2
2.	Ceiling fan	1
3.	Plastic Chairs	2
4.	Stainless covered bowl for cotton wool	1
5.	Dressing Trolley	1
6.	Cup, medicine, graduated	4
7.	Dust bin (pedal)	2
8.	Stainless Gallipot (medium size)	1
9.	Table infant weighing scale (Seward)	3
10.	Stainless instrument tray	1
11.	Stainless kidney dish (medium size)	1
12.	Wooden long benches	1
13.	Plastic bowls	1
14.	Refrigerator, gas/kerosene	1
15.	Spoon measure	3
16.	Wooden tables	2
17.	Thermometer, rectal	4
18.	Tongue depressor	2
19.	Vaccine cold box	5

20.	Length measure for babies	3
21.	Bowls stainless steel with stand	1
22.	Wall clock	1
23.	Door name plate	1
	FIRST STAGE ROOM	
1.	Stainless bedpan	3
2.	Bowls stainless steel with stand	1
3.	Ceiling fan	1
4.	Plastic chairs	3
5.	Stainless covered bowls for cotton wool	2
6.	Dressing trolley	1
7.	Stainless steel drinking mug	2
8.	Pedal dust bin	1
9.	Foetal stethoscope	1
10.	Stainless gallipot (median)	1
11.	Latex gloves, disposable pack, pack of 100	2
12.	Hospital bed with mattress covered with mackintosh	2
13.	Stainless instrument tray with stand	1
14.	Jar, forceps	2
15.	Kerosene pressure lamp	1
16.	Stainless kidney dish (median)	2
17.	Mackintosh sheet	4
18.	Nail scrubbing brush, box of 12	1
19.	Sphygmomanometer, mercurial	1
20.	Sponge holding forceps	2
21.	Stethoscope (Littman)	1
22.	Office table	1
23.	Thermometer, oral	2
24.	Tongue depressor	2
25.	Weighing scale (Seward)	1
26.	Chart holder	4
27.	Bedside cabinet	2
28.	Overbed cabinet	2
29.	Thermometer jar	4
30.	Soap/disinfectant dispenser	1
31	Urinal, female	2
32	Drip stand	1
33	Oro-pharyngeal airway (set of 7)	2
34	Wall clock	1
35	Door name plate	1
	ANTENATAL ROOM/INTERVIEW ROOM	
1.	Ceiling fan	2
2.	Plastic chairs	3
3.	Stainless covered bowl for cotton wool	2
4.	Dust bin	2
5.	Examination couch	1
6.	Foetal stethoscope	2
7.	Stainless gallipot (medium)	1

8.	Latex gloves, disposable pack, pack of 100	20
9.	Hammer, reflex	1
10.	Height measuring stick	1
11.	Wooden long benches	3
12.	Mackintosh sheet	2
13.	Nail scrubbing brush, pack of 12	1
14.	Pen torch	1
15.	Sphygmomanometer, mercurial (Accosons, table top)	1
16.	Stethoscope	1
17.	Tables	2
18.	Thermometer, oral	2
19.	Tongue depressor	6
20.	Soap/disinfectant dispenser	1
21.	Thermometer jar	1
22.	Angle poised lamp	1
23.	Bowls stainless steel with stand	1
24.	Dressing trolley	1
25.	Urine dipstick for sugar and albumin, pack of 100	20
26.	ANC gowns for patients	50
27.	Wall clock	1
28.	Door name plate	1
	NUTRITION	
1.	Spoon	10
2.	Stainless drinking mugs	10
3.	Gas cylinders	2
4.	Knives	4
5.	Gas cookers	1
6.	Weighing scale (Seward)	1
7.	Blender and mill	2
8.	Stainless tray	1
9.	Plates	10
10.	Water container	4
11.	Bucket wit lid	4
12.	Chopping board	2
13.	Cooking spoons	6
14.	Kerosene stove	2
15.	Utility table	2
16.	Cooking pot (A set of 6)	1
	STERILIZATION	
1.	Bucket autoclave	1
2.	Tape dispenser	1
3.	Srub brush dispenser	1
4.	Autoclave tape	1
5.	Storage cabinet	2
6.	Sterilizing drums, set of 3	6
7.	Soap/disinfectant dispenser	1
8.	Nail scrubbing brush, pack of 12	1
9.	Wall clock	1

10.	Door name plate	1
	Cleaning and utilization	
1.	Brooms	10
2.	Mops	10
3.	Mop buckets	3
4.	Dusters	20
5.	Buckets	10
6.	Aprons	10
7.	Wellington boots	3
8.	Latex gloves	10
9.	Kerosene pressure lamp	2
10.	Hurricane lamp	4
11.	Apron, utility	8
12.	Flash light – 24 box batteries	4
13.	Nail scrubbing brush, pack of 12	1
14.	Fire extinguishers	2
15.	Soap box	5
	Linen store	
1.	Linen cupboard	2
2.	Pedal dust bin	1
3.	Table	1
4.	Plastic chair (President)	2
5.	Bed sheet	32
6.	Draw sheet	16
7.	Pillow case	32
8.	Bath towel	24
9.	Hand towel	24
10.	Theatre gown	10
11.	Lithotomy leggings	10
12.	Perineal sheet	1
13.	Standing fan	1
14.	Wall clock	1
	Consulting cubicle	
1.	Ceiling fan (Newclime)	2
2.	Plastic Chairs	3
3.	Stainless covered bowl for cotton wool	2
4.	Dust bin	2
5.	Examination couch	1
6.	Hammer, reflex	1
7.	Height measuring stick	1
8.	Macintosh	2
9.	Pen torch	1
10.	Sphygmomanometer, mercurial (accosons, table top)	1
11.	Stethoscope	1
12.	Snellen’s chart	1
13.	Tables	2
14.	Thermometer, oral	2
15.	Tongue depressor	6

16.	Weighing scale (child)	2
17.	Bowls stainless steel with stand	1
18.	Wall clock	1
19.	Diagnostic set (Gowland)	1
	Staff room	
1.	Examination couch	1
2.	Chair	5
3.	Table	5
4.	Dust bin	2
5.	Filling cabinet	2
6.	Standing fan	1
7.	Refrigerator, kerosene	1
8.	Wall clock	1
	Records	
1.	Table	2
2.	Plastic chairs (president)	2
3.	Safe (daily cash sales)	1
4.	Standing fan (Newclime)	2
5.	Dust bin (KDK)	1
6.	Filling cabinet	2
7.	Wall clock	1
	Male ward	
1.	Angle poised lamp	1
2.	Artery forceps (medium)	2
3.	Stainless bedpan	2
4.	Bowls stainless steel with stand	2
5.	Ceiling fan (Newclime)	2
6.	Plastic chairs (president)	6
7.	Covered bowl for cotton wool	2
8.	Cup, medicine, graduated	2
9.	Dissecting forceps (medium)”	2
10.	Dressing scissors	2
11.	Stainless drinking mug	2
12.	Pedal dust bin	2
13.	Stainless gallipot (medium)	2
14.	Latex glove, disposal pack of 100	2
15.	Hospital bed and mattress covered with mackintosh	6
16.	Stainless instrument tray	1
17.	Jar forceps	1
18.	Kerosene pressure lamp	1
19.	Kidney dishes (medium)	4
20.	Length measure for babies	1
21.	Mackintosh sheet	6
22.	Nursery cots	4
23.	Pump, breast, hand rubber bulb	2
24.	Refrigerator	1
25.	Screen	1
26.	Sphygmomanometer, mercurial, (Accosons, table top)	1

27.	Spoon, measure	2
28.	Standing fan (KDK)	1
29.	Littman stethoscope	1
30.	Stitch removal/suture scissors	1
31	Syringes & needles (100) 2cc,	5
32	5cc	5
33	10cc	1
34	Tables	1
35	Tape measure	1
36	Thermometer, oral	2
37	Thermometer, rectal	2
38	Tongue depressor	2
39	Tourniquet	1
40	Vaginal speculum, Sims, set of 3	2
41	Weighing scale	1