DELTA STATE
...The Big Heart

Delta State Development Performance

Health Sector Report, 1991 - 2013

UNITED NATIONS
NIGERIA
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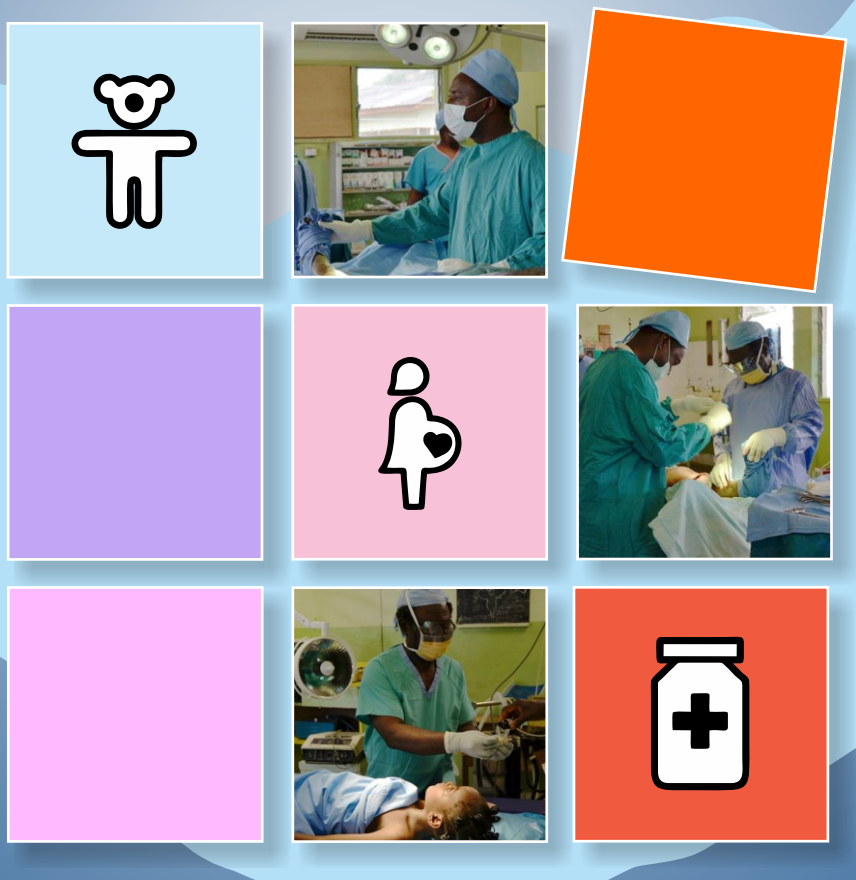

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by the

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Delta State

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Foreword

This report, which was prepared by independent consultants with the joint technical assistance of UNDP, UNICEF, WHO and FAO, is the UN's response to the request of the Delta State Government to carry out an assessment of its performance in four key sectors: education, health, agriculture, and water, sanitation and hygeine (WASH).

The analysis of each sector involved a careful examination of the policies and strategies adopted by the government, the governance and regulatory framework put in place, as well as identification of gaps and challenges in performance. It also focuses on sectoral performance using, among other things, the MDG targets and indicators.

The aim of the report is to generate lessons to strengthen the capacity of government for effective stewardship and the development of the State. The policy recommendations presented at the end of each sector appraisal provide the basis for evidence-based policy formulation and implementation, as well as for regulation and legislation which will channel resources towards enhancing the welfare of the people of Delta State. Translating these policy recommendations into action could mean reducing the incidence of disease and providing the people with better access to health care and education. In a nutshell, it means 'human development', which is about people; about expanding their choices to live full creative lives with freedom and dignity. Fundamental to expanding their choices is building human capabilities: the range of things that people can do to attain a long and healthy life, education, a decent standard of living and enjoy political and civil freedoms to participate in the life of one's community.[1]

The report highlights concerted efforts that the state and federal governments, the different communities, civil society organizations, and the private sector have helped to make to expand the opportunities available to people in Delta State. It also points out that while substantial progress has been made in meeting some of the targets, it is still necessary to develop a bolder and focused action plan where significant gaps and disparities exist in order to address the unfinished business of the MDGs and prepare for the Post-2015 Development Agenda.

It is our sincere hope that this report will help the Delta State Government build upon its successes and have a self-reflection of the progress made on the MDGs. These have obvious implications on MDG budgeting, policy directions, more targeted acceleration initiatives, and localization of targets and indicators. Achievement of the MDG targets in Nigeria and even the post-2015 development agenda depend on appropriate and effective policies and public spending by both national and subnational governments. This is particularly true because the state and local governments are closest to the people in terms of providing basic services.

The United Nations System in Nigeria will continue to partner with both states and the federal government to use the analytical evidence of what works – and what doesn't – in local development to shape policy formulation and adjustment, planning and implementation.

Daouda Toure
United Nations Resident Coordinator &
UNDP Resident Representative in Nigeria

[1] United Nations Development Programme (UNDP). 2003. Human Development Report 2003 *Millennium Development Goals: A Compact among Nations to End Human Poverty*, p. 28. New York: Oxford University Press.

Acknowledgments

This report is the outcome of the technical assistance the United Nations Country Team in Nigeria gave to the Delta State Government towards the assessment of the performance of Delta State in four key sectors of development, namely, agriculture, education, health, and water, sanitation and hygiene. The preparation and completion of the report has therefore been done with the collaborative effort and technical lead of the United Nations Country Team.

The Senior Advisor to the Governor on Foreign Ralations wishes to thank the Governor, His Excellency Dr Emmanuel Eweta Uduaghan, for willingly consenting to the independent assessment of the performance of the state by an external body. His political support and the effective participation of all stakeholders in the state have made the exercise a fruitful and reliable one.

Similarly, the Office of the Governor deeply appreciates all the key stakeholders that made the exercise possible. In particular, the technical backstopping provided by the UNCT Technical Team has been outstanding. The Delta State Government, therefore, wishes to express its special thanks to the United Nations Resident Coordinator in Nigeria, Mr Daouda Toure and the UNDP Nigeria Country Director, Mr. Pa lamin Beyai. The same appreciation is due to Jean Cough, UNICEF Representative in Nigeria; Louise L. Setshwaelo, FAO Representative in Nigeria; and Dr Vaz Rui, WHO Representative in Nigeria. The UNCT Technical Team chaired by Colleen Zamba, UNDP Economic Advisor, had on board Grace Arinze-Ononwu, UNDP Associate; George Igelegbai, UNICEF Education Specialist; Ajibade Olokun, UNICEF WASH Specialist; Precious Agbeso, FAO Asso-ciate Professional Officer, and Ogochukwu Chukwujekwu, WHO Health Economist.

We also would like to extend our appreciation to the expanded UNCT Technical Committee that provided comprehensive comments on the draft report. These included Samuel Momanyi, UNICEF Deputy Representative; Atsuko Toda, IFAD Nigeria Representative; Dennis Jobin, UNICEF Chief Planning, Monitoring & Evaluation and Field Coordinator; Rabe Mani, FAO Assistant Representative – Programme; Kwasi Amankwaah, UN Coordination Specialist; Eva Ahlen, UNICEF Chief of Education; Enrique Delamonica, UNICEF Chief of Social Policy; Paul Okunlola, UN-Habitat National Programme Officer; Oluwafunke Ilesanmi, WHO HIV Officer; Mary Stephen, WHO Programme Officer, NCD; and Adeze Molokwu, IOM Programme Assistant.

We are also grateful to the team of independent consultants recruited by the United Nations Country Team to undertake the assessment. Led by Prof. Mike I. Obadan, the team included the following sector consultants: Prof Joshua Aisiku (Education); Dr Samuel Eremie (Agriculture); Prof Eric Eboh (Agriculture); Dr Klint Nyamuryekung'e (Health); and Prof Lekan Oyebande (WASH).

The secretariat team consisting of Daniel Iruegbukpe, Michael Uwaechie and Ugo Agbaji collated a myriad of documents from the relevant ministries, departments and agencies of Delta State Government for use by the consultants.

Similarly, we like to thank the Commissioners, Advisers, Permanent Secretaries, Directors and staff of the relevant ministries, departments and agencies of the Delta State Government who participated in the various phases of the study, and provided assistance and helpful clarifications on policies, programmes and projects under their purview.

We are further grateful for the participation of all stakeholders across the state at the sensitization and validation workshops. Their contributions reflected in the various perspectives and enriched the diversity and quality of the report. We appreciate Ambassador Shola J. Omoregie and Ambassador Ejeviome Eloho Otobo who led the dialogue with the headquarters of three of the UN agencies in support of the study, as well as with the UN Country Team in Nigeria and the Delta State Government. They also provided guidance to the secretariat and facilitated the interactions between the secretariat and the team of consultants.

The study benefited greatly from the guidance of Mr. Paul Evuarherhe, the Head of Service, Delta State; Dr. Rukevwe Ugwumba, Special

Adviser, Health Monitoring; Mr Tony Obuh, the Permanent Secretary, Government House; and Hon. Oma Djebah, Senior Adviser on Foreign Relations, who provided overall government perspective critical to the assessment. While Sir Paul chaired the Technical Committee comprising the Permanent Secretaries of the Ministries of Health, Water, Education, Agriculture, Environment, and Economic Planning, Mr Obuh, and the entire team of Government House and Protocols gave us unqualified support throughout the exercise.

Finally, the vision and commitment of HE Dr. Emmanuel Uduaghan, the Governor of Delta State, towards improving the living conditions of Deltans was the driving force behind this assessment. His support and readiness to cut through bureaucratic red tape greatly facilitated the work of the consultants in bringing this assessment to fruition. All the contributions are highly appreciated.

Hon. Oma Djebah
Senior Adviser on Foreign Relations, Delta State

Overview

Introduction and Objectives

This assessment by the United Nations Country Team (UNCT) in Nigeria is a response to the request by the Delta State Government to review its performance in education, health, agriculture, and water, sanitation and hygiene sectors. The health sector assessment appraised the sector's contribution towards the achievement of the state development goals in general, and the Millennium Development Goals (MDGs) in particular. The assessment commenced on 23 April 2014 by undertaking an extensive documentary review, conducting in-depth discussions with key informants and convening as many as 10 stakeholder meetings. This overview contains a summary of the health programmes implemented, as well as the achievements, challenges, policy recommendations, and a proposal for operationalizing the recommendations.

Major Achievements and Policy Innovations

The National Health Policy (2004 revision) provides the overall guidance for health development in the entire Federation. The Delta State Government complemented this by designing specific health frameworks to provide guidance for the development and implementation of programmes in the sector. This has resulted in the following positive results and policy innovations:

- Free Maternal and Under-5 Child Healthcare Programmes based in 54 General Hospitals and the Rural Healthcare Scheme were established in the State in 2008 to provide outreach services to rural communities. These have resulted in improved preventive, diagnostic and treatment service utilization.
- The HIV & AIDS programme has expanded its services resulting in 23 per cent coverage of PMTCT services and 25 per cent coverage of Antiretroviral therapy (ART) services.
- The TB Control Programme has established a total of 106 DOTS sites and 22 operational microscopy centres, recording a steady increase in sputum smear positive rates of 28/100,000 population (2009), 30/100,000 population (2010), 30/100,000 population (2011) and 34/100,000 population, and TB cure rate of 59 per cent, 69 per cent, 75 per cent and 75 per cent in 2009, 2010, 2011 and 2012, respectively.
- The Malaria Control Programme has achieved the following results: 65 per cent households have at least one ITN, 47 per cent persons of all ages have access to ITN, 43 per cent of Under-5 children slept under ITN the night prior to the survey while 34 per cent of the Under-5 children with fever got tested and received Artemisinin Combination Therapy (ACT) within 24 hours in 2013.
- Infant mortality rate, which increased from 48/1,000 live births (2003) to 68/1,000 live births (2006), reduced to 37/1,000 live births in 2012. The national 1990 baseline value and 2015 target are 91/1,000 live births and 30.6/1,000 live births, respectively.
- Under-5 mortality rates stood at102/-1,000 live births (2003), 54.4/1,000 live births (2006), and 52/1,000 live births (2012). The national 1990 baseline value and 2015 target are 191/1,000 live births and 63.7/1,000 live births, respectively.
- The percentage of one-year-olds fully immunized against measles were 38.5 per cent, 61.3 per cent, 57.6 per cent and 60.4 per cent in 1999, 2008, 2012 and 2013, respectively. The national 1990 baseline value and 2015 target are 46 per cent and 100 per cent, respectively.
- Maternal mortality rate decreased from 456 per 100,000 births (2005) to 188 per 100,000 live births (2013). The national 1990 baseline value and 2015 target are 1,000/100,000 live births and 250/-100,000 live births, respectively.
- The proportion of births attended by skilled birth attendants was 49.1 per cent, 61.5 per cent 73.2 per cent, and 59.8 per cent in 1999, 2008, 2012 and 2013, respectively. The national 1990 baseline value and 2015 target are 45 per cent and 100 per cent, respectively.
- Contraceptive prevalence rates stood at 18.7 per cent, 26.6 per cent, 16 per cent and 28.7 per cent in 1999, 2008, 2012 and 2013, respectively.
- Antenatal care coverage of four or more visits was 74.6 per cent and 72.5 per cent in 2012 and 2013, respectively.

In summary, the MDG indicator 4.1 shows that infant mortality rate will likely be achieved by 2015, while the target for indicator 4.2 Under-5 mortality rate may have been achieved already.

Targets for indicators 4.3 – Percentage of one-year-olds fully immunized against measles; 5.2 – Proportion of births attended by skilled birth attendants; 5.3 – contraceptive prevalence rate; 5.5 – antenatal care coverage of four or more clinic visits; 6.1 – prevalence of HIV among pregnant women aged 15-24 years are falling or showing slow improvement over time. More concerted and targeted efforts will be required to achieve them by 2015.

Targets 5.1 – Maternal mortality rate – has progressively declined in the last 10 years, falling from 456 per 100,000 live births in 2005 to 188 per 100,000 live births in 2013. This shows that the 2015 target of 250 per 100,000 live births has already been achieved.

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Despite the state government's efforts, inadequate data has made it impossible to assess achievements in the remaining health-related MDGs.

Current and Emerging Challenges

The major challenges affecting the achievement of health outcomes in Delta State are:

- The weak health system characterized by inadequate numbers and poor distribution of the health workforce, inadequate equipment and weak system for their repair and maintenance, inadequate health financing, a dysfunctional referral system for patients from the PHC facilities to the secondary and tertiary facilities, inadequate logistics for con-ducting regular supervision and a dearth of reliable, timely and accurate infor-mation for planning, monitoring and evaluating health programmes.
- The socio-cultural practices that negatively influence health seeking behaviour, and contribute to the low utilization of reproductive and maternal health services by women, especially in PHC facilities.
- The stigmatization of people living with HIV & AIDS prevents them from disclosing their sero-status and accessing needed drugs and services;
- Inadequate community participation makes health service ownership and sustainability uncertain;
- Inadequate collaboration between the government and the private healthcare providers.
- The contribution of poverty, ignorance, peace and security issues, gender, food security, nutrition, and environmental degradation to poor health.

Lessons Learnt

The lessons learnt can be built upon to improve future health development efforts in Delta State. Among these lessons are the following: (i) The cluster model can strengthen the referral system, if adopted; (ii) Health facility survey is critical for determining facility readiness for service expansion; (iii) Public-Private collaboration can expand service access; (iv) Use of mobile phone technology can improve civil registration; and (v) Provision of free health services improves service utilization.

Recommendations

- The State Government, through the Ministry of Health (SMoH), the State Local Government Authority and LGA Chairmen should: initiate discussions to decentralize reproductive, maternal and child health services to PHCs.
- Expand the MSS to all the LGAs in the State to ensure that an increased number of PHCs deliver Basic Emergency Obstetric Care (EmOC) services and can refer complicated cases to a nearby facility that can deliver comprehensive EmOC services.
- Develop, cost and implement a Human Resource for Health (HRH) Plan, which will address all the current HRH issues identified;
- Establish a mechanism that provides financial protection for all citizens, especially the poor, by replacing all out-of-pocket payments for health services to a pre-payment mechanism, in a bid towards universal health coverage;
- Achieve health budgetary allocation target of 15 per cent of the State budget, as set by African leaders in Abuja in 2001.

To succeed in implementing these recommendations, it is proposed that the SMoH with technical support of the UN should organize a workshop for: (i) Representatives from the key State Ministries and Departments; (ii) LGA Chairmen; (iv) Civil Society Organizations (NGOs, CBOs, Professional Associations, etc); (v) Organized Private Sector; (vi) Federal Ministry of Health; (vii) NPHCDA; and (viii) Development Partners to discuss the findings and policy recommendations contained in this report and develop a road-map for implementation.

Acronyms & Abbreviations

ACT	Artemisinin Combination Therapy
ANC	Antenatal Clinic
ART	Antiretroviral Therapy
ARV	Antiretroviral Drugs
ATM	AIDS, Tuberculosis and Malaria
CAFOD	The official Catholic Aid Agency for England and Wales
CBOs	Community-Based Organizations
CCT	Conditional Cash Transfer
CEmOC	Comprehensive Emergency Obstetric Care
CPT	Co-trimoxazole Preventive Therapy
CSOs	Civil Society Organizations
DBS	Dried Blood Spots
DELSUTH	Delta State University Teaching Hospital
DELTASEEDS	Delta State Economic Empowerment and Development Programme
DESOPADEC	Delta State Oil Producing Areas Development Commission
DOTS	Directly Observed Therapy Short Course
DPS	Directorate of Planning and Statistics
DRF	Drug Revolving Fund
EDP	Essential Drugs Project
EID	Early Infant Diagnosis
ELSS	Elongated Life Saving Skills
EmOC	Emergency Obstetric Care
FMC	Federal Medical Centre
FRHS	Free Rural Healthcare Scheme
FU-5HP	Free Under-5 Healthcare Programme
GeneXpert	Nucleic Acid Amplification Technique for Detection of Rifampicin-Resistant TB
HiAP	Health in All Policies
HCT	HIV Counselling and Testing
HIV & AIDS	Human Immunodeficiency virus & Acquired Immunodeficiency Syndrome
HRH	Human Resource for Health
HSRP	Health Sector Reform Programme
IDSR	Integrated Disease Surveillance and Response
IHVN	Institute for Human Virology Nigeria
IMCI	Integrated Management of Childhood Illnesses
IPT	Intermittent Prevention Therapy
IPT	Isonizide Preventive Therapy
ITN	Insecticide Treated Nets
IVM	Integrated Vector Management
LGA	Local Government Authority
LGSC	Local Government Service Commission
LLINs	Long Lasting Insecticide Treated Nets
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDG-CGS	Millennium Development Goals Conditional Grants Scheme
MDGs	Millennium Development Goals

MDR-TB	Multi-drug Resistant Tuberculosis
MICS	Multiple Indicator Cluster Survey
MSS	Midwives Service Scheme
NBS	National Bureau of Statistics
NDHS	National Demographic and Health Survey
NEEDS	National Economic Empowerment and Development Strategy
NGF	Nigeria Governors Forum
NPHCDA	National Primary Health Care Development Agency
NSHDP	National Strategic Health Development Plan
OSSAP-MDGs	Office of the Senior Special Advisor to the President on MDGs
PCR	Polymerase Chain Reaction
PeTR-GS	Prevention, Education, Training, Treatment & Research – Global Solutions
PHCs	Primary Healthcare Centres
PMTCT	Prevention of Mother-to-Child Transmission of HIV
PPM	Private Partnership Mix
PRM	Peer Review Mechanism
Rapid SMS	Rapid Short Message System
RDT	Rapid Diagnostic Test
RHS	Rural Healthcare Scheme
SACA	State Action Committee on HIV & AIDS
SASCP	State AIDS and STI Control Programme
DRS/MOEP	Department of Research and Statistics of the State Ministry of Economic Planning
SHCs	State Healthcare Centres
SHMB	State Health Medical Board
SMEP	State Ministry of Economic Planning
SMoH	State Ministry of Health
SPHCDA	State Primary Health Care Development Agency
SSHDP	State Strategic Health Development Plan
STI	Sexually Transmitted Infections
SURE-P	Subsidy Re-investment and Empowerment Programme
TB	Tuberculosis
THCs	Tertiary Healthcare Centres
UNCT	United Nations Country Team
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WDC	Ward Development Committee
WHO	World Health Organization
WMHCP	Ward Minimum Healthcare Package

Introduction

Overview

Delta State was established in 1991 with a total land area of 18,050km^2, and an estimated population of 4,112,863 (2006). Administratively, it is made up of 25 Local Government Areas (LGAs) grouped under three Senatorial Districts, namely, Delta North, Delta Central and Delta South. There are 725 Primary Healthcare Centres (PHCs), 244 Secondary Health Centres (SHCs) and two Tertiary Health Centres (THCs) in the state. The health training institutions include: State School of Midwifery, Asaba; School of Nursing, Agbor; School of Nursing, Warri; School of Health Technology, Ofuoma; and, the State University Teaching Hospital.

Objectives of the Assessment

This assessment by the United Nations Country Team (UNCT) in Nigeria is a response to the request of Delta State Government. The general objective was to review the State's performance in four key sectors, namely, education, health, agriculture, and water, sanitation and hygiene. The specific objective of the health sector assessment was to gauge its contribution towards the achievement of the state development goals and the Millennium Development Goals (MDGs). The assessment was to review how the health sector programmes and policies have contributed towards progress made in reducing infant, Under-5, and maternal mortality, improving access to quality health care and improved health outcomes. The assessment was to identify bottlenecks/constraints and determine priority areas of focus to improve and accelerate performance and develop future health sector programmes.

Methodology

The assessment methodology used entailed conducting a desk review from 1-22 May 2014. The review process included using secondary data and publications obtained from state actors such as the Department of Research and Statistics of the State Ministry of Economic Planning (SMEP), the State Ministry of Health and its parastatals, as well as the Federal Ministry of Health, (see Annex A for list of documents).

The information gathered during the desk review was supplemented with face-to-face meetings with key officers in the SMoH, the State Directorate of MDGs, the Governor's Focal Person for monitoring and evaluating MDG projects, the State Hospitals Board, the State PHC Agency, the Department of Research and Statistics of the State Ministry of Economic Planning (SMEP), the State Population Commission, the State AIDS and STI Control Programme (SASCP) and the State Action Committee on AIDS (SACA). This yielded additional documentation for finalizing the desk review.

Consequently, field visits were carried out from 23 to 30 May 2014 to apply appropriate Discussion Guides to key informants. Ten such meetings were organized (see Discussion Guide Annex C).The objectives of the discussions were to: (i) Generate missing information; (ii) Clarify issues; (iii) Assess the views of beneficiaries and providers on appropriateness, quality and equity issues; and (iv) Gain perspectives on improve-ments needed.

The ten meetings were held with: (i) Departments, parastatals, and programme heads in the SMoH; (ii) The State Directorates of MDGs, Population Commission and Department of Research and Statistics of the Ministry of Economic Planning; (iii) Local Government Service Commission; (iv) LGA Health Departments; (v) Ward Development Committees; (vi) Private hospitals; (vii) Public hospitals; (viii)Public PHC facility workers (ix) Professional Associations; and (x) the Organized Private Sector and Civil Society Organizations (in a town hall setting)(see Annex B for the field visit schedule, and Annex D for the attendance list for the meetings). Findings from the meetings complemented the desk review findings to generate the draft Health Sector Assessment Report.

Structure of the Report

The health sector report is structured under eleven sections, as shown below:

Chapter 1– Introduction
Chapter 2– Governance, Institutional Arrangements, Regulatory

Governance, Institutional Arrangements, Regulatory Framework, Environment of Policy and Programme Implementation

The Delta State Ministry of Health is a professional Ministry involved in the formulation and implementation of policies/strategies for the achievement of the State Government's goals and objectives in health-related matters.

Institutional Arrangements

State Ministry of Health (SMoH)

SMoH Departments

The SMoH has seven departments, four professional and three mandatory departments, namely:

i. Department of Medical Services and Training.
ii. Department of Nursing Services.
iii. Department of Primary Health Care and Disease Control.
iv. Department of Pharmaceutical Services.
v. Department of Planning, Research and Statistics.
vi. Department of Administration; and
vii. Department of Finance and Accounts.

SMoH Parastatals

There are also six parastatals supervised by the SMoH, namely:

i. Hospitals Management Board.
ii. Traditional Medicine Board.
iii. Drug Revolving Fund.
iv. Delta State Primary Health Care Development Agency.
v. Health Systems Development Project-II.
vi. Delta State University Teaching Hospital (DELSUTH)

Responsibilities of SMoH

The SMoH, through its departments and parastatals, aims to fulfil the following responsibilities:

- Formulation of health policies.
- Development and execution of health sector development programmes.
- Administration of state government hospitals and allied health institutions through the Hospitals Management Board.
- Provision of pharmaceutical services, including inspection and licensing of patent medicine shops.
- Registration of private/voluntary medical agencies.
- Management of training institutions for nurses and midwives, health superintendents, pharmacy technicians, other para-medical staff and health workers.
- Promotion of traditional medicine.
- Promotion of primary health care and disease control activities.
- Provision of a liaison with other state agencies and national bodies in the health sector.
- Supervision of the Specialist/University Teaching Hospital in the State.

The Local Government Authority

There is no piece of legislation describing the national health system and defining the health functions of each of the three tiers of government. Therefore, the Federal, State and Local Governments shall support, in a coordinated manner, a three-tier system of health care (National Health Policy 2004).

The Local Government Authority is responsible for managing the PHC facilities. The Local Government Service Commission is responsible for employing and managing the technical personnel working in the PHC facilities, with support from NPHCDA, SPHCDA, and the SMoH.

Directorate of the MDGs

The Directorate of the Millennium Development Goals is under the Office of the State Governor.

Vision of the Directorate

As would be expected, the Vision of this Directorate is to achieve the Millennium Develop-

ment Goals by 2015.

Mission of the Directorate

To achieve the MDGs through advocacy, sensitization campaigns and facilitating MDG-based costing and budgeting by all Ministries, Departments and Agencies (MDAs)

Mandate of the Directorate

- To increase public awareness of the existence of the MDGs as articulated by the UN Heads of Government as action points for improved standard of living;
- To help raise awareness of policy initiators and executors, lawmakers and those of their organizations as platforms for complementing and monitoring goals achievement;
- To create a veritable avenue for passing information to the public on development policies and level of existing services;
- To foster and build sustainable development relations between government, its key players, civil society organizations and the citizenry with the attainment of the MDGs as a point of convergence;
- To liaise with the Office of the Senior Special Assistant to the President on MDGs (OSSAP-MDGs) to track projects and programmes allocated to Delta State through the 10 implementing Federal Ministries and monitor the implementation of the specific projects and programmes;
- To ensure a fair allocation to the State in the Project and Programme Planning of the Federal Ministries;
- To liaise and work with OSSAP-MDGs, Abuja, National Planning Commission, Federal and State MDAs, development partners and donor agencies, corporate bodies and any other such bodies for the attainment of the Millennium Development Goals; and
- To undertake any other duty that may be assigned by His Excellency, the Governor, from time to time.

DESOPADEC

The Delta State Oil Producing Areas Development Commission (DESOPADEC) was set up by an act of the Delta State House of Assembly (DTHA) and signed into law in 2007, amended in 2010.

DESOPADEC Mandate

The responsibility of the Commission is to administer exclusively the 50 per cent of the 13 per cent Oil Derivation Funds accruing to the Delta State Government for:

- Rehabilitating and developing the oil producing areas
- Embarking on other development projects as may be determined from time to time by the Commission.

DESOPADEC Implementation Sites

The mandate area is made up of five ethnic nationalities of Itsekiri, Ijaw, Urhobo, Isoko and Ndokwa, and spread across 19 of the 25 LGAs of Delta State.

Regulatory Framework

The relevant SMoH departments or parastatals, working in collaboration with the appropriate federal councils/bodies undertake the registration and regulation of the activities of health professionals, including the annual renewals of registration.

The manufacture, importation, storage, sale, distribution and dispensing of pharmaceuticals, vaccines, equipment and appliances, and other medical supplies have to comply with standard specifications and Essential Drug List.

The State Drug Revolving Fund (DRF) has a quality control laboratory which undertakes laboratory tests for medicines before they are procured for public use.

The Task Force on Counterfeit and Fake Drugs is supposed to enforce the provisions of the Counterfeit and Fake Drugs Act. However, it is yet to be constituted.

Finally, the Department of Medical Services and Training of the SMoH has a major responsibility to set and enforce the minimum care standard through policy formulation, inspection and supervision of public and private health facilities.

Environment for Policy and Programme Implementation

The National Health Policy (2004 revision) provides the overall guidance for health development in the entire federation.

The State Vision 2020 contains a chapter on human development of which education and health care are components. It defines the goals/objectives for the health sector for the period 2010-2020.

The Delta State 3-Point Agenda has interlinked components, namely: (i) Peace and Security; (ii) Infrastructural Development; and (iii) Human Capital Development. The third component incorporates education and health. Health improvement is crucial to the achievement of other components.

The Delta State Strategic Health Development Programme (SSHDP), 2010-2015, provides the health vision, mission, objectives and priority areas for the period 2010-2015. Developing and effectively implementing programmes to achieve the goals of each of the eight priority areas will strengthen the health system as a whole and the primary health care in particular.

Objectives, Policies, Strategies, Initiatives/Programmes in the Health Sector

Overview

Delta State has no proper documentation of its health policies, programmes and interventions for the period 1991-2004. Therefore, the first major policy document that could be analysed was the Delta State Economic and Empowerment Strategy (DELTASEEDS).

DELTASEEDS was designed as a broad range of policy targets for MDAs between 2004 and 2007. It contains policy thrusts and targets the SMoH formulated and implemented in the health sector during the period. The Health Sector Reform Programmes (HSRP) implemented during this same period addressed several issues, including government stewardship role; management of the state's health system; the burden of diseases; mobilization and utilization of health resources; health service delivery; consumer awareness and community participation; as well as partnership, collaboration and coordination. The following sections elaborate on the policies/strategies and programmes implemented at that time.

Policies and Strategies

DELTASEEDS Health Policy Thrusts

The policy objectives articulated in DELTASEEDS were to broaden specialized services, control and manage HIV & AIDS, improve laboratory and radiological services, provide quality drugs, improve immunization coverage by strengthening routine immunization, malaria control, promotion of gender equity, and elimination of negative practices involving women. Other core objectives were to protect the reproductive health of the citizens, promote effective disease surveillance, promote adequate information flow and management, strengthen the state TB and Leprosy Control Programme and improve access to quality/affordable and effective health services.

The Delta State Strategic Health Development Plan (SSHDP) 2010-2015

The health indicators for Delta State by the end of 2009 were: (i) Crude Birth Rate: 25/1,000 persons; (ii) Crude Death Rate: 8/1,000 persons; (iii) Infant Mortality Rate: 14/1,000 live births; and (iv) Maternal Mortality Ratio: 301/100,000 live births. The HIV sero-prevalence rate of 5 per cent in 2003 had dropped to 3.7 per cent in the 2007 survey.

The challenges experienced in 2009 with the SSHDP included the following: (i) Non-supervision of private practice despite the law mandating the SMoH to register and regulate private health institutions in the State;(ii) Inadequate funding of State Hospitals; hence the poor maintenance of vehicles, power plants and medical equipment. All these affected staff motivation and commitment.

Community participation at PHC level existed in some communities whereby Ward/Community Development Committees and Village Health Committees organized a means of transporting patients to health care facilities.

To address these challenges and improve on the unsatisfactory health indicators, the Delta State Strategic Health Development Plan (SSHDP) for the period 2010-2015 was developed.

The Vision of the SSHDP

The Vision of the SSHDP is to 'reduce morbidity and mortality rates due to communicable diseases to the barest minimum; reverse the increasing prevalence of non-communicable diseases; meet global targets on the elimination and eradication of diseases and significantly increase the life expectancy and quality of life of Nigerians and Deltans in particular'.

The Mission of the SSHDP

The Mission of the SSHDP is to 'develop and implement appropriate policies and programmes as well as undertake other necessary actions that will strengthen the state health system to deliver effective, quality and affordable health care services' in the state health sector.

The Goal of SSHDP

The goal of SSHDP is to substantially reduce morbidity and mortality through the provision of accessible, affordable and quality healthcare services. The Delta SSHDP has eight priority areas, namely: (i) Leadership and governance; (ii) Service delivery; (iii) Human resource for health; (iv) Health financing; (v) Health Management Information System; (vi) Community participation; (vii) Partnership for health; and (viii) Health research.

The Delta State Vision 2020

The Delta State Vision 2020was articulated in 2011, and it contains a chapter on Human Development of which Education and Healthcare are components. The Vision of the health sector, as articulated in the State Vision 2020 for the period 2011-2020, is 'High quality, accessible and affordable health care delivery for all Deltans'. The Mission, as contained in this document, is 'to provide standard and adequate facilities, infrastructure and human resources to achieve the highest quality of healthcare that is globally competitive'. The healthcare section defines the goals/objectives of the State Vision 2020.

Goals/Objectives of State Vision 2020

- Emphasize Primary Health Care (PHC) over curative healthcare;
- Improve doctor/nurse to patient ratio;
- Improve immunization coverage;
- Increase the distribution and use of LLINS and improve utilization among vulnerable groups;
- Improve financing of the health sector;
- Provide/upgrade medical equipment and infrastructure;
- Improve facilities in the state's Schools of Nursing and Midwifery and the School of Health Technology
- Encourage personal hygiene and daily environmental cleanliness.

Sector Targets

The following health sector targets were set in the Delta Vision 2020:

- Increase hospital beds from 7,132 to 22,000 and ratio from 165 per 100,000 to 400 per 100,000);
- Increase accommodation (55 units) for key staff and improve security at all PHCs;
- Provide accommodation (10 units) in the Secondary Healthcare Centres for key staff;
- Improve immunization coverage from the current 80 per cent to 100 per cent;
- Improve distribution of LLINs from the current 335,000 to 1,593,000 units by 2015;
- Increase doctor/patient ratio from the current 6 per 100,000 to 500 per 100,000;
- Meet WHO targets on reduction and control of HIV & AIDS and tuberculosis.

The State Vision 2020 has defined strategies for attaining the above targets. Some of these are exploiting the PPP option in the distribution and delivery of LLINs, allocating 15 per cent of the annual budget to the health sector, implementing the State's Strategic Health Development Plan 2010-2015, providing emergency ambulance services throughout the state, providing Blood Bank units, ensuring regular supply of medicines and other supplies to the health facilities.

The Delta State 3-Point Agenda

Another development strategy of Delta State is the 3-Point Agenda with inter-linked components, namely, (i) Peace and Security; (ii) Infrastructural Development; and (iii) Human Capital Development. The third component incorporates Education and Health. In order to address the major human capital development challenges, such as poverty and ignorance, health improvement is very crucial. The State accelerated the implementation of the existing programmes to increase access to health services for rural and hard-to-reach communities.

Health Programmes Implemented

Child Survival Programmes

The State has focused on reducing child mortality by implementing the following priority interventions: (i) Routine immunization, and special campaigns for measles and polio immunization; (ii) Better nutrition; and (iii) Proper diagnosis and effective application of drugs for common conditions such as diarrhoea, respiratory infections, malaria and helminthic infections. The staff of Primary and Secondary Healthcare Centres were trained on the Integrated Management of Childhood illnesses (IMCI) strategy to manage the common childhood illnesses. Before 2005, all these services were provided under a cost recovery programme at the primary, secondary and tertiary levels. But by May 2010, the Delta State Government launched the Free Under-5 Healthcare Scheme, which provided diagnostic and treatment services

free of charge to children under age five at the SHCs. At the PHCs, all medical ser-vices are still being provided at partial or full cost recovery. The only services provided free of charge are immunization and treatment of tuberculosis.

Maternal Health Programmes

In a bid to promote safe motherhood and reduce maternal deaths, family planning, antenatal, delivery, postnatal and emergency obstetric services are delivered at most primary and all secondary health facilities. The nurses have been trained on Life Saving Skills (LSS) and doctors on Elongated Life Saving Skills (ELSS). In 2005, Delta State launched the Free Maternal Healthcare Programme (FMHCP), which enabled the Public Secondary Healthcare Centres to deliver routine maternal care (antenatal, delivery and postnatal) and Comprehensive Emergency Obstetric Care (CEmOC), as well as manage complications of abortion and ectopic pregnancy free of charge to all patients. At the Primary Healthcare Centres, however, the maternal healthcare services are offered at full cost recovery.

The Rural Healthcare Scheme

The Rural Health Scheme (RHS) was first established in 2005. It aims to provide free medical services to all Deltans, especially rural dwellers who cannot afford to attend hospitals. Two phases of the scheme were executed between 2005 and 2006 during which all the 25 LGAs of the State were covered. Only medical screening and treatment of cases were carried out in these exercises. The scheme was resumed in November 2008 and expanded to cover free treatment of patients with both medical and surgical conditions at no cost to them. A core team of 48 professionals (Obstetricians and Gynaecologists, Ophthalmologists, Anaesthesiologists, Public Health and General Duty Medical Officers) and an ad-hoc team of 10-15 personnel visit each community once every year, offering services such as laboratory testing, HIV screening diagnosis and treatment of common illnesses. General medical practice as well as specialist care, including surgery, are also offered free of charge to patients. In 2011 the scheme was expanded again to include immunization and dental care.

HIV & AIDS Control Programme

The prevalence of HIV in Delta State was estimated at 5 per cent in 2003 (NSS 2003). The State Action Committee on HIV & AIDS (SACA) was established in 2005 to coordinate a multi-sectoral response to the epidemic in the state. The State AIDS and STI Control Programme (SASCP) coordinates the health sector response to HIV & AIDS, and operates in the following ways: (i) Undertaking HIV counselling and testing; (ii) Reducing HIV-related stigma and discrimination; (iii) Procuring and administering ARVs to eligible patients at subsidized cost; (iv) Preventing mother-to-child transmission; (v) Providing post-exposure prophylaxis to health workers; (vi) Implementing TB-HIV collaborative activities; and (vii) Building the capacity of health workers.

Tuberculosis Control Programme

The Stop TB strategy adopted by the National TB Control Programme targets: (i) Halting and beginning to reverse the incidence of TB by 2015; (ii) Reducing the prevalence of and deaths from TB infection by 50 per cent, compared with a baseline figures of 1990; and, by 2050, eliminate TB as a public health problem. The components of the strategy for achieving this are:

i. Pursue high-quality DOTS expansion and enhancement . This entails securing political commitment, ensuring early case detection and diagnosis through quality-assured bacteriology, providing standardized treatment with supervision and patient support, ensuring effective drug supply and management and monitoring and evaluating performance and impact;
ii. Address TB-HIV co-infection, MDR-TB, and the needs of the poor and vulnerable populations;
iii. Contribute to health system strengthening based on the primary health care plan
iv. Engage all care providers, including public, voluntary, corporate and private providers through Public-Private Mix (PPM) approaches
v. Empower people with TB and communities through partnership, advocacy, communication and social mobilization, and fostering comunity participation in TB care, prevention and health promotion; and
vi. Enable and promote research by conducting programme-based operational research.

Malaria Control Programme

Malaria is the commonest reason for out-patient consultation in the Delta State health

facilities. The State has been carrying out malaria control interventions in line with the strategy of the Federal Ministry of Health that aims to reduce the number of cases and deaths from malaria by 75 per cent by 2015 in the context of the long-term vision of a malaria-free Nigeria. The core interventions include: (i) Integrated Vector Management (IVM); (ii) Prompt diagnosis and treatment of clinical cases; (iii) Prevention and treatment of mala-ria in pregnancy; (iv) Advocacy, commu-nication and social mobilization; (v) Procure-ment and supply chain management; and (vi) Monitoring and evaluation.

Essential Drug Project (EDP)/ Drug Revolving Fund (DRF)

The Essential Drugs Project (EDP) was implemented in Delta State with support from World Bank up to 2009. The aim of the programme was to ensure the availability of safe and effective drugs and other pharmaceuticals required by the state and local government-owned health facilities at reasonable cost on a continuous basis. At the end of the project duration in 2009, the State Government took over and changed its name to the Drug Revolving Fund (DRF).

The arrangement was to provide health facilities with seed drugs and pharmaceuticals for sale to patients at full cost in order to sustain subsequent purchases from the State DRF. To date, all Secondary Health-care Centres have continued to procure their drugs and pharmaceutical supplies from the State DRF. The PHCs, however, have stopped sourcing their supplies from the State DRF, resorting to LGA or facility-based DRF instead.

The PHCs covered under the Subsidy Re-investment and Empowerment Programme (SURE-P) for maternal and child health, however, receive their drugs and pharmaceutical supplies directly from the federal level.

The State is preparing to change to the new drug distribution system in line with the guidelines from the Federal Ministry of Health. This new system has the aim of addressing the current disorganized national drugs and pharmaceuticals distribution system which allows the circulation of counterfeit and substandard medicines. In the new system, the State Drug Distribution Centres will procure drugs only from registered manufacturers and providers, while the Public Health Centres will procure their supplies from the State Drug Distribution Centres. The Private Sector Health providers will establish Drug Distribution Mega-centres from which the private facilities will be allowed to procure their supplies.

DESOPADEC Health Sector Projects

Interventions in health sector have included: (i) Building of New Primary Health Centres (PHCs) as well as the renovation/rehabilitation of the Primary Healthcare Centres; (ii) Construction of Doctors and Nurses Quarters for (PHCs); (iii) Supply of medical equipment to health centres and hospitals; (iv) Introduction of Free Medical Scheme ,which included consultation, treatment, drugs and surgery; and (vi) Supply of generators/ambulance vans to hospitals.

National Programmes Implemented in Delta State

Four national programmes are currently being implemented in the State. These include (i) The Midwives Service Scheme (MSS); (ii) Subsidy Re-investment and Empowerment Programme (SURE-P) MCH; and (iii) The Village Health Worker Scheme that are scaled up in Delta State from the federal level; and (iv) The MDG Conditional Grants Scheme.

Midwives Service Scheme (MSS)

The National Primary Health Care Development Agency (NPHCDA) established the Midwives Service Scheme (MSS) in 2009. The MSS is a collaborative effort between the three tiers of government in Nigeria, whereby, through a signed memorandum, the Federal, State and Local Governments fulfil their agreed roles and responsibilities. Delta State signed the memorandum and has been co-implementing the scheme since 2012. Under the scheme, midwives, including those newly qualified, unemployed and retired, are employed and deployed to selected PHCs in rural communities. The aim is to facilitate an increase in the coverage of Skilled Birth Attendance (SBA) to reduce maternal, newborn and child mortality. Twenty four PHCs in Delta State are involved in the MSS. They form six clusters each with four PHCs and one SHC. Under the Scheme, each PHC has four midwives. The six clusters are distributed in six LGAs, namely: Bomadi, Sapele, Warri South, Ika South, Ndokwa West, and Ughelli North. There are five components under the scheme, namely: (i) Institutionalizing community participation, whereby WDCs are reactivated for each PHC; (ii) Deploying four midwives per PHC; (iii) Providing equipment and supplies for the PHCs; (iv) Building the capacity of midwives to improve quality of care; and (v) Providing ICT communication support.

SURE-PMCH

The Subsidy Re-investment and Empowerment Programme (SURE-P), initiated at the federal level is designed to include supply and demand-side interventions. On the supply side, each PHC receives a full complement of skilled health workers, basic commodities, equipment and refurbishment of infrastructure. On the demand side, health promotion and education will be intensified through campaigns at the national, state and local government levels. The Ward Development Committees (WDCs) are being activated to boost community engagement in decision-making. Conditional Cash Transfers (CCT) will address the indirect costs of care seeking that may partially contribute to the low demand for ANC and delivery services at the PHC facilities. The SURE-PMCH is designed to run for four years (2012-2015). In Delta State, 47 PHCs are involved in the implementation of the SURE-P. Each of the 11 LGAs has four facilities while one LGA has three facilities implementing the SURE-P. Also, in Delta State, the supply-side of the programme has been implemented, including, employment and training of personnel for the facilities, infrastructural upgrading of the facilities, and provision of essential obstetric equipment. Implementation of the demand-side is yet to start.

The Village Health Worker Scheme

The Scheme started in 2011 under the Office of the Senior Special Assistant to the President on MDGs (OSSAP-MDGs). Delta State has seven of 148 LGAs currently benefiting from the Scheme nationwide. The LGAs benefiting from the Scheme are: Ukwani, Ethiope West, Warri South-West, Ndokwa East, Udu, Bomadi and Burutu. Some 100 village health workers have been selected, trained and deployed to the communities to boost the implementation of the Scheme.

The MDG Conditional Grants Scheme

Delta is one of the States that fully embraced the Millennium Development Goals (MDGs) and has committed to achieving them by 2015. The MDG Conditional Grants Scheme (MDG-CGS) started in 2007 at the federal level. However, Delta State started receiving funding from 2008. Under this scheme, Delta State has mobilized funds (federal and state counterpart) and implemented interventions pertaining to health MDGs. The following projects were accomplished by December 2013: (i) Construction of 50 PHCs, 50 maternity wards, 50 staff quarters, four solar-powered water bore holes, and toilets in five facilities; (ii) Distribution of 40,000 delivery packs; (iii) Provision of 25 units of gender-friendly squat toilets; (iv) Distribution of 400,000 LLINs, 666,732 doses of Sulfadoxine/Pyremethamine (SP) and Artemisinin Combination Therapy (ACTs) to treat pregnant women or prevent them from malaria attack; (v) Supply of 171 Essential Obstetric Care (EOC) equipment.

Public Investments and Resource Allocation to Agreed Priorities

SMoH Financing

Data on budget allocations and expenditures (disbursements) were made available for the period 2006-2013. The data are shown in Table 4.1. For two years, 2006 and 2008, the State expenditure exceeded the approved budgets. The funds released to SMoH for 2011 exceeded the approved budget for that year.

The proportion of the state budget allocated to the health sector varied between 3 per cent in 2009 and 8 per cent in 2012, declining slightly to 6 per cent in 2013. On examining the proportion of the budget actually disbursed, two exceptions are noted: in 2006, almost 100 per cent of the approved budget was released, while in 2011 the disbursement exceeded the approved budget by 69 per cent. For the rest of the period, the disbursement varied from as low as 40 per cent in 2009 to 76 per cent in 2006. The implication of the low budgetary disbursement to the health sector is that the set targets, including the MDGs, may not be achieved.

Apart from the Delta State budgetary allocations to the SMoH, health services are also funded separately through the Delta State Oil Producing Areas Development Commission (DESOPADEC) and the MDG Conditional Grants. The budgets for DESOPADEC health projects are highlighted below:

Table 4.1: SMoH Budget as a Proportion of Total State Budget, 2006-2013

Year	Delta State Budget	State Expenditure	SMoH Budget	% of State Budget to SMoH	Amount Released to SMoH	% of Amount Released to SMoH
2006	149,999,499,025	180,424,485,946.75	10,459,500,000.00	7	10,328,724,909.44	99
2007	189,959,900,152	155,624,686,053.36	10,728,625,000.00	6	8,189,676,800.49	76
2008	146,340,513,746	188,173,737,194.47	10,458,336,373.00	7	5,197,871,063.82	50
2009	237,630,296,039	183,486,827,722.92	8,028,860,271.00	3	3,225,032,501.94	40
2010	331,860,069,094	226,974,118,125.20	16,125,750,223.00	5%	11,367,207,469.82	70
2011	361,904,074,383	284,270,451,195.02	11,061,667,422.00	3%	18,708,135,429.99	169
2012	437,218,083,558	292,351,434,847.93	35,862,304,777.00	8%	16,160,499,017.62	45
2013	472,006,772,170	329,608,641,860.52	28,882,276,661.60	6%	15,680,023,310.75	54
TOTAL	2,326,919,208,167	1,840,914,382,946	131,607,320,728	6%	88,857,170,504	68

Source: SMoH

Table 4.2: DESOPADEC Budget Allocation to Health Sector Projects, 2008-2013

YEAR	Capital Budget Estimate (N)	Health Budget (N)	%
2007	32,971,432,793	3,756,232,761	11
2008	26,143,990,000	2,354,815,566	8
2009	22,814,420,196	1,249,661,263	5
2010	22,823,392,518	1,693,982,032	7
2011	21,777,974,393	1,518,886,147	7
2012	22,933,820,000	1,573,548,266	7
2013	24,297,020,000	1,554,180,829	6
TOTAL	173,762,049,900	13,701,306,864	8

Source: DESOPADEC

Table 4.3: DESOPADEC Health Budget Committed 2007-2013

Period	Completed		Ongoing		Total Value (N)
	Number	Value (N)	Number	Value (N)	
2007-2008	8	436,793,842	3	544,301,510	981,095,352
2009-2010	24	904,196,865	14	666,551,448	1,570,748,313
2011	13	451,269,954	16	318,085,435	769,355,389
2012-2013	6	207,344,053	26	1,340,695,404	1,548,039,457
Totals	51	1,999,604,714	59	2,869,633,797	4,869,238,511

Source: DESOPADEC

Table 4.4: Proportion of Budget Released by DESOPADEC for Projects, 2008-2013

Year	Budgets (N)	Committed (N) (Completed & Ongoing)	Performance (%)
2007-2008	6,111,048,327	981,095,352	16
2009-2010	2,943,643,295	1,570,748,313	53
2011	1,518,886,147	769,355,389	51
2012-2013	3,127,729,095	1,548,039,457	49
Totals	13,701,306,864	4,869,238,511	36

Source: DESOPADEC

DESOPADEC Health Financing

DESOPADEC's financing of health projects from 2008-2013 is elaborated in Table 4.2.

Table 4.2 provides the budgets committed year by year. In 2007, the health sector received N3,756,232,761, which was 11.4 per cent of the total budget DESOPADEC had for health, education and water. Over the seven-year period, 2007-2013, total DESOPADEC budget for the three sectors was N173,762,049,900 out of which the total budget for health was N13,701,306,864 which translates to 8.0 per cent over-all, ranging from 6.4 per cent (2013) to 11.4 per cent (2007).

Table 4.3 provides the number and values of completed and ongoing projects year by year, from 2007 to 2013. For two periods, 2007-2008 and 2012-2013 the value of the ongoing projects exceeded the value of the completed projects, unlike the other years, 2009-2010 and 2011 when the value of the completed projects was higher than the value of the uncompleted projects.

Table 4.4 compares for each year the budget and commitments (value of completed and ongoing projects). As can be seen, overall, the committed budget for the period 2007-2013 was N13,701,306,864 while the amount released for projects (value of completed and ongoing projects) was N4,954,123,943,which translates to the overall performance of 36 per cent. The performance was best in 2009-2010 when it recorded52 per cent, and lowest in 2007-2008 when it fell by half to26 percent.

Compared to the budget for the years, the disbursement is overall low at 36 per cent. The implication is that the planned projects will remain unimplemented while the allocated funds are not fully disbursed.

Table 4.5: Proportion of Budget Spent by MDG-CGS on Health Projects, 2008-2013

Year	Delta State Budgetary Provision (N)	Expenditure on Health (N)	Performance
2008	1,945,269,053	1,289,152,900	66
2009	1,806,059,875	1,168,044,657	65
2011	2,028,409,443	1,518,957,057	75
2012	800,000,000	337,642,007	42
2013	1,200,000,000	502,765,953	42
TOTAL	7,779,738,371	4,816,562,575	62

Source: Directorate of the MDGs

Table 4.6: Total Budget Allocation to Health Sector as a Proportion of State Budget, 2006-2013

YEAR	State Budget	SMoH Budget	DESOPADEC SPENDING	MDG-CGS Spending	Total Allocated to Health (SMoH, DESOPADEC & MDG-CGS)	% of State Budget Allocated to Health
2006	149,999,499,025	10,459,500,000			10,459,500,000	7
2007	189,959,900,152	10,728,625,000			10,728,625,000	5.6
2008	146,340,513,746	10,458,336,373	981,095,352	1,289,152,900	12,728,584,625	8.7
2009	237,630,296,039	8,028,860,271		1,168,044,657	9,196,904,928	3.9
2010	331,860,069,094	16,125,750,223	1,570,748,313		17,696,498,536	5.3
2011	361,904,074,383	11,061,667,422	769,355,389	1,518,957,057	13,349,979,868	3.7
2012	437,218,083,558	35,862,304,777		337,642,007	36,199,946,784	8.3
2013	472,006,772,170	28,882,276,661	1,548,039,457	502,765,953	30,933,082,072	6.6
TOTAL	2,326,919,208,167	131,607,320,728	4,869,238,511	4,816,562,574	141,293,121,813	6.1

MDG-CGS Health Financing

Table 4.5 depicts the proportion of the budget of the Conditional Grant Scheme of the MDG (MDGCGS) that was spent on health projects for the period 2008 – 2013.

It should be noted that N4,816,562,575 was spent by the MDG-CGS out of its total budget of N7,779,738,371, which translates to 62 per cent, over the five-year period (2008-2013). The proportion spent per year ranged from 42 per cent in years 2012 and 2013 to a maximum of 75 per cent in 2011.

These figures indicate that the health sector has had more funding from the MDG-CGS than the other sectors (education and water). Overall, N98,547,971,589 was spent on health initiatives from 2006 to 2013 by SMoH, DESOPADEC and MDG-CGS. The SMoH spent N88,857,170,504 (90 per cent), DESOPADEC spent N4,869,238,511 (5 per cent), while the MDG-CGS expenditure on health amounted to 4,816,562,574 (5 per cent).

Table 4.6 combines the budget allocation for the SMoH and expenditures by MDG-CGS and DESOPADEC, and compares the combined total allocation to the State Budget. As seen from the table, N141,293,121,813 was allocated to health initiatives from 2006 to 2013 by SMoH, DESOPADEC and MDGCGS out of a total state budget of N2,326,919,208,167 for the same period. The proportion allocated to health was lowest in 2009 and 2011 at 4 per cent each, while the highest allocation was in 2008 at 9 per cent. This implies that the budgetary allocation to the health sector needs to be increased if the Abuja Heads of African State Summit target of 15 per cent is to be achieved.

Health Sector Performance and Results of Policy/Programme Implementation

Overview

As earlier indicated, no data was provided on the achievements of the health policies, programmes and interventions of the Delta State Government from 1991-2004. The first definitive health plan for the State is contained in the DELTASEEDS designed to run from 2005-2007. This blueprint contains health policy thrusts, targets and strategies based on which the Free Maternal Healthcare (FMHCP), the Free Under-5 Healthcare (FU-5HP), the Free Rural Healthcare Scheme (RHS), as well as the HIV & AIDS, TB and malaria programmes were designed and implemented. The results of these programmes are discussed in the first part of this chapter. The second part dwells on the enabling environment that helped to achieve the recorded results.

Policy and Programme Implementation Results

Free Maternal Healthcare Programme (FMHCP) Results

The results of the Free Maternal Healthcare Programme from October 2008 to December 2012 are depicted in Table 5.1. These include 254,254 antenatal (ANC) bookings, 836,544 routine ANC visits, 12, 954 postnatal services, 116 deliveries among which 13,594 Caesarean Sections (C/S) were recorded. The maternal mortality rate per 100,000 deliveries declined over the period: 380/100,000 deliveries (2008), 430/100,000 deliveries (2009), 410/100,000 deliveries (2010), 290/100,000 deliveries (2011), and 270/100,000 deliveries (2012). Antenatal bookings remained constant over the years, ranging from 58,967 (2008), 44,309 (2009), 42,927 (2010), 52,919 (2011), and 55,132 (2012). Postnatal care visits peaked at 10,486 (2009) before declining to 7,108 (2011) and 6,103 (2012). The number of Caesarean Section however increased steadily from 2,217 (2008) to 3,624 (2012).

The Free Under-5 Healthcare Programme (FU-5HCP)

Since its introduction in 2010, the Free Under-5 Healthcare Programme, implemen-

Table 5.1: Achievements of the FMHCP, 2008-2012

Indicator	2008	2009	2010	2011	2012	TOTAL
Total ANC bookings	58,967	44,309	42,927	52,919	55,132	254,254
Routine ANC	166,061	172,415	130,780	183,062	184,226	836,544
Postnatal care	3,626	10,486	5,631	7,108	6,103	32,954
Total deliveries	22,023	22,986	19,289	25,057	27,149	116,504
Vaginal deliveries	19,806	20,394	17,041	22,144	23,525	102,910
C/S deliveries	2,217	2,592	2,248	2,913	3,624	13,594
Perinatal deaths	989	928	835	1006	1,175	4,933
Maternal deaths	83	99	80	73	72	407
Perinatal mortality ratio(per 1000 deliveries)	45	40	43	40	43	42
Maternal mortality rate (per 100,000 deliveries)	380	430	410	290	270	350
HIV prevalence	4.1%	3.7%	3.3%	3.0%	2.9%	

Source: 2012 Statistical Digest, DPRS/SMoH

Table 5.2: Hospital Data from the Free U-5 Healthcare Programme, 2011-2013

Indicator	2010	2011	2012	2013	Total
Number attending Outpatients Services	76,450	219336	330,109	327,120	953,015
Number of admissions	6,036	16,621	20,997	21,601	65,255
Total patient volume	82,486	235,957	351,106	348,721	1,018,270
Number of deaths	151	552	644	607	1,954
Under-5 case fatality rate per 1,000 pt load	1.8	2.3	1.8	1.7	1.9

Source: SMoH

ted in 53 public hospitals, has recorded a number of achievements, as shown in Table 5.2.

The records show that 1,018,270 in- and outpatients were served over the period from 2010-2013. Over the same period, the Under-5 Mortality Rates have been reducing: 1.8 per 1,000 total volume (2010), 2.3 per 1,000 total volume (2011), 1.8 per 1,000 total volume (2012), and 1.7 per 1,000 total volume (2013). The overall Mortality Rate for the period was 1.9 per 1,000 total patient load.

The Rural Health Scheme (RHS)

A summary of statistics emanating from this scheme for 2008 to 2012 is provided in Table 5.3.

Table 5.3 shows that 97,678 people registered for services under the scheme over a five-year period. In addition, 443 communities were visited, and 6,421 operations were conducted, including general surgery (1,444), obstetric and gynaecological operations (360), ophthalmic surgeries (2,562), and dental consultations (2,055). Similarly, 4,165 children aged 0-11 months were immunized. Under the scheme, both women and men were counselled and tested for HIV. The HIV prevalence recorded were 3.4 per cent (2008), 2.9 per cent (2009), 2.5 per cent (2010), 2.6 per cent (2011), and 2.9 per cent (2012).

HIV & AIDS Programme Results

The achievements of the HIV & AIDS Programme are discussed below under the key components of the health sector response to HIV & AIDS.

HIV Counselling and Testing Services

This service is available in Delta State for individuals who voluntarily wish to know their sero-status, all pregnant women attending antenatal care, as well as patients diagnosed with tuberculosis. As of December 2013, the State had 637 Counselling and Testing sites. The distribution by LGA ranges from 11 HCT sites in Warri North to 45 HCT sites in Warri South. In addition to the facility-based services, the Free Rural Healthcare Scheme also offers HCT services, whereby more than 43,000 people were counselled, tested and received their results. The statistics emana-ting from this Scheme are depicted Table 5.4.

As seen in Table 5.4, for each of the years shown, more females than males were counselled and tested. Again, in all the years surveyed, the HIV prevalence was higher among females than among males. For males,

Table 5.3: Rural Health Scheme Summary Statistics for 2008 -2012

Indicator	2008	2009	2010	2011	2012	TOTAL
Number registered	19,974	19,567	14,879	24,194	19,064	97,678
General surgery	244	377	261	352	210	1,444
O & G	85	99	49	65	62	360
Ophthalmic surgery	536	681	464	462	419	2,562
Dental cases	-	-	-	1,065	990	2,055
Immunization	-	-	-	2,217	1948	4,165
HIV Prevalence	3.40%	2.90%	2.50%	2.60%	2.90%	
Communities visited	93	101	71	100	78	443

Source: SMoH

Table 5.4: Free Rural Healthcare Scheme HIV Data, 2008-2012 with Prevalence Rate (%)

Year	Males		Females		Overall	
	No Tested	No Positive	No Tested	No Positive	No Tested	No Positive
2008	2,412	59 (2.4)	5,014	195 (3.9)	7,426	254 (3.4)
2009	3,363	81 (2.4)	6,843	218 (3.2)	10,206	299 (2.9)
2010	2,030	38 (1.9)	4,781	132 (2.8)	6,811	170 (2.5)
2011	2,931	70 (2.4)	7,570	201 (2,7)	10,501	271 (2.6)
2012	2,664	42 (1.6)	6,687	228 (1.8)	9,351	270 (2.9)
TOTAL	13,400	290 (2.0)	30,895	974(3.1)	44,295	1,264 (2.9)

Source: SMoH

the HIV prevalence was 2.4 per cent in 2008, declining to 1.6 per cent in 2012. Among females, the prevalence was 3.9 per cent in 2008 declining to 1.8 per cent in 2012. Overall, the prevalence of HIV was 3.4 per cent in 2008 declining to 2.9 per cent in 2012. A total of 44,295 people accessed HIV Counselling and Testing services over the five-year period, ranging between 6,811 (2010) to 10,501 (2011), depicting a levelling of demand for services over the years. Comparing the female HIV trends with the National HIV Sentinel Surveillance (NHSS) trends reveals the following values with Delta State in parentheses: 3.9 (3.7) in 2008 and 2.8 (4.1) in 2010.

With the current availability of the HCT services and the number of the people accessing them in Delta State, one would have expected that the social stigma associated with HIV infection would have significantly declined by now. Discussions with doctors in hospitals providing ART services show that this is not so. It appears that patients would still prefer to have their ART treatment at sites far from their localities for fear of being identified by their communities. Stigmatization thus constrains the effort to decentralize some ART services to the PHC level so as to reduce the large number attending hospital clinics.

Prevention of Mother-to-Child Transmission of HIV (PMTCT)

In line with the global agenda, the National PMTCT Scale-Up Plan 2010-2015 has the target of eliminating mother-to-child transmission of HIV by 2015. The scale-up of the services has similarly been given prominence in Delta State SACA and SASCP, with support from PeTR-GS and the Nigeria Institute for Human Virology (IHVN). These bodies conducted a physical assessment of all the health facilities in the state and found 641 health facilities delivering ANC services. Currently, a total of 503 health facilities (78 per cent of the eligible facilities) are offering PMTCT services. The PHCs have been linked to SHCs, forming 40 clusters. The SHCs are being further strengthened to support service expansion in the PHCs within their clusters.

In 2013, 47,015 pregnant women were counselled, got tested and received their results. Estimating that 168,000 pregnancies occurred in Delta State in 2013, the coverage of PMTCT was 23 per cent. The service coverage is expected to rapidly increase in 2014 when the newly activated sites become fully operational.

Antiretroviral Therapy (ART) Services

Currently, there are 94 ART sites in Delta State. Distribution by LGA ranges from one site each in Bomadi, Warri North and Warri South West to 14 sites in Sapele LGA. In 2013, some 14,236 patients were receiving ART. This translates to a coverage of about 25 per cent of the eligible people (2013 Population 4,900,000; HIV prevalence 2.9 per cent; assuming 40 per cent of PLWH are eligible for ART). Early Infant Diagnosis (EID) services are limited to collection of dried blood spots (DBS) that are transported to Obafemi Awolowo University at Ife for processing using Polymerase Chain Reaction (PCR). The capacity to carry out this diagnosis does not exist in Delta State at the moment.

HIV/TB Collaborative Activities

Interventions under this collaborative arrangement include: (i) Intensive TB case finding among patients with HIV, which is done using symptoms, Chest X-ray and GeneXpert. Patients diagnosed with active TB are referred to the TB clinic for treatment; those without active TB are referred for initiation of ART; (ii) Isonizide Preventive Therapy (IPT); (iii) Infection control measures. These are taken to prevent nosocomial infection in all clinical settings in Delta State. Additionally, environmental measures are taken to improve ventilation in TB wards and clinics; (iv) Co-trimoxazole Prevention Therapy (CPT), which is administered to all patients dually

Table 5.5: Summary of Achievements of the State TB Programme, 2009-2012

	2009	2010	2011	2012
Number of TB sites by year	155	155	155	155
Total cases	2,517	2,507	3,076	2,966
Smear positive (ss+)	1,275	1,394	1,430	1,673
Relapse	65	63	74	33
Failures	16	21	18	12
RAD	78	74	81	29
Smear negative	863	722	970	1,052
EPTB	49	54	66	59
Others	186	179	274	108
Estimated new SS+ cases	28/100,000 pop	30/100,000 pop	30/100,000 pop	34/100,000 pop
Total TB cases	2,517	2,507	3,076	2,966
Cured	251	968	1,075	1,262
Treatment completed	88	188	141	172
Failure	4	14	18	27
Died	15	60	63	93
Defaulted	59	141	89	83
Transferred out	7	23	44	36
Total evaluated	424	1,394	1,075	1,673
Cure rate	59.1%	69%	75%	75%
Success rate	80%	82.5%	85%	85.7%

infected with TB and HIV; (v) Such dually infected patients are referred for initiation of ART; (vi) All patients who are diagnosed with TB are also screened for HIV, therefore HIV counselling and testing is conducted in all DOTS clinic either on-site or by referral.

Tuberculosis Control Programme Results

The Stop TB strategy adopted by the National TB Control Programme aims to: (i) Halt and begin to reverse the incidence of TB by 2015; (ii) Reduce prevalence and deaths due to TB by 50 per cent compared with the baseline figure in1990 and, by 2050, eliminate TB as a public health problem.

DOTS Expansion

Delta State has recorded remarkable success in DOTS expansion. Currently, there are 106 sites delivering DOTS services in the State. The distribution by LGA ranges from nine sites in Warri South West to two sites each in Patani and Uvwie LGAs. Also, the State has 22 functional microscopy centres, although some of them are not functional. For example, the centres in Oshimili North, Ika North-East and Aniocha North are not functional. Conversely, Ethiope East has three functional centres; Okpe, Oshimili South, Sapele and Uvwie LGAs have two functional centres each, while Ethiope East has three functional ones.

Table 5.5 summarizes the achievements of the TB programme in Delta State by various indicators from 2009-2012. The number of TB cases diagnosed by year is 2,517 (2009), 2,507 (2010), 3,076 (2011) and 2,966 (2012). The number of sputum smear positive cases increased from 1,275 (2009) to 1,394 (2010), 1,593 (2011) and 1,673 (2011). This translates to 28.3/100,000 population (2009), 30/100,000 population (2010), 30/100,000 population (2011) and 34/100,000 population (2012), depicting a steady rise over the period.

The TB cure rate improved steadily over the years being 59 per cent, 69 per cent, 75 per cent and 75 per cent in 2009, 2010, 2011 and 2012, respectively. The Programme's success rate also improved from 80 per cent in 2009 to 85.7 per cent in 2012.

Multidrug Resistant TB

There are two GeneXpert testing facilities in Delta State, the second one in Agbor having

been installed recently while the one in Asaba has been functional for sometime now. Even before the establishment of the GeneXpert testing capacity, patients suspected to have multi-drug resistant TB were being referred out of the state for confirmation. Delta State is in the process of selecting a site to establish a treatment ward for management of the diagnosed MDR-TB cases. It was reported during the assessment that four MDR-TB cases from Delta State had completed the intensive phase of treatment in treatment centres and are now continuing with treatment in the community. Twenty patients diagnosed with MDR-TB are waiting for availability of space in the Treatment Centres to initiate their treatment. There are five patients currently undergoing treatment in centres out of the State while another recently diagnosed patient is waiting to be referred for treatment.

Malaria Control Programme Results

The State has been carrying out malaria control interventions as already described above. The achievements are further discussed in the following subsections.

Long Lasting Insecticide Net (LLIN) Distribution

Distribution, through campaigns, of Long Lasting Insecticide Net (LLIN)to Under-5 children and pregnant women attending clinics and private hospitals has made LLINs available to households. In 2013, an LLIN and Malaria Indicator Survey (Delta State LLIN Report, 2013) and a Malaria Indicator Report (Survey of Malaria Indicators Delta State 2013) revealed that:

- 65 per cent of households have at least one ITN
- 47 per cent persons of all ages have access to ITN
- 28 per cent persons of all ages slept under ITN the night before the survey
- 43 per cent of children under-5 slept under ITN the night before the survey.

Artemisinin-Based Combination Therapies (ACTs)

Since 2006, the Delta State Government has seen to the administration of Artemisinin-based Combination Therapies (ACTs) in public and private health facilities in the State. The Rapid Diagnosis Tests (RDTs) introduced in 2011 are also still being rolled out. The 2013 survey on ITN and other indicators show that 34 per cent of the Under-5 children with fever got tested and received ACTs within 24 hours (2013 Rapid Mobile-Based Phone-RAMP Survey ITN and Other Indicators).

The Delta State Strategic Health Development Programme 2010-2015

The SSHDP Monitoring and Evaluation Framework has indicators with benchmarks for monitoring performance. Most of the indicators are in the Process and Output domains, and are summarized in Annex A. Indicated below is further elaboration of the results achieved through the implementation of health interventions under each of the eight Priority Areas.

Priority Area 1 – Leadership and Governance for Health

The goal of this Priority Area 1 is to create and sustain an enabling environment for the delivery of quality health care and development. It has two outcomes, namely: (i) Improved strategic health plans implemented at Federal and State levels; and (ii) Transparent and accountable health systems management.

Regarding health planning, Delta State did not engage itself in any comprehensive strategic planning exercise for the health sector before 2009. By that year, and with the support of the Federal Ministry of Health, the State developed the Strategic Health Development Plan for 2010-2015. Applying the guidelines from the FMoH, the exercise was participatory, involving the key stakeholders.

One of the outcomes under this Priority Area is 'Strengthened accountability, transparency and responsiveness of the state health system'. LGAs were supposed to establish Health Watch Groups whose role was to assess the implementation of health interventions in their respective LGAs and provide feedback and recommendations to the LGAs and SMoH. During field assessment, however, it was revealed that none of the LGAs had established a Health Watch Group. The only community-level group linking the community to health centres and facilitating community-level health promotion activities are the Ward Development Committees (WDCs). The selection and appointment of the WDCs are facilitated by NPHCDA. A visit to two of the WDCs by the assessment team showed that those in charge were volunteers with a commitment to community development.

Apart from facilitating health promotion activities in their respective communities, the WDCs are instrumental in creating demand for services in the PHCs. In a few occasions the

WDCs contribute materially to effect minor repairs needed in their respective health facilities. The communities expressed satisfaction with the services provided through the FMHCP and the RHS. They, however, complained about the inappropriateness and insufficiency of the contents of the delivery kits distributed through the SURE-P and MSS. They also reported that the infrastructural works undertaken in PHCs under the SURE-P were incomplete, leaving most facilities without security gates, some with broken fences and none with gardeners to clean the grounds. In Riverine LGAs, there was a complaint that the PHC buildings are threatened with soil erosion following heavy rains.

Regarding the establishment of a Peer Review Mechanism (PRM), the assessment team was informed that the SMoH was represented in the Nigeria Governors' Forum (NGF) meeting to develop indicators and benchmarks for the Peer Review Mechanism in August 2010. These indicators have not been finalized for use. Consequently, there has been no Peer Review conducted at the State or LGA levels.

Priority Area 2 – Health Service Delivery

The goal here is to revitalize integrated service delivery towards a quality, equitable and sustainable healthcare. It has two outcomes, namely: (i) Universal availability and access to an essential package of primary health care services focusing in particular on vulnerable socio-economic groups and geographic areas; and (ii) Improved quality of primary health care services.

Based on the available 2012 SMoH Statistical Digest, which is compiled using routinely reported service data, two core indicators have been used to assess this Priority Area. They are: (i) The number and distribution of health facilities per 10,000 population; and (ii) The number and distribution of hospital beds per 10,000 population.

Table 5.6summarizes the findings using the above indicators for the state and by LGA.

The density of hospital beds in the State was six per 10,000 population in 2012. The table depicts wide variations between LGAs ranging from two hospital beds per 10,000 population (Oshimili South, Udu and Ughelli South LGAs) to 14 hospital beds per 10,000 (Ethiope East LGA). Eleven LGAs have a density lower than the state density.

Regarding the health facility density, the table shows 1.96 health facilities per 10,000 population. Again this ranges from 0.72/10,000 population (Warri North LGA) to 3.67/10,000 population (Uvwie LGA). Thirteen LGAs have a health facility density that is lower than that of the state.

The minimum acceptable level is at least five emergency obstetric care facilities (including at least one comprehensive facility) for every 500,000 population (WHO).

As seen from the table, the State PHC density is 244/10,000 population, ranging from 1 per 10,000 population in Okpe and Patani LGAs to 35 per 10,000 population in Uvwie LGAs.

With regard to hospitals, the State density is 1.46 hospitals per 10,000, ranging from 0.6 per 10,000 to 2.97 per 10,000 population.

The distribution of the health facilities, therefore, is far above the minimum acceptable levels. The assessment team was informed that not all the PHCs are functioning according to expectation. One of the urban health centres visited did not have a delivery room, and yet was providing antenatal (ANC) services. To undertake deliveries, the PHC needs structural repairs, continuous running water and toilet facilities.

Priority Area 3 – Human Resources for Health

The goal of this third Priority Area is to plan and implement strategies to address the needs of human resources for health by way of ensuring availability of personnel, and promoting fairness and sustaining the quality of health care. There are two outcomes from this: (i) The Federal Government implements comprehensive HRH policies and plans for health development; and (ii) All States and LGAs are actively using adaptations of the National HRH policy and plans for health development up till the end of 2015.

The SMoH has established a Human Resource Desk even though there is no Human Resource Development Plan for the State yet. The release of the guidelines from the FMoH will facilitate the development of the State HRH Plan.

No formal workload analysis has ever been conducted in Delta State. However, when asked directly, most Heads of Department in all health facilities visited complained of shortage of all categories of health workers. Table 5.7 depicts the health worker-patient ratio for 2009 to 2012.

Table 5.7 indicates that for doctors, the ratio has increased over the three years, decreased for registered nurses and remained constant for pharmacists over the three-year period.

Table 5.6: Bed and Facility Density by LGA

	LGA	Pop 2012	Patients' Beds	Hospitals	PHCs	Bed Density per 10,000	Hosp. Density per 10,000	PHC Density per 10,000
1	Aniocha North	126,494	120	8	27	9	2.13	8
2	Aniocha South	169,854	120	9	32	7	1.88	9
3	Bomadi	104,669	50	5	13	5	1.24	5
4	Burutu	253,283	150	5	24	6	0.95	5
5	Ethiope East	242,563	345	8	24	14	0.99	8
6	Ethiope West	245,946	110	6	24	4	0.98	6
7	Ika North East	221,863	160	9	50	7	2.25	9
8	Ika South	196,419	190	11	54	10	2.75	11
9	Isoko North	174,144	100	4	22	6	1.26	4
10	Isoko South	275,083	150	9	23	5	0.84	9
11	Ndokwa East	124,634	150	2	37	12	2.97	2
12	Ndokwa West	180,389	60	4	32	3	1.77	4
13	Okpe	157,079	60	1	20	4	1.27	1
14	Oshimili North	139,305	120	4	14	9	1.00	4
15	Oshimili South	180,725	30	25	31	2	1.72	25
16	Patani	81,792	30	1	11	4	1.34	1
17	Sapele	207,646	150	16	23	7	1.11	16
18	Udu	173,185	30	10	25	2	1.44	10
19	Ughelli North	387,812	300	18	48	8	1.24	18
20	Ughelli South	258,006	60	2	25	2	0.97	2
21	Ukwuani	145,435	90	5	27	6	1.86	5
22	Uvwie	231,304	60	35	50	3	2.16	35
23	Warri North	165,863	50	2	10	3	0.60	2
24	Warri South	366,537	230	42	61	6	1.66	42
25	Warri South West	140,954	130	3	17	9	1.21	3
	State Total	4,950,984	3,045	244	725	6	1.46	244

Compared to the national level (in parentheses) for year 2012, the ratios are 17 (39) doctors/100,000 population, 71 (148) registered nurses/100,000 and 5 (10) pharmacists/100,000 population, which clearly shows that for all health worker categories, Delta State is fairing worse than the national average.

The numbers and skill mix of the health workforce can contribute to increased staff motivation. The assessment team found that staff working at PHCs are demotivated by the irregular and delayed payment of salaries. In one PHC visited, the assessment team was informed that staff had not received their January salary, while payment of the April salary was also delayed. Other factors, including staff security concerns in some PHC facilities, and inadequate work tools, also contribute to demotivating staff. Supportive supervision and training can help improve motivation. The State level Agencies (LG Service Commission and SPHCDA) conduct regular (at least once per month) supervisions to LGA Health Departments. These are integrated supportive supervision visits which consist of both administrative and professional components.

Table 5.7 Health Worker Density by Category per 100,000 Population, 2009-2012

Category	2009	2011	2012
Doctors/100,000	11(1:9,063)	20 (1:4,852)	17 (1:5,905)
Nurses/100,000	48 (1:2,063)	46 (1:2,181)	71 (1:1,400)
Pharmacists/100,000	4.9 (1:20,492)	4.9 (1:16,928)	5 (1:18,442)

In each LGA visited, selected PHCs are jointly supervised by the State and the LGA teams. Identified problems are addressed on site. These visits also provide opportunities for on-the-job training of PHC staff by experienced health workers. While supervision from State to LGA is taking place as expected, the LGA Health Department Officers supervise their LGAs irregularly, due to inadequate budget for transport. At the secondary health facility level, staff are motivated by regular trainings, both formal and informal, during scheduled monthly and quarterly monitoring meetings.

Priority Area 4– Financing for Health

The goal of this is to ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and consumption at local, state and federal levels. It has two outcomes, namely: (i) Implementing health financing strategies at federal, state and local levels in consonance with the National Health Financing Policy; and (ii) Protecting the Nigerian people, particularly the most vulnerable socio-economic population groups, from financial burden and impoverishment as a result of using health services. This Priority Area has eight indicators, three of which have targets, while only one has baseline value.

The assessment revealed that contribution to a health insurance scheme is unpopular among Civil Servants in Delta State. Consequently, there is no pre-payment arrangement being implemented. The Professional Associations, however, reported their willingness to work with the SMoH to mount a campaign to educate the general public about the merits of the fund pooling arrangement that allows sharing of financial risks due to health expenditure.

The arrangement in place for those who require services that are not provided free in secondary health facilities is to access the RHS. Cases of medical emergency are handled differently where services are guaranteed for the first 24 to 48 hours, pending the arrival of relatives. Proven cases of inability to pay by relatives are referred to the Social Welfare section of the respective hospital.

Priority Area 5 – National Health Information System

The National Health Information System has two outcomes, namely: (i) The National Health Management Information System and subsystems which provide public and private sector data to inform health plan development and implementation; (ii) The National Health Management Information System and sub-systems which provide public and private sector data to inform health plan development and implementation at Federal, State and LGA levels. The team was informed that Delta State staff had attended a course on DHIS 2 in May 2014. Currently, the paper-based system is operational. There are three officers in the DPS of the SMoH whose responsibility is to contact LGAs for monthly reports. It is the responsibility of the LGA Health Department to collect the reports from the PHCs and to forward them to the DPS. Statistical digests are produced and shared with relevant officers for follow-up action, monitoring, and planning of service improvement.

Priority Area 6 – Community Participation and Ownership

This Priority Area has one outcome, namely, strengthened community participation in health development**.** The assessment team met with representatives of the Ward Development Committees (WDC) during the assessment. They were selected and trained by the National Primary Health Care Development Agency (NPHCDA) in connection with the implementation of the MSS and SURE-P. They serve as the link between the communities and the PHC facilities, while also serving to promote environmental health activities. It is not clear how active the WDC might be in communities not benefiting from the MSS.

The Village Health Worker Scheme started in 2011 under the Office of the Senior Special Assistant to the President on MDGs (OSSAP-MDGs). Delta State has seven out of the 148 LGAs that are currently benefiting from the Scheme. A total of 100 village health workers have been selected, trained and deployed to the communities.

The several community-based organizations (CBOs) undertaking various health-related interventions in the various communities are too numerous to list. What is clear from the assessment, however, is the need to recognize the importance of all the community structures and strengthen them to enable them play their role in health development. Future health development initiative will need to involve them as key partners in health. It will also be important to put in place a clear framework for community participation and define the roles of the CBOs.

Priority Area 7 – Partnership for Health

This Priority Area's outcome, namely, functional multi-partner and multi-sectoral participatory mechanisms at federal and state levels contribute to the achievement of the goals and objectives of the SSHDP.

The Private Health Providers are obligated by law to register their facilities with the SMoH. An informal arrangement exists whereby private hospital providers are required to submit their service delivery reports to the SMoH as a condition for the renewal of their registration. There is no formal arrangement in place to enhance public-private collaboration in health service delivery. It was reported that the programme on immunization was preparing a memorandum with private health care providers to enhance their participation in routine childhood immunization.

Coordination of the development partners lies with the Overseas Development Agency in the Ministry of Finance. The individual departments and programmes within the SMoH convene meetings, which are attended by development partners working in their areas.

The following factors (strengths and opportunities) have constituted an enabling environment for the state health sector to record the above achievements.

Facilitating Environment

Below is a list of factors that have facilitated the achievements made in the health sector:

- Demonstrable high-level political commitment to health development.
- Strong, committed and experienced health workforce made up of professional and non-professional cate-gories.
- Provision of free health services by the State Government to pregnant women, rural dwellers and children under-5.
- Existence of a network of health facilities, both public and private.
- Presence of agencies to facilitate effective execution of health activi-ties.
- Capacity building for LGA and State health sector staff.
- Development Partners' support for the health sector.
- Existing projects to rehabilitate heal-th facilities.
- Strong economic base for the state.

Opportunities

Opportunities exist that could be harnessed for future improved performance of the health sector. These include:

- Staff enthusiasm and feeling of ownership of health programmes
- Strong clinical capabilities.
- Large pool of trainable and trained manpower.
- Community leaders who are ready to support health initiatives.
- The bright economic opportunities that exist in the State.
- Willingness of donor partners to support health programmes
- Huge presence of the private sector.
- Improved peace and security, espe-cially in the riverine areas.

Sectoral Performance in Relation to the MDGs

Achievement of the health MDGs is better tracked using agreed indicators for each goal. Below are the MDG achievements of Delta State by goals/targets:

Goal 4: Reducing child mortality by two-thirds of the 1990 level by 2015.

- *Indicator 4.1: Infant mortality rate*. The recorded values for Delta State are: 48/1,000 live births (2003), 32.3/1,000 live births (2006), 32.3/1,000 live births (2011) and 37 per 1,000 live births (2012). The national baseline value (1990) is 91/1,000 live births while the target for this indicator is 30.3 per cent by 2015.
- *Indicator 4.2: Under-5 mortality rate.* The rates are: 102 per 1,000 live births (2003), 54.4 per 1,000 live births (2006), 108 per 1,000 live births (2011) and 52 per 1,000 live births (2012). The national baseline value (1990) is 191/1,000 live births while target for is 63.7 per cent by 2015.
- *Indicator 4.3: Percentage of one-year-olds fully immunized against measles*. The rates are 38.5 per cent (1999), 61.3 per cent (2008), 57.6 per cent (2012) and 60.4 per cent (2013).The national baseline value (1990) is 46 per cent while target is 100 per cent by 2015.

Target 5.A–to reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio.

- *Indicator 5.1.*There appear to be discrepancies in the maternal mortality rates available from the UNFPA, State Ministry of Economic Planning and SMoH sources. Nevertheless, the rates in Table 6.2 produced by the SMoH show consistent decline, excepting in 2012. The rates are 456 per 100,000 births (2005) and 188 per 100,000 live births (2013). Considering that the national

Table 6.1. Goal 4 Performance by Indicator

Indicator	1990 Baseline	2003		2006		2011		2012		2015 Target	
	Value	Value	Source	Value	Source	Value	Source	Value	Source	Value	Source
4.1 Infant mortality rate (per 1,000 live births)	91	48	Delta HHS	32.3	Delta HHS	32	Delta HHS	37	NBS_TS	30.3	
4.2 Under-5mortality rate (per live 1,000 births)	191	102	Delta HHS	54.4	Delta HHS	108	Delta HHS	52	NBS_TS		

Indicator	1990 Baseline Value	1999	Source	2008	Source	2013	Source	2015 Target
4.3 Percentage of one-year-olds fully immunized against measles	46	38.5	MICS	61.3	NDHS	60.4	NDHS	100%

Notes: HHS – Household and Housing Survey; NDHS – National Demographic and Health Survey, LB – Live births
NBS TS – National Bureau of Statistics MDG Performance Tracking Survey

Table 6.2: MDG Target 5A Performance by Indicator

Indicator	1990 Baseline	2005		2008		2011		2012		2013		2015 Target
	Value	*Value*	*Source*	*Value*	*Source*	*Value*	*Source*	*Value*	*Source*	*Value*	*Source*	
5.1 Maternal mortality rate (per	1,000	456	UNFPA	395	SMoH (HCDA)	221	SMoH	243	SMoH	188	SMoH	250
100,000 live births)												
5.2 Proportion of births attended by skilled birth attendant	45			61.5	NDHS			73.2	NBS TS	59.9	NDHS	100

Notes:

SMoH – State Ministry of Health; HCDA (Human Capital Development Agenda, Vol 2)

UNFPA – United Nations Population Fund

NDHS – National Demographic and Health Survey
NBS TS – National Bureau of Statistics MDG Performance Tracking Survey
LB – Live births

baseline value (1990) is 1000/100,000 live births while the target is 250/100,000 live births by 2015, the target has already been achieved.

- *Indicator 5.2.* Proportion of births attended by skilled birth attendants: The rates are 49.1 per cent (1999), 61.5 per cent (2008), 73.2 per cent (2012), and 59.9 per cent (2013). The national baseline value (1990) is 45 per cent while the target is 100 per cent by 2015.

Target 5.B – Achieve by 2015 universal access to reproductive health

- *Indicator 5.3.* Contraceptive prevalence rate. The rates are: 26.6 per cent (2008), 16 per cent (2012) and 28.7 per cent (2013). The national target is 100 per cent by 2015.
- *Indicator 5.4.* Adolescent birth rate (per cent).There is no data for Delta State.
- *Indicator 5.5.*Antenatal care coverage of four or more visits: The rates are 74.6 per cent (2012), 72.5 per cent (2013).
- *Indicator 5.6.* Unmet need for family planning. Only one population survey provided information on this indicator for Delta State, revealing a rate of 23.2 per cent (2012), which is slightly higher than the national value of 21.5 per cent for this indicator (2012).The national target is 0 per cent by 2015.

Target 6.A – Have halted by 2015 and begun to reverse the spread of HIV & AIDS

- *Indicator 6.1a.* HIV prevalence among pregnant women aged 15-24 years (per cent) – State level data on this indicator is not provided by the National HIV Surveys. The HIV prevalence among

Table6.3:MDG Target 5BPerformance by Indicator

Indicator	1999		2008		2012		2013	
	Value	Source	Value	Source	Value	Source	Value	Source
5.3 Contraceptive prevalence rate (%)	18.5	MICS	26.6	NDHS	16	NBS TS	28.7	NDHS
5.4 Adolescent birth rate (%)								
5.5 Antenatal care coverage of 4 or more visits					74.6	NBS TS	72.5	NDHS
5.6 Unmet need for FP (%)					23.2	NBS TS		

Note: HHS – Household and Housing Survey, NDHS – National Demographic and Health Survey

Table 6.4: MDG Target 6a Performance by Indicator

Indicator	2009		2010		2011		2012	
	Value	Source	Value	Source	Value	Source	Value	Source
6.1a HIV prevalence among pregnant women aged 15-24 years (%)	2.8	RHS/ SMoH	2.3	RHS/ SMoH	2.8	RHS/ SMoH	2.3	RHS/ SMoH
6.2 Proportion of the population aged 15-24 years with comprehensive knowledge of HIV & AIDS (%)							28.4	NBS TS
6.3 Young people aged 15 -24 reporting use of condom during sexual intercourse with a non-regular sexual partner	24	NDHS 2008						
6.4 Children orphaned by AIDS (millions)								

Notes:
HHS – Household and Housing Survey
NDHS – National Demographic and Health Survey
NBS TS – National Bureau of Statistics MDG Performance Tracking Survey
RHS/MOH – Rural Healthcare Scheme of the State Ministry of Health

women (all women, not only pregnant women) aged 15-24 years was 2.8 per cent in 2009, 2.3 per cent in 2010, 2.8 per cent in 2011 and 2.3 per cent in 2012 (FU-5HS). The 2010 National HIV Sentinel Surveillance report records a prevalence of 2.5 percent for Delta State.

- *Indicator 6.2.* Proportion of the population aged 15-24 years with comprehensive knowledge of HIV & AIDS: The NBS conducted MDG Performance Tracking Survey in 2012 which assessed this indicator among young women aged 15-24 years, revealing that 28.4 per cent had comprehensive knowledge of HIV & AIDS. The national average was 33 per cent.
- *Indicator 6.3*. Young people aged 15-24 reporting use of condom during sexual intercourse with a non-regular sexual partner. The value for both Delta State and nation was the same: 24 per cent (NDHS 2008).
- *Indicator 6.4.*Number of children orphaned by AIDS: Delta State has no data for this indicator.

Target 6.B – Percentage of people with advanced HIV infection currently receiving antiretroviral therapy.

The data shows that 14,236 patients were receiving ART in 2013, which translates to a coverage of about 25 per cent of the eligible people.

Target 6.C – Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases

- *Indicator 6.6.* Malaria prevalence: There is no data for Delta State for this indicator.
- *Indicator 6.7.* Proportion of Under-5 children sleeping under ITN (per cent): For Delta State the value was 39.1 per cent compared to 18 per cent national, in 2012 (NBS MDG Performance Tracking Survey, 2012). The value for Delta State was reported as 34 per cent in 2013 (Nigeria Red Cross Bulletin, July 2013).

Table 6.5:MDG Target 6cPerformance by Indicator

INDICATOR	2009		2010		2011		2012		REMARKS
	Value	Source	Value	Source	Value	Source	Value	Source	
6.6 Malaria prevalence (per cent)									
Death per 100,000									
6.7 Proportion of children under 5 sleeping under ITN (%)							39.1	NBD TS	
6.8 Tuberculosis prevalence (per 100,000)	33	STBLP	33	STBLP	28	STBLP	29	STBLP	Values derived from new sputum positive cases

- *Indicator 6.8.* Tuberculosis prevalence (per 100,000): This indicator, as derived from the new sputum positive cases, reveals the values as: 33/100,000 in 2009, 33/100,000 in 2010, 28/100,000 in 2011 and 29/100,000 in 2012.

Conclusions on MDG Achievement

It would appear that the targets for indicators 4.1 (Infant mortality rate) will likely be achieved by 2015, while the target for indicator 4.2 (Under-5 mortality rate) and target 5.1 (maternal mortality rate) may already have been achieved.

Targets for indicators 4.3 (Percentage of one-year olds fully immunized against measles), 5.2 (Proportion of births attended by skilled birth attendants), 5.3 (Contraceptive prevalence rate), 5.5 (Antenatal care coverage of four or more visits), 6.1 (Prevalence of HIV among pregnant women aged 15-24 years) are either levelling down or depicting slow progress over time. More concerted and targeted efforts will be required to begin to register positive trends.

For the rest of the targets, it is difficult to do any trend analysis and drawing of any conclusions owing to inadequate data.

Efficiency and Effectiveness of the Measures Implemented

Introduction

A formal assessment of the efficiency of the interventions implemented over the period was not undertaken as part of this assessment. However, areas where efficiency could be improved upon have been explored. These include: (i) Utilization of PHC services; (ii) Formalizing the Public Private Partnership in health service delivery; and (iii) Strengthening the cluster approach for a more effective two-way referral system, supportive supervision, and mentoring. More elaboration on each follows below.

Utilization of PHC Services

The goal of the National Health Policy (2004) is to deliver comprehensive health care based on primary health care to all the citizens. The essence of primary health care is to bring health services to the doorstep of the rural people. However, owing to many reasons, among which are personnel (number and distribution), infrastructural functionality, attitudes of staff and motivation, availability of medicines and other supplies, have led to significant under-utilization of PHC services, especially the maternal and child health services (Caroline Ajuyah 2013, Abdulraheem et al. 2012). This results in oversubscription at the Secondary Health Centres and overstretching of the available health workforce. Given that the same health services delivered at PHC facilities are cheaper there than at higher levels (Secondary and Tertiary Health Centres), a focus on delivering the maternal healthcare services at the PHC facilities could, therefore, be more efficient. The discussion on the merit and modalities to be used to decentralize effective, high impact health service delivery from the secondary and tertiary facilities to the PHC facilities will have to involve all the three levels of government (Federal, State and LGA).

Formalizing Public Private Partnerships

The private sector (voluntary organizations, faith-based organizations and profit-making organizations) are significant health service providers in Delta State. As many as 182 out of 244 (75 per cent) of the Secondary Health Centres in Delta State are privately owned, while 281 out of 725 (39 per cent) of the Primary Health Centres are privately owned. In acknowledging the important role of the private health service providers, the National Health Policy (2004) emphasizes the intention of the government to collaborate with voluntary organizations, professional associations and the private sector to ensure that services provides by these bodies are in consonance with overall national health policy. It goes on to state that government will promote their optimal participation in the planning, organization, operation and management of health programmes and services, particularly primary health care.

The SMoH has recorded some successes in the first category of the health policy intentions. There is a mechanism in place for inspection, registration, monitoring and renewal of registration of non-governmental healthcare providers. As a condition for registration renewal, the private health service providers are obliged to submit their annual service provision reports to the SMoH. However, there is inadequate collaboration between the SMoH and the private sector in service delivery. Exploring and adopting innovative approaches to expand partnership with the private sector health services providers could be more efficient than the current approach of constructing new health facilities.

The Cluster Approach to Health Service Delivery

This approach, which is also known as the 'Hub and Spoke' model of service delivery, has been applied in six MSS clusters in Delta State. These are located in six LGAs, namely, Bomadi, Sapele, Warri South, Ika South, Ndokwa West and Ughelli North. In each cluster, there are four PHCs and one SHC. The components implemented include: (i) Institutionalizing community participation, whereby WDCs are reactivated for each PHC; (ii) Deploying four mid-

wives per PHC; (iii) Providing equipment and supplies for the PHCs; (iv) Building the capacity of midwives to improve quality of care; and (v) Providing ICT communication support. The PHC facilities have the capacity to deliver basic obstetric care and refer complicated cases to the general hospital within the cluster. Because the PHC facilities within the cluster are playing the role of filtering patients, the workload in the general hospitals in the six clusters is expected to reduce, thereby allowing time for the experienced health workers to visit the PHCs for supportive supervision and professional mentoring. Expansion of the cluster model to all the 25 LGAs will reduce the patient flow to the SHCs, thus allowing them to conduct professional mentoring and supervision of the PHCs. This is obviously a more sustainable way of addressing the congestion in the general hospitals than recruiting more staff to handle the huge patient flow. The cluster model is a pragmatic attempt to address one of the critical weaknesses of the health service delivery system in Delta State – the dysfunctional referral system – by enhancing linkages between the three levels of health care, thus fostering the provision of health services across a continuum of care.

Monitoring and Evaluation of Policies and Programmes in the Sector

Organizational Arrangements

The Office of the Special Adviser to the Governor on Project monitoring provides a Focal Person for monitoring the health programmes. The office is mandated to monitor SSHDP implementation using the elaborate M & E Result framework. The Health Management Information System has M & E and DSN units at the SMoH, LGAs and Health Facilities to track and monitor progress. Periodic joint assessment of achievements and progress towards MDGs are carried out with the Local Government Councils. The Expanded Health Data Consultative Committees (HDCC)is used to ensure cooperation of all stakeholders in reporting on their implementation progress. More regular State Council on Health meetings (twice yearly) are used to provide broad-based consultation, coordination and collaboration on a continuous basis. The Nigerian Governor's Forum (NGF) conceived the State Peer Review Mechanism in 2009. The aim was to assist states review their achievements and challenges as they implement their development policies. Health is one of the key sectors included in this endeavour. The SMoH was represented in a meeting convened in Abuja in August 2010 to develop indicators to be applied during the conduct of State Peer Reviews. The finalization of these indicators and institution of the Peer Review Mechanism could serve a very useful purpose in ensuring that health programmes are executed as planned in order to facilitate the timely achievement of State Health and Millennium Development Goals.

Monitoring SSHDP Implementation

The monitoring and evaluation framework of the SSDP 2010-2015 incorporates indicators for all eight priority areas, namely, (i) Leadership and governance; (ii) Service delivery; (iii) Human resource for health;(iv) Health financing;(v) Health Management Information System; (vi) Community participation; (vii) Partnership for health; and (8) Health research. There was no formal assessment done on progress made in implementation of the SSHDP using the M&E framework.

The state undertook a desk review of its performance as part of the 2013 Mid-Term Review of the NSHDP 2010-2015. The first tool that was applied contained overlapping indicators with those of the SSHDP. That information has been extracted to enable assessment made in the implementation of the SSHDP.

Monitoring Outcomes and Impact

The assessment noted the non-availability of data for the measuring most of the outcome and impact indicators contained in the Monitoring and Evaluation Matrix of the SSHDP and those for tracking progress in achieving the health MDGs. The national population based surveys, such as MICS and NARHS, are not powered to provide State-level rates for most indicators. The DHS of 2008 and 2013, as well as the MDG Tracking Survey of 2013 contain rates for some outcome indicators, which were extracted to show the progress made in achieving the health MDGs. On Delta-specific impact indicators, namely, (i) Infant mortality rate; (ii) Under-5 mortality rate; and (iii) Maternal mortality rate, however, the source has been the Delta State Household and Housing Survey Reports for 2003, 2006 and 2011. These surveys were planned to be conducted every three years, but this was not the case.

Facility-based service data provide information for indicators such as maternal mortality rate, Under-5 and infant mortality rates, which are very useful in monitoring service delivery quality and determining the cause of deaths. The assessment was informed that health managers are reviewing these indicators and taking appropriate actions, to improve service quality.

The Civil Registration System could serve as the authentic data source for computing birth and death rates. However, it was reported that the completeness of Civil Registration in Delta State was less than 30 per cent. It has, therefore, not yielded the needed data for this assessment. The assessors were informed of efforts being made since 2000 to improve the birth registration of all those below age 18

years with the support of UNICEF. To generate real-time reporting, the State encourages the Rapid Short Messaging System (Rapid SMS), which is a means of reporting births through mobile phones. Full implementation of this initiative and its expansion to include child and maternal deaths will be needed to generate vital statistics. Furthermore, as the system captures real-time events, it could serve as a surveillance system that will prompt LGA and state-level officials to address the causes of child and maternal deaths with the respective communities and local authorities.

Gaps in Performance, Challenges and Constraints in the Sector

Overview

This section addresses gaps in performance, as well as the challenges encountered in the health sector.

Gaps in Performance

The main gaps in performance have been found in the following areas: (i) Implementation of the SSHDP; (ii) Tracking progress; (iii) Health sector financing; (iv) Access to safe, efficacious medicines of high quality; (v) Access to health services; and (vi) Sustainability of critical health programmes; and (vii) Inadequate diagnostic equipment.

Implementation of the SSHDP

The SMoH, using nationally developed guidelines, undertook a highly participatory exercise to develop the SSHDP, 2010-2015. It was expected that Annual Operational Plans (AOPs) would be developed, budgeted for and implemented. However, this was not done except for the first year (2010). Consequently, budget allocation to the health sector was not systematically linked to the SSHDP and its priority areas. Hence, the SSHDP remains very sparsely implemented, only 18 months to its end. Unless this situation is urgently corrected, there will be a dearth of lessons learnt to inform the development of the next plan beyond 2015.

Tracking Implementation Progress

Although monthly and quarterly monitoring meetings were reportedly occurring, it was not obvious whether the Expanded Health Data Consultative Committees (HDCC) was operational. It was reported that the State Health Council, which was expected to provide a broad policy direction on the progress of implementation, has not met for some years now.

There was evidence that the collected information is compiled into the Annual Progress Report that is compiled by the Department of Planning Research and Statistics. It is not clear how broadly these reports or the Statistical Digest are disseminated to provide a feedback to the data sources, or to make programmatic adjustments. Also, programme-specific data are compiled separately even when they relate to similar parameters. For example: the FMHCP, and IMCI report separately on (i) Total ANC booking; (ii) Postnatal care;(iii) Total deliveries; (iv) Perinatal deaths; and (v) Maternal deaths; while the Free Under-5 Health Programme and IMCI overlap in the child-related indicators reported. The FMHCP, RHS, TB and HIV & AIDS programmes provide HIV Counselling and Testing services and report their statistics separately. It, therefore, becomes difficult to quickly understand the progress based on indicators that are separately reported by more than one programme. Compilation of the data before publication would greatly enhance their value in tracking progress.

Moreover, there is insufficient data to monitor and evaluate health programmes' outcomes and impact, except for the Household and Housing (HHS) Surveys conducted irregularly by the Department of Research and Statistics of MoEP. The assessment team was informed that the HHS surveys were supposed to be conducted every three years. However the reports are available for 2003, 2006 and 2011 only. Without regularly conducting such surveys it becomes difficult to determine whether or not progress is being made towards achieving the MDGs based on infant, Under-5 and maternal mortality rates.

Health Sector Financing

It was revealed during the assessment that the SMoH, MDG-CGS and DESOPADEC were funding and implementing health programmes separately. Most of the capital projects implemented are similar, such as construction and refurbishment of health facilities and procurement and distribution of health equipment. Improved coordination of their activities would not only enhance efficiency through avoiding duplication, but also provide the SMoH an idea of how much the government is spending on health. This

information was not easy to secure during the assessment period.

Access to Safe, Efficacious Medicines of High Quality

The State Drug Revolving Fund (DRF) is functioning well and ensures the distribution of affordable, efficacious and high quality medicines and health supplies. Nevertheless, most of the PHCs are not patronizing the DRF for reasons that were not well clarified. This situation provides little or no assurance of the safety and quality of the medicines that are purchased from elsewhere.

Access to Health Services

The private sector owns 281 out of 725 (39 per cent) PHCs and 182 out of 244 (75 per cent) SHCs in the State. Except for the programme on immunization, the other SMoH programmes have not adequately engaged the private health service providers in expanding service delivery. Such collaboration would greatly increase access to health services.

Sustainability of Critical Programmes

The HIV & AIDS, TB and Malaria Programmes are enjoying substantial donor support to implement activities including provision of medicines, supplies, and reagents. There is very little funding from donors for operations. The programmes are accessing funding for operations from a common budget line which is mostly underfunded. The programmes do not have budget lines in the SMoH budget.

Inadequate Diagnostic Equipment

The two GeneXpert facilities in Delta State are grossly inadequate. Even before the establishment of the GeneXpert testing capacity, about 29 multi-drug resistant TB (MDR-TB) cases have been diagnosed in the State (four continuing with community treatment phase, 20 recently diagnosed, waiting to initiate treatment, and five undergoing treatment). There is no earmarked ward for treatment of MDR-TB cases in the State

Challenges/Constraints

The major challenges militating against the timely achievement of health outcomes in Delta State are:

- The weak health system characterized by inadequate numbers and uneven distribution of the health personnel, inadequate equipment and weak system for their repair and maintenance, inadequate health financing, a dysfunctional referral system for patients, inadequate logistics for conducting regular supervision and a dearth of reliable, timely and accurate information for planning, monitoring and evaluating health programmes.
- The socio-cultural practices that negatively influence health seeking behaviour, resulting in low utilization of reproductive and maternal health services by women especially.
- The social stigma which prevents people living with HIV & AIDS from disclosing their sero-status, thus keeping others from seeking HIV & AIDS services;
- Inadequate community involvement and participation without which health service ownership and sustainability become uncertain;
- Poverty, ignorance, peace and security issues, gender, food security, nutrition, and the environment contribute to poor health.

Observations

Observations emanating from the assessment can be itemized as follows:

1. The assessment has revealed that patients are bypassing the PHCs to seek maternal and child health services in SHCs because of cost and the perception that the SHCs are better. As a result, services in the SHCs are overstretched.

2. The Rural Healthcare Scheme (RHS) is delivered largely as an isolated outreach service to the communities without any strong linkages with the surrounding health facilities. As a result, there is no continuity of these services to the target communities between the RHS visits.
3. Delta State has done well in investing in health infrastructural rehabilitation and establishment as well as in health service delivery through innovative health programmes targeting the rural poor. Evidence points to the reduction of infant and Under-5 mortality rates. The reduction of maternal mortality rate, however, shows conflicting trends from the Delta State Household and Housing survey reports (2006 & 2011), and the SMoH service data. There is a need, therefore, to increase

efforts to reach the rural communities.

4. Diagnosis of HIV among children below 18 months poses a challenge in Delta State due to the lack of capacity for Polymerase Chain Reaction (PCR) testing. The collected dried blood spots (DBS) have to be transported to Obafemi Awolowo University at Ife for processing, and this causes unavoidable delays and loss of patients. Additionally, the rapid expansion of HIV Counselling and Testing (HCT) and Prevention of Mother-to-Child Transmission (PMT-CT) services is done in a manner that threatens to reduce their quality without adequate laboratories to support the expansion in PHC facilities.

5. The assessment has revealed that the health manpower is inadequate to deliver the needed services while maintaining their quality. Additionally, it has been found that staff motivation is affected negatively by the irregular and delayed payment of salaries especially for PHC-based and LGA staff. Other factors affecting motivation are security concerns in some PHC facilities, inadequate work tools and overwork.

6. Except for immunization, TB, malaria and HIV services, other maternal and child health services are provided through out-of-pocket payment of fees by the patient in the PHCs. Family planning commodities are free, but because supplies are not provided, the patients are asked to pay varying fees for the services. Treatment of minor ailments is provided at full cost recovery at PHCs and SHCs. Also, because of the poor awareness of the benefits of health insurance, the civil servants in Delta State refused to join the National Health Insurance Scheme (NHIS).

7. The proportion of the state budget allocated to SMoH over the years has been far below the recommended 15 per cent of the total budget except in 2012 and 2013. For most years between 2006 and 2013, only a small fraction of the approved health budget is ultimately released.

8. Since 2009, UNICEF has supported all the States in Nigeria through the National Population Commission to register and report on births using the mobile phone short messaging system (Rapid SMS). The Population Commission in Delta State has Registrars in two to five centres in each of the 25 LGAs. Through their activities, birth registration has been improving, and it has reached 30 per cent. More registration centres are needed, however, which means employment of more registrars for the registration and reporting rate to increase. Substantial support is required to expand this system to improve civil registration, and thereby generate needed vital statistics.

Current and Emerging Issues in the Health Sector

This chapter focuses on some critical issues that emanated from the assessment and needs further emphasis. These include: (i) Delivering a comprehensive and integrated healthcare package in PHCs; (ii) Striving for universal health coverage; (iii) Strengthening the health system in the context of the primary health care; (iv) Collaborating inter-sectorally; and (v) Coordinating the health actors in the State.

Ward Minimum Health Care Package

This was defined nationally by the NPHCDA in 1998 and reviewed in 2005. The proposed package to be delivered by the PHC includes: (i) Control of communicable diseases; (ii) Control of non-communicable diseases; (iii) Child survival; (iv) Maternal and newborn; (v) Nutrition; and (vi) Health education and community mobilization. Most PHCs in Delta State offer a very limited service package to patients at subsidized or full cost recovery. The most critical components of the package, namely, assessment of HIV and ART initiation and maintenance; Under-5 healthcare services; and maternal and newborn care are delivered at no cost in the SHCs. The national Health Bill currently awaiting Presidential assent says 'All Nigerians will be entitled to a guaranteed minimum package of services'.

Universal Health Coverage

Universal Health Coverage, means that 'All people can use comprehensive health services they need, of sufficient quality to be effective, while ensuring that the use of these services does not expose the user to financial hardship' (WHO 2010). The manner of allocating funds influences the direction and progress of reform toward universal coverage. Considering the three dimensions of health coverage, it will appear that Delta State, through its FMHCP, RHS, and FU-5HP, has made policy choices to expand coverage to the rural poor, to increase coverage to selected key high-impact interventions delivered through the above programmes and to provide selected services free to the patient. As the State moves further towards universal coverage, more consultations will be needed to make further policy choices with regard to expanding access to the free priority services, expanding the package of services offered free to patients, and minimizing indirect costs such as transportation to the patients. Such policy discussions will need to be transparent and inclusive to ensure accountability (Ottersen, et al. *WHO Bulletin,* June 2014).

Strengthening Health System in the context of Primary Health Care

The Delta State Strategic Heath Development Plan (SSHDP) covering 2010-2015 was developed in line with the National Strategic Health development Plan (NSHDP) covering the same period and containing the same eight Priority Areas. These are: (I) Leadership and governance for health; (ii) Service delivery; (iii) Human Resource for Health; (iv) Health Financing; (v) Health Management Information System; (vi) Community participation; (vii) Partnership for health; and (viii) Health research. The State and National SHDPs are in consonance with the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa: Achieving Better Health for Africans in the New Millennium, signed by all the member states in the African Region in April 2008.

Implementation of the SSHDP will strengthen the health system and the Primary Health Care system to enhance achievement of the health MDGs by 2015. This assessment has revealed that the SSHDP has not been systematically implemented. The annual budgetary allocations were not linked to the SSHDP Priority Areas; hence its non-systematic implementation. There has been no review of its implementation although its life span ends in 2015.

The systematic implementation of the SSHDP will strengthen the health system and the community system to address current and emerging health challenges. The SMoH may need to consider giving the SSHDP implementation a renewed impetus.

Intersectoral Collaboration

Intersectoral collaboration in health can be defined as 'organizations working together in a context in which joint action will achieve an improved health outcome. It entails dialogue and cooperation between the health sector and other partners to develop joint approaches to factors influencing health' (Linda Rudolph, Health in All Policies, 2013).

Health in All Policies (HiAP) emphasizes the consequences of public policies on health determinants, and aims to improve the accountability of policy-makers to health impacts, equity and sustainability at all levels of policy-making (WHO 2013).

Certain health challenges in Delta State have no easy solutions. They include: health inequities, the aging population and harmful traditional practices, including gender disparities. Others, such as climate change arising from environmental degradation resulting in recurrent flooding and extensive soil erosion and loss of habitat create new health problems. Influencing the above factors will play a significant role in overall population health improvement.

The SMoH, however, does not have the mandate to take action to influence the above factors. Effective action on them will require collaboration across state government, LGA the private sector, civil society, and community-based organizations.

Lessons and Policy Recommendations

This chapter consolidates all the previous discussions by reflecting on the findings of the assessment and highlighting the lessons to be learnt. It also makes appropriate policy recommendations.

Lessons Learnt

In this section, the lessons learnt are identified so as to build upon them in the future to improve health development in the State. We have learnt that: (i) The cluster model can strengthen the referral system; (ii) Health facility survey is critical for determining facility readiness for service expansion;(iii) Public-private collaboration can expand service access; (iv) Use of mobile phone technology can improve civil registration; and (v) Provision of free health services improves service utilization.

The Cluster Model

The MSS model, which is a federal programme being implemented in collaboration with the SMoH and six LGAs in Delta State, is described under section 4. Additionally, the SHMB has clustered the Secondary Health Centres in 11 zones to improve their management and administration. These two approaches demonstrate that the cluster model is useful in improving efficiency, service delivery quality and strengthening the referral system.

Health Facility Survey

Delta State SACA and SASCP, with support from Prevention, Education, Training, Treatment & Research – Global Solutions (PeTR-GS) and IHVN conducted a physical assessment of all the health facilities in the State and identified 641 of them that were providing ANC and delivery services. Currently, some 503 health facilities (78 per cent of the eligible facilities) are offering PMTCT services in the State. The facility assessment was critical in determining which of them were ready to take up PMTCT services. This has enabled a very rapid PMTCT site activation for these services in Delta State.

Public Private Partnership for Expanding Service Coverage

The Programme on Immunization of the SMoH has been collaborating with the private healthcare providers such that, upon being provided with vaccines and requisite supplies, they start providing immunization services free of charge to children. The approach has yielded good results in increasing the number of children being vaccinated. Consequently, the programme is planning to formalize the approach through signing of a Memorandum of Understanding.

Using the Mobile Phone Technology to Improve Civil Registration

Since 2000, UNICEF has been lending its support for the use of the Rapid Short Messaging System (Rapid SMS) to report births in a bid to improve birth registration. This approach has greatly improved the rate of birth registration in the State. Furthermore, the system generates real-time reporting which can be expanded upon to provide not only the needed vital statistics, but also serve as a surveillance system that could prompt action by LGA and State-level officials to address the causes of child and maternal deaths.

Provision of Free Health Services Improves Utilization

The provision of FMHCP and FU-5HP in SHCs in Delta State has resulted in increased service utilization to the extent that the healthcare workers in these facilities are complaining of overwork. This has demonstrated that out-of-pocket payment for health services is a hindrance to service utilization, and that its removal increases service utilization.

Policy Recommendations

Based on the findings of the assessment, it is recommended that:

1. The State Ministry of Health (SMoH), the State Local Government Authorities and their Chairmen should initiate discussions to explore modalities for providing free reproductive,

maternal and child health services in all PHCs in order to improve service access and relieve the workload in the SHCs.

2. The delivery of the Rural Healthcare Scheme should be re-designed. For accessible communities, the services under the scheme should be delivered in designated health facilities where regular outreach services could serve as practical, on-the-job training for health workers while also ensuring constant availability of services to the communities. Inaccessible riverine communities should be given special consideration in terms of provision of transport facilities that will make them benefit maximally from this Scheme.
3. The SMoH should further strengthen and expand the 'Hub and Spoke' arrangement that clusters several PHCs around an SHC. This allows a more structured mentoring and provision of professional support to the healthcare workers in the PHCs by experienced SHC staff in order to improve the quality of the services delivered in the PHCs as well as facilitate a two-way patient referral.
4. The SHMB, the SPHCDA and LGA Health Departments should expand the MSS to all LGAs in the State to ensure that more PHCs deliver Basic Emergency Obstetric Care (EmOC) services and can refer complicated cases to a nearby SHC that can deliver Comprehensive EmOC services. This will further reduce the maternal mortality ratio.
5. The SMoH should conduct an assessment with a view to strengthening laboratories in selected SHCs, including the establishment of Polymerase Chain Reaction (PCR) testing and other molecular testing capacity.
6. The SMoH should work towards increasing MDR-TB diagnostic capacity by providing more GeneXperttesting equipment. To enable timely initiation of treatment for the already diagnosed MDR-TB patients, a special ward for treating MDR-TB cases should be established as a matter of priority.
7. The SMoH should develop, cost and implement a Human Resource for Health (HRH) Plan, which will address the current HRH issues identified.
8. Delta State should lift the embargo on employment in the health sector in order to fill the staff gaps based on a workload analysis in the PHCs and SHCs.
9. The SMoH, with technical support from the UN, should institutionalize the State Health Account which will enable timely collection, analysis and reporting on health expenditure by source and intervention (disease) in order to link expenditures to budgets and health outputs annually in a sustainable fashion.
10. The SMoH should endeavour to establish a mechanism that provides financial protection to all its citizens, especially the poor, by replacing all out-of-pocket payments for health services to a pre-payment mechanism, in a bid to achieve universal health coverage. This will entail, among other things, creating a core group of knowledgeable people from the relevant professions to undertake mass education and community mobilization for the pre-payment plan.
11. Delta State should increase its budgetary allocation to the health sector to the 15 per cent target set by African Leaders in Abuja in 2000, and devise a strategy for increasing the disbursement of the approved health budgets.
12. The SMoH should strengthen the hands of Civil Society Organizations to mount a strong advocacy that will facili-tate passage of the Health Bill.
13. The SMoH should quickly prepare to adapt the new National Drug Distribution System in order to ensure the safety and effectiveness of the medicines delivered by all health facilities in the State, including the PHCs and the privately-owned facilities.
14. The State should embark on systematically empowering the Department of Research and Statistics (SMEP), the Population Commission and the Department of Planning and Statistics (SMoH) to collaborate in generating the information required for health planning, monitoring and evaluation through conducting household and other population surveys, as well as strengthening routine service reporting and civil registration to generate the needed data.
15. Delta State should provide the needed resources (manpower and financial) to the Population Commission to improve the RapidSMS reporting of child births and expand it to include reporting on child and maternal deaths; this will allow timely response to address causes of maternal child mortality.
16. The SMoH should invest in a participatory exercise involving the LGAs, civil society organizations, the private

sector and the development partners to evaluate the implementation of the SSHDP 2010-2015. The findings of this evaluation will inform the development of the post-2015 plan.

17. SMoH should involve a broad spectrum of stakeholders in the review of the current SSHDP and the elaboration of future health plans/strategies. The stakeholders should include LGAs, civil society organizations, the private sector and the development partners.
18. The SMoH should formalize arrangements for collaboration with the private health service providers beyond registering them and getting data reports from them. The new form of collaboration should include signing a memorandum of understanding for imp-roved access and expanded health ser-vice delivery to the people.
19. Each priority programme (AIDS, TB and malaria) should have a budget line created and the SMoH should gradually increase its contribution through budgetary allocation. This will not only alleviate the inadequate funding for operations, but also ensure sustainability of these important programmes.

Operationalizing the Recommendations

To implementing these recommendations effectively, it is proposed that the SMoH, with technical support of the UN, should organize a three-day workshop For the following categories of stakeholders in the health sector: (i) Representatives of key State Ministries and Departments; (ii) All LGA Chairmen; (iv) Civil Society Organizations (NGOs, CBOs, Professional Associations); (v) Organized Private Sector; (vi) The Federal Ministry of Health; (vii) NPHCDA; and (viii) Development Partners. The objectives of the workshop will be to:

1. Discuss the findings and policy recommendations contained in this report;
2. Prioritize the recommendations based on the urgency of each one – i.e., those that should be implemented immediately and accomplished within one year; those to be accomplished within three years and those which require ongoing implementation.
3. Develop a road-map with a timeframe, budget, responsible and collaborating technical partners.
4. Agree on how the required funding for implementing the recommendations will be mobilized.
5. Design a monitoring and evaluation framework with indicators to track progress on the implementation of the recommendations.
6. Establish a team that will be responsible for monitoring the implementation, and the frequency of monitoring meetings involving all the stakeholders.

Conclusion

1. The SSHDP 2010-2015 has not been systematically implemented. The implication of this is that when its lifespan expires in 2015, the lessons learnt will be patchy; it will be inadequate to inform the development of a subsequent State Strategic Plan. The full implementation of the SSHDP was expected to have strengthened the health system and the Primary Health Care system.
2. There is a serious shortage of the Human Resource for Health (HRH) in Delta State. Owing to the importance of HRH, all the other inputs into the health system will only have limited effectiveness without addressing it.
3. Health financing is another important health systems building block. While the proportion of state budget allocated to the health sector has recently reached (and somehow exceeded) the target set in the Abuja Declaration of 2001, the disbursement rate is still inadequate and needs to increase.
4. Partnerships, including intersectoral collaboration and Public Private Partnership, have not been adequately exploited. Establishing, strengthening and formalizing intersectoral partnerships between the government and the private sector could lead to improved health outcomes.
5. There is an abundance of service delivery data in the output domain. This data is quite useful especially for service quality improvement. For programme performance tracking, however, outcome and impact data are also needed. The lack of such specific data in Delta State has posed a constraint in assessing the impact of the investments made over the period, and hampers the determination of progress made towards achieving the MDGs.

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Annexes

Annex A: SSHDP Service Delivery – Achievements by Indicator and Target

		2008/9	2011	2012	2013	Remarks
Indicator						
	Achievement			74.6	72.5	MDG5.5
31. Percentage of pregnant women with four or more ANC visits performed according to standards*	Target	12.3 - 96.3%	25 - 100%		50 - 100%	
	Achievement	61.5	76	73.2	59.8	MDG TRACK REP
32. Proportion of births attended by skilled health personnel	Target	78.1	80		85	
	Achievement	11.2	12%		13%	FMHCP/SMoH
34. Caesarean section rate	Target	6%	5%		4%	
	Achievement	34	35	40		JAR 2013
43. Percentage of children exclusively breastfed from 0-6 months	Target	9%	12		15	
	Achievement	80	80	77		JAR 2013
44. Proportion of 12-23-month-old children fully immunized	Target	38%	45		50	
	Achievement	6.3	6.3	31		JAR 2013
46. Percentage of Under-5 Children that slept under LLINs the previous night	Target	US$6	10		15	
	Achievement	67.4	43.8	30		JAR 2013
47. Percentage of under-five children receiving appropriate malaria treatment within 24 hours	Target	17%	25		30	
50. Percentage of women who received intermittent preventive treatment for malaria during pregnancy	Target	2%	5		10	

	Achievement	2.9	2.6	2.9		JAR 2013
51. HIV prevalence rate among adults 15 years and above	Target	3.70%	3.5		3.2	
	Achievement	3.7	3.0%	2.9%		FMHCP/SMoH
52. HIV prevalence in pregnant women	Target	3.6%	3.4		3.2	
53. Proportion of population with advanced HIV infection with access to antiretroviral drugs	Achievement	50	50			JAR 2013
55. Proportion of population aged 15-24 years with comprehensive and correct knowledge of HIV & AIDS	Achievement	25	27%	31%		JAR 2013
56. Prevalence of tuberculosis	Achievement	1275	1573	1673		JAR 2013
58. Proportion of tuberculosis cases detected and cured under directly observed treatment short course	Achievement	67	59%	75%		JAR 2013
63. Percentage of health facilities with all essential drugs available at all times	Achievement	46	34	55		JAR 2013

Annexe B

List of Documents Reviewed

A. Federal-Level Documents

1. Revised National Health Policy, 2004
2. MDG Countdown Strategy 2010-205
3. National HIV & AIDS and Reproductive Health Survey 2013
4. Health Sector Report, 2012
5. WHO Country Cooperation Strategy, 2008-2013
6. National HIV Sero-prevalence Surveillance Sentinel Survey among Pregnant Women Attending Antenatal Clinics – Technical Report 2010
7. National Demographic and Health Survey Reports 2008-2013 (Prelim)
8. Multiple Cluster Indicator Survey Report 2013, 1999
9. NBS MDG Performance Tracking Survey 2012
10. Nigeria Health Workforce Profile 2012
11. Nigeria Health Facility Listing 2012
12. National Strategic Health Development Plan 2010-2015
13. National MDG Report 2010 & 2013
14. Global AIDS Response Progress Report, 2012
15. Global Fund Grants Presentations to CCM, March 2014.
16. Ward Minimum Health Care Package, 2007-2012.
17. Saving One Million Lives –Programme Document 2012

B. State Level Documents

18. Delta State Strategic Plan for HIV & AIDS (2008-2011)
19. Delta State Strategic Plan for HIV & AIDS (2010-2011)
20. DELSACA News (October 2009)
21. Delta State News – UNFPA (Nov 2007)
22. Delta State Free Maternal Health Care Programme(2012 – 2013)
23. Delta State Free Under- 5 Health Care Programme(2012 – 2013)
24. Delta State Maternal Health Care Data (2013)
25. Delta State Ministry of Health Informatics Bulletin (Soft Copy)
26. Activity Report (soft copy)
27. Research Studies and Proposals (soft copy)
28. Delta State sentinel Survey- UNFPA in collaboration with the Delta State Government (2007-2009)
29. Memorandum of Understanding (MOU) between Delta State Government and MTN Foundation - 2014
30. Memorandum of Understanding (MOU) between Delta State University Teaching Hospital, Oghara and Xenon company Ltd.
31. Report on the Delta State 2012 World Pneumonia Day
32. Survey of Malaria Indicators Delta State 2013

33. Malaria – A moving Target (A Review of the Malaria Situation in Delta State)
34. Delta State Long Lasting Insecticidal Net (LLIN) Report - 2013
35. Report on Baseline Entomological Survey in support of Indoor Residual Spraying of the MCHP – Malaria Control Project
36. 2013 Rapid Mobile – Based Phone (RAMP) Survey of ITN and Other Malaria Indicators in Delta State.
37. Jotters – Maternal Death Review Training (24th-29th March 2014)
38. Health Sector – In total transformation - 2010
39. Information memos on the Free Rural Health Scheme Programme (2008-2009)
40. Information memos on the Free Maternal Health Care Programme (2009-20012)
41. Information memos on the Free Under-5Health Care Programme (2012-2013)
42. Minutes of Zonal Hospital Committee meetings on Free maternal and Free Under-5Health Care Programmes
43. Delta State forth State Council on Health Meeting Sponsored by HSDP 11
44. Development of Indicators and Benchmark for State Peer Review Mechanism
45. Launching of the Free Under-Five Medical Care and Children's Day Celebration.
46. A presentation on the Health Sector of Delta State – 2014
47. HMB Annual Statistics – 2009
48. HMB Annual Statistics – 2010
49. Hospitals Activity Analysis – 2011
50. HMB Statically Report – 2012
51. HMB Summary Data of Hospital Activity Analysis – 2013
52. HMB Monitoring Teams Report
53. Policy Thrust of the Delta State Government
54. 2012 Joint Annual Review/Mid-Term Review of NSHD
55. Soft Copy of MDG Budget (2008-2012)
56. Soft Copy of TB Data Indices (2008 – 2013)
57. Delta State Household and Housing Survey 2003,2006 & 2011.
58. Delta State Government approved Budget (Year 2003, 2006 – 2013
59. Organogram of Drug Revolving Fund.
60. Operational Guidelines for the Delta State Drug Revolving Fund.
61. Summary of Delta State Emergency Ambulance Service
62. Report of Delta State Vital Registration Statistics (1991 – 2013)
63. Delta State Health Budget Financing (2005 – 2013)
64. DESOPADEC Presentation
65. Electronic DESOPADEC Budgets
66. Delta State MDG Report, 2010 & 2011.
67. FMOH Guideline on Drug Distribution System.

Annexe C: Field Visits Schedule

Health Sector Assessment of Development in Delta State, 21-30 May 2014

Time	Meeting with	Venue/Location
	Wed, 21May 2014	
2.00 p.m.	SMoH Directors, Heads of Sections Parastatals (HMB, SPHCDA, DRF) Programmes (SURE-P, MSS)	Office of PS, SMoH, Oshimili South LGA, Delta North Senatorial District
	Thursday, 22 May 2014	
10.00a.m	Aniocha North LGA department of Health Officers (Chairman, PHC Coordinator, HR Officer etc)	Aniocha North LGA, Delta North Senatorial District
	Friday May 23, 2014	
10.00a.m	St. Joseph Catholic Hospital Staff	Conference Room, St. Joseph Catholic Hospital, Oshimili South LGA, Delta North Senatorial District
2.00 p.m	Meeting with: PHC Staff, SURE-P Officers WDC members	PHC Umuagu, Oshimili South LGA, Delta North Senatorial District
	Monday ,26 May 2014	
10.00a.m	Meeting with PHC Staff	Urban PHC Centre Ughelli, Ughelli North LGA, Delta Central SenatorialDistrict
1.00p.m.	Meeting with CMD and staff of Central Hospital Warri	Office of CMD, Central Hospital Warri, Delta South Senatorial District
	Tuesday, 27May 2014	
10:00 am	Joint Meeting with: State Bureau of Statistics; State Population Commission Directorate of MDG	Office of PS, SMoH, Oshimili South LGA, Delta North Senatorial District
2:00 pm	Meeting with officers of the Local Government Service Commission.	Office of the Chairman, Local Government Service Commission, Oshimili South LGA, Delta North Senatorial District
	Wednesday,28May 2014	
9:00 a.m.	Meeting with IHVN Programme Officers	Office of Team Leader, IHVNAsaba Office, Oshimili South LGA, Delta North Senatorial District
11.00a.m	Meeting with Professional Associations (Medical Association, Nurse/Midwives Association, Pharmacists Association, Lab Scientists Association, Medical Records Association, Health Information Managers Association	Office of PS, SMoH, Oshimili South LGA, Delta North Senatorial District
	Friday,30May 2014	
12.00 Noon	Joint meeting with DESOPADEC Management Team	Conference Hall, Government House, Oshimili South LGA, Delta North Senatorial District
1.00p.m	Town Hall meeting with the organized private sector, civil society organizations and selected professional associations	Conference Hall, Government House, Oshimili South LGA, Delta North Senatorial District

Annexe D: Discussion Guide

SMoH Meeting with Departmental, Agency &Programme Heads

State health financing:

1. What are the issues preventing the attainment of the target of 15 per cent of total budgetary allocation to health? What do you propose should be done to increase the allocation to the sector?
2. How can the gap between allocation and disbursement be bridged? Is it possible to have the disbursements to health for the rest of the years (1995- 2013)?
3. What is your comment on SMoH budget allocation/disbursement to programmes/interventions (especially MDG programmes)?
4. In your opinion, can the State mobilize additional funds to implement the planned activities?

Human Resource for Health

1. Has the State developed and implemented a State Human Resource for Health Plan & budget?
2. Please comment on successes and constraints in implementing the Plan.
3. Please comment on the level of staffing for the various departments/or distribution of health workers by level of care (primary, secondary and tertiary).
4. What can you tell us about the level of staff motivation and satisfaction?
5. What factors affect motivation and satisfaction the most (in both good and bad ways)?
6. When was the last time staff members received training?
7. How often do you conduct supervision? How do you address the problems identified during supervision?
8. Since some health workers are managed by the LGAs, how is HRH management coordinated between the state and the LGAs?

Health Sector Leadership & Governance

1. Who were involved in the development of the State SHDP?
2. How many state health plans have been developed since 1991? Have there been any variation in the people involved in their development?
3. Have any of the plans been evaluated? Why have other plans not been reviewed/evaluated? There have been two joint annual reviews and a mid-term review of the NSHDP and the SSHDPs; does the SMoH have copies of the reports?
4. What mechanisms are there for working with the private sector?
5. What mechanisms are there for involving and coordinating the development partners working in the State?
6. What would you recommend in order to achieve the goals of the health sector?

Health Management Information System (HMIS)

1. What is the capacity of the Department of Planning and Statistics in generating statistical reports? What are the constraints? What solutions do you propose to address the constraints?
2. What arrangements are in place for the State to gather service data from LGAs? Does the State report to the federal level? Is the State using the DHIS 2 as the HMIS software adopted and promoted by the FMOH?
3. Does the State provide feedback to the reporting facilities/LGAs?
4. Does the state receive feedback from the federal level?
5. Have the state personnel received training on data quality (including timeliness, completeness, accuracy)?
6. Does the Department of Planning & Statistics organize data review/validation meetings? How frequently are they organized? Who attends these meetings? of State monthly service summary forms? How frequently?
7. Please provide an example (from the previous 12 months) of a service delivery or management decision that this facility implemented as a result of review of service statistics.

Medical Products, Vaccines, & Technologies

1. What are the successes of the State Drug Revolving Fund (DRF)?
2. What are the challenges?
3. What solutions do you propose for the mentioned problems?
4. What arrangements are there for the specific programmes? (Family Planning commodities, HIV & AIDS medicines and commodities, TB/Leprosy medicines, vaccines, lab reagents, etc.)

Service Delivery

1. Has the State developed any guidelines/standards for service delivery by LGA/private sector?
2. What are the challenges in enforcing the guidelines/standards?
3. What solutions do you propose for the mentioned problems?
4. What capacity building activities have been implemented to empower PHC workers to deliver services?
5. What professional interaction is there between programmes (Malaria, HIV/ and PHC personnel)?

State Bureau of Statistics, State Population Commission & State Ministry of MDGs

1. What is the capacity of the institution in conducting population surveys to generate data for monitoring and planning? What are the constraints? What solutions do you propose to address them?
2. Does your institution produce and disseminate reports?
3. Has anyone in your institution been trained by the federal authorities on the conduct of surveys?
4. Does a representative of your institution participate in State-level stakeholder meetings to share, review, and discuss state health service and status statistics/data?
5. Does the State Bureau of Statistics organize data review/validation of state monthly service summary forms? How frequently?
6. Please cite any challenges/constraints you face in fulfilling your institution's mandate
7. Please propose solutions for addressing the above challenges/constraints.

Discussion Guide for the Local Government Authority and SPHCDA

1. How are the LGA Health Departments being funded to fulfil their mandate?
2. Can you comment on the staffing of LGA Health Department and the PHCs? Have staff members in the LGA Health Department receiving any training in the last 12 months? What type? Who provided it?
3. How are the PHCs in the LGA accessing medicines and commodities, salaries and operational funding?
4. Please comment on your supervisory role to PHCs. How do problems identified during supervision get addressed?
5. What is your Authority's jurisdiction over the private healthcare providers?
6. Can you comment on your department's data reporting responsibilities?
7. Which PHCs in Delta State are participating in the MSS?
8. Which facilities in Delta State are involved in the SURE-P implementation?
9. How are the WDC members in each LGA appointed? Who is responsible for motivating them?
10. Why have the LGAs not bought into the free maternal health scheme of the state govt? What can be done to facilitate this?

Discussion Guide for the LGA Health Department

1. How is the LGA Health Department funded to implement its activities?
2. What is the Organogram of the LGA Health Department?
3. Can you comment on this LGA Health Department's staffing level? Have staff in the LGA Department received any training in the last 12 months? What type? Who provided it?
4. How are the PHC facilities in the LGA accessing medicines and commodities, salaries and operational funding?
5. Please comment on the LGA Department's supervisory role to PHC facilities? How do problems identified during supervision get addressed?
6. What is the jurisdiction of the LGA Health Department over the private health providers in the LGA?
7. Who supervises your department? When was the last time you were supervised?
8. Can you comment on your department's data reporting responsibilities?
9. How many PHC facilities in the LGA conduct deliveries? Are services in the facilities offered for 24 hours?
10. What challenges/constraints do you face in fulfilling your department's mandate?
11. What solutions do you propose to address these challenges/constraints?

Discussion Guide for the Ward Development Committee

1. What is the composition of this WDC?
2. Can you comment on the roles and responsibilities of the WDC?

3. Can you comment on the services delivered by the PHC under your charge?
4. What is your comment regarding health service delivery in Delta State?
5. What problems/challenges/constraints do you experience in fulfilling your role?
6. What solutions do you propose for addressing those challenges/constraints?

Discussion Guide for Health Facility-Level

1. How is your facility funded to deliver its services?
2. Are user fees charged? For which conditions? What exemption mechanisms have been put in place?
3. Please comment on this facility's staffing level. Have staff members received any training in the last 12 months? What type? Who provided it?
4. What can you tell us about the level of staff motivation and satisfaction? What factors affect motivation and satisfaction the most (in both good and bad ways)?
5. How does your facility access medicines, commodities, salaries and operational funding?
6. Who supervises your facility? When was the last time you were supervised?
7. Can you comment on your facility's data reporting responsibilities?
8. Does your facility offer BEmOC/CEmOC?
9. Are services in the facilities offered for 24 hours?
10. What challenges/constraints do you face in fulfilling your department's mandate?
11. What solutions do you propose to address these challenges/constraints?

Discussion Guide for Private Health Facility-Level

1. What type/level of collaboration exists between you and the State/LGA in respect to health services delivery?
2. In what ways would you propose to change the current level of collaboration?
3. Collaboration is a give-and-take game. What do you currently benefit from the State/LGA Health Authorities? What do you think they benefit from you?
4. What successes and challenges can you share with us?
5. How would you propose to address the mentioned challenges?
6. Please comment on this facility's staffing level. Have staff members received any training in the last 12 months? What type? Who provided it?
7. What can you tell us about the level of staff motivation and satisfaction? What factors affect motivation and satisfaction the most (in both good and bad ways)?
8. How does your facility access medicines and commodities, salaries and operational funding?
9. Who supervises your facility? When was the last time you were supervised?
10. Can you comment on your facility's data reporting responsibilities?
11. Does your facility offer BEmOC/CEmOC?
12. Are services in the facilities offered for 24 hours?
13. What challenges/constraints do you face in fulfilling your department's mandate?
14. What solutions do you propose to address these challenges/constraints?

Annex E: Meeting Attendance: List of People Met

UN Assessment Field Visit Attendance List

DAY 1 (21stMAY 2014) - State Ministry Of Health & Parastatals (HMB, SPHCDA, DRF) Programme Officers, SURE-P and MSS Focal Persons

Venue : Asaba

Team Members

1.	R. Klint Nyamuryekung'e	Health Consultant
2.	Dr. Gloria Patrick-Ferife	DMST, SMoH
3.	Dr. Ofili C.C.	DPRS, SPHCDA
4.	Dr. Ejiro Ogeneaga	ADMST, SMoH
5.	Dr. C.Iwegbu	ADPRS, SMoH
6.	Nkechi Enebuse	HEO, SMoH

Also in attendance

1.	Dr. Joseph Otumara	Hon Commissioner for Health.
2.	Dr. Otobo	Permanent Secretary, PHCDA
3.	Dr. Omatsola M. B.	Permanent Secretary, SMoH
4.	Dr. Omoraka	Chief Medical Director, (HMB)
5.	Mrs. Ndodu	Fund manager, DRF
6.	Mr. Ayodele Paul	Asst Chief Admin Officer
7.	Dr. ChukwudiOkungini	SASCAP Coordinator
8.	Ms. Omawumi Daibo	NPHCDA
9.	Dr. Zellibe Anyamele	SURE-P, Delta state
10.	Mrs. Oteri	NPHCDA
11.	Dr. Winful- Orieke Jude	SPHCDA
12.	Mrs. Ugbanaka	Asst Director, Nursing Service

Day 2 (22 May 2014) - Department of Health Aniocha North Local Government Area

Venue: Aniocha North Local Government Area Headquarter, Iselle-Uku

Team Members

• Prof.Mike Obadan	UN Lead Consultant
• Dr. Klint Nyamuryekung'e	Health Consultant
• Dr. Gloria Patrick-Ferife	DMST,SMoH
• Dr. Ofili	DPRS,SPHCDA
• Dr. Ejiro	ADMST,SMoH
• Dr. C. Iwebgu	ADPRS,SMoH
• Enebuse Nkechi	HEO,SMoH
• Obiazor N.J.	SCO,SMoH

Also in attendance

• Hon. Young Chukwuedo (JP)	Chairman
• Lady Hon. UdukaBenice	Vice-Chairman
• Mrs. Gladys Ikebuta	Coordinator,PHC
• Mr. G.N. Okonta	Head,Personnel Management
• Mr. Ben Nwanuzai	Asst. Director Of Admin II
• Mr. Alex Nwani	HOU Information
• Mr. Stephen Olisafana	PHC
• Mr. Chris Mosinti	Information
• Mr. Ugbolue Chijioku	Information
• Mr. D. Ljeh	TLG
• Mrs. I. Onwodi	Asst.Director of Admin I

Day 3 - (23 May 2014,) - PHC Umuagu (SURE-P/WDC)

Venue: PHC Umuagu, Oshimili South LGA

S/NO	NAMES	DESIGNATION
1	Dr· Klint Nyamuryekung'e	Health consultant
2	Dr Gloria Patrick-Ferife	DMST, SMoH
3	Dr C.C Ofili	DPRS, SPHCDA
4	Drlwegbu Chris	ADPRS
5	Obiazor N.J.	SMoH
6	Enebuse N. E.	HEO, SMoH
7	Joy Mordi	DNS
8	Okenyi B.D.	OIC Umuagu
9	Peace Rapu	PHC Umuagu
10	Diyoke Chinwendu	SURE-P CHEW Umuagu PHC
11	Igumbor Rosemary	SURE-P Midwife
12	Ocholor Vera	
13	AmumaAdaeze	SURE-P CHEW Oko- Amakam
14	Ohuruzor Chineye F·	SURE-P CHEW Umuagu PHC
15	Mrs OnwudinjoAmaka	WDC Sec. Umuagu
16	Mrs Veronica Okolo	WDC Member Umuagu PHC
17	Anthonia U. Ogobuegwu	(ADCH) PHC UmuaguWDC member
18	Ifueze Philomina	CHEW Umuagu PHC
19	Opene Andrew	WDC Secretary Oko-Amakon
20	Osadebe Bridget	VHW PHC Umuagu
21	Eyome Ifeoma Bright	VHW PHC Umuagu
22	Isibor Doris (Mrs)	Health Educator OSLGA
23	Nkpuechima Jessy	PWO Umuagu PHC
24	Okonweze V.N. (Mrs)	LIO
25	Ossai Angela	M&E/DSNO
26	Esther Eleagu	VHW PHC Umuagu
27	Obiorah Theresa	WDC Oko-Amakom PHC
28	Okechukwu Franca	WDC Oko-Amakom PHC
29	Ngozi Ezenyili	
30	Patricia Ogana	
31	Egbunike Chris	WDC Chairman Okwe
32	Ikechkwu Ruth	SURE-P CHEW Okwe
33	Muoh Ebere	SURE-P Midwife Okwe
34	Oluwo Susan.O	SURE-P Midwife Okwe
35	Onalugbum Ogedi	Village Health Worker
36	Mary Eshianya	WDC
37	Ishie Bridget	WDC
38	Edu Joy	SURE-P Midwife Umuagu
39	Isaac Okafor	Chairman WDC Oko-Amakom
40	Gabriel Nwazope (Chief)	Village Health Committee
41	Eucharis Nwazope	Village Health Worker
42	Vero Enebeli	Village Health Worker
43	Benedicta Obi	SURE-P CHEW Oko-Amakom
44	Agah C. Ikem	Gardener
45	Odo Esther W.	SURE-P CHEW
46	Uzogor Kenneth	Okwe
47	Grace Daniel	Village Health Worker

St Joseph Catholic Hospital ,Oshimili South LGA on23 May 2014

S/NO	NAMES	DESIGNATION
1	Rev Sr. Elizabeth Erhunmwunsee	Matron/Administrator
2	Dr Gloria Patrick-Ferife	DMST, SMoH
3	Dr· KlintNyamuruyekunig'e	Health Consultant,UN
4	Dr C.C Ofili	DPRS (SPHCDA)
5	Dr Ejiro Ogheneaga	ADMST
6	Dr· Iwegbu Chris	ADPRS
7	Mr Matthew Isehre	SCO,SMoH
8	Chibuzor Okwuone	SCO, SMoH
9	Obiazor N.J.	SCO, SMoH
10	Enebuse N. E.	HEO, SMoH

Day 4 (26 May, 2014,) - Urban Primary Health Centre, Ughelli, Ughelli North LGA

Team Members

- Dr.Klint Nyamuryekung'e — Health Consultant
- Dr.Gloria Patrick-Ferife — DMST,SMoH
- Dr Ejiro Ogheneaga — ADMST,SMoH
- Dr.C.Iwebgu — ADPRS,SMoH
- Enebuse Nkechi — HEO,SMoH
- Obiazor N.J. — SCO,SMoH

Also in attendance

- Mrs.Oyeh O Juliet — DNS/Deputy Phcc
- Oghoetsoma O.Rose — CMO/LIO

Central Hospital, Warri, on26 May 2014, Warri South LGA

Team Members

- Dr Klint Nyamuryekunge — Health Consultant
- Dr.Gloria Patrick-Ferife — DMST,SMoH
- Dr Ejiro Ogheneaga — ADMST,SMoH
- Dr.C.Iwebgu — ADPRS,SMoH
- Enebuse Nkechi — HEO,SMoH
- Obiazor N.J. — SCO,SMoH

Also in attendance

- Dr.Rukevwe Ugwumba — SPAD,Gov Delta state.
- Dr.Omoraka Funmilayo — Chief Medical Director,(HMB).
- Dr.Agholor Kingsley — ZMD,Warri Central Hospital

Annex 5.6: Water Schemes Visited by the Directorate of Project Monitoring, 18 November 2013 – 21 March 2014

S/NO	NAMES	DESIGNATION
1	Dr Klint Nyamuryekung'e	Health consultant
2	Dr Gloria Patrick-Ferife	DMST, SMoH
3	Mr Nkechi Maweemezu	MEP
4	Dr C.O. Okuguni	SAPC
5	Dr C.C. Ofili	DPRS (SPHCDA)
6	Elder Emma. Ukusare	Director Births, Deaths Reg. NPOPC Delta
7	Ebinum-Olisa G.O.	Director MDGs
8	Ndu Kanebi L.M. (Mrs)	SAO (MDGs)
9	Dr Omatsola M.B.	PS SMoH
10	Dr Ogheneaga Ejiro	ADMST
11	Dr Iwegbu Chris	ADPRS
12	Enebuse NkechiEse	HEO, DMST
13	Obiazor N. J.	SCO, DPRS

THE Local Government Service Commission on 27May 2014,Oshimili South LGA

Venue: Local Government Service Commission, Asaba

S/NO	NAMES	DESIGNATION
1	Dr Gloria Patrick- Ferife	DMST, SMoH
2	Dr Klint Nyamuryekunge	Consultant Health
3	Dr C.O. Okugum	SAPC
4	Dr C.C. Ofili	DPRS (SPHCDA)
5	Dr Iwegbu Chris	ADPRS
6	Dr Ejiro Ogheneaga	ADMST
7	Enebuse Nkechi Ese	HEO,DMST
8	Obiazor N. J.	SCO DPRS
9	Dr C. E. Eboka	PHCC/MOH
10	Dr Onyijeh L. N.	MOH
11	Agboiyi Patricia D.	ADNS
12	Onwuegbuzie Nkechi	PNO
13	Odubolu Godwin	DFCC North
14	Isibor Anthony	DFCC Central
15	Boyikokanwo Johnson	DAD
16	Egbone O. J.	SAO (Recorder)
17	Mr M. E. Onitcha	DFCC(South)
18	Dr Okolo A.N.	DHCC (Oshimili south LGA)
19	Mrs B.C. Bielonwu	DIR MOW
20	Mr James Kolo	DIR SPUTES
21	Sir C.A. Aghara	DPM
22	Barr. Paul Uwechue	Member LGSC
23	Enuekwe, M. N.	ADPM

Day 6 (28 May 2014) – Professional Associations - NMA, PSN, NANNM, HIMAN, AMLSN

Venue: Office Of The Permanent Secretary, SMoH, Asaba, Oshimili South LGA

S/NO	NAMES	DESIGNATION
1	Dr. Klint Nyamuryekung'e	Health Consultant
2	Pharm. Ekhuemelo	Chairman PSH
3	Pharm. Agbese Blessing	V. chair PSN
4	Pharm. Alabi J.O.	Secretary PSN
5	Adekuko Collins	Chairman AMLSN
6	Majoroh E. (Mrs)	Secretary HIMAN
7	Kokole Charles	Vice Chm. (HIMAN)
8	Okoh Frank	Secretary NAWNM
9	Jegede Ikpen A. (Mrs)	Vice CM NANNA
10	Ajufo B.C	Secretary AMLSM
11	Dr. C.O. Okuguni	SAPC
12	Dr. A.C Okwunze	Treasurer NMA
13	Dr C.C Ofili	DPRS (SPHCDA)
14	Dr. Ejiro Ogheneaga	ADMST
15	Dr. Iwegbu Chris	ADPRS
16	Obiazor N. J.	SCO, SMoH
17	Enebuse N. E.	HEO, SMoH