ADAMAWA STATE HEALTH SECTOR

2026 Annual Operational Plan

Foreword

Adamawa State has through successive Governments tried to improve the health status of citizens of the State. Despite the efforts, the health indices of the state remain low compared to other parts of the country. The situation is unacceptable and has to change.

The people's health is paramount to Adamawa State's transformation because it impacts all other sectors. Using the Health Sector Strategic Blueprint (HSSB) 2024 - 2027 and other documents as a guiding tool to develop the Adamawa State Annual Operational Plan 2026 sets the tone for taking forward the Government's Change Agenda. The proposed change is to improve people's well-being and give them the confidence to aspire for improvements in their lives.

We have come to understand that leadership always matters and is almost always blamed for poor performance. That is why we are strategic in our thinking, as we make a difference in the lives of our people, and health is central to the well-being of our citizens. We are therefore very supportive of this Annual Operational Plan 2026 and shall monitor its implementation to ensure the resources allocated to the sector, are judiciously used. Change is about the attitude of the individuals and the institutions entrusted with responsibilities. The health sector must transform its operations and institute measures to improve its accountability responsibilities. The commitment to deliver quality, affordable and accessible services and to account for the resources it manages on behalf of the people.

As we move the health sector into the future, the Government will continue to communicate its high-performance expectations to the citizens as a right. It is therefore the collective responsibility of all stakeholders to work towards the attainment of the strategic goals outlined in the HSSB 2024 - 2027.

Approved by the Hon. Commissioner of Health
Hon. Felix B. Tangwami
Adamawa State 22nd/12/2025

Acknowledgments

The development of the 2026 Annual Operational Plan (AOP) for the operationalization of the HSSB 2024 – 2027 was coordinated by the Department of Health Planning, Research & Statistics of the Adamawa Ministry of Health in close collaboration with Adamawa State Primary Health Care Development Agency, other MDAs, line ministries and development partners in the State.

Therefore, sincere appreciation goes to all officers of the State Ministry of Health, Adamawa State Primary Healthcare Development Agency, other MDAs and partners who took part in the development of the 2026 AOP for the State.

Our gratitude also goes to UNICEF, UNFPA, WHO, MSI, AHNI, Chigari Foundation, and NANGO who provided technical and funding support for the training of Officers, the development process, and the harmonization and Finalization of the plan.

Lastly, the Honourable Commissioner, Permanent Secretary and members of the Top Management Committee are well appreciated for their leadership role in ensuring the successful development of the 2026 Annual Operational Plan (AOP).

Dr. Stephen John
Director Planning, Research and Statistics
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Map of Adamawa State

Executive Summary

The development of the Adamawa State Annual Operational Plan (AOP) 2026 is a follow-up on the operationalization of the Health Sector Strategic Blueprint (HSSB) 2024 – 2027. This involves all the state line Ministries, Departments and Agencies (MDAs), relevant stakeholders, development partners and all other responsible health entities to jointly provide best healthcare services geared towards improving the health indices in the state. This is aligned with the national goal of the HSSB envisioned: to save lives, reduce both physical and financial pain, and produce good health for All Nigerians. The joint effort of the state actors in delivering this life-saving goal is an initiative of the Federal Ministry of Health and Social Welfare Sector Wide Approach (SWAp) geared towards actualizing One Plan, One Budget, One Report, One Conversation.

To achieve this and in alignment with the bond signed by the 36 state Honourable Commissioners of Health with the Coordinating Minister of Health, Annual Operational Plans (AOP) are to be carefully developed and methodically implemented to the latter. In view of this noble gesture to achieving the national agenda, the Adamawa state government together with all line ministries, sister agencies, development partners and other relevant stakeholders in the health sector jointly developed a 2026 health sector AOP for the state through the directive and supervision of the Honourable Commissioner for Health, Adamawa state.

Development of this Annual Operational Plan was comprehensive, taking into consideration the core programme management activities that provided the results needed. It was participatory involving over 140 stakeholders from various Ministries, Agencies and Departments. A situation analysis of the current health status, progress made in the implementation of the SSHDP II and emerging challenges were reviewed. The 2026 AOP aligns with the health priority needs identified in the HSSB which are made up of:

a) Reproductive, Maternal, Newborn, Child and Adolescent Health, plus Nutrition (RMNCAH+N)

b) Prevention and control of communicable diseases (prioritizing Malaria, HIV/AIDS, Tuberculosis, Hepatitis and Neglected Tropical Diseases and other diseases)
c) Prevention and Control of Non-Communicable Diseases (Cancers, Cardiovascular diseases, Chronic Obstructive Airways disease, Sickle cell disease, oral health, mental health, eye health and care of the elderly)
d) Health promotion and social determinants of health (focusing on water supply, food hygiene, medical waste disposal)
e) Protection from health risks and emergencies.

The 2026 AOP consists of four strategic pillars and three enablers with each area having a strategic objective, priority initiatives, key interventions and activities developed to achieve a set of defined targets. The 4 pillars are: (1) Effective Governance, (2) Efficient, equitable, and quality health system, (3) Unlocking value chains and (4) Health Security. The 3 enablers are: (1) Data and Digitalization, (2) Financing and (3) Culture and Talent.

The resource requirements for implementing and achieving the 2026 AOP targets have been determined using the current price and cost assumptions with project estimates in the coming year 2025 for the implementation of the Plan. A total number of 447 operational activities are planned to be implemented at an estimated cost of ₦39,014,166,446 which has increased by ₦21,945,646,857 from the 2025 AOP which total cost was ₦17,068,519,589. The state government fund commitment is ₦26,160,206,464 which is 67% of the total cost unlike in 2025 AOP that was just 23%. The other fund which includes development partners commitment is ₦11,056,444,950 which is 28% compared to 46% in 2025. The funding gap is at ₦ 1,797,515,032 which is 5%. It is expected that the state government would galvanize and mobilize the resources needed to bridge the gap.

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Abbreviations

AOP	Annual Operational Plan
ATM	Aids, Tuberculosis and
Malaria DP	Development Partner
DHIS	District Health Information System
DLIs	Disbursement Linked Indicators
DQA	Data Quality Assessment
FMoH&SW	Federal Ministry of Health and Social Welfare
HCT	HIV Counselling and Testing
HMIS	Health Management Information System
HRH	Human Resources for Health
HSRII	Health Sector Renewal Initiative and Investment
HSMB	Hospital Service Management Board
HSS	Health System Strengthening
HSSB	Health Sector Strategic Blueprint
ISS	Integrated Supportive Supervision
KPIs	Key Performance Indicators
LMIS	Logistics Management Information System
MDA	Ministries, Departments and Agencies
MNCH	Maternal Newborn and Child Health
NDHS	National Demographic Health Survey
NGOs	Non-Governmental Organizations
NHMIS	National Health Management Information System
NPHCDA	National Primary Healthcare Development Agency
PHC	Primary Health Care
PHCUOR	Primary Health Care Under One Roof
PMTCT	Prevention of Mother to Child Transmission of HIV
RMNCHA+N	Reproductive Maternal Newborn Child Health, Adolescent plus Nutrition
SBA	Skilled Birth Attendance
SMoH	State Ministry of Health
SPHCDA	State Primary Health Care Development Agency
SSHDP	State Strategic Health Development Plan
SWAp	Sector Wide Approach
TBAs	Traditional Birth Attendants
TBL	Tuberculosis and Leprosy Control Programme
UNFPA	United Nations Population Fund

UNICEF	United Nations Children's Fund
WDC	Ward Development Committee
WHO	World Health Organization.

1.0 Introduction

1.1 Profile of Adamawa State

Adamawa State is in the North-Eastern region of Nigeria and covers a land area of over 42,000 square kilometres. The State has an estimated population of more than 5.3 million people, projected from the 2006 national census using an annual growth rate of 2.9%. It shares boundaries with Borno State to the north, Gombe and Taraba States to the northeast and southwest respectively and has an extensive eastern border with the Republic of Cameroon. Administratively, Adamawa State is divided into 21 Local Government Areas (LGAs), which are further subdivided into 226 political wards. The State is characterized by a largely mountainous and undulating terrain, intersected by major rivers including the Benue, Gongola, and Yadzaram. Prominent physical features such as the Adamawa Mountains, Mandara Highlands, and the valleys bordering the Cameroonian Republic contribute significantly to its diverse landscape.

In a democratic system, one of the fundamental obligations of government is to enhance the standard of living and overall quality of life of its citizens. The Adamawa State Government recognizes health sector investment as a critical foundation for human capital development and sustainable socio-economic transformation. The State is guided by the principle that health is a fundamental human right and therefore prioritizes strategic and sustained investments aimed at improving health outcomes and wellbeing for its population. In line with this commitment, Adamawa State has adapted the National Health Policy (2016) and developed a context-specific state health policy. Furthermore, the State has initiated steps towards domesticating the National Health Act (2014) to provide a strong legal framework for the realization of health as a guaranteed right.

The Health Sector Strategic Blueprint (HSSB) aligns with the strategic objectives outlined in the national health framework for the next three-year planning period. It reflects the national vision, mission, goals, and priority investment areas, and is anchored on the overarching national goal of *“ensuring healthy lives and promoting the wellbeing of all*

Nigerians through improved access to quality, affordable, cost-effective, preventive, curative, rehabilitative, and promotive healthcare delivery". Based on the identified interventions and activities, the HSSB includes detailed cost estimates for public sector programmes and projects, as well as projections of the total financial resources required to implement the plan over the 2026 planning period.

1.2 Goal, Vision, Mission and core values

The development of the Annual Operational Plan (AOP) is guided by policy documents and framework, which provide the strategic and operational foundation for the planning process. Adamawa State has undertaken sustained interventions to address identified gaps in the health needs of its population. The Health Sector Strategic Blueprint (HSSB) represents continuation and consolidation of ongoing health sector reform efforts. It is designed to build on the achievements of the State Strategic Health Plan II (2018–2022), which prioritized health system strengthening, institutional reforms, and service delivery improvements. The current strategic direction also reflects the State's transition from predominantly humanitarian health assistance towards health sector recovery, resilience-building, and long-term system sustainability.

Adamawa State operates a mixed network of public and private health facilities, comprising 403 Primary Health Care (PHC) facilities providing 24-hour services, 8

General Hospitals, 18 Cottage Hospitals, two Federal Medical Centres, one Teaching Hospital, one Specialist Hospital, one Dermatological Hospital, a German Medical Centre, and over 150 registered private health facilities. Despite this extensive infrastructure, health system performance in the State continues to be constrained by persistently low health indices. These outcomes are influenced by a combination of socio-cultural practices, low levels of female education, widespread poverty, and structural weaknesses within the health system. Key system-level challenges include suboptimal service quality arising from inadequate infrastructure, shortages and maldistribution of human resources for health, financing gaps, and high fertility rates, all of which adversely affect population health outcomes.

Over the years, significant investments have been made to strengthen the health system; however, improvements across several core indicators have remained limited. The persistently low health indices reflect multifactorial constraints, including inequitable distribution of health facilities, insufficient numbers of skilled health personnel, critical equipment and commodity gaps, and limited technical capacity among service providers to deliver priority health interventions. These challenges were further exacerbated by the Boko Haram insurgency, which resulted in the destruction and damage of health facilities and the loss of health personnel. The ensuing humanitarian crisis necessitated an immediate shift in focus towards emergency health response, with particular emphasis on internally displaced persons (IDPs) and host communities.

As the State transitions from humanitarian response to recovery and development, strategic emphasis is now placed on building a resilient and sustainable health system capable of responding to public health emergencies while consistently delivering quality, affordable, and equitable health services to women, children, men, older persons, and other vulnerable populations. In response to these challenges, Adamawa State has benefited from multiple health sector initiatives and partner support, including the Nigeria State Health Investment Project (NSHIP), the Saving One Million Lives

Programme (SOML), the Basic Health Care Provision Fund (BHCPF), the IMPACT Project, and other development partners. These interventions catalyzed systemic reforms within the PHC sub-sector, notably the adoption of the Primary Health Care Under One Roof (PHCUOR) policy and the Ward Health System, leading to the establishment of at least one functional PHC facility per ward with capacity to provide round-the-clock services. In addition, the state has established a functional State Health Insurance/Contributory Agency, which serves as a critical platform for health financing reform and resource mobilization. The availability of this agency provides a sustainable mechanism for pooling funds, reducing out-of-pocket expenditure, and expanding financial risk protection for the population. As a key leveraging factor, the contributory health insurance scheme enhances the State's ability to attract and optimize donor and partner investments, improve provider payment mechanisms, strengthen accountability, and accelerate progress towards Universal Health Coverage (UHC).

In line with the Sustainable Development Goals (SDGs) 2030 agenda and the pursuit of Universal Health Coverage (UHC), Adamawa State has engaged relevant stakeholders and leveraged the State Strategic Health Development Plan II (SSHDP II), the National Health Act, and applicable health policies to develop and implement Annual Operational Plans (AOPs) for the period 2019–2025. Building on this foundation, the Health Sector Strategic Blueprint (HSSB) has been utilized to develop the 2026 Annual Operational Plan, which serves as a strategic roadmap for improving health service delivery, system performance, and health outcomes across the State.

1.3 Situation Analysis

In Adamawa, the socio-economic environment showed most of the people depend on subsistence farming for their livelihood. The level of income from subsistence farming is low and this affects the ability to access goods and services. The social environment puts a premium on large families. It is reported that in Adamawa State, each woman has an average of five children, and this influences the high growth in population. The rate of increase in population has implications for education, health and other social

health infrastructure in the State.

The most recent survey Conducted, which is the National Demographic Health Survey (NDHS, 2023/4) showed improvement in some Key Performance Indicators (KPIs) and a decline improvement in some other KPIs when compared to NDHS 2018. An example of the thematic area with improvement is fully immunized children under 1 year which increased from 36.8% (NDHS, 2018) to 38.4% (NDHS, 2023/24) and delivery Conducted at the facility from 38.9% (NDHS, 2018) to 41.6 (NDHS, 2023/4). A general improvement was noticed in the treatment of childhood illnesses such as malaria, diarrhea and pneumonia. Despite the improvement, some KPIs remained stagnant or declined, indicating poor performance in those thematic areas. An example is in ANC 4th Coverage which has declined from 66.5% to 56.4% and delivery by Skilled Birth Attendant declined from 40.8% to 24.4% (NDHS 18, NDHS 23/24). The performance of Family Planning has always been an issue in the State and at the National level because of various factors that are mainly traditional and cultural. This has implications on the population growth rate, access to education, water and sanitation services, health and other social infrastructure and support systems. The information on social determinants on health is not aggregated but the low health indices recorded through various national surveys call for a holistic approach to addressing the issue. The focus is to empower communities, promote community-based interventions and to strengthen service delivery mechanisms.

To improve the use of data for action, the State routinely Conducted quarterly data analysis of KPIs from administrative data obtained through DHIS 2 using a management tool known as RMNCAH+N Scorecard and did a comparison study with survey data over a period. The scorecard which is disseminated to relevant stakeholders at State, LGA and Health Facility Levels highlights thematic areas of low/high performance, data quality issues and poor reporting of services. The scorecard informed stakeholders to provide recommendations (action plans) that are used to improve healthcare services in the state. Over time, some indicators have

improved such as Vitamin. Some major Key Performance Indicators (KPIs) linked to Hope health project that are disbursement linked indicators (DLIs) are shown in Table 1 below based on data from the various surveys Conducted and administrative data in the State.

Table 1*: Key Performance Indicators (KPIs)*

S/N	Thematic Areas	Health Indicator	Performance	Source
1	Maternal and Child Mortality	National Maternal Mortality Ratio (per 100,000 Live births)	512	NDHS 18
2		Neonatal mortality rate (per 1000 live births)	43	NDHS, 2024
3		Infant mortality rate (per 1000 Live births)	75	NDHS, 2024
4		Under 5 mortality Rate (per 1000 Live births)	144	NDHS, 2024
5	Antenatal Care	% of pregnant women who received ANC from a skilled provider	34.7%	NDHS, 2024
6		% of pregnant women who had 4 or more ANC visits	56.4	NDHS, 2024
7	Immunization	Percentage of children age 12–23 months who were fully vaccinated (basic antigens) at any time before the survey	38%	NDHS, 2024
8	Labour and delivery	% of women whose delivery was in a Health Facility	42%	NDHS, 2024
9		% of women whose delivery was at home	58%	NDHS, 2024
10		% of women whose delivery was assisted by any skilled birth attendant	24.4%	NDHS, 2024
11	Postnatal Care	% of women with a PNC check during the 1st 2days after birth	50.6%	NDHS, 2024
12		% of births with a postnatal check during the first 2 days after birth	58.9%	NDHS, 2024
13	Reproductive Health	Fertility Rate	5.3	NDHS, 2024
14		Percentage of currently married women age 15–49 using a modern contraceptive method	18%	NDHS, 2024
15		Percentage of currently married women age 15–49 with unmet need for family planning	25%	NDHS, 2024

S/N	Thematic Areas	Health Indicator	Performance	Source
16	HIV/AIDs,	PMTCT Coverage	91%	NDARS 2025
17		HTS Coverage	52%	NDARS 2025
18		ARV Treatment Coverage	94.2	NDARS 2025
19		Maternal ARV Treatment Coverage	74.6%	NDARS 2025
20	Tuberculosis	TB Prevalence rate per 100,000 population	170	TBLCP, 2025
21		TB Treatment Success rate	99%	TBLCP, 2025
22	Malaria	Malaria Prevalence in children 6-59 months	11%	MIS 2021

2.0 National Health Sector Renewal Investment Initiative (NHSRII)

The Federal Government of Nigeria has launched the Health Sector Strategic Blueprint (2024 –2027) as a comprehensive reform framework aimed at reducing physical, financial, and systemic barriers to healthcare access, while accelerating progress towards improved population health outcomes. The Blueprint provides strategic direction for coordinated investments and reforms across the health sector.

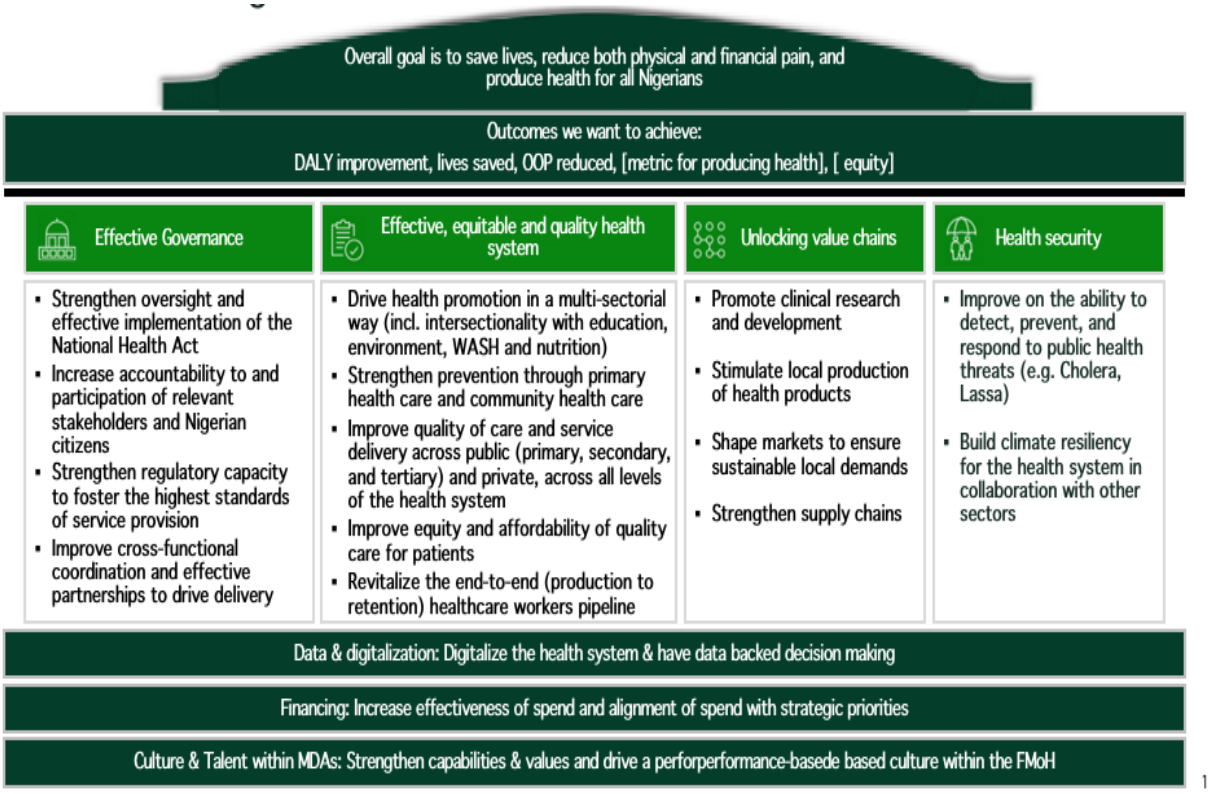
The Federal Ministry of Health and Social Welfare underscores the principle of cooperative federalism, as enshrined in the National Health Act (2014), as a central pillar of the reform agenda. This approach promotes structured collaboration among the Federal Government, State Governments, the Federal Capital Territory (FCT), the private sector, and development partners to ensure harmonized planning, efficient resource utilization, and measurable improvements in health outcomes nationwide.

On 12 December 2023, President Bola Ahmed Tinubu launched the Health Sector Renewal Investment Initiative, under which all 36 State Governors and the FCT formally entered a compact with the Federal Government. As part of this initiative, the Presidency articulated 13 priority deliverables for the health sector to be achieved within the duration of the current administration and formally assigned these deliverables to the Coordinating Minister of Health and Social Welfare. To operationalize this commitment at sub-national levels, the coordinating minister subsequently executed performance agreements with all 36 State Commissioners of Health and the FCT. These performance compacts institutionalize shared responsibility and collective accountability for improving health service delivery and outcomes across the federation.

The initiative places strong emphasis on performance management and accountability, supported by structured performance dialogues, routine monitoring, and periodic evaluations. These mechanisms are designed to track implementation progress,

enhance transparency, identify performance gaps, and promote adaptive learning and continuous improvement across all levels of the health system.

Table 2: the Health Sector Strategic Blueprint (2024 –2027)



2.1 The HSSB Strategic Framework

The Health Sector Strategic Blueprint (HSSB) is structured around a comprehensive strategic framework, consisting of the following components:

1. **Pillars**: 4 core thematic areas guiding overall sector priorities
2. **Enablers**: 3 cross-cutting mechanisms that facilitate implementation and sustainability
3. **Strategic Objectives**: 18 targeted goals aligned with national and sub-national health priorities
4. **Priority Initiatives**: 27 focused programs designed to operationalize the strategic objectives
5. **Interventions**: 262 specific actions and activities aimed at achieving measurable improvements in health system performance and outcomes

2.2 Sector Wide Approach (SWAp)

The Health Sector Renewal Investment Initiative (NHSRII) has catalyzed the conceptualization and adoption of a **Sector-Wide Approach (SWAp)**. The Coordinating Minister of Health and Social Welfare announced that President Bola Ahmed Tinubu GCFR has approved the design, domestication, and implementation of a context-sensitive SWAp as an innovative, integrated, and coordinated strategy to enhance health outcomes nationwide. The announcement was made during the opening of the 64th National Council on Health, held from 13th–17th November 2023 in Ado Ekiti, under the theme: *"Building a Resilient and Inclusive Healthcare System for a Healthy Nigeria."*

The SWAp is designed to foster a cohesive, efficient, and sustainable health sector by promoting unified planning, coordination, and accountability among all stakeholders. Under this approach, the sector is considered holistically, with consensus on strategies, progress measurement, and performance evaluation. Funding sources and flows are

made transparent and aligned with agreed programmatic priorities to minimize duplication, gaps, and inefficiencies. The Government assumes leadership in setting sectoral priorities, leveraging existing systems to optimize Technical Assistance (TA) and ensuring that support is demand driven. In collaboration with Development Partners, the Government designs strategic plans, oversees implementation, evaluates outcomes, and strengthens governance and accountability mechanisms. SWAp eliminates parallel sector dialogues and promotes transparency in financing, performance monitoring, and results reporting, thereby enhancing overall system efficiency and effectiveness.

2.3 Actualizing SWAp - Four Cardinal Focus Areas

The Sector-Wide Approach (SWAp) is organized around four interrelated and mutually reinforcing pillars, each designed to enhance coordination, accountability, and efficiency across the health sector:

1. One Plan – Strategic Alignment

- Establishes a unified understanding of shared health sector priorities among all stakeholders, including Federal and State Governments and Development Partners (DPs).
- Anchors collaborative commitment to SWAp principles, such as joint planning, harmonized programming, and alignment of sector initiatives with national and sub-national priorities.

2. One Budget – Transparent Financing and Accountability

- Ensures full visibility of all funding sources and expenditure flows relative to agreed plans.
- Strengthens accountability mechanisms, including performance-linked funding instruments such as Disbursement-Linked Indicators (DLIs).

- Promotes pooling and coordinated deployment of Technical Assistance (TA) and financial resources to minimize duplication and optimize impact.

3. One Report – Integrated Monitoring, Evaluation, Research, and Learning (MERL)

- Defines and tracks a standardized set of priority indicators to monitor sector-wide progress.
- Coordinates Development Partner missions, supportive supervision, and facility visit to reduce redundancy.
- Establishes a calendar of Joint Annual Reviews (JARs) to ensure systematic assessment of sector performance.
- Enhances MERL systems by building technical capacity, strengthening data responsiveness, and improving evidence-based decision-making.

4. One Conversation – Harmonized Sector Dialogue

- Provides structured forums for routine, sector-wide engagement, such as Quarterly Performance Dialogues.
- Utilizes Technical Working Groups (TWGs) to facilitate sub-sectoral strategic discussions, coordinate partner inputs, and prioritize sectoral needs.
- Encourages continuous communication and consensus-building to support coordinated policy implementation and sector reforms.

2.4 Disbursement Link Indicators (DLIS)

Disbursement-Linked Indicators (DLIs) are measurable performance indicators in results-based financing programmes. They are pre-agreed targets that, once achieved, trigger the disbursement of funds. DLIs ensure that the financing is tied directly to the results, enhancing accountability and performance in project implementation. Disbursement Linked Indicators (DLIs*)* constitute a development financing instrument that releases funds when tangible and verifiable results are achieved. In the AOP context, DLIs push

toward higher performance, stronger alignment with state priorities, improved data systems, and more efficient service delivery while also introducing accountability demands and performance-linked funding risks. Properly leveraged, DLIs can transform organizational effectiveness and improve health outcomes. In the Nigeria HOPE-Health Programme, the DLIs aim to improve service delivery, utilisation of essential services, and health system resilience. The document outlines 11 DLIs across key results areas such as improving the quality of services, utilisation of essential healthcare, and building health system resilience.

Here are the 11 DLIs identified in the programme document, along with a focus on DLI 4 and its related DLIs.

Results Area 1: Improving Quality of Services

DLI 1: Improved service readiness.

DLI 2: Increased availability of essential commodities. 22

Results Area 2: Improving Utilisation of Essential Services

DLI 3: Increased enrolment of poor and vulnerable populations.

DLI 4: Enhanced community delivery of health services.

DLI 5: Increased utilisation of priority secondary care services.

DLI 6: Increased primary healthcare utilisation of priority services.

DLI 7: Increased utilisation of emergency medical services.

Results Area 3: Improving Resilience of the Health System

8. DLI 8: Improved allocation and disbursement of BHCPF funds.
9. DLI 9: Enhanced pandemic preparedness and response (PPR) through deployment.
10. DLI 10: Improved climate resilience.
11. DLI 11: Stronger digital foundation

3.0 Annual Operational Plan (AOP)

The Annual Operational Plan (AOP) is a core health sector planning instrument designed to operationalize and support the attainment of the Health Sector Strategic Blueprint (HSSB). It represents the annual translation of the national and/or state health strategic framework into implementable actions within a defined fiscal year. The AOP systematically articulates priority health interventions aligned with national and state policy directions, clearly defining the activities required to achieve agreed targets, including implementation timelines, responsible entities, and coordination mechanisms.

In addition, the AOP provides a comprehensive costing of all planned activities, specifying funding requirements and identifying sources of financing, including government allocations and Development Partner (DP) contributions. Through this process, the AOP facilitates the identification of critical financial and technical resource gaps that may impede the achievement of sector priorities, thereby informing targeted resource mobilization and partner engagement.

The AOP serves as an accountability and performance management tool by linking strategic objectives to measurable outputs and assigning clear ownership to implementing units across the health system. It also supports evidence-based decision-making by highlighting underserved programmatic and geographic areas requiring additional investment or technical assistance. Furthermore, the consolidated AOP forms the basis for the state health sector budget, providing a credible and structured benchmark for integration into the broader state budgeting and Medium-Term Expenditure Framework (MTEF) processes.

The 2026 Annual Operational Plan is aimed towards achieving the Health Sector Strategic Blueprint (HSSB). An AOP is an annual translation of the nation/state strategic plan that outlines:

a) Key health priorities (national and state)

b) Activities needed to achieve set targets on the priorities (including timeline and entities) over a calendar year
c) Cost to implement each activity, including source of funds (DP, govt.)
d) Gaps in resources to achieve priorities

The development of the 2026 Annual Operational Plan (AOP) was guided by a roadmap developed with specific timelines and coordinated by the State Ministry of Health (SMoH) and the Adamawa State Primary Health Care Development Agency (ADSPHCDA), with technical and financial support from partners namely UNICEF and UNFPA (EU-SARAH Project), MSI and WHO.

Table 3: Roadmap for AOP 2026 Development

S/N	Proposed Activities	Stakeholders	Timeline
1	Development of LGA Health Department and Facilities AOP	Technical Assistant, Facilities Manager and LGA Team	16th - 19th Sept
2	Conduct 1 day Priority Mapping to identify State Priorities for AOP 2026	Top management of all MDAs	22nd Sept
3	Conduct 2 days Operational planning Refresher for 60 participants	Key Directors and Program Officers in all MDAs and Partners	23rd - 24th Sept
4	Conduct 3 Days meeting by each of the 7 MDAs to Develop their 2026 Workplan using the new AOP template.	All MDAs	25th - 27th Sept
5	Conduct 3-day workshop for Health Sector Wide AOP Review, Harmonization and Finalization by Departments and Agencies; and Partners	Head of MDAs, Key Directors and Program Officers in all MDAs and Partners	8th – 10th Oct
6	Joint AOP–Budget Harmonization/ Integration Meeting	AOP TWG and Budget	15th October
7	Conduct 1 day for Validation and Approval of 2026 AOP	TMC, Head of Departments	21st October

The development process employed a bottom-up, participatory methodology, whereby health sector priorities were identified and validated at the facility level and subsequently aggregated through the LGA and State levels. This approach ensured alignment with local service delivery realities while maintaining coherence with strategic objectives outlined in the Health Sector Strategic Blueprint (HSSB). The MDAs engaged during the AOP process are State Ministry of Health (SMoH), Adamawa State Primary Health Care Development Agency (ADSPHCDA), Adamawa State Contributory Health Management Agency (ASCHMA), Hospital Service Management Board (HSMB), Traditional Medicine Board (TMB), Adamawa State Health Supplies Management Agency (ADSHSuMA), College of Nursing and Midwifery Yola, College of Health Science and Technology Michika and Adamawa State Action for the Control of HIV/AIDS.

3.1 LGA and Facilities AOP Development

The AOP process commenced at the LGA Level with 4 day activities involving 21 State Technical Assistants, 168 LGA teams and 226 Ward Level Facilities Manager across the 21 LGAs. The output of the meeting was the SITAN and AOP for the 21 Primary Health Care Authority (Health Department) and business plans/AOPs for 226 BHCPF Ward Health Facilities.

Table 4: Summary of the LGA AOPs developed

LGA	Total AOPs develop	Total Cost of AOP
Demsa	11	53,452,500
Fufore	12	55,143,000
Ganye	11	225,388,500
Girei	10	146,408,500
Gombi	11	71,216,100
Guyuk	11	63,926,500
Hong	13	44,948,500
Jada	13	233,176,600
Lamurde	11	71,105,000
Madagali	11	38,815,000
Maiha	11	50,656,000

LGA	Total AOPs develop	Total Cost of AOP
Mayo Belwa	13	108,309,000
Michika	17	178,768,000
Mubi North	12	96,166,500
Mubi South	11	87,288,000
Numan	11	70,257,000
Shelleng	11	65,926,000
Song	12	114,833,600
Toungo	11	106,778,700
Yola North	12	210,472,000
Yola South	12	63,017,344
Total	**247**	**2,156,052,344**

3.2 Situational Analysis and Priority Setting

Following a comprehensive state-level situation analysis Conducted to assess historical trends and the status of key health indicators, and in alignment with the national roadmap guiding the preparation and implementation of the 2026 Annual Operational Plan (AOP) across sub-national levels, Adamawa State convened a one-day health sector priority-setting workshop. The workshop was held in Yola on the 22nd of September 2025 and aimed to systematically identify and validate state-specific priority initiatives for inclusion in the 2026 AOP.

The process resulted in the development of SITAN and identification of 265 high-priority interventions drawn from the Health Sector Strategic Blueprint (HSSB), reflecting the most critical health system and service delivery needs of the state. The prioritization exercise was led by Top Management Officials from relevant state-level Ministries, Departments, and Agencies (MDAs), alongside programme managers and technical officers, to ensure sector-wide ownership and technical rigor.

Interventions were selected using an agreed set of objective prioritization criteria, including effectiveness, magnitude and relevance of the health problem, cost and financial sustainability, fairness and equity, as well as the level of political commitment

and feasibility of implementation. This structured and evidence-informed approach ensured that the selected priorities are responsive to the state's epidemiological profile, aligned with national policy directions, and feasible within available and projected resources for the 2026 planning cycle.

Table 5: Situation Analysis of the Health System (SITAN)

Pillar 2: RMNCAH

Priority Areas	Key Performance Indicators	Possible Problem	Root Cause	Strategies to address the root cause
Improve Reproductive, Maternal, Newborn and Child health, and Nutrition outcome	DLI 1: Improved service readiness (BEmONC, CEmONC DLI 2: Increased availability of essential commodities (Oxytocin, RUTF, SQ-LNS, MNP, Tom-brown, Amoxicillin, Albendazole, MMS, FP, ACTs, RTKs, Penta Vaccine) DLI 4: Enhanced community delivery of health services (Malnutrition, ANC, referral, ICCM DLI 6: Increased PHC utilization of priority services (SBA & MMS). DLI 7: Increased utilization of EMS.	• inadequate mix and distribution of skilled healthcare workers • Inadequate infrastructure and equipment e.g (blood bank, unstable power supply, water supply) • Inadequate supply of essential commodities (Uterotonics, MMS, FP Commodities, RDT Kits) • Poor Health Workers attitude • Inadequate Coverage of emergency ambulance services • Poor accessibility to Health Facility • Poor uptake of PHC services	• Embargo on employment and inadequate funding for HRH • Poor renumeration and welfare of staff especially in rural and Hard to reach areas • Inadequate funding for quality Healthcare delivery • Poor logistics and management of commodities • Inadequate funding for procurement of commodities • Traditional and religious belief • Poor location of health facility and bad terrain • Lack of functional EMS to transport community members to facility	• Recruitment of skilled health workers • Capacity building of health workers on life saving skills • Capacity building of healthcare workers on SBCC, patient bill of rights and respectful maternal care • Renovation and equipping of designated BEmONC and CEmONC facilities • Establish functional blood bank facility in one General Hospital per senatorial zone. • Government to liaise with YEDC for linking GH Hospitals to band A electricity • Installation of solar power supply in designated BEmONC and CEmONC facilities. • Strengthen Domestic Resources Mobilization • Strengthen logistics and management of commodities • Strengthen Emergency transport system through engagement of public and private sector

Nutrition

Priority Areas	Key Performance Indicators	Possible Problem	Root Cause	Strategies to address the root cause
Improve Reproductive, Maternal, Newborn and Child health, and Nutrition.	DLI 2: Increased availability of essential commodities (Oxytocin, RUTF, SQ-LNS, MNP, Tom-brown, Amoxicillin, Albendazole, MMS, FP, ACTs, RTKs, Penta Vaccine) DLI 4: Enhanced community delivery of health services (Malnutrition) DLI 6: Increased PHC utilization of priority services (MMS).	• Inadequate supply of nutrition essential commodities (RUTF, SQ-LNS, MNP, Tom-brown, Amoxicillin, Albendazole). • weak capacity and training gap. • inadequate human resources • logistics and supply chain challenges. • low community awareness and engagement. • Poor data management and reporting. • Financial constraint. • Weak referral and linkage systems. • social and cultural barriers.	• Weak coordination between stakeholders • lack of integration of nutrition commodities into the national essential medicines supply chain • Insufficient number of trained health workers at the community level, limited opportunities for continuous training and supportive supervision • Poor forecasting and procurement planning for RUTF, and routing drugs, inadequate logistics and transport infrastructure for transporting nutrition commodities, heavy reliance on donor-driven supplies. • low knowledge of MIYCN practice (exclusive breastfeeding, dietary diversity, responsive feeding), weak health education SBCC at the community level.	• Strengthen joint planning and review meetings at national, state, and LGA levels. • Integrate nutrition commodities (RUTF, SQ-LNS, MNP, drugs) into the State Essential Medicines Supply Chain. • Provide continuous capacity-building through refresher trainings, mentorship, and supportive supervision. • Strengthen last-mile delivery systems (motorbikes, solar-powered cold boxes, local depots). • Promote local production of RUTF and fortified foods (e.g., Tom Brown). • Scale up MIYCN counselling during ANC, PNC, immunization, and community outreaches. • Use mass media, community radio, drama, and local leaders to promote exclusive breastfeeding and dietary diversity. • Provide regular training on nutrition registers, tally sheets, and DHIS2 reporting. • Develop a sustainability plan with cost-sharing between government, partners,

Priority Areas	Key Performance Indicators	Possible Problem	Root Cause	Strategies to address the root cause
			• lack of user-friendly digital tools at the community levels, poor data quality due to inadequate training on registers and reporting tools. • Heavy dependence of external partners and donor funding, limited government allocation for nutrition, inconsistence funding leading to program interruption.	and communities. • Explore innovative financing (private sector partnerships, CSR, health insurance). • Strengthen social protection programs (cash transfers, food vouchers) targeting vulnerable households. • Promote home gardening, small livestock, and local food fortification (e.g., Tom Brown mix).

Priority Areas	Key Performance Indicators	Possible Problem	Root Cause	Strategies to address the root cause
		Poor handling of food items during production, and processing	• Limited knowledge of food safety and hygiene practices among processors and handlers. • Inadequate storage facilities and tools • Poor water supply and sanitation facilities at production/processing sites. • Weak Regulatory & Monitoring Systems • Heavy reliance on traditional methods without modernization. • Exposure of food to dust, flies, rodents, and pests during drying, storage, or transportation. • Climate conditions (heat, humidity) lead to rapid spoilage. • Poor waste management near food production/processing areas. • Lack of use of protective gear (gloves, aprons, hair covers). Carelessness or negligence during food handling.	• Build capacity of farmers, processors, and food handlers on Good Agricultural Practices (GAP), Good Hygiene Practices (GHP), and Good Manufacturing Practices (GMP). • Conduct regular awareness campaigns on contamination risks and safe handling. • Support small-scale producers with microfinance/loans to upgrade facilities. • Strengthen enforcement of national food safety standards (e.g., NAFDAC, SON in Nigeria). • Establish community-level food safety committees for peer monitoring. • Link producers to cooperatives and value chains that encourage collective investment in safe infrastructure. • Promote low-cost innovations like solar drying instead of unsafe ground drying. • Improve pest and rodent control measures at storage and processing points. • Enforce waste management standards near food production/processing sites. • Introduce protective covers for drying and transporting foods.

ATM

Priority Areas	Key Performance Indicators	Possible Problem	Root Cause	Strategies to address the root cause
Reduce the incidence of HIV, tuberculosis, and malaria	High test positivity rate at 72%	High reporting of malaria cases from facility while survey show low malaria prevalence	• Many presumptive diagnoses without RDT/microscopy • Clinicians treating any fever as malaria. • Pressure from patients expecting malaria treatment. • Stock-outs of RDTs leading to presumptive treatment. • Poor quality of RDTs or expired test kits. • Inadequate training of health workers on proper use of RDT/microscopy.	• Strengthen capacity building of Health Worker on Case management and diagnostics • Strengthen Logistic and Management of RTKs • Strengthen community awareness and participation in Health
	TB Notification Rate: Number of new TB cases reported per 100,000 population per year.	TB is a leading cause of death worldwide	Limited access to healthcare, poor living conditions, and malnutrition due to poverty.	• Poverty Reduction: Implement poverty reduction strategies to address underlying socioeconomic factors
	Treatment Success Rate: Percentage of TB patients who complete treatment and are cured	TB cause significant illness and disability	Inadequate healthcare infrastructure and lack of access to health services	• Enhance healthcare infrastructure and access to health services. • Engage with local communities to promote TB awareness and control efforts.

Priority Areas	Key Performance Indicators	Possible Problem	Root Cause	Strategies to address the root cause
	TB Incidence Rate: Number of new TB cases per 100,000 population per year.	TB can have a substantial economic impact on individuals, families, and communities.	Social stigma, education level, and occupation	• Raise awareness about TB and promote health-seeking behavior.
Reduce the incidence of HIV, tuberculosis, and malaria	• 95% of people with HIV know their status, 95% of those diagnosed get treatment (ART), and 95% of those on treatment achieve viral suppression • % of HIV-exposed infants receiving ARV prophylaxis at birth. • % of infants born to HIV-positive mothers tested for HIV within 6 weeks of birth. • MTCT rate at 6 weeks and at 18 months postpartum. • % of HIV prevention service delivery points offering integrated STI/TB/Hepatitis screening.	• Increased HIV Incidence and Prevalence • Elevated Morbidity and Mortality • Increased Burden on the Health System • Risk of Antiretroviral Drug Resistance (ADR). • Economic and Social burden • Threat to the UNAIDS 95-95-95 Targets • Continued Transmission Dynamics • Widening Inequities in Health Outcomes	• **1. Biological Factors** • High Viral Load in Undiagnosed Individuals: • Inadequate coverage and adherence to PMTCT services contribute to vertical transmission during pregnancy, delivery, or breastfeeding. • Co-infections such as syphilis, gonorrhea, and herpes simplex virus type-2 (HSV-2) increase susceptibility to HIV by compromising mucosal integrity and enhancing viral entry. •Transmission of resistant viral strains complicates treatment initiation and contributes to onward spread of hard-to-treat infections. **2. Behavioral Factors**	• **Pillar 1: Biomedical Prevention** • Expand HIV testing services. • Scale up PrEP/PEP access with adherence support. • Implement Treatment as Prevention (TasP) via universal and immediate ART initiation. • Strengthen PMTCT programs to achieve elimination of mother-to-child transmission (eMTCT). • Integrate STI, TB, and Hepatitis services into HIV prevention platforms. **Pillar 2: Behavioral Prevention** • Deliver comprehensive sexuality education to adolescents and young people. • Scale up condom and lubricant promotion and distribution through social marketing and free outlets. • Strengthen risk-reduction counselling for key populations and vulnerable groups.

Priority Areas	Key Performance Indicators	Possible Problem	Root Cause	Strategies to address the root cause
	o % of TB patients tested for HIV and % of HIV-positive TB patients initiated on ART. 2. Behavioral Prevention KPIs • % of sexually active young people (15–24 years) reporting consistent condom use with non-regular partners. • % of key populations reached with comprehensive HIV prevention interventions (condoms, HIV testing, PrEP, counselling). • % of adolescents and young people reached with comprehensive sexuality education. • Number of PWID reached with harm reduction services (needle-syringe		• Unprotected Sexual Practices: • Multiple Sexual Partnerships elevate transmission dynamics. • Low Uptake of Prevention Services • Alcohol and injection drug use contribute to impaired judgment, needle-sharing, and risky sexual behaviors. • Irregular adherence among people already on ART leads to high viral load, reducing the prevention benefits of treatment-as-prevention (TasP). **3. Structural Factors** • Stigma and Discrimination deter individuals from seeking HIV testing and treatment. • Gender Inequalities affect uptake of health services • Poverty and Unemployment amplify HIV transmission. • Cultural Norms and Myths about HIV prevention reduce uptake of biomedical interventions. • Displacement of populations	• Implement harm reduction services for people who inject drugs (PWID). • Deploy digital/mHealth interventions for adherence and prevention awareness. **Pillar 3: Structural Prevention** • Implement stigma and discrimination reduction programs in health facilities, schools, workplaces, and communities. • Address gender-based violence (GBV) through legal enforcement, survivor care, and integration with HIV services. • Provide economic empowerment interventions for adolescent girls, young women, and vulnerable households. • Develop resilient HIV prevention services in humanitarian/conflict settings with mobile clinics and simplified ART/PrEP delivery. **Pillar 4: Systems and Programmatic Enablers** • Strengthen supply chain management to prevent stock-outs of HIV commodities. • Scale up task-shifting and task-sharing policies to optimize the use of human resources for health. • Enhance surveillance systems (NDR, NDARS, eNNRIMs, case-based surveillance, drug resistance monitoring).

Priority Areas	Key Performance Indicators	Possible Problem	Root Cause	Strategies to address the root cause
	programs, OST). • % of PLHIV retained in care 12 months after ART initiation. **3. Structural Prevention KPIs** • % of reported stigma and discrimination cases in health facilities resolved. • % of GBV survivors who received HIV post-exposure prophylaxis (PEP) within 72 hours. • % of HIV prevention programs with gender-transformative interventions for adolescent girls and young women (AGYW). **4. Systems and Programmatic KPIs** • % of facilities reporting no stock-out of HIV test kits, condoms, or ART in the last quarter.		due to insurgency and communal violence disrupts continuity of care and increases risky behaviors. **4. Systemic and Programmatic Factors** • Gaps in HIV Testing Coverage Weak Health Infrastructure Stock-Outs of Commodities • Insufficient Human Resources for Health • Weak Data Systems: • Low Political Commitment	• Institutionalize HIV prevention budget lines at federal and state levels with timely releases. • Strengthen multi-sectoral governance structures (NACA, SACAs, TWGs, CSOs, community networks). **5. Cross-Cutting Approaches** • Community engagement and ownership through involvement of PLHIV and key populations in program design and delivery. • Human rights-based approach ensuring confidentiality, non-discrimination, and equity in service provision. • Integration with Universal Health Coverage (UHC) and primary health care platforms. • Digital health innovations for service delivery, data management, and client engagement. • Sustainability through domestic resource mobilization and reduced donor dependency.

Priority Areas	Key Performance Indicators	Possible Problem	Root Cause	Strategies to address the root cause
	• % of health facilities offering integrated HIV, TB, and reproductive health services. • Number of healthcare workers trained on HIV prevention, PrEP delivery, and stigma-free service provision. • % completeness and timeliness of HIV data reporting on NDARS, NDR, and eNNRIMs.			

Pillar 3: Unlocking value change

Priority Areas	Key Performance Indicators	Possible Problem	Root Cause	Strategies to address the root cause
• Stimulate local production of health products • Strengthen commodity security and reduce the high rates of stock-outs	• Number of functional pharmaceutical/medical production facilities in Adamawa • % decrease in health product imports over 3–5 years • Number of licensed SMEs producing essential health products • Volume of locally produced essential medicines and consumables • Employment rate in local health manufacturing sector • Increased availability of essential commodities (Oxytocin, MMS, FP, ACTs, RTKs, Penta Vaccine)	• Limited or non-existent production of essential health products (e.g., drugs, medical consumables, diagnostic kits) in Adamawa State • Supply Chain Disruptions • Delays in approvals and funds release	• Poor or non-existent industrial zones with utilities (electricity, water, waste disposal) • Lack of pharmaceutical-grade infrastructure and testing labs • Inadequate access to affordable finance for startups • Shortage of skilled pharmaceutical technologists and production engineers • Bureaucratic delays from NAFDAC and other agencies • inadequate logistics and transportation system • Complex Approval Processes	• Establish a Health Industry Hub in Adamawa (through public-private partnerships) with pre-built facilities for SMEs • Set up government-backed loan schemes with microfinance banks and Bank of Industry • Partner with Adamawa State Polytechnic and vocational schools to introduce pharma-tech training programs • Launch awareness campaigns about funding/grants for health manufacturing • Digitize and decentralize NAFDAC/state licensing processes to Yola and other major towns • Offer tax holidays or duty waivers for local health manufacturers for the first 3–5 years of operation • Enhance logistics networks and adopt technology for tracking • Adopt the digitalized approval system

Pillar 4: Health Security

riority Areas	Key Performance Indicators	Possible Problem	Root Cause	Strategies to address the root cause
• Improve pandemic prevention, detection, preparedness & response	• Incidence of outbreaks across states • Performance on outbreak response activities • DLI 9: Enhanced PPR through deployment.	• Polio incidences still recorded in the state • Annual outbreaks of measles and Cholera witnessed in the state. • Poor preparedness for outbreak response • High cases of diphtheria recorded in the state • Rampant cases of Rashes and itching (Scabies) widely spread across the state • Cases of Buruli ulcer identified in the state.	• Poor immunization coverage as a result of Vaccine refusal (noncompliance), Poor community engagement and use of ineffective medium for campaigns • Poor surveillance systems due to Inadequate number of trained DSNOs at the Facility level as well as Community Informants at the community level. • Inadequate allocation of funds for disease prevention and control • Climate change and natural disasters (flash flood) • Poor Socio-economic status (overcrowding) • Poor research (to identify factors contributing to outbreak, for action)	• Strengthen community dialogue for uptake of immunization services. • Strengthen mop-up immunization campaigns • Encourage father for good health programs • Creation of immunization awareness using multimedia approach (Radio, Town announcers, Poster, Blog and social media posts, TV, Worship centers and community groups) • Recruitment and training of more disease notification officers, engagement and training of more Community informants and laboratory staff. • Provision of electronic and hard copy real time data reporting tools. • Ensure functional laboratories by provision of equipment and reagents for improved case detection. • Establishment of Advanced modern laboratory in the state for receiving referrals from lower levels. • Review of budget with priority targeted at increasing the budgetary allocation for epidemic preparedness.

				• Make Pre-positioning of Drugs and other items in anticipation of natural disasters (Flooding, Outbreak of Diseases e.g Cholera, Measles, Typhoid fever, etc). • Social and Behavioural Change communication on personal hygiene, environmental sanitation and mode of spread of diseases. • Ensuring the inclusion of research components in projects being implemented in the state, and allocation of funds for research. • Creation of a research team in collaboration with tertiary learning institutions in the State. • Strengthen the state research ethics committee by reactivating regular meetings and training to ensure compliance with international standards

Enabler 1: Data Digitalization

Priority Areas	Key Performance Indicators	Possible Problem	Root Cause	Strategies to address the root cause
Coordination	DLI 11: Stronger Digital Foundation (NDHA)	• Poor coordination	• Inconsistency in the Conduct of M&E coordination meetings	• Ensure consistent coordination meetings of M&E officers to enhance data collection, reporting and usage
Digitalization		• Inadequate HF implementing data Digitalization EMR is only implemented in few secondary and private HFs in the state	• In adequate digital tools (computers & internet access) at most HFs and LGA levels • Poor capacity and infrastructure on EMR implementation • Non implementation of EMR in the state	• Ensure DHIS2 Digitalization across all the HF on DHIS2 platform in the State • Ensure supply of digital tools and internet and capacity building at all levels
Capacity Development		Poor data quality and reporting	• Capacity gap among HFs data clerks • Stock-out of NHMIS Data tools	• Undertake training of HF data clerks on data collection, validation and reporting • Procure and distribute NHMIS data tools • Track distribution and utilization of NHMIS data tools

3.3 Operational Planning and AOP Online Tools Training

Following the identification and validation of high-priority state interventions from the Health Sector Strategic Blueprint (HSSB), Adamawa State organized a two-day step-down capacity-building workshop on the AOP process and the use of the online AOP tools to strengthen institutional readiness for the development and implementation of the 2026 Annual Operational Plan (AOP). The workshop was Conducted from 23rd – 24th September 2025 in Yola, Adamawa State, and was designed to enhance the technical capacity of programme officers across key disease and health system thematic areas.

The objective of the workshop was to familiarize programme officers with the revised HSSB planning and prioritization tools, including their application in activity definition, target setting, costing, and alignment with the state health sector budget. Emphasis was placed on ensuring that officers gained practical competence and conversance with the tool to support downstream planning processes at departmental and agency levels.

Participants were drawn from relevant line Ministries, Departments, and Agencies (MDAs)**,** including programme managers, monitoring and evaluation officers, and technical leads overseeing priority disease control and health system strengthening programmes. These officers were strategically selected to serve as master trainers within their respective MDAs and were mandated to Conduct structured step-down trainings for additional technical staff to ensure institutional diffusion of knowledge and standardized application of the HSSB tool across the state.

The step-down training approach was adopted to promote sustainability, harmonization, and ownership of the AOP development process, while minimizing capacity gaps across MDAs. By strengthening technical competencies at multiple levels of the health system, the workshop contributed to improving the quality, coherence, and implementability of the 2026 AOP, and reinforced alignment with national planning guidelines and sector performance expectations.

4.0 Development of 2026 Annual Operational Plan and Harmonization

The Annual Operational Plan (AOP) online tools are structured around four strategic pillars and three cross-cutting enablers**,** as outlined in the HSSB blueprint. The development of the 2026 Adamawa State Health Sector Annual Operational Plan was undertaken through a collaborative and multisectoral process involving the State Ministry of Health (SMoH) and other relevant line Ministries, Departments, and Agencies (MDAs). Operational activities articulated in the AOP were derived from the 206 high-priority interventions earlier identified under the Health Sector Strategic Blueprint (HSSB) and are strategically oriented toward improving key health indices and strengthening service delivery, with particular emphasis on Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition (RMNCAH+N)**.**

The Key Technical Officers trained led the 3 days AOP development process in the various MDAs liaising with all departments and units to produced robust activities linked to various Health outcomes.

During the workshop in Gombe, participants were systematically grouped according to their respective thematic and programmatic areas to optimize technical input, facilitate focused discussions, and ensure alignment of activities across agencies.

A 3 days AOP harmonization and finalization workshop was held from 8th – 10th October 2025 in Gombe. The workshop was declared open by the Honourable Commissioner of Health, represented by the Director DPRS underscoring high-level political commitment to the planning process. Participation included senior technical officers, programme managers, and planning and M&E personnel from relevant various MDAs, alongside representatives of Development Partners (DPs) and Implementing Partners (IPs)**.** These stakeholders provided strategic, technical, and programmatic inputs that strengthened the coherence, feasibility, and partner alignment of the 2026 AOP. The inclusive and consultative nature of the process ensured that the final plan reflects shared priorities,

leverages partner resources, and is aligned with national policy directions and state health system realities.

4.1 Costing of 2026 Annual Operational Work Plan

The harmonized AOP template was costed using a state budget ceiling for interventions and a standard cost assumptions template which contained standard prices and unit cost for services and goods at various levels of implementation. Costs were unanimously determined based on the current rates of goods and services. Developed operational activities were costed with projected estimates for 2026. The output of the workshop produced a plan with a grand total of ₦39,014,166,446, government commitment as ₦26,160,206,464 (67%), Development Partner ₦11,056,444,950 (28%) and a funding gap of ₦ 1,797,515,032 (5%) as presented in the attached tables 6 & 7 below.

Table 6: AOP budget and Financing by MDAs

MDAs	Total Cost ₦	Government Cost ₦	Partner Cost ₦	Funding Gap ₦
Adamawa State Primary Healthcare Development Agency	25,399,030,732	16,025,891,150	7,838,284,050	1,534,855,532
Adamawa State Ministry of Health	9,502,875,714	6,489,987,414	2,840,293,800	172,594,500
Adamawa State Contributory Health Management Agency	1,982,221,000	1,871,680,900	110,540,100	0
Adamawa State Health Supplies Management Agency	972,684,000	734,334,000	190,350,000	48,000,000
Adamawa Traditional Medicine Board	499,470,000	499,470,000	0	0
Adamawa State Action for the Control of HIV/AIDS	475,800,000	425,013,000	39,187,000	11,600,000
Adamawa State College of Health Science & Technology Michika	112,565,000	82,100,000	0	30,465,000
Adamawa State Hospital Services Management Board	45,790,000	8,000,000	37,790,000	0
College of Nursing Sciences Yola	23,730,000	23,730,000	0	0
Total by MDAs	**9,014,166,446**	**26,160,206,464**	**11,056,444,950**	**1,797,515,032**

Table 7: AOP budget and Financing by pillars

HSSB AOP PILLARS	Total Cost of AOP	Governments Commitment	Other funding	Funding Gap
Strategic Pillar One: Effective Governance	137,327,500	127,284,500	10,000,000	43,000
Strategic Pillar Two: Efficient, Equitable and Quality Health system	18,451,860,846	10,668,918,714	6,256,807,200	1,526,134,932
Strategic Pillar Three: Unlocking Value Chains	17,829,627,600	13,223,667,600	4,531,790,000	74,170,000
Strategic Pillar Four: Health Security	1,574,959,000	1,572,114,500	0	2,844,500
Enabler 1: Data Digitization	808,965,500	473,071,150	193,071,750	142,822,600
Enabler 2: Financing	64,776,000	0	64,776,000	0
Enabler 3: Culture and Talent	146,650,000	95,150,000	0	51,500,000
Total	**39,014,166,446**	**26,160,206,464**	**11,056,444,950**	**1,797,515,032**
	% Distribution	**67%**	**28%**	**5%**

4.2 Dissecting the Developed and Costed Annual Operational Plan

4.2.1 Pillar 1: Effective Governance

This Pillar is primarily focused on strengthening and effective implementation of the National Health Act, National Health Policy, increasing accountability to and participation of relevant stakeholders and Nigerian citizens, strengthen regulatory capacity to foster the highest standards of service provision and improve cross-functional coordination and effective partnerships to drive delivery.

Seventeen (17) operational activities were developed and costed at ₦137,327,500 out of which the state government was to commit ₦127,284,500 and development partners to contribute ₦10,000,000.

4.2.2 Pillar 2: Efficient, Equitable and Quality Health System

The focus of this pillar includes driving health promotion in a multi-sectoral way (inclusive intersectionality with education, environment, WASH and nutrition. This seeks to strengthen prevention through primary health care and community health care, improve quality of care and service delivery across public (primary, secondary and tertiary care) and private, across all levels of the health system, improve equity and affordability of quality care for patients, and revitalize the end-to-end (production to retention) healthcare workers' pipeline.

Given the focus of the above, pillar 2 churned out the highest number of activities across the pillars and enablers. The implication is that the state government needs to invest more specifically in RMNCAH+N and health promotion services. A total of two hundred and eighty-eight (288) operational activities were developed and costed at an estimate of ₦18,451,860,846. The state government was to contribute ₦10,668,918,714, while the partners made a contribution of ₦6,256,807,200 leaving a funding gap of ₦1,526,134,932.

4.2.3 Pillar 3: Unlocking Value Chain

The strategic objectives of this pillar seek to promote clinical research and development, stimulate local production of health products, shape markets to ensure sustainable local

demand, and strengthen supply chain. Part of the overall priority initiative of this pillar aims to re-Position Nigeria at the forefront of emerging R&D innovation, starting with local clinical trials and translational science, Strengthen the Nigeria Health Logistics Management Information System (NHLMIS) to integrate all health programmes data management including vaccines, Essential Medicines and other supply chain functionalities, strengthen research and development in the state among others.

The total cost of 57 planned and costed operational activities is put at N17,829,627,600, with the state making a contribution of N13,223,667,600, and Partners providing ₦4,531,790,000 leaving a funding gap of ₦74,170,000.

4.2.4 Pillar 4: Health Security

Part of the strategic objective of this pillar include: improve the ability to detect, prevent and respond to public health threats such as Lassa fever, cholera, etc. build climate resiliency for the health system in collaboration with all other sectors, priority initiative to establish a One Health approach for threat detection and response, incorporating climate-linked threats, Improve Public Health Emergencies prevention, detection, preparedness and response including pandemics to strengthen health security. The overall goal of this pillar is to strengthen and improve public health emergency surveillance system for timely detection and reporting of seasonal and priority diseases and conditions including cross-border collaboration to reduce mortality and morbidity in the state.

The financial cost of 42 operational activities is at ₦1,574,959,000, state government to contribute ₦1,572,114,500.

4.2.5 Enabler 1: Data and Digitization

The strategic objective of Enabler one is: Digitize the health system and have data backed decision making. This covers the Health Management Information System (HMIS), District Health Management System (DHIS), Civil Registration and Vital Statistics (CVRS), and other intervention areas of data generation and storage. The total cost of 26 planned and costed operational activities in this category amount to ₦808,965,500, with government contributing ₦473,071,150 and partner funding ₦193,071,750

4.2.6 Enabler 2: Health Finance

The strategic objective of this Enabler is to increase the effectiveness and efficiency of healthcare spending. Part of the priority initiative includes Improving oversight and monitoring of the budgeting process to increase budget utilization, Regular and effective skills and performance appraisal of top leadership, provide resource mobilization for the health sector, amongst others. The total cost of six (11) planned operational activities is put at ₦64,776,000

4.2.7 Enabler 3: Culture and Talent

The strategic objective of this Enabler is to strengthen skills, capabilities & values and drive a performance-based culture within SMoH. One of the key priority initiatives is transformation within SMoH – towards a values and performance-driven culture. The total cost of 7 planned operational activities is put at ₦146,650,000, with the state government contributing ₦95,150,000, with no contribution from the partners and a funding gap of ₦51,500,000.

5.0 Detailed 2026 Work Plan

A total of 447 operational activities has been planned and costed for implementation in the state. These activities are developed from all Pillars and Enablers and cut across all levels of authority in the state.

Table 8 ***Shows activities planned and costed based on the HSSB priority area.***

S/N	HSSB Pillar/Enabler	HSSB Priority	Total activities	Amount
1	Pillar 1	Effective Governance	17	137,327,500
2	Pillar 2	Efficient, Equitable and Quality Health System	288	18,451,860,846
3	Pillar 3	Unlocking Value Chain	57	17,829,627,600
4	Pillar 4	Health Security	42	1,574,959,000
5	Enabler 1	Data Digitization	26	808,965,500
6	Enabler 2	Financing	6	64,776,000
7	Enabler 3	Culture and Talent	7	146,650,000
Total			**447**	**39,014,166,446**

5.1 Challenges and lessons learned from the AOP Development Process

The challenges and lessons learnt from the AOP development process were as follows:

1) Some implementing partners were not fully represented during the planning workshop
2) Unavailability of funding figures/amount from partners supporting programmes during the AOP development workshop.
3) Conflicting activities which affected the timely development of the AOP

5.2 AOP developed by MDAs

Ministry of Health AOP

Code	Plan Activities	Person Responsible	Q1	Q2	Q3	Q4	Total Annual Cost
Grand Total							**9,407,875,714**
1.1.1	**Strengthen NCH as a coordinating and accountability mechanism across the health system**						**78,297,500**
1.1.1.1	**Tailor NCH/SCH Meeting and memos guidelines to ensure meetings focus on the**						**58,200,000**
1.1.1.1.1	Conduct 1 day courtesy visit to the Governor for Buy in to the State Council on Health Meeting by the Hon. Commissioner and head of MDAs under SMOH	Hon. commissioner	▲				10,000
1.1.1.1.2	Conduct 1 day non residential stakeholders planning meeting of 50 people on SCH	DPRS SMOH	▲				1,675,000
1.1.1.1.3	Conduct 3 days SCH meeting with 250 people	DPRS SMOH		▲			38,625,000
1.1.1.1.4	Support participation of 11 State delegates at the 2026 NCH meeting	DPRS SMOH				▲	17,160,000
1.1.1.1.5	Conduct 1 day meeting of 20 people from MDA on dissemination of NCH/SCH communique/ resolutions	DPRS SMOH				▲	730,000
1.1.1.2	**Scale up the capacity of NCH Secretariat members both at federal and State level to ensure their effectiveness in supporting the Technical Committee.**						**20,097,500**
1.1.1.2.1	Conduct 1 day review meeting of 30 participants on NCH/SCH resolutions implementation tracking across MDAs	DPRS SMOH				▲	795,000
1.1.1.2.2	Conduct 3 days training of 25 SCH secretariat members and on memo vetting, Harmonization, communique development.	DPRS SMOH		▲			7,292,500
1.1.1.2.3	Procure and deploy ICT infrastructure to SCH secretariat	DPRS SMOH		▲			100,000
1.1.1.2.4	Conduct 2 days residential training of 60 program officers across MDAs on memo writing and report writing	DPRS SMOH		▲			11,910,000
1.4.4	**A Sector Wide Action Plan (SWAp) to defragment health system programming and funding**						**35,935,000**
1.4.4.2	**Develop AOP and ensure alignment of partners' plans to national/state health sector AOP**						**15,660,000**
1.4.4.2.1	Conduct 1 day AOP Priority Mapping meeting of 40 people (Directors, Program Officers and partners)	Desk Officer SMOH			▲		1,405,000
1.4.4.2.2	Conduct 3 days residential workshop of 60 people for the Development of 2027 State AOP	Desk Officer SMOH			▲		13,925,000
1.4.4.2.3	Conduct 1 day validation and dissemination meeting with 20 relevant stakeholders	Desk Officer SMOH			▲		330,000
1.4.4.3	**Support to HMB, SPHCDA/B, and LGA Health Authorities on the development and consolidation of health facilities AOP (One Plan) focussing on SWAp priorities.**						**20,275,000**
1.4.4.3.1	Conduct 2 days annual LGA-level planning workshops with 147 participants as part of the state AOP development calendar	DPRS SPHCDA			▲		6,930,000
1.4.4.3.2	Conduct 2 days annual health facility level planning workshops with 473 participants as part of the state AOP development calendar	DPRS SPHCDA			▲		13,345,000

Code	Plan Activities	Person Responsible	Q1	Q2	Q3	Q4	Total Annual Cost
1.4.5	**Increase collaboration with internal and external stakeholders for better delivery and performance management**						**23,095,000**
1.4.5.2	**Strengthen capacity of relevant Federal, State and LGA stakeholders to coordinate, monitor and manage delivery and performance in the health sector.**						**23,095,000**
1.4.5.2.1	Conduct 2 days Residential Quarterly performance Dialogue meeting to review Health Sector Scorecard with 70 participants	SWAP FP	▲	▲	▲	▲	4,890,000
1.4.5.2.2	Conduct 3 days training and orientation workshops for 81 State and LGA stakeholders on SWAp, NHSRII, performance management, and results-based monitoring	DPRS SMoH		▲			13,243,000
1.4.5.2.3	Conduct 2 days Residential State Joint Annual Review, State Health Summits, LGA review meetings with 81 participants	SWAP FP			▲		4,962,000
2.5.6	**Drive multi-sectoral coordination to put in place and facilitate the implementation of appropriate policies and Programs that drive health promotion behaviours (e.g., to disincentivize unhealthy behaviours)**						**591,624,000**
2.5.6.1	**Strengthen Governance and Stewardship for Health promotion Multi-sectoral Coordination**						**21,708,000**
2.5.6.1.1	Conduct 1-day multi-sectoral stakeholders' engagement with 55 participants to establish coordination structures (TWG) of health promotion related intervention in the state	HE SMoH	▲				1,392,500
2.5.6.1.2	Conduct 1-day multi-sectoral stakeholders' engagement with 55 participants to develop and validate Terms of Reference (TOR) outlining membership, roles, accountability mechanisms, and reporting template for the newly established multi-sectoral health promotion coordination structure for all participating sectors	HE SMoH	▲				2,022,500
2.5.6.1.3	Conduct 1-day multi-sectoral stakeholders' engagement with 55 participants to formally inaugurate the State Multi-Sectoral Health Promotion Coordination Platform.	HE SMoH	▲				2,242,500
2.5.6.1.4	Conduct I day quarterly coordination and review meetings clear action points and follow-up mechanisms) with 33 participants to assess the level of implementation of all health promotion interventions	HE SMoH	▲	▲	▲	▲	1,270,500
2.5.6.1.5	Conduct 1 day sensitization meeting with 40 participants from key non-health MDAs (Education, Water Resources, Environment, Women Affairs, etc) to mainstream health promotion intervention	HE SMoH		▲			14,780,000
2.5.6.3	**Build Capacity of FMoH/SMOH/LGA program managers to provide leadership and co-ordination for Multi-sectoral Partnership including CSOs for effective collaboration.**						**446,839,500**
2.5.6.3.1	Conduct a 10-day CEmONC training for 75 participants (doctors, nurses, and midwives) across all secondary health facilities in Adamawa State	SMoH, UNFPA, UNICEF, WHO and other Partners	▲	▲			77,101,500

Code	Plan Activities	Person Responsible	Q1	Q2	Q3	Q4	Total Annual Cost
2.5.6.3.2	Conduct a 14-day Life Saving Skills (LSS) training in 2 batches for 80 midwives across all secondary health facilities	SMoH, UNFPA, UNICEF, WHO and other Partners		▲	▲		70,808,000
2.5.6.3.3	Procure and distribute RMNCAH commodities and consumables to all 21 LGA-designated secondary health facilities in Adamawa State to ensure uninterrupted service delivery and improved maternal, newborn, child, and adolescent health outcomes by 2026	SMoH, UNFPA, UNICEF, WHO and other Partners		▲			40,000,000
2.5.6.3.4	Conduct a 3-day training of 100 midwives, and nurses on cervical cancer prevention and screening procedures across all secondary health facilities.	SMoH, UNFPA, UNICEF, WHO and other Partners	▲	▲	▲		66,930,000
2.5.6.3.5	Conduct surgical fistula repair operations for 300 women at the State Specialist Hospital, Adamawa, to restore dignity, improve reproductive health outcomes, and reduce the burden of obstetric fistula in the state.	SMoH, UNFPA, UNICEF, WHO and other Partners		▲		▲	-
2.5.6.3.6	Engage 200 midwives to provide on-the-job training and mentorship monthly to newly employed health workers in the maternity wards (labour rooms) of all secondary health facilities in Adamawa State, to strengthen maternal care and improve service delivery.	SMoH, UNFPA, UNICEF, WHO and other Partners	▲	▲	▲	▲	192,000,000
2.5.6.7	**Foster and integrate effective Multisectoral Health Promotion strategy**						**33,200,000**
2.5.6.7.1	Commemorate Safe Motherhood Day targeting 5000 people at IDP Camps in collaboration with relevant stakeholders.	SMoH, UNFPA, UNICEF, WHO and other Partners		▲			33,200,000
2.5.6.10	**Increase Demand Generation to improve health service uptake including RMNCAH, Nutrition, NCD, Mental Health, NTD Vaccination, Family Planning and other health services**						**89,876,500**
2.5.6.10.1	Conduct Free Hydrocelectomy across the state	NTD Coordinator	▲	▲	▲	▲	15,000,000
2.5.6.10.2	Conduct Biannual Mass Drug Administration of Azithromycin to all children from 1-59 Months	NTD Coordinator		▲		▲	20,000,000
2.5.6.10.3	Conduct 2-days quarterly town hall meetings with 75 participants (Traditional and religious leaders) to promote positive health-seeking behaviors for RMNCAH, and other MNHCH services.	SMoH	▲	▲	▲	▲	35,117,500
2.5.6.10.4	Carryout statewide bi monthly multi- media campaigns (radio, TV and social media) to create awareness on the benefits of ANC, immunization, family planning, and mental health services.	SMoH	▲	▲	▲	▲	10,420,000
2.5.6.10.5	Conduct 1-days Training of 904 youth and women peer educators across 4 from each of the 226 political ward to disseminate messages on RMNCAH, FP, and NTD vaccination through schools, markets, and youth clubs.	SMoH		▲			13,741,000
2.5.6.10.6	Conduct 5-day residential stakeholders' engagement with 50 participants to develop and validate culturally appropriate IEC materials to promote early ANC, exclusive breastfeeding, and immunization.	SMoH				▲	15,505,000

Code	Plan Activities	Person Responsible	Q1	Q2	Q3	Q4	Total Annual Cost
2.5.6.10.7	Conduct 2-days residential training 50 participants (Principals of public and private schools) to Implement school-based health promotion activities focusing on nutrition, menstrual hygiene, and mental health awareness for adolescents.	SMoH		▲			7,055,000
2.5.6.10.8	Conduct 1 day training with 557 participants (community volunteers and town announcers.) on targeted social mobilization activities focusing RI and MNCH week interventions	SMoH	▲				8,038,000
2.5.6.10.9	Conduct Mass Drug Administration of Ivermectin (IVM) and Albendazole (ALB)to 3,542,995 School Aged Children (SAC) and Adult for treatment of Lymphatic filariasis (LF) and Onchocerciasis	NTD Coordinator	▲	▲	▲	▲	60,000,000
2.6.9	Slow down the growth rate of NCD Prevalence						22,650,000
2.6.9.1	An NCD prevention task force with a focus on high priority illnesses (Strengthen governance, coordination, collaboration and leadership)						6,000,000
2.6.9.1.1	Conduct 5 days training of 3 doctors, 10 Nurses and 10 CHEWS on management of mental health	NCDs DO	▲				4,500,000
2.6.9.1.2	Conduct Quarterly Joint enforcement operation with multi sectoral Stakeholders to check compliance with the new graphic Health warning requirement on Tobacco products packaging in Adamawa state	NCDs DO	▲	▲	▲	▲	1,500,000
2.6.9.8	Strengthen health systems to address Prevention and Control of Non-Communicable Diseases at all levels of care and contribute to reducing risk factors.						16,650,000
2.6.9.8.1	Train 21 CHEW on counselling and management of mental health for 3 days	NCDs DO		▲			3,200,000
2.6.9.8.2	Train 226 Trainees for step down on integration of NCDs in health service provision across the Health Sectors	NCDs DO	▲				13,450,000
2.6.10	**Reduce the incidence of HIV, tuberculosis, malaria, and Neglected Tropical Diseases (NTDs)**						**5,089,304,000**
2.6.10.1	**Strengthen Communicable disease prevention task forces focused on HIV, TB, Malaria and NTDs at the national and sub-national level**						**36,780,000**
2.6.10.1.1	Conduct 1 -day DPH meeting to map existing coordination platforms (HIV, TB, Malaria, NTDs) at the state levels involving 10 participants.	DPH	▲				15,000
2.6.10.1.2	Conduct 2 days non residential meeting to develop Terms of Reference (ToR) for the integrated coordination platform under the leadership of the Director of Public Health (DPH)	DPH	▲				22,500
2.6.10.1.3	Carry out 1-day meeting disseminate a coordination framework detailing roles, responsibilities, and communication channels	DPH	▲				45,000
2.6.10.1.4	Conduct 2-day non residential meeting to develop a harmonized multi-disease operational plan that integrates HIV, TB, Malaria, and NTD priorities using the State SSP, AOP and other program plans.	DPH	▲				2,075,000
2.6.10.1.5	Conduct 3 day joint advocacy on resource mobilization to support the implementation of integrated health responses.	DPH	▲				540,000

Code	Plan Activities	Person Responsible	Q1	Q2	Q3	Q4	Total Annual Cost
2.6.10.1.6	Conduct 1-day quarterly joint coordination meetings involving HIV, TB, Malaria, and NTD programs and related MDAs.	DPH	▲	▲	▲	▲	3,560,000
2.6.10.1.7	Organize quarterly joint supervision and integrated field visits to 450 HFs involving 25 officers to facilities and communities.	DPH	▲	▲	▲	▲	23,920,000
2.6.10.1.8	Conduct 1 day meeting to develop integrated dashboard for tracking program performance across HIV, TB, Malaria, and NTDs.	DPH	▲				22,500
2.6.10.1.9	Conduct 2 days residential Annual Performance Review Meeting Involving 30 persons for Integrated HIV/Malaria/TB Program	DPH				▲	6,580,000
2.6.10.3	**Increase uptake and access to HIV services (testing, treatment, care, viral suppression, including procurement of HIV rapid test kits)**	DPH, NCD					**159,418,000**
2.6.10.3.1	Conduct 1-day weekly SRM on situational analysis for identification data gaps and inequalities in HIV testing, treatment, and care services across LGAs and population groups	SMOH	▲	▲	▲	▲	13,000,000
2.6.10.3.2	Identify and deploy CBOs to scale up differentiated HIV testing strategies such as HIV self-testing, index testing, community-led testing, and mobile/outreach testing to close the gaps in HIV testing in the Adamawa State.	SMOH/SASCP/SACA	▲				300,000
2.6.10.3.3	Conduct 2 days residential training to 21 identified CBOs on dHTS	SMOH/SASCP	▲				4,284,000
2.6.10.3.4	Conduct 1 day training to 50 participants from the both CBOs and HFs on referral systems between testing points and treatment facilities to ensure same-day linkage to ART.	SASCP M&E	▲	▲	▲	▲	1,588,000
2.6.10.3.5	Conduct 1-day quarterly joint data review meetings involving government, implementing partners, and CSOs to interpret findings	SASCP M&E	▲	▲	▲	▲	20,256,000
2.6.10.3.6	Ensure steady supply and distribution of HIV test kits across facilities and community testing points through procurement of 100,000 units of RKTs.	SMOH	▲	▲	▲	▲	50,000,000
2.6.10.3.7	Conduct 2 days capacity building of 112 HCWs on the new national guideline with emphasis on same-day ART initiation for all eligible clients.	SASCP	▲				25,280,000
2.6.10.3.8	Conduct continuous mentorship for facility staff on linkage. documentation and reporting through retwntion of National state clinical mentor.	SMOH/SASCP	▲	▲	▲	▲	-
2.6.10.3.9	Retain and pay monthly stipends to 600 volunteers (SEOs, Das, DECS, Case managers, lab staffs) to ensure tracking and continuous case management	AHNi	▲	▲	▲	▲	-
2.6.10.3.10	Conduct 1 - day residential training to 30 LGA LMCU coordinators and State LMCU team on HIV logistics and the NHLMIS to ensure uninterrupted supply of ARVs and essential medicines through improved logistics and supply chain management.	LMCU		▲			-
2.6.10.3.11	Reimburse Incidentals through the reimbursement For Incidentals (RFI) mechanism Reimbursement for Incidentals (RFI) For 60 spoke sites to ensure case finding, home refills, tracking of clients, retention, and viral load sample collection in communities	IPS	▲	▲	▲	▲	-

Code	Plan Activities	Person Responsible	Q1	Q2	Q3	Q4	Total Annual Cost
2.6.10.3.12	Provide logistics support to expand DSD models across the state (community ART groups, fast-track refills, home delivery) to improve convenience and retention.	IPS-AHNi	▲	▲	▲	▲	-
2.6.10.3.13	Facilitate distribution of HIVST kits by OTZ Champions for sexually active adolescents and young people during OTZ club services to improve HIV testing across the 26 ART facilities	IPS-AHNi	▲	▲	▲	▲	-
2.6.10.3.14	Conduct 2-days residential training to 86 laboratory staff on timely sample collection, transportation, and result return through optimized viral load networks.	SASCP LAB FP			▲		20,400,000
2.6.10.3.15	Conduct monthly facility level viral load coverage and suppression data reviews to identify gaps and improve outcomes involving 12 participants/facility	ART COORDINATORS	▲	▲	▲	▲	1,890,000
2.6.10.3.16	Conduct 5 - days quarterly integrated MSV involving 10 GoN, 3 IP and the 2 Networks	SASCP	▲	▲	▲	▲	22,420,000
2.6.10.4	**Reach, treat and sustain Vertical HIV transmission and Paediatrics interventions**						**77764500**
2.6.10.4.1	Conduct 1-day non residential training to 10 HCW/Comprehensive facility and 3 HCW from private HFs in ANC, L&D, PNC, TB DOT, CMAM, In-patient, immunization, FP units across the State on HTS to increase case finding among PBFW and children.	SASCP, SPHCDA	▲				3,783,000
2.6.10.4.2	Engage CBOs and community volunteers to Increase testing among PWBF through community-based testing approaches (home-based, outreach, and community-led)	SASCP			▲		-
2.6.10.4.3	Procure and distribute 150,000 HIV dual test kits, 50,000 DBS cards, to all PMTCT and immunization service points.	SASCP/SPHCDA /SACA	▲				7,500,000
2.6.10.4.4	Provide logistics support to healthcare workers across 26 comprehensive facilities to strengthen Early Infant Diagnosis (EID) services by ensuring timely collection and transportation of dried blood spot (DBS) samples at birth, 6 weeks, and subsequent follow-up intervals in all PMTCT sites by Q4 2025	Ips	▲	▲	▲	▲	-
2.6.10.4.5	Conduct 1-day non residential capacity building of 500 HCWs and community structures on identifying and referring HIV-exposed infants (HEIs) for testing and care.	IPs			▲		9,035,500
2.6.10.4.6	Conduct 3-day residential training to 260 ART coordinators, and other key HCWs on national guidelines for ensuring same-day ART initiation for all HIV-positive pregnant, breastfeeding women and HEIs.	SASCP				▲	15,626,500
2.6.10.4.7	Conduct 3-days orientations to laboratory staff including med. Lab Scientist, lab optimizers and other lab support on sample management systems, packaging to reduce turnaround time for EID and viral load results.	SASCP				▲	4,883,000
2.6.10.4.8	Conduct 1 day training to 38 mentor mothers, 26 midwives in the labour rooms and 26 other staff on the use of defaulter tracking mechanisms (diaries, shoe rack) to reduce defaulting and missed opportunities.	SASCP			▲		1,876,000

Code	Plan Activities	Person Responsible	Q1	Q2	Q3	Q4	Total Annual Cost
2.6.10.4.9	Conduct 1 day facility level meeting involving ART coordinators, DECs, M&E officers on viral load monitoring at 32-36 weeks and prompt enhanced adherence counselling for unsuppressed clients.	SASCP	▲	▲	▲	▲	1,890,000
2.6.10.4.10	Conduct quarterly PMTCT/EID/Paediatric HIV review meetings involving 30 participants to assess program performance and address bottlenecks	SASCP	▲	▲	▲	▲	600,000
2.6.10.4.11	Strengthen supply chain management systems across 26 ART facilities to ensure uninterrupted availability of ARVs, cotrimoxazole, EID reagents, and related HIV commodities in all service delivery points by establishing timely quantification, reporting, and distribution mechanisms across all supported facilities by Q4 2025.	IPs	▲	▲	▲	▲	-
2.6.10.4.12	Print 450 copies of SOPs and guidelines and distribute to all SDPs	IPs/SASCP		▲			337,500
2.6.10.4.13	Conduct 1 day refresher training to 1808 HCW (Lab technicians, Midwife in Labour ward and PMTCT FPs) on comprehensive PMTCT services	SASCP		▲			11,913,000
2.6.10.4.14	Provision of escort services to health facilities for linkage of PPW to comprehensive sites	SASCP	▲	▲	▲	▲	10,000,000
2.6.10.4.15	Conduct 3-days training of 3 Health Care Workers from 10 Comprehensive PMTCT Facilities on Continuous Quality Improvement (CQI) Initiatives	SASCP	▲ ▲				10,320,000
2.6.10.5	**Improve access and utilisation of integrated vector control interventions (ITNs, Targeted IRS, targeted LSM, vector surveillance and insecticide resistance monitoring)**	DPH, NCD					**111,538,000**
2.6.10.5.1	Conduct 2026 integrated SMC and ITN Replacement Campaign	PM SMEP	▲	▲	▲	▲	6,080,000
2.6.10.5.2	Deployment of Larval Source Management (LSM) as a complementary strategy to IRS and ITN to reduce malaria vector density to the state and LGA officers in targeted areas	PM SMEP		▲	▲		4,255,000
2.6.10.5.3	Carry out Bimonthly Routine distribution of Long-lasting Insecticide treated mosquito nets to 759 HFs in 21 LGAs for ANC and Fully Immunised Children	PM SMEP	▲	▲	▲	▲	89,760,000
2.6.10.5.4	Conduct 150 Focus Group Discussions in 16 communities in 8 LGAs on malaria prevention and management on a quarterly basis	PM, SMOH		▲	▲		6,968,000
2.6.10.5.5	Produce radio & TV jingle in 3 different languages for environmental management and malaria prevention and control activities	PM SMEP, SMOH	▲	▲	▲	▲	1,450,000
2.6.10.5.6	Organize a one-day World Malaria Day celebration to raise awareness of malaria prevention, treatments, and services. Commemoration of World Malaria Day to increase awareness on Malaria Prevention, Treatments and Services	PM SMEP, SMOH		▲			3,025,000
2.6.10.6	**Improve generation of evidence for decision-making and impact through reporting of quality malaria data and information from at least 80% of health facilities.**						**220,108,500**
2.6.10.6.1	Conduct 5 days monthly data validation meetings in 21 LGA by 128 LGA officers	PME SMEP	▲	▲	▲	▲	56,540,000

Code	Plan Activities	Person Responsible	Q1	Q2	Q3	Q4	Total Annual Cost
2.6.10.6.2	Conduct quarterly DQA in 759 Health facilities at all levels (Tertiary Sec, and Primary) by 42 LGA and State Officers	PM SMEP	▲	▲	▲	▲	27,680,000
2.6.10.6.3	Conduct One day Quarterly data review meeting with 42 LGA RBM, M&Es and 10 state officers in the state	PM SMEP	▲	▲	▲	▲	11,872,000
2.6.10.6.4	Produce quarterly Malaria Bulletin	PM SMEP, SMOH	▲	▲	▲	▲	10,000,000
2.6.10.6.5	Conduct 5 days quarterly HMIS-LMIS Data triangulation for 19 state officers in the 21 LGAs across the state	PM SMEP, SMOH	▲	▲	▲	▲	52,820,000
2.6.10.6.6	Conduct 2 days Residential training for 42 MROs of secondary & tertiary facility on use of DHIS2	PM SMEP, SMOH	▲				7,240,000
2.6.10.6.7	Conduct 3 days Step down capacity building for 759 HF Staff on Data triangulation and NHLMIS	PM SMEP, SMOH	▲	▲			41,698,500
2.6.10.6.8	Conduct 3-days Residential training for 63 entomologists across the 21 LGAs on vector sentinel surveillance	PM SMEP, SMOH	▲	▲	▲		12,258,000
2.6.10.7	**Increase access to effective malaria prevention, diagnosis, treatment with Artemisinin-based combination therapy (ACTs) and malaria vaccine**						**2,681,221,500**
2.6.10.7.1	Deployment of Malaria Vaccines in the State and 759 HFs across the 21 LGA in the State	PM SMEP, SMOH	▲	▲	▲	▲	8,425,000
2.6.10.7.2	Conduct 5 days State and LGA integrated Microplanning on SMC/ITN for 107 State and LGA officers in 759 HFs in the state	PM SMEP, SMOH	▲				35,718,000
2.6.10.7.3	Supportive Supervision by 21 Senior Supervisors during the campaign to all the 21 LGA	PM SMEP, SMOH		▲			75,072,000
2.6.10.7.4	Inauguration of Integrated Campaign Coordinating Network (ICCN) and Monitoring of the Campaign Before and During the implementation by 42 State Officers for 4 days per cycle	PM SMEP, SMOH	▲	▲	▲	▲	85,440,000
2.6.10.7.5	Conduct monthly Last Mile distribution of SMC commodities and materials by 34 LMCU members to all the 759 HFs in the State	PM SMEP, SMOH	▲	▲	▲	▲	68,064,000
2.6.10.7.6	Conduct 3-days state level ToT of 42 laboratory Focal Persons and heads of Labs on malaria Diagnosis	PM SMEP, SMOH	▲	▲	▲	▲	11,090,000
2.6.10.7.7	Conduct 5-days step down training for 226 Health workers on Malaria Diagnosis at 21 LGA level	PM SMEP, SMOH		▲	▲	▲	33,048,000
2.6.10.7.8	Conduct 3-day Scale up training of 12 persons on quality assurance and quality control systems for malaria diagnosis	PM SMEP, SMOH		▲	▲	▲	3,084,000
2.6.10.7.9	Procure and distribute 3,367,113 doses of ACTS, 112,237 Inj. Artesunate, 1,122,371 doses of SPs, 2,244,742 RDTS kits and 28,059 pack of hand gloves to 759 HFs in 21 LGAs	PM SMEP, SMOH	▲	▲	▲	▲	2,361,280,500
2.6.10.8	**Increase access and uptake of Tuberculosis Preventive Therapy (TPT)**						**60,130,000**
2.6.10.8.1	Conduct 2-day quarterly outreach programs using 10 members to 5 hard-to-reach settlements using portable digital x-ray	PM TBLCP	▲	▲	▲	▲	1,550,000
2.6.10.8.2	Conduct 5-day quarterly monitoring and evaluation supervision to monitor the completeness of the TPT cascade	PM TBLCP	▲	▲	▲	▲	33,320,000

Code	Plan Activities	Person Responsible	Q1	Q2	Q3	Q4	Total Annual Cost
2.6.10.8.3	Organize a 2-day non-residential training for 105 community health workers (CHWs) from 3 geopolitical zones, enhancing their capacity to deliver TPT services using the new 3HP regimen (Rifapentine 300mg) and integrating TPT into existing health services for TB, Leprosy, and Buruli Ulcer diagnosis and management across 21 LGAs.	HRH TBLCP	▲		▲		9,800,000
2.6.10.8.4	Conduct 1- day supportive supervision to ensure availability of TPT shorter regimens.	PM TBLCP	▲	▲	▲	▲	820,000
2.6.10.8.5	Host a 2-days residential quarterly data review meeting for data collation and screening comprising 30 LGTBLS and State team.	PM TBLCP	▲	▲	▲	▲	14,640,000
2.6.10.9	**Improve access to Tuberculosis care - case finding and treatment**						**127,823,000**
2.6.10.9.1	Conduct 5 days community outreach screening services in 21 communities targeting 5,000 population using mobile digital x-ray machine involving 10 state team	PM TBLCP		▲			2,100,000
2.6.10.9.2	Conduct a quarterly supportive supervision plan, with 10-day visits to each of the 21 LGAs (2 visits per LGA), led by a 10-member state team.	PM TBLCP	▲	▲	▲	▲	20,048,000
2.6.10.9.3	Procure 100,000 sputum cups, 1000 booklet of sputum request forms, 1000 booklet Sputum shipment forms, 1000 hand gloves, 500 leprosy protective sandal shoes	UPM TBLCP		▲		▲	80,000,000
2.6.10.9.4	Provide laboratory capacity strengthening on TB diagnosis, including GeneXpert testing, to 5 personal each across 21 local government areas.	PM TBLCP	▲		▲		25,675,000
2.6.10.10	**Sustain and Improve Treatment Success Rate**						**300,987,500**
2.6.10.10.1	Conduct 5 days training to 25 resident doctors from tertiary and secondary hospital across the 21 LGAs including private hospital to scale up DRTB OPD service points in the spirit of a patient-centered approach	PM TBLCP		▲			13,902,500
2.6.10.10.2	Organize a 3-day training program for 105 laboratory personnel, focusing on AFB microscopy, molecular diagnosis, and quality control techniques	PM TBLCP		▲			287,085,000
2.6.10.11	**Improve access to WHO Recommended Molecular diagnostics (WRD)**						**1,257,330,000**
2.6.10.11.1	To procure machines, cartridges & consumable; instalment; provision of power back up; favourable environment; training in 9 tertiary and secondary hospitals in the state.	PM TBLCP		▲			1,257,330,000
2.6.10.12	**Improve early diagnosis and treatment of Leprosy and Buruli Ulcer**						**56,203,000**
2.6.10.12.1	Conduct 4-days MINI-LEC skin clinics for Leprosy and Buruli Ulcer case finding in 2 high burden communities targeting 5000 population across the state with 10 team members.	PM TBLCP		▲		▲	46,000,000
2.6.10.12.2	Conduct 5days training to 21 Local Government TB and leprosy Supervisors and 21 assistants (LGTBLS) on identification and management of Leprosy and Buruli.	PM TBLCP			▲		10,203,000
2.8.12	**Improve Reproductive, Maternal, Newborn, Child health, Adolescent and Nutrition**						**317,909,400**

Code	Plan Activities	Person Responsible	Q1	Q2	Q3	Q4	Total Annual Cost
2.8.12.3	**Institutionalize maternal, perinatal and child death surveillance and response (MPCDSR) at all facilities/communities for quality improvement and monitor response.**						**74,830,000**
2.8.12.3.1	Conduct 1-day Monthly Health Facility review meeting on MPCDSR in 22 secondary HFs/226 PHCs	MPCDSR Committee			▲		2,232,000
2.8.12.3.2	Conduct 4 days non-residential refresher training for 499 HWs (2 per HF) on MPCDSR/QoC across 22 Secondary HFs and 226 PHCs	MPCDSR Committee	▲	▲	▲	▲	25,898,500
2.8.12.3.3	Conduct 1 day quarterly review meeting with 22 PMOs and 21 LGA ESs on MPCDSR-QoC	MPCDSR Committee	▲	▲	▲	▲	2,608,000
2.8.12.3.4	Conduct quarterly Supportive supervision to 93 wards of 9 MAMII LGAs on CMPCDSR	MPCDSR Committee	▲	▲	▲	▲	7,920,000
2.8.12.3.5	Conduct 1-day quarterly state steering committee review meeting with 36 members on MPCDSR/QoC	MPCDSR Committee	▲	▲	▲	▲	936,000
2.8.12.3.6	Conduct 2 days refresher training with 22 MROs and 21 LGA M&Es on MPCDSR-QoC e-reporting	MPCDSR Committee		▲			5,439,500
2.8.12.3.7	Conduct 5 days Quarterly need assessment to 226 Health Facilities by 42 state Facilitators	MPCDSR Committee	▲				15,120,000
2.8.12.3.8	Scale up of CMPCDSR by Conducting a 3day non residential zonal training to 5 community MPCDSR committee members in 21 LGA of the state	MPCDSR Committee		▲			11,964,000
2.8.12.3.9	Conduct Quarterly community MPCDSR Social autopsy/Community dialogues	CMPCDSR Team	▲	▲	▲	▲	2,712,000
2.8.12.3.10	Conduct advocacy visit to state house of assembly on the legalization of MPCDSR reporting through passage of bill on compulsory reporting for sustainability	MPCDSR Committee	▲				-
2.8.12.3.11	Conduct 2 day residential refresher training for 42 MROs and four state SHMIS officer	SMOH, UNFPA, UNICEF, WHO	▲				-
2.8.12.11	**Build referral systems through TBA incentives and transport vouchers to increase SBA-assisted deliveries at the community level**						**147,399,400**
2.8.12.11.1	Conduct a 5-day capacity-building workshop for 35 members of the State Emergency Medical Treatment Committee (SEMTC) to enhance understanding of roles and responsibilities, develop state-specific SEMSAS policy and operational framework, draft standard operating procedures (SOPs), and strengthen stakeholder coordination mechanisms.	SMOH/NEMSAS	▲				6,007,500
2.8.12.11.2	Conduct a 3 days training for 1,050 participants across the 21 LGAs in clusters comprising Health Workers, Drivers, CEMTTOs, and LGA SEMSAS team members, on emergency response to maternal, neonatal, and obstetric emergencies — focusing on rapid assessment, stabilization, referral coordination, and lifesaving interventions to strengthen state capacity for reducing maternal and newborn mortality.	DPRS/SEMSAS	▲	▲	▲	▲	42,245,000
2.8.12.11.3	Hold a 2 day quarterly technical review meeting with 21 PMOs and LGA ESs to analyse SEMSAS data of transported patients from all selected Health Facilities from the 9 MAMII LGAs	DPRS/SEMSAS	▲	▲	▲	▲	16,800,000

Code	Plan Activities	Person Responsible	Q1	Q2	Q3	Q4	Total Annual Cost
2.8.12.11.4	Conduct a 3 day training for 70 participants comprising of (Health Focal Persons, PMOs, Executive Secretaries, Ward CEMTTOs, and LGA SEMSAS) team members across the 9 MAMMI LGAs on Facility and Referral Network Strengthening, between referring and receiving centers of SEMSAS transported patients to improve outcomes in emergency Maternal and Neonatal cases.	DPRS/SEMSAS		▲			8,465,000
2.8.12.11.5	Conduct media campaigns to create public awareness on SEMSAS and its utilization through radio jingles, television features, social media engagement, and community outreach programs aimed at promoting timely access to emergency medical services and increased public understanding of how to activate and benefit from SEMSAS.	DPRS/SEMSAS/ Health Educator		▲			18,930,000
2.8.12.11.6	Conduct a 3-day capacity-building training for 15 SEMSAS Program Implementation Unit (PIU) staff on program coordination, data management, monitoring and evaluation, and emergency preparedness to strengthen their capacity for effective implementation, reporting, and oversight of SEMSAS activities across the state.	DPRS/SEMSAS		▲			3,167,500
2.8.12.11.7	Conduct 2-day non residential quarterly review meetings with 21 PHC Executive Secretaries, PMOs, and Chairman of Ward Development Committees (WDCs) from the 9 MAMII LGAs to assess the progress and utilization of the SEMSAS transport system in reducing maternal and neonatal deaths, review challenges, and develop strategies for improved service delivery	DPES/ SEMSAS	▲	▲	▲	▲	26,730,000
2.8.12.11.8	Establishment of Toll free centres for communication, coordination, and rapid response within the SEMSAS network for timely emergency medical services and referrals.	DPES/ SEMSAS		▲			-
2.8.12.11.9	Conduct 2-day quarterly review meeting with the CEMTC Committee and PUI on SEMSAS activities to identify challenges and develop mitigation plans	DPES/ SEMSAS	▲	▲	▲	▲	13,260,000
2.8.12.11.10	Printing of Vouchers for transport claims of transported patience to selected facilities	DPES/ SEMSAS	▲	▲	▲	▲	1,471,000
2.8.12.11.11	Monthly CEMTC Committee meeting	DPRS/SEMSAS	▲	▲	▲	▲	2,275,000
2.8.12.11.12	Setting up of PIU Office	DPRS/PROCUMENT				▲	1,380,000
2.8.12.11.13	Conduct 1 day engagement workshop with the 21 LGA Chairmen and Vice Chairpersons on their roles in supporting, sustaining, and strengthening SEMSAS operations at the local government level.	DPRS/SEMSAS		▲	▲		4,102,000
2.8.12.11.14	Conduct a 4 day study tour to Yobe State for 4 PIU staff on SEMSAS setup and program implementation.	SEMSAS PIU	▲				2,566,400
2.8.12.26	**Accelerate implementation of Essential Newborn Care (ENC) at the Primary health facilities**						**8,080,000**
2.8.12.26.1	Establish fully functional Neonatal Resuscitation Corners in all designated secondary health facilities in Adamawa State, equipped with essential newborn resuscitation equipment and supplies, to improve survival outcomes for asphyxiated newborns.	SMOH, UNFPA< UNICEF, WHO and other Partners	▲	▲			8,080,000

Code	Plan Activities	Person Responsible	Q1	Q2	Q3	Q4	Total Annual Cost
2.8.12.53	**Expand the scope of Logistics Management Information System (LMIS) data quality for accurate forecasting of national MNCAH commodities requirements including FP**						**87,600,000**
2.8.12.53.1	Conduct 4 days training on Maternal and newborn commodities reporting tools and NHLMIS of 2700 Health Workers in Primary, Secondary and Tertiary facilities	RH Coordinator	▲				87,600,000
2.8.13	**Revitalize BHCPF to drive SWAP, to increase access to quality health care for all citizens and to increase enrolment in health insurance**						**679,360,214**
2.8.13.23	**Strengthen the oversight role of the MOC and SOC as central governance bodies.**						**18,430,000**
2.8.13.23.1	Conduct 1 day quarterly BHCPF State Oversight Committee meetings with 35 stakeholders to evaluate financial performance, monitor fund utilization, and strengthen accountability.	DPRS SMOH, EC-ADPHCDA, ES-ADSCHMA	▲	▲	▲	▲	4,990,000
2.8.13.23.2	Conduct 6 days quarterly supportive supervision to 9 selected BHCPF health facilities per quarter with 8 state Team to cross check fund used, assess service delivery performance, and provide on-the-spot guidance.	DPRS SMOH, EC-ADPHCDA, ES-ADSCHMA	▲	▲	▲	▲	13,440,000
2.8.13.30	**Conduct a rapid facility functionality assessment of CEmONC facilities for service readiness, climate resilence, and energy efficency**						**660,930,214**
2.8.13.30.1	Revitalize 5 CEmONC Healthcare facilities	DPRS SMoH	▲				660,930,214
2.9.15	**Increase availability and quality of HRH**						**614,553,000**
2.9.15.1	**Increase production of health workers**						**566,322,000**
2.9.15.1.1	Conduct a 14-days training program for 80 medical laboratory personnel, focusing on Malaria microscopy, molecular diagnosis, and quality control techniques in batches of 20.	SMoH	▲	▲	▲	▲	141,105,000
2.9.15.1.2	Conduct 5 Days Assessment performance for 100 staff by performing competency assessment to all technical staff in the facility.	SMoH	▲		▲		43,236,000
2.9.15.1.3	Conduct 5 days training on Quality Management System & Accreditation process for 50 medical laboratory scientists	SMoH		▲		▲	26,542,000
2.9.15.1.4	Conduct 5 days training of 226 Laboratory Technicians of SPHCDA on Bio risk and Biosecurity in pathogens handling, waste management, ethical codes of Conduct and sample handling of infectious disease.	SPHCDA		▲		▲	132,174,000
2.9.15.1.5	Conduct a 3 day comprehensive inventory and condition assessment of all laboratory equipment in the 21 secondary health facilities.	SMOH		▲			956,000
2.9.15.1.6	Conduct 3-day plan preventive equipment maintenance/servicing/calibration of laboratory equipment to 42 staff in all secondary health facilities.	SMOH	▲				9,715,000
2.9.15.1.7	Procure laboratory equipment; Microscopes, Haematocrit centrifuge, tube centrifuge, spectrophotometer, Haematology automated analyzer, consumables and reagents	SMOH			▲		212,594,000

Code	Plan Activities	Person Responsible	Q1	Q2	Q3	Q4	Total Annual Cost
2.9.15.4	**Undertake data-driven recruitment, deployment, and management of HRH including biometric capture & BVN data collection for atleast 80% of basic education teachers and primary health workers to ensure proper payroll integration and removal of ghost workers**						**23,850,000**
2.9.15.4.1	Procure ICT equipment for 29 HRH offices in Adamawa State	HRH Focal Officer		▲			23,850,000
2.9.15.6	**Implement comprehensive workforce capacity development plan**						**24381000**
2.9.15.6.1	Conduct 5 days residential training for 32 IHRIS focal persons across the 21 LGAs and 8 MDAs	HRH Focal Officer	▲				11,838,000
2.9.15.6.2	Conduct 1 day residential biannual meeting for 30 HRH Steering Committee members	HRH Focal Officer	▲				3,395,000
2.9.15.6.3	Conduct 1 day quarterly meeting for 26 members of HRH Technical Working Group	DPRS Ministry of Health	▲	▲	▲	▲	2,378,000
2.9.15.6.4	Conduct 4 days Residential HRH quarterly meeting with 32 participants to update iHRIS data and workforce registry across Health Facilities in Adamawa State	HRH Focal Officer		▲			6,770,000
3.13.19	**Streamline existing supply chains to remove complexity**						**78,433,600**
3.13.19.2	**Strengthen the functionality and operations of the State Medicines, Vaccines and Health Management Agencies to harmonize and coordinate all health supply chain activities (including emergency response supply chain system)**						**55,187,600**
3.13.19.2.1	Conduct last mile delivery spot check visits to 28 Health facilities during Last Mile Distribution of Malaria Commodities and execution by Third Party Logistics - for five days on a Bi-monthly basis, by 4 State Logistics Management Coordinating Unit Members & 16 Local Government Logistics Management Coordinating Unit members	MSH, LMCU	▲	▲	▲	▲	17,400,000
3.13.19.2.2	Conduct Quality improvement initiatives on Malaria-Bi-monthly Facility Stock Report (BFSR) for three (3) days - on a Bi-monthly basis by five (5) Logistics Management Coordinating Unit members.	MSH, LMCU	▲	▲	▲	▲	1,530,000
3.13.19.2.3	Conduct a One day, Targeted Capacity Building Review meeting with 30 Malaria focal persons from Health Facilities for Data Quality & Performance Improvement of logistics data - on a Quarterly basis	MSH	▲	▲	▲	▲	2,480,000
3.13.19.2.4	Conduct a three-days Proof of Delivery Review meeting and Reconciliation with approved Last Mile Distribution Plans - on a Bi-monthly basis by four (4) Logistics Management Coordinating Unit members	MEBS,GHSC-PSM & LMCU	▲	▲	▲	▲	1,920,000
3.13.19.2.5	Conduct State-Level Data Review Meeting & Last Mile Distribution Order Generation -for one day on a Bi-monthly basis, with 25 participants	LMCU, MSH, GHSC-PSM, AHNI, SFH-OSS	▲	▲	▲	▲	7,500,000
3.13.19.2.6	Conduct a one day review visit of Logistics Management Information System Data Quality Validation Spot Check to ten (10) health facilities- On a Bi-monthly basis, by Four (4) Logistics Management Coordinating Unit Members	LMCU	▲	▲	▲	▲	3,960,000

Code	Plan Activities	Person Responsible	Q1	Q2	Q3	Q4	Total Annual Cost
3.13.19.2.7	Conduct integrated monthly last-mile distribution of SMC commodities four times during the campaign and azithromycin commodities twice, with the participation of 34 LMCU members, to all 759 healthcare facilities (HFs) in the state.	LMCU	▲	▲	▲	▲	4,264,000
3.13.19.2.8	Conduct the last mile distribution of Long lasting Insecticide treated mosquito nets 6 times on a bi-monthly basis to 759 HFs in 21 LGAs	LMCU, MEBS	▲	▲	▲	▲	3,534,000
3.13.19.2.9	Conduct a one day Quarterly Procurement & Supply Management - Technical Working Group meeting involving 30 participants	SMOH, NTBLCP	▲	▲	▲	▲	1,800,000
3.13.19.2.10	Conduct Last Mile Distribution for Family planning Commodities every Quarter to 463 Health Facilities across the State	FP Coordinator/LMCU,UNFPA/PPFN	▲	▲	▲	▲	1,930,000
3.13.19.2.11	Support Two (2) LMCU Members to participate in bi-annual regional procurement & supply management - technical working group meeting outside the State.	GHSC-PSM,LMCU		▲		▲	529,600
3.13.19.2.12	Support Monthly subscription of Data Bundle for data entry & delivery note reconciliation for 10 LMCU members	LMCU, AHNi	▲	▲	▲	▲	2,100,000
3.13.19.2.13	Conduct a 2 day Last Mile Distribution of PMTCT HIV/Syphilis Dual test kits and Hepatitis Test Kit, on a Quarterly basis by 10 LMCU members	LMCU	▲	▲	▲	▲	1,440,000
3.13.19.2.14	Conduct five days Last Mile Distribution monitoring and coordination to 27 Health Facilities by two LMCU members for the ART/comprehensive sites	GHSC-PSM	▲	▲	▲	▲	4,800,000
3.13.19.3	**Strengthen the Nigeria Health Logistics Management Information System (NHLMIS) to integrate all health programmes data management including vaccines, Essential Medicines and other supply chain functionalities**						**23,246,000**
3.13.19.3.1	Support twenty-one (21) LMCU members, Conduct annual Inventory and stocktaking of all expired commodities in 759 health facilities across the state for Five (5) days, including the state medical store, SMOH, ADSHSMA, and ADSPHCDA. transportation of the commodities to the state medical store.	DFD&PS			▲		4,320,000
3.13.19.3.2	Conduct integrated data entry into Nigeria Health Logistics Management Information System for HIV, Family Planning, and MCH by 37 LMCU members on a bi-monthly basis.	MSH	▲	▲	▲	▲	12,210,000
3.13.19.3.3	Conduct the destruction of expired health product during the Commemoration of World Pharmacy Day for two days involving 50 participants from the NAFDAC, NDLEA, Civil Defence, NPF, ADSPHCDA, ADSHSMA and 35 members of the Pharmacy Council of Nigeria in the State.	DFD&PS			▲		6,716,000
4.14.20	**Improve Public Health Emergencies prevention, detection, preparedness and response including pandemics to strengthen health security**						**1,012,221,500**

Code	Plan Activities	Person Responsible	Q1	Q2	Q3	Q4	Total Annual Cost
4.14.20.1	**Establish Presidential Task Force/ Cabinet Committee for effective coordination, oversight and funding involving all relevant sectors to address public health threats under health security aligned with the new health sector agenda of the current administration at all levels as aligned with Renewed Hope Agenda of Mr President**						**804,000**
4.14.20.1.1	Inaugurate Public Health Emergency Management Committee at State level to be Chaired by the Deputy Governor or Secretary to the State Government	SMOH	▲				510,000
4.14.20.1.2	Inaugurate Public Health Emergency Management Committee at LGA level to be Chaired by the LG Council Chairman	SMOH/ADSPHCDA	▲				294,000
4.14.20.2	**Improve public awareness and behaviour on prevention, detection and control of public health threats through coordinated health promotion including campaigns, use of media, risk communication, in line with health promotion policy and framework including AMR messages**						**7,044,000**
4.14.20.2.1	Conduct 2 days sensitization and awareness creation with 20 health media correspondents on public emergencies, reporting and engagement	SHE	▲	▲	▲	▲	880,000
4.14.20.2.2	Production and airing of jingles in 3 languages in 2 TVs and 2 radio stations	SHE	▲	▲	▲	▲	844,000
4.14.20.2.3	Conduct 2 days motorized campaign across high-risk communities during disease outbreak	SHE	▲	▲	▲	▲	5,320,000
4.14.20.3	**Workforce Capacity Building - Enhances capabilities to achieve health security**						**114,701,000**
4.14.20.3.1	Conduct 3 days annual health security assessment with 25 multi-sectoral public health professionals and 5 national officers to assess a multi-hazard public health threat across the 21 LGAs in the State	SMOH/ADSPHCDA	▲				8,590,000
4.14.20.3.2	Conduct a 2-day debriefing meeting with 25 health professionals and 5 national officers to review the outcome of the health security assessment on multi-hazard public health threat	SMOH/ADSPHCDA/WHO	▲				1,437,500
4.14.20.3.3	Organise a 5-day meeting with 20persons of multi-sectoral Public Health Technical Working Group (PHTWG) with 5 partners (WHO, UNICEF, etc) to develop a multi-hazard preparedness and response plan (PRP) for public health emergency response in the State.	SMOH/ADSPHCDA/Partners	▲				2,070,000
4.14.20.3.4	Conduct 2 days state level orientation of 281 healthcare workers (12 state Surveillance officers 62 DSNOs, and 207 SFPs, HCWs) on occupational health and safety during epidemics across the state in 3 batches with 12 facilitators	SMOH/ADSPHCDA/WHO	▲	▲	▲	▲	55,906,000
4.14.20.3.5	Conduct a 2-day quarterly orientation of 55 case management staff on infection prevention and control (IPC) during disease outbreaks with 3 facilitators	SMOH/ADSPHCDA/Partners	▲	▲	▲	▲	12,730,000
4.14.20.3.6	Conduct 5 days state level training of surveillance officers (12 state surveillance officers, 62 LGA DSNOs and 207 surveillance focal persons) on 7-1-7 approach of disease surveillance and reporting across the 21 LGAs in 3 batches with 12 facilitators	SMOH/ADSPHCDA/Partners	▲	▲	▲	▲	24,202,500

Code	Plan Activities	Person Responsible	Q1	Q2	Q3	Q4	Total Annual Cost
4.14.20.3.7	Conduct a 2-day orientation of State/LGA Rapid Response Teams (15 state and 210 LGA) on one-health multi-hazard approach to response to public health outbreak investigations in 3 batches with 12 facilitators	SMOH/ADSPHCDA/Partners	▲				9,765,000
4.14.20.4	**Strengthen coordination with currently existing FMOH Supply Chain management system on medical countermeasures, pre-positioning of medical commodities, laboratory supplies for preparedness and response to epidemics and pandemics**						**179,360,000**
4.14.20.4.1	Procure an additional medicines and consumables from 25% to 75% quarterly for epidemic response	SMOH/ADPHCDA/Partners	▲				25,000,000
4.14.20.4.2	Procure vaccines and vaccine bundles and commodities annually for reactive vaccinations during disease outbreak	ASDPHCDA/Partners	▲	▲	▲	▲	100,000,000
4.14.20.4.3	Procure laboratory reagents and consumables quarterly for outbreak response	SMOH/ADPHCDA/Partners	▲				50,000,000
4.14.20.4.4	Conduct bi-annual Last Mile delivery (LMD) to LGAs/targeted facilities and hotspot communities for disease outbreak interventions	SMOH/ADSPHCDA/Partners		▲		▲	4,360,000
4.14.20.5	**Strengthen and improve public health emergency surveillance system for timely detection and reporting of seasonal and priority diseases and conditions including cross-border collaboration to reduce mortality and morbidity.**						**254,002,000**
4.14.20.5.1	Conduct a 2-day state level refresher training of 226 Field Volunteers in 2 batches with 8 facilitators and 1 day cluster level orientation of 2260 Community Key Informants (6 cluster) for routine surveillance and outbreak response 18 facilitators across the 21 LGAs	SMOH/ADSPHCDA/WHO	▲				81,500,000
4.14.20.5.2	Conduct 2 days state level quarterly data quality harmonization meeting with 29 state and LGA surveillance officers (21 LGA DSNOs, 5 state officers and 3 WHO staff) to address data quality issues in the state	SMOH/ADSPHCDA/WHO	▲	▲	▲	▲	9,392,000
4.14.20.5.3	Conduct monthly and quarterly review meeting with 21 LGA DSNOs, 21 LGA M&Es, 21 LIOs and 12 state surveillance officers plus 5 partners to review and monitor epidemic prone diseases activities in the state	SMOH/ADSPHCDA/Partners	▲	▲	▲	▲	20,382,000
4.14.20.5.4	Conduct 5 days state level training of surveillance officers (226-Surveillance Focal Persons, 21-LGA DSNOs and 21-LGA M&Es plus 5-State M&Es) on data analysis for decision making in 3 batches and with 12 facilitators annually	MOH/ADSPHCDA/Partners	▲				53,312,000
4.14.20.5.5	Conduct Active Case Search in atleast 10 wards (5 persons/ward) and Supervision with 12 State supervisors and 15 LGA DSNOs in across 8 hotspot LGAs during disease outbreak	SMOH/Partners	▲	▲	▲	▲	87,648,000
4.14.20.5.6	Procure quarterly data bundles and airtime for 21 LGA DSNOs and 5 state surveillance officers for timely report of Epidemic prone diseases on SORMAS platform and IDSR data tools	SMOH/ADSPHCDA/Partners	▲	▲	▲	▲	1,768,000

Code	Plan Activities	Person Responsible	Q1	Q2	Q3	Q4	Total Annual Cost
4.14.20.6	**Strengthen unified Tiered (National, Zonal & State) Laboratory Structure/network to ensure expanded diagnostic capacity including AST for common priority pathogens to support under collaborative surveillance to address epidemics and pandemics using one health approach.**						**118,640,000**
4.14.20.6.1	Advocate to government for early completion of the state public health laboratory to enhance disease detection and outbreak response activities	SMOH/ADSPHCDA	▲				-
4.14.20.6.2	Procure additional sample collection containers, reagents, rapid testing kits and packaging materials (Ziploc bags, falcon tubes, swabs, VTM, etc) for disease detection, investigation and confirmation quarterly and distribute across 21 LGAs	SMOH/ADPHCDA/Partners	▲	▲	▲	▲	2,260,000
4.14.20.6.3	Conduct weekly Sample Collection and Transportation from communities/LGAs to state Laboratory with 21 LGA DSNOs	SMOH, ADSPHCDA and WHO	▲	▲	▲	▲	16,380,000
4.14.20.6.4	Procure Cholera kits bi-annually for Cholera outbreak Investigation, Confirmation, and response across affected communities	SMOH, ADSPHCDA/Partners	▲	▲	▲	▲	100,000,000
4.14.20.7	**Strengthen behavioural change and control of misuse, abuse and inappropriate utilization of antimicrobials in all sectors through strengthening the current AMR surveillance system (AMRIS), prevalence surveys and other components of AMR surveillance (AMC/AMU) to address it as a silent health security threat**						**9,686,500**
4.14.20.7.1	Conduct 1-day quarterly engagement meeting with 20 Patent medicine Vendors, 20 proprietors of private Health facilities and pharmaceutical outfit, 12 state officials and 10 partners on rational drug use	SMOH/ADSPHCDA/Partners	▲				7,816,000
4.14.20.7.2	Conduct a 3-days annual survey with 12 state officials and 3 partners on rational use of antimicrobial drugs in 4 metropolitan LGAs in the state	SMOH/ADSPHCDA/Partners	▲				1,554,000
4.14.20.7.3	Conduct 2 days annual debriefing meeting with 12 state officials and 3 partners on survey Conducted on the rational use of antimicrobial drugs in 4 metropolitan LGAs in the state	SMOH, ADSPHCDA/Partners	▲				316,500
4.14.20.8	**Strengthen evidence-based policy/decision making through strengthening integrated public health research registries/management system and coordinated consortium for reducing mortality, morbidity and disabilities related to health security threats**						**8,865,000**
4.14.20.8.1	Conduct 3 days capacity building of 35 state health officials and 5 partners for research methodology and research proposal writing in public health emergencies	SMOH/ADSPHCDA/Partners	▲				2,645,000
4.14.20.8.2	Conduct 3 days operational research with 35 health officials with 2 supervisors on epidemic prone diseases in collaboration with other relevant institutions	SMOH/ADSPHCDA/Partners		▲			5,070,000
4.14.20.8.3	Support publications of atleast 15 manuscripts from the research Conducted on public health diseases in at least 5 national and international journals	SMOH/ADSPHCDA/Partners		▲			1,150,000

Code	Plan Activities	Person Responsible	Q1	Q2	Q3	Q4	Total Annual Cost
4.14.20.9	**Improve coordinated and harmonised response interventions including resource coordination, rapid deployment, enhancing surge capacity, contact tracing, isolation & quarantine, infection prevention and control, emergency response, and the use of personal protective equipment etc. to manage public health threats**						**284,200,000**
4.14.20.9.1	Upgrade PHEOC to full functionality (standardized, automated, and digitized PHEOC operations)	SMOH/WHO	▲				25,000,000
4.14.20.9.2	Conduct 28 days quarterly operational support of 55 health personnel for isolation and case management in the treatment center during disease outbreaks	SMOH/ADSPHC DA/Partners	▲	▲	▲	▲	77,770,000
4.14.20.9.3	Conduct 30 days quarterly contact tracing with 5 contact tracers par ward in 8 hotspot LGAs during disease outbreak in the state	SMOH/ADSPHC DA/Partners	▲	▲	▲	▲	120,520,000
4.14.20.9.4	Conduct 3 days quarterly outbreak investigation with 20 state rapid response team (15 state and 5 partners) and 80 LGA Rapid response teams (10 team per LGA) in 8 hotspot LGAs during disease outbreaks	SMOH/ADSPHC DA/Partners	▲	▲	▲	▲	21,000,000
4.14.20.9.5	Conduct 3 days quarterly high level coordination meeting and supervision with 8 Public Health Emergency Management Committee (PHEMC) and 15 Surveillance officers during disease outbreak in the state	SMOH/ADSPHC DA/Partners	▲	▲	▲	▲	11,880,000
4.14.20.9.6	Conduct 1 day annual meeting with 25 private health facilities and 15 PHEOC members on management of outbreaks	SMOH/ADSPHC DA/Partners		▲			1,510,000
4.14.20.9.7	Conduct weekly PHEOC meetings with 45 PHEOC government staff and 12 partners during disease outbreak	SMOH/Partners	▲	▲	▲	▲	26,520,000
4.14.20.10	**Develop and pilot urban preparedness strategies in line with Global Framework for Strengthening Emergencies in Urban Settings in priority municipalities**						**34,919,000**
4.14.20.10.1	Establish state EPR coordination and command structure and Conduct monthly meetings with 20 members	Epidemiologist	▲	▲	▲	▲	7,560,000
4.14.20.10.2	Conduct 7 days urban emergency risk profiling and hazard mapping in priority areas	Epidemiologist	▲	▲			9,114,000
4.14.20.10.3	Build capacity of 42 state and LGA actors on EPR standards through training, drills, and simulation exercises	Epidemiologist	▲	▲			5,645,000
4.14.20.10.4	Establish EPR monitoring, evaluation, reporting, and quality assurance systems to ensure compliance with standards	Epidemiologist	▲	▲	▲	▲	12,600,000
4.15.21	**Establish a One Health approach for threat detection and response, incorporating climate-linked threats**						**562,737,500**
4.15.21.3	**Develop and implement health national adaptation plan (HNAP) to address climate risks to health, and building resilience in health programmes, services and infrastructure in line with COP26 health commitment**						**562,737,500**
4.15.21.3.1	Conduct 1 day meeting with 30 Stakeholders to domesticate the Health National Adaptation Plan	Climate Change DO	▲				812,500

Code	Plan Activities	Person Responsible	Q1	Q2	Q3	Q4	Total Annual Cost
4.15.21.3.2	Planting of 12,350 trees in 247 Health facilities across the State (focal/referral)	Climate Change DO		▲			67,925,000
4.15.21.3.3	Installation of solar system for power supply and water system in 247 Health facilities	DPRS SMOH/SPHCDA		▲			494,000,000
1.16.22	**Strengthen health data collection, reporting and usage starting with the core indicators**						**31,225,000**
1.16.22.1	**Strengthen the health information system (HIS) governance frameworks to provide guidance and coordination of HIS resources and outputs**						**3,900,000**
1.16.22.1.1	Conduct 2 days monthly M&E Technical Working Groups with 30 persons from all MDAs and partner	M&E/HMIS	▲	▲	▲	▲	3,900,000
1.16.22.4	**Strengthen Civil Registration and Vital Statistics (CRVS) system to generate vital statistics of births & deaths including reporting of deaths with the causes**						**23,825,000**
1.16.22.4.1	Conduct training of 500 Health Worker on the integrated e-CVRS-DHIS2 platform	HMIS/M&E		▲			23,825,000
1.16.22.8	**Data sharing and dissemination of health information**						**3,500,000**
1.16.22.8.1	Develop and produce quarterly 800 copies of Health Performance Report for HFs, LGAs and line MDAs	M&E	▲	▲	▲	▲	3,500,000
1.16.23	**Establish and integrate "single source of truth data system that is digitized, interoperable, and accurate**						**149,030,000**
1.16.23.1	**Establish/strengthen digital health governance structure and coordination at all levels**						**7,865,000**
1.16.23.1.1	Conduct inauguration and 2 days training of 40 members of the Technical Working Group (TWG) and Steering Committees (SC) on National Digital Health Policy and Architecture	SDHI FP	▲				3,760,000
1.16.23.1.2	Conduct 1 day quarterly TWG and SC meeting of 40 members to review implementation and compliance of SDHI	SDHI FP	▲	▲	▲	▲	2,880,000
1.16.23.1.3	Conduct 1 day meeting with 40 stakeholders to develop Adamawa State digital health implementation plan	SDHI FP				▲	1,225,000
1.16.23.2	**Regulate deployment and implementation of digital health interventions to ensure alignment to established national standards**						**21,000,000**
1.16.23.2.1	Establish LGA Digital in Health Focal Person and Conduct monthly supportive supervision to trained health Workers	SDHI FP	▲	▲	▲	▲	21,000,000
1.16.23.3	**Develop an enterprise architecture to facilitate interoperability of data systems and applications within the health sector and beyond to facilitate HIE**						**94,720,000**
1.16.23.3.1	Conduct 5 days mapping of existing digital health systems and data flows in the state.	SDHI FP	▲				660,000
1.16.23.3.2	Engage a qualified vendor to support the deployment and maintenance of digital health systems	SDHI FP	▲				78,000,000
1.16.23.3.3	Conduct training of 21 LDHI Focal Persons on Health facility and health Worker registry and NIN linkages	SDHI FP	▲				5,260,000
1.16.23.3.4	Populate monthly Health Facility and Health worker registry	SDHI FP	▲	▲	▲	▲	10,800,000
1.16.23.5	**Build the capacity of healthcare providers on digital health to improve efficiency and effectiveness**						**25,020,000**
1.16.23.5.1	Conduct 2-days Training of 540 Health Workers from Primary and Secondary Facilities on the use of digital health tools and NIN registration at the LGA Level	SDHI FP	▲				25,020,000

Code	Plan Activities	Person Responsible	Q1	Q2	Q3	Q4	Total Annual Cost
1.16.23.8	**Institute monitoring and evaluation of the implementation of the National Digital Health Strategy, the data and digitization priorities of the HSSB and other initiatives**						**425,000**
1.16.23.8.1	Conduct midyear review of the implementation of digital in health initiatives	SDHI FP			▲		425,000
3.18.26	**Transformation within F/SMoH towards a values and performance driven culture**						**92,650,000**
3.18.26.1	**Strengthen F/SMOH Collaboration with stakeholders and development partners to reach a consensus on long term pursuits of defined transformation/change management actions towards a value-driven and performance-oriented culture.**						**35,000,000**
3.18.26.1.1	Conduct 5 days training of 100 Staff on Leadership and Management in Health across all MDAs	DPRS SMOH/SPHCDA	▲	▲	▲		35,000,000
3.18.26.2	**Implement change management actions that align goals with F/SMOH strategic objectives.**						**30,000,000**
3.18.26.2.1	Introduction of Digital Biometric Attendance System for Staff Time Tracking and Payroll	DPRS SMOH	▲	▲	▲	▲	30,000,000
3.18.26.3	**Develop communication resources and networks infrastructure on the mission and values of the Ministry and ensure that they are embedded throughout the F/SMOH operations.**						**13,300,000**
3.18.26.3.1	Conduct 5 days training of 50 Staff on Organization and Policy Management	DPRS SMOH	▲	▲			13,300,000
3.18.26.4	**Develop a comprehensive performance management and feedback system that sets clear, measurable, and achievable goals for F/SMOH Staff and teams.**						**14,350,000**
3.18.26.4.1	Conduct 5 days training of 50 Staff on Project management and M&E	DPRS SMOH/SPHCDA	▲	▲			14,350,000
3.18.27	**Top-talent learning program to develop well-rounded for public health leaders**						**51,500,000**
3.18.27.3	**Promote collaborative learning environment where participants can engage with each other by sharing experiences, exchange ideas and build a strong network of public health leaders.**						**37,500,000**
3.18.27.3.1	Conduct 5 days Internation and State study tour of 50 staffs on learning best practices and innovative approaches in Health System	DPRS SMOH	▲	▲			37,500,000
3.18.27.4	**Promote culture of Continuously monitoring and evaluating program's effectiveness, seeking feedback from participants, mentors, and key stakeholder**						**14,000,000**
3.18.27.4.1	Conduct 5 days training of 50 staff on result-based Management and Financing	DPRS SMOH	▲	▲			14,000,000

State Primary Health Care Development Agency AOP

Code	Plan Activities	Person Responsible	Q1	Q2	Q3	Q4	Total Annual Cost
Grand Total							**25,399,030,732**
2.5.6	**Drive multi-sectoral coordination to put in place and facilitate the implementation of appropriate policies and Programs that drive health promotion behaviours (e.g., to disincentivize unhealthy behaviours)**						**1,044,127,600**
2.5.6.1	**Strengthen Governance and Stewardship for Health promotion Multi-sectoral Coordination**						**646,518,000**
2.5.6.1.1	Conduct 1 day quarterly meeting on ACSM review activities Technical Working Group (TWG) with 18 people at the State level.	UNICEF	▲	▲	▲	▲	1,360,000
2.5.6.1.2	Roll out Community Engagement (CE) Focal Persons at LGA (21), Ward levels (226) and Traditional Leaders (11100)).	UNICEF	▲				96,608,000
2.5.6.1.3	Conduct One Day Desk Review of partners involved in ACSM and CE activities.	Chigari Foundation	▲				290,000
2.5.6.1.4	Conduct One (1) day performance bi-annual PHC review meetings with traditional leaders (15 First Class Chiefs/Emirs) (21 District Heads), (50 State Participants), (42 LGA Participants).	SPHCDA		▲		▲	6,080,000
2.5.6.1.5	Conduct 1 day state Taskforce Review Meeting by 81 persons to review RMNCAH+N PHC performance including GBV	RMNCAH+N COORDINATOR	▲	▲	▲	▲	3,273,000
2.5.6.1.6	Conduct 3 days Technical Assistance support to 57 persons on capacity development of Health policy makers and implementers on critical thinking, leadership and management including the budget mobilization for RMNCAH+N	RMNCAH+N COORDINATOR	▲				9,757,500
2.5.6.1.7	Conduct 1 day quarterly LGA Task force Review meeting by 525 persons to review LGA performance on RMNCAH+N including GBV	RMNCAH+N COORDINATOR	▲	▲	▲	▲	35,700,000
2.5.6.1.8	Conduct 1 day technical support by 5 resource persons to 63 LGA person (3 per LGA) to develop their capacity in Conducting annual budget analysis, and progress review for RMNCAH+N including GBV	RMNCAH+N COORDINATOR	▲	▲	▲	▲	7,541,000
2.5.6.1.9	Support LGA Facility managers to Conduct 5 days supportive supervisory visit by 210 persons using the supervisory tool and to organize monthly GBV coordination meetings	RMNCAH+N COORDINATOR	▲	▲	▲	▲	69,300,000
2.5.6.1.10	Conduct Quarterly DQA on FP services data in 117 facilities in MSI Nigeria supported facilities across the 21 LGAs	State Team, Master	▲	▲	▲	▲	46,032,000
2.5.6.1.11	Conduct monthly FP data collection in 117 facilities in MSI Nigeria supported facilities across the 21 LGAs	ADSPHCDA/ SMOH/MSI	▲	▲	▲	▲	46,032,000
2.5.6.1.12	Conduct quarterly data spot check on FP data in 117 MSI Nigeria supported facilities.	ADSPHCDA/ SMOH/MSI	▲	▲	▲	▲	46,032,000
2.5.6.1.13	Conduct quarterly Clinical competency assessment for 117 FP Service Providers trained by MSI	ADSPHCDA/ SMOH/MSI	▲	▲	▲	▲	46,032,000
2.5.6.1.14	Conduct 20 annual client exit interview (CEI) sessions in the selected LGAs	ADSPHCDA/ SMOH/MSI			▲		21,840,000
2.5.6.1.15	Conduct 40 monthly in-reach monitoring sessions across the 21 LGAs	ADSPHCDA/ SMOH/MSI			▲		131,520,000
2.5.6.1.16	Commemorate 2026 World Contraception Day.	ADSPHCDA/SMOH			▲		3,504,000

Code	Plan Activities	Person Responsible	Q1	Q2	Q3	Q4	Total Annual Cost
2.5.6.1.17	Conduct 6days training of trainers for 20 master trainers on Family Planning.	SMOH, UNFPA UNICEF,		▲			6,956,000
2.5.6.1.18	Conduct quarterly Integrated Joint Supportive Supervision	ADSPHCDA/ SMOH/MSI	▲	▲	▲	▲	46,032,000
2.5.6.1.19	Commemorate International Adolescents Week	ADSPHCDA/SMOH /MSI/MW&SD				▲	13,850,000
2.5.6.1.20	Conduct 2026 Outreach Scheduling Meeting with 21 LGAs DMCHs and other state stakeholders	ADSPHCDA/ SMOH/MSI				▲	3,534,500
2.5.6.1.21	Procure 5 laptops to support program implementation, data management, and reporting across designated units.	MOH, UNFPA< UNICEF, WHO		▲			3,500,000
2.5.6.1.22	Participation in 3, 5-Day Project Implementation Support Mission in Abuja	ANRiN PC	▲	▲		▲	5,244,000
2.5.6.2	**Promote Advocacy for Mullti-sectoral coordination at all Levels of health and across the sectors that are proactive health promotion**						**16,266,000**
2.5.6.2.1	Conduct 1 day state level sensitization meetings with traditional (42) and religious leaders (44) on health promotion, RMNCAH+, and immunization.	State and Partners		▲			3,146,000
2.5.6.2.2	Conduct 1 day advocacy visits to each First of the Fifteen (15) Class Emirs/Chiefs to strengthen community ownership and leadership support for health programs.	Chigari Foundation	▲	▲	▲	▲	6,150,000
2.5.6.2.3	Support ECCOH members (22) and Ward Level Traditional Leaders (226) during campaigns and inter-round activities for advocacy and supervision.	Chigari Foundation	▲	▲	▲	▲	6,970,000
2.5.6.3	**Build Capacity of FMoH/SMOH/LGA program managers to provide leadership and co-ordination for Multi-sectoral Partnership including CSOs for effective collaboration.**						**22,396,000**
2.5.6.3.1	Conduct two (2) day training of health educators (21) and Community Engagement Focal Persons (21) on SBCC	SPHCDA	▲				6,468,000
2.5.6.3.2	Conduct 1 day orientation for 21 NTLC focal persons on ACSM and Community Engagement, Coordination and Reporting.	SPHCDA		▲			2,473,000
2.5.6.3.3	Conduct 1 day capacity building for LGA HEWAs, CEFPs and TWG members (60 Participants) on leadership and coordination.	SPHCDA		▲			3,270,000
2.5.6.3.4	Conduct 5 days training for 40 state and LGA programme Managers on managerial and problem-solving skills	SPHCDA	▲			▲	10,185,000
2.5.6.6	**Strengthen accountability mechanism and community engagement to accelerate community participation and improve service delivery**						**6,250,000**
2.5.6.6.1	Conduct 3 days monitoring and supportive supervision visits to 21 Community Engagement Focal Persons and ACSM activities.	SPHCDA	▲	▲	▲	▲	4,050,000
2.5.6.6.2	Develop and disseminate CE and ACSM monitoring tools and dashboards.	SPHCDA		▲			1,260,000
2.5.6.6.3	Review ACSM and CE activity performance bi-annually using agreed indicators.	SPHCDA		▲			940,000
2.5.6.7	**Foster and integrate effective Multisectoral Health Promotion strategy**						**4,670,000**

Code	Plan Activities	Person Responsible	Q1	Q2	Q3	Q4	Total Annual Cost
2.5.6.7.1	1 day engagement meeting with CSOs, NGOs, and development partners for collaboration on ACSM and CE implementation.	SPHCDA	▲				3,910,000
2.5.6.7.2	Conduct 1 day cross-sectoral partnership meetings monthly with line ministries (Education, Agriculture, Women Affairs, and Information) (25 Participant).	SPHCDA	▲	▲	▲	▲	760,000
2.5.6.8	**Intensify SBC intervention to address risk factors, increase health literacy and healthy lifestyle and improve health outcomes**						**8,900,600**
2.5.6.8.1	Conduct 1 day sensitization with Traditional and religious leaders for behavioral change on RMNCAH, Immunisation, nutrition, GBV, NTDs, and NCDs (78 participants).	SPHCDA	▲				3,540,600
2.5.6.8.2	Produce and disseminate 250 Copies of culturally appropriate IEC/SBCC materials.	SPHCDA		▲			1,460,000
2.5.6.8.3	Support the Flag-off of World Breastfeeding Week, Mass Immunisation Campaigns, MNCHW.	SPHCDA	▲	▲	▲	▲	3,900,000
2.5.6.9	**Strengthen SBC (RCCE)multisectoral coordination mechanism to facilitate the implementation of routine and Emergency interventions.**						**8,134,000**
2.5.6.9.1	Conduct 1 day community dialogues and feedback sessions through WDCs and CE focal persons, religious leaders and traditional leaders (100 Participants)	SPHCDA	▲	▲	▲	▲	6,700,000
2.5.6.9.2	Conduct 1 day award and recognition ceremonies for best performing traditional leaders and LGAs.	SPHCDA	▲			▲	1,434,000
2.5.6.10	**Increase Demand Generation to improve health service uptake including RMNCAH, Nutrition, NCD, Mental Health, NTD Vaccination, Family Planning and other health services**						**300,888,000**
2.5.6.10.1	Support community structures (Mama-to-Mama {774}, Fathers for Good Health {320}, youth groups {210}) with logistics (15,000) to drive local health promotion.	SPHCDA	▲	▲	▲	▲	78,240,000
2.5.6.10.2	Conduct 1 day orientation for Fathers for Good Health personnel in 12 LGAs.	SPHCDA		▲			12,130,000
2.5.6.10.3	Support 1 day campaign flag-off at 21 LGAs	SPHCDA	▲	▲	▲	▲	86,100,000
2.5.6.10.4	Conduct targeted community mobilization during campaigns through town announcers, religious platforms, & social media to increase service uptake	SPHCDA	▲	▲	▲	▲	8,925,000
2.5.6.10.5	Engage and Conduct one day sensitize of male champions, youth, and religious leaders as community influencers.	SPHCDA	▲	▲	▲	▲	15,293,000
2.5.6.10.6	Conduct 1 day sensitization to 2 Densely populated communities (2 per ward 452) on Mental Health Awareness by 63 resource persons	SPHCDA		▲			4,732,000
2.5.6.10.7	Conduct 1 day media parley with 6 media Houses (3 electronic & print) on Mental Health Awareness	SPHCDA	▲	▲	▲	▲	270,000
2.5.6.10.8	Carry out 5 days Jingles Airing with 2 TV station and 5 FM radio station on Mental Health Awareness to commemorate world mental health day	ADSPHCDA DCHS			▲		2,150,000
2.5.6.10.9	Conduct 1 day Rally by 2,260 (10 per ward) Youths on Awareness to commemorate world mental health day	ADSPHCDA DCHS			▲		33,900,000

Code	Plan Activities	Person Responsible	Q1	Q2	Q3	Q4	Total Annual Cost
2.5.6.10.10	Conduct 5 Days non residential Training to 452 Health workers (2 per Ward) on mental health and psychosocial support	ADSPHCDA DCHS			▲		59,148,000
2.5.6.11	**Accelerate the Integration of awareness programs/health campaigns to improve health outcomes including primary health interventions**						**10,605,000**
2.5.6.11.1	Conduct 1 day orientation of Mama-to-Mama personnel on RMNCAH+N, Immunisation and social mobilization in all 16 LGAs.	SPHCDA	▲	▲	▲		10,605,000
2.5.6.12	**Leverage formal education system to improve healthy behaviors**						**19,500,000**
2.5.6.12.1	Conduct 1 day sensitization meetings with LGA and Ward Youth Vanguard in all 21 LGAs	SPHCDA		▲			19,500,000
2.6.8	**Accelerate immunization programs for priority antigens (e.g., DPT3, Polio, Measles, Yellow Fever) with a focus on decreasing zero dose children**						**1,112,031,300**
2.6.8.1	**Implementation of Zero-Dose Reduction Operational Plan (Z-DROP) in prioritised LGAs.**						**81,240,000**
2.6.8.1.1	Conduct 30 days routine immunisation intensification in 226 wards	SPHCDA	▲	▲	▲	▲	81,240,000
2.6.8.5	**Expand access to immunization Services.**						**341,711,300**
2.6.8.5.1	Production of 1,122371 child health cards	SPHCDA	▲				336,711,300
2.6.8.5.2	Production of 1000 copies of vaccines data tools	SPHCDA	▲				5,000,000
2.6.8.9	**Enhance the deployment of effective immunization vaccine management system to reduce stock out of vaccines such as DPT3, Polio, Measles, Yellow Fever, etc**						**689,080,000**
2.6.8.9.1	Direct deliveries of vaccines and other health commodities for equity (PUSH SYSTEM)	DIDC, SIO	▲				269,568,000
2.6.8.9.2	Maintenance of 1 vaccines delivery van	DIDC, SIO	▲				4,000,000
2.6.8.9.3	Demarcation of dry store in the cold store	DIDC, SIO	▲				10,000,000
2.6.8.9.4	Construction of 4 incinerators housing and waste collection site	DIDC, SIO	▲				40,000,000
2.6.8.9.5	Procurement of 10 additional deep refrigerators for the LGA cold stores	DIDC, SIO	▲				10,000,000
2.6.8.9.6	Maintenance of 226 SDD across the LGA s and health facilities	DIDC, SIO	▲				45,200,000
2.6.8.9.7	Procurement of 42 fire extinguisher	DIDC, SIO	▲				2,300,000
2.6.8.9.8	Procurement of 1200 geostyles	DIDC, SIO	▲				66,000,000
2.6.8.9.9	Procurement of 652 tickler boxes to health facilities	DIDC, SIO	▲				9,780,000
2.6.8.9.10	Solarisation of state walking in cold rooms	DIDC, SIO	▲				26,600,000
2.6.8.9.11	Procurement of additional 4 incinerators	DIDC, SIO	▲				80,000,000
2.6.8.9.12	Solarisation of 11 LGAs cold store	DIDC, SIO	▲				120,120,000
2.6.8.9.13	Conduct one day Monthly CCOs meeting	DIDC, SIO	▲	▲	▲	▲	1,512,000
2.6.8.9.14	Repairs and maintenance of walking in cold/freezers rooms and UCC	DIDC, SIO	▲				4,000,000

Code	Plan Activities	Person Responsible	Q1	Q2	Q3	Q4	Total Annual Cost
2.6.9	**Slow down the growth rate of NCD Prevalence**						**50,623,000**
2.6.9.8	**Strengthen health systems to address Prevention and Control of Non-Communicable Diseases at all levels of care and contribute to reducing risk factors.**						**50,623,000**
2.6.9.8.1	3 days training of 226 health care workers on the management of simple hypertension according to the National guideline for the prevention and management of hypertension in Nigeria, 2023	NCD Focal Person, HHA Coordinator		▲			50,623,000
2.6.10	**Reduce the incidence of HIV, tuberculosis, malaria, and Neglected Tropical Diseases (NTDs)**						**138,482,500**
2.6.10.3	**Increase uptake and access to HIV services (testing, treatment, care, viral suppression, including procurement of HIV rapid test kits)**						**138,482,500**
2.6.10.3.1	Conduct 5 days training for 226 Health Workers in 226 Health Facilities for HIV testing alternative entry ANC, Labour, Delivery, Postnatal Immunization and family planning unit.	DIDC ADSPHCDA	▲				66,578,500
2.6.10.3.2	Conduct 3 days on the Job training by 42 facilitators in 145 CMAM sites	DIDC ADSPHCDA	▲				9,408,000
2.6.10.3.3	Conduct 5 days quarterly MSV supervision by 42 state resource persons	DIDC ADSPHCDA		▲			62,496,000
2.8.12	**Improve Reproductive, Maternal, Newborn, Child health, Adolescent and Nutrition**						**3,727,937,000**
2.8.12.1	**Establish/revitalize MNCAH+N task force and new accountability mechanism to crash MMR & under-5 mortality at the sub-national (State and LGA) level**						**375,047,000**
2.8.12.1.1	Conduct 3 days training on quality of care for 42 state QOC team and 21 LGA Team on the Harmonized QA tool	ADSPHCDA DCHS	▲		▲		13,354,000
2.8.12.1.2	Conduct 3 days training for 452 Health workers on Integration of GBV and Adolescent care into PHCs Services	DIDC ADSPHCDA	▲			▲	41,898,000
2.8.12.1.3	Scale up the establishment of 221 One Stop shop center in 221 PHCs	DIDC ADSPHCDA	▲	▲	▲	▲	300,580,000
2.8.12.1.4	Conduct 3 Days Training on cMPCDSR for 1,130 community persons (5 per ward) to foster community dialogue and feedback mechanisms to ensure accountability and action.	ADSPHCDA DCHS		▲			19,215,000
2.8.12.3	**Institutionalize maternal, perinatal and child death surveillance and response (MPCDSR) at all facilities/communities for quality improvement and monitor response.**						**42,300,000**
2.8.12.3.1	Build capacity of Ward Development Committees (WDCs) and community volunteers to lead cMPDSR activities. Foster community dialogue and feedback mechanisms to ensure accountability and action.	ADSPHCDA DCHS	▲				42,300,000
2.8.12.12	**Deploy Doctors midwives+CHEWS/JCHEWS to high need areas, using relocation incentives and flexible arrangements for RMNCAH**						**514,056,000**
2.8.12.12.1	Conduct 6 days Training on service provision for CBHWs 2,260 (10 per ward)	ADSPHCDA DCHS	▲	▲	▲	▲	196,300,000
2.8.12.12.2	Kitting of 2,260 CBHWS	ADSPHCDA DCHS	▲	▲	▲	▲	317,756,000
2.8.12.21	**Improve access to Basic and Comprehensive emergency obstetric and newborn care (EMOnC) services through skill birth attendant.**						**774,091,000**

Code	Plan Activities	Person Responsible	Q1	Q2	Q3	Q4	Total Annual Cost
2.8.12.21.1	Conduct 7 days study tour to Tanzania by 10 persons to observe and evaluate Safer Birth Bundle of care (SBBC)	ADSPHCDA DCHS	▲				26,800,000
2.8.12.21.2	Distribution of procured Safer Birth Bundle of Care (SBBC) equipment and reporting tools to 20 SHF and 113 PHCs (MamaNatalie, Mama Birthie, Moyo/Neobeat, Upright, and Penguin)	ADSPHCDA DCHS	▲				840,000
2.8.12.21.3	Conduct 5 Days Monthly supportive supervisory visits on SBBC by 4 national facilitators and 25 State Coordinators	ADSPHCDA DCHS	▲			▲	6,928,000
2.8.12.21.4	Conduct Capacity development of 113 service providers at PHC level facilities on newborn care and KMC for management of small and sick newborn	ADSPHCDA DCHS	▲			▲	3,799,000
2.8.12.21.5	Conduct 21 days Residential MLSS Training for 452 CHEWS	ADSPHCDA DCHS	▲			▲	524,680,000
2.8.12.21.6	Conduct 10 Day residential Capacity building of 226 CHEWs on BEmONC in 8 clusters by 48 facilitators/cluster	ADSPHCDA DCHS	▲			▲	131,160,000
2.8.12.21.7	Conduct 5 days capacity building of 226 health workers for provision of clinical management of rape	ADSPHCDA DCHS	▲		▲		65,484,000
2.8.12.21.8	provision of basic household equipment to SBAs in hard to reach health facilities	SMoH/SPHCDA	▲	▲			14,400,000
2.8.12.22	**Expand access to a full range of modern contraceptives including immediate postpartum, post-abortion FP, through mobile outreach service delivery in providing a wide range of contraceptives.**						**259,515,500**
2.8.12.22.1	Conduct 3 days training to Strengthen capacities of 459 Health workers to Champion and implement self-care depot medroxyprogesterone acetate Subcutaneous (including self-injection of DMPA-SC)	ADSPHCDA DCHS	▲	▲	▲		27,490,500
2.8.12.22.2	Conduct 3 days Training of 42 resource person on CLMS.	ADSPHCDA DCHS		▲			9,271,000
2.8.12.22.3	Scale up quarterly Whole Site Orientation (WSO) on Family planning of 490 non-technical staff in 21 LGAs	ADSPHCDA DCHS	▲	▲	▲	▲	800,000
2.8.12.22.4	Conduct 1 day meeting with 21 FP providers and 21 data managers in secondary and 4 tertiary facilities alongside 21 LGA M&E Officers to improve reporting at the secondary and tertiary facilities.	ADSPHCDA DCHS		▲			1,990,500
2.8.12.22.5	Conduct 7days training of 459 Midwives and CHEWs on Long acting reversable contraceptive (LARC)from 459 health facilities providing family planning services across state.	ADSPHCDA DCHS	▲	▲	▲	▲	215,563,500
2.8.12.22.6	Conduct 1 days sensitization meeting with 300 persons to Commemorate World Contraception Day 2026	ADSPHCDA DCHS				▲	4,400,000
2.8.12.26	**Accelerate implementation of Essential Newborn Care (ENC) at the Primary health facilities**						**30,193,500**
2.8.12.26.1	Conduct 6 Day residential Capacity building of 60 HCWS (Doctors, Nurses, Midwives) in Full ENCC in 2 clusters by 3facilitators/cluster	ADSPHCDA DCHS	▲			▲	30,193,500
2.8.12.27	**Adapt and review the National Essential Newborn Care Course (ENCC) to align to the global second edition of ENCC for quality improvement**						**56,025,000**

Code	Plan Activities	Person Responsible	Q1	Q2	Q3	Q4	Total Annual Cost
2.8.12.27.1	Conduct 3 days non residential training on modified Essential Newborn Care Course (mENCC) in 8 batches for 226 CHEWs in 21 of Adamawa state	ADSPHCDA DCHS	▲		▲		56,025,000
2.8.12.28	**Promote home visits on community- based newborn through empowering communities, Outreaches and Mobile Clinics**						**251,474,500**
2.8.12.28.1	Conduct 6 Day residential Capacity building and Kitting of 226 CHEWs/JCHEWs on CNBC including support for home visit as part of postpartum/ postnatal care at community level	ADSPHCDA DCHS	▲		▲		61,111,000
2.8.12.28.2	Procure 10,170 (45 per ward) Hijab and Apron for Mama-To-Mama for visibility free access to Homes to Conduct Home Visit	ADSPHCDA DCHS	▲		▲		50,850,000
2.8.12.28.3	Conduct reactivation of Community Health System including ICCM in line with new national SOP screening/identification at ward level 6 day ward level capacity building workshop for 1800 CHWs, 300 CEFPs, 21 HEWA, 21 COMOs and 21 State facilitators, using new national guideline/manual	ADSPHCDA DCHS	▲				139,513,500
2.8.12.36	**Improve capacity skills of doctors, nurses, CHEWs at PHC for Integrated Management of Childhood Illness (IMCI) and community Health workers on Integrated Community Case Management (ICCM)**						**368,613,000**
2.8.12.36.1	Conduct 1 day training of 21 LGA CEFPs and 21 Health Educators (2/LGA) and 25 state TWG on RMCAHN objectives, including roles of participants.	ADSPHCDA DCHS	▲				3,018,000
2.8.12.36.2	Purchase of ALMANACH tablets for 395 PHCs for the use of Digital IMCI electronic Clinical Decision Support System	BHCPF Focal Person		▲			79,000,000
2.8.12.36.3	Pay for 2 ALMANACH server (Comcare and DHIS2 servers) subscriptions	DPRS		▲			14,500,000
2.8.12.36.4	Conduct 6 Days Residential Training of 452 Health workers on IMCI	ADSPHCDA DCHS			▲		200,970,000
2.8.12.36.5	Conduct 3 days training of 2,260 CBHWS on Home Visits and key household practices	ADSPHCDA DCHS	▲	▲	▲	▲	71,125,000
2.8.12.37	**Develop and implement a multisectoral actions for integrated childhood development in rolling out the child Survival Action Plan at state level**						**11,617,500**
2.8.12.37.1	Conduct 4 days residential review and domestication of National Child Survival Action plan with 11 persons including 2 national facilitators	ADSPHCDA DCHS	▲				11,617,500
2.8.12.38	**Set up a Clinical mentorship (face to face and online) system for Newborn and case management for childhood illness.**						**63,944,000**
2.8.12.38.1	Conduct 5 days quarterly ALMANACH supportive supervision to 21 LGAs.	PM ALMANACH	▲	▲	▲	▲	63,944,000
2.8.12.39	**Scale-up capacity of Doctors, Nurses, mid- Wives, CHEWs to deliver adolescent plus youth-friendly services**						**19,543,000**
2.8.12.39.1	Conduct 5 days State level training of trainers for 42 HWs on AYP health services	DIDC ADSPHCDA	▲			▲	19,543,000
2.8.12.40	**Collaborate with Ministry of Education to Review the school health Policy, adopt and domesticate school health services standards at state level.**						**127,167,000**

Code	Plan Activities	Person Responsible	Q1	Q2	Q3	Q4	Total Annual Cost
2.8.12.40.1	Support States to roll-out and operationalize targeted strategies to engage youths and adolescent in (226 Schools) adolescent in schools and out-of-school settings	ADSPHCDA DCHS	▲				4,421,000
2.8.12.40.10	Conduct 1 day Training to 452 teachers and students on personal hygiene	ADSPHCDA DCHS	▲		▲		12,642,000
2.8.12.40.2	Conduct 1 day Meeting with 410 LGA stakeholders on SHS	ADSPHCDA DCHS	▲	▲	▲	▲	10,480,000
2.8.12.40.3	Conduct 3 days Capacity Building workshop for 42 Stakeholders on SHS	ADSPHCDA DCHS	▲	▲	▲	▲	2,445,000
2.8.12.40.4	Conduct 2 days Stepdown Training for 210 LGA Stakeholders on SHS	ADSPHCDA DCHS	▲	▲	▲	▲	14,385,000
2.8.12.40.5	Conduct 3 days Stepdown Training for 210 Health Teachers SHS	ADSPHCDA DCHS	▲		▲		17,640,000
2.8.12.40.6	Creation of hand washing stations in 452 primary and secondary schools in Adamawa State	ADSPHCDA DCHS	▲				42,940,000
2.8.12.40.7	Conduct 1 day school Deworming services to 452 (2 per Ward) primary schools in Adamawa State	ADSPHCDA DCHS	▲			▲	2,552,000
2.8.12.40.8	Conduct 1 day health talk, film show, debate and quiz in 226 primary and secondary schools in Adamawa State	ADSPHCDA DCHS	▲		▲		6,102,000
2.8.12.40.9	Conduct Monthly feedback meeting with 226 community leaders and 226 P.T.A headmaster in each school	ADSPHCDA DCHS	▲			▲	13,560,000
2.8.12.41	**Empower community to support adolescent program at the community level (peer to peer support, parents' guardian etc)**						**329,646,000**
2.8.12.41.1	Support monthly engagement of 2,712 adolescents in 226 adolescent clubs (AYP Clubs ward level meetings) with ward AYP FPs to strengthen healthy practices, demand for AYFHS and AYP inclusion in community engagements/demand generation for RMNCAH+N including GBV services	ADSPHCDA DCHS	▲	▲	▲	▲	256,680,000
2.8.12.41.2	Conduct 1 day quarterly LGA level review to strengthen AYP programming for youth (525 persons) - led organizations and Communities of Practice to provide community based AYP services	DIDC ADSPHCDA	▲	▲	▲	▲	24,150,000
2.8.12.41.3	Kitting of 2712 AYP Vanguard with Aprons, T-Shirt and Face Cap	ADSPHCDA DCHS	▲	▲	▲	▲	48,816,000
2.8.12.47	**Accelerate the scale up of integrated management of acute malnutrition (IMAM) at all levels of care**						**111,975,500**
2.8.12.47.1	Conduct 6 days BPNS training for 316 HCWs in BHCPF implementing facilities (IMAM OTP, SQ-LNS, HCWM training)	ANRiN PC	▲				105,023,000
2.8.12.47.2	Conduct 6 days BPNS training for 15 HCWs from Stabilization sites (IPC + HCWM training)	ANRiN PC	▲				6,952,500
2.8.12.50	**Scaling up community Nutrition best practices**						**68,369,000**
2.8.12.50.1	Conduct 2 days IMAM training (OTP) for 790 community volunteers in 10 ANRiN implementing LGAs	ANRiN PC	z				68,369,000
2.8.12.52	**Strengthen commodity security and reduce the high rates of stock-outs at service delivery points through improved logistics data quality and resource mobilization for RMNCAH (FP, and Nutrition)**						**63,457,000**

Code	Plan Activities	Person Responsible	Q1	Q2	Q3	Q4	Total Annual Cost
2.8.12.52.1	Conduct 4 days quarterly training on Essential Drugs Management (RMNCAH+N Commodities) for 21 LGA Directors,21 LGA Logistics, 226 Facility Manager and 226 Pharm Technicians	Director Drugs and Logistics ADSPHCDA	▲	▲	▲	▲	50,291,000
2.8.12.52.2	Conduct 2 days training on IMAM commodity logistics and handling for storekeepers in ANRiN health facilities	ANRiN PC	▲				13,166,000
2.8.12.54	**Procure and utilize RMNCAH commodities, including oxytocin, family planning supplies, and essential devices (e.g., CPAP, monitors, pulse oximetry, oxygen, KMC devices, phototherapy, radiant warmers, ventilators, caffeine citrate, bag and mask, suctioning, etc), in line with National guidelines and SOPs**						**108,060,000**
2.8.12.54.1	Procure Pulse Oximeter to 403 PHCS in Adamawa State for early detection of oxygen saturation for children aged from birth up to 5 years	ADSPHCDA DCHS	▲				8,060,000
2.8.12.54.2	Procure RMNCAH +N Commodities for 886 Health Facilities (MMS, Oxytocin, FP, ACTs, HIV Test kits etc)	MCH DO	▲				100,000,000
2.8.12.60	**Configure and utilize electronic integrated supportive supervision (ISS) tools for RMNCAH+Nutrition services**						**2,808,000**
2.8.12.60.1	Undertake 2 days quarterly Integrated Supportive Supervision to 10 ANRiN LGAs	ANRiN PC	▲	▲	▲	▲	2,808,000
2.8.12.64	**Integrate trained, equipped, and supported community health workers (CHWs) into the health system**						**150,034,500**
2.8.12.64.1	Conduct reactivation of Community Health System including ICCM in line with new national SOP screening/identification at ward level 6 day ward level capacity building workshop for 2,260 CHWs, 300 CEFPs, 21 HEWA, 21 COMOs and 21 State facilitators, using new national guideline/manual	ADSPHCDA DCHS	▲				145,124,000
2.8.12.64.2	Conduct 1 day training of 21 LGA CEFPs and 21 Health Educators (2/LGA) and 25 state TWG on RMCAHN objectives, including roles of participants.	ADSPHCDA DCHS	▲		▲		4,910,500
2.8.13	**Revitalize BHCPF to drive SWAP, to increase access to quality health care for all citizens and to increase enrolment in health insurance**						**914,822,832**
2.8.13.2	**Revise and domesticate the BHCPF 2.0 guidelines to operationalize the proposed BHCPF NPHCDA Gateway reforms (in collaboration with the states and donors) including a performance and accountability framework**						**64,248,000**
2.8.13.2.1	Conduct a 5 day state level capacity building on BHCPF 2.0 guideline for 60 officers	ADSPHCDA	▲				22,300,000
2.8.13.2.2	Conduct 4 days lower-level training for 904 (Health facility managers and assistants & WDC chairman and treasures) in 226 health facilities on BHCPF 2.0 guideline	SPHCDA	▲				41,948,000
2.8.13.5	**Galvanize all government and partner resources for phased needs-based upgrades of prioritized PHCs to achieve full functionality (infrastructure, equipment, workforce, commodities etc)**						**697,410,000**

Code	Plan Activities	Person Responsible	Q1	Q2	Q3	Q4	Total Annual Cost
2.8.13.5.1	Conduct revitalisation of 27 selected BEmONC centres in the state	SMoH, SPHCDA	▲	▲	▲	▲	697,410,000
2.8.13.6	**Develop and implement a holistic Advocacy, Communication and Community Engagement strategy**						**19,990,000**
2.8.13.6.1	Conduct 2 days sensitisation/orientation of community stakeholders (2per ward) on BHCPF 2.0 implementation	SPHCDA		▲			19,990,000
2.8.13.7	**Enforce quarterly disbursement of funds in line with BHCPF guidelines**						**11,608,832**
2.8.13.7.1	Conduct a one day quarterly virtual meeting with 1 ZTO, 2 Accountant, 7 BHCPF Core team, 21 LGA focal Persons and 226 health facility managers on disbursement tracking	BHCPF Desk Officer	▲	▲	▲	▲	11,608,832
2.8.13.12	**Leverage technology for end-to-end BHCPF financial management and expenditure tracking**						**56,111,500**
.8.13.12.1	Conduct a 2 day state level training to 10 persons on PHC financial management system (PHC-FMS)	SPHCDA	▲				3,085,000
2.8.13.12.2	Conduct a 3 day training to 226, OICs, 226 WDC Chairmen, 21 PFMOs and 21 Fellows on PHC-FMS	SPHCDA		▲			53,026,500
2.8.13.13	**Utilize Financial Management Officers (FMOs) for quarterly tracking of spending with clear ToR**						**12,736,000**
2.8.13.13.1	Conduct a one day quarterly meeting with 10 state team, 21 PFMOs on financial tracking for facilities	SPHCDA	▲	▲	▲	▲	12,736,000
2.8.13.14	**Ensure an annual statutory audit is done across all levels and external audit performed on total funds**						**10,100,000**
2.8.13.14.1	Conduct 5 days quarterly internal audit by 10 persons to selected PHCs in the state	SPHCDA	▲	▲	▲	▲	10,100,000
2.8.13.17	**Provide essential commodities, utilities, maintenance of facilities, and community engagement**						**42,618,500**
2.8.13.17.1	Conduct a 2 day Planned Preventive Maintenance (PPM) training to 42 state officers	SPHCDA			▲		8,617,000
2.8.13.17.2	Conduct a 2 day LGA/HF level training of Planned Preventive Maintenance by 42 State officers to 21 LGA and 226 HF officers	SPHCDA			▲		20,215,500
2.8.13.17.3	Purchase of 226 Digital BP Apparatuses for BHCPF health facilities	BHCPF Focal Person		▲			11,300,000
2.8.13.17.4	Printing of 226 hypertension treatment guidelines, and 226 IEC for BHCPF Health Facilities	BHCPF Focal Person		▲			2,486,000
2.9.15	**Increase availability and quality of HRH**						**1,440,030,000**
2.9.15.4	**Undertake data-driven recruitment, deployment, and management of HRH including biometric capture & BVN data collection for atleast 80% of basic education teachers and primary health workers to ensure proper payroll integration and removal of ghost workers**						**1,440,030,000**
2.9.15.4.1	Engage 2,260 CBHWs to optimized community health systems to ensure provision of RMNCAH+N at community level through a high-quality gender-responsive network of CHIPS (CBHWS), including GBV	ADSPHCDA DCHS	▲				271,200,000
2.9.15.4.2	scale up the engagement of 500 community Midwives & Nurses to provide services in densely populated HFs and Hard to reach communities in 21 LGAs	ADSPHCDA DCHS	▲	▲	▲	▲	420,000,000

Code	Plan Activities	Person Responsible	Q1	Q2	Q3	Q4	Total Annual Cost
2.9.15.4.3	Logistic support to 339 Community Midwives and Nurses to provide services in high volume Health facilities and hard to reach communities across 21 LGAs of Adamawa State	ADSPHCDA DCHS	▲	▲	▲	▲	325,440,000
2.9.15.4.4	Partnership with College of Nursing and Midwifery on Community Midwifery Program to sponsor training of 113 in Community Midwifery to increase number of One PHC Per Ward which meet State MSP SBA requirement	ADSPHCDA DCHS	▲				423,390,000
3.13.19	**Streamline existing supply chains to remove complexity**						**16,277,490,000**
3.13.19.4	**Ensure establishment of sustainable funding mechanisms for drugs, vaccine and other health commodities at all levels of health services in the country**						**16,247,380,000**
3.13.19.4.1	Procurement of family Planning Commodities and Consumables for 459 PHCs across the state.	Director ED&L /DCHS/DPRS	▲				2,038,975,000
3.13.19.4.2	Biannual procurement of Nutritional Commodities for MNCH week (Vitamin A Caps, Albendazole tablets, SP & MMS, HIV Test Kits, Fesolate tablets, Folic acid tablets) for 542 PHCs across the state	Director ED&L /Director Nutrition / DPRS		▲		▲	615,980,000
3.13.19.4.3	Procurement of MUAC Tape for nutritional status assessment in 154 CMAM centres across the state	Director ED&L / DN/DPRS	▲				15,400,000
3.13.19.4.4	Procurement of Nutritional Commodities for 145 CMAM centers for treatment of SAM and MAM sites e.g. RUTF, Albendazole, SQNLs, Tom Brown, MMS, Amoxicillin 250 and F75 &F100.	Director ED&L /DN / DPRS	▲				2,703,850,000
3.13.19.4.5	Procurement of Ante Natal Care (ANC) Commodities (fesolate, Folic acid, SP Tablets, Vitamin C, PT Test strips, Urinalysis test kits and Combi II) for PHCs targeting estimated 280,593 pregnant women across the state	Director ED&L /DCHS/DPRS	▲				140,032,000
3.13.19.4.6	Biannually procurement of HIV test kits for improve uptake and access to HIV services (Unigold, Statpack, Determine, Hepatitis B&C test Kits and Benzyl Pen Injection) for 280,593 targeted pregnant women and 145 CMAM facilities for testing of 202,027 SAM children across the state.	Director ED&L /DCHS/DPRS		▲		▲	624,000,000
3.13.19.4.7	Procurement of Health Commodities for redesign Community Based Health Workers (CBHW) for 227 traditional wards (Antimalarials, Antibiotics, Analgesics, ORS, Zinc Tablets, RDTs & Data Tools) for provision primary health care service across the state.	Director ED&L / DCHS	▲				393,233,000
3.13.19.4.8	Procurement of Delivery Kits (Mama Kits) for PHCs targeting 280,593 expected pregnant mothers in the state.	Director ED&L / DCHS	▲				7,014,825,000
3.13.19.4.9	Procurement of MMS for PHCs targeting 280,593 expected pregnant women in the state (420,890 packs)	Director ED&L /DN	▲				1,894,005,000
3.13.19.4.10	Procurement of safer birth bundle of care (SBBC equipment) for 20 Sexual and reproductive primary Health facilities and 226 PHCs	Director ED&L / DCHS	▲				233,100,000

Code	Plan Activities	Person Responsible	Q1	Q2	Q3	Q4	Total Annual Cost
3.13.19.4.11	Procurement of 30 laptops for state programme officers (state FP coordinator, M&EO, logisticians, CHIPS coordinator/IMCI, SBBC desk officer, RMCAH/GBV focal person	PM SARAH /Director ED&L	▲				15,000,000
3.13.19.4.12	Procurement of 842 androids' digital devices and 447 power banks to support data management for technology driven activity implementation in the state and LGAs for data collectors (403 for PHCS, 24 for secondary institutions and 20 for private institutions, {395 Samsung 7/8'' Display 3G/4G supported,3GB RAM,16GB ROM, 510mAH for ALMANACH supported facilities})	PM SARAH/ Director ED&L/ SDHI FP	▲				210,500,000
3.13.19.4.13	Procurement of First Aid boxes and consumables for school health programme in 500 schools across the state.	Director ED&L / DCHS/DPRS	▲				100,000,000
3.13.19.4.14	Procurement of Deworming Tablets (Albendazole Tablets) for estimated 30,000 pupils in 42 schools across the state.	Director ED&L / DCHS/DPRS	▲				15,000,000
3.13.19.4.15	Procurement of SP tablets for Anti natal care services in PHCs for targeted 280,593 pregnant women across the state.	Director ED&L /DCHS/DPRS	▲				120,000,000
3.13.19.4.16	Quarterly Last mile delivery of health commodities from SPHCDA store to 226 primary health care facilities in 21 LGAs across the state	Director ED&L	▲	▲	▲	▲	4,440,000
3.13.19.4.17	Procurement of pulse oximeter for 452 PHCs to monitor oxygen circulation	Director CHS/ Director ED&L	▲				9,040,000
3.13.19.4.18	Revitalization and upgrade of 100 units of level one primary health care facilities to level two across the state.	DPRS	▲				100,000,000
3.13.19.6	**Strengthen Pharmacovigilance and Post-market surveillance of health product through out the supply chain pipeline including Monitoring of substandard and falsified health products (medicines, vaccines and other health-related products)**						**30,110,000**
3.13.19.6.1	Conduct one day quarterly state level logistics technical working group (LTWG) meeting on essential Health commodities management for 35 members of LTWG of SPHCDA and LGAs.	Director ED&L	▲	▲	▲	▲	17,280,000
3.13.19.6.2	Conduct one day quarterly state level commodity distribution planning meetings to coordinate distribution of essential commodities from SPHCDA store to LGAs and PHCs (25 participants).	Director ED&L	▲	▲	▲	▲	5,000,000
3.13.19.6.3	Conduct biannual reverse logistics of expired essential commodities from 226 primary health care facilities to SPHCDA	Director ED&L		▲		▲	7,830,000
1.16.22	**Strengthen health data collection, reporting and usage starting with the core indicators**						**628,710,500**
1.16.22.1	**Strengthen the health information system (HIS) governance frameworks to provide guidance and coordination of HIS resources and outputs**						**124,521,500**
1.16.22.1.1	Conduct 1 day Quarterly HDCC with 21 LGA M&Es and 20 state team (Health Data Consultative Committee) and HDGC and 15 (Health Data Governance Committee)	SMOH/ADSPHCDA	▲	▲	▲	▲	67,010,000

Code	Plan Activities	Person Responsible	Q1	Q2	Q3	Q4	Total Annual Cost
1.16.22.1.2	Develop Quarterly Scorecard for 226 Health Facility and 1000 Health Bulletin to Health Facilities and stake holders	SMOH/ADSPHCDA	▲	▲	▲	▲	20,420,000
1.16.22.1.3	Conduct 5 days residential training to 445 data entry clerks from Primary, Secondary and Private Health Facilities on version 2025 HMIS and HSR data tools in the State	SMOH/ADPHCDA		▲			37,091,500
1.16.22.3	**Optimize the Health Management Information System (HMIS) including the DHIS2 to collect complete and timely routine data**						**385,910,000**
1.16.22.3.1	Conduct 1 day quarterly coordination meetings of 15 State, 21 LGA 5 Partners M&Es officers to enhance data collection, reporting and usage	SMOH/ADSPHCDA	▲	▲	▲	▲	8,590,000
1.16.22.3.2	Conduct 5 days data quality assessment with 21 State Supervisors for 406 Health Facilities	SMOH/ADPHCDA	▲	▲	▲	▲	23,940,000
1.16.22.3.3	Provide Quarterly internet data bundle to 30 State/LGA M&E officers	HMIS SMOH, M&E ADSPHCDA	▲	▲	▲	▲	3,000,000
1.16.22.3.4	Print and distribute 35000, HSR data tools, 1000 HIS SOP and HMIS instructional manual version 2025 to Health Facilities	DPRS SMOH/ ADSPHCDA		▲			350,380,000
1.16.22.7	**Strengthen data analysis and use for decision making**						**9,825,000**
1.16.22.7.1	Support 10 State M&E team participate in 14 days data Visualization and management course in ABU Zaria.	DPRS SMOH/ ADSPHCDA		▲			9,825,000
1.16.22.11	**Support the monitoring, evaluation, research and learning of the HIS and broader health system**						**108,454,000**
1.16.22.11.1	Conduct 5 days quarterly ISS with 42 State Supervisors to 786 Health Facilities	DPRS SMOH/ ADSPHCDA	▲	▲	▲	▲	50,904,000
1.16.22.11.2	Conduct2 days quarterly PHC Review meeting using data analysis for 105 LGA Team & 25 State Programme Officers	HMIS SMOH, M&E SPCDA	▲	▲	▲	▲	46,940,000
1.16.22.11.3	Conduct 3 days refresher training on integrated supportive Supervision to 50 Supervisors	DPRS ADSPHCDA		▲			5,675,000
1.16.22.11.4	Conduct 3 days refresher training on quality-of-Care Assessment for 42 State Supervisors	DPRS ADSPHCDA	▲				4,935,000
2.17.24	**Improve oversight and monitoring of budgeting process to increase budget utilization**						**64,776,000**
2.17.24.4	**Strengthen health financing evidence generation and use**						**64,776,000**
2.17.24.4.1	Conduct 2 days quarterly state level training of 35 members of financial management team on financial management	Director Finance	▲	▲	▲	▲	12,028,000
2.17.24.4.2	Conduct 3days biannual state and LGA training on financial management for 56 members of financial management team	Director Finance		▲		▲	27,048,000
2.17.24.4.3	Conduct 3 days quarterly supportive supervision to LGAs on financial management for 9 financial officers (3persons/MDA)	Director Finance	▲	▲	▲	▲	8,064,000
2.17.24.4.4	Conduct 3days training on harmonised approach to cash transfer (HACT) for 60 participants (state financial team, ES and LGA M&E officers) two clusters	Director Finance	▲				17,636,000

Adamawa State Contributory Management Agency AOP

Code	Plan Activities	Person Responsible	Q1	Q2	Q3	Q4	Total Annual Cost
Grand Total							**1,982,221,000**
2.8.13	**Revitalize BHCPF to drive SWAP, to increase access to quality health care for all citizens and to increase enrolment in health insurance**						**123,016,500**
2.8.13.20	**Enhance sustainability by implementing better risk management practices, counterpart funding, defined role of TPAs and reinsurance.**						**92,756,500**
2.8.13.20.1	Attend a 5-day residential training for 50 ASCHMA staff on Risk Management in Health Insurance.	ES, ASCHMA/PRS	▲				48,000,000
2.8.13.20.2	Conduct a 2-day quarterly performance review meeting with 50 ASCHMA staff, 267 providers, and 5 HMOs to assess service delivery and review performance.	ES, ASCHMA/Program Dept.	▲	▲	▲	▲	19,780,000
2.8.13.20.3	Conduct a 3-day clustered, non-residential capacity-building training on Risk Management for 371 BHCPF-accredited Health Care Providers	ES, ASCHMA/PRS	▲				24,976,500
2.8.13.25	**Develop and adopt digital planning and reporting tools to improve transparency among the SSHIAs**						**30,260,000**
2.8.13.25.1	Engage a consultant to develop an integrated digital data management and collection system (APK-based platform) that enables ASCHMA staff to efficiently capture, submit, store, and retrieve field data and reports in real-time.	ES, ASCHMA/PRS/ICT	▲				10,000,000
2.8.13.25.2	Organize a 3-day residential training for 50 ASCHMA staff on developed ASCHMA digital platform.	ES, ASCHMA/PRS/ICT	▲				20,260,000
2.8.14	**Expand financial protection to all citizens through health insurance expansion and other innovative financing mechanisms**						**1,859,204,500**
2.8.14.1	**Expand health insurance coverage and other pre-pooling mechanism for health**						**891,335,000**
2.8.14.1.1	Conduct a 5-day residential workshop for 100 participants (ASCHMA, NHIA, ASPHCDA, Partners, HSMB, SMOH, ADSHuMA, NUT, NULGE, MHWUN) to review and validate ASCHMA 5-Year Strategic Plan (2026–2031), aligned with NHIA standards.	ES, ASCHMA/PRS	▲				52,600,000
2.8.14.1.2	Conduct a 1-day quarterly town hall meetings with 300 stakeholders (ASCHMA, District Heads, Religious Leaders, CSOs, Unions) across the three senatorial zones to share program updates, listen to feedback, discuss and resolve implementation challenges, and promote transparency and trust	ES, ASCHMA /Program Dept.	▲	▲	▲	▲	6,780,000
2.8.14.1.3	Conduct a 21-day advocacy and sensitization outreach to all the chiefdoms across 21 LGA, ensuring commitments that enhance enrolment and ownership, and of state health insurance scheme."	ES, ASCHMA /Program Dept.	▲	▲			15,412,000
2.8.14.1.4	Produce 50,000 advocacy kits (branded materials) to raise public awareness, improve visibility and promote enrolment into the state health insurance scheme.	ES, ASCHMA /Program Dept.	▲				67,000,000

Code	Plan Activities	Person Responsible	Q1	Q2	Q3	Q4	Total Annual Cost
2.8.14.1.5	Produce and broadcast radio jingles in English and Hausa on the operations of the health insurance agency, ensuring at least 2 airtime slots aired across local radio stations to increase public awareness and enrolee engagement.	ES, ASCHMA /Program Dept.	▲				560,000
2.8.14.1.6	Conduct a 90-day sensitization exercise across the state and local government MDAs to create awareness on the health insurance scheme, ensuring at least 80% of targeted MDAs are reached and engaged.	ES, ASCHMA /Program Dept.	▲	▲	▲	▲	44,820,000
2.8.14.1.7	Conduct a 1-day quarterly Health Financing Technical Working Group (TWG) meeting of 20 participants (ASCHMA, SMOH, ADSPHCDA, ADSHuMA, MOB&P, State Planning Commission), to strengthen health financing policies and practices	ASCHMA/SMOH	▲	▲	▲	▲	3,720,000
2.8.14.1.8	Conduct a 1-day quarterly BHCPF Gateways Forum meeting of 30 participants (ASCHMA, ASPHCDA, SMOH, ADSHuMA, Rep. ES Forum), ensuring participation of at least 90% of key stakeholders and generating actionable resolutions to strengthen fund management and service delivery.	ASCHMA/ADSPHCDA	▲	▲	▲	▲	3,240,000
2.8.14.1.9	Conduct a 1-day non-residential quarterly performance review meeting with all ASCHMA departments	ES, ASCHMA /Program Dept.	▲	▲	▲	▲	6,800,000
2.8.14.1.10	Conduct a 14-day joint accreditation exercise with 20 Assessors (ASCHMA and NHIA teams) across 226 healthcare facilities, including newly added BHCPF facilities	NHIA/ASCHMA		▲	▲	▲	21,600,000
2.8.14.1.11	Conduct a 3-day, clustered, non-residential orientation for 392 BHCPF providers focused on ASCHMA operational frameworks and service quality standards	Head, SQA		▲			21,153,000
2.8.14.1.12	Conduct a 2-day training of 371 enrollment officers on the newly deployed HIS platform	Program/ICT	▲	▲	▲	▲	1,980,000
2.8.14.1.13	Conduct a 10-day annual enrollment of 250,000 beneficiaries by 10 supervisors and 371 Enrollment Officers across all health insurance plans (formal/informal), ensuring equitable coverage	Program/ICT	▲	▲	▲	▲	22,930,000
2.8.14.1.14	Produce and distribute 100,000 enrollees ID and distribute	ICT/Program	▲	▲	▲	▲	10,000,000
2.8.14.1.15	Conduct a 10-day community engagement by ASCHMA, SMOH, ADSPHCDA HSMB in the 3 senatorial zones (7 LGAs) in Adamawa State on health insurance specialized package for RMNCAH/Vulnerable group to be supported by EU-SARAH Project	ES, ASCHMA/PRS/Program	▲	▲	▲	▲	13,530,000
2.8.14.1.16	Establish and operationalize 3 zonal ASCHMA offices to decentralize services, bringing enrollee support, monitoring, and oversight closer to communities across the state.	ES, ASCHMA/Admin	▲	▲			10,260,000
2.8.14.1.17	Attend a 4-day quarterly M&E peer review meeting with NHIA and SSHIAs by 5 ASCHMA Staff, producing actionable recommendations to strengthen monitoring, evaluation, and learning systems.	ES, ASCHMA/PRS	▲	▲	▲	▲	18,600,000

Code	Plan Activities	Person Responsible	Q1	Q2	Q3	Q4	Total Annual Cost
2.8.14.1.18	Produce & Publish 1,000 newsletters of the Agency on quarterly	ES, ASCHMA/Program Dept.	▲	▲	▲	▲	4,000,000
2.8.14.1.19	Conduct a 5-day residential workshop for 30 participants (ASCHMA, media, and key stakeholders) to develop standardized advocacy kits	ES, ASCHMA/Program Dept.	▲				15,910,000
2.8.14.1.20	Produce & Publish 500 copies the Agencies magazine bi-annually	ES, ASCHMA/Program Dept.		▲		▲	5,000,000
2.8.14.1.21	Printing of 500 copies (full color) Strategic Plan	ES, ASCHMA/PRS	▲				7,500,000
2.8.14.1.22	Print 1000 copies of revised operational guideline	ES ASCHMA	▲				10,000,000
2.8.14.1.23	Enroll 6,495 children and pregnant women under equity health plane	ES ASCHMA	▲				77,940,000
2.8.14.1.24	Construct ICT/Call center	ES ASCHMA	▲				450,000,000
2.8.14.2	**Improve equity of coverage through effective implementation of public subsidies**						**118,979,000**
2.8.14.2.1	Conduct a 10-day State-supported vulnerability analysis involving 60 participants (ASCHMA staff, SOCU officials, and trained enumerators) to identify and enroll 15,000 additional vulnerable individuals into the Community-Based Health Insurance Scheme (CBHIS).	ASCHMA, UNICEF	▲				15,400,000
2.8.14.2.2	Conduct 2-day non-residential clustered training on vulnerability mapping tools for 371 BHCPF PHCs, 35 newly recruited staff and 15 existing staff	ASCHMA, UNICEF	▲				22,544,000
2.8.14.2.3	Conduct a 3-day residential training for 50 ASCHMA staff on innovative financing mechanisms & resource pooling (PPPs, CBHI, digital platforms) to strengthen the financial sustainability of the state health insurance scheme.	ES, ASCHMA/PRS		▲			22,395,000
2.8.14.2.4	Conduct Client Satisfaction Survey across the 21 LGAs to assess enrollees satisfaction	ES, ASCHMA/PRS		▲	▲	▲	58,640,000
2.8.14.3	**Utilize strategic purchasing mechanism for high impact interventions**						**60,903,000**
2.8.14.3.1	Conduct a 4-day residential training for 50 ASCHMA staff on strategic purchasing in Health Insurance.	ES, ASCHMA/PRS		▲	▲		39,010,000
2.8.14.3.2	Conduct a 5-day quarterly financial joint spot-checks (NHIA/ASCHMA/VAs) and compliance across by 7 participants across all BHCPF accredited providers	ES, ASCHMA/Finance	▲	▲	▲	▲	9,380,000
2.8.14.3.3	Conduct a 3-day quarterly non-residential performance review meeting with accredited providers and HMOs to enhance service quality and enrolees satisfaction.	ES, ASCHMA/Program Dept.		▲	▲		5,325,000
2.8.14.3.4	Engage a consultant to support the Agency to review all paid claims, identify trends, discrepancies, and generate actionable recommendations.	ES, ASCHMA/SQA			▲	▲	7,188,000
2.8.14.3.5	Disburse monthly capitation and fee-for-service payments to BHCPF-accredited providers in accordance with approved rates—570 per enrollee for BHCPF capitation, 800 per enrollee under the Formal Sector Health Plan, and 350 per enrollee for administrative and fee-for-service costs—to ensure timely provider reimbursement and uninterrupted service delivery	ES ASCHMA	▲	▲	▲	▲	0

Code	Plan Activities	Person Responsible	Q1	Q2	Q3	Q4	Total Annual Cost
2.8.14.4	**Create more efficient and sustainable health insurance industry**						**672,701,500**
2.8.14.4.1	Conduct a 15-day quarterly monitoring and data quality assessment by 30 participants in all accredited health facilities. (371 PHCs, 21 SHCFs and 20 Private Providers)	ES, ASCHMA/PRS	▲	▲	▲	▲	61,880,000
2.8.14.4.2	Engage a qualified consultant to develop and validate the ASCHMA Service Improvement Plan (SIP), ensuring a roadmap for enhancing service quality.	ES, ASCHMA/PRS			▲		21,127,500
2.8.14.4.3	Conduct a 3-day non-residential clustered training for 742 PHCC F-Managers & M&E Officers and 42 SHCF PMOs i/c and Desk Officers on the newly deployed NHIA/M&E Platform	ES, ASCHMA/PRS	▲				46,713,500
2.8.14.4.4	Conduct a 3-day, 3-clustered non-residential financial management training for 392 Health Facility Managers, 21 LGA Accountants, and 21 PFMOs, facilitated by 7 resource persons to be supported by EU-SARAH Project	ES, ASCHMA/Finance		▲			19,927,500
2.8.14.4.5	Conduct a 5-day residential capacity-building training for 50 new and existing ASCHMA staff on Basics of Health Care Financing & Social Health Insurance.	ES, ASCHMA/PRS	▲				17,945,000
2.8.14.4.6	Conduct a 5-day on-the-job coaching and mentorship exercise for 392 health providers on the ASCHMA e-claims platform.	ES, ASCHMA/SQA	▲				3,320,000
2.8.14.4.7	Conduct a 1-day quarterly review meeting in collaboration with ADSHuMA to assess drug supply performance, stock management efficiency, and timely resolution of pharmaceutical-related issues.	ES, ASCHMA/SQA	▲	▲	▲	▲	5,298,000
2.8.14.4.8	Conduct quarterly residential board meetings to review ASCHMA's performance, approve key policies, and provide strategic guidance.	ES, ASCHMA/Admin	▲	▲	▲	▲	25,908,000
2.8.14.4.9	Pay annual subscriptions for three toll-free lines and broadband internet services to ensure uninterrupted communication and connectivity for ASCHMA operations	ES, ASCHMA/ICT	▲				6,600,000
2.8.14.4.10	Sponsor 50 ASCHMA staff to undergo training on digital analytic tools (Power BI, Excel, and KoboCollect).	ES, ASCHMA/PRS/ICT		▲			54,600,000
2.8.14.4.11	Attend a 4-day Quarterly SSHIA CEOs Forum on performance review to strengthen inter-agency collaboration and share best practices	ES, ASCHMA	▲	▲	▲	▲	10,960,000
2.8.14.4.12	Conduct 2-day non residential training for 371 BHCPF PHCs on the operations of BHCPF 2.0 through the engagement of a certified National BHCPF consultant	Informal Sector/PRS	▲				18,038,000
2.8.14.4.13	Procure and install a dedicated accounting software for ASCHMA Operations to be supported EU-SARAH project	ES, ASCHMA/Finance	▲				5,000,000
2.8.14.4.14	Procure 4 desktop computers, 18 laptops, and 6 printers to strengthen ASCHMA operations.	ES, ASCHMA/ICT	▲				13,000,000
2.8.14.4.15	Sponsor 50 ASCHMA staff to attend a 6-day training on data quality assurance and management.	ES, ASCHMA/PRS		▲			50,535,000

Code	Plan Activities	Person Responsible	Q1	Q2	Q3	Q4	Total Annual Cost
2.8.14.4.16	Procure 5 nos. fireproof filing cabinet in line with global best practice to be supported.	ES, ASCHMA/Finance	▲	▲			5,000,000
2.8.14.4.17	Print 500 copies of the ASCHMA Service Improvement Plan (SIP) document to all departments and contracted healthcare facilities.	ES, ASCHMA/PRS		▲			5,000,000
2.8.14.4.18	Conduct a 21-day intensive training and certification programme on Customer Relationship Management (CRM) and Call Centre Operations for 9 ASCHMA Call-Centre Agents	ES, ASCHMA/Formal Sector	▲				17,667,000
2.8.14.4.19	Engage a qualified consultant to undertake a comprehensive technical review and update of the Agency's Operational Guidelines	ES, ASCHMA/PRS	▲				52,800,000
2.8.14.4.20	Conduct a five-day residential training for 50 ASCHMA Staff on office ethics and administrative procedures	ES, ASCHMA/PRS	▲				42,435,000
2.8.14.4.21	Conduct a five-day residential capacity-building training for 50 ASCHMA staff on Programme and Project Management (PPM)	ES, ASCHMA/PRS	▲				32,240,000
2.8.14.4.22	Conduct a three (3)-day residential onboarding and orientation for thirty-five (35) newly recruited ASCHMA	ES, ASCHMA/PRS	▲				15,010,000
2.8.14.4.23	Conduct a 2-days clustered non-residential training for 371 PHCCs and 21 SHCFs staffs on Claims Processing and Disease Coding	ES, ASCHMA/SQA	▲				17,923,000
2.8.14.4.24	Conduct a 5-day training on Report Writing for 50 participants	ES ASCHMA/DPRS		▲			44,185,000
2.8.14.4.25	Conduct a 2-day orientation/sensitization meeting with 21 LGA Chairmen, Perm. Sec. Min. of Local Government Affairs, Chairmen of NUT, MHWUN & NULGE	ES ASCHMA/DPRS	▲				12,420,000
2.8.14.4.26	Conduct a 3-day orientation training for 21 level LGA Desk Officers, 3 Desk Officers of NUT, NULGE & MHWUN on operations of ASCHMA.	ES ASCHMA/DPRS	▲				15,600,000
2.8.14.4.27	Attend National level meetings, workshops and SSHIAs coordination forums	ES ASCHMA	▲	▲	▲	▲	4,160,000
2.8.14.4.28	Engage a qualified and certified consultant to Conduct a three-day, non-residential Infection Prevention and Control (IPC) training for 371 BHCPF-accredited health care providers to strengthen compliance with IPC standards	ES, ASCHMA/PRS	▲				26,889,000
2.8.14.4.29	Attend a -6-day International Conference on Local Government Governance in Health for Sustainable Development (SDG 3.8) in Istanbul, Turkey by 2 ASCHMA Staff	ES, ASCHMA/PRS	▲				20,520,000
2.8.14.5	**Improve the health insurance market efficiency**						**115,286,000**
2.8.14.5.1	Conduct a 15-day quarterly supportive supervision visit to 371 PHC, 21 SHCF and 20 Private healthcare providers	ES, ASCHMA/SQA	▲	▲	▲	▲	40,580,000
2.8.14.5.2	Conduct unannounced spot-check supervision visits across selected accredited health facilities.	ES, ASCHMA/SQA	▲	▲	▲	▲	5,318,000
2.8.14.5.3	Conduct bi-annual 14-days integrated supportive supervision (ISS) (ASCHMA, ADSPHCDA, ADSHuMA, SOCU, SMOH,), covering all zones.	ES, ASCHMA/SQA		▲		▲	28,864,000

Code	Plan Activities	Person Responsible	Q1	Q2	Q3	Q4	Total Annual Cost
2.8.14.5.4	Print 1,000 copies of the Enrollee Protection Framework (EPF) to promote enrollee rights awareness,	ES, ASCHMA/PRS	▲				10,000,000
2.8.14.5.5	Conduct a 21-day state-wide radio and community awareness campaign in English and Hausa on enrollee rights and complaint channels, using 3 ASCHMA campaign teams (3 persons per team) covering 7 LGAs each, with central oversight and coordination.	ES, ASCHMA/Program Dept.	▲				14,524,000
2.8.14.5.6	Develop and produce 1000 Patient Safety guidelines to all BHCPF Accredited Providers	ES, ASCHMA/PRS	▲				16,000,000

Hospital Services Management Board AOP

	Plan Activities	Person Responsible	Q1	Q2	Q3	Q4	Total Annual Cost
Grand Total							**45,790,000**
2.7.11	**Revitalize tertiary and quaternary care hospitals to improve access to specialized care**						**45,790,000**
2.7.11.3	Build capacity of health workers to improve access and quality to specialize care using available Resources including engagement of Nigerian Health care Personnel in the Diaspora						30,090,000
2.7.11.3.1	Conduct 5 days Quarterly supportive Supervision to all the 21 secondary facilities by 8 supervisors.	DPRS	▲	▲	▲	▲	8,000,000
2.7.11.3.2	Conduct 2 days Residential training to MROs and M&Es on digital data collection from 21 Secondary facilities 47 participants	DPRS		▲			5,416,500
2.7.11.3.3	Conduct 2 days Residential Training for Secondary Facilities Management Teams (PMOs, Lab I/c, Nurse I/c, Pharmacy I/c, Secretaries, Accountants) on Comprehensive Healthcare Management skills 126 participants	DPRS		▲			13,577,000
2.7.11.3.4	Conduct 2 days Residential training for 21 Principal Medical Officers (PMOs) on healthcare operation and management with attention on strategic thinking skills for organizational success in hospital administration	Director Medical HSMB			▲		3,096,500
2.7.11.4	Set up data tracking mechanism and link to national data system for planning and decision making on managerial capacity across the tertiary and quaternary care.						15,700,000
2.7.11.4.1	Engage vendor to Development of Database Software for Hospital Services Management Board (HSMB) Human Resource to control Recruitment, Retirements and Promotions and other related activities	DPRS		▲			10,000,000
2.7.11.4.2	Engage Vendor to Development of Digital application for data collection within the secondary facilities to the Board headquarters for data analysis.	DPRS	▲				1,000,000
2.7.11.4.3	Procurement of Table and Chairs, Desktop Computers, Laptops, Printer and Internet bundles for planning department (M&E, DPRS, ICT Office)	DPRS		▲			4,700,000

Adamawa State Health Supplies Management Agency AOP

Code	Plan Activities	Person Responsible	Q1	Q2	Q3	Q4	Total Annual Cost
Grand Total							**972,684,000**
3.13.19	**Streamline existing supply chains to remove complexity**						**972,684,000**
3.13.19.2	Strengthen the functionality and operations of the State Medicines, Vaccines and Health Management Agencies to harmonize and coordinate all health supply chain activities (including emergency response supply chain system)						451,749,000
3.13.19.2.1	Conduct 3-day non-residential clustered training for 100 supply chain officers and facility logistics focal persons across all LGAs on quantification, forecasting, warehousing, and last-mile delivery, biannual supportive supervision visits.	State Government	▲	▲	▲	▲	25,110,000
3.13.19.2.2	Conduct five days monitoring and supportive supervision program to provide quarterly technical support to LGAs and facilities.	Executive Secretary	▲	▲	▲	▲	426,450,000
3.13.19.2.3	Conduct biannual supply chain review meetings to assess progress, share lessons, and track maturity improvement across LGAs. System	Executive Secretary	▲		▲		189,000
3.13.19.4	Ensure establishment of sustainable funding mechanisms for drugs, vaccine and other health commodities at all levels of health services in the country						251,355,000
3.13.19.4.1	Conduct one day stakeholders engagement meeting to analyse funding gap and financing flows across all levels of the health system.	State Government		▲		▲	6,880,000
3.13.19.4.2	Constitute and inaugurate Supply Chain Financing Technical Working Group (TWG) under the State Supply Chain Coordination Forum to oversee resource mobilization and sustainability planning.	State Government	▲	▲	▲	▲	4,125,000
3.13.19.4.3	Conduct a 2 day training for 80 finance and logistics officers at state and LGA levels on financial planning, cost recovery, and accountability for supply chain funds.	State Government		▲			36,600,000
3.13.19.4.4	Procure one IVECO refrigerated van by the end of Q1 2026 to enhance the safe and timely delivery of cold-chain pharmaceutical products.	State Government	▲				181,000,000
3.13.19.4.5	Procure laptop computer and software and HP Notebooks Pro to the finance and logistics teams	State Government		▲			22,750,000
3.13.19.5	Ensure availability and functionality of appropriate supply chain infrastructures (warehouses at national and sub-national levels)						269,580,000
3.13.19.5.1	Establishment of zonal warehouses with modern shelving, pallet systems, cold chain units, solar power backup, and digital inventory tracking tools.	State Government		▲			16,000,000
3.13.19.5.2	Conduct a two day training for 60 state and LGA warehouse staff on good storage and distribution practices (GSDP), warehouse management, safety, and (WMS) use.	Executive Secretary		▲		▲	113,580,000
3.13.19.5.3	Procure and install solar hybrid systems in at least four key warehouses to ensure uninterrupted power supply for cold chain and inventory management systems.	SMOH		▲			140,000,000

State Action for the Control of HIV/AIDs AOP

	Plan Activities	Person Responsible	Q1	Q2	Q3	Q4	Total Annual Cost
Grand Total							**475,800,000**
2.6.10	**Reduce the incidence of HIV, tuberculosis, malaria, and Neglected Tropical Diseases (NTDs)**						**475,800,000**
2.6.10.1	Strengthen Communicable disease prevention task forces focused on HIV, TB, Malaria and NTDs at the national and sub-national level						69,180,000
2.6.10.1.1	Conduct a one day quarterly State HIV/AIDS Coordination Committee (SHACC) performance review meeting involved 30 participants.	Program Department	▲	▲	▲	▲	840,000
2.6.10.1.2	Conduct advocacy for increase state budgetary allocation to HoA and MoF towards HIV programs.	SACA, HoA, MoF	▲	▲			1,440,000
2.6.10.1.3	Conduct a one day quarterly performance review meeting with line ministries (Education, Women Affairs, Youth, Agriculture, Transport, etc.) involved 25 participants.	SACA, Line MDAs, IPs	▲	▲	▲	▲	3,500,000
2.6.10.1.4	Conduct one day quarterly coordination meeting with MDAs, CSOs, and IPs to track progress and gaps involving 25 participants.	SACA, MDA, CSOs and Ips	▲	▲	▲	▲	7,700,000
2.6.10.1.5	Conduct a 5 day mentoring visit to LACA on (roles and responsibilities, community engagement, coordination of CBOs, and FBOs organizations activities.	SACA	▲	▲	▲	▲	4,080,000
2.6.10.1.6	Conduct a one-day NHS quarterly data validation and review meetings to improve data quality and use involved 25 participants	SACA, Ips	▲	▲	▲	▲	3,700,000
2.6.10.1.7	Conduct a one day quarterly GHR response team meeting involve 30 participants.	SACA, Ips	▲	▲	▲	▲	4,240,000
2.6.10.1.8	Conduct 2 days capacity building of LGA and facility M&E officers on data collection, validation, and analysis.	SACA, SASCP, IPs		▲		▲	23,200,000
2.6.10.1.9	Conduct 1 day coordination meeting with PLHIV networks in state and LGA counter part involves 25 participants	SACA, NEPWHAN, IPs	▲	▲	▲	▲	3,700,000.00
2.6.10.1.10	Conduct 5 days advocacy and orientation sessions for traditional, religious, and community leaders on HIV coordination and ownership.	SACA, LACA, CSOs IPs		▲		▲	6,880,000
2.6.10.1.11	World AIDS Day	SACA, MoH, Ips				▲	9,900,000
2.6.10.2	Scale up integrated HIV prevention services						2,380,000
2.6.10.2.1	Production of jingles and airing to support demand creation and awareness campaigns for PrEP services.	SACA, MoH, Line Ministries,				▲	530,000
2.6.10.2.2	Establish and train community gender and human rights teams for GBV reporting and referral pathways involves 25 participants	SACA, MOJ, MWASD, NHRC		▲			1,850,000
2.6.10.3	Increase uptake and access to HIV services (testing, treatment, care, viral suppression, including procurement of HIV rapid test kits)						404,240,000
2.6.10.3.1	Procure and distribute 120,000 unit of test kits	SACA	▲	▲	▲	▲	400,000,000.00
2.6.10.3.2	Conduct a one day review meeting to identify HIV testing gaps, linkage gaps and viral load suppression gaps.	SACA, MoH, MDAs, CSOs, IPs	▲	▲	▲	▲	4,240,000

Traditional Medicine Board AOP

Code	Plan Activities	Person Responsible	Q1	Q2	Q3	Q4	Total Annual Cost
Grand Total							**499,470,000**
2.7.11	**Revitalize tertiary and quaternary care hospitals to improve access to specialized care**						**21,450,000**
2.7.11.3	Build capacity of health workers to improve access and quality to specialize care using available Resources including engagement of Nigerian Health care Personnel in the Diaspora						21,450,000
2.7.11.3.1	Conduct 5 days capacity building training for 15 staff and eighty-five (85) herbal practitioners	Executive Secretary		▲		▲	19,700,000
2.7.11.3.2	Conduct one (1) day annual international herbal celebration for five (5) facilitators and ninety five (95) herbal practitioners	Executive Secretary			▲		1,750,000
3.10.16	**Re-Position Nigeria at the forefront of emerging R&D innovation, starting with local clinical trials and translational science**						**478,020,000**
3.10.16.6	Encourage the standardization, local production, and commercialization of traditional medicines and services						478,020,000
3.10.16.6.1	Establish 21 herbal farms in Adamawa State	Executive Secretary	▲				303,000,000
3.10.16.6.2	Establish herbal medical laboratory in the state	Executive Secretary	▲				21,000,000
3.10.16.6.3	Procure of two vehicles (operational & official)	Executive Secretary	▲				120,000,000
3.10.16.6.4	procure office furniture	Executive Secretary	▲				6,350,000
3.10.16.6.5	Procure office equipment	Executive Secretary	▲				27,150,000
3.10.16.6.6	Procure fuel and maintenance of two vehicle	Executive Secretary	▲				520,000

College of Nursing and Midwifery Yola AOP

Code	Plan Activities	Person Responsible	Q1	Q2	Q3	Q4	Total Annual Cost
Grand Total							**23,730,000**
2.8.12	**Improve Reproductive, Maternal, Newborn, Child health, Adolescent and Nutrition**						**8,000,000**
2.8.12.58	Improving Infrastructure including availability of utilities in health facilities in WASH services for RMNCAEH+N services						8,000,000
2.8.12.58.1	Renovate 10 blocks of hostels toilets in the college	Deputy Provost		▲			5,000,000
2.8.12.58.2	Upgrade College Central Borehole and reticulation supply	Deputy Provost	▲				3,000,000
2.8.13	**Revitalize BHCPF to drive SWAP, to increase access to quality health care for all citizens and to increase enrolment in health insurance**						**9,045,000**
2.8.13.17	Provide essential commodities, utilities, maintenance of facilities, and community engagement						9,045,000
2.8.13.17.1	Procure Essential drugs for the College Clinic	Clinic Head	▲	▲	▲	▲	9,045,000
2.9.15	**Increase availability and quality of HRH**						**6,685,000**
2.9.15.1	Increase production of health workers						6,685,000
2.9.15.1.1	Conduct 1 day Advocacy visit to SMoH and House Standing Committee on Health to address human resource gap	Provost		▲			0
2.9.15.1.2	Conduct 2 days capacity building workshop on measurement and evaluation for 50 Academic staff	Deputy Provost	▲				1,945,000
2.9.15.1.3	Conduct a 2 day non-residential refresher training on the usage of the Students Management System portal and ICT	Deputy Provost	▲				4,740,000

College of Health Science and Technology Michika AOP

Code	Plan Activities	Person Responsible	Q1	Q2	Q3	Q4	Total Annual Cost
Grand Total							**112,565,000**
2.5.6	**Drive multi-sectoral coordination to put in place and facilitate the implementation of appropriate policies and Programs that drive health promotion behaviours (e.g., to disincentivize unhealthy behaviours)**						**2,575,000**
2.5.6.10	Increase Demand Generation to improve health service uptake including RMNCAH, Nutrition, NCD, Mental Health, NTD Vaccination, Family Planning and other health services						2,575,000
2.5.6.10.1	Conduct quarterly community health outreach programs in underserved communities to increase access to essential health services by December 2025	Community Health Dept, Provost			▲	▲	2,575,000
2.8.12	**Improve Reproductive, Maternal, Newborn, Child health, Adolescent and Nutrition**						**10,000,000**
2.8.12.58	Improving Infrastructure including availability of utilities in health facilities in WASH services for RMNCAEH+N services						10,000,000
2.8.12.58.1	Renovation of 5 classrooms and 2 laboratories	Provost	▲			▲	10,000,000
2.9.15	**Increase availability and quality of HRH**						**74,490,000**
2.9.15.1	Increase production of health workers						74,490,000
2.9.15.1.1	Accreditation of all programs (8)	Academic Board, HODs	▲	▲			60,000,000
2.9.15.1.2	Conduct semester examinations and clinical postings	Examination Committee	▲		▲		5,625,000
2.9.15.1.3	Organize staff training workshops and conferences for 50 lecturers and admin staff	Admin Dept., HR Unit	▲			▲	7,465,000
2.9.15.1.4	Introduce staff appraisal and promotion policy	HR Unit		▲			400,000
2.9.15.1.5	Establish and operationalize a Research and Ethics Committee to ensure ethical oversight and promote quality research	Provost		▲			1,000,000
3.18.27	**Top-talent learning program to develop well-rounded for public health leaders**						**2,500,000**
3.18.27.1	Design/improve on a comprehensive learning and development curriculum that covers a wide range of competencies such as strategic thinking, decision-making, policy development, stakeholder management and effective communication required for effective public health leaders.						2,500,000
3.18.27.1.1	Organize annual student orientation, mentorship, and health week programs by December 2026 to enhance student integration, academic performance, and health awareness.	Student Affairs Office/ Deputy Provost		▲		▲	2,500,000
3.13.19	**Streamline existing supply chains to remove complexity**						**23,000,000**
3.13.19.3	Strengthen the Nigeria Health Logistics Management Information System (NHLMIS) to integrate all health programmes data management including vaccines, Essential Medicines and other supply chain functionalities						8,000,000
3.13.19.3.1	Procurement of new teaching aids, ICT equipment	Provost		▲	▲		8,000,000
3.13.19.4	Ensure establishment of sustainable funding mechanisms for drugs, vaccine and other health commodities at all levels of health services in the country						15,000,000
3.13.19.4.1	Procurement of Dental Equipment	procurement	▲			▲	15,000,000