



Jigawa State Ministry of Health

2026 Annual Operational Plan (AOP)

Foreword

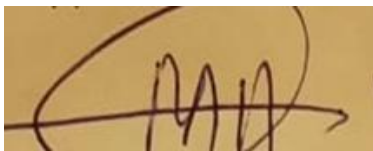
It is with great pride and responsibility that I present the Jigawa State 2026 Annual Operational Plan (AOP) for the health sector. This plan serves as a strategic roadmap for advancing the health and well-being of our people through clear priorities, resource allocation, and implementation strategies. More than a document, it reflects Jigawa State's strong commitment to strengthening the health system in line with national and global priorities. Our vision is aligned with the United Nations' Sustainable Development Goal 3, which seeks to ensure healthy lives and promote well-being for all. Accordingly, the AOP is designed to reduce maternal and child mortality, address communicable and non-communicable diseases, and advance universal health coverage.

At the state level, the plan is guided by the Comprehensive Development Framework III (CDF III) and the Governor's 12-point agenda on health, ensuring alignment with Jigawa State's broader socio-economic development goals. It also supports the Nigeria Health Sector Renewal Investment Initiative (NHSRII), including the national target of increasing fully functional primary healthcare centers from 8,809 to over 17,000 by 2027.

The AOP incorporates the principles of the Health Sector Strategic Blueprint (HSSB) 2023–2027 and focuses on 13 priority areas to address gaps in governance, service delivery, and accountability. Through the Sector-Wide Approach (SWAP), it promotes stronger collaboration among government and development partners under one plan, one budget, and one reporting framework.

Under the leadership of His Excellency Umar Namadi, Jigawa State remains committed to reducing maternal and child mortality, tackling malnutrition, strengthening health security, investing in human capital, promoting digital innovation, and engaging communities in health development.

I extend sincere appreciation to our federal partners, development agencies, healthcare workers, and all stakeholders for their continued support. Together, we will build a stronger, healthier, and more prosperous Jigawa State.



Dr. Muhammad Abdullahi Kainuwa
Honourable Commissioner for Health
Jigawa State Ministry of Health

Acknowledgment

I am deeply thankful for the opportunity to acknowledge the collective efforts that have shaped the Jigawa State 2026 Annual Operational Plan (AOP) for the health sector. As the Director of Health Planning, Research, and Statistics at the Jigawa State Ministry of Health, I extend my heartfelt gratitude to everyone who has contributed to this vital document, which serves as a practical tool for transforming our shared vision into tangible outcomes.

This AOP is firmly anchored in the Nigeria Health Sector Renewal Investment Initiative (NHSRII), the overarching national framework driving transformative reforms to strengthen primary healthcare, reduce maternal and child mortality, enhance nutrition outcomes, and build a resilient health system. By aligning with the Health Sector Strategic Blueprint (HSSB) 2023-2027, we have prioritized evidence-based strategies across key areas, including effective governance, equitable service delivery, workforce development, and data-driven decision-making to address persistent challenges and accelerate progress toward Universal Health Coverage in Jigawa State. Central to our success is the adoption of the Sector-Wide Approach (SWAp), which promotes harmonized planning, unified budgeting, joint implementation, and consolidated reporting among government entities, development partners, and stakeholders. This collaborative mechanism has enabled us to pool resources efficiently, minimize duplication, and ensure that every intervention contributes meaningfully to the state's health priorities under one cohesive plan.

I wish to express profound thanks to His Excellency, Mallam Umar Namadi FCA, the Governor of Jigawa State, for his steadfast leadership and commitment to health as a cornerstone of development. The Honourable Commissioner for Health, for his guidance, vision, and unwavering support in championing these reforms. Our dedicated staff across the Ministry of Health, State Primary Health Care Development Agency, local government health authorities, and healthcare facilities, whose tireless work in planning, data management, monitoring, and service delivery forms the backbone of this AOP. Federal counterparts at the Federal Ministry of Health and Social Welfare, the National Primary Health Care Development Agency, and other national bodies for their technical guidance and alignment with NHSRII and SWAp principles. Development partners, donors, and collaborating organizations for their invaluable financial, technical, and strategic support, which has strengthened our capacity to implement high-impact interventions. Community leaders, civil society organizations, and the people of Jigawa State, for their active participation, feedback, and partnership in advancing health outcomes.

This 2026 AOP reflects our shared resolve to deliver measurable improvements in health indicators, foster accountability, and renew hope for healthier communities. Through continued collaboration and rigorous execution, we will build on these foundations to achieve sustainable gains for the people of Jigawa State.

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Abbreviation

Acronym	Meaning
ANC	Antenatal Care
AOP	Annual Operational Plan
BHCPF	Basic Health Care Provision Fund
CHECOD	Centre for Health Economics and Development
CMD	Chief Medical Director
DHIS2	District Health Information System 2
DLI	Disbursement-Linked Indicator
DPs	Development Partners
DRF	Drug Revolving Fund
EPR	Emergency Preparedness and Response
F-MNCH	Free Maternal, Newborn and Child Health
FCT	Federal Capital Territory
HCH	Honourable Commissioner of Health
HIV	Human Immunodeficiency Virus
HRH	Human Resources for Health
HSSB	Health Sector Strategic Blueprint
HTI	Health Training Institution
ICT	Information and Communication Technology
IPTp	Intermittent Preventive Treatment in pregnancy
JAR	Joint Annual Review
JIPHARMA	Jigawa State Pharmacy and Drug Management Agency
JSPHCDA	Jigawa State Primary Health Care Development Agency
KPI	Key Performance Indicator
LAMIS	Laboratory Management Information System
LGA	Local Government Area
M&E	Monitoring and Evaluation
MDA	Ministry, Department, and Agency
MEARL	Monitoring, Evaluation, Accountability, Research and Learning
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Ratio
NCD	Non-Communicable Disease
NDARS	National Data Repository System
NDHS	Nigeria Demographic and Health Survey
NICS	National Immunization Coverage Survey
NIN	National Identification Number
ORS	Oral Rehydration Salts
OSH	Occupational Safety and Health
PHC	Primary Health Care
PHCDA	Primary Health Care Development Agency
PI	Priority Initiative

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PMP	Performance Monitoring Plan
PMTCT	Prevention of Mother-to-Child Transmission
RMNCH	Reproductive, Maternal, Newborn and Child Health
SCO	SWAp Coordinating Office
SDGs	Sustainable Development Goals
SHF	Secondary Health Facility
SITAN	Situation Analysis
SMART	Specific, Measurable, Achievable, Relevant and Time-bound
SMoH	State Ministry of Health
SWAp	Sector-Wide Approach
TB	Tuberculosis
TMC	Top Management Committee
TOT	Training of Trainers
TPT	TB Preventive Therapy
U-5	Under-5 (mortality)
UHC	Universal Health Coverage
UNICEF	United Nations Children's Fund

Executive Summary

Background

The Federal Ministry of Health and Social Welfare (FMoH&SW) launched the Health Sector Strategic Blueprint (HSSB) in November 2023 with the hallmarks of “business unusual” and “diagnosis to action”, with the goal to save lives, reduce both physical and financial pain, produce health and distribute equitably to all Nigerians. The HSSB is a reform and investment blueprint that aims to reposition the health system and scale up its resourcing to rapidly scale up coverage of essential health services, prioritizing areas of greatest need toward meeting the SDG 2030 targets. Efforts to accelerate progress under previous strategic health development plans were stymied by several challenges, key among which include constrained governance systems; limited accountability; inadequate, inefficient and inequitable health care financing.

The HSSB Framework

By design, the HSSB represents an effort to address the challenges and weaknesses that bedeviled previous national strategic plans through a set of “shifts” in the health system’s structures and processes coupled with a set of targeted “buys” in service delivery to accelerate improvement in population health outcomes. Priority Initiatives to deliver the objectives of the HSSB were carefully selected and profiled by “owner” departments, agencies and parastatals of the health sector, and strategic interventions to implement the priority initiatives were in turn profiled and organized into a framework for implementation. The Framework which comprises 18 objectives, 27 priority initiatives and 265 interventions organized into four (4) Pillars and three (3) Enablers will be operationalized through an Annual Operational Plan (AOP) to be implemented at all levels of healthcare administration (Federal, State/FCT, LGA and Health Facilities) during the Blueprint horizon. This report presents the development and summaries of the 2026 AOP.

AOP Development Process

The 2026 AOP in Jigawa State was developed using the web-based AOP tool through a bottom-up process. The process began with priority-setting at the units, Departments and Agency’s level this was then followed by harmonization and validation of the selected interventions by the Top Management Committee (TMC), chaired by the Honorable Commissioner of Health (HCH), and grounded in a context-specific situation analysis. Out of 265 HSSB strategic interventions, the state prioritized 187 interventions for implementation.

Technical assistants (TAs) from FMoH&SW, Lafiya, and CHECOD supported Jigawa State Health Sector MDAs and intervention implementers. They helped develop and cost implementation plans. This followed centralized capacity-building for all MDAs' Planning Officers. Officers in charge of Primary Healthcare facilities and the LGA Monitoring and Evaluation officers developed facilities plans and LGA AOPs across the 281 Apex PHC facilities and 27 LGAs. The Jigawa State 2026 AOPs was developed across all the units, programs, Departments, Agencies and training institutions by State actors which include, program officers and planning officers while validation of the developed plans was supported by heads of Departments, Agencies and provost of training

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institutions. Some development partners also participated in the development process to ensure alignment of DPs resources with the priorities of the government. Finally, the 6 MDAs AOPs were automatically harmonized on the tool to produce the consolidated Jigawa State 2026 AOP.

Summaries of the costed State 2026 AOP

The total cost of implementing the 2026 Annual Operational Plan (AOP) for Jigawa State is estimated at ₦98.9 billion, comprising ₦96.4 billion (97.5%) for efficient, equitable and quality health system (Pillar Two), ₦1.1 billion (1.1%) for digitizing the health system and data-backed decision-making (Enabler One), ₦720.7 million (0.7%) for health security (Pillar Four), ₦325.6 million (0.3%) for unlocking value chains (Pillar Three), ₦299.9 million (0.3%) for effective governance (Pillar One), ₦58..2 million (0.1%) to increase effectiveness of health spend and its alignment with health priorities (Enabler Two), and ₦2.1 million (0.1%) for improving culture and talent within MDAs (Enabler Three).

Financing the State 2026 AOP

In terms of financing, Government funding commitment of ₦70.2 billion accounts for 71.0% of total AOP budget while DPs (including private sector) committed ₦16.5 billion (16.7%), leaving a funding gap of ₦12.1 billion (12.3%).

HSSB AOP PILLARS	Total Cost of AOP (₦' billion)	Government's Commitment (₦' billion)	Development Partners including Private Sector (₦' billion)	AOP Funding Gap (₦' billion)	% Distribution
Service Delivery	96.4	69.4	15.4	11.6	97.5%
Data Digitization	1.1	0.2	0.6	0.3	1.1%
Health Security	0.7	0.4	0.3	0.0	0.7%
Unlocking Value Chains	0.3	0.2	0.1	0.1	0.3%
Effective Governance	0.3	0.0	0.1	0.1	0.3%
Financing	0.1	0.0	0.0	-	0.1%
Culture and Talent	0.0	0.0	0.0	0.0	0.0%
Other Organizational Functions	-	-	-	-	
Total	98.9	70.2	16.5	12.1	100.0%
% Distribution		71.0%	16.7%	12.3%	

Budget Distribution by activity cost categories

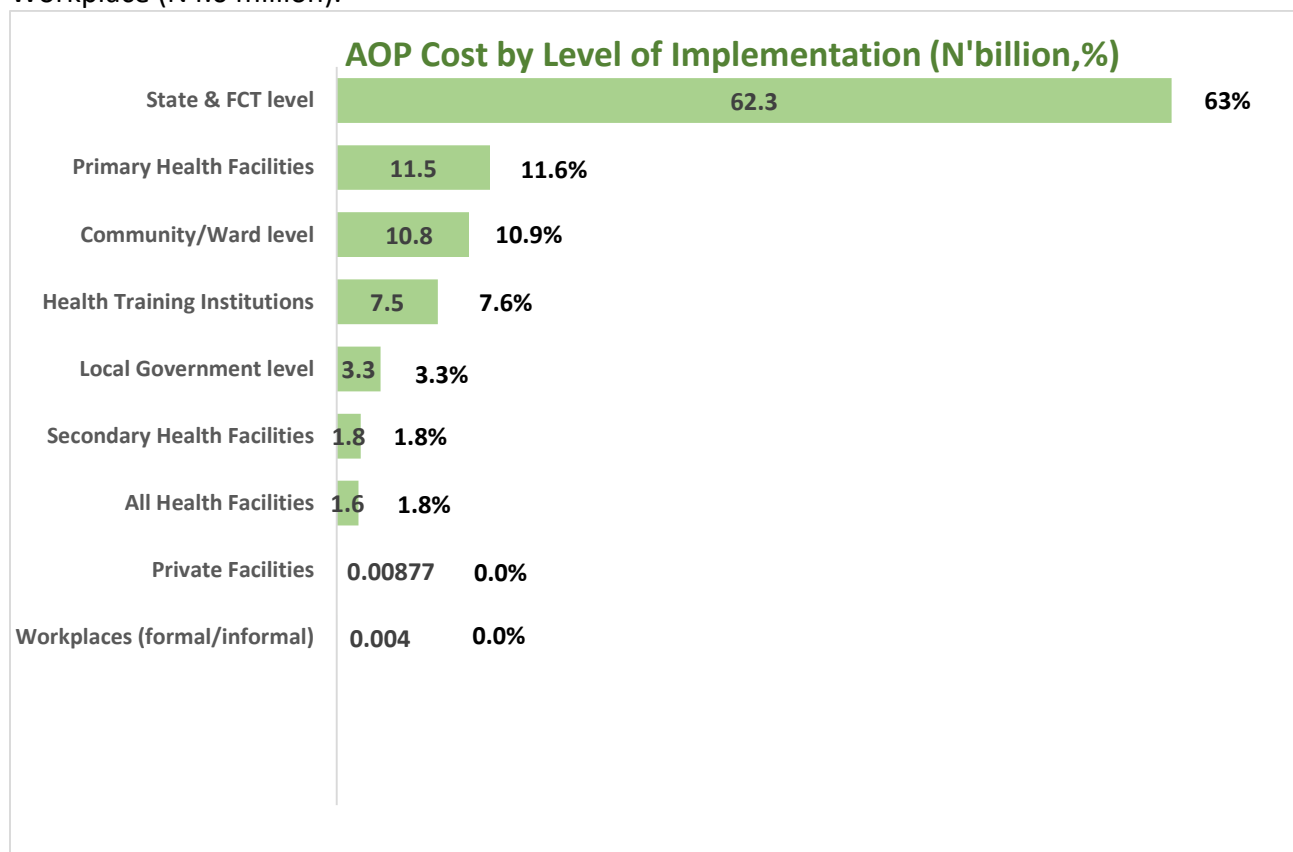
In terms of activity cost category, an estimated ₦55.8 billion (56.4%) of total AOP cost is budgeted for infrastructure and equipment, with ₦4.4 billion (4.4%) and ₦17.3 billion (17.1%) planned for human resources and direct intervention for health respectively. The remaining ₦21.5 billion (21.8%) is budgeted for program management and administration.

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Total Cost of AOP (N'billion)	Program Management and Administration (N'billion)	Human Resource for Health (N'billion)	Infrastructure And Equipment (N'billion)	Direct Intervention Cost (N'billion)
98.9	21.5	4.4	55.8	17.1
% distribution	21.8%	4.4%	56.4%	17.3%

Budget Distribution by Level of Implementation

- The State & FCT and Federal level account for more than half (63%) of the total AOP cost (₦62.3 billion).
- The budget cost at the service delivery levels including Primary Health Facilities (₦11.5 billion) Community/Ward (₦10.8 billion), Health Training Institutions (₦7.5 billion), Local government (₦3.3 billion), Secondary Facilities (₦1.8 billion), All health facilities (₦1.6 billion), Tertiary Facilities (₦1.6 billion), and Private Facilities (₦8.8 million), and Workplace (₦4.0 million).



Policy discussion/Actionable recommendations

The Annual Operational Plan (AOP) remains a vital instrument for translating the state's health priorities into actionable interventions, guiding resource allocation, and improving service delivery across all levels of care. While the planning process has steadily improved, long-standing challenges continue to affect the timeliness, quality, and effectiveness of AOP development and

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implementation. The 2026 AOP cycle provides important lessons and identifies opportunities for strengthening future planning, financing, and coordination.

The 2026 planning process reaffirmed the strong emphasis on primary healthcare as the foundation of the sector. Allocations to the area of efficient, equitable and quality health system total ₦96.4 billion, representing 97.5% of the overall AOP cost, reflecting the state's commitment to revitalizing PHC and aligning with SWAp priorities. As facility-level plans become fully integrated into the digital AOP platform, the state is expected to achieve more efficient distribution of resources and stronger alignment between service delivery needs and budget allocations.

To improve the effectiveness of future AOP cycles, the planning and costing process should commence earlier and be closely aligned with the state budget calendar. Early initiation will strengthen the linkage between AOP priorities and available financing, reduce delays, and enhance accountability in resource mapping. Strengthening coordination between MDAs, LGAs, and development partners, combined with timely reviews and improved oversight, will further enhance the accuracy, coherence, and implementation of subsequent AOPs.

1. Introduction

1.1. Background

The significance of health in advancing social development and mitigating poverty cannot be overstated, inasmuch as a robust and productive labor force is essential for sustaining long-term economic expansion. The equity of a health system is predicated on its effectiveness in prioritizing the needs of the most impoverished and vulnerable populations at the grassroots level, wherein enhancements to their health outcomes contribute to the attainment of elevated life expectancy, reduced disease burden, and the influx of further investments.

Jigawa State continues to face major health challenges. Although successes have been recorded in strengthening Primary Health Care (PHC) services, key health indicators remain weak. The State contributes substantially to Nigeria’s overall burden of maternal mortality ratio (MMR of 1,100 deaths per 100,000 live births) and childhood deaths (U-5 mortality of 158 deaths and neonatal mortality of 59 deaths per 1,000 live births). Issues such as poor health-seeking behavior, cultural barriers and inadequate infrastructure persist, while health worker distribution and availability remain uneven across LGAs.

The State Government, in collaboration with development partners, has implemented a series of programs and structural reforms aimed at strengthening the health system. Although these initiatives have yielded documented successes, persistent challenges—including fragmented planning and governance structures, inadequate coordination mechanisms, insufficient financial resources, and limited community engagement—continue to impede the effective delivery of health services and the achievement of equitable coverage.

In response, Jigawa State is aligning with the national health reform agenda through the Sector-Wide Approach (SWAp) framework endorsed by the Federal Ministry of Health and Social Welfare, which operationalizes the principles of One Plan, One Budget, One Report, and One Conversation. This framework is intended to enhance harmonization among stakeholders, promote efficiency and transparency in resource allocation, and minimize duplication of efforts. Consequently, the 2026 Annual Operational Plan (AOP) has been developed to consolidate previous gains, address persistent systemic bottlenecks, and strategically channel investments toward high-impact, equity-oriented, and data-driven interventions designed to improve health outcomes across all LGAs in the State.

1.2. The Health Sector Strategic Blueprint (HSSB) 2023-2027

The Federal Ministry of Health and Social Welfare introduced the Health Sector Strategic Blueprint (HSSB) in November 2023, anchored on the principles of “business unusual” and “diagnosis to action.” The Blueprint seeks to improve population health by saving lives, reducing physical and financial hardship, increasing the production of health services, and ensuring their equitable distribution across Nigeria. As a reform-oriented and investment-focused framework,

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the HSSB aims to reposition the national health system and scale up health resources to rapidly expand access to essential services, with particular attention to areas of greatest need in line with the SDG 2030 targets. The Blueprint is intentionally designed to address the limitations of previous national health strategies by introducing structural and process-oriented “shifts” within the health system, alongside targeted service delivery “buys” to accelerate progress toward clearly defined results. To achieve these objectives, priority initiatives have been systematically identified and articulated by responsible departments, agencies, and parastatals within the health sector. Corresponding strategic interventions have been developed and organized into a coherent implementation framework to guide effective execution of the HSSB.

The Framework, consisting of 18 Objectives, 27 Priority Initiatives, and 265 strategic interventions, is being operationalized by all levels of government (Federal, State/FCT, and LGA) over the Blueprint horizon under the terms of the Compact through the SWAp, One Plan, One Budget, One Report, and One Conversation.



Figure 1: The Health Sector Strategic Blueprint (HSSB)

2. Situation Analysis

2.1. Overview of Health System and Outcomes

2.1.1. Health Outcomes and Output Key Performance Indicators (KPIs) and Targets

Jigawa State has demonstrated notable progress in several health indicators over the past decade, though significant challenges remain in achieving Sustainable Development Goals (SDG) targets by 2030. The state's health landscape presents a complex picture of incremental improvements alongside persistent vulnerabilities that require urgent attention and strategic interventions.

The under-5 mortality rate has shown encouraging improvement, declining from 192 deaths per 1,000 live births in 2013 to 161 in 2023/24 (Table 1), representing a reduction of approximately 16% over the decade. However, this progress remains far from the ambitious SDG target of 25 deaths per 1,000 live births by 2030. More concerning is the neonatal mortality trend, which has moved in the opposite direction, increasing from 37 deaths per 1,000 live births in 2013 to 53 in 2023/24. This troubling rise highlights critical gaps in newborn care services, including inadequate postnatal care, poor management of birth complications, and limited access to essential neonatal interventions. With the SDG target set at 12 deaths per 1,000 live births, the current trajectory appears increasingly distant without urgent and comprehensive interventions.

Maternal and reproductive health services show modest but insufficient progress. Skilled birth attendance has improved from just 7.6% in 2013 to 24.6% in 2023/24, more than tripling over the period, yet this achievement pales against the 90% SDG target for 2030. Facility-based deliveries similarly increased from 6.7% to 21.4%, indicating that approximately four out of five women in Jigawa State still deliver outside health facilities, often without skilled assistance, exposing them to preventable complications and mortality risks. Antenatal care coverage shows fluctuating trends, with 76% of pregnant women receiving care from skilled providers in 2023/24, though full antenatal coverage with the recommended four visits stands at only 37.7%. These gaps suggest persistent barriers including geographical access, cultural practices, economic constraints, and limited awareness about the importance of facility-based care.

Family planning uptake remains critically low at 4.4% among women in union, having declined from a peak of 7% in 2021. This regression is particularly concerning given the high total fertility rate of 6.9 children per woman, which places significant burdens on maternal health and household resources. The extremely low contraceptive prevalence, far below the universal access target, indicates substantial unmet need for family planning services and suggests that population growth will continue to outpace health service capacity.

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The most impressive gains appear in immunization coverage, which surged dramatically from 3.6% in 2013 to 56.9% in 2023/24, demonstrating the success of strengthened immunization programs and community mobilization efforts. Despite this remarkable progress, coverage remains below the 90% SDG target, leaving significant numbers of children vulnerable to vaccine-preventable diseases.

Childhood malnutrition remains a serious public health concern. While stunting decreased from 59% to 55.7%, this rate remains alarmingly high and the state is unlikely to meet the global nutrition target of 40% reduction by 2025. Wasting increased to 13.2%, more than double the recommended 5% threshold, indicating acute food insecurity and inadequate infant and young child feeding practices.

Moving forward, Jigawa State requires accelerated, evidence-based interventions focusing on maternal health services, family planning access, neonatal care quality, and comprehensive nutrition programs to bridge the substantial gaps between current performance and national development targets.

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Table 1: Performance Indicators

Performance Indicator	NDHS 2013	MICS 2016	NDHS 2018	MICS 2021	NDHS 2023/24	Target			
Key SDG Outcomes:									
Maternal Mortality Ratio/100,000 live births						70 (SDG 2030)			
Under-5 mortality/1000 live births		192	213	174	161	25 (SDG 2030)			
Neonatal mortality/1000 live births		37	47	53	53	12 (SDG 2030)			
Key RMNCH services									
Contraception among women in union	0.9%	1.3%	4.0%	7.0%	4.4%	100% (SDG 2030)			
Total Fertility Rate (per 1000)	7.6	14.3	7.1	7.6	6.9				
Full Antenatal Coverage (4 ANC)		36.3%		45.5%	37.7%				
Antenatal care by skilled provider	49.7%	51.0%	78.6%	72.2%	76.0%				
Skilled attendance at birth	7.6%	21.2%	20.9%	22.2%	24.6%	90% (SDG 2030)			
Delivery in a health facility	6.7%	16.9%	20.1%	18.2%	21.4%				
Birth registration coverage	16.4%	23.6%	26.3%	18.0%	15.7%				
Full immunization coverage (12-23 months)	3.6%	1.8%	23.8%	43.2%	56.9%	90% (SDG 2030)			
Exclusive breastfeeding		0.5%		29.8%					
U5 sleeping under mosquito net	29.8%	76.2%	89.7%	41.7%					
Children with Diarrhoea treated with ORS					34.8%				
Prevalence of Childhood	44.1%	50.4%	42.3%		41.9%				

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Underweight										
Prevalence of Childhood Stunting	59.0%	66.0%	64.0%		55.7%	40% reduction	(Global Nutrition Targets 2025)			
Prevalence of Childhood Wasting	17.0%	13.8%	9.6%		13.2%	<5%	(Global Nutrition Targets 2025)			

Sources: 2013 Nigeria Demographic and Health Survey (NDHS) Report
 2016 – 2017 Multiple Indicator Cluster Survey (MICS) National Survey Finding Report
 2018 Nigeria Demographic and Health Survey (NDHS) Report
 2021 Nigeria Multiple Indicator Cluster Survey (MICS) & National Immunization Coverage Survey (NICS) Statistical Snapshots
 2023/24 Nigeria Demographic and Health Survey (NDHS) Report

2.1.2. SWOT Analysis by HSSB Pillars and Enablers

A diagnostic of the state’s health system was conducted to elicit the challenges and corresponding recommended actions. The prevailing conditions (challenges) are organized by pillars and enablers of the Blueprint below.

Pillar 1: Effective Governance

Pillar 2: Efficient, Equitable and Quality Health System (Service Delivery)

- Poor implementation of Free Maternal, Newborn & Child Health (F-MNCH) Program
- Poor Monitoring and supervision of the Secondary Health Facilities across the state
- Poor provision of quality health care delivery in SHFs
- Low HIV testing at ANC clinic led to poor PMTCT services outcomes
- High prevalence of Trachoma due to inadequate water supply and poor environmental Sanitation in the community.
- Low Tuberculosis Case Detection
- Sub-Optimal TB Preventive Therapy (TPT) enrolment
- Very Low Leprosy Case Notification
- Lack of Buruli Ulcer Notification
- Low uptake of IPTp leading to Maternal death due to Malaria
- Low health insurance coverage in the informal sector
- Low health insurance coverage in the organized private sector
- Low NIN registration among beneficiaries of vulnerable programmes
- Poor service delivery in our health facilities due to inadequate staff
- Health Work Force Maldistribution
- Inadequate specialist workforce to meet government’s expansion of specialist care services
- Inefficient and effective supervision of the health workforce
- Non-functional digital HRH workforce registry

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- Low production of essential health workforce by the State Health Training Institutions (HTIs)
- Lack of ICT Facilities in State HTI's
- Inadequate infrastructure in HTs
- Weak capacity of some academic staff leading to poor quality of training

Pillar 3: Unlocking Value Chains

The commodity value chains are characterized by challenges including the following:

- Lack of standard operating procedures
- Performance management and gap in communication between 3 JIPHARMA warehouses
- Frequent Stock out at some Apex PHC facilities due to Decapitalization
- Poor Data Quality for commodities supplies to FMNCH service points and Beneficiaries
- Frequent stockouts in some LGA DRF Stores due to decapitalization
- Very high operational cost for maintenance of storage conditions due to high cost of diesel
- Inadequate storage space at regional stores
- Reports on the quality of some drugs in the supply chain
- High percentage of data quality issues for Public Health commodity reports.

Pillar 4: Health Security

Key challenges in the areas of Public Health Emergencies, Preparedness and Response (EPR) include the following:

- Inadequate funding for the operation of Occupational Safety and Health (OSH) activities.
- High susceptibility of some PHCs to flood and other climate-related threats

Enabler 1: Data and Digitization

Key challenges in relation to the health information system include the following:

- Suboptimal data quality at facility level
- Staff attitude towards data documentation
- Inadequate Data tools
- Sub-optimal data quality

Table 2. SWOT ANALYSIS Table

Strengths	Weakness
INTERNAL ENVIRONMENT ANALYSIS	
<ul style="list-style-type: none"> • Availability of State HMIS team with capacity; dedicated HMIS budget line; government ownership; availability of collection tools and ICT equipment. • Well-organized supervision teams; strong political will; technical know-how for SHFs supervision; good coordination systems. • Monthly fund releases by SMOH; trained human resources; existing State MPCDSR Coordinating unit and TWC. • Enabling laws/policies; trained personnel; ICT infrastructure; existing formal/informal sector programs; communication strategies. • DRF SOPs; existence of JIPHARMA and LGA stores; functional LMCU at State/LGA levels; data visibility and skilled personnel. 	<ul style="list-style-type: none"> • Inadequate training syllabus; insufficient production of HMIS registers; absence of structured documentation. • No tracking mechanisms; weak planning; poor coordination; inadequate supportive supervision; limited M&E monitoring/reviews. • Lack of dedicated vehicles for supervision; lack of budget line for LMCU activities; lack of consistent electricity. • Limited engagement with informal/organized private sectors; lack of effective mechanism for NIN registration among enrollees. • Capacity gaps in healthcare workers; non-implementation of reward/sanction mechanisms; weak response to customer complaints.
Opportunities	Threats
EXTERNAL ENVIRONMENT ANALYSIS	
<ul style="list-style-type: none"> • Development partners willing to support capacity building, printing of registers, and minilab training. 	<ul style="list-style-type: none"> • Delays in fund disbursement to SHFs; bureaucratic bottlenecks in tool printing; non-budgetary releases.

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<ul style="list-style-type: none">• Government political will to support programs and reduce maternal mortality; accessibility to underserved populations.• Use of community structures (MHA, CBOs, FBOs); availability of media; Mobile NIN registration outlets (NIMC).• Digitalization and supply visibility systems (NHLMIS, mSupply); potential for mini transformers to improve power.	<ul style="list-style-type: none">• Poor staff attitude toward data; inadequate HIT staff; competing priorities inhibiting planned activities.• Low purchasing power and myths/misconceptions in the informal sector; lack of knowledge on health insurance benefits.• Withdrawal of partner/foundation support; donor dependency; security threats to electronic databases.
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3. AOP Development Process

3.1. The AOP development process

3.1.1. Stakeholders' composition

The Annual Operational Plan (AOP) functions as a tool for translating health strategies into practical, executable initiatives, while optimizing resource distribution and program execution. In Jigawa State, the AOP development process was headed by the State Ministry of Health (SMoH), with assistance from the SWAp Coordinating Office (SCO), Lafiya, UNICEF, the Centre for Health Economics and Development (CHECOD), and additional development partners.

3.1.2. Priority Setting

The process started with priority settings, conducted at the Unit, Department, and Agency levels. Subsequently, the Top Management Committee (TMC), under the leadership of the Honourable Commissioner of Health (HCH), and validated these interventions, guided by a state-specific situational assessment.

Technical Assistants aiding the states developed an in-depth situation analysis and directed the application of the Indicator Metrics Tool for SWOT assessments of interventions, along with establishing baselines and targets for each. The interventions were then approved by the TMC, enabling the State Administrator to input the endorsed priorities into the digital platform. In total, out of the 265 HSSB interventions available, 187 interventions were selected and SWOT-mapped.

3.1.3. Standardization of Unit costing

The standardization of the unit costs for program management across all Ministries, Departments, and Agencies (MDAs), is another process that is done and it is followed by aligning them with consensus figures agreed upon by each MDA. Once reviewed and finalized, these unified unit cost items were uploaded into the statewide AOP template to guide the planning. This approach guarantees uniform costing consistency across MDAs at both state and Local Government Area (LGA) levels.

3.1.4. Activity Generation

Planning Officers then returned to their respective Ministries, Departments, and Agencies (MDAs) to create profiles of SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) activities aimed at implementing the chosen interventions, incorporating precise costing details within each activity description.

3.1.5. Ingredient-based costing

The ingredient-based costing sheet automatically pulls planned activities and cost items from the planning sheet. Users select required cost items (ingredients) and their prices for each profiled activity from a predefined, expandable dropdown menu featuring diverse inputs such as commodity procurement, infrastructure expenses (construction, renovation, upgrades,

maintenance), and medical equipment purchases—already populated with standardized unit costs.

Costs are calculated using an ingredient-based formula: quantity × price × frequency (q × p × F). The sheet automates activity cost computations and generates narratives for each budget line. Once cost items are chosen, quantities are specified to reflect total needs. For example, 500 copies for printing training manuals. The days/nights field captures usage duration, such as entering "3" for a venue rented for a three-day workshop, while the frequency column indicates repetitions within a period, like "4" for a trainer engaged quarterly.

3.1.6. Resource Mapping

The resource mapping platform pulls the budget for each activity for mapping of government and donor commitments and estimation of potential funding gaps. Resources already committed by Government in the budget were entered against the respective budget line as well as resources committed by DPs at the level of MDAs. The funding gap was calculated as the excess of the activity budget over Government and DP commitments. The four columns – Total budget, “Government commitment, Donor commitment and Funding gap” – constitute the SWAp **One Conversation**.

3.1.7. Performance Monitoring Plan

The HSSB MEARL Framework provided output, intermediate outcome, and outcome indicators for tracking the implementation of its interventions, priority initiatives and objectives. The MDAs developing AOPs for the respective interventions were required to provide the indicator baselines and annual targets. The baseline is established using available data and information sourced from records and serves as a critical reference for measuring progress, as it captures the status of the intervention before the implementation of the AOP. The planners determined the annual output targets based on two key factors:

1. Capacity to Deliver: Planners assessed the available resources, infrastructure, and human capacity to determine what can feasibly be accomplished within the given timeframe.
2. Baseline Information: The targets are informed by the data and insights gathered during the baseline definition phase, ensuring that they are evidence-based and aligned with the current realities of the intervention.

The baselines and target information provided by various MDAs are submitted to the State admin for entry into the PMP module of the web-based tool which are eventually used for tracking AOP implementation at the respective MDA levels.

3.2. AOP Outcomes, Challenges and Lessons learned

Outcomes

- Jigawa State identified their 2026 state priorities and agenda.
- Jigawa State adapted the National roadmap to their state level for their AOP implementation process.
- The State participated in the national level training of trainers (TOT) workshop.
- Jigawa State conducted state level cascade training for state and LGA planning officers.
- The State conducted 2025 JAR /AOP Review for Quarters 1 and 2.
- The State developed and reviewed its 2026 costed AOP on the web-based AOP tool.
- Jigawa State had its designated partner support (Technical Assistance and Logistics) from National on the AOP development.
- In Jigawa State's AOP, development partners funding commitment was indicated for some costed activities.
- Jigawa State PHCDA conducted a capacity building for PHCs' managers/officers
- Jigawa State LGA Admin organized one day orientation for Primary Healthcare facility managers on SITAN and facilities plan development
- Jigawa State LGA Admin performed technical review on the developed PHCs SITAN and facilities plan before entry into the web-based AOP tool
- All the heads of agencies, provosts of training institutions and CMD of Teaching hospital participated and took ownership of Jigawa State MDA level 2026 AOP development

Challenges

- Some Disbursement Linked Indicators (DLIs) interventions were not SWOT MAPPED
- Some interventions that were SWOT MAPPED have no activity developed under the corresponding interventions
- There is miscommunication between the JSPHCDAs and the LGAs/PHC Facilities on their priorities.
- There were no SITANs provided on Pillar 1 and Enablers 2 and 3
- While the 5-Why analysis and SWOT tool were applied, the analysis in several MDAs lacked depth, often stopping at surface-level issues without adequately tracing root causes.
- Though planning officers had been previously trained on the Indicator Metrics tool, there were variations in its application, with errors in developing baselines and targets for the prioritized interventions.
- The responsibility of developing the LGA SITANs and AOPs as well as providing support for the development of facilities SITAN, plans and technical review of the plans placed on the LGA admin is overwhelming and has an effect on the quality LGA AOP.

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- Getting MDA planning officers to effect corrections on their developed AOP is usually an uphill task.

4. 2025 AOP Review

A review workshop to assess the performance of the 2025 health sector AOP was conducted prior to the development of the 2026 AOP. A summary of the harmonized implementation status for Q1, Q2, Q3, and Q4 annual operational plans.

Table 3 below presents a comprehensive overview of planned activity implementation across Q1 to Q4, encompassing a total of 1,034 scheduled activities. The data captures the funding approval and release rates, the proportion of funded but incomplete activities, full implementation rates, and overall implementation percentages. A total of 394 and 409 activities were planned in Q1 and Q2, respectively, bearing the largest share of planned activities compared to the significantly reduced numbers planned in Q3 (169) and Q4 (114).

Regarding funding performance, Q4 recorded the highest rate (74.6%) in terms of “Activities funded (funds approved & released)”, followed by Q3 (71.6%) and Q1 (62.7%), while Q2 recorded the lowest with 59.9%. For the “activities funded but not completed”, Q2 had the highest (26.9%), Q3 recorded 9.5%, while both Q4 and Q1 had the lowest values of 3.5% and 3.3%, respectively. Q4 had the highest value (71.1%) for “activities fully implemented”, while Q2 recorded the lowest value of 32.8%. Similarly, Q4 had the highest overall implementation rate of 75.0%, followed by Q3 with 68.0% and Q1 with 63.2%, while Q2 had the lowest with 51.9%. Overall, Jigawa State achieved an annual implementation rate of 60.9% across all planned activities in 2025.

Table 3: Jigawa State 2025 AOP Implementation Summary

Quarter	Total Number of activities Planned	% of activities funded (funds approved & released)	% of activities funded but not completed	% of activities fully implemented	Overall % of implementation
Q1	394	62.7	3.3	55.8	63.2
Q2	409	59.9	26.9	32.8	51.9
Q3	169	71.6	9.5	59.8	68.0
Q4	114	74.6	3.5	71.1	75.0
Total	1,086	64.3	13.2	49.4	60.9

Implementation performance was influenced by a myriad of different factors across the quarters (**Error! Reference source not found.**). It was observed that “activity memos not being raised or refined” were the most (21.2%) limiting factor that affected the overall implementation of the health sector. Inability to complete execution of funded activities was the second driving factor

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of suboptimal performance. No Cash Backing/Fund Release within the period in review also affected the MDAs performance.

There is a need for program officers across the MDAs to improve in the aspect of raising compelling memos and rigorously following up with approval and disbursement of funds for their activities, even as efforts go into making the process less tedious and seamless while still being thorough. It is also important that MDAs thoroughly identify and plan activities that speak to their situation analysis; this will facilitate better implementation performance.

Table 4: Factors challenging the full implementation of activities in 2025 AOP

Quarter	% of Activity Memos not defined	% of Approval Delayed /Denied	% of No Cash Backing/Fund Release	% of Incomplete execution of funded Activity
Q1	23.9	8.6	2.5	3.0
Q2	20.3	9.5	2.7	26.4
Q3	20.1	2.4	0.6	9.5
Q4	15.8	4.4	2.6	3.5
Average	21.2	7.6	2.3	12.9

5. Findings from Jigawa State AOP

5.1. Jigawa State Mapped Interventions

Out of 265 total interventions, Jigawa State prioritized 187, representing an average of 70.6%. **Error! Reference source not found.** shows the number of activities planned by each MDA for 026. A total of 1,042 activities were generated to actualize the interventions with the State Ministry of Health (SMoH) having the highest number of activities (497 representing 47.7% of the total activities).

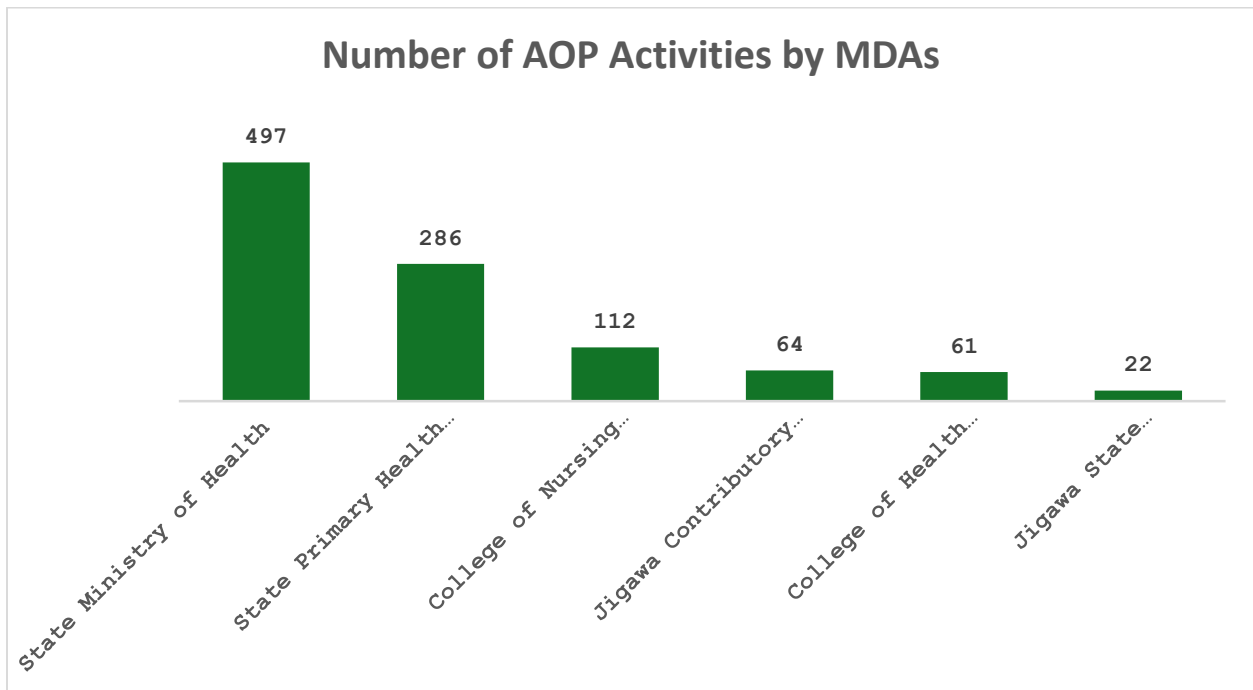


Figure 2: Breakdown of AOP activities by MDAs

5.2. Jigawa State Status of Implementation

The activities developed for the 2026 AOP were 1,042, comprising 576 ongoing projects/activities and 459 new projects/activities, while 5 activities were completed, with 2 as “no activities” as shown in

Figure 3: Jigawa State activity status by implementation

below and with emphasis on the percentage of the activities that is “new or ongoing”.

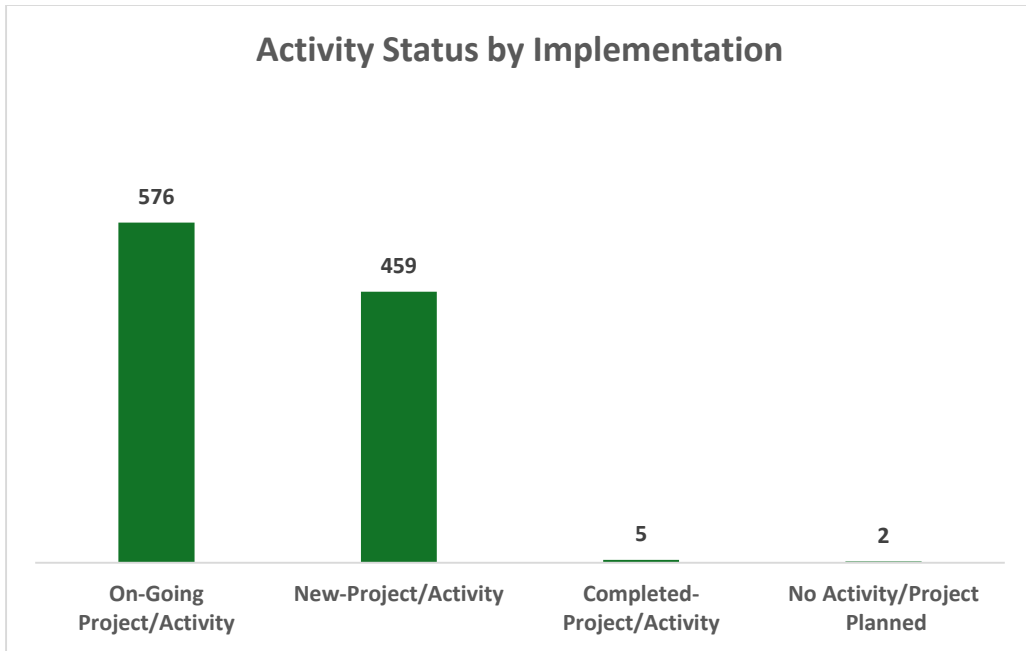


Figure 3: Jigawa State activity status by implementation

Jigawa State Activities by Level of Implementation

The table 5 below demonstrates the distribution of activities across the various levels of implementation in Jigawa State. Predominantly, the state and Federal Capital Territory (FCT) levels account for the largest share, encompassing 588 activities, which equate to approximately 56.4% of the total. Subsequently, health training institutions emerge as a significant node, with 116 activities constituting 11.1% of the aggregate. Community and ward levels follow closely, registering 104 activities (10.0%), suggestive of efforts to engender grassroots participation and localized impact. Local government tiers contribute 99 activities (9.5%), serving as intermediary conduits for implementation. The remainder is dispersed across health-centric domains: an overarching category of all health facilities records 54 (5.2%), primary health facilities 48 (4.6%), and secondary health facilities 29 (2.8%). Notably, private facilities and workplaces exhibit minimal engagement, with only 2 and 1 activities, respectively, potentially signaling opportunities for enhanced private-sector integration to bolster programmatic inclusivity and sustainability.

Table 5: Jigawa State Activities by Level of Implementation

Level of Implementation	Number of Activities
State & FCT Level	588
Health Training Institutions	116
Community/Ward Level	104
Local Government level	99
All Health Facilities	54
Primary Health Facilities	48
Secondary Health Facilities	29
Private Facilities	3
Workplaces (formal/informal)	1

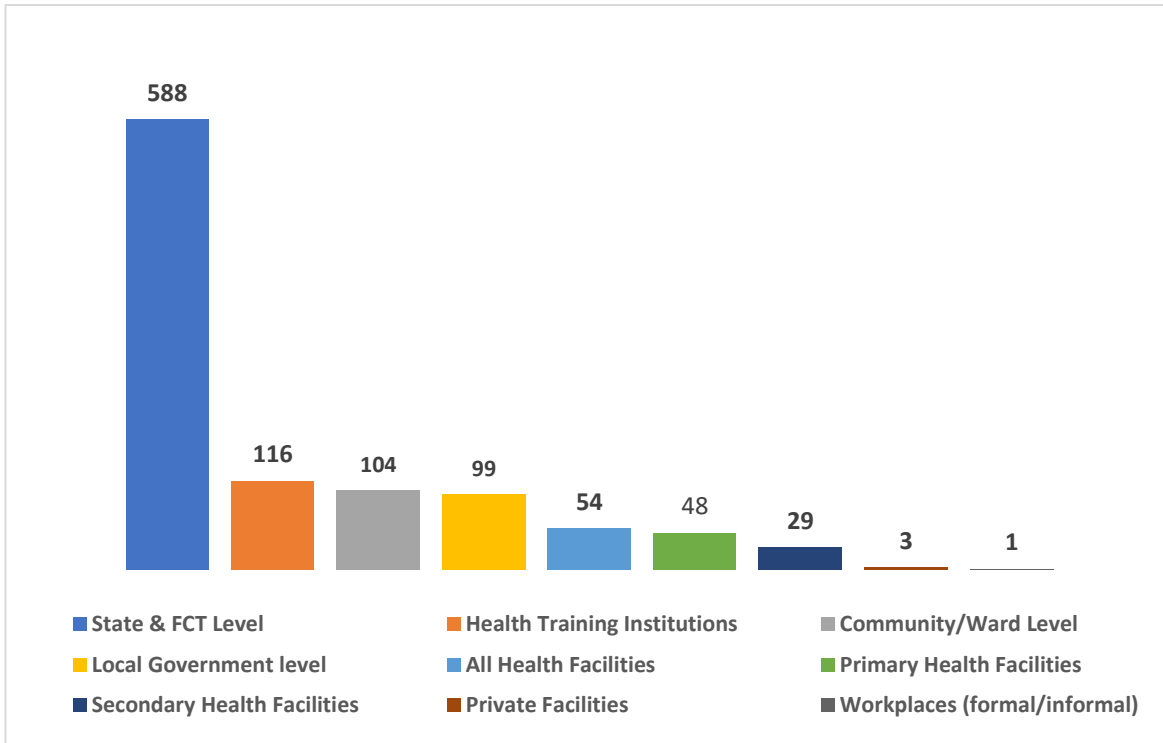


Figure 4: Jigawa State Activities by Level of Implementation

Financing the State 2026 AOP

5.3. Total Cost of AOP

The total cost of implementing the Jigawa State 2026 Annual Operational Plan (AOP) is estimated at ₦98.9 billion.

Table 6: Jigawa State AOP by funding sources

Cost of AOP (₦) Billion	Government commitment (₦) Billion	Development Partners (₦) Billion	Funding gap (₦) Billion
98,863,570,459	70,239,525,012	16,486,275,279	12,137,770,168.12
	71.0%	16.7%	12.3%

5.4. Jigawa State AOP Financing

illustrates the breakdown of cost for Jigawa State by financing sources. The government commits approximately 71.0% (₦70.2 billion) of the total cost, while development partners commit ₦16.5 billion (16.7%) leaving a funding gap of ₦12.1 billion (12.3%).

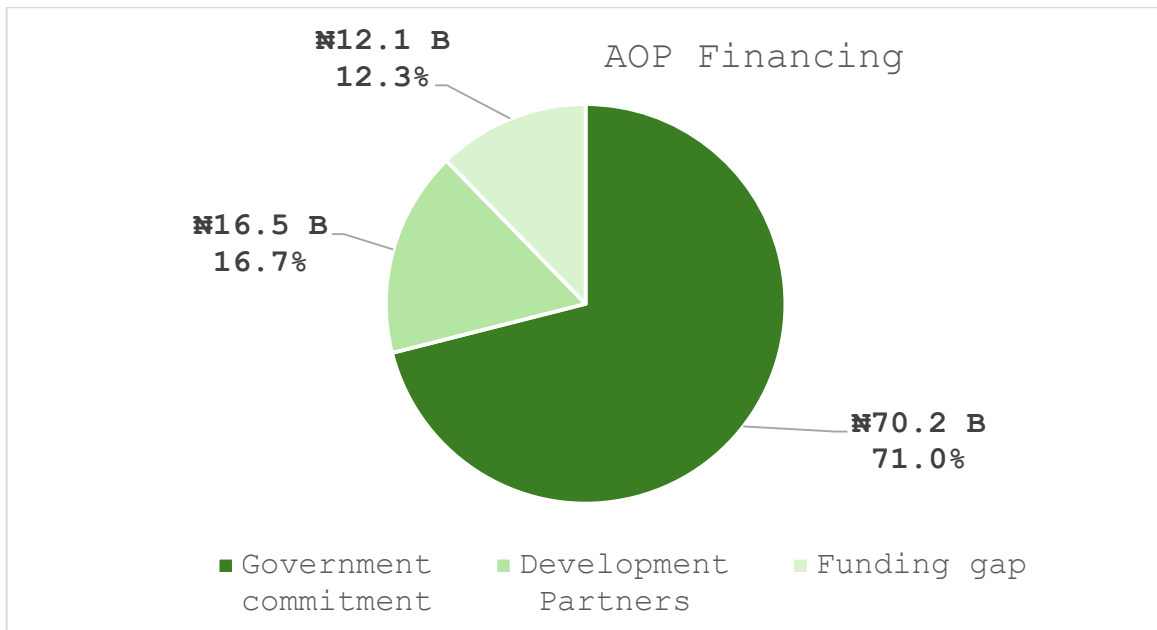


Figure 5: Jigawa State AOP Financing Sources

5.5. Jigawa State Pillars/Enablers Budget and Financing

As shown in Table 7, the total cost of the 2026 AOP is distributed across the HSSB 4 pillars, 3 enablers and other organizational functions. A total of ₦96.4 billion (97.5%) is planned for an efficient, equitable, and quality health system (Pillar Two), ₦1.1 billion (1.1%) for digitizing the health system and enhancing data-backed decision-making (Enabler One), ₦720.8 million (0.7%) for health security (Pillar Four), ₦325.6 million (0.3%) for unlocking value chains (Pillar Three), ₦0.3 billion million (0.3%) for effective governance (Pillar One), ₦58.2 million (0.1%) to increase the effectiveness of health spending and its alignment with health priorities (Enabler Two), and ₦2.1 million (less than 1%) for improving culture and talent within MDAs (Enabler Three).

Table 7: Resource Mapping for the 2026 AOP Financing

HSSB AOP PILLARS	Total Cost of AOP (₦'billion)	Government's Commitment (₦'billion)	Development Partners including Private Sector (₦'billion)	AOP Funding Gap (₦'billion)	% Distribution
Service Delivery	96.4	69.4	15.4	11.6	97.5%
Data Digitization	1.1	0.2	0.6	0.3	1.1%
Health Security	0.7	0.4	0.3	0.0	0.7%
Unlocking Value Chains	0.3	0.2	0.1	0.1	0.3%
Effective Governance	0.3	0.0	0.1	0.1	0.3%
Financing	0.1	0.0	0.0	-	0.1%
Culture and Talent	0.0	0.0	0.0	0.0	0.0%
Other Organizational Functions	-	-	-	-	
Total	98.9	70.2	16.5	12.1	100.0%
% Distribution		71.0%	16.7%	12.3%	

Error! Reference source not found. presents the budget and its financing in absolute and relative terms.

- In the service delivery pillar (Pillar Two), the government committed ₦69.4 billion (72%) and development partners committed ₦15.4 billion (15.9%), resulting in a funding gap of ₦11.6 billion (12.1%).
- To digitize the health system and enhance data-backed decision making, the government committed ₦248.1 million (23%), while development partners committed ₦577.4 million (53.4%), leaving a funding gap of ₦255.1 million (23.6%).
- To improve health security, the government is contributing 51.6% (₦ 371million), while development partners are contributing 46.2% of the budget (₦333.3 million) leaving a funding gap of only (N15.5 million) 2.2%.
- In the unlocking value chain pillar, government committed ₦159.3 million (48.9%) of the total cost), while development partners committed ₦63.1million (19.4%) leaving a funding gap of ₦103.2 million (31.7%).
- About 12.1% (₦36.0 million) of the budget for effective governance pillar will be funded by the government, with 40.1% (₦120.3 million) commitment by DPs leaving a funding gap of 47.9% (₦143.6 million).

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- The government contributes over 31.0% (₦18.0 million) of the total cost to the financing enabler, with the remaining coming from the development partners, ₦40.2 million (69.0%).
- In the culture and talent, the State Government is contributing 27.1% (₦570.0 thousand) of the total cost, the development partners' support is about ₦1.4 million (66.5%), leading to a funding gap of ₦135,000 (6.4%).
- There was no funding commitment for the other organizational functions

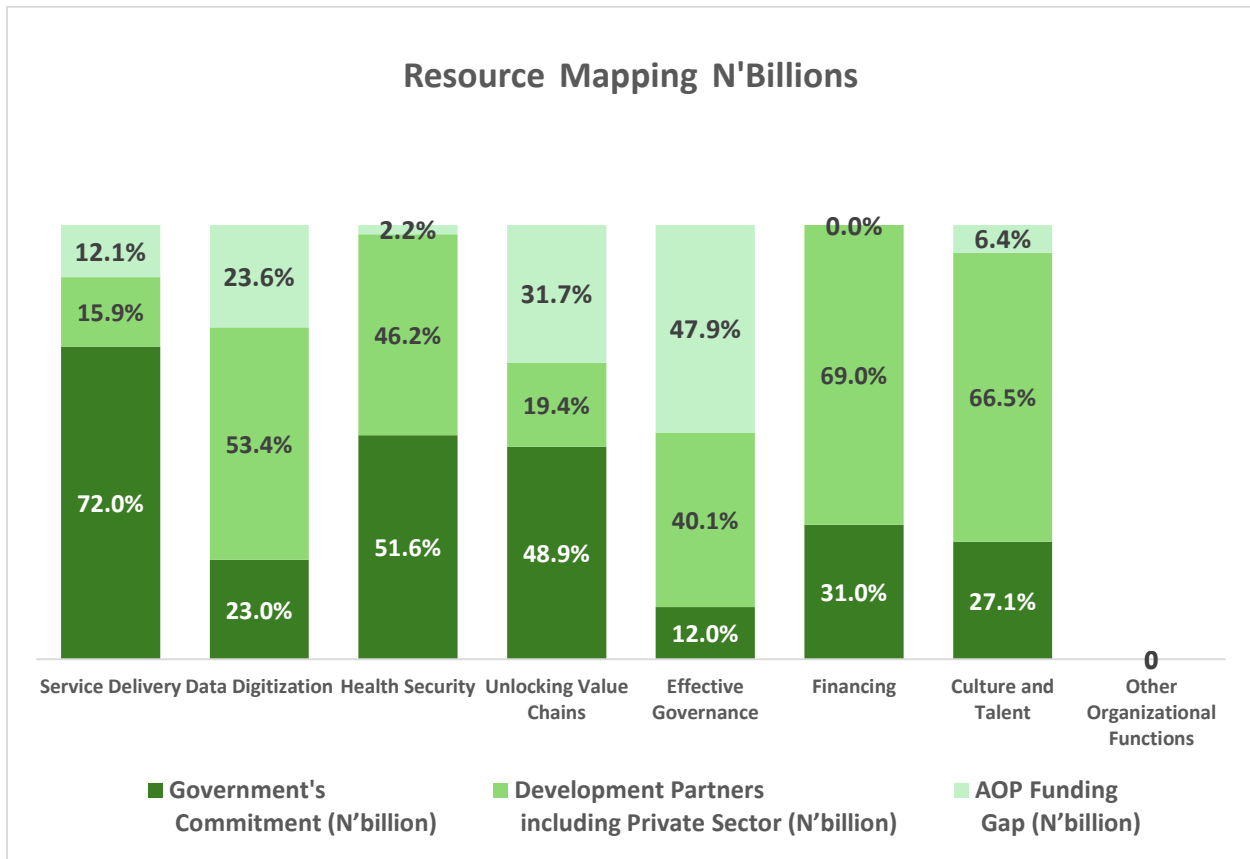


Figure 6: Resource Mapping

5.6. Jigawa State Priority Initiatives Budget and Financing

Three program areas account for a combined 81.8% of the total cost of AOP.

- Priority Initiative 13 (Revitalize BHCPF to drive SWAP, to increase access to quality health care for all citizens and to increase enrolment in health insurance), accounts for 45.6% (₦36.9 billion) of the total budget. The government commits over 90.3% of the cost (₦33.3 billion), while DP's commit ₦429 million which leaves a funding gap of ₦3.2 billion.
- Improve Reproductive, Maternal, Newborn, Child health, Adolescent and Nutrition (Priority Initiative 12) accounts for ₦24.6 billion (30.4%) of the total budget. The State

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government is committing ₦10.7 billion, the Development Partners are also committing ₦5.7 billion, leaving a funding gap of ₦8.2 billion, and

- Priority Initiative 15 which is the “Increase availability and quality of HRH” account for about 23.9% (₦19.3 billion) of the cost. DP’s commitment of ₦24 billion and government commitment of ₦3.3 billion leaves a funding gap of about ₦4.6 billion.

Overall, significant commitments have been made but funding gaps exist for critical initiatives. The initiative to Improve Reproductive, Maternal, Newborn, Child health, Adolescent and Nutrition (PI 12) had a funding gap of 33.4% (₦8.2 billion) of the total cost of ₦24.6 billion, and effort to Increase collaboration with internal and external stakeholders for better delivery and performance management (PI 5) with a deficit of ₦149.1 million representing 93.5% of the aggregate program cost of ₦159.5 million.

An overview of Annex Table-A will reveal that some crucial priority initiatives are insignificant in terms of their share of the AOP 2026 total cost. Notable among these include (PI 9) which to Slowed down the growth rate of NCD Prevalence (₦316.8 million), and no commitment was channeled to Improve oversight and monitoring of budgeting process to increase budget utilization, stimulate local production of health products (e.g. drug substance, fill and finish for vaccines, malaria bed-nets, and therapeutical foods), and Build sustain offtake agreement with development partners for locally produced products required in Nigeria. Although efforts have been put in place by the government and development partners to fund the 2026 AOP, it is essential to address the ₦44.4 billion funding gap for the effective implementation of the AOP.

6. Distribution of the State 2026 AOP Cost

6.1. Jigawa State AOP Cost Summary: Pillars by Activity Cost Categories

Error! Reference source not found. presents the total cost of the 2026 AOP, breaking down the percentage resource requirements for Program Management and Administration, Human Resources for Health, Infrastructure and Equipment, and Direct Intervention Costs. Overall, in terms of activity cost categories, an estimated ₦55.8 billion (56.4%) of the total cost is required for Infrastructure and Equipment, Program and Administration, a total ₦21.5 billion was estimated. for direct intervention, with ₦17.1 billion (17.3%), while ₦4.4 billion (4.4%) was for Human Resource for Health, respectively.

- The service delivery pillar is the core cost driver of the health sector strategy, with a share of 97.5% (₦96.4 billion) of the total cost. Of this share, direct intervention costs require ₦17.0 billion; Program Management and Administration ₦19.9 billion; Human resources ₦4.2 billion; and Infrastructure and Equipment ₦55.2 billion.
- Data and Digitization account for 1.1% (₦1.1 billion) of the total cost. Of the total cost, infrastructure and equipment account for ₦234.7 million, while ₦752.2 million and ₦93.8 million are required for program management & administration, and human resources, respectively.
- The Health Security (pillar 4) accounts for ₦720.7 million (0.7%) of the total cost. Of this, program management and administration account for ₦461.2 million of the total cost, infrastructure and equipment and direct intervention accounts for ₦197.8million and ₦12.0 million, respectively while human resources account for ₦49.8 million.
- In Unlocking Value Chain (pillar 3) accounting for ₦325.6 million (0.3%) of total cost. ₦118.6 million of the budget is channeled to Infrastructure and Equipment, followed by program management and administration at ₦128.8 million, direct intervention account for ₦77.0 million and human resource accounts ₦1.2 million.
- The Effective Governance (pillar 1) accounts for 0.3% of the total cost of AOP at ₦299.9 million. Of this, program management and administration accounts for ₦293.3million, infrastructure and equipment accounts for ₦3.6 million, direct intervention costs required ₦ 3.0 million while human resource for health had no commitment.
- About 0.1% (₦58.2 million) of the AOP cost is directed to enabler 2 (Financing), of which ₦50.1 million is costed for program management and administration and ₦8.1 million was budgeted for Human resource for health, while direct intervention and infrastructure received no commitment.
- Pillar 3 (Culture and Talent) sums up 0.0% of the total cost of AOP at ₦2.1 million with both the program management and administration as well as the Human resource for Health accounted both ₦ 1.5 million and ₦ 570 thousand respectively.

Table 8: AOP Costs by Activity Cost Categories

Pillar/Enabler	Total Cost of AOP (N'billion)	Program Management and Administration (N'billion)	Human Resource for Health (N'billion)	Infrastructure And Equipment (N'billion)	Direct Intervention Cost (N'billion)	% Distribution
Service Delivery	96.4	19.9	4.2	55.2	17.0	97.5%
Data Digitization	1.1	0.8	0.1	0.2	0.0	1.1%
Health Security	0.7	0.5	0.0	0.2	0.0	0.7%
Unlocking Value Chains	0.3	0.1	0.0	0.1	0.1	0.3%
Effective Governance	0.3	0.3	0.0	0.0	0.0	0.3%
Financing	0.1	0.1	0.0	0.0	0.0	0.1%
Culture and Talent	0.0	0.0	0.0	0.0	0.0	0.0%
Other Organizational Functions	0.0	0.0	0.0	0.0	0.0	
Total AOP Cost	98.9	21.5	4.4	55.8	17.1	100.0%
	% Distribution	21.8%	4.4%	56.4%	17.3%	

6.2. Jigawa State AOP Budget Summary: Pillars/Enablers by Level of Implementation

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details the 2026 AOP cost by the level of implementation.

- Approximately 63.5% (~~₦~~61.2 billion) of service delivery cost is required for utilization at State and FCT level. This is followed by ~~₦~~11.4 billion (11.4%) at the Primary Health Facilities and ~~₦~~10.7 billion (11.1%) at Community/wards. The remaining ~~₦~~13.1 billion cost will be utilized at Health training institutions (~~₦~~7.5 billion), Local government level (~~₦~~3.0 billion), Secondary Health Facilities (~~₦~~1.6 billion), All health facilities (~~₦~~943.5 million), workplace (~~₦~~4 million), and the private facilities (~~₦~~5.6 million).
- Out of the budget of ~~₦~~1.1 billion for data and digitization pillar, All health facilities account for more than half (52.1%) of the total cost with ~~₦~~562.7 million, followed by the State and FCT level with ~~₦~~274.0 million (25.3%). A total of ~~₦~~104.65 million (9.7%) was allocated to community/ward level while both the local government level and the primary health facilities had a share of 7.9% (~~₦~~85.4 million) and 5.0% (~~₦~~54.0 million) respectively.
- Health security has its largest share of 52.7% (~~₦~~379.8 million) allocated to the state and FCT level. About ~~₦~~212.5 million is channeled to Secondary Health Facilities, Local government level accounts for approximately 15.4% (~~₦~~111.1 million) of the cost, while community/ward level and all health facilities had ~~₦~~9.8 million and ~~₦~~7.6 million respectively.
- Approximately 48.0% (~~₦~~156.2 million) of the total cost for value chain pillar will be utilized at state and FCT level, All health facilities also had a share of 34.5% (~~₦~~112.4 million). The remaining goes to Local government with ~~₦~~22.2 million as well as the primary health facilities (~~₦~~34.9 million).
- In pillar 1 (Effective Governance), with a total cost of ~~₦~~299.9 million, more than three-quarters (79.7%), which is equivalent to ~~₦~~239.1 million is allocated to State & FCT. The remaining were allocated to Local government level ~~₦~~46.0 million, community/ward levels ~~₦~~11.7 million, and Private Facilities with ~~₦~~3.2 million.
- For the financing enabler, the state & FCT accounted with the whole allocation of ~~₦~~58.3 million (100%)
- In Culture and talent (enabler 3), the whole allocation (~~₦~~2.1 million) goes to implementation at the state & FCT

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Table 9: Jigawa State AOP Costs by Level of Implementation (N'billion)

Pillars & Enablers	Total Cost of AOP	National level	Federal level	State & FCT level	Local Government level	Community/Ward level	Workplaces (formal/informal)	Health Training Institutions	Tertiary Facilities	Secondary Health Facilities	Primary Health Facilities	Private Facilities	All Health Facilities
Service delivery	96.4	0.0	0.0	61.2	3.0	10.7	0.0	7.5	0.0	1.6	11.4	0.0	0.9
Data Digitization	1.1	0.0	0.0	0.3	0.1	0.1	0.0	0.0	0.0	0.0	0.1	0.0	0.6
Health Security	0.7	0.0	0.0	0.4	0.1	0.0	0.0	0.0	0.0	0.2	0.0	0.0	0.0
Unlocking Value Chains	0.3	0.0	0.0	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
Effective Governance	0.3	0.0	0.0	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Financing	0.1	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Culture and Talent	0.002	0.0	0.0	0.002	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Other Organizational Functions	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	98.9	0.0	0.0	62.3	3.3	10.8	0.0	7.5	0.0	1.8	11.5	0.0	1.6
	% Distribution	0.0%	0.0%	63.0%	3.3%	10.9%	0.0%	7.6%	0.0%	1.8%	11.6%	0.0%	1.8%
		100%											

Figure 7 shows the AOP cost and share by Level of Implementation. The figure shows the distribution of resources across different levels of implementation. The State and FCT level accounts for the largest share, amounting to ₦62.3 billion (63.0%), indicating that over half of the total allocation is managed at this level, reflecting the coordinating effect of the state government across all the levels. This is followed by the Primary Health Facilities with ₦11.5 billion (11.6%), Community/Ward level with ₦10.8 billion (10.9%). Health Training Institutions accounts for 7.5 billion (7.6%), Local government level 3.3 billion (3.3%), Secondary health facilities with 1.8 billion (1.8%), All health facilities with 1.6 billion (1.8%), while minimal amount (8.8 million and 4 million) was allocated to both the private facilities and workplace respectively.

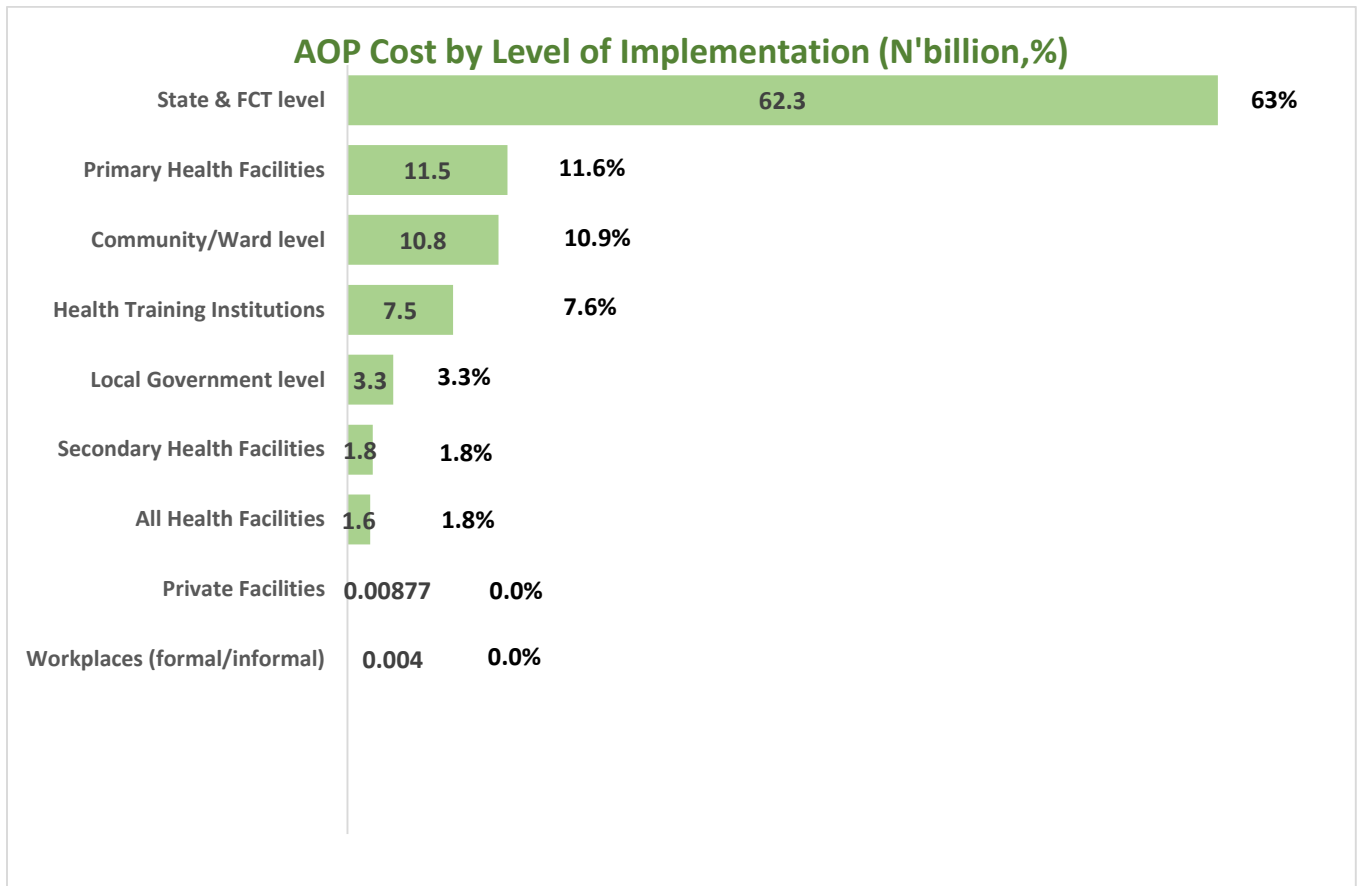


Figure 7: AOP by Level of Implementation

Furthermore, implementation levels at National, Federal and State level (System levels) accounted for a total cost of ₦62.3 billion representing 63.0%. Although there was no commitment at both the national and federal level. The implementation levels at different delivery levels to the citizens recorded the lowest share in Jigawa State 2026 AOP costs – 37.0% which totals ₦36.6 billion (Primary Health facilities ₦11.5 billion, Community/Ward level ₦10.8 billion, Health Training Institutions ₦7.6 billion, Local Government level ₦3.3 billion, Secondary

Health Facilities ₦1.8 billion, All health facilities ₦1.6 billion, Private facilities ₦8.8 million, and Workplace ₦4.0 million (Figure 9).

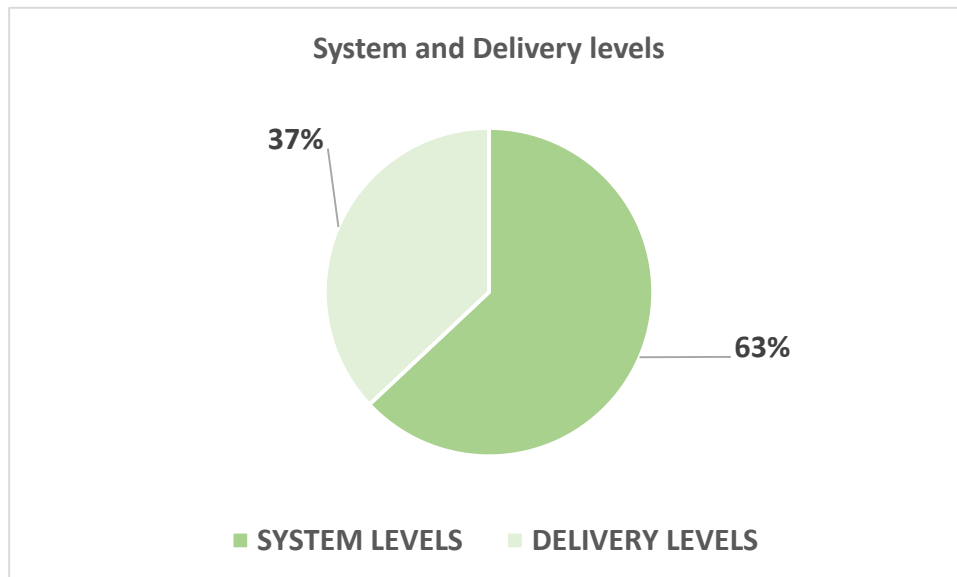


Figure 8: Jigawa State AOP by System and Service Delivery

6.3. Jigawa State AOP Budget Summary: Priority Initiative by Level of Implementation

Annex Table B shows that State and FCT level as a level of implementation received the most cost (₦62.3 billion; 63.0%) and further detail shows that ₦33.3 billion of the cost at the same level was also designated for Revitalize BHCPF to drive SWAP, to increase access to quality health care for all citizens and to increase enrolment in health insurance (PI 13). This is followed by ₦3.5 billion at the Primary Health facilities implementation level.

- Approximately ₦24.6 billion is allocated to Improve Reproductive, Maternal, Newborn, Child health, Adolescent and Nutrition (PI 12) with about 79.9% of the budget directed to interventions at the State & FCT (40.2%) as well as the Local Government level (37.7%) respectively
- In an effort to increase the availability and quality of HRH with the health system in the state, about ₦7.2 billion was budgeted where the State & FCT received a share of 62.0% of the cost and Health training institution which is expected to take much of the budget had 37.5%.
- However, there was no commitment towards PI 17 (Stimulate local production of health products (e.g., drug substance, fill and finish for vaccines, malaria bed-nets, and therapeutic foods) and PI 18 (Build sustain offtake agreement with development partners for locally produced products required in Nigeria), the state government need to prioritized these interventions to strengthens health system resilience by reducing dependence on imported commodities and ensuring reliable access to essential supplies during emergencies.

7. Policy discussion/Actionable recommendations

The 2026 Annual Operational Plan (AOP) builds on lessons from the previous cycle and demonstrates Jigawa State's sustained effort to strengthen its health system in line with the Health Sector Strategic Blueprint (HSSB) 2023–2027. Through the Sector-Wide Approach (SWAp), the plan promotes coordination, transparency, and efficiency in translating strategic priorities into implementable interventions across all levels of care.

Despite notable progress, key challenges persist, including delayed AOP reviews, weak institutional capacity at local and facility levels, funding shortfalls, and limited community participation. These gaps continue to affect the quality and timeliness of implementation, calling for practical policy actions that enhance accountability, improve financing, and build technical capacity.

To address these challenges, governance and coordination mechanisms must be strengthened. Regular AOP review cycles should be institutionalized to ensure alignment with budget timelines, while governing boards across health MDAs need to be reactivated to provide strategic oversight. Improved collaboration under the SWAp framework will also foster harmonization between government and development partners.

For a system to meet the demands and needs of its people, there must be implementation at the delivery levels. However, the analysis demonstrated about 63.0% implementation at the State & FCT while other delivery levels take remaining 37.0%.

Financing reforms are crucial for bridging the ₦12.1 billion funding gap identified in the 2026 AOP. The state should explore innovative financing mechanisms, increase domestic resource allocation, and ensure the timely release and utilization of approved funds. Development partners' support must remain aligned with state priorities to enhance complementarity and sustainability.

Equally, improving technical capacity at both LGA and facility levels will enhance the quality of planning and implementation. Continuous capacity building, validation of standardized unit costs, and better supervision will promote cost efficiency and evidence-based budgeting. Strengthening health data systems is also vital to enable timely, reliable, and interoperable reporting, particularly through platforms such as DHIS2 and NDARS.

Finally, prioritizing primary healthcare revitalization and community engagement will sustain progress in service delivery. Enhancing infrastructure, human resources, and community ownership mechanisms will promote equity, accountability, and long-term impact. By implementing these recommendations, Jigawa State will consolidate ongoing reforms and move closer to achieving Universal Health Coverage (UHC) and the Sustainable Development Goals (SDGs).

References

2013 Nigeria Demographic and Health Survey (NDHS) Report

2016 - 2017 Multiple Indicator Cluster Survey (MICS) National Survey Finding Report

2018 Nigeria Demographic and Health Survey (NDHS) Report

2021 Nigeria Multiple Indicator Cluster Survey (MICS) & National Immunization Coverage Survey (NICS) Statistical Snapshots

Strategic Blueprint Discussion Documents, SWAp Coordination Office, FMoH&SW

2023/24 Nigeria Demographic and Health Survey (NDHS) Report

Annex

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Annex Table A: Jigawa State AOP Priority Initiative and Financing

HSSB AOP PILLARS	Total Cost (₦' Million) of AOP	Governments (₦' Million) Commitment	Development Partners (₦' Million) including Private Sector	AOP Funding Gap (₦' Million)
Strengthen NCH as a coordinating and accountability mechanism across the health system	4.45	2.74	1.71	0.00
Comprehensive and intentional communication strategy for stakeholder engagement and advocacy	49.72	21.97	33.22	-5.47
Improve regulation and regulatory processes for health workers, healthcare facilities and pharmaceutical products	34.62	7.54	27.08	0.00
A Sector Wide Action Plan (SWAp) to defragment health system programming and funding	51.68	2.95	48.74	0.00
Increase collaboration with internal and external stakeholders for better delivery and performance management	159.45	0.80	9.60	149.05
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)	515.52	117.07	1,365.03	-966.58
Accelerate inter-sectorial social welfare through coordination of efforts of the social action fund	0.00	0.00	0.00	0.00
Accelerate immunization programs for priority antigens (e.g., DPT3, Polio, Measles, Yellow Fever) with a focus on decreasing zero dose children	3,200.40	580.21	2,222.49	397.70
Slow down the growth rate of NCD Prevalence	316.83	81.13	235.70	0.00
Reduce the incidence of HIV, tuberculosis, malaria, and Neglected Tropical Diseases (NTDs)	7,206.85	1,648.08	4,813.28	745.49
Revitalize tertiary and quaternary care hospitals to improve access to specialized care	0.00	0.00	0.00	0.00
Improve Reproductive, Maternal, Newborn, Child health, Adolescent and Nutrition	24,611.28	10,691.32	5,708.71	8,211.25
Revitalize BHCPF to drive SWAP, to increase access to quality health care for all citizens and to increase enrolment in health insurance	36,908.13	33,317.23	429.02	3,161.88
Expand financial protection to all citizens through health insurance expansion and other innovative financing mechanisms	4,275.94	4,117.70	99.96	58.28
Increase availability and quality of HRH	19,341.18	18,852.80	476.26	12.13

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Comprehensive and intentional communication strategy for stakeholder engagement and advocacy	0.00	0.00	0.00	0.00
Stimulate local production of health products (e.g., drug substance, fill and finish for vaccines, malaria bed-nets, and therapeutical foods)	0.00	0.00	0.00	0.00
Build sustain offtake agreement with development partners for locally produced products required in Nigeria	0.00	0.00	0.00	0.00
Streamline existing supply chains to remove complexity	325.63	159.28	63.11	103.24
Improve Public Health Emergencies prevention, detection, preparedness and response including pandemics to strengthen health security	491.44	238.77	237.15	15.52
Establish a One Health approach for threat detection and response, incorporating climate-linked threats	229.33	133.17	96.16	0.00
Strengthen health data collection, reporting and usage starting with the core indicators	678.45	171.16	478.27	29.02
Establish and integrate "single source of truth data system that is digitized, interoperable, and accurate	402.29	76.99	99.18	226.12
Improve oversight and monitoring of budgeting process to increase budget utilization	42.09	1.88	40.21	0.00
Regular and effective skills and performance appraisal of top leadership	16.16	16.16	0.00	0.00
Transformation within F/SMoH towards a values and performance driven culture	1.40	0.00	1.40	0.00
Top-talent learning program to develop well-rounded for public health leaders	0.71	0.57	0.00	0.14
Total	98,863.57	70,239.53	16,486.28	12,137.77
	% Distribution	71.00%	16.70%	12.30%
100%				

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Annex Table B: Jigawa State AOP Priority Initiatives by Level of Implementation (In Millions)

PI	HSSB AOP Priority Initiatives	Total Cost of AOP	National level	Federal level	State & FCT level	Local Government level	Community/Ward level	Workplaces (formal/informal)	Health Training Institutions	Tertiary Facilities	Secondary Health Facilities	Primary Health Facilities	Private Facilities	All Health Facilities
1	Strengthen NCH as a coordinating and accountability mechanism across the health system	4.45	0	0	4.45	0	0	0	0	0	0	0	0	0
2	Comprehensive and intentional communication strategy for stakeholder engagement and advocacy	49.722	0	0	49.722	0	0	0	0	0	0	0	0	0
3	Improve regulation and regulatory processes for health workers, healthcare facilities and pharmaceutical products	34.622	0	0	31.452	0	0	0	0	0	0	0	3.17	0
4	A Sector Wide Action Plan (SWAp) to defragment health system programming and funding	51.681	0	0	5.646	46.035	0	0	0	0	0	0	0	0
5	Increase collaboration with internal and external stakeholders for better delivery and performance management	159.45	0	0	147.79	0	11.66	0	0	0	0	0	0	0
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)	515.52	0	0	131.14	114.07	194.5	0	1.11	0	11.7	37.8	0	25.124
7	Accelerate inter-sectorial social welfare through coordination of efforts of the social action fund	0	0	0	0	0	0	0	0	0	0	0	0	0

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8	Accelerate immunization programs for priority antigens (e.g., DPT3, Polio, Measles, Yellow Fever) with a focus on decreasing zero dose children	3200.4	0	0	791.193	1449.8	523.6	0	0	0	2.4	362	0	71.569
9	Slow down the growth rate of NCD Prevalence	317.18	0	0	78.8885	83.3	150.6	0	0	0	0	4.4	0	0
10	Reduce the incidence of HIV, tuberculosis, malaria, and Neglected Tropical Diseases (NTDs)	7,206.8	0	0	4870.75	713.17	474.6	4	278	0	21	75.4	5.6	764.35
11	Revitalize tertiary and quaternary care hospitals to improve access to specialized care	0	0	0	0	0	0	0	0	0	0	0	0	0
12	Improve Reproductive, Maternal, Newborn, Child health, Adolescent and Nutrition	24,611	0	0	9,903.28	624.22	9,282	0	25.7	0	902	3,796	0	77.94
13	Revitalize BHC PF to drive SWAP, to increase access to quality health care for all citizens and to increase enrolment in health insurance	36,908	0	0	33,306	4.13	61.16	0	0	0	10.9	3,521	0	4.48
14	Expand financial protection to all citizens through health insurance expansion and other innovative financing mechanisms	4,275.9	0	0	144.756	14.06	3.78	0	0	0	641	3,473	0	0
15	Increase availability and quality of HRH	19,341	0	0	11,989.1	0	7.227	0	7,245	0	0	100	0	0
16	Re-Position Nigeria at the forefront of emerging R&D innovation, starting with local clinical trials and translational science	0	0	0	0	0	0	0	0	0	0	0	0	0
17	Stimulate local production of health products (e.g., drug substance, fill and finish for vaccines, malaria bed-nets, and therapeutical foods)	0	0	0	0	0	0	0	0	0	0	0	0	0
18	Build sustain offtake agreement with development partners for locally produced products required in Nigeria	0	0	0	0	0	0	0	0	0	0	0	0	0
19	Streamline existing supply chains to remove complexity	325.63	0	0	156.193	22.15	0	0	0	0	0	34.9	0	112.42
20	Improve Public Health Emergencies prevention, detection, preparedness and response including pandemics to strengthen health security	491.44	0	0	151.647	111.12	8.66	0	0	0	212	0	0	7.56

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21	Establish a One Health approach for threat detection and response, incorporating climate-linked threats	229.33	0	0	228.173	0	1.16	0	0	0	0	0	0	0
22	Strengthen health data collection, reporting and usage starting with the core indicators	678.45	0	0	213.988	85.426	35.18	0	0	0	0	54	0	289.86
23	Establish and integrate "single source of truth data system that is digitized, interoperable, and accurate	402.29	0	0	59.9706	0	69.48	0	0	0	0	0	0	272.84
24	Improve oversight and monitoring of budgeting process to increase budget utilization	42.085	0	0	42.085	0	0	0	0	0	0	0	0	0
25	Regular and effective skills and performance appraisal of top leadership	16.163	0	0	16.163	0	0	0	0	0	0	0	0	0
26	Transformation within F/SMoH towards a values and performance driven culture	1.4	0	0	1.4	0	0	0	0	0	0	0	0	0
27	Top-talent learning program to develop well-rounded for public health leaders	0.705	0	0	0.705	0	0	0	0	0	0	0	0	0
	Total	98,864	0	0	62,324.5	3,267.5	10,823	4	7,550	0	1,802	11,458	8.77	1,626.1
	% Distribution		0.0%	0.0%	63.0%	3.3%	10.9%	0%	7.6%	0.0%	1.8%	11.6%	0.0%	1.8%
			100%											