OYO STATE GOVERNMENT

STRATEGIC HEALTH DEVELOPMENT PLAN
(2010-2015)

Oyo State Ministry of Health

March 2010

Contents

ACRONYMS

AMTH	Adeoyo Maternity Teaching Hospital
BCC	Behaviour Change Communication
CIDA	Canadian International Development Agency
CORPs	Community oriented resource persons
CPD	Continuing professional development
CSO	Community Service Organization
DFID	Department for International Development
DHS	Nigeria Demographic and Health Survey
DP	Development Partners
DPRS	Department of Planning, Research and Statistics
FCT	Federal Capital Territory
FMOH	Federal Ministry of Health
GDP	Gross Domestic Product
GIS	Geographic Information System
GTZ	Gesellschaft für Technische Zusammenarbeit
HDCC	Health Data Consultative Committee
HF	Health Facility
HIS	Health Management Information System
HIV/AIDS	Human Immuno Deficiency Virus/Acquired Immune Deficiency Syndrome
HLM	High Level Ministerial Meeting on Health Research
HPCC	Health Partners Coordinating Committee
HRH	Human Resources for Health
HW	Health worker
IEC	Information, Education and Communication
IMCI	Integrated management of Childhood Illnesses
IMNCH	Integrated Maternal, Newborn and Child Health
IPC	Interpersonal Communication skills
ISS	Integrated supportive supervision
ITNs	Insecticide treated nets
JFA	Joint Funding Agreement
JICA	Japan International Development Agency

LGA	Local Government Area
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDAs	Ministries, Departments and Agencies
MDCN	Medical and Dental Council of Nigeria,
MDGs	Millennium Development Goals
MNCH	Maternal and Newborn Child Health
MRCN	Medical Research Council of Nigeria
NAFDAC	National Agency for Food Drugs Administration and Control
NGOs	Non-Governmental Organizations
NHA	National Health Accounts
NHIS	National Health Insurance Scheme
NHMIS	National Health Management Information System
NHREC	National Health Research Committee
NIMR	Nigerian Institute for Medical Research
NIPRD	National Institute for Pharmaceutical Research and Development
NMSP	National Malaria Strategic Plan
NPHCDA	National Primary Health Care Development Agency
NSHDP	National Strategic Health Development Plan
NSHDPf	National Strategic Health Development Plan Framework
NSTDA	National Science and Technology Development Agency
NYSC	National Youth Service Corps
OAU	Organisation of African Unity
ODA	Oversea Development Assistance
OPS	Organised Private Sector
PEPFAR	President's Emergency Plan for AIDS Relief
PERs	Public Expenditure Reviews
PHC	Primary Health Care
PHCMIS	Primary Health Care Management Information System
PPP	Public Private Partnerships
QA	Quality Assurance
RDBs	Research data banks

SHAs	State Health Accounts
SMOH	State Ministry of Health
SWAPs	Sector-Wide Approaches
TB	Tuberculosis
TBAs	Traditional birth attendants
TWG	Technical Working Group
UCH	University Teaching Hospital
UN-System	United Nations-System
VAT	Value Added Tax
VHW	Village health workers
VOC	Vote-of-charge
WHO	World Health Organization

ACKNOWLEDGEMENT

The technical and financial support from all the HHA partner agencies, and other development partners including DFID/PATHS2, USAID, CIDA, JICA, WB, and ADB, during the entire NSHDP development process has been unprecedented, and is appreciated by the Federal and State Ministries of Health. Furthermore we are also appreciative of the support of the HHA partner agencies (AfDB, UNAIDS, UNFPA, UNICEF, WHO, and World Bank), DFID/PATHS2 and Health Systems 2020 for the final editing and production of copies of the plans for the 36 States, FCT, Federal and the harmonised and costed NSHDP.

EXECUTIVE SUMMARY

Oyo State places high premium on the provision of qualitative, accessible and affordable health services. As such, the present administration is committed to providing all necessary support in making the health sector in the State attain the health related MDG goals. The development of this document thus serves as impetus to addressing the health needs of the people.

The State Ministry of Health is conscious of the great challenges being encountered in the health sector and is poised at making policies that will effectively curtail their effects. In this regard, the relevant intervention programmes in this document are designed to provide optimal health services to the people. To enhance the health services delivery and utilization, the State, LGAs and Private individuals had provided complementary facilities to cater for the health needs of the people.

In accessing the implementation of ward minimum package of care, bottleneck analysis conducted revealed the need to address the underlisted challenges;

a) Political intervention in the implementation process
b) Increased poverty level hindering access to effective health services
c) Low level of awareness on the part of the citizen in addressing their health care
d) Inadequate human resource allocation for health
e) Inadequate resources for programme implementation (modern equipment, funds and supplies)
f) Poor monitoring and evaluation process

Consequently, efforts at addressing these bottlenecks in the State will be premised on the following strategies:

i) To create awareness among political office holders on the importance of addressing the priority areas in the health sector
ii) Prompt release of funds for the implementation of health programme/projects
iii) Implementation of poverty alleviation programme across the State, Local Government and community levels.
iv) Strengthening behavioural change communication
v) Involvement of male as partners in effective maternal and child health services
vi) Adoption of National Human Resource for Health (HRH) policy
vii) Strengthening Monitoring, Supervision and Evaluation mechanism as “watch dog” in the State, LGA and Community levels.

The State minimum package is an adaptation from the national minimum package of care but with emphasis in key state priority areas. However, the following minimum package of care would be provided in an integrated manner to all people in these three (3) key packages (Family/Community Oriented, Population Oriented and Individual

Oriented). This will contain cost effective and evidence based interventions that have been documented to have the greatest impact on improvement in health status.

Strategic Priorities interventions as defined by the State, inclusive of targets and indicators are as follows:

- **Leadership and Governance for Health:** the health policy of the State is anchored on free primary health care services and subsidized secondary care with special provision for the vulnerable groups. Efficient operationalization of these facilities is hindered by inconsistency in health policies of the succeeding administration in the State, poorly defined roles and responsibilities of the stakeholders, poor accountability and improper coordination coupled with weak administrative linkage between the State and the LGA health organizational structures.

  The plan seeks to streamline the organizational and management structures to enhance service delivery, sustainable health financing, promote accountability through result based management approach**.**
- **Health Service Delivery:** The focus of the State is to institutionalize a virile and efficient health service delivery system that will engender equitable distribution of health facilities, equipment and health manpower for optimization of the quality of care available to the people of the State under Free Health Policy.

  By expectation, this strategic document covers, among other considerations, areas of weakness and challenges such as poor ownership drive by communities, vertical programming of health services, poor logistics support for programme implementation and inter-cadre wrangling among health care workers. These issues are appropriately addressed within the ambit of relevant interventions.
- **Human Resources for Health: T**his document has been able to identify human resources needs for effective health care delivery. While the State has been able to train health personnel of various cadres, the challenges are still those of inequitable distribution of personnel; high attrition rate; few employment opportunities in public health care sector resulting in inadequate personnel manning public health facilities; and infrequent on-the-job training and retraining of workers to update their skills. The above issues are addressed in the document with reference to need for comprehensive policies an plans on human resources for health development, strengthening capacity for training and retraining of health manpower and partnering with other stake holders to harness contribution from human resource for health agenda.
- **Health Financing:** The Abuja Declaration recommends that 15% of the total State budget be allocated to health. Though, Oyo State has not met this target, up to 13% of her annual budget is being allocated to health. Other sources of

health funding in the State include donor funds, international credit facilities and Private sector contributions.

This document sets out to develop health financing strategies; reduce out of pocket expenditure on health; secure a level of funding to achieve desired health development goals and ensure efficiency and equity in allocation and use of health resources at all levels in the State.

- **National Health Information System:** The State has a well-structured Health Information System in place currently, accessing data from 90% of Public health facilities and 30% of Private health facilities. However, this strategic plan document has enabled the State to come up with Harmonized Plan of Data Recording Format in place of numerous individualized vertical programmes recording format. This is to enable the State completely capture data from all existing facilities, be it public or private for effective planning and programme evaluation.
- **Community Participation and Ownership:** In order to address this priority area, the State has looked into the areas of Ward Development Committees and other structures as laid down in WMHCP. The focus is to enhance community participation and ownership of intervention programmes in all the 33 **LGAs** with involvement of the community members in major decisions pertinent to health issues; retaining committed workforce particularly in rural areas; and spelling out their expected commitment which could enhance their full participation.
- **Partnerships for Health:** Partnership is desirable in health as it addresses multi-sectorality of the State response to the provision of quality health care. The essential objective of the partnership is to harness the resources for the implementation of health services in line with the national health policy goals.
- **Research for Health:** The State has a functional Ethical Review Committee in place. The strategic plan document identifies areas of weakness such as lack of research coordination, non-adherence to ethical considerations and guidelines, poor access to research funds and lack of need-oriented research work and proffers solution.

The total cost estimate of the SSHDP covering the eight (8) priority area is consistent with the identified bottlenecks and strategies to address them at the State, Local and Community levels. The cost of the strategies documented over the next six year period amount to **sixty five billion, four hundred and fifty four million, forty one thousand, six hundred and seventy two naira (N 65,454,041,672)** It is expected that a more comprehensive costing will be undertaken at a later date. The summary of the initial costing estimates are as shown below (details in state planning tool):

S/N	Priority Areas	Cost (=N=)
1	Leadership and Governance for Health	NGN 654,540,417

2	Health Service Delivery	NGN	35,185,802,160
3	Human Resources for Health	NGN	25,414,006,976
4	Financing for Health	NGN	599,719,827
5	National Health Information System	NGN	981,810,625
6	Community Participation and Ownership	NGN	654,540,417
7	Partnerships for Health	NGN	654,540,417
8	Research for Health	NGN	1,309,080,833
Grand Total		**NGN**	**65,454,041,672**

The successful implementation of this Strategic Health Plan depends on the cooperation and commitment of all stakeholders within and outside the health sector. It is anticipated that all stakeholders will demonstrate practical commitment to the implementation of the above strategies, which will be measurable in terms of availability and adherence to prioritized and costed Annual Implementation Plans based on the strategic plan; and prompt allocation, disbursement and utilization of available funding and resource requirements.

As a means of determining implementation status of the State strategic plan, it is of high necessity that a structured monitoring and evaluation process be instituted side by side at both State and Local Government levels. The State Steering Committee will have the overall oversight responsibility for monitoring implementation of the plan to ensure compliance and linkage with the State policy makers.

Apart from this, the implementing agency (Ministry of Health) will set up a monitoring and evaluation team that would provide implementation status reports following the Monitoring & Evaluation strategy designed for the plan. Comprehensive monitoring report compiled will be presented at the annual stakeholders meetings and the State Council on Health (SCH) while outcomes will be shared with all relevant stakeholders, national and international agencies.

CHAPTER 1 BACKGROUND

1.1 INTRODUCTION

Oyo State is in the South West Geo-Political zone of the country. The State is situated within longitude 3.933^0 East of the Meridian Longitude Zero and Latitude 7.85^0 North of the Equator. The State has a total landmass of 27,249 square kilometers (Oyo state Diary 2006) with Ibadan as its capital city. By 2006 national census exercise, Oyo State was enumerated to have a population of 6,182,172.

Oyo State is bounded in the North by Kwara State, in the South by Ogun State, in the East by Kwara and Osun States and in the West, Oyo State is bounded by the Republic of Benin. As at present the State has thirty three (33) Local Government Areas (LGAs). Administratively, each of these LGAs is governed by an elected chairman and vice-chairman.

The LGAs also have elected ward councilors who administer rules, regulations and laws for the LGA. There are three senatorial districts in the State. The three senatorial districts are Oyo North, Oyo South and Oyo Central. However, the State is divided into six (6) health zones namely Ibadan Health zone, Ogbomoso Health zone, Oyo Health zone Oke-Ogun 1 Health zone, Oke-Ogun 2 Health zone and Ibarapa Health zone.

As a pacesetter of the nation, Oyo State can boast of appreciable number of health facilities. Presently, it has about 1,560 health facilities (public and private) which are distributed all over the State. By this volume of health facilities, the three levels of care (i.e. Primary, Secondary and Tertiary) are available in the State. The implementation structure is in congruence with the dictates of the National Policy of Health as the three tiers of Governments bear their respective responsibilities with the Federal for tertiary level of care, the State for secondary level of care while the primary level of care falls under operational ambit of the Local Governments. To a reasonable extent, these large numbers of health facilities in the State have a positive impact on health service coverage in the State.

It is worth mentioning at this level that the State will attain the policy of the availability of at least one General Hospital in each LGA to serve as the referral centre for the LGA before the end of this year 2009. This is because construction works are currently on-going for General Hospitals or Comprehensive Health Centers in the LGAs which hitherto are yet to have any. Again, on the completion of the construction of the on-going out-reach centers of the Ladoke Akintola University Teaching Hospital at Ogbomoso and Oyo, the State will enjoy the availability of a tertiary health care facilities in each of the three senatorial districts of the State.

Further, on Health Service Delivery, Oyo State has uniquely employed and deployed Medical Officers of Health to all the 33 LGAs in the State. Also, the State has no difficulty in sourcing for all cadres of health professionals as there are several health training institutions to produce manpower for all levels of care and all specialties needed in the State. The picture depicted in the above paragraphs may partly be responsible for some levels of improvement in the overall health care delivery in Oyo State as reflected in the indicators of health parameters of the State when compared with the National index.

In-spite of the colourful scenario painted above on health care delivery in the State; there are still gaps to be filled if the State would be able to meet the identified MDGs, particularly, as it concerns health. For instance, most of the private health facilities, public secondary and tertiary health facilities are situated in core urban communities of the State. Unfortunately, Oyo State is 25% urban and 75% semi-urban and rural (Iyiola, 2009).

By implication, there are still vast areas of the State that are presently underserved by the present health facility distribution. In addition, the present health manpower distribution is grossly inadequate to man the health facilities. For instance, Midwives are just insufficient at the PHC level while there are no Pharmacists in any of the 33 LGAs. In a different dimension, however, the State is experiencing high degrees of manpower turn-over.

To address the foregoing and other deficiencies observed and serving as impediment against the achievement of SEEDS, LEEDS, Health Reforms and MDGs, the State Strategic Health Development Plan (SSHDP) was developed along eight (8) priority areas.

1.2 ACHIEVEMENTS

- Renovation, Rehabilitation and Upgrading of the foremost health facility (Adeoyo Maternity Hospital) with state of the arts equipment for enhanced health service delivery.

- Employment, Deployment and Availability of Medical Officers of Health in every LGA to steer the ship of health sector in their respective LGA.

- Development of Website (www.health.org) for information dissemination, feedback and informed decision making on health service delivery.
- Provision of ICT facility to all Medical Officer of Health in the LGAs for information sourcing and dissemination on health services.

- Provision of Ambulance vehicles for all the 33LGAs to strengthen referral system and improve health service delivery in their respective domains.
- Establishment of functional Traditional Medicine Board of Management.
- Introduction of Public Private Partnership for adequate supply of drugs to State health facilities.
- Development of well equipped data bank for information generation, analysis and storage.
- Constitution of Task force on illegal hospitals to reduce quackery in the State.
- Constitution of Task force on fake drugs to reduce the incidence of drug abuse in the State.
- Increased percentage of immunization coverage from 40% (2004) to 85% (2008).
- Introduction of PPP on hospital cleaning services in selected State health facilities.
- Introduction of rural posting allowance for medical personnel.
- Introduction of free treatment for accident victims in the first 24 to 48hrs throughout the State.
- Introduction of free medical treatment for pregnant women at the PHC level.
- Construction of out- reach centers for Ladoke Akintola Teaching Hospital in Ogbomoso and Oyo.

CHAPTER 2 SITUATION ANALYSIS

2.1.1 SOCIO-ECONOMIC CONTEXT

Oyo State is located in the South West region of Nigeria. The capital of Oyo state is Ibadan the acclaimed largest city in Africa South of Sahara. The State has 351 political wards.

TOPOGRAPHY

Oyo state is well drained with rivers flowing from the upland in a North-south direction. The major rivers are Oba, Osun, Otin, Sasa, Erin-ile, Oyan, Ofiki and Ogun,

VEGETATION

The vegetation pattern is one of rain forest in the South and Guinea Savannah to the North. Oyo State is rich in flora and fauna. Thick forest in the south gives way to grassland.

CLIMATE

The temperature is generally high (range 25^{o}-35^{o} Celsius, average 27^{o} Celsius) and humid while rainfall varies between zones. There are two main reasons, the rainy season lasts from April to October and the dry season lasts from November to March. The climate is equatorial in nature thereby characterized by high humidity and substantial rainfall.

PEOPLE

The projected estimated population as at 2009 was 6,129,086. From this figure the State has the following population distribution pattern:

- Under 1 (4%) = 247,287
- <5yrs (20.2%) =1,236,434
- Pregnant Women (5.5%) = 340,020
- Women of Reproductive Age (22.2%) =1,360,078.

The people of the State belong to the Yoruba ethnic group of South west Nigeria. Oyo is bordered by the Republic of Benin to the West, Kwara State to the North, Osun and Kwara to the East and Ogun to the South. The people are prOyominantly farmers.

2.2 HEALTH STATUS

The effort of Oyo State Government at improving the health status of her citizen can be measured by the underlisted indicators:

- Infant Mortality Rate=6.9/1,000
- Maternal Mortality Rate= 261.5/100,000
- Crude Birth Rate= 0.6/1,000
- Still Birth Rate= 8.5%
- Low Birth Weight Rate=17.9%

(Source: Oyo State Health Bulletin 2008)

Additional indicators from the 2008 NDHS are presented in summary in the table below

POPULATION (2006 Census)	OYO
Total population	**5,580,894**
female	2,778,462
male	2,802,432
Under 5 years (20% of Total Pop)	714,034
Adolescents (10 – 24 years)	1,797,674
Women of child bearing age (15-49 years)	1,465,628
INDICATORS	**NDHS 2008**
Literacy rate (female)	70%
Literacy rate (male)	85%
Households with improved source of drinking water	71%
Households with improved sanitary facilities (not shared)	7%
Households with electricity	62%
Employment status (currently)/ female	82.1%
Employment status (currently)/ male	75.3%
Total Fertility Rate	5
Use of FP modern method by married women 15-49	18%
Ante Natal Care provided by skilled Health worker	88%
Skilled attendants at birth	76%
Delivery in Health Facility	67%
Children 12-23 months with full immunization coverage	31%
Children 12-23 months with no immunization	9%
Stunting in Under 5 children	37%
Wasting in Under 5 children	12%
Diarrhea in children	4.3
ITN ownership	2%
ITN utilization (children)	2%
ITN utilization (pregnant women)	4%
children under 5 with fever receiving malaria treatment	-
Pregnant women receiving IPT	4%
Comprehensive knowledge of HIV (female)	25%
Comprehensive knowledge of HIV (male)	19%
Knowledge of TB (female)	76.1%
Knowledge of TB (male)	91.1%

2.3 HEALTH SERVICES PROVISION AND UTILIZATION

The State Ministry of Health is conscious of the great challenges being encountered in the health sector and is poised at making policies that will effectively curtail their effects. In this regard, the relevant intervention programmes in this document are designed to provide optimal health services to the people.

To enhance the health services delivery and utilization, the State, LGAs and Private individuals had provided complementary facilities to cater for the health needs of the people. The categories of these facilities are as indicated below;

FACILITIES SNAP – SHOTS

- 2 Teaching Hospitals
- 4 State Hospitals
- 27 General Hospitals
- 1 Maternity Hospital
- 1 Children Hospitals
- 7 Dental Centers
- 1 Maternal and Child Health Unit
- 1 Cholera Control Unit
- 1 Orthopedics Center
- 351 Primary Health Centers
- 166 Health Clinics
- 113 Health Posts
- 887 Registered Private Institutions

(Source: Oyo State Health Bulletin 2008)

2.4 KEY ASSUMPTIONS IN THE IMPLEMENTATION OF THE STRATEGIES

The successful implementation of this Strategic Health Plan depends on the cooperation and commitment of all stakeholders within and outside the health sector. It is anticipated that all stakeholders will demonstrate practical commitment to the implementation of the above strategies, which will be measurable in terms of availability and adherence to prioritized and costed Annual Implementation Plans based on the strategic plan; and prompt allocation, disbursement and utilization of available funding and resource requirements. Other key assumptions include:

- Good governance
- Political stability
- Availability and prompt release of funds
- Absence of and/or limited political influence on programme implementation
- FreOyom of adherence to guidelines as stated in the strategic health plan
- Willingness of all stakeholders to participate in the planning, implementation and evaluation of the Strategic Health Plan
- Motivated and adequate workforce
- Collaborative public private partnership at State and Local government levels

CHAPTER THREE STRATEGIC HEALTH PRIORITIES

The eight Strategic Priorities for strengthening the health system in the State are outlined in details in Appendix X. Nevertheless, the following list reflects the priority high impact interventions to be delivered in the State - as part of the Essential Package of Health Services for Oyo State.

HIGH IMPACT SERVICES
A. **FAMILY/COMMUNITY ORIENTED SERVICES**
Insecticide Treated Mosquito Nets for children under 5
Insecticide Treated Mosquito Nets for pregnant women
Household water treatment
Access to improved water source
Use of sanitary latrines
Hand washing with soap
Clean delivery and cord care
Initiation of breastfeeding within 1st hr. and temperature management
Condoms for HIV prevention
Universal extra community-based care of LBW infants
Exclusive Breastfeeding for children 0-5 mo.
Continued Breastfeeding for children 6-11 months
Adequate and safe complementary feeding
Supplementary feeding for malnourished children
Oral Rehydration Therapy
Zinc for diarrhea management
Vitamin A - Treatment for measles
Artemisinin-based Combination Therapy for children
Artemisinin-based Combination Therapy for pregnant women
Artemisinin-based Combination Therapy for adults
Antibiotics for U5 pneumonia
Community based management of neonatal sepsis
Follow up Management of Severe Acute Malnutrition
Routine postnatal care (healthy practices and illness detection)

B. POPULATION ORIENTED/OUTREACHES/SCHEDULABLE SERVICES
Family planning
Condom use for HIV prevention
Antenatal Care
Tetanus immunization
Deworming in pregnancy
Detection and treatment of asymptomatic bacteriuria
Detection and management of syphilis in pregnancy
Prevention and treatment of iron deficiency anemia in pregnancy
Intermittent preventive treatment (IPTp) for malaria in pregnancy
Preventing mother to child transmission (PMTCT)
Provider Initiated Testing and Counseling (PITC)
Condom use for HIV prevention
Cotrimoxazole prophylaxis for HIV+ mothers
Cotrimoxazole prophylaxis for HIV+ adults
Cotrimoxazole prophylaxis for children of HIV+ mothers
Measles immunization
BCG immunization
OPV immunization
DPT immunization

Pentavalent (DPT-HiB-Hepatitis b) immunization
Hib immunization
Hepatitis B immunization
Yellow fever immunization
Meningitis immunization
Vitamin A - supplementation for U5

C. INDIVIDUAL/CLINICAL ORIENTED SERVICES
Family Planning
Normal delivery by skilled attendant
Basic emergency obstetric care (B-EOC)
Resuscitation of asphyctic newborns at birth
Antenatal steroids for preterm labor
Antibiotics for Preterm/Prelabour Rupture of Membrane (P/PROM)
Detection and management of (pre)ecclampsia (Mg Sulphate)
Management of neonatal infections
Antibiotics for U5 pneumonia
Antibiotics for dysentery and enteric fevers
Vitamin A - Treatment for measles
Zinc for diarrhea management
ORT for diarrhea management
Artemisinin-based Combination Therapy for children
Artemisinin-based Combination Therapy for pregnant women
Artemisinin-based Combination Therapy for adults
Management of complicated malaria (2nd line drug)
Detection and management of STI
Management of opportunistic infections in AIDS
Male circumcision
First line ART for children with HIV/AIDS
First-line ART for pregnant women with HIV/AIDS
First-line ART for adults with AIDS
Second line ART for children with HIV/AIDS
Second-line ART for pregnant women with HIV/AIDS
Second-line ART for adults with AIDS
TB case detection and treatment with DOTS
Re-treatment of TB patients
Management of multidrug resistant TB (MDR)
Management of Severe Acute Malnutrition
Comprehensive emergency obstetric care (C-EOC)
Management of severely sick children (Clinical IMCI)
Management of neonatal infections
Clinical management of neonatal jaundice
Universal emergency neonatal care (asphyxia aftercare, management of serious infections, management of the VLBW infant)
Other emergency acute care
Management of complicated AIDS

CHAPTER 4 RESOURCE REQUIREMENT

4.1 Human

The human resource requirement for the attainment of the eight priority areas as proposed in the State Strategic Health Development Plan that span a period of six years is quite enormous and the anchor for the successful implementation of all the issues raised are the Executive Governor of the State and the Honourable Commissioner for Health. The success of all the various interventions is a factor of a very strong political will from both the executive and the legislative arm of the government.

Then, going from the above, it is paramount that successful implementation of the Plan will require substantial resources and commitment of all stakeholders. The state government, local government areas, partners, professional associations, health workers unions, private practitioners and Non – Governmental organizations in areas of Health will all be required to play their roles to archive the lofty objective of the plan.

In this document, most of the human resources for health cost related to salaries and training are already being borne by the state and the local government authorities as well as the private sector at the various levels of operations. These will continue to be funded from the regular sources as usual. These are therefore not reflected in this strategic document. The costing merely reflects the amount of time spent on each activities with the aim of moving qualitative health service to the larger member of the community in every nooks and crannies of the state and it also reflects on incentives to community partakers inform of honorarium and sitting allowances. There are needs for new recruitment into the health workforce to augment the existing human capital in the state health sector. Some critical health staff are needed, these includes doctors, nurses, pharmacists, social health workers as well as the lower ranking officers. The document also delve into the areas of needs to bring the Primary Health Care Services to the enviable height of the dream of the minimum health care package for the wards as envisioned by the National Primary Health Care Development Agencies. In the state, from the available baseline record, there are 282 medical consultants, 663 general medical doctors, 3443 nurses/midwives and 166 pharmacists available in the local, state, federal and recognized private health facilities all combined together.

There are lots of initiatives on human resources requirement for health already being supported by partners in the realm of health in the state. The comprehensive and integrated state strategic health development plan aims at attracting funding agencies to join forces with governments at the two levels in the state to put in more effort for the optimum management and development of the health workforce in a well coordinated manner. The envisaged potential sources of funding for the human capital to achieve the lofty goals of the plan during the period of 2010 – 2015 as packaged are as follows:

- Government sources – state and the local government authority
- Donor and other external sources of funding
- Direct employer funding
- National Health Insurance Scheme
- Public - Private Partnership Initiatives
- Community investment in health
- Faith based organizations
- Philanthropic sources
- Other sources as may be available

The larger chunk of the funds requirement will be targeted at the critically needed staff in the underserved areas. This is to ensure that staff per 100,000 population ratios as planned by the national health policy is achieved and thus improve access to health by the grossly disadvantage group as a whole. Applying adequate human capital to achieve the document's aims and objectives may thus require staff redistribution in the state and as may be required in the local government areas.

The state will also draw from the opportunity of those that are fresh graduates from the training institutions domicile in the state to augment the state workforce in addition to youth corps members posted to serve in the state. The community are also expected to initiate and identify people from within for sponsorship health training institutions in the state with the aim of coming back to directly serve the community especially those that are remote in the nooks and crannies of the state.

In respect of research for health, the strength in these research institutions will be explored and utilized maximally to promote the research objectives in the state and thus improve the evidence based health needs. Potential capacities from the collaborating partners on health would equally be utilized.

4.2 Physical/Materials

The required physical materials as analyzed in the document are both capital projects and recurrent huge expenditures. These vary from structural inputs as well as medical consumables and those that serve as logistics back up to achieve the desire goals and objectives.

There is an urgent need to fast tract health infrastructural development in both the secondary and the primary health care level to ensure that the populace have access to qualitative and dignifying specialist and primary health care service.

As at today, there are 678 public health facilities and this includes the primary health care facilities, the secondary health care facilities and the tertiary health care facilities. The registered private health facilities are conservatively put at 887 and this constitutes 57% of all the health facilities in the state.

The means to achieve the lofty goals enshrined in the strategic plan are these existing health facilities but with a broad aim of massive renovation of the public health facilities under the state and the local government authorities. The two tiers of government are also mobilizing funds towards construction of new facilities where they do not exist. The state is also getting assistance from partners in the capital health project as can be exemplified by the HSDP's intervention in the construction of model comprehensive primary health care facilities in some local government areas in the state. The existing secondary health care facilities are also undergoing massive renovations to bring them up to the standard expected of a qualitative and functional facility.

4.3 Financial Requirements

The execution of the strategic plan for Oyo State requires a huge financial resource. As enormous as the amount might be, it cannot be compared to the cost of ill health of the populace in the real economic term.

Therefore, there is a strong need for the identification and mobilization of all available resources that could be targeted towards the realization of the goals and objectives of the development plan. There is a need for coordinated strategies that would further improve health status of the state and this can only be achieved with structured and strict budgeting. The development plan had put in activities that would create a common pool at sourcing for health funds with the aim of improving efficiency and accountability.

From the plan, about 54% of the total budget cost will be expended on personnel requirement while about 23% will be on service provision and the capital projects takes about 24%. This reflects the state's proposed financial commitment to implementing the plan. By the time the local government commitment is added, the total estimated cost would have towered above 14 billion naira intended to be expended over a period of 6 years.

Part of the means the plan is aiming to source for required funds through the community involvement in health service deliveries being a cardinal stakeholder in the sector. The community health insurance scheme being designed to cover more local government areas as against the present situation where only one or two local government are presently being involved. This is to emphasize the right of the people to own their own comfort at their own cost. The other major source of funding is being hinged on the federal government allocations, the state's internally generated revenue, special taxation, assistance from major partners like UNICEF, WHO, Dammien Foundation, African Development Bank and the World Bank amongst host of others already operating in the state.

CHAPTER 5 FINANCING PLAN

5.1 Estimated cost of the strategic orientations

The grand total cost of the entire activities in the Plan is the sum of ₦43,196,383,565.00 (Forty-Three Billion One Hundred and Ninety-Six Million Three Hundred and Eighty-Three Thousand Five Hundred and Sixty-Five)only. The break down for each of the 8 thematic areas is as reflected in the tables below.

TABLE __: ESTIMATED TOTAL COST OF OYO SSHDP BY PRIORITY AREA

S/N	PRIORITY AREA	TOTAL COST
1	Leadership and Governance for Health	654,383,201.00
2	Health Service Delivery	9,727,906,394.00
3	Human Resources for Health	17,037,885,205.00
4	Financing for Health	2,610,600,923.00
5	Health Information System	3,577,305,729.00
6	Community Participation and Ownership	1,864,672,821.00
7	Partnerships for Health	2,167,967,884.00
8	Research for Health	5,555,661,408.00
Total		**43,196,383,565.00**

TABLE ___: EXPECTED CONTRIBUTIONS OF OYO STATE GOVERNMENT TO THE IMPLEMENTATION OF THE SSHDP BY PRIORITY AREA

S/N	PRIORITY AREA	TOTAL COST
1	Leadership and Governance for Health	230,123,104.00
2	Health Service Delivery	4,526,546,302.00
3	Human Resources for Health	4,342,658,546.00
4	Financing for Health	1,002,152,356.00
5	Health Information System	1,946,546,124.00
6	Community Participation and Ownership	1,025,454,407.00
7	Partnerships for Health	1,000,637,333.00
8	Research for Health	3,566,234,890.00
Total		**17,640,353,062.00**

TABLE ___: EXPECTED CONTRIBUTIONS OF THE 33 LGAs IN OYO STATE TO THE IMPLEMENTATION OF THE SSHDP BY PRIORITY AREA

S/N	PRIORITY AREA	TOTAL COST
1	Leadership and Governance for Health	424,260,097.00
2	Health Service Delivery	5,201,360,092.00
3	Human Resources for Health	12,695,226,659.00
4	Financing for Health	1,608,448,567.00
5	Health Information System	1,630,759.605.00
6	Community Participation and Ownership	839,218,414.00
7	Partnerships for Health	1,167,330,551.00

8	Research for Health	1,989,426,518.00
Total		**25,556,030,503.00**

5.2 Assessment of the available and projected funds

TABLE ___: SHOWING HEALTH BUDGET

S/N	YEAR	STATE BUDGET	HEALTH BUDGET	AMOUNT RELEASED
1	2005	39,944,417,082.00	1,577,219,000.00	923,246,826.00
2	2006	60,798,055,785.00	1,217,747,450.00	1,604,822,823.90
3	2007	73,287,685,680.00	1,206,000,000.00	3,191,434,452.14
4	2008	92,647,450,210.00	3,849,435,551.00	1,167,776,640.54
5	2009	128,409,352,393.00	4,406,129,393.00	NA

The table above shows the relative increase in total health budget for the State in recent time though the amount released is low compared with the corresponding increase noticed in the budget allocation. It thus implies that Oyo State Government will be willing to give more if there are enough resources.

However, for the purpose of the development plan, the total cost estimate for SSHDP is ₦43,196,383,565.00 for the period of 6 years. Out of this sum, the State Government is expected to provide ₦17,640,353,062.00 while the thirty-three (33) LGAs will be required to make a combined contribution of ₦25,556,030,503.00 altogether.

Taking into account the dwindling statutory allocation to States occasioned by the global economic recession coupled with unstable oil price in the world market, it is expected that an average of ₦2,940,058,843.67 annually will be provided the State Government towards the health sector (i.e. ₦17,640,353,062.00 for the entire 6 years). In the same vein, each of the LGA's will be ready to provide the sum of ₦129,070,861.13 annually (i.e ₦25,556,030,503.00 for the entire 6 years). It thus implies that sincere and committed efforts at making the health sector viable and sustainable rest solely on both the State and Local Governments respectively.

5.3 Determining the financing gap

Despite the robust anticipation of Government commitment, the computation and forecast in the plan development might need to be shared noting dwindling resources in the face of competing needs. The State (including LGAs) should be able to budget an average of ₦4 Billion annually for the health sector. This is about ₦24 Billion for six years (2010-2015). Meanwhile the total budget for Oyo SSHDP is ₦43,196,383,565.00; hence the financing gap of ₦19,196,383,565.00

5.4 Closing the financing gap

The above sources of funds have been identified with a view to ensure appropriate mobilization of funds from each source for closing the financing gaps for SSHDP implementation in Oyo State.

It is noteworthy that Federal Allocation will remain the dominant source of funds for the implementation of SSHDP in Oyo State bearing in mind that it accounted for larger proportion of the income for the State. It should also be placed on record the

vulnerability of FAAC as a source of funding is already apparent due to shocks in the oil market occasioned by the current global economic meltdown. This is why IGR, which is far below the Federal Allocation is nevertheless a more stable and reliable source of financing for SSHDP. To this end the current drive for IGR by the present administration in State is a very welcome development that will, no doubt, boost the overall revenue of Oyo State.

Besides, Foreign Direct Investment will continue to be attracted, ODA will be welcomed from rich industrialized countries like the United Kingdom, Japan, USA (through their various developmental agencies) etc as well as from multi-lateral institutions like WHO, UNICEF, World Bank, African Development Bank, etc especially in the areas of funding for health system development and programme related activities, (HIV/AIDS, Malaria Control etc), provision of essential components of health care delivery services and facilities.

CHAPTER 6 IMPLEMENTATION FRAMEWORK

6.1 KEY ASSUMPTIONS IN THE IMPLEMENTATION OF THE STRATEGIES

The successful implementation of this Strategic Health Plan depends on the cooperation and commitment of all stakeholders within and outside the health sector. It is anticipated that all stakeholders will demonstrate practical commitment to the implementation of the above strategies, which will be measurable in terms of availability and adherence to prioritized and costed Annual Implementation Plans based on the strategic plan; and prompt allocation, disbursement and utilization of available funding and resource requirements. Other key assumptions include

- Good governance
- Political stability
- Availability and prompt release of funds
- Absent/limited political influence on programme implementation
- Freedom to adhere to guidelines as stated in the strategic health plan
- Willingness of all stakeholders to participate in the planning, implementation and evaluation of the Strategic Health Plan
- Motivated and adequate workforce
- Collaborative public/private partnership at State and Local government levels

KEY POLICY OBJECTIVES

6.2.1 GUIDING PRINCIPLES OF THE NATIONAL STRATEGIC HEALTH DEVELOPMENT PLAN

1. To strengthen capacity for active involvement of communities at all levels of health services delivery.
2. To provide support for equitable distribution of services and resources to those in greatest need based on evidence and to uphold the rights of consumers of health care, particularly vulnerable populations;
3. To provide voluntary and timely information to feed into the nationally agreed M&E framework to track, monitor and evaluate the national health system;

4. To work jointly towards complimentarily between health and related sectors (water and sanitation, basic education, infrastructure, etc), expanding utilization and delivery options and coordinating technical assistance;
5. To work in a result-focused and transparent manner, while employing participatory approaches that involve representation of all stakeholders, not only within the context of prevention, but beyond; and
6. To ensure that health development partners are well coordinated to ensure the effectiveness of aid.
7. To support the Federal Ministry of Health in discharging its mandate as the coordinating authority for health in Nigeria.

A number of interventions and strategies have been outlined for implementation within the planned period. The following are the key policy interventions with their corresponding key strategies:

Priority 1.0: LEADERSHIP AND GOVERNANCE

Strategies

1.1 Improved Strategic Planning at State and LGA levels.
1.2 Improve accountability and transparency
1.3 Enhance the performance of the health care system
1.4 To facilitate legislation and a regulatory framework for health development
1.5 Strengthen regulatory functions of government
1.6 To strengthen accountability, transparency and responsiveness of the state health system
1.7 To improve accountability and transparency
1.8 To enhance the performance of the state health system

PRIORITY 2.0: HEALTH SERVICE DELIVERY

Strategies

2.1 To ensure universal access to an essential package of care
2.2 To increase access to health care services
2.3 To improve the quality of health care services
2.4 To increase demand for health care services
2.5 To provide financial access especially for the vulnerable groups

PRIORITY 3.0: HUMAN RESOURCES FOR HEALTH

Strategies

3.1 To formulate comprehensive policies and plans for HRH for health development
3.2 To provide a framework for objective analysis, implementation and monitoring of HRH performance
3.3 To strengthen the institutional frameworks for human resources management practices in the health sector.

3.4 To strengthen the capacity of training institutions to scale up the production of a critical mass of quality, multipurpose, multi skilled, gender sensitive and mid-level health workers

3.5 To improve organizational and performance-based management systems for human resources for health

3.6 To foster partnerships and networks of stakeholders to harness contributions for human resource for health agenda

PRIORITY 4.0: HEALTH FINANCING

Strategies

4.1 To develop and implement health financing strategies at State and LGA levels consistent with the National Health Financing Policy

4.2 To ensure that people are protected from financial catastrophe and impoverishment as a result of using health services

4.3 To secure a level of funding needed to achieve desired health development goals and objectives at state and LGA levels in a sustainable manner

4.4 To ensure efficiency and equity in the allocation and use of health sector resources at state and LGA levels.

PRIORITY 5.0: NATIONAL HEALTH INFORMATION SYSTEM

Strategies

5.1 To improve data collection and transmission

5.2 To provide Infrastructural Support and ICT on Health Databases & Staff Training

5.3 To strengthen sub-systems in Health Information System

5.4 To Monitor and Evaluate the SHMIS

5.5 To strengthen analysis of data and dissemination of health information.

PRIORITY 6.0: COMMUNITY PARTICIPATION AND OWNERSHIP

Strategies

6.1 To strengthen community participation in health development

6.2 To empower communities with skills for positive health actions

6.3 To strengthen the community-health services linkages

6.4 To increase national capacity for integrated multi-sectoral health promotion

6.5 To strengthen evidence-based community participation and ownership efforts in health activities through researches

PRIORITY 7.0: PARTNERSHIPS FOR HEALTH

Strategies

7.1 To ensure that collaborative mechanisms are put in place for involving all partners in the development and sustenance of the health sector by 2011.

PRIORITY AREA 8: RESEARCH FOR HEALTH

Strategies

8.1 To strengthen the stewardship role of governments at state and LGA levels for research and knowledge management systems

8.2 To build institutional capacities to promote, undertake and utilize research for evidence-based policy making & programming in health at State and LGA levels

8.3 To develop a comprehensive repository for health research at state and LGA levels (including both public and non-public sectors)

8.4 To develop, implement and institutionalize health research communication strategies at state and LGA levels

CHAPTER 7 MONITORING AND EVALUATION LOGICAL FRAMEWORK

Implementation of the State strategic plan will be monitored at State and Local Government level. The steering committee of the state strategic health development plan will have the overall oversight responsibility for monitoring implementation of the plan.

The committee will set up a monitoring and evaluation team that will work with the Health management Information Systems (HMIS) Unit of the State Ministry of Health to develop a monitoring and evaluation framework in line with the M and E Strategic Plan.

A monitoring report will be compiled and presented at the annual stakeholders meeting of the State and National Council on Health (NCH). While at the state level, monitoring reports will be shared with all stakeholders at that level with copies of half yearly reports submitted to the National M and E observation at the Federal level.

Table below depicts some set of Monitoring and Evaluation indicators.

1.0 LEADERSHIP AND GOVERNANCE

Objective	Strategies	Indicators	Total Cost (₦)
1. To provide clear policy directions for health development	1.1 Improved Strategic Planning at State levels	All stakeholders are informed regarding health development policy directives by 2011	7,798,292
	1.2: Enhance the performance of the health care system	Increased number of health care personnel in state and LG health facilities.	
2.0.To facilitate legislation and a regulatory framework for health development	2.1: Strengthen regulatory functions of government	Health Bill signed into law by end of 2009	2,965,921
3.0: To strengthen accountability, transparency and responsiveness of the national health system	3.1: To improve accountability and transparency.	80% of States and the Federal level have an active health sector 'watch dog' by 2013	8,713,429
4.0. To enhance the performance of the national health system	4.1. Improving and maintaining Sectoral Information base to enhance performance	1. Oyo State (and their LGAs) updating SHDP annually. 2. Oyo State (and LGAs) has a costed SHDP by end 2011	880,000
TOTAL			20,357,641

2.0 Health Service Delivery

Objective	Strategies	Indicators	Total Cost (₦)
1. To ensure universal access to an essential package of care	1.1: To review, cost, disseminate and implement the minimum package of care in an integrated manner.	Minimum package of care available and disseminated	443,290,034
	1.2: To strengthen specific communicable and non communicable disease control programmes	Communicable and non communicable disease control programmes strengthened	
	1.3: To make Standard Operating procedures (SOPs) and guidelines available for delivery of services at all levels	1.0 Standard SOPs and guidelines available	
2.0. To increase access to health care services	2.1: To improve geographical equity and access to health services	1.0 Access to health services improved	3,142,963,814
	2.2: To ensure availability of drugs and equipment at all levels	1.0 Essential drugs are available at all times	
	2.3: To establish a system for the maintenance of equipment at all levels	1.0 Equipments are well maintained in the state and LGAs	
	2.4 To strengthen referral system	1.0 Reduction in morbidity and mortality rates	
	2.5 To foster collaboration with the private sector	1.0 Existence of a good collaboration with the private sector	
3.0 To improve the quality of health care services.	3.1:To strengthen professional regulatory bodies and institutions	1.0 80% of States and the Federal level have an active health sector 'watch dog' by 2013	3,111,347,384
	3.2 To develop and institutionalize quality assurance models	1.0 Quality assurance models are available	
	3.3 To institutionalize Health Management and Integrated Supportive Supervision (ISS) mechanisms.	1.0 Health Management and Integrated Supportive Supervision (ISS) mechanisms are institutionalized	

4.0. To increase demand for health care services	4.1To improve financial access especially for the vulnerable groups	1. Oyo State (and their LGAs) updating SHDP annually 2. Oyo State (and LGAs) has a costed SHDP by end 2011	366,262,803
5.0 To provide financial access especially for the vulnerable groups	To improve financial access especially for the vulnerable groups	1. Vulnerable groups identified and quantified by end 2010 2. Vulnerable people access services free by end 2015	2,438,807,809
TOTAL			**9,502,671,843**

3.0 HUMAN RESOURCES FOR HEALTH

Objective	Strategies	Indicators	Total Cost (₦)
1. To formulate comprehensive policies and plans for HRH for health development	1.1: To develop and institutionalize the Human Resources Policy framework	Human resource policy framework developed	5,924,923,624
	1.2: Reappraisal of the principles of Health work-force.	1.0 Principles of health work-force reappraised	
	1.3: Establishment and strengthening of human resources health unit	1.0 Human resource health unit established	
	1.4: Equitable distribution, right mix and retention of the right quality and quantity of health human resources	1.0 Health human resources are available and equally distributed	
2.0. To provide a framework for objective analysis, implementation and monitoring of HRH performance	2.1: To reappraise the principles of health workforce requirements and recruitment at all levels	1.0 Principles of health workforce requirements reappraised	111,598,481
3.0 Strengthen the institutional framework for human resources management practices in the health sector	*3.1:* To establish and strengthen the HRH Units	Established HRH units available at the state and LGA level	173,527,927
4.0. To strengthen the capacity of training institutions to scale up the production of a critical mass of quality, multipurpose, multi skilled, gender	4.1. To review and adapt relevant training programmes for the production of adequate number of community health oriented professionals based on national priorities	Reviewed and Adapted document for training programmes available at the state	472,474,901

sensitive and mid-level health workers	4.2 To strengthen health workforce training capacity and output based on service demand.	1.0 Training programmes are result oriented	
5.0 To improve organizational and performance-based management systems for human resources for health	5.1To achieve equitable distribution, right mix of the right quality and quantity of human resources for health	1.0 Oyo State has implemented performance management systems by end 2012	42,771,492
	5.2 To establish mechanisms to strengthen and monitor performance of health workers at all levels	1.0 Mechanisms for monitoring performance of health workers are available by end of 2012	
6.0 To foster partnerships and networks of stakeholders to harness contributions for human resource for health agenda	6.1 To strengthen communication, cooperation and collaboration between health professional associations and regulatory bodies on professional issues that have significant implications for the health system	Oyo State has regular HRH stakeholder forums by end 2011	1,167,856
TOTAL			**6,726,464,281**

4.0 FINANCING FOR HEALTH

Objective	Strategies	Indicators	Total Cost (₦)
1. To develop and implement health financing strategies at Federal, State and Local levels consistent with the National Health Financing Policy	1.1: To develop and implement evidence-based, costed health financing strategic plans at LGA, State and Federal levels in line with the National Health Financing Policy	Oyo State has a documented Health Financing Strategy by end 2012	82,284,566
	1.2: To develop and implement evidence-based, costed health financing strategic plans at LGA, State and Federal levels in line with the National Health Financing Policy		
2.0. To ensure that people are protected from financial catastrophe and impoverishment as a result of using health services	2.1: To strengthen systems for financial risk health protection	NHIS protects all Nigerians by end 2015	273,562,489
3.0 To secure a level of funding needed to achieve desired health development goals and objectives at all levels in a sustainable manner.	*3.1:* To improve financing of the Health Sector	Allocated State and LGA health funding increased by an average of 5% pa every year until 2015	42,387,122
	3.2: To improve coordination of donor funding mechanisms	Documents on all funded activities on health in Oyo State is available	

4.0. To ensure efficiency and equity in the allocation and use of health sector resources at all levels	4.1: To improve Health Budget execution, monitoring and reporting	1. Oyo State and LGAs have transparent budgeting and financial management systems in place by end of 2015 2. Oyo State and LGAs have supportive supervision and monitoring systems developed and operational by Dec 2012	662,499
	4.2 To strengthen financial management skills	Professionals are employed	
TOTAL			**398,896,677**

5.0 NATIONAL HEALTH INFORMATION SYSTEM

Objective	Strategies	Indicators	Total Cost (₦)
1.0 To improve data collection and transmission	1.1: To ensure that NHMIS forms are available at all health service delivery points at all levels	1. All LGAs making routine NHMIS returns to State level by end 2010 2. Oyo State making routine NHMIS returns to Federal level by end 2010	438,796,718
	1.2: To periodically review of NHMIS data collection forms	1. All LGAs making routine NHMIS returns to State level by end 2010 2. Oyo State making routine NHMIS returns to Federal level by end 2010	
	1.3: To coordinate data collection from vertical programmes	1. All LGAs making routine NHMIS returns to State level by end 2010 2. Oyo State making routine NHMIS returns to Federal level by end 2010	206,461,889
	1.4: To build capacity of health workers for data management	1. All LGAs making routine NHMIS returns to State level by end 2010 2. Oyo State making routine NHMIS returns to Federal level by end 2010	101,786,500
	1.5: To provide a legal framework for activities of the NHMIS programme	1. All LGAs making routine NHMIS returns to State level by end 2010 2. Oyo State making routine NHMIS returns to Federal level by end 2010.	85,548,740
	1.6: To improve coverage of data collection	1. All LGAs making routine NHMIS returns to State level by end 2010 2. Oyo State making routine NHMIS returns to Federal level by end 2010	84,252,145
	1.7: To ensure supportive supervision of data collection at all levels	1. Routine submission of NHMIS returns by all LGAs to State level by end 2010 2. Routine NHMIS returns to Federal by end 2010	4,739,051
2.0. To provide infrastructural support & ICT for	2.1: To strengthen the use of information technology in HIS	Information capacity training (ICT) infrastructure and staff capable of using HMIS in 50% of States by 2012	22,124,404

databases & staff training	2.2:To provide HMIS Minimum Package at all levels (SMOH, LGA) of data management	HMIS minimum package available at the LGAs	87,000,000
3.0 To strengthen sub-systems in Health Information System.	*3.1:* To strengthen the Hospital Information System	1. NHMIS modules strengthened by end 2010 2. NHMIS annually reviewed and new versions released	61,476,500 61,037,747
	3.2:To strengthen the Disease Surveillance System	1.0 Active disease surveillance present in the state	
4.0. To monitor and evaluate the State HMIS	4.1:To establish monitoring protocol for NHMIS implementation at all levels	1.0 State HMIS evaluated annually	395,087,560
5.0 To strengthen analysis of data &dissemination of health information	5.1 To institutionalize data analysis and dissemination at all levels	1. Oyo State has a Unit capable of analyzing health information by end 2010 2. Oyo State disseminates available results regularly	540,107
TOTAL			**962,853,083**

6.0 COMMUNITY PARTICIPATION AND OWNERSHIP

Objective	Strategies	Indicators	Total Cost (₦)

1.To strengthen community participation in health development	1.1 To provide an enabling policy framework for community participation	Policy framework reviewed by end of 2010	48,641,000
	1.2: To provide an enabling implementation framework and environment for community participation	1.0 Enabling implementation framework and environment for community participation provided by end of 2011	101,802,750
	1.3 To carry out advocacy and community sensitization of community members to the need of community participation in health development	1.0 Number of advocacy visits and sensitization held and reported by end of 2010	30,243,600
2.0. To empower communities with skills for positive health actions	2.1: To build capacity within communities to 'own' their health services.	1.0 Number of Ward Development Committee trained and their contributions to daily running of Health facilities by end of 2012	15,725,000
	2.2 To hold monthly data sharing and health education on emerging issues with community members	1.0 Minutes of data sharing meetings held	760,000
	2.3 To Identify and map out key community stakeholder for community participation in Health care delivery.	1.0 Number of stakeholders identified by end of 2010	24,166,250
	2.4 To carry out Quarterly community dialogue.	1.0 Number o f Quarterly community dialogue meetings held with minutes.	11,280,000
3.0 To strengthen the community - health services linkages.	*3.1:* To restructure and strengthen the interface between the community and the health service delivery points	1.0 Number of Health facilities restructured and strengthened per ward by the year 2011.	2,756,000
	3.2:To identify, review and improve existing linkages between health delivery structure and the community	1.0 Number of linkages identified	28,040,750
TOTAL			**263,421,350**

7.0 PARTNERSHIPS FOR HEALTH

Objective	Strategies	Indicators	Total Cost (₦)

1. To ensure that collaborative mechanisms are put in place for involving all partners in the development and sustenance of the health sector	1.1: To promote Public Private Partnerships (PPP)		**222,624,913**
	1.2: To institutionalize a framework for coordination of Development Partners		
	1.3 To engage professional groups		
	1.4 To engage with communities		
	1.5 To engage with traditional health practitioners.		
TOTAL			**222,624,913**

8.0 RESEARCH FOR HEALTH

Objective	Strategies	Indicators	Total Cost (₦)

1. To strengthen the stewardship role of governments at all levels for research and knowledge management systems	1.1: To develop health research policies at State and LGA levels	1. ENHR Committee established by end 2009 to guide health research priorities 2. SMOH publishes an Essential Health Research agenda annually from 2010	**1,540,749,693**
	1.2: To establish and or strengthen mechanisms for health research at all levels	Mechanisms for health research established	
	1.3:To institutionalize processes for setting health research agenda and priorities	Health research agenda and priorities institutionalize	
	1.4:To promote cooperation and collaboration between Oyo state Ministry of Health and LGA health authorities with Universities, communities, CSOs, OPS, NIMR, NIPRD, development partners and other sectors	Obvious Collaboration between stakeholders	
	1.5:To mobilise adequate financial resources to support health research at all levels	Funds available for health research at State and LGA levels	
	1.6:To establish ethical standards and practice codes for health research at all levels	Ethical standards and practice codes available at State and LGA	
2.0. To build institutional capacities to promote, undertake and utilize research for	2.1: To strengthen identified health research institutions at all levels	health research institutions strengthened	**200,277,033**
	2.2: To create a critical mass of health researchers at all levels	Availability of health researchers at all levels	

evidence-based policy making in health at all levels	2.3: To develop transparent approaches for using research findings to aid evidence-based policy making at all levels	Policy making is evidenced based and transparent	
	2.4: To undertake research on identified critical priority areas	Research undertaken in critical priority areas	
3.0 To develop a comprehensive repository for health research at all levels (including both public and non-public sectors).	*3.1:* To develop strategies for getting research findings into strategies and practices.	GRIPS Unit established	**49,513,419**
	3.2: To enshrine mechanisms to ensure that funded researches produce new knowledge required to improve the health system	Research undertaken in critical priority areas	
4.0. To develop, implement and institutionalize health research communication strategies at all levels	4.1: To create a framework for sharing research knowledge and its applications	A state health research communication strategy is in place by end 2012	**361,185,112**
	4.2 To establish channels for sharing of research findings between researchers, policy makers and development practitioners	A state health research communication strategy is in place by end 2012	
	To utilize health research findings to develop interventions	A state health research communication strategy is in place by end 2012	
TOTAL			

CHAPTER 8 CONCLUSION

All partners, including governments, donors and civil society need to align around an agreed set of instruments and approaches for achieving sector goals and adequate sector financing. The forum provided by this state input to the NSHDP is a welcome development and should be sustained.

Achieving the health MDGs will require support for more equitable strategies in the health sector and society generally as well as efforts to ensure that health has a more prominent place in economic and development policies. There is need for more budgetary allocation for health and for actual releases of the allocated funds regularly to allow progress in solving priority problems; there is great need now more than ever before for building capacity in leadership, management and institutional capacity within the ministries of health especially in strategic planning and budgeting; there is need for greater dialogue between health and other line ministries like finance and planning as development is an intersectoral and interdependent process. The participation of National Planning Commission in the preparation of this document again is a welcome development

If the foregoing interventions as detailed in the attached work plan are faithfully implemented, it will impact positively on the accelerated achievements of the MDGs in Oyo State in line with national and global goals and also position the State for continuous quality improvements in health care even beyond 2015.

Annex 1: Details of Oyo State Strategic Health Development Plan

OYO STATE STRATEGIC HEALTH DEVELOPMENT PLAN						
PRIORITY						
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**TOTAL EXPENDITURE 2010-2015**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
LEADERSHIP AND GOVERNANCE FOR HEALTH							
1. To create and sustain an enabling environment for the delivery of quality health care and development in Nigeria							**654,540,417**
	1.1	**To provide clear policy directions for health development**			**All stakeholders are informed regarding health development policy directives by 2011**		**252,705,138**
		1.1.1	Improved Strategic Planning at Federal and State levels				**79,776,819**
			1.1.1.1	Adaptation of the national health strategic policy	Availability of the adapted policy document	Poor Governance, political instability,Global economic meltdown	2,399,618
			1.1.1.2	Formalise the adapted document	Availability of the adapted policy document	"	-
			1.1.1.3	Print and distribute the adapted document	Availability of the reviewed document to stakeholders	"	63,989,822
			1.1.1.4	Disseminate information on policy document through workshops to stakeholders at various levels	Number of dissemination workshops organised for stakeholders	"	13,387,379
		1.1.3	Improve accountability and transparency				**127,656,912**
			1.1.3.1	Establishment of stakeholders forum to meet biannually for dialogue at State and LGA levels	20 man stakeholders forum inaugurated	"	23,514,868
			1.1.3.2	Strengthening through biannual workshops of the legislative arms of state and local governments to perform their oversight function on health budget tracking.	Number of workshops held	"	27,034,308
			1.1.3.3	Reproduction and distribution of 1000 (all stakeholders at State and LG levels) of the value reorientation component of the State Economic Empowerment Development Strategy (SEEDS) document.	The proportion of the stakeholders that have the documents	"	74,228,194
			1.1.3.4	Organise quarterly dissemination workshops to four (4) groups at State and LGA levels on the information of value reorientation component of the SEEDS document.	Number of dissemination workshops organised for stakeholders	"	2,879,542
		1.1.4	Enhance the performance of the health care system				**45,271,407**
			1.1.4.1	Identify and adopt at least four (4) policies that encourage operational research relevant to health	Number of policies identified and adopted		14,477,001
			1.1.4.2	Develop or review a state protocol to regularly collect and utilise the research findings	Availability of a state protocol on collection and utilisation of research findings.		15,116,900
			1.1.4.3	Organize advocacy workshops for law makers and policy makers on the need for adequate manpower in all state owned and local govt. health care delivery outlets	Increased number of health care personnel in state and LG health facilities.		6,718,931
			1.1.4.4	Establishment of a forum of stakeholders on siting and equipping of state and local govt. health facilities	Number of meetings held		6,079,033

			1.1.4.5	Establishment of a salary and wages commission in the Office of the Governor for remuneration and motivation packaging for health care personnel in the state	Commission established by 2010	Political Will	2,879,542
	1.2	**To facilitate legislation and a regulatory framework for health development**			**Health Bill signed into law by end of 2009**		**94,894,371**
		1.2.1	Strengthen regulatory functions of government				**94,894,371**
			1.2.1.1	5yrly review, updating and adoption of the existing policy on public-private partnership for health.	5- yearly availability of adopted PPP document on health to stakeholders		11,277,510
			1.2.1.2	Review, update and adopt the existing policy on public Health Laws in Nigeria to align with current realities e.g environmental health issues, patent medicine vendors (PMVs.)	Meeting held . Availability of the reviewed Public Health Law document		25,874,485
			1.2.1.3	Harmonize the existing database through training of the private health practitioners on the state HMIS	Training held	Availability of fund: collaboration with private practitioners	54,862,834
			1.2.1.4	Enact a law to regulate the training and pratice of traditional birth attendants by Dec of 2010.	Gazetting of the enabling law that regulates the training and practice of TBAs	Political Will	2,879,542
			1.2.1.5	Sponsoring a memo to the national council of health for regular periodic review of all policies guiding the training of different health proffessionals in various health institution to align with internationally acceptable standards	The presentation of the memo at National Council on Health	Political Will	-
	1.3	**To strengthen accountability, transparency and responsiveness of the national health system**			**80% of LGA have an active health sector 'watch dog' by 2013**		**278,785,386**
		1.3.1	To improve accountability and transparency				**278,785,386**
			1.3.1.1	Establishment of stakeholders forum on budget tracking at the state and LGA levels	20 man stakeholders forum inaugurated	Funding collaborations	3,039,517
			1.3.1.2	Biannual meeting of the stakeholders' forum	Number of meetings held	Funding collaborations	19,835,453
			1.3.1.3	Strengthening the legislative arms of state and local governments to perform their oversight function on health budget tracking through biannual workshop	Number of workshops held	Funding; political will	145,864,800
			1.3.1.4	Reproduction and distribution of 1000 copies of the value reorientation component of the State Economic Empowerment Development Strategy (SEEDS) document.	1000 copies produced and distributed	Funding; political will	55,022,808
			1.3.1.5	Organise quarterly sensitization workshops to stakeholders' groups at State and LGA levels on the information of value reorientation component of the SEEDS document.	Number of sensitization workshops organised held	Funding; political will	55,022,808
	1.4	**To enhance the performance of the national health system**			**1. 100% of LGAs updating SHDP annually**		**28,155,522**
		1.4.1	Improving and maintaining Sectoral Information base to enhance performance				**28,155,522**
			1.4.1.1	Creating a forum for annual review of results and analysis obtained from field workers to inform policy and reforms in health	Forum created by the second quarter 2010	Poor Political Will	7,038,880
			1.4.1.2	Strenghtening and equiping the zonal health offices in their function as feedback mechanism to leadership as well as organ of intervention to health service delivery	Adequate allocation for the zonal offices reflected in 2010 budget	Poor Political Will	7,038,880
			1.4.1.3	Strengthen the DPRS at State and LGA levels to initiate, coordinate and utilise research findings through workshops, seminars and meetings.	Number of orientation workshops held	Poor Political Will	7,038,880

			1.4.1.4	Review and adopt functional Central Coordinating Entities (CCE) for proper coordination of the activities of development partners and government.	Quarterly meetings of CCE		7,038,880
HEALTH SERVICE DELIVERY							0
2. To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare							**35,185,802,160**
	2.1	**To ensure universal access to an essential package of care**			**Essential Package of Care adopted by all LGAs by 2011**		**1,641,382,097**
		2.1.1	To review, cost, implement and disseminate the minimum package of care in an integrated manner				**284,926,635**
			2.1.1.1	Review the state health policy document to include the minimum health package	**Availability of the reviewed state health policy document on the minimum package of care.**	**Bureaucracy and political commitment**	43,945,510
			2.1.1.2	Train 100 health workers quarterly on the implementation of minimum package of care in an integrated manner.	**No of health workers that are trained on minimum health care package by year 2010**	**Training fund**	175,391,113
			2.1.1.3	Establishing a committee to cost the implementation of the state minimum package of care	**existence of a committee to cost the implementation of the minimum health care package by year2010**	**Distraction by committee**	15,298,607
			2.1.1.5	Quartetly supportive monitoring of implementation of minimum health care package.	**No of quarterly visit to LGA**	**funding, attrition**	50,291,404
		2.1.2	To strengthen specific communicable and non communicable disease control programmes				**1,174,476,372**
			2.1.2.1	Advocacy to law makers and Executive council for political support.	**No of advocacy visits carried out.**	**political commitment.**	14,465,630
			2.1.2.2	Purchase 4 vehicles for monitoring and office furnishing for the four major communicable disaeses programmes (computers-laptops/desktops, etc) printers,photocopiers,paper (A4))	**No of vehicles bought. No of offices furnished.**	**inavailability of vehicles for monitoring. Poorly equipped and furnished offices.**	116,487,800
			2.1.2.3	Provide Health promotion and preventive services for non-communicable diseases at LGA level	**% of PHC facilities providing health promotion and preventive services for non-communicable diseases by year 2010.**	**lack of manpower and equipment**	42,671,731
			2.1.2.4	Yearly update training (on quaterly basis) of health providers on current management of communicable and non-communicable diseases	**Proportion of Health providers trained.**	**leaving for better service.Emerging diseases. New trend in management.**	764,380,237
			2.1.2.5	Empowerment of the community members on healthy living through enlightenment.	**1)No of radio jingles aired per quarter.2) No and type of IEC materials produced.**	**Lack of information on healthy living**	236,470,974
		2.1.3	To make Standard Operating procedures (SOPs) and guidelines available for delivery of services at all levels				**181,979,091**
			2.1.3.1	Design standard operating procedures for different areas of health care provisions.	**No and type of standard operating procedure guidelines produced.**	**Limited specialist for optimal care.**	10,859,963
			2.1.3.2	Provide adequate copies of the SOPs and guidelines in all health facilities.	**No of heath facilities with adequate copies of SOPs by first quarter of 2011.**	**absent SOPs at HFs**	31,843,455

			2.1.3.3	Training of health providers on use of SOP	proportion of Health providers trained onSOP.	Limited knowledge on use of SOP.	102,999,093
			2.1.3.4	Carry out monitoring and supervisory activities to service delivery centers to ensure compliance with standard operating procedure and guidelines.	**No of quarterly report of monitoring activities received.**	**Limited fund and personnel.**	36,276,581
	2.2	**To increase access to health care services**			**50% of the population is within 30mins walk or 5km to a health service by end 2011**		**11,637,537,819**
		2.2.1	To improve geographical equity and access to health services				**3,592,673,267**
			2.2.1.1	Establish geographical Information System(GIS) for all health facilities in the state.	**Available GIS by first quarter of 2011**		172,732,227
			2.2.1.2	Review and make functional criteria for siting new health facilities through health committees at the state and L .G .A.	**Available criteria developed by first quarter of 2011.**	**frictions. poor cooperation.**	36,510,434
			2.2.1.3	Enhanced statutory allocation for the maintenance of health facilities.	**Regular monthly release of fund (allocation)**	**Lack of fund for facility maintenance.**	14,465,630
			2.2.1.4	Develop and implement guideline for outreach services	**No of outreach services conducted per year.**	**overburdening of staffs**	36,510,434
			2.2.1.5	upgrade and rehabilitate 5 Health facilities per LGA and construct 2 new health facilities per zone to provide minimum package of care	**No of health facilities rehabilitated per LGA. No of newly constructed HFs per zone by the end 2015.**	**Cost,available land,many HFs are in poor condition hence the need for repair. Also, accessibility to HFs is a challenge in some areas of the state.**	3,332,454,542
		2.2.2	To ensure availability of drugs and equipment at all levels				**3,859,409,480**
			2.2.2.1	Review the state essential drug list and ensure that all health facilities have it.	**1. Availability of a reviewed essential drug list by year 2010. (2) No. of health facilities with the newly reviewed list of the essential drugs by year 2010.**	**theft, Disregard the list**	36,510,434
			2.2.2.2	Review, repackage and adopt the drug revolving scheme	**(1) Commencement of DRF scheme at health facility level by 2nd quarter of 2010.(2) % of drugs available at each facilities purchased through DRF scheme by 4th quarter of 2010.**	**resistance by political stakeholders.Absc ence of stock-out syndrome.**	36,510,434
			2.2.2.3	Provide minimum equipment with specification for different levels of health facilities.	**(1) No of HFs with minimum equipments by year 2010.**	**Lack of essential equipments in our HFs.**	3,702,727,269
			2.2.2.4	Set up a committee to monitor adherence by all health facilities.	**Quarterly report of the committee commencing from 2nd quarter of 2011**	**victimisation, poor commitment**	41,830,672
			2.2.2.5	Strengthen and empower the state task force on fake and substandard drugs.	**% reduction of fake and substandard drugs in circulation in the state by 2012**	**abuse of power, poor support**	41,830,672
		2.2.3	To establish a system for the maintenance of equipment at all levels				**2,058,624,791**

			2.2.3.1	Ensure release of fund for maintenance of equipment and furniture.	Proportion of demand for maintenance of equipment and furniture.	leakages of fund	1,863,881,630
			2.2.3.2	Establish medical equipment and furniture maintenance workshop at each of the 6 health zones.	No. of zones with functional maintenance workshop by year 2013.	technical expertise, funding	111,081,818
			2.2.3.3	Establish a public private partnership for procurement and maintenance of hospital equipment and furniture.	% of hospital equipment maintained through private partnership by year 2012	profilteering.	41,830,672
			2.2.3.4	monitor status of furniture and medical equipment in all health facilities.	No of non-functional but serviceable equipment by end of 2013.	equipments are kept in store to showcase when dignitaries are around.Purchase/repairs are not of good quality.	41,830,672
		2.2.4	To strengthen referral system				**1,806,697,963**
			2.2.4.1	Reorientation of health personel at all levels of care on the two way referal system.	**No of training and retraining that have been organized for all cadres of health workers in the state by year 2012**	**Knowledge gap on two way referral system**	9,512,635
			2.2.4.2	Provide adequate referral forms in all HFs.	**1. Available redesigned referral form by 3rd quarter of 2010. (2) No of health facilities with the redesigned form by year 2011.(3)number of staff trained per year.**	**inavailability of referral forms**	4,398,840
			2.2.4.3	Establish and sustain a process of monitoring referral outcomes.	**No of documented feedback received per year commencing from 2010.**	**dishonesty**	14,440,636
			2.2.4.4	Provision of good communication system	**1) No of health facilities with a minimum of 1 functional phone by year 2010**	**theft, misapplied usage**	1,332,982
			2.2.4.5	Provision of transportation and other logistics for referrals.	**1) No of HFs with functional ambulance by year 2010. 2)Availability of an imprest for refferal purposes at each health facility.**	**wrong and bad usage,maintenance,corruption**	1,777,012,871
		2.2.5	To foster collaboration with the private sector				**320,132,318**
			2.2.5.1	strengthening of the supportive supervisory mechanism to the private health sector.	**no of supervisory visits to registered private health facilities per year starting year 2010**	**misjudged actions, quackery**	41,830,672
			2.2.5.2	Encourage regisration of all private health care premises.	**Availability of yearly updated list of private health care facilities from 2011**	**non-compliance and quackery**	236,470,974
			2.2.5.3	Encourage public private partnership in health care provision(in drug procurement, planning and implementation of activities)	**No of reports with evidence of public private collaboration**	**Conflict of interest. Inflated budget**	41,830,672
	2.3	**To improve the quality of health care services**			**50% of health facilities participate in a Quality Improvement**		**11,520,470,800**

					programme by end of 2012		
		2.3.1	To strengthen professional regulatory bodies and institutions				**8,968,715,551**
			2.3.1.1	Create a budget line for financial and other logistics support of the professional bodies and institutions.	% of health budget allocated for financial and logistics support to professional bodies by year 2011	poor supervision, bribery	-
			2.3.1.2	Conduct regular training for staff of the bodies.	No of training sessions organised per year starting from 2010		-
			2.3.1.3	provision of necessary security support for regulatory bodies	No of regulatory visits done with the accompaniment of security personnel per year with effect from 2010	drop out of professional, conflicts	27,390,035
			2.3.1.4	Rehabilitation and Equiping of ALL State Hospitals and Children Hosp.			7,432,844,573
			2.3.1.5	Procurement of Ambulances to ALL state Owned Hospitals			1,508,480,943
		2.3.2	To develop and institutionalise quality assurance models				**1,832,032,334**
			2.3.2.1	Develop health quality assurance guidelines for the state.	Availability of a quality assurance guidelines for the state by year 2010		26,326,701
			2.3.2.2	Establish quality assurance unit for effective service delivery.	1) % of clients making complaints /year 2) Available time book at each facility level.3) Available suggestion boxes at all health facilities.	job loss	1,155,250,908
			2.3.2.3	Providing training oportunities for health workers on total quality management.	No of health workers that received training on total quality management per year starting from 2010		650,454,725
		2.3.3	To institutionalize Health Management and Integrated Supportive Supervision (ISS) mechanisms				**719,722,916**
			2.3.3.1	Training of programme managers at all levels on the ISS mechanisms.	No of Programme Managers trained on ISS mechanisms by year 2012		650,454,725
			2.3.3.2	Development of ISS tools and guidelines specifying modalities and frequencies of the ISS at all levels	1)Available checklist by year 2010. (2) Existence of guidelines on ISS document by year 2010.		26,326,701
			2.3.3.3	Strengthening the management capabilities through team building and leadership development programmes	No of team building and leadership development programmes that have taken place by year 2012		1,110,818
			2.3.3.4	Introduction of health management courses into the curiculum of health institutions	No of institution doing health management course.	overloaded syllabus	41,830,672
	2.4	**To increase demand for health care services**			**Average demand rises to 2 visits per person per annum by end 2011**		**1,356,171,267**
		2.4.1	To create effective demand for services				**1,356,171,267**
			2.4.1.1	Review, disseminate and implement the state health behavioural change communication strategy	1) existence of a reviewed state strategy on by year 2010. (2) percentage of	shelf decay, decoration	42,440,199

					health workers that have been trained on the new statet health promo tion strategy by year 2012. (3)increase in utilization of health services by year2015		
			2.4.1.2	pay advocacy visits to stakeholders at the community level and mobilize the community	number of advocacy visits paid into the community per each local government by year 2011	rejection of personality .	12,466,157
			2.4.1.3	Capacity building to improve skill of health providers	No of community mobilization activities undertaken by 2011	need to keep abreast of advancing technology	650,632,456
			2.4.1.4	Carry out social marketing strategies	Increase in the No of new consummers.	Lack of fund	-
			2.4.1.5	Train health personnel at all levels of care on interpersonal communication	**No of staff trained /year**	**Poor inter-personal relationship**	650,632,456
	2.5	**To provide financial access especially for the vulnerable groups**			**1. Vulnerable groups identified and quantified by end 2010 2. Vulnerable people access services free by end 2015**		**9,030,240,176**
		2.5.1	To improve financial access especially for the vulnerable groups				**9,030,240,176**
			2.5.1.1	wide spread distribution of the existing state health policy on vulnerable group	% of vulnerable group with access to free health services by year 2015	poor cooperation from staff.Malingering	370,273
			2.5.1.2	Implementation of NHIS and CHIS at the state and LGA	No of health facilities listed on the scheme by year 2012.	abandonment of PHC	7,416,588,822
			2.5.1.3	Regular statutory fund allocation to meet the needs of the vulnerable groups.	No of LGA and HFs with such acount by the end of year 2010	leakages of fund.	800,085,308
			2.5.1.4	Implementation of free health programmes like free eye examination and surgery,free hernia harvest.	No of hernia repaired	leakage of fund	813,195,774
			2.5.1.5				-
HUMAN RESOURCES FOR HEALTH							
3. To plan and implement strategies to address the human resources for health needs in order to enhance its availability as well as ensure equity and quality of health care							**25,414,006,976**
	3.1	**To formulate comprehensive policies and plans for HRH for health development**			**All LGAs are actively using adaptations of the National HRH policy and Plan by end of 2015**		**22,385,616,577**
		3.1.1	To develop and institutionalize the Human Resources Policy framework				**854,059,845**
			3.1.1.1	Review and adopt Human Resources Policy document.	Availability of the adopted policy document on Human resources to all the stakeholders year 2015.	Delay in implentation	5,719,050
			3.1.1.2	Strenthening of planning ,statistics and research units in LGA through supply of equipment.	No. Personnel trained; Equipment supplied, Records of Data generated	Accidental loss of data	111,589,487
			3.1.1.3	Providing Inservice Training on short and long term basis	50 officers per year (300 officers for six years)	Breaking of Bond and Depletion of Service	736,751,308

			3.1.2.2	Creating of relevant health personnel to areas of needs/specialties instead of arbitary posting	Compliance to posting instructions	Refusal of posting instruction	-
			3.1.2.3	Re-introduction of study leave with pay,trainning grants and sabbatical leave for health personnel	provision of enabling circulars	Abuse of opportunities	1,360,156,262
			3.1.2.4	Review saiaries and wages according to dictation of the economic situation of the country	Circular on review of salary in line with State civil service scale	Inflation	30,016,703
		3.1.3	Establishment and strengthening of human resources health unit				**598,518,439**
			3.1.3.1	Adoption of human resources health units in major health facilities	Reviewed Document	Delay in implentation	30,016,703
			3.1.3.2	Adoption of Planning,Research and Statistics with Medical Record Uiit to maintain adequate record for accessi bility.	Reviewed Document	Victimization, Witchunting, Window Dressing to cover up shortcoming	29,752,228
			3.1.3.3	Recruitment of Trained Relevant Personnel to man HR unit in the Department of Planning, Research and Statistics		Political Influence resulting in recruiting non-qualified personnels.	538,749,508
		3.1.4	Equitable distribution,right mix and retention of the right quality and quantity of health human resources				**192,206,680**
			3.1.4.1	Placement of health personnels based on health needs of the community,population and service patronage	Compliance to posting instructions	Non compliance to posting instructions	-
			3.1.4.2	Harmonization of salaries and allowances as with that of federal workers	Enabling circular from the government	inflation	779,225
			3.1.4.3	Provision of social ammenities in rural areas	Provsion of basic ammenities such as electricity,good road,and schools	Over-Staffing	191,427,455
		3.1.5	Strengthening,comminication,cooperation and collaboration between health professional associations and regulatory bodies on professional issues that have significant implications for the health system				**311,871,374**
			3.1.5.1	Organize orientation and reorientation work shops on professional issues to promote team work among all health professionals	50 officers per year (300 officers for six years)	Abuse of opportunities.	283,365,888
			3.1.5.2	Hold regular meetings in order to create a forum for the head of health and health related professionals to come together.	minute of meeting and Report	Intra and inter cadre Conflict	11,504,213
			3.1.5.3	Promote regular inter ministrial meetings among health and health related stakeholders .	Number of meetings held	Risk of inconsistency	17,001,273
			3.2.1.1	Establish a coordinating HRH unit that will develop, introduce and utilize staffing norms based on workload, service availability and health sector priorities.	Established coordinating unit by 2012	Inadequate funding	54,112,360
			3.2.1.2	Establish a review committee that will regulate entry criteria and admission quotas of prospective health care providers into training institutions .	Review committee set up by 2012	Noncompliance with regulations	367,530,342
	3.3	**Strengthen the institutional framework for human resources management practices in the health sector**			**1. 100% of LGAs have functional HRH Units by end 2010**		**655,625,269**
		3.3.1	To establish and strengthen the HRH Units				**655,625,269**
			3.3.1.1	Establish a stakeholder's forum on HR management practices in the health sector.	Forum established	Political will	410,041,500
			3.3.1.2	Strengthening the HRH units through regular training programmes in human resource for health planning and management	Number of meetings held	Political will	245,583,769

	3.4	**To strengthen the capacity of training institutions to scale up the production of a critical mass of quality, multipurpose, multi skilled, gender sensitive and mid-level health workers**			**One major training institution per Zone producing health graduates with multipurpose skills and mid-level health workers by 2015**		**1,785,110,264**
		3.4.1	To review and adapt relevant training programmes for the production of adequate number of community health oriented professionals based on national priorities				**273,825,529**
			3.4.1.1	Establish a commitee that will hold regular meetings to review the functions and mandates of HRH regulatory bodies.	Number of meetings held	Inconstitency	9,350,700
			3.4.1.2	Organize special training programmes for community health workers and other cadres of supportive personnel .	Number of programmes held and No of personnel trained.	Intercadre and intracadre conflict	132,237,414
			3.4.1.3	Design special training programmes aimed at producing adequate cadres of health professionals in critical areas of need.	Number of programmes designed.	Inadequate funding	132,237,414
		3.4.2	To strengthen health workforce training capacity and output based on service demand				**1,511,284,735**
			3.4.2.1	Organize training programmes for the workforce on capacity building.	Number of training programmes held	Inconsistency	264,474,829
			3.4.2.2	Establish a review committee to update training curricula of identiied training institutions.	Review Committee established	Delayed implementation	680,078,131
			3.4.2.3	Organize continuing professional development programmes from time to time to enhance capacity building	Number of programmes held	Abuse of opportunities	566,731,776
	3.5	**To improve organizational and performance-based management systems for human resources for health**			**100% of LGAs have implemented performance management systems by end 2012**		**161,599,758**
		3.5.1	To achieve equitable distribution, right mix of the right quality and quantity of human resources for health				**127,202,885**
			3.5.1.1	Create a database of HRH from which staff will be redeployed equitably between rural and urban areas.	Database created	Problem of logistics	114,763,185
			3.5.1.2	Adapt for implementation the existing HRH policy at the state and LG levels.	Regulatory body established	Political will	10,881,250
			3.5.1.3	Create a forum of collaboration between the state MoH and federal institutions in the state in order to leverage available HR so as to expand sevice coverage and quality.	Forum created	Problem of logistics	1,558,450
		3.5.2	To establish mechanisms to strengthen and monitor performance of health workers at all levels				**34,396,873**
			3.5.2.1	Conduct training and retraining programmes on Interpersonal Communication skills and ethics for health workers.	Number of programmes conducted	Poor adherence to guidelines	33,626,085
			3.5.2.2	Institute a system of recognition, reward and sanctions for HRH which will serve as a supervisory body for health workers	System instituted	Logistics	389,613
			3.5.2.5	Establish mechanisms to monitor performance of health workers	Monitoring mechanism established	Political will	381,175
		3.5.3					**-**
	3.6	**To foster partnerships and networks of stakeholders to harness contributions for human resource for health agenda**			**100% of LGAs have regular HRH stakeholder forums by end 2011**		**4,412,406**
		3.6.1	To strengthen communication, cooperation and collaboration between health professional associations and regulatory bodies on				**4,412,406**

			professional issues that have significant implications for the health system				
			3.6.1.1	Strengthen communication,cooperation and collaboration between health professional associations and regulatory bodies by establishing a forum of stakeholders .	Meeings held	Inconsistency	3,392,332
			3.6.1.2	Establish a forum of collaboration between management and staff of public and private sectors.	Forum established.	Inconsistency	1,020,075
FINANCING FOR HEALTH							
4. To ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and consumption at Local, State and Federal levels							**599,719,827**
		4.1.1	To develop and implement evidence-based, costed health financing strategic plans at LGA, State and Federal levels in line with the National Health Financing Policy				**77,248,584**
			4.1.1.1	Setting up of technical working group in the State and all LGAs on Health Financing Strategies.	30 man committee formed	Political will	3,778,913
			4.1.1.2	Capacity buliding for the development and implementation of the Strategic plans at all levels in the state	total number of capacity building workshop held	Funds Availability	1,276,990
			4.1.1.3	State MOH to provide technical assistatnce on health financing strategies to the LGAs	Capacity building workshop held	Funds Availability and Technical know how	40,202,160
			4.1.1.4	Establishing a Health Finance monitoring committee at the state level	Monitoring committee constituted and inaugurated	Political commitment	1,934,748
			4.1.1.5	Advocacy visit to be carried out to all respective government functionaires in the State and LGAs to support initiative	Reports of series of advocacy held	Funds and political will	30,055,774
		4.1.1	To develop and implement evidence-based, costed health financing strategic plans at LGA, State and Federal levels in line with the National Health Financing Policy				**46,461,863**
			4.1.1.6	Advocacy visit at the state level to the legislative body on health financing	Reports of series of advocacy held	Funds and political will	27,665,294
			4.1.1.7	Advocacy visit at the LGA level to the relevant stakeholders on health financing	Reports of series of advocacy held	Funds and political will	18,796,569
	4.2	**To ensure that people are protected from financial catastrophe and impoverishment as a result of using health services**			**NHIS protects all citizen of the State by end 2015**		**411,286,576**
		4.2.1	To strengthen systems for financial risk health protection				**379,545,066**
			4.2.1.1	Technical meeting with HMOs on the operational procedure of NHIS	Minutes of the meetings held	Availability of funds; willingness of the HMOs to collaborate	2,499,480
			4.2.1.2	Strenthening the state implementation team on NHIS through capacity building (10 members)	Number of trainings attended;	Availability of Funds	13,884,328
			4.2.1.3	Capacity buiding for 135 state and 165 LGAs key health officials on NHIS	Total numbers of health workers trained	Availability of funds	26,024,659
			4.2.1.4	Scaling up processs of the NHIS in the state by extpanding the coverage in the LGAs	Total numbers of LGAs operating NHIS	Strong political will	138,422,317
			4.2.1.5	Establishing community based health insurance scheme in all the LGAs in the state	Documented evidence of the LGAs on Community health insurance scheme	Community accaptance	198,714,282
		4.2.2	Continue with 4.2.1 Intervention				**31,741,510**
			4.2.2.1	Scalling up of the NHIS (informal sector) into 2 LGAs per year	Total number of LGAs with NHIS involving informal sectors	Acceptability by the people	31,741,510
			4.2.2.3	Adoption of NHIS laws establishing health insurance scheme in Oyo state	Passed law on Health insurance scheme	Political stability	-
	4.3	**To secure a level of funding needed to achieve desired health development goals and objectives at all levels in a sustainable manner**			**Allocated State and LGA health funding increased**		**63,726,772**

					by an average of 15% per year until 2015		
		4.3.1	To improve financing of the Health Sector				**25,614,404**
			4.3.1.1	Advocacy meeting with legislators to enlist their support for adequate budgetry provision for health (15% of the yearly budget)	Reports of series of advocacy held	Strong political will to promote qualitative health; poor revenue generation.	13,763,112
			4.3.1.2	Production of a legal document mandating 15% of the LGA monthly allocation for health	A released circular on source funding for health	Availability of funds	1,174,943
			4.3.1.3	Advocacy towards the Estabilishing a separate account for the PHC at the LGA level	Seed fund in a designated account	political will	2,597,204
			4.3.1.4	Advocacy on the Legislation of 2.5% of VAT to health sector	A singed bill health tax	Dwindling IGR	4,039,572
			4.3.1.5	Special Health tax legislation of 2.5% on specified companies for non communicable chronic diseases	A singed bill on company health tax	Double taxation	4,039,572
		4.3.2	To improve coordination of donor funding mechanisms				**38,112,368**
			4.3.2.1	Documentation of all collaborating partners and funded activities on health in Oyo State	Document available	Cooperation from partners.	498,956
			4.3.2.2	Stakeholders forum on support for health in the state	Number of fora held and attendance list.	political will, cooperation of the partners.	6,182,922
			4.3.2.3	Inaugurate a coordinating committee for support on health funding	A committee formed and inaugurated	All interest represented	3,526,522
			4.3.2.4	Coordinating committee to assess needs,determine outcome of previous interventions and determine possible areas of intervention.	Report of assesment from M&E	logistic support	27,903,968
	4.4	**To ensure efficiency and equity in the allocation and use of health sector resources at all levels**			**1. 100% LGAs have transparent budgeting and financial management systems in place by end of 2015 2. 100% of LGAs have supportive supervision and monitoring systems developed and operational by Dec 2012**		**996,033**
		4.4.1	To improve Health Budget execution, monitoring and reporting				**747,024**
			4.4.1.1	Establishment of a Technical Team for health budget execution at State level	Technical team established	Adherence to the workplan and availabilty of funds	-
			4.4.1.2	Provision of logistic support for teachnical team on health budget execution	report on heath activities executed	Availability of funds	249,008
			4.4.1.3	Empowerment of the Medical Officers of Health for strict health vote control at the LGAs through routine organization of stakeholders forum	Number of workshops held with reports	Adherence to financial procedures at the LGAs level	-
			4.4.1.4	Formation of a Technical Team for Health Budgeet execution at LGAs level	Team formed	Bureacracy and funds availability	249,008
			4.4.1.5	Provision of logistic support for teachnical team on health budget execution	report on heath activities executed	Availability of funds	249,008
		4.4.2	To strengthen financial management skills				**249,008**
			4.4.2.1	Setting up a working committee to carry out Training Need Assessment of health workers	committee established	Adequate budget provision	-
			4.4.2.2	In service training courses and Sabaticals for health workers	Number of staff sent for training		249,008

			4.4.2.3	Right sizing and appropriate staffing of health staff exercise	Reprot of exercise conducted		-
			4.4.2.4	Re organization and Strenghtening of various Parastatals, Departments and Agencies in the MOH	Availability of report		-
NATIONAL HEALTH INFORMATION SYSTEM							
5. To provide an effective National Health Management Information System (NHMIS) by all the governments of the Federation to be used as a management tool for informed decision-making at all levels and improved health care							**981,810,625**
	5.1	**To improve data collection and transmission**			**1. 100% of LGAs making routine HMIS returns to State level by end 2010 2. 60% of States making routine NHMIS returns to Federal level by end 2010**		**446,926,309**
		5.1.1	To ensure that NHMIS forms are available at all health service delivery points at all levels		Availability of sufficient NHMIS data collection forms at all the facilities (Public & Private)		**46,088,403**
			5.1.1.1	Annual production of the required number of NHMIS forms by the State for use at the 4 levels of data collection (Community, health facilites, LGA and State).	Availability of sufficient NHMIS data collection forms at all the facilities (Public & Private)	**Positive response of all stakeholders.**	41,063,125
			5.1.1.2	Bi-annual distribution of the forms to the 33 LGAs.	Availability of the forms at LGAs at all time.	**Funds and transportation to enhance distribution**	5,025,279
			5.1.1.3	Distribution to all health facilities within each local government on request as at when needed.	Availability of forms at health facilities and community level	**Availability of transportation.**	-
		5.1.2	To periodically review of HMIS data collection forms		**HMIS data committe established and performing**		**1,091,932**
			5.1.2.1	Establishment of HMIS data collection review committee	**HMIS data committe established and performing**	**Inter-sectoral collaboration**	686,520
			5.1.2.2	Annual review of the HMIS forms	**Availability of review reports**	**Funds**	405,412
		5.1.3	To coordinate data collection from vertical programmes		**Number of meetings held**		**210,526,901**
			5.1.3.1	Inauguration of stakeholders forum educating them on the importance of data collection and collaboration.	**Stakeholders forum inaugurated**	**Funds.**	561,601
			5.1.3.2	Monthly meeting of programme oficers, SHMISO, State and LGA M&E officers for harmonization of data format.	**Number of meetings held**	**Duplication of efforts.Inter-programme collaboration.**	5,597,334
			5.1.3.2	Developing a structured pattern of retreiving data (data flow system) from private facilities and vertical programmes.	**Established structure for retreiving data from private facilities and vertical programme**	**Duplication of effort / Postive response**	143,394
			5.1.3.3	Annual feedback meetings with private facilities to disseminate data.	**Annual feedback meeting**	**Funds, good collaborative network**	143,394
			5.1.3.5	Construction and Equipping of State M&E office	**Office constructed**	**Funds**	204,081,179
		5.1.4	To build capacity of health workers for data management		Training held		**10,998,875**
			5.1.4.1	Target - oriented and performance - based training of newly employed health workers.	Number of trained newly employed health workers	Availability of resource persons and funding.	5,829,817

			5.1.4.2	Annual training and re-training on the importance of data management and HMIS for all health workers at State, LGA and Ward levels	Training held	Availability of resource persons and funding.	5,169,058
		5.1.5	To provide a legal framework for activities of the HMIS programme				**87,233,103**
			5.1.5.1	Passing of a bill proposing sanctions on private health care providers/ donor driven programmes who refuse to comply with data collection/submission in the State.	Law enacted and gazetted	**Acceptability by the State House of Assembly**	41,124,306
			5.1.5.2	Passing a bill against health data falsification.	Law enacted and enforced	"	41,124,306
			5.1.5.3	Instituting appropriate corrective measure for late submission of health data in excess of 2 weeks after stipulated time.	Letter of Warning issued	**Cooperation by stakeholders**	4,984,491
		5.1.6	To improve coverage of data collection				**86,154,737**
			5.1.6.1	Maintenance of State & 6 Zonal Banks, LGA Data Bank (Vehicle, MotorBike, Photocopier).	Availability of motorable cycles	Availability of fund	52,515,092
			5.1.6.2	Provision and maintenance of internet facilities to all LGAs to facilitate prompt data collection and dissemination.	Availability of internet facilities	Availability of funds	25,263,905
			5.1.6.3	Provision of computers and assessories to the remaining 17 LGAs yet to be supplied.	Availability of computers in the remaining 17 LGAs.	Funds	3,488,448
			5.1.6.4	Monthly verification visit by M& E and DSNO to health facility (Public and private)	Report of visits to the health facilities.	fund for Logistics	605,567
			5.1.6.5	Provision and maintenenace of generators for State and LGAs data bank.	Availability of generators in all 33 LGAs	Availability of fund and fuel	4,281,726
		5.1.7	To ensure supportive supervision of data collection at all levels				**4,832,358**
			5.1.7.1	Quarterly supervision by state HMIS and M&E officers to LGAs for data verification using a checklist	Availability of Quarterly Report	Availability of logistics	4,832,358
	5.2	**To provide infrastructural support and ICT of health databases and staff training**			**ICT infrastructure and staff capable of using HMIS in all LGAs by 2012**		**111,272,946**
		5.2.1	To strengthen the use of information technology in HIS		ALL M&E must know how to use computer efficiently before 2010		**22,560,009**
			5.2.1.1	Annual training and re-training of the 6 zonal officers and 33 LGA M&E officers on information technology.	Training held	Availability of funds	8,124,117
			5.2.1.2	Maintenance of the State HMIS website (Quarterly update)	Functional website	Funds and availability of network	1,712,110
			5.2.1.3	Payment of subscription for internet at the State level	Constant availability of network services	Funds	12,480,025
			5.2.1.4	Annual re-deploying appropriate staff to strengthen the State HMIS and M&E units.	Redeployment done.	Availability of funds. Intrasectoral collaboration	243,758
			5.2.1.5				-
		5.2.2	To provide HMIS Minimum Package at the different levels (SMOH, LGA) of data management		Availability of the items listed before 2010.		**88,712,937**
			5.2.2.1	Procurement of photocopiers (2), scanning machine, vehicles (1), utility bus at the state level.	Availability of the items listed.	Availability of funds	10,553,780
			5.2.2.2	Maintenance of photocopiers, scanning machine, vehicles (1), utility bus at the state level.	Functioning equipments	"	2,447,253
			5.2.2.3	Employment of 2 HMI specialists, public health specialist(1), computer programmer(1), system manager(1), user-services staff(1), data entry and processing clerks(3), office assisitant(3),statisticians(2),system administrator(1) at the state level.	Presence of listed personnel	Availability of funds	75,711,903

	5.3	**To strengthen sub-systems in the Health Information System**			**1. HMIS modules strengthened by end 2010 2. NHMIS annually reviewed and new versions released**		**124,926,469**
		5.3.1	To strengthen the Hospital Information System		Number of health workers trained.		**62,686,955**
			5.3.1.1	Training of the records officers for state owned health facilities on the importance of data collection, collation and dissemination.	Number of health workers trained.	Availability of established records structure at the health facilities	8,124,117
			5.3.1.2	Strengthening of medical records office by redeployment of trained staff	Availability of trained staff at the records offices	Embargo on employment	243,758
			5.3.1.3	Provision of desktop computers and accessories to 52 state-owned facilities	Availability of computers and accessories to the 52 facilities	Funds	13,255,956
			5.3.1.4	Printing and distribution of data collection tools (case notes, treatment cards, continuation sheets and OPD registers to all health facilities).	Availability of data collection tools at the health facilities.	Availability of fund. Co-operation of the HMB.	41,063,125
		5.3.2	To strengthen the Disease Surveillance System				**62,239,514**
			5.3.2.1	Annual printing of the DSN forms.	Availability of Disease survallance forms	Availability of fund	41,124,306
			5.3.2.2	Training of disease surveillance officers on effective epidemic surveillance, the need for prompt response and delivery of data, proper filling of forms and understanding of the case definitions.	Training held	Availability of funds	5,829,817
			5.3.2.3	Training of surveillance officers on effective data collection, dissemination, interpretation and analysis.	Training held	Availability of funds	5,829,817
			5.3.2.4	Provision of electronic tools for for effective disease surveillance data colllection and wide area transfer. e.g companion laptops with internet facility, calculators, telephones.	Availability of electronic tools and internel facility	Availability of funds	9,455,575
	5.4	**To monitor and evaluate the HMIS**			**HMIS evaluated annually**		**298,134,159**
		5.4.1	To establish monitoring protocol for HMIS programme implementation at all levels in line with stated activities and expected outputs				**298,134,159**
			5.4.1.1	Adoption of the Federal NHMIS protocol to the State	Availability of the adopted protocol	Availability of funds	498,890
			5.4.1.2	Production and dissemination of the protocol to other stakeholders	Printed protocol disseminated	Funds	41,124,306
			5.4.1.3	Provision of 33 vehicles for monitoring and evaluation at the LGA level.	Availability of M&E vehicles in each LGA	Availablity of funds	254,922,231
			5.4.1.4				-
			5.4.1.5	Co-ordinating the data flow system from the community ---> Health facilities----> LGA M&E officer ----> State HMIS officer.	Regular submission of data	Availlability of fund	1,588,732
		5.4.2	To strengthen data transmission				**-**
	5.5	**To strengthen analysis of data and dissemination of health information**			**1. 100% of LGAs have Units capable of analysing health information by end 2010 2. All States disseminate available results regularly**		**550,741**
		5.5.1	To institutionalize data analysis and dissemination at all levels				**550,741**

			5.5.1.1	Quarterly meeting of all stakeholders at state and local government level i.e the State Director PRS, HMIS and M&E officers, the State data analysts, statisticians, the 33 LGA MOH and M&E officers.	Quarterly Report on the meeting held	Availability of fund	306,983
			5.5.1.2	Deployment of data anaylst to each LGA PHC department	Availabilty of data analyst at the LGA PHC.	Funds	243,758
COMMUNITY PARTICIPATION AND OWNERSHIP							0
6. To attain effective community participation in health development and management, as well as community ownership of sustainable health outcomes							**654,540,417**
	6.1	**To strengthen community participation in health development**			**All States have at least annual Fora to engage community leaders and CBOs on health matters by end 2012**		**448,980,694**
		6.1.1	To provide an enabling policy framework for community participation		Policy framework reviewed by end of 2010		**120,861,503**
			6.1.1.1	Organise workshop EVERY 5 YEAR to review the existing policies to reflect current realities on community participations	workshop done	Lack committiment on the part of policy makers, fund	29,705,875
			6.1.1.2	Produce (2000 copies) and use the reviewed policy document for dessemination workshop for the policy makers in the state and LGA levels t(Executive council,legistrative council.judicial council and traditional council)	2000 copies of the reviewed policy document produced and used forworkshop	Fund and logistics	27,916,843
			6.1.1.3	3 day Capacity building (Retraining)for 60 members of the State Social mobilization committee/WDC etc .	no. of SMC/WDC trained	Limited understanding of available framework for community participation	63,238,786
		6.1.2	To provide an enabling implementation framework and environment for community participation		Enabling implementation framework and environment for community participation provided by end of 2011		**252,956,013**
			6.1.2.1	Organise 1 day annual dissemination workshop(on zonal basis) on the reviewed policies and guidrline on community participation to10 stakeholders from each local government area (330 in all)	annual dissemination workshop organised	policy abandonement, fund,political will	89,220,493
			6.1.2.2	Establish quaterly supportive supervisory visits for WDC meetings at the LGAs	quaterly supervisory visits carried out	commitment and fund, logistics	18,292,847
			6.1.2.3	Listing and mapping of eligible proposed members of WDC in all wards of all the LGA through a 5 day workshp for CDI, MOH, WFP, WDCsChairman(where there is existing WDC) (10 member ADHOC COMMITTEE).	list of proposed members of WDCs in all Wards of the LGA.	Fund and logistics	67,442,761
			6.1.2.4	Inauguration and 2-day training of 10 member WDCs in all wards in the LGA through policy statement/pronouncement by the MOH with endorsement from LGSC	WDCs formed	Fund and logistics, resistance to change. PRESSURE FROM DEVELOPMENT PARTNERS, APARTHY.	60,556,854
			6.1.2.5	Ensure institutionalisation of monthly meeting of WDCs through directive from the SMOH with endorsement of the ministry of local government and local government service commission.	Directive issued on institutionalisation of WDC monthly meeting.	Fund and logistics, beaurocracy.	17,443,057
		6.1.3	To carry out advocacy and community sensitization of community members to the need of community particpation in health development		number of advocacy visits and sensitization held and reported by end of 2010		**75,163,178**

			6.1.3.1	Produce one (1) drama scripts quarterly through working with ministry of information, media houses& performing artists on community participation	scripts produced	fund,logistics	30,698,290
			6.1.3.2	Airing of jingles 3times weekly for a year in Yoruba languages on community participations	No.of jingles produced	fund,logistics	23,033,781
			6.1.3.3	Generate quarterly press release on support obtain from opinion leaders and paramount leaders	no. of press release generated	fund,logistics	21,431,107
	6.2	**To empower communities with skills for positive health actions**			**All LGAs offer training to FBOs/CBOs and community leaders on engagement with the health system by end 2012**		**129,037,005**
		6.2.1	To build capacity within communities to 'own' their health services		Number ofWard Development Committe trained and their contributions to daily running of Health facilities by end of 2012		**39,072,946**
			6.2.1.1	Organise 1-day quarterly training-of-trainners workshop for the 33-LGA focal health workers on prevailing health issue who in turn will train the WDCs during their monthly meetings.	no of WDC,VDCS trained	fund,logistics	39,072,946
		6.2.2	To hold monthly data sharing and health education on emerging issues with community members		Minutes of data sharing meetings held		**1,888,422**
			6.2.2.1	re establish an ensure monthly meeting of the PHC management commiittee with the principal medical officer at the general hospital included.	meeting held	fund,logistics	1,888,422
		6.2.3	To Identify and map out key community stakeholder for community participation in Health care delivery.		Number of stakeholders identified by end of 2010		**60,047,477**
			6.2.3.1	Continuous resource identification for mobilisation for community participation to be done 5- times a year exercise as may be necessary by a 10- member ad-hoc Committee.	list of proposed members of WDCs in all Wards of the LGA.	Fund and logistics	54,630,687
			6.2.3.2	Bi annual Advocacy visits to the identified stakeholders(religious leaders,leaders of notable groups and organization , community leaders AND POLITICAL LEADERS) (10 member advocacy commiittee)at each LG level	visit made	logistics	5,416,790
		6.2.4	To carry out Quarterly community dialogue .		Number o f Quarterly community dialogue meetings held with minutes.		**28,028,161**
			6.2.4.1	Identification of relevant social group e.g landlord association,Egbe omo Ilu,philanthropists andCBOs.	relevant social group identified	fund,logistics	1,677,217
			6.2.4.2	5 visits per quarter to the identified social groups at their permanent meeting places by the PHC technical committee member (5 members) for community dialogue		Visits made	26,350,944
	6.3	**To strengthen the community - health services linkages**			**50% of public health facilities in the State and all LGAs have active Committees that include community representatives by end 2011**		**76,522,718**
		6.3.1	To restructure and strengthen the interface between the community and the health services delivery points		Number of Health facilities restructured and strengthened per ward by the year 2011..		**6,848,015**

			6.3.1.1	Constitute a zonal forum of Leaders of Ward Development Committee (WDC) to facilitate exchange of experience THROUGH QUARTERLY MEETING	Forum of Leaders of WDC constituted	Commitment of the WDC FUND	-
			6.3.1.2	Organize workshop to review the existing guidelines for strenghteneing the Community Health services linkages once in 5-years	Meeting held	Fund, Logistics, Commitment	4,835,355
			6.3.1.3	To establish and ensure monthly meeting of the PHC management committee with principal medical officer at the respective public health facilities	meeting held	Fund, Logistics, Commitment	2,012,660
		6.3.2	To identify,review and improve existing linkagesbetween health delivery structure and the community		Number of linkages identified		**69,674,702**
			6.3.2.1	1- day monthly training of WDC and VDCS members in all wards of 33 LGAS on their health services			8,273,028
			6.3.2.2	Regular update training of 5Health workers from each LGA on prompt attention for referred cases bi-anually on zonal bases			20,760,220
			6.3.2.3	Strengthen capacity of Community Members on Home Based Care and prompt referral			22,626,900
			6.3.2.4	Strengthening of Community Extension Health Workers to conduct home visit.			18,014,554
		6.3.3					**-**
PARTNERSHIPS FOR HEALTH							0
7. To enhance harmonized implementation of essential health services in line with national health policy goals							**654,540,417**
	7.1	**To ensure that collaborative mechanisms are put in place for involving all partners in the development and sustenance of the health sector**			**1. SMOH has an active ICC with Donor Partners that meets at least quarterly by end 2010 2. SMOH has an active PPP forum that meets quarterly by end 2010 3. All States have similar active committees by end 2011**		**654,540,417**
		7.1.1	To promote Public Private Partnerships (PPP)				**30,552,613**
			7.1.1.1	Appoint PPP Focal Officer, Constitute & Inaugurate PPP Committee at State level	Focal Officer appointed; PPP Committee constituted & inaugurated	Fund, Lack of political commitment	3,247,345
			7.1.1.2	Identify private sector organisations to be mobilized	No of Private Sector organisations idfentified		3,035,657
			7.1.1.3	Advocacy visits/meeting with umbrella body of private sector organisations (MAN, Chamber of Commerce and Industry, etc)	No. of visit/meetings held; Reports of meetings.	Logistics	1,808,686
			7.1.1.4	Inaugurate PPP forum	Inauguration done & Report of inauguration		3,629,558
			7.1.1.5	Quarterly meeting of PPP forum	No of meeting held in a year	Lack of commitment by private sectors	18,831,367
		7.1.2	To institutionalize a framework for coordination of Development Partners				**30,366,681**
			7.1.2.1	Advocacy meeting with representatives of Development Partners in the State (15 participants)	Readiness or willingness of Development Partners to buy into State Plan	Centralisation of partners authority	1,406,656
			7.1.2.2	2 day workshop on harmonization of work plan of development partners (10 Member Committee)	Documents on the Harmonization of the Work plan of Development Partners	Centralisation of partners authority	1,293,646
			7.1.2.3	Inaugurate Partners' Forum	Documents on the Forum inaugurated	Commitment on the part of partners	1,367,148

			7.1.2.4	Quaterly M&E meeting and Partners' forum	No of partners' meeting held in a year	Logistics	17,317,213
			7.1.2.5	Annual Review meeting (20 Member review Committee)	Meeting held	Logistics	8,982,018
		7.1.3	To facilitate inter-sectoral collaboration				**497,757,417**
			7.1.3.1	One day seminar to orientate on mainstreaming health care services into relevant ministries' activities (25 participants)	No of sectoral agencies mainstreaming health care delivery into their activities	Fund	1,773,618
			7.1.3.2	Biannual State Council on Health meetings involving relevant ministries, departments and agencies	No of sectoral agencies participated in State Council on Hrealth	Political will	469,134,769
			7.1.3.3	Networking among line ministries (one Coordinator)	No of sectoral agencies networking with one and another	Fund, Networking knowledge among sectoral agencies	4,269,031
			7.1.3.4	Bi-annual Inter-sectoral agencies meetings (30 Participants)	No of meeting held in a year	Fund	22,579,999
			7.1.4.1	Mobilization of representatives of professional groups	Professional groups mobilised and sensitised	Fund	73,503
			7.1.4.2	Training and retraining of professionals on team building and networking	No. of people trained and No of training conducted.	Logistics	3,531,112
			7.1.4.3	Periodic management meeting with representatives of professional groups	No of meetings with representatives of professional groups	Lack of cooperation	1,620,044
		7.1.5	To engage with communities				**4,001,529**
			7.1.5.3	Facilitate requlr meeting of community health committee	No of active Community Health Committees	Logistics	735,026
			7.1.5.4	Logistic support to community health committee	No of active Community Health Committees		-
			7.1.5.5	State joint meeting (quarterly) of representatives of community health committee	No of communities represented at joint meeting	Political interference	588,021
		7.1.6	To engage with traditional health practitioners				**86,637,517**
			7.1.6.1	One day sensitization meeting for traditional health practitioners' leaders (2 THP/LGA) to mobilize them for positive health actions	Meeting held	Fear of unknown of the outcome of the programme on the part THP	39,973,655
			7.1.6.2	Empower Traditional Health practitioner advisory board with managerial and supervisory skills	Enhanced Management and regulatory skills of board members	Fund	2,793,099
			7.1.6.3	Annual Listing and mapping of THPs in the Community in each of the 33 local government areas.	No of traditional health practitioners listed	Political interference fear of unknown by the THPs and fund	40,019,227
			7.1.6.4	Training and retraining of THP to ensure standardisation of service	No of skilled THP engaging in standard health practice	Fund	3,851,536
RESEARCH FOR HEALTH							0
8. To utilize research to inform policy, programming, improve health, achieve nationally and internationally health-related development goals and contribute to the global knowledge platform							**1,309,080,833**
	8.1	**To strengthen the stewardship role of governments at all levels for research and knowledge management systems**			**1. ENHR Committee established by end 2009 to guide health research priorities 2. SMOH publishes an Essential Health Research agenda annually from 2010**		**937,371,482**

		8.1.1	To develop health research policies at State and LGA levels				**2,521,108**
			8.1.1.1	The development of health research policies and strategies for the State and LGA-hiring 2 consultants in health policy development	A policy is developed and disseminated by the end of 2010		401,535
			8.1.1.2	Holding 6 sessions of stakeholders meeting for 22 people			1,948,312
			8.1.1.3	Production and dissemination of 250 copies of the policy document			171,261
		8.1.2	To establish and or strengthen mechanisms for health research at all levels				**426,476,513**
			8.1.2.1	Strengthening department of planning research and statistics by employing 2 epidemiologists,4 research officers, 6 research assistants,1 IT proffessional	2 epidemiologists, 4 research officers, 6 research assistance 1 IT proffessional are employed by 2011		270,656
			8.1.2.2	Establishing active research units to undertake operations research and other research related activities in LGA-by having a office`complex for research, 5 computers, 2printers,1 vehicle for monitoring,internet access,telephone, fax machines in all 33 LGA	Active Research unit established in LGAs by end of 2011		401,535,162
			8.1.2.3	Strengthening the research unit of the DPRS by having an Office complex,10 Computers, 2 Vehicles, 4 printers,Internet access, fax machines,telephones	Research findings being used for policy making by 2011		24,670,695
		8.1.3	To institutionalize processes for setting health research agenda and priorities				**488,789,938**
			8.1.3.1	Build and equip a state owned institute of health research and training	There should be a complex on ground in the state for the institute by 2012		487,569,915
			8.1.3.2	Employment of 4 epidemiologists, 4 research officers, 10 research assistants, 4 IT professionals, 5 administrative officers	Availability of listed manpower by 2012		884,792
			8.1.3.3	Develop guidelines for collaborative health research and expand health research agenda to include broad and multidimentional health determinats-Hold 4 sessions of meetings with 16 stakeholders,publish and disseminate guidelines	Published guidelines for collaborative research should be available to all health establishments by the end of 2010		335,231
		8.1.4	To promote cooperation and collaboration between Oyo state Ministry of Health and LGA health authorities with Universities, communities, CSOs, OPS, NIMR, NIPRD, development partners and other sectors				**3,821,421**
			8.1.4.1	Establish strong links between research users e.g. policy makers and research producers e.g.universities-hold quaterly meetings with researchers with relevant findings-4 session of meetings for 16 people	The State research unit should have held 4 meetings for research users and producers by the end of the year 2011		1,319,438
			8.1.4.2	Establish a forum of health research officers at the SMOH and LGA with annual convening of stakeholders to identify research priorities and harmonise research efforts-annual meeting for 50 people	By the end of year 2010, there should be an annual meeting of stakeholders already holding		834,090
			8.1.4.3	Support the development of collaborative research proposals and their implementation between government and private health research organisations-4 sessions of meetings for 16 people, and monthly meeting for 12	By the end of year 2011, already developed research proposals between government and private health research organisations must be available		1,667,892
		8.1.5	To mobilise adequate financial resources to support health research at all levels				**1,081,488**

			8.1.5.1	To ensure compliance with the African government recommendation that at least 2% of health budget be allocated for health research in state and LGA -annual meeting between the DPRS and budget section	2% of the health budget allocated to health research from 2010		54,799
			8.1.5.2	Targeted deployment of health research funds, while expanding beneficiaries of funding to researchers from both public and non public health research organisations and individuals- Quaterly meeting with HCH,DPRS,DF&A,Research unit	Health research funds available to both public and non public health research organisations and individuals by 2011		290,626
			8.1.5.3	Opportunities for accessing funds from bilateral and multilateral organisations should be explored-involve adequate writing of proposals by 4 research officers	Funds from donor agencies for health research received by 2011		736,063
		8.1.6	To establish ethical standards and practise codes for health research at all levels				**14,681,013**
			8.1.6.1	Strengthening of Ethical standards and practice codes for health research should be at the state level-ethical committee meetings-1 meeting per month for 15 members,developing of a legal framework(2 lawyers)	monthly ethical standards and practice codes meetings are held by 2010.legal framework available by end of 2011		1,564,327
			8.1.6.2	Monitoring and evaluation system to regulate research and use of research findings in the State should be strengthened-2 monitoring vehicles,4 research officers	Functioning M and E system for research by end of 2010		13,116,686
	8.2	**To build institutional capacities to promote, undertake and utilise research for evidence-based policy making in health at all levels**			**SMOH has an active forum with all medical schools and research agencies by end 2010**		**121,845,865**
		8.2.1	To strengthen identified health research institutions at all levels				**6,623,878**
			8.2.1.1	To identify health research instituiitions by inventory of all public and private instituitions and organisations undertaking health research-4 officers of the research unit (on quarterly basis) 5 days/4 times in a year	Document showing an inventory of all health research institutions in the state available by end of 2010		1,384,698
			8.2.1.2	Strengthen identified health research instituitions in other to produce research outputs that are relevant for policy making (Subscription for journals,equiping the DPRS research library-20 computers,2 photocopiers,2 printers)	Relevant research findings are availabe for policy making by end of 2010		2,367,242
			8.2.1.3	Periodic capacity assessments of health research organisations and instituitions should be carried out by monthly travel to research organisations by 4 officers			540,616
			8.2.1.4	The state, development partners and health research organisations and instituitions should develop and implement measures to address identified research capacity gaps and weaknesses-bi-annual meetings with 16 stakeholders.	Research capacity gaps and weaknesses are identified and addressed on regular basis,reports of which will be submitted to the research units from end of 2010		2,331,322
		8.2.2	To create a critical mass of health researchers at all levels				**96,733,471**
			8.2.2.2	Provide competitive research grants for 33 prospective researchers every year.	By the end of 2011, 33 health researchers should have received grants from the state		60,230,274
			8.2.2.3	Motivate increased PhD training in health in tertiary instituitions through award of PhD studentship scholarships for at least 10 students every year	10 students have received PhD student scholarship by the end of 2011		36,503,197
		8.2.3	To develop transparent approaches for using research findings to aid evidence-based policy making at all levels				**2,331,322**
			8.2.3.2	Close liason and close linkage between research users (e.g. policy makers , development partners) and	Quaterly meetings of research users and		2,331,322

				researchers should be established. Bi annual meetings between stakeholders	researchers holding by the end of 2010		
		8.2.4	To undertake research on identified critical priority areas				**16,157,193**
			8.2.4.1	Strengthen the health system, by undertaking research on critical areas already identified by different for a.	By the end of 2013, critical areas of the health system are addressed using research findings		16,157,193
	8.3	**To develop a comprehensive repository for health research at all levels (including both public and non-public sectors)**			**1. Oyo State has a Health Research Unit by end 2010 2. State Health Research Units manage an accessible repository by end 2012**		**30,123,301**
		8.3.1	To develop strategies for getting research findings into strategies and practices				**13,966,108**
			8.3.1.2	Getting research into strategies and practices (GRISP) units should be established.by having a office for`GRISP, 4 officers, 5 computers, 2printers,internet access,telephone, fax machines	A GRISP unit established by the end of 2011		11,634,786
			8.3.1.3	Bi annual health research -policy forums should be instituted	Bi annual policy documents available by 2011		2,331,322
		8.3.2	To enshrine mechanisms to ensure that funded researches produce new knowledge required to improve the health system				**16,157,193**
			8.3.2.1	Needs assessment to identify required health research gaps should be conducted	By the end of 2011,a needs assessment is conducted by the research unit		16,157,193
	8.4	**To develop, implement and institutionalize health research communication strategies at all levels**			**A state health research communication strategy put in place by end 2012**		**219,740,186**
		8.4.1	To create a framework for sharing research knowledge and its applications				**214,569,029**
			8.4.1.1	Research outputs must be communicated to large audiences for them to be meaningful	By the end of 2011, research journals are easily accessible to researchers		6,570,575
			8.4.1.2	A framework for sharing research knowledge should be developed holding 4 sessions of meeting for 16 people.	By the end of 2011, research journals are easily accessible to researchers		465,613
			8.4.1.3	Annual health conferences, seminars and workshop on key thematic areas sholud be convened	By the end of 2011, an annual health conference on key thematic areas is held		75,975,320
			8.4.1.4	Opportunities for international collaboration on national research agenda both in terms of ensuring research findings from the State are published and presented in other countries and that research updates from other countries are available	Research produced nationally are published in international journals while international journals are easily accessible by the end of 2013		1,971,173
			8.4.1.5	Motivate researchers from state and LGA to participate in international conferences on health and mainstream best practices.	Researchers are being sponsored for international conferences by the end of 2011		129,586,348
		8.4.2	To establish channels for sharing of research findings between researchers, policy makers and development practitioners				**4,258,706**
			8.4.2.1	Encourage and support subscription to national and international journals.	Research produced nationally are published in		2,920,256

					international journals while international journals are easily accessible by the end of 2013		
			8.4.2.2	Support the publication of research findings in high quality national and international journals.	Research produced nationally are published in international journals while international journals are easily accessible by the end of 2013		608,387
			8.4.2.3	Selected national journals should be disseminated to all stakeholders	By 2013, research journals are easily accessible to stakeholders		730,064
		8.4.3	To utilize health research findings to develop interventions				**912,450**
			8.4.3.1	Health research findings must be made available to national primary health care development agency (NPHCDA) and development partners by the state's research unit	By 2013, NPHCDA is receiving research findings from development partners and state research unit		912,450
Total							**65,454,041,672**

Annex 2: Results/M&E Matrix for Oyo Strategic Health Development Plan

OYO STATE STRATEGIC HEALTH DEVELOPMENT PLAN RESULT MATRIX						
***OVERARCHING GOAL*: To significantly improve the health status of Nigerians through the development of a strengthened and sustainable health care delivery system**						
OUTPUTS	***INDICATORS***	***SOURCES OF DATA***	***Baseline***	***Milestone***	***Milestone***	***Target***
			2008/9	***2011***	***2013***	***2015***
PRIORITY AREA 1: LEADERSHIP AND GOVERNANCE FOR HEALTH						
NSHDP Goal: To create and sustain an enabling environment for the delivery of quality health care and development in Nigeria						
OUTCOME: 1. Improved strategic health plans implemented at Federal and State levels						
OUTCOME 2. Transparent and accountable health systems management						
1. Improved Policy Direction for Health Development	1. % of LGAs with Operational Plans consistent with the state strategic health development plan (SSHDP) and priorities	LGA s Operational Plans	0	50	75	100%
	2. % stakeholders constituencies playing their assigned roles in the SSHDP (disaggregated by stakeholder constituencies)	SSHDP Annual Review Report	0	25	50	75%
2. Improved Legislative and Regulatory Frameworks for Health Development	3. State adopting the National Health Bill? (Yes/No)	SMOH	0	25	50	75
	4. % of LGAs enforcing traditional medical practice by-laws	LGA Annual Report	0	25%	50%	75%
3. Strengthened accountability, transparency and responsiveness of the State health system	5. % of LGAs which have established a Health Watch Group	LGA Annual Report	0	50	75	100
	6. % of recommendations from health watch groups being implemented	Health Watch Groups' Reports	No Baseline	25	50	75
	7. % LGAs aligning their health programmes to the SSHDP	LGA Annual Report	0	50	75	100
	8. % DPs aligning their health programmes to the SSHDP at the LGA level	LGA Annual Report	No Baseline	50	75	100
	9. % of LGAs with functional peer review mechanisms	SSHDP and LGA Annual Review Report	0	25	50	75%
	10. % LGAs implementing their peer review recommendations	LGA / SSHDP Annual Review Report	No Baseline	50	75	100%
	11. Number of LGA Health Watch Reports published	Health Watch Report	0	50	75	100
	12. Number of "Annual Health of the LGA" Reports published and disseminated annually	Health of the State Report	TBD	50	75	100%
4. Enhanced performance of the State health system	13. % LGA public health facilities using the essential drug list	Facility Survey Report	TBD	40	80	100%

	14. % private health facilities using the essential drug list by LGA	Private facility survey	TBD	10	25	50%
	15. % of LGA public sector institutions implementing the drug procurement policy	Facility Survey Report	TBD	50	75	100%
	16. % of private sector institutions implementing the drug procurement policy within each LGA	Facility Survey Report	TBD	10	25	50%
	17. % LGA health facilities not experiencing essential drug/commodity stockouts in the last three months	Facility Survey Report	TBD	25	50	75%
	18. % of LGAs implementing a performance based budgeting system	Facility Survey Report	TBD	25	50	75%
	19. Number of MOUs signed between private sector facilities and LGAs in a Public-Private-Partnership by LGA	LGA Annual Review Report	TBD	2	4	6
	20. Number of facilities performing deliveries accredited as Basic EmOC facility (7 functions 24/7) and Comprehensive EmOC facility (9 functions 24/7)	States/ LGA Report and Facility Survey Report	TBD	10	15	20
STRATEGIC AREA 2: HEALTH SERVICES DELIVERY						
NSHDP GOAL: To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare						
Outcome 3: Universal availability and access to an essential package of primary health care services focusing in particular on vulnerable socio-economic groups and geographic areas						
Outcome 4: Improved quality of primary health care services						
Outcome 5: Increased use of primary health care services						
5. Improved access to essential package of Health care	21. % of LGAs with a functioning public health facility providing minimum health care package according to quality of care standards.	NPHCDA Survey Report	TBD	25	50	75%
	22. % health facilities implementing the complete package of essential health care	NPHCDA Survey Report	TBD	50	75	100%
	23. % of the population having access to an essential care package	MICS/NDHS	TBD	40	75	100%
	24. Contraceptive prevalence rate	NDHS	34%	45%	55%	70%
	25. % increase of new users of modern contraceptive methods (male/female)	NDHS/HMIS	TBD	10%	15%	20%
	26. % of new users of modern contraceptive methods by type (male/female)	NDHS/HMIS	25%	40%	60%	80%
	27. % service delivery points without stock out of family planning commodities in the last three months	Health facility Survey	30%	50%	75%	100%
	28. % of facilities providing Youth Friendly RH services	Health facility Survey	TBD	20%	30%	40%
	29. % women 15-19 who have begun child rearing	NDHS/MICS	19.70%	15%	12%	10%

	30. % of pregnant women with 4 ANC visits performed according to standards*	NDHS	40%	65%	80%	100%
	31. Proportion of births attended by skilled health personnel	HMIS	76%	85%	90%	100%
	32. Proportion of women with complications treated in an EmOC facility (Basic and/or comprehensive)	EmOC Sentinel Survey and Health Facility Survey	20%	40%	50%	75%
	33. Caesarean section rate	EmOC Sentinel Survey and Health Facility Survey	3%	10%	25%	30%
	34. Case fatality rate among women with obstretic complications in EmOC facilities per complication	HMIS	TBD	20%	15%	10%
	35. Perinatal mortality rate**	HMIS	42/1000LBs	40/1000LBs	35/1000LBs	30/1000 LBs
	36. % women receiving immediate post partum family planning method before discharge	HMIS	TBD	15%	20%	25%
	37. % of women who received postnatal care based on standards within 48h after delivery	MICS	TBD	60%	70%	80%
	38. % of newborn with infection receiving treatment	MICS	No Baseline	25%	30%	40%
	39. % of children exclusively breastfed 0-6 months	NDHS/MICS	TBD	5%	10%	20%
	40. Proportion of 12-23 months-old children fully immunized	NDHS/MICS	31%	45%	65%	80%
	41. % children <5 years stunted (height for age <2 SD)	NDHSMICS	37%	25%	20%	10%
	42. % of under-five that slept under LLINs the previous night	NDHS/MICS	2%	45%	70%	90%
	43. % of under-five children receiving appropriate malaria treatment within 24 hours	NDHS/MICS	24%	50%	75%	90%
	44. % of women who received intermittent preventive treatment for malaria during pregnancy	NDHS/MICS	4%	25%	40%	65%
	45.Condom use at last high risk sex	NDHS/MICS				
	46. Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS	NDHS/MICS	22%	40%	65%	90%
	47. Prevalence of tuberculosis	NARHS	2%	2%	1%	1%
Output 6. Improved quality of Health care services	48. % of staff with skills to deliver quality health care appropriate for their categories	Facility Survey Report	20%	50%	75%	100%
	49. % of facilities with capacity to deliver quality health care	Facility Survey Report	20%	50%	75%	100%
	50. % of health workers who received personal supervision in the last 6 months by type of facility	Facility Survey Report	20%	50%	75%	100%

	51. % of health workers who received in-service training in the past 12 months by category of worker	HR survey Report	30%	50%	75%	90%
	52. % of health facilities with all essential drugs available at all times	Facility Survey Report	20%	50%	75%	100%
	53. % of health institutions with basic medical equipment and functional logistic system appropriate to their levels	Facility Survey Report	30%	50%	75%	90%
	54. % of facilities with deliveries organizing maternal and/or neonatal death reviews according to WHO guidelines on regular basis	Facility Survey Report	TBD	10%	20%	30%
Output 7. Increased demand for health services	55. Proportion of the population utilizing essential services package	MICS	20%	50%	75%	100%
	56. % of the population adequately informed of the 5 most beneficial health practices	MICS	20%	50%	75%	100%
PRIORITY AREA 3: HUMAN RESOURCES FOR HEALTH						
NSHDP GOAL: To plan and implement strategies to address the human resources for health needs in order to ensure its availability as well as ensure equity and quality of health care						
Outcome 6. The Federal government implements comprehensive HRH policies and plans for health development						
Outcome 7.All States and LGAs are actively using adaptations of the National HRH policy and plan for health development by end of 2015						
Output 8. Improved policies and Plans and strategies for HRH	57. % of wards that have appropriate HRH complement as per service delivery norm (urban/rural).	Facility Survey Report	10%	40%	60%	80%
	58. Retention rate of HRH	HR survey Report	TBD	85%	90%	95%
	59. % LGAs actively using adaptations of National/State HRH policy and plans	HR survey Report	0%	30%	50%	80%
	60. Increased number of trained staff based on approved staffing norms by qualification	HR survey Report	10%	20%	50%	75%
	61. % of LGAs implementing performance-based managment systems	HR survey Report	TBD	30%	50%	80%
	62. % of staff satisfied with the performance based management system	HR survey Report	TBD	25%	50%	80%
Output 8: Improved framework for objective analysis, implementation and monitoring of HRH performance	63. % LGAs making availabile consistent flow of HRH information	NHMIS	100%	100%	100%	100%

	64. CHEW/10,000 population density	MICS	TBD	1:4000 pop	1:3000 pop	1:2000 pop
	65. Nurse density/10,000 population	MICS	TBD	1:8000 pop	1:6000 pop	1:4000 pop
	66. Qualified registered midwives density per 10,000 population and per geographic area	NHIS/Facility survey report/EmOC Needs Assessment	TBD	1:8000 pop	1:6000 pop	1:4000 pop
	67. Medical doctor density per 10,000 population	MICS	TBD	1:8000 pop	1:7000 pop	1:5000 pop
	68. Other health service providers density/10,000 population	MICS	TBD	1:4000 pop	1:3000 pop	1:2000 pop
	69. HRH database mechanism in place at LGA level	HRH Database	20%	75%	100%	100%
Output 10: Strengthened capacity of training institutions to scale up the production of a critical mass of quality mid-level health workers						
PRIORITY AREA 4: FINANCING FOR HEALTH						
NSHDP GOAL 4 : To ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and consumption at Local, State and Federal Levels						
Outcome 8. Health financing strategies implemented at Federal, State and Local levels consistent with the National Health Financing Policy						
Outcome 9. The Nigerian people, particularly the most vulnerable socio-economic population groups, are protected from financial catastrophe and impoverishment as a result of using health services						
Output 11: Improved protection from financial catastrophy and impoversihment as a result of using health services in the State	70. % of LGAs implementing state specific safety nets	SSHDP review report	TBD	20%	50%	80%
	71. Decreased proportion of informal payments within the public health care system within each LGA	MICS	TBD	50%	30%	10%
	72. % of LGAs which allocate costed fund to fully implement essential care package at N5,000/capita (US$34)	State and LGA Budgets	TBD	40%	60%	80%
	73. LGAs allocating health funding increased by average of 5% every year	State and LGA Budgets	TBD	40%	60%	80%
Output 12: Improved efficiency and equity in the	74. LGAs health budgets fully alligned to support state health goals and policies	State and LGA Budgets	TBD	40%	60%	80%

allocation and use of Health resources at State and LGA levels						
	75.Out-of pocket expenditure as a % of total health expenditure	National Health Accounts 2003 - 2005	70%	60%	50%	40%
	76. % of LGA budget allocated to the health sector.	National Health Accounts 2003 - 2005	2%	10%	20%	30%
	77. Proportion of LGAs having transparent budgeting and financial management systems	SSHDP review report	TBD	25%	40%	60%
	78. % of LGAs having operational supportive supervision and monitoring systems	SSHDP review report	TBD	25%	40	50%
PRIORITY AREA 5: NATIONAL HEALTH INFORMATION SYSTEM						
Outcome 10. National health management information system and sub-systems provides public and private sector data to inform health plan development and implementation						
Outcome 11. National health management information system and sub-systems provide public and private sector data to inform health plan development and implementation at Federal, State and LGA levels						
Output 13: Improved Health Data Collection, Analysis, Dissemination, Monitoring and Evaluation	79. % of LGAs making routine NHMIS returns to states	NHMIS Report January to June 2008; March 2009	70%	90%	100%	100%
	80. % of LGAs receiving feedback on NHMIS from SMOH		80%	90%	100%	100%
	81. % of health facility staff trained to use the NHMIS infrastructure	Training Reports	30%	50%	80%	100%
	82. % of health facilities benefitting from HMIS supervisory visits from SMOH	NHMIS Report	20%	50%	70%	100%
	83.% of HMIS operators at the LGA level trained in analysis of data using the operational manual	Training Reports	30%	50%	75%	100%
	84. % of LGA PHC Coordinator trained in data dissemination	Training Reports	50%	60%	75%	100%
	98. % of LGAs publishing annual HMIS reports	HMIS Reports	20%	50%	80%	100%
	85. % of LGA plans using the HMIS data	NHMIS Report	30%	50%	75%	100%
PRIORITY AREA 6: COMMUNITY PARTICIPATION AND OWNERSHIP						
Outcome 12. Strengthened community participation in health development						
Outcome 13. Increased capacity for integrated multi-sectoral health promotion						
Output 14: Strengthened Community Participation in Health Development	86. Proportion of public health facilities having active committees that include community representatives (with meeting reports and actions recommended)	SSHDP review report	20%	50%	75%	90%

	87. % of wards holding quarterly health committee meetings	HDC Reports	10%	40%	60%	80%
	88. % HDCs whose members have had training in community mobilization	HDC Reports	10%	40%	75%	100%
	89. % increase in community health actions	HDC Reports	20%	50%	75%	100%
	90. % of health actions jointly implemented with HDCs and other related committees	HDC Reports	10%	40%	60%	80%
	91. % of LGAs implementing an Integrated Health Communication Plan	HPC Reports	10%	25%	40%	60%
PRIORITY AREA 7: PARTNERSHIPS FOR HEALTH						
Outcome 14. Functional multi partner and multi-sectoral participatory mechanisms at Federal and State levels contribute to achievement of the goals and objectives of the						
Output 15: Improved Health Sector Partners' Collaboration and Coordination	92. Increased number of new PPP initiatives per year per LGA	SSHDP Report	TBD	25%	40%	60%
	93. % LGAs holding annual multi-sectoral development partner meetings	SSHDP Report	TBD	25%	50%	75%
PRIORITY AREA 8: RESEARCH FOR HEALTH						
Outcome 15. Research and evaluation create knowledge base to inform health policy and programming.						
Output 16: Strengthened stewardship role of government for research and knowledge management systems	94. % of LGAs partnering with researchers	Research Reports	TBD	10%	25%	50%
	95. % of State health budget spent on health research and evaluation	State budget	TBD	1%	2%	2%
	96. % of LGAs holding quarterly knowledge sharing on research, HMIS and best practices	LGA Annual SHDP Reports	TBD	10%	25%	50%
	97. % of LGAs participating in state research ethics review board for researches in their locations	LGA Annual SHDP Reports	TBD	40%	75%	100%
	98. % of health research in LGAs available in the state health research depository	State Health Reseach Depository	TBD	40%	75%	100%
Output 17: Health research communication strategies developed and implemented	99. % LGAs aware of state health research communication strategy	Health Research Communication Strategy	TBD	40%	75%	100%