NIGER STATE GOVERNMENT OF NIGERIA

STATE STRATEGIC HEALTH DEVELOPMENT PLAN

(2010 – 2015)

March 2010

FOREWORD

The Niger state government is deeply concerned about the health and well being of its citizens. Nigeria's constitution affirms that health is a right of all Nigerians, and our government firmly believes that good health is central to development.

Since 2007, Niger state government has invested significant resources in addressing priority health challenges, training medical personnel, procuring equipment and drugs, and undertaking major policy reforms. We are also grateful to our development partners who have provided support to address priority health areas such as HIV, malaria, and polio.

Nigeria as well as Niger state is committed to achieving globally and regionally established targets such as the Millennium Development Goals and the Abuja Declaration which aim to alleviate poverty and improve health. Although significant progress has been achieved, substantial work remains as too many people continue to suffer, and unfortunately perish, from preventable diseases.

A multidimensional assessment of the health sector and the National Strategic Health Development Plan identifies eight priority areas for improving the national health systems with specific goals and strategic objectives. They are leadership and governance for health; health service delivery; human resources for health; health financing; health information systems; community ownership and participation; partnerships for health development; and research for health.

The strategies and activities highlighted in this plan can only be realized with commitment and cooperation among all stakeholders. It is hoped that through cooperative efforts among the state, the LGAs, our international and local partners, and other stakeholders, we can accomplish the goal of a vibrant health care system and that our interventions can be informed by the holistic approach to health systems development outlined in this strategic plan.

I implore all stakeholders to use the Niger State Strategic Health Development Plan to adequately harness the policy gaps and program interventions required to improve the performance of the health sector towards the delivery of quality, efficient and sustainable health care for the people of Niger state.

Signed

Dr Ibrahim Babaminin Sule, mni

Honourable Commissioner of Health and Hospital service

ACKNOWLEDGEMENT

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LIST OF ACRONYMS

BCC	Behaviour Change Communication
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
HF	Health Facility
HIS	Health Management Information System
HIV	Human Immunodeficiency Virus
AIDS	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
NPHCDA	National Primary Health Care Development Agency
NSHDP	National Strategic Health Development Plan
OAU	Organisation of African Unity
ODA	Oversea Development Assistance

OPS	Organised Private Sector
PERs	Public Expenditure Reviews
PHC	Primary Health Care
PPP	Public Private Partnerships
QA	Quality Assurance
SHAs	State Health Accounts
SMOH	State Ministry of Health
TB	Tuberculosis
TBAs	Traditional birth attendants
TWG	Technical Working Group
UN	United Nations
VAT	Value Added Tax
VHW	Village health workers
W.H.O	World Health Organization

Vision

"To reduce the morbidity and mortality rates due to communicable diseases to the barest minimum; reverse the increasing prevalence of non-communicable diseases; meet global targets on the elimination and eradication of diseases; and significantly increase the life expectancy of the people of Niger State from 54 to 75years by the year 2020 and quality of life of the people"

Mission Statement

"To develop and implement appropriate policies and programmes as well as provide a sustainable and qualitative health care services involving all the stakeholders which are available, accessible, acceptable and affordable to the large majority of the people especially the rural dwellers and the vulnerable groups"

Goal

"The overarching goal of the Niger SHDP is *to significantly improve the health status of Nigerians in Niger state through the development of a strengthened and sustainable health care delivery system"*

EXECUTIVE SUMMARY

"To reduce both infant and maternal deaths to the barest minimum and to increase life expectancy of the people of Niger State from 54 to 75years by the year 2020"

Niger State was formed out of the defunct North Western State in February 1976 and consists of 25 Local Government Areas with Minna as the state capital. The state has an area of 76,363 square km (29,484 square miles). The population of the state is put at 4,082,558(2006 census) It is made up of the old Nupe and Kontagora Kingdoms, Abuja (now Suleja), Zauzau kingdom and other political entities. The major cities are Minna, Bida, Kontagora and Suleja. The State is located in the Middle West Central of Nigeria and is bounded by Kaduna State in the North East, Kebbi State in the North West, Kwara State in the South West, Kogi in the South, Zamfara in the North and the Republic of Benin in the West. The Federal Capital Territory, Abuja, is on the state's Southeastern border.

There are 25 Local Government Areas, namely - Agaie, Agwara, Bida, Borgu, Bosso, Chanchaga, Edati, Gbako, Gurara, Katcha, Kontagora, Lapai, Lavun, Magama, Mariga, Mashegu, Mokwa, Muya, Pailoro, Rafi, Rijau, Shiroro, Suleja, Tafa, Wushishi.

The three principal cultural/ethnic groups of the state are the Nupes, the Hausa and the Gwari. Other groups include the Abishiwa, the Ayadi, the Bassa, the Bauchi, the Dukawa, the Dibo, the Fulani, the Gade, the Godara, the Gulengi, the Ganagana, the Ingwai, the Koro, the Kadara, the Kambari, the Kamuku, the Kadanda, the Mauchi, the Pangu, and the Shigini. The Nupes are found in Gboko, Lavun, Lapai, Agaie and parts of Mariga Local Government Areas in the southern part of the state, while the Gwari, Kadara and Koro are in Chanchaga, Suleja, and Shiroro in the east. The Kambari and Kamuku occupy Mariga, Magama and Rafi Local Government areas in the north. Most of the groups have instituted a king or chieftaincy system of political leadership. The predominant religions in the state are Islam and Christianity.

Some of the attraction centers of the state are (1) Brass/Glass Works, Bida Arts & Crafts/ Souvenirs, (2) Gurara Falls, Gurara LGA Natural/Physical, (3) Kainji Lake National Park Wildlife/Eco-Tourism, (4) Zuma Rock, Near Suleija Natural/Physical, (5) Shiroro Dam Tourist Resort Natural/Man-made, (6) Mayanka Water Falls Natural

More than 80 percent of the population is engaged in agricultural activities. Niger State has one of the largest and most fertile agricultural lands in the country. The Nupe are the major rice producers, while the Gwari, Koro, Kadara and Kambari are famous for yam and guinea corn production. The Hausa and Fulani in Mariga Local Government area are noted for animal husbandry. There is a National Cereals Research Institute and Agricultural Research Station at Badeggi, near Bida and an Agricultural College at Mokwa. Brass work, pottery, raffia articles, dyed cloth, glass manufacture are locally consumed and exported. Niger State has or share three dams which generate hydroelectric power and sustain irrigation projects and fishing. These dams

are (1) The Kainji Dam (1969), (2) Shiroro Gorge Dam on the Kaduna river and (3) The Jebba Dam. Kainji National Park, the largest National Park of Nigeria is also in Niger State.

The main thrust of the Niger State Development Action Plan (DAP) highlights its policy in the area of health, is to provide health services that are relevant, accessible and affordable to majority of the people, particularly the urban poor and the rural dwellers. The Health Sector provides Primary, Secondary and Tertiary health care services within the state.

Based on this premise, Primary Health Care Services provided are mainly towards prevention, promotion, protection, restoration and rehabilitation of services/care. Secondary and Tertiary Health Care provide mainly curative services including specialized care. The state has maternal mortality rate of 130/100,000 live births, under five maternal mortality of 103/100 live births, infant mortality rate is 260/100 live births and the HIV/AIDS prevalence stands at 6.2%.

The health services in Niger State over the past two (2) years have received more attention with renovation of all the existing General Hospitals. There are also three (3) additional General Hospitals that are being constructed. Additional Primary Health Care facilities are being constructed one (1) per Local Government in all the twenty five (25) Local Government Areas.

Most of the existing Primary Health Care facilities in the Local Government Areas are being renovated. The main challenge faced by the state in effective health care delivery is inadequate manpower in both quantity and quality. For example there are some General Hospitals with inadequate Medical Officers and most Local Government Areas do not have Midwives

The There is a high cost of long lasting insecticide nets, government's inability to subsidize cost, lack of awareness of the populace and inadequate capacity of manpower for the distribution of available nets. There is also unwillingness of mothers to breast feed their babies and inadequate health promoters for provision of quality information. Lack of mobility to access the rural areas by health promoters to train on exclusive breast feeding as well as on the preparation and use of ORT.

Family Planning services and antenatal care have been undermined by cultural beliefs and traditional practices. Embargo on employment has created major challenge for the sector to recruit qualified skilled delivery workers. Pneumonia and TB management have become hard to manage within communities due to non compliance to the dosage and this is compounded by lack of basic tools for treatment/management of TB at the PHC. Poverty and low household economies are generally the major bottle necks to uptake of services even if they are available.

The state will ensure the standardized Ward Minimum Health Care Package including packages for IMNCH, common CD and NCD at all levels. It will also ensure routine immunization, case management of child illnesses, exclusive breastfeeding and supplementary feeding for malnourished children. Also the state will ensure that the routine post natal care is compulsory for all nursing mothers to ensure healthy practices and proper illness detection. Household long lasting insecticide nets would be obtained and distributed to all households in the state and

LGAs.

Facility health committees are a key mechanism for strengthening community participation in health care delivery. Emphasis will be on selecting committee members that are influential or are key figures in the community to strengthen their skills for engagement with the broader community to ensure effective two way channel of communication and feedback between community and facility. This will also enhance participation and ownership by the beneficiaries to demand for quality services provided by facilities

The Minimum Package of Care was identified for the three service delivery modes based on their proven and high impact on health outcomes such as mortality and are internationally recommended interventions. The three levels are:

a. Household and Community level Interventions;
b. Population-oriented Interventions; and
c. Individual clinical Interventions

The targets to these interventions include:

a. Prevalence of communicable and non-communicable disease reduced by 50% by 2014
b. 50% of the state population is within 30mins walk or 5km of a health service by end 2012
c. 50% of obsolete equipment replaced in secondary hospitals and PHCs by 2011.
d. 100% of state-owned hospitals and the 25 LGAs supplied with 1 ambulance each by end of 2012
e. Average demand for health care services rises to 2 visits per person per annum by end 2011
f. 100% of health facilities offering nutrition and growth monitoring services by 2012. At least one CHEW in each PHC centre retrained on health promotion practices by end of 2013
g. Access to IMCI, Childhood immunizations & treatment of common childhood problems in 80% of Health facilities in the State by year 2012 and 100% by 2015
h. Routine immunisation institutionalized by 2011.
i. Prevalence of child morbidity and mortality reduced by 50% by 2013
j. 60% of deliveries are attended to by skilled staff by end of 2012 and 80% by year 2015

The cost of the 6 year state strategic health development plan is estimated at N138,442,067,507.00. Political will under the leadership of the Chief Servant of Niger state would be sought for the successful implementation of the strategic plan. The state ministry of health would conduct a workshop to train relevant stakeholders on the use of the strategic plan as well as drawing of operational plans from the strategic plan. Development partners working in the state would be encouraged to buy into the plan and Funding for the implementation of the plan would be sourced from the state government, development partners MDG Debt Relief funds, while the state would encourage community based public private partnership as a major

vehicle for the implementation of the plan

Effective monitoring and evaluation in the state has over the years witnessed some challenges. These issues which range from dearth of data collection tools, work equipment, lack of M&E plan, weak disease monitoring units that are poorly resourced, inadequate manpower as well as inadequate capacity of the existing personnel to carry out functions. Therefore in the monitoring of the SHDP, the M&E officers' capacity in the 25 LGAs in the state would be built and equipments such as monitoring vehicles procured and released to the M&E unit to facilitate mobility and efficiency. The M&E unit will liaise with the state steering committee to carry out advocacy for the employment and redeployment of qualified personnel. To promote qualitative monitoring of projects, standardised tools for monitoring and a data bank for all state and local government generated health data will be developed which will also be utilized for monitoring of the implementation of the SHDP at both state and the Local Government levels.

CHAPTER 1 INTRODUCTION

1.1 Background

Nigeria is a federation of 36 states plus the federal capital territory (FCT, Abuja). With an estimated 148 million people, Nigeria holds approximately one-sixth of Africa's population and is the most populous country on the continent. Its population is expected to rise to 200 million by the year 2025.

With the merger of Borgu Emirate from old Kwara in August 1991, Niger State is one of the largest states in Nigeria covering about 86,000km (or about 8.6million hectares) representing about 9.3% of the total land area of the Country.

Niger state has a population of 3,950,249 consisting of 2,032,725 males and 1,917,524 females based on the 2006 population census. The projected population for 2009 is 4,307,111 based on annual growth rate of 2.8%. The state is made up of 25 Local Government Areas and 17 development areas, 275 political wards spread across the 3 senatorial districts and 6 health zones

Situated in the North Central geopolitical zone of Nigeria, Niger State shares its borders with the Republic of Benin (West), Zamfara State (North), Kebbi (North- West), Kogi (South), Kwara (South West),Kaduna (North-East) and the FCT (South-East). In line with the constitution of the Federal Republic of Nigeria, two levels of government exist in the State; the State Government and the Local Government Councils.

Nigeria's overall health system performance was ranked 187th position among 191 member States by the World Health Organization (WHO) in 2000. Primary Health Care (PHC), which forms the bedrock of the national health system, remains in a prostrate state due to gross under funding, mismanagement and lack of capacity at the LGA level.

In order to meet the challenges of achieving improved health status particularly for its poorest and most vulnerable population, the health system at the national, state and LGA levels must be strengthened; proven cost-effective interventions must be scaled up and gains in health must be sustained and expanded.

The Federal Ministry of Health (FMOH) leading all the states of the federation appreciates that this can best be done by improving planning through the development of a costed National Strategic Health Development Plan (NSHDP) and State Strategic Health Development Plan (SSHDP), which is aimed at providing an overarching framework for sustained health development in the country.

The State Strategic Health Development Plan (SSHDP) is developed in line with available state level resources, policies, opportunities and challenges within the Niger state health system and the political environment, extant national health policies and legislation, and international declarations and goals to which Nigeria is a signatory to, namely; MDGs, Ouagadougou Declaration on PHC and the Paris Declaration on Aid Effectiveness.

For the attainment the expected outcome of improved planning through the Niger State Strategic Health Development Plan, 2110 2015 and in alignment with the global and national expectation, the vision and mission statements of the plan shall be linked to those of the national plan as follows:

1.2 Strategic Focus of Niger State Government on Health

- Providing with the available resources, a level of health care services for all the citizens of the State to enable them admire and enjoy socially and economically productive level
- Establish a comprehensive and integrated health care system founded on primary health care encompassing promotive, protective, preventive, restorative and rehabilitative health care.
- To provide budgetary allocation for health sector of 15% of the overall State Budget in accordance with the World Health Organization standard.
- All Local Government Areas in the State to have at least one General Hospital.
- To provide adequate and well trained manpower to mann the State Primary and Secondary Health Care facilities
- At least the State should have one tertiary health care institution that will provide all range of specialized health care through Public Private Partnership (PPP)
- To provide a comprehensive drugs production outfit

1.3 Objectives of the Niger State Ministry of Health

- To establish a functional State Primary Health Care Development Agency in the State by the year 2010.
- To establish a State Drug Management Agency by the year 2010
- To strengthen the functions of Hospital Management Board to enhance its supportive and maintenance services rendered to our Secondary Health Facilities by the year 2010.
- To provide adequate human resources for health to ensure effective and efficient health care delivery by the year 2020
- To strengthen State Epidemiology Unit to function as a centre of disease prevention and control by the year 2010
- To renovate and equip the existing 18 General Hospitals by the year 2020
- Reactivate Rural Hospital Tugunguna, including the road network including offering social amenities by the year 2020.
- To strengthen Routine Immunization Services in both Public and Private Health Care Facilities in the State by the year 2020

- To reduce infant mortality rate by 2/3 by the year 2020.
- To reduce maternal deaths by ¾ by the year 2020
- To reduce HIV prevalence to less than 1% by the year 2020
- To have halted by 2020 and begin to reverse the incidence of malaria and other major diseases
- To upgrade the Schools of Health Technologies to the status of College of Health Sciences and Technology by 2015
- To strengthen the State Agency for the Control of AIDS by the year 2011
- To incorporate trado-medical care into the State health care delivery services by the year 2020.

CHAPTER 2: SITUATION ANALYSIS

2.1 Health System in Nigeria

The Nigerian health sector is broad and is comprised of public, private for-profit, nongovernmental organizations (NGOs), community-based organizations (CBOs), faith-based organizations (FBOs), and traditional health care providers. The composition of health providers is also very heterogeneous, and includes unregistered and registered providers ranging from traditional birth attendants and individual medicine sellers to modern hospitals.

Three decades of political instability and economic crisis have led to a deterioration of national health indicators. On most core health indicators, Nigeria fares worse than similar sub-Saharan African countries. For example, the maternal mortality ratio of 800 per 100,000 live births (2000 est.) is one of the highest in the world. Similarly, under-five mortality is 194 per 1,000 people (2007 est.), and approximately 1 million children under five die every year from preventable diseases such as malaria, diarrhea, and pneumonia. (Kaiser Family Foundation, Global Health Facts 2008)

The rising disease burden from HIV/AIDS and other diseases are straining an already weak health system. HIV prevalence is estimated at 4.6% according to the 2008 seroprevance survey and 3.6% from the National AIDS and Reproductive Health Survey (NARHS, 2008). Approximately 2.6-3.0million people in Nigeria are living with HIV/AIDS (UNAIDS 2007).

Other diseases such as Malaria, Respiratory Tract Infections, Diarrhoea diseases, Meningitis, onchocerciasis, schistosomiasis, etc, are prevalent in selected rural areas across the country. As in most developing countries, the prevalence and the incidence rate of non-communicable diseases such as coronary heart disease, hypertension, diabetes and cancer is also rising in Nigeria.

Public Health Sector:

Nigeria is a federation with three tiers of government – federal, state, and local. While the federal government develops policies that are relevant across all three levels, responsibility for health service provision in the public sector reflects the three-tier structure. According to the Department of Statistics of the Federal Ministry of Health (FMOH), there were over 20,000 registered health facilities in the public sector across these three tiers in Nigeria in 2007. The levels of care in the public sector are:

- Tertiary: Tertiary facilities form the highest level of health care in the country and include specialist and teaching hospitals and federal medical centers. These facilities have special expertise and full-fledged technological capacity that enable them to serve as referral

centers for patients from the primary and secondary levels and act as resource centers for knowledge generation and diffusion. Each state has at least one tertiary facility. The responsibility for tertiary care and training falls under the mandate of the federal government and some state government.

- Secondary: Secondary care facilities include general hospitals, which provide general medical and laboratory services as well as specialized health services such as surgery, pediatrics, obstetrics and gynecology. General hospitals are typically staffed by medical officers (who are physicians), nurses, midwives, laboratory and pharmacy specialists, and community health officers (CHOs). The facilities serve as referral centers for primary health care facilities. Each district, local government area (LGA), or zone is expected to have at least one secondary-level facility. State governments are responsible for this level of care.
- Primary: Facilities at this level form communities' entry point into the health care system. They include health centers and clinics, dispensaries, and health posts which typically provide general preventive, curative, promotive, and pre-referral care. Primary facilities are typically staffed by nurses, CHOs, community health extension workers (CHEWs), junior CHEWs, and environmental health officers. LGAs are mandated by the constitution to finance and manage primary health care under the supervisory oversight of the state government.

Private Health Sector:

- The private sector (including FBO facilities) also plays a large role in the provision of care across the country. It has a wide range of providers including physician practices, maternity homes, clinics, and hospitals. Private for-profit health facilities have proliferated since the mid-1980s and together with the FBO facilities, are reported to provide 80% of health services to Nigerians. The private for-profit facilities provide mostly curative services, while the faith-based facilities provide a wider range of preventive and health promotion services. There are also traditional medicine practitioners and informal medicine vendors.
- While the private sector makes an appreciable contribution to health care in Nigeria, the sector is not very well regulated and supported. For example, private sector health care workers have fewer opportunities for training and refresher trainings than those in the public sector. Availability of policies, guidelines, and manuals is also weak in the private sector.
- Anecdotal evidence suggests that overall, there is a widespread perception that the quality of both public and private health care services is low, and that service delivery is inadequate. Indeed, the quality, access, efficiency, and the service availability of the health care system has stagnated or declined over the past decades.

2.2 Niger State Health System

The Health Sector in Niger state operates at three tiers; Primary, Secondary and Tertiary health care services. The Primary Health Care services provided are mainly preventive, promotive, protective, restorative and rehabilitation services while the Secondary health services provides mainly curative and some degree of preventive , protective and rehabilitative services. Tertiary Health Care provides mainly specialized curative and restorative services.

There are 1,323 Primary Health Care facilities, 18 Secondary Health facilities and 2 Tertiary health facilities and 446 registered Private Health facilities including hospitals, clinical, maternities, and laboratories. In addition, there are 1,200 licensed Patent Medicine Vendors

According to the Federal Ministry of Health (FMOH) based on the 2007 Health System Assessment there are 1, 841 doctors working in the North Central region of the country, 5,778 nurses/midwives, 434 Medical laboratory scientist, and 1,342 pharmacists Out of these numbers, 244 doctors work in Niger state (117 in public; 127 in private), 109 pharmacist (44 in public; 65 in private), 988 nurses in public facilities institutions, and 26 Medical laboratory scientist. There are also about 30 medical records officers in the public health facilities.

The health services in Niger State over the past two years have received more attention courtesy of several funding support with renovation of all the existing General Hospitals. There are also three additional General Hospitals that are being constructed. Additional Primary Health Care facilities are being constructed one per Local Government in all the twenty five Local Government Areas.

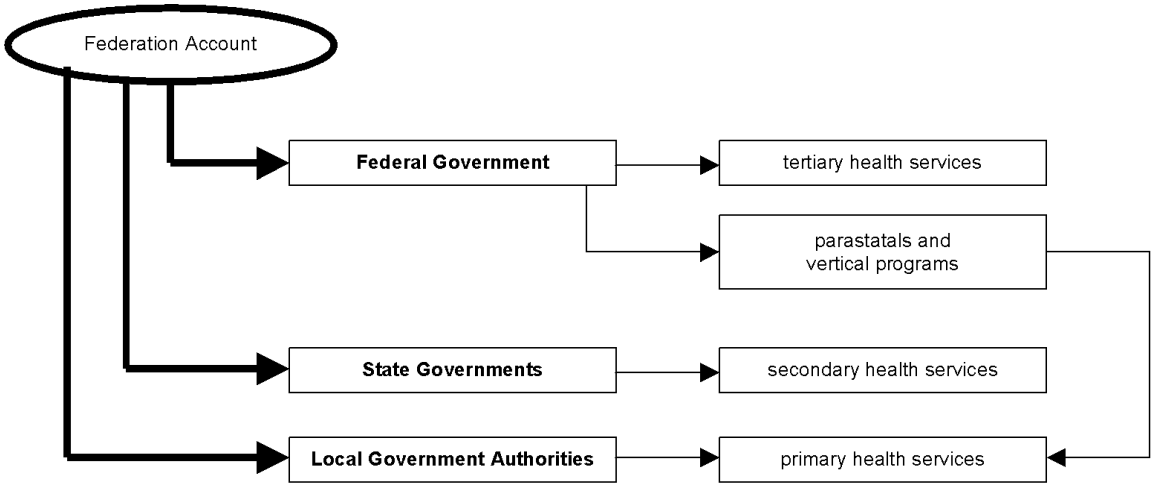
Most of the existing Primary Health Care facilities in the Local Government Areas are being renovated. The main issue in health care delivery system in Niger State is inadequate manpower in both quantity and quality, because there are some General Hospitals without a Medical Officer and most Local Government Areas do not have Midwives.

Summary of Niger State Indicators

POPULATION (2006 Census)	NIGER
Total population	**3,954,772**
female	1,950,422
male	2,004,350
Under 5 years (20% of Total Pop)	786,009
Adolescents (10 – 24 years)	1,185,681
Women of child bearing age (15-49 years)	925,143
INDICATORS	**NDHS 2008**
Literacy rate (female)	21%
Literacy rate (male)	50%
Households with improved source of drinking water	52%
Households with improved sanitary facilities (not shared)	23%
Households with electricity	35%
Employment status (currently)/ female	58.1%
Employment status (currently)/ male	99.0%
Total Fertility Rate	7.5
Use of FP modern method by married women 15-49	4%
Ante Natal Care provided by skilled Health worker	37%
Skilled attendants at birth	17%
Delivery in Health Facility	16%
Children 12-23 months with full immunization coverage	12%
Children 12-23 months with no immunization	42%
Stunting in Under 5 children	47%
Wasting in Under 5 children	20%
Diarrhea in children	9.6
ITN ownership	5%
ITN utilization (children)	1%
ITN utilization (pregnant women)	1%
children under 5 with fever receving malaria treatment	-
Pregnant women receving IPT	9%
Comprehensive knowledge of HIV (female)	12%
Comprehensive knowledge of HIV (male)	12%
Knowledge of TB (female)	33.2%
Knowledge of TB (male)	63.9%

2.3 Health Financing

The structure of the health system at national and sub-national levels has mechanisms for its financing drawn from the colonial medical system. During colonial times, services were designed principally for public servants with preventive health care, mainly in the form of hygiene and sanitation, provided to the general population. Financing for public sector service delivery points derived largely from the government budgets. Curative care was largely undertaken and funded by the missionaries, who established FBO service delivery units, many of them outside the capital and in areas that were not readily served by public sector services. Over the years, different tiers of government were implicitly charged with the different health care delivery roles described above: the federal government for tertiary care, state governments for secondary care, and local governments for primary care services.



The financing system in Niger state is multi-source including the state governments, development partners, social insurance, individual out-of-pocket payments and others. This component sought to assess how resources flow within the health system across three topical areas: revenue collection, including the amount and sources of financial resources; pooling and allocation of financial resources; and purchasing and provider payments.

The table below shows the health expenditure in Niger state in the year 2006 & 2007 as compared to other states in the North Central, Nigeria.

	Benue		Nasarawa		Niger		Kogi		Plateau		FCT	
	2006	2007	2006	2007	2006	2007	2006	2007	2006	2007	2006	2

Per capita total health expenditure, naira	NP	NP	N607.48	N1,871.1.3	N141.17	N652.19	N501.00	N626.00	N152.20	NA	N559.16	N5
Government expenditure on health as % of total government expenditure	NP	NP	12.30%	11.30%	9%	5.40%	4.90%	5.00%	1.50%	2.20%	5.06%	6.
Public (government) spending on health as % of total health expenditure	NP	NP	18.20%	16.04%	55%	60%	NP	NP	NP	NP	96.30%	27

2.4 Ongoing Programmes and Initiatives of the Niger State

There are several on-going health sector initiatives based on the vision 3:2020 of the present administration. Many of the programmes and initiatives are being supported by the state government through the Ministry of Health and Ministry of Local Government affairs, Development Partners, World Bank, Public-Private Partnership, National Primary Health Care Development Agency, Millenium Development Goal office and others. These programmes and initiatives are shown in the table below:

Key initiative and program	**Timeliness**			**Funding options**
	Short-term (2009-2010)	*Medium-term (2011 – 2015)*	*Long-term (2016-2020)*	
1. Establishing of a functional State Primary Health Care Development Agency	✔			• State Ministry of Health • Ministry for Local Government • Development Partners • National Primary Health Care Development Agency
2. Establish a State Drug Management Agency	✔			• State Ministry of Health • NAFDAC • Development partners
3. Strengthening the functions of Hospitals Management Board to enhance its supportive and services render to secondary health care	✔	✔		• State Ministry of Health
4. Provision of adequate human resources for health	✔	✔	✔	• State Ministry of Health • Public-Private-Partnership • Development Partners
5. Strengthening of State Epidemiological Unit to function as a centre for	✔	✔	✔	• State Ministry of Health • Ministry for Local Government • Development Partners

disease prevention and control				● Millennium Development Goals Fund
6. Renovation and equipping of 18 General Hospitals	✔	✔	✔	● State Gov't ● Public-Private- Partnership
7. Upgrading of School of Health Technology to the status of College of Health Sciences and Technology		✔		● State
8. Strengthening of State Agency for the control of AIDS	✔			● State ● World Bank
9. Incorporation of Trado-Medical Practice into the State Health Care Delivery System			✔	● State ● Science and Technology ● State Ministry of Culture and Tourism
10. Strengthening Routine Immunization	✔	✔	✔	● State Ministry of Health ● Local Government Area ● Development Partners ● National Primary Health Care Development Agency
11. Reduction of HIV Prevalence to less than 10%			✔	● State ● Local Government Area ● Development Partners ● Federal Ministry of Health
12. Strengthening State Malaria Control and other related diseases	✔	✔	✔	● State ● Local Government Area ● Development Partners ● Federal Ministry of Health ● National Primary Health Care Development Agency
13. Provision of free medical treatment for under-five years, pregnant women, aged and physically challenged	✔	✔	✔	● State ● Millennium Development Goals ● National Health Insurance Scheme ● Development Partners
14. Strengthening of monitoring and evaluation system in the State	✔	✔	✔	● State
15. Construction of 25No Primary Health Care Centres in the 25 Local Government Areas		✔		● State ● Local Government Area ● Millennium Development Goals

				● National Primary Health Care Development Agency
16. Establishment and equipping seven (7) Rural Hospitals in seven (7) Local Government Areas i.e. Agwara, Katcha, Mashegu, Katcha, Paiko, Enagi, Lemu and Bosso)		✔		● State ● Public-Private-Partnership
17. Strengthening the 6 Zonal Primary Health Care offices in the State		✔		● State ● Local Government Areas ● National Primary Health Care Development Agency ● Development Partners

2.5 Opportunities

There are several opportunities within the Niger State Ministry of Health and its external environment, these include:

- Improving political will of the present administration in Niger state especially with the 'Chief Servant' concept of the Governor.
- Availability of MDG funds
- FGB support
- Presence of development partners (WHO, UNICEF, FHI (GHAIN), MSH, DFID/SuNMaP, etc))
- Improving Public Private Partnership, including availability of the enabling policy
- A deliberate policy by government to incorporate traditional medical practice into State Health Care Delivery System
- National Health Insurance Scheme (NHIS)
- A subsistence number of existing primary and secondary health infrastructure for health
- A pool of qualified health care providers
- Established and upcoming training institutions e.g, College of Health Sciences, School of Nursing, School of health technology

2.6 Challenges

Although several opportunities within the health system and the political environment in Niger state, some challenges still exist, these include:

- Inadequate budgetary allocation for health at state and LGA levels
- Inadequate and inequitable distribution of manpower in both quality, quantity and mix
- Unsatisfactory remuneration and condition of service

- Political embargo on employment of health workers
- Low level of maintenance of existing structures
- Obsolete equipments
- Brain drain
- Lack of continuity in policy implementation
- Ignorance and poverty
- Fake and adulterated drugs
- Emerging and re-emerging diseases – Malaria, HIV, TB
- Inadequate support for training
- Poor level of community engagement, involvement and participation
- A weak health system

CHAPTER 3: STRATEGIC HEALTH PRIORITIES

This SHDP seeks to provide strategic guidance to the State in the selection of evidenced-based priority interventions that would contribute to achieving the desired health outcomes for the people of Niger State towards achieving sustainable universal access and coverage of essential health services within the planned period of 2010 - 2015.

The Honourable State Commissioner for Health therefore expects all the stakeholders to embrace '*the use of this SHDP for the development of the respective operational plans for the state.*'

This SHDP focuses on eight priority areas that are listed as follows:

- Leadership and governance;
- Service delivery;
- Human resources for health;
- Health financing;
- Health information system;
- Community participation and ownership;
- Partnerships for health; and,
- Research for health.

Annex I specifies the goals, strategic objectives and the corresponding interventions and activities with costs.

To improve the functionality, quality of care and utilization of services so as to positively impact the health status of the population, universal access to a package of cost-effective and evidence-based interventions detailed below is needed. This would of necessity require interventions that transform the way the health care system is resourced, organized, managed and services delivered

HIGH IMPACT SERVICES
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 REQUIREMENTS

The available resources within the Niger state health system as indicated in the table below is far below expected resources required for the implementation of the State Strategic Health Development Plan.

S/No.	ITEMS	Quantity
1.	Number of health zones	6
2.	No. of Primary health care facilities	1,323
3.	No. of Secondary Health Care facilities	18
4.	No. of Tertiary health facilities	2
5.	No. of Private Health Facilities	446
6.	No. of Doctors in public sector	117
7.	Doctor's in Private Sector	127
8.	No. of Nurses in public sector	988
9.	No. of Pharmacists Public	44
10.	No of Private Pharmacists	65
11.	Federal Medical Centre	14
12.	Pharmacist Technicians	30
13.	License Patent Medicine stores	1,200
14.	Laboratory Scientists	26
15.	Radiographers	2
16.	X-ray Technicians	6
17.	Medical Records	30
18.	Physiotherapists	2

4.1 Human Capacity Requirement:

The human resource requirement for the attainment of the Niger State Strategic Health Development Plan is quite enormous and dependent on strong political will from the State Government and other policy makers for the fulfillment of this requirement.

Then, going from the above, it is paramount that successful implementation of the State Strategic Health development 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 in order to archive the lofty objective of the development plan.

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 development document.

The costing in this plan is a reflection of important gaps and shortcoming of other existing plan including the African Development Bank supported plan. The table above showed that the existing human capital is far below the number that can cater for over 3 million people of the state, therefore there is a need for new recruitment into the health workforce to augment the existing human capital in the state health sector. There are some critically needed health staff, 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.

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 strategic health development 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 in the state as a whole.

The state will also draw from the opportunity of those that are fresh graduates from the training institution domicile in the state to augment the workforce as well as those serving in the state in cases of the N.Y.S.C with attractive incentive packages and uses a liberalized recruitment policy. The communities are also expected to initiate and identified people to come from within and be sponsored to the 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.

4.2 Infrastructure and other materials

Although the present government of Niger state has shown significant commitment to the development of the health sector, the on-going renovation and upgrading of many facilities across the state is a commendable effort if sustained, however, the average numbers of facilities as shown in the table above is suggestive of the inadequacy in the health system.

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

The means to achieve the lofty goals enshrined in the strategic development plan include construction of additional facilities as well as renovation of existing health facilities under the state and the local government authorities. 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 developed strategic health development plan for Niger state requires a huge amount of financial resources. 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 a coordinated strategy at rescuing the dwindling health status of the state and this could not be achieved with an unstructured budgeting. The development plan has put in activities that would create a common pool at sourcing for health funds with the aim of improving efficiency and accountability.

The 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, ADB, DFID and the world bank amongst host of others already operating in the state.

CHAPTER 5: FINANCIAL PLAN

5.1 Estimated cost of implementing the strategic Plan

The Niger State Strategic Health Development Plan was developed based on realistic financial expectations and limitations especially in the context of the vision 3:2020 of the state government which seeks to make the state one of the three best states in Nigeria in term of development by the year 2020.

Estimates for some priority areas such as Community Participation and ownership as well as the Financing for health and Research for health were not captured in detail because some unit cost were difficult to estimate, volunteering is expected and appropriate stakeholders were not engaged. The financial plan should therefore be subjected to periodic review owing to the above mentioned and because of possible inflation and economic realities.

However, the total cost estimates for the plan for Niger State as shown in the table below is the outcome of the development process. The total cost estimate of the plan is **N138,442,067,507**

S/No.	PRIORITY AREA	Estimated Cost (N)
1	LEADERSHIP AND GOVERNANCE FOR HEALTH	1,384,420,675
2	HEALTH SERVICE DELIVERY	68,343,842,751
3	HUMAN RESOURCES FOR HEALTH	50,590,795,268
4	FINANCING FOR HEALTH	10,508,695,100
5	NATIONAL HEALTH INFORMATION SYSTEM	2,076,631,013
6	COMMUNITY PARTICIPATION AND OWNERSHIP	1,384,420,675
7	PARTNERSHIPS FOR HEALTH	1,384,420,675
8	RESEARCH FOR HEALTH	2,768,841,350
	TOTAL COST ESTIMATE	138,442,067,507

CHAPTER 6: IMPLEMENTATION FRAMEWORK

Structures, Institutions, Strategic partners, civil society, individuals, households and other actors should be identified as well as their roles and their inter relations

Political will under the leadership of the Chief Servant of Niger state would be sought for the successful implementation of the strategic plan. The state ministry of health would conduct a workshop to train relevant stakeholders on the use of the strategic plan as well as drawing of operational plans from the strategic plan. Development partners working in the state would be encouraged to buy into the plan and Funding for the implementation of the plan would be sourced from the state government, development partners MDG Debt Relief funds, while the state would encourage community based public private partnership as a major vehicle for the implementation of the plan

The following will play various roles in the implementation of the plan:

The State Government will provide policy guidelines and direction as well as develop plans and programs to meet state and national goals and ensure the implementation of plans in line with national health policy guidelines.

Private Health care providers, including Faith-Based organizations will contribute to Health Service Delivery.

Civil Society organizations including professional groups, and community groups and the media will help to promote accountability and transparency by constituting independent watchdog systems.

Development partners will provide technical assistance and additional funding?

CHAPTER 7: CONCLUSION

The Niger State Strategic Health Development Plan was the product of contributions of stakeholders and professionals in Niger State. The Plan has the basic eight components affecting quality, coverage and effectiveness of health services.

The activities generated to achieve the strategic objectives as highlighted in this document were product of consensus and realistic appraisal of available resources. While these activities will contribute to the achievements of the goals of the SHDP, further and regular review of the interventions is recommended.

The political will demonstrated during the development of the plan is encouraging and if maintained by the various levels of government and all stakeholders, key health indices in Niger state will improve to a reasonable extent.

Annex 1: Details of Niger Strategic Health Development Plan

NIGER STATE STRATEGIC HEALTH DEVELOPMENT PLAN						
PRIORITY AREA						
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Cost 2010-2015**
	Strategic Objectives				Targets		**EXPENDITURE ITEMS**
		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							**1,384,420,675**
	1.1	**To provide clear policy directions for health development**			All stakeholders are informed regarding health development policy directives by 2011		**697,977,690**
		1.1.1	Improved Strategic Planning at Federal and State levels		Strategic planning at state and LGAs improved by 2012		**285,229,990**
			1.1.1.1	Advocate for improved political will for health systems interventions	No. of advocacy visits conducted	Consistent political environment	54,391,148
			1.1.1.2	Conduct a baseline health survey for state and LGAs to inform planning	Baseline survey at the state and LGAs conducted by 2010	Increasing political will, availability of resources	141,482,571
			1.1.1.3	Support the dissemination of the baseline survey results	Survey results disseminated by 2010	Increasing funding and Political will	14,456,435
			1.1.1.4	Mobilization of community for support, participation and involvement in health interventions at all levels	Communities mobilized by 2011	Increasing community involvement and availability of resources	74,899,837
		1.1.2	Development of State level Strategic Plan for Priority interventions		Strategic plan for major health interventions operationalized by 2011		**313,760,463**
			1.1.2.1	Conduct workshop for the development of state stretegic plan for health	SSHP for HIV & AIDS developed by 2011	Availability of fund; Continuous donor support	52,439,216
			1.1.2.2	Organize stakeholders' forum for the validation of the state strategic health plan	SSHP validated		24,201,937
			1.1.2.3	Support the printing and dissemination of State Strategic Health Plan	SSHP disseminated and operationalised	Funding	23,008,528
							-
			1.1.2.5	Support the development and operationalization of State HIV/AIDS Strategic Plan	State Strategic Plan for HIV/AIDS developed by 2011	Availability of fund; Continuous donor support	66,805,639
			1.1.2.6	Support the development and operationalization of State Malaria Strategic Plan	State Strategic Plan for Malaria developed by 2012	Availability of fund; Continuous donor support	78,512,176
			1.1.2.7	Facilitate the development of the Integrated Mother New Born and Child Health Plan	IMNCH Plan developed by 2012	Availability of fund; Continuous donor support	30,548,245
			1.1.2.8	Conduct workshop for the review of state stretegic plan for health	State Strategic Plan for Health reviewed by 2012	Availability of fund; Continuous donor support	38,244,724
		1.1.3	Strengthen the capacity of policy makers and gatekeepers on health policy implementation		Capacity of Policy makers and gatekeepers on policy issues strengthened by 2013		**98,987,237**

			1.1.3.1	Develop capacity building plan for policy makers and gatekeepers based on identified gaps	Capacity building plan developed by 2011	Consistent political environment	41,515,413
			1.1.3.2	Build capacity of Policy makers and gatekeepers on policy formulation and implementation	50% of policy makers and influencers trained by 2013	Consistent political environment	53,444,450
			1.1.3.3	Provide Technical Assistance on Policy review, implementation and evaluation	Number of TA on Policy issues provided	Consistent political environment	66,253,373
	1.2	**To facilitate legislation and a regulatory framework for health development**			Health Bill signed into law by end of 2009		**112,392,864**
		1.2.1	Strengthen regulatory functions of government		Government regulatory functions strenghtened by 2010		**101,136,385**
			1.2.1.1	Establish state regulatory bodies backed by necessary legistlation eg state primary health care development agency, Hospital management board, private health board etc	Relevant regulatory agencies established and operatinalized by 2010.	Sustained political will	22,250,005
			1.2.1.2	Improve capacity of regulatory authorities to carry out their functions through training	Capacities of the regulatory authorities strenghtened by 2010	Sustained political will and availability of funds	2,528,410
			1.2.1.3	Develop and enact a state health policy/state health act	State health policy enacted by 2011	Sustained political will	76,357,971
			1.2.1.4	Establish servicom units in MDAs xxxxxxxxxxxxxxxxxxxx	Servicom units established in state and LGAs by 2011	Sustained political will	-
			1.2.1.5				-
		1.2.2	Develop regulatory framework for the regulation of Private healh sector		Private sector regulatory framework developed by 2012		**11,256,480**
			1.2.2.1	Develop and disseminate State Service Inventory and Map.	State service inventory and map developed by 2011	Availability of fund; Continuous donor support	5,157,956
			1.2.2.2	Establish and operationalize a coordination platform for private care providers	Functional coordination mechanism for private care providers by 2011	Stakeholders' willingness	4,581,478
			1.2.2.3	Disseminate relevant policies and guidelines to private health facilities	50% of Private health facilities provided with relevent policies and guidelines by 2011	Sustained political will	-
			1.2.2.4	Conduct regular supervision to private health facilities	Number of supervisory visits conducted	Availability of fund; Continuous donor support	1,517,046
	1.3	**To strengthen accountability, transparency and responsiveness of the state health system**			80% of States and the Federal level have an active health sector 'watch dog' by 2013		**83,285,813**
		1.3.1	To improve accountability and transparency		Accountability and transperancy improved by 2012		**83,285,813**
			1.3.1.1	Constitute stakeholders forum for accountability and transparency	stakeholders forum for accountability and transperancy constituted 2011	Increasing political will	12,996,025
			1.3.1.2	Improve capacity of NGOs /civil society groups to advocate for at least 15% budgetary allocation/release for health	Improved budgetary allocation to health by 2012	Stakeholders' willingness	16,181,822
			1.3.1.3	Train civil society groups on budget tracking	60% of Mapped CSOs trained by 2015	Sustained funding supports	22,755,687

			1.3.1.4	Establish due process units in MDAs	Due process units established by 2010	Improved political will	-
			1.3.1.5	Conduct training on servicom for health personnel	60% of health personnel trained on servicom at the state and LGAs by 2011	Availability of fund; Continuous donor support	31,352,279
	1.4	**To enhance the performance of the state health system**			1. 50% of States (and their LGAs) updating SHDP annually 2. 50% of States (and LGAs) with costed SHDP by end 2011	Various levels of government have capacity to update sectoral SHDP States may not respond in a uniform and timely manner	**490,764,307**
		1.4.1	Improving and maintaining Sectoral Information base to enhance performance		sectoral information base improved and maintained by 2011		**427,554,067**
			1.4.1.1	Provision of computers for health data base management	No of computers provided by 2011	Sustained govt and donor funding	221,235,842
			1.4.1.2	Provision of internet faclities for easy informaton/data dissemination	50% of health iformation/data received via internet facilities by 2011	Sustained govt and donor funding	167,380,717
			1.4.1.3	Conduct training for staff on basic information technology/ health management information system	75% of identified staff trained on basic information technology by 2015	Sustained govt and donor funding	38,937,508
		1.4.2	Support Operation Research and evidence based programming		Health sytems interventions based on OR findings by 2012		**63,210,241**
			1.4.2.1	Establish and make functional an Operation Research (OR) sub-unit in the department of PRS	Functional Operations Research sub-unit established by 2010	Improving political will	21,238,641
			1.4.2.2	Advocate for improved funding for the OR sub-unit	Number of advocacy visits conducted	Stakeholders commitment	-
			1.4.2.3	Disseminate OR findings to all stakeholders from time to time	OR findings disseminated to 80% of mapped stakeholders	Sustained funding supports	15,676,140
			1.4.2.4	Review Strategies for health interventions based on OR findings	Health development plan reviewed as planned	Stakeholders commitment	26,295,460
HEALTH SERVICE DELIVERY							
2. To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare							**68,343,842,751**
	2.1	**To ensure universal access to an essential package of care**			Essential Package of Care adopted by all States by 2011		**62,359,619,934**
		2.1.1	To review, cost, disseminate and implement the minimum package of care in an integrated manner		Minimum package of care reviewed, costed, disseminated and implemented by 2010		**1,054,442,301**
			2.1.1.1	Conduct need assessment of the existing facilities and a 2 day meeting with all stakeholders to review the mininmum package	50% identified health facilities assessed by 2010	Stakeholders commitment	16,864,252
			2.1.1.2	Adapt and implement the National Integrated Maternal, New Born and Child Health (IMNCH) policy at state and LGA level	50% of the targetted population reached by 2015	Improving political will, sustained funding	57,359,614
			2.1.1.3	Identiify new and strengthen exisiting family planning activities at State and LGA levels	Increased by 45% women assessing family planning services by 2013	Regular client intake	23,887,042

			2.1.1.4	Train at lease 60% of health service providers on FP across board	20% service delivery points with at least 1 staff trained on FP services	Availability of adequate resources	159,701,941
			2.1.1.5	Procure and distribute to health facilities modern FP commodities	30% of service delivery points without stock of modern FP commodities by the year 2012	Funding	228,291,877
			2.1.1.4	Upgrade and refurbish existing health facilities	50% sub standard health facilities upgraded and refurbished by 2013	Availability of fund; Continuous donor support	380,281,715
			2.1.1.5	Train and retrain health presonnel on IMNCH and other minimun packages	70% of mapped health personnel retrained by 2015	Availability of fund; Continuous donor support	17,434,129
			2.1.1.6	Supply of essential drugs and equipment to each of the 25 LGAs	Essential drugs and equipment supplied to LGA by 2012	Availability of fund; Continuous donor support	170,621,732
		2.1.2	To strengthen specific communicable and non communicable disease control programmes		Disease control programme strengthened by 2011		**59,291,786,601**
			2.1.2.1	Develop and share state level strategic and annual workplan on Malaria, TB, HIV & AIDS and other common communicable and non communicable disease control programmes	Strategic and Annual Plans for Malaria, TB, HIV & AIDS developed and shared	Improving political will & Consitent funding support	46,204,365
			2.1.2.2	Mobilize resources for the implementation of the State HIV & AIDS strategic plan	60% 0f the SSP activities achieved by 2015	Improving political will & Consitent funding support	166,902,178
			2.1.2.3	Develop and implement the State Malaria Control Strategic Plan in line with the national plan	70% of the set objectives and activities achieved by 2015.	Improving political will	264,873,176
			2.1.2.4	Procure and distribute mosquito nets to school children, pregnant women and other vulnerable groups	70% distribution and use coverage achieved	Improving political will & Consitent funding support	53,997,157,616
			2.1.2.5	Conduct routine immunization activties and increase immunization coverage in 25 LGAs	90% Immunizations coverage achieved by 2015	Improving political will & Consitent funding support	97,129,321
			2.1.2.6	Train and support care providers on two way referral systems	60% of care providers trained on referral services by 2011	Improving political will & Consitent funding support	36,506,226
			2.1.2.7	Establish and strengthen functional PHCs within a 5km radius to offer IMCI Case Management of Pnuemonia	30% increase in PHCs with commodities to handle pnuemonia cases		650,068,797
			2.1.2.8	Train PHC Workers on IMCI Case Management of Pnuemonia	Increased by 60% pnuemonia case mgt. by 2015	Funding	416,317,025
			2.1.2.9	Establish TB microscopy (AFB) services at all PHCs		Personnel/funding	3,481,358,987
			2.1.2.10	Train PHCs laboratory technicians/scientists in TB diagnosis and administration of DOTs	At least 50% of PHC workers trained in TB diagonosis	Funding	135,268,909
		2.1.3	To make Standard Operating procedures (SOPs) and guidelines available for delivery of services at all levels		SOPs and guidelines delivered by 2011		**236,072,228**
			2.1.3.1	Disseminate National guidelines and SOPs on management of endemic diseases	SOP and guidelines disseminated to 60% of relevent health facilities by 2013	Consitent funding support	27,299,477
			2.1.3.2	Train and retrain care providers in charge of health facilities from 25 LGAs, on the use of SOP and guidelines	At least 50% of care providers in each of the LGAs trained	Improving political will & Consitent funding support	96,162,408

			2.1.3.3	Train at least 2 relevant health personnel on each relevant guidelines and SOPs from state health facilities.	70% of the mapped health personnel trained by 2015	Availability of fund; donor support	30,711,912
			2.1.3.4	Regular monitoring and assessment to health facilities to ensure adherence to the use of the guidelines and SOPs	60% of facilities delivered services according to the guidelines and SOPs	Availability of fund; donor support	81,898,431
			2.1.3.5	Develop treatment guides, SOPs or service protocol for locally endemic conditions when there are no national documents	Number of documents developed	Improving political will & Consitent funding support	-
		2.1.4	To rehabilite and refurbish schools of health technology		Rehabilitated and refurbished shcools of health technology 2010		**1,508,296,107**
			2.1.4.1	Construct 4 motorized boreholes for all health training institutions xxxxxxxxxxxxxxxxxxx	Boreholes contructed by 2010	Consitent funding support	1,508,296,107
			2.1.4.2	Procure and install 3 100KV generator for all health training institutions xxxxxxxxxxxxxxx	Generators procured by 2010	Consitent funding support	-
			2.1.4.3	Procure 3 30-seater buses for all health training institutions xxxxxxxxxxxxxxxxxxxxxxx	Buses procured by 2011	Consitent funding support	-
			2.1.4.4	Construct 200 bed capacity female hostel block for school of health technology xxxxxxxxxx	Hostels constructed by 2010	Consitent funding support	-
			2.1.4.5	Construct Medical, Phamacy and computer labs for school of technology xxxxxxxxxxxxxx	Medical, Phamacy and computer labs constructed by 2010	Consitent funding support	-
		2.1.5	To strengthen the PMU for efficient performance		PMU strenthened by 2010		**269,022,697**
			2.1.5.1	Conduct 1 week refresher training courses for PMU staff on computer appreciation	Trainings conducted by 2011	Improving political will	23,968,941
			2.1.5.2	Conduct training for 10 SMoH and PMU staff on Reproductive Health and other related courses	Trainings conducted by 2011	Improving political will	15,738,149
			2.1.5.3	Conduct sub-regional training on Project Manangemnet for PMU xxxxxxxxxxxxxxxxxxx	Trainings conducted by 2011	Consitent funding support	-
			2.1.5.4	Support study tour for PMU staff and SMoH	Study tour supported by 2011	Consitent funding support	204,746,078
			2.1.5.5	Support NCH and state council to convene regular health meetings	Numbers of meetings supported and convened	Improving political will	24,569,529
	2.2	**To increase access to health care services**			50% of the population is within 30mins walk or 5km of a health service by end 2011		**5,044,438,320**
		2.2.1	To improve geographical equity and access to health services		Improved geographical equity and access to health services by 2010		**384,588,208**
			2.2.1.1	Develop GIS for all health facilities for effective mapping	GIS developed by 2011	Improving political will	58,495,954
			2.2.1.2	Develop and disseminate standard checklist for distribution of health commodities including medicines across the state	Standardized checklist developed and disseminated by 2010	Improving political will	16,925,676
			2.2.1.3	Provide incentives for healthcare providers in the rural areas xxxxxxxxxxxxxxxxxxxxxx	Improved utilization of rural health facilities	Consitent funding	-
			2.2.1.4	Construct/Renovate 1 General hospital in each LGA xxxxxxxxxxxxxxxxxxxxxxxxxxx	At least 1 General Hospital constructed/renovated in each LGA by 2013	Consitent funding	-
			2.2.1.5	Construct/Renovate of 1 PHC centre in each ward xxxxxxxxxxxxxxxxxxxxxxxxxxx	At least 1 PHC constructed/renovated per ward by 2015	Consitent funding	-

			2.2.1.6	Establish PMTCT centres in each geographical zone of villages within 5km of service delivery points xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx	PMTCT centres increased by 50% at all levels by the year 2015	Funding	-
			2.2.1.7	Train at least 2 staff from each health service delivery points on PMTCT	Train up to 60% health service providers on PMTCT services by 2014	Funding	279,819,640
			2.2.1.8	Advocate for the deployment of appropraite staff (Midwives/Auxillary Nurses to all PHCs to provide ANC services as defined under the NWMHCP	Increase by 60% PHC staff by 2015		-
			2.2.1.9	Establish village outreach programme on ANC services	Increase by 80% community health programs by 2015	Accessibility/ funding	-
							-
			2.2.1.1 1	Establish, train and deploy DOTS providers to villages / community	Increase DOT activities by 50% in the year 2015	Consistent provision of special incentives to rural health workers	29,346,938
		2.2.2	To ensure availability of drugs and equipment at all levels		Availablity of drugs and equipments ensured by 2012		**1,149,307,984**
			2.2.2.1	Review and disseminate essential drugs list at all levels	Essential drugs list revised and disseminated by 2010	Sustained stakeholders commitment	23,204,555
			2.2.2.2	Establish standardized procurement and distribution system for essential drugs at all levels	Standardized procurement and logistic manual disseminated by 2010	Sustained stakeholders commitment	-
			2.2.2.3	Develop/Review equipment list for health facilities at state and LGAs	Equipment list revised and circulated by 2010	Sustained stakeholders commitment	-
			2.2.2.4	Procure and distribute equipment based on need at state and LGAs	80% of health facilities possessed minimum required equipments by 2015	Sustained stakeholders commitment	-
			2.2.2.5				-
			2.2.2.6	Procure and distribute HIV tests kits, Nevirapine, Cotrimoxazole to all PMTCT centres across the state	Improve supply of PMTCT commodities by 50% in year 2015	Funding	818,984,312
				procure and distribute FB Equipment	to ensure availability of FP equipment by 85% in tetaiary health facilities the state	Funding	102,373,039
			2.2.2.7	Procure and distribute to health facilities folic acid, fesolate and other required commodities for ANC services	Improve supply of ANC commodities by 66% in year 2015	Funding	204,746,078
		2.2.3	To establish a system for the maintenance of equipment at all levels		Functional equipment maintainance system established by 2011		**1,085,154,213**
			2.2.3.1	Adapt, disseminate and implement the relevant National Policies	Relevant policies disseminated by 2010	Sustained stakeholders commitment	40,949,216
			2.2.3.2	Create budget line for maintenance of equipment at all levels	Improved funding for equipment maintainance	Sustained stakeholders commitment	-
			2.2.3.3	Support the process of Public, Private Partnership of medical equipment purchase and maitainance	PPP operationalized by 2011	Sustained stakeholders commitment	477,740,848

			2.2.3.4	Procure basic and easy to maintain hospital equipments and furniture	90% of procured equipments functional by 2015	Sustained stakeholders commitment	566,464,149
			2.2.3.5	Advocate for transparent engagement of equipment maintainace companies	90% of procured equipments functional by 2015	Sustained stakeholders commitment	-
		2.2.4	To strengthen referral system		Referral system strengthened by 2011		**1,899,190,494**
			2.2.4.1	Conduct mapping of network linkages for two-way refferal system	Referral system strengthened by 2011	Availability of funds	49,650,924
			2.2.4.2	Support the implementation of guidelines at all levels	Referral system strengthened by 2011	Availability of funds	245,695,294
			2.2.4.3	Establish transportation, communication and other logistics for refferrals	Referral system strengthened by 2011	Availability of funds	1,603,844,277
			2.2.4.4	Support client tracking system and defaulters retrieval mechanisms	70% of defaulters retrieved annually	Availability of funds	-
			2.2.4.5				-
		2.2.5	To foster collaboration with the private sector		Improved collaboration with Private Sector		**526,197,420**
			2.2.5.1	Advocate for involvement of private sector stakeholders in health plan development	No of advocacy visits conducted	Improving political will	-
			2.2.5.2	Establish and operationalize Public-Private Sector stakeholders forum	Functional PPP forum established	Improving political will	57,328,902
			2.2.5.3	Adapt and disseminate the National PPP Policy	National PPP Policy adapted and disseminated by 2011	Improving political will	35,489,320
			2.2.5.4	Support Private Sector Stakeholders through capacity building and supply of guidelines, SOPs and other relevant documents	40% 0f mapped Private sector stakeholders trained	Availability of funds	92,135,735
			2.2.5.5	Support Private Sector with subsidized health commodities and equipments	50% of mapped private sector stakeholders supported by 2015	Availability of funds	341,243,463
	2.3	**To improve the quality of health care services**			50% of health facilities participate in a Quality Improvement programme by end of 2012		**939,784,498**
		2.3.1	To strengthen professional regulatory bodies and institutions		All regulatory bodies and institutions strengthened by 2011		**124,212,621**
			2.3.1.1	Review existing professional regulatory bodies/policies for relevance and adequacy	All state level regulatory authorities reviewed by 2010	Improving political will	34,124,346
			2.3.1.2	Establish/Reconstitute regulatory body for the control of private health services	50% of private facilities adhering to standard practice by 2011	Stakeholders commitment	21,839,582
			2.3.1.3	Establish regulatory body for the control of traditional medical practce	50% of traditional health care givers mapped and monitored by 2012	Stakeholders commitment	40,949,216
			2.3.1.4	Strenghten Regulatory authority for the control of health related media messages	75% of media messages approved before aired by 2012	Stakeholders commitment	27,299,477
			2.3.1.5				-
		2.3.2	To develop and institutionalise quality assurance models		50% of facilities operationalized QA models by 2012		**718,658,734**
			2.3.2.1	Establish quality assurance unit at the SMoH and health facilities at state and LGA levels	50% of facilities operationalized QA models by 2012	Consistent funding support	276,407,205

			2.3.2.2	Constitute and make functional Quality Assurance (QA) committee at state and LGA levels	50% of facilities operationalized QA models by 2012	Consistent funding support	-
			2.3.2.3	Develop and disseminate QA guideline and protocols	50% of facilities operationalized QA models by 2012	Consistent funding support	-
			2.3.2.4	Monitor health facilities on the implementation of QA protocols	50% of facilities operationalized QA models by 2012	Consistent funding support	442,251,528
			2.3.2.5				-
		2.3.3	To institutionalize Health Management and Integrated Supportive Supervision (ISS) mechanisms		Quarterly ISS institutionalized by 2013		**96,913,144**
			2.3.3.1	Establish mechanism for regular Integrated Supportive Supervision to health facilities at the state and LGAs	Quarterly ISS institutionalized by 2013	Political will; Funding	-
			2.3.3.2	Provide logstic support for Integrarted Supportive Supervision at state and LGA levels	Quarterly ISS institutionalized by 2013	Political will; Funding	-
			2.3.3.3	Train Health Managers and M&E officers on Integrated Supportive Supervision	Quarterly ISS institutionalized by 2013	Political will; Funding	96,913,144
	2.4	**To increase demand for health care services**			Average demand rises to 2 visits per person per annum by end 2011		**-**
		2.4.1	To create effective demand for services				**-**
	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		**-**
		2.5.1	To improve financial access especially for the vulnerable groups				**-**
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							**50,590,795,268**
	3.1	**To formulate comprehensive policies and plans for HRH for health development**			All States and LGAs are actively using adaptations of the National HRH policy and Plan by end of 2015		**620,771,481**
		3.1.1	To develop and institutionalize the Human Resources Policy framework		Policy framework developed and institutionalize by the year 2015		**620,771,481**
			3.1.1.1	Adapt national Human Resource Policy Framework for the State and Local Government	Human Resource policy framework adapted by the State and LGA by the year 2011	Improving political will	335,005,478
			3.1.1.2	Printe and Disseminate the Policy Framework	Policy Framework printed and disseminated by the year 2012	Improving political will	90,038,394
			3.1.1.3	Train staff on the use of the Policy Framework	60% of staff trained on the use of policy framework by the year 2015	Improving political will	195,727,610
			3.1.1.4	Implement HR Policy to ensure adequacy and relevance of human resource needs	50% of Health facilities achieved minimum HR needs by 2015	Improving political will	-
	3.2	**To provide a framework for objective analysis, implementation and monitoring of HRH performance**			The HR for Health Crisis in the country has		**764,005,931**

					stabilised and begun to improve by end of 2012		
		3.2.1	To reappraise the principles of health workforce requirements and recruitment at all levels		Minimum HR needs attained by the year 2015		**764,005,931**
			3.2.1.1	Advocate and facilitate government to recruit Health Workers	Number of advocacy visits conducted	Improving political will	-
			3.2.1.2	Train and re-train all categories of Health workers e.g. private and public	60% of category of health workers trained and retrained by the year 2015	Funding support is consistent	764,005,931
			3.2.1.3	Provide adequate remuneration and motivation to health workers	Adequate remuneration and motivation provided to health workers by the year 2015	Political will; Funding	-
			3.2.1.4	Provide working equipment to enhance adequate services	60% of health facilities adequately equipped by the year 2015	Funding support is consistent	-
	3.3	**Strengthen the institutional framework for human resources management practices in the health sector**			1. 50% of States have functional HRH Units by end 2010 2. 10% of LGAs have functional HRH Units by end 2010		**369,974,422**
		3.3.1	To establish and strengthen the HRH Units		HRH unit established and strengthened by 2011		**369,974,422**
			3.3.1.1	Conduct workshop to review the HR manuals the health Ministry	HR manuals reviewed by 2010.	Political will; Funding	176,532,939
			3.3.1.2	Purchase adequate working equipment i.e. Computers, Printers, Photocopiers, generators etc xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx	All workers equiped with relevent working tools by 2011	Political will; Funding	-
			3.3.1.3	Constitute and operationalize mechanisms for the purpose of feedback to staff	Mechanism for yearly staff assessment functional by 2012.	Political will; Funding	-
			3.3.1.4	Provide Information and Communication Technology i.e Internet Facility	ICT provided to support HRH by 2011	Political will; Funding	193,441,483
			3.3.1.5	Provide vehicle for logistics arrangements for HRH XXXXXXXXXXXXXXXXXXXXXXXXXX	Functional and effective HRH Unit by 2011	Political will; Funding	-
	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 workforce graduates with multipurpose skills and mid-level health workers by 2015		**48,285,174,846**
		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		60% of community health manpower needs met by 2015		**48,285,174,846**
			3.4.1.1	Implement Midwifery Scheme and Rural Doctors posting	No. of midwifes and doctors posted	Improving political will	48,191,091,942
			3.4.1.2	Develop traiining curriculum for the training programmes	Training curriculum finalized by 2011	Stakeholders commitment	94,082,903
			3.4.1.3	Renovate existing infrastructure for the training of community health professionals XXXXXXXX	60% of community health manpower needs met by 2015	Availability of funds	-
			3.4.1.4	Provide necessary staff and equipment to support the training	60% of community health manpower needs met by 2015	Political will; Funding	-
			3.4.1.5				-

		3.4.2	To strengthen health workforce training capacity and output based on service demand		Health Training Capacity and output strenghtened based on service demand by the year 2015		-
			3.4.2.1	Establish one more training institution in another senatorial disrict XXXXXXXXXXXXXXXXXX	At least one training institution per senatorial district by 2013	Political will; Funding	-
			3.4.2.2	Provide training incentives for qualified citizens of Niger state xxxxxxxxxxxxxxxxxxx	At least 50% of trainnees are citizens of the state by 2015	Availability of funds	-
			3.4.2.3	Support the existing training institutions with their infrastructural needs xxxxxxxxxxxxxxx	70% of institutional infrastructural needs provided by 2015	Availability of funds	-
			3.4.2.4	Provide the manpower need of the teaching hospital for better output xxxxxxxxxxxxxx	State teaching hospital adequately staffed by 2015	Political will; Funding	-
			3.4.2.5	Support the school of nursing with human and infrastructural requirements xxxxxxxxxx	State school of nursing fully functional by 2015	Political will; Funding	-
	3.5	**To improve organizational and performance-based management systems for human resources for health**			50% of States have implemented performance management systems by end 2012		**60,230,644**
		3.5.1	To achieve equitable distribution, right mix of the right quality and quantity of human resources for health		Equitable distribution, right mix of the right and quantity of HRH achieved by the year 2015		**35,610,819**
			3.5.1.1	Conduct an audit of the human resources for health in Niger state	Health facilities audit for HRH conducted by 2010	Political will; Funding	20,575,140
			3.5.1.2	Develop HRH intervention plan based on the findings of the assessment	HRH Management plan developed by 2011	Stakeholders commitment	15,035,679
			3.5.1.3	Recruit appropiate number and mix of health care providers based on the need assessment	70% of HRH requirement met by 2015	Political will; Funding	-
			3.5.1.4	Develop and operationalize mechanisms for the control of uncontrolled transfer of health care providres	Health worker retention rate exceeds 80% by 2015	Stakeholders commitment	-
			3.5.1.5				-
		3.5.2	To establish mechanisms to strengthen and monitor performance of health workers at all levels		100% of health worker are regularly assessed by 2015		**24,619,825**
			3.5.2.1	Adapt and operationalize the National HRH Policy	Adapted policy operationalized by 2011	Stakeholders commitment	-
			3.5.2.2	Develop performance evaluation framework for healthcare provides based on the policy	Performance eveluation framework developed by 2011	Stakeholders commitment	-
			3.5.2.3	Conduct and institutionalize quarterly performance evaluation for all care providers	100% of health worker are regularly assessed by 2015	Stakeholders commitment	24,619,825
			3.5.2.4	Support care providers to achieve their performance expectation through capacity building	100% of health worker are regularly assessed by 2015	Improving political will	-
	3.6	**To foster partnerships and networks of stakeholders to harness contributions for human resource for health agenda**			50% of States have regular HRH stakeholder forums by end 2011		**490,637,944**
		3.6.1	To strengthen communication, cooperation and collaboration between health professional associations and regulatory bodies on professional issues that have significant implications for the health system		Strengthened relatioship between professional associations and regulatory bodies by 2015		**490,637,944**

			3.6.1.1	Organize regular workshops/conferences for health professionals in the state	Number of workshops organized	Stakeholders commitment	436,122,617
			3.6.1.2	Establish and operationalize a coordination platform for the professional associations within the state	Regular Quarterly coordination meeting by 2015	Stakeholders commitment	10,551,354
			3.6.1.3	Organize an annual health worker forum and award ceremony for excellence	Number of forum successfully organized by 2015	Stakeholders commitment	-
			3.6.1.4	Ensure production of departmental newsletter and bulletin	Number of newsletter circulated by 2015	Availability of funds	43,963,973
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							**10,508,695,100**
	4.1	**To develop and implement health financing strategies at Federal, State and Local levels consistent with the National Health Financing Policy**			50% of States have a documented Health Financing Strategy by end 2012		**13,005,852**
		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		80% of LGAs have evidence based and costed health financing strategic plan by Dec.2011		**13,005,852**
			4.1.1.1	Sensitization of local governmet councils on the need to increase financing of health programmes	100% of LGAs councils sensitized by 2010	Improving political will	1,172,142
			4.1.1.2	Organise training workshops on financial accountability and transparency for Directors and LGA health team	No. of trainings conducted by 2011	Political will; Funding	698,045
			4.1.1.3	Develop and disseminate guidelines for health financing at both state and LG levels	Guidelines disseminated to all LGAs by2011	Political will; Funding	3,261,912
			4.1.1.4	Constitute a steering committee on health financing at state and LG comprising health staff and community members	steering committee constituted by 2010	Stakeholders commitment	-
			4.1.1.5	Develop and disseminate state and LGA health financing plan by 2010	70% of LGAs have health financing plan by 2012	Stakeholders commitment	7,873,752
	4.2	**To ensure that people are protected from financial catastrophe and impoverishment as a result of using health services**			NHIS protects all Nigerians by end 2015		**10,487,205,408**
		4.2.1	To strengthen systems for financial risk health protection		50% of Niger people protected by NHIS by 2015		**131,680,427**
			4.2.1.1	Sensitize civil servants on the importance of National Health Insurance Scheme.	All civil servants protected by NHIS by 2015	Stakeholders commitment	-
			4.2.1.2	Leverage on the availabilty of health care services of private organizations in our environments and ensure their commitment	50% of Niger people protected by NHIS by 2015	Stakeholders commitment	-
			4.2.1.3	Sensitize various communities on Rural health insurance scheme	50% of Niger people protected by NHIS by 2015	Improving political will	1,054,242
			4.2.1.4	Establish rural community health insurance schemes at various communities	50% of Niger people protected by NHIS by 2015	Stakeholders commitment	130,626,186
			4.2.1.5	Training of ward PHC development committees to support and monitor community health insurance programmes in their communities	50% of Niger people protected by NHIS by 2015	Political will; Funding	-
		4.2.2	To strengthen systems for financial risk health protection in the organized private sector		50% of Niger people protected by NHIS by 2015		**10,355,524,981**

			4.2.2.1	Institunalization of Formal SectorNHIS for civil servants	80% of private sector employee protected by NHIS by 2015	Stakeholders commitment	2,869,783,687
			4.2.2.2	Institunalization of In formal SectorNHIS for vulneerable groups	50% of Niger people protected by NHIS by 2015	Stakeholders commitment	7,485,741,293
			4.2.2.3	Establish mechanisms for the regulation of activities of HMOs handling the private sector beneficiaries	50% of Niger people protected by NHIS by 2015	Improving political will	-
	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 Federal, State and LGA health funding increased by an average of 5% pa every year until 2015		**3,742,871**
		4.3.1	To improve financing of the Health Sector		Allocated state and LGAs health funding increased by an average of 15% pa every year until 2015		**3,742,871**
			4.3.1.1	Advocacy visits to political office hoilders on health care financing	Number of advocacy vists conducted by 2013	Improving political will	-
			4.3.1.2	Conduct sensitization workshop for political office holders and other stakeholders on the need to adhere to regular release of funds	Number of workshops organized by 2015	Availability of funds	-
			4.3.1.3	Train and retrain health workers on key technical areas to improve performance and enhance productivity	70% of health managers and providers trained by 2015	Political will; Funding	3,742,871
			4.3.1.4	Ensure monthly documentation and progress reporting of activities and their costs in the health sector	Number of finanacial reports produced	Stakeholders commitment	-
			4.3.1.5	Organise fund raising events to support health care financing	Number of Fund raising events successfully organised	Improving economic condition	-
		4.3.2	To improve coordination of donor funding mechanisms		Coordinated donor funding by 2011		**-**
			4.3.2.1	Conduct a workshop for donor partners profiling and capacity assessment	Partners profiling conducted by 2010	Stakeholders commitment	-
			4.3.2.2	Conduct a baseline assessment of funding gaps exisiting in the system	Baseline assessment on funding gaps shared to all stakeholders by 2010 conducted	Stakeholders commitment	-
			4.3.2.3	Establish and operationalize Health Partners Forum (HPF)	Regular Quarterly Partners Forum by 2015	Political will; Funding	-
			4.3.2.4	Develop and make functional Costed Harmonized Workplan for Health intervetions	Annual costed health syatems workplan developed	Political will; Funding	-
			4.3.2.5	Promote basket funding of state level activities	Basket funding of activities promoted by 2012	Stakeholders commitment	-
	4.4	**To ensure efficiency and equity in the allocation and use of health sector resources at all levels**			1. Federal, 60% States and LGA levels have transparent budgeting and financial management systems in place by end of 2015 2. 60% of States and LGAs have supportive supervision and monitoring systems developed and operational by Dec 2012		**4,740,969**

		4.4.1	To improve Health Budget execution, monitoring and reporting		80% LGA have transparent budgeting and financial management systems in place as well as supportive supervision and monitoring systems developed and operational by 2015		**4,740,969**
			4.4.1.1	Develop a standard gudieline for budegtting and health finance reporting	Guideline for budgetting and health finance reporting developed by 2010	Political will; Stakeholders commitment	2,495,247
			4.4.1.2	Train directors and health teams on budgetting, execution, monitoring and reporting	All health manager trained on budget execution, monitoring and reporting	Political will; Funding	374,287
			4.4.1.3	Ensure the participation of Directors and health team in the preparation of budgets	Directors and health teams particpated in budget preparation	Improving political will	-
			4.4.1.4	Employment of health care financing professionals	Adequate health finance professionals employed by 2011	Availability of funds	-
			4.4.1.5	Train finance personell on budget tracking, monitoring and evaluation	100% of finance personnel trained on budget tracking by 2011	Political will; Funding	1,871,435
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							**2,076,631,013**
	5.1	**To improve data collection and transmission**			1. 50% of LGAs making routine NHMIS returns to State level by end 2010 2. 60% of States making routine NHMIS returns to Federal level by end 2010		**1,845,221,117**
		5.1.1	To ensure that NHMIS forms are available at all health service delivery points at all levels		80% of health facilities public and private having NHMIS forms by 2010.		**29,189,630**
			5.1.1.1	Carry out advocacy and sensitisation to policy makers at State and LGA levels on the importance of HMIS data.	All policy makers in the State & LGAs sensitized on the importance of NHMIS data by 2010.	Improving Political will	498,566
			5.1.1.2	Print NHMIS forms through the Ministry for Local Government and the State HSDP-II Project.	NHMIS forms printed by the Ministry for Local Govt and HSDP-II project by 2010.	Improving Political will; Continous funding support	28,220,719
			5.1.1.3	Provide budgetary allocation to HMIS and M&E officers at the State and LGA levels.	60% of LGA M&E and State NHMIS officers provided with budgetary allocation in 2015.	Improving Political will	-
			5.1.1.4	Distribute NHMIS forms to all health facilities at State and LGAs.	NHMIS forms distributed to all health facilities in the State and LGAs by 2010.	Improving Political will; Continous funding support	470,345
			5.1.1.5				-
		5.1.2	To periodically review NHMIS data collection forms		NHMIS forms periodically reviewed.		**11,946,771**

			5.1.2.1	Conduct a quarterly Health Data Consultative Committee meeting of 25 LGA M&E officers, SMOH and relevant stakeholders.	HDCC meetings held quarterly with 25 LGAs M&E officers, SMOH and relevant stakeholders.	Availability of fund	9,595,044
			5.1.2.2	Support Ferderal level review and harmonization of data collection tools	No. of national level tool review and harmonization meetings supported	Consistent stakeholders commitment	2,351,727
		5.1.3	To coordinate data collection from vertical programmes		Data collection from vertical programmes coordinated by 2010.		**10,912,011**
			5.1.3.1	Develop a State and LGA M & E framework as a guide to programming	State and LGA M&E framework developed by 2010.	Sustained stakeholders commitment; Avalability offund	8,983,596
			5.1.3.2	Constitute a State and LGA M&E Technical Working Group (TWG)	State and LGA TWG on NHMIS constituted by 2010.	Sustained stakeholders commitment; Avalability offund	1,928,416
			5.1.3.3	Strengthen the State and LGA Health Data Consultative Committee (HDCC)	State & LGAs HDCC strengthened by 2015.	Sustained stakeholders commitment; Avalability offund	-
		5.1.4	To build capacity of health workers for data management		Capacity of health workers on data management built by 2010.		**146,493,752**
			5.1.4.1	Assess the capacity needs of the state and LGA M & E systems	Reports of M&E capacity need assessment shared by 2010	Improve funding and political will	2,963,175
			5.1.4.2	Advocate for recruitment of Health Information Managers (Health Records Officers) at the State and LGA levels	Number of Information officers employed by 2015	Improve funding and political will	-
			5.1.4.3	Conduct training and retraining of health workers, in public and private health facilities on the use of NHMIS forms at State and the LGAs.	60% of health care providers trained on the use of NHMIS forms by 2011.	Improve funding and political will	32,971,207
			5.1.4.4	Train M&E officers and SMOH staff on computer applications and data management.	90% of M&E & SMOH staff trained on computer application and data management by 2015.	Improve funding and political will	16,490,307
			5.1.4.5	Provide IT equipments to support data management at state and LGA levels	60% of LGAs and the state M&E units supported by relevant IT equipments	Improve funding and political will	94,069,063
		5.1.6	To improve coverage of data collection		70% of LGAs health report received at the State by 2012.		**470,345**
			5.1.6.1	Strengthen partnership and collaboration among National Population Commission (NPC), National Bereau of Statistics (NBS) and LGAs on Data collection and management.	Data collection and management strengthened through collaboration with partners by 2015.	Improve funding and political will	-
			5.1.6.2	Timely collect NHMIS reports from State and LGAs.	80% of NHMIS reports collected from the LGAs by 2014.	Sustained stakeholders commitment; Avalability offund	470,345
			5.1.6.3	Advocate to LGA gatekeepers to improve funding of data generation at community levels	Number of advocacy visits done by 2012	Sustained stakeholders commitment	-

		5.1.7	To ensure supportive supervision of data collection at all levels		90% of supervisory visits carried out annually.		**1,646,208,607**
			5.1.7.1	Develop a Guideline for Integrated Supportive Supervision (ISS) for data collection within the overall context of the ISS for programme delivery.	Guideline on ISS developed for data collection by 2011.	Improve funding and political will	1,646,208,607
			5.1.7.2	Facilitate the implementation of the Guideline for ISS	60% of ISS guideline implemented.	Stakeholders commitment	-
			5.1.7.3	Provide 55 motorcycles for data collection and supervisions at State and LGA levels.	Number of motorcycles provided for data collection and supervision by 2011.	Availability of fund	-
			5.1.7.4	Procurement of 3 No (one per senatorial district) utility vehicle at SMOH level for HMIS activitis in the State.	Utility vehicles for SMOH HIMS unit procured by 2010.	Availability of fund	-
			5.1.7.5				-
	5.2	**To provide infrastructural support and ICT of health databases and staff training**			ICT infrastructure and staff capable of using HMIS in 50% of States by 2012		**103,475,970**
		5.2.1	To strengthen the use of information technology in HIS		50% of data managers able to use ICT by 2015.		**56,441,438**
			5.2.1.1	Procurement and installation of DHIS Software for SMOH and M&E Offices at the LGA levels.	DHIS software procured and installed for state and LGAs by 2010.	Improve funding and political will	28,220,719
			5.2.1.2	2 weeks Training of 25 LGA M&E officers, DPHCs and 22 State staff on DHIS software.	Training on DHIS software for LGAs M&E, DPHCs and SMOH staff conducted by 2011.	Improve funding and political will	28,220,719
		5.2.2	To provide HMIS Minimum Package at the different levels (FMOH, SMOH, LGA) of data management		100% HMIS minimum package provided at the State and LGAs levels by 2013.		**47,034,532**
			5.2.2.1	Advocacy to policy makers to ensure adoption and implementation of the HMIS Minimum Package.	Policy makers sensitized on adoption and implementation of NHMIS minimum package by 2010.	Stakeholders commitment	-
			5.2.2.2	Facilitate the provision of relevant manpower to manage data according to the HMIS Minimum Package at all levels.	Policy makers sensitized on recruitment of relevant manpower to manage data according to the NHMIS minimum package by 2012.	Improve funding and political will	-
			5.2.2.3	Provide DeskTop computers, high capacity printers and photocopiers for M&E activities at the LGA levels.	100% of LGAs provided with data processing equipment by 2011.	Improve funding and political will	28,220,719
			5.2.2.4	Provide furniture and metal cabinets for LGA M&E offices.	100% of LGAs provided with furniture by 2011.	Continuous and consistent funding	18,813,813
			5.2.2.5	Procurement of 26No 10KVA Generating sets for 25LGAs M&E offices and the State HMIS Unit.	100% of LGAs provided with Gen Sets by 2011.	Continuous and consistent funding	-
	5.3	**To strengthen sub-systems in the Health Information System**			1. NHMIS modules strengthened by end 2010 2. NHMIS annually reviewed and new versions released		**57,382,129**

		5.3.1	To strengthen the Hospital Information System		Hospital information system modules strengthened by 2015.		**10,347,597**
			5.3.1.1	Advocate to Health Management Board, Dept of Public and LGAs to create Information Management unit	90% of public health facilities has an organized information management unit by 2012	Continuos stakeholders commitment	-
			5.3.1.2	Provide infrastrucural support to Specialist, General, Comprehensive and Primary Health Facilities	60% of public health facilities has minimum infrastuctural needs by 2015	Continuos funding support	-
			5.3.1.3	Provide Technical Assistance and Support to Private Health Facilities	50% of private facilities with organized information sysytem by 2015	Improve funding and political will	-
			5.3.1.4	Develop, disseminate and implement the Guidelines for the management of Hospital Information System.	Guidelines for Hospital information system developed and disseminated by 2012.	Improve funding and political will	10,347,597
			5.3.1.5				-
		5.3.2	To strengthen the Disease Surveillance System		Disease Surveillance system strengthened and integreted into the NHMIS by 2012.		**47,034,532**
			5.3.2.1	Train and retrain the LGA DSN officers and the relevant officers of the state epidemiology department on IDSR	All LGA DSN officers trained on IDSR by 2011	Funding support will be sustained	28,220,719
			5.3.2.2	Print and disseminate all DSN forms to all LGAs in the state	No stock-out of DSN forms in all LGA by 2011 and beyond	Funding support will be sustained	18,813,813
			5.3.2.3	Strengthen the linkage between disease surveillance system and NHMIS.	Disease Surveillance system linkages strengthened and integreted into the NHMIS by 2012.	Improve funding and political will	-
			5.3.2.4	Provide monthly logistic/financial support to DSN officer for active data collection	80% of DSN officers provided with adequate support by 2015	Funding support will be sustained	-
	5.4	**To monitor and evaluate the NHMIS**			NHMIS evaluated annually		**70,551,797**
		5.4.1	To establish monitoring protocol for NHMIS programme implementation at all levels in line with stated activities and expected outputs				**3,292,417**
			5.4.1.1	Disseminate M & E Tools for use at different levels of data management.	60% of LGAs generates regular monthly M&E reports by 2015	Improve funding and political will	470,345
			5.4.1.2	Develop and disseminate an HMIS Quality Assurance Manual.	HMIS Quality Assurance Manual disseminated to all facilities by 2015	Improve funding and political will	2,351,727
			5.4.1.3	Conduct annual Data Quality assessment.	Number of assessments conducted	Continuous and consistent funding	470,345
		5.4.2	To strengthen data transmission				**67,259,380**
			5.4.2.1	Review/Disseminate Guidelines for data transmission from one level to another and between statkeholders	All M&E/DSN officers tranmit data as recommended by 2015	Political will shall be sustained	-
			5.4.2.2	Provide dedicated telephone for ease of communication between State and LGA M&E officers.	All M&E offices at state and LGAs have dedicated phone by2011	Improve funding and political will	1,411,036

			5.4.2.3	Provide internet access and support to state and LGA	50% of LGAs transmit data to higher levels through internet by 2015	Improve funding and political will	65,848,344
	5.5	**To strengthen analysis of data and dissemination of health information**			1. 50% of States have Units capable of analysing health information by end 2010 2. All States disseminate available results regularly		**-**
		5.5.1	To institutionalize data analysis and dissemination at all levels		Data analysis and dissemination institutionalized at State and LGAs level by 2012.		**-**
			5.5.1.1	Institutionalise data review sessions and support at State and LGA levels.	Data review sessions institutionalized at State and LGA levels by 2012.	Improve funding and political will	-
			5.5.1.2	Facilitate the production, publication and dissemination of periodic health data bulletin, Health Profile and Annual Health in Nigeria at LGAs and State levels.	60% of periodic health data bulletin produced and disseminated by 2012.	Improve funding and political will	-
COMMUNITY PARTICIPATION AND OWNERSHIP							
6. To attain effective community participation in health development and management, as well as community ownership of sustainable health outcomes							**1,384,420,675**
	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		**943,359,272**
		6.1.1	To provide an enabling policy framework for community participation		Policy framework for comminiy participation is provided by 2011		**880,493,302**
			6.1.1.1	Strengthning ward/village development committees	No. of Functional ward/village commitees operationalized by 2011	Improve political will and stakeholders commitment	854,544,486
			6.1.1.2	Develop and disseminate Policy Framework on Community Engagement and Participation	Policy disseminated to all stakeholders by 2011	Improve funding and political will	21,156,159
			6.1.1.3	Develop and share with all stakeholders a Costed Harmonized Annual Workplan on Community Participation	Number of Annual Workplan developed	Continuous and consistent funding and stakeholders commitments	4,792,657
		6.1.2	To provide an enabling implementation framework and environment for community participation		60% of LGAs consistently implement the community participation framework by 2012		**62,865,970**
			6.1.2.1	Conduct advocacy visit to policy makers and decision takers at state and LGA levels by 2010	60% of LGAs consistently implement the community participation framework by 2012	Stakeholders commitment	561,426
			6.1.2.2	Support advocacy to community leaders, gatekeepers and other stakeholders on the operatinalization of the framework.	60% of LGAs consistently implement the community participation framework by 2012	Stakeholders commitment	616,199
			6.1.2.3	Engage the community leaders and other stakeholders in the development of the Annual Workplan on community participation	60% of LGAs consistently implement the community participation framework by 2012	Continuous and consistent funding and stakeholders commitments	20,608,426

			6.1.2.4	create awareness among the communities through health education and promotion.	60% of LGAs consistently implement the community participation framework by 2012	Improve funding and political will	41,079,920
	6.2	**To empower communities with skills for positive health actions**			All States offer training to FBOs/CBOs and community leaders on engagement with the health system by end 2012		**431,339,155**
		6.2.1	To build capacity within communities to 'own' their health services		60% of LGAs consistently implement the community participation framework by 2012		**431,339,155**
			6.2.1.1	Map community and LGAs leaders, gatekeepers and other stakeholders	Local resources mapped by 2010	Improve political will and stakeholders commitment	61,619,879
			6.2.1.2	Conduct baseline and trainning needs assessment of mapped community gatekeepers.	Reports of various assessment shared with all stakeholders by 2011	Improve political will and stakeholders commitment	109,546,452
			6.2.1.3	Develop a capacity building plan for the mapped community gatekeepers and other stakeholders	60% of LGAs consistently implement the community participation framework by 2011	Continuous and consistent funding and stakeholders commitments	20,539,960
			6.2.1.4	Build capacity of community leaders and gatekeepers on basic facts on health interventions	60% of LGAs consistently implement the community participation framework by 2012	Continuous and consistent funding and stakeholders commitments	239,632,864
	6.3	**To strengthen the community - health services linkages**			50% of public health facilities in all States have active Committees that include community representatives by end 2011		**-**
		6.3.1	To restructure and strengthen the interface between the community and the health services delivery points		Strengthened interface between the community and the health facilities by 2011		**-**
			6.3.1.1	Assess and review existing interface between the community and the Service Delivery Points (SDPs).	Interface between the community and HF reviewed by 2010	Continuous community engagement and polical will	-
			6.3.1.2	Constitute/strengthen and operationalize the LGA, Ward and Community Health Development Committee	60% of LGAs have supportive committees at all levels by 2011	Continuous community engagement and polical will	-
			6.3.1.3	Encourage and support voluntary health services in the communities	Number of voluntary health workers	Continuous community engagement and polical will	-
			6.3.1.4	Promote the recruitment of competent members of the community as health workers within health facilities	50% of health workers at community level are from the community by 2015	Needed human resources will be available	-
			6.3.1.5	Support mechanisms that promotes referral and linkages between the traditional institutions and the health facilities	Strengthened interface between the community	Stakeholders commitment	-

					and the health facilities by 2011		
	6.4	**To increase national capacity for integrated multisectoral health promotion**			50% of States have active intersectoral committees with other Ministries and private sector by end 2011		**8,215,984**
		6.4.1	To develop and implement multisectoral policies and actions that facilitate community involvement in health development		Multisectoral policy disseminated by 2011		**8,215,984**
			6.4.1.1	Advocate to policy maker and community leaders on multisectoral response to health conditions	Number of advocacy visits done by 2011	Improve political will and stakeholders commitment	684,665
			6.4.1.2	Adapt/develop and disseminate multisectoral policies and plans on major health issues	Multisectoral policy disseminated by 2011	Availability of fund	6,846,653
			6.4.1.3	Constitute and operationalize the Multisectoral Operatrionalize Task Team (MOTT) at state and LGA level	MOTT operational in 60% of the LGAs and the state by 2011	Stakeholders commitment	684,665
	6.5	**To strengthen evidence-based community participation and ownership efforts in health activities through researches**			Health research policy adapted to include evidence-based community involvement guidelines by end 2010		**1,506,264**
		6.5.1	To develop and implement systematic measurement of community involvement		Community involvement of health intervention regularly measured		**1,506,264**
			6.5.1.1	Develop and share protocols for community survey and End of Programme assessment	Protocols shared with all stakeholders by 2012	Improve political will and stakeholders commitment	753,132
			6.5.1.2	Support periodic review of community engagement and participation in health interventions	Number of reviews conducted	Availability of fund	753,132
			6.5.1.3	Establish mechanisms to support communities to measure impact and document lessons learnt and best practices from specific community-level activities	60% of LGAs share reports of impact assessment and lessons learnt by 2015	Political will and sustained funding	-
PARTNERSHIPS FOR HEALTH							
7. To enhance harmonized implementation of essential health services in line with national health policy goals							**1,384,420,675**
	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. FMOH has an active ICC with Donor Partners that meets at least quarterly by end 2010 2. FMOH has an active PPP forum that meets quarterly by end 2010 3. All States have similar active committees by end 2011		**1,324,627,921**
		7.1.1	To promote Public Private Partnerships (PPP)		PPP activities Increased by 50% in the year 2020		**1,192,141,922**
			7.1.1.1	Mapping of various PPP initiatives for the state and LGAs	Initiatives on PPP mapped-out by the year 2010	Sustained political will and funding	9,665,130
			7.1.1.2	Develope state/LGA policy on PPP and operationalized same	PPP policy developed & operationalised by year 2015	Sustained political will and funding	16,040,294
			7.1.1.3	Engagement of the partners to selected PPP arrangement (contracting or out-sourcing,	50% of partners engaged in PPP arrngements by year 2015	Sustained political will and funding	20,476,971

				leases, concessions, social marketing, franchising mechanism)			
			7.1.1.4	Establish special incentives for partners in underserve areas	20% of partners in underserve areas supported by the year 2015	Sustained political will and funding	1,023,848,527
			7.1.1.5	Establish a joint M&E system	Joint M&E team constituted & functional by year 2011	Sustained political will and funding	122,111,001
		7.1.2	To institutionalize a framework for coordination of Development Partners		Framework for dev't partners institutionalized by the year 2011		**10,374,998**
			7.1.2.1	Establishment of development partners forum on PPP at both state and LGA levels and made operational	State dev't partners forum established & 40% LGA level attained by year 2012	Stakeholders commitment	68,257
			7.1.2.2	Establish data unit to coordinate resources for all PPP activities	Data unit established to coordinate all PPP activities by the year 2015	Sustained political will and funding	10,306,742
			7.1.2.3	Develop resource map and establish a joint funding agreement to coordinate PPP activities at state and LGAs	Resource map and joint agreement developed by the end of year 2010	Sustained political will and funding	-
			7.1.2.4	Develop a common basket funding system in the state/LGAs	MOU developed and signed by partners for common basket funding by the year 2012	Stakeholders commitment	-
		7.1.3	To facilitate inter-sectoral collaboration		Inter-sectoral collaboration strenghtened and functional through MDAs Forum by 2012		**819,079**
			7.1.3.1	Establish MDA forums and operationalize same	MDA forum established at state level by year 2012	Stakeholders commitment	68,257
			7.1.3.2	Hold quarterly MDAs meetings to collaborate and share progress	At least two quarterly meetings held every year	Sustained political will and funding	750,822
			7.1.3.3	Establish common resource basket for joint MDA activities	Joint MDA resource basket established by theyear 2013	Stakeholders commitment	-
			7.1.3.4	Strengthened information dissemination of MDAs inter-sectoral activities	At least 50% of the state population enlightened of MDAs intersectoral activites 2015	Stakeholders commitment	-
		7.1.4	To engage professional groups		All health professionals fully involved in health sector activities		**44,844,565**
			7.1.4.1	Train health workers on standard operation practice at all levels	90% of health workers operate SOP by the year 2015	Sustained political will and funding	20,067,431
			7.1.4.2	Engage Consultants for assessment and re-training of health professionals	66% of health professionals re-trained by 2015	Continuous funding support	17,951,478
			7.1.4.3	Strengthened the engagement of professionals in development of state and LGAs plans at all levels	State/LGA developed results oriented annual/operational plans for implementation	Stakeholders commitment	6,825,657
			7.1.4.4	Advocate for professional staff into the DPRS for research purposes	Professional staff in DPRS increased by 50% by 2012	Stakeholders commitment	-

			7.1.4.5	Collaborate with FMC Bida to conduct health research under PPP mandate	At least one research conducted every five years by each health professional group	Sustained political will and funding	-
		7.1.5	To engage with communities		70% increase of health activities at community/ward levels by 2015		**8,190,788**
			7.1.5.1	Establish Community Development Network (CDN) / Stakeholders Forum and operationalized same	CDN established in at least 50% of communities by year 2015	Stakeholders commitment	-
			7.1.5.2	Advocacy for the inclusion of PPP /health talks into community programmes	90% inclusion of Health talks and community programmes into PPP activities by 2011	Stakeholders commitment	-
			7.1.5.3	Identify and strenghten existing vulnerable groups for information dissemination e.g women in purdah, physically challenged, Orphans and Vulnerable Children (OVC) etc.	60% of vulnerable groups idenified and involved in IEC dev't and dissemination by the year 2014	Stakeholders commitment	-
			7.1.5.4	Adapt and develop state/LGA level standard operation practice for PPP in local languages	SOPs developed in three major local languages by the year 2011	Sustained political will and funding	8,190,788
			7.1.5.5	Convene Jama'a Forum on health performance, tranperency and acountability issues such as budget tracking and implementation	At least two Jama'a forums organised every year	Sustained political will and funding	-
		7.1.6	To engage with traditional health practitioners		50% of traditional health practitioners engaged in health activities by the year 2015		**68,256,568**
			7.1.6.1	Identify and collaborate with the various traditional health practitioners in the community and encourage their membership with NANTMP	NANTMP membership increased by 90% by the year 2015	Stakeholders commitment	-
			7.1.6.2	Train traditional health practitioners on their scope and limitations for standard operations	At least 50% Traditional health practitioners trained by the year 2015	Stakeholders commitment	20,476,971
			7.1.6.3	Collaborate to identify basic raw materials for drug development	30% of drugs produced should have local material sourced	Stakeholders commitment	-
			7.1.6.4	Engage traditional health practitioners as ambassadors to facilitate health promotion (e.g immunization programme, mosquito net distribution etc)	30% increase in the involvement of traditional health practitioners in health programmes by the year 2015	Sustained political will and funding	-
			7.1.6.5	Strengthen existing task force (counterfeit & fake drugs) at state level and establish new ones at the LGA levels to scrutinize health advertisements	Task force activities at State and LGA levels strengthened by 50% by 2015	Sustained political will and funding	47,779,598
	7.2						**59,792,754**
		7.2.1	Facilitate capacity building for improved health delivery		30% of private care providers have their capacity built by 2015		**59,792,754**
			7.2.1.1	Train private health care provuders on new strategies for health interventions	30% of private care providers have their capacity built by 2015	Sustained political will and funding	23,889,799
			7.2.1.2	Facilitate and support capacity building of the traditional care providers including TBAs	30% of private care providers have their capacity built by 2015	Stakeholders commitment	17,951,478

			7.2.1.3	Support training for the Patent Medicine Vendors	30% of private care providers have their capacity built by 2015	Sustained political will and funding	17,951,478
RESEARCH FOR HEALTH							
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							**2,768,841,350**
	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. FMOH publishes an Essential Health Research agenda annually from 2010		**2,069,410,073**
		8.1.1	To finalise the Health Research Policy at Federal level and develop health research policies at State levels and health research strategies at State and LGA levels		Finalized Health Research Policy, Developed and Strategized at State and LGAs by 2014.		**330,607,922**
			8.1.1.1	conduct stakeholders meeting on health research policy and strategy	Number of Stakeholder Meeting on Health Research conducted by 2010	Stakeholders commitment	55,990,051
			8.1.1.2	Inaguration of the TWG for health research policy development in the state and the LGAs	TWG for health research inaugurated at state and LGA by 2010	Improve political will and stakeholders commitment	55,990,051
			8.1.1.3	Identification of Key research Areas	Total No of research areas identified by 2010	Stakeholders commitment	-
			8.1.1.4	conduct workshops for the development of health research policies/strategies for state/LGAs and validation/printing of the documents	Policy document disseminated to all state level stakeholders and at least 50% of the LGAs	Continuous funding support	195,965,180
			8.1.1.5	Disseminate research policy document to stakeholders at the state and LGAs	Policy document disseminated to all state level stakeholders and at least 50% of the LGAs	Improve political will and stakeholders commitment	22,662,640
		8.1.2	To establish and or strengthen mechanisms for health research at all levels		Mechanism for health research strenghtened at all levels by the year 2010		**538,126,605**
			8.1.2.1	Inaugurate and operationalize ethical research committee at the state level	Ethical Research Committee inaugurated and operationalized by the year 2010	Improve political will and stakeholders commitment	4,443,655
			8.1.2.2	Purchase necessary equipments to support state and local level research	50% of Research equipment needed purchased by the year 2010	Continuous funding support	89,317,463
			8.1.2.3	Develop manpower for health research at state and LGAs	Number of people trained	Continuous funding support	-
			8.1.2.4	Advocate for Provision of healt research grants	Number of researches supported by grants	Improve political will and stakeholders commitment	-
			8.1.2.5	purchase of vehicles for logistics	No of vehicles purchased	Continuous funding support	444,365,487
		8.1.3	To institutionalize processes for setting health research agenda and priorities		Health research agenda and priorities institutionalized by 2015		**728,759,399**

			8.1.3.1	Construct research units in 3 geo-zones in the state	At least one research units constructed at the 3 geo political by 2015	Continuous funding support	88,873,097
			8.1.3.2	Furnish research units of 3 geo- zones in the state	Research units in 3 geo-zones of state well furnished by 2015	Continuous funding support	328,830,460
			8.1.3.3	Upgrade Health training institution in the state on research programmes	50 % of Heath Training institutions upgraded by the year 2012	Improve political will and stakeholders commitment	-
			8.1.3.4	organise Fund Raising on health research	Number of successful fund raising events organized	Improve political will and stakeholders commitment	-
			8.1.3.5	Train researchers on identification of relevant research agenda and priorities	60% of mapped researchers trained year 2015.	Improve political will and stakeholders commitment	311,055,841
		8.1.4	To promote cooperation and collaboration between Ministries of Health and LGA health authorities with Universities, communities, CSOs, OPS, NIMR, NIPRD, development partners and other sectors		No of meetings held by stakeholders and development partners.		**184,411,677**
			8.1.4.1	Inaugurate and make functional quarterly stakeholders Forum	Number of meetings held	Sustained stakeholders commitment and funding	-
			8.1.4.2	Organize regular annual workshop/symposium for all researchers and other stakeholders	Annual worshops held annually	Sustained stakeholders commitment and funding	184,411,677
			8.1.4.3	Organize retreat for Directorate of Primary Health Care on Health Reaserch isseus	All DPHC orientated on collaboration and cooperation in research by 2013	Sustained stakeholders commitment and funding	-
		8.1.5	To mobilise adequate financial resources to support health research at all levels		50% of financial requirements of priority health research mobilized		**91,539,290**
			8.1.5.1	Map Local resources to support health research	Local resources mapped to support health research by 2010	Stakeholders commitment	84,429,443
			8.1.5.2	Advocacy visit to stakeholder/partner for health research in the State and LGAs (public/Private)	Number of advocacy visit to stakeholders on health research conducted by the year 2010	Stakeholders commitment	7,109,848
			8.1.5.3	Develop advocacy tools and plan for health research funding	Advocacy tools and plan developed for health research by 2011	Stakeholders commitment	-
			8.1.5.4	Mobilize the organized private sector to partner with the govt on health research	40% of mapped organized private sector companies mobilized by 2015	Stakeholders commitment	-
		8.1.6	To establish ethical standards and practise codes for health research at all levels		Ethical Standards and practice codes at all level established by 2011		**195,965,180**
			8.1.6.1	Conduct stakeholders meeting for adaptation/formulation of ethical standard and practice code	Meeting conducted by 2010	Stakeholders commitment	6,665,482
			8.1.6.2	Constitute high level ethical review and practice code committee	Ethical review committee operationalized by 2011	Stakeholders commitment	2,666,193

			8.1.6.3	Develop and disseminate ethical standard code document to health research institutions	Ethical standard code document disseminated to all stakeholders	Stakeholders commitment	177,746,195
			8.1.6.4	Institutionalize monitoring and control mechanism of on-going research	On-going researches are regularly monitored by 2013	Stakeholders commitment	8,887,310
			8.1.6.5				-
	8.2	**To build institutional capacities to promote, undertake and utilise research for evidence-based policy making in health at all levels**			FMOH has an active forum with all medical schools and research agencies by end 2010		**699,431,277**
		8.2.1	To strengthen identified health research institutions at all levels		Identified health research institutions strenthenedat all levels by 2015		**506,576,655**
			8.2.1.1	Upgrade schools of health technology to colleges of Health Technology	No of schools of health tech. upgraded	Availability of fund	-
			8.2.1.2	Purchase Reaserch Equipment to the colleges of Health Technology	50%f Research equipment purchased	Improve funding and political will	222,182,744
			8.2.1.3	Train teacher on advance reaserch programmes	No of teachers trained on advanced research progrmmes	Stakeholders commitment	222,627,109
			8.2.1.4	Construct and equip research laboratories in colleges of Health Technologies	50% of laboratories equipped in colleges of healyh technology by 2013	Availability of fund	-
			8.2.1.5	Constitute ethical and code disciplinary committees in the colleges	Ethical and code disciplinary committees constituted and opeationalized by 2011	Stakeholders commitment	61,766,803
		8.2.2	To create a critical mass of health researchers at all levels		Critical mass on health research created by 2012		**134,642,743**
			8.2.2.1	Identify key researchers in different intervention areas in the State	Critical mass on health research created by 2012	Stakeholders commitment	444,365
			8.2.2.2	Constitute a forum of pricipal investigators in each intervention areas in the State	Critical mass on health research created by 2012	Stakeholders commitment	58,211,879
			8.2.2.3	Provide financial and material to the Principal Investigators	Critical mass on health research created by 2012	Improve funding and political will	-
			8.2.2.4	Conduct quarterly meetings with the Principal Investigators on research findings and decision making	Critical mass on health research created by 2012	Improve funding and political will	75,986,498
			8.2.2.5	Second relevant officers to institute for capacity building	Critical mass on health research created by 2012	Stakeholders commitment	-
		8.2.3	To develop transparent approaches for using research findings to aid evidence-based policy making at all levels		Policy development and review are based on research findings by 2012		**58,211,879**
			8.2.3.1	Publish research findings through bulletin, fact sheets and newsletter	Research finding disseminated to 50% 0f mapped stakeholders	Improve funding and political will	58,211,879
			8.2.3.2	Disseminate research policy document and findings to stakeholders at the state and LGAs	Research finding disseminated to 50% 0f mapped stakeholders	Stakeholders commitment	-
			8.2.3.3	Support the constitution and operationalization of task Force on evidence-based planning	Health activities based on research findings by 2015	Stakeholders commitment	-
							138,442,067,507

Annex 2: Niger State Results/M&E Framework

NIGER 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. Number of Laws and by-laws regulating traditional medical practice at State and LGA levels	Laws and bye-Laws	0	50	75	95
	5. % of LGAs enforcing traditional medical practice by-laws	LGA Annual Report	0	45%	65%	85%
3. Strengthened accountability, transparency and responsiveness of the State health system	6. % of LGAs which have established a Health Watch Group	LGA Annual Report	0	50	75	100
	7. % of recommendations from health watch groups being implemented	Health Watch Groups' Reports	0	25	50	75
	8. % LGAs aligning their health programmes to the SSHDP	LGA Annual Report	0	50	75	100
	9. % DPs aligning their health programmes to the SSHDP at the LGA level	LGA Annual Report	No Baseline	50	75	100
	10. % of LGAs with functional peer review mechanisms	SSHDP and LGA Annual Review Report	0	25	50	75%

	11. % LGAs implementing their peer review recommendations	LGA / SSHDP Annual Review Report	No Baseline	50	75	100%
	12. Number of LGA Health Watch Reports published	Health Watch Report	0	50	75	100
	13. Number of "Annual Health of the LGA" Reports published and disseminated annually	Health of the State Report	0	50	75	100%
4. Enhanced performance of the State health system	14. % LGA public health facilities using the essential drug list	Facility Survey Report	50	75	85	100%
	15. % private health facilities using the essential drug list by LGA	Private facility survey	40	50	75	10000%
	16. % of LGA public sector institutions implementing the drug procurement policy	Facility Survey Report	0	50	75	100%
	17. % of private sector institutions implementing the drug procurement policy within each LGA	Facility Survey Report	0	10	25	50%
	18. % LGA health facilities not-experiencing essential drug/commodity stockouts in the last three months	Facility Survey Report	5	25	50	75%
	19. % of LGAs implementing a performance based budgeting system	Facility Survey Report	0	25	50	75%
	20. Number of MOUs signed between private sector facilities and LGAs in a Public-Private-Partnership by LGA	LGA Annual Review Report	0	2	4	6
	21. 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	0	5	12	25
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	22. % of LGAs with a functioning public health facility providing minimum health care package according to quality of care standards.	NPHCDA Survey Report	5	25	50	75%

	23. % health facilities implementing the complete package of essential health care	NPHCDA Survey Report	5	50	75	100%
	24. % of the population having access to an essential care package	MICS/NDHS	20	40	75	100%
	25. Contraceptive prevalence rate (modern and traditional)	NDHS	15%	40%	50%	60%
	26. Number of new users of modern contraceptive methods (male/female)	NDHS/HMIS	4	30	50	65
	27. % of new users of modern contraceptive methods by type (male/female)	NDHS/HMIS	4	30	50	65
	28. % service delivery points without stock out of family planning commodities in the last three months	Health facility Survey	20%	25	60	85%
	29. % of facilities providing Youth Friendly RH services	Health facility Survey	0	20	45	70
	30. % of women 15-19 who have begun child bearing	NDHS/MICS	2	1	1	0.5
	31. % of pregnant women with 4 ANC visits performed according to standards*	NDHS	47	60	75	90%
	32. Proportion of births attended by skilled health personnel	HMIS	17	45	75	85
	33. Proportion of women with complications treated in an EmOC facility (Basic and/or comprehensive)	EmOC Sentinel Survey and Health Facility Survey	5	30	50	75%
	34. Caesarean section rate	EmOC Sentinel Survey and Health Facility Survey	5%	10%	15%	30%
	35. Case fertility rate among women with obstretic complications in EmOC facilities per complication	HMIS	35%	30%	30%	20%
	36. Perinatal mortality rate**	HMIS	50/1000LBs	45/1000LBs	400/1000LBs	35/1000 LBs
	37. % women receiving immediate post partum family planning method before discharge	HMIS	1%	10	30	50
	38. % of women who received postnatal care based on standards within 48h after delivery	MICS	10	30	50	75

	39. Proportion of women screened for cervical cancer	HMIS	No Baseline	20%	35%	50%
	40. % of newborn with infection receiving treatment	MICS	No Baseline	25	45	6500%
	41. % of children exclusively breastfed 0-6 months	NDHS/MICS	35	40	75	80
	42. Proportion of 12-23 months-old children fully immunized	NDHS/MICS	60.00%	80	90	98
	43. % children <5 years stunted (height for age <2 SD)	NDHSMICS	47.00%	35%	25%	10%
	44. % of under-five that slept under LLINs the previous night	NDHS/MICS	1.00%	80%	95%	98%
	45. % of under-five children receiving appropriate malaria treatment within 24 hours	NDHS/MICS	40	65%	85%	95%
	46. % malaria successfully treated using the approved protocol and ACT;	MICS	No Baseline	60%	85%	90%
	47. Proportion of children using effective malaria prevention and treatment measures	MICS	No Baseline	60%	80%	90%
	48. % of women who received intermittent preventive treatment for malaria during pregnancy	NDHS/MICS	47%	65	80	95
	49. HIV prevalence rate among adults 15 years and above	NDHS	6.20%	5.30%	4	3
	50. HIV prevalence in pregnant women	NARHS	6.2	5	4	3
	51. Proportion of population with advanced HIV infection with access to antiretroviral drugs	NMIS	67%	75	85	90
	52.Condom use at last high risk sex	NDHS/MICS	50%	65	70	80
	53. Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS	NDHS/MICS	63%	75	90	100
	54. Prevalence of tuberculosis	NARHS	3.60%	3	2	1
	55.Death rates associated with tuberculosis	NMIS	35%	30	15	5
	56. Proportion of tuberculosis cases detected and cured under directly observed treatment short course	NMIS	76	85	90	97

Output 6. Improved quality of Health care services	57. % of staff with skills to deliver quality health care appropriate for their categories	Facility Survey Report	50%	60	70	85
	58. % of facilities with capacity to deliver quality health care	Facility Survey Report	35%	55	70	85
	59. % of health workers who received personal supervision in the last 6 months by type of facility	Facility Survey Report	20	45	60	75
	60. % of health workers who received in-service training in the past 12 months by category of worker	HR survey Report	15	25	45	65
	61. % of health facilities with all essential drugs available at all times	Facility Survey Report	20	50	75	95
	62. % of health institutions with basic medical equipment and functional logistic system appropriate to their levels	Facility Survey Report	35	45	50	75
	63. % of facilities with deliveries organizing maternal and/or neonatal death reviews according to WHO guidelines on regular basis	Facility Survey Report	No Baseline	30	45	60
Output 7. Increased demand for health services	64. Proportion of the population utilizing essential services package	MICS	No Baseline	25	55	70
	65. % of the population adequately informed of the 5 most beneficial health practices	MICS	No Baseline	25	60	80
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**						
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	66. % of wards that have appropriate HRH complement as per service delivery norm (urban/rural).	Facility Survey Report	No Baseline	20	40	65
	67. Retention rate of HRH	HR survey Report	No Baseline	35	65	85
	68. % LGAs actively using adaptations of National/State HRH policy and plans	HR survey Report	No Baseline	25	45	75
	69. Increased number of trained staff based on	HR survey Report	No Baseline	20	50	75

	approved staffing norms by qualification					
	70. % of LGAs implementing performance-based managment systems	HR survey Report	No Baseline	30	45	75
	71. % of staff satisfied with the performance based management system	HR survey Report	No Baseline	25	50	75
Output 8: Improved framework for objective analysis, implementation and monitoring of HRH performance	72. % LGAs making availabile consistent flow of HRH information	NHMIS	35	45	75	10000%
	73. CHEW/10,000 population density	MICS	No Baseline	1:4000 pop	1:3000 pop	1:2000 pop
	74. Nurse density/10,000 population	MICS	No Baseline	1:8000 pop	1:6000 pop	1:4000 pop
	75. Qualified registered midwives density per 10,000 population and per geographic area	NHIS/Facility survey report/EmOC Needs Assessment	No Baseline	1:4000 pop	1:3000 pop	1:2000 pop
	76. Medical doctor density per 10,000 population	MICS	1:25,000	1:20000	1:15,000	1:10000
	77. Other health service providers density/10,000 population	MICS	No Baseline	1:4000 pop	1:3000 pop	1:2000 pop
	78. HRH database mechanism in place at LGA level	HRH Database	0	50	65	8500%
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**						
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	79. % of LGAs implementing state specific safety nets	SSHDP review report	No Baseline	10	50	85

financial catastrophy and impoversihment as a result of using health services in the State						
	80. Decreased proportion of informal payments within the public health care system within each LGA	MICS	No Baseline	70	30	15
	81. % of LGAs which allocate costed fund to fully implement essential care package at N5,000/capita (US$34)	State and LGA Budgets	0	25	45	80
	82. LGAs allocating health funding increased by average of 5% every year	State and LGA Budgets	0	25	40	75
Output 12: Improved efficiency and equity in the allocation and use of Health resources at State and LGA levels	83. LGAs health budgets fully alligned to support state health goals and policies	State and LGA Budgets	No Baseline	40	60	9500%
	84.Out-of pocket expenditure as a % of total health expenditure	National Health Accounts 2003 - 2005	70%	60%	50%	40%
	85. % of LGA budget allocated to the health sector.	National Health Accounts 2003 - 2005	10%	15%	20%	25%
	86. Proportion of LGAs having transparent budgeting and finacial management systems	SSHDP review report	No Baseline	25%	4000%	6000%
	87. % of LGAs having operational supportive supervision and monitoring systems	SSHDP review report	25	4500%	60	7500%
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	88. % of LGAs making routine NHMIS returns to states	NHMIS Report January to June 2008; March 2009	40	60	75	100
	89. % of LGAs receiving feedback on NHMIS from SMOH		25	50	75	100

	90. % of health facility staff trained to use the NHMIS infrastructure	Training Reports	20	60	75	95
	91. % of health facilities benefitting from HMIS supervisory visits from SMOH	NHMIS Report	30	45	75	85
	92.% of HMIS operators at the LGA level trained in analysis of data using the operational manual	Training Reports	No Baseline	40%	75%	100%
	93. % of LGA PHC Coordinator trained in data dissemination	Training Reports	75	100%	100%	100%
	94. % of LGAs publishing annual HMIS reports	HMIS Reports	45	75%	85%	100%
	95. % of LGA plans using the HMIS data	NHMIS Report	TBD	40%	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	96. Proportion of public health facilities having active committees that include community representatives (with meeting reports and actions recommended)	SSHDP review report	5%	25%	50%	75%
	97. % of wards holding quarterly health committee meetings	HDC Reports	TBD	25%	50%	75%
	98. % HDCs whose members have had training in community mobilization	HDC Reports	TBD	40%	75%	100%
	99. % increase in community health actions	HDC Reports	TBD	10%	25%	50%
	100. % of health actions jointly implemented with HDCs and other related committees	HDC Reports	TBD	25%	40%	60%
	101. % of LGAs implementing an Integrated Health Communication Plan	HPC Reports	TBD	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	102. Increased number of new PPP initiatives per year per LGA	SSHDP Report	TBD	25%	40%	60%
	103. % LGAs holding annual multi-sectoral	SSHDP Report	TBD	25%	50%	75%

	development partner meetings					
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	104. % of LGAs partnering with researchers	Research Reports	TBD	10%	25%	50%
	105. % of State health budget spent on health research and evaluation	State budget	N o baseline	1%	1.50%	2%
	106. % of LGAs holding quarterly knowledge sharing on research, HMIS and best practices	LGA Annual SHDP Reports	N o baseline	10%	25%	50%
	107. % of LGAs participating in state research ethics review board for researches in their locations	LGA Annual SHDP Reports	n o baseline	40%	75%	100%
	108. % of health research in LGAs available in the state health research depository	State Health Reseach Depository	N o baseline	40%	75%	100%
Output 17: Health research communication strategies developed and implemented	109. % LGAs aware of state health research communication strategy	Health Research Communication Strategy	TBD	40%	75%	100%