NASARAWA STATE GOVERNMENT

STRATEGIC HEALTH DEVELOPMENT PLAN
(2010-2015)

Nasarawa State Ministry of Health

March 2010

Contents

LIST OF ACRONYMS AND ABBREVIATIONS

CHIS	Community Health Insurance Scheme
CORPs	Community oriented resource persons
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
EMP	Elderly Medical Programme
FBOC	Free Basic Obstetric Care
FCT	Federal Capital Territory
FMOH	Federal Ministry of Health
GDP	Gross Domestic Product
HDCC	Health Data Consultative Committee
HF	Health Facility
HIS	Health Management Information System
HIV/AIDS	Human Immuno Deficiency Virus/Acquired Immune Deficiency Syndrome
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
ISS	Integrated supportive supervision
ITNs	Insecticide treated nets
JFA	Joint Funding Agreement
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
MDGs-CGs	Millennium Development Goals-Conditional Grants
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
NHIS	National Health Insurance Scheme
NHMIS	National Health Management Information System

NHREC	National Health Research Committee
NPHCDA	National Primary Health Care Development Agency
NSHDP	National Strategic Health Development Plan
SSHDPf	State Strategic Health Development Plan Framework
NYSC	National Youth Service Corps
OPS	Organized Private Sector
PHC	Primary Health Care
SPHCDA	State Primary Health Care Development Agency
PPP	Public Private Partnerships
QA	Quality Assurance
RDBs	Research data banks
SHAs	State Health Accounts
SMOH	State Ministry of Health
SWAPs	Sector-Wide Approaches
TB	Tuberculosis
TBAs	Traditional birth attendants
U-5	Under 5 years
USAID	Unites States AID
VHW	Village health workers
WHO	World Health Organization

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Ministry of Health,
Nasarawa State.

PREFACE

The Nasarawa State Strategic Health Development Plan (NSHDP) has been developed taking into consideration all other existing documents and in line with the objectives and strategies in the National Health Policy, the Health Sector Reform Strategy, and NEEDS, SEEDS, LEEDS and the MDGs. The policy and strategic directions to be pursued are well captured in this document.

In addition to the priority concerns and peculiarity of the state, and a medium-term plan, a community -based primary health care service is at the heart of this document. This will ensure that the people will receive at least basic minimum health care at a cost they and the state government can afford.

I call on Non-Governmental Organizations, Development Partners and the Private Sector to channel their energy and resources toward implementing this plan as a priority.

Hon Commissioner,
Nasarawa State

FOREWORD

This document is intended to provide guidance and ideas to implementers in the State and LGA Health Planning teams as they carry out diverse programmes to move forward the health system of our State. They are to facilitate the translation of the intentions of the State Health Policy into actions that can be monitored and will benefit our people. It will form the basis for resource allocation to be deployed by Ministries of Health and LGA Health Departments in their implementation. This SHDP also lays emphasis on the increased managerial responsibility to be assumed by the State, Local Governments, and the Communities for the operation and support of their health care services and is expected to have salutary effect on our Health development efforts.

In order to ensure adequate funding for health, consequent upon the competing demands on the State's economy, it is necessary to critically appraise our development and operating expenditures funded from government sources, and to provide guidelines for expanding public participation in the financing of health care services through cost pooling, and other cost-sharing mechanisms of state's choice, involvement of non-governmental organizations, and the private sector as desirable. The private sector, development partners and the Non- governmental organizations are expected to buy into this epoch making document by funding relevant areas of this Strategic Plan 2010-2015 and the Operational Plan for 2010.

The State Health Development Plan reflects the priority concerns and peculiarity of our State and will have improved health service delivery including community based primary health care as its centre-piece. We expect all citizens to receive at least basic minimum health care at a cost they and the government can afford.

In order to ensure effective referral support to primary health care, emphasis also has been placed on the linkages of service delivery to existing secondary health care facilities, especially general hospitals.

I urge all stakeholders to utilize this carefully crafted document and lay foundation for an efficient health system in Nasarawa State.

Permanent Secretary,
Ministry of Health,
Nasarawa State

EXECUTIVE SUMMARY

The Vision of the State SHDP is to have a State that guarantees quality health care service delivery system that drives integrated rural development while significantly increasing quality and life expectancy of the people.

Nasarawa State was created from the former Plateau State on October 1, 1996. It has a land mass of 27,117km^2, 70% of which is arable land for agriculture. The State has an official population of 1,869,377 million but is projected to be over 2 million in 2009. It is made up of 13 LGAs comprising diverse ethnic groups, such as, Alago, Eggon, Kanuri, Gwandara, Igbira, Mada, Gbagi etc. It is bounded by 7 states namely, Plateau in the North East, Kaduna in the North, Kogi in South West, Taraba in South East, Benue in South and FCT in the North West.

Majority of the people who reside in the rural areas are predominantly subsistence farmers. Common agricultural produce include: yam, cassava, rice, soya bean, sesame, sorghum, maize, groundnut, melon and other oil seeds.

The State is richly endowed with metallic, non-metallic, precious and other industrial mineral deposits.

Adult literacy level is low with less than 80% of school age children in school. Women who constitute about 55% of the population are largely illiterate, poor and have low access to economic and political rights and opportunities.

The main policy thrust of the present Administration revolves around its 13-point agenda, with health care delivery as a major component. Nasarawa State has produced its own State Strategic Health Development Plan (SSHDP) 2010-2015, in line with National strategic Health Development Plan (NSHDP) which is a pioneering effort of Government of bringing health issues to the fore in line with MDGs vision 2015 and the national targets.

Bearing in mind the vision of the State and its peculiarities, Nasarawa State has prioritized the eight thematic areas with specific goals and strategic objectives that will lead to rapid socio-economic development and significantly improve our health indices.

The thematic areas in order of priority are: Health Care Delivery, Human Resource for Health, Leadership and Governance, Financing for Health, Health Management Information System, Community Participation and Ownership, Partnerships for Health and Research for Health.

The economic mainstay of the residents is agriculture. Despite this potential, the state has not been able to convert such strength into an agro-based economic force, moreso there is a high level of malnutrition especially amongst the under – 5 children. In addition, there is huge untapped mineral wealth. The private sector is weak and unorganised with low industrial base leading to low productivity.

Major causes of morbidity, mortality and disability include Malaria, Pneumonias, Pulmonary Tuberculosis, Diarrhoeal diseases, malnutrition with accompanying anaemia, HIV/AIDS,STDs, Road Traffic Accidents (RTAs), Typhoid Fever, pregnancy related complications and malnutrition in chidren especially children under the age of 5 years. Some of the underlying factors include paucity of skilled human resource for health, skewed distribution of health care facilities leading to low access and quality of services, defective and poorly coordinated preventive and health promotive programmes. Other causes of poor health include poverty, illiteracy, cultural barriers and behaviours. All these complex and interelated factors lead to poor health indicators for Nasarawa State.

Primary Health Care which was prostrate has received a boost through MDG infrastructure intervention and the recent establishment of the State Primary Health Care Development Agency (NSPHCDA).

The major causes of the low implementation of the Ward Minimum Package of Care are paucity of skilled human resource for health, inadequate funding, skewed distribution of health facilities, poor infrastructural facilities, low awareness, low community participation, poor access and low utilization of services among the people.

The Ward Minimum Health Care Package (WMHCP), as adopted, consists of a set of health interventions and services that address health and health-related problems that would result in substantial health gains at low cost to government, development partners and the people. Nasarawa State will include the following ward minimum health care package in its SSHDP:-

1. Availability of Long Lasting Insecticidal Nets (LLINs) for all pregnant women and children under five (5) years of age.

2. Provision and use of Artemisinin-based Combination Therapy (ACT) for treatment of uncomplicated malaria; and

3. Provision of Sulphadoxine Pyrimethamine for intermittent Preventive Treatment (IPT) of malaria in pregnant women.

This includes Integrated Management of Maternal, Neonate and Childhood Health (IMNCH) strategy with particular emphasis on routine immunization, management of malaria in children under 5years of age, pneumonia, diarrhoea, HIV/AIDS, among others at State and Local Government levels. Other areas of focus are communicable diseases such as:

- Lassa fever
- Tuberculosis
- Leprosy
- Sexually Transmitted Infections (STIs)
- Neglected Tropical Diseases e.g Onchocerciasis; and

- Non-communicable diseases such as: Sickle Cell Diseases, Breast and cervical cancers, Hypertension, Diabetes and Road Traffic Accidents (RTAs)

Tracer interventions have been identified for the three levels of interventions. These interventions have been selected based on their proven and high impact on health outcomes such as mortality and are internationally recommended interventions. The three levels are: Household and Community level Interventions; Population-oriented Interventions; and Individual clinical Interventions

The targets to these interventions include:

- Prevalence of communicable and non-communicable disease reduced by 50% by 2012
- 50% of the population in the State is within 30mins walk or 5km of a health service by end 2012
- 50% of obsolete equipment replaced in secondary health care facilities and PHCs by 2011.
- 100% of state-owned hospitals and the 13 LGAs supplied with 1 ambulance each by end of 2012
- Average demand for health care services rises to 2 visits per person per annum by end 2011
- 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 2012
- Access to IMNCH, Childhood immunizations & treatment of common childhood problems in 80% of Health facilities in the State by year 2012 and 100% by 2015
- Routine immunization institutionalized by 2011.
- Prevalence of child morbidity and mortality reduced by 50% by 2013
- 60% of deliveries are attended to by skilled staff by end of 2012 and 90% by year 2015.

The total cost of the State SHDP for the period 2010 – 2015 is put as **Forty three million, one hundred billion, forty three thousand, eight hundred and ninety five (~~₦~~ 43,100,043,895)**

The Implementation Framework of the plan has as its underlining principles, transparency and accountability, which are core values of the present administration. There is a functional ‘due process ’office and a Ministerial Tenders Board to ensure the enforcement. The private sector shall play some important role in the whole financing process.

In the State Strategic Health Development Plan (SSHDP) 2010-2015 and the Operational Plan, 2010, monitoring and evaluation has been given due prominence under each priority area. This is to redress previous lapses in project management in the State. It is hoped that this will also build a base for the needed development for Health Management Information System (HMIS) in Nasarawa State.

CHAPTER 1 BACKGROUND INFORMATION

1.1 Background

Nasarawa State with capital in Lafia which is one of the 36 states in Nigeria, was created on the October 1, 1996 from the then Plateau State. It is located in the North Central geo-political zone of Nigeria between latitudes 7^{o} and 9^{o} North and longitudes 7^{o} and 10^{o} East covering a landmass of 27,117sq km. The landscape is mainly rocky and of undulating high lands reaching an average height of 1,400m above sea level providing typical tropical climate with temperatures ranging between 60^{o}F and 80^{o}F and rainfall between 132cm and 145cm. It shares common boundaries with Benue State to the south, Kogi State to the west, the Federal Capital Territory to the north-west, Kaduna and Plateau States to the north-east, and Taraba State to the south-east[1].

The 1991 census puts the State's population at 1.2 million while the 2006 census population is 1,869,377 with males making up 943,801 (51%) and females accounting for 925,567 persons (49%). However, with the increasing influx of people into Karu and Keffi LGAs due to proximity to the FCT, Abuja, the population is estimated to be over 2 million. The population has over 30 ethnic groups, who are mainly subsistence farmers with poverty prevalence increasing in the geopolitical zone from 64.7% to 74%[2].

Administratively, the State's machinery is structured in line with and complimented by the State political administrative structures. There are 13 local government areas (LGAs) and within them are 16 semi-independent development areas. The Local Governments include: Akwanga, Awe, Doma, Karu, Keana, Keffi, Kokona, Lafia, Nasarawa, Nasarawa Eggon, Obi, Toto and Wamba.

1.1.1 Human Development Indicator (HDI)

Most of the human development indicators specifically for Nasarawa State are not available due to inadequacy in the system of information management. However, the State office of statistics tries to collate and summarize available information from LGAs and the State level into annual or biannual statistics book. The latest, 2007 statistics year book, which is still in draft, has a lot of areas with incomplete information and the quality is not assured despite being information mainly from the year 2005.

The State Human Resource and Infrastructure indicators are: -

- Number of Doctors 187
- Number of Nurses 941
- Number of Midwives 165
- Number of Pharmercist 73
- Number of Pharm Tech. 50
- Radiographers 13
- Health Record Officers 112
- Medical Lab Scientists 65
- Medical Lab Tech. & Asst. 218
- Dental Technician 31
- CHO 136
- CHEW 1067
- EHO 374
- OPD attendance 167,658
- Live births reported 3,441
- Public Primary School Enrolment 647,779
- Number of Public Primary Schools 1,131
- Proportion of rural population with access to potable water 10%
- Proportion of urban population with access to potable water 20%

The disease surveillance report of 2008 revealed the following diseases conditions as being the most prevalent causes of morbidity and mortality in the state.

Malaria is one the major health problem in the state. One quarter of the population has at one time or another had a serious episode of Malaria annually. This account for a major portion of out patients cases in the state.

Table 2 Top ten causes of morbidity and mortality.

S/No.	Top ten causes of morbidity	Cases	Top ten causes of mortality	Deaths
1.	Malaria	59,716	Malaria	332
2.	Diarrhea al type	29,682	Diarrhea all type	41
3.	Tuberculosis	13,079	Tuberculosis	54
4.	Pneumonia	9,423	Pneumonia	40
5.	HIV/AIDS	8,642	HIV/AIDS	143
6.	Malaria in pregnancy	8,372	Malaria in pregnancy	8
7.	Typhoid fever	7,963	Typhoid fever	12
8.	Measles	7,326	Measles	163
9.	Sexually Transmitted Diseases (STDs)	4,214	Sexually Transmitted Diseases (STDs)	1
10.	Road Traffic Accidents (RTA)	4,374	Road Traffic Accidents (RTA)	76

Majority of the people who reside in the rural areas are predominantly subsistence farmers. Common agricultural produce include: yam, cassava, rice, soy bean, sesame, sorghum, maize, groundnut, melon and other oil seeds.

1 Nasarawa State Economic Empowerment and Development Strategy (NASEEDS)
2 Nigeria MDG Report 2005
3 2005 National HIV/Syphilis Sero-prevalence Sentinel Survey Report (National average = 4.4)

From inception on October 1, 1996, Nasarawa State was led by the military government of Wing commander Abdulahi Ibrahim until Col Bala Mande took over before the advent of democracy in 1999.

Alh Abdulahi Adamu became the Executive Governor of Nasarawa State from 1999 to May 2007.

On May 29, 2007, the administration of Alhaji Aliyu Akwe Doma, OON was inaugurated. The main policy thrust of the present Administration revolves around its 13-point agenda, with health care delivery as a major component.

Nasarawa State applied and secured the Millennium Development Goals 2007 Conditional Grants scheme to the tune of Six hundred and thirty eight million, seven hundred thousand naira (N638,700,00.00) for the purpose of upgrading 58 Primary Health Care Clinics so as to support basicquality maternal and child care services. In addition, the grant was also used to provide each one of them with potable water through Solar Powered Boreholes. This well needed support attracted from Office of the Senior Special Assistant to the President on MDGs (OSSAP-MDGs) to achieve the set purpose.OSSAP-MDGs has ignited the flame of partnership between the State Government, Local Governments and the Communities which has yielded additional funding to the project totalling about two hundred and ninety million (N290,000.000.00), used mainly in renovation, fencing, provision of external sanitary facilities and project supervision, monitoring and evaluation.

CHAPTER 2 SITUATION ANALYSIS

Nasarawa state derives most of its funds from the Federal allocation and it remains mainly a rural agrarian society. The State is richly endowed with metallic, non-metallic, precious and other industrial mineral deposits.

2.1 Socio –Economic Development

Nasarawa State has agriculture as the mainstay of its economy with the production of varieties of cash crops throughout the year. It is also contains minerals such as salt and bauxite. Other Solid Mineral in the State include Barytes (Azara) Salt mines (Keana, Awe and Azara), gypsum (Awe and Azara); Marble (Toto), galleria, tin, gemstone, mica, kaolin and columbite are found in large quantities in many parts of the State. Also available are clays, zircon, feldspars, cassiterite, and limestone.Its fledging solid mineral resources are receiving a boost from government in terms of putting in place necessary enabling environment..

Rural Electrification Policy and Infrastructure
Nasarawa State mainly depends on the National power supply of the Power Holdings Company of Nigeria which is at the moment not sufficient and not reliable. The State has in its medium plan, a hydroelectric generating plant which is currently under construction but far from completion because it is capital intensive. Most communities in the State are rural and without electricity supply.

Rural Water Supply and Sanitation Policy and Infrastructure
The water supply and Sanitation sector in Nasarawa state is still underdeveloped when compared to other states within the north central zone. Interestingly, Nasarawa state has the potentials in terms of comparative advantage for providing water to both its rural and urban populations owing to the fact that the state is naturally endured with the twin factor of geography and geology conducive for water development.

Geographically, water table depths are found within 30 to 100 meters across the state, which has two types of soil geology: Sedimentary type found around Lafia, Obi, Awe, Keana and Doma LGAs; and Basement complex in Nasarawa Eggon, Akwanga, Wamba, Kokona, Keffi, Karu, Toto and Nasarawa LGAs. Despite these, only about 10% of the rural communities and about 20% of the urban have access to potable water.

Birth Registration
Birth registration for children under 5 years in the State was 19.6 per cent. There was more female registration (21.0 per cent) than for males (19.4 per cent). Senatorial district with the highest birth registration was the North (38.1 per cent) while the least was the south (12.2 percent)[4].

2.2 Health System in Nasarawa state

Most of the health care facilities are in dire need of rehabilitation, essential drugs, consumables and equipment. Their sanitary conditions fall short of what they are meant for mainly due to scarcity of running water and waste disposal system. Worthy of note is that most PHC clinics are run as day clinics due to lack of electricity even when most women go into labour and deliver in the night. In addition, the inadequate, ill motivated available staffs per facility, their low skills and poor working conditions affect their motivation contributing to the general poor service delivery in the State.

The free obstetrics care supported by the State government recorded major successes but is limited in coverage to only a few and overstretched secondary health facilities. Immunization coverage has improved due to the contribution of the Government at all levels and support from Development Partners. Malaria, Diarrhoeal diseases, HIV/AIDS, Tuberculosis, and other major diseases are still ravaging the State with virtually only a few billboards at the State capital and some major roads holding on to the fight against them.

2.3 Health Status of the Population

The people seek health service mainly from the public system which receives low fund allocation and even lower release of the allocated fund. In 2000, only 11% of the funds allocated to Ministry of health were released and by 2009, only 7.67% was released[1]. Health is one of the priority areas in the 13 – point agenda of Nasarawa State. Furthermore, the setting up of the Primary Health Care Development Agency in line with the national policy on health is in the right direction towards achieving the state health care goals. Problems have been identified and these include: high maternal morbidity and mortality, infant & child morbidity and mortality, HIV prevalence and RTA among others.

Access to Medical Services

Access to health care was determined by the ability of household members to reach a health facility within 30 minutes. At the State level, 64.4 per cent of the population indicated that they had access to health facility. Accessibility to health facility was lowest in the South senatorial district (61.1 per cent) and highest in the North (66.7) per cent. [4]

Need for Medical Services

The need for medical services was defined for those who were sick or injured in the four weeks preceding the survey. 9.7 per cent of the population in the State and rural sector needed medical services. North senatorial district reported the greatest need (13.3 per cent) for medical services, while the least need was in the South (6.5 per cent) [4].

Usage of Medical Services

Use of medical services is defined for persons who consulted a health practitioner in the four-week period preceding the survey. 9.8 per cent of the population made use of medical services. Central senatorial district (13.4 per cent) recorded the highest and south recorded the least (6.5 per cent) usage[4].

Satisfaction with Medical Services

Satisfaction is defined for persons who consulted health practitioners in the four-week period preceding the survey and who cited no problem. The State satisfaction rate is put at 68.6 per cent. North senatorial district recorded highest satisfaction (77.1 per cent), while South recorded the lowest (60.7 per cent) satisfaction rate[4].

Immunization

About 22.9 per cent of children under 5 were fully vaccinated. North Senatorial District led the Senatorial districts with 32.0 per cent, while West had the least rate (20.3 per cent). About 21.4 per cent of the under-5 children in the State were not vaccinated at all[4].

Summary of State Indicators

Population (2006Census)	**Nasarawa**
Total	1,869,377
Female	925567
Male	943801
Under 5 years (20% of Total Pop)	357522
Adolescents (10 – 24 years)	579800
Women of child bearing age	445952
Literacy rate (female)	**24%**
Literacy rate (male)	**76%**
Households with improved source of drinking water	**48%**
Households with improved sanitary facilities (not shared)	**38%**
Households with electricity	**26%**
Employment status (currently) female	**65.8**
Employment status (currently female	**92.5**
Total fertility rate	**4.7%**
Use of FP modern method by married women 15-49 years	**11%**
Ante natal care provided by skilled health worker	**73%**
Skilled attendants at birth	**34%**
Delivery in Health Facility	**33%**
Children 12 – 23 months with full immunization coverage	**16%**
Children 12-23 months with no immunization	**40%**
Stunting in under 5 children	**44%**
Wasting in under 5 children	**6%**
Diarrheal in children	**7.2%**
ITN ownership	**14%**
ITN utilization (children)	**6%**
ITN utilization (Pregnant women)	**5%**
Children under 5 with fever receiving malaria treatment	-
Pregnant women receiving IPT	**13%**
Comprehensive knowledge of HIV (female)	**28%**
Comprehensive knowledge of HIV (male)	**35%**
Knowledge of TB (female)	**48.8%**
Knowledge of TB (male)	**74.0%**

2.4 Key issues and challenges

The challenges faced by Nasarawa State health sector are multifaceted but essentially can be identified as illiteracy, poverty, paucity of skilled health professionals, low capacity building efforts with dilapidated infrastructure and inadequate equipment.

Education
Adult literacy level is low with less than 80% of school age children in school. Women who constitute about 55% of the population are largely illiterate, poor and have low access to economic and political rights and opportunities.

The primary school completion rate at the State and rural sector was 13.0 per cent. The North senatorial district had the highest (19.5 per cent) primary school completion rate, while the least rate (10.7per cent) was recorded by the north.
Secondary school completion rate was 18.7 per cent for the State. Completion rate was higher in secondary school (18.7 per cent) when compared with the primary 13.0 per cent). North senatorial district recorded the highest secondary school completion rate (24.2 percent), while the south recorded the lowest rate (12.9 per cent)[4].

In recognition of the low school enrolment, attendance and completion rates, the government established a school feeding programme in 2005 to feed primary school children to improve the education outcomes among pupils. In the period between 2005 and February 2008, a total of 250,000 pupils were fed once daily in 511 schools.The project was adjudged to be effective as it led to an increase of about 40% in enrollment figure and a completion rate of 98%. A significant rate of increase in enrollment was recorded among the girl child pupils during this period. The cost of the programme for the period of operation is estimated to be about 1.9 billion naira. The programme is undergoing retooling to ensure the state agriculture benefits from it by utilizing home grown agricultural produce[5].

There are six (6) public tertiary institutions located in the State. They are the Nasarawa state University, Keffi; College of Education, Akwanga; College of Agriculture, Lafia; Nasarawa State Polytechnic, Lafia; School of Nursing and Midwifery, Lafia; the Federal Polytechnic, Nasarawa. There is also the School of Health Technology, Keffi.

In addition, the state is also blessed with some private tertiary institutions, e.g. Bingham University, Karu, School of Health Technology, Alushi etc

[4] *National Bureau of statisatics(NBS), Core Welfare Indicators Questionnaire (CWIQ) Survey, 2006*

[5] *School feeding Programme by Coordinator of Programme*

CHAPTER 3 STRATEGIC HEALTH PRIORITIES

3.1 PRIORITY AREAS

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

The StateMinistry of health therefore expects all the stakeholders to embrace '*the use of this SHDP for the development of the resepctive operational plans for the state.'*

The 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 1 spcifies 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 interventiuons 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.

A. **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 resources
Use of sanitary latrines
Hand washing with soap
Clean delivery and cord care
Initiation of breastfeeding with 1st hr. and temperature management
Condoms for HIV prevention
Universal extra community-based care of LBW infants
Exclusive Breastfeeding for children 0-5months
Continued Breastfeeding for children 6-11 months
Adequate and safe complementary feeding.
Supplementary feeding for manolurished children
Oral rehydration Therapy
Zinc for diarrhoeal management

Vitamin A – Treatment For Measles
Artemisinin-based comibnation 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 (health practices and illness detection)

B. POPULATION ORIENTED/OUTREACHES/SCHEDULABLE SERVICES
Family Planning
Condom use for HIV prevention
Antenatal Care
Tetanus Immunization
Deworming in pregnanacy
Detection and treatment of asymptomatic bacteria
Detection and management of syphilis in pregnancy
Prevention and treatment of iron deficiency aneamia in pregnancy
Intermittent preventive tratement (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
Yellow fever immunization
Meningitis immunization
Vitamin a supplementation for U5

C. INVIDUAL/CLINICAL ORIENTED SERVICES
Family Planning
Normal delivery by skilled attendant
Basic emergency obstetric care (B-EOC)
Resuscitation of asphyctic newborns at birth
Antenatal steriods for preterm labor
Antibiotics for preterm/prelabour rupture of membrane (P/PROM)
Detction and management of pre ecclampsia (Mg sulphate)
Management of neonatal infections
Antibiotics for U5 pneumonia
Antibiotics for dysentery and enteric fevers
Vitamin A Treamtnet For Measles
Zinc for diarrheal management
ORT for diarrheal management
Artemisinin-based Comination Theraphy for children
Artemisinin-based Comination Theraphy for pregnant women
Artemisinin-based Comination Theraphy for adults
Management of complicated malaria (2nd line drug)
Detection and management of STI
Management of oportunistic infections in AIDS
Male circumcission
First line ART for children with HIV/AIDS

First line ART for pregnant women with HIV/AIDS
First line ART for adults with HIV/AIDS
Second line ART for children with HIV/AIDS
Second line ART for pregnant women with HIV/AIDS
Second line ART for adults with HIV/AIDS
TB case detection and treatment with DOTS
Re-treatment of TB patients
Management of multidrug resistant TB (MDR)
Management of Acute Malnutrition
Comprehensive emergency obstetric care (C-EOC)
Management of severely sick children (clinic IMCI)
Management of neonatal infections
Clinical management of neonatal jaundice
Universal emergewncy 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

In an attempt to achieve the Millennium Development Goals (MDGs), many critical challenges confront healthcare systems in Nasarawa State. Development of healthcare systems and improvement in health outcomes, based on investment in programmes focusing on specific diseases, continues to fragment health systems, leaving the basic infrastructure weak and incapable of delivering equitable, broad based services. There has been much discussion about integrating the primary, secondary, and tertiary tiers of the health system but inadequate attention has been paid to identifying and strengthening the actions that are required to deliver the basic package of care.

4.1 Human

The gap analysis of the needs of the State revealed the urgent need to address the issue of poor health indices in the State. Nasarawa State has a maternal mortality rate of 1000/100,000 live birth and under 5 years mortality rate of 150/1000 live birth. Due to the persistently poor health indices, Nasarawa State was one of the states surveyed for the situation analysis in Maternal, Neonates and Child health survey in 2009 sponsored by WHO. The Doctor/Patient ratio in the State is currently 1:9,699 as against 1:500 recommended by the World Health Organization (WHO)/global standard for the health sector.

Adequate Community Resource Persons (CORPS) are yet to be trained by the state essentially at the primary health care level/LGAs. Other categories of health practitioners namely traditional and spiritual-home based birth attendants exist in the State. Also, NGOs and private hospitals provide health care services in the State. Presently, there is no formal coordination mechanism. The State has no specific RH data focusing on the implementation of MNCH. More than 80% of the health expenditure of the State government is devoted to personnel remunerations. This has significant implication for effective services in terms of facilities and equipment, among others.

The State has established a School of Nursing and Midwifery, in Lafia and a School of Health Technology, Keffi to produce middle level health manpower for both public and private health care facilities.

4.2 Physical/Materials

The physical components include the infrastructure and capital equipment. Each healthcare facility requires an efficient process for generating and using evidence in policy making, implementing services, managing procurement and distribution, organizing logistics and maintaining equipment, using human resources appropriately, and efficient financial management.

4.3 Financial

The financing of health care in Nasarawa State is challenging due to the limited resources available in the face of competing demands. As a result, free healthcare programmes and social protection strategies remain inequitable and may not be sustainable. Health care provided by the public sector is constrained by annual health budgets of 4 -7%, which is much less than the recommended 15%. Health insurance scheme is yet to commence in the state. However, other mechanisms have been devised to increase health resources. The state has implemented user fees and has established revolving funds for specific services and programmes. Such funds may be a rational response to a specific need, but having many revolving funds operating outside the financial management system of the central administration may prove overwhelming. Similarly, centrally administered accounts focused on specific diseases make it difficult to coordinate investments in the public health sector and to track donors' contributions and manage public/private partnerships

CHAPTER 5: FINANCING PLAN

5.1 Estimated cost of the strategic orientations:

The estimated cost of the Nasarawa State Health Development Plan 2010-2015 is **forty three billion, one hundred million, and forty three thousand eight hundred and ninety five naira** (N43,100,043,895**)** only**.**

The breakdown of the costs by priority areas is as follows: -

Priority Area	Estimated Cost (2010-2015)
Leadership and Governance For Health	NGN 431,000,439
Health Service Delivery	NGN 35,683,005,505
Human Resources For Health	NGN 4,583,261,483
Financing For Health	NGN 32,274,053
National Health Information System	NGN 646,500,658
Community Participation and Ownership	NGN 431,000,439
Partnerships For Health	NGN 431,000,439
Research For Health	NGN 862,000,878
Total	**NGN 43,100,043,895**

MDGs-CGS contribution to the Plan is **₦415, 226,121.20 (Four hundred and fifteen million, two hundred and twenty six thousand, one hundred and twenty one naira twenty kobo)** only.

5.2 Assessment of the Available and Projected Funds

This depends on budgetary allocation for the year 2010 and this is not yet available.

5.3 Determination of the Financing Gap

This will be measured against the budget performance.

5.4 Descriptions of Ways of Closing the Financing Gap

The State has an integrated rural development through a prioritized Health Agenda. It seeks to improve community ownership and participation to bridge the gap in geographic and financial access to health using the PHC model of health care delivery.

Policy on payment for Basic obstetric, newborn and child care: The free health policy of the state covers all phases of pregnancy and delivery, and all forms of treatments including surgical interventions. One of the challenges of the scheme is the increasing number of patients patronising services such as antenatal clinics leading to extended waiting time. The programme has implications for health budgeting. Budgeted sums are easily exhausted. The government, however, remains expectant that the MDG grant from the Federal Government and Development Partners will reduce the burden and that the scheme will run smoothly in subsequent years.

Other Payment Schemes: In addition to the modes of financing discussed above, user-fee payment scheme is a major source of health care financing in the state. Also, the State has a drug revolving scheme that fits into the larger vision of pharmaceutical management programme. One of the objectives of the programme is to have in place a self sustaining drug, diagnostics and supplies distribution network using public and private providers.

The State is in the process of implementing the State Health Insurance Scheme in line with the National Policy.

CHAPTER 6: IMPLEMENTATION FRAMEWORK

Strategies for implementing the framework will utilize the existing structure in the State. In some cases, new structures will be put in place while the weak ones will be strengthened. The Nasarawa State Ministry of Health (SMOH) formulates policies for the State. Implementations of these policies are by the Hospitals' Management Board (HMB), Dalhatu Araf Specialist Hospital, Local Government Authorities (LGAs) and the private sector. Each of the 13 LGAs is responsible for managing the Primary Health Care (PHC) system, including community health activities such as immunization and health education; hygiene and provision of basic outpatient services at its maternities, among others. The State Primary Health Care Development Agency has been inaugurated to take care of the large volume of health needs at the Primary Health Care level. The State provides a supportive linkage to the LGAs through management of referrals from the PHC level, to the secondary level as well as technical guidance.

Mechanisms for developing and maintaining relationships are being established with relevant groups and programmes in the State. For instance the World Bank, UNICEF, and other development partners are working in the State. The relationship of the healthcare managers in the State with the national health system and other public sectors will enhance adequate implementation of the framework. Also, relationships with communities and foreign development partners should be nurtured through effective communications systems.

The role of Development Partners is critical to the implementation of the framework in the State. The substantial financial aid that they provide can help to close the funding gap in operating health services in African countries—but they may be tempted to operate independently of national goals and strategies. Secondary care facilities which are outside emergency funds for MNCH, where some of the facilities had community participation, such was mostly absent in other areas. Community participation was also absent in most PHC facilities for the areas of focus except with regards to monthly community growth monitoring. Communities participate in health and nutrition education, and active screening and referrals in private health care provisioning. There is no community participation at the tertiary health facility.

The major International Development Agencies working in the State are the United Nations agencies, in particular the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF). Both are intensely involved in the childhood immunization campaign and are working together to support the State in the implementation of Expanded Programme on Immunization/Polio Eradication Initiative (EPI/PEI). Their activities include strengthening routine immunization, supplemental immunization activities, integrated disease surveillance and response, advocacy and social mobilization, vaccine security and logistics. World Bank is also providing support in the areas of health system strengthening and HIV response.

Other Bilateral Agencies include Family Health International, Institute of Human Virology, Nigeria, ENR, Netherlands Leprosy Relief (NLR), Global 2000, Carter Center, Yakubu Gowon Center, etc.

The State partners with LGAs mainly and few civil society organizations in its MNCH programme, particularly with respect to social mobilization for childhood immunization and polio eradication initiative. While there are over 250 registered NGOs in the State, less than 10 of them are active and mainly in Malaria and HIV/AIDS control programmes.

CHAPTER 7: MONITORING AND EVALUATION

7.1 Proposed mechanisms for monitoring and evaluation

There is an existing weak organizational structure for M&E in the state. As a result, there is limited human and material capacity for carrying out M&E activities. In order to monitor and evaluate the implementation of the programme in the State, there will be structural arrangement through institutional development. This will help to assign responsibilities to individuals about the program and enhance supportive supervision that is presently lacking in the State.

These issues need to be addressed towards a successful implementation of the framework-

(i.) Develop a M&E framework and identify performance indicators for the entire health system for monitoring and evaluation;
(ii.) Actively engage in operational research and data gathering on all health issues;
(iii.) Establish monitoring and evaluation committees at each local government area for effective coverage.
(iv.) Deploy and train staff;
(v.) Provide M&E vehicles to enhance activities and improve data quality
(vi.) Improve access to information through the installation of internet facility
(vii.) Create a partnership mechanism for integration of M&E data among users; and
(viii.) Provide Technical assistance on regular basis.

7.2 Costing the monitoring and evaluation component and plan

Capital and recurrent expenditures are involved in carrying out M&E of the plan. As a result, direct and indirect costs of providing M&E services are put into consideration while costing the M&E aspect of the plan. This is important because certain indirect costs may have significant effect on the extent to which M&E activities are carried out. All activities of the M&E will be meaningful when values are assigned to every activity.

CHAPTER 8: CONCLUSION

Nasarawa State is in the process of adapting the national health policy that is fairly comprehensive as a follow-up to the health reform process that has been pursued since 2006. The reform process include human resources for health, quality improvement and management, health funding, pharmaceutical management programme, policy and strategy development, performance management, communication and advocacy. The policy also covers issues related to MNCH. The State policy on free medical treatment for all pregnant women and under-five children, which has been seriously pursued by the government, demonstrates the existing State's commitment to MNCH.

Access to MNCH and related services is presently low in Nasarawa State as result of challenges in terms of the operations and the capacity of the facilities. Many health facilities are not able to provide quality health services or effectively meet the healthcare needs of clients due to lack of human and material resources. Some of the primary health care centres are not opened on 24-hour basis. Most of the health workers at all levels of care have not been trained in specific MNCH-related issues in the context of in-service activities. A significant proportion of the state public sector facilities (secondary and primary health care facilities) lack the appropriate human and materials resources. As a result, the majority of secondary and primary health care facilities fail to meet the standard for essential obstetric care facilities, implying their ineffectiveness to manage emergency obstetric and newborn conditions. The adolescent health services are provided at Dalhatu Araf Specialist Hospital Lafia (DASH), General hospital Akwanga and PHC clinics at Keffi and Karu. There has been plan to increase the services in adolescent health to other health facilities in the State. The management information system is weak. The quality of data collected is low. There are significant problems with the quality of the monitoring system at State, LGA and the facility levels.

The State partners with a number of international development organizations, especially UN agencies. The coordination mechanism is commendable. Also, the state collaborates with few civil society organizations, but this is skewed more towards malaria and HIV/AIDS activities. The partnership framework is, however, not consistently operationalized or sufficiently institutionalized. Community participation in health facility management and health care activities is generally low. The state has 14 functional PMTCT sites and 12 ARV sites. Presently, 12 partners assist with the HIV/AIDS project in Nasarawa State including Institute for Human Virology, Nigeria, Catholic Relief Services and Family Health International, Federal Ministry of Health, Enhanced Nigerian Response to HIV/AIDS (ENR) and World Bank among others also make valuable contribution in the State.

Annex 1: Committees that developed the Nasarawa SSHDP

State Approved list of Committee members

State Planning Committee

1. Alh. Musa Dangana, Permanent Secretary SMOH, Chairman .
2. Esala S Ashenanye, Director Planning Research and Statistics.
3. Deputy Director Planning, Mukaila Gunduma.
4. Dr Gamaliel Monday, Director, Medical or Hospital Services.
5. Emma Yonnah Kakpo, Director, Pharmaceutical Service.
6. Christopher Umbugadu, Director PHC&DC.
7. John Awu, Director Nursing Services.
8. Abdullahi Oboshi, Director Finance & Accounts.
9. Alh. Abdulahi Adamu, Director of Administration.
10. Dr Thomas A. Affi, Chairman/CEO HMB,
11. Dominic Bako, Representative of State Ministry of Finance.
12. Adamu Muazu Gosho, Representative of Economic Planning.
13. Ibrahim Madaki, Director of Personnel, Local Government Service Commission .
14. Dr Francis Akwash, Director PHC in the Ministry of Local Government and Chieftaincy Affairs.

All Programme Officers

1. Dr George Dangana, Chairman State Primary Health Care Development Agency
2. Mrs Mary Ashenanye, IMNCH.
3. Mr Joseph Agu, RBM.
4. Dr Danjuma Aboki, TBL.
5. Mrs Roseline Eigege, HIV/AIDS.
6. Joshua Galley Ibi, Essential Drugs Pharm.
7. Halima Musa, Nutrition
8. Kadijat Oshafu, Reproductive Health.
9. Suleiman Mohammed, State Immunization Officer.
10. Gambo Yakubu Wamba, State Epidemiologist.
11. David Anjugu, Health Education Officer.

Representative of Professional Groups

1. Dr Abe Usman, NMA.
2. Shuaibu El-Yakub Santali, PSN.
3. Obadiah Avre, NANNM
4. Alh Rabiu Yaro, Medical Lab. Scientists.
5. Alh. Alhassan Obata, Medical & Health Workers Union.
6. Mr Sule Thomas, National Association of Community Health Practitioners.
7. Dr Bala Manomi , Representatives of Association of Private Practitioners
8. Pharm Samuel O. Ewhudjakpo, Community Pharmacists.
9. Dr J. C. Abimiku, Chief Medical Officer.
10. Manasseh Katsa , Representatives of Civil Society Organizations.
11. Dr Bawa Abimiku , Representatives of FMC in the State,
12. Dr Joseph O.Ogbere, Representative of State Health Tertiary Institution.
13. Joseph Inji Chaku , Principal School of Nursing.
14. Mr Albert Chigyar , Principal School of Health Technology.
15. Pharm Haruna Wakili , PM School Feeding.
16. Alhaji Musa Abdul, Rtd. DNS.

The Steering Committee

1. Mallam Abubakar Sarki Dahiru Honourable Commissioner of Health - Chairman.
2. Bagudu Usman Danlami Honourable Commissioner of the Ministry of Local Government and Chieftaincy Affairs.
3. Alh. Ahmed A. Agyina Honourable Commissioner of the Ministry Finance.
4. Mr Emmanuel Bako Honourable Commissioner Economic Planning.

Chairmen of all Local Government Areas.

1. Hon. Musa Saidu
2. Hon. Eng. Idris Mohammed
3. Hon. Barr. M. Sani Bawa
4. Hon. Hurnua Umbugana
5. Hon. Huruna Iliya Osegba
6. Hon. Ibrahim Isyaku O.
7. Hon. Anja Baba Usman
8. Hon. Mustapha Yahaya Idris
9. Hon. Basiru Sharubutu A.
10. Hon. Arc. Stanley J.M Buba
11. Hon. Shuaibu Abdullahi
12. Hon. Rayyanu Iliyasu
13. Hon. Joseph M. Kaura
14. Adamu Ebenya
15. Hon. Yekpowudu Ozeh Joshua
16. Alh. Abdullahi Abu Galadima
17. Sanusi Abdu
18. Yakubu Ogalebe Akuki
19. Benjamin Musa Belodu
20. Adagonye Emmanuel
21. Alh. Mohammed Guto
22. Abaku Istifanus Denis
23. Hon. Bulus A. Angba (JP)
24. Ali Nanalla D.
25. Clement S. Andua
26. Pastor Alfa Yusufu
27. Dawuda Ngwai
28. Aminu Enupe
29. Hon. Sarkin Tako

Yahaya O. Usman Representative of State House Assembly

Alh. Musa Dangana The Permanent Secretary, Ministry of Health

Directors in the State Ministry of Health

1. Alh Abdullahi Adamu (DAS);
2. Christopher Umbugadu (DPHC/DC);
3. Esala S. Ashenanye (DPRS);
4. Emma Yonnah Kakpo (DPS);
5. Dr Gamaliel Monday (DCS);
6. John Awu (DNS);
7. Alh Abdullahi Oboshi (DFA).
8. Dr George Dangana Director, State Primary Health Care Development Agency.
9. Dr Thomas A. Affi Chairman/CEO, Hospital Management Board .

Dr Bala Manomi, Representatives of private medical practitioners in the State.

Representatives of all Medical and Health Professional Groups in the State

1. Dr. Abe Usman, NMA
2. Shuaibu El-Yakub Santali, PSN
3. Obadiah Avre; NANNM
4. Medical Lab. Scientists Alh. Rabiu I. O. Yaro;
5. Medical & Health Workers Union Alh. Alhassan Obata;
6. National Association of Community Health Practitioners Sule Thomas;
7. Alh Isa Mustapha Agwai 11 Chairman Nasarawa State Traditional Council

Religious Leaders

1. Bishop Mathew Ishaya Audu, Christian Association of Nigeria.
2. Alh. Zakari Yakubu, Jama'atu Nasurun / Islam.
3. Other related Ministries and Departments in the State
4. Adamu Muazu Gosho, PM Health Systems Development Project 11
5. Barrister Azara, PM HIV/AIDS
6. Pharm Haruna Wakili, PM School Feeding
7. Mr Joel Olubo, Rep Local Government Service Commission.
8. Mrs Saraya Agidi , Rep Women Association.
9. Alaku Akolo, Rep. Youth Association.
10. I.B. Gyado, Ministry of Justice.
11. Hadiza Allahkayi, Ministry of Women Affairs
12. Edward Anzaku, FBO
13. Lawani Aboki, NGO.
14. **Ashenanye, Esala Sunday**, Director, PRS-Secretary

Annex 2: Details of Nasarawa Strategic Health Development Plan

NASARAWA STATE STRATEGIC HEALTH DEVELOPMENT PLAN					
PRIORITY					
Goals			**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**TOTAL EXPENDITURE 2010 - 2015**
Strategic Objectives			**Targets**		
Interventions			**Indicators**		
Activities			**None**		
LEADERSHIP AND GOVERNANCE FOR HEALTH					
1. To create and sustain an enabling environment for the delivery of quality health care and development in Nigeria					**431,000,439**
1.1	**To provide clear policy directions for health development**		**All stakeholders are informed regarding health development policy directives by 2011**		**21,042,545**
1.1.1	Improved Strategic Planning at Federal and State levels				**21,042,545**
1.1.1.1	Review and adopt existing National Health Policy for the State		State Health policy document in place	Overcoming all the administrative bottle necks	5,375,265
1.1.1.2	Advocate for approval and implementation of health Policies in the State.				-
1.1.1.3	Capacity building for health personnel on strategic planning and implementation				15,667,280
1.2	**To facilitate legislation and a regulatory framework for health development**		**Health Bill signed into law by end of 2009**		**142,935,431**
1.2.1	Strengthen regulatory functions of government		Relevant Health Laws enacted by 2010.		**142,935,431**
1.2.1.1	Enact relevant health laws.			Implimenters adequately mobilised.	2,655,252
1.2.1.2	Constitute relevant committees to enforce the laws and strengthen existing inspectorate units.				79,989,130
1.2.1.3	Collaborate with relevant stakeholders to ensure compliance.				23,221,147
1.2.1.4	Regular supervision of all health care facilities.				33,572,742
1.2.1.5	Build capacity of Regulatory Officers				3,497,161
1.3	**To strengthen accountability, transparency and responsiveness of the national health system**		**80% of States and the Federal level have an active health sector 'watch dog' by 2013**		**10,128,813**
1.3.1	To improve accountability and transparency		improved accountability and transparency		**10,128,813**
1.3.1.1	Institute a stakeholders (change agent) monitoring team.			wilingness to be accountable and transparent by stakeholders	-
1.3.1.2	Reorientate the mind-set oif all stakeholders.				1,865,152
1.3.1.3	Hold regular consultative meetings.				8,263,661
1.4	**To enhance the performance of the national health system**		**1. 50% of States (and their LGAs)**		**256,893,649**

					updating SHDP annually 2. 50% of States (and LGAs) with costed SHDP by end 2011		
		1.4.1	Improving and maintaining Sectoral Information base to enhance performance		Sectoral information base improved and maintained		**256,893,649**
			1.4.1.1	Strengthen information network in the health delivery system		Proper information network constituted.	186,515,234
			1.4.1.2	Enhance intrasectoral and intersectoral collaboration.			70,378,415
HEALTH SERVICE DELIVERY							
2. To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare							**35,683,005,505**
	2.1	**To ensure universal access to an essential package of care**			**Essential Package of Care adopted by the State and all the LGAs by the end of 2010**		**34,914,188,713**
		2.1.1	To review, cost, disseminate and implement the minimum package of care in an integrated manner		That 50% of all LGAs would have the minimum package of care including package for MNCH by 2010.		**3,377,417,593**
			2.1.1.1	Adopt minimum package of care at all levels including MNCH.			751,009
			2.1.1.2	Sensitization and advocacy to policy makers and other stakeholders		**Minimum package of care reviewed and costed.**	1,224,342
			2.1.1.3	Provide outreach from PHC facility levels on minimum package of care including MNCH to communities and household.			102,288,678
			2.1.1.4	Expand hospital and PHC facilities/services.			2,059,962,261
			2.1.1.5	Access and strengthen supply chain system and establish financial mechanism that protects the poor and vulnerable groups using exemption, subsidy, insurance and other methods in the utilization of services including MNCH..			1,213,191,302
		2.1.2	To strengthen specific communicable and non communicable disease control programmes				**31,534,615,326**
			2.1.2.1	Conduct public enlightenment and advocacy on preventive, promotive, curative and rehabilitative programmes and strengthen collaboration between disease control programme implementers.	**Improved disease control programmes.**	**Well coordinated disease control programmes.**	475,761,295
			2.1.2.2	Establish Public Health Laboratory and blood bank services.			-
			2.1.2.3	Recruit, train and retrain additional essential personnel and provide enabling environment and incentives for public sector health care personnel to minimise the attrition of staff and brain drain syndrome in line with the human resource policy.			31,058,854,031
			2.1.2.4	Regular and joint supervision, monitoring and evaluation of disease control programmes			-
			2.1.2.5	Provide needed logistics (vehicle and funds) for implementation and supervision of programmes.			-
		2.1.3	To make Standard Operating procedures (SOPs) and guidelines available for delivery of services at all levels				**2,155,793**
			2.1.3.1	Identify and prioritise the services to be delivered	**Reviewed SOP documents.**	**Availability of SOP documents at all facilities.**	-

			2.1.3.2	Develop, review and distribute existing Standard Operating Procedures and Guidelines.			-
			2.1.3.3	Capacity building for relevant personnel.			2,155,793
			2.1.3.4	Monitor and evaluate implementation of clinical protocols			-
	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**		**321,355,365**
		2.2.1	To improve geographical equity and access to health services		Situation Analysis Report in place		**4,148,044**
			2.2.1.1	Conduct situation analysis of all public and private health facilities		**Equitable distribution of health facilities.**	1,486,754
			2.2.1.2	Advocate for the establishment of health facilities in disadvantaged areas.			1,115,066
			2.2.1.3	Institute future plans for e-medicine and tele-medicine			-
			2.2.1.4	Enhance multisectoral collaboration			1,546,224
			2.2.1.5	Provide outreach from PHC facility level to communities and households.			-
		2.2.2	To ensure availability of drugs and equipment at all levels		Available Drugs, other health commodities and equipment.		**61,317,325**
			2.2.2.1	Adapt existing National essential list for drugs and related consummables.		**Adequate funds for procurement.**	317,174
			2.2.2.2	Conduct needs assessment for equipment, drugs and other health commodities for all facilities.			690,349
			2.2.2.3	Review operational guidelines for drug revolving scheme., Procurement of drugs, equipment and other health commodities eg LLINs, Antishock garments.			52,546,963
			2.2.2.4	Regular monitoring and evaluation.			2,890,250
			2.2.2.5				4,872,589
		2.2.3	To establish a system for the maintenance of equipment at all levels		Enhanced maintenance culture.		**119,297,938**
			2.2.3.1	Set up central and health facility based maintenance units.		Established and functional maintenance units.	72,527,629
			2.2.3.2	identify, procure and equip the units.			4,955,847
			2.2.3.3	Capacity building of relevant personnel.			34,330,142
			2.2.3.4	Monitor and evaluate activities of all maintenance units.			2,533,429
			2.2.3.5	Regular update of equipment inventory			4,950,891
		2.2.4	To strengthen referral system		Strengthened Referral System		**98,161,846**
			2.2.4.1	Delineate zonal referral centers		**Designated Referral Units.**	28,847,390
			2.2.4.2	Staff zonal referral centres			-
			2.2.4.3	Equip zonal referral centres			18,515,044

			2.2.4.4	Provide equipped Ambulances, communication gadgets and other needed vehicles.			475,761
			2.2.4.5	Capacity building for relevant personnel.			50,323,651
		2.2.5	To foster collaboration with the private sector		Strengthened Collaboration.		**38,430,213**
			2.2.5.1	Identify, engage and motivate the private health facilities to scaleup services including MNCH through advocacy, pariticipation in training, policy and strategy formulation, contracting, supervision and regulation to deliver services.		Sustained cooperation from all stakeholders.	4,519,732
			2.2.5.2	Develop, legislate and implement standard guidelines for their practice and registration			10,128,760
			2.2.5.3	Develop guidelines for partnership, referral and capacity building.			12,603,313
			2.2.5.4	Develop joint performance monitoring mechanism			2,626,599
			2.2.5.5	Integrate the traditional medicine into the health care delivery system			8,551,809
	2.3	**To improve the quality of health care services**			**50% of health facilities participate in a Quality Improvement programme by end of 2012**		**4,527,662**
		2.3.1	To strengthen professional regulatory bodies and institutions		Better collaboration with Regulatory Bodies and Institutions.		**-**
			2.3.1.1	Strengthen the inspectorate units of the State Ministry of Health.		Support to strengthen inspectorate units.	-
			2.3.1.2	Sensitize all professional groups on ethical practices.			-
			2.3.1.3	Ensure that only staff who are registered with their regulatory bodies are employed			-
			2.3.1.4	Enforce the renewal of professional practice licence			-
		2.3.2	To develop and institutionalise quality assurance models		Availability of Quality Assurance Models.		**1,054,604**
			2.3.2.1	Review existing models of quality assurance		Adoption of SERVICOM Ideals	505,496
			2.3.2.2	Develop training models for capacity building			495,585
			2.3.2.3	Institute and implement selected models			53,523
			2.3.2.4	Monitor implementation by adopting the ideals of SERVICOM.			-
		2.3.3	To institutionalize Health Management and Integrated Supportive Supervision (ISS) mechanisms		ISS guidelines in place.		**3,473,057**
			2.3.3.1	Strengthen health programmes e.g MNCH managers and health teams through team building and leadership development programmes.		ISS tools and guidelines accepted.	-
			2.3.3.2	Develop ISS tools and guidelines for monitoring			3,175,707
			2.3.3.3	Institute comprehensive ISS at all levels.			237,881
			2.3.3.4	Promote use of intergrated supportive supervision tools to track progress in the implementation of programmes including MNCH interventions.			59,470
	2.4	**To increase demand for health care services**			**Average demand rises to 2 visits per**		**7,969,002**

					person per annum by end 2011		
		2.4.1	To create effective demand for services		Increased demand for Health Serviced		**7,969,002**
			2.4.1.1	Adapt the National health promotiion communication strategies to reflect their local reliaties and dessiminate same to all stakeholders.		Improved behaioural change.	594,702
			2.4.1.2	Mount effective health education on behavioural change among providers			1,724,635
			2.4.1.3	Institute annual commemorative health days (e.g, Malaria, HIV/AIDs, TB etc) and bi-annual MNCH weeks.			3,974,589
			2.4.1.4	Provide budget lines for health promotion at all levels			49,558
			2.4.1.5	Monitor and evaluate the sysem put on ground			1,625,518
	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**		**434,964,764**
		2.5.1	To improve financial access especially for the vulnerable groups		Wider coverage of vulnerable groups		**434,964,764**
			2.5.1.1	Identify vulnerable groups		Adequate funding.	1,100,198
			2.5.1.2	Review and implement existing relevant schemes e.g. FBOCs, FU5,EMP			428,789,779
			2.5.1.3	Ensure regular monitoring and evalutation of the schemes			5,074,787
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							**4,583,261,483**
	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**		**41,245,012**
		3.1.1	To develop and institutionalize the Human Resources Policy framework		State HRH policy document in place		**41,245,012**
			3.1.1.1	Adapt the National HRH policy and plans for Health Development.		State Government will approve the adapted HRH policy document.	17,366,321
			3.1.1.2	Advocate for the approval and implementation of the State HRH policy and plans			20,791,345
			3.1.1.3	Present draft document to the State Council on Health (SCH) for endorsement			2,604,948
			3.1.1.4	Present SCH resolution to the State Executive council for approval			482,398
	3.2	**To provide a framework for objective analysis, implementation and monitoring of HRH performance**			**The HR for Health Crisis in the country has stabilised and begun to improve by end of 2012**		**320,553,337**
		3.2.1	To reappraise the principles of health workforce requirements and recruitment at all levels		Gap Analysis Report produced.		**320,553,337**
			3.2.1.1	Conduct gap analysis on HRH at all levels.		The required health workforce is available	19,295,912

						in the right mix in the labour market.	
			3.2.1.2	Develop guidelines for employment and deployment of health personnel.			7,235,967
			3.2.1.3	Advocate and sensitize stakeholders on guidelines for implementation.			16,401,525
			3.2.1.4	Recruit and orientate staff based on needs.			271,348,762
			3.2.1.5	Institute multi-sectoral consultative forum on HRH			6,271,171
	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**		**1,160,890,302**
		3.3.1	To establish and strengthen the HRH Units		Endorsed proposal for establishment HRH units.		**1,160,890,302**
			3.3.1.1	Advocate for the creation of HRH units in the State and LGAs.		Seting up of the unit will be supported by the establishment division of the public service supervisory unit.	9,647,956
			3.3.1.2	Provide Office accommadation and equipment			1,128,810,848
			3.3.1.3	Capacity building of HRH unit staff at all levels.			15,195,531
			3.3.1.4				7,235,967
	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**		**2,065,144,975**
		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		Increased enrolment in Health Training Institutions.		**1,428,379,881**
			3.4.1.1	Liaise with the relevant professional bodies for the review of training curriculum in health training institutions for the production of adequate number of community health oriented professionals.		Training institutions will comply with set standards.	314,040,967
			3.4.1.2	Upgrade infrstructure and status of health training of institutions			1,114,338,914
		3.4.2	To strengthen health workforce training capacity and output based on service demand		Increased number of health professionals.		**636,765,094**
			3.4.2.1	Strengthen existing health training Institutions in the State for the introduction of programmes such as Pharmacy Technicians, Dental Technicians, Radiographers etc		Health training Institutions have the capacity to continue to turn out the required health personnel	578,877,358
			3.4.2.2	Conduct Skill enhancement training for tutors of State Health training Institutions.			57,887,736

			3.4.2.3	Liaise with relevant training institutions for the training of higher level health manpower.			-
			3.4.2.4	Advocate for review of incentives to attract and retain staff.			-
	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**		**860,356,473**
		3.5.1	To achieve equitable distribution, right mix of the right quality and quantity of human resources for health		Improved distribution of HRH in the right mix and quantity.		**843,472,551**
			3.5.1.1	Same as 3.2.1.1 to 3.2.1.4		Availability of the right mix of the workforce and willingness to be deployed.	290,644,674
			3.5.1.2	Set up a mechanism for monitoring the deployment of professional staff -mix needs and geographical spread.			542,697,523
			3.5.1.3	Establish collaboration with the FMC for the leverage of available Human Resources so as to expand service coverage and quality.			9,647,956
			3.5.1.4	Design and intensify campaigns to encourage health professionals in other states/diaspora to contribute to strengthen the human resources availability in the State and LGAs			482,398
		3.5.2	To establish mechanisms to strengthen and monitor performance of health workers at all levels		Available report of the monitoring committee.		**16,883,923**
			3.5.2.1	Set standards and identify performance indicators for health workers		Willingness to comply with set standards.	482,398
			3.5.2.2	Sensitize health workers on set standards and performance indicators			9,647,956
			3.5.2.3	Set up quality improvement committees at all levels			-
			3.5.2.4	Carry out regular monitoring and supervision of health staff at facility level.			6,753,569
	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**		**135,071,384**
		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		Regular consultative meetings.		**135,071,384**
			3.6.1.1	Strengthen multilevel communication and cooperation among professional associations and regulatory bodies.		Willingness to cooperate.	19,295,912
			3.6.1.2	Entrench regular consultative meetings of stakeholders			115,775,472
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							**32,274,053**
	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**		**1,847,866**
		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				**1,847,866**
			4.1.1.1	Constitute Technical Working Committee on health financing.	Available Document	Adequate Logistics provision	376,451

			4.1.1.2	Adapt the National Health Financing policy document.			1,130,257
			4.1.1.3	Develop Strategies for Implementation for State and LGAs			341,158
	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**		**4,631,883**
		4.2.1	To strengthen systems for financial risk health protection		Participation of state in NHIS by 2012		**4,631,883**
			4.2.1.1	Advocate to Federal to hasten appropriate amendiment of NHIS Law		The SHIS law will be passsed by 2011.	510,833
			4.2.1.2	Advocate to State Executive and Legislature on policy development /enactment of enabling law on SHIS and community health financing to cover services including MNCH.			380,070
			4.2.1.3	Mobilize and sensitize stakeholders to form indigenous HMOs.			343,873
			4.2.1.4	Sensitize and mobilize communities and individuals on SHIS.			3,397,106
	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**		**7,941,272**
		4.3.1	To improve financing of the Health Sector		15% budgetary allocation by 2010		**5,250,084**
			4.3.1.1	Advocate to State and LGAs to abide by the Abuja Declaration of 15% budgetary allocation to health with specific allocation for MNCH services as provided in the relevant laws		Political will and commitment	561,360
			4.3.1.2	Advocate to State and LGAs to increase by at least 5% annually to 2015			561,360
			4.3.1.3	Advocate for 100% release of Health funds			393,406
			4.3.1.4	Institute mechanism for effective and efficient utilization of released health funds			93,606
			4.3.1.5	Strenghten DRF and other community based health revolving funds and fund community- based MNCH services			3,640,351
		4.3.2	To improve coordination of donor funding mechanisms		Availability of adopted models of donor fund coordination		**2,691,189**
			4.3.2.1	Constitute technical committee to understudy the various models developed by the FMOH for donor fund coordination		Donor funding Models suit the state	1,128,628
			4.3.2.2	Committee to adopt the Paris declaration and Accra agenda document on donor funding coordination.			935,697
			4.3.2.3	Implement donor funding models at state and LGA levels including networking and coordination of resource for MNCH from donors and Global initiatives			626,863
	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**		**17,853,032**

					supervision and monitoring systems developed and operational by Dec 2012		
		4.4.1	To improve Health Budget execution, monitoring and reporting		Improved budget management.		**17,853,032**
			4.4.1.1	Capacity building of health finance personell on budget preparation, execution, monitoring and reporting		Transparency in Budget management.	17,853,032
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							**646,500,658**
	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**		**321,004,956**
		5.1.1	To ensure that NHMIS forms are available at all health service delivery points at all levels		Quantity of NHMIS forms and registers needed produced.		**85,868,246**
			5.1.1.1	Assess and determine the type and quantity of forms and registers needed.		**Availability of funds.**	131,053
			5.1.1.2	Produce and distribute forms to facilities and community based systems to include MNCH data forms and registers			64,101,550
			5.1.1.3	Monitor distribution and utilization of forms and registers including MNCH documents			21,635,643
		5.1.2	Periodically review NHMIS data collection forms		Regular review meetings.		**3,002,303**
			5.1.2.1	Conduct regular review meetings.		**Availability of the reviewed NHMIS forms at all levels**	2,525,747
			5.1.2.2	Collect and collate reports and recommendations of review meetings to the state			476,556
			5.1.2.3	Produce and ditribute reviewed forms and registers			-
		5.1.3	To coordinate data collection from vertical programmes		Availability of periodic reports.		**76,765,232**
			5.1.3.1	Constitute and strengthen health data consultative committee at the State and LGAs (HDCC)		**Sustainability of data collection systems**	-
			5.1.3.2	Conduct periodic meetings of SHDCC and LHDCC			59,855,436
			5.1.3.3	Carry out ISS and Monitoring of data collection from vertical programs			15,440,415
			5.1.3.4	Strengthen Partnership for effective data collection and harmonization.			1,469,381
		5.1.4	To build capacity of health workers for data management		Training Modules available.		**49,506,228**
			5.1.4.1	Develop training plans and modules for data managers		Availability of Health Data Managers.	238,278
			5.1.4.2	Conduct capacity building for Data Managers on use of registers, forms and data management and comunication of MNCH information gathered to relevant stakeholders			49,267,950
			5.1.4.3	Monitor data management processes			-

		5.1.5	To provide a legal framework for activities of the NHMIS programme		NHMIS Legal draft document available		**51,567,332**
			5.1.5.1	Conduct advocacy and sensitizaion meetings to policy makers and legislators in the state and LGA		**Executive and Legislative support**	47,198,902
			5.1.5.2	Enact HMIS relevant laws to include MNCH data management issues			1,588,520
			5.1.5.3	Sensitize health workers and communities on relevant HMIS laws.			2,779,910
		5.1.6	To improve coverage of data collection		HMIS forms distribution coverage improved		**5,845,754**
			5.1.6.1	Provide adequate logistics for data collection		Availability of adequate logistic support	5,845,754
		5.1.7	To ensure supportive supervision of data collection at all levels		Available ISS tools.		**48,449,862**
			5.1.7.1	Adopt and implement ISS tools and develop monitoring and supervision plans		Functional Supervisory teams at all levels	794,260
			5.1.7.2	Constitute Supervisory team at State level and strengthen same at LGA levels			47,655,602
			5.1.7.3	Set up Feed-back Mechanism to track data collection including MNCH data.			-
	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**		**243,122,995**
		5.2.1	To strengthen the use of information technology in HIS		Improved knowledge of Data Managers on ICT.		**191,813,797**
			5.2.1.1	Develop extensive regular capacity building programme for M&E, HMIS and Health Records Officers.		Availability of logistic back-up.	35,503,423
			5.2.1.2	Procure and install requisite ICT Hard wares and accessories			118,344,744
			5.2.1.3	Provide alternative power supply e.g generating sets, solar, wind etc			35,344,571
			5.2.1.4	Provide and update electronic data management application software			2,382,780
			5.2.1.5	Capacity building of Data Managers in the use of application softwares.			238,278
		5.2.2	To provide HMIS Minimum Package at the different levels (FMOH, SMOH, LGA) of data management		Electronic data management.		**51,309,198**
			5.2.2.1	Maintain HMIS minimum package at the State and LGA level.		ICT support at all levels.	3,653,596
			5.2.2.2	Provide and maintain ICT materials and internet services			47,655,602
			5.2.2.3	Capacity building of service providers on ICT tools and data management			-
	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**		**76,574,609**
		5.3.1	To strengthen the Hospital Information System		Availability of Hospital Information System package		**51,150,346**
			5.3.1.1	Develop a comprehensive Hospital Information System Package.		Provision of functional ICT at Hospitals.	794,260

			5.3.1.2	Institute effective hospital information system network.			47,655,602
			5.3.1.3	Capacity building on computer and HIS sofware for all cadres.			2,700,484
			5.3.1.4	Provide relevant ICT facilities, power supply and application softwares at hospital level.			-
			5.3.1.5	Institute routine maintenance system.			-
		5.3.2	To strengthen the Disease Surveillance System		Reports of review meetings.		**25,424,264**
			5.3.2.1	Sensitize communities on disease notification.		Adequate Logistics Support	9,531,120
			5.3.2.2	Capacity building of DSNOs and other health workers on prompt reporting.			2,549,575
			5.3.2.3	Provide necessary tools and logistic supports			8,101,452
			5.3.2.4	Sustain regular review meetings.			5,242,116
	5.4	**To monitor and evaluate the NHMIS**			**NHMIS evaluated annually**		**1,985,650**
		5.4.1	To establish monitoring protocol for NHMIS programme implementation at all levels in line with stated activities and expected outputs		Reports on review meetings		**555,982**
			5.4.1.1	Adapt monitoring protocol for NHMIS programme implementation.		Monitoring NHMIS will be sustained.	277,991
			5.4.1.2	Develop HMIS field monitring instruments and HIS quality assurance manual			277,991
			5.4.1.3	Conduct quarterly HIS review meetings			-
			5.4.1.4	Maintenance of NHMIS electronic data base			-
		5.4.2	To strengthen data transmission		Data Transmission Mechanism availabled		**1,429,668**
			5.4.2.1	Prompt collation and forwarding of data in hard and electronic copies		Health Record Officers mobilized.	1,429,668
			5.4.2.2	Provide Internet facilities for information management and transmission.			-
	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**		**3,812,448**
		5.5.1	To institutionalize data analysis and dissemination at all levels		Availabil;ity of harminised data		**3,812,448**
			5.5.1.1	Enhance capacity of Health Record staff and |M & E Officers on data analysis (see 5.2.1.1.)		ICT support at all levels.	-
			5.5.1.2	Harmonize data from all levels.			-
			5.5.1.3	Regular dessimination of health data information to all levels.			3,812,448
COMMUNITY PARTICIPATION AND OWNERSHIP							
6. To attain effective community participation in health development and management, as well as community ownership of sustainable health outcomes							**431,000,439**
	6.1	**To strengthen community participation in health development**			**All States have at least annual Fora to engage community**		**217,357,110**

					leaders and CBOs on health matters by end 2012		
		6.1.1	To provide an enabling policy framework for community participation		Available policy document.		**80,714,187**
			6.1.1.1	Adapt National Policy framework on community participation.		Political will to support	2,704,601
			6.1.1.2	Advocate for adoption among policy makers and legislature.			7,367,011
			6.1.1.3	Sensitize communities.			70,642,575
		6.1.2	To provide an enabling implementation framework and environment for community participation		Report of meetings.		**57,523,239**
			6.1.2.1	Strenghten community stakeholders' forum for community participation in health programs		Harmony within the community	28,862,538
			6.1.2.2	Review and harmonize existing guidelines for health development activities			14,330,351
			6.1.2.3	Plan and develop implementation, monitoring and evaluation tools for health interventions			14,330,351
		6.1.3	Building community capacity		Reports of dialogue meetings.		**79,119,683**
			6.1.3.1	Capacity building on key roles, functions and resource mobilization of community stakeholders		Community cooperation.	22,605,624
			6.1.3.2	Sustain regular dialogue between community and Government structures for maximum impact			6,055,078
			6.1.3.3	Conduct community enlightenment/sensitization programmes using IEC materials/media houses			50,458,982
	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**		**141,688,821**
		6.2.1	To build capacity within communities to 'own' their health services		Increased community participation.		**141,688,821**
			6.2.1.1	Build capacity of community members in health programme planning and ownership.		Community cooperation.	70,642,575
			6.2.1.2	Promote men involvement and facilitate the empowerment of women for financial independence.			-
			6.2.1.3	Develop the capacity of community groups and faithbased associations to appreciate and assume their roles as partners in improving health services including MNCH services.			28,660,702
			6.2.1.4	Strengthen Community and Ward Development Committees to enable them respond appropriately at times of emergencies.			26,238,671
			6.2.1.5	Advocate for increased community resources and investments in health services and institutionalize community based MNCH services.			16,146,874
	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**		**30,073,553**
		6.3.1	To restructure and strengthen the interface between the community and the health services delivery points		Guidelines and Action Plans developed.		**30,073,553**
			6.3.1.1	Review guidelines on community-health linkage.		Community cooperation.	5,247,734

			6.3.1.2	Develop action plans on health promotion capacities at community level			7,266,093
			6.3.1.3	Institute implementation strategies for reviewed guidelines.			5,247,734
			6.3.1.4	Provide technical support to strengthen community health service linkage			7,266,093
			6.3.1.5	Assess and document best practices on community-health linkage.			5,045,898
	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**		**23,009,296**
		6.4.1	To develop and implement multisectoral policies and actions that facilitate community involvement in health development		Reports of consultative meetings.		**23,009,296**
			6.4.1.1	Develop multisectoral policy for health development at community level.		Community cooperation.	4,440,390
			6.4.1.2	Constitute multisectoral consultative forum.			2,422,031
			6.4.1.3	Develop and implement action plans on multisectoral collaboration and community involvement in health programmes.			16,146,874
	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**		**18,871,659**
		6.5.1	To develop and implement systematic measurement of community involvement		Available reports.		**18,871,659**
			6.5.1.1	Develop M & E mechanism using locally adopted models for community involvement.		Community cooperation.	8,073,437
			6.5.1.2	Conduct regular meetings to share experiences with the communities.			3,733,965
			6.5.1.3	Disseminate information on lessons learnt and best practices among stakeholders			7,064,257
PARTNERSHIPS FOR HEALTH							
7. To enhance harmonized implementation of essential health services in line with national health policy goals							**431,000,439**
	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**		**431,000,439**
		7.1.1	To promote Public Private Partnerships (PPP)		National PPP policy document adapted for the state.		**27,687,005**

			7.1.1.1	Adapt existing National policy on PPP.		Acceptance by all stakeholders	5,740,590
			7.1.1.2	Identify and regularly update the private and public institutions for patnership.			18,839,394
			7.1.1.3	Identify areas for patnership.			394,542
			7.1.1.4	Set up a joint implimentation and monitoring committee.			2,712,478
		7.1.2	To institutionalize a framework for coordination of Development Partners		Improved partnership.		**8,745,424**
			7.1.2.1	Reactivate the state Inter agency Coordinating Committee ICC and establish same at the LGAs and ward levels.		Committed Partners	3,072,301
			7.1.2.2	Implement guidelines on PPP at all levels			3,817,197
			7.1.2.3	Improve coordination with patners to establish and enhance support through mechanisms such as common basket funding: SWAP, Sectoral multi- partner budget support.			1,855,927
		7.1.3	To facilitate inter-sectoral collaboration		Report of meetings.		**37,444,430**
			7.1.3.1	Identify relevant sectors for collaboration at the state, LGA's and ward levels.		Multisectoral cooperation.	17,517,677
			7.1.3.2	Create forum for interaction with identified sectors.			1,274,766
			7.1.3.3	Identify, plan, implement and monitor relevant programmes for collaboration.			18,651,987
		7.1.4	To engage professional groups		Increased participation by professional groups in health issues.		**40,912,062**
			7.1.4.1	Identify professional groups and establish consultative forum.		Willingness to collaborate	4,221,602
			7.1.4.2	Promote and implement set standards of training for health insttutions subsequent practice and professional competency assessment.			28,059,847
			7.1.4.3	Engage professional groups to plan, implement, monitor and evaluate health programmes.			4,971,233
			7.1.4.4	Promote effective communication to facilitate relationships between government, professional groups and other stakeholders.			3,264,837
			7.1.4.5	Strenghten collaboration between government and professional groups to advocate for increased coverage of essential interventions and increased funding.			394,542
		7.1.5	To engage with communities		Increased community engagement.		**269,554,446**
			7.1.5.1	Identify participating communities and key representatives of stakeholders.		Community cooperation.	7,669,902
			7.1.5.2	Communicate health information to communities using culturally appropriate and easily accessible gender sensitive dessemination channels.			88,991,380
			7.1.5.3	Enlighten the communities on rights of beneficiaries, means of accessing care at health facilities and minimum standards of quality health services.			39,727,252
			7.1.5.4	Develop indicators on health system performance at all levels.			92,007,261
			7.1.5.5	Capacity building of communities to improve health care delivery through behavioural change, social marketing, public awareness campaigns etc.			41,158,651
		7.1.6	To engage with traditional health practitioners		Joint supervisory body in place		**46,657,071**

			7.1.6.1	Adopt national guidelines on traditional health practice		Willingness of traditional practioners to collaborate,	3,492,173
			7.1.6.2	Identify and update the list of practitioners at the LGA's and ward levels.			31,405,566
			7.1.6.3	Create forum for better understanding of the traditional health practices and support research activities to gain more insight and evaluate them.			5,020,551
			7.1.6.4	Establish joint supervisory body for monitoring and training of traditional health practitioners.			5,144,831
			7.1.6.5	Collaborate with the practitioners in priority areas of nutrition,environmental sanitation, personal hygiene, immunization and family planning; document and adopt practices and technology of proven values.			1,593,951
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							**862,000,878**
	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**		**482,632,766**
		8.1.1	To finalise the Health Research Policy at State level and develop health research policies at State levels and health research strategies at State and LGA levels		Availability of the State Research document .		**140,361,535**
			8.1.1.1	Adapt the National Health Research policy at state level		Political committment	29,397,529
			8.1.1.2	Advocate to policy makers and legislators			2,333,137
			8.1.1.3	"Stakeholders mapping" to form technical research committees membership at state and LGAs			88,099,261
			8.1.1.4	Health needs and impact assessment based on Political, economic, social, technologic, ecologic and legal factors (PESTEL model).			12,598,941
			8.1.1.5	Develop and improve health research strategies.			7,932,667
		8.1.2	To establish and or strengthen mechanisms for health research at all levels		Increased number of health research activities.		**114,323,724**
			8.1.2.1	Constitute Health Research Steering and Ethics Committee at all levels for development of health research data base and guidelines		Adequate support	109,657,449
			8.1.2.2	Create critcal mass of researh officers for the health sector.			4,666,274
		8.1.3	To institutionalize processes for setting health research agenda and priorities		Health Research Agenda and Priorities in place		**122,256,390**
			8.1.3.1	Develop and review State Research Agenda and priorities.		Available Researchers.	103,591,293
			8.1.3.2	Implement State Health Research Agenda and priorities.			18,665,098
		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		Report of meetings.		**31,030,725**
			8.1.4.1	Encourage multisectorial collaboration for health research.		Cooperation by partners.	9,332,549

			8.1.4.2	Conduct regular consultative meetings.			21,698,176
		8.1.5	To mobilise adequate financial resources to support health research at all levels		Availability of Health Research Account		**32,663,921**
			8.1.5.1	Advocacy and social mobilization for health research fundings		Support from partners.	32,663,921
			8.1.5.2	Create joint basket funding for health research.			-
			8.1.5.3	Create adequate budget line for health research.			-
		8.1.6	To establish ethical standards and practise codes for health research at all levels		Availability of adopted document.		**41,996,470**
			8.1.6.1	Adopt National standard and practice code for health research		Compliance with practice codes.	18,665,098
			8.1.6.2	Desseminate information on health research standards, ethics and practice codes.			23,331,372
	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**		**290,708,898**
		8.2.1	To strengthen identified health research institutions at all levels		Increased number of health research activities		**248,245,800**
			8.2.1.1	Strengthen health instutitions and facilities to embark on health research		Cooperation by the institutions	248,245,800
		8.2.2	To create a critical mass of health researchers at all levels				**23,331,372**
			8.2.2.1	Refer to 8.1.2.2	Number of certified researchers	Available Researchers.	-
			8.2.2.2	Design and intensify campaigns to encourage health researchers in other states and diaspora to contribute to strengthen the human resource in the State.			23,331,372
		8.2.4	To undertake research on identified critical priority areas				**19,131,725**
			8.2.4.1	Identify critical and poor health indices for further research	Report on critical and poor health indices from qualitative researches	Logistic support	9,799,176
			8.2.4.2	Develop framework to reduce the poor result indices			9,332,549
			8.2.4.3	Design and intensify campaigns to encourage health professionals in diaspora to return to the service to strengthen the human resources availability in the State and LGAs			-
	8.3	**To develop a comprehensive repository for health research at all levels (including both public and non-public sectors)**			**1. All States have a Health Research Unit by end 2010 2. FMOH and State Health Research Units manage an accessible repository by end 2012**		**60,661,568**
		8.3.1	To develop strategies for getting research findings into strategies and practices				**51,329,019**
			8.3.1.1	Develop strategies for implemtation of health research findings and recommendations	Collated research findings	Availability of research findings	18,665,098
			8.3.1.2	Collate clinical and other research findings and recommendations that may be used to influence government policies			18,665,098

			8.3.1.3	Desseiminate research findings and recommendations amongst stakeholders for appropriate actions and practices.			13,998,823
		8.3.2	To enshrine mechanisms to ensure that funded researches produce new knowledge required to improve the health system				**9,332,549**
			8.3.2.1	Institute evidence based standards to assess and approve research proposals by established research and ethics committees.	Increase in number of applied research knowledge	Available research knowledge	4,666,274
			8.3.2.2	Institute feed-back mechanism to monitor use of research findings			4,666,274
	8.4	**To develop, implement and institutionalize health research communication strategies at all levels**			**A national health research communication strategy is in place by end 2012**		**27,997,647**
		8.4.1	To create a framework for sharing research knowledge and its applications		Developed document		**13,998,823**
			8.4.1.1	Develop and review guidelines for regular sharing of research findings.			13,998,823
		8.4.2	To establish channels for sharing of research findings between researchers, policy makers and development practitioners				**13,998,823**
			8.4.2.1	Set up machanism for regular publication and dessemination of findings in local and international journals	Increased number of research publications	Available research findings	13,998,823
Total							**43,100,043,895**

Annex 3: Results/M&E for Nasarawa State SHDP

NASARAWA 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	TBD	25	50	75%
2. Improved Legislative and Regulatory Frameworks for Health Development	3. State adopting the National Health Bill? (Yes/No)	SMOH	0	25	50	75
	4. % of LGAs enforcing traditional medical practice by-laws	LGA Annual Report	TBD	25%	50%	75%
3. Strengthened accountability, transparency and responsiveness of the State health system	5. % of LGAs which have established a Health Watch Group	LGA Annual Report	0	45%	75	100
	6. % of recommendations from health watch groups being implemented	Health Watch Groups' Reports	No Baseline	25	50	75
	7. % LGAs aligning their health programmes to the SSHDP	LGA Annual Report	0	50	75	100
	8. % DPs aligning their health	LGA Annual Report	No Baseline	50	75	100

	programmes to the SSHDP at the LGA level					
	9. % of LGAs with functional peer review mechanisms	SSHDP and LGA Annual Review Report	TBD	25	50	75%
	10. % LGAs implementing their peer review recommendations	LGA / SSHDP Annual Review Report	No Baseline	50	75	100%
	11. Number of LGA Health Watch Reports published	Health Watch Report	0	50	75	100
	12. Number of "Annual Health of the LGA" Reports published and disseminated annually	Health of the State Report	TBD	50	75	100%
4. Enhanced performance of the State health system	13. % LGA public health facilities using the essential drug list	Facility Survey Report	TBD	40	80	100%
	14. % private health facilities using the essential drug list by LGA	Private facility survey	TBD	10	25	50%
	15. % of LGA public sector institutions implementing the drug procurement policy	Facility Survey Report	TBD	50	75	100%
	16. % of private sector institutions implementing the drug procurement policy within each LGA	Facility Survey Report	TBD	10	25	50%
	17. % LGA health facilities not experiencing essential drug/commodity stockouts in the last three months	Facility Survey Report	TBD	25	50	75%
	18. % of LGAs implementing a performance based budgeting system	Facility Survey Report	TBD	25	50	75%
	19. Number of MOUs signed between private sector facilities and LGAs in a Public-Private-Partnership by LGA	LGA Annual Review Report	TBD	2	4	6

	20. Number of facilities performing deliveries accredited as Basic EmOC facility (7 functions 24/7) and Comprehensive EmOC facility (9 functions 24/7)	States/ LGA Report and Facility Survey Report	TBD	2	4	6
STRATEGIC AREA 2: HEALTH SERVICES DELIVERY						
NSHDP GOAL: To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare						
Outcome 3: Universal availability and access to an essential package of primary health care services focusing in particular on vulnerable socio-economic groups and geographic areas						
Outcome 4: Improved quality of primary health care services						
Outcome 5: Increased use of primary health care services						
5. Improved access to essential package of Health care	21. % of LGAs with a functioning public health facility providing minimum health care package according to quality of care standards.	NPHCDA Survey Report	TBD	25	50	75%
	22. % health facilities implementing the complete package of essential health care	NPHCDA Survey Report	TBD	50	75	100%
	23. % of the population having access to an essential care package	MICS/NDHS	TBD	40	75	100%
	24. Contraceptive prevalence rate (modern and traditional)	NDHS	12.00%	15%	20%	30%
	25. % increase of new users of modern contraceptive methods (male/female)	NDHS/HMIS	TBD	10%	15%	25%
	26. % of new users of modern contraceptive methods by type (male/female)	NDHS/HMIS	TBD	10%	15%	25%
	27. % service delivery points without stock out of family planning commodities in the last three months	Health facility Survey	TBD	10%	20%	30%

	28. % of facilities providing Youth Friendly RH services	Health facility Survey	TBD	20%	30%	40%
	29. % of women 15-19 who have begun child rearing	NDHS/MICS	19.70%	15%	13%	10%
	30. % of pregnant women with 4 ANC visits performed according to standards*	NDHS	72.00%	75%	80%	90%
	31. Proportion of births attended by skilled health personnel	HMIS	33.80%	25 -100	50 -100%	75 - 100%
	32. Proportion of women with complications treated in an EmOC facility (Basic and/or comprehensive)	EmOC Sentinel Survey and Health Facility Survey	TBD	20%	25%	40%
	33. Caesarean section rate	EmOC Sentinel Survey and Health Facility Survey	3.00%	5%	7.50%	10%
	34. Case fatility rate among women with obstretic complications in EmOC facilities per complication	HMIS	TBD	20%	18%	15%
	35. Perinatal mortality rate**	HMIS	45/1000LBs	40/1000LBs	35/1000LBs	30/1000LBs
	36. % women receiving immediate post partum family planning method before discharge	HMIS	TBD	10%	15%	25%
	37. % of women who received postnatal care based on standards within 48h after delivery	MICS	10%	20%	30%	40%
	38. % of newborn with infection receiving treatment	MICS	No Baseline	10%	20%	35%
	39. % of children exclusively breastfed 0-6 months	NDHS/MICS	1%	5%	10%	15%

	40. Proportion of 12-23 months-old children fully immunized	NDHS/MICS	16.10%	25%	35%	50%
	41. % children <5 years stunted (height for age <2 SD)	NDHSMICS	44.10%	40%	35%	30%
	42. % of under-five that slept under LLINs the previous night	NDHS/MICS	5.60%	10%	20%	30%
	43. % of under-five children receiving appropriate malaria treatment within 24 hours	NDHS/MICS	35.60%	40%	45%	60%
	44.Condom use at last high risk sex	NDHS/MICS	3.80%	5%	8%	12%
	45. Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS	NDHS/MICS	31.80%	40%	50%	60%
	46. Prevalence of tuberculosis	NARHS	1.70%	1.50%	1.00%	0.60%
Output 6. Improved quality of Health care services	47. % of staff with skills to deliver quality health care appropriate for their categories	Facility Survey Report	TBD	15%	30%	40%
	48. % of facilities with capacity to deliver quality health care	Facility Survey Report	TBD	12%	20%	30%
	49. % of health workers who received personal supervision in the last 6 months by type of facility	Facility Survey Report	TBD	20%	35%	45%
	50. % of health workers who received in-service training in the past 12 months by category of worker	HR survey Report	TBD	10%	20%	30%
	51. % of health facilities with all essential drugs available at all times	Facility Survey Report	TBD	5%	10%	15%
	52. % of health institutions with basic medical equipment and functional logistic	Facility Survey Report	TBD	5%	10%	15%

	system appropriate to their levels					
	53. % of facilities with deliveries organizing maternal and/or neonatal death reviews according to WHO guidelines on regular basis	Facility Survey Report	TBD	10%	20%	30%
Output 7. Increased demand for health services	54. Proportion of the population utilizing essential services package	MICS	TBD	15%	25%	30%
	55. % of the population adequately informed of the 5 most beneficial health practices	MICS	TBD	20%	30%	45%
PRIORITY AREA 3: HUMAN RESOURCES FOR HEALTH						
NSHDP GOAL: To plan and implement strategies to address the human resources for health needs in order to ensure its availability as well as ensure equity and quality of health care						
Outcome 6. The Federal government implements comprehensive HRH policies and plans for health development						
Outcome 7.All States and LGAs are actively using adaptations of the National HRH policy and plan for health development by end of 2015						
Output 8. Improved policies and Plans and strategies for HRH	56. % of wards that have appropriate HRH complement as per service delivery norm (urban/rural).	Facility Survey Report	TBD	10%	20%	30%
	57.Retention rate of HRH	HR survey Report	TBD	85%	90%	95%
	58. % LGAs actively using adaptations of National/State HRH policy and plans	HR survey Report	TBD	25%	40%	50%
	59. Increased number of trained staff based on approved staffing norms by qualification	HR survey Report	TBD	10%	15%	20%
	60. % of LGAs implementing performance-based managment systems	HR survey Report	TBD	10%	20%	30%
	61. % of staff satisfied with the performance based	HR survey Report	TBD	20%	30%	50%

	management system					
Output 8: Improved framework for objective analysis, implementation and monitoring of HRH performance	62. % LGAs making availabile consistent flow of HRH information	NHMIS	20%	30%	40%	50%
	63. CHEW/10,000 population density	MICS	TBD	1:4000 pop	1:3000 pop	1:2000 pop
	64. Nurse density/10,000 population	MICS	TBD	1:8000 pop	1:6000 pop	1:4000 pop
	65. Qualified registered midwives density per 10,000 population and per geographic area	NHIS/Facility survey report/EmOC Needs Assessment	TBD	1:8000 pop	1:6000 pop	1:4000 pop
	66. Medical doctor density per 10,000 population	MICS	TBD	1:8000 pop	1:7000 pop	1:5000 pop
	67. Other health service providers density/10,000 population	MICS	TBD	1:4000 pop	1:3000 pop	1:2000 pop
	68. HRH database mechanism in place at LGA level	HRH Database	TBD	20%	35%	50%
Output 10: Strengthened capacity of training institutions to scale up the production of a critical mass of quality mid-level health workers						
PRIORITY AREA 4: FINANCING FOR HEALTH						
NSHDP GOAL 4 : To ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and consumption at Local, State and Federal Levels						
Outcome 8. Health financing strategies implemented at Federal, State and Local levels consistent with the National Health Financing Policy						
Outcome 9. The Nigerian people, particularly the most vulnerable socio-economic population groups, are protected from financial catastrophe and impoverishment as a result of using health services						
Output 11: Improved protection from financial	69. % of LGAs implementing state specific safety nets	SSHDP review report	TBD	20%	35%	50%

catastrophy and impoversihmen t as a result of using health services in the State						
	70. Decreased proportion of informal payments within the public health care system within each LGA	MICS	TBD	10%	20%	30%
	71. % of LGAs which allocate costed fund to fully implement essential care package at N5,000/capita (US$34)	State and LGA Budgets	TBD	5%	10%	15%
	72. LGAs allocating health funding increased by average of 5% every year	State and LGA Budgets	TBD	10%	20%	25%
Output 12: Improved efficiency and equity in the allocation and use of Health resources at State and LGA levels	73. LGAs health budgets fully alligned to support state health goals and policies	State and LGA Budgets	TBD	20%	35%	45%
	74.Out-of pocket expenditure as a % of total health expenditure	National Health Accounts 2003 - 2005	70%	60%	50%	40%
	75. % of LGA budget allocated to the health sector.	National Health Accounts 2003 - 2005	2%	10%	20%	30%
	76. Proportion of LGAs having transparent budgeting and finacial management systems	SSHDP review report	TBD	25%	40%	60%
	77. % of LGAs having operational supportive supervision and monitoring systems	SSHDP review report	TBD	25%	40	50%
PRIORITY AREA 5: NATIONAL HEALTH INFORMATION SYSTEM						

Outcome 10. National health management information system and sub-systems provides public and private sector data to inform health plan development and implementation						
Outcome 11. National health management information system and sub-systems provide public and private sector data to inform health plan development and implementation at Federal, State and LGA levels						
Output 13: Improved Health Data Collection, Analysis, Dissemination, Monitoring and Evaluation	78. % of LGAs making routine NHMIS returns to states	NHMIS Report January to June 2008; March 2009	5%	10%	25%	40%
	79. % of LGAs receiving feedback on NHMIS from SMOH		TBD	10%	25%	40%
	80. % of health facility staff trained to use the NHMIS infrastructure	Training Reports	TBD	20%	35%	50%
	81. % of health facilities benefitting from HMIS supervisory visits from SMOH	NHMIS Report	TBD	20%	35%	50%
	82.% of HMIS operators at the LGA level trained in analysis of data using the operational manual	Training Reports	TBD	40%	75%	100%
	83. % of LGA PHC Coordinator trained in data dissemination	Training Reports	TBD	40%	75%	100%
	84. % of LGAs publishing annual HMIS reports	HMIS Reports	TBD	25%	50%	75%
	85. % 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	86. Proportion of public health facilities having active committees that include community representatives (with meeting reports and actions recommended)	SSHDP review report	TBD	25%	50%	75%
	87. % of wards holding quarterly	HDC Reports	TBD	25%	50%	75%

	health committee meetings					
	88. % HDCs whose members have had training in community mobilization	HDC Reports	TBD	40%	75%	100%
	89. % increase in community health actions	HDC Reports	TBD	10%	25%	50%
	90. % of health actions jointly implemented with HDCs and other related committees	HDC Reports	TBD	25%	40%	60%
	91. % 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	92. Increased number of new PPP initiatives per year per LGA	SSHDP Report	TBD	25%	40%	60%
	93. % LGAs holding annual multi-sectoral development partner meetings	SSHDP Report	TBD	25%	50%	75%
PRIORITY AREA 8: RESEARCH FOR HEALTH						
Outcome 15. Research and evaluation create knowledge base to inform health policy and programming.						
Output 16: Strengthened stewardship role of government for research and knowledge management systems	94. % of LGAs partnering with researchers	Research Reports	TBD	10%	25%	50%
	95. % of State health budget spent on health research and evaluation	State budget	TBD	1%	1.50%	2%
	96. % of LGAs holding quarterly knowledge sharing on research, HMIS and best practices	LGA Annual SHDP Reports	TBD	10%	25%	50%
	97. % of LGAs participating in	LGA Annual SHDP Reports	TBD	40%	75%	100%

	state research ethics review board for researches in their locations					
	98. % of health research in LGAs available in the state health research depository	State Health Reseach Depository	TBD	40%	75%	100%
Output 17: Health research communication strategies developed and implemented	99. % LGAs aware of state health research communication strategy	Health Research Communication Strategy	TBD	40%	75%	100%