KWARA STATE GOVERNMENT

STRATEGIC HEALTH DEVELOPMENT PLAN
(2010-2015)

Kwara State Ministry of Health

March 2010

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ACKNOWLEDGEMENT

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ACRONYMS

BCC	Behaviour Change Communication
CHIS	Community Health Insurance Scheme
CIDA	Canadian International Development Agency
CORPs	Community oriented resource persons
CPD	Continuing professional development
CSO	Community Service Organization
DFID	Department for International Development
DHS	Nigeria Demographic and Health Survey
DP	Development Partners
DPRS	Department of Planning, Research and Statistics
FCT	Federal Capital Territory
FMOH	Federal Ministry of Health
GDP	Gross Domestic Product
GIS	Geographic Information System
GTZ	Gesellschaft für Technische Zusammenarbeit
HDCC	Health Data Consultative Committee
HF	Health Facility
HIS	Health Management Information System
HIV/AIDS	Human Immuno Deficiency Virus/Acquired Immune Deficiency Syndrome
HLM	High Level Ministerial Meeting on Health Research
HPCC	Health Partners Coordinating Committee
HRH	Human Resources for Health
HW	Health worker
IEC	Information, Education and Communication
IMCI	Integrated management of Childhood Illnesses
IMNCH	Integrated Maternal, Newborn and Child Health
IPC	Interpersonal Communication skills
ISS	Integrated supportive supervision
ITNs	Insecticide treated nets
JFA	Joint Funding Agreement
JIDA	Japan International Development Agency
LGA	Local Government Area
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDAs	Ministries, Departments and Agencies
MDCN	Medical and Dental Council of Nigeria,
MDGs	Millennium Development Goals
MNCH	Maternal and Newborn Child Health
MRCN	Medical Research Council of Nigeria

NAFDAC	National Agency for Food Drugs Administration and Control
NGOs	Non-Governmental Organizations
NHA	National Health Accounts
NHIS	National Health Insurance Scheme
NHMIS	National Health Management Information System
NHREC	National Health Research Committee
NIMR	Nigerian Institute for Medical Research
NIPRD	National Institute for Pharmaceutical Research and Development
NMSP	National Malaria Strategic Plan
NPHCDA	National Primary Health Care Development Agency
NSHDP	National Strategic Health Development Plan
NSHDPF	National Strategic Health Development Plan Framework
NSTDA	National Science and Technology Development Agency
NYSC	National Youth Service Corps
OAU	Organisation of African Unity
ODA	Overseas Development Assistance
OPS	Organised Private Sector
PEPFAR	President's Emergency Plan for AIDS Relief
PERs	Public Expenditure Reviews
PHC	Primary Health Care
PHCMIS	Primary Health Care Management Information System
PPP	Public Private Partnerships
QA	Quality Assurance
RDBs	Research data banks
SHAs	State Health Accounts
SITAN	Situation Analysis
SMOH	State Ministry of Health
SWAPs	Sector-Wide Approaches
TB	Tuberculosis
TBAs	Traditional Birth Attendants
TWG	Technical Working Group
UN-System	United Nations-System
VAT	Value Added Tax
VHW	Village Health Workers
VOC	Vote-of-charge
WHO	World Health Organization

FOREWORD

Health is Wealth' goes the popular saying and therefore in every State, the health sector is critical to socioeconomic development with ample evidence linking productivity to quality of health care. In Kwara, the vision of industrializing the State is closely tied to the development of its human capital through the health sector.

However, the health indicators in Kwara state have remained below targets and internationally-set benchmarks including the MDGs, which have recorded very slow progress over the years. Currently, the health sector is witnessing a gradual reform, which is expected to improve the stewardship role of government, fragmented health service delivery, inadequate and inefficient financing, weak health infrastructure, inadequate number of health work force with skewed distribution in favour of urban settlement.

To address these, the State government buy in to the Health Sector Reform Program (HSRP), which addressed seven strategic thrusts revolving around government's stewardship role; management of the national health system; the burden of disease; mobilization and utilization of health resources; health service delivery; consumer awareness and community involvement; partnership, collaboration and coordination. In addition, efforts were directed at strengthening disease control programme and improving the quality of care in primary and secondary health facilities, and recently upgrading of one of the specialist hospitals to specialist status in service delivery including training of house officers. Despite these initiatives, much of the underlying weaknesses and constraints of the health sector persist.

Consequently, the State Ministry of Health buys in to the national articulated framework, which is an overarching guide for the development of the State Strategic Health Development Plan (SSHDP) with its appropriate costing. The SSHDP would result from the harmonization of States' and local governments' health plans, thereafter serving as the basis for State ownership, resource mobilisation/allocation and mutual accountability by all stakeholders – government, development partners, civil society, private sector, communities, etc. The framework is based on the principles of the Four Ones: one health policy, one State plan, one budget, and one monitoring and evaluation framework for all levels of government.

Based on a multidimensional assessment of the health sector, the framework identifies eight priority areas for improving the national health systems with specific goals and strategic objectives. They are leadership and governance for health; health service delivery; human resources for health; health financing; health information systems; community ownership and participation; partnerships for health development; and research for health.

I implore all stakeholders to use this framework to adequately harness the policy gaps and program interventions required to improve the performance of the health sector towards the delivery of quality, efficient and sustainable health care for all Kwarans.

Alh. Ladi Hassan
Honourable Commissioner of Health

VISION AND MISSION OF THE STRATEGIC PLAN

Vision

"To reduce the morbidity and mortality rates due to communicable diseases to the barest minimum; reverse the increasing prevalence of non-communicable diseases; meet global targets on the elimination and eradication of diseases; and significantly increase the life expectancy and quality of life of Kwarans".

Mission statement

"To develop and implement appropriate policies and programmes as well as undertake other necessary actions that will strengthen the Kwara State Health System to be able to deliver effective, quality, affordable and accessible health care services.

The overarching goal of the KWSSHDP is *to significantly improve the health status of Kwarans through the development of a strengthened and sustainable health care delivery system.*

EXECUTIVE SUMMARY

VISION

The vision of the State is "to reduce the morbidity and mortality rates due to communicable diseases to the barest minimum; reverse the increasing prevalence of non-communicable diseases; meet global targets on the elimination and eradication of diseases; and significantly increase the life expectancy and quality of life of Kwarans". It seeks to do so by "developing and implementing appropriate policies and programmes that will strengthen the Kwara State Health System to deliver effective, quality and affordable health services.

Kwara State was created in 1967 as one of the 12 federating units of Nigeria. It is in the North central geopolitical zone of the country. It is bounded in the north by Niger state, in the south by Oyo, Osun and Ekiti states and in the East by Kogi state. It also has an international boundary in the west with the Republic of Benin. It is situated between latitudes 11^0 2' and 11^0 45'N, longitude 2^0 45' and 6^0 4'E. Its location can be considered as midway between the Northern and Southern parts of Nigeria.

The seasonal pattern of the state is dual; with dry and wet seasons with the wettest months occurring usually between July and September. Monthly rainfall varies between 50.8mm and 241.3mm levels with the annual mean rainfall between 745.5mm and 1,409.2mm. Average atmosphere temperature is between 18^0C and 35^0C. Kwara state has 24 forest reserves covering 5,087.2sq km.

The State has an estimated population of 2,371,000 (2009 projection), with an annual growth rate of 3.4%. The State has 16 Local Government Areas grouped into 3 senatorial districts and has the state capital as Ilorin. Kwara State has many ethnic groups, the three major languages being Yoruba, Nupe and Baruba. Yoruba is the most populous tribe. The state also has a variety of natural resources, crops, fishery, livestock and forestry. The mineral resources are numerous including Marble, Tantalite and Gold among others. Kwara state revenue is derived from the Federation account, internally generated revenue, borrowing and Grants.

Kwara state is headed by the Executive Governor who is in charge of the executive arm, the political, administration and the chief security officer of the state. The legislative arm is headed by the Honorable Speaker of the House of Assembly while the Judiciary is headed by the Chief Judge. The state Grand Khadi heads the Sharia Court of Appeal. The state religious mix is a combination of Islam and Christianity with some traditional worshippers.

Health Status Indicators in Kwara State are Infant Mortality/mortality of 103/1000 to 50/1000; Child Under-5-Mortality of 185/1000 to 50/1000; Neonatal

Mortality of 53/1000 to 48/1000 and Maternal Mortality rate of 980/100,000. 2009 routine Immunization coverage is put at 96% for DPT3 and a Life Expectancy of 52 years.

The ten (10) most common diseases/health condition in the states are; Malaria, Diarrhoea without blood, Malaria in Pregnancy, Typhoid Fever, Anaemia, Hypertension, Eye Conditions, Pneumonia, Diarrhoea with Blood and Sexually Transmitted Infection (STI).

The very weak health system contributes to the limited health service coverage with proven high impact, cost-effective health services, which are outlined in the plan. For each of the priority areas, the SHDP details the goals, strategic objectives, and recommended evidence-based and cost-effective interventions required to deliver improved performance of the health system and health outcomes for Kwarans.

Documents reviewed in the planning process includes Kwara State Economic Empowerment and Development Strategy, Kwara State Health Summit (2004), Child Health Policy, Health Promotion Policy, Nigeria Health system Assessment(2008), Health sector Reform programme, Human resource for Health strategic Plan, IMNCH Strategic Plan, National Malaria Control Programme, National Health Policy (2005) etc.

The Kwara state strategic health development plan will be jointly implemented by the SMOH, Ministry of LGCA, with support from International Development Partners and CSOs working in the state. The state will institute effective supervision of the implementation of annual operational plans to ensure that planned activities are properly implemented. The state will also establish/strengthen monitoring and evaluation systems to track progress and changes, as well as correct negative practices or gaps in service availability, coverage, human resources, financing, information systems, and leadership and governance.

CHAPTER ONE: BACKGROUND

Kwara State was created in 1967 as one of the 12 federating units of Nigeria. It is in the North central geopolitical zone of the country. It is bounded in the north by Niger state, in the south by Oyo, Osun and Ekiti states and in the East by Kogi state. It also has an international boundary in the west with the Republic of Benin. It is situated between latitudes 11^0 2' and 11^0 45'N, longitude 2^0 45' and 6^0 4'E. Its location can be considered as midway between the Northern and Southern parts of Nigeria.

The seasonal pattern of the state is dual; dry and wet. The wettest months are usually between July and September. Monthly rainfall varies between 50.8mm and 241.3mm. The annual mean rainfall is about the level of national average, hovering between 745.5mm and 1,409.2mm while the national average mean is 1,394.3mm. Average atmosphere temperature is between 18 and 35^0C. Kwara state has 24 forest reserves covering 5,087.2sq km.

It has an estimated population of 2,371,000 (2009 projection)[1], with annual growth rate of 3.4%. The State has 16 Local Government Areas grouped into 3 senatorial districts,. The State capital is Ilorin. Kwara state has many ethnic groups, the three major languages being Yoruba, Nupe and Baruba. Yoruba is the most populous tribe. The state also has a variety of natural resources, crops, fishery, livestock and forestry. The mineral resources are numerous including Marble, Tantalite and Gold among others. Kwara state is headed by the Executive Governor who is in charge of the executive arm, the political, administration and the chief security officer of the state. The legislative arm is headed by the Honorable Speaker of the House of Assembly while the Judiciary is headed by the Chief Judge. The state Grand Khadi heads the Sharia Court of Appeal. The state religious mix is a combination of Islam and Christianity with some traditional worshippers. Kwara state revenue is derived from the Federation account, internally generated revenue, borrowing and Grants.

The centrality of health to State development and poverty reduction is self-evident, as improving health status and increasing life expectancy contribute to long term economic development. The legitimacy of any State health system depends on how best it serves the interest of the poorest and most vulnerable people, for which improvements in their health status is geared towards the realization of poverty reduction goals. In the Nigerian context, current reviews show that the country is presently not on course to achieving the health-related Millennium Development Goals (MDGs) by 2015. This poses a major developmental challenge, which will impede and undermine development and economic growth.

1

The State Government recognizes that, in order to achieve the State health targets, inclusive of the health-related MDGs, particularly for its poorest and most vulnerable population, the health system should be strengthened, health services must be scaled-up and existing gains in the health sector must be sustained and expanded. These improvements can be achieved through the use of an evidence-based Framework to guide the development of a State Strategic Health Development Plan (SSHDP), with appropriate costing.

CHAPTER TWO: SITUATION ANALYSIS

2.1 SOCIO-ECONOMIC CONTEXT

Social determinants of health in the state show that the literacy level of men in Kwara (62%) is below the regional and national averages, while that for women was (48%), just at the national average level. 65% and 54% of households in the State have access to drinking water and electricity respectively, thanks perhaps to the Shiroro Dam which is a source of water and electricity for not just Kwara, but Nigeria as a whole. However the state has very poor sanitation, with only 10% of households having access to improved sanitary facilities.

2.2 THE HEALTH CARE SYSTEM

Kwara State operates a pluralistic health care delivery system with the orthodox and traditional health care delivery systems operating alongside each other, albeit with hardly any collaboration. Both the private and public sectors provide orthodox health care services in the State. Kwara State has a 752 health facilities accounting for private and public health facilities, Private health facility constitute 40% of health facility and providing 60% of health care services. The State presently has 7,517 bed spaces with bed space population ratio of 1:299. More than 60% of the health work force resides in Ilorin the State capital. The Private Out-Of-Pocket-Expenditure (OOPE) in Kwara State accounts for a very high percentage of the estimated per capita expenditure on health, limiting equitable access to quality health care.

The public health service is organized into primary, secondary and tertiary levels. While the Constitution is silent on the roles of the different levels of government in health services provision, the National Health Policy ascribes responsibilities for primary health care to local governments, secondary care to states and tertiary care to the federal level.

Primary Health Care (PHC), which forms the bedrock of the national health system, is in a prostrate state because of poor political will, gross under funding, and lack of capacity at the LGA level, which is the main implementing body.

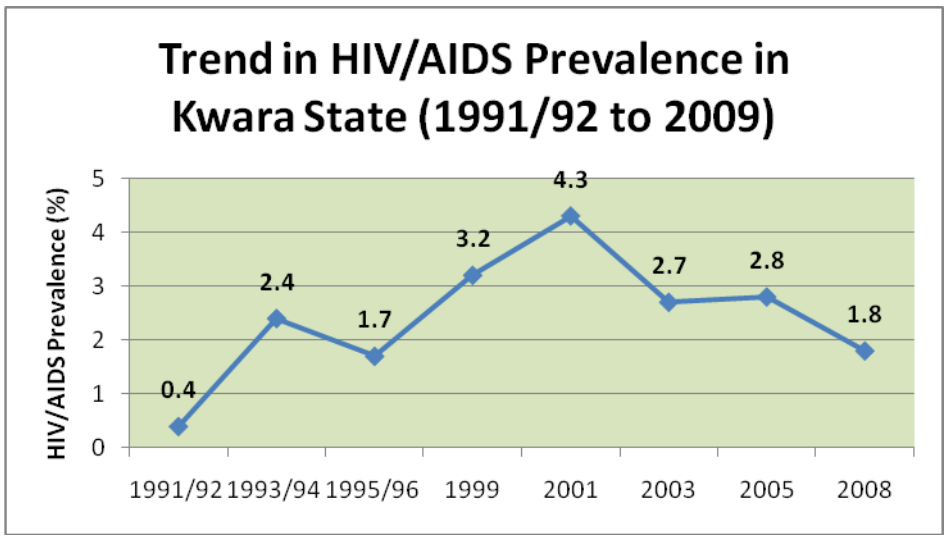
The health system remains overstretched by an ever growing population; The decayed physical facilities are currently being rehabilitated. Modern equipment are being purchased but there is scarcity of skilled health professionals in Kwara State. In addition, health sector problem is compounded by the dearth of data which renders evidence based planning, policy formulation and health systems management weak.

The very weak health system contributes to the limited coverage with proven cost-effective interventions. For example, immunization coverage for routine immunization services is only 43%, percentage of children sleeping under ITN is very low, with limited assess to intermittent preventive therapy by pregnant mothers. Contraceptive prevalence rate is low but incidentally July 2009 SITAN reveals that 68% of pregnant women delivered by skilled birth attendants.

2.3 HEALTH STATUS INDICATORS(KWARA STATE)

Women of child bearing age and children under five are the most vulnerable group in Kwara State. There are 473,071 children under five years of age and about 520, 378 women of child bearing age constituting 20% and 22% of Kwara's population at any one time. Data on burden of diseases is lacking in Kwara State as in most States in Nigeria. However the little available data shows that the State has HIV/AIDS prevalence of 1.8% which is not only lower than the national and regional averages, but it actually has the 4th lowest prevalence in the whole country. The trend (fig 1) however shows that the prevalence rate had risen from 0.4% in the 1991/92 and continued to rise until it peaked at 4.3% in 2001. Thereafter, it steadily decreased to reach the rate in 2008. In 2006, Kwara had the second lowest number of TB cases (509) after Kogi State (381). This means that the prevalence of TB in the State to be about 21 cases per 100,000 population. The ten (10) most common diseases/health conditions in the states are;

- Malaria
- Diarrhoea without blood
- Malaria in Pregnancy
- Typhoid Fever
- Anaemia
- Hypertension
- Eye Conditions
- Pneumonia
- Diarrhoea with Blood
- Sexually Transmitted Infection (STI).



Source: FMoH 2008 ANC Sentinel Survey

SUMMARY OF KWARA STATE INDICATORS

POPULATION (2006 Census)	KWARA	
Total population	2,365,353	
female	1,171,570	
male	1,193,570	
Under 5 years (20% of Total Pop)	411,342	
Adolescents (10 – 24 years)	734,257	
Women of child bearing age (15-49 years)	574,454	
INDICATORS	**NDHS 2008**	**MICS 2007**
Literacy rate (female)	48%	73.7%
Literacy rate (male)	62%	-
Households with improved source of drinking water	65%	70.9%
Households with improved sanitary facilities (not shared)	10%	34.2%
Households with electricity	54%	-
Employment status (currently)/ female	71.6%	-
Employment status (currently)/ male	80.6%	-
Total Fertility Rate	4.5	-
Use of FP modern method by married women 15-49	17%	12.9%
Ante Natal Care provided by skilled Health worker	58%	89.0%
Skilled attendants at birth	53%	67.7%
Delivery in Health Facility	49%	60.6%
Children 12-23 months with full immunization coverage	31%	-
Children 12-23 months with no immunization	22%	-
Stunting in Under 5 children	51%	37.8%
Wasting in Under 5 children	12%	12.7%
Diarrhea in children	3.4	4.7%
ITN ownership	8%	4.6%
ITN utilization (children)	5%	5.3%
ITN utilization (pregnant women)	7%	-
children under 5 with fever receiving malaria treatment	-	2.4%
Pregnant women receiving IPT	3%	
Comprehensive knowledge of HIV (female)	11%	-
Comprehensive knowledge of HIV (male)	22%	-
Knowledge of TB (female)	33.2%	-
Knowledge of TB (male)	80.7%	-

CHAPTER THREE STRATEGIC PRIORITY AREAS

The poor performance of the health system in the State call for the drafting of the State Strategic Health Development Plan in 2007 under the assistance of WHO (World Health Organization), though the attempted draft was overtaken by other events, until this beautiful national opportunity present. The plan will largely put into critical consideration issues of coordination and appropriate leadership in health care delivery. *Among challenges that are confronting health care delivery is the coordination of private sector which happens to be a major contributor in health care delivery.* In addition, the private sector, a major contributor to health care delivery in the State is poorly regulated, weak capacity of State governments to set standards and ensure compliance, are some of the factors that led to lack of strategic direction and an inefficient and a not too efficient and effective health care delivery system.

This priority area of the KWSSHDP Framework seeks to streamline and empower the State Ministries of Health and LGA Health Departments to reposition their organisational and management systems to provide the strategic and tactical leadership and governance for health. It equally recommends interventions to enhance mutual accountability and transparency in the use of health development resources, particularly through results-based management approaches.

The KWSSHDP has adopted the 8 priority areas of the NSHDP and developed state specific interventions to critically needed to achieve the goals and objectives of the KWSSHDP.

The priority areas are:

1. Leadership and Governance
2. Health Service Delivery
3. Human Resource for Health
4. Health Financing
5. National Health Management Information System
6. Community Participation
7. Partnership for Health
8. Research for Health.

Equally, the state has adopted a Minimum package of care to be delivered in the state through three service delivery modes:

HIGH IMPACT SERVICES
A. **FAMILY/COMMUNITY ORIENTED SERVICES**
Insecticide Treated Mosquito Nets for children under 5
Insecticide Treated Mosquito Nets for pregnant women
Household water treatment
Access to improved water source
Use of sanitary latrines
Hand washing with soap

Clean delivery and cord care
Initiation of breastfeeding within 1st hr. and temperature management
Condoms for HIV prevention
Universal extra community-based care of LBW infants
Exclusive Breastfeeding for children 0-5 mo.
Continued Breastfeeding for children 6-11 months
Adequate and safe complementary feeding
Supplementary feeding for malnourished children
Oral Rehydration Therapy
Zinc for diarrhea management
Vitamin A - Treatment for measles
Artemisinin-based Combination Therapy for children
Artemisinin-based Combination Therapy for pregnant women
Artemisinin-based Combination Therapy for adults
Antibiotics for U5 pneumonia
Community based management of neonatal sepsis
Follow up Management of Severe Acute Malnutrition
Routine postnatal care (healthy practices and illness detection)

B. POPULATION ORIENTED/OUTREACHES/SCHEDULABLE SERVICES
Family planning
Condom use for HIV prevention
Antenatal Care
Tetanus immunization
Deworming in pregnancy
Detection and treatment of asymptomatic bacteruria
Detection and management of syphilis in pregnancy
Prevention and treatment of iron deficiency anemia in pregnancy
Intermittent preventive treatment (IPTp) for malaria in pregnancy
Preventing mother to child transmission (PMTCT)
Provider Initiated Testing and Counseling (PITC)
Condom use for HIV prevention
Cotrimoxazole prophylaxis for HIV+ mothers
Cotrimoxazole prophylaxis for HIV+ adults
Cotrimoxazole prophylaxis for children of HIV+ mothers
Measles immunization
BCG immunization
OPV immunization
DPT immunization
Pentavalent (DPT-HiB-Hepatitis b) immunization
Hib immunization
Hepatitis B immunization
Yellow fever immunization
Meningitis immunization
Vitamin A - supplementation for U5

C. INDIVIDUAL/CLINICAL ORIENTED SERVICES
Family Planning
Normal delivery by skilled attendant
Basic emergency obstetric care (B-EOC)
Resuscitation of asphyctic newborns at birth
Antenatal steroids for preterm labor
Antibiotics for Preterm/Prelabour Rupture of Membrane (P/PROM)

Detection and management of (pre)ecclampsia (Mg Sulphate)
Management of neonatal infections
Antibiotics for U5 pneumonia
Antibiotics for dysentery and enteric fevers
Vitamin A - Treatment for measles
Zinc for diarrhea management
ORT for diarrhea management
Artemisinin-based Combination Therapy for children
Artemisinin-based Combination Therapy for pregnant women
Artemisinin-based Combination Therapy for adults
Management of complicated malaria (2nd line drug)
Detection and management of STI
Management of opportunistic infections in AIDS
Male circumcision
First line ART for children with HIV/AIDS
First-line ART for pregnant women with HIV/AIDS
First-line ART for adults with AIDS
Second line ART for children with HIV/AIDS
Second-line ART for pregnant women with HIV/AIDS
Second-line ART for adults with AIDS
TB case detection and treatment with DOTS
Re-treatment of TB patients
Management of multidrug resistant TB (MDR)
Management of Severe Acute Malnutrition
Comprehensive emergency obstetric care (C-EOC)
Management of severely sick children (Clinical IMCI)
Management of neonatal infections
Clinical management of neonatal jaundice
Universal emergency neonatal care (asphyxia aftercare, management of serious infections, management of the VLBW infant)
Other emergency acute care
Management of complicated AIDS

The detailed strategic objectives, interventions, activities and corresponding costs for implementing these interventions have also been articulated accordingly in the attached annex.

CHAPTER FOUR RESOURCES REQUIREMENT

Resources are very important in all facets of human endeavors for which health is not an exception. Health planning and delivery start with resources identification and acquisition. It is a whole and an integral part upon which good health care delivery depends.

Resources are grouped into Human, Financial, Material, Time and Communication resources. Health care delivery depends on the identified resource groups.

In this chapter, resources requirement for health will be discussed under the following headings:

1. Human
2. Physical/Materials
3. Financial

4.1 Human Resources for Health

Introduction

Human Resource for Health (HRH) is defined as people trained for specific functions with the ultimate objective of promoting, maintaining and restoring health and who work within the general boundaries of the health sector.

Human Resources for Health (HRH) comprise of trained health personnel in the public and private sector (doctors, nurses/midwives, pharmacists, relevant technicians, and community health workers e.t.c.), untrained informal health workers, including community-based health care providers e.g. herbalists, traditional birth attendants and volunteers, who play complementary roles in health care service delivery. Human Resources for Health (HRH) plays an important role in improving health system performance and should reflect the right number, mix, distribution and appropriate skills set (experience & qualifications) to provide the services required.

Kwara State is privileged to have a robust health sector recognized by the M.OH in collaboration with other line ministries and parastatals. The State has one of the frontline University Teaching Hospitals in the country (University of Ilorin Teaching Hospital) established in 1979. The State is equally blessed with 5 specialist hospitals distributed across the three senatorial districts and 12 general hospitals.

In addition, the State also has 20 cottage hospitals and 18 comprehensive health centres let alone the prototype clinics and other health clinics. Of note is the only dental hospital that serve the public interest for dental care.

The State, as at today, has 1 College of Nursing, 1 College of Midwifery, 1 School of Health Technology and an evolving School of Nursing, at Oke-ode. It is important to note that Kwara State plays host to training schools for health workers that serve virtually all the State of the North-Central Zone and some of the

neighboring States in the Southwest Zone of the federation. However, the health service delivery needs alot of urgent attention with respect to resources for health.

The State can fairly boast of 51 doctors in her service though seriously complemented by close to 500 doctors from UITH and Private for Profit Health Facilities.

Health Workforce in Kwara State.

There are about 49 doctors under the employment of Kwara State government. However, only 3 out of 16 Local Government Areas have medical doctors in their service. There are close to 450 doctors in the University of Ilorin Teaching Hospital and about 50 doctors from General Medical Practice to complement the medical service in the state.

Distribution of Health Workers by Profession

S/N	HEALTH PERSONNEL BY CADRE	NUMBER OF PERSONNEL					
		2004	2005	2006	2007	2008	2009
1.	Doctors	56	59	59	56	51	54
2.	Nurses	694	687	681	646	625	501
3.	Dental Therapist	6	4	4	4	4	5
4.	Pharmacist	20	11	16	16	16	11
5.	Pharmacy Technicians	49	49	49	49	48	45
6.	Medical Record Officers	26	26	26	26	26	3
7.	Health planners	11	11	11	11	11	11
8.	Medical Lab. Scientists/Technicians	44	50	50	50	48	44
9	Radiographer and technicians	19	16	16	15	14	7
10.	CHEWs, JCHEW&CHOs	162	161	153	153	151	154
11.	Physiotherapists	2	2	2	2	2	2
12.	Optometrists	1	1	1	1	1	1
13.	Nutritionists	16	13	13	13	12	5
14.	Health Educators	9	8	8	8	8	7
15.	Ward Orderlies/Attendants	170	220	220	206	197	136

The State Health care workforce is fractionalized by upper cadre officers who are saddled with administrative responsibilities at the expense of Patient- Care services. There are only 3 specialist doctors in the State manning the five specialist hospitals. It is important to note that the State Government often times demonstrates intention to recruit doctors and other health care workers. However, this has suffered set back on a number of occasions for reasons that Strategic Health Development Plan should address.

Number of Health Workers by 100,000 populations

S/N	**Health Personnel by Cadre**	Ratio (/100,000 population)
1.	Doctors	2.080

2.	Nurses	26.32
3.	Pharmacist	0.45
4.	CHEW	6.25
5.	Medical Record Officer	1.10
6.	Medical Lab Scientist	0.33
7.	Radiologists	0
8.	Radiographer	0
9.	X-ray Technicians	0.6

The Human resources gap with respect to supportive staff like Medical Record Officers (MRO), Radiographers, Physiotherapists, Medical Laboratory health workers constitute serious burden that explains gap in the service delivery of the state.

Situation analysis, as conceived in the operational plan, becomes so important as the State cannot presently provide what can be described as locally generated health data.

The distribution of the health workforce in the State is abysmally skewed in favor of the cities in the State. Ilorin, the state capital, holds over 90% of doctors and other critically needed health staff in the State.

4.2 Physical/ Material Resources

Physical infrastructures for health in Kwara State can be judged to be close to expectation because every ward in the State has at least one health facility. In fact, the opinion of health operators in the State is that Kwara State does not need more health facility but to improve on the existing ones for effective service delivery.

DISTRIBUTION OF STATE HEALTH FACILITIES BY LGA

No	LGA	No of PHC	SHC	PRIVATE CLINIC
1.	ASA	29	4	7
2.	BARUTEN	47	5	10
3.	EDU	38	5	10
4.	EKITI	12	4	3
5.	IFELODUN	58	7	11
6.	ILORIN EAST	31	21	19
7.	ILORIN SOUTH	26	6	61
8.	ILORIN WEST	21	3	49
9.	IREPODUN	29	8	12
10.	ISIN	25	45	3
11.	KAIAMA	24	2	3
12.	MORO	28	4	11
13.	OFFA	22	1	12
14.	OKE-ERO	12	3	1
15.	OYUN	17	4	4
16.	PATIGI	41	3	6
	TOTAL	460	65	177

Quiet a number of the health facilities are seriously begging for renovation. Conditions of access road, water supply, electricity supply should attract attention of both State and Local Governments

COMPLEMENTS OF STATE HEALTH FACILITIES BY LGA

No	LGA	No of Beds
1.	ASA	108
2.	BARUTEN	118
3.	EDU	201
4.	EKITI	66
5.	IFELODUN	345
6.	ILORIN EAST	35
7.	ILORIN SOUTH	376
8.	ILORIN WEST	50
9.	IREPODUN	346
10.	ISIN	153
11.	KAIAMA	58
12.	MORO	170
13.	OFFA	165
14.	OKE-ERO	68
15.	OYUN	135
16.	PATIGI	130
	TOTAL	2,524

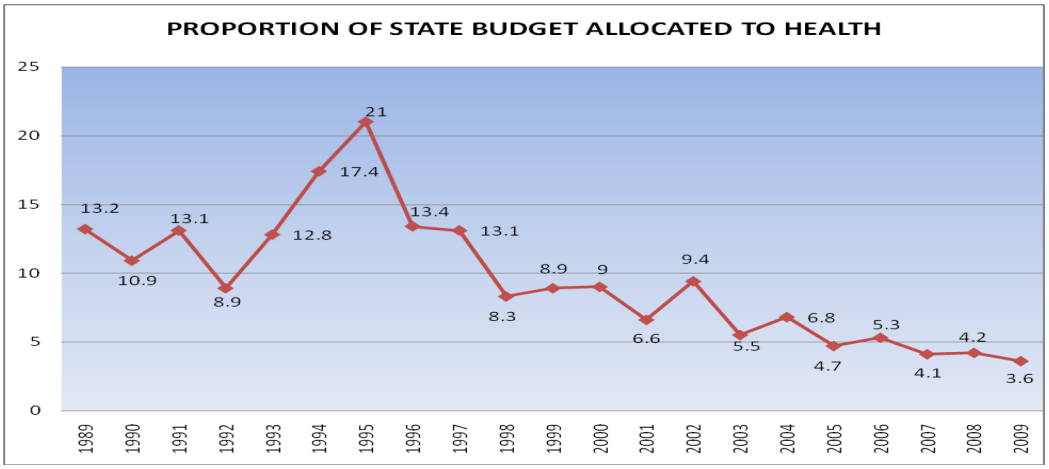
Community participation in infrastructural development is a thing of pride in some communities in Kwara State especially Kwara South.

The State Government is constantly releasing funds for renovation and equipping health facilities in the State. However, the effort should be complemented with structured procurement and monitoring system.

4.3 Finance Resources for Health.

The major health financing comes from the government and this is in form of recurrent and capital expenditures. However, equally important source of funding in the State is through out- of pocket expenditure and similar to what is observed in the country as a whole, cannot be quantified.

This is why the State Strategic Health Development Plan conceived constitution and mobilization of TWG for the development of Health financing strategic plan for the State and the LGs. This will provide opportunity for careful planning of health financing and for the State to properly advise the public on sound management of their resources for health care.



It is interesting to note that Kwara State has adopted Community Health Insurance Scheme (CHIS) which currently address the need of the poor rural dwellers with an attempt to progressively scale it up to cover the whole state.

One of the resolutions of the Northern Governor's Forum is to allocate 15% of total budgetary provision to health sector. As at today in the State, this still remains a big challenge. The State budgetary allocation to health has been on the downward trend from 1995 till date when we had 3.6% (2009) in a State that has witnessed about 21% of total budget allocated to health in 1995.

CHAPTER FIVE FINANCING PLAN

5.1 Estimated cost of the Strategic Operation

The Kwara State Strategic Health Plan was structured into the 8 main domains in accordance with the National Strategic Health Plan.

A total of N59,813,474,889 would be used to implement the Kwara State Strategic Health plan over the next 6 years (2010-2015). The breakdown of estimate for each domain of Kwara State Strategic Health Plan is shown below:

PRIORITY	BUDGET FOR 6 YEARS
RESEARCH FOR HEALTH	NGN 479,698,259
PARTNERSHIP FOR HEALTH	NGN 34,243,791,712
COMMUNITY PARTICIPATION AND OWNERSHIP	NGN 17,921,314,895
NATIONAL HEALTH INFORMATION SYSTEM	NGN 5,156,220,695
FINANCING FOR HEALTH	NGN 645,720,626
HUMAN RESOURCE FOR HEALTH	NGN 294,897,546
HEALTH SERVICE DELIVERY	NGN 395,501,432
LEADERSHIP AND GOVERNANCE FOR HEALTH	NGN 676,329,724
TOTAL	NGN 59,813,474,889

5.2 Assessment of the Available and Projected Funds.

As shown in chapter 4, the major Health sector financial source is through government and this is achieved through budgetary allocation for Health sector. As at 2009, 3.6% of Kwara State total budget was allocated to health, but in actual sense, only 1.9% is released in the same year. The Strategic Health Plan hopes to improve the budgetary allocation to Health and ensure better performance of the budget through release of all the budget estimates allocated. This is expected to be achieved through series of activities in domain one.

However, as shown above, an average of NGN 9,968,912,481.53 yearly is required to fund the Kwara State Health plan for the next 6 years. Going by 2009 Kwara State budget of ₦76,048,061,613, it will be 10.02%. This proportion is required to fund the State Health plan and this should be fully released for the plan to be effective and efficient.

In addition, the non regular funding from the donor agencies are expected to go into basket funding which is required to come through the government channels in form of budgetary provision. Regrettably, this expected funding through the donor agencies could not be quantified as proper donor mapping and data on funding are not available.

5.3 Determination of the Financial Gap

As shown in chapter 4, over the years, from 1995 till date, there has been a consistent decline in budgetary allocation to health from 21% 1995 to 3.6% in 2009. Also, the total amount of funds accrued from donors agencies are not quantified thereby making financial projection difficult to make.

5.4 *Descriptions of ways of Closing the Financial Gap*

To fund the State Strategic Health Plan successfully, over 10% of State total health budget should be allocated to health sector while there is need to properly map the donor funding of health sectors in the state. Basket Funding should be encouraged to ensure that all the external funding sources in the state are harvested and harnessed for a harmonized utilization in priority areas in health sector.

CHAPTER SIX IMPLEMENTATION FRAMEWORK

6.1. Derivation of Workplan.

Operational workplan was derived from identified high impact activities list to accelerate the attainment of MDGs 4, 5, 6. The workplan is derived with state peculiarities in ranking priorities.

A number of the activities will last the whole period of 6years earmarked for the plan. Most of the programme that will last the lifespan of the plan are routine activities that monitor the implementation of the plan through review meetings and monitoring exercise. Activities like capacity building and procurement are to be done on sustainable basis so as to cover expected population of Health workers to be trained. The implementation of this, once accomplished, is for the entire lifespan of the SHDP.

Some of the activities are to be implemented within the first year of the plan as the success of other activities is dependent on them. Some of these activities are Policy and Advocacy issues and others like the creation of agencies like Primary Health Care Development Agency that will activate most of the high impact activities for meeting MDGs 4 and 5.

The Work plan implementation will be jointly effected by all stakeholders with the State Government through the State Ministry of Health taking the lead .Developmental partners and line ministries with CEO and other NGOs are actively responsible in form of share responsibilities with the State Government.

Activities Scheduled for the First Year

1. Adaptation, production and dissemination of relevant policies, guidelines, and standard of practice
2. Advocacy to the three tiers of government and traditional institutions
3. Develop Kwara State specific MNCH advocacy tools
4. SITAN for Communicable and NCD
5. Developing SOPs for regular maintenance of the equipments and procurement of "back up" for essential equipments
6. Establish mechanisms to monitor health worker performance, including use of client feedback (exit interviews) see COPE/ETAT

Activities that will Span the 6 Year Period

1. Establishment of State Primary Health Care Development Agency
2. Capacity building on managerial and strategic planning skills at both State and LGAs (Programme Management Course and Marginal Budgeting for Bottlenecks training) and other trainings
3. Implementation of the minimum package of care by stakeholders through monitoring and evaluation
4. Conduct regular outreach to provide MNCH services in hard to reach areas

5. Accelerated increase coverage of free health care services especially for vulnerable group
6. Public sensitization through media and policy issue on compulsory inclusion of health new every week
7. Provision of free health services for under fives and mothers
8. Free Health care for the aged and orphans
9. Establishment of Programme M & E officers and NHMIS desk officer forum for integration

6.2 Training Plan.

According to Kwara State Strategic Health plan, capacity building of health work force in form of regular and continuous training was steered. All the 8 domains require training of health workforce to intimate and build capacity on interventions and activities involve in the SSHDP.

Some domains like health service delivery, Human resource for Health financing, National Health Information System and Research for Health require adequate capacity building of the workforce to improve their knowledge and widen their horizon on interventional areas. Certain specific intervention on NHIS, and Health service delivery require on the job training throughout the 6 years operational plan period.

This would afford the state health workers opportunity to have knowledge of new evidence based practice in health and how to adequately apply such to improve health service deliveries. Most of the training would be continuous throughout the operational period while some training are within the first two-years of operational period. This is due to the fact that they are pre-requsites for the take-off of some interventions and activities. Some training is on the job training which are required to improve the effectiveness and efficiency of services rendered by the health workers.

Another situation exists when training meetings are meant for the health administrator and manages to improve their managerial skills while some training is specifically targeted at other partners and stakeholders to encourage Public- Private Interventions. It is generally hoped that these many facets of training targeted to specific health workforce in SSHDP would improve the health status of Kwara state.

Training Plan for KWSSHDP

TRAINING FROM SSHP	ONCE	QUARTERLY	YEARLY
Capacity building on managerial and strategic planning skills at both State and LGAs.		X	
Capacity building on Monitoring and Evaluation of strategic planning activities		X	
Training of programme and field officer on analytical tools for health system performance		X	
Establishment and training of Economic Evaluation Analysis.		X	X
Training of SERVICOM members and health worker on COPE and ETAT		X	
Training of programme managers and M& E officers on the use of ISS tool		X	
Training of staffs of HRH unit and palnning and research unit of the SMoH.			X
Training of HW on LSS, EOC etc.		X	
Increased the training capacity of the training schools.	X		
To train HW on health ethics and job description			X
Capacity buiding for TWG for development and implementation of HFSP.	X		
Regular capacity buiding for accounting, planning and auditing staffs.			X
Build capacity and conduct Integrated Supportive Supervison (ISS) at all levels.			X
Training and retraining of HW on data collection skills			X
Training and retraining of M&E & programme officer on data analysis & interpretation.			X
Capacity buiding for Computer appreciation for M&E/DSNO.		X	
Training on the relevant software packages			X
Capacity buiding for Programme officers, DSNO/M&E			X
Training and retraining of DSNO on Hospital information system		X	
Training of the records officer on the IDSR			X
Training of CORPS including on key household practices.			X
Training on skill acquisition for income generation in collab with Min. of Women Affairs.			X

6.3 Procurement Plan

The state Strategic Development plan is built on existing procurement structure of the state ministry. Procurement unit is

Saddled with the responsibility of overseeing every procurement procedure with the desk officer as anchor staff. Desk officers for procurement would be responsible to procurement committee of the Ministry of Health which actually oversees bidding and monitoring process of procurement.

However, the plan accommodates procedure policy of other stakeholders in procurement plan and implementation. KWSSHDP also conceive plan for training and retraining officers on current issues in procurement. The training is expected to cover whole lifespan of the plan.

6.4 Financial Management Plan

Because of the importance of financial resources in the execution of implementation of KWSSHDP, the State has a robust plan for National Health Account through health financing strategies which involve mapping of funds expended on health activities in the state. This involves the Sources of funding, Monitoring of cash flow, Economic analysis of health expenditure and Monitoring of health finances. The financial management plan would involve a robust activities targeted at all the specific operational plans for each of the 80 domains.

There is a need for the development of quarterly financial management report template for the State Strategic Health Development plan.

6.5 Linkages with other Role Players.

Partnership for development is a key consideration in KWSSHDP. Health care service delivery is a multi-sectoral responsibilities where many partners and organization of different professional callings collaborate together to accomplish a set of objectives.

Some of the organizations relate with Government as donor agencies, a number of them give technical support while others are to facilitate linkages with communities to enhance participation. Others are to facilitate Policy issues.

Below are the list of key role players involve in implementation of activities in SSHDP:

- Chairman Health Committee State House of Assembly
- Judiciary/Minister of Justice
- Chairmen, 16 LGAs
- Supervisor for Health
- HOD, Health
- Ministry of Local Government and Chieftaincy Affairs
- Local Government Service Commission

- State Planning Commission
- Health Development Partners in the State
- Representative of UITH
- Representatives of Religious bodies
- Representatives of Women Organization
- Representatives of LGA Community Development Committee
- Representatives of NGOs and CBOs
- Private Consultants
- Representatives of Traditional Rulers
- Representatives of Youth Organization.

CHAPTER SEVEN MONITORING AND EVALUATION.

7.1 Proposed Mechanisms for Monitoring and Evaluation.

Monitoring and Evaluation is a key aspect of Strategic Health Plan in Kwara State. M&E, as conceived by the plan, is integrated so as to reduce the cost and increase efficiency. The plan worked on the existing structure in the State with the hope of creating better integration and collaboration for effective M&E.

The plan also makes provision for scaling-up in numeric strength and capacity building of M&E officers in the State. Training and retraining of M&E effort down to LGAs and facility level is also considered there is a robust plan, a Bottom- Top approach where community and health facility focal person are equipped with necessary tools and logistics for information flow to enhance effective and timely reporting. Supportive monitoring and supervision is also accommodated in a continuous basis to accomplish effective implementation of high impact activities

KWSSHDP did proposed training in relevant software for data management. Data collection at the community level is also considered with plan to positively enlist support of Community Development Committee for effective capture of data.

It is equally planned that level of coverage will be scaled-up for wider coverage.

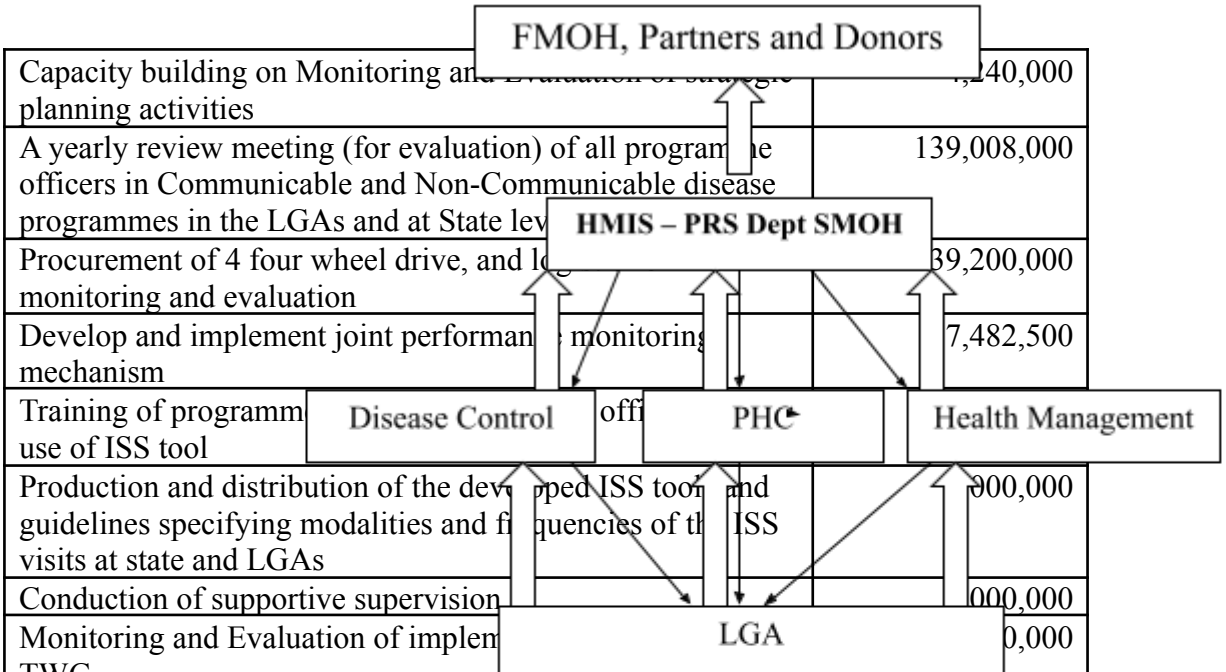
7.2 Costing of M&E Components

The M&E costing in the KWSSHDP cut across all the 8 Domains of the operational plan.

Specifically, it involves costing for all the programmatic aspect of the plan, logistics, capacity building, manpower recruitment and most importantly Health Management Information System (HMIS).

The Total cost KWSSHDP is ₦ 5,671,646,800. over the 6 year period. (2010-2015) with an annual average cost of ₦945,274,466.67 as shown below:

Administrative and Operational Structure M&E in the State



Capacity building on Monitoring and Evaluation of strategic planning activities	4,240,000
A yearly review meeting (for evaluation) of all programme officers in Communicable and Non-Communicable disease programmes in the LGAs and at State level	139,008,000
Procurement of 4 four wheel drive, and logistics for monitoring and evaluation	39,200,000
Develop and implement joint performance monitoring mechanism	7,482,500
Training of programme officers on use of ISS tool	
Production and distribution of the developed ISS tool and guidelines specifying modalities and frequencies of the ISS visits at state and LGAs	900,000
Conduction of supportive supervision	000,000
Monitoring and Evaluation of implem TWG	0,000
Development and production of M&E tools for HFSP	400,000
Sensitization meeting with all stakeholders(esp line ministries) to present analysed evaluation report of budge performance	6,960,000
Provision of office equipment for acc the purpose of budget performance m	0,000
Regular capacity buiding for accounting, planning and auditing staffs of SMoH and health de of LGAs for bdget performance monitorings.	36,080,000
To strenghten data collection using nationally standardized forms	1,67 ,056,800
To provide infrastructural su h databases and staff training	0
To strengthen sub-systems in the Health Information System	2,399,120,000
To monitor and evaluate the NHMIS	121,299,500
To strengthen analysis of data and dissemination of health information	7,790,000
Establish joint monitoring visits with private care providers with adequate feedback	416,000
Conduct research on baseline data for IMNCH indicators in the State	5,264,000
Capacity building on Monitoring and Evaluation of strategic planning activities	4,240,000
TOTAL	5,671,646,800

COSTING OF M&E ACTIVITIES IN THE KWSSHDP

CHAPTER EIGHT CONCLUSION

Though Kwara State has made attempt at developing State Strategic Health Development Plan in 2007 under the auspices of WHO. The present KWSSHP seeks to streamline and empower the SMOH and LGA health departments to reposition their organizational and management systems to provide the strategic and tactical leadership and governance for health. The KWSSHDP adopted 8 priority areas of the NSHDP and developed state specific intervention areas taken into consideration various high impact services.

The resource requirement for health was looked into with respect to Human, Physical/Material and Financial resources for health. It is addressed to bridge the gap observed in the state health sector. The financial plan aspect of KWSSHDP seek to close the financial gap in the state with adequately costed activities for the 6 year operational plan and critically assessed available funds which is government budgetary provision, while exploring financial projections from the other sources like donor agencies and private sector.

Implementation of the KWSSHDP is characterized by an adequately scheduled workplan which was derived from high impact activities list to accelerate the attainment of MDGs 4, 5 and 6. While some activities are planned for a year period, some are planned continuously for the 6 years period of the plan. A number of the activities are to be periodically executed. The training plan which also follows similar trends with workplan would take into priority practical exposure as part of training package, so as to bridge the gap between training and translation of acquired skills into practice for better performance. The procurement plan seeks to improve the effectiveness of procurement unit and develop an all encompassing procurement policy.

The KWSSHDP also identified and linked role players that span Private sectors, Community and Traditional institutions, Religious and Faith-based organizations, Political and Professionals together with Inter-governmental agencies.

Lastly, M&E as an important watchdog of the KWSSHDP was given adequate attention with focus on Logistic, and Capacity building of M&E officers. Again, effective route of information flow will be established, improvement in IT use and effective costing of all M&E components will all be strengthened.

The Kwara State Health sector performance is expected to improve greatly with the KWSSHDP and the poor health trend of the State would be reversed for good. The KWSSHDP would be executed over the next 6 years in the spirit of inter-collaboration and integration.

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Annex 1: Details of Kwara Strategic Health Development Plan

KWARA STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
Priority Area							
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 development and delivery of quality healthcare in Kwara State.							**479,698,259**
	1.1	**To provide clear policy directions for health development**			**All stakeholders are informed regarding health development policy directives by 2011**		**251,074,904**
		1.1.1	Improved Strategic Planning at State and LGA levels				**165,438,061**
			1.1.1.1	Adaptation, production and dissemination of relevant policies, guidelines, standard of practice			22,139,847
			1.1.1.2	Capacity building on managerial and strategic planning skills at both State and LGAs (Programme Management Course and Marginal Budgetting for Bottlenecks training) and other trainings			141,589,892
			1.1.1.3	Advocacy to the three tiers of government and traditional institutions			1,708,322
		1.1.2	Ensure compliance with the strategic plan at State and LGA levels				**72,595,780**
			1.1.2.1	Capacity building on Monitoring and Evaluation of strategic planning activities			5,571,756
			1.1.2.2	Development production and dissemination of performance indicator and checklist for the purpose of monitoring and evaluation			2,617,674
			1.1.2.3	Annual review meeting of programme performance of strategic health plan			58,503,441
			1.1.2.4	Annual evaluation report meeting to all stakeholders			1,971,140
			1.1.2.5	Adoption and production of trainer's manual and participant's manual			3,931,768
		1.1.3	Provide platform for efficient collaboration of related line ministries with SMOH for the purpose of health development				**6,520,532**
			1.1.3.1	Develop policy and guideline for effective collaboration between the ministry of health and relevant line ministries(e.g ministries of Agric, Education, Information,Women Affair and Environment)			1,876,525
			1.1.3.2	Biannual meeting for review of strategies and a sensitization forum for sustained and effective collaboration			4,644,006
	1.2	**To facilitate legislation and a regulatory framework for health development**			**Health Bill signed into law by end of 2009**		**23,798,233**
		1.2.1	Strengthen regulatory functions of government				**23,798,233**
			1.2.1.1	Adaptation, production and dissemination of poilcies on Public Private Partnership(PPP).			6,323,418
			1.2.1.2	PPP Forum comprising of Private peoples, policy makers, Proffessional bodies, for the purpose of identifying areas of collaboration			851,533

			1.2.1.3	Develop, production and dissemination guidelines and standards of Operation for private health sector in the State for regulation of their practice and registration			2,746,455
			1.2.1.4	Ensure compliance with the guidelines and SOP through supportive supervision and enforcement by joint monitoring team(Government, Private association, Professional bodies, Regulatory bodies)			13,561,445
			1.2.1.5	Review and update Public Health Act and Law to align with proposed National Health Bill			315,382
	1.3	**To strengthen accountability, transparency and responsiveness of the State health system**			**80% of LGA have an active health sector 'watch dog' by 2013**		**67,757,288**
		1.3.1	To improve accountability and transparency				**67,757,288**
			1.3.1.1	Training of programme managers in management, Planning and accountability at ASCON Badagri..			45,888,144
			1.3.1.2	Orient policy makers,programme managers and budget officers on financial mangement, transparency and accountability			13,246,062
			1.3.1.3	SMOH should create State Primary Health Care Development Agency and Hospital Health Management Board			501,984
			1.3.1.4	Quaterly stakeholders meeting on health sector performance			3,784,589
			1.3.1.5	Quaterly health information dissemination to the public through IEC to include quarterly bulletin			4,336,508
	1.4	**To enhance the performance of the state health system**			**1. 50% of LGAs with costed SHDP by the firt quarter of 2010**	**Various levels of government have capacity to update sectoral SHDP States may not respond in a uniform and timely manner**	**137,067,834**
		1.4.1	Improving and maintaining Sectoral Information base and establishment of evaluation system to enhance performance				**8,255,661**
			1.4.1.1	Develop a information framework that accommodate response of other line ministries in disease control			2,164,049
			1.4.1.2	Training of programme and field officer on analytical tools for health system performance			4,948,350
1			1.4.1.3	Resustation of research unit to funtional status to address research gaps in health sector in the State			315,382
			1.4.1.4	Establishment and training of Economic Evaluation Analysis such as cost effectiveness assessment, cost benefit assessment, Cost minimization Analysis, Cost utility Analysis.			827,879
		1.4.2	Establishment of Kwara State Primary Health Care Development Agency (PHCDA)		PHCDA established by 2010. M&E established for quarterly supervision		**101,387,568**
			1.4.2.1	Conduct situation analysis and micro planning for PHC			2,777,994
			1.4.2.2	Establish monitoring and evaluation unit for quarterly supervision			76,532,804
			1.4.2.3	Advocate for at least 60% proposed KWPHCDA fund to IMNCH services at the LGAs and communities			22,076,770
			1.4.2.4	Refer to 1.3.1.3 above.			-

		1.4.3	Advocacy to mobilize support for Integrated Maternal, Newborn and Child Health (IMNCH) strategy				**27,424,605**
			1.4.3.1	Develop Kwara State specific MNCH advocacy tools			262,293
			1.4.3.2	Conduct advocacy visit to stakeholders			4,218,240
			1.4.3.3	Sensitization of Health Care providers on IMNCH strategy			21,209,469
			1.4.3.4	Advocate to the excecutive and legislature for an increase in the allocation of not less than 15% of the total state budget for health			1,734,603
HEALTH SERVICE DELIVERY							
2. To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare							**34,243,791,712**
	2.1	**To ensure universal access to an essential package of care**			**All LGAs begin implementation of Essential Package of Care by 2011**		**1,084,110,635**
		2.1.1	Essential health care service package				**139,833,789**
			2.1.1.1	Standard operating Procedures (SOPs) and guidelines will be made available for delivery of services at all levels			69,997,765
			2.1.1.2	Regular review and costing of the minimum package of care			16,615,386
			2.1.1.3	Orientate programme managers on the ward health minimum package of care			18,834,001
			2.1.1.4	Make available these reviewed minimum package of care to stakeholders			1,197,578
			2.1.1.5	Ensure implementation of the minimum package of care by stakeholders through monitoring and evaluation			8,638,709
			2.1.1.6	Establish and implement guidelines for outreach services			24,550,350
		2.1.2	To strengthen specific communicable and non communicable disease control programmes				**944,276,845**
			2.1.2.1	A yearly review meeting (for evaluation) of all programme officers in Communicable and Non-Communicable disease programmes in the LGAs and at State level			756,976,982
			2.1.2.2	SITAN for communicable and NCD			18,199,150
			2.1.2.3	Standing committee to regularly liase with prospective funding organisations to implement disease control programme in the State			23,749,722
			2.1.2.4	Sensitization meeting with private health care providers on disease control programmes in the State			13,886,523
			2.1.2.5	Procurement of office equipments (laptop, desktop, printers, accessories) and furniture for programme officers			76,698,820
			2.1.2.6	Procurement of 4 four wheel drive, and logistic for monitoring and evaluation			54,765,648
	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 2012**		**24,197,631,895**
		2.2.1	To improve geographical equity and access to health services				**13,116,889,504**
			2.2.1.1	Regular review of service availability mapping of health facilities in the state and procurement of GIS equipment			8,576,812
			2.2.1.2	Build or upgrade dilapidated health facilities especially at the PHC level and upgradiing of state owned specialist hospital to specialist and training health institution status.			12,110,339,945

			2.2.1.3	Conduct regular outreach to provide MNCH services in hard to reach areas			279,022,232
			2.2.1.4	Development of criteria for siting of health facility and familiarization of the policy makers with the criteria			3,552,366
			2.2.1.5	Standing committee by the authority of SMoH to supervise adherence to guideline on linkage.			8,961,652
			2.2.1.6	Creation of budget line for health facility maintaince			706,436,497
		2.2.2	To ensure availability of drugs and equipment at all levels				**8,982,021,151**
			2.2.2.1	Review of the essential medicines list and reactivate a drug revolving fund (DRF) programme at all levels			**4,545,414**
			2.2.2.2	Strengthen task force on Counterfeit and Fake Drugs			**27,853,782**
			2.2.2.3	Conduct logistics management trainings for MNCH commodities and equipment			**149,199,388**
			2.2.2.4	Provision of anthropometric kits and conduct training for health workers on the use of nutritional assessment equipment			**53,366,231**
			2.2.2.5	Conduct sensitization mtg with related food companies on Breast Milk Subtitute (BMS) fortified food, Local production of ready to use therapeutic food (RUTF)			**4,736,489**
			2.2.2.6	Provision and equity disribution of prooven tools and commondities in PHC and disease control programme(ITN, Insecticed, FP kit, Condom, CD4, and bundles commondities)			**8,073,559,963**
			2.2.2.7	Procurement and distribution of Essential drugs with adequate quality assurance based on existing policy			**269,118,665**
			2.2.2.8	Procurement of 4WD for PHC departement, Cold chain equipment, Generating set and solar panel			**399,641,218**
		2.2.3	To establish a system for the maintenance of health equipment at all levels				**779,911,948**
			2.2.3.1	Developing SOPs for regular maintenance of the equipments and procurement of "back up" for essential equipments			6,717,875
			2.2.3.2	Employment of equipment maintenance personnel and/or training and retraining of personnel to maintain the equipments.			180,793,919
			2.2.3.3	Build a reliable medical equipment maintenance workshop in the State headquarter for training of maitenance officers			323,308,400
			2.2.3.4	Quaterly inventory of equipment including their functional state and Create budget lines for the maintenance of equipment at the resource center in government hospitals			26,884,955
			2.2.3.5	Procurement and maintainance of office equipments and furniture			242,206,799
		2.2.4	To strengthen referral system				**1,256,827,899**
			2.2.4.1	Establish a two way referal system and ensure availability of referral forms at all health facilities in the state			84,772,380
			2.2.4.2	Regular training of health workers and sensitization of the public on referral practices			588,078,108
			2.2.4.3	Ensure availability of reliable community based transport system and integration and expansion of ambulance points in every LGA for PHC referrral system			496,523,938
			2.2.4.4	Improve communication between health facilities			80,735,600
			2.2.4.5	Develop SOP for referral of cases			6,717,875
		2.2.5	To foster collaboration with the private sector				**61,981,393**
			2.2.5.1	Map and yearly update all categories of private health care providers by operational level and location			18,199,150

			2.2.5.2	Develop guidelines and standards for regulation of their practice and registration			6,717,875
			2.2.5.3	Develop guidelines for partnership, training and outsourcing of services			6,717,875
			2.2.5.4	Develop and implement joint performance monitoring mechanism			23,645,439
			2.2.5.5	Sensitization of Private Sector health care providers			6,701,055
	2.3	**To improve the quality of health care services**			**50% of health facilities participate in a Quality Improvement programme by end of 2012**		**82,993,505**
		2.3.1	To strengthen professional regulatory bodies and institutions				**29,634,002**
			2.3.1.1	Sensitize professional/regulatory bodies on IMNCH strategy and minimum health packages for all levels			7,104,733
			2.3.1.2	Committee to review, update regulatory guidelines and practices			3,067,953
			2.3.1.3	Establish of State regulatory committee(comprises of security agent, rep of regulatory bodies, and govt staff) to complement the effort of regulatory bodies with representative of the regulatory bodies in the State committee.			3,067,953
			2.3.1.4	Capacity buiding training for committee members			6,139,942
			2.3.1.5	Annual debriefing meeting of the acivities of the committee to all stakeholders			10,253,421
		2.3.2	To develop and institutionalise quality assurance models				**20,957,616**
			2.3.2.1	Institutionalize and implement quality assurance and improvement initiatives at all levels of care including Client Oriented Provider Efficiency (COPE) & Emergency Triage, Assessment and Treatment (ETAT). This programme will be supervised by State SERVICOM			7,098,005
			2.3.2.2	Establishment of the State and LGA SERVICOM			2,987,217
			2.3.2.3	Training of SERVICOM members and health worker on COPE and ETAT			10,872,394
		2.3.3	To institutionalize Health Management and Integrated Supportive Supervision (ISS) mechanisms				**32,401,887**
			2.3.3.1	Training of programme managers and M& E officers on the use of ISS tool			14,370,937
			2.3.3.2	Production and distribution of the developed ISS tools and guidelines specifying modalities and frequencies of the ISS visits at state and LGAs			6,189,729
			2.3.3.3	Conduction of supportive supervision			11,841,221
	2.4	**To increase demand for health care services**			**Average demand rises to 2 visits per person per annum by end 2011**		**1,569,698,532**
		2.4.1	To create effective demand for services				**1,569,698,532**
			2.4.1.1	Support local adaptation of the national strategy to reflect local realities			1,009,195
			2.4.1.2	Development and production of IEC materials for social mobilisation on MNCH, malaria, HIV/AIDS, Immunization Nutrition, FP etc			10,761,383

			2.4.1.3	Ensure accelerated increased coverage of free health care services especially for vulnerable group			1,345,593,327
			2.4.1.4	Health week for various programmes (IMNCH, HIV/AIDs, Malaria, Nutrition etc)			197,802,219
			2.4.1.5	Public sensitization through media and policy issue on complusory inclusion of health new every week			14,532,408
	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**		**7,309,357,145**
		2.5.1	To improve financial access especially for the vulnerable groups				**7,309,357,145**
			2.5.1.1	Expansion of Community Health Insurance Scheme to cover other communities in Kwara State			6,458,847,971
			2.5.1.2	Orient communities and community health insurance managers on community-based insurance scheme and IMNCH strategy			41,417,363
			2.5.1.3	SMOH to engage relevant funding agencies, corporate bodies on PHC fund for vulnerable groups			1,735,815
			2.5.1.4	To provide free health services for underfives and mothers (see 2.4.1.3 above)			-
			2.5.1.5	Free Health care for the aged and orphans			807,355,996
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							**17,921,314,895**
	3.1	**To formulate comprehensive policies and plans for HRH for health development**			**All LGAs are actively using adaptations of the National HRH policy and Plan by end of 2015**		**4,902,601,147**
		3.1.1	To develop and institutionalize the Human Resources Policy framework				**3,270,348,504**
			3.1.1.1	Domesticate the National HRH Policy and Strategic Plan			495,112
			3.1.1.2	Advocacy on implementation of HRH poilcy to the political class			289,931
			3.1.1.3	Production and distribution of HRH policy and implementation guideline.			5,058,174
			3.1.5.4	Allowances of health workforce currently existing in the state			742,903,738
			3.1.5.5	Basic Salary for health workforce currently existing in the State			889,348,906
	3.2	**To provide a framework for objective analysis, implementation and monitoring of HRH performance**			**The HR for Health Crisis in the State has stabilised and begun to improve by end of 2012**		**10,420,775**
		3.2.1	To reappraise the principles of health workforce requirements and recruitment at all levels				**10,420,775**
			3.2.1.1	Creation of high power committee(members such as justice Belgore, Mustapha Akanbi, Dr Oloruntoba, CAN chairman, Chief Immam of Ilorin, to be chaired by Emir of ilorin) on review HW welfare package, career progression			4,215,145

			3.2.1.2	Committee to assess Health workfoce of the State with the aim of identifing gaps and needs across professional lines			5,469,652
			3.2.1.3	Creation of the State Health Service commission who wii be saddle with recuritment, career progression and retirement of the health work force in the State.			735,978
	3.3	**Strengthen the institutional framework for human resources management practices in the health sector**			**1. States has functional HRH Units by end 2010 2. 10% of LGAs have functional HRH Units by end 2010**		**18,683,797**
		3.3.1	To establish and strengthen the HRH Units				**18,683,797**
			3.3.1.1	Establishment of HRH unit under the directorate of personnel and mangement of SMoH			652,344
			3.3.1.2	Training of staffs of HRH unit and palnning and research unit of the SMoH.			18,031,453
	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**			**Increase by half the production capacity of our training institution by 2015.**		**2,356,966,309**
		3.4.1	To review and adapt relevant training programmes for the production of adequate number of community health oriented professionals based on State priorities				**891,815,385**
			3.4.1.1	Training of HW on LSS, EOC , Home Based Care of diseases and Case Management of priority diseases			580,530,278
			3.4.1.2	Support curriculum review to integrate MNCH updates			3,512,621
			3.4.1.3	Operationalise the reviewed MNCH update in schools			307,772,487
		3.4.2	To strengthen health workforce training capacity and output based on service demand				**1,465,150,924**
			3.4.2.1	Review Training schools curriculum to accommodate LSS, EOC, HBC of disease, MNCH update			3,914,063
			3.4.2.2	Increased the training capacity of the training schools through increased funding, human capacity and infractural development			1,338,141,247
			3.4.2.3	Creation of annual TOT programme for training schools			123,095,613
	3.5	**To improve organizational and performance-based management systems for human resources for health**			**Kwara States to have implement performance management systems by end 2012**		**10,385,153,643**
		3.5.1	To achieve equitable distribution, right mix of the right quality and quantity of human resources for health				**4,665,964,715**
			3.5.1.1	Create fund to support deployment of doctors and midwives under the NYSC scheme to underserved areas yearly			2,676,282,495
			3.5.1.2	Advocate to LGAs to provide accomodation for skilled health workers in underserved areas			9,233,175
			3.5.1.3	Provision of funds to continue the Midwives Service Scheme after 2010			642,307,799
			3.5.1.4	Create fund for rural posting of health workers from tertiary health institutions			1,338,141,247
		3.5.2	To establish mechanisms to strengthen and monitor performance of health workers at all levels				**1,005,256,310**
			3.5.2.1	Establish hardship fund for health workers in rural areas			669,070,624

			3.5.2.2	Advocate for mandatory residential accommodation for health workers in rural areas			7,136,753
			3.5.2.3	Conduct routine re-orientation of health workforce on attitudinal change including training and retraining in Interpersonal Communication (IPC) skills and work ethics			274,586,584
			3.5.2.4	Institute a system of recognition, reward and sanctions at all levels of care			30,108,178
			3.5.2.5	Establish mechanisms to monitor health worker performance, including use of client feedback (exit interviews) see COPE/ETAT			24,354,171
	3.6	**To foster partnerships and networks of stakeholders to harness contributions for human resource for health agenda**			**Kwara States to have regular HRH stakeholder forums by end 2011**		**247,489,224**
		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				**247,489,224**
			3.6.1.1	Institute a system of recognition, reward and sanctions at all levels of care			30,108,178
			3.6.1.2	To train HW on health ethics and job discription			217,381,046
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 and State levels							**5,156,220,695**
	4.1	**To develop and implement health financing strategies at State and Local levels consistent with the National Health Financing Policy**			**Kwara States to have a documented Health Financing Strategy by end 2012**		**226,043,802**
		4.1.1	To develop and implement evidence-based, costed health financing strategic plans at LGA and State levels in line with the National Health Financing Policy				**226,043,802**
			4.1.1.1	Consititution and mobilization of TWG for development of health financing strategic plan for State and LGAs			66,487,440
			4.1.1.2	Capacity buiding for TWG for development and implementation of HFSP at State and LGA levels.			116,175,922
			4.1.1.3	Development and production of M&E tools for HFSP			5,397,255
			4.1.1.4	Monitoring and Evaluation of implementation of HFSP by TWG			18,755,462
			4.1.1.5	Create a line budget for the development of state Health account and operational plan of HFSP			19,227,722
	4.2	**To ensure that people are protected from financial catastrophe and impoverishment as a result of using health services**			**NHIS protects all Nigerians/Kwarans by end 2015**		**159,657,561**
		4.2.1	To strengthen systems for financial risk health protection				**159,657,561**
			4.2.1.1	Adoption and implementation of NHIS in the state and LGA.			11,233,038
			4.2.1.2	Setting up of an NHIS unit			148,424,523
			4.2.1.3	Coroborate the initial strategic plan on Free health care for vulnerable groups & Expansion Community health insurance			-
	4.3	**To secure a level of funding needed to achieve desired health development goals and objectives at all levels in a sustainable manner**			**Allocated State and LGA health funding increased by an average of 5%**		**3,823,031,152**

					pa every year until 2015		
		4.3.1	To improve financing of the Health Sector				**26,210,421**
			4.3.1.1	advocacy and sensitisation to executive and legislature to increase the state allocation to health to 15% total budget			3,373,285
			4.3.1.2	Creation of standing committee that will constantly engage the corporate organization on their socil responsibilty to health sector			11,907,695
			4.3.1.3	Exploring alternative sources of funding health in the state e.g VAT, sin tax, donations from corporations and charity, indigen in diaspora.			10,929,442
		4.3.2	To improve coordination of donor funding mechanisms				**517,988,091**
			4.3.2.1	Establish State, LGA, Ward and Community PMNCH			1,416,780
			4.3.2.2	Conduct quarterly meetings of PMNCH for regular coordination of activities and funding.			109,294,421
			4.3.2.3	Setting up a standing committee to coordinate donor funding in the state			323,889,295
			4.3.2.4	Establish of common basket funding comprises of State and LGAs for PHC programme.			83,387,596
		4.3.3	Establish funding mechanism that ensure sustainable maintance of logistic in health care services				**3,278,832,640**
			4.3.3.1	budget for maintance of project vehicles with plan for replacement as at when due			2,064,450,181
			4.3.3.2	budget for maintance of office equipment and furniture and replacement			1,214,382,459
	4.4	**To ensure efficiency and equity in the allocation and use of health sector resources at all levels**			**1. States and all LGA to have transparent budgeting and financial management systems in place by end of 2015 2. States and all LGAs have supportive supervision and monitoring systems developed and operational by Dec 2012**		**947,488,181**
		4.4.1	To improve Health Budget execution, monitoring and reporting				**306,833,968**
			4.4.1.1	Sensitization meeting with all stakeholders(esp line ministries) to present analysed evaluation report of budget performance			144,916,307
			4.4.1.2	Provision of office equipment for account and audit unit for the purpose of budget performance monitoring			161,917,661
		4.4.2	To strengthen financial management skills				**486,832,435**
			4.4.2.1	Regular capacity buiding for accounting, planning and auditing staffs of SMoH and health dept of LGAs for budget performance monitorings.			486,832,435
NATIONAL HEALTH INFORMATION SYSTEM							
5. To provide an effective National Health Management Information System (NHMIS) by all the governments of the Federation to be used as a management tool for informed decision-making at all levels and improved health care							**645,720,626**
	5.1	**To strenghten data collection using nationally standardized forms**			**1. 50% of LGAs making routine**		**200,031,181**

					NHMIS returns to State level by end 2010 2. States making routine NHMIS returns to Federal level by end 2010		
		5.1.1	To ensure that NHMIS forms are available at all health service delivery points at all levels				**44,698,990**
			5.1.1.1	Sensitization on Maternal and Peri-natal audit system.			1,421,226
			5.1.1.2	Institutionalize Maternal and Peri-natal audit system			1,391,079
			5.1.1.3	Orientation and Sensitisation of HWs on the Personnal Health Record Book (PHRB) and NHMIS forms that has link with community based information system.			9,532,263
			5.1.1.4	Production and distribution of the Personal Health Record Book (PHRB) and the new NHMIS forms			16,563,024
			5.1.1.5	Build capacity and conduct Integrated Supportive Supervison (ISS) at all levels of care.			15,791,399
		5.1.2	To periodically review of NHMIS data collection forms				**3,244,415**
			5.1.2.1	Develop review tools to be adminstered quarterly by data collectors and mangers with aim of improving on user's friendliness of NHMIS tools			3,244,415
		5.1.3	To coordinate data collection from vertical programmes				**3,003,811**
			5.1.3.1	Establish and mobilization of Health data consultative committee at state and LGA levels			602,944
			5.1.3.2	Sensitization of LGA to cascade the HDC Committee at LGA level			1,410,315
			5.1.3.3	To established Programme M & E officers and NHMIS desk officer forum for integration			990,551
		5.1.4	To build capacity of health workers for data management				**136,997,564**
			5.1.4.1	Training and retraining of HW on data collection skills			24,943,232
			5.1.4.2	Training and retraining of M&E and programme officer on data analysis and interpretation			6,280,670
			5.1.4.3	Suportive supervision of State, LGAand health facility by partners and designated officers			1,550,428
			5.1.4.4	Recuritment of biostatistician and record officers			104,223,233
		5.1.5	To provide a legal framework for activities of the NHMIS programme				**3,594,936**
			5.1.5.1	Advocacy and sensitisation to executive and legislature to give comprehensive support to NHMIS programme in the state and LGAs			26,319
			5.1.5.2	SMoH should proposed a bill on enforcement of NHMIS in collaboration house committee on health			123,221
			5.1.5.3	Creation of Task Force Team for enforcement of NHMIS in the State.			3,445,396
		5.1.6	To improve coverage of data collection				**6,122,756**
			5.1.6.1	Sensitisation of Private HF and other stakeholders (e.g NPC, Teaching Hospital, Traditional medical practioners etc) on the need to ensure health data collection and transfer as well as vital statistics			710,613
			5.1.6.2	Creation of VHW scheme to capture community data with linkage to servicing HF			3,344,905
			5.1.6.3	Empowerment of inspectorate division for the purpose of data collection from the private HF.			2,067,238

		5.1.7	To ensure supportive supervision of data collection at all levels				**2,368,710**
			5.1.7.1	Strenghten the existing routine M&E activities			1,679,631
			5.1.7.2	Supportive supervisory visit by principal officer bi-monthly			689,079
	5.2	**To provide infrastructural support and ICT of health databases and staff training**			**ICT infrastructure and staff capable of using HMIS in 50% in the State and in 40% of LGAs by 2012**		**143,235,166**
		5.2.1	To strengthen the use of information technology in HIS				**23,603,356**
			5.2.1.1	Capacity buiding for Computer appreciation for M&E/DSNO, HMIS officers and programme officer and Principal officers.			9,661,465
			5.2.1.2	Training on the relevant software packages			9,812,201
			5.2.1.3	Provision of internet access to all unit/department of the SMoH			598,159
		5.2.2	To provide HMIS Minimum Package at the different levels (SMOH, LGA) of data management				**119,631,810**
			5.2.2.1	Provision of HMIS minimum equipment at the state level (vehincles, Binding machines, Digital Camera/projector, generator, computers, printers, telephone lines, fax machines furnitures etc)			119,631,810
			5.2.2.2	Provision of Manpower			-
	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**		**287,011,068**
		5.3.1	To strengthen the Hospital Information System				**223,433,939**
			5.3.1.1	Strenghten the existing health records units of the HF in the state			215,337,258
			5.3.1.2	Production and distribution of tools			8,096,681
		5.3.2	To strengthen the Disease Surveillance System				**63,577,129**
			5.3.2.1	Production of other disease surveillance tools that will key in to HMIS (HIV, IDSR, Malaria. Oncho, Nutrition, etc)			40,067,086
			5.3.2.2	Capacity buiding for Programme officers, DSNO/M&E			11,247,783
			5.3.2.3	Provision of data management equipments (laptops, desktops, photocopier, printer, scanner, 4WD)			12,262,261
	5.4	**To monitor and evaluate the NHMIS**			**NHMIS evaluated annually**		**14,511,279**
		5.4.1	To establish monitoring protocol for NHMIS programme implementation at all levels in line with stated activities and expected outputs				**694,762**
			5.4.1.1	Conduct Meeting to develop M& E plan for IMNCH strategy			152,231
			5.4.1.2	Conduct quarterly meetings for monitoring and evaluation of the plan			279,938

			5.4.1.3	Establish evaluation meetings for HMIS reports X 2 annually			165,092
			5.4.1.4	Adoption and production of Quality Assurance manual.			97,500
		5.4.2	To strengthen data transmission				**12,932,677**
			5.4.2.1	Training and retraining of DSNO on Hospital information system			1,022,134
			5.4.2.2	Training of the records officer on the IDSR			9,733,244
			5.4.2.3	Procurement of data storage equipment (Fireproof cabinet, files, computers and storage device)			2,177,299
	5.5	**To strengthen analysis of data and dissemination of health information**			**1. Kwara States have Units capable of analysing health information by end 2010 2. All LGAs disseminate available results regularly**		**931,932**
		5.5.1	To institutionalize data analysis and dissemination at all levels				**802,729**
			5.5.1.1	Conduct regular visit to make sure NHMIS data are collected and managed-PRS Division			387,607
			5.5.1.2	Production and dissemination of state bulletin reflecting analysed HMIS reports			415,122
			5.5.5.3	Annual report meeting			473,742
COMMUNITY PARTICIPATION AND OWNERSHIP							
6. To attain effective community participation in health development and management, as well as community ownership of sustainable health outcomes							**294,897,546**
	6.1	**To strengthen community participation in health development**			**Kwara States have at least annual Fora to engage community leaders and CBOs on health matters by end 2012**		**30,050,440**
		6.1.1	To provide an enabling policy framework for community participation				**642,319**
			6.1.1.1	Creation of an Ad-hoc committee to study existing guideline on community participation with aim of formulating a community development policy for the state			566,752
			6.1.1.2	Advocacy to the Executive and legislature for enactment of policy that will involve community participation in health			75,567
		6.1.2	To provide an enabling implementation framework and environment for community participation				**29,408,121**
			6.1.2.1	Strenghten the use of existing guidelines and tools in community participation in PHC programme			3,123,432
			6.1.2.2	strenghten or establishment where it does not exist CDC to accommodate stronger representation of all stakeholders (Traditional, religious, faith base, charity)			4,219,152
			6.1.2.3	Instutionalization of traditional institution participation in PHC activities			22,065,537
	6.2	**To empower communities with skills for positive health actions**			**Kwara States offer training to FBOs/CBOs and community**		**186,717,011**

					leaders on engagement with the health system by end 2012		
		6.2.1	To build capacity within communities to 'own' their health services				**101,751,260**
			6.2.1.1	Adaptation of National Behaviour and Social Change Communication Strategy.			433,670
			6.2.1.2	Advocacy, sensitazation and mobilisation on Behaviuoral and Social Change Communication			528,968
			6.2.1.3	Training of CDC member on PHC issues/ activities.			2,703,616
			6.2.1.4	Conduction of quick survey to identify existing gap among CDC mememberss.			855,585
			6.2.1.5	resource mobilization and allocation for community level activities.			97,229,420
		6.2.2	To Strengthen individual, family and community capacity to respond to MNCH issues at home and seek health care appropriately				**84,965,751**
			6.2.2.1	Training of Trainers of CORPs to promote key household and community practices			3,064,658
			6.2.2.2	Training of CORPS including CBOs, FBOs, VHWs, CBD (Community Based Distributors), and TBAs to counsel care givers on key household practices			6,549,132
			6.2.2.3	Institutionalize counselling caregivers by CORPS, CBOs and FBOs by giving incentives and supervision			14,584,413
			6.2.2.4	Advocacy through CDC to increase community resources and investment in MNCH services and compulsory monthly meeting of CDC to put up emergency preparedness plan for the month			13,612,119
			6.2.2.5	Sensitization and Orientation of other resource psersons such as road transprt workers, securitymen, market women, ambulance drivers, for emergency response and preparedness			3,757,355
			6.2.2.6	Pull funds for NGOs, CBOs, FBOs to cascade down training on KHHP			104,954
			6.2.2.7	Organise training on skill acquisition for income generation in colloboration with Ministry of Women Affairs			7,619,663
			6.2.2.8	Production and distribution of Pictorial counselling guide			2,088,166
			6.2.2.9	Establish community-based care models for mothers and new borns in various communities			33,585,292
	6.3	**To strengthen the community - health services linkages**			**50% of public health facilities in all Kwara State have active Committees that include community representatives by end 2011**		**67,305,975**
		6.3.1	To restructure and strengthen the interface between the community and the health services delivery points				**67,305,975**
			6.3.1.1	Review and assess existing linkages between the CDC and HFs in the state.			321,159
			6.3.1.2	Establishment and strenghtening of linkages between CDC and HFs in the state.			12,493,729
			6.3.1.3	Provision of stipends for VHWs thruogh attachee HFs.			45,340,144
			6.3.1.4	Adoption and production of community linkages guidelines.			888,961

			6.3.1.5	CDC interactive forum at state level			8,261,982
	6.4	**To increase national capacity for integrated multisectoral health promotion**			**Kwara State have active intersectoral committees with other Ministries and private sector by end 2011**		**2,418,141**
		6.4.1	To develop and implement multisectoral policies and actions that facilitate community involvement in health development				**2,418,141**
			6.4.1.1	Advocacy on involvement of muiltisector in health promotion through CDC to the Community gate keepers			2,418,141
	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**		**8,405,979**
		6.5.1	To develop and implement systematic measurement of community involvement				**8,405,979**
			6.5.1.1	Develop simple tools to measure performance of existing model			522,671
			6.5.1.2	implementation of performance assessment			7,883,308
PARTNERSHIPS FOR HEALTH							
7. To enhance harmonized implementation of essential health services in line with national health policy goals							**395,501,432**
	7.1	**To ensure that collaborative mechanisms are put in place for involving all partners in the development and sustenance of the health sector**			**1. SMoH has an active ICC with Donor Partners that meets at least quarterly by end 2010 2. SMoH has an active PPP forum that meets quarterly by end 2010**		**395,501,432**
		7.1.1	To promote Public Private Partnerships (PPP)				**210,466,352**
			7.1.1.1	State to develop strategies for implementing (Public Private Partnership)PPP and PuPP(Public Public Partnership) initiatives in line with the national policy			308,032
			7.1.1.2	Conduct biannual meeting to intensify PPP and PuPP with corporate organizations in their respective areas of operation (e.g local production of MNCH commodities (e,g zinc, ORS, Ready to use therapeutic food , Family Planning etc)			1,533,060
			7.1.1.3	Undertake mechanisms for engaging the private sector - such as contracting or out-sourcing, leases, concessions, social marketing,, franchising mechanism and provision of incentives (e.g. MNCH commodities, or technical support at no cost)			851,700
			7.1.1.4	Collaboration with FBOs especially in the area of service provision and control programme e.g materials and human resources to FBOs			1,150,488
			7.1.1.5	Collaboration with various health proffessional who practiced in under-servered rural areas in areas of capacity building and provision of materials.			473,261
			7.1.1.6	Establish joint monitoring visits with private care providers with adequate feedback			32,365

		7.1.2	To institutionalize a framework for coordination of Development Partners				**103,594,789**
			7.1.2.1	Mapping of existing development parteners in the state.			340,325
			7.1.2.2	Establishment of development partners forum at the instance of SMoH			398,880
			7.1.2.3	Establishment of Health Parteners Coordinating Committee at relevant department in the SMoH			1,545,836
			7.1.2.4	Establishment of ' common basket funding' models			1,047,591
		7.1.3	To facilitate inter-sectoral collaboration				**55,246,958**
			7.1.3.1	Conduct mapping of NGOs, FBOs, and CBOs in the state			-
			7.1.3.2	Conduct training for Health Care Providers in Public and Private Sector, Teaching and Reasearch Institutions, NGOs, CBOs, FBOs on all IMNCH Services/interventions-(Life Saving Skills (LSS),Expanded Life Saving Skills (ELSS),Modified Life Saving Skills (MLSS), Emergency Obstetric and Neonatal Care (EmONC),Focussed Antenatal Care (FANC), Essential Newborn Care (ENCC-Community and Facility) ,Integrated Management of Childhood Illnesses (IMCI-Community and Facility based), Severe Acute Malnutrition (SAM-Inpatient and Out patient),Infant and Young Child Feeding (IYCF), Family Plannning (FP), Adolescent/Youth friendly services, PMTCT)			10,028,771
			7.1.3.3	Establishment of intersectoral ministerial forum for the purpose of health programme implemention			800,598
		7.1.4	To engage professional groups				**20,541,591**
			7.1.4.1	Establishment of effective partnership with proffesional group.			1,277,550
			7.1.4.2	Engagement of proffessional groups in planning, implementaton, monitoring and evaluation of health plans and programmes.			5,678,002
			7.1.4.3	Establishment of collaboration between Government and proffessional body in joint standard for training institution and practice & professional competence assessment.			1,277,550
			7.1.4.4	Establishment of linkages with Academic Institutions.			996,489
			7.1.4.5	Advocacy to the legislature and Executives to influence regulations that will allow for competency - based practice by health proffessional			8,517
		7.1.5	To engage with communities				**535,861**
			7.1.5.1	Production of IEC materials that will be acceptable to the community			3,549
		7.1.6	To engage with traditional health practitioners				**5,115,880**
			7.1.6.1	Create a comprehensive stakeholders committee to understudy the activities of traditional practisec in the state.			996,489
			7.1.6.2	Creation of traditional health practise regulatory body to be domicile in the directorate of food and drugs.			1,039,074
			7.1.6.3	Establish quarterly interactive forum for the traditional health practisioner			3,049,087
			7.1.6.4	Advocacy for regulation of advertisement of traditional herbal products on media houses			31,229
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							**676,329,724**
	8.1	**To strengthen the stewardship role of governments at all levels for research and knowledge management systems**			**1. ENHR Committee established by**		**45,875,778**

					end 2009 to guide health research priorities 2. SMoH publishes an Essential Health Research agenda annually from 2010		
		8.1.1	Develop health research policies at State levels and health research strategies at State and LGA levels				**176,097**
			8.1.1.1	Development of health research policy at state level			19,566
			8.1.1.2	Establishment health research steering community (also to serve as Ethical Research Committee)			156,530
		8.1.2	To establish and or strengthen mechanisms for health research at all levels				**40,135,996**
			8.1.2.1	Establishment of reasearch unit domicile in PRS			40,135,996
		8.1.3	To institutionalize processes for setting health research agenda and priorities				**141,312**
			8.1.3.1	To develop guidelines on health research agenda			141,312
		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				**3,853,056**
			8.1.4.1	Foster multisectorial collaboration for research purposes			3,853,056
		8.1.5	To mobilise adequate financial resources to support health research at all levels				**1,412,787**
			8.1.5.1	Steering committee to access research grant from prospective donor agency			1,336,529
			8.1.5.2	Advocate for 2% of sate health budget to research			76,258
		8.1.6	To establish ethical standards and practise codes for health research at all levels				**156,530**
			8.1.6.1	steering committee to ensure ethical standard and practice codes			156,530
	8.2	**To build institutional capacities to promote, undertake and utilise research for evidence-based policy making in health at all levels**			**SMoH has an active forum with all medical training schools and research agencies by end 2010**		**369,057,839**
		8.2.1	To strengthen identified health research institutions at all levels				**498,088**
			8.2.1.1	Mapping of existing health research institutions in the state and identify their areas of strength.			64,619
			8.2.1.2	Collaborate with the research institution on research areas			433,469
		8.2.2	To create a critical mass of health researchers at all levels				**301,019,968**
			8.2.2.1	Ensure scholarship and studenship awards on postgraduate training and short certificate courses in health research			301,019,968
		8.2.3	To develop transparent approaches for using research findings to aid evidence-based policy making at all levels				**67,539,783**
			8.2.3.1	Conduct research on baseline data for IMNCH indicators in the State			365,505

			8.2.3.2	Create a state research data bank to ensure availability of research finding for decision making			66,893,326
			8.2.3.3	Dissemmination meetings to share results of research finding with the policy makers			280,952
		8.2.4	To undertake research on identified critical priority areas				-
			8.2.4.1	see steering committtee			-
	8.3	**To develop a comprehensive repository for health research at all levels (including both public and non-public sectors)**			**SMoH has an active forum with all medical training schools and research agencies by end 2010**		**45,340,029**
		8.3.1	To develop strategies for getting research findings into strategies and practices				**40,135,996**
			8.3.1.1	Creation of Getting Resaerch into Strategies (GRISP) unit			40,135,996
		8.3.2	To enshrine mechanisms to ensure that funded researches produce new knowledge required to improve the health system				**5,204,033**
			8.3.2.1	Conduct NEEDS asessment to idenfy health research gap anually			2,006,398
			8.3.2.2	Conduct operation research at SMoH			3,197,635
	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**		**216,056,079**
		8.4.1	To create a framework for sharing research knowledge and its applications				**215,253,359**
			8.4.1.1	Publishing research in accademic journals/bulletins			1,637,549
			8.4.1.2	Creation of Annual conferences			1,011,427
			8.4.1.3	Conducting seminar and workshops			11,924,404
			8.4.1.4	Participation in internationa conferences & workshops			200,679,979
		8.4.2	To establish channels for sharing of research findings between researchers, policy makers and development practitioners				**802,720**
			8.4.2.1	SMoH to subscribe to online/web base journals			-
Total							**59,813,474,889**

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

KWARA STATE TRATEGIC 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. Number of Laws and by-laws regulating traditional medical practice at State and LGA levels	Laws and bye-Laws	TBD			
	5. % 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	6. % of LGAs which have established a Health Watch Group	LGA Annual Report	0	50	75	100
	7. % of recommendations from health watch groups being implemented	Health Watch Groups' Reports	No Baseline	25	50	75
	8. % LGAs aligning their health programmes to the SSHDP	LGA Annual Report	0	50	75	100
	9. % DPs aligning their health programmes to the SSHDP at the LGA level	LGA Annual Report	No Baseline	50	75	100
	10. % of LGAs with functional peer review mechanisms	SSHDP and LGA Annual Review Report	TBD	25	50	75%
	11. % LGAs implementing their peer review recommendations	LGA / SSHDP Annual Review Report	No Baseline	50	75	100%
	12. Number of LGA Health Watch Reports published	Health Watch Report	0	50	75	100
	13. Number of "Annual Health of the LGA" Reports	Health of the State Report	TBD	50	75	100%

	published and disseminated annually					
4. Enhanced performance of the State health system	14. % LGA public health facilities using the essential drug list	Facility Survey Report	TBD	40	80	100%
	15. % private health facilities using the essential drug list by LGA	Private facility survey	TBD	10	25	50%
	16. % of LGA public sector institutions implementing the drug procurement policy	Facility Survey Report	TBD	50	75	100%
	17. % of private sector institutions implementing the drug procurement policy within each LGA	Facility Survey Report	TBD	10	25	50%
	18. % LGA health facilities not-experiencing essential drug/commodity stockouts in the last three months	Facility Survey Report	TBD	25	50	75%
	19. % of LGAs implementing a performance based budgeting system	Facility Survey Report	TBD	25	50	75%
	20. Number of MOUs signed between private sector facilities and LGAs in a Public-Private-Partnership by LGA	LGA Annual Review Report	TBD	2	4	6
	21. Number of facilities performing deliveries accredited as Basic EmOC facility (7 functions 24/7) and Comprehensive EmOC facility (9 functions 24/7)	States/ LGA Report and Facility Survey Report	TBD	???	???	???
STRATEGIC AREA 2: HEALTH SERVICES DELIVERY						
NSHDP GOAL: To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare						
Outcome 3: Universal availability and access to an essential package of primary health care services focusing in particular on vulnerable socio-economic groups and geographic areas						
Outcome 4: Improved quality of primary health care services						
Outcome 5: Increased use of primary health care services						
5. Improved access to essential package of Health care	22. % of LGAs with a functioning public health facility providing minimum health care package according to quality of care standards.	NPHCDA Survey Report	TBD	25	50	75%
	23. % health facilities implementing the complete package of essential health care	NPHCDA Survey Report	TBD	50	75	100%
	24. % of the population having access to an essential care package	MICS/NDHS	TBD	40	75	100%
	25. Contraceptive prevalence rate	NDHS	0.2 - 49.6%	5 - 60%	10 - 70%	20 - 80%
	26. Number of new users of modern contraceptive methods (male/female)	NDHS/HMIS	0.2 - 27.5%	2 - 30%	5 - 50%	10 - 75%
	27. % of new users of modern contraceptive	NDHS/HMIS	TBD	2 - 30%	5 - 50%	10 - 75%

	methods by type (male/female)					
	28. % service delivery points without stock out of family planning commodities in the last three months	Health facility Survey	TBD	10 - 45%	20 - 75%	100%
	29. % of facilities providing Youth Friendly RH services	Health facility Survey	TBD	20 - 40%	30 - 60%	40 - 75%
	30. Adolescent (10-19 year old) Fertility rate (using teeenage pregnancy as proxy)	NDHS/MICS	2.9 - 65.0%	2.0 - 40%	1.0 - 30%	0.5 - 20%
	31. % of pregnant women with 4 ANC visits performed according to standards*	NDHS	12.3 - 96.3%	25 - 100%	50 - 100%	75 - 100%
	32. Proportion of births attended by skilled health personnel	HMIS	4.7 - 98%	25 -100	50 -100%	75 - 100%
	33. Proportion of women with complications treated in an EmOC facility (Basic and/or comprehensive)	EmOC Sentinel Survey and Health Facility Survey	TBD	10 - 40%	25 - 50%	40 - 75%
	34. Caesarean section rate	EmOC Sentinel Survey and Health Facility Survey	0.1 - 5.6%	1.0 - 10%	5.0 - 20%	10 - 30 %
	35. Case fertility rate among women with obstretic complications in EmOC facilities per complication	HMIS	TBD	10 - 60%	7 - 40%	5 - 25%
	36. Perinatal mortality rate**	HMIS	37 - 53/1000LBs	25 - 45/1000LBs	15 - 30/1000LBs	10 - 20/1000 LBs
	37. % women receiving immediate post partum family planning method before discharge	HMIS	TBD	??	??	??
	38. % of women who received postnatal care based on standards within 48h after delivery	MICS	0.5 - 22.4%	10 - 40%	25 - 60%	50 - 75%
	39. Number of women presented to the facility with or for an obstetric fistula	NDHS/HMIS	No Baseline			??
	40. Number of interventions performed to repair an obstetric fistula	HMIS	No Baseline			??
	41. Proportion of women screened for cervical cancer	HMIS				
	42. % of newborn with infection receiving treatment	MICS	No Baseline	10 -25%	25 -50%	50 - 75%
	43. % of children exclusively breastfed 0-6 months	NDHS/MICS	0 - 57.4%	10 - 65%	20 - 75%	40 - 80%
	44. Proportion of 12-23 months-old children fully immunized	NDHS/MICS	0.0 - 58.7%	40 - 70%	50 - 85%	65 - 100%
	45. % children <5 years stunted (height for age <2 SD)	NDHSMICS	12.4 - 63.5%	8.0 - 50%	5.0 - 35%	2.0 - 15%
	46. % of under-five that slept under LLINs the previous night	NDHS/MICS	1.0 - 16.1%	25 - 50%	50 - 75%	75 - 90%

	47. % of under-five children receiving appropriate malaria treatment within 24 hours	NDHS/MICS	2.0 - 49.9%	25 - 60%	40 - 75%	60 - 90%
	48. % malaria successfully treated using the approved protocol and ACT;	MICS	TBD	???	???	???
	49. Proportion of population in malaria-risk areas using effective malaria prevention and treatment measures	MICS	TBD	???	???	???
	50. % of women who received intermittent preventive treatment for malaria during pregnancy	NDHS/MICS	TBD	???	???	???
	51. HIV prevalence rate among adults 15 years and above	NDHS				
	52. HIV prevalence in pregnant women	NARHS		???	???	???
	53. Proportion of population with advanced HIV infection with access to antiretroviral drugs	NMIS		???	???	???
	54.Condom use at last high risk sex	NDHS/MICS				
	55. Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS	NDHS/MICS	6 - 61.6%	20 - 75%	40 - 90%	60 - 100%
	56. Prevalence of tuberculosis	NARHS	1.5 - 6.9%*	1.0 - 4.0	0.5 - 3%	0.1 - 2*
	57.Death rates associated with tuberculosis	NMIS				
	58. Proportion of tuberculosis cases detected and cured under directly observed treatment short course	NMIS	TBD	20 - 50%	40 - 75%	60 - 100%
Output 6. Improved quality of Health care services	59. % of staff with skills to deliver quality health care appropriate for their categories	Facility Survey Report	TBD	25 - 50%	50 - 75%	75 - 100%
	60. % of facilities with capacity to deliver quality health care	Facility Survey Report	TBD	25 - 50%	50 - 75%	75 - 100%
	61. % of health workers who received personal supervision in the last 6 months by type of facility	Facility Survey Report	TBD	20 - 40%	50 - 75%	75 - 100%
	62. % of health workers who received in-service training in the past 12 months by category of worker	HR survey Report	TBD	10 - 25%	25 - 50%	50 - 75%
	63. % of health facilities with all essential drugs available at all times	Facility Survey Report	TBD	25 - 40%	40 - 75%	75 - 100%
	64. % of health institutions with basic medical equipment and functional	Facility Survey Report	TBD	10 - 25%	25 - 40%	40 - 75%

	logistic system appropriate to their levels					
	65. % of facilities with deliveries organizing maternal and/or neonatal death reviews according to WHO guidelines on regular basis	Facility Survey Report	TBD	10 - 45%	30 - 75%	50 - 90%
Output 7. Increased demand for health services	66. Proportion of the population utilizing essential services package	MICS	TBD	25 - 50%	50 -75%	75 - 100%
	67. % of the population adequately informed of the 5 most beneficial health practices	MICS	TBD	25 - 50%	50 - 75%	75 - 100%
PRIORITY AREA 3: HUMAN RESOURCES FOR HEALTH						
NSHDP GOAL: To plan and implement strategies to address the human resources for health needs in order to ensure its availability as well as ensure equity and quality of health care						
Outcome 6. The Federal government implements comprehensive HRH policies and plans for health development						
Outcome 7.All States and LGAs are actively using adaptations of the National HRH policy and plan for health development by end of 2015						
Output 8. Improved policies and Plans and strategies for HRH	68. % of wards that have appropriate HRH complement as per service delivery norm (urban/rural).	Facility Survey Report	TBD	20 - 40%	30 - 60%	50 - 75%
	Retention rate of HRH	HR survey Report	TBD	???	???	???
	70. % LGAs actively using adaptations of National/State HRH policy and plans	HR survey Report	TBD	10 - 30%	30 - 50%	50 - 75%
	71. Increased number of trained staff based on approved staffing norms by qualification	HR survey Report	TBD	10 - 20%	25 - 50%	50 - 75%
	72. % of LGAs implementing performance-based managment systems	HR survey Report	TBD	25 - 30%	30 - 50%	50 - 80%
	73. % of staff satisfied with the performance based management system	HR survey Report	TBD	10 - 25%	25 - 50%	50 - 75%
Output 8: Improved framework for objective analysis, implementation and monitoring of HRH performance	74. % LGAs making availabile consistent flow of HRH information	NHMIS	0 - 100%	25 - 100%	50 - 100%	100%
	75. CHEW/10,000 population density	MICS	TBD	1:4000 pop	1:3000 pop	1:2000 pop
	76. Nurse density/10,000 population	MICS	TBD	1:8000 pop	1:6000 pop	1:4000 pop
	77. 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

	78. Medical doctor density per 10,000 population	MICS	TBD	1:8000 pop	1:7000 pop	1:5000 pop
	79. Other health service providers density/10,000 population	MICS	TBD	1:4000 pop	1:3000 pop	1:2000 pop
	80. HRH database mechanism in place at LGA level	HRH Database	TBD	50 - 75%	75 - 100%	100%
Output 10: Strengthened capacity of training institutions to scale up the production of a critical mass of quality mid-level health workers						
PRIORITY AREA 4: FINANCING FOR HEALTH **NSHDP GOAL 4 : To ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and consumption at Local, State and Federal Levels**						
NSHDP GOAL 4 : To ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and consumption at Local, State and Federal Levels						
Outcome 8. Health financing strategies implemented at Federal, State and Local levels consistent with the National Health Financing Policy						
Outcome 9. The Nigerian people, particularly the most vulnerable socio-economic population groups, are protected from financial catastrophe and impoverishment as a result of using health services						
Output 11: Improved protection from financial catastrophy and impoversihment as a result of using health services in the State	81. % of LGAs implementing state specific safety nets	SSHDP review report	TBD	10 -25%	25 - 50%	50 - 75%
	82. Decreased proportion of informal payments within the public health care system within each LGA	MICS	TBD	50 - 90%	30 - 75%	10 - 50%
	83. % of LGAs which allocate costed fund to fully implement essential care package at N5,000/capita (US$34)	State and LGA Budgets	TBD	25 - 40%	40 - 60%	60 80%
	84. LGAs allocating health funding increased by average of 5% every year	State and LGA Budgets	TBD	25 - 40%	40 - 60%	60 - 80%
Output 12: Improved efficiency and equity in the allocation and use of Health resources at	85. LGAs health budgets fully alligned to support state health goals and policies	State and LGA Budgets	TBD	40 - 60%	60 - 80%	100%

State and LGA levels						
	86.Out-of pocket expenditure as a % of total health expenditure	National Health Accounts 2003 - 2005	70%	60%	50%	40%
	87. % of LGA budget allocated to the health sector.	National Health Accounts 2003 - 2005	2%	10%	20%	30%
	88. Proportion of LGAs having transparent budgeting and finacial management systems	SSHDP review report	TBD	25%	40%	60%
	89. % 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	90. % of LGAs making routine NHMIS returns to states	NHMIS Report January to June 2008; March 2009	0 - 34%	25 - 50%	50 - 75%	75 - 100%
	91. % of LGAs receiving feedback on NHMIS from SMOH		TBD	25 -50%	50 - 75%	75 - 100%
	92. % of health facility staff trained to use the NHMIS infrastructure	Training Reports	TBD	30 - 60%	60 - 80%	80 -100%
	93. % of health facilities benefitting from HMIS supervisory visits from SMOH	NHMIS Report	TBD	25 - 40%	40 - 60%	60 - 80%
	94.% of HMIS operators at the LGA level trained in analysis of data using the operational manual	Training Reports	TBD	40%	75%	100%
	95. % of LGA PHC Coordinator trained in data dissemination	Training Reports	TBD	40%	75%	100%
	96. % of LGAs publishing annual HMIS reports	HMIS Reports	TBD	25%	50%	75%
	97. % 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	99. 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%

	100. % of wards holding quarterly health committee meetings	HDC Reports	TBD	25%	50%	75%
	101. % HDCs whose members have had training in community mobilization	HDC Reports	TBD	40%	75%	100%
	102. % increase in community health actions	HDC Reports	TBD	10%	25%	50%
	103. % of health actions jointly implemented with HDCs and other related committees	HDC Reports	TBD	25%	40%	60%
	104. % 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	105. Increased number of new PPP initiatives per year per LGA	SSHDP Report	TBD	25%	40%	60%
	106. % 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	107. % of LGAs partnering with researchers	Research Reports	TBD	10%	25%	50%
	108. % of State health budget spent on health research and evaluation	State budget	TBD	1%	1.50%	2%
	109. % of LGAs holding quarterly knowledge sharing on research, HMIS and best practices	LGA Annual SHDP Reports	TBD	10%	25%	50%
	110. % of LGAs participating in state research ethics review board for researches in their locations	LGA Annual SHDP Reports	TBD	40%	75%	100%
	111. % 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	112. % LGAs aware of state health research communication strategy	Health Research Communication Strategy	TBD	40%	75%	100%