KOGI STATE GOVERNMENT

STRATEGIC HEALTH DEVELOPMENT PLAN

(2010-2015)

Kogi State Ministry of Health

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List of Acronyms and Abbreviations

ACT	Artemisin Combination Therapy
CBOs	Community Based Organizations
CHEWS	Community Health Extension Workers
CMD	Chief Medical Director
CSOs	Civil Society Organisations
CSPs	Contraception Service Providers
DOTS	Directly Observed Treatment Strategy
ENHR	Essential National Health Research
EEC	European Economic Commission
FBO	Faith Based Organization
FMoH	Federal Ministry of Health
HF	Health Facility
HIV/AIDS	Human Immuno-Deficiency Virus/Acquired Immune Deficiency Syndrome
HMB	Hospital Management Board
HMIS	Health Management Information System
ICC	Interagency Coordinating Committee
ICT	Information, Communication Technology
IMNCH	Integrated maternal, Neonatal, Child Health
ITN	Insecticide Treated Nets
LGAs	Local Government Areas
MDGs	Millennium Development Goals
M & E	Monitoring and Evaluation
MICS	Multiple Indicator Cluster Surveys
MOH	Ministry of Health
MOLG	Ministry of Local Government
NGOs	Non-Governmental Organizations
NMA	Nigerian Medical Association
NPI	National Programme on immunization
NPoC	National Population Commission
NDHS	Nigerian Demographic and Health Survey
NHMIS	National Health Management Information System
OCP	Onchocerchiasis Control Programme
PHC	Primary Health Centre
PPP	Private Public Partnership
SMOH	State Ministry of Health
TBLCP	Tuberculosis and Leprosy Control programme
UNICEF	United Nations Children’s Fund
WHO	World Health Organization

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Preface

Following the advent of the Yar'Adua Administration and in consonance with the Health Sector objective of the seven points Agenda, the Hon. Minister of Health Prof. Babatunde Oshotimehin constituted a think-tank to come up with idea that would enable Government respond appropriately to the apparent crisis in the Health sector.

The result was the National Strategic Health Development Plan which necessarily would require input from State and Local government Areas. Hence the development of the Kogi State Strategic Health Development Plan (KSHDP).

Coming at a time when the vision 2020 is being packaged, one cannot but observe that the present Government at the Federal and State levels are desirous of lifting the socio-economic status of Nigerians in general and Kogites in particular. This also could not have come at a better time considering the quest for Nigeria to attain the health related Millennium Development Goals by 2015. This is in consonance with the State Government's belief that a healthy nation is a wealthy one.

The process of developing this plan was as painstaking as it was extensive, and as robust as it was engaging, often resulting in the team working very late for several days. The very broad strata of participants involved in the processes gives the confidence that the final product meets the aspiration of stakeholders in the State. Indeed, if there is any home grown health sector plan for this State since its inception in 1991, it is this.

It is our hope that the very tireless efforts put in by all participants from the Ministry of Health, Ministry of Finance, Budget and Planning Local Government and Chieftaincy Affairs, the LGAs, Development Partners and the private sector as well as the Consultant will bear the desired fruits when the implementation of the plan commenced next year.

This is indeed a worthy exercise and a testimony to our collective sense of purpose and patriotic zeal. It is our hope, that with this document in our hands and Almighty God as our guide, we are on the way to achieving our health sector related Millennium Development Goals.

Long live Kogi State, long live the Federal Republic of Nigeria.

Dr. (Mrs) Dorcas Onuminya FWACS
Hon. Commissioner for Health
Kogi State

Executive Summary

The Kogi State Strategic Health Development Plan was developed as part of the National Plan by the Federal Ministry of Health to help address previous holistic programmatic gaps in the health sector. It was borne out of the fact the State in particular, and Nigeria in general needs to have a common plan of action where all stakeholders, development partners and subsequent governments at Federal, State and Local Government levels buy into. It also will provide a uniform basis for monitoring and evaluation of identified activities, interventions, strategic objectives and goals.

The process lasted about 12 weeks in the state, consisting of advocacy visits, various planning meetings, as well as inauguration of steering committees, stakeholders' workshops and plan development workshops at both State and LGA levels. Several achievements and accomplishments were recorded in the process of plan development among which are; Mobilization of all stakeholders in the health Sector in the State to work collectively towards a common cause, renewed motivation and commitment on the part of stakeholders to address long –standing health challenges in the state and capacity building and acquisition of new skills by participants in the various training workshops held in the Strategic Plan development process. The participation of the private sector and professional association was the first of its kind in the state.

The situation analysis revealed a state with relatively high human resource among the indigenes though the government has not been able to employ all the needed human resource. Based on this plan the estimated human resource gap to enable full implementation is about 40%. The human resource gap is pronounced among the following professional; Doctors, Nurse/Midwives, Pharmacists, and Laboratory Scientists/Technicians.

Provision and utilization of health services need to be improved upon. Referral system is still very weak. Geographical and financial access to health services need to be improved considerably to reduce disease burden in the state.

Financing of health care services in the state like many other states in the country is poor. Budgetary allocation to the health sector together with other health care financing options like embracing the health insurance scheme will be required for adequate and proper implementation of strategic plan. .

All the goals, strategic objectives, and Interventions as agreed to by the extraordinary session of National Council of Health held in Abuja this year are relevant to Kogi State. However additional interventions were developed particularly in key national health programmes like Integrated Maternal, Neonatal, Child Health (IMNCH); Malaria Control and HIV and AIDS.

The activities towards achieving these goals, strategic objectives and interventions were tailored to specific needs and priorities in the state. The LGAs input were also harmonized into the state plan.

The financial resource requirement for this strategic plan is about **NGN 80,745,128,446 (eighty billion seven hundred and forty five million, one hundred and twenty eight thousand, four hundred and forty six Naira only).** The estimated financial gap is about 36% based on available sources of funding which is mainly from statutory allocations from the Federation account, responsible for about 80-90% of total monthly receipts in the state. The remaining 10-20% comes from internally generated revenue and development partners.

Monitoring and Evaluation of this Strategic plan is best done at the operational level in the state and LGAs. A single M&E approach that will comprehensively and inclusively address eight very divergent goals, with numerous strategic objectives, multiple interventions, and countless activities is hardly feasible.

The guiding principles for monitoring and evaluating the strategic framework must bear in mind that it should be a combination of implementation and result-based monitoring, and that it should be decentralized. This will cost about 1% of the entire plan budget, and will involve training all programme and field staff to be monitoring and evaluating their programmes, instead of sending information and data to a central M&E officer at the state or Local Government headquarters.

In conclusion this strategic plan and the operational plans that will evolve from it presents a unique opportunity for the state to improve health status of people in Kogi state if well implemented.

Vision, Mission and the Overarching Goal of the State Strategic Health Development 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 Nigerians".

Mission

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

Goal

The overarching goal of the Kogi SHDP is to significantly improve the health status of Kogi people through the development of a strengthened and sustainable health care delivery system.

Chapter 1: Background & Achievements

1.1 Background

Kogi state of Nigeria was created on the 27th August, 1991 from the Eastern part of the then Kwara State and the western part of the then Benue state. The two areas made up what was formerly called ‘Kabba province’.
The state occupies the central part of Nigeria and it is unique for serving as the belts for the two major rivers in Nigeria – Niger and Benue. Indeed, its state capital, Lokoja is the meeting point of the two rivers hence the appellate, ‘Confluence State’.

The state occupies an area of 28,312.6 square kilometers. It shares common boundaries with ten (10) states and the Federal Capital Territory (FCT). To the North; it shares boundaries with Niger, FCT, and Nassarawa, to the West by; Kwara, Ekiti, Ondo, Edo, and Delta, while to the East by; Benue, Anambra and Enugu states. Kogi state is made up of 239 wards, in 21 LGAs and 3 Senatorial districts.

1.2 Demography

The state had a population of 2,147,756 million by 1991 census and 3,478,029 by 2006 census. Males make up 46.8% of the population and females 53.2%.[1]

1.3 People

Kogi state is highly heterogeneous due to her location. The major indigenous ethnic groups in the state are: Igala, Ebira and Okun-Yoruba. Others include; Egbirra-koto, Bassa-komo, Bassa-Nge, Nupe and Ogori. Numerous other Nigerian ethnic groups from outside the state have found a safe haven in the state.

Agriculture remains the main occupation of the people (over 70%), cultivating cash and food crops extensively (yam, rice, maize, guinea corn & beni-seed), while the tree crops include; palm oil, cashew, cocoa and coffee. expectedly fishing is also a very significant occupation in the state. Adult literacy rate is 62.1% among males and 37.9% among females[1]

Consistent with prevailing situations in many states of Nigeria, the State is relatively blessed with human resources. However the health system is weak and the causes are multi-dimensional; the health sector is underfunded and overstretched by a burgeoning population. Similarly, a culmination of decades of neglect is responsible for high disease burdens, decaying physical facilities, obsolete equipment[2] among others. In addition, responsibilities of federal, state and local governments are poorly delineated and the roles of stakeholders are misaligned and with weak coordination systems. These challenges are further compounded by the dearth of data which renders the evidence base of planning, policy formulation and health systems management significantly weak.

[11] National Population Commission. Census 2006
Kogi State 2005 – 2007 Health Bulletin. HMIS Unit, Dept of Planning Research and Statistics, MOH, Lokoja
[2] Review of the Health Sector Reform Programme, FMH Abuja 2008.

Finally, in view of the importance of political leadership in driving the continued health sector reform agenda in the country, special consideration should be given to the issue of ensuring adequate buy-in of Governors and Local Government Chairpersons to this laudable scheme.

1.4 Achievements

(a) ***<u>The SHDP Process in Kogi State:</u>***

Details of Committees Inaugurated

The State sub-Planning Committee was set up on 24th October 2009 by the Permanent Secretary, Ministry of Health Dr. Medupin at a time a Commissioner of Health was yet to be appointed on the 24th of August 2009

i. **The State Steering Committee** consist of the following key stakeholders:
- Hon. Commissioner for Health (Chairman)
- Hon. Commissioner for LG & Chieftaincy Affairs
- Hon. Commissioner for Budget and Planning
- Hon. Commissioner for Finance
- Chief of Staff to the Executive Governor
- Chairmen of the 21 LGAs
- Permanent Secretary, Ministry of Health
- Chief Medical Director, Hospitals Management Board, MOH.
- Director, Planning Research & Statistics, MOH. (Secretary)
- Director, Primary HealthCare, MOH
- Director, Planning, Research and Statistics, MOLG
- Director, Admin.& Supply MOH.
- Director, PRS, Ministry of Finance
- Director, PRS, Ministry of Budget & Planning
- Director, Pharmaceutical Services, MOH.
- Director, Nursing Services, MOH.
- Director, Medical Services, MOH.
- Director, Vector Control & Laboratory Services, MOH.
- Deputy Director, Planning, MOH.
- Rep. of NMA, Nat. Assoc. of Nigerian Nurses & Midwives, FBOs, Civil Society org.
- Rep. of traditional & Religious leaders

ii. **The State Planning Team** consist of

- Permanent Secretary, Ministry of Health (Chairman)
- Chief Medical Director, Hospitals Management Board, MOH.
- Director, Planning Research & Statistics, MOH.
- Director, Primary Health Care, MOH
- Director, Planning Research & Statistics, MOLG
- Director, Admin. MOH.
- Director, PRS, Ministry of Finance
- Director, PRS, Ministry of Planning & Economic Development

- Director, Pharmaceutical Services, MOH.
- Director, Nursing Services, MOH.
- Director, Medical Services, MOH.
- Deputy Director, Planning, MOH. (Secretary)
- Rep. of NMA, Nat. Assoc. of Nigerian Nurses & Midwives, FBOs, Civil Society org.
- Rep. of traditional & Religious leaders
- Rep. of CMD, Federal Medical Centre & State Specialist Hospital, Lokoja.
- Programme Managers for TBLCP, Malaria, NPI, IMNCI, Safe Motherhood, Nutrition, Women in Health, OCP, .
- Rep. of Medical & Health Workers Union, Assoc. of Community Pharmacists, Assoc. of Private Medical Practitioners

(iii) **The State Reference Group:** This was also set up and inaugurated on the 24th of August, 2009 by the Permanent Secretary. The group is made up of the following:

- Permanent Secretary, Ministry of Health
- Director, Planning Research & Statistics, Ministry of Health.
- Director, Primary Health Care, Ministry of Health
- Director, Planning, Research & Statistics, Ministry of Local Government
- Development Partners; UNICEF, & WHO.
- Project Manager, HSDP

(b) ***Frequency of meetings/ activities.***

***The State Reference Group*:**

The State Reference Group (SRG) met several times (on average of 2 times weekly) in the process of developing the plan. The meetings were many because of the delay in the take off of the process. The first meeting was held on the 21st of August, 2009 at the premises of the State Ministry of Health, Lokoja.

At the initial stage, during the first 3 weeks the new Commissioner for Health Dr. (Mrs.) Dorcas Onunmiya was not yet sworn in. When the new Commissioner for Health assumed duty, she was briefed adequately on the need and process for the development of a Strategic Health Plan. The new Commissioner of Health was not privileged to attend any of the meetings held earlier with State Commissioners of Health, the State Commissioner of Health that attended these meeting was sacked just before the commencement of the State and LGA level activities.

At various times the State reference group met with the State Commissioner for Local Government and Chieftaincy Affairs (Hon T.J. Faniyi) and also addressed the Joint Allocation Committee of LGA Chairmen twice.

The State Planning Team:

The State Planning Team (SPT) met less frequently because the team was not inaugurated early enough because of late release of funding of the process.

(c) ***Major training & planning activities***

	ACTIVITY	***VENUE***	***DATE***
1	Inauguration of State Steering Committee	Confluence Hotel, Lokoja	22nd October, 2009.
2	Orientation Workshop for State Planning Team	Confluence Hotel, Lokoja	22 nd – 23rd October, 2009
3	State Plan Development Meeting	State Secretariat Conference Hall Lokoja	26th – 30th Oct. 2009
4	LGA level orientation workshop	State Secretariat Conference Hall Lokoja	28th – 29th October 2009
5	LG Plan Development meeting	State Secretariat Conference Hall Lokoja.	30th October – 2nd November . 2009.
6	Collation of Plan	State Ministry of Health	3rd – 9th Nov 2009
7	Presentation of draft plan to steering committee		

Table 1: highlighting major training and Planning activities in the state

Even though the State was assisted by WHO in 2007 to develop a 10-year Strategic Health Plan, the plan without cost. There is no evidence that the plan was ever implemented. However, the skill acquired then was useful in this process and some information on the plan was used in developing the current State Strategic Health Development Plan.

In the process of developing this plan some of the achievements include:

- Mobilization of all stakeholders in the health Sector in Kogi State to work collectively towards a common cause.
- Capacity building and acquisition of new skills by participants in the various training workshops held in the Strategic Plan development process.
- Renewed motivation and commitment on the part of stakeholders to address long –standing health challenges in the state.

- The process for the first time harnessed partnership between the private and public sector and the involvement of professional associations in health plan development.

Chapter 2: Situation Analysis

2.1 Socio-economic context

The state had a population of 2,147,756 million by 1991 census and 3,478,029 by 2006 census. Males make up 46.8% of the population and females 53.2%.[1]

Kogi state is highly heterogeneous due to her location. The major indigenous ethnic groups in the state are: Igala, Ebira and Okun. Others include; Egbirra-koto, Bassa-komo, Bassa-Nge, Nupe and Ogori. Numerous other Nigerian ethnic groups from outside the state have found a safe haven in the state.

Agriculture remains the main occupation of the people (over 70%), cultivating cash and food crops extensively (yam, rice, maize, guinea corn & beni-seed), while the tree crops include; palm oil, cashew, cocoa and coffee. expectedly fishing is also a very significant occupation in the state. adult literacy rate is 62.1% among males and 37.9% among females2

2.2 Economic resources

Kogi state is richly endowed with natural resources, which include; coal, limestone, marble, feldspar, clay, kaolin, iron ore, cassiterite, columbite, tantalite, quartz, talc 7 mica.

Sequel to the large deposits of solid mineral resources the Ajaokuta steel company and Obajana Cement Company have been established in the state.

About 61.53% of the population lives below poverty line.[2]

Industries/Peculiarities

The main industries in the state are:

a. Obajana Cement Factory;

b. Ajaokuta Steel Company;

c. Itakpe Iron Ore.

d. Okaba Coal Mines

Specific data on the health implications of these industries are not available at the moment but suffice it to say that they pose latent health risks and hence the need to incorporate Occupational Health Services into the plan. Furthermore, the state is a major road traffic link to the Federal Capital, Abuja. The busy Okene-Abuja Highway is a significant factor in the state health sector with regards to the epidemiology of road traffic accidents.

Map of Kogi State & LGAs:

2.3 *Health Status of the Population*

Annual summary of routinely notifiable diseases shows that Malaria, Diarrhea, Measles, Typhoid fever, Pneumonia are the most prevalent causes of morbidity and mortality in the state. HIV / AIDS and Tuberculosis & Leprosy also have a significant focus in the state.

Crude birth rate is 43 per thousand and fertility rate of 6 per woman. Infant mortality rate in the state is 112 per thousand.[2] The 2008 NDHS gives us a bigger picture of the health status of the people of Kogi State. This is presented in the table below.

POPULATION (2006 Census)	KOGI
Total population	**3,314,043**
female	1,641,140
male	1,672,903
Under 5 years (20% of Total Pop)	624,049
Adolescents (10 – 24 years)	1,022,542
Women of child bearing age (15-49 years)	794,092

INDICATORS	NDHS 2008
Literacy rate (female)	64%
Literacy rate (male)	90%
Households with improved source of drinking water	45%
Households with improved sanitary facilities (not shared)	16%
Households with electricity	52%
Employment status (currently)/ female	69.3%
Employment status (currently)/ male	67.9%
Total Fertility Rate	4.2
Use of FP modern method by married women 15-49	7%
Ante Natal Care provided by skilled Health worker	82%
Skilled attendants at birth	76%
Delivery in Health Facility	77%
Children 12-23 months with full immunization coverage	39%
Children 12-23 months with no immunization	14%
Stunting in Under 5 children	36%
Wasting in Under 5 children	7%
Diarrhea in children	2.9
ITN ownership	4%
ITN utilization (children)	3%
ITN utilization (pregnant women)	2%
children under 5 with fever receiving malaria treatment	-
Pregnant women receiving IPT	20%
Comprehensive knowledge of HIV (female)	24%
Comprehensive knowledge of HIV (male)	45%
Knowledge of TB (female)	49.3%
Knowledge of TB (male)	83.9%

2.4 Health Service provision and Utilization

The State Ministry of Health has 7 Directorates; Directorate of Primary Health Care, Directorate of Nursing Services, Directorate of Medical Services & Training, Directorate of Pharmaceutical Services, Directorate of Health Planning Research and Statistics and Directorate of Administration and Supply and the Directorate of Finance and Accounts. The State also has a Health Management Board (HMB) and the State Specialist Hospital.

2.4.1 State Ministry of Health

Vision

To collaborate with FMOH and other partners /NGOs to reduce mortality and morbidity rates of communicable and non-communicable diseases with a view to improving on quality of life and life expectancy of the people of the state.

Mission

To develop State health policies, adopt national health policies and programs that would strengthen and guarantee access to the delivery of quality, effective and affordable health services in the state.

Operations

The ministry has six departments, one parastatal and two schools. The departments are: Administration and finance; Planning, Research and Statistics; Medical Services and Training, Primary Health Care services, Pharmaceutical services and Nursing services.

Statutorily, the Honorable Commissioner is the chief executive officer, while the Permanent Secretary is the accounting officer.

Roles

- Policy formulation and regulation
- Implementation / enforcement of the National Health policies at state level
- Implementation of capital projects
- Supervision of the Hospitals Management Board and the Health training Institutions.
- Registration and supervision of all private and voluntary agency Health Establishments
- Registration and inspection of pharmacy shops and patent medicine vendors.
- Ensuring health promotion, preventive, rehabilitative and curative services.

2.4.2 Health training institutions

There are four (4) health training institutions in the State. Two of these institutions are run by the state, while two are mission owned with state government subventions. These are: School of Nursing Obangede (State), School of Nursing & Midwifery, Egbe (Mission), Grimard School of Midwifery, Anyigba (Mission) and School of Health Technology, Idah (State). Schools of Nursing, trains nurses only, while the School of Health technology trains; Community Health Extension Workers (CHEWs), Environmental Health Officers, Laboratory assistants and Health Management Information System (HMIS) Officers.

2.4.3 Human resource

The State has Doctor Population ratio of 1:52,697, Pharmacist ratio of 1:91,527, Nurses / Midwives 1:3,191, Laboratory Scientists 1:165,620, Laboratory Technicians 1:63,237 and Imaging Scientists 1:869,507.[2]

2.4.4 Health services

Health care delivery in Nigeria is the responsibility of the three tiers of government. That is, Tertiary care (Federal Government), Secondary care (State Government) and Primary Health care (LGAs) see, (HF by type & ownership – Table 2)

Table 2: LGAs and their Number of Health Facilities (Public and Private)

S/No.	LGA	LGA Code	Public			Private	Total
			Fed	State	LGA		
			Tertiary	Secondary	PHC		
1.	Adavi	DAV	-	2	16	17	35
2.	Ajaokuta	AJA	-	1	26	5	32
3.	Ankpa	KPA	-	1	62	12	75
4.	Bassa	BAS	-	2	95	16	113
5.	Dekina	KNA	-	7	100	15	122
6.	Ibaji	NDG	-	3	63	21	87
7.	Idah	DAH	-	1	33	10	44
8.	Igalamela/Odolu	AJK	-	2	54	4	59
9.	Ijumu	JMU	-	5	29	10	44
10.	Kabba/ Bunu	KAB	-	2	35	5	42
11.	Kogi	KKF	-	1	31	3	35
12.	Lokoja	LKJ	1	7	26	25	59
13.	Mopamuro	MPA	-	1	17	3	21
14.	Ofu	KFU	-	4	52	41	97
15.	Ogorimagongo	KFA	-	1	10	1	12
16.	Okehi	KKH		1	19 (1FED)	13	32
17.	Okene	KNE	-	2	19	27	48
18.	Olamaboro	LAM	-	2	64	6	72
19.	Omala	BJK	-	1	35	5	41
20.	Yagba East	SAN	-	2	31	6	39
21.	Yagba West	ERE	-	2	16	2	20
GRAND TOTAL			1	50	833	246	1029

2.4.5 Health financing

Health care financing in the state has come mainly from the state government, allocating 2.1% - 4.2% of annual state budgets to health. Also, the LGAs finance primary health care and Federal Government takes up the responsibility of financing tertiary health care. In 2005, 2006, 2007 and 2008 State government health expenditure as percentage of total expenditure was 5.35%, 4.49%, 5.0% and 4.41% respectively.[2]

2.4.6 Primary Health Care Department

a) Epidemiology unit

This Department is involved in the investigation of incidence and distribution of disease or health events in human population and also the condition influencing their spread and the severity. The department is not only concerned with communicable diseases like polio, cholera, etc, but also in non-communicable diseases like sickle cell diseases, malnutrition, RTA and now include the neglected tropical diseases like schistosomiasis, etc.

The Department additionally scrutinizes the effects of certain parameters like age, sex, and socio-economic factors on the distribution of diseases.

The state has a population of about 3.4 million (2006 census figure) made up of 21 LGAs, with some of these having borders with Benue State and hence have high HIV prevalence. Most of the inhabitants are peasant farmers, fishermen and petty traders.

b) Family planning unit

FP service has being on since creation of the state. Acceptors rate coverage so far is 55%, the focus is to reach 80% rate by the year 2017. Many mothers are still unaware of the FP service and some fathers are not cooperating, some couples are still having 5-10 children per family resulting in poor state of living, subjecting women's life to risk there by increasing the material morbidity and mortality rate.
The problems of the programme include; Inadequate number of Contraception Service Provides (CSPs) in many LGAs, Irregular submission of data, Lack of mobility for monitoring and evaluation of the SDPs and LGAs. Criminal abortion is still common among the youth. Ever teenage pregnancy is not uncommon.

1. Collation of data and various office work are still done under hot atmosphere manually.
2. No sponsoring agent for this programme after the European Economic Commission (EEC) folded up since 1993 i.e. no much achievement as all thing become self help issue.

c) Immunization unit

Kogi state NPI is an on-going programme since creation of the state. The state has a target population of 3,478,029. The following are the target population of various groups in the immunization programme.

- Under 1 – 139,121 (4%)
- Under 5 - 695,605 (20%)
- Under 15 – 165, 554 (47.6%)
- Pregnant women – 173,907 (5%)
- WCBA - 765,166 (22%)

d) Malaria control programme

Malaria is one of the leading causes of morbidity and mortality in Kogi State. Records show that between 2006 – 2007 a total of 76,205 cases of Malaria were reported. Under - 5 children account for 60% of the cases reported and this amounted to 45,723 cases.[2]

- The state had distributed 36,500 ITNs out of a targeted number of 92,752 representing 39% for the year 2007.
- Antimalarial drugs (ACTs) distributed and used by health facilities – 150,124 doses out of a targeted number of 742,014 doses representing 20% coverage
- Fansidar for Malaria in Pregnancy – Number distributed and used by health facilities is 53,585 out of a targeted number of 123,699 representing 43%.

e) Leprosy conrtol - There are 988 PHC Clinic even plans are on the way to add more 195 of which runs M.D.T Clinic. The state has 15 DOTS centres.[2]

f) Monitoring and Evaluation unit

Monitoring and evaluation unit is one of the units in primary health care (PHC) department which deals with collection, collation and analysis of PHC activities in the state.

Data of all PHC activities are collected and collated by the M&E offices in the various LGAs for onward transmission to the state M & E officers for analysis and interpretation before it is forwarded to the appropriate quarters for necessary action provision for feedback on M&E information at all level of health care system is of utmost importance in order to involve the community and the health team in decision making and planning on improving service delivery most of our LGA M&E offices have either been transferred or retired and replaced with new ones with little or no knowledge of the work hence the need for training and retraining of the officer to ensure effective report of PHC activities in the state.

g) Nursing Services Directorate

The directorate of Nursing Services, Ministry of Health is responsible for formulation and reviewing of policies concerning nursing education and practice. This is done in collaboration and most times according to the directive of nursing and midwifery council of Nigeria.

Specific activities of the directorate includes; training and retraining of nurses, nursing research, organizing continuing education programme and monitoring and evaluation.

h) Inspectorate unit

The inspectorate unit of the directorate of medical service and training of ministry health is charged under edict 15 of 1995 with registration, inspection and monitoring of private health providers in Kogi state, towards ensuring minimum acceptable standard of practice of private health care providers.

Services rendered by the unit include;

1. Ensuring that all private clinics, hospital are duly registered.
2. Ensuring private health providers comply with minimum standard of practice by adhering to down rule and regulations.
3. Ensuring involvement of private health care providers on current trend on health practice by continuous medical education.
4. Ensuring regular health providers and facility to reduce unethical practice.
5. Ensuring that private health provider co-operate with relevant institution foe collection of health data for proper health planning and evaluation.

i) Dental and oral health unit

The pregnant and nursing mothers and children constitute move then 50% of the entire population therefore special strategic plans to work ensuring good dental and oral health care cannot be over emphasized at the moment. Strategic plan of action for these categories of the population does almost not exist. Therefore there in need to plain adequately toward sensitizing the population an special the age pregnant nursing mother and children off school age on proper dental and oral health care.

The foregoing information was collected from sources in the State and may

2.5 *Key Issues and Challenges*

Public primary health care facilities in Kogi state are about 80% health posts. A substantial proportion of the facilities are in a state of poor repair. Given the relative shortage of alternative sources of care, Kogi health posts necessarily meet a much wider range of health care needs of the population they serve. Kogi primary health care facilities had a mean of 4.0 staff per facility. The chances that a Kogi PHC facility has a village development committee is 83%, Community participation is concentrated in the running of health posts and dispensaries.[3]

In 2000, the estimated Local Government Health Expenditure per capita in Kogi State is 379.5 Naira and proportion of Local Government Expenditure on health is 22%. In 2005, 2006, 2007 and 2008 the estimated per capita health expenditure was N516, N501, N 621 and N664 respectively[4].

Immunization coverage for children under 24 months is low, 2007 survey showed that 46.8% of the children under-24 months were fully immunized. Only 2.7% of households had at least one insecticide Treated Net (ITN) while only 36.2% use improved source of drinking water. Access to sanitary sewage disposal in the State is also low as only 8.2% has flush to septic tank or sewer system, 12.9% has access to sanitary pit latrine and the remaining 78.9% used unimproved sanitation facility. Women of reproductive age group that currently use contraceptives are 8.7% and 86.2% of pregnant women attended antenatal clinic at least once during pregnancy.[4]

The sero-prevalence for HIV in Kogi State shows this trend: 1996 – 2.3%; 1999 – 5.2%; 2001 – 5.7%; 2003 – 5.7% and 2005 – 5.5%.[2]

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[3] Gupta MD, Gauri V, Khemani S. Primary Health Care in Nigeria: Decentralized Service Delivery in the States of Lagos and Kogi, Development Research Group, The World Bank. 2003

[4] MICS Health Survey Data 2007

Chapter 3: Strategic Health Priorities

3.1 Strategic Orientations

The Strategic plan is structured after the Strategic framework which has 8 priority areas listed below:

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

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

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

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

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

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

Chapter 4: Resources Requirements

4.1 Human Resources

Currently, there are about 165 doctors, and 2,850 Nurses/midwives in the primary and secondary healthcare system of the state, the private sector inclusive. This however, varies slightly from the data in the Table below. The difference could be accounted for by the inclusion of personnel from the private sector in the data supplied by the state.

This level of human resource situation can only meet 60% of projected needs within the plan period; hence there is a shortfall of 40% for effective implementation of this framework within the plan period.

4.2 Physical/material resource requirements

The material resource needs include upgraded and refurbished health infrastructure, medical equipment, drugs, etc all of which have been captured in the annex.

4.3 Financial resource requirements

The total estimated financial requirement to implement the 2010 – 2015 (six –year) strategic plan in Kogi state is about of **N 80,745,128,446 (eighty billion seven hundred and forty five million, one hundred and twenty eight thousand, four hundred and forty six Naira only)**. The breakdown according to Goals is as follows:

	Priority Area	Estimated Cost (NGN)
1	Leadership and Governance for Health	807,451,284
2	Health Service Delivery	49,542,160,977
3	Human Resources for Health	23,303,095,402
4	Financing for Health	2,651,438,718
5	National Health Information System	1,211,176,927
6	Community Participation and Ownership	807,451,284
7	Partnerships for Health	807,451,284
8	Research for Health	1,614,902,569
	Total	**80,745,128,446**

Chapter 5: Financing Plan

5.1 Estimated cost of the strategic orientations

The total estimated financial requirement to implement the six –year strategic framework in Kogi state is about of **NGN 80,745,128,446 (eighty billion seven hundred and forty five million, one hundred and twenty eight thousand, four hundred and forty six Naira only)**. The breakdown according to Goals, Strategic objectives and interventions are shown in appendix 1.

5.2 Assessment of the available and projected funds

An assessment of the available and projected funds in Kogi State for the purpose of financing the Strategic health development plan should be undertaken in the context of the fiscal, macro & micro financial environment s in the state as well as her recent past expenditure profile.

a. *Recent Expenditure Profile.*

YEAR	RECURRENT EXPENDITURE	CAPITAL EXPENDITURE	TOTAL	SOURCE
2006	209,225,933	902,500,000	1,111,725,933	**State Budget**
2007	282,754,246	2,007,000,000	2,055,254,246	**- do -**
2008	526,349,064	2,027,000,000	2,552,349,064	**- do -**
2009	527,700,731	2,417,595,114	2,945,295,845	**- do -**
2006 - 2009	**1,546,029,974**	**7,354,095,114**	**8,900,125,088**	

An overview of the general expenditure profile as encapsulated in the table above shows that in the past 4 years, the state had budgeted about N8.9b to the health sector. In view of the increasing budgetary allocation to the health sector the estimated State government budget for health in the next 6 years is about 14 billion naira.

The Local government health expenditure in the last 4 years is not available. It is estimated that the 21 LGAs component of this plan provided for through their budgetary allocation will be about N 4 billion naira for the next 6 years.

However, budgetary allocation is most times not the same with actual expenditure at all tiers of government.

b. *Support from Development partners.*

Development partners working in the state include UNICEF, WHO and EU-Prime. They provide direct programmatic support and technical assistance to programmes. The quantum of their support is in the region of 5 - 10% of the health expenditure of Kogi State. This is estimated to be about 1.4 billion naira over the next 6 years

As a result of the above analysis, the likely available financial resources from State government, LGAs and partners is about 36% of the total estimated cost of the 2010 – 2015 strategic health plan.

5.3 Determination of the financing gap

Based on the fact that about 36% of the required funds for the State Strategic Health development Plan could be met from State government, LGAs and partners support, the financing gap is about 64%. This is subject to variations based on the statutory receipts by the State Government from the Federation account.

5.4 *Descriptions of ways of closing the financing gap*

Possible ways to close this financial gap include:

- Increase in Internally generated revenue in the state through an improved tax drive.
- Improved allocation to the Health Sector in the State
- Participation of the State in the National Health Insurance Scheme
- Plugging of possible sources of financial leakage like proper staff audit at the ministry, entrenchment of fiscal responsibility and due process in the award of contracts.
- Greater coordination & harmonization of donor assistance from development partners in line with the Paris declaration on Aid effectiveness, and Accra high level meeting. This will ensure that donor funds are better utilized, while parallel programmes by different donors and development partners are abolished.

Chapter 6: Implementation Framework

6.1 ***Macro Structures:*** The macro structure on which the entire plan revolves is the Government of Kogi State, represented by the Ministry of Health, with supporting structures that include the State Hospital Management Board, and service providers at the periphery in a symbiotic arrangement.

Role of Kogi State Ministry of Health are as follows

- Policy formulation, and regulation,
- Enforcement/Implementation of National Health Polices at the State level
- Implementation of Capital Projects,
- Supervision of the Hospitals of all private and voluntary Agency Health establishments
- Registration and inspection of Pharmacy shops and patient medicine vendors,
- Ensuring Health promotion, preventive, rehabilitative and curative Health services

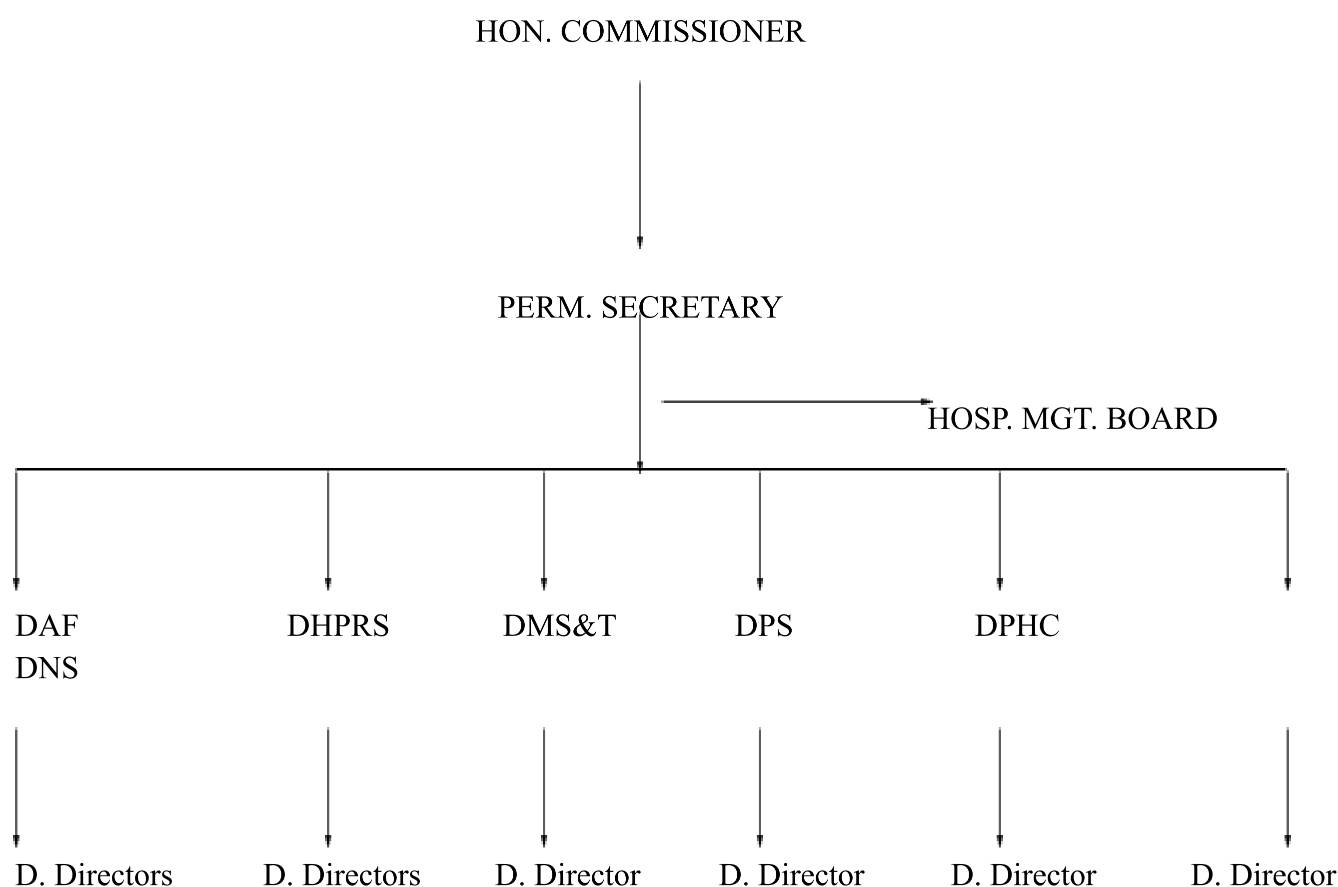
However, in consonance with the draft National Health bill of 2004, it was stated that the State Ministry of Health should ensure the implementation of the National Policy, norms and standards in the state. Consequently the under listed functions were vested in the hands of the Honorable Commissioner for Health at the state level.

- Plan and manage the State Health Information System,
- Participate in national, inter-state and inter-sectoral co-ordination and Collaboration,
- Provide technical and logistics support to Local Government Health Authorities
- Plan, co-ordinate and monitor health services delivering during disasters,
- Conduct or facilities research on health and health services,
- Plan, manage and develop human resources for rendering of health institutions and health agencies.
- Control and manage the cost and financing of public health institutions and public health agencies
- Determine financial and other assistance received by the state from foreign governments and intergovernmental organizations, the conditions applicable to receiving such assistance and the mechanisms to ensure compliance with these conditions,
- Facilitate and promote the provision of comprehensive primary health services and community hospital services

- Provide and co-ordinate emergency medical services, pathology, forensic clinical medicines and related services.
- Control the quality of all health services and facilities,
- Provide health services under the specific state health services programmes
- Provide and maintain equipment, vehicle and healthcare facilities in the public sector,
- Ensure that Local Government Health Authorities consult with communities regarding health matters
- Ensure health system research; and
- Provide Service for the management, prevention and control of communicable and non-communicable disease.

Honorable Commissioner is the Chief Executive Officer, while the Permanent Secretary is the routine officer of the Ministry

Organogram Of Kogi State Ministry Of Health



6.2 Departments and Responsibilities

a) Directorate of Medical Services and Training

The Directorate of Medical Services and Training is responsible for policy formulation, control and regulation. Secondary (curative) health care services in the state. Other specific duties of the department include:

- Regulation of Medical, Dental, Radiological, Laboratory and Physiotherapy practices in the State.
- Attend National Council on Health meeting,
- Represents the state on the Medical and Dental Council of Nigeria,
- Registrations, Inspection and Control of Private Health Institutions,
- Supervises the Hospitals Management Board,
- Co-ordinates the National Blood Transfusion Services,
- Administration of the Department of Medical Services,
- Organization of the training and the training needs of the Department and the parastatals under its supervision.

b) Directorate of Pharmaceutical Services

This department is saddled with the following responsibilities;

- Enforcement of Federal and State Health Policies on drugs and Pharmaceutical Services
- Inspection of Pharmaceutical premises/patient medicine shops throughout the State
- Procurement, storage and distribution of drugs and other Medical consumables used in all the Health facilities belonging to the State Government.
- Educating the Public on dangers of drugs abuse.
- Representation of the Pharmacists Council of Nigeria at the Federal and state levels

c) Directorate of Health Planning, Research and Statistics

The responsibilities and functions of the department are enormous. The complex role of modern government requires a Directorate with the requisite expertise to assist in the development of a culture of monitoring, utilization of information for informed decision-making process. Consequently, the general functions of the Directorate are:

- Co-ordinates the activities of all the operational Departments in the Ministry and to ensure proper implementation of Plans (Rolling, Medium and Perspective);

- Monitoring and Evaluation of Programmes, projects and plans implementation:
- Serving as Secretariat to all policy bodies within the health sector, including senior and Top Management Committees of the Ministry, National Council on Helath; and state council health.
- Serving as Secretariat of the Tenders Boards;
- Conducting research into the sectors over which the Ministry has jurisdiction, in Collaboration with other Departments and Agencies, Institutions and Parastatals;
- Conducting research into the internal organization, Operational and Management modalities of the Ministry;
- Establishment and Monitoring of Performance and Efficiency Targets for the Various Sub-divisions and staff of the Ministry, in collaboration with other Departments;
- Routine collection, collation and processing of Health Data and in custody of State Health Data Bank
- Computer services, Registry, Library, etc
- Liaison with relevant bodies outside the Ministry
- Coordinates with external bodies for technical and operational supports

d) Directorate of Administration and Finance

The Directorate is saddled with the following responsibilities:

- Implements all financial and personnel matters
- Represented in the committee on Procurement of drugs and medical equipment.
- The Department is responsible for the implementation of policies and decisions of the Ministry on Personnel and financial matters
- Oversees the various accounts and government releases
- Responsible for the preparation and settlement of salaries, allowances etc
- Co-ordination of the implementation of the staff training polices staff training
- Involved in the preparation of annual Budget.
- In-charge of staff general welfare

e) Directorate of Nursing Services

The Department performs the following functions;

- Formulation and regulation of Professional Nursing Education and Practice.

- Conducts entrance examination for admissions into schools of Nursing and Midwifery for Basic and Post Basic courses in the state.
- Oversees the activities of the schools of Nursing and Midwifery to ensure compliance with the Nursing and Midwifery Council of Nigeria;
- Co-ordinates all Nursing Council activities in the State;
- Organize continuing Education Programme for Nurses and Midwives in collaboration with the professional association.
- Facilitates registration and re-licensing of the Nursing staff in the state.

f) Directorate of Primary Health Care

The Directorate of Primary Health Care/Public Health has the following responsibilities

- Health Policy Formulation consonance with Federal Guideline (National Health Policy),
- Health Promotion services e.g. Immunization, Potable Water Borehole, ITN, VIP latrine, Nutrition, etc
- Community mobilization for full participation in Health Care Services,
- Training and Development of PHC and Public Health Technology,
- Promotion and Development of environmental and occupation/ Health Education Policies
- Liaise with health related Ministries / Departments for inter-sectoral approach in health policy implementation e.g. Ministry of Agric, Education, Information, Rural Development, etc.
- Reproductive Health Service
- Monitoring, Supervision and Evaluation of PHC activities at LGA and State level.

6.3 Micro Structures

Departments of Planning Research & Statistics, Ministry of Health (MOH);

Directorate of Primary Health Care, MOH; Primary Health Care dept of Ministry of Local Government; MOH DH PRS; Ministry of Finance; PRS; Ministry of Budget and Planning; MOLG; Dept of Accounts, MOH; Directorate of Pharmaceutical Services, MOH. Directorate of Nursing Services, MOH; Directorate of Medical Services and Training, MOH;

Others include Professional Associations; Nigeria Medical Association, National. Association of Nigerian Nurses & Midwives, Medical & Health Workers Union; Assoc. of Community Pharmacists; Assoc. of Private Medical Practitioners; Traditional Health Practitioners

Other key actors are the Programme Managers for TBLCP, Malaria, NPI, IMNCI, Safe Motherhood, Nutrition etc. FBOs, Federal Medical Centre Lokoja and State Specialist Hospital, Lokoja.

S/N	***Strategic partners***	***Roles and their Inter relations***
1	Federal Medical Centre, Lokoja	Tertiary & specialist referral
2	Proposed Kogi State College of Medicine	Tertiary & specialist referral and human resource development
3	College of Health Sc. & Tech. Idah	Env. & Comm. Health Officers
4	Schools of Nursing & Midwifery	Manpower base for Nurses
5	All PHC Health Facilities	Provide direct primary care
6	Private & Faith based practitioners	Strategic alternative service
7	Civil Society groups	Community Interface
8	Individuals and families	Primary recipient stakeholders.

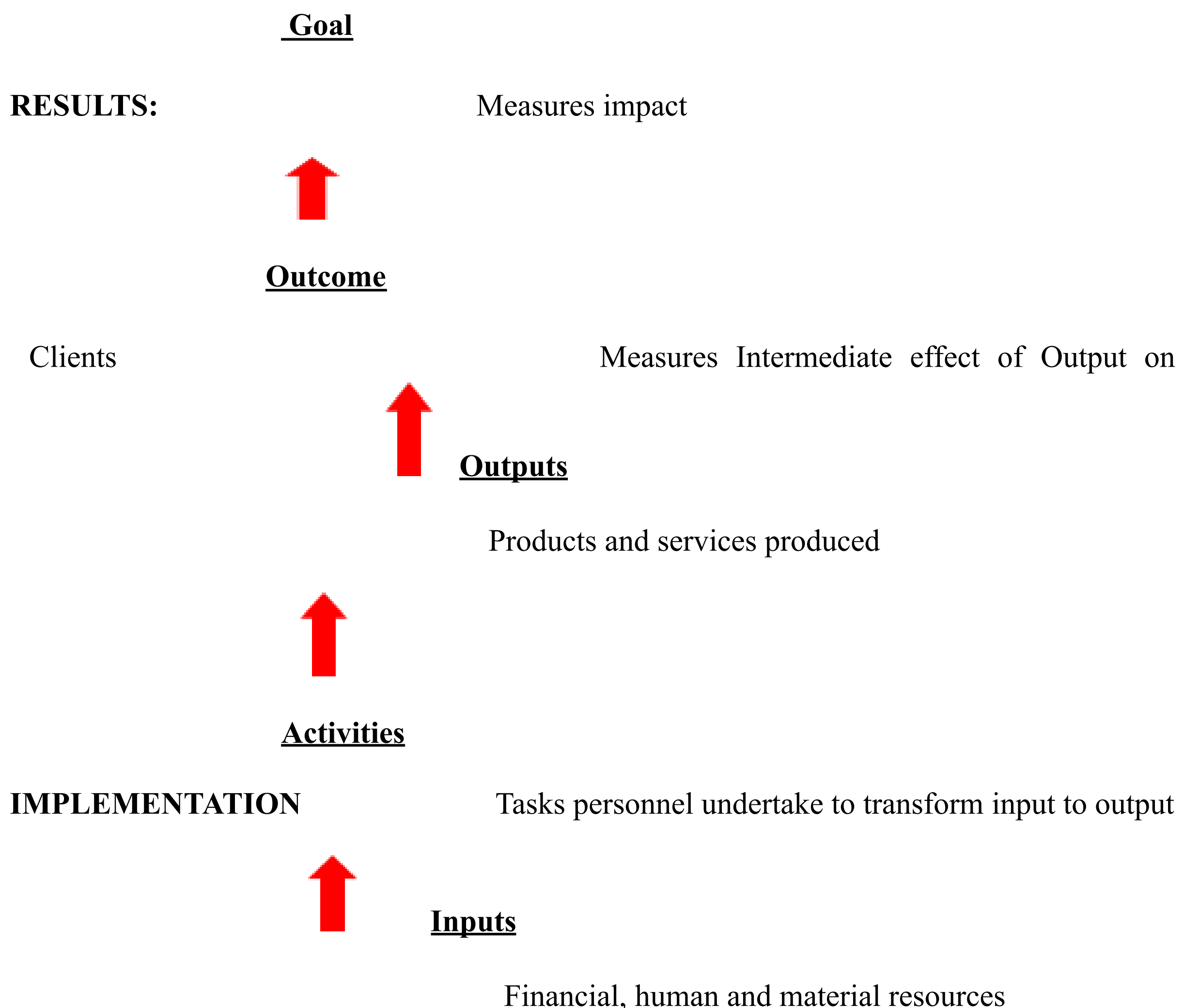
Chapter 7: Monitoring and Evaluation

7.1 Proposed mechanisms for monitoring and evaluation

Monitoring and Evaluation of a Strategic plan is best done at the operational level. It is not feasible to have a M&E approach that can effectively monitor the eight domains, with the various strategic objectives, interventions and activities. However current Monitoring and Evaluation approach in the state need to be overhauled and harmonized as much as possible to avoid parallel data collection for same interventions and activities.

However, the guiding principles for monitoring and evaluating a strategic framework in this model below can be followed:

- **Combination of Implementation monitoring and result-based monitoring[5].**



[5] Jody Zall Kusek, Ray C Rist; Ten Steps to a Result based Monitoring & Evaluation System- World Bank 2004.

** Should contain essential ingredients of the ten steps to designing, building, and sustaining a results-based Monitoring and Evaluation system, namely:**

1. Conduct a Readiness Assessment
2. Agree on Outcomes to Monitor and Evaluate
3. Select key Indicators to monitor outcomes
4. Obtain baseline data on indicators- where are we today?
5. Plan for Improvement- Select Result targets
6. Monitor for Results
7. The Role of Evaluations
8. Report Findings
9. Use findings
10. Sustain M & E system within the organization.

** Monitoring and Evaluation should be decentralized and Intervention focused.**

The present system of central monitoring and evaluation in ministries and parastatals where data are collected from various programme managers and transmitted to the state M&E focal person for collation, analysis and reporting is unsustainable, as well as disempowering to field officers and programme managers who will have to rely on the M & E unit always. Programme officers in addition to sending such data to the state M&E unit should have capacity to also use such data for their activities for monitoring and evaluation of performance.

Programme managers will require training and retraining on different aspects of performance monitoring & evaluation, as well as outcome and impact monitoring techniques. The entire M&E plan will require a different framework, and is beyond the scope of this work as presently packaged. The state can adopt the national M&E that is developed at the National level for the purpose of monitoring the plan using the indicators agreed upon at the national level.

7.2 Costing the monitoring and evaluation component and plan

The cost of the proposed M&E framework is within the internationally prescribed cost of monitoring and evaluation in the context of overall programme cost; 1%. It is therefore projected that the cost of monitoring the Kogi State Strategic Health Development Plan is N **N 2,786,056,811.00** (Two billion, seven hundred and eighty six million, fifty six thousand, eight hundred and eleven Naira only). However, some part of this amount is already built into some of the interventions and particularly to some extent taken care of in the Health Information Management System domain.

Chapter 8: Conclusion

Any strategic document, plan or programme of action is as good as the quality and level of its implementation. There is a high level of cynicism on the ability of the health actors at all levels to implement this plan based on the national framework. However, the operational plan framework has been able to show the various activities that the various actors in the State are familiar with.

The lack of implementation of plans in the past and the non-provision of adequate resources to implement such plans is a major set-back and can possibly be constraints in implementing this plan. There is need for strong political will for this plan to be implemented.

Subsequent administrations should learn to work with plans that are already well developed with minimal variation to fit in with their political agenda.

Annex 1: Detailed activities for the Kogi State strategic health development plan

KOGI STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
PRIORITY AREA							
Goals					BASELINE YEAR 2009	RISKS AND ASSUMPTIONS	Total Estimated Cost (2010-2015)
	Strategic Objectives				Targets		
		Interventions			Indicators		
			Activities		None		
LEADERSHIP AND GOVERNANCE FOR HEALTH							
1. To create and sustain an enabling environment for the delivery of quality health care and development in Nigeria							807,451,284
	1.1	To provide clear policy directions for health development			All stakeholders are informed regarding health development policy directives by 2011		550,141,278
		1.1.1	Improved Strategic Planning at State level				162,306,436
			1.1.1.1	Conduct a stakeholder meetings to develope a state strategic health development plan	1. Number ofstrategic plan drafting meetings held. 2. Availability of a draft report	Availability of funding /Attendance by stakeholders	84,725,041
			1.1.1.2	Present the strategic plan to policy makers (executive, legislature and judiciary) in a dissemination meeting.	Number of advocacy visits made	Political Will/Executive support	18,663,645
			1.1.1.3	Re-orientate and strengthen human resource capacities through retreats, workshop and seminars for members of executive, legislators and juditiary.	1. Number of retreats/seminars held. 2. proportion of executive/legislative members with corrent knowledge of the state strategic health plan.	Availability of political will	45,046,590
			1.1.1.4	Support State / LGAs in the development of health sector plans	Percentage of LGAs with developed strategic plan	Co-operation of LGA authority	6,935,580
			1.1.1.5	Institionalize the strategic health development plan in the state annual budget estimate (15% of total state budget)	15% budgeted for health in the annual budget.	Political will and commitment.	6,935,580
		1.1.2	Strengthen regulatory functions of government				81,282,220
			1.1.2.1	Include NGOs and FBOs etc in health care delivery activities through subventions and grants-in-aid	% of funding to FBOs among the total health budget per annum	Availability of funds	34,677,898
			1.1.2.2	Facilitate public-private partnership (PPP) in healthcare delivery / set up a PPP steering committee / Quarterly PPP review meeting	% representation of private sector in health committees or fora	Private health sector cooperation	6,935,580
			1.1.2.3	Set up a committee to review existing health laws and regulations	1. Health laws review committee in place. 2. No of review meetings held. 3. Minutes of meetings and draft report available	Availability of funding / skilled manpower	4,300,059
			1.1.2.4	Establish a state monitoring committee to monitor and enforce standards among private health practitioners	No of monitoring visits conducted per quarter	Availability of funding / skilled manpower	33,981,566
			1.1.2.5	Draft a bill for the regulation of practice of alternative medicine	Draft bill in place by the end of 2009 at the House of Assembly.	Availability of skilled manpower	1,387,116
		1.1.3	Improve accountability and transparency		State have an active health sector 'watch dog' by 2013		36,065,014
			1.1.3.1	Decentralize the decision-making process in the health sector	Each sector of health care delivery has a	Intersectoral cooperation	-

					Health Committee in place by end of 2010		
			1.1.3.2	Institute quarterly accountability forum on public expenditure in health	No of Quaterly Reports produced.	Availability of funds	11,096,928
			1.1.3.3	Establish an independent monitoring body to monitor and render bi-annual reports on health sector spending	A functional Independent monitoring body in place by 2010	Availability of funding / skilled manpower	8,322,696
			1.1.3.4	Approve and release funds timely as budgeted for project implementation	% of project implementation per year	Political will and commitment.	-
			1.1.3.5	Awareness creation on health projects and programmes to beneficiary communities.			16,645,391
		1.1.4	Improving and maintaining Sectoral Information base to enhance performance		State and at least 50% of LGAs update their plans annually		**270,487,607.92**
			1.1.4.1	Conduct state demographic health survey once every 2 years for data updates (both communicable and non-communicable diseases)	No of survey reports available	Stable political and social environment / Availabilty of funds	55,484,638
			1.1.4.2	Collaborate with NGOs, corporate bodies, individuals and health research institutes/universities for health researches	No of research reports available	Sectoral cooperation / Availabilty of funds	8,322,696
			1.1.4.3	Provide modern information and communication technology (ICT) in all sections of health.	No of health institutions with computers and Internet access	Availability of skilled manpower	34,677,898
			1.1.4.4	Provide fund for health system research	% of annual budgetary provision for research	Political will and commitment/availab ility of fund	27,742,319
			1.1.4.5	Adequate training of human resources to meet modern standards for operating the ICT			144,260,058
	1.2	**To facilitate legislation and a regulatory framework for health development**			**Health Bill signed into law by end of 2009**		**108,229,721**
		1.2.1	Strengthen regulatory functions of government				**108,229,721**
			1.2.1.1	Establishing Kogi state primary health care dev. Agency			9,154,965
			1.2.1.2	Set up an integrated monitoring and eveluation unit to strenghten the regulatory functions of the government.			4,854,906
			1.2.1.3	Empower of the monotring and evaluation unit adequately to enable them enforce these health regulations.			61,622,626
			1.2.1.4	Upgrade ICT facilities to facilitate regulatory communication.			21,916,432
			1.2.1.5	Set up a competition among the LGAs regulatory system by awarding best practices			10,680,793
	1.3	**To strengthen accountability, transparency and responsiveness of the national health system**			**80% of States and the Federal level have an active health sector 'watch dog' by 2013**		**45,670,792**
		1.3.1	To improve accountability and transparency				**45,670,792**
			1.3.1.1	Training on Servicom for Programme state managers & PHC Coordinators at LGAs		Trainers are themselves transparent & accountable	20,772,061
			1.3.1.2	Set up a surveillance (auditing) unit to oversee the activities of State and LGAs health accounting system on quarterly basis.			13,801,804
			1.3.1.3	Establish an account bulletin for the State and Local government publication system with a view to highlighting best practices			4,161,348

			1.3.1.4	Set up an award programme for best practices.			2,774,232
			1.3.1.5	Advocate for realistic health budgets at LGA levels to prvent fraud.			4,161,348
	1.4	**To enhance the performance of the national health system**			**1. 50% of States (and their LGAs) updating SHDP annually 2. 50% of States (and LGAs) with costed SHDP by end 2011**	**Various levels of government have capacity to update sectoral SHDP States may not respond in a uniform and timely manner**	**103,409,493**
		1.4.1	Improving and maintaining Sectoral Information base to enhance performance				**103,409,493**
			1.4.1.1	Adequate training and re-training of skilled human resources to man the information base.			72,199,385
			1.4.1.2	Provision of infrastructural equipment / logistics for improving the sectoral information base.			18,726,065
			1.4.1.3	Strengthen Servicom units at State and LGAs			8,322,696
			1.4.1.4	Improve collaboration between partners in supporting the establishment /improvement of the information base of the State and the LGAs.			4,161,348
HEALTH SERVICE DELIVERY							
2. To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare							**49,542,160,977**
	2.1	**To ensure universal access to an essential package of care**			**Essential Package of Care adopted by the State by 2011**		**5,882,934,439**
		2.1.1	To review, cost, disseminate and implement the minimum package of care in an integrated manner				**4,847,135,855**
			2.1.1.1	Review of the existing health care package		**Existing package includes IMNCH.**	13,248,331
			2.1.1.2	Disseminate information on minimum health care package to stakeholders in health care		**Stakeholder buy-in assured.**	46,174,332
			2.1.1.3	Implement the minimum health care package at all levels of health care delivery		**Stakeholder buy-in assured.**	4,460,401,474
			2.1.1.4	Create of more outreach centres to improve coverage		**Stakeholder buy-in assured.**	303,932,310
			2.1.1.5	Evaluate the impact of the health package at the LGA level.		**Stakeholder buy-in assured.**	23,379,408
		2.1.2	To strengthen specific communicable and non communicable disease control programmes				**743,192,429**
			2.1.2.1	Capacity building for all programme managers including FBOs.	**50% of programme managers trained within 1 year.**	**Capacity building of programme managers will strengthen scheme.**	143,101,462
			2.1.2.2	Capacity building for PHCC and LGA programme managers.	**50% of programme managers trained within 1 year.**	**Capacity building of programme managers will strengthen scheme.**	212,070,717
			2.1.2.3	Advocate to improve funding for the programmes.			10,520,734
			2.1.2.4	Establish / review collaboration with partners.			16,287,655
			2.1.2.5	Monitor and evaluate the programmes.			77,152,048
			2.1.2.6	Create programmes for non-communicable diseases such as Cardiovascular Diseases, cancer and diabetes awareness and prevention.			284,059,813
		2.1.3	To make Standard Operating Procedures (SOPs) and guidelines available for delivery of services at all levels				**79,879,646**

			2.1.3.1	Print 10,000 copies of SOPs & guidelines for destribution to secondary & Primary health facilities			58,448,521
			2.1.3.2	Train and re-train health service providers on the use of SOPs & guidelines.			11,689,704
			2.1.3.3	Translate SOPs to local languages with appropriate pictorial illustrations.			9,741,420
		2.1.5	To control blindness				**212,726,510**
			2.1.5.1	Create awareness about blindness & ear diseases	**80% of ppopulation is aware of prevention of blindness & ear disease**	**Availability of stakeholders at meetings &that awareness will be created**	38,342,230
			2.1.5.2	Capacity building of health workers on prevention of blindness & ear diseases	**No of health workers trained**		27,496,522
			2.1.5.3	Mass distribution of drugs & materials	**Availability of drugs & materials**		42,005,004
			2.1.5.4	Management of cataract & ear diseases	**Reduction in prevalence rate of blindness & hearing impairement**		104,882,754
	2.2	**To increase access to health care services**			**50% of the population is within 30mins walk or 5km of a health service by end 2011**		18,774,171,531
		2.2.1	To improve geographical equity and access to health services				14,041,283,052
			2.2.1.1	Map health care facilities in kogi state.	**80% of haelth faclities mapped in the state /LGA by 2010. No of h/f mapped**	**staff commitment**	9,741,420
			2.2.1.2	Develop criteria for siting of new health care facilities in kogi State.	**80% of new H/F sited in line with dev critria by 2011. NO of new H/F sited**	**staff commitment and political support**	3,896,568
			2.2.1.3	Upgrade existing health facilities in kogi State.	**80% of existing substd H/F upgraded by 2013. no of existing sustd H/F upgraded**	**political support**	11,689,704,220
			2.2.1.4	Refurblish substandard health facilities in kogi state.	**80% of existing substd H/F refurbished 2013. no of existing substd H/F refurbished**	**political support**	2,337,940,844
		2.2.2	To ensure availability of drugs and equipment at all levels				**3,887,995,624**
			2.2.2.1	Review the already existing essential drug list	**75% of H/F using the reviewed essential drug list by 2010. No of H/F using the EDL**	**staff commitmnt , adequate staffing**	7,793,136
			2.2.2.2	Strenghten the existing procurement and distribution system.	**75% of H/F operating DRF by 2010. No of H/F operat DRF**	**political support, political interference, commitmnt of staff**	89,621,066
			2.2.2.3	Revitalize and recapitalize the Drug Revolving Fund system at State and LGAs			669,430,395
			2.2.2.4	Provide 21- 4- wheel utility vehicles for colllection and distribution of drugs and other commodities.			580,588,643
			2.2.2.5	Develop Equipment list for different levels of Health Facility in line with the essential package of care.	**All levels of health facility having the equipment list**	**political suport& staff commitmnt**	7,793,136

			2.2.2.6	Procure and distribute Equipment based on need.	**75% of equipmnt proc. & dist. at all level of health care delivery.**	**Political & staff commitment**	1,948,284,037
			2.2.2.7	Refrubish and upgrade existing central equipment store, build new zonal ones.			584,485,211
		2.2.3	To establish a system for the maintenance of equipment at all levels				**128,781,575**
			2.2.3.1	Adapting the national health equipment policy in the state and LGA	National health equip policy adapted by 2010 in the state and all LGAs	political & Stake holders commitment	1,168,970
			2.2.3.2	Dev.,Disseminating and implementing the the state health equipment policy	state health equip policy dev. & disseminated by 2011 in all LGAs	political & Stake holders commitment	13,637,988
			2.2.3.3	Establishment of medical equipment and hospital maintenance workshop	Electromech/medical workshop in place by 2011.	political & Stake holders commitment	113,000,474
			2.2.3.4	Establish public private partnership in maintenance of medical equipment and furniture	Train tech service team by 2011	political and stakeholders commitment	974,142
		2.2.4	To strengthen referral system				**661,637,259**
			2.2.4.1	Mapping / Dev. Of network linkages for two way refferal system in line with national standard	**70% of 2-way referal netwk linkgs estb. In the state. No of netwk linkages estab.**	**logistics, Political &staff commitmnt**	5,844,852
			2.2.4.2	Provision of 15 standby, equiped ambulances for the referral system; 5 per zone	**100% of referal centres provided with equip ambu. By2015.no of amb prov.**	**political support and commitmnt**	596,174,915
			2.2.4.3	Establishment and implematation of guildline for two way referrals	**80% of guidline for referral estab. No. Of guidline for referral established.**		35,653,598
			2.2.4.4	Monitoring of referral outcomes and creation of two-way data	**85% of facilities monitored for referal outcomes.no of facil monitored**	**staff commitmnt , adequate staffing, political support**	23,963,894
		2.2.5	To foster collaboration with the private sector				**54,474,022**
			2.2.5.1	Mapping of all categories of private health care provider by operation and location	**80% of private sector providers mapped by 2010. No. Of private sector mapped.**	**political will and private sector committement**	11,689,704
			2.2.5.2	Develop of guidelines and standards for regulating their practice	**80% of guidline and standard developed by 2010. No. Of guidline and standard developed by 2010**	**political will and private sector committement**	25,327,692
			2.2.5.3	Adapt and implement the national policy of traditional medicine at state & LG levels	**national policy on tradomedcine adapted by Q2 2010**	**political will and coorporation from tradomed practitioners**	6,039,681
			2.2.5.4	Development of guidelines partnership training, training and outsourcing of practices	**80% of partnership guidline deve. by Q3 2010 No. Of guidline deve.**	**private sector coorporation in political will**	11,416,944
	2.3	**To improve the quality of health care services**			**50% of health facilities participate in a Quality Improvement**		**516,334,235**

					programme by end of 2012		
		2.3.1	To strengthen professional regulatory bodies and institutions				**155,512,032**
			2.3.1.1	Standardize and regulate health practices at all levels of health care delivery	80% of practitioners use the standardized practice by 2015. No. Using the practice	atitude of the health practitioners towards the lay down standard	2,182,078
			2.3.1.2	Implement the operational guidelines and policies of the professional regulatory bodies	periodic review and update of the guidline. No. Of reviews and updating done	political support and regulatory bodies committement	3,312,083
			2.3.1.3	Build the capacity of regulating professinal bodies in the State..	80% of council staff capacity built. No. Of staff of the council that had their capa. Built	political will and committement of regulatory staff	35,069,113
			2.3.1.4	Conduct regular monitoring exercises with appropriate documentation and feedback mechanism	quaterly monitoring excercises. No. Of monitoring activity carried out	monitoring staff committement	56,500,237
			2.3.1.5	Institute award system for best practices among the professional regulatory bodies.			58,448,521
		2.3.2	To develop and institutionalise quality assurance models				**95,271,089**
			2.3.2.1	Reviewing of existing quality assurance modules	75% update to the new standard adopted at all levels by 2010. adopted std reviewed	political will and committement of professional bodies	5,065,538
			2.3.2.2	To organise stakeholders forum to build consensus on the modules to be adopted	65% % of stake holders and attand the forum. No. Of forum held	committement of stake holders	5,455,195
			2.3.2.3	Capacity buiding / TOT on quality assurance training modules be cascaded to other health workers	80% of TOT caapacity built. No. Of TOTs trained	political wills and good governace	61,370,947
			2.3.2.4	Entrenching the ideals of servicom using servicom guidelines	75% of servicon guidlines entenched. No. Of practitioners using Servicon guidline	political and staff committement	**23,379,408**
		2.3.3	To institutionalize Health Management and Integrated Supportive Supervision (ISS) mechanisms				**34,484,627**
			2.3.3.1	Organising team building and leadership development programme for health management and health teams			11,689,704
			2.3.3.2	Development of intergrated supportive supervision tools			7,695,722
			2.3.3.3	Development of guidelines that will specify modalities and frequencies of ISS at all levels			7,306,065
			2.3.3.4	Institutionalization of comprehensive integrated supportive supervision at all levels			7,793,136
		2.3.4	To ensure Safe Blood transfusion				**153,135,125**
			2.3.4.1	strenghening the secondary health facilities by keying them into national blood transfusion scheme			46,758,817
			2.3.4.2	Establishing functional Ambulance services that will be coordinated at the state min of health			106,376,308
		2.3.5	To provide quality Public health laboratory services				**77,931,361**
			2.3.5.1	Establishment of a fully equiped public health laboratory in the state.			77,931,361
	2.4	**To increase demand for health care services**			**Average demand rises to 2 visits per**		**24,345,925,849**

					person per annum by end 2011		
		2.4.1	To create effective demand for services		To improve access to health care by 80% by 2015		**986,221,379**
			2.4.1.1	Establich/strengthen Servicom units in MOH LGAs to help reorientate healthworkers on the need to improve services as a means to improve demand			85,724,498
			2.4.1.2	Create bi-annual performance awards/incentives for the most patient-friendly health worker at State & LG facilities			39,744,994
			2.4.1.3	Establish/strengthen village/ ward health-development committees in all LGAs			71,696,853
			2.4.1.4	Improve the physical environment of health facilities at state & LGAs by beautification, provision of decent canteen services			748,141,070
			2.4.1.5	Regular Performance monitoring of facilities at State & LG levels to ensure quality delivery as means of improving demand.			40,913,965
		2.4.2	Increase demand for Integrated Maternal, Newborn & Child Health Services in the State		Reduce maternal and Child mortality by 75% and 67% respectively by 2015		**6,005,001,058**
			2.4.2.1	Conduct a situation analysis of MNCH in the State			12,663,846
			2.4.2.2	Orient & sensitize major stakeholders in the state on the situation of MNCH			16,560,414
			2.4.2.3	Establish a State Partnership for Maternal, Newborn & Child Health			13,637,988
			2.4.2.4	Develop Implementation Plan & Advocate for funding for MNCH			10,131,077
			2.4.2.5	Roll out the implementation of IMNCH in Pilot LGAs in each of the senatorial zones			5,952,007,732
		2.4.3	To control HIV and AIDS		Reduce burden of HIV and AIDS by 50% by 2015		**9,796,857,631**
			2.4.3.1	Scale up ART sites to eleven LGAs	100% of the LGAs have ART services		7,596,855,297
			2.4.3.2	Advocacy and Grassroot Sensitization/Awareness creation / World AIDS day celebrations			740,347,934
			2.4.3.3	Capacity building for health workers in public and private health institutions			1,130,004,741
			2.4.3.4	Intergrated stake holders meeting			50,655,385
			2.4.3.5	Monitoring and Supervision of HIV/AIDS activities			278,994,274
		2.4.4	To reduce the burden of malaria		Reduction in malaria burden by 50% yearly as from 2010		**7,270,138,780**
			2.4.4.1	capacity development for malaria control personels			31,757,030
			2.4.4.2	procure and distribute RBM Commodities and Equipments based on needs.			7,041,644,028
			2.4.4.3	Regular Performance monitoring of facilities at State & LG levels to ensure quality delivery as means of improving demand for malaria.			167,162,770
			2.4.4.4	promote occupational and Environmental Health sevices			26,808,388
			2.4.4.5	conduct advocacy visits LGA for support on Malaria			2,766,563
		2.4.5	To reduce the burden of Tuberculosis and Leprosy		Reduce the burden of Tuberculosis by 50% annually and eliminate leprosy by 2015		**287,707,000**

			2.4.5.1	Awarenes creation for Government support		stakeholders will buy into it.	149,628,214
			2.4.5.2	Conduct Qtrely statistical meeting for 30 QA and 30LGTBLS officers Qtrely			45,169,017
			2.4.5.3	ACSM			21,228,503
			2.4.5.4	Training of 2 TBLs yearly/Leprosy case finding in 5LGAs yearly			27,120,114
			2.4.5.5	Monitoringand Evaluation			44,561,152
	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**		**22,794,923**
		2.5.1	To improve financial access especially for the vulnerable groups				**22,794,923**
			2.5.1.1	Advocacy to State House of Assembly for Passage of State Health Insurance bill		Adequate provision for vulnerable groups in the draft bill	974,142
			2.5.1.2	Development of guidelines for participation of vulnerable groups in the state Social health Insurance scheme when the bill is passed.			3,506,911
			2.5.1.3	Awarenes creation for Government support for the vunerable groups at the LGA level			5,844,852
			2.5.1.4	Establish collaboration with partners in support of vunerable groups			779,314
			2.5.1.5	Recruitment of the vulnerable People in the scheme where applicable			11,689,704
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							**23,303,095,402**
	3.1	**To formulate comprehensive policies and plans for HRH for health development**			**State and all LGAs are actively using adaptations of the National HRH policy and Plan by end of 2015**		**6,099,349**
		3.1.1	To develop and institutionalize the Human Resources Policy framework				**6,099,349**
			3.1.1.1	Domesticate the national HRH policy and strategy.	All LGAS and health intitutions are actively using HRH policy and plans by end of 2010	Inadeuate personel and logistics	1,258,596
			3.1.1.2	Establish HRH unit in MOH (DPRS) & LGAs.			3,872,603
			3.1.1.3	Adapt policies on training and recruitment of health personel.	Policies updated for use by end of 2010		484,075
			3.1.1.4	Adapt PPP component of the national HRH policy framework to the State			484,075
	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**		**14,592,547,300**
		3.2.1	To reappraise the principles of health workforce requirements and recruitment at all levels				**14,592,547,300**
			3.2.1.1	Use Federal model as a template for the State health work force requirement and recruitment needs.			580,890
			3.2.1.2	Harmonised minimum wage package for all public health workers at all levels.	Harmonised minimum wage paid by 2010		5,171,860,706

			3.2.1.3	Fill existing manpower needs.			9,420,105,704
	3.3	**Strengthen the institutional framework for human resources management practices in the health sector**			**1. State have functional HRH Units by end 2010 2. 10% of LGAs have functional HRH Units by end 2010**		**51,118,354**
		3.3.1	To establish and strengthen the HRH Units				**51,118,354**
			3.3.1.1	Create HRH unit in the Health planning department at the State & LGAs.	Establiment of HRH unit in the State ministry of Health by 2010	Inadequate resources such as personel and equipment.	11,424,178
			3.3.1.2	Identify HRH training needs for the State and LGAs.			6,777,054
			3.3.1.3	Identify available HRH training institutions			6,777,054
			3.3.1.4	Train staff of newly established HRH units			26,140,067
	3.4	**To strengthen the capacity of training institutions to scale up the production of a critical mass of quality, multipurpose, multi skilled, gender sensitive and mid-level health workers**			**One major training institution per senatorial zone producing health workforce graduates with multipurpose skills and mid-level health workers by 2015**		**6,879,291,171**
		3.4.1	To review and adapt relevant training programmes for the production of adequate number of community health oriented professionals based on national priorities				**53,829,175**
			3.4.1.1	Review relevant training programmes for health workers at the community level in the State.	No. ofTrainining and admission progs. reviewed by end of2010.	Political influence on admission guidelines	13,457,294
			3.4.1.2	Train tutors of health training institutions on relevant training programmes			23,913,321
			3.4.1.3	Evaluate training institutions & programmes.			16,458,561
		3.4.2	To strengthen health workforce training capacity and output based on service demand				**6,825,461,995**
			3.4.2.1	Upgrade teaching and learning infrastructure in all health training institutions in the state.			6,680,239,399
			3.4.2.2	Acccreditation and assistiing elligble private sector health facilities for quality training			145,222,596
	3.5	**To improve organizational and performance-based management systems for human resources for health**			**States has implemented performance management systems by end 2012**		**1,756,031,626**
		3.5.1	To achieve equitable distribution, right mix of the right quality and quantity of human resources for health				**1,747,318,271**
			3.5.1.1	Recruit, select,and deploy competent and capable staff to reflect organizational objectives and needs.	No. of skilled health workers selected and deployed by end of2010	Problem of embergo, inadequate vacancies created, heath workers resisting transfers to rural areas.	1,369,739,522
			3.5.1.2	Redeploy staff equitably between rural and urban areas at different areas of health care system in relation to needs.	No. of HRH data base created in the LGAs by the end of 201		-
			3.5.1.3	Improve incentives for health workers such as rural allowances in underserved areas.		Inadequate political will.	377,578,749

		3.5.2	To establish mechanisms to strengthen and monitor performance of health workers at all levels				**8,713,356**
			3.5.2.1	Conduct routine re-orientation of workforce on attitudinal change in interpersonal communication skill and work ethics			6,777,054
			3.5.2.2	Institute a system of recognition & reward.			1,936,301
	3.6	**To foster partnerships and networks of stakeholders to harness contributions for human resource for health agenda**			**State has regular HRH stakeholder forums by end 2011**		**18,007,602**
		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				**18,007,602**
			3.6.1.1	Build the capacity of representatives of professional bodies in the Ministry	50% of LGAS have regular stakeholders forum by 2011	logistics issues and inadequate political will.	2,904,452
			3.6.1.2	Sustain joint enforcement c'ttees of professional associations regulatory councils and the Ministry.			15,103,150
FINANCING FOR HEALTH							
4. To ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and consumption at Local, State and Federal levels							**2,651,438,718**
	4.1	**To develop and implement health financing strategies at Federal, State and Local levels consistent with the National Health Financing Policy**			**State and LGAs have a documented Health Financing Strategy by end 2012**		**1,356,127,028**
		4.1.1	To develop and implement evidence-based, costed health financing strategic plans at LGA, State and Federal levels in line with the National Health Financing Policy				**25,237,946**
			4.1.1.1	To create Health Financing, technical working Groups at State and 21 LGA levels	Functional State and 21 LGAs Health Financial Technical Working groups Created by 1st quarter of 2010.	State & LGA Health Financial Technical Working Group created by 2010.	14,749,328
			4.1.1.2	Request for Technical Assisstance from FMOH to support Capacity building at the State level	No of officers required trained	84 Empowered officers are now available to Implement SHP in State and LGAs.	874,051
			4.1.1.3	Capacity building for the development of Strategic Plans at State level.	No of Officers of trained in line Ministries of MOH, MOLG, MOF, MPED, IMHA, Govt House on mainstreaming Health Financies into the Budget.		9,614,566
		4.1.2	Implement Strategic Plans`at State & LGA levels.		60% of LGAs have implemented the HSDP by the end of 2013.		**43,119,874**
			4.1.2.1	Draft and produce the State & LGA Strategic Health Plan	State & LGA Strategic Health Plan drawn by 1st Qtr 2010.	Skilled Manpower Available	-
			4.1.2.2	Build Capacity for Implementation of State & LGA Strategic Health Plans.	No of Officers trained.	Officers are Empowered to Implement the Health Strategic Plans.	43,119,874
			4.1.2.3	Implement Health Strategic Plans at State & LGA Level	50% State Health Strategic Plan Implemented by 2013.	Difficulty in accessing fund	-
		4.1.3	To establish and implement Health Insurance Scheme at State and LGA levels				**1,188,710,038**

			4.1.3.1	Liase with the relevant Agencies to draft and pass Health Insurance bill	Draft Health Insurance bill presented to the House Assembly &LGA Leg. Council	Availability of funds and manpower	-
			4.1.3.2	Establish health insurance scheme at the state & LGA level	Rolled into the NHIS	That there is adequate community mobilization & utilization	1,118,785,918
			4.1.3.3	Establish community based health insurance	Rolled into the NHIS	Adequate community mobilization	69,924,120
			4,1.3.4	Pilot implementation of CB social HIS (Basic Obst.Care)	modify the scheme where necessary	Acceptance of the Scheme	-
		4.1.4	To adopt national Health act and improve funding of health sector				**78,081,934**
			4.1.4.1	Advocate for the implemention of the stipulated 10% sectoral budget allocation to health at state level		Political will	-
			4.1.4.2	Advocate to State House of Assembly for domestication/ adoption of the National health Act in the state		Sectoral commitment	1,165,402
			4.1.4.3	Provide subventions to private-for-non-profit health providers		Political commitment and availability of funds	69,924,120
			4.1.4.4	Conduct bi-annual donor coordination meeting to harmonize partner financing		Sectoral commitment	6,992,412
		4.1.5	Health Budget Execution, Monitoring and Reporting				**20,977,236**
			4.1.5.1	Set up a budget monitoring unit at SMOH			17,481,030
			4.1.5.2	Step up Health account			3,496,206
			4.1.5.3	Harmonisation Donor Agencies			-
	4.2	**To ensure that people are protected from financial catastrophe and impoverishment as a result of using health services**			**NHIS protects all Nigerians in Kogi State by end 2015**		**1,203,044,483**
		4.2.1	Develop Social Health Protaction Mechanisms to cushion Households from Catastrophic cost of out of pocket expenditures on Health Services.		40% of population by the end of 2015. 80% coverage of vulnerable by end of 2015		**1,203,044,483**
			4.2.1.1	Provide routine free health services at Secondary health facilities to people at risk & indigent groups eg free antenatal care, free under-5 medical services	50% population coverage & 50% of Vulnerable group 2012 and 80% by 2015.	Large proportion of rural dwellers have little protection against economic costs of catastrophic illnesses	1,202,694,862
			4.2.1.2	Advocacy visit to State House of Assembly for possible amendment of NHIS bill to have regulatory authority.	NHIS bill amended by 2013.	Bill at the floor of Kogi State House of Assembly	349,621
	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% pa every year until 2015**		**16,665,249**
		4.3.1	State and LGAs to allocate at least 15% of their total budget to Health sector.				**8,157,814**
			4.3.1.1	Advocate to the State Assembly to pass a bill to secure 10% of total budget to Health.	state allocating 10% of Health budget to Health by the end of 2015.	State & LGA release fund as appropriated	1,165,402
			4.3.1.2	Advocate to facilitate the release of 100% of the State Health budget.	Percentage of Health Budget allocated to	Improvement in infrastructural	-

					capital expenditure annually.	development in Health Sector.	
			4.3.1.3	Advocate to earmark 1% of the State Health allocation for community health insurance	Percentage of Health Budget released Annually.	Inadequate fund released due to fall in State & LGA allocation.	-
			4.3.1.4	Develop Strategies to complement Health Sector funding eg Private Public Partnership (PPP)	% of Health budget allocated to Social Health Protection Programs & Research on annual basis.	Prompt Release of fund & Availability of reliable Data.	6,992,412
		4.3.2	Improve Coordination of Donor-funding mechanisms to reinforce State efforts eg. Sectorial budget support.				**4,661,608**
			4.3.2.1	Revitalize and implement guidelines for donor coordination activities in the state	State Guidelines for donor fund coordination Developed by 3rd Qtr. 2010.	Delay in Production & approval of Strategic Guideline for donor Coordination.	4,661,608
		4.3.3	10% of VAT to be dedicated to Social Health Protection Programs.				**3,845,827**
			4.3.3.1	Advocate to the State House of Assembly to pass a bill to secure 10% of State VAT allocation for Social Health Protection Programs..			3,845,827
	4.4	**To ensure efficiency and equity in the allocation and use of health sector resources at all levels**			**1. States and 50% of LGA levels have transparent budgeting and financial management systems in place by end of 2015.... 2. State and LGAs have supportive supervision and monitoring systems developed and operational by Dec 2012**		**75,601,958**
		4.4.1	Strenghten Financial management skill (competencies in buddgeting, planning, auditing, accounting, monitoring and eveluation at Local Government and State levels.				**37,813,799**
			4.4.1.1	Request for, and obtain FMOH technical assisstance to develope costed annual operational plans at State level.			1,025,554
			4.4.1.2	Build Capacity of Accounts staff of the ministry on proper recording and accounting of expenditures			36,788,245
		4.4.2	Institute creditable mechanism for monitoring and evaluating resource availability use and Health outcomes at all levels.				**37,788,160**
			4.4.2.1	Train Health financial committee to monitor the use of the annual Health accounts at State l Government level.			19,433,078
			4.4.2.2	Build capacity of State officers for supervision, monitoring and eveluation of Health Sector resource availability use.			18,355,081
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							**1,211,176,927**
	5.1	**To improve data collection and transmission**			**1. 50% of LGAs making routine NHMIS returns to State level by end 2010 2. State make routine NHMIS returns to**		**342,857,688**

					Federal level by end 2010		
		5.1.1	To ensure that NHMIS forms are available at all health service delivery points at all levels				**80,281,444**
			5.1.1.1	Create a budget line for NHMIS related activities including printing of forms	No of NHIMS forms printed and circulated	**Political will/comittment**	52,701,167
			5.1.1.2	TRAIN M & E/HMIS OFFICERS AT STATE @ LGA LEVELS ON THE USE OF NHIMS FORMS	No of M&E officers trained on NHIMS	**Political will/comittment**	23,129,957
			5.1.1.3	DISTRIBUTION OF NHMIS FORMS TO LGAs AND HEALTH FACILITES	Quarterly data reports available	**Political will/comittment**	4,450,321
		5.1.2	To periodically review of NHMIS data collection forms				**59,288,813**
			5.1.2.1	Conduct an annual review of the user friendliness of NHIMS forms at State & LGAs		**TIMELY RELEASE OF FUND**	25,033,054
			5.1.2.2	REFRESHER TRAINING ON NHMIS FORMS ON SENATORIAL DISTRICT BASES		FAILURE TO UNDERSTAND THE PROCESS	34,255,758
		5.1.3	To coordinate data collection from vertical programmes				**6,499,811**
			5.1.3.1	Establish interdepartmental & Intersectoral Health Data Consultative Committee at State & LGA levels			6,499,811
		5.1.4	To build capacity of health workers for data management				**114,229,779**
			5.1.4.1	Training and re-training of health service providers on data tools mgt. at service delivery levels.		Availability of Funds	103,777,381
			5.1.4.2	Training and re-training of Data Managers at SMOH & LGA Levels		Availability of Funds	10,452,398
		5.1.5	To provide a legal framework for activities of the NHMIS programme				**8,783,528**
			5.1.5.1	Advocate to State House of Assembly for inclusion of activities of NHMIS in Kogi State Health Bill			8,783,528
		5.1.6	To improve coverage of data collection				**14,822,203**
			5.1.6.1	Scale up Community Based Information System (CBIS) in the state through Village Development Committees and Community Based Organizations.		Availability of funds	14,822,203
		5.1.7	To ensure supportive supervision of data collection at all levels				**58,952,111**
			5.1.7.1	State/LGA M&E/HMIS officers conduct half-yearly supervision of NHMIS implementation			39,042,781
			5.1.7.2	Provide logistic support for supervision			19,909,330
	5.2	**To provide infrastructural support and ICT of health databases and staff training**			**ICT infrastructure and staff capable of using HMIS in the State and 50% of LGAs by 2012**		**125,269,035**
		5.2.1	To strengthen the use of information technology in HIS				**61,682,324**
			5.2.1.1	Periodic ICT trainings for health workers at all levels		Availability of funds	49,678,169
			5.2.1.2	Connect all departments to the Ministry internet and yearly subscription		Availability of funds	12,004,155
		5.2.2	To provide HMIS Minimum Package at the different levels (SMOH, LGA) of data management				**63,586,711**
			5.2.2.1	Construction of HMIS block at SMOH Level		Government Committement	14,639,213
			5.2.2.2	Provide computers (Laptops & Desktops) and accessories to SMOH and 21 LGAs		Avialability of funds/committements	14,639,213
			5.2.2.3	Recruitment of Computer Technologist, Analyist and Scientist.		Avialability of funds/committements	12,129,878

			5.2.2.4	Procurement of 4-wheel vehicle for HMIS unit at SMOH		Avialability of funds/committemen ts	15,224,781
			5.2.2.5	Procurement of Scientific Calculators for all Public Health Facilities		Avialability of funds/committemen ts	6,953,626
	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**		**468,594,239**
		5.3.1	To strengthen the Hospital Information System				**66,557,182**
			5.3.1.1	To provide Computers and accessories to the Public Secondary Health Facilities and HMB		Avialability of funds/committemen ts	31,035,132
			5.3.1.2	To provide Scientific Calculators to Public Secondary Health Facilities.		Avialability of funds/committemen ts	387,939
			5.3.1.3	Provision of Assorted Patient Cards		Avialability of funds/committemen ts	35,134,111
		5.3.2	To strengthen the Disease Surveillance System				**170,927,451**
			5.3.2.2	Create Public awareness on notifiable diseases through printing of IEC material, Radio/NTA jingles for state and LGAs.		Avialability of funds/committemen ts	12,706,837
			5.3.2.3	Train Disease Surveillance and Notification Officers (DSNO) at State, LGA and community levels to build capacity of relevant staff and community members.		Avialability of funds/committemen ts	27,404,607
			5.3.2.4	Train Private and Public Health Institutions on disease Surveillance and notification		Avialability of funds/committemen ts	10,452,398
			5.3.2.5	Training of Health personnel in 1130 health institution in Kogi State on surveilance and notification of outbreak of disease.		Avialability of funds/committemen ts	120,363,609
		5.3.3					**107,949,556**
			5.3.3.1	Epidemic Preparedness and Response for timely response to outbreak and to reduce mortality and morbidity due to communication disease.		Avialability of funds/committemen ts	87,835,278
			5.3.3.2	Case mgt to reduce disability and mortality		Avialability of funds/committemen ts	7,905,175
			5.3.3.3	Advocacy to LGAs chairmen , Traditional Rulers, opinon leaders in the LGAs		Avialability of funds/committemen ts	3,425,576
			5.3.3.4	Programme mgt/coordination/ Monthly meetings		Avialability of funds/committemen ts	4,391,764
			5.3.3.5	Data Mgt to ensure compete timeliness and accurate reporting.			4,391,764
		5.3.4					**123,160,050**
			5.3.4.1	Monitoring and supervision, to ensure program efficinecy, regular visit to LGAs and Health Facilites.		Avialability of funds/committemen ts	29,512,653
			5.3.4.2	Laboratory Support to ensure accurate confirmation of diagnosis		Avialability of funds/committemen ts	1,756,706
			5.3.4.3	Logistics , provision of adquate logistics support eg 2 No Hi-lux ,2No motorcyles ,2No Laptops 1No		Avialability of funds/committemen ts	84,029,082

				Desktop and scientific calculators Refrigirators & freezer			
			5.3.4.4	Annual Evaluatory meeting		Avialability of funds/committements	7,861,609
	5.4	**To monitor and evaluate the NHMIS**			**NHMIS evaluated annually**		**238,882,677**
		5.4.1	To establish monitoring protocol for NHMIS programme implementation at all levels in line with stated activities and expected outputs				**78,436,903**
			5.4.1.1	Adopt the federal check-list for NHMIS monitoring for quality assurance for state and LGA		Availability of funds	17,127,879
			5.4.1.2	Set up a joint monitoring team comprising State, LGA and comminity stakeholders.			1,815,262
			5.4.1.3	Bi annual review meetings of the State/LGA joint implementation mgt. team			59,493,762
		5.4.2	To strengthen data transmission				**160,445,774**
			5.4.2.1	Designate, train and empower CHEWs to cover specified geographical areas of the Community.			62,948,616
			5.4.2.2	Empower Private and Faith Based Health Care Providers to generate and transmit data.			26,350,583
			5.4.2.3	Motivate the Volunteer Village Health Workers to generate and transmit data at LGAs			18,445,408
			5.4.2.4	Provide logistics for HMIS/M&E officers to act as effective link for data transmission at state & LGAs			52,701,167
	5.5	**To strengthen analysis of data and dissemination of health information**			**1. State and 50% of LGAs have Units capable of analysing health information by end 2010** **2. State and LGAs disseminate available results regularly**		**35,573,288**
		5.5.1	To institutionalize data analysis and dissemination at all levels				**35,573,288**
			5.5.1.1	Zonal facility based training and re- training of health workers for Secondary/PHC facilities			28,107,289
			5.5.1.2	Production of bi-annual health journals for info update, decision making & research purposes.			878,353
			5.5.1.3	Production of Health Bulliten on yearly bases at state level			6,587,646
COMMUNITY PARTICIPATION AND OWNERSHIP							
6. To attain effective community participation in health development and management, as well as community ownership of sustainable health outcomes							**807,451,284**
	6.1	**To strengthen community participation in health development**			**State nd LGAs have at least annual Fora to engage community leaders and CBOs on health matters by end 2012**		**102,306,718**
		6.1.1	To provide an enabling policy framework for community participation				**-**
			6.1.1.1	Update the Policy framework for community participation as currently existing within the national health policy	Updated policy avaliable by end of 2009	Community Conflict, Inadequate funding, culture.religion, taboos	-
		6.1.2	To provide an enabling implementation framework and environment for community participation				**102,306,718**
			6.1.2.1	Update Guideline for Establishing Community structures	Updated guideline available by the end of 2010	community conflict, Inadequate funding, culture.religion, taboos	5,384,564

			6.1.2.2	Re-activate commmunity health development associations local town unions.			48,461,077
			6.1.2.3	Involve Communities in decision making using existing social networks.			48,461,077
	6.2	**To empower communities with skills for positive health actions**			**State and LGAs offer training to FBOs/CBOs and community leaders on engagement with the health system by end 2012**		**394,509,063**
		6.2.1	To build capacity within communities to 'own' their health services				**394,509,063**
			6.2.1.1	Identify and map-out key Community Stakeholders	Community stakeholders identified and maped out by December 2009, 20%Community leaders trained.	Religion,Cultural Belief, Ignorance,Leadership tussles.comunity conflict, Inadequate funds	33,743,268
			6.2.1.2	Assess the capacity needs of community stakehlders	Capacity needs of community stakeholders identified by December 2009	Religion,Cultural Belief, Ignorance,Leadership tussles.comunity conflict, Inadequate funds	81,845,374
			6.2.1.3	Establish key roles and functions of Community stakeholders and structures	key roles and functions established by December 2009	Religion,Cultural Belief, Ignorance,Leadership tussles.comunity conflict, Inadequate funds.	4,307,651
			6.2.1.4	Conduct orientation to community development committee, Community Resource Persons(CORPS) on their roles and responsibilities	Number of orientation activites conducted for development committees by end of 2010	Religion,Cultural Belief, Ignorance,Leadership tussles.comunity conflict, Inadequate funds	48,461,077
			6.2.1.5	Provide funding for community activities / Establish dialogue between communities and government structures	60% of the cost of health projects realized./ Two meetings held by the end of 2010	Religion,Cultural Belief, Ignorance,Leadership tussles.comunity conflict, Inadequate funds	226,151,692
	6.3	**To strengthen the community - health services linkages**			**50% of public health facilities in all States have active Committees that include community representatives by end 2011**		**27,048,460**
		6.3.1	To restructure and strengthen the interface between the community and the health services delivery points		30%CORPS,CBOs,CSOs Restructured and strenghtened.		**27,048,460**
			6.3.1.1	Review the existing health delivery structures and assess their level of interface with the community	30%CORPS,CBOs,CSOs Restructured and strenghtened.	Leadership tussle, Taboos, Cultural Conflict, Religion	7,305,059
			6.3.1.2	Identify areas of Community involvment with stakeholders and agree on operational modalities.			4,487,137
			6.3.1.3	Develope and provide guidelines for strenghtening the Community-health services interphase	Capacity of CBOs,CORPs,CSOs Developed Strengthened	Leadership tussle, etc.	4,487,137
			6.3.1.4	Provide incentives to stakeholders for their sustainabilityat State and LGA levels.			10,769,128
	6.4	**To increase national capacity for integrated multisectoral health promotion**			**State have active intersectoral**		**229,741,402**

				committees with other Ministries and private sector by end 2011		
		6.4.1	To develop and implement multisectoral policies and actions that facilitate community involvement in health development			**229,741,402**
		6.4.1.1	Undertake advocacy to community gate keepers to increase awareness and support for the use of health promotion to facilitate their involvement in health development	70% of gate keeper participate in health programmes	Leadership Tussle, Taboos,Culture, Religion	25,127,966
		6.4.1.2	Review and adapt the National health promotion policies and strategies that underscore participation of communities in health actions	30% Improvement in Knowledge, Attitude and Practice (KAP) of the Community in health programmes	Leadership Tussle, Taboos,Culture, Religion	5,384,564
		6.4.1.3	Formulate action plans to facilitate the development of health promotion capacity and support at various levels linking health with other sectors	40% Improvement in Multisectorial Participation	Leadership Tussle, Taboos,Culture, Religion	-
		6.4.1.4	Develop or adopt health promotion guidlines or frameworks on community involvement	80% Participation and Response to Health programmes	Leadership Tussle, Taboos,Culture, Religion	5,384,564
		6.4.1.5	Implement health promotion activities at Community level.			193,844,308
	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**		**53,845,641**
		6.5.1	To develop and implement systematic measurement of community involvement			**53,845,641**
		6.5.1.1	Measure the Impact of Specific Community Approaches, methods and Initiatives	Authentic Data Generated from the Community	Leadership Tussle, Taboos,Cultural conflict, Religion	10,769,128
		6.5.1.2	Disseminate and harness experiences amongst Community Stakeholders	Behavioural change amongst Stakeholders	Leadership Tussle, Taboos,Culture, Religion	43,076,513
PARTNERSHIPS FOR HEALTH						
7. To enhance harmonized implementation of essential health services in line with national health policy goals						**807,451,284**
	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. State has an active ICC with Donor Partners that meets at least quarterly by end 2010** **2. State has an active PPP forum that meets quarterly by end 2010** **3. LGAs have similar active committees by end 2011**		**807,451,284**
		7.1.1	To promote Public Private Partnerships (PPP)			**316,342,377**
		7.1.1.1	Updating the existing state PPP policy in line with the national policy with a view to leveraging technical and financial resources alongside improved management approaches for improved delivery of healthcare services.	Policy updated by 1st Q of 2010	Stable political will / enviironment	28,972,784
		7.1.1.2	Implementation of the State's PPP initiative to be in line with this national policy in the state and the LGAs.	State MOH 2011 fully implementing 2011	Stable political will / enviironment	20,213,570

			7.1.1.3	Establish a mechanism to engage the private sector eg contracting or outsourcing, concessions, provision of incentives like technical support at no cost, etc	60% of private sector have received one form of support or the other 2012.	Availability of enough fund to the state MOH	10,106,785
			7.1.1.4	Provide incentives for private care providers to set up facilities in underserved and remote areas.	60% of the underserved areas having hlth facilities from private sector 2014.	There are no community clashes. Sustained funding or support to the hlth facilities.	215,611,418
			7.1.1.5	Undertake joint monitoring visits by public and private care providers with adequate feedback.	50% of visits by the MOH will be joint by 2012	policy not eroded by bias from the operating administration.	41,437,819
		7.1.2	To institutionalize a framework for coordination of Development Partners				**25,266,963**
			7.1.2.1	Establishment of Development Partner's Forum.	90% of partners involved in the forum by 2012	Stable political will / enviironment	13,475,714
			7.1.2.2	Establish a mechanism for resource coordination through common basket funding models like Joint Funding Agreement, SWAP, Sectoral multi-donor budget	60% of donor partners will be involved by 2015	Nigeria and particularly Kogi state continues to make progress to attract these partners.	11,791,249
		7.1.3	To facilitate inter-sectoral collaboration				**6,737,857**
			7.1.3.1	Strenghten the existing state intersectoral collaboration forum.	70% of all sectors being part of this forum by 2014	Stable political will / enviironment	6,737,857
		7.1.4	To engage professional groups				**70,747,497**
			7.1.4.1	Adopt and implement standards of practice for professional groups from federal model.	60% of professional bodies involved in this jt standard setting by 2014	Proper management of professional bias.	15,497,071
			7.1.4.2	Improve communication between the MOH and the professional bodies.	60% of professional bodies involved in proper communication by 2014	Proper management of professional bias.	40,427,141
			7.1.4.3	Joint advocacy by the MOH and the professional bodies to government and partners on resource allocation.	60% of professional bodies involved in proper communication by 2012	Proper management of professional bias.	4,716,500
			7.1.4.4	Establish linkages with academic institutions to undertake research, education and monitoring through existing networks	70% linkages by 2015	Stable academic environment	10,106,785
		7.1.5	To engage with communities				**151,601,778**
			7.1.5.1	Provide gender and culture -sensitive health information to communities.	80% of the communities are informed by 2012	Availability of fund and absece of community clashes	20,213,570
			7.1.5.2	Develope health system performance indicators at the state level and facilities to improve transparency and accountability of govt to the communities.	performance indicators complete by 2011		13,475,714
			7.1.5.3	Establish an award for best health practices among communities.	Full commencement by 2011	Sustainability of hlth programmes	51,207,712
			7.1.5.4	Build the capacity of the ward health committee members, volunteer village health workers (V VHW) and community resource persons (CORPs) to undertake health promotion and prevention activities.	Fully started by 2010	Availability of fund, well motivated staff	66,704,782
		7.1.6	To engage with traditional health practitioners				**236,754,813**
			7.1.6.1	Institute modalities to regulate, control and evaluate their practices, including advertisement	80% of practices evaluated	Absence of internal Squables	28,218,144

			7.1.6.2	Integration of evidence based good practices into state healthcare delivery system	60% full regulation of all practices by 2015	Stable internal admin	38,473,162
			7.1.6.3	Training and retraining.	70% of all the practices adopted by 2014	Sustainable practice among practioners	137,856,550
			7.1.6.4	Setting up Herbarium (Botanical garden for medicinal plants)	80% must have been fully involved in the wkshp	Sustainable practice among practioners. Adequate funding	32,206,956
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							**1,614,902,569**
	8.1	**To strengthen the stewardship role of governments at all levels for research and knowledge management systems**			**1. ENHR Committee established by end 2009 to guide health research priorities 2. SMOH publishes an Essential Health Research agenda annually from 2010**		**780,525,469**
		8.1.1	To adopt and adapt the finalised federal health research policy at state level and develop same at LGA level.		1. Existence of health research policy at state and LGA levels by the end of 1st quarter of 2010. 2. Existence of functional research steering committee by the second quarter of 2010. 3. Dissemination of research results to all stake holders by the end of the last quarter of each year.		**125,339,998**
			8.1.1.1	Set up Technical Working Groups to adopt and adapt health research policies and strategies at State level.			48,303,999
			8.1.1.2	Develop and provide guidelines for the establishment of health research steering committees at State and LGA levels		Availability of funds/Commitment	26,787,028
			8.1.1.3	Monitor the activities of health research steering committees at State level to evaluate their function and value.		Availability of funds/Commitment	19,288,601
			8.1.1.4	Extend the functions of the health steering committee to cover the private health sector and the Traditional Medicine Programme (TMP)		Availability of funds/Commitment	10,675,989
			8.1.1.5	Evaluate , report and feed-back the outcome of research from the State to Federal.		Availability of funds/Commitment	20,284,380
		8.1.2	To establish and or strengthen mechanisms for health research at State & LGA levels				**277,963,943**
			8.1.2.1	Provide technical assistance to the DPRS to develop and strengthen the capacity of health research unit at the State		Availability of funds/Commitment	48,236,061
			8.1.2.2	Provide techinical assistance to organised private groups to undertake research.		Availability of funds/Commitment	72,499,674
			8.1.2.3	Provide enabling environment in the state tetiary health and education institutions to sustain health research.		Availability of funds/Commitment	157,228,208
		8.1.3	To institutionalize processes for setting health research agenda and priorities				**197,894,022**
			8.1.3.1	Implement the Essential National Health Research (ENHR) programme in the State .		Availability of funds/Commitment	28,534,008
			8.1.3.2	Expand health research agenda to include broad and multi-dimensional determinants of health.		Availability of funds/Commitment	6,308,539

			8.1.3.3	Integrate research into traditional medicine practice.		Availability of funds/Commitment	58,232,670
			8.1.3.4	Empower and reward active research in health.		Availability of funds/Commitment	17,469,801
			8.1.3.5	Publish and utilize the outcome of research.		Availability of funds/Commitment	87,349,004
		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				**73,586,683**
			8.1.4.1	Develop & disseminate guidelines for a collaborative research agenda		Availability of funds/Commitment	51,002,113
			8.1.4.2	Establish and hold periodic forum for all stakeholders in health research.		Availability of funds/Commitment	22,584,570
		8.1.5	To mobilise adequate financial resources to support health research at all levels				**9,705,445**
			8.1.5.1	Advocate for allocation of at least 2% of health budget for health research at state & LGA levels.			5,823,267
			8.1.5.2	Seek and Integrate resources for research from all stakeholders.			3,882,178
		8.1.6	To establish ethical standards and practise codes for health research at all levels				**96,035,378**
			8.1.6.1	Develop, produce and distribute guidelines on ethical standards and practise codes for research in health.			20,866,707
			8.1.6.2	Establish and empower ethical review c'mttees in the state and LGA's and strengthen those in the state's tetiary health and education institution.			64,541,209
			8.1.6.3	Review the guidelines developed in line with new technologies and advancements.			10,627,462
	8.2	**To build institutional capacities to promote, undertake and utilise research for evidence-based policy making in health at all levels**			**SMOH hold an active forum with all training institutions by end 2010**		**709,759,187**
		8.2.1	To strengthen identified health research institutions at all levels				**633,280,281**
			8.2.1.1	Provide and upgrade ICT facilities in all tertiary health and educational Institutions			415,393,043
			8.2.1.2	Provide utility vehicles for research units in identified institutions			129,567,690
			8.2.1.3	Affiliate identified institutions with corresponding local and international foreign institutions			19,410,890
			8.2.1.4	Build the capacity of key staff through participation in international workshops, symposia, etc.			68,908,659
		8.2.2	To create a critical mass of health researchers at all levels				**29,116,335**
			8.2.2.1	Create an active reserch unit in the Dept. Of PRS that cordinates research activities with all other departments			2,911,633
			8.2.2.2	Create and empower research units in secondary & primary health facilities to be coordinated by the medical records unit of the facilities			26,204,701
		8.2.3	To develop transparent approaches for using research findings to aid evidence-based policy making at all levels				**-**
			8.2.3.1	Create for a for discussion of research finding that can inform policy formulation			-
		8.2.4	To undertake research on identified critical priority areas				**47,362,571**
			8.2.4.1	Identify areas of Operational research at state & LGA levels			2,329,307
			8.2.4.2	Conduct operations research along identified lines			45,033,264
	8.3	**To develop a comprehensive repository for health research at all levels (including both public and non-public sectors)**			**1. State has a Health Research Unit by end 2010**		**3,882,178**

					2. SMOH and State Health Research Unit manage an accessible repository by end 2012		
		8.3.1	To develop strategies for getting research findings into strategies and practices				**3,882,178**
			8.3.1.1	Create a linkage between PRS Dept, MOH & Research Institutes like NIPRID, and other Health Research Institutes in Nigeria for Programmatic collaboration			3,882,178
		8.3.2	To enshrine mechanisms to ensure that funded researches produce new knowledge required to improve the health system				**-**
			8.3.2.1	Monitor research activities at all levels in the State			-
			8.3.2.2	Ensure research activities address priorities of the State and LGA			-
	8.4	**To develop, implement and institutionalize health research communication strategies at all levels**			**A State health research communication strategy is in place by end 2012**		**120,735,735**
		8.4.1	To create a framework for sharing research knowledge and its applications				**18,925,618**
			8.4.1.1	Develop and destribute a template for reporting research findings at all levels			18,925,618
		8.4.2	To establish channels for sharing of research findings between researchers, policy makers and development practitioners				**101,810,117**
			8.4.2.1	Strengthen Communiction between DPRS of MOH, Research units at all levels			52,118,239
			8.4.2.2	Create and empower a research implementation unit in the office of the Permanenet Secretary, MOH.			49,691,878
							80,745,128,446

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

KOGI STATE STRATEGIC HEALTH DEVELOPMENT PLAN RESULT MATRIX						
OVERARCHING GOAL: To significantly improve the health status of Nigerians through the development of a strengthened and sustainable health care delivery system						
OUTPUTS	**INDICATORS**	**SOURCES OF DATA**	**Baseline**	**Milestone**	**Milestone**	**Target**
			2008/9	**2011**	**2013**	**2015**
PRIORITY AREA 1: LEADERSHIP AND GOVERNANCE FOR HEALTH						
NSHDP Goal: To create and sustain an enabling environment for the delivery of quality health care and development in Nigeria						
OUTCOME: 1. Improved strategic health plans implemented at Federal and State levels						
OUTCOME 2. Transparent and accountable health systems management						
1. Improved Policy Direction for Health Development	1. % of LGAs with Operational Plans consistent with the state strategic health development plan (SSHDP) and priorities	LGA s Operational Plans	0	33	67	95%
	2. % stakeholders constituencies playing their assigned roles in the SSHDP (disaggregated by stakeholder constituencies)	SSHDP Annual Review Report	TBD	20	45	65%
2. Improved Legislative and Regulatory Frameworks for Health Development	3. State adopting the National Health Bill? (Yes/No)	SMOH	0	20	35	50
	4. % of recommendations from health watch groups being implemented	Health Watch Groups' Reports	No Baseline	25%	40%	60%
	5. % LGAs aligning their health programmes to the SSHDP	LGA Annual Report	0	25	45	65
	6. % DPs aligning their health programmes to the SSHDP at the LGA level	LGA Annual Report	No Baseline	25%	50%	75%
	7. % of LGAs with functional peer review mechanisms	SSHDP and LGA Annual Review Report	TBD	10%	25%	50%
	8. % LGAs implementing their peer review recommendations	LGA / SSHDP Annual Review Report	No Baseline	20%	40%	75%
	9. Number of LGA Health Watch Reports published	Health Watch Report	0	40%	75%	100%
	10. Number of "Annual Health of the LGA" Reports published and disseminated annually	Health of the State Report	TBD	40%	75%	100%
4. Enhanced performance of the State health system	11. % LGA public health facilities using the essential drug list	Facility Survey Report	TBD	25%	45%	65%
	12. % private health facilities using the essential drug list by LGA	Private facility survey	TBD	20%	40%	75%
	13. % of LGA public sector institutions implementing the drug procurement policy	Facility Survey Report	TBD	20%	40%	75%
	14. % LGA health facilities not-experiencing essential drug/commodity	Facility Survey Report	TBD	10%	30%	50%

	stockouts in the last three months					
	15. % of LGAs implementing a performance based budgeting system	Facility Survey Report	TBD	20%	30%	40%
	16. Number of MOUs signed between private sector facilities and LGAs in a Public-Private-Partnership by LGA	LGA Annual Review Report	TBD	5	10	15
	17. 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	3	5	8
PRIORITY 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	18. % of LGAs with a functioning public health facility providing minimum health care package according to quality of care standards.	NPHCDA Survey Report	TBD	15%	30%	55%
	19. % health facilities implementing the complete package of essential health care	NPHCDA Survey Report	TBD	10%	25%	40%
	20. % of the population having access to an essential care package	MICS/NDHS	TBD	10%	25%	40%
	21. Contraceptive prevalence rate (modern and traditional)	NDHS	7%	14%	21%	28%
	22. % increase of new users of modern contraceptive methods (male/female)	NDHS/HMIS	5%	10%	15%	20%
	23. % of new users of modern contraceptive methods by type (male/female)	NDHS/HMIS	TBD	5%	10%	15%
	24. % service delivery points without stock out of family planning commodities in the last three months	Health facility Survey	TBD	5%	10%	15%
	25. % of facilities providing Youth Friendly RH services	Health facility Survey	TBD	5%	10%	15%
	26. % of women 15-19 who have begun child bearing	NDHS/MICS	15.20%	12%	10%	8%
	27. % of pregnant women with 4 ANC visits performed according to standards*	NDHS	20%	30%	40%	60%

	28. Proportion of births attended by skilled health personnel	HMIS	69.10%	75%	85%	95%
	29. Proportion of women with complications treated in an EmOC facility (Basic and/or comprehensive)	EmOC Sentinel Survey and Health Facility Survey	TBD	5%	10%	15%
	30. Caesarean section rate	EmOC Sentinel Survey and Health Facility Survey	1%	2.50%	4%	6%
	31. Case fertility rate among women with obstretic complications in EmOC facilities per complication	HMIS	TBD	5%	10%	15%
	32. Perinatal mortality rate**	HMIS	45/1000LBs	40/1000LBs	35/1000LBs	30/1000LBs
	33. % women receiving immediate post partum family planning method before discharge	HMIS	TBD	25%	30%	40%
	34. % of women who received postnatal care based on standards within 48h after delivery	MICS	TBD	40%	50%	60%
	35. % of newborn with infection receiving treatment	MICS	No Baseline	5%	10%	15%
	36. % of children exclusively breastfed 0-6 months	NDHS/MICS	0 - 57.4%			
	37. Proportion of 12-23 months-old children fully immunized	NDHS/MICS	55.00%	75%	85%	95%
	38. % children <5 years stunted (height for age <2 SD)	NDHSMICS	30.00%	20%	15%	10%
	39. % of under-five that slept under LLINs the previous night	NDHS/MICS	8.00%	25%	55%	8o%
	40. % of under-five children receiving appropriate malaria treatment within 24 hours	NDHS/MICS	15%	25%	35%	50%
	41.Condom use at last high risk sex	NDHS/MICS	3.60%	5%	8%	10%
	42. Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS	NDHS/MICS	52.20%	60%	65%	70%
	43. Prevalence of tuberculosis	NARHS	0.04%	1.0 - 4.0	0.5 - 3%	1.50%
Output 6. Improved quality of Health care services	43. % of staff with skills to deliver quality health care appropriate for their categories	Facility Survey Report	TBD	30%	45%	55%
	44. % of facilities with capacity to deliver quality health care	Facility Survey Report	TBD	35%	45%	60%
	45. % of health workers who received personal	Facility Survey Report	TBD	10%	20%	30%

	supervision in the last 6 months by type of facility					
	46. % of health workers who received in-service training in the past 12 months by category of worker	HR survey Report	TBD	15%	25%	40%
	47. % of health facilities with all essential drugs available at all times	Facility Survey Report	TBD	35%	50%	65%
	48. % of health institutions with basic medical equipment and functional logistic system appropriate to their levels	Facility Survey Report	TBD	10%	20%	30%
	49. % of facilities with deliveries organizing maternal and/or neonatal death reviews according to WHO guidelines on regular basis	Facility Survey Report	TBD	10%	20%	30%
Output 7. Increased demand for health services	50. Proportion of the population utilizing essential services package	MICS	TBD	30%	45%	65%
	51. % of the population adequately informed of the 5 most beneficial health practices	MICS	TBD	5%	10%	15%
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	52. % of wards that have appropriate HRH complement as per service delivery norm (urban/rural).	Facility Survey Report	TBD	5%	10%	15%
	53. Retention rate of HRH	HR survey Report	TBD	85%	90%	95%
	54. % LGAs actively using adaptations of National/State HRH policy and plans	HR survey Report	TBD	5%	10%	20%
	55. % of LGAs implementing performance-based managment systems	HR survey Report	TBD	5%	10%	20%
	56. % of staff satisfied with the performance based management system	HR survey Report	TBD	20%	35%	50%
Output 8: Improved framework for objective analysis, implementation and monitoring of HRH performance	57. % LGAs making availabile consistent flow of HRH information	NHMIS		10%	20%	40%
	58. CHEW/10,000 population density	MICS	TBD	3/10000	4/10000	5/10000
	59. Nurse density/10,000 population	MICS	TBD	2/10000	3/10000	4/10000
	60. Qualified registered midwives density per 10,000 population and per geographic area	NHIS/Facility survey report/EmOC	TBD	2/10000	3/10000	4/10000

		Needs Assessment				
	61. Medical doctor density per 10,000 population	MICS	TBD	1/10000	2/10000	3/10000
	62. Other health service providers density/10,000 population	MICS	TBD	2/10000	3/10000	4/10000
	63. HRH database mechanism in place at LGA level	HRH Database	TBD	5%	15%	25%
Output 10: Strengthened capacity of training institutions to scale up the production of a critical mass of quality mid-level health workers						
PRIORITY AREA 4: FINANCING FOR HEALTH						
NSHDP GOAL 4 : To ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and consumption at Local, State and Federal Levels						
Outcome 8. Health financing strategies implemented at Federal, State and Local levels consistent with the National Health Financing Policy						
Outcome 9. The Nigerian people, particularly the most vulnerable socio-economic population groups, are protected from financial catastrophe and impoverishment as a result of using health services						
Output 11: Improved protection from financial catastrophy and impoverisihment as a result of using health services in the State	64. % of LGAs implementing state specific safety nets	SSHDP review report	TBD	10%	25%	50%
	65. Decreased proportion of informal payments within the public health care system within each LGA	MICS	TBD	70%	60%	50%
	66. % of LGAs which allocate costed fund to fully implement essential care package at N5,000/capita (US$34)	State and LGA Budgets	TBD	30%	45%	60%
	67. LGAs allocating health funding increased by average of 5% every year	State and LGA Budgets	TBD	10%	20%	40%
Output 12: Improved efficiency and equity in the allocation and use of Health resources at State and LGA levels	68. LGAs health budgets fully alligned to support state health goals and policies	State and LGA Budgets	TBD	40%	60%	80%
	69.Out-of pocket expenditure as a % of total health expenditure	National Health Accounts 2003 - 2005	80%	75%	70%	60%
	70. % of LGA budget allocated to the health sector.	National Health Accounts 2003 - 2005	5%	10%	12%	15%
	71. % of LGAs having operational supportive supervision and monitoring systems	SSHDP review report	TBD	15%	20%	30%
PRIORITY AREA 5: NATIONAL HEALTH INFORMATION SYSTEM						

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	72. % of LGAs making routine NHMIS returns to states	NHMIS Report January to June 2008; March 2009	25%	35%	45%	60%
	73. % of LGAs receiving feedback on NHMIS from SMOH		TBD			
	74. % of health facility staff trained to use the NHMIS infrastructure	Training Reports	TBD	30%	45%	65%
	75. % of health facilities benefitting from HMIS supervisory visits from SMOH	NHMIS Report	TBD	25%	355	45%
	76.% of HMIS operators at the LGA level trained in analysis of data using the operational manual	Training Reports	TBD	35%	45%	60%
	77. % of LGA PHC Coordinator trained in data dissemination	Training Reports	TBD	40%	75%	100%
	78. % of LGAs publishing annual HMIS reports	HMIS Reports	TBD	30%	60%	90%
	79. % of LGA plans using the HMIS data	NHMIS Report	TBD	25%	30%	45%
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	80. Proportion of public health facilities having active committees that include community representatives (with meeting reports and actions recommended)	SSHDP review report	TBD	15%	20%	25%
	81. % of wards holding quarterly health committee meetings	HDC Reports	TBD	5%	20%	40%
	82. % HDCs whose members have had training in community mobilization	HDC Reports	TBD	25%	35%	45%
	83. % increase in community health actions	HDC Reports	TBD			
	84. % of health actions jointly implemented with HDCs and other related committees	HDC Reports	TBD			
	85. % of LGAs implementing an Integrated Health Communication Plan	HPC Reports	TBD			
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 SHDP						
Output 15: Improved Health Sector Partners' Collaboration and Coordination	86. Increased number of new PPP initiatives per year per LGA	SSHDP Report	TBD	10%	15%	25%

	87. % LGAs holding annual multi-sectoral development partner meetings	SSHDP Report	TBD			
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	88. % of LGAs partnering with researchers	Research Reports	TBD	10%	20%	30%
	89. % of State health budget spent on health research and evaluation	State budget	TBD	0%	1.00%	2%
	90. % of LGAs holding quarterly knowledge sharing on research, HMIS and best practices	LGA Annual SHDP Reports	TBD	10%	15%	20%
	91. % of LGAs participating in state research ethics review board for researches in their locations	LGA Annual SHDP Reports	TBD	5%	10%	15%
	92. % of health research in LGAs available in the state health research depository	State Health Reseach Depository	TBD	30%	50%	75%
Output 17: Health research communication strategies developed and implemented	93. % LGAs aware of state health research communication strategy	Health Research Communication Strategy	TBD	5%	10%	20%