EBONYI STATE GOVERNMENT

STRATEGIC HEALTH DEVELOPMENT PLAN (2010-2015)

Ebonyi State Ministry of Health

March 2010

Table of Contents

Acknowledgement 4
Vision and Mission of Anambra State Strategic Health Development Plan 5
Chapter 1: Background and Achievements 10
1.1 Background 10
1.2 Achievements 10
Chapter 2: Situation Analysis 12
2.1 Socio- economic context 12
2.2 Health Status of the population 12
2.3 Diseases and conditions of priority concern 13
2.4 Health Service Delivery Organization in the State 14
2.5 Key issues and challenges 15
Chapter 3 Strategic Health Priorities 16
Preamble 16
Chapter 4: Resource Requirements 18
4.1 Human 18
4.2 Physical/Materials 18
4.3 Financial 18
Chapter 5: Financing Plan 19
5.1 Estimated cost of the strategic orientations 19
5.2 Assessment of the available and projected funds 19
5.3 Determination of the financing gap 20
5.4 Descriptions of ways of closing the financing gap 20
Chapter 6: Implementation Framework 21
Chapter 7: Monitoring and Evaluation 23
7.1 Proposed mechanisms for monitoring and evaluation 23
7.2 Costing the monitoring and evaluation component and plan 23
Chapter 8: Conclusion 24
Annex 1: Details of Ebonyi Strategic Health Development Plan 25
Annex 2: Results/M&E Framework for the Plan 45

Acronyms

CBOs	Community Based Organizations
CHEWs	Community Health Extension Workers
GH	General Hospitals
HIV/AIDS	Human Immuno Deficiency Virus/Acquired Immune Deficiency
HSR	Health Sector Reform
HRH	Human Resources for Health
IMCI	Integrated Management of Childhood illnesses
LGAs	Local Government Areas
LLINs	Long Lasting Insecticide Treated Nets
M & E	Monitoring and Evaluation
MDGs	Millennium Development Goals
NASCAP	National AIDS and Sexually Transmitted Infections Control Programme
NEEDS	National Economic Empowerment and Development Strategies
NGOs	Non Government Organizations
NHMIS	National Health Management Information System
PHC	Primary Health Care
PPP	Public Private Partnerships
RMAFC	Revenue Mobilisation Allocation and Fiscal Commission
SCH	State Council on Health
SEEDS	State Economic Empowerment and Development Strategies
SHAs	State Health Accounts
SHMIS	State Health Management Information System
SMOH	State Ministry of Health
SSHDP	State Strategic Health Development Plan
UNAIDS	United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WMHCP	Ward Minimum Health Care Package

Acknowledgement

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

Vision and Mission of Anambra State Strategic Health Development Plan

Vision
A State filled with a healthy citizenry

Mission
A well coordinated health system enjoying the highest political commitment and leadership, and providing efficient, effective, equitable and affordable services to her citizens.

Executive Summary

"The Ebonyi State SSHDP is targeted at reducing disease burden due to maternal and Infant morbidity and mortality to the barest minimum in line with the goals of the MDGs. Other priority areas include reduction of prevalence of non-communicable and communicable diseases geared towards the elimination and eradication of diseases, and significantly increase the life expectancy and quality of life of Ebonyians."

Ebonyi State was carved out from the old Abia and Enugu State in October 1, 1996 with its capital as Abakaliki. It occupies a land mass of 5,935 square kilometers and is situated between latitudes 5º40' and 6º54'N and longitudes 7º30'and 8º30'E. It has boundaries in the north with Benue State, inthe east with Cross River State, in the south by Abia State and in the west by Enugu State. Geopolitically, it belongs to the South East Zone of Nigeria but lies entirely in the Cross River Plains. Its elevation is between 125 and 245 meters above sea level, mainly of broad clay and shady basins fringed by narrow outcrops of sandstone, limestone and other rock formations. Towards the southeast border, the landscape abuts onto the hilly country of the Okigwe-Arochukwu axis.

The population of the State was put at 2,176,947 by the 2006 census. With a state growth rate of 3.5% per annum, the State will have a projected population of 2,405,527 by the end of 2009. Males constitute 48.9% while females constitute 51.1% of the population. The average population density is 286 persons per square km but is higher in the urban areas.

A further breakdown of the population shows that Infants (under one year) old make up 4%, the U5 children 20% and women of child bearing (WCBA) (15-49 years) make up 22% of the population. Ebonyi is mainly rural with about 75% of the population lives in the rural areas.

The main occupation of the people is farming, which in 1991 accounted for 87 percent of the working population, as against a national average of 61 percent. Traditionally, Ebonyi people are great yam farmers. Rice, cassava, and tree crops like palm produce and fruits are important in the south, while grain crops, groundnuts and seed crops do well in the north. Animal products include poultry, goat, sheep and a special breed of dwarf cattle much sought after throughout lgbo land for ritual and ceremonial purposes.

There is a strong tradition of commerce, with two great historic markets, Eke lmoha and Uburu, which were famous in pre-colonial times as major entry points for regional trade. The State which has few modern industrial establishments has great potential for solid minerals exploitation and mineral-based industries. The only modern enterprises so far are the moribund cement factory at Nkalagu, the stone crushing and building materials industries around Abakaliki, and the lead, zinc and granite enterprises at lshiagu and Enyigba. Salt making is an ancient traditional industry cantered in Ohaozara LGA. Craft making also engages the attention of the people. The best-known traditional crafts are the superb Pottery products from silage in Ivo and Mat making in Ishielu, and Ohaozara LGAs (Ebonyi SEEDS document 2004; Egbu 2005).

There are 13 LGAs in the state grouped into three senatorial zones namely, Ebonyi North

comprising Abakaliki, Ebonyi, Ohaukwu and Izzi LGAs; Ebonyi central made up of Ishielu, Ikwo, Ezza North and Ezza south LGAs; and Ebonyi South made up of Afikpo North, Afikpo South, Ivo, Ohaozara and Onicha LGAs.

Life Expectancy: The life expectancy at birth in Ebonyi State was 53.8 years for females and 52.6 years for males in 1991but declined to 46 years for females and 45 years for males in 2006. **Infant mortality:** The infant mortality rate (IMR) has remained high and is estimated at 99 per 1000 live births while the under age 5 years mortality rate (U5MR) is 191 per 1000 live births. **Maternal Mortality ratio**: Ebonyi State has one of the highest MMR in the country with ratio of about 1500 per 100,000 population.

Health Service Delivery Organization in the State: As in most parts of the country, health service delivery in Ebonyi State is structured into a three tier system with the primary health care at the base, supported by the secondary and tertiary health care levels. However, the health system in the State is extremely weak with the Primary and Secondary health care levels virtually collapsed. There are two tertiary health facilities in the state, the state owned University Teaching Hospital and the Federal Medical Centre are both located in Abakaliki and within a distance of less than one kilometer from each other. In addition, there is a strong presence of mission hospitals and private for profit health facilities (especially in the State capital). About 60 percent of health services in the state are provided by the mission hospitals.

In much of the rural areas, traditional medical practitioners provide much of the health services such that TBAs are the main stay for IMNCH services. This is due to near absence of health facilities in these areas.

The bottlenecks hampering the implementation of our Ward Minimum Package of Care include:-

a. Inadequate manpower
b. Low budgetary allocation and performance
c. Lack of vital equipment, deterioration or obsolescence of existing ones
d. Dilapidated building infrastructures are dilapidated
e. Inadequate facilities
f. Poor remuneration of staff.
g. Lack of training
h. Inadequate materials for a well developed Health Management Information System

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

a. Maternal mortality monitoring law. This law mandates all public and private primary health care institutions attending to women in labour to refer all labour lasting more than 10 hours to a higher center, and further mandates all public and private health institutions of all levels to report all maternal deaths to the Maternal Mortality Monitoring Committee.

b. Free maternal care services being implemented through both the government owned health institutions and Mission hospitals in the state.Adaptation of the National policy on immunization and other maternal health interventions.

Provision of good ante-natal and pre-natal care to reduce deaths of newborn infants:.

a. The childhood survival strategies of Growth Monitoring, Oral Re-hydration therapy, Breastfeeding, Immunization, Food Supplementation, Family Planning and Female Education.
b. Free treatment of Under 5 children with essential drugs.
c. Free or subsidized treatment for childhood cancers and chronic illnesses like Diabetes mellitus
d. Free Maternal Care Services from conception to delivery
e. Free VVF repair
f. The Family Law center that adjudicates in matters of domestic violence, harmful widowhood rites and other forms of discrimination against women.

The State Minimum health care package has been identified for the three service delivery modes. These clinical health services contained in the package of care have been selected based on their proven and high impact on health outcomes such as mortality. The three service delivery modes are:

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

The targets to these interventions include:

a. Prevalence of communicable and non-communicable disease reduced by 60% by 2014
b. 50% of the population in Ebonyi State is within 30mins walk or 5km of a health service by end 2014
c. 70% of obsolete equipment replaced in secondary hospitals and PHCs by 2011.
d. 100% of state-owned hospitals and the 13 LGAs supplied with 1 ambulance each by end of 2011
e. Average demand for health care services rises to 2 visits per person per annum by end 2012
f. 100% of health facilities offering nutrition and growth monitoring services by 2012. At least one CHEW in each PHC centre retrained on health promotion practices by end of 2012
g. Access to IMCI, Childhood immunizations & treatment of common childhood problems in 80% of Health facilities in the State by year 2013 and 100% by 2015
h. Routine immunisation institutionalized by 2011.
i. Prevalence of child morbidity and mortality reduced by 60% by 2013
j. 60% of deliveries are attended to by skilled staff by end of 2013 and 80% by year 2015

The bulk of the interventions and activities contained within the State SHDP are on health service delivery where there is the need to ensure health service delivery that includes specific actions such as defining and implementing a ward minimum health care package and establishment of Ebonyi State Primary Health Care Development Agency (SPHCDA).

The interventions within the Human Resource for Health target the distribution of health

manpower which is currently skewed towards urban populations. The interventions also target primary health centres that do not have sufficient manpower as recommended by regulatory agencies. The health financing interventions address the per capita health expenditure on health in the State which is about $4, much lower than the $34 recommended by the Macroeconomic Commission on Health for the attainment of the health-related MDGs. The capital budget on health for 2009 is 4.85% of the total budget of Ebonyi State – a far cry from the recommended minimum of 15% by the Abuja Declaration. About 30% of health expenditure is from out-of-pocket and the National Health Insurance Scheme is currently not operational in Ebonyi State.

Community participation in critical in Ebonyi State, as it is limited in scope, organization and impact. The SSHDP identifies strategies and interventions to address ownership and demand of health services by the community.

The total cost for the implementation of the State SHDP is N43,348,309,979.00.

Towards the effective implementation of the SSHDP, the activities identified have been costed and expected to be funded by State, LGAs and Partners. Zero tolerance to corruption is one of the values of the present administration in Ebonyi State. There is a standing Ministerial Tenders Board, Due Process Office at the Ministry and the Office
of the Commissioner for Foreign Donor and Grants. Over the years, Ebonyi State has enjoyed the support of UN Agencies and other bilateral and non-governmental agencies in enhancing the health status of its citizenry. Such organizations include UNICEF, WHO, UNFPA, World Bank, USAID etc.

Strengthening of the Health Management Information System will be carried out early in the implementation of the plan to ensure that M & E and DSN units are empowered at all levels to track and monitor progress. Specifically, periodic joint assessment of achievements and progress towards MDGs will be carried out with the Local Government Councils. Monitoring and Evaluation were incorporated as key activities in each of the 8 priority areas. Expanded Health Data Consultative Committee (HDCC), Interagency Coordinating Committee and the Forum for Development Partners will be used to ensure cooperation of all stakeholders. More regular State Council on Health meetings will be used to provide forum for broad-based consultation, coordination and collaboration on a continuous basis in Ebonyi State (Salt of the Nation).

Chapter 1: Background and Achievements

1.1 Background

Ebonyi State was carved out from the old Abia and Enugu State in October 1, 1996 with its capital at Abakaliki. It occupies a land mass of 5935 square kilometers. Situated between latitudes 5°40' and 6° 54'N and longitudes 7°30'and 8°30'E, it is bounded to the north by Benue State, to the east by Cross River State, to the south by Abia State and to the west by Enugu State. Geopolitically, it belongs to the South East Zone of Nigeria but lies entirely in the Cross River Plains. Its elevation is between 125 and 245 meters above sea level, mainly of broad clay and shady basins fringed by narrow outcrops of sandstone, limestone and other rock formations. Towards the southeast border, the landscape abuts onto the hilly country of the Okigwe-Arochukwu axis.

The population of the State was put at 2,176,947 by the 2006 census. With a growth rate of 3.5% per annum, the State will have a projected population of 2,405,527 by the end of 2009. Males constitute 48.9% while females constitute 51.1% of the population. The average population density is 286 persons per square km but is higher in the urban areas.
A further breakdown of the population shows that Infants (under one year) old make up 4%, the U5 children 20% and women of child bearing (WCBA) (15-49 years) make up 22% of the population. Ebonyi is mainly rural and so, about 75% of the population lives in the rural areas.

1.2 Achievements

The State has recorded significant achievements since inception 13 years ago. Before 1996, the territory called Ebonyi was one of the most backward in Nigeria. The State creation seems to have unleashed the creative energy of the people and channeled them into aggressive developmental strides witnessed, especially since the return to civil rule in 1999.
In the health sector, some recent achievements include:

- Reorganization/re-designation and renovation of General Hospitals in the State. Before now, there were 34 non-functional General Hospitals. 13 out of these have been truly designated General Hospitals (ensuring one in each of the 13 Local Government Areas) and are being renovated and upgraded to provide full range of secondary level health care services with strong referral linkage to PHC facilities in its area of operation.
- Enactment of the Maternal Mortality Monitoring Law. This law makes maternal mortality a reportable event, and makes it a criminal offence for a woman to be allowed to labour for more than 10 hours in any facility without referral to a higher facility. The Maternal Mortality Monitoring Committee with composition from the public, private, CSO network and FBO sectors whose duty is to ensure implementation of the law have been inaugurated.
- Establishment of the world class VVF centre by the wife of the governor. This centre has attracted the attention of virtually all the International development partners as well as the Federal government. Currently, discussion is going on now between the State and the Federal Ministry of Health on the possibility of the centre becoming a National VVF centre for the Southeast region of Nigeria.

- Collaboration between the State government and the FBO hospitals. Government commenced the disbursement of generous subventions to 6 mission hospitals to enhance their health delivery services especially in the rural areas where they are mostly based.
- Construction of 19 Unity bridges and extensive road network and water scheme. This is opening up the rural areas and making life more bearable so that health workers posted there could stay.

Chapter 2: Situation Analysis

2.1 Socio- economic context

The main occupation of the people is farming, which in 1991 accounted for 87 percent of the working population, as against a national average of 61 percent. Traditionally Ebonyi people are great yam farmers. Rice, cassava, and tree crops like palm produce and fruits are important in the south, while grain crops, groundnuts and seed crops do well in the north. Animal products include poultry, goat, sheep and a special breed of dwarf cattle much sought after throughout lgbo land for ritual and ceremonial purposes. Up to 70% of the citizens of Ebonyi State are involved with agriculture.

There is a strong tradition of commerce, with two great historic markets, Eke lmoha and Uburu, which were famous in pre-colonial times as major entry points for regional trade. The State which has few modern industrial establishments has great potential for solid minerals exploitation and mineral-based industries. The only modern enterprises so far are the moribund cement factory at Nkalagu, the stone crushing and building materials industries around Abakaliki, and the lead, zinc and granite enterprises at lshiagu and Enyigba. Salt making is an ancient traditional industry centered in Ohaozara LGA. Craft making also engages the attention of the people. The best-known traditional crafts are the superb Pottery products from silage in Ivo and Mat making in Ishielu and Ohaozara LGAs (Ebonyi SEEDS document 2004; Egbu 2005).
There are 13 LGAs in the state grouped into three senatorial zones namely, Ebonyi North comprising Abakaliki, Ebonyi, Ohaukwu and Izzi LGAs; Ebonyi central made up of Ishielu, Ikwo, Ezza North and Ezza south LGAs; and Ebonyi South made up of Afikpo North, Afikpo South, Ivo, Ohaozara and Onicha LGAs.

2.2 Health Status of the population

Mortality Statistics

INDICATORS	EBONYI
Total population	2,176,947 (1,112,791 females; 1,064,156 males)
Under 5 years (20% of Total Pop)	324,275
Adolescents (10 – 24 years)	717,396
Women of child bearing age (15-49 years)	567,757
Literacy rate	53% female; 77% men
Households with improved source of drinking water	57%
Households with improved sanitary facilities (not shared)	13%
Households with electricity	41%
Employment status (currently)	69.1% female, 82.1% male
TFR	5.6

Use of FP modern method by married women 15-49	3%
ANC	76%
Skilled attendants at birth	46%
Delivery in HF	41%
Full immunization coverage	50%
Children that have not received any immunization (zero dose)	19%
Stunting in Under 5 children	32%
Wasting in Under 5 children	8%
Diarrhea in children	8.5
ITN ownership	15%
ITN utilization	13% children, 7% pregnant women
Malaria treatment (any anti-malarial drug)	6% children, 3% pregnant women
Comprehensive knowledge of HIV	19% female, 36% men
Knowledge of TB	88.2% female, 93.7% male

Health-wise, the most at risk groups are women of child bearing age and Under Five children who constitute 22 per cent and 20 percent of population respectively. The leading cause of ill health and death in Ebonyi is malaria; accounting for over 35 per cent of mortality and more than 60 per cent of morbidity. The ten common causes of morbidity and mortality in the state are:

- Malaria
- Diarrhoea diseases including Cholera
- Respiratory tract infections
- Hypertension
- Typhoid fever
- Trauma/ RTA
- HIV/AIDS
- Tuberculosis
- Complication of pregnancy and child birth
- Measles

2.3 Diseases and conditions of priority concern

The disease of highest priority concern is **malaria** as it affects people of all age groups, with fatal consequences for many. Of growing concern is **HIV and AIDS** though the National sentinel survey of pregnant women shows a declining trend from 4.6% in 2004 to 3.6 in 2008.

Access to health care services is poor mostly due to poverty and ignorance. The 2008 End-line/Baseline Survey by the UNFPA shows for instance that only 46.3% of women attend ANC and over 70% deliver at home.

2.4 Health Service Delivery Organization in the State

As in most parts of the country, health service delivery in Ebonyi State is structured into a three tier system with the primary health care at the base, supported by the secondary and tertiary health care levels. However, the health system in the State is extremely weak with the Primary and Secondary health care levels virtually collapsed. There are two tertiary health facilities in the state, the state owned university teaching hospital and the Federal Medical Centre both located in Abakaliki, the State capital within a distance of less than one kilometer from each other.

The State government has the responsibility for secondary health care and the Ebonyi State University Teaching Hospital Abakaliki; while the local government has the responsibility of the primary health centres and health posts in their wards.
The State Ministry of Health plans and develops health programmes and supervises implementation along the national health policy guidelines. The ministry through the hospital management board provides secondary health care services.

There are a total of Five hundred and fifty-four (554) health facilities both private and public in the state. The public sector facilities consist of 370 (66.8%) while the private consist of 184 (33.2%). The public facilities include one (1) state owned teaching hospital, one (1) federal medical centre, 40 General hospitals, and 144 PHC facilities. There is a strong presence of mission hospitals and about 60 percent of health services in the state are provided by the mission hospitals.

With regard to human resources, as at 2008 there were a total of 27 doctors, 142 Nurses, 10 Medical lab scientists and 9 lab technicians. According to the National HRH strategy document, Ebonyi has a doctor population ratio of 6/100,000 population and 9/100,000 population for Nurses. The same goes for other cadres of health care workers, posing major challenges for the state with regard to meeting the health needs of the people.

The distribution of health manpower is skewed towards urban populations and the primary health centres do not have sufficient manpower as recommended by regulatory agencies.

The per capita health expenditure on health is about $4, much lower than the $34 recommended by the Macroeconomic Commission on Health for the attainment of the health-related MDGs. The capital budget on health for 2009 is 4.85% of the total budget of Ebonyi State – a far cry from the recommended minimum of 15% by WHO. About 70% of health expenditure is from out-of-pocket and the National Health Insurance Scheme is currently not operational in Ebonyi State. Community participation in Ebonyi State has been limited in scope, organization and impact.

In much of the rural areas, traditional medical practitioners provide much of the health services such that TBAs are the main stay for MNCH services. This is due to near absence of health facilities in these areas.

2.5 Key issues and challenges

With regard to delivering excellent health care to the Ebonyi populace, the bottleneck analysis identified the following key issues and challenges:

- Inadequate manpower
- Low budgetary allocation and performance
- Lack of vital equipment, deterioration or obsolescence of existing ones
- Dilapidated infrastructures
- Inadequate facilities
- Poor remuneration of staff
- Lack of training
- Inadequate materials for a well developed Health Management Information System

These bottlenecks demonstrate the priority areas for the State.

Chapter 3 Strategic Health Priorities

Preamble

The strategic priorities are based on the eight nationally identified priority areas which was adopted by the state.. They are: leadership and governance, service delivery, human resources for health, health financing, health information system, community participation and ownership, partnerships for health and research for health.

For each of these priority areas, the framework provides uniform guidance, specifying a goal with strategic objectives and corresponding recommended interventions for the States to consider. It is from this that State specific activities were selected to deliver the different interventions, which in turn will contribute to the attainment of the strategic objectives and the goals.

HIGH IMPACT SERVICES
FAMILY/COMMUNITY ORIENTED SERVICES
Insecticide Treated Mosquito Nets for children under 5
Insecticide Treated Mosquito Nets for pregnant women
Household water treatment
Access to improved water source
Use of sanitary latrines
Hand washing with soap
Clean delivery and cord care
Initiation of breastfeeding within 1st hr. and temperature management
Condoms for HIV prevention
Universal extra community-based care of LBW infants
Exclusive Breastfeeding for children 0-5 mo.
Continued Breastfeeding for children 6-11 months
Adequate and safe complementary feeding
Supplementary feeding for malnourished children
Oral Rehydration Therapy
Zinc for diarrhea management
Vitamin A - Treatment for measles
Artemisinin-based Combination Therapy for children
Artemisinin-based Combination Therapy for pregnant women
Artemisinin-based Combination Therapy for adults
Antibiotics for U5 pneumonia
Community based management of neonatal sepsis
Follow up Management of Severe Acute Malnutrition
Routine postnatal care (healthy practices and illness detection)
B. POPULATION ORIENTED/OUTREACHES/SCHEDULABLE SERVICES
Family planning
Condom use for HIV prevention
Antenatal Care
Tetanus immunization
Deworming in pregnancy
Detection and treatment of asymptomatic bacteriuria
Detection and management of syphilis in pregnancy
Prevention and treatment of iron deficiency anemia in pregnancy
Intermittent preventive treatment (IPTp) for malaria in pregnancy
Preventing mother to child transmission (PMTCT)
Provider Initiated Testing and Counseling (PITC)
Condom use for HIV prevention
Cotrimoxazole prophylaxis for HIV+ mothers
Cotrimoxazole prophylaxis for HIV+ adults

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

Chapter 4: Resource Requirements

4.1 Human

To implement the Ebonyi SSHDP, analysis shows that each LGA would need to have the following in its employment list as minimum Staff complement :-

- 3 Doctors
- 40 Nurses
- 4 Laboratory Technicians
- 60 community health extension workers
- 2 Monitoring and Evaluation Officers
- Security personnel offering 24hr. Services in the Health centres at least 2

The implication is that the state needs a total minimum of 39 doctors (3 for each of the 13 LGAs) as against the current 20. Similarly, 520 nurses will be required as against the 142; and for Laboratory Technicians, 52 will be required as against the current 10. For each cadre of health workers, there is a minimum of 50 per cent gap between current availability and need.

4.2 Physical/Materials

Additional building and reconstruction of health facilities are required. These should also be equipped to provide needed services e.g. Emergency Obstetric Care, Renal dialysis Unit, Cardiology Unit and Radiotherapy Units.

4.3 Financial

The State is in great need of financial assistance. There is much financial gap between amount needed to carry out health activities and amount provided to health.

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 Abia state is **N43,348,309,979.00; Forty-three** ***billion, three hundred and forty-eight million, three hundred and nine thousand, nine hundred and seventy-nine Naira only***. The breakdown of the costs according to priority area are as follows:

PRIORITY AREA	COST 2010-2015
Leadership and Governance for Health	433,483,100.00
Health Service Delivery	19,396,511,757.00
Human Resources for Health	11,560,966,099.00
Financing for Health	9,573,191,973.00
National Health Information System	650,224,650.00
Community Participation and ownership	433,483,100.00
Partnerships for Health	433,483,100.00
Research for Health	866,966,200.00
	43,348,309,979.00

5.2 Assessment of the available and projected funds

An assessment of the available and projected funds in Ebonyi 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.

Year	Total Budget	Total health budget	MNCH budget	Amount released
2007		N1.866 billion	N67.6 million	N3.0 million

2008		N1.87803 billion	N91 million	N8.0 million

An overview of the general expenditure profile as encapsulated in the table above shows that in the past 2 years, Ebonyi State had budgeted about N1.87b to the health sector annually. This is a far cry from the average 4.5billion annual requirement from the costed SSHDP for the next six years. The situation is even more critical considering that the actual amount released for the period is between 5-10% using the amount released for IMNCH as indicator.

b. *Fiscal, micro & macro financial environment.*

Ebonyi is not an oil producing State and has no industrial base. The State seems to depend entirely on statutory allocation from Abuja. Her internally generated revenue (IGR) profile is very poor. Ebonyi receives an average allocation of N2billion monthly. Her IGR is less than 10% of the allocation meaning that any fluctuation in oil price that negatively affects statutory allocation would put her in serious jeopardy.

c. *Support from Development partners.*

Development partners working in the state include UNFPA, UNICEF, WHO, World Bank and GLRA. 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 Ebonyi State.
As a result of the above variables, the available financial resources for SSHDP is about 10-20%.

5.3 Determination of the financing gap

Based on the fact that only 10-15% of the required funds for the State Strategic Health development Plan could be met internally, unless internally generated revenue profile significantly improves, the financial gap is over **N30** ***billion for the next 6 years.***

The above figure is also subject to variations based on the statutory receipts from 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.
- 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.
- Creating a legislative framework that allows the allocation of more funds to the health sector by the State House of Assembly in line with the Abuja declaration, provisions of the National health act on funding of primary healthcare, etc.
- 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.
- The State enrolling in the National Health Insurance Scheme.

Chapter 6: Implementation Framework

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

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

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

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

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

Development partners will provide technical assistance and additional funding

Strategic partners	***Roles and their Inter relations***
● Ebonyi State University Teaching Hospital	Tertiary, teaching & Research.
● Federal Medical Centre, Umuahia	Tertiary & specialist referral
● Development Partners	Provide programmatic technical support
● Env. & Comm. Health Officers	Provide services at the community level
● Schools of Nursing & Midwifery	Training base for Nurses
● All PHC Health Facilities	Provide direct primary care
● Private & Faith based practitioners	Strategic alternative service
● Civil Society groups	Community Interface

- Individuals and families — Primary recipient stakeholders

Zero tolerance to corruption is one of the values of the present administration in Ebonyi State. There is a standing Ministerial Tenders Board, Due Process Office at the Ministry and the Office of the Commissoner for Foreign Donor and Grants.

Chapter 7: Monitoring and Evaluation

7.1 Proposed mechanisms for monitoring and evaluation

Strengthening of the Health Management Information System will be carried out early in the plan to ensure that M & E and DSN units are empowered at all levels to track and monitor progress. Specifically, periodic joint assessment of achievements and progress towards MDGs will be carried out with the Local Government Councils. Monitoring and Evaluation were incorporated as key activities in each of the 8 priority areas. Expanded Health Data Consultative Committee (HDCC), Interagency Coordinating Committee and the Forum for Development Partners will be used to ensure cooperation of all stakeholders. More regular State Council on Health meetings will be used to provide forum for broad-based consultation, coordination and collaboration on a continuous basis in Ebonyi State(Salt of the Nation).

7.2 Costing the monitoring and evaluation component and plan

Following international standards, 1% of total plan budget would need to be allocated to M&E. By implication this would mean that of the 53.4 billion cost of the plan, about N534 million should be set aside for M&E.

Chapter 8: Conclusion

A lot of effort has gone into drawing up the Ebonyi SSHDP. What is left is for the government to demonstrate the political will and commitment to translate the plan to reality. If this SSHDP is implemented, the State hopes to achieve the MDG 4,5 and 6. This will demand increased funding to the health sector, improved monitoring and evaluation, inter-sectoral collaboration, improved Public-Private Partnership and community participation

The objective of Ebonyi SSHDP is to harmonize the design, coordination, management, organisation and delivery of PHC services the state, provide a coherent investment plan for health in the next six years and act as an advocacy document and a framework for coordinating and maximising the contributions of donors/development partner's to the strengthening of health activities in the state.

Annex 1: Details of Ebonyi Strategic Health Development Plan

EBONYI STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
PRIORITY							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total 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							**433,483,099.79**
	1.1	**To provide clear policy directions for health development**			**All stakeholders are informed regarding health development policy directives by 2011**		**23,996,072**
		1.1.1	Improved Strategic Planning at Federal and State levels				**23,996,072**
			1.1.1.1	Adapt all national policy guidelines and clinical protocols on IMNCH and other major health programmes in the State	Availability of costed annual operational plans from SSHDP and LGASHDP	Availability of skill in the State.	**23,996,072**
			1.1.1.2	Conduct regular review and planning meetings with State, LGA and other key stakeholders to monitor progress and replan to improve on implementation.			**-**
			1.1.1.3	Build managerial capacity of health management teams at State and LGA level and pay advocacy to legislature, ministry of finance and State Planning Commission on the integration of IMNCH programmes into relevant development policies and programmes in order to improve resources			**-**
			1.1.1.5	Build capacity of Programme managers at all levels of the IMNCH chain in programme management			**-**
	1.2	**To facilitate legislation and a regulatory framework for health development**			**Health Bill signed into law by end of 2009**		**320,909,377**
		1.2.1	Strengthen regulatory functions of government				**320,909,377**
			1.2.1.1	Enact the Public Health Law of Ebonyi State	Published Ebonyi State Public health law.		**13,262,357**
			1.2.1.2	Develop State public/private partnership policy and plans with agreed quality standards for IMNCH and other major health programmes, in line with the national policy on PPP.			**197,602,644**
			1.2.1.3	Conduct joint Public/Private continuous professional development and supportive supervision of IMNCH and other major health programmes			**2,424,153**
			1.2.1.4	Outsource relevant components of IMNCH and other major health			**107,620,223**

				programme service delivery to the private sector for more efficiency			
	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**		**21,479,589**
		1.3.1	To improve accountability and transparency				**21,479,589**
			1.3.1.1	Build the capacity of State IMNCH and other major health Programmes' programme managers , budget officers and LGA health teams on financial management, transparency and accountability.	Annual reports of the Joint review of the health sector by the SMOH and the Independent 'watch dogs'		**607,938**
			1.3.1.2	Build the capacity of local NGOs, CSOs and the Press to write and report on the implementation of IMNCH and other major health programmes in order to enforce fiscal discipline, transparency, accountability and consistency in the mobilization, allocation and utilization of funds for IMNCH and other major health programme services			**3,345,939**
			1.3.1.3	Build the capacity of Ward Development Committee members to be able to manage and oversee their health projects and programmes			**4,939,496**
			1.3.1.4	Institute Stakeholders' dialogue and feedback forum at the State and LGA levels in order to enlist their input into health sector decision-making.			**12,586,216**
	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**		**67,098,061**
		1.4.1	Improving and maintaining Sectoral Information base to enhance performance				**67,098,061**
			1.4.1.1	Train directors, Head of Units & Programme Officers at SMOH and LGA health teams on computer literacy and the use of data management softwares	Quarterly publication of analysed data from all programme areas	Availability of capacity for analytical work in the State.	**741,630**
			1.4.1.2	Provide all trained Officers with a laptop and accessories equipped with data management software and internet facility			**37,631,362**
			1.4.1.3	Perform routine indepth analytical work on data from monitoring and supervisory activities, routine disease notification and surveillance reports and epidemiological surveys and interventions with necessary feedback to lower levels in order to track health sector performance and drive improvements and reform.			**28,725,070**

		1.4.2	Advocacy to mobilize Support				-
			1.4.2.1	Develop IMNCH advocacy and other relevant tools to reduce maternal, newborn and child mortality and promote IMNCH strategy at various levels to improve commitment of national, political , community and religious leaders			-
			1.4.2.2	Advocate for an increase in the allocation of not less than 15% of total national budget for health in accordance to Abuja declaration.			-
			1.4.2.3	Develop an advocacy strategy to ensure allocation of a significant proportion of the total health budget to IMNCH services at all levels and the allocation of at least 60% of proposed NPHCDA fund to IMNCH services at the local government and communities			-
			1.4.2.4	7.1Conduct advocacy at all levels to promote partnership for IMNCH			-
			1.4.2.5	Establish the State Partnership for MNCH to improve coordination and support for implementation of the IMNCH strategy			-
HEALTH SERVICE DELIVERY							
2. To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare							**19,396,511,757.03**
	2.1	**To ensure universal access to an essential package of care**			**Essential Package of Care adopted by all States by 2011**		
		2.1.1	To review, cost, disseminate and implement the minimum package of care in an integrated manner				
			2.1.1.1	Establish, define and cost the Implementation of State-specific Minimum Health Care Package for MNCH at Primary, Secondary and Tertiary levels of care to include human resources, drugs, supplies, equipments, and infrastructure.	**Availability of costed minimum package of care document at all levels**		
		2.1.2	To strengthen specific communicable and non communicable disease control programmes				-
			2.1.2.1	Develop advocacy and other relevant tools and Conduct Advocacy tosensitize legislators, ministry of finance and planning offices at all levels in the integration of communicable and non-communicable diseases control programmes into relevant development policies and programmes in order to improve resources.			-
			2.1.2.2	Assess training needs and strengthen the skills and capacity of programme managers and health management teams at all levels in programme management.			-
			2.1.2.3	Build managerial capacity of health management teams at the state, and local government levels			-
			2.1.2.4	Conduct regular review and planning meetings with State, local government,			-

				and other key stakeholders to monitor progress and re-plan to improve on implementation.			
			2.1.2.5	Supervise, monitor and evaluate all communicable and non-communicable disease control programmes in an integrated manner.			-
		2.1.3	To make Standard Operating procedures (SOPs) and guidelines available for delivery of services at all levels				-
			2.1.3.1	Constitute and Inaugurate State Expert Committees for each service delivery area			-
			2.1.3.2	Develop Standard Operating Procedures for Case management of specific diseases and guidelines for service delivery by the Expert Committees, in line with acceptable international standards			-
			2.1.3.3	Produce and disseminate the SOPs and guidelines to all health facilities in the State, and update as the need arises.			-
			2.1.3.4	Train health workers on the use of the SOPs and guidelines for effective service delivery			-
			2.1.3.5	Supervise and monitor the use of the SOPs and guidelines to ensure compliance with standards			-
	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**		-
		2.2.1	To improve geographical equity and access to health services				-
			2.2.1.1	Implement minimum health care packages for MNCH at all levels of care.			-
			2.2.1.2	Expand PHC facilities/services in under-served areas including revitalization of non-functioning facilities			-
			2.2.1.3	Regular maintenance of health facilities and infrastructure			-
			2.2.1.4	Provide outreach from PHC facility level to communities and households			-
			2.2.1.5	Establish and ensure compliance to guidelines that stipulate access to care and linkages between EBSUTH and FMC with the 13 General hospitals, and between the GHs and the WHCs.			-
		2.2.2	To ensure availability of drugs and equipment at all levels				-
			2.2.2.1	Adapt, publish, disseminate and enforce compliance with the essential drugs list for all levels of care.			-
			2.2.2.2	Strengthen capacity for forecasting, procurement and distribution of essential drugs and other consumables on a sustainable basis at all levels			-
			2.2.2.3	Adapt the equipment list, and procure and distribute equipments based on need			-

				for the different levels of health facilities in line with the essential package of care			
			2.2.2.4	Assess and strengthen supply chain systems			-
			2.2.2.5	Train key staff in logistic management of drugs, vaccines, RH supplies, ITN, medical equipments etc.			-
		2.2.3	To establish a system for the maintenance of equipments at all levels				-
			2.2.3.1	Adapt, disseminate and implement the National Health Equipment Policy;			-
			2.2.3.2	Build capacity of the medical equipment and hospital furniture maintenance unit in the Works dept of the SMOH for installation and maintenance of medical equipments			-
			2.2.3.3	Collaborate with the private sector in maintenance of medical equipment and hospital furniture when the need arises.			-
		2.2.4	To strengthen referral system				-
			2.2.4.1	Resuscitate and strengthen a two way referral system through logistic support such as radio communication and transport to each local government			-
		2.2.5	To foster collaboration with the private sector				-
			2.2.5.1	Engage and motivate the private health facilities to contribute to scaling up of IMNCH and other major health programmes			-
			2.2.5.2	Strengthen the system for the registration and regulation of their practice.			-
			2.2.5.3	Adapt and implement the national policy on traditional medicine both at secondary and primary health care levels.			-
	2.3	**To improve the quality of health care services**			**50% of health facilities participate in a Quality Improvement programme by end of 2012**		-
		2.3.1	To strengthen professional regulatory bodies and institutions				-
			2.3.1.1	Organize/Involve and build capacity of private sector service providers, teaching and research institutions and professional bodies to support implementation of IMNCH and other health programmes.			-
		2.3.2	To develop and institutionalise quality assurance models				-
			2.3.2.1	Institutionalise quality assurance and improvement initiatives at all levels.			-
		2.3.3	To institutionalize Health Management and Integrated Supportive Supervision (ISS) mechanisms				-
			2.3.3.1	Promote use of integrated supportive supervision tools to track progress in the implementation of IMNCH interventions			-

			2.3.3.2	Promote the use of integrated supportive supervison tools to track progress in the implementation of IMNCH interventions and other major health programmes			-
	2.4	**To increase demand for health care services**			**Average demand rises to 2 visits per person per annum by end 2011**		-
		2.4.1	To create effective demand for services				-
			2.4.1.1	Adapt the national health promotion communication strategy based on the National Health Promotion Policy			-
			2.4.1.2	Disseminate and implement the health promotion communication strategy at all levels			-
			2.4.1.3	Institutionalise biannual MNCH weeks and strengthen the celebration of other major health events.			-
	2.5	**To provide financial access especially for the vulnerable groups**			**1. Vulnerable groups identified and quantified by end 2010 2. Vulnerable people access services free by end 2015**		-
		2.5.1	To improve financial access especially for the vulnerable groups				-
			2.5.1.1	Establish financial mechanisms that protects the poor and other vulnerable groups including exemptions, subsidies, insurance and other methods in the utilization of IMNCH and other health services.			-
			2.5.1.2	Establish mutual health funds to ensure financial access to IMNCH health services especially in the rural areas			-
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							**11,560,966,099.47**
	3.1	**To formulate comprehensive policies and plans for HRH for health development**			**All States and LGAs are actively using adaptations of the National HRH policy and Plan by end of 2015**		-
		3.1.1	To develop and institutionalize the Human Resources Policy framework				-
			3.1.1.1	Adopt the National HRH Policy and Strategic Plan to guide human resource development at all levels in the State			-
			3.1.1.2	Recruit health personnel in a non-restrictive and non-discriminatory manner irrespective of state of origin and/or gender to be able to implement the SSHDP.			-

			3.1.1.3	Adopt and implement national guidelines on task shifting for IMNCH and other major health programmes			-
	3.2	**To provide a framework for objective analysis, implementation and monitoring of HRH performance**			**The HR for Health Crisis in the country has stabilised and begun to improve by end of 2012**		-
		3.2.1	To reappraise the principles of health workforce requirements and recruitment at all levels				-
			3.2.1.1	Adopt and implement the national Career pathways for all groups of health professionals critically needed to foster demand and supply creation in the health sector	The HRH gaps identified in the National HRH plan and strategy closed by 2015		-
			3.2.1.2	Adopt and implement the staffing norms based on workload, service availability and health sector priorities.			-
			3.2.1.3	Strengthen the coordinating mechanism for consistency in HRH planning and budgeting by Ministries of Health, Finance, Education, Civil Service Commission, Regulatory bodies, Private Sector Providers, NGOs in health, and other institutions.			-
	3.3	**Strengthen the institutional framework for human resources management practices in the health sector**			**1. 50% of States have functional HRH Units by end 2010 2. 10% of LGAs have functional HRH Units by end 2010**		-
		3.3.1	To establish and strengthen the HRH Units				-
			3.3.1.1	Establish and strengthen HRH units in the SMOH and LGA health departments to perform HRH functions.			-
	3.4	**To strengthen the capacity of training institutions to scale up the production of a critical mass of quality, multipurpose, multi skilled, gender sensitive and mid-level health workers**			**One major training institution per Zone producing health workforce graduates with multipurpose skills and mid-level health workers by 2015**		-
		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				-
			3.4.1.1	Update pre-service training curriculum and approaches to be in line with evidence-based standards for MNCH care and other major health programmes			-
			3.4.1.2	Strengthen pre-service education in health training institutions to provide the necessary skills and competencies			-

			3.4.1.3	Support the school of Nursing/Midwifery at Mater Hospital, Institute of Health at Uburu and the State University (EBSU) to Expand their capacities to train Nurses/Midwives and other cadres of supportive personnel.			-
		3.4.2	To strengthen health workforce training capacity and output based on service demand				-
			3.4.2.1	Assess training needs , train and re-train and update in-service training programmes to ensure that all providers have appropriate competencies/skills, provider attitudes and ethics for IMNCH and other major health programmes			-
	3.5	**To improve organizational and performance-based management systems for human resources for health**			**50% of States have implemented performance management systems by end 2012**		-
		3.5.1	To achieve equitable distribution, right mix of the right quality and quantity of human resources for health				-
			3.5.1.1	Redeploy staff equitably between rural and urban areas and at the different levels of the health care system in relation to needs, paying attention to staff mix			-
			3.5.1.2	Deploy doctors and midwives under NYSC scheme, and midwives under the Midwifery Service Scheme to underserved areas.			-
			3.5.1.3	Collaborate with the Federal Medical Centre and Ebonyi State University Teaching Hospital to leverage available human resources so as to expand service coverage and quality.			-
		3.5.2	To establish mechanisms to strengthen and monitor performance of health workers at all levels				-
			3.5.2.1	Conduct routine re-orientation of health workforce on attitudinal change including training and retraining in Interpersonal Communication (IPC) skills and work ethics.			-
			3.5.2.2	Monitor health worker performance using client feedback (exit interviews)and institute a system of recognition, reward and sanctions for deserving health workers.			-
			3.5.2.3	Provide an enabling environment and incentives for public sector health care personnel to minimize the attrition of staff and the brain drain syndrome in line with the Human Resource Policy.			-
	3.6	**To foster partnerships and networks of stakeholders to harness contributions for human resource for health agenda**			**50% of States have regular HRH stakeholder forums by end 2011**		-
		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				
			3.6.1.1	Establish quarterly forum for Health Care Professional Associations and regulatory bodies at all levels			-
			3.6.1.2	Promote the involvement of HCPA in the design and monitoring of services to enhance cooperation amongst all actors.			-
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							**9,573,191,973.46**
	4.1	**To develop and implement health financing strategies at Federal, State and Local levels consistent with the National Health Financing Policy**			**50% of States have a documented Health Financing Strategy by end 2012**		
		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				
			4.1.1.1	Set up technical working groups for health financing at the State and LGA levels.			
			4.1.1.2	Capacity building of the TWGs for the development and implementation of the Strategic Plans at all levels			
	4.2	**To ensure that people are protected from financial catastrophe and impoverishment as a result of using health services**			**NHIS protects all Nigerians by end 2015**		-
		4.2.1	To strengthen systems for financial risk health protection				-
			4.2.1.1	Establish financial mechanisms that protect the poor and vulnerable groups including exemptions, subsidies, insurance and other methods in the utilization of IMNCH and other major health programmes			-
			4.2.1.2	Establish mutual health funds			-
			4.2.1.3	Devise a financial mechanism to regulate highly subsidized or free MNCH services at the point of uptake at all levels to remove financial barriers to services			-
	4.3	**To secure a level of funding needed to achieve desired health development goals and objectives at all levels in a sustainable manner**			**Allocated Federal, State and LGA health funding increased by an average of 5% pa every year until 2015**		-
		4.3.1	To improve financing of the Health Sector				-
			4.3.1.1	Institute budget line and ensure timely release of adequate funds for procurement and management of essential commodities			-

			4.3.1.2	Revitalise DRF and strengthen its management as well as ensure community participation and ownership.			-
			4.3.1.3	Advocate for increased community resourcs and investment			-
			4.3.1.4	Establish Special funds for chronic and emerging diseases (e.g. mental health, cancers, diabetes etc.).			-
			4.3.1.5	Institutionalise community- based MNCH services and allocate a budget for implementation			-
		4.3.2	To improve coordination of donor funding mechanisms				-
			4.3.2.1	Strengthen the donor coordination mechanism already in existence in the State.			-
	4.4	**To ensure efficiency and equity in the allocation and use of health sector resources at all levels**			**1. Federal, 60% States and LGA levels have transparent budgeting and financial management systems in place by end of 2015 2. 60% of States and LGAs have supportive supervision and monitoring systems developed and operational by Dec 2012**		-
		4.4.1	To improve Health Budget execution, monitoring and reporting				-
			4.4.1.1	Develop costed, annual operational plans at State and LGAs.			-
			4.4.1.2	Build capacity of SMOH and LGAs for improved financial management.			-
			4.4.1.3	Develop and implement State Health Account (SHA).			-
			4.4.1.4	Establish mechanism for Public Expenditure Reviews (PERs) and tracking of health budgets.			-
		4.4.2	To strengthen financial management skills				-
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							**650,224,649.68**
	5.1	**To improve data collection and transmission**			**1. 50% of LGAs making routine NHMIS returns to State level by end 2010 2. 60% of States making routine NHMIS returns to**		

					Federal level by end 2010		
		5.1.1	To ensure that NHMIS forms are available at all health service delivery points at all levels				
			5.1.1.1	Annual Printing of the data collection forms by the SMOH.			
			5.1.1.2	Distributing the forms to LGAs and appropriate facilities to ensure their utilisation			-
		5.1.2	To periodically review of NHMIS data collection forms				-
			5.1.2.1	Quarterly meeting of monitoring and evaluation officers for feedback from the field			-
			5.1.2.2	Annual meeting for review of data collection forms based on findings of the quarterly feedback fora.			-
			5.1.2.3	Review NHMIS data collection forms based on findings of the annual review meeting.			-
		5.1.3	To coordinate data collection from vertical programmes				-
			5.1.3.1	Revitalise the Health Data Consultative Committee in the State.			-
			5.1.3.2	Conduct monthly meeting of M & E officers with all programme officers in the LGA for data collation	Conduct biannual meetings of the Health Data Consultative Committee to review harmonised data collection mechanism at State and LGAs		-
			5.1.3.3	Conduct monthly meeting of the State M & E, LGA M & E and State programme officers for data analysis.			-
		5.1.4	To build capacity of health workers for data management				-
			5.1.4.1	Support and promote the use of registers in all facililites (including private facilities) through training, supervision and regular feedback			-
			5.1.4.2	Equip the health information officers with relevant ICT tools for effective data management at the State and LGA levels.			-
			5.1.4.3	Establish and build capacity for maternal, newborn and child mortality review system which links the community, LGA and State government			-
		5.1.5	To provide a legal framework for activities of the NHMIS programme				-
			5.1.5.1	Enact a law at the State and by-laws at the LGAs making submission of health data by private practitioners to relevant health authorities mandatory.			-
		5.1.6	To improve coverage of data collection				-
			5.1.6.1	Strengthen community based information for improved decision making and			-

				programming at all levels through training and retraining of CORPs			
		5.1.7	To ensure supportive supervision of data collection at all levels				-
			5.1.7.1	Promote use of integrated support supervision tools to track progress in the implementation of IMNCH interventions			-
			5.1.7.2	Promote use of integrated Supportive Supervision tools to track progress in the implementation of IMNCH and other major health interventions			-
	5.2	**To provide infrastructural support and ICT of health databases and staff training**			**ICT infrastructure and staff capable of using HMIS in 50% of States by 2012**		-
		5.2.1	To strengthen the use of information technology in HIS				-
			5.2.1.1	Equip HMIS office at the State and M & E offices at the LGAs with ICT hardwares and softwares as defined by the HMIS minimum package for the State and LGAs.			-
		5.2.2	To provide HMIS Minimum Package at the different levels (FMOH, SMOH, LGA) of data management				-
			5.2.2.1	Adapt the HMIS minimum package for data collection document.			-
			5.2.2.2	Disseminate the document on the minimum package of HMIS to all levels.			-
	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**		-
		5.3.1	To strengthen the Hospital Information System				-
			5.3.1.1	Strengthen Patient information system in the State University teaching hospital, the 13 General Hospitals and the Ward Health Centres.			-
			5.3.1.2	strengthen the Disease surveillance system.			-
		5.3.2	To strengthen the Disease Surveillance System				-
			5.3.2.1	Adaptation of national technical guidelines and reporting forms on Integrated Disease Surveillance and Response			-
			5.3.2.2	Strengthen epidemic response committees and CORPs at all levels			-
			5.3.2.3	Strengthen logistic support for IDSR activities and rehabilitation of existing public health laboratory infrastructure / equipment			-
			5.3.2.4	Regular monitoring and supervision of IDSR activities			-
	5.4	**To monitor and evaluate the NHMIS**			**NHMIS evaluated annually**		-

		5.4.1	To establish monitoring protocol for NHMIS programme implementation at all levels in line with stated activities and expected outputs				-
			5.4.1.1	Define minimum set of indicators, coverage and impact targets for monitoring and evaluation of MNCH strategy based on SITAN and design a uniform reporting format.			-
			5.4.1.2	Conduct regular HMIS monitoring activities using the HMIS QA manual as a checklist.			-
		5.4.2	To strengthen data transmission				-
			5.4.2.1	Build human and institutional capacity from public and private health facilities for data transmission.			-
	5.5	**To strengthen analysis of data and dissemination of health information**			**1. 50% of States have Units capable of analysing health information by end 2010 2. All States disseminate available results regularly**		-
		5.5.1	To institutionalize data analysis and dissemination at all levels				-
			5.5.1.1	Build human and institutional capacity from public and private health facilities for data analysis and dissemination to policy makers for decision making.			-
			5.5.1.2	Production of health data bulletin and annual reports by the DPRS and dissemination to the public and policy makers.			-
COMMUNITY PARTICIPATION AND OWNERSHIP							
6. To attain effective community participation in health development and management, as well as community ownership of sustainable health outcomes							**433,483,099.79**
	6.1	**To strengthen community participation in health development**			**All States have at least annual Fora to engage community leaders and CBOs on health matters by end 2012**		
		6.1.1	To provide an enabling policy framework for community participation				
			6.1.1.1	Adapt the revised community participation section of the National Health Policy in the State			-
			6.1.1.2	Adapt the Community Development Policy in the State when finalized.			-
		6.1.2	To provide an enabling implementation framework and environment for community participation				-
			6.1.2.1	Update and adapt guideline for establishing inter-sectoral Ward Development Committees for each ward.			-

			6.1.2.2	Develop participatory tools and approaches to enhance community involvement in planning, management, monitoring and evaluation of health interventions.			-
	6.2	**To empower communities with skills for positive health actions**			**All States offer training to FBOs/CBOs and community leaders on engagement with the health system by end 2012**		-
		6.2.1	To build capacity within communities to 'own' their health services				-
			6.2.1.1	Build capacity of CORPs and care givers for early recognition of warning signs of Obstetric and Neonatal complications and childhood illnesses.			-
			6.2.1.2	Re-orientation of community development committees and community-based health care providers on their roles and responsibilities			-
		6.2.2	To Strengthen individual, family and community capacity to respond to MNCH issues at home and seek health care appropriately				-
			6.2.2.1	Institute and support community education on MNCH issues including birth preparedness plan, newborn care and CIMI at the household care at appropriately			-
			6.2.2.2	Promote counseling services at the household level to increase utilization and timely access to IMNCH services			-
			6.2.2.3	Strengthen community and ward devlopment committees to enable them respond appropriately at times of emergencies (to mobilize community resources for emergency transport, blood donrs and other aspects of emergency preparedness			-
			6.2.2.4	Promote male involvement as part of shared responsibility and collective action to improve household healthcare seeking behaviour and other key household practices			-
			6.2.2.5	Build capacity ofand involve relevant NGOs with comparative advantage ins specific areas of interventions such as advocacy, BCC and social marketing, etc.			-
	6.3	**To strengthen the community - health services linkages**			**50% of public health facilities in all States have active Committees that include community representatives by end 2011**		-

		6.3.1	To restructure and strengthen the interface between the community and the health services delivery points				-
			6.3.1.1	Strengthen the link between LGA health system and the community through the formation and reactivation of community/ward development committees to promote greater involvement of communities in MNCH activities			-
	6.4	**To increase national capacity for integrated multisectoral health promotion**			**50% of States have active intersectoral committees with other Ministries and private sector by end 2011**		-
		6.4.1	To develop and implement multisectoral policies and actions that facilitate community involvement in health development				-
			6.4.1.1	Adapt the National Behaviour and Social Change Communication Strategy.			-
			6.4.1.2	Scale up Behavioural Change Communication activities to promote Key household activities			-
	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**		-
		6.5.1	To develop and implement systematic measurement of community involvement				-
			6.5.1.1	Implement Participatory Rural Appraisal activities to enable communities measure impact of health services and projects and document lessons learnt.			-
			6.5.1.2	Disseminate the findings from such efforts to enhance knowledge sharing amongst stakeholders			-
PARTNERSHIPS FOR HEALTH							
7. To enhance harmonized implementation of essential health services in line with national health policy goals							**433,483,099.79**
	7.1	**To ensure that collaborative mechanisms are put in place for involving all partners in the development and sustenance of the health sector**			**1. FMOH has an active ICC with Donor Partners that meets at least quarterly by end 2010 2. FMOH has an active PPP forum that meets quarterly by end 2010 3. All States have similar active committees by end 2011**		

		7.1.1	To promote Public Private Partnerships (PPP)				-
			7.1.1.1	Adapt the reviewed national PPP policy in the State			-
			7.1.1.2	Improve the working arrangements between the public and private sector to increase the involvement of the private sector in financing and the provision of IMNCH services.			-
			7.1.1.3	Establish PPP unit at the SMOH to promote, oversee and monitor PPP initiatives			-
			7.1.1.4	Provide enabling environment for the private sector to set up health facilities in rural and under-served areas to render IMNCH and other major health programme services.			-
		7.1.2	To institutionalize a framework for coordination of Development Partners				-
			7.1.2.1	Improve networking and coordination of resources for MNCH services from donors and global initiatives (GFATM, GAVI, PEPFAR)	Strengthen the donor coordination mechanism already in existence in the State.		-
		7.1.3	To facilitate inter-sectoral collaboration				-
			7.1.3.1	Establish multisectoral PMNCH at all levels including private sector			-
		7.1.4	To engage professional groups				-
			7.1.4.1	engage professional groups in planning, implementation, monitoring and evaluation of health plans and programmes			-
		7.1.5	To engage with communities				-
			7.1.5.1	Improve availability of information to communitiesthrough culturally appropriate and gender sensitive dissemination channels.			-
			7.1.5.2	Promote the concept of citizen's rights and entitlement to quality, accessible basic health services			-
			7.1.5.3	Institute mechanisms for competition between LGAs and facilities for satisfactory performance in delivery of community support programmes for health			-
		7.1.6	To engage with traditional health practitioners				-
			7.1.6.1	Establish the traditional medicine practitioners' Board as a unit in the SMOH to regulate their practice.			-
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							**866,966,199.57**
	8.1	**To strengthen the stewardship role of governments at all levels for research and knowledge management systems**			**1. ENHR Committee established by end 2009 to guide health research**		-

					priorities 2. FMOH publishes an Essential Health Research agenda annually from 2010		
		8.1.1	To finalise the Health Research Policy at Federal level and develop health research policies at State levels and health research strategies at State and LGA levels				-
			8.1.1.1	Develop State Health Research Policy on MNCH and other interventions.			-
		8.1.2	To establish and or strengthen mechanisms for health research at all levels				-
			8.1.2.1	Create Research Units within the department of PRS in the SMOH and LGAs			-
			8.1.2.2	Strengthen Health Research Units at SMOH and LGAs to coordinate and encourage research efforts.			-
		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				-
			8.1.4.1	Establish links between policy makers who use research and universities and other institutions and individuals who produce research			-
		8.1.5	To mobilise adequate financial resources to support health research at all levels				-
			8.1.5.1	Establish Ebonyi State Independent Health Research Funding Agency.			-
			8.1.5.2	Mobilise and deploy fund for research in a targeted manner			-
		8.1.6	To establish ethical standards and practise codes for health research at all levels				-
			8.1.6.1	Establish and/or strengthen ethical review committees in the state.			-
			8.1.6.2	Establish a monitoring and evaluation system to regulate research and use of research findings at all levels.			-
	8.2	**To build institutional capacities to promote, undertake and utilise research for evidence-based policy making in health at all levels**			**FMOH has an active forum with all medical schools and research agencies by end 2010**		-
		8.2.1	To strengthen identified health research institutions at all levels				-
			8.2.1.1	Identify and strengthen public and private institutions and organizations undertaking health research.			-
		8.2.2	To create a critical mass of health researchers at all levels				-
			8.2.2.1	Create a critical mass of researchers in conjunction with training institutions			-
		8.2.3	To develop transparent approaches for using research findings to aid evidence-based policy making at all levels				-

			8.2.3.1	Establish mechanisms for translating research findings into policies in the State.			-
		8.2.4	To undertake research on identified critical priority areas				-
			8.2.4.1	Conduct systematic researches on a number of topical areas to strengthen the health system			-
	8.3	**To develop a comprehensive repository for health research at all levels (including both public and non-public sectors)**			**1. All States have a Health Research Unit by end 2010 2. FMOH and State Health Research Units manage an accessible repository by end 2012**		-
		8.3.1	To develop strategies for getting research findings into strategies and practices				-
			8.3.1.1	Utilize research outputs to improve strategies and practices in the health sector.			-
		8.3.2	To enshrine mechanisms to ensure that funded researches produce new knowledge required to improve the health system				-
	8.4	**To develop, implement and institutionalize health research communication strategies at all levels**			**A national health research communication strategy is in place by end 2012**		-
		8.4.1	To create a framework for sharing research knowledge and its applications				-
			8.4.1.1	Support the publishing of Ebonyi Medical Journal and other academic based journals in the State to enhance the sharing of research findings.			-
			8.4.1.2	Convene annual health conference, seminars and workshops on key thematic areas (financing, human resources, MDGs, health research, etc).			-
			8.4.1.3	Support participation in international conferences on health and mainstream best practices at State and LGAs.			-
		8.4.2	To establish channels for sharing of research findings between researchers, policy makers and development practitioners				-
			8.4.2.1	Develop the capacity of researchers to effectively produce policy briefs targeted at informing policy-makers, as well as the broad scientific and non-scientific audiences.			-
			8.4.2.2	Conduct an inventory of State based journals according to areas of focus			-
			8.4.2.3	Select and support journals on the basis of their ability to address issues related to Essential National Health Research (ENHR) principles			-
			8.4.2.4	Support wide dissemination of selected State journals to all stakeholders at federal, state and LGA levels			-

							43,348,309,979

Annex 2: Results/M&E Framework for the Plan

EBONYI 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						
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						
OUTPUTS	**INDICATORS**	**SOURCES OF DATA**	**Baseline**	**Milestone**	**Milestone**	**Target**
			2008/9	**2011**	**2013**	**2015**
PRIORITY AREA 1: LEADERSHIP AND GOVERNANCE FOR HEALTH						
1. Improved Policy Direction for Health Development	1. % of LGAs with Operational Plans consistent with the state strategic health development plan (SSHDP) and priorities	LGA s Operational Plans	0	50	75	100%
	2. % stakeholders constituencies playing their assigned roles in the SSHDP (disaggregated by stakeholder constituencies)	SSHDP Annual Review Report	30	70	80	95%
	3. State adopting the National Health Bill? (Yes/No)	SMOH	0	yes	yes	yes
	4. Number of Laws and by-laws regulating traditional medical practice at State and LGA levels	Laws and bye-Laws	1	2	3	4%
	5. % of LGAs enforcing traditional medical practice by-laws	LGA Annual Report		50%	60%	80%
3. Strengthened accountability, transparency and responsiveness of the State health system	6. % of LGAs which have established a Health Watch Group	LGA Annual Report	5	20	40	60%
2. Improved Legislative and Regulatory Frameworks for Health Development	7. % of recommendations from health watch groups being implemented	Health Watch Groups' Reports	20	40	60	80%
	8. % LGAs aligning their health programmes to the SSHDP	LGA Annual Report	0	50	75	100

	9. % DPs aligning their health programmes to the SSHDP at the LGA level	LGA Annual Report	0	50	75	100
	10. % of LGAs with functional peer review mechanisms	SSHDP and LGA Annual Review Report	10	30	50	80%
	11. % LGAs implementing their peer review recommendations	LGA / SSHDP Annual Review Report	30	50	75	100%
	12. Number of LGA Health Watch Reports published	Health Watch Report	0	50	75	100%
	13. % of "Annual Health of the LGA" Reports published and disseminated annually	Health of the State Report	0	20%	40%	60%
	14. % LGA public health facilities using the essential drug list	Facility Survey Report	30	40	80	100%
	15. % private health facilities using the essential drug list by LGA	Private facility survey	20	40	60	85%
	16. % of LGA public sector institutions implementing the drug procurement policy	Facility Survey Report	20	50	75	100%
	17. % of private sector institutions implementing the drug procurement policy within each LGA	Facility Survey Report	15	20	40	80%
	18. % LGA health facilities not experiencing essential drug/commodity stockouts in the last three months	Facility Survey Report	50	60	80	100%
	19. % of LGAs implementing a performance based budgeting system	Facility Survey Report	50	70	80	100%
	20. Number of MOUs signed between private sector facilities and LGAs in a Public-Private-Partnership by LGA	LGA Annual Review Report	5	10	15	25

	21. Number of facilities performing deliveries accredited as Basic EmOC facility (7 functions 24/7) and Comprehensive EmOC facility (9 functions 24/7)	States/ LGA Report and Facility Survey Report	13	26	40	5300%
STRATEGIC AREA 2: HEALTH SERVICES DELIVERY						
NSHDP GOAL: To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare						
Outcome 3: Universal availability and access to an essential package of primary health care services focusing in particular on vulnerable socio-economic groups and geographic areas						
Outcome 4: Improved quality of primary health care services						
Outcome 5: Increased use of primary health care services						
5. Improved access to essential package of Health care	22. % of LGAs with a functioning public health facility providing minimum health care package according to quality of care standards.	NPHCDA Survey Report	20	25	50	75%
	23. % health facilities implementing the complete package of essential health care	NPHCDA Survey Report	30	50	75	100%
	24. % of the population having access to an essential care package	MICS/NDHS	40	50	60	80%
	25. Contraceptive prevalence rate (modern and traditional)	NDHS	6.10%	10%	20%	30%
	26. % increase of new users of modern contraceptive methods (male/female)	NDHS/HMIS	10%	15%	25%	50%
	27. % of new users of modern contraceptive methods by type (male/female)	NDHS/HMIS	10.00%	15%	25%	50%
	28. % service delivery points without stock out of family planning commodities in the last three months	Health facility Survey	40	60	70	80%
	29. % of facilities providing Youth Friendly RH services	Health facility Survey	10	20	30	60%

	30. % of women age 15-19 who have begun child rearing	NDHS/MICS	8.20%	5%	3%	2%
	31. % of pregnant women with 4 ANC visits performed according to standards*	NDHS	75.70%	80%	85%	95%
	32. Proportion of births attended by skilled health personnel	HMIS	40.70%	65%	80%	90%
	33. Proportion of women with complications treated in an EmOC facility (Basic and/or comprehensive)	EmOC Sentinel Survey and Health Facility Survey	5%	10%	15%	20%
	34. Caesarean section rate	EmOC Sentinel Survey and Health Facility Survey	3%	5%	10%	15%
	35. Case fatality rate among women with obstretic complications in EmOC facilities	HMIS	20	18	15	10
Data to be provided	36. Perinatal mortality rate**	HMIS	40/1000LBs	35/1000LBs	30/1000LBs	25/1000 LBs
	37. % women receiving immediate post partum family planning method before discharge	HMIS	40	50	60	70
	38. % of women who received postnatal care based on standards within 48h after delivery	MICS	60	75	80	95
	39. Number of women presented to the facility with or for an obstetric fistula	NDHS/HMIS	600	250	100	50
	40. Number of interventions performed to repair an obstetric fistula	HMIS	352	200	86	48
	43. % of children exclusively breastfed 0-6 months	NDHS/MICS	2.90%	10%	20%	40%
	44. Proportion of 12-23 months-old children fully immunized	NDHS/MICS	19.00%	30%	50%	65%
	45. % children <5 years stunted (height for age <2 SD)	NDHSMICS	45.90%	35%	25%	10%

	46. % of under-five that slept under LLINs the previous night	NDHS/MICS	57.10%	65%	75%	85%
	47. % of under-five children receiving appropriate malaria treatment within 24 hours	NDHS/MICS	6.40%	15%	30%	50%
	48. % malaria successfully treated using the approved protocol and ACT;	MICS	35	50	70	80
	49. Proportion of children using effective malaria prevention and treatment measures	MICS	40	60	75	87
	50. % of women who received intermittent preventive treatment for malaria during pregnancy	NDHS/MICS	60	70	80	95
	51. HIV prevalence rate among adults 15 years and above	NARHS Zonal figure	2.6%*	2%	1.50%	1%
	52.Condom use at last high risk sex	NARHS Zonal figure	3.7%*	6%	10%	15%
	53. Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS	NDHS/MICS	47.30%	65	80	97
	54. Prevalence of tuberculosis	NARHS Zonal figure	6.9%*	5%	3%	2%
Output 6. Improved quality of Health care services	55. % of staff with skills to deliver quality health care appropriate for their categories	Facility Survey Report	50	70	80	90
	56. % of facilities with capacity to deliver quality health care	Facility Survey Report	40	50	60	75
	57. % of health workers who received personal supervision in the last 6 months by type of facility	Facility Survey Report	30	40	60	78
	58. % of health workers who received in-service training in the past 12 months by category of worker	HR survey Report	20	30	40	60
	59. % of health facilities with all essential drugs available at all times	Facility Survey Report	30	40	50	63

	60. % of health institutions with basic medical equipment and functional logistic system appropriate to their levels	Facility Survey Report	40	50	60	75
	61. % of facilities with deliveries organizing maternal and/or neonatal death reviews according to WHO guidelines on regular basis	Facility Survey Report	5	10	20	40
Output 7. Increased demand for health services	62. Proportion of the population utilizing essential services package	MICS	40	50	65	87
	63. % of the population adequately informed of the 5 most beneficial health practices	MICS	40	50	70	85
PRIORITY AREA 3: HUMAN RESOURCES FOR HEALTH **NSHDP GOAL: To plan and implement strategies to address the human resources for health needs in order to ensure its availability as well as ensure equity and quality of health care**						
NSHDP GOAL: To plan and implement strategies to address the human resources for health needs in order to ensure its availability as well as ensure equity and quality of health care						
Outcome 6. The Federal government implements comprehensive HRH policies and plans for health development						
Outcome 7.All States and LGAs are actively using adaptations of the National HRH policy and plan for health development by end of 2015						
Output 8. Improved policies and Plans and strategies for HRH	64. % of wards that have appropriate HRH complement as per service delivery norm (urban/rural).	Facility Survey Report	20	40	50	70
	65.Retention rate of HRH	HR survey Report	30	35	40	50
	66. % LGAs actively using adaptations of National/State HRH policy and plans	HR survey Report	20	25	40	55
	67. Distribution of HRH by geographical location	MICS	35	50	60	75
	68. Increased number of trained staff based on approved staffing norms by qualification	HR survey Report	20	30	40	55
	69. % of LGAs implementing performance-based managment systems	HR survey Report	30	40	45	50

	70. % of staff satisfied with the performance based management system	HR survey Report	20	25	40	50
Output 8: Improved framework for objective analysis, implementation and monitoring of HRH performance	71. % LGAs making availabile consistent flow of HRH information	NHMIS	40	60	80	96%
Data to be provided	72. CHEW/10,000 population density	MICS	TBD	1:4000 pop	1:3000 pop	1:2000 pop
Data to be provided	73. Nurse density/10,000 population	MICS	TBD	1:8000 pop	1:6000 pop	1:4000 pop
Data to be provided	74. Qualified registered midwives density per 10,000 population and per geographic area	NHIS/Facility survey report/EmOC Needs Assessment	TBD	1:8000 pop	1:6000 pop	1:4000 pop
Data to be provided	75. Medical doctor density per 10,000 population	MICS	TBD	1:8000 pop	1:7000 pop	1:5000 pop
Data to be provided	76. Other health service providers density/10,000 population	MICS	TBD	1:4000 pop	1:3000 pop	1:2000 pop
	77. HRH database mechanism in place at LGA level	HRH Database	40	50	75	100%
Output 10: Strengthened capacity of training institutions to scale up the production of a critical mass of quality mid-level health workers						
PRIORITY AREA 4: FINANCING FOR HEALTH **NSHDP GOAL 4 : To ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and consumption at Local, State and Federal Levels**						
NSHDP GOAL 4 : To ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and consumption at Local, State and Federal Levels						
Outcome 8. Health financing strategies implemented at Federal, State and Local levels consistent with the National Health Financing Policy						
Outcome 9. The Nigerian people, particularly the most vulnerable socio-economic population groups, are protected from financial catastrophe and impoverishment as a result of using health services						

Output 11: Improved protection from financial catastrophy and impoversihment as a result of using health services in the State	78. % of LGAs implementing state specific safety nets	SSHDP review report	40%	60	70	85
	79. Decreased proportion of informal payments within the public health care system within each LGA	MICS	75	50	35	10
	80. % of LGAs which allocate costed fund to fully implement essential care package at N5,000/capita (US$34)	State and LGA Budgets	10	30	50	70
	80. LGAs allocating health funding increased by average of 5% every year	State and LGA Budgets	5	25	40	50
Output 12: Improved efficiency and equity in the allocation and use of Health resources at State and LGA levels	81. LGAs health budgets fully alligned to support state health goals and policies	State and LGA Budgets	10	20	40	50%
	82.Out-of pocket expenditure as a % of total health expenditure	National Health Accounts 2003 - 2005	50%	45%	30%	20%
	83. % of LGA budget allocated to the health sector.	National Health Accounts 2003 - 2005	5%	10%	15%	20%
	84. Proportion of LGAs having transparent budgeting and finacial management systems	SSHDP review report	20	25%	35%	50%
	85. % of LGAs having operational supportive supervision and monitoring systems	SSHDP review report	10	20%	30	40%
PRIORITY AREA 5: NATIONAL HEALTH INFORMATION SYSTEM						
Outcome 10. National health management information system and sub-systems provides public and private sector data to inform health plan development and implementation						

Outcome 11. National health management information system and sub-systems provide public and private sector data to inform health plan development and implementation at Federal, State and LGA levels						
Output 13: Improved Health Data Collection, Analysis, Dissemination, Monitoring and Evaluation	86. % of LGAs making routine NHMIS returns to states	NHMIS Report January to June 2008; March 2009	75	80	95	100
	87. % of LGAs receiving feedback on NHMIS from SMOH		40	50	75	100
	88. % of health facility staff trained to use the NHMIS infrastructure	Training Reports	50	60	80	100
	89. % of health facilities benefitting from HMIS supervisory visits from SMOH	NHMIS Report	30	40	60	90
	90.% of HMIS operators at the LGA level trained in analysis of data using the operational manual	Training Reports	50	60%	85%	100%
	91. % of LGA PHC Coordinator trained in data dissemination	Training Reports	50	60%	80%	100%
	92. % of LGAs publishing annual HMIS reports	HMIS Reports	20	30%	50%	85%
	93. % of LGA plans using the HMIS data	NHMIS Report	30	50%	80%	95%
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	94. Proportion of public health facilities having active committees that include community representatives (with meeting reports and actions recommended)	SSHDP review report	20	30%	50%	70%
	95. % of wards holding quarterly health committee meetings	HDC Reports	10	20%	40%	60%
	96. % HDCs whose members have had training in community mobilization	HDC Reports	10	20%	40%	70%
	97. % increase in community health actions	HDC Reports	10	20%	30%	50%

	98. % of health actions jointly implemented with HDCs and other related committees	HDC Reports	20	30%	40%	50%
	99. % of LGAs implementing an Integrated Health Communication Plan	HPC Reports	10	20%	30%	55%
PRIORITY AREA 7: PARTNERSHIPS FOR HEALTH						
Outcome 14. Functional multi partner and multi-sectoral participatory mechanisms at Federal and State levels contribute to achievement of the goals and objectives of the						
Output 15: Improved Health Sector Partners' Collaboration and Coordination	100. Increased number of new PPP initiatives per year per LGA	SSHDP Report	10	25%	40%	50%
	101. % LGAs holding annual multi-sectoral development partner meetings	SSHDP Report	5	10%	30%	50%
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	102. % of LGAs partnering with researchers	Research Reports	0	10%	20%	40%
	103. % of State health budget spent on health research and evaluation	State budget	0.5	1%	1.20%	2%
	104. % of LGAs holding quarterly knowledge sharing on research, HMIS and best practices	LGA Annual SHDP Reports	0	10%	25%	45%
	105. % of LGAs participating in state research ethics review board for researches in their locations	LGA Annual SHDP Reports	0	10%	30%	50%
	106. % of health research in LGAs available in the state health research depository	State Health Reseach Depository	5	10%	30%	55%

Output 17: Health research communication strategies developed and implemented	107. % LGAs aware of state health research communication strategy	Health Research Communication Strategy	10	30%	50%	75%