ANAMBRA STATE GOVERNMENT

STRATEGIC HEALTH DEVELOPMENT PLAN
(2010-2015)

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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.

Preface

Executive Summary

Our vision is to significantly increase the life expectancy and quality of life of people of Anambra State by reducing to the barest minimum the morbidity and mortality due to communicable diseases, reversing the increasing prevalence of non-communicable diseases, and meet global targets on the elimination and eradication of diseases.

Anambra is one of the five states in the south east geopolitical zone; with a total land area of 4,416 sq km it has a population of 4,453,964 according to 2006 population census. Great proportion of the state is devastated by flood erosion and land sliding. The state is made up of 21 LGA's, 236 wards, and 177 communities. About 75% of the population are farmers spread in three senatorial zones namely; Anambra North, Anambra South, and Anambra Central while each Senatorial zone has seven LGA's.

Anambra state has two big Markets at Onitsha and Nnewi therefore a large number of Anambra people are engaged in buying and selling enterprise. Many Anambrarians are largely artisans who are involved in crafts like blacksmithing, auto-mechanic, and others. Immunization coverage of 50% is recorded while HIV/AIDS prevalence rate is 5.6% and *Maternal mortality rate of 260-280/100,000* - source. There are 33 Secondary health facilities, 382 PHC's, 14 mission Hosp. 600 private Hosp. 186 Maternity Homes, 126 registered Pharmaceutical Premises, 9 Health Training Institutions, and 1500 licensed chemist shops. All the health facilities are well patronized by the populace.

The major bottlenecks in the implementation of minimum package of care are;

i. Inadequate manpower,
ii. Lack of adequate infrastructure,
iii. Poorly motivated staff, and weak capacity

The minimum package of care is geared towards providing various health interventions that will enable the state to achieve the MDGs especially goals 4, 5, and 6. To improve child health, we will focus on providing adequate immunization coverage for U5, adequate infant Nutrition, Provision of Vitamin A supplement, and exclusive breastfeeding. To improve maternal health, we will provide immunization coverage for pregnant mothers, and ensure delivery by skilled health personnel. To combat HIV/AIDS, malaria and other communicable diseases we will ensure provision and even spread of HCT centres, provision of LLINs for U5 and pregnant mothers, provision of family planning facilities, making health facilities accessible to pregnant mothers and U5, making of healthcare services affordable, and training and retraining of healthcare providers.

Anambra state strategic health priority interventions are ranked in the order below;

Healthcare service delivery; the interventions include to review, cost, disseminate and implement the minimum package of care. The target is to ensure that essential package of care

will be adopted by the State by 2011 while the indicator is to put in place a number of facilities able to provide minimum care package increased by 60% by 2015.

Human Resources for Health; the intervention is to develop and institutionalize the Human Resources Policy framework. Its target is to ensure that the State and LGAs are actively using adaptations of the National HRH policy and Plan by end of 2015, while the indicator is to make sure that 80% of policy framework updated and printed by end of 2015

Financing for health; its intervention is to develop and implement evidence-based, costed health financing strategic plans at the State and LGA levels in line with the National Health Financing Policy. The target is to ensure that 50% of the State have a documented Health Financing Strategy by end 2012 while the indicator is to make sure that 60% of staff are trained on budget system.

Leadership and Governance; the interventions here are to improve Strategic Planning at Federal and State levels and strengthen regulatory functions of government. The target is to ensure that 80% of State have an active health sector 'watch dog' by 2013 while the indicator is to make sure that strategic planning improved by 80% within 2015 in the state.

Community participation and ownership; the intervention is to provide an enabling policy framework for community participation. The target is to ensure that the State has at least an annual Forum to engage community leaders and CBOs on health matters by the end of 2012 while its indicator is to ensure that 100 out of 177 Communities, involvement and participation in health development strengthened by 2013.

Research for Health; the intervention is to adapt the National Health Research Policy at state and LGA levels. The target is to ensure that SHR Committee is established by end 2010 to guide health research priorities, and that SMOH publishes an Essential Health Research agenda annually from 2011 while the indicator is to ensure that by 2011 technical working group formed and health research policies developed.

Partnership for Health; the intervention here is to promote Public Private Partnerships (PPP), the target is to ensure that SMOH has an active PPP forum that meets quarterly by end 2010 while the indicator is to establish PPP units in the state by 2010.

Health Information System; the interventions are to ensure that NHMIS forms are available at all health service delivery points at all levels, and to periodically review of NHMIS data collection forms. The target is to ensure that 50% of LGAs are making routine SHMIS returns to State level by end 2010 while the indicator is to ensure that good number of SHMIS tools developed and printed, and technical advisory committee formed.

The total cost for the implementation and actualization of state strategic health development plan is N80,759,567,909.00.

It is expected that all stakeholders in the health care delivery system will be involved in the implementation; in such a way that regular sensitization and dissemination of information is provided. The implementation of the state health strategic plan will be anchored by the state Ministry of Health, under the watch dog of CBOs, Faith Based Organization, Civil Society organizations, Labour leaders etc.

Monitoring and Evaluation is aimed at tracking and assessing implementation process of health strategic plan; it also involves preparing progress reports, holding regular meetings with the stakeholders for the purpose of improving on implementation process, carrying the stakeholders along through dissemination of information and making available progress report to the relevant authorities.

Chapter 1: Background and Achievements

1.1.Background

Anambra state lies in the southeastern part of Nigeria. It has a total land area of 4,416 sq. km and is situated on a generally low elevation on the eastern side of the River Niger. It is bounded in the Northeast by Enugu state by Enugu and Abia states in the East, by Delta in the West, and, in the South and Northwest, by Imo and Kogi states respectively. The total population according to the 2006 census was 4,453,964. A good proportion of the state is affected by erosion, which renders most roads very difficult to pass especially during rainy seasons. There are 21 LGAs in Anambra state, with each administered by a Head of Local Government administration who is a civil servant. There are no elected executive chairman. There are 235 districts, 330 wards, and 177 communities, with the capital at Awka. There is good media communication system in the state with 75% of the state (mostly the rural population) agrarian.

One of the goals of the Federal Government development strategy, NEEDS, is to improve the health status of the population as a mean to reduce poverty. To achieve this goal, NEEDS emphasizes the importance of continuing the focus on the strengthening of preventive and curative primary health care services. The state government has also recognized the importance of PHC. Accordingly, the State Economic Empowerment and Development Strategies (SEEDS) also aim at improving these services. SEEDS focus on achieving economic growth, while ensuring better service delivery, a reform of government institutions, and a transformation of values to overcome corruption and inefficiency.

1.2.Achievements

1.2.1. Refurbishment and Re-equipment of General Hospitals

As part of efforts by the state government to strengthen their state health system and its management, the ministry of health has embarked on a refurbishment exercise of their secondary health facilities ***(Anambra state government: Workplan for September – December 2007).*** These include:

- Upgrading activities at GH Onitsha:
  - Completion, equipping, and commissioning of the cardio thoracic/Renal center
  - Fencing and refurbishing of interns' quarters
  - Expansion of mortuary, as demanded by Medical and Dental Council of Nigeria
- Completion of the structures of General Hospital Umuleri
- Upgrading activities at GH Awka
- Construction of 3 wards (male, female and children)
  - Construction of five 4-bedroom bungalows for House Officers
  - Expansion on main theatre, general out-patient department and emergency department
  - Construction of 8-room consulting block

- Upgrading activities of GH Ossomala:
    - Refurbishment of maternity wards
    - Fencing of General Hospitals Umuleri and Ossomala
- Expansion and re-equipping of dental clinics at two General Hospitals.
- Construction and equipping of maternity ward at General Hospital.
- Upgrading activities of GH Onitsha:
    - Construction of a maternity ward.
    - Furnishing and equipping
- Establishment and equipping of Public Health Laboratories.
- Purchasing and equipping of mobile clinic van.
- Purchase of 3 ambulances to cover all the 3 Senatorial Zones.
- Construction of 2 Doctors' quarters, security building children's and maternity wards at General Hospital Umuleri
- Completion and commissioning of central pharmaceutical stores/Warehouse complex Awka.

1.2.2. Refurbishment and Re-Equipment Of Health Training Institutions

The state has also strengthened their health training institutions by:

- Construction and equipping of 4 classroom blocks at School of Psychiatric Nursing Hospital, Nawfia.
- Commencement of Accreditation process of the School of Psychiatric Nursing Hospital, Nawfia.
- Construction of refectory and Kitchen and perimeter fencing of Hostel block at the School of Midwifery Nkpor
- Completion of auditorium and construction of 5-room classroom block at College of Health Technology Obosi.

1.2.3. Scaling Up Of Programmatic Action:

The key MDG programmes are being re-energized for improved action. These programmes include: Reproductive Health Programmes, Immunization, Integrated Management of Childhood illnesses (IMCI), NASCAP, Malaria Control Programme, and TBLCP. Some of the specific activities include:

- Operationalization of Fibre Boots for two LGAs.
- Purchase and equipping of 500 First Aid boxes for 500 pilot primary/secondary schools
- Flagging off of the School Health Programme
- De-worming of 1,000 school children in partnership with UNICEF

- Distribution of 100,000 Long-acting Insecticide Treated Nets to under-five children and pregnant mothers in 4 pilot LGAs and most recently to all the LGAs through the Anambra state malaria control booster project
- Provision of 50 Incinerators for immunization to 21 LGAs
- Routine immunization coverage has increased to 72.6%

Chapter 2: Situation Analysis

2.1. Socio-economic context

The State has an executive governor, elected by the people, who is the chief executive of the state; an executive council appointed by the executive governor but approved by the legislators; and a House of Assembly, made up of elected legislators with powers to make laws, approve appointments and state budgets. Politically, the state is divided into three senatorial districts, namely, Anambra north, Anambra south and Anambra central. Each senatorial zone is made up of 7 LGAs.

In Nigeria, over 90% of the population lives on less than $2 per day (UNAIDS, 2006). 31% of the adult population is illiterate (UNICEF 2008). However, in Anambra state, these indices are not as bad as the national figures. Women Literacy level is put at 88%[1]. The State steering committee members and LGA participants were asked to rank the state against the other states of the Federation in terms of socioeconomic status (Wealth ranking and development) and Anambra state was ranked 12th position out of the 36 states (plus Abuja).

The health system is generally funded from Federal allocation to the states and LGAs, both of which also generate about 20% internal revenue from taxes, rates and levies. The allocation of Federal revenues is fixed by the Revenue Mobilisation Allocation and Fiscal Commission (RMAFC) and approved by the National Assembly for five years. The allocation formula assigns 48.5 percent to the Federal government, 24 percent to the states and 20 percent to local government, with 7.5 percent retained for 'special' federally determined projects. Once set, the revenue sharing formula provides limited room for maneuvers on fiscal policy (World Bank, 2003*)*. The horizontal distribution formula is constitutionally fixed and allocates 40 percent to each state in equal amounts and 60 percent based on six variables. The variables are population (30 percent), land mass (10 percent), internal revenue generation efforts (10 percent), secondary school enrolment (4 percent), number of hospital beds (3 percent), and rainfall (3 percent). The revenue shares depend positively on the first three variables and negatively on the last three (Heymans & Pycroft 2003).

2.2.Health status of the population

As shown in Table 1 below, preventable endemic diseases such as malaria, diarrhea and respiratory problems are the most common occurring diseases and the cause of mortality in the state (SMOH 2008). Hypertension is also said to be the most common chronic non-communicable disease in the state.

[1] NDHS 2008

Table 1: Disease profile of Anambra state, December 2008

S/N	Disease	Reported Cases in 2008	Reported deaths in 2008	Case fatality rate
1.	Malaria Uncomplicated Severe Malaria in pregnancy	 107,052 14,205 6518	 44 27 2	 0.04 0.2 0.03
2.	Diarrhea diseases	15,345	102	0.7
3.	Pneumonia	8259	3	0.12
4.	Neonatal Tetanus	3	2	66.7
5.	HIV/AIDS	5175	0	0
6.	Hepatitis B	513	0	0
7.	Pertusis	123	0	0
8.	Measles	74	0	0
9.	Lymphatic filariasis	13	0	0
10.	Leprosy	4	0	0

Self-detection is the major source of diagnosis of illnesses in the state and especially in the case of malaria, (Onwujekwe 2006) because the term and fever are used interchangeably; it is possible that many cases of purported malaria were not malaria. This is also pertinent when viewed from the background that the major treatment providers are patent medicine dealers, many of whom lack training and knowledge about the causes, symptoms and diagnosis of malaria.

Some of the health indicators as shown in Table 3 below include a maternal mortality ratio of 260-280/100,000 live births, Current use of any modern method of contraception of 16.5%. The percentage of antenatal clinic attendance from a health professional, percentage delivered by a health professional and percentage delivered in health facilities are high. DPT3 and Measles vaccination coverage is also very encouraging. However, all vaccination coverage is low and 10.4% of eligible children have had no form of vaccination.

Table 2: Health indicators in Anambra state

	Variable	Anambra state	South East zone	Source
1.	Maternal Mortality ratio	260-280/100,000 live births		(UNFPA Anambra 2006)
2.	Current use of any modern method of contraception	16.5%	23.3%	DHS 2008
3.	TFR	5%	4.8%	DHS 2008
4.	% of Antenatal clinic from a health professional	97.7%	87.0%	DHS 2008
5.	% delivered by a health professional	95.2%	81.8%	DHS 2008
6.	% delivered in a health facilities	87.8	73.9%	DHS 2008
7.	DPT3 vaccination coverage	76.2%	54.2%	DHS 2008
8.	OPV3 vaccination coverage	63.2%	53.6%	DHS 2008
9.	Measles	71%	55.5%	DHS 2008
10.	All vaccination	51.9%	36.0%	DHS 2008
11.	No vaccination	10.4%	10.5%	DHS 2008
12.	Comprehensive knowledge of HIV	49% female 48% male	31% women, 49% men	DHS 2008
13.	Nutritional status of children underweight @ -3SD Wasting @ -3SD Stunting @ -3SD	 2.9 2.0 4.5	 3.3 3.4 9.0	DHS 2008

The Table 3 below gives a summary of state indicators

Table 3: Summary of state indicators

POPULATION (2006 Census)	ANAMBRA
Total population	**4,177,828**
female	2,059,844
male	2,177,984
Under 5 years (20% of Total Pop)	473,248
Adolescents (10 – 24 years)	1,442,075
Women of child bearing age (15-49 years)	1,137,559
INDICATORS	**NDHS 2008**
Literacy rate (female)	88%
Literacy rate (male)	99%
Households with improved source of drinking water	67%
Households with improved sanitary facilities (not shared)	43%
Households with electricity	84%
Employment status (currently)/ female	61.0%
Employment status (currently)/ male	72.3%
Total Fertility Rate	5
Use of FP modern method by married women 15-49	17%
Ante Natal Care provided by skilled Health worker	98%
Skilled attendants at birth	95%
Delivery in Health Facility	88%
Children 12-23 months with full immunization coverage	52%
Children 12-23 months with no immunization	10%
Stunting in Under 5 children	12%
Wasting in Under 5 children	6%
Diarrhea in children	3.1%
ITN ownership	13%
ITN utilization (children)	12%
ITN utilization (pregnant women)	11%
children under 5 with fever receiving malaria treatment	12%
Pregnant women receiving IPT	9%
Comprehensive knowledge of HIV (female)	48%
Comprehensive knowledge of HIV (male)	49%
Knowledge of TB (female)	98.5%
Knowledge of TB (male)	95.7%

2.3.Health services provision and utilization

Operationally, the decentralized health structures of the Federal government are in the states, while those of states are in the LGAs. The state is responsible for training nurses, midwives and the LGAs are responsible for training Community Health Extension Workers (CHEWs). The LGAs provide basic health services and manage the PHC facilities (health centres and health posts) which are normally the first contact with the health system. Each LGA has a health

department which is headed by the Primary Health Care Coordinator (PHCC). Some of the health professionals working in PHC facilities are also employed by the state government.

2.3.1. Health Services Infrastructure

Anambra state has a total of 33 secondary health facilities consisting of General Hospitals, Comprehensive Health Centers and Cottage Hospitals distributed across the whole LGAs. These hospitals are managed by the State government through the State Hospitals Management Board of the State Ministry of Health (SMOH). There are also about 382 Primary Health Care centers and health post which are managed by the LGAs. However, the Ministry of Health department of Primary Health Care/Disease Control (PHC/DC) is the overall coordinator of PHC activities in the state. There is only one tertiary health institution in the state which is owned and managed by the Federal Government through the Federal Ministry of Health. The private sector healthcare providers presence in the state shows that as at January 2006 there were 14 mission hospitals, 186 maternities, 600 private hospitals and clinics, 126 registered pharmaceutical premises and about 1,500 currently licensed medicine shops. Some of the health facilities are non-functional due to lack of equipment and manpower. There is a high number of non-governmental and private health facilities in Anambra State suggestive of high dependence on the private sector for curative services.

2.3.2. Health Manpower (Human Resources for Health)

Anambra State could not provide information on the health manpower both in the public and private sector. This is suggestive of poor health information management system and lack of Health Manpower development policy. However, a literature review shows that there are 662 Doctors, 1214 nurses and midwives, 633 medical scientists and 232 Pharmacists (Nigeria Health system assessment 2008). At the PHC level the mix of health workers as at 2008 is shown in Table 4. There is uneven distribution of health personnel as more than 60% of the PHC workers are in urban areas where less than 30% of the people live and the variations are the result of a mix of decisions and indecisions by individuals, communities and governments, which in turn are influenced by personal, professional, organizational, economic, political and cultural factors. A majority of these health workers are Community health extension worker (CHEW)

Table 4: Category of health workers in the 21 LGAs of Anambra state

Category of health workers	Number (%)
Medical officers of health	19 (0.9)
Community health officers	127 (6.0)
Principal health nurse	36 (1.7)
Staff nurse /midwife	258 (12.2)
Staff nurse	8 (0.4)
Staff midwife	15 (0.7)
Community health extension worker (CHEW)	722 (34.0)
Junior Chew	210 (9.9)
Environmental health officers	170 (8.0)
Rural health superintendent	3 (0.1)
Health attendant	554 (26)
Total	2122

Source: PHC Department, Local Government Service Commission (2008)

2.3.3. Health Services Provision

In addition to the curative services provided by the specialist and general hospitals, Anambra state also provides some technical health care programmes considered cost effective interventions and have the highest impact on reducing morbidity and mortality from the major contributors to the disease burden using existing resources. These health care programmes include:- Routine immunization, Reproductive health services, Malaria control through the Malaria control booster project, Antenatal services, Delivery services, Well baby clinics, growth monitoring, Integrated Management of Childhood Illnesses (IMCI) HIV/AIDs control. The aforementioned programmes are the components of the recently introduced Integrated Maternal Newborn & Child Health strategy that is on going in the state though not yet in integrated manner. In addition the state has Tuberculosis/Leprosy control. These ranges of health programmes if effectively provided would to a large extent reduce the disease burden of Anambra state.

However, past Nigerian studies have examined both community and hospital-level factors leading to absence of skilled attendance and delay or lack of adequate emergency obstetric care. Community-based studies have demonstrated cultural and socio-economic factors to have an important role in the health-seeking behaviour of pregnant women in southern Nigerian communities including Anambra state (Chiwuzie 1995). Transportation problems commonly hinder women from reaching an appropriate health facility on time.

Poorly organized referral of obstetric cases to higher levels of health care also causes delays. Clients inability to pay hospital costs, lack of supplies and equipment, lack of skilled staff, inability hospitals to perform caesarian sections, poor staff attitude, incorrect treatment and

mother's fear of Caesarian section have been reported to cause delays to receive care at secondary-level hospitals.

2.3.4. Health Care Financing

The sources of funds to finance health services in Anambra state are governmental allocations, user charges, donor contributions, Community contributions as well as community-based health insurance in some communities. The National Policy on Health recommends that a minimum of 10 to 15% of the state budget be allocated to health and 20% of Local Government budget. There is evidence that this is not so in Anambra state. The government expenditure on health as percentage of total government expenditure was 5.17% and 3.3% in 2006 and 2007 respectively showing a decline. However, the per capita total health expenditure increased from 18,359 Naira in 2006 to 28,092.4 Naira in 2007 (Nigeria Health system assessment 2008).

2.3.4.1. Fees for Service and Equity Issues

Anambra State has no user charge policy but charges fees, for some services. Service paid for include: Cards, Consultation, Investigations, in-patient care, drugs, antenatal care, delivery, family planning. There are no fees for immunization. There is also no policy on exemption of certain groups from paying for services but in practice orphans and known destitute are sometimes exempted. The money spent on exemptions are either paid by the State government or written off. The practice is in line with the provision of the National health policy that users shall pay for curative services while government shall subsidize preventive services. The absence of an exception policy and recovery mechanism leaves room for abuse and decapitation. It also makes it possible for cost and affordability being a barrier to access to health care. The State has no policy to ensure equity in health care services distribution; gender, age and the resources are not equitably distributed between preventive and curative services.

2.3.5. The Ward Minimum Health Care Package

Specifically, the (WMHCP) (2007-2012) strategy document developed by the NPHCDA has not been implemented in the state.

2.3.6. Health Management Information System

Anambra State has a partially functional Monitoring and Evaluation (M& E) office with a trained M & E officer. The officer is said to have been trained by the Anambra Health systems development Project. However, all the health indicators/information in the state are collected by the Disease Surveillance and notification Officers at the LGA through a network of health facility focal persons. These data are collated and then sent to the State WHO office for analysis and coordinated by the state Epidemiologist and WHO State Coordinator. This information after

analysis is then sent to the Federal Ministry of Health and WHO country office every month. The WHO funds this process. Anambra state does not collect any data from the private health sector.

2.3.7. Partnerships / Collaboration

The State Council on Health (SCH) is the main mechanisms for inter-sector coordination at the state level in Anambra, Whenever SCH are held; their outcomes are documented and disseminated for follow-up actions by the various participants. An example of such follow-up in Anambra was the purchase of mobile clinics that were agreed upon as a priority at the SCH. The pattern of documenting and disseminating outcomes of multi-stakeholder meetings for follow-up action is repeated at LGA, ward, and village levels, where health committees seek to coordinate actions among governmental and non-governmental stakeholders. State planning commissions are responsible for donor coordination in the state.

Presently Anambra State Health Sector is collaborating actively in planning and implementation of health programmes and projects with the following sectors; Education, Environment, Women Affairs, Finance, Local Government and Information. Activities of non-governmental organizations and International agencies are coordinated by the state planning commission. This is the practice nationally. The following organisations are currently contributing to health development in Anambra State.

Table 5: Agencies/Organisations working in the health sector in Anambra state

S/N	Agency	Area of Collaboration
1.	World Health Organization WHO	Disease surveillance Immunization
2.	UNICEF	Immunization, HIV/AIDs, Nutrition
3.	World Bank	Malaria Control, HIV/AIDs
4.	United Nations Funds for Population Activities:	Reproductive Health (Pulled out in 2008)
5.	Global 2000	Onchocerciasis eradication
6.	German-Leprosy Relief Association GLRA:	Tuberculosis/ Leprosy control
7.	EU PRIME	Health systems strengthening (Pulled out July 2009)

There is some presence of NGO support, but the concern is the effectiveness of state planning commission in coordinating the activities of the NGO to avoid duplication and mismanagement of donor funds and materials. These bodies contribute financially, technically and materials / equipment.

2.3.8. Community Participation, Involvement and Empowerment In Health

Anambra State has no policy to encourage community participation, involvement and empowerment. Communities are not encouraged to own and manage health facilities; community involvement in health care provision is mostly in location and site of facility, provision of land for facility and occasionally part financing of capital projects.

2.3.9. Regulation of Healthcare

There is lack of operational links among the various components of the Regulatory bodies in the healthcare delivery system in the state. Lack of funds/funding, logistics and security cover often militated against their effectiveness as regulatory bodies.

2.3.10. Leadership and Governance

Frequent changes in leadership at the state and LGA levels, corruption, lack of accountability and transparency characterize poor leadership systems and crises in governance structures in Anambra's health system. Over the past 6 years Anambra state has produced 5 governors. At present, there is no elected LGA chairman.

2.3.11. Research for Health

Little or no research goes on in the state and LGAs. Most research are conducted by researchers from research institutions and funded from outside the government

2.4.Key issues and challenges

The key issues are

- There is an institutional lack of equity in all aspects of the structures, services and services delivery in Anambra state.
- The health system exhibits poor private-sector/public sector mix in service delivery.
- There is fragmentation along vertical programming lines in the health system of donor driven programmes.
- There is very poorly established and operated health information management system.
- There is no clear-cut human resources development policy and practice.
- Financing of health services is also a problem area. There is paucity of reliable, up-to-date on the financing of the health system, on which to make a robust conclusion. However, there is a sharp decline in health expenditure, exacerbated by waste and corruption in the system.

Chapter 3: Strategic Health Priorities

3.1. Strategic orientation

The State steering committee members and LGA participants were asked to rank the 8 priority areas in order of state needs and the result are shown thus:

Table 6: Ranking of Priority Areas by Thematic Area

Priority area	Ranking
Health service delivery	1st
Human resource for health	2nd
Financing for health	3rd
Leadership and governance	4th
Community participation and ownership	5th
Research for health	6th
Partnerships for Health	7th
Health information system (HIS)	8th

However, the Essential Package of Health Services for Anambra State by service delivery mode reflects the priority high impact interventions to be delivered in the state.

Table 7: Essential Package of Health Services

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)

Essential Package of Health Services

B. POPULATION ORIENTED/OUTREACHES/SCHEDULABLE SERVICES
Family planning
Condom use for HIV prevention
Antenatal Care
Management of the 5 major contributors to maternal mortality: haemorrhage, sepsis, pre-eclampsia, post abortion complications,obstructed labour
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

Essential Package of Health Services

C. INDIVIDUAL/CLINICAL ORIENTED SERVICES
Family Planning
Normal delivery by skilled attendant
Management of the 5 major contributors to maternal mortality: haemorrhage, sepsis, pre-eclampsia, post abortion complications,obstructed labour
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

Chapter 4: Resource Requirements

4.1. Human Resources for Health

The numbers of health personnel are insufficient to meet the needs of the state . At the same time, there is serious under-utilization of personnel. Uneven distribution of health personnel persists in the state: between the public and private sectors; between rural and urban localities; and in terms of the location of specialists vis-à-vis non specialists. The capacity of health human resource across the various cadres remains weak due to inadequate curricula, poor teaching, poor funding and conditions of service. Finally, there is lack of human resource planning including data. Therefore to implement the strategic health development plan, the proper mix of manpower will be needed and this will be better estimated if the size of health human resource in both public and the private sector is determined through a survey.

Successful Implementation of the Strategic Plan will require substantial resources and commitment of all stakeholders. Federal Government, State Governments, Partners, professional associations, health workers unions, private practitioners and Non-Governmental Organisations in Health will all be required to play their roles in order to achieve the objectives of the plan.

Most of the human resources for health cost related to salaries and training are already being borne by governments and the private sector at the various levels. These will continue to be funded from the regular sources as usual. These are not reflected in the budget in this document. The costing reflects additional staff required in some places.

4.2 Physical/Materials

Implementation of the plan will require massive physical materials. This will include buildings, drugs, hospital equipments, vehicles, ambulances, boats, motor cycles, solar panels, generating sets, computers and its accessories, power point projectors, V-sat internet connectivity, furniture and stationery

4.3 Financial

Apparently next to nothing can be achieved without the availability of funds. It is the hope and expectations of the Ministry of Health that government's priority on and adequate funding of health would be sustained. The SMOH would ensure that yearly budgets are practicable and prepared on time for submission and defense, at the Ministry of Health and the house of Assembly. It is expected that early planning would mitigate the syndrome of planning based on available funds instead of seeking funds for established plans.

Potential sources of financial resources for the SHDP are as follows:

1. Government sources – Federal, state, LGA
2. Donor and other external sources
3. Direct employer funding
4. National Health Insurance Scheme
5. Public – Private Partnerships
6. Individual and community self help/ investment
7. Philanthropic sources
8. Faith based organizations
9. Other special funds

Chapter 5: Financing Plan

5.1. Estimated cost of the strategic orientations

The cost estimates for financing the State SHPD for the 6 year period is N80,759,567,909.00 broken down into:

Table 8: Cost Estimates

Priority area	Amount (N)
Leadership and governance	688,343,468
Health service delivery	39,116,970,090
Human resource for health	29,188,358,347
Financing for health	8,514,468,952
Health information system (HIS)	969,472,924
Community participation and ownership	530,538,118
Partnerships for Health	616,445,965
Research for health	1,134,970,042
Total	**80,759,567,909**

5.2 Assessment of the available and projected funds

5.3 Determination of the financing gap

Based on the above projection of government, a huge funding gap is envisaged of approximately ========== Naira for programmes. Annual funding gaps are expected to range from ===== to ===== Naira. It is thus apparent that the full participation and commitment of the private sector and Partners to the developmental plan both technically and financially is critical to its success.

Chapter 6: Implementation Plan

6.1. Establishment of partnership

The state government will work with Partners, civil society organizations, individuals and other relevant actors to establish a Partnership for health.

6.2. Capacity Building and Strengthening of Health System

1. Government in collaboration with the relevant stakeholders, including the private sector, shall ensure in an equitable and timely manner:
2. The establishment of functional health facilities and sustained provision of appropriate equipment, materials, medicines, vaccines and other consumables.
3. The training, re-training, motivation and equitable distribution of health personnel at both LGA and state level.
4. Infrastructural provision to ensure successful capacity building and strengthening of health system
5. Equity in health resource distribution and targeting of the hard-to-reach and most vulnerable groups.
6. The establishment and/or endorsement of guidelines for the planning, funding, implementation, monitoring and supervision of the training and continuing education of all health personnel at all levels. It will ensure the provision of appropriate technical support for training and continuing education programmes.
7. The upgrading of curricula of basic health institutions
8. Community capacity building

Government shall develop:

1. An advocacy strategy to mobilize policy makers, key government officials, law makers, opinion leaders, professional associations and non-governmental organizations.
2. Develop virile evidence based behaviour change communication strategy focusing on sustained behavioural change processes and interventions both for consumers and service providers.
3. Develop and support community engagement interventions using community mobilization/ involvement, community action cycle, community monitoring and evaluation processes to ensure ownership and sustainability of health services.
4. The state Ministry of Health shall support LGAs to enhance their capability to undertake relevant health research

6.3. Roles and Responsibilities

In order to achieve the set objectives of this SHDP, there is a need for proper delineation of roles and responsibilities to be undertaken by governments at State and Local Government levels, Partners, Non-Governmental Organisations, Organized Private Sectors and the Communities.

In defining these roles and responsibilities, special emphasis is placed on coordination, collaboration, decentralisation and integration in the implementation to better reach the most vulnerable group and promote Local Government /Community ownership**.**

6.3.1. State Ministry of Health (SMOH)

The State Ministry of Health shall:

1. Set up a Technical Advisory Committee, made up of professionals and other stakeholders. This committee shall be responsible for ensuring the implementation of this SHDP and the submission of periodic reports on the State of Health of Anambra people and its determinants.
2. Establish guidelines for planning, organising, conducting and supervising training of health personnel at the schools of health technology, Nursing and midwifery. It will provide appropriate technical support for curriculum development, training and continuing education. These will focus on both pre-service and in-service trainings.
3. Promote the decentralised implementation of Drug Revolving Fund, guided by the essential list,
4. Promote decentralised procurement and supply of equipment and materials
5. Review periodically the existing logistic system to ensure regular and timely distribution of supplies and equipment.
6. Review periodically the state of health infrastructure, equipments and vehicles to ensure regular and timely maintenance
7. Remove financial barriers to health care through speedy implementation of NHIS and its expansion to the community
8. Promptly release fund for the implementation of the activities,
9. Collaborate with national and international agencies, NGOs and other stakeholders to secure financial and technical assistance for implementation
10. Initiate and support research activities in collaboration with training institutions, non-governmental organisations, the private sector and the mass media.
11. Develop and support the adaptation of communication and advocacy strategies by the LGAs.
12. Disseminate information to Local Governments and other stakeholders.
13. Develop Behavioural Change Communication material and job aids in collaboration with Ministry of Information, Non Governmental Organizations and other stakeholders.
14. Support the strengthening of communication and interpersonal communication and counselling training for pre-service and in-service training.
15. Review and develop relevant legal instruments that govern and regulate health related activities in the state and LGAs in collaboration with Justice.
16. Provide mechanisms for timely response to feedback from the LGAs

17. Recruit appropriately qualified and adequately skilled health personnel in all secondary health facilities in the State.
18. Review the distribution of existing health care facilities and ensure equity in future siting of such facilities.

6.3.2. Local Government Councils

The LGA shall:

1. Mobilise the community to participate in planning, implementation and monitoring of health programs through involvement of traditional chiefs, religious leaders, other influential persons, and groups.
2. Motivate communities through community action cycle processes to undertake, own and sustain health programmes.
3. Organise regular trainings and refresher courses to update knowledge and skills of LGA health personnel
4. Establish, and strengthen existing community based outreach health services by all health facilities in the LGA including private facilities.
5. Collaborate with Ward and Village Health Committees to support functional health care services.
6. Establish, and strengthen existing village health posts for child health care to compliment the services of the Primary Health Care facilities.
7. Review periodically the existing logistic system to ensure regular and timely distribution of supplies and equipment.
8. Review periodically the state of health infrastructure, equipments and vehicles to ensure regular and timely maintenance
9. Remove financial barriers to health care through speedy implementation of community based Health Insurance Schemes and its expansion to the communities
10. Promptly release funds for the implementation of health programmes, support research and maintain LGA health care facilities.
11. Collaborate with state to facilitate data collection
12. Promote systematic and sustained community health education through health care providers, mass media, non-governmental organisation, community based organizations, schools, families and individuals in collaboration with State Government.

6.3.3. Non Governmental Organizations

1. NGOs shall in collaboration with the State and Local Governments:
2. Assist in developing Behavioural Change Communication programme
3. Support the training of Community Resources Persons and other Voluntary Village Health Workers in the delivery of health care services
4. Assist in Monitoring and Evaluation of health programme

5. Provide technical assistance to LGAs on fund raising activities, resources utilisation, planning, implementation, monitoring and evaluation
6. Assist in development and maintenance of a two-way referral system
7. Support studies on the knowledge, attitude and practice of the communities.

6.3.4. Professional Groups

The professional institutions shall:

1. Be responsible for provision of professionally competent and versatile practitioners who are capable of providing high quality care to the populace.
2. Regulate activities and practices of their members.
3. Ensure that all their members are registered with the relevant professional bodies

6.3.5. Donors/International Organizations

The Donors/International Organizations shall:

1. Provide support for implementation of all plans developed to achieve set targets
2. Provide financial and technical support to State and LGA for effective implementation of SHDP
3. Provide capacity building for health practitioners, CBOs, NGOs, Informal Health Service Providers, etc.
4. Supervise, monitor and evaluate the activities

Chapter 7: Monitoring and Evaluation

7.1. Monitoring

The plan would be monitored in collaboration with all stakeholders both internally and externally. Internal monitoring would include comprehensive in-depth reviews at the state annual review meetings, analysis of Health management information system returns and a review of supervisory reports. External monitoring would involve the state working with stakeholders, who would be encouraged to make independent assessments and present their findings for discussion.

In order to effectively monitor the plan, a structure of ensuring regular and timely reporting of the activities is most crucial. Reports on any activity conducted at any level, monthly field reports from the LGAs, quarterly and annual zonal and departmental reports would be promptly submitted, reviewed and analysed at both LGA and state levels for informed decision making.

The indicators in the SHDP will form the bases for monitoring.

7.1.2. Evaluation

A comprehensive evaluation would be conducted every 2 years by a joint team of the state and partner Agencies. The evaluation will follow the following evaluation criteria:

Relevance	The appropriateness of plan objectives to the health systems problems. Design – *i.e.* the logic and completeness of the planning process, and the internal logic and coherence of the plan design.
Efficiency	This will assess if the planned results have been achieved at reasonable cost, i.e. how well inputs/means have been converted into Activities, in terms of quality, quantity and time, and the quality of the results achieved. Alternative approaches to achieving the same results will be compared through a cost analysis to see whether the most efficient process has been adopted.
Effectiveness	This will involve an assessment of the contribution made by results to achievement of the purpose of the plan, and how assumptions have affected the achievements of results. This will include specific assessment of the benefits accruing to target groups, including under 5 children and pregnant women and indigents.
Impact	The effect of the project on its wider environment, and its contribution to the wider vision and mission.
Sustainability	An assessment of the likelihood of benefits produced by the development plan to continue to flow after external funding has ended, and with particular reference to factors of ownership by beneficiaries, policy support, economic and financial factors, socio-cultural aspects, gender equality, appropriate technology, environmental aspects, and institutional and management capacity

At the end of the plan period, i.e. December 2015, an evaluation of impact of the strategic plan is recommended and would be undertaken in the form of a national survey. External partners would be encouraged to collaborate with the state in conducting this survey.

7.1.3. Risk and Assumptions

The greatest perceived risk to the plan is the loss of political commitment at any tier of government, inadequate budgetary allocation and non release of funds. The plan rests on the assumption that all Stakeholders and Partners would re-new their commitment to health and provide continuous technical and financial support throughout the plan period.

Chapter 8: Conclusion

Any strategic document, plan or programme of action is as good as the quality and level of its implementation. What is now required is the political will and commitment to translate the plan to reality. The effective monitoring of the plan and its efficient implementation will be a major determinant of its success in achieving the set objectives.

Annex 1: Details of Anambra Strategic Health Development Plan

ANAMBRA 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						**688,343,468**
	1.1	**To provide clear policy directions for health development**		**All stakeholders are informed regarding health development policy directives by 2011**		**2,398,934**
		1.1.1	Improved Strategic Planning at State levels			**2,308,527**
			1.1.1.1 Conduct 5 advocacy visits to policy makers in the state in support of policy development and implementation	Strategic planning improved by 80% within 2015 in the state		939,284
			1.1.1.2 Develope evidence based, costed and prioriotized strategic health plans			1,459,650
	1.2	**To facilitate legislation and a regulatory framework for health development**		**Health Bill signed into law by end of 2009**		**23,514,426**
		1.2.1	Strengthen regulatory functions of government			**23,514,426**
			1.2.1.1 Set up a review committee to align laws of regulatory bodies	Public/private partnership regulatory functions strenghtened by 65% by the year 2015		123,677
			1.2.1.2 Review and update Public Health Act and Laws to strenghten regulatory framework			722,307
			1.2.1.3 Develop and produce 2000 copies of policy guidelines for public/private partnership.			6,851,922
			1.2.1.4 Disseminate the policy guidelines to 150 stakeholders			13,703,844
			1.2.1.5 Conduct supportive supervision for public /private sectors to ensure compliance			2,112,676
	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**		**661,416,595**

		1.3.1	To improve accountability and transparency				**661,416,595**
			1.3.1.1	Conduct sensitization workshop to communities to enable them manage and oversee their health project and programs	60% of each of the 177 communities sensitized to manage and oversee their health problems		49,097,447
			1.3.1.2	Support the communities in promoting the emergence of independent health sector 'watchdogs'	60% of the communities supported on emergence of independent health sector and yearly joint review of stakeholders		582,139,288
			1.3.1.3	Support yearly joint review meeting of stakeholders both private and public to improve access to information			30,179,861
	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**		**1,013,513**
		1.4.1	Improving and maintaining Sectoral Information base to enhance performance				**1,013,513**
			1.4.1.1	Conduct survey of the different health sectors to determine their performance.	Sectoral information base improved and maintained by 50% by 2015 in the state		1,013,513
HEALTH SERVICE DELIVERY							
2. To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare							**39,116,970,090**
	2.1	**To ensure universal access to an essential package of care**			**Essential Package of Care adopted by all States by 2011**		**140,939,714**
		2.1.1	To review, cost, disseminate and implement the minimum package of care in an integrated manner				**10,678,877**
			2.1.1.1	Review and adapt the minimium health care package manual	**Number of facilities able to provide minimium care package increased by 60% by 2015**		472,638

			2.1.1.2	Print 2000 copies of minimium health package manual			9,133,100
			2.1.1.3	Diseminate the printed minimum world health care package			1,073,139
		2.1.2	To strengthen specific communicable and non communicable disease control programmes				**102,161,333**
			2.1.2.1	Supplies of basic essential commodities for the control of communicable and non communicable diseases.	**80% of health facilities supplied with essential commodities**		5,350,474
			2.1.2.2	Capacity buildfing of 260 health workers on the management of communicable and non communicable diseases	**75% of health workers able to manage communicable and non communicable diseases**		96,810,859
		2.1.3	To make Standard Operating procedures (SOPs) and guidelines available for delivery of services at all levels				**28,099,504**
			2.1.3.1	Produce 60 training manuals for case management	**70% of health providers able to follow the standard operating prcedure guideline by 2015**		273,993
			2.1.3.2	Print 60 data management tools for health service delivery			273,993
			2.1.3.3	Capacity building for 60 health providers on the use of data management tools			27,551,518
	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**		**38,015,044,086**
		2.2.1	To improve geographical equity and access to health services				**29,438,949,143**
			2.2.1.1	Mapping and establishment of GIS for all health facilities in the state.	**80% of health facilities made accessible(5km or 30mins walk) to the populace by 2015**		212,572,900
			2.2.1.2	Provide guidelines for outreach services			152,218
			2.2.1.3	Develop criteria for siting of new health facilities in the state			304,437
			2.2.1.4	Upgrade and refurbish all substandard facilities especially at PHC level			29,225,919,588
		2.2.2	To ensure availability of drugs and equipment at all levels				**6,092,986,228**
			2.2.2.1	Review the essential drug and equipment list for all the levels of care in the state	**No. of health facilities able**		456,655

					to provide essential drugs and equipment increased by 50% by 2015		
			2.2.2.2	Reactivate the drug revolving fund sytem			736,737
			2.2.2.3	Conduct a needs assessment of health facilities			920,921
			2.2.2.4	Review/develop an equipment list for different levels of health facilities			1,369,965
			2.2.2.5	Procure and distribute essential drug& equipment based on needs			6,089,501,950
		2.2.3	To establish a system for the maintenance of equipment at all levels				**15,138,113**
			2.2.3.1	Adapt, produce and disseminate the state health equipment policy	Maintenance workshops established in at least 10 secondary health facilities in the state by 2015		1,666,791
			2.2.3.2	Hold medical equipment and hospital furniture maintenance workshop across the state			13,471,322
		2.2.4	To strengthen referral system				**2,450,570,525**
			2.2.4.1	Map network linkages for two way referral system in line with national standard	**By 2015 the state should be able to provide 50% of ambulances for referral system in the state**		608,873
			2.2.4.2	Printing/ distribution of referral forms			22,079,269
			2.2.4.3	Provision of 29 ambulances to ensure effective referral system			2,427,882,382
		2.2.5	To foster collaboration with the private sector				**17,400,077**
			2.2.5.1	Map all categories of private health care providers in the state to foster collaboration	**80% of all categories of private health care facilities mapped by 2015**		768,703
			2.2.5.2	Develop and produce 5000 copies of guidelines and standard for regulation of private sector's practice and registration	**5000 copies of Standardized guidelines produced by 2015**		15,830,706
			2.2.5.3	Establishment of monitoring mechanism for the private sector			800,668
	2.3	**To improve the quality of health care services**			**50% of health facilities**		**42,630,266**

					participate in a Quality Improvement programme by end of 2012		
		2.3.1	To strengthen professional regulatory bodies and institutions				**23,283,316**
			2.3.1.1	Review, update,and produce operational guidelines for all regulatory bodies at the state level	Operational guidelines reviewed		1,408,020
			2.3.1.2	Build capacity of regulatory staff to monitor compliance of providers	75% of staff trained		18,075,927
			2.3.1.3	Provide security to protect regulatory staff during monitoring for complaince			3,306,182
			2.3.1.4	Disseminate operational guidelines for all regulatory bodies at the state level			493,187
		2.3.2	To develop and institutionalise quality assurance models				**7,915,353**
			2.3.2.1	Develop quality assurance training modules to biuld capacity for both public and private health care providers	80% of the quality assurance modules developed by 2015		4,262,113
			2.3.2.2	Develop servicom guidelines at the state level	servicom guidelines developed		3,653,240
		2.3.3	To institutionalize Health Management and Integrated Supportive Supervision (ISS) mechanisms				**11,431,597**
			2.3.3.1	Capacity building of program managers to carry out intergrated supportive supervision	All program officers trained on integrated supportive supervision		10,518,287
			2.3.3.2	Produce checklist for integrated supportive supervision	No of checklist produced		913,310
	2.4	**To increase demand for health care services**			**Average demand rises to 2 visits per person per annum by end 2011**		**2,443,104**
		2.4.1	To create effective demand for services				**2,443,104**
			2.4.1.1	develop state health promotion communication policy	Health promotion communication policy developed		913,310
			2.4.1.2	Print and disseminate state health promotion communication policy	No of IEC matirials produced		1,529,794
	2.5	**To provide financial access especially for the vulnerable groups**			**1. Vulnerable groups identified and quantified by end 2010 2. Vulnerable**		**915,912,921**

					people access services free by end 2015		
		2.5.1	To improve financial access especially for the vulnerable groups				**915,912,921**
			2.5.1.1	Collect data on vulnerable members of the soceity	55% of vulnerable groups identified and quantified by 2010		2,602,933
			2.5.1.2	Establish financial protection schemes for vulnerable groups	25% of vulnerable people acess free services by 2015		913,309,987
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							**29,188,358,347**
	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**		**1,015,658**
		3.1.1	To develop and institutionalize the Human Resources Policy framework				**1,015,658**
			3.1.1.1	Update and print policy guideline on training and recruitment of health personnel	80% of policy framework updated and printed by end of 2015		221,024
			3.1.1.2	Develop a policy framework to guide existence of private and public health institutions at the state level	Policy framework developed		794,634
	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**		**3,841,608**
		3.2.1	To reappraise the principles of health workforce requirements and recruitment at all levels				**3,841,608**
			3.2.1.1	Formation of intersectoral committee to reappraise the workforce reqiurement and recuitment	Intersectoral committee formed.		1,052,495
			3.2.1.2	Develop, introduce and ensure utilization of staffing norms.	50% of staffing norms ensured and developed		263,124
			3.2.1.3	Quartely coordination meetings for committee members.	Quartely coordinatinatio n meetings held.		2,525,989
	3.3	**Strengthen the institutional framework for human resources management practices in the health sector**			**1. 50% of States have**		**16,800,459**

					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				**16,800,459**
			3.3.1.1	Establish HRH unit to perform HRH functions	State able to have functional HRH units by the end of 2010		947,246
			3.3.1.2	Capacity building for HRH unit staff to enhance the management	40% of LGA able to have functional HRH units by end 2010		15,853,213
	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**		**28,927,220,014**
		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				**17,716,485,642**
			3.4.1.1	Train different cadres of health care workers yearly	No of different cadres of health workers trained yearly improved by 35% by 2015		217,892,873
			3.4.1.2	Provision of relevant infrastructures to meet the accredition criteria	At least 60% of the relevant infrastructures provided .		17,497,737,090
			3.4.1.3	Annual assesment of training institutions and programmes to reflect task shifting requirement.	Annual assessment of training institutions and programmes conducted		855,679
		3.4.2	To strengthen health workforce training capacity and output based on service demand				**11,210,734,372**
			3.4.2.1	Three yearly provision of upgraded equipments, teaching and learning materials for the state health institutions	Upgraded equipments and learing materials		11,198,551,737

					provided for all state health institutions.		
			3.4.2.2	Capacity building for the training staff	Quality assurance ensured		11,709,012
			3.4.2.3	Establish quality assurance& education review units.			-
			3.4.2.4	Three yearly review of training curricula.			473,623
	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**		**237,232,478**
		3.5.1	To achieve equitable distribution, right mix of the right quality and quantity of human resources for health				**130,772,561**
			3.5.1.1	Establish database for HRH unit	HRH data base establshed.		2,631,239
			3.5.1.2	Develop, print and provide job discription for all categories of health workers			1,683,993
			3.5.1.3	Provide incentive for health workers working in hard to reach areas			126,299,456
			3.5.1.4	Recruitment and deployment of different cadres of health workers in the state	60% of different cadres of health workers recruited, deployed,incentive and job description provided.		157,874
		3.5.2	To establish mechanisms to strengthen and monitor performance of health workers at all levels				**106,459,916**
			3.5.2.1	Establish integrated supportive supervision mechanism	Supportive supervision mechanism established.		1,105,120
			3.5.2.2	Capacity building of health workers on IPC	No of health workers trained on IPC.		105,354,796
	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**		**2,248,130**
		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				**2,248,130**
			3.6.1.1	Establishment of HRH management team	HRH management team established		894,621

			3.6.1.2	Design a monitoring checklist	Monitoring checklist designed		431,523
			3.6.1.3	Monitoring and supervision of services to enhance coperation among all sectors	No of monitoring and supervisory visits conducted using the design checklist		921,986
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							**8,514,468,952**
	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**		**3,678,230,209**
		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				**3,678,230,209**
			4.1.1.1	Develop and implement evidence based health financing plans at the state levels	Evidence based health financing plans developed and implemented		90,851,947
			4.1.1.2	Setting up a techinical working group for health financing.	technical working group for health financing set up		117,928,280
			4.1.1.3	Capacity building for development and implementation of the strategic plan in the state	60% of staff trained on budget system.		3,386,900,188
			4.1.1.4	Develop a good budget system	Good budget system developed		82,549,796
	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**		**2,054,310,629**
		4.2.1	To strengthen systems for financial risk health protection				**2,054,310,629**
			4.2.1.1	Capacity building on NHIS in the state	No of staff trained on NHIS		1,990,629,358
			4.2.1.2	Review and amend the current law establishing the NHIS to provide the legislative backing for its regulatory authority.	Law establishing the NHIS reviewed and amended.		63,681,271
	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**		**181,420,865**

					increased by an average of 5% pa every year until 2015		
		4.3.1	To improve financing of the Health Sector				**124,815,291**
			4.3.1.1	Advocacy visits to state policy makers to ensure 15% of total budget on health in line with Abuja declaration	No of advocacy visits paid to policy makers		124,815,291
		4.3.2	To improve coordination of donor funding mechanisms				**56,605,574**
			4.3.2.1	Conduct a detailed assessment of cordination structure and functions in the state	Detailed assessment conducted		56,605,574
	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**		**2,600,507,249**
		4.4.1	To improve Health Budget execution, monitoring and reporting				**897,622,892**
			4.4.1.1	Capacity building for 10 people from the state on proper execution, monitoring and timely reporting of the implementation activities.	10 people trained on monitoring and timely reporting.		799,082,022
			4.4.1.2	Quartely monitoring and supervision of financial management in the state			98,540,870
		4.4.2	To strengthen financial management skills				**1,702,884,356**
			4.4.2.1	Capacity building of 20 staff on financial management skills	No of persons trained on financial management skills		1,702,884,356
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							**969,472,924**

	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**		**157,186,576**
		5.1.1	To ensure that NHMIS forms are available at all health service delivery points at all levels				**12,896,008**
			5.1.1.1	printing of NHMIS tools for data collection for the state			1,294,422
			5.1.1.2	train on the use NHMIS tools			10,911,981
			5.1.1.3	distribute the printed tools to appropriate facilities			117,469
			5.1.1.4	conduct monitoring of health facilities to ensure utilization of NHMIS tools			572,135
		5.1.2	To periodically review of NHMIS data collection forms				**7,675,925**
			5.1.2.1	Form a technical advisory committee from all the 21 LGA's of the state	**Technical advisory committee formed**		3,261,945
			5.1.2.2	Conduct quaterly advisory commitee meeting to ensure regular feedback from the field on the appropriateness and user friendliness of data collection tools	Quaterly advisory committee meeting held.		4,413,981
		5.1.3	To coordinate data collection from vertical programmes				**1,268,534**
			5.1.3.1	Revitalize the health data consultative committee in state	**Health data consultative committee revitalized and HIS and M&E integrated**		702,224
			5.1.3.2	Integrate the current HIS with M&E system in the state to ensure coherence and complementarity			566,310
		5.1.4	To build capacity of health workers for data management				**45,968,178**
			5.1.4.1	Comprehensive training and retraining of 210 (program officers) service providers on data collection tools, analysis and utilization of data.	210 data officers trained, and quarterly monitoring carried out.		45,482,770
			5.1.4.2	Monitoring and evaluation to ensure data quality			485,408
		5.1.5	To provide a legal framework for activities of the NHMIS programme				**5,767,947**
			5.1.5.1	Advocacy visit to policy makers in the state to make them understand the value and	No of advocacy visit		214,874

				usefullness of data so as to promulgate an enabling law and byelaws to make it mandatory	paid to policy makers		
			5.1.5.2	Select and train 21 state officials on supportive supervision of data collection	21 staff trained on supportive supervision.		5,553,072
		5.1.6	To improve coverage of data collection				**75,639,577**
			5.1.6.1	Design and print data tools	100000 copies of data tools printed		64,798,789
			5.1.6.2	Training of data collectors on birth and death registration in the state	NO.of persons trained as data collectors		10,840,788
		5.1.7	To ensure supportive supervision of data collection at all levels				**7,970,406**
			5.1.7.1	Select and train 21 state officials on supportive supervision of data collection	21 staff trained on supportive supervision.		7,319,959
			5.1.7.2	Quarterly monitoring of health facility workers on appropriate data collection			650,447
	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**		**611,187,785**
		5.2.1	To strengthen the use of information technology in HIS				**49,796,433**
			5.2.1.1	Train HIS staff on information communication technology	Public/private partnership regulatory functions strnghtened by 65% by the year 2015		17,759,476
			5.2.1.2	Provide data base for the HIS			32,036,956
		5.2.2	To provide HMIS Minimum Package at the different levels (FMOH, SMOH, LGA) of data management				**45,919,637**
			5.2.2.1	Procurement of computers for all project managers	By the end of 2011 50% of desk officers provided with HMIS minimium package in the state		12,135,211
			5.2.2.2	Providing local area network for the computers to facilitates quick access of information from the database			12,297,014
			5.2.2.3	Train relevant staff on the data base management			21,487,413
	5.3	**To strengthen sub-systems in the Health Information System**			**1. NHMIS modules strengthened by end 2010 2. NHMIS**		**51,591,149**

					annually reviewed and new versions released		
		5.3.1	To strengthen the Hospital Information System				**32,295,841**
			5.3.1.1	Establish patient information system in all the 33 General Hospitals in the state	Hospital information system establish in 16 General Hospitals by the end of 2011		32,295,841
		5.3.2	To strengthen the Disease Surveillance System				**19,295,309**
			5.3.2.1	Print and distribute forms for notifiable diseases to all health facilities	Data tools printed and distributed to all facilities		2,176,571
			5.3.2.2	Establish community based survaillance to strenghten disease survaillance system	Disease survaillance in the state strenghtened by 60% by the end of 2015		809,014
			5.3.2.3	Retraining of disease and notification survaillance officers on regular reporting of nofiable diseases to strenghten survaillance system			16,309,723
	5.4	**To monitor and evaluate the NHMIS**			**NHMIS evaluated annually**		**133,362,730**
		5.4.1	To establish monitoring protocol for NHMIS programme implementation at all levels in line with stated activities and expected outputs				**107,992,049**
			5.4.1.1	Provision of Nos 6 vehicles for NHMIS monitoring	Monitoring protocol for NHMIS program implementation improved by 30% by 2011		106,789,854
			5.4.1.2	Print HIS quality assurance (Qa) manual handbook and distribute to health care delivery points			386,709
			5.4.1.3	Conduct bi-annual review meeting in the state			815,486
		5.4.2	To strengthen data transmission				**25,370,681**
			5.4.2.1	Train health workers on NHMIS for timely and complete transmission of data in line with relevant guidelines	80% of health workers in the state train and retrained on NHMIS by 2015		25,370,681
	5.5	**To strengthen analysis of data and dissemination of health information**			**1. 50% of States have Units capable of analysing**		**16,144,684**

					health information by end 2010 2. All States disseminate available results regularly		
		5.5.1	To institutionalize data analysis and dissemination at all levels				**16,144,684**
			5.5.1.1	Establish an institution for data analysis and dissemination in the state	Institution established by 2011		533,949
			5.5.1.2	Train service providers for appropriate data analysis and dissemination of information	Human capacities on data analysis and dissemination improved to 50% by 2015		13,607,616
			5.5.1.3	Production of periodic health data bulletin on annual report			809,014
			5.5.1.4	Produce and disseminate quaterly health data bulletin			1,194,105
COMMUNITY PARTICIPATION AND OWNERSHIP							
6. To attain effective community participation in health development and management, as well as community ownership of sustainable health outcomes							**530,538,118**
	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**		**100,492,677**
		6.1.1	To provide an enabling policy framework for community participation				**5,744,738**
			6.1.1.1	Formation of state health development committee and advocacy visit to policy makers	100 out of 177 Communities, involvement and participation in health development strenghtened by 2013		3,347,530
			6.1.1.2	Reactivation of the community participation in health sector through the national health policy and finalization of the community development policy			2,397,208
		6.1.2	To provide an enabling implementation framework and environment for community participation				**94,747,939**
			6.1.2.1	Develop and adapt guidelines for establishing community structures for health development activities	60% enabling implementation framework for community participation provided by		1,797,906

					the end of 2011		
			6.1.2.2	Print and distribute tools for community involvement in planning, management, monitoring and evaluation of health interventions			5,691,657
			6.1.2.3	Establish inter sectoral stakeholders commitees involving community representatives at state level so as to enhance collaboration			12,465,482
			6.1.2.4	Conduct quaterly intersectoral committee meeting to ensure utilization of developed tools and possible need for revision			74,792,894
	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**		**50,622,187**
		6.2.1	To build capacity within communities to 'own' their health services				**50,622,187**
			6.2.1.1	Capacity building of stakeholders in management implementation as well as basic interpretation of health data to enable participate actively in health actions	60% coomunity capacity built by the end of 2015		31,352,058
			6.2.1.2	identify and map out key community stakeholders and resources			5,486,182
			6.2.1.3	Conduct reorientation of community development committee and community based health care providers on their roles and responsibilities			2,825,281
			6.2.1.4	Establish community dialogue between community and Government structures for maximium impact			2,397,208
			6.2.1.5	Conduct biannual radio/tv dialogue to enlighten and empower communities. IEC materials should be produced as well			8,561,458
	6.3	**To strengthen the community - health services linkages**			**50% of public health facilities in all States have active Committees that include community representativ es by end 2011**		**8,749,810**
		6.3.1	To restructure and strengthen the interface between the community and the health services delivery points				**8,749,810**
			6.3.1.1	Acess and review level of linkages of the existing health delivery structure with the community	Linkages between the community and health services		2,499,946

					delivery point restructured and strenghtened 2015		
			6.3.1.2	conduct quarterly referral health systems meeting to provide technical giudance and support to the community stakeholders			4,537,573
			6.3.1.3	Restructure health delivery structure to ensure adequate promotion of community participation in health development			1,712,292
	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**		**257,288,925**
		6.4.1	To develop and implement multisectoral policies and actions that facilitate community involvement in health development				**257,288,925**
			6.4.1.1	Advocacy visit to decision makers- gate keepers in the community to increase the awareness on community participation	Multisectoral policies developed by 2011		2,999,935
			6.4.1.2	Capacity building of selected community members as community oriented resource persons, and on key household practices ETC	actions to facilitate community involvement in health development of health promotion formulated		254,288,990
	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**		**113,384,520**
		6.5.1	To develop and implement systematic measurement of community involvement				**113,384,520**
			6.5.1.1	Conduct simple survey to measure impact and document lessons learnt, and best practices from community level approaches, methods and initiatives	By 2010 survey conduct in atleast 3 health zones		3,797,863
			6.5.1.2	conduct a one day workshop in five health zones to disseminate information from the survey carried out to enhance storage sharing among stakeholders			109,586,658
PARTNERSHIPS FOR HEALTH							
7. To enhance harmonized implementation of essential health services in line with national health policy goals							**616,445,965**

	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**		**616,445,965**
		7.1.1	To promote Public Private Partnerships (PPP)				**10,127,589**
			7.1.1.1	Advocacy visit to policy makers to review and update the existing state state PPP policy with a view to leveraging technical and financial resources alongside improve management approaches for improved health care services	No of advocacy visit paid to policy makers		3,810,380
			7.1.1.2	Establishment of PPP unit to provide, oversee, and monitor PPP activies	PPP unit established in the state		6,317,209
		7.1.2	To institutionalize a framework for coordination of Development Partners				**8,356,097**
			7.1.2.1	Establish the health partners co-ordinating committee (HPCC) in the state	The committee cordinating framework established		4,735,121
			7.1.2.2	Establish a joint funding agreement as a mechanism for resource cordination			3,620,975
		7.1.3	To facilitate inter-sectoral collaboration				**4,735,121**
			7.1.3.1	Reactivate the existing intersectoral ministerial collaboration in involving all relevant ministries, department and agencies	Intersectorial ministerial collaboration reactivated		4,735,121
		7.1.4	To engage professional groups				**15,040,974**
			7.1.4.1	Strengten collaboration between government and professional groups to advocate for increased coverage of essential intervention, particularly increased funding	60% of coveraged attained by 2015		4,456,585
			7.1.4.2	Promote linkage with academic institutions to undertake research, education and monitoring through existing networks	By 2015 Health care delivery improved by 70% with increased no. of skilled personnel		5,849,268
			7.1.4.3	Influence regulation and legislation to allow for competency-based practice by all types of health professionals according to the principles of 'continuum of care'			4,735,121

		7.1.5	To engage with communities				**487,522,535**
			7.1.5.1	Improve availability of informations to communities in a form that is readily assessible and useful through proper channel e.g radio.Tv	Assesibility of information improved by 70% by the year 2015		17,603,510
			7.1.5.2	Establish and empower health service charters at all levels, with civil soceity organization, traditional and religious institution to promte the concept of citizens right and entitllement to quality, assessible basic health services	Religious groups empowered by 2011		78,686,577
			7.1.5.3	Build the capacity of communities to prevent and manage priority health conditions through appropriate self-mediated mechanisms such as Behaviour Change Communication (BCC), Social marketing,			391,232,447
		7.1.6	To engage with traditional health practitioners				**90,663,649**
			7.1.6.1	train and provide supports based on identified research capacity Gaps/weakness	No. of traditional health care providers with full knowledge of improved health practices increased by 70%		3,760,244
			7.1.6.2	Adopt traditional practices and technologies of proven value into State health care system and discourage those that are harmful			9,470,243
			7.1.6.3	Seek the cooperation of traditional practitioners in promoting health programmes in such priority areas as nutrition, environmental sanitation			68,241,456
			7.1.6.4	Organize traditional medicine practioners into bodies/organization that are easy to regulate their practices			5,013,658
			7.1.6.5	Adopt tradional practices and technoligies of proven value into state health care system and discourage those that are harmful			4,178,048
RESEARCH FOR HEALTH							
8. To utilize research to inform policy, programming, improve health, achieve nationally and internationally health-related development goals and contribute to the global knowledge platform							**1,134,970,042**
	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**		**206,988,096**

					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				**7,969,425**
			8.1.1.1	Form a technical working group to develop health research policies and strategies in the state	By 2011 techncal formed and health research policies developed		4,870,204
			8.1.1.2	Establish health research steering committee in the state to shephered research activities			3,099,221
		8.1.2	To establish and or strengthen mechanisms for health research at all levels				**39,515,064**
			8.1.2.1	Conduct training for planning officers to undertake operations research and other research related activities	75% of planning officers trained by the end of 2015		39,515,064
		8.1.3	To institutionalize processes for setting health research agenda and priorities				**19,923,562**
			8.1.3.1	Establish an institutional structure for research	By 2011, one functional research intitutional structure established and guidelines developed for collaborative health research agenda		10,625,900
			8.1.3.2	Develop guidelines for collaborative health research agenda			9,297,662
		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				**123,526,082**
			8.1.4.1	Establish strong link between the users of research and the producers ie policy makers and universities	50% link b/w research users and producers established by 2015		5,534,323
			8.1.4.2	Conduct annual meeting of health research officers at the state level to identify research pririorities and harmonize research effort	At least 2% of health budget ensured for research activities by 2015		45,381,446
			8.1.4.3	Provide funds for research activities			72,610,314
		8.1.5	To mobilise adequate financial resources to support health research at all levels				**-**
			8.1.5.1	Establishment of independent national research funding	National research funding agency established		-

		8.1.6	To establish ethical standards and practise codes for health research at all levels				**16,053,963**
			8.1.6.1	Form a research ethical committee	By 2015, 50% of ethical standards and practice codes for health researches established		2,877,848
			8.1.6.2	Establish ethical standard and practice for health research in the state			3,984,712
			8.1.6.3	Conduct monitoring and evaluation, to regulate research and use of research findings in the state			9,191,403
	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**		**140,824,161**
		8.2.1	To strengthen identified health research institutions at all levels				**54,488,727**
			8.2.1.1	Conduct a survey and make an inventory of all public and private institutions and organization undertaking health research	20% health research institutions identified and strenghtened by 2012		6,614,622
			8.2.1.2	Conduct a yearly capacity assessment of health research organization and institutions			9,576,592
			8.2.1.3	Train and provide supports based on identified research capacity Gaps/weakness			38,297,513
		8.2.2	To create a critical mass of health researchers at all levels				**74,381,297**
			8.2.2.1	Capacity building of researchers in form of inservice training to produce high quality and relevant research output	75% of planners with in service training to produce high quality and relevant research output by the end of 2015		74,381,297
		8.2.4	To undertake research on identified critical priority areas				**11,954,137**
			8.2.4.1	Conduct a biennially research to estimate the burden of different diseases and health delivery systems in the state	50% research critical areas on identified by 2015		11,954,137
	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**		**45,115,799**

					an accessible repository by end 2012		
		8.3.1	To develop strategies for getting research findings into strategies and practices				**24,572,393**
			8.3.1.1	Establish a research unint in the ministry of health	A functional research unit established by the end of 2011		2,435,102
			8.3.1.2	To make annual budget provision for the research unit	Research grant provided in the annual budget with effect from 2011		22,137,291
		8.3.2	To enshrine mechanisms to ensure that funded researches produce new knowledge required to improve the health system				**20,543,406**
			8.3.2.1	Conduct needs assessment to identify required health research gaps in all health ministries, departments and agencies in the state.	Health systems improved by 50% by the end of 2015		8,633,543
			8.3.2.2	Conduct operations research to address gaps in research capacity in government institution			11,909,862
	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**		**742,041,986**
		8.4.1	To create a framework for sharing research knowledge and its applications				**583,981,730**
			8.4.1.1	Conduct an annual workshop to for large audience in five health zones research knowledge and its applications in the state	Framework for sharing research knowledge and its applications created by 2013		510,485,925
			8.4.1.2	Publish research findings in academic journals			73,495,805
		8.4.2	To establish channels for sharing of research findings between researchers, policy makers and development practitioners				**158,060,256**
			8.4.2.1	Conduct training of research personel to help them effectively produce briefs targeted at informing policy makers as well as the broad scientific and non-scientific audiences	Channels for sharing of research findings between researches and policy makers improved by 50% by the end of 2015		158,060,256
							80,759,567,909

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

ANAMBRA 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						
PRIORITY AREA 1: LEADERSHIP AND GOVERNANCE FOR HEALTH						
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**
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	80%	85%	100%
	2. % stakeholders constituencies playing their assigned roles in the SSHDP (disaggregated by stakeholder constituencies)	SSHDP Annual Review Report	20%	30%	50%	75%
2. Improved Legislative and Regulatory Frameworks for Health Development	3. State adopting the National Health Bill? (Yes/No)	SMOH	0	25%	50%	75%
	4. % of LGAs enforcing traditional medical practice by-laws	LGA Annual Report	TBD	25%	50%	75%
3. Strengthened accountability, transparency and responsiveness of the State health system	5. % of LGAs which have established a Health Watch Group	LGA Annual Report	30%	40%	60%	80%
	6. % of recommendations from health watch groups being implemented	Health Watch Groups' Reports	20%	30%	50%	75%
	7. % LGAs aligning their health programmes to the SSHDP	LGA Annual Report	0	50%	75%	100%
	8. % DPs aligning their health programmes to the SSHDP at the LGA level	LGA Annual Report	0	50%	75%	100%
	9. % of LGAs with functional peer review mechanisms	SSHDP and LGA Annual Review Report	20%	40%	60%	80%
	10. % LGAs implementing their peer review recommendations	LGA / SSHDP Annual Review Report	20%	30%	50%	80%

	11. Number of LGA Health Watch Reports published	Health Watch Report	12	18	21	21
	12. Number of "Annual Health of the LGA" Reports published and disseminated annually	Health of the State Report	10	18	21	2100%
4. Enhanced performance of the State health system	13. % LGA public health facilities using the essential drug list	Facility Survey Report	20%	40%	60%	100%
	14. % private health facilities using the essential drug list by LGA	Private facility survey	20%	30%	50%	80%
	15. % of LGA public sector institutions implementing the drug procurement policy	Facility Survey Report	30%	50%	75%	100%
	16. % of private sector institutions implementing the drug procurement policy within each LGA	Facility Survey Report	20%	40%	60%	80%
	17. % LGA health facilities not-experiencing essential drug/commodity stockouts in the last three months	Facility Survey Report	10%	30%	40%	60%
	18. % of LGAs implementing a performance based budgeting system	Facility Survey Report	10%	30%	40%	50%
	19. Number of MOUs signed between private sector facilities and LGAs in a Public-Private-Partnership by LGA	LGA Annual Review Report	2	3	5	10
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	20. % of LGAs with a functioning public health facility providing minimum health care package according to quality of care standards.	NPHCDA Survey Report	20%	30%	50%	75%
	21. % health facilities implementing the complete package of essential health care	NPHCDA Survey Report	20%	40%	60%	100%

	22. % of the population having access to an essential care package	MICS/NDHS	30%	50%	75%	100%
	23. Contraceptive prevalence rate	NDHS	34.40%	60%	70%	80%
	24. Increased number of new users of modern contraceptive methods (male/female)	NDHS/HMIS	16.60%	30%	50%	75%
	25. % of new users of modern contraceptive methods by type (male/female)	NDHS/HMIS	TBD	2 - 30%	5 - 50%	10 - 75%
	26. % service delivery points without stock out of family planning commodities in the last three months	Health facility Survey	TBD	10%	75%	100%
	27. % of facilities providing Youth Friendly RH services	Health facility Survey	TBD	20%	60%	75%
	28. Percentage of women age 15-19 who have begun child rearing	NDHS/MICS	6.20%	4%	3%	2%
	29. % of pregnant women with 4 ANC visits performed according to standards*	NDHS	97.70%	98%	99%	100%
	30. Proportion of births attended by skilled health personnel	HMIS	87.80%	90%	95%	100%
	31. Proportion of women with complications treated in an EmOC facility (Basic and/or comprehensive)	EmOC Sentinel Survey and Health Facility Survey	TBD	10%	25%	40%
	32. Caesarean section rate	EmOC Sentinel Survey and Health Facility Survey	5.60%	10%	20%	30%
	33. Case fatality rate among women with obstretic complications in EmOC facilities per complication	HMIS	TBD	40%	30%	25%
	34. Perinatal mortality rate**	HMIS	37/1000LBs	25/1000LBs	15/1000LBs	10/1000 LBs
	35. % of women who received postnatal care based on standards within 48h after delivery	NDHS 2008	43.60%	50%	60%	75%
	36. % of newborn with infection receiving treatment	MICS	No Baseline	20%	40%	75%
	37. % of children exclusively breastfed 0-6 months	NDHS/MICS	1.50%	10%	20%	40%

	38. Proportion of 12-23 months-old children fully immunized	NDHS/MICS	51.90%	70%	80%	90%
	39. % children <5 years stunted (height for age <2 SD)	NDHSMICS	17.00%	12%	8%	5%
	40. % of under-five that slept under LLINs the previous night	NDHS/MICS	28.10%	40%	60%	80%
	41. % of under-five children receiving appropriate malaria treatment within 24 hours	NDHS/MICS	12.00%	25%	40%	60%
	42. Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS	NDHS/MICS	46%	60%	75%	90%
	43. Prevalence of tuberculosis	NARHS	4%	3%	2%	1%
	44. Proportion of tuberculosis cases detected and cured under directly observed treatment short course	NMIS	TBD	20%	40%	60%
Output 6. Improved quality of Health care services	45. % of staff with skills to deliver quality health care appropriate for their categories	Facility Survey Report	TBD	35%	55%	75%
	46. % of facilities with capacity to deliver quality health care	Facility Survey Report	TBD	25%	50%	75%
	47. % of health workers who received personal supervision in the last 6 months by type of facility	Facility Survey Report	TBD	20 - 40%	50 - 75%	75 - 100%
	48. % of health workers who received in-service training in the past 12 months by category of worker	HR survey Report	TBD	10%	25%	50%
	49. % of health facilities with all essential drugs available at all times	Facility Survey Report	TBD	25 - 40%	40 - 75%	75 - 100%
	50. % of health institutions with basic medical equipment and functional logistic system appropriate to their levels	Facility Survey Report	TBD	10%	25%	50%
	51. % of facilities with deliveries organizing maternal and/or neonatal death reviews according to WHO guidelines on regular basis	Facility Survey Report	TBD	10%	30%	50%
Output 7. Increased	52. Proportion of the population utilizing	MICS	TBD	25%	50%	75%

demand for health services	essential services package					
	53. % of the population adequately informed of the 5 most beneficial health practices	MICS	TBD	25%	50%	75%
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	54. % of wards that have appropriate HRH complement as per service delivery norm (urban/rural).	Facility Survey Report	TBD	20%	40%	75%
	55. % LGAs actively using adaptations of National/State HRH policy and plans	HR survey Report	TBD	10%	30%	50%
	56. Increased number of trained staff based on approved staffing norms by qualification	HR survey Report	TBD	20%	40%	60%
	57. % of LGAs implementing performance-based managment systems	HR survey Report	TBD	25%	50%	60%
	58. % of staff satisfied with the performance based management system	HR survey Report	TBD	10%	25%	50%
Output 8: Improved framework for objective analysis, implementation and monitoring of HRH performance	59. % LGAs making availabile consistent flow of HRH information	NHMIS	25%	40%	60%	80%
	60. CHEW/10,000 population density	MICS	TBD	1:4000 pop	1:3000 pop	1:2000 pop
	61. Nurse density/10,000 population	MICS	TBD	1:8000 pop	1:6000 pop	1:4000 pop
	62. 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
	63. Medical doctor	MICS	TBD	1:8000 pop	1:7000 pop	1:5000 pop

	density per 10,000 population					
	63. Other health service providers density/10,000 population	MICS	TBD	1:4000 pop	1:3000 pop	1:2000 pop
	64. HRH database mechanism in place at LGA level	HRH Database	TBD	50 - 75%	75 - 100%	100%
Output 10: Strengthened capacity of training institutions to scale up the production of a critical mass of quality mid-level health workers						
PRIORITY AREA 4: FINANCING FOR HEALTH **NSHDP GOAL 4 : To ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and consumption at Local, State and Federal Levels**						
NSHDP GOAL 4 : To ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and consumption at Local, State and Federal Levels						
Outcome 8. Health financing strategies implemented at Federal, State and Local levels consistent with the National Health Financing Policy						
Outcome 9. The Nigerian people, particularly the most vulnerable socio-economic population groups, are protected from financial catastrophe and impoverishment as a result of using health services						
Output 11: Improved protection from financial catastrophy and impoversihment as a result of using health services in the State	65. % of LGAs implementing state specific safety nets	SSHDP review report	TBD	10%	25%	50%
	66. Decreased proportion of informal payments within the public health care system within each LGA	MICS	60%	50%	40%	30%
	66. % of LGAs which allocate costed fund to fully implement essential care package at N5,000/capita (US$34)	State and LGA Budgets	TBD	25%	40%	60%
	67. LGAs allocating health funding increased by average of 5% every year	State and LGA Budgets	TBD	25%	40%	60%
Output 12: Improved efficiency and equity in the allocation and	68. LGAs health budgets fully alligned to support state health goals and policies	State and LGA Budgets	TBD	40%	60%	80%

use of Health resources at State and LGA levels						
	69.Out-of pocket expenditure as a % of total health expenditure	National Health Accounts 2003 - 2005	60%	50%	40%	30%
	70. % of LGA budget allocated to the health sector.	National Health Accounts 2003 - 2005	5%	10%	15%	20%
	71. Proportion of LGAs having transparent budgeting and finacial management systems	SSHDP review report	20%	25%	40%	60%
	72. % of LGAs having operational supportive supervision and monitoring systems	SSHDP review report	20%	25%	40%	50%
PRIORITY AREA 5: NATIONAL HEALTH INFORMATION SYSTEM						
Outcome 10. National health management information system and sub-systems provides public and private sector data to inform health plan development and implementation						
Outcome 11. National health management information system and sub-systems provide public and private sector data to inform health plan development and implementation at Federal, State and LGA levels						
Output 13: Improved Health Data Collection, Analysis, Dissemination, Monitoring and Evaluation	73. % of LGAs making routine NHMIS returns to states	NHMIS Report January to June 2008; March 2009	34%	50%	75%	80%
	74. % of LGAs receiving feedback on NHMIS from SMOH		34%	50%	75%	80%
	75. % of health facility staff trained to use the NHMIS infrastructure	Training Reports	50%	60%	80%	100%
	76. % of health facilities benefitting from HMIS supervisory visits from SMOH	NHMIS Report	50%	60%	80%	100%
	77.% of HMIS operators at the LGA level trained in analysis of data using the operational manual	Training Reports	40%	60%	75%	100%
	78. % of LGA PHC Coordinator trained in data dissemination	Training Reports	40%	60%	75%	100%
	79. % of LGAs publishing annual HMIS reports	HMIS Reports	20%	30%	50%	75%
	80. % of LGA plans using the HMIS data	NHMIS Report	20%	40%	75%	100%
PRIORITY AREA 6: COMMUNITY PARTICIPATION AND OWNERSHIP						
Outcome 12. Strengthened community participation in health development						
Outcome 13. Increased capacity for integrated multi-sectoral health promotion						

Output 14: Strengthened Community Participation in Health Development	81. Proportion of public health facilities having active committees that include community representatives (with meeting reports and actions recommended)	SSHDP review report	10%	25%	50%	75%
	82. % of wards holding quarterly health committee meetings	HDC Reports	10%	25%	50%	75%
	83. % HDCs whose members have had training in community mobilization	HDC Reports	20%	40%	75%	100%
	84. % increase in community health actions	HDC Reports	5%	10%	25%	50%
	85. % of health actions jointly implemented with HDCs and other related committees	HDC Reports	10%	25%	40%	60%
	86. % of LGAs implementing an Integrated Health Communication Plan	HPC Reports	10%	25%	40%	60%
PRIORITY AREA 7: PARTNERSHIPS FOR HEALTH						
Outcome 14. Functional multi partner and multi-sectoral participatory mechanisms at Federal and State levels contribute to achievement of the goals and objectives of the						
Output 15: Improved Health Sector Partners' Collaboration and Coordination	87. Increased number of new PPP initiatives per year per LGA	SSHDP Report	10%	25%	40%	60%
	88. % LGAs holding annual multi-sectoral development partner meetings	SSHDP Report	10%	25%	50%	75%
PRIORITY AREA 8: RESEARCH FOR HEALTH						
Outcome 15. Research and evaluation create knowledge base to inform health policy and programming.						
Output 16: Strengthened stewardship role of government for research and knowledge management systems	89. % of LGAs partnering with researchers	Research Reports	5%	10%	25%	50%
	90. % of State health budget spent on health research and evaluation	State budget	0.50%	1%	1.50%	2%
	91. % of LGAs holding quarterly knowledge sharing on research, HMIS and best practices	LGA Annual SHDP Reports	5%	10%	25%	50%

	92. % of LGAs participating in state research ethics review board for researches in their locations	LGA Annual SHDP Reports	15%	40%	75%	100%
	93. % of health research in LGAs available in the state health research depository	State Health Reseach Depository	10%	40%	75%	100%
Output 17: Health research communication strategies developed and implemented	94. % LGAs aware of state health research communication strategy	Health Research Communication Strategy	20%	40%	75%	100%