ZAMFARA STATE GOVERNMENT

STRATEGIC HEALTH DEVELOPMENT PLAN
(2010-2015)

Zamfara State Ministry of Health

March 2010

Contents

Abbreviation/Acronyms

AIDS	Acquire Immunodeficiency Syndrome
ANC	Antenatal Care
BCC	Behavioural Change Communication
BEOC	Basic Emergency Obstetrics
CEOC	Comprehensive Emergency Obstetric Care
CHEW	Community Health Extension Worker
DPH	Director Public Health
DPHC	Director Primary Health Care
DPRS	Director Planning, Research And Statistics
DPS	Director Pharmaceutical Services
DRF	Drug Revolving Funds
ELSS	Expanded Life Saving Skills
FMOH	Federal Ministry Of Health
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRH	Human Resource For Health
IEC	Information, Education And Communication.
IMCI	Integrated Management Of Childhood Illness
IMNCH	Integrated Maternal And Neonatal And Child Health
IMR	Infant Mortality Rate
LGA	Local Government Authority
LSS	Life Saving Skills
M&E	Monitoring And Evaluation
MDG	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MLSS	Modified Life Saving Skills
MMR	Maternal Mortality Rate
NDHS	National Demo Graphic Health Survey
NGO	Non Governmental Organization
NHIS	National Health Insurance Scheme
PPP	Public-Private Partnership
PRINN-MNCH	Partnership For Revival Of Routine Immunization In Northern Nigeria
RH	Reproductive Health
SERVICOM	Service Compact
SMOH	State Ministry Of Health
SON	School Of Nursing
SWOT	Strength, Weakness, Opportunity And Threat
VVF	Vesico Vagina Fistula

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Preface

The Zamfara state strategic health plan represents the aspiration of the government and citizens of the state to bring about a remarkable transformation of the health sector to provide qualitative health service in the state

In order to address the present dismal health indices in the country the Federal Government Of Nigeria proposed a national strategic health plan and provide framework/guideline for states to develop a state specific strategic health plan as part of an overarching national plan design to produce a single document for purpose of health planning, management, implementation, monitoring and evaluation.

The Zamfara state Government in response to this initiative has developed its own state strategic plan to address health issues in the state.

The Zamfara State Government in line with national strategic plan adopts a bottom up approach in a process that foster harmonization, alignment, coordination ,ownership, and accountability etc. it is created to scale up service using evidence intervention and activities that are cost effective.

The state strategic plan is designed within the 8 thematic areas that focus on leadership and governance, service delivery, human resource for health, health financing, health management information system, community involvement, partnership and research for health.

It is design as basis for increase and long term resource mobilization, and provides guidance for strategic partners and stakeholders to support implementation of health programs in a way that improves the state activities and serves as the main guiding light for health in the state

It is the expectation of the government that all stakeholders will support this plan.

Executive Summary

Background and Achievement

The strategic plan was developed as part of an overall national response by the federal government to reverse the dismal health indices. The national response is designed to produce a single document for the purpose of health planning and implementation in the country through the provision of a common national framework for development of a national strategic plan .it adopts a bottom up approach in a process that fosters harmonization, alignment coordination, mutual ownership, transparency and accountability .it was develop in the context of federal government seven point agenda, NEEDS document, MDG 5th national development plan, Ouagadougou declaration.

The process included a review of best practices, 10 national surveys, stakeholders meeting across the six zones, development of a draft framework by the technical working group and subsequent presentation to the national council of health and federal health executive council. The state strategic plan builds on existing government efforts including current state strategic plan, ongoing construction of referral facilities, refurbishment and equipping of government facilities, open door policy of employment for essential health workforce and strengthen the free maternal and child health program among others.

Key Issues and Challenges

The zamfara state strategic plan acknowledges the disproportionate level of maternal, neonatal and child mortality in the state. It also recognises the significant challenges of human resource, limited health funding, poor health infrastructure and equipments, poor utilization of services amongst others.

Vision and Mission

The strategic plan envisions a Zamfara state in which people are healthy and well informed with access to high quality health services. It has the mission to transform the health system through establishment of an effective health system which is accessible, affordable, equitable and sustainable to all citizens of the state irrespective of status, making it a reference point in Nigeria and Africa as whole.

The plan was developed along the 8 thematic areas namely leadership and governance, service delivery, human resource for health, health financing, and health management information system, community involvement and research.

Strategic Health Priorities

These 8 Strategic Health Priority areas has its goal, objectives with targets, interventions and activities to achieve them

The First Strategic Orientation: Leadership and Governance For Health:

Government has apart of its effort to provide quality health care has demonstrated a lot of commitment through improve funding to health ,building of health facilities and cardinal program such as free maternal and child program among others.

Identify gap include weak capacity for planning; ill define roles and responsibilities donor coordination, absence of public private partnership, lack of health sector watchdog among other

The strategic priority focus on strengthen capacity for planning through training in and outside the state .it also put in place periodic review and evaluation mechanism to track progress.

To enhance efficiency and effectiveness of the proposed SPHCB which is expected to be sign into law and commence full operation. The traditional medicine board and a coordinating forum for partners will be established. The state council for health will be strengthened and an intersectoral committee put in place.

The roles of head of institutions will strengthened a system of reward and sanction of health workers will be institutionalized. Annual review of health workers performance will be revive and the present peer participatory rapid appraisal of health facilities
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The Second Strategic Orientation Is: Health Service Delivery

The state has 18 general hospitals over 600 PHCs, 42 maternal and child health clinic 20 private hospitals AND 1 federal medical centre. These numbers of facilities are above minimum requirement, however weak infrastructure inadequate equipment and drugs are identified constraints in addition utilization has been poor.

Priority action in these thematic areas is the formalization of the proposed minimum service packaged. This will be costed based on requirement; identified gaps will met in a phased process. The Integrated maternal neonatal and maternal and child health will be accorded high priority. The free maternal child health program will be back by appropriate policy guideline and legislation. An emergency response plan for accident and emergency will be developed and operationalized, other major focus include communicable and non communicable disease .malaria, TB and HIV interventions will be strengthened. Intervention on immunization will be intensified. The drug revolving funds will be revived and mechanism for equipment maintenance put in place.

Integrated supportive supervision will be intensify, servicom units ill be established in health facilities. The referral network in the sate will be mapped out and appropriate logistics provided

The Third Strategic Orientation: Human Resources For Health

This is a critical priority area as all other resources depend on it for optimal utilization

Human resource for health is major issues in the state as essential manpower such Doctors Nurses Pharmacist are in short supply this is also compounded by their skewed distribution.

The major activities include development of a human resource for health policy; development of a human resource data bank .Staffing norm is developed to guide the redistribution of staff in line with requirement .the HRH unit of SMOH which will be strengthened.

A locum arrangement will be establish with federal institution within and outside the state to ensure coverage of referral facilities. Recruitment of health workers will be on a continuous basis and present salary structure will be maintain and improve upon

The existing training institution SONM and SOHT will be strengthened and additional school of nursing and midwifery establish before expiration of the time line.

CHEWs in the state will be trained to conduct safe delivery and refer during emergencies

The Fourth Strategic Orientation: Financing For Health:

Over the years Government has improve funding to the health sector, this however below the recommended level of 15 % .Despite donor funding of programs in the state there is still need for coordination.

This priority area focus on development of financing strategy for health, it aim at improving funding to the health sector, it also target the initiation of a NHIS scheme in the state. Private health insurance will also be encouraged. Additional funding will be source from partners, zakat board charity organizations, MDGs and corporate bodies. A common basket funding by partner will be explored

Efficient use of available funds will be encouraged through appropriate mechanism and training. Budget will be in line with annual plan and tracking of expenditure will be put in place

The Fifth Strategic Orientation: National Health Information System

The NHMIS system is an important management tool for informed decision making at all levels to improve health care. The HMIS in the state at present is weak

Major interventions in this priority area include improvement of data collection and transmission by printing adequate number of forms and making them available at service delivery points.

There will be collaboration with FMOH to streamline data collection, capacity building for medical records staff will also be of priority .integrated supportive supervision will be institutionalize for data collection.

The state will collaborate with NPC to strengthen vital registration which will be made compulsory.

Adequate ICT infrastructure will be made available to improve data collection transmission and analysis .a internet based data transmission process will be established

Community Participation and Ownership

Health system exists because of the community more often than not the community have minimal participation in health activities. The community involvement activities is anchored though the social mobilization unit of the SMOH

The main activities include strengthening of the social mobilization unit, advocacy tools will be develop and implemented. There will be awareness creation, and revitalization of village health and ward development communities. Joint hospital and community development community will be initiated. Public awareness campaign on various health issues and use of IEC material to disseminate messages are priority actions.

Communities will be encourage to monitor, support and evaluate health interventions and facilities in their area

Partnerships For Health

Government alone cannot meet the demand for quality health care necessary other key player exist in the health sector such as the private sector the traditional medicine practitioners and developmental partners. Despite the activities of these players in the state, there is no public private partnership policy in place, donor coordination is weak and control of traditional medicine practitioner is also weak.

Priority action is include strengthening of donor coordinating mechanism, establishment of a public private partnership, collaboration and engagement with professional bodies ,regulation of activities of traditional medicine practitioner.

Research For Health

Research undertaking in the estate is still at infancy level .research is require to guide policy and provide insight into various challenges facing the health system.

Important steps include adopting a state research policy setting up of an ethic and research committee, setting up of state research agenda. The nahuche research centre will be equipped

ad staff to commence full operation. Institutional capacity for research will be assessed and identify gaps corrected. Link with be establish journal and publication for dissemination of research findings which will also include annual meetings and participation in conference. A budget line will be establish for research

Implementation And Framework:

This strategic plan is design to accelerate the transformation of the health system.

It will be implemented by all stakeholders as a multi-sectoral strategy for comprehensive health care delivery. The implementation will be coordinated by reference group headed by the permanent secretary

The implementation will be in phases .There is an initial phase from 2010-2012 where emphasis is to determine the gaps and ensuring that minimum standard of service provision are met and appropriate function mechanism put in place.

The second phase is that of consolidation this builds on the initial phase to scale up services and promote demand for services

On annual basis a work plan will be developed that clearly delineate roles and responsibility in line with the state strategic plan

Proposed Mechanism For Monitoring And Evaluation*:*

To track progress the mechanism will be through [1] routine M and E [2] Annual review process [3] Mid term review progress in compliance with the plan

The monitoring and evaluation components will require # 257,407,750

Resource Requirements:

The state presently experience human resource challenges in critical areas of manpower such as Doctors, Nurse/Midwives pharmacist etc. The need to meet the minimum health resource requirement in the state is therefore very important. Although accurate number of health workers in the state could not be ascertain, the minimum number of doctors require for the state is 638 based on 1 doctor /5000 population in this strategic plan the state will at minimum meet at least 50% of the human resource gap through annual employment of at least 30 doctors per annual and also through redistribution of existing workforce and it will sign MOU with federal institution within and out side the state to ensure coverage of key health facilities in the state

In addition a human resource mobilization committee is to be established to encourage and counsel secondary school students to take up career in medicine and allied courses.

It is also proposed that an additional school of nursing and midwifery will be established by 2015 A gradual and refurbishment of health facilities will be undertaken to ensure they meet

minimum standard. In addition a system of equipment and supply and maintenance will be put in place to ensure sustainability

New structures such as public health laboratory, quality control laboratory, epidemiology complex will be completed .on going construction of referral centres in Gusau, Shinkafi and Talata Mafara will also be completed

The cancer centre and renal dialysis centre will also be completed during the duration of the plan

The training institution SONM an SOHT will have their infrastructure strengthen during the span of the strategic plan, this include building additional class room, auditorium staff quarters

A new school of nursing/midwifery will be constructed before end of the time line

The state pharmaceutical company will also be completed during this period

Financial plan:

Although the current global economic melt down poses limiting constraints to the strategic plan. Enormous amount of fund will be required to drive the implementation of the strategic plan which needs improved funding from government and other sources

The strategic plan aims at attracting funding agencies to collaborate with governments at the various levels to put in more support for the optimum management and development of the health system in the state in a well coordinated manner. Potential sources of funding for the strategic plan during the period 2010--2015 are as follows:

1. Government sources: state, LGA
2. Donor and other external sources of funding
3. Millennium development goal
4. National Health Insurance Scheme
5. Public – Private Partnerships
6. Individual and community self help/ investment in human resources development
7. Philanthropic sources
8. Zakaat board

9 Faith based organization

Conclusion

The Zamfara state strategic plan is a road map to attain the government hope of providing qualitative health services to the populace and it highlight key areas of focus. it is the expectation of the state that all health programs will be guided by the provision of the plan

Vision, Mission and the Overarching Goal of the State Strategic Health Development Plan

Vision

Envision a Zamfara state in which people are healthy and well informed with access to high quality health services.

Mission

To transform the health system through to provide promote and facilitate access to an effective health system which is accessible affordable equitable and sustainable to all citizens of the state irrespective of status, making it a reference point in Nigeria and Africa as whole

Chapter 1: Background and Achievement

1.1 Background

The basic objective of development is to create an enabling environment for people to enjoy long, healthy and creative lives. The health sector is critical to social and economic development with ample evidence linking productivity to quality of health care. In Nigeria, the vision of becoming one of the leading 20 economies of the world by the year 2020 is closely tied to the development of its human capital through the health sector. However, the health indicators in Nigeria have remained below country targets and internationally-set benchmarks including the MDGs, which have recorded very slow progress over the years. Currently, the health sector is characterized by lack of effective stewardship role of government, fragmented health service delivery, inadequate and inefficient financing, weak health infrastructure, mal-distribution of health work force and poor coordination amongst key players. Per capita health expenditure is ranged from $10-$15 with 70% coming from private out-of-pocket thus limiting equitable access

PHC (the bedrock of the health system) is in a prostate state because of under funding and inadequate political will

There is inadequate capacity at the LGA level which is expected to be the operational level for PHC.

Result is low coverage with proven cost effective interventions (immunization is 23%; 6% children U-5 years sleep under ITNs, 8.9% CPR, and 47% PW delivered by skilled birth attendants)

Over the years a number of policies and programs have been developed despite these initiatives, much of the underlying weaknesses and constraints of the health sector persist. In addition dynamic changes are occurring in the health sector, the need arises for an evidenced based, plan that will track investment to attain global set targets, i.e. MDGs, and foster ownership.

Consequently, the Federal Ministry of Health has articulated a framework, as an overarching guide for the development of the National Strategic Health Development Plan (NSHDP) with its appropriate costing. The NSHDP would result from the harmonization of Federal, States' and local governments' health plans, thereafter serving as the basis for national ownership, resource mobilisation/allocation and mutual accountability by all stakeholders – government, development partners, civil society, private sector, communities, etc. The framework is based on the principles of the Four Ones: one health policy, one national plan, one budget, and one monitoring and evaluation framework for all levels of government. It also provides the template to concretize the health sector development component of the 7-point Agenda,

Vision 2020 and a platform for achieving the MDGs. the guiding principle also include ,the ouagadougou declaration, the fifth national development plan.

The process included a review of best practices, 10 national surveys, stakeholders meeting across the six zones, development of a draft framework by the technical working group and subsequent presentation to the national council of health and federal health executive council.

At the state level which was preceded by training at the national level a similar bottom up participatory approach was adopted, this included orientation meeting, Training of state stakeholders, Development of strategic plan, LGA training series of review/Planning sessions by the reference group and development of draft, Presentation to stakeholders, review of draft report and adoption of a final plan.

1.2 Achievements:

The state government has recorded significant successes in the area of health. Over the years there has been an increasing budgetary allocation to health. It has improved from 4.85% of total budget in 2005 to 9.1% in 2009

A state council of health has been established and strategic plan for health has been developed though to be reviewed

The government operates the free maternal and child health services at a limited level. The school of nursing and midwifery has commenced academic activities but yet to graduate students.

There is more engagement and presence of developmental partners working in the area of health in the state. They include WHO, UNICEF,EU-PRIME,ACCESS ,PRINNMNCH ,SFH. this as resulted in undertaking of many baseline surveys such as HRH survey, peer participatory rapid appraisal survey,CEOC and BEOC survey ETC and several capacity building programs

The state government has embarked on construction of referral centers across the three senatorial districts in the state. Salaries of all health workers including non technical staff have been increased. More health personnel including doctors nurse pharmacist has been recruited. A pharmaceutical company is to be constructed by government. Establish human resource unit in the ministry of health and established a research centre

It has commence an annual rapid appraisal process of health facilities in the state as well as integrated supportive supervision [ISS]

The process of establishing a state primary health care board has reached advance state.

Government has purchase medical equipments and the process of its distribution has commenced

Chapter 2: Situation Analysis

2.1 *Socio-Economic Context.*

Zamfara state was carved out of the then old Sokoto state on the 18th October 1996 by military regime headed by General Sani Abacha. It covers an area of 32,247 square kilometres, representing about 4% of the landmass of Nigeria. It is situated towards the extreme north west portion of Nigeria, lying between latitudes 10 degrees 52' and 13 degrees 10 to the north, as well as longitudes 4 degrees 40 and 7 degrees 10' to the east by Katsina state in the south by Niger state and partly Kebbi state on the west by Sokoto state and on the north by republic of Niger (sharing about 7o kilometres of border area.

The state has 3 senatorial districts and consist of 14 Local Government Areas namely .Gusau, Tsafe, Bungudu, Maru, Anka, Maradun, Bakura, Talata-mafara, Bukkuyum ,Gumi, Kaura, Shinkafi, Birinin-magaji, zurmi It has 147 political wards

The state has a population of 3,582,912 as at 2009 based on the 2006 census population. It has a pregnant population of 179, 146, women of child bearing age constitute 788,241[15-45] the annual growth rate is 3.2% children under 1 are 143,316 and under 5 are 716,582.

The inhabitants of this state can be classified into the following ethnic groups: Zamfarawa Burmawa, Falani (Alibawa), Gobirawa, Kabawa katsinawa and kambarin Barebari. It has a common and all pervading language, Hausa. Other Nigerian ethnic group such as Ibos, Edos and Yoruba, are peacefully settled and conduct their economic and commercial activities duly. Over 99.9% of the people (particularly the indigenes are predominantly) Muslim, while the remaining 0.1% consist of a few Christians and animists, located in the village of Tsafe, Kotorkoshi and Maradun, where traditional religion and Christianity are practiced without molestation.

2.2 *Health Status of the Population*

Despite laudable government efforts like most part of the North West the health indices are still poor infant mortality rate is 101/1000, under 5 is 166/1000 compare to national levels of 86/1000 and 138/1000 ,maternal mortality rate is 1025 [MICS 2007]

The incidence of HIV is however encouraging it has reduced to 2.1%. Compared to 2.4 % in North West and national figure of 4.6% [national HIV sentinel survey 2008]

2.3 *Health Service Provision and Utilisation*

The state has 18 general hospitals, over 600 primary health care centre, 47 maternal and child health clinic and 20 private hospitals. Survey of general hospital by PRINNMNCH in 2008 reveal that none of the 17 GH surveyed met the criteria.

- Antenatal attendance is poor 13.1%, compared with North West level of 31% and national figure of 58%. [NDHS 2008]
- Deliveries in health facilities is 7.7% compared to 8.4% in the North West zone and national level of 35% [NDHS 2008]
- Contraceptive prevalence rate is 2.5 %, compared to 2.8 % in the North West and 15 % at the national level

- Immunization coverage has improved by national figures 35% DPT3 however for the state it is 8.8% ,14.1 % were immunized against measles compared to 19.5 for north west ,south west has the highest figure of 65.5% [NDHS 2008] 9.8% pregnant women had tetanus toxoid compared to north west of 19.9% and south east of 80.5%.
- 23.2% of children received treatment from health workers following diarrhoea disease compared with 32.6% for North West
- Breast feeding 6.7% North West compared to 30.9% north central
- 1.8% of children sleep under insecticide treated net compared to 7.9% south south

A summary of key health status/service utilisation indicators for the State are shown in the table below.

POPULATION (2006 Census)	ZAMFARA
Total population	**3,278,873**
female	1,637,250
male	1,641,623
Under 5 years (20% of Total Pop)	662,736
Adolescents (10 – 24 years)	948,089
Women of child bearing age (15-49 years)	766,233
INDICATORS	**NDHS 2008**
Literacy rate (female)	13%
Literacy rate (male)	34%
Households with improved source of drinking water	28%
Households with improved sanitary facilities (not shared)	28%
Households with electricity	19%
Employment status (currently)/ female	44.1%
Employment status (currently)/ male	92.3%
Total Fertility Rate	7.5
Use of FP modern method by married women 15-49	2%
Ante Natal Care provided by skilled Health worker	13%
Skilled attendants at birth	8%
Delivery in Health Facility	7%
Children 12-23 months with full immunization coverage	5%
Children 12-23 months with no immunization	52%
Stunting in Under 5 children	54%
Wasting in Under 5 children	11%
Diarrhea in children	10.2
ITN ownership	5%
ITN utilization (children)	3%
ITN utilization (pregnant women)	3%
children under 5 with fever receiving malaria treatment	9%
Pregnant women receiving IPT	4%
Comprehensive knowledge of HIV (female)	6%
Comprehensive knowledge of HIV (male)	13%
Knowledge of TB (female)	62.7%
Knowledge of TB (male)	88.2%

2.4 Key Issues and Challenges

Despite the laudable efforts of government the state is bedevilled with a lot of challenges such as poverty, inadequate health manpower, and inappropriate mix of health workers. Poorly equipped health facilities and infrastructures etc

A recent survey by PRINNMNCH on HRH reveals a critical shortage of doctors and midwives with inadequate no of CHEW, misdistribution of health workforce and urbanization of chews exist, lack of staffing norms and preponderance of health assistant/attendants far in excess of requirement , service quality are in need of improvement, low work load in significant number of health facilities

Budgetary allocation to health as improve over the years, it has however fall short of the 15% affirm by the Abuja declaration.

Poor utilization of health services is a major challenge for instance more 90% women still deliver at home [PRINN MNCH study of state in Northern Nigeria]

Chapter 3: Strategic Health Priority for each of the 8 Priority Areas
Priority areas

3.1 Leadership and governance

3.1.1 **Context**

The state Government is firmly committed to provision of health care services in the state This evidence in the government programs such as free maternal and children under 5 health, Government support to immunization activities, procurement of drugs and equipment, in addition a state council of health has been establish inaugural sitting was last year .the state has also develop a 3 year strategic plan in 2008.free accident and emergency services.

The state has commenced an annual rapid peer review of health facilities which are presented to stakeholders. However, poor performance of the health system is prevalent in part due to lack of clearly defined roles and responsibilities which results in duplication of efforts, poor coordination, lack of communication between various actors, lack of transparency and poor accountability.

There exist a coordinating mechanism for partners in the state but its function has been. Though fund allocation to the health sector has improved over the years it has been constrained by delay in release of fund while budget performance is suboptimal.

Importantly, existing government program such as maternal and child are not supported by appropriate policy, assumption, guideline and legislation to ensure effective implementation and sustainability.

There is absence of health sector watch dogs to monitor activities of the health sector

Private health practitioner, traditional practitioner and birth attendant are key players in the health sector in the state and enjoy a lot of patronage by the population, however mechanism to coordinate and monitor there activities is weak. Despite the recognised intersectoral nature of health activities a coordinating structure is not on ground.

The procurement system in the state in mainly centralized through the finance and general purpose committee

Other challenges include weak planning capacity, administrative bottle necks, which hinder efficient running of programs.

This priority area of the state strategic Framework seeks to streamline and empower the Ministries of Health at the State levels as well as LGA Health Departments to reposition their organisational and management systems to provide the strategic and tactical leadership and governance for health. It equally address underlying issues and challenges highlighted above through evidence and results-based management approaches

3.1.2 .Goal: To create and sustain an enabling environment for the delivery of quality health care and development in Nigeria

3.1.3 Objective:

3.1.3.1 To provide clear policy directions for health development

3.1.3.2. To facilitate legislation and a regulatory framework for health development

3.1.3.3. To strengthen accountability, transparency and responsiveness of the national health system.

3.1.3.4. To enhance the performance of the national health system
To provide clear policy directions for health development.

3.1.4. Intervention:

Evidence Based On Intervention Contributing To The Achievement Of Specific Objective Are Described Below:

3.1.4.1 **Improved Strategic Health Planning at State and LGA levels**

[1] The State & LGA Strategic Health planning committee set up at state and LGA will be strengthened. There will be a biannual review of the annual plan to ensure that activities are on track. The strategic plan and its implementation status will be widely disseminated to all stake holders. The development of annual plan will be preceded by review of previous years plan; same process will be supported at LGA level. The strategic plan will be subjected to a mid term review

[2] An intra-sectoral committee will be establish with membership drawn from line ministries, areas of collaboration will be identify and guideline develop for its activities this committee will meet at least twice in a year.

[3] The capacity for health policy development will be strengthened, through a process that involve the conduct of comprehensive need assessment for managerial and technical competence at state and LGA level .thereafter 2 members of staff from PRS for masters in health planning and management, an in-house training of 12 staff of the ministry will also be conducted. Existing government program in the state will be documented and formulated in to appropriate policy.

[4] The attainment of policy synergy will be enhanced through strengthening of the state council of health with appropriate logistics and funding. There will be annual conduct of a week long state council of health meeting. Monthly departmental meeting/Top management meeting will be conducted in the SMOH and LGA

To Facilitate Legislation And A Regulatory Framework For Health Development

3.1.4.2 **Strengthen regulatory functions of government**

[1] Regulatory function of government will be strengthened through the Development a state health policy and act in line with the national health policy and national act. The bill for the passage of the creation of state primary health care development board will be facilitated. Council approval and take off of the traditional medicine board will also be facilitated

[2] Standard operating procedures will be review and adopted from national guideline appropriate trainings will be provided. It will be made widely available an its use will be made compulsory

[3] Collaboration between the public and private sector will be foster to improve health through the development of PPP policy in line with national guideline and strengthening of identify areas

[4.] Public health acts and laws will be review and enforce and jobs regulations streamline. This will be achieve in part through strengthening of the inspectorate department of SMOH and SMENV

To Strengthen Accountability, Transparency And Responsiveness Of The National Health System

3.1.4.3 **To improve accountability and transparency**

[1] Sensitization workshop will be organized to encourage formation of independent advocacy/vanguard group on health issues. all procurement and contract award will be advertise in line with due process .beneficiary community of health intervention will e educated on their right and obligation. Annual report from health facilities will institutionalize and made compulsory. Annual budgets will be in line with annual operational plan.

[2] The decision making process of the health sector will be decentralised. The activities include establishment and take off of the SPHCB, development of a decentralization mechanism, with TOR .The functions of head of facilities will strengthen to improve their effectiveness

[3] Strengthen general administration of ministry of health: in order to reduce bureaucratic and improves efficiency in the ministry present mechanism will be strengthened to support travels and transportation, utility services, entertainment. Procurement of office stationeries furniture and equipments. Maintenance of pool of vehicles will be given priority. Staff training will be supported through the office of head of service and general finances streamline

[4] Create platform for interaction with health sector advocacy group

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[5] Access to information required for yearly review will be improved and made available to public: this will be achieved through provision of quarterly/yearly of health sector to members of the public. Activities of the ministry will be publicised through dissemination of bulletin, periodical and pamphlet. the peer participatory rapid assessment of health facilities commence by SMOH will be strengthened and report made available to member of the public

To Enhance The Performance Of The National Health System

3.1.4.4 Sectoral Information base will be improve and maintain to enhance performance through creation of linkage between research and health management information system to provide health information status of the state

3.2 *Health service delivery*

3.2.1 Context

The state has a pregnant population of 179, 146, women of child bearing age constitute 788,241[15-45] the annual growth rate is 3.2% children under 1 are 143,316 and under 5 are 716,582.

It has 18 general hospitals, over 600 primary health care centres, 47 maternal and child health clinic and 20 private hospitals and 1 tertiary centre [federal medical centre Gusau].Service provision in most of these health facilities are suboptimal[quality and quantity] and there are challenges of weak infrastructure equipment and staffing.

The state has undertaking an assessment of some the health facilities and has proposed a minimum service package along three levels of care namely health clinic, PHC and General hospitals

Survey of general hospital by PRINNMNCH in 2008 reveal that none of the 17 GH surveyed met the criteria for a comprehensive emergency obstetric care [CEOC] Antenatal attendance is poor 13.1%, compared with North West level of 31% and national figure of 58%. [NDHS 2008].

Deliveries in health facilities are 7.7% compared to 8.4% in the North West zone and national level of 35% [NDHS 2008]. Contraceptive prevalence rate is 2.5 %, compared to 2.8 % in the North West and 15 % at the national level

Most social mobilization activities significantly focus on Immunization activities. Utilization has been poor, coverage has improved by national figures 35% for DPT3 however for the

state it is 8.8% ,14.1 % were immunized against measles compared to 19.5 for north west ,south west has the highest figure of 65.5% [NDHS 2008] 9.8% pregnant women had tetanus toxic compared to north west of 19.9% and south east of 80.5%.

23.2% of children received treatment from health workers following diarrhoea disease compared with 32.6% for North West. Breast feeding 6.7% North West compared to 30.9% north central. 1.8% of children sleep under insecticide treated net compared to 7.9% south -south

3.2.2 Goal: To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare

3.2.3: Objective

3.2.3.1 To provide an essential package of care.

3.2.3.2 To increase access to health care services

3.2.3.3 To improve the quality of health care services

3.2.3.4 To increase demand for health care services

3.2.3.5 To provide financial access especially for the vulnerable groups

To provide an essential package of care

Intervention

3.2.4.1 **To review, cost, disseminates and implements the minimum package of care in an integrated manner**

[1] The minimum service document for the proposed three level of care will be finalized and council approval obtain. A survey of the health facilities in the state to determine the level of infrastructure, personnel equipment and drugs in line with the identified 3 levels of health care in the state. The gaps will be costed and implementation of the costed item will proceed in phased manner

[2]. INMCH program will be instituted and roll out through the formation of a core technical committee, adequate support will be provided for their activities the free maternal and child program will be strengthened and backed by appropriate policy guideline an legislation.

[3] Adolescence health and development will be accorded priority and a desk officer to coordinate its activities

[4] An emergency response plan for accident and disasters will be develop and implemented (see minimum package of care below)

3.2.4.2. **To strengthen specific communicable disease control programmes**

[1] The EPR committee in the state will be strengthened and an emergency preparedness and response plan for communicable diseases will be develop. Drugs and appropriate logistics and training will be provided to enhance its activities

3.2.4.3. **To strengthened non communicable diseases**

[1] Public awareness campaign about non communicable diseases such as DM Hypertension asthma etc will be conducted through IEC materials AND MEDIA.

[2] Health workers will receive appropriate training on non communicable diseases.

[3] Periodic screening program for early detection of non communicable diseases will be institutionalize

[4] The ongoing cancer centre project will be supported and relevant personnel train for its effective take off

3.2.4.4 **Improving TB and HIV and malaria intervention**

[1] Malaria prevention intervention by government will include provision of free ITNS to pregnant women and under 5 children in clinics and during campaign. Free sulphadoxine pyremethamine (sp) in will also be made available in ANC clinics for intermittent preventive treatment of malaria in pregnancy. Other activities include monthly environmental sanitation and periodic spraying of insecticide in all LGA. Part funding for malaria control in the state will be provided

[2] Counterpart part funding for TB and leprosy control activities in the state will be provided to support training and provision of drugs and other logistics

[3] HIV and STI control activities in the state will be strengthened through part funding to scale up behavioral change, provision of free testing and anti retroviral virus

3.2.4.5 **Strengthening Immunisation and increasing immunisation coverage**

[1] Activities of task team on immunization will be strengthened through the procurement of relevant equipment for immunization, outreach immunization services will be scale up Health facilities will be strengthened to provide routine immunization service.

[2] Intensify supplemental immunization activities. Will be intensify a measles eradication campaign will be conducted

To Increase Access To Health Care Services

3.2.4.6 **To improve geographical equity and access to health services**

[1] Mapping of Health Facility by type and number required for each level of service will be conducted in line with minimum service package

[2] Gradual and phased refurbishment /upgrading of facilities and provision of equipment based will be done on identified gap.

3.2.4.7 **To Ensure Availability of Drugs at all Levels**

[1] Drug revolving fund will be revive other activities include establish the drug revolving committee at state and LGA levels ,funds will be provided for regular procurement, storage and distribution of essential drugs.

[2] Obstetrics drugs will be procure and stock in all MCH UNITS

3.2.4.8 **To establish a system for the availability and maintenance of equipment at all levels**

[1] Medical equipments will be procured based on identified gaps. Maintenance units in State and LGAs will be strengthened to undertake the continuous repairs, refurbishing and preventive maintenance of structures, transports and equipments.
[2] The central medical stores will be refurbished and satellite units will be establish across the senatorial zone

3.2.4.9 **To strengthen referral system**

[1] Mapping of referral link between different levels of facilities will be conducted; guide lines establish for referrals. .Adequate logistics [ambulances and others] and communication facilities to enhance referral services.

[2] A monitoring mechanism and documentation of referrals and outcomes will be put in place.

3.2.4.10. To **Foster Collaboration with the Private Sector**

Improve the Quality of Health Care Services

3.2.4.1. **To strengthen professional regulatory bodies and institutions**

[1] Professional regulatory bodies and institutions in the state shall be revived and strengthened, regulatory guideline will be enforce by monitoring teams.

[2] A system of documentation and feedback of monitoring activities will be established

3.2.4.12. **To Develops and Institutionalises quality Assurance Models**

[1] A quality assurance model will be adopted and institutionalize at all levels, Capacity of provider in both private and public HC will be strengthened along this line, quality assurance guidelines will be printed and disseminated, in addition there will be Public enlightenment activities on quality assurance in health facility.

[2] There will be Establishment of a servicom unit at all level of care

3.2.4.13. **To institutionalize Health Management and Integrated Supportive Supervision (ISS) mechanisms**

[1] Health managers at all levels including LGA & Wards will be giving a degree of autonomy that will enhance efficiency and effectiveness.

[2] Quarterly ISS visits will be conducted to facilities at all level to monitor performance and provide needed support.

[3] The coordinated school health services program will be strengthened across the state to improve provision of health services

3.2.4.14. **To Reduce Incidence of Fake and Substandard Product/Quackery**

[1] A task force on fake and substandard drugs and product will be establish and quarterly monitoring visits will be conducted

To Increase Demand For Health Care Services

3.2.4.15. **To Create Effective Demand for Services**

[1] A State communication strategy for health will be develop, there will also be dissemination of health promotion policy and implementation and capacity building on behavioural change for all health workers at all levels

Zamfara Minimum Ward Health Care Package

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

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

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

3.3 Human Resources For Health

3.3.1 Context

HRH is major problem country wide, it is of major concern in the state presently the numbers are inadequate and the distribution is skewed with more than 50% of doctors and Nurses stationed in the state capital.

- The number of doctors is less than 100; nurse/midwives are between 300-400 pharmacists none in the state general hospitals
- The government operate an open door policy for recruitment of health workers
- State government has taken bold measures to address this issue. This include establishment of a human resource for health unit headed by deputy director
- Distribution of staff in health facilities is proposed to follow an establish staffing norms
- The school of nursing and midwifery in the state has commence academic activities 2 years ago this complement the role of the existing school of health technology in the state
- At present salary of medical workers in the health sector are among the highest in the country .the present program of midwifery corps offers very useful opportunity to improve HRH crisis in the state
- The priority area seek to address this challenges an holistic and systematic manner

3.3.2. 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

3.3.3.1. To formulate comprehensive policies and plans for human resource for health development.

3.3.3.2. To provide a framework for objective analysis, implementation and monitoring of HRH performance.

3.3.3.3 To strengthen the institutional frameworks for human resources management practices in the health sector.

3.3.3.4 To strengthen the capacity of training institutions to scale up the production of a critical mass of multipurpose and mid-level health workers.

3.3.3.5 To improve organizational and performance-based management systems for human resources for health.

3.3.3.6. To foster partnerships and networks of stakeholders to harness contributions for human resource for health agenda

To Formulate Comprehensive Policies And Plans For Hrh For Health Development

3.3.4.1. **To Develop and Institutionalize the Human Resources Policy Framework**

[1] A committee to develop a human resource policy frame work will be formed and provided with necessary train, in addition for effective implementation of the policy will be outline. Advocacy to policy makers and other stake holders on the human resources policy frame work will be conducted similar activities will be encourage at LGA level

To Provide A Framework For Objective Analysis, Implementation And Monitoring Of Hrh Performance

3.3.4.2. **To Reappraises the Principles of Health Workforce Requirements and Recruitment At All Levels**

[1] A baseline survey to establish staffing needs will be conducted and guideline develop for health workforce requirement for various levels of facilities.

[2] Staffing norms for each level of care will be disseminated to the relevant stakeholders and operationalize in line with human resource requirement for MSP

Strengthen The Institutional Framework For Human Resources Management Practices In The Health Sector.

.3.3.4.3. **To Establishes and Strengthens the HRH Units**

[1] Training of staff on health planning and management for the effective take off of the human resources for health Unit., the unit will also be provide with relevant logistics/equipment for effective functioning.

[2] A sector wide stakeholder forum to provide oversight functions: including regularly reviewing and facilitating integrated HR planning.

[3] A HRH data base of all health workforces in the state and human resources research as a tool to improve health staff management in public and private sector

3.3.4.4**. Strengthened in-Service Training and continue Staff Development€ Approaches**

[1] A comprehensive human resource development plan for the health sector will be established.

[2] Managerial training for senior MOH staff will be conducted.

[3] A continuous scientific meeting program in health facilities in the state will be institutionalize

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

3.3.4.5 **To Review and Adapt Relevant Training Programmes for the Production of Adequate Number of Community Health Oriented Professionals Based on State Priorities.**

[1] A review of training programs in training institutions in the state will be conducted identified gaps will be addressed. This assessment will be on a regular basis to ensure they address priority need of the state

[2] A special training for CHEWS to acquire midwifery skills to reverse the dismal maternal mortality Indices will be given priority attention.

[3] An additional school of nursing and midwifery will be established

3.3.4.**6 To Strengthen Health Workforce Training Capacity and Output Based on Service Demand**

[1] The activities include building capacity of staff of SONM and SOHT, In addition adequate teaching and learning materials will be provided.

[2] Provision of funds for logistics and strengthened of infrastructure which includes class room auditorium, staff quarters and perimeter fencing.

[3] There will be establishment of quality assurance units in the training institutions to maintain standard and ensure alignment with state priority.

[4] A coordinating body to monitor activities of the training institutions and maintain active link between the HR requirements and programs of institutions in the state will be establish

3.3.4.7 **To Improve Health workforce Training Based on Service Demand**

[1] Capacity of health workers will be build on maternal and child health activities such as expanded live saving skills for doctors live saving skills for nurses modified live saving skills for CHEW etc.

[2] Training of health workers on immunization, interpersonal skills, infection prevention and bio hazards.

[3] Health workers will also be train on TB, HIV/STI and related activities i.e. HCT PMTCT etc.

[4] A Continuing Medical Education Committee will be established at SMOH and LGA

To Improve Organizational And Performance-Based Management Systems For Human Resources For Health

3.3.4.8. **To Achieve Equitable Distribution, Right Mix of the Right Quality and Quantity of Human Resources for Health**

[1] Re- distribution of existing health work force in terms of need, mix and geographical spread will be a priority to improve equity and maximise efficient use of human resource.

[2] Employment of unemployed and retired health professionals to meet the gap.

[3] A locum arrangement with federal institutions within and out side the state for coverage of referral centres in the state.

[4] Recruitment of at least 20 doctors, 30 nurse/midwives, and other health workers annually in line with human resource requirement

3.3.4.9 **To Establish Mechanisms to Strengthen and Monitor Performance of Health Workers At All Levels**

[1]. A system of reward, recognition and sanction for health workers in the state will be instituted.

[2] The use of annual appraisal for all health workers in the state will be revive and strengthened.

[3] Establishment of a system to monitor health workers performance, including use of client exit interview.

[4] There will be Establishment and enforced use of job description in health facilities

To Foster Partnerships And Networks Of Stakeholders To Harness Contributions For Human Resource For Health Agend

3.3.4.10. To strengthen communication, cooperation and collaboration between health professional associations and regulatory bodies on professional issues that has significant implications for the health system

[1] Existing regulatory and professional bodies in the state will be identify a stake holder forum comprising representative of professional and regulatory bodies that will meet regularly.

[2]. An effective dialogue and complaint channels between staff and regulatory bodies will be establish

3.4 Health Financing

3.4.1 Context

Poor utilisation of modern health services leading to poor health outcomes for majority of the citizens of Nigeria is not only influenced by lack of knowledge and negative perception but also by health care costs that include cost of services, travel to health facilities and opportunity costs. Poverty level is therefore a major factor responsible for individual and household decision making on utilization of health services.
In Nigeria the total per capita health expenditure is estimated at between $10 at average exchange rates with private out of pocket expenditure (OOPE) accounting for 70%[1]. It is also recognized that the poor spend a disproportionately higher percentage of disposable household income on healthcare and in the absence of social protection mechanisms (health insurance, social security or credible exemptions), this population face challenges of financial barriers to health care at the time of need. This no doubt deters the poor from seeking health care on time or deepens their impoverishment when they are compelled to make health expenditure.
Financing is a key factor for effective implementation of any program. the present global economic melt down poses limiting challenges for funding.
The state government has over the years improved funding to the health sector. To…. .this commendable effort still fall short of the affirm 15% at the Abuja declaration [2001].The effort of government is complemented by funding from developmental partners such PRINNMNCH,WHO,UNICEF EU PRIME ACCESS,PPFN, counterpart fund world bank assisted HSDP and SACA program.
These donor supports are not coordinated and no common mechanism to align with government priority

Despite the high prevalence of poverty, there is lack of safety net for the poor, the state offer a free maternal and child health care scheme. This program is limited in scope. Presently no insurance scheme in place

[1] Federal Ministry of Health (2004) Health Sector Reform Program: Strategic Thrusts and Log frame

3.4.2 Goal: 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

3.4.3 **OBJECTIVE:**

3.4.3.1 To develops and implements health financing strategies at Local, State and Federal levels consistent with the National Health Financing Policy.

3.4.3.2 To ensure that people are protected from financial catastrophe and impoverishment as a result of using health services.

3.4.3.3 To secure a level of funding needed to achieve desired health development goals and objectives at all levels in a sustainable manner.

3.4.3.4 To ensure efficiency and equity in the allocation and use of health sector resources at all levels

To Develop And Implement Evidence-Based, Costed Health Financing Strategic Plans At State And Lga, Levels In Line With The National Health Financing Policy

3.4.4.1 Strategic Health Finacing Plan

[1] A technical working group for health finance strategic plan will be at State and Local Government level to develop a plan that takes into account the local needs and financial ability of the state and LGA .stake holders will be sensitize on the effective implementation of the plan.

[2] A finance desk officer will be appointed at SMOH to keep track of the financial strategy.

To Ensure That People Are Protected From Financial Catastrophe And Impoverishment As A Result Of Using Health Services

3.4.4.2 **To Strengthen Systems for Financial Risk Health Protection**

[1] A state NHIS committee will be set up to develop modalities for the implementation of NHIS in the state, Support will be provided for the roll out of NHIS in the state.

[2] The activity of Private Health Insurance in the state will be encourage

To Secure A Level Of Funding Needed To Achieve Desired Health Development Goals And Objectives At All Levels In A Sustainable Manner

3.4.4.3.**1To Improve Financing of the Health Sector**

[1] Advocacy activities will be strengthened to improve budgetary allocation to health to at least 15 % of the state total budget.

[2] A funding mechanism to seek/receive donations from private individual's charities and corporate organizations will be established.

[3] Advocate to the Zakaat board to improve funding of the health sector also same process extended for more funding from developmental partners and MDG based on the state strategic health plan

3.4.4.4 **To Improve Coordination of Donor Funding Mechanism**

[1] The donor coordination unit of the PRS department will be support, quarterly donor coordinating meeting will be organized and appropriate common basket funding for development partners on areas of priority needs will be explored

To Ensure Efficiency And Equity In The Allocation And Use Of Health Sector Resources At All Levels

3.4.4.5 **To Improve Health Budget Execution, Monitoring and Reporting**

[1] Concretize arrangement with political leaders that budget will be tied to operational plan will be concretized; annual operational plan will be prepared well in advance of budget.

[2] Relevant staff will be train to Improve internal reporting and maintain accounts according to expenditures and timely submission of financial report.

[3] Quarterly tracking of budget performance in line with operational plan will be conducted.

3.4.4.6 **To Strengthen Financial Management Skills**

[1] A credible budget plan will be develop with appropriate account and auditing.

[2] The financial management systems will be review, identify gaps and recommendations will be supported and implemented to enhance effectiveness print and distribute.

3.5 National Health Information Systems

3.5.1 Context

The NHMIS/M&E remains weak and fragmented with numerous vertical programmes and systems, which are mostly donor driven. In addition, there are multiplicity of data collection tools, too many indicators, and reluctance of developmental partners and the vertical programmes which they support (including programmes within the FMoH), to utilise national tools. Furthermore, there is no national M&E policy, framework and plan and there is lack of integration between the NHMIS and M&E systems. Even though the private sector provides 60% of healthcare in the country, there is very limited capture of their data into the NHMIS. Other major problems include lack of forms; incomplete, untimely, and largely incorrect reporting of data; grossly inadequate capacity to analyse and utilise data for decision making at all levels; and poor feedback mechanisms. In addition donor supported programs tends to utilize data capturing form that may be different from existing one

3.5.2 GOAL: 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

3.5.3. Proposed Strategic Objectives

3.5.3.1 To improve data collection and transmission

3.5.3.2 To provide Infrastructural Support and ICT on Health Databases and Staff Training

3.5.3.3 To strengthen sub-systems in Health Information System

3.5.3.4 To Monitor and Evaluate the NHMIS

3.5.3.5 To strengthen analysis of data and dissemination of health information

To Improve Data Collection And Transmission

3.5.4.1 To ensure that NHMIS forms are available at all health service delivery points at all levels

[1] HMIS and monitoring tools will be printed and distributed to facilities in the state, same process extended to the LGAs

3.5.4.2 To periodically review of NHMIS data collection forms

[1] There will be regular feed back on the use of the HMIS that will form part of the periodic review of the Forms.

[2] The state will collaborate and support the FMOH during periodic review of the HMIS FORM

3.5.4.3 To coordinate data collection from vertical programmes

[1] The health data consultative committee will be strengthened to streamline data collection; quarterly meeting will be organized with all health partners to discuss health data.

[2] Mechanism will be established to ensure all vertical programs submit their data through the HMIS.

3.5.4.4 To build capacity of health workers for data management

[1] There will be provision of logistics for monthly data collation and analysis of data in both state and LGA.

[2] Training will be providing for staff on to build capacity of on DHIS, HMIS in the state and LGA.

[3] More HMIS personnel will be recruited and train to achieve minimum standard

3.5.4.5 **To provide a legal framework for activities of the NHMIS programme**

[1] A mechanism to enforce sanction and make data collection/utilisation mandatory at all level will be established.

[2] Advocacy to policy makers to understand usefulness of data collection and to promulgate laws and bye laws to make vital registration mandatory

3.5.4.**6To improve coverage of data collection**

[1] A mechanism to enhance data collection from all public and private HFs in the State will be develop and a community data collecting system will be establish and regular follow up of defaulters ensured.

[2] There will be collaboration and support of activities of the national population commission in the state to strengthen vital registration activities.

3.5.4.7 **To ensure supportive supervision of data collection at all levels**

[1] Monthly visits of state HMIS officers to LGA for data collection and data quality check will be institutionalized and supported.

. **To Provide Infrastructural Support And Ict Of Health Databases And Staff Training**

3.5.4.8. **To strengthen the use of information technology in HIS**

[1] A system of for the submission/feedback of data via the internet between state and LGA will be develop and operationalized.

[2] A public private partnership in the management of data warehouse will be promoted

3.5.4.9. To provide HMIS Minimum Package at the different levels (SMOH, LGA) of data management

[1] The state HMIS unit will be equipped with laptops and desk top computers; in addition internet facilities will be established

To Strengthen Sub-Systems In The Health Information System

3.5.4.10. **To strengthen the Hospital Information System**

[1] Medical record department of GH will be equipped with desk top computers, training will be provided for medical records staff regular data quality audit of hospital data will be conducted.

3.5.4.11. **To strengthen the Disease Surveillance System**

[1] Regular reporting of notifiable diseases by all health facilities will be ensured to monitor and evaluate the NHMIS

3.5.4.12.1 **To establish monitoring protocol for NHMIS programme implementation at all levels in line with stated activities and expected outputs.**

[1] Quarterly meeting of all program officers /PHC teams from state and LGAS will be conducted.

[2] Quality assurance hand book for HMIS to health facility will be made available

To Strengthen Data Transmission

3.5.4.13. To strengthen analysis of data and dissemination of health information

3.5.14.1 To institutionalize data analysis and dissemination at state and LGA levels

[1] There will be training on data analysis for state and LGA staff.

[2] Monthly summaries of analyzed data will be made available to policy makers in MOH and line ministries

3.6 Community Ownership and Participation

3.6.1 Context:

Traditional self help and community efforts in health development through community safety nets and other support mechanisms have been part of the history of communities in Nigeria. These efforts at community participation have however been limited in scope, organization and impact. Lack of clear policy framework to empower the community as the draft Community Development Policy is yet to be finalized may be contributory. National efforts at promoting community participation in health began with the introduction of PHC in the country in 1986. National guidelines were developed for PHC planning and implementation, including those for community participation. They included very prescriptive guidelines for setting up village health committees across the country with definitions of the size, composition and functions, which resulted in little or no efforts in the identification and strengthening of existing local social organizations, thereby pre-empting a crisis of legitimacy.

There are a lot of community mobilization activities for immunization activities in the state. The village health committees are functioning at varying degree of effectives

The state government has community poverty reduction program [CRP] that encourages community to come up with programs/project peculiar to their needs including health related activities

3.6.2 Goal: To attain effective community participation in health development and management, as well as community ownership of sustainable health outcomes

3.6.3. Strategic Objectives

3.6.3.1. To strengthen community participation in health development

3.6.3.2. To empower communities with skills for positive health actions

3.6.3.3. To strengthen the community-health services linkages

3.6.3.4. To increase national capacity for integrated multi-sectoral health promotion

3.6.3.5. To strengthen evidence-based community participation and ownership efforts in health activities through researches

To Strengthen Community Participation In Health Development

3.6.4.**1To provides an enabling policy framework for community participation**.

[1] A technical working group on community participation will be established, meetings will be organized to review existing policy and development of a framework for community participation

3.6.4.2 To provide an enabling implementation framework and environment for community participation.

[1] Guideline for social mobilization activities will be developed and distributed, necessary logistics, training will be provided on community mobilization in addition monitoring mechanism will be instituted

3.6.4.**3 Build Community capacity**

3.6.4.4. **Improving social development mobilization and advocacy**

[1] Public awareness on health issues will be conducted there will be support fort the LGA SMC s to resuscitate VDCs and WDC.

[2] Advocacy tools will be develop and regular advocacy conducted

3.6.4.5. **Production of logistics for distribution and IEC materials**

[1] A vehicle with public address system will be provided to each LGA.

[2] There will be development of IEC material on key health problems/needs including airing of 240 TV, jingles AND 480 radio jingles on maternal and child health, HIV, TB, malaria, measles, CSM etc annually

To Empower Communities With Skills For Positive Health Actions

3.6.4.6 **To build capacity within communities to 'own' their health services**

[1] There will be training of the community on identified training Gaps

To Strengthen The Community - Health Services Linkages

3.6.4.7 To restructure and strengthen the interface between the community and the health services delivery points

[1] Each health facility will be encourage to form joint community committees which will be provided with guideline for its activities to facilitate its function

3.6.4.8. To increase national capacity for integrated multisectoral health promotion.

3.6.4.9. To develop and implement multisectoral policies and actions that facilitates community involvement in health development

[1] There will be capacity building for line agencies such as Ministries of women Affairs, health, LG, Information, budget etc.

[2] Advocacy to communities will be conducted to create awareness about community participation and health promotion, community health development programs will be develop and implemented. The capacity of communities will be build on health promotion and provide linkage with other sector.

To Strengthen Evidence-Based Community Participation And Ownership Efforts In Health Activities Through Researches

3.6.4.10. To develop and implement systematic measurement of community involvement

[1] A guideline for measuring community involvement will be developed and full support offer for roll out of community engagement activities. This will be monitor and evaluated

3.7 Partnerships for Health Development

3.7.1 Context

Health is a multidimensional issue and government alone cannot meet the all the health needs of the people in Nigeria. Partnership with the private sector, non-governmental organisations, communities and development partners (donors) as well as other social and economic sectors is essential to deliver health services that can meet the needs of the population on a sustainable basis.

At present partner working in the state include W.H.O, UNICEF, ACCESS, PPFN, PRINN- MNCH, SFH and FHI/GHAIN

Private health facilities also play significant role in health care delivery in the state. The state has no public private partnership policy though a donor coordinating body exist it functions at a limited level

No mechanism exist at the moment to regulate activities of traditional medicine practitioner who are ubiquitous in the state

3.7.2 Strategic Objectives

3.7.3.1 To ensure that collaborative mechanisms are put in place for involving all partners in the development and sustenance of the health sector by 2011.

TO ENSURE THAT COLLABORATIVE MECHANISMS ARE PUT IN PLACE FOR INVOLVING ALL PARTNERS IN THE DEVELOPMENT AND SUSTENANCE OF THE HEALTH SECTOR

3.7.4.1. **To promote Public Private Partnerships (PPP)**

[1] A PPP committee will be constituted and other PPP options will be explored, sensitization workshop/media activities on PPP will be conducted to create awareness.

[2] Incentives to encourage the private sector to establish healthcare facilities in rural areas in Zamfara State will be provided and the activities of PPP in the State and LGA will be monitored

3.7.4.2. **To institutionalize a framework for coordination of Development Partners**

[1] All the developmental partners in the state will be identify, quarterly meeting of MOH and partners in health will be conducted.

[2] Measures to attract more developmental partners to the state will be developed
.

3.7.4.3 **To facilitate inter-sectoral collaboration**

[1] Joint collaboration and implementation with the relevant ministries, department and agencies will be institutionalized a quarterly joint monitoring and evaluation of activities will be commenced.

3.7.4.4 **To engage professional groups**

[2] Professional groups in the state will be identify and documented, there will be collaboration in line with ministry mandate

3.7.4.5 **To engage with traditional health practitioners**

[1] The national policy on traditional medicine will be reviewed and adopted there will be mapping and documentation of traditional medicine practitioners in the state. There activities will be streamlined in line with national guideline

3.8 Research For Health

3.8.1 Context

Over the years successive government have introduced various initiatives to promote research for health in Nigeria. In particular, the Medical Research Council of Nigeria (MRCN) was established by Decree No 1 of 1972 and inaugurated in January 1973. In 1977 the National Science and Technology Development Agency (NSTDA) was established. The Nigeria Institute for Medical Research (NIMR) was initially an agency under the NSTDA, which transmuted into the Federal Ministry of Science and Technology until it was transferred to the FMOH. In 1988, the reorganization of civil service by Federal Government for effective, efficient and productive service created the Department of Planning, Research and Statistics (DPRS) in all ministries. One of the responsibilities of the department is to co-ordinate research activities as well as spear-head planning. Consequently, there is now a Department of Planning and Research at the Ministries of Health at the Federal and State government

levels. To conduct research in the area of Pharmaceutical commodities, the National Institute for Pharmaceutical Research was established under the oversight of the Federal Ministry of Health. A draft National Health Research Policy as well as National Health Research Priorities were produced in 2001, both document have been reviewed and merged in 2006. A Country report on status of health research was also produced by the FMOH in 2006.

Funding for health research in Nigeria is meager with evidence indicating at most 0.08% of health expenditure at the federal level with hardly any funding at lower levels. This is contrary to the 2% allocation to research for health prescribed by African Health Ministers and agreed to by the National Council on Health. The paucity of these allocations to the Health Sector had affected the quality and depth of health research in particular[2]. There is also an internationally accepted guideline that Donor agencies provide 5% of Aid to research.

Research undertaken is at embryonic level in the state. A research centre has recently been Nahuche in the state. There is no budgetary allocation for research as a separate line. This priority area seek to accord research the needed priority action

3.8.1. To utilize research to inform policy, programming, improve health, achieve nationally and internationally health-related development goals and contribute to the global knowledge platform

3.8.2. Strategic Objectives.

3.8.3.1 To strengthen the stewardship role of governments at all levels for research, and knowledge management systems

3.8.3.2 To build institutional capacities to promote, undertake and utilise research for evidence-based policy making in health at all levels.

3.8.3.3 To develop mechanisms for getting research findings from the public and non-public sectors into strategies and practices at all levels

3.8.3.4 To develops, implement and institutionalize health research communication strategies at all levels

To Strengthen The Stewardship Role Of Governments At All Levels For Research And Knowledge Management Systems

3.8.4.1 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

[1]Review and Adopt a finalize National health research policy will be review and adopted an ethic and research committee will be constituted and its activities supported

2

3.8.4.2 To establish and or strengthen mechanisms for health research at all levels

[1] An advisory board for the Nahuche health and demographic surveillance site will be constituted

[2] A strong linkage with National/Federal/International research institutes for capacity building. will be establish, training programs to be put in place for building research capacities for health researchers. Research activities will be encourage in All general hospitals in the state and provide necessary logistics.

3.8.4.3 To institutionalize processes for setting health research agenda and priorities

[1] a research agenda will be develop for health in the state

3.8.4.4 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.

[1] The state will with FMOH developmental partners, research institute etc on health research.

[2] Enabling tools for research will be procure e.g. journals, computer etc. all OR activities of all partners will be coordinate.

3.8.4.5 To mobilise adequate financial resources to support health research at all levels

[1] A separate budget line will be establish for health research and financial support solicited from partners

3.8.4.6 To establish ethical standards and practise codes for health research at all levels

[1] National guideline on research and ethics will be review and adopted oversight function will be provided for all OR activities in the state

To Build Institutional Capacities To Promote, Undertake And Utilise Research For Evidence-Based Policy Making In Health At All Levels

3.8.4.7. **To strengthen identified health research institutions at all levels**.

[1] An inventory of public, private and Non governmental organizations/institution with capacity for health research will be conducted and gaps identified.

[2] Necessary logistics will be provided for successful take off of the Nahuche research centre at least 3 staff will be posted to the centre.

[3] Resources from individuals, private sector, foundations, partners and the government to strengthened capacity of institutions

3.8.4.**8 To create a critical mass of health researchers at all levels**

[1] Assessment of knowledge gap in conduct of health research under taken will be performed and appropriate training interventions for research based on the identified needs at all levels.

3.8.4.9. **To develop transparent approaches for using research findings to aid evidence-based policy making at all levels**

[1] Linkages will be and promote consultations between researchers, policy makers and developmental partners.

[2] A peer review mechanism will be establish to assess research undertakings

3.8.4.10. **To undertake research on identified critical priority areas**

[1] Conduct of research in the state will be facilitated according to agenda developed by the state in a systematic manner; there will be provision of special competitive research grant for researchers under taken in the state

3.8.4.11 To develop a comprehensive repository for health research at all levels (including both public and non-public sectors)

3.8.4.12 **To develop strategies for getting research findings into strategies and practices**

[1] Get Research into Policy committee [GRIP] will be established

3.8.4.13. **To enshrines mechanisms to ensure that funded researches produce new knowledge required to improve the health system.**

[1] There will be dissemination of research findings to all relevant stakeholders through the GRIP and biannual research to policy forum

To Develop, Implement And Institutionalize Health Research Communication Strategies At All Levels

3.8.4.14. **Creates a framework for sharing research knowledge and its applications**.

[1] A framework for sharing research knowledge at state and LGA levels will be developed, annual health conferences/seminars and workshops will be convene at state and LGAS on key thematic areas.

[2] There will be collaboration with international bodies on the state research agenda to facilitate exchange of publications

[3] The state will participate in national and international conferences on health research and best practices will be mainstream at, state and LGA levels

3.8.4.15 **Establish channels for sharing of research findings between researchers, policy makers and development practitioners**

[1] The state will select journals to be supported that address issues related to Essential National and state Health Research (ENHR) principles. Research findings will be disseminated to policy makers and partners and same will be publish in reputable journals.

Chapter 4: Resource Requirements

4.1 Human

The human resource is perhaps the most crucial element to achieve set targets as other resources depend on it for optimum performance. The state presently experience human resource challenges in critical areas of manpower such as Doctors, Nurse/Midwives pharmacist etc. The need to meet the minimum health resource requirement in the state is therefore very important. Although accurate number of health workers in the state could not be ascertain, the minimum number of doctors require for the state is 638 based on 1 doctor /5000 population in this strategic plan the state will at minimum meet at least 50% of the human resource gap through annual employment of at least 30 doctors per annual and also through redistribution of existing workforce and it will sign MOU with federal institution within and out side the state to ensure coverage of key health facilities in the state ,this will also allow for building the capacity of existing workers in the institution on the long term the state will sustain and improve on the present scholarship arrangement for medical students both within and outside the country,

- In addition a human resource mobilization committee is to be established to encourage and counsel secondary school students to take up career in medicine and allied courses.
- The newly establish human resource unit in the ministry is to be strengthen through improvement of number of man power, capacity building provision of office equipment and other necessary logistics.
- The state is to commence rational deployment and effective utilization of existing staffing structure in line with establish staffing norms in the minimum service package
- Capacity building in various aspect of the minimum package will be conducted through the period for both old and new staff
- A comprehensive human resource data bank will be establish to enhance effective and efficient staff deployment and management
- At present the state health work force salary is one of the highest in the zone this will be sustain and improve upon to foster staff retention.
- Alternative measures to bridge human resource gap leveraging on existing human resource base such as training of CHEWS on modified life saving skills will be undertaken at the initial stages of the strategic plan
- A Parastatal to coordinate the activities of training institution in the state is also proposed. This will also require its own staff through recruitment and redeployment
- Another school of nursing and midwifery is proposed at the later part of the strategic plan period to improve staff production on a long term basis
- Of importance is the institutionalization of continuous training as standing program in health facilities level in the state

Apart from core health workers necessary for service provision other categories such as administrators, managers' consultants in various field are also required at the ministry and other areas to drive the strategic plan for instance the planning the department need to be strengthened desk officers need to be appointed for finance PPP and other areas. To rationalize this process a comprehensive need assessment will be conducted and corrective measure put in place this might involve redeployment from other ministries or department and also recruitment other measures are capacity building through workshops Successful Implementation of the HRH 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 Organizations 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 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 funds for training and also strengthening of existing training institution and the proposed additional school of nursing others include establishing process /mechanism such data bank etc .

It is envisaged that previous capacity program supported by partner such as those on immunization maternal child health HIV/AIDS and others will continue.

4.2 Physical/Material

Basic infrastructure and equipment is an important ingredient for effective function of the health system. A gradual and refurbishment of health facilities will be undertaken to ensure they meet minimum standard.

- In addition a system of equipment and supply and maintenance will be put in place to ensure sustainability
- New structures such as public health laboratory, quality control laboratory, and epidemiology complex will be completed
- on going construction of referral centres in Gusau, Shinkafi and Talata- mafara will also be completed
- The cancer centre and renal dialysis centre will also be completed during the duration of the plan
- The training institution SONM an SOHT will have their infrastructure strengthen during the span of the strategic plan, this include building additional class room, auditorium staff quarters
- A new school of nursing/midwifery will be constructed before end of the time line
- The state pharmaceutical company will also be completed during this period
- The research centre at Nahuche will also be fully equipped

4.3 Financial

The current global economic melt down poses familiar limiting constraints to the strategic plan

The strategic plan aims at attracting funding agencies to collaborate with governments at the various levels to put in more support for the optimum management and development of the health system in the state in a well coordinated manner. Potential sources of funding for the strategic plan during the period 2010--2015 are as follows:

1. Government sources: state, LGA
2. Donor and other external sources of funding
3. Millennium development goal
4. National Health Insurance Scheme
5. Public – Private Partnerships
6. Individual and community self help/ investment in human resources development
7. Philanthropic sources
8. Zakaat board

9 Faith based organizations

10 Health system development project 11

11. Other special funds

Chapter 5: Financial Plan

5.1 Estimated cost of the strategic orientations

Priority Area	Cost (NGN)
Leadership and Governance for Health	480,296,165
Health Service Delivery	26,907,554,136
Human Resources for Health	21,164,798,801
Financing for Health	3,279,307,112
National Health Information System	694,217,901
Community Participation and Ownership	414,647,240
Partnerships for Health	450,385,938
Research for Health	860,035,193
Total	**54,251,242,485**

5.2 Assessment of the available and projected funds

Projected funds **54,251,242,485**

Available funds 17,532,000,000

5.3. Determination of the financial gap

The financial gap is determine based on the difference between available funds and projected funds as stated above .the available fund was determine based on the budget history of the state

Projected funds minus available funds **36,719,242,485**

5.4 Descriptions of ways of closing the gaps

The financial Gap will be met through funding from additional sources .HSDP is expected to bring in about 2.000,000,000 others include PRINN MNCH,WHO,UNICEF,SFH,ZAKAAT BOARD,MDG office etc.

Chapter 6: Implementation and Framework

This strategic plan is design to accelerate the transformation of the health system.

It will be implemented by all stakeholders as a multi-sectoral strategy for comprehensive health care delivery.

Annual plan

On annual basis a work plan will be developed outlining key responsibility of all essential stakeholder and players in the planning, implementation, monitoring and evaluation as agreed upon and integrated in to the annual plan that clearly delineate roles and responsibility in line with the state strategic plan .in defining roles and responsibility special emphasis is placed on coordination, collaboration, decentralization and integration in the implementation to better reach most vulnerable group and promote sustainability.

The annual plan will also factor in experience and evidence gain from previous year of monitoring research and evaluation.

Phase implementation.

Initial phase 2010-22

This is the foundation phase where emphasis on determine the gaps and ensuring that minimum standard of service provision are met and appropriate function mechanism put in place. The emphasis is place in supply side and establishes mechanism for the demand side.

Consolidation phase 2012-15

In this phase build on the initial phase to scale services and promote demand for services, It will be implemented in collaboration with all relevant stakeholders including State, SMOH, individuals, LGA, developmental partners, related ministries, CSO, CBO PROFFESSIONAL BODIES

Reference Group

i. The reference group shall take responsibility for the driving the implementation process of the strategic plan.
ii. It shall take responsibility for coordinating the activities
iii. Ensure resources are mobilized to implement the activities
iv. Ensure timely implementation of activities
v. Shall conduct quarterly meeting to keep track of the implementation process
vi. Institutions and other relevant stake holders such as SMOH, LGA, Individuals, Developmental partners, related ministries, CSO, C .B.O .and professional bodies. Strategic partner and society, households and other actors should be identified as well as their roles and their inter relations will be streamline

Chapter 7: Monitoring and Evaluation

7.1 Proposed mechanism for monitoring and evaluation

Monitoring and evaluation are key functions for success of any plan. Presently the M&E system in the state is week this strategic plan has put in place mechanism to strengthen it. The HMIS will be strengthened to make it more robust and functional through provision of essential logistic and policy measures to ensure compliance. The m and e will use data through HMIS as part of indicator to monitor progress, data from vertical program and community based sources will also be routed through the HMIS.Other indicator as reflected through the strategic plan will combine to serve as basis for the M and E. They will be as follows:

Monitoring and evaluation are key functions for success of any plan.

M and E is critical to assess the implementation of strategic plan to asses implementation, policy input and important indicator which will determine progress.

The M and E mechanism will be through [1] routine M and E [2] Annual review process [3] Mid term review progress in compliance with the plan.

[1] Routine M and E

Based on agreed work plan all stake holders will establish and support routine monitoring mechanism that will utilize the indicator and target set out in the strategic plan .to facilitate this process HMIS will be strengthened through provision of adequate logistics ad enabling environment. Joint monitoring activities with private sector and community will also be conducted to ensure lesson learn are shared between stake holders.

Annual review process

An analysis of each objective and expected outcome will be undertaken to guide the development of the next work plan and also provide assistance in prioritization of available resources. During the process gaps in technical and financial resources will be identify and utilized as foundation for resource mobilization .it will also bring to light critical pr.

A comprehensive mid term evaluation of the strategic plan will be undertaken to further assess the progress made identify challenges and recommend appropriate mechanism to improve the planning process. The results/M&E matrix in annex 2 will be the main tool for monitoring progress in implementing the state's SHDP.

The indicators for monitoring will be:

- Proportion of LGA with a functional Strategic Health Planning committee in place by 2010.
- A functional intra-sectoral committee in place by 2010
- Proportion of policy makers trained on policy formulation for health by 2011
- Availability of guideline for health policy formulation by 2011
- All existing health program in the state are backed by appropriate policy by 2010

- State council of health meeting conducted successfully annually
- A functional secreteriat for state council of health in place by 2011
- Minutes of monthly management meeting at SMOH and LGAs
- Finalised national health bill reviewed and adopted by the state by end of 2011
- Proportion of health facilities using SOPS by 2011
- A state working document on PPP developed before end of 2010
- Joint task force on public health operational by 2011
- Number of Advocacy/vanguard groups formed on health matters by 2012
- Number of communities sensitize on their health rights and obligations
- Number of communities sensitize on their health rights and obligations
- A functioning state primary health agency before end of 2010
- An operational Zonal structure by 2015
- HAA summit conducted annually.
- 2 Costed MSP at each level of health care in place by end of 2010
- Committee on minimum service package established before Dec 2010
- Completion of survey of health facilities by 2010
- A functional epidemiology office complex and public health laboratory by 2011
- Emergency response plan available by 2010
- Proportion of health workers trained on effective surveillance
- Proportion of health facilities with infectious and waste management units
- Number of radio and TV jingles aired on communicable diseases
- Number of health workers trained on communicable diseases
- Number of outreach program conducted annually
- A functional cancer centre by 2011
- A functional renal dialysis centre by 2011
- Number of people receiving treatment for malaria
- Number of people receiving treatment for HIV
- Number of people receiving treatment for TB
- Proportion of health facilities offering routine immunization
- Number of outreach services conducted
- Number of health facilities upgraded/refurbished to improve geographical access
- A Functional DRF and drug revolving committee in place before end of 2010
- State pharmaceutical company completed before end of 2011
- Proportion of functional maintenance units in LGAs by 2011
- Number of equipment and ambulances procured and distributed
- Proportion of LGA with a functional maintenance unit by 2012.
- A Functional referral system in place by 2011
- An active regulatory bodied/institutions by 2011
- Quality assurance model adopted and widely disseminated by 2012
- Proportion of health facilities with a servicom unit by 2015
- Proportion of health managers trained
- Task force on fake and substandard product established by 2010
- State communication strategy for health available by 2012
- Proportion of health workers trained on behavioural change communication by 2015
- 3 Development of a state specific human resource for health policy frame work by 2011
- Proportion of LGA with HRH policy frame work by 2012
- Guideline for health workforce requirement and recruitment in place and operational by end of 2011
- An up to date database of all health workers in the state

- The State to have secured approval for additional intake of students by 2011.
- Intake of students based on projected requirement
- Numbers of CHEWS trained to acquire midwifery skills
- Establishment of additional school of midwifery by the State by 2014.
- a functional quality assurance unit in place by training unit by 2012
- Number of health workers trained on early detection and treatment of TB
- Number of health workers trained on cold chain maintenance
- Number of heath workers trained
- Number of doctors trained on ELSS
- Number of CORPS trained
- Number of nurses trained on ELSS
- Number of CHEW Trained on MLSS
- Number of heath workers trained on infection control and waste management
- Number of health workers trained on post abortal care
- Regular appraisal of staff and feedback on reports
- Job description institutionalised in health facilities
- Commencement of annual appraisal of health workers by 2010
- Stake holders' forum established by 2010
- Number of meetings of forum conducted
- The state and LGA to have a documented health financial strategy by 2011
- NHIS covers 60% of the State by 2015
- Free maternal and child policy operational by 2011
- Allocated State and LGA health funding increased by 5% PA until 2015
- The State and LGA have transparent budgeting and financial management system in place by 2011
- Frequency of quarterly tracking of budget performance from 2010
- Proportion of staff train on budgeting, accounting, auditing etc
- Availability of HMIS forms annually from 2009-2015
- **Number of quarterly meetings conducted**
- Proportion of HMIS officer in the state train on data management
- Well established vital registration system by end of 2010
- Proportion of public and private health facilities making submission of data by 15th of every month
- Institutionalisation of ISS team by end of 2010
- Proportion of LGA visited for ISS activities
- Proportion of LGA using IT for data management
- Centralised software established and installed by 2011
- Minimum package provided by State and LGA before end of 2011
- Availability of computers and accessories by 2011
- Provision of computers and capacity building of staff at all levels
- Proportion of health facilities using patient management information system
- Proportion of health facilities having the quality assurance hand book for HMIS
- Frequency of monthly and quarterly meeting
- Annual reports by department of planning and statistics
- SMOH to adopt and finalise policy framework for community participation by 4th quota of 2011
- Number and distribution of community members that have capacity building Advocacy tools developed by 2011
- Number of vehicles purchased with public address system
- Number and type of IEC material produced

- Number of TV and radio jingles produced
- Number of communities that are involve in their own health services
- Proportion of community that have health facility and community joint community
- 70% of HFs has active committee that include community representative by 3rd quota 2011.
- Number of community that have community health development program
- Development and implementation of guideline to measure community participation by 2011
- An active PPP forum that meet quarterly by the end of 2010
- State should have active committee that meet with donor partners quarterly by 2015
- State should have an active inter-sectoral committee with other MDAs by the end of 2014
- State to facilitate the establishment of professional body forum by 2015
- Profile of all traditional medicine practitioners available by 2011
- Health research policy adopted by 2011
- Number of annual research undertaking in the state
- Health research agenda set by 2011
- Numbers of partners in collaborating with state on research
- Separate budget line established by 2011
- Adoption of national guideline on health research
- Number of institutions in the state undertaking research undertaking
- Number of health workers undertaking research under taking in the state
- Establishment of a peer review mechanism for research undertaking
- Number of research undertaking in priority areas in the state
- Establishment of a get research in to policy committee
- Number of national and international conferences attended
- Inventory of journals and periodicals in collaboration with the state
- SMOH have functional fully equipped health education unit by 1st quota 2011
- Availability of technical support and commitment by state and LGA
- Commitment by SMOH and cooperation of other line ministries
- Availability of technical support and commitment by state and LGA
- Availability of funds
- Signing in to law of the national health bill
- Availability of SOPs
- Cooperation of the private sector
- Cooperation of the members o he public
- Commitment by SMOH and cooperation of the public
- Commitment of the SMOH
- Commitment of the SMOH and availability of funds
- Availability of funds

7.2 Costing the monitoring and evaluation components and plan

Chapter 8: Conclusion

The Zamfara state strategic plan is a road map to attain the government hope of providing qualitative health services to the populace and it highlight key areas of focus. it is the expectation of the state that all health programs will be guided by the provision of the plan

Annex: The duty completed Excel Planning Toolkit, Log frame with Goals, Strategic orientations, Objectives Verifiable indicators and targets and Means of verification; 2010 Operational Plans etc.

Annex 1: Zamfara State Strategic Health Development Plan

ZAMFARA 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							480,296,165
	1.1	**To provide clear policy directions for health development**			**All stakeholders are informed regarding health development policy directives by 2011**		58,342,330
		1.1.1	Improved Strategic Planning at Federal and State levels				28,668,519
			1.1.1.1	To establish and strengthened the State & LGA strategic planing committee and conduct mid year review of Strategic plan			7,748,248
			1.1.1.2	To conduct a review in may and September of the annual plan			13,233,656
			1.1.1.3	To disseminate the reviewed strategic plan and its implementation status			2,315,670
			1.1.1.4	organize a retreat to review annual plans and develop next year annual plan			3,521,931
			1.1.1.5	support the review of the LGAs annual plans and develop next year annual plan			1,849,014
		1.1.2	Establish intra-sectoral mechanism for policy synergy in the health sector		A functional intra-sectoral committee in place by 2010		714,732
			1.1.2.1	Establish an intersectoral committee with membership drawn from mins of health,women affairs,water and sanitation ,finance and budget min LGA			521,026
			1.1.2.2	Identify areas of sectoral collaboration			-
			1.1.2.3	Develop a guideline for its actvity			193,706
		1.1.3	identify and implement capacity building and orientation for health policy development at state and LGA levels.		Proportion of policy makers trained on policy formulation for health by 2011		13,022,340
			1.1.3.1	conduct a comprehensive traininng need assesment for improved managerial and technical competence for state/Training through HOS			1,925,322
			1.1.3.2	facilitate a comprehensive traininng need assesment for improved managerial and technical competence for LGA			164,357
			1.1.3.3	train 2 staff of PRS for msters in health plannning and management and others	Availability of guideline for health policy formulation by 2011		-
			1.1.3.4	organize house training for staff on health plannig and management.	All existing health program in the state are backed by appropriate policy by 2010		10,768,304

			1.1.3.5	Ensure that existing health programs in the state are documented and formulated in to appropriate policy			164,357
		1.1.4	institutte coordination mechanism for achieving policy synergy		State council of health meeting conducted successfully annualy		15,936,738
			1.1.4.1	strenghen the State council on health and encourage formation of similar platform at the LGA levels			1,232,676
			1.1.4.2	organise a week long council of health meeting	A functional secreteriat for state council of health in place by 2011		13,647,483
			1.1.4.3	Conduct monthly departmental/top management meeting in SMOH & LGA			1,056,579
	1.2	**To facilitate legislation and a regulatory framework for health development**			**Health Bill signed into law by end of 2009**		9,422,046
		1.2.1	Strengthen regulatory functions of government		Finalised national health bill reviewed and adopted by the state by end of 2011		4,167,618
			1.2.1.1	Develop a state health policy in line with the national health policy			82,178
			1.2.1.2	develop a state health act based on the national act			82,178
			1.2.1.3	Facilitate the passage of a bil on the cfreation of the SPHCDB			58,699
			1.2.1.4	Facilitate council approval and take off traditional medicine board.			3,944,563
		1.2.3	Develop standard operating procedure with QS and supervision		Proportion of health facilities using SOPS by 2011		3,904,354
			1.2.3.1	Review and adopt all SOP			82,178
			1.2.3.2	provide appropriate training on the SOPs			1,620,969
			1.2.3.3	Ensure SOPS are made compulsory and available in all facilites			2,201,207
		1.2.4	Foster public sector collaboration with private sector to improve health		a state working document on PPP developed before end of 2010		469,591
			1.2.4.1	Develop a public private partnership policy in line with national guideline			352,193
			1.2.4.2	Collaborate with private sectors in the identify areas .			117,398
		1.2.5	Review and enforce public health acts and laws and streamline jobs regulations				880,483
			1.2.5.1	strenghened the Inspectorate department of SMOH and SMENV to enforce public health acts and laws	Joint task force on public health operational by 2011		880,483
	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**		410,770,824
		1.3.1	To improve accountability and transparency		Number of Advocacy/vanguard groups formed on health matters by 2012		7,198,607
			1.3.1.1	Organize a sensitization workshop to encourage the formation of independent advocacy/vanguard groups on health issue			521,026

			1.3.1.2	Advertise all procurement and contract award in line with due process	Number of comunities sensitize on their health rights and obligations		528,290
			1.3.1.3	educate beneficiary communities on their right and obligations			760,737
			1.3.1.4	Establish and Make compulsory annual report of health facilities in the state	Annual report from health facilities are available from 2011		5,388,555
			1.3.1.5	Ensure annual budgets are in line with annual operational plan			-
		1.3.2	effective decentralisation of decision making process in health sector		A functioning state primary health agency before end of 2010		293,482,520
			1.3.2.1	Facilitate the establishment and take off of the SPHCMB			128,843,980
			1.3.2.2	Establish a mechanism for decentralization in the health sector	An operational zonal structure by 2015		246,535
			1.3.2.3	Develop a TOR and obtain TA for 1.3.2.2			35,219
			1.3.2.4	Review ,streamline and strenghened the function of head of facilities to improve their effectiveness			164,356,785
		1.3.3	strengthen general admnistration of ministry of healtth/parastals/projects				96,882,455
			1.3.3.1	support travels and transport of staff			17,609,656
			1.3.3.2	utility services			22,892,552
			1.3.3.3	procure office stationaries			17,609,656
			1.3.3.4	procure office furniture and equipment			17,609,656
			1.3.3.5	maintain pool vehicle in the ministry/procurement of vehicle			21,160,936
		1.3.5	Improving access to information required for yearly review ad making such available to public		PPRHAA summit conducted annually.		13,207,242
			1.3.5.1	Provide qarterly/ yearly review of health sector to members of the public			1,760,966
			1.3.5.2	Disseminate periodic activity of the ministry to the public through bulletin, periodiical and phamplet	Numbers of Monthly bulletins,periodicals and phamplets produced by ministry of health		5,282,897
			1.3.5.3	Strenghened the peer participatory rapid assessment of facilities and make report available to members of the public			6,163,379
	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**		1,760,966
		1.4.1	Improving and maintaining Sectoral Information base to enhance performance				1,760,966
			1.4.1.1	Create linkage between research and health management information system to provide health information status of the state			1,760,966
		1.4.2	Expand the analytical work at State and LGA				-
		1.4.3	Outcome future analytical work to universities, private sector research firms and national research institute				-
HEALTH SERVICE DELIVERY							
2. To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare							26,907,554,136

	2.1	**To ensure universal access to an essential package of care**			**Essential Package of Care adopted by all States by 2011**		4,506,922,215
		2.1.1	To review, cost, disseminate and implement the minimum package of care in an integrated manner		Costed MSP at each level of health care in place by end of 2010		157,031,671
			2.1.1.1	finalize the minimum service document and obtain council approval	**Committee on minimum service package established before Dec 2010**		289,193
			2.1.1.2	To conduct a survey of the health facilities in the state to determine the level of infrastructure ,personel equipment and drugs in line with the identify 3 levels of health care in the state	**Completion of survey of health facilities by 2010**		4,048,699
			2.1.1.3	Cost the requirement to attain the minimum service package for each level of care			4,048,699
			2.1.1.4	to ensure the provision of all the costed items for the effectvie implementation of MSP			4,048,699
			2.1.1.5	support the implementation of IMNCH activities			144,596,382
		2.1.2	To strengthen specific communicable and non communicable disease control programmes				1,482,112,913
			2.1.2.1	strengthened EPR committee in the state	**a functional epidemiology office complex and public health laboratory by 2011**		7,229,819
			2.1.2.2	Develop and implement an emergency preparednss and response plan for communicable diseases	**Emergency response plan available by 2010**		14,459,638
			2.1.2.3	procurement of EPR drugs	**proportion of health workers trained on effective surveillance**		1,445,963,818
			2.1.2.4	provide adequte logistics and training for effectvie survellance	**Proportion of health facilities with infectious and waste management units**		14,459,638
			2.1.2.5	To establish and implement a state eye care program [zamsescp]			-
		2.1.3	To make Standard Operating procedures (SOPs) and guidelines available for delivery of services at all levels				828,833,690
			2.1.3.1	to create awaereness to the public about non communicable diseases DM , hypertentsion asthma etc through IEC materials AND MEDIA	**Number of radio and TV jingles aired on communicable diseases**		78,082,046
			2.1.3.2	To train health workers on non communicable diseases.	**Number of health workers trained on communicable diseases**		13,310,097
			2.1.3.3	To organize periodic screening PROGRAM FOR EARLY DETECTION OF NON COMMUNICABLE DISAESES	**Number of outreach program conducted annually**		14,459,638
			2.1.3.4	estblish cancer centre and train relevant personel for its effective take off	**A functional cancer centre by 2011**		722,981,909
			2.1.3.5		**A functional renal dialysis centre by 2011**		-
		2.1.4	Improving TB and HIV and malaria intervention				1,556,821,044

			2.1.4.1	To provide free ITNS to pregnant women and under 5 children in clinics and during campaign	**Number of people receiving treatment for malaria**		1,235,094,095
			2.1.4.2	To provide free sulphadoxine promethaxine (sp) in ANC clinics for intermittent preventive treatment of malaria in pregnancy.			54,223,643
			2.1.4.3	Observe monthly enviromental sanitation and periodic spraying of insecticide in all LGA			50,608,734
			2.1.4.4	provide part fundiing for malaria control in the state	**Number of people receiving treatment for HIV**		144,596,382
			2.1.4.5	provide part funding for TB and leprosy control activites in the state			72,298,191
		2.1.5	Strengthening Immunisation and increasiing immunisation coverage		Coverage of increase immunization by 50% by 2012		482,122,896
			2.1.5.1	Support the activities of task team on immunization/Plan and implementation measles eradication campaign			72,298,191
			2.1.5.2	procure relevant equipment for immunization	**Proportion of health facilities offering routine immunization**		28,919,276
			2.1.5.3	strenghened outreach immunization where applicable	**Number of outreach services conducted**		306,062,341
			2.1.5.4	strenghten routine immunization activites			17,004,535
			2.1.5.5	intensify supplemental immunization activities .			57,838,553
	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**		22,227,718,748
		2.2.1	To improve geographical equity and access to health services				3,643,828,821
			2.2.1.1	Establish type of Health Facility and the number required for each level of service in minimum package	**50% of health facilities upgraded/refurbished by 2012**		-
			2.2.1.2	Refurbishment /upgrading of facilities and provision of equipment based on identified gap.			3,643,828,821
		2.2.2	To ensure availability of drugs and equipment at all levels				17,518,744,779
			2.2.2.1	Revive DRF and establish the drug revolving committee at state and LGA levels	**A Functional DRF and drug revolving committee in place before end of 2010**		5,783,855
			2.2.2.2	Provide funds for regular Procurement, storage and distribution of essential drugs .			9,109,572,054
			2.2.2.3	procure and stock obstetrics drugs to all MCH UNITS			802,511,365
			2.2.2.4	Develop inventory checklist and conduct regular checks.	**State pharmaceutical company completed before end of 2011**		9,567,461
			2.2.2.5	Procure medical equipment based on identifed gaps			7,591,310,045
		2.2.3	To establish a system for the maintenance of equipment at all levels				825,476,644

			2.2.3.1	strenghened of maintenance units in State and LGAs to undertake the continuous repairs, refurbishing and preventive maintenance of structures, transports and equipments.			9,109,572
			2.2.3.2	rehabilitate the central medical stores	Number of equipment and ambulances procured and distributed		722,981,909
			2.2.3.3	procure a mobile service van for a workshop	Proportion of LGA with a functional maintainanace unit by 2012.		93,385,163
		2.2.4	To strengthen referral system				239,668,503
			2.2.4.1	Mapp out refferal link between different level of facilitties and establish guide line for refferals			963,976
			2.2.4.2	To provide adequate logistics and communication facilities to enhance refferal services			238,704,527
			2.2.4.3	Establish monitoring mechanism and documentation of referrals and outcomes.			-
		2.2.5	To foster collaboration with the private sector				-
	2.3	**To improve the quality of health care services**			**50% of health facilities participate in a Quality Improvement programme by end of 2012**		122,485,185
		2.3.1	To strengthen professional regulatory bodies and institutions				7,519,012
			2.3.1.1	Revive and strenghened proffessional regulatory bodies and institutions in the state.			7,229,819
			2.3.1.2	Ensure regulatory guideline are enforce by monitoring teams			-
			2.3.1.3	Establish a system of documentation and feedback of monitoring activites			289,193
		2.3.2	To develop and institutionalise quality assurance models				41,800,404
			2.3.2.1	Review and Adopt quality assurance model at all levels	Quality assurance model adopted and widely disseminated by 2012		481,988
			2.3.2.2	Capacity building to private and public HC providers			9,507,212
			2.3.2.3	Print and disseminate guidelines			2,891,928
			2.3.2.4	Provide Public enlightenment on quality assurance in health facility			14,459,638
			2.3.2.5	Establish servicom unit at all level of care	Proportion of health facilities with a servicom unit by 2015		14,459,638
		2.3.3	To institutionalize Health Management and Integrated Supportive Supervision (ISS) mechanisms				51,476,312
			2.3.3.1	Provide autonomy to health managers at all levels (LGA & Wards)	2010-2015		-
			2.3.3.2	Conduct quarterly ISS visits at all LGA			16,194,795
			2.3.3.3	Conduct quarterly performance review and implemet corrective actions	Proportion of health managers trained		20,821,879
			2.3.3.4	strenghened coordinated school health services program across the state			14,459,638
		2.3.4	To reduce incidence of fake and substandard product/Quackery				21,689,457

			2.3.4.1	Establish a task force on fake and substandard drugs and product	Task force on fake and substandard product established by 2010		7,229,819
			2.3.4.2	conduct quartely monitoring visits			14,459,638
	2.4	**To increase demand for health care services**			**Average demand rises to 2 visits per person per annum by end 2011**		50,427,988
		2.4.1	To create effective demand for services				50,427,988
			2.4.1.1	Development of State communication strategy for health	State communication strategy for health available by 2012		963,976
			2.4.1.2	Dessimination of health promotion policy and implementation			14,459,638
			2.4.1.3	Capacity building on behavioural change for all health workers at all levels	Proportion of health workers trained on behavioral change communication by 2015		14,459,638
			2.4.1.4	to conduct advocacy to key stakeholders on maternal and child health immunization ,breast feeding			20,544,736
	2.5	**To provide financial access especially for the vulnerable groups**			**1. Vulnerable groups identified and quantified by end 2010 2. Vulnerable people access services free by end 2015**		-
		2.5.1	To improve financial access especially for the vulnerable groups				-
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							21,164,798,801
	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**		8,732,805
		3.1.1	To develop and institutionalize the Human Resources Policy framework				8,732,805
			3.1.1.1	Establish a committee to develop a human resource policy frame work .			686,850
			3.1.1.2	Develop strategic plan for effective implementation of the policy .			686,850
			3.1.1.3	Conduct advocacy to policy makers and other stake holders on the human reources policy frame work			7,359,105
			3.1.1.4	Each LGA to carry out similar activities			-
	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**		2,060,549
		3.2.1	To reappraise the principles of health workforce requirements and recruitment at all levels				2,060,549
			3.2.1.1	conduct a baseline survey to establish staffing needs	Guideline for health workforce reguirement and recruitment in place and operational by end of 2011		1,373,700

			3.2.1.2	develop guideline for health workforce requirement for various levels of facilities			686,850
			3.2.1.3	Disseminate developed staffing norms for each level of care to the relevant stakeholders			-
			3.2.1.4	operationalize the developed staffing norms according in line with human resource requirement for MSP			-
	3.3	**Strengthen the institutional framework for human resources management practices in the health sector**			**1. 50% of States have functional HRH Units by end 2010 2. 10% of LGAs have functional HRH Units by end 2010**		31,104,485
		3.3.1	To establish and strengthen the HRH Units				22,077,316
			3.3.1.1	Training of staff on health planning and management for the effective take off of the human resources for health unit.			490,607
			3.3.1.2	Provision of relevant logistics/equipment for effective functioning of the unit.			14,718,210
			3.3.1.3	Set up a sector wide stakeholder forum to provide oversight functions: regularly review and facilitate intregated HR planning			981,214
			3.3.1.4	Establish HRH data base of all health workforce in the state	An upto date database of all health workers in the state		4,415,463
			3.3.1.5	Establish human resources research as a tool to improve health staff management in public and private sector			1,471,821
		3.3.2	Strenghened in-service training and continue staff development approaches				9,027,169
			3.3.2.1	Established a comprhensive human resource development plan for the health sector			686,850
			3.3.2.2	conduct management training for senoir MOH staff			3,924,856
			3.3.2.3	Institutionalize a continouos scientific meeting program in health facilities in the state			4,415,463
	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**		21,111,715,122
		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				17,435,044,841
			3.4.1.1	To conduct a review of training programs in institutions in the state	The State to have secured approval for additional intake of students by 2011.		4,121,099
			3.4.1.2	ADDRESS GAPS BASED 3,4,1,1			1,373,700
			3.4.1.3	Regular assessment of training institution to ensure theyaddress priority needs of the state	Intake of students based on projected requirement		-

			3.4.1.4	Organized for speciial training for CHEWS to acquire midwifery skills to reverse the dismal maternal mortality indices	Numbers of CHEWS trained to acquire midwifery skills		258,304,592
			3.4.1.5	Establish additional school of nursing and midwifery	Establishment of additional school of midwifery by the State by 2014.		17,171,245,451
		3.4.2	To strengthen health workforce training capacity and output based on service demand				2,884,891,887
			3.4.2.1	build capacity of staff of SONM and SOHT	build capacity of staff of SONM and SOHT		49,060,701
			3.4.2.2	Provide adequate teaching and learning materials,for SONM and SOHT	Provide adequate teaching and learning materials,for SONM and SOHT		154,541,209
			3.4.2.3	provide financial support and strenghened infrastructure	provide financial support and strenghened infrastructure		2,555,694,582
			3.4.2.4	Establish quality assurance units in the training institutions	Establish quality assurance units in the training institutions		2,943,642
			3.4.2.5	Establish a coordinating body to monitor activities of the training institutions and maintain active link between the HR requirements and programs of institutions in the state	Establish a coordinating body to monitor activities of the training institutions and maintain active link between the HR requirements and programs of institutions in the state		122,651,753
		3.4.3	To improve health workforce training based on service demand.				787,362,930
			3.4.3.1	to build capacity of health workers on maternal and child health activites[LLS,ELLS,MLSS new born care etc]			500,357,827
			3.4.3.2	Build capcity of health workers on immunization related activites			73,591,052
			3.4.3.3	Build capacity on health promotion interpersonal skills etc			73,591,052
			3.4.3.4	Build capacity of health workers on TB,HIV/STI and related activites			73,591,052
			3.4.3.5	Build capacity on infection prevention and bio hazards			66,231,947
		3.4.4	To improve health workforce training based on demand 2				4,415,463
			3.4.4.1	Establsih a Continuing Medical Education Committee at SMOH and LGA			4,415,463
	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**		8,242,198
		3.5.1	To achieve equitable distribution, right mix of the right quality and quantity of human resources for health				-
			3.5.1.1	ensure re- distribution of health work force in terms of need,mix and geographical spread.			-
			3.5.1.2	Employment of unemployed and retired health professionals to meet the gap			-

			3.5.1.3	Establish a locum arrangement with federal institutions within and out side the state for coverage of referal centres in the state			-
			3.5.1.4	Recruit at least 20 doctors, 30 nurse/midwives ,and other health workers annuallly in line with requirement			-
			3.5.1.5				-
		3.5.2	To establish mechanisms to strengthen and monitor performance of health workers at all levels				8,242,198
			3.5.2.1	.To institute a system of reward,recognition and sanction for health workers in the state			4,121,099
			3.5.2.2	Revive and strenghened the use of annual appraisal for all health workers in the state.	Regular appraisal of staff and feedback on reports		4,121,099
			3.5.2.3	Establish a system to monitor health workers perfomance, including use of client exit interview			-
			3.5.2.4	Establish and enforced use of job description in health facilities	Job describibition institutionalised in health facilities		-
			3.5.2.5		Cmmencement of annual appraisal of health workers by 2010		-
	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**		2,943,642
		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				2,943,642
			3.6.1.1	Identfify existing regulatory and professional bodies in the state			-
			3.6.1.2	Establish a stakeholder forum comprising repesentative of professional and regulatory bodies and meet regularly	stake holders forum established by 2010		2,943,642
			3.6.1.3	Establish effective dialogue and complaint channels between staff and regulatry bodies	Number of meetings of forum conducted		-
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							3,279,307,112
	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**		720,571,944
		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				720,571,944
			4.1.1.1	Set up technical working group for health finance strategic plan at State and Local Government.	The state and LGA to have a documented health financial strategy by 2011		95,677,602
			4.1.1.2	Develop a health finanacing strategic plan that takes into account the Local needs and financial ability of the state and LGA			512,558,585
			4.1.1.3	To sensitize stakeholders on the effective implementation of the plan			112,335,756

			4.1.1.4	To appoint a finance desk officer at SMOH and support its activites			-
	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**		95,677,602
		4.2.1	To strengthen systems for financial risk health protection				95,677,602
			4.2.1.1	Set upa state NHIS committee to delop modalities for the implementation of NHIS in the state	NHIS covers 60% of the State by 2015		47,838,801
			4.2.1.2	Suport the roll out of NHIS in the state	Free maternal and child policy operational by 2011		47,838,801
			4.2.1.3	Encourage the activity of Private Health Insurance			-
	4.3	**To secure a level of funding needed to achieve desired health development goals and objectives at all levels in a sustainable manner**			**Allocated Federal, State and LGA health funding increased by an average of 5% pa every year until 2015**		307,535,151
		4.3.1	To improve financing of the Health Sector				-
			4.3.1.1	advocate for at least 15 % of the state budget to health	Allocated State and LGA health funding increased by 5% PA until 2015		-
			4.3.1.2	Establish a a funding mechanism to seek/receive donations from private individuals charities and coporate organizations			-
			4.3.1.3	Advocate to the zakaat board to improve funding of the health sector			-
			4.3.1.4	Advocate for more funding from developmental partners and MDG based on the state strategic health plan			-
		4.3.2	To improve coordination of donor funding mechanisms				307,535,151
			4.3.2.1	support the activities of the donor coordination unit of the PRS department			102,511,717
			4.3.2.2	organize quarterly donor coordinating meeting			205,023,434
			4.3.2.3	Explore appropriate common basket funding for development partners on areas of priority needs			-
	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**		2,155,522,415
		4.4.1	To improve Health Budget execution, monitoring and reporting				1,007,391,185
			4.4.1.1	concretize arrangement with political leaders that budget will be tied to operational plan	The State and LGA have transperent budgeting and financial		-

					management system in place by 2011		
			4.4.1.2	Prepare annual operational plan well in advance of budget			-
			4.4.1.3	Train relevant staff to Improve internal reporting and maintain accounts according to expenditures and timely submission of financial report			168,503,635
			4.4.1.4	conduct quarterly tracking of budget performance in line with operational plan	Frequency of quartely tracking of budget performance from 2010		574,065,615
			4.4.1.5	conduct external audit of projects account			264,821,935
		4.4.2	To strengthen financial management skills				1,148,131,230
			4.4.2.1	Develop a credible budget plan with appropriate account and auditing.			-
			4.4.2.2	review finanacial management systems and make recconmedations on areas of improvement			574,065,615
			4.4.2.3	support the implementation of the review			574,065,615
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							694,217,901
	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**		516,332,617
		5.1.1	To ensure that NHMIS forms are available at all health service delivery points at all levels				339,816,713
			5.1.1.1	print and distribute HMIS and monitoring tools to state			169,908,357
			5.1.1.2	facilitate printing and distribution of HMIS by LGA			169,908,357
		5.1.2	To periodically review of NHMIS data collection forms				-
			5.1.2.1	Provide regular feed back on the use of the HMIS that will form part of the periodic review of the Forms			-
			5.1.2.2	Collaborate and support the FMOH during periodic review of the HMIS FORM			-
		5.1.3	To coordinate data collection from vertical programmes				5,663,612
			5.1.3.1	Strenghened health data consultative committee to streamline data collection			1,618,175
			5.1.3.2	Conduct quaterly meeting with all health partners to discuss health data	**Number of quarterly meetings conducted**		3,236,350
			5.1.3.3	Ensure all vertical programs submit their data through the HMIS			809,087
		5.1.4	To build capacity of health workers for data management		Proportion of HMIS officer in the state train on data management		99,760,478
			5.1.4.1	provide logistics for monthly data collation and analysis of data in both state andLGA			3,883,620
			5.1.4.2	Build capacity of on DHIS ,HMIS state and LGA			95,876,858
			5.1.4.3	Recruit and train more HMIS personel to achieve minimum standard			-

		5.1.5	To provide a legal framework for activities of the NHMIS programme				1,618,175
			5.1.5.1	To establish mechanism to enforce sanction and make data collection/utilisation mandatory at all level			-
			5.1.5.2	To conduct advocacy to policy makers to understand usefulness of data collection and to promulgate laws and bye laws to make ivital registration mandatory			1,618,175
		5.1.6	To improve coverage of data collection		proportion of public and private health facilities making submition of data by 15th of every month		1,510,297
			5.1.6.1	Develop a mechanism to enhance data collection from all public and private HFs in the State			1,510,297
			5.1.6.2	Establish community data collecting system			-
			5.1.6.3	Ensure follow up of defaulters			-
			5.1.6.4	Collaborate and support the national population commission in the state to strenghen vital registration activties			-
		5.1.7	To ensure supportive supervision of data collection at all levels		Institutionalisation of ISS team by end of 2010		67,963,343
			5.1.7.1	support monthly visits of 5state HMIS officers to LGA for data collection and data quality check	Proportion of LGA visited for ISS activites		67,963,343
	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**		**20,213,701**
		5.2.1	To strengthen the use of information technology in HIS				**1,510,297**
			5.2.1.1	Develop a a system of for the submision/feedback of data via the internet between state and LGA			1,510,297
			5.2.1.2	Establish public private partnership in the management of data warehouse			-
		5.2.2	To provide HMIS Minimum Package at the different levels (FMOH, SMOH, LGA) of data management				**18,703,404**
			5.2.2.1	Provide laptops computers for state HMIS UNIT	minimum package provided by State and LGA before end of 2011		7,645,876
			5.2.2.2	instal internet facility at the HMIS unit	Availability of computers and accessories by 2011		11,057,528
			5.2.2.3		Provision of computers and capacity building of staff at all levels		-
	5.3	**To strengthen sub-systems in the Health Information System**			**1. NHMIS modules strengthened by end 2010 2. NHMIS annually reviewed and new versions released**		**44,285,399**
		5.3.1	To strengthen the Hospital Information System				**24,867,302**
			5.3.1.1	provide computer [desk top to medical record department of GH	Proportion of health facilities using patient management information system		15,291,752
			5.3.1.2	Buid capacity of medical records staff			9,575,550

			5.3.1.3	conduct regular data quality audit of hospital data			-
		5.3.2	To strengthen the Disease Surveillance System				**19,418,098**
			5.3.2.1	Ensure regular reporting of notifiable diseaes by all health facilites			19,418,098
	5.4	**To monitor and evaluate the NHMIS**			**NHMIS evaluated annually**		97,433,003
		5.4.1	To establish monitoring protocol for NHMIS programme implementation at all levels in line with stated activities and expected outputs				37,851,806
			5.4.1.1	Organize quartely meeting of all program officers /PHC teams from state and LGAS	Proportion of health facilities having the quality assurance hand book for HMIS		3,236,350
			5.4.1.2	Provide quality assurance hand book for HMIS to health facility	Frequency of monthly and quartely meeting		2,427,262
			5.4.1.3	build capcity of planning unit on M and E	Provision of sufficient check list forms to State and LGAs		32,188,194
		5.4.2	To strengthen data transmission				59,581,197
			5.4.2.1	To build capacity of staff on computer			59,581,197
	5.5	**To strengthen analysis of data and dissemination of health information**			**1. 50% of States have Units capable of analysing health information by end 2010 2. All States disseminate available results regularly**		15,953,181
		5.5.1	To institutionalize data analysis and dissemination at all levels				15,953,181
			5.5.1.1	tprovide training on data analysis for state and LGA staff	Annual reports by department of planning and statistics		4,787,775
			5.5.1.2	produce disseminate monthly summaries of anaysed data To policy makers in MOH and line ministries			3,883,620
			5.5.1.3	support monthly M and E meeting			7,281,787
COMMUNITY PARTICIPATION AND OWNERSHIP							
6. To attain effective community participation in health development and management, as well as community ownership of sustainable health outcomes							414,647,240
	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**		228,702,088
		6.1.1	To provide an enabling policy framework for community participation				9,951,574
			6.1.1.1	establish a technical working group on community participation	SMOH to adopt and finalise policy framework for community participation by 4th quota of 2011		2,786,441
			6.1.1.2	Organised meeting of technical working group			7,165,133
			6.1.1.3	review of existing policy			-
			6.1.1.4	develop framework for community participation			-
			6.1.1.5				-

		6.1.2	To provide an enabling implementation framework and environment for community participation		SMOH have functional fully equiped health education unit by 1st quota 2011		57,136,960
			6.1.2.1	Develop and distribute guideline for social mobilization activites			2,786,441
			6.1.2.2	Provide guideline and logistics for their activites			2,985,472
			6.1.2.3	train staff on community mobilization			27,481,270
			6.1.2.4	institute a monitoring mechanism of community engaggement activites			23,883,777
		6.1.4	Improving social development mobilization and advocacy				39,408,231
			6.1.4.1	Conduct public awareness activities on health issues			7,165,133
			6.1.4.2	support the LGA SMC s to resuscitate VDCsand WDC	Advocacy tools developed by 2011		5,572,881
			6.1.4.3	Develop advocacy tools			2,786,441
			6.1.4.4	Conduct regular Advocacy			23,883,777
		6.1.5	Production of logistics for distribution and IEC materials				122,205,323
			6.1.5.1	Provide one vehicle with public address system to each LGA	Number of vehicles purchased with public address system		-
			6.1.5.2	Develop and produce IEC material on key health problems/needs	Number and type of IEC material produced		2,786,441
			6.1.5.3	Develop and air 240 TV,jingles AND 480 radio jingles on maternal and child health ,HIV,TB , malaria,measles,CSM etc annually	Number of TV and radio jingles produced		119,418,883
	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**		91,554,477
		6.2.1	To build capacity within communities to 'own' their health services				49,757,868
			6.2.1.1	conduct training to build capacity of the community on identified training Gaps	Number of communities that are invove in their own health services		49,757,868
		6.2.2	cConduct community dialoque				41,796,609
			6.2.2.1	support the LGA to conduct community dialoque			41,796,609
	6.3	**To strengthen the community - health services linkages**			**50% of public health facilities in all States have active Committees that include community representatives by end 2011**		11,941,888
		6.3.1	To restructure and strengthen the interface between the community and the health services delivery points				11,941,888
			6.3.1.1	establish health facility and community joint commitees	70% of HFs have active committee that include community representative by 3rd quota 2011.		5,970,944
			6.3.1.2	Establish guideline for its actvites and facilitate its function			5,970,944

	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**		48,016,342
		6.4.1	To develop and implement multisectoral policies and actions that facilitate community involvement in health development		Number of community that have community health development program		48,016,342
			6.4.1.1	Build capacity of line agencies such as Ministries of women Affairs, health, LG, Information, budget etc			39,258,958
			6.4.1.2	Conduct advocacy to communites to create awareness about community participation and health promotion			5,970,944
			6.4.1.3	develop and implement community health development programs			2,786,441
	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**		34,432,445
		6.5.1	To develop and implement systematic measurement of community involvement				34,432,445
			6.5.1.1	Establish a guideline for measuring communinty involvement			2,786,441
			6.5.1.2	support roll out of community engagement activities			14,927,360
			6.5.1.3	monitor and evalute utilization of guideline and assess the impact			16,718,644
PARTNERSHIPS FOR HEALTH							
7. To enhance harmonized implementation of essential health services in line with national health policy goals							450,385,938
	7.1	**To ensure that collaborative mechanisms are put in place for involving all partners in the development and sustenance of the health sector**			**1. SMOH has an active ICC with Donor Partners that meets at least quarterly by end 2010 2. SMOH has an active PPP forum that meets quarterly by end 2010 3. All States have similar active committees by end 2011**		450,385,938
		7.1.1	To promote Public Private Partnerships (PPP)		An active PPP forum that meet quartely by the end of 2010		210,905,802
			7.1.1.1	Constitute PPP committee and explore PPP options			6,803,413
			7.1.1.2	Conduct sensitisation workshop/media activities on PPP to create awareness			204,102,389
			7.1.1.3	Provide incentives to encourage the private sector to establish healthcare facilitles in rural areas in zamfara State			-
			7.1.1.4	To monitor the activities of PPP in the State and LGA			-

		7.1.2	To institutionalize a framework for coordination of Development Partners				81,640,956
			7.1.2.1	To identify and document all the developmental partners in the state	State should have active committee that meet with donor partners quaterly by 2015		-
			7.1.2.2	conduct quarterly meeting of MOH and partners in health			81,640,956
			7.1.2.3	Develop and implement measures to attract more developmental partners to the state.			-
		7.1.3	To facilitate inter-sectoral collaboration				-
			7.1.3.1	Facilitate Joint activities implementation with the relevant ministries, department and agencies	State should have an active inter-sectral committee with other MDAs by the end of 2014		-
			7.1.3.2	Conduct quarterly joint monitoring and evaluation of activities.			-
		7.1.4	To engage professional groups				-
			7.1.4.1	Identify and document all proffessional group in the state	state to faciltate the establishment of professional body forum by 2015		-
			7.1.4.2	involve proffesional in activities of the ministries			-
		7.1.5	To engage communities				-
			7.1.5.1	Identify and document all proffessional group in the state	state to faciltate the establishment of professional body forum by 2015		-
			7.1.5.2	involve proffesional in activities of the ministries			-
		7.1.6	To engage traditional health practitioners				157,839,181
			7.1.6.1	Review and Adopt national policy on traditional medicine			38,099,113
			7.1.6.2	Identify and document all traditional medicine practitioners in the state	Profile of all traditional medicine practitional available by 2011		38,099,113
			7.1.6.3	streamline activities of traditional medicine practitioner in line with national guideline			81,640,956
RESEARCH FOR HEALTH							
8. To utilize research to inform policy, programming, improve health, achieve nationally and internationally health-related development goals and contribute to the global knowledge platform							860,035,193
	8.1	**To strengthen the stewardship role of governments at all levels for research and knowledge management systems**			**1. ENHR Committee established by end 2009 to guide health research priorities 2. FMOH publishes an Essential Health Research agenda annually from 2010**		309,935,867
		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				13,753,097
			8.1.1.1	Review and Adopt a finalise National health research policy			6,876,549
			8.1.1.2	constitute and support activities of ethic and research committee			6,876,549

		8.1.2	To establish and or strengthen mechanisms for health research at all levels				110,515,959
			8.1.2.1	Constitute an advisory board for the nahuche health and demographic survellance site			73,677,306
			8.1.2.2	Establish Strong linkage with National/Federal/International research institutes for capacity building.			-
			8.1.2.3	Training programmes to be put in place for building research capacities for health researchers.			-
			8.1.2.4	Encourage research activities in All general hospitals in the state and provide neccesary logistics.			36,838,653
			8.1.2.5				-
		8.1.3	To institutionalize processes for setting health research agenda and priorities				6,876,549
			8.1.3.1	Develop a research agenda for health in the state			6,876,549
		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				135,075,061
			8.1.4.1	Collaborate with FMOH developmental partners,research institute etc on health research			24,559,102
			8.1.4.2	Procure enabling tools for research e.g. journals, computer etc.			73,677,306
			8.1.4.3	Coordinate all OR activities of all partners			36,838,653
		8.1.5	To mobilise adequate financial resources to support health research at all levels				-
			8.1.5.1	Establish budget line for health research			-
			8.1.5.2	Solicit financial support from partners			-
		8.1.6	To establish ethical standards and practise codes for health research at all levels				43,715,202
			8.1.6.1	Review and Adopt national guideline on research and ethics			6,876,549
			8.1.6.2	Provide oversight for all OR acttivities in the state			36,838,653
	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**		340,119,004
		8.2.1	To strengthen identified health research institutions at all levels				129,672,059
			8.2.1.1	Conduct an inventory of public,private and Non govermental organizations/instittution with capacity for health research and identify gaps			6,876,549
			8.2.1.2	Deploy at least 3 staff to nahuche research centre			-
			8.2.1.3	Support take off of the nahuche research centre			122,795,510
			8.2.1.4	Mobilize resources from individuals,private sector ,foundations ,partners and the governent to strenghtened capacity of institutions			-
			8.2.1.5				-

		8.2.2	To create a critical mass of health researchers at all levels				26,253,680
			8.2.2.1	Identify knowledge gap in conduct of health research under taken			6,876,549
			8.2.2.2	Provide appropriate training interventions for research based on the identified needs at all levels.			19,377,131
		8.2.3	To develop transparent approaches for using research findings to aid evidence-based policy making at all levels				36,838,653
			8.2.3.1	Create linkages and promote consultations between researchers ,policy makers and developmental partners			36,838,653
			8.2.3.2	Establish a peer review mechanism to assess research undertakings			-
		8.2.4	To undertake research on identified critical priority areas				147,354,612
			8.2.4.1	To stimulate the conduct of research in the state according to agenda developed by the state in a systematic manner			-
			8.2.4.2	Provision of special competive research grant for researchers under taken in th state			147,354,612
	8.3	**To develop a comprehensive repository for health research at all levels (including both public and non-public sectors)**			**1. All States have a Health Research Unit by end 2010 2. FMOH and State Health Research Units manage an accessible repository by end 2012**		25,787,057
		8.3.1	To develop strategies for getting research findings into strategies and practices		Establishment of a get research in to policy committee		3,683,865
			8.3.1.1	To establish a Get Research Into Policy committee[GRIP]			3,683,865
		8.3.2	To enshrine mechanisms to ensure that funded researches produce new knowledge required to improve the health system				22,103,192
			8.3.2.1	ensure dessiminatination of reseach findings to all relevant stakeholders through the GRIP and bianual research to policy forum			22,103,192
	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**		184,193,265
		8.4.1	To create a framework for sharing research knowledge and its applications				184,193,265
			8.4.1.1	Develop a framework for sharing research knowledge at state and LGA levels.			-
			8.4.1.2	Convene annual health conferecne/seminars and workshops at state and LGAS on key thematic areas.			73,677,306
			8.4.1.3	collaboration with international bodies on the state research agenda to facilitate echange of publications			36,838,653

			8.4.1.4	Participate in national and international conferences on health research,	Number of national and international conferences attended		73,677,306
			8.4.1.5	mainstream best practices at, state and LGA levels			-
		8.4.2	To establish channels for sharing of research findings between researchers, policy makers and development practitioners				-
			8.4.2.1	Select journals to be supported that address issues related to Essential National and state Health Research (ENHR) principles.			-
			8.4.2.2	Disseminate research findings to policy makers and partners and publish same in reputable journals			-
TOTAL							**54,251,242,485**

Annex 2: Results/M&E Framework for Zamfara Strategic Health Development Plan

ZAMFARA STATE STRATEGIC HEALTH DEVELOPMENT PLAN RESULT MATRIX						
OVERARCHING GOAL: To significantly improve the health status of Nigerians through the development of a strengthened and sustainable health care delivery system						
OUTPUTS	**INDICATORS**	**SOURCES OF DATA**	**Baseline**	**Milestone**	**Milestone**	**Target**
			2008/9	**2011**	**2013**	**2015**
PRIORITY AREA 1: LEADERSHIP AND GOVERNANCE FOR HEALTH						
NSHDP Goal: To create and sustain an enabling environment for the delivery of quality health care and development in Nigeria						
OUTCOME: 1. Improved strategic health plans implemented at Federal and State levels						
OUTCOME 2. Transparent and accountable health systems management						
1. Improved Policy Direction for Health Development	1. % of LGAs with Operational Plans consistent with the state strategic health development plan (SSHDP) and priorities	LGA s Operational Plans	100	100	100	100%
	2. % stakeholders constituencies playing their assigned roles in the SSHDP (disaggregated by stakeholder constituencies)	SSHDP Annual Review Report				
2. Improved Legislative and Regulatory Frameworks for Health Development	3. State adopting the National Health Bill? (Yes/No)	SMOH	0	0	100	100
	4. Number of Laws and by-laws regulating traditional medical practice at State and LGA levels	Laws and bye-Laws	0	1	1	1
	5. % of LGAs enforcing traditional medical practice by-laws	LGA Annual Report	0	25%	50%	75%
3. Strengthened accountability, transparency and responsiveness of the State health system	6. % of LGAs which have established a Health Watch Group	LGA Annual Report	0	25	50	75
	7. % of recommendations from health watch groups being implemented	Health Watch Groups' Reports	No Baseline	25	50	75
	8. % LGAs aligning their health programmes to the SSHDP	LGA Annual Report	0	50	75	100
	9. % DPs aligning their health programmes to the SSHDP at the LGA level	LGA Annual Report	No Baseline	50	75	100
	10. % of LGAs with functional peer review mechanisms	SSHDP and LGA Annual Review Report	7	25	50	75%
	11. % LGAs implementing their peer review recommendations	LGA / SSHDP Annual Review Report	No Baseline	50	75	100%
	12. Number of LGA Health Watch Reports published	Health Watch Report	0	2	6	10
	13. Number of "Annual Health of the LGA" Reports published and disseminated annually	Health of the State Report	0	1	1	1
4. Enhanced performance of the State health system	14. % LGA public health facilities using the essential drug list	Facility Survey Report	TBD	43	79	86%
	15. % private health facilities using the essential drug list by LGA	Private facility survey	TBD	40	60	80%
	16. % of LGA public sector institutions implementing the drug procurement policy	Facility Survey Report	TBD	21	50	79%
	17. % of private sector institutions implementing the drug procurement policy within each LGA	Facility Survey Report	TBD	10	25	50%

	18. % LGA health facilities not experiencing essential drug/commodity stockouts in the last three months	Facility Survey Report	TBD	21	43	71%
	19. % of LGAs implementing a performance based budgeting system	Facility Survey Report	TBD	25	50	75%
	20. Number of MOUs signed between private sector facilities and LGAs in a Public-Private-Partnership by LGA	LGA Annual Review Report	TBD	2	4	6
	21. Number of facilities performing deliveries accredited as Basic EmOC facility (7 functions 24/7) and Comprehensive EmOC facility (9 functions 24/7)	Facility Survey Report (PRRINN=MNCH)	0	10	25	35
STRATEGIC AREA 2: HEALTH SERVICES DELIVERY						
NSHDP GOAL: To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare						
Outcome 3: Universal availability and access to an essential package of primary health care services focusing in particular on vulnerable socio-economic groups and geographic areas						
Outcome 4: Improved quality of primary health care services						
Outcome 5: Increased use of primary health care services						
5. Improved access to essential package of Health care	22. % of LGAs with a functioning public health facility providing minimum health care package according to quality of care standards.	NPHCDA Survey Report	TBD	25	50	75%
	23. % health facilities implementing the complete package of essential health care	NPHCDA Survey Report	TBD	50	75	100%
	24. % of the population having access to an essential care package	MICS/NDHS	TBD	40	60	80%
	25. Contraceptive prevalence rate	NDHS	2%	15%	30%	60%
	26. % of new users of modern contraceptive methods (male/female)	NDHS/HMIS	0.20%	10%	15%	50%
	27. % of new users of modern contraceptive methods by type (male/female)	NDHS/HMIS		10	15	30
	28. % service delivery points without stock out of family planning commodities in the last three months	Health facility Survey	<5	30	50	75%
	29. % of facilities providing Youth Friendly RH services	Health facility Survey	<2	20	50	75
	30. Adolescent (10-19 year old) Fertility rate (using teeenage pregnancy as proxy)	NDHS/MICS	47	30%	20%	10%
	31. % of pregnant women with 4 ANC visits performed according to standards*	NDHS	<10	50	60	75%
	32. Proportion of births attended by skilled health personnel	HMIS	8	50	70	80
	33. Proportion of women with complications treated in an EmOC facility (Basic and/or comprehensive)	EmOC Sentinel Survey and Health Facility Survey	<5	20	40	60%
	34. Caesarean section rate	EmOC Sentinel Survey and Health Facility Survey	0.01%	5	20	50
	35. Case fatility rate among women with obstretic complications in EmOC facilities per complication	HMIS	??	40	30	20
	36. Perinatal mortality rate**	HMIS	37 - 53/1000 LBs	25 - 45/1000LBs	15 - 30/1000LBs	10 - 20/1000 LBs
	37. % women receiving immediate post partum family planning method before discharge	HMIS	0	10	30	50

	38. % of women who received postnatal care based on standards within 48h after delivery	MICS	0.5 - 22.4%	10 - 40%	25 - 60%	50 - 75%
	39. Number of women presented to the facility with or for an obstetric fistula	NDHS/HMIS	No Baseline			??
	40. Number of interventions performed to repair an obstetric fistula	HMIS	No Baseline			??
	41. Proportion of women screened for cervical cancer	HMIS				
	42. % of newborn with infection receiving treatment	MICS	No Baseline	10 -25%	25 -50%	50 - 75%
	43. % of children exclusively breastfed 0-6 months	NDHS/MICS	6.7	25%	50	75
	44. Proportion of 12-23 months-old children fully immunized	NDHS/MICS	0%	25	50	75
	45. % children <5 years stunted (height for age <2 SD)	NDHSMICS	54.00%	40	30	15%
	46. % of under-five that slept under LLINs the previous night	NDHS/MICS	43.00%	50	60	75
	47. % of under-five children receiving appropriate malaria treatment within 24 hours	NDHS/MICS	8.7	25	40	60
	48. % malaria successfully treated using the approved protocol and ACT;	MICS	0	20	40	60
	49. Proportion of population in malaria-risk areas using effective malaria prevention and treatment measures	MICS	TBD	???	???	???
	50. % of women who received intermittent preventive treatment for malaria during pregnancy	NDHS/MICS	3.8	15	30	50
	51. HIV prevalence rate among adults 15 years and above	NDHS	?	3	2	1
	52. HIV prevalence in pregnant women	NARHS	2	2	1	1
	53. Proportion of population with advanced HIV infection with access to antiretroviral drugs	NMIS		???	???	???
	54.Condom use at last high risk sex	NDHS/MICS				
	55. Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS	NDHS/MICS	6 - 61.6%	20 - 75%	40 - 90%	60 - 100%
	56. Prevalence of tuberculosis	NARHS	??	4	3	2
	57.Death rates associated with tuberculosis	NMIS	??	2	1	1
	58. Proportion of tuberculosis cases detected and cured under directly observed treatment short course	NMIS	??	40	50	70
Output 6. Improved quality of Health care services	59. % of staff with skills to deliver quality health care appropriate for their categories	Facility Survey Report	??	25	50	75
	60. % of facilities with capacity to deliver quality health care	Facility Survey Report	TBD	25	50	75
	61. % of health workers who received personal supervision in the last 6 months by type of facility	Facility Survey Report	<4	30	40	70
	62. % of health workers who received in-service training in the past 12 months by category of worker	HR survey Report	TBD	10	25	50
	63. % of health facilities with all essential drugs available at all times	Facility Survey Report	TBD	25	40	60
	64. % of health institutions with basic medical equipment and functional logistic system appropriate to their levels	Facility Survey Report	TBD	15	30	60
	65. % of facilities with deliveries organizing maternal and/or neonatal death	Facility Survey Report	TBD	10	30	50

	reviews according to WHO guidelines on regular basis					
Output 7. Increased demand for health services	66. Proportion of the population utilizing essential services package	MICS	TBD	25 - 50%	50 -75%	75 - 100%
	67. % of the population adequately informed of the 5 most beneficial health practices	MICS	TBD	25 - 50%	50 - 75%	75 - 100%
PRIORITY AREA 3: HUMAN RESOURCES FOR HEALTH **NSHDP GOAL: To plan and implement strategies to address the human resources for health needs in order to ensure its availability as well as ensure equity and quality of health care**						
NSHDP GOAL: To plan and implement strategies to address the human resources for health needs in order to ensure its availability as well as ensure equity and quality of health care						
Outcome 6. The Federal government implements comprehensive HRH policies and plans for health development						
Outcome 7.All States and LGAs are actively using adaptations of the National HRH policy and plan for health development by end of 2015						
Output 8. Improved policies and Plans and strategies for HRH	68. % of wards that have appropriate HRH complement as per service delivery norm (urban/rural).	Facility Survey Report	TBD	20	40	60
	Retention rate of HRH	HR survey Report	TBD	70	80	90
	70. % LGAs actively using adaptations of National/State HRH policy and plans	HR survey Report	TBD	25	50	75
	71. Increased number of trained staff based on approved staffing norms by qualification	HR survey Report	TBD			
	72. % of LGAs implementing performance-based managment systems	HR survey Report	TBD	25	50	75
	73. % of staff satisfied with the performance based management system	HR survey Report	TBD	50	75	75
Output 8: Improved framework for objective analysis, implementation and monitoring of HRH performance	74. % LGAs making availabile consistent flow of HRH information	NHMIS	0	25	50	75%
	75. CHEW/10,000 population density	MICS	TBD	1:4000 pop	1:3000 pop	1:2000 pop
	76. Nurse density/10,000 population	MICS	TBD	1:8000 pop	1:6000 pop	1:4000 pop
	77. Qualified registered midwives density per 10,000 population and per geographic area	NHIS/Facility survey report/EmOC Needs Assessment	TBD	1:8000 pop	1:6000 pop	1:4000 pop
	78. Medical doctor density per 10,000 population	MICS	TBD	1:8000 pop	1:7000 pop	1:5000 pop
	79. Other health service providers density/10,000 population	MICS	TBD	1:4000 pop	1:3000 pop	1:2000 pop
	80. HRH database mechanism in place at LGA level	HRH Database	TBD	25	50	75%
Output 10: Strengthened capacity of training institutions to scale up the production of a critical mass of quality mid-level health workers						
PRIORITY AREA 4: FINANCING FOR HEALTH **NSHDP GOAL 4 : To ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and consumption at Local, State and Federal Levels**						
NSHDP GOAL 4 : To ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and consumption at Local, State and Federal Levels						
Outcome 8. Health financing strategies implemented at Federal, State and Local levels consistent with the National Health Financing Policy						

Outcome 9. The Nigerian people, particularly the most vulnerable socio-economic population groups, are protected from financial catastrophe and impoverishment as a result of using health services						
Output 11: Improved protection from financial catastrophy and impoversihment as a result of using health services in the State	81. % of LGAs implementing state specific safety nets	SSHDP review report	0%	14	36	50
	82. proportionn(decreased) of informal payments within the public health care system within each LGA	MICS	TBD	75	50	25
	83. % of LGAs which allocate costed fund to fully implement essential care package at N5,000/capita (US$34)	State and LGA Budgets	0	14	36	71
	84. LGAs allocating health funding increased by average of 5% every year	State and LGA Budgets	??	29	50	71
Output 12: Improved efficiency and equity in the allocation and use of Health resources at State and LGA levels	85. % of LGAs health budgets fully alligned to support state health goals and policies	State and LGA Budgets	??	29	50	79%
	86.Out-of pocket expenditure as a % of total health expenditure	National Health Accounts 2003 - 2005	70%	60%	50%	40%
	87. % of LGA budget allocated to the health sector.	National Health Accounts 2003 - 2005	2%	10%	15%	20%
	88. Proportion of LGAs having transparent budgeting and finacial management systems	SSHDP review report	??	14%	36%	79%
	89. % of LGAs having operational supportive supervision and monitoring systems	SSHDP review report	14	50%	71	86%
PRIORITY AREA 5: NATIONAL HEALTH INFORMATION SYSTEM						
Outcome 10. National health management information system and sub-systems provides public and private sector data to inform health plan development and implementation						
Outcome 11. National health management information system and sub-systems provide public and private sector data to inform health plan development and implementation at Federal, State and LGA levels						
Output 13: Improved Health Data Collection, Analysis, Dissemination, Monitoring and Evaluation	90. % of LGAs making routine NHMIS returns to states	NHMIS Report January to June 2008; March 2009	0	50	79%	93%
	91. % of LGAs receiving feedback on NHMIS from SMOH		0	50	100	100
	92. % of health facility staff trained to use the NHMIS infrastructure	Training Reports	<5	25	50	75
	93. % of LGAs/health facilities benefitting from HMIS supervisory visits from SMOH	NHMIS Report	14	50	79	86
	94.% of HMIS operators at the LGA level trained in analysis of data using the operational manual	Training Reports	40%	70%	100%	100%
	95. % of LGA PHC Coordinator trained in data dissemination	Training Reports	14%	79%	93%	100%
	96. % of LGAs publishing annual HMIS reports	HMIS Reports	14	21%	43%	79%
	97. % of LGA plans using the HMIS data	NHMIS Report	14	43%	79%	100%
PRIORITY AREA 6: COMMUNITY PARTICIPATION AND OWNERSHIP						
Outcome 12. Strengthened community participation in health development						
Outcome 13. Increased capacity for integrated multi-sectoral health promotion						
Output 14: Strengthened Community Participation in Health Development	99. Proportion of public health facilities having active committees that include	SSHDP review report	<5%	25%	50%	75%

	community representatives (with meeting reports and actions recommended)					
	100. % of wards holding quarterly health committee meetings	HDC Reports	<2%	25%	50%	75%
	101. % HDCs whose members have had training in community mobilization	HDC Reports	<5%	25%	50%	75%
	102. % increase in community health actions	HDC Reports	??	10%	25%	50%
	103. % of health actions jointly implemented with HDCs and other related committees	HDC Reports	??	25%	50%	75%
	104. % of LGAs implementing an Integrated Health Communication Plan	HPC Reports	0	21%	43%	57%
PRIORITY AREA 7: PARTNERSHIPS FOR HEALTH						
Outcome 14. Functional multi partner and multi-sectoral participatory mechanisms at Federal and State levels contribute to achievement of the goals and objectives of the						
Output 15: Improved Health Sector Partners' Collaboration and Coordination	105. Number of new PPP initiatives per year per LGA	SSHDP Report	0	1	2	2
	106. % LGAs holding annual multi-sectoral development partner meetings	SSHDP Report	0	25%	50%	75%
PRIORITY AREA 8: RESEARCH FOR HEALTH						
Outcome 15. Research and evaluation create knowledge base to inform health policy and programming.						
Output 16: Strengthened stewardship role of government for research and knowledge management systems	107. % of LGAs partnering with researchers	Research Reports	0	10%	25%	50%
	108. % of State health budget spent on health research and evaluation	State budget	Near zero	1%	1.00%	1%
	109. % of LGAs holding quarterly knowledge sharing on research, HMIS and best practices	LGA Annual SHDP Reports	0	21%	50%	71%
	110. % of LGAs participating in state research ethics review board for researches in their locations	LGA Annual SHDP Reports	0	43%	71%	100%
	111. % of health research in LGAs available in the state health research depository	State Health Reseach Depository	0	36%	71%	93%
Output 17: Health research communication strategies developed and implemented	112. % LGAs aware of state health research communication strategy	Health Research Communicatio n Strategy	0	36%	71%	93%