YOBE STATE GOVERNMENT

STRATEGIC HEALTH DEVELOPMENT PLAN
(2010-2015)

Yobe State Ministry of Health

March 2010

Contents

Acronyms

BCC	Behaviour Change Communication
CORPs	Community oriented resource persons
CPD	Continuing professional development
CSO	Community Service Organization
DFID	Department for International Development
DHS	Nigeria Demographic and Health Survey
DP	Development Partners
DPRS	Department of Planning, Research and Statistics
DRF	Drug Revolving Fund
FMC	Federal Medical Centre
FMOH	Federal Ministry of Health
GDP	Gross Domestic Product
GIS	Geographic Information System
HEC	Health Equity Committee
HF	Health Facility
HFIS	Health Facility Information System
HFMC	Health Facility Management Committee
HIV/AIDS	Human Immune Deficiency Virus/Acquired Immune Deficiency Syndrome
HMIS	Health Management Information System
HRH	Human Resources for Health
HW	Health worker
IEC	Information, Education and Communication
IMCI	Integrated management of Childhood Illnesses
IMNCH	Integrated Maternal, Newborn and Child Health
IPC	Interpersonal Communication skills
ISS	Integrated supportive supervision
ITNs	Insecticide treated nets
LGA	Local Government Area
M&E	Monitoring and Evaluation
MBEP	Ministry of Budget & Economic Planning
MCH	Maternal and Child Health
MDAs	Ministries, Departments and Agencies
MDGs	Millennium Development Goals
MFLGCA	Ministry of Local Government and Chieftaincy Affairs
MNCH	Maternal and Newborn Child Health
NDHS	National Demographic and Health Survey
NGOs	Non-Governmental Organizations
NICS	National Immunization Coverage Survey
NPC	National Population Commission
NPHCDA	National Primary Health Care Development Agency
NYSC	National Youth Service Corps
OPS	Organized Private Sector
PHC	Primary Health Care

PPP	Public Private Partnerships
PRRINN	Partnership for Reinforcing Routine Immunization in Northern Nigeria
QA	Quality Assurance
SMOH	State Ministry of Health
SWAPs	Sector-Wide Approaches
TBAs	Traditional birth attendants
TWG	Technical Working Group
VHW	Village health workers
WHO	World Health Organization

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Executive summary

Yobe State, lies in the North-eastern region of Nigeria. The state occupies a land mass of 47,153 sq km. and shares national boundaries with Borno to the East, Jigawa to the Northwest, Bauchi and Gombe States to the West. Yunusari, Machina, Yusufari LGAs lie along Nigeria's common border with Niger Republic to the North. Damaturu is the state capital.

The state is characterised by savannah vegetation with evident desertification which makes most parts of the State sandy (and muddy in the rainy season) as a result of which the terrain is mostly difficult. The topography is varied with hard-to-reach areas in Gulani, Yunusari, Geidam, Yusufari, Karasuwa, Machina and Jakusko LGAs.[1] The state has seventeen (17) LGAs and one hundred and seventy-eight (178) political wards distributed across the three senatorial zones. Bade, Ngizim, Hausa, Fulani Karekare and Kanuri are the major ethnic groups in the state. This is in addition to other minority ethnic groups including Ngamo, Bolewa, Yoruba and Igbos.

Farming and commerce are the main occupation of the people. Islam is the predominant religion of the people. In some of the semi-urban centres (Gujba, Bade, Damaturu, Jakusko Bursari and Geidam) the influence of local religious leaders is very strong.The SMOH takes charge of the secondary health care facilities numbering to twenty one with thirteen general hospitals and eight comprehensive health centres.We have 45 primary health care facilities like in the states of the federation they are the responsibilities of the local governments.There is one tartiary health facility in the state and that's the federal medical centre at Nguru.There are 72 medical doctors in the state with 452 trained nurse/midwives and about 800 chews and other categories of trained health personnel working across the public health facilities in the state.To further bring resources both men and material together and improve on the health indices of the state the government has recently established the state primary health care management board.

Yobe is one of the worst states in the northeast zone displaying shocking health statistics as exemplified by the percentage of Yobe women who received antenatal care from a health professional during the last live birth was 36% compared to a zonal average of 43% and percentage of pregnant women d[2]elivered by a health professional was 9.3% compared to the zonal average of was 15.5%.

The main health problems afflicting the people of Yobe are Malaria, Diarrhoeal diseases, Respiratory tract infections including Tuberculosis; Anemia, Malnutrition, Hypertension and HIV/AIDS.[3]

[1] Yobe Diary
[2] NDHS 2008
[3] Data from Yobe State Ministry of Health, 2009.

The key issues and challenges of the system …

- Dearth of health personnel and maldistribution of same
- Lack of coordination of vertical programmes
- Inadequate resource allocation
- Poor management and weak institutional arrangement

The State's minimum package of care include *antenatal care, immunization, health promotion activties like nutrition services, health education, behavioural change communication concerning communicable and non-communicable diseases, simple curative services e.g. ORT, deworming and antimalaria treatment, etc. TB treatment under directly observed treatment scheme (DOTS), and support for HIV/AIDS activities.*

In order to attain the health MDGs Yobe state shall focus on interventions so as to reduce the burden of diseases in our communities: maternal and child health care will be subsidised. We will ensure equitable distribution of health facilities, building new ones where needed, we will ensure regular monitoring and supervision of the health facilities. We will give incentives for rural health workers. We will motivate the general health workforce. We will ensure a regular continuous professional development. We will support HIV/AIDS activities. We will make available drugs for the treatment of common ailments like malaria, diarrhoea diseases, helminthiasis onchocerciasis, and guineaworm. Finally we will ensure adequate funding for HEALTH

Estimated cost of the strategic interventions is N61, 305, 690, 505. The sum of sixty one billion three hundred and five million, six hundred and ninety thousand five hundred and five naira only is required for the complete implementation of the plan. Health service delivery will consume the largest chunk of the total cost, largely due to the minimum service package component.

In Yobe state, Government is the major source of funds, however other donor agencies are partnering with the state to fund some health interventions; these partners include WHO, UNICEF, World Bank (health systems, HIV/AIDS, TB, Malaria, Avian Influenza etc), Netherlands Leprosy Relief (Leprosy and TB), APOC/CBM (onchocerciasis, blindness prevention), DFID-PRRINN (immunization, PHC system), EU-PRIME (immunization) etc.

The Yobe state strategic health development plan will be jointly implemented by the SMOH, MFLGCA and with support from International Development Partners and NGOs working in the state. The SMOH is the public sector agency mandated to have oversight of the health sector in state. Its functions are policy formulation and regulation, resource mobilization, social protection of the disadvantaged and external relations.

The first step in establishing a monitoring and evaluation system for Yobe state health

development plan is establishing a powerful monitoring and evaluation committee. This committee will include all the members of the plan implementation committee; and the state M&E and HMIS Officers. The committee will meet regularly (quarterly) to review the plans and implemented activities in line with the timeline. Along side, the monitoring and evaluation systems to track progress and changes, as well as correct negative practices or gaps in service availability, coverage, human resources, financing, information systems, and leadership and governance will be strengthened..

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

Vision

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

Mission Statement

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

Chapter One

1.1 Background

Yobe State is one of the states with the worst health indices in Nigeria; and incidentally fall among the states that are backwards educationally and economically. The percentage of pre-school age population of the state who have access to primary education may well be below the national figure of 47%. Similarly, those not enrolled in primary school may well be over the national percentage of 15.4% of primary school-aged population. Yobe State is basically an agrarian state with a rich agro-allied and mineral base. Despite the rich natural endowment of the state, it is yet to be exploited to its fullest potential. The means of production of the agro and mineral resources of the state are dominated by traditional methods of production.

In order to reverse the current state of its populace hindering the attainment of the MDGs, Yobe state organized a state economic and development summit in 2008. This effort is further supported by the Federal Ministry of Health by recruiting and training consultants to support the states with the development of Strategic health development plan covering the period 2010-2015.

These plans from the states will culminate into one National strategic health development plan using an evidence-based framework developed by the Federal Ministry f Health. The SMOH in its drive towards the attainment of the MDG goals has mapped out strategies one of which is bringing donors/partners together and harmonise there plans with the SMOH plan to eliminate duplication and it also established the state primary health care management board to address the issue of primary health as the first entry point in health care delivery.

Chapter Two

(Situation Analysis)

2.1 Socioeconomic context

Yobe State lies in the North-eastern region of Nigeria. It was carved out of the old Borno State in 1991. It derived its name from the River Yobe which runs across the entire State. The state occupies a land mass of 47,153 sq km. and shares national boundaries with Borno to the East, Jigawa to the Northwest, Bauchi and Gombe States to the West. Yunusari, Machina, Yusufari LGAs lie along Nigeria's common border with Niger Republic to the North. Damaturu is the state capital. The state is characterised by savannah vegetation with evident desertification which makes most parts of the State sandy (and muddy in the rainy season) as a result of which the terrain is mostly difficult. The topography is varied with hard-to-reach areas in Gulani, Yunusari, Geidam, Yusufari, Karasuwa, Machina and Jakusko LGAs.[4]

Yobe state has an estimated population of 2,321,591 and an annual growth rate of 3.5%.[5] The under one and under five populations in the state were estimated to be 96,114 and 480,569 respectively; while pregnant women and women of child bearing age (15-49 years) were estimated at 120,142 and 528,626 in the same order. A higher proportion of the population resides in the rural areas of the state. The state has seventeen (17) LGAs and one hundred and seventy-eight (178) political wards distributed across the three senatorial zones. Bade, Ngizim, Hausa, Fulani Karekare and Kanuri are the major ethnic groups in the state. This is in addition to other minority ethnic groups including Ngamo, Bolewa, Yoruba and Ibos. Farming and commerce are the main occupation of the people. Islam is the predominant religion of the people. In some of the semi-urban centres (Gujba, Bade, Damaturu, Jakusko Bursari and Geidam) the influence of local religious leaders is very strong.

2.2 Health status of the population

Most of the state specific health indices for Yobe are not available. However, important indices can be projected using figures for the north-east geopolitical zone of Nigeria and the national figures as proxies. It is well acknowledged that the available statistics for the northeast geopolitical zone have the worst health indices in the country. Yobe State being in the northeast does not fare better and could arguably be described as being worst off than the other states in the zone. This is corroborated by results from a recent National survey[6] that reported a neonatal mortality rate of 61 per 100,000 live births and infant

[4] Yobe Diary

[5] National Population Commission. The 2006 National Population Census

[6] National Population Commission (NPC) [Nigeria] and ORC Macro. 2004. *Nigeria Demographic and Health Survey 2003*. Calverton, Maryland: National Population Commission and ORC Macro.

mortality rate of 125 for the northeastern zone of Nigeria compared to national figures of 53 per 100,000 live births and 109 per 100,000 live births for the respective indices.

The Maternal Mortality Ratio for Nigeria now stands at 545/100000LB[7]. Although this does not give the zonal picture, a projecting from the 2003 DHS reinforces the fact that Yobe still has one of the worst figures as a Northe Easthern state (National MMR- 800 ; NE zone MMR-1549)[8] The percentage of Yobe women who had a live birth in the five years preceding the 2008 DHS survey who received antenatal care from a health professional during the last live birth was 36% compared to a zonal average of 43% for the northeast zone. Similarly, the percentage of the women whose last live birth was protected against neonatal tetanus was 25% as against the zonal average of 29.8% for the northeast zone. In addition, among all live births during the same period, percentage of pregnant women delivered by a health professional was 9.3% compared while the zonal figure was 15.5%. Table 1 summarises the health status indicators for Yobe State as reported in the 2008 NSHDS.

Table 1: Selected health status indicators for Yobe State

POPULATION (2006 Census)	YOBE
Total population	**2,321,339**
female	1,116,305
male	438,853
Under 5 years (20% of Total Pop)	713,608
Adolescents (10 – 24 years)	526,931
Women of child bearing age (15-49 years)	526,931
INDICATORS	**NDHS 2008**
Literacy rate (female)	12%
Literacy rate (male)	32%
Households with improved source of drinking water	50%
Households with improved sanitary facilities (not shared)	27%
Households with electricity	25%
Employment status (currently)/ female	32.1%
Employment status (currently)/ male	95.6%
Total Fertility Rate	7.5
Use of FP modern method by married women 15-49	2%
Ante Natal Care provided by skilled Health worker	39%
Skilled attendants at birth	9%
Delivery in Health Facility	6%
Children 12-23 months with full immunization coverage	4%
Children 12-23 months with no immunization	57%

[7] NDHS 2008
[8] NDHS 2003

Stunting in Under 5 children	54%
Wasting in Under 5 children	21%
Diarrhea in children	18.7
ITN ownership	5%
ITN utilization (children)	2%
ITN utilization (pregnant women)	4%
children under 5 with fever receiving malaria treatment	10%
Pregnant women receiving IPT	8%
Comprehensive knowledge of HIV (female)	12%
Comprehensive knowledge of HIV (male)	4%
Knowledge of TB (female)	40.0%
Knowledge of TB (male)	37.0%

The main health problems afflicting the people of Yobe are Malaria, Diarrhoeal diseases, Respiratory tract infections including Tuberculosis; Anemia, Malnutrition, Hypertension and HIV/AIDS.[9]

2.3 Health services provision and utilization

Yobe state, like many other states in Nigeria operates a pluralistic health care delivery system with the orthodox and traditional health care delivery systems operating alongside each other, albeit with hardly any collaboration. Both the private and public sectors provide orthodox health care services in the state. Yobe state has a total of 528 health facilities comprising of 508 public and 20 private health facilities.[10] Out of the public health facilities, there is a Federal Medical Centre at Nguru; 12 General Hospitals located in 12 LGAs and 495 PHC facilities fairly distributed amongst all LGAs. Though these provide some primary health and secondary care services the quality of care is judged to be poor. Drugs and medical supplies are inadequate, several health facilities are in deplorable conditions, professional staff numbers and mix are inadequate and staff moral is low. Underlying this situation is poor management and a weak institutional arrangement that has led to duplication of functions and services delivery, poor coordination and inadequate funding.[11]

The public health service in the state is also organized into primary, secondary and tertiary levels. Although the Nigerian constitution is silent on the roles of the different levels of government in health services provision and there is no specific state health policy document, the National Health Policy ascribes responsibilities for primary health

[9] Data from Yobe State Ministry of Health, 2009.
[10] Yobe State Health Facilities. Department of Planning Research and Statistics. Yobe State Ministry of Health, 2007.
[11] Achieving Health Millennium Development Goals in Yobe State. Paper presented by the Health Committee, Yobe Economic Summit. 2008.

care to local governments, secondary care to states and tertiary care to the federal level. Although national policies, formulated by the Federal Ministry of Health provide some level of standardization, each level is largely autonomous in the financing and management of services under its jurisdiction. In an attempt to improve the poor management and coordination of health activities, particularly at PHC level, Yobe state is making a thrust towards the establishment of State Primary Health Care Management Board. Arrangements have been concluded and the bill is about being signed into law at State House of Assembly.

The very weak health system contributes to the limited coverage with proven cost-effective interventions as highlighted under the section 2.2 above.

Chapter Three

(Strategic Health Priorities)

This plan discusses eight evidenced-based priority areas identified to improve the performance of the health sector in Yobe State, through a holistic approach at the state and LGA levels. They are: leadership and governance, service delivery, human resources for health, health financing, health information system, community participation and ownership, partnerships for health and research for health.

For each of these priority areas, the plan specifies a goal with strategic objectives and corresponding interventions; and the required activities that is expected to contribute to the attainment of the stated objectives and goals as detailed in appendix 1. However, the Essential Package of Health Services for Yobe State by service delivery mode as listed reflects the priority high impact interventions to be delivered in the state.

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)

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

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

Chapter Four

(Resource requirements)

4.1 Human Resource

The human resource requirement for the full implementation of the Yobe state strategic plan varies with the stipulated activities. Although the state has been reported to have deficiency in human resource for health both in number and in capacity to perform highly skilled tasks, this has been factored in the choice of the required man power for performing the tasks. In view of this therefore, health specialists as consultants and from the health training institutions and universities both within and outside Nigeria will be used to complement the HRH requirement for the implementation of the plan.
For improving leadership and governance in the state, the Permanent Secretary, Directors and deputy Directors from the SMOH, MLGCA, the ministry of budget and economic planning and other line ministries and parastatals will be used in performing most of the identified tasks. The development partners working in the state will support these activities by providing technical assistance to anchor the processes.

The service delivery component of the plan will be implemented by the programme officers, deputy programme officers and their subordinates in both the state and LGA levels. These cadres of staff will be supervised by their respective directors. Effective implementation of the MSP in the state will however require recruitment of additional staff from all cadres of HRH manpower at the service delivery points. Specifically the numbers of doctors, nurses, community health workers and other primary health care workers will have to be augmented to carter for service delivery in both primary and secondary healthcare facilities. The state and LGA programme officers will be supported to implement progammes for the control of specific communicable and non-communicable diseases. This will be accomplished under the overall control of the PHC directors at state and LGA levels. Other interventions for increasing access to, demand and quality of healthcare services in the state and LGAs will be coordinated by the respective directors of DPRS, Budget and Planning, PHC, MFLG, Finance and development partners working in the state.

Although there is a disproportionate distribution of health manpower in the state, the recently concluded HRH audit will provide baseline for rationalization of these staffs in both primary and secondary healthcare facilities. HRH planning and training requirement will be met by relevant directors and deputy directors with support in form of technical assistance from the development partners. In addition, technical assistance will be sought from health specialists in FMOH, universities and other health institutions; and from independent consultants from Nigeria and other parts of the world. PPP and collaboration with other non health sectors will be used in building the HRH in Yobe.

The activities for improving financing of the health system in the state will be implemented by officers from DPRS, MBEP, Finance, state and LGA PHC departments under the supervision of the directors and deputy directors of the respective ministries and departments. High level activities involving systems development, membership of technical working groups and planning will however be carried out at the levels of the PS, Directors and the deputy directors of the respective ministries.

The M&E/ HMIS officers in the state and the DSNOs at the LGA level will implement the activities identified for improving the Health Management Information System (HMIS) in the state and LGA levels. Their activities will also be supervised by the higher level manpower (deputy directors and directors from DPRS and PHC and the State Epidemiologist). The members of the HDCC will also provide guidance for M&E and HMIS activities in the state.

The State health educator and other staff from the health education units of the SMOH and the LGAs will spearhead the implementation of the activities for improving community participation and ownership in the state and LGAs. The communities, training institutions and development partners in the state will also add to the human resource for the activities. Similarly, high level activities for securing budget line and improvement of funding for community participation and ownership activities; and the directors and deputy directors of the relevant units and ministries will provide support and supervision for these activities.

The DPRS will take the leadership in promoting partnership for health in Yobe state. The support for the implementation of the activities to achieve this will be provided by the other departments in SMOH, other line ministries and sectors; the private sector and partners working in the state. Technical support for high level activities and trainings will be sourced from health training institution in the state, FMOH and universities within and outside Nigeria.

The use of *research* findings to inform policy formulation, programming and to improve health is not a common practice in Yobe. This will however be institutionalized in the state by creating research units in DPRS, developing the capacity of DPRS personnel to perform this function; and supporting other staff from health training institutions in the state in his regard. The PS and director of planning, SMOH are responsible for driving these processes.

4.2 Physical/ Material resource

The current physical health infrastructure for Yobe is sufficient to implement the SSHDP. However, to make the health system more robust, additional structures will be put in place to support the establishment of the PHC management board. These include construction of one central and 6 zonal medical stores; upgrade and refurbishment of health centres and supply of equipments and ambulances most of whom were identified

during Yobe state summit. Details of there requirement are captured in the framework of the Yobe State Strategic Health Development Plan in annex.

Chapter Five

(Financing plan)

5.1 Estimated cost of the strategic orientation

The estimated cost for the six years implementation of the Yobe state strategic development plan by the strategic orientations is as summarized in the table that follows. The sum of sixty one billion three hundred and five million, six hundred and ninety thousand five hundred and five naira only is required for the complete implementation of the plan. Health service delivery will consume the largest chunk of the total cost, largely due to the minimum service package component.

Priority Area	Cost (NGN)
Leadership And Governance For Health	674,411,997.47
Health Service Delivery	39,582,833,011.98
Human Resources For Health	21,438,286,315.63
Financing For Health	2,034,249,451.09
National Health Information System	1,011,617,996.20
Community Participation And Ownership	674,411,997.47
Partnerships For Health	674,411,997.47
Research For Health	1,348,823,994.94
Total	**67,439,046,762.23**

5.2 Assessment of the available and projected funds/ Determination of financing gap

Over the years, budgets for the health sector is pegged at about 4% of the total government budget as shown in the table that follows.

Trend in budgetary allocation for health in Yobe state

Year	Funding
2004	1,076,680,000
2005	1,108,108 ,000
2006	1,462,340 ,000

2007	1,179,446 ,000
2008	6,836,936,440

The government budget for the SMOH for the year 2010 has been pegged at 2.6Billion naira only. SMOH operationalised the 2010 budget together with partners and all stakeholders in health. The SMOH allowed for some gaps of about 1.5 Billion which was covered by partners to complement the process of financial support for the state. Since the year 2008 looks like an outlier, we used budgets from 2004 to 2007. Assuming an un-weighed average of the historical budget of the State from 2004 to 2007, the total available funding for the State is (sum of available funding plus annual 12.5% inflation rate, for the period 2010-2015). The available funding is thus NGN 9,916,548,908.

The financing gap is the difference between projected required and projected available funding – **NGN67,439,046,763 minus NGN9,916,548,908 = NGN 57,522,497,854.23**

5.3 Ways of closing the financing gap

Funding of the health sector is as critical as the provision of health care itself. In Yobe state, Government is the major source of funds, however other donor agencies are partnering with the state to fund some health interventions; these partners include WHO, UNICEF, World Bank (health systems, HIV/AIDS, TB, Malaria, Avian Influenza etc), Netherlands Leprosy Relief (Leprosy and TB), APOC/CBM (onchocerciasis, blindness prevention), DFID-PRRINN (immunization, PHC system), EU-PRIME (immunization) etc. Three major challenges are easily recognizable with regards to funding of the health care sector; these are: non release of budgeted funds (which itself is less than the recommended 15% of total annual budget), non provision of funds for recurrent activities like supervision, monitoring and evaluation in the annual budgets and non coordination of donor supports which often lead to duplication.

In order to close the financing gap for the implementation of the Strategic plans a partners meeting for the state was convened to deliberate on the 2010-2015 SSP; 2010 state operational plan and to harmonize the plans for the partners with the state operational plan. Although the partners were not fully in position to finalize decisions on their 2010 plans because they are not yet approved, but it was agreed that partners will support activities in their areas of interest as depicted on the 2010 Yobe State health Operational plan in attachment.

Chapter Six

(Implementation framework)

The Yobe state strategic health development plan will be jointly implemented by the SMOH, MFLGCA and with support from International Development Partners and NGOs working in the state. The SMOH is the public sector agency mandated to have oversight of the health sector in state. Its functions are policy formulation and regulation, resource mobilization, social protection of the disadvantaged and external relations. It is headed by a politically appointed Commissioner of Health, and a technical Permanent Secretary with a team of directors representing major division of the health sector. The MFLGCA on the other hand MFLGCA is responsible for the implementation of PHC in the state. This shows therefore that harmony in coordination between the two ministries is crucial for improved health activities that will translate into improved health status in Yobe state.

International Multilateral and Bi-lateral Organizations also play a major role by providing funds and technical assistance for health programmes. While these are in general well intentioned and welcomed they can affect efficient health service development in one important way; by strategically directing these funds donors can influence policies and programmes towards their own mandates and priorities and create duplication that diverts staff and resources away from essential routine services to vertical programmes. Partner coordination is therefore of paramount importance for the successful implementation of plans.
It is proposed that the implementation of the YSHDP will follow a process detailed below:

- Set up plans implementation Committee (including State, LGA, Institutions, private sector) Chaired by PS SMOH and with the DPRS as the secretary of the committee.
- Government (with technical support from partners) will produce advocacy materials and technical and training guides
- Advocacy and sensitization of government officials will be carried out by the committee members. Government officials to target will include (the executive and legislative arms of State and LGA.
- Training of State programme managers; PHC coordinators and OICs; as well as MOIC on critical areas of the plan especially the MSP
- Develop a Memorandum of Agreement/Understanding for partners and LGA chairpersons to sign
- Implementation of the plan

- Monitoring and evaluation

The members of the implementation committee cited in bullet one above should at minimum include the following:

● The Permanent Secretary, SMOH	Chairman
● Director, Planning Research and Statistic, SMOH	Secretary
● Director, Primary Health Care, SMOH	Member
● Director, Primary Health Care, MFLGCA	Member
● State Epidemiologist, SMOH	Member
● Director Budget, Ministry of Budget and Economic Planning	Member
● Representative of Development Partners	Member
● Representative of Private sector	Member
● Representative of community organizations	Member

The list of committee members could be broadened to include any other stakeholder deemed appropriate for the successful implementation of the plan. This committee should be constituted and inaugurated with immediate effect by the Honorable Commissioner of Health. The committee should meet at least quarterly to plan/ review implementation of the plan.

Chapter Seven

(Monitoring and Evaluation)

7.1 Supervision, monitoring and evaluation

Monitoring and evaluation of plans are crucial to effective implementation of agreed plans. Monitoring ensures that the implementation of pertinent interventions and activities is on course, whereas evaluation is vital for informing progress made by implemented activities/ interventions.

The first step in establishing a monitoring and evaluation system for Yobe state health development plan is establishing a powerful monitoring and evaluation committee. This committee will include all the members of the plan implementation committee; and the state M&E and HMIS Officers. The committee will meet regularly (quarterly) to review the plans and implemented activities in line with the timeline. Along side, the monitoring and evaluation systems to track progress and changes, as well as correct negative practices or gaps in service availability, coverage, human resources, financing, information systems, and leadership and governance will be strengthened.

An important function of the M&E committee will be to examine the functionality and adequacy of monitoring and evaluation systems through the completeness, regularity and quality of reports as well as the level of use in improving the performance of local health systems. To facilitate this, LGA's should develop monitoring frameworks based on set targets, using coverage and other performance indicators to clarify type of data, sources, analysis and periodicity of review. Collected data should be disaggregated by geography, gender, age and income level for targeting those in greatest need. Each level of service within the LGA health system should have a role and responsibility in monitoring and evaluation of their plans. LGA health management team should take the overall responsibility to guide and provide support to lower levels to undertake their monitoring and evaluation activities; and the health facility staff and/or community health workers should provide support to communities in monitoring activities undertaken at community level.

Annex 1: Yobe State Strategic Health Development Plan

YOBE STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
PRIORITY							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	Estimated Cost (2010-2015)
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
LEADERSHIP AND GOVERNANCE FOR HEALTH							
1. To create and sustain an enabling environment for the delivery of quality health care and development in Nigeria							674,411,997
	1	**To provide clear policy directions for health development**			**All stakeholders are informed regarding health development policy directives by 2011**		69,907,736
		1.1.1	Improving Strategic Planning at State level		Costed Strategic and operational plans produced timed in State and LGAs		69,907,736
			1.1.1.1	Support development of evidence based, costed, and prioritized strategic and operational health plans for the health sector			65,117,834
			1.1.1.2	Re-orient and strengthen human resources capacities in SMOH and LGAs on policy formulation, planning and implementation of health plans			3,864,022
			1.1.1.3	Conduct advocacy at State level in support of policy development and implementation of agreed plans			925,880
			1.1.1.4				0
	1	**To facilitate legislation and a regulatory framework for health development**			**Health Bill signed into law by end of 2009**		125,629,758
		1.2.1	Strengthening regulatory functions of government				32,391,333
			1.2.1.1	Develop State health policy and health act			3,468,064
			1.2.1.2	Develop public/private partnership policies and plans in State in line with national policy on PPP			3,468,064
			1.2.1.3	Provide technical support on implementation of strategic plans to ensure that the regulatory function of government is strategic and agreed quality standards are set, monitored, and delivered			20,244,832
			1.2.1.4	Review, update and enforce Public Health Acts and Laws			2,244,472
			1.2.1.5	Set up review committees to revise and streamline roles and responsibilities of regulatory institutions and laws (private health institutions registration, other professional bodies etc) to align with the State Health Bill			2,965,901
		1.2.2	Rationalizing institutional framework for health care delivery and facilitating decentralization of management		PHC Board established in State		93,238,426
			1.2.2.1	Complete process for establishing of PHC Board			5,133,116
			1.2.2.2	Establish PHC service delivery fund			43,434,593
			1.2.2.3	Strengthen Traditional Medicine Board			825,646

			1.2.2.4	Institute mechanisms for regular conduct of State Council on Health			43,845,070
			1.2.2.5				0
	1	**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**		478,874,503
		1.3.1	To improve accountability and transparency		Number os PPRHAA campaigns implemented in state per annunm		478,874,503
			1.3.1.1	Institute facility appraisal mechanisms with community linkages- eg PPRHAA and ISS			478,874,503
			1.3.1.2	Promote voice and accountability			0
			1.3.1.3				0
	1	**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**		0
		1.4.1	Improving and maintaining Sectoral Information base to enhance performance		List of priority areas for further analytical work compiled		0
			1.4.1.1	Outsource prioritised list of areas for further analytical work to Universities, private sector research firms and research institutes (Refer 8.2.4.1 and 8.2.4.2)			0
			1.4.1.2				0
HEALTH SERVICE DELIVERY							
2. To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare							39,582,833,012
	2	**To ensure universal access to an essential package of care**			**Essential Package of Care adopted by all States by 2011**		38,442,916,372
		2.1.1	To review, cost, disseminate and implement the minimum package of care in an integrated manner		Proportion of HFs operating within MSP		38,438,378,986
			2.1.1.1	Design a strategy to ensure facilities operate within the Minimum Services Package			1,685,468
			2.1.1.2	Implement MSP in State and LGAs			38,436,693,518
			2.1.1.3				0
		2.1.2	To strengthen specific communicable and non communicable disease control programmes		Prevalence of communicabe and non communicable diseases in LGA by		1,193,204
			2.1.2.1	Review the disease pattern in the LGA using clinical data			1,193,204
			2.1.2.2	Improve malaria prophylaxis (prevention) (Refer 2.1.1.2)			0
			2.1.2.3	Improve case detection and treatment for TB (Refer 2.1.1.2)			0
			2.1.2.4	Reduce STI/HIV/AIDS transmission (Refer 2.1.1.2)			0
			2.1.2.5				0
		2.1.3	To make Standard Operating procedures (SOPs) and guidelines available for delivery of services at all levels		Proportion of HFs using SOPs and guidelines for service delivery		3,344,182
			2.1.3.1	Produce and distribute standing orders to health facilities			3,344,182

			2.1.3.2				0
	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**		1,085,348,815
		2.2.1	To improve geographical equity and access to health services		Number of HFs upgraded/maintained		725,334,425
			2.2.1.1	Map out all health facilities			947,312
			2.2.1.2	Assess repair and equipment needs of all health facilities in state and LGAs			1,503,749
			2.2.1.3	Upgrade/ refurbish and supply equipment for primary and secondary health facilities, and LGA drug stores based on identified gap			481,562,249
			2.2.1.4	Develop and implement guidelines for outreach services			241,321,115
			2.2.1.5				0
		2.2.2	To ensure availability of drugs and equipment at all levels		Proporion of HFS with Eds and functional equipment at all times		236,353,762
			2.2.2.1	Assess the drugs and equipment needs of all facilities taking into consideration using the MSP, Essential Drugs List and catchment population as a guide			1,509,229
			2.2.2.2	Develop and implement a system to ensure procurement and distribution of essential drugs on a sustainable basis			135,104,964
			2.2.2.3	Establish drug management agency			94,305,940
			2.2.2.4	Training of pharmacy staff on books of account			5,433,627
			2.2.2.5				0
		2.2.3	To establish a system for the maintenance of equipment at all levels				10,699,848
			2.2.3.1	Adopt, disseminate and implement the National Health Equipment Policy			799,928
			2.2.3.2	Establish medical equipment and hospital furniture maintenance workshops			6,099,788
			2.2.3.3	Explore public private partnership in maintenance of medical equipment and hospital furniture			3,210,415
			2.2.3.4	Provide/ review budget lines for preventive maintenance of health facilities and equipment			589,716
			2.2.3.5				0
		2.2.4	To strengthen referral system		Proportion of HFS with functional referral system		108,581,844
			2.2.4.1	Map network linkages for two-way referral systems in line with national standards			107,270,796
			2.2.4.2	Develop/ review and implement Transportation, communication and other logistics for referrals			1,311,049
			2.2.4.3				0
		2.2.5	To foster collaboration with the private sector				4,378,936
			2.2.5.1	Map out all categories of private health care providers by operational level and location			1,698,845

			2.2.5.2	Develop guidelines and standards for regulation of the registration and practice of private health care providers			1,986,433
			2.2.5.3	Develop and implemt a joint performance monitoring mechanism for the private sector			187,262
			2.2.5.4	Adapt and implement the national policy on traditional medicine			506,397
			2.2.5.5				0
	2	**To improve the quality of health care services**			**50% of health facilities participate in a Quality Improvement programme by end of 2012**		40,170,587
		2.3.1	To strengthen professional regulatory bodies and institutions				16,302,007
			2.3.1.1	Build capacity of regulatory staff to monitor compliance of providers to the regulatory guidelines			10,144,911
			2.3.1.2	Provide budget lines and funding for professional regulatory bodies			1,341,473
			2.3.1.3	Conduct regular monitoring exercises with appropriate documentation and feedback			4,815,622
			2.3.1.4	Empower regulators through the provision of necessary security			0
			2.3.1.5				0
		2.3.2	To develop and institutionalise quality assurance models				12,544,236
			2.3.2.1	Develop State SERVICOM guidelines			588,899
			2.3.2.2	Build institutional capacity and train staff for its implementation			10,144,911
			2.3.2.3	Develop and implement strategies for monitoring implementation of quality of care			1,810,425
			2.3.2.4				0
		2.3.3	To institutionalize Health Management and Integrated Supportive Supervision (ISS) mechanisms		Number of ISS vists conducted in LGA		11,324,344
			2.3.3.1	Provide budget line and funding for ISS in state			1,179,432
			2.3.3.2	Develop capacities of programme managers at all levels in state on the ISS mechanism			10,144,911
			2.3.3.3	Institutionalize comprehensive ISS (Refer 1.3.1.1)			0
			2.3.3.4				0
	2	**To increase demand for health care services**			**Average demand rises to 2 visits per person per annum by end 2011**		12,410,805
		2.4.1	To create effective demand for services		Number of BCC activites (by type) conducted		12,410,805
			2.4.1.1	Develop, disseminate and implement a State health promotion communication strategy based on the National Health Promotion Policy			2,201,810
			2.4.1.2	Provide budget lines and funding for health promotion through Behavioural Change Communication			577,751

			2.4.1.3	Strengthen programme monitoring and evaluation system			9,631,245
			2.4.1.4				0
	3	**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**		1,986,433
		2.5.1	To improve financial access especially for the vulnerable groups				1,986,433
			2.5.1.1	Explore models for financial protection for the vulnerable groups (e.g. Pregnant women, under fives, orphans and the aged) such as exemption schemes vouchers, health cards, pre payment schemes			1,986,433
			2.5.1.2	Strengthen free MCH programme in State (Refer 2.1.1.2)			0
			2.5.1.3	Adopt and implement the identified financial protection model			0
			2.5.1.4				0
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							21,438,286,316
	3	**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**		613,775,663
		3.1.1	To develop and institutionalize the Human Resources Policy framework				613,775,663
			3.1.1.1	Develop State HRH Policy inline with National HRH			372,359,993
			3.1.1.2	Formulate/periodic review and Implementation of training and recruitment policy for health personel			85,464,131
			3.1.1.3	Establish HRH forum involving all stakeholders			104,973,493
			3.1.1.4	Develop and implement guidelines on retension, task shifting and establish a forum for public-private practitioners to institutionalize HRH policy reviews, supervisory and monitoring frameworks			50,978,045
			3.1.1.5				0
	3	**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**		336,578,733
		3.2.1	To reappraise the principles of health workforce requirements and recruitment at all levels		Staffing norms implented in State		336,578,733
			3.2.1.1	Develop staffing norms based on workload, service availbility and health sector priority			48,740,533
			3.2.1.2	Operationalise the staffing norms			0
			3.2.1.3	Establish coordinating mechanisms for consistency in HRH planning and budgeting by Ministries of Health, Finance, Education, Civil Service Commission, Regulatory bodies, Private			287,838,200

				Sector Providers, NGOs in health, and other institutions			
			3.2.1.4				0
	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**		835,222,876
		3.3.1	To establish and strengthen the HRH Units		List of trainees and implemented training programmes		835,222,876
			3.3.1.1	Establish training programmes in human resources for health planning and management at all levels			835,222,876
			3.3.1.2				0
	3	**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**		15,356,794,936
		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		Improvement on number of community oriented professionals produced in state		10,442,839,267
			3.4.1.1	Improve health training infrastructure in state			2,129,888,511
			3.4.1.2	Improve the quality of tutors in state healthtraining institution			1,629,783,580
			3.4.1.3	Improve training materials in health training institutions in state			941,040,867
			3.4.1.4	Establish school of midwifery in state			5,566,376,822
			3.4.1.5	Increase number of community health workers and other cadres of supportive programme staff in state			175,749,487
		3.4.2	To strengthen health workforce training capacity and output based on service demand		Training opportunities for health professionals facilitated in state		4,913,955,669
			3.4.2.1	Facilitate accreditation of eligible private sector health facilities to increase training opportunities for internship and post-basic training for all sector health professionals			0
			3.4.2.2	Promote human capital capacity building and continuing professional development (CPD)			4,773,356,079
			3.4.2.3	Establish coordination with professional regulatory bodies to link sponsorship to bonding of healthcare providers to mitigate migration across states and outside the country			140,599,590
			3.4.2.4				0
	4	**To improve organizational and performance-based management systems for human resources for health**			**50% of States have implemented performance management systems by end 2012**		4,061,581,458

		3.5.1	To achieve equitable distribution, right mix of the right quality and quantity of human resources for health		Equitable distribution of health manpower achieved in State and LGAs		787,177,425
			3.5.1.1	Create a database of HRH, develop and provide job descriptions and specifications for all categories of health workers in line with MSP			250,165,103
			3.5.1.2	Promote mandatory rotation of health workers to underserved rural areas, e. g through NYSC scheme for doctors, pharmacists and appropriate scheme for midwives and nurses			0
			3.5.1.3	Provide budget line and funding for payment of attractive rural allowance for staffs posted to underserved areas			341,735,114
			3.5.1.4	Rationalise health manpower in state and LGAs			195,277,208
			3.5.1.5				0
		3.5.2	To establish mechanisms to strengthen and monitor performance of health workers at all levels		System of recognition, reward and saction operational in state and LGAs		3,274,404,033
			3.5.2.1	Institute a sustainable system of recognition, reward and sanctions			77,979,602
			3.5.2.2	Establish system to monitor health worker performance, including use of client feedback (exit interviews)			2,578,957,899
			3.5.2.3	Conduct routine re-orientation of health workforce on attitudinal change including training and retraining in Interpersonal Communication (IPC) skills and work ethics			617,466,533
			3.5.2.4				0
	4	**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**		234,332,650
		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		Health workers and professional groups form part of management teams for health services in state		234,332,650
			3.6.1.1	Ensure involvement of health workers and professional groups in management teams, design and monitoring of health services			234,332,650
			3.6.1.2				0
FINANCING FOR HEALTH							
4. To ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and consumption at Local, State and Federal levels							2,034,249,451
	4	**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**		104,470,191
		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		Financing system and plan developed for state		104,470,191

			4.1.1.1	Develop a health financing system for the state			39,124,267
			4.1.1.2	Setup technical working group for health financing			65,345,924
			4.1.1.3	Develop and implement health financing plan as a component of the State strategic health development plan			0
			4.1.1.4				0
	4	**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**		790,662,534
		4.2.1	To strengthen systems for financial risk health protection				790,662,534
			4.2.1.1	Explore/ review existing Health insurance schemes (HIS) and innovative social health protection approches			20,780,062
			4.2.1.2	Develop state-wide HIS			19,830,566
			4.2.1.3	Implement identified system			750,051,906
			4.2.1.4				0
	4	**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**		207,318,621
		4.3.1	To improve financing of the Health Sector				129,530,563
			4.3.1.1	Increse the allocation of public resources to the health sector by 15% of total budget in line with Abuja Declaration			82,277,293
			4.3.1.2	Explore other sources of funding for health sector			47,253,270
			4.3.1.3				0
		4.3.2	To improve coordination of donor funding mechanisms				77,788,058
			4.3.2.1	Explore mechanism for coordinating donor resources with that of government for health development - Common basket funding through options such as joint funding agreements, sector-wide approches (SWAs) and sectional multi donor budget support etc			77,788,058
			4.3.2.2				0
	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**		931,798,106
		4.4.1	To improve Health Budget execution, monitoring and reporting		Number of financial reports produced		760,561,255
			4.4.1.1	Develop costed, annual operational plans			379,988,045
			4.4.1.2	Ensure proper internal recording and accounting of expenditures; and that timely and detailed financial management reports are produced periodically			215,714,928

			4.4.1.3	Promote financial transparency through the development of State Health Accounts (SHAs) and Public Expenditure Reviews (PERs) and tracking of health budgets			164,858,282
			4.4.1.4				0
		4.4.2	To strengthen financial management skills		Number of owrkshops and seminars held		171,236,850
			4.4.2.1	Build capacity of health workers in budgeting, planning, accounting, auditing, monitoring and evaluation			171,236,850
			4.4.2.2				0
NATIONAL HEALTH INFORMATION SYSTEM							
5. To provide an effective National Health Management Information System (NHMIS) by all the governments of the Federation to be used as a management tool for informed decision-making at all levels and improved health care							1,011,617,996
	5	**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**		388,899,267
		5.1.1	To ensure that NHMIS forms are available at all health service delivery points at all levels		Timely availability of HMIS forms in HFs		38,786,963
			5.1.1.1	Assess the requirement of HMIS tools in the state			4,042,536
			5.1.1.2	Formulate a stakeholders committee within HDCC for planning, resource mobilization, production and distribution of HMIS tools			5,979,423
			5.1.1.3	Ensure provision of Adequate Budget for Printing and reprinting of standardized HMIS tools			3,401,879
			5.1.1.4	Ensure timely printing and distribution of adequate quantities of HMIS tools for the state on quarterly basis			0
			5.1.1.5	Strengthen Supervision to ensure appropriate utilization of the distributed HMIS tools in the state			25,363,124
		5.1.2	To periodically review of NHMIS data collection forms		Annual number of HMIS reviews conducted		43,329,055
			5.1.2.1	Conduct bi-annual review of HMIS in state			7,138,324
			5.1.2.2	Empower health managers at States and LGAs to create mechanisms to ensure regular feedback from the field on the appropriateness and user friendliness of data collection tools			36,190,732
			5.1.2.3				0
		5.1.3	To coordinate data collection from vertical programmes		Data collection and reporting in state harmonised		24,326,564
			5.1.3.1	Review guidelines and standards for data collection and reporting in State to ensure linkages in data flow			5,816,504
			5.1.3.2	Strengthen Health Data Consultative Committee State levels in collaboration with partners and other government agencies to streamline and strengthen data collection systems			18,510,059
			5.1.3.3				0

		5.1.4	To build capacity of health workers for data management		Number of HMIS staff recruited; number of HMIS trainings conducted		54,816,887
			5.1.4.1	Identify existing health information personnel in state and determine the gap			1,287,902
			5.1.4.2	Prepare proposal for the recruitment of health information personnel to fill the identified gaps			16,487
			5.1.4.3	Develop and implement a sustainable system of comprehensive training and retraining of service provider on data collection tools, analysis and utilization of data for action in health programining and policy formulation on a quarterly basis			41,642,082
			5.1.4.4	Establish adequate monitoring systems at State levels to ensure data quality			11,870,417
			5.1.4.5				0
		5.1.5	To provide a legal framework for activities of the NHMIS programme		HMIS activities guided by state HMIS policy		174,918,312
			5.1.5.1	Adapt/ Develop and implement a state HMIS policy in line with national policy			3,910,587
			5.1.5.2	Provide guidelines for implementing the HMIS policy (Ref 5.1.5.1)			0
			5.1.5.3	Conduct advocacy to policy makers to make them understand the value and usefulness of data as well as promulgate an enabling law and bye laws to make this mandatory			171,007,725
			5.1.5.4				0
		5.1.6	To improve coverage of data collection		Proportion of public and private facilities reporting timely and complete data		25,072,555
			5.1.6.1	Strengthen strategies for timely and complete collection of data from all public and private health facilities; and the community (Ref 5.1.1.5)			11,870,417
			5.1.6.2	Strengthen community based data collection system in the state			11,870,417
			5.1.6.3	Strengthen relationship between ministry of Health and National Population Commission to strengthen vital statistics of birth and death registration both at state and LGAs			1,331,721
			5.1.6.4				0
		5.1.7	To ensure supportive supervision of data collection at all levels		Complete and timely data collection and reporting in state and LGAs		27,648,931
			5.1.7.1	Create budget line and realistic budget for supervision of data collection at state and LGAs			8,732,701
			5.1.7.2	Facilitate timely release of fund for routine supervision of data collection			18,751,363
			5.1.7.3	Develop schedule for routine supervision of data collection at the state and LGA level			164,867
			5.1.7.4				0
			5.1.7.5				0
	5	**To provide infrastructural support and ICT of health databases and staff training**			**ICT infrastructure and staff capable of using**		43,425,942

					HMIS in 50% of States by 2012		
		5.2.1	To strengthen the use of information technology in HIS		Proportion of LGA with functional DHIS		32,999,759
			5.2.1.1	Install Internet Service at the state HQ and zonal Health Offices (5)			0
			5.2.1.2	Strengthen DHIS in state and LGAs			31,535,741
			5.2.1.3	Explore use of GSM for data transfer			1,464,018
			5.2.1.4				0
		5.2.2	To provide HMIS Minimum Package at the different levels (FMOH, SMOH, LGA) of data management		% of LGAs with functional HIS minimum package		10,426,183
			5.2.2.1	Define HIS minimum package in state			6,548,513
			5.2.2.2	Provide/Repair non functional computers and power supply set to all the LGAs as part of basic Infrastructures for data storage, analysis and transmission system			0
			5.2.2.3	Establish and implement a sustainable system of preventive maintenance of HMIS equipment in state and LGAs			3,877,669
			5.2.2.4				0
	5	**To strengthen sub-systems in the Health Information System**			**1. NHMIS modules strengthened by end 2010 2. NHMIS annually reviewed and new versions released**		38,110,633
		5.3.1	To strengthen the Hospital Information System				15,767,870
			5.3.1.1	Establish and strengthen patient information systems as well as systems for mapping disease			15,767,870
			5.3.1.2				0
		5.3.2	To strengthen the Disease Surveillance System		No.of LGAs that reported diseases timely		22,342,762
			5.3.2.1	Ensure regular reporting of notifiable diseases by all health facilities is carried out			11,870,417
			5.3.2.2	Strengthen community based surveillance to strengthen disease Surveillance System in State and LGAs (Ref 5.1.6.2)			10,472,346
			5.3.2.3				0
	5	**To monitor and evaluate the NHMIS**			**NHMIS evaluated annually**		10,472,346
		5.4.1	To establish monitoring protocol for NHMIS programme implementation at all levels in line with stated activities and expected outputs		Monitoring protocol for HIS in place		10,472,346
			5.4.1.1	Ensure availability of logistics materials (vehicles or motorcycles) and use of HMIS field monitoring instruments at all levels (Ref 5.3.2.1)			0
			5.4.1.2	Develop/adapt, produce and distribute HIS Quality Assurance (QA) manual (Handbook)			10,472,346
			5.4.1.3	Support LGAs to hold monthly HIS review meeting (5.1.2.2)			0
			5.4.1.4	Develop and implement schedule for bi-annual review meeting at state level (Ref 5.1.2.1)			0
			5.4.1.5				0
	6	**To strengthen analysis of data and dissemination of health information**			**1. 50% of States have Units capable of analysing health**		530,709,810

					information by end 2010 2. All States disseminate available results regularly		
		5.5.1	To institutionalize data analysis and dissemination at all levels		Data used to inform decision and programming in State and LGAs		530,709,810
			5.5.1.1	Establish a functional Database across the state			481,249,740
			5.5.1.2	Develop human capacity for Data analysis (Ref 5.1.4.3)			0
			5.5.1.3	Produce periodic health bulletin and annual reports			49,460,070
			5.5.1.4				0
COMMUNITY PARTICIPATION AND OWNERSHIP							
6. To attain effective community participation in health development and management, as well as community ownership of sustainable health outcomes							674,411,997
	6	**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**		182,980,614
		6.1.1	To provide an enabling policy framework for community participation				158,521,370
			6.1.1.1	Strengthen state community mobilization team			86,369,436
			6.1.1.2	Reorientate community development committee and community based institutions (CBOs, CDAs, VOs, Interfaith, etc.)			72,151,934
			6.1.1.3				0
		6.1.2	To provide an enabling implementation framework and environment for community participation				24,459,244
			6.1.2.1	Identify already existing bodies in the community i.e. Red cross society, TBAs, Youths clubs, JNI, private clinics, pharmaceutical stores and patent drugs vendors.			10,760,091
			6.1.2.2	Develop tools and approach for community participation in planning, management, monitoring and evaluation of health facility and health related activities.			13,699,152
			6.1.2.3				0
	6	**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**		427,578,136
		6.2.1	To build capacity within communities to 'own' their health services				427,578,136
			6.2.1.1	Empower communities with health knowledge and capacity in management, implementation, as well as basic interpretation of health data			163,526,133
			6.2.1.2	Define key roles and functions of community stakeholders and structures and re-orient community development committees and community-based health			84,903,888

				care providers on their roles and responsibilities			
			6.2.1.3	Provide budget line and funding for community level activities			6,384,092
			6.2.1.4	Identify and map out key community stakeholders and resources with community assessment of capacity needs			9,237,891
			6.2.1.5	Organize community dialogue between communities and government structures; and information, education and communication (IEC) activities and media to enlighten and empower communities for positive action			163,526,133
			6.2.5.5				0
	6	**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**		15,684,450
		6.3.1	To restructure and strengthen the interface between the community and the health services delivery points				15,684,450
			6.3.1.1	Review and assess the level of linkages of the existing health delivery structures with the community			119,958
			6.3.1.2	Support community stakeholders to develop guidelines for strengthening the community-health services linkage			1,169,586
			6.3.1.3	Promote community participation in health development using health delivery structures			14,394,906
			6.3.1.4				0
	6	**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**		38,679,015
		6.4.1	To develop and implement multisectoral policies and actions that facilitate community involvement in health development				38,679,015
			6.4.1.1	Conduct advocacy to community gatekeepers to increase their awareness on community participation and health promotion			9,889,203
			6.4.1.2	Organize community health development programmes			14,394,906
			6.4.1.3	Provide support to various levels to link health with other sectors using the health promotion guidelines			14,394,906
			6.4.1.4				0
	7	**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**		9,489,783
		6.5.1	To develop and implement systematic measurement of community involvement				9,489,783
			6.5.1.1	Develop/adapt models that will be used to establish simple mechanisms to support communities to measure impact and			9,489,783

				document lessons learnt and best practices from specific community-level approaches, methods and initiatives			
			6.5.1.2				0
PARTNERSHIPS FOR HEALTH							
7. To enhance harmonized implementation of essential health services in line with national health policy goals							674,411,997
	7	**To ensure that collaborative mechanisms are put in place for involving all partners in the development and sustenance of the health sector**			**1. FMOH has an active ICC with Donor Partners that meets at least quarterly by end 2010 2. FMOH has an active PPP forum that meets quarterly by end 2010 3. All States have similar active committees by end 2011**		674,411,997
		7.1.1	To promote Public Private Partnerships (PPP)		PPP initiatives in state implemented inline with national PPP policy		**89,037,806**
			7.1.1.1	Develop strategies for implementing PPP initiatives in line with state PPP policy			6,772,921
			7.1.1.2	Establish PPP desk at DPRS at state level to promote, oversee and monitor PPP initiatives			30,826,232
			7.1.1.3	Undertake mechanisms for engaging the private sector – such as contracting or out-sourcing, leases, concessions, social marketing, franchising mechanism and provision incentives (e.g health commodities, or technical support at no cost)			51,438,654
			7.1.1.4	Explore mechanism for motivating private sector to set up health facilities in rural and under-served areas (Refer 7.1.1.3)			0
			7.1.1.5	Establish joint monitoring visits by public and private care providers with adequate feedback (Refer ISS)			0
		7.1.2	To institutionalize a framework for coordination of Development Partners		Partners support in state coordinated inline state framework and guidelines		**37,909,857**
			7.1.2.1	Develop a framework and guidelines for the harmonization and aligment of development partners support			1,600,012
			7.1.2.2	Establish the Health Partners Coordinating Committee (HPCC) as a government coordinating body with all other health development partners			36,309,845
			7.1.2.3	Establish Mechanism for coordination of partner resource in State			0
			7.1.2.4				0
		7.1.3	To facilitate inter-sectoral collaboration		Intersectoral Ministerial forum meeting on quarterly basis		**64,845,107**
			7.1.3.1	Establish intersectoral Ministerial forum at DPRS state level to facilitate inter sectoral collaboration			64,845,107
			7.1.3.2	Conduct Quarterly Meetings (Refer 7.1.3.1)			0

			7.1.3.3				0
		7.1.4	To engage professional groups		All professional groups involved in Planning and Implementation of health activities in the State		**34,785,625**
			7.1.4.1	Identify Professional Groups in the State			12,612,407
			7.1.4.2	Engage professional groups in planning, implementation, monitoring and evaluation of health plans and programmes (Refer 7.1.3.1)			0
			7.1.4.3	Support professioal bodies in their continuing education activities to enhance the skills of health professionals			0
			7.1.4.4	Strengthen collaboration b/w govt. and professional groups to advocate for increased coverage of essential interventions, particularly increased funding			22,173,218
			7.1.4.5	Promote effective communication to faciltate relationship b/w professional groups and SMOH (Refer 7.1.3.1)			0
		7.1.5	To engage with communities		Numbers of Jingles aired on Radio and TV weekly, and Instructional materials on health of communities distributed		**257,459,279**
			7.1.5.1	Improve availability of information to communities, in a form that is readily accessible and useful through proper culturally appropriate and gender sensitive dissemination channels			16,855,306
			7.1.5.2	Organize quarterly sensitization meetings between senior SMOH officials and community leadership			37,878,143
			7.1.5.3	Produce and distribute information packages for community (Refer 7.1.4.5)			0
			7.1.5.4	Develop and disseminate Health charter at all levels			12,233,690
			7.1.5.5	Build Capacity of community to prevent and manage Priority Health conditions through BCC, social marketing Public awareness, education and communication (IEC)			190,492,141
		7.1.6	To engage with traditional health practitioners				**190,374,323**
			7.1.6.1	Strengthen traditional medicine practitioners board and regulate their practice			33,293,748
			7.1.6.2	Organise research activities to gain more insignt and understanding of traditional health practice			0
			7.1.6.3	Provide traditional Health Practitioners with additional skills to improve their practices of proven value e.g referal system			53,991,350
			7.1.6.4	Train traditional health practitioners to improve their skills, to know their limitations and ensure their use of the referral system			51,544,612

			7.1.6.5	Work with traditional practitioners in promoting health programmes in such priority areas as nutrition, environmental sanitation, personal hygiene, immunisation and family planning			51,544,612
			7.2.2.5				0
RESEARCH FOR HEALTH							
8. To utilize research to inform policy, programming, improve health, achieve nationally and internationally health-related development goals and contribute to the global knowledge platform							1,348,823,995
	8	**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**		808,940,927
		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		Presence of authenticated State health Research Policy 2010		35,103,600
			8.1.1.1	Develop State health research policy			21,105,556
			8.1.1.2	Develop health research strategies			5,894,114
			8.1.1.3	Establish Health research steering committees			8,103,930
			8.1.1.4				0
		8.1.2	To establish and or strengthen mechanisms for health research at all levels		Number of functiona research units in State		113,874,690
			8.1.2.1	Strengthen research unit at state and create unit in LGAs			29,310,297
			8.1.2.2	Strenthen DPRS at State level, and establish DPRS at LGAs			82,470,801
			8.1.2.3	Ensure coordinated implementation of the Essential National Health Research (ENHR) guidelines			2,093,593
			8.1.2.4				0
		8.1.3	To institutionalize processes for setting health research agenda and priorities		Availability of Guidelines; understanding and implementation of the Guidelines by all principal actors		607,878,806
			8.1.3.1	Establish/ strengthen functional institutional structures for research			602,954,676
			8.1.3.2	Develop and implement guidelines for collaborative health research agenda			4,924,130
			8.1.3.3				0
		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		Health research forum established; Budgetary allocation by stakeholders for reasearch		31,937,105
			8.1.4.1	Establish a forum of health research officers at state and LGAs			22,887,682
			8.1.4.2	Organize annual convening of multi-stakeholders forum to identify research priorities and harmonize research efforts			9,049,423

			8.1.4.3	All stakeholders to provide budget line and funding for research proposals and implementation			0
			8.1.4.4				0
		8.1.5	To mobilise adequate financial resources to support health research at all levels		% of SMOH and LGA budgets released for research		12,512,944
			8.1.5.1	Allocate at least 2% of health budget for health research at State and LGA levels			5,625,104
			8.1.5.2	Explore other sources of funding for research			6,887,841
			8.1.5.3				0
		8.1.6	To establish ethical standards and practise codes for health research at all levels		State ethical board and regulatory standards and guidelines established		7,633,781
			8.1.6.1	Establish State ethical board			3,210,812
			8.1.6.2	Establish ethical standards and guidelines			4,422,969
			8.1.6.3	Strengthen monitoring & evaluation system to regulate research & use of research findings at State and LGAs			0
			8.1.6.4				0
	8	**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**		469,972,124
		8.2.1	To strengthen identified health research institutions at all levels		Number of institutions receiving technical support from SMOH		42,545,707
			8.2.1.1	Identify and strengthen identified health research institutions for collaboration			1,339,899
			8.2.1.2	Conduct periodic capacity assessment of health research organizations and institutions			22,363,474
			8.2.1.3	Implement measures to address identified research capacity gaps and weaknesses			18,842,334
			8.2.1.4				0
		8.2.2	To create a critical mass of health researchers at all levels		Number of research grants and scholarship awards for PHD		144,269,072
			8.2.2.1	Develop appropriate training interventions for research, based on the identified needs at all level			4,735,311
			8.2.2.2	Provide competitive research grants for prospective researchers while motivating increased PhD training in health in tertiary institutions through award of PhD studentship scholarships			75,369,335
			8.2.2.3	Provide on the job training for heath personnel for reasearch			64,164,427
			8.2.2.4				0
		8.2.3	To develop transparent approaches for using research findings to aid evidence-based policy making at all levels		Number of reseaches translated into policies		25,405,584
			8.2.3.1	Develop mechanisms for translating research findings into policies			10,099,285
			8.2.3.2	Establish close liaison and linkages between research users (e.g. policy makers, development partners) and researchers			15,306,300
			8.2.3.3				0

		8.2.4	To undertake research on identified critical priority areas				257,751,760
			8.2.4.1	Conduct needs assessment to identify required health research gaps at all levels			6,520,645
			8.2.4.2	Conduct research in focus areas			251,231,115
			8.2.4.3				0
	8	**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**		0
		8.3.1	To develop strategies for getting research findings into strategies and practices		No of research finding gone into programmes and policies		0
			8.3.1.1	Establish a mechanism for "getting research into programmes and policies at all levels; & instituting bi-annual Health research policy fora at all levels (Refer 8.2.3.1 and 8.2.3.2)			0
			8.3.1.2				0
	8	**To develop, implement and institutionalize health research communication strategies at all levels**			**A national health research communication strategy is in place by end 2012**		69,910,944
		8.4.1	To create a framework for sharing research knowledge and its applications				38,755,122
			8.4.1.1	Develop a framework for sharing research knowledge at all levels			1,020,208
			8.4.1.2	Convene annual health conferences, seminars and workshops at State levels on key thematic areas (financing, human resources, MDGs, health research, etc)			37,734,913
			8.4.1.3				0
		8.4.2	To establish channels for sharing of research findings between researchers, policy makers and development practitioners				31,155,823
			8.4.2.1	Identify persons with ability to develop policy briefs			204,149
			8.4.2.2	Develop the capacity of researchers, and identified persons to effectively produce policy briefs targetted at informing policy makers as well as the broad scienctific and non scientific audiences			30,951,673
			8.4.2.3				0
TOTAL							**67,439,046,762**

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

YOBE STATE STRATEGIC HEALTH DEVELOPMENT PLAN RESULT MATRIX						
OVERARCHING GOAL: To significantly improve the health status of Nigerians through the development of a strengthened and sustainable health care delivery system						
OUTPUTS	**INDICATORS**	**SOURCES OF DATA**	**Baseline**	**Milestone**	**Milestone**	**Target**
			2008/9	**2011**	**2013**	**2015**
PRIORITY AREA 1: LEADERSHIP AND GOVERNANCE FOR HEALTH						
NSHDP Goal: To create and sustain an enabling environment for the delivery of quality health care and development in Nigeria						
OUTCOME: 1. Improved strategic health plans implemented at Federal and State levels						
OUTCOME 2. Transparent and accountable health systems management						
1. Improved Policy Direction for Health Development	1. % of LGAs with Operational Plans consistent with the state strategic health development plan (SSHDP) and priorities	LGA s Operational Plans	0	30	50	70%
	2. % stakeholders constituencies playing their assigned roles in the SSHDP (disaggregated by stakeholder constituencies)	SSHDP Annual Review Report	TBD	25	50	75%
2. Improved Legislative and Regulatory Frameworks for Health Development	3. State adopting the National Health Bill? (Yes/No)	SMOH	0	25	50	75
	4. Number of Laws and by-laws regulating traditional medical practice at State and LGA levels	Laws and bye-Laws	TBD			
	5. % of LGAs enforcing traditional medical practice by-laws	LGA Annual Report	TBD	25%	50%	75%
3. Strengthened accountability, transparency and responsiveness of the State health system	6. % of LGAs which have established a Health Watch Group	LGA Annual Report	0	50	75	100
	7. % of recommendations from health watch groups being implemented	Health Watch Groups' Reports	No Baseline	25	50	75
	8. % LGAs aligning their health programmes to the SSHDP	LGA Annual Report	0	50	75	100
	9. % DPs aligning their health programmes to the SSHDP at the LGA level	LGA Annual Report	No Baseline	50	75	100
	10. % of LGAs with functional peer review mechanisms	SSHDP and LGA Annual Review Report	TBD	25	50	75%
	11. % LGAs implementing their peer review recommendations	LGA / SSHDP Annual Review Report	No Baseline	50	75	100%
	12. Number of LGA Health Watch Reports published	Health Watch Report	0	50	75	100
	13. Number of "Annual Health of the LGA" Reports published and disseminated annually	Health of the State Report	TBD	50	75	100%
4. Enhanced performance of the State health system	14. % LGA public health facilities using the essential drug list	Facility Survey Report	TBD	40	60	80%
	15. % private health facilities using the essential drug list by LGA	Private facility survey	TBD	10	25	50%

	16. % of LGA public sector institutions implementing the drug procurement policy	Facility Survey Report	TBD	20	40	70%
	17. % of private sector institutions implementing the drug procurement policy within each LGA	Facility Survey Report	TBD	10	25	50%
	18. % LGA health facilities not experiencing essential drug/commodity stockouts in the last three months	Facility Survey Report	TBD	25	50	75%
	19. % of LGAs implementing a performance based budgeting system	Facility Survey Report	TBD	20	40	70%
	20. Number of MOUs signed between private sector facilities and LGAs in a Public-Private-Partnership by LGA	LGA Annual Review Report	TBD	2	4	6
	21. Number of facilities performing deliveries accredited as Basic EmOC facility (7 functions 24/7) and Comprehensive EmOC facility (9 functions 24/7)	States/ LGA Report and Facility Survey Report	TBD	3	5	8
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	15	35	60%
	23. % health facilities implementing the complete package of essential health care	NPHCDA Survey Report	TBD	30	50	80%
	24. % of the population having access to an essential care package	MICS/NDHS	TBD	15	40	70%
	25. Contraceptive prevalence rate (modern and traditional)	NDHS	2%	3%	5%	8%
	26. % increase of new users of modern contraceptive methods (male/female)	NDHS/HMIS	10%	25%	40%	60%
	27. % of new users of modern contraceptive methods by type (male/female)	NDHS/HMIS	TBD	25%	40%	60%
	28. % service delivery points without stock out of family planning commodities in the last three months	Health facility Survey	TBD	10%	15%	25%
	29. % of facilities providing Youth Friendly RH services	Health facility Survey	TBD	10%	20%	30%
	30. % of women 15-19 who have begun child bearing	NDHS/MICS	41.70%	40%	35%	30%
	31. % of pregnant women with 4 ANC visits performed according to standards*	NDHS	36%	50%	65%	90%
	32. Proportion of births attended by skilled health personnel	HMIS	10%	25%	50%	70%
	33. Proportion of women with complications treated in an EmOC facility (Basic and/or comprehensive)	EmOC Sentinel Survey and Health Facility Survey	TBD	6%	20%	50%
	34. Caesarean section rate	EmOC Sentinel Survey and Health Facility Survey	3%	6%	10%	20%

	35. Case fatality rate among women with obstretic complications in EmOC facilities	HMIS	TBD	50%	35%	25%
	36. Perinatal mortality rate**	HMIS	53/1000 LBs	45/1000LBs	30/1000LBs	20/1000 LBs
	37. % women receiving immediate post partum family planning method before discharge	HMIS	TBD	5%	10%	15%
	38. % of women who received postnatal care based on standards within 48h after delivery	MICS	5%	10%	20%	35%
	39. % of newborn with infection receiving treatment	MICS	No Baseline	10%	20%	30%
	40. % of children exclusively breastfed 0-6 months	NDHS/MICS	7%	10%	20%	40%
	41. Proportion of 12-23 months-old children fully immunized	NDHS/MICS	7%	15%	20%	25%
	42. % children <5 years stunted (height for age <2 SD)	NDHSMICS	50%	40%	35%	25%
	43. % of under-five that slept under LLINs the previous night	NDHS/MICS	5%	10%	15%	25%
	44. % of under-five children receiving appropriate malaria treatment within 24 hours	NDHS/MICS	4%	10%	15%	20%
	45.Condom use at last high risk sex	NDHS/MICS				
	46. Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS	NDHS/MICS	6%	8%	10%	12%
	47. Prevalence of tuberculosis	NARHS	1.50%	1.20%	1.00%	0.50%
	48. Proportion of tuberculosis cases detected and cured under directly observed treatment short course	NMIS	TBD	40%	60%	80%
Output 6. Improved quality of Health care services	49. % of staff with skills to deliver quality health care appropriate for their categories	Facility Survey Report	TBD	10%	20%	30%
	50. % of facilities with capacity to deliver quality health care	Facility Survey Report	TBD	15%	35%	60%
	51. % of health workers who received personal supervision in the last 6 months by type of facility	Facility Survey Report	TBD	15%	35%	60%
	52. % of health workers who received in-service training in the past 12 months by category of worker	HR survey Report	TBD	10%	20%	40%
	53. % of health facilities with all essential drugs available at all times	Facility Survey Report	TBD	10%	25%	50%
	54. % of health institutions with basic medical equipment and functional logistic system appropriate to their levels	Facility Survey Report	TBD	15%	20%	45%
	55. % of facilities with deliveries organizing maternal and/or neonatal death reviews according to WHO guidelines on regular basis	Facility Survey Report	TBD	10 - 45%	30 - 75%	50 - 90%
Output 7. Increased demand for health services	56. Proportion of the population utilizing essential services package	MICS	TBD	25 - 50%	50 -75%	75 - 100%
	57. % of the population adequately informed of the 5 most beneficial health practices	MICS	TBD	25 - 50%	50 - 75%	75 - 100%

PRIORITY AREA 3: HUMAN RESOURCES FOR HEALTH						
NSHDP GOAL: To plan and implement strategies to address the human resources for health needs in order to ensure its availability as well as ensure equity and quality of health care						
Outcome 6. The Federal government implements comprehensive HRH policies and plans for health development						
Outcome 7.All States and LGAs are actively using adaptations of the National HRH policy and plan for health development by end of 2015						
Output 8. Improved policies and Plans and strategies for HRH	58. % of wards that have appropriate HRH complement as per service delivery norm (urban/rural).	Facility Survey Report	TBD	10%	15%	20%
	59. Retention rate of HRH	HR survey Report	TBD	85%	90%	95%
	60. % LGAs actively using adaptations of National/State HRH policy and plans	HR survey Report	TBD	10%	15%	20%
	61. Increased number of trained staff based on approved staffing norms by qualification	HR survey Report	TBD	15%	30%	45%
	62. % of LGAs implementing performance-based managment systems	HR survey Report	TBD	5%	10%	15%
	63. % of staff satisfied with the performance based management system	HR survey Report	TBD	20%	30%	50%
Output 8: Improved framework for objective analysis, implementation and monitoring of HRH performance	64. % LGAs making availabile consistent flow of HRH information	NHMIS	TBD	20%	30%	50%
	65. CHEW/10,000 population density	MICS	TBD	1:4000 pop	1:3000 pop	1:2000 pop
	66. Nurse density/10,000 population	MICS	TBD	1:8000 pop	1:6000 pop	1:4000 pop
	67. 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
	68. Medical doctor density per 10,000 population	MICS	TBD	1:8000 pop	1:7000 pop	1:5000 pop
	69. Other health service providers density/10,000 population	MICS	TBD	1:4000 pop	1:3000 pop	1:2000 pop
	70. HRH database mechanism in place at LGA level	HRH Database	TBD	25%	35%	45%
Output 10: Strengthened capacity of training institutions to scale up the production of a critical mass of quality mid-level health workers						
PRIORITY AREA 4: FINANCING FOR HEALTH						
NSHDP GOAL 4 : To ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and consumption at Local, State and Federal Levels						
Outcome 8. Health financing strategies implemented at Federal, State and Local levels consistent with the National Health Financing Policy						
Outcome 9. The Nigerian people, particularly the most vulnerable socio-economic population groups, are protected from financial catastrophe and impoverishment as a result of using health services						

Output 11: Improved protection from financial catastrophy and impoversihment as a result of using health services in the State	71. % of LGAs implementing state specific safety nets	SSHDP review report	TBD	20%	35%	50%
	72. Decreased proportion of informal payments within the public health care system within each LGA	MICS	TBD	90%	75%	50%
	73. % of LGAs which allocate costed fund to fully implement essential care package at N5,000/capita (US$34)	State and LGA Budgets	TBD	5%	10%	15%
	74. LGAs allocating health funding increased by average of 5% every year	State and LGA Budgets	TBD	5%	10%	15%
Output 12: Improved efficiency and equity in the allocation and use of Health resources at State and LGA levels	75. LGAs health budgets fully alligned to support state health goals and policies	State and LGA Budgets	TBD	25%	40%	60%
	76.Out-of pocket expenditure as a % of total health expenditure	National Health Accounts 2003 - 2005	70%	60%	50%	40%
	77. % of LGA budget allocated to the health sector.	National Health Accounts 2003 - 2005	2%	5%	10%	15%
	78. Proportion of LGAs having transparent budgeting and finacial management systems	SSHDP review report	TBD	25%	40%	60%
	79. % of LGAs having operational supportive supervision and monitoring systems	SSHDP review report	TBD	15%	35%	45%
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	80. % of LGAs making routine NHMIS returns to states	NHMIS Report January to June 2008; March 2009	TBD	25%	30%	50%
	81. % of LGAs receiving feedback on NHMIS from SMOH		TBD	20%	40%	65%
	82. % of health facility staff trained to use the NHMIS infrastructure	Training Reports	TBD	20%	40%	65%
	83. % of health facilities benefitting from HMIS supervisory visits from SMOH	NHMIS Report	TBD	15%	40%	60%
	84.% of HMIS operators at the LGA level trained in analysis of data using the operational manual	Training Reports	TBD	25%	45%	65%
	85. % of LGA PHC Coordinator trained in data dissemination	Training Reports	TBD	30%	60%	80%
	86. % of LGAs publishing annual HMIS reports	HMIS Reports	TBD	25%	50%	75%

	87. % of LGA plans using the HMIS data	NHMIS Report	TBD	40%	75%	100%
PRIORITY AREA 6: COMMUNITY PARTICIPATION AND OWNERSHIP						
Outcome 12. Strengthened community participation in health development						
Outcome 13. Increased capacity for integrated multi-sectoral health promotion						
Output 14: Strengthened Community Participation in Health Development	88. Proportion of public health facilities having active committees that include community representatives (with meeting reports and actions recommended)	SSHDP review report	TBD	25%	50%	75%
	89. % of wards holding quarterly health committee meetings	HDC Reports	TBD	25%	50%	75%
	90. % HDCs whose members have had training in community mobilization	HDC Reports	TBD	40%	75%	100%
	91. % increase in community health actions	HDC Reports	TBD	10%	25%	50%
	92. % of health actions jointly implemented with HDCs and other related committees	HDC Reports	TBD	25%	40%	60%
	93. % of LGAs implementing an Integrated Health Communication Plan	HPC Reports	TBD	25%	40%	60%
PRIORITY AREA 7: PARTNERSHIPS FOR HEALTH						
Outcome 14. Functional multi partner and multi-sectoral participatory mechanisms at Federal and State levels contribute to achievement of the goals and objectives of the SHDP						
Output 15: Improved Health Sector Partners' Collaboration and Coordination	94. Increased number of new PPP initiatives per year per LGA	SSHDP Report	TBD	25%	40%	60%
	95. % LGAs holding annual multi-sectoral development partner meetings	SSHDP Report	TBD	25%	50%	75%
PRIORITY AREA 8: RESEARCH FOR HEALTH						
Outcome 15. Research and evaluation create knowledge base to inform health policy and programming.						
Output 16: Strengthened stewardship role of government for research and knowledge management systems	96. % of LGAs partnering with researchers	Research Reports	TBD	10%	25%	50%
	97. % of State health budget spent on health research and evaluation	State budget	TBD	1%	1.50%	2%
	98. % of LGAs holding quarterly knowledge sharing on research, HMIS and best practices	LGA Annual SHDP Reports	TBD	10%	25%	50%
	99. % of LGAs participating in state research ethics review board for researches in their locations	LGA Annual SHDP Reports	TBD	20%	40%	60%
	100. % of health research in LGAs available in the state health research depository	State Health Reseach Depository	TBD	20%	30%	50%
Output 17: Health research communication strategies developed and implemented	101. % LGAs aware of state health research communication strategy	Health Research Communication Strategy	TBD	25%	50%	70%