TARABA STATE GOVERNMENT

STRATEGIC HEALTH DEVELOPMENT PLAN
(2010 – 2015)

Taraba State Ministry of Health

March 2010

Table of Contents

List of acronyms and abbreviations

CORPs	Community oriented resource persons
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
FCT	Federal Capital Territory
FMOH	Federal Ministry of Health
GDP	Gross Domestic Product
HDCC	Health Data Consultative Committee
HF	Health Facility
HIS	Health Management Information System
HIV/AIDS	Human Immune Deficiency Virus/Acquired Immune Deficiency Syndrome
HPCC	Health Partners Coordinating Committee
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
ISS	Integrated supportive supervision
ITNs	Insecticide treated nets
JFA	Joint Funding Agreement
LGA	Local Government Area
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDAs	Ministries, Departments and Agencies
MDCN	Medical and Dental Council of Nigeria,
MDGs	Millennium Development Goals
MNCH	Maternal and Newborn Child Health
MRCN	Medical Research Council of Nigeria
NAFDAC	National Agency for Food Drugs Administration and Control
NGOs	Non-Governmental Organizations
SHIS	Social Health Insurance Scheme
NHIS	National Health Insurance Scheme
NHMIS	National Health Management Information System
NHREC	National Health Research Committee
NPHCDA	National Primary Health Care Development Agency
NSHDP	National Strategic Health Development Plan
SSHDPf	State Strategic Health Development Plan Framework
NYSC	National Youth Service Corps
OPS	Organized Private Sector
PHC	Primary Health Care
PHCMIS	Primary Health Care Management Information System
PPP	Public Private Partnerships

QA	Quality Assurance
RDBs	Research data banks
SHAs	State Health Accounts
SMOH	State Ministry of Health
SWAPs	Sector-Wide Approaches
TB	Tuberculosis
TBAs	Traditional birth attendants
VHW	Village health workers
WHO	World Health Organization

Acknowledgement

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

Preface

The performance of the health system in Taraba State declined to an unacceptable level over the last few years, resulting in the evident poor health outcomes for the citizenry. Efforts hitherto put in place did not produce the desired results.

This is why the present administration of Pharm. Danbaba Danfulani Suntai is taking a bold step to prepare a policy document for the health sector. The health policy document will guide stakeholders in health to actualize the provision of affordable and qualitative health care for all the citizens of the State. This policy can only be meaningful both in the short and long terms, if it is appropriately located within the context of the overall developmental programmes.

It is important to emphasize that this policy document is a product of wide range consultations involving diverse health sector actors in the private and public health system. Our royal fathers were also not left out in the preparation of this document. Considering the caliber of the membership of the Steering and Planning Committees, I have no doubt in my mind that they were able to come up with a workable strategic health plan to deliver qualitative, efficient, affordable and accessible health care services, as a real dividend of democracy, to the people.

I am heavily indebted to all those who contributed to the successful production of this document. In this regard, permit me to single out the contribution of Governor Danbaba Danfulani Suntai who provided the resources. Secondly, the presence and wise counsel of our royal fathers assisted in no small measure towards the early completion of the assignment. Finally the contributions of our Development partners, especially the World Health Organization, and technocrats towards the success of this assignment will ever remain indelible in our hearts.

Engr. Muhammad Y Bose
Hon. Commissioner for Health,
Taraba State, Nigeria.

Executive summary

Background and Achievement

In Taraba State, review of data showed that the state's effort to achieving the health Millennium Development Goals (MDGs) by 2015 lacks proper planning and programming. This poses a major developmental challenge, which can hinder and undermine development and economic growth of the state. However, the Taraba State Government recognizes the fact that the health system ought to be strengthened, health services scaled-up and the existing gains in the health sector, sustained and expanded in order to achieve the state's health targets, including the health-related MDGs, especially for its poorest and most vulnerable populations. These improvements can be achieved through the use of an evidence-based Framework to guide the development of a State Strategic Health Development Plan (SSHDP), with appropriate costing. The Taraba State government has initiated a number of policies and policy actions in the health sector in the last few years aimed at improving access to quality and affordable services.

SITUATION ANALYSIS

Taraba State has a population of 2,300,736 (2006 census). Males constitute 52.2% of the population. Approximately 80 per cent of the population lives in the rural areas. Women of reproductive age constitute 21.9% of the population and under-five children 21%.

Strategic Health Priorities

Leadership and governance The impact of leadership and governance in the State Health Systems is weak as a result of lack of continuity, accountability and transparency in government programmes. Interventions developed and incorporated into the

State Strategic Health Plan document to address these inherent weaknesses include the enactment of the appropriate legislation and the provision of the regulatory frameworks. Also included are the interventions of generating state and local government consensus through the meetings of the State Councils on Health, effective decentralization of decision making processes, intergovernmental and multi-sectoral collaboration and coordination of all stakeholders including Public-Private Partnership and strengthening of

the stewardship role of government with proper accountability and transparency through advocacy.

Health service delivery: The Taraba State Health System has all along been characterized by inequitable distribution of resources, infrastructural decay, poor resource allocation strategies, and weak referral systems. In addition, lack of cost-effective interventions with a concomitant lack of integration and poor supportive supervision has been the bane of the state's health system. Recommended interventions include strengthening health services management; implementing the minimum health care package; increased access to quality health services; rehabilitation of health infrastructure, sustainable procurement system for health commodity security; rational use of medicines; strengthening referral system; attitudinal change through SERVICOM; institutionalizing of a system of staff motivation and establishing of a quality assurance mechanism.

Human resource for health: In the state, there is a dearth of quality health care workers with a skewed distribution in favor of the urban dwellers. The recommended interventions include implementation of the National Human Resource Policy which supports lower levels to develop HRH plans and to establish a system of continuing professional training. It also, addresses the critical human resource shortages in the state and encourages the implementation of incentives to attract the appropriate cadres of scarce HRH to work in the State.

Financing for health: Financing health care in Taraba State is fraught with a lot of challenges because of the scarce resources available to the State Government and also the unplanned attempts by government to provide access to health services for some of the vulnerable population. The recommended interventions include increasing government allocation to health at the State and Local Government levels, implementation of community-based health insurance schemes and the pooling of funds using common basket approaches by all actors involved in financing health in the state.

Health information system (HIS): The existing gaps in the state's HIS include, chiefly, non-adherence to reporting guidelines, inadequate supply of standardized tools, poor capacity for data interrogation and nonchalant attitude of private providers towards data collection. The recommended interventions include advocacy for funding; capacity building at all levels for data collection and interpretation; availability of data collection tools at all levels; collaboration with the private sector; harmonization of data collecting systems with key indicators; dissemination and utilization of data to inform policy formulation and programming.

Community participation and ownership: The current level of community participation is weak and has implications for a sustainable health system in the state. The recommended interventions include empowerment and engagement of the communities through community-based organizations and advocacy as platforms for promoting community participation; appointment of community leaders and private individuals into committees set up by government to oversee the affairs of health facilities located within their neighborhood.

*Partnerships for Health***:** Although a number of development partners are working in the state, their efforts are poorly coordinated. It is, therefore, difficult to determine their levels of success and coverage. The recommended interventions proffered include effective Public Private Partnerships; Inter- and intra- governmental collaboration; coordination mechanisms with health development partners including multilateral, bilateral and the civil society; partnerships with professional groups and alternative health care providers.

*Research for health***:** This is almost non-existent in the state. The recommended interventions include setting up and building the capacity of Research Units at the State and Local Government levels. Requisite training and funding is expected to be provided by the two tiers of governments.

Resources Requirements

The emphasis of the Taraba State Government, which until recently, was on the establishment of highly specialized hospital facilities including mainly, but not limited to the State Specialist and the First Referral Hospitals, left much to be desired. It did not strengthen the health system but, rather, weakened it as it did not address equitable, broad based services. The gap analysis of the needs of the State revealed the urgent need to address the issue of non-availability of health indices such as MMR, IMR and under five mortality rates. The new global ranking released by UNICEF placed Nigeria as the 8th worst out of the 198 Countries with the largest number of under five mortality and the second country with the highest number of maternal mortality in the world (800/100,000 live birth). While the figure for the MMR for Taraba State is not known, it is incontrovertible that Taraba will have a MMR well above the national average of 800/100,000 live births.

The State has no specific RH data focused on the implementation of MNCH. However, with the situation in PHC setting whereby the same sets of health worker undertake various activities and with specialized focus of the wards at secondary level, it is possible to approximate number of health workers that may be potentially available for MNCH services.

More than 80% of the health expenditure of the State government is devoted to personnel emoluments. This has significant implication for effective services in terms of facilities and equipment, among others.

The State owns a College of Nursing and Midwifery, and a College of Health Technology in Jalingo and Takum respectively. The Director of Nursing Services in the Ministry of Health has oversight function for the College of Nursing and Midwifery, while the Director of Primary Health Care and Disease Control has oversight function for College of Health Technology, Takum.

The physical components include the infrastructure and capital equipment. Each healthcare facility requires an efficient process for generating and using evidence in policy making, implementing services, managing procurement and distribution, organizing logistics and maintaining equipment, using human resources appropriately, and efficient financial management.

The financing of health care in Taraba State is challenging due to the limited resources available in the face of competing demands. As a result, free healthcare programmes and social protection strategies remain inequitable and do not have sustainability plans. Health care provided by the public sector is constrained by annual health budgets less recommended 2 - 5% of annual budget. Various mechanisms have been devised to increase health resources. Health insurance scheme is yet to commence in the state. The state has implemented user fees and has established revolving funds for specific services and programmes.

Financing Health Plan

This depends on the budgetary allocation for the year of implementation. It also involves the support of the implementing partners. It is expected that resources will be harnessed from budgetary and donors to finance the plan.

Implementation Framework

The Taraba State Ministry of Health (SMOH) formulates policies for health services delivery and implementation with the Health Services Management Board (HSMB) as well as Local Government Authorities (LGAs). Each of the 16 LGAs is responsible for managing the Primary Health Care (PHC) system, including community health activities such as immunization and health education; hygiene and provision of basic outpatient services at its maternities, among others. The State provides a supportive linkage to the LGAs through management of referrals from the PHC level, to the secondary level as well as technical guidance.

Mechanisms for developing and maintaining relationships have been established with relevant groups and programmes in the state. For instance the World Bank, UNICEF, and other development partners are working in the state. The relationship of the healthcare managers in the state with the national health system and other public sectors will enhance adequate implementation of the framework. Also, relationships with communities and foreign development partners will be nurtured through effective communications systems.

Monitoring and Evaluation

Monitoring and evaluation system lacks organizational structure in the state. As a result, both human and material capacities required to do the work are limited. Hence, it is proposed that the human and material capital of the state be built to be able to respond properly to the challenges of monitoring and evaluating the plan. Both direct and indirect cost involved in M&E activities are costed.

Conclusion

Taraba State has a written and published health policy that is fairly comprehensive, and a health reform process has been pursued over the last five years. Core elements of the policy and reform process are: human resources for health, quality improvement and management, health fund, pharmaceutical management programme, policy and strategy development, performance management, and communication and advocacy. The policy aptly covers the issue of MNCH. The State policy on free medical treatment for all pregnant women and under-five children, which has been vigorously funded by the government, epitomizes of the State's commitment to MNCH.

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

Vision

"To reduce the disease burden associated with both communicable and non communicable diseases, particularly, those that occur in epidemic proportions; meet nationally set targets on the elimination and eradication of diseases and, in the process, increase life expectancy and the quality of life of Tarabans"

Mission Statement

"To synthesize relevant policies and programmes and assiduously pursue the implementation of these policies and programmes in a transparent manner that will lead to a purposeful strengthening of the State Health Systems that will usher in an affordable quality health for Tarabans".

Chapter 1: Background and Achievements

1.1 Background

Health is an inevitable social and cultural currency for the continuity of humanity. It has direct relationship with national development and poverty alleviation because "a healthy nation is a wealthy nation". Improved health status and increased life expectancy contribute to long term economic planning and development. An effective health system is one with pro-poor agenda as its focus. Hence, the performance of a national health system can be measured in terms of how best it serves the interest of the poorest and most vulnerable populations. In Taraba State, review of data showed that the state's effort to achieving the health Millennium Development Goals (MDGs) by 2015 lacks proper planning and programming. This poses a major developmental challenge, which can hinder and undermine development and economic growth of the state.

However, Taraba State Government recognizes the fact that the health system should be strengthened, health services must be scaled-up and existing gains in the health sector must be sustained and expanded in order to achieve the state's health targets, including the health-related MDGs, especially for its poorest and most vulnerable populations,. These improvements can be achieved through the use of an evidence-based Framework to guide the development of a State Strategic Health Development Plan (SSHDP), with appropriate costing.

1.2 Achievements

The Taraba State government has initiated a number of policies and policy actions in the health sector in the last five years, under the umbrella of a health reform agenda, aimed at improving access to quality and affordable services. The State health care system has three levels of care:

- Primary health care – which focuses on the provision of general health care services such as preventive, curative, promotive and rehabilitative care for the population as the entry of the health care system. This level of care is mostly the responsibility of local government area (LGA). Most private health facilities also provide health care at this level;
- Secondary health care – which provides specialized services to patients referred from the primary health care level to out-patient and in-patient services of comprehensive health centers and general hospitals for medical, surgical, pediatric patients and community health services. This level of care is largely the responsibility of the State government.
- Specialized health care – this is being provided by special hospitals, which provide care for specific diseases or conditions, such as eye, psychiatric, and pediatrics hospitals.

Presently, the state has designated three categories of health facilities in the State (excluding the Federal Medical Centre, *Jalingo*) based on bed space and services coverage (Table 3). These include specialist hospital (at *Jalingo*), General hospitals (at *Bambur, Zing, Bali, Wukari, Gembu and Warwar*), First Referral Hospitals (at *Pantisawa, Sunkani, Mutum Biyu, Ibi, Serti, Lau, Donga and Baissa*). Other categories are cottage general hospital (8 facilities), comprehensive health centers (18 facilities) and basic health centers (203 facilities). These efforts, however, does not reflect in the name of the health facilities currently because the facilities still bear their old names.

Available MNCH data indicate a weak but an improving MNCH status. According to the State Health Policy, the infant mortality rate is 70 per 1,000 live births[10] but no specific state statistics were available for neonatal and maternal mortality ratio. The life expectancy for the State is 53 years[10].

Also, the State has enunciated a policy of establishing one basic health centre in each of the 203 political wards in the state, with a general hospital and one comprehensive health centre with appropriate staff to offer back-up services to the BHCs. The number of wards

with a BHC increased from 151 in October 2003 to 170 by early 2007. In addition quality assurance programme has been initiated through accreditation of facilities, with clear criteria, including relevant drugs and material, specified in the assessment system.

Chapter 2: Situation Analysis.

2.1 Socio-economic context

Taraba State with a land area of 60291.82 km² was created on August 27, 1991 out of the former Gongola State. Jalingo is the state capital. It has a population of 2,300,736 (NPC 2006)[1], of which 1,100,887 are females and 1,199,849 males. Taraba State lies approximately between latitude 6°30″ and 9°36″ north and longitude 9°10″ east. It is bound in the north by Bauchi State and Gombe State in the north east and Adamawa in the east with Plateau on the North West. Taraba is bounded on west by Nassarawa and Benue State while it shares an international border with the Republic of Cameroun to the south and south east.

The state is made up of sixteen Local Government Areas. There are over eighty ethnic groups in Taraba state each with its distinct historical and cultural heritage. Some of these ethnic groups include Mumuye, Ichen, Wurkun, Mambilla, Kuteb, Chamba, Jukun, Yandang, Fulani, Jenjo, Kunini, Lo, Ndoro, Kambu, Kaka, Bandawa, Munga, Tiv, Zo, and Bambuka. Hausa is commonly spoken by most indigenes of the State.

The dry and rainy season common to tropical region are the dominant climatic features. The rainy season runs from April through October with the dry season being between November and March. The dry season reaches its peak in January and February when the dusty north east trade winds (harmattan) blows across the State. The State comprise three types of vegetation zones viz: the Guinea Savannah, which is marked by mainly forest and tall grass are found in the southern part of the State like Wukari, Takum, Donga; the sub-Sudan type characterized short grasses interspersed with short trees are found in

[1] National Population Commission (2008) National Development Plan

Jalingo, Lau, Ardo Kola; while the semi temperate zone are characterized by luxuriant pasture and short trees is found on the Mambilla plateau.

As a result of the agrarian nature of the State, the predominant occupation is farming by about 75% of the population.

2.2 Health status of the population

There is limited data to monitor the health status of Tarabans. However available data from the recent NDHS, 2008 shows that 39% of women attend ANC, 26% women have access to skilled attendant at birth, only 14% of children 12-23 months are fully immunized, with 43% of under 5 children stunted among others. The State is ranked 26th of 36 States and the FCT in terms in a recent exercise by the World Bank using some of these indicators. Other indicators for the state are presented in the table below.

POPULATION (2006 Census)	TARABA
Total population	**2,294,800**
female	1,122,869
male	1,171,931
Under 5 years (20% of Total Pop)	428,318
Adolescents (10 – 24 years)	702,890
Women of child bearing age (15-49 years)	543,653
INDICATORS	**NDHS 2008**
Literacy rate (female)	42%
Literacy rate (male)	69%
Households with improved source of drinking water	19%
Households with improved sanitary facilities (not shared)	10%
Households with electricity	19%
Employment status (currently)/ female	61.2%
Employment status (currently)/ male	97.7%
Total Fertility Rate	5.9
Use of FP modern method by married women 15-49	4%
Ante Natal Care provided by skilled Health worker	39%
Skilled attendants at birth	26%
Delivery in Health Facility	21%
Children 12-23 months with full immunization coverage	14%
Children 12-23 months with no immunization	8%
Stunting in Under 5 children	43%
Wasting in Under 5 children	9%
Diarrhea in children	15.8
ITN ownership	9%
ITN utilization (children)	4%
ITN utilization (pregnant women)	4%
children under 5 with fever receiving malaria treatment	30%
Pregnant women receiving IPT	5%
Comprehensive knowledge of HIV (female)	16%
Comprehensive knowledge of HIV (male)	73%
Knowledge of TB (female)	69.8%
Knowledge of TB (male)	84.9%

2.3 Health services provision and utilization

Taraba State operates a pluralistic health care delivery system with the orthodox and traditional health care delivery systems operating alongside each other, with minimal collaboration. Both the private and public sectors provide orthodox health care services in the state.

In Taraba State, healthcare services are provided by broad spectrum of health care institution both public and private. About 75% of the state's population is rural dwellers. Greater majority of population are exposed to diseases and lower standard of living especially in the rural areas. They have limited access to qualitative health care facilities, most of which are situated in urban areas. Presently, there is a renewed push for improved health care. Malaria, diarrhea dysentery pneumonia, typhoid fever, hypertension and HIV/AIDS constitute the major health challenges facing the state. The Adult HIV/AIDS prevalence is 5.2 (2008) and the state now has its own Anti-Retroviral Treatment Centre. In addition, all General Hospitals are designated HIV Screening Centres. The Multi-scrotal Taraba State Action Committee on AIDS (TASACA) coordinates the state's response to the HIV/AIDS pandemic.

The Taraba State Ministry of Health (SMOH) formulates policies for health services delivery and implementation with the Hospitals' Management Board (HMB) as well as Local Government Authorities (LGAs). Each of the 16 LGAs is responsible for managing the Primary Health Care (PHC) system, including community health activities such as immunization and health education; hygiene and provision of basic outpatient services at its maternities, among others. The State provides a supportive linkage to the LGAs through management of referrals from the PHC level, to the secondary level as well as technical guidance[2].

[2] Ibid

2.4 Key issues and challenges

The strength of the Taraba State SHDP includes high level political will and commitment, existence of a comprehensive Health plan, conducive social and Policy environment.

Also, the weaknesses include, among others, inadequate budgetary allocation for Health in line with WHO requirement, inefficient integration and linkages in Health Services, availability of obsolete and less than adequate number of medical equipment, difficulty in reaching riverine communities and remote areas, non implementation of existing policies and Poor condition of service for health services personnel.

In addition, the opportunities by the document are involvement of development partners in Health Sector programmes in the State. Also addressed in the Taraba State SHDP document are alternative health financing measures such as the National Health Insurance scheme and other sources of health funds including technical assistance from Federal government and International Agencies. Favorable democratic atmosphere for relevant legislations.

Finally, the threats are exodus of skilled medical personnel, inconsistent Government policies, dwindling State Government revenue, activities of unskilled and unlicensed health practitioners, prevalence of fake and adulterated drugs and preponderance of unregulated traditional medical practitioners.

Chapter 3: Strategic Health Priorities

3.1 Priority Area 1: Leadership And Governance For Health

3.1.1 Context

Taraba State has adopted a number of sectoral health policies since its creation in1991. The initial guiding philosophy of pre-1985 policies was based on the assumption that improving the health of the population was essentially dependent upon the availability of health providers and access to health facilities[3].

In 1988 a PHC focused Health policy was adopted by the state and subsequently reviewed in 2004. This policy was the first to provide direction hinged on the principle of primary health care (PHC) based on the evidence of the disease burden of the state. In line with the constitution of Nigeria (1999) in the Forth Schedule, Section 2, sub-section C the State and the Local Government Councils (of the State) provide and maintain health services.

The lack of clear cut role performance by key stakeholders led to the poor performance of the health system in the state. In some instances, apparent duplication of roles, lack of communication between various actors and poor accountability are critical factors responsible for the lack of strategic direction and an inefficient and ineffective health care delivery system in the state. This is why deliberate attempts were made to enhance leadership and governance for health in the Taraba SSHDP.

The private health sector is a major contributor to healthcare delivery in the state and is often the first point of contact with the health system for the majority of people. Quality of service delivery is extremely variable and the capacity of the State government to set standards and ensure compliance needs to be strengthened.

3

This priority area of the SSHDP Framework seeks to streamline and empower the Ministry of Health in the State and the LGA Health Departments to reposition their organisational and management systems to provide better strategic and tactical leadership and governance for health. Also, the plan seeks to enhance accountability and transparency in the use of health development resources.

3.1.3. Goal

To create and sustain an enabling environment for health development in the state

3.1.4. Strategic Objectives.

3.1.4.1 To provide clear policy directions for health development

3.1.4.2 Facilitate legislation and a regulatory framework for health development

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

3.1.4.4 To enhance the performance of the national health system

3.1.5 Interventions

Descriptions of evidence-based interventions contributing to the achievement of each specific objective are presented below

To provide clear policy directions for health development:

3.1.5.1 Improve Strategic Planning at State and LGA levels

(i) Establish and Strengthen Stakeholders' consensus at State and LGA levels with a view of implementing directives for Health Development. The activities are: conducting bi-annual stakeholders' meeting for the implementation of the plan in the state; conducting quarterly meeting of the planning committee; advocate for the approval of the SSHDP; conduct annual review of the SSHDP; and collection of baseline data for situation analysis.

(ii) Effective implementation of the Taraba State strategic plan, including dissemination and advocacy at State and LGA levels for policy formulation and implementation. The activities are to establish quarterly Stakeholders' meetings to ensure effective implementation of the programme; establish Monitoring and Evaluation Committee to

collect data to review progress, achievements and challenges of the SHDP; establish bi-annual feedback to the State Executive Council; and develop annual report.

(iii) Increase accountability and transparency at the state and LGA levels. The activities are to strengthen Stakeholders' consultative fora such as State Council on Health, various Development Committees and Community Dialogues; to strenghten advocacy and communication for SSHDP framework i.e enligthenment programme through prints and electronic media; to produce and distribute bulletin; and to establish feedback mechanism in the health sector.

To facilitate legislation and a regulatory framework for health development

3.1.5.2 Strengthen Regulatory Functions of government

(i) Strengthen regulatory functions of government. The activities include development of public/private partnerships in the state and LGAs in line with the FG policy on PPP; development of standard operating procedure to guide service delivery and aid supportive supervision at state and LGA levels; review, update and enforce public health acts and laws; and revise and streamline regulatory institutions roles and responsibilities to align with the national health bill.

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

3.1.5.3. Improve Accountability and Transparency

The activities are aimed at: (i) the decentralization of decision making processes at the state and LGA levels thereby establishing bi-annual stakeholders fora with appropriate feedback for health sector decision makers; (ii) empowering beneficiary communities through sensitization activities to manage and oversee health projects and programmes; (iii) improvement of access to information required for yearly joint review of the health sector and making such review available to the public.

To enhance the performance of the national health system

3.1.5.4 Improving and maintaining Sectoral Information base to enhance the performance

(i) Expand the analytical work at both Federal and State Government levels required to understand health sector performance and drive improvements and reform; and (ii) Outsource future analytical work to Universities, private sector research firms and national research institutes..

3.2 Priority Area 2: Health Service Delivery

3.2.1 Context

Through the primary, secondary and tertiary levels health care services are provided comprehensively in an integrated manner to the beneficiary state. Increasing demand and supply of services with the goal of expanding coverage for improved health status of the population is the target of the current state health care agenda. Health care services are provided in the state by public, private including orthodox for profit and not-for-profit organizations, pharmacies, patent medicine vendors, the traditional health care providers and faith healers.

There is evidence that health services in the state are delivered through a weak health care system that is unable to provide basic, cost-effective services for the prevention or management of common health problems despite successive governments' investments in the health sector. This is due to poor access to information and services leading to poor health outcomes in the state. Management of Health Services at the LGA and Ward levels are not well implemented in the State. Availability of functional health facilities and other health infrastructure are variable and limited with majority of the public PHC facilities in the state not well equipped.

To improve the functionality and utilization of service delivery in the state, key cost-effective and evidence-based interventions ranging from transformation of health management and organizational systems with clear demarcation of roles and responsibilities of health managers at the various levels is required.

3.2.2 Goal

To revitalize integrated service delivery towards a quality, equitable and sustainable access to healthcare

3.2.3 Strategic Objectives

3.2.3.1 To provide an essential package of care

3.3.3.2 To increase access to health care services

3.3.3.3 To improve the quality of health care services

3.3.3.4 To increase demand for health care services

3.3.3.5 To provide financial access especially for the vulnerable groups

3.3.4 Interventions

The state plans to review and cost a minimum package of care/or services that will be expected to be provided at the minimum at every health care facility. The core elements of the minimum service package include evidence based high impact interventions considered necessary for scaling up to universal coverage. These are categorized according to the channels through which they are to be provided. In other words according to service delivery modes. These services are presented in the tables below.

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

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

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

3.3.4.1 To map out health facilities and service delivery

The state intends to map health facilities and service delivery in the state and LGAs. The activities include establishment of committee to facilitate the mapping; provide logistic support for the activity; conduct mapping of health facilities in the state and LGAs and disseminate the information.

To increase access to health care services

3.3.4.2 Development and wide distribution of SOPs and guidelines for quality delivery of services at the state and LGA levels.

To inaugurate the working committee comprising all professionals; develop, print and distribute Standard Operating Procedures (SOPs). The LGAs will implement the SOPs.

3.3.4.3 Regular accreditation of health facilities

The state and LGAs will set up accreditation team to review standards for accreditation, provide logistics support for carrying out accreditation. This will help to regulate health care practice in the state.

3.3.4.4 Upgrade and refurbish health facilities to standard

The activities include identification and prioritizing facility needs from the accreditation findings; budget for the identified needs; and implement the upgrade and refurbishing of health facilities.

3.3.4.5 Dissemination of accreditation report to stakeholders

The activities include obtaining approval of the accreditation, print and distribute the document to all stakeholders at the state and LGA levels.

To increase access to health care services

3.3.4.6 **Provide health rangers scheme (eye camp, festival of surgery, community outreach) to those in need**

The activities are to constitute a committee for each component of the Health Rangers scheme; identified logistics; recruit personnel and execute the programmes.

3.3.4.7 IMNCH (free U5 & pregnant women, IMCI, LSS, FP, midwifery service scheme, neonatal nursing care prog.)

The activities include identify the needs of IMNCH components; develop proposal to implement IMNCH programme; Obtain approval for the implementation of IMNCH programme; and Implement the IMNCH at the state and LGA levels.

3.3.4.8 Establish standard blood banking services & Upgrading of diagnostic services

The activities are to constitute a blood banking committee to develop the central blood screening operational modalities and legal framework; Identify diagnostic needs per facility types from accreditation report; Put in place infrastructural and HR needs for blood banking services and diagnostic services; and procurement of equipment at the state level.

3.3.4.9 **Provision of standard laboratory at the LGA level**.

The activities are to identify laboratory needs and procure need laboratory equipments. It also includes monitoring and supervises laboratory services.

To improve the quality of health care services

3.3.4.12 **Continuation of activities on immunization, non- communicable dxs,TB& leprosy, Schisto, Oncho, RBM, and HIV/AIDS.**

The activities include identification of needed facilities, capacity building and procurement of identified needs for implementation of the programmes.

3.3.4.13 Provision of Personal Protective Equipment for health and industrial workers

The activities include constituting a committee to develop the legal framework for the provision of PPE at both public and private institutions; procure and distribute PPE for health facilities; and monitor the use of PPE in both public and private health facilities.

3.3.4.14 Conduct Health Education Programmes at the State and LGA levels.

The activities include advocacy to stakeholders, production and distribution of IEC materials, radio and television programmes, review of health education for primary, secondary and tertiary health institutions in the state.

3.3.4.15 Establishment of State Primary Health Care Development Agency

The activities are constituting committee to facilitate the implementation of the project; provision of logistics, provision of infrastructure, recruitment and training of personnel.

3.3.4.18 Improve Two-Way Referral Services

To achieve this, procurement of facilities to equip intensive care unit was proposed as well as improving inter and intra communication services. Logistics will be provided to enhance referral services.

3.3.4.19 Procurement of Drugs

The activities involved in this intervention are procurement of drugs according to the essential drug list and distribution to health facilities in the state.

3.3.4.20 Conduct regular monitoring exercises & ensure appropriate documentation & feedback

To achieve this intervention, logistic supports and HR are provided for M & E units. It also involves capacity building for HR development.

To provide financial access especially for the vulnerable groups

3.3.4.2,2 **Establish quality assurance unit in MOH & all public health facilities.**

A committee to develop the terms of reference for the establishment of quality assurance in health care delivery will be put in place. Logistics support will be provided while personnel will be recruited and trained to implement the activity.

3.3.4.2.2 Establish SERVICOM in all health facilities

A committee to develop the terms of reference for the establishment of SERVICOM in all health facilities will be put in place. Logistics support will be provided while personnel will be recruited and trained to implement the activity.

3.3 Priority Area 3: Human Resources For Health

3.3.1 Context

The role of Human Resources for Health (HRH) in improving health system performance cannot be overemphasized. Although the State provides continuous education for its health staff exodus of health workers especially physicians, nurses and pharmacists to Federal institutions continue to cripple service deliver in the state.

In order to provide dedicated care for mother and child and to effectively reduce the delay in care provided at the healthcare service centers, which has been identified in the State as being one of the contributing factor to maternal mortality in the state there is need to address the HRH gap.

3.3.2 Goal

The goal is to plan and implement strategies to address the human resources for health needs in order to enhance its availability as well as ensure equity and quality of health care.

3.3.3 Strategic Objectives

2.3.3.1 To formulate comprehensive policies and plans for human resource for health development

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

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

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

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

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

3.3.4 Proposed Interventions

Evidence-based interventions that contribute to the achievement of each specific objective were considered for both the state and LGA as indicated below.

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

3.3.4.1 Development and Institutionalization of the Human Resources Policy framework

The activities of the intervention include domestication of National HRH Policy and Strategic Plan by the State and the LGAs; develop a policy framework to guide existence of private and public practitioners at all levels of health service delivery at the state; and establish a fora for public-private practitioners to institutionalize HRH policy reviews, supervisory and monitoring frameworks at the state and LGA. In addition, the LGAs will implement the reviewed policy.

3.3.4.2 Review existing policy on public/private practice

To achieve this intervention, a committee will be constituted to review public/private policy at the state, forward same to the Executive Council for approval and disseminate the information to stakeholders. The LGAs will implement the approved policy guidelines.

3.3.4.3 Produce adequate manpower human resources for health

The activities include identification of HRH needs, recruitment and training of personnel at both the state and LGA levels. In addition, the reviewed remuneration will be implemented by both state and LGAs.

3.3.4.4 Institutionalize continuous assessment of health training institution to meet accreditation standard of regulatory bodies

To achieve this intervention, it was considered necessary to provide minimum level of infrastructure for teaching learning materials and welfare package for retention of health workers. Also, provision of equipment, tutors' training materials for the midwifery service scheme and the community midwifery programme. In addition, the state will establish accreditation committee for health training institutions.

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

3.3.4.5 Reappraisal of the principles of health workforce recruitment at State and LGA levels

The state plans to establish a coordinating committee for consistency in HRH planning and budget and strengthening State and LGA capacities to assess Federal Government Circulars, guidelines and policies relating to HRH. The LGAs will adopt the principle of health workforce requirements and recruitment.

Strengthen the institutional framework for human resources management practices in the health sector

3.3.5 To establish and strengthen the HRH Units

The state and the LGAs will establish HRH units to strengthen HRH performance as well as organize training programmes in human resource on health planning and management at all levels to enhance the HRH managers. Also, they will review and adapt relevant training programmes for health workers in critical areas of need. In addition, the LGAs will provide monitoring and supportive activities.

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

3.3.4.4. Review and adaptation of relevant training programmes for the production of adequate number of community health oriented professionals based on national priorities

The state will design special training programmes aimed at producing middle level cadre of health professionals in critical areas of need (e.g community midwives). It will also s strengthening HRH regulatory body for regular review of functions and mandates and private - public partnership in HRH development and management.

3.3.4.5 Strengthening of health workforce training capacity and output based on service demand

The state will establish quality assurance and education units in all the training institutions and strengthen accreditation system for the institutions. It will also set up a committee to review curriculum for the institutions and establish a regulatory body to promote and coordinate capacity building in the state.

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

3.3.4.6 Equitable distribution, right mix and retention of the right quality and quantity of health human resource

Both the state and LGAs will embark on recruitment, selection and deployment of competent health workers in critical areas of need and redeployment of health workers equitably to both rural and urban. They will also institute performance based incentives for workers.

3.3.4.7 Establishment of mechanisms to strengthen and monitor performance of health workers at all levels

Re-orientation of health workforce on positive attitudinal changes, including training on Interpersonal Communication skills (IPC), work ethics will be established by the state and the LGAs. Both state and LGAs will design a check list for monitoring work force performance and establish a feedback mechanism.

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

3.3.4.8 Strengthening communication, cooperation and collaboration between health professional associations and regulatory bodies on professional issues that have significant implications for the health system

Both the state and LGAs will creation of a partnership forum between intra and inter health professional associations and involve representatives of professional associations in management boards.

3.4 Priority Area 4: Health Financing

3.4.1 Context

Poverty level is a major factor affecting individual and household decision making on utilization of health services. Due to poverty majority of the people of Taraba State under-utilize modern health care services leading to poor health outcomes. This is due to lack of knowledge and negative perception and cost of services including costs of drugs, consumables and even travel to health facilities.

It has been recommended by the Commission for Macroeconomics and Health estimates a cost of about US$34 per person per year (per capita) to deliver an essential package of interventions to meet the Millennium Development Goals (MDGs). It is also recognized that the poor spend a disproportionately higher percentage of disposable household income on healthcare and in the absence of social protection mechanisms (health insurance, social security or credible exemptions), this population face challenges of financial barriers to care. at the time of need [NSHDP]. As a result, the poor find it difficult to seek care in time or deepens their impoverishment when they are compelled to make health expenditure.

In Taraba State, healthcare is financed from budgetary allocations from States and LGAs, private out-of-pocket expenditure, external development funding, grants from corporations and charities and a small but growing. Recently, the state commenced a

programme aimed at protecting vulnerable population from the financial risk of ill-health, such as free maternal and child health services. Nonetheless, in order to achieve the level of funding required for meeting the health needs of the whole population, the state has to put in place mechanisms for increased funding both in absolute terms and as a proportion of the total budget as well as the coordination of all the resources available to the sector from all sources. Measures will be put in place to establish Community-based Health Insurance Scheme (CHIS) that incorporates programmes covering informal sector workers and community-based health insurance; social health protection models targeted at the poor and vulnerable groups such as free maternal and child health (MCH) services,.

3.4.2 Goal

To ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and consumption at LGA, State and Federal levels.

3.4.3 Strategic Objectives

2.4.3.1 To develop and implement health financing strategies at Local, State and Federal levels consistent with

the National Health Financing Policy

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

health services

3.4.3.3 To secure a level of funding needed to achieve desired health development goals and objectives at all

levels in a sustainable manner

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

3.4.4 Interventions

Descriptions of evidence-based interventions contributing to the achievement of each specific objective are presented below. Appropriate interventions were identified based on the stewardship role and mandate of both the state and LGA.

To develop and implement health financing strategies at Local, State and Federal levels consistent with the National Health Financing Policy

3.4.4.1 Strategic Health Financing Plans

Both the state and LGAs will develop, disseminate and implement evidence-based, costed, and prioritised health financing strategic plans in line with National Health Financing Policy. Also, they will set up technical working groups for health financing at and conduct capacity building identified local persons.

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

3.4.4.2 System for Financial Risk Health Protection

Both the state and LGAs plan to explore existing and innovative approaches for sustainable health financing with protective measures against the financial risks associated with ill health. They will also scale up successful approaches to achieve wide population coverage and establish Community-based health Insurance Scheme.

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

3.4.4.3 Improving Financing of the Health Sector

Both the state and LGAs will establish a guideline for a specific percent of IGR to be ploughed back into the health system and sensitize relevant stakeholder to the need to plough back specific percent of IGR into health system. The LGAs will set up Local Government Health Authority to enhance health expenditures.

3.4.4.4 Donor Coordination of Funding Mechanisms

The state and LGAs will explore available health care financing option and strengthen existing ones. They will also strengthen existing government and development partners structures and functions and establish joint funding for coordinating government and donor resources.

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

3.4.4.5 Health Budget Execution, Monitoring and Reporting

The state and LGAs will update the existing health accounts and strengthen monitoring and evaluation unit in the health sector. They will also establish credible mechanism to increase financial transparency through institutionalization of state/Local Government Health Account (SHA/LGHA) and public expenditure review

3.4.4.6 Strengthening Financial Management Skills

The state and LGAs proposed capacity building on financial management skills

3.5 Priority Area 5: National Health Information System

3.5.1 Context:

The health information management system functions fairly efficiently. Data collected from the health facilities in a LGA are submitted to the LGA Monitoring & Evaluation Officers and from there forwarded to the Directorate of Planning, Research and Statistics of the State Ministry of Health. From there, they are forwarded to the equivalent department at the Federal Ministry of Health. Available evidence shows prompt submission of the completed data form to the State level from the LGA. The overall quality of data being collected in the State in terms of its accuracy, as the 2008 data quality self-assessment indicated that it was high[14]. However, as the result of the QDS further shows, there are significant problems with the quality of the monitoring system at

the LGA level, with the score for all the five elements of interest – recording, archiving, use of data, demographics, and core outputs being low.

3.5.3 Goal

To provide an effective National Health Management Information System (NHMIS) by all the governments of the Federation to be used as a management tool for informed decision-making at all levels and improved health care

3.5.4 Proposed Strategic Objectives

3.5.4.1 To improve data collection and transmission

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

3.5.4.3 To strengthen sub-systems in Health Information System

3.5.4.4 To Monitor and Evaluate the NHMIS

3.5.4.5 To strengthen analysis of data and dissemination of health information

3.5.5 Interventions

Evidence-based interventions that have potential to contribute to the achievement of the specific objective are presented below. Appropriate interventions are based on the stewardship role and mandate of the state and LGAs.

To strengthen data collection using nationally standardized forms

3.5.5.1 Ensure availability of NHMIS tools at all health service delivery points at all levels

Both the state and LGAs proposed to provide data collection tools and internet Acess for HMIS and PHCM&E (for MOH&HMB), capacity building for HMIS and PHCM&E activities, training of private health facilities and TBAs on PHC data collection and processing, provide budget line for HMIS and PHC M&E and establish monthly review meeting on data collected from all health facilities at the LGA level.

3.5.5.2 Periodic review of NHMIS data collection forms

The state will print and distribute data collection tools to LGAs for onward distribution to health facilities to collect data. The capacity of staff will be strengthened to collect data from both public and private health facilities. While data will be collected from public and private health facilities the LGAs will provide feed back to all health facilities. The state will ensure to provide budget line and release fund for actualization of the activities.

3.5.5.3 Coordinate data collection from vertical programmes

The activities of this intervention include regular data collection from LGAs. The data will be collated and processed. While data collection activities will be monitored and supervised appropriate coordinating measure will be put in place. There will be regular review meetings of data collection officers and collaboration between HMIS and PHCs M&E.

3.5.5.4 Build capacity of health workers for data management

Comprehensive training and re-training of M&E and HMIS officers and health workers in both public and private health facilities on data collection tools, analysis and utilization of data for action in health programming and policy formulation will be conducted at both state and LGA levels. Also, there will be advocacy for SMOH to recruit health management information officers into all health facilities. The LGAs will train all Medical Records officers & head of all health facilities on data base and advocate for Local Government Service Commission to recruit health management information officers into all Health facilities.

3.5.5.5 Provide legal framework for activities of the NHMIS programme

There will be advocacy and sensitization workshop for policy makers on compulsory health data reporting while legal backing will be provided for data generation. Printing, dissemination, distribution, and enforcement of health data law will be carried out

throughout the state. The state will provide adequate monitoring and evaluation mechanisms.

3.5.5.6 Improve coverage of data collection

There will be printing and distribution of data collection tools to all health facilities (Public and Private) and provision of fund for M&E officers for data collection from all health facilities in the LGAs. Also, there will be monthly cluster meetings and submission of data at State level and sensitization workshop on data flow path for stake holders in health sector. The LGAs will provide fund for M&E officers for data collection from all health facilities and organize sensitization workshop on data flow path for stakeholders in health sector.

3.5.5.7 Supportive supervision of data collection at all levels

At the state level, there will be advocacy to SMOH to provide Vehicles for Monitoring and Supervision and quarterly Monitoring of all health facilities (Public and Private) as well as bi - annual review meetings with all stakeholders. In addition, the LGAs will put in place strategies for sustainable use of existing means of transportation for Monitoring and Supervision.

To provide infrastructural support and ICT for health databases and staff training

3.5.5.8 Strengthen the use of Information technology in HIS

There will be capacity building for all data officers on ICT and provision IT platform at both the State and LGA levels.

3.5.5.9 Provision of HIS Minimum Package at the LGA level of data management

Office space & Infrastructure will be provided for M&E unit in the LGAs.

To strengthen sub-systems in Health Information System

3.5.5.10 Strengthen Hospital Information System

H.ealth workers will be trained on data collection at the health facility level. At the LGA level strategies will be put in place to provide and sustain alternative power supply. Also, the LGAs will train and re-train all health workers.

3.5.5.11 Strengthen Disease Surveillance

Strategies will be put in place to integrate disease surveillance into Monitoring and Evaluation at all levels. While the state and the LGAs will build the capacity of DSNO/M&E officers there will be monthly review meeting of HDCC and PHCM&E data collection officers from the 18 LGAs. Both the state and LGAs will strengthen active surveillance activities.

To monitor and evaluate NHMIS

3.5.5.12 Establishment of monitoring protocol for NHMIS programme implementation at all levels in line with stated activities and expected outputs

There will be advocacy to State to provide Vehicles for Monitoring and supervision activities. Two State M&E officers will be trained on E-Monitoring and quarterly health service review meeting will be held with all stakeholders.

3.5.5.13 Strengthen data transmission

Monthly meeting of data collection officers will be held for submission of data. Also, quarterly review meeting will be held with data collection officers and other stakeholders

*To strengthen analysis of data and dissemination of health informatio*n

3.5.5.14 Institutionalize data analysis and dissemination at all levels

M&E and HMIS officers will be trained on data analysis and internet process at the state and LGA levels. Information generated will be disseminated to policy makers on health and there will be printing and distribution of quarterly bulletin and website development

for health information. In addition, the LGAs will provide bi-annual policy briefs to communicate to policy makers.

3.6 Priority Area 6: Community Participation And Ownership

3.6.1 Context

Community participation in health development is a major strategy adopted and practiced in Taraba State with limitations in scope, impact and the lack of clear policy framework. Although the state's attempts to promote community participation in health development started with the introduction of PHC in 1986 in line with the Nigeria health policy. The state adopted the national guidelines developed for PHC planning and implementation, including those for community participation.

Following the introduction of PHC in the state training of various practitioners including the traditional birth attendant (TBAs) and village health workers (VHWs) took place. The TBAs were to assist in home deliveries while the VHWs were to provide basic curative care and health education. While there were guidelines for linking this cadre of health care providers to the formal health sector, they were never implemented. The system for replenishing their health commodities was badly implemented. Also, the mechanism for their supervision was not appropriately implemented leading to the collapse of the programme. However, other programs have continued to train and support this cadre of workers, albeit on a limited scale. More recently, many programmes have successfully introduced the training of different cadres of community-based health care providers like community drug distributors of ivermectin for onchocerciasis, community-based distribution agents for family planning commodities, vaccinators for polio eradication campaigns, community oriented resource persons (CORPs) for IMCI, community volunteers for the community-based TB programme, home-based care providers for home management of HIV/AIDS and role model mothers for home-based malaria treatment and control.

In 1987, community participation propagated the concept of Bamako initiative through which essential drugs were distributed for improving maternal and child health by the improving the quality of the PHC services. A nationwide evaluation of BI by NPHCDA in 2001 showed a massive decapitalization of the funds and minimal evidence of community participation in the management of the drugs. In Taraba State presently, the health sector pays for services through out-of-pocket expenditure; thus limiting access to health services.

Despite the introduction of community participation in Taraba State there was minimal engagement of the people leading to limited involvement of the people in health care provision. Community participation was reduced to nothing more than provision of building, land and some financial commitments. Generally, communities still rely very much on government to provide all social services. In Taraba State, inadequate community participation has also resulted in inappropriate sitting of PHC facilities in places where they are not accessible or acceptable locations. Hence, this has led to gross underutilization of PHC services in many parts of the state.

3.6.3. Goal

To attain effective community participation in health development, as well as community ownership of sustainable health outcomes

3.6.4. Strategic Objectives

3.6.4.1. To strengthen community participation in health development

3.6.4.2. To empower communities with skills for positive health actions

3.6.4.3. To strengthen the community-health services linkages

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

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

2.6.5 Interventions

Below are the descriptions of evidence-based interventions that can contribute to the achievement of each specific objective.

To strengthen community participation in health development

3.6.5.1 Provide an enabling policy framework for community participation

The state will conduct a needs assessment to be able to determine areas where community participation will be most appropriate. Stakeholders will be involved in the community health policy formulation. Community health bill will be prepared and disseminated to the stakeholders and at the LGA level.

3.6.5.2 Provide an enabling implementation framework for community participation

The activities include establishment of new and revival of existing health committees. There will be capacity building activities at the community levels and conduct regular community stakeholders dialogues. Budget line will be provided for community-based activities while monitoring and supervision mechanisms will be put in place.

3.6.5.3 To provide effective monitoring, supervision and evaluation of community health services

The state and the LGAs will establish community level monitoring and evaluation unit and provide capacity building at the community level. They will also procure M&E tool, equipments and material for use and put in place structures for documentation and reporting system.

To empower communities with skills for positive health actions

3.6.5.3 Building community capacity

There will be training of community level health officers at both the state and LGA levels. Community level stakeholders dialogues will be conducted while community

participation will involve procurement of equipment and materials. Also, regular skill acquisition workship/seminars will be conducted.

To strengthen the community-health services linkages

3.6.5.4 Restructure and strengthen the linkages between the community and health services delivery points

(i) Review and assessment of the levels of linkages of existing health delivery structures with the community; (ii) provide technical guidance and support to community stakeholders for the development of guidelines to strengthen community-health services linkage; (iii) restructuring of health delivery structures to ensure adequate promotion of community participation in health development; and (iv) facilitate exchange of experiences between and among communities development committees

To increase national capacity for integrated multi-sectoral health promotion

3.6.5.5 Develop and implement multi-sectoral policies and actions that facilitates community involvement in health development

At the state level, there will be promotion of easy access to health care services as well as utilization of health care services. The state will also promote referral of health cases between traditional health practitioners and health facility. Enabling environment will be provided for public/private partnership. The LGAs proposed to mainstream nutritional issues and water and sanitation to community health system.

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

3.6.5.6 To develop and implement systematic measurement of community involvement

Community involvement in health services will be diagnosed. Community involvement and ownership mechanism will be established, documented and reported. Linkage

between community and research institutions will be provided and provide community focused health research.

3.7 PRIORITY AREA 7: PARTNERSHIPS FOR HEALTH

3.7.1 Context

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

3.7.1 Goal

To enhance harmonized implementation of essential health services in line with national health policy goals.

3.7.2 Strategic Objectives

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

3.7.4 Recommended Interventions

Descriptions of evidence-based interventions contributing to the achievement of each specific objective are presented below.

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

3.7.4.1 Public Private Partnerships (PPP)

A 10-member- committee will be set up to develop guidelines for implementing PPP initiatives. Also, a 5-member committee will be set up to monitor the implementation of

PPP initiative. Training and quarterly meetings will be organized for stakeholders in the PPP initiative. Adequate budgetary allocation will be made for PPP in the state, DPRS/ Consultants. The state will establish 3 zonal medical stores.

3.7.4.2 Coordination of Development Partners

A unit will be established at the state MOH for the implementation of PPP initiative as well as initiate and ensure the passing of an enabling Act to legalize the activities of PPP. Adequate logistics will be provided for the activities of the PPP and establish State Health Insurance scheme for Under-5 and Pregnant Women.

3.7.4.3 Inter-Sectoral Collaboration

An inter-sectoral committee involving Finance, Education, Agriculture, Water resources will be established as well as enlist the interest of development partners (Donors) in providing financial/ technical support. Bi-annual meetings between the various development partners in the PPP project will be put in place.

3.7.4.4 Engaging Professional Groups

The interest of all Medical and health professional institutions e.g NMA, PSN, AGPMPN, NACHPN, NANMN, AMLS will be enlisted. Also, guidelines will be developed for the involvement of the participating professional institutions as well as accredit various professional institutions interested and willing to participate in the PPP project. Participating institutions will be trained on the scope of PPP.

3.7.4.5 Engaging Communities

A functional PHC management committee at the LGAs will be established. Also, LGA staff and other stakeholders will be trained on the PPP project. Ten major communities in each ward will be sensitized about the products available for healthcare delivery. The PPP project at the LGA level for Under 5 and Pregnant women will be implemented. In addition, the existing LGDC, WDC & VDC committees will be strengthened while the LGA staff and other stakeholders on the PPP project will be trained. Then the PPP project in line with MDGs 4,5&6 will be implemented.

3.7.4.6 Traditional Medical Practitioners

Guidelines will be developed for the involvement of traditional medicine practitioners as well as enlist the interest of registered traditional practitioners in health care delivery. Practicing ones will be accredited and trained regularly on the PPP project.

3.8 Priority Area 8: Research For Health

3.8.1 Context

Despite the importance of research for health little or no research activities have been embarked upon by Taraba State. As a result, the state has minimal relationship with research institutions but rely heavily on data from development partners and related organizations for decision making. As a result, funding for health research in the state is meager with evidence indicating less that the recommended 2% of health expenditure by African Health Ministers and agreed to by the National Council on Health. The paucity of these allocations to the Health Sector had affected the quality and depth of health research in particular as the case is at the federal level.

Inadequacies in health research in the state are due to lack of coordination in research, lack of regular fora to discuss health research, poor linkage between research and policy, as well as between international and national research agenda [NSHDP]. Similarly, inadequate research priority setting, dearth of research infrastructure, capacity building strategies, documentation and publication are also responsible factors. The state has weak Research Ethics Committee resulting in poor adherence to ethical guidelines in medical research. Also, monitoring and evaluation of research is limited and researchers are not adequately motivated. Currently, there is no legal framework mandating a depository of researches and output of databases in the country. To fill these gaps it is important to develop strategic agenda that will enhance functional research for health activities in the state.

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

3.8.2. Strategic Objectives.

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

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

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

3.8.4.4 To develop, implement and institutionalize health research communication strategies at all levels

3.8.5 Recommended Interventions

Some evidence-based interventions that have potential to contribute to the achievement of each specific objective are presented below

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

3.8.4.1 To develop health research policies and strategies at state and LGA levels.

Technical working group will be convened to develop health Research policies and Strategy in the state and in the LGAs. Also, guidelines will be developed and provided for the establishment of health research Steering Committee at State & LGA levels and monitor and evaluate the activities of the Health Research Steering Committee at State & LGA levels

3.8.4.2 Establish and or strengthen mechanisms for health research at all levels

Technical assistance will be provided to develop & strengthen the capacity of health research division & units in the State. Also, technical assistance will be provided to strengthen DPRS to be able to undertake active research work as well as in the area of data collection, storage & management at the State & LGAs levels. In addition, the LGAs will implement mechanisms for health research and undertake active research works as well as data collection, storage and management.

3.8.4.3 Institutionalize processes for setting health research agenda and priorities

Essential National Health Research programmes will be adopted with modifications for implementation at the State and LGA levels. Also, health research will be mainstreamed into health determinant factors at the State and LGA levels.

3.8.4.4 Promote cooperation and collaboration between Ministries of Health and LGA health authorities with Universities, communities, CSOs, OPS, NIMR, NIPRD, Development partners and other sectors

While a stakeholders' forum will be convened to stimulate research activities guidelines will be developed and disseminated for a collaborative research agenda. A forum of health research Officers in SMOH, LGA, FG Institutions will be established at state and LGA levels. Also, support development & implementation of collaborative research committee to harmonize proposals will be set up at state and LGA levels.

3.8.4.5 Mobilization of adequate financial resources to support health research at all levels

In line with the recommendation of African governments the state and the LGAs plan to allocate at least 2% of health budget for health research and advocate collaboration with development partners to support in the funding of essential health research activities at state and LGA levels. Individuals and Non-Governmental Organizations will be encouraged to support and or participate in the conduct of health research at state and LGA levels. Also, the state and the LGAs will encourage various health institutions in the State to sponsor research in areas of relevant health service delivery.

3.8.4.6 Establish ethical standards and practice codes for health research at all levels

The state and the LGAs proposed to establish and/or strengthen health research ethical mechanisms, guidelines and ethical review committees. They also proposed to establish Mechanism to monitor, evaluate & regulate research activities and utilization of research findings.

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

3.8.4.7 Strengthen identified health research institutions at all levels

The state and the LGAs planned to take inventory of all public and private Institution and organization undertaking health research projects. They also will conduct bi-annual assessment of all research institution engaging in health research and develop capacity of all institution/organizations engaging in health research. The state and the LGAs plan to Collaborate with development partners for funding of research projects collaborate with development partners for funding of research projects.

3.8.4.8 Create a critical mass of health researchers at all levels

The state and LGAs propose to develop appropriate training intervention for research based on the identified needs and establishment of competitive research grants for researchers to access. Scholarships will be provided for PhD and internships by the state and the LGAs.

3.8.4.9 Develop transparent approaches for using research findings to aid evidence-based policy making at all levels

While the state will establish research-to-policy research agenda the LGAs will do the implementation. Also, why policy makers will be engaged in evidence-to-policy decision making researchers will be engaged in policy oriented researches at state and LGA levels.

3.8.4.10 Undertake research on critical areas already identified in different forums

Both the state and LGAs will conduct burden of disease, health delivery, system of governance and human resource for health researches bi-annually. Also, they will conduct health financing risk protection, equity, efficiency and value of all health financing strategies annually.

3.8.4.11 Undertake research on identified critical priority areas

Both the state and LGAs will track inflow and outflow of resources in the health sector.

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

3.8.4.12 Develop strategies for getting research findings into strategies and practices

The state and LGAs will develop data banking and research library. The state will develop a website for research activities.

3.8.4.13 Enshrine mechanisms to ensure that funded researches produce new knowledge required to improve the health system

Needs assessment will be conducted by the state and the LGAs to identify required health research gaps. While the state will also develop guidelines for annual operation research to be conducted by Departments and agencies in SMOH and LGAs, the LGAs will implement guidelines for annual operational research to be conducted by Departments at the LGA.

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

3.8.4.14 Create a framework for sharing research knowledge and its applications:

The state will develop and Implement a framework for sharing research knowledge in the State. Annual review meetings will be organized by the state and the LGAs to deliberate on utilization of research findings in the State as well as convene annual conference,

workshops and seminars for information dissemination. Research findings will be published in journals and periodicals.

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

Annual seminars and workshops will be established for policy makers and researchers on research findings by the State and the LGAs while researchers' capacities will be developed to write policy briefs, articles and reviews. The state will take an inventory of national journals according to areas of focus and publish research findings. In addition, the LGAs will conduct annual seminars and workshops for policy makers and researchers on research findings.

3.8.4.16 Encourage subscription for high quality health sector journal in the state

The state and LGAs will subscribe to high quality impact making health journals.

Chapter 4: Resource Requirements

An attempt to achieve the millennium development goals, many critical challenges confronts healthcare systems in Taraba State. Development of healthcare systems and improvement in health outcomes, based on investment in programmes focusing on specific diseases, continues to fragment health systems, leaving the basic infrastructure weak and incapable of delivering equitable, broad based services. There has been much discussion about integrating the primary, secondary, and tertiary tiers of the health system but inadequate attention has been paid to identifying and strengthening the actions that are required to deliver the basic package of care

4.1 Human

The gap analysis of the needs of the State revealed the urgent need to address the issue of worsening health indices in the state. Taraba State has a maternal mortality rate of 371/100,000 live birth and an infant mortality rate of 68/1000 live birth and was pronounced by the world bank in June 2009 as having the worst health indices in the South/Western zone of the country[4].

The Doctor/Patient ratio in the State is currently 1:14,000 as against 1:5,000 recommended by the World Health Organization (WHO)/global standard for the health sector. According to a recent study in the state[5], he health workers in the employment of the State government include: 10 consultants, 138 medical officers, 908 nurses, 116 medical laboratory technologists/scientists, 75 X-ray technologists, and 21 medical laboratory officers. The study also indicated that the density of health workers for the State is approximately 0.35 per 1000 population. The density increases to 0.48 per 1,000 population with the addition of doctors and nurses at the Federal Medical Centre, Owo,

[4] Fatusi A, Situation analysis of maternal, newborn and t.

and will be improved still with the addition of health care workers in private practices but an accurate statistics or reliable estimates were not available in that respect.

A total of 1932 Community Resource Persons (CORPS) have been trained by the state essentially at the primary health care level/LGAs. Other categories of health practitioners namely traditional and spiritual-home based birth attendants exist in the State. Also, NGOs and private hospitals provide health care services in the state. Presently, there is no formal coordination mechanism. The State has no specific RH data focusing on the implementation of MNCH. More than 80% of the health expenditure of the State government is devoted to personnel remunerations. This has significant implication for effective services in terms of facilities and equipment, among others.

The State owns a School of Nursing and Midwifery in Jalingo, and two Schools of Health Technology in Takum and Wukari. The Director of Nursing Services in the Ministry of Health has oversight for the Schools of Nursing and Midwives, while the Director of Health of Primary Health Care has oversight for Schools of Health Technology.

4.2 Physical/Materials

The physical components include the infrastructure and capital equipment. Each healthcare facility requires an efficient process for generating and using evidence in policy making, implementing services, managing procurement and distribution, organizing logistics and maintaining equipment, using human resources appropriately, and efficient financial management.

Lack of adequate number of functioning equipment will affect the quality of service provision. Data showed that the tertiary and private were well equipped with basic medical and surgical equipments. The situation is contrary in the secondary health care facilities and extremely poor in the PHC.

4.3 Financial

The financing of health care in Taraba State is challenging due to the limited resources available in the face of competing demands. As a result, free healthcare programmes and social protection strategies remain inequitable and are not sustainable. Health care provided by the public sector is constrained by annual health budgets less recommended 2 - 5% of annual budget. Various mechanisms have been devised to increase health resources. Health insurance scheme is yet to commence in the state. The state has implemented user fees and has established revolving funds for specific services and programmes. Such funds may be a rational response to a specific need, but having many revolving funds operating outside the financial management system of the central administration may prove overwhelming. Similarly, centrally administered accounts focused on specific diseases make it difficult to coordinate investments in the public health sector and to track donors' contributions and manage public/private partnerships

Chapter 5: Financing plan

5.1 Estimated cost of the strategic orientations

Total for the State and sixteen LGAs is four billion, seven hundred and forty eight million, nine hundred and nine thousand, six hundred and three naira (NGN43,748,909,603) only. This is detailed by priority area in the table below.

PRIORITY AREA	COST (NGN)
Leadership And Governance For Health	**254,724,231**
Health Service Delivery	**24,255,560,782**
Human Resources For Health	**13,179,877,142**
Financing For Health	**3,079,854,738**
National Health Information System	**1,230,523,863**
Community Participation And Ownership	**620,214,341**
Partnerships For Health	**495,950,477**
Research For Health	**632,204,030**
TOTAL	**43,748,909,603**

5.2 Assessment of the available and projected funds

Data from the recent ranking of states by the World Bank shows that Taraba State along with its LGAs spend USD 10.9 per capita. Applying this to a population of 2,300,736 people, gives a total health spending by the State and its LGAs of USD 25,078,022.40 equivalent to NGN 3,761,703,360.00. Assuming that this level of expenditure will be sustained over the next 6 years, the projected funds will be 22,570,220,160.00 for the period 2010-2015.

5.3 Determination of the financing gap

This is the difference between available and projected funds and the estimated cost of the Taraba State SHDP. NGN**43,748,909,603 minus NGN**22,570,220,160.00 = NGN21,178,689,443 over the six year period or NGN3,529,781,573.86 annually.

5.4 Descriptions of ways of closing the financing gap

*Community-based Health Insurance***:** The state needs to initiate the process of operating community-based health insurance scheme (CHIS). Similarly funds from sources such as Debt Relief Gains/ MDG fund and donor assistance will go a long in ensuring implementation of the SHDP

Policy on payment for cases of emergency obstetric, newborn and child care: The free health policy of the state covers all phases of pregnancy and delivery, and all forms of treatments including surgical interventions. One of the challenges of the scheme is the increasing number of patients patronising services such as antenatal clinics leading to extended waiting time.

Other Payment Schemes: In addition to the modes of financing discussed above, user-fee payment scheme is a major source of health care financing in the state. Also, the State has a drug revolving scheme that fits into the larger vision of pharmaceutical management programme. One of the objectives of the programme is to have in place a self sustaining drug, diagnostics and supplies distribution network using public and private providers.

Chapter 6: Implementation Framework

Strategies for implementing the framework will utilize the exiting structure in the state. In some cases, new structures are put in place while the weak ones will be strengthened. The Taraba State Ministry of Health (SMOH) formulates policies for health services delivery and implementation with the Hospitals' Management Board (HMB) as well as Local Government Authorities (LGAs). Each of the 16 LGAs is responsible for managing the Primary Health Care (PHC) system, including community health activities such as immunization and health education; hygiene and provision of basic outpatient services at its maternities, among others. The State provides a supportive linkage to the LGAs through management of referrals from the PHC level, to the secondary level as well as technical guidance.

Mechanisms for developing and maintaining relationships have been established with relevant groups and programmes in the state. For instance the World Bank, UNICEF, and other development partners are working in the state. The relationship of the healthcare managers in the state with the national health system and other public sectors will enhance adequate implementation of the framework. Also, relationships with communities and foreign development partners should be nurtured through effective communications systems.

The role of development partners is critical to the implementation of the framework in the state. The substantial financial aid that they provide can help to close the funding gap in operating health services in African countries—but they may be tempted to operate independently of national goals and strategies. Secondary care facilities which is outside emergency funds for MNCH, where 50% of the facility had the community participating, community participation was mostly absent in other areas. Community participation was also absent in most PHC facilities for the areas of focus except with regards to monthly community growth monitoring. Communities participate in three – emergency transportation, health and nutrition education, and active screening and referrals in

private health care provisioning. There is no community participation at the tertiary health facility.

The major international development agencies working in the State are the United Nations agencies, in particular the World Health Organisation (WHO) and the United Nations Children's Fund (UNICEF). Both are intensely involved in the childhood immunisation campaign and are working together to support the State in the implementation of Expanded Programme on Immunisation/Polio Eradication Initiative (EPI/PEI). Their activities include strengthening routine immunisation, supplemental immunisation activities, integrated disease surveillance and response, advocacy and social mobilisation, vaccine security and logistics. World Bank is also providing support in the areas of health system strengthening and HIV response.
United States Agency for International Development (USAID) through Society for family Health (SFH) and Global HIV/AIDS in Nigeria (GHAIN) has also funded some studies relating to MNCH in the context of the national HIV/AIDS and Reproductive Health Survey and the Behavioural Surveillance Survey. Family Health International/GHAIN is also providing support to the Federal Medical Centre, Jalingo in respect of HIV/AIDS screening and case management. Other partners involved in HIV care and control are Institute of Human Virology and UNICEF. A coordination mechanism for donors exists mainly in the context of a coordination committee for EPI/PEI.

The State partners with civil society organisations in its MNCH programme, particularly with respect to social mobilisation for childhood immunisation and polio eradication initiative. These include National Council of Women Societies, Rotary Club, Red Cross, Market Women society, National Union of Road Transport Workers, Chairman of the Christian Association of Nigeria, and the Chief Imam. Network of people living with HIV/AIDS is involved in HIV work in the State, including the provision of home-based care. The faith-based groups are involved in HIV testing and related HIV/AIDS care and management services in the State. Planned Parenthood Federation of Nigeria is involved in family planning services in the State.

Chapter 7: Monitoring and Evaluation

6.1 Proposed mechanisms for monitoring and evaluation

There is weak organizational structure for M&E in the state. As a result, there is limited human and material capacity for carrying out M&E activities. In order to monitor and evaluate the implementation of the programme in the state first the will be structural arrangement through institutional development. This will help to assign responsibilities to individuals about the program. This will enhance supportive supervision that is presently lacked in the state.

Towards a successful implementation of the framework

(i.) develop performance indicators for the entire health system for monitoring and evaluation;

(ii.) actively engage in operational research and data gathering on all health issues; and

(iii.) establish monitoring and evaluation committees at each local government area for effective coverage.

6.2 Costing the monitoring and evaluation component and plan

Capital and recurrent expenditures are involved in carrying out M&E of the plan. As a result, direct and indirect costs of providing M&E services are put into consideration while costing the M&E aspect of the plan. This is important because certain indirect costs may have significant effect on the extent to which M&E activities are carried out. All activities of the M&E will be meaningful when values are assigned to every activity. The unit cost of activities are summed up to give total amount that will be required to do the work.

Chapter 8: Conclusion

Taraba State has a written and published health policy that is fairly comprehensive, and a health reform process has been pursued over the last five years. Core elements of the policy and reform process are: human resources for health, quality improvement and management, health fund, pharmaceutical management programme, policy and strategy development, performance management, and communication and advocacy. The policy covers the issue of MNCH. The State policy on free medical treatment for all pregnant women and under-five children, which has been seriously pursued by the government, demonstrates the State's commitment to MNCH.

While access to MNCH and related services is fairly high in Taraba State, there are challenges in terms of the operations and the capacity of the facilities. Many health facilities are not able to provide quality health services or effectively meet the healthcare needs of clients due to lack of human and material resources. More than a quarter of the secondary health care facilities and majority of the primary health care centres are not opened on 24-hour basis. Most of the health workers across at all levels of care have not been trained in specific MNCH-related issues in the context of in-service activities. A significant proportion of the state public sector facilities (secondary and primary health care facilities) lack the appropriate human and materials resources. As a result, the majority of secondary and primary health care facilities fail to meet the standard for essential obstetric care facilities, implying their ineffectiveness to manage emergency obstetric and newborn conditions. The adolescent health service has particularly received poor attention in the State health care plans and activities. The activities of the health facilities in the areas of health prevention, promotion and clinical preventive services, including health education and counseling, lag behind management of diseases and health conditions considerably. In general, the private facilities are better endowed than the state public sector facilities.

The management information system functions fairly well. The quality of data collected is high. However, there are significant problems with the quality of the monitoring system at both the LGA and the facility level.

The State partners with a number of international development organizations, especially UN agencies. However, the coordination mechanism is weak. Also, the state collaborates with civil society organizations, but this is skewed more towards child immunization activities and HIV/AIDS. The partnership framework is, however, not consistently operationalized or sufficiently institutionalized. Community participation in health facility management and health care activities is generally low.

Annex1: Completed State Strategic Health Development Plan

TARABA STATE STRATEGIC HEALTH DEVELOPMENT PLAN						
PRIORITY						
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
LEADERSHIP AND GOVERNANCE FOR HEALTH							
1. To create and sustain an enabling environment for the delivery of quality health care and development in Nigeria							**254,724,231**
	1.1	**To provide clear policy directions for health development**			**All stakeholders are informed regarding health development policy directives by 2011**		**33,285,082**
		1.1.1	Improved Strategic Planning at State andLGA levels				**33,285,082**
			1.1.1.1	Re orientation and strengthening of Human resource capacity (State Planning Team)	100% skilled staff trained by 2013	Availability of fund	5,241,924
			1.1.1.2	Advocacy at State and LGA Levels in support of policy and implementation(one per year)	No of advocacy meetings carried out	Availability of fund	6,539,280
			1.1.1.3	Yearly Review of SSHDP/Preparatory meeting at LGA	No of review meetings held	Availability of fund	21,503,878
	1.2	**To facilitate legislation and a regulatory framework for health development**			**Health Bill signed into law by end of 2009**		**72,406,872**
		1.2.1	Strengthen regulatory functions of government				**72,406,872**
			1.2.1.1	yearly supportive supervision to 16 LGAs toEnforce Public acts and laws.	No of LGAs visited in a year	Availability of fund, cooperation of Law enforcement agent	5,920,168
			1.2.1.2	Joint Public-private professional development workshop(Biannual)	No. of joint public/private professional workshop held in a year	Availability of funds and cooperation of care providers	37,335,555
			1.2.1.3	Advocacy meeting with LGAs	Advocacy meeting held by 2010	Availability of funds and political will	251,150
			1.2.1.4	LGAs to appoint law firms to guide on the review	Law firm appointed by 2010	Availability of funds and political will	3,400,000
			1.2.1.5	Review and update all bye laws in line with National Health Care law	Bye laws reviewed and passed by 2011	Availability of funds and political will	25,500,000
	1.3	**To strengthen accountability, transparency and responsiveness of the national health system**			**80% of States and the Federal level have an active health sector 'watch dog' by 2013**		**149,032,277**
		1.3.1	To improve accountability and transparency				**149,032,277**
			1.3.1.1	Strenthening monthly management meeting at facility Level/Establish LG Health Project monitoring Unit	No. of HF holding monthly management meeting	lack of fund, monitoring and supervision, lack of commitment at Fac	136,003,081
			1.3.1.2	institute stakeholders' dialogue and feedback forum for enlisting input into health sector decision making.	Yearly holding of State council on health	lack of fund,and political commitment	7,780,686

			1.3.1.3	Advocacy meeting with traditional, religious and youth leaders on the need to form community watch dogs	% of LGAs with Community watch dogs by 2013	Availability of funds and willingness of the community to cooperate	232,794
			1.3.1.4	Create a data bank containing information on health projects	Health Project Monitoring Unit established by 2010	Availability of funds and political will	204,000
			1.3.1.5	Establish a joint forum between LG officials and stakeholders in health for exchange of information	Joint forum between LG officials and stake holders established by 2010	Availability of funds and political will	4,811,716
	1.4	**To enhance the performance of the State health system**			**1. 50% of States (and their LGAs) updating SHDP annually 2. 50% of States (and LGAs) with costed SHDP by end 2011**		**-**
		1.4.1	Improving and maintaining Sectoral Information base to enhance performance				**-**
HEALTH SERVICE DELIVERY							
2. To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare							**24,255,560,782**
	2.1	**To ensure universal access to an essential package of care**			**Essential Package of Care adopted by all States by 2011**		**3,914,085,050**
		2.1.1	To review, cost, disseminate and implement the minimum package of care in an integrated manner				**2,127,246,864**
			2.1.1.1	Review and cost minimun package at the State and LGA levels	costed min. package available	**Availability of Min. package from FMOH**	2,729,801
			2.1.1.2	Produce, distribute and implement minimun package to all HF	**% HF having mininmum package**	**availability of fund**	485,566
			2.1.1.3	Implementation of the IMNCH Strategy	1. Under-5 mortality rate 2. maternal mortality ratio	Availability of funds	2,124,031,497
		2.1.2	To strengthen specific communicable and non communicable disease control programmes				**1,563,335,108**
			2.1.2.1	Scale up RBM programme intervention to at least 80% of target population	**To reduce the Malaria burden by 50% by 2015**	**availability of fund and commodities**	438,983,300
			2.1.2.2	STD and HIV/AIDs control programme	**Reduction in prev. Rate of state HIV**	**Availability fund, cont. supports of partners**	771,488,342
			2.1.2.3	Scaling up of TBL control programmes to all Health Facilities	**Detection rate of 70% and cure rate of 85% of detected cases by 2013**	**Availability fund, cont. supports of partners**	108,249,143
			2.1.2.4	Onchocerciasis and Blindness control	**80% of community can sustain CDTI by 2015**	**Availability fund, cont. supports of partners**	61,016,259
			2.1.2.5	Immunization and Nutrition	**90% RI coverage and 98% <5 children not malnourished**	**Fund available and partners support**	183,598,064
		2.1.3	To make Standard Operating procedures (SOPs) and guidelines available for delivery of services at all levels				**223,503,078**

			2.1.3.1	Access SOPs from FMOH	**Availability of SOPs in SMOH**	**Availability of fund**	2,770,548
			2.1.3.2	Dessimination of SOPs to all HF	**% of Health Facilities with SOPs annually**	**Availability of fund**	4,855,663
			2.1.3.3	Conduct a bienniel training workshop for CHEWs and JCHEWs	**Training workshop conducted annually**	**Availability of funds and political will**	208,884,713
			2.1.3.4	Reproduce and distribute the Standing Order to CHEWs and JCHEWs	**Standing Orders reproduced and distributed 2010**	**Availability of funds and political will**	6,992,154
	2.2	**To increase access to health care services**			**50% of the population is within 30mins walk or 5km of a health service by end 2011**		**17,701,702,568**
		2.2.1	To improve geographical equity and access to health services				**8,972,488,472**
			2.2.1.1	Construction of FRH in Ussa LGA and new PHC Clinics in all the LGAs	**FRH functional in Lissam by 2011**	**Fund available and friendly environment**	4,960,690,823
			2.2.1.2	Completion and equipping of GH Takum	**Functional GH in Takum by 2010**	**Fund available and friendly environment**	902,307,153
			2.2.1.3	Renovation of all existing GH and LG PHC clinics	**All existing GH and LG PHC Clinics renovated**	**Fund available**	3,070,235,611
			2.2.1.4	Expansion of office accommodation in HSMB HQRS	**More office accommodation provided**	**Fund available**	39,254,885
		2.2.2	To ensure availability of drugs and equipment at all levels				**7,254,742,639**
			2.2.2.1	Review law establishing the EDP and HSMB	**EDP and HSMB reviewed laws available**	**Political will**	134,196
			2.2.2.2	Procurement and distribution of essential medicines annually	**Essential medicines available in all health facilities at all times**	**Available funds and logistic**	1,899,075,251
			2.2.2.3	Procurement and Distribution of equipments and consumables annually	**Quality equipment based on the MOH standard list available in all health facilities annually**	**Available funds**	4,674,597,931
			2.2.2.4	Engage the services of a biomedical engineering firm to take inventory, refurbish and do preventive maintenance of equipment and train local staff on simple maintenance	**All equipments refurbished**	**Availability of funds**	664,254,676
			2.2.2.5	Biannual monitoring and evaluation for the EDP	**Proportion of facilities monitored and evaluated**	**Availability of funds and logistics**	16,680,586
		2.2.3	To establish a system for the maintenance of equipment at all levels				**102,997,737**
			2.2.3.1	Establish hospital equipment/Funiture maintenance workshop at Wukari, Bali and Zing hospitals	3 maintenance workshops established by 2012	availability fund	43,700,966
			2.2.3.2	Employment of 9 medical equipment technicians	9 medical tecnicians trained	available fund	59,296,772
		2.2.4	To strengthen referral system				**1,360,348,445**

			2.2.4.1	Provision of Ambulances in all primary and secondary HFs	**All secondary HFs with functional Ambulances by 2012**	**Availability of funds**	1,228,482,697
			2.2.4.2	Provision of internet services in all HFs	**Internet services available in all HFs by 2012**	**Availability of funds**	76,758,318
			2.2.4.3	Establish communication unit in all HFs	**communication unit with Desk officer in all HFs**	**Availability of funds**	22,934,833
			2.2.4.4	Printing and distribution of referral forms to all HF	**Referral forms printed and distributed annually**	**Availability of funds**	6,867,850
			2.2.4.5	Monitoring and Evaluation of the referral system in the State and all LGAs		**Availability of funds**	25,304,747
		2.2.5	To foster collaboration with the private sector				**11,125,275**
			2.2.5.1	Mapping out of all private health care providers, location and operational level	**No. of Private Care Providers identified by 2010**	Timely release of budgetted funds	4,871,150
			2.2.5.2	Establish traditional medicine board	**Traditional Medicine Board by 2010**	Provided Ministry of Justice produces the draft bill in time	1,942,265
			2.2.5.3	Meeting with and registration of all private healthcare providers in the LGAs	**Meeting/Registration of private healthcare providers conducted annually**	**Availability of funds and political will**	357,004
			2.2.5.4	Meeting with and registration of all traditional medical practitioners in all the LGAs	**Meeting/Registration of traditional medical practitioners conducted annually**	**Availability of funds and political will**	225,707
			2.2.5.5	Implementation on the National Policy on traditional medicine as it affects all LGAs	**National Policy on traditional medical practitioners implemented in all LGAs**	**Availability of funds and political will**	3,729,149
	2.3	**To improve the quality of health care services**			**50% of health facilities participate in a Quality Improvement programme by end of 2012**		**120,561,826**
		2.3.1	To strengthen professional regulatory bodies and institutions				**20,526,661**
			2.3.1.1	State regulatory officers to attend regular national meetings	No. of meetings attended by designated officers annually	Availability of funds and invitation letters are received early	14,706,104
			2.3.1.2	Supportive supervision to ensure implementation of regulatory guidelines	16 LGAs covered twice annually	Timely availability of funds	4,871,150
			2.3.1.3	Prosecution of offenders	Percentage of offenders prosecuted	Availability of funds and cooperation of law enforcement agencies	949,407
		2.3.2	To develop and institutionalise quality assurance models				**96,599,614**

			2.3.2.1	Establish SERVICOM in all State Health facilities and institutions	Percentage of Health facilities and institutions with SERVICOM in place	Availability of funds	61,848,683
			2.3.2.2	Building institutiional capacity and Training of Staff for its implementation	% of identified staff trained	Availability of funds	416,130
			2.3.2.3	Implementation of SERVICOM ideals in health facilities of all LGAs	Implementation of SERVICOM commenced by 2010	Availability of funds and political will	34,334,800
		2.3.3	To institutionalize Health Management and Integrated Supportive Supervision (ISS) mechanisms				**3,435,552**
			2.3.3.1	Develop ISS tools and guidelines	ISS tools and guidelines developed by 2010	Provided FMH develops ISS tool	96,280
			2.3.3.2	Training of programme managers and health team members at the State and LGA level on ISS mechanism	% of PM and health team members trained on ISS	Availability of funds and training materials	3,339,272
	2.4	**To increase demand for health care services**			**Average demand rises to 2 visits per person per annum by end 2011**		**146,420,108**
		2.4.1	To create effective demand for services				**146,420,108**
			2.4.1.1	Advocacy to traditional and religious leaders	Proportion of advocacy meetings held	Availability of funds	9,872,258
			2.4.1.2	production and Airing of jingles	Proportion of planned jingles aired	Availability of funds	50,489,182
			2.4.1.3	Production of IEC materials at the State and LGA levels	IEC materials produced annually	Availability of funds	76,913,699
			2.4.1.4	Organize workshop to strengthen village/ward health development committee	No. of workshops organized and material support delivered	Availability of funds	2,347,041
			2.4.1.5	Puchase of PAS-vehicle	**PAS vehicle purchased by 2010**	**Availability of funds**	6,797,928
	2.5	**To provide financial access especially for the vulnerable groups**			**1. Vulnerable groups identified and quantified by end 2010 2. Vulnerable people access services free by end 2015**		**2,372,791,230**
		2.5.1	To improve financial access especially for the vulnerable groups				**2,372,791,230**
			2.5.1.1	Documentation of the vulnerable groups including orphans, pregnant women, under 5s, over 70years, the mentally ill, prisoners and detained inmates	% of Health Budget allocated to the vulnerable groups	Availability of funds and logistics	6,222,350
			2.5.1.2	Phasing in the documented vulnerable groups into the Health Insurance Scheme adopted by the State	All the documented vulnerable groups included the Taraba State HIS	Availability of funds	728,349,425
			2.5.1.3	Commencement of exemption policy for orphans, the aged and disabled in all LGAs	Exemption policy implementation commenced in all LGAs	Availability of funds	470,805,069
			2.5.1.4	Monitoring and evaluation of the exemption policy instituted at the LG level	Monitoring and evaluation of the	Availability of funds and political will	113,040

					exemption policy commenced by 2010		
			2.5.1.5	Expansion of the exemption policy to include pregnant women and the under 5s	Pregnant women and the under 5s included in the exemption policy by 2011	Availability of funds and political will	1,167,301,346
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							**13,179,877,142**
	3.1	**To formulate comprehensive policies and plans for HRH for health development**			**All States and LGAs are actively using adaptations of the National HRH policy and Plan by end of 2015**		**12,202,668,023**
		3.1.1	To develop and institutionalize the Human Resources Policy framework				**12,202,668,023**
			3.1.1.1	Expand bonding policy to Physiotherapy, Health record, Bio medical engineer and Radiographers (not benefiting from the existing scheme)	Approved expanded bond policy on ground	Availability of funds	39,239,496
			3.1.1.2	Advocacy meeting with Executive and Legislative arms of govt. on the new National Policy on HRH	Advocacy meeting held by 2010	Availability of funds and political will	594,835
			3.1.1.3	Adopt and adapt the new National Policy on HRH at LGA	Policy document on HRH adopted by 2010	Availability of funds and political will	347,605
			3.1.1.4	Implementation of the National Policy on HRH	Implementation commenced by 2010	Availability of funds and political will	249,063
			3.1.1.5	Provision of funds to remunerate all the HRH in the State	HRH adequately remunerated monthly	Availability of funds	12,162,237,025
	3.2	**To provide a framework for objective analysis, implementation and monitoring of HRH performance**			**The HR for Health Crisis in the country has stabilised and begun to improve by end of 2012**		**3,654,762**
		3.2.1	To reappraise the principles of health workforce requirements and recruitment at all levels				**3,654,762**
			3.2.1.1	HRH mapping for the State (public and private)	HRH inventory available by 2010	Availability of funds and logistics	1,157,792
			3.2.1.2	Access, adopt, adapt and implement Federal government circulars related to HRH	Approved adapted policy available	Timely release of circulars by FMOH	65,209
			3.2.1.3	Monitoring and Evaluation of HRH Policy in the State and all LGAs	Monitoring and evaluation of new policy commenced by 2010	Availability of funds and political will	2,431,761
	3.3	**Strengthen the institutional framework for human resources management practices in the health sector**			**1. 50% of States have functional HRH Units by end 2010 2. 10% of LGAs have functional HRH Units by end 2010**		**1,793,254**
		3.3.1	To establish and strengthen the HRH Units				**1,793,254**

			3.3.1.1	Establish HRH unit under DPRS SMOH and at the LGAs	HRH unit established by 2010	Availability of guidelines and staff	1,793,254
	3.4	**To strengthen the capacity of training institutions to scale up the production of a critical mass of quality, multipurpose, multi skilled, gender sensitive and mid-level health workers**			**One major training institution per Zone producing health workforce graduates with multipurpose skills and mid-level health workers by 2015**		**942,492,719**
		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				**183,766,809**
			3.4.1.1	Establish Health Records training at College of health Technology Takum	Health Record Training accredited in Takum by 2012	Availability of funds	24,880,913
			3.4.1.2	Establish pharmacy technician training at college of health Technology Takum	Pharmacy TectnicianTraining accredited in Takum by 2013	Availability of funds	24,880,913
			3.4.1.4	promote midwifery service scheme by paying relevant allowances	Release of budgeted funds annually	Availability of funds	134,004,983
		3.4.2	To strengthen health workforce training capacity and output based on service demand				**758,725,910**
			3.4.2.1	Completion, equipping and furnishing of college of Nursing and Midwifery Jalingo	College of Nursing and Midwifery completed by 2011	Availability of funds	702,474,792
			3.4.2.2	Expansion, furnishing and equipping of college of Health Technology Takum	Expansion, equipping and furnishing completed by2011	Availability of funds	40,887,097
			3.4.2.3	Human Resources capacity building	% of staff trained annually	Availability of funds	13,552,653
			3.4.2.4	Promote continued professional development	No. of professional continuous training workshops conducted annually	Availability of funds/Cooperation of training bodies	1,811,368
	3.5	**To improve organizational and performance-based management systems for human resources for health**			**50% of States have implemented performance management systems by end 2012**		**27,162,669**
		3.5.1	To achieve equitable distribution, right mix of the right quality and quantity of human resources for health				**120,003**
			3.5.1.1	Redeploy health staff equitably between urban and rural areas	Implement equitable distribution of staff by 2012	Availability of funds and political will	120,003
		3.5.2	To establish mechanisms to strengthen and monitor performance of health workers at all levels				**27,042,666**
			3.5.2.1	Training of all care providers on IPC skills, work ethics and attitudinal change.	% staff trained by 2015	Availability of funds	6,303,560
			3.5.2.2	Establish M and E in HSMB	M and E Unit in place at HSMB	Availability of funds	926,838
			3.5.2.3	Creation of database for HRH in LGAs	Database on HRH available by 2010	Availability of funds and political will	2,165,264
			3.5.2.4	Re-orientation workshop for health workers on attitudinal change with special emphasis on IPC	Re-orientation workshop conducted by 2011	Availability of funds and political will	6,575,019

			3.5.2.5	Provide a motor cycle, fridge and a lelevision to reward the 3 best health workers in the LGAs	3 best health workers rewarded annually	Availablitity of funds and political will	11,071,985
	3.6	**To foster partnerships and networks of stakeholders to harness contributions for human resource for health agenda**			**50% of States have regular HRH stakeholder forums by end 2011**		**2,105,715**
		3.6.1	To strengthen communication, cooperation and collaboration between health professional associations and regulatory bodies on professional issues that have significant implications for the health system				**2,105,715**
			3.6.1.1	Create inter professional forum to meet once a year	Inter professional forum held annually	Availability of funds	2,105,715
FINANCING FOR HEALTH							
4. To ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and consumption at Local, State and Federal levels							**3,079,854,738**
	4.1	**To develop and implement health financing strategies at Federal, State and Local levels consistent with the National Health Financing Policy**			**50% of States have a documented Health Financing Strategy by end 2012**		**780,561**
		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				**780,561**
			4.1.1.1	Set up Technical working group for the State Health Care Financing	State Health Care Financing Committee on ground by 2010	Availability of funds	780,561
	4.2	**To ensure that people are protected from financial catastrophe and impoverishment as a result of using health services**			**NHIS protects all Nigerians by end 2015**		**3,000,188,047**
		4.2.1	To strengthen systems for financial risk health protection				**3,000,188,047**
			4.2.1.1	Establish community based Health Insurance scheme in the State	Community -based Health Insurance Scheme in place by 2011	Availability of funds	3,000,000,000
			4.2.1.2	Conduct workshop for stakeholders on NHIS	Workshop conducted by 2010	Timely release of funds	188,047
			4.2.1.3	Phased implementation of the NHIS beginning with the organized formal sector	Proportion of parastatals and Ministries implementing the NHIS	Availability of funds/Political will	-
	4.3	**To secure a level of funding needed to achieve desired health development goals and objectives at all levels in a sustainable manner**			**Allocated Federal, State and LGA health funding increased by an average of 5% pa every year until 2015**		**55,000,000**
		4.3.1	To improve financing of the Health Sector				**55,000,000**
			4.3.1.2	Source for grants from partners	Grants received from donor partners annually	Continuous donor support	55,000,000
	4.4	**To ensure efficiency and equity in the allocation and use of health sector resources at all levels**			**1. Federal, 60% States and LGA levels have transparent budgeting and financial**		**23,886,130**

					management systems in place by end of 2015 2. 60% of States and LGAs have supportive supervision and monitoring systems developed and operational by Dec 2012		
		4.4.1	To improve Health Budget execution, monitoring and reporting				**8,494,949**
			4.4.1.1	Establish State Health account Unit	State Health Account Unit established by 2010	Availability of HRH for the Unit	8,494,949
		4.4.2	To strengthen financial management skills				**15,391,182**
			4.4.2.1	Provide adequate training for Accounting staff and Heads of Units on financial management skills	% of accounting staff and heads of units trained	Availability of funds	15,391,182
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							**1,230,523,863**
	5.1	**To improve data collection and transmission**			**1. 50% of LGAs making routine NHMIS returns to State level by end 2010 2. 60% of States making routine NHMIS returns to Federal level by end 2010**		**428,801,996**
		5.1.1	To ensure that NHMIS forms are available at all health service delivery points at all levels				**201,339,364**
			5.1.1.1	Printing of NHMIS forms for State and LGA HFs	NHMIS forms printed annually	**Availability of funds**	199,903,800
			5.1.1.2	Distribution of forms to all Facilities	Forms available at all Health Facilities	**Availability of funds**	1,435,564
		5.1.2	To periodically review of NHMIS data collection forms				**5,465,936**
			5.1.2.1	Attendance at the biannual review meetings of NHMIS	**State represented at review meeting**	**Availability of funds**	5,465,936
		5.1.3	To coordinate data collection from vertical programmes				**73,100,000**
			5.1.3.1	Collection of data from vertical programmes by State M and E officer	**All data from vertical programmes available at the MOH**	**Availability of funds**	360,000
			5.1.3.2	Procurement and distributiion of motor cycles to strengthen data collection	**Motor cycles procured and distributed to all LGAs**	**Availability of funds and political will**	72,740,000
		5.1.4	To build capacity of health workers for data management				**108,937,819**
			5.1.4.1	Recruitment of 150 Health Management information personnel	150 HMIS personnel recruited by 2015	Availability of funds	98,686,856
			5.1.4.2	Traininng and retraining of all cadres of HMIS Staff on HMIS	% of staff trained by 2015	Availability of funds	2,888,434

			5.1.4.3	Hold annual workshop on the use of NHMIS forms at the LGA level	Workshop on NHMIS forms held annually	Availaility of funds and political will	7,362,529
		5.1.5	To provide a legal framework for activities of the NHMIS programme				**24,533,943**
			5.1.5.1	Two advocacy meetings with the Executive arm of Govt and State House of Assembly/LGA	Two advocacy meetings held 2010	**Political will**	57,458
			5.1.5.2	Making o f bye - law that makes it mandatory for Public/Private Health Care Providers in LGAs to forward their NHMIS forms to LGAs	Bye- Law passed by 2011	**Availability of funds and political will**	24,476,486
		5.1.6	To improve coverage of data collection				**7,337,484**
			5.1.6.1	Quarterly meetings with LGA NHIS Officers	Four meetings held annually	Availability of funds	7,337,484
		5.1.7	To ensure supportive supervision of data collection at all levels				**8,087,450**
			5.1.7.1	Provision of adequate logistics for officials to supervise data collection twice a year per LGA	% of supervisory visits undertaken per LGA per year	Availability of funds	2,155,564
			5.1.7.2	Advocacy meeting with extended Stakeholders on the need to strengthen vital registration in all LGAs	Advocacy meeting held by 2010	Availability of funds	1,226,486
			5.1.7.3	Estabilshment of Vital Registration Units in all LGAs	Vital Registration Units established in all LGAs by 2011	Availability of funds	4,705,400
	5.2	**To provide infrastructural support and ICT of health databases and staff training**			**ICT infrastructure and staff capable of using HMIS in 50% of States by 2012**		**315,381,964**
		5.2.1	To strengthen the use of information technology in HIS				**219,937,404**
			5.2.1.1	provision of computer hardwares and necessary soft wares Data Base for data collection and analysis (at least 100)	% Health facilities that use computers for data collection by 2012	Availability of funds	16,050,000
			5.2.1.2	Training workshop on the use of computers for the collection of NHMIS data for LGA NHMIS Officers	LGA NHMIS Officers trained on use of computers	Availability of funds and political will	14,652,404
			5.2.1.3	Procurement and distribution of computers and generators to all LGA HFs	Computers and generators procured for LGAs by 2012	Availability of funds and political will	189,235,000
		5.2.2	To provide HMIS Minimum Package at the different levels (FMOH, SMOH, LGA) of data management				**95,444,560**
			5.2.2.1	Provision of minimun package at State	Implementation of minimum package in place by 2013	Availability of funds	69,673,044
			5.2.2.2	Training of relevant staff on software system	200 staff trained on soft ware by 2015	Availability of funds	8,350,800
			5.2.2.3	Capacity building workshop for Managers of Health Team members on Minimum Package of HIS at LGA level	Capacity Building workshop held by2010	Availability of funds	1,220,716
			5.2.2.4	Implementation of the Minimum Package on HIS in all LGAs	Minimum Package on HIS implemented by 2012	Availability of funds	16,200,000
	5.3	**To strengthen sub-systems in the Health Information System**			**1. NHMIS modules strengthened by end 2010 2. NHMIS annually reviewed**		**462,457,138**

					and new versions released		
		5.3.1	To strengthen the Hospital Information System				**72,147**
			5.3.1.1	Set up State Committee for mapping of disease	Committee in place by 2010	Availability of funds	72,147
		5.3.2	To strengthen the Disease Surveillance System				**462,384,991**
			5.3.2.1	Implementation of the community based disease surveillance system including the provision of vehicle for disease surveillance	Community based disease surveillance system and vehicle provided by 2010	Availability of funds	20,720,000
			5.3.2.2	Construction/furnishing of the State Epidemiology unit	Epidemiology Unit constructed and furnished by 2013	Availability of funds and political will	405,000,000
			5.3.2.3	Sensitization meeting with community leaders on community based disease surveillance system/monthly Review meetings of state and LGA DSNOs	Sensitization meetings held by 2010/12 review meetings held annually	Availability of funds	20,849,656
			5.3.2.4	Production of bulletin and feedback (biannual)/workshop on notifiable diseases for Health Team Managers at the LGA	Bulletin produced twice a year/workshop held by 2010	Availability of funds	8,815,294
			5.3.2.5	Supportive supervision to LGAs to ensure use of tools and validity of Data	No. of LGA visited per year	Availability of funds	7,000,042
	5.4	**To monitor and evaluate the NHMIS**			**NHMIS evaluated annually**		**18,782,765**
		5.4.1	To establish monitoring protocol for NHMIS programme implementation at all levels in line with stated activities and expected outputs				**18,782,765**
			5.4.1.1	Biannual review meetings / LGA quarterly HIS Review Meetings	Review meetings held annually	Availability of funds	18,782,765
	5.5	**To strengthen analysis of data and dissemination of health information**			**1. 50% of States have Units capable of analysing health information by end 2010 2. All States disseminate available results regularly**		**5,100,000**
		5.5.1	To institutionalize data analysis and dissemination at all levels				**5,100,000**
			5.5.1.1	Production biannual periodic health data bulletin	2 bulletins produced annually	Availability of funds	3,600,000
			5.5.1.2	production of annual report	Annual Report produced every year	Availability of funds	1,500,000
COMMUNITY PARTICIPATION AND OWNERSHIP							
6. To attain effective community participation in health development and management, as well as community ownership of sustainable health outcomes							**620,214,341**
	6.1	**To strengthen community participation in health development**			**All States have at least annual Fora to engage community leaders and CBOs on health matters by end 2012**		**20,049,482**
		6.1.1	To provide an enabling policy framework for community participation				**404,609**
			6.1.1.1	Develop guideline for engaging community participation	Guideline produced by 2010	Availability of funds	404,609

		6.1.2	To provide an enabling implementation framework and environment for community participation				**19,644,873**
			6.1.2.1	Establish intersectoral stakeholders committee on community participation at the Stateand LGA levels	Committee in place by 2011	Availability of funds	19,644,873
	6.2	**To empower communities with skills for positive health actions**			**All States offer training to FBOs/CBOs and community leaders on engagement with the health system by end 2012**		**273,968,150**
		6.2.1	To build capacity within communities to 'own' their health services				**273,968,150**
			6.2.1.1	Empower community positively through IEC activities	IEC materials produced	Availability of funds	52,230,000
			6.2.1.2	Commmunity mapping of stakeholders	Stakeholders identified by 2010	Availability of funds	518,150
			6.2.1.3	Dialogue with community stakeholders annually	Single dialogue session held annually	Availability of funds	6,000,000
			6.2.1.4	Involment of community leaders in the development and implementation of LGA SHDP	LGA SHDP developed and implemented annually	Availability of funds	103,020,000
			6.2.1.5	production of IEC materials to empower community members for positive action	IEC materials produced by 2010	Availability of funds	112,200,000
	6.3	**To strengthen the community - health services linkages**			**50% of public health facilities in all States have active Committees that include community representatives by end 2011**		**311,225,167**
		6.3.1	To restructure and strengthen the interface between the community and the health services delivery points				**311,225,167**
			6.3.1.1	Develop guideline for community linkage	Guidelines developed by 2010	Availability of funds	404,609
			6.3.1.2	Setting up and inauguration of District Management Committees for all Hospitals and Primary Health clinics	Proportion of hospitals with District Management Committees	Availability of funds	310,820,558
	6.4	**To increase national capacity for integrated multisectoral health promotion**			**50% of States have active intersectoral committees with other Ministries and private sector by end 2011**		**13,916,190**
		6.4.1	To develop and implement multisectoral policies and actions that facilitate community involvement in health development				**13,916,190**
			6.4.1.1	Advocacy to the community Gatekeepers at State and LGA levels	Advocacy visit made by 2010	Availability of funds	8,588,509
			6.4.1.2	Develop Health promotion plans at State and LGA levels	Health promotion plan developed by 2010	Availability of funds	2,267,681
			6.4.1.3	Incorporation of action plans to SSHDP	SSHDP developed and implemented annually	Availability of funds	3,060,000

	6.5	**To strengthen evidence-based community participation and ownership efforts in health activities through researches**			**Health research policy adapted to include evidence-based community involvement guidelines by end 2010**		**1,055,350**
		6.5.1	To develop and implement systematic measurement of community involvement				**1,055,350**
			6.5.1.1	Building capacity of service providers on operational research on community participation	Training provided for service providers by 2010	Availability of funds	1,055,350
PARTNERSHIPS FOR HEALTH							
7. To enhance harmonized implementation of essential health services in line with national health policy goals							**495,950,477**
	7.1	**To ensure that collaborative mechanisms are put in place for involving all partners in the development and sustenance of the health sector**			**1. FMOH has an active ICC with Donor Partners that meets at least quarterly by end 2010 2. FMOH has an active PPP forum that meets quarterly by end 2010 3. All States have similar active committees by end 2011**		**495,950,477**
		7.1.1	To promote Public Private Partnerships (PPP)				**237,442,140**
			7.1.1.1	Development of State PPP policy	PPP committee and Policy in place by 2010	Availability of funds/Logistics	372,758
			7.1.1.2	Provide Support/Grant to "Not for profit Organizations "	No. of Not-for-profit organizations receiving support by 2011	Availability of funds	45,315,944
			7.1.1.3	Advocacy meetings on PPP with LG Officials and other stakeholders	Advocacy meeting held by 2010	Availability of funds and political will	1,170,556
			7.1.1.4	Setting up of PPP Units in all LGAs	PPP Unit established by 2010	Availability of funds and political will	47,888,514
			7.1.1.5	Posting of HRH at no cost to private health care providers and faith-based organizations in rural areas	Posting of HRH to private and faith-based organization commenced by 2012	Availability of funds and political will	142,694,367
		7.1.2	To institutionalize a framework for coordination of Development Partners				**374,045**
			7.1.2.1	Establish Health Development partner committee	Health Development Partner Committee established by 2010	Availability of funds/partners' support	10,876
			7.1.2.2	Commencement of annual meeting of Health Development Partner Committee	Health Development Partner Committee Meeting held annually	Availability of funds	363,169
		7.1.3	To facilitate inter-sectoral collaboration				**30,409,322**

			7.1.3.1	Establish intersectoral ministerial forum to enhance collaboration	Intersectoral Ministerial forum established by 2011	Availability of funds	31,268
			7.1.3.2	School Health services (annual deworming and health promotion)	Proportion of primary school pupils dewormed annually	Availability of funds/Logistics	30,378,054
		7.1.4	To engage professional groups				**181,263,778**
			7.1.4.1	Construction of Comprehensive Health centre at Gembu For UMTH	One Comprehensive Health Centre constructed by 2011	Availability of funds	181,263,778
		7.1.6	To engage with traditional health practitioners				**46,461,192**
			7.1.6.1	Enact law guiding the traditional medical practice	State Traditional Medicine Board Bill signed into law by 2011	Cooperation of Min of Justice and House of Assembly	1,631,374
			7.1.6.2	Establish State Traditional Medicine Board	Traditional Medicine Board established by 2011	Availability of funds and political will	36,452,066
			7.1.6.3	Workshop for traditional medical practitioners annually	Annual workshop for Traditional Medical Practitioners held every year	Availability of funds	4,034,932
			7.1.6.4	Encourage traditional medical practitioners to form organised unions in the LGAs e.g NANTMP	Association of traditional medical practitioners formed by 2010	Availability of funds	620,403
			7.1.6.5	Dialogue with NANTMP on the need to stop advertizing	Dialogue meeting held annually	Availability of funds	3,722,418
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							**632,204,030**
	8.1	**To strengthen the stewardship role of governments at all levels for research and knowledge management systems**			**1. ENHR Committee established by end 2009 to guide health research priorities 2. FMOH publishes an Essential Health Research agenda annually from 2010**		**219,953,540**
		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				**209,297,322**
			8.1.1.1	Innaugurate State technical research committee at the State and LG levels	State technical research committee inaugurated by 2010	Availability of funds	3,257,322
			8.1.1.2	Health Research Committees to identify areas of health research	Areas of health research identified by 2010	Availability of funds and political will	2,040,000
			8.1.1.3	Commission Health Research in areas of need	Health Research commissioned by 2010	Availability of funds and political will	204,000,000
		8.1.2	To establish and or strengthen mechanisms for health research at all levels				**10,287,761**
			8.1.2.1	Estblish Research unit under DPRS-SMOH	State Research Unit established by 2011	Availability of funds	10,272,761

			8.1.2.2	Access national Research guidelines for adaptation in the State	Copy of the National research guidelines accessed by 2010	Availability of funds	15,000
		8.1.4	To promote cooperation and collaboration between Ministries of Health and LGA health authorities with Universities, communities, CSOs, OPS, NIMR, NIPRD, development partners and other sectors				-
		8.1.5	To mobilise adequate financial resources to support health research at all levels				**368,458**
			8.1.5.1	Sensitization of development partners, Rsearchers and top government functionaries	Sensitization meeting held by 2011	Availability of funds	368,458
		8.1.6	To establish ethical standards and practise codes for health research at all levels				-
			8.1.6.1	Establish State Health research steering/ethical committee			-
	8.2	**To build institutional capacities to promote, undertake and utilise research for evidence-based policy making in health at all levels**			**FMOH has an active forum with all medical schools and research agencies by end 2010**		**336,100,616**
		8.2.1	To strengthen identified health research institutions at all levels				-
			8.2.1.1	Take inventory of institutions involved in research activities			-
		8.2.2	To create a critical mass of health researchers at all levels				**25,665,395**
			8.2.2.1	provide sponsorship for 3 PhD scholars	3 scholars sponsored for phD programme by 2015	Availability of funds	25,665,395
		8.2.4	To undertake research on identified critical priority areas				**310,435,222**
			8.2.4.1	Conduct Reproductive and Health survey to establish vital statistics for the State every 2 years	Base line data for IMR, CMR, MMR and Life Expectancy by 2011	Availability of funds	20,000,000
			8.2.4.2	Prevalence study of communicable diseases	Prevalence rate for Malaria available by 2012	Availability of funds	15,000,000
			8.2.4.3	Prevalence study of non- communicable diseases	Prevalence rate for Diabetes mellitus available by 2012	Availability of funds	15,000,000
			8.2.4.4	Establishmennt of reference standard for all Lab. Investigations	Reference standards for lab inv. Worked out by 2013	Availability of funds	260,435,222
			8.2.4.5	Establish standard for drinking and bathing water			-
	8.3	**To develop a comprehensive repository for health research at all levels (including both public and non-public sectors)**			**1. All States have a Health Research Unit by end 2010 2. FMOH and State Health Research Units manage an accessible repository by end 2012**		**6,922,799**
		8.3.1	To develop strategies for getting research findings into strategies and practices				**6,122,799**

			8.3.1.1	Biennial Health research forum	3No. Health research forum meeting held by 2015	Availability of funds	2,050,500
			8.3.1.2	Disseminate outcome of health research to important stakeholders in health	Research findings disseminated to stakeholders biennially	Availability of funds	2,372,299
			8.3.1.3	Result of research to guide in the development of new SSHDP	Research findings incorporated in the SSHDP annually	Availability of funds	1,700,000
		8.3.2	To enshrine mechanisms to ensure that funded researches produce new knowledge required to improve the health system				**800,000**
			8.3.2.1	Conduct operational research	No. operational research conducted yearly	Availability of funds	800,000
	8.4	**To develop, implement and institutionalize health research communication strategies at all levels**			**A national health research communication strategy is in place by end 2012**		**69,227,075**
		8.4.1	To create a framework for sharing research knowledge and its applications				**68,227,075**
			8.4.1.1	Provide fund to attend National council on Health	% of NCH Meeting attended in a year	Availability of funds	8,741,724
			8.4.1.2	Host State council on Health meeting yearly	State Council on Health held annually	Availability of funds	25,725,706
			8.4.1.3	International conferences/training	No. of international conferences attended annually	Availability of funds	33,759,645
		8.4.2	To establish channels for sharing of research findings between researchers, policy makers and development practitioners				**1,000,000**
			8.4.2.1	Access selected Health journals	Assorted health journal available	Availability of funds	1,000,000
TOTAL							**43,748,909,603**

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

TARABA 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	50	75	100%
	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)	SMOH	0	25	50	75
	4. % of LGAs enforcing traditional medical practice by-laws	LGA Annual Report	TBD	25%	50%	75%
3. Strengthened accountability, transparency and responsiveness of the State health system	5. % of LGAs which have established a Health Watch Group	LGA Annual Report	0	50	75	100

	6. % of recommendations from health watch groups being implemented	Health Watch Groups' Reports	No Baseline	25	50	75
	7. % LGAs aligning their health programmes to the SSHDP	LGA Annual Report	0	50	75	100
	8. % DPs aligning their health programmes to the SSHDP at the LGA level	LGA Annual Report	No Baseline	50	75	100
	9. % of LGAs with functional peer review mechanisms	SSHDP and LGA Annual Review Report	TBD	25	50	75%
	10. % LGAs implementing their peer review recommendations	LGA / SSHDP Annual Review Report	No Baseline	50	75	100%
	11. Number of LGA Health Watch Reports published	Health Watch Report	0	50	75	100
	12. 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	13. % LGA public health facilities using the essential drug list	Facility Survey Report	TBD	40	80	100%
	14. % private health facilities using the essential drug list by LGA	Private facility survey	TBD	10	25	50%
	15. % of LGA public sector institutions implementing the drug procurement policy	Facility Survey Report	TBD	50	75	100%
	16. % of private sector institutions implementing the drug procurement policy within each LGA	Facility Survey Report	TBD	10	25	50%

	17. % LGA health facilities not experiencing essential drug/commodity stockouts in the last three months	Facility Survey Report	TBD	25	50	75%
	18. % of LGAs implementing a performance based budgeting system	Facility Survey Report	TBD	25	50	75%
	19. Number of MOUs signed between private sector facilities and LGAs in a Public-Private-Partner ship by LGA	LGA Annual Review Report	TBD	2	4	6
	20. 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	10	30
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	21. % of LGAs with a functioning public health facility providing minimum health care package according to quality of care standards.	NPHCDA Survey Report	TBD	25	50	75%
	22. % health facilities implementing the complete package of essential health care	NPHCDA Survey Report	TBD	50	75	100%
	23. % of the population having access to an essential care package	MICS/NDHS	TBD	40	75	100%
	24. Contraceptive prevalence rate (modern and traditional)	NDHS	2.1	4%	6%	10%

	25. %increase of new users of modern contraceptive methods (male/female)	NDHS/HMIS	TBD	20%	40%	50%
	26. % of new users of modern contraceptive methods by type (male/female)	NDHS/HMIS	TBD	20%	40%	50%
	27. % service delivery points without stock out of family planning commodities in the last three months	Health facility Survey	TBD	10	30%	75%
	28. % of facilities providing Youth Friendly RH services	Health facility Survey	TBD	20%	30%	40%
	29. % of women 15-19 who have begun child bearing	NDHS/MICS	21.50%	20%	18%	15%
	30. % of pregnant women with 4 ANC visits performed according to standards*	NDHS	39.30%	40%	45%	50%
	31. Proportion of births attended by skilled health personnel	NDHS	25.90%	30%	35%	40%
	32. Proportion of women with complications treated in an EmOC facility (Basic and/or comprehensive)	EmOC Sentinel Survey and Health Facility Survey	TBD	20%	30%	40%
	33. Caesarean section rate	EmOC Sentinel Survey and Health Facility Survey	0.10%	0.50%	1%	5%
	34. Case fatality rate among women with obstretic complications in EmOC facilities	HMIS	TBD	50%	40%	30%
	35. Perinatal mortality rate**	HMIS	50/1000LBs	45/1000LBs	30/1000LBs	
	36. % women receiving immediate post partum family planning method before discharge	HMIS	TBD	5%	10%	20%

	37. % of women who received postnatal care based on standards within 48h after delivery	MICS	TBD	5%	10%	15%
	38. % of newborn with infection receiving treatment	MICS	No Baseline	10%	20%	30%
	39. % of children exclusively breastfed 0-6 months	NDHS/MICS	5.10%	10%	20%	40%
	40. Proportion of 12-23 months-old children fully immunized	NDHS/MICS	14.10%	16%	20%	40%
	41. % children <5 years stunted (height for age <2 SD)	NDHSMICS	43.00%	40%	35%	30%
	42. % of under-five that slept under LLINs the previous night	NDHS/MICS	36.40%	40%	50%	75%
	43. % of under-five children receiving appropriate malaria treatment within 24 hours	NDHS/MICS	60%	65%	70%	75%
	44.Condom use at last high risk sex	NDHS/MICS	3.10%	5%	10%	20%
	45. Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS	NDHS/MICS	40.50%	45%	50%	70%
	46. Prevalence of tuberculosis	NARHS	1.50%	1.20%	1.00%	0.50%
	47. Proportion of tuberculosis cases detected and cured under directly observed treatment short course	NMIS	TBD	30%	50%	75%
Output 6. Improved quality of Health care services	48. % of staff with skills to deliver quality health care appropriate for their categories	Facility Survey Report	TBD	20%	30%	40%
	49. % of facilities with capacity to deliver quality health care	Facility Survey Report	TBD	25%	35%	45%

	50. % of health workers who received personal supervision in the last 6 months by type of facility	Facility Survey Report	TBD	20%	50%	75%
	51. % of health workers who received in-service training in the past 12 months by category of worker	HR survey Report	TBD	10%	20%	30%
	52. % of health facilities with all essential drugs available at all times	Facility Survey Report	TBD	30%	50%	75%
	53. % of health institutions with basic medical equipment and functional logistic system appropriate to their levels	Facility Survey Report	TBD	10%	20%	25%
	54. % of facilities with deliveries organizing maternal and/or neonatal death reviews according to WHO guidelines on regular basis	Facility Survey Report	TBD	5%	10%	15%
Output 7. Increased demand for health services	55. Proportion of the population utilizing essential services package	MICS	TBD	15%	20%	25%
	56. % of the population adequately informed of the 5 most beneficial health practices	MICS	TBD	25%	50%	75%
PRIORITY AREA 3: HUMAN RESOURCES FOR HEALTH **NSHDP GOAL: To plan and implement strategies to address the human resources for health needs in order to ensure its availability as well as ensure equity and quality of health care**						
NSHDP GOAL: To plan and implement strategies to address the human resources for health needs in order to ensure its availability as well as ensure equity and quality of health care						
Outcome 6. The Federal government implements comprehensive HRH policies and plans for health development						
Outcome 7.All States and LGAs are actively using adaptations of the National HRH policy and plan for health development by end of 2015						
Output 8. Improved policies and Plans and strategies for HRH	57. % of wards that have appropriate HRH complement as per service delivery norm (urban/rural).	Facility Survey Report	TBD	5%	10%	20%
	58. Retention rate of HRH	HR survey Report	TBD	85%	90%	95%

	59. % LGAs actively using adaptations of National/State HRH policy and plans	HR survey Report	TBD	10%	30%	50%
	60. Increased number of trained staff based on approved staffing norms by qualification	HR survey Report	TBD	10%	25%	50%
	61. % of LGAs implementing performance-based managment systems	HR survey Report	TBD	5%	10%	20%
	62. % of staff satisfied with the performance based management system	HR survey Report	TBD	10%	25%	50%
Output 8: Improved framework for objective analysis, implementation and monitoring of HRH performance	63. % LGAs making availabile consistent flow of HRH information	NHMIS	0 - 100%	25%	50%	75%
	64. CHEW/10,000 population density	MICS	TBD	1:4000 pop	1:3000 pop	1:2000 pop
	65. Nurse density/10,000 population	MICS	TBD	1:8000 pop	1:6000 pop	1:4000 pop
	66. 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
	67. Medical doctor density per 10,000 population	MICS	TBD	1:8000 pop	1:7000 pop	1:5000 pop
	68. Other health service providers density/10,000 population	MICS	TBD	1:4000 pop	1:3000 pop	1:2000 pop
	69. HRH database mechanism in place at LGA level	HRH Database	TBD	10%	20%	25%

Output 10: Strengthened capacity of training institutions to scale up the production of a critical mass of quality mid-level health workers						
PRIORITY AREA 4: FINANCING FOR HEALTH						
NSHDP GOAL 4 : To ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and consumption at Local, State and Federal Levels						
Outcome 8. Health financing strategies implemented at Federal, State and Local levels consistent with the National Health Financing Policy						
Outcome 9. The Nigerian people, particularly the most vulnerable socio-economic population groups, are protected from financial catastrophe and impoverishment as a result of using health services						
Output 11: Improved protection from financial catastrophy and impoversihment as a result of using health services in the State	70. % of LGAs implementing state specific safety nets	SSHDP review report	TBD	10%	25%	30%
	71. Decreased proportion of informal payments within the public health care system within each LGA	NHA	85%	80%	75%	70%
	72. % of LGAs which allocate costed fund to fully implement essential care package at N5,000/capita (US$34)	State and LGA Budgets	TBD	25%	40%	60%
	73. LGAs allocating health funding increased by average of 5% every year	State and LGA Budgets	TBD	25%	40%	60%

Output 12: Improved efficiency and equity in the allocation and use of Health resources at State and LGA levels	74. LGAs health budgets fully alligned to support state health goals and policies	State and LGA Budgets	TBD	60%	80%	100%
	75.Out-of pocket expenditure as a % of total health expenditure	National Health Accounts 2003 - 2005	70%	60%	50%	40%
	76. % of LGA budget allocated to the health sector.	National Health Accounts 2003 - 2005	2%	10%	20%	30%
	77. Proportion of LGAs having transparent budgeting and finacial management systems	SSHDP review report	TBD	25%	40%	60%
	78. % of LGAs having operational supportive supervision and monitoring systems	SSHDP review report	TBD	25%	40	50%
PRIORITY AREA 5: NATIONAL HEALTH INFORMATION SYSTEM						
Outcome 10. National health management information system and sub-systems provides public and private sector data to inform health plan development and implementation						
Outcome 11. National health management information system and sub-systems provide public and private sector data to inform health plan development and implementation at Federal, State and LGA levels						
Output 13: Improved Health Data Collection, Analysis, Dissemination, Monitoring and Evaluation	79. % of LGAs making routine NHMIS returns to states	NHMIS Report January to June 2008; March 2009	0 - 34%	25%	50%	75%
	80. % of LGAs receiving feedback on NHMIS from SMOH		TBD	25%	50%	75%
	81. % of health facility staff trained to use the NHMIS infrastructure	Training Reports	TBD	30%	60%	80%
	82. % of health facilities benefitting from HMIS supervisory visits from SMOH	NHMIS Report	TBD	25%	40%	60%

	83.% of HMIS operators at the LGA level trained in analysis of data using the operational manual	Training Reports	TBD	40%	75%	100%
	84. % of LGA PHC Coordinator trained in data dissemination	Training Reports	TBD	40%	75%	100%
	85. % of LGAs publishing annual HMIS reports	HMIS Reports	TBD	25%	50%	75%
	86. % 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	87. Proportion of public health facilities having active committees that include community representatives (with meeting reports and actions recommended)	SSHDP review report	TBD	20%	50%	70%
	88. % of wards holding quarterly health committee meetings	HDC Reports	TBD	20%	50%	70%
	89. % HDCs whose members have had training in community mobilization	HDC Reports	TBD	20%	50%	70%
	90. % increase in community health actions	HDC Reports	TBD	10%	25%	50%
	91. % of health actions jointly implemented with HDCs and other related committees	HDC Reports	TBD	25%	40%	60%
	92. % of LGAs implementing an Integrated Health Communication Plan	HPC Reports	TBD	20%	40%	60%
PRIORITY AREA 7: PARTNERSHIPS FOR HEALTH						

Outcome 14. Functional multi partner and multi-sectoral participatory mechanisms at Federal and State levels contribute to achievement of the goals and objectives of the						
Output 15: Improved Health Sector Partners' Collaboration and Coordination	93. Increased number of new PPP initiatives per year per LGA	SSHDP Report	TBD	20%	40%	60%
	94. % LGAs holding annual multi-sectoral development partner meetings	SSHDP Report	TBD	20%	50%	70%
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	95. % of LGAs partnering with researchers	Research Reports	TBD	10%	25%	50%
	96. % of State health budget spent on health research and evaluation	State budget	TBD	1%	1.50%	2%
	97. % of LGAs holding quarterly knowledge sharing on research, HMIS and best practices	LGA Annual SHDP Reports	TBD	10%	20%	40%
	98. % of LGAs participating in state research ethics review board for researches in their locations	LGA Annual SHDP Reports	TBD	40%	75%	100%
	99. % of health research in LGAs available in the state health research depository	State Health Reseach Depository	TBD	30%	50%	75%
Output 17: Health research communication strategies developed and implemented	100. % LGAs aware of state health research communication strategy	Health Research Communication Strategy	TBD	30%	50%	75%