SOKOTO STATE GOVERNMENT

STRATEGIC HEALTH DEVELOPMENT PLAN
(2010-2015)

Sokoto State Ministry of Health

March 2010

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Acronyms

BCC	Behaviour Change Communication
CORPs	Community oriented resource persons
CPD	Continuing professional development
CSO	Community Service Organization
DFID	Department for International Development
DHS	Nigeria Demographic and Health Survey
DP	Development Partners
DPRS	Department of Planning, Research and Statistics
FMOH	Federal Ministry of Health
GDP	Gross Domestic Product
GHS	Gunduma Health System
GIS	Geographic Information System
HF	Health Facility
HIS	Health Management Information System
HIV/AIDS	Human Immuno Deficiency Virus/Acquired Immune Deficiency Syndrome
HRH	Human Resources for Health
HW	Health worker
IEC	Information, Education and Communication
IMCI	Integrated management of Childhood Illnesses
IMNCH	Integrated Maternal, Newborn and Child Health
IPC	Interpersonal Communication skills
ISS	Integrated supportive supervision
ITNs	Insecticide treated nets
SSSHDP	Sokoto State Strategic Health Development Plan
LGA	Local Government Area
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDAs	Ministries, Departments and Agencies
MDGs	Millennium Development Goals
MNCH	Maternal and Newborn Child Health
NGOs	Non-Governmental Organizations
NPHCDA	National Primary Health Care Development Agency
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
SHAs	State Health Accounts
SMOH	State Ministry of Health
SWAPs	Sector-Wide Approaches
TB	Tuberculosis
TBAs	Traditional birth attendants
TWG	Technical Working Group

UN-System	United Nations-System
VHW	Village health workers
WHO	World Health Organization

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Executive Summary

The strategic vision of Sokoto state is “to reduce the morbidity and mortality rates due to communicable diseases to the barest minimum; reverse the increasing prevalence of non-communicable diseases; meet state and national targets on the elimination and eradication of diseases; and significantly increase the life expectancy and quality of life of residents in Sokoto state”. To achieve this, the state is committed “to develop and implement appropriate policies and programmes that will strengthen the State Health System in order to deliver effective, quality and affordable health care services."

Sokoto State is tagged “The Seat of the Caliphate” and is located in the North-western part of Nigeria between longitude 11” 30 to 13” 50 and latitude 4” to 6”. It borders Niger Republic to the North and Benin Republic to the North West, Kebbi State to South and Zamfara State to the East. It has a land mass area of about 32,000 square kilometres, 23 LGAs, 120 health districts and 244 political wards. A greater proportion of the inhabitants are rural dwellers (80%) with only 20% dwelling in the urban settlements. The predominant tribes are Hausa and Fulani while Islam is the main religion. Agriculture, petty trading and craftsmanship are the main occupations of the people in the State with industries in the State being cement, leather, aluminium and groundnut oil factories.

With a total population of 4.2 million, neonates, children under one year, Children under-5, Children under 15 years, women of child-bearing age (15-49), and pregnant mothers constitute 2% (80,514), 4% (161,028), 20% (805,142), 40% (1,610,283), 20% (805,142), and 4% (161,028) respectively.

Current health indices are poor in the state as indicated by MICS 2007 and NDHS 208 among other studies. Crude Birth Rate is 41.7 per 1000, Infant Mortality Rate is 100 per 1,000 live births, Under Five Mortality Rate is 166/1000 live births and Maternal Mortality Rate 850/100,000. Current use of contraception, any method is 2.1%, with any modern method as 1.9%.

Other maternal health indicators in the State include 13.8% receiving ANC from a health professional, 6.8% Percentage of pregnant women whose last live birth was protected against NNT, Percentage delivered by a health professional is 5.1%; and Percentage delivered in a health facility is 4.4%.

Childhood Immunization indicators are 4.5% BCG coverage, 2.0% DPT3, 10.9% OPV3, 3.5% Measles with fully immunized children standing at 1.0% and zero dose of 64.7%. Other indications of poor utilization of health services are illustrated by the fact that 30.4% of children with fever received treatment from a health facility/provider, 33.8% of children with diarrhea were treated in a health facility/provider and 12% of children with diarrhoea were given, any ORT.

The factors responsible for high infant, child and maternal deaths in Sokoto State are not different from that obtainable elsewhere in Northern Nigeria. They include low utilization of existing health services, dearth of health personnel, early marriage and early child bearing, high frequency of childbearing, low literacy rates, especially among the female gender, gender discrimination and other harmful traditional/ cultural practices. The other underlying factors that contribute to the dismal picture in the state include poverty and low community awareness of the health services existence as well as poor attitude of the personnel delivering the services. In addition, inadequate and inequitable distribution of human resource for health, inadequate and poorly maintained health care infrastructures, poor state of health management information and disease surveillance systems, inadequate funding and weak governance systems remain major challenges to effective planning, implementation and evaluation of the State's health system.

In general, malaria, diarrhoea, pneumonia, measles, HIV and TB still constitute the major burden of prevailing diseases in the general population within the state.

In addressing these issues, the Sokoto Strategic Health Development Plan has outlined key interventions, inclusive of high impact cost effective health services to be delivered in the state. The total estimated cost of implementing the Sokoto State Strategic Health Development Plan in Naira is ₦ 68,601,615,696.

The plan will be jointly implemented by Sokoto State Ministry of Health, Sokoto State Health Systems Project II, Sokoto State Ministry of Local Government, Organized Private Sector and CSOs with the support of the Federal Ministry of Health and International Development Partners

Effective monitoring and evaluation (M&E) is crucial to successful implementation of the SHDP. The significance of a multidisciplinary and multisectoral approach to a successful M&E process and outcome cannot be overemphasized.

The State Executive Council, State House of Assembly, Ministries of Health, Education, Women Affairs, Water and Sanitation, Finance, Budget & Economic planning and others that may be identified, are committed to collaborate and towards the implementation of the State's strategic health development plan.

Chapter One: Background

Sokoto State tagged "The Seat of the Caliphate" is one of the 36 States of Nigeria. It is located in the North-western part of Nigeria between longitude 11" 30 to 13" 50 and latitude 4" to 6" and has a land mass area of about 32,000 square kilometers. The State has a land area of about 32000 sq km, 23 LGAs, 120 health districts and 244 political wards and a population of 4.2 million. The population is projected to double in 24 years. It borders Niger Republic to the North and Benin Republic to the North West, Kebbi State to South and Zamfara State to the East.

The State Strategic Health Development Team was able to accomplish the Constitution of State SHDP development teams.

One was the State Steering Committee (SSC) and the other was the State Planning Team (SPT). Each of the two committees had 52 and 32 people memberships respectively. The composition of the two teams was compliant with the specification of the Federal guideline.

Several preliminary meetings were held prior to the State planning team meetings by the core group [State Directors of PHC & Planning , Research & Statistics, the director of PHC at the Ministry of LG affairs, the State UNFPA coordinator and the State SHDP Consultant for necessary preparatory arrangements.

The Opening ceremony of the State Health Council provided a window of opportunity for a wide segment sensitization forum in the State, to deliver lecture on the Strategic Health Development Plan. The Governor was represented in the forum while some Commissioners, Permanent Secretaries, State directors, LG Chairmen and directors were present.

Booking of workshop venue and arrangement of all training logistics were duly planned and achieved. Courtesy call on the Hon Commissioner for Health was also achieved at the very early stage. The Core group of the State Planning Team [DPRS, SMOH; DPHC,SMOH; DPHC, Min of LG affairs; & the State Consultant] met on Monday, 24th August 2009.

The group agreed on proposed dates for the State & LG levels training & came up with draft budgets for the committee's activities.

Sources of funding for the development of the State's SHDP were identified to include the Sokoto Health Systems Development Project II fund and the UNFPA support fund.

The State Steering Committee meeting/sensitization workshop on the SHDP took place on Thursday, 27th August, 2009. The workshop was attended and chaired in person by the Hon. Commissioner of Health, Dr. Muhammad Jabbi Kilgori. Also in attendance were the Representatives of the Hon Commissioners of Local Government Affairs, the Permanent Secretary Health, the Chairmen of the

23 LGAs in the State, Directors of the State Ministry of Health, Rep of the Sultan, Development Partners, CSOs, Professional bodies, etc.

State level training for State level actors/stakeholders with representatives of LGAs [SPT] took place on 1st & 2nd September, 2009. The training was attended and chaired in person by the Permanent Secretary, State Ministry of Health, Alhaji (Pharm) Umaru Attahiru. Also in attendance were the Directors & Program Officers in the State Ministry of Health, Rep of the Sultan, Professional bodies, etc. A total of 33 members attended.

Preparations for the LG level training was commenced with notifications sent from the Min of LG to the LGA authorities and participants. The LGA trainings were successfully conducted on the 7th & 8th of September, 2009. The exercise took place concurrently in 3 locations in headquarters of three senatorial zones- Gwadabawa (for 8 LGAs), Sokoto central for 8 LGAs, and Yabo for 7 LGAs. The turn out of the LGA participants was very good. Ten (10) participants were drawn from each LGA, constituting the LGA Planning Team with the responsibility to develop the LG SHDPlan.

The composition of the LGA planning team comprised of:

i. The LG Director of PHC
ii. The LG Director of Personnel Management
iii. The LG Planning Officer
iv. The PMO or CHO in a health facility in the LGA
v. Community representative
vi. The LG Director of Finance & Supplies
vii. Rep of the Community Health Practitioners of Nigeria
viii. The LG Coordinator of RH
ix. The LG Coordinator of RBM
x. The LG M&E/DSN Officer

The LGA level training was supported by the SPT with 3 LGA facilitators selected from the best performed in the Post test after the State level training and one data manager for each of the 3 groups of LGA trainers in the 3 zones.

The Development of SHDPs at the State level and LGAs started on Monday 14th September 2009 and continued until activities were slowed down by preparations for the Eid il Fitri celebrations on Thursday 17th Sept. As at this time, the State Planning Team had identified and listed several activities for each and all of the 8 domains of the plan. The SPT was chaired daily by the Perm Sec, Health and attended by all directors & program officers in the State Ministry of Health, professional bodies, CSOs & community representative.

Chapter Two: Situation Analysis

2.1: Socioeconomic context

A greater proportion of the inhabitants are rural dwellers (80%) with only 20% dwelling in the urban settlements. The predominant tribes are Hausa and Fulani while Islam is the main religion. Agriculture, petty trading and craftsmanship are the main occupations of the people in the State. Industries in the State are mainly, the cement, leather, aluminium and groundnut oil factories.

2.2: Health Status of the Population

Neonates (children under one month), children under one year , Children under-5, Children under 15 years , women of child-bearing age (15-44), and pregnant mothers constitute 2% (80,514), 4% (161,028), 20% (805,142), 40% (1,610,283), 20% (805,142), and 4% (161,028) respectively. By virtue of their numbers, women and children are the major consumers of health services, of whichever form and therefore huge investment is needed in this aspect of health care services.

The health status indices of Sokoto State are among the worst in Nigeria. Vaccine-preventable diseases and infectious and parasitic diseases continue to exact their toll on health and survival of the Sokoto people, remaining the leading causes of morbidity and mortality. The National Demographic & Health Survey, 2008 revealed the followings for Sokoto State: Current use of contraception, any method = 2.1%, and any modern method = 1.9%. Crude Birth Rate is 41.7 per 1000, Infant Mortality Rate of 100 per 1,000 live births, Under Five Mortality Rate 166/1000 live births (UNICEF, 2008) and Maternal Mortality Rate 850/100,000 (UNFPA, 2007).

Other basic indicators in the State include the followings:

1. Maternal care indicators
   - Percentage with ANC from a health professional = 13.8%
   - Percentage whose last live birth was protected against NNT = 6.8%
   - Percentage delivered by a health professional = 5.1%
   - Percentage delivered in a health facility = 4.4%
2. Childhood Immunization indicators
   - % BCG at birth = 4.5%
   - % DPT3 = 2.0%
   - % Polio 3 = 10.9%
   - % Measles = 3.5%
   - % All = 1.0%
   - % No vaccinations = 64.7%
   - % with a vaccination card = 1%
4. Utilization of health services

- % of children with fever for whom treatment was sought from a health facility/provider = 30.4%
- % of children with diarrhea for whom treatment was sought from a health facility/provider = 33.8%
- % of children with diarrhoea given, any ORT = 12%

5. Nutritional status of children
   - % severely stunted children (below -3 SD) = 32.1%
   - % moderately stunted children (below-3SD) = 53.6%
   - % severely wasted children (below -3SD) = 11.3%.
   - % moderately wasted children (below -2SD) = 24.4%
   - % severely under-weight children (below- 3SD) = 19.1%
   - % moderately under-weight children (below -2SD) = 45.8%

The factors responsible for high maternal death in Sokoto State are not different from that obtainable elsewhere in Northern Nigeria. They include low utilization of existing health services, dearth of health personnel, early marriage and early child bearing. Other factors also known to contribute to the alarming rate are high frequency of childbearing and delay in putting stop to child bearing. The rest are low literacy level especially among the female gender, gender discrimination and other negative cultural practices that are overbearing on health seeking behavior in the state. Vesico-vaginal fistula is still an issue in Sokoto state and family planning utilization is very low. The other underlying factors that do contribute to the ugly picture include poverty and low community awareness of the maternal health services existence as well as poor attitude of the personnel delivering the services.

Clinically, women die mainly from complications during pregnancy and delivery which include Hemorrhage, Sepsis, pregnancy induced Hypertension, Anemia, Malaria and unsafe abortion. The situation is tragic especially when one realizes that these women are dying simply because we are failing to provide known, affordable, simple and cost effective services to majority of them particularly those who reside in the rural areas and largely poor and uneducated.

Malaria, diarrhoea, pneumonia, measles, HIV and TB still constitute the major burden of prevailing diseases in the general population.

Other summary health status indicators for Sokoto State are as presented in the table below:

POPULATION (2006 Census)	SOKOTO
Total population	**3,702,676**
female	1,838,963
male	1,863,713
Under 5 years (20% of Total Pop)	748,444
Adolescents (10 – 24 years)	1,061,750
Women of child bearing age (15-49 years)	860,143

INDICATORS	NDHS 2008
Literacy rate (female)	9%
Literacy rate (male)	45%
Households with improved source of drinking water	25%
Households with improved sanitary facilities (not shared)	57%
Households with electricity	23%
Employment status (currently)/ female	58.5%
Employment status (currently)/ male	96.3%
Total Fertility Rate	8.7
Use of FP modern method by married women 15-49	2%
Ante Natal Care provided by skilled Health worker	14%
Skilled attendants at birth	5%
Delivery in Health Facility	4%
Children 12-23 months with full immunization coverage	1%
Children 12-23 months with no immunization	65%
Stunting in Under 5 children	54%
Wasting in Under 5 children	24%
Diarrhea in children	14
ITN ownership	6%
ITN utilization (children)	3%
ITN utilization (pregnant women)	3%
children under 5 with fever receiving malaria treatment	12%
Pregnant women receiving IPT	1%
Comprehensive knowledge of HIV (female)	17%
Comprehensive knowledge of HIV (male)	3%
Knowledge of TB (female)	65.8%
Knowledge of TB (male)	63.2%

2.3: Health Services Provision and Utilization

The provision of health services follow the same pattern with what is obtained in other States; ie the Federal, State and Local Governments operating at three different levels in provision of services with the complementary efforts of development partners and the civil society.

The provision of highly specialized health care services in the state is shared by the Federal Government through the Teaching Hospital, Neuropsychiatry Hospital and the State Specialist Hospital. The Secondary Health Services are provided by the State Government through 20 General Hospitals while 23 Local Government Councils are charged with the provision of primary level of health care, which is essentially promotive, preventive and curative through PHC Centers, Dispensaries, Clinics and Health Posts with 45 PHCs and 501 clinics. There are 38 private health facilities. Other hospitals in the State include the Noma Children Hospital, Maryam Abacha Women & Children Hospital, Army General Hospital and Police Hospital.

2.4: Key issues and challenges

Inadequate and inequitable distribution of human resource for health, inadequate and poorly maintained health care infrastructures, and poverty are amongst key issues with respect to health services provision and utilization in the state. The poor state of health management information and disease surveillance and control systems and inadequate funding are major challenges to effective planning, implementation and evaluation of the State's health system.

Chapter Three: Strategic Health Priorities

This SHDP seeks to provide strategic guidance to the State in the selection of evidenced-based priority interventions that would contribute to achieving the desired health outcomes for the people of Sokoto State towards achieving sustainable universal access and coverage of essential health services within the planned period of 2010 - 2015. This SHDP focuses on eight priority areas that are listed as follows:

- Leadership and governance;
- Service delivery;
- Human resources for health;
- Health financing;
- Health information system;
- Community participation and ownership;
- Partnerships for health; and,
- Research for health.

Annex I specifies the goals, strategic objectives and the corresponding interventions and activities with costs.

To improve the functionality, quality of care and utilization of services so as to positively impact the health status of the population, universal access to a package of cost-effective and evidence-based interventions detailed below is needed. This would of necessity require interventions that transform the way the health care system is resourced, organized, managed and services delivered.

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

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

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

Chapter Four: Resource Requirements

Human

The table below shows the status of human resource for health in the State.

S/N	HEALTH PERSONNEL				NIGERIANS		NON NIGERIANS		TOTAL
	CATEGORIES	STATE	LGA	PRIV-ATE	M	F	M	F	
1	Specialists Doctors								0
A	Surgeons	3			9		2		11
B	Physians	2		4	7			1	8
C	Paediatrician	3		1	6				6
D	Obstetrics & Gynaecologists	2		4	10	2			12
E	Others (Pls specify)	2			2	1			3
2	Medical Practitioner	73	6	3	87	8	1	1	97
3	Dental Practitioner	2	2		5	1			6
4	Health planners/Administrators	3	2	3	7	1			8
5	Health Researchers								0
6	Nurses (SRNs/SCMs)	432	73	40	429	500			929
7	Nurses Midwives (RMs/SCMs)	81	15	26		323			323
8	Specialist Nurses	35		1	92	63			155
9	Pharmacists	8		30	38	4			42
10	Pharmacy Technicians	38	66	11	112	9			121
11	Environmental Health Officers	17	50		67				67
12	Med. Lab. Technologist	14		7	60	12			72
13	Med.Lab. Technicians	32	42	7	82	5			87
14	Med. Lab. Assistants	14	10	5	32	3			35
15	Statistics/Health Records Officers	121	70	7	209	50			259
16	Radiographers	1		1	8	1			9
17	Community Health Officers	5	77	4	79	9			88
18	Comm. Health Ext. Workers	30	1301	36	1174	200			1374
19	Physiotherapists	2			5	2			7
20	Dental Technologist	3			3	1			4
21	Dental Theapists				2				2
22	Optometrists	2			1				1
23	TBAs		160			160			160
24	Health Educators	1	29		36	3			39
25	Epidemilogists								0
26	Pyschiatrist								0
27	Health Inspectors								0
28	Nursing Aide	16			14	2			16
29	Leprosy Attd								0
30	Rur. Health Supt								0
31	Others	1018		13	709	322			1031
	Total	**1960**	**1903**	**203**	**3285**	**1682**	**3**	**2**	**4972**

Table 2: Health personnel in the State by cadre, gender and rural-urban distribution

Distribution	Urban		Rural		Total	
	M	F	M	F	M	F
Non specialist doctors	114	29	24	0	143	29
Specialist doctors	129	28	4	0	133	28
Nurses/midwives	367	493	160	217	527	710
CHS	25	12	583	660	608	672
Pharmacists/technicians	73	17	117	5	190	22
Laboratory technicians	66	26	42	6	108	32
TOTAL	774	605	930	888	1709	1493
GRAND TOTAL	1379		1818		3202	

(Source: Sokoto State Health Manpower survey, Sokoto State Health Systems Project II, SMOH, 2005).

About 85.6% of non-specialist and 98.7% of specialist doctors, 69.5% of nurses/midwives, 2.8% of Community health extension workers/CHOs , 42% of pharmacists/technicians and 65.7% of laboratory technicians work in the urban areas. (Source: SHD Project, 2005).

The gap between the current human resource situation and requirements in the State is huge.

Based on the WHO recommendation (1994) of 1 doctor to 2060 people, 1 nurse to 980 people, 1 midwife to 600 people and 1 pharmacist to 10,000 people, the disparity between what is required and what is available is shown below:

CADRE OF HEALTH WORKER	NO REQUIRED	NO AVAILABLE	GAP (SHORTFALL)
DOCTOR	2039	287 (137 in State employment & about 150 in Fed employment)	1752
NURSE	4286	1584 (1084 in State employment & about 500 in Fed employment)	2702
MIDWIFE	700	423 (323 in State employment & about 100 in Fed employment)	277
PHARMACIST	420	62 (42 in State employment & about 20 in Fed employment)	358

It is anticipated that with proper planning and adequate financial commitment, these gaps can be systematically met over a 10-year period.

Equipment & Materials

A comprehensive assessment of the status of equipment and supplies of medical consumables in the State is not currently available. This will go a long way, if done, to meet the need in the State.

The summary of the expected cost of the Sokoto State Strategic Health Development Plan in Naira is depicted in the table below, with a total of ₦68,601,615,696.

Priority Area	Cost (NGN)
Leadership And Governance For Health	318,183,000
Health Service Delivery	25,639,557,496
Human Resources For Health	37,226,134,000
Financing For Health	518,148,500
National Health Information System	3,350,363,200
Community Participation And Ownership	780,336,500
Partnerships For Health	393,282,000
Research For Health	375,611,000
Total	**68,601,615,696**

Chapter Five: Financing Plan

5.1 Estimated cost of the strategic orientations

Currently, healthcare is financed in the State similar to that of Federal Government from a mixture of budgetary allocations from the State and 23 LGAs, private out-of-pocket expenditure, external development funding, grants from corporations and charities and a small but growing social health insurance contributions.

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. In 2009, the health budget accounted for 10% of the total state budget and the same for the proposed 2010 budgets. The 23 LGAs are equally increasing the total allocation to health borrowing a good example from the state. The summary of the expected cost of the Sokoto State Strategic Health Development Plan in Naira is N68,601,615,696

5.2 Assessment of the available and projected funds

In all, we are projecting the sum of N30 billion from State, N25 billion from 23 LGAs of the State. The development partners like USAID funded organizations such T-SHIP, GHAIN, Fistula Project will contribute about N1billion Naira over Six years. Similarly, the contribution from UNFPA, UNICEF, WHO, MSF, HSDP11, UNDP, GAVI and MDG Grant is expected to be about N5billion over the Six years. Other sources of funds are donation from Philanthropies and contribution from NGOs and Communities. In this, the sum ofN1billion is expected to be realized while user fees will contribute the sum of N2billion.

5.3 Determination of the financing gap

The financing gap for the implementation of the plan will be N68,601,615,696 less N64billion which is equal to N4,601,615,696.

5.4 Descriptions of ways of closing the financing gap

In view of the prevalent situation of economic recession and competing interest by each social sector, the will be gaps in funds available to implement the prioritized interventions, activities in the health care sector. For this five year plan, the following areas are identified to fill up the gaps:

- ✔ Federal Government through Special Grant for health intervention
- ✔ Attraction of additional funding from Development Partners.
- ✔ Additional funding from Communities, NGOs and health users
- ✔ External/internal loan to be sourced by the State and 23 LGAs of the State

Chapter Six: Implementation Framework

The plan will be jointly implemented by the followings;

- The Federal Government of Nigeria. The role and responsibilities of the Federal Government of Nigeria through the Federal Ministry of Health is to provide leadership, policy guidelines, monitoring the implementation of the plan. The Federal Ministry of Health will also take part in provision of technical guidance and backstopping as well as ensuring that prospective development partners are made to understand the disadvantaged states with a view to work in such state like Sokoto.. the Federal Government is alos to provide special intervention funds from time to time to ensure that factor such as inadequate funding is minimized in the implementation of the Plan.

- The Sokoto State Ministry of Health will be the main implementer of the State Strategic Health Development Plan in collaboration with State Ministry for Local Governments as well as Development Partners. It is the core technical implementing agency for the plan and by this will ensure that the activities are monitrored and evaluated periodically to achieved the so desired results.

- The Sokoto State Health Systems Project II. This will serve as a co-finnacing agency in the implementation of the Strategic Plan and offer technical guidance when the need arises

- The Sokoto State Ministry of Local Government: This will serve as co-implementing partner of the State Strategic Health Development Plan and directly lobby, encourage, advocate and influence Local Government Area Councils in the implementation of the Strategic Plan.

- The Organized Private Sector: They will directly contribute towards the achievement of the planned objectives by execution of some activities and financial contribution to relevant agency for the health care provision in the state.

- International Development Partners. The have crucial role to play in the areas of technical support, financial contribution and direct service delivery as well as participate in ensuring the tracking of the activities.

- NGOs and other agencies: They have the role in service provision, engagement of the communities for health service delivery and make assessment of the Plan progress and challenges. They will also contribute financially towards the implementation of the Plan.

Chapter Seven: Monitoring and Evaluation

7.1: Proposed Mechanism for Monitoring and Evaluation

Effective monitoring and evaluation (M&E) is crucial to successful implementation of this Strategic Plan and to identify areas for further program improvement. The significance of a multidisciplinary and multi-sectoral approach to a successful M&E process and outcome cannot be overemphasized.

To this end, the State House of Assembly, Ministries of Justice, Finance, Budget & Economic Planning, Education, Health and its Agencies have to collaborate and cooperate to achieve the goal of the State's strategic health development plan.

The anticipated impact of the State Government's commitment to the success of the entire program needs no further elaboration.

Chapter Eight : Conclusion

This unprecedented State Strategic Health Development Plan covering the period of 2010-2015 developed by Sokoto State Minsitry of Health in collaboration with key Statholders in response to the request by the Federal Ministry of Health is to serve as a platform and road map for health care delivery in the State. This well thought, costed plan with 8 thematic areas namely; leadership and governance, service delivery, health financing, human resources for health, health information system, community participation and ownership, partnerships for health development and research for health. It will cost the State the sum of N581 billion over the period of six years and is expected to be financed by the State, the 23 Area Councils, Development Partners, NGOs and intervention from the Federal Government. A mechanism is put in place to monitor the progress and evaluate performance.

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Annex 1: Detailed activities for Sokoto State Strategic Health Development Plan

SOKOTO STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
Priority							
Goals					**Baseline year 2009**	**Risks and assumptions**	**Total (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							318,183,000
	1.1	To provide clear policy directions for health development			All stakeholders are informed regarding health development policy directives by 2011		218,855,000
		1.1.1	Improved strategic planning at federal and state levels		Availability of strategic health development plan in the state & all lgas by end of year 2009		186,241,000
			1.1.1.1	Identification of focal health planning officers in the state moh, hsmb, lg health department & health facilities		Government commitment to implementation of the strategic health development plan at all levels under political stability and continuity of program with successive governments.	5,000
			1.1.1.2	Constitute a shdplanning committee at the state & lg levels			-
			1.1.1.3	Quarterly meetings of planning committees at the state & lg levels			27,864,000
			1.1.1.4	Provision & maintenance of computers, internet service, stationeries, generators back-up, office furniture at state & lga health development planning offices.			25,622,000
			1.1.1.5	Training & retraining of health development planning personnel at state & lga levels			132,750,000
		1.1.2	Effective monitoring and evaluation of the shdplan		Availability of quarterly/annual strategic health development plan m&e reports		32,614,000
			1.1.2.1	Constitute a shdplan monitoring & evaluation committee at the state & lg levels		Sustained commitment to m&e of the plan.	180,000
			1.1.2.2	Provision and maintenance of m&e 4 wheeldrive & motorcycles			6,100,000
			1.1.2.3	Provision of data collection tools for m&e of implementation of shdp at state & lga levels			5,760,000
			1.1.2.4	Training & retraining of m&e personnel at state & lga levels on m&e of shdp			18,750,000

			1.1.2.5	Dissemination of m&e results to stakeholders-quarterly			1,824,000
	1.2	To facilitate legislation and a regulatory framework for health development			Health bill signed into law by end of 2009		34,280,500
		1.2.1	Strengthen regulatory functions of government		Availability of legislation(s) on implementation of the shdp in the state by end of year 2010		34,280,500
			1.2.1.1	Review of public health laws in the state		Lack of government commitment to enforcement of health regulatory laws	617,000
			1.2.1.2	Enforce compliance with government rules & regulations at state & lga levels			15,072,000
			1.2.1.3	Monitor compliance with government regulations in the state & lga			17,952,000
			1.2.1.4	Propose bill to the state house of assembly on the structure, functions/activities of the shdp committees at the state & lga levels			617,000
			1.2.1.5	Passage of bill by the state house of assembly on the setting and implementation of shdp in the state & lg levels			22,500
	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		64,477,500
		1.3.1	To improve accountability and transparency		Availability of quarterly/annual reports on budget implementation		8,100,000
			1.3.1.1	Full implementation of due process at state & lga levels		In-apparent effort of government officials to hinder the process of accountability & transparency.	6,120,000
			1.3.1.2	Compliance with budgetary provisions at state & lga levels		Community's commitment to ensure public accountability & transparency	-
			1.3.1.3	Constitute budget implementation monitoring team at state & lga levels			720,000
			1.3.1.4	Quarterly reports on budgetary implementations at state & lga levels			720,000
			1.3.1.5	Compose stakeholders forum on budget accountability&transparency at state & lga levels			540,000
		1.3.2	Improve documentation of accounts & financial processes		Availability of centrally accessible electronic database accounts network system in the state by end of year 2012		55,975,000

			1.3.2.1	Provision of tools for proper documentation of accounts at state & lga levels		Availability of required funds, necessary tools, skilled & motivated staff.	12,440,000
			1.3.2.2	Keep proper records of all documents at state & lga f & s depts			1,535,000
			1.3.2.3	Training & retraining of personnel for proper accounting & financial documentation			42,000,000
		1.3.3	Integration of health account system		Existence of integrated account system in the state/lgas by end of year 2011		402,500
			1.3.3.1	Identify contributions of all development partners (dps) through meeting with them		Cooperation of all stakeholders & common electronically accessible account network (federal,state, & lgas).	22,500
			1.3.3.2	Provide tools for gathering data on contributions of dps			10,000
			1.3.3.3	Pool & rationalise the contributions of dps			120,000
			1.3.3.4	Train personnel on integration of health accounts system at state & lgas			250,000
	1.4	To enhance the performance of the national health system			1. 50% of states (and their lgas) updating shdp annually 2. 50% of states (and lgas) with costed shdp by end 2011		570,000
		1.4.1	Improving and maintaining sectoral information base to enhance performance		Availability of sectoral information database in the state moh & 25% of lgas by the end of year 2011 & in 25% of lgas every year		570,000
			1.4.1.1	Produce database (tools for collection & storage of collected & analysed data) at state & lga		Frequent transfers of capable hands & "political" interference.	-
			1.4.1.2	Sectoral training on data tools & management at state & lga		Availability of stable human resource capability.	250,000
			1.4.1.3	Monitor timeliness & completeness of submission of data from primary sources			320,000
Health service delivery							
2. To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare							25,639,557,496
	2.1	To ensure universal access to an essential package of care			Essential package of care adopted by all states by 2011		11,752,283,496
		2.1.1	To review, cost, disseminate and implement the minimum package of care in an integrated manner		Availability of a costed shdp at state/lga level by the end of 2009		11,468,879,000
			2.1.1.1	Constitute a committee to adopt minimum package of care at state & lg levels		Identification of the most common health problems in the area is a prerequisite	5,292,000

			2.1.1.2	Provision of a costed essential package of care for malaria,hiv/aids, endemic diseases control, anc, family planning, delivery, & referal of complications			4,393,587,000
			2.1.1.3	Provision of a costed essential package of care for child health: malaria, rtis, diarrhoea, immunization			7,070,000,000
		2.1.2	To strengthen specific communicable and non communicable disease control programmes		% decrease in prevalence of priority communicable & non-communicable diseases by end of every year		277,332,496
			2.1.2.1	Appointment of state epidemiologist & data manager for the epidemiology unit		Wrongly prioritized diseases	38,492,496
			2.1.2.2	Upgrading & staffing of state public health laboratory		Adequate provision of basic requirements.	184,200,000
			2.1.2.3	Provision & maintenance of hilux 4 wheel drive truck for disease surveilance & response.			11,260,000
			2.1.2.4	Provision & maintenance of computers, internet service, stationeries, & power back-up(generators) for the epidemiology unit.			1,880,000
			2.1.2.5	Provision of disease surveillance forms & training of surveillance personnel on surveillance data management			41,500,000
		2.1.3	To make standard operating procedures (sops) and guidelines available for delivery of services at all levels		% of health facilities in the state having manuals on sops & guidelines on service delivery at the end of each year		6,072,000
			2.1.3.1	Provide manuals on standard operating procedures and guidelines on common conditions & diseases in the state		Availability of funds for early production of the manuals.	6,072,000
			2.1.3.2			Non compliance of health workers to standard guidelines/operating procedures.	-
	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		11,421,877,000
		2.2.1	To improve geographical equity and access to health services		% of lgas having general hospital in the state at the end of each year; % of wards having a phc in the lga at the end of each year		2,806,292,000
			2.2.1.1	Mapping out of health facilities catchment area in the state		Inflated contract costs of proposed interventions & lack of motivated workers to	1,292,000

						serve in distant & remote areas may hinder successful implementation,	
			2.2.1.2	Construction of one general hospital in each lga and 1 phc clinic in each ward		Adequately motivated staff*.	1,350,000,000
			2.2.1.3	Upgrade and renovate dilapidated health facilities (to approved standard)			1,380,000,000
			2.2.1.4	Establish gis for all health facilities			75,000,000
		2.2.2	To ensure availability of drugs and equipment at all levels		% of hfs having adequate stock of essential drugs at any time		8,076,166,000
			2.2.2.1	Implement guidelines for drug selection quantitifcation,procurement and storage conduct of equipment survey, procurement of medical furniture & equipment		Availability of an essential drug list and adequate funding	3,804,000,000
			2.2.2.2	(a) provide and implement essential drug lists at all levels of health care (b) provide essential equipment to all health facilities in the state (c) train& retrain healthworkers on the concept & practice of essential drugs&rational use of drugs			63,000,000
			2.2.2.3	Transfer drug supplies & administration of dispensaries & pharmacies in health facilities in the state to reputable drug manufacturers & registered pharmacies under private public partnership guidelines.			10,000
			2.2.2.4	(a) print copies of drf/bi guidelines for all health facilities in the state & lga (b) timely provision of essential drugs through drf & b.i in all health facilities at state & lga			4,201,200,000
			2.2.2.5	Monitoring and evaluation of drf and bi schemes			7,956,000
		2.2.3	To establish a system for the maintenance of equipment at all levels		Availability of a central medical equipment maintenance workshop&mobile workshop at the end of 2011		32,700,000
			2.2.3.1	Centralization of medical equipment maintenance unit in the smoh - provision of office furniture		Availability of trained/skilled personnel & machineries	440,000
			2.2.3.2	Provision of mobile workshop vehicle and maintenance tools			15,500,000
			2.2.3.3	Training and retraining of medical equipment maintenance personnel			1,400,000

			2.2.3.4	Provision of logistics for medical equipment maintenance at central workshop and health facilities			360,000
			2.2.3.5	Upgrade state central medical equipment maintenance workshop			15,000,000
		2.2.4	To strengthen referral system		% of hfs in the state having functional ambulances at the end of each year		499,496,000
			2.2.4.1	Implement and train health workers on two way referral system		Adequate sensitization of health workers & community members.	18,000,000
			2.2.4.2	Provision of one ambulance to each gen hospital & phcs in all health facilities in the state			426,000,000
			2.2.4.3	Procure and install communication gadgets for referral in all gen. Hospitals & phcs in the state			46,340,000
			2.2.4.4	Sensitize community and other stakeholders on referral system			1,476,000
			2.2.4.5	Establish a system to monitor referral outcome/effeectiveness			7,680,000
		2.2.5	To foster collaboration with the private sector		No of ppp collaborative projects per annum		7,223,000
			2.2.5.1	Identiy all categories of private health care facilities using a grading system in the state and lgas		Continuous dialogue & consensus.	327,000
			2.2.5.2	Review and disseminate guidelines and standards for regulation of private health care providers in the state and lgas			50,000
			2.2.5.3	Provide technical support to private health facilities			1,434,000
			2.2.5.4	Implement a joint performance monitoring mechanism for the private sector in the state and lgas			1,092,000
			2.2.5.5	Quarterly meeting of the ppp forum			4,320,000
	2.3	To improve the quality of health care services			50% of health facilities participate in a quality improvement programme by end of 2012		1,599,052,000
		2.3.1	To strengthen professional regulatory bodies and institutions		No of interaction with professional regulatory bodies on quality of care at the end of each year		120,000,000
			2.3.1.1	Support workshop organised by professional bodies on continuing education and promotion of ethical practice		Adequate sensitization, motivation & support to professional groups.	90,000,000
			2.3.1.2	Support professional bodies in their supervision of quality of care & professional standards in health facilities			30,000,000

			2.3.1.3	Support professional bodies to ensure that only qualified members of various health professional groups practice in health facilities in the state and lgas			-
			2.3.1.4	Ensure adequate and proper staffing of health facilities at the state and the lga levels			-
			2.3.1.5	Ensure adequate release of budgeted funds to professional training institutions			-
		2.3.2	To develop and institutionalise quality assurance models		No of hfs/institutions having quality assurance committees at the end of each year		218,024,000
			2.3.2.1	Establish quality assurance committee at state, lga, and facilities level		Existence of established standards & capacity to develop qa models.	28,752,000
			2.3.2.2	Develop the purpose, the vision and the scope of activities for the quality assurance			200,000
			2.3.2.3	Training and retraining of the personnel to improve their professional (technical) competence			187,200,000
			2.3.2.4	Foster commitment to quality through team work			-
			2.3.2.5	Disseminate the activities of the quality assurance to stake holders			1,872,000
		2.3.3	To institutionalize health management and integrated supportive supervision (iss) mechanisms		% of hfs visited by hm/iss teams and with documented reports at the end of each year		1,261,028,000
			2.3.3.1	Identify supportive group for effective supervision		Availability of adequate fund & sustained supervision drive.	-
			2.3.3.2	Provide 4 wheel drive vehicle for supervision at state and lga			1,211,288,000
			2.3.3.3	Training of health personnel on basic managerial skills			19,500,000
			2.3.3.4	Ensure adequate and proper staffing of health facilities at the state and the lga			-
			2.3.3.5	Quarterly visits of integrated supportive supervisory teams to health facilities in the state			30,240,000
	2.4	To increase demand for health care services			Average demand rises to 2 visits per person per annum by end 2011		32,565,000
		2.4.1	To create effective demand for services		No of jingles aired on local radio/tv at the end of each quarter		32,565,000
			2.4.1.1	Regular health education jingles on tv & radio on popular/essential health problems		Adequate funds & sustained community mobilization	900,000
			2.4.1.2	Periodic radio and television reports on available health services in health facilities in the state			1,440,000

			2.4.1.3	Production and airing of health jingles on radio & tv in the state			-
			2.4.1.4	Print and distribute iec materials (posters, handbills) on common health problems in the state			30,000,000
			2.4.1.5	Conduct advocacy on health care services to line ministeries/media houses (information, women affairs, local government, nta, rtv & rima radio)			225,000
	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		833,780,000
		2.5.1	To improve financial access especially for the vulnerable groups		% of vulnerable group with provision for free medical care at the end of each year		833,780,000
			2.5.1.1	Establish database for members of vulnerable groups in the state		Integration & scaling up of the existing free medical care to cater for the vulnerable groups. Established community social insurance models & schemes.	5,750,000
			2.5.1.2	Scale up community health social insurance scheme		Absence of existing database & estimation of the target groups.	828,000,000
			2.5.1.3	Strengthen free medical care for pregnant mothers, children under five and destitutes/vulnerables in the state			-
			2.5.1.4	Adopt/customize child right act or laws to basic education, health and nutrition at state and lga levels by the state housee of assembly			30,000
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							37,226,134,000
	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		10,500,000
		3.1.1	To develop and institutionalize the human resources policy framework		Availability of hrh policy framework at state & lgas by the end of 2011		9,780,000
			3.1.1.1	Identify, estimate and document the human resources requirements for health in the state & lgas		Available man power and skilled personnel, available political will and funds at state & lgas,	2,000,000
			3.1.1.2	Formulate policy on hrh need&distribution in the state		Lack of skilled personnel & poor dissemination & implementation of policy framework.	2,000,000

			3.1.1.3	Identify strategies for the development and sourcing of hrh in the state			2,000,000
			3.1.1.4	Revive and strengthen needs assessment & hrh development committee at the state and lgas			3,780,000
			3.1.1.5				-
		3.1.2	To establish database of hrh at state & lga levels		Availability of database on hrh at state & lgas by the end of 2010		720,000
			3.1.2.1	Adapt & produce a tool for hrh database at the state & lga levels		Available tools, skilled personnel, funds for collection and documentation of database.	720,000
			3.1.2.2	Strengthen database of hrh at the state & lga levels			-
	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		34,149,600,000
		3.2.1	To reappraise the principles of health workforce requirements and recruitment at all levels		Availability of updated health workforce requirements at state & lgas at the end of every year		34,149,600,000
			3.2.1.1	Identify, estimate and document the human resources requirements for health in the state		Availability of hr for recruitment and availability of funds	32,205,600,000
			3.2.1.2	Identify strategies for the development and sourcing of hrh in the state ****** duplicate			-
			3.2.1.3	Identify the basis of hrh needs and recruitment in the state &lgas			1,944,000,000
			3.2.1.4	Conduct annual staff audit to assess relevance and adequacy			-
			3.2.1.5	Provide incentives to create & sustain condusive work environment to attract and retain health workers in the state and lgas			-
	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		2,375,000
		3.3.1	To establish and strengthen the hrh units		Existence of hrh units in the state/lgas by the end of 2012		2,375,000
			3.3.1.1	Strengthen hrh unit in the state moh & health depts of lga in the state		Availability of logistics & political will.	300,000
			3.3.1.2	Constitutes hrh development consultative forum with professional bodies, community representatives			1,575,000

			3.3.1.3	Capacity building for officers responsible for hrh planning, management & development			-
			3.3.1.4	Provide necessary logistic support for effective & efficient performance of hrh units (eg: computers, vehicles etc)			500,000
	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		2,424,885,000
		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		No of adapted relevant training programmes for the production of community health oriented professionals by the end of 2012		906,960,000
			3.4.1.1	Conduct regular accreditation of our health training institutions and affiliation with relevant universities and colleges		Available manpower, training institutions, materials and information on various programmes and adequate funding	6,960,000
			3.4.1.2	Update training curriculum to include vertical programmes (eg: malaria, tb, hiv and other infectious diseases)		Strikes in training institutions	-
			3.4.1.3	Provide scholarship for trainees/residency in needed specialities to attract them to such specialization and bond them to serve after training			900,000,000
			3.4.1.4	Conduct regular on- the- job training for health care providers			-
			3.4.1.5	Monitor and evaluate performance of health care providers			-
		3.4.2	To strengthen health workforce training capacity and output based on service demand		% of scheduled trainings implemented at the end of every year		1,517,925,000
			3.4.2.1	Identify areas of need of health workforce based on service demand		Available trained personnel and appropriate funding	1,500,000
			3.4.2.2	Conduct quarterly departmental or facility level seminars		Lack of time and willingness of personnel to be trained	1,440,000,000
			3.4.2.3	Train and retrain health personnel in various fields as per current trends in management of disease condition in healthcare delivery			73,800,000
			3.4.2.4	Adopt the reviewed competencies-based curriculum for on the job training of healthworkers in the state, lgas & facilities			2,625,000
	3.5	To improve organizational and performance-based management systems for human resources for health			50% of states have implemented performance		628,774,000

					management systems by end 2012		
		3.5.1	To achieve equitable distribution, right mix of the right quality and quantity of human resources for health		% increase in proportion of hrh posted to rural areas at the end of each year		613,250,000
			3.5.1.1	Develop policy framework on equitable distributtion of human resource at all levels		Availability of mixed quality of hrh	1,400,000
			3.5.1.2	Provide additional incentives to those hrh posted to rural & remote areas			-
			3.5.1.3	Provide comprehensive database on distribuution hrh at all levels			450,000
			3.5.1.4	Train emergency staff to support referral arrangements			611,400,000
			3.5.1.5				-
		3.5.2	To establish mechanisms to strengthen and monitor performance of health workers at all levels		Availability of quarterly report on health workers performance		15,524,000
			3.5.2.1	Implement policy framework/guidelines to strenghthen and monitor performance of health workers in the state & lga		Available logistics and strong motivation/commitment	-
			3.5.2.2	Develop monitoring tool(s) for assessment of health workers performance			96,000
			3.5.2.3	Conduct quarterly monitoring, supervision and evaluation of the hrh			8,588,000
			3.5.2.4	Provide logistic support for effective monitoring, supervision & evaluation of hrh in the state & lgas			-
			3.5.2.5	Conduct bi-annual identification & reward of best performing healthworkers in sections, departments or units of health facilities&institutions/establishments.			6,840,000
	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		10,000,000
		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		No of interactions between health professional associations & regulatory bodies on health system issues at the end of each year		10,000,000
			3.6.1.1	Establish all health workers forum at state & lga levels for the discussions of health problems & joint activities for health advancement		Available intersectoral collaboration and good communication network.	-

			3.6.1.2	Conduct annual state conference on health			5,000,000
			3.6.1.3	Conduct state council on health meeting			5,000,000
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							518,148,500
	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		72,103,500
		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		Availability of costed strategic development plan at state & lgas by the end of 2009		60,466,000
			4.1.1.1	Develop evidence-based, costed health financing strategic plans at state&lga levels		political will & commitment	26,870,000
			4.1.1.2	Determine the total population and estimate cost per head for healthcare in the state & lgas			13,800,000
			4.1.1.3	Implement the nhis health financing mechanisms at state and lga levels			-
			4.1.1.4	Setting up of technical working group for health financing at state and lga levels			14,575,000
			4.1.1.5	Build capacity of key personnel for development and implementation of health financing strategies			5,221,000
		4.1.2	To establish and strengthen the source of finance		Availability of policy framework on sourcing of funds for health care financing at state & lgas by the end of 2010		570,000
			4.1.2.1	Adopt policy framework for the sourcing, estimation of amount, coordination, appropriation&harmonization of healthcare financing in the state&lga level		Political will and harmonisation of funding sources	570,000
			4.1.2.2	Identify&document sources of healthcare financing at state&lga levels			-
		4.1.3	To encourage sustenable collaboration between government, stakeholders, other donor organization and benefiting communities.		No of quarterly meetings (with minutes) of the health sector stakeholders forum held		11,067,500
			4.1.3.1	Review composition of health sector stakeholders forum to enhance efficiency for discussions&dialogue on health development		Willingness of government and other stakeholders for collaboration	87,500
			4.1.3.2	Develop terms of reference of the health sector stakeholders forum			-

			4.1.3.3	Quarterly meetings of the health sector stakeholders forum			10,980,000
	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		389,225,000
		4.2.1	To strengthen systems for financial risk health protection		Implementation of the nhis by the state & % of lgas implementing the health insurance sheme at the end of each year		8,200,000
			4.2.1.1	Implementation of the national health insurance scheme for workers at state and lga levels		Functional nhis at state, lga and community levels	-
			4.2.1.2	Introduce and implement community health insurance schemes for workers & individuals in the community at state & lga levels			4,600,000
			4.2.1.3	Scaling up of social health protection models such as free medical care for pregnant mothers and children underfive as well as rural mobile care for underserved communities & exemption vulnerable groups in terms of scope (ito) - level of care , target beneficiary			-
			4.2.1.4	Advocate & sensitize philantropists & ngos to establish private non-profit health facilities & funds for service delivery in the state & lga			3,600,000
			4.2.1.5				-
		4.2.2	To establish and strengthen drug revolving scheme in health care		No of hfs having functional drf/bi scheme in the state at the end of each year		381,025,000
			4.2.2.1	Setup/review drug revolving scheme/bi in all health facilities in the state & lgas		Existence of a drug revolving scheme and available funds.	265,000
			4.2.2.2	Provision of logistics for management of drf/bi schemes at state & lga levels			2,400,000
			4.2.2.3	Training & retraining of drf/bi staff at state & lga levels			371,460,000
			4.2.2.4	Establish separate drf/bi management units in the state & lga levels			6,900,000
			4.2.2.5	Separate and cost exemptions from drf scheme and merge it with fremcare			-
		4.2.3	To ensure improved quality of services		No of hfs having quarterly assessment report on drf/bi scheme in the state/lgas		-

			4.2.3.1	Setup and review drug revolving/bi scheme m&e committees at state & lga level in the state		Good monitoring and evaluation of existing services	-
			4.2.3.2	Train & retraining of health workers on rational prescribing and laboratory investigations			-
			4.2.3.3	Quarterly assessment of drf/bi scheme in all health facilities at state & lgas			-
	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		990,000
		4.3.1	To improve financing of the health sector		% of state/lga budget allocated to health each year		-
			4.3.1.1	Collaborate with private partners to fund health programs/projects		Political will and involvement of development partners in health sector financing including the organised private sector & ngos.	-
			4.3.1.2	State and lgas to apportion at least 15% of the total budget to health			-
			4.3.1.3	Advocate for increase taxation of non essential commodities that could cause harm to people			-
			4.3.1.4	Establish health resource mobilization committee to attract financial flow to the health sector from dev.partners, fgn and other agencies at state and lga levels			-
		4.3.2	To improve coordination of donor funding mechanisms		No of integrated donor funds at the end of each year		-
			4.3.2.1	Review the existing donor funding coordination mechanism at state and lga levels		Political interference	-
			4.3.2.2	Establish integrated donor funds coordination & management committees at state level			-
			4.3.2.3	Adequate linking and proper monitoring of activities of donor agencies from state down to lg level			-
		4.3.3	To facilitate sustenable private funding mecanism		No of integrated private funds at the end of each year		990,000
			4.3.3.1	Advocacy to, and contribution of zakat/waqaf committees to health financing		lack of cooperation of the organised private sector	990,000
	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 management systems in place by end of 2015 2. 60% of states and lgas have supportive supervision and		55,830,000

					monitoring systems developed and operational by dec 2012		
		4.4.1	To improve health budget execution, monitoring and reporting		1. Completeness & timeliness of quarterly progress reports on health budget implementation in the state/lgas. 2. Availability of annual external audit report of the health budget implementation at state/lgas		15,330,000
			4.4.1.1	Strenghten multidisciplinary implementation monitoring, quality assurance teams at state and lga levels		accountability and transparency in implementation of health budget	10,170,000
			4.4.1.2	Quarterly progress reports on health budgetary implementations at state & lga levels			1,200,000
			4.4.1.3	Annual external auditing of health account			600,000
			4.4.1.4	Provision of logistics and working tools for budget computing and tracking			3,360,000
		4.4.2	To strengthen financial management skills		1. No of trainings & retrainings conducted on financial management skills in the state/lgas at the end of each year. 2. No of workers trained/retrained on financial management skills in the state/lgas		40,500,000
			4.4.2.1	Supportive supervision of financial management staff by the min. Of finance & audit dept		availability of trained staff, working tools and proper supervision	10,440,000
			4.4.2.2	Capaicity building on financial management			27,000,000
			4.4.2.3	Provision of logistic such as computers and accessories to enhance financial management performance			3,060,000
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							3,350,363,200
	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		2,886,709,800
		5.1.1	To ensure that nhmis forms are available at all health service delivery points at all levels		Availability of adequate quantities of		125,527,000

					nhmis forms in hfs at all times		
			5.1.1.1	Bulk production of hmis data forms based on quantified estimate at state and lga levels		bulk production & distributionof the forms for successive year in the last quarter of preceding year.	105,415,000
			5.1.1.2	Distribute annually the hmis data collection forms to public and private health facilities in the state &lgas			5,520,000
			5.1.1.3	Monitor the availability & utilization of hmis data forms at all levels on quarterly basis			14,592,000
		5.1.2	To periodically review of nhmis data collection forms		No of quarterly reports of the hdcc		3,142,500
			5.1.2.1	State health team attends annual national data review meeting		Availability of a designated desk officer for the review of collected data	1,680,000
			5.1.2.2	Inauguration of hdcc and quarterly review of completed data generated in the state			1,462,500
		5.1.3	To coordinate data collection from vertical programmes		No of integrated vertical programs at the end of each year		9,601,300
			5.1.3.1	Print and implement the tor of hdcc (include all relevant professionals bodies, organized private health sector, development partners & community reps) in line with the national hmis policy guideline		Cooperation of all stakeholders	1,300
			5.1.3.2	Strength coordination of data collection through quarterly meeting with vertical programme by the hdcc			2,484,000
			5.1.3.3	support with calculators (for private), sensitization meeting with the deveolpment partners, public & private health facilities to submit their data to lgas where they operate			7,116,000
		5.1.4	To build capacity of health workers for data management		No of health workers trained/retrained on health data management in the state/lgas at the end of each year		842,298,000
			5.1.4.1	Assessment of training needs of health workers on data management & design a training package		Iinadequate funds & frequent transfer of trained staff.	4,600,000
			5.1.4.2	Provide computers and stationeries for the trainees (health workers) to 20 gen. Hosps & 50 phcs in the state			29,400,000
			5.1.4.3	Print and distribute hmis policy document to health workers in the state			2,798,000

			5.1.4.4	Training and retraining of health workers on hmis data mangement at state level			112,500,000
			5.1.4.5	Training and retraining of health workers on hmis data management at lga level			693,000,000
		5.1.5	To provide a legal framework for activities of the nhmis programme		Existence of law on mandatory rendition of health data to state/lga authorities by the end of 2010		54,000
			5.1.5.1	Draft a bill for state house of assembly to make necessary legislations to ensure mandatory data rendition to enforce compliance		successful development of a legal framework.	54,000
		5.1.6	To improve coverage of data collection		% completeness & timeliness of health data submission to the state/lgas at the end of each month		1,884,566,500
			5.1.6.1	Strengthen data transmission from source to the lg hq /state through production and distribution of data flowchart		Availability of logistics for mobility	1,926,500
			5.1.6.2	Provide allowances and transport for data collection staff			1,670,640,000
			5.1.6.3	Provide logistic support to data collection			212,000,000
			5.1.6.4	Adequate production and distribution of data collection forms to all health facilities in the state			-
		5.1.7	To ensure supportive supervision of data collection at all levels		No of quarterly supervision reports on nhmis data collection in the state/lgas at the end of each year		21,520,500
			5.1.7.1	Provide checklist and supervision vehicles and allowances for the supervisors		Availability of logistics for mobility.	1,048,500
			5.1.7.2	Provide incentive/reward for hardworking data collection staff			1,140,000
			5.1.7.3	Production of quarterly supervision report for state & lga			13,572,000
			5.1.7.4	Provide quarterly feedback on timeliness & completeness of hmis data submission at state & lga levels			5,760,000
	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		115,155,000
		5.2.1	To strengthen the use of information technology in his		No of his staff trained on ict, data analysis & reporting at the end of each year		37,759,000
			5.2.1.1	Provide computers, printers, internet facilities, camcorders,		availability of ict & trained personnel	16,759,000

				projectors, screens & consumables to dept. Hprs			
			5.2.1.2	Train his staff on ict,.data analysis, reporting and dissemination of information			21,000,000
		5.2.2	To provide hmis minimum package at the different levels (fmoh, smoh, lga) of data management		No of hmis depts/sections equiped with hmis minimum package at state/lgas at the end of each year		77,396,000
			5.2.2.1	Provide computers, printers, photocopier,multimedia projector, scanning machines, binding machine, calculators, internet facilities, generator and vehicles at state level		Availability of working materials & competent staff	5,054,000
			5.2.2.2	Provide computers, printers, calculators, internet facilities, generators and motorcycles for data collection at lga headquarters			65,502,000
			5.2.2.3	Provide calculators to health facilities for data returns to lga hqtrs			6,840,000
	5.3	To strengthen sub-systems in the health information system			1. Nhmis modules strengthened by end 2010 2. Nhmis annually reviewed and new versions released		332,398,000
		5.3.1	To strengthen the hospital information system		1.no of health managers trained/retrained on hospital data processing/management. 2. No of hfs equiped with appropr data mgmt facilities in the state/lgas at the end of each year		66,362,000
			5.3.1.1	Training and retraining of his staff on data processing and management		availability of working materials & competent staff	21,000,000
			5.3.1.2	Provide working equipment i.e. Computers, printers, photocopiers, calculators, internet facility in general hospitals			42,050,000
			5.3.1.3	Provide transport allowance for data returns			3,312,000
		5.3.2	To strengthen the disease surveillance system		1. Availability of state epidemiologist/ epid data manager/ surveillance vehicle at state hq level. By the end of 2010. 2. No of disease surveillance staff trained/retrained at the end of each year.		266,036,000
			5.3.2.1	Training and retraining of disease surveillance staff		inadequate funds for daily running of surveillance vehicles.	21,000,000

			5.3.2.2	Appoint epidemiologist and data manager at state level			29,970,000
			5.3.2.3	Provide logistic and vehicles for disease surveillance at state & motorcycles at lga level			29,066,000
			5.3.2.4	Provide emergency drugs and equip to public health laboraotry			180,000,000
			5.3.2.5	Annual production of disease surveillance and notification data forms			6,000,000
		5.3.3					-
	5.4	To monitor and evaluate the nhmis			Nhmis evaluated annually		16,100,400
		5.4.1	To establish monitoring protocol for nhmis programme implementation at all levels in line with stated activities and expected outputs		1.availability of nhmis monitoring protocol at state /lgas at the end of 2010. 2. Availability of quarterly/biannual/annual hmis reports		16,000,400
			5.4.1.1	Develop & produce monitoring protocol for nhmis program at all levels		Inadequate funds for routine transportation of monitoring committees	2,000,000
			5.4.1.2	Constitute m&e committees to monitor hmis implementation at state and lgas level			2,400,000
			5.4.1.3	Production of checklist/assessment form for monitorring the hmis program			410,400
			5.4.1.4	Produce & disseminate quarterly, bi-annual reports & annual bulletin			11,190,000
		5.4.2	To strengthen data transmission		Availability of website designed to host hmis & health information in the state by the end of 2010		100,000
			5.4.2.1	Develop website to strengthen data/information transmission at state level		Availability of ict/ internet facility & skilled workers	100,000
	5.5	To strengthen analysis of data and dissemination of health information			1. 50% of states have units capable of analysing health information by end 2010 2. All states disseminate available results regularly		-
		5.5.1	To institutionalize data analysis and dissemination at all levels		1.no of hfs with capacity for data managementat the end of every year. 2.no of hfs adequately equiped for health data management		-
			5.5.1.1	Train and retrain of health information management staff & other relevant health workers on		availability of sufficient no of workers to cope with volume of other works.	-

				data analysis and report writing at state and lga levels			
			5.5.1.2	Provide working material/working tools - computers, printers, softwares, internet facility, we\bsite, bulletin, magazine			-
			5.5.1.3	Strengthen health data analysis units at state &lg levels			-
Community participation and ownership							
6. To attain effective community participation in health development and management, as well as community ownership of sustainable health outcomes							780,336,500
	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		452,412,500
		6.1.1	To provide an enabling policy framework for community participation		Availability of policy guidelines on community participation in the state/lga by the end of 2010		147,330,000
			6.1.1.1	Develop or update and disseminate policy guidelines for community participation in the state&lga		identification& sensitization of appropriate target groups & cooperation of community members.	147,015,000
			6.1.1.2	Develop or update and disseminate policy guidelines for community participation in the state &lga			315,000
		6.1.2	To provide an enabling implementation framework and environment for community participation		No of community leaders aware of policy provisions on community participation by the end of 2010		305,082,500
			6.1.2.1	Establish intersectoral stakeholders committee to enhance collabration at state and lga levels		Successful development of the implementation framework.	102,500
			6.1.2.2	Develop the framework for implementation of community participation			780,000
			6.1.2.3	Sensitization workshop on policy framework&implementation guidelines on community participation for community leaders&leaders of community based organisations such as vhc,wdc,whc,tha,women groups,youth group,tbas,etc.			7,200,000
			6.1.2.4	Identify & reactivate community structures for community participation			90,000,000
			6.1.2.5	Encourage&support community initiated programs&projects			207,000,000
	6.2	To empower communities with skills for positive health actions			All states offer training to fbos/cbos and community leaders on engagement		85,512,500

					with the health system by end 2012		
		6.2.1	To build capacity within communities to 'own' their health services		1. No of community members trained on capacity to initiate & maintain health programs/projects by the end of each year. 2. No of communities with self initiated health programs/projects in the state/lgas by the end of each year.		85,512,500
			6.2.1.1	Identify key cbos and other stakeholders & assess their capacity		Cooperation of community members to spare persons & time for such training.	102,500
			6.2.1.2	Conduct orientation to community development committees,commmunity resource persons (corps) on their roles and responsibilities			780,000
			6.2.1.3	Provide appropriate training to identify health problems in their communities & to develop & implement health programs&projects.			84,545,000
			6.2.1.4	Encourage communities to source/mobilise funds for community health programs/projects			-
			6.2.1.5	Establish key roles and functions of community stake holders and structures.			85,000
	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		54,967,500
		6.3.1	To restructure and strengthen the interface between the community and the health services delivery points		No of joint health facility&community members meetings at state/lga levels at the end of each year		54,967,500
			6.3.1.1	Review the existing health delivery structures and assess their levels of interface with the community.		Interactions fora with the community	247,500
			6.3.1.2	Quarterly meetings of health service points & communities in their catchment areas/neighbourhoods.			54,720,000
	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		177,720,500

		6.4.1	To develop and implement multisectoral policies and actions that facilitate community involvement in health development		1. Existence of a policy document on multisectoral community involvment in health development. 2. No of quarterly intersectoral committee meetings (with reports) at state & lga levels at the end of each year		177,720,500
			6.4.1.1	Formation of intersectoral committees on health at state&lga levels		Interactions fora with the community	679,500
			6.4.1.2	Quarterly meetings of the committee			83,766,000
			6.4.1.3	Develop&implement policy framework for intersectoral collaboration			23,000,000
			6.4.1.4	Identify&implement multisectoral actions to facilitate community involvement in health development			47,275,000
			6.4.1.5	Empower communities with health knowledge,behavioral communication change and uptake mechanism.			23,000,000
		6.4.2					-
	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		9,723,500
		6.5.1	To develop and implement systematic measurement of community involvement		1.no of existing ward health development committees at the end of each year . 2. No of community initiated ward health projects at the end of each year		9,723,500
			6.5.1.1	Develop tools for the assessment of community participation		Availability of expertise to develop easy and measurable assessment tools.	787,500
			6.5.1.2	Assessment of community participation in health programs&projects			936,000
			6.5.1.3	Measure impact of community participation on health development			8,000,000
Partnerships for health							
7. To enhance harmonized implementation of essential health services in line with national health policy goals							393,282,000
	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		393,282,000

					quarterly by end 2010 3. All states have similar active committees by end 2011		
		7.1.1	To promote public private partnerships (ppp)		1. Availability of policy guidelines on ppp in the state/lga by the end of 2010. 2. No of ppp projects/programs in the state/lgas by the end of each year		4,940,000
			7.1.1.1	Adopt & customize policy guidelines for public private partnership at state and lga levels		Identification of priority areas for ppp	1,940,000
			7.1.1.2	Identify areas of need of support of the private sector to the public health sector			3,000,000
		7.1.2	To institutionalize a framework for coordination of development partners		% of devpt partnership programs integrated/harmonized into state health program by the end of 2010		4,603,000
			7.1.2.1	Harmonize workplan of development partners		Cooperation of development ent partners	1,343,000
			7.1.2.2	Quaterly private partners meetings			3,260,000
		7.1.3	To facilitate inter-sectoral collaboration		1. Availability of policy guidelines on intersectoral collaboration./ 2. No of dps on the membership of the state health stakeholders forum by the end of 2010		35,085,000
			7.1.3.1	Inclusion of development partners in intersectoral committees on health at state level		Sustained periodic meetings of the committee	10,000
			7.1.3.2	Regular, quarterly meetings of the committee			-
			7.1.3.3	Develop&implement policy framework for intersectoral collaboration			167,500
			7.1.3.4	Identify&implement multisectoral actions to facilitate community involvement in health development			167,500
			7.1.3.5	Empower communities with health knowledge,behavioral communication change and uptake mechanism in the state			34,740,000
		7.1.4	To engage professional groups		% of all professional groups in the membership of health stakeholders forum		756,000
			7.1.4.1	Include professional groups in the intersectoral committees on health at the state & lga levels		cooperation of professional groups	756,000

			7.1.4.2	Encourage active participation & contribution of professional groups on health development at state & lga levels			-
		7.1.5	To engage with communities		1.no of ward health devpt committees/ 2. No of community initiated ward health projects. / 3. No of govt/community co funded health projects at the end of each year		258,024,000
			7.1.5.1	Provide basic health information to the communities using both electronic and print media		sustainability of community dialogues	-
			7.1.5.2	Advocacy/meetings to promote community participation and involvement			25,323,000
			7.1.5.3	Community empowerment through small and medium scale enterprises			213,726,000
			7.1.5.4	Reactivation and funding of health and developmental committees at all levels			-
			7.1.5.5	Capacity building of community members on prevention and care of common illness			18,975,000
		7.1.6	To engage with traditional health practitioners		Existence of joint committee of traditional & orthodox medical practitioners on traditional medicine by the end of 2010		89,874,000
			7.1.6.1	Constitute joint health committee of pharmacists, modern and traditional medical practitioners at all levels		constant interactions & collaborations	-
			7.1.6.2	Regular meetings with the traditional medicine practitioners to appraise and reappraise their activities			25,920,000
			7.1.6.3	Training and retrainig to improve the skills of tmps, to know their limitations and the need for referrals			43,920,000
			7.1.6.4	Establish a unit of traditional medicine under the ministry of health			290,000
			7.1.6.5	Provide logistic support for supervision to enhance the performance of tmps at state & lga levels			19,744,000
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							375,611,000

	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		148,224,500
		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		Adopt with modification the national health research policy by the end of 2010		112,839,000
			8.1.1.1	Advocacy&sensitization on need for health research in the state & lga		poorly constituted state research committee	1,101,000
			8.1.1.2	Adapt the national policy guidelines for health research at state and lga levels			270,000
			8.1.1.3	Equip the research unit of the state ministry of health and lga m&e units with laptop computers, internet modem, vehicles,motorcycles, calculators, printers, office furniture,			111,468,000
			8.1.1.4	Develop mechanism for communication and utilization of the research findings			-
			8.1.1.5				-
		8.1.2	To establish and or strengthen mechanisms for health research at all levels		% of state&lga budget allocated for health research per annum.		27,522,000
			8.1.2.1	Constitute state & lgas health research teams		Adequate funding & sourcing of resource persons	13,392,000
			8.1.2.2	Conduct advocacy to policy makers and other stakeholders to gain support for health research			675,000
			8.1.2.3	Identify priority areas for health research&identify sources, mobilise & allocate adequate funding for health research			13,392,000
			8.1.2.4	Include the academia & professional bodies in the composition of health research teams			5,000
			8.1.2.5	Advocate to min of mep to allocate 2% of annual health budget to health research			58,000
		8.1.3	To institutionalize processes for setting health research agenda and priorities		Existence of state health research coordination & ethical committee by end of 2010		2,160,000
			8.1.3.1	Constitute state health research coordination and ethical committee & implement the essential state health research (eshr) programme		appropriately constituted state health research coordination committee.	1,188,000

			8.1.3.2	Prioritize health research agenda to include broad and multi-dimensional determinants of health			972,000
			8.1.3.3	Coordination of health research agenda by the department of prs at the state level			-
		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		No of intersectoral collaborative health research at the end of each year		4,356,000
			8.1.4.1	Advocacy to corporate organizations, philanthropists, ngos and other development partners		Fear of domination of state & lgas staff by federal agencies	304,000
			8.1.4.2	Involvement of intersectoral partners in the conduct and dissemination of research and implementation of research findings			-
			8.1.4.3	Develop strategies to promote public private partnership (pppp) for health system research			3,080,000
			8.1.4.4	Develop proposals and source funds from relevant agencies/development partners for health research			972,000
		8.1.5	To mobilise adequate financial resources to support health research at all levels		Allocation of 10% of non-govt harmonised funds to health research each year		79,000
			8.1.5.1	Identify & document health research institutions in the state		Lack of appreciation of relevance of adequate funding for health research	5,000
			8.1.5.2	Advocacy for budgetary allocation from state government to finance research activities			36,000
			8.1.5.3	Assess and support the capacity of health research institutions in the state including the academia, professional bodies, community reps, csos, etc for health research			38,000
		8.1.6	To establish ethical standards and practise codes for health research at all levels		Availability of state guidelines on ethics of health research by end of 2010		1,268,500
			8.1.6.1	Adopt national ethical guidelines for health research in the state		Appropriately constituted research ethics committee	80,500
			8.1.6.2	Quarterly meetings of the research coordination and ethical committee			1,188,000
	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		206,221,500
		8.2.1	To strengthen identified health research institutions at all levels		1.no of state funded health research. 2. % of budgeted funds to health research		1,925,000

					released at the end of each year.		
			8.2.1.1	Follow up for the release of annual alotted funds to selected health researches in health institutions in the state		adequate funding	5,000
			8.2.1.2	Support health research institutions with laptop computers and accessories in the state			1,920,000
		8.2.2	To create a critical mass of health researchers at all levels		No of health workers trained/retrained on health research in the state/lgas by the end of each year		119,591,000
			8.2.2.1	Sensitization of health workers and other stakeholders on health research at state & lga levels		adequate funding	1,775,000
			8.2.2.2	Train health workers on health research at state & lga levels			117,816,000
		8.2.3	To develop transparent approaches for using research findings to aid evidence-based policy making at all levels		No of research dissemination forum organised in a year		12,660,000
			8.2.3.1	Conduct research dissemination workshops for policymakers, health planners and managers on research findings for integration and implementation		Adequate sensitization of target groups for the utilization of reseach findings	7,092,000
			8.2.3.2	Dissemination of health research reports to policymakers, health institutions, libraries and other stakeholders			4,608,000
			8.2.3.3	Publish health research findings in health journals, bulletins and magazines			960,000
		8.2.4	To undertake research on identified critical priority areas		No of conducted research focused on selected/priority health issues in the state each year		72,045,500
			8.2.4.1	Identify & document criteria to determine critical/priority health research area in the state&lga		Sourcing the expertise of experienced researchers	45,500
			8.2.4.2	Conduct health resaerch on selected critical/priority areas in the state&lga			72,000,000
	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		20,038,000
		8.3.1	To develop strategies for getting research findings into strategies and practices		1.existence of state health library in smoh & no of lga health depts having technical report library by the end of each year		16,450,000

			8.3.1.1	Strengthen state health library in the state ministry of health with computers, internet modem curreent professional textts/reference books and establish technical report libraries at zonal and lga phc levels		Experienced implementation committee	16,450,000
		8.3.2	To enshrine mechanisms to ensure that funded researches produce new knowledge required to improve the health system		No of identified high impact researches each year		3,588,000
			8.3.2.1	Critical assessment & selection of research proposals by the ethical committee on health research		Selection & funding of only researches with well defined protocols	1,188,000
			8.3.2.2	Provide incentives (merit award) for best researches that have produced significant impact on any aspect of the health system in the state.			2,400,000
	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		1,127,000
		8.4.1	To create a framework for sharing research knowledge and its applications		Availability of research dissemination guidelines by end of 2010		45,500
			8.4.1.1	Develop a research dissemination guidelines for the state & lgas		Existence of appropriate forum of reseachers & potential users	45,500
		8.4.2	To establish channels for sharing of research findings between researchers, policy makers and development practitioners		No of research dissemination forum organised in a year		1,081,500
			8.4.2.1	Disseminate research findings at annual state scientific health conference		Existence of forum for interaction	600,000
			8.4.2.2	Disseminate research findings at state executive council meeting			180,000
			8.4.2.3	Disseminate research findings at state council on health meeting			300,000
			8.4.2.4	Disseminate research findings through the website of the state minisry of health			1,500
Total							68,601,615,696

Annex 2: Results/M&E matrix for Sokoto Strategic Health Development Plan

SOKOTO 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%	65%	100%
	2. % stakeholders constituencies playing their assigned roles in the SSHDP (disaggregated by stakeholder constituencies)	SSHDP Annual Review Report	0	20	30	60%
2. Improved Legislative and Regulatory Frameworks for Health Development	3. State adopting the National Health Bill? (Yes/No)	SMOH	0	Yes	Yes	Yes
	4. Number of Laws and by-laws regulating traditional medical practice at State and LGA levels	Laws and bye-Laws	TBD	1	3	5
	5. % of LGAs enforcing traditional medical practice by-laws	LGA Annual Report	TBD	25%	50%	75%
3. Strengthened accountability, transparency and responsiveness of the State health system	6. % of LGAs which have established a Health Watch Group	LGA Annual Report	0	20	35	75%
	7. % of recommendations from health watch groups being implemented	Health Watch Groups' Reports	No Baseline	15%	45%	65%
	8. % LGAs aligning their health programmes to the SSHDP	LGA Annual Report	0	40	60%	100%
	9. % DPs aligning their health	LGA Annual Report	No Baseline	50	75	100

	programmes to the SSHDP at the LGA level					
	10. % of LGAs with functional peer review mechanisms	SSHDP and LGA Annual Review Report	No Baseline	15	45	65%
	11. % LGAs implementing their peer review recommendations	LGA / SSHDP Annual Review Report	No Baseline	50	75	100%
	12. Number of LGA Health Watch Reports published	Health Watch Report	0	30	75	100
	13. Number of "Annual Health of the LGA" Reports published and disseminated annually	Health of the State Report	0	50	75	100%
4. Enhanced performance of the State health system	14. % LGA public health facilities using the essential drug list	Facility Survey Report	TBD	50	80	100%
	15. % private health facilities using the essential drug list by LGA	Private facility survey	TBD	20	40	60%
	16. % of LGA public sector institutions implementing the drug procurement policy	Facility Survey Report	TBD	30	50	80%
	17. % of private sector institutions implementing the drug procurement policy within each LGA	Facility Survey Report	TBD	20	40	50%
	18. % LGA health facilities not experiencing essential drug/commodity stockouts in the last three months	Facility Survey Report	TBD	30	50	75%
	19. % of LGAs implementing a performance based budgeting system	Facility Survey Report	TBD	20	45	65%
	20. Number of MOUs signed between private sector facilities and LGAs in a Public-Private-Partnership by LGA	LGA Annual Review Report	TBD	2	4	6
	21. Number of facilities performing deliveries accredited	States/ LGA Report and	TBD	74	100	150

	as Basic EmOC facility (7 functions 24/7) and Comprehensive EmOC facility (9 functions 24/7)	Facility Survey Report				
STRATEGIC AREA 2: HEALTH SERVICES DELIVERY						
NSHDP GOAL: To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare						
Outcome 3: Universal availability and access to an essential package of primary health care services focusing in particular on vulnerable socio-economic groups and geographic areas						
Outcome 4: Improved quality of primary health care services						
Outcome 5: Increased use of primary health care services						
5. Improved access to essential package of Health care	22. % of LGAs with a functioning public health facility providing minimum health care package according to quality of care standards.	NPHCDA Survey Report	TBD	20	45	65%
	23. % health facilities implementing the complete package of essential health care	NPHCDA Survey Report	TBD	50	75	100%
	24. % of the population having access to an essential care package	MICS/NDHS	TBD	40	75	100%
	25. Contraceptive prevalence rate	NDHS	2%	10%	20%	30%
	26. Number of new users of modern contraceptive methods (male/female)	NDHS/HMIS				
	27. % of new users of modern contraceptive methods by type (male/female)	NDHS/HMIS	TBD	2 - 30%	5 - 50%	10 - 75%
	28. % service delivery points without stock out of family planning commodities in the last three months	Health facility Survey	TBD	20%	45%	100%
	29. % of facilities providing Youth Friendly RH services	Health facility Survey	TBD	20%	50%	60%
	30. Adolescent (10-19 year old) Fertility rate (using teeenage pregnancy as proxy)	NDHS/MICS	8.70%	5%	3.50%	2.50%
	31. % of pregnant women with 4 ANC visits performed	NDHS	13.80%	30%	50%	75%

	according to standards*					
	32. Proportion of births attended by skilled health personnel	HMIS	5.10%	30%	50%	75%
	33. Proportion of women with complications treated in an EmOC facility (Basic and/or comprehensive)	EmOC Sentinel Survey and Health Facility Survey	TBD	10%	25%	45%
	34. Caesarean section rate	EmOC Sentinel Survey and Health Facility Survey	3%	3.50%	6%	8%
	35. Case fertility rate among women with obstretic complications in EmOC facilities per complication	HMIS	TBD	20%	!2%	7%
	36. Perinatal mortality rate**	HMIS				
	37. % women receiving immediate post partum family planning method before discharge	HMIS	TBD	??	??	??
	38. % of women who received postnatal care based on standards within 48h after delivery	MICS	5%	15%	25%	50%
	39. Number of women presented to the facility with or for an obstetric fistula	NDHS/HMIS	No Baseline			
	40. Number of interventions performed to repair an obstetric fistula	HMIS	1,400	900	400	100
	41. Proportion of women screened for cervical cancer	HMIS				
	42. % of newborn with infection receiving treatment	MICS	No Baseline	25%	40%	55%
	43. % of children exclusively breastfed 0-6 months	NDHS/MICS	9%	25%	50%	55%
	44. Proportion of 12-23 months-old children fully immunized	NDHS/MICS	1.00%	40%	60%	75%

	45. % children <5 years stunted (height for age <2 SD)	NDHSMICS	32.10%	20%	15%	10%
	46. % of under-five that slept under LLINs the previous night	NDHS/MICS	8.00%	75%	85%	95%
	47. % of under-five children receiving appropriate malaria treatment within 24 hours	NDHS/MICS	2.0 - 49.9%	25 - 60%	40 - 75%	60 - 90%
	48. % malaria successfully treated using the approved protocol and ACT;	MICS	TBD			
	49. Proportion of population in malaria-risk areas using effective malaria prevention and treatment measures	MICS	TBD			
	50. % of women who received intermittent preventive treatment for malaria during pregnancy	NDHS/MICS	9%	30%	50%	60%
	51. HIV prevalence rate among adults 15 years and above	NDHS				
	52. HIV prevalence in pregnant women	NARHS	6.00%	5.00%	4.50%	2.50%
	53. Proportion of population with advanced HIV infection with access to antiretroviral drugs	NMIS	1,550	1,750	1,200	850
	54.Condom use at last high risk sex	NDHS/MICS				
	55. Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS	NDHS/MICS	No Baseline	20%	45%	60%
	56. Prevalence of tuberculosis	NARHS				
	57.Death rates associated with tuberculosis	NMIS				
	58. Proportion of tuberculosis cases detected and cured under directly observed treatment short course	NMIS	TBD	20 - 50%	40 - 75%	60 - 100%

Output 6. Improved quality of Health care services	59. % of staff with skills to deliver quality health care appropriate for their categories	Facility Survey Report	TBD	25%	50%	75%
	60. % of facilities with capacity to deliver quality health care	Facility Survey Report	TBD	25%	45%	65%
	61. % of health workers who received personal supervision in the last 6 months by type of facility	Facility Survey Report	TBD	20	40	60
	62. % of health workers who received in-service training in the past 12 months by category of worker	HR survey Report	TBD	40%	60%	75%
	63. % of health facilities with all essential drugs available at all times	Facility Survey Report	TBD	30%	50%	75%
	64. % of health institutions with basic medical equipment and functional logistic system appropriate to their levels	Facility Survey Report	TBD	50%	60%	75%
	65. % of facilities with deliveries organizing maternal and/or neonatal death reviews according to WHO guidelines on regular basis	Facility Survey Report	TBD	26%	30%	40%
Output 7. Increased demand for health services	66. Proportion of the population utilizing essential services package	MICS	TBD	25%	50%	75%
	67. % of the population adequately informed of the 5 most beneficial health practices	MICS	TBD	25%	40%	65%
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	68. % of wards that have appropriate	Facility Survey Report	TBD	20 - 40%	30 - 60%	50 - 75%

and Plans and strategies for HRH	HRH complement as per service delivery norm (urban/rural).					
	69. Retention rate of HRH	HR survey Report	TBD			
	70. % LGAs actively using adaptations of National/State HRH policy and plans	HR survey Report	TBD	10 - 30%	30 - 50%	50 - 75%
	71. Stock (and density) of HRH	HR survey Report	TBD	1 CHW:4000 pop; 1 Nurse or MW:8000 pop; 1 Dr & Dentist:8000 pop; 1 Pharmacist: 20,000 pop;	1 CHW:3000 pop; 1 Nurse or MW:6000 pop; 1 Dr & Dentist:7000 pop; 1 Pharmacist: 15,000 pop;	1 CHW:2000 pop; 1 Nurse or MW:4000 pop; 1 Dr & Dentist:5000 pop; 1 Pharmacist: 10,000 pop;
	72. Distribution of HRH by geographical location	MICS	TBD			
	73. Increased number of trained staff based on approved staffing norms by qualification	HR survey Report	TBD	20%	50%	65%
	74. % of LGAs implementing performance-based managment systems	HR survey Report	TBD	30%	40%	70%
	75. % of staff satisfied with the performance based management system	HR survey Report	TBD	25%	45%	55%
Output 8: Improved framework for objective analysis, implementation and monitoring of HRH performance	76. % LGAs making availabile consistent flow of HRH information	NHMIS	0 - 100%	25 - 100%	50 - 100%	100%
	77. CHEW/10,000 population density	MICS	TBD	1:4000 pop	1:3000 pop	1:2000 pop
	78. Nurse density/10,000 population	MICS	TBD	1:8000 pop	1:6000 pop	1:4000 pop
	79. 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
	80. Medical doctor density per 10,000 population	MICS	TBD	1:8000 pop	1:7000 pop	1:5000 pop

	81. Other health service providers density/10,000 population	MICS	TBD	1:4000 pop	1:3000 pop	1:2000 pop
	82. HRH database mechanism in place at LGA level	HRH Database	TBD	50 - 75%	75 - 100%	100%
Output 10: Strengthened capacity of training institutions to scale up the production of a critical mass of quality mid-level health workers						
PRIORITY AREA 4: FINANCING FOR HEALTH NSHDP GOAL 4 : To ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and consumption at Local, State and Federal Levels						
NSHDP GOAL 4 : To ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and consumption at Local, State and Federal Levels						
Outcome 8. Health financing strategies implemented at Federal, State and Local levels consistent with the National Health Financing Policy						
Outcome 9. The Nigerian people, particularly the most vulnerable socio-economic population groups, are protected from financial catastrophe and impoverishment as a result of using health services						
Output 11: Improved protection from financial catastrophy and impoversihment as a result of using health services in the State	83. % of LGAs implementing state specific safety nets	SSHDP review report	TBD	10 -25%	25 - 50%	50 - 75%
	84. Decreased proportion of informal payments within the public health care system within each LGA	MICS	TBD	50 - 90%	30 - 75%	10 - 50%
	85. % 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%	40 - 60%	60 80%
	86. LGAs allocating health funding increased by average of 5% every year	State and LGA Budgets	TBD	25 - 40%	40 - 60%	60 - 80%
Output 12: Improved efficiency and equity in the allocation and use of Health	87. LGAs health budgets fully alligned to support state health goals and policies	State and LGA Budgets	TBD	40 - 60%	60 - 80%	100%

resources at State and LGA levels						
	88.Out-of pocket expenditure as a % of total health expenditure	National Health Accounts 2003 - 2005	70%	60%	50%	40%
	89. % of LGA budget allocated to the health sector.	National Health Accounts 2003 - 2005	10%	12%	14%	15%
	90. Proportion of LGAs having transparent budgeting and finacial management systems	SSHDP review report	TBD	30%	40%	60%
	91. % 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	92. % of LGAs making routine NHMIS returns to states	NHMIS Report January to June 2008; March 2009	34%	50%	60%	75%
	93. % of LGAs receiving feedback on NHMIS from SMOH		TBD	25%	75%	100%
	94. % of health facility staff trained to use the NHMIS infrastructure	Training Reports	TBD	30%	50%	80%
	95. % of health facilities benefitting from HMIS supervisory visits from SMOH	NHMIS Report	TBD	25 - 40%	40 - 60%	60 - 80%
	96.% of HMIS operators at the LGA level trained in analysis of data using the operational manual	Training Reports	TBD	40%	75%	100%
	97. % of LGA PHC Coordinator trained in data dissemination	Training Reports	TBD	40%	75%	100%
	98. % of LGAs publishing annual HMIS reports	HMIS Reports	TBD	25%	50%	75%

	99. % 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	100. Proportion of public health facilities having active committees that include community representatives (with meeting reports and actions recommended)	SSHDP review report	TBD	25%	50%	75%
	101. % of wards holding quarterly health committee meetings	HDC Reports	TBD	25%	40%	60%
	102. % HDCs whose members have had training in community mobilization	HDC Reports	TBD	40%	75%	100%
	103. % increase in community health actions	HDC Reports	TBD	10%	25%	50%
	104. % of health actions jointly implemented with HDCs and other related committees	HDC Reports	TBD	25%	40%	60%
	105. % of LGAs implementing an Integrated Health Communication Plan	HPC Reports	TBD	25%	40%	60%
PRIORITY AREA 7: PARTNERSHIPS FOR HEALTH						
Outcome 14. Functional multi partner and multi-sectoral participatory mechanisms at Federal and State levels contribute to achievement of the goals and objectives of the						
Output 15: Improved Health Sector Partners' Collaboration and Coordination	106. Increased number of new PPP initiatives per year per LGA	SSHDP Report	TBD	25%	40%	50%
	107. % LGAs holding annual multi-sectoral development partner meetings	SSHDP Report	TBD	25%	50%	55%
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	108. % of LGAs partnering with researchers	Research Reports	TBD	10%	25%	50%

knowledge management systems						
	109. % of State health budget spent on health research and evaluation	State budget	TBD	1%	1.50%	2%
	110. % of LGAs holding quarterly knowledge sharing on research, HMIS and best practices	LGA Annual SHDP Reports	TBD	10%	25%	50%
	111. % of LGAs participating in state research ethics review board for researches in their locations	LGA Annual SHDP Reports	TBD	30%	65%	75%
	112. % of health research in LGAs available in the state health research depository	State Health Reseach Depository	TBD	40%	75%	95%
Output 17: Health research communication strategies developed and implemented	113. % LGAs aware of state health research communication strategy	Health Research Communication Strategy	TBD	40%	60%	85%