PLATEAU STATE GOVERNMENT OF NIGERIA

STATE STRATEGIC HEALTH DEVELOPMENT PLAN (2010 – 2015)

Plateau State Ministry of Health

March 2010

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List of acronyms and abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante Natal Care
APIN	Aids Prevention Initiative in Nigeria
BPE	Bureau of Public Enterprises
BPP	Bureau of Public Procurement
CBOs	Church Based Organizations
CHEWs	Community Health Extension Workers
CMD	Chief Medical Director
COCIN	Church of Christ in Nigeria
CORPS	Community Resource Persons
CRS	Catholic Relief Services
DRF	Drug Revolving Fund
EBF	Exclusive Breast feeding
ELSS	Emergency Life Saving Skills
ETAT	Emergency Triage and Treatment
FBOs	Faith Based Organizations
FGD	Focused Group Discussion
FGN	Federal Government of Nigeria
FMOH	Federal Ministry of Health
GHAIN	Global HIV/AIDS Initiative in Nigeria
GRISP	Getting Research findings into Strategic Projects
HCP	Health Care Professional
HIV	Human Immune Deficiency Virus
HMIS	Health Management Information System
HSDP	Health System Development Project
IEC	Information Education Communication
IHVN	Institute of Human Virology Nigeria
IMCI	Integrated Management of Childhood Illnesses
IMNCH	Integrated Maternal Newborn and Child Health
IMR	Infant Mortality Rate
ITN	Insecticide Treated Net
IT	Information Technology
JUTH	Jos University Teaching Hospital
LGA	Local Government Area
LLIN	Long Lasting Insecticide Net
LSS	Life Saving Skills
MDGs	Millenium Development Goals
MICS	Multiple Indicator Cluster Survey
MLSS	Minimum Life Saving Skills
MMR	Maternal Mortality Rate
MOH	Ministry of Health
NACA	National Agency for the Control of AIDS
NACHPN	National Association of Community Health Physicians of Nigeria

NDHS	Nigeria Demographic and Health Survey
NEEDS	Nigeria Economic Empowerment and Development Strategy
NGOs	Non Governmental Organizations
NHIS	National Health Insurance Scheme
NIMR	National Institute of Medical Research
NMR	Neonatal Mortality Rate
OPS	Organized Private sector
PHC	Primary Health Care facility
PLACA	Plateau Agency for the Control of AIDS
PMTCT	Prevention of Mother To Child Transmission of HIV/AIDS
RBM	Roll Back Malaria
RH	Reproductive Health
SAM	Severe Acute Malnutrition
SHDP	Strategic Health Development Plan
SEEDS	State Economic Empowerment & Development Strategies
SERVICOM	Service Compact with all Nigerians
SITAN	Situation Analysis
SOPs	Standard Operating Procedures
SPT	State Planning Team for State Strategic Health Development Plan
SRG	State Reference Group for State SHDP
TOT	Training Of Trainers
U5MR	Under-5 Mortality Rate
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WDC	Ward Development Committee
WHO	World Health Organization
WMHCP	Ward Minimum Health Care Package

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EXECUTIVE SUMMARY

The health and well being of any population is central to their development and reduction in poverty hence no health system can claim legitimacy unless its serves the interest of its poorest and most vulnerable people.

Plateau state has adopted the evidence based NSHDP Framework with its overarching goal of improving and maintaining the health status of its more than 3million people as well as meeting the MDGs in 2015. Plateau state's overall health system performance is far from efficient in terms of policy, leadership and governance, health financing, health service delivery, human resource for health among others. In addition, there is gross underfunding of the health sector especially in the last decade, at both state and LGA levels, with 6% of the state budget and <15% of the LGAs budget allocated to health respectively. Health service delivery in the state is seriously hampered by low Human Resource for Health occasioned by embargo on employment, mal-distribution of available Health Care Professionals (Doctors and Nurses/midwives), frequent drug stock outs, high cost of medical services, no health insurance as well as geographic inaccessibility in some LGAs.

Plateau state, with a population of 3,383,027 million makes up about 2.3% of Nigeria's 148 million citizens (2008), with male to female components of 1,694,949 and 1,688,078 respectively, as well as the state annual growth rate of 2.83%. The State has 17 Local Government Area councils and is located in the North Central Zone of the country. The predominant occupation of its population is agriculture but a significant proportion of its people engage in mining. Its internally generated revenue is low both at state and LGA levels and its revenue comes mainly from federal government allocation.

There are about 1,000 health facilities in the state Public, private, FBO-owned, which are inclusive of 2 tertiary, 59 secondary and 940 PHC facilities. Its population per health facility 1.4/1,000 (2/1000-Nig, 2.5/1000-WHO benchmark)

Plateau state has recorded some improvements in childhood immunization, although constrained by poor utilization, poor coverage and sole donor funding, with rates of OPVo35%, BCG 62.5%, and measles 55%.

- Child health indices shows that wasting in under-5 children is 2.6%, stunting 37.4%, while underweight prevalence is 5.5% (NDHS 2008).
- ITN use rate in pregnant women is 1.6% in the state as availability is restricted to 3 out of the state's 17 LGAs (17.6%).

- Its Exclusive Breastfeeding rate stands at 57% due to insufficient awareness of the population of its many benefits.
- 84% of pregnant women in the state received ANC from a health professional in 2008 while delivery by skilled attendant rose from 24% in 2007 to 30.7% in 2008. Health facility delivery rate stands at 30.2%.
- Access to improved water source stands at rural/urban 48.2%/76.9% while access to improved latrines is rural/urban 48.2%/75.2% respectively.

The bottlenecks include inadequate human resource and commodities and funds, poor utilization of services, poor accessibility and low coverage in some of the components of WMHPC. The causes of these bottlenecks ranged from poor political will, poor funding, donor dependency, lack of awareness of benefits of some of the health interventions such as Exclusive Breastfeeding <6months by mothers as well as poor data collection & management. Also inadequate manpower, poor supply logistics, and socio-cultural and socioeconomic constraints played key roles.

Strategies planned to overcome these bottlenecks are adequate funding, IEC activities at community & health facility levels, production of nurses, CHEWs and CORPS to serve at PHC and communities, as well as Waivers/exemption schemes for to improve accessibility, utilization and sustain effective coverage for IMNCH services, inclusive of family planning.

Plateau state's Ward Minimum Health Care Package includes a wide range of primary health care interventions and referral services at secondary care. To improve access, the State plans to offer free services to pregnant women, newborn and under-five children aimed at significantly reduce MMR, U-5MR, IMR and NMR, as well as improve the health status of the citizens.

Proposed contents of the State WMHCP are as follows:

- Primary health care: immunization, prevention, diagnosis and treatment of common diseases such as malaria, childhood pneumonia, hepatitis, tuberculosis and HIV/AIDS among others will be available to all citizens.
- It also includes four (4) ANC visits, delivery (normal and assisted), iron & folic acid supplementation, Post Natal care, Newborn care as well as treatment of STIs, PMTCT and Family Planning.
- Preventive health care, diagnosis and treatment of illnesses to under-5 children including laboratory tests, management of moderate and severe acute malnutrition and micronutrient supplementation).

The primary and secondary care will be available at the PHC and secondary facilities in the state .Funding for free services to pregnant women and children under five will be provided by the state government while LGA councils will contribute to yearly capitation funds to PHC facilities in their domain. The scheme will be implemented in phases starting with the pregnant women and under-5 children in 2011 while the other members of the populace will be accommodated yearly till 2015.The scheme will be monitored closely and regular evaluation and adjustments made as needed.

The Strategic Priorities interventions as defined by the State, inclusive of targets and indicators include:

1. LEADERSHIP AND GOVERNANCE

The strategic objective planned to address gaps in this area are to provide clear policy directions for health development in plateau state with the target of putting the state's strategic committee in place by beginning 2010.This will be indicated by having the state's strategic plan implementation begin by 2nd quarter of 2010 and obtaining legislative backing for state health policy by end 2010. Planned interventions include improvement of Strategic Planning at State and LGA levels, initiating and implementing state health policy in line with FMOH, strengthening of regulatory functions of government as well as improving accountability and transparency in the governance at state and LGA levels.

2. HEALTH SERVICE DELIVERY

In the area of service delivery, the strategic objectives are to ensure universal access to an essential package of care, scale up access to health care services, improve the quality of health care services and increase demand for health care services in the state. It will also provide financial access especially for the vulnerable groups. The indicators are to provide essential package of care in the state by mid 2011 and ensure a 10% yearly increase in government funding for disease control programmes and100% urban/75% rural access to improved latrines and portable water by end 2011 as well as have referral centres in place by end 2013. .

Planned interventions are to review, cost, disseminate and implement the minimum package of care in an integrated manner, strengthen specific communicable and non communicable disease control programmes as well as make Standard Operating procedures (SOPs) and guidelines available for delivery of services at the state and LGA levels. Additional interventions would address the gaps in this area include improvement environmental sanitation at household levels

in Plateau state, improve geographical equity and access to health services, ensure availability of drugs and equipment at all levels, establish a system for the maintenance of equipment at all levels, strengthen the state referral system in the 3 zones and to foster collaboration with the private sector. Plans are in place to strengthen professional regulatory bodies and institutions, develop and institutionalise quality assurance models, institutionalize Health Management and Integrated Supportive Supervision (ISS) mechanisms, create effective demand for services as well as improve financial access especially for the vulnerable groups in the state.

3. HUMAN RESOURCES FOR HEALTH

To address the huge gap identified, the strategies are to formulate comprehensive policies and plans for HRH for health development, provide a framework for objective analysis, implementation and monitoring of HRH performance and 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 in the state. Indicators include the training of 100 nurses and 100 midwives each year from our 4 existing nursing, midwives and training of 50% nurses/chews at state and each LGA on LSS/MLSS, IMCI, EmONC by end 2012 as well as recruitment of 1 doctor, 4 nurse/midwife per PHC by 2015.

The target is that the HR for Health Crisis in the state has stabilised and begun to improve by end of 2012. Hence planned interventions include reappraising the principles of health workforce requirements and recruitment at state and LGA levels, establishing and strengthening the HRH Units at state health facilities, institutions and PHC facilities.

Quality assurance systems are to be established in all state health training institutions.

4. FINANCING FOR HEALTH

The strategies for adequate financing of health in Plateau state is to develop and implement health financing strategies at State and Local levels consistent with the National Health Financing Policy with the target of having a documented Health Financing Strategy by end 2012, ensure that people are protected from financial catastrophe and impoverishment as a result of using health services and to secure a level of funding needed to achieve desired health development goals and objectives at all levels in a sustainable manner. The targets are to put SHIS in place for all Plateau state citizens by end 2015, increase health allocation at State and LGAs increased by an average of 5% yearly until 2015. To achieve optimal state and LGA health sector funding therefore, plans are in place to develop and implement evidence-based, costed

health financing strategic plans at LGA and State levels in line with the National Health Financing Policy as well as improving the coordination of donor funding mechanisms for all health partners in the state. Additionally, plans have been made to improve health budget execution, monitoring and reporting as well as strengthening financial management skills at state and LGA levels.

5. NATIONAL HEALTH INFORMATION SYSTEM

The strategies in this area are to improve data collection and transmission, to provide infrastructural support and ICT of health databases and staff training as well as strengthen the sub-systems in the Health Information System at state and 17 LGAs. Target is that 50% of the LGAs in Plateau will be making routine NHMIS returns to state level plus state will be making NHMIS returns to federal level aided by the adjunct target of ensuring 50% ICT infrastructure and staff capable of using HMIS at state and LGAs by 2012.

Planned interventions include actions to strengthen the Hospital Information System at state level and Disease control reporting systems at PHC and community levels by ensuring that that NHMIS forms are available at all health service delivery points at state and 17 LGAs. Additional plans are to coordinate data collection from vertical programmes, build capacity of health workers on data management, provide a legal framework for activities of the NHMIS programme and improve coverage of data collection at the state and LGAs. The plan also provides for supportive supervision of data collection at all levels, strengthening the use of information technology in HIS and the provision of HMIS Minimum Package at the different levels (SMOH, LGA) of data management. Monitoring protocol for NHMIS programme implementation at state and LGA levels will be established in line with stated activities and expected outputs.

6. COMMUNITY PARTICIPATION AND OWNERSHIP

To strengthen community participation in health development, a key ingredient for scaling up health utilization, awareness and improvement in the overall health of any population, Plateau state plans to provide an enabling policy framework for community participation, build capacity within communities to 'own' their health services, restructure and strengthening the interface between the community and the health services delivery points. It also seeks to develop and implement multi-sectoral policies and actions that facilitate community involvement in health development in addition to developing and implementing systematic measurement of community involvement

7. PARTNERSHIPS FOR HEALTH

For this crucial area of the state, plans are in place to promote Public Private Partnerships (PPP), institutionalize a framework for coordination of Development Partners, facilitate inter-sectoral collaboration as well engage professional groups, communities and traditional health practitioners.

8. RESEARCH FOR HEALTH

The state plans to develop health research policies at State levels and health research strategies at State and LGA levels by establishing and strengthening mechanisms for health research at all levels. Other interventions include promoting cooperation and collaboration between it and its 17 LGA health authorities with Universities, communities, Civil Service Organizations, Organized Private Sector etc, development partners and other sectors. Provision has also been made for provision of an enabling policy framework for community participation for all stakeholders in health research in the state, build capacity within communities to 'own' their health services as well as restructuring and strengthening the interface between the community and the health services delivery. It will also establish ethical standards and practise codes for health research at all levels. Additionally it will strengthen identified health research institutions at all levels, create a critical mass of health researchers at all levels and develop transparent approaches for using research findings to aid evidence-based policy making at state and LGA levels while undertaking research on identified critical priority areas. Channels for sharing of research findings between researchers, policy makers and development practitioners are also in the plan to ensure that the gains of feedback of findings are fully harnessed to improve on health service delivery and systems in Plateau state.

Next steps towards completion of the SSHDP in Plateau State include:

a) Comprehensive costing of the SSHDP - The costing of the state and 17LGAs Plan for Plateau state is still in progress as per the NSHDP process.

b) Implementation Framework - The implementation of Plateau's state and LGAs plan are still being determined and would follow the completion of the plan costing process.

The State SHDP when implemented will be monitored on a quarterly basis at the minimum in line with the M&E Framework, specifying indicators and targets. Appropriate M&E mechanisms would be established and/or strengthened.

Chapter 1: Background and Achievements

1.1 Background

The centrality of health to development and poverty reduction is self-evident, as improving health status and increasing life expectancy contribute to long term economic development. The legitimacy of any national or state health system depends on how best it serves the interest of the poorest and most vulnerable people, for which improvements in their health status gear towards the realization of poverty reduction goals. In Plateau state and within the Nigerian context, current reviews show that both the state and the country are presently not on course to achieving the health Millennium Development Goals (MDGs) by 2015. This poses a major developmental challenge, which will impede and undermine development and ec onomic growth.

Plateau state in alignment with the Federal Government of Nigeria recognizes that, in order to achieve the state's as well as country health targets, inclusive of the health-related MDGs, particularly for its poorest and most vulnerable population the health system should be strengthened, health services must be scaled-up and existing gains in the health sector must be sustained and expanded. These improvements can be achieved through the use of an evidence-based Framework to guide the development of a state ***Strategic Health Development Plan (SHDP) including LGA Strategic Health Development Plan ,*** *with appropriate costing in alignment with the National Strategic Health Development Plan(NSHDP.)* This is in harmony with the vision and mission of the National Strategic Health Plan stated earlier.

Plateau state's overall health system performance is far from efficient in terms of policy, leadership and governance, health financing, health service delivery, human resource for health among others. There is gross underfunding of the health sector especially in the last decade, at both state and LGA levels, with <6% of the state budget and <1% of the LGA budget allocated

to health respectively. Health service delivery in the state is seriously hampered by low Human Resource for Health, mal-distribution of the Health Care Professionals (Doctors and Nurses/midwives), frequent drug stock outs, high cost of medical services, no health insurance as well as geographic inaccessibility in some local government areas such as Jos East. It is against this background that the state, along with other relevant stakeholders assented to the NSHDP declaration in Abuja, in July, 2009 at the council of health meeting. The state has keyed into the SHDP in the spirit of one health policy, one national plan incorporating states and LGAs, one budget and one monitoring and evaluation framework at all three levels of government. Plateau state therefore seeks to use the SHDP framework at the state and LGA levels to adequately harness the policy gaps and program interventions required to improve the performance of the health sector towards the delivery of quality, efficient and sustainable health care for all its citizens.

1.2 Achievements

The Plateau state health system has undergone some changes in the last few years, giving rise to some improvements in the health service delivery in the state but the problems of poor health financing as well as dearth of Health Care Professionals (HCP) persists, eroding the modest gains made in that sector. However support by development partners such as UNICEF, WHO, World bank (HSDP11), EU-Prime, Netherlands Leprosy programme among others have made some positive impact on the quality of health of the people of the state.

Some of these achievements include:

- scale up of childhood immunization activities with resultant markedly improved coverage for all vaccines
- system development to support IT services and HMIS mechanisms
- scale up in the management and care for patients with HIV/AIDS, TB and leprosy, onchocerciasis and trachoma
- Establishment of special centres for the diagnosis, treatment, care, prevention and research
- Health infrastructural improvements at some health facilities

- Community mobilization and sensitization activities especially for IMCI, malaria prevention and treatment, HIV/AIDS and childhood immunization.

The state has utilized the findings of its existing Health situation analysis and the eight thematic health areas of the NSHDP as a guide in identifying the gaps and opportunities its health sector and addressing those gaps within the NSHDP framework tool for the next 6 years, in order to improve the health status of its citizens as well as meet the MDGs by 2015.

Chapter 2: Situation Analysis

2.1 Socioeconomic status

It is estimated that more than half of Nigerian population (54.4% or 76million) live in poverty, with majority (70.8%) living below the poverty line of less than $1 per day. The poverty is more in the Northern part of Nigeria where the state is located and more in the rural than urban areas. Despite this state of affairs, most (70%) health services cost are out of pocket as there is no form of health insurance scheme at state and LGA levels. Despite Nigeria's increase in GDP and decreasing inflation, development shortfalls remain pervasive as evidenced by Low individual earnings, poor social indicators and significant disparities by income, gender and location. Lately the global economic recession has further worsens the already bad socioeconomic situation

Plateau state, with a population of 3,383027 million makes up about 2.3% of Nigeria's 148million citizens (2008). Its estimated population for year 2015, is 4,131870, based on an annual growth rate of 2.83%. Its estimated annual primary school enrolment is 775601. It has 17 Local Government Area councils and is located in the North Central Zone of the country. Similar to the rest of the country, the predominant occupation of its population is agriculture although a significant proportion of the population is involved in mining. Its internally generated revenue is low both at state and LGA levels as most other states while its revenue comes mainly from federal government allocation.

2.2 Health status of the population

Plateau state's population ratio is 1694949:1688078 respectively. 622266 of the women are within the reproductive age group of 15-49 years. There are 466699 Under-5 children in the state presently. It has an annual growth rate of 2.83% and a projected population of 4,131870 by 2015.There are about 1000 health facilities in the state Public, private, FBO-owned), made up of 2 tertiary, 59 secondary and 940 PHC facilities. Its HCP is 1.4/1000(2/1000-Nig, 2.5/1000-WHO benchmark.)

Plateau state has recorded some improvements in childhood immunization, although constrained by poor utilization, poor coverage and sole donor funding, with rates of OPVo35%, BCG 62.5%, and measles 55%.

MMR in Plateau state is 800/100000 live births, with an estimated annual maternal deaths of 1000 (Nigeria- MMR-800). 21,000 U-5 children die in the state every year from malaria, pneumonia, diarrhoea, HIV/AIDS as well as vaccine-preventable diseases such as measles, with

an U-5MR of 165/1000 (Nigeria- U-5MR is 138 (MICS 2007). Its Neonatal Mortality Rate NMR is 53 (Nigeria 48) with annual number of neonatal deaths put at 7000, making up 32% of total U-5 deaths.

The newborns suffer and die mainly from preventable illnesses like prematurity, birth asphyxia, neonatal infections such as tetanus as well as congenital abnormalities.

In addition to malaria, some common *communicable diseases affect the adult population in Plateau State such as t*uberculosis, cerebrospinal meningitis, hepatitis, leprosy, HIV /AIDS, lymphatic filariasis , onchocerciasis, schistosomiasis, trachoma, and typhoid fever.

Data from the NDHS 2008 gives us a broader picture of the health status of people of the state and is presented in the following table.

POPULATION (2006 Census)	PLATEAU
Total population	**3,206,531**
female	1,607,533
male	1,598,998
Under 5 years (20% of Total Pop)	549,730
Adolescents (10 – 24 years)	1,024,181
Women of child bearing age (15-49 years)	778,845
INDICATORS	**NDHS 2008**
Literacy rate (female)	54%
Literacy rate (male)	83%
Households with improved source of drinking water	35%
Households with improved sanitary facilities (not shared)	14%
Households with electricity	15%
Employment status (currently)/ female	37.4%
Employment status (currently)/ male	87.5%
Total Fertility Rate	5.3
Use of FP modern method by married women 15-49	10%
Ante Natal Care provided by skilled Health worker	84%
Skilled attendants at birth	31%
Delivery in Health Facility	30%
Children 12-23 months with full immunization coverage	31%
Children 12-23 months with no immunization	13%
Stunting in Under 5 children	59%
Wasting in Under 5 children	5%
Diarrhea in children	2.4
ITN ownership	13%
ITN utilization (children)	8%
ITN utilization (pregnant women)	6%
children under 5 with fever receiving malaria treatment	-
Pregnant women receiving IPT	2%
Comprehensive knowledge of HIV (female)	27%
Comprehensive knowledge of HIV (male)	40%
Knowledge of TB (female)	61.2%
Knowledge of TB (male)	86.8%

2.3 Current Health Resources

2.3.1 Health Facilities

Plateau state has 904 Primary Health Care (PHC) Facilities, 59 Secondary Health Facilities and 2 tertiary Health Facilities (1- FGN owned teaching hospital, 1- State specialist hospital).
Most of the secondary health facilities>50% are owned by Private/NGO/ Christian FBOs or missions.

Distribution of the public/government facilities is fairly equitable by location. One of the secondary health care facility is reserved for Leprosy management and care. Most PHCs do not offer 24hour coverage, as both equipment and staffing levels are inadequate. Majority of the public secondary health care facilities are also understaffed with inadequate equipments.

2.3.2 Human Resource for Health

Plateau state has only 323 nurses/midwives in 908 PHCs 0.3/PHC (minimum recommended is 4/facility to be able to provide standard IMNCH services) to the women, their newborns and U-5 children.

Plateau state has 589 doctors, 1772 nurses/midwives in the public/government secondary health facilities. The Jos University Teaching Hospital acounts for >70% of doctors and >25% of nurses in the state. There is mal-distribution of HCP due to their concentration in JUTH and Plateau state specialist hospital (Jos North LGA). The Health Care Professional ratio (HCP)/1000 population in the State is 1.4/1000 population as compared to country standard (Nigeria 2/1000) and WHO recommended ratio, (WHO 2.5/1000). However, doctors and nurses/midwives in FBOs and private health facilities are not included in the HCP estimation.

2.4 Key Issues and Challenges

The key issues and challenges in the health sector in Plateau state are numerous, complex and underlined by poor health financing at the state and local government levels. There are serious gaps in the area of health financing as evidenced by ≤6% of state budget allocated to health in

the last 5-10 years while the some LGA councils allocated about 1% of their total budget to health, much less than the minimum allocation of 15% set by the Abuja declaration. The late release of the actual budget sum further compounds the situation. Other issues have to do with lack of political will and problems with leadership and governance and poor human resource for health resulting in a poor and inefficient health service delivery system. Plateau state also have problems with health policy implementation, data management, community participation and ownership in relation to health programmes and interventions, co-ordination of local and international health partners as well as evidence-based health research.

The challenges in the health system in Plateau state are enormous as it has to do with improved health status of its population, particularly for women, newborn and young children, the poorest and most vulnerable. The health system is weak and requires the gaps in the thematic areas of health financing, leadership & government as well as human resource for health to be addressed initially before health services can be scaled up to avoid a full crash of the system. In addition, equipment and infrastructure in the health facilities need to be updated while essential drugs supply needs to be provided for. The state also has to collaborate with the LGA councils in the area of health in order to ensure equal access to minimum health package for all its citizens.

2.4.1 Health system

The capacity for strategic planning in Plateau state ranges from sub-optimal at state level to minimal/ non-existent at LGA levels although there are some co-ordination mechanisms in place with regards to the 17 LGAs and health partners. The state is presently developing its health policy which it hopes to implement in order to standardize access to health care and minimum health care package to its people as well as sustain the gains made in that sector.

Leader and governance in Plateau state has major gaps arising from the poor political will, the absence of a state health policy and comprehensive SSHDP as well as late release of the budget leading to poor performance. This thematic area is impacted upon by poor budget allocation to the health sector, significantly less than the minimum recommended figure of 15% of total budget reflecting poor health financing.

In the areas **of Health Service Delivery** and **Human Resource for Health**, the high cost of health services as well as staff constraints at the health facilities combine to limit access to health care for majority of Plateau citizens. Moreover, existing staff especially HCPs (doctors and nurses) are inequitably distributed among the secondary health facilities as most are at the 2 tertiary hospitals. Data collection, collation and transmission have been inadequate and inefficient at best arising from irregular supply of the NHMIS forms and the DSNO cards, poor IT capacity and poor logistics, hence highlighting serious gaps in the **Health Information**

system area of Plateau's health system. It plans to address these gaps by training and retraining of data officers at state and LGA levels in data management and IT, in addition to providing the needed funds and logistics. Collaboration with all health partners in the state is in the plan such that everyone uses the NHMIS forms for data collection at all levels.

For **Partnerships for Health**, the state wants to regularly meet with their partners in health including NGOs and the private sector since both play major roles in the provision of health services in the state. It will establish a co-ordinating unit at Research, Planning and Statistics (RPS) to help in co-ordinating their activities. This will ensure efficiency and the elimination of too many vertical programmes and provide help where it is needed. Emphasis is now been placed on activities at the community levels that promote and sustain **community participation and ownership** in health through provision of funds, personnel, logistics and various community health activities, ensuring sensitization on cost effective, high impact health interventions such as use of LLIN by pregnant mothers and their U-5 children, FANC and the benefits of delivery at health facilities supervised by skilled attendants etc. Community participation will be ensured at every level for programmes from planning to implementation and evaluation to further sustain ownership. **Research for Health** was almost non-existent apart from those going on at the 2 tertiary facilities in the state. Hence the state has now provided both budget lines for needed research at the facilities once the planned guidelines and ethical committees have been established.

Chapter 3: Strategic Health Priorities

Eight evidence-based priority areas have been identified to improve the performance of the health sector, through a holistic approach at all levels of health care delivery (See Appendix 1). For each of these priority areas, there is a goal with strategic objectives, interventions and activities. These activities have targets and verifiable indicators. The strategic orientations or priority areas are:

- Priority Area 1: Leadership and governance for health
- Priority Area 2: Health service delivery
- Priority Area 3: Human resource for health
- Priority Area 4: Financing for health
- Priority Area 5: Health information system
- Priority Area 6: Community participation and ownership
- Priority Area 7: Partnerships for health
- Priority Area 8: Research for health

Nonetheless, the following list reflects the priority high impact interventions to be delivered in the State - as part of the Essential Package of Health Services for Plateau State.

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

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 4: Resource requirements

4.1 Human

Plateau state has about 589 doctors including specialists and 1772 nurses/midwives, excluding private hospitals and faith based organizations. However, they are inequitably distributed with majority of the doctors and nurses in the urban areas and tertiary hospitals in the state such as JUTH and Plateau state specialist Hospital.

Health Care Professional ratio using the tall of HCP in Public health facilities in Plateau state is 1.4/1000 population as against 2/1000(national benchmark and 2.5/1000 WHO benchmark).Therefore there is a huge HCP gap of 0.6-1.1/1000. 300-400 doctors required such that majority of the PHC facilities offering Maternal and Child health services can be manned by doctors.

Also there are about 900 public PHC facilities in the state with between 0-2 nurses per PHC as against the minimum of 4 nurse/midwives per PHC-Nurses/midwives about 1800 required to achieve 2-3/PHC facility.

There are 4 trained planners at SMOH and HMIS officers at the state secondary facilities but there is only one Monitoring and Evaluation officer per LGA. About 12 trained Planning, Research and Statistic officers required at SMOH to help with planning at state and LGA levels. 2 more trained M&E officers required per LGA (17LGA X2=34)

Information Technology (Computer use) capacity is required at both state and LGA levels.

4.2 Physical/Materials

Most of the 900 public health facilities in plateau state are bedeviled by poor infrastructure and old, nonfunctional equipments.

Essential Equipments and drugs required at the secondary health facilities and PHC facilities at the state and LGA levels. (This includes medical equipments, furniture, ambulances, computers/printers and internet access equipments).

Refurbishment and maintenance of existing infrastructure required at most secondary and primary health facilities.

Water supply, power alternatives required at most health care facilities.

Appropriate well ventilated buildings for health care services are required for health facilities at state and LGA levels.

Walling/fencing and security required for some health facilities.

Residential accommodation for staff within the Health facility compound to encourage 24 hour service coverage required at some health facilities.

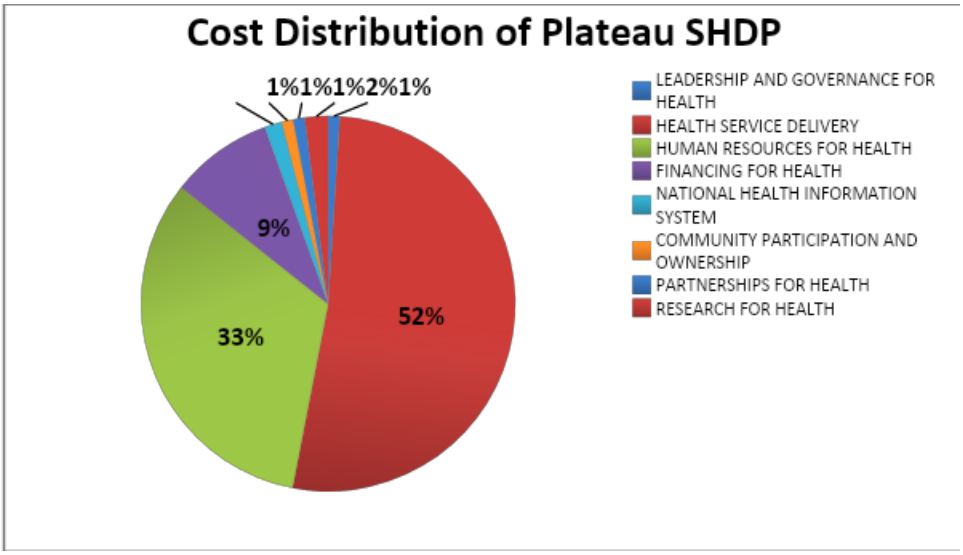
Training space and communication equipment for Continuing Medical Education required for all health staff especially at the secondary health facilities.

4.3 Financial

The total cost required to finance the State SHDP is N 60,812,385,619over the period 2010-2015, and N10,135,397,603.10 annually. When disaggregated by priority area, the majority

of the costs are in the health service delivery and human resources for health priority areas with 52% and 33% of the cost respectively.

Priority Area	Cost NGN for 6 years (2010-2015)	Cost NGN for 1 year
Leadership and governance	608,123,856	101,353,976.03
Health Service	31,656,233,702	5,276,038,950.27
Human Resources for Health	19,817,072,333	3,302,845,388.80
Financing for Health	5,386,274,519	897,712,419.83
National Health Information System	912,185,784	152,030,964.05
Community Ownership and Participation	608,123,856	101,353,976.03
Partnership for Health	608,123,856	101,353,976.03
Research for Health	1,216,247,712	202,707,952.06
Total	60,812,385,619	10,135,397,603.10



Plateau state requires funding for services at primary health care centres, secondary/tertiary referral centres, medical equipment, ambulances and communication equipments as well as investment infrastructure.

The state also needs funds to recruit thousands of Health Care Professionals, regular supply of essential drugs and build managerial and IT capacity for existing staff. It also requires funding for committees set up to initiate and implement state health policy and drive strategic direction for the next 6 years (2010-2015).

Other financial requirements include funding for recruitment of academic staff, infrastructure and equipment for the nursing/midwifery schools and colleges of technology.

It will need extra funds to align itself with the recently approved consolidated medical salary scale for medical and dental practitioners in order to retain existing staff as well as recruit new ones.

Chapter 5: Financing the plan

5.1 Estimated cost of the plan

The total cost required to finance the State SHDP is N 60,812,385,619over the period 2010-2015, and N10,135,397,603.10 annually.

5.2 Assessment of the available fund and projected funds in Plateau state

Year	Total state Budget	%Health Allocation
1999	3.6billion	6.3%
2000	7.8billion	8.8%
2001	14.4billion	8.6%
2002	15.43billion	8.3%
2003	16.76billion	2.5%
2004	20.48billion	1.6%
2005	29.18billion	1.2%
2006	31.87billion	1.5%
2007	35.42billion	2.20%
2008	63.016 billion	5.5%
2009	79.51 billion	7.8%

Note: There is a downward trend in allocation to health till 2008 and 2009 although total State budget has risen significantly in the same period.

Other funds include funds for ongoing projects, IGR, as well as support from international partners whose funding portfolio are not fully captured here.

From the table above, the available funding for health in 2009 was N 6,201,000,000. If we assume that this will remain constant over the planning period 2010-2015 with an annual inflation rate of 10.5%, the projected funding from 2010 to 2015 will be N 41,900,467,050. The funding gap which is the difference between available and projected funds and the estimated cost

of the strategic plan is estimated as N 18,911,918,568.61 for the period 2010-2015. This amounts to an annual funding gap of N3.15billion naira.

.Based on the table above, the funding gaps can be addressed via:

- Establishing a unified DRF at all levels for efficient management
- Phased implementation of the SHIS and CHIS with full support of the communities and LGA councils
- Intensifying efforts on the proposed PPP scheme.
- Harnessing Community self help abilities as much as possible to augment funds
- More efficient co-ordination of donor funds and activities in the state.
- Strengthening of the government stewardship and leadership roles at all levels
- Strict implementation of the costed 6-year state's SHDP and yearly operational plan.
- Capacity building of stakeholders and health workers on financial management and resource mobilization.

5.3 Descriptions of ways of closing the financing gap

Projected funds from the donors, HSDP11 project and MDG grants could be used to close the financing gap with good co-ordination. Also funding from the state government is expected to increase to 15% or more through regular advocacy and that will help in closing the gaps.

Other ways that may help in addressing the funding gaps include:

- Establishing a unified DRF at all levels for efficient management
- Phased implementation of the SHIS and CHIS with full support of the communities and LGA councils.
- Intensifying efforts on the proposed PPP scheme.
- Harnessing Community self help abilities as much as possible to augment funds
- More efficient co-ordination of donor funds and activities in the state.
- Strengthening of the government stewardship and leadership roles at all levels
- Strict implementation of the costed 6-year state's SHDP and yearly operational plans.
- Capacity building of stakeholders and health workers on financial management and resource mobilization.

Chapter 6: Implementation framework

6.1 Structures/Roles/Interrelations

Plateau State Ministry of Health is the policy making body and is responsible for implementation of the SSHDP at the state as well as LGA level. It plans to work closely with LGA Chairmen, councils and LGA PHC departments to ensure strict plan implementation, community participation and ownership of health services/programmes.

Heads and staff of health facilities and Nursing/midwifery schools as well as health technology schools also have a role to play in training and retraining needed health manpower in the state.

Strategic partners such as Nigerian Medical Association, National Association of Nurses and Midwives, International partners such as WHO, UNICEF, EU-Prime, NGOs, FBOs and others have significant roles to play in funding, training and standardizing health care services.

Individuals must see to their own health by ensuring their environmental and personal hygiene as well as taking advantage of the provided preventive and curative health services in the state. Individual capitation fees for social health insurance will have to be made to ensure access to health care service when it is most needed.

Traditional health practitioners need to collaborate with SMOH such that their practice is streamlined and well regulated.

Other stakeholders include ward development committees, and communities themselves.

Civil rights groups and consumer protection organizations, religious bodies, traditional leaders as well as the political class.

The roles and responsibilities of each group of stakeholders needs to be clearly defined by using guidelines for their participation in

- Capacity building at the state, LGA and community levels.
- Resource mobilization

- Activities implementation
- Quality assurance
- Budget performance review
- Community mobilization and rights' awareness

  Full Community participation should be emphasized to foster ownership of health programmes.

6.2 Implementation

The successful implementation of the state strategic plan requires a joint, sustained and committed action by all stakeholders at the state and 17 LGAs. The roles and responsibilities will be shared with each doing its part in a collaborative manner to provide health for all using the available approaches and resources efficiently. The SMOH is expected to step into its leadership and co-ordinating role throughout the process of implementation and beyond, utilizing its six departments of Finance & Administration, Medical Services, Nursing Services, Planning, Research and Statistics, Primary Health Care/Disease Control and Pharmaceutics, food and drug control services. The envisaged new state health policy with its relevant components will aid Plateau SMOH in this process, as it will be enabled to set a vision, roles, responsibilities as well as performance objectives with short and medium timelines in view of the 6-year period of the plan. It will also ensure compliance through regulation and maintain a reliable and accessible data & information base for informed decision making, M&E and assessment performance.

Chapter 7: Monitoring and Evaluation

This is being determined at the national level and Plateau state will adopt the nationally proposed M&E mechanisms in the spirit of one plan and one framework, using the NHMIS as a monitoring framework for Plateau state SHDP. However, it must take into account the dynamic nature of the state data base as this must be used to make necessary adjustments to the M&E tools. Periodic checks will also be made on the M&E to assist in tracking to timely achievement of the set targets and objectives. Results obtained from the M&E will reflect the quality of the health service delivery as seen by all stakeholders and clients alike.

In order to achieve the above, the state has provided plans for the following activities:

- Routine and timely NHMIS returns from LGA to SMOH to FMOH
- State Demographic Health surveys targeting specific areas as need arises
- Household pilot studies on health interventions
- Annual policy implementation review meetings by relevant stakeholders
- Operational Health research on the performance of the different thematic areas of the plan

However all the above success of the above activities will hinge on the following conditions presence of standardized M&E tools by the end of 2012 as well as implementation and M&E of at least 80% of the planned activities on the state SHDP. The results/M&E matrix in annex 2 will be the major tool for monitoring progress in the implementation of the SHDP

Chapter 8: Conclusion

Nigeria's health indices have remained poor despite successive efforts to address the many gaps. At the state and local government levels, the gaps and challenges are even worse, heightened by regional variations in health care access, utilization childhood and maternal mortality rates. It is against this background that this harmonized one policy one framework plan was developed to assist planning and implementation of priority health interventions at each level in every location in the country within the next 6 years.

Having keyed into the plan, Plateau state has identified its priority areas of intervention in Health service delivery, human resource for health, health financing as well as leadership and governance among others. It has planned for the gaps in these areas by providing funds, for implementation of low cost high impact health interventions, staff recruitment and training, essential equipment and drugs as well as community health activities to scale up access to health care and enhance community ownership of health programmes/facilities.

It has also provided for regular collaboration with all stakeholders and better co-ordination of donors and their support.

The commencement of the 2010 work plan implementation, with all key players on board will begin to yield the expected gains of improved and strengthened state and LGA health systems, with better utilization, resulting in the improved overall health status of Plateau citizens especially the poorest and most vulnerable.

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

PLATEAU STATE STRATEGIC HEALTH DEVELOPMENT PLAN						
Priority Area						
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Estimated Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities				
LEADERSHIP AND GOVERNANCE FOR HEALTH							
1. To create and sustain an enabling environment for the delivery of quality health care and development in Nigeria							**608,123,856**
	1.1	**To provide clear policy directions for health development**			**All stakeholders are informed regarding health development policy directives by 2011**		**409,572,076**
		1.1.1	Improved Strategic Planning at Federal and State levels				127,646,836
			1.1.1.1	Strategic planning committees advocate to govement for adoption of the strategic plan			-
			1.1.1.2	Establish Committee to review and align existng State & LGA Public Health Acts and Laws			-
			1.1.1.3	Development of Public/Private Partnership policies and plans in the state in line with national PPP policy			47,263,979
			1.1.1'4	Advocacy visits LGA chairmen, leaders legislative council and traditional council on strategic health plan and other health matters in the communities devlopemnt			28,828,680
			1.1.1.5	Establish and inaugurate strategic planning committee at LGA levels			28,828,694
			1.1.1.6	Commmittees members meet yearly to review strategic plan			22,725,483
		1.1.2	To initiate and implement state health policy in line with FMOH				281,925,239
			1.1.2.1	Formulate and align Plateau state health policy using state Strategic health committee(components-RH health, Child health, adolescent health, and others			47,263,979
			1.1.2.2	Advocacy to the Governor and his Cabinet & LGA Chairmen, state lawmakers on support and legal backing for state health policy			-
			1.1.2.3	Convene stakeholders' meeting on state health policy using the state stakeholders' list			13,068,051
			1.1.2.4	Phased implementation of the state health policy at state and LGA levels			-
			1.1.2.5	Monitoring and Evaluation of the state health policy implementation at LGA and state levels			221,593,209
		1.1.3					-
	1.2	**To facilitate legislation and a regulatory framework for health development**			**Health Bill signed into law by end of 2009**		**91,781,500**

		1.2.1	Strengthen regulatory functions of government				91,781,500
			1.2.1.1	Strategic planning committees advocate to governent for adoption of the strategic plan			-
			1.2.1.2	Establish Committee to review and align existng State & LGA Public Health Acts and Laws			19,386,668
			1.2.1.3	Development of Public/Private Partnership policies and plans in the state in line with national PPP policy			43,566,152
			1.2.1.4	Advocacy to the Governor and his Cabinet & LGA Chairmen, state lawmakers on support and legal backing for state health policy			28,828,680
		1.2.2					-
	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**		**106,770,281**
		1.3.1		To improve accountability and transparency			106,770,281
			1.3.1.1	Establish a due process unit in institutions to oversee all proucrement processes in Plateau state			38,055,312
			1.3.1.2	Bi-annual interactions between state government and stake holders on health services			9,836,939
			1.3.1.3	Provision of access to information for independent evaluation of the health sector at state and LGA levels			-
			1.3.1.4	Adopt and implement SERVICOM at all Health departments and facilities in the state and LGAs			39,491,361
			1.3.1.5	Produce yearly report on PHC facilities and disseminate to communities at LGA level			19,386,668
HEALTH SERVICE DELIVERY							-
2. To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare							**31,656,233,702**
	2.1	**To ensure universal access to an essential package of care**			**Essential Package of Care adopted by all States by 2011**		**25,317,874,360**
		2.1.1	To review, cost, disseminate and implement the minimum package of care in an integrated manner				16,461,778,206
			2.1.1.1	Budget, procure and distribute components of Ward minimum care package for the population using PHC facilities			2,207,431,736
			2.1.1.2	Recruit 1 doctor and 4 midwives per PHC facility for 1000 PHC facilities in the 17 LGA s of the state			-
			2.1.1.3	Provide Standard Operation Procedure (SOP) and guidelines for service delivery at secondary & PHC facility levels			35,286,916
			2.1.1.4	Set up stock/inventory (FIFO) system and M&E for the WMC package			-
			2.1.1.5	Construct and equip 5 nos. Sixty-bed capacity secondary care (general) hospitals			13,499,244,858
		2.1.1.6		Renovate 15 general hospitals (5 per zone, 4 hospitals each year)			719,814,696
		2.1.2	To strengthen specific communicable and non communicable disease control programmes				4,435,194,557

			2.1.2.1	Improve funding from government and development partners to about 10% for disease control programme			-
			2.1.2.2	Orient health personnel,procure logistics , drugs and supplies for the control of the following diseases, Malaria, HIV/AIDS and STIs,			2,303,407,029
			2.1.2.3	Construction of 1 no Public Health epidemiology Laboratory Unit for the state			565,614,393
			2.1.2.4	One cold store vehicle each for 3 zonal cold stores for vaccine distibution			95,975,293
			2.1.2.5	Construction and equiping of 3 zonal cold stores for vaccine storage			447,884,700
			2.1.2.6	Provide funding and logistics for the control of Diabetes and Hypertension at state and LGA levels			-
			2.1.2.7	Provide funding yearly for IMNCH and childhood nutritional activities at state and LGA levels(MAMA kits etc)			306,433,434
			2.1.2.8	Provide funding for control of poliomyelitis, measles, hepatitis and other vaccine preventable diseases at state & LGA levels including Polio Eradication Initiative (PEI).			715,879,709
			2.1.2.9	Funding for control and treatment progamme for TB and Leprosy at state & LGA levels			-
			2.1.2.10	Funding for control of filariasis, onchocerciasis, shistosomiasis, trachoma and disease surveillance at state & LGA levels.			-
		2.1.3	To make Standard Operating procedures (SOPs) and guidelines available for delivery of services at all levels				-
			2.1.3.1	Produce all relevant SOPs and Guidelines			-
			2.1.3.2	Distribute SOPs and guidelines to all health facilities and institutions(general hospitals and PHC facilities)			-
		2.1.4	To improve enviromental sanitation at household levels in Plateau state		100%urban /75% rural access to improve lateine and portable water end 2015		4,420,901,597
			2.1.4.1	Provide improved latrines to all households in the 17 LGAs of the state			3,340,987,602
			2.1.4.2	Provide portable water to households in the 17 LGAs of the state			-
			2.1.4.3	insecticide indoor spraying /laviciding spraying of high risk communities in the 17 LGAs			283,421,438
			2.1.4.4	House to house imspection			56,139,148
			2.1.4.5	procure and distribute LLINs			740,353,409
	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**		**4,926,955,642**
		2.2.1	To improve geographical equity and access to health services				2,283,668,110
			2.2.1.1	Conduct comprehensive mapping of all health facilities in the state(all LGAs)			-
			2.2.1.2	Develop and adopt criteria for siting of new health facilities in the state			-

			2.2.1.3	Establish more outreach health services in the state in all LGAs based on need			2,283,668,110
			2.2.1.4	Provide funding for repair of roads at the LGAs (4-6 LGA per year)			-
			2.2.1.5	Provide funding for maintenance of the roads in the LGAs (6 per year in a cyclic manner)			-
		2.2.2	To ensure availability of drugs and equipment at all levels				1,284,597,303
			2.2.2.1	Provide funding for essential equipment in all public secondary health facilities			-
			2.2.2.2	Ensure that governement make bulk procurement of drugs and consummables to beef up the already existing DRF in all health facilities			-
			2.2.2.3	Procure and distribute Operation tables to all general hospitals in the state			-
			2.2.2.4	Provide funding for essential drugs and equipment to all PHC facilitities in the LGAs according to need			543,859,993
			2.2.2.5	Monitoring and Evaluation of the drugs and equipments at secondary and PHC levels			740,737,310
		2.2.3	To establish a system for the maintenance of equipment at all levels				53,426,246
			2.2.3.1	Ensure that all equipment have warrantee of maintenance and replacment from the manufacturers at purchase			-
			2.2.3.2	Recruit Technical staff to maintain the equipments(2 per general hospital and 1per PHC facility yearly till 2013)			-
			2.2.3.3	Train and re-train technical staff on all health equipments			53,426,246
			2.2.3.4	Involve public private partnership (PPP) on maintenace of the equipment			-
			2.2.3.5	Conduct regular maintainance of Equipment			-
		2.2.4	To strengthen referral system				1,305,263,983
			2.2.4.1	Establish 1 referral centre for each of the 3 zones of the state			-
			2.2.4.2	Provide Standard referral forms in all general hospitals and PHC facilities in the state			-
			2.2.4.3	Provide Transport and Communication facilities at public secondaryand PHC facilities for referrals			1,305,263,983
			2.2.4.4	Provide solar batteries to all secondary health facilities and PHCs in the state			-
			2.2.4.5	Make available referral guidelines at both secondary and PHC levels			-
		2.2.5	To foster collaboration with the private sector				-
			2.2.5.1	Establish Public Private Partnership committees in Plateau state			-
			2.2.5.2	Mapping of all categories of private health care providers in the state and LGAs			-
			2.2.5.3	Develop guidelines & standards for regularisation of Private health care registration and practicein the state			-
	2.3	**To improve the quality of health care services**			**50% of health facilities participate in a Quality Improvement programme by end of 2012**		**758,771,708**

		2.3.1	To strengthen professional regulatory bodies and institutions				-
			2.3.1.1	Provide funding and logistic supports to all health inspectorate departments/units in the state and LGAs			-
			2.3.1.2	Implement operational guidelines of all regulatory bodies in the state			-
		2.3.2	To develop and institutionalise quality assurance models				-
			2.3.2.1	Establish SERVICOM in all health facilities and institutions in the state(including LGAs)			-
			2.3.2.2	Monitor implementation of the quality assurance			-
			2.3.2.3	Capacity building (Training & TOT) on quality assurance among health staff			-
		2.3.3	To institutionalize Health Management and Integrated Supportive Supervision (ISS) mechanisms				758,771,708
			2.3.3.1	Constitute suportive supervision team and its modalities and frequency of visits at LGA and state levels			595,200,376
			2.3.3.2	Train LGA and state health staff on supportive supervision methods			122,368,498
			2.3.3.3	Provide relevant tools for supervsion(standardized checklist)at state and LGA levels			3,132,634
			2.3.3.4	Provide logistics (personnel, transport, per diem) for supervision at state and LGA levels			38,070,199
			2.3.3.5	Conduct biannual supervisory visits to all secondary & PHC facilities and health training instutions in the state			-
		2.3.4					-
	2.4	**To increase demand for health care services**			**Average demand rises to 2 visits per person per annum by end 2011**		**652,631,991**
		2.4.1	To create effective demand for services				652,631,991
			2.4.1.1	Regular Community advocacy/Sensitization activities + (Radio jingles, TV commercials and Bill board adverts)			-
			2.4.1.2	Provide training, seminars,role plays and IEC materials for all health workers at state and LGA levels			-
			2.4.1.3	Organize communitiy activities in LGAs, where sensitization on health matters are done eg MNCH			652,631,991
	2.5	**To provide financial access especially for the vulnerable groups**			**1. Vulnerable groups identified and quantified by end 2010 2. Vulnerable people access services free by end 2015**		-
		2.5.1	To improve financial access especially for the vulnerable groups				-
			2.5.1.1	Needs assessment of number and needs of vulnerable groups by LGA			-
			2.5.1.2	Establish subsidy schemes to aged, physically challenged people, HIV AIDS, Orphans and terminally ill people at ward level			-

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							**19,817,072,333**
	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**		**-**
		3.1.1	To develop and institutionalize the Human Resources Policy framework				-
			3.1.1.1	Adopt and implement the national human resource policy frame-work document at state and 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**		**18,493,334,391**
		3.2.1	To reappraise the principles of health workforce requirements and recruitment at all levels				13,870,895,855
			3.2.1.1	Carry out staff need assessment at the state, LGA and Health Instituttions			-
			3.2.1.2	Set up a committee for health workforce recuitments at state and LGA levels			-
			3.2.1.3	Implement the principle of health workforce recruitment policy in the state and LGAs			-
			3.2.1.4	Recruit 1 doctor and 4 midwives per PHC facility for 1000 PHC facilities in the 17 LGA s of the state			13,790,133,953
			3.2.1.5	Recruiment of 64 Mwives for MSS Scheme in the state			69,821,729
			3.2.1.6	Annual M & E of health staff at state and LGA levels			10,940,173
		3.2.2	reduction of maternal and neo natal child mortality and mobirdity				4,622,438,536
			3.2.2.1	provide life saving skills,yndromic management of sti and familly planning technology for mid-wives,doctors and chew			341,808,581
			3.2.2.2	conduct technical advisory meeting			1,019,895
			3.2.2.3	Salaries for doctors and nurses for Facilities to be constructed under 2.1.1.5			4,120,161,637
			3.2.2.4	Salaries for public health lab staff in 2.1.2.3			30,165,918
			3.2.2.5	Recruit Technical staff to maintain the equipments(2 per general hospital and 1per PHC facility yearly till 2013)			129,282,506
		3.2.3					-
	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**		**55,106,668**

					functional HRH Units by end 2010		
		3.3.1	To establish and strengthen the HRH Units				55,106,668
			3.3.1.1	Create human resource for health (HRH) units in the health planning departments of SMOH, health facilities and institutions at state & LGA levels			10,234,865
			3.3.1.2	Train and retrain HR unit staff at state and LGA levels			44,871,803
	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**		**1,154,216,256**
		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				490,196,168
			3.4.1.1	Collaborate with the existing schools of health technology and nursing and midwifery to train relevant health man power for the state			-
			3.4.1.2	Train 200 nurses/ midwives per year (50/school)in the state's 4 schools of nursing and midwifery			251,382,650
			3.4.1.3	Provide for annual in-service training of health workers on MLSS/ELSS/LSS/ETAT/IMCIat 100 for state and 10 per LGA			238,813,518
			3.4.1.4				-
			3.4.1.5				-
		3.4.2	To strengthen health workforce training capacity and output based on service demand				656,370,873
			3.4.2.1	Provide for continuous medical education (CME) for all cadre of health workers at state and LGA levels			238,813,518
			3.4.2.2	Upgrade the schools of nursing and midwifery to college status and include IMCI, LSS, EmONC into curriculum			287,294,457
			3.4.2.3	Recruit 5 retired tutors per school (4 schools) as an interim measure			51,713,002
			3.4.2.4	Train and re-train of 72 qualified Nurse educators on LSS, EMONC and ETAT			25,138,265
			3.4.2.5	Training of 200 middle level staff on mamgement (MLM) on basic strategy &Techniques on immunization.			53,411,631
		3.4.3	To set up quality assurance system in the training institutions				7,649,215
			3.4.3.1	Establish a quality assurance unit in the state			-
			3.4.3.2	Establish quality assurance committees at the training institutions in the state			-
			3.4.3.3	Quarterly meeting of quality assurance committees at the different training institutions mederated by state quality assurance unit staff			7,649,215

			3.4.3.4	Provide transport for supervision of students on clinical/practical training			-
	3.5	**To improve organizational and performance-based management systems for human resources for health**			**50% of States have implemented performance management systems by end 2012**		**100,409,413**
		3.5.1	To achieve equitable distribution, right mix of the right quality and quantity of human resources for health				71,105,378
			3.5.1.1	Carry out a compressive assessment of all health care staff based on number and their proficiences in the state (SITAN-Facility/staff assessment)			10,773,542
			3.5.1.2	Recruit qualified health staff and redistribute them equitably among the whole health facilities			-
			3.5.1.3	Provide rural allowances for staff posted to rural areas in allthe 17 LGAs in the state			60,331,836
			3.5.1.4	Provide housing/utility incentives to health workers working in rural areas in all LGAs of the state			-
			3.5.1.5				-
		3.5.2	To establish mechanisms to strengthen and monitor performance of health workers at all levels				29,304,035
			3.5.2.1	Carry out quarterly supervision at state and LGA levels, using relevant tools and methods			-
			3.5.2.2	Carry out annual monitoring visits to all PHC and secondary health facilities in Plateau state			-
			3.5.2.3	Re-engage the services of the retired mid-wives for interim supervisory roles at PHCs in the 17 LGAs of the state			29,304,035
			3.5.2.4				-
	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**		**14,005,605**
		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				14,005,605
			3.6.1.1	Conduct quarterly meeting between SMOH and managements of public and private sector health facilities to foster cooperations			-
			3.6.1.2	Conduct annual meeting between SMOH and regulatory bodies and associations (state council on health meeting)			14,005,605
			3.6.1.3	Conduct annual stakeholder's meeting using Plateau Strategic HDP stakeholder's list			-
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							**5,386,274,519**
	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**		**4,095,460,628**

					Strategy by end 2012		
		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				4,095,460,628
			4.1.1.1	Set up health financing technical comittees in the LGA and state levels			-
			4.1.1.2	Advocacy to governor & chaimen of LGAs to Implement Abuja declaration for heath financing(15% of budget)			4,095,460,628
			4.1.1.3	Monitor the yearly implementation of this financing plan at state and the 17 LGAs			-
			4.1.1.4				-
	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**		**1,222,393,794**
		4.2.1	To strengthen systems for financial risk health protection				1,222,393,794
			4.2.1.1	Provide budget line for counterpart funding for implementation of HIS at state and LGA levels using NHIS as a guide			1,222,393,794
			4.2.1.2	Advocacy to governor and LGA chairmen on need for Social Health Insurance for their people andimportance of legislative backing for Health Insurance in the state and 17 LGAs			-
			4.2.1.3	Implement IMNCH strategy in Plateau state and the 17 LGAs in phases using PHCs and general hospital as delivery points			-
			4.2.1.4	CapitationHealth Insurance dues by individuals at state and community levels			-
			4.2.1.5	provide life saving skills for mid-wives,doctor and chew			-
	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**		**68,420,097**
		4.3.1	To improve financing of the Health Sector				60,338,716
			4.3.1.1	Advocate to state and LG Council governments to ensure health budget is 15% or > as per Abuja declaration			20,814,650
			4.3.1.2	Monitor strict implementation of state and LGA Health Budgets in Plateau			18,709,416
			4.3.1.3	Scale up social insurance to include everybody in the state			-
			4.3.1.4	Advocate for private sector participation in financing health			20,814,650
			4.3.1.5	Set up budget lines for control of chronic diseases like Diabetes, mental illness and cancer at state and LGA levels			-
		4.3.2	To improve coordination of donor funding mechanisms				8,081,381
			4.3.2.1	Set up a donor co-ordinating unit at the SMOH			-
			4.3.2.2	Mapping of donors as per intervention area, Fund commitment, timeline/duration and present status			-
			4.3.2.3	Monitoring and Evaluation of all donors and their activities at state and LGA levels			-

			4.3.2.4	Donors-SMOH meeting every quarter to align activities			8,081,381
	4.4	**To ensure efficiency and equity in the allocation and use of health sector resources at all levels**			**1. Federal, 60% States and LGA levels have transparent budgeting and financial management systems in place by end of 2015 2. 60% of States and LGAs have supportive supervision and monitoring systems developed and operational by Dec 2012**		**-**
		4.4.1	To improve Health Budget execution, monitoring and reporting				-
			4.4.1.1	Advocacy to the Governor and his Cabinet and Yearly Visit to commissioner of Finance& LGA Chairmen for prompt release of budgeted funds			-
		4.4.2	To strengthen financial management skills				-
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							**912,185,784**
	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**		**784,950,840**
		5.1.1	To ensure that NHMIS forms are available at all health service delivery points at all levels				690,433,452
			5.1.1.1	Provide adequate funds for the production of NHMIS forms and cards at state and 17 LGAs in Plateau			689,858,570
			5.1.1.2	Distribute adequate numbers of NHMIS forms & cards to all PHC and secondary health facilities and institutions on a regular basis			574,882
		5.1.2	To periodically review of NHMIS data collection forms				-
			5.1.2.1	Feedback questionaire to get feedback from users at the LGA and state levels on the friendliness of the data collection tool			-

		5.1.3	To coordinate data collection from vertical programmes				84,744,391
			5.1.3.1	Meeting of state and LGA program officers to Allign programme M and E indicator with NHIMS,followed by annual meetings			61,072,773
			5.1.3.2	Recruit, train and re-train staff of the health planning department in the state and 17 LGAs on data management			23,671,618
		5.1.4	To build capacity of health workers for data management				-
			5.1.4.1	Conduct comprehensive training and re-training of state and LGA health workers on data management			-
		5.1.5	To provide a legal framework for activities of the NHMIS programme				-
			5.1.5.1	Carry out advocacy and sensitisation workshop to policy makers and legislators on compulsory health data reporting in the state and LGAs			-
		5.1.6	To improve coverage of data collection				9,772,996
			5.1.6.1	Collaboration with the National Population Commission on data collection in the state and 17 LGAs			-
			5.1.6.2	Institute appropriate sanctions and motivation to public and private health facilities on data collections at state and LGA levels			-
			5.1.6.3	Collaborate with transport cooperative societies/unions at the LGAs on data collections and regular transmission			-
			5.1.6.4	Establish appropriate ICT (Computer training and internet access) facilities for data collections in the 3 zones of the state for the use of state and LGA health staff			9,772,996
			5.1.6.5				-
		5.1.7	To ensure supportive supervision of data collection at all levels				-
			5.1.7.1	Establish supportive supervisory mechanisms for data collection at all state and LGA health delivery points			-
			5.1.7.2	Provide transport and other logistics to enhance the performance of the relevant officials in supevision of data collection			-
	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**		**27,053,277**
		5.2.1	To strengthen the use of information technology in HIS				-
			5.2.1.1	Establish zonal and district centres for the collection of data using modern communication system			-
			5.2.1.2	Creat PPP in the management of data ware houses eg collaborate with ICT providers			-
			5.2.1.3	Establish mechanism to enhance the wide use of e-health data such as electronic mangement intelligent information system web sites, patient information system			-
		5.2.2	To provide HMIS Minimum Package at the different levels (FMOH, SMOH, LGA) of data management				27,053,277
			5.2.2.1	Provide basic infrastructure for data storage analysis and transmission (computer, power supplies and internet) to health managers in the state and 17 LGAs			-

			5.2.2.2	Acquire and distribute and install health data based soft ware at PHC and secondary health care facilities			3,381,660
			5.2.2.3	Train and re-train data staff at LGA and state levels on data based software			23,671,618
	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**		**25,277,906**
		5.3.1	To strengthen the Hospital Information System				15,217,468
			5.3.1.1	Develop guideline and technical specification for the establishment of disease mapping in LGAs			-
			5.3.1.2	Carry out disease mapping in the 17 LGA s of the state			15,217,468
		5.3.2	To strengthen the Disease Surveillance System				10,060,437
			5.3.2.1	Print and Distribute DNS forms to all PHC and secondary health facilities in the state			-
			5.3.2.2	Train community resource persons (CORPS) on disease notification and alert in the 17 LGAs			10,060,437
			5.3.2.3	Regular retraining of relevant state and LGA (DSNOs and M&E officers) and other health workers on disease surveillance			-
			5.3.2.4				-
	5.4	**To monitor and evaluate the NHMIS**			**NHMIS evaluated annually**		**59,686,293**
		5.4.1	To establish monitoring protocol for NHMIS programme implementation at all levels in line with stated activities and expected outputs				59,686,293
			5.4.1.1	Provide for timely availability of logistic materials for data collection and transmission at LGA and state levels(Vehicles and Motorcycles)			-
			5.4.1.2	Utilise HIS manuals (hand book) at PHC and secondary health care delivery points to monitor quality of data generated			-
			5.4.1.3	Conduct quarterly HIS review meetings at the 17 LGAs, ILGA and state health staff co-ordinated by SMOH			53,294,956
			5.4.1.4	Bi-annual review meetings at state level			6,391,337
			5.4.1.5				-
		5.4.2	To strengthen data transmission				-
			5.4.2.1	Provide transport to transport data from LGA to state and to National level			-
			5.4.2.2	Regular monitoring and evaluation of data transmission process at LGA and state levels			-
			5.4.2.3				-
	5.5	**To strengthen analysis of data and dissemination of health information**			**1. 50% of States have Units capable of analysing health**		**15,217,468**

					information by end 2010 2. All States disseminate available results regularly		
		5.5.1	To institutionalize data analysis and dissemination at all levels				15,217,468
			5.5.1.1	Advocate for the production of healllth data bulletin and annual reports both the state and LGAs levels			15,217,468
			5.5.1.2	Introduce data management SOPs at state and PHC facilities			-
COMMUNITY PARTICIPATION AND OWNERSHIP							-
6. To attain effective community participation in health development and management, as well as community ownership of sustainable health outcomes							**608,123,856**
	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**		**608,123,856**
		6.1.1	To provide an enabling policy framework for community participation				405,415,904
			6.1.1.1	Set up and inaugurate health development committees involving the PHCs, wards, LGAs and state Ministry of health			202,707,952
			6.1.1.2	Conduct orientation for members of the community health development committees on the National and state health Policy regarding community ownership			202,707,952
		6.1.2	To provide an enabling implementation framework and environment for community participation				202,707,952
			6.1.2.1	Adopt and implement guidelines for establishing community structure at the LGAs levels			-
			6.1.2.2	Develop and utilise participatory tools and approaches to enhance community involvement in planning , management, monitoring and evaluation of health interventions			202,707,952
			6.1.2.3	Conduct pilot annual evaluation of the community health interventions in 9 LGAs per year			-
	6.2	**To empower communities with skills for positive health actions**			**All States offer training to FBOs/CBOs and community leaders on engagement with the health system by end 2012**		-
		6.2.1	To build capacity within communities to 'own' their health services				-
			6.2.1.1	Identify and map out key community stakeholdersin all the wards of the 17 LGAs			-
			6.2.1.2	Conduct training and re-orientations to community development committees, community resource persons on their roles and responsibilities			-

			6.2.1.3	Community participation and contribution to their own health activities via annual community health sensitization activitieswhere feedbacks from PHC data are presented			-
	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**		-
		6.3.1	To restructure and strengthen the interface between the community and the health services delivery points				-
			6.3.1.1	Train community stakeholders on available health services and utilisation and SERVICOM			-
			6.3.1.2	Annual meetings of community stakeholders to share experiences			-
	6.4	**To increase national capacity for integrated multisectoral health promotion**			**State has active intersectoral committee with other Ministries and private sector by end 2011**		-
		6.4.1	To develop and implement multisectoral policies and actions that facilitate community involvement in health development				-
			6.4.1.1	Advocacy visits to community gate keepers soliciting their suport to increase awareness, support and involvement in community health development			-
			6.4.1.2	Train health workers on community behavioural change process			-
	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**		-
		6.5.1	To develop and implement systematic measurement of community involvement				-
			6.5.1.1	Carry out KAP survey on specific health care programme in selected communities in some LGAs			-
			6.5.1.2	Disseminate the findings to stakeholders/community members			-
PARTNERSHIPS FOR HEALTH							-
7. To enhance harmonized implementation of essential health services in line with national health policy goals							**608,123,856**
	7.1	**To ensure that collaborative mechanisms are put in place for involving all partners in the development and sustenance of the health sector**			**1. SMOH has an active ICC with Donor Partners that meets at least quarterly by**		**608,123,856**

					end 2010 2. SMOH has an active PPP forum that meets quarterly by end 2010		
		7.1.1	To promote Public Private Partnerships (PPP)				428,450,899
			7.1.1.1	Establish state health partners coordinating committees			248,777,941
			7.1.1.2	Conduct bi-annual review meetings of the coordinatiing commitees			179,672,958
			7.1.1.3	Contract and or lease out certain specialised services (maintenance of hosptal equipments) to private partners.			-
			7.1.1.4	Subsidise health services through provision of grant to private health providers			-
			7.1.1.5	Training and re-training of staff in private sectors			-
		7.1.2	To institutionalize a framework for coordination of Development Partners				179,672,958
			7.1.2.1	Annual review meetings to cordinate the development partners			179,672,958
			7.1.2.2	Establish a donor co-ordinating unit manned by 6 staff members at the SMOH			-
		7.1.3	To facilitate inter-sectoral collaboration				-
			7.1.3.1	Annual review meetings to facilitate coolaboration between SMOH, professional groups and other health related sectors			-
		7.1.4	To engage professional groups				-
			7.1.4.1	Provide logisitics to the various health professionals groups to enforce the existing professional standard of regulation and practices			-
		7.1.5	To engage with communities				-
			7.1.5.1	Provide IEC materials to communities for health information dissemination			-
			7.1.5.2	Make provision for yearly awards for excellent performance by communities(Community Health Day award for excellence)			-
			7.1.5.3	Organize focused group discussions at ward and community levels to assess local health situation and foster understanding & community participation			-
		7.1.6	To engage with traditional health practitioners				-
			7.1.6.1	Provide logisitics to the monitoring body to supervise the activities of the traditional health providers			-
			7.1.6.2	Set up a meeting between SMOH and executives of the traditional healers' organization in Plateau state			-
			7.1.6.3	Establish a board to regulate and standardise the practice of traditional medicine			-
			7.1.6.4	Provision/establishment of traditional medicine resarch institude			-
			7.1.6.5	Provision of herbal medicine practioners Edit			-
RESEARCH FOR HEALTH							-

8. To utilize research to inform policy, programming, improve health, achieve nationally and internationally health-related development goals and contribute to the global knowledge platform							**1,216,247,712**
	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. SMOH aligns with the Essential Health Research agenda from 2011**		**1,216,247,712**
		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				1,216,247,712
			8.1.1.1	Establish and inugurate a state health research ethical committee			292,354,224
			8.1.1.2	Formulate health reaserch policies and guidllines in line with the national policy			712,748,771
			8.1.1.3	hold quarterly meeting of research ethnical committee			211,144,717
		8.1.2	To establish and or strengthen mechanisms for health research at all levels				-
			8.1.2.1	Strengthen the DPRS at state and LGA levels to undertake operational researches			-
			8.1.2.2	Coordinate the implementation of essential national health research guidelines in collaboration with the federal ministry of health			-
		8.1.3	To institutionalize processes for setting health research agenda and priorities				-
		8.1.4	To promote cooperation and collaboration between Ministries of Health and LGA health authorities with Universities, communities, CSOs, OPS, NIMR, NIPRD, development partners and other sectors				-
			8.1.4.1	Establish a feedbck mechanism between consumers of reaserches and producers of reaserches			-
			8.1.4.2	Conduct annaual stakeholder forum to identify research priority areas and harmnoise reaserches efforts.			-
		8.1.5	To mobilise adequate financial resources to support health research at all levels				-
			8.1.5.1	Advocate the designation at least 2% of health budget for reaserch at the state and LGA levels			-
			8.1.5.2	Provide budget lines for health paralstatals and facilties for health research in a targeted manner			-
		8.1.6	To establish ethical standards and practise codes for health research at all levels				-
			8.1.6.1	Establish ethical standards in the conduct of research in the state and LGAs			-
	8.2	**To build institutional capacities to promote, undertake and utilise research for evidence-based policy making in health at all levels**			**SMOH has an active forum with all medical schools and research**		-

					agencies by end 2011		
		8.2.1	To strengthen identified health research institutions at all levels				-
			8.2.1.1	Take inventory of all public and private institution and organisation undertaking health reaserch in the state and LGAs			-
			8.2.1.2	Advocate to tertiary institutions to increase Post graudate level enrolment and graduation in health training institutions through the awarding Post graduate scholarship			-
			8.2.1.3	Develop and implement measure to address research capacity gap/weakneses at state and LGAs			-
			8.2.1.4	Mobilise extra fund from private sector foundation and individuals for health research			-
		8.2.2	To create a critical mass of health researchers at all levels				-
			8.2.2.1	Develop appropriate training intervention for research based on the identified health needs at the state and 17 LGAs			-
			8.2.2.2	Advocate to tertiary institutions to increase Post graudate level enrolment and graduation in health training institutions through the awarding Post graduate scholarship			-
		8.2.3	To develop transparent approaches for using research findings to aid evidence-based policy making at all levels				-
			8.2.3.1	Establish mechanism for improving liaison and links between research users eg policy maker, development partners and researchers			-
			8.2.3.2	Involve wide range actors including researchers in policy making			-
		8.2.4	To undertake research on identified critical priority areas				-
			8.2.4.1	Establish a process for the bi-annual estimation of the burden of the identified prioity diseases in the communities			-
			8.2.4.2	Under take bi-annual studies into human resources for health needs at state and LGA levels			-
			8.2.4.3	Undertake annual studies into health system development and management at state and the 17 LGAs (HSDP projects)			-
			8.2.4.4	Conduct annual SITAN of the state and LGA health delivery systems			-
			8.2.4.5	Conduct stuides yearly on financial risk protection, equity, efficiency and values of different health financing mechanisms at state and LGA levels			-
	8.3	**To develop a comprehensive repository for health research at all levels (including both public and non-public sectors)**			**1. State has a Health Research Unit by end 2010 2. SMOH Health Research Units manage an accessible repository by end 2012**		-
		8.3.1	To develop strategies for getting research findings into strategies and practices				-
			8.3.1.1	Establish ways and means of getting research findings into strategies (GRISP) unit at state and LGA levels			-
		8.3.2	To enshrine mechanisms to ensure that funded researches produce new knowledge required to improve the health system				-

			8.3.2.1	Institute a state and LGA bi-annual health research policy forum			-
			8.3.2.2	Conduct need assessment to inform required health research at state and LGA levels			-
			8.3.2.3	Provide and promote guidelines for annual operational research to be conducted by all departments, agencies and parastatals in state minstry of health and PHC departments in the 17 LGAs			-
	8.4	**To develop, implement and institutionalize health research communication strategies at all levels**			**A l health research communicatio n strategy is in place by end 2012**		-
		8.4.1	To create a framework for sharing research knowledge and its applications				-
			8.4.1.1	Develop and implement a framework for sharing reaserch knowledge at state and LGA levels			-
		8.4.2	To establish channels for sharing of research findings between researchers, policy makers and development practitioners				-
			8.4.2.1	Present an annual health conference at the state and LGA levels			-
			8.4.2.2	Conduct annual seminars and workshops on the key thematic areas (financing, human resources, MDG, health researches etc) at state and LGAs			-
			8.4.2.3	Prepare guidelines and develop capacity of researchers to produce policy briefs			-
			8.4.2.4	Support a critique of national high quality health journals			-
			8.4.2.5	circulate identified journals to SMOH and LGAs regularly			-
							60,812,385,619

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

PLATEAU 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 2008/9**	**Milestone 2011**	**Milestone 2013**	**Target 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	TBD	50	75	100%
	2. % stakeholders constituencies playing their assigned roles in the SSHDP (disaggregated by stakeholder constituencies)	TBD	TBD	25	50	75%
2. Improved Legislative and Regulatory	3. State adopting the National Health Bill? (Yes/No)	SMOH	TBD	25	50	75

Frameworks for Health Development						
	4. % of LGAs enforcing traditional medical practice by-laws	TBD	TBD	25%	50%	75%
3. Strengthened accountability, transparency and responsiveness of the State health system	5. % of LGAs which have established a Health Watch Group	TBD	TBD	25%	75	100
	6. % of recommendations from health watch groups being implemented	TBD	No Baseline	25	50	75
	7. % LGAs aligning their health programmes to the SSHDP	LGA Annual Report	TBD	50	75	100
	8. % DPs aligning their health programmes to the SSHDP at the LGA level	LGA Annual Report	No Baseline	50	75	100
	9. % of LGAs with functional peer review mechanisms	SSHDP and LGA Annual Review Report	TBD	25	50	75%
	10. % LGAs implementing their peer review recommendations	LGA / SSHDP Annual Review Report	No Baseline	50	75	100%
	11. Number of LGA Health Watch Reports published	Health Watch Report	0	50	75	100
	12. Number of "Annual Health of the LGA" Reports published and disseminated annually	Health of the State Report	TBD	50	75	100%
4. Enhanced performance of the State health system	13. % LGA public health facilities using the essential drug list	Facility Survey Report	TBD	40	80	100%
	14. % private health facilities using the essential drug list by LGA	TBD	TBD	10	25	50%
	15. % of LGA public sector institutions implementing the drug procurement policy	Facility Survey Report	TBD	50	75	100%
	16. % of private sector institutions implementing the drug procurement policy within each LGA	Facility Survey Report	TBD	10	25	50%
	17. % LGA health facilities not experiencing essential drug/commodity stockouts in the last three months	Facility Survey Report	TBD	25	50	75%
	18. % of LGAs implementing a performance based budgeting system	Facility Survey Report	TBD	25	50	75%
	19. Number of MOUs signed between private sector facilities and LGAs in a Public-Private-Partnership by LGA	LGA Annual Review Report	TBD	2	4	6
	20. Number of facilities performing deliveries accredited as Basic EmOC facility (7 functions 24/7) and	States/ LGA Report and Facility Survey Report	TBD	155	165	185

	Comprehensive EmOC facility (9 functions 24/7)					
STRATEGIC AREA 2: HEALTH SERVICES DELIVERY						
NSHDP GOAL: To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare						
Outcome 3: Universal availability and access to an essential package of primary health care services focusing in particular on vulnerable socio-economic groups and geographic areas						
Outcome 4: Improved quality of primary health care services						
Outcome 5: Increased use of primary health care services						
5. Improved access to essential package of Health care	21. % of LGAs with a functioning public health facility providing minimum health care package according to quality of care standards.	NPHCDA Survey Report	TBD	25	50	75%
	22. % health facilities implementing the complete package of essential health care	NPHCDA Survey Report	TBD	5	8	12%
	23. % of the population having access to an essential care package	MICS/NDHS	TBD	8	12	15%
	24. Contraceptive prevalence rate (modern and traditional)	NDHS	11.10%	15%	20%	25%
	25. % increase of new users of modern contraceptive methods (male/female)	MICS 2007	15.60%	30%	55%	70%
	26. % of new users of modern contraceptive methods by type (male/female)	MICS 2007	15.6	30	55	70%
	27. % service delivery points without stock out of family planning commodities in the last three months	Health facility Survey	10%	50%	70%	90%
	28. % of facilities providing Youth Friendly RH services	Health facility Survey	10%	20%	30%	40%
	29. % women 15-19 who have begun child bearing	NDHS 2008	15%	12%	10%	8%
	30. % of pregnant women with 4 ANC visits performed according to standards*	TBD	84.10%	85%	90%	95%
	31. Proportion of births attended by skilled health personnel	HMIS 2005	24%	35	50 -100%	75 - 100%
	32. Proportion of women with complications treated in an EmOC facility (Basic and/or comprehensive)	EmOC Sentinel Survey and Health Facility Survey	TBD	10%	25%	30%
	33. Caesarean section rate	EmOC Sentinel Survey and Health Facility Survey	1.90%	2%	4%	7,5%
	34. Case fatality rate among women with obstretic	TBD	TBD	50%	40%	30%

	complications in EmOC facilities					
	35. Perinatal mortality rate**	TBD	TBD	45/1000LBs	40/1000LBs	35/1000LBs
	36. % women receiving immediate post partum family planning method before discharge	TBD	TBD	10%	20%	30%
	37. % of women who received postnatal care based on standards within 48h after delivery	MICS	20%	25%	30%	40%
	38. % of newborn with infection receiving treatment	TBD	No Baseline	10%	20%	30%
	39. % of children exclusively breastfed 0-6 months	MICS 2007	57%	70%	60%	90%
	40. Proportion of 12-23 months-old children fully immunized	NDHS 2008	55.00%	80%	90%	100%
	41. % children <5 years stunted (height for age <2 SD)	MICS 2007	29.00%	20%	10%	5%
	42. % of under-five that slept under LLINs the previous night	NDHS 2008	8.00%	40%	60%	75%
	43. % of under-five children receiving appropriate malaria treatment within 24 hours	TBD	10.30%	12%	15%	20%
	44.Condom use at last high risk sex	NDHS/MICS	4%	5%	7.50%	10%
	45. Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS	NDHS 2008	31%	35%	40%	50%
	46. Prevalence of tuberculosis	WHO 2009	1.50%	1.20%	1%	0.50%
	47. Proportion of tuberculosis cases detected and cured under directly observed treatment short course	WHO 2009	51.20%	46%	39%	33%
Output 6. Improved quality of Health care services	48. % of staff with skills to deliver quality health care appropriate for their categories	TBD	TBD	15%	20%	30%
	49. % of facilities with capacity to deliver quality health care	TBD	TBD	20%	25%	30%
	50. % of health workers who received personal supervision in the last 6 months by type of facility	TBD	TBD	10%	15%	20%
	51. % of health workers who received in-service training in the past 12 months by category of worker	TBD	TBD	20%	25%	30%
	52. % of health facilities with all essential drugs available at all times	TBD	TBD	5%	10%	15%
	53. % of health institutions with basic medical equipment and functional logistic system appropriate to their levels	TBD	TBD	5%	10%	15%

	54. % of facilities with deliveries organizing maternal and/or neonatal death reviews according to WHO guidelines on regular basis	TBD	TBD	2%	5%	15%
Output 7. Increased demand for health services	55. Proportion of the population utilizing essential services package	TBD	TBD	10%	20%	30%
	56. % of the population adequately informed of the 5 most beneficial health practices	TBD	TBD	10%	20%	30%
PRIORITY AREA 3: HUMAN RESOURCES FOR HEALTH						
NSHDP GOAL: To plan and implement strategies to address the human resources for health needs in order to ensure its availability as well as ensure equity and quality of health care						
Outcome 6. The Federal government implements comprehensive HRH policies and plans for health development						
Outcome 7.All States and LGAs are actively using adaptations of the National HRH policy and plan for health development by end of 2015						
Output 8. Improved policies and Plans and strategies for HRH	56. % of wards that have appropriate HRH complement as per service delivery norm (urban/rural	TBD	TBD	5%	10%	15%
	57. Retention rate of HRH	TBD	TBD	85%	90%	95%
	58. % LGAs actively using adaptations of National/State HRH policy and plans	TBD	TBD	10%	15%	20%
	59. Increased number of trained staff based on approved staffing norms by qualification	TBD	TBD	10%	20%	30%
	60. % of LGAs implementing performance-based managment systems	TBD	TBD	5%	10%	15%
	61. % of staff satisfied with the performance based management system	TBD	TBD	25%	40%	50%
Output 8: Improved framework for objective analysis, implementation and monitoring of HRH performance	62. % LGAs making availabile consistent flow of HRH information	NHMIS	TBD	5%	10%	25%
	63. CHEW/10,000 population density	TBD	1:739			
	64. Nurse density/10,000 population	TBD	TBD			
	65. Qualified registered midwives density per 10,000 population and per geographic area	TBD	1:2,623	1::2550	1::2550	1::2550
	66. Medical doctor density per 10,000 population	TBD	1:3600 pop	1:3400 pop	1:3200 pop	1:2800 pop
	67. Other health service providers density/10,000 population	TBD	TBD	1:4000 pop	1:3000 pop	1:2000 pop
	68. 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						
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	69. % of LGAs implementing state specific safety nets	TBD	TBD	25%	35%	40%
	70. Decreased proportion of informal payments within the public health care system within each LGA	MICS	78%	75%	70%	65%
	71. % of LGAs which allocate costed fund to fully implement essential care package at N5,000/capita (US$34)	State and LGA Budgets	TBD	5%	10%	15%
	72. LGAs allocating health funding increased by average of 5% every year	State and LGA Budgets	TBD	10%	20%	25%
Output 12: Improved efficiency and equity in the allocation and use of Health resources at State and LGA levels	73. LGAs health budgets fully alligned to support state health goals and policies	State and LGA Budgets	TBD	25%	40%	50%
	74.Out-of pocket expenditure as a % of total health expenditure	National Health Accounts 2003 - 2005	70%	60%	50%	40%
	75. % of LGA budget allocated to the health sector.	National Health Accounts 2003 - 2005	2%	10%	20%	30%
	76. Proportion of LGAs having transparent budgeting and finacial management systems	SSHDP review report	TBD	25%	40%	60%
	77. % 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						
Output 13: Improved Health Data Collection, Analysis, Dissemination, Monitoring and Evaluation	78. % of LGAs making routine NHMIS returns to states	NHMIS Report January to June 2008; March 2009	0-10%	10-25%	30-50%	50-70%
	79. % of LGAs receiving feedback on NHMIS from SMOH		TBD	25 -50%	50 - 75%	75 - 100%
	80. % of health facility staff trained to use the NHMIS infrastructure	Training Reports	TBD	10-30%	35-60%	60-85%

	81. % of health facilities benefitting from HMIS supervisory visits from SMOH	NHMIS Report	TBD	15-25%	25-40%	40-70%
	82.% of HMIS operators at the LGA level trained in analysis of data using the operational manual	Training Reports	TBD	10%	25%	55%
	83. % of LGA PHC Coordinator trained in data dissemination	Training Reports	TBD	10%	25%	55%
	84. % of LGAs publishing annual HMIS reports	HMIS Reports	TBD	2%	5%	7%
	85. % of LGA plans using the HMIS data	NHMIS Report	TBD	30%	55%	75%
PRIORITY AREA 6: COMMUNITY PARTICIPATION AND OWNERSHIP						
Outcome 11. Strengthened community participation in health development						
Outcome 12. Increased capacity for integrated multi-sectoral health promotion						
Output 14: Strengthened Community Participation in Health Development	86. Proportion of public health facilities having active committees that include community representatives (with meeting reports and actions recommended)	SSHDP review report	TBD	10%	25%	50%
	87. % of wards holding quarterly health committee meetings	HDC Reports	TBD	10%	255%	70%
	88. % HDCs whose members have had training in community mobilization	HDC Reports	TBD	20%	30%	50%
	89. % increase in community health actions	HDC Reports	TBD	10%	25%	50%
	90. % of health actions jointly implemented with HDCs and other related committees	HDC Reports	TBD	25%	50%	60%
	91. % of LGAs implementing an Integrated Health Communication Plan	HPC Reports	TBD	10%	15%	30%
PRIORITY AREA 7: PARTNERSHIPS FOR HEALTH						
Outcome 13. Functional multi partner and multi-sectoral participatory mechanisms at Federal and State levels contribute to achievement of the goals and objectives of the SHDP						
Output 15: Improved Health Sector Partners' Collaboration and Coordination	92. Increased number of new PPP initiatives per year per LGA	SSHDP Report	TBD	5%	15%	35%
	93. % LGAs holding annual multi-sectoral development partner meetings	SSHDP Report	TBD	20s%	35s%	55s%
PRIORITY AREA 8: RESEARCH FOR HEALTH						
Outcome 14. Research and evaluation create knowledge base to inform health policy and programming.						
Output 16: Strengthened stewardship role of government for research and knowledge management systems	94. % of LGAs partnering with researchers	Research Reports	TBD	2s%	5s%	12s%
	95. % of State health budget spent on health research and evaluation	State budget	TBD	1%	1.50%	2%

	96. % of LGAs holding quarterly knowledge sharing on research, HMIS and best practices	LGA Annual SHDP Reports	TBD	5%	8s%	15%
	97. % of LGAs participating in state research ethics review board for researches in their locations	LGA Annual SHDP Reports	TBD	15s%	30%	55%
	98. % of health research in LGAs available in the state health research depository	State Health Reseach Depository	TBD	5%	10s%	25%
Output 17: Health research communication strategies developed and implemented	99. % LGAs aware of state health research communication strategy	Health Research Communication Strategy	TBD	5%	10%	25%