OSUN STATE GOVERNMENT

STRATEGIC HEALTH DEVELOPMENT PLAN

(2010-2015)

Osun State Ministry of Health

March 2010

Contents

Acknowledgement

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

Acronyms

BCC	Behaviour Change Communication
CIDA	Canadian International Development Agency
CORPs	Community oriented resource persons
CPD	Continuing professional development
CSO	Community Service Organization
DFID	Department for International Development
DHS	Nigeria Demographic and Health Survey
DP	Development Partners
DPRS	Department of Planning, Research and Statistics
FCT	Federal Capital Territory
FMOH	Federal Ministry of Health
GDP	Gross Domestic Product
GIS	Geographic Information System
GTZ	Gesellschaft für Technische Zusammenarbeit (German NGO)
HDCC	Health Data Consultative Committee
HF	Health Facility
HIS	Health Management Information System
HIV/AIDS	Human Immuno Deficiency Virus/Acquired Immune Deficiency Syndrome
HLM	High Level Ministerial Meeting on Health Research
HPCC	Health Partners Coordinating Committee
HRH	Human Resources for Health
HW	Health worker
IEC	Information, Education and Communication
IMCI	Integrated management of Childhood Illnesses
IMNCH	Integrated Maternal, Newborn and Child Health
IPC	Interpersonal Communication skills
ISS	Integrated supportive supervision
ITNs	Insecticide treated nets
JFA	Joint Funding Agreement
JICA	Japan International Development Agency
LGA	Local Government Area
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDAs	Ministries, Departments and Agencies
MDCN	Medical and Dental Council of Nigeria,
MDGs	Millennium Development Goals
MNCH	Maternal and Newborn Child Health
MRCN	Medical Research Council of Nigeria
NAFDAC	National Agency for Food Drugs Administration and Control

NGOs	Non-Governmental Organizations
NHA	National Health Accounts
NHIS	National Health Insurance Scheme
NHMIS	National Health Management Information System
NHREC	National Health Research Committee
NIMR	Nigerian Institute for Medical Research
NIPRD	National Institute for Pharmaceutical Research and Development
NMSP	National Malaria Strategic Plan
NPHCDA	National Primary Health Care Development Agency
NSHDP	National Strategic Health Development Plan
NSHDPF	National Strategic Health Development Plan Framework
NSTDA	National Science and Technology Development Agency
NYSC	National Youth Service Corps
OAU	Organisation of African Unity
ODA	Oversea Development Assistance
OPS	Organised Private Sector
PEPFAR	President's Emergency Plan for AIDS Relief
PERs	Public Expenditure Reviews
PHC	Primary Health Care
PHCMIS	Primary Health Care Management Information System
PPP	Public Private Partnerships
QA	Quality Assurance
RDBs	Research data banks
SHAs	State Health Accounts
SMOH	State Ministry of Health
SWAPs	Sector-Wide Approaches
TB	Tuberculosis
TBAs	Traditional birth attendants
TWG	Technical Working Group
UN-System	United Nations-System
VAT	Value Added Tax
VHW	Village health workers
VOC	Vote-of-charge
WHO	World Health Organization

Vision and Mission of the Strategic Health Development Plan

Vision

To provide quality, accessible and affordable healthcare services to the population by 2015

Mission

To initiate cost effective but proven evidence-based intervention activities, mobilize human and financial resources to and ensure that the citizens of Osun State receive the best and sustainable health care services in a transparent and diligent manner.

Executive Summary

The modern Osun State was created in 1991 from part of the old Oyo State. The state's name is derived from the River Onus, the venerated natural spring that is the manifestation of the Yoruba goddess of the same name. The major sub-ethnic groups in Ọsun State are Ife, Ijesha, Oyo, Ibolo and Igbomina of the Yoruba nation, although there are also people from other parts of Nigeria. Yoruba and English are the languages of the people for official and business transactions. The total population stands at approximately 3.5 million (2006 census). There are more men than women in the state with the number of males at about 1,734,149 while the females are about 1,682,810. Under 5 years old children comprise about 20% of the total population. (*NDHS 2008)*

Traditionally, the people engage in agriculture and produce sufficient food and cash crops for domestic consumption and as inputs for agro-allied industries as well as for export. A substantial number of the people are also traders and artisans while some others engage in cloth weaving, mat weaving, cloth dying, soap making, wood carving, etc.

The State is divided into three federal senatorial districts, namely, Osun I, Osun II and Osun III each of which is composed of two administrative zones. The state consists of thirty (30) Local Government Areas plus one Area office (at Modakeke).

Through its partial free health service programme, Osun State has recorded substantial increase in health care service patronage over the years. Recently, the State government has commenced the construction of Osun State Drug manufacturing company at Osogbo, with the purpose of enhancing drug availability in government hospitals. Also, the Pharmaceutical Inspectorate has been strengthened through the employment of two (2) additional Pharmacists. Furthermore, in order to ensure that only good quality drugs are circulated in the State, drug distribution outlets are sanitized through regular effective Pharmaceutical Inspectorate activities.

In the area of routine immunization much progress has been made through a network of 854 health facilities at which 99% BCG coverage was recorded by July 2009. In fact, only 5% of children in the state have not received any immunization (zero dose) (*NDHS 2008).*

The State government purchased 31 ambulances for the 30 LGA and the Ife East Area office for easy referral process to higher level hospitals. These are apart from six (6) Special Ambulances that were purchased and distributed to the six (6) zones in the State.

The State has achieved 70% case detection of TB patients and cure 85% of all the cases detected. This success can be attributed to mounted efforts to educate the general populace on the symptoms of TB and where to go for assistance. The 2008 NDHS report shows that 81.3% of females and 97.1% of males have the knowledge of TB. The State has also achieved a consistently high cure rate since 2001 of 87.4% which is slightly above the National average.

Another area of achievement is the fight against genital mutilation. In 2004, the State governor signed the Osun State Female Circumcision and Genital Mutilation Prohibition Law, which outlawed the practice throughout Osun State. Even though the ban is taken quite seriously, eradicating a deeply rooted cultural tradition will require additional efforts.

There are, however, outstanding challenges despite the record of achievements. These problems are heightened by the persistent high infant mortality rate in the State and the inadequate number of key

health personnel as well as physical infrastructure. Put together, the health sector in the State is still confronted by some critical challenges, notably:

a) Inadequate funding
b) Shortage of health manpower
c) Poverty,
d) Ignorance (cultural/religious barriers)
e) poor attitude of people to their health
f) Shortage of equipment
g) Prevalence of fake drugs
h) Quack doctors
i) Below standard private clinics.

Selection of interventions to be included in Osun State Minimum Package of Care are consistent with the states epidemiological profile, current state of its health system, equity issues and the principle of the continuum of care that starts before pregnancy, through pregnancy to birth, the newborn period, infancy and older childhood across the health system which including the home, the community, first level facility and the referral facility. Health Interventions would be targeted at each stage of the life cycle in order to maximize impact. Facility based interventions will be balanced with those at home and community level, since prevention and management of illnesses begins in the home.

Informed decisions would be made about the choice of the delivery mechanism, the sequence of action and the pace at which services can be expanded. Strong health systems will therefore, be required, based on the bottlenecks analysis done above.

Global evidence suggest that cost effective evidence based high impact interventions are best delivered through the three delivery modes namely family and community oriented services, population services and individual oriented clinical services.

In view of the above the Osun State Minimum Package of care includes the following:

I. **Family/community based care**
- Care of the newborn and special care for Low Birth Weight
- Early, exclusive & prolonged breastfeeding + complementary feeding
- Use of Insecticide treated nets, safe water sanitation & hygiene practices
- Oral Rehydration with Zinc for diarrhea
- HIV/AIDS Prevention & Care; Care & Support for orphans

II. **Population oriented schedulable services**
- Micronutrient supplementation and
- Immunisation of children and mothers
- Ante- and Post-Natal Care + family planning
- Preventing Mother-Child Transmission AIDS

III. **Individual oriented non-schedulable services**
- Skilled attendance during delivery
- Case management of diarrhoea, pneumonia, malaria, neonatal sepsis, severe malnutrition, very low birth-weight, HIV/AIDS and TB

- Emergency Obstetric and Newborn Care

Estimated costing of the strategies over the period of 6 years is about **N64.24 billion.**

Chapter 1: Background and Achievements

1.1 Background

As at the time the State was drawing up its Economic Empowerment and Development Strategy (SEEDS) in 2004, the authors had cause to point to its health status as "poor" a replication of the national picture. The need to take remedial measures was logically embraced on the note that: There is need for health interventions to reduce or control the prevalence of health problems and bring down high mortality and morbidity rates in Osun State (Osun SEEDS document, 2005, p.50). Therein stated as the health objectives of the government are the following:

i. To reduce diseases burden
ii. To improve access to quality health care services
iii. To make health care deliveries community owned, community driven and community operated
iv. To cultivate the culture of personal obligation for better health in the community
v. To encourage effective collaboration and partnership with all health actors.

From the above stated objectives, it is evident that the State had been in full alignment with the spirit of the current National Strategic Health Development Plan (NSHDP) given the priority Areas of the Plan. Therefore, if as it appears, the health condition in the State has not radically improved since the articulation of these sentiments in a medium term strategy framework, something must be missing and should serve as a lesson for the current strategic initiative.

Allied to this was the recognition of the problem of understaffing of health institutions in the State. As the accompanying Table shows, at the inception of the SEEDS, there was shortage of every cadre of health worker in the State.

Table I: Critical staff needs in Osun Hospitals as at 2005

S/N	Staff	Situation as at 2004	Ideal Situation (for 2004)
I	Medical Consultants	2	72
ii	Medical Officers	59	229
iii	Dentists	13	22
iv	Nurses	632	1446
v	Medical Laboratory Technologists/ Scientists	24	115
vi	Physiotherapists	5	81
vii	Radiographers	1	27
viii	Pharmacists	13	160
ix	Medical Record Technologists	13	133

The picture captured on the staffing situation in the hospitals does not reveal the fact that and as noted in the SEEDS document, "in reality, some of the hospitals cannot meet the standards of their designations due to lack of accommodation and facilities". In summary, it was acknowledged that the health sector in the State was confronted by some specific problems, notably:

a) Inadequate funding

b) Shortage of health manpower

c) Poverty, ignorance and attitude of people to their health
d) Shortage of equipment
e) Prevalence of fake drugs, quack doctors and substandard clinic.

1.2 Achievements

One area of observable success is the free health policy of the State government which has led to a rise in hospital attendance by citizens who have experienced reduced turn-around time coupled with effective drug stock control system leading to relative abundant supply of drugs and dressings at the right quantity and time. Furthermore, more recently the State government has commenced the construction of Osun State Drug manufacturing company at Osogbo, with the purpose of enhancing drug availability in government hospitals.

The state performance in immunization is impressive. Over the years, the percentage of one year old children fully immunized against measles has been on the increase ranging from 26.1, 65.1, 54.7, 67.1 and 81.9 percent from 2004, 2005, 2006 and 2007. The state has already surpassed the national target and by year 2015, if current efforts are sustained, the percentage could reach 100%.

The Pharmaceutical Inspectorate has been strengthened through the employment of two (2) additional Pharmacists. Also, in order to ensure that only good quality drugs are circulated in the State, drug distribution outlets are sanitized through regular effective Pharmaceutical Inspectorate activities.

The State government purchased 31 ambulances for the 30 LGA and the Ife East Area office for easy referral process to higher level hospitals. These are apart from six (6) Special Ambulances that were purchased and distributed to the six (6) zones in the State.

Progress has been made towards better disease surveillance and notification system such that disease trends are easily monitored and impending epidemics are detected early followed by prompt intervention activities. Similarly, progress made on HIV/AIDS control and prevention is fair, considering the downward trend of the HIV prevalence rates among pregnant mothers ranging from 3.7, 4.3, 1.2, 2.0 and 1.2 in 1999, 2001, 2003, 2005 and 2008 respectively. Also the rate of condom use among non-regular sexual partners is above 50%.

Malaria is responsible for high rates of maternal and childhood mortality. Malaria prevention strategy remains a challenge in the State. Only 1.9% of households have at least one ITN. Available figure to the SMOH indicate that the incidence of malaria cases among the vulnerable groups is on the increase; under-5 children 158, 937 (2006), 230, 579 (2007); pregnant women – 619 (2006), 9,731 (2007). Only about 10% of under-5 children with reported cases of malaria were treated appropriately with ACT in 2007. The main challenges being faced by RBM programme in the state include, inadequate and high cost of ACT drugs, drugs for IPT in pregnancy and ITNs, low level awareness on the benefit of ITNs; inappropriate technical capacity of health workers to manage and prevent malaria infection. Diagnostic equipment (RDTs) are not available at primary health care level.

The State has achieved 70% case detection of TB patients and cure 85% of all the cases detected. The State has also achieved consistently high cure rate since 2001 more than the National target i.e. 87.4% in Osun State whereas nationally it is 85%. While death associated with TB is declining from

35, 20.5, and 21.2 in 2004, 2005 and 2006, incidence of positive TB per 100,000 populations has not shown the same trend; rather it has been fluctuating. Incidence of positive TB was 23.6, 25.6 and 24.5 in 2004, 2005, and 2006 respectively. This may be due to high awareness making people willing to go for test; efforts are still needed to stem the tide in the State.

In 2004, the State governor signed the Osun State Female Circumcision and Genital Mutilation Prohibition Law, which outlawed the practice throughout Osun State. Even though the ban is taken quite seriously, actually eradicating a deeply rooted cultural tradition will require additional efforts (UNFPA 2007).

Chapter 2: Situation Analysis

Introduction

The federal structure of the country does not preclude the harmonization of policies, programmes and even projects across the three tiers of government duly recognized under the Constitution. This is especially in view of the benefits of synergy and knowledge sharing that has proven to facilitate development. This is why, like other states in the federation, Osun willingly participated in the consultative processes that culminated in the Plan Framework subsequently agreed upon by all the three tiers of administration across the nation.

Whereas the Plan Framework established common methodology and time frame, it explicitly recognizes the reality of differences that ultimately define the uniqueness of each planning space. The specific health needs and challenges faced by the people of this State, therefore, are what inform the content of the State Strategic Health Development Plan. Logically, the first major step in the process of drafting the plan, following the consultations among stakeholders, is the situation analysis of the state's health sector as foundation for establishing the current state of things and then proceeding to ascertain the gaps between what is and what ought to be. After all, the essence of planning conceptually and in practice is to move society from a given condition to a preferred one through appropriate resource mobilization and allocation within a coherent policy framework.

2.1 Socio-economic context

The modern Osun State was created in 1991 from part of the old Oyo State.The state's name is derived from the River Onus, the venerated natural spring that is the manifestation of the Yoruba goddess of the same name. The major sub-ethnic groups in Ọsun State are Ife, Ijesha, Oyo, Ibolo and Igbomina of the Yoruba nation, although there are also people from other parts of Nigeria. Yoruba and English are the languages of the people for official and business transactions. The total population stands at approximately 3.5 million (2006 census).

Traditionally, the people engage in agriculture and produce sufficient food and cash crops for domestic consumption and as inputs for agro-allied industries as well as for export. A substantial number of the people are also traders and artisans while some others engage in cloth weaving, mat weaving, cloth dying, soap making, wood carving, etc.

The State is divided into three federal senatorial districts, namely, Osun I, Osun II and Osun III each of which is composed of two administrative zones. The state consists of thirty (30) Local Government Areas plus one Area office (at Modakeke).

Health Policy

On taking over the administration of the State, the present regime met a free health programme policy which it has subsequently sustained with two major components of primary and secondary health care. Under the Primary Health Care, the following strategies have been adopted since 2003:

- Free immunization for children 0-5 years against the six childhood killer diseases
- Free immunization for women of reproductive age against tetanus
- Free distribution of micronutrient to children 0-5 years and pregnant women
- Free mass immunization against the deadly diseases of yellow fever, hepatitis B and cerebrospinal meningitis

- Free treatment of citizens against onchocerciasis
- Free treatment for confirmed cases of tuberculosis and leprosy and
- Provision of health information

The Free Secondary Health Care consists of:

i. Free registration of patient
ii. Free consultations
iii. Free minor investigations like P.C.V, malaria parasite and uninanalysis
iv. Free medication with essential drugs
v. Free minor surgeries like incision and drainage
vi. Care of pregnant women that include:
   a) Free pre-natal care
   b) Free normal deliveries
   c) Free suturing of episiotomies
   d) Free medication with essential drugs during labour and delivery
   e) Free emergency caesarian section
   f) Free assisted delivery (forceps/vacuum) and
   g) Free post-natal care

Under its drug supply policy, the State gets drugs dispensed free of charge to patients in all the State and Local Government owned health facilities.

2.2 Health status of the population

The health situation in the State is not very much unlike the national scene characterized by poor indicators, historically worsened by rapidly growing population that stretches health resources.

The current situation of diseases prevalence includes the following:

i. High infant mortality rate, 115/1000 live births
ii. High under-5 mortality rate, 205/1000
iii. High maternal mortality ratio (for South-West is 166/100,000)
iv. High morbidity and mortality is prevalent in communicable and non-communicable diseases
v. Diarrhea, measles, malaria, pneumonia are most common among children under 5 especially in rural areas
vi. Routine immunization coverage rate that was about 90% in the 1990s actually started to fall until recently
vii. Public expenditure on health is far less than $5 per capita compared with $14 recommended internationally
viii. Life expectancy is 54 years.

Summary of Osun State Indicators

POPULATION (2006 Census)	OSUN
Total population	**3,416,959**
female	1,682,810
male	1,734,149
Under 5 years (20% of Total Pop)	406,929
Adolescents (10 – 24 years)	1,160,136
Women of child bearing age (15-49 years)	728,981
INDICATORS	**NDHS 2008**
Literacy rate (female)	78%
Literacy rate (male)	93%
Households with improved source of drinking water	76%
Households with improved sanitary facilities (not shared)	13%
Households with electricity	67%
Employment status (currently)/ female	68.8%
Employment status (currently)/ male	62.6%
Total Fertility Rate	4
Use of FP modern method by married women 15-49	27%
Ante Natal Care provided by skilled Health worker	94%
Skilled attendants at birth	89%
Delivery in Health Facility	85%
Children 12-23 months with full immunization coverage	59%
Children 12-23 months with no immunization	5%
Stunting in Under 5 children	31%
Wasting in Under 5 children	12%
Diarrhea in children	4.9
ITN ownership	2%
ITN utilization (children)	2%
ITN utilization (pregnant women)	0%
Children under 5 with fever receiving malaria treatment	-
Pregnant women receiving IPT	5%
Comprehensive knowledge of HIV (female)	37%
Comprehensive knowledge of HIV (male)	58%
Knowledge of TB (female)	81.3%
Knowledge of TB (male)	97.1%

2.3 Health services provision and utilization

There are about one thousand and twenty (1020) health care facilities scattered throughout the State. Two of these are Tertiary Teaching Hospitals, 55 are Secondary health care facilities owned and managed by Osun State Government; 532 are Primary health care facilities owned and managed by the 30 LGAs plus 1 Local office while about 430 are owned and managed by private practitioners.

Table II: State Health workers by Cadre

Cadre	Number
Doctors	129
Mid-wives	66
Nurses	599
Medical Lab Scientists	45
Medical lab Technologists	4
Scientific officers	6
Pharmacists	28
Pharmacy Technicians	58
Environmental Health officers	45

Community Health Workers	37
Health Record officers	11
Health Record Technicians	26
Health Record Assistants	64
Physiotherapists	13
Dental Technician	13
Dental Technologists	11
Health Attendants	290

At the level of heath training institutions, currently the State has one (1) School of Nursing, one (1) School of Mid-wifery both located in Osogbo and currently on provisional accreditation status, the state capital has one School of Heath Technology located in Ilesa and it is fully accredited for all the courses it offers.

The number of patients that are attending the State owned hospitals is very significant in determining the utilization of the qualitative free health programme of the government. The figures below reflect the hospital attendance during the period, 2003-2008

Table III: Attendance in State Government Hospitals, 2003-2008

Year	Out-Patients Attendance	Hospitals Admission	Ante-natal Clients	Deliveries
2003	607100	6290	32785	2919
2004	600246	8176	42533	4447
2005	585359	8556	38626	4245
2006	549496	8517	32934	4053
2007	410144	5801	30892	3194
2008	495988	8133	35817	3795

Table IV: Annual Patients Mortality in Public Hospitals in the State, 2002-7

Year	**Adults**			**Children**			**Infants**			**Maternal**
	M	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	
2002	24	16	40	4	3	7	2	1	3	3
2003	33	30	63	5	3	8	11	8	19	0
2004	59	55	114	23	18	41	4	2	6	2
2005	66	50	116	36	38	74	2	1	3	1
2006	42	55	97	34	24	58	2	0	2	0
2007	31	38	69	17	12	29	0	1	1	0
Total	**255**	**244**	**499**	**119**	**98**	**217**	**21**	**13**	**34**	**6**

There are seven health professional groups in the state as listed below:

i. Nigeria Medical Association
ii. National Association of Nigerian nurses and midwives
iii. Association of Medical laboratory Scientists
iv. Pharmaceutical society of Nigeria
v. Community Health Practitioners
vi. Environmental health officers Association of Nigeria
vii. Nigerian Society of Physiotherapists

- **Organization of the State and LG Health system**

The State Ministry of Health (SMOH) is the agency in charge of policy formulation, interpretation, monitoring and supervision and in some cases policy execution-as for example where a community in underserved, builds an hospital there. There is the Hospital Management Board saddled with service delivery at the Secondary Health Care level. Primarily, the local Government is saddled with implementation of the Primary Health Care under the PHC Department of the SMOH.

- **Relationship between Public and Private Sector**

The public health sector is regulated and controlled by the SMOH- specifically the Department of Tertiary and Non-Governmental Institutions. The activities of private medical practitioners are regulated by the SMOH.

- **Traditional Health Sector**

Currently, there is a lot of carefree but dangerous operation by traditional herbal practice (THP). The contents of their drugs are unknown and most serious, side effects yet to be established. There is no formal policy statement on this sector although attempt is on-going to find ways of regulating their practice through formal registration.

2.4 Key issues and challenges

2.4.1 Physical Resources

Medical equipment can never be adequate especially as upgrading is a constant requirement and this is on-going.

2.4.2 Human Resources

There is shortage of staff but recruitment is currentlyon for doctors, nurses and other paramedics

2.4.3 External Funding

- The World Bank is supporting on the Health Sector Development Project II
- Demien Foundation (of Belgium) is working is assistingin the area of TB and leprosy
- WHO is working consistently on polio vaccination
- CIDA is working on Maternal Health Care
- UNICEF is working on the Children front

The challenges that the State has to contend with in reducing child mortality include: low prevalence of exclusive breastfeeding, high prevalence of childhood diseases such as; malaria, respiratory problem, measles, diarrhea and malnutrition etc. others are; Malnutrition (which accounts for over 50% underlying causes of childhood mortality), and how to curb HIV that now contributes to infant's mortality in alarming rate. This will require curbing prevalence of HIV/AIDS to reduce mother to child transmission, how to curb increasing care and fostering of children orphaned by HIV/AIDS, high turnover of unemployed health personnel and how to further accelerate immunization coverage that will be required in order to reduce child mortality in the State.

Furthermore, the rate of exclusive breastfeeding among 0 – 6 months babies in the State is about 17% which further predisposes to malnutrition.

Although, there is no robust data on maternal mortality in the State, available data for the south western states show that the rates are worsening from 580, 620 and 728/100,000 live births in 2002, 2004, and 2005 respectively in the States. Non availability of state based data shows that there is a data gap due to weakness in data-gathering capacities and monitoring and evaluation. It is unlikely that the target of reducing maternal mortality by three quarters by 2015 will be achieved. Between 1999 and 2006, though maternal health indicators worsened in the state, however, it is better than the national average of 800/100,000. At the same time, there are outstanding challenges that include poor referral services, high prevalence of micro and macro nutrients deficiency disorders, with their attendant problems of anemia, low birth weight etc. Others are childhood malnutrition resulting from inaccessibility to adequate dietary intake, shortage of some specialized health manpower.

At the level of disease surveillance, specific challenges identified by operators in the Unit include the following:

- Inadequate competent manpower
- Non-availability of running imprest
- Inadequate logistic support
- Inadequate tools such as computers, calculators and stationery

However, the unit has some strength, including:

I. Periodic training on the job i.e capacity building
II. Prompt payment of salary
III. Timely promotion and payment of annual leave allowances

What is stated in the foregoing sections apply in a moderated way to the third tier of government, the Local Government Area as typified by one of them; the Atakumosa East LGA which brief is given below:

Atakunmosa East Local Government has an estimated population of which 54% are female and 48% male. This Local Government is divided into 10 political wards. The people of Atakunmosa East Local Government are predominantly farmers. Gold had been discovered to the major natural resources endowed to this Local Government.

The Local Government operates Primary Health Care delivery system with the orthodox and traditional health care delivery system which operates alongside with each other, though without any collaboration. The LGA PHC provides curatives and preventive measures of Health Care delivery service to the people of their community. Some of the services rendered are:

- Provision of quality routine immunization services
- Provision of ante-natal care services
- Provision of good water and sanitation
- Provision of infant welfare clinic service
- Control of communicable and non-communicable disease
- Provision of family planning and nutrition and growth monitoring services.
- Caring and counseling of people living with HIV/AIDS

- Provision of quality and, accurate data for planning and decision making at the Local Government level.

The challenges and problems facing the health sector at the Local Government Area Level include:

- Inadequate provision of medical equipment to the health facility.
- Poor road access to the health centres.
- Problem of funds.
- Employment of non-professional to the health sector.
- Mobility and logistic problems.
- Shortage of health personnel.

Chapter 3 Priority Areas of the State SHDP

This SHDP seeks to provide strategic guidance to the State in the selection of evidenced-based priority interventions that would contribute to achieving the desired health outcomes for the people of Osun Statet wards achieving sustainable universal access and coverage of essential health services within the planned period of 2010 - 2015.

The Honourable State Commissioner for Health therefore expects all the stakeholders to embrace '*the use of this OSHDP for the development of threspective operational plans for the state.*'

This SHDP focuses on eight priority areas that are listed as follows:

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

Annex 2 specifies the goals, strategic objectives and the corresponding interventions and activities with costs. To improve the functionality, quality of care and utilization of services so as to positively impact the health status of the population, universal access to a package of cost-effective and evidence-based interventions detailed below is needed. This would of necessity require interventions that transform the way the health care system is resourced, organized, managed and services delivered

Oyo State Minimum Health Care Package

HIGH IMPACT SERVICES
A. 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

Human Resources for Health comprise of trained health personnel in the State's public health sector (Doctor, Nurses, Medical Record Officer, Pharmacists, Community Health Extension Workers, Science Laboratory, Pharmacist Tech and Health Assistant/Attendants. Human resources play an important role in improving health system performance. In the State, there are trained and untrained health personnel.

In view of the above, the availability of Human Resources in the Health development plan cannot be over emphasized.

Mechanisms to minimize work hazards through management of physical risks and mental stress, with full compliances with prevention and protection need to be strengthened. Also, there should be establishment of mechanisms to monitor performance of health workers at the health centres.

4.2 Physical

The refurbishing of existing facilities and the construction of new ones is taken as an integral part of the necessary challenges to be taken on board within the plan.

4.3 Financial

The most ready claim of defense by governments in Nigeria and beyond for performance failure on the index service delivery is lack of funds. In Osun State, from the planned interventions in the health sector and the accompanying estimated costs, it is evident that the financial resources required to deliver on the health sector MDGs is huge. This raises the challenge of cost effectiveness and the need to ensure value for money. More important, it points to the need for appropriate prioritization of interventions.

At a more general but nonetheless programmatic level, the challenge of finance in Osun State dictates the broadening of the revenue base of government.

Chapter 5: Financing Plan

Below is a simplified, almost simplistic presentation of the financial plan for the period 2010-2015. The only year with objectively verifiable cost companion is 2010.

	YEAR					
	2010	2011	2012	2013	2014	2015
APPROXIMATED PLAN COST (N Billion)	10.7	10.7	10.7	10.7	10.7	10.7

5.1 Estimated cost of the strategic orientations

TOTAL COST	**NGN 64,238,862,790**
BY PRIORITY AREA:	
LEADERSHIP AND GOVERNANCE FOR HEALTH	NGN 642,388,628
HEALTH SERVICE DELIVERY	NGN 36,620,095,212
HUMAN RESOURCES FOR HEALTH	NGN 17,785,350,581
FINANCING FOR HEALTH	NGN 5,657,890,915
NATIONAL HEALTH INFORMATION SYSTEM	NGN 963,582,942
COMMUNITY PARTICIPATION AND OWNERSHIP	NGN 642,388,628
PARTNERSHIPS FOR HEALTH	NGN 642,388,628
RESEARCH FOR HEALTH	NGN 1,284,777,256

5.2 Assessment of the available and projected funds

The most critical element here would appear to be the preference of the political leadership. For example, in the 2010 budget, the provision for the health sector comes as **10e**-which is undefined and therefore remains in the realm of executive decision. However, it is anticipated that development partners will continue to give their valued assistance in order to bridge any fiscal deficit.

5.3 Determination of the financing gap

Whereas the costing of the interventions indicates clearly the financial outlay called for by the plan, given the uncertainty on the decision making outcome on actual budgetary provision by the executive, the issue of financing gap remains speculative. However, from the historical budgetary trends, what the health sector needs poses additional challenges to overall sectoral allocation. Hence there is need for public pressure to scale up allocation to the health sector during the plan.

5.4 Descriptions of ways of closing financing gap

From the foregoing, it is only logical to assume that the historical trend in budgetary allocation in the State to health points to the inevitability of a financing gap. Although it is impossible right now to give value to the gap, the absolute figure is really not the most important factor but the principle of addressing such gaps.

Three obvious ways of closing the financing gap suggest themselves:

a) Diversification of economic base: As alluded to above, the current fiscal status of the State, like most of its counterparts in the country, is determined largely bits share of revenue allocation which itself depends critically on a single source, oil. Clearly, the most sustainable approach to addressing the financing gap in this and any other sector is through the diversification of the State's economic base.
b) Cutting edge public financial management: Budgeting in Nigeria has become a routine of self-serving exercise rather a developmental tool through efficient resource allocation. A lot of wastage can be avoided with the application of appropriate and modern financial management tools, thus reducing the actual (ex-post) financing gap initially anticipated.
c) Realistic costing: The third approach is useful at the very beginning of the planning process with realism in costing as guide.

Chapter 6: Implementation Framework

The framework should comprise those that are involved in the process of health development plan 2010 – 2015. Happily, the framework is already in place concerning all the goals, strategic objectives interventions, proposed activities and actions, risk and assumption, time frame and budgeting.
The outstanding challenge, therefore, is implementation.

The first step is to ensure that actions and activities are allocated resources for implementation. Already, the plan contains a responsibility matrix showing who is to take leading role for the implementation of specific interventions. However, of all the actors involved in the implementation, the Planning, Research and Statistics Department has foremost responsibility for ensuring that all functions allocated are duly communicated to the respective agents. This will also serve as input into the monitoring process.

It is apposite to point to the fact that there can be no successful implementation without the collaborative efforts of other MDAs outside the health sector and indeed outside of the public sector. Hence, inter-ministerial consultation for synergy and effective participation by CSOs and other stakeholders is a vital element in the implementation of this plan.

Chapter 7: Monitoring and Evaluation

Monitoring is a systematic process of collection and analysis of data to track project implementation and use of information in the project management.

Evaluation also is a system of periodic assessment of effectiveness of the programme organization in the achievement of its stated goals. At the bottom of monitoring and evaluation is the critical role of information and in particular, the Health Information System (HIS) in place. In the present context, HIS is defined as a set of components and procedures organized with the objective of generating information which will improve health care management decisions in Osun State.

7.1 Proposed mechanism for monitoring and evaluation

As can be seen in the section on Strategic Priorities, the proposed mechanism for monitoring and evaluation are as follows:

- To ensure availability of NHMIS tools at all health services delivery point.
- There will be periodic review of NHMIS data collection forms.
- Co-ordinate data collection from all the health facility and other programme officers.
- There will be supportive supervision of data collection at all health facility provision for adequate logistics for officials to supervise data collection needs to be ensured.
- In order to have good data base, the coverage of data collection will be improved.
- There will be uniformity of NHMIS forms.
- Also use of information technology on HIS will be strengthened.
- A strengthened data transmission mechanism will be ensured.
- To ensure regular reporting of notifiable diseases by all health facilities in the State and especially at LGA level.
- There will be process of data analysis, compilation and dissemination of information to the LGA level.

7.2 Costing the monitoring and evaluation component of the plan

The costing of the M&E component of the plan is duly factored in as can be seen in the provision for M&E officers to be exposed to some form of training periodically. However, training is not all that is involved; there is also the provision for hard and soft ware to complement the human element.

Chapter 8: Conclusion

Considering the goals, strategic objectives and interventions along with the costing articulated in this plan, the State is evidently clear about the direction it wants to take its health sector. Critical to this is the political leadership's attitude. Before this plan, some form of free health care had been in place and this fits well into the overall desire of the MDGs. The sustenance of this policy line will facilitate the realization of the plan's objectives, even if at a huge cost.

Borrowing from past experience with planning in Nigeria-at national and sub-national levels, the greatest undoing of most plans is poor implementation. With sustained implementation, this plan is capable of transforming the landscape of the healthsector.

Annexure 1: Generalized LGA Costing*****

For a typical LGA, the following cost schedule applies over the 2010-15 Plan period

S/N	INTERVENTION	PARTICULAR	COST (N)
1.	Construction & renovations	Construction of 2 standard H/C renovation of 5 Health Centres	20,000,000
2.	Purchase of medical equipments		20,000,000
3.	Training	H/workers, Posters, Hand Bills	15,000,000
4.	Advocacy	Advocacy visit to Kabiyesi and other political leaders	3,000,000
5.	Sensitization	Health workers, market women, communities & political functionaries	2,500,000
6.	Publicity & Advertisement	Radio Jingle, TV, Commercial Banners	6,000,000
7.	Printing of NHMIS Forms	M & E Forms	3,000,000
8.	Purchase of Drugs		45,000,000
9.	Team Supervision	Hiring of vehicles, fuelling, transportation allowance	6,000,000
10.	Other Miscellaneous expenses		5,000,000
11.	Prevention of malaria transmission through vector control indoor Residual Spraying (IRS)	(a) Sprayers (b) Chemicals (c) Protective materials e.g gloves, mask etc (d) Personnel (e) Training (f) Wages (Salary) (g) Miscellaneous Sub-Total	500,000.00 1,000,000.00 500,000.00 2,000,000.00 1,000,000.00 3,000,000.00 500,000.00 **8,500,000.00**
12.	Prompt diagnosis and adequate treatment of clinical cases at all levels including private sector for effective management of all uncomplicated and severe cases	RTDs Procurement 1st Line Anti-malaria Drugs 2nd Line Anti-malaria IEC Materials Training & Retraining Vehicles to be used **Sub-Total**	 2,000,000.00 1,000,000.00 500,000.00 2,000,000.00 **5,500,000.00**
13.	Preventing of malaria in pregnancy with the use of sulfadioxide & pyrimethanine drugs (Sp) for IPT	Sulfadixide and Pyrimethanine Drugs Training of Personnel IEC **Sub Total**	 2,000,000.00 500,000.00 500,000.00 **3,000,000.00**
14.	LLITN's 2 LLITN's per Household	NETS Sub-Total	6,000,000.00 **6,000,000.00**
		Grand Total	**N138,500,000.00**

Note: At the local government level across the State, the strategic health plan is projected to require approximately N4.2 billion in financial outlay. The recourse to this generalized costing is as a result of failure to get reports from the other LGAs in the State, apart from Atakumosa East.

Annex 2: Details of Osun State Strategic Health Development Plan

OSUN STATE STRATEGIC HEALTH DEVELOPMENT PLAN						
PRIORITY						
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Estimated costs in NGN 2010-2015**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
LEADERSHIP AND GOVERNANCE FOR HEALTH							
1. To create and sustain an enabling environment for the delivery of quality health care and development in Osun State							642,388,628
	1.1	**To provide clear policy directions for health development**			**All stakeholders are informed regarding health development policy directives by 2011**		631,323,939
		1.1.1	Improved Strategic Planning at Federal and State levels				631,323,939
			1.1.1.1	Strengthening and re-focus the human resource for health base to engender enhanced commitment in Osun State	Positive feedback from patients	Willingness of staff	595,092,936
			1.1.1.2	Advocacy across the State in support of policy development and implementation	Inputs Soliticited from stakeholders annually	Political commitment	33,720,957
			1.1.1.3	Sustain Federal support for the development of evidence-based, costed and prioritised health plan	Signing of MOU	Cooperation between governments	-
			1.1.1.4	Ensure a wide base of contribution of stakeholders into the State's health plan	Stakeholders training and consultation	Policy consistency on the part Federal Government	2,510,045
	1.2	**To facilitate legislation and a regulatory framework for health development**			**Health Bill signed into law by end of 2009**		4,039,490
		1.2.1	Strengthen regulatory functions of government				4,039,490
			1.2.1.1	Foster collaboration with the private sector on professional development	Signed Agreement and Meeting by 2nd qtr of 2010	Private secotr suspicion	-
			1.2.1.2	Collaborate with the private operators on setting, monitoring and delivery of quality standards	Signed MOU by 2nd qtr of 2010	Level of response	-
			1.2.1.3	Jointly undertake the promotion of professional development	Meetings held on professional Development	Buy-in by private sector operators	2,458,820
			1.2.1.4	Generate health information for public use	Public announcements on new health issues	Willing cooperation by the Public	1,580,670
			1.2.1.5	Review of the Public Health Acts in the State to align with the National provisions	Reviewed Acts on Public Health	Cooperation of Legislators	-
	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**		4,829,825
		1.3.1	To improve accountability and transparency				4,829,825
			1.3.1.1	Promote stakeholders dialogue on health matters in the State	Meeting held on health issues within 2nd qtr of 2011	Positive public response	2,458,820

			1.3.1.2	Nurture and promote community awareness on public health responsibilities	Responses from the public	Buy-in by the public	1,580,670
			1.3.1.3	Encourage the emergence of independent health watch dogs	Reports from Independent Watch Dogs	Public understanding and cooperation	263,445
			1.3.1.4	Facilitate public access to health information in the State	Reports from the public	Public response	526,890
	1.4	**To enhance the performance of the national health system**			**1. 50% of States (and their LGAs) updating SHDP annually 2. 50% of States (and LGAs) with costed SHDP by end 2011**		2,195,375
		1.4.1	Improving and maintaining Sectoral Information base to enhance performance				2,195,375
			1.4.1.1	Ascrtain the priority areas outstanding analytical work in collaboration with donors, and private researchers	Outcome of meeting on priority areas every first qtr of the year	Response and cooperation among parties	2,195,375
			1.4.1.2	Forge necessary links between health priority areas and health information system	Published linkage outcomes	Application	-
HEALTH SERVICE DELIVERY							
2. To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare							36,620,095,212
	2.1	**To ensure universal access to an essential package of care**			**Essential Package of Care adopted by all States by 2011**		14,761,945,522
		2.1.1	To review, cost, disseminate and implement the minimum package of care in an integrated manner				14,358,802,793
			2.1.1.1	Detailed mapping of health facilities across the State	**Mapping result**	**Availability of perasonnel**	6,487,104
			2.1.1.2	Establish GIS in all PHC facilities in the State	**Establish GIS in at least 100 PHCs annually**	**Timely Funding**	7,000,472,243
			2.1.1.3	Agree on and Publish Criteria for siting of new health facilities at State level		**Cooperation of Legislators**	180,846
			2.1.1.4	Refurbish facilities not refurbished in the previous four years		**Funds availability**	7,350,495,855
			2.1.1.5	Streamline and publishing of referral guidelines fot health facilities			1,166,745
		2.1.2	To strengthen specific communicable and non communicable disease control programmes				386,458,270
			2.1.2.1	Indoor residual spraying of houses	**Number of houses sprayed**	**Acceptability**	272,117,223
			2.1.2.2	Procuerement and distribution of LLINS	**Coverage of distribution**		26,835,144
			2.1.2.3	Procurement and distribution of 1st and 2nd lines of anti-malaria drugs	**Coverage of distribution**	**Acceptability**	35,002,361
			2.1.2.4	Procurement and distribution of SP for IPT to women attending ANC	**Number of women covered**	**Acceptability**	35,002,361
			2.1.2.5	Procurement and distribution of RDTS to all Public health facilities for immediate and effective clinical diagnsis			17,501,181
		2.1.3	To make Standard Operating procedures (SOPs) and guidelines available for delivery of services at all levels				16,684,459
			2.1.3.1	Carry out a review of the existing Standard operating Procedures	**A reviewed copy**	**Funds availability**	-

			2.1.3.2	Do a costing of the minimum package of care	**Costed minimum package**	**Funds availability**	-
			2.1.3.3	Strengthening of specific communicable and non-communicable disease control programmes	**Recruitment and equipment beef up**		16,626,122
			2.1.3.4	Disseminate information on SOPs to all health facilities	**Produced health education materials**	**Funds availability**	58,337
	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**		21,820,585,156
		2.2.1	To improve geographical equity and access to health services				21,701,463,953
			2.2.1.1	Detailed mapping of health facilities across the State	**Mapping result**	**Personnel availability**	-
			2.2.1.2	Establish GIS in all PHC facilities in the State	**GIS established in 100 PHCs annually**		-
			2.2.1.3	Upgrading of sub-standard facilities	**Number of facilities refurbished**	**Funding**	16,101,086,159
			2.2.1.4	Renovation of health facilities	**At least 140 health facilities renovated annually**	**Funding**	5,600,377,794
		2.2.2	To ensure availability of drugs and equipment at all levels				117,808,614
			2.2.2.1	Carry out a review the essential drugs list	**A reviewed drug list available by second qtr of 2010**	**Logistics**	-
			2.2.2.2	Streamline and enforce essential drug purchase procedures	**Cases of infringement detected**	**Logistics**	-
			2.2.2.3	Streamline and enforce essential drug distirbution procedures	**Publish rules by first qtr of 2010**		-
			2.2.2.4	Review the list of equipment needs in all health facilities	**Reviewed List**		1,134,077
			2.2.2.5	Procurement and distribution of equipment on need basis	**New equipment distributed**	**Funds availability**	116,674,537
		2.2.3	To establish a system for the maintenance of equipment at all levels				1,195,914
			2.2.3.1	Adapt the National Health Equipment Policy at the State lefvel	Policy adoption		-
			2.2.3.2	Disseminate and implement the National Health Equipment Policy at the State level	Circulated Policy paper		58,337
			2.2.3.3	Sensitize health workers on health equipment maintenance	Sensitization workshops held	Logistics	845,890
			2.2.3.4	Encourage PPP on the maintenance of health equipment	Number of partners showing interest in equipment maintenance	Buy-in by private operators	291,686
		2.2.5	To foster collaboration with the private sector				116,675
			2.2.5.1	Mapping of all private health care providers	**SERVICOM for health**	Public appreciation	58,337
			2.2.5.2	Development of guidelines and standards for private practice	**Published guidelines**	Acceptance by private operators	58,337
			2.2.5.3	Development of guidelines for partnership, training and outsourcing	**Published guidelines**	**Compliance by private operators**	-
			2.2.5.4	Set up government/private sector joint monitoring mechanism	**Constitution of monitoring body**	**Cooperation of private operators**	-

			2.2.5.5	Adoption and implementation of national policy on tradomedicine	**Adoption Policy**	**Availability of the National Policy**	-
	2.3	**To improve the quality of health care services**			**50% of health facilities participate in a Quality Improvement programme by end of 2012**		14,817,666
		2.3.1	To strengthen professional regulatory bodies and institutions				1,166,745
			2.3.1.1	Review and updating of operational guidelines of all professional regulatory bodies in the state	A reviewed guideline	Cooperation of profewssional regulatory bodies	-
			2.3.1.2	Implementation of reviewed guidelines	Monitoring Reports	Cooperation of the professional groups	-
			2.3.1.3	Capacity building of staff of regulatory bodies	Number of staff trained	Commitment of staff	1,166,745
		2.3.2	To develop and institutionalise quality assurance models				816,722
			2.3.2.1	Customization of SERVICOM to health care services in Osun State	Produced SERVCOM for health	Appreciation by the public	58,337
			2.3.2.2	Cascading SERVICOM in health care sector to the Local Government level			58,337
			2.3.2.3	Sensitzing the public on health SERVICOM	Radion and TV broadcasts	Attitudinal Change	700,047
		2.3.3	To institutionalize Health Management and Integrated Supportive Supervision (ISS) mechanisms				12,834,199
			2.3.3.1	Upgrading management skilss of health workers in all PHCs	Number of health workers trained	Application of Knowledge	12,834,199
			2.3.3.2	Training Needs analysis of management capacity of programme Managers			-
			2.3.3.3	Development and application of performance measuring tools		Adaptation to change	-
	2.4	**To increase demand for health care services**			**Average demand rises to 2 visits per person per annum by end 2011**		22,746,868
		2.4.1	To create effective demand for services				22,746,868
			2.4.1.1	Training of health workers on maternal care	Number of health workers trained on maternal care	Application of Knowledge imparted	4,993,670
			2.4.1.2	Provision of family planning commodities	Number of women accessed	Acceptance by the women	17,501,181
			2.4.1.3	Create and raise family planning awareness	Attendance at the family planning clinic	Improper application	252,017
	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	Continue with the free immunization policy			-
			2.5.1.2	Strengthen the free prenatal care			-

			2.5.1.3	Continue with the free normal delivery and emergency caecerian			-
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							17,785,350,581
	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	Update policies on hg and recruitment of health personnel.	Availability of support by the State Government	Availability of support by the State Government	-
			3.1.1.2	Establishment of policy framework to guide both public and private practitioners at all levels of health care delivery	Production of policy framework	Acceptability	-
			3.1.1.3	Institution of non-discriminatory processes irrespective of place of origin or gender	Issuance of circular	Enforcement	-
			3.1.1.4	Development and implementation of guidelines on basic shifting	Issuance of circular	Enforcement	-
			3.1.1.5	Estblishment of joint public/private sector review platform on policy of institutionalizing HR practices	Jointly signed Policy Statement	Enforcement	-
	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**		45,827,795
		3.2.1	To reappraise the principles of health workforce requirements and recruitment at all levels				45,827,795
			3.2.1.1	Develop and structure career pathways for all health professionals in the State	Issuance of policy document on HRM	Compliance	-
			3.2.1.2	Develop and utilize staffing norms based on workload, availability and health priorities	Issuance of circular	Compliance	-
			3.2.1.3	Establsh coordinating mechanism for consistency in HRH planning and budgeting by all stakeholders	Number of meetings held	Attendance at meetings	4,166,163
			3.2.1.4	Strengthen capacity to implement FG circulars, guidelines and policies related to HRH	Number of guidelines implemented	Application	41,661,632
			3.2.1.5	Review entry criteria and admission guides for health care providers	Issuance of circular	Compliance	-
	3.3	**Strengthen the institutional framework for human resources management practices in the health sector**			**1. 50% of States have functional HRH Units by end 2010 2. 10% of LGAs have functional HRH Units by end 2010**		7,615,746,278
		3.3.1	To establish and strengthen the HRH Units				**7,615,746,278**
			3.3.1.1	Creation of HRH Unit in the Ministry of Health	Established unit	Inadequate staff	-
			3.3.1.2	Improving Capacity on health planning and mangement	New recruitment/infrastructure upgrade	Funding	7,615,746,278

	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**		6,790,845,970
		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				**3,457,915,433**
			3.4.1.1	Establishment of special training programmes for the production of adequate number of needed community-oriented professionals based on State priorities	Establihed training programme in each senatorial district by 2013	Funding	3,332,930,538
			3.4.1.2	Training of Community Health Workers and other supporting personnel	Not less than 20% of community health workers undergo training annually	Knowledge application	124,984,895
			3.4.1.3	Strenthening the production of qualified health professionals via appropriate accreditation and regulatory bodies	Number of acredited professional courses	Infrastucture	-
			3.4.1.4	Strengthening of P.P.P in HRH development and mangement	Number of private operators in HRH		-
			3.4.1.5	Promotion of National Midwives Servce Scheme and Community Midwifery Programme	20% annual increase in number of midwives	Interest in the Profession	-
		3.4.2	To strengthen health workforce training capacity and output based on service demand				**3,332,930,538**
			3.4.2.1	Periodic upgrading of teaching and learning materials	Improvements in teaching aids	Funding	833,232,634
			3.4.2.2	Provision of inftrstruture to health training institutions			2,499,697,903
			3.4.2.3	Provision of financial support as incentive to staff	15% upward review of allowances of health workers annually as from 2011	Funding	-
			3.4.2.4	Establishment of quality assurance and education review units in the training institutions	At least one unit established in every institution annually		-
			3.4.2.5	Programme curricula would be tailored towards disease burden in the State	Reviewed Curricular		-
	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**		3,332,930,538
		3.5.1	To achieve equitable distribution, right mix of the right quality and quantity of human resources for health				-
			3.5.1.1	Creation of database on HRH, job description and specification for all categories of health workers	Data base in place by first qtr of 2011		-
			3.5.1.2	Liasing with institutions in the State to leverage available human resource to expand service coverage and quality	Sign at least one MOU by 2nd qtr of 2011		-
			3.5.1.3	Develop retention strategy for health workers	15% annual increase in allowances fro health workers		-

			3.5.1.4	Posting of health workers to underserved areas	60% of new postings to go to the rural areas af from 2011		-
		3.5.2	To establish mechanisms to strengthen and monitor performance of health workers at all levels				3,332,930,538
			3.5.2.1	Provide training and re-training in interpersonal communication skills and work committees to improve quality of care	Approval of training attendance by 2nd qtr of every year	Funding	3,332,930,538
			3.5.2.2	Establishment of a system of recognition, reward and sanction	published reward critieria by end of 2010	Published reward criteria	-
			3.5.2.3	Establishment of individual support, supervision with adequate eresource commitment for all cadres	Issuance of ppolicy statement	Impementation	-
	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**		-
		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				-
			3.6.1.1	Establishment of dialogue and complaint channel between management and staff and HRH regulatory bodies	Exchange of correspondence	Responsiveness	-
			3.6.1.2	Involvement of professional groups in management teams	Released observations	Application	-
			3.6.1.3	Design of monitoring services to enhance cooperation among all actors	Published indicatos	Acceptance to actors	-
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							5,657,890,915
	4.1	**To develop and implement health financing strategies at Federal, State and Local levels consistent with the National Health Financing Policy**			**50% of States have a documented Health Financing Strategy by end 2012**		1,618,448
		4.1.1	i				1,618,448
			4.1.1.1	Setting up technical working group for health financing at the State level	Inauguration of Technical Working group	Adequate provision of logistic support	231,207
			4.1.1.2	Capacity Building for the development and implementation of strategic health financing plans	Seminars held before end of 2nd qtr 2010	Adequate provision of logistic support	220,197
			4.1.1.3	Provision of technical assistance to support the process at the local government level	Signe MOU	Adequate provision of logistic support	1,167,044
	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**		1,420,271
		4.2.1					1,420,271
			4.2.1.1	Exploring existing and innovative social health protection approaches-NHIS & CBHI	Report of findings	Adequate number of enrollees	-
			4.2.1.2	Rapid scaling up of successful approaches to achieving wider populaton coverage	Monitoring Reports	Adequate enrolment	-
			4.2.1.3	Strengthenin NHIS capacity in the State	Established office in every senatorial district	Manpower availability	1,420,271
			4.2.1.4	Provision of legal backing to health insutrance in the State	Passage of the law by the House of Assembly	Cooperation of the judiciary and the legislature	-

	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**		5,615,022,967
		4.3.1	To improve financing of the Health Sector				5,615,022,967
			4.3.1.1	Ensuring increased budgetary allocation to health in the State	At least 15% budget allocation to health as from 2011	Political will	-
			4.3.1.2	Ensuring effective and efficient utilization of resource allocated to health		Accountability Principle endorsement	-
			4.3.1.3	Attract alternative financial flows into the State's health sector	Formalisation of a new source of financial inflow	Donor/private Sector receptivity	-
			4.3.1.4	Improved usage of existing and potential alternative financing strategies	10% reduction in cost annually	Partner cooperation	-
			4.3.1.5	Establishment of special funds for chronic and emerging diseases	Fund establishment by First Quarter of 2011	Success in economic diversification strategy	5,615,022,967
		4.3.2	To improve coordination of donor funding mechanisms				-
			4.3.2.1	Establishment of mechanism for donor support coordination	Designated office by 2nd Quarter of 2010	Availbilty of qualified personnel	-
	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**		39,829,230
		4.4.1	To improve Health Budget execution, monitoring and reporting				920,423
			4.4.1.1	Capacity building on proper recording and accounting of expenditures	At least one training course per year	Availability of willing learners	237,813
			4.4.1.2	Regular production of detailed financial reports	Annual production of financial reports	Staff efficiency	330,295
			4.4.1.3	Establishment of credible mechanism for increased financial transparency	Issuance of financial guidelines by 2010	Compliance	352,315
		4.4.2	To strengthen financial management skills				38,908,806
			4.4.2.1	Capacity building on budgeting, planning, auditing, M&E	Train 20% of relevant staff every year	Application of knowledge acquired	36,894,004
			4.4.2.2	Conduct of training needs assessment in financial mamnagement	Staff audit every two years	Devotion of trainees	165,148

			4.4.2.3	Intensification and broadening of on-the job-training on financial management systems	Annual training sessions throughout the plan period	Performance measurement	1,849,655
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							963,582,942
	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**		958,869,671
		5.1.1	To ensure that NHMIS forms are available at all health service delivery points at all levels				113,300
			5.1.1.1	Ensure adequate provision of data collection forms	Printed forms	**Provision of adequate logistics support**	45,320
			5.1.1.2	Ensure distribution of NHMIS forms to all health facilities in the State and at LG levels		**Provision of adequate logistics support**	67,980
			5.1.1.3	Ensure provision of adequate funds for the printing of forms periodically	Raised vouchers for form printing	**Provision of adequate logistics support**	-
		5.1.2	To periodically review of NHMIS data collection forms				-
			5.1.2.1	Regular feedback from the field on the appropriateness and user-friendliness of data collection tools	**Reports receipt**	**Provision of necessary logistics support**	-
			5.1.2.2	Establish mechanism for annual review	By 2nd quarter 2010 an officer designated to oversee the process	Provision of necessary logistics support	-
		5.1.3	To coordinate data collection from vertical programmes				11,330
			5.1.3.1	Revitalise Health Data consultative Committee at the State level	**Conveyance of Committee Meeting early 2010**	**Activeness of committee members**	11,330
			5.1.3.2	Collaborate with development partners and other government agencies on strengthening data collection systems	**Exchange of correspondence**	**Positive response from partners**	-
		5.1.4	To build capacity of health workers for data management				958,742,775
			5.1.4.1	Conducting comprehensive training and re-training on data collection tools, analyses and data utilization for health programming	At least 4 major local trainings and 3 foreign tranings annually	Funding	951,718,188
			5.1.4.2	Establisment of adequate monitoring systems at the State and LGA levels to ensure data quality	M&E Reports		906,398
			5.1.4.3	Recruitment of needed health system support personnel	New Staff placements	Budgetary provision	6,118,188
		5.1.5	To provide a legal framework for activities of the NHMIS programme				**2,266**
			5.1.5.1	Put in place the legal framework for activities of the HMIS at State and local government levels	Passage of the law by the House of Assembly	**Political will**	-

			5.1.5.2	Systematic advocacy targeted at policy makers on data appreciation	Advocacy visits to the House of Assembly	**Reception**	2,266
			5.1.5.3	Creation of enabling environment to enhance health data status	Executive announcement	**Political will**	-
		5.1.6	To improve coverage of data collection				-
			5.1.6.1	Develop innovative strategies for data collecton	A new strategy		-
			5.1.6.2	Improve collection of community-based data	A new style of data-collection	Acceptance of innovation	-
		5.1.7	To ensure supportive supervision of data collection at all levels				-
			5.1.7.1	Supervision of data collection at the LGA level	Improved data feedback from the LGAs	Logistic support	-
	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**		**2,948,060**
		5.2.1	To strengthen the use of information technology in HIS				627,681
			5.2.1.1	Promote application of IT	ICT apprceciation workshop held	Application of aquired knowledge	462,263
			5.2.1.2	Establishment of data warehouse under a public-priavte managenment arrangement	Constitution of a Managememt Committee	Cooperation of relevant parties	165,418
		5.2.2	To provide HMIS Minimum Package at the different levels (FMOH, SMOH, LGA) of data management				2,320,380
			5.2.2.1	Defining HIS minimum package at State and LG levels	Circular on minimum package	Consensus across tiers og government	-
			5.2.2.2	Provision of HIS Mininmum Package for data management at State and LG levels	Acquisition of the packages by end 2010	Cost-effetiveness	2,320,380
			5.2.2.3	Build capacity of relevant staff on data base	Train at least 5 data personnel annually	Funding	-
	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**		97,438
		5.3.1					90,640
			5.3.1.1	Establish patient information and the system for mapping disease	Patient Data Base Format in place by 1st Qtr 2010	Maintenance	-
			5.3.1.2	Strengthen the pateint information system and the system for mapping disease	Installation of improved hard and soft wares annually from 2011	Funding	90,640
		5.3.2	To strengthen the Disease Surveillance System				6,798
			5.3.2.1	Institution of mechanism for regular reporting/notification of diseases	Issuance of circular by early 2010	Logistics/funding	6,798
	5.4	**To monitor and evaluate the NHMIS**			**NHMIS evaluated annually**		**770,439**
		5.4.1	To establish monitoring protocol for NHMIS programme implementation at all levels in line with stated activities and expected outputs				226,600

			5.4.1.1	Provision of monitoring logistics (mainly vehilces)	Dedicate 2 vehicles for monitoring work	Logistics/Funding	226,600
		5.4.2	To strengthen data transmission				**543,839**
			5.4.2.1	Adherence to existing guidelines on data transmission	Publicise the guidelines	Adherence	9,064
			5.4.2.2	Building of institutional and human capacity for timely data transmission	Undertake system review by 1st qtr of 2011	Adherence	534,775
	5.5	**To strengthen analysis of data and dissemination of health information**			**1. 50% of States have Units capable of analysing health information by end 2010 2. All States disseminate available results regularly**		897,334
		5.5.1	To institutionalize data analysis and dissemination at all levels				897,334
			5.5.1.1	Build institutional and human capacity for data analysis and dissemination	Train at least 2 data analysts annually	Funding	571,031
			5.5.1.2	Formalise and strengthen the mechanism for data dissemination for decision making	M&E Reports	Compliance	-
			5.5.1.3	Production of periodic healklth bulletin and annual reports		Funding	326,303
COMMUNITY PARTICIPATION AND OWNERSHIP							
6. To attain effective community participation in health development and management, as well as community ownership of sustainable health outcomes							642,388,628
	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**		9,641,557
		6.1.1	To provide an enabling policy framework for community participation				2,195,430
			6.1.1.1	Adopt existing guidelines for engaging communities' participation in health development in Osun State	Formal adoption of the guidelines by first qtr of 2010	Existing Guidelines may not applicable to State	-
			6.1.1.2	Develop state policy for community participation in health	Publication of the policy	Community cooperation	651,391
			6.1.1.3	Adopt revised community particpation section of the National Health Policy to foster effective community participation in health actions in the State			-
			6.1.1.4	Adopt finalized Community Development Policy (CDP) to foster community participation in health actions at the State level	Public validation before end-2010	Effective public participation	1,544,039
		6.1.2					7,446,127
			6.1.2.1	Update and adapt the existing guidelines for establishing community development practice in Osun State	Published guidelines		868,522
			6.1.2.2	Develop and utilise participatory tools and approaches to enhance community involvement in planning, management and monitring and evaluation of health interventions in Osun State	Finalise tools by first quarter of 2010	Validate the tools	1,019,066
			6.1.2.3	Establish intersectoral stakeholder committees involving community representatives at all levels so as to enhance collaboration in Osun State	Committee Meets quarterly	Active participation	5,558,539

	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**		14,205,156
		6.2.1	To build capacity within communities to 'own' their health services				14,205,156
			6.2.1.1	Development, upgrading or modification of existing partipatory tools for mobilizing communities in planning and management	Annually revised tools	Availability of Competent hands	-
			6.2.1.2	Identification and mapping out of key community stakholders and resources with community assessment of community needs	A list of key stakeholders with contacts	Community cooperation	5,867,347
			6.2.1.3	Re-orientation of Community Development Committees (CDCs) and Community Health Care Providers on their roles and resposiblities & mobillization and allocation of resources for funding for community level actitvities			8,337,809
			6.2.1.4	Establish community dialogue between communities and government structures for maximum impact and the use of information, education and communication (IEC) actitvities and the media to enlighten and empower communities for positive action	At least 2 meetings per quarter	Attendance	-
			6.2.1.5	Involve communities at all levels in programme planning, implementation and monitoring of health activities	At least 1 meeting per quarter starting 2010	Commitment	-
	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**		563,728,540
		6.3.1	To restructure and strengthen the interface between the community and the health services delivery points				563,728,540
			6.3.1.1	Review and assessment of the level of linkages of the existing health delivery structures within the community	Report of linkages published by 2012	Buy-in	-
			6.3.1.2	Provide technical guidance and support to community stakeholders for the development of guidelines for strengthening the community health servives linkage	Hold community education	Buy-in	4,786,520
			6.3.1.3	Restructuring of health delivery structures to ensure adequate health promotion of community participation in health developemnt	Report on extant structures by	Report on existing structures by 2011	-
			6.3.1.4	Promotion of facilitation of exchange of experiences between community development committees	Host inter-community assembly	Attendace and openess at discussions	558,942,020
	6.4	**To increase national capacity for integrated multisectoral health promotion**			**50% of States have active intersectoral committees with other Ministries and private sector by end 2011**		54,041,356
		6.4.1	To develop and implement multisectoral policies and actions that facilitate community involvement in health development				54,041,356
			6.4.1.1	Advocacy to community gatekeepers to increase their awareness on community particiaption and health promotion	Formal interactions with gatekeepers by first quarter 2012	Attendance and active participation	54,041,356

			6.4.1.2	Development and implementation of community health development programmes			-
			6.4.1.3	Formulation of action plans to facilitate the development of health promotion capacities at community levels			-
			6.4.1.4	Supporting various levels to link health with other sectors using the health promotion guidelines			-
	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**		772,019
		6.5.1	To develop and implement systematic measurement of community involvement				772,019
			6.5.1.1	Establish simple mechanisms to support communities to measure impact of community involvement efforts of locally adapted models	Publication of the model	Buy-in	-
			6.5.1.2	Documentation of lessons learnt and best practices from specific community level approaches, methods and initiatives of locally adapted models	Report of the evaluation of the model	Manpower	-
			6.5.1.3	Dissemination of findings from community involvement efforts of locally adapted models to enhance knowledge sharing among stakeholders	Distribution of reports at LGA level	Buy-in	772,019
PARTNERSHIPS FOR HEALTH							
7. To enhance harmonized implementation of essential health services in line with national health policy goals							642,388,628
	7.1	**To ensure that collaborative mechanisms are put in place for involving all partners in the development and sustenance of the health sector**			**1. FMOH has an active ICC with Donor Partners that meets at least quarterly by end 2010 2. FMOH has an active PPP forum that meets quarterly by end 2010 3. All States have similar active committees by end 2011**		642,388,628
		7.1.1	To promote Public Private Partnerships (PPP)				818,316
			7.1.1.1	Setting up of PPP units at the Stae level to promote, oversee and monitor PPP initiatives	Inauguration of PPP Units by second quarter of 2010	Effectiveness of participation	818,316
			7.1.1.2	Concession, leasing contracting and provision of technical support to the private sector	Sign MOU with Leasors before end-2011	Adaptation by the private sector	-
			7.1.1.3	Encourage private sector to set up facilities in the rural areas especially the underserved	Minutes reflecting agreement with private operators	Walking the talk	-
		7.1.2	To institutionalize a framework for coordination of Development Partners				1,472,968
			7.1.2.1	Establishment of a framework to harmonize and align the efforts of development partners	Formal policy statement	Agreement among MDAs	-
			7.1.2.2	Establish a Development Partner forum as an entry point for engaging partners	Meeting of the Forum before the end of 2010	Assignment of roles	1,472,968

			7.1.2.3	Establisment of mechanism for resource coordination	A shared framework available to development partners	Agreement on template	-
		7.1.3	To facilitate inter-sectoral collaboration				2,618,610
			7.1.3.1	Creation of an inter-sectoral forum to enhance health care delivery	Meeting of the Forum before the end of 2010	Achieving consensus on budget	2,618,610
		7.1.4	To engage professional groups				548,489,645
			7.1.4.1	Engaging professional groups in planning, implementation and M&E of plans and programmes	Formal meeting with professional groups during 2011	Effectiveness of participation	2,945,936
			7.1.4.2	Promote effective communication with professional groups	At least two coreespondences per year from 2012	Active response and engagement	-
			7.1.4.3	Promote continuing education among professional groups	Hold meeting on professional training before end of 2012	Agreement on priority	-
			7.1.4.4	Devote 3% of health budget to private research	Make the 13% provision in the 2011 budget	Political commitment	545,543,709
		7.1.5	To engage with communities				34,434,719
			7.1.5.1	Provision of information that are gender sensitive to communities	Public announcement on gender related health issue	Level of public response	-
			7.1.5.2	Provision of information that is easilyn accessible to communities	Issuance of user friendly information though CDCs	Level of public response	-
			7.1.5.3	Proper monitoring of health care facilities especially with regard to service provision	M&E Reoprt by 3rd quarter of 2010	Quality of report	19,966,900
			7.1.5.4	Involvement of CSOs in the monitoring of health care facilities	Joint M&E report by end 2010	Forging consensus	4,909,893
			7.1.5.5	Build capacity of communities to manage priority health conditions through BCC and social marketing	Sensitization Workshop on BCC within 2010	Time sacrifice	9,557,926
		7.1.6	To engage with traditional health practitioners				54,554,371
			7.1.6.1	Organize traditional health practioners with the intention to regulate them	Meeting with traditional health practitioners representatives before end 2011	Willing cooperation by practitioners	-
			7.1.6.2	Adopt proven practices with a view to integrating them	Agreed pracice to be adopted	Making a choice	-
			7.1.6.3	Train THP to improve their skills, know their limitations and ensure use of referral system	First batch of trainees handled by 2012	Cooperation of partiy concerned	54,554,371
			7.1.6.4	Discourage THPs from adverising in the media	Signed MOU with Advertising Board by 2011	Cooperation of concerned regulator	-
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							1,284,777,256
	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**		165,778,140

					health research priorities 2. FMOH publishes an Essential Health Research agenda annually from 2010		
		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				-
			8.1.1.1	Develop health research strategy at the State level	Internal working paper developed	Availability of fund and logistics	-
			8.1.1.2	Develop a State health research policy	Publication of Policy paper by 2011	Inputs from stakeholders	-
			8.1.1.3	Setting up Technical Working Groups to facilitate research strategy and policy formulation and implementation	Inauguration of Technical Working Group by 4th qtr 2010	Choice of members	-
			8.1.1.4	Establishment of health research steering committee to shepherd research actitvities	Constitution of Steering Committee	Active participation	-
			8.1.1.5	Creatring active research units in the State to undertake operations research and other related activities	Composed research units by 3rd qtr 2010	Personnel	-
		8.1.2	To establish and or strengthen mechanisms for health research at all levels				143,734,425
			8.1.2.1	Strengthening research departments to coordinate and encourage research efforts	Installation support systems for research	Funds	143,734,425
			8.1.2.2	Linking of research and creating communities of practices	Issuance of protocol	Implementation and monitoring	-
			8.1.2.3	Adoption of ENHR guidelines when put on stream	Published paper		-
			8.1.2.4	Develop functional instituional structures	Circcular on new structures	Follow up	-
			8.1.2.5	Expanding HR agenda to include broad and multidimensional determionants of health	Issuance of HRH Policy paper	Implementation and monitoring	-
		8.1.3	To institutionalize processes for setting health research agenda and priorities				-
			8.1.3.1	Ensure cross linages with areas beyond traditional boundaries	Policy adoption	Implementation and monitoring	-
			8.1.3.2	Development of broad guidelines for collaborative research agenda	Issuance of policy paper on collaborative research by 2nd qtr 2010	Implementation	-
		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				2,435,500
			8.1.4.1	Developing a strong link between policy makers and producers of research-e.g Universities	Signed MOUs with at least two institutions by 2011	Response and implementation	-
			8.1.4.2	Formation of a forum of health research officers at State and LGA levels	Convene the forum by mid-2010	Emrgence of new ideas	794,088
			8.1.4.3	Annual convening of a multi-stakeholders forum to map out research priorities	Letters/Notices of invitation	Stakeholders meeting held first quarter 2011	1,641,412
			8.1.4.4	Total support for collaborative research proposals	Public declaration	Sustanenace of initiative	-
			8.1.4.5	Development of implementation strategy on research results	Published/gazetted strategy	Implementation	-
		8.1.5	To mobilise adequate financial resources to support health research at all levels				-

			8.1.5.1	Provision of adequate financial resources for HR	Improved budgetary provisions	Political Commitment	-
			8.1.5.2	Deployment of allocated funds in a targeted manner	Regualr M&E	Implementation	-
			8.1.5.3	Expanding of beneficiaries of funding to researches from both public and non-public HR institutions	Annual incfrease of number of beneficiaries by 10% from 2011	Funds	-
			8.1.5.4	Development of linkage with natural research punching	M&E Reports	Follow up	-
		8.1.6	To establish ethical standards and practise codes for health research at all levels				19,608,215
			8.1.6.1	Development of ethical research mechanisms, guidelines and review committees	Circulars on progress issued quarterly	Follow up	-
			8.1.6.2	Estabishment of similar bodies in research institutions	Signed agreement by end-2010	Implementation	-
			8.1.6.3	Establishment of an M&E System to regulate the use of research findings	Office alloted and staffed by 3rd quarter 2010	Funding	19,608,215
	8.2	**To build institutional capacities to promote, undertake and utilise research for evidence-based policy making in health at all levels**			**FMOH has an active forum with all medical schools and research agencies by end 2010**		834,901,814
		8.2.1	To strengthen identified health research institutions at all levels				887,250
			8.2.1.1	Map all identified research institutions in the State	Publised list of such institutions by first qtr 2010	None	-
			8.2.1.2	Conduct capacity assessment of these institutions	Visit to at least two insttituions by 2nd qtr 2010	Funds and Logistics	887,250
			8.2.1.3	Joint tracking of identified research capacity gaps and weaknesses	Track Reports out by 2011	Funds and Logistics	-
			8.2.1.4	Develop research mobilzation strategies targeting private sector, foundations and individuals for health	Policy document on Mobilization Strategy	Implementation	-
		8.2.2	To create a critical mass of health researchers at all levels				319,409,833
			8.2.2.1	Creation of a critical mass of researchers jointly with training institutions	10% annual increase in number of new researchers	Interest in health research	-
			8.2.2.2	Develop appropriate training interventions for research based on needs	New training interventions introduced	Logistics Support	-
			8.2.2.3	Provision of competitive grants by the government	Approved awards by 2nd qtr 2010	Funds	266,174,861
			8.2.2.4	Promotion of increased PhD training in tertiary institutions through incentives such as award of sholarships	Approved Scholarships to at least 2 PhD students annually	Funds	53,234,972
		8.2.3	To develop transparent approaches for using research findings to aid evidence-based policy making at all levels				-
			8.2.3.1	Develop a mechanism for translating research findings into policies	Issuance of circular	Implementation	-
			8.2.3.2	Develop close liason between users of research output and researchers	Reported feedback	Follow up	-
			8.2.3.3	Enlarge the range of actors including research producers involved in policy making consultations	Town Hall Meeting of Stakeholders held by end of first qtr 2011	Stakeholders response	-

		8.2.4	To undertake research on identified critical priority areas				514,604,731
			8.2.4.1	Systematic research in topical areas such including disease burden	M&E Reports	Follow up	-
			8.2.4.2	Undertake biannual studies of human resources for health	Report on human resource needs by 2nd qtr 2010	Follow up	266,174,861
			8.2.4.3	Undertake studies on health system governance	Published Report by 2011	Implementation	26,617,486
			8.2.4.4	Undertake studies on health delivery systems	Published Findings by early 2011	Follow up	177,449,907
			8.2.4.5	Undertake studies on financial risk protection, equity, efficiency and value of different health financing mechanisms	Published findings by early 2011	Implementation and Funding	44,362,477
	8.3	**To develop a comprehensive repository for health research at all levels (including both public and non-public sectors)**			**1. All States have a Health Research Unit by end 2010 2. FMOH and State Health Research Units manage an accessible repository by end 2012**		17,744,991
		8.3.1	To develop strategies for getting research findings into strategies and practices				-
			8.3.1.1	Utilize research output in the short to medium term to improve strategies and practices in the health sector	Progress Report	Follow up	-
			8.3.1.2	Establishment of bi-annual health policy research forum	Maiden Forum Meeting during 2010	Follow up Action	-
		8.3.2	To enshrine mechanisms to ensure that funded researches produce new knowledge required to improve the health system				17,744,991
			8.3.2.1	Conduct need assessment to identify research gaps	Needs Assessment Report by end 2012	Follow up Action	17,744,991
			8.3.2.2	Undertake operation research by government	White paper	Implementation	-
			8.3.2.3	Involvement of public and private research organizations	Convened joint meeting	Consensus among parties	-
	8.4	**To develop, implement and institutionalize health research communication strategies at all levels**			**A national health research communication strategy is in place by end 2012**		266,352,311
		8.4.1	To create a framework for sharing research knowledge and its applications				213,117,339
			8.4.1.1	Wide dissemination of research outputs	Distribution of research findings at LGA level	Follow up	177,450
			8.4.1.2	Development of framework for sharing research outputs	Circulated framework	Implementation	-
			8.4.1.3	Convening of annual health conferences, workshops and seminars	At least one of each event every year	Logistics support	212,939,889
			8.4.1.4	International collaboration on research agenda	Joint Communique	Funding	-
			8.4.1.5	Receipt of research updates from other countries	Copies in the State Library	Application	-
		8.4.2	To establish channels for sharing of research findings between researchers, policy makers and development practitioners				53,234,972
			8.4.2.1	Conduct of inventory of journals	Published list of journals	Consultation	-

			8.4.2.2	Publishing of reputable journals for dissemination of research results	Published list of featured articles	Consultation	35,489,981
			8.4.2.3	Production of policy briefs by researhers for policy makers	Circulated Briefs	Application	17,744,991
TOTAL							64,238,862,790

Annex 3: Results/M&E Matrix for Osun Strategic Health Development Plan

OSUN STATE STRATEGIC HEALTH DEVELOPMENT PLAN RESULT MATRIX						
OVERARCHING GOAL: To significantly improve the health status of Nigerians through the development of a strengthened and sustainable health care delivery system						
OUTPUTS	**INDICATORS**	**SOURCES OF DATA**	**Baseline**	**Milestone**	**Mileston e**	**Target**
			2008/9	**2011**	**2013**	**2015**
PRIORITY AREA 1: LEADERSHIP AND GOVERNANCE FOR HEALTH						
NSHDP Goal: To create and sustain an enabling environment for the delivery of quality health care and development in Nigeria						
OUTCOME: 1. Improved strategic health plans implemented at Federal and State levels						
OUTCOME 2. Transparent and accountable health systems management						
1. Improved Policy Direction for Health Development	1. % of LGAs with Operational Plans consistent with the state strategic health development plan (SSHDP) and priorities	LGA s Operational Plans	0	50	75	100%
	2. % stakeholders constituencies playing their assigned roles in the SSHDP (disaggregated by stakeholder constituencies)	SSHDP Annual Review Report	TBD	25	50	75%
2. Improved Legislative and Regulatory Frameworks for Health Development	3. State adopting the National Health Bill? (Yes/No)	SMOH	0	0	50	80
	4. % of LGAs enforcing traditional medical practice by-laws	LGA Annual Report	100	100%	100%	100%
3. Strengthened accountability, transparency and responsiveness of the State health system	5. % of LGAs which have established a Health Watch Group	LGA Annual Report	2	5	10	20
	6. % of recommendations from health watch groups being implemented	Health Watch Groups' Reports	2	5	10	20
	7. % LGAs aligning their health programmes to the SSHDP	LGA Annual Report	0	50	75	100
	8. % DPs aligning their health programmes to the SSHDP at the LGA level	LGA Annual Report	0	25	50	75
	9. % of LGAs with functional peer review mechanisms	SSHDP and LGA Annual Review Report	10	25	50	75%
	10. % LGAs implementing their peer review recommendations	LGA / SSHDP Annual Review Report	10	25	50	75%
	11. Number of LGA Health Watch Reports published	Health Watch Report	0	25	50	75
	12. Number of "Annual Health of the LGA" Reports published and disseminated annually	Health of the State Report	0	20	65	80%

4. Enhanced performance of the State health system	13. % LGA public health facilities using the essential drug list	Facility Survey Report	50	80	100	100%
	14. % private health facilities using the essential drug list by LGA	Private facility survey	25	40	65	80%
	15. % of LGA public sector institutions implementing the drug procurement policy	Facility Survey Report	50	100	100	100%
	16. % of private sector institutions implementing the drug procurement policy within each LGA	Facility Survey Report	2	10	15	25%
	17. % LGA health facilities not experiencing essential drug/commodity stockouts in the last three months	Facility Survey Report	20	40	60	80%
	18. % of LGAs implementing a performance based budgeting system	Facility Survey Report	45	55	65	80%
	19. Number of MOUs signed between private sector facilities and LGAs in a Public-Private-Partnership by LGA	LGA Annual Review Report	5	10	15	20
	20. Number of facilities performing deliveries accredited as Basic EmOC facility (7 functions 24/7) and Comprehensive EmOC facility (9 functions 24/7)	States/ LGA Report and Facility Survey Report	50	100	150	200
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	10	25	40	70%
	22. % health facilities implementing the complete package of essential health care	NPHCDA Survey Report	0	25	50	65%
	23. % of the population having access to an essential care package	MICS/NDHS	25	40	50	50%
	24. Contraceptive prevalence rate (traditional and modern)	NDHS	21.90%	25%	30%	35%
	25. % increase of new users of modern contraceptive methods (male/female)	NDHS/HMIS	TBD	10%	20%	30%
	26. % of new users of modern contraceptive methods by type (male/female)	NDHS/HMIS	TBD	10%	20%	30%

	27. % service delivery points without stock out of family planning commodities in the last three months	Health facility Survey	50	75	90	100%
	28. % of facilities providing Youth Friendly RH services	Health facility Survey	5	10	15	25
	29. % of women 15-19 who have begun child bearing	NDHS/MICS	5%	4%	3%	2%
	30. % of pregnant women with 4 ANC visits performed according to standards*	NDHS	93.60%	95%	97%	99%
	31. Proportion of births attended by skilled health personnel	HMIS	89.20%	92%	95%	97&
	32. Proportion of women with complications treated in an EmOC facility (Basic and/or comprehensive)	EmOC Sentinel Survey and Health Facility Survey	50	60%	75%	100%
	33. Caesarean section rate	EmOC Sentinel Survey and Health Facility Survey	5%	7.50%	10%	15%
	34. Case fatality rate among women with obstretic complications in EmOC facilities	HMIS	TBD	20%	15%	10%
	35. Perinatal mortality rate**	HMIS	10/1000LBs	10/1000LBs	5/1000LBs	2.5/1000 LBs
	36. % women receiving immediate post partum family planning method before discharge	HMIS	50	65	75	100
	37. % of women who received postnatal care based on standards within 48h after delivery	MICS	10 - 50%	20 - 75	25 - 100%	50 - 75%
	38. Number of women presented to the facility with or for an obstetric fistula	NDHS/HMIS	0.1	0	0	0
	39. Number of interventions performed to repair an obstetric fistula	HMIS	1	0	0	0
	40. Proportion of women screened for cervical cancer	HMIS	50	75	100	100
	41. % of newborn with infection receiving treatment	MICS	TBD	15%	25%	30%
	42. % of children exclusively breastfed 0-6 months	NDHS/MICS	TBD	5%	10%	20%
	43. Proportion of 12-23 months-old children fully immunized	NDHS/MICS	80.00%	90	100	100
	44. % children <5 years stunted (height for age <2 SD)	NDHSMICS	31.20%	30%	25	20%
	45. % of under-five that slept under LLINs the previous night	NDHS/MICS	TBD	20%	30%	40%
	46. % of under-five children receiving appropriate malaria treatment within 24 hours	NDHS/MICS	49.90%	52%	60%	75%

	47. % malaria successfully treated using the approved protocol and ACT;	MICS	65	75	85	100
	48. Proportion of population in malaria-risk areas using effective malaria prevention and treatment measures	MICS	65	75	85	100
	49. % of women who received intermittent preventive treatment for malaria during pregnancy	NDHS/MICS	75	80	85	100
	50. HIV prevalence rate among adults 15 years and above	NDHS	1.2	1	0.5	0
	51. HIV prevalence in pregnant women	NARHS	1.2	1	0.5	0
	52. Proportion of population with advanced HIV infection with access to antiretroviral drugs	NMIS	25	50	75	100
	53.Condom use at last high risk sex	NDHS/MICS	3.1	5%	10%	15%
	54. Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS	NDHS/MICS	42.70%	50%	60%	75%
	55. Prevalence of tuberculosis	NARHS	1.80%	1.50%	1%	0.50%
	56.Death rates associated with tuberculosis	NMIS	3.8	3	2.5	1
	57. Proportion of tuberculosis cases detected and cured under directly observed treatment short course	NMIS	60	75	88	100
Output 6. Improved quality of Health care services	58. % of staff with skills to deliver quality health care appropriate for their categories	Facility Survey Report	TBD	20%	30%	40%
	59. % of facilities with capacity to deliver quality health care	Facility Survey Report	TBD	30%	40%	45%
	60. % of health workers who received personal supervision in the last 6 months by type of facility	Facility Survey Report	TBD	20%	30%	40%
	61. % of health workers who received in-service training in the past 12 months by category of worker	HR survey Report	TBD	10%	20%	30%
	62. % of health facilities with all essential drugs available at all times	Facility Survey Report	TBD	10%	20%	30%
	63. % of health institutions with basic medical equipment and functional logistic system appropriate to their levels	Facility Survey Report	TBD	10%	20%	30%
	64. % of facilities with deliveries organizing maternal and/or neonatal death reviews according to WHO guidelines on regular basis	Facility Survey Report	TBD	10%	20%	30%

Output 7. Increased demand for health services	65. Proportion of the population utilizing essential services package	MICS	TBD	10%	25%	35%
	66. % of the population adequately informed of the 5 most beneficial health practices	MICS	TBD	25%	40%	50%
PRIORITY AREA 3: HUMAN RESOURCES FOR HEALTH **NSHDP GOAL: To plan and implement strategies to address the human resources for health needs in order to ensure its availability as well as ensure equity and quality of health care**						
NSHDP GOAL: To plan and implement strategies to address the human resources for health needs in order to ensure its availability as well as ensure equity and quality of health care						
Outcome 6. The Federal government implements comprehensive HRH policies and plans for health development						
Outcome 7.All States and LGAs are actively using adaptations of the National HRH policy and plan for health development by end of 2015						
Output 8. Improved policies and Plans and strategies for HRH	66. % of wards that have appropriate HRH complement as per service delivery norm (urban/rural).	Facility Survey Report	10%	25%	30%	40%
	67. Retention rate of HRH	HR survey Report	40	50	75	75
	68. % LGAs actively using adaptations of National/State HRH policy and plans	HR survey Report	10%	25%	30	40%
	69. Increased number of trained staff based on approved staffing norms by qualification	HR survey Report	TBD	10%	15%	25%
	70. % of LGAs implementing performance-based managment systems	HR survey Report	TBD	10%	20%	30%
	71. % of staff satisfied with the performance based management system	HR survey Report	TBD	25%	40%	50%
Output 8: Improved framework for objective analysis, implementation and monitoring of HRH performance	72. % LGAs making availabile consistent flow of HRH information	NHMIS	TBD	20%	30%	40%
	73. CHEW/10,000 population density	MICS	1: 4000 pop	1:3500 pop	1:1000 pop	1:1000 pop
	74. Nurse density/10,000 population	MICS	1: 4000 pop	1: 3500 pop	1:3500 pop	1:4000 pop
	75. Qualified registered midwives density per 10,000 population and per geographic area	NHIS/Facility survey report/EmOC Needs Assessment	1: 4000 pop	1:3500 pop	1:3000 pop	1:2500 pop
	76. Medical doctor density per 10,000 population	MICS	1: 6000 pop	1:5500 pop	1:5000 pop	1:5000 pop

	77. Other health service providers density/10,000 population	MICS	1: 3000 pop	1:2500 pop	1:2000 pop	1:2000 pop
	78. HRH database mechanism in place at LGA level	HRH Database	TBD	10%	20%	30%
Output 10: Strengthened capacity of training institutions to scale up the production of a critical mass of quality mid-level health workers						
PRIORITY AREA 4: FINANCING FOR HEALTH **NSHDP GOAL 4 : To ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and consumption at Local, State and Federal Levels**						
NSHDP GOAL 4 : To ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and consumption at Local, State and Federal Levels						
Outcome 8. Health financing strategies implemented at Federal, State and Local levels consistent with the National Health Financing Policy						
Outcome 9. The Nigerian people, particularly the most vulnerable socio-economic population groups, are protected from financial catastrophe and impoverishment as a result of using health services						
Output 11: Improved protection from financial catastrophy and impoversihment as a result of using health services in the State	79. % of LGAs implementing state specific safety nets	SSHDP review report	TBD	10%	25%	40%
	80. Decreased proportion of informal payments within the public health care system within each LGA	MICS	TBD	70%	60%	50%
	81. % of LGAs which allocate costed fund to fully implement essential care package at N5,000/capita (US$34)	State and LGA Budgets	TBD	10%	20%	30%
	82. LGAs allocating health funding increased by average of 5% every year	State and LGA Budgets	TBD	10%	25	40%
Output 12: Improved efficiency and equity in the allocation and use of Health resources at State and LGA levels	83. LGAs health budgets fully alligned to support state health goals and policies	State and LGA Budgets	TBD	20%	35%	50%
	84.Out-of pocket expenditure as a % of total health expenditure	National Health Accounts 2003 - 2005	40%	30%	25%	10%

	85. % of LGA budget allocated to the health sector.	National Health Accounts 2003 - 2005	5%	20%	35%	40%
	86. Proportion of LGAs having transparent budgeting and finacial management systems	SSHDP review report	25	35%	65%	80%
	87. % of LGAs having operational supportive supervision and monitoring systems	SSHDP review report	45	20%	25	100%
PRIORITY AREA 5: NATIONAL HEALTH INFORMATION SYSTEM						
Outcome 10. National health management information system and sub-systems provides public and private sector data to inform health plan development and implementation						
Outcome 11. National health management information system and sub-systems provide public and private sector data to inform health plan development and implementation at Federal, State and LGA levels						
Output 13: Improved Health Data Collection, Analysis, Dissemination, Monitoring and Evaluation	88. % of LGAs making routine NHMIS returns to states	NHMIS Report January to June 2008; March 2009	TBD	20%	35%	50%
	89. % of LGAs receiving feedback on NHMIS from SMOH		TBD	20%	35%	50%
	90. % of health facility staff trained to use the NHMIS infrastructure	Training Reports	TBD	20%	35%	50%
	91. % of health facilities benefitting from HMIS supervisory visits from SMOH	NHMIS Report	TBD	30%	40%	50%
	92.% of HMIS operators at the LGA level trained in analysis of data using the operational manual	Training Reports	40	75%	100%	100%
	93. % of LGA PHC Coordinator trained in data dissemination	Training Reports	50	75%	100%	100%
	94. % of LGAs publishing annual HMIS reports	HMIS Reports	15	50%	75%	100%
	95. % of LGA plans using the HMIS data	NHMIS Report	45	75%	100%	100%
PRIORITY AREA 6: COMMUNITY PARTICIPATION AND OWNERSHIP						
Outcome 12. Strengthened community participation in health development						
Outcome 13. Increased capacity for integrated multi-sectoral health promotion						
Output 14: Strengthened Community Participation in Health Development	96. Proportion of public health facilities having active committees that include community representatives (with meeting reports and actions recommended)	SSHDP review report	45	65%	75%	100%
	97. % of wards holding quarterly health committee meetings	HDC Reports	25	50%	75%	100%

	98. % HDCs whose members have had training in community mobilization	HDC Reports	50	75%	100%	100%
	99. % increase in community health actions	HDC Reports	20	30%	45%	50%
	100. % of health actions jointly implemented with HDCs and other related committees	HDC Reports	50	60%	70%	100%
	101. % of LGAs implementing an Integrated Health Communication Plan	HPC Reports	20	30%	50%	75%
PRIORITY AREA 7: PARTNERSHIPS FOR HEALTH						
Outcome 14. Functional multi partner and multi-sectoral participatory mechanisms at Federal and State levels contribute to achievement of the goals and objectives of the						
Output 15: Improved Health Sector Partners' Collaboration and Coordination	102. Increased number of new PPP initiatives per year per LGA	SSHDP Report	25	30%	45%	70%
	103. % LGAs holding annual multi-sectoral development partner meetings	SSHDP Report	25	40%	60%	80%
PRIORITY AREA 8: RESEARCH FOR HEALTH						
Outcome 15. Research and evaluation create knowledge base to inform health policy and programming.						
Output 16: Strengthened stewardship role of government for research and knowledge management systems	104. % of LGAs partnering with researchers	Research Reports	5	10%	20%	50%
	105. % of State health budget spent on health research and evaluation	State budget	1	1%	1.50%	2%
	106. % of LGAs holding quarterly knowledge sharing on research, HMIS and best practices	LGA Annual SHDP Reports	5	10%	25%	50%
	107. % of LGAs participating in state research ethics review board for researches in their locations	LGA Annual SHDP Reports	25	30%	45%	75%
	108. % of health research in LGAs available in the state health research depository	State Health Reseach Depository	15	45%	50%	75%
Output 17: Health research communication strategies developed and implemented	109. % LGAs aware of state health research communication strategy	Health Research Communication Strategy	40	50%	75%	100%