LAGOS STATE GOVERNMENT

STRATEGIC HEALTH DEVELOPMENT PLAN
(2010-2015)

Lagos State Ministry of Health

March 2010

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EXECUTIVE SUMMARY

Lagos State which is one of the largest populated cities in Africa is located at the South-Western Region of Nigeria. Lagos was the capital of Nigeria from 1914 up till 1991 when the purpose-built capital city of Abuja was established. Lagos State's peculiarities are evident in terms of its limited geographic size as compared to its ever-growing explosive population, diverse ethnicity, commercial activities and infrastructure.

Health is a fundamental resource for everyday life and needs to be nurtured and supported by government. According to its Health Mission Statement, Lagos State is committed to institutionalize an evidence-based health system that promotes the delivery of quality, effective, affordable, accessible, acceptable, cost-efficient and equitable health services to the people of Lagos State, applying appropriate technology and driven by a highly motivated staff, thereby contributing to the sustainable economic development of the State. The **vision** of the State health sector is articulated as "to attain excellence in health service delivery by applying best practices at all levels of care". The state's policy thrust is thus geared towards the implementation of its set goals.

The priority areas for health were identified by the state's present administration as in its Ten-Point agenda and these have tremendously improved the healthcare delivery system vis`a vis the health service coverage, disease burden and the basic health indicators in the state. The priority areas include:

- Infrastructural upgrade
- Revitalization of PHC system
- Human Resources for Health
- Health financing
- Health Management Information System
- Health promotion
- Community ownership and participation
- Partnership for health development

The state is however continually faced with peculiar challenges such as inadequate financial resources, the weak commitment of the local governments to health service delivery, Inadequate human resources and capacity at the health facilities especially at PHC level, weak health management Information network/system and high poverty levels.

The Strategic Health Development Plans 2010-2015 for Lagos State were developed using the eight strategic domains/directions adopted by the Federal Ministry of Health, which are:

1. Leadership and governance
2. Health service delivery
3. Human resources for health
4. Health financing
5. National Health information systems
6. Community ownership and participation
7. Partnerships for health development
8. Research for health

The goals and strategic objectives are as couched by the Federal Ministry of Health. The interventions are also as enunciated by the Federal Ministry of Health but the State Government has the activities tailored to suite the peculiarities of the State.

The activities were either selected from the Lagos State SEEDS work-plan or amended to fulfil expectations. This indicates that the State is committed to these activities and issues with funding have also been considered during the drafting phase so as to ensure the smooth implementation of the plans. However, cost differentials would need to be sourced for along with the cost for the newly generated activities. The estimated cost of the State's Strategic Health Development Plan for Year 1 is put at a sum of Twenty Seven Billion, Six Hundred and Forty Nine Million Thirty thousand Six Hundred and Seventy Seven Naira only(N**27,649,030,677.00).**

In order to ensure the effective implementation of the state's plans, a co-ordinating mechanism was developed linking the State's Coordination Group to those of the Federal and local governments. The co-ordinating body at the Local Government Level shall meet on a quarterly basis to track progress and make necessary recommendations through the Chairman to the State SHDP for MDG Coordination Group while that of the state reports bi-annually to the National body.

In furtherance to the smooth implementation of the outlined activities in the SSHDP, monitoring activities has been earmarked in phases which would be analysed by competent technical supports to inform program appraisal. The indicators identified in the main body of the plan document, the milestones and expected targets as in the operational plan and the result matrix would be used for tracking achievements attained and otherwise.

The development of this State Health Development Plan using this framework has been an exciting exercise and has posed minimal challenges in view of the State's stipulated relevant priority areas for healthcare delivery and ample strategic documents for Health and development. The framework has provided an opportunity for harnessing constructively the various strategies, objectives and programmes on-going and proposed to ensure optimal health outcomes geared at accelerating the attainment of the MDGs. It is hoped that it would consequently contribute to the colossal accomplishment of the national goals of the National Strategic Health Development Plan.

CHAPTER 1- SOCIO ECONOMIC BACKGROUND

BACKGROUND INFORMATION

History of the State

Lagos was a Yoruba settlement of Awori people initially called Eko. Lagos derives its name from a Yoruba deity. The Yoruba still use the name Eko when they speak of 'Lagos', a name which never existed in Yoruba language. It is likely that the name 'Lagos' was given to the town by the first Portuguese settlers who navigated from a coastal town of the same name in Portugal. The present day Lagos State has a higher percent of Awori, who migrated to the area from Isheri along the Ogun river. Throughout history, it was home to a number of warring ethnic groups who had settled in the area. During its early settlement, it also saw periods of rule by the Kingdom of Benin.

From 1404-1889 it served as a major centre for the slave trade, ruled over by Yoruba kings called the Oba of Lagos. In 1841 Oba Akitoye ascended to the throne of Lagos and tried to ban slave trading. Lagos merchants, most notably Madam Tinubu, resisted the ban, deposed the king and installed his brother Oba Kosoko. While exiled, Oba Akitoye met with the British, who had banned slave trading in 1807, and got their support to regain his throne. In 1851 he was reinstalled as the Oba of Lagos.

Lagos was formally annexed as a British colony in 1861. This had the dual effect of crushing the slave trade and establishing British control over palm and other trades.

The remainder of modern-day Nigeria was seized in 1887, and when the Colony and Protectorate of Nigeria was established in 1914, Lagos was declared its capital. It continued to be the capital when Nigeria gained its independence from Britain in 1960.

Lagos was the capital of Nigeria from 1914 up till 1991 when the purpose-built city of Abuja was established. However, most government functions (especially the Head of State) stayed in Lagos till 1991when the head of State and other government functionaries were finally relocated to the Capital city, Abuja.

Geography

The city of Lagos lies in south-western Nigeria, on the Atlantic coast in the Gulf of Guinea, west of the Niger River delta, located on longitude 3° 24' E and latitude 6° 27' N. On this stretch of the high-rainfall West African coast, rivers flowing to the sea form swampy lagoons like Lagos Lagoon behind long coastal sand spits or sand bars. Some rivers, like Badagry Creek flow parallel to the coast for some distance before finding an exit through the sand bars to the sea. The two major urban islands of Lagos are Lagos Island and Victoria Island. These islands are separated from the mainland by the main channel draining the lagoon into the Atlantic Ocean, which forms Lagos Harbour. The islands are separated from each other by creeks of varying sizes and are connected to Lagos Island by bridges. However the smaller sections of some creeks have been sand filled and built over.

Lagos has a tropical savannah climate that is similar to that of the rest of southern Nigeria. There are two rainy seasons, with the heaviest rains falling from April to July and a weaker rainy season in October and November. There is a brief relatively dry spell in August and September and a longer dry season from December to March. Monthly rainfall between May and July averages over 300 mm (12 in), while in August and September it is down to 75 mm (3 inches) and in January as low as 35 mm (1.5 inches). The main dry season is accompanied by harmattan winds from the Sahara Desert, which between December and early February can be quite strong. The average temperature in January is 27°C (79°F) and for July it is 25°C (77°F). On average the hottest month is March; with a mean temperature of 29°C (84°F); while July is the coolest month

Commerce

Lagos Island contains many of the largest markets in Lagos, its central business district, the National Museum, the central mosque, and the Oba palace are located there. Though formerly in derelict condition, Tinubu Square on Lagos Island is a site of historical importance; it was here that the Amalgamation ceremony that unified the North and South protectorate to form Nigeria took place in 1914.

Transportation

Lagos has one of the largest and most extensive road networks in West Africa. Lagos has suburban terrains and has some ferry services. Highways are usually congested in peak hours, due in part to the geography of the city, as well as to its explosive population growth. Lagos is also linked by many highways and bridges.

The Lagos Metropolitan Transport Authority (LAMATA)[14] agency was recently created in order to solve the transport issues in the state. The Bus Rapid Transit scheme was launched on 4 June 2006. It has been estimated that the system will transport about 10,000 passengers in each direction per hour during peak travel times

Lagos's importance as a commercial centre and port and its strategic location have led to it being the end-point of threeTrans-African Highway routes using Nigeria's national roads:

- The Trans-West African Coastal Highway leaves the city as the Badagry Expressway to Benin and beyond as far as Dakar and Nouakchott.
- The Trans-Sahara Highway to Algiers, which is close to completion, leaves the city as the Lagos-Ibadan Expressway.
- The Lagos-Mombasa Highway also leaves the city as the Lagos-Ibadan Expressway, but the route is far from completion between East Africa and West Africa and is practical only for travel to neighbouring Cameroon.

A planned railway line running through the Lagos metropolis is being constructed with plans of completion as early as 2012.

Lagos State Ferry Services Corporation runs a few regular routes, for example between Lagos Island and the mainland, modern ferries and wharves. Private boats run irregular passenger services on the lagoon and on some creeks.

Tourism

Lagos is fast becoming a tourist destination of major magnitude, being one of the largest cities in Africa and the world at large, it is finally realizing its potential "mega city" status. The 2009 Eyo carnival which took place on the 25th April, was a step in the right direction. Lagos is blessed with a number of sandy beaches by the Atlantic Ocean. Two of the popular beaches include Bar Beach and Lekki Beach. In addition to these tourists sites, in January 2009, a privately owned zoo was commissioned in the Epe area of Lagos and is a sight to behold as it serves as a home for many animals that originated from Africa.

Demography

S/N	LGA	2006 State Population
1	Agege	1,033,064
2	Ajeromi-Ifelodun	1,435,295
3	Alimosho	2,047,026
4	Amuwo-Odofin	524,971
5	Apapa	522,384
6	Badagry	380,420
7	Epe	323,634
8	Eti-Osa	983,515
9	Ibeju-Lekki	99,540
10	Ifako-Ijaiye	744,323
11	Ikeja	648,720
12	Ikorodu	689,045
13	*Kosofe*	934,614
14	*Lagos Island*	859,849
15	Lagos Mainland	629,469
16	Mushin	1,321,517
17	Ojo	941,523
18	Oshodi-Isolo	1134548
19	Somolu	1,025,123
20	Surulere	1,274,362
	TOTAL	**17,552,942**

Source: Lagos State Government. Subsequent projections based on an annual growth rate of 3%.

Health is a fundamental resource for everyday life and needs to be nurtured and supported by government. The peculiarities of Lagos State in terms of the size of its population, diverse ethnicity, commercial activities, infrastructure and the electoral promises of the current administration posed peculiar challenges for the health sector.

CHAPTER 2 - SITUATION ANALYSIS

HEALTH SYSTEMS

Vision

The **vision** of the State health sector is articulated as "to attain excellence in health service delivery by applying best practices at all levels of care"

Mission statement

To institutionalize an evidence-based health system that promotes the delivery of quality, effective, affordable, accessible, acceptable, cost-efficient and equitable health services to the people of Lagos State, applying appropriate technology and driven by a highly motivated staff, thereby contributing to the sustainable economic development of the State.

Goal

To protect, promote and restore the health of Lagosians and to facilitate the unfettered access to qualitative healthcare services without financial or other barriers.

Policy thrust

1. Free community-based primary healthcare services
2. Provision of comprehensive secondary healthcare services
3. Institution of the Health Sector Reform Program

Organization

The political/executive head of the Ministry is the Honourable Commissioner for Health, through whom policy matters effecting health in the State are channeled to State Executive Council and State Executive Governor. The Commissioner is assisted by the Permanent Secretary who is the accounting officer/head of the Ministry's civil service and through whom all the directors report to the Honourable Commissioner.

There are nine Directorates viz:

- Health Care Planning, Research & Statistics
- Primary Health Care: Disease Control & Family Health/Nutrition
- Hospital Services: Health Facility Monitoring and Accreditation Agency (HEFAMAA) & Lagos State Ambulance Service (LASAMBUS)
- Occupational Health & Staff Clinic
- Pharmaceutical Services
- Medical Administration & Training
- Nursing
- Accounts
- Finance and Administration

In addition, the Public Relations Unit is under the Honourable Commissioner's Office while the Internal Auditor and Legal officer report directly to the Permanent Secretary.

Under the HSR law, as a means of improving the health systems and their management the **Health Service Commission (HSC)** was established. The HSC replaced the old Hospital Management Board (HMB) and it is charged with staff matters including employing, dismissal, promotions, trainings etc. The law also approved the establishment of Governing boards of HSC and all secondary and tertiary hospitals leading to decentralization of hospital activities and granting them autonomy with the Ministry of Health retaining oversight functions.

Also in conformity with Part 6 of the Health Service Reform Law of 2006, the 12 member **State Primary Health Care Board** was inaugurated in February 2009 to coordinate the planning, budgeting, monitoring and evaluation of all primary health care services, recruiting, promoting, training / staff development of PHC employees on Gradelevel 07 and above amongst others.

The institutionalization of a system of quality assurance of health services provision led to the establishment of:

- State Health Facility Monitoring and Accreditation Agency (HEFAMAA) - This Agency is charged with the accreditation and regulation of all public and private health facilities in the State. The agency commenced operations in the second quarter of 2007
- A Monitoring unit of the Ministry of Health regularly monitors the operations of the public health facilities to ensure that these conform to set guidelines.
- The Task Force on Fake and Counterfeit Drugs and Unwholesome processed foods which commenced surveillance activities in 2001
- A system of registration and regulation of traditional and alternative medical practitioner's through the Board of Traditional medicine.
- An effective blood screening/transfusion service through the Lagos State Blood Transfusion and Certification Committee which was inaugurated in the year 2005.

HEALTH SERVICE DELIVERY

The health service delivery system in the state is tiered along the primary, secondary and tertiary care of service.

- Public Primary Health Care facilities - 141
- Public Secondary Health Care facilities – 24 (inclusive of specialist hospitals in paediatrics, O & G and infectious diseases)
- Public Tertiary health Care facilities – 5 (1-state, 4-Federal)
- Private health facilities -1,548 accredited health facilities
- Public health workers: Doctors-1,265, Nurses-3,372, Pharmacists-209, Lab scientists-253
- Private Health workers: Doctors-1,342, Nurses-2,134, Pharmacists-47, Lab scientists – 216

Priority Areas

- Infrastructural upgrade
- Revitalization of PHC system
- Human Resources for Health

- Health financing
- Health Management Information System
- Health promotion
- Community ownership and participation
- Partnership for health development

Infrastructure and equipment

Criteria considered in the formulation of the State Health Sector Infrastructural Development include:

1. New infrastructural projects -LGA population and characteristics; the development of new infrastructural projects in the health sector must keep pace with population growth. Currently underserved areas identified based on guideline that each LGA should have at least one public secondary health facility, deserve priority.
2. Upgrade of existing health care facilities – facility development taken into consideration includes need for future expansion, basic equipping and optimal utilization of available land space by exploring multi-storey buildings.
3. Infrastructural and functional upgrade of mono-specialist facilities- with a view to upgrading to centres of excellence with the ability to deliver services in all related sub specialties.
4. Vulnerable groups – proposed plan driven by health policies, which are skewed in favour of attaining the hMDGs. The health of women and childrenwere therefore prioritized.
5. Special focus on stand alone centres – dialysis, burns, cardiothoracic and infectious diseases.
6. Enhancement of the State emergency response – especially in the disaster prone areas.

Achievements and on-going projects:

Primary Health Care

The achievements at this level of service delivery are for the revitalization of primary health care. The following were achieved:

- In collaboration with the African Development Bank, **Igbonla PHC** and the **Community Health Training Institute, Agbowa were** renovated
- **Procurement of equipment** for **Orile Iganmu Primary Health Clinic and ten other mini- health clinics** in partnership with the Ministry of Rural Development.

Secondary Health Care

The objective of scaling up the infrastructure in public secondary health facilities was essentially to decongest the tertiary health facility by providing quality services at this level of care,

- Construction and equipping of **four storey 100 Bed Maternal and Child Health Complexes at Ajeromi, Ikorodu, Isolo and Ifako-Ijaiye General Hospitals and Gbaja, Surulere**.
- Construction and equipping of **four storey 110 Bed Maternal and Child Health Complex at Amuwo Odofin**, **Alimosho and Lekki.**
- Construction and equipping of **20 bed Highway Accident and Emergency Centre** at the Toll gate, Lagos Ibadan Expressway.
- Construction of a **new staff clinic** for the Secretariat at Alausa-Ikeja.

- Construction of a **three storey 80 bed integrated trauma and burns centre** at the LASUTH Annex, Gbagada.
- Construction of **three floor building at Harvey Road Health Centre**
- Construction of a new School of Nursing in Alimosho
- **Rehabilitation of ten X-ray sites** – Ikorodu, Ifako Ijaiye, Lagos, Somolu, Surulere, Badagry, Mushin, Alimosho, Isolo General Hospitals and Massey Street Children's Hospital
- Supply and installation of ophthalmic, theatre, endoscopy, sluice room equipment and accessories
- Procurement of critical paediatric, dental, laboratory, physiotherapy, ENT, obstetric and basic equipment for the secondary health facilities.
- Procurement of six anaesthetic machines
- Procurement of generating sets for eleven General Hospitals
- Supply and installation of PABX system in 6 hospitals.
- Procurement of blood banks for 3 hospitals
- Installation of bed lifts at Lagos Island Maternity Hospital

Tertiary Health Care

Transforming LASUTH and LASUCOM to centres of excellence with respect to statutory functions of research, training and clinical service are of primary concern to the State. To this end the following have been undertaken:

- A sizeable parcel of the premises of Gbagada General Hospital was designated as LASUTH's Annex to allow for expansion and development
- Completion and commissioning of the construction and equipping of the Bola Tinubu Health and Diagnostic and Bola Tinubu Paediatric Complexes
- Award of contracts for the following projects:
    - Construction of three storey cardiac and renal centre at the LASUTH Annex, Gbagada.
    - Supply, installation and commissioning of hospital equipment and furniture for the three storey cardiac and renal centre at the LASUTH Annex, Gbagada
    - Construction of **combined clinics and wards** at the LASUTH Annex, Gbagada.
    - Construction of three storey **student hostel block at LASUCOM**.
    - Construction of **Faculty of Clinical Sciences office block at LASUCOM**
    - Supply of **four anaesthetic machines and two Datex anaesthetic gas monitors**.
    - Purchase of equipment for Critical Care Unit and Ayinke House
    - Procurement of **1,000 KVA generator** for LASUTH.
    - Procurement of **one 500KVA ge**nerator for Ayinke House, LASUTH
    - Procurement of **ultrasound machine** for Ayinke House, LASUTH
    - Procurement of **neurosurgery equipment**:

Utilisation figures for Lagos State Public Secondary and Tertiary Health Facilities Services (HMIS returns)

Year	Total New Cases Out-Patient Attendances	Admissions (In-Patients)	Bed Occupancy Rate (%)
2005	1,756,247	38,805	38.50
2006	2,202,993	45,059	30.65
2007	2,521,921	49,404	32.57
2008	3,150,718	57,388	47.07

Basic State Health Indicators

- Infant Mortality Rate (IMR): 75/1000 live births
- Child Mortality Rate (CMR): 88/1,000 live births
- Crude Mortality Rate (CMR): 150/1000 live births
- Maternal Mortality Rate (MMR) : 650/100000 live births
- HIV Prevalence Rate: 5.1% in 2008
- Routine Immunisation Coverage (Jan – Sept 2009): BCG = 101%, DPT3 = 71%, OPV3 = 72%, Measles = 69%, HBV3 = 66% and TT2 = 38%.

Disease Burden: Five leading diseases in the State: Malaria, Diarrhoea, Pneumonia, STI and Tuberculosis

Service Coverage (MICS 2007 and NDHS 2008)

- Antenatal care (rate): 99.2% (one or more ANC clinic attendance)
- Delivery by health professional (rate): 87%
- Facility-based delivery (rate):81.7%
- Modern Contraceptive Prevalence Rate: 27.5%
- TB Cure Rates: 65%
- Insecticide Treated Nets Ownership (rate):6%

Other health status indicators from NDHS 2008

INDICATORS	NDHS 2008
Literacy rate (female)	90%
Literacy rate (male)	96%
Households with improved source of drinking water	63%
Households with improved sanitary facilities (not shared)	24%
Households with electricity	91%
Employment status (currently)/ female	66.7%
Employment status (currently)/ male	81.4%
Total Fertility Rate	4
Use of FP modern method by married women 15-49	28%
Ante Natal Care provided by skilled Health worker	88%
Skilled attendants at birth	83%
Delivery in Health Facility	77%
Children 12-23 months with full immunization coverage	53%
Children 12-23 months with no immunization	12%
Stunting in Under 5 children	21%
Wasting in Under 5 children	10%
Diarrhea in children	6.1
ITN ownership	9%
ITN utilization (children)	7%
ITN utilization (pregnant women)	2%
children under 5 with fever receiving malaria treatment	-
Pregnant women receiving IPT	6%
Comprehensive knowledge of HIV (female)	83%
Comprehensive knowledge of HIV (male)	89%
Knowledge of TB (female)	27.0%
Knowledge of TB (male)	38.0%

Special Programs

S/n	Program	2008	2009
1	HIV/AIDS control program		
2	Malaria Control program		
3	Tuberculosis control program		
4	NPI		
5	School Health Program • General consultation • Dental consultation	 5,875 3,868	
6	Blindness prevention program • Total screened • Reading glasses given • Special order glasses given • Surgeries	 30,466 5,635 2,454 1,503	
7	Hypertensive and diabetes screening program • Total screened	 161,772	
8	Avian influenza control program		
9	Nutrition program • Total beneficiaries	 53,058	
10	Free health program • 0-12 years beneficiaries • Over 60 years beneficiaries • ANC • Civil servants	 169,290 67,992 180,245 219,929	
11	Limb deformity corrective surgery and rehabilitative program • Total screened • Surgeries • Physiotherapy • Mobility aids given	 642 78 206 295	
12	Cleft palate and lip surgery program • Total screened • Surgeries	 284 118	
13	Breast cancer screening program • Total screened	 4,368	
14	Prostate cancer screening program • Total screened	 1,405	
15	Cervical cancer screening program • Total screened	 989	

Other programs include Maternal Mortality Reduction Program, Adult reproductive health program, onchocerciasis and leprosy control programs.

Challenges and Issues

- Inadequate Financial Resources - The financing system is still largely based on budgetary allocation; In spite of increase in health sector budget allocation in absolute terms, the percentage of the total State budget allocated to the health sector has remained between 5% and 6 % which is still inadequate;
- Governance - Improving yet still weak commitment of the local governments to health service delivery in terms of infrastructure, personnel and service delivery;
- Human Resources/ Capacity-Inadequate staff strength especially at PHC level and general high attrition rate;
- Health Management Information System still weak;
- Socioeconomic – high poverty levels.

CHAPTER 3- STRATEGIC HEALTH PRIORITIES

The Eight (8) Strategic Directions of focus for the country are

1. Leadership and governance
2. Health service delivery
3. Human resources for health
4. Health financing
5. National Health information systems
6. Community ownership and participation
7. Partnerships for health development
8. Research for health

The Lagos State Minimum Package of Care will include Control of Communicable Diseases (malaria, tuberculosis, HIV/AIDS), Child Survival (Immunization, diarrhoeal diseases and ARI), Maternal and Newborn Care (EmONC, ANC, skilled delivery), Nutrition, Non-Communicable Diseases Prevention, Health Education and Community Mobilization.

These above-stated services will be complemented by the provision of adequate human resources at all levels, provision of infrastructure where required and facility upgrading with complementary equipment as necessary. The sustained provision of drugs and commodities for all interventions is also paramount to the successful implementation of these interventions.

The goals and strategic objectives are as couched by the Federal Ministry of Health. The interventions are also as enunciated by the Federal Ministry of Health but the State Government has the activities tailored to suite the peculiarities of the State.

The activities were either selected from the Lagos State SEEDS work-plan or amended to fulfil expectations. This indicates that the State is committed to these and so funding should not pose a big problem. However, cost differentials would need to be sourced for along with the cost for the newly generated activities.

However, the Essential Package of Health Services for Lagos State by service delivery mode reflects the priority high impact interventions to be delivered in the state.

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

Funding Gaps- This is to be bridged through the community based health insurance scheme with a fundamental component for the reduction of MMR and the PPP projects.

*LGA Health Development Plans***:**

Due to funding constraints, this had to be done **in a** very cost effective way. Training and plan development took place together. All LGAs and LCDA were grouped into three making sure that contiguous ones were in same group. Facilitators were assigned from the core group. Training was done on days 1 and 2, activities were identified by the second day and consensus reached on their suitability for achieving the interventions. The third day was spent costing the activities. The Medical Officers of Health were given the responsibility of concluding the exercise and working with a facilitator after two days. The resultant plans would be joint plan for all LGAs in the group. Subsequently the state and LGA plans have been merged into a consolidated document.

LOG Frame:

A log frame was developed indicating the goals, Strategic objectives and interventions as indicated in the guide and corroborated by one of the federal facilitators. This is attached in the appendix.

CHAPTER 4 - HUMAN RESOURCES FOR HEALTH

The **Health Service Commission (HSC)** has as its statutory responsibilities issues of recruitment, deployment, promotion, discipline, staff welfare and professional development matters amongst others.

Human Resources Information

- Total Number of Health Workers by categories (2009)

Health Workers	No in the state	Public/Private
Doctors	2,607	Private-1,342 Public – 1,265
Pharmacists	256	Private – 47 Public – 209
Nurses and Midwives	5,506	Private – 2,134 Public – 3,372
CHO/CHEW	658	Private – 54 Public - 604
Lab Scientists	469	Private – 216 Public - 253
Lab Technicians/Assistants	90	Public – 67 Private – 23

- Recruited 240 officers and 155 by special dispensation to replace the 287 that exited
- Recruited of 1,701 health personnel for the six (6)Maternal and Child Health Complexes under construction
- Engaged an additional 50 neighbourhood watchmen
- Promoted 1,230 senior staff on Grade level 07 and above
- Organised Clinical update courses for 85 doctors
- 196 doctors and nurses drawn from the tertiary and public health facilities participated in Emergency Obstetric Care sessions organized during the year.
- 66 health personnel also participated in International Practical Obstetric Skills sessions
- 160 nurses attended the refresher programme organized by the Commission in collaboration with the Administrative and Staff College of Nigeria (ASCON)
- 38 personnel were trained as **paramedics** and thereafter engaged as Community Health Extension Workers
- 350 personnel, selected by the Ministry of Special Duties were trained as **first responders** during the year.
- 307 health personnel, selected from the various hospital units, as **second responders** trained in basic and advanced life support.
- Institutionalization of a yearly professional exchange program

Health Services Facilities

Primary Health Centres	- 237
Secondary Health Facilities	- 21 General Hospitals
	- 3 Specialists (O&G, Paediatrics and Infectious Diseases)
Tertiary Health Facilities	- 1 State owned (LASUTH)
	- 3 Federal (LUTH, National Orthopaedic Hospital, FMC)
Private Health Facilities	- 1548 accredited by State Government

CHAPTER 5 - HEALTH FINANCING

Estimate cost of the strategic priority areas

The estimated cost of the Lagos State strategic health development plan for the period 2010-2015 is NGN 155,768,767,051. This amounts to NGN 25,961,461,175.13 per annum. The table below shows the distribution of the costs according to the priority areas. Most of the planned investment as can be seen in the table below will be in health service delivery and human resources priority areas.

Priority area	Estimated Cost (2010-2015)
Leadership and Governance For Health	1,557,687,671
Health Service Delivery	74,401,124,439
Human Resources For Health	52,340,733,148
Financing For Health	18,901,939,606
National Health Information System	2,336,531,506
Community Participation And Ownership	1,557,687,671
Partnerships For Health	1,557,687,671
Research For Health	3,115,375,341
Total cost	**155,768,767,051**

	2004 PROVISION	2005 PROVISION	2006 PROVISION	2007 PROVISION	2008 PROVISION
MOH TOTAL	3,013,879,266	3,699,083,802	9,542,834,882	10,095,885,963	
OVERHEAD	674,530,000	803,495,000	1,250,000,000	1,500,000,000	3,078,000,000
PERSONNEL	649,349,266	1,099,083,802	1,792,834,882	1,795,885,963	6,391,000,000
CAPITAL	1,690,000,000	1,796,505,000	6,500,000,000	6,800,000,000	14,648,000,000Q2
HMB TOTAL	1,640,688,912	2,485,384,341	2,252,723,121	3,782,721,876	
OVERHEAD	200,572,000	220,000,000	523,011,983	95,000,000	
PERSONNEL	1,370,686,912	2,265,384,341	341,795,600	3,687,721,876	
CAPITAL	69,430,000	-	-		
O'head % of THB	19	17	13	11	
Pers. % of THB	43	54	32	40	
Captal% of THB	38	29	55	49	
TOTAL HLTH BUDG (THB)	4,654,568,178	6,184,468,143	11,795,558,003	13,878,607,839	24,115,000,000

% OF STATE BUDGE	6.01%	5.49%	5.26%	5.07%	
TOTAL STATE BUDGET(TSB)	77,407,000,000	112,729,000,000	171,103,000,000	274,000,000,000	403,401,000,000
RECURRENT	53,902,000,000	65,503,000,000	115,748,000,000		146,752,000,000
CAPITAL	24,315,000,000	47,226,000,000	108,484,000,000		256,649,000,000

Public Private Initiatives – The excessive dependence and pressure on government in the provision of healthcare services and the low level of public private sector interaction in health financing at the inception of this administration led to the development of PSP in health matters.

The objective was to broaden financing options and thereby ensure sustainable financing of the health sector. The partnerships currently in operation are:

- Fee Paying Hospital Pharmacy available in Lagos, Gbagada, Isolo, Orile-Agege and Surulere General Hospitals. Also present at LASUTH, Apapa and Ebute Metta Health centres.
- Mortuary services in LASUTH and General Hospital, Gbagada.
- Management contract of the Critical Care Unit, LASUTH, Ikeja
- Blood screening and certification centres in 5 public hospitals
- Histopathology services in LASUTH
- CT scan services in GH Lagos.

A Community Based health Insurance Scheme was established in July, 2008 to create a social insurance for the informal sector. The pilot scheme is based in Ikosi Isheri LCDA and plans are underway to scale up to 5LCDAs

Thirteen hospitals currently participate in the NHIS as primary and secondary provider providing an alternate source of funding.

The State Ministry of health participated in the 2003-2005 National Health Accounts project and some highlights of the report include:

- Out of pocket expenditure - 69.8%
- Total public funding agents – 18.2%
- Total private funding agents – 81.8%
- Total spent on curative care – 77%

Plans are underway to conduct the 2006-2008 NHA project.

CHAPTER 6 - IMPLEMENTATION FRAME-WORK

Co-ordination Mechanism

For effective implementation of the framework at all levels, there is a need for coordination of all activities. The coordination mechanism will function across the two tiers of governments within the State and must be linked to the federal level. The roles and responsibilities of each level must be clearly defined.

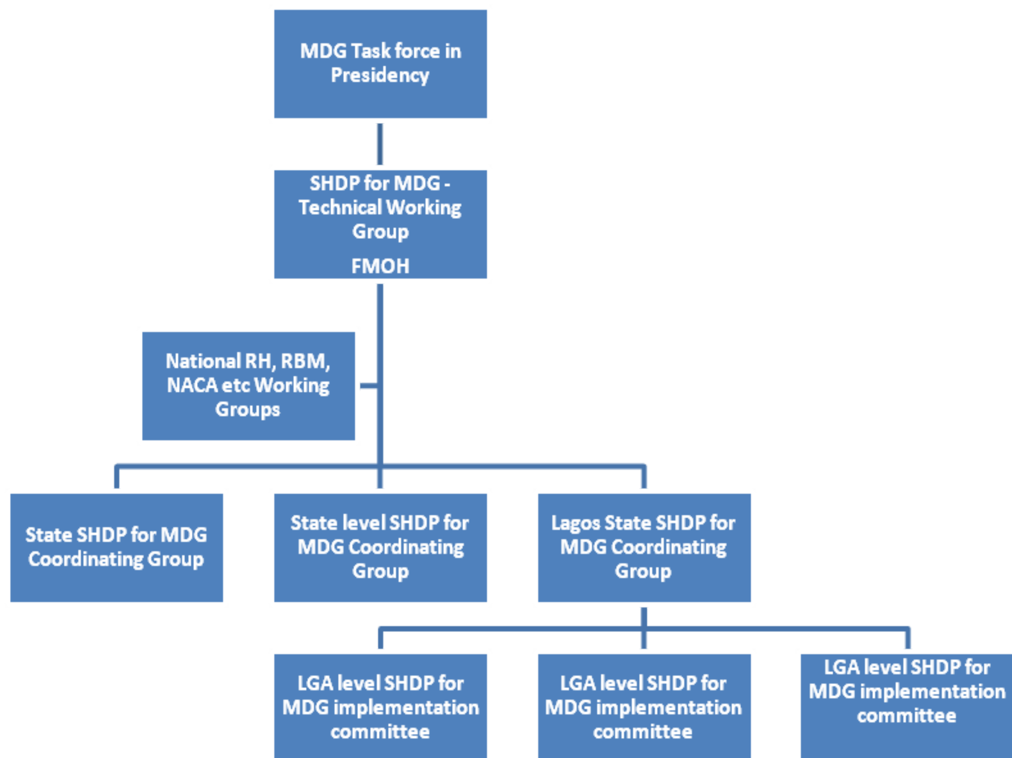
At the National level, there is a need for a FMOH Technical Working Group on MDGs/SHDP that will be responsible for co-ordinating the national implementation of the Strategic Health Development Plan. The group will report to the Office of the Special Adviser to the President on MDGs as the thrust is on the attainment of the MDGs.

In the State, a co-ordinating body, State SHDP for MDGs Coordination Group, will be formed comprising key officials from MOH including Key health programmes reflected in the MDGs especially IMNCH, RBM, TB and HIV; PHC Board, NPHCDA at State/Zonal level, State Planning Commission, Ministry of Finance, Ministry of Women Affairs, Ministry of Education, Ministry of Local Govt and Chieftaincy Affairs, community, civil organisation, development partners, private sector including private health practitioners and any other relevant bodies selected by the State. This body will be under the leadership of the Office of the Secretary to State Government. It will report bi-annually to the National body.

Coordination at the LGA level, will be undertaken by a body the SHDP for MDG implementation committee under the leadership of the LGA Chairman. The Committee will comprise the Supervisory Councillor for health, the Medical Officer for Health, the LGA Planning/Budget officer, the representative of NPHCDA through the zonal/State Office, the PHC Coordinator, LGA Education Officer, community based organisations and the Chairman for the LGA Community Development Committee. The committee shall meet on a quarterly basis to track progress and make necessary recommendations through the Chairman to the State SHDP for MDG Coordination Group.

This coordination mechanism is illustrated diagrammatically overleaf.

Coordination Mechanism Reporting Flow Chart



CHAPTER 7- MONITORING AND EVALUATION

Monitoring

For the successful and smooth implementation of outlined activities in this SHDP, monitoring is a key activity that will feature throughout the life span of implementation. This is a period of 6 years divided into three phases namely the early implementation phase, the mid implementation phase and the end term phase. This will culminate in the sixth year for evaluation, report writing and submission.

The monitoring structure will be at the three levels of Government with clearly defined roles and responsibilities and reporting lines. It is expected that monitoring activities at the LGAs will be monthly, quarterly at the State level and annually at the Federal level. Each monitoring team is expected to have a member competent to offer technical backstopping to reinforce knowledge and skills, especially at the LGA level.

Analysis will be done at all levels to inform programme appraisal. However more comprehensive analysis will be done at the State and National level.

The indicators identified in the main body of the plan document will be used for tracking changes attained.

Evaluation

The detailed indicators and write up are clearly stated in the body of the document. However, the sequence of evaluation activities is tabulated below.

	Purpose	**Responsible Agency**	**Type of Activity**
Beginning of year 1	To have a situation analysis and baseline data. Resource mobilisation activities	FMOH, SMOH, LGA	Baseline assessment Resource mobilisation
Middle of year 2	To analyse progress for appraisal of outputs and modify as appropriate	FMOH, SMOH, LGA	Progress assessment
Middle of year 3	To track progress, identify practices for replication and scale up. In addition, to enhance commitment and resource mobilisation	FMOH, SMOH, LGA	Mid-term assessment

Beginning of year 6	To assess the levels attained and plan for sustenance of gains achieved.	FMOH, SMOH, LGA	End- term assessment
End of Year 6	Compile SHDP report and submit	Presidential task force on MDGs and FMOH	Reporting

CHAPTER 8 - CONCLUSION

The State has demonstrated high level of commitment by making large investments for the emergence of Lagos as a prime national destination for persons in quest of quality medical care. With a vision that is appropriately tied to excellence, the strategies adopted and the aforementioned unique initiatives/programmes currently being implemented were geared towards improving performance and ultimately, the quality of life of residents in spite of evident nationwide poverty.

The Ministry of Health under the visionary, competent, creative and audacious leadership of His Excellency, the Governor of the State, Mr Babatunde Raji Fashola (SAN) is making giant strides in the improvement of health services especially provision of universal access to quality care. The huge catalogue of achievements and expansion of services attest to this stance. Documented presence and encouragement of the First Lady, Her Excellency Mrs. Abimbola Fashola and members of the council of wives of commissioners of Lagos State at child survival and other health promotion programmes, even at short notice equally underscores the State executives' commitment. The House Committee on Health's performance of its oversight functions to ensure that the State's objectives for the health sector are met and the immense moral support, technical and financial contributions of the developmental partners in the State- WHO, UNICEF, COMPASS, JICA, GHAIN, MSF. IHVN, EU-PRIME etc further augment the health agenda of the State.

The Ministry also enjoyed appreciable collaboration from many professional bodies – MDCN, NMA, AGMPMPN, PCN, NANNM and Laboratory Scientists Association etc as well as other State Ministries like Women Affairs, Agriculture and most especially Local Government Service Commission and Ministry of Local Government on issues relating to policy formulation, regulation and implementation as well as service provision.

Development of this State Health Development Plan using this framework posed very little challenge because the State had ample strategic documents for Health and development that were very useful. The framework has provided an opportunity for harnessing constructively the various strategies, objectives and programmes on-going and proposed to ensure optimal health outcomes geared at accelerating the attainment of the MDGs.

It is hoped that with the current political will in the State and concerted efforts at other levels (Federal and LGAs), Private sector and the development partners' conscientious implementation will go a long way in accelerating the national goals of the national Strategic Health development Plan.

Annex 1: Details of Lagos State Strategic Health Development Plan

LAGOS STATE STRATEGIC HEALTH DEVELOPMENT PLAN						
DOMAIN						
Goals				**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Estimated Cost (2010-2015)**
	Strategic Objectives			**Targets**		
		Interventions		**Indicators**		
			Activities	**None**		
LEADERSHIP AND GOVERNANCE FOR HEALTH						
1. To create and sustain an enabling environment for the delivery of quality health care and development in Nigeria						**1,557,687,671**
	1	**To provide clear policy directions for health development**		**All stakeholders are informed regarding health development policy directives by 2011**		**1,464,604,250**
		1.1.1	Improved Strategic Planning at Federal and State levels			**1,464,604,250**
			1.1.1.1 Review existing Strategic Health Plan and adopt the revised State Strategic Health Plan			2,148,610
			1.1.1.2 Sensitization of Government on revised State Strategic Health Plan			1,169,870
			1.1.1.3 Support implementattion of the Local Government Strategic Health Plan			1,460,349,713
			1.1.1.4 Development of Monitoring and Evaluation Program for implementation of the State Strategic Health Development Plan			936,057
	1	**To facilitate legislation and a regulatory framework for health development**		**Health Bill signed into law by end of 2009**		**7,465,299**
		1.2.1	Strengthen regulatory functions of government			**7,465,299**
			1.2.1.1 Review existing Health Sector Reform Law to address standards and compliance			2,162,267
			1.2.1.2 Constitute a system to facilitate the implementation and enforcement of the Law.			2,162,267
			1.2.1.3 Harmonise the State Health PPP Protocol with the State Disease			1,081,566
			1.2.1.4 Review existing Public Health Acts and Laws in alignment with rules and regulations of professional regulatory bodies			2,059,199
			1.2.15 Institute Monitoring mechanisms to improve health care delivery at the LG levels			-
			1.2.1.6 Facilitate Domestication of National and State health laws as LGA Bye-Laws with regulatory bodies as well as mandating the LGA to support all health programme			5,199,455
	1	**To strengthen accountability, transparency and responsiveness of the national health system**		**80% of States and the Federal level have an active health sector 'watch dog' by 2013**		**66,443,746**
		1.3.1	To improve accountability and transparency			**66,443,746**
			1.3.1.1 Ensure the convening of bi-annual State Council on Health Meeting			15,979,549

			1.3.1.2	Establish the mechanisms to correct identified gaps of decentralisation of decision-making process			990,482
			1.3.1.3	Promote the spirit of accountability and transparency through setting up an appropriate mechanism involving inter-sectoral collaboration			14,283,504
			1.3.1.4	Encourage the emergence and relevance of "independent watchdogs"			2,162,267
			1.3.1.5	To facilitate activities to enhance the accountability and transparecncy at the LG level			33,027,943
	1	**To enhance the performance of the national health system**			**1. 50% of States (and their LGAs) updating SHDP annually 2. 50% of States (and LGAs) with costed SHDP by end 2011**	**Various levels of government have capacity to update sectoral SHDP States may not respond in a uniform and timely manner**	**19,174,376**
		1.4. 1	Improving and maintaining Sectoral Information base to enhance performance				**19,174,376**
			1.4.1.1	***Improve the centralisation of theState Health Information System (data base)			-
			1.4.1.2	Establish a system of facilitating the development and implementation of evidence-based policies, projects and programs			1,689,732
			1.4.1.3	Improve the HMIS Infomation Base at the LGA Level	subject to political will & availability of funds	LGA, LSMOH, LSPHCB	17,484,644
HEALTH SERVICE DELIVERY							
2. To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare							**74,401,124,439**
	2	**To ensure universal access to an essential package of care**			**Essential Package of Care adopted by all States by 2011**		**33,657,553,797**
		2.1. 1	To review, cost, disseminate and implement the minimum package of care in an integrated manner				**16,337,811,613**
			2.1.1.1	Build capacity for and disseminate the minimum package of care protocol			59,762,981
			2.1.1.2	Adapt the National minimum package of care to reflect State strategies on IMNCH, HIV/AIDS prevention and care oncludung PMTCT, RBM and TB			-
			2.1.1.3	Monitor implementation of the package of care			35,409,271
			2.1.1.4	Build Capacity of Service Providers on Minimum Health Care Package..	**75% of service provider to be enlightened on minimum health care package by mid 2010**	**availability of funds**	64,720,279
			2.1.1.4	facilitate the provision for Minimum Health Care package (IMNCH)- maternal component	**50% reduction in maternal mortality by 2015**	**passage of National health act and we assumme all pregnant women will attend access services at the PHC**	4,129,416,121
			2.1.1.5	facilitate the provision for minimum health care package(IMNCH) -newborn and child component	**50% reduction in Under 5 Mortality Rate by 2015.**	**passage of National health**	12,048,502,960

						act and funding of IMNCH	
		2.1.2	To strengthen specific communicable and non communicable disease control programmes				**204,838,701**
			2.1.2.1	Evaluate the effectiveness of existing programmes			34,753,544
			2.1.2.2	Review implementation approaches of the programmes			7,045,134
			2.1.2.3	Build capacity of staff for programme implementation			126,542,244
			2.1.2.4	Increase public awareness of the programmes through advocacy, communication and social mobilisation			36,497,779
			2.1.2.5	To strenghten current communicable and non communicable disease programming including but not limited to (Roll back malaria program, HIV control program,TB/Leprosy control program,Disease survellance,Immunization programs,school health programs,Blindness prevention programs,ambulance noat services/rural health program,Nutrition programs)			-
		2.1.3	To make Standard Operating procedures (SOPs) and guidelines available for delivery of services, especially for IMNCH, Malaria, TB and HIV/AIDS, at all levels				**22,612,098**
			2.1.3.1	Convene stakeholders' meeting for input and consensus building on SOPs developed			16,262,036
			2.1.3.2	Compile, review and integrate SOPs and Standard treatment guidelines and develop integrated service delivery protocols for all levels			1,377,027
			2.1.3.3	Disseminate developed STPs and SOPs to all service delivery points			2,061,606
			2.1.3.4	timely continous availability of family planning method	**% of service delivery point with at least 1 staff trained of family planning services**		826,216
			2.1.3.5	Mobilise adequate funding for the programme.			2,085,213
		2.1.4	To strengthern specific screening, treatment and rehabilitative programs in the state.				**17,090,638,953**
			2.1.4.1	To strenghten current screening programming including but not limited to (Breast Cancer screening program,proatate Cancer screening Program, Cervical Cancer Screening Program, Hearing Screening, Sickle Cell Screening, Hypertension and Diabetes screening Program).			-
			2.1.4.2	To strenghten current treatment and rehabilitative programming including but not limited to (Limb Deformity Rebabilitative Program,Cleft Lip and Palate-Operation smile rehabilitative program, Blindness prevention Program,Medical Mission, Cardic Missions, Mini Medical Missions,Free health program,)			7,868,726,986
			2.1.4.3	To strenghten current health promotion programming including but not limited to (Occupational Health,SEHMU).			8,817,905,294

			2.1.4.4	Upgrade and refurbish PHC to be able to provide minimum Health care package	**% of PHC with complement structure and eqiupment as contained in the minimum health package**		394,262,566
			2.1.4.5	Create awareness on Minimum Health Care Package in the Community.	**% of clinic mothers making use of PHC. % of pregnant women accessing ANC services and delivery in our PHC**		9,744,107
		2.1. 5					**1,652,433**
			2.1.5.1	management of communicable diseases		**75% of TP are infected with malaria and typhoid,3.6 % of TP have TB, 5.1% of TP have HIV, 10% of TP have STI**	826,216
			2.1.5.2	management of non-communicable diseases		**25% of the population are at risk of HT & DM,female of age 20 and above are at risk of ca cervix,female of age 40 and above at risk of breast CA,male of age 50 and above are at risk of postate CA**	826,216
			2.1.5.3				-
	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**		**32,320,491,839**
		2.2. 1	To improve geographical equity and access to health services				**13,370,475,322**
			2.2.1.1	Undertake a population based mapping and situation analysis of all health care facilities in the state		**Availability of funds, data integrity**	119,381,703
			2.2.1.2	Development of plan of action based on gaps and deficiences identitified.			9,574,444,050
			2.2.1.3	Implement phased infrastructural development for state owned secondary and tertiary health care facilities	**Number of newly built, equipped & staffed secondary health facilities, Number of upgraded secondary health facilities.**	**Availability of funds**	3,410,607,910
			2.2.1.4	uggrading and refurbishing phc			265,215,443
			2.2.1.5	conduct outreach services	**% of villages within 5km**		826,216

					covered by the outreach services		
		2.2. 2	To ensure availability of drugs and equipment at all levels				**7,761,095,916**
			2.2.2.1	Review and update exising essential drugs list	**Updated essential drug list**	**Availability of funds. EDL should be reviewed every 5 years.**	30,032,308
			2.2.2.2	Develop a system for ensuring availability of quality esential drugs at all levels	**Proportion of health facilities having no stock out of essential drugs within 3 months.**	**Political will at health facility level**	5,356,176,887
			2.2.2.3	Set up process for the manufacture of basic essential drugs	**No of essential drugs approved and registered by regulatory agencies.**	**Commitment of private investor. Government approval.**	3,606,500
			2.2.2.4	Develop and institute a state basic essential medical equipment list at all levels.	**Proportion of health facilities with basic essential medical equipments.**	**Provision and correct utilization of medical equipments**	2,370,454,005
			2.2.2.5	Establish a drug revolving fund in the LGAs	**% of PHC operating DRF, % of PHC with regular supply of essential drugs**		826,216
		2.2. 3	To establish a system for the maintenance of equipment at all levels				**116,874,202**
			2.2.3.1	Adapt, disseminate and implement National Equipment Maintenance policy.			66,475,006
			2.2.3.2	Build capacity for maintenance of equipment	Number of officers trained per secondary health facility.	Political will at health facility level	-
			2.2.3.3	establish medical equipment maintenance unit	% of PHC with adequate maintenance system		826,216
			2.2.3.4	recruit biomedical engineer and technician	availability of a bioengineer and a technician		49,572,980
		2.2. 4	To strengthen referral system				**11,072,046,399**
			2.2.4.1	Map out network linkages for two-way referral			2,360,618
			2.2.4.2	Develop implementation guidelines for referral of all cases/ referral protocol			18,919,043
			2.2.4.3	Provide logistics support for referral			10,963,759,601
			2.2.4.4	Monitor the referral system at all levels/conduct quartherly stake holders meeting on referal at the LGAs			74,057,835
			2.2.4.5	build capacity of service providers on referal in the LGA level			12,949,302
	2	**To improve the quality of health care services**			**50% of health facilities participate in a Quality Improvement programme by end of 2012**		**8,092,608,007**
		2.3. 1	To strengthen professional regulatory bodies and institutions				**6,353,986,550**

			2.3.1.1	Review, update and implement operational guidelines for all regulatory bodies (i.e HEFAMAA, Blood Transfusion Committee and Board of Traditional Medicine and Task Force on Fake and Counterfeit Drugs)	Availability of reviewed and updated guidelines.		8,015,610
			2.3.1.2	Carry out regular monitoring exercises with appropriate documentation and feedback.	% monitoring exercises carried out as planned: report on feedback meetings	Adequate budgetary provision and release. Strong political commitment and support	3,324,379,777
			2.3.1.3	Provide adequate security to regulators.	Number of monitoring visits carried backed by adequate security.	Release of security agents (Police) by relevant authorities.	3,021,591,163
		2.3. 2	To develop and institutionalise quality assurance models				**833,969,653**
			2.3.2.1	Review available quality assurance (QA) models and adopt appropriate ones	Availability of adopted QA models.		52,641,784
			2.3.2.2	Develop/adopt QA training modules to build capacity of both public and private health care providers	Availability of developed/adopted QA Training modules.		4,695,007
			2.3.2.3	Conduct a TOT training on QA			-
			2.3.2.4	Conduct cascade training on QA for both public and private health care providers	% of Public and Private Healthcare providers trained on QA as planned	Availability of funds.	83,240,640
			2.3.2.5	Establish a QA Coordinating Unit	Reports		685,523,495
			2.3.2.6	Monitor implementation of quality of care	Monitoring Reports.		7,868,727
		2.3. 3	To institutionalize Health Management and Integrated Supportive Supervision (ISS) mechanisms				**904,651,804**
			2.3.3.1	Establish an ISS Coordinating Unit	Report of activities	Availability of adequate and relevant human capital .	685,523,495
			2.3.3.2	Develop tools and guidelines (including checklist) for integrated supportive supervision (ISS)	Availability of ISS tools and Guidelines		17,809,552
			2.3.3.3	Conduct team building and leadership development programs for health managers at State, LGA and Ward Levels	Number of trainings conducted as planned.		83,240,640
			2.3.3.4	Develop capacities of Program Managers at all levels on the ISS mechanism	% of Program Managers targeted and trained		82,170,493
			2.3.3.5	Carry out quarterly review meetings of ISS activities and Provide support for integrated supportive supervision	Report of review meetings		35,907,624
	2	**To increase demand for health care services**			**Average demand rises to 2 visits per person per annum by end 2011**		**47,117,937**
		2.4. 1	To create effective demand for services				**47,117,937**
			2.4.1.1	Adapt, disseminate and implement National Health Promotion and Communication strategy			10,580,815
			2.4.1.2	Monitor and evaluate communication implementation strategies			12,327,672

			2.4.1.3	create awareness for Health Care Services.	% of people making use of thePHC		3,449,125
			2.4.1.4	Provide health education equipment and materials	number of health education sessions held		13,376,836
			2.4.1.5	evalute service utilization			7,383,489
	3	**To provide financial access especially for the vulnerable groups**			**1. Vulnerable groups identified and quantified by end 2010** **2. Vulnerable people access services free by end 2015**		**283,352,859**
		2.5.1	To improve financial access especially for the vulnerable groups				**283,352,859**
			2.5.1.1	Develop exemption/subsidy level criteria and identify the vulnerable groups.			6,557,272
			2.5.1.2	Establish a trust fund for the vulnerable group			263,117,116
			2.5.1.3	Educate the community on financial access to health services.			13,678,470
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							**52,340,733,148**
	3	**To formulate comprehensive policies and plans for HRH for health development**			**All States and LGAs are actively using adaptations of the National HRH policy and Plan by end of 2015**		**461,711,582**
		3.1.1	To develop and institutionalize the Human Resources Policy framework				**360,256,346**
			3.1.1.1	Call up for an ALL stakeholders forum/meetings to adapt and develop a StateHRH policy and formulate a consensus at both state and LGA levels.		Availability of funds, political will.	301,596,405
			3.1.1.2	Develop a plan of action for implementation of HRH policy(submission of policy to Exco for consideration and approval).		Availability of funds, political will.	-
			3.1.1.3	Implementation of the HRH policy at ALL levels(disseminationof policy and workplan to all stakeholders for iimplementation).		Availability of funds, political will.	1,009,059
			3.1.1.4	Adoption of state policies on human resourses for health development			57,650,882
		3.1.2					**101,455,237**
			3.1.2.1	Stakeholders meeting on review of health workforce requirements and recruitments at LG level.			61,743,175
			3.1.2.2	Development of guidelines for the recruitment and resource allocation of healthworkers			39,712,062
	3	**To provide a framework for objective analysis, implementation and monitoring of HRH performance**			**The HR for Health Crisis in the country has stabilised and begun to improve by end of 2012**		**127,365,619**
		3.2.1	To reappraise the principles of health workforce requirements and recruitment at all levels				**127,365,619**
			3.2.1.1	Call up for ALL stakeholders meetngs to review,standardise			95,299,979

				1.Requirement,recruitement,and selection criterias. 2.Harmonise on categorization and advancement criterias for all health workers.			
			3.2.1.2	Production of report,guidelines/manual			-
			3.2.1.3	Presentation of harmonised categorization/advancement, requirement criterias to NCE for consideration and approval.			31,392,934
			3.2.1.4	Dissemination of document to appropriate stakeholders/end-users.			672,706
	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**		**572,214,711**
		3.3. 1	To establish and strengthen the HRH Units				**572,214,711**
			3.3.1.1	Create and strenghten at all levels including the organised private sector an HR unit.			540,709,659
			3.3.1.2	Development of astandardised format on HR reporting (call for stakeholders meeting and training of end users)			24,777,995
			3.3.1.3	Facilitate the implementation of a standardised format			6,727,057
	3	**To strengthen the capacity of training institutions to scale up the production of a critical mass of quality, multipurpose, multi skilled, gender sensitive and mid-level health workers**			**One major training institution per Zone producing health workforce graduates with multipurpose skills and mid-level health workers by 2015**		**50,917,276,597**
		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				**50,562,984,909**
			3.4.1.1	Phased infrastructural development (Refurbishment) and equiping of the College of Health Technology			4,281,772,014
			3.4.1.2	Phased infrastructural development and equiping of the School of Nursing/Hostel			44,027,469,289
			3.4.1.3	Capacity building for School of Anaesthetic studies			2,012,511,329
			3.4.1.4	Capacity building for the proposed Family Medicine training programe			28,029,406
			3.4.1.5	Build capacity of community health workers(both formal and informal sectors) based on national priorities.			213,202,871
		3.4. 2	To strengthen health workforce training capacity and output based on service demand				**325,141,106**
			3.4.2.1	Develop a comprehensiveState Health workers training program at all levels based on needs asssessment.			-
			3.4.2.2	Implement the trainiing programs.			504,529
			3.4.2.3	Monitoring of the trainees and evaluation of the training programs.			308,323,463
			3.4.2.4	Develop a white(concept) paper to ensure that orientation on attitudinal change (as			2,298,411

				part of training for all health workers) takes 10% of the training vote to be reflected in State HR policy.			
			3.4.2.5	To adopt and modify state HR training policy for LG use			14,014,703
		3.4. 3					**29,150,582**
			3.4.3.1				29,150,582
	4	**To improve organizational and performance-based management systems for human resources for health**			**50% of States have implemented performance management systems by end 2012**		**198,223,957**
		3.5. 1	To achieve equitable distribution, right mix of the right quality and quantity of human resources for health				**188,469,724**
			3.5.1.1	Stakeholders meeting with HR managers to develop a template for situation analysis/needs assessment ofHRH manpower.			20,293,290
			3.5.1.2	Hiring of HR consultants to identify and proffer solutions to problems of the States HR situation.			168,176,434
			3.5.1.3	Create HRH database to include provision of job descriptions and specifications for all categories of health workers			-
			3.5.1.4	Provision of incentives for health workers in underserved areas			-
			3.5.1.5				-
		3.5. 2	To establish mechanisms to strengthen and monitor performance of health workers at all levels				**9,754,233**
			3.5.2.1	Develop an effective health workforce based performance assesment criteria that is objective and ALL encompassing.			-
			3.5.2.2	Dissemination of assessment tool for adoption by HR managers/end users.			1,681,764
			3.5.2.3				8,072,469
	4	**To foster partnerships and networks of stakeholders to harness contributions for human resource for health agenda**			**50% of States have regular HRH stakeholder forums by end 2011**		**63,940,680**
		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				**63,940,680**
			3.6.1.1	Regular fora /meetings with all proffessional associatons and regulatory bodies on emerging proffessional issues.			63,940,680
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							**18,901,939,606**
	4	**To develop and implement health financing strategies at Federal, State and Local levels consistent with the National Health Financing Policy**			**50% of States have a documented Health Financing Strategy by end 2012**		**205,987,722**
		4.1. 1	To develop and implement evidence-based, costed health financing strategic plans at LGA, State and				**205,987,722**

			Federal levels in line with the National Health Financing Policy				
			4.1.1.1	Undertake preplanning activities and baseline research/surveys/analyses			190,684,176
			4.1.1.2	Institute Lagos State Health Financing Strategic Plan/Policy (HFPP) development process			6,401,835
			4.1.1.3	Establish technical working group for health financing at the LGA level.		stable polity and the political will.	8,901,711
	4	**To ensure that people are protected from financial catastrophe and impoverishment as a result of using health services**			**NHIS protects all Nigerians by end 2015**		**411,815,880**
		4.2. 1	To strengthen systems for financial risk health protection				**411,815,880**
			4.2.1.1	To facilitate the completion of the State Health Financing Law (HFL)			6,333,889
			4.2.1.4	To establish an effective regulatory body for the State health Financing Law			405,158,349
			4.2.1.5	Facilitate the establishment of community based health insurance schemes in all LGAs.			**323,641**
			4.2.1.6	Institutionalize effective regulatory framework for social health insurance programmes.			-
	4	**To secure a level of funding needed to achieve desired health development goals and objectives at all levels in a sustainable manner**			**Allocated Federal, State and LGA health funding increased by an average of 5% pa every year until 2015**		**18,205,445,724**
		4.3. 1	To improve financing of the Health Sector				**18,204,052,828**
			4.3.1.1	Institute Evidence-Based Advocacy Program for Health Financing			29,075,369
			4.3.1.2	Develop Framework for Alternative Health Financing Programs al all levels			18,167,309,542
			4.3.1.3	Strengthening of DRF in the PHCs.			7,667,917
		4.3. 2	To improve coordination of donor funding mechanisms				**1,392,897**
			4.3.2.1	Facilitate the Publishing and Dissemination of the State Strategic Health Plan and Budget			883,300
			4.3.2.2	Harmonise activities of LGA and donor groups.			509,596
	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**		**78,690,280**
		4.4. 1	To improve Health Budget execution, monitoring and reporting				**51,734,954**

			4.4.1.1	Facilitate development of costed annual operational State health plans			29,170,569
			4.4.1.2	Institute State Health Accounts and PETA (Public Expenditure Tracking) systems			19,198,602
			4.4.1.3	Set up an equitable resource allocation mechanism .			2,661,316
			4.4.1.4	Institutionalization of checks and balances.			704,466
			4.4.1.5				-
		4.4. 2	To strengthen financial management skills				**26,955,325**
			4.4.2.1	Develop and Implement Capacity Building Plan for Financial Management at all levels			26,955,325
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							**2,336,531,506**
	5	**To improve data collection and transmission**			**1. 50% of LGAs making routine NHMIS returns to State level by end 2010** **2. 60% of States making routine NHMIS returns to Federal level by end 2010**		**26,893,892**
		5.1. 1	To ensure that NHMIS forms are available at all health service delivery points at all levels				**5,145,922**
			5.1.1.1	Advocate for funding for NHMIS especially at the LGA level in line with the NCH(1995) recommended NHMIS vote of charge consisting of 0.5% to 1% of annual capital health budget.		**The LGAs/LCDAs may not accord NHMIS high priority.**	137,149
			5.1.1.2	Mobilize private health practitioners to comply with NHMIS processes.			3,813,882
			5.1.1.3	Advocacy to policy makers/ Stakeholders			736,474
			5.1.1.4	Ensuring the availability of NHMIS Forms at LGA level			458,417
		5.1. 2	To periodically review of NHMIS data collection forms				**6,350,768**
			5.1.2.1	Conduct periodic reviews of NHMIS data collection tools in the State and feedback findings to FMOH.			501,025
			5.1.2.2	Capacity Building of1 M.O.H1 M& E officerper LGA /LCDA,& 20 M&E officers from Private Hospitals /10 officers in charge of PHC`s(10)/CHEW`s/1 M&E officer from Gen.Hosps in LGA. on data collection tools,analysis and utilisation /dessemination of information			5,218,480
			5.1.2.3	Monitoring of collection of data forms from service delivery points			631,263
		5.1. 3	To coordinate data collection from vertical programmes				**8,743,902**
			5.1.3.1	Strengthen linkages and collaboration for data collection through extension of membership of the Health Data Consultative Committee to include development partners, representatives of private health facilities and relevant government MDAs.	**No. of HDCC meetings held/year.**		4,986,384

			5.1.3.2	Integration of HMIS and M&E at the State level.	**Presence of a state HMIS/M&E plan, %tage of LGAs with State HMIS/M&E plan.**		3,757,519
		5.1.4	To build capacity of health workers for data management				**2,824,664**
			5.1.4.1	Comprehensive training and retraining of health information personnel(public & private) on data collection tools, analysis and utilization of data for health purposes.	%tage of required personnel trained and retrained		901,805
			5.1.4.2	Advocate for the recruitment of qualified HMIS officers into the Local Government and Health Service Commission.			183,367
			5.1.4.3	Strenghthen the instittution for training health information officers.		The needs of the Health Information Management department may not be fully addressed.	1,739,493
		5.1.5	To provide a legal framework for activities of the NHMIS programme				**353,207**
			5.1.5.1	Establish mechanisms to enforce sanctions stipulated in the State Health Sector Reform law and National Health Bill (when passed into law) on mandatory data collection and utilization at all levels.			353,207
		5.1.6	To improve coverage of data collection				**1,248,248**
			5.1.6.1	Institute social mobilization for registration of vital medical events.			-
			5.1.6.2	Organise quarterly meetings with M&E Officers (Private and Public) with a view to evaluating LGA data.	2 meetings annually	All LGAs must have atleast 1 M.O.H	1,248,248
		5.1.7	To ensure supportive supervision of data collection at all levels				**2,227,181**
			5.1.7.1	Establish mechanisms for supportive supervision of data collection at all levels.			1,595,918
			5.1.7.2	Mobilisation of Data Management Team for supervision			631,263
	5	**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**		**2,245,653,003**
		5.2.1	To strengthen the use of information technology in HIS				**1,235,808,304**
			5.2.1.1	Adapt and utilize FMOH- developed software for data management at the State and LGA levels.			84,544
			5.2.1.2	Strengthen the mechanism for wide use of e-health in the State.			1,235,723,759
		5.2.2	To provide HMIS Minimum Package at the different levels (FMOH, SMOH, LGA) of data management				**1,009,844,700**
			5.2.2.1	Needs assessment and workload analysis of the HMIS units in State owned public health facilities.			9,393,797
			5.2.2.2	Scale up NHMIS minimum package at the State and LGA level in line with the recommendations of the needs assessment and work load analysis.			1,000,450,902

	5	**To strengthen sub-systems in the Health Information System**			**1. NHMIS modules strengthened by end 2010** **2. NHMIS annually reviewed and new versions released**		**10,491,819**
		5.3.1	To strengthen the Hospital Information System				**10,491,819**
			5.3.1.1	Carry out needs assessment of the Hospital Information System (public health facilities).		Time frame and intensive nature of carrying out the needs assessment at all the health facilities.	4,687,505
			5.3.1.2	Service Availability Mapping of Public Health Facilities		Highly technical nature of the mapping project.	5,804,315
	5	**To monitor and evaluate the NHMIS**			**NHMIS evaluated annually**		**12,328,420**
		5.4.1	To establish monitoring protocol for NHMIS programme implementation at all levels in line with stated activities and expected outputs				**12,328,420**
			5.4.1.2	Establish state monitoring protocol for NHMIS programme implementation.	Ensure that all activities are captured on the checklists		-
			5.4.1.3	Training of key officers on the use of field monitoring checklists for NHMIS programme.			161,573
			5.4.1.4	Provision of adequate logistics to facilitate HIS processes.	Appropriates utility vehicles are provided		12,166,846
	6	**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**		**41,164,371**
		5.5.1	To institutionalize data analysis and dissemination at all levels				**41,164,371**
			5.5.1.1	Periodic production of the health data bulletin at the State level.			41,009,562
			5.5.1.2	Quarterly evaluation of LGA data			154,810
COMMUNITY PARTICIPATION AND OWNERSHIP							
6. To attain effective community participation in health development and management, as well as community ownership of sustainable health outcomes							**1,557,687,671**
	6	**To strengthen community participation in health development**			**All States have at least annual Fora to engage community leaders and CBOs on health matters by end 2012**		**174,947,084**
		6.1.1	To provide an enabling policy framework for community participation				**113,201,054**
			6.1.1.1	To adapt the National Health Policy and National Community Development Policy for use at the State Level			113,201,054

		6.1.2	To provide an enabling implementation framework and environment for community participation				**61,746,030**
			6.1.2.1	Develop State Policy Implementation Guidelines and strategies to co-ordinate community actions and participation for Health services.			61,746,030
	6	**To empower communities with skills for positive health actions**			**All States offer training to FBOs/CBOs and community leaders on engagement with the health system by end 2012**		**932,920,761**
		6.2.1	To build capacity within communities to 'own' their health services				**932,920,761**
			6.2.1.1	Advocacy programme (Mobilization and Sensitization Program advocacy visit to Obas/Chiefs/State/LGA/Wards/Village Level meetings			677,045,214
			6.2.1.2	Building community capacity and participation			255,875,547
	6	**To strengthen the community - health services linkages**			**50% of public health facilities in all States have active Committees that include community representatives by end 2011**		**449,819,826**
		6.3.1	To restructure and strengthen the interface between the community and the health services delivery points				**449,819,826**
			6.3.1.1	Documentation of best health practices.			-
			6.3.1.2	Data collection and Information gathering on best health practices.			-
			6.3.1.3	Compilation an collation of best health practices.			449,819,826
			6.3.1.4	Sensitization and dissemination of information to the community on best health practices.			-
	6	**To increase national capacity for integrated multisectoral health promotion**			**50% of States have active intersectoral committees with other Ministries and private sector by end 2011**		**-**
		6.4.1	To develop and implement multisectoral policies and actions that facilitate community involvement in health development				**-**
	7	**To strengthen evidence-based community participation and ownership efforts in health activities through researches**			**Health research policy adapted to include evidence-based community involvement guidelines by end 2010**		**-**
		6.5.1	To develop and implement systematic measurement of community involvement				**-**
PARTNERSHIPS FOR HEALTH							
7. To enhance harmonized implementation of essential health services in line with national health policy goals							**1,557,687,671**

	7	To ensure that collaborative mechanisms are put in place for involving all partners in the development and sustenance of the health sector			1. FMOH has an active ICC with Donor Partners that meets at least quarterly by end 2010 2. FMOH has an active PPP forum that meets quarterly by end 2010 3. All States have similar active committees by end 2011		1,557,687,671
		7.1.1	To promote Public Private Partnerships (PPP)				779,822,012
			7.1.1.1	To develop implementation framework for the PPP policy.			434,382
			7.1.1.2	Strenghten the MOH PPP unit to effectively oversee and implement according to policy as it relates to health.			399,312,319
			7.1.1.3	Organisation of Stakeholders Forum on Communal Health Needs for 500 participants	Stakeholders Forum/Committee	It is assumed that the forum meets quarterly	261,874,849
			7.1.1.4	Provide guidelines on avenues for individual and corporate social responsibilities	Printed copy of the guidelines	The Local Govt creates a PPP unit which would work along with a consultant.	13,617,565
			7.1.1.5	Provide Incentive for Private Sector Involvement	% of tax rebate for Private sector involved in the PPP	We are hoping that the govt would be positively disposed to giving the proposed tax rebate	104,582,898
		7.1.2	To institutionalize a framework for coordination of Development Partners				62,862,310
			7.1.2.1	To develop a framework for the harmonisation of development partners support in health,.			799,188
			7.1.2.2				44,252,801
			7.1.2.3				12,159,941
			7.1.2.4	Create a PPP unit and a check list of identified health needs of the LGA	PPP Unit and the Check list	All the LGA health needs are forum	1,300,024
			7.1.2.5	Establish Monitoring, Evaluation and Feedback Mechanisms on all Collaborative/Partnership Efforts	Standardised form for reporting PPP activities		4,350,358
		7.1.3	To facilitate inter-sectoral collaboration				181,876,631
			7.1.3.1				145,995,256
			7.1.3.2	Establishment of protocol for PPP Operations	Protocol Booklet	the protocols are created usng the guidelines	13,762,819
			7.1.3.3	Educate policy makers at LGA level on sectoral collaboration			5,109,310
			7.1.3.4				17,009,246
			7.1.3.5				-

		7.1.4	To engage professional groups				**66,009,820**
			7.1.4.1	Promote effective partnerships with professional medical organization.			12,734,711
			7.1.4.2				12,734,711
			7.1.4.3	Create a forum for PPP unit and the relevant professional groups to discuss the identified health needs of the LGA			16,377,391
			7.1.4.4	Establish Monitoring, Evaluation and Feedback Mechanisms on selected health programmes			24,163,007
			7.1.4.5				-
		7.1.5	To engage with communities				**456,222,845**
			7.1.5.1	To support the Local Government to engage communities.			456,222,845
		7.1.6	To engage with traditional health practitioners				**10,894,052**
			7.1.6.1	To Facilitate the dissemination of traditional health practioners policy.			10,894,052
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							**3,115,375,341**
	8	**To strengthen the stewardship role of governments at all levels for research and knowledge management systems**			**1. ENHR Committee established by end 2009 to guide health research priorities 2. FMOH publishes an Essential Health Research agenda annually from 2010**		**1,196,294,851**
		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				**311,550,908**
			8.1.1.1	Develop health research policy and guidelines for Lagos state (adapted from the federal)		health research policy docoment ready at the federal level	63,683,673
			8.1.1.2	Srengthen Health Research Committee (inagurated in 2007) for the implementattion of the policy document		committee members meet quarterly for 4 hours	229,883,034
			8.1.1.3	Create research unit in the LGA		Adequate personel with reaserch skills	-
			8.1.1.4	Develop health research Agenda and strategy at the LG level		There iscapacity to do reaserch and fund	17,984,201
		8.1.2	To establish and or strengthen mechanisms for health research at all levels				**379,905,224**
			8.1.2.1	To develop protocols and guidelines for conducting research activies		committee meets regularly once in two months for 4 hours	111,646,607
			8.1.2.2	Capacity building for research team		Fund Availability	58,244,590
			8.1.2.3	Incentives for researchers		Fund availability	12,600,842
			8.1.2.4	Funding of research		Fund availability and political will	197,413,185

			8.1.2.5	Provision of technical surport for reasearch		Fund availability and political will	-
		8.1.3	To institutionalize processes for setting health research agenda and priorities				**6,300,421**
			8.1.3.1	Establishment of research protocols			420,028
			8.1.3.2	Periodic Scientific Review of research findings		Fund availability	5,880,393
		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				**213,619,268**
			8.1.4.1	Organise interactive Fora regularly between LGA and the research bodies		Readiness of the stakeholders to collaborate	57,403,834
			8.1.4.2	advocacy to policy makers in strengthening the association			5,425,362
			8.1.4.3	co-ordinate the unit to work with relevant groups		Leadrship skill	150,790,071
		8.1.5	To mobilise adequate financial resources to support health research at all levels				**240,781,082**
			8.1.5.1	advocacy to policy makers for political will		Fund Availability	945,063
			8.1.5.2	Utilisation of PPP Working Committee			239,836,019
		8.1.6	To establish ethical standards and practise codes for health research at all levels				**44,137,948**
			8.1.6.1	Setting up of ethical committee, standards and protocols		Adequate personel with reaserch skills	44,137,948
	8	**To build institutional capacities to promote, undertake and utilise research for evidence-based policy making in health at all levels**			**FMOH has an active forum with all medical schools and research agencies by end 2010**		**1,103,708,032**
		8.2.1	To strengthen identified health research institutions at all levels				**342,127,166**
			8.2.1.1	Identification and assessment of all health research institutins and organisations in the state			-
			8.2.1.1.a	Develop checklist/framework for registeration of research institutions/organisations			5,992,575
			8.2.1.1.b	Public sensitization for registration of research institution/organization/individual		All Public & Private Research institutions/organizations respond	110,257,364
			8.2.1.1.c	Conduct assessment of all the registered research institution			225,877,226
			8.2.1.5	Support research activities in identified institutions/organizations on government priority areas.		2% of health budget set aside for research	-
		8.2.2	To create a critical mass of health researchers at all levels				**193,492,923**
			8.2.2.1	Collaboration with Identified Research Institutions		Readiness of the stakeholders to collaborate	18,481,234
			8.2.2.2	LGA research fund to support researchers involved in community health identified priority problem		Community Participation and political will	140,009,351
			8.2.2.3	employ the services of a community health professional body to determine beneficiaries with a local committee		Fund Availability	35,002,338
		8.2.4	To undertake research on identified critical priority areas				**568,087,943**

			8.2.4.1	conduct bi-annual studies to identify priority diseases		There is Fund and Capacity	189,362,648
			8.2.4.2	annual studies to identify childhood priority deseases and proffer solutions		There is Fund and Capacity	189,362,648
			8.2.4.3	annual studies to identify and improve priority causes of maternal mortality		There is Fund and Capacity	189,362,648
			8.2.5.5	Srengthen Health Research Committee (inagurated in 2007) for the implementattion of the policy document		committee members meet quarterly for 4 hours	-
	8	**To develop a comprehensive repository for health research at all levels (including both public and non-public sectors)**			**1. All States have a Health Research Unit by end 2010 2. FMOH and State Health Research Units manage an accessible repository by end 2012**		**118,566,919**
		8.3. 1	To develop strategies for getting research findings into strategies and practices				**113,666,592**
			8.3.1.1	organise interactive Fora between LGA and the researcher bi-annually		Collaboration and Political will	82,164,488
			8.3.1.2	publish key findings			31,502,104
		8.3. 2	To enshrine mechanisms to ensure that funded researches produce new knowledge required to improve the health system				**4,900,327**
			8.3.2.1	Advocacy to the policy makers		Staff Commitment	4,900,327
	8	**To develop, implement and institutionalize health research communication strategies at all levels**			**A national health research communication strategy is in place by end 2012**		**696,805,540**
		8.4. 1	To create a framework for sharing research knowledge and its applications				**619,261,360**
			8.4.1.1	Estabish a mechanism for regular interaction between Programmers, Researchers and Policy makers for promotion of positive health developments; bi-annual research forum		all stakeholders attend	615,341,099
			8.4.1.2	support the functions of the mechanism			-
			8.4.1.3	Implementation of national and state strategies at the local level		Staff Commitment	3,920,262
		8.4. 2	To establish channels for sharing of research findings between researchers, policy makers and development practitioners				**77,544,179**
			8.4.2.1	Create Interactive Forum for reserchers, policy makers and development partners		There is Fund and Capacity	77,544,179
Total							**155,768,767,051**

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