KEBBI STATE GOVERNMENT

STRATEGIC HEALTH DEVELOPMENT PLAN
(2010-2015)

Kebbi State Ministry of Health

March 2010

Contents

LIST OF ACRONYMS AND ABBREVIATIONS

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
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
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
UN-System	United Nations-System
VAT	Value Added Tax
VHW	Village health workers
VOC	Vote-of-charge
WHO	World Health Organization

ACKNOWLEDGEMENT

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

PREFACE

Nigeria's overall health system performance was ranked 187th position among 191 member States by the World Health Organization (WHO) in 2000. Primary Health Care (PHC), which forms the bedrock of the national health system, remains in a prostrate state due to gross under funding, mismanagement and lack of capacity at the LGA level. The 2003 NDHS indicators demonstrating the performance of the health system indicate an immunization coverage of 23%; 6% of under-fives sleeping under insecticide treated nets (ITNs) with only a third of children with fever appropriately treated with antimalarials at home and less than half of deliveries attended to by skilled health personnel. It is noted that wide variations of these indicators exist in different geographical zones, states and rural/urban locations.

Recognizing that recent improvement in Nigeria's macroeconomic performance have not translated into discernable improvement in the health system and quality of life of Nigerians, the Federal Government's 7-Point Development Agenda has underscored human capital development as the bedrock of this national agenda with explicit reference to the health sector. Access to quality health care and prevention services are therefore considered vital for poverty reduction and economic growth, particularly as Nigeria is lagging behind in attaining the health-related MDGs.

In order to meet the challenges of achieving improved health status particularly for its poorest and most vulnerable population, the health system must be strengthened; proven cost-effective interventions must be scaled up and gains in health must be sustained and expanded. The Federal Ministry of Health (FMOH) appreciates that this can best be done within the context of a costed National Strategic Health Development Plan (NSHDP), which is aimed at providing an overarching framework for sustained health development in the country. The NSHDP is to be developed in accordance with extant national health policies and legislation, and international declarations and goals to which Nigeria is a signatory to, namely; MDGs, Ouagadougou Declaration on PHC and the Paris Declaration on Aid Effectiveness.

As a prelude to the development of the NSHDP, a generic Framework has been developed to serve as a guide to federal, states and LGAs in the selection of evidenced-based priority interventions that would contribute to achieving the desired health outcomes for Nigerians. It is expected therefore, that in using this Framework, the Federal, States and LGAs would respectively develop their respective costed plans through participatory approaches to reflect their context and prevailing issues. The end product being a harmonized National Strategic Health Development Plan with its appropriate costing will thereafter serve as the basis for

collective ownership, adequate resource allocation, inter-sectoral collaboration, decentralization, equity, harmonization, alignment, and mutual accountability in Nigeria. It would also stipulate requirements for future health investments towards achieving sustainable universal access and coverage within the planned period of 2009 - 2015.

Major steps adopted in the development of the NSHDP Framework included the conduct of 10 background studies; inauguration of a steering committee and technical working group comprising of government, development partners, CSOs, private sector, academicians and experts in development planning. Through the review of technical resource materials, wide consultations and participatory techniques, eight priority areas of concern to improve the Nigerian health system were identified namely: leadership and governance, service delivery, health financing, human resources for health, health information system, community participation and ownership, partnerships for health development and research for health. For each of the priority areas, this framework details the context, goals, strategic objectives, and recommended evidence-based and cost-effective interventions required to deliver improved performance of the health system and health outcomes for Nigerians.

Immunization is one of the most successful and cost-effective health interventions ever. It has eradicated small-pox, lowered the global incidence of polio so far by 99% and achieved dramatic reductions in illness, disability and death from diphtheria, tetanus, whooping cough and measles. In 2003 alone, it is estimated that immunization averted more than 2 million deaths.

Immunization services are increasingly used to deliver other important health interventions, making them a strong pillar of health systems.

Immunization will help to achieve the Millennium Development Goals on reducing child mortality, improving maternal health and combating diseases, eventually including malaria and HIV/AIDS.

In spite of its undisputed past success and promising future, however, immunization remains an unfinished agenda.

It is alarming that globally and in some regions immunization coverage has increased only marginally since the early 1990s.

Approximately 2.5 million children under five years of age die every year as a result of diseases that can be prevented by vaccination using currently available or new vaccines.

Together we can and will change these sobering statistics.

Global Immunization Vision and Strategy guides countries on how to immunize more people against more diseases; introduce newly available life-saving vaccines and technologies; and

provide other critical health interventions (e.g. nutrition and malaria control) at immunization contacts.

Global interdependence has increased the vulnerability of people everywhere to the uncontrolled spread of diseases through epidemics. The mounting threat of an influenza pandemic highlights the need to strengthen international solidarity, mutual support and work through partnerships to contribute to improving global health and security.

EXECUTIVE SUMMARY

Kebbi state vision by 2015 is "to reduce the morbidity and mortality rates due to communicable diseases to the barest minimum; reverse the increasing prevalence of non-communicable diseases; meet global targets on the elimination and eradication of diseases; and significantly increase the life expectancy and quality of life of Kebbi State indigenes in particular and Nigerians in general". This is expected to be achieved by "developing and implementing appropriate policies and programmes as well as undertaking all other necessary actions that will strengthen the Kebbi State Health System to deliver effective, quality and affordable health care services.

The overarching goal of the Kebbi State SHDP is to significantly improve the health status in Kebbi States through the development of a strengthened and sustainable health care delivery system.

Kebbi state was created in 1991 and has a projected 2009 total population of 3,549,253. It comprises of 21 LGA's and 225 political wards spread into 4 Emirate Councils (Argungu Emirate, Gwandu Emirate, Yauri Emirate and Zuru Emirate). The major tribes include Hausas, Fulani, Kabawa, Dakarkari, Fakkawa, Gungawa and Kambarawa, all of which have predominant economic activities as farming and trading.

The State shares international borders with Niger Republic in the North and Republic of Benin in the North west, in-country to its south it shares borders with Niger state and in the east with Sokoto and Zamfara states.

The health system remains overstretched by a burgeoning population; physical facilities are decaying, equipment are obsolete and there is scarcity of skilled health professionals. In addition, the roles of stakeholders are misaligned and coordination systems are weak. These are further compounded by the dearth of data which poses a challenge to evidence based planning, policy formulation, resource allocations and health systems management.

Many of the public primary health care (PHC) facilities serve only 5-10% population of their capacities or potential patients load due to loss of confidence in public PHC facilities, as such the secondary and tertiary facilities are used more or less as primary health care facilities. The referral system between the various levels of health care is inefficient and virtually non-existent. The 2008 NHDS indicates very weak health indicators inclusive of BCG 15.1%, DPT3 7.2%, Polio3 28.3% and Measles 21.1%. Percentage with antenatal care from a health professional is 12.3%, Percentage whose last live birth was protected against neonatal tetanus is 11.7%, 6.2% of pregnant women were delivered by a health professional with 4.8% delivered in a health facility.

It is important to note that the in contrast to the above, for the period Jan to Sept 2009, Routine Immunization coverage by antigens shows much higher coverage (BCG 58%, DPT3 65%, HB3 68%, Polio3 80%, Measles 72%, TT2+ 45%).

Despite this indication of progress, concerted efforts are needed to resuscitate the decaying infrastructure, address the serious technical manpower deficiencies e.g. urban areas typically have more health workers than rural areas, which is at variance to the poor health indicators in rural areas.

The State budget for health represents the primary and major source of health financing especially for the Secondary health facilities, while the ministry of local government affairs bears the cost of salaries and allowances for human resource for health. The trend for total health expenditure as percentage of State budget is still difficult to arrive at because not all health expenditure has been captured. However, the total health budget by State Ministry of Health as against Kebbi State Budget using 2008 and 2009 budgets is about 11%.

Under the strategic direction to address the aforementioned challenges and limitations, a state minimum health care package to deliver improved health outcomes for the state has been adopted and contains high impact cost effective health services. It serves as the platform for strengthening the health system in the state alongside the 8 priority areas.

Implementation modalities for the plans includes roles and responsibilities for state and LGA levels, community participation, professional bodies, CSOs, Public-Private Partnership, and inter-sectoral collaborations

The 1991 Report of the Committee on Blue Print for the Development of Kebbi State (Health chapter) recommended that there should be regular inspection of the secondary health institutions. The Task Force Committee on Health (1991) for the newly created Kebbi State recommended the reorganisation of the Kebbi State Ministry of Health according to the then civil service reforms which assigned the role of monitoring and evaluation to the Directorate of Planning Research and Statistics, which replaced the Inspectorate Division that used to carry out the function of monitoring and evaluation.

The monitoring and evaluation of the implementation of the SHDP plan will incorporate all the monitoring and supportive supervision in an integrated manner. It will employ an integrated tool designed to capture relevant indicators in the 8 components of Kebbi state SHDP

VISSION AND MISSION

Vision

"To reduce the morbidity and mortality rates due to communicable diseases to the barest minimum; reverse the increasing prevalence of non-communicable diseases; meet global targets on the elimination and eradication of diseases; and significantly increase the life expectancy and quality of life of Kebbi State indigenes in particular and Nigerians in general".

Mission Statement

"To develop and implement appropriate policies and programmes as well as undertake other necessary actions that will strengthen the Kebbi State Health System to be able to deliver effective, quality and affordable health.

The overarching goal of the Kebbi State SHDP is to significantly improve the health status in Kebbi States through the development of a strengthened and sustainable health care delivery system.

CHAPTER 1: BACKGROUND AND ACHIEVEMENTS

1.1 Background

Kebbi state was created in 1991, it has a population of 3,238,628 in the 2006 census, this will amount to a projected population of 3,549,253 in 2009There are 21 LGA's, and 225 political wards spread into 4 Emirate Councils (Argungu Emirate, Gwandu Emirate, Yauri Emirate and Zuru Emirate)

The major tribes include Hausas, Fulani, Kabawa, Dakarkari, Fakkawa, Gungawa and Kambarawa.

The State shares international border with Niger republic in the North and Benin republic in the North western part, while in the South it shares borders with Niger state and in the east Sokoto and Zamfara states.

The health facilities in the state include 1 tertiary hospital, 32 secondary health facilities and 124 PHC and 584 clinics. The state also has a Public health laboratory and 6 other laboratories, with 1 referral laboratories.

1.2 Achievements

Over the years, since the creation of Kebbi State 17 years ago, successive governments of the state have made tremendous efforts to improve the healthcare delivery system. Progress has been made in provision of infrastructural facilities with fairly equitable distribution across the whole state including coverage of areas that have been, hitherto, underserved.

Adoption of the Ward Health System as a deliberate policy to ensure community participation in PHC delivery which is in line with the current National Health Policy to improve and ensure sustainable health services with full and active participation of people at the grass root level.

In the last 17 years efforts have been made to alleviate the poverty level in the general population and improve the health care delivery to the poor.

Many different programmes targeted at improving the health status of the population had been initiated (Ahmed 2007). The scheme that provides free drugs to all pregnant women and children under 5 years is one of such initiatives.

Surgical consumables are subsidized by government for all patients, while drug

dispensing under the DRF programme includes provision of waivers for a variety of patients-including the paupers.

Furthermore, some special treatments are free. These include treatments for HIV/AIDS, TB & leprosy.

It is also worth noting that free catering service is extended to the paupers in some general hospitals-particularly Sir Yahaya Memorial Hospital, Birnin Kebbi.

CHAPTER 2: SITUATION ANALYSIS

2.1 Socio-economic context

The predominant economic activities among people in Kebbi State are farming and trading, x% of people in Kebbi State are said to be living in poverty. Key socio economic determinants of health in Kebbi State show that, literacy level is very low at 13% for females and 62% for men; households with improved source of drinking water are 72%, households with electricity are 38%, employment status is 58% for females and 88.6% for male, while 38% of households have improved sanitary facilities. These data shows varying degrees of access to basic services with much needing improvement.

There has been a downward trend in health performance and development since 1993. Preventable diseases accounts for most of Nigeria's disease burden and poverty is a major cause of these problems.

70% of total health expenditure is born mostly out of pocket expenses despite the endemic nature of poverty.

Our maternal mortality rate about one mother die in every one hundred births is one of the highest in the world and most of these women deliver at home either unattended to or by Traditional Birth Attendants (TBAs).

Under 5's mortality rate and adult mortality rates are higher than average for most of the states in Nigeria and increasing poverty in general coupled with the current economic melt down compounds the situation.

2.2 Health status of the population

Women and children under five constitute 22.9% and 20.18% of the population of Kebbi State respectively. These are the mos at risk groups. The leading cause of morbidity in Kebbi State is Malaria with 250,359 cases in 2008 as reported by the State epidemiology unit.

Other disease of priority in the state are as shown the following tables and figures

Table 1: Priority diseases in Kebbi State

		IDS PRIORITY DISEASES IN KEBBI STATE 2002 TO 2008						
	2002	2003	2004	2005	2006	2007	2008	
DISEASES	CASES	CASES	CASES	CASES	CASES	CASES	CASES	Rank
CSM	39	34	49	36	70	25	1770	13
Measles	784	4087	3171	7591	162	740	6413	7
Poliomyelitis	1	38	36	86	3	8	9	15
Leprosy	728	270	635	519	132	269	358	8
NNT	76	57	78	51	18	14	3	14
Acute Watery Diarrhoea	39792	43205	53664	71095	24497	70636	75904	2
B Diarrhoea	27443	26627	33675	46938	15250	47567	47086	3
Pneumonia	12933	16144	17947	18912	6279	34781	26702	4
TB	530	245	445	494	307	367	591	10
STIs	1228	1973	3446	10484	1713	4316	3382	6
Hepatitis	101	84	69	95	14	31	0	12
Malaria	92118	98151	143788	243792	86755	328066	250359	1
Pertussis	1048	616	1220	630	216	364	393	9
HIV/AIDs	140	82	49	62	17	477	424	11
		KBER=Kebbi State Epidemiologist Report (State Ministry of Health)						

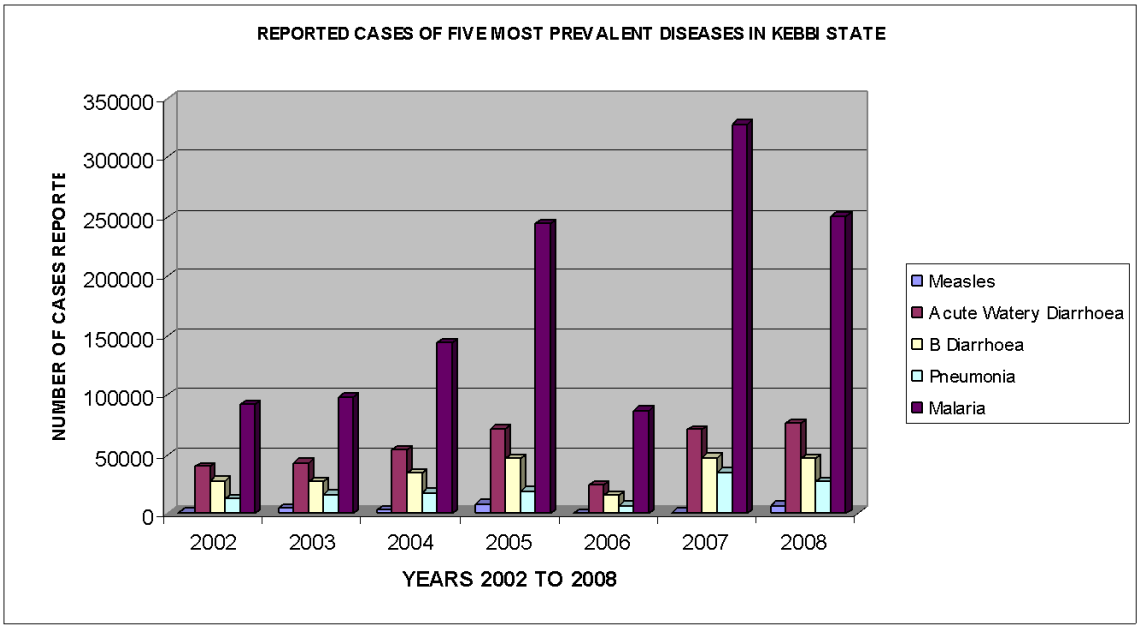

Figure 1: reported cases of five most prevalent diseases in Kebbi State

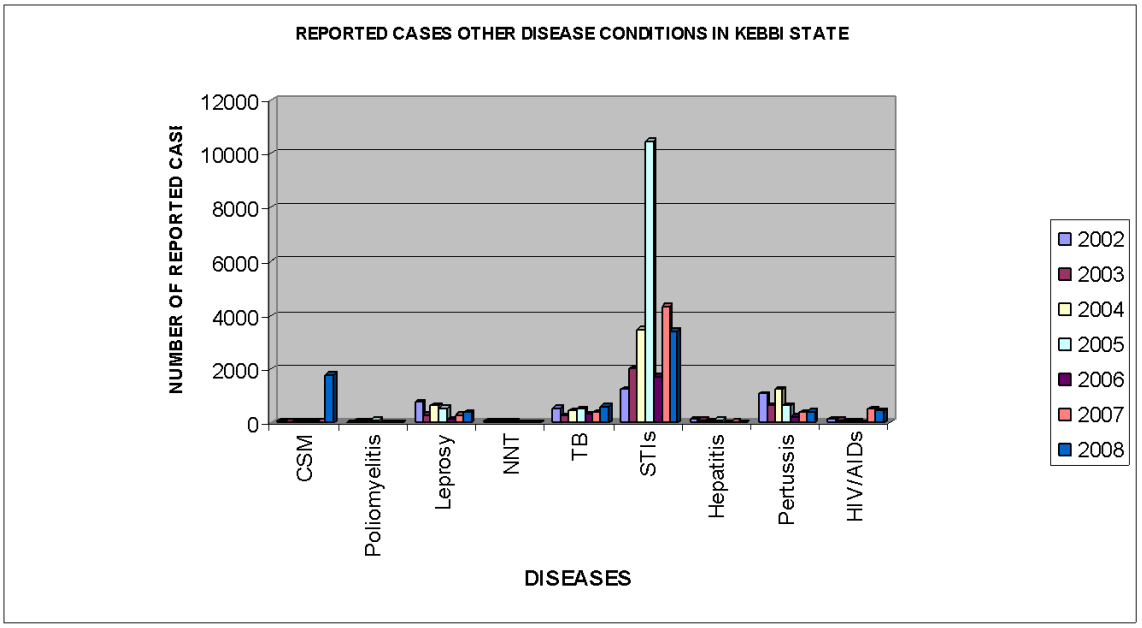

Figure 2: reported cases of other disease conditions in Kebbi State

Table 2: Deaths related to some priority diseases in Kebbi State

	IDS PRIORITY DISEASES IN KEBBI STATE 2002 TO 2008						
	2002	2003	2004	2005	2006	2007	2008
DISEASES	DEATHS	DEATHS	DEATHS	DEATHS	DEATHS	DEATHS	DEATHS
CSM	12	2	11	8	7	4	49
Measles	40	177	186	389	4	11	94
Poliomyelitis	1	0	0	0	0	0	0
Leprosy	0	0	0	0	0	0	0
NNT	0	8	4	7	3	2	1
Acute Watery Diarrhoea	51	165	150	157	51	113	156
B Diarrhoea	53	56	103	68	27	77	41
Pneumonia	53	103	116	87	19	18	97
TB	5	1	2	2	4	1	3
STIs	0	5	23	0	1	1	6
Hepatitis	0	1	4	2	1	3	0
Malaria	340	645	644	592	216	634	764
Pertussis	1	7	7	1	4	0	0
HIV/AIDs	10	5	1	1	1	1	13

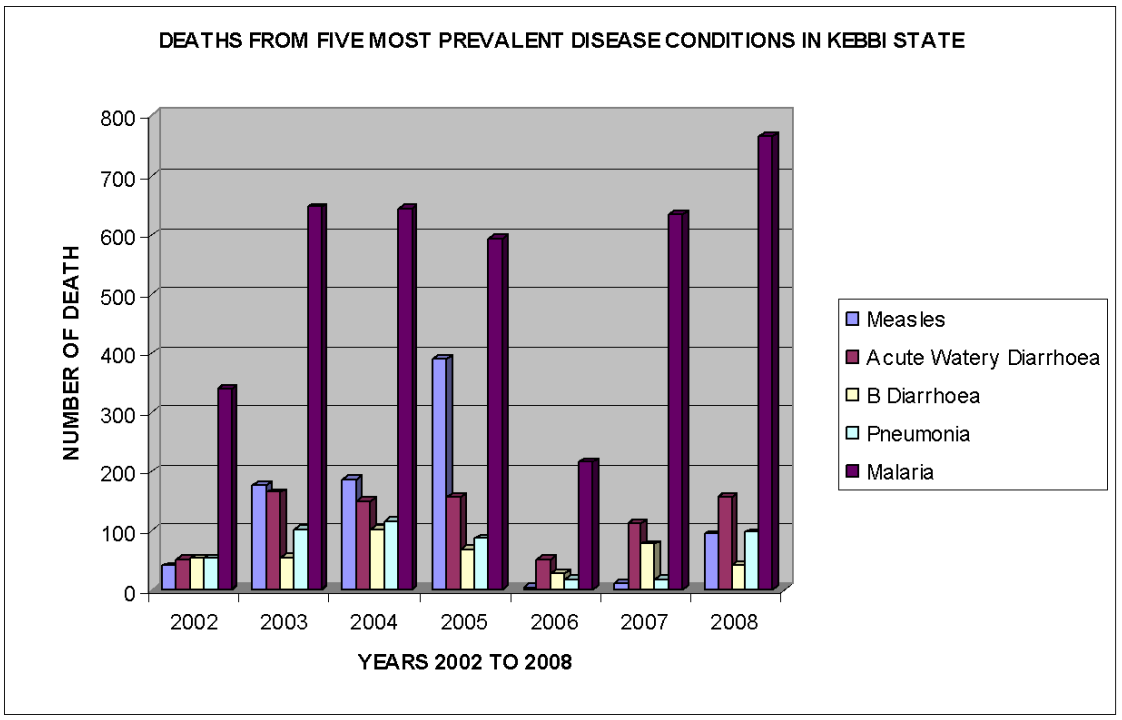

Figure 3: Deaths from five most prevalent disease conditions in Kebbi State

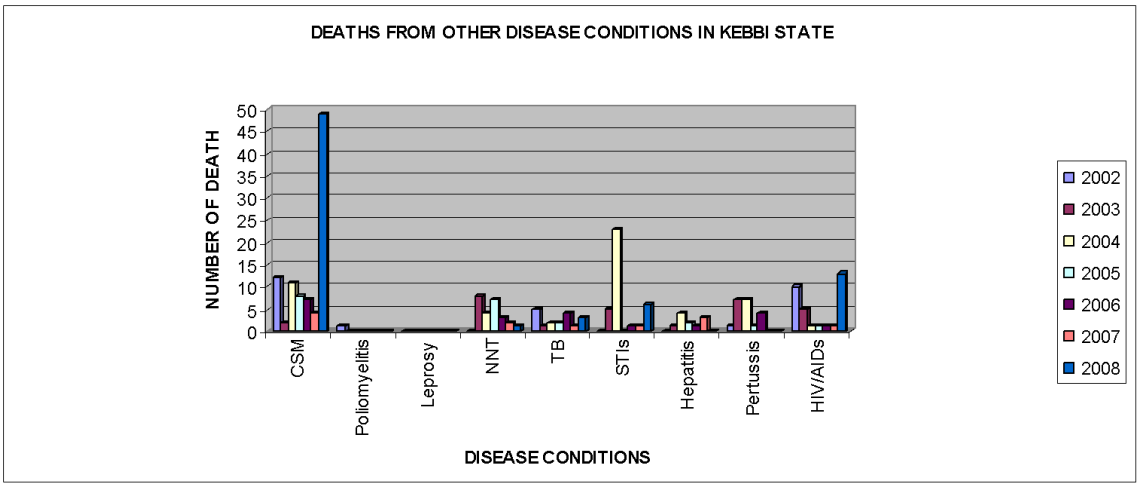

Figure 4. Deaths from other disease conditions in Kebbi State

2.3 Health services provision and utilization

Disease programs such as HIV/AIDs, TB, Malaria, Reproductive health care etc are being implemented within a weak health system and little or no impact is being made. Routine immunization coverage is low below 25% for most of the antigens used as proxy indicator such as DPT3 and Measles.

Kebbi State government has the responsibility for secondary health care through its secondary facilities and the Federal Medical Centre, Birnin Kebbi provides tertiary care services; while the local government has the responsibility of the primary health centres and health posts in their wards. The State also Hafsat Eye Centre and VVF Centre which provide specialist care services.

Many of the primary health care (PHC) facilities serve only 5-10% population of their capacities or potential patients load due to loss of confidence in PHC facilities as such the secondary and tertiary facilities are used more or less as primary health care facilities.

The referral system between the various levels of health care is inefficient and virtually non existent. Until 2008 when deliberate efforts have been to reverse the situation, in this regard twenty four ambulances procured were distributed to the 15 general hospitals. Furthermore, 15 call duty vehicles have also been procured and distributed. In addition, one ambulance vehicle has also been procured by each LGA in the State. These will no doubt impact positively on the patient care generally and referral system in particular.

Available health service performance/utilization data from the NDHS 2008 shows the following:

Table 3. Health service performance/utilization indicators for Kebbi State

POPULATION (2006 Census)	KEBBI
Total population	**3,256,541**
female	1,624,912
male	1,631,629
Under 5 years (20% of Total Pop)	657,356
Adolescents (10 – 24 years)	946,208
Women of child bearing age (15-49 years)	747,801
INDICATORS	**NDHS 2008**
Literacy rate (female)	13%

Literacy rate (male)	62%
Households with improved source of drinking water	72%
Households with improved sanitary facilities (not shared)	38%
Households with electricity	38%
Employment status (currently)/ female	58.0%
Employment status (currently)/ male	88.6%
Total Fertility Rate	6
Use of FP modern method by married women 15-49	2%
Ante Natal Care provided by skilled Health worker	12%
Skilled attendants at birth	6%
Delivery in Health Facility	5%
Children 12-23 months with full immunization coverage	5%
Children 12-23 months with no immunization	51%
Stunting in Under 5 children	64%
Wasting in Under 5 children	35%
Diarrhea in children	8.6
ITN ownership	5%
ITN utilization (children)	4%
ITN utilization (pregnant women)	2%
children under 5 with fever receiving malaria treatment	7%
Pregnant women receiving IPT	2%
Comprehensive knowledge of HIV (female)	39%
Comprehensive knowledge of HIV (male)	14%
Knowledge of TB (female)	47.3%
Knowledge of TB (male)	73.5%

Source: NDHS 2008

Table 4. Immunization Coverages

BCG	15.1
DPT 1 DPT 2 DPT 3	26.5 19.9 7.2
POLIO 0	12.7

POLIO 1 POLIO 2 POLIO 3 Measles	48.8 42.2 28.3 21.1
All	4.8
No Vaccination	50.6
Percentage with a vaccination card	4.2
Number of children	126

Source: NDHS 2008

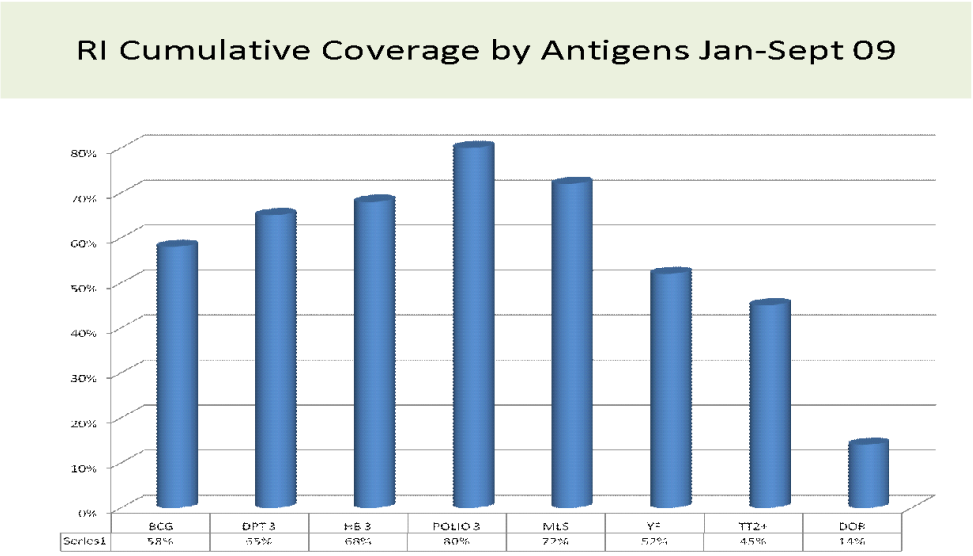

Figure 5.

The 2009 Jan to Sept. Routine Immunization coverage by antigens however shows much higher coverage (BCG 58%, DPT3 65%, HB3 68%, Polio3 80%, Measles 72%, TT2+ 45%) as indicated from state data on Routine Immunization (RI) than reported on the NDHS 2008 draft (BCG 15.1%, DPT3 7.2%, Polio3 28.3 and Measles 21.1%

2.4 Key issues and challenges

Significant progress have been made in the rehabilitation of physical infrastructure. The challenges of health manpower need to be address frontally. The disparity in the manpower

disposition between urban and rural areas needs to be addressed. Accordingly health indicators in rural areas are worse than in urban areas. For example, 26% of women in rural areas deliver with a doctor, nurse, or midwife compared with 59% of women in urban areas (NDHS 2003).

Nigeria with an estimated infant mortality rate of 75 per 1000 live births, child mortality rate of 88 per 1,000 live births, under 5 mortality rate of 157 per 1,000 live births[1] and a maternal mortality ratio of 800 per 100,000 live births, contributes a disproportionate 10% to the global burden of maternal and also infant mortality[2]. Infant and child mortality in the North West zone of the country is generally twice the rate in the southern zones while the maternal mortality in the North West is 9 times the rate of 165/100, 000 recorded in the South West Zone[7].

There is need to focus on high-impact health interventions, including tackling the deteriorating primary healthcare facilities, widen the scope of the Ministry of Health, consolidate the gains of poverty alleviation programmes and the public-private partnership, mount and sustain vigorous monitoring and evaluation programme-including the component of reliable data gathering, concentrate on enforcing attitudinal change of the health staff and involve the community at all levels of healthcare delivery as well as poor coordination of donors and development partners.

3.1.1 General Observations on Primary Health Care Facilities

3.1.1.1 The Need to improve PHC facilities

The general consensus that improvement of the secondary and tertiary health care facilities without, parri passu, improving the primary health care, will continue to aggravate the current situation whereby, the communities lose confidence in primary health care facilities, and flock to the secondary and tertiary centres – rendering the latter overcrowded and also ineffective.

3.1.1.2 General Deterioration of Facilities

While some primary health centres (e.g. Gwandu, Besse, Ambursa) have solid building structures and may even have a doctor (usually from NYSC), the vast majority of the facilities –including the rural dispensaries are grossly dilapidated and all suffer from non-functional utilities – poor water supply and non-functional power generating plants.

3.1.1.3 Lack of Running Cost

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[1] National Population Commission (2008) *National Demographic and Health Survey* Abuja: National Population Commission

[2] Federal Ministry of Health (2008) *Integrated Maternal, Newborn and Childhealth Strategy.* Federal Ministry of Health, Abuja

Except for the Model Primary Health Centre in Besse, and the one in Bagudo which are given N10,000 per month, most of the PHCs have not received any funding for running the facilities – since 2002. Where generators exist, the plants lie dormant due to lack of fuel.

3.1.1.4 Poor Equipment Base

The equipment base of most of the primary health care facilities is extremely poor, the laboratories are either virtually non-existent or are very rudimentary – below the WHO standard for provision of basic laboratory investigations recommended for the developing countries.

3.1.1.5 **Staffing Situation/Paucity of Qualified Midwives**

There is paucity of qualified midwives to handle deliveries in maternal and child health clinics until recently (MCHs). Consequently, with the arrival of 96 midwives under the Midwives Service Scheme (MSS), the staffing situation will greatly improve at the LGAs.

3.1.1.6 **Poor Attitude to Work**

The attitude of both the clinical and administrative staff to work is very poor. This leads to loss of confidence of the community in utilizing the health care facilities.

3.1.1.7 **Some Positive Aspects**

The immunization coverage is very good – thanks to availability of functional solar refrigerators in all the PHCs and MCHs-ensuring the maintenance of the cold chain. However, training of staff on the use and maintenance of these refrigerators is an issue that has not been addressed. The other commendable aspect is that salaries of all staff are regularly paid, although some PHCs have problems with payments of call duty and shift duty allowances.

3.1.1.8 **Community Participation**

Community involvement in health care delivery, in the maintenance of facilities and in decision making is not well developed. Consequently, some of the facilities are grossly neglected and have fallen into total disuse. This poor attitude is particularly more glaring with regards to rural dispensaries, where for instance, some dispensary buildings (e.g. at Gulmare) have completely collapsed, with no signs of any intension of rehabilitation.

3.1.1.9 **Drug Revolving Fund/Bamako-Initiative Variant**

The Drug Revolving Fund does not exist in the PHC facilities. Drugs are often purchased by the pharmacy technician in charge with personal resources and sold to the public at prices dictated by the owner of the drugs, but sold in the public facilities.

3.1.1.10 **Poverty Alleviation Programme/Free Drug Scheme**

The free-drug scheme of the State Government has not been extended to the PHC facilities which mainly serve the rural populace-whose poverty is known to be more severe than in urban population. Method of payment for drugs and consumables at the primary health care is predominantly an out-of-pocket basis. This form of health care financing is considered the most regressive form of health care financing, because the poor's burden of payments for health care is not shared by the richer segments of the society.

Poor Referral System: None of the 33 PHCs has a functional ambulance service. Hence referral of critically ill patients is very problematic – leading deaths that are potentially avoidable.

Treatment Protocols: Of the 33 PHCs only the model PHC in Besse has written treatment protocols (which were also outdated). Basic literature for primary health care is not widely available. Standard tests, such as WHO guidelines on immunization techniques, district laboratory manuals, IMCI protocols, posters on BFHI, code of ethnics of marketing BMS are not available in any of the primary health care facilities.

Other Primary Health Care activities of the promotive/preventive aspects of primary health care. Growth monitoring is the least practiced. Appropriate scales are rarely available

CHAPTER 3: STRATEGIC HEALTH PRIORITIES

The Eight Strategic Health Priorities for strengthening the health system in the State as detailed Annex 1, have been re-priotized by the State and are as listed below;

1. Health Service Delivery
2. Human Resource for Health
3. Governance and Leadership
4. Health Financing
5. National Health Management Information Systems
6. Community Participation and Ownership
7. Partnership for Health
8. Research for Health

However, the Essential Package of Health Services for Kebbi 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

CHAPTER 4: RESOURCE REQUIREMENTS

4.1 Human

Kebbi State has an existing human resource policy, plan to meet the human resource needs and other identified critical issues especially by implementing the recommendations of the technical team report on health.

NUMBER OF HEALTH PERSONNEL BY TYPE.

Table 5: Distribution of Doctors in 14 General Hospital, Kebbi State, April 2008

General Hospital	Consultant	PMO/CMO	Doctors >10yrs post-qualification	Other Doctors	Total	Short fall
Argungu	Nil	1	2	3 + 1 Dentist	6	-
Aliero	Nil	1	1	3	5	1
Zauro-Ambursa	Nil	1	-	1	2	2
Dirin Daji	Nil	1	-	-	1	3
Illo	Nil	1	0	-	1	4
Jega	Nil	1	-	3	4	5
Kamba	Nil	1	-	3	4	2
Koko	Nil	1	-	3	4	2
Maiyama	Nil	1	-	1	2	2
Senchi	1	-	-	-	1	3
Wasagu	Nil	1	-	-	1	2
Wara	Nil	1	-	1	2	3
Yauri	Nil	1	2	2	5	3
Zuru	Nil	1	1	3	5	4
Total	**1**	**12**	**6**	**23**	**43**	**50**

Source: findings on human resources Kebbi State, april, 2008 secondary health care

Table 6: distribution of nursing staff in general hospitals & moh

General Hospital	CNO	ACNO	PNO	SNO	NO I	NO II	Mid wives	Total
Sir Yahaya Mem. Hosp.	38	10	2	2	3	31	8	93
Gen. Hospital Argungu	3	2	6	2	1	10	2	6
Gen. Hospital Am/Zauro	7	1	1	-	-	2	-	11
Gen. Hospital Aliero	5	1	2	2	-	7	-	17
Gen. Hospital Bena	3	-	2	2	-	1	1	9

Gen. Hospital Dirin Daji	1	2	4	-	-	2	1	10
Gen. Hospital Illo	2	-	1	-	1	2	1	7
Gen. Hospital Jega	10	3	-	1	1	5	1	21
Gen. Hospital Kamba	5	2	1	1	1	2	1	13
Gen. Hospital Koko	19	1	3	6	2	6	-	37
Gen. Hospital Maiyama	2	2	2	-	-	3	2	11
Gen. Hospital Senchi	2	-	1	2	-	1	-	6
Gen. Hospital Wasagu	4	1	3	1	-	1	-	10
Gen. Hospital Warra	3	1	2	-	1	3	-	10
Gen. Hospital Yauri	21	2	4	1	5	8	2	43
Gen. Hospital Zuru	28	2	15	5	3	8	2	63
Centre F.V.V	8	-	3	1	2	1	2	15
TOTAL	185	30	44	23	18	85	16	412

3.1.2 **Current Status of Human Resources in Primary Health Care Facilities**

The staffing situation in all the PHC facilities is grossly inadequate.

Table gives detailed distribution of the various cadres of personnel in all the PHCs visited. It is obvious that:

1. Except 3 NYSC doctors, none of the remaining 124 PHCs have a doctor.
2. Overall, the total number of CHOs is 17, which is half of what is required to cover the existing PHC's.
3. The situation with regards to midwives is particularly precarious-as there are only 3 qualified midwives for the 33 PHCs in the services of the LGAs. However, 96 midwives have been deployed under the MSS.

3.2.1.6 <u>Staffing in secondary health Care facilities in Kebbi State</u>

The staffing situation is not only grossly inadequate, but has the following undesirable peculiar characteristics:

(a) *Doctors*: There are only 7 consultant/specialist in general hospitals in Kebbi State. There is also grossly inadequate medical manpower to handle general hospitals.

(b) *Nurses*: in all the general hospitals the top-level cadre of nursing staff (ACNO's, CNO's) is blown out of proportion to the lower level cadre – with the result that the quality of nursing care in most general hospitals has deteriorated, since the CNO's and ACNO's do

not usually run duty shifts. The few junior nurses that do most of the bedside nursing are often overworked and rendered inefficient.

Table 7: distribution of staff in secondary health care facilities in Kebbi State

S/N	Name of Facility	No. of Pharmacists	No. of Pharm. Tech.
1.	Headquarters	2	3
2.	State Medical Stores	1	5
3.	Gen. Hospital Argungu	2	9
4.	Gen. Hospital Koko	-	5
5.	Gen. Hospital Jega	1	4
6.	Gen. Hospital Senchi	-	3
7.	Gen. Hospital Aliero	-	4
8.	Gen. Hospital Wasagu	-	1
9.	Gen. Hospital Maiyama	-	2
10.	Gen. Hospital Wara	-	3
11.	Gen. Hospital Yauri	3	6
12.	Gen. Hospital Illo	-	2
13.	Gen. Hospital Kamba	-	8
14.	Gen. Hospital Dirin Daji	-	1
15.	Gen. Hospital Zauro/Ambursa	-	5
16.	Gen. Hospital Zuru	2	8
17.	Gen. Hospital Bena	1	1
18.	V.V.F. Centre	-	5
TOTAL		**12**	**75**

There is dearth of qualified pharmacists. 12 pharmacy units in general hospitals of Kebbi State are manned mainly by pharmacy technicians. There are only 8 pharmacists practicing in the general hospitals in the State. Overall, currently there are only 10 trainee pharmacists of Kebbi State origin, distributed in only 2 pharmacy faculties in Nigerian Universities (3 in ABU Zaria, and 7 in the newly created Faculty of Pharmacy in UDUS). Trained pharmacists of Kebbi State origin do not readily take up appointment with Kebbi State, and if they do, they rarely remain in the State. This is because they are poorly motivated and poorly remunerated. The remunerations are not attractive. A starting grade level – 9 (Hatiss 8) for a pharmacy graduate – who trained for 8 years (6 years in the University, 1 year as pharmacy intern and 1 year as NYSC pharmacist) is not attractive. The Kebbi State Government has not yet implemented the recommended Salary Grade Level 10 as the entry – point for pharmacists.

(d) *Laboratory Staff*: There is gross inadequacy of qualified laboratory scientists in the State with histopathology worst affected. There is not a single histopathology lab scientist in the State. Coupled with total absence of a consultant histopathologist, the manpower in this important aspect of lab medicine is virtually non-existent, so are the services.

(e) Other Supporting Staff:

Table 8: distribution laboratory staff in secondary health care facilities in Kebbi State

General Hospital	Laboratory Staff					Total
	Consultant Specialist	Lab Scientist	Lab Technicians	Lab Assistant	Non-Registrable Lab Staff	
Sir Yahaya Mem. Hosp.	-	6	30		7	36
Gen. Hospital Argungu	-	1	18			19
Gen. Hospital Amb/Zauro	-	-	3			3
Gen. Hospital Aliero	-	-	4			4
Gen. Hospital Dirin Daji	-	-	5			5
Gen. Hospital Illo	-	-	1			1
Gen. Hospital Jega	-	1	11			12
Gen. Hospital Kamba	-	1	4			5
Gen. Hospital Koko	-	1	10			11
Gen. Hospital Maiyama	-	-	3			3
Gen. Hospital Senchi	-	-	3			3
Gen. Hospital Wasagu	-	-	9			9
Gen. Hospital Yauri	-	1	9			10
Gen. Hospital Zuru	-	1	15		2	16
Gen. Hospital Wara	-	-	2			2
TOTAL		**8**	**97**		**9**	**139**

Table 9: distribution of medical record officer at health facilities

S/N	Facilities	No. of Officers
1.	Ministry of Health Headquarters	22
2.	Gen. Hospital Yauri	6
3.	Gen. Hospital Argungu	18
4.	Gen. Hospital Koko	11
5.	Gen. Hospital Zuru	14
6.	Gen. Hospital Jega	4
7.	Gen. Hospital Aliero	3
8.	Gen. Hospital Bunza	4
9.	Gen. Hospital Illo	3
10.	Gen. Hospital Wara	3
11.	Gen. Hospital Senchi	2
12.	Gen. Hospital Kamba	7

13.	Gen. Hospital Maiyama	3
14.	Gen. Hospital Zauro/Ambursa	3
15.	Sir Yahaya Memorial Hospital	15
16.	Gen. Hospital D/Daji	2
17.	Hafsat Eye Centre	9
18.	V.V.F. Centre	5
19.	Gen. Hospital Gwandu	2
20.	Gen. Hospital Bagudo	3
21.	Gen. Hospital K/Giwa	2
22.	Gen. Hospital Bena	3
23.	Gesse Clinic	6
24.	M.C.H. B/Kebbi	1
25.	M.C.H. Yauri	1
26.	ZHO Argungu	2
27.	ZHO Yauri	1
28.	ZHO Zuru	1
29.	ZHO Bunza	3
30.	ZHO Jega	1
31.	S.H.T. Jega	5
32.	Epid Unit	1

Table 10: distribution of technical & supporting staff in General hospitals: Kebbi State, April, 2008

General Hospital	Radiographers	Radiography Technicians	Physiotherapists
Sir Yahaya Mem. Hosp.	-	1	1
Gen. Hospital Argungu	-	1	
Gen. Hospital Aliero	-	-	
Gen. Hospital Ambursa/Zauro	-	-	
Gen. Hospital Dirin Daji	-	-	
Gen. Hospital Illo	-	-	
Gen. Hospital Jega	-	-	
Gen. Hospital Kamba	-	-	
Gen. Hospital Koko	-	-	
Gen. Hospital Maiyama	-	-	
Gen. Hospital Senchi	-	-	
Gen. Hospital Wasagu	-	1	
Gen. Hospital Warra	-	-	
Gen. Hospital Yauri	-	1	
Gen. Hospital Zuru	-	1	

The number of ward assistants/maids and cleaners in all general hospitals is inadequate. Casual labourers perform the jobs of this cadre of staff, but these labourers are paid through the meagre allocation from the overhead costs.

(f) *Continuing Medical Education*: Facilities for continuing medical education are virtually non-existent in all the general hospitals. Good medical practice entails some form of continuing education for doctors, nurses and all other health care staff. No general hospital in the state has stock of books and journals (no matter how small) and this is unacceptable. In-house seminars are rarely conducted in general hospitals. Sponsorship for seminars, workshops and conferences is rare.

3.2.8 Human Resources

Doctors

The distribution of doctors in the 14 general hospitals is shown in Table 3.2(a).

Nurses

The distribution of nursing staff in 15 general hospitals (including SYMH) is shown on

Laboratory Staff

There are only 8 qualified, registered Lab. Scientists in the whole state. This is grossly inadequate. The 97 Lab. Technicians cannot function as lab scientist, since they cannot handle the equipment to be procured, and they cannot delivery the services needed.

Pharmacy Staff

There are only 7 pharmacists practising in the state-owned general hospitals. This is grossly inadequate. Meanwhile there are 76 pharmacy technicians. These cannot replace the qualified pharmacists in general hospitals. Unfortunately except for the 1st and 2nd generation hospitals (S.Y.M.H., Argungu, Zuru, Yauri), all the pharmacy unit in other hospitals are manned by pharmacy technicians-who are not qualified to work in general hospitals.

Radiographers (Table 3.2e)

The situation with radiographers is the worst. There is no single radiographer in any of the state's hospitals including SYMH. This is unacceptable in modern medical practice-bearing in mind the large number of patients seen in the hospitals-and the vital role of x-rays in diagnosis.

Physiotherapists

There is only one physiotherapist in the whole state in S.Y.M.H.

3.5 FINDINGS ON SCHOOL OF NURSING AND MIDWIFERY, KEBBI STATE

Established 2003

Accredited 5th February 2007

by Nursing and Midwifery Council of Nigeria – full accreditation.

3.5.1 Programmes

1. Nursing
2. Midwifery

} Both accredited 5th February 2007

Facilities

Generally good.

Major problems of the school;

1. Hostel accommodation is inadequate
2. Allocation of ₦500,000.00 inadequate for running cost

3.6 FINDINGS ON SCHOOL OF HEALTH TECHNOLOGY, JEGA

3.6.1 Introduction

The School was established in 1978 in Former Sokoto State.

3.6.2 Programmes

It runs 5 professional programmes as follows:

	Programme	Professional Accreditation Body	Accreditation Status/Date Visited
(A)	Medical Lab. Technician programme	MLSCN	Visited December 2007. Not yet accredited
(B)	Health Information Technician programme (new programme stated 6/Oct./2007	HRORBW	Not yet visited expected visit on 5/5/2006. Not yet fully accredited. Programme started

			with permission of Board
(C)	Pharmacy Technician programme	PCN	Visited June 2007. Provisional accreditation in August 2007.
(D)	CHEW programme stopped since 2006	CHPRB	Programme has been stopped school asked not to admit new students
(E)	Environmental Health	WAHEB EHORECON	Never visited. Not yet accredited. Major programme – lack of Environmental design ground

3.6.3 Staffing situation

(A) Medical Lab. Technician programme

		Available			Comment on qualification
	Minimum Council Requirement	Full Time	Part time	Total	
Con/Chemical Pathologies	1	1	1	2	Qualified $ licensed
Con/Haematologists	1	1	0	1	Licensed
Con/Microbiologists	1	3	0	3	Licensed
Deficient Histopthalogists	1	0	0	0	Nil
Deficient Virologists	1	0	1	½	Licensed

HOD Qualified.

- Secretariat Staff. 3 for the whole school. Inadequate.
- Stand-by generator for the School – not available.
- Library needs more stock of books

Table 11: A Comparison of the Current Situation on Consultant/Specialist Cadre with that of 1991 at Sir Yahaya Memorial Hospital, Birnin Kebbi

S/No	SPECIALITY	NOVEMBER 1991	APRIL 2008
1	Consultant Surgeon	1	3
2	Consultant ENT Surgeon	Nil	1
3	Consultant Physician	Nil	2
4	Consultant Opthalmologist	Nil	1
5	Consultant Dental Surgeon	1	Nil
6	Consultant Paediatrician	Nil	1
7	Consultant Gynaecologist	Nil	1
8	Consultant Pathologist	Nil	Nil
9	Consultant Haematologist	Nil	Nil
10	Consultant Orthopaedic Surgeon	Nil	Nil
11	Consultant Medical Microbiologist	Nil	Nil
12	Consultant Chemical Pathologist	Nil	Nil
13	Consultant Public Health	Nil	Nil
14	Consultant Demochologist	Nil	1
		3	**10**

4.2 Physical/Materials

3.1.3 **Status of Equipment in Primary Health Care Facilities**

The status of equipment in terms of adequacy, for antenatal care, out patient clinics, in-patient care, labour room and laboratories is extremely poor. In 15(45%) of the 124 Primary Health Care Centres visited, the remaining 18 (55%) PHCs have been adequately equipped by the Federal Government of Nigeria through the NPHCDA.

The 18 PHCs that need no extra equipment at the moment are as follows:

Location		LGA
Augie	-	Augie
Libata	-	Ngaski
Mahuta	-	Fakai
Kaliel	-	Bagudo
Besse	-	Koko-Besse
Felande	-	Argungu
Aljannare	-	Suru
Raha	-	Bunza
Kare	-	Arewa
Dalijan	-	Gwandu
Makuku	-	Sakaba
Zamare	-	Yauri

Tungan Zazzagawa	-	Argungu
Bayawa	-	Augie
Digi	-	Kalgo
Raha	-	Shanga
Bui	-	Arewa
Ayu	-	Danko-Wassagu

These PHCs however need boreholes and generators which are supposed to be put in place bys the State Government.

The estimated cost of construction of the boreholes and installation of the 25KVA generators has been given in Volume II of this report.

The remaining 15 PHCs irrespective of what is currently available in terms of equipment, urgently need improved in the equipment status to enable them provide the minimum standards of care required at the community level.

The standard equipment list required for Primary Health Care Centre is given in chapter 4 (see table 4.1).

3.1.4 **Drugs and other Consumables**

As has been mentioned under section 3.1.1.9, the DRF at the Primary Health Care facilities has collapsed. Furthermore, essential drug list (of the Federal Government of Nigeria or that of Kebbi State Ministry of Health) was not available in most of the Primary Health Care facilities.

Specific Findings on General Hospitals in Kebbi State

Equity in Distribution

All the general hospitals under Kebbi State Ministry of Health can be categorized into 4 groups based on year establishment.

Group I: Sir Yahaya Memorial Hospital – the oldest and the Premier Hospital established 1952 – the only general hospital owned by the State Government serving as a Specialist Hospital and offering both secondary and some level of tertiary care.

Group II: Five General Hospitals termed ‘second generation’ established in the 1980’s-1990’s.

Distributed – one per Emirate.
Argungu General Hospital (Argungu Emirate)
Koko General Hospital (Gwandu Emirate)
Yauri General Hospital (Yauri Emirate)
Zuru General Hospital (Zuru Emirate)

Group III: Third generation: (1990's-2000's)

Distributed as follows:

Argungu Emirate	-	1
Gwandu Emirate	-	5
Yauri Emirate	-	1
Zuru Emirate	-	3

One of these in Zuru (Senchi) is part of public private partnership.

The 15 General Hospitals including Sir Yahaya Memorial Hospital are listed in Table 3.2 (a) – 3.2 (d)

Group IV: Primary Healthcare (PHC) recently upgraded to General Hospitals/ Construction of new ones.

These are 14 in number – with the following distribution:

Argungu	-	2
Gwandu	-	8
Yauri	-	1
Zuru	-	3

Therefore, the overall distribution of general hospitals in the State (excluding Sir Yahaya Memorial Hospital) according to Emirates and LGA's is as follows:

Table 12: Distribution of General Hospital according to Emirates in Kebbi State

Emirate	LGA	2nd Generation	3rd Generation	New upgraded	Total
Argungu	4	1	1	2	4 (12.9%)
Gwandu	9	1	8	8	17 (54%)
Zuru	5	1	3	3	7 (22.6%)
Yauri	3	1	1	1	3 (9.7%)

From this distribution, based on No of LGA's and Emirates, there is a fairly equitable distribution of general hospitals in the State.

3.2 FINDINGS ON SECONDARY HEALTH CARE FACILITIES

3.2.1 General Observations on 14 General Hospitals in Kebbi State (Nov., 2009)–(Sir Yahaya Memorial Hosp. Excluded)

3.2.1.1 Nomenclature

General hospitals are meant to provide secondary health care to the community. This care is supposed to be of general clinical nature – covering at least, the 4 major clinical

medical disciplines of medicine, surgery, obstetrics and gynaecology and paediatrics. In a general hospital set-up these 4 departments must be established, and they are all equally essential for the alleviation of the distress of patients and for saving lives. For such departments to be optimally functional they must be supported by hospital non-clinical support services and facilities (such as water and sanitation, security and safety, reliable electricity supply, adequate laundry service) and other essential supporting units, including laboratory and radiology services. The manpower needs of the hospitals have been addressed following the Technical Committee Report recommendations. All the hospitals have been rehabilitated at a total cost of about N200 million. Equipment and instrument worth N1.6 billion have been procured and delivered. A 24 number ambulances, 15 call duty vehicles and 15 mortuary vans have been procured and delivered. Furthermore, 12 numbers Toyota Hilux have been procured for monitoring and supervision services.

3.2.1.2 <u>Paediatric Care</u>: The situation up to April 2008 is as follows:-
Except for General Hospital Zuru, reasonable paediatric care at the secondary level is non-existent. Paediatric wards are a rare phenomenon. In a few hospitals where such wards exist, they are empty-devoid of patients and/or the necessary facilities. In a few hospitals that admit children, these sick children are forced to share the wards with sick adult females. Considering that children in our environment are most vulnerable to mortality and morbidity, and that they constitute 45% of the entire population and more than 50% of the outpatient and inpatient load, this trend is unacceptable and is contrary to the MDG on child health. Secondary health care facilities are supposed to be equipped to handle not only curative aspects of paediatric care, at a level higher than what is obtainable at the primary health care facilities, but also preventive and promotive aspects of child (similar to what is obtainable at the primary health care centres). The near – total neglect of provision of child health care facilities, as observed in 1991 in the general hospitals in Kebbi State by both the Task Force on Health and the Sub-Committee on Health for the Blue print of Development of the newly created Kebbi State, has virtually remained un addressed in the last 17 years. There is no Special Care Baby Unit (SCBU) in any of the State – owned hospitals. The implication is that many babies die of treatable conditions. Following the Technical Committee Report recommendation, the issues raised above have been addressed by the Implementation Committee on Health

3.2.1.3 <u>Surgical Care</u> April, 2008
The provision of surgical care in all the general hospitals is very poor. Surgeons in Kebbi State general hospitals are doing their best, but operate under extremely difficult circumstances – with inadequate theatre facilities, obsolete or improvised operating tables and no properly functional theatre lamps. The issues have now been addressed and required equipment procured and delivered.

3.2.1.4 Utilities: Water Supply

Following the Technical Committee Report recommendation, all the boreholes and electric generating sets have been rehabilitated and put to use. Furthermore, the monthly cash allocation has been increased from N50,000/N800,000 to N250,000/N3,000,00.

3.2.1.5 Electric Power Supply

All the 14 general hospitals are connected to PHCN. There are also 19 standby generators of various capacities. Five of the general hospital i.e. Argungu, Kamba, Koko, Wara and Wassagu have two generators each while the remaining 9 hospitals have one generator each. All the malfunctioning generators have been repaired and put to use at a total cost of N6,3007,010.00

3.2.1.7 Laboratories

Following the Technical Committee Report recommendation, all the laboratories have been rehabilitated and equipped with equipment procured at a total cost of N790 million Naira.

3.2.1.8 Radiology

Following the Technical Committee Report recommendation, 4 static and 15 mobile X-ray machines have been procured, supplied and installed at 15 general hospitals. The X-ray Technicians that we have and doctors have been trained by the suppliers on the use and maintenance of the machines.

3.2.1.9 Central Centralizing Supply Department (CCSD)

Following the Technical Committee Report recommendation, equipment for CCSD has been procured to allow for sterilization at the department.

3.2.1.10 Drug Revolving Fund

In all the general hospitals the Drug Revolving Fund has been rendered ineffective, mainly due to accumulation of unrefunded exemption bills. Following the Technical Committee Report recommendation, efforts are being made to pay the bills and recapitalize the scheme.

3.2.1.11 The Free Drug Policy for Pregnant Women and Children under 5 years

This programme is commendable. In the year 2009 drugs and medical supplies worth N561 million Naira have been procured and delivered, items have already been distributed to the 15 general hospitals.

3.2.1.12 Ambulance Service

The State Government has procured 24 number ambulances for our referral services. Ina addition, 15 number call duty vehicles have also been procured.

3.2.1.13 Running Costs

The monthly allocation given to the PMO's to run the hospitals have been increased significantly. The current monthly allocation ranges from N250,000 to N3,000,000 as against the previous allocation of N50,000 to N800,000.

3.2.1.14 Safety

None of the general hospitals has clear written evacuation and fire policies. Most general hospitals have no fire extinguishers

3.2.1.15 Rubbish Disposal

Most general hospitals have sent staff for short training on rubbish disposal, but no general hospital has clearly written cleaning policies or written policies on disposal of various types of rubbish. The method of rubbish disposal in most general hospitals in inadequate.

3.2.1.16 Mortuary Facilities

The State Government has procured and installed new chilling units at the 15 general hospitals at a total cost of N194 Million Naira.

3.2.1.17 Housemanship and Internship

There is not a single hospital in the State (SYMH inclusive) that is accredited for either housemanship (for new medical graduates) or internship (for intern-pharmacists and lab-scientists). The Technical Committee's inspection of facilities and staffing revealed that no hospital has satisfied the minimum standards of the accreditation bodies – i.e. the Medical & Dental Council of Nigeria MDCN- (for doctors), the Pharmacy Council of Nigeria – PCN (for pharmacists) and the Medical Laboratory Council of Nigeria – MLCN (for medical lab scientist) up to April 2008. However, following the procurement of equipment and employment of needed manpower, the PCN has accredited Sir Yahaya and is hoped that soon the MDCN will follow as well.

3.2.1.18 Lack of computers/Poor Record Keeping:

Except for Sir Yahaya Memorial Hospital, there is no general hospital with a single desk-top computer for use in the office and in Medical Record Dept. Even manual record keeping is very poor, generally. The International Classification of Diseases (ICD) manuals (2 volumes) are not available in any of the hospitals including S.Y.M.H. Manual or electric type writers are also not available. All the typing needed in these hospitals are done outside the hospital in commercial outfits. However, since the report was submitted, arrangement has been concluded to procure 79 units of desktop computers for hospitals.

3.2.3 Equipment base of the 14 General Hospitals (Group II & II Hospitals)

The equipment base of these hospitals adequate. This was as a result of the N1.6 Billion Naira worth of equipment for laboratories, pharmacist and X-ray procured.

3.2.4 Building Infrastructure

The 14 general hospitals have all been rehabilitated at a total cost of N200 Million Naira.

3.2.5 Utilities: Electricity

The problem with electricity supply in each of the 14 general hospitals have been addressed. All the generators have been repaired.

3.2.6 Utilities: Water Supply

There are 17 boreholes in 14 general hospitals, all the boreholes that were not functioning up to April 2008, have all been provided with the needed spare parts and are now functioning properly.

3.3 FINDINGS ON SIR YAHAYA MEMORIAL HOSPITAL, BIRNIN KEBBI

3.3.1 General Observations on Sir Yahaya Memorial Hospital

The hospital was established in 1952 and is the premier hospital in the state.

3.3.1.1 Clinical Scope and Facilities

Sir Yahaya Memorial Hospital has been supplied clinical equipment worth N100 million. It has a total of 43 doctors out of which seven (7) are Consultants. There are 91 Nurses and Midwives in the hospital, 33 of which are midwives. The hospital has also some facilities for tertiary healthcare, e.g. some special laboratory investigations e.g. CD_4 cell count for management of HIV/AIDS, renal dialysis unit, ophthalmological, urological, dental surgery and ENT units and some equipment for special care baby unit (e.g. baby incubators).

3.3.1.2 Management

The hospital-under the leadership of Dr. S. M. Kaoje the Permanent Secretary/Chief Consultant Surgeon/CMD. All the Departmental Heads of the hospital wish the CMD constitute the management.

3.3.1.3 The Need for Accreditation of the Hospital for Housemanship and Internship

The facilities of this hospital has improved to enable the hospital achieve accreditation for training of house officers, pharmacy interns and medical lab scientists interns. Achievement of accreditation for training of these professional groups will greatly contribute to the manpower development of this important cadre of healthcare workers in Kebbi State. However, the hospital is deficient in a number of areas, and these deficiencies should be corrected before the hospital could gain accreditation from the various professional regulatory bodies e.g. Medical and Dental Council of Nigeria (for housemanship), Pharmacy Council of Nigeria (for pharmacy-internship) and Medical Laboratory Council of Nigeria (medical laboratory science-internship). Areas needing attention are highlighted under specific findings.

3.3.2 Specific Findings on Sir Yahaya Memorial Hospital With regards to Hospital Non-clinical Support Services and Facilities.

3.3.2.1 Administrative facilities

Office rooms available are well furnished. However, some senior officers still share offices. More offices are needed.

3.3.2.2 Office equipment/facilities

This is the best equipped hospital in terms of office equipment, with TV and satellite system, fridge, ACs and 3 laptop computers. More laptops, printers, internet access, scanner and file cabinets are needed.

3.3.2.3 Safety

Communication system within hospital is poor. The intercom machine got burned and needs replacement. A few fire extinguishers are available. More fire extinguishers are needed.

3.3.2.4 Utilities

Sir Yahaya Memorial Hospital has the best water supply system among all the state hospitals. It is connected to the municipal water supply system and has two functional boreholes, with an overhead tank. An underground tank is needed in addition to one borehole for the maternity ward. The electricity supply is fair. There are 4 stand-by generators: two 250KVA generators, one 187KVA Rolls Royce generator (which is >30years old, with unavailable spare parts) and one 30KVA generator. The Rolls Royce generator needs replacement.

3.3.2.5 Laundry Services

The industrial washing machines have broken down. The pressor is not functioning. There are no driers. Supply of more clean beddings, towels and washable blankets is urgently needed. However, the issue is being addressed by the Implementation Committee.

3.3.2.6 Cleaning Services

The little amount of overhead funds is also used to employ casual labourers-making maintenance of cleanliness inadequate. Equipment cleaning and cleaning of toilets is fair but more ward assistants (servants) are needed. However, the increased cash allocation from N800,000 to N3,000,00 tangible improvement would soon be realized.

3.3.2.7 Rubbish Disposal

Inadequate incinerators. Needle destroyers not available.

3.3.2.8 Facility and Utility Maintenance Service

Maintenance unit is functional and maintained on contract for maintenance of buildings, utilities, equipment and sewage system. There

is no Biomedical Engineering Unit for maintenance of hospital equipment.

3.3.2.9 Pottering Service

Few wheel chairs available. More needed.

3.3.2.10 Catering Services

Free feeding for some patients. Service doest not cater for special diets for those requiring them.

3.3.2.11 Ambulance Services

Three ambulances available. A call duty vehicle, utility vehicle and mortuary van have been supplied to the hospitals.

3.3.2.12 Mortuary Facility

A 12-body capacity chilling unit available, functioning well. Additional chilling unit with 6 body capacity has been installed

3.3.2.13 CSSD

No CSSD at all and no trained staff. However, contract has been awarded worth N7.5 million to supply the CSSD to the four premier hospitals.

3.3.2.14 Physiotherapy

The unit is very narrow and needs expansion for equipment procured.

3.3.2.15 Support Services of Special Significance for Housemanship/Internship

There are no library facilities, books, journals or internet services. Similarly there are no side laboratories for the clinical departments. However, 28 houses that were under construction have been completed. These will no doubt facilitate housemanship/internship at the hospital.

3.3.3 FINDINGS ON CLINICAL EQUIPMENT AND FACILITIES Nov., 2009.

This is the best equipped hospital owed by Kebbi State Government. The level of equipment in both quality and quantity-particularly in the general surgical and urological specialists is good.

Medicine: Basic equipment such thermometers, sphygmomanometers and sunction machines are available. Oxygen concentrators and ambu-bags are available. Indeed all the need equipment were supplied early 2009.

Surgical Bed: There are no orthopaedic beds adequate basic equipment. There are two theatres 2 operating tables, but ceiling lamps need replacement. There is only one Boyle's anaesthetic machine. A good supply of basic surgical instruments, specialized instruments for Urology, Opthamologist, ENT Dental Surgery have been made early 2009.

O&G: Theatre available and its facilities are generally good. Basic equipment available, additional supply of equipment was made early 2009.

Paediatrics: No Special Care Baby Unit though incubators (3) available but the functional status is not known. This is the most poorly equipped at clinical

department. However, needed equipment have been supplied equipped early 2009.

Other Clinical Unit: Intensive Care Unit is not available. Physiotherapy, Dental Unit, ENT, Ophthalmology have been properly equipped early 2009.

3.3.4 Clinical Support Departments

- The pharmacy dept is fairly equipped with excellent cooling system. There is room for improvement.
- The x-ray department has been equipped with a state of the art
- Static x-ray machines and a mobile unit.
- The laboratory is the best in the State and should be maintained. However histopathological investigations are not available. Facilities and expertise for these are also not available. This is a very serious problem for a hospital of this status.

3.3.5 Staff Compliment: Details on staff compliment with regards to doctors is shown in table 3.3.5.

There are only 7 Consultants/Specialists skewed to surgical sub-specialists with consultant physician offering clinical services in the hospital. The number of junior doctors is 27. This will affect delivery of services. Considering a minimum number of 6 junior doctors attached to one consultant (i.e. 2 non-consultant senior doctors and 4 non-consultant junior doctor) and a PMO needs 3 doctors attached to him/her, the shortfall on number of doctors is up to 36. Furthermore, consultants will be needed as shown in table 3.3.5(b) which shows that in 1991 when Kebbi State was created there were 3 consultants (2 clinicians and 1 public health specialist). The picture has changed by about 50% as shown in table 3.36, as against the table 3.3.5(b).

3.3.6 Building Infrastructure

The hospital is overcrowded with buildings and there is no room for future expansion.

3.4 FINDINGS ON SPECIALISED HEALTH CENTRES

3.4.0 Findings on Hafsat Eye Centre, Birnin Kebbi

3.4.1 Background Information

Cataract out-reached programme was first initiated in May 1997 by the State Government in collaboration with Sight Savers International, during which all the local governments were visited by the team and over 2,509 patients were screened. Eight hundred and eighty three patients (883) were treated of minor eye ailments while six hundred and twenty six (626) patients awaited major surgeries. This was however not possible due to some logistics problems.

Cataract out-reached programme became a reality only when the ten Governor of Kebbi State Alh. Muhammad Adamu Aliero approved the take-up of the programme. Four eye camps were organized and conducted in collaboration with Sight Savers International. T he first Eye Camp was organized and conducted in September 1999, second in December 2000 respectively. During the period, two hundred and four (204) patients were successfully operated upon and sights restored.

3.4.2 An Excellent Example of Public Private-Partnership

As a result of these achievements recorded by Kebbi State Government in collaboration with Sight Savers International in eye Care Programme, the TULSI CHANRAI FOUNDATION, an NGO from India also join in partnership with Kebbi State Government to provide Eye Care service to the people within and outside Kebbi State. Government in partnership with Tulsi Chanrai Foundation started to implement a Community Eye Care Programme in the year 2002 when 804 surgeries were successfully conducted and vision was restored to these needy patients. T he State Government seeing the success of the Eye Camp embarked on a new project of setting up a permanent Eye Centre in the state in partnership with the Tulsi Chanrai Foundation.

3.4.3 Scope and Clinical Services offered to the Community

Hafsat Eye Centre started as a permanent eye centre in the State in August 2004, and was officially commissioned on s10th December 2004, by His Excellency, the Vice President of the Federal Republic of Nigeria Alh. Abubakar Atiku (Turakin Adamawa). The Centre has so far conducted cataract surgeries to 1600 patients who are now able to see the colours of life once again with their own eyes. Thus in total the State Government in partnership with Tulsi Chanrai Foundation was able to restored sight to about 14,000 patients.

The Eye Care Programme run by the State Government and Tulsi Chanrai Foundation is unique in the sense that it served patients not only from Kebbi State, but also from various nearly states and neighbouring countries like Niger and Benin Republic. The cataract surgery was done in such away that no patient is charged a kobo as the state government in partnership with Tulsi Chanrai Foundation takes the responsibility of the cost i.e. it is done FREE OF CHARGE. Since its inception to date and the programme will continue to be free.

3.4.4 Achievement of the Centre

Hafsat Eye Centre was established in 2004. Since its inception it has successfully performed 14,000 surgeries. The centre is also serving as a raining institution for doctors and nurses. Furthermore, it has applied for accreditation visitation from the West African College of Surgeons and therefore needs to upgrade its facilities and improve infrastructure. Equipment for the centre has been ordered.

3.4b Vesico Vaginal Fistula (VVF) Centre, Birnin Kebbi

The Vesico Vaginal Fistula (VVF) Centre was established in 1993 but was moved to the new complex at Gesse Phase I in the year 2005. The Centre has 50-bed capacity and is patronised by patients from far and near. All the services including drugs are free at the Centre. Over 200 patients have successfully been operated.

Furthermore, the Centre is being managed by both the Ministry of Health and that of Women Affairs.

Facilities/Equipment

Most of the facilities are functional. Some of the facilities were provided by Non Governmental Organizations (NGOs). There are no mortuary facilities at the Centre.

Funding
The Centre has a monthly allocation of N150,000.00 as running cost.

Feeding of the Patients
The Centre receives N300,000.00 for feeding patients. This is a commendable gesture of the government, considering the fact that most of these patients of this nature are among the poorest. This is an important component of poverty alleviation and is in the spirit of Kebbi SEEDs.

Staff Situation
The Centre has two doctors and one NYSC doctor. The number of nurses and midwives is adequate, but there are not enough labourers to clean the wards on 24 hours basis.

Clinic within the Centre
The centre shares accommodation with Gesse Basic Health Clinic. This has been a source of friction between the management of both health facilities.

4.3 Financial

4.3.0 Health Financing

The major sources of health financing in Kebbi State are as follows:

- FMOH
- Ministry of Finance
- FMOH MDGs
- FGN MDGs
- Local Government
- Developmental Partners
- Donors
- Firms
- Households

The State budget for health represents the Primary and major source of health financing especially for the Secondary Health Facilities while the Ministry of Local Government & Chieftaincy Affairs bears the cost for health at the LGAs.

The trends for total health expenditure as percentage of State budget is still difficult to arrive at because not all health expenditure has been captured. However, total health budget by State Ministry of Health as against Kebbi State Budget using 2008 and 2009 budgets is about 11% .

Table 13: Government allocation to the health sector in Kebbi State

	EXPENDITURE	**SMOH BUDGET(N) 2008**	**2009**
	CAPITAL	5.619 Billion	5.24 Billion
	RECURRENT	1.04 Billion	1.432 Billion
TOTAL		6.659 Billion	6.672 Billion
STATE BUD. (NAIRA)		61 Billion	59.909 Billion
HEALTH EXP.AS %AGE OF STATE BUD.		**10.92%**	**11.14%**

4.3.1 Public Funding

Public expenditures budgeted and actual (recurrent) for 2008/2009. Find below breakdown according to major line items.

S/Head	Details of Expenses	Estimates 2008	Actual Expenditure Jan-Dec. 2008	Estimates 2009
101	Salaries and Allowances	978, 000, 000.00	968, 737, 503.00	1, 215, 054, 038.00
102	Transport and travelling	5, 000, 000.00	5, 164, 200.00	20, 000, 000.00
103	Utility Services	800, 000.00	764, 750.00	1, 000, 000.00
104	Telephone Services	580, 000.00	388, 500.00	590, 000.00
105	Stationaries	1, 000, 000.00	890, 000.00	3, 000, 000.00
106	Maint. of furniture/Equip	1, 000, 000.00	3, 383, 250.00	20, 000, 000.00
107	Maint of veh and C/assets	2, 500, 000.00	4, 337, 750.00	10, 000, 000.00
108	Consultancy Services	0.00	0.00	0.00
109	Grant and Contributions	60, 000.00	0.00	60, 000.00
110	Training and Staff Dev.	2, 000, 000.00	1, 006, 000.00	13, 000, 000.00
111	Entertainment and Hosp.	60, 000.00	0.00	2, 000, 000.00
112	Miscellaneous Expenses	2, 000, 000.00	1, 483, 000.00	2, 000, 000.00
113	Bicycle Advance	0.00	0.00	0.00
114	Seminars and Workshops	200, 000.00	99, 000.00	5, 000, 000.00
115	Replacement of Hosp	200, 000.00	97, 000.00	500, 000.00
116	Equip	50, 000.00	0.00	50, 000.00
117	Contribution to Int. Org.	40, 000, 000.00	79, 530, 536.00	80, 000, 000
118	Medical Treatment	1, 000, 000.00	815, 000.00	1, 000, 000.00
119	Overseas	500, 000.00	431, 000.00	500, 000.00
120	Drug and Dressing	25, 000, 000.00	24, 015, 050.00	25, 000, 000.00
121	Vaccinations	200, 000.00	0.00	1, 000, 000.00
122	N.P.I and O.R.T	17, 400, 000.00	20, 629, 500.00	17, 400, 000.00
123	Health Education	30, 000.00	0.00	30, 000.00
124	Medical Treat. In Nigeria	500, 000.00	486, 000.00	500, 000.00
125	Drug abuse contr prog	5, 000, 000.00	3, 300, 000.00	5, 000, 000.00
126	Aid Contr. Prog	1, 000, 000.00	691, 500.00	1, 000, 000.00
127	Feeding of Patient	2, 000, 000.00	0.00	2, 000, 000.00
128	Print of medical records	0.00	0.00	0.00
129	Maint. of Generators	3, 700, 000.00	1, 605, 000.00	4, 000, 000.00

130	Cont Education	500, 000.00	90, 000.00	500, 000.00
131	Out break of Disease	1, 000, 000.00	1, 000, 000.00	1, 000, 000.00
132	Health Information syst.	2, 000, 000.00	0.00	0.00
	Nurse Uniforms (student)	**1, 093, 280, 000.00**	**1, 118, 944, 539.00**	**1, 431, 984, 038.00**
	UNICEF Contr prog			
	SUMMARY OF RECURRENT			
1	EXPENDITURE			
2	Basic Salary	593, 248, 399.00		
3	Leave Grant	59, 324, 839.90		
	Allowances	272, 426, 761.10		**1, 215, 054, 038.00**
4	**Personnel Cost Total**	**925, 000, 000.00**		216, 430, 000.00
	Overhead Cost	115, 280, 000.00		
	GRAND TOTAL	**1, 040, 280, 000.00**		**1, 431, 484, 038.00**

Find details attached as annex

- Government policy on user fees in public facilities, recovery rate and existence and effectiveness of exemption policies are on.
- Population coverage of social health insurance (mandatory and pay roll deductions) is yet to be implemented.
- Funds provided by donor agencies in form of project support
- Resource allocation and budgeting mechanism used is Medium Term Expenditure Framework (MTEF).

4.3.2 Private funding

Private health expenditures (households, firms, NGOs, private health insurance, community financing schemese.g. Community based Poverty Alleviation Project (CPRP).

These have not been captured adequately because of non availability of appropriate mechanism and data collection tools.

4.3.3 External Funding

Major development agencies active in the health sector and their key programmes are listed below

- World Health Organization (WHO) - Immunization (RI/IPDs), Surveillance (AFP/Measles/YF) and Logistics
- United Nations Children Education Fund (UNICEF) – Immunization, Social Mobilization, Logistic management, Reproductive health (MCH)
- United Nations Population Fund (UNFPA) – reproductive health, operations surveys
- Tulsi Chanrai Foundation (NGO) - Eye Care
- Management Sciences for Health (MSH) – HIV/AIDs
- AQUIRE Project – VVF
- Global Health and AIDs Initiative in Nigeria (GHAIN) – HIV/AIDs
- SAMI TRUST – HIV/AIDs
- Sight Savers International – Eye Care

ESTIMATES OF SUPPORT TO KEBBI STATE

WHO (JAN-OCT 2009) – =N= 212, 439, 967.00 ANNEX--------

FMOH (DRUGS) – 200 Million Naira

FMOH MDG PROJECTS 18 clinics at 45M (12 completed) – 810 Million Naira

FGN MDGs 70 Clinics – 800 Million Naira plus 1 (one) Billion Naira Kebbi State

UNICEF----------

UNFPA ----------

Others 500 Million

CHAPTER 5: FINANCING PLAN

5.1 Estimated cost of the strategic orientations

Estimates for each component of Kebbi State SHDP

Priority Area	**Cost (2010-2015)**
Leadership And Governance For Health	NGN 430,897,820
Health Service Delivery	NGN 23,640,846,418
Human Resources For Health	NGN 18,529,228,485
Financing For Health	NGN 3,438,405,106
National Health Information System	NGN 626,462,510
Community Participation And Ownership	NGN 381,124,296
Partnerships For Health	NGN 408,220,565
Research For Health	NGN 785,555,502
Total	**NGN 48,240,740,702**

5.2 Assessment of the available and projected funds

Judging from the historical budget allocations to the health sector, in 2009, government allocated nearly 6.7 billion naira to the health sector. If we assume this will remain constant, we could project that the available funding will be (6.7x6) about 40.2 billion naira for the period 2010-2015. However it is important to note that this does not take into account, available/projected funding from donor agencies and may thus be an underestimation.

5.3 Determination of the financing gap

Financing gap = 5.1 – 5.2 (48.2 billion Naira minus 40.2 Billion Naira) = 8 Billion Naira

5.4 Descriptions of ways of closing the financing gap

Ways of closing the gap includes resource mobilization strategies

- Influencing government and policy makers to increase allocation to health sector
- Attracting more development partners to Kebbi state
- Capacity building of the roles of all stakeholders towards buying and keying in into the SHDP

- Implement health programmes beneficial to communities and identify multilateral and bilateral agencies with special interest in such programmes
- Access and make effective and efficient use of health insurance schemes
- Sensitize philanthropists and communities to own and drive specific health programmes
- Generate funds through luncheons or involvement of companies and other groups operating within the State
- Training of Stakeholders on resource mobilization strategies.

CHAPTER 6: IMPLEMENTATION FRAMEWORK

6.1 REFERRAL SYSTEM

Medical referrals in Kebbi State are basically of 3 types:

(1)Referral within the health care delivery system in Kebbi State.

(2) Referral to other health facilities outside Kebbi, within the Nigerian borders

(3) Referral of patients for medical treatment abroad.

6.1.1 Referral within the Healthcare Delivery System in Kebbi State

In Kebbi State there is one Tertiary Health Institution owned by the Federal Government (FMC, Birnin Kebbi) and one Specialist Hospital (SYMH) in the State Capital both hospitals provide secondary healthcare and some level of Tertiary Healthcare. In addition in Birnin Kebbi there are also2 specialised health institutions;

The Hafsat Eye Centre offers ophthalmologist care and the VVF Centre.

In addition there are 14 established general hospitals and 14 new hospitals under construction, indeed three have been completed. Additionally there are 124 PHCS and over 700 rural clinics.

Facilities exist to provide primary, secondary and tertiary care within the health delivery system in Kebbi State.

However, the referral system from one level of care to the next and the two-way referral systems are inefficient. The major challenges against efficient referral system are:

(1) At the primary healthcare level, the facilities are poorly funded leading to poor services and customer dissatisfaction resulting in massive self referral of patients to secondary and tertiary centres-converting the latter into primary healthcare facilities and rendering them less efficient.

(2) Most of the Primary Healthcares (PHCs) have no functional ambulances. Therefore referral care for delivery complications – a determinant of maternal mortality is least available to the poor in rural areas. The Ministry for Local Government and Chieftaincy Affairs has just procured 21 number Ambulances for referral services at the LGAs.

(3) The 14 well established secondary healthcare facilities have been supplied with equipment worth N50 million Naira each only. Furthermore, each of the hospitals have been supplied with an Ambulance, call duty vehicle and a mortuary van. Additional staff have also been recruited, under the MDG, 96 midwives have

also been deployed to Kebbi State. With these huge investment it is hoped will translate into positive outcomes.

(4) Two-way referrals are rare partly due to poor ambulance services at LGAs and also attitude of both the patients and the healthcare providers. The secondary healthcare provider, after treating the patient from the rural areas rarely has the confidence to refer the patient to a rural facility of the patient's abode, because of lack of confidence in the ability of the rural health post to deliver proper treatment.

(5) Referrals between private providers of healthcare and the public institutions are rare due to the rivalry between the two groups of healthcare providers.

6.12 To improve the referral system and save lives, the following measures would be taken by the Government;

(i) Expediate action on the refurbishing of the Primary Healthcare (PHC) facilities through the KBSPHCDA and make these centres efficient.

(ii) Expediate action on the implementation of the recommendation of the Committee on equipping, rehabilitating and staffing of the PHCs and clinics in the LGAs.

(iii) Supervise the Local Governments through the KBSPHCDA

(iv) Encourage cooperation and collaboration between the for-project providers of health and the Kebbi State Ministry of Health through the public-private partnership programme.

(v) Continue to give assistance to the Federal Medical Centre, Birnin Kebbi.

6.1.3 Referral of Patients Outside Kebbi State to other Nigerian Health Institutions

In some cases patients will have to be referred from the health institution of Kebbi State to other Centres in Nigeria where highly specialized facilities and expertise are available for treatment of such cases. Improvement of facilities in Kebbi state will minimize unnecessary, costly and risky referrals to distant places. An efficient ambulance system

is again necessary for such referrals, especially in precarious circumstances. The 24 ambulances should be put to use.

6.1.4 Medical Referrals Abroad

With regards to medical referrals abroad it should be borne in mind that:

(1) With regards to Civil Servants, approval for journeys outside Nigeria for medical treatment will only be given by the Ministry of Establishment on the recommendations of the Chief Medical adviser and will be confined to serious cases where a patient's life is in danger or where the examination is necessary for diagnosis of difficult cases, or to ensure that a patient is fully recovered to undertake the duties of his office (FGN, 1974).

(2) In the last 2 decades indigenous medical expertise has been allowed to drain elsewhere abroad, especially to the Middle East, Europe and North America and sometimes, even elsewhere in Africa, where facilities are provided and remunerations are attractive. Consequently, medical or surgical procedures that could be performed in Nigeria more than 30 years ago in Nigeria, by Nigerians such as open heart surgery, are no longer easily available in the country, because of deteriorating infrastructure and the exodus of experts to greater pastures (Ahmed H, 1996).

(3) There are, it seems, good reasons for occasional referrals abroad for a few selected patients who can afford the cost (Ahmed H, 1996).

It is recommended that:

(i) Government should intensify efforts to curtail those referrals that are unnecessary and ensure strict enforcement of relevant civil service rules.

(ii) Provision of conducive atmosphere and facilities in our health institutions will minimize needless and often risky trips for medical treatment abroad.

(iii) The modest allocation of N40 million for medical treatment abroad and N80 million for medical treatment in Nigeria (outside Kebi State) can be retained.

6.2 COMMUNITY PARTICIPATION AND INVOLVEMENT IN HEALTH CARE DELIVERY

6.2.1 Primary Health Care Level

The Committee recommends that the State Government adopts the Ward Health System as a deliberate policy to ensure community participation in PHC delivery. This is in line with the current National Health Policy.

The Ward Health System is based on the WHO review team of 1992 which noted that "Community mobilization would greatly be assisted if the boundaries of the health district are the same as the electoral ward (20,000 to 30,000 people) which elects a councillor to the LGA. The LGA – District/Village" structure, therefore gave way to the LGA-Ward Community/Village structure. The goal of the ward health system is to improve and ensure sustainable health services with full and active participation of people at the grass root level.

In order to make the WHS functional, there shall be established in each ward where a PHC health facility exists, a Ward Development Committee (WDC) selected by the community and headed by the elected councillor or the ward head with other influential member of the community as member and the head of the health facility in the ward as member/secretary.

6.2.1 Membership of the Ward Development Committee

1. Elected Councillor or Ward Head (Chairman)
2. Influential members of the Community (a minimum of 5 members)
3. Head of PHC facility – Secretary/member

6.2.2 Functions of the Ward Development Committee

1. Mobilizes and motivates active participation of the people.
2. Identifies health and social needs of the ward and plans for their solution.
3. Mobilizes local resources to meet the health needs of community.
4. Supports and monitors the implementation of work plans including activities of the community-based workers and health facility staff.
5. Forwards all health development plan to the LGA.
6. Provides feedback regularly to the communities
7. Serves as the linkage between communities and government/other parties.

There shall also be established Village Development Committees that have similar functions and operational guidelines to that of the Ward Development Committee but are limited to their respective communities/villages.

It is believed that if this system is implemented, it will improve and ensure sustainable health services with full and active participation of people at the grass root level. This is exactly the principle behind Primary Health Care.

6.2.3 SECONDARY HEALTH CARE

At this level, the hospital management committee being proposed should include in its membership, the most senior community leader in the area. This could be the Emir, District Head or Village Head as the case may be.

Inclusion of the Community leader in these management committee is expected to empower the communities to be part of the hospital management, recognize

and take positive action, ensure resource mobilization for the success of the hospital in their domain.

6.2.4 Role of the Kebbi State Ministry of Health (KBMOH) in Community Mobilization for effective participation of the Community in Health Care

The Directorate of Primary Health Care of the KBMOH should be empowered, as a matter of urgency, to enable it collaborate with the relevant local governments department and other stakeholders to ensure mobilization of the local communities to form the ward and village development committees. Plan of action attached as annex.

It should be borne in mind that the process of mobilization and monitoring the progress of the ward health system are continuous and deserve regular monthly allocation of funds to make it effectives.

6.3 PUBLIC – PRIVATE PARTNERSHIP

There are various reports that indicate that in Nigeria the private sector contributes substantially to the health service delivery system (World Bank Reports 2005). The revised National Health Policy (2003) recognizes the importance of the private health care sector. This new policy also recognizes the need to develop public-private partnership in provision of health service delivery system that makes optimal utilization of resources, covers more people and improves the quality of care.

Collaboration with private health care sector already exists to a limited extent on some health issues including a few disease control areas and in delivery of some services in a few states in Nigeria including Kebbi State. The general consensus is that there is an opportunity to build on the good experiences and expand this public-private partnership.

The Committee made use of the recent classification of the private health care providers in Nigeria (World Bank Report No. 34177NG of 2005) as it applies to provision of private health care in Kebbi State. Similar to what obtains in other Nigerian states; private health care providers in Kebbi State are varied and consist of Patent Medicine Vendors (PMVs), private pharmacies, private hospitals and clinics, numerous drug hawkers, practitioners of traditional medicine and traditional birth attendants. The Committee mainly addressed areas of possible collaboration with organized private sector of health care provision.

6.3.1 Private health care providers

Private health care providers in Kebbi State consist of 2 main groups:

a) The for-profit providers
b) The non-profit providers

6.3.1.1 For-Profit Providers

For-profit providers include registered Patent Medicine Vendors (PMVs), registered pharmacy shops and registered private hospitals and clinics. There are 663 registered PMVs distributed across the whole state, 8 registered private pharmacy shops distributed thus: 3 in Birnin Kebbi, 2 in Yauri and 3 in Zuru.

There are also 20 private accredited private hospitals and clinics offering services of general clinical nature.

Constraints in the Provision of Clinical and Preventive Services by For-Profit Private Hospitals and Clinics

1. Water Supply:

Assessment of for-profit private hospitals and clinics in Kebbi State revealed that most of them have serious problems regarding water supply. Even the biggest and best equipped of the hospitals (Godiya Hospital, Birnin Kebbi) has no borehole. Connection to municipal water supply is poor and the water supply is erratic. Similar to many hospitals in the State, the private hospitals and clinics also rely on water vendors for their supply.

2. Hospital Waste Disposal:

Furthermore, all the clinical hospitals have serious problems with regards to hospital waste disposal. It is commendable that Godiya Hospital –the best organized private, for-profit facility-has sent one pharmacist for training on hospital waste disposal. However, the waste from this hospital and from other private clinics is dumped in available open spaces on the outskirts of the towns. This method exposes the public (including children) to the hazards of hospital waste including infections and injuries form contaminated sharp objects.

3. Scope of Clinical and Preventive Services Offered:

A wide range of curative services are provided in the for-profit health facilities with little attention to preventive services. The equipment base of all the hospitals is very poor and often below the standard for provision of acceptable primary health care. Although in many of such hospitals some secondary health care activities including major surgical operations (eg. Caesarean Section) do take place, the operating theatres are in poor condition and the equipment is rudimentary.

4. Neglect of Primary Health Care activities:

In some of the hospitals that conduct deliveries infant weighing scales are available, but there are no weighing scales for children. Therefore, basic primary health care activities such as growth monitoring – are not conducted. Other primary health care activities e.g. promotion of breast feeding, free immunization of children, free treatment of malaria for children and pregnant women and free treatment of tuberculosis cannot be conducted in private clinics because they attract no profit and will constitute a drain on the resources of the private providers – in both money and time. For similar reasons free voluntary HIV testing and counselling is not provided in the profit-driven practice.

5. Poor Referral System:

Private practitioners in Kebbi State tend to opt for small scale facilities. It is not surprising that they do not offer diagnostic services like x-ray and laboratory investigations (except for the most basic types). Therefore, these private facilities tend to rely on outsourcing or referral to public hospitals for radiological and

laboratory investigations. In Kebbi State, these referral in the light of 19 X-rays machines procured will make it a lot easier. Within the state with good equipoment base of over N1.6 million, X-ray machine (19) procured at a total cost of N339 million, procured of 24 number ambulances, the referral system will be greatly enhanced.

6. Lack of Continuing Medical Education:

In-house training and continuing medical education is rarely available to private practitioners in Kebbi State. This professional isolation also compromises quality of services provided. Although the Medical and Dental Council of Nigeria has planned a programme of recertification in which evidence of continuing medical education will be required from all practitioners before the annual practising licence is issued, the council has not yet enforced this programme.

7. Other Peculiarities:

There is a general consensus (as has been shown in other states in Nigeria) that the main source of contraception is the private sector followed by the public sector and other sources in that order. Users of pills and male condoms tend to patronize the private sector, where as users of indictable and intrauterine devices tend to patronize the government owned health facilities. This peculiarity can be exploited by government to enhance family planning, HIV/AIDS prevention and other reproductive health measures.

6.3.1.2 The Private Non-Profit Providers

With regards to the private non-profit providers there are a few of such facilities in Kebbi State. The most prominent of these are the Sundu Bamaiyi Memorial Hospital, in Senchi, the Hafsat Eye Centre in B/Kebbi and some faith-based NGO clinics – the most conspicuous of which is the Muslim Umma Health Organization (MUHO).

6.3.1.2.1 Sundu Bamaiyi Memorial Hospital

This hospital was built and equipped by the Bamaiyi family. The State government has provided support with regards to staffing (including payment of salaries of the staff) and running costs of N400,000/month. The hospital in turn provides free curative and preventive services to the community.

6.3.1.2.2 Hafsat Eye Centre

This is an excellent example of public-private partnership in the provision of health care to the community and this centre has been covered in details in chapters 2,3 and 4 of the main report.

6.3.1.2.3 Muslim Umma Health Organization

This is a faith based NGO and provides non-profit curative and preventive services, and functions like other faith-based providers of health care such as the Christian Health Association of Nigeria (CHAN), which is the umbrella

organization for church – sponsored health care programs in Nigeria. Faith-based NGOs as providers of health care play a less prominent role in Kebbi State than in other states – such as Enugu where the Christian mission facilities provide the majority of health care services (PATHS 2004). It has been reported that CHAN institutions collaborate with Muslim Organizations in some areas of health care e.g. interfaith forum on HIV/AIDS and sexual and reproductive health of which Federation of Muslim Women of Nigeria (FOMWAN) is also a member. There is evidence that some assistance from KBSMOH is rendered to Muslim Umma Health Organization in the provision of HIV testing and counselling of patients.

6.3.2 Contribution from Philanthropists

There is evidence from the public in Kebbi State that some rich individuals who want to contribute funds or facilities for improvement of health care in the state are not sure of the correct approach of doing this.

6.3.3.Private Pharmacies and PMVs

These are adequately regulated by the Kebbi State Ministry of Health.

6.3.4 The Role of the Ministry of Health

Similar to other Ministries of Health in Nigeria (World Bank Reports 2005) and those in many developing countries (e.g. Indonesia – WHO 2003, Middle Eastern Countries WHO 2004), the Kebbi State Ministry of Health traditionally focuses on government owned (public) hospitals and clinics. It is observed that while the Kebbi State Ministry of Health (KBSMOH) can give direct instructions and budgetary allocations to the public sector system including its public health components, which it completely controls, when it engages with other sectors and non-governmental providers it cannot give direct orders on every aspect of provision of health care. It is true that the Ministry can influence the conduct of these providers by various forms of regulatory actions – such as restrictive licensing, positive accreditation or outright closure of the health facility. This limited scope of the ministry seems to hinder collaboration with for-profit private provider of health care not only in Kebbi State but in many other Nigerian states. Furthermore the public-based providers and the for-profit private providers do not cooperate very well in the provision of health care for the populace – as the for-profit providers regard the public sector as rival competing for patronage of patients. Because of this rivalry, cross referral between the private and public sector is not common and is mainly dependent on personal relationships.

The Ministry of Health, similarly, cannot give direct instructions to public agencies in other sectors vital to improved health status of the population and achievement of the MDG, such as education, agriculture and nutrition sectors and water supply and sanitation along with provision of improved economic opportunities. The main function it can perform in such cases is mainly advocacy on intersectoral collaboration relevant to health issues of the

population. The Committee observed that the Kebbi State Ministry of Health is ready to widen its scope if supported by government.

6.3.4.1 Increase the Central Role of Kebbi State Ministry of Health

Public-private partnership can be enhanced and expanded by increasing collaboration of the Kebbi State Ministry of Health with private – providers of health care. It is essential that the Kebbi State Ministry of Health should take a wider view of its responsibilities than is traditional. A new strategy is urgently needed. This strategy should enhance the capability and cooperation of the private providers of health to participate in government's programmes that are aimed at improving health care of the population within the Kebbi State SEEDs plan aimed at achieving the MDGs. This public –private partnership should be extended beyond the regulatory role of the Ministry and should involve collaborative agreements on areas beneficial to the Ministry and the private providers of health care.

The Kebbi State Ministry of Health should also be involved in active intersectoral collaboration with relevant public sectors in areas that can significantly improve the health status of the community (e.g water supply, education & school health, environmental sanitation, agriculture etc).

6.3.4.1 Engagement of the Kebbi State Ministry of Health with Non-Governmental providers of Medical Care in specific areas

It is recommended that public-private partnership can be worked out in the following areas.

a) Child Immunization

The private facilities should be encouraged to offer free immunizations to children by supplying free vaccines bundled to the facilities.

b) Incentives to Private-Providers

With regards to other health related MDGs and other incentives to be given to the private providers that comply with Kebbi SEEDs should be considered-including waving or reduction of taxes.

KBSMOH could also assist the private-providers (who participate in its programmes) with regards to water supply, rubbish disposal and concessional consideration in electricity supply by PHCN.

Disease Control Programmes

Modalities could be worked out on how to involve private providers in disease control programmes by providing not only vaccines for child immunizations but also anti TB drugs free of charge to private providers who want to participate in the programs; as has been done in some States of the Federation.

Involvement of Non-Profit Providers in the Free Drug Scheme of the State Government

The non-profit providers of health care should be encouraged to participate in the free drug scheme of the State Government (Sundu Bamaiyi Memorial Hospital, Faith-based NGOs). The allocation of N400,000.00 to Sundu Bamaiyi Memorial Hospital have been increased to from N250,000 and is commendable.

Assistance to Hafsat Eye Centre

The Hafsat Eye Centre's requirements should be addressed urgently (these have been highlighted in the relevant sections)

Creation of a Unit of Public-Private Partnership

A unit of public private partnership could be established in the KBSMOH with the aim of coordinating public-private partnership in various areas of health care. The unit should be equipped to carry out advocacy on this partnership and invite the public to participate. Philanthropists interested in participation in the partnership should know who to approach and what areas of priority exist for this partnership.

6.4 DRUG REVOLVING FUND (DRF)

6.4.1 Initial Seed Stock

The Drug Revolving Fund started with initial seed stock money of N1,000,000.00 provided by the Federal Government in 1990 (Former Sokoto State). Furthermore the former Sokoto Health Project purchased drugs worth N30,000,000.00. Following the creation of Kebbi State in 1991 the share for Kebbi State was one third of the total (the sharing formular after Kebbi State creation). The total drug seed stock for Kebbi State came to about N10,400,000.00.

6.4.2 The Problem of Lack of Refund of Waivers/Exemptions

From the seed stock, drugs worth over N5,000,000.00 were supplied to the 16 local government in 1991 – 1994 (as they were then), out of this few Local Government have shown to make some payments. And as at April 2007, the local government had an outstanding balance of N4,260,659.48 to be paid to the DRF account (see table below). Unpaid exemption bills from various hospitals Epidemic Control, Boarding School, Hajj Camp Operation, Fishing Festivals etc in the state amounted to N8,692,129.80 as at 2002/2003. Therefore the current unpaid money due to accrue to the DRF account is N12,952,789.20. This shows that exempted cases has eaten deep into DRF capital.

6.4.2 OUTSTANDING PAYMENTS AGAINST LGAS IN THE STATE

S/No	Local Govt.	Outstanding Amount

1.	Jega	289,319.95
2.	Arewa	241,553.95
3.	Argungu	250,192.30
4.	Bagudo	431,2421.01
5.	Birnin Kebbi	335,389.38
6.	Bunza	337,001.41
7.	Dandi	241,680.99
8.	Wasagu	299,653.80
9.	Zuru	5,892.85
10.	Gwandu	282,026.75
11.	Koko/Besse	90,920.98
12.	Maiyama	291,123.84
13.	Ngaski	369,292.64
14.	Sakaba	217,166.90
15.	Yauri	336,983.50
16.	Suru	243,219.26
TOTAL		**N4,260,659.50**

6.4.4 Procurement Method of DRF

The procurement method of the DRF is usually by contract method at ministerial level. This method is not cost effective and counter productive since contractors are bound by profit making. This makes the final drug cost to the patient exorbitant. This negates the very fundamental principles of DRF – which is to ensure steady supply of good quality drug at affordable price.

6.4.5 Unpaid Exemption Bills

The Committee recommends the urgent refund of exemption bill amounting to N8,694,129.80 to the DRF account.

6.4.6 Local Government's Unpaid Drug Supplies

The Local Governments should be directed to pay N4,260,659.48 to the DRF account which is a fall out from drug supplies made to them by the State Government from DRF stock.

6.4.7 Regular Refund of Exemptions to DRF

Exemption bills should be paid at least quarterly to prevent accumulation and depletion of the DRF account. Exemption policy should be reviewed.

6.4.8 **Facilitating Monitoring of DRF Operations**

A four-wheel drive vehicle should be made available to DRF unit for close monitoring of the DRF operations.

6.4.9 **The Need for Additional Seed Stock**

In addition to the unpaid balance, N20,000,000.00 should be urgently added to the seed stock of the DRF to enable it operate efficiently.

6.4.10 Improvement on Procurement Method for DRF

The Committee strongly recommends for the procurement of drug meant for DRF to be by direct purchase from manufacturers not by contract. This, in the opinion of the Committee, will make final cost to the patient affordable.

Furthermore, there are many other advantages of this method of drug procurement: Drug source directly from manufacturers are standard, qualitative, effective and manufactured according to official specification of NAFDAC and other regulatory bodies and are therefore devoid of faking; Direct procurement is cheaper and cost effective since the issue of middlemen/distributors does not arise; it ensures drugs with long shelf life are delivered to the State. Experts are involved in manufacture, transport, handling up to the State Medical Store thereby eliminating degradation of the active constituents due to ignorance of the supplier who is not an expert in the field.

6.5 FREE DRUG SCHEME TO PREGNANT WOMEN AND CHILDREN UNDER 5 YEARS OF STATE GOVERNMENT

6.5.1 The free drug or Health Service to pregnant women and children under five years was started in the year 2000 by the State Government. And it appears Kebbi State was the first to start the programme after which others copied. This poverty alleviation programme may have been informed by high cost of drugs and medical supplies, and the low capacity of the population to pay for these drugs due to extreme poverty. This good gesture from the government will prevent catastrophic household health expenditure (Xu et al, 2003, World Bank Reports, 2005, Ahmed, 2007)

As at 2006 drug worth about N500,000,000.00 have been invested in the programme. The impact can be seen in various hospitals. In year 2009 drugs and medical supplies worth N561 billion have been procured.

6.5.2 Scope of the Scheme

The programme is restricted to state government hospitals only, which are mostly in the urban centres.

The scheme covers pregnant women and children under 5 years.

6.5.3 Procurement Method of Drug under the Free Drug Scheme

This is usually by contract method to various individuals, companies and sometimes to individual who have no knowledge of pharmaceuticals.

6.5.3.1 Wider Coverage

The scheme should continue and be extended to local government health institutions in the state where poverty is at its worst level. Local Government should be encouraged to contribute funds to the scheme.

6.5.3.2 Customized Contract Procurement

It is recommended that drug procurement under this scheme should be by customized contract manufacturing with inscription "Property of Kebbi State Government" on the drugs. This will minimize pilfering and stealing of the drugs. Since manufacturers are involved, drug delivery can be staggered as and when due.

6.5.3.3 Cost of Drugs for 1year

The population of Kebbi State is projected to be about 3.4 million (2006). Children under 5years constitute one quarter of a given population; this is also true of women of child bearing age. Therefore, about half the population is expected to benefit. The Committee, after due consideration of the population, drug quantification, and studies of the Kebbi State Health System Development Project II (2005) have come up with N500,000,000.00 to be set aside for the programme for 1year.

6.5.3.4 Subsidized Surgical Material (50% Subsidy)

This programme is laudable and should be continued. However, the subsidy should be sustained to prevent depletion of the stock. Otherwise after 4 rounds of supply and purchase, the funds will be completely exhausted. Therefore the funds should be replenished after every purchase.

6.6 STATE MEDICAL STORES

The State Medical Stores was constructed immediately after Kebbi State creation. The store is meant to keep all drugs and related materials in good condition. The store consists of 3 big stores and a small store meant for thermolabile products. Attached to the store is a small drug quality control laboratory meant for on the-spot quality test of drugs coming into the stores.

The 3 big stores are marked store A, B. & C. Store A for storage of infusion, syrups capsules and ointments while store B is for tables and injections. And store C meant for storing surgical consumables.

Condition of the Structure

The structure is solid but needs rehabilitation as the roof is leaking. The store has now been rehabilitated with three giant industrial Air Conditions installed to each.

Equipment of Quality Control Laboratory

The equipment are in deplorable condition, old and obsolete. The equipment for the slide laboratory have now been procured and supplied.

Cooling System

The cooling system is inadequate as there are only 15 fans and air conditions available to provide the required temperature for drug store conducive. No thermometer for monitoring the temperature of the stores.

Store Vehicles

The two vehicles are grounded.

Fire Extinguishers
There are only 2 fire extinguishers for the whole structure.
Book Keeping
Ledgers tally cards, S.I.V. & SRV's are all kept and updated.

Staffing
At least more pharmacists and one technicians are recommended to be employed for the store.

6.7 National Health Insurance Scheme (NHIS)

Currently, health financing in most developing countries-including Nigeria relies predominantly on out of pocket payments (OPP) by individuals at the time of treatment. Although a National Health Insurance Scheme has recently been introduced in Nigeria (Airede LR, 2003), the scheme is still in its initial stages of implementation and has not yet covered all Nigerians including the poor, unemployed and the rural populace. Another consequence of OPP is what is currently termed catastrophic health costs (CHC) or catastrophic health expenditure (CHHE). CHHE is defined as spending 40% or more of household income on health problems after meeting subsistence needs. Nigeria's rate of CHHE is within the high range (i.e. more than 5% of the population may be affected by CHHE – Ahmed, 2007). This is so because all the three components leading to CHHE are prevalent in the country – i.e. services requiring payments, low capacity to pay and lack of repayment or health insurance.
Out of pocket payments account for 68% of total health financing in Nigeria (World Bank reports 2005). Out of pocket payments by the poor are considered the most regressive form of healthcare financing because the poor's burden of payments for health services and catastrophic health expenditures are not shared by the richer segments of society (World Bank, 2005).

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There are currently six programmes of the NHIS (NHIS Handbook 2002).

1- The Formal Sector Social Insurance Health Programme – is expected to cover formal sector employees-made up or public sector employees and those of the organised private sector (OPS). Only OPS members of 10 or more employees are qualified to participate in this programme. The contribution rate is 15% of the employee's basic salary with the employer paying 10% and the employee 5% to make up the total. The beneficiaries are the contributor, one spouse and up to 4 children under 18years. Benefit package covers wide range of healthcare, except malignancies and ARV drugs.

2- Rural Community Based Social Health Insurance Programme.

3- Urban Self-Employed Social Health Insurance Programme.

4- The Children Under-Five Social Health Insurance Programme. This is wholly funded by the Federal Government of Nigeria and administered by National Health Insurance Scheme.

5- The Permanently Disabled Persons Social Insurance Programme-again wholly sponsored by Federal Government of Nigeria.

6- The Prison Inmates Social Health Insurance Programme also paid for by the Federal Government of Nigeria and administered by National Health Insurance Scheme.

There is evidence that all the 6 schemes have now commenced at various levels of operation in various parts of the country. In Kebbi State, it seems only the employees of Federal Government of Nigeria are currently involved in the scheme (Scheme No 1).
The Kebbi State Government has not yet been involved in any of the schemes. It is, however, worth noting that the free drug scheme of the Kebbi State Government for the under-5 and pregnant women is a form of an insurance against OPP for these most vulnerable groups of patients.
It is recommended that the Kebbi State Ministry of Health should dialogue with the National Health Insurance Scheme officials on how the State Government can fit into the scheme for the benefit of Kebbi citizens.

The following documents should be available to Kebbi State Ministry of Health officials for perusal.

1. National Health Insurance Scheme: Handbook. Heritage Press, 2002.

2. National Health Insurance Scheme: Operational Guidelines, Abuja. Heritage Press 2002.

3. National Health Insurance Scheme: Rules and regulations Abuja. Heritage Press 2002.

6.8 **SCHOOL HEALTH SYSTEM**

This important aspect of health care is virtually non existent in the vast majority of boarding in the State. Even the best school with regards to school health programme, scored below the minimum acceptable standard based on recognized scoring system for this aspect of paediatric care. It is therefore recommended that attention should be paid to the following three components of the school health programme:

1. Health Care Services:
   In most of the schools there is no health care personal of any type to supervise the health programme. It is advised that a health supervisor e.g. health educator, nutritionist, nurse/midwife/doctor should be involved in provision of health care services in boarding schools.
2. Time allotted to health institution should be increased to a minimum of 2 periods/week, and the scope/conduct of health education curriculum should conform with the one suggested in appendix viii of this report.
3. Attention should be paid to healthful school environment-by improving water supply and access to safe water, refuse disposal, sewage disposal, adequacy of toilets (minimum of 1:20 pupils) and ensuring safety of buildings in the school.
4. The school health programme should be resuscitated urgently and should form part of responsibilities of the Inspectorate Division of the KBSMOH.

6.9 Health Services Management Board/Hospital Management Committee

1n 1996 Kebbi State established Hospital Management Committees for each hospital. T here is an edict on this. At the same time the law in Kebbi State, also provides for a Hospital Management Board. Both edicts are still in the laws of Kebbi State.

Currently, however it is the Hospital Management Committees that are operational. There are arguments against and for both systems. The Health Services Management Board is highly centralized and delegates little financial responsibilities to the hospital management. With the Hospital Management Committees hospital staff and the local community are delegated to mange the hospital with supervision from the Ministry. The Hospital Management Committees can be effective if funding is for running costs is adequate, otherwise collapse of the system is eminent. For Hospital Management Committee to function effectively, proper funding is needed.

It is recommended that Health Management Committees system be continued. M & E from the Inspectorate Dept. should be able to assess the efficiency of this system within 2 years. Funding the hospital on running cost should be increased as recommended.

6.10 MENTAL HEALHT CARE

The Committee accepts the expert report from Professor Obembe a renewed psychiatrist who physically inspected the facilities of the mental home in Jega. Recommendations attached are endorsed by the Committee for implementation by Government.

The Rehabilitation Centre was established in 1997 by Col. S.B. Chema under the supervision of Ministry of Women Affairs and Social Development. It has 20 beds with capacity for additional 20 beds. The bed occupancy rate is one hundred percent (100%)

and records average of 3 new psychiatric cases weekly. A Consultant Psychiatrist visits the centre once every fortnight.

Averagely a patient on admission takes two (2) months to improve. The Ministry for Women Affairs and Social Development takes complete care of the patient's needs including feeding, accommodation and medication. The nurses dispense and administer prescribed medication and when such drugs are not available at the Centre, patients have to travel to Birnin Kebbi to purchase them. There is no single pharmacy shop in Jega. Water is available as there is a functional bore-hole system. The only available source of light is from the Power Holding. There is no stand-by generator.

STAFF SITUATION

Staff compliments as on 10th April 2008:

S/N	Designation	Rank	No.
1.	Officer-in-charge Social Worker	Principal (SWO)	1
2.	SWO	SWO I	1
3.	Messenger	-	1
4.	Attendant	-	3
5.	Security Officer	-	1
6.	Cooks	-	2
7.	Chief Nursing Officers (from Min. of Health)	-	2
8.	Community Health Extension Workers	-	4

The Centre was formerly a lodging facility and has suffered neglect and is completely in a state of disrepair. The wards have no ceiling, the walls have cracked and virtually there is no kitchen. Food is being prepared in the open. I was privileged to meet the visiting consultant psychiatrist consulting under a tree shade. Three rooms are fully equipped each with carpentry tools, sewing and knitting and computers. These were donated by the British High Commission as vocational tools. These tools are yet to be utilized since installations.

The World Health Organization proposes that community-based mental health services should be developed through integration of mental health into existing Primary Health Care system and mobilization of community resources. This system is more accessible, affordable, efficient and effective. It is important to develop a culturally-sensitive approaches and models that can be adapted to the Kebbi State situation. It must be accessible, comprehensive and equitable. Important obstacle has been lack of human resources and the difficulty retaining staff especially in the rural areas. In order to

facilitate detection, referral and rehabilitation of persons with mental disorders, it is necessary to collaborate with traditional leaders and spiritual leaders. The community is also important in providing a base of local expertise upon which mental health care might be built. The community needs to be sensitized regarding mental disorders and anti-stigma campaigns. The absolute necessity of a reliable supply of essential medications and need for transport facilities for outreach and attending to the logistical aspects of providing care are important.

For a population of about 3.239 million, Kebbi State needs 14 psychiatrists (recommended: 1 psychiatrist to 250,000). It is being proposed that the State Government should deliberately seek out its indigenes who are interested in Psychiatry, and there are quite a lot of them in the medical school (UDUS). Two (2) at a time can be sent to Jega as corpers. At the end of service year they should be encouraged to have the Diploma in Mental Health being coordinated by the Faculty of Psychiatry of the West African College of Physicians at the Department of Mental Health, Obafemi Awolowo University, Ile-Ife as a short term measure. It is one (1) year programme leading to a Diploma of the College. On return they should be sponsored to any of the accredited University Departments of Psychiatry or one of the eight (8) Psychiatric Hospitals in the Country for a four (4) year Fellowship training programme in Psychiatry as a long term measure. This could be worked out for other members of the "psychiatric team".

- Clinical Psychologists
- Psychiatric Nurses
- Psychiatric Social Workers
- Occupational Therapists

The Federal Ministry of Health runs programmes at the Psychiatric Hospital, Yaba, Lagos in Occupational Therapy and Psychiatric – Social Work. A training school exists in Sokoto for psychiatric nurses.

The School of Health Technology in Jega should be strengthened to train sufficient Community Health Extension Workers with appropriate exposure to mental health care. Also needed are the community health officers and the importance of linkage with educational system and the judiciary.

All the staffs should be encouraged and supported in attending refresher courses and short courses to keep them in tune with current innovations in mental health care and its adaptation.

In order to avoid turnover of staff which undermines every effort to expand provision of mental health care, there is need for strong support in the field together with adequate remuneration.

The nomenclature of the Centre need to be more appropriate and under a proper ministry. It is proposed that the State should have a psychiatric hospital of its own in the Ministry of Health, with a department of mental health in place. Owing to the peculiar nature of the local government distribution into the senatorial districts, four (4) community-based

mental health services integrated into the existing PHC is being suggested along emirate councils.

Emirate Council	L.G. (Proposed)
Argungu	Argungu
Yauri	Yauri
Zuru	Zuru

It is expected that these three (3) local governments are central enough in their various emirate council to serve the citizens. Since the responsibility for the finance of the PHC falls on the LG, the LGs in each council should be able to jointly fund the service, possibly deducted by the State Government from source, mutually agreed. Severe mental disorders in these services can then be referred to the State Psychiatric Hospital at Jega.

The State Psychiatric Hospital would need expansion for:

- Administrative block with secretarial staff
- Staff offices
- Ambulance
- Functional kitchen
- Consultation rooms
- Nursing stations on the wards
- Stand-by generator
- Psychiatric nurses
- Psychiatric social workers
- Psychiatric beds
- Regular supply of essential psychotropic drugs
- Refrigerators
- Occupational therapist for vocational/recreational aids especially (tailoring and carpentry)
- Pharmacist and pharmacy technicians.
- Laboratory and other life support systems.

6.11 **EPIDEMIOLOGICAL UNIT**

The Epidemiological Unit should be supported to function effectively. It is recommended that:

1. Distribution of Insecticide Treated Nets (ITN) be extended to isolated communities like the Cattle Fulani and the reverine communities within the State.
2. Residual spraying should be supported including supply of lavaecides.
3. The World Bank Assisted project on malaria control is worth participating in.

6.12 REQUEST FOR ASSISTANCE FROM FEDERAL MEDICAL CENTRE, BIRNIN KEBBI: COMMITTEE'S ASSESSMENT AND RECOMMENDATIONS

This Federal tertiary institution is very important in the healthcare delivery system of Kebbi State as it offers secondary and tertiary healthcare to the populace and is an important base for future training of House Officers, Resident Doctors, Pharmacy Interns, Laboratory Interns and Physiotherapy Interns. It compliments the efforts of the State Government in improvement of the health status of the population and attainment of Millennium Development Goals (MDGs).

A memorandum received from the Management of the Hospital requested for assistance from the State Government in the following areas:

1. **Construction of a Paediatric Surgical Ward.** Estimated to cost ₦20 million and equipment worse ₦25 million. Note that list of equipment with quantity and unit cost has not been indicated in the memorandum.

2. **Construction of a Trauma Ward.** Estimated to cost ₦25 million and equipment worse ₦30 million. Note that list of equipment, quantity and unit cost has not been indicated in the memorandum.

3. **Construction of Amenity Ward**. Estimated to cost ₦30 million and equipment worse ₦40 million. Note that list of equipment, quantity and unit cost has not been indicated in the memorandum.

4. **Construction of three (3) block of Classrooms and stock of Library books in School of Optical Dispensing Technology.** Estimated to cost ₦15 million and Optical workshop worse ₦20 million.

   Other observations in the memorandum have been taken into consideration in various parts of the report.

   The estimated cost of projects requested amount to ₦205 million.

   It is the view of the Committee that this institution should receive some form of assistance to enable it function effectively. Details on the construction plan and cost of individual equipment is required for guiding the Government on the level of assistance to be provided by the Kebbi State Government.

CHAPTER 7: MONITORING AND EVALUATION

7.1 Proposed mechanisms for monitoring and evaluation

7.1.1 The 1991 Report of the Committee on Blue Print for the Development of Kebbi State (Health chapter) recommended that there should be regular inspection of the secondary health institutions. The Task Force Committee on Health (1991) for the newly created Kebbi State recommended the reorganisation of the Kebbi State Ministry of Health according to the then civil service reforms which assigned the role of monitoring and evaluation to the Directorate of Planning Research and Statistics, which replaced the Inspectorate Division that used to carry out the function of monitoring and evaluation.

Over the years, the Inspectorate Division has been virtually dormant due to poor funding of its activities-rendering monitoring and evaluation of programmes and other regulatory functions difficult or impossible to perform.

7.1.2 The Urgent Need for Empowering the Kebbi State Ministry of Health to carry out effective Monitoring and Evaluation.

Currently, the need to create the Inspectorate Department of the Ministry for effective monitoring and evaluation of its programmes is very urgent for the following reasons.

1. Monitoring and evaluation of the health sector is crucial for achieving the objectives of the Kebbi SEEDS with regards to attainment of the health-related MDGs.

2. The traditional regulatory role the ministry can be effective only if there is efficient monitoring and evaluation.

3. With the widening of the scope of the ministry beyond its traditional role, and with its commitment to be involved in collaborative engagement on important health innovations such as public-private partnership and mobilization of the communities for effective community participation in healthcare delivery, the Inspectorate Division together with the Directorate of Primary Healthcare will need to play a central role in monitoring and evaluating the effectiveness of programmes.

4. Having heavily invested in infrastructural rehabilitation of healthcare facilities and the procurement of vast amount of hospital equipment, the Government needs to monitor the availability of the health resources provided, and how effectively these resources are managed.

5. The free drug scheme of the Government for pregnant women and children needs continuous assessment of performance.

6. Other investments of the Government such as procurement of ambulances for improvement of the referral system can be protected by monitoring and evaluation.

7. Through effective monitoring and evaluation, inefficiencies in programmes and public expenditure can be detected and corrected, and transparency, accountability and efficiency will improve.

7.1.3 Facilities and Funding

To enable the Kebbi State Ministry of Health (KBSMOH) carry out its statutory functions, including effective monitoring and evaluation the current monthly allocation ₦700,000 is grossly inadequate.

The State Government has approved N3.5 million monthly cash allocation.

The State Government has procured 1-8 seater bus, 12 Toyota Hilux for monitoring and supervision.

7.2 Costing the monitoring and evaluation component and plan

The monitoring and evaluation plan is on the drawing board and will incorporate all the monitoring and supportive supervision aspects of the Kebbi state SHDP in an integrated manner employing an integrated tool to be designed to capture relevant indicators in the 8 components of Kebbi state SHDP.

CHAPTER 8: CONCLUSION

The Strategic Health Development Plan (2010-2015) with a costed estimate of 123 Billion Naira, has the eight basic components affecting quality and effective provision of health services. With the depth and excellent layout of the Strategic plan, implemented with political will by the various levels of government and all stakeholders keying in, will definitely result in Kebbi state health indices improving well above average for the North West zone, Nigeria and Sub- Sahara region as a result of sustainability and universal access. The estimated cost of the 2010 operational plan is 20.5 Billion Naira.

There is need to salute the courage of The Federal Ministry of Health taking the bull by the horn at this point in time to accelerate achieving health indicator goals especially the MDG related goals with the development and hopefully implementation to the later of the National and State Strategic Health Development Plans.

The firm commitment of the Executive Governor of Kebbi State. His Excellency Alh. Sai'idu Usman Dakingari and his health team headed by the Honourable Commissioner of Health is an example to be emulated.

Annex 1: Details of Kebbi State Strategic Health Development Plan

KEBBI STATE STRATEGIC HEALTH DEVELOPMENT PLAN						
PRIORITY						
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							**430,897,820**
	1.1	**To provide clear policy directions for health development**			**All stakeholders are informed regarding health development policy directives by 2011**		**4,448,020**
		1.1.1	Improved Strategic Planning at Federal and State levels		At least 3 Health Development Policies directives adapted by Kebbi State by 1st qtr 2010.		**4,448,020**
			1.1.1.1	The policy and strategic leadership of the State Ministry of Health will be strengthen through an integrated organizational change and development programme which will incorporate the re-orientation and strengthening of human resource capacities.	Organizational change and development programme in place by 1st qtr 2010	Delay in passing National Health Bills into law.	1,164,250
			1.1.1.2	Emphasis on effective implementation of agreed plans and this will include advocacy at State Level in support of policy development and implementation.	At least 3 advocacy visits at state and 1 visit to each of the 21 LGAs and outcomes	Inability to meet commitment	811,851
			1.1.1.3	Development of evidence based, costed and prioritized strategic health plans.	Kebbi state strategic plan developed and costed by 4th quarter 2009	All input for evidence based, costed and prioritzed strategic health plan is made available	1,128,396
			1.1.1.4	Optimization of the contribution of Stakeholders in development of Strategic Health Plans	All stakeholders contributed to development of kebbi state strategic health plan by 4th qtr 2009	Commitment of Stakeholders to the development of the Strategic health plan	203,347
			1.1.1.5	Review, Adaptation, Printing & Dissemination of existing State Health Policies	At least 3 State health policies printed and disseminated by 2nd qtr 2010	Availability of existing state health policies and budget release.	1,140,176
	1.2	**To facilitate legislation and a regulatory framework for health development**			**Health Bill signed into law by end of 2009**		**329,191,112**
		1.2.1	Strengthen regulatory functions of government		Percentage of regulatory bodies functioning and the number of policies implemented by 4th quarter 2010		**329,191,112**
			1.2.1.1	Strengthening capacity of State Government in setting standards and ensuring compliance of quality service delivery.	quarterly reorientation workshops and monthly monitoring and supervisory visits conducted by 2010	Timely release of funds budgetted	4,474,142
			1.2.1.2	State Ministry of Health will adopt public/private partnership policies and plans in line with the National policy on PPP.	Public /private /partnership policies and plans adopted by kebbi state by 2nd qtr 2010	Availability of Public/Private Partnership policies	979,599
			1.2.1.3	Technical support from State Ministry of Health on implementation of Strategic Plans to ensure that regulatory functions of Local Government is	1. At least 2 trainings conducted on implementation of the strategic plans 2.	Timely provision of technical support by SMoH.	2,661,436

				strengthened and set standards are delivered and monitored.	Reports of quarterly supportive supervisory visits to the LGAs by 2010		
			1.2.1.4	Kebbi State government will collaborate with Private Sector to improve their health delivery system through joint continuous professional development, supportive supervision and generation of public health information and intellegence.	Percentage of private health service providers collaborating with the State by 2010	Appropriate mechanism for collaboration is put in place	6,554,222
			1.2.1.5	Out-sourcing of some components of health service delivery to the private sector.	number and type of key health services that are out sourced to private sector by 4th quarter of 2010	Outsourced services is backed with necessary logistics	314,521,713
	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**		**15,743,757**
		1.3.1	To improve accountability and transparency		Number of Guidelines and Reporting Procedures Institutionalized by 4th quarter 2010		**15,723,269**
			1.3.1.1	Institutionalize demand for accountability, transparency and responsiveness of National Health System through effective decentralization of the decision making process in the Health Sector.	Number of communities demanding for documented report/feedback by 4th quarter 2010	decision making process in the health sector effectively decentralised	949,635
			1.3.1.2	Institute Stakeholder's Dialogue at State and LGAs levels and feedback forum for enlisting input into health sector decision making.	Number of meetings held with Stakeholders, minutes and decisions reached by 3rd quarter 2010	Stakeholders forum in place and functional	1,987,882
			1.3.1.3	Creating platforms for interaction and collaboration with health sector advocacy groups, empowering beneficary communities through sensitization to manage and oversee their health projects and programmes.	Number of meetings held with health sector advocacy groups by 4th quarter 2010.	Platforms for interaction and collaboration in place and active	4,171,939
			1.3.1.4	Promote emergence of independent health sector watch dogs.	Number of independent monitoring groups in place by 2010.	Health sector watch dogs are available and active.	2,480,114
			1.3.1.5	State Ministry of Health to support the process of improving access to information required for yearly joint review of health sector and put such information in the public domain.	Number of health Journals, Newsletters, Periodicals and Reports produced by the State by 2010.	Kebbi State health information readily accessible and in public domain	6,133,698
		1.3.2	To improve administrative process of timely release of funds		percentage of timely quarterly fund released in 2010		**20,488**
			1.3.2.1	Timely submission of planned quarterly activities and budgets		Planned quaterly activities and budgets are submitted timely	-
			1.3.2.2	Follow up on submissions to ensure timely approval as well as release of funds and logistics		Timely approvals and release of funds and logistics	20,488
	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**		**81,514,931**
		1.4.1	Improving and maintaining Sectoral Information base to enhance performance		Number of Health Information System to be strengthen by 2010.		**51,587,605**

			1.4.1.1	Expansion and Deepening of analytical work at State level required in understanding health sector performance and in driving improvement and reforms.	Number of Health personnel trained in Data Management and Softwares by 1st Quarter 2010.	Capacities for analytical work available	2,645,045
			1.4.1.2	In conjunction with development partners, a priortized list of areas for further analytical work will be out-source to universities, health institutions, private sector research firms and research institutes e.g. Needs Analysis,	Number of Prioritized Areas out-sourced by 2nd Quarter 2010.	Prioritized list of areas for further analysis is outsourced to relevant institutions	42,806,300
			1.4.1.3	Linkage with relevant areas in the research and health informationn system of this framework.	Number of researches carried out supported with evidence from the Health Information System by 4th Quarter 2010.	Research is linked to HIS of this framework	6,136,259
		1.4.2	Identifying and using common indicators		Number of Indicators identified by 1st Quarter 2010.		**29,927,326**
			1.4.2.1	Train health workers on the indicators	Number of Health Workers trained on the use of Indicators by 1st Quarter 2010.	Number of indicators to be reported on are defined.	13,039,807
			1.4.2.2	Workshops on the importance of record keeping	Number of Workshop and Personnel trained on record keeping by 1st Quarter 2010	Training budget on record keeping is released in a timely manner	4,040,302
			1.4.2.3	Timely collection and submission of complete reports	Number of reports submitted timely (monthly/quarterly)	Complete reports are collected and submitted timely	9,302,733
			1.4.2.4	Utilization of data on monthly basis to plan/strategise and improve performance	Number of health facilities (HFs) using data to improve performance through informed decision making by 2nd quarter 2010	Availability of data for planning, strategising and informed decision	3,544,484
HEALTH SERVICE DELIVERY							
2. To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare							**23,640,846,418**
	2.1	**To ensure universal access to an essential package of care**			**Essential Package of Care adopted by all States by 2011**		**5,338,946,018**
		2.1.1	To review, cost, disseminate and implement the minimum package of care in an integrated manner		Number of LGAs delivery service using the Minimum Healthcare Package by 4th qtr 2011.		**4,228,597,057**
			2.1.1.1	Strengthen specific communicable and non-communicable disease programmes		Case definition of diseases are properly understood by care givers and minimum care package is available	3,990,082,171
			2.1.1.2	Provision of Standard Operating Procedures (SOPs) and guidelines for service delivery at all levels.		Availability of SOPs and guidelines for service delivery	65,504,969
			2.1.1.3	Print and distribute materials on minimum package of care to all LGAs and institutions		Timely release of funds budgetted	13,445,816
			2.1.1.4	provide all essentials for implementation of minimum package of care		All essentials are provided for implementation of minimum package	151,055,510
			2.1.1.5	supportive supervision to ensure integration of services		Timely Provision of necessary logistics	8,508,593
		2.1.2	To strengthen specific communicable and non communicable disease control programmes		Number of communicable and non communicable disease programmes strengthened by 2nd qtr 2010		**1,089,469,322**

			2.1.2.1	strengthen routine immunization		Availability of RI plans	110,141,494
			2.1.2.2	strengthen HIV/AIDs, STI and TBL programmes		Avialability of HIV/AIDs, STI and FBL plans	403,150,558
			2.1.2.3	Combat malaria		Avalability of malaria control plan	318,764,351
			2.1.2.4	collaborate with other agencies on water and sanitation		Avalability of plans	175,685,647
			2.1.2.5	collaborate with other agencies on IEC		Availability of action plans	81,727,272
		2.1.3	To make Standard Operating procedures (SOPs) and guidelines available for delivery of services at all levels		Percentage of health facilities delivering services in accordance with SOPs and guidelines 4th quarter 2010 to 2015		**20,879,639**
			2.1.3.1	Identify and list standard operating procedures available for specific service areas and those that need to be provided.		All service areas are identified	-
			2.1.3.2	Estimation of quantity of SOPs to be printed and distributed		Estimation and forecasting properly done	-
			2.1.3.3	Training on the use of SOPs by Health Workers (HW)		relevant health workers are trained on use of SOPs	8,726,905
			2.1.3.4	Supportive supervision to ensure the use of SOPs and guidelines		Timely release of funds budgetted and vailability of integrated check list	12,152,733
			2.1.5.5				-
	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**		**12,468,791,270**
		2.2.1	To improve geographical equity and access to health services		**1. Increase by 30% number of communities accessing services within 5km in LGAs by the 4th Quarter 2010.**		**232,295,777**
			2.2.1.1	Mapping of Health facilities, establishing GIS for all health facilities in the State as well as developing criteria for citting of new health facilities at State and LGAs levels.		All health facilities are mapped with GIS established	23,180,317
			2.2.1.2	Upgrade and refurbish all sub-standard faciliteis especially at PHCs level		Budget is released in a timely fashion for upgrade and refurbishment	108,652,490
			2.2.1.3	Adherence to guidelines stipulating standards for access and linkages of different levels of care		Guidelines are adhered to	8,463,811
			2.2.1.4	Develop and implement guidelines for out-reach services and provide budget lines for maintenance of health facilities.		Guidelines are implemented and budgets are released	91,999,159
			2.2.1.5	Establish and implement guidelines for task shifting as well as strengthen the use of telemedicine.		task shifting guidelines are implemented and telemedicine	-
		2.2.2	To ensure availability of Essential Drugs and equipment at all levels		1. System established to procure and distribute essential drugs by 2nd quarter 2010 2. Equipments procured and distributed in line with essential care package by 4th quarter 2010		**11,475,614,588**
			2.2.2.1	Review of Essential Drug List		Availability of essential drug list	8,830,464

			2.2.2.2	Establishing a system to ensure procurement and distribution of essential drugs on sustainable basis at State and LGAs levels.		Sustainable system of procurement and distrbution established	8,720,495,876
			2.2.2.3	Develop/review equipment lists for different levels of health facilities in line with the essential package of care.		Equipment list reviewed appropriately in line with assential package of care	12,594,956
			2.2.2.4	Procure and distribute equipment based on need.		Equipment is procured and distributed	2,733,693,292
			2.2.2.5				-
		2.2.3	To establish a system for the maintenance of equipment at all levels		Number of LGAs in the state implementing the National Health Equipment Policy by 3rd quarter of 2010.		**613,178,453**
			2.2.3.1	Adapt, Disseminate and Implement the National Health Equipment Policy		Availability of funds and National Health Equipment Policy	14,274,284
			2.2.3.2	Create budget lines for the maintenance of equipment and furniture at all levels		Availability of maintenance budgets	27,988,792
			2.2.3.3	Establish medical equipment and hospital furniture maintenance workshops across the State.		Availability of skilled personnel for effective management of medical equipment and hospital furniture workshop	531,787,046
			2.2.3.4	Explore Public-Private Partnership in maintenance of medical equipment and hosptial furniture.		Availability of MOU for effective public/private partnership	5,961,613
			2.2.3.5	Provision of Tracking System to ensure all maintenance are carried out as at when due		Tracking system is in place	33,166,718
		2.2.4	To strengthen referral system		1. Network linkages mapped for 2 way referral systems by 3rd quarter 2010 2. Percentage of health facilitis within the LGAs monitored on referral outcomes by 4th quarter 2010.		**77,736,071**
			2.2.4.1	Mapping Network linkages for two-way referral systems in line with National standards, with implementation guidelines for all cases such as emergency obsteric care, complicated malaria, road traffic accident etc.		Network linkages for Two-way referralsystems Mapped	4,030,386
			2.2.4.2	Establish transportation, communication and other logistics for referrals to ensure effective referrals.		Transportation, communication and other logistics established	46,181,507
			2.2.4.3	Establish System to monitor referral outcomes		Monitoring system for referral outcome established	24,075,959
			2.2.4.4	Establish and implement guideline for two-way referral		Guideline implemented	3,448,219
			2.2.4.5				-
		2.2.5	To foster collaboration with the private sector		Number of meetings held and reports submitted per quarter 3rd quarter 2010 to 4th quarter 2015		**69,966,382**
			2.2.5.1	Mapping of all categories of private health care providers by operational level and location.		All categories of private health care providers mapped	15,309,869
			2.2.5.2	Develop guidelines and standards for regulation of their practice		Guidelines and standards developed	2,057,176
			2.2.5.3	Develop guidelines for partnership, training and out-sourcing of services		Guidelines for partnership, training and out-sourcing developed	14,596,155

			2.2.5.4	Develop and implement joint performance monitoring mechanism for private sector.		Joint performance monitoring mechanism developed and implemented	9,062,771
			2.2.5.5	Adapt and implement National Policy on traditional medicine at all levels		Availability of National policy on Traditional medicine	28,940,411
	2.3	**To improve the quality of health care services**			**50% of health facilities participate in a Quality Improvement programme by end of 2012**		**170,373,374**
		2.3.1	To strengthen professional regulatory bodies and institutions		Percentage of health facilities and institutions accessed using quality improvement criteria by 2012		**47,547,360**
			2.3.1.1	Support implementation of operational guidelines of all regulatory bodies at State and LGAs levels.		Availability of operational guidelines of regulatory bodies	7,528,985
			2.3.1.2	Build capacity of regulatory staff to monitor compliance of providers to the regulatory guidelines.		provision of funds for capacity building	11,363,450
			2.3.1.3	Create budget lines and provide necessary resources.		Availability of funds and Necessary resources	-
			2.3.1.4	Strengthen regular monitoring exercises with appropriate documentation and feedback.		Availability of monitoring logistics	14,660,529
			2.3.1.5	Empower regulators through provision of necessary security.		Security is provided	13,994,396
		2.3.2	To develop and institutionalise quality assurance models		Number of quality assurance models adopted and institutionalised by 4th Quarter 2010		**38,965,996**
			2.3.2.1	Review available quality assurance models and build concesus on the models to adopt.		Appropriate quality assurance models adopted.	11,853,253
			2.3.2.2	Develop quality assurance training modules to build capacity of both public and private health care providers, training of trainers (TOT) conducted and cascaded to other health workers.		Quality assurance training modules developed	13,994,396
			2.3.2.3	Institutionalise and implement quality assurance and improvement initiatives at all levels		Quality assurance institutionalised.	-
			2.3.2.4	Development of SERVICOM guidelines, building institutional capacity and training staff for its implementation at all levels.		Availability of SERVICOM guidelines	6,997,198
			2.3.2.5	Provide strategics for monitoring implementation of quality of care.		Availability of monitoring strategies	6,121,149
		2.3.3	To institutionalize Health Management and Integrated Supportive Supervision (ISS) mechanisms		Percentage of LGAs applying Health Management and Integrated Supportive Supervision Skills by 4th quarter 2010		**83,860,018**
			2.3.3.1	Strengthen management capabilities of health managers and health teams especially at LGAs and Ward levels through team building and leadership development programmes.		Conduct of team building and leadership development programmes	22,335,056
			2.3.3.2	Institutionalize comprehensive Integrated Supportive Supervision (ISS) at all levels.		Availability of comprehensive integrated supportive supervision check list	6,051,177
			2.3.3.3	Develop capacities of programme managers at all levels on the ISS mechanisms		Trainings on integrated supportive supervision conducted.	30,269,878
			2.3.3.4	Develop ISS tools and guidelines specifying modalities and frequencies of the ISS visits at all levels.		ISS tools and guidelines developed	5,877,646

			2.3.3.5	Build capacity on Behaviourial change communication		Timely release of funds for Behavioural change communication capacity building	19,326,261
	2.4	**To increase demand for health care services**			**Average demand rises to 2 visits per person per annum by end 2011**		**64,892,014**
		2.4.1	To create effective demand for services		Number of communities with functional WDCs and VDCs by 1st quarter 2011		**64,892,014**
			2.4.1.1	Dissemination and Implementation of National Health Promotion Communication Strategy based on the National Health Promotion Policy.		Availability of National Health Promotion Communication Strategy	6,073,568
			2.4.1.2	Provide budget lines for health promotion through behavioural change communication at all levels.		Budget lines for health promotion released timely	29,989,991
			2.4.1.3	Establish Programme monitoring and evaluation mechanism		Programme monitoring and evaluation mechanism established	-
			2.4.1.4	Community mobilization for participation and ownership		Participation and ownership by communities	28,828,456
	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**		**5,597,843,742**
		2.5.1	To improve financial access especially for the vulnerable groups		1. Percentage of LGAs providing free healthcare services to Vunerable groups by 4th quarter 2010. 2. Number of LGAs with established Health financing technical working groups by 3rd quarter 2011.		**5,597,843,742**
			2.5.1.1	Explore models for financial protection for the vulnerable groups (e.g. pregnant women, under fives, orphans and the aged). Such as exemption schemes vouchers, health cards, pre-payment schemes.		Vulnerable groups protected financially	13,994,396
			2.5.1.2	Scale up existing financial protection schemes.		Financial protection schemes scaled up	2,616,952,041
			2.5.1.3	Free access to Immunization, HIV/AIDS, TB, VVF and Eye care services		Availability of Immunisation, HIV/AIDs, TBL, VVF and Eye care services	2,943,021,466
			2.5.1.4	Develop costed health financing strategic plan at State and LGAs level		Costed health financing strategic plan developed	19,592,154
			2.5.1.5	Create health financing technical working groups at all levels		Health financing technical working groups created	4,283,685
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							
	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		1. State adaptation and implementation of HRH Policy and Plans by 2nd Qaurter 2011 2. Percentage of LGAs that have adapted and institutionalized HRH		

					policy and plan by 3rd Quarter 2011.		
			3.1.1.1	Adaptation of HRH policy and plan by the State and LGAs to guide human resource development			
			3.1.1.2	Develop a model to project professional staff needs for the State			
			3.1.1.3	Set up committee to liase with health educational institutions to secure placement to students			
			3.1.1.4	Strengthening of institutional framework for human resources management practices in health sector.			
			3.1.1.5	Develop/adapt policy framework to guide existence of private and public practitioners at all levels of health service delivery as well as develop and implement guidelines on task shifting and establish a fora for public-private practitioners to institutionalise HRH policy reviews, supervisory and monitoring frameworks.			
	3.2	**To provide a framework for objective analysis, implementation and monitoring of HRH performance**			**The HR for Health Crisis in the country has stabilised and begun to improve by end of 2012**		
		3.2.1	To reappraise the principles of health workforce requirements and recruitment at all levels		Recruitment mechanism for HRH planning and budgetting established by 1st quarter 2010.		
			3.2.1.1	Develop and streamline career pathways for all groups of health professionals in the State critically needed to foster demand and supply creation in the health sector.			
			3.2.1.2	Establish and strengthen HRH capacity, SMOH & LGA Health Depts with the view to designing, implementing, evaluating and reporting HRH components.			
			3.2.1.3	Develop, introduce and utilize norms based on workload, service availability and health sector priorities to guide HRH planning in the state.			
			3.2.1.4	Establish coordinating mechanisms for consistency in HRH planning and budgeting by ministries of health, Finance, education, Civil Service Commission, Regulatory bodies, Private Sector Providers, NGOs in health and other institutions			
			3.2.1.5	Review of entry criteria and admission quotas of prospective health care providers into training institutions			
	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**		
		3.3.1	To establish and strengthen the HRH Units		1. Establishment of HRH Unit by SMOH Planning Dept. by 1st Quarter 2010 2. Percentage of LGAs with established HRH Units by 3rd quarter 2010.		
			3.3.1.1	Create/strengthen HRH Unit in the Health Planning Dept. at State Minsitry of Health.			
			3.3.1.2	Development of guidelines and training programmes in human resources for health planning and management for State and LGA HRH Units to enhance the HRH managers.			
			3.3.1.3	Establish multi-sectoral HRH system for planning, management and development at State & LGA levels.			

			3.3.1.4	Provision of equipments and materials e.g. Computers, Photocopiers, Scanner, Printer and other accessories.			
	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**		
		3.4.1	To review and adapt relevant training programmes for the production of adequate number of community health oriented professionals based on state priorities		1. Number of facilities with adequately trained health personnel at LGA levels by 2012.		
			3.4.1.1	Provision of Teaching Aids, Books and Training equipment to State School of Nursing & Midwifery and School of Health Technology.			
			3.4.1.2	Establish programme to fund in-service training, human capital capacity building and continuing professional development.			
			3.4.1.3	Establish a process and financial resources to sponsor candidates and bond them to return to serve for an agreed period after training.			
			3.4.1.4	Rationalize and allign supply of health workforce to the priority of the health sector			
			3.4.1.5	Create a State Database of human resources for health			
		3.4.2	To strengthen health workforce training capacity and output based on service demand		At least 50% of workforce adequately traind/re-trained based on service demand by 4th quarter of 2011.		
			3.4.2.1	Develop and provide job descriptions and specifications for all categories of health workers			
			3.4.2.2	SMOH to collaborate with Federal Institutions located in the State to liverage available human resource as to expand service coverage and quality.			
			3.4.2.3	Design and embark on a campaign to encourage the diaspora trained health professionals to return to the service to strengthen the human resource availability in the country.			
			3.4.2.4	Sensitization, Counselling and Motivation of students to read health related courses and promotion of Midwifery service Scheme and Community Midwifery Programme.			
			3.4.2.5	Support design and implementation of special training programmes aimed at producing adequate cadres of health professionals in critical areas of need.			
	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**		
		3.5.1	To achieve equitable distribution, right mix of the right quality and quantity of human resources for health		1. Number of facilities with adequately trained health personnel at State and LGA levels by 3rd quarter 2012.		
			3.5.1.1	Develop and refine recruitment selection and development of competent and capable staff to reflect organization's objectives and needs.			
			3.5.1.2	Drawing up of plan to equitably re-distribute staff between rural and urban areas and at the different levels of health care system in relation to needs.			

			3.5.1.3	Use of intra and extra mural private practice services to improve underserved areas and provision of incentives for health workers in under served areas.			
			3.5.1.4	Encourage in-service training and continuing education as well as mandatory rotation of health workers to under served rural areas e.g. through NYSC schemes for doctors, pharmacists, and appropriate schemes for midwifes and nurses			
			3.5.1.5	Establish performance based incentives			
		3.5.2	To establish mechanisms to strengthen and monitor performance of health workers at all levels		Percentage of communities with increased access to Healthcare delivery and feedback by 4th quarter 2011.		
			3.5.2.1	Conduct Routine re-orientation of health workforce on attitudinal change including training and retraining in Interpersonal Communication (IPC) skills and work ethics for the promotion of client satisfaction and improvement of quality of care.			
			3.5.2.2	Institute system of recognition, reward and sanctions.			
			3.5.2.3	Establish and institutionalize framework for integrated supportive supervision with adequate committed resources for all types and levels of care providers across public and private sectors			
			3.5.2.4	establish mechanisms to monitor health workers performance, including use of client feedback (exit interviews).			
	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		Percentage of LGAs with established HRH stakeholders forum by 2nd quarter 2011.		
			3.6.1.1	promote intra and inter-professional respect, harmony and team work among all discplines of health care workers for optimum health service delivery.			
			3.6.1.2	establish effective dialoque and complaints channels between management and staff of public and private sectors as well as HRH regulatory bodies and associations.			
			3.6.1.3	Involvement of workers and professional groups in management teams, design and monitoring of services to enhance cooperation amongst all 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							**3,438,405,106**
	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**		**50,201,865**
		4.1.1	To develop and implement evidence-based, costed health financing strategic plans at LGA, State and Federal levels in line with the National Health Financing Policy		Technical working group for health financing established by State and LGAs by 2nd quarter 2010.		**50,201,865**
			4.1.1.1	Set up technical working groups for health financing at state and LGA levels			26,680,413
			4.1.1.2	Capacity buiding for development and implementation of the strategic plan at state and LGA levels			23,521,452
	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**		**2,531,416,215**

		4.2.1	To strengthen systems for financial risk health protection		1. State keys into NHIS and other Health Insurance Schemes by 4th Quarter 2010. 2. Number of Health facilities registered to provide services to enrollees 2010 to 2015		**2,531,416,215**
			4.2.1.1	Establish or key into existing or innorvative social health insurance schemes			937,037,439
			4.2.1.2	Support formation of community based health insurance schemes			1,510,111,360
			4.2.1.3	support establishment of pre paid health insurance schemes			15,581,361
			4.2.1.4	Provide support for the effectiive implementation of NHIS in Kebbi State			68,686,055
	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**		**677,693,155**
		4.3.1	To improve financing of the Health Sector		1. State health sector funding increased by at least 5% per annum from 2010 to 2015. 2. Number of LGAs with increased funding by at least 5% per annum from 2010 to 2015.		**33,841,436**
			4.3.1.1	Identify, test and implement strategies with support from Federal Government for attracting alternative financial flows to the health sector			18,783,011
			4.3.1.2	Put mechanism in place to get State Government to increase allocation to health sector to 15% of total state budget			15,058,425
		4.3.2	To improve coordination of donor funding mechanisms		Coordination structures and functions in collaboration with development partners established by 4th quarter 2010.		**643,851,720**
			4.3.2.1	SMOH in collaboration with development partners conduct detailed assessment of cordination structures and functions			49,305,403
			4.3.2.2	Establish effective coordination model in kebbi State			109,496,414
			4.3.2.3	Coordination of donors resources with that of government for health development to take the form of common basket funding			485,049,903
			4.3.5.5				-
	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**		**179,093,871**
		4.4.1	To improve Health Budget execution, monitoring and reporting		Availability of audited annual reports at State		**95,893,672**

					and LGA levels by 4th quarter 2010 to 2015.		
			4.4.1.1	Development of State and LGA costed annual operational plans			14,998,661
			4.4.1.2	Build capacity in accounting and record keeping to ensure proper internal recording and accounting expenditures are maintained			29,882,062
			4.4.1.3	Periodic production of timely and detailed finacial management reports			5,122,639
			4.4.1.4	Entrench mechanism to increase financial transparency through development of state health accounts (SHA) and Public expenditure reviews (PER)			18,014,615
			4.4.1.5	Develop and implement tracking system of health budgets			27,875,695
		4.4.2	To strengthen financial management skills		Percentage of personnel trained on financial management at State and LGA level by 3rd quarter 2011.		**83,200,199**
			4.4.2.1	Build capacity at State and LGA Levels in critical areas such as budgeting, planning, accounting, auditing, monitoring and evaluation etc			43,713,188
			4.4.2.2	Carry out hands on training and competency transfer in financial management systems			39,487,011
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							**626,462,510**
	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**		**271,686,761**
		5.1.1	To ensure that NHMIS forms are available at all health service delivery points at all levels		Number and types of NHMIS forms available at health service delivery point by 1st Quarter 2010.		**17,888,284**
			5.1.1.1	List NHMIS data collection tools (DCT) to be used			413,757
			5.1.1.2	Esimate quantity and budget for each DCT to be printed every 6 months buffer stock and reorder stock inclusive			6,602,628
			5.1.1.3	Ensure release of budget and printing of adequate DCTs			9,324,099
			5.1.1.4	Allocate and distribute DCT according to forecasted usage of LGAs			1,547,800
		5.1.2	To periodically review of NHMIS data collection forms		Stakeholder's forum/technical working group established at state level to recommend review of NHMIS management tools by 1sr quarter 2010.		**40,431,624**
			5.1.2.1	Establish feedback mechanism on appropriateness and user friendliness of data collection tools			24,627,276
			5.1.2.2	Establish mechanism for annual reviews of DCTs at state level			15,804,348
		5.1.3	To coordinate data collection from vertical programmes		Availability of harmonized data through integrated HIS and M&E at state		**31,071,394**

					and LGA level by 4th quarter 2010.		
			5.1.3.1	Revive health data consultative committee at state level in collaboration with partners and other government agencies to streamline and strengthen data collection system			12,214,570
			5.1.3.2	Utilise the integrated current HIS with M&E systems to enhance coherence and complimentality			7,510,562
			5.1.3.3	Establish and strengthen linkages and harmonised data collection mechanisms at state and support LGA levels			11,346,263
		5.1.4	To build capacity of health workers for data management		Percentage of Health workers trained on Data Management at State and LGA levels from 2010 to 2015.		**80,126,644**
			5.1.4.1	conduct comprehensive training and retraining of service providers on data collection tools, analysis and utilization of data for action in health programming and policy formulation			28,129,641
			5.1.4.2	establish monitoring systems to ensure data quality			12,159,791
			5.1.4.3	Recruit health information personnel			39,837,213
		5.1.5	To provide a legal framework for activities of the NHMIS programme		Legal framework of NHMIS programme adapted and implemented by State and LGAs from 1st quarter 2010 to 2015.		**39,718,331**
			5.1.5.1	Mandatory data collection and utilisation enforced as contained in draft health bill			3,878,825
			5.1.5.2	Establish mechanism to enforce sanctions			2,331,025
			5.1.5.3	Advocacy to policy makers			8,449,965
			5.1.5.4	Strengthening of vital registration system in the state and LGAs			25,058,516
		5.1.6	To improve Data Collection and Reporting		1. Percentage of facilities submitting timely and complete reports to LGAs from 3Rrd quarter 2010 to 2015. 2. Percentage of LGAs submitting timely and complete reports to State from 2010 to 2015.		**54,699,827**
			5.1.6.1	Improve data collection process and coverage			9,692,401
			5.1.6.2	Device innovative strategies to collect data from all private and public health facilities and communities			36,130,883
			5.1.6.3	Support National Population Census to strenghten registration of births and deaths in the state			6,526,869
			5.1.6.4	Ensure availability of adequate DCT			2,349,673
		5.1.7	To ensure supportive supervision of data collection at all levels		1. Timely submission of complete monthly and quaterly reports by LGAs by 3rd quarter of 2010 2. Availability of completed supervisory checklist for all visits by 4th quarter 2010		**7,750,657**
			5.1.7.1	Provide adequate logistics to officials to supervise data collection at state and LGA levels			3,088,608

			5.1.7.2	Provide adequate integrated and harmonised supervision checklist			4,662,049
	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**		**212,671,818**
		5.2.1	To strengthen the use of information technology in HIS		Percentage of health institutions at LGAs and State level using Health Information Technology by 4th Quarter 2011.		**89,915,394**
			5.2.1.1	Strengthening of information technology on HIS			8,061,460
			5.2.1.2	Promotion of decentralised software-based systems for data collection and analysis			4,428,947
			5.2.1.3	Establishment of public - private partnership in management of data warehouses			18,181,993
			5.2.1.4	Put in place mechanisms to enhance wide use of e-health data,			23,053,835
			5.2.1.5	Training on utilisation of e-health data, electrononic management intelligent information system, websites, patient information system, drug information systems and other identified health packages			36,189,159
		5.2.2	To provide HMIS Minimum Package at the different levels (FMOH, SMOH, LGA) of data management		Percentage of health facilities operating minimum package of HMIS by 2nd quarter 2011		**122,756,425**
			5.2.2.1	Definition of HIS minimum package at state and LGA levels of data management..			1,282,064
			5.2.2.2	Provision of basic infrastructure (computers, power supply, internet etc) for data storage, analysis and transmission			109,360,026
			5.2.2.3	Monitoring of appropriate use of computer hardwares			-
			5.2.2.4	Capacity buiding of relevant staff on database			12,114,336
	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**		**82,132,491**
		5.3.1	To strengthen the Hospital Information System		Percentage of hospitals in the state utilising Hospital Information System for informed decision by 4th quarter 2011		**36,002,677**
			5.3.1.1	Establish Patient Information Systems at State and LGAs level			11,655,124
			5.3.1.2	Strengthening Patient Information Systems through capacity building			10,623,645
			5.3.1.3	Establish System for Mapping Disease			13,723,908
		5.3.2	To strengthen the Disease Surveillance System		Number of LGAs and Health Facilities submmiting timely and completed weekly/monthly surveillance reports from 1st quarter 2010 to 2015		**46,129,814**
			5.3.2.1	Regular reporting of notifiable diseases by all Health Facilities			25,535,211

			5.3.2.2	Initiate and Strengthen Community Based Surveillance			8,939,480
			5.3.2.3	Dissemination of guidelines to LGAs, Public and Private health facilities and case definition			4,312,396
			5.3.2.4	Monthly review meetings			7,342,728
	5.4	**To monitor and evaluate the NHMIS**			**NHMIS evaluated annually**		**39,953,764**
		5.4.1	To establish monitoring protocol for HMIS programme implementation at all levels in line with stated activities and expected outputs		HMIS monitoring protocol established at all levels and minutes/reports of all meetings/ monitoring visits available from 1st quarter 2010 to 2015		**33,566,756**
			5.4.1.1	Provision and timely availability of logistics materials (vehicles and/or motorcycles)			17,342,824
			5.4.1.2	Use of HMIS field monitoring instrument at all levels			4,650,394
			5.4.1.3	Use of HIS quality assurance manual at each level of health care delivery			3,496,537
			5.4.1.4	Quarterly HIS Review Meetings at State level			8,077,001
		5.4.2	To strengthen data transmission		1. Percentage of facilities within the LGA submitting complete report on time to the LGA. 2. Number of LGA submitting complete reports on time to the State from 2010 to 2015		**6,387,008**
			5.4.2.1	Strengthening Data Analysis			4,638,739
			5.4.2.2	Dissemination of Health Information			1,748,269
	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**		**20,017,675**
		5.5.1	To institutionalize data analysis and dissemination at all levels		Number of bulletins, periodicals and annual reports produced yearly by the State from 2010 to 2015		**20,017,675**
			5.5.1.1	Institutionalize human capacities for appropriate data analysis and dissemination of information			6,963,936
			5.5.1.2	Institutionalize and Strengthen human capacities for appropriate informed decision making and programming			9,324,099
			5.5.1.3	Production of Periodic Health Data Bulletin and Annual Report by Dept. of Planning, Research & Statistics at State level			3,729,640
COMMUNITY PARTICIPATION AND OWNERSHIP							
6. To attain effective community participation in health development and management, as well as community ownership of sustainable health outcomes							**381,124,296**
	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**		**66,211,691**
		6.1.1	To provide an enabling policy framework for community participation		1. Percentage of communities with		**27,263,637**

					community development committees (CDC) within the LGAs in the State 1st quarter 2010 2. Minutes of meetings held from 2010 to 2015.		
			6.1.1.1	Provide enabling policy environment to foster effective community participation in health actions.			25,961,027
			6.1.1.2	Dissemination of policy on community participation section of the National Health Policy			1,302,610
		6.1.2	To provide an enabling implementation framework and environment for community participation		1. Percentage of communities with community development committes (CDC) within the LGAs 1st quarter 2010 2. Minutes of meetings held from 2010 to 2015.		**38,948,054**
			6.1.2.1	Update and Adapt existing guidelines for establishing Community structures for Health Development activities.			8,466,968
			6.1.2.2	Develop and utilize participatory tools and approches to enhance community involvement in Planning, Management, Monitoring and Evaluation of Health Intentions			19,539,157
			6.1.2.3	Establish Inter-Sectoral Stakeholder's Commitees involving community representatives at all levels so as to enhance collaboration.			10,941,928
	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**		**149,344,299**
		6.2.1	To build capacity within communities to 'own' their health services		Percentage of WDCs/CDCs/FBOs/CBOs and VDCs trained and type of training conducted from 2010 to 2015		**149,344,299**
			6.2.1.1	Empower communities with health knowledge and capacity in management, implementation, and basic interpretation of health data to enable communities to actively participate in health actions.			48,847,893
			6.2.1.2	Define key roles and functions of community stakeholders and structures			2,084,177
			6.2.1.3	Development, Upgrading and Modification of existing participatory tools for mobilizing communities in planning & management			3,842,701
			6.2.1.4	Identification and mapping out of key community stakeholders and resources with community assessment of capacity needs.			16,543,153
			6.2.1.5	Re-orientation of community development communities and community based-health providers on their roles and responsisibilities and resources mobilized and allocated for funding community activities.			78,026,375
	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**		**45,467,619**
		6.3.1	To restructure and strengthen the interface between the community and the health services delivery points		Number of health facilities development		**45,467,619**

					community meetings held and minutes of meetings available from 1st quarter 2010 to 2015.		
			6.3.1.1	Review and Access the level of linkages of existing health delivery structures with the community.			13,032,618
			6.3.1.2	Provide technical guidance and support to community stakeholders for the development of guidelines for strengthening community health services linkages.			23,446,989
			6.3.1.3	Re-structuring of Health Delivery Structures to ensure adequate promotion of community participation in health development			-
			6.3.1.4	Promotion and facilitation of exchange of experiences between community development committees			8,988,012
	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**		**88,186,730**
		6.4.1	To develop and implement multisectoral policies and actions that facilitate community involvement in health development		Percentage of communities with inter-sectoral committees and minutes of meetings held from 1st quarter 2010 to 2011.		**88,186,730**
			6.4.1.1	Utilization of approved and acceptable approaches, people and systems in Health Development by Community involvement			29,960,041
			6.4.1.2	Advocacy to Community Gate-Keepers to increase their awareness on commmunity participation and health promotion.			6,773,575
			6.4.1.3	Support the development and Implementation of Community Health Development Programmes			18,236,547
			6.4.1.4	Formulate action plans to facilitate the development of Health promotion capacities at Community levels.			26,052,210
			6.4.1.5	Support LGAs and Communities to link health with other sectors using the Health Promotion Guidelines.			7,164,358
	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**		**31,913,957**
		6.5.1	To develop and implement systematic measurement of community involvement		Percentage of communities with documented impact assessment and lessons learnt by 4th quarter 2010 to 2015.		**31,913,957**
			6.5.1.1	Adapt local models to establish simple mechanisms to support communities to measuure impact and document lessons learnt.			11,723,494
			6.5.1.2	Support the disseminatation of best practices from specific community level approaches, methods and initiatives, and findings to enhance knowledge sharing amongst stakeholders.			20,190,463
PARTNERSHIPS FOR HEALTH							
7. To enhance harmonized implementation of essential health services in line with national health policy goals							**408,220,565**
	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**		**408,220,565**

					quarterly by end 2010 3. All States have similar active committees by end 2011		
		7.1.1	To promote Public Private Partnerships (PPP)		1. Availability of adapted PPP Policy at State level by 4th quarter 2010.. 2. Number of MOUs signed 1st quarter 2010 to 2015 3. Availability of minutes of meetings held from 1st quarter 2010 to 2015		**155,913,683**
			7.1.1.1	Adapt operated National PPP Policy with a view to liverage technical and financial resources as well as improve management approaches for improve delivery of health care services.			11,334,667
			7.1.1.2	Develop strategies for implementing PPP initiatives in line with adapted National Policy and PPP Units at all levels to promote, oversee and monitor PPP initiatives.			35,821,214
			7.1.1.3	Undertake and establish mechanisms for engaging private sector: such as contracting or out-sourcing, leasing, concessions, social marketing, franchazing machanism and provision incentives (e.g. health communities or technical support at no cost)			8,088,487
			7.1.1.4	Explore other options that encourage the private sector to set up health facilities in rural & under-served areas.			92,235,718
			7.1.1.5	Establish joint monitoring visits by public and private care providers with adequate feedback			8,433,596
		7.1.2	To institutionalize a framework for coordination of Development Partners		Development Partners Cordination Committee established by 1st Quarter 2010.		**21,299,683**
			7.1.2.1	Institutionize framework for the alignment and harmonization of development partner's support			9,166,952
			7.1.2.2	Establishment of Deveopment Partners Forum comprising of only Health Development Partners at State level as single entry point for engaging with partners.			2,156,930
			7.1.2.3	Strengthening of Health Partners Coordinating Committee (HPCC) as a Government Co-ordinating body with all other health development partners.			5,661,941
			7.1.2.4	Establishment of similar mechanisms for resource coordination through common basket funding models such as joint funding agreement, sector wide approaches and sectorial multi-donor budget support.			4,313,860
		7.1.3	To facilitate inter-sectoral collaboration		Inter-Sectoral Committee established by 1st Quarter 2010.		**17,255,440**
			7.1.3.1	Establish Inter-Sectoral Ministerial forum at all levels to facilitate Inter-Sectoral collaboration involving all relevant MDAs directly engaged in the implementation of specific health programmes - such as Environment in Malaria Control & Prevention, Agriculture in Nutrition Programmes, Water Resources in Control of Water Borne or related diseases, Women Affairs in Maternal, Newborn and Child Health and Information and Behaviour Change Communication (BCC) programmes.			17,255,440
		7.1.4	To engage professional groups		Number and types of Services provided by professional groups from 2010 to 2015.		**85,252,657**

			7.1.4.1	Promotion of effective partnership with professional groups through joint setting standards of training by health institutions, subsequent practice and professional competency assessment.			13,480,812
			7.1.4.2	Engage professional groups in planning, implementation, monitoring and evaluation of health plans and programmes.			14,020,045
			7.1.4.3	Promote effective communication to facilitate relationships between professional groups and LGAs.			9,706,185
			7.1.4.4	Strengthen collaboration between Government and professional groups to advocate for increase coverage of essential interventions, particularly increased funding.			12,725,887
			7.1.4.5	Promote linkages with academic institutions to undertake research, education and monitoring thorugh existing network			35,319,728
		7.1.5	To engage with communities		1. Number of IEC materials made available, media engagement, community dialogues, sensitization meetings by 4th quarter 2010. 2. Number of community development project undertaken from 2010 to 2015.		**58,237,109**
			7.1.5.1	Improve availability of information to communities, in a form that is readily accessible and useful through proper culturally appropriate and gender sensitive dissemination channels.			9,706,185
			7.1.5.2	Information packages for community consumption should include rights of beneficiaries, means of accessing care at health facilities and minimum standards of quality health services.			-
			7.1.5.3	Develop indicators on health systems performance at State, LGAs and Facilities to improve transparency and accountability of government to its citizens.			5,931,557
			7.1.5.4	Institute mechanisms for competition between LGAs and Facilities for satisfactory performance in delivery of community support programmes for health.			18,873,137
			7.1.5.5	Build capacity of communities to prevent and manage priority health conditions through appropriate self mediated mechanisms such as behaviour change communication, social marketing, public awareness campaign, information, education and communication resources (IEC).			23,726,230
		7.1.6	To engage with traditional health practitioners (THP)		1. Number and types of trainings conducted for traditional health practitioners from 3rd quarter 2010 to 2015. 2. Number of meetings held with traditional health practitioners from 2010 to 2015.		**70,261,994**
			7.1.6.1	Seek to have better understanding of traditional health practices and support research activities to gain more insight and evaluate them.			21,030,067
			7.1.6.2	Organize traditional medicine practitioners into bodies/organizations that are easy to regulate and actually regulate their practice.			8,412,027
			7.1.6.3	Train traditional health practitioners to improve their skills to know their limitations and ensure their use of referral system.			12,240,578
			7.1.6.4	Where applicable, seek the cooperation of traditional practitioners in promoting health programmes in such			22,647,765

				priority areas as nutrition, environmental sanitation, personal hygiene, immunization and family planning.			
			7.1.6.5	Adopt traditional practices and technologies of proven value into State Healthcare System and discourage those that are harmful.			5,931,557
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							**785,555,502**
	8.1	**To strengthen the stewardship role of governments at all levels for research and knowledge management systems**			**1. ENHR Committee established by end 2009 to guide health research priorities 2. FMOH publishes an Essential Health Research agenda annually from 2010**		**380,523,883**
		8.1.1	Adapt health research policies at State levels and health research strategies at State and LGA levels		Availability of State health research policy by 2nd quarter 2010.		**20,549,923**
			8.1.1.1	Make available draft Health Research policy at state level			13,388
			8.1.1.2	Adaption of finalised health reseach Policy by Federal level at state level through a technical working group			3,333,505
			8.1.1.3	Establish Health Research steering committee to drive and monitor research activities at state level			4,462,524
			8.1.1.4	Identify Health Reseach Strategies for Kebbi state			6,492,972
			8.1.1.5	Prioritise Health research needs of Kebbi state			6,247,534
		8.1.2	To establish and or strengthen mechanisms for health research at all levels		1. A Research Unit established in DPRS of SMOH by 2011. 2. Availability of research guidelines by 4th quarter 2010.		**44,558,302**
			8.1.2.1	Establish research divisions and units in Kebbi state MOH DPRS and build capacity to coordinate and carry out research			19,835,919
			8.1.2.2	Strengnthen research Capacity of DPRS of SMOH to provide technical assisstance to LGAs DPRS			7,229,289
			8.1.2.3	Ensure coordinated implementation of Essential National Health Research guidelines as it applies to Kebbi State			13,744,574
			8.1.2.4	Set up a forum between researchers and communities			3,748,520
		8.1.3	To institutionalize processes for setting health research agenda and priorities		1. Guidelines for collaborative health research developed by 1st quarter 2011. 2. Number of researches supported by 4th quarter 2011.		**37,168,362**
			8.1.3.1	Establish functional institutional structures for research and/or strengthen existing institutions			2,008,136
			8.1.3.2	Expansion of health research agenda to include broad and multidimentional determinants of health and ensure cross linkages			17,180,717
			8.1.3.3	Develop guidelines for collaborative research at State level			1,918,885
			8.1.3.4	support the development of collaborative research proposals and their implementation between governments and public and private health research organisations			16,060,624
		8.1.4	To promote cooperation and collaboration between Ministries of Health and LGA health authorities with Universities,		1. Health Research Officer's Forum		**30,702,165**

			communities, CSOs, OPS, NIMR, NIPRD, development partners and other sectors		established and report of research findings from 4th quarter 2010 to 2015.		
			8.1.4.1	Establish a forum of health research officers at kebbi SMOH and promote same at LGAs			1,338,757
			8.1.4.2	Convene multistakeholders forum to identify research priorities and harmonise research efforts			8,032,543
			8.1.4.3	Support the development of collaborative research proposals and their implementation between governments and public and private health research organisations			21,330,865
		8.1.5	To mobilise adequate financial resources to support health research at all levels		1. Percentage of fund allocated to research from 2010 to 2015. 2. Number of researches funded by organizations, agencies and individuals from 2010 to 2015.		**224,545,282**
			8.1.5.1	Allocate at least 2% of SMOH budget to health resreach			133,875,720
			8.1.5.2	deployment of funds for health research in a targeted manner while expanding beneficiaries of funding to public and non public health research organisations including individuals			64,706,598
			8.1.5.3	Explore opportunities for accessing funds from bilateral and multilateral organizations, research funding agencies and through North - South and South - South collaboration			4,127,835
			8.1.5.4	establish credible and transparent independent funding agency			21,835,130
		8.1.6	To establish ethical standards and practise codes for health research at all levels		Ethical Review Committee established and availability of research guidelines by 1st quarter 2011.		**22,999,849**
			8.1.6.1	Establish and or strenghten health research ethical mechanisms, guidelines and ethical review committees			5,355,029
			8.1.6.2	Monitoring and evaluation systems to regulate research and use of research findings at state and LGAs			5,774,506
			8.1.6.3	Strengthening of mechanisms in secondary health and educational institutions			11,870,314
	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**		**272,137,654**
		8.2.1	To strengthen identified health research institutions at all levels		Number of health research institutions supported by the State from 4th quarter 2010 to 2015.		**90,211,707**
			8.2.1.1	Strengthen identified health research institutions. Public, private and all organisations undertaking health research			42,239,575
			8.2.1.2	Conduct periodic capacity assessment of all health research organisations and institutions			2,677,514
			8.2.1.3	Development and implementation measures to address identified research capacity gaps and weaknesses by state government, development partners and health research organisations/institutions			26,105,765
			8.2.1.4	Development and implementation of resourse mobillization strategies targeting the private sector, foundations and individuals for health research			19,188,853
		8.2.2	To create a critical mass of health researchers at all levels		Number of individual and health personnel trained		**97,004,115**

					on health research from 2011 to 2015.		
			8.2.2.1	Create a critical mass of adequate and qualified human resources for health research in conjuction with training institutions.			25,101,697
			8.2.2.2	Develop appropriate training interventions for research based on identified needs			20,081,358
			8.2.2.3	Provision of competitive research grant for prospective researchers			12,495,067
			8.2.2.4	Award of PhD studentship scholarships to motivate increased PhD training in health in tertiary institutions			39,325,993
		8.2.3	To develop transparent approaches for using research findings to aid evidence-based policy making at all levels		Number of health policies formulated based on research findings from 2010 to 2015.		**19,768,981**
			8.2.3.1	Evolve mechanism for translating research findings into policies in order to achieve evidence-based policy formulation			8,166,419
			8.2.3.2	Establish close laison and linkages between research users and researchers			5,355,029
			8.2.3.3	Involvement of stakeholders including research producers in policy making consultations			6,247,534
		8.2.4	To undertake research on identified critical priority areas		Number and types of priorities health researches conducted from 2010 to 2015.		**65,152,850**
			8.2.4.1	Systematic researches on estimation of different diseases bi-annually			9,817,553
			8.2.4.2	Studies on Human resources for health bi-annually			15,172,582
			8.2.4.3	Bi-annual studies on health delivery system			14,726,329
			8.2.4.4	Studies on finanacial risk protection, equity, efficiency and value of different health financing mechanisms bi-annually.			25,436,387
	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**		**14,146,201**
		8.3.1	To develop strategies for getting research findings into practices		1. GRISP established by 4th quarter 2010 2. Percentage of research findings translated into strategic plan from 2010 to 2015.		**7,898,667**
			8.3.1.1	Establish getting research findings into strategic plan (GRISP)			2,543,639
			8.3.1.2	Institute biannual health research policy forums			5,355,029
		8.3.2	To enshrine mechanisms to ensure that funded researches produce new knowledge required to improve the health system		Number of needs assessment, operations research and impact assessment conducted 1st quarter 2011 to 4th quarter 2015.		**6,247,534**
			8.3.2.1	Conduct needs assessment and operations research to identify required health reseach gaps			6,247,534
			8.3.2.2	Collaboration of government with public, and non public research organisations/institutions in the conduct of operations research thereby addressing gaps in research capacity in government institutions			-

	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**		**118,747,763**
		8.4.1	To create a framework for sharing research knowledge and its applications		1. Framework for sharing research findings/knowledge established and number of reports shared with stakeholders by 4th quarter 2011. 2. Number of confrences and workshops organized and attended from 2nd quarter 2011 to 4th quarter 2015.		**73,899,397**
			8.4.1.1	Development of a framework for sharing research findings/knowledge at all levels			2,454,388
			8.4.1.2	Convene annual health conferences, seminars and workshops at state and LGA levels on key thematic areas (health financing, human resources for health, MDGs, health research etc)			4,953,402
			8.4.1.3	International collaboration on State research agenda			15,618,834
			8.4.1.4	Participation in international conferences on health and mainstream best practices at state and lga levels			49,534,016
			8.4.1.5	Publish research findings in acedemic journals			1,338,757
		8.4.2	To establish channels for sharing of research findings between researchers, policy makers and development practitioners		Research Dissemination Committee (RDC) established by 3rd quarter 2010.		**44,848,366**
			8.4.2.1	Development of researchers capacity by government and development partners/donors to effectively produce policy briefs targeted at informing policy makers, scientific and non scientific audiences			12,495,067
			8.4.2.2	Conduct inventory of national journals according to areas of priority			2,454,388
			8.4.2.3	Selection of national journals on the basis of their ability to address issues related to the Essential National Health Research (ENHR) principles.			4,908,776
			8.4.2.4	Publication of high quality journal by government and donors support, following a review of editorial boards, establishing appropriate linkages between editors of national journals and reputable publishers and international collaborators			12,048,815
			8.4.2.5	Wide dissemination of selected national journals to all stake holders at federal, state and lga levels			12,941,320
							29,711,512,217

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

KEBBI STATE STRATEGIC HEALTH DEVELOPMENT PLAN RESULT MATRIX OVERARCHING GOAL: To significantly improve the health status of Nigerians through the development of a strengthened and sustainable health care delivery system						
OUTPUTS	**INDICATORS**	**SOURCES OF DATA**	**Baseline**	**Milestone**	**Milestone**	**Target**
			2008/9	**2011**	**2013**	**2015**
PRIORITY AREA 1: LEADERSHIP AND GOVERNANCE FOR HEALTH						
NSHDP Goal: To create and sustain an enabling environment for the delivery of quality health care and development in Nigeria						
OUTCOME: 1. Improved strategic health plans implemented at Federal and State levels						
OUTCOME 2. Transparent and accountable health systems management						
1. Improved Policy Direction for Health Development	1. % of LGAs with Operational Plans consistent with the state strategic health development plan (SSHDP) and priorities	LGA s Operational Plans	0	50%	65%	95%
	2. % stakeholders constituencies playing their assigned roles in the SSHDP (disaggregated by stakeholder constituencies)	SSHDP Annual Review Report	0	20	30	60%
2. Improved Legislative and Regulatory Frameworks for Health Development	3. State adopting the National Health Bill? (Yes/No)	SMOH	0	Yes	Yes	Yes
	4. Number of Laws and by-laws regulating traditional medical practice at State and LGA levels	Laws and bye-Laws	TBD	1	3	5
	5. % of LGAs enforcing traditional medical practice by-laws	LGA Annual Report	TBD	25%	50%	75%
3. Strengthened accountability, transparency and responsiveness of the State health system	6. % of LGAs which have established a Health Watch Group	LGA Annual Report	0	20	35	75%
	7. % of recommendations from health watch groups being implemented	Health Watch Groups' Reports	No Baseline	15%	40%	60%
	8. % LGAs aligning their health programmes to the SSHDP	LGA Annual Report	0	40	65%	90%
	9. % DPs aligning their health programmes to the SSHDP at the LGA level	LGA Annual Report	No Baseline	50	75	100
	10. % of LGAs with functional peer review mechanisms	SSHDP and LGA Annual Review Report	No Baseline	15	45	65%
	11. % LGAs implementing their peer review recommendations	LGA / SSHDP Annual Review Report	No Baseline	50	75	95%
	12. Number of LGA Health Watch Reports published	Health Watch Report	0	30	60	90%
	13. Number of "Annual Health of the LGA" Reports published and disseminated annually	Health of the State Report	0	40	65	85%
4. Enhanced performance of the State health system	14. % LGA public health facilities using the essential drug list	Facility Survey Report	TBD	50	80	100%

	15. % private health facilities using the essential drug list by LGA	Private facility survey	TBD	20	40	60%
	16. % of LGA public sector institutions implementing the drug procurement policy	Facility Survey Report	TBD	30	50	80%
	17. % of private sector institutions implementing the drug procurement policy within each LGA	Facility Survey Report	TBD	20	40	50%
	18. % LGA health facilities not experiencing essential drug/commodity stockouts in the last three months	Facility Survey Report	TBD	30	50	75%
	19. % of LGAs implementing a performance based budgeting system	Facility Survey Report	TBD	20	45	65%
	20. Number of MOUs signed between private sector facilities and LGAs in a Public-Private-Partnership by LGA	LGA Annual Review Report	TBD	1	2	4
	21. Number of facilities performing deliveries accredited as Basic EmOC facility (7 functions 24/7) and Comprehensive EmOC facility (9 functions 24/7)	States/ LGA Report and Facility Survey Report	TBD	70	95	120
STRATEGIC AREA 2: HEALTH SERVICES DELIVERY						
NSHDP GOAL: To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare						
Outcome 3: Universal availability and access to an essential package of primary health care services focusing in particular on vulnerable socio-economic groups and geographic areas						
Outcome 4: Improved quality of primary health care services						
Outcome 5: Increased use of primary health care services						
5. Improved access to essential package of Health care	22. % of LGAs with a functioning public health facility providing minimum health care package according to quality of care standards.	NPHCDA Survey Report	TBD	20	45	65%
	23. % health facilities implementing the complete package of essential health care	NPHCDA Survey Report	TBD	50	70	90%
	24. % of the population having access to an essential care package	MICS/NDHS	TBD	50	75	100%
	25. Contraceptive prevalence rate modern and traditional)	NDHS	2%	10%	20%	30%
	26. %increase of new users of modern contraceptive methods (male/female)	NDHS/HMIS	TBD	20%	40%	50%
	27. % of new users of modern contraceptive methods by type (male/female)	NDHS/HMIS	TBD	20%	40%	50%
	28. % service delivery points without stock out of family planning commodities in the last three months	Health facility Survey	TBD	30%	45%	90%
	29. % of facilities providing Youth Friendly RH services	Health facility Survey	TBD	20%	50%	60%
	30. % of women 15-19 who have begun child rearing	NDHS/MICS	7.50%	5%	3.00%	2.00%
	31. % of pregnant women with 4 ANC visits performed according to standards*	NDHS	15.00%	35%	55%	75%

	32. Proportion of births attended by skilled health personnel	HMIS	5.00%	30%	50%	75%
	33. Proportion of women with complications treated in an EmOC facility (Basic and/or comprehensive)	EmOC Sentinel Survey and Health Facility Survey	TBD	10%	25%	45%
	34. Caesarean section rate	NDHS	0%	4.00%	7%	10%
	35. Case fatality rate among women with obstretic complications in EmOC facilities	HMIS	TBD	20%	13%	8%
	36. Perinatal mortality rate**	HMIS	60/1000LBs	45/1000LBs	40/1000LBs	35/1000LBs
	37. % women receiving immediate post partum family planning method before discharge	HMIS	TBD	5%	10%	15%
	38. % of women who received postnatal care based on standards within 48h after delivery	MICS	5%	15%	25%	50%
	39. Number of women presented to the facility with or for an obstetric fistula	NDHS/HMIS	No Baseline			
	40. Number of interventions performed to repair an obstetric fistula	HMIS	1,400	900	400	100
	41. % of newborn with infection receiving treatment	MICS	No Baseline	20%	35%	50%
	42. % of children exclusively breastfed 0-6 months	NDHS/MICS	10%	25%	50%	60%
	43. Proportion of 12-23 months-old children fully immunized	NDHS/MICS	5.00%	50%	65%	80%
	44. % children <5 years stunted (height for age <2 SD)	NDHSMICS	50.00%	25%	15%	10%
	45. % of under-five that slept under LLINs the previous night	NDHS/MICS	25.00%	75%	85%	95%
	46. % of under-five children receiving appropriate malaria treatment within 24 hours	NDHS/MICS	15%	35%	55%	65%
	47. % of women who received intermittent preventive treatment for malaria during pregnancy	NDHS/MICS	10%	30%	50%	60%
	48. HIV prevalence in pregnant women	NARHS	2.90%	5.00%	4.50%	2.50%
	49. Proportion of population with advanced HIV infection with access to antiretroviral drugs	NMIS	1,550	1,750	1,200	850
	50.Condom use at last high risk sex	NDHS/MICS	3.80%	4%	6%	10%
	51. Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS	NDHS/MICS	No Baseline	20%	45%	60%
	52. Prevalence of tuberculosis	NARHS	1.50%	1%	0.70%	.0.5%
Output 6. Improved quality of Health care services	53. % of staff with skills to deliver quality health care appropriate for their categories	Facility Survey Report	TBD	25%	50%	75%
	54. % of facilities with capacity to deliver quality health care	Facility Survey Report	TBD	25%	45%	65%
	55. % of health workers who received personal supervision in the last 6 months by type of facility	Facility Survey Report	TBD	20	40	60
	56. % of health workers who received in-service training in the	HR survey Report	TBD	40%	60%	75%

	past 12 months by category of worker					
	57. % of health facilities with all essential drugs available at all times	Facility Survey Report	TBD	30%	50%	75%
	58. % of health institutions with basic medical equipment and functional logistic system appropriate to their levels	Facility Survey Report	TBD	60%	70%	85%
	59. % of facilities with deliveries organizing maternal and/or neonatal death reviews according to WHO guidelines on regular basis	Facility Survey Report	TBD	25%	30%	40%
Output 7. Increased demand for health services	60. Proportion of the population utilizing essential services package	MICS	TBD	25%	50%	75%
	61. % of the population adequately informed of the 5 most beneficial health practices	MICS	TBD	25%	40%	65%
PRIORITY AREA 3: HUMAN RESOURCES FOR HEALTH						
NSHDP GOAL: To plan and implement strategies to address the human resources for health needs in order to ensure its availability as well as ensure equity and quality of health care						
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	62. % of wards that have appropriate HRH complement as per service delivery norm (urban/rural).	Facility Survey Report	TBD	5%	10%	15%
	63. Retention rate of HRH	HR survey Report	TBD	85%	90%	95%
	64. % LGAs actively using adaptations of National/State HRH policy and plans	HR survey Report	TBD	10%	20%	30%
	65. Increased number of trained staff based on approved staffing norms by qualification	HR survey Report	TBD	20%	50%	65%
	66. % of LGAs implementing performance-based managment systems	HR survey Report	TBD	30%	40%	70%
	67. % of staff satisfied with the performance based management system	HR survey Report	TBD	25%	45%	55%
Output 8: Improved framework for objective analysis, implementation and monitoring of HRH performance	68. % LGAs making availabile consistent flow of HRH information	NHMIS	TBD	25%	40%	60%
	69. CHEW/10,000 population density	MICS	TBD	1:4000 pop	1:3000 pop	1:2000 pop
	70. Nurse density/10,000 population	MICS	TBD	1:8000 pop	1:6000 pop	1:4000 pop

	71. Qualified registered midwives density per 10,000 population and per geographic area	NHIS/Facility survey report/EmOC Needs Assessment	TBD	1:8000 pop	1:6000 pop	1:4000 pop
	72. Medical doctor density per 10,000 population	MICS	TBD	1:8000 pop	1:7000 pop	1:5000 pop
	73. Other health service providers density/10,000 population	MICS	TBD	1:4000 pop	1:3000 pop	1:2000 pop
	74. HRH database mechanism in place at LGA level	HRH Database	TBD	15%	25%	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						
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	75. % of LGAs implementing state specific safety nets	SSHDP review report	TBD	25%	40%	50%
	76. Decreased proportion of informal payments within the public health care system within each LGA	NHA	80%	75%	70%	65%
	77. % of LGAs which allocate costed fund to fully implement essential care package at N5,000/capita (US$34)	State and LGA Budgets	TBD	5%	10%	15%
	78. LGAs allocating health funding increased by average of 5% every year	State and LGA Budgets	TBD	20%	30%	40%
Output 12: Improved efficiency and equity in the allocation and use of Health resources at State and LGA levels	79. LGAs health budgets fully alligned to support state health goals and policies	State and LGA Budgets	TBD	25%	40%	50%

	80.Out-of pocket expenditure as a % of total health expenditure	National Health Accounts 2003 - 2005	70%	55%	40%	30%
	81. % of LGA budget allocated to the health sector.	National Health Accounts 2003 - 2005	10%	12%	14%	15%
	82. Proportion of LGAs having transparent budgeting and finacial management systems	SSHDP review report	TBD	30%	40%	60%
	83. % of LGAs having operational supportive supervision and monitoring systems	SSHDP review report	TBD	25%	45	60%
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	84. % of LGAs making routine NHMIS returns to states	NHMIS Report January to June 2008; March 2009	35%	50%	60%	75%
	85. % of LGAs receiving feedback on NHMIS from SMOH		TBD	25%	75%	100%
	86. % of health facility staff trained to use the NHMIS infrastructure	Training Reports	TBD	30%	50%	80%
	87. % of health facilities benefitting from HMIS supervisory visits from SMOH	NHMIS Report	TBD	40%	60%	80%
	88.% of HMIS operators at the LGA level trained in analysis of data using the operational manual	Training Reports	TBD	50%	75%	95%
	89. % of LGA PHC Coordinator trained in data dissemination	Training Reports	TBD	40%	75%	100%
	90. % of LGAs publishing annual HMIS reports	HMIS Reports	TBD	25%	50%	75%
	91. % of LGA plans using the HMIS data	NHMIS Report	TBD	50%	75%	95%
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	92. Proportion of public health facilities having active committees that include community representatives (with meeting reports and actions recommended)	SSHDP review report	TBD	25%	50%	75%
	93. % of wards holding quarterly health committee meetings	HDC Reports	TBD	25%	40%	60%
	94. % HDCs whose members have had training in community mobilization	HDC Reports	TBD	40%	75%	100%
	95. % increase in community health actions	HDC Reports	TBD	10%	25%	50%
	96. % of health actions jointly implemented with HDCs and other related committees	HDC Reports	TBD	25%	40%	60%
	97. % of LGAs implementing an Integrated Health Communication Plan	HPC Reports	TBD	25%	40%	60%

PRIORITY AREA 7: PARTNERSHIPS FOR HEALTH						
Outcome 14. Functional multi partner and multi-sectoral participatory mechanisms at Federal and State levels contribute to achievement of the goals and objectives of the SHDP						
Output 15: Improved Health Sector Partners' Collaboration and Coordination	98. Increased number of new PPP initiatives per year per LGA	SSHDP Report	TBD	25%	40%	50%
	99. % LGAs holding annual multi-sectoral development partner meetings	SSHDP Report	TBD	25%	50%	55%
PRIORITY AREA 8: RESEARCH FOR HEALTH						
Outcome 15. Research and evaluation create knowledge base to inform health policy and programming.						
Output 16: Strengthened stewardship role of government for research and knowledge management systems	100. % of LGAs partnering with researchers	Research Reports	TBD	10%	25%	50%
	101. % of State health budget spent on health research and evaluation	State budget	TBD	1%	1.50%	2%
	102. % of LGAs holding quarterly knowledge sharing on research, HMIS and best practices	LGA Annual SHDP Reports	TBD	10%	25%	50%
	103. % of LGAs participating in state research ethics review board for researches in their locations	LGA Annual SHDP Reports	TBD	30%	65%	75%
	104. % of health research in LGAs available in the state health research depository	State Health Reseach Depository	TBD	40%	75%	95%
Output 17: Health research communication strategies developed and implemented	105. % LGAs aware of state health research communication strategy	Health Research Communication Strategy	TBD	40%	60%	85%