IMO STATE GOVERNMENT

STRATEGIC HEALTH DEVELOPMENT PLAN
(2010-2015)

Imo State Ministry of Health

March 2010

Contents

LIST OF ACRONYMS & ABBREVIATIONS

Achiev…	Achievement
ANC	Antenatal Care
CS	Caesarean Section
CSOs	Civil Society Organisations
Evaluat...	Evaluation
EXCO	Executive Committee
FGD	Focus Group Discussion
FGM	Female Genital Mutilation
FMH	Federal Ministry of Health
FMWA&SD	Federal Ministry of Women Affairs and Social Development
FP	Family Planning
Frame..	Framework
HIV/AIDS	Human Immuno-Deficiency Virus/Acquired Immune Deficiency Syndrome
HMB	Hospital Management Board
ICPD	International Conference on Population and Development
IDI	In-depth Interview
IHSDP	Imo Health System Development Project
MDGs	Millennium Development Goals
MHI	Maternal Health Indicators
MICS	Multiple Indicator Cluster Surveys
MMR	Maternal Mortality Ratio
MVA	Manual Vacuum Aspiration
NGOs	Non-Governmental Organizations
NPoC	National Population Commission
NDHS	Nigerian Demographic and Health Survey
PHC	Primary Health Centre
PMTCT	Prevention of Mother to Child Transmission of HIV/AIDS.
PNC	Postnatal Care
RVF	Rector-Vaginal Fistulae
SE	South- East
SEEDS	State Economic Empowerment and Development Strategy
SOGON	Society of Obstetricians & Gynaecologists of Nigeria.
SP	Sulphadoxine Pyrimethamine.
STI	Sexually Transmitted Infection
TBAs	Traditional Birth Attendants
TT	Tetanus Toxoid.
UN	United Nations
UNICEF	United Nations Children's Fund
VVF	Vesico-Vaginal Fistulae
WHO	World Health Organization

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PREFACE

The Imo State Strategic Health Development Plan presents yet another opportunity for all stakeholders to systematically and collectively come up with appropriate interventions and activities to help better the health Status of Ndi Imo, if properly implemented.

Coming at a time when the vision 2020 is being packaged, one cannot but observe that the present Government at the Federal and State levels are desirous of lifting the socio-economic status of Nigerians in general and ndi Imo in particular. This also could not have come at a better time considering the quest for Nigeria to attain the health millennium goals in 2015, mindful of the fact that a healthy Nation is a wealthy one.

The process of developing this framework was as painstaking as it was extensive, and as robust as it was engaging, often resulting in the team working till about mid night in designated hotels. This gives us the confidence that the final product meets the aspirations of all stakeholders in the State.

It is our hope that the very tireless efforts put in by all of us in the Ministry of Health, as well as the ministries of Finance , Economic Development & Planning as well as that of the Consultant will bear the desired fruits when the implementation of the framework commences next year.

This was indeed a worthy exercise, a testimony to our collective sense of purpose and patriotic zeal.

Long live Imo State, long live the Federal Republic of Nigeria.

***Nkechi S.Onumajulu; mni.*(Mrs)**
Permanent Secretary
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EXECUTIVE SUMMARY

Imo State has a vision to "significantly improve the quality of life of Imo citizenry and increase life expectancy through reduction of morbidity and mortality rates due to communicable and non communicable diseases to meet global targets on the elimination and eradication of diseases''

Imo State is one of the 36 States of the Federal Republic of Nigeria created on February 6, 1976. The state has 27 LGAs, and a total population of 4,314,296 (2009) made up of 2,171,087 males and 2,143,209 (2009) projected from the 2006 Census.

Relative to the abundant human resources the growth of the health sector in Imo State is sub-optimal. The health sector is underfunded and overstretched by a burgeoning population. Similarly, a culmination of decades of neglect is responsible for high disease burdens, decaying physical facilities, obsolete equipment[1] among others.

The Imo State Economic Empowerment & Development Strategy (SEEDS) specifically identified the following weaknesses in the health system of the state: Lack of reliable and timely data for planning and decision making purposes; absence of an effective system to harmonize the efforts of government and communities; as well as dilapidated health infrastructures[2].

The State Strategic Health Development Plan is designed as a holistic programme to tackle the problems, meet the challenges and achieve the State health targets.

Very recently, the state government procured 27 brand new Buses for all 27 Primary Health Care Coordinators (PHCC) in the state and approved a mandatory imprest of N60,000 in an effort to enhance Primary Health Care which is the foundation of the health system.

Education is the most thriving industry in the state, and this probably accounts for the high adult literacy level in the state in comparison to some other states in Nigeria. This probably explains why 94% of pregnant women in the state are delivered in a health facility, while 98%[3] of same gro is delivered by a health professional, according to the 2008 NDHS.
There are eight tertiary educational institutions in the state, as well as 1,230 primary and 307 secondary schools respectively.

There are 27 Local Government Areas spread across the three senatorial zones; Orlu senatorial zone with twelve (12) LGAs has the highest. Owerri zone has nine (9) LGAs, while Okigwe senatorial zone has six (6) LGAs.

Imo state has one of the highest proportions of females in top positions in the state civil service, and this is also reflected in the Ministry of Health, where the Permanent Secretary and eight other directors are women who constitute over 60% of the top management of the Ministry.

Though an Oil producing state, Imo has considerable resource challenge due to her high monthly wage bill, low internally generated revenues and peculiar ecological problems,

[1] Review of the Health Sector Reform Programme, FMH Abuja 2008.
[2] Imo State SEEDS, State Planning and Economic Development Commission, Owerri; 2004.
[3] National Demographic Health Survey 2008; Preliminary Report.

notable among which is gully erosion. This has resulted in the reduction in funds available for development. However, with an estimated poverty incidence of 26.7%, the state is in an above average situation compared to other states in Nigeria.

While specific data on the burden of other diseases is lacking as in most States in Nigeria, the common causes of illness include Malaria; Helminthiasis; Gastroenteritis; Respiratory tract Infection; Anemia; Malnutrition; Cancer; Hypertension; Diabetes Mellitus; Arthritis; TB; Typhoid Fever; HIV Infection; and Hepatitis

Presently there are a total of 602 secondary health care facilities in Imo State. The State also has a total of 563 primary health care facilities in the State, with at least 6 in every the LGAs.

In terms of human resources, the State has 0.36 doctors per 1000 population and 1.15 nurse/midwives per 1000 population, which are below the standard recommended health care worker per population ratio.

There is mixed data on access to health care services in the state. While some measures of access to maternal services are high with ANC 96%, some measures of access to childhood services are low with only 40% full immunization coverage, and14% ITN.

In order to improve the health care service delivery system in the State, the Imo SSHDP has identified a minimum package of care for delivery at three different care levels; family and community; outreach; and clinical level. This package entails effective and efficient preventive and curative health services. The package will include immunization for pregnant mothers and children U5, nutrition, Anti Natal Care, growth monitoring, HIV/AIDs, Malaria, Reproductive health, health education and promotion, sanitation and treatment of simple common illnesses.

Furthermore, the Imo State SSHDP has been developed in line with the eight priority areas of the NSHDP. Activities in each of these priority areas targeted at improving the health system in the state have been identified and costed.

At the apex of the implementation is the Governor of the state represented by the Hon Commissioner for Health. Other supporting structures include the Hospitals Management Board, the State Primary Health Care Development Agency, the State Health Insurance Scheme and their service providers both public and private. National and International partners as well as relevant ministries.

Monitoring and Evaluation of the SSHDP will be jointly performed by all partners using already developed monitoring and evaluation indicators. Monitoring will be done at regular intervals and reports sent to the authorities to facilitate possible corrective actions and management decision making. A Mid Term Evaluation will take place in 2011 while the End of Programme Evaluation will be conducted at the expiration of the life of the plan after 2015.

Vision and Mission of the Imo State Strategic Health Development Plan

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 Imo citizens ".

Mission:

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

The overarching goal of the IMSHDP is to significantly improve the health status of Imo Citizens through the development of a strengthened and sustainable health care delivery system with primary health care as the driving force.

CHAPTER 1: Background & Achievements.

1:1. Background.

Imo State is one of the 36 States of the Federal Republic of Nigeria. The State was created when the former East Central State of Nigeria was split into Anambra and Imo State, on February 6, 1976. It lies within latitudes 4^0 45^1 N and 7^0 15^1 N, and longitudes 6^0 50^1 E and 7^0 25^1; occupying the area between River Niger and Upper and Middle Imo River.

There are 27 Local Government Areas spread across the three senatorial zones; Orlu senatorial zone with twelve (12) LGAs has the highest. Owerri zone has nine (9) LGAs, while Okigwe senatorial zone has six (6) LGAs. The major ethnic group in the State is Igbo.

The Imo State Economic Empowerment & Development Strategy (SEEDS) specifically identified the following weaknesses in the health system of the state: Lack of reliable and timely data for planning and decision making purposes; absence of an effective system to harmonize the efforts of government and communities as well as dilapidated health infrastructures[4].

In spite of the above draw backs, there appears to be some light at the end of the tunnel, as seen by the findings in the 2008 National Demographic Health Survey (NDHS). Marginal improvements have occurred in the area of proportion of skilled health attendant at delivery, immunization coverage, contraceptive use, infant & child welfare especially some reduction in mortality figures, and most importantly literacy levels.

Desirous as they seem to be, these marginal gains must be sustained, if they cannot be improved upon. One of the greatest threats to the attainment of better health outcomes in the state is funding. In the past two years.

1:2. Achievements

It is important to stress at this point that this is not yet time for unwarranted chest beatings, as we have more challenges to contend with. Have we achieved anything in setting out to develop a strategic framework for Nigeria? Perhaps to some extent, yes considering the fact that this is unprecedented, though only in nomenclature as similar, but less comprehensive exercises have taken place in the past, with only marginal successes in the State, and elsewhere in Nigeria.

- However, we may lay claim to the following achievements, or rather accomplishments in the state: Very recently, the state government procured 27 brand new buses for all 27 Primary Health Care Coordinators (PHCC) in the state
- Approved a mandatory imprest of N60,000 in an effort to enhance Primary Health Care which is the foundation of the health system.

[4] Imo State SEEDS, State Planning and Economic Development Commission, Owerri; 2004.

CHAPTER 2: Situation Analysis

2:1. Socio-economic Context

Imo State has a population of 4,314,296 with 2,171,089 **males** and 2,143,296 **females (2009) projected from the 2006 Census.** The population of Imo State is projected to be ***5,124,578 in the year 2015***.

The State has a high population density which puts considerable pressure on the relatively few available land resource. Rural farming is present at subsistent levels, where crops like palm oil, yam, cassava, maize, rice, plantain and vegetables are produced.

Education is the most thriving industry in the state, and this probably accounts for the high adult literacy level in the state in comparison to some other states in Nigeria. This probably explains why 94% of pregnant women in the state are delivered in a health facility, while 98%[5] of same cohort is delivered by a health professional, according to the 2008 NDHS.

Imo state has one of the highest proportions of females in top positions in the state civil service, and this is also reflected in the Ministry of Health, where the Permanent Secretary and eight other directors are women who constitute over 60% of the top management of the Ministry.

Though an Oil producing state, Imo has considerable resource challenge due to her high monthly wage bill, low internally generated revenues and peculiar ecological problems, notable among which is gully erosion. This has resulted in the reduced in funds available for development. However, with an estimated poverty incidence of 26.7%, the state is in an above average situation compared to other states in Nigeria.

The status of social determinants of health in Imo State shows that Imo State has one of highest literacy rates in the South East geographical zone of the country for both men and women at 93% and 97% respectively. This may be as a result of the burgeoning education sector in the state. More than 60% of the households in the state have access to improved source of drinking water and electricity. 50% of the households in the state use improved sanitary facilities. While this coverage is higher than the regional average (37%) it is low relative to the literacy rates and employment status of men and women in the state. It is likely that this may be as a result of poor remuneration for the employed in the state, and/or access to health promotion information.

Indicator	State	Region
Literacy rate	93% women; 97% men	81% women; 94% men
Households with improved source of drinking water	68%	68%
Households with improved sanitary facilities (not shared)	53%	37%
Households with electricity	62%	64%
Employment status (currently)	54.4% female, 64.1% male	

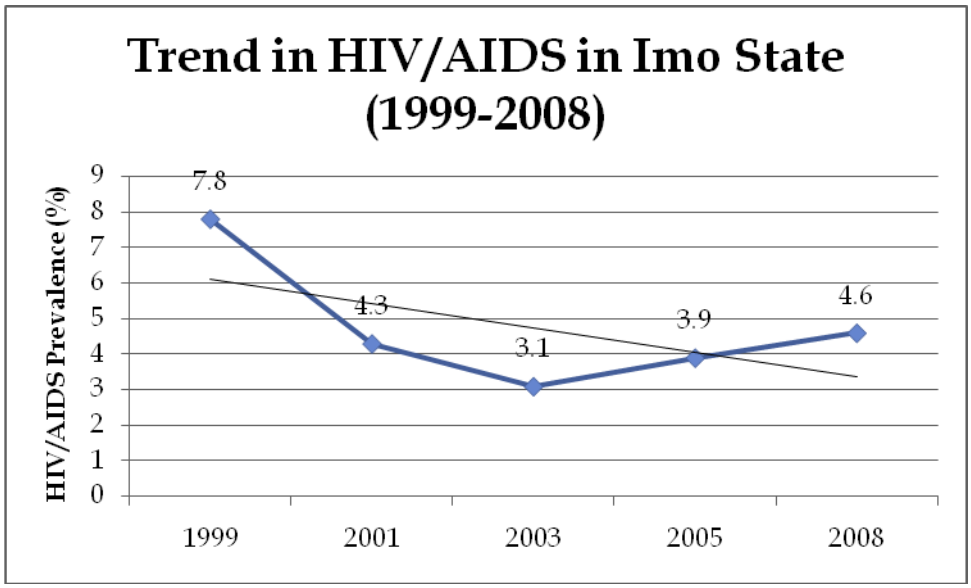
[5] National Demographic Health Survey 2008; Preliminary Report.

2:2. Health Status of the Population in Imo State.

Available demographic data show that there are 1,056,308 women of reproductive age, and 463,331 children under 5 years of age (2006) accounting for 42% of the total population of the State

Available data on the burden of diseases in Imo State shows that the State has a HIV/AIDS prevalence of 4.6% in 2008. This is the same as the national prevalence, but higher than the regional prevalence (3.7%). However the from fig 1, Imo State has recorded an increase form 3.1 recorded from the 2005 sentinel survey.

Imo State has a high TB burden with a total TB notification of 1119, and a prevalence of 35.5/100,000 population in 2006 (Annual TBL report 2006). It is expected however that this burden would have reduced with the intensified TB control in the country.



Source of data: FMoH 2008 ANC Sentinel Survey

Specific data on the burden of other diseases is lacking, however following the general disease trend in the country, other common diseases of illness include:

a. Malaria
b. Helminthiasis
c. Gastroenteritis
d. Respiratory tract Infection
e. Anemia
f. Malnutrition
g. Cancer
h. Hypertension
i. Diabetes Mellitus
j. Arthritis, TB
k. Typhoid Fever, HIV Infection
l. Hepatitis
m. Impaired Vision, Cancer

2.3 Health Services Provision & Utilization in Imo State

Like all States in the Federal Republic of Nigeria, Imo State is responsible for providing secondary health care services, while the local governments in the state are responsible for providing primary health ca re services. Experience has shown that the LGAs lack he capacity to carry out this function.

Presently there are a total of 602 secondary health care facilities in Imo State; 536 private and 19 public health facilities spread across the 27 LGAs in the State **While** there are at least 3 private health care facilities in **e**ach LGA, 12 of the 27 LGAs have no secondary health care facility.

In addition, there are a total of 563 primary health care facilities in the State, 414 public and 149 private respectively. There are at least 6 public primary health care facilities in all the LGAs. Most of the primary health care centres exits merely in name. In these communities, the bulk of health care services are delivered by voluntary/Mission hospitals. Their services account for about 55% . Cost of accessing health care is considered high by the people hence the people's preference for Patient Medicine Dealers resulting in low patronage of the public health facilities

In terms of human resources, the State has a total of 1140 doctors and 3626 nurse/midwives. This translates to 0.36 doctors per 1000 population and 1.15 nurse/midwives per 1000 population, which are way below the standard recommended health care worker per population ratio.

There is mixed data on access to health care services in the state. While some measures of access to maternal services are high with ANC 96%, skilled attendance at birth 98%, delivery in health care facility 94%, some measures of access to childhood services are low with only 40% full immunization coverage, 14% ITN. Other measures are shown in the table below.

INDICATOR	VALUE (NDHS 2008)
TFR	4.8
Use of FP modern method by married women 15-49	9%
ANC	96%
Skilled attendants at birth	98%
Delivery in HF	94%
Full immunization coverage	40%
Children that have not received any immunization (zero dose)	15%
Stunting in Under 5 children	24%
Wasting in Under 5 children	8%
Diarrhoea in children	3.2
ITN ownership	12%
ITN utilization	14% children, 6% pregnant women
Malaria treatment (any anti-malarial drug)	17% children, 6% pregnant women

The low immunization coverage, high proportion of children that are stunted, low proportion of households with ITNs, in relation to the high coverage of some of the

services for mothers, show a high level of access to clinical services but low level of access to outreach/schedulable services

2.4 Key Issues and Challenges

Inter linkages between the three Levels of Health Care Delivery

There is a weak two way Inter-referral linkages existing between these 3 levels of the health care delivery in the state which requires to be strengthened.

Conventionally, the State Ministry of health should be collaborating with FMC Owerri in terms of reporting, but there is little or no feedback mechanism from the Federal Medical Center to the state ministry of health.

MAJOR DIFFICULTIES

1. Technical: Among the health service organizations in the sate only a few are technically equipped to carry out standardized service delivery. They include: Federal Medical Center, Owerri, IMSUTH and General Hospital, Owerri and they are usually referral centers. Majority of the health service organizations are inadequately equipped technically.

2.Operational: The operational level of health service delivery organizations in the state could be described as below average. This has led to the upsurge of private/mission health services mostly in the rural areas where access to health facilities could be made available to rural people. Their operations are not optimally utilized due to several factors such as bad roads, low electric power generation, lack of pipe borne water and other life supporting amenities. The poverty level pervading the rural populace also hinders the optimal operation of these health service facilities.

3.Managerial: The number of professionals engaged in the health service sector is below the international standards. This scenario has led to pressure of work on the few engaged in the provision of service. The economic situation in the state vis- a -vis other states in the country has made it difficult for health organizations--both public and private to retain medical professionals giving rise to brain drain--a situation where these professionals abandon the state for greener pastures.

SPECIFIC OPPORTUNITIES & CHALLENGES:

- ***Strengths:*** Bountiful enthusiasm on the part of State & LG actors, especially non-politicians, technocrats & civil servants. Presence of highly skilled workforce with good gender balance at the State & LGA levels.
- ***Weaknesses:*** Considerable gulf & disconnect between state/LG political leadership & technical staff of the Ministry of Health, resulting in difficulty in

implementing successive health budgets, especially in the last two years. Lack of sufficient funds to power the SSHDP Process due to over dependence on donor funds.

- ***Opportunities:*** Commitment by staff of the State Ministry of Health, as well as those of the PHC Department of the 27 LGAs. Cooperation by different departments & divisions of the ministry could be harnessed and leveraged upon to implement other interventions of public health importance, thereby minimizing the preponderance of parallel programming by the ministry, with the tacit support of development partners. Technical and financial assistance from the Federal Ministry of health.

- ***Threats:*** Sustainable funding for the strategic Plan may be difficult because of absence of considerable political buy-in at the highest levels at the State & LGAs. Attrition of skilled health manpower to other states and the federal level.

Other key challenges facing health care service delivery in the state include:

- Weak health information managements system
- Poor coordination of various actors in the health system
- Weak monitoring and evaluation system
- No clear delineation of the role between the levels of care

CHAPTER 3: Strategic Health Priorities

The Imo State Planning team reviewed and adopted the eight priority areas of the NSHDP in developing its own SSHDP. These strategic health priorities as identified by the state planning team do not connote any hierarchy but a set of areas all of which specific interventions are needed together to help improve the performance of the health system in the State. These priority areas are:

1. Leadership and Governance for Health;
2. Health Service Delivery;
3. Human Resource for Health;
4. Finance for Health;
5. National Health Information System;
6. Community Participation;
7. Partnership for Health; and
8. Research for Health

Detailed activities needed to translate these priority areas into actions have been developed and are attached in the activity matrix in annex 1.

Recognizing that any health system is only as good as it is able to provide services efficiently, the state has also identified a set of highly effective interventions for implementation as an essential package of care at all the health care facilities in the state.

State Minimum Package of Care

In line with the Ward Minimum Health Care Package (WMHCP) developed by the National Primary Health Care Development Agency, the Imo State Planning team has adapted and developed an essential/minimum package of care. This will be the basic minimum set of services that the people of the state should expect any health care facility to be able to provide. It contains a set of evidence based high impact interventions that have proven effectiveness internationally. The package has been customized according to three main channels through which services are provided namely: at family /community level; through outreach/at scheduled sessions; and those services provided only at the clinic either primary, secondary or tertiary clinics. A summary of these interventions are shown in the following tables.

HIGH IMPACT SERVICES
FAMILY/COMMUNITY ORIENTED SERVICES
Insecticide Treated Mosquito Nets for children under 5
Insecticide Treated Mosquito Nets for pregnant women
Household water treatment
Access to improved water source
Use of sanitary latrines
Hand washing with soap
Clean delivery and cord care
Initiation of breastfeeding within 1st hr. and temperature management
Condoms for HIV prevention
Universal extra community-based care of LBW infants
Exclusive Breastfeeding for children 0-5 mo.

Continued Breastfeeding for children 6-11 months
Adequate and safe complementary feeding
Supplementary feeding for malnourished children
Oral Rehydration Therapy
Zinc for diarrhea management
Vitamin A - Treatment for measles
Artemisinin-based Combination Therapy for children
Artemisinin-based Combination Therapy for pregnant women
Artemisinin-based Combination Therapy for adults
Antibiotics for U5 pneumonia
Community based management of neonatal sepsis
Follow up Management of Severe Acute Malnutrition
Routine postnatal care (healthy practices and illness detection)

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

C. INDIVIDUAL/CLINICAL ORIENTED SERVICES
Family Planning
Normal delivery by skilled attendant
Basic emergency obstetric care (B-EOC)
Resuscitation of asphyctic newborns at birth
Antenatal steroids for preterm labor
Antibiotics for Preterm/Prelabour Rupture of Membrane (P/PROM)
Detection and management of (pre)ecclampsia (Mg Sulphate)
Management of neonatal infections
Antibiotics for U5 pneumonia
Antibiotics for dysentery and enteric fevers
Vitamin A - Treatment for measles
Zinc for diarrhea management
ORT for diarrhea management
Artemisinin-based Combination Therapy for children
Artemisinin-based Combination Therapy for pregnant women
Artemisinin-based Combination Therapy for adults

Management of complicated malaria (2nd line drug)
Detection and management of STI
Management of opportunistic infections in AIDS
Male circumcision
First line ART for children with HIV/AIDS
First-line ART for pregnant women with HIV/AIDS
First-line ART for adults with AIDS
Second line ART for children with HIV/AIDS
Second-line ART for pregnant women with HIV/AIDS
Second-line ART for adults with AIDS
TB case detection and treatment with DOTS
Re-treatment of TB patients
Management of multidrug resistant TB (MDR)
Management of Severe Acute Malnutrition
Comprehensive emergency obstetric care (C-EOC)
Management of severely sick children (Clinical IMCI)
Management of neonatal infections
Clinical management of neonatal jaundice
Universal emergency neonatal care (asphyxia aftercare, management of serious infections, management of the VLBW infant)
Other emergency acute care
Management of complicated AIDS

CHAPTER 4: Resources Requirements

4.1 Human Resources

Available information reveals that currently, there are about 1,140 doctors, and 3,626 Nurses/midwives in the primary and secondary healthcare system of the state, the private sector inclusive. This however, varies slightly from the data in the table[6] below. The difference could be accounted for by the inclusion of personnel from the private sector in the data supplied by the state.

State	Doctors	Nurses And Midwives	Medical Lab Scientists	Pharmacists
Anambra	669	1214	633	232
Ebonyi	130	199	34	38
Enugu	1017	NA	487	241
Imo	**914**	**2074**	**520**	**138**
Edo	480	1427	436	192
TOTAL	3210	4914	2110	841

TABLE 9: Distribution of Health Care Workers by State, South East Zone

Taking the data above as the baseline, and as identified earlier, the state has a doctor per 1000 population ratio of 0.36 and a nurse/midwife per 1000 population ratio of 1.15. In order to achieve the international recommended standard of a ration of about 2.5 health worker per population ratio therefore the shortfall is nearly 8687 and 6121 doctors and nurse/midwives respectively. It is expected that the state shoul improve the ratio of the various categories of its manpower to the population.

4:2 . Physical/material resource requirements

The material resource needs include upgraded and refurbished health infrastructure, medical equipment, drugs, etc all of which have been captured in the annex (Detailed costed activity schedule) Emphasis should be in the upgrading of existing health facilities to providing the minimum package of care. Efforts will also be made to establish all requirements for increasing the MSS cluster in the state.

4.3 Financial resource requirements

The total estimated financial requirement to implement the six –year strategic framework in Imo state is about of **N26,626,987,001; Twenty six *billion, Six hundred andtwenty six million, nine hundred and eighty seven thousand one Naira only***. The breakdown according to Goals is as follows:

[6] Nigeria Health System Assessment, USAID/FMOH 2008.

CHAPTER 5: Financing Plan

5.1 Estimated cost of the strategic orientations

The total estimated financial requirement to implement the six –year strategic framework in Imo state is about of **N**26,316,412,001**; Twenty Six *billion, three hundred and sixteen million, four hundred and twelve thousand one Naira only*.** The breakdown according to Goals is as follows:

Priority Area	**Estimated Cost (N)**
Leadership and Governance for Health	NGN 573,523,000
Health Service Delivery	NGN 9,377,295,000
Human Resources for Health	NGN 11,676,094,001
Financing for Health	NGN 1,312,175,000
National Health Information System	NGN 206,933,000
Community Participation and Ownership	NGN 198,735,000
Partnerships for Health	NGN 1,627,700,000
Research for Health	NGN 1,343,957,000
Total Estimated Cost	NGN 26,316,412,001

5.2 Assessment of the available and projected funds

An assessment of the available and projected funds in Imo State for the purpose of financing the Strategic health development plan should be undertaken in the context of the fiscal, macro & micro financial environment s in the state as well as her recent past expenditure profile.

a. *Recent Expenditure Profile.*

YEAR	**RECURRENT EXPENDITURE**	**CAPITAL EXPENDITURE**	**SOURCE**
2004	2,191,786,950.40	-	State Budget
2005	1,575,341,741.00	788,997,926.00	- do -
2006	3,606,86510.00	880,948,222.00	- do -
2007	1,835,018,036.57	758,657,362.80	- do -
2008	2,753,471,553.74	112,706,668.55	- do -

An overview of the general expenditure profile as encapsulated in the table above shows that in the past 5 years, the state had budgeted about N14.3b to the health sector. Taken on the face value, it is logical to conclude that a state that could cumulatively budget such an amount over a 5- year period should comfortably fiancé the SSHDP over the 6 year period. However, based on available figures from the State Ministry of Health actual disbursements significantly fall short of budgeted figures. ***For instance in the past two years, money released to the ministry is in the about 30-40% of budgeted figures.*** Worse

still, there has been on capital releases within this period, as there has been an embargo on capital projects in the ministry.

b. *Fiscal, micro & macro financial environment.*

Based on her position as a marginal oil producing state, Imo receives an average of N3-4b monthly from the Federation Accounts Allocation committee. However, the internally generated revenue profile is less than 20% of the statutory allocation, hence placing the state's finances in a volatile situation; subject to the inevitable fluctuations in the International crude Oil price. Revenue from Personal income tax is also low, while there are no major manufacturing industries in the state.

c. *Support from Development partners.*

Development partners working in the state include UNICEF, WHO, UNFPA, EU Prime, World Bank, ADB, Carter Foundation, Tulsi Chanrai Foundation, UNDP etc. They provide direct programmatic support and technical assistance to programmes. The quantum of their support is in the region of 5-10% of the health expenditure of Imo State.

As a result of the above variables, the available financial resources to power this scheme is in the region of 20-25%.

5.3 Determination of the financing gap

Based on the fact that only 40-50% of the required funds for the State Strategic Health development Plan could be met internally, unless internally generated revenue profile significantly improves, the financial gap is in the region of ***N20-N22billion over the next 6 years.***

The above figure is also subject to variations based on the statutory receipts from the State Government from the Federation account.

5.4 Descriptions of ways of closing the financing gap

Possible ways to close this financial gap include:

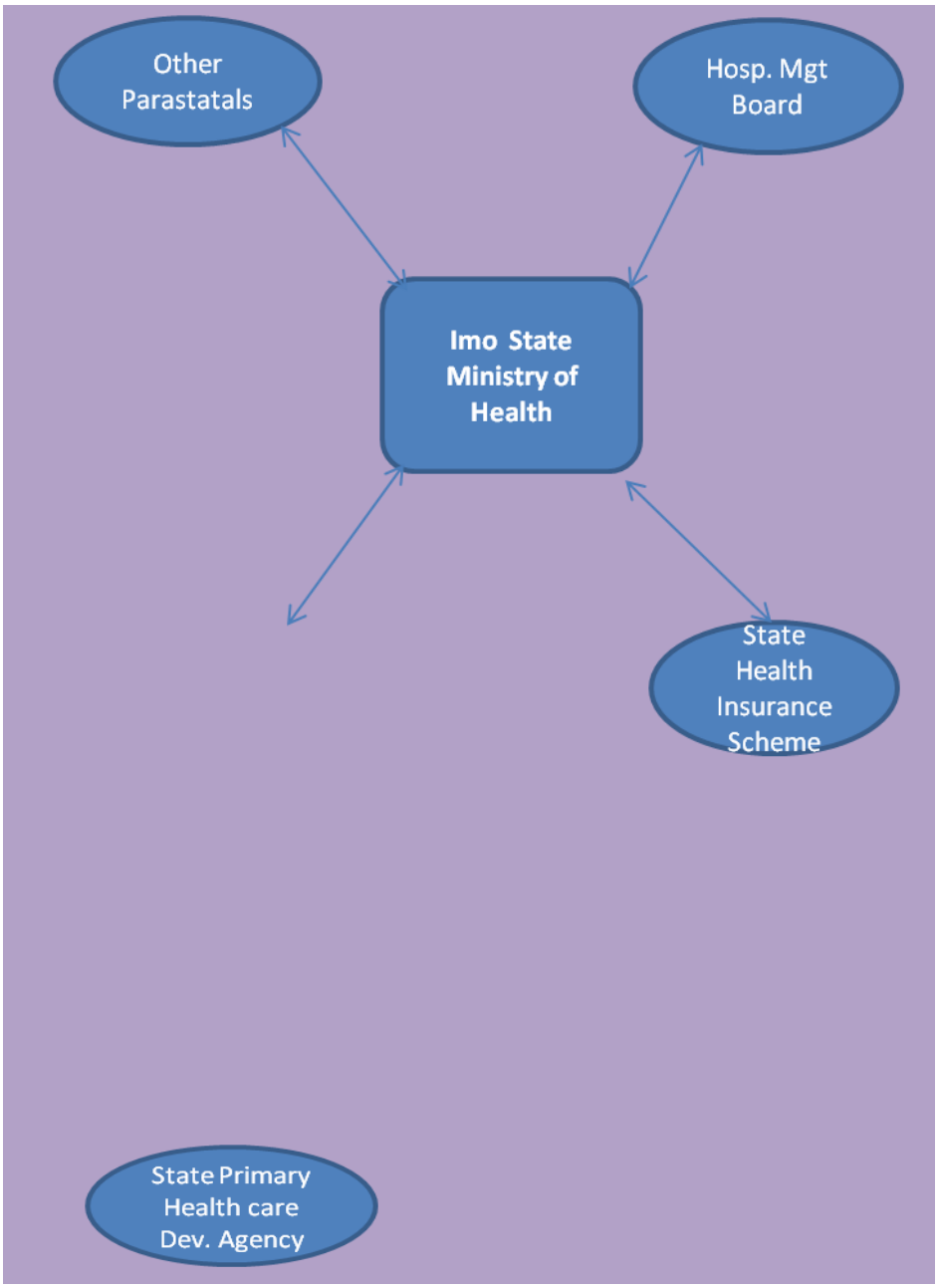
- Increase in Internally generated revenue in the state through an improved tax drive.
- Plugging of possible sources of financial leakage like proper staff audit at the ministry, entrenchment of fiscal responsibility and due process in the award of contracts.
- Creating a legislative framework that allows the allocation of more funds to the health sector by the State House of Assembly in line with the Abuja declaration, provisions of the National health act on funding of primary healthcare, etc.
- Increase in statutory allocation to the Oil producing states from the current 13%.

- Greater coordination & harmonization of donor assistance from development partners in line with the Paris declaration on Aid effectiveness, and Accra high level meeting. This will ensure that donor funds are better utilized, while parallel programmes by different donors and development partners are abolished.

CHAPTER 6: Implementation Framework

Structures, Institutions, Strategic partners, civil society, individuals, households and other actors should be identified as well as their roles and their inter relations

Macro Structures: The macro structure on which the entire framework revolves is the Government of Imo State, represented by the Ministry of Health, with supporting structures that include the Hospital Management board, and service providers at the periphery in a symbiotic arrangement.



Micro Structures: State and Federal Ministries of health, Departments of Planning Research & Statistics, Ministry (SMOH); Primary Health Care Dept, MOH; Primary Health Care of the Ministry Of Local Government and Cheftaincy Affairs, Ministry of

Finance; Ministry of Planning & Economic Development. Minstry of Environment, other departments in the SMOH. FBOs, Catholic Diocese of Owerri, Diocese of Owerri Anglican Communion; Imo State University Teaching Hospita (IMSUTH), Federal Medical Centre(FMC) Owerri;

STRATEGIC PARTNERS

Strategic partners	***Roles and their Inter relations***
● Imo State University Teaching Hospital	● Tertiary, teaching & Research.
● Federal Medical Centre, Owerri	● Tertiary & specialist referral
● College of Health Sc. & Tech. Amaigbo	● Env. & Comm. Health Officers
● Schools of Nursing & Midwifery	● Manpower base for Nurses
● All PHC Health Facilities	● Provide direct primary care
● Private & Faith based practitioners	● Strategic alternative service
● Civil Society groups	● Community Interface
● Individuals and families	● Primary recipient stakeholders.

CHAPTER 7: Monitoring and Evaluation (M&E)

6.1 Proposed mechanisms for monitoring and evaluation

Monitoring and Evaluation of a Strategic plan is best done at the operational level because there is 'no- one-size fits all' approach that will comprehensively and inclusively address eight very divergent goals, with numerous strategic objectives, multiple interventions, and countless activities. Previous monitoring arrangement involved only government officials. Monitoring and evaluation of Imo SSHDP will be done jointly by all relevant stakeholders.

The M&E framework has already been developed and annexed to the plan.

CHAPTER 8: Conclusion

Any strategic document, plan or programme of action is as good as the quality and level of its implementation. There is a high level of cynicism on the ability of the health actors at all levels to implement this framework, and justifiably so. The Health Sector reform programme of the previous administration at both the state and federal level recorded minimal progress. The SSHDP with its clearly defined M&E framework, its detailed costed activities is unique and therefore expected to produce improved outcomes for the health sector of Imo State.

The Challenge of all stakeholders is to get this document off the shelf, and run with it. Only then can our labour will not have been in vain.

Long live Imo State!!!, Long live the Federal Republic of Nigeria.!!!!!

ANNEXES

Annex 1: Distribution of Health Care Facilities and Health Care Providers in Imo State

S/N	LGA	PRIMARY FACILITIES		SECONDARY FACILITIES		SKILLED PERSONNEL AVAILABLE	
		PUBLIC	**PRIVATE**	**PUBLIC**	**PRIVATE**	DOCTORS	NURSES AND MIDWIVES
1	ABOH MBAISE	**13**	**3**	**1**	**23**	**28**	**195**
2	AHIAZU MBAISE	**18**	**-**	**1**	**13**	**20**	**97**
3	EHIME MBANO	**16**	**-**	**-**	**9**	**14**	**88**
4	EZINIHITTE MBAISE	**16**	**5**	**1**	**22**	**21**	**82**
5	IDEATO NORTH	**19**	**3**	**2**	**22**	**21**	**131**
6	IDEATO SOUTH	**13**	**1**	**-**	**8**	**10**	**24**
7	IHITTE UBOMA	**17**	**3**	**1**	**11**	**21**	**49**
8	IKEDURU	**19**	**23**	**-**	**31**	**59**	**72**
9	ISIALA MBANO	**22**	**2**	**10**	**10**	**13**	**55**
10	ISU	**17**	**7**	**1**	**12**	**20**	**67**
11	MBAITOLI	**16**	**25**	**2**	**22**	**40**	**209**
12	NGOR OKPALA	**25**	**4**	**1**	**11**	**20**	**70**
13	NJABA	**9**	**8**	**-**	**14**	**22**	**23**
14	NKWERRE	**6**	**-**	**1**	**3**	**6**	**17**
15	NWANGELE	**14**	**2**	**-**	**5**	**13**	**32**
16	OBOWO	**19**	**1**	**-**	**11**	**17**	**63**
17	OGUTA	**12**	**1**	**1**	**10**	**18**	**34**
18	OHAJI/EGBEMA	**18**	**1**	**2**	**15**	**20**	**120**
19	OKIGWE	**19**	**1**	**1**	**11**	**18**	**121**
20	ONUIMO	**7**	**-**	**-**	**4**	**8**	**28**
21	ORLU	**15**	**8**	**2**	**25**	**158**	**618**
22	ORSU	**15**	**12**	**-**	**11**	**13**	**44**
23	ORU EAST	**13**	**6**	**-**	**9**	**21**	**87**
24	ORU WEST	**10**	**13**	**-**	**18**	**25**	**25**
25	OWERRI MUNICIPAL	**13**	**-**	**2**	**56**	**397**	**663**
26	OWERRI NORTH	**16**	**3**	**-**	**21**	**47**	**489**
27	OWERRI WEST	**19**	**17**	**-**	**15**	**40**	**123**
	TOTAL	**414**	**149**	**563**	**19**	**1140**	**3626**

Table 2 showing health facilities and Personnel by location.

Table 3 Health Care Training Institutions in Imo State

S/N	INSTITUTION	CAPACITY	OWNERSHIP
1.	Tertiary a. F M C Owerri	Internship for Medical Lab Scientist Internship for Pharmacist Housemanship; Residency in: O & G, Paediatrics, Family Medicine, Radiology. Radiography Internship for Medical Lab Scientist Internship for Pharmacist Housemanship;	Fed Govt.
	b. IMSUTH	Residency in: O & G, Surgery Paediatric, Family Medicine, Community Medicine Radiology.	Imo State Govt.
	c. Imo State College of Health Science & Technology Amaigbo	**SECONDARY FACILITIES** Environmental health technology, Environmental health technician, Community health Extension workers, Health Records Technician Pharmacy Technicians,	Imo State Govt.
	d. School of Health Technology Okporo	Medical Lab Technicians and Assistants. Environmental health technology, Environmental health technician, Community health Extension workers, Health Records Technician Medical Lab Assistants.	FBO
	e. General Hospital Owerri	Housemanship for Doctors, Internship for Optometrists	Imo State Govt.
	f. School of Public Health Nursing Owerri	Public health Nursing, Health Assistants, Public Health Technicians Nurses	Imo state Govt. Imo State Govt.
	g. School of Nursing Owerri.	Nurses Nurses	FBO FBO

	h. School of Nursing Umulogho Obowo	Midwives (Basic)	Imo State Govt.
	i. School of Nursing Amaigbo.	Post Basic Midwifery	Imo State Govt.
	j. School of Midwifery Aboh Mbaise		
	k. School of Midwifery Awo- Omamma.	Nurses & Midwives	FBO
	l. School of Nursing & Midwifery Emekuku	Nurses	FBO
	m. School of Nursing Isiala Mbano		

Annex 2: Details of Imo State Strategic Health Development Plan

IMO STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
Priority Area							
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							**573,523,000**
	1.1	**To provide clear policy directions for health development**			**All stakeholders are informed regarding health development policy directives by 2011**		**423,154,288**
		1.1.1	Improved Strategic Planning at State level				**139,803,109**
			1.1.1.1	Conduct a stakeholder meetings to develope a state strategic health development plan	1. Number ofstrategic plan drafting meetings held. 2. Availability of a draft report	Availability of funding /Attendance by stakeholders	47,758,281
			1.1.1.2	Present the strategic plan to policy makers (executive, legislature and judiciary) in a dissemination meeting.	Number of advocacy visits made	Political Will/Executive support	9,356,136
			1.1.1.3	Re-orientate and strengthen human resource capacities through retreats, workshop and seminars for members of executive, legislators and juditiary.	1. Number of retreats/seminars held. 2. proportion of executive/legislative members with corrent knowledge of the state strategic health plan.	Availability of political will	40,702,012
			1.1.1.4	Support State / LGAs in the development of health sector plans	Percentage of LGAs with developed strategic plan	Co-operation of LGA authority	35,720,011
			1.1.1.5	Institionalize the strategic health development plan in the state annual budget estimate (15% of total state budget)	15% budgeted for health in the annual budget.	Political will and commitment.	6,266,669
		1.1.2	Strengthen regulatory functions of government				**105,377,792**
			1.1.2.1	Include NGOs and FBOs etc in health care delivery activities through subventions and grants-in-aid	% of funding to FBOs among the total health budget per annum	Availability of funds	62,672,952
			1.1.2.2	Facilitate public-private partnership (PPP) in healthcare delivery / set up a PPP steering committee / Quarterly PPP review meeting	% representation of private sector in health committees or fora	Private health sector cooperation	6,266,669
			1.1.2.3	Set up a committee to review existing health laws and regulations	1. Health laws review committee in place. 2. No of review meetings held. 3. Minutes of meetings and draft report available	Availability of funding / skilled manpower	3,885,335
			1.1.2.4	Establish a state monitoring committee to monitor and enforce standards among private health practitioners	No of monitoring visits conducted per quarter	Availability of funding / skilled manpower	32,552,837
			1.1.2.5	Draft a bill for the regulation of practice of alternative medicine	Draft bill in place by the end of 2009 at the House of Assembly.	Availability of skilled manpower	-
		1.1.3	Improve accountability and transparency				**15,040,005**

			1.1.3.1	Decentralize the decision-making process in the health sector	Each sector of health care delivery has a Health Committee in place by end of 2010	Intersectoral cooperation	-
			1.1.3.2	Institute quarterly accountability forum on public expenditure in health	No of Quaterly Reports produced.	Availability of funds	-
			1.1.3.3	Establish an independent monitoring body to monitor and render bi-annual reports on health sector spending	A functional Independent monitoring body in place by 2010	Availability of funding / skilled manpower	-
			1.1.3.4	Approve and release funds timely as budgeted for project implementation	% of project implementation per year	Political will and commitment.	-
			1.1.3.5	Awareness creation on health projects and programmes to beneficiary communities.			15,040,005
		1.1.4	Improving and maintaining Sectoral Information base to enhance performance				**162,933,383**
			1.1.4.1	Conduct state demographic health survey once every 2 years for data updates (both communicable and non-communicable diseases)	No of survey reports available	Stable political and social environment / Availabilty of funds	112,800,034
			1.1.4.2	Collaborate with NGOs, corporate bodies, individuals and health research institutes/universities for health researches	No of research reports available	Sectoral cooperation / Availabilty of funds	6,266,669
			1.1.4.3	Provide modern information and communication technology (ICT) in all sections of health.	No of health institutions with computers and Internet access	Availability of skilled manpower	18,800,006
			1.1.4.4	Provide fund for health system research	% of annual budgetary provision for research	Political will and commitment/availability of fund	25,066,674
			1.1.4.5	Adequate training of human resources to meet modern standards for operating the ICT			-
	1.2	**To facilitate legislation and a regulatory framework for health development**			**Health Bill signed into law by end of 2009**		**58,280,018**
		1.2.1	Strengthen regulatory functions of government				**58,280,018**
			1.2.1.1	Setting up a stakeholder's forum to constantly discuss the regulatory functions of the government at state and local government levels.			-
			1.2.1.2	Set up an integrated monitoring and eveluation unit to strenghten the regulatory functions of the government.			4,386,668
			1.2.1.3	Empower of the monotring and evaluation unit adequately to enable them enforce these health regulations.			24,346,007
			1.2.1.4	Upgrade ICT facilities to facilitate regulatory communication.			19,896,673
			1.2.1.5	Set up a competition among the LGAs regulatory system by awarding best practices			9,650,670
	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**		**41,266,012**
		1.3.1	To improve accountability and transparency				**41,266,012**
			1.3.1.1	Training on Servicom for Programme state managers & PHC Coordinators at LGAs		Trainers are themselves transparent & accountable	18,768,672
			1.3.1.2	Set up a surveillance (auditing) unit to oversee the activities of State and LGAs			12,470,670

				health accounting system on quarterly basis.			
			1.3.1.3	Establish an account bulletin for the State and Local government publication system with a view to highlighting best practices			3,760,001
			1.3.1.4	Set up an award programme for best practices.			2,506,667
			1.3.1.5	Advocate for realistic health budgets at LGA levels to prvent fraud.			3,760,001
	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**	**Various levels of government have capacity to update sectoral SHDP States may not respond in a uniform and timely manner**	**50,822,682**
		1.4.1	Improving and maintaining Sectoral Information base to enhance performance				**50,822,682**
			1.4.1.1	Adequate training and re-training of skilled human resources to man the information base.			22,622,674
			1.4.1.2	Provision of infrastructural equipment / logistics for improving the sectoral information base.			16,920,005
			1.4.1.3	Strengthen Servicom units at State and LGAs			7,520,002
			1.4.1.4	Improve collaboration between partners in supporting the establishment /improvement of the information base of the State and the LGAs.			3,760,001
HEALTH SERVICE DELIVERY							
2. To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare							**9,377,295,000**
	2.1	**To ensure universal access to an essential package of care**			**Essential Package of Care adopted by all States by 2011**		**1,372,522,733**
		2.1.1	To review, cost, disseminate and implement the minimum package of care in an integrated manner				**1,193,804,616**
			2.1.1.1	Review of the existing health care package		**Existing package includes IMNCH.**	3,400,725.31
			2.1.1.2	Disseminate information on minimum health care package to stakeholders in health care		**Stakeholder buy-in assured.**	11,852,527.92
			2.1.1.3	Implement the minimum health care package at all levels of health care delivery		**Stakeholder buy-in assured.**	1,154,546,242.92
			2.1.1.4	Create of more outreach centres to improve coverage		**Stakeholder buy-in assured.**	18,003,839.88
			2.1.1.5	Evaluate the impact of the health package at the LGA level.		**Stakeholder buy-in assured.**	6,001,279.96
		2.1.2	To strengthen specific communicable and non communicable disease control programmes				**158,213,744**
			2.1.2.1	Capacity building for all programme managers including FBOs.	**50% of programme managers trained within 1 year.**	**Capacity building of programme managers will strengthen scheme.**	37,482,994.42
			2.1.2.2	Capacity building for PHCC and LGA programme managers.	**50% of programme managers trained within 1 year.**	**Capacity building of programme managers will strengthen scheme.**	55,936,930.29
			2.1.2.3	Advocate to improve funding for the programmes.			2,700,575.98

			2.1.2.4	Establish / review collaboration with partners.			1,180,251.73
			2.1.2.5	Monitor and evaluate the programmes.			21,304,543.86
			2.1.2.6	Create programmes for non-communicable diseases such as Cardiovascular Diseases, cancer and diabetes awareness and prevention.			39,608,447.73
		2.1.3	To make Standard Operating Procedures (SOPs) and guidelines available for delivery of services at all levels				**20,504,373**
			2.1.3.1	Print 10,000 copies of SOPs & guidelines for destribution to secondary & Primary health facilities			15,003,199.90
			2.1.3.2	Train and re-train health service providers on the use of SOPs & guidelines.			3,000,639.98
			2.1.3.3	Translate SOPs to Igbo language with appropriate pictorial illustrations.			2,500,533.32
	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**		**6,297,428,123**
		2.2.1	To improve geographical equity and access to health services				**4,319,376,241**
			2.2.1.1	Map health care facilities in Imo state.	**80% of haelth faclities mapped in the state /LGA by 2010. No of h/f mapped**	**staff commitment**	2,500,533.32
			2.2.1.2	Develop criteria for siting of new health care facilities in Imo State.	**80% of new H/F sited in line with dev critria by 2011. NO of new H/F sited**	**staff commitment and political support**	1,000,213.33
			2.2.1.3	Upgrade existing health facilities in Imo State.	**80% of existing substd H/F upgraded by 2013. no of existing sustd H/F upgraded**	**political support**	2,010,383,776.91
			2.2.1.4	Refurblish substandard health facilities in Imo state.	**80% of existing substd H/F refurbished 2013. no of existing substd H/F refurbished**	**political support**	2,305,491,717.86
		2.2.2	To ensure availability of drugs and equipment at all levels				**734,956,752**
			2.2.2.1	Review the already existing essential drug list	**75% of H/F using the reviewed essential drug list by 2010. No of H/F using the EDL**	**staff commitmnt , adequate staffing**	-
			2.2.2.2	Strenghten the existing procurement and distribution system.	**75% of H/F operating DRF by 2010. No of H/F operat DRF**	**political support, political interference, commitmnt of staff**	23,004,906.51
			2.2.2.3	Revitalize and recapitalize the Drug Revolving Fund system at State and LGAs			121,825,983.18
			2.2.2.4	Provide 28- 4- wheel utility vehicles for colllection and distribution of drugs and other commodities.			140,029,865.73
			2.2.2.5	Develop Equipment list for different levels of Health Facility in line with the essential package of care.	**All levels of health facility having the equipment list**	**political suport& staff commitmnt**	-
			2.2.2.6	Procure and distribute Equipment based on need.	**75% of equipmnt proc. & dist. at all level of health care delivery.**	**Political & staff commitment**	300,063,997.99

			2.2.2.7	Refrubish and upgrade existing central equipment store, build new zonal ones.			150,031,998.99
		2.2.3	To establish a system for the maintenance of equipment at all levels				**33,057,050**
			2.2.3.1	Adapting the national health equipment policy in the state and LGA	National health equip policy adapted by 2010 in the state and all LGAs	political & Stake holders commitment	300,064.00
			2.2.3.2	Dev.,Disseminating and implementing the the state health equipment policy	state health equip policy dev. & disseminated by 2011 in all LGAs	political & Stake holders commitment	3,500,746.64
			2.2.3.3	Establishment of medical equipment and hospital maintenance workshop	Electromech/medical workshop in place by 2011.	political & Stake holders commitment	29,006,186.47
			2.2.3.4	Establish public private partnership in maintenance of medical equipment and furniture	Train tech service team by 2011	political and stakeholders commitment	250,053.33
		2.2.4	To strengthen referral system				**169,836,223**
			2.2.4.1	Mapping / Dev. Of network linkages for two way refferal system in line with national standard	**70% of 2-way referal netwk linkgs estb. In the state. No of netwk linkages estab.**	**logistics, Political &staff commitmnt**	1,500,319.99
			2.2.4.2	Provision of 15 standby, equiped ambulances for the referral system; 5 per zone	**100% of referal centres provided with equip ambu. By2015.no of amb prov.**	**political support and commitmnt**	153,032,638.97
			2.2.4.3	Establishment and implematation of guildline for two way referrals	**80% of guidline for referral estab. No. Of guidline for referral established.**		9,151,951.94
			2.2.4.4	Monitoring of referral outcomes and creation of two-way data	**85% of facilities monitored for referal outcomes.no of facil monitored**	**staff commitmnt , adequate staffing, political support**	6,151,311.96
		2.2.5	To foster collaboration with the private sector				**1,040,201,855**
			2.2.5.1	Mapping of all categories of private health care provider by operation and location	**80% of private sector providers mapped by 2010. No. Of private sector mapped.**	**political will and private sector committement**	553,117,969.62
			2.2.5.2	Develop of guidelines and standards for regulating their practice	**80% of guidline and standard developed by 2010. No. Of guidline and standard developed by 2010**	**political will and private sector committement**	432,592,263.76
			2.2.5.3	Adapt and implement the national policy of traditional medicine at state & LG levels	**national policy on tradomedcine adapted by Q2 2010**	**political will and coorporation from tradomed practitioners**	51,560,996.99
			2.2.5.4	Development of guidelines partnership training, training and outsourcing of practices	**80% of partnership guidline deve. by Q3 2010 No. Of guidline deve.**	**private sector coorporation in political will**	2,930,625.05
	2.3	**To improve the quality of health care services**			**50% of health facilities participate in a Quality Improvement programme by end of 2012**		**71,225,191**
		2.3.1	To strengthen professional regulatory bodies and institutions				**37,918,087**
			2.3.1.1	Standardize and regulate health practices at all levels of health care delivery	80% of practitioners use the standardized practice	atitude of the health practitioners	560,119.46

					by 2015. No. Using the practice	towards the lay down standard	
			2.3.1.2	Implement the operational guidelines and policies of the professional regulatory bodies	periodic review and update of the guidline. No. Of reviews and updating done	political support and regulatory bodies committement	850,181.33
			2.3.1.3	Build the capacity of regulating professinal bodies in the State..	80% of council staff capacity built. No. Of staff of the council that had their capa. Built	political will and committement of regulatory staff	9,001,919.94
			2.3.1.4	Conduct regular monitoring exercises with appropriate documentation and feedback mechanism	quaterly monitoring excercises. No. Of monitoring activity carried out	monitoring staff committement	12,502,666.58
			2.3.1.5	Institute award system for best practices among the professional regulatory bodies..			15,003,199.90
		2.3.2	To develop and institutionalise quality assurance models				**24,455,216**
			2.3.2.1	Reviewing of existing quality assurance modules	75% update to the new standard adopted at all levels by 2010. adopted std reviewed	political will and committement of professional bodies	1,300,277.32
			2.3.2.2	To organise stakeholders forum to build consensus on the modules to be adopted	65% % of stake holders and attand the forum. No. Of forum held	committement of stake holders	1,400,298.66
			2.3.2.3	Capacity buiding / TOT on quality assurance training modules be cascaded to other health workers	80% of TOT caapacity built. No. Of TOTs trained	political wills and good governace	15,753,359.89
			2.3.2.4	Entrenching the ideals of servicom using servicom guidelines	75% of servicon guidlines entenched. No. Of practitioners using Servicon guidline	political and staff committement	6,001,279.96
		2.3.3	To institutionalize Health Management and Integrated Supportive Supervision (ISS) mechanisms				**8,851,888**
			2.3.3.1	Organising team building and leadership development programme for health management and health teams			3,000,639.98
			2.3.3.2	Development of intergrated supportive supervision tools			1,975,421.32
			2.3.3.3	Development of guidelines that will specify modalities and frequencies of ISS at all levels			1,875,399.99
			2.3.3.4	Institutionalization of comprehensive integrated supportive supervision at all levels			2,000,426.65
	2.4	**To increase demand for health care services**			**Average demand rises to 2 visits per person per annum by end 2011**		**1,630,267,705**
		2.4.1	To create effective demand for services				**1,453,409,985**
			2.4.1.1	Establich/strengthen Servicom units in MOH LGAs to help reorientate healthworkers on the need to improve services as a means to improve demand			22,004,693.19
			2.4.1.2	Create bi-annual performance awards/incentives for the most patient-friendly health worker at State & LG facilities			10,202,175.93
			2.4.1.3	Establish/strengthen village/ ward health-development committees in all LGAs			18,403,925.21

			2.4.1.4	Improve the physical environment of health facilities at state & LGAs by beautification, provision of decent canteen services			192,040,958.71
			2.4.1.5	Production of IEC materials,sensitization and mobilization			1,200,255,991.94
			2.4.1.5	Regular Performance monitoring of facilities at State & LG levels to ensure quality delivery as means of improving demand.			10,502,239.93
		2.4.2	Increase demand for Integrated Maternal, Newborn & Child Health Services in the State				**176,857,720**
			2.4.2.1	Conduct a situation analysis of MNCH in the State			3,250,693.31
			2.4.2.2	Orient & sensitize major stakeholders in the state on the situation of MNCH			4,250,906.64
			2.4.2.3	Establish a State Partnership for Maternal, Newborn & Child Health			3,500,746.64
			2.4.2.4	Develop Implementation Plan & Advocate for funding for MNCH			2,600,554.65
			2.4.2.5	Roll out the implementation of IMNCH in Pilot LGAs in each of the senatorial zones			163,254,819.17
		2.4.3	Pomotion of IMNCH activity				
			2.4.3.1	Mid level mgt training for health workers at all levels			
			2.4.3.2	Increase clusters for the provision of MSS			
			2.4.3.3	Procurement of LLINs for pregnant women and U5 Children			
			2.4.3.4	Establishment of complementry food centres in the 3 sentorial zones			
			2.4.3.5	Procurement of IPT & ACT drugs for pregnant women & u 5 children respectively			
	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**		**5,851,248**
		2.5.1	To improve financial access especially for the vulnerable groups				**5,851,248**
			2.5.1.1	Advocacy to State House of Assembly for Passage of State Health Insurance bill		Adequate provision for vulnerable groups in the draft bill	250,053.33
			2.5.1.2	Development of guidelines for participation of vulnerable groups in the state Social health Insurance scheme when the bill is passed.			900,191.99
			2.5.1.3	Awarenes creation for Government support for the vunerable groups at the LGA level			1,500,319.99
			2.5.1.4	Establish collaboration with partners in support of vunerable groups			200,042.67
			2.5.1.5	Recruitment of the vulnerable People in the scheme where applicable			3,000,639.98
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							**11,676,094,001.00**
	3.1	**To formulate comprehensive policies and plans for HRH for health development**			**All States and LGAs are actively using**		**300,122.84**

					adaptations of the National HRH policy and Plan by end of 2015		
		3.1.1	To develop and institutionalize the Human Resources Policy framework				**300,122.84**
			3.1.1.1	Domesticate the national HRH policy and strategy.	All LGAS and health intitutions are actively using HRH policy and plans by end of 2o10	Inadeuate personel and logistics	90,036.55
			3.1.1.2	Establish HRH unit in MOH (DPRS) & LGAs.			100,040.61
			3.1.1.3	Adapt policies on training and recruitment of health personel.	Policies updated for use by end of 2010		100,040.61
			3.1.1.4	Adapt PPP component of the national HRH policy framework to the State			10,005.06
	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**		**8,369,477,653.71**
		3.2.1	To reappraise the principles of health workforce requirements and recruitment at all levels				**8,369,477,653.71**
			3.2.1.1	Use Federal model as a template for the State health work force requirement and recruitment needs.			300,121.84
			3.2.1.2	Harmonised minimum wage package for all public health workers at all levels.	Harmonised minimum wage paid by 2010		3,652,762,867.13
			3.2.1.3	Fill existing manpower needs.			4,716,414,664.74
	3.3	**Strengthen the institutional framework for human resources management practices in the health sector**			**1. 50% of States have functional HRH Units by end 2010 2. 10% of LGAs have functional HRH Units by end 2010**		**2,675,085.97**
		3.3.1	To establish and strengthen the HRH Units				**2,675,085.97**
			3.3.1.1	Create HRH unit in the Health planning department at the State & LGAs.	Establiment of HRH unit in the State ministry of Health by 2010	Inadequate resources such as personel and equipment.	59,023.96
			3.3.1.2	Identify HRH training needs for the State and LGAs.			1,020,414.24
			3.3.1.3	Identify available HRH training institutions			1,025,416.28
			3.3.1.4	Train staff of newly established HRH units			570,231.49
	3.4	**To strengthen the capacity of training institutions to scale up the production of a critical mass of quality, multipurpose, multi skilled, gender sensitive and mid-level health workers**			**One major training institution per Zone producing health workforce graduates with multipurpose skills and mid-level health workers by 2015**		**2,353,055,240.84**
		3.4.1	To review and adapt relevant training programmes for the production of adequate number of community health oriented professionals based on national priorities				**2,157,976,046.94**
			3.4.1.1	Review relevant training programmes for health workers at the community level in the State.	No. ofTrainining and admission progs. reviewed by end of2010.	Political influence on admission guidelines	5,452,213.37
			3.4.1.2	Train tutors of health training institutions on relevant training programmes			12,355,015.61

			3.4.1.3	Evaluate training institutions & programmes.			4,301,746.33
			3.4.1.4	Continous upgrading of facilities at health training institutions			2,135,867,071.64
		3.4.2	To strengthen health workforce training capacity and output based on service demand				**195,079,193.90**
			3.4.2.1	Upgrade teaching and learning infrastructure in all health training institutions in the state.			120,048,734.71
			3.4.2.2	Acccreditation and assistiing elligble private sector health facilities for quality training			75,030,459.19
	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**		**946,284,151.32**
		3.5.1	To achieve equitable distribution, right mix of the right quality and quantity of human resources for health				**902,766,484.99**
			3.5.1.1	Recruit, select,and deploy competent and capable staff to reflect organizational objectives and needs.	No. of skilled health workers selected and deployed by end of2010	Problem of embergo, inadequate vacancies created, heath workers resisting transfers to rural areas.	707,687,291.09
			3.5.1.2	Redeploy staff equitably between rural and urban areas at different areas of health care system in relation to needs.	No. of HRH data base created in the LGAs by the end of 201		-
			3.5.1.3	Improve incentives for health workers such as rural allowances in underserved areas.		Inadequate political will.	195,079,193.90
		3.5.2	To establish mechanisms to strengthen and monitor performance of health workers at all levels				**43,517,666.33**
			3.5.2.1	Conduct routine re-orientation of workforce on attitudinal change in interpersonal communication skill and work ethics			3,501,421.43
			3.5.2.2	Institute a system of recognition & reward.			25,010,153.06
			3.5.2.3	International training for implementation & monitoring of SSHDP (DPHC-MOH, DPHC-MOLG, DPRS-MOH)			15,006,091.84
	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**		**4,301,746.33**
		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				**4,301,746.33**
			3.6.1.1	Build the capacity of representatives of professional bodies in the Ministry	50% of LGAS have regular stakeholders forum by 2011	logistics issues and inadequate political will.	1,500,609.18
			3.6.1.2	Sustain joint enforcement c'ttees of professional associations regulatory councils and the Ministry.			2,801,137.14
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							**1,312,175,000**

	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**		**313,810,558**
		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				**24,348,606**
			4.1.1.1	To create Health Financing, technical working Groups at State and LGA levels	Functional State and 27 LGAs Health Financial Technical Working groups Created by 1st quarter of 2010.	State & 27 LGA Health Financial Technical Working Group created by 2010.	477,424
			4.1.1.2	Request for Technical Assisstance from FMOH to support Capacity building at the State and LGAs		84 Empowered officers are now available to Implement SHP in State and LGAs.	-
			4.1.1.3	Capacity building for the development of Strategic Plans at State and LGA levels.	No of Officers of trained in line Ministries of MOH, MOLG, MOF, MPED, IMHA, Govt House on mainstreaming Health Financies into the Budget.		23,871,182
		4.1.2	Implement Strategic Plans`at State & LGA levels.		60% of LGAs have implemented the HSDP by the end of 2013.		**14,465,936**
			4.1.2.1	Production of copies of the State and LGA Strategic Health Plans	State & 60% LGA Strategic Health Plan drawn by 1st Qtr 2010.	Skilled Manpower Available	1,909,695
			4.1.2.2	Build Capacity of Health Accounts Staff to produce health accounts	No of Officers trained.	Officers are Empowered to Implement the Health Strategic Plans.	12,556,242
			4.1.2.3	Implement Health Strategic Plans at State & LGA Levels	50% State & LGA Health Strategic Plan Implemented by 2013.	Difficulty in accessing fund	-
		4.1.3					**80,207,171**
			4.1.3.1	Advocate for the quick passage of the state health insurance bill	Minutes and reports of the TRC available	Availability of funds and manpower	2,864,542
			4.1.3.2	Establish community based health insurance scheme	pecentage of communities implementing HFS	That there is adequate community mobilization & utilization	77,342,629
		4.1.4					**137,498,008**
			4.1.4.1	Advocate for the implemention of the stipulated 15% sectoral budget allocation to health at state and LGA levels		Political will	2,864,542
			4.1.4.2	Advocate to State House of Assembly for domestication/ adoption of the National health Act in the state		Sectoral commitment	2,864,542
			4.1.4.3	Provide subventions to private-for-non-profit health providers		Political commitment and availability of funds	114,581,673
			4.1.4.4	Conduct bi-annual donor coordination meeting to harmonize partner financing		Sectoral commitment	17,187,251
		4.1.5	Health Budget Execution, Monitoring and Reporting				**57,290,837**

			4.1.5.1	Set up a budget implementation unit at SMOH and LGA health departments			57,290,837
	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**		**928,398,008**
		4.2.1	Develop Social Health Protaction Mechanisms to cushion Households from Catastrophic cost of out of pocket expenditures on Health Services.		40% of population by the end of 2015. 80% coverage of vulnerable by end of 2015		**928,398,008**
			4.2.1.1	Provide routine free health services at Secondary health facilities to special at risk & indigent groups eg free antenatal care, free under-5 medical services	50% population coverage & 50% of Vulnerable group 2012 and 80% by 2015.	Large proportion of rural dwellers have little protection against economic costs of catastrophic illnesses	928,111,554
			4.2.1.2	Advocacy visit to State House of Assembly for amendment of NHIS bill to have regulatory authority.	NHIS bill amended by 2010.	Bill at the floor of Imo State House of Assembly	286,454
	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**		**16,041,434**
		4.3.1	State and LGAs to allocate at least 15% of their total budget to Health sector.				**9,071,049**
			4.3.1.1	Advocate to the State Assembly to pass a bill to secure 15% of total budget to Health.	state & at least 60% LGA allocating 10% of Health budget to Health by the end of 2015.	State & LGA release fund as appropriated	2,864,542
			4.3.1.2	Advocate to facilitate the release of 100% of the State Health budget.	Percentage of Health Budget allocated to capital expenditure annually.	Improvement in infrastructural development in Health Sector.	2,864,542
			4.3.1.3	Advocate to earmark 1% of the State & LGA Health allocation for community health insurance	Percentage of Health Budget released Annually.	Inadequate fund released due to fall in State & LGA allocation.	2,864,542
			4.3.1.4	Develop Strategies to complement Health Sector funding eg Private Public Partnership (PPP)	% of Health budget allocated to Social Health Protection Programs & Research on annual basis.	Prompt Release of fund & Availability of reliable Data.	477,424
			4.3.1.5				-
		4.3.2	Improve Coordination of Donor-funding mechanisms to reinforce State efforts eg. Sectorial budget support.				**3,819,389**
			4.3.2.1	Revitalize and implement guidelines for donor coordination activities in the state	State Guidelines for donor fund coordination Developed by 3rd Qtr. 2010.	Delay in Production & approval of Strategic Guideline for donor Coordination.	3,819,389
		4.3.3	10% of VAT to be dedicated to Social Health Protection Programs.				**3,150,996**
			4.3.3.1	Advocate to the State House of Assembly to pass a bill to secure 10% of State VAT allocation for Social Health Protection Programs..			3,150,996
	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....**		**53,925,000**

					2. 60% of States and LGAs have supportive supervision and monitoring systems developed and operational by Dec 2012		
		4.4.1	Strenghten Financial management skill (competencies in buddgeting, planning, auditing, accounting, monitoring and eveluation at Local Government and State levels.				**22,964,077**
			4.4.1.1	Request for, and obtain FMOH technical assisstance to develope costed annual operational plans at State and LGA levels.			477,424
			4.4.1.2	Build Capacity of Accounts staff of the ministry and LGAs on proper recording and accounting of expenditures			22,486,653
		4.4.2	Institute creditable mechanism for monitoring and evaluating resource availability use and Health outcomes at all levels.				**30,960,923**
			4.4.2.1	Train Health financial committee to monitor the use of the annual Health accounts at State and Local Government levels.			15,922,078
			4.4.2.2	Build capacity of State and LGA Officers for supervision, monitoring and eveluation of Health Sector resource availability use.			15,038,845
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							**206,933,000**
	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**		**88,864,641**
		5.1.1	To ensure that NHMIS forms are available at all health service delivery points at all levels				**18,778,178**
			5.1.1.1	Create a budget line for NHMIS related activities including printing of forms	No of NHIMS forms printed and circulated		190,758
			5.1.1.2	Train M&E officer, PHCC at State and LGA levels on the use of NHMIS forms	No of M&E officers trained on NHIMS		10,194,086
			5.1.1.3	Train Private Providers & FBO on completion and use of NHMIS forms	Quarterly data reports available		1,738,014
			5.1.1.4	Train HMIS & PHCC on data analysis using the operational manual & data dissemination			2,416,263
			5.1.1.5	Print 50,000 additional copies of the revised copies of NHMIS forms			-
			5.1.1.6	Production of annual health bulletin/journals for info update, decision making & research purposes.			4,239,058
		5.1.2	To periodically review of NHMIS data collection forms				**3,476,027**
			5.1.2.1	Conduct an annual review of the user friendliness of NHIMS forms at State & LGAs			2,543,435
			5.1.2.2	Support DPRS & HMIS to conduct Supervisory visits to LGAs			932,593

		5.1.3	To coordinate data collection from vertical programmes				**19,075,760**
			5.1.3.1	Establish interdepartmental & Intersectoral Health Data Consultative Committee at State & LGA levels			6,358,587
			5.1.3.2	Harmonize data collection from both public & private health institutions at State & LGAs			12,717,174
		5.1.4	To build capacity of health workers for data management				**12,611,197**
			5.1.4.1	Training and re-training of health service providers on data tools mgt. at service delivery levels			11,466,651
			5.1.4.2	Training of staff of HMIS unit on data management			1,144,546
		5.1.5	To provide a legal framework for activities of the NHMIS programme				**1,271,717**
			5.1.5.1	Advocate to State House of Assembly for inclusion of activities of NHMIS in Imo health bill			1,271,717
		5.1.6	To improve coverage of data collection				**25,434,347**
			5.1.6.1	Scale up Community Based Information System (CBIS) in the state			12,717,174
			5.1.6.2	Train and re-train public and private health facility staff at the LGA level on the use of HMIS			12,717,174
		5.1.7	To ensure supportive supervision of data collection at all levels				**8,217,414**
			5.1.7.1	State & LGA M&E officers conducts half-yearly supervision of NHMIS implementation			5,334,854
			5.1.7.2	Provide logistic support for supervision			2,882,559
	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**		**35,650,476**
		5.2.1	To strengthen the use of information technology in HIS				**31,835,324**
			5.2.1.1	Periodic ICT trainings for health workers at all levels			10,300,911
			5.2.1.2	Provide internet access networking			9,325,927
			5.2.1.3	Set up a decentralized software-based systems for data collection and analysis/Internet Acess in the ministry			6,782,493
			5.2.1.4	Pilot the above e-health data system in selected public and private hospitals			5,425,994
		5.2.2	To provide HMIS Minimum Package at the different levels (SMOH, LGA) of data management				**3,815,152**
			5.2.2.1	Provide computers (Laptops & Desktops) and accessories to State & LGA M&E units			3,815,152
	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**		**16,680,693**
		5.3.1	To strengthen the Hospital Information System				**-**

			5.3.1.1	Support public & private hospitals to produce and fowrad data to state level			-
		5.3.2	To strengthen the Disease Surveillance System				**16,680,693**
			5.3.2.1	Harmonize all the existing disease surveillance and notification approaches			1,843,990
			5.3.2.2	Create Public awareness on notifiable diseases.			6,358,587
			5.3.2.3	Train Disease Surveillance and Notification Officers (DSNO) at State, LGA and community levels.			4,239,058
			5.3.2.4	Train Disease Surveillance and Notification Officers (DSNO) for private and Faith Based health care providers.			4,239,058
	5.4	**To monitor and evaluate the NHMIS**			**NHMIS evaluated annually**		**55,054,764**
		5.4.1	To establish monitoring protocol for NHMIS programme implementation at all levels in line with stated activities and expected outputs				**13,427,216**
			5.4.1.1	Adopt the federal check-list for NHMIS monitoring for quality assurance.			105,976
			5.4.1.2	Set up a joint monitoring team comprising State, LGA and comminity stakeholders.			2,405,665
			5.4.1.3	Provision of field vehicles and or logistics support			2,649,411
			5.4.1.4	Bi annual review meetings of the State/LGA joint implementation mgt. team			8,266,163
		5.4.2	To strengthen data transmission				**41,627,548**
			5.4.2.1	Designate, train and empower CHEWs to cover specified geographical areas of the Community.			9,325,927
			5.4.2.2	Empower Private and Faith Based Health Care Providers to generate and transmit data.			6,358,587
			5.4.2.3	Motivate the Volunteer Village Health Workers to generate and transmit data.			18,312,730
			5.4.2.4	Provide logistics for M&E officers to act as effective link for data transmission.			7,630,304
	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**		**10,682,426**
		5.5.1	To institutionalize data analysis and dissemination at all levels				**10,682,426**
			5.5.1.1	Zonal facility based training and re training of health workers			10,173,739
			5.5.1.2	Production of bi-annual health journals for info update, decision making & research purposes.			508,687
COMMUNITY PARTICIPATION AND OWNERSHIP							
6. To attain effective community participation in health development and management, as well as community ownership of sustainable health outcomes							**198,735,000**
	6.1	**To strengthen community participation in health development**			**All States have at least annual Fora to engage community leaders and**		**28,500,000**

					CBOs on health matters by end 2012		
		6.1.1	To provide an enabling policy framework for community participation				-
			6.1.1.1	Update the Policy framework for community participation as currently existing within the national health policy	Updated policy avaliable by end of 2009	Community Conflict, Inadequate funding, culture.religion, taboos	-
		6.1.2	To provide an enabling implementation framework and environment for community participation				**28,500,000**
			6.1.2.1	Update Guideline for Establishing Community structures	Updated guideline available by the end of 2010	community conflict, Inadequate funding, culture.religion, taboos	1,500,000
			6.1.2.2	Re-activate commmunity health development associations local town unions.			13,500,000
			6.1.2.3	Involve Communities in decision making using existing social networks.			13,500,000
	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**		**83,700,000**
		6.2.1	To build capacity within communities to 'own' their health services				**83,700,000**
			6.2.1.1	Identify and map-out key Community Stakeholders	Community stakeholders identified and maped out by December 2009, 20%Community leaders trained.	Religion,Cultural Belief, Ignorance,Leadership tussles.comunity conflict, Inadequate funds	5,400,000
			6.2.1.2	Assess the capacity needs of community stakehlders	Capacity needs of community stakeholders identified by December 2009	Religion,Cultural Belief, Ignorance,Leadership tussles.comunity conflict, Inadequate funds	10,800,000
			6.2.1.3	Establish key roles and functions of Community stakeholders and structures	key roles and functions established by December 2009	Religion,Cultural Belief, Ignorance,Leadership tussles.comunity conflict, Inadequate funds.	-
			6.2.1.4	Conduct orientation to community development committee, Community Resource Persons(CORPS) on their roles and responsibilities	Number of orientation activites conducted for development committees by end of 2010	Religion,Cultural Belief, Ignorance,Leadership tussles.comunity conflict, Inadequate funds	13,500,000
			6.2.1.5	Provide funding for community activities / Establish dialogue between communities and government structures	60% of the cost of health projects realized./ Two meetings held by the end of 2010	Religion,Cultural Belief, Ignorance,Leadership tussles.comunity conflict, Inadequate funds	54,000,000
	6.3	**To strengthen the community - health services linkages**			**50% of public health facilities in all States have active Committees that include community**		**7,535,000**

					representatives by end 2011		
		6.3.1	To restructure and strengthen the interface between the community and the health services delivery points		30%CORPS,CBOs,CSOs Restructured and strenghtened.		**7,535,000**
			6.3.1.1	Review the existing health delivery structures and assess their level of interface with the community	30%CORPS,CBOs,CSOs Restructured and strenghtened.	Leadership tussle, Taboos, Cultural Conflict, Religion	2,035,000
			6.3.1.2	Identify areas of Community involvment with stakeholders and agree on operational modalities.			1,250,000
			6.3.1.3	Develope and provide guidelines for strenghtening the Community-health services interphase	Capacity of CBOs,CORPs,CSOs Developed Strengthened	Leadership tussle, etc.	1,250,000
			6.3.1.4	Provide incentives to stakeholders for their sustainability.			3,000,000
	6.4	**To increase national capacity for integrated multisectoral health promotion**			**50% of States have active intersectoral committees with other Ministries and private sector by end 2011**		**64,000,000**
		6.4.1	To develop and implement multisectoral policies and actions that facilitate community involvement in health development				**64,000,000**
			6.4.1.1	Undertake advocacy to community gate keepers to increase awareness and support for the use of health promotion to facilitate their involvement in health development	70% of gate keeper participate in health programmes	Leadership Tussle, Taboos,Culture, Religion	7,000,000
			6.4.1.2	Review and adapt the National health promotion policies and strategies that underscore participation of communities in health actions	30% Improvement in Knowledge, Attitude and Practice (KAP) of the Community in health programmes	Leadership Tussle, Taboos,Culture, Religion	1,500,000
			6.4.1.3	Formulate action plans to facilitate the development of health promotion capacity and support at various levels linking health with other sectors	40% Improvement in Multisectorial Participation	Leadership Tussle, Taboos,Culture, Religion	-
			6.4.1.4	Develop or adopt health promotion guidlines or frameworks on community involvement	80% Participation and Response to Health programmes	Leadership Tussle, Taboos,Culture, Religion	1,500,000
			6.4.1.5	Implement health promotion activities at Community level.			54,000,000
	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**		**15,000,000**
		6.5.1	To develop and implement systematic measurement of community involvement				**15,000,000**
			6.5.1.1	Measure the Impact of Specific Community Approaches, methods and Initiatives	Authentic Data Generated from the Community	Leadership Tussle, Taboos,Cultural conflict, Religion	3,000,000
			6.5.1.2	Disseminate and harness experiences amongst Community Stakeholders	Behavioural change amongst Stakeholders	Leadership Tussle, Taboos,Culture, Religion	12,000,000
PARTNERSHIPS FOR HEALTH							
7. To enhance harmonized implementation of essential health services in line with national health policy goals							**1,627,700,000**
	7.1	**To ensure that collaborative mechanisms are put in place for involving all partners in the development and sustenance of the health sector**			**1. State has an active ICC with Donor Partners that meets at least quarterly by end**		**1,627,700,000**

					2010 2. State has an active PPP forum that meets quarterly by end 2010 3. All States have similar active committees by end 2011		
		7.1.1	To promote Public Private Partnerships (PPP)				**301,425,926**
			7.1.1.1	Updating the existing state PPP policy in line with the national policy with a view to leveraging technical and financial resources alongside improved management approaches for improved delivery of healthcare services.	Policy updated by 1st Q of 2010	Stable political will / enviironment	92,372,461
			7.1.1.2	Implementation of the State's PPP initiative to be in line with this national policy in the state and the LGAs.	State MOH 2011 fully implementing 2011	Stable political will / enviironment	21,391,517
			7.1.1.3	Establish a mechanism to engage the private sector eg contracting or outsourcing, concessions, provision of incentives like technical support at no cost, etc	60% of private sector have received one form of support or the other 2012.	Availability of enough fund to the state MOH	29,170,251
			7.1.1.4	Provide incentives for private care providers to set up facilities in underserved and remote areas.	60% of the underserved areas having hlth facilities from private sector 2014.	There are no community clashes. Sustained funding or support to the hlth facilities.	38,893,668
			7.1.1.5	Undertake joint monitoring visits by public and private care providers with adequate feedback.	50% of visits by the MOH will be joint by 2012	policy not eroded by bias from the operating administration.	119,598,029
		7.1.2	To institutionalize a framework for coordination of Development Partners				**72,925,627**
			7.1.2.1	Establishment of Development Partner's Forum.	90% of partners involved in the forum by 2012	Stable political will / enviironment	38,893,668
			7.1.2.2	Establish a mechanism for resource coordination through common basket funding models like Joint Funding Agreement, SWAP, Sectoral multi-donor budget	60% of donor partners will be involved by 2015	Nigeria and particularly Imo state continues to make progress to attract these partners.	34,031,959
		7.1.3	To facilitate inter-sectoral collaboration				**19,446,834**
			7.1.3.1	Strenghten the existing state intersectoral collaboration forum.	70% of all sectors being part of this forum by 2014	Stable political will / enviironment	19,446,834
		7.1.4	To engage professional groups				**262,532,258**
			7.1.4.1	Adopt and implement standards of practice for professional groups from federal model.	60% of professional bodies involved in this jt standard setting by 2014	Proper management of professional bias.	44,727,718
			7.1.4.2	Improve communication between the MOH and the professional bodies.	60% of professional bodies involved in proper communication by 2014	Proper management of professional bias.	175,021,505
			7.1.4.3	Joint advocacy by the MOH and the professional bodies to government and partners on resource allocation.	60% of professional bodies involved in proper communication by 2012	Proper management of professional bias.	13,612,784
			7.1.4.4	Establish linkages with academic institutions to undertake research, education and monitoring through existing networks	70% linkages by 2015	Stable academic environment	29,170,251

		7.1.5	To engage with communities				**665,081,720**
			7.1.5.1	Provide gender and culture -sensitive health information to communities.	80% of the communities are informed by 2012	Availability of fund and absece of community clashes	58,340,502
			7.1.5.2	Develope health system performance indicators at the state level and facilities to improve transparency and accountability of govt to the communities.	performance indicators complete by 2011		38,893,668
			7.1.5.3	Establish an award for best health practices among communities.	Full commencement by 2011	Sustainability of hlth programmes	315,038,710
			7.1.5.4	Build the capacity of the ward health committee members, volunteer village health workers (V VHW) and community resource persons (CORPs) to undertake health promotion and prevention activities.	Fully started by 2010	Availability of fund, well motivated staff	252,808,841
		7.1.6	To engage with traditional health practitioners				**306,287,634**
			7.1.6.1	Institute modalities to regulate, control and evaluate their practices, including advertisement	80% of practices evaluated	Absence of internal Squables	29,170,251
			7.1.6.2	Integration of evidence based good practices into state healthcare delivery system	60% full regulation of all practices by 2015	Stable internal admin	69,036,260
			7.1.6.3	Training and retraining.	70% of all the practices adopted by 2014	Sustainable practice among practioners	110,846,953
			7.1.6.4	Setting up Herbarium (Botanical garden for medicinal plants)	80% must have been fully involved in the wkshp	Sustainable practice among practioners. Adequate funding	97,234,170
			7.1.6.5			Availaibility of political will and cooperation among traditional health practitioners.	-
RESEARCH FOR HEALTH							
8. To utilize research to inform policy, programming, improve health, achieve nationally and internationally health-related development goals and contribute to the global knowledge platform							**1,343,957,000**
	8.1	**To strengthen the stewardship role of governments at all levels for research and knowledge management systems**			**1. ENHR Committee established by end 2009 to guide health research priorities 2. FMOH publishes an Essential Health Research agenda annually from 2010**		**916,107,000**
		8.1.1	To adopt and adapt the finalised federal health research policy at state level and develop same at LGA level.		1. Existence of health research policy at state and LGA levels by the end of 1st quarter of 2010. 2. Existence of functional research steering committee by the second quarter of 2010. 3. Dissemination of research results to all stake holders by the end of the last quarter of each year.		**190,572,000**

			8.1.1.1	Set up Technical Working Groups to adopt and adapt health research policies and strategies at State and LGA level.			30,885,000
			8.1.1.2	Develop and provide guidelines for the establishment of health research steering committees at State and LGA levels			103,800,000
			8.1.1.3	Monitor the activities of health research steering committees at State and LGA levels and evaluate their function and value.			9,937,000
			8.1.1.4	Extend the functions of the health steering committee to cover the private health sector and the Traditional Medicine Programme (TMP)			35,500,000
			8.1.1.5	Evaluate , report and feed-back the outcome of research from LGA to State and State to Federal.			10,450,000
		8.1.2	To establish and or strengthen mechanisms for health research at State & LGA levels				**150,200,000**
			8.1.2.1	Provide technical assistance to the DPRS & PHCC to develop and strengthen the capacity of health research unit at State and LGAs respectively			24,850,000
			8.1.2.2	Provide techinical assistance to organised private groups to undertake research.			44,350,000
			8.1.2.3	Provide enabling environment in the state tetiary health and education institutions to sustain health research.			81,000,000
		8.1.3	To institutionalize processes for setting health research agenda and priorities				**482,950,000**
			8.1.3.1	Implement the Essential National Health Research (ENHR) programme in the State and LGAs.			54,700,000
			8.1.3.2	Expand health research agenda to include broad and multi-dimensional determinants of health.			23,250,000
			8.1.3.3	Integrate research into traditional medicine practice.			270,000,000
			8.1.3.4	Empower and reward active research in health.			90,000,000
			8.1.3.5	Publish and utilize the outcome of research.			45,000,000
		8.1.4	To promote cooperation and collaboration between Ministries of Health and LGA health authorities with Universities, communities, CSOs, OPS, NIMR, NIPRD, development partners and other sectors				**37,910,000**
			8.1.4.1	Develop & disseminate guidelines for a collaborative research agenda			26,275,000
			8.1.4.2	Establish and hold periodic forum for all stakeholders in health research.			11,635,000
		8.1.5	To mobilise adequate financial resources to support health research at all levels				**5,000,000**
			8.1.5.1	Advocate for allocation of at least 2% of health budget for health research at state & LGA levels.			3,000,000
			8.1.5.2	Seek and Integrate resources for research from all stakeholders.			2,000,000
		8.1.6	To establish ethical standards and practise codes for health research at all levels				**49,475,000**
			8.1.6.1	Develop, produce and distribute guidelines on ethical standards and practise codes for research in health.			10,750,000

			8.1.6.2	Establish and empower ethical review c'mttees in the state and LGA's and strengthen those in the state's tetiary health and education institution.			33,250,000
			8.1.6.3	Review the guidelines developed in line with new technologies and advancements.			5,475,000
	8.2	**To build institutional capacities to promote, undertake and utilise research for evidence-based policy making in health at all levels**			**FMOH has an active forum with all medical schools and research agencies by end 2010**		**365,650,000**
		8.2.1	To strengthen identified health research institutions at all levels				**326,250,000**
			8.2.1.1	Provide and upgrade ICT facilities in all tertiary health and educational Institutions			214,000,000
			8.2.1.2	Provide utility vehicles for research units in identified institutions			66,750,000
			8.2.1.3	Affiliate identified institutions with corresponding local and international foreign institutions			10,000,000
			8.2.1.4	Build the capacity of key staff through participation in international workshops, symposia, etc.			35,500,000
		8.2.2	To create a critical mass of health researchers at all levels				**15,000,000**
			8.2.2.1	Create an active reserch unit in the Dept. Of PRS that cordinates research activities with all other departments			1,500,000
			8.2.2.2	Create and empower research units in secondary & primary health facilities to be coordinated by the medical records unit of the facilities			13,500,000
		8.2.4	To undertake research on identified critical priority areas				**24,400,000**
			8.2.4.1	Identify areas of Operational research at state & LGA levels			1,200,000
			8.2.4.2	Conduct operations research along identified lines			23,200,000
	8.3	**To develop a comprehensive repository for health research at all levels (including both public and non-public sectors)**			**1. All States have a Health Research Unit by end 2010 2. FMOH and State Health Research Units manage an accessible repository by end 2012**		**-**
	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**		**62,200,000**
		8.4.1	To create a framework for sharing research knowledge and its applications				**9,750,000**
			8.4.1.1	Develop and destribute a template for reporting research findings at all levels			9,750,000
		8.4.2	To establish channels for sharing of research findings between researchers, policy makers and development practitioners				**52,450,000**
			8.4.2.1	Strengthen Communiction between DPRS of MOH, Research units at all levels			26,850,000
			8.4.2.2	Create and empower a research implementation unit in the office of the Permanenet Secretary, MOH.			25,600,000

							26,316,412,001

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

IMO 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%	80%	100%	100%
	2. % stakeholders constituencies playing their assigned roles in the SSHDP (disaggregated by stakeholder constituencies)	SSHDP Annual Review Report	0%	30%	50%	75%
2. Improved Legislative and Regulatory Frameworks for Health Development	3. State adopting the National Health Bill? (Yes/No)	SMOH	0%	25%	50%	75
	4. Number of Laws and by-laws regulating traditional medical practice at State and LGA levels	Laws and bye-Laws	0%	10%	30%	50%
	5. % of LGAs enforcing traditional medical practice by-laws	LGA Annual Report	0%	10%	30%	50%
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	30%	50%	70%
	7. % of recommendations from health watch groups being implemented	Health Watch Groups' Reports	No Baseline	25	50	75
	8. % LGAs aligning their health programmes to the SSHDP	LGA Annual Report	0	50	75	100
	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	2%	25	50	75%
	11. % LGAs implementing their peer review recommendations	LGA / SSHDP Annual Review Report	0%	50	75	100%
	12. Number of LGA Health Watch Reports published	Health Watch Report	0	50	75	100
	13. Number of "Annual Health of the LGA" Reports published and disseminated annually	Health of the State Report	0%	50	75	100%

4. Enhanced performance of the State health system	14. % LGA public health facilities using the essential drug list	Facility Survey Report	5%	40	80	100%
	15. % private health facilities using the essential drug list by LGA	Private facility survey	TBD	10	25	50%
	16. % of LGA public sector institutions implementing the drug procurement policy	Facility Survey Report	TBD	50	75	100%
	17. % of private sector institutions implementing the drug procurement policy within each LGA	Facility Survey Report	0%	10	25	50%
	18. % LGA health facilities not experiencing essential drug/commodity stockouts in the last three months	Facility Survey Report	50%	25	50	75%
	19. % of LGAs implementing a performance based budgeting system	Facility Survey Report	0%	25	50	75%
	20. Number of MOUs signed between private sector facilities and LGAs in a Public-Private-Partnership by LGA	LGA Annual Review Report	0%	2	4	6
	21. Increased 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	5%	20%	50%	75%
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	10%	25	50	75%
	23. % health facilities implementing the complete package of essential health care	NPHCDA Survey Report	2%	50	75	100%
	24. % of the population having access to an essential care package	MICS/NDHS	20%	40	75	100%
	25. Contraceptive prevalence rate (modern & traditional)	NDHS	36.60%	45%	55%	65%
	26. % Increase of new users of modern contraceptive methods (male/female)	NDHS/HMIS	22.70%	28%	35%	40%
	27. % of new users of modern contraceptive methods by type (male/female)	NDHS/HMIS	9%	20%	50%	75%
	28. % service delivery points without stock out of family	Health facility Survey	50%	60%	70%	75%

	planning commodities in the last three months					
	29. % of facilities providing Youth Friendly RH services	Health facility Survey	0%	5%	15%	25%
	30. % women 15-19 who have begun child bearing	NDHS/MICS	7.90%	6%	4%	2%
	31. % of pregnant women with 4 ANC visits performed according to standards*	NDHS	96%	100%	100%	100%
	32. Proportion of births attended by skilled health personnel	HMIS	94.30%	96%	100%	100%
	33. Proportion of women with complications treated in an EmOC facility (Basic and/or comprehensive)	EmOC Sentinel Survey and Health Facility Survey	20%	40%	50%	75%
	34. Caesarean section rate	EmOC Sentinel Survey and Health Facility Survey	1%	10%	20%	30%
	35. Case fatality rate among women with obstretic complications in EmOC facilities per complication	HMIS	20%	15%	10%	5%
	36. Perinatal mortality rate**	HMIS	37/1000LBs	30/1000LBs	25/1000LBs	20/1000LBs
	37. % women receiving immediate post partum family planning method before discharge	HMIS	0%	5%	10%	20%
	38. % of women who received postnatal care based on standards within 48h after delivery	MICS	30%	40%	60%	75%
	39. Number of women presented to the facility with or for an obstetric fistula	NDHS/HMIS	No Baseline	0%	0%	0%
	40. Number of interventions performed to repair an obstetric fistula	HMIS	No Baseline			??
	41. Proportion of women screened for cervical cancer	HMIS	5%	15%	25%	50%
	42. % of newborn with infection receiving treatment	MICS	10%	25%	50%	75%
	43. % of children exclusively breastfed 0-6 months	NDHS/MICS	9%	20%	30%	40%
	44. Proportion of 12-23 months-old children fully immunized	NDHS/MICS	50.00%	60%	70%	80%
	45. % children <5 years stunted (height for age <2 SD)	NDHSMICS	15.00%	10%	5%	2%
	46. % of under-five that slept under LLINs the previous night	NDHS/MICS	25.00%	30%	40%	50%
	47. % of under-five children receiving appropriate malaria treatment within 24 hours	NDHS/MICS	25%	35%	60%	75%
	48. % malaria successfully treated using the approved protocol and ACT;	MICS	25%	40%	65%	80%
	49. Proportion of population in malaria-risk areas using	MICS	60%	75%	85%	100%

	effective malaria prevention and treatment measures					
	50. % of women who received intermittent preventive treatment for malaria during pregnancy	NDHS/MICS	20%	30%	40%	50%
	51. HIV prevalence rate among adults 15 years and above	NDHS	3.90%	3.80%	3.00%	2.50%
	52. HIV prevalence in pregnant women	NARHS	3.80%	3.40%	3%	2.50%
	53. Proportion of population with advanced HIV infection with access to antiretroviral drugs	NMIS	5%	15%	25%	50%
	54.Condom use at last high risk sex	NDHS/MICS	7%	15%	12%	20%
	55. Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS	NDHS/MICS	33%	43%	55%	70%
	56. Prevalence of tuberculosis	NARHS	3.50%	2%	1.50%	0.50%
	57.Death rates associated with tuberculosis	NMIS	5.60%	4%	3.50%	3%
	58. Proportion of tuberculosis cases detected and cured under directly observed treatment short course	NMIS	80%	88%	90%	100%
Output 6. Improved quality of Health care services	59. % of staff with skills to deliver quality health care appropriate for their categories	Facility Survey Report	30%	50%	75%	100%
	60. % of facilities with capacity to deliver quality health care	Facility Survey Report	10%	50%	75%	100%
	61. % of health workers who received personal supervision in the last 6 months by type of facility	Facility Survey Report	20%	40%	55%	80%
	62. % of health workers who received in-service training in the past 12 months by category of worker	HR survey Report	20%	50%	75%	100%
	63. % of health facilities with all essential drugs available at all times	Facility Survey Report	15%	40%	75%	100%
	64. % of health institutions with basic medical equipment and functional logistic system appropriate to their levels	Facility Survey Report	5%	25%	40%	75%
	65. % of facilities with deliveries organizing maternal and/or neonatal death reviews according to WHO guidelines on regular basis	Facility Survey Report	2%	20%	45%	50%
Output 7. Increased demand for health services	66. Proportion of the population utilizing essential services package	MICS	10%	25%	50%	75%
	67. % of the population adequately informed of the 5 most beneficial health practices	MICS	30	50	75	100
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	68. % of wards that have appropriate HRH complement as per service delivery norm (urban/rural).	Facility Survey Report	TBD	20%	30%	40%
	69. Retention rate of HRH	HR survey Report	TBD	85%	90%	95%
	70. % LGAs actively using adaptations of National/State HRH policy and plans	HR survey Report	TBD	30%	50%	75%
	71. Increased number of trained staff based on approved staffing norms by qualification	HR survey Report	TBD	10%	25%	35%
	72. % of LGAs implementing performance-based managment systems	HR survey Report	TBD	25%	30%	45%
	73. % of staff satisfied with the performance based management system	HR survey Report	TBD	25%	35%	50%
Output 8: Improved framework for objective analysis, implementation and monitoring of HRH performance	74. % LGAs making availabile consistent flow of HRH information	NHMIS	0 - 100%	25%	35%	50%
	75. CHEW/10,000 population density	MICS	TBD	1:4000 pop	1:3000 pop	1:2000 pop
	76. Nurse density/10,000 population	MICS	TBD	1:8000 pop	1:6000 pop	1:4000 pop
	77. 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
	78. Medical doctor density per 10,000 population	MICS	TBD	1:8000 pop	1:7000 pop	1:5000 pop
	79. Other health service providers density/10,000 population	MICS	TBD	1:4000 pop	1:3000 pop	1:2000 pop
	80. HRH database mechanism in place at LGA level	HRH Database	TBD	25%	40%	60%
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	81. % of LGAs implementing state specific safety nets	SSHDP review report	0%	10%	25%	50%
	82. Decreased proportion of informal payments within the public health care system within each LGA	MICS	70%	50%	30%	10%
	83. % of LGAs which allocate costed fund to fully implement essential care package at N5,000/capita (US$34)	State and LGA Budgets	0%	25%	40	60%
	84. LGAs allocating health funding increased by average of 5% every year	State and LGA Budgets	20%	40%	60%	80%
Output 12: Improved efficiency and equity in the allocation and use of Health resources at State and LGA levels	85. LGAs health budgets fully alligned to support state health goals and policies	State and LGA Budgets	20%	40%	60%	100%
	86.Out-of pocket expenditure as a % of total health expenditure	National Health Accounts 2003 - 2005	70%	60%	50%	40%
	87. % of LGA budget allocated to the health sector.	National Health Accounts 2003 - 2005	2%	10%	20%	30%
	88. Proportion of LGAs having transparent budgeting and finacial management systems	SSHDP review report	0%	25%	40%	60%
	89. % of LGAs having operational supportive supervision and monitoring systems	SSHDP review report	10%	25%	40	50%
PRIORITY AREA 5: NATIONAL HEALTH INFORMATION SYSTEM						
Outcome 10. National health management information system and sub-systems provides public and private sector data to inform health plan development and implementation						
Outcome 11. National health management information system and sub-systems provide public and private sector data to inform health plan development and implementation at Federal, State and LGA levels						
Output 13: Improved Health Data Collection, Analysis, Dissemination, Monitoring and Evaluation	90. % of LGAs making routine NHMIS returns to states	NHMIS Report January to June 2008; March 2009	55%	80%	100%	100%
	91. % of LGAs receiving feedback on NHMIS from SMOH		2%	25%	75%	100%
	92. % of health facility staff trained to use the NHMIS infrastructure	Training Reports	30%	60%	80%	100%

	93. % of health facilities benefitting from HMIS supervisory visits from SMOH	NHMIS Report	30%	40%	60%	80%
	94.% of HMIS operators at the LGA level trained in analysis of data using the operational manual	Training Reports	0%	40%	75%	100%
	95. % of LGA PHC Coordinator trained in data dissemination	Training Reports	0%	40%	75%	100%
	96. % of LGAs publishing annual HMIS reports	HMIS Reports	0%	25%	50%	75%
	97. % of LGA plans using the HMIS data	NHMIS Report	5%	40%	75%	100%
PRIORITY AREA 6: COMMUNITY PARTICIPATION AND OWNERSHIP						
Outcome 12. Strengthened community participation in health development						
Outcome 13. Increased capacity for integrated multi-sectoral health promotion						
Output 14: Strengthened Community Participation in Health Development	98. Proportion of public health facilities having active committees that include community representatives (with meeting reports and actions recommended)	SSHDP review report	0%	25%	50%	75%
	99. % of wards holding quarterly health committee meetings	HDC Reports	10%	25%	50%	75%
	100. % HDCs whose members have had training in community mobilization	HDC Reports	10%	40%	75%	100%
	101. % increase in community health actions	HDC Reports	10%	10%	25%	50%
	102. % of health actions jointly implemented with HDCs and other related committees	HDC Reports	5%	25%	40%	60%
	103. % of LGAs implementing an Integrated Health Communication Plan	HPC Reports	2%	25%	40%	60%
PRIORITY AREA 7: PARTNERSHIPS FOR HEALTH						
Outcome 14. Functional multi partner and multi-sectoral participatory mechanisms at Federal and State levels contribute to achievement of the goals and objectives of the						
Output 15: Improved Health Sector Partners' Collaboration and Coordination	104. Increased number of new PPP initiatives per year per LGA	SSHDP Report	0%	25%	40%	60%
	105. % LGAs holding annual multi-sectoral development partner meetings	SSHDP Report	7%	25%	50%	75%
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	106. % of LGAs partnering with researchers	Research Reports	0%	10%	25%	50%

	107. % of State health budget spent on health research and evaluation	State budget	0.01%	1%	1.50%	2%
	108. % of LGAs holding quarterly knowledge sharing on research, HMIS and best practices	LGA Annual SHDP Reports	0%	10%	25%	50%
	109. % of LGAs participating in state research ethics review board for researches in their locations	LGA Annual SHDP Reports	TBD	40%	75%	100%
	110. % of health research in LGAs available in the state health research depository	State Health Reseach Depository	TBD	40%	75%	100%
Output 17: Health research communication strategies developed and implemented	111. % LGAs aware of state health research communication strategy	Health Research Communicatio n Strategy	TBD	40%	75%	100%