ENUGU STATE GOVERNMENT OF NIGERIA

STATE STRATEGIC HEALTH DEVELOPMENT PLAN

(2010 – 2015)

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Enugu State Ministry of Health 2009 ©

Acronyms

Acronym	Meaning
BCC	Behaviour Communication Change
BI	Bamako Initiative
BEOC	Basic Emergency Obstetric Care
CIDA	Canadian International Development Agency
CPD	Continuing professional development
CSO	Civil Society Organization
DFID	Department for International Development
DHB	District Health Board
DP	Development Partners
DPRS	Department of Planning, Research and Statistics
FMOH	Federal Ministry of Health
GIS	Geographic Information System
HDCC	Health Data Consultative Committee
HF	Health Facility
HIS	Hospitals Information System/Health Insurance Scheme
HIV/AIDS	Human Immuno Deficiency Virus/Acquired Immune Deficiency Syndrome
HPCC	Health Partners Coordinating Committee/Health Planning and Coordinating Committee
HRH	Human Resources for Health
HW	Health worker
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illnesses
IMNCH	Integrated Maternal, Newborn and Child Health
IPC	Interpersonal Communication skills
ISS	Integrated Supportive Supervision
ITNs	Insecticide Treated Nets
JICA	Japan International Development Agency
KM	Knowledge Management
LGA	Local Government Area
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDCN	Medical and Dental Council of Nigeria
MDGs	Millennium Development Goals
MNCH	Maternal and Newborn Child Health
MRCN	Medical Research Council of Nigeria
NAFDAC	National Agency for Food Drugs Administration and Control
NDHS	Nigeria Demographic and Health Survey
NGOs	Non-Governmental Organizations
NHA	National Health Accounts
NHIS	National Health Insurance Scheme
NHMIS	National Health Management Information System
NHREC	National Health Research Committee
NIMR	Nigerian Institute for Medical Research
NIPRD	National Institute for Pharmaceutical Research and Development

NMSP	National Malaria Strategic Plan
NMA	Nigerian Medical Association
NANNM	National Association of Nigerian Nurses and Midwives
PSN	Pharmaceutical Society of Nigeria
ACHPN	Association of Community Health Practitioners of Nigeria
NPHCDA	National Primary Health Care Development Agency
NSHDP	National Strategic Health Development Plan
NSHDPF	National Strategic Health Development Plan Framework
NYSC	National Youth Service Corps
OPS	Organized Private Sector
PERs	Public Expenditure Reviews
PHC	Primary Health Care
PHCMIS	Primary Health Care Management Information System
PPP	Public Private Partnerships
PTF	Petroleum Trust Fund
QA	Quality Assurance
RDBs	Research data banks
SHA	State Health Accounts
SHDP	State Health Development Plan
SMOH	State Ministry of Health
TB	Tuberculosis
TBAs	Traditional birth attendants
TWG	Technical Working Group
UN-System	United Nations-System
VAT	Value Added Tax
VHW	Village health workers
VOC	Vote-of-charge
WHO	World Health Organization

Vision and Mission of the Enugu State health system

Vision

"To reduce the morbidity and mortality rates due to communicable diseases to the barest minimum; reverse the increasing prevalence of no-communicable diseases; meet global targets on the elimination and eradication of diseases; and significantly increase the life expectancy and quality of life of Nigerians"

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 NSHDP is to "significantly improve the health status of Nigerians through the development of a strengthened and sustainable health care delivery system".

Executive Summary

Enugu State is one of the 36 states of Nigeria and is located in the south East geo-political zone of the country. Its capital is Enugu, otherwise known as the coal city State. Enugu State was carved out from the former Anambra State and it has 17 Local Government Areas. The state has a 2009 projected population of **3,541,743** at an annual growth rate of 2.8% based on the 2006 population census figures, and 1,775,707 (50.1%) of the population are females while 1,7366,036 (49.9%) are males. The population density is about 360 persons per square kilometer and is more than three times the mean national population density of 96 persons per square kilometer. About 59% of the population in Enugu state lives in the rural areas.

Economically, the State is predominantly rural and agrarian, with a substantial portion of its working population engaged in farming, although trading (18%) and services (12.9%) are also practiced. In urban areas, trading is the predominant occupation followed by service provision. A small proportion of the population is engaged in manufacturing services with the most pronounced in Enugu, Oji-River and Nsukka areas.

The Health indicators of the state were unacceptably high as were the health indicators of the rest of the country. While figures were not readily available for Enugu State specific health status indices; it is believed that the infant mortality rate is below the national indices of 97 infant per 1,000 live births (2007), neonatal mortality rate of 47/1,000 live births (2004) and Under 5 mortality rate of 189/1,000 live births (2007)[1]. Out of 158 children sampled by NDHS (2008), only 28% had received all vaccines in the national schedule while another 38% had not received any antigen at all. Coverage rates were 66.2% (BCG), 50% (DPT3), 35.5% (OPV3) and 53.6% (Measles)[2]. Sixty eight percent (68%) of pregnant Enugu women received anti-natal care from a health professional. Slightly less than this number (65%) had delivery assisted by a health professional. Another 54% delivered their babies in a health facility[3]. The modern contraceptive prevalence rate defined by the use of male and female condoms, pills and IUD was 11.3% in Enugu State.

This negative trend was as a result of the fragmented health care delivery system, poor referral mechanism, lack of joint planning, poor management of available resources, and dilapidated state of public health facilities and high cost of health care, as well as poor institutional, system and human capacity.

[1] UNICEF (2008)
[2] NDHS (2008)
[3] NDHS (2008)

Enugu State operates the District Health System (DHS) which was signed into law in August 2005. The model of the DHS includes 7 District Health Boards (DHBs) for service delivery at District level and 56 Local Health Authorities (LHAs) which serve as local service delivery at local government level. There were 366 public primary Healthcare Centers (PHCs) (including comprehensive health centres health centres, health clinics and health posts), 35 cottage hospitals, 3 sub-district hospitals, 6 district hospitals and one State tertiary health centre[4]. Supporting these were about 700 private health facilities.

The Enugu health system shares and adopts the national vision and mission for healthcare as defined in the framework. The strategic thrusts of the Enugu SHDP are presented below.

S/NO	PRIORITY	STRATEGIC THRUSTS
1	Leadership & Governance	● Development/review of policies, strategies and specific guidelines consistent with provisions of national policies and plans. New health legislation. Creation of database for same. ● Convocation and attendance of statutory coordination meetings such as ENUGU STATE Council of Health, NCH, Partners forum, etc. ● Linking of planned activities to budget. Budget performance monitoring. ● Health system performance management
2	Service Delivery	● Increased resourcing of child health, maternal health and ATM in pursuit of the MDGs ● Disease control through national strategies e.g. IMNCH, WMHCP ● Construction and equipping of public health laboratory ● Construction/renovation and equipping of primary and secondary health facilities in underserved areas
3	Human Resources for Health	● Establish HRH units at HHSS and Area Councils ● Recruitment, orientation, managerial and technical capacity building of health workers ● Establish and implement a performance management and reward system ● Improved engagement of professional associations and regulatory bodies
4	Health Financing	● Implementation of community based social health insurance ● Advocate for greater public funding of the health sector through evidence ● Rigorously engage the private sector. ● Improve financial management system through FM manuals and accounting software. Build health finance personnel capacity
5	Health Management Information System	● Procure HIS software for SHC facilities ● Provision of the HMIS minimum package at State and LGA levels ● Establish a resource centre with electronic library and ICT facilities ● Revitalize Health Data Consultative Committee (HDCC) ● Develop, produce, disseminate and implement Knowledge Management Strategies and Plans
6	Community Ownership & Participation	● Revive Ward Development and Village Health Committees ● Training of community focal groups on community health management

[4] SMOH: DHS Brochure

		● Support participation of traditional/religious leaders and opinion leaders in community health management
7	Partnerships	● Institute joint planning, monitoring and evaluation of programmes and projects ● Explore PPP opportunities
8	Research for Health	● Provide a budget line annually for research ● Collaborate with academia and research institutions in identification and implementation of research interventions

The State Minimum Package of Care contains provision of services for:

a) Communicable Diseases
b) Child Survival
c) Safe Motherhood
d) Nutrition
e) Non Communicable Diseases
f) Health Education and Community Mobilization
g) Laboratory
h) Equipment

Staffing: Adequate number, right mix and quality staff

The State priority interventions are:

1. To increase the percentage of fully immunized children

2. To increase the percentage of HIV+ pregnant women receiving ART

3. To reduce the percentage of children 0 – 59 with diarrhea

4. To increase the percentage of household sleeping under LLITNs

5. To increase the percentage of deliveries attended by skilled personnel

6. To increase the percentage of facilities providing BEOC

The targets set are:

. • Achieve Universal Immunization Coverage among children aged 0-5 years by 2015;

. Reduce infant mortality from 110/1000 to 35/1000 by 2015;

. Reduce under 5 mortality from 170/1000 to 55/1000 by 2015;

. Reduce by 50% mother-to-child transmission of HIV by 2015

. Reduce by 65% the percentage of children 0 – 59 months with diarrhea by 2015

. Reduce the incidence of malaria from 82,503/100,000 to 43,727/100,000 by 2015

• Reduce the level of maternal mortality by 2015 from 144/10,000 population to 95/10,000 population

• Increase by 50% the facilities providing BEOC by 2015

Enugu State strategic plan has been costed at a total of N74,908,161,737 over the six year plan period. Total personnel and recurrent costs amount to about 68% of the Plan. These represent the statutory contribution of government to keep the health system operational. Capital costs, the release of which would make the difference in the Enugu health system account for the balance of 32%. Expectedly, about 50% of Plan costs shall finance the delivery of health services followed by Human Resources for Health. Health research would gulp about 6% of cost estimates. The contributions of the 17 LGAs, federal funds (FMOH, PHCF & MDGs) as well as the financial support of the development partners would easily bridge the gap.

The key role players in the implementation of the strategic plan are government at the three levels and strategic partners such as development agencies, civil society organizations, professional associations, regulatory bodies and the various communities. Government has responsibility for governance and stewardship and as such takes the lead in driving the process. However, every stakeholder's plan has been incorporated or nested into the Plan. This has curtailed vertical programmes and ensured integration of service delivery.

The framework for the M&E plan for Enugu SHDP is defined by the strategic plan summary showing the various interventions and their indicators. The indicators selected shall be used to measure progress towards the strategic objective targets. Precisely how this is to be done shall be described by the yearly operational plan. The M&E component has not been sufficiently addressed to be realistically costed. However, according to WHO, 5% of programme or project costs should be earmarked for M&E activities in order to effectively measure its performance. In this case, that sum would be about N1.5b over the plan period or N250m per annum.

Chapter 1. Introduction

1.1 Background

Enugu State is located in the South East geopolitical zone of Nigeria. The State is administratively divided into 17 Local Government Areas (LGAs). The population was approximately 3.3m with a growth rate of 3% in 2006[5].The population profile showed a large, relatively young population, with approximately 60% of the people aged 15 or below.

The Federal Government has identified priorities, designed a template and provided a consultant to Enugu State for the development of the strategic healthcare plan based on the health Millennium Development Goals (MDGs). The purpose is to lay a solid foundation for the planning, organization and management of health services in Enugu State. The strategic plan would provide an opportunity for development agencies and other stakeholders to buy into it thereby mobilizing resources for the health system. The plan will also establish a roadmap for monitoring the implementation of health activities and evaluating performance.

The goals of the Strategic Healthcare plan are as follows:

1. To create and sustain an enabling environment for the delivery of quality health care and development in Nigeria.
2. To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare
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
4. To ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and consumption at Local, State and Federal levels
5. 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
6. To attain effective community participation in health development and management, as well as community ownership of sustainable health outcomes
7. To enhance harmonized implementation of essential health services in line with national health policy goals
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

The State Ministry of Health published a framework, the ‘Strategy for Health 2008-2013’[6]. Its aim was to provide for the State a strategic direction for health with the core purpose of moving the state increasingly towards the achievement of the MDG as well as meeting the wider health needs of the population.

The strategy was focused around four strategic themes:

- Service delivery
- Underpinning systems
- Working in partnership
- Research and development which were predicated on a number of principles.

Other areas of focus were

[5] National Population Commission (2006)
[6] SMOH (2008): Strategy for Health 2008-2013

- Targeting the needs of the poor
- The provision of a minimum service package to be delivered by every public health facility
- Achieving affordable and accessible services
- Increased community engagement
- Promoting public /private partnership

It is noteworthy that these thrusts are all in tandem with national health aspirations.

1.2 Methodology

Approach
The development of the State Strategic Health Development Plan (SHDP) was driven by Enugu State. The role players were multidisciplinary and widely inclusive involving several sectors and interests. It was evidence based as it drew on the findings of several previous assessments and activities carried out with the support of development partners notably United Kingdom Department for International Development (DFID) funded Partnerships for Transforming Health Systems 1 and 2 (PATHS1 and 2) and the World Bank funded Health Systems Development Project II (HSDP II). The Plan is anticipated to be realistic; costing being a major component.

Process
Three workshops were planned – capacity building, strategic planning retreat and plan presentation. The purpose of the capacity building workshop is to impart on selected participants the skills to write the plan using the FMOH developed framework and tools. In between the capacity building workshop and the planning retreat, the Microsoft Excel template of the plan was completed by individual institutions, adding interventions from the perspective of their functions. Individual plans in accordance with the eight priority areas were presented, critiqued and amended by plenary at the strategic planning retreat. Then, these plans were joined together, cleaned and packaged for presentation. The State Steering and Planning Committees' meetings held to provide planning and oversight respectively for all activities. It was decided to bring all participants under one roof instead of decentralized workshops. This was due to administrative, logistics and financial reasons.

The plan development process is summarized below:

- The Enugu State Planning Committee held meetings at agreed mileposts
- Capacity building workshop for writing the strategic plan held
- Preparation of draft thematic plans (office based work by nominated groups based on thematic areas with Consultant's assistance)
- Presentation of draft plan of thematic areas to plenary at strategic planning retreat for stakeholders inclusion and critique
- Consultant tidying up of output of strategic planning retreat
- Presentation of final draft plan to Enugu State (yet to be done)
- Final write up and submission to FMOH

State Ministry of Health Management Retreat
The SHDP planning process was kick started with the SMOH Management Retreat in Abakaliki, Ebonyi State, which held between 3rd-5th September 2009. This followed preliminary consultations with the State Reference group, the Commissioners of Health and Local Government and Chieftaincy Affairs. The meeting had in attendance all the Directors of the SMOH, their deputies as well as Chairmen of all the 7 District Health Boards. It was chaired by the Permanent Secretary and addressed by the National

Programme Manager, PATHS2. The score cards of the SMOH departments and the boards were presented. Key issues to take forward to the plan development process were identified.

Inauguration of State Steering and Planning Committees

The State Steering and State Planning Committees were inaugurated by the Honourable Commissioner for Health on 8th September 2009. The meeting also finalized the details of the planned capacity building workshop. The inauguration ceremony was well attended with the Commissioner of Special Duties and a former Commissioner of Health as well as the Permanent Secretaries of the Ministries of Finance, Works, Education, Local Government and Chieftaincy Affairs supporting the Permanent Secretary of Health. Also in attendance was the Chairman of Udi LGA, representing LGA Chairmen. PATHS2 was represented by the State Team Leader. The Directors of the SMOH, State Health Board and heads of the Health Districts also attended. These were complemented by representatives of the private sector and the FMOH. A short presentation of overview and process of the Enugu State Strategic Health Development Plan was made by Consultant to enable members of the two committees have a deeper understanding of the tasks ahead. The meeting also discussed, debated and agreed on participants, dates, modalities and financing for delivering the first phase of the strategic plan.

Capacity Building Workshop

A capacity building workshop for 30 participants was held at Nondon hotel, Enugu between 15th and 16th September, 2009, with the support of PATHS2. Participants were drawn from the SMOH, SHB and District Health Board with officers responsible for healthcare delivery at the Local Government Area (LGA) level. These included Directors, planning and service delivery managers at State and LGA level. PATHS2 and the World Bank supported HSDP II participated fully in the workshop. The Permanent Secretary chaired the sessions.

The FMOH developed training tools; the strategic plan framework and its MS Excel templates were the main instruction tools. These were complemented by the ‘Enugu Strategy for Health (2008-2013)’ previously developed by the SMOH with PATHS1 support, management retreat documents (supported recently by PATHS2) and other key planning documents. These were flavoured with presentations made by SMOH Directors detailing key health challenges of Enugu State from the perspectives of their offices. Technical sessions were held on building the capacity of participants on basic MS Excel skills as a prelude to group work on the thematic priority areas of the strategic plan. An attempt was made at costing the developed interventions. Eight groups were constituted to develop the plan in accordance with the thematic areas at both State and LGA levels. Arrangements were made for meeting places, times and logistics.

Strategic Planning Retreat

The purpose of the planning retreat was to give every participant the opportunity to contribute to and criticize thematic group presentation in order to get a robust output. The Enugu State strategic planning retreat finally held at Abakaliki over a 3-day period between the 22nd and 24th October 2009. In attendance were the Honourable Commissioner for Health, Permanent Secretary and the Chairmen of both the House Committees on Appropriation and Health. Four PATHS2 officials and HSDP II officials were in attendance. It is noteworthy that though the health districts were adequately represented, the LGAs were not. The Chairmen of the Enugu State House of Assembly Committees on Health and Appropriation respectively participated actively at the retreat giving useful insights on how the system can improve through health legislation and resource mobilization. The workshop was supported by the HSDP II.

The teams previously constituted at the capacity building workshop presented their findings to plenary for contributions and critique. Participation of role players was very high. Strategic interventions were populated with activities, their indicators, responsibilities and timelines. However, costing of activities

received scant attention. Inputs from federal policy and strategy documents, HSDP II work plans and certain presentations by PATHS2 were mainstreamed into the draft plan.

1.3 Achievements

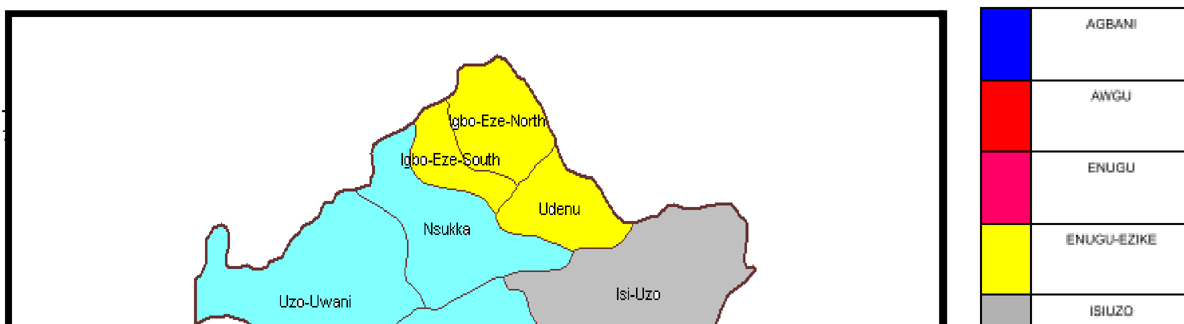
The main achievement of the Enugu State health system today is the restructuring to the District health System and its subsequent enactment into law. The District Health System approach to health care provides for a functional integration of the Local Government and State Government health services through a structured co–operation and collaboration for the purposes of eliminating fragmentation and duplicity and raising the efficiency and quality of health care delivery (see Map 1).

The minimum standard was that each district hospital shall contain six units namely: Medicine, Surgery, Obstetrics and Gynaecology, Paediatrics, Diagnostic Laboratory and Pharmacy; The district hospital is linked to all the PHC centres and cottage hospitals in the district to ensure that each facility provides health services appropriate to their resources, capacity and role, and to facilitate effective patient referral.[7]

The other features of this health system are:

- Integrates both the primary and secondary health care service and delivers it in a comprehensive and continuous manner under a single management;
- The service is delivery to a defined population within a geographical area to which the management is accountable; The population sizes of the health district in Enugu State vary from 160-600,000 which correspond to the World Health Organization guidelines.
- Enables the community members to participate in decisions concerning their health care thus ensuring a community driven and responsive health service.
- Allows the Local Governments to collaborate in planning and management of Health Service;
- Has a district hospital as the focus of its secondary care as a referral centre;
- The district hospital shall contain as a minimum standard , six department including : Medicine , Surgery, Obstetrics and Gynecology , Pediatrics , Diagnostics Services (X – ray and laboratory) and Pharmacy;
- The District Hospital shall be linked to all the primary health care centres and cottage hospitals to ensure that each health facility focused on health service appropriate to their resources, capacity and role;
- Ensures a functional two –way referral system between the primary, secondary and tertiary level of health care.
- Has public and private partnership and collaboration in health service delivery.

Map 1: Administrative Map of Enugu State showing the Health Districts and LGAs



Chapter 2. Situation Analysis

2.1 Socio-economic context

Enugu state has a 2009 projected population of **3,541,743** at an annual growth rate of 2.8% based on the 2006 population census figures, and 1,775,707 (50.1%) of the population are females while 1,7366,036 (49.9%) are males. The population density is about 360 persons per square kilometer and is more than three times the mean national population density of 96 persons per square kilometer. About 59% of the population in Enugu state lives in the rural areas. The 3 LGAs of Enugu municipality together account for 22% of the population and Nsukka, a rapidly growing university town in the State a further 10% of the population. The other 13 LGAs are mainly rural, with widely varying population densities between 60 persons per square kilometer in the West and more than 500 persons per square kilometer in the north of the state.

Majority of Enugu state indigenes are farmers who produce a wide variety of staple crops, the major one being cassava, which is cultivated by 87% of rural households, mostly women; other crops include yam, maize, vegetables and fruits. Rice, the specialty crop of some of the zones is mainly cultivated in Adani in Uzo Uwani, Ugbawka in Nkanu West, Oduma in Aninri, while cash crops such as oil palms and cashew can be found across the State in general. Approximately 48% of the State's land area is under cultivation with 5.4% devoted for forest reserves. The bulk of small-scale farmers are women, who do not typically own land, but have access to it only through their husbands or adult sons. Cassava processing into *gari*, foofoo and tapioca is the most common of all food processing activities by women in the rural areas. In the northern part of the State, the processing of palm oil and palm kernel nuts is also widely undertaken by women (ENSEEDS 2004-2009)

2.2 Health status of the population

Maternal and Newborn Health

Sixty eight percent (68%) of pregnant Enugu women received anti-natal care from a health professional. Slightly less than this number (65%) had delivery assisted by a health professional. Another 54% delivered their babies in a health facility[8]. The modern contraceptive prevalence rate defined by the use of male and female condoms, pills and IUD was 11.3% in Enugu State.

Child Health

While figures were not readily available for Enugu State specific health status indices; it is believed that the infant mortality rate is below the national indices of 97 infant per 1,000 live births (2007), neonatal mortality rate of 47/1,000 live births (2004) and Under 5 mortality rate of 189/1,000 live births (2007)[9]. Out of 158 children sampled by NDHS (2008), only 28% had received all vaccines in the national schedule while another 38% had not received any antigen at all. Coverage rates were 66.2% (BCG), 50% (DPT3), 355

[8] NDHS (2008)
[9] UNICEF (2008)

(OPV3) and 53.6% (Measles)[10]. Results which were consistently lower than those for the South East geopolitical Zone (SEZ) but better than national averages indicate that an unacceptable high proportion of Enugu children are susceptible vaccine preventable diseases. Thirteen percent of children with fever sought treatment from health facilities or service providers. Malnutrition indices in Enugu State measured by anthropometric indices of stunting (height for age), wasting (weight for height) and underweight (weight for age) were 11%, 8% and 3% respectively in 2008.

HIV/AIDS, Tuberculosis and Malaria

Below is the HIV Prevalence Trends in Enugu state 1991 to 2008 respectively according to the NHSS 2008

Enugu	1.3	3.7	10.2	4.7	5.2	4.9	6.5	5.8

Total tuberculosis cases in Enugu are 1253 according to the FMoH NTBLCP Annual TB Progamme Report and the percentage of children <5 are 27.0 (NDHS 2008).

2.3 Health Service Provision & Utilization

Enugu State health system is characterized by inequitable distribution of resources, decaying infrastructure, poor management of human resources for health, weak referral systems; poor coverage with high impact cost-effective interventions, lack of effective integration and poor supportive supervision. Health care services in the State are provided by a multiplicity of health care providers - public, private including for profit and not-for-profit, patent medicine vendors and the traditional health care providers. Despite decentralization and integration of the health system and considerable investment in the health sector over the years, available evidence suggests that health services throughout the State are delivered through a weak health care system. Consequently it is unable to provide basic, cost-effective services for the prevention and management of common health problems especially at the LGA and Ward levels. The capacity to provide basic emergency obstetric services is very limited. This limited coverage of basic health services results in under utilization of services. Availability and distribution of functional health facilities and other health infrastructure are variable across the State. The majority of the public health facilities especially PHC centres are in a state of disrepair. Although the State currently has a tertiary institution, it is yet to function at optimal capacities in the provision of quality specialist care. Most public health facilities across the State are poorly equipped. The essential drug list in the country including Enugu State was developed in 1988.

Enugu State has defined Minimum Service Package at both primary and secondary levels. It is a protocol to be observed by all health care providers which includes where health care will be provided, by whom and to what basic and specific standard. The package spells out in detail the services to be provided at this level, the roles of various cadres of health personnel and operational guidelines to implementation. Costing the MSP requires review.

Health services in Enugu State were delivered in both private and public sector facilities. The private sector includes both for-profit and non-profit facilities and also a large number of faith-based health facilities. Public sector services are provided mainly through the DHS, although some services are actually provided outside the DHS, for example tertiary health services.

From official records, there were 366 public primary Healthcare Centers (PHCs) (including comprehensive health centres, health centres, health clinics and health posts), 35 cottage hospitals, 6 district hospitals and one State tertiary health centre[11]. Supporting these were about 700 private health facilities. From this

[10] NDHS (2008)
[11] SMOH: DHS Brochure

data on the number of available health facilities, it is obvious that private sector participation is quite high in the State as private facilities outnumber the public health facilities. The quality of service provided varied from one facility to another based on inherent weaknesses in the system.

SUMMARY OF ENUGU STATE SITUATION ANALYSIS

INDICATORS	ENUGU
Total population	3,267,837(1,671,795 females; 1,596,042 males)
Under 5 years (20% of Total Pop)	384,464
Adolescents (10 – 24 years)	1,124,842
Women of child bearing age (15-49 years)	721,355
Literacy rate	73% female; 95% men
Households with improved source of drinking water	63%
Households with improved sanitary facilities (not shared)	19%
Households with electricity	48%
Employment status (currently)	51.9% female, 77.8% male
TFR	4.4
Use of FP modern method by married women 15-49	11%
ANC	68%
Skilled attendants at birth	66%
Delivery in HF	54%
Full immunization coverage	28%
Children that have not received any immunization (zero dose)	28%
Stunting in Under 5 children	20%
Wasting in Under 5 children	17%
Diarrhea in children	7.4
ITN ownership	6%
ITN utilization	8% children, 2% pregnant women
Malaria treatment (any anti-malarial drug)	2% children, 1% pregnant women
Comprehensive knowledge of HIV	8% female, 45% men
Knowledge of TB	83.8% female, 75.3 % male

2.4 Key Issues and Challenges

The main challenges of the health system may be summarized as

- Lack of overarching strategy to improve, monitor and evaluate service delivery

- Manpower adequacy, distribution, training
- Weak referral mechanisms between the health centres and the hospitals
- Inadequate provision of drugs and hospital equipment
- Dilapidated state of the public health facilities especially at the primary level
- Weak budget performance
- Economic inaccessibility of primary health care
- Inadequate blood transfusion equipment

The Enugu State Economic Empowerment and Development Strategy[12] sets out Enugu State's plans for achieving the MDGs and for promoting broader development in the State. It places poverty reduction at the heart of its development strategy through the enhancement of human capabilities, including improving the effectiveness and efficiency in the delivery of basic social services of which health is one of the priority service areas [13]. The Enugu State Economic Empowerment and Development Strategy (SEEDS) also sets out a number of health objectives whose achievement is expected through the following means:

- Continued implementation of the District Health System
- Improvements in health supervisory and monitoring systems
- Strengthening quality of preventive and curative healthcare at all levels
- Involving civil society and private sector
- Giving attention to priority diseases such as HIV/AIDS, Tuberculosis, Malaria and childhood diseases
- Consolidating health resources from various levels of government and international organizations
- Improving health infrastructure at all levels
- Integrating primary and secondary health care services.

[12] Ministry of Human Development and Poverty Reduction (2004)
[13] SMOH (2008): Strategy for Health 2008-2013

Chapter 3. State's Strategic Health Priorities

3.1 Background

A generic framework was developed by the FMOH to serve as a guide to federal, state and LGAs in the selection of evidenced-based priority interventions that would contribute to achieving the desired health outcomes for Nigerians. The end product being a harmonized National Strategic Health Development Plan with its appropriate costing will thereafter serve as the basis for collective ownership, adequate resource allocation, inter-sectoral collaboration, decentralization, equity, harmonization, alignment, and mutual accountability in Nigeria. It would also stipulate requirements for future health investments towards achieving sustainable universal access and coverage with a defined package of essential services within the planned period of 2009 - 2015.

This framework discusses eight evidenced-based priority areas identified to improve the performance of the health sector, through a holistic approach at Federal, State and LGA levels. They are: leadership and governance, service delivery, human resources for health, health financing, health information system, community participation and ownership, partnerships for health and research for health. For each of these priority areas, the framework provides uniform guidance, specifying a goal with strategic objectives and corresponding recommended interventions. The aforementioned priority areas are presented in sections 3.2 to 3.9 with an introductory context.

3.2 Priority Areas

The strategic priority areas for the State are:

1: Leadership and Governance for Health
2: Health Service Delivery
3: Human Resources for Health
4: Health Financing
5: Health Management Information System
6: Community participation and ownership
7: Partnerships for Health
8: Research for Health

Detailed interventions are available as an Annex.

The Essential Package of Health Services for Enugu State by service delivery mode listed reflects the priority high impact interventions to be delivered in the state.

HIGH IMPACT SERVICES
FAMILY/COMMUNITY ORIENTED SERVICES
Insecticide Treated Mosquito Nets for children under 5
Insecticide Treated Mosquito Nets for pregnant women
Household water treatment
Access to improved water source
Use of sanitary latrines
Hand washing with soap
Clean delivery and cord care

Initiation of breastfeeding within 1st hr. and temperature management
Condoms for HIV prevention
Universal extra community-based care of LBW infants
Exclusive Breastfeeding for children 0-5 mo.
Continued Breastfeeding for children 6-11 months
Adequate and safe complementary feeding
Supplementary feeding for malnourished children
Oral Rehydration Therapy
Zinc for diarrhea management
Vitamin A - Treatment for measles
Artemisinin-based Combination Therapy for children
Artemisinin-based Combination Therapy for pregnant women
Artemisinin-based Combination Therapy for adults
Antibiotics for U5 pneumonia
Community based management of neonatal sepsis
Follow up Management of Severe Acute Malnutrition
Routine postnatal care (healthy practices and illness detection)

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

C. INDIVIDUAL/CLINICAL ORIENTED SERVICES
Family Planning
Normal delivery by skilled attendant
Basic emergency obstetric care (B-EOC)
Resuscitation of asphyctic newborns at birth
Antenatal steroids for preterm labor

Antibiotics for Preterm/Prelabour Rupture of Membrane (P/PROM)
Detection and management of (pre)ecclampsia (Mg Sulphate)
Management of neonatal infections
Antibiotics for U5 pneumonia
Antibiotics for dysentery and enteric fevers
Vitamin A - Treatment for measles
Zinc for diarrhea management
ORT for diarrhea management
Artemisinin-based Combination Therapy for children
Artemisinin-based Combination Therapy for pregnant women
Artemisinin-based Combination Therapy for adults
Management of complicated malaria (2nd line drug)
Detection and management of STI
Management of opportunistic infections in AIDS
Male circumcision
First line ART for children with HIV/AIDS
First-line ART for pregnant women with HIV/AIDS
First-line ART for adults with AIDS
Second line ART for children with HIV/AIDS
Second-line ART for pregnant women with HIV/AIDS
Second-line ART for adults with AIDS
TB case detection and treatment with DOTS
Re-treatment of TB patients
Management of multidrug resistant TB (MDR)
Management of Severe Acute Malnutrition
Comprehensive emergency obstetric care (C-EOC)
Management of severely sick children (Clinical IMCI)
Management of neonatal infections
Clinical management of neonatal jaundice
Universal emergency neonatal care (asphyxia aftercare, management of serious infections, management of the VLBW infant)
Other emergency acute care
Management of complicated AIDS

Chapter 4. Resource Requirements

4.1 Human Resources

A Human Resource audit and training needs assessment in the Enugu State to reveal the types and numbers of health personnel at all levels is a preliminary activity though the NDHS suggests that more technical and managerial manpower exist to strengthen the weak health system. Continuous professional training is advocated in the SHDP.

4.2 Physical/Material Resources

The Plan envisages serious investments in physical structures and infrastructure through new civil works and renovations of existing health facilities. New hospitals and PHCs in under-served areas based on scientific evidence are planned. Well constructed and decorated physical structures would at once provide a conducive working atmosphere for health workers as well as restore public confidence in their patronage. These rehabilitated health facilities would have to be provided with modern equipment, devices and supplied with safe and efficacious drugs. The resource centre planned for the HMIS Unit which would serve as a repository would be equipped with Information Communication Technology (ICT) and electronic library equipment and software to support the maintenance of a website. Finally, transportation equipment including 4-wheel drive utility vehicles, ambulances and motorcycles shall be supplied.

4.3 Financial Resources

State level
Enugu State receives budgetary allocation and release from the federation account like other States. The State also enjoys allocation of Value Added Tax (VAT), proceeds from excess crude oil sales (if available) and MDG funds. Enugu State's allocation to health over the 5 year period between 2003 and 2008 averaged 4% of the total State's aggregate budget. Using budgetary allocation as evidence of political commitment of the State leadership over the 5 years, health has been accorded medium priority status as budgeted amounts are far below the 15% recommended by World Health Organization (WHO) for developing countries.

Appropriation for health in 2008 totalled over N4billion. The actual amount released could not be verified. It was generally believed to be significantly below the 50% marked. This poor budget performance has been characteristic over the last 5 years but has been accentuated in the last 2 years owing to dwindling oil revenue a consequent of the global economic meltdown. Taken together, Enugu State has the potential to adequately fund its health service delivery. The challenge is to use these resources judiciously.

Local Government Areas
Appropriation and release Figures were not readily available from any of the 17 LGAs. Apart from inadequate record keeping, lack of independent audit of accounts, officials were highly 'secretive' when it came to requests regarding their budget and its performance. Also worthy of note is that there were no holistic plans for the health departments though certain programme plans such as immunization were developed with support from development agencies. What was clear is that LGA health plans and budget were not linked. Often request for funding of specific interventions such as polio eradication

Immunization Plus Days (IPDs) were approved on the whims of the political leaders. Nonetheless, considerable financial resources exist at the LGA level. The challenge is getting political commitment and strategic planning.

Other public funding sources
Other sources of funds from the public sector include VAT which is shared and disbursed quarterly. The proceeds go into the Enugu State budget from where health is expected to receive a share. In this category also are MDG funds. Goals 3, 4 and 5 address child health, maternal health and HIV&AIDS, Malaria and Tuberculosis respectively. The budget lies with the office of the special adviser to the President of Nigeria. Releases to Enugu was through requests from the MDGs desk in Governor's office consistent with the State MDGs plan e.g. funds were allocated for the development of strategic plans of action. The last potential source of public funding is the National Health Insurance Scheme (NHIS). Though the structure exists in the State, actual operations are yet to begin.

Private sector resources
The private sector plays a considerable role in the provision of health services in Enugu State. Private health facilities actually outnumber public health facilities. Nevertheless, figures were not available to determine the financial resources expended in this sector. It is plausible that even more resources are provided by this sector than the public sector.

Chapter 5. Financing Plan

5.1 Estimated cost of the strategic orientations

An activities-based costing approach was employed for the SHDP. The Enugu State strategic plan has been costed at a total of N74,908,161,737 over the six year plan period. The total cost works out nicely at about N12 billion per annum.

Total personnel and recurrent costs amount to about 68% of the Plan. These represent the statutory contribution of government to keep the health system operational. Capital costs, the release of which would make the difference in the Enugu health system account for the balance of 32%. Responsibility for this financial envelope is shared by government (Federal, Enugu State and the LGAs) and other role players. Expectedly, about 50% of Plan costs shall finance the delivery of health services (Priority Area 2) followed by Human Resources for Health (Priority Area 3). The long neglected Health research component would gulp almost 6% of cost estimates while HMIS accounts for about 3% of total costs. (Table 1).

Table 1: Cost estimates of Enugu SHDP (2010-2015)

ENUGU STATE STRATEGIC HEALTH DEVELOPMENT PLAN		TOTAL BUDGET (N)
DOMAIN	GOAL	
LEADERSHIP AND GOVERNANCE FOR HEALTH		
1. To create and sustain an enabling environment for the delivery of quality health care and development in Nigeria		641,701,471
HEALTH SERVICE DELIVERY		
2. To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare		35,114,989,579
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		26,383,281,356
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		9,709,881,240
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		906,989,671
COMMUNITY PARTICIPATION AND OWNERSHIP		
6. To attain effective community participation in health development and management, as well as community ownership of sustainable health outcomes		502,619,167
PARTNERSHIPS FOR HEALTH		
7. To enhance harmonized implementation of essential health services in line with national health policy goals		578,334,352
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		1,079,364,901
Total		**74,908,161,737**

A further breakdown of costs to the strategic component level has been documented for each priority area[14]**.** The detailed Enugu SHDP (2010-2015) is presented in a separate MS Excel document[15].

5.2 Assessment of available and projected funds

Total cost estimates for Enugu State strategic plan for the period between 2010 and 2015 is approximately N30b. Enugu State health budget has consistently exceeded the N4b mark since 2007. This translates to about N24b over the 6-year Plan period. Though figures were not readily available, the contributions of the 17 LGAs, federal funds (FMOH & MDGs) as well as the financial support of the development partners would easily bridge the gap ordinarily. It must be noted however that Enugu State budget performance has been erratic and characterized by sometimes poor implementation. This has lately been attributed to the downturn in oil prices (Nigeria’s major foreign exchange earner) in the international market and the global meltdown in economic performance. A reversal of both trends point the way forward to a better budget performance.

5.3 Determination of the financing gap

Assuming a case scenario of 50% of Enugu State budget implementation, N12b would be available from that source to implement the Plan. Financing gap then is roughly N18b.

5.4 Descriptions of ways of closing the financing gap

A number of possibilities exist for closing this gap:

Government

- Enugu State commitment (budget) at current level with improved budget performance
- More government commitment (Enugu State and LGAs through increased health budget) at both levels with improved budget performance
- The Primary Healthcare Fund (PHF) anticipated with the imminent passage of the Health Bill into law
- Health insurance

A robust engagement with the relevant committees of the State House of Assembly which passes law and conduct oversight functions for Enugu State shall be invaluable.

Development agencies

There is a plethora of development agencies active in the health sector in Nigeria. Only a few notably the UN organizations have been consistently supporting Enugu State health system (WHO, UNICEF, UNDP, and UNFPA). Though figures were not available, it is believed by Enugu State health leadership that development partners’ contributions were substantial. Opportunities lie with greater engagement of current and potential donors such as bilateral developmental partners such as USAID, JICA, CIDA, Netherlands Foundation, etc. The Bill Gates and McArthur Foundations are renown private international organizations that may wish to support the health system. The development and marketing of this plan document should be a first step in that direction.

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[14] Annex 1: Table 2 showing estimated costs to strategic objectives level

[15] **Attachment 1: Costed Enugu strategic plan (2010-2015) in MS Excel template**

Chapter 6. Implementation Framework

The key role players in the implementation of the strategic plan are government at the three levels and strategic partners such as development agencies, civil society organizations, professional associations, regulatory bodies and the various communities. Government has responsibility for governance and stewardship and as such takes the lead in the process. However, every stakeholder's plan has been incorporated or nested into the SHDP. This has curtailed vertical programmes and ensured integration of service delivery. The Plan represents the totality of health activities in Enugu State over the plan period. However, since it is a living document, the Plan may be reviewed periodically say every two years or so.

Government leadership and stewardship role
Enugu State is the principal driver of this strategic plan. The SMOH provides governance and oversight while the HMB and DHBs deliver services. At the LGA level, the Local Health Authourities (LHAs) carry out the oversight functions and coordinate the delivery of services. Overall responsibility for the SHDP implementation and performance monitoring lies with the DPRS, and DPHS, SMOH and the Health Administrator (SHB) at the State level.

As a first step, a number of sub-plans are immediately derivable from the strategic plan on a short term basis (usually 1 year). These include:

- Operational/business plan
- Human resources development plan
- Procurement plan
- M&E plan
- Financial management plan, etc.

For example, the framework for the M&E plan for the ENUGU STATE is defined by the plan summary showing the various Interventions and their indicators (see relevant sheet in the MS Excel template). The indicators selected shall be used to measure progress towards the strategic objective targets. Precisely how this is to be done shall be described by the yearly operational plan.

Partners with government
The second immediate prerogative of the SMOH is linkages with other role players especially federal and development partners. From the Plan is isolated all activities that reflect non-government stakeholder participation. These are then agglomerated as the 'shopping list' of a particular partner for its engagement.

Implementation arrangements
One of the objectives of the ONE plan for the Enugu health sector is to foster joint planning, implementation, monitoring and evaluation of activities. It is expected that this will be carried out by all the stakeholders and institutionalized. In this way, resources shall be judiciously utilized as wastages shall be reduced to a number and service delivery shall be truly integrated. Furthermore, implementation of activities shall be cost-effective and 'allocative efficiency' enhanced.

The major stakeholders apart from government and development partners include: regulatory bodies such as NAFDAC, MDCN, PCN, etc., professional associations such as NMA, PSN, etc., Ward Development Committees, Village Health Committees, the media, servicom, etc. (Please see Attachment 1 for their individual responsibilities).

Chapter 7. Monitoring and Evaluation

7.1 Monitoring framework

From the point of view of the Enugu State strategic plan, a coherent M&E system helps ensure that all M&E efforts best contribute to health system and reporting needs. Shared planning, execution, analysis or dissemination of data collection can reduce overlap in programming and increase co-operation between government and partners.

Features of a monitoring and evaluation system
The five major components of an effective M&E system are presented in Table below:

Table 2: Features of an M&E system

S/NO	COMPONENTS	SUB-COMPONENTS
1	M&E Unit	M&E Unit Adequate budget (5%) Link with research institutions Indigenous expertise in epidemiology, data processing and data dissemination
2	Clear Goals	Policy, guidelines and strategies of implementation Clear objectives, interventions, targets and indicators Regular reviews Coordination with other role players
3	Indicators	SMART Minimum numbers Comparable over time 'Priority' or 'key' indicators exist
4	Data collection & analyses	Overall plan for data collection Standardized monitoring tools that have been agreed by stakeholders Close link with Integrated Supportive Supervision Surveillance system
5	Data dissemination	Annual reports/Bulletins Academic journals M&E Unit as clearing house for information dissemination Database (Repository or 'Archives')

Enugu State strategic plan's response
The draft Enugu State strategic health plan has responded positively taking the features described above into cognizance (details in Activities sheet of MS Excel template).

7.2 Costing the monitoring and evaluation component and plan

The M&E component has not been sufficiently addressed to be realistically costed. However, according to WHO[16], 5% of programme or project costs should be earmarked for M&E activities in order to effectively measure its performance. In this case, that sum would be about N1.5b over the plan period or N250m per annum.

[16] WHO (2000): World Health Report – Assessing the performance of world health systems

Chapter 8: Conclusion

The Enugu SHDP (2010-2015) is a reflection of the priority concerns and peculiarity of the Enugu health system. The ownership of the plan therefore resides with all stakeholders in the health sector albeit under the leadership of the State SMOH. The plan shares the vision and mission of the FMOH in the spirit of ONE plan, ONE budget and ONE monitoring purpose. It has therefore imbibed the eight priority areas and their strategic objectives as its fulcrum. The challenge is to pursue its implementation with which it was developed by Enugu State stakeholders. If this is achieved, there is no doubt that it will go a long way in improving the management and delivery of health care services in the State nay Nigeria.

Annex 1: Conceptual Definitions of Leadership and Governance

Stewardship: The WHO Health Report 2000 refers to stewardship as "function of a government responsible for the welfare of the population, and concerned about the trust and legitimacy with which its activities are viewed by the citizenry"[17] The concept of the stewardship role of government in health as stated above means: the way in which governments mobilize and spend revenues and make regulations and policies that deal with the issue of accountability and transparency in the health system, with specific regard to: (i) Oversight (ii) Financing (iii) Human and Physical Resources (Development and Utilization) (iv) Improvement of Performance (v) Promotion of the Health of the People (vi) Leverage of Health Program Implementation and Outcomes.

Governance: Governance for health is the exercise of economic, political and administrative authority to manage the country's health affairs at all levels – States and LGAs; as well as mechanisms, processes and institutions, through which citizens and groups articulate their interests, exercise their legal rights, meet their obligations and mediate their differences[18]. It includes formulation of Enugu State health policy and health strategic plans (defining the vision and directions), exerting influence through regulations and advocacy, collecting and using information, and accountability[19].

Leadership: Leadership in health includes providing direction and the enabling environment for the various stakeholders to articulate the complex social processes which impact on the healthcare delivery system at their level in a participatory way, allowing people's viewpoints and assumptions about their local health system and economy to be brought to light, challenged and tested and jointly developing a mechanism for achieving positive change. It is imperative for strategic oversight to be provided through collaboration and coordination mechanisms across sectors within and outside government including civil society. Leadership will influence action on key health determinants and access to health services while ensuring accountability. Leadership ensures that policy formulation is deliberately structured and linked to programme planning, project selection and task implementation arising from a common shared vision.

[17] WHO (2000) World Health Report 2000: Health Systems - Improving Performance. Geneva: World Health Organization, Geneva.
[18] Governance For Sustainable Human Development: A UNDP Policy Document 10-12-2008
[19] Frame work for implementation of the Ouagadougou declaration on PHC and health system in Africa; 2008

Annex 2: Details of Enugu Strategic Health Development Plan

ENUGU STATE STRATEGIC HEALTH DEVELOPMENT PLAN					
PRIORITY AREA					
Goals		**BASELINE YEAR 2009**	**Remarks/ Major Assumptions**	**Stakeholder/ Responsibility**	**Total 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					**641,701,471**
1.1	**To provide clear policy directions for health development**	**All stakeholders are informed regarding health development policy directives by 2011**			**72,316,733**
1.1.1	Improved Strategic Planning at Federal and State levels	State strategic health plan reviewed by 2012			**72,316,733**
1.1.1.1	Train State health planning and other managers on strategic plan development and implementation		Train 10 officers bi-annually at Nigeria training institution for 2 weeks	DPRS	48,070,377
1.1.1.2	Review existing State health strategy framework & policies and mainstream national policies and strategies		Coordination function only. Policies to be developed and costed within each Prioirity area (AD Admin + 6 GL 14 officers + 3 Consultants from PATH II / HSDP II to meet 5 days in twice in 6 years)	Consultant, PATHS II, HSDP	2,762,226
1.1.1.3	Develop/review and disseminate State health strategy document		6 member committe to develop, review and print 1000 copies of State health strategy document and disseminated to all role players every 3 years	DPRS	11,333,740
1.1.1.4	Organize review meetings to monitor and evaluate the implementation of the Strategic Health Plan		A meeting of 50 stakeholders	Consultant, PATHS II, HSDP DPRS	10,150,389

						meets once for 5 days every 3 years		
	1.2	**To facilitate legislation and a regulatory framework for health development**			**State Health policies developed by 2012**			**21,317,876**
		1.2.1	Strengthen regulatory functions of government		Health legislation in placeby 2012			**21,317,876**
			1.2.1.1	Review existing and develop new health laws with federal policies		Committee of 10 members for 5 days meets once in a year every 3 years. Work with House Committee on Health	DPRS, FMOH, SMOJ, House of Assembly,PATHS 2, HSDP2 , other development agencies	2,266,860
			1.2.1.2	Develop/review and disseminate guidelines on healthcare practises		5 member committee to develop / review and print 1000 copies of guidelines and disseminate copies every 3 years	DPRS	5,186,960
			1.2.1.3	Organize meetings with professional regulatory bodies		6 member committee meeting with 10 reps once a year	Meeing with 10 reps once a year	6,121,085
			1.2.1.4	Organize meetings with professional associations and groups		6 member committee meeting with 10 reps once a year	Meeing with 10 reps once a year	2,600,660
			1.2.1.5	Organize meetings with healthcare providers and suppliers		6 member committee meeting with 10 reps once a year	Meeing with 10 reps once a year	5,142,312
	1.3	**To strengthen accountability, transparency and responsiveness of the national health system**			**Enugu State has an active health sector 'watch dog' by 2013**			**107,911,446**
		1.3.1	To improve accountability and transparency		Audited accounts published annually			**107,911,446**
			1.3.1.1	Development/review of financial management system: procedures, manuals, etc.		Committee of 10 members for 5 days meets once in a year every 2 years	DFA, DPRS, PATHS2, HSDP 2, other development partners	3,440,547
			1.3.1.2	Development/review of procurement management system: procedures, manuals, etc.		Committee of 10 members for 5 days meets once in	DFA, DPRS, PATHS2, HSDP 2, other development partners	4,569,135

						year every 2 years		
			1.3.1.3	Procurement and installation of financial management software		Selection and contracting of supplier	DFA, consultant, contractor	12,629,327
			1.3.1.4	Training of finance and procurement officers on FM system and software		Consultant to train 10 officers on the job for 5 days a year every year	DFA, consultant	39,622,460
			1.3.1.5	Engagement of external auditors to assess FM practises and publication of accounts		Firm engaged to carry out audit services yearly	DFA, consultant	47,649,977
	1.4	**To enhance the performance of the national health system**			**1. Enugu State (and its LGAs) updating SHDP annually 2. Enugu State (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**	MoH, CSOs and development partners	**440,155,415**
		1.4.1	Improving and maintaining Sectoral Information base to enhance performance		State Data Bank established			**440,155,415**
			1.4.1.1	Construct and furnish Enugu State Health Data Bank		Selection and contracting a builder and supplier	DPRS, DFA, Partners	237,273,488
			1.4.1.2	Procure electronic library and ICT equipment and software for data bank		Selection and contracting a supplier	DPRS, DFA, Partners	157,866,592
			1.4.1.3	Train data management personnel on databank operations		Consultant to train 10 officers on the job for 5 days a year every year	DPRS, DFA, Partners	38,201,661
			1.4.1.4	Collect, collate, analyze and store data on health sector; publish Health bulletin		Printing and dissemination of 1,000 copies of health bulletin yearly	DPRS, HMIS, Health Research	5,544,686
			1.4.1.5	Organize coordination meetings with DPRS, HMIS and Health Research staff		10 people meet for 2 days yearly	DPRS, HMIS, Health Research	1,268,988
HEALTH SERVICE DELIVERY								
2. To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare								**35,114,989,579**
	2.1	**To ensure universal access to an essential package of care**			**50% of Enugu population is aware of minimum packages at primary and**			**2,212,922,234**

					secondary levels by 2012			
		2.1.1	To review, cost, disseminate and implement the minimum package of care in an integrated manner		Revised PoC document distributed to all primary & secondary healthcare facilities by 2011			**77,016,915**
			2.1.1.1	Review the Enugu State Packages of Care (PoC) document, in line with the Standard Treatment Guidelines		10 man committee to meet for 5 days every 3 years	DPRS/HA	6,476,634
			2.1.1.2	Produce and disseminate revised PoC document to all healthcare facilities in the Enugu State		Produce and disseminate 1,000 copies each of the revised PoC document to all healthcare facilities in the Enugu State every 2 years	DPRS/HA	6,299,145
			2.1.1.3	Training of facility based healthcare providers on the revised PoC		Train/retrain 500 facility healthcare providers annually in a phased manner over 5 years (100/year)	DPRS/HA	48,308,460
			2.1.1.4	Carry out media campaign to inform the populace on PoC available to them		Radio communication, interactive sessions twice a year	DPRS/HA	15,932,676
		2.1.2	To strengthen specific communicable and non communicable disease control programmes		Report of Joint SMoH P&DCC activities			**2,124,254,185**
			2.1.2.1	Set up/organize meetings of a Joint SMoH (PDPD/SHB) Programmes & Diseases Control Committee to consider, prioritise, review and update communicable & non-communicable disease burden/profile of Enugu State		12 member JPDC committee meets for 5 days once a year every year	Health Administrator	1,395,675
			2.1.2.2	Advocate for increased funding and specific budget lines for disease control		HCH leads a 5 member delegation to House of Assembly once a year	DPRS/Health Administrator	290,797
			2.1.2.3	Train service providers at all levels on national strategies and operational guidelines for the implementation of disease control programmes		Train/retrain 500 facility healthcare providers annually in a phased	Health Administrator	48,308,460

						manner over 5 years (100/year)		
			2.1.2.4	Recruit, deploy and motivate service providers at peripheral health facilities		Recruit 200 various health workers over a 5 year period	DFA/Health Administrator	2,046,433,139
			2.1.2.5	Conduct quarterly monitoring and supervisory visits to ensure the implementation of disease control guidelines		Link with ISS quarterly visits elsewhere in the plan	DPHC&DC/Health Administrator	27,826,116
		2.1.3	To make Standard Operating procedures (SOPs) and guidelines available for delivery of services at all levels					**11,651,134**
			2.1.3.1	Develop/review with FMOH and disseminate clinical and operational guidelines and standard lists for service delivery		10 man committee to meet for 5 days every 3 years see (2.1.1.1)	DPRS/HA	2,017,877
			2.1.3.2	Print and dosseminate SOPs and guidelines to all health facilities		Produce and disseminate 1,000 copies each of the revised SOP document to all healthcare facilities in the Enugu State every 3 years	HA	9,633,257
	2.2	**To increase access to health care services**			**A service provising health facilities within 5km of any community by 2014**			**14,520,627,766**
		2.2.1	To improve geographical equity and access to health services		25% annual increase in facilities that offer 24/7 service in Enugu State			**11,296,543,740**
			2.2.1.1	Update GPS map of health facilities in Enugu State to identify under-served areas		Select and contract a consultant every 3 years	DPRS	29,264,467
			2.2.1.2	Conduct a needs assessment to evaluate the status of health facilities in the State		Select and contract a consultant every 3 years	DPRS	63,980,584
			2.2.1.3	Develop and implement guidelines for outreach healthcare services		10 man committee to meet for 5 days every 3 years (see 2.1.1.1)	DPHC&DC	6,331,732
			2.2.1.4	Procure and distribute vehicles and equipment to implement aoutreach services		Select and contract a	DPHC&DC/DFA	719,067,682

						vendor every 3 years		
			2.2.1.5	Recruit, deploy, train and motivate service providers at peripheral health facilities		See 2.1.2.4	DPRS/DFA	2,054,583,879
			2.2.1.6	Build, renovate, and equip new and existing health facilities		Refurbish 200 primary health facilities and build/equip 3 new Health Facilities per LGA over a 5 year period; refurbish and equip 10 SHCs	DPRS/HA	8,423,315,395
		2.2.2	To ensure availability of drugs and equipment at all levels		100% of prescribed essential drugs available at 75% of peripheral PHCs by 2012			**2,005,370,630**
			2.2.2.1	Review policy for the establishment of the State Drug Management Agency and develop strategies to coordinate the procurement, distribution and maintenance of drug inventory and equipment		10 man committee to meet for 5 days every 3 years (see 2.1.1.1)	DPRS/HA	1,199,784
			2.2.2.2	Advocate for increased funding for the procurement of drugs and equipment		HCH leads a 5 member delegation to House of Assembly once a year (2.1.2.2)	DPRS/HA	290,797
			2.2.2.3	Review of EDL by State DRF committee to reflect the requirements of the PoC/Standard of care documents		10 man committee to meet for 5 days every 3 years (see 2.1.1.1)	DPRS/HA	1,199,784
			2.2.2.4	Create the CMS at health districts level (stores/offices/furniture)		Select and contract a contractor and/or a vendor	DPRS/HA	105,991,470
			2.2.2.5	Produce and disseminate quarterly drug bulletin on management to all health districts and LHAs		Produce and disseminate 1,000 copies each of the revised SOP document to all healthcare facilities in the Enugu State every 3 years	DPRS/HA	7,204,783
			2.2.2.6	Conduct equipment inventory and needs assessment in all the healthcare facilities		Select and contract a consultant every 3 years	DPRS/HA	70,018,170

		2.2.2.7	Procure requisite drugs and equipment along the determined facilities' needs		Select and contract vendors every 3 years	DPRS/HA	92,779,868
		2.2.2.8	Procure/upgrade and instal a Logistics Management Information System at State and DHB		Select and contract vendors	DPRS/HA	23,226,881
		2.2.2.9	Recruit, orientate and train more pharmacists and biomedical engineers at State and DHB levels		Recruit 50 professionals every 3 years	DPRS/HA	1,019,419,455
		2.2.2.10	Train the managers and service providers at all levels on drug and equipment guidelines and management		Once a year workshop training for 600 personnel phased	DPRS/HA	48,308,460
		2.2.2.11	Construct and equip 7 DHB-based drug/equipment bulk stores to ensure streamlined distribution lines		Phased delivery of 7 bulk stores	DPRS/HA	317,559,181
		2.2.2.12	Procure 7 weather-proof truks for haulage of drug/equipment		Phased delivery of 7 trucks	DPRS/HA	318,171,996
	2.2.3	To establish a system for the maintenance of equipment at all levels		PPM workshops operational at DHB level by 2011			**713,368,181**
		2.2.3.1	Develop & implement a State Health Equipment policy/operational guidelines/procurement/mamagement system in line with the national document		Engage Consultants to work with SMOH	DPRS/HA	1,199,784
		2.2.3.2	Consolidate the scheme of service of the Planned Preventive Maintenance staff and recruit biomedical engineers		Formally engage and motivate personnel	DPRS/HA	103,028,215
		2.2.3.3	Conduct annual DHB-based inventory and status report of healthcare equipment in all the healthcare facilities		Develop, complete and analyze checklists	DPRS/HA	1,730,637
		2.2.3.4	Conduct training of DHB-based biomedical engineers/technicians on PPM personnel to update them on current operations of healthcare equipment		Conduct on-the-job mentoring and training	DPRS/HA	3,218,323
		2.2.3.5	Establish 8 PPM workshops for the SHB & 7 DHBs in collaboration with identified partner (GE Medical System, USA)		Contract builders and vendors	DPRS/HA	604,191,223
	2.2.4	To strengthen referral system		Proportional increase in referrals from PHC to SHC level per annum			**491,883,963**
		2.2.4.1	Develop/review State policy/guidelines for two-way referral system in line with national standards		Committee	DPRS/HA	1,199,784
		2.2.4.2	Training/retraining all facility officers-in-chargeand key service providers on the referral policy/guidelines and feedback			DPRS/HA	48,308,460
		2.2.4.3	Develop and operationalise the State Ambulance/Emergency Scheme			DPRS/HA	1,199,784

			2.2.4.4	Procure ambulances, specialized motorcycles and communication equipment for referral services		Contract vendors	DPRS/HA	423,829,745
			2.2.4.5	Develop and implement clients referrals' initiative with transport unions and communities to ensure effective referral.		Committee	DPRS/HA	1,199,784
			2.2.4.6	Conduct advocacy to transport & town unions, community leaders etc on clients' referral initiative		Committee	DPRS/HA	16,146,406
		2.2.5	To foster collaboration with the private sector		Enugu State PPP policy operational by 2011			**13,461,252**
			2.2.5.1	Review/update the GPS map and directory of all categories of private sector healthcare providers in Enugu State.		Engage consultants	DPRS/HA	1,171,871
			2.2.5.2	Finalise the State PPP policy/guidelines and organize Committee meetings for their operations		Committee	DPRS/HA	1,491,863
			2.2.5.3	Engage private sector providers, professional associations and corporate organizations on the implementation PPP policy/guidelines		Committee	DPRS/HA	2,699,380
			2.2.5.4	Conduct annual stakeholders' summit with private sector providers on level of co-operation between government and private institutions		Committee	DPRS/HA	8,098,139
								-
	2.3	**To improve the quality of health care services**			**1.) Reduce maternal mortality rate by 60% from current level by 2012 2.) Reduce Peri-natal Mortality Rate by 60% from current level by 2012 3.) Reduce infant mortality rate from current level by 60% by by 2012**			**18,238,898,572**
		2.3.1	To strengthen professional regulatory bodies and institutions		Report of Joint Inspecorate meetings			**15,275,712**
			2.3.1.1	Review and update guidelines and regulatory functions of the Joint Inspectorate		Committee	DPRS/HA	3,512,179
			2.3.1.2	Conduct meetings of the Joint Inspectorate		Committee	DPRS/HA	3,665,393
			2.3.1.3	Conduct State-level annual meetings with regulatory agencies for assessment and feedback on service delivery regulation		Committee	DPRS/HA	8,098,139
			2.3.1.4					-
		2.3.2	To develop and institutionalise quality assurance models		PPRHAA reports disseminated			**173,851,720**
			2.3.2.1	Establish State Servicom: develop/review guidelines and set up desks at DHB level		Committee	DPRS/HA	1,199,784

			2.3.2.2	Review and adopt PPRHAA operational guidelines as QA model in Enugu State		Committee	DPRS/HA	1,199,784
			2.3.2.3	Recruit, orientate and train 7 Servicom officers at DHB level		Recruitment of personnel	DPRS/HA	164,064,877
			2.3.2.4	Procure and distribute opinion/complaints boxes at all health facilities		Contract vendors	DPRS/HA	7,387,276
		2.3.3	To institutionalize Health Management and Integrated Supportive Supervision (ISS) mechanisms		ISS reports disseminated			**730,713,912**
			2.3.3.1	Print and disseminate the State ISS guidelines and tools		Committee	DPRS/HA	9,921,697
			2.3.3.2	Train:Conduct TOT on ISS processes to PDPD, SHB and cascade to DHB and LHA ISS team levels		Engage consultants	DPRS/HA	13,042,922
			2.3.3.3	Conduct regular quarterly ISS visits by the various service delivery arms of Enugu State public sector healthcare system (SHB, 7 DHBs and 56 LHAs)		ISS teams conduct quarterly visits to cover all health facilities in a year	DPRS/HA	156,149,308
			2.3.3.4	Conduct quarterly reviews by the SHB (for 7 DHBs) and DHBs (for the 56 LHAs)		Review meetings	DPRS/HA	84,480,752
			2.3.3.5	Procure 13 4-WD project vehicles, ICT and office equipment for the SHB & LHA monitoring and supervision teams		Contract vendors	DPRS/HA	467,119,234
		2.3.4	To strengthen the capacity to improve Malaria Control Programme		Increase the ownership of ITN to at least 80% for Under-5yrs and pregnant women by end 2012			**3,459,380,751**
			2.3.4.1	Procurement and distribution of ITNs to pregnant women and children U5		Contract vendors		1,811,991,435
			2.3.4.2	Procurement and distribution of Artemisin-based combination therapy for chidlren, pregnant women and adults		Contract vendors		755,413,948
			2.3.4.3	Provision of intermittent preventive treatment for malaria in pregnancy		Contract vendors		529,004,487
			2.3.4.4	Procurement and distribution of second line drugs for the management of complicated malaria		Contract vendors		362,970,882
			2.3.4.5					-
		2.3.5	To strengthen the capacity to improve Maternal and Newborn Care		At least two trained midwives in Ward BEOC Centre by end of 2012			**3,357,198,604**
			2.3.5.1	Construct and equip and provide BEOC packages in 170 wards		Select contractors and vendors	HA	2,566,689,639
			2.3.5.3	Provision of ANC packages (folic acid, lab testing, SP, TT) to pregnant women at health facilities		Select contractors and vendors	HA	453,534,666
			2.3.5.4	Training of birth attendants in obstetric care, resuscitation of asphytic newborns and community		Workshop and facility based	HA	154,554,108

				based management of neonatal sepsis and other infections		practical training		
			2.3.5.5	Procurement and distribution of midwifery kits neonatal		Select contractors and vendors	HA	182,420,191
			2.3.5.6	Support supervisory visits to health facilities using ISS tools		Link with ISS plan	HA	-
		2.3.6	To strengthen the capacity to improve Child Health		DPT3 coverage increased from 50% to 80% by 2015			**9,675,776,186**
			2.3.6.1	Develop, disseminate and implement guidelines for outreach healthcare services		Production and dissemination of 2000 copies of guidelines for outreach healthcare services & year-round outreach services		8,577,714
			2.3.6.2	Develop, disseminate and implement strategic plan (involving but not limited to IEC materials and media programmes on clean cord delivery, cord care, etc. in English & local language) for managing childhood illnesses		Production and dissemination of 2000 copies each of posters, flyers and radio programmes		12,049,325
			2.3.6.3	Strengthen breastfeeding, infant & young child feeding practices		Nourished and healthy children		38,104,940
			2.3.6.4	Increase the up-take of routine and supplementary immunization, Vit A Supplementation & zinc prevention		Avalability of BCG, OPV, DPT, Hep b, Yellow fever, Meningitis, Pneumococal, & Rotavirus vaccines , Vit A supplement, & anti-malarials for children		9,273,316,682
			2.3.6.5	Promote and strengthen detection & management of childhood illnesses		Continual health education through various media		343,727,525
		2.3.7	To strengthen the capacity to improve HIV/AIDS Control		HIV prevalence rate			**719,651,302**
			2.3.7.1	Training of 35 health care workers from 7 district Hospitals and Parklane on risk reduction, universal precaution and medical waste management.		Engage training consultants	DPH/SASCP	43,472,353
			2.3.7.2	Strenthening the capacity of 35 doctors, nurses and lab scientist from		Engage training consultants	DPH/SASCP	43,472,353

				the 7 district hospital on the syndromic management of STI				
			2.3.7.3	Strengthening of the capacity of 68 doctors and nurses on circumcision		Engage training consultants	DPH/SASCP	79,335,612
			2.3.7.4	To establish 3 counselling and testing sites per LGA in the state and build the capacity of 24 Health care workers on the PMTCT of HIV		Contract vendors	DPH/SASCP	493,393,235
			2.3.7.5	To establish 3 counselling and testing sites per LGA in the state			DPH/SASCP	162,332
			2.3.7.6	To build the capacity of 2 persons per LGA in M & E .		Engage training consultants	DPH/SASCP	44,559,119
			2.3.7.7	To establish 2 DOTs centre per LGA		Contract vendors	DPH/SASCP	15,256,297
		2.3.8	To strengthen the capacity to improve Tuberculosis Control		TB prevalence rate			**107,050,384**
			2.3.8.1	To equip 3 DOT Centres in each of all the 17 Local Government in Enugu State		Contract vendors	DPH/STBLCP	15,558,176
			2.3.8.2	Procurement and Distribution of First Line Anti-Tuberculusis Drugs & reagents		Contract vendors	DPH/STBLCP	30,954,019
			2.3.8.3	To equip the MDR Laboratory fro Diagnosis		Contract builder and vendors	DPH/STBLCP	60,538,189
			2.3.8.4					-
	2.4	**To increase demand for health care services**			**Average demand rises to 2 visits per person per annum by end 2011**			**131,140,103**
		2.4.1	To create effective demand for services		25% annual increase in patient attendance at health facilities			**131,140,103**
			2.4.1.1	Develop and implement a State health promotion communication strategy based on the national health promotion policy		Committee	HA	3,747,645
			2.4.1.2	Conduct studies on demand creation & barriers to access and also media pooling to determine health demand - clients perception on quality of services, stewardship and governance role of government.		Engage a Consultant	HA	31,936,678
			2.4.1.3	Hold regular health education/promotion programmes on radio		Health education committee	HA	10,724,489
			2.4.1.4	Conduct interactive sessions between service providers and beneficiary communities (Town Hall meetings)		Health teams visits communities	HA	72,642,204
			2.4.1.5	Conduct quarterly advocacy visits to community leaders, market women groups and town unions on the benefits of good healthcare services.		costed in 2.4.1.4	HA	-
			2.4.1.6	Adapt Behavioural Change Communication & Knowledge Management processes for application at the district and facility level		Constitute expert team and organize meetings	HA	1,935,915

			2.4.1.7	Establsh BCC & KM committees at the DHB level for implementation of the adapted processes.		Committee	HA	10,153,172
	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**			**11,400,905**
		2.5.1	To improve financial access especially for the vulnerable groups		Social health insurance implemented in 50% of communities by 2012			**11,400,905**
			2.5.1.1	Review the operational modalities of the Free MCH Programme to include vulnerable groups		Committee	HA	1,199,784
			2.5.1.2	Conduct semi-annual advocacy visits to Enugu State House of Assembly Committee on Health & the State Exco for increase in budgetary allocation and release for the FMCH programme		Committee	HA	290,797
			2.5.1.3	Develop a Ccommunity Health Insurance policy and strategy for Enugu State and implement in 3 pilot health districts.		Committee	HA	6,162,679
			2.5.1.4	Review the DRF guidelines with reference to the Deferral & Exemption process to favour the vulnerable		Committee	HA	3,747,645
			2.5.1.5					
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								**26,383,281,356**
	3.1	**To formulate comprehensive policies and plans for HRH for health development**			**Enugu State and LGAs are actively using adaptations of the National HRH policy and Plan by end of 2015**			**9,891,507**
		3.1.1	To develop and institutionalize the Human Resources Policy framework		State HRH policy developed by 2011			**9,891,507**
			3.1.1.1	Develop/review the State HRH policy, strategies and guidelines in line with national policy		10-man Committee (DFA, DPRS, GM HMB/Director Estb. & Training along with 6 Heads of Professions) meeting 5 times in the first year of the Plan to develop State HRH Policy	SMOH, DPRS, DFA, DPHC, GM HMB, PATHS 2, HSDP2 , other development agencies	9,891,507

						and meet 5 times in the 2nd quarter of the 4th year to review the policy.		
	3.2	**To provide a framework for objective analysis, implementation and monitoring of HRH performance**			**The HR for Health Crisis in the State has stabilised and begun to improve by end of 2012**			**1,912,351,207**
		3.2.1	To reappraise the principles of health workforce requirements and recruitment at all levels		HR Audit and Training Needs Assessment conducted	Low capacity at LGA level to develop staff norms		**39,208,336**
			3.2.1.1	Conduct HR audit and training needs assessment at all health facilities		4 member committee each in the 7 Districts to carry needs assessment within 14days at 1st quarter of each year	DFA DPRS, DHB	36,867,993
			3.2.1.2	Review entry criteria and admission quota of healthcare providers into training institutions to regulate output to existing vacancies.		DPRS, DHB & 5 others not below GL 14 to meet for 5 days 1st quarter of the first and 4th years of the Plan	SMOH, DPRS, DHB	2,340,343
			3.2.1.3					-
		3.2.2	Strengthen the institutional frame works for HR management practices in the health sector.		HRH Units established			**1,319,520,471**
			3.2.2.1	Develop/review the State HRH policy, strategies and guidelines in line with national policy	see 3.1.1.1 above			-
			3.2.2.2	Establish and equip HRH units in the State and DHB to plan and manage HRH functions.		Establish HRH Units in the State and DHB to ensure effective services and engage a contractor to equip the unit	DFA, SMOH, DHB	1,153,619,450
			3.2.2.3	Conduct training programs for health planning and mangement in the State, DHB and LHA levels		Conduct Health Management Training for 10 Management Staff each from the state, DHB	DPRS, DFA, DHB, HA	165,901,021

						and LHA locally		
		3.2.3	Enhance Personnel Production through proper management and motivation		HRH guidelines published			**553,622,400**
			3.2.3.1	Develop and streamline career pathways critically needed to foster demand and supply in HRH.		9-man Committee (DFA and DHB along with 6 Heads of Professions) supported by 1 Middle-Level Officer meeting 3 times in the first year and once a year thereafter to review performance and projections	DPRS, DFA	2,268,591
			3.2.3.2	Review of remuneration of health sector workers/committee through audit of the payroll		Conduct annual review and engage Consultant to develop Payroll Software System for easy report generation	DFA, DPRS, DHB, LHA	308,700,235
			3.2.3.3	Establish coordinating organs for consistency in HRH planning and budgeting		Engage a Consultant to equip the HRH Units in all the facilities with relevant human resources software and use the auto generated report from the software for annual proper Planing and Budgeting	DFA, DPRS,	232,779,363
			3.2.3.4	Assess and implement circulars, guidelines and policies relating to HRH policy		20-man committee (3 from the SMOH and 1 each from LGA to meet 5 times every year		9,874,211
	3.3	**Strengthen the institutional framework for human resources management practices in the health sector**			**1. 50% of DHBs have functional HRH Units by end**			**192,428,617**

					2012 2. 10% of LGAs have functional HRH Units by end 2012			
		3.3.1	To establish and strengthen the HRH Units in SMOH, SHB, DHBs & LGAs		HRH Units established			**192,428,617**
			3.3.1.1	Establish and equip HRH units in the State and DHB to plan and manage HRH functions.	see 3.2.2.2 above	Create room and provide office equipment		182,151,254
			3.3.1.2	Organise training workshops for middle level management HRH staff to understand and internalise the principles and practice of HRH		1 off-site 3-day Seminar per year for 30 staff of HRH unit for 2 years to be co-ordinated by a senior-level officer and conducted by externally-sourced HRH consultants	DFA, HA, DHB	10,277,363
	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**			**State health training institution per Zone producing health workforce graduates with multipurpose skills and mid-level health workers by 2015**			**1,175,399,392**
		3.4.1	To review and adapt relevant training programmes for the production of adequate number of community health oriented professionals based on State priorities		Curricula of State health training institutions reviewed			**3,828,428**
			3.4.1.1	Review curricula of health programmes of health training institutions		DPRS, DHB & 5 others not below GL 14 to meet for 5 days 1st quarter of the first and 4th years of the Plan	SMOH, DPRS, DHB	2,340,343
			3.4.1.2	Review entry criteria and admission quota of healthcare providers into training institutions to regulate output to existing vacancies.	see 3.2.1.2 above	DPRS, DHB & 5 others not below GL 14 to meet for 5 days 1st quarter of the first and 4th years of the Plan		1,488,085
		3.4.2	To strengthen health workforce training capacity and output based on service demand		Training plan for cadres of health professionals developed			**431,018,270**

			3.4.2.1	Assess the capacity and training needs of the workforce		Engage a Consultant to setup IT based Need-Assess ment tools that is simple, tranparent and accessible to senior management (e.g. clicking on a health facility will reveal manning levels and deficiencies). It will be linked to existing personnel database.	DFA, DPRS	22,728,262
			3.4.2.2	Assess the service demand needs		Use the same tools above for this activity	DFA, DPRS	121,935
			3.4.2.3	Conduct special training programs aimed at producing adequate cadres of health professionals in critical areas of need.		Send 5 various health proffessionals for oversea training on special areas of need annualy	DFA, DPRS	408,168,074
		3.4.3	To improve physical structures and infrastructure of Health Training Instituions		New equipment procured for HTIs			**740,552,694**
			3.4.3.1	Rehabilitation and new civil works in Schools of Health Technology, Nursing & Midwifery		Engage a contractor to carry on rehabilitation in the 2nd quarter of the first year and embark on the new civil works at the 3rd quarter of the 2nd year	DFA, DPRS, HSDPII	511,425,569
			3.4.3.2	Procurement and installation of equipment, teaching aids and books in Schools of Health Technology, Nursing & Midwifery		Engage a contractot through Due Process to procure and install modern Teaching Equipment, Books.	DFA, DPRS, HSDPII	13,478,635

			3.4.3.3	Procurement of vehicles for Schools of Health Technology, Nursing & Midwifery		Procure two (3) 30 Seater Bus, 2 Utility Vehicles through a contractor under the Due Process approval.	DFA, DPRS, HSDPII	83,035,671
			3.4.3.4	Procurement and installation of ICT equipment in Schools of Health Technology, Nursing & Midwifery		Engage a contractor to procure and install Servers, Desktop and Laptop Computer Systems, fully Netwok school environment with Internet Connection throughout the Plan Year including 6 years maintenance terms		132,612,818
	3.5	**To improve organizational and performance-based management systems for human resources for health**			**50% of DHBs have implemented performance management systems by end 2012**			**23,071,422,345**
		3.5.1	To achieve equitable distribution, right mix of the right quality and quantity of human resources for health		Proportion of health facilities with appropriate number of workers			**25,770,206**
			3.5.1.1	Equitable deployment processes in terms of mix, needs and geographical spread and Redeploy staff equitably between rural and urban areas at different levels.		Setuup 10 member committee to meet 2 times very 3rd quarter annully to decide on the deployment processes	DPRS, HSDP II	3,302,583
			3.5.1.2	Creation of data base of HRH, develop and provide job descriptions and specifications for health workers in the State and LGAs.		Engage a consultant to extract the necessary information from the HRH Database Server inplace	DPRS	1,803,381
			3.5.1.3	Redeploy staff equitably between rural and urban areas at different levels.	see cost in 3.5.1.1 above			-

			3.5.1.4	Encourage mandatory rotation of health workers to underserved rural areas, eg. Rural Doctor service, etc.		The Committee in 3.5.1.1 above to cordinate and monitor the effective compliance	DPRS	20,664,242
			3.5.1.5	The use of Intra- or Extra-mural private practice services to improve HRH in underserved areas.				-
		3.5.2	To establish mechanisms to strengthen and monitor performance of health workers at all levels		Performance management system established			**39,077,715**
			3.5.2.1	Integrated Supportive Supervision to enhance service delivery in HRH		Engage consultants to train 100 Health workers in Health Facilities on ISS mechanisms every year	DPRS	33,944,329
			3.5.2.2	Establishment of performance based incentives for health workers in underserved areas.		Inaugurate 6 member committee to establish Parformance Based Incentive for the Health Workers in Underserved Areas.	DFA, DPRS	861,100
			3.5.2.3	Develop/Review Performance Management System		6-man committee to meet 5 times to develop the performance management system at the 1st quarter of the first year and review every last quarter of every year.	DPRS	1,028,433
			3.5.2.4	Develop and implement guidelines to motivate HRH in peripheral health facilities		The Same Committee above to handle this activity		3,243,853
			3.5.2.5					-
		3.5.3	To recruit health professionals in areas of need based on evidence		Proportion of health workers resident within 5km of health facilities			**23,006,574,424**
			3.5.3.1	Recruit and remunerate various cadres of health professionals to fill gaps		Engage and motivate	DFA, DPRS	22,996,019,437

						health professionals: 50 PHC workers/LGA yearly for 6 years and 100 SHC workers/SHC yearly for 6 years		
			3.5.3.2	Orientate newly recruited HRH and develop individual career paths		Engage appropriate consultants to enligthen the newly recruited personnel on their various proffessional field.	DFA, DPRS	7,408,991
			3.5.3.3	Review recruitment guidelines to allow for engagement of workers resident around health facilities		Committee of 10-man panel comprising of 6 Directors and 6 Other Supported Proffessionals to carry out the review.	DPRS, DFA	3,145,996
	3.6	**To foster partnerships and networks of stakeholders to harness contributions for human resource for health agenda**			**50% of DHBs have regular HRH stakeholder forums by end 2013**			**21,788,288**
		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					**21,788,288**
			3.6.1.1	Establishing effective dialogue and complaint channels between management and staff to promote intra- and inter- professional respect, harmony and team work in HRH.		68-member representatives hold a day interactive meeting in a hotel per annum		3,060,587
			3.6.1.2	Involvement of workers and professional groups in management teams, design and monitoring of services to enhance cooperation amongst all personnel.		7 teams of 5 persons per DHB to organise 2 days conference meeting to ensure maximum cooperation every 2 years		9,094,247
			3.6.1.3	Organize and hold quarterly stakeholders meetings to review the health status of the state		15-member representatives hold a day quarterly interactive		9,633,454

						meeting in a hotel		
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								**9,709,881,240**
	4.1	**To develop and implement health financing strategies at Federal, State and Local levels consistent with the National Health Financing Policy**			**Enugu State have a documented Health Financing Strategy by end 2012**			**1,973,031,715**
		4.1.1	Develop costed health financing strategic plans at the state level.		State health finance plan developed			**712,716,805**
			4.1.1.1	Health Financing Technical working group develops health financing plans for year 2010-2015	Link with Priority Area 1	Plans developed and midterm review carried out by 3rd year	Perm Sec/DFA	84,558,972
			4.1.1.2	Develop State health finance mobilization strategy		Committee	PATHS 2/HSDP 11	59,682,198
			4.1.1.3	Engage a consultant to develop community Health Insurance Scheme policies and strategies		Engage consultant		271,830,135
			4.1.1.4	Engage a consultant to develop/review implementation strategies and guidelines on D and E		Engage consultant		276,793,566
			4.1.1.5	Strenghten the implementation of the FMCH to make it easily more accessible by the health facilities.		Engage consultant		19,851,934
		4.1.2	To implement the strategic plans at all state levels		State health account developed			**669,786,499**
			4.1.2.1	Conduct advocacy visits to all local government areas to sensitize communities on the importance of community health Insurance/Mobilize the communities to accept the community health insurance scheme.		Committee to visit LGAs	Comm/Perm Sec	639,671,442
			4.1.2.2	Conduct advocacy visit to House Committees on Health and also Appropriation for legislation and increased funding			DMS	8,385,068
			4.1.2.3	Engage Partners and other funding stakeholders		Conduct meetings	Comm/ Perm Sec	21,729,989
			4.1.2.4				DPRS/CEOs of DHBs	-
		4.1.3	State and local government to allocate at least 15% of their total budget to health.		Proportion of State budget allocated to health			**590,528,411**
			4.1.3.1	Advocate to State House of Assembly, LGA Chairmen and other stakeholders for increased budgetary allocations to health and stronger oversight functions for budget performance			Commissioner/ DPRS/DFA	8,385,068
			4.1.3.2	Training of planning personnel in evidence based budget praparation		Once in 2 years	DPRS/DFA	321,866,405
			4.1.3.3	Training of planning personnel in writing proposals to assess			DPRS/DFA	260,276,938

				competitive FMOH (MDGs/PHC Fund) and other donor funds				
	4.2	**To ensure that people are protected from financial catastrophe and impoverishment as a result of using health services**			**NHIS protects Enugu citizens by end 2015**			**96,819,391**
		4.2.1	To strengthen systems for financial risk health protection		Law assuring health services for vulnerable groups enacted			**96,819,391**
			4.2.1.1	Develop/review policies, strategies and guidelines on free health services to vulnerable population, accident/robbery victims, etc.		Committee		77,961,932
			4.2.1.2	Promote legislation on community based NHIS		Advocacy to state House of Assembly		18,857,459
	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 State and LGA health funding increased by an average of 5% pa every year until 2015**			**285,358,331**
		4.3.1	To improve financing of the Health Sector		House committes on Health & Appropriation engeged yearly			**51,034,799**
			4.3.1.1	Pay Advocacy visits to the State House of Assembly to Promote Increased Budgetary Allocation		Advocacy visits to House of Assembly by a committee of 6 for 2 days every year to promote Budget Increased.	DFA	51,034,799
		4.3.2	To improve coordination of donor funding mechanisms		State Donor Coordination forum meeting quarterly			234,323,532
			4.3.2.1	Organize coordination meetings/involvement of donors in planning-implementation-monitoring-evaluation		Meetings of 10 members (once a year) to be coordinated by DFA and Others.	DFA, DHB, HA	234,323,532
	4.4	**To ensure efficiency and equity in the allocation and use of health sector resources at all levels**			**1. Enugu State and DHBs have transparent budgeting and financial management systems in place by end of 2015 2. Enugu States and DHBs have supportive supervision and monitoring systems**		Federal and State Governments show continuous commitment to health sector reform	**7,354,671,803**

					developed and operational by Dec 2014			
		4.4.1	To improve Health Budget execution, monitoring and reporting		State health account developed by 2013			**4,850,789,225**
			4.4.1.1	Develop State Health Accounts		Engage Consultants		4,374,047,566
			4.4.1.2	Conduct annual budget performance and public expenditure review annualy		10-man members committee to hold a day conference (once a year) to be coordinated by DFA and Others.		199,504,991
			4.4.1.3	Publication of annual audited accounts		Publish annual audited account on Radio Jingles and State TV Station, Print 500 Copies of Annual Health Audited Account and disseminate		277,236,668
			4.4.1.4					-
		4.4.2	To strengthen financial management skills		Finance officers trained on FMS			**2,503,882,578**
			4.4.2.1	Design and instal financial management system (manual & software) at State and DHB levels		Engage consultants		1,890,559,948
			4.4.2.2	Train Finance and Admin personnel on the appreciation and application of FMS at State and DHB levels		Engage consultants		613,322,631
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								**906,989,671**
	5.1	**To improve data collection and transmission**			**1. 50% of LGAs making routine NHMIS returns to State level by end 2012** **2. Enugu State making routine NHMIS returns to Federal level by end 2010**			**334,451,389**
		5.1.1	To ensure that NHMIS forms are available at all health service delivery points at all levels					**111,046,801**
			5.1.1.1	Printing and distribution of NHMIS to all health facilities in the State	Printing HMIS forms (25,000 copies)/Distribute HMIS forms to 500 Health	DHPRS, State HMIS Officer & Procurement Officer	DPRS	103,814,999

					facilities and other users, monthly.			
			5.1.1.2	Distribution of NHMIS to all health facilities in the State		DHPRS, State HMIS Officer & Procurement Officer		3,531,684
			5.1.1.3	Monitor the availabilty of forms at Health facilities	Link to ISS plan	2 officers (HMIS officer and 1 middle mgt staff) to conduct monitoring to ensure compliance every quarter		3,700,118
			5.1.1.4					-
		5.1.2	To periodically review of NHMIS data collection forms		NHMIS data collection forms reviewed every 2 years			**1,108,169**
			5.1.2.1	Annual review of HMIS data collection system/form		24 members committee (1 DHPRS + 12 SMOH staff +2 tertiary Hospital Staff + 9 NGOs) to meet once a year to identify and solve problems (Meetings at Federal, Zonal, State and LGA)		1,108,169
			5.1.2.2					-
		5.1.3	To coordinate data collection from vertical programmes		HDCC fora hold quarterly			**8,988,157**
			5.1.3.1	Conduct meetings of HDCC quarterly		To incorporate 24 key stakeholders (1 DHPRS + 12 Mid Mgt Staff + 2 Tertiary Hosps Staff + 9 NGOs)	DPRS	8,199,286
			5.1.3.2	Decenralize data collection at the district level		1 DPRS and 2 Mid Mgt Staff		58,161
			5.1.3.3	Conduct quarterly meetings of Programme Officers to collect and collate their data				730,710
		5.1.4	To build capacity of health workers for data management		Data managers trained			**202,482,774**
			5.1.4.1	Develop training materials for sensitization and training on revised forms for health workers in public and private health facilities.		DPRS + 2 Mid Management Level Officers	DPRS , HMIS Officer	62,012

			5.1.4.2	Train health workers on data handling and management, basic word processing and calculation skills, DQA, computer appreciation and application, etc.	technical personnel: Facility information officers-HRO/CHEWS/TBA (LHA level) on forms and tally sheets; 56 M&E officers at state level on DHIS software, /other technical professionals	Engage a Consultant to conduct In-House Training for 1000 Personnel (800 Private Health Fac Staff + 40 SMOH staff + 160 public Health Fac Staff) on the use of the NHMIS forms & registers for 5 days once in 6 years through Due Process.	DPRS , HMIS Officer	31,214,671
			5.1.4.3	Conduct managerial training programmes for personnel at State level: computer appreciation-ICT/M&E officers/DC programme officers at State level (22). DQA training. Health facilities assessment/survey		22 Officers for local training to sharpen their knowledge on data collation & analysis for 5 days once every year; and 5 Officers for international training for 5 days once every 3 years.	DPRS , HMIS Officer	89,782,325
			5.1.4.4	Train data managers on health facilities/systems assessments			DPRS , HMIS Officer	78,833,623
			5.1.4.5	Advocate for SMOH & LGAs to train and employ health information personnel for health facilities.			DHPRS, DPH	2,590,143
		5.1.5	To provide a legal framework for activities of the NHMIS programme		Law compels private health facilities to make data returns by 2012			**3,437,342**
			5.1.5.1	Advocacy and sensitization workshop to Policy makers on compulsory health data reporting.		4 officers to meet and establish smooth relationship among 12 stakeholders 6 times per year	DPRS	2,815,362
			5.1.5.2	Advocate for the enactment of HMIS reporting by the private sector to legislators.			DPRS	621,980
			5.1.5.3					-
		5.1.6	To improve coverage of data collection		Data transmission improved to 80% target by 2012			**1,234,846**

			5.1.6.1	Work with agencies to assist the State to develop innovative startegies to collect data from all private and public health facilities.		Annual meeting to strategise for the year		356,388
			5.1.6.2	Provide support to National Population Commission to improve birth and death registration.		Provision of registration forms		878,458
			5.1.6.3					-
		5.1.7	To ensure supportive supervision of data collection at all levels		Data ISS conducted quarterly			**5,045,130**
			5.1.7.1	Advocate to SMoHs & LGAs to provide appropriate logistics for official to supervise data collection at lower levels	link with ISS		DPRS + 1 director	2,590,143
			5.1.7.2	Conduct supervisory visits to HFs		2 Officers to ascertain quality of data in 20 Public & Private Health Facilities for 3 days once in every quarter	DHRS, HMIS Officer	2,454,987
			5.1.7.3					-
	5.2	**To provide infrastructural support and ICT of health databases and staff training**			**ICT infrastructure and staff capable of using HMIS in Enugu State by 2012**			**309,289,318**
		5.2.1	To strengthen the use of information technology in HIS		NHIS/DHIS used for data processing and reporting by 2012			**208,578,815**
			5.2.1.1	Instal NHIS/DHIS software for data collection at State & DHB level		Engage a vendor	HMIS Officer	3,774,325
			5.2.1.2	Provide internet infrastructure at 7 Health district and LGA level		Engage a vendor	DPRS	94,209,101
			5.2.1.3	Promote the use of e-health (electronics management intelligence information system, website, Patient information system) widely.		Training Data managers and health workers on e-health every 2 years	DPRS , HMIS Officer	17,557,565
			5.2.1.4	Create a website for SMOH		Engage a vendor	DPRS	93,037,823
			5.2.1.5					-
		5.2.2	To provide HMIS Minimum Package at the different levels (FMOH, SMOH, LGA) of data management		HMIS minimum package in place at LGAs			**100,710,503**
			5.2.2.1	Procure and distribute HMIS minimum package to state and LGA levels		Engage a contractor to supply HMIS package and distribute to 20 facilities twice in 6 years	DPRS , HMIS Officer	21,751,983
			5.2.2.2	Training of HMIS personnelon DHIS and database management		Engage a Consultant	DPRS , HMIS Officer	78,833,623
			5.2.2.3	Advocate to Health & Appropriation Committees of House of Assembly to		Committee	DPRS	124,896

				increase running costs budget for HMIS				
	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**			**216,079,225**
		5.3.1	To strengthen the Hospital Information System		HIS installed in every SHC			**46,736,242**
			5.3.1.1	Develop guidelines that govern Hospitals Information System			DPRS , HMIS Officer	160,462
			5.3.1.2	Procure and instal Hospital Information Software at State and District levels		Engage a contractor to supply Software package and instal at 20 facilities twice in 6 years	DPRS , HMIS Officer	21,751,983
			5.3.1.3	Provide operating costs for the Hospitals Information system		Bugdetary provision is made and timely released is ensured	DPRS	234,603
			5.3.1.4	Train medical records officers on Hospital Information systems management		Engage a Consultant to conduct In-House Training for 160 public Health Fac Staff on the use of the HIS for 5 days twice in 6 years	DPRS , HMIS Officer	24,589,195
			5.3.1.5					-
		5.3.2	To strengthen the Disease Surveillance System		DSS personnel trained			**169,342,983**
			5.3.2.1	Develop guidelines and implement a process for the regular reporting of notifiable diseases by all health facilities.		Committee	DPRS , HMIS Officer	160,462
			5.3.2.2	Develop guidelines and initiate pilot projects with selected States to strengthen community based surveillance.		Committee	DPRS , HMIS Officer	160,462
			5.3.2.3	Establish a Disease Outbreak Response Committee and provide it with logistics - (training/packages/communication/data management/vehicle/			DPHC & DC/DPRS	11,651,843
			5.3.2.4	Train DSS personnel on methods and emergency response		Once in 2 years	DPRS , HMIS Officer	24,622,977

			5.3.2.5	Establish a Public Health Laboratory in Enugu		Engage a builder and vendors	DPRS	53,359,174
			5.3.2.6	Provide logistics support (vehicles & communication equipment) to implement DSS		7 Vehicles to be provided for effective coverage in 3 years	DPRS	73,149,249
			5.3.2.7	Carry out ISS visits to districts on DSS			DPRS + 1 director	2,590,143
			5.3.2.8	Mobilize communities for DSS		Committee	DPRS + 1 director	3,648,673
	5.4	**To monitor and evaluate the NHMIS**			**NHMIS evaluated annually**			**3,648,673**
		5.4.1	To establish monitoring protocol for NHMIS programme implementation at all levels in line with stated activities and expected outputs		Monitoring protocol developed			**3,812,095**
			5.4.1.1	Design a monitoring checklist for HMIS		Committee	DPRS , HMIS Officer	160,462
			5.4.1.2	Train key SMoH officers on the use of the monitoring checklist instrument for HMIS program.		Engage a Consultant	DPRS , HMIS Officer	3,651,634
			5.4.1.3					-
		5.4.2	To strengthen data transmission		Budget release for data transmission from Health Facilities to LGAs			**15,688,029**
			5.4.2.1	Establish and promote guidelines to ensure monthly and quaterly transmission of HMIS data from health facilities to federal level		20 Officers to meet every 6 months to review progress & problems	DHPRS	768,664
			5.4.2.2	Monitor only quarter transmission of HMIS data and evaluate the problems that prevent complete and regular transimmion of the data		2 Officers to ascertain quality of data in 20 Public & Private Health Facilities for 3 days once in every quarter	DHRS, HMIS Officer	2,454,987
			5.4.2.3	Advocate for the release of budget for Data transmission at the DHB level			HMIS Officer	10,480,190
			5.4.2.4	Organize quarterly meetings of HDCC		To incorporate 24 key stakeholders (1 DHPRS + 12 Mid Mgt Staff + 2 Tertiary Hosps Staff + 9 NGOs)	DHPRS	1,984,188
	5.5	**To strengthen analysis of data and dissemination of health information**			**Enugu State has Units capable of analysing health information by end 2010**			**43,521,066**
		5.5.1	To institutionalize data analysis and dissemination at all levels		Website established at SMOH			**43,521,066**

			5.5.1.1	Establish and maintain website at SMOH		costed above	DPRS	-
			5.5.1.2	Publish, print and disseminate State health Bulletin/Journal periodically		1000 booklets produced to spread information on health activities to stakeholders & receive feedback every year	DPRS, HMIS Officer	18,962,187
			5.5.1.3	Establish the infrastructure and process for regular production of healthdata bulletine (electronic web based and hard copy prints)			DPRS, HMIS Officer	18,962,187
			5.5.1.4	Compile the annual reports of the DPRS and monitor annual reports at State & LGA levels			DPRS	308,633
			5.5.1.5	Use radio/TV programmes to inform about health		Health education Committee	DPRS	5,288,058
			5.5.1.6	Develop, produce, disseminate and implement Knowledge Management Strategies and Plans at State and LGA levels		Functional TWG/SMOH KM Team	PS	-
COMMUNITY PARTICIPATION AND OWNERSHIP								
6. To attain effective community participation in health development and management, as well as community ownership of sustainable health outcomes								**502,619,167**
	6.1	**To strengthen community participation in health development**			**Enugu State has annual Fora to engage community leaders and CBOs on health matters by end 2012**			**163,355,760**
		6.1.1	To provide an enabling policy framework for community participation		Policy framework for community participation developed			**41,614,931**
			6.1.1.1	Develop/review community development policy, strategies and guidelines		5 member committe meets 1 day, 2 times in a year with 1 support staff for every two years	PHC board, Head(Health promotion & education), ICT Support officer	2,214,244
			6.1.1.2	Reactivate Ward Development and Village Health Committees through constitution and meetings		10 participants from each LGA to participate in a one day training programme once a year	LGA Service Comm / PHC Coordinatos	29,351,161
			6.1.1.3	Organize meetings and train Facilities management Committee members on community health management		17 participants (1 per LGA) in a two day	D PHC&DC / PHC Coordinators at LGAs	5,024,763

						training per year		
			6.1.1.4	Train Ward Development and Village Health Committee members on community health management		17 participants (1 per LGA) in a two day training per year		5,024,763
			6.1.1.5					-
		6.1.2	To provide an enabling implementation framework and environment for community participation		Community stakeholders meet regularly			**121,740,829**
			6.1.2.1	Organize meetings with FBOs, CBOs, traditional, religious leaders, opinion leaders, etc		5 officials to organize regular 1 day quarterly meetings with traditional rulers	D PHC&DC / PHC Coordinators at LGAs	87,081,294
			6.1.2.2	Training of FBOs, CBOs on health management at the facility level		3 resource person to facilitate 8 session of a three day training on health mangemt	D PHC&DC / PHC Coordinators at LGAs	34,659,535
	6.2	**To empower communities with skills for positive health actions**			**Enugu State offers training to FBOs/CBOs and community leaders on engagement with the health system by end 2012**			**28,133,578**
		6.2.1	To build capacity within communities to 'own' their health services		WDC and VHC members trained on community health management			**28,133,578**
			6.2.1.1	Training of FBOs, CBOs on health management at the facility level	costed above		D PHC&DC / PHC Coordinators at LGAs	-
			6.2.1.2	Train Ward Development and Village Health Committee members on community health management	costed above		D PHC&DC / PHC Coordinators at LGAs	-
			6.2.1.3	Community assessment of capacity needs and available healthcare services		A team of 5 per LGA to conduct community needs assessment using checklist in 10 days	D PHC&DC / PHC Coordinators at LGAs	28,133,578
	6.3	**To strengthen the community - health services linkages**			**50% of public health facilities have active**			**171,657,618**

					Indicator	Target/Output	Responsible	Cost
					Committees that include community representatives by end 2012			
		6.3.1	To restructure and strengthen the interface between the community and the health services delivery points		Health educations sessions held at community level			**171,657,618**
			6.3.1.1	Conduct Facility Management Committees-Community health Volunteers feedback sessions		hold quarterly feedback sessions for 30 participants in 17 LGA twice a year	PHC Coordinators at LGA	134,577,743
			6.3.1.2	Conduct meetings with traditional rulers, community and religious leaders		A day community dialogue with traditional rulers in each LGA	PHC Coordinators at LGA	23,123,566
			6.3.1.3	Conduct health education public awareness campaigns at community level		Issuance of printing job order for 3000 posters & 5,000 leaflets. logistics arrangement for distribution (2 health educators & 2 drivers)	PHC Coordinators at LGA	13,956,310
	6.4	**To increase national capacity for integrated multisectoral health promotion**			**Enugu State has active intersectoral committees with other Ministries and private sector by end 2012**			**6,525,957**
		6.4.1	To develop and implement multisectoral policies and actions that facilitate community involvement in health development		Inter-sector meetings held			**6,525,957**
			6.4.1.1	Conduct coordination meetings with Education, Finance, Women Affairs, LGA on health management issues		yearly meeting with 40 participants		6,525,957
	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 2012**			**132,946,254**
		6.5.1	To develop and implement systematic measurement of community involvement		Level of community			**132,946,254**

				awareness on health indicators			
		6.5.1.1	Conduct review of utilization of health services		health records review quarterly	DPRS / State HMIS officer	2,427,120
		6.5.1.2	Conduct specialized surveys to assess community participation in healthcare delivery		Consultants consult surveys to assess	DPRS / Consultant	130,519,135
PARTNERSHIPS FOR HEALTH							
7. To enhance harmonized implementation of essential health services in line with national health policy goals							**578,334,352**
	7.1	**To ensure that collaborative mechanisms are put in place for involving all partners in the development and sustenance of the health sector**		**1. SMOH has an active ICC with Donor Partners that meets at least quarterly by end 2012 2. SMOH has an active PPP forum that meets quarterly by end 2012**			**578,334,352**
		7.1.1	Institutionalize Public Private Partnership	PPP Unit established at SMOH			**269,952,395**
		7.1.1.1	Finalize/review, print and disseminate State PPP policy, plan and guidelines on health		15 member review committee meets 5 days twice in 6 years. With help from two support staff	DPRS, REG (PHERMC), DO(PPP), Legal unit and other partners in the healthcare industry	11,664,885
		7.1.1.2	Establish/improve PPP Unit at HCH office and at DHB level, procure furniture and equipment		Create an office for PP unit and procurement of office furniture and equipment (2 computers , photocopier, i binding machine etc)	DFA / Procurement officer	23,124,624
		7.1.1.3	Train PPP unit personnel		Conduct a 5 days intensive training for 5 key personnel on PPP	DPRS / Consultant	226,386,238
		7.1.1.4	Hold periodic coordination meetings with PPP forum		15 member representatives hold a day interactive meeting in a hotel every year	DPH / DPRS /	8,776,648
		7.1.1.5					-
		7.1.2	To institutionalize a framework for coordination of Development Partners	Stakehoder-wide annual health			**42,451,704**

					review meeting held			
			7.1.2.1	Initiate and conduct meetings of State Health Planning & Coordination Committee (quarterly)		50 participants hold a one day meeting in a hotel	DD PRS	37,165,280
			7.1.2.2	Joint development of business plan, implementation, monitoring & evaluation, etc. with partners		Two sessions meeting of 10 persons meets a day		5,286,424
			7.1.2.3					-
		7.1.3	To facilitate inter-sectoral collaboration		Inter=sector coordination meetings held			**38,651,050**
			7.1.3.1	Initiate and conduct meetings of State Health Planning & State ministries of Agric, education, Women Affairs, LGA, etc. Coordination Committee (quarterly)		40 participants hold a one day meeting in a hotel quarterly		33,364,626
			7.1.3.2	Involve State ministries of Agric, Education, Women Affairs, LGA, etc. in annual planning and evaluation				5,286,424
			7.1.3.3					-
		7.1.4	To engage professional groups					**61,407,901**
			7.1.4.1	Promote effective communication between professional groups and SMoH through periodic meetings		20 particpants hold a non residential one day meeting quarterly		25,224,891
			7.1.4.2	Engage professional groups in health planning and programs		Two sessions meeting of 10 persons meets a day		5,286,424
			7.1.4.3	Engage professional groups in continuing professional development program for health personnel		5 days meeting with the professional each year		30,896,587
			7.1.4.4					-
		7.1.5	To engage with communities		VHCs and WDCs meet at least once a quarter			**47,645,715**
			7.1.5.1	Organize regular meetings with traditional rulers, town unions, FBOs, CBOs, market women, etc.		5 PPP officials to organize regular 1 day quarterly meetings with traditional rulers		2,811,443
			7.1.5.2	Revitalize Facility Health Committee, VHCs and WDCs through meetings and training of members on community health management		10 participants from each LGA to participate in a one day training	D PHC & PHC Coordinators at the LGAs	28,489,722

						programme once a year		
			7.1.5.3	Health educate communities by providing information on health plans and programs		State officials to conduct health education session in conjuction with LGA officials		4,779,453
			7.1.5.4	Review and disseminate health service charter			D PHC & PHC Coordinators at the LGAs	-
			7.1.5.5	Organize meetings and training programmes for hospital- community committees		172 particpants (170 representativ e of hospital-com munity committees + 2 facilitators at each meeting)	D PHC & PHC Coordinators at the LGAs	11,565,096
		7.1.6	To engage with traditional health practitioners		Traditional health practitioners trained			**118,225,587**
			7.1.6.1	Review guidelines to include or create diffrent board for Alternative Medicine		10 member committee meet 5 days to review the guidelines	D PRS	8,308,508
			7.1.6.2	Adapt and implement national policy on Traditional Medicine		The committe above will also ensure that the national policy is implemented	D PRS	-
			7.1.6.3	Review edit on, and reconstitute Traditional Medicine Board		Committe in 7.1.6.1 above will act on this	D PRS	592,225
			7.1.6.4	Carry out research on Traditional health practice		engage Consultants to carry out a research once every three years	D PRS	85,064,227
			7.1.6.5	Train traditional health practitioners		170 participants (10 per LGA) in a two day training per year	D PHC&DC / PHC Coordinators at LGAs	24,260,627
			7.1.6.6	Adapt useful Traditional practices and technology into State healthcare system				-
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								**1,070,364,901**

	8.1	**To strengthen the stewardship role of governments at all levels for research and knowledge management systems**			**1. HR Committee established by end 2010 to guide health research priorities 2. Enugu publishes an Health Research agenda annually from 2011**			**51,518,584**
		8.1.1	To finalise the Health Research Policy at Federal level and develop health research policies at State levels and health research strategies at State and LGA levels		Health research policy and strategy document developed by 2010			**3,730,509**
			8.1.1.1	Establish a Health Research Policy Committee and organize meetings to develop/review health research policy and strategy		Committee of 5 officials and 5 Experts meets 4 times a year in 2010 and 2013	DPRS, Universities and other research institutions	3,730,509
			8.1.1.2					-
		8.1.2	To establish and or strengthen mechanisms for health research at all levels		HR Journals published by 2011			**8,231,959**
			8.1.2.1	Establish and organize meetings of Health Research Committee to develop/review health research agenda		10 member Committee meets twice every year	DPRS,UNTH,ES UTH, NOHE	5,082,781
			8.1.2.2	Pay advocacy visits to and arganize advocacy meetings for House Committee, development partners and private sector for funding for health research		HCH leads delegation. Hold workshop for 25 people for 1 day every year	House Committee, other role players	881,279
			8.1.2.3	Publish, print and disseminate health research findings in State Health Journal		1,000 copies printed and distributed. 1 presentation meeting per year		2,267,900
			8.1.2.4					-
		8.1.3	To institutionalize processes for setting health research agenda and priorities		Report of meetings of HRC			**15,840,397**
			8.1.3.1	Recruit/deploy an Officer for Research in DPRS		Deploy existing first. Recruit in Year 3	DPRS	9,876,337
			8.1.3.2	Establish and organize meetings of Health Research Committee to develop/review health research agenda	see 8.1.2.1 for details and costs	10 member Committee meets twice every year	DPRS,UNTH,ES UTH, NOHE	5,082,781
			8.1.3.3	Pay advocacy visits to and arganize advocacy meetings for House Committee, development partners and private sector for funding for health research	see 8.1.2.2 for details and costs	HCH leads delegation. Hold workshop for 25 people for 1 day every year	House Committee	881,279

		8.1.3.4					-
	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		5 Stakeholders have signed MOUs by 2012			**858,939**
		8.1.4.1	Enter into/review MOUs with key health research stakeholders		DPRS drafts MOUs and meets with stakeholders	LGAs, ESUTH,UNTH, CSOs, development partners and Guild of Med directors	144,521
		8.1.4.2	Conduct stakeholders' research fair (meetings) to share health research findings		DPRS organized meetings/seminars in Enugu once yearly		714,418
		8.1.4.3					-
	8.1.5	To mobilise adequate financial resources to support health research at all levels		Per cent increase in health research funding per annum			**21,959,942**
		8.1.5.1	Pay advocacy visits to and organize advocacy meetings for House Committee, development partners and private sector for funding for health research	see 8.1.2.2 for details and costs	HCH leads delegation. Hold workshop for 25 people for 1 day every year	DPRS/House Committee	881,279
		8.1.5.2	Train health research officers to write proposals to access funds from donor organizations		5 officers per year in Nig management training institutions	DPRS/Development Partners	21,078,664
		8.1.5.3					-
	8.1.6	To establish ethical standards and practise codes for health research at all levels		Ethical standards and practised codes established by 2012			**896,838**
		8.1.6.1	Establish and organize meetings of Ethical Committee on health research		5 member Committee meets twice every year	DPRS	896,838
		8.1.6.2					-
	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**			**913,954,082**
		8.2.1	To strengthen identified health research institutions at all levels				**275,223,971**
		8.2.1.1	Pay advocacy visits to and organize advocacy meetings for House Committee, development partners and private sector for funding for health research	see 8.1.2.2 for details and costs	HCH leads delegation. Hold workshop for 25 people for 1 day every year	House Committee	881,279

			8.2.1.2	Procurement of books, journals, equipment for research		Needs assessment. Procurement of goods	DPRS/DFA/Development Partners	274,342,692
			8.2.1.3					-
		8.2.2	To create a critical mass of health researchers at all levels		health workers trained on research methodology			**59,243,114**
			8.2.2.1	Training of officers of SMOH/SHB/DHB/LGAs on research methodology and applications		Train 50 officers yearly on short courses in Nigerian institutions	DPRS/Partners	37,036,263
			8.2.2.2	Pay advocacy visits to and arganize advocacy meetings for House Committee, development partners and private sector for funding for health research	see 8.1.2.2 for details and costs	HCH leads delegation. Hold workshop for 25 people for 1 day every year	House Committee	881,279
			8.2.2.3	Train Sponsorship 2 officers for PhDs in areas of health	Sponsorship for PhDs in areas of health	Train 1 officer yearly on long courses in Nigerian institutions		21,325,572
			8.2.2.4					-
		8.2.3	To develop transparent approaches for using research findings to aid evidence-based policy making at all levels					**4,018,256**
			8.2.3.1	Publish, print and disseminate health research findings to policy makers	See 8.1.2.3 for costs	1,000 copies printed and distributed. 1 presentation meeting per year		4,018,256
			8.2.3.2					-
		8.2.4	To undertake research on identified critical priority areas		Research findings published yearly			**531,968,303**
			8.2.4.1	Develop/review protocols (instruments, guidelines, etc) on health research		Committee of 5 to meet twice a year every 2 years	DPRS	942,947
			8.2.4.2	Undertake research on identified topical areas using teams only or collaborate with other institutions to carry out research		Using a combination of SMOH teams or collaborating with other institutions to carry out research	DPRS/Partners/ Research institutions	439,472,941
			8.2.4.3	Commission Consultants to carry out identified complex research			DPRS/DFA/Partners	91,552,416
			8.2.4.4					-
		8.2.5	To develop a comprehensive repository for health research at all levels.		Repository established by 2011			**43,500,437**
			8.2.5.1	Procure equipment for repository (furniture, computers, ICT, office equipment)		Needs assessment		42,759,712

						followed by procurement		
			8.2.5.2	Training of officers on electronic repository/archiving		2 Research officers trained on short courses in Nig institutions		740,725
			8.2.5.3					-
	8.3	**To develop a comprehensive repository for health research at all levels (including both public and non-public sectors)**			**1. Enugu State has a Health Research Unit by end 2010 2. Enugu State Health Research Unit manages an accessible repository by end 2012**			**13,306,560**
		8.3.3	To create a framework for sharing research knowledge and its applications		Journal of health published			**13,306,560**
			8.3.3.1	Conduct stakeholders' research fair (meetings) to share health research findings	see details for costs above	DPRS organized meetings/se minars in Enugu once yearly	DPRS	-
			8.3.3.2	Publish, print and disseminate health research findings in State Health Journal	see details for costs above	1,000 copies printed and distributed. 1 presentation meeting per year	DPRS	-
			8.3.3.3	Procure equipment for repository (furniture, computers, ICT, office equipment)	costing details in 8.2.5.1	Needs assessment followed by procurement	DPRS	-
			8.3.3.4	Training of officers on electronic repository/archiving	costing details in 8.2.5.2	2 Research officers trained on short courses in Nig institutions	DPRS	-
			8.3.3.5	Sponsor participation of officersin international conferences on health research		2 SMOH officers attend international meetings every 2 years	DPRS	13,306,560
			8.3.3.6					
		8.3.4	Establish channels for sharing of research findings between researchers, policy makers and development practitioners.					**-**
			8.3.4.1	Conduct stakeholders' research fair (meetings) to share health research findings	see details for costs above	DPRS organized meetings/se minars in Enugu once yearly	DPRS	-
			8.3.4.2	Publish, print and disseminate health research findings in State Health Journal	see details for costs above	1,000 copies printed and distributed. 1	DPRS	-

						presentation meeting per year		
	8.4	**To develop, implement and institutionalize health research communication strategies at all levels**			**A State health research communication strategy is in place by end 2012**			**91,585,675**
		8.4.1	To create a framework for sharing research knowledge and its applications					-
			8.4.1.1	Procure equipment for repository (furniture, computers, ICT, office equipment)	costing details in 8.2.5.1	Needs assessment followed by procurement		-
			8.4.1.2	Training of officers on electronic repository/archiving	costing details in 8.2.5.2	2 Research officers trained on short courses in Nig institutions		-
			8.4.1.3					-
		8.4.2	To establish channels for sharing of research findings between researchers, policy makers and development practitioners					**91,585,675**
			8.4.2.1	Construct and equip an ICT resource center in all the DHB		Build and equip and ICT Resource Centres in the 7 DHB	DFA/DHB/Head of Research	91,585,675
Total								**74,908,161,737**

Annex 3: Results/M&E Matrix for Monitoring Implementation of the Plan

ENUGU STATE STRATEGIC HEALTH DEVELOPMENT PLAN RESULT MATRIX						
OVERARCHING GOAL: To significantly improve the health status of Nigerians through the development of a strengthened and sustainable health care delivery system						
OUTPUTS	**INDICATORS**	**SOURCES OF DATA**	**Baseline**	**Milestone**	**Milestone**	**Target**
			2008/9	**2011**	**2013**	**2015**
PRIORITY AREA 1: LEADERSHIP AND GOVERNANCE FOR HEALTH						
NSHDP Goal: To create and sustain an enabling environment for the delivery of quality health care and development in Nigeria						
OUTCOME: 1. Improved strategic health plans implemented at Federal and State levels						
OUTCOME 2. Transparent and accountable health systems management						
1. Improved Policy Direction for Health Development	1. % of LGAs with Operational Plans consistent with the state strategic health development plan (SSHDP) and priorities	LGA s Operational Plans	0	50	75	100%
	2. % stakeholders constituencies playing their assigned roles in the SSHDP (disaggregated by stakeholder constituencies)	SSHDP Annual Review Report	TBD	25	50	75%
2. Improved Legislative and Regulatory Frameworks for Health Development	3. State adopting the National Health Bill? (Yes/No)	SMOH	0	25	50	75
	4. Number of Laws and by-laws regulating traditional medical practice at State and LGA levels	Laws and bye-Laws	TBD			
	5. % of LGAs enforcing traditional medical practice by-laws	LGA Annual Report	TBD	25%	50%	75%
3. Strengthened accountability, transparency and responsiveness of the State health system	6. % of LGAs which have established a Health Watch Group	LGA Annual Report	0	50	75	100
	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	TBD	25	50	75%
	11. % LGAs implementing their peer review recommendations	LGA / SSHDP Annual Review Report	No Baseline	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	TBD	50	75	100%
4. Enhanced performance of the State health system	14. % LGA public health facilities using the essential drug list	Facility Survey Report	TBD	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	TBD	10	25	50%
	18. % LGA health facilities not-experiencing essential drug/commodity stockouts in the last three months	Facility Survey Report	TBD	25	50	75%
	19. % of LGAs implementing a performance based budgeting system	Facility Survey Report	TBD	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	TBD	2	4	6
	21. Number of facilities performing deliveries accredited as Basic EmOC facility (7 functions 24/7) and Comprehensive EmOC facility (9 functions 24/7)	States/ LGA Report and Facility Survey Report	TBD	10	15	20
STRATEGIC AREA 2: HEALTH SERVICES DELIVERY						
NSHDP GOAL: To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare						
Outcome 3: Universal availability and access to an essential package of primary health care services focusing in particular on vulnerable socio-economic groups and geographic areas						
Outcome 4: Improved quality of primary health care services						
Outcome 5: Increased use of primary health care services						
5. Improved access to essential package of Health care	22. % of LGAs with a functioning public health facility providing minimum health care package according to quality of care standards.	NPHCDA Survey Report	TBD	25	50	75%
	23. % health facilities implementing the complete package of essential health care	NPHCDA Survey Report	TBD	50	75	100%
	24. % of the population having access to an essential care package	MICS/NDHS	TBD	40	75	100%
	25. Contraceptive prevalence rate (modern and traditional)	NDHS	21.00%	30%	40%	50%
	26. % increase of new users of modern contraceptive methods (male/female)	NDHS/HMIS	11.30%	15%	25%	35%
	27. % of new users of modern contraceptive methods by type (male/female)	NDHS/HMIS	11.30%	15%	25%	35%

	28. % service delivery points without stock out of family planning commodities in the last three months	Health facility Survey	TBD	10%	20%	35%
	29. % of facilities providing Youth Friendly RH services	Health facility Survey	TBD	20%	30%	40%
	30. % of women age 15-19 years who have begun child bearing	NDHS/MICS	6%	5%	4%	3%
	31. % of pregnant women with 4 ANC visits performed according to standards*	NDHS	68.10%	75%	80%	85%
	32. Proportion of births attended by skilled health personnel	HMIS	53.60%	60%	70%	80%
	33. Proportion of women with complications treated in an EmOC facility (Basic and/or comprehensive)	EmOC Sentinel Survey and Health Facility Survey	TBD	20%	25%	40%
	34. Caesarean section rate	EmOC Sentinel Survey and Health Facility Survey	5.60%	10%	15%	20%
	35. Case fatality rate among women with obstretic complications in EmOC facilities	HMIS	TBD	10	7.50%	12%
	36. Perinatal mortality rate**	HMIS	37/1000LBs	30/1000LBs	25/1000LBs	20/1000 LBs
	37. % of women who received postnatal care based on standards within 48h after delivery	MICS	40.00%	50%	60%	70%
	38. % of newborn with infection receiving treatment	MICS	No Baseline	20%	30%	40%
	39. % of children exclusively breastfed 0-6 months	NDHS/MICS	2%	5%	10%	15%
	40. Proportion of 12-23 months-old children fully immunized	NDHS/MICS	28.40%	40%	50%	65%
	41. % children <5 years stunted (height for age <2 SD)	NDHSMICS	20.00%	15%	10%	5%
	42. % of under-five that slept under LLINs the previous night	NDHS/MICS	64.20%	70%	75%	80%
	43. % of under-five children receiving appropriate malaria treatment within 24 hours	NDHS/MICS	30%	40%	50%	60%
	44.Condom use at last high risk sex	NARHS/NDHS	3.60%	5%	10%	15%
	45. Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS	NDHS/MICS	23	30%	40%	50%
	46. Prevalence of tuberculosis	NARHS	6.9%*	6%	4%	2%
	47. Proportion of tuberculosis cases detected and cured under directly observed treatment short course	NMIS	TBD	50%	60%	70%

Output 6. Improved quality of Health care services	48. % of staff with skills to deliver quality health care appropriate for their categories	Facility Survey Report	TBD	50%	60%	70%
	49. % of facilities with capacity to deliver quality health care	Facility Survey Report	TBD	40%	55%	65%
	50. % of health workers who received personal supervision in the last 6 months by type of facility	Facility Survey Report	TBD	30%	50%	60%
	51. % of health workers who received in-service training in the past 12 months by category of worker	HR survey Report	TBD	10%	25%	40%
	52. % of health facilities with all essential drugs available at all times	Facility Survey Report	TBD	25%	40%	50%%
	53. % of health institutions with basic medical equipment and functional logistic system appropriate to their levels	Facility Survey Report	TBD	10%	25%	40%
	54. % of facilities with deliveries organizing maternal and/or neonatal death reviews according to WHO guidelines on regular basis	Facility Survey Report	TBD	10%	20%	30%
Output 7. Increased demand for health services	55. Proportion of the population utilizing essential services package	MICS	TBD	25%	40%	50%
	56. % of the population adequately informed of the 5 most beneficial health practices	MICS	TBD	20%	30	40%
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	57. % of wards that have appropriate HRH complement as per service delivery norm (urban/rural).	Facility Survey Report	TBD	20%	30%	40%
	58. % LGAs actively using adaptations of National/State HRH policy and plans	HR survey Report	TBD	10%	25%	40%
	59. Increased number of trained staff based on approved staffing norms by qualification	HR survey Report	TBD	10%	25%	40%
	60. % of LGAs implementing performance-based managment systems	HR survey Report	TBD	10%	20%	30%
	61. % of staff satisfied with the performance based management system	HR survey Report	TBD	10%	30%	40%
Output 8: Improved framework for	62. % LGAs making availabile consistent flow of HRH information	NHMIS	50	60%	70%	80%

objective analysis, implementation and monitoring of HRH performance						
	63. CHEW/10,000 population density	MICS	TBD	1:4000 pop	1:3000 pop	1:2000 pop
	64. Nurse density/10,000 population	MICS	TBD	1:8000 pop	1:6000 pop	1:4000 pop
	65. 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
	66. Medical doctor density per 10,000 population	MICS	TBD	1:8000 pop	1:7000 pop	1:5000 pop
	67. Other health service providers density/10,000 population	MICS	TBD	1:4000 pop	1:3000 pop	1:2000 pop
	68. HRH database mechanism in place at LGA level	HRH Database	TBD	10%	20%	30%
Output 10: Strengthened capacity of training institutions to scale up the production of a critical mass of quality mid-level health workers						
PRIORITY AREA 4: FINANCING FOR HEALTH						
NSHDP GOAL 4 : To ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and consumption at Local, State and Federal Levels						
Outcome 8. Health financing strategies implemented at Federal, State and Local levels consistent with the National Health Financing Policy						
Outcome 9. The Nigerian people, particularly the most vulnerable socio-economic population groups, are protected from financial catastrophe and impoverishment as a result of using health services						
Output 11: Improved protection from financial catastrophy and impoversihment as a result of using health services in the State	69. % of LGAs implementing state specific safety nets	SSHDP review report	TBD	10%	30%	50%
	70. Decreased proportion of informal payments within the public health care system within each LGA	MICS	TBD	20%	30%	40%
	71. % of LGAs which allocate costed fund to fully implement essential care package at N5,000/capita (US$34)	State and LGA Budgets	TBD	5%	10%	15%
	72. LGAs allocating health funding increased by average of 5% every year	State and LGA Budgets	TBD	20%	30%	40%

Output 12: Improved efficiency and equity in the allocation and use of Health resources at State and LGA levels	73. LGAs health budgets fully alligned to support state health goals and policies	State and LGA Budgets	TBD	30%	40%	50%
	74.Out-of pocket expenditure as a % of total health expenditure	National Health Accounts 2003 - 2005	70%	60%	50%	40%
	75. % of LGA budget allocated to the health sector.	National Health Accounts 2003 - 2005	2%	10%	20%	30%
	76. Proportion of LGAs having transparent budgeting and finacial management systems	SSHDP review report	TBD	25%	40%	60%
	77. % of LGAs having operational supportive supervision and monitoring systems	SSHDP review report	TBD	25%	40	50%
PRIORITY AREA 5: NATIONAL HEALTH INFORMATION SYSTEM						
Outcome 10. National health management information system and sub-systems provides public and private sector data to inform health plan development and implementation						
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	78. % of LGAs making routine NHMIS returns to states	NHMIS Report January to June 2008; March 2009	20%	30%	40%	50%
	79. % of LGAs receiving feedback on NHMIS from SMOH		TBD	30%	40%	50%
	80. % of health facility staff trained to use the NHMIS infrastructure	Training Reports	TBD	50%	60%	70%
	81. % of health facilities benefitting from HMIS supervisory visits from SMOH	NHMIS Report	TBD	25%	40%	60%
	82.% of HMIS operators at the LGA level trained in analysis of data using the operational manual	Training Reports	TBD	40%	75%	100%
	83. % of LGA PHC Coordinator trained in data dissemination	Training Reports	TBD	40%	75%	100%
	84. % of LGAs publishing annual HMIS reports	HMIS Reports	TBD	25%	50%	75%
	85. % of LGA plans using the HMIS data	NHMIS Report	TBD	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	86. Proportion of public health facilities having active	SSHDP review report	TBD	25%	50%	75%

Community Participation in Health Development	committees that include community representatives (with meeting reports and actions recommended)					
	87. % of wards holding quarterly health committee meetings	HDC Reports	TBD	25%	50%	75%
	88. % HDCs whose members have had training in community mobilization	HDC Reports	TBD	40%	75%	100%
	89. % increase in community health actions	HDC Reports	TBD	10%	25%	50%
	90. % of health actions jointly implemented with HDCs and other related committees	HDC Reports	TBD	25%	40%	60%
	91. % of LGAs implementing an Integrated Health Communication Plan	HPC Reports	TBD	25%	40%	60%
PRIORITY AREA 7: PARTNERSHIPS FOR HEALTH						
Outcome 14. Functional multi partner and multi-sectoral participatory mechanisms at Federal and State levels contribute to achievement of the goals and objectives of the						
Output 15: Improved Health Sector Partners' Collaboration and Coordination	92. Increased number of new PPP initiatives per year per LGA	SSHDP Report	TBD	25%	40%	60%
	93. % LGAs holding annual multi-sectoral development partner meetings	SSHDP Report	TBD	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	94. % of LGAs partnering with researchers	Research Reports	TBD	10%	25%	50%
	95. % of State health budget spent on health research and evaluation	State budget	TBD	1%	1.50%	2%
	96. % of LGAs holding quarterly knowledge sharing on research, HMIS and best practices	LGA Annual SHDP Reports	TBD	10%	25%	50%
	97. % of LGAs participating in state research ethics review board for researches in their locations	LGA Annual SHDP Reports	TBD	40%	75%	100%
	98. % 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	99. % LGAs aware of state health research communication strategy	Health Research Communicatio n Strategy	TBD	40%	75%	100%