CROSS RIVER STATE GOVERNMENT

STRATEGIC HEALTH DEVELOPMENT PLAN
(2010-2015)

Cross River State Ministry of Health

March 2010

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List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante-Natal Care
AOP	Annual Operational Plan
ARV	Anti-Retroviral
ATBU	Abubakar Tafawa Balewa University
ATBUTH	Abubakar Tafawa Balewa University Teaching Hospital
BACATMA	Bauchi State Agency for the Control of AIDS, TB & Malaria
BASEEDS	Bauchi State Economic Empowerment & Development Strategy
BASICS	Basic Support for Institutionalizing Child Survival
BASSHDP	Bauchi State Strategic Health Development Plan
BEOC	Basic Emergency Obstetric Care
BMS	Breast Milk Substitute
CBO	Community Based Organization
CDAs	Community Development Associations
CEDPA	Center for Development & Population Activities
CEOC	Comprehensive Emergency & Obstetric Care
COMPASS	Community Participation for Action in Social Sector
CONTISS	Consolidated Tertiary Institutions Salary Structure
CIET	Community Information for Empowerment and Transparency
CIDA	Canadian International Development Agency
DOTS	Direct Observe Therapy Short course
DPHC/DC	Department of Primary Health Care and Disease Control
DRF	Drug Revolving Fund
EU-PRIME	European Union- Promoting Routine Immunization
FAO	Food and Agriculture Organization
FHI	Family Health International
FGN	Federal Government of Nigeria
FP	Family Planning
FMOH	Federal Ministry of Health
GHAIN	Global HIV/AIDS Initiative Nigeria
HATISS	Harmonized Tertiary Institution Salary Structure
HIV	Human Immuno-deficiency Virus
HMB	Health Management Board
HMIS	Health Management Information System
HRH	Human Resources for Health
HSDP	Health System Development Project
IDRC	International Development Research Centre
IMR	Infant Mortality Rate
IMCI	Integrated Management of Childhood Illness

ITN	Insecticide Treated Net
LGA	Local Government Authority
LLIN	Long Lasting Insecticide Net
MCH	Maternal and Child Health
MDA	Ministries, Departments and Agencies
MDG	Millennium Development Goals
MMR	Maternal Mortality Rate
MSS	Multi-Stakeholder System for Information and Planning
MTCT	Mother To Child Transmission
M&E	Monitoring and Evaluation
NDHS	National Demographic & Health Survey
NEHSI	Nigerian Evidence-based Health System initiative
NGO	Non-Governmental Organization
NHIS	National Health Insurance Scheme
NPHCDA	National Primary Health Care Development Agency
NPopC	National Population Commission
NSHDP	National Strategic Health Development Plan
OI	Opportunistic Infection
OOP	Out-Of-Pocket
OPV	Oral Polio Vaccine
ORT	Oral Rehydration Therapy
PHC	Primary Health Care
PITC	Provider-Initiated Testing & Counseling
PLWH	People Living With HIV
PMTCT	Prevention of Mother To Child Transmission
PPFN	Planned Parenthood Federation of Nigeria
PPP	Public Private Partnership
PRS	Planning Research and Statistics
RH	Reproductive Health
RI	Routine Immunization
SCD	Sickle Cell Disease
SFH	Society for Family Health
SHS	School Health Services
SMOH	State Ministry of Health
SOP	Standard Operating Procedure
SPHCDA	State Primary Health Care Development Agency
SSHDP	State Strategic Health Development Plan
STI	Sexually Transmitted Infections
TAG	Technical Advisory Group

TB	Tuberculosis
TFR	Total Fertility Rate
TSHIP	Targeted States High Impact Project
U5	Under-5
U5MR	Under-5 Mortality Rate
UNICEF	United Nations Children Funds
USAID	United States Agency for International Development
WB	World Bank
WHCMP	Ward Health Care Minimum Package
WHO	World Health Organization

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Acknowledgement

We most sincerely acknowledge the wonderful cooperation from the Honourable Commissioner for Health and other members of the Steering Committee. The LGA Chairmen of Ogoja and Ikom contributed in making the zonal trainings a success. The PRS, PHC, Supervisory Councillors of Health and M&E officers of all the 18 LGA contributed immensely in providing their activities. The State blue print 2009 – 2011 was adapted into the SSHDP and so we are grateful to all who contributed to its production but whose names have not been mentioned. The immense inputs from the Department of Maternal and Child Health, Abuja are highly appreciated. Lastly, the Consultant from Federal Ministry of Health, Dr Emmanuel N. Aguwa was very helpful in the development of the SSHDP.

Preface

Nigeria has undergone several health reforms in trying to implement health service delivery to her citizens. Some of these include the Basic Health Services Scheme (BHSS) and the Primary Health Care. Some of the reasons for the failure of BHSS were the lack of Community Participation and inter sectorial collaboration. The communities were not involved at the planning stages of the scheme and so they felt it was "government thing". Patronage/utilization of the health services became poor.

Presently, the country is adopting the PHC programme. One of the key principles of this programme, without which it will not succeed is community participation. Hence the introduction of the National Health Strategic Development Plan will encourage community participation. This is because its activities are derived from those of the communities (Local Government Area Strategic Health Development Plan, LGASHDP). Such activities from the communities when added up forms the State Strategic Health Development Plan (SSHDP). These SSHDPs from various states then help in developing the NSDP. This "bottom-top" approach has been observed to be crucial in achieving community participation. Another very important aspect of the SHDP is that it provides objective way of costing and identifying health priority areas for resource allocation especially at these periods of global recession. This will greatly improve health service delivery. Capacity is also developed at the local communities by involving the communities (LGASHDP) and consequently sense of ownership by the community which prior to now has been lacking.

Cross River State has imbibed the culture of planning and due process especially with the present government. Last year she adopted a "blue print" for strategic health planning for the years 2009 – 2011. This has been operationalized and some of the activities have already being implemented. So, with the NSHDP, every person is expected to key into this laudable plan as a very important component of not only strengthening the PHC but also improving health service delivery to our citizens.

Executive summary

> "Cross River State Aspires (By 2020) To Be The Leading Nigerian State With Prosperous, Healthy And Well Educated Citizens, Living In Harmony With People And Nature And Pursuing Their Legitimate Interests In Freedom Moderated By Good Governance"

Cross River State is in the South-South Geopolitical Zone of Nigeria with Calabar as the capital. It has eighteen Local Governments areas with a projected 2006 *2,888,966, with 1,492,465 males and 1,396,501 females (Census 2006).* Additionally there are 196 political wards in the State. The State shares common boundaries with Cameroon Republic in the East, Benue State in the North, Enugu and Abia States in the West and the Atlantic Ocean and Akwa Ibom State in the South

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There are many languages in the State with English as the official language. The vegetation varies from tropical rain forest in the south and savannah in the north.

The people of Cross River are predominantly farmers and fishermen with a few petty traders and civil servants. The main sources of State income are from federal subvention, oil producing areas derivation fund (currently in controversy), income taxes from few companies and large quantities of limestone in Akamkpa LGA

In order to reposition the State as an economic giant the State Government has embarked on an aggressive economic transformation underpinned by Tourism and Agricultural development.

The decay in PHC services delivery and the overall functioning of the health system in Cross River State has over the years led to the poor health status of people of the State.

Available data on disease specific morbidities shows that Cross River State has a malaria prevalence of 19.8% (NDHS 2008), TB prevalence of 73/100,000 (Annual TBL report 2006), and a HIV prevalence of 8%.

While the malaria prevalence is low compared to regional and national averages, this is still a high burden in relation to national and international goals and targets. Measures of access to health care services in the state including antenatal care (68%)births assisted by a skilled provider (44%); births delivered in a health facility (39%); percentage of children 12–23 months who fully immunised (38%); contraceptive prevalence rate (16.0%) among others, shows that health services coverage are unacceptably low.

However the state has also recorded some important achievements which include: development of policies and laws to promote Primary Health Care; renovation of 130 Health Centres across the State; Successful take off of Project HOPE & Project COMFORT(A project designed to offer financial assistance to people living below the poverty line/provision of free health care to pregnant women and under five children); Establishment of 12 additional voluntary counseling and testing (VCT) centres across the state, bringing the total from 42 in 2007 to 54 in 2008; improved ICT infrastructure in all 18 LGAs; has established and sustained a Free Eye Care Programme to provide service to the blind and partially blind and recorded over 12,000 surgeries in 2008; increased average coverage from the 18 Local Government Areas to about 84%; established there (3) zonal offices of Food Safety and Inspection Services (FSIS) established – one each at Ogoja, Ugep and Calabar; and has aggressively pursued the roll back malaria programme by providing large quantities of ATCs, ITNs and Sulphadoxine-pyrimethamine (for IPT) to all LGAs.

However despite these efforts several bottlenecks are encountered in delivery of health services in the state. These include: inadequate community based personnel, inadequate sensitization/lack of IEC materials, and paucity of data and non equitable distribution of materials to the communities. Others include: government dependent on development Partners, political bias, poor M & E, poverty and ignorance and lack of political will.

This plan seeks to overcome most of these bottlenecks in order to improve the availability, accessibility, demand, and efficient utilization of a set of evidence based, high impact health interventions contained in the State's Minimum Package of Care, in order to significantly improve the health of the people of Cross River State.

The Minimum Health Care Package (WMHCP), consists of a set of health interventions and services that address health and health-related problems that would result in substantial health gains at low cost to government and its partners. Cross River State has adopted and adapted the interventions within this package to suite its peculiar health needs.

In order to deliver the package of care, Cross River State will: revise and cost its minimum package of care, revise and implement the state's blue print on PHC; develop and implement a *Clear and sustainable financing framework for health services* which will ensure increase budgetary allocation to health to 7.5% of the state's annual budget; and reactivate and sustain the Bamako initiative programme as the core element of drugs and consumables management system for the state among others.

Following the framework of the National Strategic Health Development Plan (NSHDP), the Cross River State SSHDP has been set out in Eight Priority Areas. However, based on the situation analysis and the unique strengths and weaknesses of the state in the various departments that comprise the health sector, the Cross River planning team re-ordered the Eight Priority Areas of the NSHDP in order of greatest importance as follows:

1. Health service delivery
2. Human Resources for Health
3. Finance for Health
4. National Health Management Information System
5. Research for health
6. Leadership and governance for health
7. Partnership for health
8. Community participation

Implementation of the Cross River SSHDP will be a joint responsibility of the the State and Local Governments, private health care providers, health development partner agencies working in the State, Communities, Civil Society Organizations, and Non-Governmental Organizations. The State and the LGAs will provide leadership in the coordination of the activities of these various players to ensure efficiency.

Cross River State will make use of the sub-national M&E framework that has been developed to monitor implementation of the SSHDPs, while adapting it to suit the state's identified strategic health priorities. This will involve increased personnel, improved internet serves for real-time situation report, offices in each LGA that are well equipped for documentation and vehicles to ease mobility. There is increased need for GIS especially in disease monitoring.

The evaluation will be a time bound exercise that will assess systematically the relevance, performance and success of ongoing and completed programmes. It will determine whether or not inputs into an operation have been effectively utilized to produce results

Vision and Mission

Vision Statement: To have the best quality and most accessible health care services that addresses Public Health issues in Nigeria

Mission Statement

To create and sustain a professionally run health service that will deliver the best possible care to the people of Cross River State nearest to where they live and work.

Chapter 1: Background and Achievements

Background

Cross River State is one of the 36 States of the Federal republic of Nigeria. The political evolution of Cross River State started during the colonial era, when Calabar and Ogoja served as the administrative headquarters of Calabar and Ogoja provinces respectively. On the 27th of May 1967, the two provinces, excluding the Igbo –speaking areas, were carved out of the then Eastern Region of Nigeria by the General Gowon Military Administration to form South Eastern State. When the Nineteen States structure came into effect in 1987 the South Eastern State was renamed Cross River State. The present Cross River State came into being on the 23rd of September, 1987, when the then military administration again restructured the country from its nineteen states structure to twenty-one, Akwa Ibom State was carved out from the old Cross River State.

Cross River State is located within the tropical rain forest belt of Nigeria. It lies between latitude 4º28' and 6º 55' North of the equator and longitude 7º50' and 9o28' East of Greenwich Meridian. It shares common boundaries with Republic of Cameroun in the East, Benue State in the North, Ebonyi and Abia States in the West, Akwa Ibom State in the Southwest and the Atlantic Ocean in the South. It has a total landmass of about 23,000 square kilometers. The State enjoys a tropical climate with the Obudu Plateau at an altitude of 1,595.79 meters above sea level and a temperate climate. Cross River records heavy rainfall during the wet season (April – November). At least five distinct ecological zones are represented in the State ranging from mangrove and swamp forests towards the coast, tropical rain forests further inland, and savannah woodlands in the northern parts of the State. The favorable climate of tropical, humid, dry and wet seasons, gives rise to rich agricultural lands that encourage both perennial and annual crop cultivation.

In February 2000, both the Private Specialist Group (PSG) and the Species Survival Commission (SSC) recognized Cross River State to be home for gorilla (gorilla diehil), as distinct and critically endangered subspecies. It is considered the rarest and most endangered subspecies of gorillas. With an estimated total population of 250 individuals, the Cross River gorilla is rarer than the Mountain gorilla of the Virunga's in east Africa. Eighty-five (85) tree species belonging to 68 genera and 26 families considered endangered by the Forestry Research Institute of Nigeria are found in the forest of Cross River State. The state is also blessed with crystalline and other identified mineral resources such as limestone, zinc, manganese, gypsum, barites, uranium and mica, most of which are yet to be exploited.

Achievements

The following are some of the numerous achievements recorded in the health sector:

- Development of Cross River State Primary Health Care Blue Print
- Development of draft Law for CRS Primary Health Care Development Agency
- Renovation of 130 Health Centres across the State
- Distribution of computer sets to the 130 renovated health facilities
- Participation in 3 rounds NIPDs
- Conduct Mop – up Immunization in wild polio high risk LGAs
- Inauguration of PHC Council
- Successful take off of Project HOPE & Project COMFORT(A project designed to offer financial assistance to people living below the poverty line/provision of free health care to pregnant women and under five children)
- Successful take off of GAVI (Global Alliance for Vaccine Initiative) Project
- Benefited from EU PRIME MPP6 programme.
- Establishment of 12 additional voluntary counseling and testing (VCT) centres across the state, bringing the total from 42 in 2007 to 54 in 2008.
- Training of Public Health Care (PHC) workers on HIV counseling and testing, prevention of stigma against PLWA in and out of Hospitals, Traditional Birth Attendants (TBAs) in Ikom, Yakurr and
  Akamkpa on basic counseling skills and Prevention of Mother To Child Transmission (PMTCT) of HIV during delivery.
- To enhance mobility and performance for effective Health Care Services Delivery, government procured and distributed 19 Ford/Hilux Ranger Pick-up vehicles for Medical Superintendents, some programme managers and Principals of Schools of Nursing/Midwifery.
- In partnership with the MDGs office in Abuja, massive renovation of 130 PHCs across the State including the provision of equipment, motorized boreholes and solar lighting has been undertaken and will be commissioned soon.
- In order to have a robust database for an effective health care delivery system, government in collaboration with the MDGs OFFICE in Abuja trained 557 Health workers (both public and private) responsible for data collection in our health facilities on ICT/Health management information system (HMIS).
- To further improve service delivery, 219 desktop computers with accessories have been purchased for distribution to all the (196 political wards) Health Centres (one each), 18 to M & E in 18 LGAs and 5 for the Department of PRS in the Ministry's Headquarters.
- The Free Eye Care Programme continued to provide service to the blind and partially blind and recorded over 12,000 surgeries in 2008.

- Routine Immunization coverage rate has been scaled up. The average coverage from the 18 Local Government Areas is about 84%.
- Various staff welfare schemes were introduced to motivate the Health Workers and to reduce the internal „Brain Drain" in the sector: this includes, In-service training, promotions, scholarship awards and increased pay.
- In order to regain accreditation requirement for our six (6) schools of Nursing/Midwifery for training of new students, government released funds for the upgrading of facilities including renovation work, Supply of equipment, vehicles and furniture.
- Government is committed to providing access to affordable health care services across the State. To meet Government desire for the provision of Free Health Care Services promised the people, all the secondary health facilities (Hospitals) in the State are undergoing upgrading of facilities. Funds have also been released for the completion of 6 on-going general-hospital projects.
- Essential Drugs Programme (EDP) continued to enjoy the support of the Administration in ensuring a steady provision of drugs in our health facilities across the state.
- The College of Health Technology, Calabar, which provides middle level man-power for our PHC programmes has undergone massive renovation, up-grading of facilities, and has procured vehicles to ease staff and students movement.
- There (3) zonal offices of Food Safety and Inspection Services (FSIS) were established – one each at Ogoja, Ugep and Calabar.
- In line with statutory requirements, the Departments of Medical, Pharmaceutical and Inspection Services intensified their routine inspection services to ensure that private clinics/hospitals, pharmacies/patent medicine stores and hospitals in the state met regulatory standards.
- To expand the State health services horizon, the State government is partnering with the UCTH for the establishment of a school of Post Basic ENT Nursing.
- Nurses, pharmacists and other cadre of Health workers considered under the new national treatment policy.
- About 36 doctors, 150 nurses and 250 primary care health workers from Health facilities across the State have accordingly been trained. Over 180 role model mothers have also been trained.
- Also during the year under review, 208,000 doses of coartem and 5,670 doses of Larimal (all ACTs) donated by Global fund and the Federal Ministry of Health respectively were distributed to all the public health facilities for effective case management.
- Similarly, 36,833 pieces of Long Lasting Insecticide treated nets (LLINs) donated to the State were distributed in Yakurr and Ogoja LGAs using stand alone method. 35,000 pieces of LLINs donated by USAID/Nets mark were equally distributed in Ikom and Odukpani LGAs this year. Only recently, we received additional 560,000 LLINs from the

Canadian Red Cross for distribution to our people. This is the single largest donation to any state in the country.

- During the year, 7,555 doses of Sulphadoxine Pyrimethamine (SP) were also distributed to Health facilities across the state for Intermittent
- Preventive Treatment (IPT) with Sulphadoxime Pyrimethamine (SP). About 36 doctors, 150 nurses and 250 health care providers were trained in Intermittent Preventive Treatment (IPT) using Sulphadoxime Pyrimethamine (SP).
- Aggressive environmental campaign against malaria through capacity building of health workers across the State were also carried out, while indoor/out door spraying of government lodges, public office premises and even private quarters are even now being carried.

Chapter 2: Situation Analysis

Socio-economic context

In 2006, Cross River State was estimated to have a population of 2,888,966, with 1,492,465 males and 1,396,501 females (Census 2006). Cross River is one of the fastest growing states in Nigeria. Its main and growing economic sector is agriculture, which accounts for approximately 42 percent of State GDP (2005). Other major sources of income are from federal subvention, oil producing areas derivation fund (currently in controversy), income taxes from few companies and large quantities of limestone in Akamkpa LGA

The state is the largest producer of palm oil in Nigeria and also produces sizeable amounts of rice and cocoa. The country's cultural heritage and natural beauty has helped to make tourism a leading sector, with 61 registered hotels and 226 registered restaurants. Cross River has oil and gas deposits, some under development, and supplies services to the oil and gas industry. Almost all industrial output is manufactured in Cross River's Export Promotion Zones.

The business climate in Cross River State has improved significantly with ongoing efforts to upgrade Cross River's infrastructure and adopt investment-friendly policies. These reforms, coupled with the state's advantageous location, many natural resources, and its reputation for being a peaceful place makes Cross River State a prime location for investment.

The state's economy is dominated by the public service, which has about 20,000 employees on its payroll. The private sector is relatively under-developed and is dominated by activities in the informal sector. The public sector has been the prime mover of major activities in the economy. This is the case despite attempts by previous administrations to privatize government enterprises and promote private investment.

The status of social determinants of health in Cross River State shows the relative poor health status of the people of the state. As shown in table 1, for all the determinants, Cross River State consistently has rates that are lower than regional averages.

Table 1 Social Determinants of Health

Socioeconomic determinant	State (%)	Regional (%)
Literacy (male)	79	89
Literacy (women)	70	78
Percentage of households with an improved source of drinking	26	59
Percentage of households with improved (not shared) sanitary facility	10	22
Percentage of households with electricity	32	56

State Development Challenges

In spite of the relatively impressive social and human development indices, Cross Rivers is still a poor state whose potential has not been fully utilized. Some of the challenges include:

- Weak industrial base and low rate of investment have rendered economic resources of the state largely underutilized.
- A large percentage of the population lives in abject poverty. Over 70 percent of the population is living below the national poverty line.
- Patronage of the various tourism sites in the state has remained low compared to what is obtained elsewhere in the world.
- Socioeconomic progress is depressed by poor infrastructure for communication, transportation, electricity supply, and water supply and sanitation. Intrastate and interstate communal conflicts.
- Health care delivery is still below the international average standards.
- Education standards and school enrolment are consistently declining.
- Inadequate entrepreneurial skills and a weak private sector economy.
- Lack of indigenous technical capability needed to stimulate investment and competition within the State economy.
- Abundant and untapped natural resources backed up by an underutilized resourceful people.

- Immature public-private sector synergy. Inadequate Funds for industrial development projects and weak capacity for internally generated revenue (IGR) (http://crossriverstate.gov.ng

2.2 Health status of the population

The demographics in Cross River State shows that women and children under 5 who are the most vulnerable, constitute 22% and 20% of the total population of the state respectively. The poor performance of the PHC services and the overall functioning of the health system in Cross River State has over the years led to the poor health status of people of the State.

Health indicators such as maternal (2000/100,000), Under-five (176/1000) and infant (120/1000) mortality rates ranks CRS amongst the States with the highest maternal and child death in Nigeria. Considering that women constitute 22% and under five children 20% of the total population of the state, this implies that the health system was failing them. Common causes of the high maternal mortality are post partum and ante partum haemorrhages, pregnancy induced hypertension, eclampsia, anaemia, sepsis and malaria in pregnancy. While the common causes of infant mortality rates include preventable diseases such as malaria, measles, malnutrition, diarrhoea and pneumonia.

Available data on disease specific morbidities shows that Cross River State has a malaria prevalence of 19.8% (NDHS 2008), TB prevalence of 73/100,000 (Annual TBL report 2006), and a HIV prevalence of 8%. More of the health status indicators for the state from the NDHS 2008 are presented in the table below.

POPULATION (2006 Census)	CROSS RIVER
Total population	**2,892,988**
female	1,421,021
male	1,471,967
Under 5 years (20% of Total Pop)	372,909
Adolescents (10 – 24 years)	676,070
Women of child bearing age (15-49 years)	764,359
INDICATORS	**NDHS 2008**
Literacy rate (female)	70%
Literacy rate (male)	79%
Households with improved source of drinking water	26%
Households with improved sanitary facilities (not shared)	10%
Households with electricity	32%
Employment status (currently)/ female	69.8%
Employment status (currently)/ male	84.7%

POPULATION (2006 Census)	CROSS RIVER
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female	1,421,021
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Under 5 years (20% of Total Pop)	372,909
Adolescents (10 – 24 years)	676,070
Women of child bearing age (15-49 years)	764,359
INDICATORS	**NDHS 2008**
Total Fertility Rate	5.4
Use of FP modern method by married women 15-49	16%
Ante Natal Care provided by skilled Health worker	68%
Skilled attendants at birth	44%
Delivery in Health Facility	39%
Children 12-23 months with full immunization coverage	42%
Children 12-23 months with no immunization	16%
Stunting in Under 5 children	32%
Wasting in Under 5 children	6%
Diarrhea in children	6.7%
ITN ownership	16%
ITN utilization (children)	16%
ITN utilization (pregnant women)	14%
children under 5 with fever receiving malaria treatment	20%
Pregnant women receiving IPT	12%
Comprehensive knowledge of HIV (female)	86%
Comprehensive knowledge of HIV (male)	93%
Knowledge of TB (female)	37.0%
Knowledge of TB (male)	34.0%

While the malaria prevalence is low compared to regional and national averages, this is still a high burden in relation to national and international goals and targets.

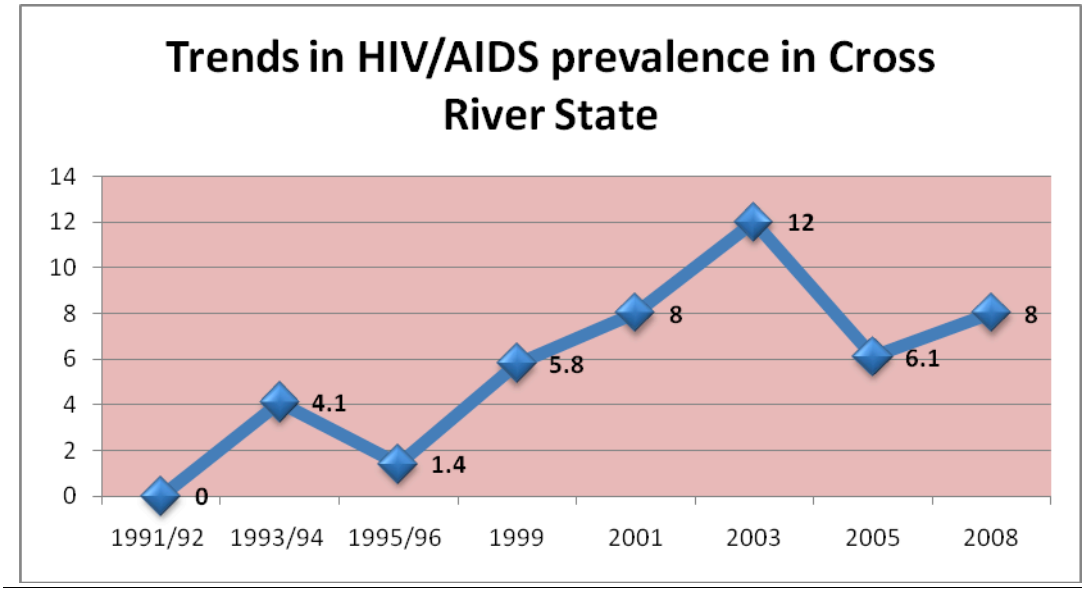

Table 2 Trends in HIV/AIDS Prevalence in Cross River State

Source of data: FMoH 2008 ANC Sentinel Survey

The HIV prevalence of 8% is the highest in the country, and the increaasing trend in HIV prevalence in the state is worrisome and therefore makes HIV control a major priority area for the state ministry of health.

2.3 Health services provision and utilization

In line with the provisions of the National Health Policy, the Cross River State Government is responsible for providing secondary health care services, while the local governments in the state are responsible for providing primary health care services. The Federal Government is responsible for providing tertiary healthcare services in each state. The complement of these, including the services provided by the private sector depict the availability of health services in each state.

Measures of access to health care services in the state shows the following coverages: antenatal care (68%)births assisted by a skilled provider (44%); births delivered in a health facility (39%); percentage of children 12–23 months who fully immunised (38%); contraceptive prevalence rate (16.0%) among others.

Except for ANC with has a coverage of nearly 70%, the coverage of most of these interventions, are too low to contribute any significant improvement in the health status of the people of the state. These is therefore need to strengthen the state's health system in order to improve the coverage of these and other services to near universal coverage.

2.4 Key issues, challenges and proposed action

Efforts by successive governments to achieve sustainable improvement in the health indicators of the State have been short lived because of lack of sincere political commitment. Invariably, most components of PHC have been implemented vertically with donor support without sustainable State mechanisms leading to a progressive decay of infrastructure with overworked and de-motivated staff.

Governance and Leadership

2.4.1 Statutory and policy framework for PHC in the state

Issues: The state lacks any policy or statutory instrument that clearly outlines the boundary, institutional framework and financing of PHC in the state. This has over the years seen the State and the LGAs without the necessary legal and policy frameworks to effectively define the operational and relational architecture within and between the state and the LGAs. In addition the lack of defined accountability and weak communication/information flow between State Ministry of Health and Local Government PHC Offices has limited the effectiveness of the overall health system. This blurring of institutional and operational accountability have seen LGA Chairpersons often shirk their statutory responsibility of leading and managing the PHC level of the healthcare system.

The lack of management structures at LGA, ward and community levels, indicative of the weak stewardship over many years have constrained the effective functioning of the nationally recommended Ward Health System (WHS)

Proposed Actions: The recently constituted CRS PHC council with His Excellency the Governor as chairperson will over the short term be institutionalized with an enabling law passed by the State House of Assembly. It will act as the highest leadership organ for PHC in the state: bringing the LGA and the State together under a common vision and providing the platform for harmonization in the design, financing, service delivery and accountability of the PHC system.

The process of institutionalizing the PHC council will recognize various operating organs needed for the effective function of the council. These include:

- the Technical PHC Committee and the International Development Partner's coordinating forum (convened by the Special Assistant to the Governor on IDS) at state level
- LGA PHC committee
- Ward PHC committee
- Village development Committee

- Health Facility Management Committee.

The enabling statutes for the state PHC will spell out the functions of each of these levels and how they will be funded and the overall accountability flow. The enabling law will also spell out relational issues amongst the stakeholders involved in the actualization of PHC and make partnership management easier.

Health Care Financing

2.4.2 Clear and sustainable financing framework for health services

Issues: The lack of political will for many years to support health service delivery and strengthen the health system is reflected in the limited budgetary commitments over the years. This poor and irregular nature of health funding has contributed significantly to the near complete crippling of the delivery of health services. This has resulted in a situation where the bulk of financing of the sector is now mostly donor driven. Even when budgetary allocations are made for health, these are often not released making coherent planning and implementation processes difficult. The lack of floats to health facilities to meet recurrent costs on a regular basis makes the system dysfunctional and even major equipments are left idle because of the inability to buy basic consumables needed to run them. There is also no budgetary provision for health promotion, media and community support activities.

Proposed Actions: There should be increased budgetary allocation to health. It is proposed that 7.5% of the State budget will be allocated as a first line charge to PHC. In addition, Each LGA will allocate 5% of their budget to PHC (outside staff cost). International development partners working in the state will align their support to the state and ensure that it is captured within the broad budgetary estimates on a yearly basis.

Health Services Delivery

2.4.3 Organization of Services and effective Referral system

692 health facilities comprising of 2 tertiary health care facilities in Calabar Municipality and Calabar South, 15 secondary health care facilities (general hospital) in 10 out of the 18 LGAs, 8 comprehensive health care centres in 6 out of the 18 LGAs; 5 LGAs have neither a general hospital not a comprehensive health care centre; 95 primary health care centres, 174 health centres, 271 health posts and 118 patent medicine vendors. However these are not disaggregated into ownership.

Issues: Management and organisation of health services in the state up till now has been disorganised, disjointed and lack any clear shared vision. There is overstaffing and under-

utilization of health staff of LGA. There is also very poorly implemented Drug Revolving Fund strategy and Essential Drugs Programme services often are not available on a 24 hours basis at village level. The organization of services has no provision for vulnerable group such as mothers, infants and children.

Programmes such as immunisation, HIV/AIDS and maternal and child health initiatives are often supported by donors or National level effort and they tend to be poorly integrated into routine management processes. The bulk of health resources with the exception of the human resource cost tend to thus operate outside the regular budgetary system. This raises issues on the sustainability of many of these Primary Health Care initiatives. Finally a good referral system is the backbone of an effective health service delivery system. The State up till now lacks an effective ambulance service.

Proposed Actions: The state will adopt the Ward Health system (Tulsi Chanrai model) of PHC and adapt it to the peculiar circumstances in the state. Four (4) LGAs will form part of the inception phase of the State Blueprint of 2009 - 2010. Lesson and experience from the annual joint review in mid 2010 will be used in expanding to seven (7) more LGAs. Final seven (7) LGAs will be phased in by 2011.

The PHC Strategy to be phased as described above will see Junior Community Health Extension Workers (JCHEW) actively managing 300 households on an ongoing basis (including scheduled home visit and service delivery at the Health Post). The Senior Community Health Extension Workers (SCHEW) working out of a Health Centre will provide ongoing supervisory support to four-ten (4 – 10) Health Post. Four to ten health centre will in turn be supported by a PHC centre with a minimum of one doctor and four nurse/midwives.

2.4.4 Provision of new and/or renovation of dilapidated infrastructure and equipment

Issues: The state health system is replete with dilapidated structures and facilities which are not enough to meet the national objective of at least 1 facility to 10,000 – 20,000 people. Table 3 gives a profile of the number of facilities in the state starting from 271 Health Post up to 95 PHC centres as at January 2009 for the population of about 3 million Cross Riverians. Most existing facilities have not had a face lift for a long time before the present government refurbishment programme. Many of the health facilities are in poor state of repair, with little or no equipment, and are often not fenced. The latter is important considering cases of breakage and vandalisation of equipment. Basic utilities like water, electricity and sewage system are non functional. Even where provisions were made initially for these services, non payment of utility bills often leads to the providers withdrawing their services. An analysis of the problem of infrastructures show that in the majority of cases, there is no mechanism for ongoing maintenance of these facilities and there is no standing plan to meet recurrent cost of paying utility bills.

There is no provision of accommodation for Health Staff at the health facility. Considering transportation bottlenecks in many communities, staff are rarely available to respond to the needs of the many obstetric clients who often presents in the night. This worsens the outcome for such clients. Ideally Health workers should be provided with accommodation at the health facility or at the least live in the community within 10-20 minutes walking distance from the health centres/posts.

Community based Essential Drug Programme (Bamako Initiative-BI) is not working effectively because of the lack of community ownership. In addition, the lack of proper storage facilities including an efficient Cold chain continues to weaken the provision of quality drugs.

Proposed Actions: The ongoing renovation of health facilities will be continued till mid 2010 and all completed facilities will be equipped before the end of 2010. In order to meet the desired design of the state PHC system, communities will provide designated health post and accommodation for Junior Community Health Extension Workers (JCHEW) that will be deployed to that level of the care system. A mechanism will be set up for ongoing maintenance of health facilities. This will be in the form of a recurrent monthly float to be managed by the relevant PHC committee at that facility. Such float will be used to pay utility bills and carry out scheduled routine maintenance of such facilities. The SMOH and State drug programme will devise mechanism in partnership with the LGAs to reactivate and sustain the Bamako initiative programme as the core element of drugs and consumables management system for the state to improve health service delivery at the community level.

Human Resources for Health

2.4.5 Retraining, reorientation and appropriate use of existing human resources

Issues: Multiple human resource factors limit performance at the PHC level. These include shortages of Medical Officers, Midwives, Laboratory Technicians, Medical Records Officers and Community health workers (CHW). In addition, mal-distribution of the staff, particularly in favour of the urban area result in the rural areas lacking appropriate staffs while a glut of staffing occurs in urban areas.

The skills of healthcare workers need to be improved to align with changing trends in care delivery. Many staff for example lack basic computer and data management skills. There is the need for the re training of all health workers on a continuous education basis. In the case of JCHEWs and Traditional Birth Attendants, their training needs to be better coordinated in order to improve referrals/linkages with local health facilities as part of their training and mentoring programme. Health Workers need to be retrained on the use of Standing Orders and national protocols. Lack of supportive supervision by the SMOH has over the years resulted in the erosion of the morals of PHC staff.

Proposed Actions: In the short term, to kick start the operation of this ward health system, structured three week training will be provided to the various levels of health care workers in the chain. The JCHEW will be trained on the operations of the WHS, home visitation, data collection methods, growth monitoring, mobilization for immunization, pregnancy, monitoring treatment of minor illness, referrals, Reproductive Health and environmental sanitation, and control of endemic diseases, while SCHEW will be trained on operation of the WHS, home visitation, data collection methods, supportive supervision, routine immunisation, identification and treatment of childhood illness, pregnancy monitoring, normal deliveries and referral system. PHC programme functionaries at State level will also be trained on the functioning of the WHS, data management, supporting evidence based planning and programme management. A longer term structured human resources development plan will be put in place. All trainings from all the PHC programmes from the state will be coordinated and delivered in one structured training every year.

Partnerships for Health/Community Engagement

2.4.6 Partnership Management

Issue/Actions: Community participation in health governance and management

Community involvement is a key prerequisite for strengthening the demand element of PHC. Weak community involvement and the attendant lack of ownership have over the years seriously impaired the responsiveness of PHC to the needs of communities.

Chapter 3: Strategic Health Priorities

Cross River State has developed strategic health priorities in line with those of the National Strategic Health Development Plan. While maintaining the 8 strategic health priorities in the NSHDP namely: Leadership and governance for health; Health service delivery; Human Resource for Health; Finance for Health; National Health Information System; Community participation; Partnership for health; and Research for health, the state has re-prioritized these to reflect its own peculiarities as follows:

Table 3 Strategic Health Piorities

S/N	Priority Health Area
1	Health service delivery
2	Human Resources for Health
3	Finance for Health
4	National Health Management Information System
5	Research for health
6	Leadership and governance for health
7	Partnership for health
8	Community participation

Furthermore, a number of strategic interventions for each of these strategic health priorities have been identified by the state planning team as shown in annex 1.

For emphasis on health service delivery, which is the area of highest priority for the state, a n essential package of care was also identified by the planning team. These are evidence based high impact interventions which when their coverages are significantly scaled up, contribute significantly towards improving the health of the people. The essential packages of care is shown below.

State Minimum Package of Care

The Ward Minimum Health Care Package (WMHCP), consists of a set of health interventions and services that address health and health-related problems that would result in substantial

health gains at low cost to government and its partners. Cross River State has included the following ward minimum health care package in its SSHDP:-

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 Resource

The State requires many more manpower to occupy various health positions.

Medical doctor: The State needs to employ a doctor in each of the 18 LGAs as the Medical of Health. Then at least two more doctors are needed for each of the 17 General hospitals in the State. This makes it a total of at least 52 doctors.

Specialist doctors: These are needed in various fields especially with the Specialist Hospital that will be constructed by next year.

Other health staff needed include: Nurses – 61, Lab. Tech – 189, Pharm. Tech – 175, CHEW-965, M&E- 392, Physiotherapists - 17

4.2 Physical/Materials – Building and reconstruction of health facilities are required. These should also be equipped to provided needed services e.g. Emergency Obstetric Care, Renal dialysis Unit, Cardiology Unit and Radiotherapy Units.

4.3 Financial: the State is in great need of financial assistance. There is much financial gap between amount needed to carry out health activities and amount provided to health.

Chapter 5: Financing plan

5.1 Estimated cost of the strategic orientations: The estimated cost of the strategic orientations is NGN **88,159,307,877.** This is presented according to each priority area below.

Priority Area	Estimated Cost (2010-2015)
Leadership And Governance For Health	881,593,079
Health Service Delivery	43,924,622,484
Human Resources For Health	23,143,116,702
Financing For Health	15,361,213,679
National Health Information System	1,322,389,618
Community Participation And Ownership	881,593,079
Partnerships For Health	881,593,079
Research For Health	1,763,186,158
Total	**88,159,307,877**

5.2 Assessment of the available and projected funds: The available and expected funds for the six year activities is calculated as follows:

Table 4 Financing Plan

A	**Year 2008 budget to Ministry of Health (Cross River State)**	**N8,305,581,779**
B	Projected budget for 2010 to 2015 (6 years) = N8,305,581,779 x 6	49,833,490,674
C	Addition of possible inflation = N8,305,581,779 x 6 x 15%	7,475,023,601
D	Projected budget for the 6 years (2010 – 2015) = B + C	57,308,514,275

5.3 Determination of the financing gap

Expected financial gap is: expected expenditure minus the expected available funds.

i.e. NGN 88,159,307,877 - N57,308,514,270 = NGN 30,850,793,602

5.4 Descriptions of ways of closing the financing gap

The various ways the State expects to close the financial gap include:

a. Financial intervention from Federal Government
b. Increased allocation by State Government to Health
c. Increased participation from NGOs and other multi-national agencies
d. Increased involvement of the private sector and other philanthropists.

Chapter 6: Implementation Framework

Implementation of the Cross River SSHDP will be a joint responsibility of the the State and Local Governments, private health care providers, health development partner agencies working in the State, Communities, Civil Society Organizations, and Non-Governmental Organizations. The State and the LGAs will provide leadership in the coordination of the activities of these various players to ensure efficiency. The following have played, and some are still playing, major roles in health care delivery in the State

Table 5 Framework Implementation

Agency	Role in health care
WHO	Funds, etc.
World Bank	Funds
ICAP	HIV management
CIDA	Technical Assistance
GAVI	Funds
UNICEF	Funds/Technical Assistance
GLRA	Drugs and logistics
GHAIN	Structural development

Chapter 7: Monitoring and Evaluation

7.1 Proposed mechanisms for monitoring and evaluation

The availability of accurate, timely, reliable and relevant health information is the most fundamental step towards informed public health action. This underscores the fact that Monitoring and Evaluation (M and E) stands out as an essential component necessary for achieving success in implementing the Ward Minimum Health Package. M and E are essential management functions that are interactive and mutually supportive. Both are crucial for the attainment of a sustainable Primary Health Care system.

Monitoring is a continuous function that aims to provide programme implementers with early indication of progress or lack of it in the achievement of programme objectives. Monitoring enables a manager to identify and assess potential problems or success of a programme. The requirements for effective monitoring include baseline data, indicators of performance, supervisory reports as well as planned actions such as field visits and meetings. It therefore makes it necessary for effective M and E to be instituted so that routine data collection, collation, analysis & interpretation, can be undertaking and immediate responses designed and provided to the programme for action. The state M&E officer shall be strengthened with modern IT equipment to handle all data from different partners and programmes especially with NEHSI.

Evaluation will be a time bound exercise that will assess systematically the relevance, performance and success of ongoing and completed programmes. It will determine whether or not inputs into an operation have been effectively utilized to produce results. The M&E framework shall follow a cycle of baseline survey, Annual Work plan development and periodic supervision and review meetings.

Cross River State will make use of the sub-national M&E framework that has been developed to monitor implementation of the SSHDPs, while adapting it to suit the state's identified strategic health priorities.

The State M & E frame work will also monitor the implementation of the 113 indicators from result matrix developed as follows from 2010 to 2015 with provision for reviews:

Priority Area 1: Leadership and Governance for Health - 21 indicators;

Priority Area 2: Health Service Delivery with 45 indicators;

Priority Area 3: Human Resource for Health - 15 **indicators;**

Priority Area 4: Financing for Health - 9 indicators;

Priority Area 5: NHIS 8 indicators;

Priority Area 6: Community Participation and Ownership 6 indicators;

Priority Area 7: Partnership for Health – 2 indicators;

Priority Area 8: Research for Health – 6 indicators;

This will involve increased personnel, improved internet services for real-time situation report, offices in each LGA that are well equipped for documentation and vehicles to ease mobility. There is increased need for GIS especially in disease monitoring.

7.2 Costing the monitoring and evaluation component and plan

This has been done in the log frame. Each intervention will have to be monitored and evaluated by the M&E Unit of the Ministry of Health and LGA M&E units. Cost estimate will include: furnishing of offices – 2.4 million; vehicles (3 Hilux vans) – 15 million (5 million each); motorcycles – 1,800,000 (100,000 each for the 18 LGAs); computers – 3 million (20computers-1 for each LGA and 2 at headquarter); Internet provider – 15 million; Personnel – 5,880,000; DTA – 7,200,000 (for the 6 years), Consumables – 6 million. All amounts are in Naira.

Chapter 8: Conclusion

Cross River State is in the right path to improving health care delivery. There is the political will and commitment to succeed. With the SSHDP the State hopes to achieve the MDG 4,5 and 6. What is now required is increased funding to the health sector, improved monitoring and evaluation, inter-sectoral collaboration, improved Public-Private Partnership and very importantly, community participation.

Table 6 State Strategic Health Development Priority Areas for 2010 Activities

Priority areas	Operational Activities for 2010	Average Score (Ranking)
1	Implementation of Zonal Health Management Policy	2.5 (11th)
1	Ministerial Due process	3.2 (4th)
2	Establishment of CRS PHC development agency	3.5 (1st)
2	Establishment of a Renal Dialysis Unit in the General Hospital Calabar	3.5 (1st)
2	Provision of maternity complex in radio-diagnosis center in General Hospital Calabar	3.5 (1st)
2	Control of Communicable Diseases	3.4 (2nd)
2	Strengthening Directorate of Pharmaceutical services	3.4 (2nd)
2	Strengthening task force on counterfeit and fake drugs	3.4 (2nd)
2	Strengthening implementation of Integrated Maternal New Born and Child health	3.4 (2nd)
2	Strengthening of clinical governance	3.3 (3rd)
2	Construction of House Officers Quarters (phase 1) in General Hospital Calabar.	3.3 (3rd)
2	SERVICOM: Improve services through SERVICOM	3.3 (3rd)
2	Payment of Honorarium to outreach for 10 nurses, 10 pharmacists, 1 physiotherapist and 8 medical consultant	3.3 (3rd)
2	Consultancy fee for State Ministry f Health (SMOH)	3.2 (4th)
2	Construction of Ministry of Health Annex/Furnishing	3.2 (4th)
2	Equipping of six hospitals at Okem (Odukpani), Efrraya (Etung). CRS participation at National Council on Health (NCH)	3.2 (4th)
2	Strengthening drugs revolving fund (DRF) operation	3.2 (4th)
2	Strengthening Mechanism for monitoring and evaluation	3.1 (5th)
2	Procurement of office equipments and furniture	3.1 (5th)
2	Renovation of Ministry of Health Headquarters	3.1 (5th)
2	Control of Non-communicable diseases	3.1 (5th)
2	Strengthening Pharmaceutical inspection of drugs distribution	3 (6th)

Priority areas	Operational Activities for 2010	Average Score (Ranking)
	channels and health facilities with emphasis on free health scheme	
2	Collection and distribution of anti-malarias and narcotic analgesics	3 (6th)
2	Construction of General Hospital Ikom and renovation of TBL hospital Mbembe (phase 1)	3 (6th)
2	Completion of 6 General Hospitals	2.9 (7th)
	One year training of 20 No. of House officers in General Hospitals	2.9 (7th)
2	Strengthening routine immunization/polio eradication	2.9 (7th)
2	Baseline Survey of infant and maternal mortality	2.8 (8th)
2	Restructuring/redesign of existing hospital pharmacies to meet PCN and NHIS requirement	2.8 (8th)
2	Establishing of Medical maintenance workshop for training of maintenance officers	2.7 (9th)
2	Purchase of WD pickup vehicle Hilux 4x42700DLx2	2.7 (9th)
2	Census of Health Facilities (Public and Private)	2.7 (9th)
2	Strengthening pharmacovigilance, drug information Service and Prescription Monitoring	2.6 (10th)
2	Establishment of Emergency Health Care Service	2.6 (10th)
2	Construction of Staff Quarters in the six General Hospitals	2.6 (10th)
2	Provision of State Community Mental and Dental services	2.6 (10th)
2	Construction of Resident Doctors Quarters	2.5 (11th)
2	Elevation/modification of building at General Hospital Calabar	2.4 (12th)
2	Furnishing of offices in Headquarters and at the zones in Calabar Ugep and Ogoja	2.4 (12th)
2	Strengthen infection prevention and Control of Health Care Waste	2.4 (12th)
3	Training of ten health research fellows to South Africa and visit of CRS Health	3.3 (3rd)
3	Capacity building/tour to India for key staff	3.3 (3rd)
3	Full accreditation of schools	3.2 (4th)
3	Council on Health (SCH)	3.2 (4th)
3	Personal Audit/Physical identification exercise	2.7 (9th)
3	Workshops and Trainings for Health Professionals across the state	2.7 (9th)
3	Training of Health Professionals in the Medical and Dental services	2.6 (10th)
3	Training of Personnel Staff	2.5 (11th)
3	Accreditation of General Hospital Calabar for housemanship and Residency Training	2.4 (12th)
4	Implementation of National Health Insurance Scheme (NHIS)	3.5 (1st)
4	Counterpart funding for Specialist Hospital on PPP basis	3.4 (2nd)
4	CRS participation in HSDP 111 (counterpart fund contribution)	2.8 (8th)
5	Strengthening of HMIS for collection, collation and dissemination of information	3.4 (2nd)

Priority areas	Operational Activities for 2010	Average Score (Ranking)
5	Monitoring and Evaluation of programs/capital projects of the Ministry	3.4 (2nd)
5	Capacity building on data collection, M&E activities for PRS staff	3.1 (5th)
6	Encouraging community participation in all aspects of health programme	2.9 (7th)
7	Construction of canteen for catering services under PPP at General Hospital Calabar, Ugep, Ogoja	3.2 (4th)
8	Research Ethics Committee (CR-HREC) to South Africa Medical Research Council (MRC)	3.3 (3rd)
8	Research in Health Care	2.5 (11th)

Table 1: Cross River State LGAs and their Population

SN	Local Govt Area	Headquarters	No of Wards	No. of communities	Population	Pregnant Women	Population Under-Five
1	ABI	ITIGIDI	10	24	153,322	7,666	30,664
2	AKAMPKA	AKAMPKA	10	94	160,017	8,001	32,003
3	AKPABUYO	IKOT NAKANDA	10	32	287,364	14,368	57,473
4	BAKASSI	ABANA	10	20	34,291	1,715	6,858
5	BEKWARRA	ABOUCHICHE	10	43	112,049	5,602	22,410
6	BIASE	AKPET CENTRAL	11	33	179,138	8,957	35,828
7	BOKI	BOJE	11	129	197,094	9,855	39,419
8	CALABAR MUNCIPALITY	CALABAR	10	35	189,948	9,497	37,990
9	CALABAR SOUTH	ANANTIGHA	12	35	202,906	10,145	40,581
10	ETUNG	EFFRAY	10	31	84,915	4,246	16,983
11	IKOM	IKOM	11	96	171,938	8,597	34,38
12	OBANLIKU	SANKWALA	10	67	116,816	5,841	23,363
13	OBUBRA	OBUBRA	11	24	182,591	9,130	36,518
14	OBUDU	OBUDU	10	44	169,527	8,476	33,905
15	ODUKPANI	ODUKPANI	13	65	203,768	10,188	40,754
16	OGOJA	OGOJA	10	56	182,016	9,101	36,403
17	YAKURR	UGEP	13	100	208,009	10,400	41,602
18	YALA	OKPOMA	14	211	223,249	11,162	44,650
	TOTAL		196	1139	3,058,956	152,948	611,791

Annex 1: Detailed activities for the Cross River Strategic Health Development Plan

CROSS RIVER STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
PRIORITY							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**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							**881,593,079**
	1.1	**To provide clear policy directions for health development**			**All stakeholders are informed regarding health development policy directives by 2011**		787,891,351
		1.1.1	To improve Strategic Planning at State and LGA levels		State SHDP developed. Advocacy visit carried out. All stakeholders identified and contributions solicited for.		71,315,922
			1.1.1.1	Re-orientation and strengthening of the human resource capacities of the health sector at both State and LGA			2,276,550
			1.1.1.2	Advocacy at State level in support of policy development and implementation.		Political will present	1,437,821
			1.1.1.3	Development of evidence-based policies, strategies, guidelines, protocols, standards,tools, costed and priotised health plans			2,300,514
			1.1.1.4	Optimize the contribution of the stakeholders at both State and LGAs.		Stakeholders are committed	599,092
			1.1.1.5	Capacity building on managerial and strategic planning skills at both State and LGAs (Programme Management Course and Marginal Budgetting for Bottlenecks training) and other trainings		Appropriate trainable persons present	64,701,945
		1.1.2	Ensure regular updating and access to the State Strategic Health Plan		Committee formed and yearly update of State SHDP done		13,743,172
			1.1.2.1	Formation of SHDP review committee		SHDP review committee committed	647,019
			1.1.2.2	Meeting of the committee at least once every six months		Meeting of committee feasible	1,773,313
			1.1.2.3	To provide hard copies of the State Strategic health plan to stakeholders		Production of Hard copies of SHDP is possible	59,909
			1.1.2.4	Establish a committee for the yearly development of operational activities			359,455

CROSS RIVER STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
PRIORITY							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
			1.1.2.5	Meeting of the State Planning team at least once every 6 months/Conduct MNCH regular review and annual planning meetings at State and LGAs			10,903,476
		1.1.3	Establish intra-sector mechanism for policy synergy in the health sector		Bi-annual meeting of state council on health done		22,789,463
			1.1.3.1	State council on health meetings once every 6 months to consider and adopt health policies		Funds available for meetings	12,317,333
			1.1.3.2	Identify and implement capacity building and reorientation initiatives for health policy development at all levels		Appropriate personnel present and willing	10,472,130
			1.1.3.3				-
		1.1.4	Building greater political commitment, defining the statutory and policy framework and managerial infrastructures for PHC at Community, Ward, LGA and State level		PHC committees at all levels established		615,017,463
			1.1.4.1	Formation of technical PHC committee forum/quarterly meetings		Funds are available	3,450,770
			1.1.4.2	Reactivating of various PHC committees/quarterly meetings		PHC committees previously meeting	7,074,079
			1.1.4.3	Passage of enabling law by the State House of Assembly		State House of Assebly committed to passing the law	119,818
			1.1.4.4	Establishment of CRS PHC development Agency		Political support present	259,479,699
			1.1.4.5	Construct Ministry of Health office Annex/Furnishing, renovate Ministry of Health headquarter and elevate/modify buildings at General Hospital Calabar			344,893,096
		1.1.5	Identify and implement capacity building and reorientation/initiatives for health policy development at all levels		Capacity dev. For health policy		65,025,331
			1.1.5.1	Develop, publish and institutionalise framework for the formulation and implementation of policies		Political will is present	958,547
			1.1.5.2	Hold Zonal training sessions with LGAs to explain and popularise the policy development frameworks		Funds are available	8,626,926
			1.1.5.3	Sustain implementation of the National Policy on HIV/AIDS in the workplace		Health workers willing to implement the National policy on	55,439,858

CROSS RIVER STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
PRIORITY							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
						HIV/AIDS	
			1.1.5.4				-
	1.2	**To facilitate legislation and a regulatory framework for health development**			**Health Bill signed into law by end of 2009**		15,995,759
		1.2.1	Strengthen regulatory functions of government		Public health Laws established and enforced with full cooperation of the PPP		11,730,223
			1.2.1.1	The State government will set quality standards for and ensure compliance in delivery of health services		Political will present	287,564
			1.2.1.2	The State Ministry of health will support the development of public/private partnership policies and plans in the LGAs in line with the national policy on PPP		Private practitioners are registered and easily identified	1,198,184
			1.2.1.3	LGAs will be offered opportunites for technical support on implementation of the strategic plans to ensure that the regulatory function of government is strengthened and agreed quality standard are set, monitored and delivered			8,626,926
			1.2.1.4	Review committees will be set up to review and align laws of regulatory bodies		Laws of regulatory bodies present	179,728
			1.2.1.5	Regular reviewing, updating and enforcing Public Health Acts and Laws as well as revising and streamlining roles and responsibilities of regulatory institutions to align with the National Health Bill that is to be passed into law		Structures are available to enforce Public Health Laws	1,437,821
		1.2.2	Defining and communicating roles and responsibilities of regulatory agencies to stakeholders		Training of stakeholders on functions of regulatory agencies carried out		2,875,642
			1.2.2.1	Training and sensitization of stakeholders on the functions of regulatory agencies		Stakeholders are willing to be trained	2,875,642
			1.2.2.2				-
		1.2.3	Update/enforce Public health acts and laws in line with the PHC approach		1. Appropriate public health legislation		958,547

CROSS RIVER STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
PRIORITY							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
					passed and each accented to at all levels. 2. Number of convictions for public health violations		
			1.2.3.1	Review health legislation to ensure that gaps are filled in areas which need improvement		Legislators are committed to public health	467,292
			1.2.3.2	Update/Review public health acts and laws by involving legislators		Funds are available and Legislators are committed to public health	467,292
			1.2.3.3	Submit to legislators and advocate for enactment into law			23,964
		1.2.4	Review/Streamline roles and responsibilities of regulatory institutions to align with Cross River State Health Bill		Responsibilities of regulatory institutions reviewed by 2010		431,346
			1.2.4.1	Set up committees for review and alignment of regulatory bodies			95,855
			1.2.4.2	Amend roles and responsibilities of regulatory institutions		Regulatory bodies existing	173,737
			1.2.4.3	Develop capacity of regulatory institutions to fulfill their roles and responsibilities		Funds are available	161,755
			1.2.4.4				-
	1.3	**To strengthen accountability, transparency and responsiveness of the national health system**			**80% of States and the Federal level have an active health sector 'watch dog' by 2013**		14,173,421
		1.3.1	To improve accountability and transparency		Mechanisms to ensure accountability and transprency established		10,424,202
			1.3.1.1	The State and LGAs will institute stakeholders' dialogue and feedback forum for enlisting input into the health sector decision making			2,444,296
			1.3.1.2	Creation of platforms for interaction and collaboration with health sector advocacy groups		Health sector advocacy groups are identifiable and committed to collaborate	2,444,296
			1.3.1.3	Empower beneficiary communities through sensitization to manage and			1,222,148

CROSS RIVER STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
PRIORITY							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
				oversee their health projects and programmes			
			1.3.1.4	Promote the emergence of independent health sector "watch dog"		Political will present	2,875,642
			1.3.1.5	The State MOH will lead a process for improved access to information required for yearly joint review of the health sector and put such information in the public domain and on demand by stakeholders.			1,437,821
		1.3.2	To improve the responsiveness of the State health system		Zonal Health Management Policy is implement by 2011		3,749,218
			1.3.2.1	Scale up leadership and management development		Structures on ground to scale up mgt. dev.	239,637
			1.3.2.2	Implementation of Zonal Health Management Policy		Zonal Health Management Policy exists	3,509,582
			1.3.5.5				-
	1.4	**To enhance the performance of the national health system**			**1. 50% of States (and their LGAs) updating SHDP annually 2. 50% of States (and LGAs) with costed SHDP by end 2011**		63,532,548
		1.4.1	Improving and maintaining Sectoral Information base to enhance performance				241,374
			1.4.1.1	Deepen and expand the analytical work at both State government and LGAs, which is required to understand health sector performance and to drive improvements and reform			58,855
			1.4.1.2	In conjunction with development partners a prioritised list of areas for further analytical work will be outsourced to Universities, private sector research firms and research institutes.		Collaboration with universities exist	132,759
			1.4.1.3	Linkages will be established with the relevant activities in the research and health information system priority areas of the framework.			49,761
		1.4.2	Establishment of Cross River State Primary Health Care Development Agency (PHCDA)		PHCDA established by 2010. M&E established for		8,387,289

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PRIORITY							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
					quarterly supervision		
			1.4.2.1	Conduct situation analysis and micro planning for PHC		Funds are available	3,594,553
			1.4.2.2	Establish monitoring and evaluation unit for quarterly supervision		M&E unit empowered	3,594,553
			1.4.2.3	Advocate for at least 60% proposed CRSPHCDA fund to IMNCH services at the LGAs and communities			1,198,184
		1.4.3	Develop health leadership at State level				838,729
			1.4.3.1	Develop training guidelines and clear job description for Cross River State health professionals		Funds available	838,729
		1.4.4	Develop health leadership at LGA level		1. 20% of LGAs have a Medical Officer of Health by 2013. 50% of LGAs have a Medical Officer of Health by 2015		52,558,588
			1.4.4.1	Ensure that Cross River State provides a Medical Officer of Health to provide competent leadership at each LGA		Health personnels willing to work as MoH and political will is present	52,408,576
			1.4.4.2	Develop training guidelines and clear job description for Cross River State to provide to LGA Medical Officers of Health		Health personnels willing to be trained as MoH in the LGAs	150,013
		1.4.5	Update SSHDP to ensure integrated management and provision of comprehensive minimum health package		50% of LGAs provide comprehensive minimum package by 2013		1,506,567
			1.4.5.1	Set up a process for updating the SSHDP		Capacity developed for regular updates	78,068
			1.4.5.2	Update and cost SSHDP following a situation analysis showing the gaps to address			1,085,699
			1.4.5.3	Create an environment for effective implementation of the SSHDP at all levels of the health system			64,822
			1.4.5.4	Clarify roles and responsibility of various stakeholders		Stakeholders are able to identify their roles and willing to maintain it	86,269
			1.4.5.5	Institute an external review mechanism of senior citizen experts in health at each			191,709

CROSS RIVER STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
PRIORITY							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
				level			
HEALTH SERVICE DELIVERY							
2. To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare							**43,924,622,484**
	2.1	**To ensure universal access to an essential package of care**			**Essential Package of Care adopted by all States by 2011**		1,962,006,463
		2.1.1	To review, cost, disseminate and implement the minimum package of care in an integrated manner		Minimum package of care made universally accessible to all stakeholders by 2011		7,038,579
			2.1.1.1	Standard operating Procedures (SOPs) and guidelines will be made available for delivery of services at all levels		**SOPs and guidelines are available**	443,739
			2.1.1.2	Regular review and costing of the minimum package of care		**Minimum package of care available**	3,586,390
			2.1.1.3	Make available these reviewed minimum package of care to stakeholders		**Funds are available**	1,345,886
			2.1.1.4	Ensure implementation of the minimum package of care by stakeholders through monitoring and evaluation		**M&E unit conversant with minimum package of care**	475,018
			2.1.1.5	Establish and implement guidelines for outreach services			1,187,546
		2.1.2	To strengthen specific communicable and non communicable disease control programmes		Achieve at least 80% immunization coverage in both mothers and children by 2011		1,609,787,735
			2.1.2.1	Strengthen routine immunization, NIDs (polio eradication) and immunization of pregnant women against tetanus (tetanus toxoid)		**Adequate and committed health workers are available**	408,423,568
			2.1.2.2	Improve access to ITN and anti-malaria drugs especially for mothers and children		**ITN and anti-malaria drugs are available and affordable**	23,254,746
			2.1.2.3	Improve school health programme like school meals among primary school children to reduce malnutrition		**Mechanisms of providing the school meals available**	158,339,499
			2.1.2.4	To ensure early identification of MDR TB from the six focal sites in the state and treatment with second line TB drugs for MDR TB, strengthen HIV and		**facilities drugs are available and affordable**	715,978,089

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PRIORITY							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
				onchocerciasis control			
			2.1.2.5	Establish free checks for non-communicable diseases like diabetes, hypertension and some cancers (breast, cervix and prostate)		**funds and materials are available**	303,791,833
		2.1.3	To make Standard Operating procedures (SOPs) and guidelines available for delivery of services at all levels		SOPs and guidelines available, distributed and training carried out by 2010		267,150,402
			2.1.3.1	Training all health workers on need for SOPs and guidelines for delivery of health services		**Willingness of health workers to use SOPs when trained**	261,656,022
			2.1.3.2	Develop S.O.P. guidelines for delivery of services at all levels			300,845
			2.1.3.3	Distribute the SOPs and guidelines for delivery of services to each health facility			1,583,395
			2.1.3.4	To regularly update SOPs as need arises		**Health workers are committed to update SOPs**	2,897,613
			2.1.3.5	To monitor completeness and utilization of the SOPs			712,528
		2.1.4	Consultation with MDG stakeholders, LGAs, communities and other stakeholders		At least 1 meeting held with MDG stakeholders in the state and in 50% of the LGAs by first quarter of 2010		54,001,728
			2.1.4.1	Renovation of stores A and B of the state essential drug programme and eighteen essential drug store of the eighteen LGAs		**funds are available**	32,459,597
			2.1.4.2	Mobilise and harmonize activities of stakeholders towards MDG achievements		**Stakeholders agree to identify with the MDGs**	7,916,975
			2.1.4.3	Encourage regular consultations with stakeholders before any major activity is carried out			4,750,185
			2.1.4.4	Identify areas of community "felt needs" and including such in health programmes		**Communities able to harmonize their felt needs**	520,937
			2.1.4.5	Include all stakeholders in such programme as obtaining survey of infant and maternal mortality		**Stakeholders agree to be involved**	8,354,034
		2.1.5	Establish or strengthen Health Facilities Maintenance/Finance Committee		To increase the number of health		24,028,019

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PRIORITY							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
					facilities with Facility Maintenance/Finance Committee by 75% by end of 2012		
			2.1.5.1	Increase the number of health facilities with Facility Maintenance/Finance Committee		**Funds are available**	14,250,555
			2.1.5.2	Strengthen the health facilities maintenance/finance committee		**Political will present**	395,849
			2.1.5.3	Review membership of these committees to enhance function		**Objectivity is used in selecting membership of committee**	39,585
			2.1.5.4	Review performance of these committees every 6 months			1,425,055
			2.1.5.5	Make budgetary provision for effective performance of the committee		**Political will present**	7,916,975
	2.2	**To increase access to health care services**			**50% of the population is within 30mins walk or 5km of a health service by end 2011**		**23,358,449,988**
		2.2.1	To improve geographical equity and access to health services		Aleast 85% of PHC renovated by end of 2010 and 100% of the LGAs adopt the Ward Health System of PHC by 2011		17,331,142,774
			2.2.1.1	Mapping, categorizing and establishing GIS for all health facilities (both public and private) in the state and develop criteria for siting of new facilities at all levels and site new health facility especially where necessary		**Facilities available to conduct GIS**	67,633,818
			2.2.1.2	Build or upgrade dilapidated health facilities especially at the PHC level and build a State owned Specialist Hospital		**Money is available**	17,044,327,505
			2.2.1.3	Establishment of a renal dialysis unit in the General Hospital Calabar		**Funds are available**	174,450,543
			2.2.1.4	Develop and implement guidelines for outreach services and for task shifting			30,480,354
			2.2.1.5	State to adopt the Ward Health System (Tulsi Chanrai Model) of PHC and adapt it to the peculiar circumstances in the state		**Political will present**	14,250,555
		2.2.2	To ensure availability of drugs and equipment at all		Essential drugs and		

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	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
			levels		equipments available in all health facilities by 2013		4,825,376,344
			2.2.2.1	Review of the essential medicines list and establish a drug revolving fund (DRF) programme at all levels		**EML and DRF programme present**	3,902,356,530
			2.2.2.2	Strengthen Directorate of Pharmaceutical Services and Establish a system to ensure procurement and distribution of essential medicines and commodities on a sustainable basis at all levels with emphasis on free health scheme		**Department of Pharm. Committed**	713,851,672
			2.2.2.3	Strengthen task force on Counterfeit and Fake Drugs		**Task force on fake drugs present**	33,411,298
			2.2.2.4	Conduct Sensitization meetings with related food companies on Breast milk substitutes (BMS), fortified foods, local production of Ready -to-Use Therapeutic Foods (RUTF)			3,325,129
			2.2.2.5	Build and equip a standard drug store at the state headquarter and 1 drug store at each LGA		**funds are available**	172,431,714
		2.2.3	To establish a system for the maintenance of equipment at all levels		SOP for equipment maintenance available and personnel for maintenance employed by 2013		406,283,969
			2.2.3.1	Developing SOPs for regular maintenance of the equipments and procurement of "back up" for essential equipments		List of essential equipments requiring "back up" available	42,894,170
			2.2.3.2	Employment of equipment maintenance personnel and/or training and retraining of personnel to maintain the equipments.		Effective equipment maintenance officer available	395,849
			2.2.3.3	Identify/build a reliable medical equipment maintenance workshop in the State headquarter for training of maitenance officers			63,165,157
			2.2.3.4	Quaterly inventory of equipment including their functional state and Create budget lines for the maintenance of equipment at the resource center in government hospitals			87,086,724

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PRIORITY							
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	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
			2.2.3.5	Procurement of office equipments and furniture		funds are available	212,742,069
		2.2.4	To strengthen referral system		Necessary referral forms available in 85% of health facilities by 2013		778,071,217
			2.2.4.1	Establish a two way referal system and ensure availability of referral forms at all health facilities		**Health facilities registered and identifiable**	7,916,975
			2.2.4.2	Regular training of health worker on referral practices		**funds available for training**	475,018
			2.2.4.3	Ensure availability of reliable community based transport system especially in times of emergency and ambulance vehicle		**Community participation achieved**	92,628,607
			2.2.4.4	Improve communication between health facilities and Establish emergency Health Care Services		**Mechanisms available for emergency health care service**	676,021,410
			2.2.4.5	Establish SOP for referral of cases			1,029,207
		2.2.5	To foster collaboration with the private sector		1. Map of all health facilities are available by 2011. 2. National policy on traditional medicine adapted and implementation started by 2015		17,575,684
			2.2.5.1	Map and yearly update all categories of private health care providers by operational level and location		Private health facilities are all registered and identifiable	6,096,071
			2.2.5.2	Develop guidelines and standards for regulation of their practice and registration		Private practitioners agree to abide with the guideline and standard	1,583,395
			2.2.5.3	Develop guidelines for partnership, training and outsourcing of services		**Collaboration between private and public health sectors present**	395,849
			2.2.5.4	Develop and implement joint performance monitoring mechanism		**Private sector willing to be part of monitoring**	8,708,672

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PRIORITY							
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	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
			2.2.5.5	Adapt and implement National policy on traditional medicine at both State and LGAs		**Copies of National policy on traditional medicine available**	791,697
	2.3	**To improve the quality of health care services**			**50% of health facilities participate in a Quality Improvement programme by end of 2012**		**2,986,449,863**
		2.3.1	To strengthen professional regulatory bodies and institutions		Operational guidelines of all regulatory bodies updated by 2011		42,096,478
			2.3.1.1	Review, update and implement operational guidelines of all regulatory bodies at all levels		Functional regulatory bodies present	475,018
			2.3.1.2	Empower regulatory staff to monitor compliance of providers to the regulatory guidelines/provision of necessary security		Regulatory staff committed	31,667,900
			2.3.1.3	Sensitize professionals/regulatory bodies on IMNCH strategies and minimum health care packages for all levels		Political will is present	158,339
			2.3.1.4	Strengthen regular monitoring exercises with appropiate documentation and feedback		Facilities available for documentation and feedback	4,908,524
			2.3.1.5	Restructuring/redesigning of existing hospital pharmacies to meet PCN and NHIS requirements		funds are available	4,886,696
		2.3.2	To develop and institutionalise quality assurance models		Quality assurance models developed and institutionalized by 2015		362,119,539
			2.3.2.1	Review, adopt, and train on available quality assurance models to both public and private health care providers			554,188
			2.3.2.2	Strengthen Pharmacovigilance, Drug Information Service and Presciption Mornitoring		Capacity to carry out pharmacovigilanc e is present	91,899,653
			2.3.2.3	Institutionalize and implement quality assurance and improvement initiatives at all levels of care		Health workers aware of quality assurance	165,367,151
			2.3.2.4	Implement SERVICOM guidelines, build		Health staff	

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		Interventions			**Indicators**		
			Activities		**None**		
				institutional capacity and train staff for its implementation at state and LGAs		motivated to implement SERVICOM guidelines	18,209,042
			2.3.2.5	Strengthen Clinical Governance and Develop strategies for monitoring and implementation of quality of care		Functional Clinical Governance Unit exists in the Mininstry of health	86,089,504
		2.3.3	To institutionalize Health Management and Integrated Supportive Supervision (ISS) mechanisms		Health Management and Integrated Supportive Supervision institutionalized at all levels by 2015		118,042,096
			2.3.3.1	Strengthen the management capabilities of health managers and health teams especially at the LGAs and Ward levels through team building and leadership development programmes, and institutionalization of comprehensive ISS at all levels		Health managers are team players	40,851,591
			2.3.3.2	Develop capacities of programme managers at state and LGA levels on the ISS mechanism		Programme managers are committed to ISS mechanism	395,849
			2.3.3.3	Print and distribute, developed ISS tools and guidelines specifying modalities and frequencies of the ISS visits at state and LGAs		Time available for ISS visits	4,037,657
			2.3.3.4	To prepare a preceptor handbook for the practical side for CHEW/JCHEW training			4,354,336
			2.3.3.5	Organise seminars/worshop on basic standards in health procedures		Health workers and other stakeholders attend seminars/worksho ps	68,402,664
		2.3.4	Stregthening implementation of intergrated maternal, newborn and child health (IMNCH) services for the free health programme		1. Six General hospitals upgraded for EOC by 2011. 2. 50% of Midwives trained on MSS by 2010. 3. National policy on IMNCH adopted by 2010		1,120,248,601

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	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
			2.3.4.1	Upgrading of 6 general hospitals for Emergency Obstetric Care (EOC) services		funds and political will are present	304,011,838
			2.3.4.2	Training of TBAs on danger signs of pregnancy, training and deployment of midwives for MSS scheme and training of SCHEW on ELSS		Facilities for training available	27,709,412
			2.3.4.3	Adopting the national policy on IMNCH services provision of obstetric delivery kits		Health staff able to use the obstetric delivery kits	3,641,808
			2.3.4.4	Establishment of VVF treatment center and management support tool		Community support is present	9,183,691
			2.3.4.5	Ensure 24 hours services especially for IMNCH in all health facilities		Manpower and supporting facilities are available and adequate to operate 24 hr service	775,701,851
		2.3.5	To establish Quality Assurance / Control Unit		1. Quality Assurance/Control Unit established by 2010. 2. Drug inventory unit establishe in all secondary health facilities by 2010		1,343,943,149
			2.3.5.1	Establish quality assurance unit in State Ministry of Health and the secondary health facilities		Structures are available for the Control Unit to be established	63,335,800
			2.3.5.2	Establish drug inventory unit to document drug availability and expiration dates		Committed and motivated staff available	1,741,734
			2.3.5.3	To highlight Ethical Standards in health management of cases in both LGAs and State		Procedures are available to ensure ethical standards at all levels	680,860
			2.3.5.4	To establish regularity of quality assurance / control tests and produce Clinical Governance Handbook		Funds are available	2,770,941
			2.3.5.5	Completion of 6 New General Hospitals, construction of Staff Qtrs in the 6 General Hospitals and construct resident doctors' qtrs		Funds are available and project monitored regularly	1,275,413,814

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PRIORITY						
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	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
	2.4	**To increase demand for health care services**			**Average demand rises to 2 visits per person per annum by end 2011**		**2,486,881,127**
		2.4.1	To create effective demand for services		1. 50% of Staff trained on Behavioural Change Communication by 2011. 2. Handbooks on patients' rights and responsibility produced and available in 50% of secondary health facilities by 2011		397,867,576
			2.4.1.1	Provide budget lines for health promotion through Behavioural Change Communication (BCC)		Political commitment present	395,849
			2.4.1.2	Put in place a programme monitoring and evaluation system for effectiveness of the BCC strategy		Funds and mobility present for M&E	427,517
			2.4.1.3	Train staff on Behavioural Change Communication Skills		Objectivity in selecting staff to be trained on BCC Skills	14,678,072
			2.4.1.4	Produce and disseminate hand books on patient's right and reponsibility to health care			2,193,002
			2.4.1.5	Support local adaptation of the national strategy to reflect local realities - conduct biannual MNCH weeks		**Local Staff conversant with the National strategy on BCC**	380,173,137
		2.4.2	To introduce patient friendly initiatives		1. Public relations office established in 50% of the secondary health facilitites by 2010. 2. Two Hilux vehicles and 18 ambulance vehicles purchased and distributed by 2015		199,122,301
			2.4.2.1	To improve patient/health worker relationship			15,833,950
			2.4.2.2	To establish public relations office especially in secondary health facilities		Appropiate personnel	26,126,017

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PRIORITY							
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	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
				and produce directional signs in 22 hospitals in the state for easy access to health services		available to function as PRO in hospitals.	
			2.4.2.3	To shorten time taken for patient to be seen by health staff (i.e. waiting time) through regular meetings, seminars and workshops in 22 hospitals in the State		Health workers are committed to shortening patients' waiting time	43,543,362
			2.4.2.4	To establish or strengthen baby friendly hospitals in State and LGAs		Funds are available	71,252,774
			2.4.2.5	Purchase vehicles and ambulances to assist patients in times of need (purchase of WD pickup vehicle Hilux 4x4 2700DLX x 2)		Funds are available	42,366,197
		2.4.3	To actively engage the CHEW, TBAs, VHW and other stakeholders		1. Increase by 50% of 2009 numbers the CHEWs that are trained by 2011. 2. Wefare package available to all staff working in rural communities by 2015		879,932,258
			2.4.3.1	To improve home visitations of CHEW, TBAs and VHW (CORPs)		Communities accept home visitations	85,503,329
			2.4.3.2	To appropiately identify and train CHEW, TBA and VHW who live and work in the community		Trained CHEW, etc agree to work in their respective communities	7,125,277
			2.4.3.3	Empower community nurses and midwives to work in the communities		Political commitment present	95,003,699
			2.4.3.4	Engage all health workers and other stakeholders in advocacy and disemination of information on the services available in health facilities			9,025,351
			2.4.3.5	Strengthen Infection Prevention and Control of Health Care Waste Management by actively engaging all stakeholders		Infection Prevention and Control Unit present	683,274,600
		2.4.4	Establish specialized health programmes targeted at areas of health needs		At least 5 specialised health facilities established by 2015		967,603,177
			2.4.4.1	Identify and prioritise health needs of the community and disseminate the Health Promotion Policy and implement the policy provisions		Political commitment present	2,040,996

CROSS RIVER STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
PRIORITY							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
			2.4.4.2	Establish appropriate health programmes to solve these needs e.g. Well Women Clinic, Onchocerciasis Treatment center, etc.		Funds and adequate manpower are available	55,418,825
			2.4.4.3	Improve existing health services at the PHC and WHC to make health more accessible to people		Health services when available are also affordable	427,516,647
			2.4.4.4	Establish a state blood bank for easy access of blood and blood products, train and employ staff to manage it		Funds are available	395,848,747
			2.4.4.5	Provision of Maternity complex in radio-diagnosis center in General Hospital Calabar		Funds and adequate manpower are available	86,777,962
		2.4.5	To strengthen IEC strategies at both the LGAs and State		IEC materials available in at least 85% of all health facilities by 2014		42,355,816
			2.4.5.1	Develop IEC materials relevant to either rural or urban communities		Possibility to identify appropiate IEC materials in each community	2,375,092
			2.4.5.2	Develop mechanisms for distributing the IEC materials by community members		All communities are accessible	395,849
			2.4.5.3	Regular updating of the IEC materials making them relevant to present health needs		funds are available	7,125,277
			2.4.5.4	Monitor and evaluate the effectiveness of the IEC materials		funds are available and tools to objectively monitor IEC materials available	28,501,110
			2.4.5.5	Production of Ministry of Health News bulletins		Political support present	3,958,487
	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**		**13,130,835,043**
		2.5.1	To improve financial access especially for the		Free maternal and		

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PRIORITY							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
			vulnerable groups		health services started in all government hospitals in the state by 2010		12,279,861,494
			2.5.1.1	Explore and scale up financial protection for the vulnerable groups like vouchers, health cards, pre payment schemes		Political support present	1,583,394,988
			2.5.1.2	To provide free health services for underfives and mothers		Funds are available	9,500,369,931
			2.5.1.3	To assist in provision of essential care to the physically challenged		Funds are available	1,187,546,241
			2.5.1.4	Encourage NGOs and other Multi-national companies to assist in health care financing of vulnerable groups as part of their social responsibilities		NGOs committed to assisting vulnerable groups	1,583,395
			2.5.1.5	Orient communities on community-based insurance scheme and IMNCH strategy			6,966,938
		2.5.2	Prevention of mother to child transmission of HIV/AIDS		State emergency HIV/AIDS lab established by 2011. Three new ART sites established by 2010		502,727,909
			2.5.2.1	Establishment of state emergency HIV/AIDS laboratory that provides free or subsidized services		Funds and manpower are available	197,924,374
			2.5.2.2	Establish of three new ART sites to provide free or subsidized drugs		Funds are available	23,750,925
			2.5.2.3	Provision of support to infected HIV/AIDS patients			237,509,248
			2.5.2.4	Establishing special care facilities for management of HIV positive pregnant women		Funds and manpower are available	43,543,362
			2.5.2.5				-
		2.5.3	Strengthening financial assistance of the physically challenged people		State Community Mental Health Service established by 2014		348,245,641
			2.5.3.1	To evaluate the existing schools of the physically challenged		Mechanisms available to evaluate schools of physically challenged	158,339
			2.5.3.2	Establish and strengthen schools of skill acquisition for the physically challenged			34,042,992
			2.5.3.3	Provision of State Community Mental Health Services		Funds are available	314,044,309

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PRIORITY						
Goals				**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Cost (2010-2015)**
	Strategic Objectives			**Targets**		
		Interventions		**Indicators**		
			Activities	**None**		
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						**23,143,116,702**
	3.1	**To formulate comprehensive policies and plans for HRH for health development**		**All States and LGAs are actively using adaptations of the National HRH policy and Plan by end of 2015**		**19,861,438,704**
		3.1.1	To develop and institutionalize the Human Resources Policy framework	National HRH Policy and Strategic Plan adapted to State by 2010. Policy framework for existence of health practitioners developed by 2010		**1,345,518,495**
			3.1.1.1 Adapt the National HRH Policy and Strategic Plan to guide human resource development at State and LGAs (each general hospital to have 8 lab scientists, 16 lab tech, 3 radiographers, 8 X-ray tech, 6 general practitioners)		Funds are available	32,304,504
			3.1.1.2 Update policies on training and recruitment of health personnel to make them non-restrictive and ensure non-dicriminatory process irrespective of LGA of origin and/or gender		Objective ways training and recruitment of personnel available	589,234,157
			3.1.1.3 Develop a policy framework to guide existence of private and public practitioners at all levels of health service delivery		Objectives means of assessing health workers is available	1,794,695
			3.1.1.4 Develop and implement guidelines on task shifting			2,871,511
			3.1.1.5 Establish for public-private practitioners to institutionalize HRH policy reviews and monitoring frameworks			719,313,628
		3.1.2	To develop mechanisms for monitoring implementation of Human Resource Policy	Policy on staff promotions, employment and retirement reviewed by 2010. New medical officers employed and operating as MoH in 50% of LGAs by 2011		**13,825,322,785**

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PRIORITY							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
			3.1.2.1	Regularly review policy on staff promotions, employment and retirement		Policy review to be done objectively	14,357,557
			3.1.2.2	Monitor the adaptation of the state non-discriminatory policies		M&E to be done without intimidation	2,871,511
			3.1.2.3	Monitor and evaluate nursing and midwifery practice		M&E to be done without intimidation	17,229,069
			3.1.2.4	Create/strengthen HRH units at all levels to perform HRH functions			13,639,679,567
			3.1.2.5	Employment of Medical Officers		Funds are available	151,185,080
		3.1.3	Establish a programme to fund in-service training, human capital capacity building and Continuing Professional Development (CPD) by government and healthcare provider institutions and coordination of same by professional regulatory bodies		Funds are allocated for in service training by 2011		**2,830,410,008**
			3.1.3.1	Establish a process and the financial resources to sponsor candidates and bond them to return to serve for an agreed period after training		Such bonds are legally binding on recipients	41,564,724
			3.1.3.2	Establish objective modalities for selecting those deserving of such sponsorship			1,137,119
			3.1.3.3	Capacity building/study tour to India for key staff		Collaborating training institution in India already identified	21,536,336
			3.1.3.4	Establish regular Consultancies for the State Ministry of Health		Funds are available	2,584,360,339
			3.1.3.5	Conduct workshops and trainings for Health Professionals across the State		Trained health professionals will eventually work in the State	181,811,490
		3.1.4	To improve system for management and performance of the health workforce; to improve recruitment, utilization, retention, task shifting and performance		1. State database of HRH created by 2010. 2. 175 Pharmacy Technicians and 61 newly qualified nurse/midwives appointed by 2015		**822,906,276**
			3.1.4.1	Create a state database of Human Resources for Health		All HRH are registered with there various	34,458,138

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	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
						professional groups	
			3.1.4.2	Develop and provide job descriptions and specifications for all categories of health workers		Job descriptions will not overlap	1,407,041
			3.1.4.3	Appointment of 175 Pharmacy Technicians		Funds and facilities where they will work are available	508,795,942
			3.1.4.4	Promote the National Midwifery Scheme and the Community Midwifery Programme			106,411,037
			3.1.4.5	Employ 61 newly qualified nurses/midwives		Funds are available	171,834,119
		3.1.5	To develop and implement retention strategies including management of migration, development and implementation of bilateral and multilateral agreements to reverse and contain the crises		Retention strategies developed by State and implemented by at least 50% of LGAs before 2011		**1,037,281,140**
			3.1.5.1	To develop and implement incentives to retain health workers particularly in deprived areas		Incentives are enough to retain staff	323,045,042
			3.1.5.2	Design and embark on a campaign to encourage retired trained health professionals to return to the service		Criteria of selecting retired staff who are still productive are available	315,866
			3.1.5.3	Payment of Honorarium to outreach Nurses (10), Pharmacists (10), Physiotherapist (1), and Medical Consultants (8)		Funds are available	123,015,552
			3.1.5.4	CRS Participation at National Council on Health (NCH) meeting organization of yearly State Council on Health (SCH)		CRS aware of such yearly meetings	41,405,062
			3.1.5.5	Appointment of 189 Laboratory Technicians		Funds are available	549,499,617
	3.2	**To provide a framework for objective analysis, implementation and monitoring of HRH performance**			**The HR for Health Crisis in the country has stabilised and begun to improve by end of 2012**		**2,589,268,250**
		3.2.1	To reappraise the principles of health workforce requirements and recruitment at all levels		Principles of health worforce requirements and recruitment reappraised and		**5,699,950**

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PRIORITY							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
					updated by 2010		
			3.2.1.1	Develop and streamline career pathways for all groups of professionals critically needed to foster demand and supply creation in the health sector			3,188,814
			3.2.1.2	Develop, introduce and utilize staffing norms based on workload services availability and health sector priorities.		Workload services criteria are available	430,727
			3.2.1.3	Establish coordinating mechanisms for consistency in HRH planning and budgeting by Ministries of Health, Finance, Education, Civil Service Commission, Regulatory bodies, Private Sector Providers, NGOs in health and other institutions		Political support present	308,687
			3.2.1.4	Strengthen State and LGA capacities to access and implement federal government circulars, guidelines and policies related to HRH			330,224
			3.2.1.5	Review entry criteria and admission quotas of prospective health care providers into training institutions		Objectivity in selection criteria	1,441,499
		3.2.2	To strengthen monitoring and evaluation of HRH performance at both State and LGAs		M&E committee on HRH established in the State and 50% of LGAs by 2011		**1,753,312,923**
			3.2.2.1	Establish a committee to routinely monitor and evaluate HRH performance		Funds are available	1,722,907
			3.2.2.2	To develop criteria for objective evaluation of HRH performance			447,956
			3.2.2.3	Personnel Audit/Physical identification exercise		All personnel present for the audit	6,297,681
			3.2.2.4	Accreditation of Gen. Hospital Calabar for Housemanship and Residency training		Funds available and hospital management committed	61,456,663
			3.2.2.5	Employment of College Health Technology (CHT) past graduates		Funds are available	1,683,387,716
		3.2.3	To acquire equipments that facilitate HRH development		Teaching aids purchased by 2010. 2 Generators purchased by 2010		**25,096,723**
			3.2.3.1	Purchase of teaching aids e.g. Projectors, laptops and internet facilities		Funds are available	4,307,267
			3.2.3.2	Ensure reliable alternative to power supply e.g. generators		Funds are available	14,357,557

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	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
			3.2.3.3	Furnishing of offices in Headquaters and at the Zones in Calabar, Ugep and Ogoja			6,431,899
		3.2.4	Develop a model to project the professional staff needs of the State and liase with Ministry of Education and training institutions to plan how to train sufficient graduates		Model for professional staff needs developed by the state in 2011		**637,175,232**
			3.2.4.1	Collect baseline data, consult professionals and examine international literature to identify appropiate health professional targets		International literature available	315,866
			3.2.4.2	Construct a model to project training and output requirements to provide for the health professional needs of the State			4,594,418
			3.2.4.3	Construction of House Officers Quarters (Phase 1) in General Hospital, Calabar		Funds are available	536,540,128
			3.2.4.4	Training of Heaith Professionals in the Medical and Dental Services Department		Lecturers to conduct training are available	95,724,819
		3.2.5					**167,983,422**
			3.2.4.5	Advocacy and construction/upgrade of mandatory residential accommodation for health workers in rural areas.			167,983,422
	3.3	**Strengthen the institutional framework for human resources management practices in the health sector**			**1. 50% of States have functional HRH Units by end 2010 2. 10% of LGAs have functional HRH Units by end 2010**		**152,034,345**
		3.3.1	To establish and strengthen the HRH Units		HRH Units created in the State and 50% of LGAs by 2011		**7,063,918**
			3.3.1.1	Create/strengthen HRH units at all levels to perform HRH functions		Availability of personnel at LGAs	3,589,389
			3.3.1.2	Establish training programmes in human resource for health planning and management at state and LGAs to enhance the HRH managers		Funds are available	3,474,529
		3.3.2	Design and implement training programmes/build technical capacity at all levels of the health sector		Training programme/manual developed by the State and implemented by at least 50% of LGAs		**60,311,859**

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PRIORITY							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
					by 2011		
			3.3.2.1	Establish a training programme/manual for the training of managers in human resource planning and management		Personnel to develop manual and funds are available	7,178,779
			3.3.2.2	Identify existing training institutions that are willing and able to provide training courses for HRH management and planning		Training institutions willing to conduct training	14,357,557
			3.3.2.3	Train managers in human resource planning and management for health.			17,731,583
			3.3.2.4	Monitor training courses and output on HRH management and planning			5,096,933
			3.3.2.5	Monitoring and Evaluating Programmes/Capital Projects of the Ministry		Funds available	15,947,007
		3.3.3	Re-orientation of health workforce towards positive attitudinal change		More than 50% of health service users report being treated with care, respect and dignity by 2013		**3,085,439**
			3.3.3.1	Develop and promote a course for health providers to train health workers on interpersonal Communication (IPC) skills	No of health workers at state and LGA levels trained on Interpersonal Communication (IPC) skills	Trainers are available	308,687
			3.3.3.2	Develop and promote a course for health providers to re-train workers on work ethics	No. of health workers at state and LGA levels trained on work ethics	Workers willing to adapt work ethics in their practice	493,900
			3.3.3.3	Develop and institute a system of recognition, reward and sanction	State and LGAs have instituted a system of recognition, reward and sanction	System developed will be objective	129,218
			3.3.3.4	Create a complaint/feedback mechanism		Mechanism when created will be productive	2,153,634
			3.3.3.5				-
		3.3.4	Establish multi-sectoral HRH system for planning, management and development at State and LGA level		1. Functioning State intersectoral HRH Committees in at least 6 LGAs by end of 2009. 2. Functioning intersectoral		**70,273,731**

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PRIORITY							
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	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
					Committees in all LGAs by end of 2015		
			3.3.4.1	Establish State level intersectoral committee to discuss issues of human resource for health and meet quaterly	No of functional intersectoral committees in place at State and LGA levels	Funds are available	4,594,418
			3.3.4.2	Promote the establishment of State level intersectoral committee to discuss issues of human resource for health		Political commitment present	3,632,462
			3.3.4.3	Encourage the establishment of LGA level intersectoral committee to discuss issues of human resource for health		Appropiate personnel available at the LGAs and willing to collaborate	62,024,648
			3.3.4.4				22,202
		3.3.5	Promote proactive regular engagement with various professional groups so as to promote dialogue and harmony		1. Functioning State Health Professions Fora in at least 6 LGAs by end of 2009. 2. Functioning State Health Professions Fora in all LGAs by end of 2015		**11,299,398**
			3.3.5.1	Establish a State level forum for meetings of professional groups		Professional groups are registered and can be identified	3,158,663
			3.3.5.2	Conduct regular meetings of State representatives of professional groups with SMOH management		Funds are available	4,666,206
			3.3.5.3	Promote the establishment of State level for regular meetings of professional groups at State level		Funds are available	172,291
			3.3.5.4	Encourage the establishment of LGA level for regular meetings of professional groups at local level		Professional groups are registered, can be identified and attend meetings	2,584,360
			3.3.5.5	Monitor the meetings that are taking place and the matters discussed and resolved at the State and LGA Health Professional Fora		Monitoring team available	717,878
	3.4	**To strengthen the capacity of training institutions to scale up the production of a critical mass of quality,**			**One major training institution per Zone**		**149,852,713**

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PRIORITY						
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
		multipurpose, multi skilled, gender sensitive and mid-level health workers			**producing health workforce graduates with multipurpose skills and mid-level health workers by 2015**		
		3.4.1	To review and adapt relevant training programmes for the production of adequate number of community health oriented professionals based on national priorities		National Midwives Service Scheme initiated by 2010 in the state. Training programmes of other health related institutions in HRH reviewed by the state before end of 2011		**43,003,756**
			3.4.1.1	Review training programmes of health related institutions in HRH in line with national priorities		National priority areas made available to state	577,174
			3.4.1.2	Design and implement special training programmes aimed at producing cadres of health professional in critical areas of need-IMNCH		Funds are available	36,066,184
			3.4.1.3	Promote the national Midwives Service Scheme and the Community Midwifery programme		Assistance obtained from National body	5,254,866
			3.4.1.4	Review admission criteria for relevant disciplines in response to the HRH crisis in disavantaged areas of the state and strengthen adequate production of qualified health professionals through appropriate accreditation and regulatory bodies		Admission criteria used in admitting staff	459,442
			3.4.1.5	Conduct regular review of functions and mandates of HRH regulatory bodies and strengthen public private partnership in HRH development			646,090
		3.4.2	To strengthen health workforce training capacity and output based on service demand		1. 2 schools of midwifery renovated by end of 2013. 2. 300 delivery kits supplied by 2013. 3. 120 midwives and 100 SCHEWs trained for emergency obstetric care by 2013		**57,965,192**

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PRIORITY							
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	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
			3.4.2.1	Map the capacity for production of health care providers by training institutions in Cross River State		Health care providers are registered and can be identified	1,938,270
			3.4.2.2	Review of training curricula of identified training institutions to reflect the disease burden situation in the state			790,527
			3.4.2.3	Promote human capital capacity building and continuing professional development (CPD)			4,623,133
			3.4.2.4	Ensure periodic upgrading of teaching and learning material, infrastruction and financial support as incentive for retention of staff.		Funds are available	5,501,816
			3.4.2.5	Establish mechanisms for identifying areas of service demand and train manpower accordingly		Mechanisms for identifing areas of health service demand available	45,111,445
		3.4.3	To improve or strengthen communication and collaboration between ministry of health and and other health related ministries and training institutions		Curriculum review committee with representatives from MoH and other training institutions established by 2010		**5,146,610**
			3.4.3.1	To establish areas of cooperation in terms of HRH between Ministry of health and training institutions		Commitment by both MoH and other training institutions	1,895,198
			3.4.3.2	Establish curriculum review committee with representatives from the Ministry of health and training institutions		Curriculum to be reviewed is available	763,966
			3.4.3.3	Establish HRH committee that will regularly review manpower needs and communicate same to training institutions			287,869
			3.4.3.4	Monitor and evaluate functions of the committee on yearly basis		M&E motivated to their functions	2,199,578
		3.4.4	Establish the situation of training institutions and include training on quaity assurance		1. Comprehensive data base of Health training institutional capacity (infrastructure, teachers, other resources) established and maintained by end of 2009.		**37,918,036**

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	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
					2. Incentive programme implemented for academic staff in 2011		
			3.4.4.1	Establish quality assurance units and education units in all training institutions with incentives for satisfactory performance			3,101,232
			3.4.4.2	Set up and strengthen training institutions for production of health care providers in Cross River State based on need	No of training institutions for production of health care providers set up		3,101,232
			3.4.4.3	Conduct a survey to establish the requirements for infrastructure, teaching and learning materials and budget financial support for training institutions	No and type of infrastructure, teaching and learning materials provided by training institution. Level of financial support provided for training institutions.	Availability of fund in the context of global economic meltdown	3,618,104
			3.4.4.4	Ensure Full accreditation of schools	No of training institutions with quality assurance units and education units	School authorities commited and funds are available	28,097,467
			3.4.4.5	Establish incentives and regular upgrading structure for academic staff so as to ensure their retention	Incentives and upgrading structures for academic staff established	Funds are available and incentives are enough to improve staff retention	-
		3.4.5	Review and refine the functions, mandates and responsibilities of professional regulatory bodies with view to strengthening adequate production of various health professionals		1. Initial review of functions and mandates of all health professions regulatory bodies completed by end 2010. 2. 50% of training insitutions have amended curriculae for health professions by end 2011. 3. 10% increased production of key auxilliary workers by end of		**5,819,118**

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	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
					2011		
			3.4.5.1	Establish a process to review the functions and mandates of regulatory bodies on an ongiong process with aim of strengthening adequate production and registration of health professionals	No of regulatory bodies with functions and mandates reviewed		1,148,605
			3.4.5.2	Establish or strengthen the regular monitoring process to ensure that training curricula and programmes are reviewed and appropriately accredited and that theregulatory bodies ensure that they reflect multi-tasking and task shigting as appropriate	No of training curricula and programmes reviewed by accrediting and regulatory bodies		933,241
			3.4.5.3	With the regulatory bodies and training institutions review admission criteria for disciplines in response to HRH crisis in disadvantaged areas of the State	No of disciplines with admission requirements reviewed in response to HRH	Potential risk of reducing quality of products from the training institutions	459,442
			3.4.5.4	Continuously review assessment conducted by training institutions to meet accreditation and professional requirement	No of training institutions at State levels assessd to meet accreditation		1,780,337
			3.4.5.5	Establish or expand training of auxilliary cadres of HRH such as community health workers and multipurpose health workers	No of training centers established for training of auxilliary cadres of HRH such as community health workers and multipurpoe health workers	Funds are available	1,497,493
	3.5	**To improve organizational and performance-based management systems for human resources for health**			**50% of States have implemented performance management systems by end 2012**		**334,707,686**
		3.5.1	To achieve equitable distribution, right mix of the right quality and quantity of human resources for health		Database of HRH developed and house numbering done by 2013		**10,165,151**
			3.5.1.1	Create a database of HRH and develop and provide job descriptions and specifications for all categories of health workers/House numbering			4,594,418
			3.5.1.2	Redeploy staff equitably between rural and urban areas and at the different levels of the health care system in		Staff agree to serve in rural communities	1,722,907

CROSS RIVER STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
PRIORITY							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
				relation to needs, paying attention to staff mix			
			3.5.1.3	State MoH will collaborate with Federal institutions located in the state to leverage available human resource so as to expand service coverage and quality		Federal training institutions are located in the state to train health personnels	1,177,320
			3.5.1.4	To promote mandatory rotation of health workers to underserved rural areas, e.g through NYSC scheme for doctors, pharmacists and appropriate scheme for midwives and nurses		Adequate number of NYSC, etc posted to the state	804,023
			3.5.1.5	Institute use of intra or extra mural private practice services to improve services in underserved areas as well as provision of incentives for health workers in underserved areas			1,866,482
		3.5.2	To establish mechanisms to strengthen and monitor performance of health workers at all levels		Check list for objective assessment of performance developed by 2011		**24,929,027**
			3.5.2.1	Conduct routine re-orientation of health workforce on attitudinal change including training and retraining in Interpersonal Communication (IPC) skills and work ethics		Health workers are committed to IPC skills	2,153,634
			3.5.2.2	Institute a system of recognition, reward and sanctions at all levels of care		Such system will be objective and unbiased	2,182,349
			3.5.2.3	Establish and institutionalize a framework for an integrated supportive supervision with adequate committed resources for all types and levels of care providers across public and private sectors.			1,895,198
			3.5.2.4	Establish mechanisms to monitor health worker performance, including use of client feedback (exit interviews)			18,697,847
			3.5.2.5				-
		3.5.3	To develop objective assessment mechanisms of health cadre		Objective assessment mechanism of health cadre developed by 2011		**4,852,854**
			3.5.3.1	Evaluate existing appraisal mechanisms of health staff		An appraisal mechanism	1,033,744

CROSS RIVER STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
PRIORITY							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
						already exists	
			3.5.3.2	Establish a 6 monthly appraisal of staff using objective, verifiable method		Time and fund available	804,023
			3.5.3.3	An appraisal committee should be strengthened and protected from intimidation		Appraisal committee has politicy backing	143,576
			3.5.3.4	Staff complaint forum should be set up for agrieved staff. These should meet every 6 months		Complaint forum is unbiased	861,453
			3.5.3.5	Budgetary provision for the appraisal committee to be made		Political commitment present	2,010,058
		3.5.4	Motivation of the health workforce by the creation of incentives for health workers along with recognition of hard work and service with emphasis on those that will attract and retrain staff in ruarl and deprived locations		Workplace satisfaction improved by 5% per year from 2010		**4,737,994**
			3.5.4.1	Define performance incentives and management system and encourage SMOH to implement	No of LGAs that have defined performance incentives and management system. No of LGAs that are implementiing defined performance incentives and management system		430,727
			3.5.4.2	Develop guidelines and recommendations on additional incentives for health workers working in rural and deprived areas	No of LGAs providing additional incentives for health workers working in rural and deprived areas		344,581
			3.5.4.3	Develop guidelines on what constitutes an enabling work environment and promote the compliance with the standards at State and LGAs	No of LGA work places providing enabling work environment		344,581
			3.5.4.4	Establish mechanisms to minimize work place hazards through management of physical risks and mental stress as well as full compliance with prevention and protection guidelines	No of LGA work places with mechanisms to minimize work place hazards. No of LGA work places that are fully compliant with prevention and protection guidelines		459,442
			3.5.4.5	Intervene where ever possible to ensure that health workers are paid on time	Proportion of health workers at LGA levels that are paid	Funds are available	3,158,663

CROSS RIVER STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
PRIORITY							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
					on time		
		3.5.5	Develop and institute a system for mandatory deployment of newly qualified health workers to underserved rural areas (includes NYSC scheme for doctors, pharmacists, midwives and nurses)		State and all LGAs have established database of fresh graduates by 2011		**290,022,660**
			3.5.5.1	Establish and maintain database of fresh graduates of professionals for one year mandatory health services in rural areas and for re-absorption and posting for services in rural areas respectively	State and LGAs have established database of fresh graduates of health professionals	Availability of enabling legislation	2,871,511
			3.5.5.2	Work with the SMOH to ensure that facilities have accomodation and adequate professional supervision for deployed junior staff (Construction of staff quarters)			287,151,149
	3.6	**To foster partnerships and networks of stakeholders to harness contributions for human resource for health agenda**			**50% of States have regular HRH stakeholder forums by end 2011**		**55,815,005**
		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		Number of committee meetings involving all stakeholders held by end of 2012		**55,240,702**
			3.6.1.1	Establish effective dialogue and complaints channels between management and staff of public and private sectors as well as HRH regulatory bodies and associations.			3,374,026
			3.6.1.2	Involvement of workers and professional groups in management teams, design and monitoring of services to enhance cooperation among all actors			179,469
			3.6.1.3	Establish quarterly forum for health care professional associations and regulatory bodies at all levels on MNCH issues			51,687,207
		3.6.2	Develop and institutionalize forum for policy review, supervisory and monitoring support framework for private and public practitioners at all levels of health service delivery in the state		All health practitioner policies professionally reviewed by end of 2013		**574,302**
			3.6.2.1	Joint policy review for a organized for private and public practitioners and meetings taking place quarterly	No of joint review for a organized for policy review supervisory and monitoring support framework for private and public		574,302

CROSS RIVER STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
PRIORITY							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
					practitioners at State level and fore all of health care delivery		
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							**15,361,213,679**
	4.1	**To develop and implement health financing strategies at Federal, State and Local levels consistent with the National Health Financing Policy**			**50% of States have a documented Health Financing Strategy by end 2012**		**302,075,680**
		4.1.1	To develop and implement evidence-based, costed health financing strategic plans at LGA and State levels in line with the National Health Financing Policy		State and LGAs to have devloped costed Health Financing Strategic Plans by 2010		35,020,705
			4.1.1.1	Technical working groups for health financing at LGA and State will be set up			3,060,062
			4.1.1.2	Capacity will be built for the development and implementation of the Strategic plan at both LGA and State			2,380,048
			4.1.1.3	Draft the Strategic Plans at all levels		Personnel to draft the Strategic plan at LGA available	13,600,274
			4.1.1.4	Yearly review of the strategic plan at both LGA and state		Strategic plan in both State and LGAs exists	15,980,322
		4.1.2	To establish accurate accounting and auditing mechanisms at both State and LGAs		Ministerial Due Process established by 2010		266,204,958
			4.1.2.1	To establish Ministerial Due Process			266,204,958
		4.1.3	To strengthen legislation on health insurance		Existing legislation on health insurance evaluated by 2010		850,017
			4.1.3.1	Evaluate the existing legislation on health insurance		Legislation on health insurance exists	850,017
	4.2	**To ensure that people are protected from financial catastrophe and impoverishment as a result of using health services**			**NHIS protects all Nigerians by end 2015**		**10,075,203,783**
		4.2.1	To strengthen systems for financial risk health protection		40% coverage of the population by end of 2015 80% coverage of vulnerable groups by		9,401,189

CROSS RIVER STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
PRIORITY							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
					end of 2015		
			4.2.1.1	Support LGAs to explore existing and innovative social health protection approaches-social health insurance, other pre-paid schemes, community-based health insurance schemes, etc - for sustainable health financing with protective measures against the financial risks associated with ill health.		Health insurance scheme exists in the State and LGAs	3,060,062
			4.2.1.2	Provide Technical support to LGAs to rapidly scale up successful approaches to achieve wider population coverage.			2,210,044
			4.2.1.3	strenghten the capacity of the health insurance scheme to provide effective regulatory framework for social health insurance and protection programmes in the state		Health insurance scheme exists in the State and LGAs	4,131,083
		4.2.2	To establish and strengthen community health financing mechanism at the LGAs		Communities with existing community financing mechanism listed by 2010		3,060,062
			4.2.2.1	To identify different communities or groups with existing community financing mechanism		various financing options are identifiable	850,017
			4.2.2.2	To provide technical assistance that will encourage and strengthen community financing			2,210,044
		4.2.3	To improve coverage of Cross Riverians on the National Health Insurance Scheme		Improve National Health insurance Scheme coverage by 50% of 2010 values		9,953,766,939
			4.2.3.1	Carry out a situation analysis and obtain percentage of people presently on NHIS		NHIS existing in the state	8,500,171
			4.2.3.2	To ensure a phased coverage of NHIS starting with the formal sector and eventually covering all parts of the state			9,938,055,223
			4.2.3.3	To identify the most appropriate payment mechanisms for the NHIS bearing in mind the national method			2,091,042
			4.2.3.4	To identify the diseases that will initially be covered by te NHIS			714,014
			4.2.3.5	Monitor and evaluate the implementation of the scheme every 6 months			4,406,489
		4.2.4	To harmonize all the various health insurance scheme to improve its effectiveness		Public enlightenment campaign carried out in all the LGAs by 2013		581,412

CROSS RIVER STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
PRIORITY							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
			4.2.4.1	Identify the various existing financing options and establish forum for regular discussions			581,412
			4.2.4.2	Carry out public enligthenment campaigns to highlight need for health insurance		Appropiate health education campaign to be used	2,254,245
		4.2.5	To provide free maternal and child health services		Free maternal and child health services started in all public health facilities by 2010		108,394,182
			4.2.5.1	Estabilshment of health facilities in all LGAs that provide free MCH services		Political commitment present and funds available	108,394,182
	4.3	**To secure a level of funding needed to achieve desired health development goals and objectives at all levels in a sustainable manner**			**Allocated Federal, State and LGA health funding increased by an average of 5% pa every year until 2015**		**4,746,779,442**
		4.3.1	To improve financing of the Health Sector		State govt allocate 7.5% and all LGAs allocate 5% of their budgets to PHC activities by 2011		1,023,080,592
			4.3.1.1	State government and LGAs will allocate 7.5% and 5% of their budgets respectively to PHC activities		Political will is present	-
			4.3.1.2	Yearly review of the budgetary allocation will be carried out to meet up with the 15% Abuja declaration.		Political will is present	3,060,062
			4.3.1.3	To Strenghten the Existing and potential financing strategies such as pre-payment schemes, and health insurance schemes, grants from the Federal Government, proportion of Value Added Tax (VAT), "sin tax" from alcohol and cigarette and donations from corporations and charities through advocacy.			-
			4.3.1.4	Establishment of special funds for chronic and emerging diseases (e.g. mental health, cancers, diabetics etc.		Funds are available	1,020,020,531
			4.3.1.5	Establish careful consideration of the			

CROSS RIVER STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
PRIORITY							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
				impact on poverty and gender and financing safety nets			-
		4.3.2	To improve coordination of donor funding mechanisms		State and LGAs to have functional donor coordinating mechanisms by end of 2010		6,533,231
			4.3.2.1	International development partners will align their support to the state and ensure it is captured within the broad budgetary estimates on a yearly basis		International dev. Partners are in the State and willing to partner with the state	-
			4.3.2.2	The State Ministry of health in collaboration with Development Partners will conduct a detailed assessment of coordination of donor agencies which exist in the state		Development partners operating in the state are identifiable	1,054,021
			4.3.2.3	Appropriate models for more effective coordination between state and Development partners will be established including State /LGA/Communities partnership MNCH			5,479,210
			4.3.2.4	Mechanisms for coordinating donor resources with that of State and LGAs will take the form of common basket funding through options such as joint funding agreements, secto-wide approaches (SWAps) and sectoral multi-donor budget support, PMNCH etc.			-
			4.3.2.5	The implementation of Paris declaration on aid effectiveness with a follow up of the Accra agenda will be promoted			-
		4.3.3	Identify all other possible sources of health funding		Other counterpart health funding indentified for Specialist Hospitl on PPP basis by 2011		3,657,861,624
			4.3.3.1	Indentify and encourage philantropy and counterpart funding for Specialist Hospital on PPP basis		Public spirited persons and agencies present in the State	3,060,061,592
			4.3.3.2	Establish a committee responsible to finding ways to improve Public-Private Partnership in health funding			2,278,046
			4.3.3.3	To set up a committee to identify possible foreign partners to assist in health financing in the state			510,010

CROSS RIVER STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
PRIORITY							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
			4.3.3.4	CRS participation in HSDP 111 (counterpart fund contribution)		CRS still participating in HSDP 111	595,011,976
		4.3.4	Government at both State and LGA levels to allocate at least 15% of their total budgets to health		State and LGAs allocate 15% of their budget to health by 2015		57,263,953
			4.3.4.1	Secure statutory protection through LGA and State Assembly to allocate 15% of budgets to health sector		Political commitment present and appropiate bill passed by legislators	54,928,106
			4.3.4.2	Ensure that 45% of the health buget is allocated to capital expenditure		Political commitment present and appropiate bill passed by legislators	901,018
			4.3.4.3	Ensure that one tenth of the target 15% allocation (i.e. 1.5%) should be earmarked for social health protection programmes		Political commitment present and appropiate bill passed by legislators	340,007
			4.3.4.4	Ensure that 2% of the consolidated fund from the Federation Account is released for Primary Health Care as provided in the National Health Bill		Political commitment present and appropiate bill passed by legislators	397,808
			4.3.4.5	Ensure that 2% of the total health budget is allocated to research for health at all levels		Political commitment present and appropiate bill passed by legislators	697,014
		4.3.5	10% of VAT to be dedicated to social health programmes		Legislation passed for 10% of VAT to be dedicated to social health programmes		2,040,041
			4.3.5.1	Work with the SMOH and other key stakeholders to secure support for allocating a dedicated portion of VAT for social health protection programmes			255,005
			4.3.5.2	Draft a bill for the State Assembly to pass to secure 10% of VAT for social		State Assembly ready to pass the	935,019

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PRIORITY							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
				health protection programmes		bill	
			4.3.5.3	Get the State Assembly to pass a bill to secure 10% of VAT for social health protection programmes			850,017
	4.4	**To ensure efficiency and equity in the allocation and use of health sector resources at all levels**			**1. Federal, 60% States and LGA levels have transparent budgeting and financial management systems in place by end of 2015 2. 60% of States and LGAs have supportive supervision and monitoring systems developed and operational by Dec 2012**		**237,154,773**
		4.4.1	To improve Health Budget execution, monitoring and reporting		Health budget execution, monitoring and reporting improved by 2011		44,710,900
			4.4.1.1	The State Ministry of health will provide technical assistance to aid LGAs in developing costed, annual operational plans.			36,720,739
			4.4.1.2	Additional capacity will be built to ensure that proper internal recording and accounting of expenditures are maintained and that timely and detailed financial management reports are produced periodically.		External auditors available to audit the unit	6,800,137
			4.4.1.3	Credible mechanisms will be put in place to increase financial transparency through the development of State and LGA Health Accounts (SHA and LHAs) and Public Expenditure Reviews (PERs) tracking of health bugets)			1,190,024
		4.4.2	To strengthen financial management skills		Training on financial management conducted in the state by 2013		185,983,743
			4.4.2.1	Hands-on training and competency transfer will be conducted to enable the			22,780,459

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PRIORITY							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
				State and LGAs manage their financial management systems			
			4.4.2.2	Yearly retraining of the health staff involved in finance at both LGA and State		Funds are available	163,203,285
		4.4.3	To ensure equity in allocation and distribution of health resources		Checks carried out for location of various health resources by end of 2012		6,460,130
			4.4.3.1	To conduct regular checks and location of various health resources e.g. manpower and materials		All health resources in the State and LGAs identifiable	3,570,072
			4.4.3.2	To identify areas of health need and relative resource distribution			2,890,058
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							1,322,389,618
	5.1	**To improve data collection and transmission**			**1. 50% of LGAs making routine NHMIS returns to State level by end 2010 2. 60% of States making routine NHMIS returns to Federal level by end 2010**		**1,099,844,560**
		5.1.1	To ensure that NHMIS forms are available at all health service delivery points at all levels		NHMIS forms available in 80% of the health facilities by 2011		586,845,900
			5.1.1.1	State and LGAs to provide adequate budget and ensure funds are released for printing/distribution of the data collection forms		**Funds are available**	586,325,390
			5.1.1.4	Review best mechanisms for making sure the forms are available at the health facilities		**Health facilities are accessible**	9,464
			5.1.1.5	Indentify a point person whose responsibility it is to ensure the forms are always available		**Person is committed**	511,046
		5.1.2	To periodically review of NHMIS data collection forms		Adapted NHMIS forms reviewed by 2010		4,208,243
			5.1.2.1	State and LGAs to create mechanisms to			

CROSS RIVER STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
PRIORITY							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
				ensure regular feedback from the field on the appropriateness and user friendliness of data collection tools			56,783
			5.1.2.2	State and LGAs to establish mechanisms for annual review of the NHMIS			340,697
			5.1.2.3	State to establish NHMIS review committee and adapt it to SHMIS			340,697
			5.1.2.4	Budgetary allocation made available for activities of the committee activities		Political commitment present	1,892,763
			5.1.2.5	Establishment of an "Alert Mechanism" for emergency review or introduction of new NHMIS data collection forms			1,577,302
		5.1.3	To coordinate data collection from vertical programmes		Health Data Consultative Committee formed by 2010		136,625,929
			5.1.3.1	Revitalise the Health Data Consultative Committee in the state in collaboration with partners and other government agencies to streamline and strenghten data collection systems.			946,381
			5.1.3.2	Establish and strenghten linkages and harmonized data collection mechanism at state and LGA level including maternal and perinatal audit system.			347,007
			5.1.3.3	Ensure appropriate and timely transmission of collected data		**Mechanisms are place to reduce time spent in reporting data**	18,927,628
			5.1.3.4	Conduct Integrated Supportive Supervision monthly by State and weekly by LGA		**Ongoing Vertical programmes in the State and LGAs are reported to appropriate health authorities**	115,837,084
			5.1.3.5	Hold quaterly meetings to review data collection in the State			567,829
		5.1.4	To build capacity of health workers for data management		Training on data collection tools conducted by 2013. ICT equipments provided to 80% of the data managers		43,033,224

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PRIORITY							
Goals						**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Cost (2010-2015)**
	Strategic Objectives					**Targets**		
		Interventions				**Indicators**		
			Activities			**None**		
			5.1.4.1	Conduct comprehensive training and re-training of service providers on data collection tools, analysis and utilization of data for action in health programming and policy formulation		Facilities available for data entry and analysis at health facilities	3,154,605
			5.1.4.2	Establish adequate monitoring systems at state level to ensure data quality		System to monitor data quality established	3,406,973
			5.1.4.3	Recruitment of health information personnel, where grossly inadequate		Objectivity used in personnel employment	10,578,651
			5.1.4.4	To provide ICT equipments to data managers		Data managers conversant with ICT equipments	3,179,842
			5.1.4.5	To create or strengthen data management unit at both State and LGAs		Manpower to establish data management unit at the LGAs present	22,713,154
		5.1.5	To provide a legal framework for activities of the NHMIS programme			Legal framework for activities of the NHMIS programme established in the State by 2010		11,088,435
			5.1.5.1	Establishment of sanction of private care providers that fail to submit health data to the relevant health authorities			**Supporting legislation passed**	47,319
			5.1.5.2	Establish mechanisms to enforce these sanctions				1,324,934
			5.1.5.3	Put in place additional legal framework for activities of the NHMIS programme in both state and LGAs			**Legal frameworks in both state and LGAs don't conflict with each other**	1,892,763
			5.1.5.4	Embark upon systemic advocacy to policy makers to make them understand the value and usefulness of data as well as promulgate an enabling law and bye laws to make this mandatory				1,987,401
			5.1.5.5	Strengthen vital registration system in the State and LGAs			**Facilities available for carry out vital registration in State and LGAs**	5,836,019
		5.1.6	To improve coverage of data collection			Data collected monthly from at least		304,834,499

CROSS RIVER STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
PRIORITY							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
					80% of health facilities in the State by 2013		
			5.1.6.1	Develop innovative strategies to collect data from all public and private health facilities and equally improve the collection of community based data		Cooperation of the public and private health workers present	112,304
			5.1.6.2	Ensure presence of adequate number of data collecting tools		List of data collecting tools available	17,034,865
			5.1.6.3	Improve follow up mechanisms for defaulting health facilities		Existence of all health facilities present	9,766,656
			5.1.6.4	Conduct household enumeration as part of assigning each JCHEW to 300 households for collection of vital statistics, etc.		JCHEW acceptable by assigned households	25,552,298
			5.1.6.5	Ensure that all levels (including Ward Health Facilities) are involved in data collection		All health facilities are knowledgeable on data collection	252,368,375
		5.1.7	To ensure supportive supervision of data collection at all levels		1. Check list developed for supervision of data collection by 2010. 2. Health personnels that will be responsible for supervising data collection appointed by 2010		13,208,330
			5.1.7.1	Identify and train personnel for supportive supervision of data collection at all levels including ISS		Data collection already taking place	3,312,335
			5.1.7.2	Provide adequate logistics to supervise data collection at lower levels			3,586,786
			5.1.7.3				-
			5.1.7.4	To develop a check list for the supervisors of data collection			1,577,302
			5.1.7.5	Develop a check list for the supervisors of data collection			4,731,907
	5.2	**To provide infrastructural support and ICT of health databases and staff training**			**ICT infrastructure and staff capable of using HMIS in 50% of States by 2012**		**100,171,633**
		5.2.1	To strengthen the use of information technology in		1. Training on use of		

CROSS RIVER STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
PRIORITY							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
			HIS		information technology in HIS carried out by 2010. 2. Software-based systems for data collection present in ata least 50% of LGAs by 2013		34,050,803
			5.2.1.1	Strengthen use of information technology on HIS by training and re-training		Funds are available	22,713,154
			5.2.1.2	Promote decentralized software-based systems for data collection analysis		LGA personnels able to use software	851,743
			5.2.1.3	Establish mechanisms to enhance the wide use of e-health data eg. through electronic Management Intelligence Information System, websites, patient infromation system, etc.			4,731,907
			5.2.1.4	Establish public-private partnerships in the management of data warehouses			170,349
			5.2.1.5	Provide computers and internet facilities for State and all LGAs		Regular electric supply present in both State and LGAs	5,583,650
		5.2.2	To provide HMIS Minimum Package at the different levels (SMOH, LGA) of data management		HMIS Minimum Package present at State and 50% of LGAs by 2011		59,811,620
			5.2.2.1	Identify and implemeent HIS Minimum Package at both State and LGA levels of data management		Political commitment present	15,773,023
			5.2.2.2	Provide adequate and timely availability of the NHMIS Minimum Package at state and LGA levels for data management, inclusive of basic infrastructure for data storage, analysis and transmission systems (computers, power supply and internet).			79,181
			5.2.2.3	Monitor appropiate use of computers hardware systems		Appropiate personnel to monitor use of hardware systems available	34,069,731
			5.2.2.4	Acquire printers at both State and LGA levels		Funds are available	425,872
			5.2.2.5	Build capacity of relevant staff on the database			9,463,814

CROSS RIVER STATE STRATEGIC HEALTH DEVELOPMENT PLAN						
PRIORITY						
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
		5.2.3	Improve monitoring and evaluation		ICT gadgets available to M&E unit by 2010		6,309,209
			5.2.3.1	Provision of ICT gadgets to M & E unit		Funds are available	4,731,907
			5.2.3.2	Capacity building on data collection, M&E activities for PRS staff			1,577,302
	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**		104,748,649
		5.3.1	To strengthen the Hospital Information System		Guidelines for establishment and strengthening of patient information system developed by 2011		1,009,474
			5.3.1.1	SMoH to establish and strengthen patient information systems as well as systems for mapping disease		Political commitment present	946,381
			5.3.1.2	Develop guidelines and technical specifications for the establishment and strengthening of patient information system			63,092
		5.3.2	To strengthen the Disease Surveillance System		1. State GIS established by 2015. 2. Training on DSN carried out in the State and 85% of LGAs by 2013		87,120,718
			5.3.2.1	State and LGAs to ensure that regular reporting of notifiable diseases by all health facilities is carried out		Supervisors available to ensure this	5,678,288
			5.3.2.2	Initiate and strengthen community based surveillance to strengthen disease Surveillance System			315,460
			5.3.2.3	Training and re-training of community based focal persons in disease surveillance and notification		Trained focal persons agree to remain and work in the communities	2,261,852
			5.3.2.4	Establish state GIS to assist in disease surviellance and notification		GIS equipment maintenance possible in the community	78,865,117

CROSS RIVER STATE STRATEGIC HEALTH DEVELOPMENT PLAN						
PRIORITY						
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
		5.3.3	To involve all stake holders in disease surviellance and notification (DSN)		Committee involving all stakeholders established by 2011		416,408
			5.3.3.1	Establish committees that involve all stakeholders including traditional institutions		Traditional institutions agree to be involved	208,204
			5.3.3.2	Establish way to encourage and reward those who are actively involved in DSN		Mechanisms to objectively reward people involved in DSN is in place	208,204
		5.3.4	To establish regular house numbering exercise and establish Home based records		1.House nubering exercise carried out by 2011. 2. Home based records available in 85% of households.		16,202,050
			5.3.4.1	To carry out an updated house hold numbering exercise		Enumerators and funds are available	6,309,209
			5.3.4.2	Produce and distribute home based records		Homes agree to use the home based records	9,892,840
	5.4	**To monitor and evaluate the NHMIS**			**NHMIS evaluated annually**		14,183,103
		5.4.1	To establish monitoring protocol for NHMIS programme implementation at all levels in line with stated activities and expected outputs		HIS Quality Assurance manual produced by 2011. Key SMoH officers trained in the use of the monitoring check list.		13,501,708
			5.4.1.1	Provide timely availability of logistics materials (vehicles or motorcycles) and facility use of NHMIS field monitoring instruments at all levels	No of vehicles purchased	Funds are available	5,299,736
			5.4.1.2	Provide HIS Quality Assurance (QA) manual (Handbook) to be used at each level of health care delivery	Quality data produced		1,261,842
			5.4.1.3	Institute HIS review meetings at LGA level and bi-annual review meetings at state level.			3,154,605
			5.4.1.4	Train key SMOH officers in the use of the field monitoring check list instrument for NHMIS programme	Monitoring conducted with check list		3,785,526
		5.4.2	To strengthen data transmission		Mechanisms available for data transmission		681,395

CROSS RIVER STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
PRIORITY							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
			5.4.2.1	Monitor monthly and quaterly transmission of HMIS data and evaluate the problems that prevent complete and regular transmission of HMIS data	Timeliness of data transmission		681,395
	5.5	**To strengthen analysis of data and dissemination of health information**			**1. 50% of States have Units capable of analysing health information by end 2010 2. All States disseminate available results regularly**		3,441,674
		5.5.1	To institutionalize data analysis and dissemination at all levels		Guidelines and training programme on data analysis for use at State and LGAs developed by2011		3,441,674
			5.5.1.1	Strengthen institutional and human capacities for appropriate data analysis and dissemination of information and data to inform decision making and programming		Availability of capacity to analyze data at LGA level	1,104,112
			5.5.1.2	Production of periodic health data bulletin and annual reports by state Department of Planning, Research and Statistics	No of bulletin produced		981,082
			5.5.1.3	Develop guidelines and a training programme on data analysis for use at all levels	No of health facilities with analyzed data		757,105
			5.5.1.4	Promote the use of data at all levels for informed decision making using pilot sites	No of decision made based on analyzed data		31,546
			5.5.1.5	Monitor Annual Reports of the National Director of Planning Research and Statistics by the State	Report of Director DPRS available		567,829
COMMUNITY PARTICIPATION AND OWNERSHIP							
6. To attain effective community participation in health development and management, as well as community ownership of sustainable health outcomes							881,593,079
	6.1	**To strengthen community participation in health development**			**All States have at least annual Fora to engage community leaders and CBOs on health matters by end 2012**		**59,832,378**
		6.1.1	To provide an enabling policy framework for		Updated guidelines		

CROSS RIVER STATE STRATEGIC HEALTH DEVELOPMENT PLAN						
PRIORITY						
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
			community participation		available by end of 2009		2,776,488
			6.1.1.1	Create an enabling policy environment to foster effective community participation in health actions through the appropiate revision of community participation section of the National Health Policy and finalization of the Community Development Policy		Political commitment present	2,776,488
		6.1.2	To provide an enabling implementation framework and environment for community participation		Intersectoral stakeholder committees established by 2010		923,361
			6.1.2.1	Update and adapt the guidelines for establishing community development	Updated guidelines available by end of 2009		150,691
			6.1.2.2	Develop and utilise participatory tools and approaches to enhance community involvement in planning, management, monitoring and evaluation of health interventions			320,596
			6.1.2.3	Establish inter-sectoral stakeholder committees involving community representatives at all levels so as to enhance collaboration	Committees established at each level by 2010	Inter-sectoral collaboration will eventually improve health service	452,074
		6.1.3	Reactivate and sustain Village Development Committee (VDC) and Ward Health Committee (WHC)		VDC and WHC established by 2011. Budgetary allocation made by 2015.		56,132,528
			6.1.3.1	Establish or reactivate the VDC and WHC			5,650,926
			6.1.3.2	Define the roles of these committees			-
			6.1.3.3	Make budgetary allocation for the sustenance of the VDC and WHC			30,138,270
			6.1.3.4	Ensure regular meetings of these committee at least once every 6 months		Funds are available	10,849,777
			6.1.3.5	Establish community dialogue with TBAs, CBO,youths and other groups			9,493,555
	6.2	**To empower communities with skills for positive health actions**			**All States offer training to FBOs/CBOs and community leaders on engagement with the health system by end 2012**		**800,998,748**

CROSS RIVER STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
PRIORITY							
Goals						**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Cost (2010-2015)**
	Strategic Objectives					**Targets**		
		Interventions				**Indicators**		
			Activities			**None**		
		6.2.1	To build capacity within communities to 'own' their health services			Key stakeholders in the State and LGAs identified and mapped out by 2013		7,120,543
			6.2.1.1	Develop, upgrade or modify existing participatory tools for mobilising communities in planning and management				3,239,864
			6.2.1.2	Identify and map out key community stakeholders and resources with community assessment of capacity needs.		Community stakeholders certified and mapped out by December 2010		1,883,642
			6.2.1.3	Re-orient community development committees and community-based health care providers on their roles and responsibilities and mobilize resources and allocate funds for community level activities			Funds are available	866,475
			6.2.1.4	Establish community dialogue between communities and government structures for maximum impact and information, education and communication (IEC) activities and media used to enlghten andempower communities for positive impact				377,105
			6.2.1.5	Involve communities at all levels in program planning, implementation and monitoring				753,457
		6.2.2	To strenghten individual, family, and community capacity to respond to MNCH issues at home and seek health care appropriately					793,878,205
			6.2.2.1	create an enabling policy environment to foster effective community participation in health actions through the appropiate revision of community participation section of the National Health Policy and finalization of the Community Development Policy				5,424,889
			6.2.2.2	Training of CORPS including CBOs and Faith - based Organizations to counsel care givers on key household practices				13,562,222
			6.2.2.3	Support CORPs to promote key household practices with cash incentives				175,440,899
			6.2.2.4	State to support LGA to conduct monthly meeting of Community Development Committee (CDC) and VDC/WDC to mobilize community resources for				531,639,088

CROSS RIVER STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
PRIORITY							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
				emergency transportation, blood donors, and other emergency preparedness			
			6.2.2.5	Establish community-based care models for mothers and new borns in various communities			67,811,108
	6.3	**To strengthen the community - health services linkages**			**50% of public health facilities in all States have active Committees that include community representatives by end 2011**		8,303,093
		6.3.1	To restructure and strengthen the interface between the community and the health services delivery points		Guidelines for strengthening community-health services interphase developed by 2011		8,303,093
			6.3.1.1	Review and assess level of linkages of the existing health delivery structures			165,760
			6.3.1.2	Provide technical guidance and support to community-health service linkage			2,712,444
			6.3.1.3	Restructure health delivery structure to ensure adequate promotion of community participation in health development		Sense of community ownership of health programmes is present	421,936
			6.3.1.4	Promote the exchange of experiences between community development committees		Functional community development committees present	399,332
			6.3.1.5	Develop guidelines for strengthening the community-health services interphase			4,603,621
	6.4	**To increase national capacity for integrated multisectoral health promotion**			**50% of States have active intersectoral committees with other Ministries and private sector by end 2011**		10,966,563
		6.4.1	To develop and implement multisectoral policies and actions that facilitate community involvement in health development		Advocacy visits paid to all community gatekeepers by 2015		10,966,563
			6.4.1.1	Undertake advocacy to community gatekeepers to increase their awareness on community participation and health		Community gatekeepers are idntifiable and	2,486,407

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PRIORITY							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
				promotion		health conscious	
			6.4.1.2	Develop and implement community health development programmes			2,486,407
			6.4.1.3	Formulate action plans to facilitate the development of health promotion capacities at the community levels			75,346
			6.4.1.4	Use the health promotion guidelines to link health with other sectors		Health promotion guidelines available to 85% of health workers	37,673
			6.4.1.5	Empower communities with health knowledge, behavioural communication change and uptake mechanisms to promote key household and community practices			5,880,730
	6.5	**To strengthen evidence-based community participation and ownership efforts in health activities through researches**			**Health research policy adapted to include evidence-based community involvement guidelines by end 2010**		1,492,296
		6.5.1	To develop and implement systematic measurement of community involvement		Modality for measurement of community involvement developed by 2011		1,492,296
			6.5.1.1	Use locally adapted models to establish simple mechanisms to support communities to measure impact			173,747
			6.5.1.2	Document lessons learnt and best practices from specific community-level approaches, methods and initiatives			414,401
			6.5.1.3	Disseminate above findings to enhance knowledge sharing among stakeholders		Knowledge sharing among stakeholders will led to improved participation	904,148
PARTNERSHIPS FOR HEALTH							
7. To enhance harmonized implementation of essential health services in line with national health policy goals							881,593,079
	7.1	**To ensure that collaborative mechanisms are put in place for involving all partners in the development and sustenance of the health sector**			**1. FMOH has an active ICC with Donor Partners that meets at least quarterly by end 2010**		**881,593,079**

CROSS RIVER STATE STRATEGIC HEALTH DEVELOPMENT PLAN						
PRIORITY						
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
					2. FMOH has an active PPP forum that meets quarterly by end 2010 3. All States have similar active committees by end 2011		
		7.1.1	To promote Public Private Partnerships (PPP)		Strategies for implementing PPP initiative in line with the National policy developed by 2011		89,224,418
			7.1.1.1	State to develop strategies for implementing PPP initiatives in line with the national policy		National policy on PPP known by state staff	252,426
			7.1.1.2	Conduct meeting to intensify PPP with corporate organizations in their respective areas of operation including local production of MNCH commodities (e,g zinc, ORS, Ready to use therapeutic food , Family Planning etc)			6,361,131
			7.1.1.3	Undertake mechanisms for engaging the private sector - such as contracting or out-sourcing, leases, concessions, social marketing,, franchising mechanism and provision incentives (e.g. MNCH commodities, or technical support at no cost)			15,145,550
			7.1.1.4	Explore other options that encourage the private sector set up health facilities in rural and under-served areas e.g. construction of canten for catering services under PPP at General Hospitals Calabar, Ugep and Ogoja			66,433,244
			7.1.1.5	Establish joint monitoring visits by public care providers with adequate feedback		Time available and both private and public health staff are committed	1,032,068
		7.1.2	To institutionalize a framework for coordination of Development Partners		Development Partners Forum established by 2010. HPCC established by 2010		7,240,078
			7.1.2.1	Establish Development Partners Forum comprising only health development		Political commitment	1,476,691

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PRIORITY							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
				partners at state level as single entry point for engaging with partners in collaboration with International Donor Support (IDS) department .		present	
			7.1.2.2	Establish and strengthen Health Partners Coordinating Committee (HPCC) as a government coordinating body with all other health development partners			3,382,506
			7.1.2.3	Establish mechanisms for resource coordination through common basket funding models such as Joint funding Agreement, Sector Wide Approaches and sectoral multi-donor budget support			757,277
			7.1.2.4	Establish State/LGA multi-sectoral partnership for MNCH at all levels including private sector			1,623,603
		7.1.3	To facilitate inter-sectoral collaboration		Inter-sectoral ministerial forum set up at the State level by 2010		781,197,366
			7.1.3.1	Establish an inter-sectoral ministerial forum at all levels to facilitate inter-sectoral collaboration, involving all relevant MDAs directly engaged in the implementation of specific health programmes - such as Environment in Malaria control and prevention, Agriculture in nuitrition programmes, Water Resources in control of water borne or related diseases, etc.			1,262,129
			7.1.3.2	In collaboration with Ministry of Env and other donor agencies to strengthen infection prevention, control and health care waste management in the PHC		Mechanism present for collaboration present	18,618,929
			7.1.3.3	In collaboration with other stakeholders, strengthen food safety and inspection services			1,514,555
			7.1.3.4	Build capacity of NGOs in the state with skills related to their roles and responsibilities in IMNCH implementation			2,524,258
			7.1.3.5	Conduct training for Health Care Providers in Public and Private Sector, Teaching and Reasearch Institutions, NGOs, CBOs, FBOs on all IMNCH Services/interventions-(Life Saving Skills (LSS),Expanded Life Saving Skills (ELSS),Modified Life Saving Skills			757,277,494

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	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
				(MLSS), Emergency Obstetric and Neonatal Care (EmONC),Focussed Antenatal Care (FANC), Essential Newborn Care (ENCC-Community and Facility) ,Integrated Management of Childhood Illnesses (IMCI-Community and Facility based), Severe Acute Malnutrition (SAM-Inpatient and Out patient),Infant and Young Child Feeding (IYCF), Family Plannning (FP), Adolescent services friendly,			
		7.1.4	To engage professional groups		At least 1 public health lecture involving professional associations held by 2010		953,665
			7.1.4.1	Promote effective partnership with professional groups through jointly setting standards of training by health institutions, subsequent practice and professional competency assessments		Professional competence assessments acceptable by all health workers	63,106
			7.1.4.2	Engage professional groups in planning, implementation, monitoring and evaluation of health plans and programmes		Professional groups agree to be involved	252,426
			7.1.4.3	Promote effective communication to facilitate relationships between professional groups and Ministry of Health			166,601
			7.1.4.4	Strengthen collaboration between government and professional groups to advocate for increased coverage of essential interventions, particularly increased funding		Funds available	67,650
			7.1.4.5	Convene public lectures through a coordinated approach by professional associations to enhance the provision of skilled care by health professionals			403,881
		7.1.5	To engage with communities		Indicators on health system performance developed at State and 80% of the LGAs by 2011. Health Service Charter with NGOs and other stakeholders by 2011		476,012
			7.1.5.1	Improve availability of information to		Culturally	

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	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
				communities, in a form that is readily accessible and useful through proper culturally appropriate and gender sensitive dissemination channels		acceptable methods of information dissemination identified	34,267
			7.1.5.2	Information packages for community consumption should include rights of beneficiaries, means of accessing care at health facilities and minimum standards of quality health services			-
			7.1.5.3	Develop indicators on health system performance at State, LGAs and facilities to improve transparency and accountability of the government to its citizens.		Political commitment present	176,698
			7.1.5.4	Institute mechanisms for competition between LGAs and facilities for satisfactory performance in delivery of community support programmes for health			126,213
			7.1.5.5	Establish and empower Health Service Charters at all levels, with Civil Society Organizations, traditional and religious institutions to promote the concept of citizen's rights and entitlement to quality, accessible basic health services		Collaboration exists between the different institutions	138,834
		7.1.6	To engage with traditional health practitioners		Traditional health practitioners organised into organisation by 2011. At least 50% of registered traditional healers trained by 2013.		2,501,540
			7.1.6.1	Seek to have better understanding of traditional health practices and support research activities to gain more insight and evaluate them			113,592
			7.1.6.2	Organise traditional medicine practitioners into bodies/organisatons that are easy to regulate and actually regulate their practice		Traditional healers easy to be identified and are willing to cooperate	429,124
			7.1.6.3	Adopt traditional practices and technologies of proven value into State health care system and discourage those that are harmful		Efficacy of traditional practices and technologies	302,911

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PRIORITY							
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	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
						possible to be proven	
			7.1.6.4	Train traditional health practitioners to improve their skills, to know their limitations and ensure their use of the referral system		Traditional healers willing to be trained	1,514,555
			7.1.6.5	Seek the cooperation of traditional practitioners in promoting health programmes in such priority areas as nutrition, enironmental sanitation, personal hygiene, immunisation and family planning			141,358
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							1,763,186,158
	8.1	**To strengthen the stewardship role of governments at all levels for research and knowledge management systems**			**1. ENHR Committee established by end 2009 to guide health research priorities 2. FMOH publishes an Essential Health Research agenda annually from 2010**		267,695,959
		8.1.1	To finalise the Health Research Policy at State level and develop health research policies at State levels and health research strategies at State and LGA levels		1. Technical working groups convened by 2010. 2. State and LGA level policies and strategies developed by 2011. 3. Health research steering committees established by 2011. 3. HREC established by 2011		33,296,189
			8.1.1.1	Convene Technical working groups to finalise or develop State and LGA health research policies and strategies			3,087,746
			8.1.1.2	Establish Health research steering committees at all levels to shepherd research activities at all levels			617,549
			8.1.1.3	Strengthen Health Research Ethics Committee (HREC) in Cross River State		Membership of HREC objectively done	20,584,970
			8.1.1.4				-
			8.1.1.5	Monitor and evaluate the activities of		Guidelines	

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PRIORITY							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
				CRS-HREC		available for M&E of activities	9,005,924
		8.1.2	To establish and or strengthen mechanisms for health research at all levels		Essential National Health Research (ENHR) guideline implementation initiated by 2010		23,325,344
			8.1.2.1	Establish or strengthen the capacities of health research divisions and units at all levels to coordinate and encourage research efforts, linking researchers and creating communities of practice		Facilities available for research activities	771,936
			8.1.2.2	Strengthen Departments of Planning Research and Statistics (DPRS) as well as create active research units in the State and LGAs to undertake operations research and other research-related activities			964,920
			8.1.2.3	Ensure the coordinated implementation of the Essential National Health Research (ENHR) guidelines			1,003,517
			8.1.2.4	Provide technical assistance to develop and strengthen Health Research in all hospitals and health institutions in the state			7,719,364
			8.1.2.5	Provide assistance to strengthen Clinical Governance and SERVICOM units in the state to enhance research in the hospitals			12,865,606
		8.1.3	To institutionalize processes for setting health research agenda and priorities		Guidelines for collaborative health research agenda developed by 2011		24,753,427
			8.1.3.1	Establish and or strengthen functional institutional structures for research		Political commitment present	1,029,249
			8.1.3.2	Expand health research agenda to include broad and multidimentional determinants of health and ensure cross-linkages with areas beyond traditional boundaries and categories			3,267,864
			8.1.3.3	Develop guidelines for collaborative health research agenda at all levels			2,830,433
			8.1.3.4	Implement essential National Research programme			4,245,650
			8.1.3.5	Expansion of the health research agenda to include broad and multidimension of			13,380,231

CROSS RIVER STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
PRIORITY							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
				health with cross linkages beyond its traditional bounderies and categories			
		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		Multi-stakeholders forum hold meeting at least once by 2011. Guidelines for a collaborative research agenda developed by 2011		65,357,280
			8.1.4.1	Establish a forum of health research officers at the SMoH and LGA			6,432,803
			8.1.4.2	Annual convening of multi-stakeholders forum to identify research priorities and harmonize research efforts			23,158,092
			8.1.4.3	Governments at all levels to support the development of collaborative research proposals and their implementation between governments and public and private health research organizations			3,602,370
			8.1.4.4	Develop and disseminate guidelines for a collaborative reseach agenda			6,432,803
			8.1.4.5	Support development of collaborative research proposals and their implementation			25,731,213
		8.1.5	To mobilise adequate financial resources to support health research at all levels		1. Research funding agency established by 2015		41,169,940
			8.1.5.1	At least 2% of health budget will be allocated for health research at all levels		Political commitment present	-
			8.1.5.2	Funds for health research to be deployed in a targeted manner while expanding beneficiaries of funding to researchers from both public and non-public health research organizations and individuals		Facilities available for research activities	-
			8.1.5.3	To explore opportunities for accessing funds from bilateral and multilateral organizations and research funding agencies			257,312
			8.1.5.4	Establish transparent independent state research funding agency			37,052,946
			8.1.5.5	Mobilize adequate funds to support MNCH Research and disemination of results			3,859,682
		8.1.6	To establish ethical standards and practise codes for health research at all levels		Research Ethics Committee set up in the State MoH		79,793,777

CROSS RIVER STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
PRIORITY							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
					(Planning , Rsearch and Statistcs) by 2011		
			8.1.6.1	Establish and or strengthen health research ethical mechanisms, guidelines and ethical review committees at state and LGA levels		Manpower available at the LGAs	19,787,303
			8.1.6.2	Strengthen similar mechanisms in tertiary health and education institutions		Research Units already exist in the tertiary and education institutions	13,690,292
			8.1.6.3	Establish monitoring and evaluation system to regulate research and use of research findings at all levels in the state		Funds are available	25,731,213
			8.1.6.4	Strengthen the established CRS-REC		CRS-REC already existing	20,584,970
	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**		829,051,788
		8.2.1	To strengthen identified health research institutions at all levels		Bulletin on research procedures published by the State		19,298,410
			8.2.1.1	Strengthen identified health research institutions identified by inventory of all public and private institutions and organizations undertaking health research		Private and public institutions are engaged in research	5,146,243
			8.2.1.2	Conduct periodic capacity assessment of health research organizations and institutions			6,432,803
			8.2.1.3	Develop and implement measures to address identified research capacity gaps and weaknesses			5,146,243
			8.2.1.4	Ensure the development and implementation of resource mobilization strategies targeting private sector, foundation and individuals for health research			1,286,561
			8.2.1.5	Publicize/advertise information to encourage health workers to carry out research		Fund available	1,286,561
		8.2.2	To create a critical mass of health researchers at all levels		1. 6 health workers trained in South		485,540,097

CROSS RIVER STATE STRATEGIC HEALTH DEVELOPMENT PLAN						
PRIORITY						
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
					Africa by 2015. 2. 3 PhD students awarded sholarship by 2015		
			8.2.2.1	Develop appropriate training interventions for research, based on the identified needs at all levels		funds and political will are present	1,286,561
			8.2.2.2	Government to provide competitive research grants for prospective researchers		Research grants awarded to desrving persons	25,731,213
			8.2.2.3	Motivate increased PhD training in health institutions through award of PhD studentship scholarships		Funds are available	87,549,300
			8.2.2.4	Motivate and encourage health institutions to encourage their students on health research through seminars and workshops		Management of these training institutions are interested in research	6,432,803
			8.2.2.5	Training of Health Research Fellows to South Africa		Funds are available	364,540,221
		8.2.3	To develop transparent approaches for using research findings to aid evidence-based policy making at all levels		Policy makers involved in 80% of research works in the State by 2015		23,158,092
			8.2.3.1	To evolve mechanisms for translating research findings into policies		Political commitment present	15,438,728
			8.2.3.2	Establish close liason and linkages between research users (e.g. policy makers, development partners) and researchers		Political commitment present	2,573,121
			8.2.3.3	Involve a wide range of actors including research producers in policy-making consultations			5,146,243
		8.2.4	To undertake research on identified critical priority areas		1. At least 2 studies done in 2010 on HRH. 2. 2 studies done in 2011 on health system governance. 3. 2 studies done in 2012 on health delivery system in CRS.		301,055,190
			8.2.4.1	Establish a process for the bi-annual estimation of the burden of identified priority disease		Disease priority identified and funds available	23,158,092
			8.2.4.2	Undertake bi-annual studies into human		Accurate data on	

CROSS RIVER STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
PRIORITY							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
				resources for health		human resource for health available	61,754,911
			8.2.4.3	Undertake bi-annual studies into health system governance		Political will and funds available	61,754,911
			8.2.4.4	Conduct bi-annual studies into health delivery system		Political will and funds available	77,193,638
			8.2.4.5	Conduct studies on financial risk protection, equity, efficiency and value of different financing mechanism bi-annually		Political will and funds available	77,193,638
	8.3	**To develop a comprehensive repository for health research at all levels (including both public and non-public sectors)**			**1. All States have a Health Research Unit by end 2010 2. FMOH and State Health Research Units manage an accessible repository by end 2012**		470,881,194
		8.3.1	To develop strategies for getting research findings into strategies and practices		Operational activities identified in all State strategic plans by 2010		84,913,002
			8.3.1.1	Establish ways and means of getting research into strategies in the state			84,913,002
		8.3.2	To enshrine mechanisms to ensure that funded researches produce new knowledge required to improve the health system		Guidelines for annual operations research conducted by health institutions by 2011		30,877,455
			8.3.2.1	Institute the state bi-annual health research policy forum			12,865,606
			8.3.2.2	Conduct needs assessment to inform required health research in CRS		Rationality used in assessing required health research in CRS	5,146,243
			8.3.2.3	Promote and provide guidelines for annual operations research to be conducted by health institutions, hospitals and departments in MOH			12,865,606
		8.3.3	To conduct regular monitoring and evaluation of all research actitivies		IT facilities to enhance monitoring purchased by 2011		355,090,736
			8.3.3.1	M&E of all research work will be done regularly both before, during and after the programme		Funds are available	316,493,917
			8.3.3.2	Purchase of IT facilities to enhance		Funds available	

CROSS RIVER STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
PRIORITY							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
				monitoring and communication of findings			38,596,819
	8.4	**To develop, implement and institutionalize health research communication strategies at all levels**			**A national health research communication strategy is in place by end 2012**		195,557,217
		8.4.1	To create a framework for sharing research knowledge and its applications				5,146,243
			8.4.1.1	Develop and implement a framework for sharing research knowledge in all government hospitals and health institutions	Framework for sharing knowledge developed by 2011	The skills and other resources for developing the framework exists	5,146,243
		8.4.2	To establish channels for sharing of research findings between researchers, policy makers and development practitioners				190,410,975
			8.4.2.1	Present an annual health conference at the state level	Annual health conference held in the State	Political Will and resources are available	77,193,638
			8.4.2.2	Conduct bi-annual seminars and workshops on key thematic areas e.g. human resources, MDGs, finance, health research etc. at the state level	Annual health workshop held in the State	Political Will and resources are available	77,193,638
			8.4.2.3	Prepare guidelines and develop capacity of researcher to produce policy briefs	HR institutions produce and disseminate 100 policy brief per year	Availability of appropiate learning resources and willingness of researchers to produce policy briefs	12,865,606
			8.4.2.4	Support a critical mass of high quality sector journals			7,719,364
			8.4.2.5	Circulate identified journals to SMOH and LGAs regularly	Journals distributed (electronically and in print) quarterly to SMOH, all LGAs, Development partners, etc.	Availability of resources and a good distribution system	15,438,728
							88,159,307,877

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

CROSS RIVER 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	Facility Survey	TBD	50	75	100%

CROSS RIVER 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**
	implementing the drug procurement policy	Report				
	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	20	30
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	66%	68%	70%	75%
	23. % health facilities implementing the complete package of essential health care	NPHCDA Survey Report	22%	50	75	100%
	24. % of the population having access to an essential care package	MICS/NDHS	25%	40	75	100%
	25. Contraceptive prevalence rate (modern and traditional)	NDHS	20.30%	30%	40%	60%
	26. Number of new users of modern contraceptive methods (male/female)	NDHS/HMIS	9110	20%	30%	50%
	27. % of new users of modern contraceptive methods by type (male/female)	NDHS/HMIS	16%	30%	50%	75%
	28. % service delivery points without stock out of family planning commodities in the last three months	Health facility Survey	0%	20%	35%	60%
	29. % of facilities providing Youth Friendly RH services	Health facility Survey	0%	30%	50%	75%
	30. % of women age 15-19 who have begun child rearing	NDHS/MICS	18%	15%	10%	5%
	31. % of pregnant women with 4 ANC visits performed according to standards*	NDHS	68%	70%	80%	80 - 100%
	32. Proportion of births attended by skilled health personnel	DHS 2008	44.20%	55%	65%	70 -85%

CROSS RIVER 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**
	33. Proportion of women with complications treated in an EmOC facility (Basic and/or comprehensive)	EmOC Sentinel Survey and Health Facility Survey	TBD	25%	40%	60%
	34. Caesarean section rate	EmOC Sentinel Survey and Health Facility Survey	2.50%	10%	20%	25%
	35. Case fatality rate among women with obstretic complications in EmOC facilities per complication	HMIS	TBD	25%	15%	10%
	36. Perinatal mortality rate**	HMIS	40/1000 LBs	30/1000LBs	25/1000LBs	20/1000 LBs
	37. % of women who received postnatal care based on standards within 48h after delivery	MICS	8.1	15%	30%	50%
	38. % of newborn with infection receiving treatment	MICS	No Baseline	15%	30%	50%
	38. % of children exclusively breastfed 0-6 months	NDHS/MICS	11.10%	25%	50%	75%
	39. Proportion of 12-23 months-old children fully immunized	NDHS/MICS	80.90%	85%	90%	95%
	40. % children <5 years stunted (height for age <2 SD)	NDHSMICS	38.30%	30%	20%	15%
	41. % of under-five that slept under LLINs the previous night	NDHS/MICS	16.00%	50%	75%	75 - 90%
	42. % of under-five children receiving appropriate malaria treatment within 24 hours	NDHS/MICS	20%	30%	50%	75%
	43. % of women who received intermittent preventive treatment for malaria during pregnancy	NDHS/MICS	12%	25%	40%	65%
	44. HIV prevalence rate among adults 15 years and above	NDHS	3.50%	2.50%	1.50%	1%
	45..Condom use at last high risk sex	NDHS/MICS				
	46. Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS	NDHS/MICS	37.30%	45%	60%	80%
	47. Prevalence of tuberculosis	NARHS	3.00%	2%	1%	0.50%
	48.Death rates associated with tuberculosis	NMIS				
	49. Proportion of tuberculosis cases detected and cured under directly observed treatment short course	NMIS	TBD	25%	40%	60%
Output 6. Improved quality of Health care services	50. % of staff with skills to deliver quality health care appropriate for their categories	Facility Survey Report	TBD	40%	55%	75%
	51. % of facilities with capacity to deliver quality health care	Facility Survey Report	TBD	35%	50%	70%
	52. % of health workers who received personal supervision in the last 6 months by type of facility	Facility Survey Report	TBD	20%	40%	60%
	53. % of health workers who received	HR survey	TBD	25%	40%	60%

CROSS RIVER 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**
	in-service training in the past 12 months by category of worker	Report				
	54. % of health facilities with all essential drugs available at all times	Facility Survey Report	TBD	25%	40%	60%
	55. % of health institutions with basic medical equipment and functional logistic system appropriate to their levels	Facility Survey Report	TBD	25%	40%	60%
	56. % of facilities with deliveries organizing maternal and/or neonatal death reviews according to WHO guidelines on regular basis	Facility Survey Report	TBD	10 - 45%	30 - 75%	50 - 90%
Output 7. Increased demand for health services	57. Proportion of the population utilizing essential services package	MICS	TBD	25 - 50%	50 -75%	75 - 100%
	58. % of the population adequately informed of the 5 most beneficial health practices	MICS	TBD	30%	45%	75%
PRIORITY AREA 3: HUMAN RESOURCES FOR HEALTH **NSHDP GOAL: To plan and implement strategies to address the human resources for health needs in order to ensure its availability as well as ensure equity and quality of health care**						
NSHDP GOAL: To plan and implement strategies to address the human resources for health needs in order to ensure its availability as well as ensure equity and quality of health care						
Outcome 6. The Federal government implements comprehensive HRH policies and plans for health development						
Outcome 7.All States and LGAs are actively using adaptations of the National HRH policy and plan for health development by end of 2015						
Output 8. Improved policies and Plans and strategies for HRH	59. % of wards that have appropriate HRH complement as per service delivery norm (urban/rural).	Facility Survey Report	TBD	20%	30%	50%
	60. Retention rate of HRH	HR survey Report	TBD	50%	65%	75%
	61. % LGAs actively using adaptations of National/State HRH policy and plans	HR survey Report	TBD	25%	50%	75%
	62. Increased number of trained staff based on approved staffing norms by qualification	HR survey Report	TBD	10%	25%	50%
	63. % of LGAs implementing performance-based managment systems	HR survey Report	TBD	10%	25%	50%
	64. % of staff satisfied with the performance based management system	HR survey Report	TBD	10%	25%	50%
Output 8: Improved framework for objective analysis, implementation and monitoring of HRH performance	65. % LGAs making availabile consistent flow of HRH information	NHMIS	25%	40%	60%	80%
	66. CHEW/10,000 population density	MICS	TBD	1:4000 pop	1:3000 pop	1:2000 pop
	67. Nurse density/10,000 population	MICS	TBD	1:8000 pop	1:6000 pop	1:4000 pop
	68. Qualified registered midwives density per 10,000 population and per	NHIS/Facility survey	TBD	1:8000 pop	1:6000 pop	1:4000 pop

CROSS RIVER 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**
	geographic area	report/EmOC Needs Assessment				
	69. Medical doctor density per 10,000 population	MICS	TBD	1:8000 pop	1:7000 pop	1:5000 pop
	70. Other health service providers density/10,000 population	MICS	TBD	1:4000 pop	1:3000 pop	1:2000 pop
	71. HRH database mechanism in place at LGA level	HRH Database	TBD	50 - 75%	75 - 100%	100%
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	72. % of LGAs implementing state specific safety nets	SSHDP review report	TBD	25%	50%	75%
	73. Decreased proportion of informal payments within the public health care system within each LGA	MICS	TBD	40%	30%	20%
	74. % of LGAs which allocate costed fund to fully implement essential care package at N5,000/capita (US$34)	State and LGA Budgets	TBD	25%	40%	60%
	75. LGAs allocating health funding increased by average of 5% every year	State and LGA Budgets	TBD	25%	40%	60%
Output 12: Improved efficiency and equity in the allocation and use of Health resources at State and LGA levels	76. LGAs health budgets fully alligned to support state health goals and policies	State and LGA Budgets	TBD	40%	60%	80%
	77.Out-of pocket expenditure as a % of total health expenditure	National Health Accounts 2003 - 2005	70%	60%	50%	40%
	78. % of LGA budget allocated to the health sector.	National Health Accounts 2003 - 2005	2%	10%	20%	30%
	79. Proportion of LGAs having transparent budgeting and finacial management systems	SSHDP review report	TBD	25%	40%	60%
	80. % of LGAs having operational	SSHDP review	TBD	25%	40	50%

CROSS RIVER 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**
	supportive supervision and monitoring systems	report				
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	81. % of LGAs making routine NHMIS returns to states	NHMIS Report January to June 2008; March 2009	25%	50%	75%	100%
	82. % of LGAs receiving feedback on NHMIS from SMOH		25%	50%	75%	100%
	83. % of health facility staff trained to use the NHMIS infrastructure	Training Reports	30%	60%	80%	100%
	84. % of health facilities benefitting from HMIS supervisory visits from SMOH	NHMIS Report	TBD	30%	40%	60%
	85.% of HMIS operators at the LGA level trained in analysis of data using the operational manual	Training Reports	TBD	40%	75%	100%
	86. % of LGA PHC Coordinator trained in data dissemination	Training Reports	TBD	40%	75%	100%
	87. % of LGAs publishing annual HMIS reports	HMIS Reports	TBD	25%	50%	75%
	88. % 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 Community Participation in Health Development	89. Proportion of public health facilities having active committees that include community representatives (with meeting reports and actions recommended)	SSHDP review report	TBD	25%	50%	75%
	90. % of wards holding quarterly health committee meetings	HDC Reports	TBD	25%	50%	75%
	91. % HDCs whose members have had training in community mobilization	HDC Reports	TBD	40%	75%	100%
	92. % increase in community health actions	HDC Reports	TBD	10%	25%	50%
	93. % of health actions jointly implemented with HDCs and other related committees	HDC Reports	TBD	25%	40%	60%
	94. % of LGAs implementing an Integrated Health Communication Plan	HPC Reports	TBD	25%	40%	60%
PRIORITY AREA 7: PARTNERSHIPS FOR HEALTH						
Outcome 14. Functional multi partner and multi-sectoral participatory mechanisms at Federal and State levels contribute to achievement of the goals and objectives of the SHDP						
Output 15: Improved	95. Increased number of new PPP	SSHDP Report	TBD	25%	40%	60%

CROSS RIVER 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**
Health Sector Partners' Collaboration and Coordination	initiatives per year per LGA					
	96. % 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	97. % of LGAs partnering with researchers	Research Reports	TBD	10%	25%	50%
	98. % of State health budget spent on health research and evaluation	State budget	TBD	1%	1.50%	2%
	99. % of LGAs holding quarterly knowledge sharing on research, HMIS and best practices	LGA Annual SHDP Reports	TBD	10%	25%	50%
	100. % of LGAs participating in state research ethics review board for researches in their locations	LGA Annual SHDP Reports	TBD	40%	75%	100%
	101. % 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	102. % LGAs aware of state health research communication strategy	Health Research Communication Strategy	TBD	40%	75%	100%