ADAMAWA STATE GOVERNMENT

STRATEGIC HEALTH DEVELOPMENT PLAN
(2010-2015)

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Acronyms

ACT	Artemisinin Combination Therapy
AfDB	African Development Bank
ANC	Antenatal Care
ART	Anti-Retroviral Therapy
BCC	Behaviour Change Communication
CBOs	Community Based Organizations
CPD	Continuing Professional Development
CPT	Cotrimoxazole Preventive Therapy
CSOs	Civil Society Organisations
DFID	UK Department for International Aid
DPRS	Department of Planning and Research Statistics
DSO	Disease Surveillance Officers
EmNOC	Emergency Obstetric and Neonatal Care
ENHR	Essential National Health Research
FMoH	Federal Ministry of Health
GBV	Gender Based Violence
HIV/AIDS	Human Immuno Deficiency Virus/Acquired Immune Deficiency
HMB	Hospital Management Board
HMIS	Health Management Information System
HPCC	Health Partners Coordinating Committee
HSDP II	Health Systems Development Project
HSMB	Health Services Management Board
ICT	Information Communication Technology
INMCI	Integrated Management of Neonatal and Childhood Illnesses
IPC	Interpersonal Communication
ITN	Insecticide Treated Nets
JICA	Japan International Cooperation Agency
LGAs	Local Government Areas
LLINs	Long Lasting Insecticide Treated Nets
LSS	Life Saving Skills

M & E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MDR	Multi-Drug Resistance
NGOs	Non Government Organizations
NHMIS	National Health Management Information System
NPC	National Population Commission
NSHDP	National Strategic Health Development Plan
NYSC	National Youth Service Corp
PATHS2	Partnership for Transforming Health System2
PERs	Public Expenditure Reviews
PMTCT	Prevention of Mother to Child Transmission
PPP	Public Private Partnerships
QA	Quality Assurance
RTA	Road Traffic Accidents
SHAs	State Health Accounts
SMOH	State Ministry of Health
SOPs	Standard Operating Procedures
SSHDP	State Strategic Health Development Plan
SWAPs	Sector-Wide Approaches
TBAs	Traditional Birth Attendants
USAID	United States Agency for International Development
VTTC	Vocational Technical Training Centres
WB	World Bank
WHO	World Health Organization

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Executive Summary

Vision

"To reduce morbidity and mortality rates due to communicable diseases; reverse the increasing prevalence of non-communicable diseases; meet global targets on the elimination and eradication of diseases; and significantly increase the life expectancy and quality of life of Adamawa People"

Background

Adamawa State is one of the 36 States of the Federal Republic of Nigeria and is located in the North East Geo-Political zone. The State is administratively divided into 21 LGAs with elected councils in place. It also has 25 legislative constituencies and 3 senatorial zones. The State health policy is guided by the National Health Policy; however specific attention is being paid to issues like governance, Human resource, financing and some high impact interventions.

Situation analysis

With a projected population of about 3,374,108, the male: female ratio of approximately 1.3:1 (2,294,800 (1,122,869 females; 1,171,931 males[1]), children under 5 years make up 20% and 23.6% of the total population[1]. The economy is mostly agarian (subsistence farming), hence poverty ratio is high. The State has an Infant mortality rate of 120/1,000 live births compared to the North Eastern average of 109/1000 live births [1] under 5 mortality of 222/1000 live births (North Eastern average) [1] and a maternal mortality ratio of between 1,100 – 1,500/100,000 live births compared to the National average of 547/100,000 live births [1] as well as an HIV prevalence of 4.2% reflecting the poor the state of its health services.

There are 1, 032 health facilities, most of them dilapidated, poorly equipped and poorly staffed. Coverage of key high impact health interventions like PMTCT, use of insecticide treated nets 2% in children and pregnant women respectively [1], skilled attendants at birth 15% [1] ,delivery in a health facility 11% [1] ,Full immunization coverage 19% [1] etc remain very low (about 30-40%). Community based interventions are also implemented on a low scale due to poor funding, low capacity and poor logistics.

Bottleneck analysis for implementation of the Ward Minimum Package of Care

Poor community infrastructure for health promotion, poor funding of programmes leading to low engagement of appropriate number of skilled manpower. Low capacity at State, LGA and Community levels to adequately implement health promotion activities. Also there is poor availability of funds and logistics to adequately carryout population based high impact health interventions. There is generally inadequate availability of service outlets due to the state of

[1] NDHS 2008

dilapidation of most health facilities, poor equipment and drug supply, and low number of private providers.

States Minimum Package of Care

The selection and inclusion of interventions in the States minimum package of care were based on the following principles:

- consistency with the states epidemiological profile
- equity issues
- the principle of the continuum of care which takes into account the human life cycle from pre-pregnancy, pregnancy, through birth, the newborn period, infancy and older childhood as well as across the health system which includes the home and community, first level facility and referral facility
- the choice of the delivery mechanism

They are best delivered through the 3 delivery modes as suggested by available evidence.

The interventions as packaged across the delivery modes are:

a. Family and Community Oriented Services;
    - The interventions within this mode are: Exclusive breastfeeding among children 0-6 months
    - Continued Breastfeeding for children 6-11 months
    - Adequate and safe complementary feeding
    - Supplementary feeding for malnourished children
    - Oral Rehydration Therapy
    - Zinc for diarrhoea management
    - Vitamin A - Treatment for measles
    - Follow up Management of Severe Acute Malnutrition as well as continue other health promotion activities
b. Population Oriented Outreaches/Schedulable Services; The interventions within this mode are:
    - Family Planning
    - HIV prevention
    - Ante-natal care
    - Home based care
    - Immunization
c. Individual Oriented Clinical Services
    - Basic Emergency Obstetrics Care
    - Comprehensive Emergency Obstetrics Care
    - Strengthening referral services

It is hoped that streamlining this outlined State priority interventional activities and achieving them will greatly impact on the lives of the citizenry and improve the National Human Development Indicators as desired.

States Strategic Objectives to scale up the minimum package of care

- Improve access to quality childcare services
    - Improve access to quality information on exclusive breast feeding
    - Improve access to quality preventive and curative malaria control services
    - Improve access to quality Integrated Management of Neonatal and Childhood Illnesses (INMCI) services
    - Improve access to immunization services
- Improve maternal health
    - Improve access to ante-natal care services
    - Scale up Basic Emergency Obstetrics Care Services
    - Scale up Comprehensive Emergency Obstetrics Care Services
    - Improve access to family planning services
    - Improve access to Nutrition services
    - Improve access to immunization services
- Combating HIV and AIDS, Malaria, Tuberculosis and other communicable diseases
    - Improve access to HIV Counselling and Testing
    - Improve access to Prevention of Mother to Child Transmission (PMTCT) services
    - Improve access to Co-trimoxazole Preventive Therapy (CPT) services
    - Improve access to Anti-Retroviral Therapy (ART) services
    - Scale up availability, distribution and utilization of Long Lasting Insecticide Treated Nets (LLINs)
    - Improve access to Artemetisin Combination Therapy (ACT) to the communities
    - Establish adequate Multi-Drug Resistance (MDR) TB screening and treatment services
    - Establishment of public health laboratory at the State and senatorial zones

Monitoring and Evaluation Process

The SSHDP will be translated into detailed annual implementation plans that will have embedded in it, the monitoring and Evaluation plan. Periodic review of the SSHDP will be carried out annually while the implementation plans will be reviewed on quarterly basis.

Vision, Mission and the Overarching Goal of the State Strategic Health Development Plan

Vision

"To reduce morbidity and mortality rates due to communicable diseases; reverse the increasing prevalence of non-communicable diseases; meet global targets on the elimination and eradication of diseases; and significantly increase the life expectancy and quality of life of Adamawa People"

Mission

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

Goal

The overarching goal of the Adamawa SHDP is to significantly improve the health status of Adamawa people through the development of a strengthened and sustainable health care delivery system.

Chapter1: Background and Achievements

1.1. *Background*

Every government has a social contract to uplift the socio-economic status of its citizenry; this is more so for a responsible democratic government. To reinforce this point, the largest gathering ever of the Heads of the state ushered in the new Millennium by adopting the United Nation's Millennium Declaration in September, 2000. This Declaration was translated into a road map setting out goals referred to as Millennium Development Goals (MDG's), to be achieved by the year 2015. This has been endorsed by 189 Countries including Nigeria.

Adamawa State Government has realised that health, gender-equality, education, access to clean water and good sanitary environment are the corner stone to economic development. Agriculture will form the bedrock stimulus for sustainable development in the State.

The State's agriculture master plan has been developed with focus on improving animals and crops yields using mechanized schemes. All aspects of the production chain are being carefully considered, including the local and international markets for products. Vocational Technical Training programmes for skills development to service and maintain agricultural machineries within the communities have been put in place. Three Vocational Technical Training Centres (VTTC) are built at Mubi, Yola and Mayo-Belwa with 200 apprentices in each have started the 3-year training programmes since January 2009 in collaboration with the ITS, a German corporation that has been in knowledge and skills transfer business for over 40 years.

Health care delivery in the state has been inefficient and non-responsive to local and global demands. This is due to poor institutional capacity to manage the health sector, decayed infrastructure to support services, near absence of monitoring of health services, few and non-motivated staff..

Adamawa state was created out of the former Gongola State with Headquarters in Yola. It is one of the fifth generation states in Nigeria created by the Military Administration in 1991. Before 1913 medical care was based on traditional medicines providers. By 1913 Missionaries brought some form of modern medical care which was not uniform in coverage and mainly curative. In 1938 the colonial masters came and provided a form of medical care to the take care of their workers and their immediate family wherein some hospitals were built in places like Yola and Mubi in 1938.

With the creation of North-Eastern State in 1967, Comprehensive Health care was introduced which provided both preventive and curative services. More health facilities were built with the creation of Gongola and Adamawa States in 1976 and 1991 respectively.

The state is located between latitudes 7° 28 and 10° 15 North and latitude 11½° and 13¾° East. It has a land mass of 423.158sq km. The State is bounded by the Republic of Cameroun to the North, Taraba State to the South and to the West by parts of Taraba State and Gombe

State. The State is a picturesque mountainous land transverse by Rivers Benue, Gongola and Yadzaram. The river Gongola starts from Bauchi State highland and joins river Benue in Numan Local Government of Adamawa State.

River Benue starts from Cameroun Mountains, flows into Adamawa State through the State capital, Yola and joins River Niger at Lokoja. The Yadzaram River starts from the Mandara high lands, flows through Mubi North and Michika Local Government Areas and flows into Lake Chad. The Valleys of Cameroun Republic, Mandara high lands and Adamawa Mountains form parts of the undulating landscape.

Adamawa State has a tropical Climate marked by distinct dry and raining seasons. The raining seasons start in the month of April and ends in October. The average rainfall is 79mm in the North and 101mm in the South. The wettest months are August and September. The dry season starts in November and ends in April. This is the period marked with the presence of dust-laden North –eastern trade wind from the desert known as the harmattan. The period is cool and dry. Relative humidity is Thirteen (13%), and average temperature is 15.7° C, while the maximum is 45°C. There are two (2) vegetation zones namely the Sub-Sudan Zone and the Northern Guinea Savannah. The Sub-Sudan is marked by short grasses and interposed by short trees found in the Northern parts. To the South the Vegetation is thick with tall grasses and trees.

1.2. *People*

Adamawa state has a large number of ethnic groups; among them are Fulani, Bille, Burah, Bwatiye, Chamba, Fali, Ga'anda, Gude, Higi, Lunguda, Kanakuru, Kilba, Margi, Mbula, Yandang, Yungur and Verre. These ethnic groups live in segmented communities, speaking different languages and dialects. Fulfulde and Hausa are widely spoken in the state, while English remains the official language.

Culture is the way of life. The people of Adamawa state are known by their numerous cultural festivals. Amongst them are the wrestling contests, fishing festival, harvest initiation into manhood, festival marking the beginning and the end of raining season etc. The culture of the state is reflected in its past history, craftsmanship, music and dances, dress patterns, the people hospitality and cordial relationship.

1.3.*Achievements*

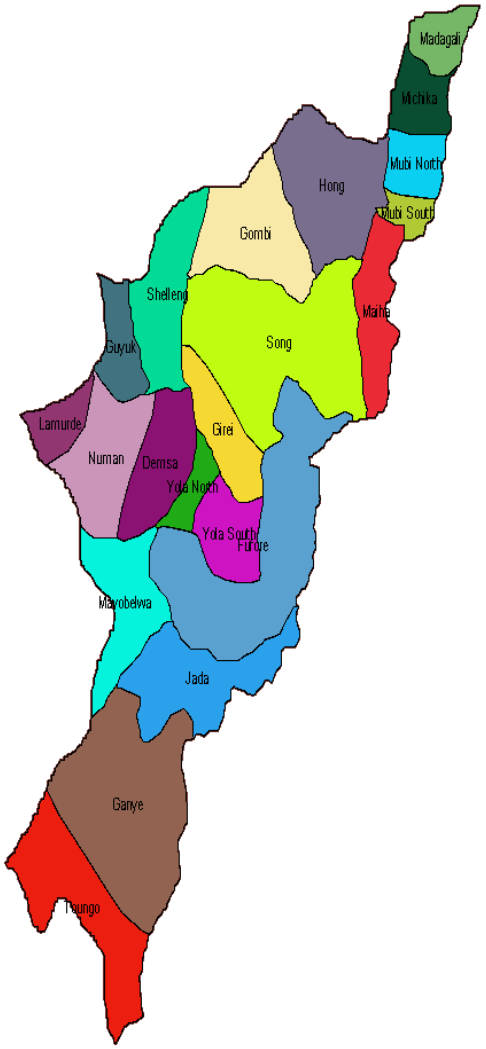
The Adamawa State Health Sector has slowly evolved through the years. The public sector provides various health services through a wide range of health facilities from a health post in a remote village to the Specialist Hospital in the capital city. These facilities still operate because the State and Local Governments support them through the payment of staff remuneration and the maintenance of the infrastructure.

The State participated in the World Bank Assisted Health Systems Development Project (HSDP) I & II that mainly focused on capacity building by improving the pre-service training

of Paramedics. In partnership with the State Government, the HSDP also began the renovation of dilapidated health facilities and scaling up secondary health facilities by upgrading some cottage hospitals to general hospitals.

Recently, the Millennium Development Goals' Conditional Grants Scheme (MDGs-CGS) earmarked four PHC clinics per LGA for renovation and provision of equipment to support basic maternal and child care services in rural areas. Integration of these efforts and linking the primary care to secondary and tertiary care is the main thrust of this strategic plan.

Figure 1: Adamawa State Map showing the LGAs



Chapter 2: Situation analysis

2.1.*Socio-economic context*

The State mainly depends on Federal allocation that mostly services governance and government activities. The private sector is completely in shambles with subsistence farming dominating the population's major economic activities. It has provided subsistence for about 90% of the population. The prevalence of poverty is very high.

Other economic activities in the state are furniture making, tailoring, wielding and iron fabrication, hairdressing, motor mechanic, restaurant business, photography trading in assorted goods, GSM repairs. Recently the present administration has begun training youths in skills acquisition in order to promote small scale businesses.

Currently, the large scale private companies that are operational in the state are Savannah Sugar Company in Numan; Mubi burnt bricks, Afcot Nig. Ltd., Sabore Farms in Mayo – Belwa, Bajabure Industry Complex and others. The small scale manufacturing Industries include Yola office stationery, Michika Animal feeds mill, Yola oil mill, Gombi chalk Industry, Ganye rice mill, Mayo Belwa Animal concentrates, Adamawa Poultry production unit Yola etc. Cattle rearing and other live stock breeding (sheep, goat, poultry etc) are some other economic activities).

2.2.*Health status of the population*

The 1963 Census figure put the state population at 1,604,600, while the 1991 Census figure for the State is 2,102,053, The projected population as at December 2003 is put at 2,939,163. At the population annual growth rate of 2.8%. The projected population figures of the |State are;

- 1995 = 2,347,994
- 2001 = 2,694,732
- 2005 = 3,094,222

By 2006 Census, the State has a population of 3,168,101. This consists of 1,606,123 males and 1,561,978 females given a population density of 80 people per square km.

The population distribution by gender shows that five (5) Local Government Areas out of twenty one (21), shows that males are more than females. The local Areas are as follows; - Ganye, Mubi North and South, Fufore and Yola.

The distribution by age shows that the population of Children 10years and below is 33.3%; below 15years is 44.8%. In this age group, there are slightly more males (45.5%) than females.

Table 1 : Summary of Socio-demographic Indicators

Indicator	State Estimate	National Estimate	Year	Source
Demographic				
Total population	3,359,463 3,178,950[2]	149,141,144	2008	2006 Census
Childre n< 5 years	592,401 635,790 [2]	29,828,229	2008	2006 Census
Pregnant women	321,801	7,457,057	2008	NPHCDA
Women of child bearing age	749,629 749,701 [2]	32,811,052	2008	2006 Census
Crude birth rate		40.6	2008	NDHS
Total fertlity rate		5.7	2008	NDHS
Mortality/morbidity				
Crude death rate				
Infant mortality rate	120 109 NE average [2]	100	2009	MoH Yola
Under five mortality rate	120 222 [2]	201	2009	MoH Yola
Maternal Mortality ratio	1,100 547 NA [2]	704	1999	MoH Yola
Children <5 yrs stunted below -3 SD (height-for-age)	26.7% 42% [2]	19.6%	2008	NDHS

2.3. Health services provision and utilization

The State is providing most of the basic health services with minimal support from donor agencies. The State government is committed to reducing the burden of disease that is contributing to the poor national health indices. Free maternal and child care services are provided at all secondary health facilities in the State from the beginning of present administration. This has greatly reduced the cost accessing health services particularly by the urban dwellers. The situation in the rural communities still remains a big problem due to large funding gap to scale up these services.

[2] NDHS 2008

Table 2: Summary of Health Indicators

Indicator	State Estimate	National Estimate	Year	Source
Health Services Coverage				
1. Reproductive Health				
Antenatal care by health professional	61.2%	57.7%	2008	NDHS
Deliveries supervised a health professional	14.6%	31.9%	2008	NDHS
Women who had a live birth delivered in a health facility	11.8%	35.0%	2008	NDHS
Currently married women who used any modern method of contraception (it this only for married women or eligible women)	2.8%	3.5%	2008	NDHS
2. Immunization				
DPT-3 coverage	30.2%	35.4%	2008	NDHS
Measles coverage among	41.4%	41.4%	2008	NDHS
Fully immunized	19.1%	22.7	2008	NDHS
3. Management of childhood illnesses				
Children < 5 yrs with ARI symptoms who sought for treatment from health provider	31.2%	46.5%	2008	NDHS
Children < 5 yrs with Diarrhoea who sought for treatment from health facility/provider	37.8%	32.0%	2008	NDHS
Children < 5 yrs with diarrhoea given solution from ORT packet	18.9%	25.5%	2008	NDHS
4. Malaria				
Households who own at least one ITN	27.8%	16.9%	2008	NDHS
Pregnant women who slept under ITNs	2% [3]	4.8%	2008	NDHS
Children <5 yrs who slept under ITNs	2% [3]	12.0%	2008	NDHS
Pregnant women who received IPT during ANC visit	2% [3]	33.5%	2008	NDHS

NB: Please include the following service coverage rates; TB cure rate, Share of outpatient care provided by private sector as well as in patient care provided by private sector.

2.4.*Health Financing*

The proportion of the State budget allocated to the health sector is below the recommended 5% in the year 2008 but the performance has not changed as shown in Table 3 below:

Table 3: State MoH budget in relation to State budget

Year	State Budget	Budget Provision for Health	% to Health	Actual Release	Budget Performance
2006	36,396,059,495.00	1,876,000,000.00	5.1%	682,906,557.00	**36%**
2007	39,905,900,405.00	2,114,000,000.00	5.2%	326,165,177.60	**15%**
2008	**43,549,501,860.00**	**1,525,000,000.00**	**3.5%**	**574,264,946.71**	**38%**

[3] NDHS 2008

2.5.Key issues and challenges

The Health Ministry and its parastatals are faced with the following challenges which include;

- Inadequate numbers of skilled health personnel needed to adequately take charge of evidence based planning and implementation of strategic plans that will provide the much needed changes required to improve the health sector.
- Mal-distribution of available resources both human and material
- Poor remuneration
- Lack of incentives especially for health workers working in the rural areas.
- Poor funding
- Weak referral system
- Poor distribution system
- Low awareness of the populace on the benefits of seeking proper health care

Chapter 3: Strategic Health Priority Areas

The Strategic plan is structured after the Strategic framework which has 8 priority areas listed below:

1. Leadership and Governance for Health
2. Health Service Delivery
3. Human Resources for Health
4. Financing for Health
5. National Health Information System
6. Community Participation and Ownership
7. Partnerships for Health
8. Research for Health

3.1.*Leadership and Governance for Health*

Goal

Create and sustain an enabling environment for responsive health development in Adamawa State

Strategic Objectives

3.1.1. To provide clear policy directions for health development
3.1.2. To facilitate legislation and a regulatory framework for health development
3.1.3. To strengthen accountability, transparency and responsiveness of the state health system
3.1.4. To enhance the performance of the state health system

3.1.1. To provide clear policy directions for health development

Intervention Areas

Intervention Area 1: Improve Strategic Planning at State level

The activities are advocacy to the policy makers on the need to adhere to formulated policies on health, involvement of all stakeholders (Public and Private) in the development and revision of Strategic health Plan of the State, inter-ministerial cooperation in the provision of health related services, strengthen capacities (commodities, knowledge and skills) of State and LGA key planning staff on policy formulation, planning and implementation of health plans.

3.1.2. To facilitate legislation and a regulatory framework for health development

Intervention Areas

Intervention Area 1: Strengthen Regulatory Functions of government

The private health sector is a major contributor to healthcare delivery in Adamawa State and is often the first point of contact with the health system for many people. Quality of service

delivery is extremely variable and the capacity of the State government to set standards and ensure compliance needs to be strengthened.

The activities are:

- Develop State Health Policy
- Ensure passage State Health Bill
- Ensure availability of Health Policy Documents to stakeholders and general public; Strengthen information gathering on key quality indicators and publish annual reports
- Set up and support the functioning of a well represented State ethical health committee.

3.1.3. To strengthen accountability, transparency and responsiveness of the national health system

Intervention Areas

Intervention Area 1: Improve Accountability and Transparency

Demand for accountability, transparency and responsiveness of the health system will be institutionalized through effective decentralization of the decision making process in the health sector.

The activities are:

- Involvement of all stake holders in decision making process in the Health sector
- Provision of detailed annual State MoH implementation report to the public by print and electronic means through a dedicated website
- Engage and ensure functioning of at least 3 CSOs to provide feedback on efficiency of the MoH.

3.1.4. To enhance the performance of the state health system

Intervention Areas

Intervention Area 1: Improving and maintaining Sectoral Information base to enhance performance

There is a need to deepen and expand the analytical work at both State and Local Government levels, which is required to understand health sector performance and to drive improvements and reform.

The activities are:

- Review and implement a uniform salary scale for all health workers
- Ensure involvement of all professional unions in deciding and implementing salaries and allowances for health workers
- Ensure adequate budgetary provisions for the health sector
- Involvement of different ministries in the health plan, e.g. Ministries of Environment and Water Resources etc; and organising meetings with the representatives of these ministries on quarterly basis.

3.2.*Health Service Delivery*

Goal

Revitalize integrated service delivery towards a quality, equitable and sustainable healthcare.

Strategic Objectives

3.2.1. To ensure universal access to an essential package of care
3.2.2. To increase access to health care services
3.2.3. To improve the quality of health care services
3.2.4. To increase demand for health care services
3.2.5. To provide financial access especially for the vulnerable groups

3.2.1. *To ensure universal access to an essential package of care*

Intervention Areas

Intervention Area 1: Review, cost, disseminate and implement the minimum package of care in an integrated manner.

The activities are:

- Carryout baseline assessment and provide status report of the current health infrastructure and level of functioning in the State
- Identify, plan and implement priority impact interventions based on the current baseline report (see bottleneck analysis)
- Revise and develop current SOPs for key services, especially the impact interventions

Please see table below for Adamawa state essential package of care.

Figure 2: Priority High Impact Services

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

Intervention Area two: To strengthen specific communicable and non communicable disease control programmes

The activities are:

- Train health workers on condom programming, syndromic management of STI, HCT, PMTCT,, RHHIV integration, Sex work & HIV,
- Sensitization of in-school youth on ASRH and HIV prevention,

- Provision of integrated SRH/HIV/AIDs services in health facilities

Intervention Area three: To make Standard Operating procedures (SOPs) and guidelines available for delivery of services at all levels

The activities are:

- Revise, produce and distribute SOPs including Standing Orders to all health facilities

3.2.2. *To increase access to health care services*

Intervention Areas

Intervention Area one: Improve geographical equity and access to health services

The activities are:

- Develop GIS map locations of all health facilities by categories,
- Renovate and upgrade existing health facilities, and provide new ones to emerging communities,
- Increase number of outlet providing family planning services in the state,
- Increase number of facility providing ANC, Delivery, EmNOC and PNC services.,
- Strengthen referral services and develop outreach clinical services to remote communities

Intervention Area two: Ensure availability of drugs and equipment at all levels

The activities are:

- Assess the drugs and equipment needs of all facilities taking into consideration using the MSP,
- Essential Drugs List and catchment population as a guide, Develop and implement a system to ensure procurement and distribution of essential drugs on a sustainable basis,
- Establish drug management agency,
- Training of pharmacy staff on drugs and logistics management

Intervention Area three: Establish a system for the maintenance of health facilities and equipment at all levels

Availability of equipment is critical to service delivery.
The activities are:

- Adapt, disseminate and implement the National Health Equipment Policy;
- Provide/ review budget lines for preventive maintenance of health facilities and equipment
- Explore public private partnership in maintenance of medical equipment and hospital furniture.

- Establish medical equipment and hospital furniture maintenance workshops

Intervention Area four: Strengthen referral system

The activities are:

- Map network linkages for two-way referral systems in line with national standards
- Provide guidelines for management of emergencies e.g. EmOC, complicated malaria, RTA
- Provide adequate ambulances and alternative transport
- Provide toll free communication linkages
- Monitoring and evaluation of referral linkages

Intervention Area five: Foster collaboration with the private sector

The private sector plays a key role in provision of health services in the country. Therefore, collaboration with the private sector health care providers will be fostered.

The activities are:

- Mapping of all categories of private health care providers by operational level and location, development of guidelines and standards for regulation of their practice and their registration.
- Guidelines for partnership, training and outsourcing of services will be Developed
- Joint performance monitoring mechanism for the private sector will be developed and implemented.
- National policy on traditional medicine will be adapted and implemented at all levels.

3.2.3. *To improve quality of health services*

Intervention Areas

Intervention Area one: Strengthen professional regulatory bodies and institutions

The need to standardise and regulate practice cannot be over emphasised.

The activities are:

- Review, update and implement operational guidelines of all regulatory bodies at all levels Build capacity of regulatory staff to monitor compliance of providers to the regulatory guidelines.
- Budget lines are to be created and necessary resources provided.
- Regular monitoring exercises with appropriate documentation and feedback will be strengthened and regulators empowered through the provision of necessary security.

Intervention Area two: Develop and institutionalise quality assurance models

The activities are:

- Develop State SERVICOM guidelines
- Build institutional capacity and training staff for its implementation
- Develop and implement strategies for monitoring implementation of quality of care

Intervention Area three: Institutionalize Health Management and Integrated Supportive Supervision (ISS) mechanisms

Integrated supportive; supervision is an important strategy for ensuring that health workers are adequately supported in the process of providing health care services. This concept is predicated on the fact that many problems occur in the health facilities of which providers will not have immediate solutions. This helps in boosting the moral of the workers in their health facilities setting.

The activities are:

- Provide budget line and funding for ISS in state
- Develop capacities of programme managers at all levels in state on the ISS mechanism
- Institutionalize comprehensive ISS

3.2.4. *To increase demand for health care services*

Intervention Area one: Creating effective demand for services

The activities are:

- Develop a comprehensive BCC strategy for health promotion in the state.
- Regular airing of health promotion messages and drama in the state electronic media in two major local languages and English
- Develop IEC materials on health promotion in two major local languages and English
- Strengthen programme monitoring and evaluation system
- Training of health workers on LSS
- Provide essential equipment, drugs and supplies in all health facilities

3.2.5. *To provide financial access especially for the vulnerable groups*

Intervention Areas

Intervention Area one: Improving financial access especially for the vulnerable groups

The costs associated with health care can be a barrier to accessing health services especially for the vulnerable groups.

The activities are:

- Provide free IMNCH services for pregnant women & Under fives in all secondary health facilities,
- Explore models for financial protection for the vulnerable groups (e.g. Pregnant women, under fives, orphans and the aged) such as exemption schemes vouchers, health cards, pre payment schemes
- Strengthen free MCH programme in State Adopt and implement the identified financial protection model
- Provision of free Mama kits for every woman that delivers in a health facility

3.3. Human Resources for Health

Wide gap exist in all segments of the human capacity requirements to adequately implement this strategic plan. Structural reorganization of the health sector human resource by way of placements, deployment, employment and training is necessary in order to achieve the desired results.

Table 4: Available human resource for service delivery at State level

S/N	Cadre	TOTAL
1	Doctors	47
2	Supportive staff	73
3	Nurses/Midwives	981
4	Medical Laboratory Scientists	17
5	Laboratory Technician	26
6	Supportive staff	77
7	Pharmacist	13
8	Pharmacy Technician	5
9	Supportive staff	88
10	Admin and Finance	1,379
11	**TOTAL**	**2,706**

The administration and planning departments of the Ministry of Health and the Health Services Management Board (HSMB) must be strengthened through a deliberate capacity building plan that is closely monitored to improve their effectiveness and efficiency; otherwise none of the changes expected could occur. The number and quality of service providers is grossly inadequate at all levels of health care and in all cadres of health care workers.

Goal

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.

Strategic Objectives

3.3.1. To formulate comprehensive policies and plans for HRH for health development

3.3.2. To provide a framework for objective analysis, implementation and monitoring of HRH performance

3.3.3. To strengthen the institutional frameworks for human resources management practices in the health sector

3.3.4. To strengthen the capacity of training institutions to scale up the production of a critical mass of quality, multipurpose, multi skilled, gender sensitive and mid-level health workers

3.3.5. To improve organizational and performance-based management systems for human resources for health

3.3.6. To foster partnerships and networks of stakeholders to harness contributions for human resource for health agenda

3.3.1. ***To formulate comprehensive policies and plans for human resource for health development***

Intervention Areas

Intervention Area one: Development and Institutionalization of the Human Resources Policy framework

The activities are:

- Develop State Human Resource for Health Policy inline with National HRH,
- Formulate/periodic review and Implementation of training and recruitment policy for health personnel,
- Establish HRH forum involving all stakeholders,
- Develop and implement guidelines on retention, task shifting and establish a forum for public-private practitioners to institutionalize HRH policy reviews, supervisory and monitoring frameworks

3.3.2. ***To provide a framework for objective analysis, implementation and monitoring of HRH performance***

Intervention Areas

Intervention Area one: Reappraisal of the principles of health workforce recruitment at all levels

The activities are:

- Develop staffing norms based on workload, service availability and health sector priority,
- Operationalize the staffing norms,
- Establish coordinating mechanisms for consistency in HRH planning and budgeting by Ministries of Health, Finance, Education, Civil Service Commission, Regulatory bodies, Private Sector Providers, NGOs in health, and other institutions

3.3.3. ***Strengthen the institutional framework for human resources management practices in the health sector***

Intervention Areas

Intervention Area one: Establishment and strengthening of the HRH Units

The activities are:

- Establish training programmes in human resources for health planning and
- management at all levels

3.3.4. ***To strengthen the capacity of training institutions to scale up the production of a critical mass of multipurpose and mid-level health workers***

Intervention Areas

Intervention Area one: Review and adaptation of relevant training programmes for the production of adequate number of community health oriented professionals based on national priorities

The activities are:

- Assessment of the health institutions in the State,
- Strengthening the quality of tutors,
- Strengthening the quality of training materials,
- Improve number of paramedical staff in general in the State, Improve private participation in HRH

Intervention Area two: Strengthening of health workforce training capacity and output based on service demand

The activities are:

- Training of health workers on LSS,
- Facilitate accreditation of eligible private sector health facilities to increase training opportunities for internship and post-basic training for all sector health professionals,
- Promote human capital capacity building and continuing professional development (CPD),
- Establish coordination with professional regulatory bodies to link sponsorship to bonding of healthcare providers to mitigate migration across states and outside the country

3.3.5 To improve organizational and performance-based management systems for human resources for health

Intervention Areas

Intervention Area one: Equitable distribution, right mix and retention of the right quality and quantity of HRH

The activities are:

- Create a database of HRH,
- develop and provide job descriptions and specifications for all categories of health workers in line with MSP , 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 ,
- Provide budget line and funding for payment of attractive rural allowance for staffs posted to underserved areas , Rationalise health manpower in state and LGAs

Intervention Area two: Establishment of mechanisms to strengthen and monitor performance of health workers at all levels

The activities are:

- Institute a sustainable system of recognition, reward and sanctions,
- Establish system to monitor health worker performance, including use of client feedback (exit interviews),
- Conduct routine re-orientation of health workforce on attitudinal change including training and retraining in Interpersonal Communication (IPC) skills and work ethics

3.3.6 To foster partnerships and networks of stakeholders to harness contributions for human resource for health agenda

Intervention Areas

Intervention Area one: Strengthening communication, cooperation and collaboration between health professional associations and regulatory bodies on professional issues that have significant implications for the health system

The activities are:

- Ensure involvement of health workers and professional groups in management teams, design and monitoring of health services

3.4.Health Financing

Goal

Ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and consumption at LGA, State and Federal levels

Strategic Objectives

3.4.1. To develop and implement health financing strategies at Local, State and Federal levels consistent with the National Health Financing Policy

3.4.2. To ensure that people are protected from financial catastrophe and impoverishment as a result of using health services

3.4.3. To secure a level of funding needed to achieve desired health development goals and objectives at all levels in a sustainable manner

3.4.5. To ensure efficiency and equity in the allocation and use of health sector resources at all levels

3.4.1. To develop and implement health financing strategies at Local, State and Federal levels consistent with the National Health Financing Policy

Intervention Areas

Intervention Area one: develop and implement evidence-based, costed health financing strategic plans at LGA, State levels in line with the National Health Financing Policy.

The activities are:

- Constitute Technical working group for health financing,
- Capacity building for working groups to enhance their development and implementation capacities
- Provision of computers, printers/accessories and stationeries to fast track funds usage
- Establish functional social insurance scheme and other pre-paid schemes at the state level,
- L.G.As will be supported to explore the existing and innovative social health protection approaches for sustainable health financing
- Establish technical working group on health insurance .develop capacity of the health insurance working group in the state.

Intervention Area two: To secure a level of funding needed to achieve desired health development goals and objectives at all levels in a sustainable manner

The activities are:

- Ensure involvement of health workers and professional groups in management teams, design and monitoring of health services,
- To enact health financial control policies in the state towards uninterrupted financial flows to the health sector.,
- Seek for more funding to the state health sector from the Federal govt. and other related bodies to improve health delivery system in the state.,
- Financial safety nets will be in place to cater for the poor , gender sensitive health matters and vulnerable group

Intervention Area three: Donor Coordination of Funding Mechanisms

The activities are:

- Explore mechanism for coordinating donor resources with that of government for health development - Common basket funding through options such as joint funding agreements, sector-wide approaches (SWAPs) and sectional multi donor budget support etc

Intervention Area four: To ensure efficiency and equity in the allocation and use of health sector resources at all levels

The activities are:

- Establishment of health budget implementation, monitoring and evaluation committee in the state.
- Capacity building for the committee to enhance effective budget implementation and timely reporting in the state.
- Performance bond mechanism policy towards the effective execution of health projects and programmes will be established in the state

3.4.2 To ensure that people are protected from financial catastrophe and impoverishment as a result of using health services

Intervention Areas

Intervention Area one: Strengthen System for Financial Risk Health Protection

The activities are:

- Establish budget monitoring and evaluation department in the State Ministry of Health,
- Capacity building towards the enhancement of managerial skills of officers in charge of health budgeting, accounting and auditing.,
- Explore/ review existing Health insurance schemes (HIS) and innovative social health protection approaches, Scale up state-wide Health Insurances Scheme

3.4.3. To secure a level of funding needed to achieve desired health development goals and objectives at all levels in a sustainable manner

Intervention Areas

Intervention Area one: To improve financing of the Health Sector

The activities are:

- Increase the allocation of public resources to the health sector by 15% of total budget in line with Abuja Declaration,
- Explore other sources of funding for health sector

Intervention Area two: To improve coordination of donor funding mechanisms

The activities are:

- Explore mechanism for coordinating donor resources with that of government for health development - Common basket funding through options such as joint funding agreements, sector-wide approaches (SWAPs) and sectional multi donor budget support etc

3.4.4. To ensure efficiency and equity in the allocation and use of health sector resources at all levels

Intervention Areas

Intervention Area one: To improve Health Budget execution, monitoring and reporting

The activities are:

- Develop costed annual operational plans,
- Ensure proper internal recording and accounting of expenditures; and that timely and detailed financial management reports are produced periodically,
- Promote financial transparency through the development of State Health Accounts (SHAs) and Public Expenditure Reviews (PERs) and tracking of health budgets

Intervention Area two: To strengthen financial management skills

The activities are:

- Build capacity of health workers in budgeting, planning, accounting, auditing, monitoring and evaluation.

3.5.National Health Management Information System

The NHMIS/M&E remains weak and fragmented with numerous vertical programmes and systems, which are mostly donor driven. In addition, there are multiplicity of data collection tools, too many indicators, and reluctance of developmental partners and the vertical programmes which they support (including programmes within the FMoH), to utilise national tools. Furthermore, there is no national M&E policy, framework and plan and there is lack of integration between the NHMIS and M&E systems. Even though the private sector provides 60% of healthcare in the country, there is very limited capture of their data into the NHMIS. Other major problems include lack of forms; incomplete, untimely, and largely incorrect

reporting of data; grossly inadequate capacity to analyse and utilise data for decision making at all levels; and poor feedback mechanisms.

Goal

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

Strategic Objectives

3.5.1 *To improve data collection and transmission*

3.5.2 *To provide Infrastructural Support and ICT on Health Databases and Staff Training*

3.5.3 *To strengthen sub-systems in Health Information System*

3.5.4 *To Monitor and Evaluate the NHMIS*

3.5.5 *To strengthen analysis of data and dissemination of health information*

3.5.1. *To improve data collection and transmission*

Intervention Areas

Intervention Area one: Ensure availability of NHMIS tools at all health service delivery points at all levels

The activities are:

- Advocacy for adequate budgetary allocation and timely release of funds for data management at both State and LGAs,
- Regular printing of adequate quantities of data collection tools at all levels,
- Ensure regular and equitable distribution of data tools at both primary and secondary health facilities

Intervention Area two: Periodic review of NHMIS data collection forms

The activities are:

- conduct data quality assurance exercise,
- conduct data review meetings,
- Participate in periodic review of NHIMS data collection forms.

Intervention Area three: Coordinate data collection from vertical programmes

The activities are:

- Establish data consultative committee.
- Conduct regular consultative meetings with stakeholders ,
- To establish linkage with private sector on data collection mechanism at all levels ,
- Conduct regular state and LGA M&E committee coordination meeting

Intervention Area four: Build capacity of health workers for data management

The activities are:

- Conduct Health manpower need assessment and where necessary recruit Health Information personnel to fill in the gaps.,
- Training and re-training of service providers on data management at all levels including private Health Facilities, Training of planners, statistician, M&E officers and programme managers on data and result based managements ,
- Develop and use GBV monitoring tools

Intervention Area five: To provide a legal framework for activities of the NHMIS programme

The activities are:

- Dissemination meeting for stakeholders on their role and responsibilities on data collection and management
- Advocacy for policy makers, legislators etc. On usefulness as well as the need for promulgation of enabling laws and bye laws to support data collection system.
- Collaboration with NPC in improving systems at state and LGA levels.

Intervention Area six: Improve coverage of data collection

The activities are:

- Strengthen strategies for timely and complete collection of data from all public and private health facilities; and the community ,
- Strengthen community based data collection system in the state ,
- Strengthen relationship between ministry of Health and National Population Commission to strengthen vital statistics of birth and death registration both at state and LGAs

Intervention Area seven Supportive supervision of data collection at all levels

The activities are:

- Create budget line and realistic budget for supervision of data collection at state and LGAs ,

- Facilitate timely release of fund for routine supervision of data collection ,
- Develop a schedule for routine supervision of data collection at the state and LGA level

3.5.2. ***To provide infrastructural support and ICT for health databases and staff training***

Intervention Areas

Intervention Area one: Strengthen the use of Information technology in HIS

The activities are:

- Strengthen the use of information technology in HIS,
- Establish a Health Information Unit at all levels including private Health Facilities.
- Purchase and installation of ICT equipment at state, Local Government Areas and service delivery points. Orientation training of data management on use of acquired Information Communication Technology (ICT) equipments / gadgets.

Intervention Area two: Provision of HIS Minimum Package at the different levels (FMOH, SMOH, and LGA) of data management

The activities are:

- Production and dissemination of minimum package for Health Management Information System (HMIS), Procurement of adequate computers and accessories and power supply,
- Training of relevant staff on use of data base software,
- Procurement, installation and utilization of equipment for data processing and utilization

3.5.3. ***To strengthen sub-systems in Health Information System***

Intervention Areas

Intervention Area one: Strengthen Hospital Information System

The activities are:

- Create unit for patient Information System for mapping diseases,
- Identify and designate a focal person for the establishment unit,
- Provide adequate logistics, equipment s and relevant materials

Intervention Area two: Strengthen Disease Surveillance

The activities are:

- Support disease surveillance officers (DSO) meetings,
- Conduct training on disease surveillance and notification for Health Workers at all levels.

- Orientation / Advocacy of community leaders (traditional, religious, influential members etc) and Community Based Organization (CBO) on disease surveillance

3.5.4. ***To monitor and evaluate NHMIS***

Intervention Areas

Intervention Area one: Establishment of monitoring protocol for NHMIS programme implementation at all levels in line with stated activities and expected outputs

The activities are:

- Advocacy and prompt release of funds for monitoring and supervision.
- Health Information System (HIS), Quality Assurance (QA) manual (Hand Book) at both primary and secondary Health Facilities,
- Conduct biannual quarterly HIS review meetings at sites and local Government Areas respectively

Intervention Area two: Strengthen data transmission

The activities are:

- Establish a functional Database across the state,
- Develop human capacity for Data analysis ,
- Produce periodic health bulletin and annual reports

3.5.5. ***To strengthen analysis of data and dissemination of health information***

Intervention Areas

Intervention Area one: Institutionalize data analysis and dissemination at all levels

The activities are:

- Training of HIS officers on data analysis and dissemination skills,
- Production of periodic data bulletins and reports ,
- Conduct dissemination back meetings for stakeholders at state and Local levels ,
- Training of programme managers, CSOs & NGOs in the integration of population issues in development planning , Sensitization of policy makers on incorporation of population issues into developmental frameworks and policies

3.6.Community Participation and Ownership

Goal

Attain effective community participation in health development and management, as well as community ownership of sustainable health outcomes

Strategic Objectives

3.6.1. To strengthen community participation in health development

3.6.2. To empower communities with skills for positive health actions

3.6.3. To strengthen the community-health services linkages

3.6.4. To increase national capacity for integrated multi-sectoral health promotion

3.6.5. To strengthen evidence-based community participation and ownership efforts in health activities through researches

3.6.1. ***To strengthen community participation in health development***

Intervention Areas

Intervention Area one: Provide an enabling policy framework for community participation

The activities are:

- Strengthen state community mobilization team
- Re-orientate community development committee and community based institutions (CBOs, CDAs, VOs, Interfaith, etc.)

Intervention Area two: Provide an enabling implementation framework for community participation

The activities are:

- Identify already existing bodies in the community i.e. Red cross society, TBAs, Youths clubs, JNI, private clinics, pharmaceutical stores and patent drugs vendors.
- Develop tools and approach for community participation in planning, management, monitoring and evaluation of health facility and health related activities.

3.6.2. ***To empower communities with skills for positive health actions***

Intervention Area one: Building community capacity

The activities are:

- Sensitization of religious leaders, Politicians, Law enforcement agents, traditional and community leaders on GBV,
- Empower communities with health knowledge and capacity in management, implementation, as well as basic interpretation of health data,
- Define key roles and functions of community stakeholders and structures,
- Develop, upgrade or modify existing participatory tools for mobilising communities in planning and management,
- Identify and map out of key community stakeholders and resources with community assessment of capacity needs

3.6.3. ***To strengthen the community-health services linkages***

Intervention Areas

Intervention Area one: Restructure and strengthen the linkages between the community and health services delivery points

The activities are:

- Review and assess the level of linkages of the existing health delivery structures with the community,
- Support community stakeholders to develop guidelines for strengthening the community-health services linkage,
- Promote community participation in health development using health delivery structures,
- Re-orient community development committees and community-based health care providers on their roles and responsibilities,
- Provide budget line and funding for community level activities,
- Organize community dialogue between communities and government structures,
- Organize information, education and communication (IEC) activities and media to enlighten and empower communities for positive action

3.6.4. ***To increase national capacity for integrated multi-sectoral health promotion***

Intervention Areas

Intervention Area one: Develop and implement multi-sectoral policies and actions that facilitates community involvement in health development

The activities are:

- Support establishment of functional CDC in health facilities ,
- Conduct advocacy to community gatekeepers to increase their awareness on community participation and health promotion ,
- Organize community health development programmes ,
- Provide support to various levels to link health with other sectors using the health promotion guidelines

3.6.5. ***To strengthen evidence-based community participation and ownership efforts in health activities through researches***

Intervention area one: To develop and implement systematic measurement of community involvement

The activities are:

- Develop/adapt models that will be used to establish simple mechanisms to support communities to measure impact and document lessons learnt and best practices from specific community-level approaches, methods and initiatives,

3.7.Partnerships for Health

Goal

Enhance harmonized implementation of essential health services in line with national health policy goals.

Strategic Objectives

3.7.1. ***To ensure that collaborative mechanisms are put in place for involving all partners in the development and sustenance of the health sector by 2011.***

Intervention Areas

Intervention Area one: Public Private Partnerships (PPP)

The activities are:

- Develop strategies for implementing PPP initiatives in line with state PPP policy ,
- Establish PPP desk in DPRS at state level to promote, oversee and monitor PPP initiatives ,
- Undertake mechanisms for engaging the private sector – such as contracting or out-sourcing, leases, concessions, social marketing, franchising mechanism and provision incentives (e.g health commodities, or technical support at no cost),
- Explore mechanism for motivating private sector to set up health facilities in rural and under-served areas , Establish joint monitoring visits by public and private care providers with adequate feedback

Intervention Area two: Coordination of Development Partners

The activities are:

- Develop a framework and guidelines for the harmonization and alignment of development partners support ,
- Establish the Health Partners Coordinating Committee (HPCC) as a government coordinating body with all other health development partners ,
- Establish Mechanism for coordination of partner resource in State

Intervention Area three: Inter-Sectoral Collaboration

The activities are:

- Establish intersectoral Ministerial forum at DPRS state level to facilitate inter sectoral collaboration,
- Conduct inter-ministerial Quarterly Meetings

Intervention Area four: Engaging Professional Groups

The activities are:

- Identify Professional Groups in the State,
- Engage professional groups in planning, implementation, monitoring and evaluation of health plans and programmes,
- Support professional bodies in their continuing education activities to enhance the skills of health professionals,
- Strengthen collaboration b/w govt. and professional groups to advocate for increased coverage of essential interventions, particularly increased funding,
- Promote effective communication to facilitate relationship b/w professional groups and SMOH

Intervention area five: Engaging Communities

The activities are:

- Improve availability of information to communities, in a form that is readily accessible and useful through proper culturally appropriate and gender sensitive dissemination channels,
- Organize quarterly sensitization meetings between senior SMOH officials and community leadership, Produce and distribute information packages for community,
- Develop and disseminate Health charter at all levels,
- Build Capacity of community to prevent and manage Priority Health conditions through BCC, social marketing Public awareness, education and communication (IEC)

Intervention area six: Traditional health practitioners

The activities are:

- Strengthen traditional medicine practitioners board and regulate their practice,
- Organise research activities to gain more insight and understanding of traditional health practice, Provide traditional Health Practitioners with additional skills to improve their practices of proven value e.g. referral system,

- Train traditional health practitioners to improve their skills, to know their limitations and ensure their use of the referral system,
- Work with traditional practitioners in promoting health programmes in such priority areas as nutrition, environmental sanitation, personal hygiene, immunisation and family planning

3.8.Research for Health

Goal

Utilize research to inform policy, programming, improve health, achieve nationally and internationally health-related development goals and contribute to the global knowledge platform.

Strategic Objectives

3.8.1. To strengthen the stewardship role of governments at all levels for research, and knowledge management systems

3.8.2. To build institutional capacities to promote, undertake and utilise research for evidence-based policy making and programming in health at all levels

3.8.3. To develop a comprehensive repository for health research at all levels (including both public and non-public sectors)

3.8.4. To develop, implement and institutionalize health research communication strategies at all levels

3.8.1. ***To strengthen the stewardship role of governments at all levels for research and knowledge management systems***

Intervention Areas

Intervention area one: Finalise Health Research Policy at Federal level and develop health research policies and strategies at state and LGA levels.

The activities are;

- Develop State health research policy,
- Develop health research strategies ,
- Establish Health research steering committees

Intervention area two: Establish and or strengthen mechanisms for health research at all levels

The Activities are;

- Strengthen research unit at state and create unit in LGAs ,
- Strengthen DPRS at State level, and establish DPRS at LGAs ,
- Ensure coordinated implementation of the Essential National Health Research (ENHR) guidelines

Intervention area three: Institutionalize processes for setting health research agenda and priorities

The activities are:

- Establish/ strengthen functional institutional structures for research ,
- Develop and implement guidelines for collaborative health research agenda

Intervention area four: Promote cooperation and collaboration between Ministries of Health and LGA health authorities with Universities, communities, CSOs, OPS, NIMR, NIPRD, Development partners and other sectors

The activities are;

- Establish a forum of health research officers at state and LGAs,
- Organize annual convening of multi-stakeholders forum to identify research priorities and harmonize research efforts,
- All stakeholders to provide budget line and funding for research proposals and implementation

Intervention area five: Mobilisation of adequate financial resources to support health research at all levels

The activities are:

- Allocate at least 2% of health budget for health research at State and LGA levels
- Explore other sources of funding for research

Intervention six: Establish ethical standards and practice codes for health research at all levels

The activities are:

- Establish State ethical board,
- Establish ethical standards and guidelines
- Strengthen monitoring & evaluation system to regulate research & use of research findings at State and LGAs

3.8.2. ***To build institutional capacities to promote, undertake and utilise research for evidence-based policy making in health at all levels***

Intervention Areas

Intervention Area one: Strengthen identified health research institutions at all levels

The activities are:

- Identify and strengthen identified health research institutions for collaboration ,
- Conduct periodic capacity assessment of health research organizations and institutions
- Implement measures to address identified research capacity gaps and weaknesses

Intervention Area two: Create a critical mass of health researchers at all levels

The activities are:

- Develop appropriate training interventions for research, based on the identified needs at all level ,
- Provide competitive research grants for prospective researchers while motivating increased PhD training in health in tertiary institutions through award of PhD studentship scholarships ,
- Provide on the job training for heath personnel for research

Intervention area three: Develop transparent approaches for using research findings to aid evidence-based policy making at all levels

The activities are;

- Develop mechanisms for translating research findings into policies,
- Establish close liaison and linkages between research users (e.g. policy makers, development partners) and researchers

Intervention area five: Undertake research on critical areas already identified in different forums

The activities are:

- Conduct needs assessment to identify required health research gaps at all levels ,
- Conduct research in focus areas

3.8.3. ***To develop a comprehensive repository for health research at all levels (including both public and non-public sectors)***

Intervention Areas

Intervention Area one: Develop strategies for getting research findings into strategies and practices

The activities are:

- Establish a mechanism for "getting research into programmes and policies at all levels; & instituting bi-annual Health research policy fora at all levels

Intervention Area two: Enshrine mechanisms to ensure that funded researches produce new knowledge required to improve the health system

The activities are:

- Develop a framework for sharing research knowledge at all levels,
- Convene annual health conferences, seminars and workshops at State levels on key thematic areas (financing, human resources, MDGs, health research, etc)

3.8.4. ***To develop, implement and institutionalize health research communication strategies at all levels***

Intervention Area one: Create a framework for sharing research knowledge and its applications

The activities are:

- Develop a framework for sharing research knowledge at all levels ,
- Convene annual health conferences, seminars and workshops at State levels on key thematic areas (financing, human resources, MDGs, health research, etc)

Intervention Area two: Establish channels for sharing of research findings between researchers, policy makers and development practitioners

The activities are:

- Identify persons with ability to develop policy briefs ,
- Develop the capacity of researchers, and identified persons to effectively produce policy briefs targeted at informing policy makers as well as the broad scientific and non scientific audiences

Chapter 4: Financing Plan

4.1. Estimated cost of the strategic orientations

The total estimated financial requirement to implement the six –year strategic framework in Adamawa state is about of **N**35,880,846,683 **(thirty five billion, eight hundred and eighty million, eight hundred and forty six thousand, six hundred and eighty three naira).** The breakdown according to Goals, Strategic objectives and interventions are shown in the Table below.

Table 5: Breakdown of Estimated financial requirement

	Priority Area	**Estimated Cost (NGN)**
1	Leadership and Governance for Health	NGN 313,400,893
2	Health Service Delivery	NGN 17,698,854,993
3	Human Resources for Health	NGN 12,175,706,494
4	Financing for Health	NGN 4,148,767,206
5	National Health Information System	NGN 448,918,122
6	Community Participation and Ownership	NGN 260,375,764
7	Partnerships for Health	NGN 289,242,179
8	Research for Health	NGN 545,581,032
	TOTAL ESTIMATED COST	NGN 35,880,846,683

4.2 Available and Projected Funding

From the table 3 above, in years 2006, 2007 and 2008, the sums of NGN1,876,000,000.00, NGN2,114,000,000.00, and NGN1,525,000,000.00 were allocated to the health sector. From these figures, we can project that an unweighed average of NGN 1.84 billion naira could be available annually in years 2010-2015. Factoring an annual inflation rate of 12.5% will give us a new projected funding of NGN15.11 billion naira over the period 2010-2015.

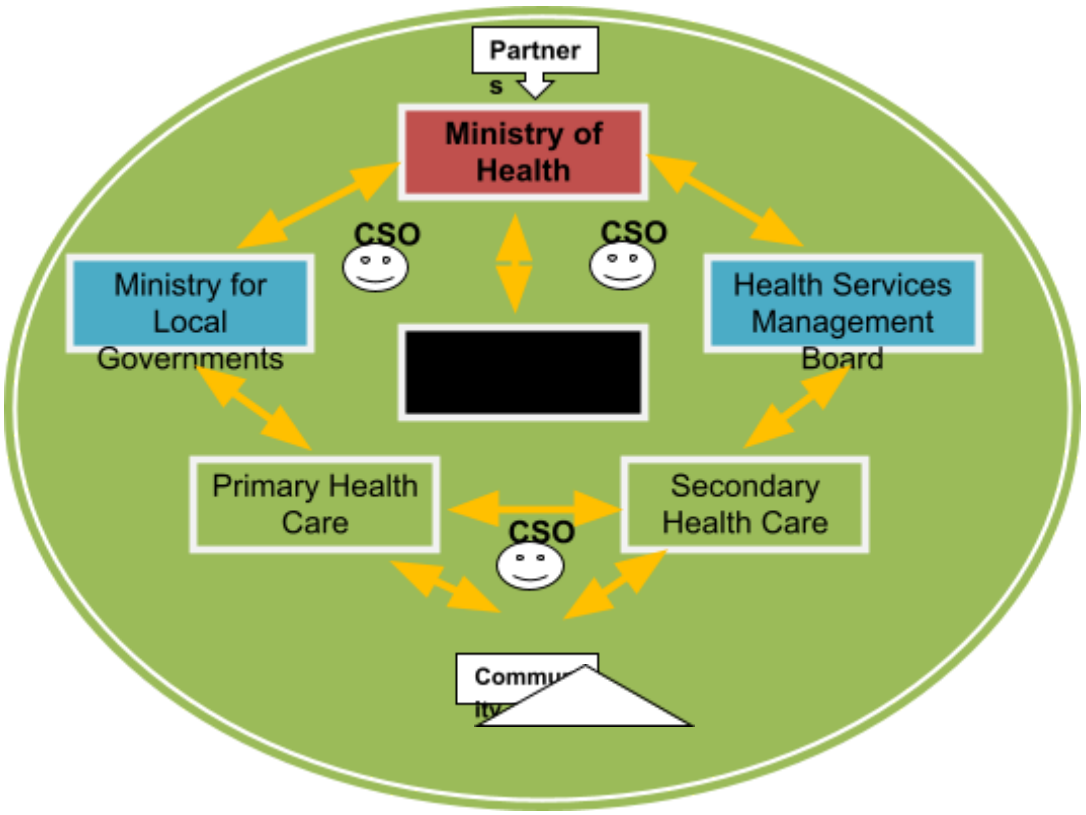
4.3 Determination of the Financing Gap

The gap is the difference between the estimated cost of the plan and the available/projected funding for the state. This is NGN35.88 billion less NGN15.11 billion, which is a total of NGN20.77 billion naira only. This is however a guide since the funding projections did not take into account, resources from development partner agencies, which was unavailable at the time of this exercise.

Chapter 5: Implementation Framework

The illustration below demonstrates the complexity of the structures that are in place to be coordinated in order to effectively implement this strategic plan.

Figure 3: Community Structure for Health Service Provision



Chapter 6: Monitoring and Evaluation

6.1. Proposed mechanisms for monitoring and evaluation

Routine activity reporting will be improved by strengthening the NMHIS in the State capturing essential information on service provision. The department of Planning Research and Statistics, whose mandate is to track all the agreed indicators, will be charged with the responsibility of coordination of all the activities within the strategic plan. The department will also ensure proper and timely activity implementation and complete and accurate reporting by all stakeholders as stipulated in the strategic plan.

Chapter 7: Conclusion

Any strategic document, plan or programme of action is as good as the quality and level of its implementation. There is a high level of cynicism on the ability of the health actors at all levels to implement this plan based on the national framework. However, the operational plan framework has been able to show the various activities that the various actors in the State are familiar with.

The lack of implementation of plans in the past and the non-provision of adequate resources to implement such plans is a major set-back and can possibly be constraints in implementing this plan. There is need for strong political will for this plan to be implemented.

Subsequent administrations should learn to work with plans that are already well developed with minimal variation to fit in with their political agenda.

Annex 1: Details of Adamawa Strategic Health Development Plan

ADAMAWA STATE NATIONAL 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							**313,400,893**
	1.1	**To provide clear policy directions for health development**			**All stakeholders are informed regarding health development policy directives by 2011**		**229,504,163.66**
		1.1.1	Improved Strategic Planning at Federal and State levels		Participation by stakeholders in strategic planning		**83,150,980.50**
			1.1.1.1	Advocacy to the policy makers on the need to adhere to formulated policies on health.	Annual review of strategic plans	Resistance to the execution of the plans.	**6,152,426.81**
			1.1.1.2	Involvement of all stakeholders (Public and Private) in the development and revision of Strategic health Plan of the State.			**16,126,815.72**
			1.1.1.3	Interministerial cooperation in the provision of health related services.			**279,655.76**
			1.1.1.4	Strengthen capacities (commodities, knowledge and skills) of State and LGA key planning staff on policy formaulation, planing and implementation of health plans			**60,592,082.20**
		1.1.2	Strengthen regulatory organs in the Health Sector in the State.		The Regulatory organs in the health sector have powers and full autonomy.		**90,422,030.36**
			1.1.2.1	Develop State Health Policy and Ensure passage State Health Bill	Regular inspections by regulatory bodies observed	poor outcome of expected result	**74,574,870.40**
			1.1.2.2	Ensure availability of Health Policy Documents to stakeholders and general public	There is private sector involvement in the health delivery system in the state.	Low involvement of the private sector at the local gov't level.	**13,982,788.20**

			1.1.2.3	Strengthen information gathering on key quality indicators and publish annual reports	All Professional bodies working in harmony	Dorminance of one professional body in the health sector.	**0**
			1.1.2.4	Set up and support the functioning of a well represented State ethical health committee			**1,864,371.76**
		1.1.3	Improve Accountability and Transparency		Community members are satisfied with services at the various health facilities.		**55,931,152.80**
			1.1.3.1	Involvement of all stake holders in decision making process in the Health sector.	Stakeholders show a high level of understanding of the operations of the system.	Inadequate funding	**0**
			1.1.3.2	Provision of detailed annual State MoH implementation report to the public by print and electronic means through a dedicated website	Less complaints from beneficiary communities.		**0**
			1.1.3.3	Engage and ensure functioning of at least 3 CSOs to provide feedback on efficiency of the MoH	Less complaints from beneficiary communities.		**55,931,152.80**
		1.1.4	Improve Remuneration of Health Workers		Workers well motivated		**0**
			1.1.4.1	Review and implement a uniform salary scale for all health workers.	less agitation by the various professional groups.	Brain drain	**0**
			1.1.4.2	Ensure involvement of all professional unions in deciding and implementing salaries and allowances for health workers.	less agitation by the various professional groups.	Inceasant strike action	**0**
			1.1.4.3	Ensure adequate budgetary provisions for the health sector	Less complaints from the various department and beneficiary communities.	Constraints of fund	**0**
		1.1.5	Interministerial cooperation		Proper implementation of health programs		**0**
			1.1.5.1	Involvement of different ministries in the health plan, e.g. Ministries of Environment and Water Resources etc.	Proper implementation of health programs	A specific aspect of the health program not taken care of due to none invovelment of the related ministry.	**0**

			1.1.5.2	Meetings with the representatives of these ministries on quarterly basis.	Proper implementation of health programs		**0**
	1.2	**To facilitate legislation and a regulatory framework for health development**			**Health Bill signed into law by end of 2010**		**52,202,409.28**
		1.2.1	Strengthen regulatory functions of government		Health Bill review and enactment committee inaugurated and functioning		**52,202,409.28**
			1.2.1.1	Develop State health policy and health act and support periodic reviews	Number of gender sensitive health policies,laws & bills passed	Political will	**0**
			1.2.1.2	Provide technical support on implementation of strategic plans to ensure that the regulatory function of government is strategic and agreed quality standards are set, monitored, and delivered			**10,254,044.68**
			1.2.1.3	Explore and support arrangements under which state governments may wish to outsource some components of health service delivery to the private sector			**0**
			1.2.1.4	Set up review committees to review and align laws of regulatory bodies: private health institutions registration, other professional bodies etc			**27,965,576.40**
			1.2.1.5	Streamline roles and responsibilities of regulatory institutions with the State Health Bill			**13,982,788.20**
	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**		**0**
		1.3.1	To improve accountability and transparency		eAccounting system in place and operational		**0**
			1.3.1.1	Involvement of all stake holders in decision making process in the Health sector.			**0**

			1.3.1.2	Provision of detailed annual State MoH implementation report to the public by print and electronic means through a dedicated website			**0**
			1.3.1.3	Engage and ensure functioning of at least 3 CSOs to provide feedback on efficiency of the MoH			**0**
	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**		**31,694,319.92**
		1.4.1	Improving and maintaining Sectoral Information base to enhance performance				**31,694,319.92**
			1.4.1.1	Advocacy to state house of assembly health committee to ensure RHCS in the state	Percent increase in RHCS	Political stability & commitment	**19,575,903.48**
			1.4.1.2	Produce and disseminate fact sheets on NGP and CEDAW	Number of fact sheets disseminated	Financial support	**12,118,416.44**
HEALTH SERVICE DELIVERY							
2. To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare							**17,698,854,993**
	2.1	**To ensure universal access to an essential package of care**			**Essential Package of Care adopted by all States by 2011**		**469,981,410.03**
		2.1.1	To review, cost, disseminate and implement the minimum package of care in an integrated manner				**263,103,437.69**
			2.1.1.1	Carryout basline assessment and provide status report of the current health infrastructure and level of functioning in the State			**14,453,118.62**
			2.1.1.2	Identify, plan and implement priority impact interventions based on the current baseline report (see bottleneck analysis)			**235,897,567.36**
			2.1.1.3	Revise and develop current SOPs for key services, especially the impact interventions			**14,453,118.62**

		2.1.2	To strengthen specific communicable and non communicable disease control programmes				**204,610,816.47**
			2.1.2.1	Train health workers on condom programming, syndromic management of STI, HCT, PMTCT,, RHHIV integration, Sex work & HIV	Proportion of health workers trained	Political will. Adequate financing	**100,888,435.82**
			2.1.2.2	Sensitization of in-school youth on ASRH and HIV prevention	Proportion of school sensitized	Poltical support	**30,039,815.16**
			2.1.2.3	Provision of integrated SRH/HIV/AIDs services in health facilities	Proportion of health facility providing integrated services	Political commitment	**73,682,565.49**
		2.1.3	To make Standard Operating procedures (SOPs) and guidelines available for delivery of services at all levels				**2,267,155.86**
			2.1.3.1	Revise, produce and distribute SOPs including Standing Orders to all health facilities			**2,267,155.86**
	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**		**10,920,318,556.48**
		2.2.1	To improve geographical equity and access to health services				**8,419,461,435.16**
			2.2.1.1	Develop GIS map locations of all health facilities by categories			**34,007,337.92**
			2.2.1.2	Renovate and upgrade existing health facilities, and provide new ones to emerging communities			**7,113,012,870.14**
			2.2.1.3	Increase number of outlet providing family planning services in the state	Proportion of facility providing at least 3 FP methods	Poltical commitment	**0**
			2.2.1.4	Increase number of facility providing ANC, Delivary, EmNOC and PNC services.	Proportion of facility providing safe motherhood services.	Political will. Adequate financing	**1,159,083,434.04**
			2.2.1.5	Strengthen referral services and develop outreach clinical services to remote communities			**113,357,793.06**

		2.2.2	To ensure availability of drugs and equipment at all levels				**464,547,037.43**
			2.2.2.1	Assess the drugs and equipment needs of all facilities taking into consideration using the MSP, Essential Drugs List and catchment population as a guide			**15,019,907.58**
			2.2.2.2	Develop and implement a system to ensure procurement and distribution of essential drugs on a sustainable basis			**161,818,249.59**
			2.2.2.3	Establish drug management agency			**279,207,045.77**
			2.2.2.4	Training of pharmacy staff on drugs and logistics management			**8,501,834.48**
		2.2.3	To establish a system for the maintenance of equipment at all levels				**1,865,421,510.49**
			2.2.3.1	Adopt, disseminate and implement the National Health Equipment Policy			**129,596,296.92**
			2.2.3.2	Establish medical equipment and hospital furniture maintenance workshops			**1,339,072,937.86**
			2.2.3.3	Explore public private partnership in maintenance of medical equipment and hospital furniture			**0**
			2.2.3.4	Provide/ review budget lines for preventive maintenance of health facilities and equipment			**396,752,275.71**
		2.2.4	To strengthen referral system				**81,746,838.89**
			2.2.4.1	Map network linkages for two-way referral systems in line with national standards			**17,254,756.47**
			2.2.4.2	Provide guidelines for management of emergencies e.g. EmOC, complicated malaria, RTA	Emergency guidelines provided	Political commitment/stability	**31,816,698.57**
			2.2.4.3	Provide adequate ambulances and alternative transport	committee to review school hygiene	Political commitment/stability. Hyperinflation	**0**

					corriculum inaugurated in 2010		
			2.2.4.4	Provide toll free communication linkages	Toll free lines provided	Political commitment/stability	**0**
			2.2.4.5	Monitoring and evaluation of referral linkages	Referral M & E conducted	Political commitment/stability	**32,675,383.85**
		2.2.5	To foster collaboration with the private sector				**89,141,734.52**
			2.2.5.1	Map out all categories of private health care providers by operational level and location			**33,823,131.50**
			2.2.5.2	Develop guidelines and standards for regulation of the registration and practice of private health care providers			**19,525,879.85**
			2.2.5.3	Develop and implemt a joint performance monitoring mechanism for the private sector			**17,032,008.41**
			2.2.5.4	Adapt and implement the national policy on traditional medicine			**11,534,155.44**
	2.3	**To improve the quality of health care services**			**50% of health facilities participate in a Quality Improvement programme by end of 2012**		**2,694,566,885.62**
		2.3.1	To strengthen professional regulatory bodies and institutions				**74,759,464.52**
			2.3.1.1	Build capacity of regulatory staff to monitor compliance of providers to the regulatory guidelines			**11,619,173.79**
			2.3.1.2	Provide budget lines and funding for professional regulatory bodies			**1,275,275.17**
			2.3.1.3	Conduct regular monitoring exercises with appropriate documentation and feedback			**35,367,631.43**
			2.3.1.4	Empower regulators through the provision of necessary security			**26,497,384.13**

		2.3.2	To develop and institutionalise quality assurance models				**172,720,435.34**
			2.3.2.1	Develop State SERVICOM guidelines			**0**
			2.3.2.2	Build institutional capacity and training staff for its implementation			**90,544,537.21**
			2.3.2.3	Develop and implement strategies for monitoring implementation of quality of care			**82,175,898.13**
		2.3.3	To institutionalize Health Management and Integrated Supportive Supervision (ISS) mechanisms				**2,447,086,985.76**
			2.3.3.1	Provide budget line and funding for ISS in state			**509,462,228.98**
			2.3.3.2	Develop capacities of programme managers at all levels in state on the ISS mechanism			**1,924,957,023.40**
			2.3.3.3	Institutionalize comprehensive ISS			**12,667,733.37**
	2.4	**To increase demand for health care services**			**Average demand rises to 2 visits per person per annum by end 2011**		**813,965,633.07**
		2.4.1	To create effective demand for services				**258,512,447.07**
			2.4.1.1	Develop a comprehensive BCC strategy for health promotion in the state.	State BCC stategy developed in 2010	Sustained political commitment	**0**
			2.4.1.2	Regular airing of health promotion messages and drama in the state electronic media in two major local languages and English	Regular airing commenced in 2010	Readily available resources	**28,339,448.27**
			2.4.1.3	Develop IEC materials on health promotion in two major local languages and English	IEC materials in at least two local languages available in 2010	Readily available resources	**19,837,613.79**
			2.4.1.4	Strengthen programme monitoring and evaluation system			**151,332,653.74**
			2.4.1.5	Training of health workers on LSS	Proportion of health workers trained	Political commitment. Financial commitment.	**59,002,731.29**
		2.4.2					**555,453,185.99**
			2.4.2.1	Provide essential equipment, drugs	Availability of essential drugs in all	Political commitment	**555,453,185.99**

				and supplies in all health facilities	health facilities by 2012		
	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**		**2,800,022,506.93**
		2.5.1	To improve financial access especially for the vulnerable groups				**2,800,022,506.93**
			2.5.1.1	Provide free IMNCH for pregnant women & Under fives in all secondary health facilities	Availability of free IMNCH care in 50% of health facility by 2012	Sustained Political commitment	**242,330,622.11**
			2.5.1.2	Explore models for financial protection for the vulnerable groups (e.g. Pregnant women, under fives, orphans and the aged) such as exemption schemes vouchers, health cards, pre payment schemes			**570,954,864.19**
			2.5.1.3	Strengthen free MCH programme in State			**1,136,553,572.67**
			2.5.1.4	Adopt and implement the identified financial protection model			**0**
			2.5.1.5	Provision of free Mama kits for every woman that delivers in a health facility	Availability of Mama kits for all pregnant women by 2013	Improved state financial resources	**850,183,447.95**
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							**12,175,706,494**
	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**		**0**
		3.1.1	To develop and institutionalize the Human Resources Policy framework				**0**
			3.1.1.1	Develop State Human Resource for Health Policy inline with National HRH			**0**
			3.1.1.2	Formulate/periodic review and Implementation of training and recruitment policy for health personel			**0**

			3.1.1.3	Establish HRH forum involving all stakeholders			0
			3.1.1.4	Develop and implement guidelines on retension, task shifting and establish a forum for public-private practitioners to institutionalize HRH policy reviews, supervisory and monitoring frameworks			0
	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**		0
		3.2.1	To reappraise the principles of health workforce requirements and recruitment at all levels				0
			3.2.1.1	Develop staffing norms based on workload, service availbility and health sector priority			0
			3.2.1.2	Operationalise the staffing norms			0
			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			0
	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**		0
		3.3.1	To establish and strengthen the HRH Units				0
			3.3.1.1	Establish training programmes in human resources for health planning and management at all levels			0
	3.4	**To strengthen the capacity of training institutions to scale up the production of a critical mass of quality, multipurpose, multi skilled,**			**One major training institution per Zone producing health workforce graduates**		0

		gender sensitive and mid-level health workers			**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				**0**
			3.4.1.1	Assessment of the health institutions in the State			**0**
			3.4.1.2	Strengthening the quality of tutors			**0**
			3.4.1.3	Strengthening the quality of training materials			**0**
			3.4.1.4	Improve number of paramedical staff in general in the State			**0**
			3.4.1.5	Improve private participation in HRH			**0**
		3.4.2	To strengthen health workforce training capacity and output based on service demand				**0**
			3.4.2.1	Training of health workers on LSS	Proportion of health workers trained	Political commitment	**0**
			3.4.2.2	Facilitate accreditation of eligible private sector health facilities to increase training opportunities for internship and post-basic training for all sector health professionals			**0**
			3.4.2.3	Promote human capital capacity building and continuing professional development (CPD)			**0**
			3.4.2.4	Establish coordination with professional regulatory bodies to link sponsorship to bonding of healthcare providers to mitigate migration across states and outside the country			**0**
	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**		**0**

		3.5.1	To achieve equitable distribution, right mix of the right quality and quantity of human resources for health				0
			3.5.1.1	Create a database of HRH, develop and provide job descriptions and specifications for all categories of health workers in line with MSP			0
			3.5.1.2	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			0
			3.5.1.3	Provide budget line and funding for payment of attractive rural allowance for staffs posted to underserved areas			0
			3.5.1.4	Rationalise health manpower in state and LGAs			0
		3.5.2	To establish mechanisms to strengthen and monitor performance of health workers at all levels				0
			3.5.2.1	Institute a sustainable system of recognition, reward and sanctions			0
			3.5.2.2	Establish system to monitor health worker performance, including use of client feedback (exit interviews)			0
			3.5.2.3	Conduct routine re-orientation of health workforce on attitudinal change including training and retraining in Interpersonal Communication (IPC) skills and work ethics			0
	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**		**0**

		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				**0**
			3.6.1.1	Ensure involvement of health workers and professional groups in management teams, design and monitoring of health services			**0**
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							**4,148,767,206**
	4.1	**To develop and implement health financing strategies at State and Local levels consistent with the National Health Financing Policy**			**50% of States have a documented Health Financing Strategy by end 2012**		**3,155,045,058**
		4.1.1	To develop and implement evidence-based, costed health financing strategic plans at LGA, State and Federal levels in line with the National Health Financing Policy				**73,761,416.61**
			4.1.1.1	Technical working group for health financing in place at headquarters	10 nos technical working group drawned from MDAs in place/functional by 2010	Political will or intrest.,Instability in govt,, Fund availability,.	**7,954,743.73**
			4.1.1.2	Capacity building for working groups to enhance their development and implementation capacities	Technical working group members trained in financial mgt and control by 2010	Political intrest, Fund availabiltyd, Willingness of members to attain training.	**41,387,844.58**
			4.1.1.3	Provision of computers, printers/accessories and stationaries to fast track funds usage	2 table desktop, 2 printers, 1 photocopier, 2 labtops for secreteriate by 2010	Fund availabilty, Supply of substandard Equipment.	**24,418,828.30**
		4.1.2					**3,053,471,009.58**
			4.1.2.1	Social Insurance scheme and other pre-paid schemes to be in place and functional at the state level	functional Social insurance scheme in place by the end of 2010	Government stability.	**1,250,037,069.85**
			4.1.2.2	L.G.As will be supported to explore the existing and innovative social health protection approaches for sustainable health financing.	All health workers in the state ministry will be enlightened and insured under the social insurance scheme by 2011	Fund availabilty.	**1,738,289,472.36**

			4.1.2.3	Technical working group on health insurance to be in place.	21 No. local government in the state will be supported to form social insurance schemes and other pre-paid scheme by 2012	Technical Manpower and availability of fund.	**8,567,283.83**
			4.1.2.4	To .enhance the training of the health insurance working group in the state.	A 12 member technical group will be formed to coordinate the health social insurance scheme in the state by 2010.	Manpower and logistic support.	**56,577,183.54**
			4.1.2.5		Technical health group trained in health insurance scheme and other pre-paid scheme by 2011.	Availability of fund and interest of the personnel to be trained.	**0**
		4.1.3	To secure a level of funding needed to achieve desired health development goals and objectives at all levels in a sustainable manner.				**0**
			4.1.3.1	To increase State health budget allocation from present status to at least 15% ot the state total budget.	Increase current budgetary allocation of 5% gradually to 15% by the end of 2015	Economic fluctuations at both National and International levels.	**0**
			4.1.3.2	To inact health financial control policies in the state towards uninterupted financial flows to the health sector.	A sound and functional health financial policy control measure in place by 2011	Stability in government.	**0**
			4.1.3.3	Seek for more funding to the state health sector from the Federal govt. and other related bodies to improve health delivery system in the state.	Advocacy for more fundind to the State health sector from Federal and other related bodies towards the achievement of 15% total state budget to health sector.	Willingness and cooperation of the International Donor Agencies, Federal Government and other Stakeholders.	**0**
			4,1.3.4	Financial safety nets will be in place to cater for the poor , gender sensitive health matters and vulnerable group	10 cases for chronic and emerging diseases(eg. Mental health, cancer, diabeties, Hiv, v.v.s,etc) will be identified in each of the 21 L.G.As each year for special funding.	Availability of fund and lack of medical experts.	**0**
		4.1.4	Esterblishment of donor coordinating funding mechanism.				**0**
			4.1.4.1	A Donor resource coordinating mechanism in collaboration with	Donor Resourse Technical co-ordinating Unit in place by 2010	Technical experts and lack of fund.	**0**

				the Federal govt. to be in place in the State..			
		4.1.5	To ensure efficiency and equity in the allocation and use of health sector resources at all levels.				**27,812,631.56**
			4.1.5.1	Establishment of health budget implementation, monitoring and evaluation committee in the state.	Budget Implemntation, Monitorin, and Evaluation Department in place 2010.	Manpower and other logistic supports.	**0**
			4.1.5.2	Capacity building for the committee to enhance effective budget implementaion and timely reporting in the state.	Principal Officers on G.L 14-16 Trained and aquanted with nescessary budgetary skills by 2011.	Availability of fund.	**15,644,605.25**
			4.1.5.3	Performance bond mechanism policy towards the effective execution of health projects and programmes will be established in the state..	Performance Bond Mechanism to enhance sound financial control and efficient budget implementation to be in place by 2010.	Due process.	**12,168,026.31**
	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**		**481,795,898.76**
		4.2.1	To strengthen systems for financial risk health protection				**481,795,898.76**
			4.2.1.1	To establish budget monitoring and evaluation department in the State Ministry of Health	Sound and functional Budget Department in place at the Head Quarters by 2010	Manpower and other logistic supports.	**28,474,837.07**
			4.2.1.2	Capacity building towards the enhancement of managerial skills of officers in charge of health budgeting, accounting and auditing.	Train 5No key principal officers on budget necessary skills by 2011.	Availability of fund.	**31,040,883.44**
			4.2.1.3	Explore/ review existing Health insurance schemes (HIS) and innovative social health protection approches			**0**
			4.2.1.4	Scale up state-wide Health Iinsurance Scheme			**422,280,178.25**
	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**		**0**

					average of 5% pa every year until 2015		
		4.3.1	To improve financing of the Health Sector				**0**
			4.3.1.1	Increse the allocation of public resources to the health sector by 15% of total budget in line with Abuja Declaration			**0**
			4.3.1.2	Explore other sources of funding for health sector			**0**
		4.3.2	To improve coordination of donor funding mechanisms				**0**
			4.3.2.1	Explore mechanism for coordinating donor resources with that of government for health development - Common basket funding through options such as joint funding agreements, sector-wide approches (SWAs) and sectional multi donor budget support etc			**0**
	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**		**0**
		4.4.1	To improve Health Budget execution, monitoring and reporting				**0**
			4.4.1.1	Develop costed, annual operational plans			**0**
			4.4.1.2	Ensure proper internal recording and accounting of expenditures; and that timely and detailed financial management reports are			**0**

				produced periodically			
			4.4.1.3	Promote financial transparency through the development of State Health Accounts (SHAs) and Public Expenditure Reviews (PERs) and tracking of health budgets			**0**
		4.4.2	To strengthen financial management skills				**0**
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							**448,918,122.13**
	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**		**448,918,122.13**
		5.1.1	To ensure that NHMIS forms are available at all health service delivery points at all levels				**448,918,122.13**
			5.1.1.1	Advocacy for adequate budgetary allocation and timely release of funds for data management at both State and LGAs		Lack of funds	**16,163,389.27**
			5.1.1.2	Regular printing of adequate quantities of data collection tools at all levels	Number of reports received from state and LGA's facilities	Low political commitment	**432,754,732.85**
			5.1.1.3	Ensure regular and equitable distribution of data tools at both primary and secondary health facilities		Poor communication network	**0**
			5.1.1.4			**Insecurity**	**0**
			5.1.1.5			**Frequent Industrial strike by Health workers**	**0**
		5.1.2	To periodically review of NHMIS data collection forms				**0**
			5.1.2.1	Data Quality Assurance Exercise	Number of coordination meetings held annuly	Lack of funds. Lack of political commitment	**0**
			5.1.2.2	To conduct review meetings			**0**

			5.1.2.3	To participate in periodic review of NHIMS data collection forms.			**0**
		5.1.3	To coordinate data collection from vertical programmes				**0**
			5.1.3.1	To establish data consultative commitee.	Number of coordination meetings held annuly	Conflict of interest of other partners. Withdrawal of Partner support	**0**
			5.1.3.2	To conduct regular consultative meetings with stakeholder			**0**
			5.1.3.3	To establish linkage with private sector on data collection mechanism at all levels			**0**
			5.1.3.4	Conduct regular state and LGA M&E committee coordination meeting	Proportion of meeting with action points implemented	Financial support	**0**
		5.1.4	To build capacity of health workers for data management				**0**
			5.1.4.1	To conduct Health manpower need assessment and where necessay recruit Health Information personnel to fill in the gaps.	No of training conducted yearly	Poor Funding. Shortage of Human manpower.	**0**
			5.1.4.2	Training and re-training of service providers on data mangement at all levels including private Health Facilities			**0**
			5.1.4.3	Training of planners, statistician, M&E officers and programme managers on data and result based managements	Proportion of state planners skilled in data management.	Political commitment. Financial commitment.	**0**
			5.1.4.4	Develop and use GBV monitoring tools	Number of tools utilized	Political will	**0**
		5.1.5	To provide a legal framework for activities of the NHMIS programme				**0**
			5.1.5.1	Dissemination meeting for stakeholders on their role and responsibilities on data collection and mangement	Number of Advocy/Dissemination meetings conducted	Poor commitment. Frequent changes in Leadership.	**0**
			5.1.5.2	Advocacy for policy makers, legialators etc. On usefullnes			**0**

				as well as the need for promugation of enabling laws and bye laws to support data collection system.			
			5.1.5.3	Collaboration with NPC in improving systems at state and LGA levels.			0
		5.1.6	To improve coverage of data collection				0
			5.1.6.1	Strengthen strategies for timely and complete collection of data from all public and private health facilities; and the community			0
			5.1.6.2	Strengthen community based data collection system in the state			0
			5.1.6.3	Strengthen relationship between ministry of Health and National Population Commission to strengthen vital statistics of birth and death registration both at state and LGAs			0
		5.1.7	To ensure supportive supervision of data collection at all levels				0
			5.1.7.1	Create budget line and realistic budget for supervision of data collection at state and LGAs	Number of supervisory reports received	Poor funding. Inadequate Health manpower .	0
			5.1.7.2	Facilitate timely release of fund for routine supervision of data collection			0
			5.1.7.3	Develop a schedule for routine supervision of data collection at the state and LGA level			0
	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**		0
		5.2.1	To strengthen the use of information technology in HIS				0
			5.2.1.1	Esthablish a Health Information Unit at all levels including private Health Facilities.	Number of ICT units established. Number of personnel trained on ICT use	Lack of funds. Resistant to changes.	0

			5.2.1.2	Purchase and installation of ICT equipment at state, Loval Government Areas and service delivery points.			**0**
			5.2.1.3	Orientation training of data management on use of acquired Information Communication Technology (ICT) equipments / gadgets.			**0**
		5.2.2	To provide HMIS Minimum Package at the different levels (FMOH, SMOH, LGA) of data management				**0**
			5.2.2.1	Production and dissemination of minimum package for Health Management Information System (HMS)	Availability of procurement reports on HMIS	Inadequate funding. Poor attitude of personnel.	**0**
			5.2.2.2	Procurement of adequate computers and accesssories and power supply.			**0**
			5.2.2.3	Training of relevant staff on use of data base software.			**0**
			5.2.2.4	Procurement, installation and utilization of equipment for data processing and utilization	Increase use of data processing equipment.	Poltical will. Financial support	**0**
	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**		**0**
		5.3.1	To strengthen the Hospital Information System				**0**
			5.3.1.1	Create unit for patient Information System for mapping diseases.	Availability of established functional patient information unit	Poor commitment. Inadequate funding.	**0**
			5.3.1.2	Identify and designate a focal person for the establishment unit.			**0**
			5.3.1.3	Provide adequate logistics, equipment s and relevant materials.			**0**
		5.3.2	To strengthen the Disease Surveillance System				**0**

			5.3.2.1	Support disease surveillance officers (DSO) meetings	Number of meeting/training conducted. Number of advocacy/oreintation held.	Poor funding. Lack of commitment .	**0**
			5.3.2.2	Conduct traing on disease surveillance and notification for Health Workers at all levels.			**0**
			5.3.2.3	Oreintation / Adocacy of comunity leaders (traditional, religious, influncila members etc) and Community Based Organization (CBO) on disease surveillance.			**0**
	5.4	**To monitor and evaluate the NHMIS**			**NHMIS evaluated annually**		**0**
		5.4.1	To establish monitoring protocol for NHMIS programme implementation at all levels in line with stated activities and expected outputs				**0**
			5.4.1.1	Advocay and prompt releae of funds for monitoring and supervision.	Availability of monitoring and supervision reports	Poor financial commitment	**0**
			5.4.1.2	Health Information System (HIS), Quality Assurance (QA) manual (Hand Book) at both primary and secondary Health Facilities.			**0**
			5.4.1.3	Conduct biannual quarterly HIS review meetings at sites and local Government Areas respectively.			**0**
		5.4.2	To strengthen data transmission				**0**
			5.4.2.1	Establish a functional Database across the state			**0**
			5.4.2.2	Develop human capacity for Data analysis			**0**
			5.4.2.3	Produce periodic health bulletin and annual reports			**0**
	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**		**0**

					available results regularly		
		5.5.1	To institutionalize data analysis and dissemination at all levels				**0**
			5.5.1.1	Training of HIS officers on data analysis and dissemination skills	Number of officers trained on ICT skills. Number of feedback meetings held	Lack of adequate funding. Poor commitment.	**0**
			5.5.1.2	Proviuction of periodic data bu;;etins and reports			**0**
			5.5.1.3	Condudt dissemination bacmeetings for stakeholders at state and Local levels			**0**
			5.5.1.4	Training of programme managers, CSOs & NGOs in the integration of population issues in development planning	Proportion of plans with integration of population issues.	Political will	**0**
			5.5.1.5	Sensitization of policy makers on incorporation of population issues into developmental frameworks and policies	Proportion of policies with integration of population issues.	Political will	**0**
COMMUNITY PARTICIPATION AND OWNERSHIP							
6. To attain effective community participation in health development and management, as well as community ownership of sustainable health outcomes							**260,375,764.25**
	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**		**0**
		6.1.1	To provide an enabling policy framework for community participation				**0**
			6.1.1.1	Strengthen state community mobilization team			**0**
			6.1.1.2	Reorientate community development committee and community based institutions (CBOs, CDAs, VOs, Interfaith, etc.)			**0**
		6.1.2	To provide an enabling implementation framework and environment for community participation				**0**

			6.1.2.1	Identify already existing bodies in the community i.e. Red cross society, TBAs, Youths clubs, JNI, private clinics, pharmaceutical stores and patent drugs vendors.			**0**
			6.1.2.2	Develop tools and approach for community participation in planning, management, monitoring and evaluation of health facility and health related activities.			**0**
	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**		**0**
		6.2.1	To build capacity within communities to 'own' their health services				**0**
			6.2.1.1	Sensitization of religious leaders, Politicians, Law enforcement agents, traditional and community leaders on GBV	Number of stakeholders sensitized	Political will	**0**
			6.2.1.2	Empower communities with health knowledge and capacity in management, implementation, as well as basic interpretation of health data			**0**
			6.2.1.3	Define key roles and functions of community stakeholders and structures			**0**
			6.2.1.4	Develop, upgrade or modify existing participatory tools for mobilising communities in planning and management			**0**
			6.2.1.5	Identify and map out of key community stakeholders and resources with community			**0**

				assessment of capacity needs			
		6.2.2					0
			6.2.2.1	Re-orient community development committees and community-based health care providers on their roles and responsibilities			0
			6.2.2.2	Provide budget line and funding for community level activities			0
			6.2.2.3	Organize community dialogue between communities and government structures			0
			6.2.2.4	Organize information, education and communication (IEC) activities and media to enlighten and empower communities for positive action			0
	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**		0
		6.3.1	To restructure and strengthen the interface between the community and the health services delivery points				0
			6.3.1.1	Review and assess the level of linkages of the existing health delivery structures with the community			0
			6.3.1.2	Support community stakeholders to develop guidelines for strengthening the community-health services linkage			0
			6.3.1.3	Promote community participation in health development using health delivery structures			0
	6.4	**To increase national capacity for integrated multisectoral health promotion**			**50% of States have active intersectoral committees with other Ministries and**		0

					private sector by end 2011		
		6.4.1	To develop and implement multisectoral policies and actions that facilitate community involvement in health development				**0**
			6.4.1.1	Support establishment of functional CDC in health facilities	Proportion of health facility with functional CDC		**0**
			6.4.1.2	Conduct advocacy to community gatekeepers to increase their awareness on community participation and health promotion			**0**
			6.4.1.3	Organize community health development programmes			**0**
			6.4.1.4	Provide support to various levels to link health with other sectors using the health promotion guidelines			**0**
	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**		**0**
		6.5.1	To develop and implement systematic measurement of community involvement				**0**
			6.5.1.1	Develop/adapt models that will be used to establish simple mechanisms to support communities to measure impact and document lessons learnt and best practices from specific community-level approaches, methods and initiatives			**0**
PARTNERSHIPS FOR HEALTH							
7. To enhance harmonized implementation of essential health services in line with national health policy goals							**289,242,178.51**
	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**		**0**

					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)				**0**
			7.1.1.1	Develop strategies for implementing PPP initiatives in line with state PPP policy			**0**
			7.1.1.2	Establish PPP desk in DPRS at state level to promote, oversee and monitor PPP initiatives			**0**
			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 health commodities, or technical support at no cost)			**0**
			7.1.1.4	Explore mechanism for motivating private sector to set up health facilities in rural and under-served areas			**0**
			7.1.1.5	Establish joint monitoring visits by public and private care providers with adequate feedback			**0**
		7.1.2	To institutionalize a framework for coordination of Development Partners				**0**
			7.1.2.1	Develop a framework and guidelines for the harmonization and aligment of development partners support			**0**
			7.1.2.2	Establish the Health Partners Coordinating Committee (HPCC) as a government coordinating body			**0**

				with all other health development partners			
			7.1.2.3	Establish Mechanism for coordination of partner resource in State			0
		7.1.3	To facilitate inter-sectoral collaboration				0
			7.1.3.1	Establish intersectoral Ministerial forum at DPRS state level to facilitate inter sectoral collaboration			0
			7.1.3.2	Conduct inter-ministerial Quarterly Meetings			0
		7.1.4	To engage professional groups				0
			7.1.4.1	Identify Professional Groups in the State	Proportion of teachers trained	Finacial support	0
			7.1.4.2	Engage professional groups in planning, implementation, monitoring and evaluation of health plans and programmes			0
			7.1.4.3	Support professioal bodies in their continuing education activities to enhance the skills of health professionals			0
			7.1.4.4	Strengthen collaboration b/w govt. and professional groups to advocate for increased coverage of essential interventions, particularly increased funding			0
			7.1.4.5	Promote effective communication to faciltate relationship b/w professional groups and SMOH			0
		7.1.5	To engage with communities				0
			7.1.5.1	Improve availability of information to communities, in a form that is readily accessible and useful through proper culturally appropriate and gender sensitive			0

				dissemination channels			
			7.1.5.2	Organize quarterly sensitization meetings between senior SMOH officials and community leadership			**0**
			7.1.5.3	Produce and distribute information packages for community			**0**
			7.1.5.4	Develop and disseminate Health charter at all levels			**0**
			7.1.5.5	Build Capacity of community to prevent and manage Priority Health conditions through BCC, social marketing Public awareness, education and communication (IEC)			**0**
		7.1.6	To engage with traditional health practitioners				**0**
			7.1.6.1	Strengthen traditional medicine practitioners board and regulate their practice			**0**
			7.1.6.2	Organise research activities to gain more insignt and understanding of traditional health practice			**0**
			7.1.6.3	Provide traditional Health Practitioners with additional skills to improve their practices of proven value e.g referal system			**0**
			7.1.6.4	Train traditional health practitioners to improve their skills, to know their limitations and ensure their use of the referral system			**0**
			7.1.6.5	Work with traditional practitioners in promoting health programmes in such priority areas as nutrition, environmental sanitation, personal hygiene,			**0**

				immunisation and family planning			
RESEARCH FOR HEALTH							
8. To utilize research to inform policy, programming, improve health, achieve nationally and internationally health-related development goals and contribute to the global knowledge platform							**545,581,032.16**
	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**		**0**
		8.1.1	To finalise the Health Research Policy at Federal level and develop health research policies at State levels and health research strategies at State and LGA levels				**0**
			8.1.1.1	Develop State health research policy			**0**
			8.1.1.2	Develop health research strategies			**0**
			8.1.1.3	Establish Health research steering committees			**0**
		8.1.2	To establish and or strengthen mechanisms for health research at all levels				**0**
			8.1.2.1	Strengthen research unit at state and create unit in LGAs			**0**
			8.1.2.2	Strenthen DPRS at State level, and establish DPRS at LGAs			**0**
			8.1.2.3	Ensure coordinated implementation of the Essential National Health Research (ENHR) guidelines			**0**
		8.1.3	To institutionalize processes for setting health research agenda and priorities				**0**
			8.1.3.1	Establish/ strengthen functional institutional structures for research			**0**
			8.1.3.2	Develop and implement guidelines for collaborative health research agenda			**0**
		8.1.4	To promote cooperation and collaboration between Ministries of Health and LGA				**0**

			health authorities with Universities, communities, CSOs, OPS, NIMR, NIPRD, development partners and other sectors				
			8.1.4.1	Establish a forum of health research officers at state and LGAs			0
			8.1.4.2	Organize annual convening of multi-stakeholders forum to identify research priorities and harmonize research efforts			0
			8.1.4.3	All stakeholders to provide budget line and funding for research proposals and implementation			0
		8.1.5	To mobilise adequate financial resources to support health research at all levels				0
			8.1.5.1	Allocate at least 2% of health budget for health research at State and LGA levels			0
			8.1.5.2	Explore other sources of funding for research			0
		8.1.6	To establish ethical standards and practise codes for health research at all levels				0
			8.1.6.1	Establish State ethical board			0
			8.1.6.2	Establish ethical standards and guidelines			0
			8.1.6.3	Strengthen monitoring & evaluation system to regulate research & use of research findings at State and LGAs			0
	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**		**0**
		8.2.1	To strengthen identified health research institutions at all levels				0
			8.2.1.1	Identify and strengthen identified health research institutions for collaboration			0
			8.2.1.2	Conduct periodic capacity assessment of			0

				health research organizations and institutions			
			8.2.1.3	Implement measures to address identified research capacity gaps and weaknesses			0
		8.2.2	To create a critical mass of health researchers at all levels				0
			8.2.2.1	Develop appropriate training interventions for research, based on the identified needs at all level			0
			8.2.2.2	Provide competitive research grants for prospective researchers while motivating increased PhD training in health in tertiary institutions through award of PhD studentship scholarships			0
			8.2.2.3	Provide on the job training for heath personnel for reasearch			0
		8.2.3	To develop transparent approaches for using research findings to aid evidence-based policy making at all levels				0
			8.2.3.1	Develop mechanisms for translating research findings into policies			0
			8.2.3.2	Establish close liaison and linkages between research users (e.g. policy makers, development partners) and researchers			0
		8.2.4	To undertake research on identified critical priority areas				0
			8.2.4.1	Conduct needs assessment to identify required health research gaps at all levels			0
			8.2.4.2	Conduct research in focus areas			0
	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**		**0**

				repository by end 2012		
		8.3.1	To develop strategies for getting research findings into strategies and practices			**0**
			8.3.1.1 Establish a mechanism for "getting research into programmes and policies at all levels; & instituting bi-annual Health research policy fora at all levels			**0**
		8.3.2	To enshrine mechanisms to ensure that funded researches produce new knowledge required to improve the health system			**0**
			8.3.2.1 Develop a framework for sharing research knowledge at all levels			**0**
			8.3.2.2 Convene annual health conferences, seminars and workshops at State levels on key thematic areas (financing, human resources, MDGs, health research, etc)			**0**
	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**		**0**
		8.4.1	To create a framework for sharing research knowledge and its applications			**0**
			8.4.1.1 Develop a framework for sharing research knowledge at all levels			**0**
			8.4.1.2 Convene annual health conferences, seminars and workshops at State levels on key thematic areas (financing, human resources, MDGs, health research, etc)			**0**
		8.4.2	To establish channels for sharing of research findings between researchers, policy makers and development practitioners			**0**
			8.4.2.1 Identify persons with ability to			**0**

				develop policy briefs			
			8.4.2.2	Develop the capacity of researchers, and identified persons to effectively produce policy briefs targetted at informing policy makers as well as the broad scienctific and non scientific audiences			**0**
Total Cost							**35,880,846,683.05**

Annex 2: Result/M&E Matrix for Adamawa Strategic Plan

ADAMAWA 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	25	50	75%
	2. % stakeholders constituencies playing their assigned roles in the SSHDP (disaggregated by stakeholder constituencies)	SSHDP Annual Review Report	TBD	10	25	45%
2. Improved Legislative and Regulatory Frameworks for Health Development	3. State adopting the National Health Bill? (Yes/No)	SMOH	0	0	25	75%
	4. Number of Laws and by-laws regulating traditional medical practice at State and LGA levels	Laws and bye-Laws	TBD	0	25	50%
	5. % of LGAs enforcing traditional medical practice by-laws	LGA Annual Report	TBD	0%	25%	50%
	6. % LGAs aligning their health programmes to the SSHDP	LGA Annual Report	0	25	50	75
	7. % DPs aligning their health programmes to the SSHDP at the LGA level	LGA Annual Report	No Baseline	25	50	75
	8. Number of "Annual Health of the LGA" Reports published and disseminated annually	Health of the State Report	TBD	10	25	50%
4. Enhanced performance of the State health system	9. % LGA public health facilities using the essential drug list	Facility Survey Report	TBD	25	50	75%
	10. % of LGA public sector institutions implementing the drug procurement policy	Facility Survey Report	TBD	0	25	50%
	11. % of private sector institutions implementing the drug procurement policy within each LGA	Facility Survey Report	TBD	0	0	0%

	12. % LGA health facilities not-experiencing essential drug/commodity stockouts in the last three months	Facility Survey Report	TBD	25	50	75%
	13. 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	20	30	50
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	14. % of LGAs with a functioning public health facility providing minimum health care package according to quality of care standards.	NPHCDA Survey Report	TBD	10	35	50%
	15. % health facilities implementing the complete package of essential health care	NPHCDA Survey Report	TBD	25	50	75%
	16. % of the population having access to an essential care package	MICS/NDHS	TBD	40	50	75%
	17. Contraceptive prevalence rate	NDHS	15%	20%	25%	30%
	18. Number of new users of modern contraceptive methods (male/female)	NDHS/HMIS	1	5%	10%	15%
	19. % of new users of modern contraceptive methods by type (male/female)	NDHS/HMIS	TBD	1%	5%	10%
	20. % service delivery points without stock out of family planning commodities in the last three months	Health facility Survey	TBD	10	25	30%
	21. % of facilities providing Youth Friendly RH services	Health facility Survey	TBD	5	10	15
	22. % of women age 15-19 who have begun child rearing	NDHS/MICS	8.3	6	4	2
	23. % of pregnant women with 4 ANC visits performed according to standards*	NDHS	79.20%	85%	90%	95%
	24. Proportion of births attended by skilled health personnel	HMIS	78.1	80	85	90

	25. Proportion of women with complications treated in an EmOC facility (Basic and/or comprehensive)	EmOC Sentinel Survey and Health Facility Survey	TBD	20%	30%	50%
	26. Caesarean section rate	EmOC Sentinel Survey and Health Facility Survey	6.00%	5%	4%	3%
	27. % of women who received postnatal care based on standards within 48h after delivery	NDHS	22.40%	30%	35%	50%
	28. % of children exclusively breastfed 0-6 months	NDHS/MICS	9%	12	15	20%
	29. Proportion of 12-23 months-old children fully immunized	NDHS/MICS	38.00%	45	50	55%
	30. % children <5 years stunted (height for age <2 SD)	NDHSMICS	35.00%	30	25	20%
	31. % of under-five that slept under LLINs the previous night	NDHS/MICS	6.00%	10	15	20%
	32. % of under-five children receiving appropriate malaria treatment within 24 hours	NDHS/MICS	17	25	30	40%
	33. % of women who received intermittent preventive treatment for malaria during pregnancy	NDHS/MICS	2%	5	10	15%
	34. HIV prevalence rate among adults 15 years and above	NDHS/SENTINEL SURVEY	3.70%	3.5	3.2	3%
	35. HIV prevalence in pregnant women	NARHS/SMOH	3.60%	3.4	3.2	3%
	36.Condom use at last high risk sex	NDHS/MICS	10%	25%	50%	75%
	37. Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS	NDHS/MICS	24.20%	35%	50%	75%
	38. Prevalence of tuberculosis	NARHS	2	1.5	1.3	1
	39. Proportion of tuberculosis cases detected and cured under directly observed treatment short course	NMIS/SMOH	53%	58%	65%	70%
Output 6. Improved quality of Health care services						
	40. % of health facilities with all essential drugs available at all times	Facility Survey Report	TBD	10	20	30%
	41. % of facilities with deliveries organizing	Facility Survey Report	TBD	2	5	10%

	maternal and/or neonatal death reviews according to WHO guidelines on regular basis					
Output 7. Increased demand for health services						
PRIORITY AREA 3: HUMAN RESOURCES FOR HEALTH						
NSHDP GOAL: To plan and implement strategies to address the human resources for health needs in order to ensure its availability as well as ensure equity and quality of health care						
Outcome 6. The Federal government implements comprehensive HRH policies and plans for health development						
Outcome 7.All States and LGAs are actively using adaptations of the National HRH policy and plan for health development by end of 2015						
Output 8. Improved policies and Plans and strategies for HRH						
Output 8: Improved framework for objective analysis, implementation and monitoring of HRH performance						
	42. CHEW/10,000 population density	MICS	TBD	5	6	7
	43. Nurse density/10,000 population	MICS	TBD	4	5	6
	44. Qualified registered midwives density per 10,000 population and per geographic area	NHIS/Facility survey report/EmOC Needs Assessment	TBD	4	5	6
	45. Medical doctor density per 10,000 population	MICS	TBD	3	4	5
	46. Other health service providers density/10,000 population	MICS	TBD	3	4	5
	47. HRH database mechanism in place at LGA level	HRH Database	25%	50%	75%	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						
Output 12: Improved efficiency and equity in the allocation and use of Health resources at State and LGA levels	48. LGAs health budgets fully alligned to support state health goals and policies	State and LGA Budgets	TBD	20	40	60%
	49. % of LGA budget allocated to the health sector.	National Health Accounts 2003 - 2005	2%	4%	5%	6%
	50. % of LGAs having operational supportive supervision and monitoring systems	SSHDP review report	TBD	10%	20	30%
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	50. % of LGAs making routine NHMIS returns to states	NHMIS Report January to June 2008; March 2009	30	35	50	70%
	51. % of LGAs receiving feedback on NHMIS from SMOH	DSN Meeting Report	60	70	80	90%
	52.% of HMIS operators at the LGA level trained in analysis of data using the operational manual	Training Reports	80%	82%	85%	90%
	53. % of LGA PHC Coordinator trained in data dissemination	Training Reports	60%	70%	80%	90%
	54. % of LGAs publishing annual HMIS reports	HMIS Reports	0	0%	10%	20%
	55. % of LGA plans using the HMIS data	NHMIS Report	0	15%	25%	40%
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	56. Proportion of public health facilities having active committees that include community representatives (with meeting reports and actions recommended)	SSHDP review report	TBD	15%	25%	50%

	57. % increase in community health actions	HDC Reports	TBD	5%	10%	15%
PRIORITY AREA 7: PARTNERSHIPS FOR HEALTH						
Outcome 14. Functional multi partner and multi-sectoral participatory mechanisms at Federal and State levels contribute to achievement of the goals and objectives of the						
Output 15: Improved Health Sector Partners' Collaboration and Coordination						
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						
Output 17: Health research communication strategies developed and implemented						