ONDO STATE GOVERNMENT

STRATEGIC HEALTH DEVELOPMENT PLAN
(2010-2015)

Ondo State Ministry of Health

March 2010

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List of acronyms and abbreviations

CORPs	Community Oriented Resource Persons
CSO	Community Service Organization
DFID	Department for International Development
DHS	Nigeria Demographic and Health Survey
DP	Development Partners
DPRS	Department of Planning, Research and Statistics
FCT	Federal Capital Territory
FMOH	Federal Ministry of Health
GDP	Gross Domestic Product
HDCC	Health Data Consultative Committee
HF	Health Facility
HIS	Health Management Information System
HIV/AIDS	Human Immuno Deficiency Virus/Acquired Immune Deficiency Syndrome
HPCC	Health Partners Coordinating Committee
HRH	Human Resources for Health
HW	Health worker
IEC	Information, Education and Communication
IMCI	Integrated management of Childhood Illnesses
IMNCH	Integrated Maternal, Newborn and Child Health
ISS	Integrated Supportive Supervision
ITNs	Insecticide Treated Nets
JFA	Joint Funding Agreement
LGA	Local Government Area
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDAs	Ministries, Departments and Agencies
MDCN	Medical and Dental Council of Nigeria,
MDGs	Millennium Development Goals
MNCH	Maternal and Newborn Child Health
MRCN	Medical Research Council of Nigeria
NAFDAC	National Agency for Food Drugs Administration and Control
NGOs	Non-Governmental Organizations
SHIS	Social Health Insurance Scheme
NHIS	National Health Insurance Scheme
NHMIS	National Health Management Information System
NHREC	National Health Research Committee

NPHCDA	National Primary Health Care Development Agency
NSHDP	National Strategic Health Development Plan
SSHDPf	State Strategic Health Development Plan Framework
NYSC	National Youth Service Corps
OPS	Organized Private Sector
PHC	Primary Health Care
PHCMIS	Primary Health Care Management Information System
PPP	Public Private Partnerships
QA	Quality Assurance
RDBs	Research data banks
SHAs	State Health Accounts
SMOH	State Ministry of Health
SWAPs	Sector-Wide Approaches
TB	Tuberculosis
TBAs	Traditional Birth Attendants
VHW	Village Health Workers
WHO	World Health Organization

Acknowledgements

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

Ministry of Health,
Ondo State.

Preface

The performance of the health system in Ondo State declined to an unacceptable level, resulting in the evident poor health outcomes for the citizenry. Efforts put in place so far had only yielded little dividend.

The present administration is taking a bold step to prepare a policy document for the health sector. The health policy intends to guide stakeholders in health to actualize the provision of affordable and qualitative health care for all citizens of Ondo State. This is to be accomplished through strategies emplaced in the 12-point developmental programmes of this administration tagged **"A CARING HEART"**. This policy can only be meaningful both in the short and long terms, if it is appropriately located within the context of the overall developmental programmes.

It is important to emphasize that this policy document is a product of wide consultations involving diverse health sector actors in the private and public health system. Considering the caliber of the membership of the Steering and Planning Committees, I had no doubt in their ability to come up with a workable strategic health plan to deliver qualitative, efficient, affordable and accessible health care services as a real dividend of democracy to the people.

I wish to acknowledge the special contributions of all that had been closely involved in the preparation of this policy document. Your good work is stamped indelibly on my memory!

Dr. Adeola Lawrence Adegbemiro
Hon. Commissioner for Health,
Ondo State, Nigeria.

Executive summary

Background and Achievement:

In Ondo State, review of data showed that the state's effort to achieving the health Millennium Development Goals (MDGs) by 2015 lacks proper planning and programming. This poses a major developmental challenge, which can hinder and undermine development and economic growth of the state. However, Ondo State Government recognizes the fact that the health system should be strengthened, health services must be scaled-up and existing gains in the health sector must be sustained and expanded in order to achieve the state's health targets, including the health-related MDGs, especially for its poorest and most vulnerable populations,. These improvements can be achieved through the use of an evidence-based Framework to guide the development of a State Strategic Health Development Plan (SSHDP), with appropriate costing. The Ondo State government has initiated a number of policies and policy actions in the health sector in the last five years, under the umbrella of a health reform agenda, aimed at improving access to quality and affordable services.

Situation Analysis

Ondo State has a population size of 3,441,024 in 2006; males constitute 51.18% of the population. Approximately 60.92 per cent of the population lives in the rural areas. Women of reproductive age constitute 24% of the population and under-five children 13.5%.

Strategic Health Priorities

Leadership and Governance: The state health system leadership and governance strategies are weak due to lack of continuity in government programmes, lack of accountability and transparency. Recommended interventions to address these include appropriate legislation and regulatory frameworks; generating state and local government consensus through State Councils on Health; effective decentralization of decision-making processes; intergovernmental and multi-sectoral collaboration and coordination of all stakeholders including Public-Private Partnership; strengthening stewardship role of government with proper accountability and transparency through advocacy.

Health Service Delivery: Inequitable distribution of resources, infrastructural decay, poor resource allocation strategies, weak referral systems; poor coverage with high impact

cost-effective interventions, lack of integration and poor supportive supervision characterized the state's health system.
Recommended interventions include strengthening health services management; implementing the minimum health care package; increased access to quality health services; rehabilitation of health infrastructure, sustainable procurement system for health commodity security; rational use of drugs; strengthening referral system; attitudinal reorientation through SERVICOM; institutionalizing staff motivation and establishing quality assurance mechanisms.

Human resource for health: In the state, there is quality, quantity and mix of health care workers with a skewed distribution towards the urban areas. Also, these categories of health care providers vary from orthodox to traditional. The recommended interventions include implementation of the National Human Resource Policy; supporting lower levels to develop HRH plans; establishing a system of continuing professional training. It also, addressed the critical human resource shortages in the state; accreditation and periodic curriculum reviews by the training institutions and regulatory bodies.

Financing for health: Financing health care in Ondo State faces challenges because of limited resources available as well as the uncoordinated attempts to provide safety nets for vulnerable populations towards achieving universal access to health care. The recommended interventions include increasing government allocation to health at all levels, implementation of the community-based health insurance schemes, pooling funds using common basket approaches by all actors involved in financing health in the state.

Health Information System (HIS): The existing gaps in the state's HIS include non-adherence to reporting guidelines, poor availability and utilization of standardized tools, poor capacity for data interrogation, non-involvement of private providers, and so on. The recommended interventions include advocacy for funding; capacity building at all levels for data collection and interpretation; availability of data collection tools at all levels; collaboration with the private sector; harmonization of data collecting systems with key indicators; dissemination and utilization of data to inform policy formulation and programming.

Community participation and ownership: The current level of community participation is weak and has implications for a sustainable health system in the state. The recommended interventions includes empowerment and engagement of the communities through community-based organizations and kinship groups as platforms for promoting community participation; implementation of bottom-top approach planning methods, implementation and monitoring

*Partnerships for Health***:** Although a number of development partners are working in the state but their efforts are poorly coordinated.
Hence, it is difficult to determine their level of performance and coverage. The recommended interventions include effective Public Private Partnerships; Inter- and intra-governmental collaboration; coordination mechanisms with health development partners, including multilaterals, bilateral and the civil society; partnerships with professional groups, alternative health care providers.

*Research for health***:** This is poorly coordinated in the state. The recommended interventions include strengthening the capacity for research at all levels through training, increased funding and networking with research institutions; formalization of a forum for interaction and coordination of health research; and formation of Research Ethics Committees (RECs).

Resources Requirements
Development of healthcare systems and improvement in health outcomes, based on investment in programmes focusing on specific diseases, continues to fragment health systems, leaving the basic infrastructure weak and incapable of delivering equitable, broad based services. The gap analysis of the needs of the State revealed the urgent need to address the issue of worsening health indices in the state. The new global ranking released by UNICEF has placed Nigeria as 8th out of the 198 Countries with the largest number of under five mortality and second with the highest number of maternal mortality in the world (800/100,000 live birth). Ondo State has a maternal mortality rate of 371/100,000 live birth and an infant mortality rate of 68/1000 live birth and was pronounced by the world bank in June 2009 as having the worst health indices in the South western zone of the country.

The State has no specific RH data focused on the implementation of IMNCH. However, with the situation in PHC setting whereby the same sets of health worker undertake various activities and with specialized focus of the wards at secondary level, it is possible to approximate number of health workers that may be potentially available for MNCH services.

More than 80% of the health expenditure of the State government is devoted to personnel remunerations. This has significant implication for effective services in terms of facilities and equipment, among others.

The State has three tertiary health institutions: School of Nursing, School of Midwifery, and School of Health Technology, all of which are based in Akure. Hitherto, the Director of Nursing Services in the Ministry of Health has oversight for the Schools of Nursing and Midwives, while the Director of Primary Health Care and Disease Control has oversight for School of Health Technology. Lately, the Government resolved to grant autonomy to these schools in order to enhance efficiency in their management.

The physical components include the infrastructure and capital equipment. Each healthcare facility requires an efficient process for generating and using evidence in

policy making, implementing services, managing procurement and distribution, organizing logistics and maintaining equipment, using human resources appropriately, and efficient financial management.

The financing of health care in Ondo State is challenging due to the limited resources available in the face of competing demands coupled with dwindling allocation from the federation revenue account. As a result, free healthcare programmes and social protection strategies remain inequitable and sustainability is thus threatened. Health care provided by the public sector is constrained by annual health budget which is lesser than the WHO recommended 15% of state annual budget. Various mechanisms have been devised to increase health resources. Health insurance scheme is yet to be embraced by the organized and informal sectors in the state. The state has implemented user fees and has established revolving funds for specific services and programmes.

Financing Health Plan

This depends on the budgetary allocation for the year of implementation. It also involves the support of the implementing partners. It is expected that resources will be harnessed from budgetary provision and donor assistance to finance the plan.

Implementation Framework

The Ondo State Ministry of Health (SMOH) formulates policies for health services delivery and implements same in conjunction with the Hospitals' Management Board (HMB) and the Local Government Authorities (LGAs). Each of the 18 LGAs is responsible for managing the Primary Health Care (PHC) system, including community health activities such as immunization and health education, and provision of basic outpatient services at its maternities, among others. The State provides a supportive linkage to the LGAs through management of referrals from the PHC level, to the secondary level as well as technical guidance.

Mechanisms for developing and maintaining relationships have been established with relevant groups and programmes in the state. For instance the World Bank, UNICEF, and other development partners are working in the state. The relationship of the healthcare managers in the state with the national health system and other public sectors will enhance adequate implementation of the framework. Also, relationships with communities and foreign development partners should be nurtured through effective communications systems.

Monitoring and Evaluation

Monitoring and evaluation system lacks organizational structure in the state. As a result, both human and material capacities required to do the work are limited. Hence, it is proposed that the human and material capital of the state be built to be able to respond favourably to the challenges of monitoring and evaluating the plan. Both direct and indirect cost involved in M&E activities are costed.

Conclusion

Ondo State has a written and published health policy that is fairly comprehensive, and a health reform process has been pursued over the last five years. Core elements of the policy and reform process are: human resources for health, quality improvement and management, health fund, pharmaceutical management programme, policy and strategy development, performance management, and communication and advocacy. The policy aptly covers the issue of IMNCH. The State policy on free medical treatment for all pregnant women and under-five children, which has been vigorously funded by the government, epitomizes the State's commitment to IMNCH.

Vision and Mission of the Strategic Plan

Vision

"To reduce the burden of diseases on the people to enable them live an economic and socially productive life; meet national targets on the elimination and eradication of diseases; and significantly increase the life expectancy and quality of life of the citizen".

Mission Statement

"To put in place appropriate policies and programmes under a transparent and honest leadership to be able to strengthen the health system to ensure affordable and qualitative health care for all citizens of Ondo State'.

Chapter 1: Background and Achievements

Background

Health is an inevitable social and cultural currency for the continuity of humanity. It has direct relationship with national development and poverty alleviation because "a healthy nation is a wealthy nation". Improved health status and increased life expectancy contribute to long term economic planning and development. An effective health system is one with pro-poor agenda as its focus. Hence, the performance of a state health system can be measured in terms of how best it serves the interest of the poorest and most vulnerable populations. In Ondo State, review of data showed that the state's effort to achieving the health Millennium Development Goals (MDGs) by 2015 lacks proper planning and programming. This poses a major developmental challenge, which can hinder and undermine development and economic growth of the state.

However, Ondo State Government recognizes the fact that the health system should be strengthened, health services must be scaled-up and existing gains in the health sector must be sustained and expanded in order to achieve the state's health targets, including the health-related MDGs, especially for its poorest and most vulnerable populations. These improvements can be achieved through the use of an evidence-based Framework to guide the development of a State Strategic Health Development Plan (SSHDP), with appropriate costing.

1.2 Achievements

The Ondo State government has initiated a number of policies and programmes in the health sector in the last five years, under the umbrella of a health reform agenda, aimed at improving access to quality and affordable services. The State health care system has three levels of care:

- Primary health care – which focuses on the provision of general health care services such as preventive, curative, promotive and rehabilitative care for the population as the entry point of the health care system. This level of care is

mostly the responsibility of local government area (LGA). Most private health facilities also provide health care at this level;

- Secondary health care – which provides specialized services to patients referred from the primary health care level to out-patient and in-patient services of comprehensive health centres and general hospitals for medical, surgical, paediatric patients and community health services. This level of care is largely the responsibility of the State government.

- Specialised health care – this is being provided by special hospitals, which provide care for specific diseases or conditions, such as eye, psychiatric, and paediatrics hospitals.

Presently, the state designated six categories of health facilities in the State (excluding the Federal Medical Centre, *Owo*) based on bed space and service coverage (Table 3.1). These include specialist hospital (at *Akure*), reference general hospitals (at *Ikare*, *Okitipupa*, and *Ondo*), district general hospitals (at *Owo*, *Igbokoda*, *Ore*, *Idanre*, *Ile-Oluji*, *Igbara-Oke and Igbotako*). Other categories are cottage general hospital (8 facilities), comprehensive health centres (18 facilities) and basic health centres (203 facilities). These efforts, however, does not reflect in the name of the health facilities currently because the facilities still bear their old names.

Available MNCH data indicate a weak but an improving MNCH status. According to the State Health Policy, the infant mortality rate is 70 per 1,000 live births[10] but no specific state statistics were available for neonatal and maternal mortality ratio. The life expectancy for the State is 53 years[10].

Also, the State has enunciated a policy of establishing one basic health centre in each of the 203 political wards in the state, with a general hospital and one comprehensive health centre with appropriate staff to offer back-up services to the BHCs. The number of wards with a BHC increased from 151 in October 2003 to 170 by early 2007. In addition quality assurance programme has been initiated through accreditation of facilities, with clear criteria, including relevant drugs and material, specified in the assessment system.

Chapter 2: Situation Analysis

2.1 Socio-economic context

Ondo State with a land area of 14,606 km² which represents only 1.66 percent of the total surface area of Nigeria was created on 3 February, 1976 from the former Western State. It originally included what is now Ekiti State, which was carved out in 1996. Akure is the state capital. It has a population of 3,423,535 (NPC 2006)[1], of which 1, 679,761 are females and 1,761,263 males. It is located in the South Western part of Nigeria. The state lies within latitudes 50 45' and 80 15' North and longitudes 40 45' and 6' East. It is bordered in the Northwest by Ekiti and Kogi States; West-Central by Osun State; Northeast and East Central by Edo State; Southwest by Ogun State and Southeast by Delta State. The southern coastline rests on the Atlantic Ocean with considerable territorial waters offshore, and is rich in aquatic, mineral and oil resources of significant importance.

The state is made up of eighteen Local Government Areas. The majority of the state's citizens live in urban centers. The ethnic composition of Ondo State is largely from the Yoruba subgroups of the Akoko, Akure, Ikale, Ilaje, Ondo, and Owo. Ijaw minority (such as Apoi and Arogbo) populations inhabit the coastal areas. Ondo State contains the largest number of public schools in Nigeria - over 880 primary schools and 190 secondary schools.

The state has a variety of land forms from the coastline in and around Ilaje and Ese-Odo LGAs, the land rises to an undulating landscape with considerable elevations in the Idanre hills, in Idanre LGA and Oka Hill in Akoko-South West LGA. Geologically, the state's rock structure is made up of the pre-combrian crystalline basement complex which

[1] National Population Commission (2008) National Development Plan

form part of the main Nigerian rock mass. These crystalline rocks are fairly heavily mineralised with some evidence of gold and iron ore.

Both rock types occupy more than 80 percent of the state. There are also younger rocks of sedimentary origin in most of the southern end of the state, which are found to be endowed with such minerals as limestone and petroleum amongst others. Therefore, the economic potentials of the state's mineral resources appear very high and promising.

Ferruginous tropical soils largely cover the remaining area of Ondo State. Crystalline acid rocks constitute the main parent materials of these soils. The soils are generally considered to be of high natural fertility.
They are however susceptible to erosion and occasional water logging as a result of the clay sub-soil. Areas with ferruginous soil are particularly suitable for cocoa production as evident in the long history of significant cocoa production in the state. The soils have exceptional clayey texture, but combine good drainage with good properties of moisture and nutrient retention. In terms of productivity and potentialities, the coastal alluvial soils of Ilaje and Ese-Odo LGAs are
low. The other soil of the state is of medium to high productivity, with good potentialities for both food and non-food agricultural production.

The climatic conditions in Ondo State follow the pattern in South Western Nigeria, where the climate is influenced mainly by the rain-bearing southwest monsoon winds from the ocean and dry Northwest winds from the Sahara Desert. High temperatures and high humidity also characterize the climate, which facilitate the growth of tropical crops and high forest. There are two distinct seasons, the rainy and dry seasons. The rainy season lasts for about seven months (April to October) while the main dry season lasts generally from late October to March. The amount and pattern of rainfall remain the most important climatic factor in agricultural production possibilities in Ondo State. In general terms, the state is well endowed with high rainfall that varies from about 2540mm a year in the south-eastern strip to 2032mm along the remaining coastline; 1524mm in the middle part, and 1270mm along the northern part made up mainly of the four Akoko LGAs. The atmospheric temperature ranges between 28^0C and 31^0C and a mean annual relative humidity of about 30 percent.

Agriculture is the predominant occupation of the people of the state; the estimated GDP for 2007 was $8.41 billion and $2,392 per capital[2]. The State and LGAs internally generated revenues, contribute to funding for health care in addition to allocations from the federal revenue account and support from development agencies working in the state.

Ondo State is unique in terms of its ecological diversity and its endowment with mineral and natural resources, despite its relatively small land mass. However, the state is strongly susceptible to ecological damage and severe degradation if not carefully protected and managed. More importantly, the coastal zone of the state constitutes part of

[2] National Planning Commission: 2008 Draft National Development Plan

the Niger Delta wetlands that is of global significance and this is where endangered species should be protected. Apart from being described as having the longest coastline in the federation, it has beaches that are generally muddy unlike other coastlines. Both are being eroded at an alarming rate of between 30 and 90 meters per annum.

The state is confronted with other environmental challenges that must be tackled if programmes that are intended for socio-economic upliftment are to be sustained and have the desired impact on the quality of life of its citizenry. To address threatening environmental problems, the government has taken a number of steps in line with the national framework of protecting the natural resource base.
In 1993, the state government established the State Environmental Protection Agency through the enactment of an environmental protection law – edict 14 of 1993. The Agency was saddled with some statutory responsibilities, which include:
(i) the formulation of policies that would enhance the protection, conservation and development of its environment;
(ii) encouragement of a productive and enjoyable harmony between man and his environment; and
(iii) ensuring the compliance of any development project with Environmental Impact Statement, Planning Permit and other regulations guiding development.

2.2 Health status of the population

Ondo State has a maternal mortality rate of 371/100,000 live birth and an infant mortality rate of 68/1000 live birth and was pronounced by the world bank in June 2009 as having the worst health indices in the South West zone of the country.

In 2009, the per capita health expenditure was $4 as against the standard of $34 recommended by the Macroeconomic commission on health for the attainment of health related MDGs. However, there is a scale up in health investment by the state in the proposed 2010 budget with per capita health expenditure of $ 12

The Doctor/Patient ratio in the State is currently 1:14,000 as against 1:5,000 recommended by the World Health Organization (WHO)/global standard for the health sector. The total number of antenatal attendance recorded in the 18 General and State Specialist Hospitals is 115,299 in 2008 while the total Caesarean Section amounts to 3,875. In order to provide dedicated care for mother and child and to considerably reduce the delay in care provided at the healthcare service centers, which has been identified in the State as being one of the contributing factors to maternal mortality, specialized health facilities are being constructed to reduce the perennial delay. These specialized health facilities are tagged “Mother and Child” Hospitals and are to be adequately equipped and appropriately staffed.

The NDHS 2008 provides us with the most recent data on some important health status indicators country-wide. The selected indicators for Ondo State are presented in the table below.

Summary health status indicators for Ondo State

POPULATION (2006 Census)	ONDO
Total population	**3,460,877**
female	1,715,820
male	1,745,057
Under 5 years (20% of Total Pop)	439,479
Adolescents (10 – 24 years)	1,151,477
Women of child bearing age (15-49 years)	904,436
INDICATORS	**NDHS 2008**
Literacy rate (female)	75%
Literacy rate (male)	80%
Households with improved source of drinking water	63%
Households with improved sanitary facilities (not shared)	15%
Households with electricity	48%
Employment status (currently)/ female	63.4%
Employment status (currently)/ male	69.0%
Total Fertility Rate	4.9
Use of FP modern method by married women 15-49	15%
Ante Natal Care provided by skilled Health worker	70%
Skilled attendants at birth	51%
Delivery in Health Facility	47%
Children 12-23 months with full immunization coverage	37%
Children 12-23 months with no immunization	23%
Stunting in Under 5 children	32%
Wasting in Under 5 children	6%
Diarrhea in children	6.6
ITN ownership	5%
ITN utilization (children)	4%
ITN utilization (pregnant women)	1%
children under 5 with fever receiving malaria treatment	-
Pregnant women receiving IPT	5%
Comprehensive knowledge of HIV (female)	20%
Comprehensive knowledge of HIV (male)	33%
Knowledge of TB (female)	68.8%
Knowledge of TB (male)	88.0%

2.3 Health services provision and utilization

Ondo State operates a pluralistic health care delivery system with the orthodox and traditional health care delivery systems operating alongside each other, with minimal collaboration. Both the private and public sectors provide orthodox health care services in private health facilities) of which 75.2% are primary health care facilities, 21.0% secondary and 0.4% Dental clinics, 1.0% optical centers and 0.8% others (medical laboratories, ART centres, Chest Clinics and PMTCT Centers). The state has a total of 2,388 medical personnel[3].

In Ondo State, healthcare services are provided by broad spectrum of health care institution both public and private. About 60.92% of the state's population is rural dwellers and 39.08% reside in the urban areas of Akure, Ondo, Owo, Ikare and Okitipupa.
Greater majority of population are exposed to diseases and lower standard of living especially in the rural areas. They have limited access to qualitative health care facilities, most of which are situated in urban areas.
Presently, there is a renewed push for improved health care. Malaria, diarrhea, dysentery, pneumonia, typhoid fever, hypertension and HIV/AIDS constitute the major health challenges facing the state. The Adult HIV/AIDS prevalence is 2.4% (2008) and the state now has its own Anti-Retroviral Treatment Centre. In addition, all General Hospitals are designated HIV Screening Centres. The Multi-sectoral Ondo State Action Committee on AIDS (ODSACA) coordinates the state's response to the HIV/AIDS pandemic.

The Ondo State Ministry of Health (SMOH) formulates policies for health services delivery and implement in conjunction with the Hospitals' Management Board (HMB) as well as Local Government Authorities (LGAs). Each of the 18 LGAs is responsible for managing the Primary Health Care (PHC) system, including community health activities such as immunization and health education; hygiene and provision of basic outpatient services at its maternities, among others. The State provides a supportive linkage to the LGAs through management of referrals from the PHC level to the secondary level as well as technical guidance[4].

2.4 Key issues and challenges

The strength of the SSHDP in the state includes high level political will and commitment; Existence of a comprehensive Health plan; Conducive social and Policy environment.

Also, the weaknesses include Inadequate Budgetary allocation for Health in line with WHO requirement; Ineffective integration and linkages in Health Services; Inadequate

[3] Fatusi A, Situation analysis of maternal, newborn and child health in Ondo State Draft Report.

[4] Ibid

and obsolete medical equipment; Difficulty in accessing the riverine and other remote areas; Lack of continuity in policy conceptualization and implementation; and grossly Inadequate remuneration for health personnel.

In addition, the opportunities are Involvement of development partners in Health sector programmes; Alternative Health financing measures such as National Health Insurance Scheme and other Health funds; Technical assistance from Federal government and International Agencies and Favorable democratic atmosphere for relevant legislations.

Finally, the threats are: exodus of skilled health personnel; inconsistent Government Policies; dwindling State Government revenue; activities of unskilled and unlicensed health practitioners; prevalence of adulterated and fake drugs; unregulated traditional medical practice.

Chapter 3: Strategic Health Priorities

3.1.1 Context

Ondo State has adopted several sectoral health policies since its creation in 1976. Some of these policies were derived from the various national development plans formulated between 1975 and 1985. The initial guiding philosophy of pre-1985 policies was based on the assumption that improving the health of the population was essentially dependent upon the availability of health providers and access to health facilities[5].

In 1988 a PHC focused Health policy was adopted by the state and subsequently reviewed in 2004. This policy was the first to provide direction hinged on the principle of primary health care (PHC) based on the evidence of the disease burden of the state. In line with the constitution of Nigeria (1999) in the Forth Schedule, Section 2, sub-section C the State and the Local Government Councils provide and maintain health services.[6]

The lack of clear cut role performance by key stakeholders led to the poor performance of the health system in the state. Duplication of roles, lack of communication between various actors, and poor accountability are critical factors responsible for the lack of strategic direction and an inefficient and ineffective health care delivery system in the state among many others. However, attempts have been made to enhance leadership and governance for health. These efforts included the convocation of the Ondo health summit,a conference of all stakeholders in the health sector of the state including indigenes from the diasporas to develop a state strategic health development plan in consonance with the eight evidence-based priority areas identified and prescribed in the NSHDP to improve the performance of the health sector, through a holistic approach at all levels of health care delivery.
Each of these priority areas carry goals with strategic objectives, interventions and activities. These activities have targets and verifiable indicators. The strategic orientations or priority areas are:

Priority Area 1: Leadership and governance for health
Priority Area 2: Health service delivery
Priority Area 3: Human resource for health
Priority Area 4: Financing for health
Priority Area 5: Health information system
Priority Area 6: Community participation and ownership

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[5] Nigeria Heath Review 2006 of Health Reform Foundation of Nigeria.

[6] 1999 Constitutions of the Federal Republic of Nigeria

Priority Area 7: Partnerships for health
Priority Area 8: Research for health

These priority areas of the SSHDP Framework seek to streamline and empower the Ministry of Health in the State and the LGA Health Departments to reposition their organizational and management systems to provide the strategic and tactical leadership and governance for health. Also, the plan seek to enhance accountability and transparency in the use of health development resources

However, the following list reflects the priority high impact interventions to be delivered in the State - as part of the Essential Package of Health Services for Ondo State which currently operates free for all pregnant women and under – 5 children.

HIGH IMPACT SERVICES
A. **FAMILY/COMMUNITY ORIENTED SERVICES**
Insecticide Treated Mosquito Nets for children under 5
Insecticide Treated Mosquito Nets for pregnant women
Household water treatment
Access to improved water source
Use of sanitary latrines
Hand washing with soap
Clean delivery and cord care
Initiation of breastfeeding within 1st hr. and temperature management
Condoms for HIV prevention
Universal extra community-based care of LBW infants
Exclusive Breastfeeding for children 0-5 mo.
Continued Breastfeeding for children 6-11 months
Adequate and safe complementary feeding
Supplementary feeding for malnourished children
Oral Rehydration Therapy
Zinc for diarrhea management
Vitamin A - Treatment for measles
Artemisinin-based Combination Therapy for children
Artemisinin-based Combination Therapy for pregnant women
Artemisinin-based Combination Therapy for adults
Antibiotics for U5 pneumonia
Community based management of neonatal sepsis
Follow up Management of Severe Acute Malnutrition
Routine postnatal care (healthy practices and illness detection)

B. POPULATION ORIENTED/OUTREACHES/SCHEDULABLE SERVICES
Family planning
Condom use for HIV prevention
Antenatal Care
Tetanus immunization
Deworming in pregnancy
Detection and treatment of asymptomatic bacteriuria
Detection and management of syphilis in pregnancy
Prevention and treatment of iron deficiency anemia in pregnancy
Intermittent preventive treatment (IPTp) for malaria in pregnancy

Preventing mother to child transmission (PMTCT)
Provider Initiated Testing and Counseling (PITC)
Condom use for HIV prevention
Cotrimoxazole prophylaxis for HIV+ mothers
Cotrimoxazole prophylaxis for HIV+ adults
Cotrimoxazole prophylaxis for children of HIV+ mothers
Measles immunization
BCG immunization
OPV immunization
DPT immunization
Pentavalent (DPT-HiB-Hepatitis b) immunization
Hib immunization
Hepatitis B immunization
Yellow fever immunization
Meningitis immunization
Vitamin A - supplementation for U5

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

Chapter 4: Resource Requirements

In the attempt to achieve the millennium development goals, many critical challenges confront healthcare systems in Ondo State. Development of healthcare systems and improvement in health outcomes, based on investment in programmes focusing on specific diseases, continues to fragment health systems, leaving the basic infrastructure weak and incapable of delivering equitable, broad based services. There has been much discussion about integrating the primary, secondary, and tertiary tiers of the health system but inadequate attention has been paid to identifying and strengthening the actions that are required to deliver the basic package of care

4.1 Human

The gap analysis of the needs of the State revealed the urgent need to address the issue of worsening health indices in the state. Ondo State has a maternal mortality rate of 371/100,000 live birth and an infant mortality rate of 68/1000 live birth and was pronounced by the world bank in June 2009 as having the worst health indices in the South West zone of the country[7].

The Doctor/Patient ratio in the State is currently 1:14,000 as against 1:5,000 recommended by the World Health Organization (WHO)/global standard for the health sector. According to a recent study in the state[8], the health workers in the employment of the State government include: 10 consultants, 138 medical officers, 908 nurses, 116 medical laboratory technologists/scientists, 75 X-ray technologists, and 21 medical laboratory officers. The study also indicated that the density of health workers for the State is approximately 0.35 per 1000 population. The density increases to 0.48 per 1,000 population with the addition of doctors and nurses at the Federal Medical Centre, Owo, and will be improved still with the addition of health care workers in private practices but an accurate statistics or reliable estimates were not available in that respect.

A total of 1932 Community Resource Persons (CORPS) have been trained by the state essentially at the primary health care level/LGAs. Other categories of health practitioners namely traditional and spiritual-home based birth attendants exist in the State. Also, NGOs and private hospitals provide health care services in the state. Presently, there is no formal coordination mechanism. The State has no specific RH data focusing on the implementation of MNCH. More than 80% of the health expenditure of the State government is devoted to personnel remunerations. This has significant implication for effective services in terms of facilities and equipment, among others.

The State owns a School of Nursing, a School of Midwifery, and a School of Health Technology, all of which are based in Akure.

[7] Fatusi A, Situation analysis of maternal, newborn and child health in Ondo State Draft Report.

[8] Ibid

The Director of Nursing Services in the Ministry of Health has oversight for the Schools of Nursing and Midwives, while the Director of Health of Primary Health Care has oversight for School of Health Technology.

4.2 Physical/Materials

The physical components include the infrastructure and capital equipment. Each healthcare facility requires an efficient process for generating and using evidence in policy making, implementing services, managing procurement and distribution, organizing logistics and maintaining equipment, using human resources appropriately, and efficient financial management.

Lack of adequate number of functioning equipment will affect the quality of service provision. Data showed that the tertiary and private were well equipped with basic medical and surgical equipments. The situation is contrary in the secondary health care facilities and extremely poor in the PHC. For example, a recent study[9] in the state indicated that only 14,3% of secondary facilities had resuscitation table, 42.9% had incubators and 28.6% had phototherapy machine, 14.3% had neonatal laryngoscope, and 28.6% had infant airway. The PHC facilities fare worse.

4.3 Funding

The financing of health care in Ondo State is challenging due to the limited resources available in the face of competing demands and dwindling allocation from the Federation accounts. As a result, free healthcare programmes and social protection strategies remain inequitable and the likelihood of sustainability is daunting. Health care provided by the public sector is constrained by annual health budgets less the WHO recommended 15% of State annual budget. Various mechanisms have been devised to increase health resources. Health insurance scheme is yet to commence in the state. The state has implemented user fees and has established revolving funds for specific services and programmes. Such funds may be a rational response to a specific need, but having many revolving funds operating outside the financial management system of the central administration may prove overwhelming.

Similarly, centrally administered accounts focused on specific diseases make it difficult to coordinate investments in the public health sector and to track donors' contributions and manage public/private partnerships

[9] Ibid

Chapter 5: Financing plan

5.1 Estimated cost of the strategic orientations.

The estimated cost implication for the priority areas of the SSHDP are as outlined below:

Priority Area	Estimated Cost (2010-2015)
Leadership and Governance For Health	NGN 595,410,461
Health Service Delivery	NGN 28,572,199,014
Human Resources For Health	NGN 19,539,678,528
Financing For Health	NGN 7,559,000,560
National Health Information System	NGN 893,115,691
Community Participation and Ownership	NGN 595,410,461
Partnerships For Health	NGN 595,410,461
Research For Health	NGN 1,190,820,922
Total	**NGN 59,541,046,099**

5.2 Assessment of the available and projected funds

This depends on budgetary allocation for the year 2010 and this not available yet.

5.3 Determination of the financing gap

This will be measure against the budget performance.

5.4 Descriptions of ways of closing the financing gap:

*Community-based Health Insurance***:** The state has initiated the process of operating community-based health insurance scheme (CHIS) starting with six pilot LGAs. The initiative will fill important gaps in the state health care financing when it is scaled up to other LGAs in the state.

Policy on free treatment for cases of emergency obstetric, newborn and child care: The free health policy of the state covers all phases of pregnancy and delivery, and all forms of treatments including surgical interventions. One of the challenges of the scheme is the increasing number of patients patronising services such as antenatal clinics leading to extended waiting time. The programme has implications for health budgeting. As indicated by the immediate past administration in the state, "A budget of ₦200 million

was initially provided in the 2007 budget for maternal and child health programme and within four months the money had almost been exhausted so that a supplementary budget of ₦800 was provided for in June 2007"[9]. The government, however, was expecting the MDG grant from the federal government which will reduce the burden and make the scheme will run smoothly in subsequent years".

Other Payment Schemes: In addition to the modes of financing discussed above, user-fee payment scheme is a major source of health care financing in the state. Also, the State has a drug revolving scheme that fits into the larger vision of pharmaceutical management programme. One of the objectives of the programme is to "have in place a self sustaining drug, diagnostics and supplies distribution network using public and private providers"[10].

Chapter 6: Implementation Framework

Strategies for implementing the framework will utilize the exiting structure in the state. In some cases, new structures are to be put in place while the weak ones will be strengthened. The Ondo State Ministry of Health (SMOH) formulates policies for health services delivery and implement in conjunction with the Hospitals' Management Board (HMB) as well as Local Government Authorities (LGAs). Each of the 18 LGAs is responsible for managing the Primary Health Care (PHC) system, including community health activities such as immunization and health education; hygiene and provision of basic outpatient services at its maternities, among others. The State provides a supportive linkage to the LGAs through management of referrals from the PHC level, to the secondary level as well as technical guidance.

Mechanisms for developing and maintaining relationships have been established with relevant groups and programmes in the state. For instance the World Bank, UNICEF, and other development partners are working in the state. The relationship of the healthcare managers in the state with the national health system and other public sectors will enhance adequate implementation of the framework. Also, relationships with communities and foreign development partners should be nurtured through effective communications systems.

The role of development partners is critical to the implementation of the framework in the state. The substantial financial aid that they provide can help to close the funding gap in operating health services in the state—but they may be tempted to operate independently of state goals and strategies. Secondary care facilities which is outside emergency funds for MNCH, where 50% of the facility had the community participating, community participation was mostly absent in other areas. Community participation was also absent in most PHC facilities for the areas of focus except with regards to monthly community growth monitoring and disease surveillance. Communities participate in three – emergency transportation, health and nutrition education, and active screening and referrals in private health care provisioning. There is no community participation at the tertiary health facility.

The major international development agencies working in the State are the United Nations agencies, in particular the World Health Organisation (WHO) and the United Nations Children's Fund (UNICEF). Both are intensely involved in the childhood immunisation campaign and are working together to support the State in the implementation of Expanded Programme on Immunisation/Polio Eradication Initiative (EPI/PEI). Their activities include strengthening routine immunisation, supplemental immunisation activities, integrated disease surveillance and response, advocacy and social mobilisation, vaccine security and logistics. World Bank is also providing support in the areas of health system strengthening and HIV response. The United Nations system also has one of its Millennium development villages in the State (*Ibaram/Ikaram-Akoko*),

where the agencies are pursuing an agenda of integrated development aimed at achieving the Millennium Development Goals.

United States Agency for International Development (USAID) through Society for family Health (SFH) and Global HIV/AIDS in Nigeria (GHAIN) has also funded some studies relating to MNCH in the context of the national HIV/AIDS and Reproductive Health Survey and the Behavioural Surveillance Survey. Family Health International/GHAIN is also providing support to the Federal Medical Centre, Owo in respect of HIV/AIDS screening and case management. Other partners involved in HIV care and control are Institute of Human Virology and UNICEF. A coordination mechanism for donors exists mainly in the context of a coordination committee for EPI/PEI.

The State partners with civil society organizations in its MNCH programme, particularly with respect to social mobilization for childhood immunization and polio eradication initiative. These include National Council of Women Societies, Rotary Club, Red Cross, Market Women society, National Union of Road Transport Workers, Chairman of the Christian Association of Nigeria, and the Chief Imam. The State also benefited from the expertise of the Centre for Health Sciences Training Research and Development, a non-governmental organization (NGO), in evolving its health reform programme. The State is also a designated learning site for health strengthening in Africa under the ACOSHED, and co-hosted the planning meeting of African Civil Society Organisations on the strengthening of African health systems in July/August 2006. Network of people living with HIV/AIDS is involved in HIV work in the State, including the provision of home-based care. The faith-based group – the daughters of charity – is involved in HIV testing and related HIV/AIDS care and management services in the State. Planned Parenthood Federation of Nigeria is involved in family planning services in the State.

Chapter 7: Monitoring and Evaluation

7.1 Proposed mechanisms for monitoring and evaluation

There is weak organizational structure for M&E in the state. As a result, there is limited human and material capacity for carrying out M&E activities. In order to monitor and evaluate the implementation of the programme in the state, first, there will be structural arrangement through institutional development. This will help to assign responsibilities to individuals about the program. This will also enhance supportive supervision that is presently lacking in the state.

Towards a successful implementation of the framework:

(i.) develop performance indicators for the entire health system for monitoring and evaluation;

(ii.) actively engage in operational research and data gathering on all health issues; and

(iii.) establish monitoring and evaluation committees at each local government area for effective coverage.

7.2 Costing the monitoring and evaluation component and plan

Capital and recurrent expenditures are involved in carrying out M&E of the plan. As a result, direct and indirect costs of providing M&E services are put into consideration while costing the M&E aspect of the plan. This is important because certain indirect costs may have significant effect on the extent to which M&E activities are carried out. All activities of the M&E will be meaningful when values are assigned to every activity. The unit cost of activities are summed up to give total amount that will be required to do the work.

Chapter 8: Conclusion

Ondo State has a written and published health policy that is fairly comprehensive, and a health reform process has been pursued over the last five years. Core elements of the policy and reform process are: human resources for health, quality improvement and management, health fund, pharmaceutical management programme, policy and strategy development, performance management, and communication and advocacy. The policy covers the issue of MNCH. The State policy on free medical treatment for all pregnant women and under-five children, which has been seriously pursued by the government, demonstrates the State's commitment to MNCH.

While access to MNCH and related services is fairly high in Ondo State, there are challenges in terms of the operations and the capacity of the facilities. Many health facilities are not able to provide quality health services or effectively meet the healthcare needs of clients due to lack of human and material resources. More than a quarter of the secondary health care facilities and majority of the primary health care centres are not opened on 24-hour basis. Most of the health workers across at all levels of care have not been trained in specific MNCH-related issues in the context of in-service activities. A significant proportion of the state public sector facilities (secondary and primary health care facilities) lack the appropriate human and materials resources. As a result, the majority of secondary and primary health care facilities fail to meet the standard for essential obstetric care facilities, implying their ineffectiveness to manage emergency obstetric and newborn conditions. The adolescent health service has particularly received poor attention in the State health care plans and activities. The activities of the health facilities in the areas of health prevention, promotion and clinical preventive services, including health education and counseling, lag behind management of diseases and health conditions considerably.

The Health management information system functions fairly well. The quality of data collected is high. However, there are significant problems with the quality of the monitoring system at both the LGA and the facility level.

The State has partners with a number of international development organizations, especially the UN agencies. However, the coordination mechanism is weak. Also, the state collaborates with civil society organizations, but this is skewed more towards child immunization activities and HIV/AIDS. The partnership framework is, however, not consistently operationalized or sufficiently institutionalized. Community participation in health facility management and health care activities is generally low.

Annex 1: Details of Ondo Strategic Health Development Plan Framework

ONDO STATE STRATEGIC HEALTH DEVELOPMENT PLAN						
Priority Area						
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**TOTAL EXPENDITURE 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							**595,410,461**
	1	**To provide clear policy directions for health development**			**All stakeholders are informed regarding health development policy directives by 2011**		**346,528,990**
		1.1.1	Establish and Strenghten Stakeholders' consensus at State and LGA levels with a view to implementing directives for Health Development		Availability of revised SHDP at State and LGA departments by the end of each year of implementation		**167,559,476**
			1.1.1.1	Conduct bi-annual stakeholders' meeting for the implementation of the plan in the state	Meeting held twice as sheduled every year	Political will, Adequate Funding	32,956,675
			1.1.1.2	Conduct quarterly meeting of the State Planning Committee		Adequate Funding	65,913,349
			1.1.1.3	Advocate for the approval of the SSHDP		Political will	12,734,418
			1.1.1.4	Conduct annual review of the state Health Development Plan		Fund, availability of technocrats	12,658,012
			1.1.1.5	Collection of baseline data for situation analysis		Inconsistent government policy, fund, political will, beruacracy,	43,297,022
		1.1.2	Implement the Ondo State Strategic Health Development Plan Framework		The SHDP implemented in all state departments and LGA establishments by the end of 2011		**166,235,096**
			1.1.2.1	Establish bi-annualStakeholders' meetings to ensure effective implementation of the programme.		1. Inconsistent government policies 2. Lack of political will 3. Funding gap 4.Bureaucracy	32,956,675
			1.1.2.2	Establish Monitoring and Evaluation Committee to collect data to review progress, achievements and challenges of the SHDP.		1. Inconsistent government policies 2. Lack of political will 3. Funding gap 4.Bureaucracy	20,884,446
			1.1.2.3	Convene Bi-Annual State Council on Health	State Council on Health meets as sheduled x2 in a year.	1. Inconsistent government policies 2. Lack of political will 3. Funding gap 4.Bureaucracy	111,502,566
			1.1.2.4	Production of annual report		1. Inconsistent government policies 2. Lack of political will 3. Funding gap 4.Bureaucracy	891,409
		1.1.3	Increase accountability and transparency		Institutionalized financial accountability by end of 2010		**12,734,418**

			1.1.3.1	Strenghten Stakeholders' consultative fora such as State Council on Health, various Development Committees and Community Dialogues.		1. Inconsistent government policies 2. Lack of political will 3. Funding gap 4.Bureaucracy 5. Political interferrence in the placement of competent personnel1	-
			1.1.3.2	Strenghten advocacy and communication for SSHDP framework i.e enligthenment programme through prints and electronic media		1. Inconsistent government policies 2. Lack of political will 3. Funding gap 4.Bureaucracy 5. Political interferrence in the placement of competent personnel1	-
			1.1.3.3	Production and distribution of bulletin		Fund	12,734,418
			1.1.3.4	Establish a feedback mechanism in the health sector		Fund, Bureaucracy	-
	1	**To facilitate legislation and a regulatory framework for health development**			**Health Bill signed into law by end of 2009**		**156,684,282**
		1.2.1	Strengthen regulatory functions of government		Institute public health laws and acts by the end of 2011		**156,684,282**
			1.2.1.1	Develop public/private partnerships in the state and LGAs in line with the FG policy on PPP		1. Inconsistent government policies 2. Lack of political will 3. Funding gap 4.Bureaucracy 5. Political interferrence in the placement of competent personnel1	-
			1.2.1.2	Develop standard operating procedure to guide service delivery and aid supportive supervision at state and LGA levels		1. Inconsistent government policies 2. Lack of political will 3. Funding gap 4.Bureaucracy 5. Political interferrence in the placement of competent personnel1	15,790,679
			1.2.1.3	Foster public/private sector collaboration to improve service delivery through joint professional development and generation of public health information		1. Inconsistent government policies 2. Lack of political will 3. Funding gap 4.Bureaucracy 5. Political interferrence in the placement of competent personnel1	92,451,877
			1.2.1.4	Review and enforce public health acts and laws		1. Inconsistent government policies 2. Lack of political will 3. Funding gap 4.Bureaucracy 5. Political interferrence in the placement of	29,824,008

						competent personnel1	
			1.2.1.5	Revise and streamline regulatory institutions roles and responsibilities to align with the national health bill		1. Inconsistent government policies 2. Lack of political will 3. Funding gap 4.Bureaucracy 5. Political interferrence in the placement of competent personnel1	18,617,720
	1	**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**		**92,197,188**
		1.3.1	To improve accountability and transparency		All stakeholders are informed regarding health development policy directives by 2011		**92,197,188**
			1.3.1.1	Decentralise decision making processes at the state and LGA levels		1. Inconsistent government policies 2. Lack of political will 3. Funding gap 4.Bureaucracy 5. Political interferrence in the placement of competent personnel1	-
			1.3.1.2	Establish bi-annual stakeholders' fora for appropriate feedback for health sector decision making		1. Inconsistent government policies 2. Lack of political will 3. Funding gap 4.Bureaucracy 5. Political interferrence in the placement of competent personnel1	-
			1.3.1.3	Create fora for interaction with health sector advocacy group		1. Inconsistent government policies 2. Lack of political will 3. Funding gap 4.Bureaucracy 5. Political interferrence in the placement of competent personnel1	37,693,878
			1.3.1.4	Empower beneficiary communities through sensitization to manage and oversee health projects and programmes			37,693,878
			1.3.1.5	Improve access to information required for yearly joint review of the health sector and make such review available to the public			16,809,432
	1	**To enhance the performance of the national health system**			**1. 50% of States (and their LGAs) updating SHDP annually 2. 50% of States (and LGAs) with costed SHDP by end 2011**	**Various levels of government have capacity to update sectoral SHDP States may not respond in a uniform and timely manner**	**-**

		1.4.1	Improving and maintaining Sectoral Information base to enhance performance				-
HEALTH SERVICE DELIVERY							
2. To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare							**28,572,199,014**
	2	**To ensure universal access to an essential package of care**			**Essential Package of Care adopted by all States by 2011**		**613,625,729**
		2.1.1	Mapping of health facilities and service delivery		100% Mapping by end of 2010		**260,512,014**
			2.1.1.1	Establish a committee to facilitate the mapping activities		**Availability of technocrats**	154,410,547
			2.1.1.2	Provide logistics support for carrying out the mapping		**Availability of fund**	78,209,388
			2.1.1.3	Conduct mapping of health facilities in the state		**Availability of fund and manpower**	-
			2.1.1.4	Disseminate information from the mapping		**Availability of fund**	27,892,079
		2.1.2	Development and wide distribution of SOPs and guidelines for quality delivery of services at the state and LGA levels.		SOPs and Guidelines delivered to all stakeholders by end of 2010		**147,270,175**
			2.1.2.1	Inaugurate the working committee on the development of SOPs and guidelines		**Technocrat, Fund**	22,313,663
			2.1.2.2	Provide logistics support		**Fund**	94,275,226
			2.1.2.3	Develop the SOPs and guidelines and submit report		**Personnel, Fund**	-
			2.1.2.4	Printing of the SOPs and guidelines		**Fund**	27,892,079
			2.1.2.5	Distribution of the SOPs and guidelines		**Fund**	2,789,208
		2.1.3	Regular accreditation of health facilities		All health facilities accredited by end of 2010		**154,801,036**
			2.1.3.1	Constitute accreditation team to review standards for accreditation		**Fund, Bureacracy**	4,741,653
			2.1.3.2	Provide logistic support		**Fund**	148,943,700
			2.1.3.3	Inspect and assess health facilities		**Fund, Bureacracy**	-
			2.1.3.4	Produce & Submit report of the accreditation exercise to SMOH		**Fund, Personnel**	1,115,683
		2.1.4	Upgrade and refurbish health facilities to standard		All health facilities upgraded by end of 2015		**-**
			2.1.4.1	Identify and prioritize facility needs from accreditation report		**Fund, Personnel**	-
			2.1.4.2	Budget for the provision of the needs		**Political will, Fund**	-
			2.1.4.3	Implement the upgrading and refurbishing indentified from the excercise		**Fund, Personnel**	-
		2.1.5	Dissemination of accreditation report to stakeholders		All stakeholders receive accreditation report by end of 2010		**51,042,504**
			2.1.5.1	Obtain approval of accreditation report for dissermination		**Political will, Bureaucracy**	-
			2.1.5.2	Print the approved accreditation report		**Fund**	27,892,079
			2.1.5.3	Disseminate the approved accreditation report to stakeholders		**Fund**	23,150,425

	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**		**11,485,455,898**
		2.2.1	Provide health rangers scheme (eye camp, festival of surgery, community outreach) to those in need		80% coverage of target population by end of 2010		**11,464,759,975**
			2.2.1.1	Constitute a committee for each component of the health rangers scheme		**Political will, Fund, Technocrat**	167,352,471
			2.2.1.2	Identify logistics and submit report		**Political will, Fund, Technocrat**	32,633,732
			2.2.1.3	Recruit & train HR for each component		**Political will, Fund, Technocrat**	11,264,773,772
			2.2.1.4	Develop work plan per component		**Political will, Fund, Technocrat**	-
			2.2.1.5	Implement programs		**Political will, Fund, Technocrat**	-
	###	2.2.2	IMNCH (free U5 & pregnant women, IMCI, LSS, FP, midwifery service scheme, neonatal nursing care prog.)		80% coverage of target population by end of 2015		**-**
			2.2.2.1	Identify needs of IMNCH components		**Personnel, Fund**	-
			2.2.2.2	Develop proposal for implementing IMNCH needs		**Peronnel, Fund**	-
			2.2.2.3	Obtain approval for implementing IMNCH needs		**Political will, Fund, Bureaurcracy**	-
			2.2.2.4	Implement IMNCH needs		**Fund, Bureaucracy**	-
		2.2.3	Establish standard blood banking services & Upgrading of diagnostic services		50% coverage by end of 2015		**20,695,922**
			2.2.3.1	Constitute a blood banking committee to develop the central blood screening operational modalities and legal framework		Political will, Fund, Technocracts	15,675,348
			2.2.3.2	Identify needs of blood banking services at the specialist hospitals and GH Ore from the accreditation report		Political will, Fund, Technocracts	5,020,574
			2.2.3.3	Identify diagnostic needs per facility types from accreditation report		Political will, Fund, Technocrats	-
			2.2.3.4	Put in place infrastructural and HR needs for blood banking services and diagnostic services		Political will, Fund, Technocrats	-
			2.2.3.5	Procure equipment for blood banking and diagnostic services		Political will, Fund, Technocrats	-
			2.2.3.6	Procure automated equipment for diagnosis in all specialist hospitals		Political will, Fund, Technocrats	-
			2.2.3.7	Create awareness for safe blood and blood donation		Political will, Fund	-
			2.2.3.8	Build capacity on current diagnostic techniques		Political will, Fund	-
		2.2.4	Upgrading of Public Health Laboratory at Oke-eda, Akure		All public health laboratory upgraded by end of 2015		**-**
			2.2.4.1	Reconstruction and restructuring of the Public health lab to accommodate diagnostic unit, research & epidemiology unit and non-body fluid unit.		**Political will, Fund, Space**	-
			2.2.4.2	Procurement of equipment as identified by the accreditation report.		**Political will, Fund**	-
			2.2.4.3	Redistribute exsisting personnel to appropriate unit and employ personnel.		**Political will, Fund**	-
			2.2.4.4	Identify and budget for prog of public health importance e.g food handlers/vendors survey, outbreaks response team,water bacteriology, food screening & analysis, diagnostic services etc		**Political will, Fund**	-

		2.2.5	Strenghten Accident and Emergency preparedness and Response services		All A&E provided with resources to function effectively by end of 2012		-
			2.2.5.1	Review HR of the team		**Fund**	-
			2.2.5.2	Budget for identified logistics		**Political will, Fund**	-
			2.2.5.3	Ensure adequate M&E		**Fund**	-
	2	**To improve the quality of health care services**			**50% of health facilities participate in a Quality Improvement programme by end of 2012**		**1,030,835,440**
		2.3.1	Continuation of activities on immunization, non-communicable dxs,TB& leprosy, Schisto, Oncho, RBM, and HIV/AIDS.		80% Reduction in morbidity and mortality		**417,209,711**
			2.3.1.1	Procurement of essential commodities		Political will, Fund	111,568,314
			2.3.1.2	Capacity building		Political will, Fund	26,720,611
			2.3.1.3	Identification and procurement of needed logistics		Political will, Fund	167,352,471
			2.3.1.4	Identification and provision of logistics for M&E		Political will, Fund	111,568,314
		2.3.2	Provision of Personal Protective Equipment for health and industrial workers		50% coverage by end of 2015		**111,568,314**
			2.3.2.1	Constitute a committee to develop the legal framework for the provision of PPE at both public and private institutions		Willingness of the private sector to collaborate, political will, funds	-
			2.3.2.2	Procure and distribute PPE for public health facilities		Fund	111,568,314
			2.3.2.3	Monitor the use of PPE at both public and private institutions		Fund	-
			2.3.2.4	Conduct Hepatitis screening & Vaccination for all Health Workers		Fund	-
		2.3.3	Conduct health education programmes		100% coverage of the entire population by end of 2011		**502,057,414**
			2.3.3.1	Conduct advocacy visit and enlightenment campaign to stakeholders and opinion leaders		Political will, Fund	-
			2.3.3.2	Produce and distribute IEC materials for all services in the health sector		Political will, Fund	111,568,314
			2.3.3.3	Develop and air radio and television jingles		Political will, Fund	111,568,314
			2.3.3.4	Review health education curriculum for primary, secondary and tertiary institutions		Political will, Fund	-
			2.3.3.5	Enlightenment campaign to the various groups within the community.		Political will, Fund	278,920,786
		2.3.4	Establishment of State Primary Healthcare Development Agency		A functional State Primary Healthcare Development Agency by end of 2011		-
			2.3.4.1	Constitute a committee to develop the terms of reference		Political will, Fund	-
			2.3.4.2	Provide infrastructures and logistics for operation		Political will, Fund	-
			2.3.4.3	Employ, appoint, redistribute HR based on terms of reference		Political will, Fund	-

			2.3.4.4	Commence operation		Political will, Fund	-
		2.3.5	Establish a Teaching Hospital.		A functional Teaching Hospital by end of 2015		-
			2.3.5.1	Constitute a committee to develop the terms of reference		political will, fund	-
			2.3.5.2	Obtain necessary approval from House of Assembly, NUC, etc		political will, fund	-
			2.3.5.3	Provide infrastructures and logistics for operation		political will, fund	-
			2.3.5.4	Employ, appoint, redistribute HR based on terms of reference		political will, fund	-
			2.3.5.5	Commence operation		Political will, fund	-
	2	**To increase demand for health care services**			**Average demand rises to 2 visits per person per annum by end 2011**		**15,348,676,132**
		2.4.1	Establish Dental clinics in all GH's, upgrade Dental surgeries & labs in all Specialist hosp & revive dental school education prog.		A funcition Dental Clinic in all Government Hospital by end of 2012		**6,415,178,071**
			2.4.1.1	Procure Dental surgical &Laboratory equipment for dental hospitals in Akure, Ondo, O'pupa and Ikare.		Political will, fund	836,762,357
			2.4.1.2	Constitute a committee to develop the terms of reference for the establishment of dental clinics in all 14 GHs, school dental prog and the integration of oral dental prog into PHC		Political will, fund	-
			2.4.1.3	Provide infrastructures and logistics for operation		Political will, fund	5,578,415,714
			2.4.1.4	Employ, appoint, redistribute HR based on terms of reference		Political will, fund	-
			2.4.1.5	Commence operation		**Political will, fund**	-
		2.4.2	Improve two-way referral service		Effective two-way referral service by end of 2010		**2,935,362,349**
			2.4.2.1	Procurement of intensive care unit ambulances		Political will, fund	2,789,207,857
			2.4.2.2	Strenghthen the existing Referral services		Political will, fund	-
			2.4.2.3	Create a referral unit in all Hospitals in the State			-
			2.4.2.4	Monitoring & Sensitization by HMB			37,933,227
			2.4.2.5	Training & Reorientation of Staffs			108,221,265
		2.4.3	Procurement and distribution of drugs		Essential drugs available in all governernt hospitals by end of 2010		**5,578,415,714**
			2.4.3.1	Circulate the current essential drug list to all health facilities		Availability of essential drug list	-
			2.4.3.2	Procure drugs acccording to the essential drug list		Adequate funding	5,578,415,714
			2.4.3.3	Distribute drugs based on request from facilities		Adequate logistics	-
			2.4.3.4	Upgrade the medical Stores			-
		2.4.4	Revive medical equipment & hospital furniture maintainance unit in health facilities.		Functional medical equipment and hospital furniture maintenance unit in all the government		**104,204,806**

					health facilities by end of 2011		
			2.4.4.1	Identify the needs of biomedical & maintainance units for all health facilities from accreditation report		Political will, fund	-
			2.4.4.2	Establish workshops based on identified health facility needs		Political will, fund	-
			2.4.4.3	Provide the needed HR, logistics and equipment		Political will, fund	-
			2.4.4.4	Train & Re-train Personnel			104,204,806
		2.4.5	Conduct regular monitoring exercises & ensure appropriate documentation & feedback		Effective M&E activities by end of 2010		**315,515,193**
			2.4.5.1	Provide logistic support and HR for the M&E unit		Fund	203,612,174
			2.4.5.2	Capacity building for HR development		Fund	33,805,199
			2.4.5.3	Disseminate information to care Providers			78,097,820
	3	**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**		**93,605,816**
		2.5.1	To improve financial access especially for the vulnerable groups				**-**
		2.5.3	Establish quality assurance unit in MOH & all public health facilities.		Functional quality assurance unit in MOH & all public helath facilities by end of 2010		**39,829,888**
			2.5.3.1	Constitute a committee to develop the terms of reference		Political will, Technocrats	39,829,888
			2.5.3.2	Submit report to SMOH		Logistics	-
			2.5.3.3	Provide infrastructures and logistics for operation		Political will, fund	-
			2.5.3.4	Employ, appoint, redistribute HR based on terms of reference		Political will, fund	-
			2.5.3.5	Commence operation		Political will, fund	-
		2.5.4	Establish SERVICOM in all health facilities		Functional SERVICOM by end of 2010		**53,775,927**
			2.5.4.1	Constitute a committee to develop the terms of reference		Political will, Technocrats, fund	53,775,927
			2.5.4.2	Submit report to SMOH		Fund	-
			2.5.4.3	Provide logistics and infrastructure for operation		Political will, fund	-
			2.5.4.4	Employ, appoint, redistribute HR based on terms of reference		Political will, fund	-
			2.5.4.5	Commence operation		Politicall will, fund	-
		2.5.5					**-**
HUMAN RESOURCES FOR HEALTH							
3. To plan and implement strategies to address the human resources for health needs in order to enhance its availability as well as ensure equity and quality of health care							**19,539,678,528**
	3	**To formulate comprehensive policies and plans for HRH for health development**			**All States and LGAs are actively using**		**6,492,784,909**

					adaptations of the National HRH policy and Plan by end of 2015		
		3.1.1	To develop and institutionalize the Human Resources Policy framework		All department and 50% LGAs must have adopted the HRH policy the end of2010		**145,998,254**
			3.1.1.1	Domesticate the national HRH policy and strategic plan		Political will	-
			3.1.1.2	Develop a policy framework to guide the existence of private and public practitioners at all levels of health service delivery		Fund, Political will	56,846,370
			3.1.1.3	Establish fora for public-private practitioners to institutionalize HRH policy reviews,supervisory and monitoring frameworks.		Fund, Political will	89,151,884
			3.1.1.4				-
			3.1.1.5				-
		3.1.2	Review exisiting policy on public private practice		Policy document disseminated to all stakeholders by 2010		**112,389,184**
			3.1.2.1	Constitute a committee on the review of policy on public and private practce		Fund, Political will	39,673,438
			3.1.2.2	Develop a draft policy on private and public practice		Fund, Political will	44,377,575
			3.1.2.3	Forward draft policy to state exco for approval		Fund, Political will	-
			3.1.2.4	Disseminate policy document to stakeholders		Fund, Political will	28,338,170
		3.1.3	produce adequate manpower human resources for health		Recruitment of workers increased by 10% annually, 70% of health workers trained by the end of 2015		**6,234,397,472**
			3.1.3.1	Identify HRH needs		Logistics	-
			3.1.3.2	Recruit HRH based on need		Fund, Political will	-
			3.1.3.3	Capacity building for all health workers		Fund, Political will	6,234,397,472
			3.1.3.4	Review remunerations of health workers		Fund, Political will	-
		3.1.4	Instutionalize continous assesment of health training instutution to meet accreditation standard of regulatory bodies		All health institutiions accredited by the end of 2015		**-**
			3.1.4.1	Provide minimum level of infrastructure for health training Institutions		Fund, Bureaucracy	-
			3.1.4.2	Provide equipment and tutors' training materials for all health training Institutions		Fund, Bureaucracy	-
			3.1.4.3	Establish state accreditation committee for health training institutions		Fund, Technocrats	-
	3	**To provide a framework for objective analysis, implementation and monitoring of HRH performance**			**The HR for Health Crisis in the country has stabilised and begun to improve by end of 2012**		**-**
		3.2.1	To reappraise the principles of health workforce requirements and recruitment at all levels		Awareness of the principles of health workforce requirements and recruitment at State		**-**

					and LGA leves by year 2011.		
			3.2.1.1	Establish coordinating committee for consistency in HRH planning and budget		Bureaucracy	-
			3.2.1.2	Strenghten State and LGA capacities to access Federal Govt Circulars, guidelines and policies relating to HRH		Technocrats, Bureaucracy	-
			3.2.1.3	Advocate for the creation of health service commission			-
	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**		**8,501,451,098**
		3.3.1	To establish and strengthen the HRH Units		80% health workers trained by end of 2010		**8,501,451,098**
			3.3.1.1	Establish HRH units at all levels to strengthen HRH performance		Fund	-
			3.3.1.2	Conduct training programmes in human resource on health planning and management at all levels to enhance the HRH managers.		Fund,	8,501,451,098
			3.3.1.3	Review and adapt relevant training programmes for health workers in critical areas of need		Fund, Bureaucracy	-
	3	**To strengthen the capacity of training institutions to scale up the production of a critical mass of quality, multipurpose, multi skilled, gender sensitive and mid-level health workers**			**One major training institution per Zone producing health workforce graduates with multipurpose skills and mid-level health workers by 2015**		**3,967,343,846**
		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		Effective training curriculum in place to train all cadres of health workforce by end 2011.		**-**
			3.4.1.1	Design special training programmes to produce adequate cadres of health professionals in critical areas of need		Logistics	-
			3.4.1.2	Strenghten HRH regulatory body for regular review of functions and mandates		Logistics	-
			3.4.1.3	Strengthen public-private partnership in HRH development and management		Logistics	-
		3.4.2	To strengthen health workforce training capacity and output based on service demand		A standardized assessment procedure put in place by end 2010		**3,967,343,846**
							-
			3.4.2.1	Establish quality assurance and education units in all the training institutions to identify areas of service demand		Logistics	-
			3.4.2.2	Review of training curriculum by the unit		Bureaucracy	-
			3.4.2.3	Train Personnel to meet Identified areas of service demand			3,967,343,846
	4	**To improve organizational and performance-based management systems for human resources for health**			**50% of States have implemented performance management systems by end 2012**		**578,098,675**
		3.5.1	To achieve equitable distribution, right mix of the right quality and quantity of human resources for health		All workers transfered at least once by end 2012		**-**

			3.5.1.1	Recruit and deploy competent health workers in critical areas of need		Fund	-
			3.5.1.2	Redeploy health workers to rural and urban health facilities based on need			-
			3.5.1.3	Institute performance based incentives for health workers		Fund	-
		3.5.2	To establish mechanisms to strengthen and monitor performance of health workers at all levels		Quarterly monitoring report		**578,098,675**
			3.5.2.1	Conduct orientation programme for health workers on Inter- Personal Communication skills and work ethics		Fund, Bureaucracy	283,381,703
			3.5.2.2	Set up a committee to design Profession specific checklist to assess & monitor health workers performance			-
			3.5.2.3	Produce performance checklist		Personnel	11,335,268
			3.5.2.4	Conduct training on the use of use of checklist by health workers		Bureaucracy	283,381,703
	4	**To foster partnerships and networks of stakeholders to harness contributions for human resource for health agenda**			**50% of States have regular HRH stakeholder forums by end 2011**		**-**
		3.6.1	To strengthen communication, cooperation and collaboration between health professional associations and regulatory bodies on professional issues that have significant implications for the health system		Annual meeting between health professonal associations and regulatory bodies on professional issues		**-**
			3.6.1.1	Create a partnership forum for intra and inter health professional associations.		Commitment	-
			3.6.1.2	Nominate representatives of professional associations on management boards.		Commitment	-
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							**7,559,000,560**
	4	**To develop and implement health financing strategies at Federal, State and Local levels consistent with the National Health Financing Policy**			**50% of States have a documented Health Financing Strategy by end 2012**		**273,381,575**
		4.1.1	To develop and implement evidence-based, costed health financing strategic plans at LGA and State levels in line with the National Health Financing Policy		Health financing costed for state and LGAs		**273,381,575**
			4.1.1.1	Develop, disseminate and implement evidence based, costed and prioritized health financing strategic plan at the LGA and State levels		Personnel	-
			4.1.1.2	Set up Technical working group at the State and LGA levels to design health financing strategic plans		Bureaucracy	-
			4.1.1.3	Build capacity of identified focal persons at the state and LGA levels		Logistics	273,381,575
	4	**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**		**6,834,539,385**
		4.2.1	To strengthen systems for financial risk health protection		Coverage of vulnerable population scaled up by end of 2012		**6,834,539,385**
			4.2.1.1	Explore existing and innovative approaches for sustainable health financing with protective measures against the financial risks associated with ill health		Bureaucracy	-
			4.2.1.2	Scale up successful approaches to achieve wide population coverage		Logistics	-

			4.2.1.3	Establish community based health insurance scheme		Fund, Political will	6,834,539,385
	4	**To secure a level of funding needed to achieve desired health development goals and objectives at all levels in a sustainable manner**			**Allocated Federal, State and LGA health funding increased by an average of 5% pa every year until 2015**		**-**
		4.3.1	To improve financing of the Health Sector		Increased financial resources for health at state and LGA levels		**-**
			4.3.1.1	Establish a guideline for a specific percent of IGR to be ploughed back into the health system.		Political will	-
			4.3.1.2	Advocacy/sensitization of relevant stakeholders on the need to plough back specific percent of IGR into health system		Political will	-
		4.3.2	To improve coordination of donor funding mechanisms		Accountability for available financial resources		**-**
			4.3.2.1	Explore available health care financing option and strengthen existing ones		Bureaucracy	-
			4.3.2.2	Strengthen exisiting goverment and development partners structures and functions		Bureaucracy	-
			4.3.2.3	Harmonise activities of government and donor Agencies		Bureaucracy	-
	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**		**451,079,599**
		4.4.1	To improve Health Budget execution, monitoring and reporting		Streghtened transparent budget execution		**314,388,812**
			4.4.1.1	Update the existing state heath account		Logistics	-
			4.4.1.2	Strenghten M&E units in health sector		Bureaucracy	314,388,812
			4.4.1.3	Establish credible mechanism to increase financial transparency through institutionalization of State Health Account (SHA) and Public Expenditure Review		Political will, bureaucracy	-
		4.4.2	To strengthen financial management skills		All management staff trained in financial management skill at state and LGA levels.		**136,690,788**
			4.4.2.1	Build capacity on financial management skill		Fund, Logistics	136,690,788
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							**893,115,691**
	5	**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**		**745,042,409**

					Federal level by end 2010		
		5.1.1	To ensure that NHMIS forms are available at all health service delivery points at all levels		Effective use of NHMIS forms in all departments of State and LGAs		**469,678,060**
			5.1.1.1	Print & distribute NHMIS forms to Public & Private Health facilities		**Logistics**	103,911,075
			5.1.1.2	Provide internet Acess for HMIS and PHCM&E (MOH&HMB)		**Availability of fund**	2,078,222
			5.1.1.3	Build capacity for HMIS and PHCM&E activities		**Fund, Logistics**	51,955,538
			5.1.1.4	Conduct training for private health care providers and TBAs on PHC data management		**Bureaucracy**	51,955,538
			5.1.1.5	Convene quarterly review meetings of HDCC and PHCM&E data collection officers from the 18 LGAs		**Political will, Fund**	155,866,613
			5.1.1.6	Provide feed back to all levels		**Bureaucracy**	103,911,075
		5.1.2	To periodically review of NHMIS data collection forms		Availability of Revised NHMIS data collection forms at the end of 2010		**-**
		5.1.3	To coordinate data collection from vertical programmes		Reliable data collected at the end of 2015		**-**
			5.1.3.1	Collect ,collate & analyse data from the 18 LGAs		**Logistics**	-
			5.1.3.2	Monitor and Supervise data generated from HFs level		**Personnel**	-
			5.1.3.3	Monthly meeting of data collection officers		**Personnel**	-
			5.1.3.4	Ensure collaboration between HMIS and PHCs' M&E		**Bureaucracy**	-
		5.1.4	To build capacity of health workers for data management		Training of health workers within public and private sector by the end of		**155,866,613**
			5.1.4.1	Train M&E and HMIS officers on HIS		Logistics	51,955,538
			5.1.4.2	Train Medical Record Officers on data Management		Logistics	51,955,538
			5.1.4.3	Train Medical Record Personnel in private HFs		Logistics, Availability of qualitfied personnel	51,955,538
			5.1.4.4	Advocate for recruitment of health management information officers into SMOH		Political will, fund	-
		5.1.5	To provide a legal framework for activities of the NHMIS programme		Legal backing for NHNIS programmes by the end of 2011		**57,151,091**
			5.1.5.1	Constitute a committee to develop a legal framework on data generation		**political will, fund**	-
			5.1.5.2	Print, disseminate and distribute data law.		**political will, fund**	5,195,554
			5.1.5.3	Conduct advocacy and sensitisation workshop for policy makers on compulsory health data reporting		**Political will, bureaucracy**	31,173,323
			5.1.5.4	Enforce Health data law		**Fund, Bureaucracy**	10,391,108
			5.1.5.5	Conduct Monitoring and Evaluation of level of compliance		**Political will**	10,391,108
		5.1.6	To improve coverage of data collection		All facilities comply with data collection procedure by the end of 2011		**20,782,215**

			5.1.6.1	Advocate for fund for data collection activities		Fund	-
			5.1.6.2	Conduct monthly cluster meetings and submission of data		Fund, Bureaucracy	20,782,215
		5.1.7	To ensure supportive supervision of data collection at all levels		Availability of logistics supports for effective supervison of data collection by end of 2010		**41,564,430**
			5.1.7.1	Advocate for provision of Vehicles for Monitoring and Supervision		Political will, Fund	-
			5.1.7.2	Conduct quarterly monitoring of public and private HFs		Fund	20,782,215
			5.1.7.3	Conduct bi - annual review meeting with all stakeholders.		Political will, Fund	20,782,215
	5	**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**		**-**
		5.2.1	To strengthen the use of information technology in HIS		All data officers trained at the state and LGA levels and provided with computers by the end of 2010		**-**
			5.2.1.1	Train data officers on use of ICT		Fund	-
			5.2.1.2	Procure desktop/ laptop computers for HFs		Fund	-
			5.2.1.3	Provide internet facilities in all HFs		Fund	-
		5.2.2	To provide HMIS Minimum Package at the SMOH and LGA levels of data management		Availability of HMIS minimum package at the state and LGA levels of data managemetn by end of 2010		**-**
	5	**To strengthen sub-systems in the Health Information System**			**1. NHMIS modules strengthened by end 2010 2. NHMIS annually reviewed and new versions released**		**31,173,323**
		5.3.1	To strengthen the Hospital Information System		All hospitals at the state and LGA leves equiped with HMIS by end of 2011		**-**
		5.3.2	To strengthen the Disease Surveillance System		Effective disease surveillance programme put in place by the end of 2010		**31,173,323**
			5.3.2.1	Conduct training on disease surveillance for DSNO/M&E officers		Beaurocracy	31,173,323
	5	**To monitor and evaluate the NHMIS**			**NHMIS evaluated annually**		**5,195,554**
		5.4.1	To establish monitoring protocol for NHMIS programme implementation at all levels in line with stated activities and expected outputs		Effective monitoring and supervision activities put in place by end of 2010		**5,195,554**
			5.4.1.1	Esthablish a committee to develop protocols for NHMIS programme implementation		Political will, Fund	-
			5.4.1.2	Produce & disseminate Protocol		Fund	5,195,554
		5.4.2	To strengthen data transmission		Routine periodic data review meeting established by end of 2010		**-**

	6	**To strengthen analysis of data and dissemination of health information**			**1. 50% of States have Units capable of analysing health information by end 2010 2. All States disseminate available results regularly**		**111,704,406**
		5.5.1	To institutionalize data analysis and dissemination at all levels		All M&E and HMIS officers trained on data analysis and dissemination by end of 2010		**111,704,406**
			5.5.1.1	Re-train M&E and HMIS officers on data management		Fund	-
			5.5.1.2	Disseminate health data information to policy makers		Fund	2,597,777
			5.5.1.3	Produce and distribute health data bulletin bi-annually		Fund	5,195,554
			5.5.1.4	Create state website for health information		Fund	103,911,075
COMMUNITY PARTICIPATION AND OWNERSHIP							
6. To attain effective community participation in health development and management, as well as community ownership of sustainable health outcomes							**595,410,461**
	6	**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**		**318,475,363**
		6.1.1	To provide an enabling policy framework for community participation		Policy framework for community participation put in place by end of 2010		**115,389,624**
			6.1.1.1	Conduct Community Needs Assessment in collaboration with Community/ward health Committees	Timely needs assessment survey coducted	Logistics,Fund	115,389,624
			6.1.1.2	Involve Stakeholders at community level in Health Policy Formulation	Number of Community Stakeholders / Influence on the Policy Formulation	Willingness of community stakeholders to participate	-
			6.1.1.3	Preparation/presentation of community health policy bill	Community Health Policy Bill signed into law	Technocrats	-
			6.1.1.4	Disseminate community health policy to stakeholders at the state level	Number of media involved and scope of dissemination	Fund	-
			6.1.1.5	Disseminate community health policy to stakeholders at the LGA level	Number of LGAs /Stakeholders that domesticated the law	Fund	-
		6.1.2	To provide an enabling implementation framework and environment for community participation		Community health committees trained and financial resource base established by end of 2010		**203,085,739**
			6.1.2.1	Establish/ Revive Community Health Committees	Number of functioning Community Health Committees Establish	Local politics	-
			6.1.2.3	Conduct Regular Community Stake holder Conversations/dialogue	Number of Community Dialoque held	Local politics	184,623,399
			6.1.2.4	Advocate for funds for community level activities	Budgetary Allocation for Community Health Project Activities	Political will, Fund	-

			6.1.2.5	Conduct Monitoring, Supervision and Evaluation of Community Health Programmes undertaken by CHC	Number of CHC equiped to monitor, evaluate and supervise.	Local politics	18,462,340
		6.1.3	To provide effective monitoring, suppervision and evaluation of community health services		Community level monitors and evaluators trained by end of 2010		-
			6.1.3.1	Establish Community Level Monitoring and Evaluation Unit	Number of Units Establihed and Functioning	local politics	-
			6.1.3.3	Procure M&E Tools, Equipment and Materials	Qunatity of Tools, Material and Equipment Procured	Fund	-
			6.1.3.4	Ensure adequate documentation and reporting system	Available Documents and Reports Written	technocrats	-
	6	**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**		**276,935,098**
		6.2.1	To build capacity within communities to 'own' their health services		Effective participation of communities in health care delivery		**276,935,098**
			6.2.1.1	Conduct training of Community level Health Officers	Number of Community level Officers Trained	Fund	92,311,699
			6.2.1.2	Conduct Regular Community Stakeholder Conversations/dialogue	Number of Community meetings held	Commitiment of community stakeholders	92,311,699
			6.2.1.3	Encourage community participation in equipment and material procurement	Qunatity of Tools, Material and Equipment Procured by the community	Commitiment of community stakeholders	-
			6.2.1.4	Conduct bi-annual Skill Enhancement Workshop/Seminars	Number of Skill Enhance,ent Workshop conducted	Fund	92,311,699
	6	**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**		**-**
		6.3.1	To restructure and strengthen the interface between the community and the health services delivery points				**-**
			6.3.1.1	Promote easy access to health facilities		Logistics	-
			6.3.1.2	Facilitate effective utilization of Health services		Logistics	-
			6.3.1.3	Promote referral of health cases between traditional health practioners and health facility		Logistics, Bureaucracy	-
			6.3.1.4	Promote feedback between the health facilities and community		Bureaucracy	-
	6	**To increase national capacity for integrated multisectoral health promotion**			**50% of States have active intersectoral committees with other Ministries and private sector by end 2011**		**-**
		6.4.1	To develop and implement multisectoral policies and actions that facilitate community involvement in health development		Effective delivery of health services at the grass root level		**-**
			6.4.1.1	Adapt National policies on nutritional issues and water and sanitation to community health system	Functional mainstreamed health system in place.	Commitiment of community stakeholders	-

			6.4.1.2				-
			6.4.1.3		Number of CBOs, FBOs, NGOs, CDAs involved		-
			6.4.1.4		Number of private outfits that collaborate with the community.		-
	7	**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**		**-**
		6.5.1	To develop and implement systematic measurement of community involvement				**-**
			6.5.1.1	Assess the level of Community Involvement in Health services	Community level involvement in health services established	Fund	-
			6.5.1.2	Establish baseline for community involvement and ownership	Report of baseline survey conducted	Fund	-
			6.5.1.3	Document and Report community participation and involvement	Available Documents and Reports Written	Fund, Bureaucracy	-
			6.5.1.4	Provide linkage between community and research institutions	repoted level of interaction	Commitment of community stakeholders	-
			6.5.1.5	Promote community focused health researches	Number of resaeches coducted	Information	-
PARTNERSHIPS FOR HEALTH							
7. To enhance harmonized implementation of essential health services in line with national health policy goals							**595,410,461**
	7	**To ensure that collaborative mechanisms are put in place for involving all partners in the development and sustenance of the health sector**			**1. FMOH has an active ICC with Donor Partners that meets at least quarterly by end 2010 2. FMOH has an active PPP forum that meets quarterly by end 2010 3. All States have similar active committees by end 2011**		**595,410,461**
		7.1.1	To promote Public Private Partnerships (PPP)		PPP institutiionalized at the end of 2010		**170,117,275**
			7.1.1.1	Set up a Technical committee to develop guidelines for implementing PPP initiatives	Existence of State PPP committee	technocrats, political will	-
			7.1.1.2	Set up Professional committee to monitor the implementation of PPP initiative	Existence of State PPP monitoring committee	Logistics, Bureaucracy	-
			7.1.1.3	Organise training for stakeholders in the PPP initiative	No of stakeholders trained and availability of training modules	Fund,	85,058,637
			7.1.1.4	Organise quarterly meetings of Stakeholders	No of meetings organised per annum	Availability of members	85,058,637
			7.1.1.5	Advocate for budgetary provision for PPP in the state	Amount budgetted and percentage released for PPP within the year	Fund, Political will	-
		7.1.2	To institutionalize a framework for coordination of Development Partners		Effective framework for coordination put in place at the state level by end of 2010		**-**
			7.1.2.1	Establish a unit at the state MOH for the implimentation of PPP initiative	Existence of a functional PPP Unit	Political will, Fund	-
			7.1.2.2	Initiate and ensure the passing of an enabling Act to legalise the activities of PPP	Availability of enabling Act	Political will, bureaucracy	-

			7.1.2.3	Provide adequate logistics for the activities of the PPP	Availability of adequate logistics	Fund	-
			7.1.2.4	Set up a committee to develop PPP modalities for free Under-5 and Pregnant Women services	Existence of functional State HIS	Political will, bureaucracy	-
		7.1.3	To facilitate inter-sectoral collaboration		Effective intersectoral committee put in place by the end of 2010		**85,058,637**
			7.1.3.1	Establish a PPP inter-sectoral committee to include Finance,Education,Agriculture,Water resources & others Stakeholders	Availability of functional inter-sectoral committee	Bureaucracy	-
			7.1.3.2	Collaborate with development partners (Donors) in providing financial/ technical support.	No of development partners involved in the project	Bureaucracy	-
			7.1.3.3	Conduct bi-annual meetings between the various development partners in the PPP project.	No of meetings held with development partners.	Logistics, Bureaucracy	85,058,637
		7.1.4	To engage professional groups		Professional institutions acredited and trained on the scope of PPP by end of 2010		**85,058,637**
			7.1.4.1	Collaborate with all Medical and health professional association e.g NMA, PSN, AGPMPN, NACHPN, NANMN,AMLS.,e.tc.	No of health professional groups involved in PPP	Bureaucracy	-
			7.1.4.2	Develop a guidelines for the involvement of the participating professional Associations	No of institutions accredited	Bureaucracy	-
			7.1.4.3	Accreditation of various professional Association interested and willing to participate in the PPP project.	Existence of policy guidelines for PPP.	Logistics, Bureaucracy	-
			7.1.4.4	Train participating Associations on the scope of PPP	No of workshops /training organised	Fund	85,058,637
		7.1.5	To engage with communities		Functional PHC management committees at the LGA enlisted and training of LGA staff and other stakeholders to implement PPP project by end of 2010		**170,117,275**
			7.1.5.1	Strenghten PHC management committee at the LGAs	Proportion of functional PHC mgt committees in the state	Logistics, Bureaucracy	-
			7.1.5.2	Train LGA staff and other stakeholders on the PPP project.	Proportion of Trainings conducted for the LGA staff and other stakeholders.	Fund	85,058,637
			7.1.5.3	Sensitise major communities in each ward as to the PPP products available for Healthcare delivery	proportion of major communities sensitized in each ward	Logistics	85,058,637
		7.1.6	To engage with traditional health practitioners		Registered traditional practitioners acredited through a guideline for involving them in the PPP project		**85,058,637**
			7.1.6.1	Develop guidelines for integration of traditional medicine practices	Existence of policy guidelines	Bureaucracy	-
			7.1.6.2	Establish a Tradition Medicine Board to coordinate the integration of traditional medicine into PPP			-
			7.1.6.3	Integrate & Register traditional medicine practitioners into PPP projects			-
			7.1.6.4	Organise regular workshops for Traditional and Traditional medicine practitioners on the PPP	No of registered traditional/alternative	Logistics	85,058,637

					medicine practitioners involved.		
			7.1.6.5	Accredit participating traditional medicine groups .	No of alternative medicine practitioners accredited	Information	-
RESEARCH FOR HEALTH							0
8. To utilize research to inform policy, programming, improve health, achieve nationally and internationally health-related development goals and contribute to the global knowledge platform							**1,190,820,922**
	8	**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**		**164,691,395**
		8.1.1	To develop health research policies at State level		Approved health research policy provided by the end of 2010		**17,075,561**
			8.1.1.1	Convene Technical working group to develop health Research policies and Strategy in the state.	Health research policy and strategy developed	Logistics, Bureaucracy	11,968,851
			8.1.1.2	Develop and provide guidelines for the esthablishment of health research Steering Committee at State & LGA levels	Steering Committees established in the State and at least 50% of LGAs	Logistics	3,989,617
			8.1.1.3	Monitor and evaluate the activities of the Health Research Steering Committee at State & LGA levels	Monitoring and evaluation tools developed	Logistics, Fund	1,117,093
		8.1.2	To establish and/or strengthen mechanisms for health research at all levels		Staff trained and facilities provided to enhance health research at all levels by end of 2010		**79,792,343**
			8.1.2.1	Provide technical assistance to develop & strengthen the capacity of health research division & units in the State	DPRS of SMOH and research units of LGAs staffed by appropriately qualified personnel and evidence of training and retraining of DPRS staffs	Logistics, Bureaucracy, Avaiability of qualified personnel	79,792,343
			8.1.2.2	Provide technical assistance to strengthen PRS to undertake active research work at the State & LGAs levels	published result of research works	Logistics, Bureaucracy, Avaiability of qualified personnel	-
		8.1.3	To institutionalize processes for setting health research agenda and priorities		Essential health research priority research policy by end of 2010		**-**
			8.1.3.1	Adapt Essential National Health Research programmes for implementation in the State	Identification of priority diseases/health conditions and implementation of the essential health research programme	Logistics	-
		8.1.4	To promote cooperation and collaboration between Ministries of Health and LGA health authorities with Universities, communities, CSOs, OPS, NIMR, NIPRD, development partners and other sectors		Harmonized health research prority agenda by the end of 2010		**67,823,491**
			8.1.4.1	Convene a Stakeholders' forum to stimulate research activities in the state	Stakeholder forums organised		31,916,937
			8.1.4.2	Develop and Disseminate guidelines for collaborative research agenda	Publication and advertisement of research schedule		3,989,617
			8.1.4.3	Establish a forum of health research Officers in SMOH,LGA ,FG Institutions in the State	Annual scientific seminars/workshops for		31,916,937

					research officers organised.		
			8.1.4.4	Support development & implementation of collaborative research committee to harmonise proposals in the State	Publication and advertisement of research schedule		-
		8.1.5	To mobilise adequate financial resources to support health research at all levels		Available financial resources by the end of 2015		-
			8.1.5.1	Appropriate a minimum of 2 - 5% of health budget to health research	2-5% of health budget allocated to health research	Political will, Fund	-
			8.1.5.2	Advocate collaboration with development partners to support funding of essential health research activities in the State	Evidence of development partners participation in research activities.	Bureaucracy	-
			8.1.5.3	Encourage individuals and non govermental Organisations to support and or participate in the conduct of health research in the State	Evidence of NGOs participation.	Commitment of stakeholders, fund	-
			8.1.5.4	Encourage various health institutions in the State to sponsor research in relevant health care delivery	Participation of health institutions in reseach activities.	Commitment of health institutions, fund	-
		8.1.6	To establish ethical standards and practise codes for health research at all levels		Functional Ethical Review Committee in place by end of 1st Quarter 2010		-
			8.1.6.1	Establish Ethical Review Committee in the State	Ethical review committee established	Bureaucracy,Logistics	-
			8.1.6.2	Develop guidelines on ethical standards for health research in the State	guidelines on ethical standards for health research developed	Logistics	-
			8.1.6.3	Establish Mechanism to monitor,evaluate & regulate research activities and utilisation of research findings	monitoring and evaluation tools developed	Logistics, Personnel, Fund	-
	8	**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**		**398,961,713**
		8.2.1	To strengthen identified health research institutions at all levels		All health institutions engage in research by end of 2011		-
			8.2.1.1	Take inventory of all public and private Institution and organisation undertaking health research projects in the State		Logistics, fund	-
			8.2.1.2	Conduct bi-annual assessment of all research institution engaging in health research		Logistics, Fund	-
			8.2.1.3	Develop capacity of all institution/organizations engaging in health research		Logistics. Fund	-
			8.2.1.4	Collaborate with development partners for funding of research projects		Logistics, Fund, Bureaucracy	-
		8.2.2	To create a critical mass of health researchers at all levels		A list of qualified research generated by end of 2015		-
			8.2.2.1	Develop appropriate training intervention for research based on the identified needs in the State	Publication of list of public/private Institution and organisation undertaking health research projects	Fund, Logistics	-
			8.2.2.2	Establish competitive research grants for researchers to access		Political will, Fund	-
			8.2.2.3	Provide scholarship for researches relevant to health needs up to Phd level		Political will, Fund	-
		8.2.3	To develop transparent approaches for using research findings to aid evidence-based policy making at all levels		Number of policies based of research findings by end of 2015		-

			8.2.3.1	Establish research-to-policy research agenda		Logistics, Personnel, Fund	-
			8.2.3.2	Engage policy makers in evidence-based policy decision making		Logistics, Bureaucracy	-
			8.2.3.3	Engage researchers in conducting policy oriented researches		Logistics	-
		8.2.4	To undertake research on identified critical priority areas		Number and types of research conducted by end of 2015		**351,086,308**
			8.2.4.1	Conduct burden of disease research biannually		Fund, Logistics	95,750,811
			8.2.4.2	Undertake biannual studies in health delivery system		Fund, Logistics	63,833,874
			8.2.4.3	Conduct health financing risk protection, equity, efficiency and value of all health financing strategies annually		Fund, Logistics	63,833,874
			8.2.4.4	Conduct health system governance studies biannually		Fund, Logistics	63,833,874
			8.2.4.5	Undertake biannual human resource for health research		Fund, Logistics	63,833,874
		8.2.5	Tracking resources in the health sector		Guideline for tracking inflow and outflow of resources in health sector by end of 2010		**47,875,406**
			8.2.5.1	Track inflow and outflow of resources in health sector		Bureaucracy	47,875,406
	8	**To develop a comprehensive repository for health research at all levels (including both public and non-public sectors)**			**1. All States have a Health Research Unit by end 2010 2. FMOH and State Health Research Units manage an accessible repository by end 2012**		**383,003,245**
		8.3.1	To develop strategies for getting research findings into strategies and practices		Electronic facilities put in place for data storage and information dissemination by end of 2010		**319,169,371**
			8.3.1.1	Develop an electronic data bank and Research library		Fund	159,584,685
			8.3.1.2	Develop a website for research activities		Fund	159,584,685
		8.3.2	To enshrine mechanisms to ensure that funded researches produce new knowledge required to improve the health system		Guidelines for carrying out health research in the state in place by end of 2010		**63,833,874**
			8.3.2.1	Conduct need assessment to determine required health research		Fund, Logistics	31,916,937
			8.3.2.2	Develop guidelines for annual operation research to be conducted by Departments and agencies in SMOH and LGAs		Fund, Logistics	31,916,937
	8	**To develop, implement and institutionalize health research communication strategies at all levels**			**A national health research communication strategy is in place by end 2012**		**244,164,569**
		8.4.1	To create a framework for sharing research knowledge and its applications		Framework for sharing research knowledge in place by end of 2010		**65,429,721**
			8.4.1.1	Develop and Implement a framework for sharing research knowledge in the State		Logistics	31,916,937
			8.4.1.2	Organise annual review meetings to deliberate on utilization of research findings in the State		Fund, Logistics	-

			8.4.1.3	Convene annual conference, workshops and seminars for information dissemination		Fund, Logistics	31,916,937
			8.4.1.4	Publish research findings in journals and periodicals		Fund, Personnel	1,595,847
		8.4.2	To establish channels for sharing of research findings between researchers, policy makers and development partners		Channels for sharing research findings established by end of 2010		**178,734,848**
			8.4.2.1	Conduct annual seminars and workshops for policy makers , researchers & development partners on research findings in the State		fund	63,833,874
			8.4.2.2	Develop capacity of researchers to write policy briefs, journal articles and reviews		fund	79,792,343
			8.4.2.3	Conduct inventory of national jornals according to areas of focus		fund	-
			8.4.2.4	Establish and publish a scientific journal		fund, Personnel	31,916,937
			8.4.2.5	Identify and publish in international journal of relevance		Personnel	3,191,694
		8.4.3	Encourage subscription for high quality health sector journal in the state		Number of high quality health journals subscribed to by end of 2015		**-**
			8.4.3.1	Advocate for funds to subscribe to high quality health sector journals within & outside the Country		Fund, Information, Bureaucracy	-
Total							**59,541,046,099**

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

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	75	100	100%
	2. % of stakeholders constituencies playing their assigned roles in the SSHDP (disaggregated by stakeholder constituencies)	SSHDP Annual Review Report	0	25	50	75%
2. Improved Legislative and Regulatory Frameworks for Health Development	3. State adopting the National Health Bill? (Yes/No)	SMOH	0	100		100%
	4. Bills and by-laws regulating traditional medical practice at State and LGA levels passed and signed into law.	Laws and bye-Laws	TBD	25		
	5. % of LGAs enforcing traditional medical practice by-laws	LGA Annual Report	TBD	25%	50%	75%
3. Strengthened accountability, transparency and responsiveness of the State health system	6. % of LGAs which have established a Health Watch Group	LGA Annual Report	0	50	75	100
	7. % of recommendations from health watch groups being implemented	Health Watch Groups' Reports	No Baseline	25	50	75
	8. % LGAs aligning their health programmes to the SSHDP	LGA Annual Report	0	50	100	100
	9. % DPs aligning their health programmes to the SSHDP at the LGA level	LGA Annual Report	100	100	100	100
	10. % of LGAs with functional peer review mechanisms	SSHDP and LGA Annual Review Report	TBD	25	50	75%
	11. % LGAs implementing their peer review recommendations	LGA / SSHDP Annual Review Report	No Baseline	50	75	100%
	12. Number of LGA Health Watch Reports published	Health Watch Report	0	50	75	100
	13. Number of "Annual Health of the LGA" Reports published and disseminated annually	Health of the State Report	TBD	50	75	100%
4. Enhanced performance of	14. % LGA public health facilities using the essential drug list	Facility Survey Report	TBD	40	80	100%

the State health system						
	15. % private health facilities using the essential drug list by LGA	Private facility survey	TBD	10	25	50%
	16. % of LGA public sector institutions implementing the drug procurement policy	Facility Survey Report	TBD	50	75	100%
	17. % of private sector institutions implementing the drug procurement policy within each LGA	Facility Survey Report	TBD	10	25	50%
	18. % LGA health facilities not experiencing essential drug/commodity stockouts in the last three months	Facility Survey Report	TBD	25	50	75%
	19. % of LGAs implementing a performance based budgeting system	Facility Survey Report	TBD	25	50	75%
	20. Number of MOUs signed between private sector facilities and LGAs in a Public-Private-Partnership by LGA	LGA Annual Review Report	TBD	2	4	6
	21. Number of facilities performing deliveries accredited as Basic EmOC facility (7 functions 24/7) and Comprehensive EmOC facility (9 functions 24/7)	States/ LGA Report and Facility Survey Report	38	98	158	203
STRATEGIC AREA 2: HEALTH SERVICES DELIVERY						
NSHDP GOAL: To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare						
Outcome 3: Universal availability and access to an essential package of primary health care services focusing in particular on vulnerable socio-economic groups and geographic areas						
Outcome 4: Improved quality of primary health care services						
Outcome 5: Increased use of primary health care services						
5. Improved access to essential package of Health care	22. % of LGAs with a functioning public health facility providing minimum health care package according to quality of care standards.	NPHCDA Survey Report	TBD	25	50	75%
	23. % health facilities implementing the complete package of essential health care	NPHCDA Survey Report	57	75	90	100%
	24. % of the population having access to an essential care package	MICS/NDHS	TBD	40	75	100%
	25. Contraceptive prevalence rate	NDHS	15%	30%	50%	75%
	26. Number of new users of modern contraceptive methods (male/female)	NDHS/HMIS	0.2 - 27.5%	2 - 30%	5 - 50%	10 - 75%
	27. % of new users of modern contraceptive methods by type (male/female)	NDHS/HMIS	TBD	2 - 30%	5 - 50%	10 - 75%
	28. % service delivery points without stock out of family planning commodities in the last three months	Health facility Survey	TBD	10 - 45%	20 - 75%	100%
	29. % of facilities providing Youth Friendly RH services	Health facility Survey	TBD	20 - 40%	30 - 60%	40 - 75%
	30. Adolescent (10-19 year old) Fertility rate (using teeenage pregnancy as proxy)	NDHS/MICS	2.9 - 65.0%	2.0 - 40%	1.0 - 30%	0.5 - 20%

	31. % of pregnant women with 4 ANC visits performed according to standards*	NDHS	70%	85%	95%	100%
	32. Proportion of births attended by skilled health personnel	HMIS	51%	80%	100%	100%
	33. Proportion of women with complications treated in an EmOC facility (Basic and/or comprehensive)	EmOC Sentinel Survey and Health Facility Survey	TBD	10 - 40%	25 - 50%	40 - 75%
	34. Caesarean section rate	EmOC Sentinel Survey and Health Facility Survey	TBD	2%	1.20%	1.20%
	35. Case fertility rate among women with obstretic complications in EmOC facilities per complication	HMIS	TBD	10 - 60%	7 - 40%	5 - 25%
	36. Perinatal mortality rate**	HMIS	37 - 53/1000LBs	25 - 45/1000LBs	15 - 30/1000LBs	10 - 20/1000 LBs
	37. % women receiving immediate post partum family planning method before discharge	HMIS	TBD	??	??	??
	38. % of women who received postnatal care based on standards within 48h after delivery	MICS	0.5 - 22.4%	10 - 40%	25 - 60%	50 - 75%
	39. Number of women presented to the facility with or for an obstetric fistula	NDHS/HMIS	No Baseline			??
	40. Number of interventions performed to repair an obstetric fistula	HMIS	No Baseline			??
	41. Proportion of women screened for cervical cancer	HMIS	TBD			
	42. % of newborn with infection receiving treatment	MICS	No Baseline	10 -25%	25 -50%	50 - 75%
	43. % of children exclusively breastfed 0-6 months	NDHS/MICS	17.60%	10 - 65%	20 - 75%	40 - 80%
	44. Proportion of 12-23 months-old children fully immunized	NDHS/MICS	37.00%	40 - 70%	50 - 85%	65 - 100%
	45. % children <5 years stunted (height for age <2 SD)	NDHSMICS	32.00%	25%	18%	10%
	46. % of under-five that slept under LLINs the previous night	NDHS/MICS	4.00%	10-15%	30-45%	60-75%
	47. % of under-five children receiving appropriate malaria treatment within 24 hours	NDHS/MICS	69.60%	80%	90%	95%
	48. % malaria successfully treated using the approved protocol and ACT;	MICS	5.60%	15%	30%	50%
	49. Proportion of population in malaria-risk areas using effective malaria prevention and treatment measures	MICS	TBD	???	???	???
	50. % of women who received intermittent preventive treatment for malaria during pregnancy	NDHS/MICS	5%	20%	50%	60%
	51. HIV prevalence rate among adults 15 years and above	NDHS	*0.9%	?	?	?
	52. HIV prevalence in pregnant women	NARHS	2.30%	2.10%	1.90%	1.60%

	53. Proportion of population with advanced HIV infection with access to antiretroviral drugs	NMIS	TBD(**2000)	???	???	???
	54.Condom use at last high risk sex	NDHS/MICS				
	55. Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS	NDHS/MICS	26.50%	40%	40 - 90%	60 - 100%
	56. Prevalence of tuberculosis	NARHS	1.5 - 6.9%*	1.0 - 4.0	0.5 - 3%	0.1 - 2*
	57.Death rates associated with tuberculosis	SMOH	6.90%	5%	3%	2%
	58. Proportion of tuberculosis cases detected and cured under directly observed treatment short course	SMOH	17%	20%	25%	32%
Output 6. Improved quality of Health care services	59. % of staff with skills to deliver quality health care appropriate for their categories	Facility Survey Report	45%	60%	75%	77
	60. % of facilities with capacity to deliver quality health care	Facility Survey Report	58%	70%	85%	89%
	61. % of health workers who received personal supervision in the last 6 months by type of facility	Facility Survey Report	TBD	20 - 40%	50 - 75%	75 - 100%
	62. % of health workers who received in-service training in the past 12 months by category of worker	HR survey Report	25%	35%	45%	55%
	63. % of health facilities with all essential drugs available at all times	Facility Survey Report	53.60%	68%	85%	100%
	64. % of health institutions with basic medical equipment and functional logistic system appropriate to their levels	Facility Survey Report	53.60%	60%	75%	100%
	65. % of facilities with deliveries organizing maternal and/or neonatal death reviews according to WHO guidelines on regular basis	Facility Survey Report	3%	15%	30%	50%
Output 7. Increased demand for health services	66. Proportion of the population utilizing essential services package	MICS	TBD	?	?	?
	67. % of the population adequately informed of the 5 most beneficial health practices	MICS	TBD	?	?	?
PRIORITY AREA 3: HUMAN RESOURCES FOR HEALTH						
NSHDP GOAL: To plan and implement strategies to address the human resources for health needs in order to ensure its availability as well as ensure equity and quality of health care						
Outcome 6. The Federal government implements comprehensive HRH policies and plans for health development						
Outcome 7.All States and LGAs are actively using adaptations of the National HRH policy and plan for health development by end of 2015						
Output 8. Improved policies and Plans and strategies for HRH	68. % of wards that have appropriate HRH complement as per service delivery norm (urban/rural).	Facility Survey Report	TBD	?	?	?
		HR survey Report	TBD	???	???	???

	70. % LGAs actively using adaptations of National/State HRH policy and plans	HR survey Report	35%	40%	50%	75%
	71. Stock (and density) of HRH	HR survey Report	TBD	1 CHW:4000 pop; 1 Nurse or MW:8000 pop; 1 Dr & Dentist:8000 pop; 1 Pharmacist: 20,000 pop;	1 CHW:3000 pop; 1 Nurse or MW:6000 pop; 1 Dr & Dentist:7000 pop; 1 Pharmacist: 15,000 pop;	1 CHW:2000 pop; 1 Nurse or MW:4000 pop; 1 Dr & Dentist:5000 pop; 1 Pharmacist: 10,000 pop;
	72. Distribution of HRH by geographical location	MICS	TBD	???	???	???
	73. Increased number of trained staff based on approved staffing norms by qualification	HR survey Report	TBD	10 - 20%	25 - 50%	50 - 75%
	74. % of LGAs implementing performance-based managment systems	HR survey Report	10%	20%	30%	50%
	75. % of staff satisfied with the performance based management system	HR survey Report	TBD	?	?	?
Output 8: Improved framework for objective analysis, implementation and monitoring of HRH performance	76. % LGAs making availabile consistent flow of HRH information	NHMIS	65%	75%	88%	100%
	77. CHEW/10,000 population density	MICS	TBD	1:4000 pop	1:3000 pop	1:2000 pop
	78. Nurse density/10,000 population	NHMIS	1:11000	1:8000 pop	1:6000 pop	1:4000 pop
	79. Qualified registered midwives density per 10,000 population and per geographic area	NHIS/Facility survey report/EmOC Needs Assessment	TBD	1:8000 pop	1:6000 pop	1:4000 pop
	80. Medical doctor density per 10,000 population	NHMIS	1:15000	1:8000 pop	1:7000 pop	1:5000 pop
	81. Other health service providers density/10,000 population	MICS	TBD	1:4000 pop	1:3000 pop	1:2000 pop
	82. HRH database mechanism in place at LGA level	HRH Database	TBD	50 - 75%	75 - 100%	100%
Output 10: Strengthened capacity of training institutions to scale up the production of a critical mass of quality mid-level health workers						
PRIORITY AREA 4: FINANCING FOR HEALTH						

NSHDP GOAL 4 : To ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and consumption at Local, State and Federal Levels						
Outcome 8. Health financing strategies implemented at Federal, State and Local levels consistent with the National Health Financing Policy						
Outcome 9. The Nigerian people, particularly the most vulnerable socio-economic population groups, are protected from financial catastrophe and impoverishment as a result of using health services						
Output 11: Improved protection from financial catastrophy and impoversihment as a result of using health services in the State	83. % of LGAs implementing state specific safety nets	SSHDP review report	TBD	10 -25%	25 - 50%	50 - 75%
	84. Decreased proportion of informal payments within the public health care system within each LGA	MICS	TBD	50 - 90%	30 - 75%	10 - 50%
	85. % of LGAs which allocate costed fund to fully implement essential care package at N5,000/capita (US$34)	State and LGA Budgets	TBD	25 - 40%	40 - 60%	60 80%
	86. LGAs allocating health funding increased by average of 5% every year	State and LGA Budgets	TBD	25 - 40%	40 - 60%	60 - 80%
Output 12: Improved efficiency and equity in the allocation and use of Health resources at State and LGA levels	87. LGAs health budgets fully alligned to support state health goals and policies	State and LGA Budgets	TBD	40 - 60%	60 - 80%	100%
	88.Out-of pocket expenditure as a % of total health expenditure	National Health Accounts 2003 - 2005	70%	60%	50%	40%
	89. % of LGA budget allocated to the health sector.	National Health Accounts 2003 - 2005	6 - 8%	10%	20%	30%
	90. Proportion of LGAs having transparent budgeting and finacial management systems	SSHDP review report	TBD	25%	40%	60%
	91. % of LGAs having operational supportive supervision and monitoring systems	SSHDP review report	TBD	25%	40	50%
PRIORITY AREA 5: NATIONAL HEALTH INFORMATION SYSTEM						
Outcome 10. National health management information system and sub-systems provides public and private sector data to inform health plan development and implementation						
Outcome 11. National health management information system and sub-systems provide public and private sector data to inform health plan development and implementation at Federal, State and LGA levels						
Output 13: Improved Health Data Collection, Analysis, Dissemination, Monitoring and Evaluation	92. % of LGAs making routine NHMIS returns to states	NHMIS Report January to June 2008; March 2009	70%	100%	100%	100%

	93. % of LGAs receiving feedback on NHMIS from SMOH	STATE HMIS	0%	100%	100%	100%
	94. % of health facility staff trained to use the NHMIS infrastructure	STATE HMIS	100%	100%	100%	100%
	95. % of health facilities benefitting from HMIS supervisory visits from SMOH	STATE HMIS	0%	25 - 40%	40 - 60%	60 - 80%
	96.% of HMIS operators at the LGA level trained in analysis of data using the operational manual	STATE HMIS	100%	100%	100%	100%
	97. % of LGA PHC Coordinator trained in data dissemination	Training Reports	100%	100%	100%	100%
	98. % of LGAs publishing annual HMIS reports	HMIS Reports	0%	25%	50%	75%
	99. % of LGA plans using the HMIS data	NHMIS Report	0%	40%	75%	100%
PRIORITY AREA 6: COMMUNITY PARTICIPATION AND OWNERSHIP						
Outcome 12. Strengthened community participation in health development						
Outcome 13. Increased capacity for integrated multi-sectoral health promotion						
Output 14: Strengthened Community Participation in Health Development	100. Proportion of public health facilities having active committees that include community representatives (with meeting reports and actions recommended)	SMOH	90%	100%	100%	100%
	101. % of wards holding quarterly health committee meetings	HDC Reports	60%	75%	85%	100%
	102. % HDCs whose members have had training in community mobilization	HDC Reports	70%	80%	90%	100%
	103. % increase in community health actions	HDC Reports	TBD	10%	25%	50%
	104. % of health actions jointly implemented with HDCs and other related committees	HDC Reports	TBD	25%	40%	60%
	105. % of LGAs implementing an Integrated Health Communication Plan	HPC Reports	TBD	25%	40%	60%
PRIORITY AREA 7: PARTNERSHIPS FOR HEALTH						
Outcome 14. Functional multi partner and multi-sectoral participatory mechanisms at Federal and State levels contribute to achievement of the goals and objectives of the SHDP						
Output 15: Improved Health Sector Partners' Collaboration and Coordination	106. Increased number of new PPP initiatives per year per LGA	SSHDP Report	TBD	25%	40%	60%
	107. % LGAs holding annual multi-sectoral development partner meetings	SSHDP Report	TBD	25%	50%	75%
PRIORITY AREA 8: RESEARCH FOR HEALTH						
Outcome 15. Research and evaluation create knowledge base to inform health policy and programming.						
Output 16: Strengthened stewardship role of government for research and knowledge management systems						
	109. % of State health budget spent on health research and evaluation	State budget	TBD	1%	1.50%	2%

	110. % of LGAs holding quarterly knowledge sharing on research, HMIS and best practices	LGA Annual SHDP Reports	TBD	10%	25%	50%
	111. % of LGAs participating in state research ethics review board for researches in their locations	LGA Annual SHDP Reports	TBD	40%	75%	100%
	112. % of health research in LGAs available in the state health research depository	State Health Reseach Depository	TBD	40%	75%	100%
Output 17: Health research communication strategies developed and implemented	113. % LGAs aware of state health research communication strategy	Health Research Communication Strategy	TBD	40%	75%	100%