OGUN STATE GOVERNMENT

STRATEGIC HEALTH DEVELOPMENT PLAN

(2010-2015)

Ogun State Ministry of Health

March 2010

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Acronyms

CBOs	Community Based Organizations
CHEWs	Community Health Extension Workers
GH	General Hospitals
HIV/AIDS	Human Immuno Deficiency Virus/Acquired Immune Deficiency
HSR	Health Sector Reform
HRH	Human Resources for Health
IMCI	Integrated Management of Childhood illnesses
LGAs	Local Government Areas
LLINs	Long Lasting Insecticide Treated Nets
M & E	Monitoring and Evaluation
MDGs	Millennium Development Goals
NASCAP	National AIDS and Sexually Transmitted Infections Control Programme
NEEDS	National Economic Empowerment and Development Strategies
NGOs	Non Government Organizations
NHMIS	National Health Management Information System
PHC	Primary Health Care
PPP	Public Private Partnerships
RMAFC	Revenue Mobilisation Allocation and Fiscal Commission
SCH	State Council on Health
SEEDS	State Economic Empowerment and Development Strategies
SHAs	State Health Accounts
SHMIS	State Health Management Information System
SMOH	State Ministry of Health
SSHDP	State Strategic Health Development Plan
UNAIDS	United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
WHO	World Health Organization

WMHCP Ward Minimum Health Care Package

Acknowledgement

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Foreword

From the popular definition of Health as a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity, we can say without fear of contradiction that all about life is about health and all about health is about life. Therefore in every country, the health sector is critical to social and economic development with ample evidence linking productivity to quality of health care. In Nigeria, the vision of becoming one of the leading 20 economies of the world by the year 2020 is closely tied to the development of its human capital through the health sector.

However, the health indicators in Nigeria have remained below country targets and internationally-set benchmarks including the MDGs, which have recorded very slow progress over the years. Currently, the health sector is characterized by lack of effective stewardship role of government, fragmented health service delivery, inadequate and inefficient financing, weak health infrastructure, mal-distribution of health work force and poor coordination amongst key players.

To address these, the federal government implemented the Health Sector Reform Program (HSRP) from 2004-2007, which addressed seven strategic thrusts revolving around government's stewardship role; management of the national health system; the burden of disease; mobilization and utilization of health resources; health service delivery; consumer awareness and community involvement; partnership, collaboration and coordination. The HSRP recorded a number of policy and legislative initiatives, notable among which are the National Health Policy review, the National Health Bill and strengthening the National Health Insurance Scheme. In addition, efforts were directed at strengthening disease programmes and improving the quality of care in tertiary health facilities. Despite these initiatives, much of the underlying weaknesses and constraints of the health sector persist.

Consequently, the Federal Ministry of Health has articulated an overarching guide for the development of the National Strategic Health Development Plan (NSHDP) with its appropriate costing. The FMOH has also directed the States to do same. The NSHDP would result from the harmonization of Federal, States' and local governments' health plans, thereafter serving as the basis for national ownership, resource mobilisation/allocation and mutual accountability by all stakeholders – government, development partners, civil society, private sector, communities, etc. The framework is based on the principles of the Four Ones: one health policy, one national plan,

one budget, and one monitoring and evaluation framework for all levels of government. It also provides the template to concretize the health sector development component of the 7-point Agenda, Vision 2020 and a platform for achieving the MDGs.

Based on a multidimensional assessment of the health sector, the framework identifies eight priority areas for improving the national health systems with specific goals and strategic objectives. They are leadership and governance for health; health service delivery; human resources for health; health financing; health information systems; community ownership and participation; partnerships for health development; and research for health.

I joined the Minister of Health to implore all stakeholders to use this framework to adequately harness the policy gaps and program interventions required to improve the performance of the health sector towards the delivery of quality, efficient and sustainable health care for all Nigerians.

Dr. Iziaq Adekunle Salako

Honourable State Commissioner for Health

October, 2009

Executive Summary

To provide quality, accessible and affordable health care services to all people living within Ogun State. By this, the vicious cycle of ill health, poverty and low level development will be turned to the virtuous cycle of improved health status, increased wellbeing and sustainable development

Health is a state of complete well-being, so we can say without any fear of contradiction that all about health is about life, and all about life is about health. Ogun State places high premium on the Health of its citizens. However our health indices are not optimal. Antenatal clinic (ANC) attendance is 89.9%, delivery by health practitioner 71.8%, and delivery in health facility 63.8%. Our maternal mortality rate is 119/100,000 and child mortality rate 24/1000. About 18.2 percent of the children are underweight and about 10% of the population have one mosquito net per household. About 85% have knowledge about AIDS. Realising the importance of health, the present administration has employed more skilled health workers by almost 100 percent as part of the efforts to reduce disease burden in Ogun State.

Situation Analysis

Ogun State was carved out of the defunct Western State on the 3rd of February, 1976 and has a total land area of 16,409.26 sq.km. with Abeokuta as state capital. The State is made up of 20 LGAs. The estimated population is 3,728,098(2006 population census).

The underserved populations are mainly in the rural areas and they constitute about 40-50% of the total population. The population is served by a mix of public and private health care services. The main occupation of the peole is farming; Ogun state is the largest producer of cassava and one of the main producers of cocoa. In order to solve the problem of unemployment among our youths, programs such as Ogun State Employment Generating Program (OGEGEP) and Ogun State Graduate Employment Scheme (OGUNGRAD) have been developed.

Bottleneck analysis for implementation of the Ward Minimum Package of care

The aim of the administration is to ensure that primary health care is available within a 5km distance to the place of abode every individual living in Ogun State. The PHC should be able to provide maternal and child health services and simple curative cares. Major challenges identified are inadequate funding, inadequate executive support especially at the LGA levels, human resource gap especially due to high attrition rates and inequitable distribution of human resources

to the detriment of the rural populace. Strategies to mitigate these bottlenecks include increased funding and motivation of rural health workers.

SSHDP States Minimum Package of Care

The State's minimum package of care include antenatal care, immunization, health promotion activities like nutrition services, health education, behavioral change communication concerning communicable and non-communicable diseases, simple curative services e.g. ORT, deworming and antimalaria treatment, etc. TB treatment under directly observed treatment scheme (DOTS), and support for HIV/AIDS activities.

States Strategic Health Priority interventions

In pursuance of the health MDGs the following interventions will be undertaken to reduce the burden of diseases in our communities: maternal and child health care will be subsidised. We will ensure equitable distribution of health facilities, building new ones where needed, we will ensure regular monitoring and supervision of the health facilities. We will give incentives for rural health workers. We will motivate the general health workforce. We will ensure a regular continuous professional development. We will support HIV/AIDS activities. We will make available drugs for the treatment of common ailments like malaria, diarrhoea diseases, helminthiasis, onchocerciasis, and guineaworm. Finally we will ensure adequate funding for HEALTH.

Monitoring & Evaluation

To track the progress made, we will establish a baseline data for the health indicators and do quarterly evaluation of progress. We will adequately fund the health information management system (with 0.5-1.0% of the health capital project).

Chapter 1: Background

The vision of the Government of Ogun State to provide quality, accessible and affordable health care service to all the people living within Ogun State is on course. This is evident in the publication on health indicators which measures the progress using the indicators on the provision of health care, socioeconomic and health status. By and large, the Otunba Gbenga Daniel's Administration is committed toward the repositioning of the health system in the state.

Our Vision
To provide quality, accessible and affordable health care services to all people living in Ogun State.

Our Mission Statement
The Ministry will continue to enhance health care services that will cater for all individuals, families and communities within the state through team work, commitment to excellence, integrity, competence, promptness, and the dignity of the people of the state.

Chapter 2: Situation Analysis

2.1 State Economic and Demographic Information

Location

Ogun State is one of the 36 States in the Federal Republic of Nigeria. It was carved out of the defunct Western State on the 3rd day of February, 1976 and has a total land area of 16,409.26 sq. km. It is bounded in the North by Oyo and Osun States in the East by Ondo State, in the South by Lagos, and in the West by the Republic of Benin. The state capital is Abeokuta, which is about 100km north of Lagos, Nigeria's business capital. The State is made up of 20 LGAs.

The People

The estimated population is 3,728,098 (2006 Ogun State Census). The people of the state are largely Yoruba. The sub-groups are mainly the Egba, Ijebu, Yewa, Egun, Awori, Remo, Ikale, and Ilaje.

2.2 The Economy

The main occupation of the State is farming. The State is one of the highest producers of cocoa in the country. Petty trading and white-collar jobs are the major occupations in urban centres. Unemployment rate is generally high. However, the State Government has introduced a number of poverty reduction programmes. The industrial/manufacturing base for development in the State is fair with its Industrial Estates located at Abeokuta, Ota, and Agbara.

2.3 Health

Ogun State is well served by health care services. There are 3 major tertiary health care facilities in the state

- the Olabisi Onabanjo Teaching Hospital Sagamu
- Neuropsychiatry Hospital Aro Abeokuta, established about 60years ago and which now serves as WHO training center for the mentally ill.
- Federal Medical Center Idi Aba Abeokuta.

One of the oldest private hospitals in the country the Sacred Heart Hospital Lantoro Abeokuta was established in 1959(Shran, 1973). In addition the State Government funds/manages schools of nursing and midwifery. And one school of health technology four specialist hospitals one each in one of the major towns in each of its four divisions along with other general, cottage and primary health care facilities. There are over 800 registered private health care facilities scattered all over the state that can be categorized into three tiers of health care. Finally, Ogun State has 428 Primary Health Care Centers.

Table 1

S/N	Health Indicators	National	Ogun
1.	Under-five mortality	198/1000	24/1000
2.	Neonatal mortality	53/1000	12/1000
3.	Maternal Morality	800/100000	119/100000
4.	HIV Prevalence Rate	4.4%	1.7%
5.	Incidence of Smear Positive TB	126/100000	64.4/100000
6.	Physicians	Nil	4/100000
7.	Nurses and Midwives	Nil	8/10000
8.	Doctors and Nurses	Nil	12/10000
9.	Ratio of Nurses and Midwives to Physicians	Nil	2:1
10.	No of Hospital beds	Nil	1/10000
11.	Life Expectancy	Nil	45 years
12.	Total Fertility Rate	Nil	5.7
13.	% of Users of Modern Contraceptive Methods	Nil	4.9%

2.4 Health System

The concept of leadership and governance for the Ogun State Health System is derived from the definition and clarification by WHO in extant literature.

Health care services in Ogun State are provided by a multiplicity of health care providers - public, private including for profit and not-for-profit, patent medicine vendors and the traditional health care providers.

Despite considerable investment in the health sector over the years, available evidence suggests that health services throughout the State are delivered through a weak health care system. Consequently it is unable to provide basic, cost-effective services for the prevention and management of common health problems especially at the LGA and Ward levels. For example, the proportion of PHC facilities providing full immunisation services range from 31% in Odogbolu LGA to 129% in the Ifo LGA for DPT3 in 2007. Also the capacity to provide basic emergency obstetric services is very limited as only 20% of facilities are able to provide this service[1]. This limited coverage of basic health services results in under utilisation of services.

Availability and distribution of functional health facilities and other health infrastructure are variable across the State. And many new PHC facilities being built are wrongly sited. Majority of the public health facilities especially PHC centres are in a state of disrepair. Although the State currently has three tertiary institutions, nonetheless they are not functioning at optimal capacities in the provision of quality specialist care.

Most public health facilities across the State are poorly equipped as indicated in findings from a 2001 survey of public PHC facilities[2]. The report shows that only a quarter of health facilities had more than 50% of the minimum equipment package and 40% had less than a quarter. However, in the past few years a significant level of capital investment has been made to improve the medical equipment and infrastructure of a cohort of federal teaching hospitals and 350 model PHC facilities have been constructed and equipped.

The Essential Drugs Programme, including the Ogun State essential drug list in the country was developed in 1988. The Bamako Initiative aimed at strengthening PHC through ensuring sustainable quality drug supply systems was re-invigorated in all LGAs in 1998 under the Petroleum Trust Fund. These initiatives are now moribund due to poor commitment to the establishment of systemic procurement systems for health commodities resulting in loss of confidence and decreased utilization of public sector health facilities due to drug stock-outs. One of the consequences of these is the proliferation of patent medicine vendors and drug hawkers which is compounding the problem of irrational drug use in the State. The market is also replete with substandard and fake drugs. However, there is a perception of increased confidence in the drug regulatory framework operated by NAFDAC in recent years.

Most services provided by private and public providers are clinic-based, with minimal outreach, home and community-based services. The services are fragmented, with many vertical disease control programs. Referral systems are weak and even tertiary facilities are used for provision of

[1] FMOH/UNFPA study on essential obstetric care in Nigeria (2002-2003)

[2] Adeniyi. J, Ejembi CL, et al (2001) The Status of Primary Health Care in Nigeria: Report of a Needs Assessment Survey. National Primary Health Care Development Agency.

primary care thus diminishing the continuum of care and making the system inefficient. Also, despite the private sector delivering more than 60% of health care in the State, private-public partnership is very weak.

Even though Ogun has one of the largest stocks of human resources for health in Nigeria, it is still inadequate to meet the State's needs. In 2006, an inventory of health care personnel in the State indicated one doctor per 2992 population and one nurse per 1411 population for the year 2004[3]. The planning and management of HRH still poses a major challenge to health development in the state as evidenced by absence of a human resource plan, especially at lower levels, lack of coordination, alignment and harmonization of HRH needs at all levels of government. In addition, dearth of skills, problems with HRH mix, poor motivation, differential conditions of service, remuneration and work environment; negative attitude to work and poor supervision are added challenges, some of which contribute to inequitable distribution to the disadvantage of lower levels of care, rural areas and high attrition rates observed. Also, the ceilings placed on enrolment to schools of midwifery and nursing by their regulating body are limitations to addressing the very critical HRH challenges in Ogun State.

The Commission for Macroeconomics and Health estimates a cost of about US$34 per person per year (per capita) to deliver an essential package of interventions to meet the Millennium Development Goals (MDGs)[4]. In Nigeria the total per capita health expenditure is estimated at between $10 at average exchange rates with private out of pocket expenditure (OOPE) accounting for 70%[5]. It is also recognized that the poor spend a disproportionately higher percentage of disposable household income on healthcare and in the absence of social protection mechanisms (health insurance, social security or credible exemptions), this population face challenges of financial barriers to health care at the time of need. This no doubt deters the poor from seeking health care on time or deepens their impoverishment when they are compelled to make health expenditure.

Currently, healthcare is financed in Nigeria from a mixture of budgetary allocations from the Federal, States and LGAs, private out-of-pocket expenditure, external development funding, grants from corporations and charities and a small but growing social health insurance contributions. Lately, many States including Ogun State have also commenced programmes aimed at protecting vulnerable groups from the financial risk of ill-health, such as free maternal and child health services and Ogun State Rural Medical Services (OGRUMED). Nonetheless, in order to achieve the level of funding required for meeting the health needs of the whole population, the state has to put in place mechanisms for increased funding both in absolute terms and as a proportion of the total budget. In addition, there is a need to coordinate all the resources

[3] Health Reform Foundation of Nigeria (2007) *Nigerian Health Review* Abuja: Health Reform Foundation of Nigeria p.55

[4] Commission for Macroeconomics and Health (2001) *Macroeconomics and Health: Investing in Health for Economic Development*. Geneva: World Health Organization

[5] Federal Ministry of Health (2004) Health Sector Reform Program: Strategic Thrusts and Logframe

available to the sector from all sources. The Draft National Health Bill, when enacted into law will assure significant improvement in health care financing in the country as it will earmarks 2% of the consolidated state revenue for health, with a large proportion of it assigned for PHC. Ogun State will follow the national footsteps.

In the recent past, a range of potential measures are being established, including the National Health Insurance Scheme Scheme (NHIS) that incorporates programmes covering formal sector workers; community-based health insurance; social health protection models targeted at the poor and vulnerable groups such as free maternal and child health (MCH) services, voucher schemes, health cards and exemptions; and private health insurance. However, none of these options have been scaled up to the point of providing adequate financial risk protection for majority of people in Nigeria[6] and in Ogun State.

There is no Ogun State M&E policy, framework and plan and there is lack of integration between the NHMIS and M&E systems. Even though the private sector provides 60% of healthcare in the state, there is very limited capture of their data into the Ogun HMIS. Other major problems include lack of forms; incomplete, untimely, and largely incorrect reporting of data; grossly inadequate capacity to analyse and utilise data for decision making at all levels; and poor feedback mechanisms. The last health bulletin was published in 2006.

Traditional self help and community efforts in health development through community safety nets and other support mechanisms have been part of the history of communities in Ogun State. The efforts at community participation have however been limited in scope, organization and impact. Lack of clear policy framework to empower the community as the draft Community Development Policy is yet to be finalized may be contributory.

Health research is the systematic generation of new knowledge in the field of medical, natural, social, economic and behavioral science and its use to improve the health of individuals or group. Yet, Ogun State has paid little or no attention to research for health. No funds are earmarked for research while collaboration with state-owned research institutions has been feeble.

2.5 Policy Thrust

The main policy thrust of the government is to increase access to quality health care especially in rural community and continuously provide affordable, efficient and effective health care services across the state. The ways in which this goal will be achieved are by:

- Enhancing confidence in the public health institutions in order to increase their utilization and improve quality of life;

[6] National Health Insurance Scheme. (2008). *Blueprint for the Implementation of Social Health Insurance Programme in Nigeria*. Abuja: National Health Insurance Scheme

- Establishing an alternative source of health care financing through participation in the Ogun State Health Insurance scheme (NHIS);
- Revitalizing and strengthening the primary health care delivery system in order to promote child survival strategies through immunization and the other cost effective interventions;
- Combating the scourge of HIV/AIDS malaria, TB, and other epidemic diseases;
- Continuing to promote public /private participation in health care delivery; and
- Encouraging research activities.

2.6 Targets

Ogun state has set the following targets in consonance with the MDGs.

- Reduce child mortality from 24/1000 live birth (LB) to 16/1000LB by the end of 2015.
- Reduce Maternal Mortality by at least two-thirds from present levels by end of 2015
- Reduce HIV/AIDS prevalence rate of 1.7%by 10% biannually by 2011
- Increase the proportion of TB cases under DOTS from 76.5% by at least 5% annually by the end of 2015.

2.7 The broad strategies are:

- Commence participation in the formal sector of the social health insurance scheme (NHIS) at the State level.
- Encourage the take-off of the community base social health insurance programme (CBSHIP).
- Establishment of the State Action Committee on AIDS(SACA) as a statutory body responsible for the control of HIV and AIDS in the State (Already achieving results).
- Ensure universal access to HIV/AIDS prevention, treatment, care and support services.
- Enhance quality Medical Laboratory services in both public and private sectors including safe blood services. Ogun State blood transfusion services NBTS was established in Ogun state since Feb, 2009.
- Regular payment of salary and allowances
- Strengthen the reward system for health care providers both at the secondary and primary levels to enable motivation and performance.
- Provide an effective and efficient referral system as well as ensuring the availability of essential drugs supplies and equipment in all public health facilities to improve utilization and quality of service.
- Collaboration with Pharmaceutical Council of Nigeria (PCN) and NAFDAC to control menace of fake drugs.
- Constitute active anti-drug abuse control committee.
- Further recapitalized the drugs revolution scheme in the hospitals.
- Re-invigorate the drug-free clubs in the secondary schools in the state with the view to reducing the prevalence of drug abuse.
- Strengthen the decentralized hospital management committee of each hospital to improve supervision, effectiveness and efficiency of service.

- Intensify life saving intervention programmes like Ogun state Rural Medical scheme (OGRUMED) and Ogun state Accident services (OGSAS) and establish emergency outbreak response committee to reduce morbidity, mortality and improve quality of life.
- Advocate for more government funding of health care services so as to ensure sustainability of health programmes.
- Established Primary Health care development Agency for effective service delivery and supreme advocacy. (Already on course).
- Further strengthen health promoting activities to reduce the incidence of common endemic diseases (communicable and non-communicable) teenage pregnancy, maternal and childhood illness and deaths.
- Continue to enhance the health information system, through improved data collection computerized data storage retrieval system analysis and feedback mechanisms.
- Improve periodic monitoring of private health facilities in order to enhance quality control and standard of practice.
- Promote regular maintenance and renovation of public health facilities as and when due.
- Enhance capacity of formal health care providers, traditional birth attendants (TBAs) and alternative medical practitioners (Amps) by continuous training.
- Continue to ensure the provision of free anti TB drugs in all the primary health care centers in the 20 LGAs in the state.
- Contract out to the private sector, the services that cannot be provided for by the government.

Ogun State Ministry of H currently collaborates with:

- USA based concerned Nigerians for surgical expedition at the State Hospital Abeokuta,
- Dideolu Specialist Hospital Ikenne and Olabisi Onabanjo Teaching Hospital, Sagamu
- Rotary International Ogun State Nigeria and Western Australia to carry out free cataract surgery for 400 people at Otunba Olumayowa Olukoya Memorial Hospital Ijebu Ife and provision of artificial limbs(below elbow) at State Hospital, Ijaiye, Abeokuta.
- Lagos University Teaching Hospitals (LUTH) to carry out surgical repair of cleft lips & palates by SMILE TRAIN INTERNATIONAL USA an NGO.
- Lions Club International also provided and equipped an Eye clinic at State Hospital Ota.
- Indo-Eye care International (An Indian Community) provided free surgery at the state Hospital Abeokuta.
- Gateway Front Foundation provides free medical care to the rural populace.
- WHO,UNFPA, UNICEF, EU PRIME, FOOD BASKET INTL among others to provide quality life and abundant good health to our people.

Chapter 3 Priority Areas of the Ogun State SHDP

This SHDP seeks to provide strategic guidance to the State in the selection of evidenced-based priority interventions that would contribute to achieving the desired health outcomes for the people of Ogun State towards achieving sustainable universal access and coverage of essential health services within the planned period of 2010 - 2015.

The Honourable State Commissioner for Health therefore expects all the stakeholders to embrace '*the use of this OSHDP for the development of the respective operational plans for the state.*'

This SHDP focuses on eight priority areas that are listed as follows:

- Leadership and governance;
- Service delivery;
- Human resources for health;
- Health financing;
- Health information system;
- Community participation and ownership;
- Partnerships for health; and,
- Research for health.

The Ogun State SHDP toolkit framework specifies the goals, strategic objectives and the corresponding interventions and activities with estimated costs..

To improve the functionality, quality of care and utilization of services so as to positively impact the health status of the population, universal access to a package of cost-effective and evidence-based interventions detailed below is needed. This would of necessity require interventions that transform the way the health care system is resourced, organized, managed and services delivered.

HIGH IMPACT SERVICES
FAMILY/COMMUNITY ORIENTED SERVICES
Insecticide Treated Mosquito Nets for children under 5
Insecticide Treated Mosquito Nets for pregnant women
Household water treatment
Access to improved water source
Use of sanitary latrines
Hand washing with soap
Clean delivery and cord care
Initiation of breastfeeding within 1st hr. and temperature management
Condoms for HIV prevention
Universal extra community-based care of LBW infants
Exclusive Breastfeeding for children 0-5 mo.
Continued Breastfeeding for children 6-11 months
Adequate and safe complementary feeding
Supplementary feeding for malnourished children

Oral Rehydration Therapy
Zinc for diarrhea management
Vitamin A - Treatment for measles
Artemisinin-based Combination Therapy for children
Artemisinin-based Combination Therapy for pregnant women
Artemisinin-based Combination Therapy for adults
Antibiotics for U5 pneumonia
Community based management of neonatal sepsis
Follow up Management of Severe Acute Malnutrition
Routine postnatal care (healthy practices and illness detection)

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

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

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

Chapter 4: Resource Requirements

4.1 Human

Manpower in the health sector ranges from the high-level modern technology trained doctors to the community-oriented appropriate technology-based health workers and traditional practitioners. Each is endowed with skills required to operate in his jurisdiction.

The categories of workers are as follows:

a. The professional such as doctors, nurses, pharmacists / technicians / assistants, radiologists /radiographers /X-ray technicians, dentists / technicians / assistants, nutritionists (dieticians)
b. Management personnel such as administrators, planning officers
c. Community health workers
d. Clerical officers
e. Ancillary personnel
f. Traditional practitioners

The above workers constitute the 'Health Team'. However, a big gap exists between the professional and the community health workers. The former are usually officers with urban background and have had high formal education, while the latter are usually officers with rural background with minimum education. These workers enumerated above have had basic education in their respective professions and therefore are equipped with the basic skills required to execute their functions. But with the ever-increasing demand for health care and introduction of new technology in the system, the skills acquired become inadequate or obsolete rendering them ineffective and unproductive. The adverse effect of this is deterioration in the provision of health care to the citizenry, which leads to increase in mortality and morbidity rates in the State.

Chapter 5: Financing Plan

The budget expenditure allocated to health in the 2009 budget was 6% of the total budget which is about N4.3 billion out of N77.34 billion of the State budget.

Sources of fund allocated to health care delivery mainly come from the Federal Government of Nigeria and the developmental partnerssuch as World Bank, UNICEF, EU-PRIME, PEPFAR, GHAIN,and DFID. A meagre percentage comes from internally generated revenue.

5.1 *Estimated cost of implementing the strategic Plan*

Based on the per capital requirement of $34 for health care expenditure with 5% added to allow for inflation the total estimated financial requirement to implement the six –year strategic framework in Ogun state is about NGN **76,493,329,488** ***Naira only***. The breakdown of the costs according to Priority Areas is approximately as follows:

Table 2: Cost Estimates for Key Strategic Intervention Areas

S/No.	KEY INTERVENTION(PRIORITY AREAS	ESTIMATED COST
1	Leadership and Governance for Health	NGN 651,961,059
2	Health Service Delivery	NGN 38,860,872,296
3	Human Resources for Health	NGN 25,041,282,822
4	Financing for Health	NGN 8,859,806,236
5	National Health Information System	NGN 918,211,863
6	Community Participation and ownership	NGN 502,447,582
7	Partnerships for Health	NGN 583,841,406
8	Research for Health	NGN 1,074,906,224
	TOTAL	**NGN 76,493,329,488**

On an annual basis, adequate resource mobilization would be carried out within government and from Development Partners operational in the state.

Chapter 6: Implementation Modalities

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

The following will play various roles in the implementation of the plan:

The State Government will provide policy guidelines and direction as well as develop plans and programs to meet state and national goals and ensure the implementation of plans in line with national health policy guidelines.

Private Health care providers, including Faith-Based organizations will contribute to Health Service Delivery. They will be closely monitored.

Civil Society organizations including professional groups, and community groups and the media will help to promote accountability and transparency by constituting independent watchdog systems

Development partners will provide technical assistance and additional funding

Chapter 7 Monitoring and Evaluation

7.1 Proposed mechanism for monitoring and evaluation

Plans will be monitored and evaluated by the implementing departments and special units (inbuilt M & E) and a central M & E Unit (Planning Division, PRS Department).

There are two perspectives to monitoring and evaluation in the context of the SSHDP and its implementation process. First, it is important to monitor and evaluate the plan's operational elements (in this case, the required activities) that are essential ingredients in ensuring the successful implementation of the plan. Secondly, it is equally essential to monitor and evaluate programme outputs and impacts. The latter concerns measurable variables and changes in the health status of the population and the health services as a consequence of the implementation of the SHDP.

The major categories of indicators that are relevant for monitoring and evaluating the State SHDP include the policy and socioeconomic indicators as well as the health prevention and utilization indicators.

7.2 Types and sources of data

The sources of data for the monitoring and evaluation of the state of health of the population and the health system are:

a) disease and related reporting mechanisms
b) vital statistics, e.g. from the National Population Commission
c) sentinel surveillance, focusing on the monitoring of key health indicators in the general population or in special population
d) registries – mostly for monitoring the public health impact of non-acute diseases, e.g. exposure and work related registries may be particularly useful in tracking the health protection objectives
e) surveys – health demographic surveys
f) administrative and routine service data collection system

7.3 Categories of data

The four major categories of data are:

1. Input database

   Input refers to resources and requirements to create and enable the success of health programmes. They are the precedent actions that must be taken (invested) for the health system. They are not limited to physical inputs, but may also include provision of appropriate institutional arrangements, policy instruments and legislation.

2. Process database

   Process refers to a set of activities that must be undertaken or actions and rules and regulations that are required to take place. This may include for instance protocols for immunization, for collecting, storing, processing and making available health data, etc.

3. Output database

   Output database will concern itself to keeping the time-series data on activities completed in relation to set targets. An example is interval data on immunization status of children under 5 years of age. Another example is the efficiency of health intervention programmes, e.g. the eradication of poliomyelitis and the control of tuberculosis.

4. Outcome or impact database

   These are concerned with health status measures or indicators. An example is the level of morbidity and mortality for a given condition and specific target population, e.g. under-5 mortality rate, maternal mortality rate and prevalence of HIV/AIDS.

Overall statutory responsibility for monitoring, evaluating and reporting on SSHDP is vested in the Department of Planning, Research and Statistics (DPRS) of the State Ministry of Health. Health priority areas implementing agencies shall work in concert with the DPRS to establish a simple, flexible and acceptable monitoring and evaluation protocols.

7.4 Costing the Operational Monitoring and Evaluation Component and Plan

The department of PRS coordinates the entire monitoring and evaluation activities in the State. However each LGA and the PHCDB has seperate M&E units. The money allocated to the central M&E unit in the 2010 budget is N1,000,000 which is grossly inadequate for adequate data collection in the State. The HMIS will require at least 0.5% of the State health budget.

Chapter 8: Conclusion

The Ogun State SSHDP for the period 2010 to 2015 has been drafted with State-wide consultations. Intensive work has been done by the Reference group, Planning and Steering committees of the OgunSSHDP. The cooperation of the 20 LGAs of the State is appreciated.

Tools used in the preparation of this document include:

FMOH's NSHDP Framework 2010- 2015
Ogun State Health Bulletin (2006 Edition)
National Population Census (2006)
National Demographic and Health Survey (2008)

The FMOH NSHDP team provided guidance. The document is still subject to review.

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Appendix 1: Conceptual Definitions of Leadership and Governance

Stewardship: The WHO Health Report 2000 refers to stewardship as "function of a government responsible for the welfare of the population, and concerned about the trust and legitimacy with which its activities are viewed by the citizenry"[7] The concept of the stewardship role of government in health as stated above means: the way in which governments mobilize and spend revenues and make regulations and policies that deal with the issue of accountability and transparency in the health system, with specific regard to: (i) Oversight (ii) Financing (iii) Human and Physical Resources (Development and Utilization) (iv) Improvement of Performance (v) Promotion of the Health of the People (vi) Leverage of Health Program Implementation and Outcomes.

Governance: Governance for health is the exercise of economic, political and administrative authority to manage the country's health affairs at all levels – States and LGAs; as well as mechanisms, processes and institutions, through which citizens and groups articulate their interests, exercise their legal rights, meet their obligations and mediate their differences[8]. It includes formulation of Ogun State health policy and health strategic plans (defining the vision and directions), exerting influence through regulations and advocacy, collecting and using information, and accountability[9].

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

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Appendix 2: Details of Ogun State Strategic Health Development Plan

OGUN STATE STRATEGIC HEALTH DEVELOPMENT PLAN						
PRIORITY AREA						
Goals				**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Cost 2010-2015**
	Strategic Objectives			**Targets**		
		Strategies		**Indicators**		
			Activities	**None**		
LEADERSHIP AND GOVERNANCE FOR HEALTH						
1. Create and sustain enabling environment for health development						**651,961,058.77**
	1.1	**To provide clear policy directions for health development**		**All stakeholders are informed regarding health development policy directives by 2011**		**-**
		1.1.1	Institutionalize intergovernmental and intersectoral actions for improving health determinants	1. 80% of States and 50% of LGAs have developed and are following SHDPs by end of 2013 2. All States and 75% of LGAs have developed and are following SHDPs by end of 2015	Political inertia Lack of political will Rapid turn over of political appointees & technical leadership All levels of leadership will buy into development of SHDP	**-**
			1.1.1.1 Generate States and local consensus on the development and operationalization of the State strategic frame work	ii Existence of functional inter-governmental/inter-sectoral committees at federal , States & LGA levels		**-**
			1.1.1.2 Create intersecoral and intergovernmental steering committees for follow-up of progress on health determinants in line with the PHC & Secondary H.C			**-**
			1.1.1.3 Documents & present annual progress reports on improvement of health determinants at all levels			**-**
		1.1.2	Establish intra-sector mechanisms for policy synergy in the health sector	National Council on Health meets at scheduled 2 x per annum every year		**-**
			1.1.2.1 State Council on Health meets 1 x per year to consider and adopt health policies			**-**
			1.1.2.2 Technical Committees of the SCH will be established and meeting quarterly to discuss policy issues and develop recommendations for SCH			**-**

			1.1.2.3	Technical Committees of the SCH will be established and meeting quarterly to discuss policy issues and develop recommendations for SCH			-
			1.1.2.4	To establish ICC Committee & Epidemic Prepareness Committee to be made functional			-
			1.1.2.5	Other Health Related Committees to be inaugurated			-
		1.1.3	Identify and implement capacity building and reorientation/ initiatives for health policy development at all levels		80% of States and 50% of LGAs have institutionalised policy management processes by end of 2013	Availability of Progress reports	-
			1.1.3.1	Develop, publish and institutionalise framework for the formulation and implementation of adopted National Policies			-
			1.1.3.2	Hold Zonal training sessions with LGAs to explain and popularise the policy development frameworks			-
		1.1.4	Institute coordination mechanism for achieving policy synergy		80% of States have functional State Councils on Health by end of 2013	No of policy reviews and changes implemented as a result of policy reviews	-
			1.1.4.1	To ensure States to institute functional State Councils on Health (SCH)			-
			1.1.4.2	Hold annual reviews of health sector policies to align with changing priorities			-
			1.1.4.3	State councils on health to set up committees/teams to oversee the implementation of outcomes of policy reviews			
	1.2	**To facilitate legislation and a regulatory framework for health development**			**Health bill signed into law by end of 2009**		-
		1.2.1	Update/enforce Public health acts and laws in line with the PHC approach		1. Appropriate public health legislation passed and each accented to at all levels 2. Number of convictions for public health violations	Poor to no enforcement of legislations Non Cooperation of parliamentarian at al levels	-
			1.2.1.1	Review health legislation to ensure that gaps are filled in areas which need improvement			-
			1.2.1.2	Update/ Review public health acts and laws by involving parliamentarians			-
			1.2.1.3	Submit to parliament and advocate for enactment into law			-
		1.2.2	Revise/streamline roles and responsibilities of regulatory institutions to align with National Health Bill		Roles and responsibilities of regulatory bodies amended and appropriate		-
			1.2.2.1	Set up committees for review and alignment of regulatory bodies			-

			1.2.2.2	Amend roles and responsibilities of regulatory institutions			-
			1.2.2.3	Develop capacity of regulatory institutions to fulfill their roles and responsibilities			-
	1.3	**To strengthen accountability, transparency and responsiveness of national health system**			**80% of States and the Fed level have an active health sector 'watch dog' by 2013**		-
		1.3.1	To institute measure for ensuring effective decentralization of decision making in the health sector		1. 50% of States and 20% of LGAs have stakeholders forums by end of 2013 2. 50% of States and the FMOH have websites with regularly posted programme reports and updates by 2013	Same political agenda for health Leadership of all political platform accept that health is a right of every citizen Reduction in the level of corruption	-
			1.3.1.1	Institute stakeholders dialogue and feed back forum for enlisting input into health sector decision making			-
			1.3.1.2	Create platform for interaction/collaboration with health sector advocacy groups,partners and all stakeholders			-
			1.3.1.3	Empower beneficiary communities to manage & oversee their health projects and programmes			-
			1.3.1.4	Promote emergence of independent health sector watch dogs for leadership at all levels State & LGAs			-
			1.3.1.5	Provide access to information needed for independent evaluation of health sector			-
			1.3.1.6	Ensure autonomy of boards in hospitals			-
			1.3.1.7	Enabling environment for government to hold her self accountable for corruption Publish /put in public domain MoH and donors agencies budget			-
			1.3.1.8	Scale up leadership and management development			-
	1.4	**To enhance the performance of the national health system**			**1 Number of States and LGAs updating SHDP 2 Number of studies carried out to identify the gaps to be addressed 3 No of Sates and LGAs with costed SHDP**	**Various levels of government have capacity to update sectoral SHDP States may not respond in a uniform and timely manner**	-
		1.4.1	Update OSHDP to ensure integrated management and provision of comprehensive minimum health package		50% of States providing comprehensive minimum health package by 2013		-
			1.4.1.1	Set up a process for updating the SSHDP			-

			1.4.1.2	Update and cost SSHDP following a situation analysis showing the gaps to address			-
			1.4.1.3	Create an environment for effective implementation of the SSHDP at all levels of the health system			-
			1.4.1.4	Clarify roles and responsibility of various stakeholders			-
			1.4.1.5	Institute an external review mechanism of experts in health at each level			-
		1.4.2	Generate intelligence and ensure optimal utilization of health information for decision making		FMOH and 50% of States using health information from NHIMS for decision making by 2013		-
			1.4.2.1	To utilize existing data base			-
		1.4.3	Develop health leadership at LGA level / each LGA		1. 20% od LGAs have a Medical Officer of Health by 2013 2. 50% of LGAs have a Medical Officer of Health by 2015		-
			1.4.3.1	Ensure a Medical Officer of Health to provide competent leadership			-
			1.4.3.2	Develop training guidelines and a clear job description for LGA Medical Officers of Health			-
SERVICE DELIVERY							
2. To enhance the organization and management of health inputs and services towards a sustainable, equitable access to a continuously improving integrated quality health care for all the citizens of Ogun State							**38,860,872,296.15**
	2.1	**To provide an essential package of care**					
			2.1.1.1	Review, cost and implement the minimum package of care			
			2.1.1.2	Strengthen specific disease control programmes			
			2.1.1.2.1	**Strenghten TB Control**			
				To Establish a budget-line for TB, Buruli Ulcer& Leprosy Control at State and LGA level	TB, BU and Lep Budget line established at state and all LGAs by 2011		
				Training of General Health workers on management of TB,BU and Lep in line with National guideline.	At least 2 GHW trained in 30% of PHC and secondary HF annually		
				Provision of Diagnostic facilities , Lab reagent and materials for TBL services	All LGAs have min of 2 Labs by 2014		
				Printing of Recording and Reporting materials for TBL services	TB Cards, forms and registers are available at all levels		
				To promote behaviour change in the community such that 70% of adult population has correct knowledge of TB by 2012	(1)Jingles in Local languages developed and aired, (2)World TB and World Leprosy		

					day marked annually		
			2.1.1.2.2	**Strenghtening onchocerciasis control**			
				Monitoring and evaluation			
				Training of Health Workers			
				Training of Community Directed distributors in Endemic LGAs			
				Distribution of drugs			
				Review meeting at State, Zonal and National level			
				Data Collection			
			2.1.1.3	Provide Standard Operating Procedures (SOPs) and guidelines for service delivery at all levels			-
	2.2	**2.0 To increase access to health services**					-
		2.2.1	Improve geographical equity and access to health services				-
			2.2.1.1	Carry out a comprehensive mapping of health facilities at all levels			-
			2.2.1.2	Establish a functional and sustainable GIS of health facilities in the State			
			2.2.1.3	Develop a criteria for siting of new health facilities at LGAs / Ward Level			
			2.2.1.4.	Upgrade all existing substandard facilities, especially at the PHC level			
			2.2.1.5.	Establish and implement guidelines for outreach services			
			2.2.1.6	Create budget lines for the maintenance of health facilities			
			2.2.1.7.	Establish and implement task shifting			
		2.2.2	Ensure availability of medicines and equipment at all State and LGAs levels				-
			2.2.2.1	Review the essential drugs list. LGA should have their own drug system			-
			2.2.2.2.	Establish a system to ensure provision of essential drugs on a sustainable basis at State nad LGA levels			
			2.2.2.3.	Develop an equipment list for different levels of health facilities in line with the essential package of care. Task force be provided to enforce compliance in consultation with end-users.			
			2.2.2.4	Procure and distribute equipment			-
		2.2.3	Establish a system for the maintenance of equipment at State Level				-
			2.2.3.1	Enter into a post warranty maintenance agreement with manufacturers/supplies			-
			2.2.3.2	Create budget lines for the maintenance of equipment and furniture at the State and LGA facility Level			-
			2.2.3.3	Establish medical equipment and hospital furniture maintenance workshops across the State & LGA			-
			2.2.3.4	Explore public private partnership in maintenance of medical equipment and hospital furniture			-
		2.2.4	Strengthen referral system				-
			2.2.4.1	Mapping out referral centres			-
			2.2.4.2	Develop a network of PHC centres linked to secondary referral facilities for emergency care and other medical Emergency Obsteric			

			2.2.4.3	Establish and implement guidelines for two-way referrals			
			2.2.4.4	Provide logistics (transport) and communication facilities for referrals			
			2.2.4.5	Implement referral guidelines			
			2.2.4.6	Monitor the effectiveness and outcome of referrals			
		2.2.5.	Foster collaboration with the private sector health care providers				
			2.2.5.1.	Conduct mapping of all categories of private health care providers			
			2.2.5.2.	Develop guidelines and standards for regulation of their practice			
			2.2.5.3	Register the private health care providers & Update annually			
			2.2.5.4.	Develop guidelines for partnership, collaboration and outsourcing of services			
			2.2.5.5.	Organize training programs for the private health care providers & for different categories			
			2.2.5.6	Monitor performance of the private health care providers			
	2.3	**3.0 To improve the quality of health care services**					-
		2.3.1	Strengthen professional regulatory bodies and institutions				-
			2.3.1.1	Review and implement operational guidelines of all regulatory bodies at the State & LGA Level			-
			2.3.1.2	Build capacity of regulatory staff			-
			2.3.1.3	Monitor compliance with regulatory guidelines			-
		2.3.2	Adopt National quality management models				-
			2.3.2.1	3.2.1 Review available models and build consensus on model to adopt			-
			2.3.2.2	3.2.2 Develop quality assurance training modules			-
			2.3.2.3	3.2.3 Conduct training of trainers			-
			2.3.2.4	3.2.4 Cascade training to lower levels			
			2.3.2.5	3.2.5 Institutionalise and implement quality improvement initiatives			
			2.3.2.6	Adopt and implement Servicom guidelines for all levels of care			
			2.3.2.7	3.2.7 Train relevant staff on Servicom			
			2.3.2.8	3.2.8 Monitor implementation of Servicom			
		2.3.3.	Institutionalize integrated supportive supervision mechanism				
			2.3.3.1	Constitute supportive supervision teams at the State & LGA Level			
			2.3.3.2	Develop capacities of persons that will conduct supervision			
			2.3.3.3	Review tools for integrated supportive supervision. Institutionalize supervision for every Health Programme ensure provision of Adequate logistics. Transport & other logistics			
			2.3.3.4	Agree on modalities and frequencies of visits for support at all levels			
	2.4	**To increase demand for health care services**					
		2.4.1	Promote positive health care seeking behaviour				-
			2.4.1.1	4.1.1 Adopt the National behavioural change communications strategy for health			-
			2.4.1.2	4.1.2 Support local adaptation of the national strategy to reflect local realities			-

			2.4.1.3	4.1.3 Build human resource capacity for implementation of the strategy			-
			2.4.1.4	4.1.4 Provide budget lines for BCC at all levels			-
			2.4.1.5	4.1.5 Implement the BCC strategy			
			2.4.1.6	4.1.6 Monitor effectiveness of the BCC strategy			
		2.4.2	Promote healthy lifestyles for disease risk reduction				-
			2.4.2.1	Disseminate the Health Promotion Policy			-
			2.4.2.2	Implement the policy provisions at State & LGA Levels			-
	2.5	**To provide financial access to health services especially for the vulnerable groups**					
		2.5.1	Improve financial access for the poor and vulnerable groups				-
			2.5.1.1	Explore and scale up models for financial protection like vouchers, health cards, pre payment schemes			-
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							**25,041,282,821.74**
	3.1	**To formulate and implement comprehensive policies and plans for health workforce development within the context of National health policies and strategies**			**All States and LGAs are actively using adaptations of the National HRH policy and Plan by end of 2015**		
		3.1.1	To adapt the National HRH 2006 policy and Strategic plan at State and LGA levels to guide human resources for health development and to implement the plan		1. At least 1 State in each Zone with adapted and implemented HR Plans by end 2009 2. At least 5 LGAs per State with adapted and implemented HR Plans by end of 2011	Adaptation to be based on State peculiarities in order to be followed Usually policy changes with a change in Administration	
			3.1.1.1				
			3.1.1.2	Develop a training programme and material to train at least 1 State per Zone on how to customise the National HRH 2006 policy and Strategic plan			
			3.1.1.3	Prepare Programmes to train LGAs to costomize their own Health Programme			
			3.1.1.4	Assist at least 6 the States (one pilot per Zone) to prepare programmes to train LGAs to customise their own HR Plans			-
			3.1.1.5	Develop and promote a roll-out of the customisation of the National HRH policy and Plan by all States			-
			3.1.1.6	Develop and promote a roll-out of the customisation of the State HRH policies and Plans by all LGAs			-
			3.1.1.7				-
		3.1.2	Develop / Promote non-discriminatory recruitment policies at State and LGA levels specially for critically needed professionals, irrespective of their States of origin		At least 10 States have non-discriminatory recruitment policies for health	Political will to accept non-discriminatory policies in some States with low	-

					professionals by end of 2010	human resource capacity	
			3.1.2.1	Update federal policy on recruitment to ensure non-discriminatory recruitment of health personnel			-
			3.1.2.2	Develop a training programme and material to train all the LGA's on non-discriminatory recruitment policies			-
			3.1.2.3	Monitor non-implementation of non-discriminatory recruitment policies			-
	3.2	**To provide a framework and objectively analysing the HRH crisis in the country and implement and monitoring plans to address the crisis**			**The HR for Health Crisis in the country has stabilised and begun to improve by end of 20112**		-
		3.2.1	Reappraise the principles of health workforce requirements and recruitment at all levels		Number of Federal States/LGAs using WISN in health workforce recruitment		-
			3.2.1.1	Develop staffing norms based on workload to guide planning and use service availability and health sector priorities to determine staffing needs and introduce for utilization by Federal, State and LGA health service providers	Document on staffing norms based on workload (WISN) developed for ALL levels	Low capacity at LGA level to develop staff norms	-
			3.2.1.2	Set up a committee with State and LGA representation to develop principles of health workforce recruitment by the relevant bodies	Committee to develop principles of health workforce established		-
			3.2.1.3	Establish coordinating mechanisms towards mutual consistency in human resources for health planning and budgeting among the Ministries of Health, Finance, Education, Civil Service Commission, Regulatory bodies, Private Sector Providers, NGOs in health and other institutions	Functional coordinating mechanisms in place		-
		3.2.2	Develop a model to project the professional staff needs for the State, then liaise with Ministry of Education and training institutions to plan how to train sufficient graduates		Targets for key professional output have been set and agreed with training institutions by end of 2010		-
			3.2.2.1	Update and collect baseline data, consult professionals and examine international literature to identify appropriate health professional targets			-
			3.2.2.2	Adopt a model to project training and output requirements to provide for the health professional needs of the State			-
	3.3	**Strengthen the institutional framework for human resources management practices in the health sector**			**1. 50% of States have functional HRH Units by end 2010 2. 10% of LGAs have functional HRH Units by end 2010**		-

		3.3.1	Establish and strengthen HRH capacity in SMOHs and LG health departments with view to designing, implementing, evaluating, and reporting HRH components		Programme of strengthening HR departments implemented in FMOH and rolled out to SMOHs and LG Health Units	Challenge of acceptance of HRH unit in DPRS with the current Directorate of Human Resource or Personnel in the SMOH and FMOH	-
			3.3.1.1	Create HRH unit in the Health Planning department at SMOH			-
			3.3.1.2	FMOH HRH Unit to develop guidelines and training material for State and LGA HRH Units			-
			3.3.1.3	Motivate all LGAs to create HRH unit in the Health Planning departments			-
			3.3.1.5	Roll out the implementation and training of HRH Units in our States and LGAs			-
		3.3.2	Design and implement training programmes ot build technical capacity at all levels of the health sector and other relevant sectors for human resources, planning and management		1. Functioning HRH planning and management courses being run in at least 6 States by end of 2010 2. At least 200 graduates per annum from FMOH approved HRH planning and management courses by end of 2011		-
			3.3.2.1	Establish a training programme and manual for the training of managers in human resource planning and management from the health and other relevant sectors			-
			3.3.2.2	Identify existing training institutions that are willing and able to provide the training courses for HRH managemant and planning			-
			3.3.2.3	Train managers in human resource planning and management from the health and other relevant sectors			-
			3.3.2.4	Monitor training courses output on HRH managemant and planning			-
		3.3.3	Establish multi-sectoral HRH system for planning, management and development at Federal, State and Local Government level		1. Functioning Federal Intersectoral HRH Committee by end of 2009 2. Functioning State Intersectoral HRH Committees in at least 6 States by end of 2009 3. Functioning State Intersectoral HRH Committees in at all States by end of 2015		-

			3.3.3.1	Establish State level intersectoral committee to discuss issues of human resource for health and meet quarterly	No of functional intersectoral committees in place at Federal, State and LGA levels		-
			3.3.3.2	Promote the establishment of State level intersectoral committee to discuss issues of human resource for health			-
			3.3.3.3	Encourage LGAs to promote the establishment of LGA level intersectoral committee to discuss issues of human resource for health			-
		3.3.4	Promote proactive regular engagement with various professional groups so as to promote dialogue and harmony		1. Functioning Federal Health Professions Forum by end of 2009 2. Functioning State Health Professions Fora in at least 6 States by end of 2009 3. Functioning State Health Professions Fora in at all States by end of 2015	Dialogue to reduce the tension and rivalry among professional groups in health sector	-
			3.3.4.1	Establish a State level national forum for regular meetings of professional groups			-
			3.3.4.2	Conduct regular meetings of state representatives of professional groups with SMOH management			-
			3.3.4.3	Promote the establishment of State level fora for regular meetings of professional groups at State level			-
			3.3.4.4	Encourage the States to promote the establishment of LGA level fora for regular meetings of professional groups at local level			-
			3.3.4.5	Monitor the meetings that are taking place and the matters discussed and resolved at the State and LGA Health Professional Fora			-
	3.4	**To strengthen the capacity of training institutions to scale up the production of the health workforce which will include training a critical mass of multipurpose and mid-level health workers who will deliver promotive, preventive and curative health care**			**One major training institution per Zone producing health workforce graduates with multipurpose skills and mid-level health workers by 2015**		-
		3.4.1	Review and adapt relevant training programmes for the production of adequate number of community health oriented professionals based on national priorities		Training programmes of all health related institutions adapted to national priorities by 2012 academic year		-
			3.4.1.1	Meet with State Ministries of Health to devise a plan to meet all health related training institutions to discuss the adapt of curriculae for training programmes for national priorities			-

			3.4.1.2	Meet with all health related training institutions to discuss the adapt curriculae of training programmes for national priorities			-
			3.4.1.3	Ongoing discussions with all health related training institutions to monitor adaptation of training programmes for national priorities			-
		3.4.2	Review and refine the functions, mandates and responsibilities of professional regulatory bodies with a view to strengthening adequate production of various health professionals		1. Initial review of functions and mandates of all health professions regulatory bodies completed by end 2010 2. 50% of training institutions have amended curriculae for health professions by end 2011 3. 10% increased production of key auxiliary workers by end 2011		-
			3.4.2.1	Establish aprocess to review the functions and mandates of regulatory bodies on an ongoing process with the aim of strengthening adequate production and registration of health professionals to be undertaken by the FMOH	No of regulatory bodies with functions and mandates reviewed		-
			3.4.2.2	Establish or strengthen the regular monitoring process to ensure that training curricula and programmes are reviewed and appropriately accredited and that the regulatory bodies ensure that they reflect multi-tasking and task shifting as appropriate	No of training curricula and programmes reviewed by accrediting and regulatory bodies		-
			3.4.2.3	With the regulatory bodies and training institutions, review admission criteria for disciplines in response to HRH crisis in disadvantaged areas of the country	Number of disciplines with admission requirements reviewed in response to HRH crisis in disadvantaged areas	Potential risk of reducing quality of products from the training institutions	-
			3.4.2.4	Continuously review assessment conducted by training institutions to meet accreditation and professional requirement	No of training institutions at Federal and State levels assessed to meet accreditation and professional requirement		-
			3.4.2.5	Expand training of auxiliary cadres of HRH such as community health workers and multipurpose HW	Number of training centres established for the training of auxiliary cadres of HRH such as community health workers and multipurpose HW Number of training		-

					centres expanded for the training of auxiliary cadres of HRH such as community health workers and multipurpose HW		
			3.4.2.6	Promote the training and deployment of community based health care workers as appropriate	Number of community based health care workers trained at LGA level		-
		3.4.3	Improve health workforce training capacity and output based on service demand		1. Comprehensive data base of Health training instutional capacity (infrastructure, teachers, other resources) established and maintained by end of 2009 2. Incentive programme implemented for academic staff in 2011		-
			3.4.3.1	Map the capacity of for production of health care providers by training institutions in States			-
			3.4.3.2	Strengthen training institutions for production of health care providers in States based on need	Number of training institutions for production of health care providers set up at state level		-
			3.4.3.3	Conduct a survey to establish the requirements for infrastructure, teaching and learning materials and budget financial support for training institutions	Number and type of infrastructure, teaching and learning materials provided by training institution; Level of financial support provided for training institutions	Availability of fund in the context of global economic meltdown	-
			3.4.3.4	Promote the establishment of quality assurance units and education review units in all training institutions	Number of training institutions with quality assurance units and education review units established	Locating quality assurance unit in the institution may lead to variation in standards	-
			3.4.3.5	Establish an incentives and regular upgrading structure for academic staff so as to ensure their retention	Incentives and upgrading structures for academic staff established		-
			3.4.3.6	Develop and implement a reward system for training institutions to promote high quality standards and innovations		Reward system for training institutions with high quality standards and	-

						innovations established	
		3.4.4	Revitalization and periodic accreditation of all institutions involved in the training of health personnel		Training curricula of 50% of health professional training institutions reviewed for appropriateness and adapted by end of 2010		-
			3.4.4.1	Conduct a formal review of all training curricula of health professional training institutions to assess the appropriateness of training in the context of disease burden	Number of training institutions with training curricula reviewed	Information on burden of disease	-
			3.4.4.2	Establish horizontal communication and cooperation systems among accreditation bodies	Mechanisms for horizontal communication and cooperation among accreditation bodies established		-
			3.4.4.3	Strengthen regulatory bodies to enable them to establish and enforce professional standards	Number of regulatory bodies that have established and published professional standards		-
			3.4.4.4	Facilitate accreditation of eligible private sector health facilities to increase training opportunities for internship and post-basic training for all health professionals	Types and number of eligible private sector health facilities accredited for internship and post-basic training for health professionals	Ability of private health facilities to pay those on internship as in public health facilities	-
		3.4.5	Establish a programme to fund in-service training, human capital capacity building and Continuing Professional Development (CPD) by government and healthcare provider institutions and coordination of same by professional regulatory bodies		CPD programme implemented in at least one pilot State per Zone by end 2010		-
			3.4.5.1	Establish a process and the financial resources to sponsor candidates and bond them to return to serve for an agreed period after training	Number of candidates (with bond stipulations) sponsored for in-service training by type and by level		-
	3.5	**To improve system for management and performance of the health workforce; to improve recruitment, utilization, retention, task shifting and performance**					-
		3.5.1	Rationalize and align supply of health workforce to the priorities of the health sector				-
			3.5.1.1	Create a State database of Human Resources for Health	Database of Human Resources for Health in place	Collaboration with Ministry of Education to obtain list of products	-
			3.5.1.2	Develop and provide job descriptions and specifications for all categories of health workers	Job descriptions and specifications for all categories of	Reduces multitasking and	-

					health workers developed	flexibility in work performance	
			3.5.1.3	Collaborate in designating, refurbishing and equipping zonal colleges to cater for the special training needs of states within the zones in medical, paramedical, nursing and midwifery education	Number of zonal colleges designated for the special training needs of states within the zones in medical, paramedical, nursing and midwifery education Number of zonal colleges refurbished and equipped		-
			3.5.1.4	Promote the National Midwifery Scheme and the Community Midwifery Programme	National Midwifery Scheme in place Community Midwifery Programme in place		-
		3.5.2	Equitable distribution, right mix of the right quality and quantity of health human resources		5% increase in personnel employed in the public health services each year from 2010		-
			3.5.2.1	Develop and refine recruitment, selection and deployment of competent and capable staff to reflect organizational objectives and needs	Number of competent and capable staff recruited at Federal, State and LGA levels to reflect organizational objectives and needs	Ability to determine level of competence at the point of recruitment. Possession of certificate does not guarantee competence	-
			3.5.2.2	Monitor the deployment of professional staff to promote equity – in mix, needs and geographical space	Proportion of deployment of staff to institutions that show equity – in mix, needs and geographical space at all levels	Political will to take care of challenges to provide incentives for workforce in rural and disadvantaged areas	-
			3.5.2.3	States MOH to Collaborate with Federal institutions located in their states to leverage available human resource so as to expand service coverage and quality	Number of State MOH collaborating with Federal institutions located in their states to leverage available human resource	Number of State MOH collaborating with Federal institutions located in their states to leverage available human resource	-
			3.5.2.4	Design and embark on a campaign to encourage diaspora trained health professionals to return to the service to strengthen the human resource availability in the country	Number and type of professionals in diaspora harnessed to strengthen the human resource availability in the country	Number and type of professionals in diaspora harnessed to strengthen the human resource	-

						availability in the country	
		3.5.3	To develop and implement retention strategies including management of migration, development and implementation of bilateral and multilateral agreements to reverse and contain the crises		10% decrease in migration of personnel out of the public health services each year from 2010		-
			3.5.3.1	To develop and implement incentives to retain health workers particularly in deprived areas	Incentives to retain health workers established	Determination of incentives that is enough to retain workers in deprived areas	-
			3.5.3.2	Design and embark on a campaign to encourage retired trained health professionals to return to the service	Types and numbers of retired trained health workers contracted as per needs		-
			3.5.3.3	Develop and enter into bilateral and multilateral agreements with developed countries and others who poach professionals in order to limit the impact of brain drain		Ability to keep to the agreement because of the pull factor	-
		3.5.4	Motivation of the health workforce by the creation of incentives for health workers along with recognition of hard work and service, with emphasis on those that will attract and retain staff in rural and deprived locations		Workplace satisfaction improved by 5% per year from 2010		-
			3.5.4.1	Define performance incentives and management system and encourage the Federal parastatals, SMOHs & LGAs to implement.	Number of Federal, State and LGAs that have defined performance incentives and management system Number of Federal, State and LGAs that are implementing defined performance incentives and management system		-
			3.5.4.2	Develop guidelines and recommendations on additional incentives for health workers working in rural and deprived areas	Number of States and LGAs providing additional incentives for health workers working in rural and deprived areas		-
			3.5.4.3	Develop guidelines on what constitutes an enabling work environment and promote the compliance with the standards at States and LGAs	Number of Federal, State and LGA work places providing enabling work environment		-
			3.5.4.4	Establish mechanisms to minimize work place hazards through management of physical risks and mental stress as well as full compliance with prevention and protection guidelines	Number of Federal, State and LGA work places with mechanisms to minimize work	Involvement of associations and health personnel in identifying work place hazards	-

					place hazards Number of Federal, State and LGA work places that are fully compliant with prevention and protection guidelines		
			3.5.4.5	Intervene whereever possible to ensure that health workers are paid on time	Proportion of health workers at Federal, State and LGA levels that are paid on time		-
		3.5.5	Re-orientation of health workforce towards positive attitudinal change		More than 50% of helath service users report being treated with care, respect and dignity by end 2013		-
			3.5.5.1	Develop and promote a course for health providers to train health workers on Interpersonal Communication skills (IPC)	No of health workers at Federal, State, and LGA levels trained on Interpersonal Communication skills (IPC)		-
			3.5.5.2	Develop and promote a course for health providers to re-train health workers on work ethics	No of health workers at Federal, State, and LGA levels trained on work ethics		-
			3.5.5.3	Develop and institute a system of recognition, reward and sanction	Federal, States, and LGAs have instituted a system of recognition, reward and sanctions		-
		3.5.6	Develop a framework for and institutionalize supportive supervision		FMOH and 50% of States have institutions support programmes in place by end 2012		-
			3.5.6.1	Develop and work with LGAs to implement a framework for integrated supportive supervision	Federal, States, and LGAs have established framework for integrated supportive supervision		-
			3.5.6.2	Develop and provide guidelines and training to LGAs for routine supportive supervision	Federal, State and LGAs have deployed resources (tools, manpower, logistics, funds) for integrated supportive supervision deployed Integrated		-

					supportive supervision conducted		
		3.5.7	Develop and institute a system for mandatory deployment of newly qualified health workers to underserved rural areas (includes NYSC scheme for doctors, pharmacists, midwives and nurses)		Improved staffing of designated rural facilities by 5% per annum from 2011		-
			3.5.7.1	Establish and maintain database of fresh graduates of health professionals for one year mandatory health services in rural areas and for re-absorption and posting for services in rural areas respectively	Federal, State and LGAs have established database of fresh graduates of health professionals	Availability of enabling legislation	-
			3.5.7.2	Work with the SMOHs to ensure that facilities have accomodation and adequate professional supervision for deployed junior staff			-
		3.5.8	Establishment of mechanisms to strengthen and monitor performance of health workers at all levels		Each Zone has an active Peer Review panel for each registerable professional category by end 2011		-
			3.5.8.1	Collaborate with Local government: cross- state collaboration to encourage implementation and monitoring of Federal Government circulars, guidelines and policies	Federal, State and LGAs have instituted cross-state collaboration to encourage implementation and monitoring of federal government circulars, guidelines and policies States implementing federal government circulars, guidelines and policies		-
			3.5.8.2	Set up Peer Review structures and monitoring systems in the geo-political zones to effectively monitor professional practices	Federal, State and LGAs have set up structures and monitoring systems in the geo-political zones to monitor professional practices		-
		3.5.9	Develop and streamline career pathways for all groups of health professionals critically needed to foster demand and supply creation in the health sector (e.g health promotion)		New career pathways operational for all registerable helath porofessions by end 2013	Federal, State and LGAs are implementing the career pathway for all cadres of health professionals at all levels	-
			3.5.9.1	Define and streamline the career pathway for all cadres of health professionals at all levels	Federal, State and LGAs have defined and streamlined the career pathway for all cadres of health		-

					professionals at all levels		
			3.5.9.2	Implement the re-defined career pathways for all cadres of health professionals at all levels	Federal, State and LGAs are implementing the career pathway for all cadres of health professionals at all levels		-
	3.6	**To foster partnership and networks for stakeholders for joint ownership and harnessing contributions of all for the health workforce agenda**					-
		3.6.1	Develop and institutionalize forum for policy review, supervisory and monitoring support framework for private and public practitioners at all levels of health service delivery		All health practitioner policies professionally reviewed by end of 2013		-
			3.6.1.1	Joint policy review fora organized for private and public practitioners and meetings taking place quarterly	Number of joint policy review fora organized for policy review, supervisory and monitoring support framework for private and public practitioners at Federal and State levels and for all levels of health care delivery		-
		3.6.2	Strengthen communication, cooperation and collaboration between health professional associations and regulatory bodies on professional issues that have significant implications for the health system				-
			3.6.2.1	Promote quarterly meetings between management and staff of public and private sectors	Number of meetings between management and staff of public and private sectors as well as regulatory bodies and associations at Federal and State levels	Availability of a body to initiate and sustain collaboration among professional associations	-
			3.6.2.2	Promote bi-annual meetings between management and regulatory bodies and associations			-
HEALTH FINANCING							
4. 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							**8,859,806,236.26**
	4.1	**To develop and implement health financing strategies at Federal, State and Local levels consistent with the National Health Financing Policy**					
		4.1.1	Develop costed health financing strategic plans at Federal, State and Local levels		Federal and 60% of States and LGAs developed costed Health Financing Strategic Plans by mid 2010	Capacity of Governments at all levels to manage reforms improves	

			4.1.1.1	Create Health Financing Technical Working Groups at all levels			
		4.1.2	Implement the Strategic Plans at all levels		1. At least 1 State in each Zone has implemented a HSDP by end of 2009 2. 50% of States have implemented HSDPs by end of 2013		-
			4.1.2.1	Draft the Strategic Plans at all levels			-
			4.1.2.2	Build capacity for the development and implementation of the Strategic Plans at State & LGAs levels			-
	4.2	**To ensure that people are protected from financial catastrophe and impoverishment as a result of using health services**					-
		4.2.1	Develop social health protection mechanisms to cushion households from catastrophic cost of out-of-pocket expenditures on health services		40% coverage of the population by end of 2015 80% coverage of vulnerable groups by end of 2015		-
			4.1.3.1	Scale-up all Social Health Insurance programmes (formal, informal, and community-based) at all levels			-
			4.1.3.2	Develop and implement social health protection models (Free maternal and child health services, vouchers, Health Card, Exemptions) for targeting vulnerable groups such as children less than 5 years of age, pregnant women, TB and HIV/AIDS patients etc, to access essential services			-
			4.1.3.3	Re-orientate the NHIS to provide effective regulatory framework (rather than implementation) for Social Health Insurance and Protection Programmes			-
	4.3	**To secure a level of funding needed to achieve desired health development goals and objectives at all levels in a sustainable manner**			**Allocated Federal, State and LGA health funding increased by an average of 5% pa every year until 2115**		-
		4.3.1	Governments at all levels to allocate at least not less that 15% of their total budgets on health		1. Federal and 60% of States allocating 15% of budget on health by end 2015 2. 60% increase in non-salary share of recurrent public health expenditure in 60% of the States by end 2012 3. 60% increase in per capita total public expenditure on health at the Federal and 60%	National economic growth is not significantly affected despite global economic meltdown Efforts to tackle corruption begins to take effect	-

					State and LGA levels by end 2012		
			4.3.1.1	Secure statutory protection through LGA, State and National Assemblies to allocate 15% of budget to the health sector			-
			4.3.1.2	Ensure that 45% of the health budget is allocated to capital expenditure			-
			4.3.1.3	Ensure that 100% of the health budget is released			-
			4.3.1.4	Ensure that one tenth of the target 15% allocation (i.e. 1.5%) should be earmarked for social health protection programmes			-
			4.3.1.5	Ensure that 2% of the consolidated fund from the Federation Account is released for Primary Health Care as provided in the National Health Bill			-
			4.3.1.6	Ensure that 2% of the total health budget is allocated to research for health at all level			-
		4.3.2	Improve coordination of donor funding mechanisms to reinforce country efforts (e.g. SWAp, sectoral budget support)		Federal and 60% of States have functional donor coordinating mechanisms by end of 2010	No significantly substitution of Government resources with donor funds (high fungibility)	-
			4.3.2.1	Develop guidelines and recommendations for States to use for donor coordination			-
			4.3.2.2	Establish a mechanism for coordinating resources and resource management for health development			-
		4.3.3	10 % of VAT to be dedicated to social health protection programmes		10% of VAT allocated to social health protection programmes by end 2015	Strong political will and citizens support is obtained to make this happen	-
			4.3.3.1	Work with the FMOF and other key stakeholders to secure support for allocating a dedicated portion of VAT for social health protection programmes			-
			4.3.3.2	Draft a bill for the National Assembly to pass to secure 10% of VAT for social health protection programmes			-
			4.3.3.3	Get the National Assembly to pass a bill to secure 10% of VAT for social health protection programmes			-
	4.4	**To ensure efficiency and equity in the allocation and use of health sector resources at all levels**			**1. Federal, 60% States and LGA levels have transparent budgeting and financial management systems in place by end of 2015 2. 60% of States and LGAs have supportive supervision and monitoring systems**		-

					developed and operational by Dec 2012		
		4.4.1	Strengthen financial management skills (including competencies in budgeting, planning, accounting, auditing, monitoring and evaluation) at Local and State levels		100 managers graduated from accredited financial management training courses by end 2011		-
			4.4.1.1	Develop training material and accredit training institutions to deliver approved courses to strengthen financial management skills (including competencies in budgeting, planning, accounting, auditing, monitoring and evaluation) at Local and State levels			
			4.4.1.2	Conduct hands-on training for Health Management Teams on budgeting, planning, bookkeeping, monitoring and evaluation			-
		4.4.2	Institute credible mechanism for monitoring and evaluating resource availability, use and health outcomes at all levels		Federal and 60% of States have annually monitored NHAs by end of 2013		-
			4.4.2.1	Monitor the use of the annual health accounts at States and LGAs on an annual basis			-
			4.4.2.2	Develop and implement annual expenditure tracking, annual health accounts at all levels			-
HEALTH INFORMATION SYSTEMS							
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							**918,211,862.56**
	5.1	**To strengthen data collection using nationally standardised forms**			**1. 50% of LGAs making routine NHMIS returns to State level by end 2010 2. 60% of States making routine NHMIS returns to Federal level by end 2010**		
		5.1.1	Ensure that NHMIS forms are available at all health service delivery points at all levels		All public health facilities at all levels have NHMIS forms at all times from end 2010	Political will to allocate adequate funds	
			5.1.1.1	Adequate funding of NHMIS through budgetary provision for production of NHMIS forms at all levels	% of capital budget allocated to NHMIS		
			5.1.1.2	Ogun States will produce and distribute adequate numbers of NHMIS forms on a regular basis	Adequacy of forms at all facilities		-
		5.1.2	Periodic review of NHMIS data collection forms		NHMIS data collection forms and tools are reviewed and appropriately updated annually from 2009	Feedback will be used for review, otherwise users will cease sending feedback	-

			5.1.2.1	Create a mechanism for feedback from users on forms being used			-
			5.1.2.2	Annual review of data collection forms			-
		5.1.3	Coordinate data collection from linear programmes		1. Functional coordination committee in place by end 2009 2. M&E of all major linear programmes integrated into NHMIS by end 2010	Willingness of Agencies and partners to mainstream their data into NHMIS Avoid duplication of data captured by partners and HMIS	-
			5.1.3.1	Establish a committee for collaboration of Agencies and Partners in data management			-
			5.1.3.2	Integrate Programme M&E with NHMIS			-
		5.1.4	Build capacity of health workers for data management		20% of Federal and State health facilities have Health Information Officers by end of 2012		-
			5.1.4.1	Develop training material for sensitization and training on revised forms for health workers in public and private health facilities		Low interest of private sector in data reporting	-
			5.1.4.2	Monitoring the delivery of training workshops by the SMOHs to health workers in public and private facilities	No. of workshops monitored	Availability of funding and logistic support to monitor training	-
			5.1.4.3	Advocate for Federal and State MOHs to train and employ health information personnel for health facilities	% of Health facilities with Health Information Officers	Adequate budgetary provision to recruit health information officers	-
		5.1.5	Provide legal framework for activities of the NHMIS programme		Appropriate NHMIS laws and bye-laws promulgated by end 2011	Political will to promulgate enabling laws and bye laws Reporting of incorrect data to avoid sanctions	-
			5.1.5.1	Advocacy and sensitization workshop to policy makers on compulsory health data reporting	No. of advocacy visits and sensitization conducted		-
			5.1.5.2	Draft enabling NHMIS laws and bye-laws for promulgation by legislators	Availability of enabling laws and bye-laws		-
		5.1.6	Improve coverage of data collection				-
			5.1.6.1	The States will develop innovative strategies to collect data from all private and public health facilities	% of private and public health facilities reporting	Adequate forms made available to all facilities and need to follow-up with defaulting facilities	-
			5.1.6.2	The States will develop innovative strategies to collect data from communities	Quantity and quality of community based data collected	Demand for incentives by community based health workers	-

						before provision of data	
			5.1.6.3	Provide support to National Population Commission to improve birth and death registration	% of births and deaths from health facilities registered	Willingness of NPC to partner with the health sector	-
		5.1.7	Supportive supervision of data collection at all levels				-
			5.1.7.1	Advocate to SMOHs to provide appropriate logistics for officials to supervise data collection at lower levels	No. of supportive supervisory visits to lower levels	Availability of logistic support for supervision	-
	5.2	**To provide infrastructural support and computerisation of health databases and staff training**					-
		5.2.1	Strengthen the use of information technology in HIS				-
			5.2.1.1	FMOH to roll out use of software for data collection nationwide	Use of software at LGA, SMOH, Secondary and Tertiary health facilities	GSM networks companies in Nigeria can be used to advantage	-
			5.2.1.2	Pursue Public Private Partnerships in the management of a data warehouse	Level of PPP in data management	Sustenance of private sector participation with changing economic policies	-
			5.2.1.3	Promote the use of e-health (Electronic Management Intelligence Information System, websites, Patient Information System) widely	No. of states with active websites	Stability in power supply to sustain e-health	-
		5.3.2	Provision of HMIS Minimum Package at the different levels (FMOH, SMOH, LGA) of data management				-
			5.3.2.1	Advocate to Federal and State health managers to provide basic infrastructure for data storage, analysis and transmission (Computers, power supply, internet)	Basic infrastructure provided	Potential to misuse computers for activities unrelated to HIS	-
			5.3.2.2	Deployment and acquisition of database software at all levels	Database deployed to all levels		-
			5.3.2.3	Training Technical Staff at all levels on database software	No. of technical staff trained on use of software	Practice of moving trained health staff to areas where their training will not be useful	-
				Strenghten active search detective and timely reporting for diseases for eradication and elimination			
			5.3.2.4	States to provide adequate number of vehicles to support quaitative surveilance at State & LGAs			
	5.3	**To strengthen sub-systems in Health Information System**					-
		5.3.1	Strengthen Hospital Information System			Maintenance of HIS infrastructure support	-
			5.3.1.1	Develop guidelines and technical specifications for the establishment and strengthening of Patient information systems	No. of health facilities with effective Patient information System		-
			5.3.1.2	Develop guidelines and technical specifications for the establishment of disease mapping in States	Available of disease mapping at Federal and State levels		-
		5.3.2	Strengthen Disease Surveillance System			Early response to reported epidemics	-

						stimulate early reporting	
			5.3.2.1	Develop guidelines and implement a process for the regular reporting of notifiable diseases by all health facilities	Completeness and timeliness of disease notification		-
			5.3.2.2	Implement guidelines with all LGAs to strengthen community based surveillance	Availability of community based surveillance volunteers		-
	5.4	**To Monitor and Evaluate the NHMIS**					
		5.4.1	Establishment of monitoring protocol for NHMIS programme implementation at all levels in line with stated activities and expected outputs				-
			5.4.1.1	Encourage States to purchase appropriate support service vehicles to facilitate HMIS processes at all levels	No. of support vehicles purchased		-
			5.4.1.2	Train key SMOH officers and LGAs Officers in the use of the field monitoring checklist instrument for NHMIS programme	Monitoring conducted with checklist		-
			5.4.1.3	Promote the use of HMIS Quality Assurance (QA) Manual (Handbook) at each level of health care delivery	Quality of data prodced		-
			5.4.1.4	Encourage States to establish quarterly HIS review meetings at LGA level and Bi-annual review meetings at State level (Where HFs present data at LGA level and LGAs present data at State level)		Data presentation and review meetings will stimulate data collection	-
		5.4.2	Strengthening of data transmission			Support transmission with telecommunicatio n	-
			5.4.2.1	Establish and promote guidelines to ensure monthly and quarterly transmission of HMIS data	Timeliness of data transmission		
			5.4.2.2	Monitor monthly and quarterly transmission of HMIS data and evaluate the problems that prevent complete and regular transmission of the data			-
	5.5	**To strengthen analysis of data and dissemination of health information**					
		5.5.1	Institutionalize data analysis and dissemination at all levels			Availability of capacity to analyze data at lower levels	-
			5.5.1.1	Develop guidelines and a training programme on data analysis for use at all levels	No of health facilities with analyzed data		-
			5.5.1.2	Promote the use of data at all levels for informed decision making using pilot sites and specific examples	No. of decision made based on analyzed data		-
			5.5.1.3	Establish the infrastructure and process for regular production of the health data bulletin (electronic web-based and hard-copy print)	No. of bulletin produced		-
			5.5.1.4	Compile the Annual Report of the Director of Planning Research and Statistics at State and monitor Annual Reports at LGAs level	Reports of Director DPRS available		-
COMMUNITY OWNERSHIP AND PARTICIPATION							
6. To attain effective community ownership and participation in health development							**502,447,582.35**
	6.1	**To strengthen community participation in health development**					

		6.1.1	Provide an enabling policy framework for community participation				
			6.1.1.1	Update the policy framework for community participation as currently exists within the national health Policy	Updated policy available by end of 2009		-
		6.1.2	Provide an enabling implementation framework for community participation				-
			6.1.2.1.	Update guidelines for establishing community structures	Updated guidelines available by end of 2009		
			6.1.2.2	Promote the use of existing participatory tools for community involvement in planning and management	Proportion of communities mobilized using participatory tools		
			6.1.2.3	Establish intersectoral stakeholder committee to enhance collaboration at all levels	Number of intersectoral stakeholder committees established at each level by 2010		
	6.2	**To empower communities to play their roles**					
		6.2.1	Building community capacity				-
			6.2.1.1	2.1.1 Identify and map out key community stakeholders	Community stakeholders identified and mapped out by December 2009		-
			6.2.1.2	2.1.2 Assess the capacity needs of community stakeholders	Capacity needs of Community stakeholders identified by December 2009		-
			6.2.1.3	2.1.3 Establish key roles and functions of community stakeholders and structures	Key roles and functions established by December 2009		-
			6.2.1.4	2.1.4 Conduct orientation to community development committees, community resource persons (CORPS) on their roles and responsibilities	Number of orientation activities conducted for development committees by end of 2010		-
			6.2.1.5	2.1.5 Provide funding for community activities			-
			6.2.1.6	2.1.6 Establish dialogue between communities and government structures			-
	6.3	**To strengthen the community-health services interphase**					-
		6.3.1	Restructure and strengthen the community health services interphase				-
			6.3.1.1	Review the existing health delivery structures and assess their level of interphase with the community			-
			6.3.1.2	Develop guidelines for strengthening the community-health services interphase			-
			6.3.1.3	Restructure health delivery structures to ensure adequate promotion of community participation in health development			-
			6.3.1.4	Provide technical guidance and support to community stakeholders			-

			6.3.1.5	Facilitate exchange between and among communities			-
	6.4	**4.0 To increase national capacity for integrated multisectoral health promotion**					-
		6.4.1	4.1 Develop and implement multisectoral policies and actions that facilitate community involvement in health development				-
			6.4.1.1	Undertake advocacy to community gate keepers to increase awareness and support for the use of health promotion to facilitate their involvement in health development			-
			6.4.1.2	Review the national health promotion policies and strategies that underscore participation of communities in health across the State.			-
			6.4.1.3	Formulate action plans to facilitate the development of health promotion capacity and support at various levels linking health with other sectors			-
			6.4.1.4	Adopt health promotion guidelines or frameworks on community involvement			-
			6.4.1.5	Strengthen the health promotion component in priority health and health related programmes			-
			6.4.1.6	Empower communities with health knowledge, behavioural communication change and uptake mechanisms			
	6.5	**To increase research based strengthening of community participation**					-
		6.5.1	Develop and implement systematic measurement of community involvement				-
			6.5.1.1	Measure the impact of specific community approaches, methods and initiatives			-
			6.5.1.2	Disseminate and harness experiences amongst community stakeholders			-
PARTNERSHIPS FOR HEALTH DEVELOPMENT							
7. To enhance harmonized implementation of essential health services in line with national health policy goals							**583,841,406.19**
	7.1	**To ensure that collaborative mechanisms are put in place for involving all partners in the development and sustenance of the health sector**					
		7.1.1	Institutionalize a framework for harmonization and alignment of partner support at all levels				
			7.1.1.1		Federal and 60% of States have functioning Partners Coordinating Fora by mid 2010	Capacity to coordinate donor activities exist at all levels Development Partners are willing to harmonize their activities in line with national health priorities	-
				Develop guidelines and promote the establishment of Public Private Partnership (PPP) Units at all levels to oversee, promote and monitor all PPP initiatives.	Federal and 60% of States implementing PPP initiatives by mid 2012		

			7.1.1.2	Improve coordination with partners to establish and enhance support through mechanisms such as 'common basket funding', SWAp, Sectoral multi-partner budget support	Federal and 60% of States and LGAs have functional resource coordination mechanism by end of 2012	Nigeria continues to make progress to attract international development assistance	-
							-
			7.1.1.3	Promote the establishment of Inter-Ministerial (MDA) Fora at all levels to facilitate inter-sectoral collaboration	Federal and 60% of States and LGAs have Inter – MDA Fora for coordinating health actions		-
				Ensure that relevant MDAs are directly involved in the implementation of specific health intervention programmes e.g. Environment in Malaria control and prevention, Agriculture in nutrition programmes, Water Resources in control of water borne or related diseases and Information in many of the programmes involving Behaviour Change Communication (BCC)	Environmental control component of Malaria Programmes led by Ministry of Environment at Federal and 60% of States		-
			7.1.1.4	Develop mechanisms for incorporation of community, CSOs and other stakeholders views and inputs to planning, budgeting, and management systems	Federal and 60% of States and LGAs able to demonstrate that policies and strategies are informed and modified by participatory planning and performance feedback mechanisms by mid 2012	Long-term political stability communities re-engage with publicly managed health services	-
				Maintain partnership with CSOs to promote the concept of citizen rights and entitlement to quality, accessible basic health services	60% of the population with awareness of rights and entitlements available within the health system by end of 2012		-
				Enhance the capacity of citizens to prevent and manage priority health conditions themselves through appropriate mechanisms such as BCC, Social marketing, Public Awareness Campaign, IEC, etc	60% of mothers of children under 5 who know and follow the correct treatment for priority health conditions by Dec. 2012		-
RESEARCH FOR HEALTH							
8. To utilize research to improve evidence-based policy making so as to achieve nationally and internationally health-related development goals at local, state and federal levels							**1,074,906,224.22**
	8.1	**To sterngthen the stewardship role of governments at all levels for research, information and knowledge management systems**					**-**
		8.1.1	Finalise Health Research Policy at Federal level and develop health research policies and strategies at State and LGA				**-**
			8.1.1.1	Convene Technical Working Groups to finalise or develop health research policies and strategies	Establishment of Health Research	The political will at the Federal and	

				at the State and LGA level and encourage States to do the same	steering committees at all levels	sub-national levels and technical capacity exists to develop the policies and strategies	
			8.1.1.2	Develop and provide guidelines for the establishment of Health Research Steering Committees at all levels	Steering committees established by FMOH and 50% of states by 2011		-
			8.1.1.3	Monitor the activities of Health Research Steering Committees at all levels and eveluate their function and value			-
		8.1.2	Establish and or strengthen mechanisms for health research at all levels				-
			8.1.2.1	Provide technical assistance to develop and strengthen the capacity of health research divisions and units at all levels	DPRS of FMOH and 50% of SMOH and research units of LGAs staffed by appropriately qualified people	There are enough people willing to have a research work focus	-
			8.1.2.2	Provide technical assistance to strengthen DPRS at all levels and for creation of active research units in FMOH, SMOHs and LGAs	1 FMOH DPRS and at least 50% of SMOH DPRS either undertaking or actively collaborating in health research 2 FMOH and 50% of SMOH and local research units undertaking capacity building for staff on different aspects of health research	Governments at all levels and health research institutions provide enabling environment for collaborative research Political will and resources exist	-
		8.1.3	Institutionalize processes for setting health research agenda and priorities				-
			8.1.3.1	Implement the Essential National Health Research (ENHR) programme	ENHR undertaken annually the FMOH and 50% of all states and LGAs	Research capacity exists for ENHR	-
			8.1.3.2	Promote the expansion of the health research agenda to include broad and multidimensional determinants of health and ensure cross-linkages with areas beyond its traditional boundaries and categories			-
		8.1.4	Promote cooperation and collaboration between Ministries of Health and LGA health authorities with Universities, communities, CSOs, OPS, NIMR, NIPRD, development partners and other sectors				-
			8.1.4.1	Develop and disseminate guidelines for a collaborative research agenda	FMOH and 50% of SMOH and LGA health research units have developed guidelines for collaborative	Capacity exists to develop the guidelines	-

					research developed by 2011 at all levels		
			8.1.4.2	Establish a forum of health research officers at the FMOH and promote the same at SMOHs and LGAs	FMOH and 50% of SMOH and LGA research units have established credible forum for research officers	Existence of political and administrative will as well as willingness of different actors to form the forums at all levels	-
			8.1.4.3	Convene a multi-stakeholder forum to identify research priorities and for harmonization of research efforts	Annual multi-stakeholders research priority forum convened by FMOH and 50% of SMOH	Adequate resources exists as well as organisation sagacity	-
			8.1.4.4	Support development of collaborative research proposals and their implementation	Collaborative research proposals developed and undertaken		-
		8.1.5	Mobilise adequate financial resources to support health research at all levels				-
			8.1.5.1	Promote the designation of at least 2% of health budgets for health research at all levels	FMOH and 50% of stated allocate at least 2% of health budgets for research at all levels	Existence of political will by all arms of government and active cooperation of FMOF	-
			8.1.5.2	Encourage all health ministries to deploy mobilised funds for health research in a targeted manner	More than 80% of mobilised research funds used to undertake health research (human resources, financing, service delivery, ENHR etc) by FMOH, SMOH and LGA units		-
		8.1.6	Establish ethical standards and practise codes for health research at all levels				-
			8.1.6.1	Develop and promote guidelines on ethical standards for research in health		There are adequate qualified human resources willing to undertake the role	-
			8.1.6.2	Encourage the establishment of Ethical Review Committees at States and strengthen the ones at Federal level and in tertiary health and education institutions	Functional Ethical review committees established and strengthened at state and federal levels and in all tertiary institutions by 2011		-
			8.1.6.3	Establish mechanisms to monitor, evaluate and regulate research and the use of research findings at all levels	Directories of major researches and researchers established and evaluated annually	Researchers are willing to submit their studies to the directory	-

					at all levels from 2011		
	8.2	**To build institutional capacities to promote, undertake and utilise research for evidence-based policy making in health at all levels**					-
		8.2.1	Strengthen identified health research institutions at all levels				-
			8.2.1.1	Take inventory of all public and private institutions and organizations undertaking health research at all levels	Directory with special focus area listings of HR institutions and organizations established at FMOH and 50% of states by 2011	There are enough resources to produce the directory at all levels	-
			8.2.1.2	Conduct periodic capacity assessment of health research organizations and institutions	1. Bi-annual research capacity assessment of HR institutions 2. Number of researches undertaken identified	Resources exist to undertake the assessment	-
			8.2.1.3	Develop and implement measures to address research capacity gaps/weaknesses at all levels	20% increase in number of researches undertaken at all levels		-
			8.2.1.4	Mobilise extra funds from the private sector, foundations and individuals for health research	At least 5% of all development assistance earmarked for the health sector is deployed for health research and MOUs signed with the private sector		-
		8.2.2	Create a critical mass of health researchers at all levels				-
			8.2.2.1	Develop appropriate training intervention for research based on the identified needs at all level	50% increase in number of researchers undertaking research relevant for evidence-based policy making	Availability of resources	-
			8.2.2.2	Establish a fund and adjudication mechanism for provision of competitive research grants for prospective researchers	60 grants awarded annually by FMOH and states and LGA award at least 5 grants annually	Ditto and political will exists	-
			8.2.2.3	Motivate tertiary education institutions to increase PhD level enrolment and graduation in health through the awarding of PhD student scholarships	30 competitive PhD scholarships awarded annually	Political will exists	-
		8.2.3	Develop transparent approaches for using research findings to aid evidence-based policy making at all levels				-
			8.2.3.1	Establish mechanism for improving liaison and links between research users (e.g. policy makers, development partners) and researchers	One researcher-policy makers forum held annually at federal	Existence of political will and capacity to use research findings to aid	-

					and at least 50% of states and LGAs	evidence-based policy making	
			8.2.3.2	Involve wide range of actors including researchers in policy-making	Number of researchers involved in policy-making at all levels by 2011	Willingness of all the actors to work together and political will on the part of the research users to involve other actors in the policy making process	-
		8.2.4	Undertake research on identified critical priority areas already identified in different fora				-
			8.2.4.1	Establish a process for the bi-annual estimation of the burden of identified priority diseases	Biennial Burden of diseases computed at federal level and by 50% of the states	Existence of resources and political will by the government and development partners	-
			8.2.4.2	Undertake bi-annual studies into Human Resources for Health	Biennial HRH research conducted by the federal and 50% of the states		-
			8.2.4.3	Undertake bi-annual studies into health system governance (HSG)	Biennial HSG studies conducted by the federal and 50% of the states		-
			8.2.4.4	Conduct bi-annual studies into health delivery systems	Biennial Health system delivery studies conducted by the federal and 50% of the states		-
			8.2.4.5	Conduct studies on financial risk protection, equity, efficiency and value of different health financing mechanisms bi-annually	Biennial Health financing studies conducted by the federal and 50% of the states		-
	8.3	**To develop mechanisms for getting research findings into strategies and practices at all levels**					-
		8.3.1	Develop strategies for the identification of research findings and incorporation into strategies and practices				-
			8.3.1.1	Establish ways and means of getting research into strategies (GRISP) units at all levels	More than 50% of health strategies at all levels informed by research findings	Political will and capacity exists at policy-makers level plus existence of readiness by research producers to openly share their findings	-
		8.3.2	Enshrine mechanisms to ensure that funded researches produce new knowledge required to improve the health system				-
			8.3.2.1	Institute a State bi-annual Health Research Policy Forum and promote the same at State and LGA levels	Bi-annual Health Research-Policy forum held at federal and 50% of states and LGAs	Availability of resources	-

			8.3.2.2	Conduct needs assessment to inform required health research at all levels	Needs assessment conducted at Federal and at least 50% of the states and LGAs		-
			8.3.2.3	Promote and provide guidelines for annual operations research to be conducted by all Departments, Agencies and Parastatals in FMOH, SMOH and LG	Operations research undertaken by 60% of programmes in FMOH and in 50% of states and LGAs and used to improve programmes by 2011		-
	8.4	**To develop, implement and institutionalize health research communication strategies at all levels**					
		8.4.1	Create a framework for sharing research knowledge and its applications				-
			8.4.1.1	Develop and implement a framework for sharing research knowledge at all levels	Framework for sharing research knowledge developed by 2011	The skills and other resources for developing the framework exists	-
		8.4.2	Establish channels for sharing of research findings between researchers, policy makers and development practitioners				-
			8.4.2.1	Present an annual health conference at State and promote the same at LGA level	Annual health conferences held at Federal levels and in 50% of the states	Political will and resources are available	-
			8.4.2.2	Conduct annual seminars and workshops on key thematic areas (financing, human resources, MDGs, health research etc) at State level and promote the same at LGA level	Annual health workshops held at Federal levels and in 50% of the states		-
			8.4.2.3	Prepare guidelines and develop capacity of researchers to produce policy briefs	HR institutions produce and disseminate 100 policy briefs per year	Availability of appropriate learning resources and willingness of researchers to learn	-
			8.4.2.4.	Support a critical mass of national high quality health sector journals			
				Undertake inventory of national journals according to priority health areas	Directory of national journals established	Availability of resources and political will	-
				Select journals to be supported whose information address issues related to Essential National Health Research (ENHR) and have discussions with the editors	12 key journals selected	Having a transparent system for selection of the journals	-
				Review editorial boards of the selected journals and encourage them to become more transparent before FMOH endorses them	Editorial boards of the 12 key selected journals reviewed by 2011	Willingness of the selected journals to reform	-
				Link the journals to reputable publishers and northern collaborators so as to improve their quality	Journals linked to at least 3 reputable publishers	Production of high quality papers by researchers and willingness of reputable publishers to	-

						publish the journals	
				Circulate identified journals to FMOH, SMOHs and LGs regularly	Journals distributed (electronically and in print) quarterly to FMOH, SMOH, all LGAs, Development partners and other stakeholders	Availability of resources and a good distribution system	-
							76,493,329,488.24

Annex 2: Results/M&E Matrix for the Plan

OGUN STATE STRATEGIC HEALTH DEVELOPMENT PLAN RESULT MATRIX						
OVERARCHING GOAL: To significantly improve the health status of Nigerians through the development of a strengthened and sustainable health care delivery system						
OUTPUTS	**INDICATORS**	**SOURCES OF DATA**	**Baseline**	**Milestone**	**Milestone**	**Target**
			2008/9	**2011**	**2013**	**2015**
PRIORITY AREA 1: LEADERSHIP AND GOVERNANCE FOR HEALTH						
NSHDP Goal: To create and sustain an enabling environment for the delivery of quality health care and development in Nigeria						
OUTCOME: 1. Improved strategic health plans implemented at Federal and State levels						
OUTCOME 2. Transparent and accountable health systems management						
1. Improved Policy Direction for Health Development	1. % of LGAs with Operational Plans consistent with the state strategic health development plan (SSHDP) and priorities	LGA s Operational Plans	0	50	75	100%
	2. % stakeholders constituencies playing their assigned roles in the SSHDP (disaggregated by stakeholder constituencies)	SSHDP Annual Review Report	0	25	50	75%
2. Improved Legislative and Regulatory Frameworks for Health Development	3. State adopting the National Health Bill? (Yes/No)	SMOH	0	25	50	75
	4. % 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	5. % of LGAs which have established a Health Watch Group	LGA Annual Report	0	50	75	100
	6. % of recommendations from health watch groups being implemented	Health Watch Groups' Reports	No Baseline	25	50	75
	7. % LGAs aligning their health programmes to the SSHDP	LGA Annual Report	0	50	75	100

	8. % DPs aligning their health programmes to the SSHDP at the LGA level	LGA Annual Report	100	100	100	100
	9. % of LGAs with functional peer review mechanisms	SSHDP and LGA Annual Review Report	TBD	25	50	75%
	10. % LGAs implementing their peer review recommendations	LGA / SSHDP Annual Review Report	No Baseline	50	75	100%
	11. Number of LGA Health Watch Reports published	Health Watch Report	0	50	75	100
	12. Number of "Annual Health of the LGA" Reports published and disseminated annually	Health of the State Report	TBD	50	75	100%
4. Enhanced performance of the State health system	13. % LGA public health facilities using the essential drug list	Facility Survey Report	TBD	40	80	100%
	14. % private health facilities using the essential drug list by LGA	Private facility survey	TBD	10	25	50%
	15. % of LGA public sector institutions implementing the drug procurement policy	Facility Survey Report	TBD	50	75	100%
	16. % of private sector institutions implementing the drug procurement policy within each LGA	Facility Survey Report	TBD	10	25	50%
	17. % LGA health facilities not experiencing essential drug/commodity stockouts in the last three months	Facility Survey Report	TBD	25	50	75%
	18. % of LGAs implementing a performance based budgeting system	Facility Survey Report	TBD	25	50	75%
	19. 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

	20. 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	21. % 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%
	22. % health facilities implementing the complete package of essential health care	NPHCDA Survey Report	57	75	90	100%
	23. % of the population having access to an essential care package	MICS/NDHS	TBD	40	75	100%
	24. Contraceptive prevalence rate (modern and traditional)	NDHS	15%	30%	50%	75%
	25. Number of new users of modern contraceptive methods (male/female)	NDHS/HMIS	TBD	10%	20%	30%
	26. % of new users of modern contraceptive methods by type (male/female)	NDHS/HMIS	TBD	10%	20%	30%
	27. % service delivery points without stock out of family planning commodities in the last three months	Health facility Survey	TBD	10%	20%	35%
	28. % of facilities providing Youth Friendly RH services	Health facility Survey	TBD	20%	30%	40%

	29. % women 15-19 who have begun child bearing	NDHS/MICS	12%	10%	8%	5%
	30. % of pregnant women with 4 ANC visits performed according to standards*	NDHS	70%	85%	95%	100%
	31. Proportion of births attended by skilled health personnel	HMIS	51%	80%	100%	100%
	32. Proportion of women with complications treated in an EmOC facility (Basic and/or comprehensive)	EmOC Sentinel Survey and Health Facility Survey	TBD	25%	40%	50%
	33. Caesarean section rate	EmOC Sentinel Survey and Health Facility Survey	1.70%	3%	5.00%	10.00%
	34. Case fatality rate among women with obstretic complications in EmOC facilities	HMIS	TBD	25%	20%	15%
	35. Perinatal mortality rate**	HMIS	42/1000LBs	40/1000LBs	35/1000LBs	30/1000 LBs
	36. % women receiving immediate post partum family planning method before discharge	HMIS	TBD	10%	20%	30%
	37. % of women who received postnatal care based on standards within 48h after delivery	MICS	45%	50%	60%	65%
	38. % of newborn with infection receiving treatment	MICS	No Baseline	25%	35%	50%
	39. % of children exclusively breastfed 0-6 months	NDHS/MICS	17.60%	20%	25%	30%
	40. Proportion of 12-23 months-old children fully immunized	NDHS/MICS	23.10%	30%	45%	60%
	41. % children <5 years stunted (height for age <2 SD)	NDHSMICS	32.00%	25%	18%	10%
	42. % of under-five that slept under LLINs the previous night	NDHS/MICS	4.00%	10%	30%	45%

	43. % of under-five children receiving appropriate malaria treatment within 24 hours	NDHS/MICS	69.60%	80%	90%	95%
	44. % malaria successfully treated using the approved protocol and ACT;	MICS	5.60%	15%	30%	50%
	45. % of women who received intermittent preventive treatment for malaria during pregnancy	NDHS/MICS	5%	20%	50%	60%
	46. HIV prevalence in pregnant women	NARHS	2.30%	2.10%	1.90%	1.60%
	47.Condom use at last high risk sex	NDHS/MICS	3.10%	5%	10%	20%
	48. Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS	NDHS/MICS	26.50%	40%	40 - 90%	60 - 100%
	49. Prevalence of tuberculosis	NARHS	1.8%*	1.50%	1%	0.50%
	50.Death rates associated with tuberculosis	SMOH	6.90%	5%	3%	2%
	51. 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	52. % of staff with skills to deliver quality health care appropriate for their categories	Facility Survey Report	45%	60%	75%	77
	53. % of facilities with capacity to deliver quality health care	Facility Survey Report	58%	70%	85%	89%
	54. % of health workers who received personal supervision in the last 6 months by type of facility	Facility Survey Report	TBD	10%	20%	30%
	55. % of health workers who received in-service training in the past 12 months by category of worker	HR survey Report	25%	35%	45%	55%
	56. % of health facilities with all essential drugs available at all times	Facility Survey Report	53.60%	68%	85%	100%

	57. % of health institutions with basic medical equipment and functional logistic system appropriate to their levels	Facility Survey Report	53.60%	60%	75%	100%
	58. % 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	59. Proportion of the population utilizing essential services package	MICS	TBD	10%	20%	35%
	60. % of the population adequately informed of the 5 most beneficial health practices	MICS	TBD	25	40%	50%
PRIORITY AREA 3: HUMAN RESOURCES FOR HEALTH **NSHDP GOAL: To plan and implement strategies to address the human resources for health needs in order to ensure its availability as well as ensure equity and quality of health care**						
NSHDP GOAL: To plan and implement strategies to address the human resources for health needs in order to ensure its availability as well as ensure equity and quality of health care						
Outcome 6. The Federal government implements comprehensive HRH policies and plans for health development						
Outcome 7.All States and LGAs are actively using adaptations of the National HRH policy and plan for health development by end of 2015						
Output 8. Improved policies and Plans and strategies for HRH	61. % of wards that have appropriate HRH complement as per service delivery norm (urban/rural).	Facility Survey Report	TBD	10%	20%	30%
	62. Retention rate of HRH	HR survey Report	TBD	85%	90%	95%
	63. % LGAs actively using adaptations of National/State HRH policy and plans	HR survey Report	35%	40%	50%	75%
	64. Increased number of trained staff based on approved staffing norms by qualification	HR survey Report	TBD	10%	20%	30%
	65. % of LGAs implementing performance-based managment systems	HR survey Report	10%	20%	30%	50%
	66. % of staff satisfied with the performance based management system	HR survey Report	TBD	25%	45%	60%

Output 8: Improved framework for objective analysis, implementation and monitoring of HRH performance	67. % LGAs making availabile consistent flow of HRH information	NHMIS	65%	75%	88%	100%
	68. CHEW/10,000 population density	MICS	TBD	1:4000 pop	1:3000 pop	1:2000 pop
	69. Nurse density/10,000 population	NHMIS	1:11000	1:8000 pop	1:6000 pop	1:4000 pop
	70. 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
	71. Medical doctor density per 10,000 population	NHMIS	1:15000	1:8000 pop	1:7000 pop	1:5000 pop
	72. Other health service providers density/10,000 population	MICS	TBD	1:4000 pop	1:3000 pop	1:2000 pop
	73. HRH database mechanism in place at LGA level	HRH Database	TBD	20%	35%	50%
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	74. % of LGAs implementing state specific safety nets	SSHDP review report	TBD	25%	50%	75%
	75. Decreased proportion of informal payments within the public health care system within each LGA	NHA	80%	75%	70%	65%
	76. % of LGAs which allocate costed fund to fully implement essential care package at N5,000/capita (US$34)	State and LGA Budgets	TBD	10%	20%	30%
	77. LGAs allocating health funding increased by average of 5% every year	State and LGA Budgets	TBD	15%	30%	50%
Output 12: Improved efficiency and equity in the allocation and use of Health resources at State and LGA levels	78. LGAs health budgets fully alligned to support state health goals and policies	State and LGA Budgets	TBD	25%	40%	60%
	79.Out-of pocket expenditure as a % of total health expenditure	National Health Accounts 2003 - 2005	70%	60%	50%	40%
	80. % of LGA budget allocated to the health sector.	National Health Accounts 2003 - 2005	6 - 8%	10%	20%	30%
	81. Proportion of LGAs having transparent budgeting and finacial management systems	SSHDP review report	TBD	25%	40%	60%
	82. % 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	83. % of LGAs making routine NHMIS returns to states	NHMIS Report January to June 2008; March 2009	70%	100%	100%	100%
	84. % of LGAs receiving feedback on NHMIS from SMOH	STATE HMIS	0%	100%	100%	100%
	85. % of health facility staff trained to use the NHMIS infrastructure	STATE HMIS	100%	100%	100%	100%
	86. % of health facilities benefitting from HMIS supervisory visits from SMOH	STATE HMIS	0%	10%	20%	40%
	87.% of HMIS operators at the LGA level trained in analysis of data using the operational manual	STATE HMIS	100%	100%	100%	100%
	88. % of LGA PHC Coordinator trained in data dissemination	Training Reports	100%	100%	100%	100%
	89. % of LGAs publishing annual HMIS reports	HMIS Reports	0%	25%	50%	75%
	90. % 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	91. Proportion of public health facilities having active committees that include community representatives (with meeting reports and actions recommended)	SMOH	90%	100%	100%	100%
	92. % of wards holding quarterly health committee meetings	HDC Reports	60%	75%	85%	100%
	93. % HDCs whose members have had training in community mobilization	HDC Reports	70%	80%	90%	100%

	94. % increase in community health actions	HDC Reports	TBD	10%	25%	50%
	95. % of health actions jointly implemented with HDCs and other related committees	HDC Reports	TBD	25%	40%	60%
	96. % of LGAs implementing an Integrated Health Communication Plan	HPC Reports	TBD	25%	40%	60%
PRIORITY AREA 7: PARTNERSHIPS FOR HEALTH						
Outcome 14. Functional multi partner and multi-sectoral participatory mechanisms at Federal and State levels contribute to achievement of the goals and objectives of the						
Output 15: Improved Health Sector Partners' Collaboration and Coordination	97. Increased number of new PPP initiatives per year per LGA	SSHDP Report	TBD	25%	40%	60%
	98. % 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	99. % of LGAs partnering with researchers	Research Reports	TBD	10%	25%	50%
	100. % of State health budget spent on health research and evaluation	State budget	TBD	1%	1.50%	2%
	101. % of LGAs holding quarterly knowledge sharing on research, HMIS and best practices	LGA Annual SHDP Reports	TBD	10%	25%	50%
	102. % of LGAs participating in state research ethics review board for researches in their locations	LGA Annual SHDP Reports	TBD	40%	75%	100%

	103. % 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	104. % LGAs aware of state health research communication strategy	Health Research Communicatio n Strategy	TBD	40%	75%	100%