KATSINA STATE GOVERNMENT

STRATEGIC HEALTH DEVELOPMENT PLAN

(2010-2015)

Katsina State Ministry of Health

March 2010

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Acknowledgement

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

Vision and Mission of the Strategic Plan

Vision

"To provide quality and equitable healthcare to the people of the state without any form of discrimination in order to accelerate achievement of the MDGs and sustain economicdevelopment"

Mission Statement

"To develop and implement appropriate policies and programs as well as undertake other necessary actions that will strengthen the state health system to be able to deliver effective and sustainable quality health care to the people"

Executive Summary

Katsina State was created out of old Kaduna State on 23rd September 1987. It has a land mass area of 24,517 sq km and a projected population of 6,143,080 (2006). Katsina State shares common boundaries with Zamfara State on the West, Jigawa State on the East, Kaduna State on the South and an international boundary with the Republic of Niger on the North. Administratively, the State is divided into 34 Local Government Areas, 361 political wards and seven health zones Katsina State has two Emirates Councils namely Katsina and Daura. The State is homogenous and predominantly inhabited by the Hausa/Fulani. Islam is the major religion among the citizens.

The state ministry of health has three other important arms; the State Primary Health Care Development Agency (bridging the gap between PHC and secondary level), the Hospital services management board responsible for hospitals and State College of Health Sciences which is responsible for training of Mid-level Health cadre. The policy and regulatory functions are done by the SMOH, while the LGAs have the mandate of providing PHC services to the communities the state PHC Development Agency co-ordinates, collaborates and supervises the Local Governments.

The total population is about 6 million, of which 4% are infants, 20% under 5s, and 22% are women between the ages of 15-49. Important health indices related to the state are Neonatal Mortality Rate 55/1,000 live births; IMR 114/1,000 live births; U5MR 269/1,000 live births; MMR 1,000/100,000 live births; Total Fertility Rate of 7. The fully immunized child (FIC) is below 5% from the 2006 NICS, and vaccine preventable diseases remain major causes of childhood morbidity and mortality. The state has one of the highest MMR in the country and efforts are directed at addressing this problem. It has 1,427 health facilities, 21 general hospitals and 22 CHC. ANC attendance is about 55% but delivery in HF by skilled attendants is about 10%. There are 480 midwives and 981 nurses in the state with one each in some LGAs. The main occupation of the people of thestate is farming and cattle rearing.

The present administration has provided visionary leadership and shown a lot of political commitment to ensuring all indigenes of the State benefit from quality health services e.g. free medical care, mobile ambulance services to the hard to reach rural areas. A lot has been achieved, however there are still constraints.

The priority constraints to delivery of health services in the State have been stratified along the following coverage determinants:

i. **Availability of Commodity**: Weak procurement process, Inadequate funds, Lengthy bureaucratic processes
ii. **Availability of Human Resources**: Poor recruitment policy, Low institutional capacity for training and re-training of personnel
iii. **Accessibility**: Several routine distribution Health Facilities are not well maintained / not functional,
iv. **Initial and Continuous Utilization:** Very low awareness level, Poor IPC skills and attitude
v. **Effective Coverage:** Poor health seeking behavior and low awareness level

The SSDHP has provided a State wide framework for streamlining all health activities in Katsina State. It has however found it imperative to identify among these activities, certain priority, low cost and high impact interventions that are particularly targeted at meeting the 7 point Agenda and Millennium Development Goals. They have been categorized under three main service delivery modes listed below:

a. Family/Community Oriented Services: LLIN for children under 5 and pregnant women, Household water treatment and 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, EBF for children 0-5 mo, Continued BF for children 6-11 months, Adequate and safe complementary feeding, Supplementary feeding for malnourished children, ORT, Vitamin A supplementation, ACT for malaria treatment, Antibiotics for U5 pneumonia, Follow up Management of SAM, Routine postnatal care.
b. Population Oriented/Outreaches/Schedulable Services: Family planning, Antenatal Care, Meningitis immunization, Prevention and treatment of iron deficiency anemia in pregnancy, (IPTp) for malaria in pregnancy, preventing mother to child transmission (PMTCT), Cotrimoxazole prophylaxis for HIV+ adults, Measles immunization, BCG immunization, OPV immunization, DPT immunization, Hepatitis B immunization.
c. Individual/Clinical Oriented Services: Basic emergency obstetric care (B-EOC), Normal delivery by skilled attendant, Antibiotics for Preterm/Prelabour Rupture of Membrane (P/PROM), Resuscitation of asphyxiated newborns at birth, Detection and management of (pre) eclampsia (Mg Sulphate).

The following strategies have been identified as imperative to redress the constraints in the health delivery process. They are stratified along the coverage determinants stated below:

a. Availability of Commodity: Advocacy to FMOH, state, LGAs for increased budgetary allocation and timely release of funds for the purchase of commodities, Strengthening the budgetary Implementation Monitoring Mechanism, Shortening the length of commodity procurement systems
b. Availability of Human Resources: Revision of recruitment policy, Institutionalize a periodic merit based recruitment mechanism that is based on need, Strengthening institutional capacity in the State for training/retraining (upgrade training institutions)
c. Accessibility: Strengthening the Supervision, Monitoring and Evaluation mechanism, Strengthening of reward/incentive system to motivate workers, Strengthening / Privatizing maintenance of health infrastructure
d. Initial Utilization: Defining a Communication Strategy. Subjecting IEC materials to the proper message development process, Conduct a State wide Awareness Campaign as defined in the Communication Strategy
e. Continuous Utilization Community participation and ownership of health campaign activities through the involvement of Development Committees
f. Effective Coverage**:** Commissioning a major LLIN distribution campaign, Sustained Health Awareness Campaign, Training and retraining of distribution and health awareness personnel

The Strategic State Health Development Plan for Katsina State has done an item cost for activities listed in the thematic areas of its plan. Below is a summary presentation of each of the coasted thematic section:

The Katsina State government and Partners have developed an Annual Operational Plan for implementing the State Strategic Health Development Plan. It is therefore imperative that this Operational Plan be used as the basis for guiding all activities directed at achieving the State's goal of providing adequate, affordable and quality health service efficiently to all communities within the State.

The Katsina State Integrated Supportive Supervision Team was recently repositioned for effective supervision and monitoring of the entire health care provision in the state. Among their Terms of Reference is the responsibility of Supervising, and Monitoring the implementation of activities in the SSHDP and Evaluating its periodic and overall impact.

Chapter 1: Background and Achievements

1.1. *Background*

Katsina State was carved out of old Kaduna State twenty two years ago. It shares boundaries with Zamfara state to the West, Jigawa State on the East, Kaduna State on the South and International boundary with the Republic of Niger on the North. The State is divided into 34 Local Government Areas, 174 health districts and 54 administrative districts. The Local government Area is the closest to where people live and may be seen, as a point of linkage between local communities' needs and the National goals, policies and resources allocation.

Islam is the main religion of the people but there is a small percentage of Christians. Polygamy and early marriage are practiced. The state is homogenous and inhabited by predominantly Hausa and Fulani. Citizens from other parts of the nation as well as some expatriates also inhabit the state. Hausa is the predominant language, however a small number of the people speak English.

The total Population is about 6 million, of which 4% are infants, 20% under 5s, and 22% are women between the ages of 15-49. The health indices of the population are below the acceptable levels necessary towards achieving the Millennium Development Goals. Important health indices related to the state are Neonatal Mortality Rate 55/1,000 Live Birth; IMR 114/1,000 Live Birth; U5MR 269/1,000 Live Birth; MMR 1,000/100,000 Live Birth; Total Fertility Rate 7. The fully immunized child (FIC) is below 5% from the 2006 NICS, and vaccine preventable diseases remain major causes of childhood morbidity and mortality. There are episodes of outbreaks in vaccine preventable diseases in the state. Undoubtedly, the state has one of the highest MMR in the country and efforts are directed at this problem.

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, inadequate and mal-distribution of health work force and weak coordination amongst key players.

1.2. *Achievements*

The achievement s of the state health sector will be divided into various areas for emphasis. As a whole these achievements have made health more accessible to the population and have provided care for the vulnerable population of women and children. The state has made progress in the control and or prevention of communicable and non-communicable diseases.

1.2.1. **Drugs supply and control policy**

There is quarterly release of funds for Free Medicare and under the scheme drugs are available for the following category of diseases and conditions

- Malaria
- ANC, delivery, and pregnancy related problems
- All drugs for treatments of children below the age of 5 years
- Accident cases within the first 48 hours
- Furthermore, subsidized drugs (by 25%) in the DRF is available
- Procurement of drugs based on essential drug list
- Effective collaboration with NAFDAC

1.2.2. **Disease Control Strategy**

1.2.2.1. Roll Back Malaria (RBM) initiative

This is a global strategy for malaria control that has been adopted by the FGN and is supported by the NGDO. The strategy focuses on:

- Prompt Management of cases

- Prevention of malaria with LLIN
- Use of IPT in pregnancy
- Health promotion and monitoring and evaluation
- Integrated vector management targeting different ecological settings with appropriate strategic components
- Capacity building and reorientation of relevant groups on the new treatment policies and record keeping
- Massive BCC targeted at various segments on environmental sanitation
- Multispectral partnership/collaboration and coordination

1.2.2.2. Rapid and sustainable increase in routine immunization coverage

1.2.2.3. Early/timely detection, diagnosis and response to epidemics

The state has malaria has the number 1 reason for HF attendance but low deaths are recorded because of the free ACT and health promotion activities by SPHCDA, SMOH, HSMB and state environmental protection agency (SEPA). In the last 3 years, the state has increased budgetary allocation to malaria control activities and with the support of partners such as DFID.

1.2.3. Coordinated efforts by the federal MOH and development partners

Partners (Pathfinder International, UNICEF, WHO, DFID/PRRINN, ACCESS, EU-PRIME, GHAIN, COMPASS etc) have been involved in the planning and implementation of the MDG interventions in the state. These include

- Reduction of disease burden from malaria, TB and HIV/AIDS
- Revitalizing of the PHC system to deliver the minimum package of care which include routine immunization
- Development of appropriate response to HIV/AIDS, malaria, TB (and other infectious diseases), and maternal mortality
- Promoting healthy lifestyles and consequently reduce risk factors for communicable and non-communicable diseases

1.2.4. Public Private Partnership (PPP) for Health

In the last decade, the state has continued to increase engagement with the private sector in order to improve access to health for the people. PPP has been employed in health planning, policy formulation and implementation of prioritized activities. There is increasing collaboration in awareness creation and compliance with the referral system.

1.2.5. Strengthening of secondary health care services

- Improved public spending on health care services particularly MNCH
- Provision of infrastructural facilities has been improved with the construction of two new women and children hospital. Furthermore, all maternity departments of hospitals have been upgraded.
- The on-going training of needed health personnel especially in midwives
- Rehabilitation/improvement of some HF with manpower and equipment
- Integration of reproductive health services into existing services
- Mandatory CME for HCW

1.2.6. Specific efforts in MCH

Katsina has one of the highest MMR in the country. Some of the issues associated with the high MMR involve the dominance of males in decision making regarding the health of women. The NGDO are collaborating with the state to reduce harmful traditional practices, delays in pregnant women and children seeking care at HF, reaching or receiving care at HF.

- Construction and upgrading of 39 HF to primary and CHC
- Integration of MNCH activities into existing HF

- Training and retraining of nurses and midwives in RH, IMCI, LSS, EOC, and EPC and VCT. Close to 200 HW have benefited from these trainings. There are about 250 medical students in Universities sponsored by the state while 27 doctors are in various post-graduate trainings in and outside the country.
- Intake into the school of midwifery has been drastically increased
- A modern VVF theatre have been constructed and fully equipped
- Training and kitting of 432 TBAs

1.2.7. **Mobile ambulance services and provision of other vehicles**

- At least two Ambulances in all the 21 General Hospitals
- Mobile Ambulances 34 in Number (one in each LGA)
- At least one Ambulance in 24 comp health centers
- Twelve No. emergency Ambulances at major high ways
- Numerous utility vehicles at state Min of Health and its paratatals

Chapter 2: Situation Analysis

2.1. Socioeconomic context

'Health is Wealth' goes the popular saying and 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.

The predominant occupation of the people is agriculture mainly farming of food and cash crops, and cattle rearing. The state population remains essentially rural with only 30% living in the urban area. The workforce is predominantly male. There is about 5% of the population in the service of the state and federal government. The out of pocket expenditure for health is not known and the average spending per family on health is also not specified.

2.2. Health status of the population

Rates (Zonal Data NDHS 2003)	
Neonatal Mortality Rate …….	55/1,000 Live Birth
IMR ……..	114/1,000 Live Birth
U5MR ……...	269/1,000 Live Birth
MMR …….	1,000/100,000 L Birth
Total Fertility Rate …….	7
HIV sero prevalence ……	3%
Life expectancy…….	55 years
Low birth weight……..	31.1%
No. of health facilities ……..	1427
Nutritional status of U5	
Wasting ……	17.3%
Under weight ……	35%
Stunting ……	36.9%
Vitamin A supplementation ……	70%
Iodization of salt ……	99%

2.3. Health services provision and utilization

Health services provision in Katsina is organized like in other parts of the country- into three levels of tertiary, secondary and primary levels. The federal government is responsible for the provision of tertiary services in Federal Medical centre, Katsina, while the state runs the secondary health care centers through the hospital services management board, and the SPHCDA which helps with coordination and technical support of PHC activities and partners' activities. The health facilities in the state are distributed over the LGAs and state capital as shown in the table below.

2.3.1. Summary of health facilities in the state

Total number of PHC	=100
Total number of Maternal and Child Health	=154
Total number of health Clinics	=518
Total number of Dispensaries	=460
Grand Total	**=1427**

2.3.2. Summary of human resource available for provision of services

This has been presented in the table 2. The table shows the dire shortage of midwives and nurses as well as doctors. Aside from this, there is mal-distribution of the available workforce evident by the large number of those in the urban area compared to the rural area despite the fact that 70% of the population live in rural area.

2.3.3. Recent Performance and Coverage of Services (utilization):

I. DPT3 Coverage in 2008 was …….. 85%
II. BCG Vaccination…….. 50.4%
III. OPV 3…….. 58.5%
IV. Measles vaccination…… 95.7%
V. Pregnant women receiving ANC…….. 66%
VI. Skilled Health attendance at delivery…….. 35%

Table 1: KATSINA STATE 34 LGAs HEALTH FACILITIES BY CATEGORY AND OWNERSHIP AS AT DEC. 2007

S/N	LGAs	OWNERSHIP	General Hosp	CHC	MCHC	PHC	H/C	Dispensary	H/POST	PRIVATE	BEDS
1	DAURA	ST/ LGA/ PRIV	1	1	7	0	5	0	0	3	317
2	Baure	ST/LGA	1	0	6	0	34	0	0	0	134
3	Maiadua	ST / LGA	0	1	4	0	24	1	0	0	93
4	Sandamu	ST /LG FG	0	1	4	1	19	0	0	1	115
5	Zango	ST /LG / FG	0	1	6	I	1	22	0	0	154
6	DUTSAMMA	ST/LG/FG/PRIV	1	1	0	7	1	29	2	3	206
7	Batsari	ST/LG/ FG/	1	0	10	5	6	53	0	1	148
8	Danmusa	'ST/ LG/FG/PRI	1	1	0	3	0	28	0	0	168
9	Kurfi	ST/LG/FG/	1	0	1	2	23	0	1	0	351
10	Safana	ST/ LG/FEPRIV	0	1	6	4	2	12	1	0	234
11	FUNTUA	ST/ LG/FEPRIV	1	1	1	6	8	5	13	10	424
12	Dandume	ST/ LGA/ PRIV	0	1	5	0	9	16	0	2	
13	Faskari	ST/LG/ FG/	0	1	2	3	5	39	0	1	582
14	Sabuwa	ST/LG/Fed/Priv	0	1	1	5	24	0	1	0	412
15	Katrina	ST/ LG/ FG/PRI	4	0	12	1	19	3	1	17	656
16	Batarawa	ST/LG/FG/	1	1	0	2	12	31	0	1	407
17	Jibia	ST/ LGA/ PRIV	1	0	3	4	1	31	2	1	
18	Kaita	ST / LGA	0	1	3	2	24	2	0	0	168
19	Rimi	ST/LG/FG/	1	0	3	5	3	18	0	0	107
20	KANKIA	ST/LG/FG/PRIV	1	0	6	4	8	10	5	1	236
21	Ingawa	ST / LGA	1	0	6	1	32	0	19	0	236
22	Kusada	ST/ LGA/ PRIV	0	1	6	6	21	0	0	0	920
23	Musawa	ST/ LG/FG/PRI	1	0	4	1	52	0	0	0	244
24	Matazu	ST/LG/Fed/Priv	0	1	4	3	23	0	0	0	88
25	MANI	ST/ LG/ FG	1	0	9	4	11	0	14	0	187
26	Bindawa	' "	0	1	5	4	3	37	0	0	288
27	Charanchi	ST/LG/FG/	0	1	8	3	0	37	0	0	89
28	Dutsi	ST / LG / FG	0	1	15	2	7	5	0	0	700
29	Mashi	ST / LG / FG.	0	1	6	2	33	0	0	0	152
30	MALUMFASHI	ST/ LGA/ PRIV	2	0	1	7	33	0	14	6	427
31	Bakori	ST/ LG/FEPRIV	0	1	4	5	46	0	16	2	186
32	Danja	ST /LGA /	0	1	0	2	3	35	0	0	189
33	Kafur	ST/ LG/ Fed/Priv	0	1	1	2	7	35	4	0	385
34	Kankara	ST/LG/Fed/Priv	1	0	5	4	19	11	9	1	177
	TOTAL		**21**	**22**	**154**	**100**	**518**	**460**	**102**	**50**	**9180**

Table 2: CURRENT HEALTH RESOURCES: PER CADRE PER LGA.

N		DOCTORS	MID WIVES	NURSES	JCHEW	CHO	CHEW	EHO	EHA	LAB TEC	PHARM	PHARM TEC	DSA	DS
	Daura	4 +1NYSC	3	2	27	4	83	32	14	5	0	0	4	10
	Baure	0	1	1	34	4	45	13	9	0	0	2	4	4
	Mai,adua	1NYSC	2	4	18	3	57	13	13	1	0		3	3
	Sandamu	1	4	2	11	3	45	19	4	1	1NYSC	0	2	1
	Zango	1	4	9	41	5	35	43	24	7	0	4	6	6
	Dutsin ma	3	4	48	8	4	20	18	3	5	1	5	2	4
	Batsari	2	10	14	56	5	35	34	16	3	0	12	2	1
	Danmusa	3	7	27	21	6	24	2	13	3	0	3	2	3
	Kurfi	1	2	24	9	2	40	12	10	3	0	4	0	1
	Safana	1	2	2	2	2	44	29	15	4	0	2	2	0
	Funtua	9	35	81	21	3	56	7	10	8	2	17	7	8
	Dandume	3	1	1	25	5	35	2	5	5	0	0	2	2
	Faskari	3	2	3	15	6	45	35	6	8	0	3	5	0
	Sabuwa	0	2	6	33	9	46	25	14	9	0	9	10	0
	KATSINA	123	295	490	20	28	132	26	27	42	7	**27**	0	0
	Batagarawa	9	12	62	42	6	119	24	22	10	1	5	3	5
17	Jibia	2	1	0	10	6	43	24	23	3	0	2	2	0
	Kaita	1 NYSC	**2**	2	46	7	43	13	6	2	0	1	2	1
	Rimi	2	3	24	9	2	30	21	16	4	1	4	2	4
	KANKIA	4	13	21	13	4	82	12	40	4	1	4	4	8
	Ingawa	0	2	3	27	6	41	24	16	2	0	2	6	7
	Kusada	0	1	0	13	5	26	5	11	0	0	0	0	0
	Musawa	2	6	8	6	1	40	0	6	5	1	3	3	0
	Matazu	0	2	7	7	2	37	10	6	2	0	1	2	0
	MANI	0	0	1	6	4	51	11	15	1	0	2	4	3
	Bindawa	3NYSC	3	0	50	3	63	32	53	9	1NYSC	3	3	1
	Charanchi	2	4	5	11	2	24	10	1	4	2	2	1	2
	Dutsi	0	2	0	31	5	55	26	14	4	0	2	6	6
	Mashi	1 NYSC	5	5	28	2	43	21	24	3	0	4	6	6
	Malumfashi	14	35	79	64	5	73	19	28	25	4	15	14	0
	Bakori	2	10	13	47	8	76	13	19	9	2	4	4	4
	Danja	0	4	5	19	6	50	22	22	4	0	5	2	2
	Kafur	1	0	1	38	8	57	36	15	7	0	1	2	0
	Kankara	3	1	1	20	5	19	24	67	4	0	0	3	2
	TOTAL	191	480	951	828	176	1714	657	587	206	22	148	120	94

2.4. Key issues and challenges

2.4.1. Key issues

The main causes of mortality and morbidity in the state is from mainly preventable diseases which include malaria (70% of OPD attendance), diarrheal diseases and cholera, acute respiratory infections especially pneumonia, cerebrospinal meningitis and measles together with nutritional problems. Cases of severe acute malnutrition continue to be a problem in the state. Data from the facilities while not completely representative of the disease burden provides an insight into the main issues with regard to diseases.

Table 3: Main causes of death and illnesses

SN	Diseases	Incidence/1000pop	Case fatality/1000cases
1	Malaria	77	6
2	Diarrhea (without blood)	12	10
3	Diarrhea (with blood)	14	4
4	Measles	0.3	4
5	Pneumonia	8	NA
6	Gastro enteritis	2	15
7	Pertusis	0.6	4
8	Malaria in Pregnancy	5	3
9	STIs	1	0.2
10	CSM	0.1	66
11	HIV/AIDS (tested positive)	190	NA

Other major issues are related to maternal deaths which is associated with low utilization of the HF for delivery due mainly to socio-cultural and traditional beliefs. In a small percentage of women, deaths may be related to financial constraints, ignorance and service related constraints such as delays in provision of emergency care and referral of cases.

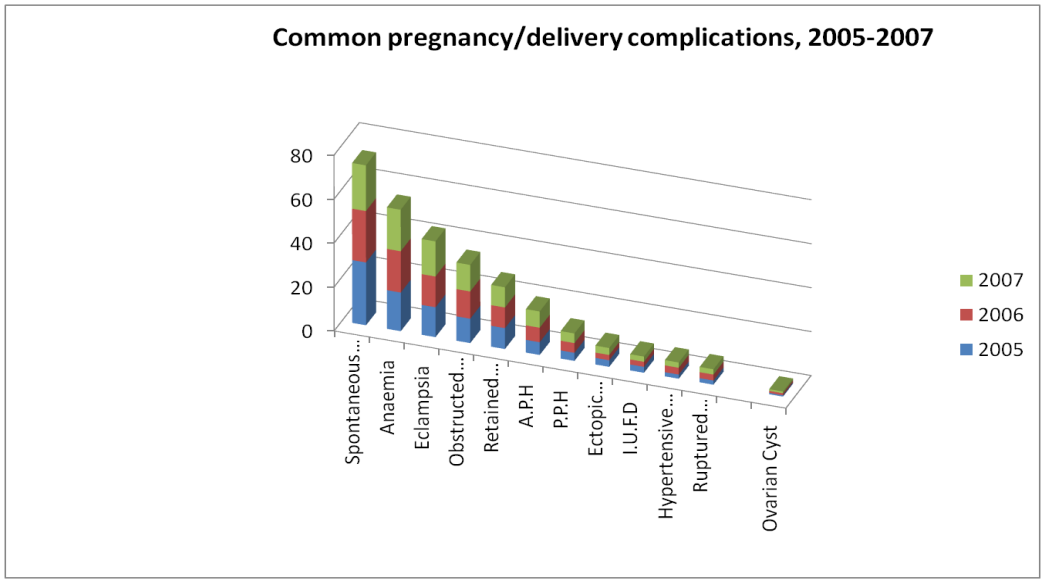
Immunization Coverage

Data quality surveys show that administrative coverage figures cannot be relied on and the only coverage survey figures we have are the National Immunization Coverage Survey (NICS). Immunization coverage according to NICS preliminary report issued 10Jan 2007 fully immunized figures are as shown below.

NAME OF STATE	CRUDE COVERAGE		VALID COVERAGE		VALID COVERAGE BY 52 WKS	
	(%) fully immunized by card or history	(%) fully immunized by card	(%) fully immunized by card or history	Percent (%) fully immunized by card only	(%) fully immunized with valid doses by 52 weeks of age (card or history)	(%) fully immunized with valid doses
KATSINA	21.3	4.5	8.8	1.9	2.2	0.5

CHILDREN 0 – 11 MONTHS IMMUNIZED (%) BY SPECIFIC ANTIGEN

Source: Immunization coverage from Katsina MOH administrative immunization data



Source: Katsina Maternity Department, General Hospital, Katsina is the largest, provided with fairly adequate resources and situated at the state capital.

2.4.2. Major difficulties/challenges in Health care provision:

The challenges in health provision are related to system failures and include

- Inadequate personnel especially Doctors and Mid-wives
- Inadequate Tutors in schools of The College of HealthSciences
- Low level of awareness among the rural populace among services and their benefits
- Low literacy level especially among women
- Poor health seeking behavior among the majority of the people
- Occasional outbreak of some diseases e.g. malaria, gastroenteritis, CSM, measles and Pertusis
- Limited funding at lower level
- Weak supervision due to inadequate capacity, logistic support and funding especially at LGA level

Chapter 3: Strategic Health Priorities

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 Katsina State towards achieving sustainable universal access and coverage of essential health services within the planned period of 2010 - 2015.

The Honorable State Commissioner for Health therefore expects all the stakeholders to embrace '*the use of this SHDP 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.

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

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

Pentavalent (DPT-HiB-Hepatitis b) immunization
Hib immunization
Hepatitis B immunization
Yellow fever immunization
Meningitis immunization
Vitamin A - supplementation for U5

C. INDIVIDUAL/CLINICAL ORIENTED SERVICES
Family Planning
Normal delivery by skilled attendant
Basic emergency obstetric care (B-EOC)
Resuscitation of asphyctic newborns at birth
Antenatal steroids for preterm labor
Antibiotics for Preterm/Prelabour Rupture of Membrane (P/PROM)
Detection and management of (pre)eclampsia (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

3.6. *Human resource*

The health human resource of the state is inadequate and the needs are enormous. The estimates for the population as it is available from the 2007 data is shown below

Health worker	Health worker/population ratio
Doctors	1/43,234
Pharmacists	1/157,009
Nurses/midwives	1/6,978
Laboratory technologists	1/170,467
Pharmacy technicians	1/75,523
Dental technologists	1/5,966,355

Those needed as tutors of nursing and midwifery-

3.7. *Physical requirements*

The College of Health Sciences has limited capacity for training nurses and midwives. The state plans to build another school of midwifery that will complement the 50 midwives that the state can currently train/ year. If the school is constructed and adequate tutors employed, the problem of inadequate skilled attendants at HF can be solved if they are properly distributed. Rehabilitation of facilities in hospitals and training institutions is ongoing and need to upgrade training facilities exist though this has yet to be well estimated

3.8. *Financial requirements*

In the last 5 years, the state increased its budgetary allocation to health by 190% from 2004. The approximately 6-10% allocation to health is below the recommended WHO 15% but above the national average of 5%. The budgetary allocation for health has been in the range of 3-3.5 billion naira. It is important to note that though amount allocated to health has been increasing in the state, the proportion of total budget has been decreasing in the last 5 years- 2004, 10.9%; 2005, 9.8%; 2006, 8.6%; 2007, 6.3%; 2008,2009 ?.

From the current SHDP, an average of 13.5 billion naira will be need over the 6 years of plan without accounting for contingencies and inflation over the plan period. It therefore means that Katsina should have adequate funds to implement the cost-effective strategies in the new plan. It must be mentioned that the budgetary allocation will be supported by donations from partners. However, donors support interventions in their focus areas such as MNCH and routine immunization which is actively supported by DFID/PRRINN in the state.

Chapter 5: Financing plan

5.1. Estimated cost of the strategic orientations

The Strategic State Health Development Plan for Katsina State has done an item cost for activities listed in the thematic areas of its plan. Below is a summary presentation of each of the coasted priority section:

Priority Area	Cost 2010-2015
Leadership and Governance for Health	434,001,273.13
Health Service Delivery	28,132,587,027.09
Human Resources for Health	12,038,933,355.65
Financing for Health	407,598,655.36
National Health Information System	651,001,909.70
Community Participation and Ownership	434,001,273.13
Partnerships for Health	434,001,273.13
Research for Health	868,002,546.27
Total	**43,400,127,313.48**

5.2. Assessment of the available and projected funds

It can be projected that about 3 billion will be made available and spent on health in the state annually. This will amount to 18 billion naira.

5.3. Determination of the financing gaps

The funding gap is NGN43.4 billion, which is the cost of the SHDP minus NGN18 billion which is the projected available funding. Thus the gap is NGN 25.4 billion for the period 2010-2015.

5.4. Descriptions of the ways of closing the financinggap

Chapter 6: Implementation framework

Katsina State and Partners have developed an Operational Plan for implementing the State Strategic Health Development Plan in 2010. It is therefore imperative that this Operational Plan be used as the basis for guiding all activities directed at achieving the State's goal of providing adequate, affordable and quality health service efficiently to all communities within the State.

6.1. Structures and institutions

6.1.1. Existing Services System:

i. Description of Health Service Organization:

- There exists the state min of Health who is saddled with the responsibility of stewardship of all the health services in the state.
-The state Primary Health Care Development Agency whose mandate is to provide technical support primary health care services across the state
- The health Services Management Board takes charges of the secondary care manage all general hospitals
- The State College of Health Sciences is responsible for training of Mid-level Health care cadre

ii. There exists a strong team for Integrated Supportive Supervision in the state

6.1.2. Private sector participants

The private sector though important has not become a major player in the health of the people in the state particularly because they are concentrated in the urban areas where just 30% of the populace lives. Nevertheless, they are important institutions that need to be given more encouragement to explore operations in the rural areas. They can be actively engaged in regulatory functions, capacity building, M&E, supportive supervision and community mobilization.

6.2. Strategic partners

6.2.1. Traditional and religious leaders

The successful engagement of the communities in Nigeria can be facilitated by the Traditional and Religious leaders and main players in an area. These are well respected leaders who are better trusted than the government workers when it comes to health services in Katsina. The two emirates- Katsina and Daura- are very well respected with large followership. These leaders and their followers can be reached and engaged as sustainable and strategic partners in a bid to upscale the cost-effective health interventions like LLIN and routine immunization. These leaders can be involved in leveraging of funds from the community for health financing.

6.2.2. Non-Governmental Development Organizations (NGDO)

The strategic role the NGDOs play in the health sector in Katsina state and Nigeria as a whole cannot be overemphasized. They are important in providing technical support and funding as well as logistic support to the sector. Partners in Katsina work in the major areas of maternal and child health as well as control of communicable diseases such as HIV and locally endemic diseases such as malaria. They recognize the low utilization of HF and low uptake for interventions in Katsina hence the inclusion of demand creation in the focus of many of the agenciesworking in the state.

6.3. Individuals and households

The interventions that are directed at individuals and households require them to accept and utilize the services. The understanding of the benefits of health services by the heads of households and individuals is cardinal to their health-seeking behavior. The overall low literacy level of individuals especially women has made it difficult to engage them on some key RH interventions that can improve MMR and the health of women and children as a whole. The decision making powers of the head of a household (HH) can impact negatively or positively on the health of the members of the household.
The socioeconomic status of individuals and HH also affects their ability to access certain health services due to cost.

6.4. Professional and regulatory bodies

They are stakeholders in ensuring that implementation of policies, guidelines and SOP are adhered to and appropriate sanctions are meted out to erring members of bodies in the health sector. They can also be of importance in providing technical assistance to HW when new guidelines and SOPs are introduced.

Chapter 7: Monitoring and Evaluation

Katsina State Integrated Supportive Supervision Team was recently repositioned for effective supervision and monitoring of the entire health care provision in the state. Among their Terms of Reference is the responsibility of Supervising, and Monitoring the implementation of activities in the SSHDP and Evaluating its periodic and overall impact using an updated ISS checklist. ISS activities in the state occur monthly and at least each HF is visited by the team several times in a year depending on logistic support. ISS is also one of the important points of collaboration between public and private practitioners, NGDO and the community. All these people can play major roles in M&E.

Chapter 8: Conclusion

This SSHDP has the potential to transform the health system of the state and improve the dismal health indices in maternal and child health. The effective monitoring of the implementation will be a major determinant of its success in achieving the set objectives.

Annex 1: Participants for the development of the strategic plan

MEMBERS OF THE STATE PLANNING COMMITTEE

SN	Name	Organization	Designation
	Dr Tanimu Gidado	PS (MOH)	Chairman
1	I A Saulawa	DPRS (MOH)	Secretary
2	Dr Maawiya Aliu	DPHC (SPHCDA)	MEMBER
3	Alh Halliru Idriss	DPH (SMOH)	"
4	Mohamed Abdullahi	Dir Planning (SMOF)	"
5	Mohamed Kabir Barau	DDP (SMOF)	"
6	Safiyanu Maikano	Provost (SHS)	"
7	Dr Bashir Abdullhi	DMS (HSMB)	"
8	Tijjani Umar	ADP (SMOF)	"
9	Lawal Sule Kuro	PSON 9NGO)	"
10	Abba Sada Dikko	DNS(SMOH)	"
11	Jibrin Garba	SIO(SPHCDA)	"
12	Umar yusuf	DDPHC(SPHCDA)	"
13	Ibrahim Yusuf Kurfi	DPHC (LGA)	"
14	Ibrahim M Kaita	ADF(SMOH)	"
15	Kabir Lawal S/Kuka	REP DEP OF LGA/Chieftaincy AFFAIR	"
16	Dr. Aisha Abdulkarim	FMOH, Consultant	Consultant

STATE STRATEGIC HEALTH DEVELOPMENT PLANNING STEERING COMMITTEE

SN	Name	Organization	Designation
1	ALH Aminu Jamo Daura	Hon Com (SMOH)	Chairman
2	DR Tanimu Gidado	P Sec (SMOH)	Secretary
3	Dr Ahamad Mohamad Qabasiyu	Executive Chairman (SPHCDA)	
4	DR Ado Bwaka	WHO Katsina	
5	Dr Sam Bugri	PRRINN/ MNCH-DFID	
7	Dr Maawuyya Aliu	DPHC	
8	Alh Musa Adamu Funtua	Hon Com MOF LGA	
9	Moh Abdullahi	Dir Planning SMOF	
10	Hajia Mrs. Nasiru	P Sec MOWAF	

Annex 2: Details of Katsina State Strategic Health Plan

KATSINA STATE STRATEGIC HEALTH PLAN 2010 - 2015							
PRIORITY AREA							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Cost 2010-2015**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
LEADERSHIP AND GOVERNANCE FOR HEALTH							
1. To create and sustain an enabling environment for the delivery of quality health care and development in Nigeria							**434,001,171**
	1.1	**To provide clear policy directions for health development**			**All stakeholders are informed regarding health development policy directives by 2011**		**434,001,171**
		1.1.1	Improved Strategic Planning at Federal and State levels		All stakeholders are informed regarding health development policy directives by 2011		**383,757,137**
			1.1.1.1	Re-orient and strengthen human resources for strategic planning	100% of LGAs developed strategic health development plans by 2010		159,582,831
			1.1.1.2				50,895,497
			1.1.1.3	Organize sensitization meeting with relevant stakeholders on the need to have evidence based strategic planning			72,831,456
			1.1.1.4	Encourage LGA to decentralize the decision making process			13,925,008
			1.1.1.5	Institutionalize community feedback mechanism for decision making			86,522,345
		1.1.2	Strenghen regulatory function of government		By 2010 Health bill on Public-PP and non orthodox vendors have been sign into law		**10,179,099**
			1.1.2.1	Adapt PPP policies and plans in the states and LGAs in line with national policies			-
			1.1.2.2	Adapt and disseminate SOPs to guide service delivery and supportive supervision of health care workers			10,179,099
			1.1.2.3				-
			1.1.2.4	State should provide adequate support for regulatory units to be fully functional			-
			1.1.2.5	Foster collaboration between the public and private sector in regulatory function			-
			1.1.2.5	State to review, enact or update laws and acts on maternal, new born and child health			-
		1.1.3	Improving and maintaining Sectoral Information base to enhance performance		80% of the LGAs have functional M&E team by 2010		**40,064,935**
			1.1.3.1	Establish and update a database for health management information system	95% of ward development committees reactivated by 2011		40,064,935
			1.1.3.2	Outsource analytical work to institutions and other partners			-
			1.1.3.3	Expand analytical capacity of the state and LGA to use health information for better performance			-

	1.2	**To facilitate legislation and a regulatory framework for health development**			**Health Bill signed into law by end of 2009**		**-**
		1.2.1	Strengthen regulatory functions of government				**-**
	1.3	**To strengthen accountability, transparency and responsiveness of the national health system**			**80% of States and the Federal level have an active health sector 'watch dog' by 2013**		
		1.3.1	To improve accountability and transparency				
			1.3.1.1	The state and LGAs should decentralize decision making process			
			1.3.1.2	Institutionalize stakeholders dialogue with appropriate feedback			-
			1.3.1.3	Create platform for interaction with health sector advocacy groups and improve access to information			-
			1.3.1.4	Empower communities for adequate participation in health programmes			-
			1.3.1.5	Promote independent health sector watch-dogs			-
	1.4	**To enhance the performance of the national health system**			**1. 50% of States (and their LGAs) updating SHDP annually 2. 50% of States (and LGAs) with costed SHDP by end 2011**	**Various levels of government have capacity to update sectoral SHDP States may not respond in a uniform and timely manner**	**-**
		1.4.1	Improving and maintaining Sectoral Information base to enhance performance				**-**
HEALTH SERVICE DELIVERY							
2. To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare							**28,132,587,027**
	2.1	**To ensure universal access to an essential package of care**			**Essential Package of Care adopted by all States by 2011**		**2,487,905,832**
		2.1.1	Essential health service package				**2,468,375,703**
			2.1.1.1	To review, cost, disseminate and implement the integrated minimum service package			5,814,664
			2.1.1.2	Strengthen control programmes for communicable diseases			510,058,210
			2.1.1.3	Strengthen control programmes for non-communicable diseases			9,563,591
			2.1.1.4	Strengthen interventions for maternal, new born and child Health			1,305,366,475
			2.1.1.5	Strengthen intervention management of Severe acute malnutrition			-
			2.1.1.6	Develop and distribute Standard Operating Procedures, Guidelines and Job Aids			637,572,763
		2.1.2	To strengthen specific communicable and non communicable disease control programmes				**7,650,873**
			2.1.2.1	Establish standing committee for the control of communicable diseases			7,650,873
			2.1.2.2	Establish agency for the control of infectious diseases including HIV/AIDS, TB and STIs			-
			2.1.2.3	Establish committees for the control of non-communicable diseases especially Diabetes and Hypertension			-

			2.1.2.4	Establish the State Core Technical Committee for Maternal, Newborn and Child Health			-
			2.1.2.5				-
		2.1.3	To make Standard Operating procedures (SOPs) and guidelines available for delivery of services at all levels				**11,879,256**
			2.1.3.1	Develop SOPs and guidelines for use by facility health care workers			4,335,495
			2.1.3.2	Build capacity of health workers to adequately use the SOPs and guidelines			3,208,266
			2.1.3.3	Institutionalize the review of the SOPs and guidelines by experts			-
			2.1.3.4	Disseminate essential SOPs and guidelines to end users			4,335,495
	2.2	**To increase access to health care services**			**50% of the population is within 30mins walk or 5km of a health service by end 2011**		**25,644,681,195**
		2.2.1	To improve geographical equity and access to health services		Health facilities mapped across the state and GIS established		**141,770,680**
			2.2.1.1	Mapping of health facilities and establishing GIS for all health facilities in the state		**Poor funding**	-
			2.2.1.2	Developing criteria for siting of new health facilities at all levels in the state and LGAs			140,648,551
			2.2.1.3	Upgrading and refurbishment of all substandard health facilities especially PHCs in the state	**Substandard health facilities upgraded**		-
			2.2.1.4	Development of guidelines for outreach services and ensure adherence in implementation			1,122,128
			2.2.1.5	Develop budget line for maintainance of health facilities			-
		2.2.2	To ensure availability of drugs and equipment at all levels		Essential list for drugs and equipment		**25,502,910,516**
			2.2.2.1	Ensure availability of drugs and equipment at all levels in the state		**Funds may be a limiting factor for procurement of drugs and equipment**	12,751,455,258
			2.2.2.2	Review state essential drugs list and strenghten the system for sustainanble Supply Chain Management			5,100,582,103
			2.2.2.3	Develop/Review an equipment list for different level of health facilities in line with integrated minimum service package			-
			2.2.2.4	Procure and distribute equipment based on need			5,100,582,103
			2.2.2.5	Ensure availability of diagnostic reagents for all prevalent diseases eg meningitis			2,550,291,052
		2.2.3	To establish a system for the maintenance of equipment at all levels		Medical equipment and hospital furniture workshop		**-**
			2.2.3.1	Adapt, disseminate and implement national health equipment policy in the LGA and state		National health equipment policy may not be in place for the state to adapt	-
			2.2.3.2	Create budget line for the maintenance of equipment and furniture at all levels in the state			-

			2.2.3.3	Establishment of medical equipment and hospital furniture maintenance workshops across the state			-
			2.2.3.4	Explore public private partnership in maintenance of medical equipments and hospital furniture			-
			2.2.3.5	Strengthen capacity for installation and maintenance of medical equipment and hospital furniture			-
		2.2.4	To strengthen referral system		Transportation and ccommunication for referrals		-
			2.2.4.1	Map network and build capacity for two-way referral system in line with national standard		**Funds may be limiting factor**	-
			2.2.4.2	Develop and establish system for transportation and other logistics for referrals			-
			2.2.4.3	Ensure adequate access to communication facilities at all levels			-
			2.2.4.4	Establish and institutionalize a system to monitor referral outcome			-
			2.2.4.5	Update the data on referral linkages on a regular basis			-
		2.2.5	To foster collaboration with the private sector		Strong and effective PPP		-
			2.2.5.1	Map all categories of private health care providers by operational level and location		**Cooperation from the private sector may be limited as for them time is money**	-
			2.2.5.2	Develop guidelines and standards for regulation of their registration and practice in the state			-
			2.2.5.3	Development of guidelines for partnership, training and outsourcing of services			-
			2.2.5.4	Adapt the national policy on traditional medicine			-
			2.2.5.5	Integrate Private Sector in Policy development and implementation			-
	2.3	**To improve the quality of health care services**			**50% of health facilities participate in a Quality Improvement programme by end of 2012**		-
		2.3.1	To strengthen professional regulatory bodies and institutions		Operational guidelines adapted and available regulatory bodies		-
			2.3.1.1	Adapt and implement operational guidelines of all regulatory bodies at all levels in the state		Operational guidelines might not be available	-
			2.3.1.2	Strengthen the capacity of regulatory staff to monitor compliance		Budget line might be lacking	-
			2.3.1.3	Create budget line for regulatory bodies			-
			2.3.1.4	Strengthen regular monitoring exercises with appropriate documentation and feedback			-
			2.3.1.5	Provide necessary security to empower regulators			-
		2.3.2	To develop and institutionalise quality assurance models		QA models and training modules		-

			2.3.2.1	Review and adopt QA models		QA models may not be existing and training modules not developed	-
			2.3.2.2	Develop QA training modules to build capacity of public and private health care providers			-
			2.3.2.3	TOT to be conducted and cascaded to other health workers			-
			2.3.2.4	Institunationalise and implement quality assuarance and improvement initiative at all levels in the state			-
			2.3.2.5	Adopt SERVICOM guidelines, build institutional capacity and train staff for implementation at all levels			-
		2.3.3	To institutionalize Health Management and Integrated Supportive Supervision (ISS) mechanisms		Number of health managers trained on ISS		-
			2.3.3.1	Strengthen the managerial capacities of health workers		Lack of funds may hinder development of ISS tools and guidelines	-
			2.3.3.2	Review ISS tools and guidelines specifying modalities and frequencies of ISS visits			-
			2.3.3.3	Institutionalise comprehensive ISS at all levels in the state and develop capacities of programme managers on ISS mechanisms			-
	2.4	**To increase demand for health care services**			**Average demand rises to 2 visits per person per annum by end 2011**		-
		2.4.1	To create effective demand for services		Number and % accessing health SDP		-
			2.4.1.1	Adapt, disseminate and implement a national health promotion communication strategy		Absence of national health policy	-
			2.4.1.2	Provide budget line for behavioural change communication		Failure to have budget line	-
			2.4.1.3	Institutionalize bi-annual MNCH Weeks			-
	2.5	**To provide financial access especially for the vulnerable groups**			**1. Vulnerable groups identified and quantified by end 2010 2. Vulnerable people access services free by end 2015**		-
		2.5.1	To improve financial access especially for the vulnerable groups		Models for financial protection		-
			2.5.1.1	Develop and establish models for financial protection for the vulnerable groups			-
			2.5.1.2	Explore and scale up existing financial protection 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							**12,038,933,356**
	3.1	**To formulate comprehensive policies and plans for HR for health development**			**All States and LGAs are actively using adaptations of**		**61,144,743**

					the National HRH policy and Plan by end of 2015		
		3.1.1	To develop and institutionalize the Human Resources Policy framework				**61,144,743**
			3.1.1.1	Adopt the National HRH Policy and Strategic Plan	A State-specific policy on HRH document adopted for use by both state and LGAs by 2010.		35,526,144
			3.1.1.2	Review policy on recruitment, posting and retention of staff.			16,578,867
			3.1.1.3	Advocate for automatic absorption of female CHEWs, Midwives and Nurses			-
			3.1.1.4	Formulate policy on admission into training institutions to provide for geopolitical and gender consideration.			9,039,731
	3.2	**To provide a framework for objective analysis, implementation and monitoring of HRH performance**			**The HR for Health Crisis in the country has stabilised and begun to improve by end of 2012**		**723,178,504**
		3.2.1	To reappraise the principles of health workforce requirements and recruitment at all levels				**723,178,504**
			3.2.1.1	Review and analyze current State's HRH capacity and identifty gaps	State and LGAs HRH capacity established by 2nd Qtr 2010		-
			3.2.1.2	Develop Plan to bridge identified gaps in HRH			-
			3.2.1.3	Establish and update mechanism for projecting HRH requirements			723,178,504
	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**		**144,635,700,859**
		3.3.1	To establish and strengthen the HRH Units				**144,635,700,859**
			3.3.1.2	Establish a continuing education unit in all hospitals and the health zones.	All hospitals and zones organizing programs by their CEUs by 2011.		144,635,700,859
			3.3.1.3	Institutionalize human resource developmental achievements for career progression	A state-specific caree path operational by 2013		-
			3.3.1.4	Establish coordination mechanism for consistency in HRH planning and budgeting by PPP			-
	3.4	**To strengthen the capacity of training institutions to scale up the production of a critical mass of quality, multipurpose, multi skilled, gender sensitive and mid-level health workers**			**One major training institution per Zone producing health workforce graduates with multipurpose skills and mid-level health workers by 2015**		**12,038,933,356**

		3.4.1	To review and adapt relevant training programmes for the production of adequate number of community health oriented professionals based on national priorities				**12,038,933,356**
			3.4.1.1	Review training programs of Health training Institutions to reflect the State's priority	A state sensitive curriculum developed for each program by 2011		7,050,990
			3.4.1.2	Establish an additional School of Midwifery	A SoM established at Turai Yarádua Maternity Hospital by 2011		12,022,842,634
			3.4.1.3	Review the curricular of Community Health Workers and improve the MNCH component			4,519,866
			3.4.1.4	Review the Nursing and Midwifery Council's training curricula for Nurses and Midwives to address the peculiar issues in the state.			4,519,866
			3.4.1.5	Provide an abridgement program on MNCH for existing female Nurses and CHEWs			
			3.4.1.6	Identify and train middle-aged women resident in rural areas for training on home-based Life Saving skills.			-
		3.4.2	To strengthen health workforce training capacity and output based on service demand				**-**
			3.4.2.1	Obtain full accreditation for the 4 existing training Schools	Full accreditation for the four Schools achieved by 2nd Qrt of 2010.		-
			3.4.2.2	Recruit six Midwives annually for training as Tutors			-
			3.4.2.3	Provide ten VSOs' Tutors as bridge-gap strategy	All Schools meet Tutor:Student ratio as stipulated by 2013		-
			3.4.2.4	Upgrade physical and instructional facilities in the 4 Schools			-
			3.4.2.5	Advocate and establish mechanism for task shifting for MNCH			-
	3.5	**To improve organizational and performance-based management systems for human resources for health**			**50% of States have implemented performance management systems by end 2012**		**1,056,563,795**
		3.5.1	To achieve equitable distribution, right mix of the right quality and quantity of human resources for health				**36,882,104**
			3.5.1.1	Determine staffing needs using the minimum service package	Database established by 2010		18,441,052
			3.5.1.2	Establish HRH database			18,441,052
			3.5.1.3	Deploy doctors and other health workers on NYSC scheme and redeploy staff based on needs	60% 0f health facilities have adequate staff in the right mix by 2015		-
			3.5.1.4	Provide additional incentives for staff deployed to rural areas.			-
			3.5.1.5	Provide incentives for Private practitioners ready to operate in rural areas.			-
		3.5.2	To establish mechanisms to strengthen and monitor performance of health workers at all levels				**1,019,681,691**
			3.5.2.1	Establish a standard staff appraisal system that is holistic.	A Standard and functional staff		-

					appraisal system by 2010		
			3.5.2.2	Establish and properly fund 3 zonal inspectorate units cum continuing education units	3 zonal CEU and 5 hospital CEUs opened by 4th Quarter of 2010.		1,019,681,691
	3.6	**To foster partnerships and networks of stakeholders to harness contributions for human resource for health agenda**			**50% of States have regular HRH stakeholder forums by end 2011**		**62,374,146**
		3.6.1	To strengthen communication, cooperation and collaboration between health professional associations and regulatory bodies on professional issues that have significant implications for the health system				**62,374,146**
			3.6.1.1	Include members of Professional Associasions and regulatory bodies in all management and technical committees [PIE]	All Committees include a member each of professional associatioss.		62,374,146
			3.6.1.2			Inability to draw the appropriate staff for deployment	-
FINANCING FOR HEALTH							
4. To ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and consumption at Local, State and Federal levels							**407,598,655**
	4.1	**To develop and implement health financing strategies at Federal, State and Local levels consistent with the National Health Financing Policy**			**50% of States have a documented Health Financing Strategy by end 2012**		**161,062,376**
		4.1.1	To develop and implement evidence-based, costed health financing strategic plans at LGA, State and Federal levels in line with the National Health Financing Policy				**161,062,376**
			4.1.1.1	develop evidence-based and costed health financing strategic plans with technical assistance from partners			18,633,120
			4.1.1.2	provide support to LGAs to develop evidence-based costed annual plans			93,376,800
			4.1.1.3	Constitute technical working groups for health financing at state and LGAs			49,052,456
			4.1.1.4	build Capacity to develop and implement the strategic health plan by state and LGAs			-
	4.2	**To ensure that people are protected from financial catastrophe and impoverishment as a result of using health services**			**NHIS protects all Nigerians by end 2015**		
		4.2.1	To strengthen systems for financial risk health protection				
			4.2.1.1	provide enabling policy and environment for social health insurance			-
			4.2.1.2	foster partnership between State/LGAs and NGDOs to facilitate access to social health insurance etc			-
			4.2.1.3	provide logistic support for the NHIS regulatory functions in the state			
	4.3	**To secure a level of funding needed to achieve desired health development goals and objectives at all levels in a sustainable manner**			**Allocated Federal, State and LGA health funding increased by an average of 5% pa every year until 2015**		**96,946,728**
		4.3.1	To improve financing of the Health Sector				**96,946,728**

			4.3.1.1	Advocate to all levels for at least 15% of the total budget to health			1,566,953
			4.3.1.2	Advocate for timely release of allocated funds for health			6,812,841
			4.3.1.3	Advocate for increased community resources and investment in health especially MNCH			6,812,841
			4.3.1.4	build capacity for the efficient and effective use of financial resources at state and LGAs			27,251,364
			4.3.1.5	Strengthen partnerships to leverage funds for health			-
			4.3.1.6	Provide special funds for chronic and emerging diseases e.g. mental health			27,251,364
			4.3.1.7	Provide special funds to support free health care for vulnerable groups e.g. women and children, orphans			27,251,364
		4.3.2	To improve coordination of donor funding mechanisms				-
			4.3.2.1	strengthen the functioning of ICC			-
			4.3.2.2	build-capacity at state and LGAs for coordination of donor and government resources			-
			4.3.2.3	Create donor coordination mechanism in the form of a common basket funding			-
	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**		**149,589,551**
		4.4.1	To improve Health Budget execution, monitoring and reporting				**149,589,551**
			4.4.1.1	Build capacity at state level for detailed financial management			11,241,188
			4.4.1.2	provide technical assistance to the LGAs to develop an internal control for financial management			18,210,724
			4.4.1.3	Ensure periodic financial auditing			131,378,827
			4.4.1.4	Undertake review of expenditure and tracking of health budget			-
		4.4.2	To strengthen financial management skills				-
			4.4.2.1	Build capacity at the state and LGA level for detailed financial flow analysis			-
			4.4.2.2	Facilitate transfer of skills from the FMOH and partners to the state and LGAs to improve effective transparent budgeting, accounting, auditing, monitoring and evaluation			-
NATIONAL HEALTH INFORMATION SYSTEM							
5. To provide an effective National Health Management Information System (NHMIS) by all the governments of the Federation to be used as a management tool for informed decision-making at all levels and improved health care							**651,001,910**
	5.1	**To improve data collection and transmission**			**1. 50% of LGAs making routine NHMIS returns to State level by end 2010 2. 60% of States**		**615,764,396**

					making routine NHMIS returns to Federal level by end 2010		
		5.1.1	To ensure that NHMIS forms are available at all health service delivery points at all levels				**221,238,059**
			5.1.1.1	Advocate for budget line and funds release for HMIS	Budget release letter		-
			5.1.1.2	Provide regular procurement, printing and distribution of data tools to all HFs	No. of forms distributed		6,690,667
			5.1.1.3	Strengthen M&E systems for effective data tools utilization	No. of trained.		135,597,520
			5.1.1.4	Institutionalize a system to register maternal and perinatal deaths and make them notifiable events	Check list and itinery of supervision.		78,949,872
		5.1.2	To periodically review of NHMIS data collection forms				**74,935,472**
			5.1.2.1	Develop a format for regular feedback from service providers and data managers at all levels	**Private practitioners participation assumed.**	SMOH, HDCC and Partners	61,554,137
			5.1.2.2	Establish periodic review of data tools and systems		SMOH, HDCC and Partners	13,381,334
		5.1.3	To coordinate data collection from vertical programmes				**25,870,579**
			5.1.3.1	Establish regular data review and harmonisation between stakeholders		SMOH, HDCC and Partners.	-
			5.1.3.2	Streamline and harmonise all data management activities (HMIS, IDSR etc)	**Private practitioners participation assumed.**	SMOH, HDCC and Partners.	25,870,579
		5.1.4	To build capacity of health workers for data management				**248,669,794**
			5.1.4.1	Train adequate manpower in data management	SMOH, HDCC and Partners.		134,259,387
			5.1.4.2	Provide regular re-training of HWs and data managers on new or revised tools	SMOH, HDCC and Partners.		91,885,162
			5.1.4.3	xx Establish and build capacity for MNC mortality review system	SMOH, HDCC and Partners.		22,525,246
		5.1.5	To provide a legal framework for activities of the NHMIS programme				**5,129,511**
			5.1.5.1	Advocate for laws to encourage data reporting from all HFs including private facilities		SMOH, HDCC and Partners.	669,067
			5.1.5.2	Review existing guidelines on HMIS		SMOH, HDCC and Partners.	4,460,445
		5.1.6	To improve coverage of data collection				**18,510,846**
			5.1.6.1	To develop innovative strategies for improved data collection from all private and public health facilities.		SMOH, HDCC and Partners.	17,841,779
			5.1.6.2	To develop innovative strategies for improved data collection from communities.		SMOH, HDCC and Partners.	-
			5.1.6.3	Advocacy for strenghtening of National Population Commission to improve vital registration.		State, SMOH, HDCC and Partners.	669,067
		5.1.7	To ensure supportive supervision of data collection at all levels				**21,410,135**
			5.1.7.1	Integrate HMIS in the supportive supervision program of the STATE.			-

			5.1.7.2	Conduct DQA activities periodically.			21,410,135
	5.2	**To provide infrastructural support and ICT of health databases and staff training**			**ICT infrastructure and staff capable of using HMIS in 50% of States by 2012**		**2,007,200**
		5.2.1	To strengthen the use of information technology in HIS				**669,067**
			5.2.1.1	Review and adapt the existing National policy and guidelines on ICT for implementation in the state.	Policy reviewed and adopted		669,067
			5.2.1.2		Guidelines reviewed and adopted		-
		5.2.2	To provide HMIS Minimum Package at the different levels (FMOH, SMOH, LGA) of data management				**1,338,133**
			5.2.2.1	Advocate for SMOH to provide for data management tools (Computers, power supply, internet) for HMIS activities.			-
			5.2.2.2	Distribution of procured data management tools (Computers, power supply, internet) to all levels.			-
			5.2.2.3	Advocacy for Procurement,Training and re-training of Technical ICT Staff at all levels.			669,067
			5.2.2.4	Advocate for review of curricular at COHESKAT to include basic ICTskills.			669,067
	5.3	**To strengthen sub-systems in the Health Information System**			**1. NHMIS modules strengthened by end 2010 2. NHMIS annually reviewed and new versions released**		**18,956,890**
		5.3.1	To strengthen the Hospital Information System				**18,956,890**
			5.3.1.1	Advocate for adoption of National guidelines for establishing and sustaining Patient information systems			-
			5.3.1.2	Advocate for adoption of National guidelines for the establishment of disease mapping in States			-
			5.3.1.3	Training of service providers and data managers on the adopted guidelines.			18,956,890
		5.3.2	To strengthen the Disease Surveillance System				**-**
			5.3.2.1	Strengthen LGA DSNOs activities.			-
			5.3.2.2	Establish HF / Community disease sentinel surveillance sites.			-
	5.4	**To monitor and evaluate the NHMIS**			**NHMIS evaluated annually**		**14,273,423**
		5.4.1	To establish monitoring protocol for NHMIS programme implementation at all levels in line with stated activities and expected outputs				**1,784,178**
			5.4.1.1	Advocate for logistic support for M & E activities in HMIS			-
			5.4.1.2	Update the HMIS check list for M & E and integrate into the state ISS program.			1,784,178
			5.4.1.3	provide DQA tools at state and LGA levels			-
			5.4.1.4	Organise DQA review meetings at state and LGA levels.			-
		5.4.2	To strengthen data transmission				**12,489,245**

			5.4.2.1	Strengthen human and infrastructural capacities for data management.			3,568,356
			5.4.2.2	Empower the DPRS at SMOH to analyse and disemminate data / information vertically and horizontally.			8,920,889
	5.5	**To strengthen analysis of data and dissemination of health information**			**1. 50% of States have Units capable of analysing health information by end 2010 2. All States disseminate available results regularly**		**-**
		5.5.1	To institutionalize data analysis and dissemination at all levels				**-**
COMMUNITY PARTICIPATION AND OWNERSHIP							
6. To attain effective community participation in health development and management, as well as community ownership of sustainable health outcomes							**434,001,273**
	6.1	**To strengthen community participation in health development**			**All States have at least annual Fora to engage community leaders and CBOs on health matters by end 2012**		**8,628,876**
		6.1.1	To provide an enabling policy framework for community participation				**2,249,745**
			6.1.1.1	Review the guide lines for community participation			519,812
			6.1.1.2	Review and update the state's community development policy in consonance with the National Health Policy			1,330,718
			6.1.1.3	Review the state's environmental health laws to ensure effective community involvement in decision making and implementation			399,215
			6.1.1.4	establish advocacy team at state level and direct local governments to do the same.			-
			6.1.1.5				-
		6.1.2	To provide an enabling implementation framework and environment for community participation				**5,967,440**
			6.1.2.1	Strengthen community linkages for participation e.g development committees at LGA, wards and community levels			-
			6.1.2.2	Promote inter-sectoral collaboration between development partners and the development committees at all levels			3,742,645
			6.1.2.3	Conduct training for development committee members on basic health skills and data management.			187,132
			6.1.2.4	Develop and implement community involvement methods and models			1,663,398
			6.1.2.5	Enhance information sharing among stakeholders on findings			374,265
			6.1.2.6	Ensure adequate use of radio and television jingles emphasising on health activities			-
			6.1.2.7	organise and conduct interactive sessions for development committee members at LGA and zonal levels to share experiences in their various localities.			
		6.1.3	Review the level of linkages of the existing Development Committees and the service delivery points.				**411,691**
			6.1.3.1	Conduct a review of existing development committees and their linkages			37,426
			6.1.3.2	Strengthen community involvement in planning, implementation and evaluation of health activities in their localities			374,265

	6.2	**To empower communities with skills for positive health actions**			**All States offer training to FBOs/CBOs and community leaders on engagement with the health system by end 2012**		**142,553,190**
		6.2.1	To build capacity within communities to 'own' their health services				**67,700,290**
			6.2.1.1	Re orient development communities and community based health care providers on their roles and responsibilities			14,138,881
			6.2.1.2	Produce and distribute IEC materials to the communities			12,475,483
			6.2.1.3	Promote adequte use of radio and T.V jingles on health activities			36,927,431
			6.2.1.4	Strengthen individual, family and community to respond to MNCH issues at home and seek health care			4,158,494
		6.2.2	creating awareness among women group on health promotion				**74,852,900**
			6.2.2.1	Promote Key household Practices and counselling services in the communities			70,694,406
			6.2.2.2	Sensitization of women groups on healthy life style at all social gatherings			2,079,247
			6.2.2.3	Promote house to house women mobilization on positive health habit			2,079,247
	6.3	**To strengthen the community - health services linkages**			**50% of public health facilities in all States have active Committees that include community representatives by end 2011**		**282,819,207**
		6.3.1	To restructure and strengthen the interface between the community and the health services delivery points				**212,124,802**
			6.3.1.1	Institutionalize community based MNCH services			70,694,406
			6.3.1.2	Promote male involvement to improve HH care seeking behaviour and other KHHP			70,735,991
			6.3.1.3	Facilitate income generating activities and girl child education			70,694,406
		6.3.2	Improve community mobilization, involvement and participation				**70,694,406**
			6.3.2.1	Establish regular meetings with DC and health care providers			56,555,525
			6.3.2.2	Sensitize traditional ,religious and political leaders for promotion of community involvement			14,138,881
	6.4	**To increase national capacity for integrated multisectoral health promotion**			**50% of States have active intersectoral committees with other Ministries and private sector by end 2011**		**-**
		6.4.1	To develop and implement multisectoral policies and actions that facilitate community involvement in health development				**-**
			6.4.1.1	Advocacy to community members for greater involvement in health development			-
	6.5	**To strengthen evidence-based community participation and ownership efforts in health activities through researches**			**Health research policy adapted to include evidence-based**		**-**

				community involvement guidelines by end 2010		
PARTNERSHIPS FOR HEALTH						
7. To enhance harmonized implementation of essential health services in line with national health policy goals						**434,001,273**
	7.1	**To ensure that collaborative mechanisms are put in place for involving all partners in the development and sustenance of the health sector**		**1. FMOH has an active ICC with Donor Partners that meets at least quarterly by end 2010 2. FMOH has an active PPP forum that meets quarterly by end 2010 3. All States have similar active committees by end 2011**		**434,001,273**
		7.1.1	To promote Public Private Partnerships (PPP)	1. Existence of an active PPP unit at State and LGA levels by end of 2010 2. Number of Quarterly meetings held		**51,606,093**
			7.1.1.1 Develop a policy to encourage private sector to establish Health Facilities in rural areas		Development of PPP policy by the National level	1,551,166
			7.1.1.2 Establish PPP units at State and LGA levels based on the Federal guidelines			-
			7.1.1.3 Develop strategies to implement PPP initiative in line with the National policy			-
			7.1.1.4 Provide a mechanism for coordination between public and private care providers			26,310,158
			7.1.1.5 Support capacity building for the PPP unit members			23,744,769
			7.1.1.6 Promote PPP in financing and provision of IMNCH commodities and services			
		7.1.2	To institutionalize a framework for coordination of Development Partners	1. Number of monthly meetings 2. A joint resource management agreement signed by end 2010		**34,874,383**
			7.1.2.1 Strengthen and institutionalize the existing State Interagency Coordinating Committee			-
			7.1.2.2 Develop a Joint resource management agreement between the State and Development Partners	Failure in meeting the MOU		581,687
			7.1.2.3 Support the development of framework to harmonize Development Partners at LGA level			26,686,018
			7.1.2.4 Support the LGAs in the establishment of Coordinating committee of all Development partners			7,606,678
		7.1.3	To facilitate inter-sectoral collaboration	1. Number of quarterly meetings held 2. A joint resource management agreement signed by end 2010		**347,520,797**

			7.1.3.1	Establish an inter-sectoral forum at State level		Lack of awareness	2,684,710
			7.1.3.2	Support LGAs in establishing inter-sectoral forum at LGA level		Guidelines not well defined	-
			7.1.3.3	Support capacity building of all relevant stakeholders			-
			7.1.3.4	Develop monitoring and feedback mechanism to evaluate the impact of the collaboration			50,711,189
			7.1.3.5	Facilitate the functioning of inter-sectoral forum at LGA level			294,124,898
RESEARCH FOR HEALTH							
8. To utilize research to inform policy, programming, improve health, achieve nationally and internationally health-related development goals and contribute to the global knowledge platform							NGN 868,002,546
	8.1	**To strengthen the stewardship role of governments at all levels for research and knowledge management systems**			**1. ENHR Committee established by end 2009 to guide health research priorities 2. FMOH publishes an Essential Health Research agenda annually from 2010**		**-**
		8.1.1	To finalise the Health Research Policy at Federal level and develop health research policies at State levels and health research strategies at State and LGA levels				-
			8.1.1.1	Adapt the National health reseach policy (NHRP) in the State	Availability of the NHRP document	Delay in the enactment of the NHRP	-
			8.1.1.2	Constitute the state technical working group and steering commitees for research			-
			8.1.1.3	support local governments to establish technical working group and steering commitees for research			-
		8.1.2	To establish and or strengthen mechanisms for health research at all levels				-
			8.1.2.1	Stengthen heath research divisions and units			-
			8.1.2.2	Strengthen departments of planning reseach and statistics			-
			8.1.2.3	Coordinate and implement essential N.H.R guidelines		Availability of ENHR guidelines	-
		8.1.3	To institutionalize processes for setting health research agenda and priorities		health research agenda and priorities developed and obtained		-
			8.1.3.1	Establish/strengthen institutional structures for research			-
			8.1.3.2	Develop guidelines for collaborative health research agenda			-
		8.1.4	To promote cooperation and collaboration between Ministries of Health and LGA health authorities with Universities, communities, CSOs, OPS, NIMR, NIPRD, development partners and other sectors		cooperation and collaboration between Ministries of Health and LGA health authorities with Universities, communities, CSOs, OPS, NIMR, NIPRD, development		-

					partners and other sectors obtained		
			8.1.4.1	Establish linkages between users of research and producers of research through research fora			-
			8.1.4.2	support the development of collaborative research activities			-
		8.1.5	To mobilise adequate financial resources to support health research at all levels		2% of the state budget allocated to support health research each year		-
			8.1.5.1	allocate at least 2% of health budget for health research in line with the recommendations of African Governments.		Delay in legislative process	-
			8.1.5.2	Advocate to organisations for sponsorship of research actitivities.			-
			8.1.5.3	deploy mobilised funds for focused research on priority issues eg MNCH			-
		8.1.6	To establish ethical standards and practise codes for health research at all levels		ethical standards and practise codes for health research esterblished		-
			8.1.6.1	Establish/strengthen guidelines and ethical review committees for health research in the state.			-
			8.1.6.2	Strengthen similar mechanisms in tertiary health and educational institutions in the State.			-
			8.1.6.3	Establish monitoring and evaluation system to regulate research and use of research findings.			-
	8.2	**To build institutional capacities to promote, undertake and utilise research for evidence-based policy making in health at all levels**			**FMOH has an active forum with all medical schools and research agencies by end 2010**		-
		8.2.1	To strengthen identified health research institutions at all levels		research institutions identified at all level		-
			8.2.1.1	Strengthen identified health research institutions			-
			8.2.1.2	conduct periodic capacity assessment of health research organisations at the institutions			-
			8.2.1.3	develop and implement measures to address research capacity gaps/ weakness			-
		8.2.2	To create a critical mass of health researchers at all levels		health research work at all levels obtained		-
			8.2.2.1	create a critical mass of researchers in conjunction with training institutions			-
			8.2.2.2	develop appropriate training for research based on identified needs			-
			8.2.2.3	provide competitive research grants for prospective researchers			-
		8.2.3	To develop transparent approaches for using research findings to aid intervention on identified critical priority areas		research on identified critical priority areas conducted		-
			8.2.3.1	Evolve mechanisms for translating research findings into action			-
		8.2.4	To undertake research on identified critical priority areas		research on identified critical priority areas carried out		-

			8.2.4.1	Conduct research systematically on burden of different diseases and conditions			-
			8.2.4.2	Conduct research on MNCH issues			-
			8.2.4.3	Undertake studies on health system governance			-
			8.2.4.4	Conduct studies on health system delivery			-
			8.2.4.5	Conduct studies on financial risk protection, equity, efficiency and value of different health financing mechanisms biennially as determined by policy makers and other stake holders			-
	8.3	**To develop a comprehensive repository for health research at all levels (including both public and non-public sectors)**			**1. All States have a Health Research Unit by end 2010 2. FMOH and State Health Research Units manage an accessible repository by end 2012**		**-**
		8.3.1	To develop strategies for getting research findings into strategies and practices		develop strategies for getting research findings are put into practices		**-**
			8.3.1.1	institute health research policy development forum in the state and local governments			-
		8.3.2	To enshrine mechanisms to ensure that funded researches produce new knowledge required to improve the health system		An improved haelth system obtained		**-**
			8.3.2.1	conduct need assessment to identify required research gaps in the state and local governments			-
			8.3.2.2	undertake operational research by Ministry of health, departments and agencies in the state and local governments			-
			8.3.2.3	contract public and non-public research organisations/institutions/individuals to collaborate with government in the conduct of operational research			-
	8.4	**To develop, implement and institutionalize health research communication strategies at all levels**			**A national health research communication strategy is in place by end 2012**		**-**
		8.4.1	To create a framework for sharing research knowledge and its applications		framework for sharing research knowledge and its applications avialable		**-**
			8.4.1.1	Develop a framework for sharing health research knowledge in the state and local goverments			-
			8.4.1.2	Convene annual health conferences, seminars and workshops in the state on key thematic areas (financing, human resources, MDGs and health research)			-
			8.4.1.3	Pursue opportunities for international collaboration on state research agenda in terms of ensuring research findings are published and presented in other countries			-
			8.4.1.4	Ensure that research updates from other countries are shared with the state health institutions			-
		8.4.2	To establish channels for sharing of research findings between researchers, policy makers and development partners		Channels for sharing of research findings obtained		**-**

			8.4.2.1	Develop capacity of researchers to effectively produce policy briefs targetted at informing policy makers as well as broad scientific and non-scientific audiences			-
			8.4.2.2	Conduct an inventory of national journals according to areas of focus			-
			8.4.2.3	Select journals to be supported that address issues related to essential national health research principles			-
			8.4.2.4	establish an editorial board for a state journal			-
			8.4.2.5	Support the publication of high quality state journal following a review of the editorial board			
			8.4.2.6	Establish appropriate linkage between editors of the state journal with those of the national journals, reputable publishers (especially free web access publishers) and other collaborators to improve the quality of the state journal			
			8.4.2.5	Disseminate selected state journals to all stake holders at the state and local governments			-
				Establish a website for sharing information on researches			
							43,400,127,212

Annex 3: Results/M&E Matrix for the State Strategic Health Plan

KATSINA STATE SHDP RESULT FRAMEWORK						
OUTCOME	**INDICATORS**	**SOURCE OF DATA**	**Baseline**	**Target**		
			2008/9	**2011**	**2013**	**2015**
OVER-ARCHING GOAL: To significantly improve the health status of Nigerians through the development of a strengthened and sustainable health care delivery system						
	1. FULL IMMUNISATION COVERAGE Proportion of 1 year old immunized against measles	NDHS	1%	40%	70%	95%
	2. Prevalence of children under five years of age who are underweight	NDHS	20%	15%	7.50%	5%
	3. Percentage of children under 5 sleeping under insecticide-treated bed nets	NDHS	1%	25%	50%	80%
PRIORITY AREA 1: LEADERSHIP AND GOVERNNANCE FOR HEALTH						
NSHDP GOAL: To create and sustain an enabling environment for the delivery of quality health care and development in Nigeria						
1. Improved strategic health plans implemented at Federal and State levels						
2. Transparent and accountable health systems management						
STRATEGIC AREA 2: HEALTH SERVICES DELIVERY						
NSHDP GOAL: To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare						
3. Universal availability and access to an essential package of primary health care services focusing in particular on vulnerable socio-economic groups and geographical areas	1. % wards with a functioning public health facility providing minimum health care package according to quality of care standards.	PRRINN-MNCH / PRRAHH	30%	45%	65%	80%
4. Improved quality of primary health care services	1. Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS	NDHS	13% FEM. AND 21% MALE	30%	60%	85%
5. Increased use of primary health care services						
	KNOWLEDGE OF T.B.	NDHS	57.1 FEM. AND 84.2 MALE	90%	95%	95%
	MALARIA TREATMENT RECIEVED	NDHS	22% CHILDRN AND 1% PREG. WOMEN	30 AND 10%	60 AND 80%	90%
	21. % of women with pregnancy within the last 2 years who received intermittent preventive treatment for malaria	NDHS, HMIS, MICS	18% (NDHS, 2008)	38%	60%	80%

	2. Proportion of 12-23 months-old children fully immunized	NDHS	1%	30%	70%	85%
	25. % of under-five children sleeping under ITN in the previous night.	NDHS	1%	25%	50%	80%
	HOUSE HOLDS WITH IMPROVEED SOURCE OF DRINKING WATER	NDHS	38%	45%	60%	75%
	HOUSE HOLDS WITH ELECTRICITY	NDHS	30%	35%	40%	50%
	30. Number of new wild poliovirus cases	WHO Global Update	24	5	0	0
	31. Unmet need for Family Planning	NDHS	99%	75%	45%	15%
	32. % of pregnant women with 4 ANC visits performed according to standards	NDHS	14%	35%	70%	80%
	33. Proportion of births attended by skilled health personnel	5%	20%	50%	70%	85%
	34. Proportion of all births in Basic and Comprehensive EMoC Facilities	NDHS/ PRRINN	4%	10%	20%	40%
PRIORITY AREA 3: HUMAN RESOURCES FOR HEALTH						
NSHDP GOAL: To plan and implement strategies to address the human resources for health needs in order to ensure its availability as well as ensure equity and quality of health care						
6. The Federal government implements comprehensive HRH policies and plans for health development	38. % of wards that have appropriate HRH complement as per service delivery norm (urban/rural).	NDHS / NPHCDA	No baseline	10%	25%	45%
7. All States and LGAs are actively using adaptations of the National HRH policy and plan for health development by end of 2015						
8. Find HRH policy to copy targets	39. Proportion of Health Professionals per population	NHMIS/HRHIS	TBD	1:20000	1.083333	>1:1000
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						
9. Health financing strategies implemented at Federal, State and Local levels consistent with the National Health Financing Policy	40. % state budget allocated to the health sector.	STATE SMOH	10%	7.50%	10%	15%

10. 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	41. Proportion of Nigerians covered by any risk-pooling mechanisms	State review PER/NHA	TBD	5%	10%	30%
	42. Out-of pocket expenditure as a % of total health expenditure	NHIS	67.2% (2006 – NHA 2003-2005)	65%	60%	<50%
PRIORITY AREA 5: NATIONAL HEALTH INFORMATION SYSTEM						
NSHDP GOAL 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, including Monitoring & Evaluation, for informed decision-making at all levels and improved health care						
11. National health management information system and sub-systems provides public and private sector data to inform health plan development and implementation at Federal, State and LGA levels	43. % of States whose routine HMIS returns meet minimum requirement for data quality standard	State reports/Integrated Disease Surveillance System	TBD	40%	60%	80%
	44. % of States that timely submit disease surveillance reports	Federal reports/Integrated Disease Surveillance System	TBD	40%	60%	80%
	45. % of Federal and State plans and strategies that are based on routine HMIS data to improve coverage and quality of high impact interventions	Rapid Annual Household and Facility Surveys (TBD)	No baseline	40%	60%	80%
PRIORITY AREA 6: COMMUNITY PARTICIPATION AND OWNERSHIP						
NSHDP GOAL 6: To attain effective community participation and responsibility in health development.						
12. Strengthened community participation in health development	46. % LGAs with policy and implementation framework for community participation in health with multi-sectoral focus in place	Policy and Implementation Framework	60%	70%	80%	90%
13. Increased capacity for integrated multi-sectoral health promotion	47. Proportion of public health facilities having active committees (at least 4 meetings per year) that include community representatives	PRRINN, PRRAH AND SPHCDA SURVEYS	55%	70%	80%	95%
PRIORITY AREA 7: PARTNERSHIPS FOR HEALTH						
NSHDP GOAL 7: To enhance harmonized implementation of essential health services in line with national health policy goals.						

14. Functional multi partner and multi-sectoral participatory mechanisms at Federal and State levels contribute to achievement of the goals and objectives of the NSHDP.	48. Proportion of LGAs implementing at least 4 new PPP initiatives per year.	LGAs and state PPP reports	No baseline	5%	10%	15%
	49. % of with standards and mechanisms for graded accreditation of private providers in place	State reports	100%	100%	100%	100%
	50. % of LGAs and State multi-sectoral and development partner meetings held according to extant coordination mechanism	LGAs and state MOH reports	100%	100%	100%	100%
PRIORITY AREA 8: RESEARCH FOR HEALTH						
15. Research and evaluation create knowledge base to inform health policy and programming.	51. % of health budget spent on health research and evaluation at federal level	PRRINN AND SPHCDA	1%	1-5%	1.50%	2%
	52. Proportion of research and evaluation studies undertaken on identified critical areas in the SSHDP framework.	PRRINN, SPHCDA AND SMOH	12%	20%	40%	60%