KADUNA STATE GOVERNMENT

STRATEGIC HEALTH DEVELOPMENT PLAN
(2010-2015)

Kaduna State Ministry of Health

March 2010

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ACRONYMS

ABU	Ahmadu Bello University
ALGON	Association of Local Government Chairmen of Nigeria
BCC	Behaviour Change Communication
BEOC	Basic Emergency Obstetric Services
CEOC	Comprehensive Emergency Obstetric Services
CIDA	Canadian International Development Agency
CORPs	Community oriented resource persons
CPD	Continuing professional development
CSO	Community Service Organization
DFID	Department for International Development
DFID	Department for International Development
DHS	Nigeria Demographic and Health Survey
DP	Development Partners
DPRS	Department of Planning, Research and Statistics
DRF	Drug Revolving Fund
ENCC	Emergency, Neonate Child Care
EU	European Union
FMOH	Federal Ministry of Health
GDP	Gross Domestic Product
HDCC	Health Data Consultative Committee
HF	Health Facilities
HF	Health Facility
HIS	Health Management Information System
HIV/AIDS	Human Immuno Deficiency Virus/Acquired Immune Deficiency Syndrome
HRH	Human Resources for Health
HRH	Human Resources for Health
HW	Health worker
HW	Health worker
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illness
IMCI	Integrated management of Childhood Illnesses
IMNCH	Integrated Maternal, Newborn and Child Health
IPC	Interpersonal Communication skills
ISS	Integrated Supportive Supervision
ISS	Integrated supportive supervision
ITNs	Insecticide treated nets
IYCF	Infants, Young Children Feeding
JFA	Joint Funding Agreement
JICA	Japan International Development Agency
KDSU	Kaduna State University
LGA	Local Government Area
LSS	Life Saving Skills
M&E	Monitoring and Evaluation

MCH	Maternal and Child Health
MDAs	Ministries, Departments and Agencies
MDGs	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MLSS	Modified Life Saving Skills
MNCH	Maternal and Newborn Child Health
MRCN	Medical Research Council of Nigeria
MSS	Midwifery Service Scheme
NAFDAC	National Agency for Food Drugs Administration and Control
NBS	National Bureau of Statistics
NDHS	Nigeria Demographic and Health Survey
NGOs	Non-Governmental Organizations
NHA	National Health Accounts
NHIS	National Health Insurance Scheme
NHMIS	National Health Management Information System
NMSP	National Malaria Strategic Plan
NPHCDA	National Primary Health Care Development Agency
NPHCDA	National Primary Health Care Development Agency
NSHDP	National Strategic Health Development Plan
NSHDPf	National Strategic Health Development Plan Framework
NYSC	National Youth Service Corps
OPS	Organized Private Sector
PERs	Public Expenditure Reviews
PHC	Primary health Care
PHC	Primary Health Care
PPP	Public Private Partnerships
QA	Quality Assurance
QAR	Quality Assurance Recognition
RDBs	Research data banks
SESN	Socio-Economic Survey in Nigeria
SHAs	State Health Accounts
SMoH	State Ministry of Health
SMOH	State Ministry of Health
SWAPs	Sector-Wide Approaches
TB	Tuberculosis
TBAs	Traditional birth attendants
TBD	To be determined
UNDP	United Nations Development Programme
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Fund for Children
USAID	United States Agency for International Development
VHW	Village health workers
WHO	World Health Organization

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.

EXECUTIVE SUMMARY

Kaduna State is the third most populous State in Nigeria. It has an estimated population of 6.4 million people (2009) spread across 23 LGAs and 255 wards. Subsistence agriculture is the dominant occupation of the people. There is a wide diversity in culture and lifestyle between the predominantly Moslem Hausa northern population and the southern Christian population of a variety of ethnic groups. The poverty level, though lower than the zonal average, is still very high.

Health care services in the State are provided from a total of 1,692 health care facilities; 40.2% of these health facilities belong to the private sector. 96.5% of all the health facilities are primary health care, 3.2% secondary health care and 0.3% tertiary health care facilities. In addition, there is a rich network of traditional healers and patent medicine vendors that provide care. Free maternal and child health services is provided in all the 34 health facilities belonging to the State government and 116 LGA-owned PHC facilities

Health indices are poor as can be seen in the maternal mortality ratio of 1025/10000 live births, infant mortality and child mortality rates are 114 and 269/ 1000 live births respectively. The prevalence of HIV and TB are on the increase and non communicable diseases are increasingly becoming public health problems. This, in part is because of low coverage of high impact cost-effective interventions. For example, only 22% of children are fully immunized, less than 20% of women deliver in a health facility and only a fifth have their deliveries supervised by a trained health professional.

Political commitment to health development, especially at the Local Government level is poor. While the State government has articulated a number of policies and laws aimed at reforming the health services, some crucial ones are yet to be operationalised with a whole lot suffering from implementation problems. There is poor coordination and lack of effective health leadership, especially at the LGA level. Health funding is low, unpredictable and not timely. Out-of pocket expenditure remains the dominant method of financing health care in the State. There is gross inequity in the distribution of health facilities and health personnel. Shortages of drugs remain a problem as well as dearth of equipment, especially at the PHC level. There are gaps in the quantity, quality and mix of health care personnel. Services remain fragmented, not integrated and essentially limited to clinic-based interventions, and referral systems are poorly developed. The health management information system is poorly developed and it excludes the private sector. Community participation is poor and the state public private partnership policy is yet to become fully operational. There are no budget lines for research, and neither the state nor the LGAs conduct any health research

Kaduna State has an Essential Services and Systems Package that has defined the essential services to be provided, the infrastructure, staffing and drugs required for each level of the public health care system. What is left is to revise it to include all integrated maternal, newborn and child health components. The main components of the KESSP are:

- Integrated maternal newborn and child health that includes childhood immunizations, provision of child spacing, antenatal, delivery, basic emergency and comprehensive emergency services and newborn resuscitation services; growth monitoring promotion of exclusive breastfeeding and micronutrient supplementation.
- Malaria prevention and control through provision of ACT, intermittent preventive therapy to pregnant women, long lasting insecticide treated nets to pregnant women and children aged less than 5 years.
- HIV/AIDS and TB prevention and control interventions
- Control of non-communicable diseases namely hypertension, diabetes and cancers.
- Strategic behavioural change communication to create demand for services and modify lifestyle and health care seeking behaviour appropriately

The Strategic Priorities interventions as defined by the State, inclusive of targets and indicators are as follows:

- Development of a State Health Policy that harmonizes and integrates all existing health policies by the end of 2010
- Operationalizing the Primary Health Care Development Agency and the Drug Management Agency Laws before the end of 2010
- Revision and implementation of the Essential Services and Systems Package by the end of 2010 with the following key targets:
    - 80% of all public health facilities (State and LGA) implementing the KESSP in an integrated manner by 2013
    - 50% of all deliveries supervised by a trained birth attendant by 2012 and 80% by 2015;
    - 80% measles coverage by 2012 and 50% full immunization coverage by 2015;
    - 25% reduction of maternal mortality from its current level by 2013
    - 50% reduction in child mortality from its current level by 2013
    - 30% reduction of malaria prevalence from its current level by 2012
    - Reduction to 4% the prevalence of HIV sero-positivity by 2011
    - 60% of pregnant women and children under five sleep under ITN by 2011 and 50% of pregnant women receive IPT by 2015
    - 60% of under-fives receiving appropriate treatment for cough/difficult breathing, fever and diarrhea within 24 hours of onset of illness.
    - Improve access to essential drugs to 100% in all public health facilities by 2011

- Funding to the health sector to be increased at the State level to at least 15% and 20% at the LGA level by 2012. By 2010, the State should finalize and begin to implement the social health insurance scheme for the formal sector and the community-based HIS by 2011 with a coverage target of 60% by 2015

- Reviewing of the current budgeting arrangement to move from ceiling-based funding to needs based funding by 2010 and ensuring timely and complete release of budget in line with operational plans.
- Development and implementation of a human resource for health development plan by 2011; achieving 80% appropriate number, mix and skills in all public health facilities by 2013
- Development of a depository and SMoH website with portal links to all departments, LGAs and development partners by 2010. Uploading all information on health plans, budgets and expenditures on the web.
- Strengthening the health management information system by supporting routine data collection in all Health facilities with 80% of facilities reporting by 2015
- Building research capacity at State and LGA levels and allocating at least 2% of all health budgets for research

The provisional costing of the SSHDP has been undertaken. The implementation of the SSHDP for the period 2010 – 2015 will cost a total of **eighty five billion four hundred and eighty four million three hundred and fifty eight thousand, two hundred and ninety naira ~~₦~~85,484,358,290**. This will be funded jointly by the State, LGAs and development partners.

A Steering Committee, consisting of representatives of the SMoH, the LGAs, and other stakeholders in the State shall be established under the office of the Commissioner of Health to oversee the implementation of the SSHDP. The Steering Committee will develop a detail plan for implementation that will include production and distribution of the State Strategic Plan. Production of advocacy materials and conduct of advocacy in support of implementation of the plan, conduct of sensitization/advocacy workshop for LGA chairmen and other key stakeholders will be conducted as a prelude to getting the LGAs to sign an MOU with the State for the joint funding and implementation of key PHC interventions. Government, with technical support from development partners will develop the state policy, revise the Essential Services and System Package and conduct the relevant capacity building and strengthening activities. The implementation will be phased and annual costed operational plans will be developed jointly with the LGAs in line with the phasing of the implementation. The costed ESSP will be used as an advocacy tool for resource mobilization. There will be a midterm evaluation in 2013 and another in 2015

The HMIS units at the LGA and State levels will be strengthened, including capacity building of Staff for timely data collection, analysis and use. The data collection tools and indicators will be reviewed and harmonized. Forms will be produced centrally at State level and distributed to all public and private health facilities through the LGAs. All health facilities would submit completed forms to LGAs who in turn will forward LGA reports to the State. Quarterly monitoring of field data collection will be undertaken by State level Staff. The system at the State level will be computerized and feedback will be through quarterly bulletins and annual reports. The epidemiology unit at the state will be strengthened so also the integrated supervision unit at State and LGA level. Annual review meetings will be carried out to review performance and tract progress.

CHAPTER 1 BACKGROUND AND ACHIEVEMENTS

1.1 Background

Nigeria's commitment to ensuring every Nigerian attains a level of health that will allow him/her live an economically and socially productive life, as stated in Nigeria's Health Policy remains a distant dream. This is because the health care delivery system, the vehicle that should be the delivery platform for the universal delivery of high impact, cost effective interventions remains very weak. In fact, the WHO ranked Nigeria's health care system as 187th out of 191 countries assessed in 2000.[1] The poor performance of the health care system is not unconnected with serious underling problems within the system. These include poor stewardship and governance, inadequate and unpredictable funding, challenges in coordination, fragmentation and verticalization of services, poor management of resources, human resources for health crises and poor management. The government, at the national level has responded over the years by providing leadership in terms of formulations of policies and development of health plans and programs. The last one aimed at reforming the health system was the Health Sector Reform Program for the period 2003 to 2007. This effort did not cascade down to lower levels - the states and local governments, hence little success was achieved.

Health in Nigeria is a joint responsibility of all tiers of government. The federal, state and LGA levels are all semi-autonomous in the governance, funding and management of the level of care they are responsible for. The Federal has responsibility for tertiary level care, the state for secondary level care and the LGAs for primary level care.

While Kaduna State did not key into the National Health Sector Reform Program of 2003 to 2007, on its own and with the support of development partners notably PATHS 2 , undertook some reforms in recent years in the State to strengthen her health care delivery system. The State is currently implementing the Medium Term Health Plan for the period 2008 -2011. However, these efforts are yet to have the desired effects as the performance of the health sector in the state leaves much to be desired as evidenced by the poor health indicators. The problems enunciated at the federal level are mirrored in Kaduna State. It is evident that at current rate of progress the attainment of the MDGs, Kaduna State Government's 11-point Agenda and the attainment of Vision 20/2020 remains a mirage. This is because of the centrality of health to socio-economic development.

At the national level, the FMoH has appreciated that In order to meet the challenges of achieving improved health status particularly for its poorest and most vulnerable population, the health system must be strengthened; proven cost-effective interventions

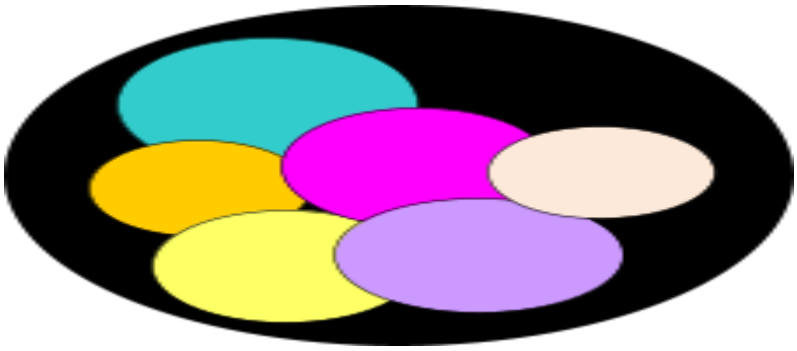
[1] WHO World Health Report 2000.

must be scaled up and gains in health must be sustained and expanded. The Federal Ministry of Health (FMOH) noted that this can best be done within the context of a costed National Strategic Health Development Plan (NSHDP), which is aimed at providing an overarching framework for sustained health development in the country. The NSHPD development plan is derived from harmonization of States' and LGA SHDPs. As a prelude to the development of the plans at national, state and LGA level, the FMoH developed a National Strategic Health Development Plan Framework to guide the development of the plans at all levels.

In Kaduna State, a 65 member State Planning Team was constituted, with the Permanent Secretary, Ministry of Health as Chairman, to provide oversight for the development of the State and LGA plans. The membership of the SPT included all the Directors in the SMoH, development partners, representatives of development partners, academic institutions working/present in Kaduna State, Program Focal Persons from SMoH, representatives from relevant Ministries in the state, proprietors of health establishments from the public and private sector, representatives of ALGCON and LGA PHC coordinators from the three zones that make up the State, the media and CSOs/FBOs. The nucleus of the STP consisted of the Director of DHPR, DPHC, Program Manager HSDP II, Staff of PATHS and a few key officials of the State MoH and who provided leadership in developing the States' work plan, sourcing for funds meeting in between workshops to continue with the process. The work plan for the development of the State and LGA plan is attached as Appendix 1. This has not been followed because of difficulties in securing funds. This draft document has been developed over two workshops that held for one week each at the State level in October 2009. Other activities will be undertaken as funds become available.

The Kaduna State SHDP has to be developed in accordance with extant national and State health policies and legislation. The NSHDP was the overarching document that guided the development of the KSSHDP as shown in the diagram below.

Figure 1: Policies and Plans that guided the Development of KSSHDP



CHAPTER 2 SITUATION ANALYSIS

2.1 Socio-economic context

Located in the North West geo-political zone, Kaduna State is the twelfth largest State in Nigeria accounting for some 5% of Nigeria's total landmass. With a 6.06 million (2006 census), it is the third most populous state in the country. Nearly 2 million people live in the two towns of Kaduna and Zaria. The population is culturally very diverse with distinct differences in religion, ethnicity, traditions and social norms between the predominantly Hausa/Moslem population in the northern part of the State and Christians of a variety of ethnic groups to the south. The population is spread across 23 Local Government Areas and 255 political wards. Kaduna town, the state capital, was the administrative and military capital of the defunct Northern Region and remains the unofficial political capital of the northern region.

Subsistence agriculture is the mainstay of the economy accounting for 70% of employment and income. Maize, yams sorghum, ginger, beans and cocoyam are the main foods grown. However, increasingly, animal husbandry and mechanized cash crop farming are being practiced. The State is richly endowed with yet to be adequately tapped reserves of lime, gemstones emerald, aquamarine, columbite and deposits of iron and granite. In addition, Kaduna State has many industries, majority of them located in the state capital. They consist of agro-allied, textile, banking and finance, beverages, petroleum (oil refinery) communications and entertainment industries. Most of these industries are owned by the private sector.

According to the Nigeria Living Standards survey of 2005, the poverty level of the state has improved to 50%, from 67% in 1996. But the current level is still high compared to other zones of the country. There is a clear relationship between poverty, health determinants, access to information and services and health outcomes.

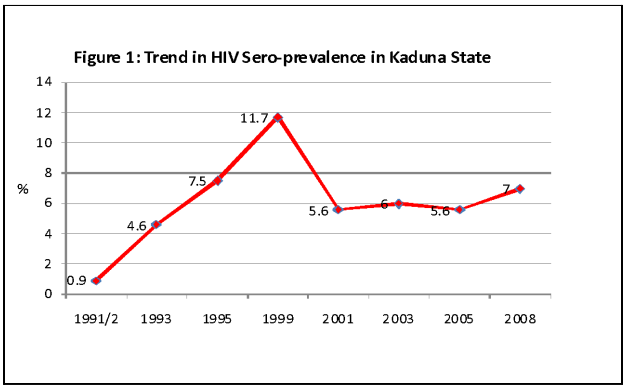
2.2 Health status of the population

State specific data on morbidity and mortality are lacking. Estimates for child and maternal morbidity and mortality are derived from the North Western figures, which are rather dated, as the figures still being quoted are from the 2003 NDHS. However, the available data indicate that Kaduna State though better than other state in the zonal still has unacceptably high mortality rates and disease burden. The maternal mortality ratio is 1,025/100,000 live births; a figure that is almost six times the rate in the South West Zone[2]. The infant and child mortality rates are 114 and 269/1000 live births respectively,[3] twice the rates in the southern zones of the country. (These values may however be an over estimation of the real values as the maternal and child health

[2] FOS and UNICEF 1999 Multiple Indicator Cluster Survey
[3] NPC 2003 National Demographic and Health Survey

service coverage indicators of Kaduna State are much better than the North West zonal average.) The high infant and child mortality are from diseases that can be prevented or treated at low cost; they include diarrhea, malaria, malnutrition, measles and acute respiratory tract infections.

HIV/AIDS and tuberculosis are on the increase in the State, with adverse consequences on the weak health care delivery system. Between 1991 and 1999, there was an exponential increase in the sero-prevalence rate of HV in Kaduna State. As shown in Figure 1, after a period of decline after 1999, the rate has begun to increase to 7% in 2008, the highest state rate in the NW zone.[4] Very wide variations in the HIV sero-prevalence are observed across the State, but generally, the rates are higher in the more southern settlements. Tuberculosis is also worse in the southern part of the state to the higher rates of HIV and poverty in that area.



Schistosomiasis and onchocerciasis are also endemic in the State. In 2008, the Kaduna State Onchocersiasis Control Program reported that 16LGAs and 2,677 communities are still onchocerciasis endemic[5].

The prevalence and incidence of non communicable diseases, notably hypertension, diabetes, coronary heart disease, RTAs and cancers are on the increase in the state.

TABLE 1: SUMMARY OF SOCIO-DEMOGRAPHIC AND HEALTH INDICATORS

Indicator	State Estimate	National Estimate	Year	Source
Demographic				
Total population	6,436,016	149,141,144	2008	NPHCDA
Children aged < 1 year	257,441	5,965,646	2008	NPHCDA
Childre n< 5 years	1,287,203	29,828,229	2008	NPHCDA
Pregnant women	321,801	7,457,057	2008	NPHCDA
Women of child bearing age	1,415,924	32,811,052	2008	NPHCDA
Crude birth rate		45	2003	NDHS
Total fertlity rate				
Mortality/morbidity				
Crude death rate				
Infant mortality rate	114 *	100	2003	NDHS
Under five mortality rate	269*	201	2003	NDHS
Maternal Mortality ratio	1,025 *	704	1999	MICS

[4] Federal Ministry of Health. 2008 National HIV/AIDS Sero-Prevalence Survey
[5] Kaduna State MoH 2008 Onchocericiasis Report

Children <5 yrs stunted below -3 SD(height-for-age)	33.0%	19.6%	2008	NDHS
Health Services Coverage				
1. Reproductive Health				
Antenatal care by health professional	62.1%	57.7%	2008	NDHS
Deliveries supervised a health professional	21.8%	31.9%	2008	NDHS
Women who had a live birth delivered in a health facility	18.4%	35.0%	2008	NDHS
Women who had a live birth delivered by a health professional	21.8%	31.9%	2008	NDHS
Currently married women who used any modern method of contraception	8.4%	3.5%	2008	NDHS
2. Immunization				
DPT-3 coverage	32.7%	35.4%	2008	NDHS
Measles coverage among	56.9%	41.4%	2008	NDHS
Fully immunized	21.4	22.7	2008	NDHS
3. Management of childhood illnesses				
Children < 5 yrs with ARI symptoms who sought for treatment from health provider	31.6%	46.5%	2008	NDHS
Children < 5 yrs with Diarrhoea who sought for treatment from health facility/provider	40.9%	32.0%	2008	NDHS
Children < 5 yrs with diarrhoea given solution from ORT packet	36.9%	25.5%	2008	NDHS
Children <5 yrs with fever who took anti-malarial drugs same/next day	31.7%*	24.6%		NDHS
4. Malaria				
Households who own at least one ITN	7.9%	8.0%	2008	NDHS
Pregnant women who slept under ITNs	1.1% (N/W Zone)	1.3%	2003	NDHS
Children <5 yrs who slept under ITNs	1.7% (N/W Zone)	1.2%		NDHS
Pregnant women who received IPT during ANC visit	1.2% (N/W Zone)	1.0%		NDHS

Table 1 gives the demographic and health indicators of the State.

2.3 Health services provision and utilization

Kaduna State, like the rest of Nigeria, has a broad health care service, comprising a wide range of service providers, public, private for profit and faith-based organizations. The health care providers are also very heterogeneous, varying from traditional birth attendants, medicine hawkers to specialists in teaching hospitals. Excluding the Patient Medicine Vendor (PMVs), 40.2% of the health facilities in the State belong to the private sector. The distribution of health facilities in the State by type and ownership is shown in Table 2; 96.5% of the 1682 health facilities in the State are primary health care, 3.2% secondary and 0.3% tertiary health care facilities.

Table 2: Health Facilities Available in Kaduna State

Type of Facility	Ownership					Availability
	Federal	State	LGA	Private	Total	
Tertiary	5	1	0	0	5	1: 1,218,091
Secondary	2	34	0	20	54	1: 112,861

Primary	2	0	965	656 plus 2500 PMVs	1623 (excluding PMV)	1: 4362

The State has five tertiary health facilities belonging to the federal government, four of which provide specialized care, while the Ahmadu Bello University serves as the apex reference tertiary health care facility. In addition there are two hospitals belonging to the armed forces. All the federal government health facilities are based in Kaduna/Zaria. The general hospitals belonging to the state have been categorized as either rural hospitals, general hospitals or specialist hospitals, with range of services and skills available for service delivery improving along as one moves from the rural hospitals to the specialists hospitals. The primary health care facilities are divided into health clinics and Primary Health Care Centers (PHC), with the PHC centers expected to provide the full complement of PHC services. These are all owned by the LGAs. The state is comparatively well endowed with private health facilities, majority providing primary care.

A number of disease control and health programs are run by the state, majority driven by donors or the FMoH and are run essentially as vertical programs. These include the TB/Leprosy Program, the AIDS Control Program (PMTCT, ART, HCT), Onchocerciasis Control Program, NPI and the Malaria Control Program. In the past year, the State has invested significantly in malaria control, considered a State priority.

Integrated supportive supervision was introduced in the State in 2007, with a unit created in the Department of Health Planning. The programme started with 28 hospitals and 54 PHCs in 2007, it was latter scaled up to 200 health facilities. Quarterly supervision is undertaken to these facilities. Quality assurance and recognition in which health facilities were scored and recognized based on service quality has also been introduced.

Fee for service at point of service delivery is the dominant method of financing health care services in the State. However, with the introduction of free MCH, a total of 115 public PHCs and 28 secondary health facilities currently provide some components of MCH free. In addition, through the Sustainable Drug Supply Program, drug revolving funds have been revamped in 55 facilities in an effort to ensure availability of drugs in public primary and secondary health facilities. There are plans to increase the number to 150 (both Primary and Secondary Health Facilities).

Coverage

Coverage with key cost effect, high impact interventions, while higher than the zonal average, remains low. Coverage with selected maternal and child health interventions is shown in Table 1. Generally, the coverage is much higher than that of the North West zonal average, but usually much lower than the rate for the states with the highest coverage. Figure 3 gives examples of some of these indicators for maternal care coverage from the 2008 preliminary report. Only 8% of women in the reproductive age group in the state use modern contraceptives; 62% of pregnant women receive antenatal care from a trained professional while 22% of the deliveries are supervised by a trained birth attendant.

Only one in five children is fully immunized while 56.9% have been immunized against measles. These figures are about three times the zonal average. The NDHS coverage figures are lower than the estimated generated by the Kaduna State Epidemiology Unit; this underscore the importance of surveys to generate credible data.

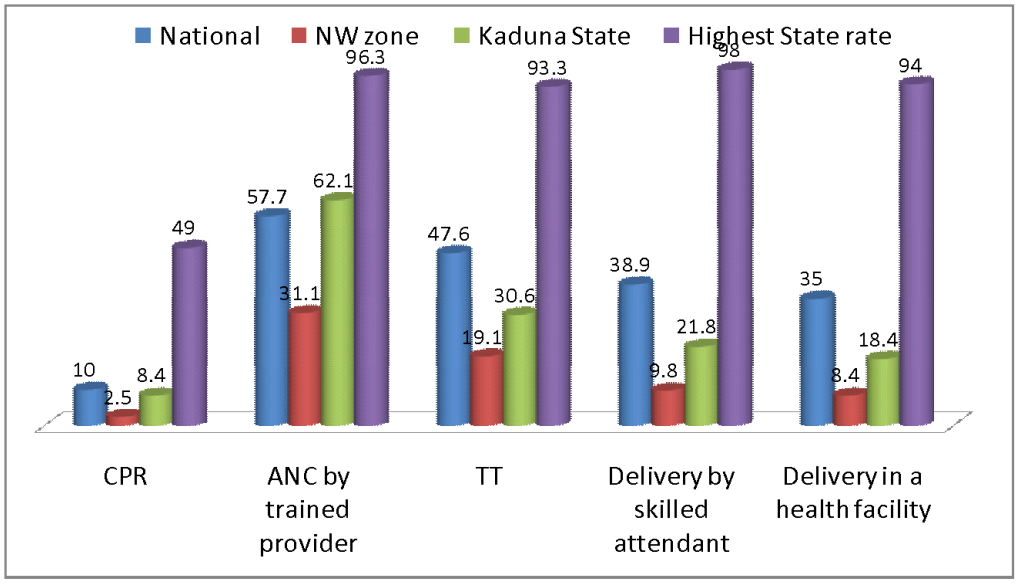


Figure 2: Coverage with Maternal Care Services

Appropriate and timely treatment of children for common childhood illnesses remain poor as less than a third of children with acute respiratory tract infections and less than a half of children with diarrhea are taken to a trained health care provider for professional care. Slightly more than a third of the children with diarrhea are given oral rehydration solution. Appropriate and timely treatment of malaria in children is also very poor and coverage with for both pregnant women and children with ITNs remains abysmally low.

2.4 Key issues and challenges

In spite of a number of improvements in the public health sector in the state, a number of problems and challenges continue to frustrate the attainment of the desired goals in the health sector. These are enumerated below.

Leadership and governance

- While there is some evidence of political commitment to health at the state level, this is hardly the case at the LGA level, where they still command responsibility for the provision of primary health care services. This has very negative implications as PHC is the fulcrum of our national policy and has been identified as central to the attainment of the MDGs and Health for All.

- In the discharge of its stewardship responsibilities, the State, in the past few years, has enacted a number of policies and laws and developed heath plans to move the health agenda forward as shown in Table 3 Some of these laws, like the law establishing the Kaduna State PHC Agency and the Drugs Management Agency and the PPP policy are yet to be operationalized, while others are suffering from problems with effective implementation.

Table 3: Laws and Policies enacted in Kaduna State

SN	Policies/Laws enacted	Year	Key Provisions/purpose
1.	Free MCH Policy	2007	o Aimed at increasing attendance at health facilities for pregnant women and children aged less than five years, through free treatment o Target is to increase attendance at health facilities from 10-15% in 2006 to 40% by the end of 2007, 60-80% by end of 2008 and above 90% by 2009. o Phased implementation- 1 facility per Political Ward by the end of 2007; 2 facilities in each Political Ward by the end of 2008 with minimal equipment and personnel required to function. To date, there are 143 health facilities enrolled in the program throughout the State in all the 23 LGAs.
2.	State PHCDA Act	2008	o Yet to become operational o Purpose is to strengthen the coordination and management of PHC across the state
3	Sustainable drug supply policy		o Aimed at ensuring availability of good quality drugs in all public health facilities in the State.
4	State Drug Management Agency Act		o Purpose is to harmonize all drug systems in the State (The free MCH and the SDSS and ensure that drug supply in public health facilities in the State is sustainable. o Yet to become operational
4	Public-Private Partnership policy		o National PPP domesticated for foster closer partnership with the private sector
5	Essential Service Package and Systems Policy (KESSP)	2008	o The costed KESSP aims at domesticating the Minimum Health Care Package of NPHCA; categorizing all public health institutions in the state and defining the minimum human and equipment resources for each level, including

			the services to be provided at each level. The KESSP also has a plan for human capacity development.
6	State Medium Term Health Plan for the period 2008 – 2011	2008	It provides strategic, direction for healthcare within the period of the plan
7	Hospital Boards Management Law	2007	This law seeks to make secondary health facilities semi-autonomous through the establishment of Bards and the direct funding of these facilities.

- Governance responsibilities for health, which is the responsibility of all tiers of government, are further shared between the three branches of government, where the executive takes responsibility for policy formulation and implementation, the legislature provides oversight, representation, and laws, and the judiciary protects voice and ensures accountability. In practice in Kaduna State the executive, as obtains across the country, wield substantial powers in the health system while the other arms of government appear relatively weak in health matters. This may not be unconnected with capacity challenges.

- The role of the civil society organizations and professional bodies as the watchdogs to foster accountability in governance and project the voices of the people is not evident in the governance of health in the state. This is as result of lack of capacity and strong platform for action.

- The institutional arrangements for channeling voice and accountability in the State is weak:
  - The State Council on Health meets irregularly. While the meeting is supposed to be at least annually, the last meeting held more than two years ago. The recommendations from the meetings are hardly implemented.
  - There is no channel for giving voice to the ordinary citizens as there is no functional mechanism on ground for channeling their concerns and preferences. The ideals of SERVICOM are yet to gain grounds in the State.
- There are issues also with accountability and transparency as the State has no mechanism to place in the public domain information on health plans, budgets, level of execution of the plans and health expenditure. There is also no system in place for budget tracking by independent monitors.
- Coordination between the State and LGAs and between the federal and State remains very weak. Donor coordination has started with the creation of the Partners' Forum, in May 2009. The Forum is to meet quarterly, it is hoped that this will improve the coordination of development partners in the State as this is currently weak. Intersectoral collaboration, especially at the State level is weak.
- Health leadership in some of the departments in the SMoH is weak. The problem is much worse at the LGA level as none of the 23 LGAs has a Medical Officer of health for provision of health leadership at that level

Health Financing

- The percentage of the State government's budget allocated to the health sector fluctuates from year to year (Table 5). It is currently below the 15% target set by the Northern Governors as contained in the resolutions from the First Health Summit of the Northern Governors that held in 2007.
- Budget release is not timely, neither is it complete. In the years 2007 and 2008 only a quarter and less than 50% of the State health budgets were released respectively. Also, even though annual operational plans exist, apart from salaries, all financial requests have to be taken to the Governor as funds are not released to SMOH for implementation of the annual plans.

Table 4: State Total and Health Budget 2002-2008 (millions of naira)

Details in '000	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
State Expenditure	23.696	25.093	33.548	36.058	43.831	77,053	94,079
MOH Expenditure	1.573	2.504	1.856	2.416	2.452	6,306	4,630
MOH as % of State	6.6	10.0	5.5	6.7	5.6	8.2	4.9

- In 2007, in an effort to remove financial barriers to health services utilization for pregnant women and children aged less than five years, the State government introduced free MCH services in all its secondary health facilities and selected primary health care facilities. The secondary health facilities are provided funds ranging from N500, 000 to N1,500, 000 monthly to fund the scheme, based on the categorization of the facility while the primary health care facilities are given some drugs for selected conditions. Both the fund release and free drug supply have not been regular as expected.
- The global recommendation is to move from out-of-pocket financing towards pre-payment schemes that pool funds and risks. Nigeria bas adopted the social health insurance. The National Health Insurance Scheme has put in place various social health insurance packages – the formal sector social health insurance, the social health insurance for the informal sector and the community-based social health insurance scheme for the rural populations. None of these schemes is yet to take off in Kaduna State: the State government has been in discussion with the

NHIS for the introduction of the Social Health Insurance Scheme for the formal sector while the State will be one of the sites for the piloting of the Community-based Social Health Insurance Scheme.

- Development Partners make significant contributions to health development in Kaduna State. Unfortunately it is difficult to quantify this as their resource envelop is not known and no effective mechanism is in place to track the funds they spend in the State. The efficiency of the use of the resources they bring cannot be ascertained.
- Financing health care in Kaduna State is unpredictable, insufficient, and inefficient.
- There is no health account to ascertain the relative contributions of the different stakeholders to health care financing in the State

Service Delivery

- The well designed and costed Kaduna State Essential Services and Systems Package that seeks to strengthen the health care system and ensure provision of a defined essential package of health care services for each level of the health care system has neither been disseminated nor implemented.

- Health infrastructure: while the State has renovated all its secondary health facilities, most of the LGA health facilities are in a dilapidated state. Basic infrastructure- water, toilet facilities, electricity are lacking in many of the LGA and some of the state facilities. (Currently, the State has secured MDG funding for the rehabilitation of 46 PHC facilities, where free MCH is being provided and plans to refurbish more as funds become available.) Many of the LGAs health facilities do not meet any criteria to be considered as health facilities. Also, in spite of the huge number of health facilities at the LGA level that lack health care providers, many LGA chairmen, because of political considerations are still building new ones. There is thus a disconnect between the huge number of facilities and the staff available. There is gross inequity in the distribution of health facilities to the disadvantage of rural and the southern senatorial zone.

- A baseline IMNCH assessment conducted in the State in April 2009 showed that key component services are not being provided at both PHC and hospital level due to a combination of factors – inadequate staff, lack of skills, faulty clinic scheduling, inadequate resources and lack of commitment. Also, hardly any community-based services provided by the PHC facilities in line with IMCI and IMNCH and PHC and there is minimal investment in health promotion and demand creation.

- Drug situation is worrisome: While the Sustainable Drug Supply Program and the Free MCH is a joint venture between the State and the LGA, their coverage, especially at the PHC level is limited. In spite of this, none of the LGAs runs any DRF. Even health facilities benefiting from the free MCH and the SDSS have a dearth of drugs.

- Dearth of basic equipment is a common feature of PHC facilities. The LGAs are not procuring equipment and there does not appear to be any system in place to ensure needed equipment is available. As a component of the free MCH program, equipment were to be supplied to the facilities providing the service, but this has not materialized.

- Operating hours and other public health facility schedules remain limitation to access and use, especially at the PHC level as most of the LGA facilities do not open on weekends and run only one shift

- Utilization of government health facilities remains very low. Even where communities have donated buildings to be use as health facilities, they still do not use the facilities.

- Traditional health care providers and informal sector providers are functioning without support and linkage to the formal sector and the services they provide are of questionable quality. Many studies have documented that PMVs are a major source of primary care provision and their utilization is higher than even the PHC facilities.

- The referral systems are very weak and PPP in the area of service provision is non existent.

- though quality assurance mechanism have been planned, implementation is been delayed by availability of resources and staff are not provided SOPs or job aids

Human Resources for Health

- Gross inequity exists in the human resource distribution at zonal, LGA, rural/urban and health facility levels.

- Critical expertise is lacking at the LGA and State levels. In spite of availability of adequate supply of human resources in other Institutions within the State which

could be use to augment what the State has to enhance service delivery quality and coverage.

- There is a comparatively an adequate number of Health training institutions in the State made up of schools of nursing (8), schools of midwifery (4) and two Schools of Health Technology, owned by either the state, ABUTH or faith-based organizations. Recently, the State government started a School of Midwifery that offers basic midwifery training. In addition to these schools, ABUTH has six other schools for the training of various categories of health care providers.
- The remuneration of health workers in Kaduna State compared to neighboring states is very low and there is disparity in the salaries between the LGA and state employees. The very high turnover of health workers, especially doctors because of migration to other states is a source of concern. While rural posting allowance is given to state-level staff working in rural facilities as incentive, in many of the rural areas, housing is not available for staff.
- Whereas the State does not discriminate in its employment policy, the poor remuneration package frustrates employment drive.
- There is no system in place for linking motivation of staff to performance
- .
- Though there is a huge market of private healthcare providers in the State there is minimal interaction with them to derive maximum benefit for the improvement of health services in the State.
- There is a dearth of critical skilled human resources in some departments of the ministry, the LGA PHC departments.

Table 3 below presents the categories of health personal available in the Kaduna State employment only. It does no include those in the private sector or institutions in the State.

Table 3: Health Human Resources Available in Kaduna State

Categories of Health Personnel	**Numbers**					**Total**
	State	LGA	ABU	Military and Paramilitary	Private Sector	
Doctors o Consultants o Dental Surgeons o General Practitioner	180 o 10 o 7 o 163					
Pharmacists (Pharm Technicians)	**64 (149)**					

Lab Scientists/Technicians	**91**					
Radiographers/x-ray technicians	**3 (11)**					
Registered nurses • Nurse midwives	**1234** o **886**	**400**				
Community Health Officers Community Health Technicians Environmental Health Officers Health educators	**26** **43** **36** **2**	**15**				

Community Participation and Partnership

- CBO and self help groups have been in existence in Kaduna for a long time, but their activities are at local level and their impact on a broader scale very limited.

- The Village Development Committees and District Development Committees set up during the Prof. Olukoye Ransome Kuti era lacked legitimacy, capacity and support and thus many died a natural death. However, more recently, with the model PHCs of NPHCDA and the effort of PATHS, facility-based and ward development communities have been established in selected sites and they appear functional

- The village health workers and traditional birth attendants trained in the 80s as part of PHC renaissance, were never linked to the formal sector, supported or supervised and thus have long since ceased to function. However in more recent times, there are attempts to reintroduce community-based health care workers (CORPs with community IMCI – in very few settlements, community volunteers for community TB program; community-based distributors of ivermectin etc. Also, PATHS 2 supports 12 community health volunteers per LGA in six LGAs, who counsel people to increase use of health services and track pregnant women and unimmunized children and refer them to appropriate health facilities. Inadequate supervision and poor linkage to health facilities remain problems.

- There is minimal constructive engagement with communities to foster real community participation and ownership and misconceptions still abound on what community participation is all about.

- There is a wide range of partnerships in existence in the state (with development partners, private sector, other sectors, communities, training institutions etc). However, PPP policy domesticated but yet to be implemented. However, more recently, an office of PPP has been opened in

the office of the governor to coordinate PPP across the state, starting with the construction of the 200 bed specialist hospital in the millennium city.

- A development partners' forum has been formed; it became functional in May 2009. . Aimed at improving information sharing and coordination of partners, the plan is for quarterly meeting of the forum.
- There is little evidence of effective inter-sectoral collaboration for health at all levels in the state
- Partnership with the private sector that provide care and corporate organizations remains weak
- There is no organized platform for engagement with professional bodies
- While a committee has been set up for coordination of traditional healers at the state level, the factionalization of the group militates against this coordination and this partnership forum is still in its infancy.

Health Research

- Research culture is completely absent at state and LGA levels, and whatever research is undertaken is supported by development partners, This is evidenced by the fact that there is no budget line for research in the SMoH and in any LGA (even though there is a recommendation that at least 2% of health budget should go to research) and while a Research Unit exists in the DHPR, it is non functional, largely due to lack of qualified human resource.
- There is a disconnect between researches in training institutions and policy and research is not translated into policy
- The capacity for research is low. Most of the research proposals reviewed by the State Ethical Committee in the past years were all external proposals
- A research unit is said to exist in the Department of Health Planning and Research, but is prostate and since the officer in charge died some years back, there has been no replacement.
- The database for secondary research is poor.
- There is poor appreciation of role of research to contribution to knowledge base

- An Ethical Review Committee exists at the state level and is said to be composed of Directors in the Ministry of Health with the Director of Hospital Services as chair.

Health Information System

HMIS and M&E capacity and performance in the state is less than satisfactory.

- Poor data culture
- Inadequate use of data for evidence-based planning
- Dearth of data collection tools. Even though the State has responded by producing and distributing one year supply to LGAs in 2008, there is a need to have a sustainable system in place
- Very weak disease surveillance unit that is not well resourced and has become almost dormant.
- Inadequate financing of HMIS
- Inadequate working tool
- Non participating/involvement of the private sector in data gathering
- Vertical disease reporting systems still rife
- Too many indicators
- Lack of transportation for M&E of HIS (data verification, validation and assessment) of HMIS in the state
- Dearth of capacity especially at the LGA level
- Non periodic reviews of the system

2.4 SWOT Analysis

Strengths ● Good network of public & private health facilities ● Renovation of secondary health facilities ● Impressive policy documents exists ● Support of development partners ● Compared to other states in the zone, human resource better ● Presence a number of well resourced tertiary health facilities ● Government commitment at the state level to health sector improvement ● Increasing access to health care services for pregnant women and children through the free MCH program	***Weaknesses*** ● Poor state of infrastructure, especially at the LGA level ● Underfunding of the sector ● Poor political commitment, especially at LGA level ● Late release of funds; having to seek governor's approval for all spending ● Weak Institutional capacity ● High burden of disease ● Poor PPP ● Weak capacity of CSO to perform its functions optimally ● Poor implementation of policies/laws ● Weak HMIS ● Poor investment in health research ● Inadequate community participation
Opportunities ● MDGs providing global commitment to improving health (MDGs 4,5,6) ● Kaduna State Governor's 11 point Agenda ● Vision 20:2020	***Threats*** ● Widespread poverty ● Ignorance ● Change in political leadership with forthcoming elections may affect current health policies

3 STRATEGIC HEALTH PRIORITIES

The eight Strategic Priorities for strengthening the health system in the State are outlined in details in appendix 1. Nonetheless, the following list reflects the priority high impact interventions to be delivered in the State - as part of the Essential Package of Health Services for Kaduna State.

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

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

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

CHAPTER 4 RESOURCE REQUIREMENTS

4.1 Human

- The State lacks a human development plan, including a continuing education plan for professional skills' enhancement.
- Gross inequity exists in the human resource distribution at zonal, LGA, rural/urban and health facility levels.
- Critical expertise is lacking at the LGA and State level. In spite the availability of adequate supply of human resources at the Ahmadu Bello University Teaching Hospital and other public Health Institutions like Arm forces and Air force Hospitals Kaduna, the State has been unable to leverage these resources to augment what it has so as to enhance service delivery quality and coverage.
- There is a comparatively inadequate number of schools of nursing (8), schools of midwifery (4) and two Schools of Health Technology in the state, owned by either the state, ABUTH or faith-based organizations. Recently, the State government started a School of Midwifery that offers basic midwifery training. However, the ceiling placed on admission by the regulatory boards limit exploitation of these institutions to rapidly scale up the numbers of the needed human resource. In addition to these schools, ABUTH has six other schools for the training of various categories of health care providers, which is not optimally leveraged by the State
- The remuneration of health workers in Kaduna State compared to neighboring states is very low and there is disparity in the salaries between the LGA and state employees. The very high turnover of health workers, especially doctors because of migration to other states is a source of concern. While rural posting allowance is given to state-level staff working in rural areas as incentive, in many of the rural areas, housing is not available for staff.
- Whereas the State does not discriminate in employment policy, the poor remuneration package frustrates employment drive. Recently the State government went to Egypt to recruit staff, whose competencies and the disparity in their salaries are causing disenchantment among other doctors.
- There is no system in place for linking motivation of staff to performance
- There are incessant complaints of the deployment and rotation of staff being done in favour of some staff, which in part was identified as reason for the inequity in staff distribution.

- The very negative attitude of health care providers has recurrently come to the fore in many discussion fora in the state.
- There is minimal interaction with the private sector health care providers, including those working in the informal sector.
- There is a dearth of critical skilled resources in some departments of the ministry, the LGA PHC departments, where there isn't a single medical officer of health and in the health facilities.

Table 3: Health Human Resources Available in Kaduna State						
Categories of Health Personnel	**Numbers**					**Total**
	State	LGA	ABU	Military and Paramilitary	Private Sector	
Doctors o **Consultants** o **Dental Surgeons** o **General Practitioner**	180 o 10 o 7 o 163					
Pharmacists (Pharm Technicians)	**64 (149)**					
Lab Scientists/Technicians	**91**					
Radiographers/x-ray technicians	**3 (11)**					
Registered nurses • **Nurse midwives**	**1234** o **886**	**400**				
Community Health Officers **Community Health Technicians** **Environmental Health Officers** **Health educators**	**26** **43** **36** **2**	**15**				

4.2 *Physical/Materials*

Kaduna state currently have 30 secondary facilities, 744 primary healthcare facilities, 7 health offices, 656 private health establishment including faith base health facilities, over 200 pharmaceutical companies and over 2500 patent and proprietary medical vendors licences. The secondary healthcare facilities have a combined bed capacity of 2067. The state is also blessed with 5 tertiary health institutions which includes ABU Teaching Hospital Shika, Neuropsychiatric Hospital, National Eye centre, National Ear Care Centre, Armed forces Reference Hospital and Nigeria Air Force Hospital Kaduna. The state is currently building a 300 bed specialist hospital in Kaduna Millennium City. This will also serve as the Teaching Hospital for the Kaduna State University.

There are 13 health institution in the state 3 of which are state owned, 6 faith based and 4 belonging to the federal government. While all the 30 secondary health facilities have been renovated and equipped the 115 PHCs in which the free treatment programme for

children under 5 and pregnant women is been implemented have been renovated and equipped. In addition 16 PHCs have been constructed and equipped by the HSDP II, 88 PHCs are being renovated and equipped through the MDG grant and over 20 model PHCs by the NPHCDA through the constituency projects. By the end of 2010 510 PHCs would be offering free Treatment Programme. The DFID through the Health Commodities Project has procured medical equipment and drugs worth one Billion Naira (₦1, 000,000,000). They have been received and are being distributed to the Secondary and Primary Health Facilities both for Public and Private Health Institutions (Mostly Faith based).

The state has procured huge amount of drugs for its free MCH and War against Malaria Programme and the sustainable drug supply system, including what it has received from development partners such as DFID, Sightsavers, International, the Onchocerciasis programme, the Netherlands TB & Leprosy Programme and the MDG grant. Other resource and materials are ITNs and LLITNS purchased by the State Government, the MDG grant and those procured from the Global Fund for HIV/AIDs & Malaria Control.

4.3 Financial

Financial resource available for the implementation of the SSHDP is provided for in the annual plan and budget. This ranges from between 6-10 % of the state annual budget. The problem has not always been provision but, the timely release of the funds. An assessment of the 2009 budget has shown that while implementation for recurrent and capital was 70% and 62% respectively, release of funds was much less. A Table detailing expenditure in relation to budget for the ministry is presented bellow.

Table 4: State Total and Health Budget 2002-2008 (millions of naira)

Details in '000	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
State Expenditure	23.696	25.093	33.548	36.058	43.831	77,053	94,079
MOH Expenditure	1.573	2.504	1.856	2.416	2.452	6,306	4,630
MOH as % of State	6.6	10.0	5.5	6.7	5.6	8.2	4.9

CHAPTER 5 FINANCING PLAN

5.1 Estimated cost for implementing the State Strategic Health Development Plan

Implementing the SSHDP for the period 2010-2015 will cost a total of **eighty five billion four hundred and eighty four million three hundred and fifty eight thousand, two hundred and ninety naira ₦85,484,358,290**. This will be funded jointly by the State, LGAs and development partners. The break down of the budget is shown below.

PRIORITY AREA	COST (2010-2015)
LEADERSHIP AND GOVERNANCE FOR HEALTH	NGN 731,296,787
HEALTH SERVICE DELIVERY	NGN 44,386,959,359
HUMAN RESOURCES FOR HEALTH	NGN 29,081,881,629
FINANCING FOR HEALTH	NGN 7,807,328,563
NATIONAL HEALTH INFORMATION SYSTEM	NGN 1,032,631,545
COMMUNITY PARTICIPATION AND OWNERSHIP	NGN 570,309,020
PARTNERSHIPS FOR HEALTH	NGN 657,949,347
RESEARCH FOR HEALTH	NGN 1,216,002,041
TOTAL COST	**NGN 85,484,358,290**

5.2 Assessment of the available and projected funds

The state is going to fund its strategic plan through the following:

Historical budget

Details in '000	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
State Expenditure	23.696	25.093	33.548	36.058	43.831	77,053	94,079
MOH Expenditure	1.573	2.504	1.856	2.416	2.452	6,306	4,630
MOH as % of State	6.6	10	5.5	6.7	5.6	8.2	4.9

Projections

2009	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
86,789.46	102,369.18	117,948.89	133,528.61	149,108.32	164,688.04	180,267.75
5,348.52	6,294.70	7,240.87	8,187.05	9,133.22	10,079.39	11,025.57

From the table above, it is expected that the total available/projected allocation to health in Kaduna State will be about 51,960.80 billion naira over the period 2010-2015.

5.3 Determination of the financing gap

The budget of the ministry is based on projected revenue from various sources including revenue from federation account, internally generated revenue, grants, credits and joint funding form LGAs. Any short fall between cost of project and what is provided through the budget is the gap.

5.4 Descriptions of ways of closing the financing gap

Funding to the health sector to be increased at the state level to at least 15% and 20% at LGA level by 2012. By 20110, the state should finalize and begin to implement the social health insurance scheme for the formal sector and the community-based HIS by 2011 with a coverage target of 60% by 2015

Reviewing the current budgeting arrangement to move from ceiling based funding to need base funding by 2010 and timely and complete release of budget lines with operational plans.

Additional financing will be sourced from the following:

a. Funds from the federation account as appropriated in the annual budget.
b. Internally generated revenue.
c. Grants from DFID and other Development partners.
d. Credit HSDP II
e. Credit SACA
f. Credit IDB
g. Loan PPP
h. Grant MDGs
i. Joint Project State and local Government.
j. ETF – Shehu Idris College of Science and Health Technology

CHAPTER 6: IMPLEMENTATION FRAMEWORK

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

A steering committee, consisting of representatives of the SMoH, the LGAs, and other stakeholders in the State shall be established in the Office of the Commissioner of Health to oversee the implementation of the SSHDP. The Steering Committee will develop a detail plan for the implementation that will include production and distribution of the State Strategic Plan. Production of advocacy materials and conduct of advocacy in support of implementation of the plan, conduct of sensitization/advocacy workshop for LGA Chairmen and other key stakeholders will be conducted as a prelude to getting the LGAs to sign an MoU with the State for the joint funding and implementation of key PHC interventions. Government, with technical support from development partners will develop the state policy, revise the Essential Service and System Package and conduct the relevant capacity building and strengthening activities. The implementation will be phased and annual costed operational plan will be developed jointly with the LGAs in line with the phasing of the implementation. The costed ESSP will be used as an advocacy tool for resource mobilization. There will be a midterm evaluation in 2013 and another in 2015.

CHAPTER 7: MONITORING AND EVALUATION

6.1 Proposed mechanisms for monitoring and evaluation

The HMIS units at the LGA and State levels will e strengthened, including capacity building of staff for timely data collection, analysis and use. The data collection tools and indicators will be reviewed and harmonized. Forms will be produced centrally at state level and distributed to all public and private health facilities through the LGAs. All health facilities would summit complete forms to the LGA M&E Officers who in turn will forward LGA report to the State. Quarterly monitoring of field data collection will be undertaken by state level staff. The system at the state level will be computerized and feedback will be through quarterly bulletin and annual reports. The epidemiology unit at the state will be strengthened so also the integrated supportive supervisory unit at the state and LGA level. Annual review meetings will be carried out to review performance and tract progress.

6.2 Costing the monitoring and evaluation component and plan

CHAPTER 8: CONCLUSION

The Kaduna State Strategic Development Plan is intended to facilitate the translation of State programmes, plans and policies into practical objectives and strategies which will form the basis for resources allocation at the State and LGAs for their implementation. The main focus of the Kaduna State Strategic Health Development Plan is to provide basic and minimum healthcare to our citizens, hence the emphasis on Primary Healthcare. In designing the plan care was taken to include only high impact interventions that will translate into achieving health MDGs within the period of its implementation.

One of the problems in budget implementation in the country, generally is the non release of budgeted funds. The signing of the National Partnership on Health Declaration and Mutual Accountability for Improved and Measureable Health Result in Nigeria by Governors of States in the Federation would improve budget implementation in the country generally. In Kaduna State we believe signing such a declaration by the LGA Chairmen will also improve the situation in the State.

The State Strategic Health Plan in line with the National Strategic Health Development Plan has Identify Eight (8) priority areas with strategic goals and objectives. The Eight (8) priority areas are:

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

These priorities over the six years period (2010 – 2015) of the plan will cost **eighty five billion four hundred and eighty four million three hundred and fifty eight thousand, two hundred and ninety naira ₦ 85,484,358,290** which translates to an average of ₦14,247,393,048.39 per year. Faithful implementation of this plan will transform healthcare in the State for the better in addition to achieving the Millennium development goals for Health.

Annex 1: Details of Kaduna SSHDP

KADUNA STATE STRATEGIC HEALTH DEVELOPMENT PLAN						
PRIORITY						
Goals				**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	
	Strategic Objectives			**Targets**		**TOTAL EXPENDITURE 2010-2015**
		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 Kaduna State						**731,296,787**
	1.1	**To provide clear policy directions for health development in Kaduna State**		**(1) All stakeholders are informed regarding health development policy directives by 2011 (2) Kaduna State health policy in place by end of 2010 (3) PPP operational plan in place by end of 2010 (4) A functional Kaduna State PHCDA in place (5) Kaduna State and 50% of the LGAs updating their SHDP annually (6) 80% of LGAs with costed SHDP by end of 2010**		**523,817,100**
		1.1.1	Improve Strategic Planning at State and Local Government levels	Availability of Kaduna State Health Sector Strategic Plan 2010-2015 and LGA level plans		**58,052,473**
			1.1.1.1 Develop Kaduna State Health Policy that includes all existing policies e.g FMCH, PPP		That Funds are available, Technical Experts are Engaged and Stakeholders are involved	19,164,040
			1.1.1.2 Prepare a credible long term sector strategy that reflects and articulates priorities in Kaduna State Development Plan & MTEF		Commitment of policy makers	4,819,028
			1.1.1.3 Develop and review operational partnership agreements with development partners, CSOs and other stakeholders		Willingness and commitment of all stakeholders to go into an MoU with the State	5,155,239
			1.1.1.4 Prepare joint annual operational plans for all LGA, Health facilities and Departments that are linked to budget and sector strategy and include resolutions by SCH		The call circular is timely and consistent and budgets are known	28,914,166
			1.1.1.5 Support LGAs to develop an evidence - based, costed, prioritized strategic health plan		That funds are available and partners are involved	-
		1.1.2	S	(1) No. of Health Bills passed and laws operationalized, (2) No. of state specific health policies		**243,304,862**

					developed and/or adapted from National		
			1.1.2.1	Establish a functional Kaduna State PHCDA		Commitment of Executive to operationalize thde already existing gazzetted K SPHCA law	224,140,821
			1.1.2.2	Enact appropriate legistlations in support of health reforms and strengthened health systems, including laws to back integrated KESSP and regulate private practice		Capacity to identify key issues for legislation and politcial commitment	6,388,013
			1.1.2.3	Domesticate existing National policies, protocols and guidelines using evidence-based standards including (IMNCH and ensure wide dissemination to service delivery points		Availability and dissemination of national policies and guidelines to states and LGAs	12,776,027
		1.1.3	Strengthen organizational capacity for reform				**64,440,486**
			1.1.3.1	Implement/provide support to issues necessary for reform in the SMOH, all LGA PHC departments and among other stakeholders including SWAp	SWAp is in finance		64,440,486
		1.1.4	Improve Coordination and Management of Health Sector in the State		(1) No. of functional coordination platforms, mechanisms or technical groups established (2) No. & frequency of meetings and summits held		**158,019,279**
			1.1.4.1	Convene annual State Council on Health		Availability of funds and commitment	70,604,359
			1.1.4.2	Hold State Health Summits on Kaduna State priority health issues		Availability of funds, insight into the health issues and commitment	70,604,359
			1.1.4.3	Conduct annual health sector programmatic review meeting linked to State Council of Health meeting		Technical competence and availability of technical officers to generated evidence-based analytical annual state health reports	16,810,562
		1.1.5					**-**
	1.2	**To facilitate legislation and a regulatory framework for health development**			**80% of Policy Makers including legislators trained in health regulation by end of 2012**		**89,264,082**
		1.2.1	Strengthen regulatory functions of Kaduna State government for health development		Proportion of policy makers including legislators trained on health regulations		**89,264,082**
			1.2.1.1	Build capacity of health policy makers and health care providers to utilize the policies and guidelines			38,328,080
			1.2.1.2	Build the capacity of legislature on formulation of relevant health laws			9,582,020
			1.2.1.3	Enforce government regulatory regulation on all public and private facilities			16,138,139

			1.2.1.4	Provide logistics support and neccesary tools for effective work			25,215,842
	1.3	**To strengthen accountability, transparency and responsiveness of the state health system**			**(1) The States and 60% of the LGAs have an active health sector 'watch dog' by 2012 (2) All state -owned public hospitals and 50% of LGA-owned health facilities have individual budgets linked to their activities by 2013 (3) Achieve 80% performance of health budget at state and LGA level by 2013 (4) By the end of 2010, the SMoH will be producing and dissemminating annual information on health plans, budgets, expenditure and status of implementation of health plans**		**49,535,122**
		1.3.1	Improve accountability and transparency		(1) Release of timely annual financial and programmatic state health reports (2) % of LGAs with active CSO watch dogs (3) Proportion of legal personnel trained on health legislation		**49,535,122**
			1.3.1.1	Publish and disseminate information on annual health plans and budget to all stakeholders, including the public		Availability of technically competent staff and commitment of policy makers to accountability	16,810,562
			1.3.1.2	Provide timely annual reports on status of implementation of State Health Plans including expenditure to all stakeholders, including the public.		Availability of technically competent staff and commitment of policy makers to accountability	-
			1.3.1.3	Increase public access to health information through the creation of a State Health information depository		Availability of resources, including technically competent staff and appreciation of value of documentation by policy makers	22,414,082
			1.3.1.4	Create a Civil Society Platform that will dialogue with key stakeholders in both public and private sectors and act as a 'watch dog' to ensure accountability and project the voice of the people to foster responsiveness of services		That the SMOH is willing to Share information and use innovative ways of sharing information. Also the CSO have the capacity to act as watch dogs	7,217,334

			1.3.1.5	Build the capacity of Judiciary on relevant Health laws to protect the voice of the people and ensure accountability		Availability of skilled trainers and willingness of legal to submit to training	3,093,143
	1.4	**To enhance the performance of the State and Local Government Health system**			**(1)Functional Kaduna SMoH Website in place by the end of 2010 (2) X % of relevant health personnel in both public and private sectors trained in data and computer based knowledge management**		**68,680,483**
		1.4.1	Improve and maintain Sectoral Information base to enhance performance		(1) No. of portal linkages established through a functional SMoH website (2) Proportion of relevant health personnel in both public and private sectors trained in data and computer based knowledge management		**68,680,483**
			1.4.1.1	Create a centralized internet-based health data base in SMOH with portal linkages to different Department, LGAs and other stakeholders	Availability of funds, technically competent persons and infrastructure	That funds and Human Resource are available	37,356,804
			1.4.1.2	Improve data analytical capacity of relevant personel at State and LGA levels inclusive of both Public and Private health practitioners	Availability of funds, technically competent persons, infrastructure and trainable health personnel	That funds are available and that benficiaries are willing to sign up	28,746,060
			1.4.1.3	Establish linkages with relevant academic institutions from within and outside the state for information sharing	Willingnessof the academic institutions to share information with the state	That funds will be available and stakeholders will understand	2,577,619
HEALTH SERVICE DELIVERY							
2. To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare							**44,386,959,359**
	2.1	**To ensure universal access to an essential package of care**			**(1) 80% of all public health facilities (State and LGA) implementing the KESSP in an integrated mannern by 2013 (2) 50% of all deliveries supervised by a trained birth attendant by 2012 and 80% by 2015; (3) 80% measles coverage by 2012 and 50% full immunization coverage by 2015; (5) 25% reduction of maternal mortality from its current level by 2013; (6) 50% reduction in child mortality from its current level by 2013 (7) 30% reduction of malaria prevalence from its current level by 2012 (8) Reduce to 4% the prevalence of HIV seropositivity by 2011; (9) Sputum positivity reduced to less than 1 person in 10,000 by the end of 2011**		**24,632,741,482**

					(10) 60% of pregnant women and children under five sleep under ITN by 2011 (11) 50% of pregnant women receive IPT (12) 80% of children immunized against measles by age one by 2012 (13) 80 percent coverage with Vit. A suppllementation among children aged 6 - 59 months by 2012 (12) 60% of under fives receiving appropriate treatment for cough/difficult breathing, fever and diarrhea within 24 hours of onset of illness. (13) 80% of health workers and state and LGA facilities using the job aids, SOPs and guidelines for service delivery by 2012		
		2.1.1	Review, cost, disseminate and implement the minimum package of care in an integrated manner		(1) Proportion of health facilities implementing the KESSP interventions in an integrated manner (2) Proportion of secondary health facilities implementing the KESSP package (3) % of children aged 12 -23 months fully immunized (4) Percentage of children aged one year immunized against measles (5) infant mortality rate (6) maternal mortality rate (7) underfive mortality rate (8) maternal mortality ratio (9) percentage of deliveries supervisied by a trained birth attendant (10) HIV sero-prevalence rate (10) Precentage of pregnant women and children under five who sleep under ITN (11) Percentage of children aged 6 - 59 months receiving vit. A supplementation within 4 months of data collection (12) % of under fives receiving appropriate treatment for cough/difficult breathing, fever and diarrhea within 24 hours of onset of illness.		**24,599,571,084**
			2.1.1.1	Review the Kaduna State Esential Service and Systems Package, including costing , in line with currrent national guidelines including IMNCH		**National guidelines and protocols**	2,203,553

						available at state level; funds are available and there is committed leadership to drive the process	
			2.1.1.2	Produce and Disseminate the KESSP to all service delivery points (private and public) in the state		**Logistic support available**	6,078,401
			2.1.1.3	Train health care providers in the key service components contained in the KESSP (eg IMCI, IMNCH, IMAI, LSS, MLSS, ELSS, VCT, PMTCT etc)		Availability of health workers for training	2,235,488,997
			2.1.1.4	Implement all the service components of the KESSP of care in an integrated manner. This includes IMNCH, HIV/AIDS, TB, Malaria, Nutrition and control of other communicable and non communicable diseases as outlines in the essential service package of the state.		**Availability of adequate funding, infrstructure, drugs and commodities and right human resource number, mix and skills equitably distributed**	22,354,889,969
			2.1.1.5	State Government endorsement of the State Minimum Pacage of Care			910,163
		2.1.2	Strengthen specific communicable and non communicable disease control programmes				**-**
			2.1.2.1	See activities under 2.1.1			-
		2.1.3	Make Standard Operating procedures (SOPs) and guidelines available for delivery of services at all levels		% of health facilities and health workers (State and LGA) using the SOPs, job aids and guidelines for service delivery by 2012		**33,170,399**
			2.1.3.1	Develop/adapt Standard Operating procedures (SOPs), job aids and guidelines		**National guidelines and protocols available at state level; funds are available and there is committed leadership to drive the process**	1,820,327
			2.1.3.2	Produce and distribute the SOPs, job aids and guidelines to all public and private service delivery points at State and LGA levels			3,619,363
			2.1.3.3	Train health care providers on the use of the SOPs, job aids and guidelines		**Availability of health care providers for training**	27,730,709
	2.2	**To increase access to health care services**			**(1)50% of the population is within 30mins walk or 5km of a PHC health service by end 2011 (2) One PHC centre per political ward by 2011 (2) At least 2 health facilities providing BEOC per LGA by 2011 (4) One hospital**		**19,135,790,071**

				providing comprehensive EOC per LGA by 2011			
		2.2.1	Improve geographical equity and access to health services		(1) The % of the population that live within 30 minutes walk of a PHC centre (2) Proportion of wards with a functional PHC centre (3) Number of LGAs with a general hospital providing CEOC services		**18,639,847,902**
			2.2.1.1	Update map all public and private health facilities in the state (LGA and State levels) based on operational level and location		**Availability of funds, technical expertise**	2,938,071
			2.2.1.2	Conduct a survey on the health care seeking behaviour of people in the state		**Availability of funds, technical expertise**	7,345,178
			2.2.1.3	Draw rational plan of siting various levels of health care facilities in line with national guidelines and norms defined by the state as contained in the KESSP, which when reviewed will include the mapping of BEOC and CEOC health facilities		**Political will and commitment to develop an equity-based health facility and infrastrcuture plan**	489,679
			2.2.1.4	Construction and Renovation of the health facility and infrastructure in the State		**Availability of funds and political commitment to implementing the plan**	18,629,074,974
		2.2.2	Ensure adequate availability and accessiblity of safe and efficacious essential drugs & consummables at all levels		(1) Percentage of LGAs wth operational and well managed DRFs (2) % of public health facilities with at least 80% of drugs on the EDL for that category of health facility		**117,927,367**
			2.2.2.1	Operationalize the Drug Management Agency Law		Commitment of Executive to operationalize the already existing gazzetted DMA law	85,161,486
			2.2.2.2	Strengthen the State Medical Stores (SMS) to support Sustainable Drug Supply Sys (SDSS) (Link to 2.2.2.1)		**Capacity of the SMS personnel to manage the SMS**	-
			2.2.2.3	Strengthen capacity for supply chain management and ensure quarterly forecasting of all drug and consummable needs (free and not free) in the state for all state and LGA facilities		**Availability of adequate funds, infrastructure and skilled personnel**	5,460,980
			2.2.2.4	Strengthen the management and logistics of health commodities at heallth facility level (all government secondary and PHC facilities) through provision of seed stocks for revamping the DRFs of HFs.		**Availability of funds and political commitment of LGAs to buy into the SDSS for all their health facilities**	13,652,451
			2.2.2.5	Train health care providers in public and private health insitutions, including those in the informal sector (e.g. PMVs) on rational drug use			13,652,451

		2.2.3	Establish a system for the maintenance of equipment at all levels		(1) Proportion of functional equipment available in public health establishments at state and LGA level (2) Number of equipment maintenance units established at zonal level and in state health facilities (3) Number of biomedical engineers trained		**35,373,952**
			2.2.3.2	Establish medical equipment and hospital furniture maintenance units / workshops in the state, at zonal levels and in state hospitals			31,935,557
			2.2.3.3	Develop a comprehensive preventive maintenance plan for equipment and furniture for all public health insitutions and offices in the state			244,839
			2.2.3.4	Develop and implement training agreements and needs-based plans for Bio - Medical Engineers with manufacturers and Ahmadu Bello University Teaching Hospital.			3,193,556
			2.2.3.5	Establish Public Private Partnership in maintenance of medical equipment and hospital furniture, including turnkey agreements with manufacturers			-
		2.2.4	Strengthen referral system		Proportion of LGAs and secondary health facilities with functional ambulance services		**338,527,550**
			2.2.4.1	Map network linkages for two-way referral systems in line with national guidelines FMoH and NPHCDA).			-
			2.2.4.2	Conduct a inventory of ambulances in the state in the public and private health sectors and at state and LGA levels			255,484
			2.2.4.3	Set up a harmonized State Ambulance Services and procure the needed ambulances , communication gadgets and other logistics for referral needed to ensure effective referrals and a system put in place to monitor referral outcomes.			266,129,642
			2.2.4.4	LGAs to enter agreement with Transport Unions to augment the vehicles available in State Ambulances Services			-
			2.2.4.5	Re- orientate the health care providers in both public and private health facilities at all levels on the two -way referal system.			72,142,423
		2.2.5	Foster collaboration with the private sector				**4,113,300**
			2.2.5.1	Map and update of private/public health facilities base on operational levels and location (see 2.2.1.1)			-
			2.2.5.2	Create a functional pivate - public stakeholders' forum for coordination of health sector activies			-
			2.2.5.3	Establish a unit in SMoH to coordinate partnership and collaboration between the private and public health sector			4,113,300
			2.2.5.4	Develop and implement health services partnership agreement between the state, LGAs and private sector based on comparative advantages			-
	2.3	**To improve the quality of health care services**			**50% of health facilities participate in a Quality Improvement programme by end of 2012**		**583,458,370**

		2.3.2	Develop and institutionalise quality assurance models				**161,338,434**
			2.3.2.3	To establish and implement a client friendly /focussed feedback system in all public/private hospital and clinics, including institutionalization of servicom across the state and LGA health establishments			95,806,671
			2.3.2.4	Train health care providers in interpersonal communication skills			32,765,882
			2.3.2.5	Review and implement the SERVICOM guidelines at all levels of the health care delivery system in both the public and private sector			32,765,882
		2.3.3	Institutionalize Integrated Supportive Supervision (ISS) mechanisms				**412,816,043**
			2.3.3.1	Establish Integrated and Supervisory Unit at the SMOH			3,255,298
			2.3.3.2	Conduct quaterly Integrate Supportive Suppervision(ISS) and Annual Appraisal			324,979,423
			2.3.3.3	Develop the capacity of programme managers and supervisors at all levels in ISS using the IMPACT+methodology			-
			2.3.3.4	Conduct monthly supervision of health facilities and HWs			55,184,643
			2.3.3.5	Conduct annual quality assessment and recognition (QAR) of all LGA and state health facilities			29,396,680
		2.3.4	Ensure availability and adequacy of equipment for all state and LGA health facilities		% of LGA and State health facilities fully equipped to deliver the full range of KESSP interventions		**9,303,892**
			2.3.4.1	Review and produce KESSP equipment list for the different categories of health facilities in line with national guidelines (FMoH and NPHCDA)		Commitment of LGAs to work with states towards developing a harmonized equipment procurement system for all public facilities in the state	4,705,172
			2.3.4.2	Conduct a needs assessment of equipment and furniture for SMoH health departments and Agencies, Ministry of Local Government PHC Department, state and LGA health Facilities		Availability of funds & technical competence	4,598,720
			2.3.4.3	Set up a centralized system for procurement of needed equipment and procure and distribute the needed equipment in line with established equipping norms (Refer to 2.2.21)		Availability of funds, political will and commitment	-
	2.4	**To increase demand for health care services**			**Average demand for health care services rises to 2 visits per person per annum by end 2011**		**34,969,435**
		2.4.1	To create effective demand for services		(1) % of the general population making at least 2 visits to health facilities to demand for services (2) % of health facilities with an adequate supply of BCC materials		**34,969,435**
			2.4.1.1	Conduct health services utilization surveys (Refer to 2.2.13)			-

			2.4.1.2	Review and domesticate the National Health Promotion policy			1,213,551
			2.4.1.3	Develop and implement a segmented strategic behavioral communication strategy, based on findings from 2..4.1.1			1,820,327
			2.4.1.4	Ensure that all public/private health facilities and departments deliver agreed minimum standard of care based on SOPs and treatment protocols (Link to monthly supervision/ISS)			-
			2.4.1.5	Conduct annual IMNCH weeks			31,935,557
		2.4.2	Strenghten the management of drugs and consummables at all levels				-
			2.4.2.1	See activities under 2.2.2			-
	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				-
			2.5.1.1	Refer to Healthcare Finanncing			-
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							**29,081,881,629**
	3.1	**To formulate comprehensive policies and plans for HRH for health development**			**(1) The State and all LGAs actively using adaptations of the National HRH policy and implementing the State HR Plan by end of 2013 (2) The state and 60% of the LGAs have functional HR units by 2012**		**21,811,060**
		3.1.1	Develop and institutionalize the Human Resources Policy as aplanning tool for rationalizing, distributing, producing and utilzing health personnel iin the state		(1) Availability of Kaduna State HRH policyand HRH plan (2) The proportion of LGAs with functional HRH units (3) the proportion of LGAs actively implementing the HRH plan		**14,144,211**
			3.1.1.1	Domesticate the National HRH policy		(1) Political will and commitment, especially at the LGA level (2) functional SPHCA (3) availability of funds and competent HR mamagers to drive the process (4) willingness of the private sector to buy into the process	588,434
			3.1.1.2	Review stafffing norms contained in the KESSP based on service availability and workload to guide the			440,465

				development of a comprehensive Kaduna State medium and long term HRH plan			
			3.1.1.3	Develop an inclusive State HRH medium and long term plan			588,434
			3.1.1.4	Establish a coordination mechanism for consistency in HRH planning and budgeting for all stakeholders (Ministries of Finance, Health, Economic Planning, LGA, Local Government Commission, Private sector, CSO, regulatory bodies)			3,799,013
			3.1.1.5	Develop a comprehensive HRH information system, including a comprehensive data base of all health personnel in the state			8,727,865
		3.1.2		Strengthen the institutional framework for human resources management practices in the health sector at sTate and LGA levels	The proportion of LGAs with functional HRH units		**7,666,848**
			3.1.2.1	Review HRH planning, management and development capacities and structures at state and LGA levels for needs assement		Availability of funds, skilled personnel and trainable HR managers	5,065,351
			3.1.2.2	Establish and support functional Human Resource Units at State and LGA levels			550,582
			3.1.2.3	Build capacity of Human resource managers at state and LGA levels			784,579
			3.1.2.4	Establish policy frameworks for integrating human resource planning, health infrastructure development and health technology planning to avoid mismatch			1,266,338
	3.2	**Rationalize and align health workforce to the priorities of the health sector in the state**			**(1)70% of public (state and LGA) and private sector facilities meet the minimum staffing standards in line with defined norms by the end of 2012(2) 50% of health care providers in primary and secondary health care facilities of both public and private sectors have necessary skills appropriate for their cadre and job description by 2012**		**1,070,902,139**
		3.2.1		Scale up the production of a critical mass of quality, multipurpose, multi skilled, gender sensitive and mid-level health workers based on service requirements in training institutions			**212,181,523**
			3.2.1.1	State health institutions to adapt the curricula and other essential requirement of trainning programmes that meet the State/National priorities.	**(% of public (state and LGA) and private sector facilities meet the minimum staffing standards in line with defined norms by the end of 2012(2) % of health care providers in primary and secondary health care facilities of both public and private sectors have necessary skills appropriate for their cadre and job description by 2012**	Political will, especially at LGA level, adequate funds and adequate capacity of training institutions to absord all the potential candidates	2,116,298

			3.2.1.2	Introduce trainning programmes that meet the health priorities and needs of the State in Sate health institutions including basic midwifery training programs			183,527,193
			3.2.1.3	SMOH to mainstream IMCI, EMONC,LSS,IYCF,ENCC.etc.into pre-service training curricula of Schools of Health technology and Nursing			4,588,180
			3.2.1.4	Conduct needs-based in-service training and re-training of health care providers, especially PHC workers			19,820,937
			3.2.1.5	Conduct admissions to the state health institutions based on predetermined requirements of each LGA			2,128,915
		3.2.2	Strengthen the institutional capacity of HRH trainining institutions		Number of health training schools meeting minimum accreditation standards of their regulatory bodies		**717,276,208**
			3.2.2.1	Upgrading teaching and learning materials and infrastructurein the State health institutions to meet minimum requirement for accreditation by the regulatory bodies.			579,630,814
			3.2.2.2	Establish Quality Asurance and educational review units in all State health institutions			-
			3.2.2.3	SMOH to promote human capital capacity building and continuning professional development for trainers			137,645,395
		3.2.3	Ensure equitable distribution, right mix of the right quality and quantity of human resources for health				**141,444,408**
			3.2.3.1	Implement staffing norms		Political will and commitment at all levels; availability of adequate number and mix of health professionals; willingness of the private sector to collaborate; willingness of the NYSC office to post all health professionals to SMoH for approriate deployment	-
			3.2.3.2	Develop initiatives and provide funds for their implementation so as to attract and retain health workers in underserved rural and hard to reach areas (initiatives include deployment of all NYSC doctors and nurses posted to the State to underserved areas, hardship /deprived area allowance for LGA level, MSS etc)			-
			3.2.3.3	Monitor the deployment of health professionals to promote equity, in staff and geographical distribution.			-
			3.2.3.4	SMOH to colaborate with federal health institutions in the state to leverage available human resources incluuding critical expertise so as to expand service coverage and quality.			137,645,395
			3.2.3.5	Establish a mecahism for collaborating with the private sector on staff development and deployment			3,799,013
	3.3	**To improve organizational and performance-based management systems for human resources for health**			**(1) All categories of health personnel to have written job descriptions by 2010 (2) 80% of health workers**		**27,987,268,924**

					to attend at least one workshop/conference per pear by 2012		
		3.3.1	Establish mecahnisms to enhance and monitor performamce of health personnel		% of HW attending professional training workshops per year		**101,605,816**
			3.3.1.1	Develop/Revise and provide job descriptions and specifications for all categories of health workers at all levels		DHPR	1,899,506
			3.3.1.2	Strengthen professional continuing education and make it mandatory			82,587,237
			3.3.1.3	Inplementf Quality Assesment and Recognition(QAR) and Integrated Supportive Supervision(ISS) (Refer to 2.3.3.4 & 2.3.3.5)			-
			3.3.1.4	Train and retrain health personnel in interpersonal communication skills and work ethics			14,122,418
			3.3.1.5	Establish and institutionalize mechanisms for mentorship and appraisal among health professionals			2,996,655
		3.3.2	Motivate health workers through the creation of performance-based incentives.				**27,885,663,108**
			3.3.2.1	Define and implement perfomance-based incentives		Political commitment, availability of funds	1,376,454
			3.3.2.2	Develop and implement guidelines on additional incentives for health workers in critical areas of need and locations.			-
			3.3.2.3	Provide an enabling work environment for public health sector personnel to minimise attrition			-
			3.3.2.4	Harmonize salaries and allowances of State and LGA health workers with that of the Federal Government.			27,873,192,435
			3.3.2.5	Develop a system of managing performance of all health workers in public and private sector			11,094,219
	3.5	**To foster partnerships and networks of stakeholders to harness contributions for human resource for health agenda**					**1,899,506**
		3.5.1	Strengthen communication, cooperation and collaboration between health professional associations and regulatory bodies on professional issues that have significant implications for the health system				**1,899,506**
			3.5.1.1	To provide a platform for inter and intra professional collaboration in order to ensure mutual respect,harmony and team work among all health professionals.			1,899,506
			3.5.1.2	Establish framework that will foster and support implementation of resolution agreed upon.			-
			3.5.1.3	Establish dialogue and complaints channels between management, staff of public and private sectors, regulatory bodies and associations.			-
			3.5.1.4	Adequate representation of workers and professional groups in management teams, design and monitoring of service.			-
FINANCING FOR HEALTH							
4. To ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and consumption at Local, State and Federal levels							**7,807,328,563**
	4.1	**To develop and implement health financing strategies at, State and Local Governemnt levels consistent with the National Health Financing Policy**			**The State and 80% of the LGAs have a documented Health Financing Strategy by end 2012**		**236,036,243**
		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		Number of LGAs with costed strategic and		**236,036,243**

					operational health financing plans in place		
			4.1.1.1	Set up a technical working group at State and LGA levels , with capacity built, charged with the responsbility of overseeing the development and implementation of the State and LGA strategic health care financing plans respectively		The State and LGAs committed to improving the financing of the health sector through a planned process	121,940,174
			4.1.1.2	Domesticate the National Health Financing policy		Funds are avaliablle and the forthcoming elections will not disrupt the plan	32,802,620
			4.1.1.4	Health Financing TWG oversee the development and implementation of the State and Local Governments' evidence-based strategic and operational health care financing plans in line with the State health care financing policy		Funds are available and the TWG is committed and have the relevant capacity	81,293,449
	4.2	**To ensure that people are protected from financial catastrophe and impoverishment as a result of using health services**			**At least 60% of the population in the state covered by the NHIS by 2015 (2) 80% of state and LGA facilities implementing free MCH**		**3,168,637,993**
		4.2.1	Strengthen systems for financial risk health protection		(1) % of the population benefiting from NHIS (2) Proportion of State and LGA facilities providing free MCH		**3,168,637,993**
			4.2.1.1	Review, adopt and implement the NHIS designed community-based social health insurance and the social health insurance for the community, formal and informal sectors in the State		Commitment of government and willingness of citizens	273,165,005
			4.2.1.2	Review the free MCH policy and implementation in the State to expand scope and make it more effective		Political commitment	32,802,620
			4.2.1.3	Expand payment exemptions to other vulnerable groups (the aged, disable, destitutes and mentally ill, etc) in line with the resolutions from the Northern Governor's Health Summit		Funds available	2,862,670,369
	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 State and LGA health funding increased by an average of 5% pa every year until 2015**		**4,024,501,130**
		4.3.1	To improve financing of the Health Sector		percentage annual increase in fund allocation to State and LGA health ministry and departments respectively		**3,982,047,885**
			4.3.1.1	Conduct advocacy to LGA Chairmen and State Executive and legislature to increase fund allocation to SMOH to at least 15% of the budget, in line with the resolutions from the Northern Governors' Health Summit and 20% for LGAs		Commitment of government; reversal of economic meltdown	69,503,522
			4.3.1.2	Explore and implement resource mobilization strategies that will provide alternative sources of health care financing like VAT and 'sin tax' on alcohol and cigarettes and donations from corporate organizations		Political will	87,473,653
			4.3.1.3	Establish special funds for chronic and emerging diseases		Availability of funds	3,803,202,297

			4.3.1.4	Advocate to executive to review current annual budgeting method from ceiling-based to needs- based		Government is committed	21,868,413
		4.3.2	To improve coordination of donor funding mechanisms				**42,453,246**
			4.3.2.1	Conduct joint assessment of all development partners' and government's coordination mechanism, especially as it related to funding		Political commitment	3,422,882
			4.3.2.2	Strengthen the established Donor Coordination Forum for effectiveness and common basket funding (Including the establishment of functional donor secretariat)		Development partners are willing to work together	14,547,249
			4.3.2.3	Promote the implementation of Paris Declration on aids effectiveness inlcuding the Implement ation of Nigeria - UNDAF 11in the state.			24,483,115
	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**		**378,153,197**
		4.4.1	Improve Health Budget execution, monitoring and reporting				**212,892,172**
			4.4.1.1	Develop annual costed operational plans at State and LGA levels(Linked to 1.1.1.4)		Government is committed and staff have requisite capacity	-
			4.4.1.2	Develop a robust accounting system for tracking flow of funds to the health sector at state and LGA levls			95,080,057
			4.4.1.3	Build institutional capacity to improve internal recording, timely accounting of expenditures and submission of periodic comprehensive accounting reports			81,301,372
			4.4.1.4	Provide budget line for each health facility linked to activities			-
			4.4.1.5	Establish mechanisms to improve financial transparency through the establiishment of State Health Account			36,510,742
		4.4.2	To strengthen financial management skills				**165,261,025**
			4.4.2.1	Conduct training of financial staff to build their capacity on financial mamagement systems		Funds are available and trainers have the capacity	81,293,449
			4.4.2.2	Conduct competency transfer on financial management systems through hands-on training and mentorship	h	Same as above	83,967,576
NATIONAL HEALTH INFORMATION SYSTEM							
5. To provide an effective Kaduna State Health Management Information System (NHMIS) as a component of the NHMIS by all the governments of the Federation to be used as a management tool for informed decision-making at all levels and improved health care							**1,032,631,545**
	5.1	**To improve data collection and transmission**			**(1.) 60% of all public and private health facilities making routine and timely HMIS returns to the LGAs by 2011 (2) 90% of LGAs making routine and timely NHMIS returns to State**		**652,873,103**

					level by end 2011 (3) Kaduna State. making routine and timely HMIS 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		% of all health facilities in the state with essential data collection tools available.		**433,969,971**
			5.1.1.1	Strengthen logistics for forecasting needs of data collection tools in all public and private health facilities across the state		**Availability of an adequate number of competent staff**	-
			5.1.1.2	Establish a mechanism for sustainable funding of production and distribution of data collection forms to all private and public health facilities at all levels in the state		**Commitment of all public and private health care providers to buying into the state driven HMIS**	-
			5.1.1.3	Produce and regularly distribute of the HMIS Tools (Registers/Forms) to all public and private health facilities in the state		**Fund and logisitcs availability**	433,969,971
		5.1.2	Harmonize and periodically review of NHMIS data collection forms				**5,988,786**
			5.1.2.1	Establish a forum of all key stakeholders - The State HMIS consultative Committee, that will review and harmonize all the stakeholders, programs and State HIS,needs , tools and indicators in line with national HIS and State information needs		**Willingness of the different stakeholders to work together towards harminization of the system**	-
			5.1.2.2	Conduct bi-annual consultative meeting to review NHIS data collection tools			5,988,786
		5.1.3	Coordinate data collection from vertical programmes				**-**
			5.1.3.1	See 5.1.2.1			-
		5.1.4	Strengthen capacity for data collection and management				**74,204,525**
			5.1.4.1	Conduct a needs assessment for HIS staffing, equipment and infrastructure at all levels in both private and public sectors			5,832,556
			5.1.4.2	Develop an evidence-based comprehensive HIS plan			5,988,786
			5.1.4.3	Implement the human resource component of the HIS plan, including recruting, training and retraining of HIS staff at all levels in both the private and public sector			51,533,934
			5.1.4.4	Procure and distribute equipment, inclduing computers and furniture in line with HIS plan			10,849,249
		5.1.5	Provide a policy & legal framework for activities of the NHMIS programme				**6,878,424**
			5.1.5.1	Develop a State HIS policy			6,878,424
			5.1.5.2	Promulgate enabling law in the State that makes compliance with State HIS plan mandatory by all stakehoders in the State			-
		5.1.6	Improve coverage of data collection				**131,831,398**
			5.1.6.1	Sensitize of propriators of private health establishments and health care providers (including traditional medical practioners) at all levels in the State on NHMIS to			61,840,721

				increase apprecaition of importance of HIS and ensure compliance			
			5.1.6.2	Conduct active follow-up to defaulting stakeholders to retrieve data			69,990,677
			5.1.6.3	Introduce incentives and sanctions for defaulters			-
		5.1.7	Ensure Completeness and Quality of data collection and analysis				-
			5.1.7.1	Provide and maintain of vehicles for supportive supervision on data collection form public and private health facilities (Link this to supportive supervison in service delivery)			-
			5.1.7.2	Development, distribution and use of supervisory checklist at the State, LGA and ward levels			-
			5.1.7.3	Supervise and monitor data collection, quality and transmission			-
	5.2	**To strengthen the ICT component of the State HIS**			**ICT infrastructure and staff capable of using HMIS in 50% of States by 2012**		**105,859,741**
		5.2.1	To develop a Kaduna State HIS data management using ICT				**97,860,228**
			5.2.1.1	Desing and set up an Internet -based data State HIS data bank with portal links to departments, LGAs and other health stakeholders			43,396,997
			5.2.1.2	Train Hospital Medical Record Personnel and LGA M&E Officers on ICT, DHIS software and electronic Management Information Systems			37,104,432
			5.2.1.3	Establish and maintain of a Web site for health data and information to the general publice			17,358,799
		5.2.2	Provide HMIS Minimum Package at the different levels (Tertiary health facilities in the state, SMOH, LGA) of data management				**7,999,513**
			5.2.2.1	Review member of State HIS Consultative Forum and Forum to develop minimum HIS data set for the state - link to 5.1.2.1			-
			5.2.2.2	Review and disseminate the NHMIS minimum package to stakeholders, data managers and service providers			7,999,513
	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**		**154,117,202**
		5.3.1	Strengthen the Hospital Information System				**-**
			5.3.1.1	Review data collection tools and processess in all hospitals in the state			-
			5.3.1.2	Review, produce and distribute data collection tools to all health hospitals			-
			5.3.1.3	Provide HIS infrastructure in health facilities, in line with state HIS plan in line with state Minimum HIS package			-
			5.3.1.4	Train hospital record clerks and sensitize of propriators and medical of public and private health establishments and health care providers (including traditional medical practioners) at all levels in the State on NHMIS to increase apprecaition of importance of HIS and ensure compliance			-
			5.3.1.5	Introduce medical audit, including peri-natal and maternal mortality audits in hospitals			-

		5.3.2	To strengthen the Disease Surveillance System				**154,117,202**
			5.3.2.1	Ungrade and refurbish the State Epidemiological Unit		Commitment of department to surveillance, fund availability	12,078,831
			5.3.2.2	Build capacity of State, LGA and health facility focal officers in integrated disease surveillance and response and outbreak investigation and management			22,262,659
			5.3.2.3	Produce and distribute of disease investigation/surveillance tools to State/LGAs health facilities			-
			5.3.2.4	Provide logistic support, including transport for active surveillance and outbreak investigation and management			119,775,712
	5.4	**To monitor and evaluate the NHMIS**			**NHMIS evaluated annually**		**44,921,678**
		5.4.1	Establish monitoring protocol for NHMIS programme implementation at all levels in line with stated activities and expected outputs				**44,921,678**
			5.4.1.1	Conduct bi-annual Data Quality Assessment (DQS) in randomly selected health service delivery points		Fund and logistics availability	4,996,441
			5.4.1.2	Conduct quaterly review meetings with State HMIS Team, Hospital Medical Record Officers and LGA PHC M&E Officers			39,925,237
	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**		**74,859,820**
		5.5.1	To institutionalize data analysis and dissemination at all levels				**74,859,820**
			5.5.1.1	Train State/LGA/ programme officers on data analysis, interpretation, presntation and use for action		Funds available	61,840,721
			5.5.1.2	Analyse returns submitted by facilities and LGAs and provide feedback to all levels		Technical capacity present and ICT installed	-
			5.5.1.3	Produce and disseminate a quarterly Kaduna State State epidemiological bulletin		Funds available and committed skilled personnel	13,019,099
COMMUNITY PARTICIPATION AND OWNERSHIP							
6. To attain effective community participation in health development and management, as well as community ownership of sustainable health outcomes							**570,309,020**
	6.1	**To strengthen community participation in health development**			**(1) All States have at least annual Fora to engage community leaders and CBOs on health matters by end 2012 (2) State 60% of health facilities have functional health committees that include community members by 2011**		**206,749,505**
		6.1.1	To provide an enabling policy framework for community participation				**10,688,972**
			6.1.1.1	Develop a state policy and plan on community participation in health		Political commitment	7,807,848

			6.1.1.2	Enact a law for establishing ward and facility based committees for PHCs			2,881,125
		6.1.2	To provide an enabling implementation framework and environment for community participation		% of wards/ villages with funtional development committees		**196,060,532**
			6.1.2.1	Resuscitate/establish and strengthen Facility and Ward development Committees at all levels		Availability of funds and political will	123,168,079
			6.1.2.2	Establish voice and accountability mechanism at the community level, for example town hall meetings & community dialogues			53,012,693
			6.1.2.3	Update and adopt participtory approaches that ensure community participation at the level of planning, , management, monitoring and evaluation			-
			6.1.2.4	Introduce Community-Health Social Health Insurance Scheme (link to appropriate section in finance)			-
			6.1.2.5	Establish community health information boards in all health facilities			19,879,760
	6.2	**To empower communities with skills for positive health actions**			**States and LGAs offer training to FBOs/CBOs and community leaders on engagement with the health system by end 2012**		**204,502,227**
		6.2.1	To build capacity within communities to 'own' their health services				**204,502,227**
			6.2.1.1	Implementation of BCC Intervention		Availability of skilled manpower	96,114,318
			6.2.1.2	Train, supervise and support community-based health workers, based on needs (e.g CORPS for community IMCI; community-based distributors for Ivercmetin, TBAs etc)			49,267,231
			6.2.1.3	Training and retraining of key community stakeholders on health prograammes, e.g community development communities, ward development communities			29,560,339
			6.2.1.4	Identify and build capacity of community groups and CBOs for active participation in health programmes			29,560,339
	6.3	**To strengthen the community - health services linkages**					**123,168,079**
		6.3.1	To restructure and strengthen the interface between the community and the health services delivery points				**123,168,079**
			6.3.1.1	Resuscitate and strengthen Community Development Committees (See 6.1.2.1)			123,168,079
	6.4	**To increase state capacity for integrated multisectoral health promotion**			**The state and 70% of the LGAs have active intersectoral committees with other Ministries , departments and private sector by end 2011**		**20,648,060**
		6.4.1	To develop and implement multisectoral policies and actions that facilitate community involvement in health development				**20,648,060**
			6.4.1.1	Develop state policy and guidelines for intersectoral collaboration		Commitment of the diferent sectors and departments to work with health for community development; availability of funds	3,860,707
			6.4.1.2	Constitute functional intersectoral committees at state and LGA level			883,545

			6.4.1.3	Intersectoral committees to develop and support implementation of health action plans that foster community participation			15,903,808
	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**		**15,241,149**
		6.5.1	To develop and implement systematic measurement of community involvement				**15,241,149**
			6.5.1.1	Develop a framework for measurement of community involvement efforts		Funds availability and personnel skilled in participatory appraisal methods	-
			6.5.1.2	establish simple and locally adaptable mechanism to support ciommunities to measure impact and documentation			8,614,563
			6.5.1.3	Establish platform to share findings, lessons learnt and best practices to be disseminated			6,626,587
PARTNERSHIPS FOR HEALTH							
7. To enhance harmonized implementation of essential health services in line with national health policy goals							**657,949,347**
	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**		**657,949,347**
		7.1.1	Promote Public Private Partnerships (PPP) (Link 7.1.1 to PPP under service delivery 2.2.5)				**100,095,252**
			7.1.1.1	Establish/Strengthen the PPP unit to oversee and monitor PPP initiatives in the State (Link to service delivery)			11,627,226
			7.1.1.2	Implementation of PPP initiative in the State			-
			7.1.1.3	Setting up the mechanism for engaging the private sector to implement the PPP initiative(such as Contracting , out-sourcesing,leasing, consesions etc.)			87,204,197
			7.1.1.4	Establish and update a comprehensive data base of private and public health facilities base on category and level of service they render			1,263,829
		7.1.2	Institutionalize a framework for coordination of Development Partners				**-**
			7.1.2.1	Strengthen the Development Partners forum at the SMOH , including developing of mechanisms for joint funding (Link to 4.3.2.2)	No. of Meetings held by the Development Partners Forum		-
		7.1.3	Facilitate inter-sectoral collaboration				**335,546,584**
			7.1.3.1	Strengthen Kaduna health forum		STAKEHOLDERS ARE WILLING TO PARTICIPATE AND FUNDS ARE AVAILABLE	270,143,436

			7.1.3.2	Establish a forum for intersecrtorial collaboration (Link to 6.4.1.2)		STAKEHOLDERS ARE WILLING TO PARTICIPATE	-
			7.1.3.3	Conduct joint planning and budgeting , monitoring and evaluation with relevant Ministires and agencies		STAKEHOLDERS ARE WILLING TO PARTICIPATE AND FUNDS ARE AVAILABLE	65,403,148
		7.1.4	To engage professional groups				**87,204,197**
			7.1.4.1	Strengthen the Medical and Health Workers' Consultative Forum and establish a forum for regular dialogue with state policy makers		SMOH IS WILLING TO TAKE THE INITIATIVE	43,602,098
			7.1.4.2	Strengthen the platform for inter-professional collaboration		PROFESSIONAL GROUPS ARE WILLING TO PARTICIPATE	43,602,098
		7.1.5	To engage with communities (Link to relevant activities under community participation and ownership)				**-**
		7.1.6	To engage with traditional health practitioners				**135,103,314**
			7.1.6.1	Domesticate the National Policy for Traditional Medicine		Political commitment	7,898,931
			7.1.6.2	Create a functional coordinating forum for TM at state level		Traditional healers willing to work together	65,403,148
			7.1.6.3	Develop and implement a plan of action for regulating, standardizing and upgrading standards of practice of TM in the state, in line with the national policy		Political Commitment and availability of funds	18,199,137
			7.1.6.4	Establish a platform for collaboration between traditional health practitioners and SMOH		Traditional healers and orthodox health workers willing to collaborate	43,602,098
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							**1,216,002,041**
	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. SMOH publishes an State Essential Health Research agenda annually from 2010**		**369,832,734**
		8.1.1	Adapt the draft national Health Research Policy and develop state health research agenda and strategiess at State and LGA levels				**34,171,918**
			8.1.1.1	Domesticate the draft National Health Research policy		There is political will and technical capacity at the state level.	9,121,588
			8.1.1.2	Establish a functional technical health research stearing committee to guide research agenda and activities in the state			25,050,331
		8.1.2	To establish and or strengthen mechanisms for health research at all levels		Number of persons trained (2) number of researches funded and completed		**8,713,158**
			8.1.2.1	Establish and strengthen the research unit in the Planning Dept of the SMOH		Competent staff available	-

			8.1.2.2	Establish a system for competitive funding of research proposal			-
			8.1.2.3	Support the conduct of health systems research based on the State's research agenda		Existence of political will by the state and LGAs.	-
			8.1.2.4	Establish linkages with other Research units, organizations and training institutions to foster research activities in the state		Lack of funding for government	8,713,158
		8.1.3	To institutionalize processes for setting health research agenda and priorities				**125,251,653**
			8.1.3.1	Hold annualmeetings of stakeholders and programme managers to identify health problems and research prirorities			125,251,653
		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				**125,251,653**
			8.1.4.1	Convene a multistakeholders forum to identify research priorities and for harmonisation of research efforts.			125,251,653
			8.1.4.2	Support development of collaborative research proposals and their implementation			-
		8.1.5	To mobilise adequate financial resources to support health research at all levels				**28,113,550**
			8.1.5.1	Establish budget lines and allocate at least 2% of health budgets for health research at state and LGA levels		Political commitment	-
			8.1.5.2	Establish linkages with with major research insitutions (nationally and internationally) so as to leverage additional resources for research		Knowledge of these institutions and having links	8,713,158
			8.1.5.3	Build capacity of staff of HRU and researchers on proposal writing and research funds mobilization		Existence of political will by the state and LGAs.	19,400,392
		8.1.6	To establish ethical standards and practise codes for health research at all levels				**48,330,801**
			8.1.6.1	Review the Research Ethical Committee and build capacity of members		There are adequate qualified human resources willing to undertake the role	17,460,353
			8.1.6.2	Develop and disseminnate ethical guidelines for health research in the state		Willingness of Government to release fund for research purpose.	5,820,118
			8.1.6.3	Set up a functional committee for monitoring clincal trials in the state and also the conduct of other researches			25,050,331
	8.2	**To build institutional capacities to promote, undertake and utilise research for evidence-based policy making in health at all levels**					**248,092,665**
		8.2.1	To strengthen identified health research institutions at all levels				**12,538,780**
			8.2.1.1	Conduct an assessment of research capacities of training and research institutions in the state (include tertiary institutions located in the state)		Funds availability and skilled persons to conduct the assessment	7,841,843
			8.2.1.2	Based on the assessment findings, develop an intervention plan for research			4,696,937
			8.2.1.3	Implement interventions to address the identified esearch capacity gaps/ weaknesses.			-

		8.2.2	To create a critical mass of health researchers at all levels				**75,661,528**
			8.2.2.1	Develop training interventions for research based on identified needs in the state		Availability of resources	17,460,353
			8.2.2.2	Build the capacity of staff of the HRU at all levels		Political will Exist	-
			8.2.2.3	Motivate tertiary educational Institutions to increase PhD levels enrolment & graduation in health-related disciplines through the award grants and scholarships			-
			8.2.2.4	Conduct training of potential researchers at all levels			58,201,176
		8.2.4	Undertake research on identified critical priority areas				**159,892,357**
			8.2.4.1	Conduct surveys to generate baseline indicators e.g. maternal mortality, infant and child mortality, malaria, non communicable (hypertension, diabetes, cancers etc)			68,676,480
			8.2.4.2	Assess the effects of some of the health policies being implemented e.g free MCH, SDSS, MSS			91,215,878
			8.2.4.3	Studies to track equity in implementation of pre-payment schemes			-
	8.3	**To develop a comprehensive repository for health research at all levels (including both public and non-public sectors)**					**132,058,808**
		8.3.1	Develop strategies for getting research findings into strategies and practices				**132,058,808**
			8.3.1.1	Create policy briefs and factsheets from research findings and disseminate to policy makers and other relevant stakeholders		Political will Exist	54,457,240
			8.3.1.2	Conduct sensitization workshops for policy makers and health care providers to share research findings and appraise them on policy and practice implications		Inadequate capacity at LGA levels	38,800,784
			8.3.1.3	Promoote use of Operations Research findings during the development of operational plans to ensure identified gaps are redressed in the plans			38,800,784
	8.4	**To develop, implement and institutionalize health research communication strategies at all levels**					**466,017,835**
		8.4.1	To create a framework for sharing research knowledge and its applications				**466,017,835**
			8.4.1.1	Conduct annual research conferences for funded and other reseachers to present their researchers		prodution of high qulity papers by researchers and willingness of reputable	38,800,784
			8.4.1.2	Establish a mechanism for providing feedback to communities on research findings using innovative approaches			18,787,748
			8.4.1.3	Support participation of researchers in national and international conferences			272,286,202
			8.4.1.4	Support publication of research findings in recognized national and international journals			136,143,101
Total							**85,484,358,290**

Annex 2: Results/M&E matrix for Kaduna SSHDP

KADUNA STATE STRATEGIC HEALTH DEVELOPMENT PLAN RESULT MATRIX						
OVERARCHING GOAL: To significantly improve the health status of Nigerians through the development of a strengthened and sustainable health care delivery system						
OUTPUTS	**INDICATORS**	**SOURCES OF DATA**	**Baseline**	**Milestone**	**Milestone**	**Target**
			2008/9	**2011**	**2013**	**2015**
PRIORITY AREA 1: LEADERSHIP AND GOVERNANCE FOR HEALTH						
NSHDP Goal: To create and sustain an enabling environment for the delivery of quality health care and development in Nigeria						
OUTCOME: 1. Improved strategic health plans implemented at Federal and State levels						
OUTCOME 2. Transparent and accountable health systems management						
1. Improved Policy Direction for Health Development	1. % of LGAs with Operational Plans consistent with the state strategic health development plan (SSHDP) and priorities	LGA s Operational Plans	0	25	50	70%
	2. % stakeholders constituencies playing their assigned roles in the SSHDP (disaggregated by stakeholder constituencies)	SSHDP Annual Review Report	0	25	30	50%
2. Improved Legislative and Regulatory Frameworks for Health Development	3. State adopting the National Health Bill? (Yes/No)	SMOH	0	25	50	75
	4. Number of Laws and by-laws regulating traditional medical practice at State and LGA levels	Laws and bye-Laws	0	20	35	60
	5. % of LGAs enforcing traditional medical practice by-laws	LGA Annual Report	0	10%	25%	50%
3. Strengthened accountability, transparency and responsiveness of the State health system	6. % of LGAs which have established a Health Watch Group	LGA Annual Report	0	10	25	50
	7. % of recommendations from health watch groups being implemented	Health Watch Groups' Reports	No Baseline	10	20	40
	8. % LGAs aligning their health programmes to the SSHDP	LGA Annual Report	0	50	75	100
	9. % DPs aligning their health programmes to the SSHDP at the LGA level	LGA Annual Report	No Baseline	50	75	100
	10. % of LGAs with functional peer review mechanisms	SSHDP and LGA Annual Review Report	0	15	25	40%

	11. % LGAs implementing their peer review recommendations	LGA / SSHDP Annual Review Report	0	10	25	40%
	12. Number of LGA Health Watch Reports published	Health Watch Report	0	5	25	40
	13. Number of "Annual Health of the LGA" Reports published and disseminated annually	Health of the State Report	0	20	30	50%
4. Enhanced performance of the State health system	14. % LGA public health facilities using the essential drug list	Facility Survey Report	20	40	60	80%
	15. % private health facilities using the essential drug list by LGA	Private facility survey	0	5	20	30%
	16. % of LGA public sector institutions implementing the drug procurement policy	Facility Survey Report	20	40	60	80%
	17. % of private sector institutions implementing the drug procurement policy within each LGA	Facility Survey Report	0	3	5	20%
	18. % LGA health facilities not experiencing essential drug/commodity stockouts in the last three months	Facility Survey Report	5	15	25	40%
	19. % of LGAs implementing a performance based budgeting system	Facility Survey Report	0	10	25	40%
	20. Number of MOUs signed between private sector facilities and LGAs in a Public-Private-Partnership by LGA	LGA Annual Review Report	0	5	15	25
	21. Number of facilities performing deliveries accredited as Basic EmOC facility (7 functions 24/7) and Comprehensive EmOC facility (9 functions 24/7)	States/ LGA Report and Facility Survey Report	10	15	25	40
STRATEGIC AREA 2: HEALTH SERVICES DELIVERY						
NSHDP GOAL: To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare						
Outcome 3: Universal availability and access to an essential package of primary health care services focusing in particular on vulnerable socio-economic groups and geographic areas						
Outcome 4: Improved quality of primary health care services						
Outcome 5: Increased use of primary health care services						

5. Improved access to essential package of Health care	22. % of LGAs with a functioning public health facility providing minimum health care package according to quality of care standards.	NPHCDA Survey Report	0	5	15	40%
	23. % health facilities implementing the complete package of essential health care	NPHCDA Survey Report	5	15	25	40%
	24. % of the population having access to an essential care package	MICS/NDHS	15	25	35	50%
	25. Contraceptive prevalence rate (modern & traditional)	NDHS	11%	15%	25%	30%
	26. % increase of new users of modern contraceptive methods (male/female)	NDHS/HMIS	10%	15%	20%	25%
	27. % of new users of modern contraceptive methods by type (male/female)	NDHS/HMIS	10%	15%	20%	25%
	28. % service delivery points without stock out of family planning commodities in the last three months	Health facility Survey	TBD	10%	20%	30%
	29. % of facilities providing Youth Friendly RH services	Health facility Survey	TBD	20%	30%	40%
	30. % of women age 15-19 who have begun child bearing	NDHS/MICS	31.60%	28%	22%	18%
	31. % of pregnant women with 4 ANC visits performed according to standards*	NDHS	62%	70%	75%	80%
	32. Proportion of births attended by skilled health personnel	HMIS	22%	30%	50%	70%
	33. % of women who received postnatal care based on standards within 48h after delivery	MICS	TBD	22%	30%	40%
	34. % of children exclusively breastfed for 6 months		TBD	5%	10%	15%
	35. Proportion of 12-23 months-old children fully immunized	NDHS/MICS	21.80%	30%	40%	50%
	36. % children <5 years stunted (height for age <2 SD)	NDHSMICS	51.80%	45%	40%	30%

	37. % of under-five that slept under LLINs the previous night	NDHS/MICS	2.00%	5	10	20
	38. % of under-five children receiving appropriate malaria treatment within 24 hours	NDHS/MICS	20	30	40	50
	39. % malaria successfully treated using the approved protocol and ACT;	MICS	30	40	50	60
	40. % of women who received intermittent preventive treatment for malaria during pregnancy	NDHS/MICS	2	5	4	10
	41. HIV prevalence rate among adults 15 years and above	NDHS	7	5	4	3
	42.Condom use at last high risk sex	NDHS/MICS	TBD	10%	20%	25%
	43. Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS	NDHS/MICS	56	60	65	70
	44. Prevalence of tuberculosis	NARHS	2.40%	2%	1.50%	1.00%
Output 6. Improved quality of Health care services	45. % of staff with skills to deliver quality health care appropriate for their categories	Facility Survey Report	20	30	50	70
	46. % of facilities with capacity to deliver quality health care	Facility Survey Report	10	15	40	60
	47. % of health workers who received personal supervision in the last 6 months by type of facility	Facility Survey Report	10	25	45	70
	48. % of health workers who received in-service training in the past 12 months by category of worker	HR survey Report	15	25	40	60
	49. % of health facilities with all essential drugs available at all times	Facility Survey Report	15	25	40	60
	50. % of health institutions with basic medical equipment and functional logistic system appropriate to their levels	Facility Survey Report	10	20	35	50
	51. % of facilities with deliveries organizing	Facility Survey Report	10	15	25	40

	maternal and/or neonatal death reviews according to WHO guidelines on regular basis					
Output 7. Increased demand for health services	52. Proportion of the population utilizing essential services package	MICS	5	15	20	30
	53. % of the population adequately informed of the 5 most beneficial health practices	MICS	TBD			
PRIORITY AREA 3: HUMAN RESOURCES FOR HEALTH						
NSHDP GOAL: To plan and implement strategies to address the human resources for health needs in order to ensure its availability as well as ensure equity and quality of health care						
Outcome 6. The Federal government implements comprehensive HRH policies and plans for health development						
Outcome 7.All States and LGAs are actively using adaptations of the National HRH policy and plan for health development by end of 2015						
Output 8. Improved policies and Plans and strategies for HRH	54. % of wards that have appropriate HRH complement as per service delivery norm (urban/rural).	Facility Survey Report	TBD	10%	20%	30%
	55. Retention rate of HRH	HR survey Report	TBD	85%	90%	95%
	56. % LGAs actively using adaptations of National/State HRH policy and plans	HR survey Report	TBD	15%	25%	40%
	57. Increased number of trained staff based on approved staffing norms by qualification	HR survey Report	TBD	10%	20%	40%
	58. % of LGAs implementing performance-based managment systems	HR survey Report	TBD	25%	35%	45%
	59. % of staff satisfied with the performance based management system	HR survey Report	TBD	20%	35%	50%
Output 8: Improved framework for objective analysis, implementation and monitoring of HRH performance	60. % LGAs making availabile consistent flow of HRH information	NHMIS	TBD	15%	25%	40%
	61. CHEW/10,000 population density	MICS	TBD			
	62. Nurse density/10,000 population	MICS	TBD			
	63. Qualified registered midwives density per	NHIS/Facility survey report/EmOC Needs Assessment	TBD			

	10,000 population and per geographic area					
	64. Medical doctor density per 10,000 population	MICS	TBD			
	65. Other health service providers density/10,000 population	MICS	TBD			
	66. HRH database mechanism in place at LGA level	HRH Database	TBD			
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	67. % of LGAs implementing state specific safety nets	SSHDP review report	25%	30	40	60
	68. Decreased proportion of informal payments within the public health care system within each LGA	MICS	TBD	70%	60%	50%
	69. % of LGAs which allocate costed fund to fully implement essential care package at N5,000/capita (US$34)	State and LGA Budgets	2	10	20	30
	70. LGAs allocating health funding increased by average of 5% every year	State and LGA Budgets		15	25	40
Output 12: Improved efficiency and equity in the allocation and use of Health resources at State and LGA levels	71. LGAs health budgets fully alligned to support state health goals and policies	State and LGA Budgets	20	40	50	70%

	72.Out-of pocket expenditure as a % of total health expenditure	National Health Accounts 2003 - 2005	50%	40%	40%	40%
	73. % of LGA budget allocated to the health sector.	National Health Accounts 2003 - 2005	7%	9%	12%	15%
	74. Proportion of LGAs having transparent budgeting and finacial management systems	SSHDP review report	0	5%	20%	40%
	75. % of LGAs having operational supportive supervision and monitoring systems	SSHDP review report	20	40%	60	70%
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	76. % of LGAs making routine NHMIS returns to states	NHMIS Report January to June 2008; March 2009	15	20	30	50
	77. % of LGAs receiving feedback on NHMIS from SMOH		5	10	30	50
	78. % of health facility staff trained to use the NHMIS infrastructure	Training Reports	30	40	50	60
	79. % of health facilities benefitting from HMIS supervisory visits from SMOH	NHMIS Report	25	40	60	75
	80.% of HMIS operators at the LGA level trained in analysis of data using the operational manual	Training Reports	10	25%	40%	60%
	81. % of LGA PHC Coordinator trained in data dissemination	Training Reports	25	40%	60%	80%
	82. % of LGAs publishing annual HMIS reports	HMIS Reports	5	15%	25%	40%
	83. % of LGA plans using the HMIS data	NHMIS Report	5	10%	25%	40%
PRIORITY AREA 6: COMMUNITY PARTICIPATION AND OWNERSHIP						
Outcome 12. Strengthened community participation in health development						
Outcome 13. Increased capacity for integrated multi-sectoral health promotion						
Output 14: Strengthened Community Participation in Health Development	84. Proportion of public health facilities having active committees that include community representatives (with	SSHDP review report	25	40%	55%	70%

	meeting reports and actions recommended)					
	85. % of wards holding quarterly health committee meetings	HDC Reports	20	40%	50%	60%
	86. % HDCs whose members have had training in community mobilization	HDC Reports	5	10%	25%	40%
	87. % increase in community health actions	HDC Reports		5%	10%	20%
	88. % of health actions jointly implemented with HDCs and other related committees	HDC Reports	5	20%	30%	40%
	88. % of LGAs implementing an Integrated Health Communication Plan	HPC Reports	0	5%	10%	20%
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	89. Increased number of new PPP initiatives per year per LGA	SSHDP Report	0	5%	10%	20%
	90. % LGAs holding annual multi-sectoral development partner meetings	SSHDP Report	0	5%	10%	20%
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	91. % of LGAs partnering with researchers	Research Reports	0	5%	10%	15%
	92. % of State health budget spent on health research and evaluation	State budget	0	1%	1.00%	1%
	93. % of LGAs holding quarterly knowledge sharing on research, HMIS and best practices	LGA Annual SHDP Reports	0	2%	5%	10%
	94. % of LGAs participating in state research ethics review board for researches in their locations	LGA Annual SHDP Reports	0	5%	10%	15%
	95. % of health research in LGAs	State Health Reseach Depository	0	3%	5%	10%

	available in the state health research depository					
Output 17: Health research communication strategies developed and implemented	96. % LGAs aware of state health research communication strategy	Health Research Communication Strategy	1	10%	25%	40%