JIGAWA STATE GOVERNMENT

STRATEGIC HEALTH DEVELOPMENT PLAN
(2010-2015)

Jigawa State Ministry of Health

March 2010

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Acknowledgement

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

Acronyms

BCC	Behaviour Change Communication
CORPs	Community oriented resource persons
CPD	Continuing professional development
CSO	Community Service Organization
DBEP	Directorate of Budget & Economic Planning
D & E	Deferral and Exemption
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
FMC	Federal Medical Centre
FMOH	Federal Ministry of Health
GDP	Gross Domestic Product
GHS	Gunduma Health System
GHSB	Gunduma Health System Board
GHSC	Gunduma Health System Council
GIS	Geographic Information System
HEC	Health Equity Committee
HF	Health Facility
HFIS	Health Facility Information System
HFMC	Health Facility Management Committee
HMIS	Health Management Information System
HIV/AIDS	Human Immuno Deficiency Virus/Acquired Immune Deficiency Syndrome
HRH	Human Resources for Health
HW	Health worker
IEC	Information, Education and Communication
IMCI	Integrated management of Childhood Illnesses
IMNCH	Integrated Maternal, Newborn and Child Health
IPC	Interpersonal Communication skills
ISS	Integrated supportive supervision
ITNs	Insecticide treated nets
JSSHDP	Jigawa State Strategic Health Sector Development Plan
JSEED	Jigawa State Economic Empowerment and Development Strategy
LGA	Local Government Area
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDAs	Ministries, Departments and Agencies
MDGs	Millennium Development Goals
MNCH	Maternal and Newborn Child Health
NGOs	Non-Governmental Organizations
NPHCDA	National Primary Health Care Development Agency
NYSC	National Youth Service Corps
OPS	Organized Private Sector

PATHS2	Partnership for Transforming Health System 2
PHC	Primary Health Care
PHCMIS	Primary Health Care Management Information System
PPP	Public Private Partnerships
PRRINN	Partnership for Reinforcing Routine Immunization in Northern Nigeria
QA	Quality Assurance
SHAs	State Health Accounts
SMOH	State Ministry of Health
SWAPs	Sector-Wide Approaches
TB	Tuberculosis
TBAs	Traditional birth attendants
TWG	Technical Working Group
UN-System	United Nations-System
VHW	Village health workers
WHO	World Health Organization

Executive Summary

Jigawa State is one of the States with poor health indices in Nigeria as indicated by the benchmarking exercise carried out in 2000The State was reported to have one of the lowest health indicators, especially diseases/conditions targeted for reduction by 2015 by the Millennium Development Goals (MDGs), such as the maternal mortality, infant and under five mortality, malaria and HIV/AIDS.

The indices galvanized state action and attracted the support of the development partners for the State Reform Agenda in the health sector. The reform process culminated in the introduction of several interventions that are gradually improving the quality of health services delivery and structural change which integrated both primary and secondary health care services under a single line of authority and accountability. Secondly, the powers and authority of the Ministry of health were decentralized into 9 Gunduma Governing councils with a Governing Board to oversee their activities

Jigawa is one of the poorest States in Nigeria with 85% of the population being rural with low literacy level and more than 70% classified as very poor. The socio-economic indices of Jigawa State are aptly described below:

a. Population: 4,598,265 (2009 projection)
b. Male: 2,345,115 (51%)
c. Female: 2,253,150 (49%)
d. Rural: 85%
e. Life Expectancy: 47.8 years (male); 48.5 years (female)
f. Employment: 68.7% self employed
g. Occupation: 70% subsistence agriculture
h. Formal Education: 4.4% post secondary
i. Major Tribes: Hausa/Fulani, Kanuri, Badawa

Jigawa state has unacceptably high mortality rates and burden of diseases profile. The 2008 Multiple Indicators Cluster Survey (MICS) and National Demographic and Health Survey (NDHS) show the following rates:

a. Infant Mortality Rate: 101/1000 live births
b. Under 5 Mortality Rate: 166/1000 live births
c. Maternal Mortality Ratio: 2000/100,000 live births
d. Immunization coverage: BCG- 8.4%; Measles-8.6%; DPT 3- 0%
e. Incidence of Malaria: 11,317/100,000

f. HIV/AIDS prevalence: Less than 2% (lowest in the Country)

The 2008 NDHS and records from the SMoH also reveal the following for the State:

a. Access to medical services: 53.5%
b. Number of health facilities: 606
c. Number of Medical Doctors: 123
d. Number of Nurses/Midwives: 564
e. Number of Pharmacists: 61
f. Number of Laboratory Scientists: 44

Government, which is the major public health service provider, has recently introduced free IMNCH services, and Exemption scheme into the health sector at both State and LGA levels to improve utilization of services, while fast tracking the attainment of MDGs 4 & 5. Accident and Emergency (A&E) services are also offered free to residents in the state.

International multilateral and bi-lateral organizations play a major role by providing financial and technical assistance for health programmes. Partner support in the State is geared towards; staff and institutional capacity building, community health insurance scheme, strengthening Routine Immunization, Safe Motherhood Initiative, Drug Revolving Fund Scheme and health research.

The major challenges for implementation include poverty at household and community level, unhealthy lifestyles and inappropriate health-seeking behaviour due in part to ignorance about causes and consequences of ill-health, acute shortage of staff, a weak health service delivery system characterized by inadequate funding, weak infrastructure, mal-distribution of available resources and poorly regulated service providers and a weak data management system.

In order to improve health care services in the state through the implementation of this strategic plan, the state has identified a Minimum Package of Care to be provided at all levels of care which contains provision of services for:

i. Communicable diseases
ii. Child Survival
iii. Safe Motherhood
iv. Nutrition
v. Non Communicable Diseases
vi. Health Education and Community Mobilization
vii. Laboratory Equipment
viii. Staffing: Adequate number, right mix and quality staff

The State priority interventions are:

Meatless Mortality reduction.
Exclusive breastfeeding.

i. To increase the percentage of fully immunized children
ii. To increase the percentage of HIV+ pregnant women receiving ART
iii. To reduce the percentage of children 0 – 59 with diarrhea
iv. To increase the percentage of household sleeping under LLITNs
v. To increase the percentage of deliveries attended by skilled personnel
vi. To increase the percentage of facilities providing BEOC

The targets set are:

i. Achieve Universal Immunization Coverage among children aged 0-5 years by 2015;
ii. Reduce infant mortality from 101/1000 to 35/1000 by 2015;
iii. Reduce under 5 mortality from 166/1000 to 55/1000 by 2015;
iv. Reduce by 50% mother-to-child transmission of HIV by 2015
v. Reduce by 60% the percentage of children 0 – 59 months with diarrhea by 2015
vi. Reduce the incidence of malaria from 11,317/100,000 to 6000/100,000 by 2015
vii. Reduce the level of maternal mortality by 2015 from 2000/100,000 live births to 600/100,000 live births
viii. Increase by 50% the facilities providing BEOC by 2015

The total cost of the 6 year strategic plan is 67.8 billion Naira. This is 15.545 N per capita. The main financing sources are the State Ministries of Health and Local Government, Gunduma Board and Development Partners.

The plan will be jointly implemented by SMOH, Guduma Health System, Development Partners, NGOs and their coalitions. Oversight for the entire strategic plan lies with the SMoH. The Gunduma Board and Councils have direct responsibility for developing and implementing operational plans based on the strategic plan.

Jigawa State Government through the SMOH and Gunduma Health System will ensure institutionalized and effective supervision of the implementation of operational plans at all levels. The outputs from the monitoring and evaluation will be measured against the targets set by the state.

Vision and Mission of Jigawa State Strategic Health Development Plan

Vision

"To have a healthy and productive population in Jigawa State".

Mission

"To promote the health status of the people of Jigawa State through improved integrated and decentralized health care services, awareness on health and health related matters, to ensure good resource mobilization and practices with increased public–private partnership (PPP) and effective community participation and ownership to ensure that basic health services are made available, accessible, affordable and acceptable to the people of Jigawa State"

Chapter 1: Introduction

1.1 Background

Jigawa State is one of the States with poor health indices in Nigeria. The benchmarking exercise carried out in 2000 placed Jigawa State among those having lowest health indicators, especially diseases/conditions targeted for reduction by 2015 under Millennium development goals such as the maternal mortality, infant and under five mortality, malaria and HIV/AIDS. This attracted the support of the development partners for the State to reform its health sector

The setting up of the health sector reform forum and subsequent situation analysis of the health sector revealed myriad problems such as weak Health Management Information System (HMIS) which is lacking in basic tools for data collection, collation and analysis. In addition, there were infrastructural decay, poor access to health services, poor managerial capacity and limited capacity for policy plan formulation, implementation and monitoring and evaluation at both State and Local government levels.

The reform process culminated into the introduction of several interventions that led to drastic improvements in the quality of health services delivery and structural change which integrated both primary and secondary health care services under a single line of authority and accountability. Secondly, the powers and authority of the Ministry of health were decentralized into 9 Gunduma Governing councils with a Governing Board to oversee their activities.

1.2 Health Sector Policy Thrusts and Objectives

- In line with National Health Policy, Primary Health Care approach will be the main focus of State Health Care delivery System. The primary objective of policy is therefore to improve the health status of the people of the state in a sustainable manner. This entails continuous improvement in all key health indicators in the state through improved accessibility to affordable and qualitative healthcare services; reduction in health and disease burden among the people; and other targeted intervention programmes specifically aimed at the attainment of the health-related MDGs. Also in consistent with the National Health Policy, the goal is to pursue a decentralized and integrated health system that addresses the provision of primary health care services that is “promotive, curative and preventive and rehabilitative.” The following are the primary objectives for achieving the overall goal:-
- To create an enabling environment and better regulatory frame work to encourage, among others, private sector participation
- To decentralize the health care system in order to improve management and ensure community participation in planning and administration of health activities.

- To focus on preventive health service with emphasis on the major elements of primary Health Care System and targeted interventions to convert the spread of HIV/AIDs and specific diseases.
- To introduce a strong health management information system to ensure systematic planning and motoring including surveillance and control major diseases
- To improve human resource for health in mix and number
- To develop health infrastructure and provision of equipment and drugs
- To foster more effective and efficient collaboration, coordination with all stakeholders and in the health sector as well as ensuring a closer partnership with International Development Partners and NGOs
- To attain public sector spending to a minimum of 15% in line with 2003 Abuja declaration and
- To introduce community operational Research for Health

1.3 Opportunities and Potentials in the Health Sectors

- Political will for Health sector reform
- The institutionalization of the decentralized and integrated healthcare delivery system – that is the *Gunduma* health system.
- Increased budgetary allocation for Health
- Removal of embargo to employment of Health Professionals
- Integration and decentralization of health care services
- Development of Strategic Plan for the Health sector
- Development of Minimum Service Package (MSP) in the provision of basic and primary healthcare services throughout the state.
- Health Promotion, community involvement and participation
- Support from a significant number of international development organizations including among others
    - United Nations Children's Fund (UNICEF),
    - World Health Organization (WHO),
    - British Department for International Development (DFID),
        - PATHS 2
        - PRRINN- MNCH
    - *Medicines Sans Frontiers*,
    - Netherlands Relief Agency.
- Global regional and national initiatives for health and development (MDGs, NEPAD, Vision 20/2020

Table of indicators for Jigawa State

INDICATORS	JIGAWA
Total population	4,361,002(2,162,926 females; 2,198,076 males)
Under 5 years (20% of Total Pop)	878 581
Adolescents (10 – 24 years)	1 247 905
Women of child bearing age (15-49 years)	1 020 407
Literacy rate	6% female; 58% men
Households with improved source of drinking water	79 %
Households with improved sanitary facilities (not shared)	22 %
Households with electricity	19 %
Employment status (currently)	45.4% female, 98.3% male
TFR	7,1
Use of FP modern method by married women 15-49	<1%
ANC	20 %
Skilled attendants at birth	5 %
Delivery in HF	5 %
Full immunization coverage	0 %
Children that have not received any immunization (zero dose)	54 %
Stunting in Under 5 children	53 %
Wasting in Under 5 children	34 %
Diarrhea in children	8,2
ITN ownership	21 %
ITN utilization	11% children, 14% pregnant women
Malaria treatment (any anti-malarial drug)	10% children, 7% pregnant women
Comprehensive knowledge of HIV	12% female, 13% men
Knowledge of TB	48.4% female, NA% male

Chapter 2: Situation Analysis

2.1 Socioeconomic context

Jigawa State is one of thirty-six States that constitute the Federal Republic of Nigeria. Jigawa State motto *"A New World*" suggests a virgin land full of opportunities. It was created out of the old Kano State on Tuesday 27th August 1991 It was excised from Kano State and got its initial legal backing through the State Creation and Transitional Provisions Decree No. 37 of 1991. Jigawa State is situated in North-western geo political part of the country between Latitudes 11.00^{o}N to 13.00^{o}N and Longitudes 8.00^{o}E to 10.15^{o}E. Kano and Katsina States border Jigawa to the west, Bauchi State to the east and Yobe State to the northeast and to the north, Jigawa shares an international border with the Republic of Niger.

Maximum temperatures (up to about 42^{0}C) are recorded between the months of March to September. Lower temperatures, especially at nighttimes during the harmatan season, are as low as 10^{0}C and thi cooler temperature occurs during the period between October and February

Jigawa State ranked 8th among the most populous states in Nigeria. The population of the state based on the 2006 Population Census is 4,348,649 of which 51% amounting to 2,215,897 are males while the remaining 49% (2,132,752) are females. The population of the state is predominantly rural (estimated at over 85%). Based on the national estimates, life expectancy at birth in Jigawa State, as of 2008, was 47.8 years for males and 48.5 years for females. Data from the 2006 CWIQ Survey indicates that about 68.7% of household heads were self-employed 70% of this relies on subsistence agriculture as their main occupation. While 81.3% of the household heads have never had any form of formal education, only 4.4% were reported as having acquired a post-secondary education. The socio-cultural situation in Jigawa State could be described as homogeneous with Hausa/Fulani found in all parts of the State. Kanuri are largely found in Hadejia Emirate, with some traces of Badawa mainly in its North-eastern parts.

The Government of Jigawa State generates about 80% its revenue from Internal Revenue and Federal Transfers. Other sources include grants from the Federal Government and other Agencies, and development loans from multilateral agencies such as African Development Bank (ADB) and International Bank for Reconstruction and Development (IBRD).

It is the plan of State Government to increase the percentage contributed through the internally generated revenue to finance a significant proportion of Government's recurrent expenditure. In recent years, efforts have been put to improve the State's fiscal strategy. This was directly consequent to DFID supported Public Expenditure Management Reform Programme under which budgeting, accounting and reporting systems are being reformed.

Relation with Multilateral Agencies: Major multi-lateral and bi-lateral agencies cooperating with Government of Jigawa State include the World Bank, UNDP, UNICEF, DFID IFAD, ADF.

Their efforts are directed at pro-poor programmes in poverty reduction, education, and good governance and improved public expenditure management.

2.2 Health Status of the Population

Jigawa state has unacceptably high mortality rates and burden of diseases profile. For every thousand children born 98 will die by age 5 years. Leading causes of ill health and death in children are communicable diseases and malnutrition. Malaria, diarrhoea diseases, respiratory tract infections, malnutrition and vaccine preventable diseases top the list. Malaria incidence stands at 11,317/100,000. Maternal mortality ratio (MMR) is estimated at 2,000 deaths per 100,000 live births. Mothers die frequently from complications of pregnancy and childbirth: anaemia, obstetric haemorrhage, shock, sepsis and toxaemias. Other reasons for the high maternal mortality in the State include low ANC coverage which stands at 20.1%; delivery by health professional and facility based delivery rates are 5.1% and 4.5% respectively, while modern contraceptive prevalence rate is abysmally low at 0.2%. Malaria is associated with 70% of illnesses in pregnancy and though the use of insecticide treated net (ITN) is known to be an effective preventive measure, its distribution in the state is erratic with only about 5% of the population owning ITN while other malaria preventive measures are not getting to the people. Other causes of ill health and death among the population include cerebo-spinal meningitis.

The 2006 CWIQ Survey indicates that over half of the population in Jigawa State has access to Health facilities as against the two-fifths reported in a similar survey conducted in 2002. Specifically the survey indicated that 51.2% of all households could reach a health facility in less 30 minutes walking distance. The 2006 survey also indicates that over seventy-six percent of people who use Health facilities expressed satisfaction with the services provided. Furthermore, while there are improvements in the nutritional status of children, a very important measure of societal wellbeing (48% and 42% under weight and stunted) and recent DHS 2008 survey (25.5% underweight and 34.3% stunted) but much still needs to be done with regards to nutritional status of the population. The MICs 2008 Survey shows that infant mortality rate is 101/1000 live births.

Under-five morality rate of about 98/1000 – mainly attributable to neonatal causes and other communicable diseases including malaria, pneumonia and diarrhoea; a maternal mortality ratio of 2000 per 100,000 live births and full immunization coverage of only about 67%. Doctor – population and nurse – population ratio were reported to be only about 1:90,000 and 1:10,800 respectively all of which are pathetically below the national average of 1:333 and 1:1000 respectively.

Even though on track, the state is still behind in the attainment of two of the most critical health-related MDGs –these are reducing under-five mortality rate by two-thirds and maternal mortality ratio by three-quarters between 1990 and 2015. HIV knowledge for female is 96.6% while male is 96.7%. However, HIV/AIDS prevalence in the state is relatively low, (less than 2%

which is the lowest in the country), concerted effort is still required to combat the decimating effect of the plague and other similar deadly conditions such as TB which has a cure rate of about 74%, malaria and other vaccine-preventable child-killer diseases. Immunization coverage is also another vital health indicator, with the State among those having lowest coverage in the Country e.g. BCG 8.6%, DPT1 11.7%, Measles 8.3% from 2008 DHS survey report. This is partly attributed to poor record keeping at the facility and household levels.

2.3 Health Services Provision and Utilization

.Only about 53% of the population has access to medical services; the rate is higher in urban areas (55%). Seventy percent of those who consulted a heath facility expressed satisfaction with the services provided but this does not necessarily reflect the true level of satisfaction within the general population as the majority of population does not access the health services.

There is a general shortage of resources for health service delivery except for drug supplies that is reported to have improved due to the introduction of sustainable drug supply scheme supported the PATHS programme. Health facilities and major equipment are in general state of disrepair and require major rehabilitation or replacement

Although the formal private sector in the State is not organized and prominent as a result of poor operating environment, the informal sector is heavily patronized by the citizenry and accounts for about 35% outpatient care. However, inpatient care provided by the private sector is less than 5%.

Government is the major health service provider and has three sometime competing modes of service delivery; the local government responsible for environmental sanitation, state government providing primary health care, first and second levels hospital services and training institutions and the federal government facilities that provide tertiary services. The SMOH also has responsibility for formulating state policies or translating national health policies for local implementation and regulating the services. Until recently this dual role of regulator and provider has compromised its role as oversight agency for all health services, public and private (including not-for profit sub-sector), and has rather been regarded as competitor with the private sector. With the creation of the Gunduma Health System and separation of service provision from policy and regulation it is expected a more even playing field will be available for all parties to participate in the development of cost-effective services for the population.

The per capita expenditure on health is less than N500:00 which is far less than the $34 (about N4250:00) minimum international benchmark provided by the Commission on Macroeconomics and Health (CMH) and the average per capita out of pocket health expenditure in the State, according to data from the Nigerian Living Standard Measurement Survey (NLSMS 2004), is about N2500:00 compared to less than N400:00 per capita that is spent through the public revenue.

Recently the Government has introduced free MNCH services and Deferral and Exemption scheme into the health sector at both State and LGA levels to fast track the attainment of MDGs 4 & 5. Accident and Emergency (A&E) services also are offered free.

International multilateral and bi-lateral organizations play a major role by providing funds and technical assistance for health programmes. While these are in general well intentioned and welcomed they can affect efficient health service development in one important way; by strategically directing these funds – and if without coordination by SMoH - donors can influence policies and programmes towards their own mandates and priorities and create duplication that diverts staff and resources away from essential routine services to vertical programmes.

Partner support in the State is geared towards; staff and institutional capacity building, community health insurance scheme, strengthening RI, SMI, DRF and health research.

Household and community are the consumers. Current levels of outpatient utilization (about 0.25 per capita in 2007) are regarded low by regional and international standards and are often a reflection of client lack of confidence in the quality of care provided.

The SMOH is the public sector agency mandated to have oversight of the health sector in Jigawa. Under the emerging reforms its functions are policy formulation and regulation, resource mobilization, social protection of the disadvantaged and external relations. It is headed by a politically appointed Commissioner of Health, and a technical Permanent Secretary with a team of directors representing major division of the health sector. It has different degrees of responsibilities toward service providers' key among which is the Gunduma Health System that has integrates state and local government health services.

The Gunduma Health System is headed by a Director General who reports to the Commissioner of Health and who is supported by a team of directors; the team provides the secretariat for the Gunduma Board which among other functions provides strategic planning and development for heath and local government sectors, recommends policy changes to Ministries of Health and Local Government and Community Development, sets fees and charges, coordinates and promotes collaboration among all health care providers in the state and supervise and monitor health teams at other levels of care. There are nine (9) Gundumas each headed by a council to oversee service delivery at that level. Within each Gunduma is a hierarchy of health facilities ranging from general hospital to basic health clinic. Other service providers are to be supervised by Gunduma Board

2.4 Key issues and challenges

The major challenge of the health sector is to effectively tackle prevailing diseases and their underlying causes in a practical and sustainable manner. The underlying causes include poverty at household and community level, unhealthy lifestyles and inappropriate health-seeking behaviour due in part to ignorance about causes and consequences of ill-health, and a weak

health service delivery system characterized by a weak infrastructure, mal-distribution of available resources and poorly regulated service providers. The weaknesses of the health delivery system are caused in part by poorly developed management and accountability systems, inappropriate packaging and delivery of services, exclusion of client and community perspectives in design and delivery of services and a general lack of reliable information for planning and critical management decision. Communities in general have a poor perception of the quality of care in public facilities and readily resort to patronage of alternative health practitioners and quacks especially by the poor.

These problems are well articulated in J-SDSD (2005) which also contains specific strategies to deal with them. These include:

- Creating an enabling environment and better regulatory framework to encourage, among others, private sector participation;
- Decentralization of the health system to improve management and ensure community participation in planning and administration of health activities. Local Government Councils would also assume greater roles in the management of Primary Health Centres and Clinics;
- Greater focus on preventive health service with emphasis on the major elements of Primary Health Care System and targeted interventions to combat the spread of HIV/AIDS and specific diseases
- Introduction of a strong health management information system to ensure systematic planning and monitoring including surveillance and control of major diseases;
- Provision of additional manpower;
- Infrastructure development and provision of medical equipment
- To foster more effective collaboration, coordination with all stakeholders in the health sector as well as ensuring a closer partnership with international Development Partners and NGOs; and.
- Sustained improvement of public sector spending on health. A minimum of 6% of the total public expenditure would be earmarked for financing the health sector including recurrent and capital spending during the period of 2004 – 2010 (the target is 15% of annual budget as per the 2003 Abuja Declaration).

Others challenges of the heath sector are;

The health sector in the State is faced with a number of constraints. While some are rooted in the socio-cultural set-up of the population others are institutional.

- Low income / high poverty incidence
- low literacy level among the population
- Acute shortage of health staff
- Weak health delivery system

- Weak data management system

Chapter 3: Strategic Health Priorities

3.1 The Eight Strategic Health Priorities

The Eight Strategic Health Priorities for strengthening the health system in the State as detailed in Appendix are:

1. Leadership and governance for health
2. Health service delivery
3. Human resources for health
4. Health financing
5. National health information system
6. Community participation and ownership
7. Partnerships for health
8. Research for health

However, the Essential Package of Health Services for Bayelsa State by service delivery mode listed reflects the priority high impact interventions to be delivered in the state.

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

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

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

Chapter 4 Resource Requirements

4.1 Facilities

The state of health service delivery is currently improving though only about half of the population has access to health services – an improvement upon a 2004 survey that indicated a lesser percentage – general access is hindered due to, among others, decay in infrastructure, shortage of skills and quantity of staff, poor attitude of health care providers, lack and poorly maintained equipment, low outreach services, poor preparedness for emergencies as well as poor private sector participation. There is not a single FBO or NGO health facility in the State and all public health facilities are under the administration of the GHSB.

Currently there are 604 public health facilities in the State categorized as follows;

Hospital	Nos
Federal Medical Centre	1
Specialist Hospital	1
General Hospitals	8
Cottage Hospitals	4
PHCs	20
Health Posts	310
BHCs & Dispensaries	259
TB & Leprosy Hospital	1
Private clinics/hospitals	10

Of the 603 State owned public health facilities, none has full contingent of staff and only eight (8) are offering services as provided for in the Minimum Service Package.

Although the nine (9) Gunduma councils are offering outreach services to their catchment areas, the coverage is ineffective due to severe logistics problems coupled with inadequate funding as well as inability to properly identify many of the underserved populations.

4.2 Human Resources

The human resource (HR) situation in Jigawa State health sector could best be described as grossly inadequate in terms of the total numbers, skills mix and gender balance. Data obtained from available records from the GHSB show that there are in the State service, as at end of October, 2009, the following categories of health workers;

S/No	CADRE	MALE	FEMALE	TOTAL

1	Medical Doctors	72	9	81
2	Nurses	219	108	327
3	Midwives	_	14	14
4	Nurse/Midwives	_	54	54
5	Pharmacists	20	1	21
6	Pharmacy Technicians	43	1	44
7	Pharmacy Assistants	8	_	8
8	Medical Laboratory Scientists	32	4	36
9	Lab Technicians	65	5	70
10	Lab Assistants	112	8	120
11	Dentists	2	_	2
12	Dental Technicians	5	_	5
13	Dental Assistants	5	1	6
14	Physiotherapists	10	2	12
15	Community Health Officers	84	4	88
16	SCHEWs	675	222	897
17	JCHEWs	768	279	1,047
18	Environmental Health Officers	98	_	98
19	Env. Health Technicians	20	_	20
20	Env. Health Assistants	60	4	64
21	Nutritionists	6	9	15
22	Public Health workers	83	52	135
23	Health Attendants	882	268	1,150
24	Health Record Officers	94	7	101

25	Administrative HR personnel	211	35	246
26	Radiographers	17	_	17
27	Others	482	158	640
	GRAND TOTAL	4,073	1,245	5,318

Staffing norms do not exist; recruitment, selection, and distribution of health workers are often not based on need and are thus inappropriate and lopsided. The result is that some services are being rendered by people without required competences, or non-availability of services to those in critical need.

Due to the rural setting of the State, it was faced with the serious problem of staff exiting from public service especially the Medical Doctor cadre with an attrition rate of about 15% in previous years. The situation has however greatly improved with the present administration's upward review of salary packages, introduction of incentives such as rural allowances, performance linked incentives and motivation of staff through in-service trainings and further capacity building.

Key HRH challenges are lack of a policy on HRH, poor working environment and different remuneration and condition of service for staff, inadequate distribution of staff with rural areas the worst hit and attrition. Other major challenges are the ceiling on the admission slots allocated to training institutions as well as entry requirements into these schools.

Provision of adequate, trained, right mix of staff and financial resources are key to implementing the plan. Gaps in HRH will be filled based on needs and geographical space while collaboration with partners will ensure their financial support. The table below gives an indication of financial contributions expected from some development partners in the State.

The first step in realizing this intervention is adaptation of the national HRH policy to be followed by development and implementation of strategy for strengthening HRH. SMoH is to lead in creating awareness and engaging stakeholder dialogue on HRH policy and strategy as well as monitoring and evaluating the policy.

A description of possible activities that can contribute to the achievement of each specific objective and intervention are presented below.

Although no official data is available, however, the number of staff, especially professional, exiting from the State health service is worrisome. Jigawa is still considered as a rural State with non provision of some necessary facilities that are readily available in other developed States and this is the root cause of the problem, notwithstanding the good salary package offered by the State as compared to others. The SMoH is expected to periodically review and improve the package and also advise the State Government to provide a conducive atmosphere for health personnel and others to live comfortably in the State.

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

Staffing norms are to be developed and implemented. These will cover recruitment, selection, distribution, workload, service availability and health service priority. To genuinely address the HRH problem a human resource audit will be conducted and mechanism for filling in the gap will be developed and implemented.

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

The newly created HRH units in the SMoH and GHSB will be strengthened to effectively discharge their duties also HRH managers will be given training on planning and management in HRH.

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

Training institutions related to HRH will be supported to review their programmes in line with identified priorities for the State. Existing training institutions will be expanded and new ones established to address the paucity in HRH while further capacity building for academic staff will be vigorously pursued.

Continuous capacity building for health sector managers in the field of governance and leadership will be pursued while their skills in routine administration will be improved upon as well.

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

To achieve an adequate HRH situation in the State, staff should be equitably distributed in terms of mix, needs and geographical space. A data base for all health workers in the State with job specifications should be created and a strategic reduction in the proportion of non health workers to health workers be implemented.

A system of setting and evaluating performance targets as well as rewarding and sanctioning staff will be put in place. It is equally important to strengthen the system for in-service training and also develop and implement plan for training all categories of administrative staff to improve their skills

Chapter 5 Financial Plan

Estimated cost of the strategic orientations: The total cost of the 6 year strategic plan is 67,8 billion Naira. This is 15.545 N per capita. The main financing sources are the State Ministries of Health and Local Government, Gunduma Board and Development Partners.

5.1 Estimated costs of the strategic orientations

Estimated costs for six years in Naira

S/No.	Priority Area	Estimated Cost
1.	Leadership and governance for health	677 922 987
2.	Health service delivery	41 625 490 646
3.	Human resources for health	20 610 120 010
4.	Financing for health	1 150 188 671
5.	National health information system	1 016 884 481
6.	Community participation and ownership	677 922 987
7.	Partnerships for health	677 922 987
8.	Research for health	1 355 845 975
	Total	67 792 298 746

5.2 Assessment of the available and projected fund

From the data provided on operational plan and budget for the state, the proposed budget for 2010 which included budgets from both the SMOH and Gunduma Health Service, stood at NGN4,890,476,400. If we apply an inflation rate of 12.5% annually till 2013, the total available funding for health is some NGN40,191,364,230 over the period 2010-2015.
The table below shows some information on planned spending by some donor agencies. It is well to observe here that on average, an additional 2,016,000,000 billion naira can be projected for the period 2010-2015 (average of 1.4million GBP x 6 years @240 naira per GBP). This would bring the total available and projected funding for the health sector to about N42,207,364,230
.

Sources of additional funding for Jigawa State SHDP

	2010	**2011**	**2012**	**2013**	**2014**	**2015**
Jigawa State Government (SMOH plus Gunduma)	4,890,476,400					
PATHS 2/DFID	GBP 1.3m	GBP 1.3 m	GBP 1.3m	GBP 1.3m	GBP 1.3m	
PRINN/MNCH/DFID	GBP 600,000	GBP 600,000	GBP 300,000			
HSDP2/WB/Malaria	N300m	N500m	N500m			
WHO						
UNICEF						
TOTAL						

5.3 Determination of the financing gap

This is basically the difference between available/projected funds and the estimated of the SHDP. This amounts to N67 792 298 746 minus N40,191,374,230 = 27,600,924,516 naira only.

Chapter 6 Implementation Plan

The plan will be jointly implemented by SMOH, Guduma Health System, Development Partners, NGOs and their coalitions. Oversight for the entire strategic plan lies with the SMoH. The Gunduma Board and Councils have direct responsibility for developing and implementing operational plans based on the strategic plan.

Jigawa State Government through the SMOH and Gunduma Health System will ensure institutionalized and effective supervision of the implementation of operational plans at all levels. The outputs from the monitoring and evaluation will be measured against the targets set by the state.

6.1 Implementation framework

The SMOH is the public sector agency mandated to have oversight of the health sector in Jigawa. Under the emerging reforms its functions are policy formulation and regulation, resource mobilization, social protection of the disadvantaged and external relations. It is headed by a politically appointed Commissioner of Health, and a technical Permanent Secretary with a team of directors representing major division of the health sector. It has different degrees of responsibilities toward service providers' key among which is the Gunduma Health System that integrates state and local government health services.

The Gunduma Health System is headed by a Director General who reports to the Commissioner of Health and who is supported by a team of directors; the team provides the secretariat for the Gunduma Board which among other functions provides strategic planning and development for heath and local government sectors, recommends policy changes to Ministries of Health and Local Government and Community Development, sets fees and charges, coordinates and promotes collaboration among all health care providers in the state and supervise and monitor health teams at other levels of care. There are nine (9) Gundumas each headed by a council to oversee service delivery at that level. Within each Gunduma is a hierarchy of health facilities ranging from general hospital to primary health clinic. Other service providers also are to be supervised by Gunduma Board

International Multilateral and Bi-lateral Organizations play a major role by providing funds and technical assistance for health programmes. While these are in general well intentioned and welcomed they can affect efficient health service development in one important way; by strategically directing these funds donors can influence policies and programmes towards their own mandates and priorities and create duplication that diverts staff and resources away from essential routine services to vertical programmes.

NGOs and coalitions

Coalition for Better Health

Jigawa State Coalition for Development

International Federation of Female Lawyers

Joint National Association of persons with Disabilities.

Household and community are the consumers

Chapter 7 Monitoring and Evaluation

7.1 Proposed Mechanism for Monitoring and Evaluation

A functional and effective monitoring and evaluation (M&E) system serves to provide the data needed to guide the planning, coordination, and implementation of the strategic plan and identify areas for program improvement. However, the effectiveness of the M&E systems is itself dependant on commitment of the health system to put necessary human and financial resources for its implementation.

Jigawa State Government through the SMOH and Gunduma Health System should institute effective supervision of the implementation of operational plans at all levels to ensure that;

1. Planned activities are properly implemented
2. establish/strengthen monitoring and evaluation systems to track progress and changes
3. correct negative practices or gaps in service availability, coverage, human resources, financing, information systems, and leadership and governance
4. examine the functionality and adequacy of monitoring and evaluation systems through the completeness, regularity and quality of reports as well as the level of use in improving the performance of local health systems
5. SMOH and Gunduma Health System should develop monitoring frameworks based on set targets, using coverage and other performance indicators to clarify type of data, sources, analysis and periodicity of review
6. Data should be disaggregated by geography, gender, age and income level for targeting those in greatest need
7. Each level of service should have a role and responsibility in monitoring and evaluation of their plans
8. MOH should take the overall responsibility to guide and provide support to lower levels to undertake their monitoring and evaluation activities
9. The health facility staff and/or community health workers should provide support to communities in monitoring activities undertaken at community level.
10. Capacities of staff to be involved in M&E is to be built at all levels but especially LGA level.
11. Ensure adequate financing of the M&E process at all levels..

Annex 1: Details of Jigawa State Strategic Health Development Plan

JIGAWA STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
PRIORITY							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	
	Strategic Objectives				**Targets**		**ETIMATED 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.							**677,922,987**
	1.1	**To provide clear policy directions for health development**			**All stakeholders are informed regarding health development policy directives by 2011**		**671,137,317**
		1.1.1	Improved Strategic Planning at Federal and State levels		Strategic plans available and actively implemented at all tiers of Govt by second quarter 2010		**2,121,609**
			1.1.1.1	Strengthen the capacity of the SMOH in policy formulation, monitoring and evaluation		Political will and commitment. Support from Development Partners	1,763,788
			1.1.1.2	Undertake Advocacy to political, religious, traditional leaders and other stakeholders		Active advocacy team in place	234,878
			1.1.1.3	Develop and harmonize state policy on health and health related issues including referrals		Availability of policies, plans and strategies on specific health programmes	65,054
			1.1.1.4	Develop guidelines for policy implementation and monitoring		Harmonized policy produced	57,888
		1.1.2	Rationalize and strengthen the institutional framework for health care		Regulatory framework available in all departments of SMoH by fourth quarter 2010		**669,015,708**
			1.1.2.1	Support repositioned departments in SMOH to effectively discahrge their duties		Availability of fund and staff to be trained. Support from Development Partners	83,844,258
			1.1.2.2	Strengthen the Gunduma Board and the 9 Gunduma Health System management teams		Availability of fund and staff to be trained. Support from Development Partners.	584,888,359
			1.1.2.3	Monitor implementation of appropriate regulations in line with all State health laws		Availability of trained staff and funds	283,090
	1.2	**To facilitate legislation and a regulatory framework for health development**			**All State Health Bills signed into law by end of 2010**		**3,245,944**
		1.2.1	Strengthen regulatory functions of government		All departments in SMoH with		**3,245,944**

					regulatory frameworks being enforced in the public and private sectors by second quarter 2011		
			1.2.1.1	Strengthen capacity in the development and enforcement of regulatory policies		Availability of funds and staff to be trained	1,458,552
			1.2.1.2	Design regulatory framework and periodically monitor, review and improve the Regulatory System		Availability of funds. Support from Development Partners	1,160,352
			1.2.1.3	Review policy & guidelines on private practice and patent medicine vendors.		Policy on private practice available	247,540
			1.2.1.4	Review and enforce laws and by - laws on environmental health and sanitation		Availability of staff and evvironmental health and sanitation laws	224,164
			1.2.1.5	Review and disseminate public health Edicts (Law).			155,335
	1.3	**To strengthen accountability, transparency and responsiveness of the national health system**			**All LGAs and the State are monitored by an active health sector 'watch dog' by 2011**		**3,539,727**
		1.3.1	To improve accountability and transparency		Active policy that is evidenced - based, gender sensitive, pro - poor and increasingly responsive to citizens views by third quarter 2010		**3,539,727**
			1.3.1.1	Enforce adherence to Procedures for promoting transparency and accountability		Sensitized workforce. Favourable political and economic conditions	916,985
			1.3.1.2	Develop and monitor implementation of the Performance Agreement between the SMOH/SMoLG and the Gunduma Health System			647,219
			1.3.1.3	The Gunduma Health System Board and Governing Councils to periodically account for their stewardship to SMOH/MoLG		Positive political leadership	748,363
			1.3.1.4	Constitute and orient State Health Audit Team.			324,223
			1.3.1.5	Disseminate bi - annual health audit reports			902,938
	1.4	**To enhance the performance of the national health system**			**1. 50% of States (and their LGAs) updating SHDP annually 2. 50% of States (and LGAs) with costed SHDP by end 2011**		
		1.4.1	Improving and maintaining Sectoral Information base to enhance performance				
HEALTH SERVICE DELIVERY							
2. To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare							**41,640,273,644**

	2.1	**To ensure universal access to an essential package of care**			**Essential Package of Care reviewed and adopted by 2010**		**4,626,865,892**
		2.1.1	To review, cost, disseminate and implement the minimum package of care in an integrated manner		Minimum Health Package in place and operational in 50% of health facilities by third quarter 2011		**244,605,461**
			2.1.1.1	Review and update the State MSP for health at all levels		**MSP document and trained staff available**	443,964
			2.1.1.2	Cost the MSP		**MSP document and trained staff available**	1,152,200
			2.1.1.3	Dessiminate the MSP		**MSP document**	2,536,561
			2.1.1.4	Support facilities to improve provision of services such as RI, MNCH, Malaria etc. as outlined in the MSP		**Support from Development Partners and availability of State funds and trained staff**	90,693,239
			2.1.1.5	Strengthen skills in LSS, IMCI, Malaria, Family Planning, BEOC etc		**Support from Development Partners and availability of State funds**	149,779,497
		2.1.2	To strengthen specific communicable and non communicable disease control programmes		Decrease in morbidity and mortality caused by specific communicable and non communicable diseases by 20% by fourth quarter 2013		**4,361,941,038**
			2.1.2.1	Procure and distribute ITNs, SP, drugs for TB, HIV/AIDS and onchocerciasis to the communities		**Availability of State funds and support from Development Partners**	1,547,831,286
			2.1.2.2	Provide cold chain and diagnostic equipment & reagents to ensure effective control of Malaria, TB, HIV/AIDS, Child survival and Maternal Care/EOC		**Availability of State funds and support from Development Partners**	657,042,348
			2.1.2.3	Strengthen strategies for prevention and control of epidemic diseases		**Availability of State funds, support from Development Partners and enlightened citizens**	810,646,405
			2.1.2.4	Develop and strengthen strategies for provision of services for non communicable diseases particularly diabetes mellitus, sickle cell, hypertension and cancers (breast, cervix and prostate)		Availability of State funds, support from Development Partners and enlightened citizens	818,733,219
			2.1.2.5	Develop strategy to improve and monitor the provision of services for primary eye care, VVF and Noma		**Availability of State funds, support from Development Partners and enlightened citizens**	527,687,781

		2.1.3	To make Standard Operating procedures (SOPs) and guidelines available for delivery of services at all levels		SOPs and guidelines for priority health conditions developed and displayed in 80% of facilities by fourth quarter 2012		**20,319,393**
			2.1.3.1	Develop SOPs for priority disease conditions and services		**Support from Development Partners. Trained staff**	14,093,354
			2.1.3.2	Train service providers on SOPs		**Availability of funds**	3,939,062
			2.1.3.3	Monitor and evaluate the implementation of SOPs		**Availability of funds**	2,286,977
	2.2	**To increase access to health care services**			**50% of the population is within 30mins walk or 5km of a health service by end 2011**		**26,281,929,116**
		2.2.1	To improve geographical equity and access to health services		Mapping of all health facilities in the State conducted and completed by third quarter 2010		**22,694,637,506**
			2.2.1.1	Construct new health facilities and implement the simplified, standard typology of health facilities		**Favourable political and economic conditions.**	22,411,811,016
			2.2.1.2	Establish a Geographic Information System (GIS) for the Gunduma Health System and link to that of the SMoH		**Availability of funds and trained staff**	38,274,625
			2.2.1.3	Develop, implement and monitor MSP coverage plan at all levels of care		**MSP plan and trained staff available**	6,191,703
			2.2.1.4	Review/update catchment maps and micro plans and set clear target in all healths facilities			1,867,147
			2.2.1.5	**Strengthen system for the provision of outreach services in hard to reach areas**		**Funds and trained staff available**	236,493,014
		2.2.2	To ensure availability of drugs and equipment at all levels		Sustainable Drug Supply System and functional, adequate, basic and essential equipment provided in 80% of facilities by fourth quarter 2014		**3,300,248,339**
			2.2.2.1	Strengthen the capacity of JIDMA to effectively manage the sustainable drugs supply system		**Availability of funds**	458,176,402
			2.2.2.2	Improve the drugs procurement, distribution and monitoring system		**Positive political leadership and availability of funds**	1,562,946,826
			2.2.2.3	Procure and distribute equipment in accordance withMSP and distribute/supply to facilities		**Positive political leadership and availability of funds**	1,154,071,472

			2.2.2.4	Provide refresher training for DRF service providers.		**Developmental Partner's support and availability of State funds**	19,937,152
			2.2.2.5	Strengthen M&E for DRF schemes at all facilities		**Trained staff and funds available. Support from Development Partners**	105,116,488
		2.2.3	To develop and implement physical assets policy		Active policy on physical assets in place by first quarter 2011		**54,852,663**
			2.2.3.1	Develop standard asset inventory system across the state			542,410
			2.2.3.2	Develop terms of reference for maintenance officers identified from within the facilities and support them to develop maintenance schedules		Qualified Maintenance officers available. Support from Development Partners	6,489,784
			2.2.3.3	Develop and implement clinical equipment and health care waste management system		Support from Development Partners	5,936,908
			2.2.3.4	Strengthen PPM for vehicle, infrastructure, machinery and equipment		Support from Development Partners	25,587,110
			2.2.3.5	Strengthen security system for the protection of physical assets			16,296,450
		2.2.4	To strengthen referral system		50% of facilities with an active referral system by fourth quarter 2013		**188,293,321**
			2.2.4.1	Develop, implement and monitor guidelines on referral of patients			1,628,669
			2.2.4.2	Incorporate information about referral practice into Annual Health Summit		**Conduct of annual PPRHAA**	1,515,994
			2.2.4.3	Produce and distribute referral tools to all facilities		**Availability of funds**	15,493,428
			2.2.4.4	Train key facility staff on use of referral tools		**Availability of funds**	6,407,399
			2.2.4.5	Establish cluster of facilities and provide transport for referrals in each cluster		**Availability of funds**	163,247,831
		2.2.5	To foster collaboration with the private sector		50% of private health facilities providing services as outlined in the MSP by fourth quarter 2014		**43,897,288**
			2.2.5.1	Create enabling environment for private practitioners to operate in the State		Conducive political, economic environment and policy	3,257,946
			2.2.5.2	Develop SOP and guidelines for private practice		Support from Development Partners. Availability of funds	13,360,934
			2.2.5.3	Strengthen the PPP unit in the SMoH		**Availability of funds, staff and support from Development Partners**	24,721,629
			2.2.5.4	Establish linkages between facilities and private health practitioners		**Conducive operating environment for private health**	1,682,296

						practitioners and sensitized public health workers	
			2.2.5.5	Strengthen linkage with professional bodies in the State for improved health services		Conducive operating environment for professional bodies and sensitized public health workers	874,482
	2.3	**To improve the quality of health care services**			**50% of health facilities participate in a Quality Improvement programme by end of 2012**		**6,948,588,628**
		2.3.1	To strengthen professional regulatory bodies and institutions				**-**
		2.3.2	To develop and institutionalise quality assurance models		10% of facilities turned into quality assurance models by fourth quarter 2012		**31,632,743**
			2.3.2.1	Strengthen the existing quality assurance systems and monitor implementation		Availability of trained staff and existing quality models. Availability of funds	26,718,121
			2.3.2.2	Bi - annually review and analyze set targets for health services e.g. RI; ANC;PNC etc		Leadership and commitment from SMoH. Availability of trained staff	4,914,621
		2.3.3	To institutionalize Health Management and Integrated Supportive Supervision (ISS) mechanisms		PPRHAA and ISS institutionalized in all facilities by fourth quarter 2013.		**668,256,578**
			2.3.3.1	Strengthen and institutionalise PPRHHA and ISS processes		Availability of funds. Trained staff. Support from Development Partners	52,904,390
			2.3.3.2	Plan and undertake ISS in all facilities		Availability of funds and trained staff	612,179,366
			2.3.3.3	Use ISS to measure performance in the implementation of plans, budgets and set targets.		Conduct of ISS	2,084,503
			2.3.3.4	Disseminate ISS findings to SIACC and Health Sector Reform Forum		Conduct of ISS	1,088,319
		2.3.4	Rehabilitation of infrastructure		All facilities requiring rehabilitation assessed by fourth quarter 2010. 2) 30% of assessed facilities rehabilitated by fourth quarter 2012		**6,243,331,759**
			2.3.4.1	Assess facilities and staff quarters requiring infrastructural rehabilitation and prepare bills of quantity			613,779
			2.3.4.2	Rehabilitate assessed facilities and staff quarters in line with MSHP.		Availability of funds	5,109,052,488

			2.3.4.3	Identify and provide water, electricity, and sanitation in all facilities lacking these services		Availability of funds	1,133,665,493
			2.3.4.4	Procure and distribute basic office equipment and furniture for furninshing offices and health facilities		Availablity of funds	-
		2.3.5	To strengthen transport system for health		Active transport policy in place by fourth quarter 2010		**5,367,549**
			2.3.5.1	Review and monitor implementation of the transport policy		Transport policy available	754,222
			2.3.5.2	Conduct situation analysis of vehicles in all facilities, Gunduma Board and councils and SMoH		Availability of funds and technical officers	565,272
			2.3.5.3	Develop plan for replacing old vehicles and increasing fleet to meet needs at all levels		Availability of funds	606,469
			2.3.5.4	Implement monitoring system to ensure efficient use of transport for effective health service delivery		Availability of funds	3,441,586
	2.4	**To increase demand for health care services**			**Average demand rises to 2 visits per person per annum by end 2011**		**-**
		2.4.1	To create effective demand for services				**-**
			2.4.1.1	Develop a comprehensive BCC strategy for health promotion in the state.			-
			2.4.1.2	Conduct regular health promotion campaigns for the State Minimum Pcakage of Care - Community dialogues, town hall meetings, etc			-
		2.4.2	To establish voice and accountability..				**-**
			2.4.2.1	Develop comprehensive servicom committees.			-
			2.4.2.2	Establish community based oversight committees.			-
			2.4.2.3	To establish Patients Charter in all Health institutions.			-
	2.5	**To provide financial access especially for the vulnerable groups**			**1. Vulnerable groups identified and quantified by end 2011 2. Vulnerable people access services free by beginning 2012**		**3,782,890,007**
		2.5.1	To improve financial access especially for the vulnerable groups		50% of vulnerable people access free services by fourth quarter 2013		**3,782,890,007**
			2.5.1.1	Annually undertake an Analysis of health equity issues to assess effectiveness		Active health equity committee	188,358
			2.5.1.2	Define, Identify and quantify vulnerable people/groups in all LGAs		Proper identification of vulnerability. Sensitized citizens. Support from LGAs	3,816,674

			2.5.1.3	Identify and provide free services to vulnerable people/groups		Political will and favourable economic condition	3,778,884,976
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							**20,610,120,010**
	3.1	**To formulate comprehensive policies and plans for HRH for health development**			**State and LGAs are actively using adaptations of the National HRH policy and Plan by end of 2015**		**93,664,197**
		3.1.1	To develop and institutionalize the Human Resources Policy framework		Active HR policy and Plan in place by fourth quarter of 2011		**59,188,670**
			3.1.1.1	Adapt the National HRH policy		Political will and commitment.	1,903,244
			3.1.1.2	Assess capacity needs, develop and implement plan and strategy for HRH strengthening			10,110,309
			3.1.1.3	Disseminate HRH policy, strategy and plan to stakeholders		Policy and strategy developed	37,285,906
			3.1.1.4	Monitor and evaluate implementation of HRH policy		Availability of funds	9,889,211
			3.1.1.5				-
		3.1.2	To create enabling environment for staff retention		Less than 0.25% of professional staff exiting service each year up to 2015		**34,475,527**
			3.1.2.1	Periodically review and improve wages and welfare package for staff		Political commitment and favourable economic condition	34,475,527
	3.2	**To provide a framework for objective analysis, implementation and monitoring of HRH performance**			**The HR for Health Crisis in the State has stabilised and begun to improve by end of 2012**		**57,414,108**
		3.2.1	To reappraise the principles of health workforce requirements and recruitment at all levels		HR requirement and recruitment plan actively being pursued by third quarter 2012		**57,414,108**
			3.2.1.1	Review and strengthen the present system for staff appraisal		Low capacity of HR unit staff	30,299,981
			3.2.1.2	Undertake a human resource audit to identify gaps in staffing situation			19,354,967
			3.2.1.3	Design mechanism for filling in the gap from HR audit			7,759,160
	3.3	**Strengthen the institutional framework for human resources management practices in the health sector**			**SMoH and GHSB have functional HRH Units by end 2010**		**214,733,224**
		3.3.1	To establish and strengthen the HRH Units		Active HR department in the SMoH by fourth quarter 2010		**214,733,224**

			3.3.1.1	Strengthen the newly established HRH Departments in SMoH & GHSB		Availability of funds and staff. Support from Development Partners	214,733,224
	3.4	**To strengthen the capacity of training institutions to scale up the production of a critical mass of quality, multipurpose, multi skilled, gender sensitive and mid-level health workers**			**Training institutions producing quality, gender sensitive health workforce graduates with multipurpose skills and mid-level health workers by 2015**		**19,963,674,811**
		3.4.1	To review and adapt relevant training programmes for the production of adequate number of community health oriented professionals based on national priorities		1) Training programmes reviewed and adapted for all training institutions by fourth quarter 2011. 2) Training institutions producing 20% workforce above their present capacity third quarter 2015		**19,849,427,319**
			3.4.1.1	Support training schools in organizing appropriate training for health workers and students		Availability of adequate number of academic staff	2,991,204,565
			3.4.1.2	Develop a strategy for expanding existing training institutions to increase intake of students		Availability of adequate number of academic staff and funds	52,485,682
			3.4.1.3	Review policy on establishment of training Institutes and establish new training schools to address staff needs – midwifery, college of sciences etc.		Availability of adequate number of academic staff and funds	16,705,752,517
			3.4.1.4	Further capacity building for academic staff in training institutions		Availability of funds	99,984,554
			3.4.1.5				-
		3.4.2	To strengthen health workforce training capacity and output based on service demand		80% of management staff trained on managerial leadership by third quarter 2015		**114,247,493**
			3.4.2.1	Train managers in the health sector on governance and transformational leadership		Availability of funds and Support from Development Partners	73,617,582
			3.4.2.2	Develop skills for effective routine administration in SMOH, Gunduma Board and Councils		Availability of funds and Support from Development Partners	40,629,911
	3.5	**To improve organizational and performance-based management systems for human resources for health**			**SMoH, GHSB & GHSCs actively implementing the performance management systems by end 2012**		**280,633,671**

		3.5.1	To achieve equitable distribution, right mix of the right quality and quantity of human resources for health		1) Health workforce mapping conducted and completed by first quarter 2012. 2) Health workforce equitably distributed by first quarter 2015		**5,676,148**
			3.5.1.1	Distribute staff to ensure good mix in all facilities.		Adequate number of disaggregated health workers. Political interference	2,499,614
			3.5.1.2	Develop and implement a strategic reduction in the proportion of non-health professional workers to professionals		Adequate number of disaggregated health workers. Political interference	3,176,534
			3.5.1.3				-
			3.5.1.4				-
			3.5.1.5				-
		3.5.2	To establish mechanisms to strengthen and monitor performance of health workers at all levels		Annual performance evaluation of all health workers instituted by fourth quarter of 2011		**274,957,523**
			3.5.2.1	Establish performance targets and enforce systems for rewarding and sanctioning staff		Political interference and sensitized workforce	124,980,692
			3.5.2.2	Strengthen the system for in-service training for all cadres in health care.			49,992,277
			3.5.2.3	Develop a plan and train all categories of administrative staff to improve skills			99,984,554
	3.6	**To foster partnerships and networks of stakeholders to harness contributions for human resource for health agenda**			**50% of States have regular HRH stakeholder forums by end 2011**		
		3.6.1	To strengthen communication, cooperation and collaboration between health professional associations and regulatory bodies on professional issues that have significant implications for the health system				
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 and State levels							**1,150,188,671**
	4.1	**To develop and implement health financing strategies at State and Local levels consistent with the National Health Financing Policy**			**A documented Health Financing Strategy for the State by end 2012**		**49,205,568**
		4.1.1	To develop and implement evidence-based, costed health financing strategic plans at LGA and State levels in line with the National Health Financing Policy		Active health financing strategic plans available at State and Gunduma levels by first quarter 2012		**49,205,568**
			4.1.1.1	Implement and monitor policy on equity, gender and poverty		Active health equity committee.	10,639,595

			4.1.1.2	Disseminate, implement and monitor a coordinated health financing policy		Active health financing policy.	38,565,973
	4.2	**To ensure that people are protected from financial catastrophe and impoverishment as a result of using health services**			**NHIS protects 30% residents in the State by end 2015**		**183,360,086**
		4.2.1	To strengthen systems for financial risk health protection		80% of facilities operating deferral and exemption system by fourth quarter 2014		**183,360,086**
			4.2.1.1	Revitalise and Strengthen the Health Equity Committee in the SMOH		Support from Development Partners	60,886,975
			4.2.1.2	Review and strengthen the Deferral & Exemptions system and broaden scope to cover PHCs		Favourable political and economic conditions	25,129,980
			4.2.1.3	Implement and monitor Deferral & Exemptions system and conduct annual review			74,889,890
			4.2.1.4	Develop, implement and institutionalise a health Insurance scheme at all levels		Sensitized workforce. Favourable political and economic conditions	22,453,240
	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 SMoH and Gunduma health funding increased by an average of 5% pa every year until 2015**		**80,283,494**
		4.3.1	To improve financing of the Health Sector		At least 5% annual increase in the allocated funds budgeted and utilised for health services up to 2015		**46,144,863**
			4.3.1.1	Review and assess options for Health care financing and develop strategy		Support from Development Partners	33,405,323
			4.3.1.2	Establish a common pool account for the GHSB and SMOLG and monitor its application		Support from Development Partners.	2,391,151
			4.3.1.3	Establish and strenghten the State Health Accounts systems in SMOH and GHSB		Support from Development Partners. Trained staff	10,348,389
		4.3.2	To improve coordination of donor funding mechanisms		Bi - annual meeting of Donor Cordination Forum for joint review and planning by fourth quarter 2010		**34,138,631**
			4.3.2.1	Promote joint planning and funding of health activities with donor agencies		Leadership and commitment by SMoH. Active participation by Donors	12,771,498
			4.3.2.2	Broaden participation in health planning to include private sector		Leadership and commitment by SMoH. Active participation of	21,367,133

						sensitized private sector.	
	4.4	**To ensure efficiency and equity in the allocation and use of health sector resources at all levels**			**a) Transparent budgeting and financial management systems in place for SMoH, GHSB & Councils by end of 2012 b)Supportive supervision and monitoring systems developed and operational in SMoH, GHSB and Councils by end 2012**		**837,339,523**
		4.4.1	To improve Health Budget execution, monitoring and reporting		SMoH, Gunduma Board and councils and 70% of facilities implementing activity - based budget by last quarter 2012		**120,198,624**
			4.4.1.1	Review and strengthen the capacity of management staff to manage the budget process, including tracking and monitoring implementation		Availability of funds. Support from Development Partners	38,008,203
			4.4.1.2	Improve mechanisms for monitoring and accounting for Internally Generated Revenue		Availability of trained staff	31,767,903
			4.4.1.3	Periodically review and monitor implementation of annual plans and budgets		Availability of trained staff	10,432,423
			4.4.1.4	Undertake annual plan and budget review process (with stakeholder participation) to assess effectiveness of Strategic Plan implementation		Sensitized and trained stakeholders. Support from Development Partners	16,458,550
			4.4.1.5	Strengthen capacity of personnel in healthcare financing and monitoring		Availability of funds. Support from Development Partners	23,531,547
		4.4.2	To strengthen financial management skills		50% of planning and budget staff at all levels and 50% of facility managers trained on preparation of annual plans and budget process by second quarter 2012		**717,140,899**
			4.4.2.1	Improve appropriate financial management skills for accounting officers and accounts staff in SMOH and GHS		Support from Development Partners	16,600,818
			4.4.2.2	Improve capacity in the preparation of evidence based annual plans and budget for accessing funding		Support from Development Partners	46,932,828

			4.4.2.3	Improve PBT's capacity in the development of 3-year rolling plans for health services delivery		Support from Development Partners	18,124,995
			4.4.2.4	Establish mechanism for involving the communities/middle level managers in the planning process		Sensitized and trained communities and middle level managers. Support from Development Partners	635,482,258
NATIONAL HEALTH INFORMATION SYSTEM							
5. To provide an effective National Health Management Information System (NHMIS) to be used as a management tool for informed decision-making at all levels and improved health care							**1,016,884,481**
	5.1	**To improve data collection and transmission**			**All LGAs making routine NHMIS returns to State level by end 2011**		**555,472,177**
		5.1.1	To ensure that NHMIS forms are available at all health service delivery points at all levels		NHMIS forms avallable and in use in all health facilities by third quarter 2010		**96,819,427**
			5.1.1.1	Develop and implement SOPs for HMIS		**Availability of funds. Support from Development Partners**	12,796,952
			5.1.1.2	Produce, print and distribute standardised tools for data collection		**Availability of funds**	84,022,475
		5.1.2	To establish and strengthen Knowledge Management at all levels		Active Knowledge Management unit in SMoH, GHSB and GHSCs by fourth quarter 2010		**66,246,121**
			5.1.2.1	Identify, constitute and inaugurate TWG and key staff groups		**Political and financial commitment**	10,741,232
			5.1.2.2	Establish KM units in SMoH, GHSB and GHSCs		Political and financial commitment. Availability of trained staff	51,995,908
			5.1.2.3	Conduct assessment of knowledge needs, inventory,mapping and flow analysis		Trained staff	535,341
			5.1.2.4	Develop and adopt State KM strategy			2,149,890
			5.1.2.5	Disseminate assessment findings		Availability of funds	823,750
		5.1.3	To coordinate data collection from vertical programmes		50% of private health providers and all Development partners submitting data to HMIS unit by first quarter 2011		**5,735,358**
			5.1.3.1	Develop mechanism for data collection and analysis from private sector providers and Development Partners		**Leadership and commitment by SMoH. Sensitized and trained private sector**	1,647,500
			5.1.3.2	Develop mechanism for harmonisation and verification of data		**Availability of data from all sources**	4,087,858

		5.1.4	To build capacity of health workers for data management		70% of HMIS officers and 50% of facility managers at all levels re - trained on data management by second quarter 2011		**28,623,656**
			5.1.4.1	Develop and implement appropriate HMIS training plan for strengthening capacity at the SMoH,GHB, GHSC and facility level		Availability of funds. Support from Development Partners	6,747,540
			5.1.4.2	Strengthen the capacity of facility managers in data collation and analysis		Availability of funds. Support from Development Partners	13,616,583
			5.1.4.3	Strengthen SMOH/GHSB capacity in the use of analysed data for policy review and target setting		Support from Development Partners	8,259,533
		5.1.5	To provide a legal framework for activities of the NHMIS programme		Active HMIS policy by fourth quarter 2010		**-**
			5.1.5.1	Strengthen and monitor the use of Standard Operating Procedures and policy guidelines on data collection		**SOP and policy guidelines available**	-
			5.1.5.2	Strengthen policy guidelines on data management and utitlisation at all level		**Policy guidelines and trained staff available**	-
		5.1.6	To improve coverage of data collection		80% of facilities submitting complete data by fourth quarter 2014		**14,992,246**
			5.1.6.1	Extend data collection to facilities that are not submitting		Availability of trained staff and data collection tools	14,992,246
		5.1.7	To ensure supportive supervision of data collection at all levels		Supportive supervision of data collection institutionalised in 70% of facilities by third quarter 2013		**343,055,370**
			5.1.7.1	Conduct monthly facility supervision		Availability of funds and trained staff	16,013,695
			5.1.7.2	Conduct quarterly data review meetings		Availability of funds and trained staff. Support from Development Partners	296,760,514
			5.1.7.3	Conduct quarterly State Data Consultative review meetings		Support from Development Partners	9,224,709
			5.1.7.4	Conduct Data quality survey		Availability of funds and trained staff	10,107,474
			5.1.7.5	Conduct annual data review meetings		Availability of funds and trained staff	10,948,978
	5.2	**To provide infrastructural support and ICT of health databases and staff training**			**ICT infrastructure and staff capable of using HMIS in SMoH, GHSB & Councils and 60% of LGAs by 2013**		**288,460,689**
		5.2.1	To strengthen the use of information technology in HIS		SMoH, GHSB, all GHSCs, 60% of HMIS LGA offices		**288,460,689**

					and 10% of facilities are provided with ICT by fourth quarter 2013		
			5.2.1.1	Computerise the data collection, utilisation and analysis processes in the 10 General Hospitals		Availability of funds . Support from Development Partners	9,427,816
			5.2.1.2	Provide internet services in all HMIS offices in the State		Availability of funds and trained staff	103,297,395
			5.2.1.3	Provide HMIS office accomodation in all the 27LGAs and 9 GHSCs		Collaboration withLGAs	97,976,796
			5.2.1.4	Provide computers and generators to all the 27 LGAs and 9 GHSCs		Availability of funds. Support from Development Partners	77,758,682
		5.2.2	To provide HMIS Minimum Package at the different levels (FMOH, SMOH, LGA) of data management				-
	5.3	**To strengthen sub-systems in the Health Information System**			**NHMIS annually reviewed and adapted by 2010**		**64,455,535**
		5.3.1	To strengthen the Health Facility Information System		Health Facility Information System institutionalised in 50% of facilities by second quarter 2014		**64,455,535**
			5.3.1.1	Support facility managers to utilise analysed data in measuring performance		Funds available	19,365,533
			5.3.1.2	Assess HFIS sitituation in all hospitals		Availability of funds and trained staff	28,615,007
			5.3.1.3	Fill in gaps identified in the assessment		Funds available	16,474,995
		5.3.2	To strengthen the Disease Surveillance System		Active Disease Surveillance System institutionalized in all LGAs by first quarter 2011		-
			5.3.2.1	Strengthen surveillance and notification systems		Availability of funds and trained staff	-
	5.4	**To monitor and evaluate the NHMIS**			**NHMIS evaluated annually**		-
		5.4.1	To establish monitoring protocol for NHMIS programme implementation at all levels in line with stated activities and expected outputs				-
	5.5	**To strengthen analysis of data and dissemination of health information**			**a) 70% of LGAs have Units capable of analysing health information by end 2011 b) Regular dissemination of available results by SMoH by end 2011**		**108,496,080**
		5.5.1	To institutionalize data analysis and dissemination at all levels		SMoH, GHSB, all GHSCs are analysing and		**108,496,080**

					dessiminating data bi - annually by first quarter 2012		
			5.5.1.1	Provide up to date analysed data to policy makers to enhance decision making		Analysed data available	3,056,112
			5.5.1.2	Utilise analysed data for decision making at Health Sector Reform Forum and SIACC Meetings		Political support for reforms remains	8,237,498
			5.5.1.3	Provide upto date analysed data to stakeholders to inform planning		Up to data available	4,118,749
			5.5.1.4	Conduct survey on prioritized health indices		Availability of funds and trained staff	82,374,975
			5.5.1.5	Print and circulate copies of annual HMIS bulletin		Availability of funds and trained staff	10,708,747
COMMUNITY PARTICIPATION AND OWNERSHIP							
6. To attain effective community participation in health development and management, as well as community ownership of sustainable health outcomes							**677,922,987**
	6.1	**To strengthen community participation in health development**			**A State annual Forum to engage community leaders and CBOs on health matters by end 2012**		**135,849,844**
		6.1.1	To provide an enabling policy framework for community participation		Active policy on community participation by fourth quarter 2011		**2,986,788**
			6.1.1.1	Develop and monitor policy on community participation		Sensitized communities. Support from Development Partners	2,986,788
		6.1.2	To provide an enabling implementation framework and environment for community participation		State Health Communication and Social Mobilization Group meets bi - annually to review community participation by second quarter 2011		**132,863,057**
			6.1.2.1	Strengthen the State Health Communications & Social Mobilization Group		Availability of funds and Support from Development Partners	19,671,290
			6.1.2.2	Establish and strenghten the Health Promotion & Demand Creation unit in the Gunduma Health System		Availability of funds and Support from Development Partners	40,155,764
			6.1.2.3	Create opportuntities for enhancing the activities of the Health Promotion & Demand Creation unit in the Gunduma Health System		Political support for reforms remains	4,720,702
			6.1.2.4	Develop social marketing approaches to create demand and mobilise communities		Availability of funds	67,463,888
			6.1.2.5	Develop strategies for engaging communities in the policy process			851,412
	6.2	**To empower communities with skills for positive health actions**			**All GHSCs offer training to FBOs/CBOs and community leaders on**		**182,418,038**

					engagement with the health system by end 2012		
		6.2.1	To build capacity within communities to 'own' their health services		60% of CBOs/FBOs and community leaders in the State are trained on engagement with the health system by fourth quarter 2012		**182,418,038**
			6.2.1.1	Identify and train community volunteers to disseminate health information		Availability of funds	51,570,297
			6.2.1.2	Train/retrain HW, CRPersons & Comm Volunteers to provide interactive HE & comm mobilization on minimum ward health package themes		Availability of funds	44,509,475
			6.2.1.3	Strengthen and revitlaise the operations of the WDC/VDC, women groups and other institutions.		Availability of funds	58,418,686
			6.2.1.4	Provide sustainable support to the existing CBOs, WDC, VDCs and FMCs		Availability of funds	17,803,790
			6.2.1.5	Educate communities on the use of ITNs		Availability of funds and sensitized communities	10,115,790
	6.3	**To strengthen the community - health services linkages**			**50% of public health facilities have active Committees that include community representatives by end 2011**		**22,123,232**
		6.3.1	To restructure and strengthen the interface between the community and the health services delivery points		70% of facilities have active committees conforming with an agreed standard of community participation by second quarter 2014		**22,123,232**
			6.3.1.1	Involve the communities in planning, implementation and evaluation of activities of the health facilities		Sensitized communities.	20,231,580
			6.3.1.2	Develop and implement NGO/CBO strategy for sensitizing local communities		Collaboration with NGOs/CBOs	1,891,653
	6.4	**To increase State capacity for integrated multisectoral health promotion**			**An active State intersectoral committee with other Ministries and private sector by end 2011**		**321,444,395**
		6.4.1	To develop and implement multisectoral policies and actions that facilitate community involvement in health development		State Health Communication and Social Mobilization Group implementing 70% of targeted health communication		**237,923,377**

					strategies by second quarter 2011		
			6.4.1.1	Solicit support through advocacy to community and religious leaders		Sensitized community and religious leaders.	3,034,737
			6.4.1.2	Print copies and Disseminate the Charter of Patients Rights in all facilities and communities		Availability of funds	20,231,580
			6.4.1.3	Monitor the implementation of the Charter of Patients Rights at the Facilities		Sensitized workforce.	1,213,895
			6.4.1.4	Create community awareness through sensitization meeting and workshops on health issues		Availability of funds	203,327,375
			6.4.1.5	Strengthen and broaden the community engagement initiatives to increase demand and change attitudes and behaviours		Sensitized communities	10,115,790
		6.4.2	To strengthen Advocacy, Communication and use of IEC		State Health Communication Strategy developed and in use by third quarter 2010		**83,521,019**
			6.4.2.1	Strengthen health staff capacity in community engagement and advocacy at all levels		Availability of funds and sensitized communities and health staff	7,315,402
			6.4.2.2	Develop, print & distribute IEC materials on priority diseases to communities	Availability of funds	Availability of funds	35,742,457
			6.4.2.3	Utilize the media to increase public awareness of the causes/effects of poor health and the benefits of prevention and treatment		Availability of funds	40,463,159
	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 2011**		**16,087,478**
		6.5.1	To develop and implement systematic measurement of community involvement		30% of target groups (e.g. mothers of under 5) are aware of and follow correct protocols for preventing and/or managing selected health conditions (e.g. malaria) by first quarter 2013		**16,087,478**
			6.5.1.1	Design tools and undertake client satisfaction surveys in selected communities		Trained staff	10,746,341
			6.5.1.2	Work with communities to appreciate their roles in the management and ownership of facilities		Sensitized communities and trained health staff	5,341,137
PARTNERSHIPS FOR HEALTH							
7. To enhance harmonized implementation of essential health services in line with national health policy goals							**677,922,987**

	7.1	**To ensure that collaborative mechanisms are put in place for involving all partners in the development and sustenance of the health sector**			**a) SMoH has an active ICC with Donor Partners that meets at least quarterly by end 2010 b) SMoH has an active PPP forum that meets quarterly by end 2011**		**677,922,987**
		7.1.1	To promote Public Private Partnerships (PPP)		Active State PPP Policy and strategies by fourth quarter 2010		**19,663,181**
			7.1.1.1	Develop, implement and monitor strategies for improving Private-Public-Partnerships (PPP)		Sensitized private sector. Trained staff. Support from Development Partners	19,663,181
		7.1.2	To institutionalize a framework for coordination of Development Partners		SIACC and SHSRF meet quarterly to coordinate activities of Development Partners by fourth quarter 2010		**9,073,566**
			7.1.2.1	Coordinate activities of development partners and NGOs through SIACC and the State Health Sector Reform Forum		Will for political reform sustained. Collaboration with Development Partners. Availability of funds	9,073,566
		7.1.3	To facilitate inter-sectoral collaboration		SIACC meets bi - annually to review plans on inter - sectoral collaboration by first quarter 2011		**102,924,479**
			7.1.3.1	Develop mechanism for inter sectoral collaboration		Sensitized staff from relevant MDAs.	7,621,795
			7.1.3.2	Work with ministry of social welfare and other key ministeries to improve social services in the urban and rural areas.		Collaboration with key ministries.	18,147,131
			7.1.3.3	Revitalise and strengthen SIACC to enhance performance and provide technical support		Support fromDevelopment Partners.	59,008,422
			7.1.3.4	Secure technical & financial assistance to support the activities and meetings of SIACC		Availability of funds. Support from Development Partners. Collaboration with other key ministries.	12,098,087
			7.1.3.5	Create mechanisms for monitoring the implementation of SIACC sub-committees work plans		Trained staff. Availability of funds	6,049,044
		7.1.4	To engage professional groups		Active State PPP committee meets bi - annually by third quarter 2011		**139,510,091**
			7.1.4.1	Establish and train State PPP committee		Political commitment, sensitized private	109,567,324

						sector, support from Development Partners	
			7.1.4.2	Assess the operations of private sector health care providers and jointly set standards		Sensitized private health practitioners.	6,049,044
			7.1.4.3	Strengthen the collaboration of Health sector reform forum with the Union of Road Transport Workers		Collaboration with sensitized NURTW. Favourable political and economic conditions	8,468,661
			7.1.4.4	Periodically Review performance of the health sector with partners, NGO and professional groups participation		Collaboration with PARTNERS/NGOs.	15,425,062
		7.1.5	To engage with communities		Bi - annual meeting of SHSRF by first quarter 2011		**10,951,505**
			7.1.5.1	Review, reconstitute and revitalise the Health Sector Reform Forum		Sustined Political commitment to health reform. Support from Development Partners	10,951,505
		7.1.6	To engage with traditional health practitioners		State Traditional Health Practitioners Board established and functioning by second quarter 2012		**395,800,165**
			7.1.6.1	Develop, implement and monitor policy on traditional health practice			12,290,792
			7.1.6.2	Establish a State Traditional Health Practitioners Board		Political commitment and favourable economic condition	326,043,458
			7.1.6.3	Collaborate with traditional health practitioners to support provision of services e.g. RI; IPDs; ANC		Sensitized traditional health practitioners	45,367,828
			7.1.6.4	Provide support to existing groups of TBAs		Availability of funds. Trained TBAs	12,098,087
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							**1,355,845,975**
	8.1	**To strengthen the stewardship role of governments at all levels for research and knowledge management systems**			**Regular conduct and dissemination of research findings by 2011**		**701,982,107**
		8.1.1	To develop health research policies at State levels and health research strategies at State and LGA levels		Active State health research policy and strategies by fourth quarter 2011		**38,696,278**
			8.1.1.1	Develop a policy and strategies for promoting operational health research activities		Support from Development Partners. Trained staff	38,696,278
		8.1.2	To establish and or strengthen mechanisms for health research at all levels		A State Health Research and Demographic Centre established and functioning by end 2010		**655,475,110**
			8.1.2.1	Establish a State Health and Demographic Research Centre		Availability of funds. Trained staff. Support	629,353,137

						from Development Partners. Political will	
			8.1.2.2	Design an approach for undertaking research into communicable diseases		Trained staff	26,121,973
		8.1.3	To institutionalize processes for setting health research agenda and priorities				-
		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				-
		8.1.5	To mobilise adequate financial resources to support health research at all levels		Multi - sectoral Health Reasearch Fund operational by first quarter 2013		**7,810,719**
			8.1.5.1	Advocacy to stakeholders		Availability of funds. Trained staff.	7,810,719
			8.1.5.2	Sensitization of health practitioners		Availability of funds	-
		8.1.6	To establish ethical standards and practise codes for health research at all levels				-
	8.2	**To build institutional capacities to promote, undertake and utilise research for evidence-based policy making in health at all levels**			**A State Health Research Team that meets bi - annually by end 2011**		**653,863,868**
		8.2.1	To strengthen identified health research institutions at all levels				-
		8.2.2	To create a critical mass of health researchers at all levels		Active State Health Research Team meets quarterly by third quarter 2011		**76,095,621**
			8.2.2.1	Identify and build capacity of selected personnel in operation research activities		Political commitment. Availability of funds.	76,095,621
		8.2.3	To develop transparent approaches for using research findings to aid evidence-based policy making at all levels				-
		8.2.4	To undertake research on identified critical priority areas		State Public Health Laboratory estalished and functional by third quarter 2010		**577,768,247**
			8.2.4.1	Establish public health laboratory for research in public health & commmunicable diseases.		Political will and availability of funds. Trained staff	514,244,945
			8.2.4.2	Conduct research into and establish quality control process for traditional pharmaceutical products		Sensitized traditional health practitioners. Availability of research structures	63,523,301
	8.3	**To develop a comprehensive repository for health research at all levels (including both public and non-public sectors)**			**1. All States have a Health Research Unit by end 2010 2. FMOH and State Health Research Units manage an accessible repository by end 2012**		-

		8.3.1	To develop strategies for getting research findings into strategies and practices			-
		8.3.2	To enshrine mechanisms to ensure that funded researches produce new knowledge required to improve the health system			-
	8.4	**To develop, implement and institutionalize health research communication strategies at all levels**		**A national health research communication strategy is in place by end 2012**		-
		8.4.1	To create a framework for sharing research knowledge and its applications			-
Total						**67,807,081,744**

Annex 2: Jigawa State SHDP Results and M&E Matrix

JIGAWA STATE RESULT FRAMEWORK						
OUTCOME	**INDICATORS**	**SOURCE OF DATA**	**Baseline**	**Target**		
			2008/9	**2011**	**2013**	**2015**
	1. Literacy Rate(Female)	NDHS/MICS	6%			
	2. Literacy rate (Male).		53%			
OVER-ARCHING GOAL: To significantly improve the health status of Nigerians through the development of a strengthened and sustainable health care delivery system	2. Under-five mortality rate	NDHS/MICS	166/1000 LBs (NDHS, 2008)	146/100 0 LBs	126/1000 LBs	106/1000 LBs
	3. Infant mortality rate	NDHS/MICS	110 (NDHS, 2008)	90/1000 LBs	70/1000 LBs	50/1000 LBs
	4. Proportion of 1 year old immunized against measles	NDHS/MICS/Health Facility Surveys	8.6 (NDHS 2008)	45%	60%	95%
	5. Prevalence of children under five years of age who are underweight	NDHS/MICS/Health Facility Surveys	25.5% (NDHS, 2008)	20%	18%	15%
	6 Percentage of children under 5 sleeping under insecticide-treated bed nets	NDHS/MICS	11%(NDHS, 2008)	50%	75%	95%
	7. Maternal mortality ratio	1) Develop demographic surveillance sites (DHSS)	850/100,000 LBs (NDHS 2008)	600/100,000 LBs	400/100,000 LBs	200/100,000 LBs
		2) Expert Committee on mortality estimation				
	8. Adolescents Birth Rates	NDHS/Maternal Death Audits	126 per 1000	114/r 1000	102/1000	90/1000
	9. HIV prevalence among population aged 15-24 years	HMIS, Disease surveillance	4.5(MICS, 2007)	3.50%	2.50%	1.50%
PRIORITY AREA 1: LEADERSHIP AND GOVERNNANCE FOR HEALTH						
NSHDP GOAL: To create and sustain an enabling						

environment for the delivery of quality health care and development in Nigeria						
1. Improved strategic health plans implemented at Federal and State levels	10. National Health Act gazetted.	Government gazette	N/A	2010	-	-
	11. Percentage of State adopting the National Health Bill (to their LGAs)	SMOH annual reports	0	25	50	75%
2. Transparent and accountable health systems management						
	1. % of states executing more than 70% of the annual non-personnel budget	1. Federal and State Accountants General Reports				
		2. Federal and States Auditors General Reports				
		3. Federal and State Public Expenditure Reviews	0%	30%	55%	80%
	1. % of federal and states/FCT with published annual Health Watch Reports	Health Watch Reports,	N/A	33%	66%	100%
STRATEGIC AREA 2: HEALTH SERVICES DELIVERY						
NSHDP GOAL: To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare						
3. Universal availability and access to an essential package of primary health care services focusing in particular	1. % wards with a functioning public health facility providing minimum health care package	NPHCDA Survey Report	24%	50%	65%	80%

on vulnerable socio-economic groups and geographical areas	according to quality of care standards.					
4. Improved quality of primary health care services						
	1. Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS	NDHS/MICS/NARHS	22.2% (female) 32.6% male (NDHS 2008)	50%	76%	95%
5. Increased use of primary health care services						
	1. % of HIV infected pregnant women who receive ARV prophylaxis to reduce the risk of MTCT.	NDHS/MICS/NARHS	4.50%	30%	60%	90%
	1. Proportion of population with advanced HIV infection with access to antiretroviral drugs	NARHS	No baseline	20%	40%	60%
	1. Prevalence of tuberculosis	Sentinel/Health Facility Surveys	2.9% (NARHS 2007)	2%		
					1%	0.50%
	.19 Proportion of tuberculosis cases detected and cured under directly observed treatment short course	Sentinel Surveys	74%	80%	85%	90%
	20. Malaria incidence among under-five children	NDHS /MICS/ Sentinel Surveys	16% (NDHS 2008)	10%	7%	5%
	21 . % of women with pregnancy within the last 2 years who received intermittent preventive treatment for malaria	NDHS, HMIS, MICS	18% (NDHS, 2008)	38%	60%	80%

	2. Proportion of 12-23 months-old children fully immunized	NDHS/MICS/Immunization coverage surveys	0.0%(NDHS, 2008)	40%	60%	95%
	23. % of children 6-59 months receiving Vitamin A supplements twice a year	NDHS/MICS/Immunization coverage surveys	83% (Immunization coverage surveys May 2009)	90%	95%	100%
	24. % of children under 6 months exclusively breastfed	NDHS	13% (NDHS, 2008)	15%	20%	50%
	25. % of under-five children sleeping under ITN in the previous night.	NDHS	5.5 (NDHS, 2008)	30%	55%	80%
	26. % of children under 5 with suspected pneumonia receiving appropriate treatment from a health provider	NDHS/ Sentinel Surveys/ Health Facility Surveys	22.5% - ARI (NDHS, 2008	40%	60%	80%
	27. % of newborns and mothers visited within 48 hours of delivery by a skilled health care provider	MICS/NDHS/Sentinel Surveys	No baseline	15%	35%	50%
	28. Prevalence of malaria in children under-five years of age*	MICS/NDHS/Sentinel Surveys/ Health Facility Surveys	15.9% (NDHS 2008)	12%	8%	5%
	29. Proportion of children under 5 with fever who are treated with appropriate anti-malarial drugs	NDHS 2008/MICS/ Sentinel Surveys/ Health Facility Surveys	33.2% (NDHS 2008)	50%	65%	80%
	30. Number of new wild poliovirus cases	WHO Global Update	382 (WHO Global Update Oct 28, 2009)	5	3	0
	31. Unmet need for Family Planning	MICS/NDHS	21% (NDHS 2008)	18%	12%	10%
	32. % of pregnant women with 4 ANC visits performed	NDHS/MICS	20.1% (NDHS 2008)	40%	60%	80%

	according to standards					
	33. Proportion of births attended by skilled health personnel	NDHS/ Sentinel Surveys/ Health Facility Surveys	5.1 (NDHS, 2008)	20%	40%	60%
	34. Proportion of all births in Basic and Comprehesive EMoC Facilities	EOC Survey/ Sentinel Surveys/ Health Facility Surveys	4.50%	10%	20%	25%
	35 Case fatality rate among women with obstretic complications in EmOC facilities	EOC Survey	TBD	25%	10%	1%
	36. Contraceptive prevalence rate (Modern)	NDHS/MICS	1.9(NDHS, 2008)	5%	10%	30%
	37. Health facilities experiencing stock-outs of key health commodities within the last one month	NHMIS/ Sentinel Surveys/ Health Facility Surveys	TBD	80%	40%	<10%
PRIORITY AREA 3: HUMAN RESOURCES FOR HEALTH						
NSHDP GOAL: To plan and implement strategies to address the human resources for health needs in order to ensure its availability as well as ensure equity and quality of health care						
6. The Federal government implements comprehensive HRH policies and plans for health development	38. % of wards that have appropriate HRH complement as per service delivery norm (urban/rural).	NPHCDA Survey	No baseline	20%	40%	>60%
7. All States and LGAs are actively using adaptations of the National HRH policy and plan for health development by end of 2015						

8. Find HRH policy to copy targets	39. Proportion of Health Professionals per population	NHMIS/HRHIS	TBD	1.430556	0.736111	>1:500
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						
9. Health financing strategies implemented at Federal, State and Local levels consistent with the National Health Financing Policy	40. % of federal, state and LGA budget allocated to the health sector.	Federal and State review PER/NHA	TBD	10%	12%	15%
10. The Nigerian people, particularly the most vulnerable socio-economic population groups, are protected from financial catastrophe and impoverishment as a result of using health services	41. Proportion of Nigerians covered by any risk-pooling mechanisms	Federal and State review PER/NHA	TBD	5%	10%	30%
	42. Out-of pocket expenditure as a % of total health expenditure	NHA	67.2% (2006 – NHA 2003-2005)	65%	60%	<50%
PRIORITY AREA 5: NATIONAL HEALTH INFORMATION SYSTEM						
NSHDP GOAL 5: To provide an effective National Health Management						

Information System (NHMIS) by all the governments of the Federation to be used as a management tool, including Monitoring & Evaluation, for informed decision-making at all levels and improved health care						
11. National health management information system and sub-systems provides public and private sector data to inform health plan development and implementation at Federal, State and LGA levels	43. % of States whose routine HMIS returns meet minimum requirement for data quality standard	State reports/Integrated Disease Surveillance System	TBD	40%	60%	80%
	44. % of States that timely submit disease surveillance reports	Federal reports/Integrated Disease Surveillance System	TBD	40%	60%	80%
	45. % of Federal and State plans and strategies that are based on routine HMIS data to improve coverage and quality of high impact interventions	Rapid Annual Household and Facility Surveys (TBD)	No baseline	40%	60%	80%
PRIORITY AREA 6: COMMUNITY PARTICIPATION AND OWNERSHIP						
NSHDP GOAL 6: To attain effective community participation and responsibility in health development.						

12. Strengthened community participation in health development	46. % States with policy and implementation framework for community participation in health with multi-sectoral focus in place	Policy and Implementation Framework	None in place	40%	60%	80%
13. Increased capacity for integrated multi-sectoral health promotion						
	47. Proportion of public health facilities having active committees (at least 4 meetings per year) that include community representatives	Health Facilities Survey (TBD)	TBD	40%	60%	80%
PRIORITY AREA 7: PARTNERSHIPS FOR HEALTH						
NSHDP GOAL 7: To enhance harmonized implementation of essential health services in line with national health policy goals.						
14. Functional multi partner and multi-sectoral participatory mechanisms at Federal and State levels contribute to achievement of the goals and objectives of the NSHDP.	48. Proportion of states implementing at least 4 new PPP initiatives per year.	Federal and state PPP reports	No baseline	15%	30%	50%
	49. % of states with standards and mechanisms for graded accreditation of private providers in place	State reports	No baseline	30%	60%	80%
	50. % of Federal and State	Federal and state MOH reports	TBD	40%	70%	90%

	multi-sectoral and development partner meetings held according to extant coordination mechanism					
PRIORITY AREA 8: RESEARCH FOR HEALTH						
NSHDP GOAL 8: To utilize research to generate knowledge to inform policy, improve health, achieve nationally and internationally health-related development goals and contribute to the global knowledge platform.						
15. Research and evaluation create knowledge base to inform health policy and programming.	51. % of health budget spent on health research and evaluation at federal level	FMOH report	TBD	0.50%	1%	2%
	52. Proportion of research and evaluation studies undertaken on identified critical areas in the NSHDP framework.	FMOH report	TBD	20%	40%	60%
* Using fever as proxy						