GOMBE STATE GOVERNMENT

STRATEGIC HEALTH DEVELOPMENT PLAN

(2010-2015)

Gombe State Ministry of Health

March 2010

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List of acronyms and abbreviations

APOC	African Programme for Onchocerciasis Control
BCC	Behaviour Change Communication
BMOC	Basic Management of Obstetric Conditions
BOT	Build Operate and Transfer
CBOs	Community Based Organisations
CHCs	Comprehensive Health Centres
CHIS	Community Health Insurance Scheme
CHIS	Community Health Insurance Scheme
CLMS	Contraceptive Logistic Management System
CSM	Cerebro-spinal meningitis
DOTs	Directly Observed Treatment Scheme
EDL	Essential Drug List
EMOC	Emergency Management of Obstetric Conditions
EU-PRIME	European Union Partnership for Routine Immunisation
FHI/GHAIN	Family Health International/ Global HIV/AIDS Initiative in Nigeria
FMC	Federal Medical Centre
FMOH	Federal Ministry of Health
GFATM	Global Fund against, AIDS, Tuberculosis and Malaria
GLORI	Global research initiative
GMSPHCDA	Gombe State Primary Health Care Development Agency
GOMSACA	Gombe State AIDS control agency
HFs	Health facilities
HRH	Human Resource for Health
HRH	Human Resource for Health
HSMB	Health Services Management Board
ICAP-	International Centre for AIDS Prevention
ICRC	International Committee of the Red Cross and Red Crescent
IDPs	International Development Partners
IEC	Information Education Communication
IHVN	Institute for Human Virology in Nigeria
IMCI	Integrated Management of Childhood illnesses
IPC	Interpersonal Communication skills
KPHA	Key Positive Health Actions
LACAs	Local Government Action Committee against AIDS
LGA	Local Government Areas
MDGs	Millennium Development Goals
MDT	Multiple Drug Treatment
MMR	Maternal Mortality Rate
MOA	Ministry of Agriculture
MOH	Ministry of Health
MRC-UK	Medical Research Council of the United Kingdom
MSF	Médicins Sans Frontières

NABDA	National Biotechnology Development Agency
NDHS	National Demographic Health Survey
NHIS	National Health Insurance Scheme
NIH	National Institutes of health
NIMR	National Institute for Medical research
NIPRID	National Institute for Pharmaceutical Research and Development
NLR	Netherlands' Leprosy Relief Organisation
OTPS	Out-Patient Therapeutic Sites
PHC	Primary Health Centres
SOP	Standard Operating Procedures
SRH	Sexual and Reproductive Health
STI	Sexually Transmissible Diseases
TBL	Tuberculosis and Leprosy control program
UNDP	United Nations Development Programme
UNICEF	United Nations' Children's Fund
WHO	World Health Organisation
WPV	Wild Polio Virus

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.

Preface

Health as a determinant of economic strength has been thrust of the statement, "Health is wealth". It is therefore not surprising that some of the poorest communities in the world have a high disease burden with health indices illustrating the ominous state of health delivery. The Nigerian response to this is human capital development through improved health systems. Attempts by previous governments to improve the state of health of all citizens have been part of a global effort at improving health while addressing the inequities in health care delivery hence the development of concept of the millennium development goals (MDG) concept. In furtherance to this is the vision 20:20:20, which is a homegrown mechanism to address our developmental inadequacies while meeting global targets. The thrust of vision 20:20:20, aims at positioning Nigeria in the top twenty economies of the world by the year 2020 through providing equitable and sustainable health systems and services using the bottom to top approach with the active participation of all. In Gombe state, the health challenges are being addressed by active participation of all tiers of government in health programs that aim achieving the MDGs with emphasis on goals 4 and 5.

The most prevalent infectious diseases in the state are: malaria, measles, diarrhoeal diseases, HIV/AIDS, tuberculosis, and typhoid fever. Malnutrition, blindness, automobile accidents, and snake bites contribute to the morbidity of the population. Low literacy rate, especially of the girl child, poor utilization of antenatal and obstetrical services, poverty, low vaccine utilization, are contributory factors to high maternal and child mortality in the state. This confirms the adage that "**The welfare of a society is reflected by the health of its women folk".** Although previous governments have made efforts at improving the health of Gombe citizens through training and infrastructural development, the absence of a health policy resulted in uncoordinated planning of the sector and has made sustainability difficult. The development of a state strategic health plan therefore aims at closing all gaps in the health sector with the active participation of all stakeholders.

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Executive Summary

Gombe state is one the six states of the North-east geo-political zone. It covers an area of 20265sq. km with a population of 2, 587, 159 million, of which 1,296,166(50.1%) are males and 1,290,993 (49.9%) are females. The population of children aged 5years and below is 501388. The annual growth rate is 3.2%. It was created from the old Bauchi state on 1st October 1996 with 11 local government areas. It is located in the Sahel Savannah with a climate characterised by long dry season and a short rainy season. The terrain is undulating with hilly projections rising above 1200m above sea level. It is crossed by rivers that are tributaries of the Upper Benue river basin, a significant portion of which a seasonal. Its mineral resources include gypsum, limestone, silica, dolomite, talc, uranium and kaolin. It is a multi-ethnic state, some of which are Fulanis, Tangale, Waja, Tera, Bolewa Tula, Cham, Lunguda, Awak, Kamo and Dadiya. Many citizens are engaged in commercial cropping and livestock farming.

Situation Analysis

The economy of Gombe state is driven by Industrial activity in two forms viz: Large scale manufacturing e.g. Ashaka Cement Factory, and numerous medium and small industries. The total budget of the state is ₦ 51.6 billion; the budgetary allocation for health is ₦1.1 billion, which accounts for 2.1% of Government expenditure. The Government total per capita expenditure on health is ₦342.66. Majority of the citizens (72.2%) live below $1/day. The potentials of the state are limited by infant mortality rate of 20.7/1000 live births, maternal mortality rate of 1002/100,000 live births, an HIV prevalence of 3.9%, an under5 mortality rate of 104/1000. The principal causes of morbidity and mortality are malaria, pneumonia, vaccine preventable diseases, snake envenomiation, road traffic accidents, Acquired Immune Deficiency Syndrome (AIDS). The total fertility rate is 7. There are 563 health facilities, of this, 14 general hospitals, 1 state owned specialist hospital, 1 Federal Medical Centre, 58 private health facilities, and 505 government owned primary health facilities. The bed capacity is between 11 and 14 beds /10000 of population.

Bottlenecks in the provision of minimum package of care at the primary health care are: Inadequate supply of health care intervention commodities like long lasting insecticide treated nets (LLINs). Although human resource for family planning is adequate, there is a severe shortage of human resource for long lasting insecticide treated nets, which poses a medium level bottleneck. To overcome this, there may be a need to engage all health workers in the health education and behaviour change communication towards increased sustained use of the long lasting insecticide treated nets. Accessibility is a medium level bottleneck for all high impact interventions this may be reduced by increasing the number of community based health workers that are multi- tasked to reduce personnel costs. Girl child education is a strategy that will increase the demand for family planning, and LLIN usage.

The state plans to adopt the Federal Government's Primary Health Care Ward Minimum Package of Care with emphasis on the use of high impact interventions. The state will develop and implement policy that will ensure that all facilities within the state provide the minimum ward package that will improve the health of the citizens especially towards achieving the millennium development goals. The state will inaugurate the task force for the implementation and monitoring of vaccination and re-vitalization of

primary health care service in the state.

The SSHDP would be implemented at four levels namely:

At the ward and family levels-Families will be mobilized to adopt positive health actions (KHHP) through BCC, the agents of mobilization in the community being traditional rulers who mediate between the health sector and traditional institutions practices. A heterogeneous mix of traditional rulers registered and accredited traditional medical practitioners and preventive health practitioners will sustain BCC and adoption of health seeking behaviors.

Civil society organizations and the private sector (both Profit oriented and the not for profit organization).
These initiate and coordinate BCC related concepts and programs.
Local Government areas provide the necessary infrastructure, personnel and an enabling environment for health care delivery at the primary level.

The State Government provides quality health services at the secondary and tertiary levels, train, recruit and deploy staff, to all health facilities. The state is also establishing a college of medical sciences that will produce the HRH. It is in partnership with NIPRD, NIMR towards establishing a herpetology research institute.

The implementation of the SHDP will be monitored periodically led by the monitoring and evaluation team. Implementation progress will be assessed quarterly, while in 2013, a mid-term review is proposed

Vision and Mission

Vision

"*To reduce the morbidity and mortality rates due to communicable diseases to the barest minimum; reverse the increasing prevalence of non-communicable diseases; meet global targets on the elimination and eradication of diseases; and significantly increase the life expectancy and quality of life of the people of Gombe State* ".

Mission Statement

"*To develop and implement appropriate policies and programmes as well as undertake other necessary actions that will strengthen the State Health System to be able to deliver effective, quality and affordable health*".

Chapter 1: Background

1.1 Introduction

Gombe state is one of the six states of the North-east geo-political zone of Nigeria. It covers an area of 20,265sq. km with a population of 2, 587, 159 million, of which 1,296,166(50.1%) are males and 1,290,993 (49.9%) are females (2006 population census). The population of children aged 5years and below is 501388. The annual population growth rate is 3.2%. It was created from the old Bauchi state on 1st October 1996 with 11 local government areas. It shares common boundaries with Borno to the east, Yobe to the north-east, Bauchi to west, Taraba to the south, and Adamawa to the South East. It is located in the Savannah region with a predominantly grassland vegetation that is interspersed by rivers of the Upper Benue river basin, a feature that supports livestock farming on a mineral rich terrain, and enhanced by economic networks with other states, hence the eponym **"JEWEL IN THE SAVANNAH"**

The terrain is undulating with hilly projections characteristic of the Northern Plateau with places rising above 1500m above sea level. The climatic conditions are characterized by a dry season lasting from October to April, while the rainy season lasts between May and September. The soil is predominantly sandy loam in the northern parts while a mixture of sandy loam and humus is in the southern parts. The arable soil features make Gombe state an agricultural state. The major food and cash crops include sorghum, maize, millet, cotton, groundnuts, cowpeas, tomatoes and vegetable fruits. Gombe state is endowed with mineral resources like gypsum, byrite, limestone, coal, silica, dolomite, talc, uranium and kaolin. Climate change, flooding, deforestation, waste management, and mining are emerging environmental challenges.

It is a multi-ethnic state with eleven (11) local government areas, and one hundred and fourteen (114) wards. Some of the ethnic groups are Fulanis, Tangale, Waja, Tera, Jukun, Bolewa, Tula, Cham, Lunguda, Awak, Kamo and Dadiya. Hausa is the inter-ethnic medium of communication The location of Gombe state in the centre of major trade routes has made it an important commercial centre in the north-east region, linked to other parts of the country by road, air, and rail networks. The existence of good road networks within the state has improved accessibility to most parts of the state. The citizens are mostly farmers, cattle-herdsmen and traders.

1.1.1 Education-

Gombe State has numerous primary schools run by the Local Education Authorities and by Private school proprietors. Post-primary Schools are in three major categories namely: Public schools with a total student population of 10,6776 which females are 35961 (33.7%), the Community Secondary Schools with a student enrolment of 18,154 of which females are 7,261(40%); and the private schools with an enrolment of 136,047 of which females are 48,663(35.7). The total high school population is 260,977 females account for 91,885(35.2%). The state has a college of Administration and Business studies in

Kumo, a School of Nursing and Midwifery in Gombe, a Farm Training Centre in Tumu, a College of Arabic and Islamic Studies in Gombe, A college of Education in Gombe, a school of Health Technology in Kaltungo, a college of Horticulture inYamaltu-Deba and a the Gombe State University all offering tertiary education.

1.1.2 Health Institutions

There are 547 primary health care facilities, 18 general hospitals, 1 specialist hospital and the Federal Medical Centre, which provide tertiary services. There are 58 and 13 private clinics and laboratory services respectively. One hundred and eleven doctors, 889 nurses and midwives, 1,464, community and environmental health workers, 33 pharmacists, 97 medical laboratory staff and 3 health planners are employed by either the state government or the Federal Medical Centre. The state has 1 school of health technology, 1 school of nursing and midwifery, and a proposed college of Medical Sciences at the Gombe State University.

International Development Partners (IDPs) in the health sector are WHO, UNICEF, EU-PRIME, ICAP, FHI/GHAIN, UNDP, WORLD BANK, NLR, APOC, IHVN, MSF, ICRC, Dark and Light, GFATM, and MTN Foundation. The MDG office in the Presidency and the NHIS are partnering with the Gombe State Government in achieving the MDG goals 4, 5, 6. There are also local non-state actors that contribute to health delivery.

1.2 Achievements

The state government adopted a 5-point programme in an effort to address the challenges in the health sector. They are:

1. Renovation of existing health facilities
2. Construction of new hospitals
3. Purchase of equipment and drugs
4. Human resource development (Short- term and long-term)
5. Re-invigoration of the drug revolving scheme and the introduction of free maternal services.

1. Renovation of existing health facilities
   The seven existing hospitals were comprehensively renovated and supplied with state of the art equipment.
2. Construction of new hospitals
   Seven new cottage hospitals located at Bambam, Degri, Mallam Sidi, Hina, Tumu, Bojude and Pindiga were constructed. The hospitals are secondary health facilities. Also 4 general hospitals located at Nafada, Deba, Kashere and Talasse were constructed.

3. Purchase of equipment, drugs and supplies

The state government embarked on bulk purchase of equipment, drugs, and essential supplies for the renovated and newly constructed hospitals. All hospitals are adequately furnished, equipped and stocked for effective health care delivery.

4. Human resource development (Short- term and long-term)

   In addressing the acute shortage of human resource in the health Care sector, the state government recruited 933 Medical Personnel as a short-term measure. Under the long-term, the government established the school of Nursing and Midwifery and re-invigorated the school of Health Technology to address the production of relevant manpower. Also, the state introduced the Medical Student scheme wherein state indigenes that acquire admission into Health manpower training institutions are given automatic employment and placed on salary on presentation of admission letters. Currently there are more than 500 students on the scheme.

   In order to boost the morale of health workers, the state government approved an upward review of their allowances thereby bridging the gap between state and Federal Health Workers. To address the rural- urban disparity in staff posting, the rural posting allowance was introduced.

5. Re-invigoration of the drug revolving scheme for non-obstetric services and the introduction of free maternal services.

   In order to ensure availability of drugs in our health facilities on a sustainable basis, the DRF was re-invigorated and re-capitalized to the tune of 15million naira (₦ 15m). Presently, the scheme is worth over 60million naira and drugs are always available in our health facilities. Also, the state government introduced the free maternal scheme in all secondary health facilities as a way of addressing the high incidence of maternal and infant mortality in the state, this is limited by the shortage of the necessary human resource to deliver effective IMNCH services. Under the scheme, pregnant mothers are treated free including emergency obstetric services. It is hoped that the free scheme will be extended to all primary health facilities in the state by 2015.

1.2.1 Control of communicable and non-communicable Diseases

A. **Guinea-worm**

In the last 5 years, there has been no new case of guinea worm infestation in the state.

B. **Leprosy**

Access to MDT services has increased while the prevalence of leprosy has reduced with achievement of target of 1case/10000 population.

C. **Tuberculosis-**

DOTs services have been extended with consequent increased access to treatment, increased case notification from 14% to 40% between 2001 and 2008, with a cure rate of 81%.

D. **HIV/AIDS-**

There has been increased access and utilization of HIV prevention, care and support services with consequent reduction in prevalence from 8.2% in 2001 to 4.0% in 2008. The state is working towards the achievement of 80% universal access by 2015 through supporting LACAs, line ministries, and NGOs.

There are HIV/TB collaborative activities with the aim of improving treatment outcome and quality of life of HIV/TB co-infected patients in the state.

E. **Malaria** The malaria control program received 1.5 million ITNs in 2009 for distribution to households in the state. Environmental sanitation activities have been stepped up to reduce mosquito breeding grounds.

F. **Polio**

The last case of WPV infection was reported in August 2009.

G. C**erebro-spinal meningitis (CSM)**

The programme organized State-wide training sessions for clinicians and Laboratory focal persons on specimen collection and case management of Cerebro-spinal meningitis. IEC materials translated to major language groups in the state were produced and distributed with reference to case distribution patterns. Mass Vaccination campaigns were carried out and 600,000 doses of CSM vaccine were administered.

H. **Cholera and diarrhoeal Diseases**

An outbreak of cholera in 3 LGAs was contained by mass water treatment in the communities, production of treatment protocols for the management of diarrhoeal diseases, and positioning of drugs in the affected LGAs.

I. **Measles**

Follow-up campaigns were carried out in all LGAs in the state leading to a reduction of measles with only 54 cases being reported.

J. **Neonatal Tetanus**

Case based surveillance is on going for neonatal tetanus. No new cases have been documented in the last year

K. **Yellow fever and Lassa fever**

Surveillance is on going for these notifiable diseases.

L. **Onchocerciasis**

In 2009, APOC delivered 4.8 million tablets of Mectizan® and 369990 tablet of albendazole to the state. The distribution of Mectizan® is on-going in 10 LGAs, while that of albendazole is in 2 LGAs. Insecticides were sprayed at the major vector breeding sites around Dadinkowa dam in Yamaltu-Deba Local Government Area.

M. **Avian Flu**

So far there has been no reported human case of bird flu in the state. The Bird flu programme took delivery of 250 doses of Tamiflu with an expiry date of 2012.

N. **Malnutrition**

There is a community-based programme for the management of acute severe malnutrition in the state. Fifteen OTP sites have been established in 3 LGAs of Dukku, Nafada and Gombe. So far a total 1300 severely malnourished children have been admitted in the centres. The Programme is run in collaboration with UNICEF. By 2015, the programme would have been scaled up to other LGAs in the state.

O. **Snake bites Control Programme**

The Kaltungo based EchiTab® study has successfully completed Phase III clinical trials of EchiTabG® and EchiTab Plus® which have been found to be efficacious and safe for the clinical management of Echis ocellatus bite in Nigeria and its neighbours. So far, of the 400 participants recruited for the study there has been no death. The findings of the research have been published in peer-reviewed journals like the Lancet, Toxicon International, and some Nigerian Journals. It is ready to be incorporated as part of the protocol for echis species bite management.

Challenges

Ward accommodation is inadequate considering the fact that citizens of other states in the North-east region are patronizing the centre.

Basic clinical and resuscitation equipment is grossly inadequate

Like other components of the Gombe state health system, the programme faces perennial manpower shortage

1.2.2

IMCI-The IMCI tool is the essential component of childcare in the state but HRH is a key issue.

SRH services

The state has a well-established CLMS, which provides family planning services to 144 clinics across the state.

Prevention of blindness

A partnership with Dark and Light an NGO that supports ophthalmic services in the Gombe specialist aids in the management of ophthalmic conditions and screening for cataracts and other

blindness preventable conditions**. A strategic plan for the prevention of blindness is currently being developed.**

BMOC and EMOC

Maternity centres have been constructed. Plans are on to recruit midwives that will provide obstetric services in the centres

Chapter 2: Situation Analysis

2.1 Socio-economic context

The economy of Gombe state is sourced from internally generated sources and to a lesser extent federal allocation. Industrial activity is in two forms viz: Large scale manufacturing e.g. Ashaka Cement Factory, and numerous medium and small scale industries, and other forms of commercial activities, activities, farming (crop and livestock). It is also endowed with vast solid mineral deposits other than gypsum and limestone.

Education is in two forms, viz: Western or European style and Islamic or Qur'anic education. There are efforts to integrate Qur'anic education in the European school curriculum. Although there is a steady increase in the girl-child school enrolment, girl child education is at a low level, as girls' form 35.8% of high school enrollees. In the Senior Secondary III class, females account of for 26.8% of the student population. Water supply is in the form of pipe-borne water, underground water (bore whole and domestic) water.

2.2 Health status of the population

The total budget of the state in 2009 is ₦ 51.6 billion; the budgetary allocation for health is ₦1.4 billion, which accounts for 2.7% of Government expenditure. The Government total per capita expenditure on health is ₦342.66, this falls below the WHO recommended level of $34/person. Majority of the citizens (72.2%) live below $1/day (NDHS2008) The potentials of the state are limited by an infant mortality rate of 20.7/1000 live births, maternal mortality rate of 1002/100,000 live births, an HIV prevalence of 3.9%, an under5 mortality rate of 104/1000(2008 estimates); the principal causes of morbidity and mortality are malaria, pneumonia, vaccine preventable diseases, snake bite, road traffic accidents, and Acquired Immune Deficiency Syndrome (AIDS). Immunisation coverage in 2008 is 68% for yellow fever, 92% for BCG, 86% for pertussis, 81% for tetanus, 75% for polio and 110% for measles. This state figures contrasts with NDHS 2008 figure of 19.1% as immunization coverage rate in the under 5 group. The total

fertility rate is 7. A summary of selected health status indicators from the 2008 NDHS is shown in the table below.

Table 1: Summary of health status indicators for Gombe State,

POPULATION (2006 Census)	GOMBE
Total population	**2,365,040**
female	1,120,812
male	1,244,228
Under 5 years (20% of Total Pop)	460,489
Adolescents (10 – 24 years)	755,522
Women of child bearing age (15-49 years)	422,644
INDICATORS	**NDHS 2008**
Literacy rate (female)	30%
Literacy rate (male)	68%
Households with improved source of drinking water	23%
Households with improved sanitary facilities (not shared)	45%
Households with electricity	32%
Employment status (currently)/ female	43.7%
Employment status (currently)/ male	94.1%
Total Fertility Rate	7.4
Use of FP modern method by married women 15-49	5%
Ante Natal Care provided by skilled Health worker	45%
Skilled attendants at birth	18%
Delivery in Health Facility	17%
Children 12-23 months with full immunization coverage	16%
Children 12-23 months with no immunization	26%
Stunting in Under 5 children	52%
Wasting in Under 5 children	17%
Diarrhea in children	15.3
ITN ownership	20%
ITN utilization (children)	12%
ITN utilization (pregnant women)	15%
children under 5 with fever receiving malaria treatment	4%
Pregnant women receiving IPT	4%
Comprehensive knowledge of HIV (female)	19%
Comprehensive knowledge of HIV (male)	43%
Knowledge of TB (female)	63.0%
Knowledge of TB (male)	88.9%

2.3 Health services provision and utilization

There are 563 health facilities, of this, 58(10.3%) are private health facilities, 18(3.2%) general hospitals providing secondary level care, 1 (0.2%) state owned specialist hospital providing both secondary and tertiary level care, 1(0.2%) Federal Medical Centre for tertiary care, and 505(89.7%) local government owned primary health care facilities; some of which are maternity centre and others are comprehensive health centres. Outreach services are non-existent probably due to human resource shortage. The bed capacity is between 11 and 14 beds /10000 of population. The health human resource is as follows:

Table 2: Distribution of Health Personnel Working in Gombe State

Cadre	State Govt	Private	Federal	Total
Doctors	61	21	81	163
Pharmacists	45	12	12	69
Med Lab Scientists	37	12	17	66
Nurses/Midwives	974	26	159	1159
CHOs	114	0	0	114
CHEWs	1168	40	1	1209
JCHEWs	484	65	56	605
EHOs/EHT/EHAs	557	0	3	560
TBA(	260	0	0	260
Dentists	6	0	5	11
VHW	181	0	0	181
Health Planner	8	0	0	8
Statistician	2	0	0	2
Medical Record Staff	32	0	0	32
Hospital Assistants	1249	0	92	1341
Med Lab Technologists	4	29	10	43
Med Lab Assistants	11	0	0	11
Xray Assistants	48	0	0	48
Xray Technicians	0	0	2	2
Dental Assistants	4	0	0	4
Radiologists	0	0	2	2
Radiographers	1	0	4	5
Cooks	99			99

LGA	CHEWs
Akko	151
Balanga	66
Billiri	130
Dukku	95
Funakaye	31
Gombe	157
Kaltungo	93
Kwami	66
Nafada	78
Shongom	76
Y/Deba	121

Total	1064

Table 3: Distribution of Community Health Personnel by Local Government

Table 4: Distribution of Health facilities by Local Government Areas in Gombe

LGA	Gen. Hosp	CHC	Maternity	Dispensary
Akko	2	4	11	33
Balanga	1	3	13	18
Billiri	1	5	6	45
Dukku	1	3	12	36
Funakaye	1	1	14	21
Gombe	2		8	11
Kaltungo	1	1	23	24
Kwami	-	3	8	24
Nafada	1	1	8	20
Shongom	-	2	15	10
Y/Deba	2	2	21	21
Total	12	25	139	263

2.3.3 Morbidity and mortality patterns in Gombe State

Malaria, acute severe malnutrition, diarrheal diseases, ARI, CSM, are most important causes of morbidity in the state. In addition to this, women in the reproductive age are prone to complications of pregnancy and childbirth. Low patronage of health facilities for vaccination and obstetric care and other forms of health care delivery are factors militating against effective health service. Data obtained from the HMIS are either incomplete, or out of harmony with expected reality or not computerized.

Table 5: Bi-annual report of disease patterns in Gombe State LG Primary Health facilities 2008

Disease	Jan-Jun 08	Jul -Dec08	Total
Cholera	15254	7627	22881
CSM	84	42	126
Measles	11455	5742	17197
Diarrhoea with blood	122621	61895	184516
Diarrhoea without blood	50901	25726	76627
HIV/AIDS	25886	13097	38983
Malaria	72147	36445	108592
Malaria in pregnancy	125	63	188
Tetanus	0	0	0
Onchocerciasis	10020	5010	15030
Oral Conditions	58398	29396	87794
Pneumonia	378	189	567
Polio	7400	3709	11109
STI	11283	5673	16956
TB	17226	8613	25839
Typhoid	18025	9118	27143
Anaemia	44	22	66
Coronary Heart Disease	854	427	1281
Diabetes Mellitus	6894	3447	10341
Hypertension	13111	6663	19774
Malnutrition	22660	11330	33990
Mental Conditions	117	61	178
Sickle Cell Disease	117	61	178
Total	**465000**	**234356**	**699356**

Source: Gombe State HMIS Statistics

Diseases prevented by sanitation and hygiene constitutes the bulk of morbidity data. Diarrhoeal diseases and malaria are predominant disease conditions accounting for 161139 and 108780 respectively. Next in distribution are the vaccine preventable diseases like measles, polio, tetanus CSM and TB. Although non-communicable diseases are uncommon, primary prevention with emphasis on life-style changes may prevent an increasing prevalence. There is a need to step- up STI and AIDS prevention strategies with emphasis on peer education targeting the youth.

Morbidity is higher in the first half of the year, and this may be due to exhaustion of food stores, inadequate food and processing methods and the dry season during which stable food cropping gives way to horticultural farming. The contrast is true for the July to December period, which is the harvest period, and morbidity in this period accounts for about 33% of the total annual ill

health data. Therefore, food shortage, and consequent malnutrition in the under-5 group and women in the reproductive age group provides a milieu for ill health, and sometimes death in the state.

2.3.3.2 Snake bite

The vegetation, climatic conditions and encroachment of the 'wild' by humans due to urbanisation in Gombe state has resulted in increased incidence of snake bites. A wide spectrum of snake variety is present especially around Kaltungo, Dadinkowa and Shongom localities, these include the vipers notable is *Echis oscellatus*, the elapids like the cobra and some colubrids. This observation prompted Echitab® intervention research in the 1990s. The research centre in Kaltungo transformed into a regional referral centre for snake bite research, serving Adamawa, Borno, Yobe, Bauchi, and Taraba States.

Males are more predisposed to snakebites as they form more than two thirds of snake bite victims because they are the 'bread winners' and they spend more time on the farms. The peak incidence of incidence of is highest between the months of April and October when farming activity is at its highest during the rainy season. The morbidity and mortality pattern due to snake bite is as follows:

Table 6: Pattern of morbidity and mortality due to snake bite 2007-2009

Month	Admission			Death		
	2007	2008	2009	2007	2008	2009
January	39	69	105	0	0	3
February	95	67	104	0	1(referred from Jalingo, Taraba	2
March	110	181	173	1	0	2
April	181	206	254	1	2(1from Adamawa)	4
May	160	201	245	3	2(1fromMutumbiyu,Taraba)	2
June	158	242	264	0	3(2 from Alkaleri,Bauchi)	5
July	190	269	271	0	3(1 each Adamawa, Bauchi, and Yobe states)	3
August	177	234	288	2	0	9
September	173	196	262	2	4(1 from Adamawa)	8
October	232	288	345	1	3(1 each from Taraba and Bauchi)	4
November	190	157	255	0	0	3
December	98	106	102	0	1(from Alkaleri in Bauchi)	3
Total	1803	2216	2668	10	19(12 were referred from other states mentioned above)	48(24 of which were referred from Adamawa, Bauchi, Borno, Taraba and Yobe

2.4 Key issues and challenges

Climatic conditions in Gombe are typical of the Sudan savannah zone characterized by long dry and short rainy seasons. This influences water and food supply, basic sanitation and hygiene, transmission of water and air borne diseases like gastro-enteritis, meningitis, and pulmonary tuberculosis. Being a state that is traversed by tributaries of the upper Benue River, onchocerciasis is endemic in the state. Suffice to say that Gombe is a predominantly agrarian state with vast arable land and a wide variety of livestock. Extensive involvement of the populace in primitive agricultural practices results in a lower output than expected. **This places a heavy toll on human effort with minimal economic impact.** Although schools abound, the introduction of the Universal Basic Education scheme has increased the number of primary and post primary schoolsbut the girl child has a lower probability of school enrolment. Whenever she gets enrolled, the drop-out rate is higher than among boys with attendant early marriage resulting in a low female completion of the high school curriculum. In the final year, girls account for 26.7% of the student population. The girl child's vulnerability is further increased by her lack of skills that empower her and her family. Her lack of basic education and awareness reduces the likelihood of the development of health promotion practices and the ability to appropriately seek health assistance. The male child does not fare better as he is sent to seek Qur'anic education under the tutelage of a renowned Sheikh several kilometers away from home-Almajiranci. This results in low enrolment and retention rates for both genders with consequent low awareness and markedly reduced likelihood of adopting health-seeking behavior. Living conditions in the Tsangaya (a boarding facility for boys living with the Sheikh) are squalid and bereft of basic provisions for hygiene and nutrition. It is therefore common to find a high prevalence of water-washed diseases like tinea (which includes wit cop and ringworm), scabies, trachoma and gastro-enteritis in this group. The substandard living conditions in the Tsangaya make it a nucleus for the commencement and spread of CSM epidemics. The traditional ruling institutions are an influential component of governance and guidance that can aid improvement in the provision and uptake of health and educational services; therefore they are the link for active community participation in health care delivery.

2.4.1 Challenges

1. Low school enrolment and retention with a resultant suboptimal literacy rate of <60%, with attendant low health seeking health promotion and proactive participation in health service delivery.
2. Health human capital is inadequate for both the available facilities and the population. It is the result of low school enrolment, and a progressive decline in educational standards, skilled health personnel limited to the urban centres and the state capital.

3. High maternal, infant (125/1000 live births) and under5 mortality rates with poor ill-health outcomes with lower life expectancy.

4. Poor sanitation conditions due to inadequate water supply. Most communities depend on water from seasonal streams, or irregularly functional boreholes.

5. Low vaccine coverage rates resulting in a high prevalence of vaccine preventable diseases prompting the need to develop sustainable strategies that encourage vaccine utilization
6. A high poverty incidence of 72.2%(NDHS 2008), and a high index of out of pocket spending for illness. The NHIS predominantly benefits Federal civil servants, and only a small portion of state government employee's benefit from it. NHIS is currently a pilot scheme operated in 3 local government areas in Gombe State.
7. Low health promotion knowledge and widespread adoption of cultural practices, which are harmful to health on a background of ethic and lingual plurality.
8. Absence of indigenous partners in health delivery thereby limiting the impact of health partnerships with UNICEF, WHO, Netherlands Leprosy relief Organization recently concluded EU-PRIME and occasionally Rotary Club.
9. Inadequately mobilized traditional ruling institutions in health care delivery.
10. Lack of outreach/extension services in preventive health service/health promotion.
11. Primitive food production practices coupled with inadequate storage systems and limited processing methods may contribute to the high incidence rate of malnutrition in the first half of the year a period characterized by depletion of food stores while the converse is true for the second half which coincides with the harvest period.
12. Poorly coordinated activities of alternative/ traditional medicine practitioners..

Chapter 3: Strategic Health Priorities

The Gombe state strategic plan is organized along the eight national strategic priority areas which are:

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

However, much emphasis is placed on governance for health, health service delivery, community participation and partnership for health. The interventions selected were chosen after an expanded stakeholders meeting looked at the health profile of the state and the challenges of improving the health system

High impact interventions have been selected to be delivered in a focused manner going from an initial baseline coverage level as reflected in the situation analysis, then scaling up to full coverage over the six years of this plan. These interventions are highlighted below:

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

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

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

Chapter 4: Resource Requirements

4.1 Human resources

Human resource for health in Gombe is in a desperate situation. Although there are a few health professionals, they are grossly inadequate for the population. The staff in the few private clinics is stretched resulting in the engagement of non-registered professionals with consequent quackery and impersonation. In summary, there is an urgent need for recruitment and deployment of HRH to all components and levels of health care delivery in the state.

In view of the high maternal and perinatal mortality rates, there is a need to massively recruit staff to remedy the situation. In the short-term there may be a need to partner with Federal Medical Centre in the provision of the expertise for service delivery and training/mentorship for sustainable improvement in health care delivery.

In an attempt to meet HRH needs in line with the bottom-up PHC concept, the following minimum PHC staff complement (in line with the WMHCP) is suggested:

S/No	Staff Cadre	Numbers required
1.	CHO	114
2.	CHEWs	728
3.	JCHEWs	386
4.	Public Health Nurses	114
5.	Registered Nurses and Midwives	456
6.	Med Assistant (optional)	114
7.	Medical Record Officers	114
8.	Environmental Health Officers	114
9.	Medical Officer of Health	33
10.	Administrative Officer	11

NB

LGA PHC coordinating committees will be formed from this complement in addition with an active stakeholder input from the community.

In order to address the high maternal and perinatal mortality rate, the following specialists should be employed.

S/N	Staff Cadre	Numbers /Senatorial Zone

1	Paediatricians	3
2	Obstetricians/Gynaecologists	3

In the long term, the following HRH ratios are to be met by massive training, employment and deployment of HRH to all health facilities.

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

4.2 Physical/Material Requirements

Presently, parastatals and directorates and divisions in the Ministry of Health are housed in rented apartments, and run down desolate buildings in the state capital hence the need to construct a ministry of Health headquarters and its components. The recently constructed health facilities suffer from perennial human capital shortage, thus the need for training and construction and expansion of training facilities. Physical materials required for effective coordination of health care delivery are:

I. The State Ministry of Health should be expanded
II. College of Medical Sciences in the State University
III. A State Primary Health Care Development Agency (GoSPHCDA)
IV. A State Hospital Services Management Board
V. A Herpetology and snake antivenom development Research Centre in Kaltungo
VI. A vaccine development centre and pharmaceutical factory
VII. An infectious disease Control Agency and Infectious disease Hospital

4.3 Financial

The current budgetary allocation to health accounts for 2.1% of the budget is grossly inadequate for effective health care delivery. Thus attainment of the millennium development goals will require multiples of the current budgetary allocation. To control endemic conditions like acute severe malnutrition, vaccine responsive diseases, diarrhoeal diseases, malaria, and acute childhood illnesses. Budgetary allocations would be required for environmental sanitation,

vector control, safe water supply, and nutritional intervention. A minimum of 15% of state budgetary should be allocated to health will be required to significantly improve on the health of the citizens.

Chapter 5: Financing plan

5.1 Estimated cost of the strategic orientations

The amount that will be required to implement the SHDP successfully has been estimated during the development of the various SHDPs. This total amount is NGN 39,599,887,121.28 for the period 2010-2015, with a corresponding annual and per capita annual costs NGN 6,599,981,186.88, NGN 2,790.64, which is equivalent to $USD18.60. the costs per priority area as follows.

Priority Area	Estimated Cost (2010-2015)
Leadership and Governance For Health	354,872,999.71
Health Service Delivery	21,048,689,761
Human Resources For Health	12,425,252,907
Financing For Health	3,948,808,704
National Health Information System	517,029,802
Community Participation And Ownership	316,625,366
Partnerships For Health	337,447,042
Research For Health	651,160,538
Total	**39,599,887,121.28**

5.2 Assessment of the available and projected funds

NB *Not captured in the sum total of projected funds from PLAN TOOL

Available funds for health for 2010 stand at ₦ 1.1 billion which is proportionate to 2.1%. The projected available funds considering inflationary trends of 12.5% annually amounts to nine billion, forty million, one hundred and twenty one thousand, four hundred and fifty nine naira, and ninety six kobo only (₦ 9,040,121,459.96). The deficit is thirty billion, five hundred and fifty nine million, seven hundred and sixty five thousand, six hundred and sixty one naira and thirty two kobo only (₦ 30,559,765,661.32)

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5.3 Determination of the financing gap

The deficit is ₦ 30,559,765,661.32; the shortfall is as a result of inadequate allocation. The wide gap between available funds and projected funds is due to plan to execute capital projects, train the much needed human resource and massively recruit personnel to manage the health system. The current allocation to health is far less than the minimum National and WHO recommended allocation of 5% to the health sector.

5.4 Descriptions of ways of closing the financing gap

There is an urgent need to increase allocation to health.

5.4.1 This may be actualized by increasing the state government's allocation to health.

5.4.2 Increased Federal Government fiscal support for high impact interventions, and support from partnerships.

5.4.3 Organize IDP funding into common basket facility and expand such support to impact on some urgent public health needs.

5.4.4 Mobilize IDPs to participate in all aspects of health improvement.

5.4.5 CSO participation is to be coordinated in a manner to reduce expenditure on HRH especially in the adoption of preventive schemes.

5.4.6 Mobilization of funds from NHIS and CHIS. CHIS funds may be mobilized in a manner that that is user friendly. For instance, farmers may submit their premiums during the harvest season, while artisans, traders and other low-income earners may remit their contributions at the time of business premises renewals annually.

5.4.7 The state government could go into partnership with neighbouring training institutions for refresher training of personnel or continuing education. Public health interventions can be up scaled in partnership with the Public Health Departments of University Teaching Hospitals, and the Federal Medical Centre. In this arrangement, communities may be used in pilot schemes for health improvement programmes

Chapter 6: Implementation Framework

The SSHDP would be implemented at four levels namely:

At the ward and family levels-Families will be mobilized to adopt positive health actions (KHHP) through BCC, the agents of mobilization in the community being traditional rulers who mediate between the health sector and traditional institutions. Practices. The solution to crises in the health sector is benchmarked on mass education/ literacy, public awareness, girl child education and female empowerment. The traditional institution forms the thrust of family education and awareness and is able to reach out to all members of the community through its hierarchy. A heterogeneous mix of traditional rulers registered and accredited traditional medical practitioners and preventive health practitioners will sustain BCC and adoption of health seeking behaviors.

Civil society organizations and the private sector (both Profit oriented and the not for profit organization).
These initiate and coordinate BCC related concepts and programs. CSOs liaise with the MOH and LG health departments to harmonize mass enlightenment programs in an all-embracing manner to ensure equitable health improvement.

Local Government areas provide the necessary infrastructure, personnel and an enabling environment for health care delivery at the primary level.

The State Government provides quality health services at the secondary and tertiary levels, train, recruit and deploy staff, to all health facilities. The state is also establishing a college of medical sciences that will produce the HRH. It is in partnership with NIPRD, NIMR towards establishing a herpetology research institute.

Health committees in Traditional institutions will be established to facilitate the formation of an interface between the health system and the communities.

Harmonization of appropriate remunerations for all HRH in the state irrespective of the level of engagement.

Gombe is endowed with a experienced, renowned health researchers who can be mobilized to train, mentor and coordinate ethical research on critical health issues.

Chapter 7: Monitoring and Evaluation (M&E)

7.1 Proposed mechanisms for monitoring and evaluation.

M&E is carried out by multi-disciplinary groups on a monthly basis and quarterly meetings will be held to assess the impact of various interventions. This will enable M&E committees from lower level in the health system forward the contributions for management action. The M&E committee membership should also include members of the user community, as this will strengthen the stewardship role expected of the health system. A feed back mechanism will be put in place a tool for M&E.

7.2 Costing the monitoring and evaluation component and plan.

M&E committees are to meet to review data and their health implications.

Chapter 8: Conclusion

The prevalent health problems in Gombe are preventable and amenable to public health measures. Maternal, perinatal, and under5 mortality will be reduced by the adoption of high impact public health interventions like use of LLINs, provision of safe water, upscaling of obstetric services, increased access to immunization, and sustained monitoring of vaccine coverage together with prompt treatment of acute childhood illnesses. Non communicable disease surveillance and prevention can be coordinated by CSO activity to encourage a demand driven preventive health system by instituting regular screening programs. There is an urgent need to massively recruit quality human resource for effective health service delivery. Most of the HFs in the state are grossly understaffed. Although the Midwives Service scheme is a short-term measure to bridge the HR gaps, the long-term measure will involve the training and re-training of staff and establishment of partnerships with neighboring institutions to provide staff on a locum tenens basis.

Adequate funding for health is a pre-requisite for the achievement of all proffered recommendations.

Annex 1: Detailed activities for Gombe Strategic Health Development Plan

GOMBE STATE STRATEGIC HEALTH DEVELOPMENT PLAN 2009							
PRIORITY							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	
	Strategic Objectives				**Targets**		**TOTAL EXPENDITURE 2010-2015**
		Interventions			**Indicators**		
			Activities		**None**		
LEADERSHIP AND GOVERNANCE FOR HEALTH							
1. To create and sustain an enabling environment for the delivery of quality health care and development in Nigeria							**354,872,999.71**
	1.1	**To provide clear policy directions for health development**			**All stakeholders are informed regarding health development policy directives by 2011**		**67,557,784**
		1.1.1	Improved Strategic Planning at State and Local Government levels				**282,718**
			1.1.1.1	Conduct annual meetings between government and partners to review implementation status and update the SSHDP.		Commissioner of health as chair	142,078
			1.1.1.2	Assign roles for health partners.			-
			1.1.1.3	Formation of traditional medical practice regulatory agency.			74,346
			1.1.1.4	To conduct programme courses and senitization workshops for IMNCH managers.			26,434
			1.1.1.5	Formation/ strengthening of a state health partnership forum			39,861
		1.1.2	Intersectoral collaboration towards strengthening integration and co-ordination of health programs.				**116,006**
			1.1.2.1	Conduct annual meetings of State Council on Health			83,498
			1.1.2.2	Meeting with line ministries and the directorates in the ministry of Health to review policy and standard protocols like regulation of traditional medical practice, food /beverage services and health related tourism services.	50% of food/beverage vendors/ hoteliers to adhere to regulations by 2013		20,214
			1.1.2.3	Establish multisectoral health partnership			-
			1.1.2.4	To mobilise/motivate the private sector to engage in IMNCH programs in Gombe State.	60% of faith-based organisations and manufacturers in the state to develop and implement infrastructural and outreach support IMNCH programs.		6,147
			1.1.2.5	Collaborating with non health related private sectors -eg farmers, manufacturers,industrialists and tourism related businesses in an effort to contribute towards health development in the state.			6,147
		1.1.3	Needs assesment for capacity building and re-orientation.				**23,208**
			1.1.3.1	To generate State and Local Government concensus on the strategy framework.			-
			1.1.3.2	Form Village Health Councils.			5,664
			1.1.3.3	Quarterly Meeting with Faith Based Organisations (FBOs).			6,923

			1.1.3.4	Quarterly Meting with Community Based Organisations (CBOs).			5,581
			1.1.3.5	Conduct a survey to determine the strength and distribution of human resource for health			5,040
		1.1.4	Achieving synergy				**185,449**
			1.1.4.1	Support L.G.As to establish L.G.A.and ward partnerships for health and hold quarterly planning meetings.			-
			1.1.4.2	Hold regular reviews of health sector policies to align with changing priorities.			27,936
			1.1.4.3	Formation of Implimentation committees to oversee implementation from the state to the ward level.			35,203
			1.1.4.4	Support traditional rulers to form health implementation Committees within their domains.			50,351
			1.1.4.5	Form partnerships with faith based organisation with health related programs	70% of FBOs in Gombe State to be registered with defined roles in health care delivery		71,959
		1.1.5	Infrastructural provision for governance				**66,950,403**
			1.1.5.1	Consctruction of State Ministry of Health Administrative Headquarters.			16,856,522
			1.1.5.2	Contruction of motorable roads linking all health care establishments in the state and local governments.			25,661,573
			1.1.5.3	Provision of communication equipment such as telephones, E-mail etc in all heath care institutions in the state.			4,822,449
			1.1.5.4	Adequate accommodation for health managers at all levels.			19,609,858
			1.1.5.5	Establish and build capacity for equipment maitenance in all health facilities across the state.			-
	1.2	**To facilitate legislation and regulatory framework for health development**			**Health Bill signed into law by end of 2009**		**-**
		1.2.1	Review and update all the existing laws and bye-laws in in the state in respect to health issues.				**-**
			1.2.1.1	(a)Present health bill to state house of assembly prohibiting drug hawking, blood sale; incentives utilisation of obstetric and immunisation services for all citizens especially children and pregnant women; free health care for all accident victims; state derived NHIS bill to widen its coverage,enact a law for free health services for all pregnant women and under five children.			-
			1.2.1.2	Submit to House of Assembly and advocate for laws to regulate and broaden IDP activities beyond their primary mandates.			-
			1.2.1.3	Health committee of the house of assembly to conduct quarterly oversight visits to health care establishments in the state.			-
			1.2.1.4	To form lobby groups with IDPs, women groups and NAFDAC for easy legislation on related matters			-

			1.2.1.5	Enlighten public on the need for laws that promote health of the citizens especially children and women			-
		1.2.2	Strengthen regulatory functions of government				-
			1.2.2.1	Set up a professional licence examination/review committee in every local government area	By 2012, all Local Government areas to form licence review committees with operational guidelines		-
			1.2.2.2	Provide guidelines for establishing health facilities in the state.			-
			1.2.2.3	Conduct biennial update courses on ethical health care delivery for all cadres of health personnel.	SMOH, Professional Regulatory bodies		-
			1.2.2.4	Review all licences and regulate the activties of private health care providers and patent medicine vendors in the state and L.G.A.s.			-
			1.2.2.5	To develop the capacity of regulatory bodies in the state in line with the national standard.			-
		1.2.3	Provide legislative support for environmental sanitation				-
			1.2.3.1	Enact laws and guidelines for environmental sanitation			-
			1.2.3.2	Encourage the establishment of environmental sanitation companies at ward,and local government levels			-
			1.2.3.3	Provide guidelines to regulate the activities of environmental sanitation companies			-
			1.2.3.4	Regulation of environmental health officers' services and practices			-
			1.2.3.5	Provide regulatoryframework for sanctions against perons and corporate bodies who break sanitation laws			-
		1.2.4	Legislation against cultural practices that are detrimental to health				-
			1.2.4.1	Adopt health education as a right for all citizens			-
			1.2.4.2	Provide health education via press, and electronic media			-
			1.2.4.3	Antenatal, natal and post-natal services must be provided by trained health professionals and in health facilities			-
			1.2.4.4	Corrective measures against communities with high incidence of preventable maternal mortality and vaccine preventable diseases.			-
			1.2.4.5	Enact laws on prevention of cultural practices that are detrimental to health			-
		1.2.5	Ensuring the sustainability of best practices in health care delivery				-
			1.2.5.1	Conduct investigations on all negligence related maternal and under5 mortality		Autopsies may not be carried out but HMIS records can be used	-
			1.2.5.2	Establish a code of audit for health service related activities			-
			1.2.5.3	Establish a health service quality maintenance taskforce to monitor public and private health facilities			-

			1.2.5.4	Design curricula for continuing education programmes for all health related cadres in the state			-
			1.2.5.5	Establish career opprtunities for physically challenged persons assign roles to serve identically challenged persons			-
	1.3	**To strengthen accountability, transparency and responsiveness of State/ L.G.A. health system.**			**80% of States and the Federal level have an active health sector 'watch dog' by 2013**		**-**
		1.3.1	To improve accountability and transparency- Devolution of power and responsibility in the health sector.				**-**
			1.3.1.1	To establish health fora from village, ward and local government levels while building capacity for health management teams at both state and local government levels in respect to maternal and child health.			-
			1.3.1.2	Establish feedback partnership with associations, societies and clubs.			-
			1.3.1.3	Empower beneficiary communities to manage and oversee their health projects and programmes.			-
			1.3.1.4	Promote emergence of independent health sector 'watch dogs' for leadership at all levels.			-
			1.3.1.5	Domesticate fiscal responsibility bill and procurement to state and local government levels with a view to ensure financial autonomy for all health management..			-
		1.3.2	Utilisation of health information for community based intervention				**-**
			1.3.2.1	Periodic collation of health data for submission to community leaders at all levels			-
			1.3.2.2	Formation of health intervention committees at community, ward, and local government and state levels		Traditional Institutions to form health-culture interface	-
			1.3.2.3	Assign roles for traditional rulers in disease control activities			-
			1.3.2.4	Distribute HMIS data to all levels of leadership in the state, traditional, legislative and executive			-
			1.3.2.5	Develop state wide disease specific control programs e.g. diabetes week, hypertension week,			-
		1.3.3	Develop health audit system in all local government areas				**-**
			1.3.3.1	Form health audit commitees in all levels of health care deilivery			-
			1.3.3.2	Place suggestion and complaint boxes in strategic areas of health care delivery outlets			-
			1.3.3.3				-
			1.3.3.4				-
			1.3.3.5				-
		1.3.4	Establish regulation guidelines for the conduct all health businesses(food vendors, patent medicine vendors, pharmaceutical shops, traditional health practitioners, water vendors etc) in the state				**-**

			1.3.4.1	Produce a health business code for all related businesses in the state			-
			1.3.4.2	Disseminate information and sensitise the public through print and electronic media on the concept of health business code and its positive impact on health			-
			1.3.4.3	Strengthen existing licencing offices and open new offices for business thst were previously not covered			-
			1.3.4.4	Include the health business in the social studies and health education curricula of primary and junior secodary school			-
	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**		**287,315,215**
		1.4.1	Improving and maintaining Sectoral Information base to enhance performance				**287,315,215**
			1.4.1.1	Establish an advisory committee of senior citizens in the health sector.			-
			1.4.1.2	Conduct annual review of SSHDPs with a view to identifying priority areas for subsequent budgetting			-
			1.4.1.3	Construct and establish of Health Services Management Board			199,143,024
			1.4.1.4	Establish State Primary Health Care Development Agency			88,172,191
			1.4.1.5				-
		1.4.2	Set up a process for reviewing the SSHDP & LGSHDP.				-
			1.4.2.1	Periodic training of all staff in the health sector and line ministries in respect of SHDP.			-
			1.4.2.2	Update and cost SSHDP following a situation analysis showing the gaps to address.			-
			1.4.2.3	Harmonise HIV/AIDS, TB-Leprosy, onchocerciasis, IMNCH, MALARIA, IMNCH, NUTRITION STRATEGIC PLANS with SSHDP			-
			1.4.2.4	Create an international development partner/ Corporate partner development forum with a view to developing an assistance common basket concept			-
			1.4.2.5				-
		1.4.3	Advocacy to mobilize support for IMNCH related programes.				-
			1.4.3.1	Establish and annually review guidelines on improved newborn care			-
		1.4.4	Generate intellingence and ensure optimal utilization of health information for decision making.				-
			1.4.4.1	Encourage the use of HMI in decision making.			-
			1.4.4.2	Quality submission and review of state wide health information and survailance data to the DPRS.			-
			1.4.4.3	Establish a community generated feedback data base which informs the government on community's perception on morbidity trends.			-
		1.4.5	Equitable distribution of health promotion resources				-

			1.4.5.1	Formulate a personnel recruitment and deployment policy			-
			1.4.5.2	Training and retraining of health workers to improve performance			-
HEALTH SERVICE DELIVERY							
2. To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare							**21,048,689,761**
	2.1	**To ensure universal access to an essential package of care**			**Essential Package of Care adopted by all States by 2011**		**21,048,689,761**
		2.1.1	To review, cost, disseminate and implement the minimum package of care in an integrated manner				**8,491,767,194**
			2.1.1.1	Adapt/adopt costed minimum package of care developed at the national level		**X**	-
			2.1.1.2	Reproduction, orientation, and dissemination of the ward minimum health package manuals			-
			2.1.1.3	Train health care workers on minimum package of care manuals and guidelines		**X**	8,491,767,194
			2.1.1.4	Capacity and need assessments of health facilities at different level to deliver minimum package of care			-
		2.1.2	To strengthen specific communicable and non communicable disease control programmes				**11,705,295,674**
			2.1.2.1	Capacity and need assessments of disease control programmes and bridge identified gaps in the programmes			-
			2.1.2.2	Stregthen programs for the control of malnutrition, visual impairment			-
			2.1.2.3	Upscale malaria control activities e.g distribution of LLIN, community based malarial case management, IPT for pregnant women, provision and use of ACT for malaria			10,781,915,214
			2.1.2.4	Establish agency for the control of infectious diseases including HIV/AIDS, TB, STIs			-
			2.1.2.5	Establish committees for the control of non-communicable diseases e.g. diabetes and hypertension, kidney disease,			923,380,461
		2.1.3	To make Standard Operating procedures (SOPs) and guidelines available for delivery of services at all levels				**-**
			2.1.3.1	Inventory of available SOPs and guidelines and identify services delivery points lacking SOPs			-
			2.1.3.2	Adapt/adopt existing SOPs & guidelines			-
			2.1.3.3	Reproduction of adapted/adopted SOPs			-
			2.1.3.4	Orientation and dissemination of adopted/adapted SOPs and guidelines			-
			2.1.3.5				-
		2.1.4	Improve health by adopting the minimum health care package concept appropriate for the level of care and disease condition				**851,626,892**
			2.1.4.1	Provide facilities for neonatal resuscitation and asphyxia prevention and management (HR,			-
			2.1.4.2	Provide anti-snake bite management protocol at the local government and ward levels			352,528,744
			2.1.4.3	Prevent maternal anaemia by universal administration of haematinic preparations, antihelminthic and antimalarial prophylaxis			95,090,073
			2.1.4.4	Provide VitaminA , oral rehydration therapy and zinc for all under 5 children with diarrhoea			157,910,068

			2.1.4.5	Provide infrasructural support and protocol for the management of complicated pregnancy, labour and delivery with a view to reducing maternal mortality			246,098,007
		2.1.5	To universally deliver high impact intervention at ward levels				-
			2.1.5.1	Ensure increased access and utilization of LLIN	**LLIN use @30% by 2010, LLIN use @70% by 2014**		-
			2.1.5.2	Exclusive breastfeeding support groups in all wards including the recruitment of village health promoters			-
			2.1.5.3	Provide safe water supply in all communities			-
			2.1.5.4	Provide basic and comprehensive obstetric and neonatal care			-
			2.1.5.5	To expand reproductive health services and upscale life-saving services across the state			-
	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**		-
		2.2.1	To improve geographical equity and access to health services				-
			2.2.1.1	Take an inventory, map and assess the capacity of existing health facilities at State and LGA level			-
			2.2.1.2	Develop criteria for siting new HF at State and LGA levels			-
			2.2.1.3	Renovation of existing sub-standard primary health facilities and establishing new ones where needed			-
			2.2.1.4	Adapt/adopt and implement guidelines for outreach services			-
			2.2.1.5	Strengthen the capacity of CSOs to plan and implement outreach services			-
		2.2.2	To ensure availability of drugs and equipment at all levels				-
			2.2.2.1	Review essential drug list (EDL)			-
			2.2.2.2	Strengthen and sustain mechanism for the provision of essential drugs			-
			2.2.2.3	Review equipment list at different level of health facilities to provide the essential package of health care			-
			2.2.2.4	Refurbishment, Procurement and distribution of essential equipment			-
			2.2.2.5	Strengthen logistic management information system (LMIS)			-
		2.2.3	To establish a system for the maintenance of equipment at all levels				-
			2.2.3.1	Enter and enforce warranty aggreement and post-warranty maintenance agreement with manufacturers and suppliers			-
			2.2.3.2	Training and mentoring of health workers on the proper use and maintenance of hospital equipment and furniture			-
			2.2.3.3	Advocate the release of maintenance of equipment and furniture budget			-

			2.2.3.4	Establish a maintenance workshop in each of the three senatorial districts (Ensure appropriate equiping, staffing and funding of such maintennance workshops)			-
			2.2.3.5	Promote the participation of communities and private sector in the maintenance of medical equipments and furniture			-
		2.2.4	To strengthen referral system				-
			2.2.4.1	Assess existing two-way referral system			-
			2.2.4.2	Building a consensus with relevant stakeholders on establishment of gatekeeping mechanism			-
			2.2.4.3	Advocate and mobilize community leaders and community members on the existence and significance of adhering to the referral system			-
			2.2.4.4	Provide logistics for referrals (Transportation and Communications) through the provision of coupons e.t.c			-
			2.2.4.5	Training, enlightenment and monitoring of HCWS and clients on the SERVICOM concept and practices			-
		2.2.5	To foster collaboration with the private sector				-
			2.2.5.1	Assess existing public-private partnership			-
			2.2.5.2	Strengthen/establiish Public Private Partnership coordinating mechanisms on service delivery at State and LGA levels			-
			2.2.5.3	Promote full participation of private health care providers in all activities concerning service delivery at State and LGA levels (Training, development of guidelines and protocols, committees etc)			-
			2.2.5.4	Establish a training programme and code of practice in health related matters for faith based organisations			-
			2.2.5.5				-
	2.3	**To improve the quality of health care services**			**50% of health facilities participate in a Quality Improvement programme by end of 2012**		**-**
		2.3.1	To strengthen professional regulatory bodies and institutions				-
			2.3.1.1	Support national regulatory bodies and institutions to ensure regular licensure, accreditation and certification (Quality Monitoring Mechanism)			-
			2.3.1.2	Support State regulatory bodies (Private Hospital Regulatory Authority, Propriety Vendor etc)			-
			2.3.1.3	Establish state branches of regulatory and licence offices for regulatory agencies			-
			2.3.1.4	Link professional integrity to appointments			-
			2.3.1.5	encourage regulatory bodies to liaze with LGA PHC coordinators in the discharge of their duties			-
		2.3.2	To develop and institutionalise quality assurance models				-

			2.3.2.1	Establish and build capacity of an integrated Quality Asurance Expert Committee			-
			2.3.2.2	Establish and regularly update minimum quality standard of all components of health care system in the State			-
			2.3.2.3	Conduct annual health care quality assessment			-
			2.3.2.4	Support and enforce the implementation of recommendations of the quality assessment for quality improvement			-
			2.3.2.5	Conduct annual professional continuing education and assessment programmes for all cadres			-
		2.3.3	To institutionalize Health Management and Integrated Supportive Supervision (ISS) mechanisms				-
			2.3.3.1	Constitute integrated supportive supervisions teams at all levels			-
			2.3.3.2	Capacity assessment and development of supportive supervisions teams			-
			2.3.3.3	Develop supervision tools for integrated supportive supervision (Checklist)			-
			2.3.3.4	Develop, produce and disseminate agreed supervisory calendar			-
			2.3.3.5	Establish a budget line and financial mechanisms for integrated supportive supervision			-
		2.3.4	To equip the state specialist hospital and all secondary health facilities in an effort to improve health care delivery				-
			2.3.4.1	To provide theatre facilities in all hospitals			-
			2.3.4.2	To set up intensive care units for the management of eclampsia and other obstetrical emergencies			-
			2.3.4.3	To provide refrigerated centrifuge/ blood component seperator for efficient and safe transfusion services			-
			2.3.4.4	Establish neonatal intensive care units in the specialist hospital and all secondary health facilities			-
			2.3.4.5	To provide electric power plants in hospitals(solar powered)			-
		2.3.5	Relate SSHDP implementation to feed back responses				-
			2.3.5.1	Annually review SSHDP targets with reference to current settings			-
			2.3.5.2	Establish budgetary allocation based on the SSHDP priority demands			-
			2.3.5.3				-
			2.3.5.4				-
			2.3.5.5				-
	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 promote positive health care seeking behaviour				-
			2.4.1.1	Adapt National BCC Strategy for health/ Develop healthy public policy			-
			2.4.1.2	Development, production of IEC materials and their distribution during community dialogues			-

			2.4.1.3	Provide budget line and ensure release of fund for the implementation SBCC Strategy for health			-
			2.4.1.4	Implement, monitor and evaluate SBCC Strategy for health			-
			2.4.1.5	Support the public to form health promotion peer groups e.g diabetic society			-
		2.4.2	To improve the responsiveness of health care workers				-
			2.4.2.1	Train health care workers on interpersonal communication			-
			2.4.2.2	Establish grievance procedure system and appoint ombudsmen in all health facilities			-
			2.4.2.3	Implement strategies that will reduce workload and motivate HCW (See HRH)			-
			2.4.2.4	Reduce the turn around time for consultations and laboratory investigations	Attain a max waiting period of 1hr in all clinics		-
			2.4.2.5	Implement health service delivery audit reports; reward deserving staff			-
		2.4.3	Reduce the prevalence of common diseases and increase access to health care delivery				-
			2.4.3.1	Introduce counseling programs for diseases like sickle cell anaemia, HIV/AIDS, hypertension, Eye care and diabetes mellitus			-
			2.4.3.2	Organise large scale screening programs for conditions like sickle cell anaemia,TB, diabetes mellitus, hypertension and HIV/AIDS, Eye care, oral health			-
			2.4.3.3	Disseminate health education information on primary prevention of common diseases.			-
			2.4.3.4	Encourage the adoption of WASH and KAHP strategies in health promotion			-
			2.4.3.5				-
		2.4.4	Develop a Gombe State health promotion policy as a component of health care delivery				-
			2.4.4.1	Develop a geographically and culturally relevant health promotion policy			-
			2.4.4.2	Develop and disseminate mass media based IEC materials on individual and community's right to health and health care			-
			2.4.4.3	Adopt health promotion information and skill acquition in schools			-
			2.4.4.4	Mobilize Trade unions and professional organizations towards adopting health promotion progammes as a component of memebership package			-
			2.4.4.5	Formulate a health promotion and health education policy			-
		2.4.5	Identify and eliminate bottlencks in health delivery				-
			2.4.5.1	Increase access to health facilities by locating them within 5km radius of the user			-
			2.4.5.2	Establish the village health worker scheme in areas of nutrition oral rehydration therapy and breastfeeding, antenatal care, family planning pneumonia and malaria case identification			-
			2.4.5.3	Allocate health budget reflecting bottleneck needs			-
			2.4.5.4				-

			2.4.5.5				-
	2.5	**To provide financial access especially for the vulnerable groups**			**1. Vulnerable groups identified and quantified by end 2010 2. Vulnerable people access services free by end 2015**		**-**
		2.5.1	To improve financial access especially for the vulnerable groups				**-**
			2.5.1.1	Establish and scale-up evidence-informed models for financial protection e.g. vouchers, coupons, cash transfer and free schemes			-
			2.5.1.2	Implement evidence informed financial protection strategies			-
			2.5.1.3	Mobilize communities and philanthropists to establish financial protection schemes for the vulnerable			-
			2.5.1.4	Establish a vulnerable persons' service fund in every health facility across the state where they can access treatment vouchers			-
			2.5.1.5	Establish an audit system to oversee vulnerable persons' fund			-
		2.5.2	Establsh identification scheme for vulnerable persons				**-**
			2.5.2.1	Establish contact point for vulnerable persons in all coummunities in the the state			-
			2.5.2.2	Set criteria for identification of vulnerable persons			-
			2.5.2.3	Design identity cards for all vulnerable persons where possible			-
HUMAN RESOURCES FOR HEALTH							
3. To plan and implement strategies to address the human resources for health needs in order to enhance its availability as well as ensure equity and quality of health care							**12,425,252,907**
	3.1	**To formulate comprehensive policies and plans for HRH for health development**			**All States and LGAs are actively using adaptations of the National HRH policy and Plan by end of 2015**		**4,567,368,553**
		3.1.1	To develop and institutionalize the Human Resources Policy framework		At least 5 LGAS in the state will adapt and implement HRH by the end of 2010.		**4,567,368,553**
			3.1.1.1	To review, confirm and adapt the National Human Resources for Health policy and strategic plan.	strategic plan for HRH policy in place by the year 2011		1,826,947,421
			3.1.1.2	Develop a training programme and materials to train Local governments in each senatorial district on how to costomize the national human resources for health policies strategic plan.			2,740,421,132
			3.1.1.3	To develop and promote a rollout and the customisation of the state human resuorses policies and plan.			-
			3.1.1.4	Monitor the adaptation of the national human resourses for health policies and plans for implementation by the state and LGAs			-
			3.1.1.5				-

		3.1.2	To develop and promote non discriminatory recruitment policies within the state civil service and all local government areas for critically needed professionals inrespective of their state/local government origin.		At least the state and LGA will have non discriminatory recruitment policies for health professionals by the end of 2010.		-
			3.1.2.1	To update state policy on staff recruitment and monitoring within the state health care service.	Adaptation of non discriminatory recuitment policy in place by the year 2010		-
			3.1.2.2	To monitor the adaptation of the state non-discriminatory recruitment policies.			-
			3.1.2.3	To develop a training programme on recruitment policies			-
			3.1.2.4	Adopt non-discriminatory employment and staff deployment policy			-
			3.1.2.5				-
		3.1.3	Strengthen capacity structures and systems for responsive planning management and development at state and local government levels				-
			3.1.3.1	Review existing HRH planning mangement and development capacity, systems and structures at state and local government levels across the sector			-
			3.1.3.2	Establish and support appropriate HRH structure both within and outside state and local government health departments for HR policy, planning and mangement			-
			3.1.3.3	Review and refine fucntions, mandates and responsibilities of regulatory bodies			-
	3.2	**To provide a framework for objective analysis, implementation and monitoring of HRH performance**			**The HR for Health Crisis in the country has stabilised and begun to improve by end of 2012**		**4,176,903,320**
		3.2.1	To reappraise the principles of health workforce requirements and recruitment at all levels				-
			3.2.1.1	To develop staff norms based on workload to guide planning and use of service availability and health sector priorities to determine the staff needs and introduce for utilization by state and local government service providers.	Document on staffing norms based on workload developed for all levels.		-
			3.2.1.2	To set up a committee with state and local government representatives to develop principles of health workforce recruitment by the relevant bodies.	Committee to develop principles of health workforce established by the end of 2010		-
			3.2.1.3	To estabish coordinating mechanism to wards mutual consistency in human resources for health planning, budgeting among the ministry of health, finance, education, civil service commission, regulatory bodies, NGOs, private sector providers in the health and other institutions	A funtional coordinating mechanism will be established by the end of 2011.		-
			3.2.1.4				-
			3.2.1.5				-
		3.2.2	To develop a model to project staff needs for the state, then liaise with MOE and training institutions to plan how to train sufficient personel.		Target for key funtional output have been set and agreed with		**3,044,912,368**

					training institutions by the end of 2011.		
			3.2.2.1	To collect base line data, consult professionals and examine international literature to identify appropriate health professional target.			-
			3.2.2.2	To constract a model to project training and out put requirements to provide for health professional needs of the state.			3,044,912,368
		3.2.3	To strengthen the activities of M&E units in the state and local government areas.		Functional M&E units in the state and LGA by the end of 2011		**1,131,990,951**
			3.2.3.1	Capacity building for all monitoring and evaluation team personel.	no of trainings held		1,131,990,951
			3.2.3.2	Monitoring all M&E activities all level in the state.			-
			3.2.3.3	Evaluation of all health and health related activities in the state.			-
			3.2.3.4	Ensuring proper supply of M&E requsired data tools e.g. Computer and its accessories			-
			3.2.3.5	Set up a mechanism fo rthe establishment of a school of health information system and management technology.			-
		3.2.4	Develop and streamline carrier pathways for all group of health professional critically needed to foster demand and supply creation in the health sector (Health promotion)		All cadres of health professionals are in place by the year 2012		**-**
			3.2.4.1	Define carrier pathway for all cadres of health professionals			-
			3.2.4.2	Streamline carrier pathway for all cadres of health professional.			-
			3.2.4.3	Implementing carrier pathway for all cadres of health professionals in the state			-
			3.2.4.4	Strengthen the training of HRH in all specalized health related fields			-
			3.2.4.5	Ensure capacity building to enhance human resources for health	No of workshops/seminars held for each professional health care group		-
		3.2.5	Develop a framework for an institutionalised supportive supervision				**-**
			3.2.5.1	Develop and work with LGs to implement frame work for intergrated supportive supervision.	State and Local Government have institutions support programme in place by the end of 2011		-
			3.2.5.2	Develop and provide guidelines and training to SMOHs for routine supportive and supervision.			-
	3.3	**Strengthen the institutional framework for human resources management practices in the health sector**			**1. 50% of States have functional HRH Units by end 2010 2. 10% of LGAs have functional HRH Units by end 2010**		**-**
		3.3.1	To establish and strengthen the HRH Units		States and local will have funtional HRH units by the end of 2012.		**-**

			3.3.1.1	State Ministry of Health HRH Unit to develop guideline and training materials for the state and Local Government Areas HRH units.	Guide and training materialsfor HRH units will be in place by the end of 2011.		-
			3.3.1.2	Roll-out the emplementation of HRH unit within the Local Government Areas.			-
			3.3.1.3	State Ministry of health and Local Government Areas Health department against orientation workshops, seminars to enhance capacity building.			-
			3.3.1.4	Recruitment of qualified personel at the state and local government levels.			-
			3.3.1.5				-
		3.3.2	Design and implement training programme to build technical at all levels of the health sector and other relevant sectors for human resources, planning and management.		Training programme designto all health sector on HRH planing and management by the end of 2011		-
			3.3.2.1	Establish a training programme and manual for training of staff in the HRH management and planning.			-
			3.3.2.2	Identify existing institutions that are willing and able to provide the training courses for HRH management and planning.			-
			3.3.2.3	Train managers in human resources planning and management from the health and other relevant sectors.	no. of managers trained annually		-
			3.3.2.4	Monitor training courses output on HRH management and planning.			-
			3.3.2.5				-
		3.3.3	Establish multi sectoral human resources for health system for planning, management and development at state and local government levels.		Functioningstate intersectoral HRH committeesin at all state and local governmnt areas by the end of 2011.		-
			3.3.3.1	Establish the multi sectoral committee to discuss issues by HRH and meets quarterly.			-
			3.3.3.2	Encourage the state and local government areas to promote the establishment of local government area levels intersectoral committee for regular meetings to professional groups.			-
			3.3.3.3	Monitor the meetings that are taking place and the matters discussed and resolved at the state/local government area levels.			-
			3.3.3.4	Adapt issues discuss at the multi-sectoral meetings at state and local government areas levels			-
			3.3.3.5				-
		3.3.4	Promote proactive regular engagement with various professional groups so as to promote dialoque and harmony.		Functioning state health professional for a in state and local government areas by the end of 2012.		-
			3.3.4.1	Establish a state forum for regular meeting of professional groups	Existence of such group by Dec. 2009		-

			3.3.4.2	Conduct regular meettings of state representatives of professional groups with SMOH management	No of such meetings being conducted annually		-
			3.3.4.3	Promote the establishment of local government level fora for regular meettingof professional groups at LGA level			-
			3.3.4.4	Monitor the meetings that are taking placeand the matters discussed and resolvedat the state and LGA health professional bodies' meeting for administrative action			-
	3.4	**To strengthen the capacity of training institutions to scale up the production of a critical mass of quality, multipurpose, multi skilled, gender sensitive and mid-level health workers**			**One major training institution per Zone producing health workforce graduates with multipurpose skills and mid-level health workers by 2015**		**-**
		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		trainig programmesof all health related institutionsadaptedto nationalpriorities by 2011 academic year		**-**
			3.4.1.1	Meet with all health training institutions to discuss the acceptable curricular of training programme for state priorities.			-
			3.4.1.2	Establish ongoing discussions with all health related training institutions to monitor adaptation of training programmes for state priorities.			-
			3.4.1.3	Review of the institutional training curiculum to reflect the state priorities			-
			3.4.1.4	Support multiple stakeholder contribution in HRH training curriculum design			-
			3.4.1.5				-
		3.4.2	To strengthen health workforce training capacity and output based on service demand				**-**
			3.4.2.1	Map out the capacity for production of health care providers in the state based on need.			-
			3.4.2.2	Set up and strengthen training institutions in the state base on need.			-
			3.4.2.3	Conduct a survey to establish the requirement for infrastructure, teaching and learning materials, budget and financial support for training institutions.			-
		3.4.3	Review and refine the functions, mandate and responsibilities of professional regulatory bodies with a view to strengthening adequate production of various professionals.				**-**
			3.4.3.1	Establish a process to review the functions and mandates of regulatory bodies on an ongoing process with aim of strengthening adequate production and registration of health professionals.			-
			3.4.3.2	Establish or strengthen the regular monitoring process to ensure that training curriculum and programmes are reivewed and appropiately accredited and the regulatory bodies ensure	Reports from such meetings		-

				the reflect the multi tasking and shifting as appropiate.			
			3.4.3.3	With the regulatory bodies and training institutions review admission policy and creteria for discipline in response toHRH crisis in disadvantage areas of the state.			-
			3.4.3.4	Continuously review assessment conducted by training institution to meet accreditation and professional requirement.			-
			3.4.3.5	Promote the training and deployment of community based health care workers as appropiate.			-
		3.4.4	Autonomy, Revatilization and periodic accreditation for all institutions involved in the training of health personel.				-
			3.4.4.1	Granting autonomy to all training health institutions in the state.	Autonomy granted to health trainiing institutions by the year 2012		-
			3.4.4.2	Ensure adequate funding of the training health institutions			-
		3.4.5	Establish a programme for in-service training, human capital capacity building and continue professional development by government, institutions and regulatory bodies.				-
			3.4.5.1	Establish a process and the financial resources to sponsor candidateS and bond them to return to serve for agreed period after training.			-
	3.5	**To improve organizational and performance-based management systems for human resources for health**			**50% of States have implemented performance management systems by end 2012**		**3,665,145,399**
		3.5.1	To achieve equitable distribution, right mix of the right quality and quantity of human resources for health				-
			3.5.1.1	Develop and refine recruitment selection and deployment of competent and capable staff to reflect organizational objectives/needs.			-
			3.5.1.2	Monitor the deployment of professional staff to promote equity in mix, need and geographical space.			-
			3.5.1.3	The state Ministry of Health will collaborate with the federal institution in the state to leverage on available HRH so as to sustained service coverage and quality.			-
			3.5.2.1	Create a state database of HRH in line with the NHIS.			-
			3.5.2.2	Develop and provide job discription for all categories of health workers			-
			3.5.2.3	Promote the national midwifery scheme and the community midwifery programme.			-
		3.5.3	Motivation of health workforce by the creation of incentive for health workers along with recognition of hardwork and service with emphasis on these that will attract and retain staff in rural areas.				-
			3.5.3.1	The state Ministry of health should implement performance incentives in recognition of hard work service.			-

			3.5.3.2	Develop and implement guidelines and recommendation on additional incentives for health workers working in rurural and deprived areas.			-
			3.5.3.3	Establish mechanisms or minimise work place harzard though management of physical risk and mental stress as well as full compliance with prevention and protection guidelines.			-
			3.5.3.4	Ensure as much as possible that health care workers are paid on time and promoted when due.			-
			3.5.3.5	The state government should be encouraged as much as possible to adopt and implement federal government circulars and guidelines for the enumeration of all cadres of health care workers within the state/local government to checkmate the brain drain syndrome.			-
		3.5.4	Re-orientation of health workforce toward attitudinal change.				**-**
			3.5.4.1	To develop and work with the local government areas to implement a framework for intergrated supportive supervision.			-
			3.5.4.2	Develop and provide guidelines and training to local government areas for routine supportive supervision.			-
			3.5.4.3	Develop mechnasim and implementation of the establishment of the state hospital management board(HMB) to enhance greater efficiency and strengthen supportive supervision of health care facilities and HRH.			-
			3.5.4.4	Ensure disciplinary measures are taken when due to promote productivity and efficiency.			-
			3.5.4.5				-
		3.5.5	To develop/ institute a system for mandatory deployment of newly qualified staff/health workers to underserved rural areas.				**3,665,145,399**
			3.5.5.1	The state Ministry of health to work with local government areas and communities involved to ensure that facilities have accommodation and adequate professional supervision for the deployed staff.			3,408,095
			3.5.5.2	Establish and maintain database of fresh graduates of health professionals to be deployed to any area of the state for work especially in the rural areas/deprived areas.			3,660,729,861
			3.5.5.3	Develop a policy on rural/community outreach positing as part of induction for all newly employed staff			1,007,443
	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**		**15,835,636**
		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				**7,405,588**
			3.6.1.1	Joint policy review forum for private public practitioners and meeting taking place quarterly with HRH regulatory bodies			3,013,689

			3.6.1.2	Involvement of workers and professional groups in management teams, design and monitoring of services to enhance cooperation among all actors.			2,458,885
			3.6.1.3	Conduct regular meetings with stakeholders to review health policies/programmes.			690,699
			3.6.1.4	Conduct annual interractive meetings on ethical conduct among professional groups			1,242,315
			3.6.1.5				-
		3.6.2	Foster collaboration between public sector and non-government health providers				**8,430,047**
			3.6.2.1	Develop accrediation giudelines for private health sector participation in post basic training and internship			712,920
			3.6.2.2	Promote training collaboration between public and private health provider to ensure adequate numbers of quality health staff			7,717,127
FINANCING FOR HEALTH							
4. To ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and consumption at Local, State and Federal levels							**3,948,808,704**
	4.1	**To develop and implement health financing strategies at Federal, State and Local levels consistent with the National Health Financing Policy**			**50% of States have a documented Health Financing Strategy by end 2012**		**3,308,096,971**
		4.1.1	To develop and implement evidence-based, costed health financing strategic plans at LGA, State and Federal levels in line with the National Health Financing Policy				**3,308,096,971**
			4.1.1.1	Increase budgetary allocation to the health sector to at least 20% of annual budget			3,200,158,403
			4.1.1.2	Implementation of the National Health Insurance Scheme across the Board.			102,487,161
			4.1.1.3	Enacting ligislation whereby Financial Institutions and companies to contribute not less than 5% of their profits to the Health sector			1,975,404
			4.1.1.4	General Development levy on adults to at least N100.00 per annum to fund the Health sector.			2,278,359
			4.1.1.5	Five percent of all state Government contracts be dedicated to the Health sector.			1,197,644
	4.2	**To ensure that people are protected from financial catastrophe and impoverishment as a result of using health services**			**NHIS protects all Nigerians by end 2015**		**417,042,381**
		4.2.1	To strengthen systems for financial risk health protection				**417,042,381**
			4.2.1.1	Free maternal and child Health services.			263,782,903
			4.2.1.2	Free Health services to TB HIV/AIDS patients and the elderly.			79,388,219
			4.2.1.3	Community Health Saving Scheme to be put in place towards Health needs of the community			72,964,169
			4.2.1.4	Introduction of subsidy on Drugs and other medical services such as laboratory tests X-Rays etc.			460,632
			4.2.1.5	Evolving drugs, laboratory and X-ray services revolving scheme.			446,459
	4.3	**To secure a level of funding needed to achieve desired health development goals and objectives at all levels in a sustainable manner**			**Allocated Federal, State and LGA health funding increased by an average of 5% pa every year until 2015**		**201,756,981**

		4.3.1	To improve financing of the Health Sector				**201,756,981**
			4.3.1.1	Enacting a law by the state Assembly by allocating 20% of the state Budget to the health sector.			1,644,103
			4.3.1.2	Ensuring 100% of the Health sector Budget is released			-
			4.3.1.3	Ensuring that 40% of the total Health sector Budget goes to capital Expenditure (building, heavy machines and equipment)			-
			4.3.1.4	The 60% of the Health sector Budget is allocated as follows: (Hospital Drugs - 30%, Personnel cost - 20%, Research Laboratories - 10%)			200,112,878
			4.3.1.5	Improve coordination of donor funding mechanism to supplement state efforts.			-
	4.4	**To ensure efficiency and equity in the allocation and use of health sector resources at all levels**			**1. Federal, 60% States and LGA levels have transparent budgeting and financial management systems in place by end of 2015 2. 60% of States and LGAs have supportive supervision and monitoring systems developed and operational by Dec 2012**		**21,912,371**
		4.4.1	To improve Health Budget execution, monitoring and reporting				**21,912,371**
			4.4.1.1	Strengthening financial management skills through training of health personnel.			12,047,308
			4.4.1.2	Establishment of health management fund committee to constantly monitor the use of health funds.			8,404,769
			4.4.1.3	Tracking mechanism for the use of health funds for proper and timely use of funds			482,335
			4.4.1.4	Legislation to control the use of health funds.			524,412
			4.4.1.5	Government and Donor Agencies to constitute committees that will monitor and evaluate the use of health funds on regular basis.			453,546
NATIONAL HEALTH INFORMATION SYSTEM							
5. To provide an effective National Health Management Information System (NHMIS) by all the governments of the Federation to be used as a management tool for informed decision-making at all levels and improved health care							**517,029,802**
	5.1	**To improve data collection and transmission**			**1. 50% of LGAs making routine NHMIS returns to State level by end 2010 2. 60% of States making routine NHMIS returns to Federal level by end 2010**		**312,351,809**

		5.1.1	To ensure that NHMIS forms are available at all health service delivery points at State and LGAs levels				**208,022,543**
			5.1.1.1	Printing of NHMIS Forms periodically	70% of Health Facilities has NHMIS Form		-
			5.1.1.2	Provision of Fund in the State Budget for the printing of NHMIS Forms	20% of the state and LGAs budget is allocated for the printing of NHMIS Forms		-
			5.1.1.3	Adequate Logistical support for the constant distribution of the forms	Effective and timely distribution of NHMIS Forms		204,196,411
			5.1.1.4	Quarterly Stock taking of NHMIS Forms at all levels	70% of Health Facilities does not experience out stock		3,115,322
			5.1.1.5	Quarterly Supervision at LGA and Health levels	Adequate supervision conducted		710,810
		5.1.2	To periodically review of NHMIS data collection forms				**30,609,056**
			5.1.2.1	Quarterly State/LGAs Health Data Consultative Committees Meetings	**State Health Data Consultative Committee (SHDCC) is on ground**		30,609,056
			5.1.2.2	Implementation of the recommendations reached during subsequent meetings			-
			5.1.2.3	Implememtation of Health Data Consultative ommittee			-
			5.1.2.4	Encourage Community participation in collection of Health Data			-
			5.1.2.5	Encourage Youth involment in Data reviews			-
		5.1.3	To coordinate data collection from vertical programmes in the State and LGAs		Collection of data from all Stakeholders of health data to centralized data Bank by 2010		**-**
			5.1.3.1	Incoperating vertigal programme data collection forms in to NHMIS Forms			-
			5.1.3.2	Provision of a Centralised Data Bank for Health data			-
			5.1.3.3	Encourage participation of private sectors in data collection			-
			5.1.3.4	Have a centralized data Bank at the LGAs level			-
			5.1.3.5				-
		5.1.4	To build capacity of health workers for data management				**73,720,210**
			5.1.4.1	Conduct workshops at both State, LGAs and Facility levels	Workshops to be conduct at all levels by Year 2010		13,604,025
			5.1.4.2	Conduct on the Job trainings for staff	On job to be conduct to all staff, at all levels by Year 2010		19,100,051
			5.1.4.3	Sensetizations at all levels on importance of Health data in decision making			9,522,817
			5.1.4.4	Creating faculty for Health Information Courses at School of Health Technology			30,677,076
			5.1.4.5	Training of staff at Tertiary levels	10% of Staff should send for the training		816,241
		5.1.5	To provide a legal framework for activities of the NHMIS programme				**-**

			5.1.5.1	Review the existing Laws for NHMIS activities to suit state government policy	Number of Advocacy/Sensitization conducted by 2011		-
			5.1.5.2	Encourage community participation in decision making			-
			5.1.5.3	Sensetizations of Legislatives on the need for NHMIS reforms			-
			5.1.5.4	Advocacy at the state and local govt. Levels			-
			5.1.5.5				-
		5.1.6	To improve coverage of data collection				-
			5.1.6.1	Employment of Man power (Health Information officers)	30 health information officers recruited by 2010		-
			5.1.6.2	Procurement of NHMIS Minimum Packages at all levels	NHMIS minimum packages provided by 2010		-
			5.1.6.3	Provision of International Classification of Diseases			-
			5.1.6.4				-
			5.1.6.5				-
		5.1.7	To ensure supportive supervision of data collection at state and LGA levels				-
			5.1.7.1	Draw monitoring Checklist at all levels	on groound		-
			5.1.7.2	Provision of Logistics for supervision both state and LGAs			-
			5.1.7.3	Collaborate with Private Hospital Registration and Regulation Authority to ensure effective supervision			-
			5.1.7.4	Ensure community support			-
			5.1.7.5	Develop guide line on hierrachial specifications for patients information	Develop hierrachial guide line by 2011		-
	5.2	**To provide infrastructural support and ICT of health databases and staff training**			**ICT infrastructure and staff capable of using HMIS in 30% of State by 2012**		**200,045,823**
		5.2.1	To strengthen the use of information technology in HIS				**176,102,740**
			5.2.1.1	Employment of IT staff			66,660
			5.2.1.2	Procurement of NHMIS Softwares			11,155,300
			5.2.1.3	Provision of internet facilities and Computers			544,161
			5.2.1.4	Provision of IT Equipments eg. Geographical information System (GIS)			164,336,619
			5.2.1.5				-
		5.2.2	To provide HMIS Minimum Package at the different levels (SMOH, LGA) of data management		Provide HMIS minimum packages at State, LGAs, and Health Facilities		**23,943,084**
			5.2.2.1	Provision of office and office equipment			16,324,830
			5.2.2.2	Vehicles and Motocycles			1,360,402
			5.2.2.3	Computers			544,161
			5.2.2.4	NHMIS Softwares			5,441,610
			5.2.2.5	NHMIS Forms			272,080
	5.3	**To strengthen sub-systems in the Health Information System**			**1. NHMIS modules strengthened by end 2010 2. NHMIS annually reviewed and new versions released**		**4,632,170**

		5.3.1	To strengthen the Hospital Information System				**4,632,170**
			5.3.1.1	Employment of Health Information officers - 20 No			3,543,848
			5.3.1.2	Provision of office and office equipment			816,241
			5.3.1.3	Provision of NHMIS minimum packages			-
			5.3.1.4	Conducting on - Job training			272,080
			5.3.1.5	Training of staff at Tertiary levels			-
		5.3.2	To strengthen the Disease Surveillance System		Provision surveillance offices by 2010		**-**
			5.3.2.1	Develop guide line on disease Surveillance			-
			5.3.2.2	Advocacy at the state, local govt. And Community Levels			-
			5.3.2.3	Formation of yourth groups on need to strengthen disease surveillance			-
			5.3.2.4	Develop Disease Surveillance working tools			-
			5.3.2.5	Sensitization of the Community			-
		5.3.3	To Strengthen Primary Health Care Information System at LGAs		Effective primary health care information system established by 2011		**-**
			5.3.3.1	Advocacy to policy makers and community leaders on the importance of data			-
			5.3.3.2	Production of data Forms and manuals			-
			5.3.3.3	To strengthen community based surveillance			-
			5.3.3.4	Provision of office and office equipment at the LGAs and facility levels			-
	5.4	**To monitor and evaluate the NHMIS**			**NHMIS evaluated bi -annually**		**-**
		5.4.1	To establish monitoring protocol for NHMIS programme implementation at all levels in line with stated activities and expected outputs				**-**
			5.4.1.1	Development M & E working tools			-
			5.4.1.2	Establish disease mapping both state and LGAs			-
			5.4.1.3	Community involment			-
			5.4.1.4	Establish monitoring units at state and LGAs			-
			5.4.1.5				-
		5.4.2	To strengthen data transmission		By 2010 adequate linkages are put on ground		**-**
			5.4.2.1	To strengthen individuals, familly and community to respond to NHMIS issues			-
			5.4.2.2	To empower community on skills			-
			5.4.2.3	Ensure feedback mechanism.			-
			5.4.2.4	Conduct regular visits to Health facilities to ensure that data are collected			-
	5.5	**To strengthen analysis of data and dissemination of health information at state and LGAs level**			**1. 20% of LGAs have Units capable of analysing health information by end 2010 2. All LGAs disseminate available results regularly**		**-**
		5.5.1	To institutionalize data analysis and dissemination at all levels				**-**
			5.5.1.1	Production of Health data bullettin			-

			5.5.1.2	Encourage data analysis at LGAs level			-
			5.5.1.3	Harmonize all data from all organizations			-
COMMUNITY PARTICIPATION AND OWNERSHIP							
6. To attain effective community participation in health development and management, as well as community ownership of sustainable health outcomes							**316,625,366**
	6.1	**To strengthen community participation in health development**			**All States have at least annual Fora to engage community leaders and CBOs on health matters by end 2012**		**295,944,084**
		6.1.1	To provide an enabling policy framework for community participation				**249,872,678**
			6.1.1.1	Update the policy frame work inline within national health guidelines.			9,448,559
			6.1.1.2	Formulate policies to define roles and responsibilities of health committees in all tiers of government			218,103,994
			6.1.1.3	Formation of community leaders forum which will interact with the health system.			4,950,225
			6.1.1.4	Formulation of a policy to accommodate the health needs of special groups like adolescents, and physically and mentally challenge persons, HIV OVCs, prisoners, pensioners.			1,960,485
			6.1.1.5	Establish health committees in all tiers of government.			15,409,415
		6.1.2	To provide an enabling implementation framework and environment for community participation				**35,141,700**
			6.1.2.1	Update guidelines for establishing community structures			4,607,141
			6.1.2.2	Conduct KAP studies to address the ethnic multiplicity of the state and the effect of cultural practices on the health of the citizens			13,282,288
			6.1.2.3	Institutionalise community representation in the mangement boards of health facilities			4,901,213
			6.1.2.4	Periodic planning meetings between the community representatives and the management of health care facilities.			5,391,335
			6.1.2.5	Set up skill acquisition centres on a basic health care and hygiene skills			6,959,723
		6.1.3	Enhance traditional ruler participation in health care delivery				**10,929,706**
			6.1.3.1	Form 7 member health committees in all traditional/ emirate/ chieftancy councils (with 2-year tenure)			3,430,849
			6.1.3.2	Replicate Traditional health committees within the context of the traditional political system.			3,528,874
			6.1.3.3	Conduct quarterly meetings of traditional health committee			-
			6.1.3.4	Appoint two health officers in each chieftancy/emirate council			3,969,983
			6.1.3.5				-
		6.1.4	Mobilising target groups of health programmes as owners of health programmes				**-**
			6.1.4.1	Identify programme target groups within a community and direct programs to the groups			-

			6.1.4.2	Form stakeholder committees and assign roles within the context of the programme			-
			6.1.4.3	Establish interractive fora between target groups, programme partners and other health related stakeholders			-
			6.1.4.4	Assign responsibility roles to members of the target group based in the community			-
			6.1.4.5	Establish youth friendly health centres (within existing PHC facilities)			-
		6.1.5	Partnership with line ministries in building community capacity				-
			6.1.5.1	Partner with education ministry in curriculum design towards the adoption of health related careers by youths in the community			-
			6.1.5.2	Develop and reactivate social programmes that positively impact on the health of the community			-
			6.1.5.3	Organise equipment development/ maintenance apprenticeship programs in all communities			-
			6.1.5.4	Form advocacy groups that partner with line ministries in health improvement programs			-
			6.1.5.5	Strengthen existing health equipment maintenance/development centre in all Senatorial districts			-
	6.2	**To empower communities with skills for positive health actions**			**All States offer training to FBOs/CBOs and community leaders on engagement with the health system by end 2012**		**-**
		6.2.1					-
			6.2.1.1	Establish training/ education committees geared towards selecting candidates in health related programmes.			-
			6.2.1.2	Train the needed health human resource from community derived resources (human and material)			-
			6.2.1.3	Encourage communities to participate in research teams as members of ethical and/or research monitoring committees.			-
			6.2.1.4	Conduct continuing education programmes in health related matters to members of the community			-
			6.2.1.5	Develop feedback mechanisms like sugesstion boxes, radio programmes that audit health systems			-
		6.2.2	Building community capacity for health care delivery and control of endemic diseases				-
			6.2.2.1	Training immunisation assistants			-
			6.2.2.2	Developing curricular for training volunteer health workers in the community			-
			6.2.2.3	Set up skill acquisition centres on a basic health care and hygiene skills			-
			6.2.2.4	Disseminate health awareness programs by print and electronic media			-

			6.2.2.5	Health education as a component of school curriculum			-
		6.2.3	Integrating traditional medicine as a component of primary health care				-
			6.2.3.1	Establish a state and local traditional medicine board			-
			6.2.3.2	Register all traditional medicine facilities in the wards and local government areas			-
			6.2.3.3	Form a referral network between the traditional medicine facilities and hospitals			-
			6.2.3.4	Conduct quarterly audit of referrals hospitals and traditional health facilities			-
	6.3	**To strengthen the community - health services linkages**			**50% of public health facilities in all States have active Committees that include community representatives by end 2011**		-
		6.3.1	To restructure and strengthen the interface between the community and the health services delivery points				-
			6.3.1.1	Encourage communities to select members of health facility management committees			-
			6.3.1.2	Form primary health care committees in each community			-
			6.3.1.3	Organise periodic interractions between the community representatives and health providers			-
			6.3.1.4	Appoint health committees in all educational institutions			-
			6.3.1.5	Appoint health committees in the road transport industry			-
		6.3.2	Development of health information dissemination media				-
			6.3.2.1	Appointment of town criers in rural communities			-
			6.3.2.2	Training and appointment of peer educators/ demonstrators in the communities			-
			6.3.2.3	Adoption of electronic media in dissemination of information			-
			6.3.2.4	The use of advertorials and announcements in print media			-
			6.3.2.5	The use of bill boards, flyers, and posters			-
		6.3.3	Support communites to form disease specific focal groups				-
			6.3.3.1	Educate members on endemic disease patterns			-
			6.3.3.2	Sensitise communities on community based disease control strategies			-
			6.3.3.3	Establish a localsourcing point/ contact persons for obtaning community based intervention			-
		6.3.5	Improve child health by community participation				-
			6.3.5.1	Reactivate school health programme			-
			6.3.5.2	Communities to develop school sanitation facilities- safe water supply, hygiene, toilet provosion sanitation. Community leaders to oversee WASH activities			-
			6.3.5.3	Encourage the formation of advocacy groups towards protection of children from injury			-
			6.3.5.4	Form community child health support groups			-
			6.3.5.5				-

	6.4	**To increase national capacity for integrated multisectoral health promotion**			**50% of States have active intersectoral committees with other Ministries and private sector by end 2011**		**-**
		6.4.1	To develop and implement multisectoral policies and actions that facilitate community involvement in health development				**-**
			6.4.1.1	Partner with ministries of the education, women affairs, agriculture, information, local government, higher education and youth development in developing programs that will enable the youth and other members of the community adopting sustainable preventive health promotive behaviour			-
			6.4.1.2	Form policy that will encourage the formation health related organisations			-
			6.4.1.3	Establish community based advocacy groups with faith based organisations and the other CSOs in health promomtion programs			-
			6.4.1.4	Form a men's advocacy group to promote health activities and related matters in all tiers of government			-
			6.4.1.5	Mobilise youth to form food security action group to combat endemic malnutrition			-
	6.5	**To strengthen evidence-based community participation and ownership efforts in health activities through researches**			**Health research policy adapted to include evidence-based community involvement guidelines by end 2010**		**20,681,282**
		6.5.1	To develop and implement systematic measurement of community involvement				**20,681,282**
			6.5.1.1	Periodic estimation of community derived health projects			7,748,818
			6.5.1.2	Appoint a health information manager from the community in all tiers of government			12,932,464
			6.5.1.3	Establish a health information management sytem in the traditional system which reports to the paramount leader for onward submssion to the local government and state health administrations			-
			6.5.1.4	Appoint disease surveillance committees in all tiers of government and in the traditional rulers' council			-
			6.5.1.5	Form health information and data harmonising committees in all tiers of government to avoid duplication or ommission of data			-
PARTNERSHIPS FOR HEALTH							
7. To enhance harmonized implementation of essential health services in line with national health policy goals							**337,447,042**
	7.1	**To ensure that collaborative mechanisms are put in place for involving all partners in the development and sustenance of the health sector**			**1. FMOH has an active ICC with Donor Partners that meets at least quarterly by end 2010**		**323,694,114**

					2. FMOH has an active PPP forum that meets quarterly by end 2010 3. All States have similar active committees by end 2011		
		7.1.1	To promote Public Private Partnerships (PPP)				**45,284,883**
			7.1.1.1	Identify all public and private partners within the State.			1,604,857
			7.1.1.2	Establish monitoring unit of partners backed by operational guidelines for resource harmonization, quality assurance and relavance to State specific need.			3,070,162
			7.1.1.3	Establish inter-sectoral collaboration to support multi-sectoral intervention for optimum health result.			3,181,804
			7.1.1.4	Undertake holistic trainning of staff as part of capacity building to facilitate ownership and sustainability and also conduct research on new innovation for decomentation.			23,786,775
			7.1.1.5	Conduct of quarterly review meeting of stakeholders to reflect on activities and maintain vision.			13,641,286
		7.1.2	To institutionalize a framework for coordination of Development Partners				**36,911,715**
			7.1.2.1	Institute stakeholders dialoque and feedback forum for enlisting input into public and private partners decision making			-
			7.1.2.2	Create an enabling environment for both public and private health partners including NGOs in the execution of their activity.			-
			7.1.2.3	Empower the beneficiary communities to manage and oversee their health project and programmes instituted by varied partners and NGOs.			-
			7.1.2.4	Develop capacities of persons for support and supervision at all levels.			27,561,678
			7.1.2.5	Hold regular meeting with partners.			9,350,038
		7.1.3	To facilitate inter-sectoral collaboration				**7,361,410**
			7.1.3.1	Build capacity of SMOH to be able to undertake lead role in the allocation of task and funding by partners.			2,093,292
			7.1.3.2	Conduct of periodic dialoque among partners on information sharing including complimentary activities for uniformity in programme implementation.			5,268,118
			7.1.3.3	Promote multi-sectoral approach to ensure necessary impact for the achievement of the health roles.			-
			7.1.3.4	Establishment of inter-sectoral forum at all level.			-
			7.1.3.5				-
		7.1.4	To engage professional groups				**-**
			7.1.4.1	Provide orientation to public and private partners especially non professionals (in other fields) to share vision.			-

			7.1.4.2	Promote referal on needs to appropriate partners for resource mobilization or programme funding.			-
			7.1.4.3	Develop and undertake trainning on skills update for competence against challenges.			-
			7.1.4.4	Regulation on practice amongs professionals to guide ethic and practices for friendly programmes.			-
			7.1.4.5	Develop a master plan on human resources as major ingrediants towards sustainability.			-
		7.1.5	To engage with communities				**223,424,032**
			7.1.5.1	Identify every community partners to facilitate good entry partnership development and sustainability			-
			7.1.5.2	Advocacy visit to the community concern.			-
			7.1.5.3	Carry out a need assessment to establish community felt needs based on priority.			-
			7.1.5.4	Conduct orientation to community development committees on their roles and responsibilities			2,163,068
			7.1.5.5	Trainning of indigenes of the community on current programmes to encourage sustainability.			221,260,963
		7.1.6	To engage with traditional health practitioners				**10,712,073**
			7.1.6.1	Advocacy visit to the key officers of the traditional health practisioners, to disseminate information on the strategic health pan.			7,087,887
			7.1.6.2	Sensitization meeting to bring traditionals on board for partnership and to facilitate health service delivery.			3,624,186
			7.1.6.3	Establish research unit/institusion to jointly work with herbalist on efficacy and safty of herbs extensively used for various treatment.			-
			7.1.6.4	Provide regulatory body on ethics and practices for quality and public safty.			-
			7.1.6.5	Establish orientation amongst the traditional health pratisioners on varied herbs through regular seminars/workshop annually to meet the milennium challenges.			-
	7.2	**To enhance harmonize implementation of essential health service in line with National health policy goal.**					**13,752,928**
		7.2.1	Coordination of Development Partners				**13,752,928**
			7.2.1.1	Establishment of development partners forum comprising only health development partners at State level as entry points for engaging with partners.			-
			7.2.1.2	Establish sectoral multi-donor budget support at the State and LGA level.			-
			7.2.1.3	Provide adequate feedback to the development Partners on the activities carried out			6,684,579
			7.2.1.4	Create health partners development committee to enhance coordination			1,604,857
			7.2.1.5	Quarterly meeting with partners concern.			5,463,492
		7.2.2	Partnership for drug development and manufacture				**-**
			7.2.2.1	Partner with National Institute for Pharmaceutical Research and Development (NIPRID) for pre-clinical and clinical trials on traditional medicines with therapeutic potentia and vaccine developmentl			-

			7.2.2.2	Encourage drug manufacture/ mass supply by providing incentives			-
			7.2.2.3				-
			7.2.2.4				-
			7.2.2.5				-
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							**651,160,538**
	8.1	**To strengthen the stewardship role of governments at all levels for research and knowledge management systems**			**1. ENHR Committee established by end 2009 to guide health research priorities 2. FMOH publishes an Essential Health Research agenda annually from 2010**		**-**
		8.1.1	To finalise the Health Research Policy at state level and develop health research policies at State and LGA levels				**-**
			8.1.1.1	Establishment of health research Steering Committee at state and some LGAs	fully functional HRSC by the end of 2010		-
			8.1.1.2	Adapt health research policies and strategies in the state	HRSC reach 50% implementation of guidelines by the end of 2011		-
			8.1.1.3	Conduct needs Assessment on research in the state	50% of the reseach need identifed at the inception		-
			8.1.1.4	Enact policy on research in the state that wiill be need-driven	policy enacted by the end of 2010		-
			8.1.1.5	Monitor activities of HRSC in the state and some LGAs	Report of activities of HSRC by end of 2012		-
		8.1.2	To establish and or strengthen mechanisms for health research at all levels				**-**
			8.1.2.1	Establish research unit in the MOH	reseach unit should be present at the beginning of 2010		-
			8.1.2.2	Set-up mentoring group in the state	mentoring goup established by second quarter of 2010		-
			8.1.2.3	Identify research personnel in the state	atleast one research personnel per center identified by the end of 2010		-
			8.1.2.4	Provide technical; assistance to strengthen the capacity of research units in the State	Atleast 50% of research personnel are engaged in reseach by the end of 2010		-
			8.1.2.5	Collaboration with research centers outside the state to enhance the capacity of researchers in the state	contact with atleast one research center ouside the state by the end of 2011		-
		8.1.3	To institutionalize processes for setting health research agenda and priorities				**-**
			8.1.3.1	Implement the essential state health research (ESHR) programme	ESHR undertaken annually in the state,starting in 2011		-

			8.1.3.2	Promote the expansion of the health research to agriculture such as the impact of agricultural product on health	Atleast one research is conducted by the end of 2012		-
			8.1.3.3	Promote the expansion of the health research to Ministry of water resourses such as the impact of water supply on health	Atleast one research is conducted by the end of 2013		-
			8.1.3.4	Promote the expansion of the health research to Ministry of works such as the impact of road network on maternal and child mortality	Atleast one research is conducted by the end of 2014		-
			8.1.3.5	Strengthen epidermiological unit of MOH,so that major impact diseases can be identifed and prioritized	atleast 2 major diseases identifed and researched annually beginning in 2011		-
		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				-
			8.1.4.1	Adapt and disseminate guidelines for a collaborative research agenda	atleast 50% of research units in the state have guidlines by the end of 2010		-
			8.1.4.2	Establish a forum of health research officers in the state	forum had atleast 2 meeting by the end of 2011		-
			8.1.4.3	Conduct a multi-stakeholder forum to identify research priorities and for harmonisation of research efforts	annual multi-stakeholder meeting conducted commencing in 2011		-
			8.1.4.4	Support development of collaborativeb research proposals and their implementation	atleast one collaborative research proporsal developed by the end of 2012		-
			8.1.4.5	promote community driven research in the the state	atleast one community driven research conducted by the end of 2012		-
		8.1.5	To mobilise adequate financial resources to support health research at all levels				-
			8.1.5.1	Create budget line for research in the state	reseach budget is included in 2010 budget		-
			8.1.5.2	promote the designation of 2% of health budget at state level	availability of fund in the state for research in the SMOH by 2nd Qrt.2010		-
			8.1.5.3	SMOH to deploy mobilised funds for health research in a targeted manner	availability of fund in the state for research in the SMOH by 2nd Qrt.2011		-
			8.1.5.4	Mobilise extra funds from the private sector and foundations (social or coporate responsibility)	Atleast one private sector or foundation have earmarked funds for research by 2011		-
			8.1.5.5	establish mechanism to monitor,evaluate and regulate research and the use of research findings in the state	Directories of major researches and researchers established by 2011 and annual evaluation		-

					conducted beginning in 2012		
		8.1.6	To establish ethical standards and practise codes for health research at all levels				-
			8.1.6.1	strengthen existing ethical committee in the state	functional ethical committee exist in the state through conducting of quarter		-
			8.1.6.2	Adopt guidelines on ethical review standard for research in the state	implementation of guidelines commenced by 2011		-
			8.1.6.3	Create a unit for ethical standard and practice codes in the department of DPRS	Unit established by the end of 2010		-
			8.1.6.4	Establish a local ethical commiitee at each research institutions in the state	Quartely meeting of the committtee commence in 2012		-
			8.1.6.5	establish mechanism to monitor,evaluate and regulate activities of research ethical committee in the state	Report of M&E by the end of 2011		-
	8.2	**To build institutional capacities to promote, undertake and utilise research for evidence-based policy making in health at all levels**			**FMOH has an active forum with all medical schools and research agencies by end 2010**		**-**
		8.2.1	To strengthen identified health research institutions at all levels				-
			8.2.1.1	Take inventory of all public and private researches taking place or carried out in the state	Directories of researches conducted in the state available by the end of 2010		-
			8.2.1.2	conduct periodic capacity assessment of health research organisations	Annual research capacity assessment of the research institution is being conducted beginning in 2011		-
			8.2.1.3	develop and implement measures to address research capacity gaps/weakness in the state	10% increase in number of researches undertaken in the state		-
			8.2.1.4	Mobilise extra funds from the private sector and foundations (as social or coporate responsibility)	Atleast 50% of all private sector and foundation reached and atleast 5% earmarked funds for reseach at end of 2015		-
			8.2.1.5	Link-up research institutions in the state to higher research centers	By the end of 2012 atleast one higher research center is collaborating with research centers in the state		-
		8.2.2	To create a critical mass of health researchers at all levels				-
			8.2.2.1	develop appropriate training intervention for research based on the identifed need in the state	training interventions developed by end 2011		-
			8.2.2.2	establish a fund for provision of competitive research grants for prospective researchers	grants available in the state for competative research in the state by 2012		-

			8.2.2.3	Motivate tertiary education institutions to increase PhD student scholarships	3-5 competitive phD scholarships awarded annually		-
			8.2.2.4	To link-up research with 2 science based jounals	atleast 25% annual increase of research output ,starting in 2012		-
			8.2.2.5	Sponsoring publications of research findings in reputables national journals	atleast 25% of research output in the state are published by 2012		-
		8.2.3	To develop transparent approaches for using research findings to aid evidence-based policy making at all levels				-
			8.2.3.1	establish mechanism for improving liaison and links between research users through conducting research policy makers forum	one research policy makers forum held annually		-
			8.2.3.2	involve wide range of actors including reserachers in policy -making	Number of reseachers involved in policy making at 2011		-
			8.2.3.3	researchers to make policy briefs to relevants policy makers	Number of policy briefs written		-
			8.2.3.4	Create awareness to community members on research	atleast 2 community awareness conducted by 2013		-
			8.2.3.5	M & E of the above activities	reports of M& E by 2012		-
		8.2.4	To undertake research on identified critical priority areas				-
			8.2.4.1	Establish a process for biannual estimation of burden of identifed priority diseases	Biennial burden of diseases computed in the state		-
			8.2.4.2	undertake bi-annual studies into Human resources for health	Biennial HSR research conducted in the state		-
			8.2.4.3	undertake bi-annual studies into Health sys (HSG)	Biennial HSG studies conducted in the state		-
			8.2.4.4	conduct bi-annual studies into health delivery systems	Biennial Health sytem delivery studies in the state		-
			8.2.4.5	conduct studies on financial risk protection ,equity ,efficiency and value of different health financing mechanism bi-annually	Biennial Health financing studies in the state		-
	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**		**300,596,356**
		8.3.1	To develop strategies for getting research findings into strategies and practices				-
			8.3.1.1	harness research findings of practical application	list of usable research available by 2013		-
			8.3.1.2	identify areas where research findings can be applied in the state	Report of identifed areas of application of research by the end of 2013		-
			8.3.1.3	forward research findings to relevant authorities	User MDA have received findings of research by 2014		-

			8.3.1.4	ensure the use of research findings by MDAs	By the beginning of 2015,research findings are reflected in strategic policies		-
			8.3.1.5	M &E for the strategies for identification of research findings	By end of 2015 research based policies are implemented		-
		8.3.2	To enshrine mechanisms to ensure that funded researches produce new knowledge required to improve the health system				**300,596,356**
			8.3.2.1	establish a health research policy forum in the state	annual health research forum held in the state beginning from 2011		-
			8.3.2.2	Conduct need Assessment to inform required health research in the state	Need asssement conducted by 2011		-
			8.3.2.3	Operationals research to be conducted by MDAs in the state	operational reserch undertaken by 50% of MDAs in the state		-
			8.3.2.4	promote operational research by disease control programmes and other relevant health sector in the state	operational reserch undertaken by 50% of programmes in the state		6,367,874
			8.3.2.5	M &E of policy implementation	report of monitoring and evaluation by end of 2013		294,228,482
	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**		**350,564,183**
		8.4.1	To create a framework for sharing research knowledge and its applications				**-**
			8.4.1.1	Adapt and implement national framework for sharing research knowledge and its appplications	frame-work for sharing research knowledge developed by 2011 and atleast 50% of activities in the framework are implemented by end of 2012		-
			8.4.1.2	create website at research and statistics unit of MOH for shaing information and research findings	website developed by end of 2011		-
			8.4.1.3	create State network	functional network exist by 2012		-
			8.4.1.4	presentation of research findings to communities concerned through workshops	report of workshops available by the end of 2011		-
			8.4.1.5	establish mechanism to monitor,evaluate activities of sharing research knowledge and its applications in the state	M&E report available by 2012		-
		8.4.2	To establish channels for sharing of research findings between researchers, policy makers and development practitioners				**16,899,357**
			8.4.2.1	conduct an annual health conference of reserchers in the state where researches present theirs researchs to policy makers and partners in the state	annual report of conference beginning from 2011		-

			8.4.2.2	conduct annual seminars and workshops on key thematic areas (financing ,HRD,MDG,health research	reports of seminars and workshops annually starting in 2012		-
			8.4.2.3	Adopt guidelines for sharing of research findings between researchers, policy makers and development practitioners	implementation of activities in the guidelines commenced by 2011		-
			8.4.2.4	Develop capacity of researchers to produce policy briefs	Atleast 50% of researchers in the state have produced policy brief and presented to policy makers by 2013		-
			8.4.2.5	Provide access to relevant journals to the research institutions in the state	all research institutions in the state have access to atleast 2 jounals by 2012		16,899,357
		8.4.3	Assessment of potential medicines and cures				**186,023,551**
			8.4.3.1	Determine the safety of potential cures			-
			8.4.3.2	Analyse the pharmaco-potentials of medicines			-
			8.4.3.3	Determine the risk benefit ratio of cures			-
			8.4.3.4	Conduct pre-clinical trials			-
			8.4.3.5	Arrange clinical trials traditional drug claims			186,023,551
		8.4.4	Conduct periodic surveys to assess effectiveness of IMNCH services				**147,641,274**
			8.4.4.1	Determine the incidence of pregnancy related complications			7,883,536
			8.4.4.2	Determine the outcome of management of complicated pregnancies and deliveries			24,507,061
			8.4.4.3	Conduct clinical audit quality control assessment of neonatal care			25,146,461
			8.4.4.4	Research to assess vaccination efficiency			58,963,680
			8.4.4.5	Determine contraceptive prevalence			31,140,535
	Total						39,599,887,121.28

Annex 2: Results/M&E Framework for Gombe Strategic Health Development Plan

GOMBE STATE STRATEGIC HEALTH DEVELOPMENT PLAN 2010 RESULT MATRIX						
OVERARCHING GOAL: To significantly improve the health status of Nigerians through the development of a strengthened and sustainable health care delivery system						
OUTPUTS	**INDICATORS**	**SOURCES OF DATA**	**Baseline**	**Milestone**	**Milestone**	**Target**
			2008/9	**2011**	**2013**	**2015**
PRIORITY AREA 1: LEADERSHIP AND GOVERNANCE FOR HEALTH						
NSHDP Goal: To create and sustain an enabling environment for the delivery of quality health care and development in Nigeria						
OUTCOME: 1. Improved strategic health plans implemented at Federal and State levels						
OUTCOME 2. Transparent and accountable health systems management						
1. Improved Policy Direction for Health Development	1. % of LGAs with Operational Plans consistent with the state strategic health development plan (SSHDP) and priorities	LGA s Operational Plans	0	60%	80%	100%
	2. % stakeholders constituencies playing their assigned roles in the SSHDP (disaggregated by stakeholder constituencies)	SSHDP Annual Review Report	0	30%	55%	80%
2. Improved Legislative and Regulatory Frameworks for Health Development	3. State adopting the National Health Bill? (Yes/No)	SMOH	0	30%	55%	80%
	4. Number of Laws and by-laws regulating traditional medical practice at State and LGA levels	Laws and bye-Laws	0	20%	40%	60%
	5. % of LGAs enforcing traditional medical practice by-laws	LGA Annual Report	0	15%	30%	60%
3. Strengthened accountability, transparency and responsiveness of the State health system	6. % LGAs aligning their health programmes to the SSHDP	LGA Annual Report	0	25%	45%	65%
4. Enhanced performance of the State health system	7. % LGA public health facilities using the essential drug list	Facility Survey Report	TBD	30%	45%	75%
	8. % private health facilities using the essential drug list by LGA	Private facility survey	TBD	5%	15%	25%
	9. % LGA health facilities not experiencing essential drug/commodity stockouts in the last three months	Facility Survey Report	TBD	25%	50%	70%
STRATEGIC AREA 2: HEALTH SERVICES DELIVERY						
NSHDP GOAL: To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare						
Outcome 3: Universal availability and access to an essential package of primary health care services focusing in particular on vulnerable socio-economic groups and geographic areas						
Outcome 4: Improved quality of primary health care services						
Outcome 5: Increased use of primary health care services						
5. Improved access to essential package of Health care	10. % of LGAs with a functioning public health facility providing minimum health care package according to quality of care standards.	NPHCDA Survey Report	TBD	25%	50%	75%
	11. % health facilities implementing the complete package of essential health care	NPHCDA Survey Report	TBD	20%	40%	60%

	12. % service delivery points without stock out of family planning commodities in the last three months	Health facility Survey	TBD	10%	20%	35%
	13. % of facilities providing Youth Friendly RH services	Health facility Survey	TBD	15%	25%	35%
	14. Proportion of births attended by skilled health personnel	HMIS	18%	40%	60%	80%
	15. Caesarean section rate	EmOC Sentinel Survey and Health Facility Survey	TBD	60%	40%	20%
	16. % of children exclusively breastfed 0-6 months	NDHS/MICS	TBD	20%	30%	40%
	17. Proportion of 12-23 months-old children fully immunized	NDHS/MICS	16%	25%	35%	45%
	18. % children <5 years stunted (height for age <2 SD)	NDHSMICS	52%	65%	75%	85%
	19. % of under-five that slept under LLINs the previous night	NDHS/MICS	12%	35%	45%	55%
	20. % of under-five children receiving appropriate malaria treatment within 24 hours	NDHS/MICS	4%	20%	40%	60%
	21. % malaria successfully treated using the approved protocol and ACT;	MICS	TBD	10%	20%	40%
	22. % of women who received intermittent preventive treatment for malaria during pregnancy	NDHS/MICS	4%	15%	25%	40%
	23. HIV prevalence in pregnant women	NARHS	TBD	15%	25%	40%
	24.Condom use at last high risk sex	NDHS/MICS	TBD	15%	25%	40%
	25. Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS	NDHS/MICS	TBD	15%	25%	40%
	26. Proportion of tuberculosis cases detected and cured under directly observed treatment short course	NMIS	TBD	4%	2%	!%
Output 6. Improved quality of Health care services	27. % of staff with skills to deliver quality health care appropriate for their categories	Facility Survey Report	TBD	20%	40%	60%
	28. % of health workers who received in-service training in the past 12 months by category of worker	HR survey Report	TBD	10%	20%	30%
	29. % of health facilities with all essential drugs available at all times	Facility Survey Report	TBD	25%	50%	70%
Output 7. Increased demand for health services	30. Proportion of the population utilizing essential services package	MICS	TBD	20%	30%	45%
	31. % of the population adequately informed of the 5 most beneficial health practices	MICS	TBD	5%	15%	30%
PRIORITY AREA 3: HUMAN RESOURCES FOR HEALTH						

NSHDP GOAL: To plan and implement strategies to address the human resources for health needs in order to ensure its availability as well as ensure equity and quality of health care						
Outcome 6. The Federal government implements comprehensive HRH policies and plans for health development						
Outcome 7.All States and LGAs are actively using adaptations of the National HRH policy and plan for health development by end of 2015						
Output 8. Improved policies and Plans and strategies for HRH	32. % of wards that have appropriate HRH complement as per service delivery norm (urban/rural).	Facility Survey Report	TBD	10%	20%	40%
Output 9: Improved framework for objective analysis, implementation and monitoring of HRH performance	33. % LGAs making availabile consistent flow of HRH information	NHMIS	TBD	5%	10%	20%
	34. CHEW/10,000 population density	MICS	TBD	1:4000 pop	1:3000 pop	1:2000 pop
	35. Nurse density/10,000 population	MICS	TBD	1:8000 pop	1:6000 pop	1:4000 pop
	36. Qualified registered midwives density per 10,000 population and per geographic area	NHIS/Facility survey report/EmOC Needs Assessment	TBD	1:8000 pop	1:6000 pop	1:4000 pop
	37. Medical doctor density per 10,000 population	MICS	TBD	1:8000 pop	1:7000 pop	1:5000 pop
PRIORITY AREA 4: FINANCING FOR HEALTH						
Outcome 8. Health financing strategies implemented at Federal, State and Local levels consistent with the National Health Financing Policy						
Outcome 9. The Nigerian people, particularly the most vulnerable socio-economic population groups, are protected from financial catastrophe and impoverishment as a result of using health services						
Output 12: Improved protection from financial catastrophy and impoversihment as a result of using health services in the State	38. % of LGAs implementing state specific safety nets	SSHDP review report	TBD	10%	20%	45%
Output 13: Improved efficiency and equity in the allocation and use of Health resources at State and LGA levels	39. LGAs health budgets fully alligned to support state health goals and policies	State and LGA Budgets	TBD	20%	35%	55%
	40.Out-of pocket expenditure as a % of total health expenditure	National Health Accounts 2003 - 2005	50%	40%	30%	20%
	41. % of LGA budget allocated to the health sector.	National Health Accounts 2003 - 2005	2%	10%	20%	30%
PRIORITY AREA 5: NATIONAL HEALTH INFORMATION SYSTEM						
Outcome 10. National health management information system and sub-systems provides public and private sector data to inform health plan development and implementation						
Outcome 11. National health management information system and sub-systems provide public and private sector data to inform health plan development and implementation at Federal, State and LGA levels						
Output 14: Improved Health Data Collection, Analysis, Dissemination, Monitoring and Evaluation	42. % of LGAs making routine NHMIS returns to states	NHMIS Report January to June 2008; March 2009	100	100%	100%	100%

	43. % of LGAs receiving feedback on NHMIS from SMOH		100	100%	100%	100%
	44. % of health facility staff trained to use the NHMIS infrastructure	Training Reports	100	100%	100%	100%
	45. % of health facilities benefitting from HMIS supervisory visits from SMOH	NHMIS Report	TBD	40%	50%	60%
	46. % of LGAs publishing annual HMIS reports	HMIS Reports	TBD	5%	10%	30%
PRIORITY AREA 6: COMMUNITY PARTICIPATION AND OWNERSHIP						
Outcome 12. Strengthened community participation in health development						
Outcome 13. Increased capacity for integrated multi-sectoral health promotion						
Output 15: Strengthened Community Participation in Health Development	47. Proportion of public health facilities having active committees that include community representatives (with meeting reports and actions recommended)	SSHDP review report	TBD	15%	20%	40%
PRIORITY AREA 7: PARTNERSHIPS FOR HEALTH						
Outcome 14. Functional multi partner and multi-sectoral participatory mechanisms at Federal and State levels contribute to achievement of the goals and objectives of the SHDP						
Output 16: Improved Health Sector Partners' Collaboration and Coordination	48. Increased number of new PPP initiatives per year per LGA	SSHDP Report	TBD	5%	15%	25%
	49. % LGAs holding annual multi-sectoral development partner meetings	SSHDP Report	TBD	5%	15%	25%
PRIORITY AREA 8: RESEARCH FOR HEALTH						
Outcome 15. Research and evaluation create knowledge base to inform health policy and programming.						
Output 17: Strengthened stewardship role of government for research and knowledge management systems	50. % of LGAs partnering with researchers	Research Reports	TBD	5%	10%	15%
	51. % of State health budget spent on health research and evaluation	State budget	TBD	1%	1.50%	2%

Annex 3: Names of State Planning Committee Members that participated in the development of the SHDP

Names	**Designation**
Dr Daniel Mohammed, mni	Perm Sec
Yerima Danzaria Kumo	DPRS
Dr Nuhu Kumangh	Dir PHC
Alh Isiaku Garba	DNS
Dr J.M. Dilla	DHS
Alh Mohammed Kwami	DDC
Pharm Waziri Mohammed	DPS
Dr Suraj Abdulkarim	TBL coordinator
Mrs Ladi Aluke	Avian Influenza
Dr Umar Adamu Usman	PM. GOMSACA
Dr Ibrahim Bebeji	UNICEF
Dr Bashir Abba	WHO coordinator
Mrs Talatu Danzaria	Onchocerciasis Coordinator
Abdu Usman	NHIS Desk Officer
Bala Sarki	Principal Admin Officer
Bulus Kudi	Dep. Director Information Officer
Demas Laubayum	NANNM Chairman
Paulina Doka	Deputy Director Nursing
Maryam Abubakar	Reproductive Health Coordinator
Pharm Manalaku Repeh	Deputy Director Pharmaceuticals
David S Lawal	M&E Officer
Hassan Mohammed	Registrar School of Nursing and Midwife
Alhaji Bappah Ali	Director Min for Local LG
Mrs Rejoice Bala	Reproductive Health Officer
Ms Sarah Nalban	Rotary Club
Mr.Yasa Haskainu	Desk officer, Health Account
Mr. A.B. Shinga	Chief Statistic Officer, SMOH
Dr Godfrey, O	NMA Chairman Gombe State
Alh. M. B. Nafada	DAF SMOH
Alhaji Yahya Mohammed	Community Coordinator Gombe UNICEF Office
Mal. Ahmed Yusuf	Chief Typist, SMOH
Dr Abubakar Saidu	CMAC FMC Gombe

Mr. Victor Iliya	NANNM
Hajiya Asabe Umar	Deputy Director Planning
Alhaji Auwal Ibrahim	Deputy Director Research & Statistics
Mr. Epics Yila Idi	HMIS Officer
Alhji Damina Abubakar	DDPHC
All Local Government PHC Coordinators and All Local Government M&E Officers	
Alh. Audi Waziri	PM HSDP II
Dr. Abubakar G. Dukku	Training Officer HSDP II
Dr Arnold Abel	PM Malaria Booster Project
Mr. Ibrahim Hassan	SACA Coordinator, SMOH
Alh. Bala Shehu	Traditional Medicine Unit
Pharm Bappah Usman	Asst. Dir. Pharmaceuticals
Mal. Abubakar Hinna	Records Assist./ Planning Unit
Dr Aisha I Mamman	State Consultant NSHDP