EKITI STATE GOVERNMENT

STRATEGIC HEALTH DEVELOPMENT PLAN
(2010-2015)

Ekiti State Ministry of Health

March 2010

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Foreword

This Administration met an unwholesome health trend on ground. Disease burden was high; some non-communicable disease conditions such as schistosomiasis were neglected while funding on health was grossly inadequate and haphazard. All these grave concerns and the determination to achieve the Millennium Development Goals gave rise to Governor Segun Oni's initial "Monthly Health Intervention Programme".

A massive survey and mapping of the endemicity of schistosomiasis in Ekiti State was carried out in 2008. The report indicated that 50% of the population harboured the causative agent of schistosomiasis. Some of the Primary Health Care centers opt for the idea of deliberately concealing the mortality data to avoid a negative image of their practice. The Private Health institutions and Federal Medical Centre also have been reluctant to submit data to the Monitoring & Evaluation units of PHC in the Local Government Areas.

Consequent to the new wave of reforms sweeping through the state and nation, the State Ministry of Health inaugurated both the State Steering Committee and the Technical Working Group to develop the State Strategic Health Development Plan (SSHDP). This State Plan utilized the template of the National Strategic Health Development Plan framework that identifies eight priority areas for improving the National Health Systems with specific goals and objectives. These are Leadership and Governance for Health, Health Service Delivery, Human Resources for Health, Health Financing, Health Information Systems, Community Ownership and Participation, Partnerships for Health Development, and Research for Health.

I implore all stakeholders (SMOH, HMB, SPHDB, LGAs, PHCs, CSOs, Committees e.t.c.,.) to implement this SSHDP to improve the performance of the health sector towards the delivery of quality, efficient and sustainable health care for all the people of Ekiti State.

Dr. Femi Thomas

Hon. Commissioner for Health
20th October, 2009

List of acronyms and abbreviations

BCC	Behaviour Change Communication
CORPs	Community oriented resource persons
CSOs	Community Service Organizations
DFID	Department for International Development
GRISP	Getting Research into Strategies and Practice
FMOH	Federal Ministry of Health
SMOH	State Ministry of Health
HDCC	Health Data Consultative Committee
SWOT	Strength, Weakness, Opportunities and Threats
HIV	Human Immuno Deficiency Virus
HRH	Human Resources for Health
IEC/BCC	Information, Education and Communication
IMCI	Integrated management of Childhood Illnesses
IMNCH	Integrated Maternal, Newborn and Child Health
IPC	Interpersonal Communication skills
ISO	International Standard Organization
ITNs	Insecticide treated nets
LGA	Local Government Area
M&E	Monitoring and Evaluation
MDAs	Ministries, Departments and Agencies
MDGs	Millennium Development Goals
SERVICOM	Service Compact with All Nigerians
LGSC	Local Government Service Commission
NHA	National Health Accounts
NHIS	National Health Insurance Scheme
NHMIS	National Health Management Information System
NIMR	Nigerian Institute for Medical Research
NPHCDA	National Primary Health Care Development Agency
SPHCDA	State Primary Health Care Development Agency
NSHDP	National Strategic Health Development Plan
SSHDP	State Strategic Health Development Plan
EMOC	Emergency Obstetric Care
PHC	Primary Health Care
TBAs	Traditional birth attendants
CHEWS	Community Health Extension Workers
NTDs	Neglected Tropical Disease
WHO	World Health Organization
HSDP	Health Systems Development Project
UDRF	Unified Drug Revolving Fund
HCT	HIV counseling and testing
HMB	Hospital Management Board
ARV	Anti Retroviral Drugs
PMCTC	Prevention of Mother to Child Transmission
ACT	Artemisin Based Combination Therapy
MLSS	Modified Life Saving Skills

Executive summary

Health acts as a vehicle for development and countries with functional health systems have been known to make giant strides in the developmental arena. However, inequities and inefficiencies still exist in our health system and may debar us from achieving the Millennium Development Goals. The State Strategic Health Development Plan is a document which spells out the aspirations of the government and people of Ekiti State and identifies the resources and investments needed to bring about an improvement in the health status of the generality of the populace. It highlights the developmental priorities in health and health related fields to be pursued by the state and local governments.

Ekiti State of Nigeria came into existence on 1st October, 1996 with Ado Ekiti as the state capital. The state has an estimated population of 2,398,957 million consisting of 1,215,487 males and 1,183,470 females as at 2006. The Ekiti people are made up of predominantly farmers and civil servants. The state is endowed with a rich milieu of warm springs and beautiful landscape characterized by old plains broken by steep – sided out-crops dome rocks that may occur singularly or in groups. In the year under reference (2008), coverage was 71% for $DPT_{3,}$ 94.5% for measles and proportion of children fully immunized before the age of 12 months was 63.6%. In addition, 38% of eligible women received at least 2 doses of tetanus toxoid. In total, 5835 people were screened for HIV, out of which 7.6% were positive for HIV.

The proportion of deliveries attended to by a skilled birth attendant (professional health worker) was 54.7% while 17.1% of births were delivered by a trained traditional Birth attendant. This falls short of acceptable standards. In addition, new born babies weighing less than 2.5kg accounted for approximately 10% of total live births. Moreover, the prevalence rate of underweight among children under 5 years of age who were weighed was 3.5%. Of the 254 primary health care facilities, 196 offer antenatal and delivery services. Moreover, with only 21facilities at the LGA level offering STI and counseling and testing services, many of the populace still lack access to this valuable service. Only 2 centres in the state offer ARV treatment with the resultant lack of access to comprehensive care by those infected with HIV.

One area in which the state had performed excellently well is in the implementation of the Unified Drug Revolving Fund (UDRF). The UDRF has ensured 100% coverage of both secondary and primary health care facilities in the state and thus all these health facilities have been capitalized. Also the availability of essential DRF items in the state is put at 96%

The bottlenecks identified are in the areas of making local government authorities responsive and accountable for providing the needed support for PHC; ensuring the right mix of health workers at all levels (i.e., reducing allocative and distributive inefficiencies); creating a critical mass of skilful and knowledgeable middle level management (gap exists currently between top and middle level management staff skills and leadership capacity); harmonizing, integrating and sustaining the current vertical health initiatives to make room for continuous utilization of the evidence based interventions; and problems of fast tracking health development especially in the rural areas of the state without jeopardizing quality (i.e., ensuring effective coverage based on equity and assurance of quality).

*The states minimum package is adapted from the national minimum package of care but with emphasis on key state priority areas. The state would deliver the following minimum package of care in an integrated fashion to all people of the state. This package will contain cost effective and evidence based clinical interventions that have been documented to have the greatest impact on improvement in health status. These include: Control of Communicable Diseases (*Malaria, STI/HIV/AIDS, TB and Neglected Tropical Diseases like Schistosomiasis, Onchocerciasis e.t.c.,*); Child survival; Maternal and Newborn Care; Nutrition; Non Communicable Disease Prevention and; Health Education and Community Mobilization.*

For implementation to be effective, active community participation will be pursued. It is also expected that the state will make a sustained effort in health infrastructure development, and the identification and capacity building of the human resource for health. The state would also allocate and release 15% of the budget to health while ensuring that the success story of the unified drug revolving fund is sustained by giving it maximal backing to ensure that 100% of essential drugs are available.

In broad terms, it is expected that 80% of all planned activities as contained in the State Strategic plan being implemented will be monitored and periodically evaluated; 100% feedback to data generators, health planners and communities will be ensured; all relevant programme officers at state level and 60% of LGAs will collect, analyse and interpret their generated data by 2012; all intervention programmes will have quantifiable involvement of civil society groups and communities at all stages.

The initial costing done estimates that the total cost of the strategies documented over the six year period will amount to Forty one billion, seven hundred and eighty nine thousand, two hundred and sixty three naira (₦ 41,789,988,263). However, it is expected that a more comprehensive costing will be undertaken at a later date. The summary of the initial costing estimates are as shown below (details in state planning tool)

S/N	Thematic areas	Cost
1.	LEADERSHIP AND GOVERNANCE FOR HEALTH	34,892,522
2.	HEALTH SERVICE DELIVERY	26,908,918,080
3.	HUMAN RESOURCES FOR HEALTH	1,748,509,477
4.	FINANCING FOR HEALTH	12,824,462,762
5.	NATIONAL HEALTH INFORMATION SYSTEM	74,305,793
6.	COMMUNITY PARTICIPATION AND OWNERSHIP	35,785,475

7.	PARTNERSHIPS FOR HEALTH	32,502,952
8.	RESEARCH FOR HEALTH	130,611,201
9.	**TOTAL**	**41,789,988.263**

Implementation of this unique strategic health development plan is a collaborative effort that brings together all stakeholders in the health system (at the state, local government and community levels, as well as CSOs and the private sector). The collaborative roles and responsibilities of these different stakeholders will be clearly defined and streamlined. It is a shared responsibility premised on the principle of health for all – i.e working together for health . The State Government through the Ministry of Health and its related agencies will provide the leadership needed to coordinate the activities of these different players.

The main objective of the M&E system will be to establish a dynamic system that generates health data, continuous update of the state and national database and monitoring progress towards the agreed targets and objectives. This system will be essential in assuring the quality of health services, serve as a roadmap for achievement of the MDGs.

Its usefulness will be improved by orientating people to the paradigm shift of "knowledge for action" rather than archival data collection. The State Health Management Information Systems (SHMIS) is poised to provide the leadership necessary. Data generation in the public sector will be supplemented from community-based health organizations and the private sector. Therefore, the effective and efficient implementation of the interventions will be measured using multiple approaches as follows: routine SHMIS returns; quarterly and annual reviews of policy implementation (including stakeholders review meetings); representative surveys like facility-based and demographic health surveys; operational research findings; household and community surveys and; professional groups and regulatory body reviews. It is also expected that Civil Society Organizations will act as "watchdogs" towards ensuring that the State is on track to achieving stated objectives and coverage targets.

CHAPTER 1: Background and Achievements

1.1 Background

The role of health as a vehicle for development has long been understood. Countries with functional health systems have been known to make giant strides in the developmental arena. WHOin assessing health systems "Better health is unquestionably the primary goal of a health system. 'Better health is unquestionably the primary goal of a health system' hence it forms the yardstick for assessing it. This is clearly stated by WHO., Since health care can be catastrophically costly and the need for it unpredictable, mechanisms for sharing risk and providing financial protections are important. A second goal of health system is therefore fairness in financial contribution. A third goal, responsiveness to people's expectations in regards to non-health matters, reflects the importance of respecting people's dignity, autonomy and the confidentiality of information"[1]. Thus, protection of the poor plays a key role in making this happen. However, inequities still exist in our health system making the rich and educated access better health care services than the uneducated and poverty stricken that need it most. This has continued to bedevil the legitimacy of our health system and remains the most important factor for our not being[1] on course to achieving health Millennium Development Goals (MDGs) by 2015.

The Federal Governments health reform initiative brought out the realization that national development and achievement of set targets in health care will not occur within the context of our weak health system. In addition, the reality of many vertical programmes that "never meets" with the potential of further fragmenting an already weak system necessitated a central concerted effort aimed at addressing the myriad of problems. This builds on past experiences while consolidating on scaling up existing gains and strengthening the health systems. The costed **National Strategic Health Development Plan (NSHDP)** is seen as a means of bringing about this turnaround. However, states are at different stages of development and will have to develop a State Strategic Health Development Plan in the context of state needs and priorities and in alignment with national goals. The Ekiti State's plan draws on the experience gained in recent years in strengthening the health systems while also taking into consideration the aspirations of the people of the state.

Vision[2]

An equitable, accessible and participatory health care service to all in Ekiti State.

Mission Statement[2]

Provision of high quality personnel, infrastructures, equipment and supplies in collaboration with all stakeholders for the attainment of functional health care delivery system in Ekiti State.

The overarching goal of the NSHDP is to significantly improve the health status of Nigerians through the development of a strengthened, coordinated, re-invigorated and sustainable health care delivery system[3].

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[1] World Health Organisation (2000). World Health Report.

1.2 Achievements

Over the years, the health system has gone through series of constructive transformation with attendant positive impact on the quality of health services in the State. Project/Programmes by development partners (i.e., World Bank (HSDP II) PATHS, WHO UNICEF PAS EDHFO) acting in collaboration with the State Government were initiated and sustained.

The success story of the various collaborative efforts includes:

- Continuous capacity building of the workforce in the health sector
- System development to support service delivery
- Improvement in the Health Information System
- Skills acquisition in the area of integrated supervision.
- Improved/enhanced health activities and facilities utilization
- Unified Drug Revolving Fund Scheme
- Creation of community awareness and mobilization for participation
- Development of Public/Private partnership in service delivery

In addition, the introduction of the monthly medical intervention programme by the present administration of Engr. Olusegun Oni brought innumerable joy to thousands in Ekiti State. Some of these interventions include: the eye camp (screening, glasses and surgery); surgical festival; child health week; population screening for diabetes and hypertension; schistosomiasis screening and; de-worming exercise amongst many others.

CHAPTER 2:Situation Analysis

2.1 State profile

Summary of Ekiti State Profile

Ekiti State of Nigeria came into existence on 1st October, 1996 with Ado-Ekiti as the state capital. The state has an estimated population of 2,384,212 million as at 2006[4]. Ekiti State is entirely within the tropical region. It is located between longitude $4^{o} 45^{1}$ $5^{0} 45^{1}$ east of the Greenwich Meridian and latitudes 7^{0} 15^{1} to 8^{0} 5^{1} North of the Equator. It is situated South of Kwara and Kogi States as well as East of Osun State. It is bounded in the East and in the South by Ondo State. The state is mainly an upland zone. It rises above 250 meters above sea level. It lies within the areas underlain by metamorphic rocks of the basement complex. It also has a generally undulating land surface with a characteristics landscape that consists of old plains broken by steep – sided out-crops dome rocks that may occur singularly or in groups.

Ekiti as a people settle in nucleus urban patterns, well linked with network of roads. There are sixteen Local Governments and more than 127 large and small towns (ancient and modern) located on hills and valleys that characterize the state from which the confinement takes its name, Ekiti, that is, "Okiti" meaning Hills. The state is endowed with warm springs and the main staple food is pounded yam with vegetable soup. The Ekitis are Yorubas and are culturally homogenous with their dialect known as Ekiti[5].

2.2 Health systems

2.2.1 Health services organization

Similar to other states in the Nigerian federation, health care services is provided by both orthodox and traditional medical practitioners. In recent years, there has been a conscious effort

Ekiti State Ministry of Health provides guidelines for the regulation and coordination of traditional medicine practice.

There are 283 primary health care facilities at the Local Government (LGA) level, i.e., basic health centres, comprehensive health centres, maternity centres/dispensary centres, while the state has 17 secondary health-care centres, 3 specialist health facilities and 1 tertiary health facility. One federal owned tertiary health facility is also located in the state. Furthermore, there exist 163 registered private health facilities and 7 mission health facilities in the state.

The State Ministry of Health provides overall direction for the organization of health services in the state while also having the responsibility for health manpower development and organization and implementation of secondary health care. The State acting through the ministry of health also provides technical assistance to the local governments as regards primary health care and disease control. The Local Government on the other hand organizes and implements primary health care activities at the grassroots level and also has the responsibility of funding and coordinating service delivery at local level. However, local governments have performed poorly in the funding and execution of primary health care programmes. This is sometimes hinged on the insincerity of responsible authorities and the

lack of clear delineation of roles by the 1999 constitution. Thus, the responsibilities of local governments are sometimes taken over by the state government in order to provide succour to the people.

2.2.2 Health Indicators

A lot of the initiative of the state has been geared towards improving the health status of the population. However, the inequity that is the main bane of many health initiatives still persist. A sizeable proportion still lives below the poverty line while access to qualitative health care services in rural areas is still far from ideal.

Many communities are still grappling with the double burden of diseases with infectious diseases in gridlock with non-communicable diseases in a poor environment. Data from the Planning Research and Statistics department of the ministry of health for year 2008 only presents an iceberg view of the true picture as the capacity for community generated data is still not adequate. Nonetheless, the currently available data gives the DPT3 coverage as 71%, those fully immunized before the age of 12months as 32,881 and women with at least 2 doses of Tetanus toxoid as 38%[6]. This data though not too bad still falls short of expected standard for achieving the millennium development goals.

In the year under reference, 5835 people were screened for HIV, out of which 7.6% were positive for HIV. The pattern also reflects the disadvantaged position of females with a disproportionate infection rate of 9.5% compared to 5.2% for males. The number of people infected with HIV with access to ARV stands at 152. Furthermore, those co-infected with tuberculosis and HIV was 750[6].

The proportion of deliveries attended to by a skilled birth attendant was 54.7% while 17.1% of births were delivered by a trained traditional birth attendant. This falls short of acceptable standards. In addition, new born babies weighing less than 2.5kg accounted for approximately 10% of total live births. Moreover, the prevalence rate of underweight among children under 5 years of age who were weighed was 3.5%[6].

2.3. Health services provision and utilization

Ekiti State has invested a lot in the past years on providing the populace with qualitative health care services. However, the great investments made in provision of health care services have not translated to qualitative access to care especially by the rural poor. Of the 254 primary health care facilities, 196 offer antenatal and delivery services. Moreover, with only 21facilities at the LGA level offering STI and counseling and testing services, many of the populace still lack access to this valuable service. Only 2 centres in the state offer ARV treatment with the resultant lack of access to comprehensive care by those infected with HIV.

One area in which the state had performed excellently well is in the implementation of the Unified Drug Revolving Fund (UDRF). The UDRF has ensured 100% coverage of both secondary and primary health care facilities in the state and thus all these health facilities have been capitalized. Also the production and distribution of the essential drug list based on national guidelines has ushered in an era of 96% availability of essential DRF items. The UDRF has also been expanded to private health facilities. Therefore the drug store had transformed into a mega depot with a monthly sale in excess of N10.5million. The guiding principle is that quality and affordable drugs will be assured for the people of the state

irrespective of where they seek medical care. Suffice it to say that the final stage of the ISO certification is in progress.

Another initiative related to the UDRF is the Emergency Ordering System (EOS) which ensures that drugs required in any facility in Ekiti State could be ordered on phone and delivery made within 2 hours ("Just –In –Time delivery").

Summary of Ekiti State Situation Analysis

INDICATATORS	EKITI
Total population	2,398,957 (1,183,470 females; 1,215,487 males)
Under 5 years (20% of Total Pop)	479,791
Adolescents (10 – 24 years)	863,027
Underfive-Moratlity rate	89/1000LB[2]
Infant Mortality rate	59/1000LB[3]
Maternal Mortality ration	545/100000LB[4]
WCBA (15-49 years)	641,144
Literacy rate	84% female; 92% male
Households with improved source of drinking water	63%
Households with improved sanitary facilities (not shared)	17%
Households with electricity	63%
Employment status (currently)	55.6% female, 70.5% male
TFR	5.0
Use of FP modern method by married women 15-49	15%
ANC	93%
Skilled attendants at birth	81%
Delivery in HF	75.2%
Full immunization coverage	58%
Children with no immunization	2%
Stunting in Under 5 children	33%
Diarrhea in children	9.1%
ITN ownership	12%
ITN utilization	13% children, 5% pregnant women
Malaria treatment (any anti-malarial drug)	23% children, 5% pregnant women
Comprehensive knowledge of HIV	18% female; 42% male
Knowledge of TB	61.5% female, 92.2% male

2.4 Key issues and challenges

2.4.1 Key issues

A major concern of the state is how to fast track health development especially in the rural areas of the state without jeopardizing quality. In this regard, the state had enjoyed tremendous support from development partners including World Bank (HSDP II) PATHS, WHO UNICEF PAS EDHFO, DFID e.t.c.,. The various collaborative efforts ushered in an era of many health initiatives and a climate of continuous improvement in service delivery. Currently in Ekiti State, there are about 21 health initiatives brought on board through collaborative efforts. However, the sustainability status of some of these initiatives is quite doubtful.

[2] [3]Zonal Average, NDHS 2008

[3]

[4] National Average NDHS 2008

2.4.2 **Challenges**

Despite the various collaborative efforts and the commitment to bring about a meaningful change in the health status of the citizenry of Ekiti State, major challenges still remain. A key challenge is ensuring the right mix of health workers at all levels.

2.5 SWOT analysis matrix

***Strength* (S)**	***Opportunities* (O)**
1. Capacity of senior level officers already built on health systems improvement 2. High level of community awareness on involvement in health programmes 3. UDRF already in existence	1. Creation of the State Primary Health Care Development Bureau 2. National and State reform activities 3. Highly trained core of resource persons in the state
***Weakness* (W)**	***Threat* (T)**
1. Local Governments found wanting in the execution of their stewardship roles 2. Multiple initiatives that has not been properly re-integrated into existing programmes 3. Poor maintenance and sustainability culture 4. Inequity in health manpower distribution 5. Low level capacity of middle level officers on management and programming 6. Often poor work environment and conditions of service at the LGA level.	1. Information overload 2. Competing vertical programme needs 3. Global and national economic meltdown

S-O strategy: The number of senior officers with a deep knowledge of what needs to be done to improve the health systems will be crucial in taking advantage of the reform initiatives and making the newly created State Primary Health Care Development Bureau to transform into a fully fledged agency. Thus the ministry of health will have to be proactive in harnessing their potentials.

W-O strategy: The low capacity level of middle level management staff will really make it difficult to pursue the available opportunities to a logical conclusion unless there is a conscious organizational effort to overcome this weakness. It is also hoped that a radical approach to redress the inequity in health manpower distribution will make it possible for divisions, units, departments, LGAs and facilities to benefit maximally from the national and state reform initiatives.

S-T strategy: The high level of expertise exhibited by key officers can be tapped into to find a common integrating platform for vertical programme needs. This can also be tapped into to reasonably manage and harmonize the large volume of information from various initiatives (i.e., the existing 21 initiatives) which sometimes address the same issues but with different names. The strong showing of the UDRF could also be used to mitigate the threat posed by the global and national economic meltdown. Thus the existing strength of the health system

in Ekiti State can be used innovatively to reduce the vulnerability of the system to external threats.

W-T strategy: In order to prevent the weaknesses identified in the Ekiti health system from making it highly vulnerable to external threats, the ministry of health acting in concert with other Ministries, Departments and Agencies (MDAs) and with the support of government will need to establish a defensive plan which includes: securing the commitment of government at state and local levels; creating an enabling environment which motivates workers to put in their best and; harmonizing all similar health initiatives.

CHAPTER 3: Strategic Health Priorities

The strategic priorities are based on the eight nationally identified priority areas which was adopted by the state. 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.

3.1. Leadership and Governance for Health

3.1.1 Context

Government stewardship roles can only be actualized when the various actors possesses the skills and managerial ability to lead. Because transparency and honesty in governance will invariably translate to development, it will be important to ensure trust between the different actors. For all these to happen, the state will develop the leadership capacity of key actors in the health sector to lead and manage the implementation of the health plan as a performance improvement and reform process.

3.1.2 Goal

To create and sustain an enabling environment for the delivery of quality health care and development in Nigeria.

3.1.3 Strategic Objectives

1. To provide clear policy directions for health development
2. To facilitate legislation and a regulatory framework for health development
3. To strengthen accountability, transparency and responsiveness of the national health system
4. To enhance the performance of the national health system

3.1.4 Interventions

To provide clear policy directions for policy directions for health development

3.1.4.1 Improve capacity for health development

For meaningful development to take place, the capacity of stakeholders in the policy formulation process will need to be built. This will ensure that all policies (including the Ekiti State Health Policy) are reviewed, harmonized and well presented. It is to be expected that these policies will be given legal backing by ensuring that it is signed into law at the state level.

All relevant stakeholders will be identified at the state, local and community levels and trained on the policy process. A mechanism will also be put in place to adapt all relevant national policies including that on MNCH within the context of the Ekiti State health system.

3.1.4.2 Improve strategic planning at State and Local Government level

Planning is a recipe for development. State health planning shall relate to giving a strategic direction/focus for health development in the state. It also determines the broad priorities and their translation into concrete plans for the utilization of resources. However, since capacity

for planning and translation is still poor especially at the LGA and facility levels, the state will empower the medical officers of health, M&E officers and heads of facilities at state and local levels to be able to carry out and oversee planning activities. Other stakeholders at the community level will also be trained while the LGAs, state health agencies and institutions will be empowered to carry out mid-term reviews and evaluation of their strategic plans. Programme officers at the state level and LGAs will also be assisted to translate strategic plans into annual operational plans for action.

To facilitate legislation and a regulatory framework for health development

3.1.4.3 **Strengthen regulatory functions of government**

Health development cannot take place in the absence of standards for the kind of care people receive. The private sector sometimes is not coordinated and many fail to meet the aspirations of the people in terms of quality of care. Government will provide the framework for harmonizing all existing rules and regulations on standard of care and ensure that these laws are given the legal backing that it deserves. These laws will be made freely available to all players within the health system in Ekiti and this will ensure sanity within the system. All processes leading to the development and enactment of a state public health law to take care of public health concerns will also be fast tracked.

To strengthen accountability, transparency and responsiveness of the national health system

3.1.4.4 **Improve accountability and transparency**

Accountability and transparency is important for systems improvement. Therefore, the state will ensure that stakeholders have access to information at all times to carry out a review of the performance of the health system. This will be done through the state council of health which will be expanded and the initiation of joint stakeholders review meetings at the state, local and community levels. The civil society organizations will be facilitated to transform into a coalition to serve as "watchdogs" for the system while communities will be empowered to oversee projects and programmes being implemented in their domains.

To enhance the performance of the national health system

3.1.4.5 **Improving and maintaining sectoral information base to enhance performance**

Information is important for the decision making process. The state will undertake to build the capacity of health managers at the state and local government levels to manage and use data to measure health systems performance. For a sound base which guarantees access to information, a platform for information sharing through e-technologies like the web, internet and innovative texting will be explored. It is also expected that the conduct of household survey will give health manager's access to key household practices and preferences which ay influence health service utilization and the burden of disease.

3.1.4.6 **Develop leadership for health at state and LGA levels**

The leadership role of managers is generally lacking and many managers lack the capacity to inspire their subordinates to achieve organizational set goals. In this regard, the leadership and management skills of middle and senior level PHC staff as well as medical directors of

secondary health facilities will be built. Clear job description will also be provided for PHC level officers based on NPHCDA guidelines. A mechanism for leadership performance of the medical officer of health will be instituted through the review of the annual LGA report of the medical officer of health.

3.2 Health Service delivery

3.2.1 Context

Many inequalities exist in health care delivery system. This reflects in ¾ of the health personnel and infrastructure being available in urban areas whereas ¾ of the populace live in the rural areas. There also exist wide differentials in the coverage for essential services with the vulnerable sector being often neglected. Vertical programme needs makes it even more expensive to provide a full range of services for the needy. This makes it quite difficult to convince health authorities especially at the local government level to allocate resources to conflicting health programmes with virtually the same purpose. Thus this plan will set out the broad strategies needed to build the capacity of health care planners to pull resources for more effective programming in the spirit of integration. It is also hoped that the plan will be able to redress the inequities inherent in access and utilization with a firm commitment of protecting the poor against catastrophic spending on health.

3.2.2 Goal

To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare

3.2.3 Strategies

1. To ensure universal access to an essential package of care
2. To increase access to health care services
3. To improve the quality of health care services
4. To increase demand for health care services
5. To provide financial access especially for the vulnerable groups.

3.2.4 Interventions

To ensure universal access to an essential package of care

3.2.4.1 Essential health service package

A minimum package of care will be guaranteed for every individual. This will be made possible through the review of the requisite minimum that every facility will be required to implement in an integrated manner. This minimum package will be costed and standard operating procedures made available for its implementation. For effective delivery of these services, case management guidelines for MNCH, priority diseases and other priority health conditions will be put in place. The capacity of programme officers of non-communicable and communicable disease to manage and coordinate the provision of effective interventions for these programmes will be improved through trainings. A major thrust of health care interventions in the state will be the allocation of community health workers to a predetermined population size in order to ensure that personalized health care services is provided in the context of the Ekiti State health care reform.

HIGH IMPACT SERVICES
A. FAMILY/COMMUNITY ORIENTED SERVICES
Insecticide Treated Mosquito Nets for children under 5

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

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

3.2.4.2 **Strengthen specific non-communicable and non-communicable disease control programmes including Neglected Tropical Diseases (NTDs)**

Schistosomiasis is endemic in Ekiti State and many harbor the responsible organism. The state will identify and implement cost effective strategies for the distribution of drugs for the four neglected tropical disease (onchocerciasis, lymphatic filariasis, schistosomiasis and soil transmitted helminths) prevalent within its communities. It will also be prudent to carry out a mapping of water sources in the state especially for schistosomiasis with a view to providing safe water sources. Effective interventions for the control of malaria like the distribution of insecticide treated bed-nets as well as the use of ACTs especially for under-fives and IPTs for pregnant women will be scaled up. To fully engage the community in the management of disease conditions, a conscious effort will be undertaken to increase the awareness of the

public about risk behaviour for communicable and non-communicable diseases. The laboratory component of disease control will be strengthened by the setting up of a functional public health laboratory at the state level.

3.2.4.3 **Establish mechanism for continuum of care**

It is important to begin to accelerate progress towards the attainment of the millennium development goals 4, 5 and 6. Therefore, a minimum package of MNCH services will be made available in all health facilities in the state. The capacity of health workers will also be built on priority health interventions such as LSS, MLSS, EMCO, FP, IMCI e.t.c.,. A strengthening of the TB/HIV collaborative activities including VCT will be scaled up while a mechanism will be put in place to guarantee continuous access of an increasing number of PLWHA to HAART and support services. To ensure that nobody is left out in the provision of health services, linkages will be established for appropriate health care services and interventions within occupational settings.

To increase access to health care services

3.2.4.4 **Improve geographical equity and access to health services**

The government will carry out a mapping of health facilities in the state and its human resource capacity. This will create the template for the redistribution of workers based on needs. For health care service provision to be functional, a minimum ward health package will be put in place to ensure that every ward is reached and that every ward will have an improved access to essential obstetric care services. For the redistribution of workers to be effective and acceptable to the generality of workers, motivational package for those working in rural, underserved and hard-to-reach areas will be put in place.

3.2.4.5 **To ensure availability of drugs and equipment at all levels**

Ekiti State had gone beyond the provision of essential drugs. Now a unified drug revolving fund which covers all public health facilities is in place. Therefore, a key activity will be to review the performance of the UDRF and use the results of such a review for improvement. Additional “M supply” licenses will also be acquired for the expansion of the inventory system. The drug system will be expanded to include MNCH commodities like contraceptives, magnesium sulphate and misoprotol. The capacity of all stakeholders will be built on DRF and its sub-systems while the capitalization of the UDRF will be increased for extension to more private health facilities. Standardization of the mega-drug depot will be embarked upon to ensure that essential drugs are stored according to acceptable standards.

3.2.4.6 **To establish a system for the maintenance of equipment at all levels**

The maintenance culture in health care circles is quite defective as there is no conscious effort to ensure the functionality of equipments. Thus, an adaption of the national health equipment policy will be pursued and budget lines created for the maintenance of equipments and furniture at all levels. Maintenance workshops will be established by the state to ensure the sustainability and guaranteed functionality of medical equipments. Public private partnerships for preventive maintenance will also be pursued especially in areas where the capacity of the state is still low.

3.2.4.7 To strengthen referral system

For an effective and efficient implementation of the referral guidelines, PHC centres will be linked support services at the secondary and tertiary levels especially for emergency obstetric services. A mechanism for logistics, transportation and communication will be put in place while the current "patient-in-transit" scheme for transportation of referred patients will be strengthened.

3.2.4.8 To foster collaboration with the private sector

Private sector participation is important for the proper functioning of the health system. Private health providers offer service for a sizeable proportion of the population. Mapping of the private health care providers by operational level and location will facilitate the development of guidelines for partnership, training, and outsourcing of services. Genuine dialogue with the private sector will be initiated and guidelines developed for the regulation of their practice. Eventually, the fostering of partnership will engender a mechanism for joint performance monitoring for the private sector.

To improve the quality of health care services

3.2.4.9 To strengthen professional regulatory bodies and institutions

To standardize the provision of care and protect the populace, regulatory guidelines will be reviewed and updated while budget lines will be created to accommodate resource mobilization plans for regulatory functions of government. The capacity of regulatory staff for compliance monitoring will be built and a mechanism for proper documentation and feedback set up. A quality assurance laboratory will be established in the state to monitor the quality of drugs dispensed to the public within the wider context of the drug revolving scheme and the mega-drug depot.

3.2.4.10 To develop and institutionalize quality assurance models

Health care providers will need to assure the public and themselves of the quality of service for which they are responsible. Therefore consensus will be built for the entrenchment of the principle of quality assurance and improvement in the state. All stakeholders involved with quality assurance will be brought on board to adopt a cost effective model for the state that will be implemented at all levels of the health system. The implementation of SERVICOM guidelines will be encouraged while community appraisal of disease control activities will be carried out to inform programme improvement.

3.2.4.11 To institutionalize health management and integrated supportive supervision

Over reliance on the vertical health approach brings with it an attendant prohibitive cost of supervision and monitoring. Therefore, the management capacity of health workers for team building and leadership will have to be improved upon. This team building will facilitate the establishment of a common mechanism for comprehensive integrated supportive supervision at all levels. To this effect, tools and guidelines for integrated supportive supervision will be developed.

3.2.4.12 To improve health infrastructure development

Quality is not limited to standard of health care but also include minimum standard for health infrastructure. In the recent past, many health facilities have become dilapidated and lacking in basic equipment to guarantee a minimum standard of acceptable quality. However as currently being carried out under the "blue hospital" initiative, the substandard health facilities in the state will be refurbished and upgraded. A minimum package of equipments for primary and secondary health facilities will also be put in place. In the spirit of public-private partnership, a modern diagnostic centre will be established in collaboration with the private sector while the eye centre will also be established to cater for the special needs of the state citizens. Infrastructural development will in addition be undertaken at the teaching hospital to further upgrade the status of the centre. To make the unique patient-in-transit scheme run efficiently, more buses will be procured for it either by direct government purchase or through collaborations with donor organizations.

To increase demand for health services

3.2.4.13 To create effective demand for health services

Communication strategy reflecting the local realities and based on the National Health Promotion Policy will be embraced and adopted. This will open up avenues for the establishment of partnerships for key health initiatives like MNCH, PMCTC, e.t.c.,. Budget lines will also be created for health promotion.

3.2.4.14 Promoting positive lifestyles for disease prevention

For people to be in good health, they need to adopt a lifestyle that shuns habits that predispose them to ill health or foster the future development of disease conditions. In this regard, the state adapted BCC strategy will be widely disseminated and implemented while the development of health promotion initiatives by the community will be encouraged. The school environment constitutes a good place for health promotion initiatives to be implemented. To this end, a comprehensive school health programme will be established which will build on the achievements of the current implementation of the programme. To be better positioned to facilitate the culture of voluntary health promotion, the skills of health workers, teachers and other stakeholders regarding inter-personal communication and counseling will be further improved through trainings and supportive supervision.

To provide financial access especially for the vulnerable groups

3.2.4.15 To improve financial access especially for the vulnerable groups

Cost deferral and exemption scheme is already incorporated and functioning in the Ekiti State UDRF. However, the poorest of the poor are still left unprotected by the current system because they remain largely unidentified. Thus, a broad based guideline for protecting these highly vulnerable groups against catastrophic health spending will be developed and implemented. As a step in the process of protection, clear guidelines for the costing of health care services will be developed and disseminated widely. Ultimately, community options for refining and improving the current cost and deferral system will be explored.

3.3 Human Resources for Health

3.3.1 Context

The greatest resource for health is human. However, there is often allocative inefficiency in the distribution of the health workforce. Health needs are not matched with human resource and to ensure the right mix of health workers is often a mirage. Even at the national level, policies have often focused on creating new cadres of staff rather than exploring innovative ways of getting the best out of the existing ones. Attracting the right kind of cadre to specific areas of need has also suffered from lack of commitment to provide the right kind of motivational package for essential and specialist staff. The human workforce interface is characterized by unhealthy rivalries often fueled by political considerations and inordinate ambitions to grow beyond mandates and job descriptions. Communities and families should also be seen as active collaborators in the delivery of health care services and as such mechanisms will need to be put in place for shifting specific tasks to them. This phenomenon of task shifting does not apply only at the community/family level but also applies to shifting of task between specialists, general practitioners, nurses/midwives, community health workers, medical scientists and other members of the health care delivery system. This will be put in place to make effective and efficient use of the health workforce.

3.3.2 Goal

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

3.3.3 Strategic Objectives

1. To formulate comprehensive policies and plans for HRH for health development
2. To provide a framework for objective analysis, implementation and monitoring of HRH performance
3. Strengthen the institutional framework for human resources management practices in the health sector
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
5. To improve organizational and performance-based management systems for human resources for health
6. To foster partnerships and networks of stakeholders to harness contributions for human resource for health agenda

3.3.4 Interventions

To formulate comprehensive policies and plans for HRH for health development.

3.3.4.1 To develop and institutionalize the human resources framework

The national framework on human resources will be adapted and adopted and a strategic plan for the review of state and LGA human resource needs will be developed. Guidelines to guide the existence of public-private practitioner's forum will be put in place while HRH policy reviews, supervision and monitoring framework will be institutionalized for these meetings. Guidelines and standard operating procedures for task shifting will also be developed and implemented

3.3.4.2 Strengthen State PHC Development Agency in Ekiti State

In accordance with the national health bill, the setting up of a state development agency has been set in motion. Presently, it enjoys the status of a bureau. However, with time; the legislative process for transforming it into a full-fledged agency will be completed. It is hoped that this agency is to jumpstart primary health care development at the grassroots and lead eventually to systems improvement. To actualize this dream, the functions of the agency will be streamlined in accordance with the NPHCDA guidelines. The managerial skills of the agency staff as well as the capacity for health systems research and improvement will be developed. To ensure an equitable utilization of the PHC allocated fund, a mechanism for its sharing and monitoring will be put in place.

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

3.3.4.3 To reappraise the principles of health workforce requirements and recruitment at all levels

All existing policies on recruitment and training of personnel will be reviewed and guidelines developed for assessing staffing needs based on developmental priority and workload. A mechanism will also be set up for the regular translation and adoption of federal circulars on HRH guidelines.

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

3.3.4.4 To establish and strengthen the HRH Units

All HRH units in the state (e.g., HMB, LGSC,SMoH, e.t.c,.) will be reappraised and quarterly interactive sessions organized with professional groups on HRH issues. A re-orientation and training of staff especially in the HRH units will be done and job description and task analysis incorporated into HRH guidelines

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

3.3.4.5 To review and adapt relevant training programmes for the production of adequate number of community health oriented professionals based on national priorities

The relevant supervisory bodies within the ministry of health will facilitate the review of the curricula of the school of nursing/midwifery and the school of health technology to reflect current understanding and state health priority needs. These health institutions will also be upgraded to meet modern standards. Early opportunities for further training will be instituted and workers bonded to ensure return after training. Critical areas of health manpower needs will be identified and admissions increased to meet these needs.

3.3.4.6 To strengthen health workforce training capacity and output based on service demand.

A deliberate effort to identify and update human resource needs will be undertaken. To attract and retain professionals in priority areas, guidelines will be developed for linkage of sponsorship of professional training with bonding. Performance based financial incentives will also be embraced.
Plans of the state to fold in and take ownership of the Midwives Service Scheme needs to be included

3.3.4.7 **Strengthening of Quality assurance**
Quality assurance and education review units will be established in all training institutions in the state. Government will also create opportunities for retraining and attendance at continuing education sessions. This will be extended to professional bodies through their membership registration and licensing preconditions. It is also expected that a common platform will be instituted for inter-training institutions collaboration and dialogue.

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

3.3.4.8 **To achieve equitable distribution, right mix of the right quality and quantity of human resources for health**
The state will put in place a package for its human resource needs and harmonize the existing human resource units at the LGA, State, HMB and SPHCA levels. With this harmonization, it will be easier for the state to equitably distribute staff based on verifiable needs. Underserved areas will get first priority in the posting of professionals on the mandatory National Youth Service Corps scheme while all efforts will be geared towards providing a safe and motivating work environment especially for workers in underserved and rural areas.

3.3.4.9 **To establish mechanisms to strengthen and monitor performance of health workers at all levels**
One key area where a major investment of time will be useful is the re-orientation of the health workforce on their attitude to work and clients. This will be given its full recognition by improving interactive personal working relationship through workshops and strengthening of monitoring, evaluation, supervision, support and sanction. Client feedbacks will be encouraged and all health initiatives will be monitored for clients input.

To foster partnerships and networks of stakeholders to harness contributions for human resource for health agenda

3.3.4.10 **To strengthen communication, cooperation and collaboration between health professional associations and regulatory bodies on professional issues that have significant implications for the health system**
For the health system to function maximally, the input of health professional groups will be required. Therefore, interactive meetings and dialogue will be promoted between the public and private sector as well as the regulatory bodies. The membership of key areas of human resource management like the LGSC and civil service commission will also be expanded to accommodate health professionals. In essence, monitoring of performance will be a joint

venture between regulatory bodies, human resource management units and professional groups.

3.3.4.11 Strengthening communication, cooperation between health professional associations and health users

Promotion of interaction between clients and providers usher in service improvement. In this regard, a mechanism for greater interaction and feedback from clients will be put in place. In addition, mothers will be empowered in clinics and at the community levels with adequate knowledge for improving key household and community practices as well as family health care seeking behavior.

3.4 Financing for Health

3.4.1 Context

The double burden of disease evident in communities places much financial strain on already impoverished families. The poor and the poorly educated also have inadequate access to health care; perhaps due to the prohibitively large amount of disposable household income that they spend on health care. The poor health status of children and the worsening maternal mortality estimates makes it quite clear that a lot of resources will have to be devoted to guaranteeing access to a minimum package of care for under-fives and pregnant women. Providing these resources will task the resourcefulness of health planners especially with donor agencies becoming apprehensive of the lack of appreciable progress made towards the achievement of the MDGS despite massive influx of financial resources in the past years. Insincerity of policy makers and lack of transparency in the allocation and utilization of funds further compounds the lack of trust between funding organizations and government. Therefore novel initiatives and financing options including the community driven partnerships will have to be identified and nurtured. Government will also need to change the way it does business and allocate more efficiently financial resources to health as well as effectively implement the National Health Insurance and Community Insurance schemes.

3.4.2 Goal

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

3.4.3 Strategic Objectives

1. To develop and implement health financing strategies at Federal, State and Local levels consistent with the National Health Financing Policy
2. To ensure that people are protected from financial catastrophe and impoverishment as a result of using health services
3. To secure a level of funding needed to achieve desired health development goals and objectives at all levels in a sustainable manner
4. To ensure efficiency and equity in the allocation and use of health sector resources at all levels

3.4.4 Interventions

To develop and implement health financing strategies at Federal, State and Local levels consistent with the National Health Financing Policy

3.4.4.1 To develop and implement evidence-based, costed health financing strategic plans at LGA, State, levels in line with the National Health Financing Policy

The setting up of a technical working group on health care financing will be fast tracked and all members of the group will have their capacity built for optimal functioning.

3.4.4.2 **Creating mechanism for the development and use of evidence-based costed health financing strategic plans at the State and LGA levels**

The LGAs will be assisted to develop evidence based costed health financing strategic plans and translate these into annual health financing operational plans. The government will also provide leadership for an annual performance appraisal of health financing plans.

To ensure that people are protected from financial catastrophe and impoverishment as a result of using health services

3.4.4.3 **To strengthen systems for financial risk health protection**

The NHIS scheme will be adopted at the state and LGA levels to offer protection against catastrophic spending on health. The members of the public will also be sensitized on the benefits of the social health insurance scheme with a view of getting people to enroll.

3.4.4.4 **Exploring innovative social health protection approaches**

Consensus building on community based initiatives on health insurance will be undertaken and training updates will be provided for the various health management committees on health care financing. It is to be expected that the community insurance scheme will be adapted, adopted and implemented.

To secure a level of funding needed to achieve desired health development goals and objectives at all levels in a sustainable manner

3.4.4.5 To improve financing of the Health Sector

Engagement of banks, industries and companies in dialogue on corporate social responsibilities will be proactively pursued as a financing option for health while communities willing to participate in partnering for health care funding will be offered incentives.

3.4.4.6 To improve coordination of donor funding mechanisms

One major drawback of the health sector had been the uncoordinated nature of health interventions and their funding with a resultant duplication of efforts. Funding gaps will be identified and guidelines put in place for donor coordination based on national guidelines. It is expected that implementation of funding agreements will be closely monitored and evaluated.

3.4.4.7 To improve government allocation of public resources to the health sector

Advocacy will be intensified for the adoption of the Abuja declaration on allocation of at least 15% of total government budget to health at the state and local government levels. For epidemic prone diseases, high burden health priorities and special accelerated interventions like emergency obstetric care, a special fund will be set up to remove bureaucratic bottle necks.

To ensure efficiency and equity in the allocation and use of health sector resources at all levels

3.4.4.8 To improve health budget execution, monitoring and reporting
The capacity of health staff and CSOs will be built on tracking and analysis of health budget and advocacy to the state assembly on institutionalizing public expenditure review will be stepped up. The use of health accounts information for health management and planning will be given utmost importance and the state will also endevaour to provide technical assistance to LGAs on establishing clear priorities for their health expenditure plans.

3.4.4.9 To strengthen financial management skills
The skills and training needs of key personnel involved in health budgeting and accounting will be appraised and their capacity built on budgeting, auditing and accounting. To ensure strict compliance with financial management principles, the state will carry out supportive supervision of health staff at the LGA through its relevant agencies and organs.

3.5 National Health Information System

Often the information generated by health workers have no bearing on the task they perform with the result that vital information becomes archival documents. The health information system is vital to health systems improvement yet it is majorly data driven and fragmented rather than being action-driven and tools for effective management decisions. There exists many health programmes with competing information needs and enormous data that must be collected. Our surveillance systems are also not sensitive or efficient enough for an evidence based pubic health response. Much of community driven data are also lost and private heath providers are reluctant to volunteer data to a system that on face value appears to contribute little to the survival of their practices. Therefore, the skills of appropriate personnel will have to be developed to bring about the desired changes in the system. A system of feedback and linkage of information with decision making will also need to be put in place while vertical information needs harmonized. This is already happening in Ekiti State and will need to be scaled up to include all health information and the integration of community driven data into the HMIS.

3.5.2 Goal

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

3.5.3. Strategic objectives

1. To develop and implement health financing strategies at Federal, State and Local levels consistent with the National Health Financing Policy
2. To ensure that people are protected from financial catastrophe and impoverishment as a result of using health services
3. To secure a level of funding needed to achieve desired health development goals and objectives at all levels in a sustainable manner
4. To ensure efficiency and equity in the allocation and use of health sector resources at all levels

3.5.4. Interventions

To improve data collection and transmission

3.5.4.1 **To ensure that NHMIS forms are available at all health service delivery points at all levels**

The health ministry will establish a mechanism for bi-annual stock taking and redistribution of NHMIS forms. Advocacy will be intensified for creation of budget lines at state and LGA levels. The state will initiate the production of NHMIS forms and distribute same to public and private health facilities biannually. Health Data Consultative Committee (HDCC) at facility, LGA and state levels will be set up. A major strategic thrust will be the strengthening of the mechanism for electronic transfer of data from LGAs to the state level.

3.5.4.2 **To periodically review of NHMIS data collection forms**

The review of the NHMIS forms will be undertaken on an annual basis and this will be linked to a mechanism for accommodating end users feedback on the forms.

3.5.4.3 **To coordinate data collection from vertical programmes**

The state is already leading in the harmonization of vertical programmes information needs. This on-going initiative will be strengthened and a platform created for information sharing among programme officers.

3.5.4.4 **To build capacity of health workers for data management**

For data to be more than an archival document, it must be used for decision making. Therefore strategies will be put in place to encourage data use for planning and performance monitoring. Health workers will be trained on health data collection and a simple self-assessment checklist on data quality will be developed for data collectors and collators.

3.5.4.5 **To provide a legal framework for activities of the NHMIS programme**

The enthusiasm for data rendition is abysmally low amongst private health providers. There is presently no law regulating the process of data rendition. Thus advocacy to the state house committee on health will be stepped up to have an enabling law guiding data rendition. In addition, guidelines for the publication of health data/information will be put in place to make health data access easier and to prevent the publication and dissemination of information with doubtful scientific basis and rigour.

3.5.4.6 **To improve coverage of data collection**
For private health care providers to be responsive to the call for data rendition, they will need to have a stake in the process. In view of this, a platform will be created which will involve both private and public health facilities in health data collection and default monitoring. The management capacity of these facilities will be built on data management and tools for data management made available in adequate amounts. Community health workers will also be empowered and trained to collect the much needed community based data.

3.5.4.7 **To ensure supportive supervision of data collection at all levels**
To ensure that the quality of data being generated is high, a framework will be instituted and implemented for regular supportive supervisory visits to health facilities at the state and LGA levels. For this to have the desired effect, simple task linked supervisory checklist will be developed.

To provide infrastructural support and ICT of health databases and staff training

3.5.4.8 To strengthen the use of information technology in HIS
The use of information technology in the daily routine of the HIS will be strengthened through the provision of more computers, software's, internet access, GSM and other Information Technology equipments at both the state and LGA levels. The proposed SMoH website will also be used as a platform for information sharing and dissemination.

3.5.4.9 To provide HMIS Minimum Package at the different levels (FMoH, SMoH, LGA) of data management
A minimum package for HIS will be defined as provided in the NHMIS policy document and same made available at the state and LGA levels. For sustainability and preservation of the HMIS equipment, an inventory system with bi-annual monitoring will be established.

To strengthen sub-systems in the Health Information System

3.5.4.10 To strengthen the Hospital Information System
All health record personnel in hospitals in the state will have their capacity built on the implementation of HMIS activities. All data management systems in hospitals will also be linked with the data management system of the LGA in which each hospital is domiciled.

3.5.4.11 To strengthen the Disease Surveillance System
Community based health care providers constitute a veritable resource for health data generation. Therefore their capacity will need to be built on quality data collection, analysis and interpretation and use of data for decision making. Senior Community Health Extension workers will be empowered to supervise community based health service providers within the context of health data collection on priority health conditions and disease notification.

To monitor and evaluate the NHMIS

3.5.4.12 To establish monitoring protocol for NHMIS programme implementation at all levels in line with stated activities and expected outputs
Regular monitoring is key to high quality data generation. In this regard, a framework for regular monitoring of LGAs and facilities on data quality will be instituted and implemented. This will be linked to the carrying out of regular review meetings at the state and LGA levels. A checklist for monitoring will be reviewed and vehicles/motorcycles and other logistics provided for monitoring activities at the state, LGA and community levels as appropriate.

3.5.4.13 To strengthen data transmission
Data flow and feedback system at the facility and LGA levels will be further established and strengthened while consensus will be built on deadline dates for data submission at all levels of data generation. A sanctions and incentives system will also be implemented for data timeliness and completeness.

To strengthen analysis of data and dissemination of health information

3.5.4.14 To institutionalize data analysis and dissemination at all levels
Data is meaningless if it cannot be used at the level at which it is generated for programme and/service improvement. Thus, health data producers will be trained on data analysis and use. An annual health data feedback and consensus building activity will be held at state and LGA levels. Medical officers of Health and medical officers will also be empowered and facilitated to hold annual community feedback forum at the LGA level. The Ekiti State health bulletin will be regularly published and disseminated annually.

3.6 **Community participation and ownership**

3.6.1 Context

In Ekiti State, the existence of social mobilization committees for promoting immunizations has been remarkable across all communities. This accounts for the relative better uptake of the service compared to other states. The Community Resource Persons (CORPS) for integrated management of Childhood illnesses (IMCI) are already in all the primary health facilities/communities in the State. This process was done between 2005- and 2007. Thirdly there exist also the Drug Revolving Fund committees that later metamorphosed to facility health committees across the over 170 primary health care centres and also the hospital management committees in all the secondary health facilities. The health committees have responsibilities to supervise DRF operations, deferral and exemption scheme service and primarily serve as communication link between the community and the health workers and health policy makers at both local and state levels on all health issues.

No doubt, there are existing structures for community participation but the concept of community ownership is not yet assimilated by the health consumers. Also the various community or facility committees for health actions are confusing and create community fatigue to participation. Persons tend to be involved in plethora of activities (that are not remunerated) all the time, while the pattern of volunteerism defer from one committee to another; thus producing unnecessary insinuation especially about finance. Thirdly there is poor supervision and monitoring of the committees by policy makers and health managers at

both local and state government levels. These challenges produce a weakening of the committees and poor sustainability of existing programmes.

3.6.2 Goal:

To attain effective community participation in health development and management, as well as community ownership of sustainable health outcomes

3.6.3 Strategic objectives

1. To strengthen community participation in health development
2. To empower communities with skills for positive health actions
3. To strengthen the community - health services linkages
4. To increase national capacity for integrated multisectoral health promotion
5. To strengthen evidence-based community participation and ownership efforts in health activities through researches

3.6.4 Interventions

To strengthen community participation in health development

3.6.4.1 **To provide an enabling policy framework for community participation**

A major strategic direction will be to review the Ekiti State health policy with a view to including the central issue of community participation which is vital to the proper functioning of any health system. In addition, advocacy will be scaled up for the development of an Ekiti State community development policy which looks at health within a developmental framework. This cannot be made possible unless a core team for community participation and ownership is put in place. This will of necessity be facilitated at the state and LGA levels. For community participation to work, people must have access to information about policy directions of government. For this reason, the Ekiti State health policy as well as the revised National Health policy will be made available to relevant stakeholders at the state, LGA and community levels.

3.6.4.2 **To provide an enabling implementation framework and environment for community participation**

Many community initiatives exist that their sustainability is either doubtful or has not been evaluated. Therefore, a participatory review of existing guidelines on community participation and health committees as well as other community initiatives like role model mothers, social mobilization committees, e.t.c., will be undertaken. Based on the evaluation, harmonization of community initiatives and committees will be carried out and revised guidelines on community participation produced and disseminated. The capacity of community stakeholders on utilization of tools for planning, management and monitoring and evaluation of health interventions will be built.

3.6.4.3 **Create information platform between health care provider and the community**

There must be a mechanism by which the community can provide a feedback on the services they receive without waiting for the time of the annual reviews. The provision of mandatory suggestion boxes at health facilities to be coordinated by facility committee chairmen and community awareness drives on patient's rights when accessing health services will go a long way in meeting this concern. For maximal monitoring of CHEWS compliance with their mandates of spending a greater percentage of their time within the communities, community health information will be set up at facility levels to provide information about the work schedule of these set of workers and communities encouraged to give a feedback of their activities within the communities.

3.6.4.4 **Strengthen community voluntary participation and support for health services**
Communities will be oriented towards better involvement in health care delivery and an annual reward system put in place for the best communities supporting health care delivery in terms of resource mobilization, health planning, implementation and evaluation. The linkage and integration of an annual health week into the existing celebration of community days will be advocated for and facilitated. The best CBO supporting the delivery of health care services will also be identified on LGA basis and recognized on an annual basis.

To empower communities with skills for positive health actions

3.6.4.5 **To build capacity within communities to 'own' their health services**
A key way to measure community participation is the number of initiatives put in place by the community out of their own volition. For this to happen, community stakeholders and harmonized health committees will have to be trained and retrained on planning, resource mobilization e.t.c,. Community assessment of stakeholder's participation will be carried out and a framework for regular meetings between community and LGA/State service providers/policy makers on key health issues and feedback created and implemented.
Health promotion activities aimed at empowering communities to take health actions needs be put in place.

3.6.4.6 Coordinating existing traditional, faith based health care providers and private health providers
Traditional health providers already account for a sizeable proportion of health care consultations. Unfortunately many of their activities are shrouded in secrecy and are not properly monitored to protect the populace from charlatans. The existing profile of TBAs, traditional healers, CBWs and faith based healers will be reviewed and updated and a quarterly partnership forum between them and LGAs health management team facilitated. The profile of private clinics, hospitals, nursing homes and patent medicine vendors will also be reviewed and updated on an annual basis.

3.6.4.7 Establish and strengthen existing structures for community dialogue on health
Community dialogue will be encouraged and the guidelines for streamlining the process will be set up. The roles and responsibilities of various community stakeholders will be delineated through the consensus building process.

To strengthen the community - health services linkages

3.6.4.8 To restructure and strengthen the interface between the community and the health services delivery points

All existing community linkages will be identified and guidelines developed to strengthen them. To actively share and learn from experiences, annual joint forum for community health committees will be organized on a senatorial basis. It is also expected that the community linkages will provide an avenue for the conduct of an annual participatory development of community health needs for inclusion into LGAs annual health plans.

3.6.4.9 Engaging local human resources for health service delivery

All the existing channels of health communication will be evaluated and training conducted for community resource persons such as town announcers and cultural/musical troupes. The CORPS scheme in the state will also be integrated into the harmonized health committees.

3.6.4.10 To strengthen the capacity of civil society organizations (CSOs) to improve linkages between communities and health service delivery points

The CSOs are very crucial to improving the linkage between health service points and the communities. Therefore, the resource potential of the state (human, financial and media) will be identified and documented and the available CSOs trained on community dialogue and advocacy tools.

To increase national capacity for integrated multisectoral health promotion

3.6.4.11 To develop and implement multisectoral policies and actions that facilitate community involvement in health development

A basic principle of "health for all" is that all will participate in ensuring that health development takes place and that everyone takes part in the process pertaining to the health of the community. So, a state health promotion policy will be developed based on national health promotion policy to address community participation. To ensure the success of getting every body on board, awareness creation drives will be intensified among community gatekeepers (community leaders, women leaders, school heads, e.t.c.,) on the benefits of community participation. In addition, community action plans will be developed for health promotion and community sensitive IEC/BCC produced and disseminated. The partnership with CSOs will also include the building of health promotion initiatives into CSOs agenda and programmes.

To strengthen evidence-based community participation and ownership efforts in health activities through researches

3.6.4.12 To develop and implement systematic measurement of community involvement

For systems improvement, mechanisms must be put in place for systematic measurement and learning. The state will build the capacity of harmonized health committees at the state, LGA and community levels in this regard. Simple tools and checklists will also be developed for monitoring and evaluation of health promotion services while an annual Knowledge,

Attitude, Behaviour, Experience and Practices survey will be outsourced to inform policies and implementation strategies at the state, LGA and ward levels.

3.6.4.13 Involvement of community in information management and evidence based decision making

Because community interventions must be based on sound evidence, the capacity of health committees will be built on data use for decision making while the creation and implementation of a framework for the conduct of biannual meetings on the implications of data generated will go a long way in getting decision making to be evidence based. These will piggy back on the development of guidelines for community feedback after research to prevent the exploitation of communities and increase the beneficence of research programmes.

3.7 PARTNERSHIPS FOR HEALTH

3.7.1 Context

Health development cannot be implemented without the active participation of major stakeholders. Government alone cannot do it and as such partnerships that cut across all areas of human endevaour needs to be identified. These partnerships must be such that will be mutually beneficial and take into consideration the developmental priorities of government and the aspirations of the citizenry.

3.7.2 Goal

To enhance harmonized implementation of essential health services in line with national health policy goals

3.7.3 Strategic objective

1. To ensure that collaborative mechanisms are put in place for involving all partners in the development and sustenance of the health sector

3.7.4 Interventions

To ensure that collaborative mechanisms are put in place for involving all partners in the development and sustenance of the health sector

3.7.4.1 To promote Public Private Partnerships (PPP)

There will be a need to conduct advocacy visits to identified stakeholders on public private partnership and thereafter establish coordinating committees for this at the state, LGA and community levels. Budget lines for the activities of the PPP will be created and the state in collaboration with the identified stakeholders will develop a policy and guideline for implementation of PPP. In addition, joint monitoring activities will be conducted quarterly.

3.7.4.2 To institutionalize a framework for coordination of Development Partners

Development assistance must occur in the context of state developmental priorities for it to be meaningful. In this regard, government in exercising its leadership and stewardship role will establish a health partners coordinating committee which will also be tasked with the

function of putting in place and implementing the modalities for a multi-donor state health sector budget and funds basket. This will ensure that all technical and funding assistance are in alignment with state developmental priorities.

3.7.4.3 To facilitate inter-sectoral collaboration

The permanence of "Health for All" and that inter-sectoral collaboration must be made a force for it was re-affirmed at Riga[7]. Therefore, an inter-sectoral committee which includes all relevant MDAs will be set up at the state level and a framework for its regular meeting created and implemented. For effectiveness of this committee, all relevant MDAs will have their capacity to appreciate health issues built and advocacy will be stepped up to include inter-sectoral collaboration in the state health policy.

7. World Health Organization (1988). *Alma-Ata reaffirmed at Riga.* World Health Organization, Geneva.

3.7.4.4 To engage professional groups

Professional groups are essential for the planning and implementation of many health programmes. They often serve as watchdogs for health policy implementation. It is therefore very important that they are engaged early in the planning, implementation and monitoring and evaluation of health programmes and platforms created for information sharing with them. Their skills in vital health development areas will also be improved through trainings. Advocacy will be stepped up for self-regulation of professional groups on competency-based practice while the membership of various regulatory committees will be reconstituted to include relevant professional groups

3.7.4.5 To engage with communities

An often poorly understood concept is that communities constitute a good resource for health development. Therefore, the capacity of communities to prevent and provide co-management of priority health conditions will be built. The minimum essential service package manual will also be disseminated to community stakeholders on health while the "bill of rights on health" will be produced and widely disseminated to community groups to give a "voice" to consumers of health care services. Simplified indicators on health system performance that can be used at the state, LGA and facility levels will be developed and this will allow communities to monitor their own health system. To promote better community involvement, an annual recognition award will be instituted for LGAs and health facilities with functional community health programmes.

3.7.4.6 To engage with traditional health practitioners

Traditional health practitioners provide care for a sizeable proportion of the population. They are often accessible to the people and cater for their psychological needs. However, their practice is largely unregulated and prone to abuse by charlatans. Government will create and develop a framework based on research for understanding traditional health practice. The capacity of traditional health practitioners will also be built on skills improvement and referral while a monitoring team will be put in place for traditional health practices at State and LGA levels. To maximally benefit from any partnership with the traditional health care providers, government will proactively involve their representatives in health promotion and

planning at the state and LGA levels. However, a legislation to regulate their practice and eliminate false claims advertising by charlatans will be facilitated

3.8 Research for health

3.8.1 Context

Research is still not being appreciated as the driving force for systems improvement. It is often thought of as belonging to the ivory towers. This belief pervades every level of health care delivery in the state. Capacity to translate research into policy or even initiate the process is very poor and the ability to use the findings for decision making is also abysmally low. Currently in the state, there is no ethical review board at the state level. Therefore, a conscious effort must be undertaken to place research in the context of the operational changes needed for systems improvement.

3.8.2 Goal

To utilize research to inform policy, programming, improve health, achieve nationally and internationally health-related development goals and contribute to the global knowledge platform

3.8.3 Strategic objectives

1. To strengthen the stewardship role of governments at all levels for research and knowledge management systems
2. To build institutional capacities to promote, undertake and utilize research for evidence-based policy making in health at all levels
3. To develop a comprehensive repository for health research at all levels (including both public and non-public sectors)
4. To develop, implement and institutionalize health research communication strategies at all levels

3.8.4 Interventions

To strengthen the stewardship role of governments at all levels for research and knowledge management systems

3.8.4.1 To develop health research policies at State levels and health research strategies at State and LGA levels

The state will develop a state health research policy based on national guidelines and a health research steering committee set up at state level to oversee its implementation. It will also be important to include research for health in the revision of the state health policy

3.8.4.2 To establish and or strengthen mechanisms for health research at all levels

In strengthening the mechanism for health research, the existing health research division and/units at the state and LGA levels will be restructured and linked with the existing HMIS sections. The Enhanced National Health Research guidelines will be adopted and implemented while the capacity of health staff at State and LGA levels will be built on research.

3.8.4.3 To institutionalize processes for setting health research agenda and priorities
To institutionalize health research at all levels, budget lines will be created for research at the State and LGA levels and guidelines developed for a collaborative research agenda involving ministry of health and its related agencies and boards, LGAs and research institutions. Guidelines for incorporating operational research into annual monitoring and evaluation plans will also be developed and implemented.

3.8.4.4 To promote cooperation and collaboration between Ministries of Health and LGA health authorities with research institutions, communities, CSOs, NIMR, development partners and other sectors
Promotion of cooperation is essential for collaborative research efforts. In this regard, a collaborative research committee will be set up among research users (SMoH, LGA, CSOs, OPS). For this committee to function effectively; an appropriate framework will be developed for its workings and the terms of reference and functions specified. The convocation of an annual multi-stakeholders forum to identify research priorities will also be done.

3.8.4.5 To mobilise adequate financial resources to support health research at all levels
Direct budget lines for health research activities will be created and advocacy stepped up to bring about an adoption and implementation of the recommendation of African governments on funding of health research i.e., setting aside of at least 2% of health budget for health research. To increase the funding for research activities, research funding organizations will be identified and partnerships built with them.

3.8.4.6 To establish ethical standards and practice codes for health research at all levels
At present, no ethical review committee exists at the state level. This will be set up as a matter of priority and linked with the establishment of a monitoring and evaluation sub-committee to oversee health research implementation. Tools will be developed for monitoring and evaluation of research implementation and a feedback mechanism put in place for health research activities. It is expected that the newly established ethical review committee will meet at least quarterly.

To build institutional capacities to promote, undertake and utilise research for evidence-based policy making in health at all levels

3.8.4.7 To strengthen identified health research institutions at state level
To bring about an expanded research capability in the state, an annual inventory of health research institutions and research partnering organizations will need to be done and their research capacity assessed to identify gaps, weaknesses and training needs.

3.8.4.8 To create a critical mass of health researchers at all levels
A critical mass of health workers with good understanding of research will have to be created in order for research to have its desired effect. This will be brought about by training and retraining health workers on operational research at every level and creating advanced studentship opportunities like masters and PhD and fellowships to eligible health workers. Grants will also be created for research annually at state level.

3.8.4.9 To develop transparent approaches for using research findings to aid evidence-based policy making at all levels

For research to be meaningful, it has to be translated to policy. A technical working committee will be established to bring about the realization of this objective. This committee's work will be facilitated by a designated officer who shall act as liaison between researchers and policy makers. This designated officer will be trained on the process of getting research into policy.

3.8.4.10 To undertake research on identified critical priority areas

The state will need to facilitate the technical working committees to identify critical priority areas where research can be done to have deeper understanding. The results of these researches will be disseminated to stakeholders to engender good personal and corporate decision making.

To develop a comprehensive repository for health research at all levels (including both public and non-public sectors)

3.8.4.11 To develop strategies for getting research findings into strategies and practices

To further entrench the culture of using research findings to inform policy directions, a "Getting Research into Strategies and Practice" (GRISP) unit will be established within the planning research and statistic department of the State Ministry of Health. This unit will be overseen by the designated officer acting as liaison between researchers and policy makers and will be charged with organizing biannual "translating health research into policy" forum.

3.8.4.12 To enshrine mechanisms to ensure that funded researches produce new knowledge required to improve the health system

For systems improvement, a forum will be established for effective collaboration and sharing of experiences on operational research. A mechanism will also be put in place to make operational research part of the M&E plans within the private and public sectors.

To develop, implement and institutionalize health research communication strategies at all levels

3.8.4.13 To create a framework for sharing research knowledge and its applications

For knowledge from research to be useful, it has to be shared and lessons learnt discussed interactively. This will be brought about by creating a forum for sharing research knowledge biannual using appropriate methods of engagement and collaboration. Other avenues like participation of health workers at national, regional and international conferences will be largely encouraged and sponsored to harness best practices for health.

3.8.4.14 To establish channels for sharing of research findings between researchers, policy makers and development practitioners

Research findings must transcend the realms of being largely archival in nature; it must inform policy and decision making. For this to happen, those who are likely to be in need of findings of research must have access to them. Therefore appropriate linkages will be established between editors of national and international journals, reputable publishers and international collaborators. In addition, state bulletins and research synopsis will be widely disseminated through the website of the State Ministry of Health and other media.

CHAPTER 4: Resource Requirements

4.1. Human resource

The health resource requirement of the state has not been fully met. There are still critical areas needing systematic manpower development and recruitment. It is expected that where gaps are evident, the training institutions in the state will be strengthened to provide the right mix of human resource for health.

Allocative inefficiency exists in the health sector and this also translates to the distribution of health workers. The three quarter rule operates where ¾ of the human and other health resource are available at the urban level while ¾ of the populace live in the rural area. This inequity is sometimes borne out of political exigencies and non-adherence to the guidelines on minimum compliment of staffing for health service delivery.

Data from the planning research and statistics department shows that there are 192 doctors, 20 dental surgeons, 37 pharmacists, 1041 nurses and 31 consultants working in Ekiti State. This translates to 7 doctors/100,000 population, 1 dental surgeon/100,000 population, 1 medical consultant/100,000 population, 1 pharmacist/100,000 population and, 40 nurses or midwives/100,000 population. This compliment of professionals is far below the WHO recommended standard. Thus it is evident that to provide the minimum compliment of staff for qualitative health care delivery in Ekiti State, Government will need to proactively attract the right mix of professionally competent health workers through motivational packages that also includes PHC workers. In addition, guidelines will need to be put in place for the effective use of these officers through task analysis and shifting. The community provides a veritable resource for the transfer of predetermined tasks especially in the area of self care and family support.

4.2 **Physical/Materials**

Rapid health infrastructural development is to be fast tracked to ensure that the populace has access to qualitative specialist and primary care within the state. Many primary health care facilities and some at the secondary health care level will need to be upgraded and renovated to meet the expectations of the populace. A previous assessment by the state in this regard was the basis for the ongoing renovation of 116 health facilities under the "blue health initiative". It is planned that the second phase will take care of other health facilities. Other infrastructural developments that have attracted the attention of government include: the renovation of 20 secondary health facilities and the dental centre with the provision of relevant minimum compliment of equipment, establishment of the eye centre, the building and equipping of a modern diagnostic centre through public private partnership and the infrastructural development of the state university teaching hospital. It is also expected that a quality assurance laboratory and a public health laboratory will be set up. All these development are meant to standardize the provision of secondary and specialized health services as well as ensure access to qualitative health care by the inhabitants of the state.

4.3 Financial requirements

The operability of the Ekiti State Strategic Health Development Plan will require identification and mobilization of multiple sources of funding. The health system of the state is still in its infancy and thus will need a large initial financial outlay. The poor will need to be protected from catastrophic spending on health while some initiatives will need to be scaled up. Providing the framework for guaranteeing these will task both the resources as well as the capacity of the health care system. Therefore, there will be a need for pluralistic approaches which recognizes the right of the people to decide their health and development priorities and the means of achieving these. A valid fear of government and other funding agencies is that giving a voice to the people might impede the efficiency of the system. On the contrary, choice allows responsiveness and appropriateness of service while ushering in transparency and accountability[8]. Sources of funding to bring about a turn around in the health systems will include: federal, state and local governments; the community through innovative financing options; public-private partnership; NHIS; social insurance; developmental partners like WHO and UNICEF; and self help initiatives.

CHAPTER 5: Financing plan

5.1 Estimated cost of the strategic orientations

It is estimated that the total cost of the strategies documented over the six year period will amount to Forty one billion, seven hundred and eighty nine thousand, two hundred and sixty three naira (₦ 41,789,988,263). The details are as provided in the planning tool.

Table 2: Breakdown of cost by thematic area

S/N	Thematic areas	Cost
1.	LEADERSHIP AND GOVERNANCE FOR HEALTH	34,892,522
2.	HEALTH SERVICE DELIVERY	26,908,918,080
3.	HUMAN RESOURCES FOR HEALTH	1,748,509,477
4.	FINANCING FOR HEALTH	12,824,462,762
5.	NATIONAL HEALTH INFORMATION SYSTEM	74,305,793
6.	COMMUNITY PARTICIPATION AND OWNERSHIP	35,785,475
7.	PARTNERSHIPS FOR HEALTH	32,502,952
8.	RESEARCH FOR HEALTH	130,611,201
9.	TOTAL	41,789,988,263

5.2 Assessment of available and projected funds

The five year trend of health budgeting is as shown on the next page

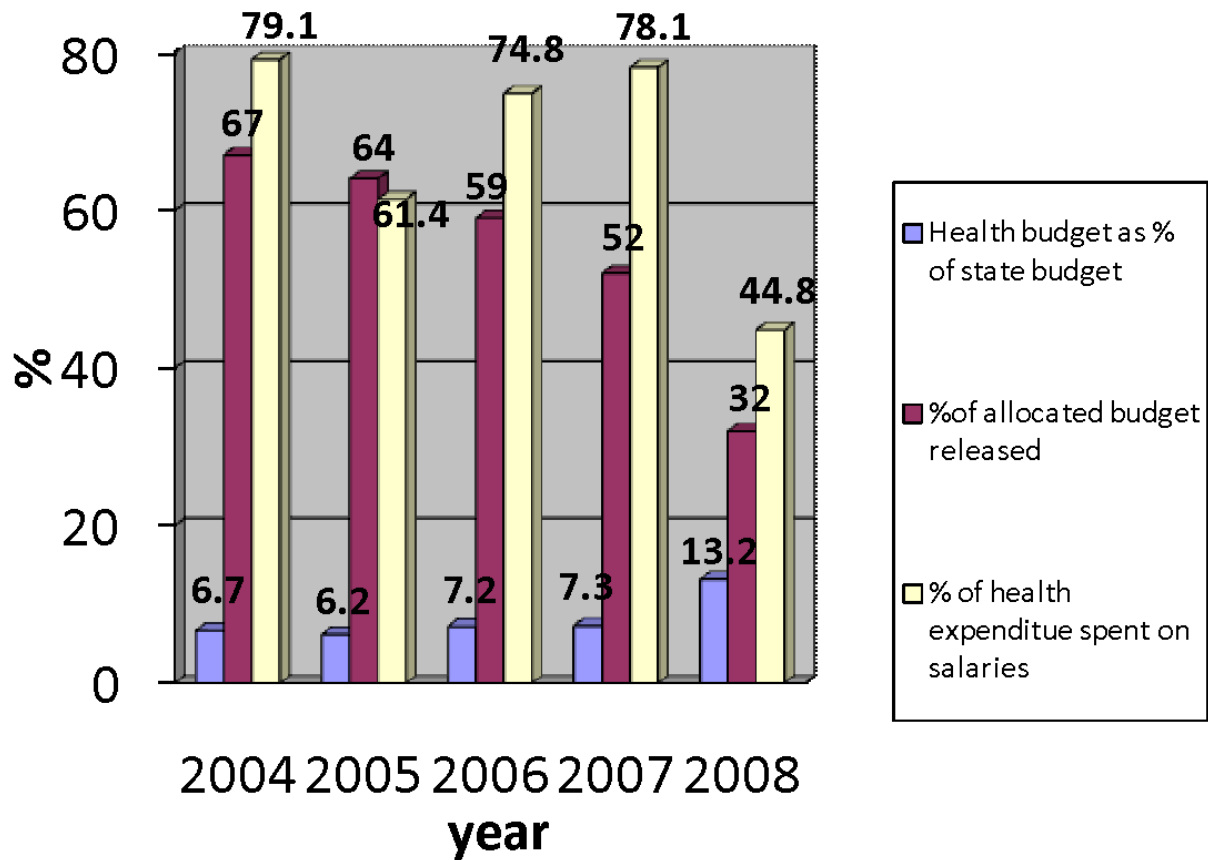
s/n	Line item	2004	2005	2006	2007	2008	*2009
1.	State Budget	16,994,368,370.00	20,954,415,902.00	26,196,908,839.68	36,253,154,812.78	81,428,834,960.14	52,104,812,489.35
2.	Amount allocated to health	1,139,120,898.00	1,289,008,663.00	1,895,008,663.00	2,657,601,444.00	10,756,190,090.00	3,436,561,864.00
3.	Government health expenditure (capital)	60,086,995.00	63,144,000.00	202,679,000.00	212,968,535.00	1,881,634,230.99	1,161,357,421.59
4.	Government health expenditure (recurrent)	702,753,000.00	761,514,000.00	920,300,000.00	1,177,940,021.00	1,611,477,199.09	1,121,596,188.94
5.	Total expenditure borne by developmental partners	101,674,000.00	307,968,000.00	337,458,529.00	129,695,577.00	946,718,921.00	2,774,485,363.25
6.	Total health expenditure	864,513,995.00	1,132,626,000.00	1,460,437,529.00	1,520,604,133.00	4,439,830,351.08	5,057,438,973.78

Table 2: Five years trend of health financing in Ekiti State

*Financial year 2009 has not ended. So the budget for the year is only presented to reflect the current situation

The total available/projected funding for the period 2010-2015 for the state is NGN 28,980,043,878.88. This is based on a simple linear trend plot of the historical total health expenditure, with additional 5% inflation increase annually.

Figure1: Trend of health care expenditure in Ekiti State

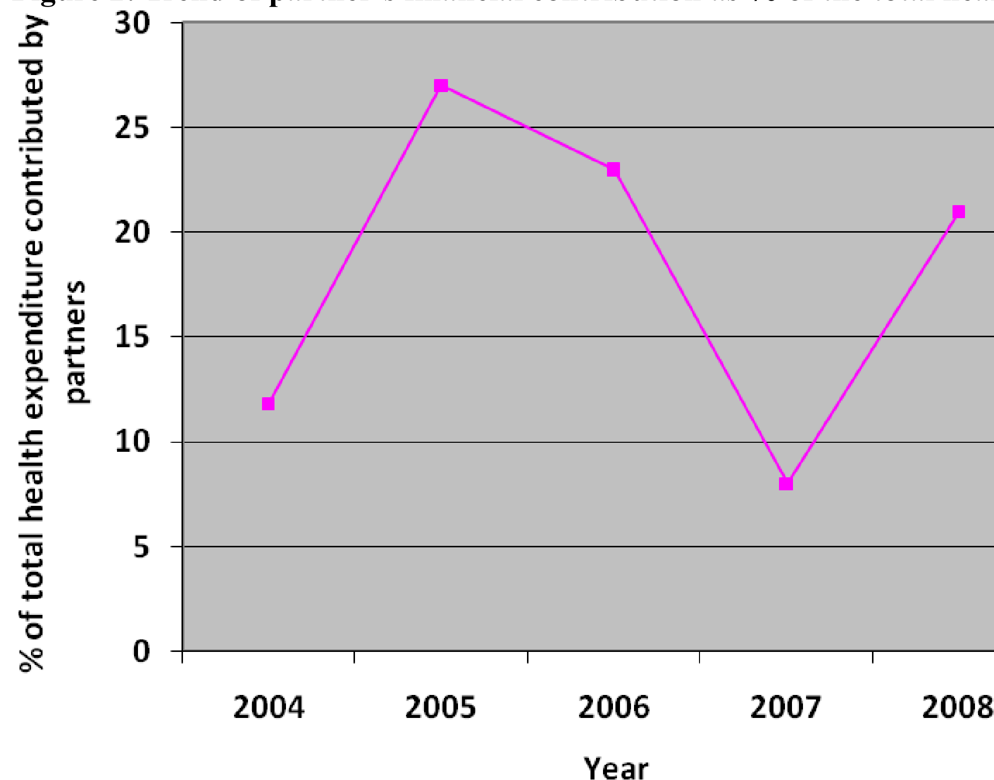


5.3. **Financing gap analysis**

With an available/projected funding of NGN28,980,043,878.88, the finance gap is NGN12,809.944,384.12 over the planning period, 2010-2015.

While this simple funding gap analysis gives a composite picture of the financing needs, it doesn't reflect developmental partners spending as a percentage of the total health expenditure over the years.

Figure 2: Trend of partner's financial contribution as % of the total health expenditure



5.4 **Closing the financing gap**

The capacity to effectively and efficiently mobilize and manage the scarce financial resources available for health care has always been sub-optimal in Nigeria. Quite often, the consumer is left at the receiving end of catastrophic health spending occasioned by many real and subtle "out-of-pocket" expenses. There are many competing needs at federal, state and local levels which often makes it difficult for health planners to get the maximum cooperation needed from government. More depressing is the apparent lack of interest by local government chairmen to adequately fund health programmes believing (albeit erroneously) that health is a "give and give" sector with little or no added value in the political arena. The situation will definitely task the ability of the health planner to respond, thus requiring polyvalent skills in the area of health financing, advocacy and resource mobilization. Therefore, only by embracing affordable contributory and innovative financing options could the expectations and targets for health care financing be met. This will not happen in an environment of poor accountability and transparency. Collaborators and governments need to have evidence of effective and efficient use of funds before committing more of the already depleted finances.

Based on historical analysis and projections, it is expected that the funding gaps identified in this document will be addressed through the following:

1. Scaling up and efficient management of the UDRF at all levels
2. Implementation of the National Health Insurance scheme
3. Implementation of the Social Health Insurance scheme

4. Dogged pursuit of public-private partnership
5. Community financing options such as deferment and exemption, linkage of health finance advocacy with "community day" celebrations, e.t.c.,.
6. Linkage of community development associations and committees with external sources of funding to reduce over dependence on government funding i.e., Japan developmental small projects award
7. Creation of a platform for coordination of external funding

Mutual partnerships with previous developmental bodies who have contributed to the development of the health systems and funding of specific programmes in Ekiti State will be explored and a mechanism put in place to ensure donor confidence. These strategies will include:

- Facilitating the formation of health sector watch dog through the civil society organizations
- Strengthening the stewardship role of government
- Development of a costed plan and yearly operational plan
- Capacity building of stakeholders and health workers on financial management and resource mobilization
- Development of guidelines on donor coordination
- Institutionalizing transparent public expenditure review
- Institutionalizing the framework for documenting real cost of health services through the State Health Accounts.

CHAPTER 6: Implementation framework

6.1 Structure

Implementation of this unique strategic health development plan is a collaborative effort that brings together all stakeholders in the health system. It is a shared responsibility premised on the principle of health for all – that is all will work together for health and that people will use the available approaches for better health[9,10] . The State Government through the Ministry of Health will provide the leadership needed to coordinate the activities of these different players. This stewardship has been defined as consisting of three basic tasks.

- Setting an explicit health policy developmental framework, with a clearly defined vision, roles and responsibilities, and performance objectives (deliverables) for short and intermediate periods;
- Exerting influence and ensuring compliance through regulation; and
- Generating intelligence, that is, establishing a reliable data and information base for informed decision-making, monitoring, evaluation and performance assessment.

The Ministry of Health will carry out these responsibilities through its six departments and its related agencies namely: finance and administration department, planning research and statistics department, primary health care and disease control department, hospital services and training department, nursing services department, food, drugs administration and control department; the hospitals management board and the various health manpower training institutions i.e., School of Health Technology, University Teaching Hospital, School of Nursing and the School of

Midwifery; and the recently created State Primary Health Care Development Bureau which was created in keeping with national guidelines to coordinate and fast track primary health care development at the local government level.

Various stakeholders at the state, local government and community levels are also expected to be involved at the implementation and evaluation stages just like their involvement at the planning stage. The collaborative roles and responsibilities of these different stakeholders will be streamlined. These stakeholders include:

- Health ministry
- Other relevant MDAs needs to be explicitly listed
- Civil society organizations
- Professional bodies and associations
- Health regulatory organs
- Community based developmental organizations
- Non governmental organizations
- Trade group organizations
- Women and youth organizations
- Consumer protection and civil rights groups
- International development organizations
- Religious bodies and organizations
- Traditional leaders

- Community leaders and gatekeepers
- Traditional medicine practitioners
- Health workers
- The political class

For implementation effectiveness and efficiency, stakeholders will be aggregated along the lines of state, local and community structures.

6.2 Expected roles and responsibilities

Coordination of stakeholders input is critical to the success of the state SHDP. The health system is evidenced by blurring roles of stakeholders as well as poorly defined and overlapping functions. Furthermore there is a lack of interface between the private and public sectors with the resultant effect of seemingly parallel health systems within the same state. It is imperative that government through its regulatory organs clearly define the roles expected of each player in the health sector especially before the commencement of the implementation process. Some of these guidelines already exists but are presented in fragmented and often conflicting frameworks. Therefore one prerequisite for the operationalizing of this strategic plan is to harmonize and update existing guidelines on the roles and responsibilities of different stakeholders in the health sector. Broadly speaking though, the areas of role definitions for implementation will include:

- Resource mobilization
- Implementation of activities
- Quality assurance and improvement
- Budget performance and review
- Community mobilization
- Rights awareness
- Capacity building

In essence, the fulcrum of the implementation strategy will be community participation. Although many use this "magic phrase" in their planning functions, the true meaning had eluded many health care planners and donor organizations who erroneously equate it to the "tokenism" of health interventions. Samuel Paul in defining community participation identified its five components namely.

1. Sharing project costs
2. Sharing project efficiency
3. Increasing project effectiveness
4. Increasing beneficiary capacity
5. Increasing community empowerment

It is envisaged that implementing this strategic plan will transcend the traditional delivery of health care services into the realm of community empowerment and poverty alleviation.

Chapter 7 Monitoring and Evaluation

7.1 Mechanism for monitoring and evaluation

The main objective of the M&E system will be to establish a dynamic system that continuously update the database and monitor the progress towards the agreed targets and objectives. This system will be essential in assuring the public and ourselves of the quality of service we provide as well as serve as a roadmap for quality improvement and achievement of the millennium development goals.

The NHMIS will provide a rich source for the monitoring and evaluation of the strategic plan. Its usefulness will be improved by orientating people to the paradigm shift of "knowledge for action" rather than archival data collection. However, NHMIS alone as currently implemented will not fulfill our M&E needs. It will be supplemented by other sources which provide better access to community and private sector data while the implementation interventions of the SHDP strengthens the NHMIS. Therefore, the effective and efficient implementation of the interventions will be measured using multiple approaches as follows:

- Routine NHMIS returns
- Quarterly and annual reviews of policy implementation (including stakeholders review meetings)
- Representative surveys like demographic health surveys
- Operational research findings
- Household and community surveys
- Professional and regulatory bodies reviews

According to the UNDP office of evaluation, the paradigm shift in evaluation is towards assessing the contributions of various factors to a given development outcome, with such factors including outputs, partnerships, policy advice and dialogue, advocacy and brokering/coordination[13]. Thus the strategic plan takes into consideration the key performance indicators as objective measurements of progress. Therefore in broad terms, the indicators identified for this strategic plan as in annex expects that:

- 100% of M&E tools will be standardized by end of 2012
- 80% of all planned activities as contained in the State Strategic plan being implemented will be monitored and periodically evaluated.
- 100% feedback to data generators, health planners and communities
- All relevant programme officers at state level and 60% of LGAs will collect, analyse and interpret their generated data by 2012
- Transparency in data dissemination and documentation
- All intervention programmes will have quantifiable involvement of civil society groups and communities at all stage

M&E capacity

State level: HMIS staff, M&E officer, Epidemiology unit staff, Specific Programme Officers, CSOs

LGA: MOH, M&E officer, health facility heads, community level committee members, CSOs

1.1 Costing Resource Requirements for SHDP M&E Framework

Detailed costing of the relevant portions of the M&E component is as shown in the expanded logframe. However, the core components are:

To improve data collection and transmission	16,480,838
To monitor and evaluate the NHMIS	49,280,564
To strengthen analysis of data and dissemination of health information	3,813,919
To strengthen sub-systems in the Health Information System	4,416,548
To provide infrastructural support and ICT of health databases and staff training	2,142,424

For the 6 years under reference, the following are expected:

Monitoring

Monitoring at LGA@ N5, 000/Month x 16LGAs x 12months x 6 years	=	5,760,000
Monitoring at State@ N30, 000/ Month x12 months x 6years	=	2,160,000
Integrated Supportive Supervision to 16 LGAs	=	3,988,117
Evaluation for the six years	=	52,958,473
Ekiti household health survey	=	4,405,235

Chapter 8: Conclusion

The Ekiti State Strategic Health Development builds on the previous attempts to reform the health systems in the state. Many partners (including Partnership for Transforming Health Systems) have played notable roles in this regard. The selection of the intervention was based on the situation analysis of the health system and the feasibility of carrying out the identified interventions in a cost effective manner.

The process of developing the strategic plan was very rigorous with full participation of all stakeholders and community groups. It is expected the participation of these stakeholders would not stop at only the development stage but as highlighted in the plan would involve the implementation and dogged monitoring and evaluation of the progress made towards achieving the targets set out in the document.

The plan sets broad outlines which if followed carefully will lead to an improvement in the health system of the state. The plan lays great emphasis on the creation of a critical mass of middle level management staffs that are knowledgeable enough and possess the requisite technical and leadership skills to drive the developmental approach employed.

A lot of emphasis is also laid on actively learning from experience and building on the achievements of the past. It is hoped that the actualization of this plan will serve as a recipe for giant strides in the health development of the state. Mid-term evaluations will ensure that we are still on track and government will ensure that it exercises its stewardship role in a transparent way.

Annex 1: Participants for development of the Strategic Plan

Steering Committee Members

Dr. Femi Thomas	-	Hon. Commissioner for Health (Chairman)
Dr. Mrs. Omobolanle Fakule	-	Permanent Secretary, MoH
Mr. Femi Ojo	-	Hon. Commissioner Ministry of Local Government & Culture
Mr Akin Osho	-	Rep Hon .Comm for Finance &E.Plann
Dr. A.O. Adebiyi	**-**	**External Consultant (FMOH/WHO)**

Chairmen of all Local Government Areas represented by:

i.	Prince Sanmi Olubumo	-	Chairman ALGON
ii.	Chief Mrs. Tosin Aluko		
iii.	Hon. Obafemi Falayi		
iv.	Mrs. Modupe Ola	-	Representative of State House of Assembly

All Directors in the State Ministry of Health:

i.	Dr. Joshua Ileke	-	Director PRS,
ii.	Dr. F. R Ibikunle	-	Director PHC
iii.	Dr. D.K. Aina	-	Director Hospital Services
iv.	Mr. Gbenga Faseluka	-	DFA,
v.	Dr. (Mrs.) Mary Adeyanju	-	Director DNS
vi.	Pharm. l. Bamisaye	-	Director Pharmaceutical Service
vii.	Dr. Dare Ojo	-	Executive Secretary, State PHCD Bureau
viii.	Dr. Sola Babalola	-	Chairman, Hospital Management Board
ix.	Dr Adedapo Tade	-	Representative of Private Medical Practitioners

Representative of all Medical and Health Professional Groups in the State:

i.	Dr Ade Ojo	-	NMA
ii.	Pharm. Onuoha James	-	PSN
iii.	Mrs. O. O. Oyewole	-	NANNM
iv.	Mr. Ojo A. Abiodun	-	Medical Lab Scientist
v.	Comrade Kayode Agbaje Ola	-	Medical and health workers union
vi.	Rev. Emmanuel Olajide	-	National Association of Community Health Practitioners

Traditional and Religious Leaders:

i.	HRM. Oba (Dr.) E. Aladejare	-	Alaaye of Efon Alaaye
ii.	Ven. Joseph Ariyo Agbaje		
iii.	Bishop M. O. Fagun		
iv.	Alhaji I. O. Owoseni		
v.	Mrs. Lola Ologuntoye	-	Other related MDAs

State Planning Team

1. Dr. Mrs. Omombolanle Fakunle - Permanent Secretary SMOH, (Chairperson)
2. Dr. Joshua Ileke - Director Planning Research and Statistics
3. Dr. A.O. Adebiyi - External Consultant (FMOH/WHO)
4. Rev. E. A Adewale - Deputy Director DPR&S
5. Dr. D. K. Aina - Director Medical and Hospital Services
6. Pharm E. I. Bamisaye – Director Pharmaceutical Services -
7. Dr. Mrs. Mary Adeyanju - Director Nursing Services
8. Dr.Mrs.Folakemi Olomojobi - HSDP II
9. Dr. Clara Akele - WHO Ekiti State Coordinator
10. Mrs. A.O Ogunlaja - WHO, Ekiti State
11. Mrs. Olalotiti-Lawal - UNICEF, Ekiti State
12. Mr. Ayodeji Ajibola - Director Finance and Accounts
13. Dr. F. R. Ibikunle - Director PHC and DC
14. Mr. Gbenga Faseluka - Director of Administration
15. Dr. Sola Babalola Chairman/CEO - HMB
16. Mr. Akin Osho - Representative of State Ministry of Finance (Budget Office)
17. Mr. Tewogbola - Representative of Economic Planning
18. Mr. S. M. Ajayi - Director of Personnel, LGSC
19. Dr. Dare Ojo - Executive Secretary State PHCD Bureau
20. Rep. of Chieftaincy Affairs – Mrs. Peju Babafemi
21. Representative of NMA - Dr. Dare Ojo
22. RepresentativePSN Pharm. - Onuoha James
23. RepresentativeNANNM - Mrs. O. O. Oyewole
24. RepresentativeMedical Lab. Scientists - Mr. O. O. Adebo
25. RepresentativeMedical and Health Workers Union - Comrade Agbajeola
26. Rep of National Ass. of Com. Health Practitioners – Mrs. Ajibulu
27. Representativeof Association of Practitioners - Dr. Adedapo Tade
28. Rep of Private Nurses Association - Comrade Lawrence Adu
29. RepresentativeAssociation of Pharmacists - Pharm. Onuoha James
30. Representativeof Civil Society Organizations - Mr. D. O. Benson
31. of Teaching Hospital and FMC in the State - Dr. Patrick Adigun
32. Representativeof Academia - Dr. C. T. Oluwadare
33. Rep Ass of Medical Officers of Health in Nigeria - Dr. Akeju
34. Rep Ass Medical Officers of Health in Nigeria - Dr. S.O Oluwafemi
35. Representative of Non Governmental Organizations - Kazeem Balogun

Annex 2: Details of Ekiti State Strategic Health Development Plan

EKITI STATE STRATEGIC HEALTH DEVELOPMENT PLAN				
PRIORITY				
Goals		**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**ESTIMATED COST 2010-2015**
	Strategic Objectives	**Targets**		
	Interventions	**Indicators**		
	Activities	**None**		
LEADERSHIP AND GOVERNANCE FOR HEALTH				
1. To create and sustain an enabling environment for the delivery of quality health care and development in Nigeria				**34,892,522**
1	**To provide clear policy directions for health development**	**All stakeholders are informed regarding health development policy directives by 2011**		**9,360,751**
1.1.1	Improved capacity for health policy development	1. Revised Ekiti State Health policy approved by State EXCO by end of 2010 2. Major stakeholders at state and LGA levels are informed about the state health policy by end of 2011		**3,632,581**
1.1.1.1	Build capacity of stake holders on health policy development and analysis at state and LGA levels.		Availability of funds	1,358,694
1.1.1.2	Participatory review,adaptation of MNCH policies and update of draft Ekiti State Health Policy.			1,417,592
1.1.1.3	Initiate mechanism for signing draft health policy into law			45,647
1.1.1.4	Produce and circulate approved policy to stakeholders	No of health policy document produced and distributed by end of 2011		810,647
1.1.2	Improve strategic planning at State and Local Government level	1. All LGAs have a costed plan by 2011 and a health research unit by end 2010 2. All programme officers at state level and at least 80% of LGAs initiate review of their strategic plans by 2nd quarter of 2013		**5,728,171**
1.1.2.1	Build capacity of M&E Officers,Programme officers and Medical Officer of Health to oversee Planning,Research & Statistics activities at the LGA Level	All medical officers of health and M&E officers trained on PR&S implementation by 2011		925,176
1.1.2.2	Build capacity of stakeholders on stategic planning,monitoring and evaluation at state,Local Government and community level			839,111
1.1.2.3	Produce and circulate strategic plans to all stakeholders			636,111

			1.1.2.4	Conduct mid-term review of strategic plans at State and Local Government annual review at the community level.			2,514,294
			1.1.2.5	Support LGA's in the development of evidence-based, costed and prioritized health plans.			813,479
	1	**To facilitate legislation and a regulatory framework for health development**			**Health Bill signed into law by end of 2012**		**3,506,461**
		1.2.1	Strengthen regulatory functions of government		1. Availability of guiding law on standard of health care by 2012 2. Availability of Ekiti State public health law by 2013		**3,506,461**
			1.2.1.1	Harmonize existing rules and regulation on standard of health care for passage into law.			824,196
			1.2.1.2	Facilitate passage of law on regulation of standard of health care.		Willingness of state assembly members	111,588
			1.2.1.3	Print and distribute laws on regulation of standard of health care			671,588
			1.2.1.4	Develop and facilitate passage of Ekiti State public health law in concert with the national Public health Law.			1,899,088
	1	**To strengthen accountability, transparency and responsiveness of the national health system**			**Active health sector 'watch dog' available at state and 80% of LGAs by 2013**		**7,759,271**
		1.3.1	To improve accountability and transparency		1. Coalition of health sector advocacy group formed by 2012 2. 80% of health projects and programmes actively monitored by beneficiary communities by 2012		**7,759,271**
			1.3.1.1	Expand composition of members of State Council on Health to include relevant stakeholders in health.	Publish statutory list of the composition of State and LG council on Health by 2010.	Willingness of stakeholders to participate	7,647
			1.3.1.2	Establish LGA Health Forum to include relevant Stakeholders.			419,447
			1.3.1.3	Establish and implement mechanism for quarterly stakeholders joint review meeting on health at State,LGA and community levels	80% of scheduled stakeholders joint meeting held as planned		5,085,883
			1.3.1.4	Facilitate the coalition of Health Sector Advocacy Group as a watch dog.		continued presence in the state of specific CSOs involved in Advocacy group	930,647
			1.3.1.5	Empower beneficiary communities to provide oversight functions for health projects and programmes.			1,315,647
	1	**To enhance the performance of the national health system**			**1. The State and 50% of LGAs updating SHDP annually** **2. The State and 60% of LGAs with**		**14,266,039**

					costed SHDP by end 2011		
		1.4.1	Improving and maintaining Sectoral Information base to enhance performance		1. 60% of LGAs carrying out an assessment of their health system performance by end of 2011. 2. Availability of an assessment of the performance of the Ekiti state health system by 2012		**5,750,470**
			1.4.1.1	Build capacity of health managers at State and Local Government level on data management			436,064
			1.4.1.2	Build capacity to measure performance of the health system in the state			180,562
			1.4.1.3	Review guidelines for health care services.			720,962
			1.4.1.4	Create an expanded platform for information sharing			7,647
			1.4.1.5	Outsource the conduct of Ekiti household health survey	Document on Ekiti household health survey available by end of 2013	Availability of funds	4,405,235
		1.4.2	Develop leadership for Health at the LGA Level.		1. All LGAs submitting an annual report of the medical officers of health by 2012 2. 60% of middle and senior level PHC management with capacity built on leadership and management by 2011		**8,515,569**
			1.4.2.1	Develop clear guidelines and job description for PHC level officers including Medical Officers of Health based on NPHCDA guidelines.	Availability of job description document for PHC staff by end of 2010	Assent to law setting up State PHCDA	88,196
			1.4.2.2	Establish forum for review of the annual report of the Medical Officer of Health and operational plan for the next year.	100% of LGA annual reports reviewed.		4,822,177
			1.4.2.3	Build capacity of middle and senior level PHC management staff on leadership and management			3,605,196
HEALTH SERVICE DELIVERY							
2. To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare							**19,751,319,080**
	2	**To ensure universal access to an essential package of care**			**Essential Package of Care adopted by all LGAs by 2011**		**14,238,225,341**
		2.1.1	Essential health service package		1. Costed minimum package of health care available for all levels of health care by 2011 2. Availability of clear protocols on service delivery in 60% of LGA facilities and 80% of state facilities by 2011		**6,061,102,656**
			2.1.1.1	Review,cost,disseminate and implement the minimum package of care for Essential Health		**"Buy in" by political class**	6,002,073,294

				System and service package in an integrated manner at all levels of Health care.			
			2.1.1.2	Make Standard Operating Procedures (SOPs) and guidelines available for delivery of services at all levels			382,489
			2.1.1.3	Institutionalize "Ekiti personalized health service" package through the ESSP delivery	**60% of communities (by wards) with access to personalized health service by 2012**	**Adequate recruitment of health workforce**	57,029,089
			2.1.1.4	Strengthen management capacities of programme managers of high burden non communicable and communicable diseases			1,090,489
			2.1.1.5	Provide service protocols and case management guidelines at Primary and Secondary Health facilities for priority diseases on MNCH, communicable and non -communicableetc.	**% of health facilities using Service protocols and case management guidelines.**		527,294
		2.1.2	To strengthen specific non communicable and communicable disease control programmes including NTDs		1. 60% of children under 5 sleeping under ITNs by 2011 and 80% of pregnant women with access to IPT 2. 80% of elligible people in endemic communities with access to NTD drugs by end of 2010		**6,090,560,578**
			2.1.2.1	Identify and implement strategies for effective mass distibution of drugs for NTDs like onchocerciasis, lymphatic filariasis, schistosomiasis and soil transmitted helminths		**Adequate donation of ivermectin, praziquantel and mebendazole by donor agencies**	6,893,173
			2.1.2.2	Establish and implement framework for effective distribution of ITNs to vulnerable groups and households and scaling up of ACT and IPT use			4,852,782
			2.1.2.3	Conduct water mapping and implement safe water projects			6,003,793,175
			2.1.2.4	Carry out risk behaviour awareness and monitoring for communicable and non communicable disease			2,380,959
			2.1.2.5	Strengthen laboratory component of the disease control programme	**Availability of a functional state public health laboratory by 2011**		72,640,489
		2.1.3	To establish mechanism for continuum of care		1. Essential package of child and maternal health interventions available in 80% of health facilities by 2012 2. 50% of LGAs have initiated TB/HIV collaborative actives by 2012		**2,086,562,107**
			2.1.3.1	Provide a minimum package of MNCH services in all health facilities in the state		**Political goodwill at local government level**	1,906,160,173
			2.1.3.2	Build capacity of health workers on priority MNCH interventions e.g., LSS,MLSS, EMOC, FP, Nutrition,IMCI, Malaria, HIV/AIDS e.t.c.,			11,513,489

			2.1.3.3	Institutionalise provision of appropriate health care services and interventions in occupational settings	**20% of registered trade groups and industries linked to occupational health services by 2011**		3,875,460
			2.1.3.4	Strengthen TB/HIV collaborative activities including scaling up of VCT services within public and private sector	**50% of public and 20% of private health facilities offering VCT services by end of 2011**		95,585,936
			2.1.3.5	Establish mechanism for continuity in access to a package of ARV treatment and care and support by PLWHA		**Federal government's continued support for ARV procurement**	69,427,049
	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**		**469,590,903**
		2.2.1	To improve geographical equity and access to health services		1. 60% of facilities with the minimum compliment of appropriate staff by 2011 2. 80% of wards in each LGA implementing the minimum ward package by 2012		**331,712,215**
			2.2.1.1	Map and link health facilities to human resource availability.	**50% of Health facilities have the required human resource prescribed by the end of 2012.**		162,928
			2.2.1.2	Develop and implement guidelines for siting of new health facilities	**80% of Ekiti State public health facilities sited according to the guidelines by 2012.**		367,647
			2.2.1.3	Institutitionalise a "minimum ward health package" including Reaching Every Ward(REW)for MNCH services and social mobilization, et.c.,	**% coverage of specific health interventions at the ward level e.g., immunization coverage**	**LGA support for ward package**	7,679,784
			2.2.1.4	Improve accessibility, quality and utilization of essential obsttetric care (EOC) services	**Geographical spread of BEOC and CEOC facilities**	**Readiness of community to use services**	37,416,928
			2.2.1.5	Establish motivational package for workers in rural and under-served areas of the state.	**60% of staff working in rural and underserved areas receiving refurbishing loan/advance by 2013**	**Political goodwill**	286,084,928
		2.2.2	To ensure availability of drugs and equipment at all levels		1. 0% out of stock syndrome by 2014 All public health facilities and 80% of private health facilities covered by		**65,145,151**

					the UDRF by 2012 2. 50% of public health facilities with capacity to use the M supply inventory system by end of 2012		
			2.2.2.1	Review and strengthen performance of the unified drug revolving fund	**30% Increase turnover by 2010 and consequent yearly % increase to attain 500 million naira annual turnover by 2015.**	**Retention of staff**	1,257,196
			2.2.2.2	Expand the use of "M supply" inventory system and include MNCH commodities (Contraceptives,Magnesium sulphate and Misoprotol) in the inventory system	**3 extra licenses purchased by 2010 and reduce waiting time by 50% by 2011.**		5,810,196
			2.2.2.3	Build capacity of all stakeholders on DRF and its sub-systems	**1. 25% of technical staff attend National/International training. 2. 75% improvement in the yearly quality management report by 2010.**		4,801,353
			2.2.2.4	Increase capitalisation of UDRF for extension to more private health facilities	**25 million yearly increase to the CMS from 2011 through 2013.**	**Government support**	27,245,883
			2.2.2.5	Standardize and upgrade drug warehousing to include provision of metal shelving e.t.c.,	**Purchase and installation of metal shelves and MHE by end of 2011.**		26,030,523
		2.2.3	To establish a system for the maintenance of equipment at all levels		1. Medical equipment and maintenance workshop established by 2013. 2. 50% of LGA health departments and 60% of secondary health facilities with budget lines for maintenance of medical equipments by end of 2012		**32,248,484**
			2.2.3.1	Adapt and implement the National Health Equipment Policy.			112,747
			2.2.3.2	Create budget lines for the maintenance of equipments and furniture at all levels.			26,179
			2.2.3.3	Establish medical equipment and hospital furniture maintenance workshops in the State.			30,030,111
			2.2.3.4	Explore public private partnership in maintenance of medical equipments and hospital furniture.			2,079,447
		2.2.4	To strengthen referral system		1. 80% of all pregnant women has access to emergency obstetric care when needed by 2012		**36,078,144**

					2. 80% of all public health facilities displaying and utilizing their referral linkages by 2012 3 . 50% of referral slips returned		
			2.2.4.1	Develop and implement mechanism for linking PHC centres with support sevices at the secondary and tertiary levels especially for emergency obstetric service			11,767,909
			2.2.4.2	Implement guidelines for two-way referral system system based on national standard.			450,611
			2.2.4.3	Establish and implement mechanism for logistics,transportation and communication for referrals.			20,666,664
			2.2.4.4	Strengthen and scale up the "patient-in transit" scheme	**60% of patients having access to appropriate health care within a few hours of referral by end of 2012**		3,192,960
		2.2.5	To foster collaboration with the private sector		1. 60% of performance monitoring done in conjuction with the private sector 2. 30% of registered private health facilities actively reflected and participating in state health plans by 2011		**4,406,910**
			2.2.5.1	Provide a forum for dialogue with the private sector.			373,696
			2.2.5.2	Mapping of categories of private health care providers by operational level and location.		Initial mapping should have been done in 2010	1,004,088
			2.2.5.3	Develop guidelines and standards for regulation of practice and registration.			465,196
			2.2.5.4	Develop guidelines for partnership, trainning and outsourcing of services.	**Availability of guidelines for private sector collaboration by 2011**		214,447
			2.2.5.5	Joint performance monitoring mechanism for private sectors to be developed and implemented.			2,349,482
	2	**To improve the quality of health care services**			**50% of health facilities participate in a Quality Improvement programme by end of 2012**		**4,978,788,908**
		2.3.1	To strengthen professional regulatory bodies and institutions		1. All health regulatory bodies carrying out regular monitoring and providing quarterly feedback to SMOH by 2011		**51,550,366**
			2.3.1.1	Review, update and implement regulatory guidelines of regulatory bodies.			2,623,494
			2.3.1.2	Build capacity of regulatory staff for compliance monitoring.			652,924

			2.3.1.3	Create budget lines and resource mobilization plans for regulatory functions.			433,294
			2.3.1.4	Establish regular monitoring,documentation and feedback mechanism			1,339,694
			2.3.1.5	Establish a state quality assurance laboratory	State quality assurance laboratory established by 2012	funding availability	46,500,959
		2.3.2	To develop and institutionalise quality assurance models		1. 80% state and 50% LGA yearly facility reports on PCQA documents quantifiable improvement by 2011.		**4,284,865**
			2.3.2.1	Review and build consensus on the adoption of a cost effective Quality Assurance model in conjuntion with professional bodies.			804,196
			2.3.2.2	Entrench quality improvement concept and interventions at all levels.			171,660
			2.3.2.3	Build institutional capacity for servicom implementation at all levels in the state			1,131,755
			2.3.2.4	Conduct community appraisal of disease control activities			2,177,255
		2.3.3	To institutionalize Health Management and Integrated Supportive Supervision (ISS) mechanisms		100% of quarterly ISS reports rendered ,adopted and implemented by management at State and LGA levels by 2011.		**8,719,459**
			2.3.3.1	Review and update guidelines and tools for Integrated Supervision.			95,047
			2.3.3.2	Strengthen mechanism for monthly and quarterly Integrated Supportive Supervision(ISS) at LGA and Sate levels respectively			3,559,470
			2.3.3.3	Strengthen management capacity of Health workers through team building and leadership development programmes.			1,897,647
			2.3.3.4	Institutionalize comprehensive integrated supportive supervision at all levels.		management support	3,167,294
		2.3.4	To improve health infrastructure development		80% of State Health Facilities have the minimum required infrastructure by the year 2012.		**4,914,234,218**
			2.3.4.1	Upgrade and refurbish substandard facilities in the state as being carried out under "blue health" initiative		Continued government commitment	3,340,075,384
			2.3.4.2	Renovate and provide minimum package of equipments for primary secondary health facilities			184,052,979
			2.3.4.3	Procure buses for patient-in transit scheme			140,016,971
			2.3.4.4	Provide an "up to date" diagnostic centre and eye centre			750,050,832
			2.3.4.5	Carry out infrastructural development in the teaching hospital			500,038,052
	2	**To increase demand for health care services**			**Average demand rises to 2 visits per person per annum by end 2011**		**12,909,620**
		2.4.1	To create effective demand for services		50% increase in health facility utilization and		**3,852,800**

					service provision by 2011.		
			2.4.1.1	Adapt communication strategy reflecting local realities based on the National Health Promotion Policy.			1,248,111
			2.4.1.2	Create budget lines for health promotion .			6,357
			2.4.1.3	Establish partnership for key health initiatives like IMNCH, PMCTC, IPT e.t.c.,	Existence of PPP initiatives	Cooperation of all stakeholders	2,598,332
		2.4.2	Promoting positive lifestyles for disease prevention		1. 60% of population adopting healthy lifestyles by 2015		**9,056,821**
			2.4.2.1	Disseminate and implement the State adapted BCC Strategy			941,611
			2.4.2.2	Build capacity for Inter-personal communcation and counselling..			1,237,696
			2.4.2.3	Create mechanism for community driven health promotion initiatives.			149,792
			2.4.2.4	Resuscitate/establish and strengthen comprehensive school health programmes in all schools in the state	50% of schools with functional school health programme by end of 2011	Cooperation of ministry of education	6,727,721
	3	**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**		**51,804,307**
		2.5.1	To improve financial access especially for the vulnerable groups		I. 80% Increased facility utilization of the Deferral and Exemption scheme 2.Community Health Insurance instituited by 2011.		**51,804,307**
			2.5.1.1	Provide and implement guidelines for protection of vulnerable groups against high health care cost			50,409,647
			2.5.1.2	Explore community options for cost deferral and exemption for vulnerable people		functioning facility health committees	555,196
			2.5.1.3	Develop and disseminate clear guidelines for costing of health care services			839,464
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							**4,747,409,477**
	3	**To formulate comprehensive policies and plans for HRH for health development**			**State and LGAs are actively using adaptations of the National HRH policy and Plan by end of 2015**		**1,014,599,981**
		3.1.1	To develop and institutionalize the Human Resources Policy framework		1. Advocacy for and implemenatation of the Health Human Resource policy at State and 80% of LGAs by end of 2010.		**6,193,783**
			3.1.1.1	Adapt and adopt national framework on human resources		political goodwill	854,576
			3.1.1.2	Develop policies to guide existence of Public-Private Practitioners forum.			636,330

			3.1.1.3	Establish forum for Public-Private Practitioners to institutionalize HRH policy reviews, supervision and monitoring framework.			464,350
			3.1.1.4	Develop strategic plan for review of State and LGA human resources needs			1,219,993
			3.1.1.5	Establish and implement guidelines and SOPs for task shifting especially for population based outreaches	Availability of guidelines on task shifting by end of 2012		3,018,535
		3.1.2	Strentghen State PHC Development Agency in Ekiti State		State PHCDA take up all her statutory functions as recommended by NPHCDA by 2010.		**1,008,406,197**
			3.1.2.1	Streamline the functions of state PHCDA in accordance with NPHCDA guidelines		Passage of agency status bill by house of assembly	586,059
			3.1.2.2	Develop mechanism for equitable distribution of PHC allocated fund			704,888
			3.1.2.3	Build managerial skills of state PHCDA staff			1,007,115,250
			3.1.2.4	Build capacity of state PHCDA staff on health systems research including M&E	State PHCDA staff carrying out idependent health rsearch and evaluations by 2013		-
	3	**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**		**2,031,153,795**
		3.2.1	To reappraise the principles of health workforce requirements and recruitment at all levels		1. Availability of revised guideline on health personnel recruitment		**2,031,153,795**
			3.2.1.1	Review existing policies on recruitment and training of health personnel.		Political goodwill	395,693
			3.2.1.2	Create mechanism for regularly accessing, translating and adopting federal government circulars on HRH guidelines and policies			155,449
			3.2.1.3	Strengthen contract scheme for retired skill professionals in areas of need			2,030,100,449
			3.2.1.4	Develop guidelines for assessing staffing needs based on work load, availability of service and developmental priority			502,204
	3	**Strengthen the institutional framework for human resources management practices in the health sector**			**1. Functions of related HRH Units at state level harmonized by end 2010** **2. 10% of LGAs have functional HRH Units by end 2010**		**22,415,795**
		3.3.1	To establish and strengthen the HRH Units		80% of all public Health facilities have the requisite HRH requirements by 2012.		**22,415,795**
			3.3.1.1	Reappraise existing HRH units in the State e.g.HMB,LGSC,SPHCDA,SMOH etc.			556,062
			3.3.1.2	Organise quarterly interactive sessions with other professional groups on HRH issues.			1,079,292

			3.3.1.3	Conduct training and re-orientatation of staff to enhance better job performance.			20,327,492
			3.3.1.4	Incorporate job description and task analysis into HRH guidelines			452,950
	3	**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**			**All major training institution in the state producing health workforce graduates with polyvalent skills and mid-level health workers by 2015**		**123,295,135**
		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		Review of SHT and SON curricula by 2011. Upgrade of SHT by 2011.		**1,901,838**
			3.4.1.1	Facilitate the review of the training curricula of the School of Nursing/Midwifery and School of Health Technology based on current knowledge and state needs.		availability of institutional grant	1,406,869
			3.4.1.2	Upgrade Health Institutions in identified critical fields in Ekiti State.			159,231
			3.4.1.3	Review current training circular to accommodate early opportunities for formal training with bonds and sponsorship			167,304
			3.4.1.4	Advocate for increase in admission quota into health institutions in priority areas of HRH needs			168,435
		3.4.2	To strengthen health workforce training capacity and output based on service demand		1. Achieve 80% retention rate of workers in critical fields by 2012		**75,379,729**
			3.4.2.1	Develop and implement mechanism for identifying and updating human resource needs			114,588
			3.4.2.2	Create and implement guidelines for linkage of sponsorship with bonding to attract professionals in priority areas		Availability of resources	249,847
			3.4.2.3	Establish a performance based financial and training incentives to enhance staff retention			75,015,294
		3.4.3	Strengthening of Quality assurance and education review units		60% of professional bodies with guidelines on continuing education for members by 2013		**46,013,567**
			3.4.3.1	Establish quality assurance and education review units in the state training institutions			292,702
			3.4.3.2	Government collaboration with all professional bodies through registration, licensing, retraining programme and renewal of licenses before promotion	No of professional bodies duely licensed annually by the State Government.	Cooperation of professional bodies	15,136,547
			3.4.3.3	Create opportunities for retraining and refresher courses for teachers in educational institutions	Proportion of teachers of health training institutions undergoing refresher course.		30,045,516
			3.4.3.4	Create platform for Inter institutional collaborations among training centres			154,702
			3.4.3.5	Strengthen the referral system between public and private practice	50% increase in the total No of 2 way referral forms cited annually,from the year 2010.		384,102

	4	**To improve organizational and performance-based management systems for human resources for health**			**Evidence of state Implementation of performance management systems by end 2012**		**1,404,508,678**
		3.5.1	To achieve equitable distribution, right mix of the right quality and quantity of human resources for health		80% of public health facilities have the requisite HHR by end of 2011		**1,279,342,383**
			3.5.1.1	Develop a human resources for Health package based on State needs			228,894
			3.5.1.2	Create and harmonise the existing human resource at LGA, HMB and SPHCA levels			144,290
			3.5.1.3	Provide mechanism for equitable distribution of staff based on verifiable needs			90,062
			3.5.1.4	Mandate posting of NYSC health professionals to underserved LG Areas		Cooperation of NYSC management	1,278,727,647
			3.5.1.5	Develop and implement guidelines for safe and motivating work environment		Political goodwill	151,490
		3.5.2	To establish mechanisms to strengthen and monitor performance of health workers at all levels		1. State and 60% of LGAs carrying out annual performance based evaluations of workers by 2013		**125,166,295**
			3.5.2.2	Re-orientate health workforce on attitudinal charge			33,018,290
			3.5.2.3	Improve interactive personal working relationship through joint seminar and workshops on IPC		Funds availability	84,015,294
			3.5.2.4	Strengthen intergrated monitoring, evaluation, supervision, support and sanction (IMESS&S), Quality Recognition and Reward (QRR), Patient Client (PPRHAA) initiatives at all levels	% of client satisfied with services		5,180,784
			3.5.2.5	Provide feedback on initiatives like PCQA			2,951,927
	4	**To foster partnerships and networks of stakeholders to harness contributions for human resource for health agenda**			**80% of scheduled HRH stakeholder forums held by end 2011**		**151,436,093**
		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		60% of professional bodies regularly participating in joint sessions		**144,683,185**
			3.6.1.1	Strengthen the use of organizational chart at all levels			56,020,930
			3.6.1.2	Promote interactive meetings and dialogue between staff of public and private sector and regulatory bodies	No of joint publi-private sector meetings held	Willingness of private sector practitioners	16,050,981
			3.6.1.3	Promote inter and intra joint professional trainings within all levels of health care delivery			42,550,981
			3.6.1.4	Inclusion of health professionals in the managerial leaderships of LGSC, Civil Service. Commission, LGA etc.			18,007,647
			3.6.1.5	Design and implement health care monitors teams to include member of professional groups			12,052,647
		3.6.2	Strengthening communication, cooperation between health professional associations and Health users		60% improvement in provider performance		**6,752,908**
			3.6.2.1	Create awareness for feedback from clients		Cooperation from community based orbanizations	258,464
			3.6.2.2	Create mechanism for interactive sessions between Health workers and Clients			547,464

			3.6.2.3	Empower mothers/households with adequate knowledge for improving key household and community practices and family health care seeking behaviour	60% of households with adequate health knowledge for self care and family care initiatives		5,946,981
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							**16,983,161,762**
	4	**To develop and implement health financing strategies at Federal, State and Local levels consistent with the National Health Financing Policy**			**State and 50% of LGAs have a documented Health Financing Strategy by end 2012**		**12,633,966**
		4.1.1	To develop and implement evidence-based, costed health financing strategic plans at LGA, State levels in line with the National Health Financing Policy		Technical working groups set up in 80% of LGAs		**3,507,861**
			4.1.1.1	Set up technical working groups for health care financing at State and LGA levels		LGA support	790,529
			4.1.1.2	Build capacity of technical working group members through "hands on" workshops			2,717,333
		4.1.2	Creating mechanism for the development and use of evidence-based costed health financing strategic plans at the State and LGA levels		50% of LGAs with costed health financing plans by 2012		**9,126,104**
			4.1.2.1	Assist LGAs to develop evidence-based costed health financing strategic plans			2,630,855
			4.1.2.2	Develop annual health financing operational plans	Availability of annual health financing operational plans		2,320,132
			4.1.2.3	Undertake annual performance appraisal of health financing plans			4,175,118
	4	**To ensure that people are protected from financial catastrophe and impoverishment as a result of using health services**			**NHIS protects 70% of Ekiti State populace by end 2015**		**16,765,574,455**
		4.2.1	To strengthen systems for financial risk health protection		80% of households protected against catastrophic spending on health by 2013		**4,760,490,343**
			4.2.1.1	Adapt, adopt and implement the NHIS scheme at State and LGA levels		Commitment of government	4,758,720,701
			4.2.1.2	Advocate for and sensitize the public on embracing social health insurance			1,769,642
		4.2.2	Exploring innovative social health protection approaches		Social health protection approaches implemented by all LGAs by 2013		**12,005,084,112**
			4.2.2.1	Build consensus on community-based initiatives on health insurance			2,066,700
			4.2.2.2	Provide training updates to health mangement committes on financing options for the existing deferral and exemption scheme	No of health managemet committees trained		2,828,654
			4.2.2.3	Adapt, adopt and implement the community health insurance scheme	% of health facilities on community health insurance scheme	Community commitment and involvement	12,000,188,759
	4	**To secure a level of funding needed to achieve desired health development goals and objectives at all levels in a sustainable manner**			**Allocated State and LGA health funding increased by an average of 5% pa every year until 2015**		**196,181,121**

		4.3.1	To improve financing of the Health Sector		60% of health care projects and programmes with joint financing mechanism by 2013		**120,772,416**
			4.3.1.1	Engage banks, industries and companies in dialogue on corporate social responsibility as related to health			706,338
			4.3.1.2	Provide incentives for communities willing to participate in partnering for health care funding		Community commmitment	120,066,078
		4.3.2	To improve coordination of donor funding mechanisms		Availability of coordination mechanism		**2,917,038**
			4.3.2.1	Identification and documentation of funding gaps			302,423
			4.3.2.2	Adapt and adopt national guidelines on funding coordination			500,890
			4.3.2.3	Develop and implement guideline for donor collaboration and partnership			1,090,267
			4.3.2.4	Create common platform for monitoring and evaluation of implementation of funding agreements	% of health projects and programmes with joint M&E agreements	Continued support of donors	1,023,459
		4.3.3	To improve government allocation of public resources to the health sector		State and 50% of LGAs allocating 15% of their total budget to health by end of 2012		**72,491,668**
			4.3.3.1	Adoption of Abuja declaration on allocation of at least 15% of total budget to health sector at State and LGA levels		Government commitment	438,473
			4.3.3.2	Set up special funds for epidemic prone and high burden disease priorities as well as Emergency Obsteric care at State and LGA levels	Availability of special fund for priority emergency situations		72,053,194
	4	**To ensure efficiency and equity in the allocation and use of health sector resources at all levels**			**1. State and 60% LGAs have transparent budgeting and financial management systems in place by end of 2015** **2. State and 60% LGAs have supportive supervision and monitoring systems developed and operational by Dec 2012**		**8,772,220**
		4.4.1	To improve health budget execution, monitoring and reporting		State and 40% of LGAs undertaking budget tracking and public expenditure review by end of 2012		**6,130,773**
			4.4.1.1	Build capacity of health staff and CSOs on tracking and analysis of health budget	No of reports on health budget performance	Cooperation of CSOs	1,519,123
			4.4.1.2	Advocate with the State Assembly on institutionalizing public expenditure review		Political goodwill	67,656
			4.4.1.3	Buid capacity for the use of health account information for management and planning in the health sector			2,251,423

			4.4.1.4	Develop a costed annual operational plan for 2010			1,295,259
			4.4.1.5	Advocate and provide technical assistance to LGAs for establishing clear priorities as basis for health expenditure plans	60% of LGAs with health expenditure plans	Willingness of LGA Health Officials	997,311
		4.4.2	To strengthen financial management skills		1. Availability of clear guidelines on health budgeting 2. 50% of LGAs with documented budgeting process for health by 2012		**2,641,448**
			4.4.2.1	Appraise skills and training needs of key health personnel involved in health budgeting and accounting	Report of needs assessment available by end of 2010	Funds availability	417,695
			4.4.2.2	Build capacity of administrative and finance staff on budgeting,auditing and accounting			1,805,291
			4.4.2.3	Carry out supportive supervision of LGA staff on financial management			418,462
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							**74,305,793**
	5	**To improve data collection and transmission**			**1. 50% of LGAs making routine NHMIS returns to State level by end 2010**		**16,480,838**
		5.1.1	To ensure that NHMIS forms are available at all health service delivery points at all levels		State and 80% of LGAs must have vote of charge for printing HIS tools by end of 2010		**5,159,659**
			5.1.1.1	Advocate on creation of budget line for NHMIS	60% of LGAs must have been visited as evidenced by quarterly reports of meetings with relevant authorities	**Available funding**	65,392
			5.1.1.2	Establish mechanism for bi-annual stock taking and redistribution of NHMIS forms			130,270
			5.1.1.3	Establish Health Data Consultative Committee (HDCC) at facility,LGA and State level.	HDCC should have constituted by 80% of facilities at state and 50% of facilities at LGA level by 2nd quarter of 2011	**Requisite data management skills at facility level**	447,394
			5.1.1.4	Initiate joint production and distribution of forms to public and private health facilities biannually			2,454,927
			5.1.1.5	Stregthen mechanism for electronic transfer of data from LGAs to State level	All LGAs to have modem for internet access by 1st quarter of 2011	**Avalability of funds**	2,061,675
		5.1.2	To periodically review of NHMIS data collection forms		By end of 2010 minutes of yearly review meetings are available		**1,600,010**
			5.1.2.1	Hold yearly review meeting on NHMIS tools for input into FMOH reviews			1,064,716
			5.1.2.2	Create mechanism for accomodating endusers feedback on NHMIS forms			535,294
		5.1.3	To coordinate data collection from vertical programmes		By end of 2010, common template for capturing		**710,832**

					programme information available		
			5.1.3.1	Strengthen the existing state harmonization initiative for vertical programmes			375,294
			5.1.3.2	Provide platform for health information sharing and networking between programmes		**State ministry of health website will be functional and all programme offices will connected by a network system**	335,538
		5.1.4	To build capacity of health workers for data management		50% of managers and programme officers should be trained on data use for planning by 2012		**4,109,829**
			5.1.4.1	Organize training and retraining programmes for staff on health data collection at all levels			1,077,143
			5.1.4.2	Develop and implement strategies for encouraging data use for planning and monitoring quality by programme officers			351,143
			5.1.4.3	Develop data quality checklist for self-assessment by health workers	60% of health facilities carrying out data quality assessment by end of 2011	Enabling tools made available by management	2,681,543
		5.1.5	To provide a legal framework for activities of the NHMIS programme		SMOH must have sponsored a bill to SHA on data rendition and regulation by 2nd quarter of 2011		**373,763**
			5.1.5.1	Advocacy to House Committee on Health and other relevant stakeholders to facilitate promulgation of enabling laws/bye laws for mandatory data rendition by private and public health service providers		**Cooperation of SHA**	257,188
			5.1.5.2	Facilitate setting up guidelines regulating the publication of health data/information			116,574
		5.1.6	To improve coverage of data collection		60% of public and 50% of private health facilities analysing and making use of their data for informed decision making by end of 2011		**3,012,244**
			5.1.6.1	Create platform for involving all public and private health facilities in health data collection and monitoring of default in data rendition			213,046
			5.1.6.2	Build data management capacity of public and private health facilities and provide instruments for data management			1,118,758
			5.1.6.3	Empower and train community health workers on collection of community based data	80% of LGAs initiating mechanism for collection of community based data by end of 2012	Political goodwill at the LGA level	1,680,440
		5.1.7	To ensure supportive supervision of data collection at all levels		80% of data generated from state and LGAs of high quality by 20111		**1,514,501**
			5.1.7.1	Institute and implement framework for regular supportive supervisory visits to facilities and LGAs on data quality and feedback		Availability of funds	1,340,976

			5.1.7.2	Develop supervisory checklist for effective supervision	Supervisory checklist available by end of 2010		173,525
	5	**To provide infrastructural support and ICT of health databases and staff training**			**ICT infrastructure and staff capable of using HMIS in 50% of LGAs by 2012**		**2,142,424**
		5.2.1	To strengthen the use of information technology in HIS		Availability of ICT facilities in all LGAs and HMIS related units at state level by first quarter of 2013		**1,430,514**
			5.2.1.1	Strengthen the existing Data bank by providing computers,softwares, internet access,GSM, calculators and other facilities for data collection, analysis at all levels		Availability of funds	1,215,257
			5.2.1.2	Create link on proposed SMOH website for information sharing and dissemination		Creatio of website for ministry	215,257
		5.2.2	To provide HMIS Minimum Package at the different levels (FMOH, SMOH, LGA) of data management		Availability of HIS tools in all HMIS relate units at state and all LGAs by end of 2012		**711,910**
			5.2.2.1	Provide HIS minimum package at all levels as defined in NHMIS policy document			207,562
			5.2.2.2	Establish inventory system for biannual monitoring of HMIS equipment	Inventory available in state and all LGAs by end of 2010		504,347
	5	**To strengthen sub-systems in the Health Information System**			**1. NHMIS modules strengthened by end 2010** **2. NHMIS annually reviewed and new versions released**		**4,671,548**
		5.3.1	To strengthen the Hospital Information System		80% of hospitals rendering data to LGAs where situated by end of 2011		**2,283,188**
			5.3.1.1	Involve and build capacity of health record personnel in hospitals on implementation of state HMIS activities	70% of health records personnel in hospitals had their capacity built on HMIS by end of 2011	Cooperation of hospital heads	1,735,346
			5.3.1.2	Link data management system in hospitals to data management of the LGA in which hospital is domiciled			547,842
		5.3.2	To strengthen the Disease Surveillance System		50% of LGAs with community based health care providers actively collecting and making use of data by 2012		**2,388,360**
			5.3.2.1	Build capacity of community based health care providers on health data collection, analysis, interpretation and use		Adequacy of community based health care providers	1,493,846
			5.3.2.2	Facilitate LGAs empowerment of SCHEWS to supervise community based health service providers in data collection, notification of diseases and feedback	60% of LGAs providing imprest for supervisory work by CHEWS by 2nd quarter of 2012	Political goodwill	894,514
	5	**To monitor and evaluate the NHMIS**			**NHMIS evaluated annually**		**47,065,064**

		5.4.1		To establish monitoring protocol for NHMIS programme implementation at all levels in line with stated activities and expected outputs	State and 80% of LGAs carrying out scheduled monitoring for NHMIS by 2012		**38,688,404**
			5.4.1.1	Develop NHMIS monitoring checklist for the state based on national guidelines	Guideline available by end of 2010		780,111
			5.4.1.2	Institute and implement framework for regular monitoring of LGAs and facilities on quality of data		Funding availability	1,774,244
			5.4.1.3	Provide vehicle and/motorcycles and other logistics for monitoring activities at all levels as appropriate	60% of LGAs providing vehicle/motorcycle for monitoring activities by 2012	Political goodwill	34,820,392
			5.4.1.4	Carry out quarterly review meetings at LGA and biannual review meetings at the state level	No of scheduled meetings held	Availability of funds	1,313,657
		5.4.2		To strengthen data transmission	1. 80% of data from all levels received at the state level by the 7th day of every month by 2011		**8,376,660**
			5.4.2.1	Establish data flow and feedback system at health facility and LGA levels	Standard flow and feedback mechanism in operation by end of 2010	Cooperation of all stakeholders	214,660
			5.4.2.2	Build consensus on deadline dates for data submission at all levels			604,860
			5.4.2.3	Institute sanctions and incentives system for late and timely data submission respectively			7,557,140
	6	**To strengthen analysis of data and dissemination of health information**			**1. 50% of LGAs have Units capable of analysing health information by end 2011** **2. State disseminate available results regularly**		**3,945,919**
		5.5.1		To institutionalize data analysis and dissemination at all levels	Rendition of annual data review feedback by State and all LGAs every year		**3,945,919**
			5.5.1.1	Buid capacity of health data producers, managers and programme officers on data analysis, interpretation and use	70% of managers and programme officers with capacity to analyse and make use of data	Willingness of managers and programme officers	809,042
			5.5.1.2	Publish and disseminate annual Ekiti State health bullentin and report	Annual state health bullentin available		680,253
			5.5.1.3	Hold annual health data feedback and consensus building activities at state and LGA levels			654,253
			5.5.1.4	Facilitate and empower medical officers of health and records officer to hold annual community feedback forum	Annual health data/information fair held	Availability of funds	1,802,371
COMMUNITY PARTICIPATION AND OWNERSHIP							
6. To attain effective community participation in health development and management, as well as community ownership of sustainable health outcomes							**35,785,475**
	6	**To strengthen community participation in health development**			**State and LGAs have at least annual Fora to engage community leaders and CBOs**		**13,763,139**

					on health matters by end 2012		
		6.1.1	To provide an enabling policy framework for community participation		Revised Ekiti state health policy with community participation embedded in it available by end of 2010		**3,810,090**
			6.1.1.1	Review Ekiti State Health policy to address the issue of community participation in health development at LGA and community level	No of review meetings held	Cooperation SHA members	-
			6.1.1.2	Advocate for the development of Ekiti State Community Development policy	No of advocacy visits		55,294
			6.1.1.3	Produce and disseminate Ekiti State Health policy to community stakeholders	80% of LGAs with access to policy by end of 2011		372,111
			6.1.1.4	Reproduce and disseminate the revised National Health policy			188,464
			6.1.1.5	Develop core team for community participation and ownership for health at LGA/State levels	Core team in place by 2nd quarter of 2010		3,194,221
		6.1.2	To provide an enabling implementation framework and environment for community participation		1. Harmonized community health committees in place in 80% of LGAs by 1st quarter of 2012		**2,684,732**
			6.1.2.1	Conduct participatory review of existing guidelines on community participation in health care delivery			560,258
			6.1.2.2	Produce and disseminate revised guidelines on community participation	No of recepients of guidelines by age and gender by 2011	Availability of funds	122,927
			6.1.2.3	Evaluate the performance of existing community/facility health committees such as DRF, CORPS, Role model mothers,CDDs, State social mobilization and facility health committees .	Availability of performance report by end of 2011		1,023,783
			6.1.2.4	Harmonize community health committees based on performance evaluation report			199,794
			6.1.2.5	Build capacity of community stakeholders on utilization of tools for planning, management, monitoring and evaluation of health interventions	60% of community stakeholders by LGA and ward utilizing tools for planning and M&E	Cooperation of stakeholders	777,970
		6.1.3	Create information interphase between health care provider and the community		1. 50% of health facilities with health information boards by end of 2010 2. 60% of PHC centres with documented activities for community awareness by end of 2011		**2,151,311**
			6.1.3.1	Provide mandatory suggestion boxes at all health care facilities to be coordinated by chairman of facility committee			616,928
			6.1.3.2	Establish community health information board in all primary health care centres for display of workers community health schedule			488,429
			6.1.3.3	Conduct community awareness drives on patients bill of rights			323,196

			6.1.3.4	Establish community feedback mechanism for monitoring CHEWS compliance with community health work	No of monitoring reports on community health work	Provision of enabling tools	722,758
		6.1.4	Strengthen community voluntary participation and support for health services		1. 60% of communities celebrating an annual health week by 2011 2. 60% of health projects and programmes actively supported by community groups and organizations		**5,117,006**
			6.1.4.1	Create platform for community orientation towards improved involvement in health care delivery	No of orientation programmes carried out by end of 2011		737,864
			6.1.4.2	Create annual reward system for best communities supporting health care delivery in terms of resource mobilization, health planning and implementation	No of awards given by 2015	Availability of funds	2,223,192
			6.1.4.3	Identify and provide recognition for the best community based organization (CBO) supporting health care delivery system on LGA basis			2,107,192
			6.1.4.4	Facilitate and institutionalise linkage of annual community health week celebration with existing community day celebrations			48,758
	6	**To empower communities with skills for positive health actions**			**State offer training to FBOs/CBOs and community leaders on engagement with the health system by end 2012**		**6,098,686**
		6.2.1	To build capacity within communities to 'own' their health services		1. 60% of LGAs holding scheduled stakeholders meetings with communities 2. 60% of communities involved in health related developmental activities by 3rd quarter of 2012		**4,515,603**
			6.2.1.1	Conduct community assessment of stakeholders participation in health related and community development activities	Assessmen report available by end of 2012		765,928
			6.2.1.2	Train and retrain community stakeholders and harmonized health committees on priority health areas such as planning, resource mobilization e.t.c	No of community stakeholders trained by 2013	Availability of funds	1,822,185
			6.2.1.3	Create and implement framework for quarterly meetings between community and LGA/State service providers/policy makers on health issues and feedback	No of scheduled meetings held by 2015	Strikes or any disruption in work days	1,927,490
		6.2.2	Coordinating existing traditional, faith based health care providers and private health providers		1. 80% of scheduled meetings with traditional and faith based health care providers held by 2011 2. Updated profile of all practitioners of		**901,972**

					medicine (traditional and orthodox) available by end of 2011		
			6.2.2.1	Review and update existing profile of TBAs, traditional healers, VHWS, faith based healers and maternity homes			83,927
			6.2.2.2	Facilitate the creation of quarterly partnership forum between LGAs health management and the traditional and faith based health providers	Mechanism for quarterly forum created by 1st quarter of 2011	Cooperation of traditional and faith based medicine providers	680,192
			6.2.2.3	Review and update the profile of private health providers like nursing homes, patent medine vendors, hospitals and clinics, et.c.	Profile of private health providers available by last quarter of 2011		63,860
			6.2.2.4	Facilitate the creation of quarterly partnership forum between LGAs health management team and private orthodox health providers			73,992
		6.2.3	Establish and strengthen existing structures for community dialogue on health		1. Community dialogue structure in place at state and all LGAs by end of 2011		**681,112**
			6.2.3.1	Establish structure for community dialogue where presently not available			97,792
			6.2.3.2	Provide guidelines for streamlining the operations of community dialogue process	Availability of guidelines for community dialogue by end of 2010		198,660
			6.2.3.3	Build consensus for key roles and responsiblities of various community stakeholders			384,660
	6	**To strengthen the community - health services linkages**			**50% of public health facilities in the State have active Committees that include community representatives by end 2011**		**7,128,909**
		6.3.1	To restructure and strengthen the interface between the community and the health services delivery points		1. Communities participating in identification of needs and priorities in 50% of public health facilities by end of 2011		**3,694,670**
			6.3.1.1	Review and assess the level of existing linkages	Availability of assessment report by 2nd quarter of 2011		441,379
			6.3.1.2	Develop guidelines for strengthening community health service linkages	Availability of guidelines for community linkage by end of 2011		294,856
			6.3.1.3	Conduct annual community health committees joint forum by senatorial zones to facilitate experience sharing	No of joint for a held at senatorial levels by end of 2015	Cooperation of contigent local governments	1,181,056
			6.3.1.4	Facilitate conduct of annual participatory development of community health needs for inclusion into the LGAs annual budget			1,777,379
		6.3.2	Engaging local human resources for health service delivery		1. 80% of LGAs utilizing traditional channels for health communication by end of 2012		**1,790,809**

			6.3.2.1	Conduct evaluation of existing channels for health communication			655,074
			6.3.2.2	Conduct training for community resource persons involved with health communication such as town announcers and cultural/musical troupes	No of community resource people trained	Availability of funds	918,856
			6.3.2.3	Streamline and integrate the existing CORPS in line with the harmonized health committees	Existence of functional harmonized structure in 80% of LGAs by end of 2012	Political goodwill	216,879
		6.3.3	To strengthen the capacity of civil society organizations (CSOs) to improve linkages between communities and health service delivery points		60% of CSOs developing and using radio and television jingles for health communication by end of 2012and		**1,643,430**
			6.3.3.1	Identification and documentation of resource potential (human, financial, media) at the state and LGA levels	Profile on resource potential available by 2nd quarter of 2011		403,574
			6.3.3.2	Conduct training for CSOs on community dialogue and advocacy tools	No of CSOs trained by 2012	Availability of funds	1,239,856
	6	**To increase national capacity for integrated multisectoral health promotion**			**Active intersectoral committees with other Ministries and private sector available in state by end of 2011**		**2,905,425**
		6.4.1	To develop and implement multisectoral policies and actions that facilitate community involvement in health development		1. 60% of LGAs with community action plans for health promotion by 2013 2. 60% of health programmes producing community sensitive IEC/BCC materials by end of 2012		**2,905,425**
			6.4.1.1	Develop State health promotion policy addressing community participation based on national health promotion policy	Availability of State health promotion policy by 1st quarter of 2012		479,392
			6.4.1.2	Produce and distribute community sensitive IEC/BCC materials for health promotion	No of specific IEC/BCC materials produced and disseminated by 2012	Availability of funds	989,392
			6.4.1.3	Awareness creation with community gatekeepers(community leaders, women leaders, school heads e.t.c) to increase community participation			578,392
			6.4.1.4	Develop community action plans at community and LGA levels for health promotion			606,588
			6.4.1.5	Build partnership with CSOs and CBOs to incorporate health promotion information in their respective projects	% of CSOs and CBOs incorporating health promotion information in their projects	Cooperation of CSO and CBOs	251,660
	7	**To strengthen evidence-based community participation and ownership efforts in health activities through researches**			**Health research policy adapted to include evidence-based community involvement**		**5,889,316**

				guidelines by end 2011		
		6.5.1	To develop and implement systematic measurement of community involvement	1. 60% of community health committees carrying out an evalutaion of health services and interventions by end of 2014		**3,868,873**
			6.5.1.1 Build capacity of harmonized community health committees at state/LGA/community levels on health systems research initiatives for service improvement			570,392
			6.5.1.2 Develop checklist and simple tools for monitoring and evaluation of health promotion and services	Checklist and M&E tools available by 1st quarter of 2011		267,892
			6.5.1.3 Conduct annual Knowledge, Attitude, Behaviour, Experience and Practices (KABEP) at community to inform policies at ward, LGA and State levels	No of annual community based surveys carried out by 2015	Availability of funds	3,030,588
		6.5.2	Involvement of community in information management and evidence based decision making	1. 60% of community health committees utilizing data generated for their decision making by end of 2012		**2,020,443**
			6.5.2.1 Build capacity of community health committees on data use for decision making			957,427
			6.5.2.2 Create and implement mechanism for biannual meetings with community health committees on implications of data generated for community development	No of scheduled meetings held by 2015	Cooperation of LGAs	800,388
			6.5.2.3 Develop guidelines for community feedback after research to prevent exploitation of communities	Guidelines on community feedback of research findings available by 2011		262,627
PARTNERSHIPS FOR HEALTH						
7. To enhance harmonized implementation of essential health services in line with national health policy goals						**32,502,952**
	7		**To ensure that collaborative mechanisms are put in place for involving all partners in the development and sustenance of the health sector**	**1. State has an active ICC with Donor Partners that meets at least quarterly by end 2011**		**32,502,952**
		7.1.1	To promote Public Private Partnerships (PPP)	Existence of PPP initiatives by end of 2011		**2,377,026**
			7.1.1.1 Conduct advocacy to identified stakeholders on PPP	No of advocacy visits by 2010 end		153,312
			7.1.1.2 Establish PPP coordinating committee at state, LGA and community levels	All LGAs with coordinating committees by end of 2012	Cooperation of private sector	992,697
			7.1.1.3 Develop state policy and guideline on PPP based on national guidelines			664,506
			7.1.1.4 Create budget line for PPP activities			31,299
			7.1.1.5 Conduct joint public and private monitoring activities quarterly	No of joint monitoring activities carried out by 2015		535,213
		7.1.2	To institutionalize a framework for coordination of Development Partners	1. Availability of coordinating mechanism by end of 2010		**3,873,286**

			7.1.2.1	Establish state health partners coordinating committee		Cooperation of partners	993,890
			7.1.2.2	Establish multi-donor state health sector budget and funds basket			2,399,506
			7.1.2.3	Produce guidelines for alignment of donors funding and activities with state's developmental priorities	Availability of guideline on state developmental priorities by end of 2010		479,890
		7.1.3	To facilitate inter-sectoral collaboration		80% of relevant MDAs attend scheduled meetings of inter-sectoral committee by 2013		**3,775,811**
			7.1.3.1	Constitute inter-sectoral committee including relevant MDAs involved in specific health related programmes	Availability of inter-sectoral committee by 1st quarter of 2011	Cooperation of relevant MDAs	188,361
			7.1.3.2	Create and implement framework for conduct of quarterly meetings of inter sectoral committee			1,073,451
			7.1.3.3	Build capacity of related MDAs on health related issues to strengthen intersectoral collaboration	No of MDAs trained y end of 2011		2,249,238
			7.1.3.4	Conduct advocacy for inclusion of intersectoral collaboration among MDAs in state health policy			264,762
		7.1.4	To engage professional groups		1. All regulatory bodies with professional groups as members by 2010 end 2. 60% of health programmes with professional groups participating in its evaluation by 2012		**4,240,989**
			7.1.4.1	Reconstitute the various standard regulatory committees to include relevant professional groups			870,579
			7.1.4.2	Conduct relevant training for professional groups to promote engagement and strengthen skills in vital areas	No of professional groups trained by 2011	Willingness of professional groups	257,680
			7.1.4.3	Engage professional groups in planning, implementation, monitoring and evaluation of health programmess			1,006,212
			7.1.4.4	Advocate for self-regulation of professional groups on competency-based practice			1,446,724
			7.1.4.5	Create and promote linkages with professional groups for exchange of information	Documented linkages with professional groups		659,794
		7.1.5	To engage with communities		1. 70% of communities knowledgable about priority health problems by 2012 2. 60% of health facilities attendees are aware about their health rights by end of 2012		**11,365,914**
			7.1.5.1	Develop, disseminate and promote manual on "bill of rights on health" to communities	Manual on bill of rights available by end of 2011		581,895
			7.1.5.2	Disseminate minimum essential service package manual to community stakeholders on health			342,708
			7.1.5.3	Build capacity of communities to prevent and manage priority health conditions	80% of LGAs carrying out systematic education	Cooperation of LGAs	3,475,574

					of the populace by 2012		
			7.1.5.4	Develop indicators on health system performance at state, LGA and facility level to enhance transparency	List of indicators available for measuring health system performance		699,489
			7.1.5.5	Conduct annual recognition award to LGA and health facility (public and private) with functional community health programes	No of awards given by 2015	Availability of funds	6,266,247
		7.1.6	To engage with traditional health practitioners		1. Availability of functional traditional health practitioners board at state level by end of 2012		**6,869,926**
			7.1.6.1	Create and develop framework for understanding traditional health practice through research			1,476,479
			7.1.6.2	Buid capacity of traditional practititioners on skills improvement and referral	No of traditional practitioners trained by 2012 end	Cooperation of traditional health practititioners	1,576,599
			7.1.6.3	Constitute monitoring team on traditional health practices at state and LGA levels			1,745,280
			7.1.6.4	Proactively involve representatives of traditional health practitioners in health promotion and planning at LGA and state levels	State and 50% of LGAs with traditional practitioners involved with health planning by end of 2013	Cooperation of LGAs	1,612,570
			7.1.6.5	Facilitate legislation to regulate false claims advertising by traditional practices	Passage of bill on regulation traditional health practice	Cooperation of SHA	458,999
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							**130,611,201**
	8	**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**		**14,831,679**
		8.1.1	To develop health research policies at State levels and health research strategies at State and LGA levels		1. State health research policy available by 2011. 2. Steering committee established at state level and meets at least thrice a year		**2,170,826**
			8.1.1.1	Develop state health research policy based on national guidelines	State health research policy available by 2011	Political will and technical capacity of top level management	2,018,979
			8.1.1.2	Establish health research steering committee at state level			151,847
			8.1.1.3	Review of existing state health policy to include research for health in the document			-
		8.1.2	To establish and or strengthen mechanisms for health research at all levels		1. 60% of LGAs with active health research units by 2012		**6,505,164**
			8.1.2.1	Restructure the existing health research division and unit at state and LGAs			820,148

			8.1.2.2	Create active health research unit in the HMIS section in the LGAs			3,952,196
			8.1.2.3	Adoption and implementation of the ENHR guidelines		Steering committee already in place	666,883
			8.1.2.4	Capacity building of staff at state and LGA levels to enhance their research capacity	No of staff trained on health research by 2012 end		1,065,937
		8.1.3	To institutionalize processes for setting health research agenda and priorities		1. State with a definitive health research agenda by end of 2011		**529,953**
			8.1.3.1	Provide direct budget line for health research at state and LGA levels	50% of LGAs with budget lines for health research by end of 2011	Political goodwill	32,391
			8.1.3.2	Develop guidelines for collaborative health research agenda between the ministry, LGA, research unit and research institutions			155,000
			8.1.3.3	Develop and implement guidelines for incorporating operational research in annual monitoring and evaluation plans	Guidelines available for operational research by 2011 end		342,562
		8.1.4	To promote cooperation and collaboration between Ministries of Health and LGA health authorities with research institutions, communities, CSOs, OPS, NIMR, NIPRD, development partners and other sectors		Existence of collaborative mechanism by end of 2011		**1,257,228**
			8.1.4.1	Set up collaborative research committee among research users (SMOH, LGA, CSOs, OPS)			367,898
			8.1.4.2	Design appropriate framework and specify the functions of the collaborative committee			37,094
			8.1.4.3	Convocation of annual multi-stakeholders forum to identify research priorities	60% of annual multi-stakeholders meeting held as sheduled by 2015	Cooperation f stakeholders	852,235
		8.1.5	To mobilise adequate financial resources to support health research at all levels		State and 30% of LGAs allocating 2% of health budget to health research by 2012		**73,188**
			8.1.5.1	Create direct budget line for health research activities			-
			8.1.5.2	Identify and build partnership with research funding organizations	Evidence of linkage with funding organizations by 2011		46,694
			8.1.5.3	Adopt and implement the recommendation of African governments to set aside at least 2% of health budget for health research		Political goodwill	26,494
		8.1.6	To establish ethical standards and practise codes for health research at all levels		1 State Ethical Review Committee in place by end of 2010 2. Report on findings from all research available at state level by 2013		**4,295,320**
			8.1.6.1	Establish ethical review committees at state level			1,136,946
			8.1.6.2	Establish monitoring and evaluation committee for health research oversight functions			215,498
			8.1.6.3	Develop tools for monitoring and evaluation of health research implementation	Availability of tools for M&E by 2011 2nd quarter		843,247
			8.1.6.4	Establish mechanism for feedback on health research activities			23,664

			8.1.6.5	Ethical review committee meetings scheduled at least once every quarter	80% of scheduled meetings held by 2015	Availability of proposals to review	2,075,965
	8	**To build institutional capacities to promote, undertake and utilise research for evidence-based policy making in health at all levels**			**SMOH has an active forum with all health institutions and research organizations by end 2010**		**89,445,358**
		8.2.1	To strengthen identified health research institutions at state level		1. Assessment of research capacity and needs of research institutions carried out by 2011		**436,864**
			8.2.1.1	Produce annual inventory of health research institutions and research partnering organizations			89,320
			8.2.1.2	Carry out research capacity assessment to identify gaps and weaknessess			347,543
		8.2.2	To create a critical mass of health researchers at all levels		1. % increase in health workers carrying out health research with a 5% annual increase from baseline in 2009 to 2015		**86,924,719**
			8.2.2.1	Train and retrain health workers on operational research at all levels			2,609,895
			8.2.2.2	Award advanced studentship opportunities like masters and PhD and Fellowships to elligible health workers	No of scholarship awards given by 2015	Availability of funds	44,120,588
			8.2.2.3	Create grants for research annually at the state level	No of research grants given out by 2015	Availability of funds	40,194,235
		8.2.3	To develop transparent approaches for using research findings to aid evidence-based policy making at all levels		1. 20% of research findings translated to policy by 2015		**1,038,894**
			8.2.3.1	Establish technical working committee for translating research findings to policy		Cooperation of government agencies	733,047
			8.2.3.2	Create close liasion between researchers and policy makers by designating and training an officer in DPRS /SMOH for this purpose			305,847
		8.2.4	To undertake research on identified critical priority areas		1. Mechanism for identifying critical areas for research established by 2012		**1,044,882**
			8.2.4.1	Facilitate technical working committee to identify critical areas for systematic researches	No of scheduled meetings held by 2015		705,888
			8.2.4.2	Create forum for disseminating information on findings on critical areas to stakeholders			338,993
	8	**To develop a comprehensive repository for health research at all levels (including both public and non-public sectors)**			**1. Functional Health Research Unit at the state level by end 2010 2. State Health Research Units manage an accessible repository by end 2012**		**2,669,752**
		8.3.1	To develop strategies for getting research findings into strategies and practices		Coordinating mechanism for		**2,319,457**

					research to practice established by 2011		
			8.3.1.1	Establish "getting research into strategies and practice" (GRISP) unit in DPRS/SMOH			717,098
			8.3.1.2	Conduct bi-annual health research policy forums at all levels	70% of scheduled fora held by 2015		1,602,359
		8.3.2	To enshrine mechanisms to ensure that funded researches produce new knowledge required to improve the health system		1. 50% of operational researches linked to quality improvement in health programmes by 2011		**350,295**
			8.3.2.1	Create forum for effective collaboration and sharing of experience on operations research			231,547
			8.3.2.2	Make operational research part of the M & E plans within private and public sector	30% of private and 50% of public health facilities with documented results of operational research by 2012	Cooperation of private and public health facility staff	118,748
	8	**To develop, implement and institutionalize health research communication strategies at all levels**			**A State health research communication strategy is in place by end 2012**		**23,664,413**
		8.4.1	To create a framework for sharing research knowledge and its applications		Availability of framework on knowledge management by 2011		**9,940,138**
			8.4.1.1	Create forum for sharing research knowledge biannually using locally available methods			1,878,961
			8.4.1.2	Ensure participation of officers in national, regional and international conferences on health to mainstream best practices	% increase of 10% over baseline of health workers attending scientific conferences by 2012	Availability of funds	8,061,177
		8.4.2	To establish channels for sharing of research findings between researchers, policy makers and development practitioners		Platform for research patnerships established by 2012		**13,724,275**
			8.4.2.1	Conduct regular research partners meeting at state and LGA level	70% of partners meeting held as scheduled by 2015	Cooperation of research partners	245,481
			8.4.2.2	Establish appropriate linkages between editors of national journals, reputable publishers and international collaborators	List of identified collaborators available by 2011		572,766
			8.4.2.3	Disseminate state bullentins and research findings to all stakeholders through the state website.	State health bullentin disseminated to all stakeholders annually		12,906,028
							41,789,988,263

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

EKITI STATE STRATEGIC HEALTH DEVELOPMENT PLAN RESULT MATRIX						
OVERARCHING GOAL: To significantly improve the health status of Nigerians through the development of a strengthened and sustainable health care delivery system						
OUTPUTS	**INDICATORS**	**SOURCES OF DATA**	**Baseline**	**Milestone**	**Milestone**	**Target**
			2008/9	**2011**	**2013**	**2015**
PRIORITY AREA 1: LEADERSHIP AND GOVERNANCE FOR HEALTH						
NSHDP Goal: To create and sustain an enabling environment for the delivery of quality health care and development in Nigeria						
OUTCOME: 1. Improved strategic health plans implemented at Federal and State levels						
OUTCOME 2. Transparent and accountable health systems management						
1. Improved Policy Direction for Health Development	1. % of LGAs with Operational Plans consistent with the state strategic health development plan (SSHDP) and priorities	LGA s Operational Plans	40%	80%	100%	100%
	2. % stakeholder constituencies playing their assigned roles in the SSHDP (disaggregated by stakeholder constituencies)	SSHDP Annual Review Report	0%	60%	80%	100%
2. Improved Legislative and Regulatory Frameworks for Health Development	3. State adopting the National Health Bill? (Yes/No)	SMOH	-	-	-	100%
	4. % of LGAs enforcing traditional medical practice by-laws	LGA Annual Report	0%	50%	80%	90%
3. Strengthened accountability, transparency and responsiveness of the State health system	5. % of LGAs which have established a Health Watch Group	LGA Annual Report	0%	50%	95%	100%
	6. % of recommendations from health watch groups being implemented	Health Watch Groups' Reports	0%	50%	90%	100%
	7. % LGAs aligning their health programmes to the SSHDP	LGA Annual Report	0%	100%	100%	100%
	8. % DPs aligning their health programmes to the SSHDP at the LGA level	LGA Annual Report	0%	100%	100%	100%
	9. % of LGAs with functional peer review mechanisms	SSHDP and LGA Annual Review Report	50%	80%	100%	100%
	10. % LGAs implementing their peer review recommendations	LGA / SSHDP Annual Review Report	50%	80%	100%	100%
	11. Number of LGA Health Watch Reports published	Health Watch Report	0%	20%	50%	90%
	12. Number of "Annual Health of the LGA" Reports published and disseminated annually	Health of the State Report	0%	40%	60%	100%
4. Enhanced performance of	13. % LGA public health facilities using the essential drug list	Facility Survey Report	80%	90%	100%	100%

the State health system						
	14. % private health facilities using the essential drug list by LGA	Private facility survey	10%	20%	50%	85%
	15. % of LGA public sector institutions implementing the drug procurement policy	Facility Survey Report	80%	90%	100%	100%
	16. % of private sector institutions implementing the drug procurement policy within each LGA	Facility Survey Report	5%	10%	40%	80%
	17. % LGA health facilities not experiencing essential drug/commodity stockouts in the last three months	Facility Survey Report	90%	95%	100%	100%
	18. % of LGAs implementing a performance based budgeting system	Facility Survey Report	0%	30%	60%	80%
	19. Number of MOUs signed between private sector facilities and LGAs in a Public-Private-Partnership by LGA	LGA Annual Review Report	0%	20%	40%	s
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	20. % of LGAs with a functioning public health facility providing minimum health care package according to quality of care standards.	NPHCDA Survey Report	TBD	70%	80%	100%
	21. % health facilities implementing the complete package of essential health care	NPHCDA Survey Report	TBD	75%	95%	100%
	22. % of the population having access to an essential care package	MICS/NDHS	TBD	70%	85%	100%
	23. Contraceptive prevalence rate	NDHS	15%	30%	40%	50%
	24. Number of new users of modern contraceptive methods (male/female)	NDHS/HMIS	15%	10%	10%	10%
	25. % of new users of modern contraceptive methods by type (male/female)	NDHS/HMIS	15%	10%	10%	10%
	26. % service delivery points without stock out of family planning commodities in the last three months	Health facility Survey	0%	40%	60%	80%
	27. % of facilities providing Youth Friendly RH services	Health facility Survey	10%	30%	40%	60%
	28. Adolescent (10-19 year old) Fertility rate (using teenage pregnancy as proxy)	NDHS/MICS	TBD			
	29. % of pregnant women with 4 ANC visits performed according to standards*	NDHS	47%	55%	65%	70%
	30. Proportion of births attended by skilled health personnel	HMIS	90%	90%	95%	100%

	31. Perinatal mortality rate**	HMIS	42/1000LBs	37/1000LBs	30/1000LBs	25/1000 LBs
	32. % women receiving immediate post partum family planning method before discharge	HMIS	TBD	20%	30%	50%
	33. % of women who received postnatal care based on standards within 48h after delivery	MICS	15%	25%	40%	60%
	34. % of children exclusively breastfed 0-6 months	NDHS/MICS	50%	60%	70%	80%
	35. Proportion of 12-23 months-old children fully immunized	NDHS/MICS	58.00%	70%	80%	90%
	36. % children <5 years stunted (height for age <2 SD)	NDHSMICS	33.00%	30%	20%	10%
	37. % of under-five that slept under LLINs the previous night	NDHS/MICS	10.00%	20%	40%	90%
	38. % of under-five children receiving appropriate malaria treatment within 24 hours	NDHS/MICS	87%	90%	95%	98%
	39. % malaria successfully treated using the approved protocol and ACT;	MICS	75.00%	80%	85%	95%
	40. Proportion of population in malaria-risk areas using effective malaria prevention and treatment measures	MICS	80%	85%	90%	95%
	41. % of women who received intermittent preventive treatment for malaria during pregnancy	NDHS/MICS	85%	90%	95%	100%
	42. HIV prevalence rate among adults 15 years and above	NDHS	6%	5%	3%	0.50%
	43. HIV prevalence in pregnant women	NARHS	5%	4%	5%	0.50%
	44. Proportion of population with advanced HIV infection with access to antiretroviral drugs	NMIS	80%	85%	90%	100%
	45.Condom use at last high risk sex	NDHS/MICS				
	46. Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS	NDHS/MICS	2%	50%	80%	90%
	47. Prevalence of tuberculosis	NARHS	4%	3.00%	2%	1%
	48.Death rates associated with tuberculosis	NMIS	1%	0.50%	0.10%	0%
	49. Proportion of tuberculosis cases detected and cured under directly observed treatment short course	NMIS	50%	50%	60%	85%
Output 6. Improved quality of Health care services	50. % of staff with skills to deliver quality health care appropriate for their categories	Facility Survey Report	30%	50%	80%	90%
	51. % of facilities with capacity to deliver quality health care	Facility Survey Report	50%	60%	80%	90%
	52. % of health workers who received personal supervision in the last 6 months by type of facility	Facility Survey Report	30%	50%	80%	95%

	53. % of health workers who received in-service training in the past 12 months by category of worker	HR survey Report	10%	20%	30%	40%
	54. % of health facilities with all essential drugs available at all times	Facility Survey Report	80%	95%	90%	95%
	55. % of health institutions with basic medical equipment and functional logistic system appropriate to their levels	Facility Survey Report	70%	75%	80%	85%
	56. % of facilities with deliveries organizing maternal and/or neonatal death reviews according to WHO guidelines on regular basis	Facility Survey Report	25%	30%	50%	80%
Output 7. Increased demand for health services	57. Proportion of the population utilizing essential services package	MICS	60%	80%	85%	90%
	58. % of the population adequately informed of the 5 most beneficial health practices	MICS	50%	60%	80%	85%
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	59. % of wards that have appropriate HRH complement as per service delivery norm (urban/rural).	Facility Survey Report	40%	55%	80%	95%
	60. Retention Rate of HRH	HR survey Report	80%	85%	90%	95%
	61. % LGAs actively using adaptations of National/State HRH policy and plans	HR survey Report	-	-	-	-
	62. Distribution of HRH by geographical location	MICS	30%	50%	65%	85%
	63. Increased number of trained staff based on approved staffing norms by qualification	HR survey Report	100%	15%	35%	50%
	64. % of LGAs implementing performance-based managment systems	HR survey Report	60%	70%	80%	95%
	65. % of staff satisfied with the performance based management system	HR survey Report	60%	80%	90%	100%
Output 8: Improved framework for objective analysis, implementation and monitoring of HRH performance	66. % LGAs making availabile consistent flow of HRH information	NHMIS	30%	90%	95%	100%

	67. CHEW/10,000 population density	MICS	TBD	1:4000 pop	1:3000 pop	1:2000 pop
	68. Nurse density/10,000 population	MICS	40:100 000	40: 8000	40:6000	40:4000
	69. Qualified registered midwives density per 10,000 population and per geographic area	NHIS/Facility survey report/EmOC Needs Assessment	40:100 000	40:8000	40:6000	40:4000
	70. Medical doctor density per 10,000 population	MICS	9:100 000	9:8000)	9:7000)	9:5000)
	71. Other health service providers density/10,000 population	MICS	1:100 000	1:4000 pop	1:3000 pop	1:2000 pop
	72. HRH database mechanism in place at LGA level	HRH Database	80%	80%	90%	100%
Output 10: Strengthened capacity of training institutions to scale up the production of a critical mass of quality mid-level health workers						
PRIORITY AREA 4: FINANCING FOR HEALTH						
NSHDP GOAL 4 : To ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and consumption at Local, State and Federal Levels						
Outcome 8. Health financing strategies implemented at Federal, State and Local levels consistent with the National Health Financing Policy						
Outcome 9. The Nigerian people, particularly the most vulnerable socio-economic population groups, are protected from financial catastrophe and impoverishment as a result of using health services						
Output 11: Improved protection from financial catastrophy and impoversihment as a result of using health services in the State	73. % of LGAs implementing state specific safety nets	SSHDP review report	100%	100%	100%	100%
	74. Decreased proportion of informal payments within the public health care system within each LGA	MICS	20%	40%	60%	80%
	75. % of LGAs which allocate costed fund to fully implement essential care package at N5,000/capita (US$34)	State and LGA Budgets	0%	10%	50%	100%
	76. LGAs allocating health funding increased by average of 5% every year	State and LGA Budgets	0%	10%	50%	100%
Output 12: Improved efficiency and equity in the	77. LGAs health budgets fully alligned to support state health goals and policies	State and LGA Budgets	0%	10%	50%	100%

allocation and use of Health resources at State and LGA levels						
	78.Out-of pocket expenditure as a % of total health expenditure	National Health Accounts 2003 - 2005	-	5%	5%	10%
	79. % of LGA budget allocated to the health sector.	National Health Accounts 2003 - 2005	2%	5%	8%	10%
	80. Proportion of LGAs having transparent budgeting and finacial management systems	SSHDP review report	25%	30%	50%	80%
	81. % of LGAs having operational supportive supervision and monitoring systems	SSHDP review report	25%	35%	50%	100%
PRIORITY AREA 5: NATIONAL HEALTH INFORMATION SYSTEM						
Outcome 10. National health management information system and sub-systems provides public and private sector data to inform health plan development and implementation						
Outcome 11. National health management information system and sub-systems provide public and private sector data to inform health plan development and implementation at Federal, State and LGA levels						
Output 13: Improved Health Data Collection, Analysis, Dissemination, Monitoring and Evaluation	82. % of LGAs making routine NHMIS returns to states	NHMIS Report January to June 2008; March 2009	50%	50%	80%	100%
	83. % of LGAs receiving feedback on NHMIS from SMOH		50%	50%	80%	100%
	84. % of health facility staff trained to use the NHMIS infrastructure	Training Reports	100%	100%	100%	100%
	85. % of health facilities benefitting from HMIS supervisory visits from SMOH	NHMIS Report	30%	50%	60%	70%
	86.% of HMIS operators at the LGA level trained in analysis of data using the operational manual	Training Reports	10%	20%	50%	60%
	87. % of LGA PHC Coordinator trained in data dissemination	Training Reports	75%	85%	95%	95%
	88. % of LGAs publishing annual HMIS reports	HMIS Reports	100%	100%	100%	100%
	89. % of LGA plans using the HMIS data	NHMIS Report	100%	100%	100%	100%
PRIORITY AREA 6: COMMUNITY PARTICIPATION AND OWNERSHIP						
Outcome 12. Strengthened community participation in health development						
Outcome 13. Increased capacity for integrated multi-sectoral health promotion						
Output 14: Strengthened Community Participation in Health Development	90. Proportion of public health facilities having active committees that include community representatives (with meeting reports and actions recommended)	SSHDP review report	60%	85%	90%	100%
	91. % of wards holding quarterly health committee meetings	HDC Reports	85%	90%	95%	100%

	92. % HDCs whose members have had training in community mobilization	HDC Reports	60%	85%	90%	100%
	93. % increase in community health actions	HDC Reports	40%	50%	60%	80%
	94. % of health actions jointly implemented with HDCs and other related committees	HDC Reports	20%	25%	30%	50%
	95. % of LGAs implementing an Integrated Health Communication Plan	HPC Reports	80%	85%	90%	100%
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 15: Improved Health Sector Partners' Collaboration and Coordination	96. Increased number of new PPP initiatives per year per LGA	SSHDP Report	0%	5%	10%	20%
	97. % LGAs holding annual multi-sectoral development partner meetings	SSHDP Report	80%	85%	95%	100%
PRIORITY AREA 8: RESEARCH FOR HEALTH						
Outcome 15. Research and evaluation create knowledge base to inform health policy and programming.						
Output 16: Strengthened stewardship role of government for research and knowledge management systems	98. % of LGAs partnering with researchers	Research Reports	0%	10%	20%	30%
	99. % of State health budget spent on health research and evaluation	State budget	0.50%	1%	2.50%	3%
	100. % of LGAs holding quarterly knowledge sharing on research, HMIS and best practices	LGA Annual SHDP Reports	0%	2%	10%	20%
	101. % of LGAs participating in state research ethics review board for researches in their locations	LGA Annual SHDP Reports	40%	40%	80%	100%
	102. % of health research in LGAs available in the state health research depository	State Health Reseach Depository	40%	50%	80%	100%
Output 17: Health research communication strategies developed and implemented	103. % LGAs aware of state health research communication strategy	Health Research Communication Strategy	40%	40%	50%	100%