DELTA STATE GOVERNMENT

STRATEGIC HEALTH DEVELOPMENT PLAN
(2010-2015)

Delta State Ministry of Health

March 2010

Contents

ACRONYMS AND ABBREVIATIONS

BCC	Behaviour Change Communication
CIDA	Canadian International Development Agency
CORPs	Community Oriented Resource Persons
CPD	Continuing professional development
CSO	Community Service Organization
DFID	Department for International Development
DHS	Nigeria Demographic and Health Survey
DP	Development Partners
DPRS	Department of Planning, Research and Statistics
FCT	Federal Capital Territory
FMOH	Federal Ministry of Health
GDP	Gross Domestic Product
GIS	Geographic Information System
GTZ	Gesellschaft für Technische Zusammenarbeit
HDCC	Health Data Consultative Committee
HF	Health Facility
HIS	Health Management Information System
HIV/AIDS	Human Immuno Deficiency Virus/Acquired Immune Deficiency Syndrome
HLM	High Level Ministerial Meeting on Health Research
HPCC	Health Partners Coordinating Committee
HRH	Human Resources for Health
HW	Health worker
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illnesses
IMNCH	Integrated Maternal, Newborn and Child Health
IPC	Interpersonal Communication skills
ISS	Integrated supportive supervision
ITNs	Insecticide treated nets
JFA	Joint Funding Agreement
JICA	Japan International Development Agency
LGA	Local Government Area
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDAs	Ministries, Departments and Agencies
MDCN	Medical and Dental Council of Nigeria,
MDGs	Millennium Development Goals
MNCH	Maternal and Newborn Child Health
MRCN	Medical Research Council of Nigeria
NAFDAC	National Agency for Food Drugs Administration and Control
NGOs	Non-Governmental Organizations
NHA	National Health Accounts
NHIS	National Health Insurance Scheme
NHMIS	National Health Management Information System
NHREC	National Health Research Committee
NIMR	Nigerian Institute for Medical Research
NIPRD	National Institute for Pharmaceutical Research and Development
NMSP	National Malaria Strategic Plan
NPHCDA	National Primary Health Care Development Agency
NSHDP	National Strategic Health Development Plan

NSHDP	National Strategic Health Development Plan Framework
NSTDA	National Science and Technology Development Agency
NYSC	National Youth Service Corps
OAU	Organisation of African Unity
ODA	Overseas Development Assistance
OPS	Organised Private Sector
PEPFAR	President's Emergency Plan for AIDS Relief
PERs	Public Expenditure Reviews
PHC	Primary Health Care
PHCMIS	Primary Health Care Management Information System
PPP	Public Private Partnerships
QA	Quality Assurance
RDBs	Research data banks
SHAs	State Health Accounts
SMOH	State Ministry of Health
SWAPs	Sector-Wide Approaches
TB	Tuberculosis
TBAs	Traditional birth attendants
TWG	Technical Working Group
UN-System	United Nations-System
VAT	Value Added Tax
VHW	Village health workers
VOC	Vote-of-charge
WHO	World Health Organization

ACKNOWLEDGEMENT

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

PREFACE

There is a popular saying that 'Health is Wealth.' Therefore in every country, the health sector is critical to social and economic development with ample evidence linking productivity to quality of health care. In Nigeria, the vision of becoming one of the leading 20 economies of the world by the year 2020 is closely tied to the development of its human capital through the health sector.

However, the health indicators in Nigeria have remained below country targets and internationally-set benchmarks including the MDGs, which have recorded very slow progress over the years.

The Federal Government of Nigeria recognizes that, in order to achieve the country's health targets, inclusive of the health-related Millennium Development Goals (MDGs), the health system should be strengthened, health services must be scaled-up and existing gains in the health sector must be sustained and expanded. These improvements can be achieved through the use of an evidence-based Framework to guide the development of a National Strategic Health Development Plan (NSHDP), with appropriate costing. The NSHDP would result from the harmonization of Federal, States and Local Governments' health plans, thereafter serving as the basis for national ownership, resource mobilization/allocation and mutual accountability by all stakeholders – government, development partners, civil society, private sector, communities, etc.

The NSHDP framework is based on the principle of Four Ones: one health policy, one national plan, one budget, and one monitoring and evaluation framework for all levels of government. The framework identifies eight priority areas for improving the national health systems with specific goals and strategic objectives. They 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; and research for health. The framework spreadsheets are laid out using the Federal Ministry of Finance budget template so that it will be relatively easy to convey the figures that are generated into a budget for submission in the correct format.

In formulating the Delta State Strategic Health Development Plan (SSHDP), covering the period 2010 – 2015, detailed considerations were given to the need to have practical strategic objectives, interventions specifying what to be done to achieve the stated objectives, and activities that need to be undertaken to ensure that specified interventions are achieved. The SSHDP focused on Primary Health Care as the bedrock of healthcare service delivery, including linkages of service delivery to existing secondary health care facilities, especially the General

and Central hospitals, emphasized managerial responsibilities at State, LGAs and the Communities for the operation and support of health care services.

The need to move away from vertical approach to an integrated one has become very critical to providing a continuum of care and building synergy for the impact. This paradigm shift has received a promise for commitment from the highest levels of government, hence the integration of programmes such as Integrated Maternal Newborn and Child Health, Immunization, Roll Back Malaria, HIV/AIDS, Water and Sanitation, etc) into this document. The Free Maternal Health Care and Free Rural Health Scheme will also be strengthened and sustained. The care of other vulnerable groups such as the elderly has been included into the programme.

It is envisaged that the SSHDP would achieve/provide functional health policy with its orientation towards the PHC approach that is, people-centred, community-based and Local Government managed programmes; generate needed awareness and consensus on the package; and evolve monitoring mechanisms in relation to health management and health achievements.

Health is a major determinant of the socio-economic development of a people. Delta State Ministry of Health is one of the newest in the nation, having come into existence only in 1991. We are however determined to actualize the concept of living a qualitative and productive life today and bequeathing a bright and healthy future for the coming generations. I sincerely urge all stakeholders to buy-in to the implementation of the Delta State Strategic Health Development Plan in order to adequately exploit the interventions required to improve the performance of the health sector towards the delivery of quality, efficient and sustainable health care for our citizens.

Dr. Joseph.S .Otumara
Honourable Commissioner for Health,
Delta State Government.

Novemberr 30, 2009.

VISION AND MISSION

Vision: "To reduce morbidity and mortality rates due to communicable diseases to the barest minimum; reverse the increasing prevalence of non-communicable diseases; meet global targets on the elimination and eradication of diseases and significantly increase the life expectancy and quality of life of Nigerians and Deltans in particular"

Mission Statement: "To develop and implement appropriate policies and programmes as well as undertake other necessary actions that will strengthen the State health system to deliver effective, quality and affordable health care services".

CHAPTER ONE

BACKGROUND AND ACHIEVEMENTS

1.1 Background

On August 27, 1991, Delta State was created out of the former Bendel State by President Ibrahim Babangida's administration. The first head of government of the state was a Military Administrator in person of Group Captain (now retired Air Commodore) Chijiuba Ochulor. Olorgun Felix Ibru was the first Civilian Executive Governor (January 2; 1992 – Nov. 16, 1993. Between 1993 and 1999 when democratically elected civilian government came to power, there were four military administrators who administered the state one after the other.
At creation, Delta State had 12 Local Government Areas which were increased to 19 on September 27, 1991 as a result of creation of additional new Local Government Areas nation wide, by then President I. Babangida. Following another creation of more Local Government Areas nationwide in 1996 by late General Sani Abacha's administration, the number of local governments in Delta State was increased to 25. The State is divided into three Senatorial Districts namely Delta North, South and Central.

Delta State, known as the "Big Heart" of Nigeria, lies between longitudes $5^{0}00$ and $6^{0}45$ east, and latitudes $5^{0}00$ and $6^{0}30$ north with a total area of 18,050km^2 of 60% is land. One third of the state lies in mangrove swamp. The State is located in the western part of the Niger Delta by the Gulf of Guinea in the Atlantic Ocean. The coast line is 167km. It is bounded on the south by Bight of Benin, on the west by Ondo State, on the north by Edo State, on the east by Anambra State and south east by Bayelsa State.
The State capital is Asaba, a developing town located at the River Niger to the Northern end of the State. It has a net-work of good roads; and a master plan for transforming it into a modem city has been established by the State Government.

The major tribes in the State are Urhobos, Izons, Isokos, Ibos and Itsekiris. Basically, they have identical customs, beliefs and cultures. The cultural identity is manifested in their festivals, traditional marriage ceremonies, while certain words are common to many tribes. Their systems of Traditional Administration tend to be identical as well as their folktales, dances, arts and crafts.

Demography

The population of Delta State is 4,098,391 made up of 2,074,308 males and 2,024,085 females spread in the 25 Local Government Areas as follows:

S/N	LGA	HEADQUARTERS	MALE	FEMALE	TOTAL
1.	Aniocha North	Issele-Uku	52,634	52,077	104,711
2.	Aniocha South	Ogwashi-Uku	69,632	70,972	140,604
3.	Bomadi	Bomadi	43,083	43,561	86,644
4.	Burutu	Burutu	110,416	99,250	209,666
5.	Ethiope-East	Isiokolo	100,257	100,537	200,794
6.	Ethiope-West	Oghara	102,445	101,147	203,592
7.	Ika North-ast	Owa-Oyibu	91,414	92,243	183,657
8.	Ika South	Agbor	79,628	82,966	162,594
9.	Isoko North	Ozoro	71,820	72,335	144,155

10.	Isoko South	Oleh	114,391	113,321	227,712
11.	Ndokwa East	Aboh	52,350	50,821	103,171
12.	Ndokwa West	Kwale	79,018	70,307	149,325
13.	Okpe	Orerokpe	67,995	62,034	130,029
14.	Oshimili North	Akwukwu-Igbo	56,405	58,911	115,316
15.	Oshimili South	Asaba	80,274	69,329	149,603
16.	Patani	Patani	34,046	33,661	67,707
17.	Sapele	Sapele	85,305	86,583	171,888
18.	Udu	Otor-Udu	71,242	72,119	143,361
19.	Ughelli North	Ughelli	159,192	161,836	321,028
20.	Ughelli South	Otu-Jeremi	109,379	104,197	213,576
21.	Ukwuani	Obiaruku	59,162	61,228	120,390
22.	Uvwie	Effurun	95,051	96,421	191,472
23.	Warri North	Koko	69,754	67,546	137,300
24.	Warri South	Warri	156,098	147,319	303,417
25.	Warri South-West	Ogbe-Ijoh	63,315		116,681
	Grand total		2,074,306	2,024,085	4,098,391

Economy Structure

As much as 30% of the total crude oil produced in Nigeria comes from Delta State making it a state that leads in crude oil and gas production. The oil and gas reserve is quite enormous: There are Refinery and Petrochemical Company at Warri; Gas Plant at Utorogu; Delta steel complex at Ovwian-Aladja; two gas fired electricity stations at Ughelli and Ogorode-Sapele and two oil export terminals at Forcados and Escravos. The State has abundance of raw materials that can support any established agro-allied industry. The State is interconnected by good roads and has Osubi airstrip, water transportation facilities and telecommunication facilities while Asaba airport is under construction.

Sectoral Contribution to Delta State GDP

1.	Oil and Gas and Solid Minerals	73.29%
2.	Agriculture	11.24%
3.	Manufacturing	8.59%
4.	Commerce/Services	3.37%
5.	Real Estate/Construction	2.06%
6.	Financial Institutions/Insurance	1.45%
	Total	**100%**

It is a fact that more than 75% of Deltans are engaged in agriculture.
Market-oriented industrial activities are also found in the major towns of the state such as Warri, Asaba, Sapele, Oleh, Ughelli, Agbor and other semi-urban areas. Commercial activities complement industrial activities in the State.

1.2 Achievements

Highlights of Achievements in the Health Sector

1. **Establishment of the Rural Health Scheme:-** This was done in 2005 to help bring health care services to the door-steps of our citizens, particularly those in the rural and riverine areas. The Scheme has recently been expanded to include screening for non-

communicable diseases, treatment of minor ailments, surgical interventions (minor & major) including ophthalmic surgeries.

2. **Free Maternal Health Programme:-** This program launched in November, 2007 was put in place with a view to achieving one of the goals of the Health-related Millennium Development Goals (MDG's) which is the reduction of the highly unacceptable maternal mortality rate of about 800 per one hundred thousand births in the State. This scheme covers Ante-natal care, normal delivery and assisted delivery including Caesarean Section, provision of routine drugs throughout the duration of the pregnancy and up to one week after delivery.
3. **Health Training Institutions:-** There are six health training institutions.
   - Schools of Nursing at Agbor, Eku and Warri
   - Schools of Midwifery at Asaba and Sapele
   - School of Health Technology at Ofuoma

   These schools have been provided with the much needed facilities to meet accreditation requirements.

   In addition, there is the College of Health Sciences at Delta State University Abraka

Infrastructural Development in the Health Sector

1. Increase in the number of primary health care centres from 290 to 344 primary health care centres.
2. Government Hospitals have increased from 35 in 1999 to 62 (including 6 Central and 53 General Hospitals).
3. There are presently, 53 registered private/mission hospitals and 345 private clinics as well as 186 private/mission maternity homes.
4. Staff strength of 4,937 in the medical sector. This is made up of 300 doctors, 1,775 nurses and 2,862 other staff.
5. On health information, awareness is being created on HIV scourge via the State Action Committee and AIDs (SACA), Malaria Prevention, Drug abuse and other health related problems are being tackled head long.
6. The State Government-owned Central Hospital in the capital city of Asaba is also under construction.

Situation of the State Environment

A situation analysis of the State's environment considers what the environment was (past), what it is now (present), and what it should be (future). The analysis accepts forests, soils, surface water, air quality, fisheries, climate and fauna as the major environmental components, using 1974 as the best year. The 1974 SLAR imagery revealed that the percentage of forest cover of Delta State was over 60%. Forest plantations were established at 10 locations; 13 Forest Reserves had been constituted only African Timber and Plywood (ATP) and four sawmills existed; 102 protected tree species had been gazetted as protected, while no plant specie was declared endangered or extinct. Above 40% of the rural people depended on the forest for sustainable livelihood. No wildlife was reported extinct.

The soils of the State were regarded as highly productive and self-replenishing without fertilizer application because of the large practice of shifting cultivation. Surface water was unpolluted largely because of the small size and scale of pollution sources, particularly industries. Hydrocarbon and heavy metal pollution were not problematic elements in Delta State. The air quality was regarded as positive, with values of less than 0.01 parts per million (ppm) recorded for SO_2, NO_2, and H_2S and 0.1 ppm for CO.

At present, fresh water swamp forests are limited, to sections of the coastal zones particularly along the banks of the Niger, Ethiope, Nana, Warri and Benin Rivers and their creeks. The

present forest cover in Delta State is 28% (from 60% in 1974). The mangrove forest has reduced from 75% in 1974 to 48% in 2001. At present, there are 102 sawmills and over 500 bench mills consuming about 3000m^3 of wood from the reducing forest estate. Presently about 25 tree species are extinct while elephants and hippopotamus are also reported extinct.

Coastal erosion is presently ravaging about 60 rural communities. Soil erosion is presently ravaging about 105 communities. Estimated productive land lost to coastal and soil erosion since 1976 is 5670 ha. The number of people who today depend on the forestland for sustainable development has increased to about 60% from 40% in 1974. More people in urban areas now depend on forest products for living. Soil productivity is presently very low because of inappropriate land use practices. At Agbarho for instance, values recorded in 2003 were 0.9%, 2.1% and 2.8% for Nitrogen (N), Phosphorus (P) and Potassium (K) respectively compared to 1.8, 4.6% and 3.3% recorded in 1982.
The present state of the environment in Delta State reveals that the forest, soils and land resources, air, surface and ground water, sediments, wildlife and metrological conditions are highly stressed, contaminated or polluted.

Safety Nets for Vulnerable Groups
Situation Analysis

The growing numbers of destitutes, the mentally ill, the physically challenged (disabled), ex-lepers, orphans and widows pose a serious challenge to the social responsibility of Government to its citizenry. The State Government has, embarked on the following:

(i) The establishment of 7 leprosoria in the State. These are located at Eku, Jeddo, Ayakoromo, ;Ibrede, Okwagbe, Ute-Enugu and Aboh Ogwashi-uku. A total of four hundred and fifty nine (459) ex-lepers are being resettled in these settlements.
(ii) The approval of 8 orphanage homes in the State.
(iii) The establishment of one centre for the elderly at Asaba.
(iv) Government has approved four (4) Trado-medical psychiatric Healing homes at Ogwashi-uku, Agbor, Oki-Agbor and Sapele to which two hundred and twenty-three (223) destitutes and vagrant lunatics have been sent for treatment.
(v) The establishment of correctional institutions, known as Remand Homes/Detention centers, where young offenders awaiting trial, and those beyond parental control, care and protection are confined to. Presently, Government has a Remand Home at Sapele with a total of 92 inmates.

Delta State Government recognizes the importance of the health sector in the socio-economic development of the state as good health is associated with high productivity. But most health indicators are lower than national and international standards including the MDGs. At present, there is fragmented health care delivery among public-private health care providers; inadequate and inefficient financing; weak health infrastructure; mal-distribution of health workforce and poor co-ordination among key players.

Between 2004-2007, Delta State implemented the Health Sector Reform Programmes (HRSP), during which effort was made to address the following: government stewardship role; management of the state health system; the burden of diseases; mobilization and utilization of health resources; health service delivery; consumer awareness and community participation; partnership, collaboration and coordination. Inspite of the commendable effort of Government, the underlying weaknesses and constraints of the health sector still persist.

As an attempt to have a breakthrough in addressing the issues, the Federal Ministry of Health has articulated the National Strategic Health Development Plan Framework to guide States and Local Government Areas in developing their State Strategic Health Development Plan to be harmonized into one costed NSHDP and M&E frame work. To accomplish this task at state level, FMOH appointed a Consultant to work with the State Team following several meetings and workshops at federal level.

The frame work has eight priority areas which are:

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

Each priority area has specific goals, strategic objectives and programmes interventions

The development of the Delta State SHDP started with great expectations. There were several meetings of the technical committee before the SSHDP commenced

The first formal activity was the inauguration of the Steering Committee on Tuesday 20th October, 2009. The delay was due to some challenges. It was well attended by a cross section of the expected participants. From October 21st-23rd 2009, the IMNCH Team from FMOH Abuja worked with the State Technical Committee including the Consultant, MCH Desk Officers, Representatives of professional groups, WHO Representative and State M&E Officer to incorporate the IMNCH component into the SSHDP Framework.

State level training for State Planning Committee with representatives from LGAs was held. In attendance were Directors of different departments in SMOH, Health related Ministries and parastatals, Representatives of WHO, NGOs, CSOs, Medical and Nursing Professions, and Private practitioners.

The training started with an introductory session which provided the opportunity for the participants to have an overview of the SSHDP process; understand the guide to SHDP and a preview of the SHDP content. This was followed by the workshop during which situation analysis was done to elicit background data needed to execute the development of a six-year SHDP that will improve performance of the health sector towards the delivery of quality, efficient and sustainable health care to the people of Delta State.

The framework developed for this purpose from the FMOH was adapted to develop the plan. The process of developing the SSHDP and LGASHDP were the same. At the state level, the participants came with their computers to work on the framework. But at the LGA level the participants had to write out theirs as they did not come with computers. This made the work to be much and time consuming. In spite of challenges the draft reports of the SSHDP and LGASHDP have emerged.

The twenty five LGAs in Delta State were grouped into two according to their geographical location. The first group was invited to Agbor town while the second was invited to Ughelli town. The two centers were considered to be central, easily accessible and have suitable venues for the activities. At the LGA level, the agenda was the same as that of the state. The activities started with training which was followed with work on the LGASHDP. Attendance during the LGASHDP was encouraging as different cadres of health personnel in the Local Government health service were present. These included Supervisory Councilors (Health),

HODs (Health)/PHC Coordinators, HODs of Community Health, and Environmental Health, Officers in charge of Reproductive Health, Immunization, Role Back Malaria, M&E, and other Programme Managers.

It is important to note that the participants at both State and LGA levels were shared into eight groups; each group handled a priority area and developed the SHDP on that area. The groups then made presentations of the SHDP developed to the larger body for corrections, comments, addition or even deletion of inappropriate parts. It was a period participants shared their knowledge and experiences. Thus, the purpose of working together to develop the SSHDP and LGASHDP to make the output their own was achieved. The excel sheets worked on at state level were merged into one log framework. At the LGA level, the participants in the two venues did not come with computers to work directly on the excel sheet, they wrote on plain sheets which were then entered into the excel spread sheet. Though tedious and time consuming, the work was put together as one piece.

CHAPTER TWO

SITUATION ANALYSIS

2.1 Socio-Economic Content

The population of Delta State from the 2006 National census is 4,098,391 made up of 2,074,308 males and 2,024,085 females spread in the 25 Local Government Areas.

Farming, Fishing and Hunting are the major occupations of the inhabitants of Delta State, as about 80% of the active labour force are engaged in these occupational activities with the remaining 20% engaged in other occupations

As much as 30% of the total crude oil produced in Nigeria comes from Delta State making it a leading producer of oil and gas in the country. The oil and gas reserve is quite enormous: There are Refinery and Petrochemical Company at Warri; Gas Plant at Utorogu; Delta steel complex at Ovwian-Aladja; three gas fired electricity stations at Ughelli, Ogorode-Sapele and Okpai and two oil export terminals at Forcados and Escravos. The State has abundance of raw materials that can support any established agro-allied industry. The State is interconnected by good roads and has an air at Osubi near Warri, water transportation facilities and telecommunication facilities while Asaba airport is under construction.

Sectoral Contribution to Delta State GDP

1.	Oil and Gas and Solid Minerals	73.29%
2.	Agriculture	11.24%
3.	Manufacturing	8.59%
4.	Commerce/Services	3.37%
5.	Real Estate/Construction	2.06%
6.	Financial Institutions/Insurance	1.45%
	Total	100%

The State budget for 2009 is as follows;

	State	MOH
Capital	N168,083,331,057	N8,028,860,271
Recurrent	N85,676,864,982	N7,604,972,371

It is a fact that more than 75% of Deltans are engaged in agriculture. Market-oriented industrial activities are also found in the major towns of the state such as Warri, Asaba, Sapele, Oleh, Ughelli, Agbor and other semi-urban areas. Commercial activities complement industrial activities in the State.

2.2 Health Status of the Population

The critical health indicators for Delta State include Crude Birth Rate (25/1,000 persons). Crude Death Rate is (8/1,000 persons), infant Mortality Rate (114/1,000 live births), and from the State's free maternal health statistics, Maternal Mortality Ratio (301/100,000 live births). With respect to child health: measles immunization coverage rate – and DPT3 rates are relatively

high-86% and 94% respectively, while the 2003 HIV sero-prevalence rate of 5 % has dropped to 3.7 % in the 2007 survey.
Common causes of illness and death among under – 5 children are Malnutrition, Measles, Pneumonia, Diarrhoea, Malaria, HIV/AIDS, Sickle Cell Anaemia , Anaemia, mortality in the new born due to Low Birth Weight, Asphyxia, Neonatal Jaundice, and Acute Respiratory Tract Infection.

Among mothers, common causes of death include: Haemorrhage, Malaria, Hypertension in Pregnancy, Sepsis (post abortion), Anaemia in pregnancy, HIV/AIDS, Diabetes Mellitus, Obstructed Labour and Pelvic Inflammatory Disease.

General causes of illness and death include: Hypertension, Diabetes Mellitus, Tuberculosis, Malaria, HIV/AIDS, Heart Disease and Cancer: while major causes of disability are Poliomyelitis, Accident, Leprosy, Arthritis, Congenital malformation, Birth injury and Cardio-Vascular Accident Common.
Communicable Diseases in the state are: Malaria, Diarrhea, Tuberculosis, HIV, Typhoid fever and Onchocerciasis

2.3 Health Services Provision and Utilization

There are 344 Primary Health Care (PHC) Centres in addition to 25 Public Health Clinics and 8 dispensaries in the State. At the secondary level the State has 62 government hospitals made up of: 53 general; 6 central; one specialist; one Federal Medical centre, one State Teaching Hospital (soon to be commissioned). There are 53 registered private/mission hospitals and 345 private clinics as well as 186 private/mission maternity homes in the State. In the area of human resources, in 2009 there were 300 medical doctors and 1,775 nurses. In addition, there is a large pool of registered and unregistered, unregulated traditional and alternative medical practitioners; who enjoy patronage by the people.

The state is responsible for secondary health care, while the LGAs are responsible for PHC. However, the State health facilities also provide PHC services at their various locations. In addition, some State owned hospitals like Central Hospitals and the emerging Teaching Hospital render services that tertiary hospitals offer. The private sector is also involved in providing primary and secondary health care services. There exists in nearly all communities the practice of traditional medicine.

Safety Nets for Vulnerable Groups:
The growing number of destitutes, the mentally ill, the physically challenged (disabled), ex-leprosy patients, orphans and widows pose a serious challenge to the social responsibility of Government to its citizenry. The State Government has, embarked on the following:
(i) The establishment of 7 leprosoria in the State. These are located at Eku, Jeddo, Ayakoromo, Ibrede, Okwagbe, Ute-Enugu and Aboh Ogwashi-uku. A total of four hundred and fifty nine (459) ex-leprosy patients are being resettled in these settlements.
(ii) The approval of 8 orphanage homes in the State.
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(v) The establishment of correctional institutions, known as Remand Homes/Detention centers, where young offenders awaiting trial, and those beyond parental control, care and

protection are confined to. Presently, Government has a Remand Home at Sapele with a total of 92 inmates.

There are inter-linkages for referral system in the State health care services. The referral is from community to Health Centre and from there to General Hospital where cases are referred to Central Hospital and from there to Teaching Hospital. The referral is also done in the reversal manner, from higher to lower level

Supervision is carried out by higher level over lower level. For instance SMOH supervises HMB, while HMB supervises hospitals. SPHCDA supervises PHC at LGAs. Generally, private practice is not supervised, although private health institutions are required by law to register with SMOH. Technical, operational and managerial problems and challenges to health services provision include availability of funds, transportation, motivation and commitment. Each State hospital has at least an ambulance that needs regular maintenance, but the imprest to each hospital is not enough for regular maintenance of the vehicles and the electricity generating plants.

The State Government makes effort to provide adequate equipment for the hospitals and health centres but there is need for regular maintenance of these equipment.

There is a functional Drug Revolving Fund (DRF) in the State. An essential drug list is in existence. There is also, a quality assurance laboratory within the premises of the DRF

Community participation at PHC level exists in some communities. Ward/Community Development Committee and Village Health Committee sometimes assist in providing transport to move clients to health care facilities.

Immunization performance in the state shows that the cumulative coverage data for Jan-Aug 2009 are as follows: BCG = 88% ,DPT3 = 94%, OPV3 = 83% , Measles Vaccine = 86% , Yellow Fever = 78%, and Tetanus Toxoid (women of child bearing Age) = 45%

The proportion of pregnant women receiving antenatal care and skilled attendance at delivery are 77.6% and 69.7% respectively, while contraceptive prevalence rate is 12.7% (MICS 2007)

Available services utilization data from the NDHS shows among others that the state has 78% ANC coverage, 62% of the pregnant women in the state are attended to by a skilled health care provider at the time of delivery, 57% of pregnant women deliver in a health care facility, 38% of children are fully immunized, 17%, and 2% of children and pregnant women that have malaria are treated using the right antimalarial drug respectively.

A summary of health status indicators in the state are shown in the following table

INDICATORS	DELTA
Total population	4,098,391 (2,074,308 males and 2,024,085 females)
Under 5 years (20% of Total Pop)	819,678
Adolescents (10 – 24 years)	1,376,652
Women of child bearing age (15-49 years)	901,646
Literacy rate	77% female; 89% men
Households with improved source of drinking water	72%
Households with improved sanitary facilities (not shared)	22%
Households with electricity	64%
Employment status (currently)	60.3% female, 68.1% male
TFR	4.5
Use of FP modern method by married women 15-49	15%

ANC	78%
Skilled attendants at birth	62%
Delivery in HF	57%
Full immunization coverage	38%
Children that have not received any immunization (zero dose)	8%
Stunting in Under 5 children	35%
Wasting in Under 5 children	6%
Diarrhea in children	2.5
ITN ownership	6%
ITN utilization	6% children, 5% pregnant women
Malaria treatment (any anti-malarial drug)	17% children, 2% pregnant women
Comprehensive knowledge of HIV	24% female, 26% men
Knowledge of TB	58.6% female, 76.9% male

Disease control services provided by the State Government are:
Malaria, Schistosomiasis, Guinea worm eradication, Lymphatic filariasis, HIV, Tuberculos, Leprosy, Human African Trypanosomiasis and Avian Influenza .

2.4 KEY ISSUES AND CHALLENGES

SWOT analysis was done to identify the key issues and challenges.

SWOT ANALYSIS

Strengths

- Strong and committed / dedicated staff made up of technical, professional and non professional categories
- Provision of free health services by the State Government to pregnant women and rural dwellers
- Large number of primary and secondary health care facilities provided in the state(62 Govt Hospitals & 344 PHCCs)
- Strong political will
- Right professionals in positions of leadership
- Presence of agencies to facilitate effective execution of health activities
- Lots of training and retraining by Partners for LGA staff
  And at the State level, there is capacity building for the health sector
- Financial and technical support given by Development Partners
- Regular rehabilitation of existing Health Facilities including PHCCs and strengthening their capacities to provide effective, efficient, affordable and quality (PHC) services

Weaknesses

- Inadequate personnel
- Inadequate security for staff in some HFs at night
- Lack of Vertical level coordination
- Inadequate maintenance of equipment
- Absence of data base for each facility
- Inability to use generated data from field for planning
- Absence of community involvement in some areas
- Poverty and illiteracy among the people
- Inadequate infrastructure in some health facilities
- Poor attitude to work
- Poor communication
- Poor ethical adherence affecting clear cut roles
- Inadequate training (capacity building) on data
- Top-down instead of bottom-up decision on what to purchase and supply

- Inadequate and poor quality equipment
- Poor access due to difficult terrain
- Inadequate funds
- Non implementation of free maternal health care at LGA level
- Inequitable distribution of health care personnel at all levels especially at the rural and hard to reach areas.
- Weak referral system
- Undefined Blood Banking system

Opportunities

- Large crop of trainable and trained manpower
- Community leaders are ready to support
- Willingness of communities to embrace health services
- Willingness of donor partners to invest
- Improved peace and security especially in the riverine areas

Threats

- poor utilization of health care services
- Corruption
- Unethical practice of health workers
- Quackery

CHAPTER THREE

STRATEGIC HEALTH PRIORITIES

This SHDP seeks to provide strategic guidance to the State in the selection of evidenced-based priority interventions that would contribute to achieving the desired health outcomes for the people of Delta state towards achieving sustainable universal access and coverage of essential health services within the planned period of 2010 - 2015.

The Honourable State Commissioner for Health therefore expects all the stakeholders to embrace '*the use of this SHDP for the development of the respective operational plans for the state.*'

This SSHDP focuses on eight priority areas that are listed as follows:

- Leadership and governance;
- Service delivery;
- Human resources for health;
- Health financing;
- Health information system;
- Community participation and ownership;
- Partnerships for health; and,
- Research for health.

Annex I specifies the goals, strategic objectives and the corresponding interventions and activities with costs.

To improve the functionality, quality of care and utilization of services so as to positively impact the health status of the population, universal access to a package of cost-effective and evidence-based interventions detailed below is needed. This would of necessity require interventions that transform the way the health care system is resourced, organized, managed and services delivered

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

Follow up Management of Severe Acute Malnutrition
Routine postnatal care (healthy practices and illness detection)

B. POPULATION ORIENTED/OUTREACHES/SCHEDULABLE SERVICES
Family planning
Condom use for HIV prevention
Antenatal Care
Tetanus immunization
Deworming in pregnancy
Detection and treatment of asymptomatic bacteriuria
Detection and management of syphilis in pregnancy
Prevention and treatment of iron deficiency anemia in pregnancy
Intermittent preventive treatment (IPT) 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 asphyxiated newborns at birth
Antenatal steroids for preterm labor
Antibiotics for Preterm/Prelabour Rupture of Membrane (P/PROM)
Detection and management of (pre)eclampsia (Mg Sulphate)
Management of neonatal infections
Antibiotics for U5 pneumonia
Antibiotics for dysentery and enteric fevers
Vitamin A - Treatment for measles
Zinc for diarrhea management
ORT for diarrhoea management
Artemisinin-based Combination Therapy for children
Artemisinin-based Combination Therapy for pregnant women
Artemisinin-based Combination Therapy for adults
Management of complicated malaria (2^{nd} 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 HIV/AIDS
Second line ART for children with HIV/AIDS
Second-line ART for pregnant women with HIV/AIDS
Second-line ART for adults with AIDS
TB case detection and treatment with DOTS
Re-treatment of TB patients
Management of multidrug resistant TB (MDR)
Management of Severe Acute Malnutrition
Comprehensive emergency obstetric care (C-EOC)
Management of severely sick children (Clinical IMCI)
Management of neonatal infections
Clinical management of neonatal jaundice

Universal emergency neonatal care (asphyxia aftercare, management of serious infections, management of the VLBW infant)
Other emergency acute care
Management of complicated AIDS

CHAPTER 4

RESOURCE REQUIREMENTS

Delta State will require the following human, physical and financial resources to be able to implement this Strategic Health Development Plan:-

4.1 Human

Even though there is generally inadequate manpower in Delta State Civil Service, the State is endowed with committed public health work force of made up of 4,594 staff of the Hospitals Management Board and 343 staff of the Ministry of Health.

4.2 Physical

There are currently 926 health facilities in Delta State made up as follows:-

Tertiary	= 2
Secondary	= 113
Primary	= 875
TOTAL	**= 990**
Public	= 406
Private/Mission	= 584

4.3 Financial

The SSHDP will obviously require a huge financial investment if the various interventions and activities are to be attained. To make the laudable and ultimate goals and strategic objectives of the SSHDP realizable, it is pertinent to clear financing and implementation sources, the strategies and measures to implement the SHDP in Delta State.

The major sources of **funds** for the projects in the State include the following:-

- Monthly statutory allocation from the Federation Account (FAAC);
- Internally Generated Revenue;
- Accruals from Value Added Tax (VAT);
- Accruals from Derivation Account (DACC);
- Oversea Development Assistance (ODA)
- Loans; and
- Grants

These are the human, physical and financial resources currently available for us to implement Delta SSHDP. No doubt, the human resources are likely to be inadequate to comprehensively execute the entire Plan unless there is recruitments in the health sector as proposed in the Plan.

CHAPTER 5

FINANCING PLAN

5.1 Estimated cost of the strategic orientations

The grand total cost of the entire activities in the Plan is the sum of one hundred and thirty one billion, nine hundred and thirteen million, sixty eight thousand, eight hundred and seventy three naira (NGN 131,913,068,873) only. The break down for each of the 8 thematic areas (strategic orientations) is as reflected in the Table below.

PRIORTY AREA	ESTIMATED COST 2010-2015
LEADERSHIP AND GOVERNANCE FOR HEALTH	NGN 1,319,130,689
HEALTH SERVICE DELIVERY	NGN 73,850,512,743
HUMAN RESOURCES FOR HEALTH	NGN 44,790,436,568
FINANCING FOR HEALTH	NGN 4,697,770,085
NATIONAL HEALTH INFORMATION SYSTEM	NGN 1,978,696,033
COMMUNITY PARTICIPATION AND OWNERSHIP	NGN 1,319,130,689
PARTNERSHIPS FOR HEALTH	NGN 1,319,130,689
RESEARCH FOR HEALTH	NGN 2,638,261,377
TOTAL	NGN 131,913,068,873

5.2 Assessment of the available and projected funds

The total budget for Delta SHDP is NGN 131,913,068,873. In view of the dwindling statutory allocation to States attendant on the global economic meltdown and the low price of oil, we expect an average of NGN 18,808,262,130.63 annually from Delta State Government in the health sector. The total for the projected funding for the period 2010-2015 is NGN 112,849,572,783.80. This is based 2009 budget to the health sector and with an annual inflation rate of 12.5%.

5.3 Determination of the financing gap

From our computation and forecast, the State should be able to budget an average of NGN 18,808,262,130.63 annually. This is about NGN 112,849,572,783.80 for six years (2010-2015). The total budget for Delta SHDP is NGN 131,913,068,873 hence the financing gap of NGN19,063,496,089.20.

5.4 Descriptions of ways of closing the financing gap

The above sources of funds have been identified with a view to ensure appropriate mobilization of funds from each source for closing the financing gaps for SSHDP implementation in Delta State. It is noteworthy that FAAC will remain the dominant source of funds for the implementation of SSHDP in Delta State. However, the vulnerability of FAAC as a source of funding is already apparent due to shocks in the oil market occasioned by the current global

economic meltdown. This is why IGR, which though ranks much lower than FAAC is nevertheless a more stable and reliable source of financing for SSHDP.

ODA will be welcomed from rich industrialized countries like the USA, Britain, Canada, France, Germany, Russia, China, Japan, Netherlands, etc as well as from multi-lateral institutions like WHO, UNICEF, World Bank, African Development Bank, etc especially in the areas of funding for health system development, HIV/AIDS, malaria control, provision of essential components of health care delivery services and facilities.

CHAPTER 6

IMPLEMENTATION FRAMEWORK

6.1. Structures

The judicious utilization of the funds available for implementing the Delta SSHDP will to a large extent depend on the extent of transparency or openness in the procurement process. Wherever the procurement is tinted with corruption, it would be difficult to realize the goals and strategic objectives of the SSHDP.

In Delta State, there are Financial Instructions governing procurement of goods. In addition there are various circulars regulating procurement, receipt, verification, storage and usage of items procured. Although these rules and regulations exist, it is observed that the level of compliance by officials of the establishments is low. Some of the lapses in the system include:-

- Authorization of procurement above individual approval limit.
- Inadequate storage facilities in most Government Ministries/Institutions
- Short supply of well trained personnel to handle the procurement and storage units of government ministries/institutions

However, all these drifts are not in the character of the State Ministry of Health. All procurements in the past 10 years were approved before execution and within the ambit of approval capacity of the approving Officers/Chief Executive; there is a standing Ministerial Tenders Board in the Ministry made up of Directors with the Permanent Secretary as Chairman; there is a State Tenders Board made up of the Deputy Governor as Chairman, Secretary to the State Government, Honourable Commissioners in the Ministries of Justice, Economic planning, Finance, Works, Health, Agriculture, Water Resources Development and Housing, Due Process Officer from the office of the governor and the Executive Assistant to the Governor. There is an Engineer/ Procurement Officer and an architect attached to the department of planning in the Ministry of Health. The Ministry also stores all its procured goods and equipment at State Medical Stores in the Drug Revolving Fund premises and Hospitals Management Board Headquarters in Asaba.

6.2. Institutions

The following institutions in Delta State will be involved in the implementation of the SSHDP:-

- Government House (Office of Fiscal Governance)
- Office of the Hon. Commissioner for Health
- Office of the Permanent Secretary, Ministry of Health
- Ministry of Budget, Planning & Economic Development
- Ministry of Finance
- Delta State Tenders Board
- Ministry of Health's Ministerial Tenders Board
- Delta State Steering Committee (SSC) of the SSHDP
- Department of Planning, Research & Statistics, Ministry of Health
- Office of the Accountant General of Delta State
- Office of the Auditor General of Delta State
- Ministry of Works
- Ministry of Housing
- Ministry of Water Resources Development
- Ministry of Power and Energy

6.3. Strategic Partners

Over the years, Delta State has enjoyed the support of UN Agencies and other bilateral and Non-Government Agencies in its preventive health programmes in enhancing Child Survival, Safe Motherhood, Immunization, Essential Drug Supplies, Disease Control, and programme management. Such organizations include:-

- UNICEF (for the promotion of better nutrition and other child survival programmes)
- WHO (for the support in Disease Control and Surveillance)
- UNFPA (for the just concluded support to Reproductive Health programmes)
- World Bank (for support in Health system Development Project II)
- Global 2000 (for Guinea Worm Eradication)
- GLRA (for the just concluded support in TB and Leprosy Control)
- FHI/GHAIN (for support to PMTCT, VCT, treatment of HIV/AIDS)
- Rotary International (for the supply of vaccines especially for Polio)
- FMOH (for overall support both to the State and Local Government Councils)

The judicious use of public funds shall be an important way of attracting donors into the State. The ability to achieve the targeted financing strategy would largely depend on how serious government is on getting value for money in public spending.

6.4. Civil society

The private sector shall be involved in the whole financing process. The vehicle for achieving this should be by intensive advocacy, close interactions among stakeholder all of whom will be expected to buy into the SSHDP. There shall be annual meeting of State Steering Committee (SSC) with stakeholders on implementation issues to facilitate identification of problems and subsequent resolution. This will also be discussed at the bi-annual State Council on Health meetings.

Some of the infrastructural interventions shall take the form of Public-Private-Partnership (PPP) framework. Some important ones such as laboratory and diagnostic services may involve Build Operate and Transfer (BOT), and Rehabilitate Operate and Transfer (ROT). An important approach to ensure the achievement of partnership in development is value for money in service delivery.

The following civil societies/ professional associations will be involved in the implementation of SSHDP:-

Nigerian Medical Association (NMA)
Pharmaceutical Society of Nigeria (PSN)
National Association of Nigerian Nurses and Midwives(NANNM)
Association of Medical Laboratory Scientists of Nigeria
Medical and Allied Health Workers Union
Association of Community Pharmacists of Nigeria (ACPN)

6.5. Individuals

Individuals and communities also have a role to play in the form of counterpart funding

CHAPTER 7

MONITORING AND EVALUATION

7.1 Proposed mechanisms for monitoring and evaluation

Deliberate efforts will be made to guide and ensure faithful implementation of the plan. Strengthening of the Health Management Information System will be carried out early in the plan to ensure that M & E and DSN units are empowered at all levels to track and monitor progress. Specifically, periodic joint assessment of achievements and progress towards MDGs will be carried out with the Local Government Councils. Monitoring and Evaluation were incorporated as key activities in each of the 8 priority areas. Expanded Health Data Consultative Committees (HDCC), Interagency Coordinating Committee and the Donor Agencies Forum will be used to ensure cooperation of all stakeholders. More regular State Council on Health meetings (twice yearly) will be used to provide forum for broad-based consultation, coordination and collaboration on a continuous basis.

Successful implementation of the goals, strategic objectives of SSHDP largely depend on monitoring. The Office of the Special Adviser to the Governor on Project monitoring shall provide focal point for monitoring efforts. This office shall follow the bench M & E Result framework which is attached here as annex ….. in monitoring progress towards achieving the goals and targets of this plan.

7.2 Costing the monitoring and evaluation component and plan

Details are available in the Work Plan.

CHAPTER 8

CONCLUSION

In order to achieve the sector goals and adequate sector financing of the SSHDP, all partners, including governments, donors and civil society need to align themselves with the agreed set of instruments and approaches. The forum provided by this state input to the NSHDP is a welcome development and should be sustained.

Achieving the health MDGs will require support for more equitable strategies in the health sector and society generally as well as efforts to ensure that health has a more prominent place in economic and development policies. The need for more budgetary allocation for health and for actual releases of the allocated funds regularly need not be over emphasized. This will ensure progress in solving priority problems. There is great need now more than ever before for building capacity in leadership, management and institutional capacity within the ministries of health especially in strategic planning and budgeting; there is need for greater dialogue between health and other line ministries like finance and planning as development is an intersectoral and interdependent process.

If all the interventions detailed in the attached work plan are faithfully implemented, it will impact positively on the accelerated achievements of the MDGs in Delta State in line with national and global goals and also position the State for continuous quality improvements in health care delivery beyond 2015.

Annex 1: Delta State Reference Group

S/N	NAME	POSITION / AGENCY
1	DR. O.P. OFILI (CHAIRMAN)	PERMANENT SECRETARY, MOH
2	DR. (MRS) L.O. OKPAKO	DPRS, MOH
3	DR. C.O. OKUGUNI	ACTING DPHC/DC, MOH
4	MRS. M. ASHIKODI	REP. DPHC DIRECTORATE. OF LG
5	DR AGWAI	WHO
6	DR. TOBI. MAJOROH	SPHCDA
7	MR. N. AJUAR	HSDP 11
8	DR. SAM AKPOVI	SHDP CONSULTANT
9	MR MIKE UDUJE	M&E OFFICER, MOH

Annex 2: Details of Delta Strategic Health Development Plan 2010-2015

DELTA STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
PRIORITY AREA							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Stakeholder/ Responsibility**	**TOTAL COST ESTIMATE 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								**1,319,130,689**
	1.1	**To provide clear policy directions for health development**			**All stakeholders are informed regarding health development policy directives by 2011**			**383,189,017**
		1.1.1	Improved Strategic Planning at State and LGA levels					**238,894,740**
			1.1.1.1	Review MNCH Policies, strategies, guidelines and protocols based on state needs, print and distribute document to state and LGAs	Policies and guideline develop and disseminated by 70 % in the State and LGA levels by the end of 2010	Lack of political will and enabling environment; Materials in circulation	DPHC/DC,S DPRS(MOH) & DPHCS (DSPHCDA)	133,960,204
			1.1.1.2	Capacity building of Health Managers at state and LGA level on Programme management course and Marginal Budgetting for Bottleneck tool	Capacity of Health Mangers that are gender-sensitive improved on programme management and budgetting by 45% in the State and LGA by mid 2012	Lack of collaboration and effective participation, Assumed previous knowledge 5%	DPRS (MOH) & DSMA (DSPHCDA)	63,790,573
			1.1.1.3	Effecttive implementation of agreed plans that will include advocacy at LGA level in support of policy development	Advocacy visits to LGA policy makers 1st yr and improved by 15% twice yrly subsequently by the end of 2015	Political inertia,lack of political will,rapid turn over of political appointees & technical leadership. All levels of leadership will key into the dev of SHDP	DPRS (MOH) & DSMA (DSPHCDA)	21,551,007
			1.1.1.4	Support the LGA in the development of evidence- based, costed, and prioritised strategic health plans for the sector	To have PHC Programme Officers trained and 70% knowledgeable in developing the strategic	Availability and prompt release of fund	DPRS (MOH) & DSMA (DSPHCDA)	6,834,841

					health plan by the end of 2010			
			1.1.1.5	Develop strategic health plans in such a way as to maximise the contribution of the wider stakeholders at the state and LGA.	Provide a guide and Inform all stakeholders of State & LGAs on SHP(State & LGA)	Lack of understanding of the expected SHP by the Policy makers.	DPRS (MOH) & DSMA (DSPHCDA)	12,758,115
		1.1.2	Ensure regular updating and access to the State Strategic Health Plan					**52,435,851**
			1.1.2.1	Formation of SHDP review committee	Committee formed and yearly update of State SHDP done	commitment from the SHDP review committee	State	5,613,570
			1.1.2.2	Meeting of the committee at least once every six months	Committee meeting sustained and resources provided	Political will and inertia, Lack of funds and enabling enironment	State	10,461,654
			1.1.2.3	To provide hard copies of the State Strategic health plan to stakeholders	Hard copies made available in the State by the end of 2010	Political will and inertia, Lack of funds and enabling enironment	State	1,913,717
			1.1.2.4	Establish a committee for the yearly development of operational activities	Resources provided and committee member encouraged	Political will and inertia, Lack of funds and enabling enironment	State	5,358,408
			1.1.2.5	Meeting of the State Planning team at least once every 6 months/Conduct MNCH regular review and annual planning meetings at State and LGAs	Resources provided and committee member encouraged	Political will and inertia, Lack of funds and enabling enironment	State	29,088,501
		1.1.3	Establish intra-sector mechanism for policy synergy in the health sector					**31,767,706**
			1.1.3.1	State council on health meetings once every 6 months to consider and adopt health policies	State and LGAs have instituted a system for appraisal of health policies	Funds available for meetings	MOH, Dept of Clinical governance, SERVICOM, E-Health	3,061,948
			1.1.3.2	Identify and implement capacity building and reorientation initiatives for health policy development at all levels	Strategies in place for continuous capacity building by 2011	Political will and inertia, Lack of funds and enabling enironment	MOH, Dept of Clinical governance, SERVICOM, E-Health	28,705,758
		1.1.4	Identify and implement capacity building and reorientation/initiatives for health policy development at all levels					**60,090,720**
			1.1.4.1	Develop, publish and institutionalise framework for the formulation and implementation of policies	Frameworks developed and operational in the State by 2010	Political will and inertia, Lack of funds and enabling enironment	State and LGAs	13,651,183
			1.1.4.2	Hold Zonal training sessions with LGAs to explain and popularise the policy development frameworks	Zonal training held and	Political will and inertia, Lack of funds and	State and LGAs	37,508,857

					processes documented	enabling enironment		
			1.1.4.3	Sustain implementation of the National Policy on HIV/AIDS in the workplace	Legislation in place and watchdogs established by 2011	Political will and inertia, Lack of funds and enabling enironment	State and LGAs	8,930,680
	1.2	**To facilitate legislation and a regulatory framework for health development**			**Health Bill signed into law by end of 2009**			**793,044,408**
		1.2.1	Strengthen regulatory functions of government					**752,728,766**
			1.2.1.1	Set standard, ensure compliance and proper monitoring of the practise for the private health sector as a contributor to health care delivary	Model of practice establised & Private health Practitioners trained	availability of fund for the activities. Lack of cooperation of the private practitioners. Improved compliance of the private practitioners with the national policy on PPP.	DMST, DNS, DPHC/DC & DPS (MOH) & DPHCS (DSPHCDA)	637,905,734
			1.2.1.2	SMoH to support the development of public/private partnership policies and plans in the state /LGA in line with the national policy on PPP	Increased Public enlightenmen t & technical support to stakeholders on PPP	availability of fund for the activities. Lack of cooperation of the private practitioners. Improved compliance of the private practitioners with the national policy on PPP.	DMST, DNS, DPHC/DC & DPS (MOH) & DPHCS (DSPHCDA)	63,790,573
			1.2.1.3	Technical support on implementation of PPP strategic plans	15% achievement level of practice in the 1st year of the PPP	Inertia among the private practitioners of an achievable PPP. Achievable PPP	DMST, DNS, DPHC/DC & DPS (MOH) & DPHCS (DSPHCDA)	25,516,229
			1.2.1.4	SMOH to set up committee to periodically review and enforce public health acts and laws in line with National health bills	Achieve quarterly supervision & monitoring of public and private practice	Lack of fund for the activities. Lack of cooperation of the private practitioners. Non availability of statistics of level of compliance. Improved comptiliance of the private practitioners with the National Health acts and Laws.	DMST, DNS, DPHC/DC & DPS (MOH) & DPHCS (DSPHCDA)	25,516,229
			1.2.1.5	Advocacy visit on operational standards to the LGA Legislative arm & private health service providers	Copies of operational standards printed and ciculated	Lack of funds and political will	Supervisor Health/ HOD health, LGHMC & Private	-

							Health Service providers	
		1.2.2	Defining and communicating roles and responsibilities of regulatory agencies to stakeholders		Training of stakeholders on functions of regulatory agencies carried out			**16,457,968**
			1.2.2.1	Training and sensitization of stakeholders on the functions of regulatory agencies	Training of stakeholders on functions of regulatory agencies carried out	Lack of funding, conflict of interest. Effective collaboration among stakeholders	State, Stateholders	16,457,968
		1.2.3	Review/Streamline roles and responsibilities of regulatory institutions to align with Delta State Health Bill					**17,861,361**
			1.2.3.1		Regulatory committee established and provided with resources by 2010	Political will, Lack of funds and enabling enironment	State and Regulatory institutions	3,827,434
			1.2.3.2	Amend roles and responsibilities of regulatory institutions	Responsibiliti es of regulatory institutions reviewed by 2011	Political will, Lack of funds and enabling enironment	State and Regulatory institutions	5,741,152
			1.2.3.3	Develop capacity of regulatory institutions to fulfill their roles and responsibilities	Capacities of regulatory institutions built by 60% by the end of 2011	Political will, Lack of funds and enabling enironment	State and Regulatory institutions	8,292,775
		1.2.4	Update/enforce Public health acts and laws in line with the PHC approach					**5,996,314**
			1.2.4.1	Review health legislation to ensure that gaps are filled in areas which need improvement		Availability of Public Health Laws	DPHC/SPHCDA	4,592,921
			1.2.4.2	Review/update public health acts and laws by involving legislators		Legislators are committed to public health	DPHC/SPHCDA	1,275,811
			1.2.4.3	Submit to legislators and advocate for enactment into law	Appropriate public health legislation passed and each accented to	Legislators are committed to public health	DPHC/SPHCDA	127,581
	1.3	**To strengthen accountability, transparency and responsiveness of the national health system**			**80% of States and the Federal level have an active health sector 'watch dog' by 2013**			**22,926,332**
		1.3.1	To improve accountability and transparency					**13,357,746**
			1.3.1.1	Conduct meetings to orientate health managers and budget officers on financial management, transparency and accountability at State and LGA levels.			DFA(SMOH)/LGA SUPER HEALTH & HOD HEALTH	4,210,178

			1.3.1.2	SMOH to set up a joint stakeholders forum for the purpose of dialogue and creating platform for interaction and collaboration with health sector advocacy groups	Hold bi-annual stakeholders meeting	Poor attendance and participation. Non availability of fund. Full collaboration and participation of pertners.	DPRS (MOH) & DSMA (DSPHCDA)	8,509,662
			1.3.1.3	SMoH to Create platform for the emergence of Health Sector watchdog	Increased activities of health sector watch dogs in LGAs	Lack of Public awareness	DPRS (MOH) & DSMA (DSPHCDA)	637,906
			1.3.1.4	Render to the public(community) bi-annual progress report of Health activities/programmes	No of reports given	Lack of commitment	Chairman, Supervisor Health/HOD Health	-
		1.3.2	To improve the responsiveness of the State health system					**9,568,586**
			1.3.2.1	Scale up leadership and management development			State	5,741,152
			1.3.2.2	Implementation of Zonal Health Management Policy				3,827,434
	1.4	**To enhance the performance of the national health system**			**1. 50% of States (and their LGAs) updating SHDP annually 2. 50% of States (and LGAs) with costed SHDP by end 2011**	**Various levels of government have capacity to update sectoral SHDP States may not respond in a uniform and timely manner**	MoH, CSOs and development partners	**119,970,931**
		1.4.1	Improving and maintaining Sectoral Information base to enhance performance					**27,429,947**
			1.4.1.1	SMoH to strenghten Research and analytical unit to liaise with universities, private sector research firms and research institutes	Capacity of Research and Analytical Unit improved by 50% in 2012 and improved capacity for efficiency by 2015	Lack of funding, conflict of interest. Effective collaboration of the research unit with universities	DPRS (MOH) & DSMA (DSPHCDA)	17,223,455
			1.4.1.2	Encourage the publication of research work for the information and benefit of members of the public	Training and capacity building for research staff in DPRS and other professional departments.	Lack of effective participation and Funding;	DPRS (MOH) & DSMA (DSPHCDA)	10,206,492
			1.4.1.3	Strengthen information and statistics gathering, by retraining of Health Facilitys staff on NHMIS	Up-to -date information and statistics rendered as and at when due to the State level regularly	Lack of mobility. Under-reporting and untimely report on the part of HF staff.	PHC Cordinators, HMIS units, M&E	-
		1.4.2	Advocacy to Mobilize support					**20,464,016**

			1.4.2.1	Develop State Specific IMNCH advocacy Tools, Print and Distribute	IMNCH advocacy tools disseminated		DPHC/DC, DPRS (MOH) & DSMA (DSPHCDA)	15,360,770
			1.4.2.2	Conduct advocacy visits to, legislatures, Religious and traditional rulers, CBOs, Partners etc to promote Partnership for IMNCH.			DPHC/DC, DPRS (MOH) & DSMA (DSPHCDA)	1,275,811
			1.4.2.3	Adovcacy for an increase in the allocation of not less than 15% of total Budget for health in accordance to Abuja Declaration			DPHC/DC, DPRS (MOH) & DSMA (DSPHCDA)	1,275,811
			1.4.2.4	Develop Advocacy strategy to ensure allocation of at least 70% of proposed SPHCDA fund to IMNCH services at LGA and communities			DPHC/DC, DPRS (MOH) & DSMA (DSPHCDA)	2,551,623
		1.4.3	Develop health leadership at State level					**15,692,481**
			1.4.3.1	Develop training guidelines and clear job description for Delta State health professionals		Funds available	SMoH	15,692,481
		1.4.4	Develop health leadership at LGA level		1. 20% of LGAs have a Medical Officer of Health by 2013. 50% of LGAs have a Medical Officer of Health by 2015			**15,564,900**
			1.4.4.1	Deploy Medical Officer of Health to provide competent leadership at each LGA			State	3,827,434
			1.4.4.2	Develop training guidelines and clear job description for Delta State to provide to LGA Medical Officers of Health			State	11,737,465
		1.4.5	Update SSHDP to ensure integrated management and provision of comprehensive minimum health package		50% of LGAs provide comprehensive minimum package by 2013			**40,819,588**
			1.4.5.1	Set up a process for updating the SSHDP			State and LGAs	7,348,674
			1.4.5.2	Update and cost SSHDP following a situation analysis showing the gaps to address			State and LGAs	13,491,706
			1.4.5.3	Create an environment for effective implementation of the SSHDP at all levels of the health system			State and LGAs	6,379,057
			1.4.5.4	Clarify roles and responsibility of various stakeholders			State and LGAs	-
			1.4.5.5	Institute an external review mechanism of senior citizen experts in health at each level			State and LGAs	13,600,150
HEALTH SERVICE DELIVERY								0
2. To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare								**73,850,512,743**
	2.1	**To ensure universal access to an essential package of care**			**Essential Package of Care adopted by all States by 2011**			**4,669,010,465**

		2.1.1	To review, cost, disseminate and implement the minimum package of care in an integrated manner					**3,025,523,164**
			2.1.1.1	Review and adapt National Minimum Health Care Package for stakeholders at State and LGA			SMOH,(PS,DPH CDC)SPHCDA(D PHCS)	27,391,455
			2.1.1.2	Ensure implementation of the Minimum Health Care package at LGA level Through M & E			DSPHCDA	246,523,095
			2.1.1.3	Establish and implement guidelines for outreach services			State and LGAs	287,062,449
			2.1.1.4	Make available these reviewed minimum package of care to stakeholders			State and LGAs	33,554,532
			2.1.1.5	Develop policies on training & recruitment of Health Personels in all the LGA to make them non restrictive and ensure a non discriminatory process irrespective of gender and cadre	70% of LGAs have developed HRH training and recruitment Policies by 2011	Political will, commitment availability of funds	LGA Chairman, Councillors, Super Health, HOD Health Dept	2,430,991,633
		2.1.2	To strengthen specific communicable and non communicable disease control programmes					**1,643,487,301**
			2.1.2.1	Strengthening specific disease control programmes in State and LGAs	**50% of disease control programs strengthened by 2011.**	**Availability of Funds**	SMOH-DPH/DC /SPHCDA and LGA Super Health & HOD Health	1,643,487,301
			2.1.2.2	Improve access to ITN and anti-malaria drugs especially for mothers and children			DPHC	-
			2.1.2.3	Improve school health programme like school meals among primary school children to reduce malnutrition			DPHC	-
			2.1.2.4	Strengthen routine immunization, NIDs (polio eradication) and immunization of pregnant women against tetanus (tetanus toxoid)			DPHC	-
			2.1.2.5	Train and Retrain of Health Service Providers in the LGAs on the control of communicable and non communicable diseases like HIV/AIDS, Malaria and Diabetes Miletus.	**80% of LGAs train Health Service Providers starting 2011**	**Attitude of health workers, availability of funds**	LGA Chairman, Supervisor Health	-
		2.1.3	To make Standard Operating procedures (SOPs) and guidelines available for delivery of services at all levels					**-**
			2.1.3.1	Provide standard operative proceedure and guideline for service delivery at the state and LGA level	**Standard operative proceedure provided at state and 60% of LGA by 2011**	**Availability of standard operative guildeline from FMOH and Funds**	FMOH/SMOH-DPRS,DPH/DC, LGA	-
			2.1.3.2	Distribute the SOPs and guidelines for delivery of services to each health facility			DMS, DPHC, DPRS	-
			2.1.3.3	To regularly update SOPs as need arises			DMS, DPHC, DPRS	-
			2.1.3.4	To monitor completeness and utilization of the SOPs			DMS, DPHC, DPRS	-
			2.1.3.5	Training all health workers on need for SOPs and guidelines for delivery of health services			DMS, DPHC, DPRS	-

		2.1.4	Establish or strengthen Health Facilities Maintenance/Finance Committee					**-**
			2.1.4.1	Increase the number of health facilities with Facility Maintenance/Finance Committee			State and Stakeholders	-
			2.1.4.2	Strengthen the health facilities maintenance/finance committee			State and Stakeholders	-
			2.1.4.3	Review membership of these committees to enhance function			State and Stakeholders	-
			2.1.4.4	Review performance of these committees every 6 months			State and Stakeholders	-
			2.1.4.5	Make budgetary provision for effective performance of the committee			State and Stakeholders	-
		2.1.5	Consultation with MDG stakeholders, LGAs, communities and other stakeholders					**-**
			2.1.5.1	Mobilise and harmonize activities of stakeholders towards MDG achievements			State, LGAs	-
			2.1.5.2	Encourage regular consultations with stakeholders before any major activity is carried out			State, LGAs	-
			2.1.5.3	Identify areas of community "felt needs" and including such in health programmes			State, LGAs	-
			2.1.5.4	Include all stakeholders in such programme as obtaining survey of infant and maternal mortality				-
	2.2	**To increase access to health care services**			**50% of the population is within 30mins walk or 5km of a health service by end 2011**			**32,812,223,965**
		2.2.1	To improve geographical equity and access to health services in Delta State					**24,059,969,300**
			2.2.1.1	Conduct Assessment of Health Facilities for delivery of the minimum packages				92,446,161
			2.2.1.2	Renovate, Equip and staff the Health faciliities appropriately at State & LGA.				23,282,736,764
			2.2.1.3	Conduct regular outreach to provide MNCH services in hard to reach areas.				684,786,375
			2.2.1.4	Mapping of health facilities and services (including 2-way referral systems) in line with the State Minimum Package of Care				-
		2.2.2	To ensure availability of drugs and equipment at all levels					**4,129,946,630**
			2.2.2.1	Strengthen Supply System (DRF, Vaccine, MNCH Commodities) -conduct assessment of supply chain at all level, conduct logistic management training for MNCH Commodities				4,108,718,253
			2.2.2.2	Conduct Sensitization meetings with pharmaceutical companies on local production of Essential drugs and MNCH commodites (Family Planning, ITNs, Mgso4, Mistolprosol, ORS, Zinc etc)				21,228,378
			2.2.2.3	Review of the essential medicines list and strengthen the drug revolving fund (DRF) programme at all levels				-
			2.2.2.4	Re-activate/sustain DRF at all health facilities in LGAs/State	**No drug out of stock**	**Lack of fund, and**	Supervisor Health and HOD	-

						commitment of staff	(Health)/Fund Manger DRF.	
		2.2.3	To establish a system for the maintenance of equipment at all levels					**-**
			2.2.3.1	Train maintenance officers in installation and maintenance of equipment and regular supervision on process of equipment .maintenance at State & LGA.			State, LGAs, Stakeholders	-
			2.2.3.2	Employment of equipment maintenance personnel.			State, LGAs, Stakeholders	-
			2.2.3.3	Identify/build a reliable medical equipment maintenance workshop in the State headquarter for training of maintenance officers			State, LGAs, Stakeholders	-
			2.2.3.4	Quaterly inventory of equipment including their functional state and Create budget lines for the maintenance of equipment at State and LGA Health facilities.			State, LGAs, Stakeholders	-
			2.2.3.5	Procurement of office equipment and furniture			State, LGAs, Stakeholders	-
		2.2.4	To strengthen referral system					**4,505,894,350**
			2.2.4.1	Ensure avaliability of community-based appropriate means of transportation for referral-Ambulances and Boats with communication gadgets and Running Cost at State and LGA			State, LGAs	4,368,937,075
			2.2.4.2	Establish a two way referal system and ensure availability of referral forms at all health facilities at State and LGA.	**A 2-way referal system established in 50% health facilities by 2011.**		State, LGAs	136,957,275
			2.2.4.3	Train Health care providers at State and LGA levels on 2- way referral System at the state and LGA level.			State, LGAs	-
			2.2.4.4	Improve communication between health facilities and Establish emergency Health Care Services			State, LGAs	-
			2.2.4.5	Establish SOP for referral of cases			State, LGAs	-
		2.2.5	To foster collaboration with the private sector					**116,413,684**
			2.2.5.1	Sensitization of Private Sectors care providers on IMNCH services	**60% of private sector care providers sensitized on IMNCH services by 2011.**		State, LGAs	58,891,628
			2.2.5.2	Develop guidelines and standards for regulation of their practices and registration			State, LGAs	41,087,183
			2.2.5.3	Map and yearly update all categories of private health care providers by operational level and location			State, LGAs	16,434,873
			2.2.5.4	Establish a joint monitoring mechanism with the private sector to regulate delivery of quality health care services at the state and LGA levels.	**70% of Private HFs collaborating with Public HFs**	Lack of Political will, commitment and lack of funds	SMOH (DMST), HMB/LGA Chairman, Super-Health, HOD (Health) DPM, TLG, Health Edu	-
			2.2.5.5	Adapt the National policy on traditional medicine at the state and LGA level.			State, LGAs	-

	2.3	**To improve the quality of health care services**			**50% of health facilities participate in a Quality Improvement programme by end of 2012**			**2,507,276,835**
		2.3.1	To strengthen professional regulatory bodies and institutions					**612,883,806**
			2.3.1.1	Review, update and implement operational guidelines of all regulatory bodies at all levels			SMOH, Regulatory bodies	9,587,009
			2.3.1.2	Empower regulatory staff to monitor compliance of providers to the regulatory guidelines/provision of necessary security			SMOH, Regulatory bodies	547,829,100
			2.3.1.3	Sensitize professionals/regulatory bodies on IMNCH strategies and minimum health care packages for all levels			SMOH, Regulatory bodies	55,467,696
			2.3.1.4	Strengthen regular monitoring exercises with appropiate documentation and feedback			SMOH, Regulatory bodies	-
			2.3.1.5	Restructuring/redesigning of existing hospital pharmacies to meet PCN and NHIS requirements			SMOH, Regulatory bodies	-
		2.3.2	To develop and institutionalise quality assurance models					**141,339,908**
			2.3.2.1	Institutionalize and implement quality assurance and improvement initiatives at all levels of care including Client Oriented Provider Efficiency (COPE) & Emergerncy Triage Assessment and Treatment (ETAT)			MOH, SERVICOM	141,339,908
			2.3.2.2	Provision of stardardised training modules to all cardres of health workers.			MOH, SERVICOM	-
			2.3.2.3	Incoperate ideals of servicom into our health care delivery system at the state and LGA levels.	SMOH/No. of LGA operationalizing the SERVICOM by the end of 2010	Lack of Political will, commitment and lack of funds	SMOH Servicom/LGA Chairman, Super-Health, HOD (Health) DPM	-
			2.3.2.4	Ensure regular monitoring of quality health care services at state and LGA levels.			MOH, SERVICOM	-
		2.3.3	To institutionalize Health Management and Integrated Supportive Supervision (ISS) mechanisms					**1,753,053,121**
			2.3.3.1	Training of supervisors and M & E officers on the use of Integrated supportive supervision tool	ISS tools printed and distributed by 2011.			1,711,965,939
			2.3.3.2	Print and distribute, developed ISS tools and guidelines specifying modalities and frequencies of the ISS visits at state and LGAs (IMNCH, BCC etc)				41,087,183
			2.3.3.3	Adapt and implement the National Health Management and integrated supportive supervision in the state and LGA level.	80% of supervisors and M & E officers trained on the use of			-

					integrated supportive supervision tools by the end of 2011.			
		2.3.4	Stregthening implementation of intergrated maternal, newborn and child health (IMNCH) services for the free health programme					-
			2.3.4.1	Upgrading of 6 general hospitals for Emergency Obstetric Care (EOC) services			DPHC	-
			2.3.4.2	Training and deployment of midwives for MSS scheme and training of SCHEW on MLSS			DPHC	-
			2.3.4.3	Adopting the national policy on IMNCH services provision of obstetric delivery kits			DPHC	-
			2.3.4.4	Establishment of VVF treatment center and management support			DPHC	-
			2.3.4.5	Ensure 24 hours services especially for IMNCH in all health facilities			DPHC	-
		2.3.5	To establish Quality Assurance / Control Unit					-
			2.3.5.1	Establish quality assurance unit in State Ministry of Health and the secondary health facilities			SERVICOM	-
	2.4	**To increase demand for health care services**			**Average demand rises to 2 visits per person per annum by end 2011**			**6,351,256,675**
		2.4.1	To create effective demand for services					**6,351,256,675**
			2.4.1.1	Provide a programme for monitoring and evaluating Behavioural Change Communication at the state and LGA levels.	80% of health staff trained on the behavioural change communicatio n skills.		SMOH/LGA,Dev . Partners	-
			2.4.1.2	Train staff on Behavioural Change Communication Skills				253,918,788
			2.4.1.3	Support local adaptation of the national strategy to reflect local realities - conduct bi-annual IMNCH weeks				6,097,337,887
			2.4.1.4	Produce and disseminate hand books on patient's right and reponsibility to health care to State and LGA			State, LGAs	-
		2.4.2	To introduce patient friendly initiatives					-
			2.4.2.1	To improve patient/health worker relationship			State	-
			2.4.2.2	To establish public relations office especially in secondary health facilities and produce directional signs in hospitals in the state for easy access to health services			State	-
			2.4.2.3	To shorten time taken for patient to be seen by health staff (i.e. waiting time) through regular meetings, seminars and workshops in 22 hospitals in the State			State	-
			2.4.2.4	To establish or strengthen baby friendly hospitals in State and LGAs			State	-
			2.4.2.5	Purchase vehicles and ambulances to assist patients in times of need (purchase of WD pickup vehicles Hilux 4x4 2700DLX)			State	-

		2.4.3	Establish specialized health programmes targeted at areas of health needs					-
			2.4.3.1	Identify and prioritise health needs of the community and disseminate the Health Promotion Policy and implement the policy provisions			DPRS, DPHC	-
			2.4.3.2	Establish appropriate health programmes to solve these needs e.g. Well Women Clinic, Onchocerciasis Treatment center, etc.			DPRS, DPHC	-
			2.4.3.3	Improve existing health services at the PHC and WHC to make health more accessible to people			DPRS, DPHC	-
			2.4.3.4	Establish a state blood bank for easy access of blood and blood products, train and employ staff to manage it			DPRS, DPHC	-
			2.4.3.5					-
		2.4.4	To actively engage the CHEW, TBAs, VHW and other stakeholders					-
			2.4.4.1	To improve home visitations of CHEW, TBAs and VHW (CORPS)			DPHC	-
			2.4.4.2	To appropiately identify and train CHEW, TBA and VHW who live and work in the community			DPHC	-
			2.4.4.3	Empower community nurses and midwifes to work in the communities			DPHC	-
			2.4.4.4	Engage all health workers and other stakeholders in advocacy and disemination of information on the services available in health facilities			DPHC	-
			2.4.4.5	Strengthen Infection Prevention and Control of Health Care Waste Management by actively engaging all stakeholders				-
		2.4.5						-
			2.4.5.1	Develop IEC materials relevant to rural and urban communities			State and LGAs	-
			2.4.5.2	Develop mechanisms for distributing the IEC materials by community members			State and LGAs	-
			2.4.5.3	Regular updating of the IEC materials making them relevant to present health needs			State and LGAs	-
			2.4.5.4	Monitor and evaluate the effectiveness of the IEC materials			State and LGAs	-
			2.4.5.5	Production of Ministry of Health News bulletins			State and LGAs	-
	2.5	**To provide financial access especially for the vulnerable groups**			**1. Vulnerable groups identified and quantified by end 2010 2. Vulnerable people access services free by end 2015**			**27,510,744,803**
		2.5.1	To improve financial access especially for the vulnerable groups					**27,510,744,803**
			2.5.1.1	Explore and scale up financial protection for the vulnerable groups like vouchers, health cards, pre payment schemes		Availability of funds	State, LGAs and Stakeholders	27,391,455,017
			2.5.1.2	Orient communities on community-based insurance scheme and IMNCH strategy		Availability of funds	State, LGAs and Stakeholders	119,289,787

			2.5.1.3	Scale up/Implement the free maternal health care service at State and LGA level respectively.		Availability of funds	State, LGAs and Stakeholders	-
			2.5.1.4	A model for free treatment of under 5, orphans and the aged should be instituted at the state and LGA levels.		Availability of funds	State, LGAs and Stakeholders	-
			2.5.1.5					-
		2.5.2	Prevention of mother to child transmission of HIV/AIDS					**-**
			2.5.2.1	Establishment of state emergency HIV/AIDS laboratory that provides free or subsidized services			DPHC	-
			2.5.2.2	Establish more ART sites to provide free or subsidized drugs			DPHC	-
			2.5.2.3	Provision of support to infected HIV/AIDS patients			DPHC	-
			2.5.2.4	Establish special care facilities for management of HIV positive pregnant women			DPHC	-
			2.5.2.5					-
		2.5.3	Strengthening financial assistance of the physically challenged people					**-**
			2.5.3.1	To evaluate the existing schools of the physically challenged			State, LGAs and Stakeholders	-
			2.5.3.2	Establish and strengthen schools of skill acquisition for the physically challenged			State, LGAs and Stakeholders	-
			2.5.3.3	Provision of State Community Mental Health Services			State, LGAs and Stakeholders	-
HUMAN RESOURCES FOR HEALTH								0
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								**44,790,436,568**
	3.1	**To formulate comprehensive policies and plans for HRH for health development**			**All States and LGAs are actively using adaptations of the National HRH policy and Plan by end of 2015**			**-**
		3.1.1	To develop and institutionalize the Human Resources Policy framework					**-**
			3.1.1.1	Develop a tranning programme and material to train at least 4 health workers from MOH and 2 health workers from each Local Government on how to customise the National and States policy and strategic plan.				-
			3.1.1.2	Monitor the adaptation of the State HRH policy and plan by the LGA				-
			3.1.1.3	Assist at least 2 LGA (as pilot area) to prepare programme to train LGAs to customize their own HR plans				-
			3.1.1.4	Develop and promote a roll-out of the customisation of the state HRH policies and plans by all LGAs				-
		3.1.2	Develop/promote non-discriminatory recruitment policies in the State and all the LGAs especially for critically needed professionals irrespective of their Local Government of origin.		At least 5 LGAs should have non-discriminatory recruitment policy for health workers by			**-**

					the end of 2010.			
			3.1.2.1	Update State policy on recruitment to ensure non-discriminatory recruitment of health personnel				-
			3.1.2.2	Develop a training programme and material to train personnels on non-discriminatory recruitment policies				-
			3.1.2.3	Monitor the adaptation of the State non-discriminatory recruitment policies				-
			3.1.2.4	Develop and promote a roll-out of the State non-discriminatory recruitment policies by all LGA				-
			3.1.2.5					-
		3.1.3	To provide a framwork and objectively analysing the HRH crises in the State and implement a monitoring plan to address the crises					-
			3.1.3.1	Develop staffing norms based on workload to guide planning and use service availability and health sector priorities to determine staffing needs for utilization by State and LG health providers				-
			3.1.3.2	Set up a Committee with State and LGA representation to develop principles of health workforce recruitment by the relevant bodies				-
			3.1.3.3	Establish coordinating mechanisms towards mutual consistency in human resources for health planning and budgeting among the Ministries, Civil Service Commission, Local Government Service Commission, Regulatory Bodies, Private Sector Provider, NGOs in Health and other institutions				-
			3.1.3.4	Develop a model to project the professional staff needed for the State, then liaise with Ministry of Education and training institutions to plan how to train sufficient graduates				-
			3.1.3.5	Collect baseline data, consult professionals and examine internaitonal literature to identify appropriate health professional targets				-
			3.1.3.6	Reappraise the principles of health workforce requirement and recruitment at all levels				-
		3.1.4	Construct a model to project training and output requirement to provide for the health professional needs of the State					-
			3.1.4.1	Strengthen the institutional framework for human resources management practices in the health sector				-
			3.1.4.2	Establish and strengthen HRH capacity in SMOH and LG health departments with a view to designing, implementing, evaluating and reporting HRH components				-
			3.1.4.3	Create HRH unit in the Health Department				-
			3.1.4.4	Motivate pilot Local Government to create HRH unit in the Health planning programmes.				-
			3.1.4.5					-

		3.1.5	To develop and implement retention strategies including management of migration, development and implementation of bilateral and multilateral agreements to reverse and contain the crises					-
			3.1.5.1	Develop and implement incentives to retain health workers particularly in deprived areas			State, SMOH	-
			3.1.5.2	Design and embark on a campaign to encourage retired trained health professionals to return to the service			State, SMOH	-
			3.1.5.3	Payment of Honorarium to outreach Nurses (10), Pharmacists (10), Physiotherapist (1), and Medical Consultants (8)			State, SMOH	-
	3.2	**To provide a framework for objective analysis, implementation and monitoring of HRH performance**			**The HR for Health Crisis in the country has stabilised and begun to improve by end of 2012**			**1,111,540,324**
		3.2.1	To reappraise the principles of health workforce requirements and recruitment at all levels					-
			3.2.1.1	Develop staffing norms based on workload to guide planning and use service availibility and health sector priorities to determine staffing needs for utilization by state and LG Health Providers.				-
			3.2.1.2	Set up a committee with state and LGA representation to develop principles of health workforce recruitment by the relevant bodies				-
			3.2.1.3	Establish coordinating mecahanism towards mutual consistency in Human resources for Health plannlng and budgeting among the ministries,Civil Service Commission,Local Government Service Commission,Regulatory Bodies, Private sector Providers, NGOs in Health and other Institutions.				-
			3.2.1.4					-
			3.2.1.5					-
		3.2.2	Develop a model to project the professional Staff needed for the State,then liaise with Ministry of Education and Training Institutions to plan how to train sufficient Graduates;					-
			3.2.2.1	Collect baseline data, consult professionals and examine international literature to identify appropriate health professional targets				-
			3.2.2.2	Construct a model to project training and output requirements to provide for the health Professional needs of the state.				-
		3.2.3	To acquire equipment that facilitate HRH development					-
			3.2.3.1	Purchase of teaching aids e.g. Projectors, laptops and internet facilities			State,SMOH	-
			3.2.3.2	Ensure reliable alternative to power supply e.g. generators			State,SMOH	-
		3.2.4	Develop a model to project the professional staff needs of the State and liase with Ministry of					**1,111,540,324**

			Education and training institutions to plan how to train sufficient graduates					
			3.2.4.1	Collect baseline data, consult professionals and examine international literature to identify appropiate health professional targets	baseline data collected and collated		State, SMOH	51,699,550
			3.2.4.2	Construct a model to protect training and output requirements to provide for the health professional needs of the State	model to protect training output constructed		State, SMOH	103,399,100
			3.2.4.3	Advocacy and construction/upgrade of mandatory residential accommodation for health workers in rural areas.	No of residential accomodation contructed		State, SMOH	956,441,674
	3.3	**Strengthen the institutional framework for human resources management practices in the health sector**			**1. 50% of States have functional HRH Units by end 2010 2. 10% of LGAs have functional HRH Units by end 2010**			**1,748,478,779**
		3.3.1	To establish and strengthen the HRH Units					**217,138,110**
			3.3.1.1	Establish a training programme and manual for the training of managers/personnel in human resource planning and management from the health and other relevant sectors at State and LGA.			State, SMOH/ LGSC & LGA Chairman	85,304,257
			3.3.1.2	Monitor trainning courses output on HRH management and planning.			State, SMOH/ LGSC & LGA Chairman	93,059,190
			3.3.1.3	Create/strengthen HRH units at all levels to perform HRH functions at State and LGA			State, SMOH/ LGSC & LGA Chairman	38,774,662
		3.3.2	Design and implement trainning programmes to build technical capacity at all levels of the Health sector and other relevant sectors for human resource planning and management					**982,291,449**
			3.3.2.1	Establish a training programme/manual for the training of managers in human resource planning and management			State	38,774,662
			3.3.2.2	Identify existing training institutions that are willing and able to provide training courses for HRH management and planning			State	5,169,955
			3.3.2.3	Train managers in human resource planning and management for health.			State	853,042,574
			3.3.2.4	Monitor training courses and output on HRH management and planning			M&E	23,264,797
			3.3.2.5	Monitoring and Evaluating Programmes/Capital Projects of the Ministry			M&E	62,039,460
		3.3.3	Establish multi-sectoral HRH system for planning management and development at State and Local Government Level					**373,270,751**
			3.3.3.1	Establish State level intersectoral committee to discuss issues of human resource for health and meet quaterly	No of functional intersectoral committees in place at State		State	37,223,676

					and LGA levels			
			3.3.3.2	Promote the establishment of State level intersectoral committee to discuss issues of human resource for health			State	25,849,775
			3.3.3.3	Encourage the establishment of LGA level intersectoral committee to discuss issues of human resource for health			LGAs	310,197,300
		3.3.4	Promote proactive regular engagement with various professional groups so as to promote dialogue and harmony.					**23,264,797**
			3.3.4.1	conduct regular meetings of State representative with MOH management	No of meetings held		SMOH	12,924,887
			3.3.4.2	Monitor the meetings that are taking place and the matters discussed and resolved at the State and LGA Health Professional Fora	No. of meetings monitored		SMOH	10,339,910
		3.3.5	Re-orientation of health workforce towards positive attitudinal change		More than 50% of health service users report being treated with care, respect and dignity by 2013			**152,513,672**
			3.3.5.1	Develop and promote a course for health providers to train health workers on inter personal Communication (IPC) skills	No of health workers at state and LGA levels trained on Inter personal Communication (IPC) skills		State,SMOH	25,849,775
			3.3.5.2	Develop and promote a course for health providers to re-train workers on work ethics	No. of health workers at state and LGA levels trained on work ethics		State,SMOH	87,889,235
			3.3.5.3	Develop and institute a system of recognition, reward and sanction	State and LGAs have instituted a system of recognition, reward and sanction		State,SMOH	25,849,775
			3.3.5.4	Create a complaint/feedback mechanism			State,SMOH	12,924,887
	3.4	**To strengthen the capacity of training institutions to scale up the production of a critical mass of quality, multipurpose, multi skilled, gender sensitive and mid-level health workers**			**One major training institution per Zone producing health workforce graduates with multipurpose skills and mid-level health workers by 2015**			**31,329,358,573**
		3.4.1	To review and adapt relevant training programmes for the production of adequate number of					**15,727,520,090**

			community health oriented professionals based on national priorities					
			3.4.1.1	Training and deployment of midwives for MSS scheme.				180,948,425
			3.4.1.2	Adopting the national policy on IMNCH services provision of obstetric delivery kits				36,706,680
			3.4.1.3	conduct pre-service training on IMNCH Interventions (Focused Antenatal Care, Emergency Obsetritic and Neonatal care, Life Saving Skill (LSS) for Midwives & Nurses, Integrated Management of Child hood Ilness, Modified LSS, Expanded LSS, Infant Young Child Feeding, Severe Acute Malnutrition, Community /facility based Essential newborn care)				15,509,864,984
			3.4.1.4	On-going discussions with all health related training institutions to monitor adaptation of training programmes for National and State policies.				-
		3.4.2	To strengthen health workforce training capacity and output based on service demand					**15,522,789,872**
			3.4.2.1	conduct trainings needs and skilled assessment on in -service training of IMNCH interventions (Focused Antenatal Care, Emergency Obsetritic and Neonatal care, Life S aving Skill (LSS) for Midwives & Nurses, Integrated Management of Child hood Ilness (Community and facility based Modified LSS, Expaned LSS, Infant Young Child Feeding, Severe Acute Malnutrition, Community /facility based Essential newborn care)			State, SMOH	15,509,864,984
			3.4.2.2	Establish or strengthen the regular monitoring process to ensure that training curricula and programmes are reviewed and appropriately accredited and that the regulatory bodies ensure that they reflect multi-tasking and task shifing as appropriate.			State, SMOH	12,924,887
			3.4.2.3	Send staff from LGAs to be trained in Heaalth Institutons and Colleges for production of quality Health Care providers	10% of LGA health staff sent biennially for training with effect from 2011.	Availability of funds and political will	LGA Chairman,Super Health and HOD Health.	-
		3.4.3	To improve or strengthen communication and collaboration between ministry of health and other health related ministries/departments and training institutions					**35,103,994**
			3.4.3.1	To establish areas of cooperation in terms of HRH between Ministry of health and training institutions			State	13,958,878
			3.4.3.2	Establish curriculum review committee with representatives from the Ministry of health and training institutions			State	6,669,242
			3.4.3.3	Establish HRH committee that will regularly review manpower needs and communicate same to training institutions			State	2,067,982
			3.4.3.4	Monitor and evaluate functions of the committee on yearly basis			State	12,407,892

		3.4.4	Review and refine the functions, mandates and responsibilities of professional regulatory bodies with view to strengthening adequate production of various health professionals					**43,944,617**
			3.4.4.1	Establish a process to review the functions and mandates of regulatory bodies on an ongiong process with aim of strengthening adequate production and registration of health professionals	No of regulatory bodies with functions and mandates reviewed		SMOH, Regulatory Bodies	5,169,955
			3.4.4.2	Establish or strengthen the regular monitoring process to ensure that training curricula and programmes are reviewed and appropriately accredited and that the regulatory bodies ensure that they reflect multi-tasking and task shifting as appropriate	No of training curricula and programmes reviewed by accrediting and regulatory bodies		SMOH, Regulatory Bodies and Training Institutions	3,877,466
			3.4.4.3	With the regulatory bodies and training institutions review admission criteria for disciplines in response to HRH crisis in disadvantaged areas of the State	No of disciplines with admission requirements reviewed in response to HRH	Potential risk of reducing quality of products from the training institutions	SMOH, Regulatory Bodies and Training Institutions	3,877,466
			3.4.4.4	Continuously review assessment conducted by training institutions to meet accreditation and professional requirement	No of training institutions at State levels assessd to meet accreditation		SMOH, Regulatory Bodies and Training Institutions	31,019,730
			3.4.4.5	Establish or expand training of auxilliary cadres of HRH such as community health workers and multipurpose health workers	No of training centers established for training of auxilliary cadres of HRH such as community health workers and multipurpoe health workers		SMOH, Regulatory Bodies and Training Institutions	-
	3.5	**To improve organizational and performance-based management systems for human resources for health**			**50% of States have implemented performance management systems by end 2012**			**10,409,704,382**
		3.5.1	To achieve equitable distribution, right mix of the right quality and quantity of human resources for health					**10,339,909,989**
			3.5.1.1	Ensure 24 hours services especially for IMNCH in all health facilities			SMOH, Regulatory Bodies and Training Institutions	5,169,954,995
			3.5.1.2	Redeploy staff equitably between rural and urban areas and at the different levels of the health care system in relation to needs, paying attention to staff mix at State and LGA.			SMOH, Regulatory Bodies and Training Institutions	-

			3.5.1.3	To promote mandatory rotation of health workers to underserved rural areas, e.g through NYSC scheme for doctors, pharmacists and appropriate scheme for midwives and nurses			SMOH, Regulatory Bodies and Training Institutions	-
			3.5.1.4	State MoH will collaborate with Federal institutions located in the state to leverage available human resource so as to expand service coverage and quality			SMOH, Regulatory Bodies and Training Institutions	-
			3.5.1.5	Renovate / construct residential accommodation for health workers in all PHC facilities			SMOH, Regulatory Bodies and Training Institutions	5,169,954,995
		3.5.2	To establish mechanisms to strengthen and monitor performance of health workers at all levels					**69,794,392**
			3.5.2.1	Institute a system of recognition, reward and sanctions at all levels of care and hardship allowance				7,754,932
			3.5.2.2	Establish mechanisms to monitor health worker performance, including use of client feedback (exit interviews)				62,039,460
			3.5.2.3	Define performance incentives and management system and encouragement for all Health Workers.				-
			3.5.2.4	Organise re-orientation workshop at the LGA level for routine training of health workforce on work ethics and attitudinal change for the promotion of clients' satisfaction & improvement of quality of care	20% LGA PHC Dept staff trained on ethics of practice annually	Availability of funds.		-
		3.5.3	To develop objective assessment mechanisms of health cadre					**-**
			3.5.3.1	Evaluate existing appraisal mechanisms of health staff			State	-
			3.5.3.2	Establish a 6 monthly appraisal of staff using objective, verifiable method			State	-
			3.5.3.3	An appraisal committee should be strengthened and protected from intimidation			State	-
			3.5.3.4	Staff complaint forum should be set up for agrieved staff. These should meet every 6 months			State	-
			3.5.3.5	Budgetary provision for the appraisal committee to be made			State	-
		3.5.4	Re-orientation of health workforce toward postive attitudunal charge.					**-**
			3.5.4.1	Develop course of action for re-orientation of Health workers to improve inter personal Communication (IPC) skill.				-
		3.5.5	Motivation of the health workforce by the creation of incentives for health workers along with recognition of hard work and service with emphasis on those that will attract and retrain staff in rural and deprived locations					**-**
			3.5.5.1	Define performance incentives and management system and encourage SMOH to implement	No of LGAs that have defined performance incentives and management system.		State	-

					No of LGAs that are implementiin g defined performance incentives and management system			
			3.5.5.2	Develop guidelines and recommendations on additional incentives for health workers working in rural and deprived areas	No of LGAs providing additional incentives for health workers working in rural and deprived areas		State	-
			3.5.5.3	Develop guidelines on what constitutes an enabling work environment and promote the compliance with the standards at State and LGAs	No of LGA work places providing enabling work environment		State, LGAs	-
			3.5.5.4	Establish mechanisms to minimize work place hazards through management of physical risks and mental stress as well as full compliance with prevention and protection guidelines	No of LGA work places with mechanisms to minimize work place hazards. No of LGA work places that are fully compliant with prevention and protection guidelines		State	-
			3.5.5.5	Intervene where ever possible to ensure that health workers are paid on time	Proportion of health workers at LGA levels that are paid on time		State	-
	3.6	**To foster partnerships and networks of stakeholders to harness contributions for human resource for health agenda**			**50% of States have regular HRH stakeholder forums by end 2011**			**191,354,510**
		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					**191,354,510**
			3.6.1.1	Establish quarterly forum for health care professional associations and regulatory bodies at all levels on IMNCH issues		Availability of funds and commitment	State/LGA and Professional groups	186,118,380
			3.6.1.2	Involvement of workers and professional groups in management teams, design and monitoring of services to enhance cooperation amongst all actors		Availability of funds and commitment	State/LGA and Professional groups	-

			3.6.1.3	Produce and circulate decisions of the public/private managers meetings to all Health Staff	80% of health workers will have access to each circulated decisions	availability of funds	LGA, Health Dept	5,236,130
FINANCING FOR HEALTH								0
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								**4,697,770,085**
	4.1	**To develop and implement health financing strategies at Federal, State and Local levels consistent with the National Health Financing Policy**			**50% of States have a documented Health Financing Strategy by end 2012**			**2,978,234,915**
		4.1.1	To develop and implement evidence-based, costed health financing strategic plans at LGA, State and Federal levels in line with the National Health Financing Policy					**2,978,234,915**
			4.1.1.1	Establish LGA health financing system and technical working committee	LGA finacial working group operational and system strengthened by 60% by the end of 2011	Poor Political wil, bureaucratic bottle neck, irregular adquate federal allocation /IGR, mismanagement of funds	LGA Chairman, Super Healths, PHC Coord., Treasurer to the LGA, PDM, Councillor Health Committee, Councillor Finance Committee, Com. Dev. Officer, Environment Officer	2,978,234,915
			4.1.1.2	Build capacity of staff for the development/implementation of the Health financing Strategic Plan at both the L.G.A and the State.	capacity built in 50% of state and LGA staff in planning dept.	Availability of trainable staff and funds	Sate Min. of Health and LGA health Department, NationalmPlanning	-
			4.1.1.3	Yearly review of the Strategic Plan at both the L.G.A and the State			Sate Min. of Health and LGA health Department, NationalmPlanning	-
		4.1.2	To strengthen legislation on health insurance					**-**
			4.1.2.1	Evaluate the existing legislation on health insurance				-
		4.1.3	To establish accurate accounting and auditing mechanisms at both State and LGAs					**-**
			4.1.3.1	To establish Ministerial Due Process				-
	4.2	**To ensure that people are protected from financial catastrophe and impoverishment as a result of using health services**			**NHIS protects all Nigerians by end 2015**			**-**
		4.2.1	To strengthen systems for financial risk health protection					**-**
			4.2.1.1	Support LGAs to explore existing and innovative social health protection approaches-social health insurance, other pre-paid schemes, community-based health insurance schemes, etc - for sustainable health	50% of LGAs supported by 2011			-

				financing with protective measures against the financial risks associated with ill health.				
			4.2.1.2	Establish/strenghten the capacity of the health insurance scheme to provide effective regulatory framework for social health insurance and protection programmes in the state and LGA.				-
			4.2.1.3	Institute Free IMNCH services at the LGA levels of care.				-
			4.2.1.4	Expand & sustain the Free Rural Health Scheme.	100% of population covered.	Availability of funds & personnel.	SMOH	-
		4.2.2	To establish and strengthen Community Health financing mechanism at the L.G.As					-
			4.2.2.1	Carry out Public enlighthenment Campaigns to highlight the importance and the need for Health Insurrance				-
			4.2.2.2	Provide Technical assistance that will encourage and strenghthen Community financing.				-
			4.2.2.3	Institute phased coverage of Health Insurance Scheme starting with the formal sector and eventually cover all.				-
		4.2.3	To improve coverage of the National Health Insurance Scheme in Delta State					-
			4.2.3.1	Carry out a situation analysis and obtain percentage of people presently on NHIS			State	-
			4.2.3.2	Ensure a phased coverage of NHIS starting with the formal sector and eventually covering all			State	-
			4.2.3.3	Identify the most appropriate payment mechanisms for the NHIS bearing in mind the national method			State	-
			4.2.3.4	Identify the diseases that will initially be covered by NHIS			State	-
			4.2.3.5	Monitor and evaluate the implementation of the scheme every 6 months			State	-
	4.3	**To secure a level of funding needed to achieve desired health development goals and objectives at all levels in a sustainable manner**			**Allocated Federal, State and LGA health funding increased by an average of 5% pa every year until 2015**			**1,719,535,170**
		4.3.1	To improve financing of the Health Sector					-
			4.3.1.1	Yearly review of the budgetary allocation will be carried out to meet up with the 15% Abuja declaration by State and LGA			State, LGAs	-
			4.3.1.2	Revitalize LGA DRF and strengthen its management as well as ensure community particiaption and ownership by training LGA personnel			State, LGAs	-
			4.3.1.3	Establish Special Funds to take care of patients with Chronic and emerging diseases, such as Cancer,Mental health etc.			State, LGAs	-
			4.3.1.4	Allocate 2% of the total health budget to health research and statistics.			State, LGAs	-

		4.3.2	To improve coordination of donor funding mechanisms					**1,719,535,170**
			4.3.2.1	International development partners will align their support to the state and ensure it is captured within the broad budgetary estimates on a yearly basis			State, LGAs	-
			4.3.2.2	Appropriate models for more effective coordination between state and Development partners will be established including State /LGA/Communities partnership			State, LGAs	1,719,535,170
			4.3.2.3	Mechanisms for coordinating donor resources with that of State and LGAs will take the form of common basket funding through options such as joint funding agreements, sector-wide approaches (SWAPs) and sectoral multi-donor budget support, PMNCH etc.			State, LGAs	-
			4.3.2.4	State Government will attract and collaborate with Donor Agencies/Development partners.			state, LGAs	-
		4.3.3	To identify all other possible sources of health funding					**-**
			4.3.3.1	Identify and encourage philantropy and counterpart funding for specific health programmes.				-
			4.3.3.2	Establish a committee responsible for finding ways to improve public-private-partnership in health funding including foreign partners to assist in health financing in the state.				-
			4.3.3.3	Delta State to participate in HSDP 111 (counterpart fund contribution)				-
		4.3.4	Government at both State and LGA levels to allocate at least 15% of their total budgets to health					**-**
			4.3.4.1	Secure statutory protection through LGA and State Assembly to allocate 15% of budgets to health sector			State, LGAs	-
			4.3.4.2	Ensure that 45% of the health buget is allocated to capital expenditure			State, LGAs	-
			4.3.4.3	Ensure that one tenth of the target 15% allocation (i.e. 1.5%) should be earmarked for social health protection programmes			State, LGAs	-
			4.3.4.4	Ensure that 2% of the consolidated fund from the Federation Account is released for Primary Health Care as provided in the National Health Bill			State, LGAs	-
			4.3.4.5	Ensure that 2% of the total health budget is allocated to research for health at all levels			State, LGAs	-
	4.4	**To ensure efficiency and equity in the allocation and use of health sector resources at all levels**			**1. Federal, 60% States and LGA levels have transparent budgeting and financial management systems in place by end of 2015** **2. 60% of**		Federal and State Governments show continuous commitment to health sector reform	**-**

				States and LGAs have supportive supervision and monitoring systems developed and operational by Dec 2012			
		4.4.1	To improve Health Budget execution, monitoring and reporting				**-**
			4.4.1.1	The State Ministry of health will provide technical assistance to aid LGAs in developing costed, annual operational plans.			State, LGAs	-
			4.4.1.2	Put in place credible mechanisms to increase financial transparency through the development of State and LGA Health Accounts (SHA and LHAs) and Public Expenditure Reviews (PERs) tracking of health bugets			State, LGAs	-
			4.4.1.3	Build capacity to ensure that proper internal recording and accounting of expenditures are maintained and that timely and detailed financial management reports are produced periodically.			State, LGAs	-
		4.4.2	To strengthen financial management skills					**-**
			4.4.2.1	Yearly training and retraining of the health staff involved in finance at both LGA and State				-
		4.4.3	To ensure equity in allocation and distribution of health resources					**-**
			4.4.3.1	Conduct regular checks on the location of various health resources e.g. manpower and materials etc			State, LGAs	-
			4.4.3.2	Identify areas of health need and relative resource distribution			State, LGAs	-
NATIONAL HEALTH INFORMATION SYSTEM								0
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								**1,978,696,033**
	5.1	**To improve data collection and transmission**		**1. 50% of LGAs making routine NHMIS returns to State level by end 2010** **2. 60% of States making routine NHMIS returns to Federal level by end 2010**				**1,794,123,585**
		5.1.1	To ensure that NHMIS forms are available at all health service delivery points at all levels					**213,349,873**
			5.1.1.1	Sensitization meetings on Maternal and perinatal audit system in the context of the Free maternal health care services			State, LGAs	81,866,812

			5.1.1.2	Institutionalise the Maternal and perinatal audit system at state and LGA			State, LGAs	42,173,812
			5.1.1.3	Print and distribute the revised NHMIS forms with commuinty based information system to state , LGA Health facilities and communities			State, LGAs	89,309,249
			5.1.1.4	Provide adequate fund and ensure timely release for HMIS activities at state and local government levels	Funds provided	**Non availability of funds**	State, LGAs	-
			5.1.1.5	Create functional M&E Unit in each LGA of the State	Functional M&E Unit established in each LGA by 2011	**Lack of commitemnt, Political will and poor funding.**	LGA Chairman, DPM, TLG, Super-Health, HOD (Health),	-
		5.1.2	To periodically review NHMIS data collection forms					**62,516,474**
			5.1.2.1	State and LGAs to create mechanisms to ensure regular feedback from the field on the appropriateness and user friendliness of data collection tools			State, LGAs	62,516,474
			5.1.2.2	Quarterly review meetings on HMIS data collected at LGA,Health facilities & communities	No of Review meetings held		State, LGAs	-
			5.1.2.3	Budgetary allocation made available for activities of the committee activities			State, LGAs	-
		5.1.3	To coordinate data collection from vertical programmes					**1,131,250,490**
			5.1.3.1	Conduct Integrated Supportive Supervision monthly by State and weekly by LGA (IMNCH Interventions)			State, LGAs	952,631,992
			5.1.3.2	Hold quaterly meetings to review data collection in the State			State, LGAs	178,618,498
			5.1.3.3	Re-establish and strengthen State and LGAs Health data consultative committee.	**HDCC established and strengthened**		State, LGAs	-
			5.1.3.4	Integrate M&E of all health programmes into the HMIS by holding quarterly meetings with M&E officers			State, LGAs	-
		5.1.4	To build capacity of health workers for data management					**89,309,249**
			5.1.4.1	Conduct regular training on the use of the HMIS forms (programme/ M&E officers in public and private facilities)			State, LGAs	89,309,249
			5.1.4.2	Conduct regular training for State, LGA , Public and Private Health facilities on computer literacy and hardware maintenance and software applications			State, LGAs	-
			5.1.4.3	Monitor training workshops at the LGA levels			State, LGAs	-
			5.1.4.4	Advocacy to LGAs to train and employ Health information personnel for health facilities			State, LGAs	-
		5.1.5	To provide a legal framework for activities of the NHMIS programme					**-**
			5.1.5.1	Strenghten vital registration system in the state and LGAs			State, LGAs	-
			5.1.5.2	Advocate for adaptation of the NHMIS policy document at the LGA , Private and Public Health facility level	No. of LGAs using NHMIS policy document		State, LGAs	-
			5.1.5.3	Establish sanctions on private care providers that fail to submit health data to the relevant health authorities			State, LGAs	-
			5.1.5.4	Establish mechanisms to enforce these sanctions			State, LGAs	-

		5.1.6	To improve coverage of data collection					-
			5.1.6.1	Assist the LGA to develop innovative strategy to collect data from all private and public health facilities			State, LGAs	-
			5.1.6.2	Assist the LGA to develop innovative strategy to collect data from communities using the CHEWs and the JCHEWs			State, LGAs	-
			5.1.6.3	Ensure that all levels (including Ward Health Facilities) are involved in data collection			State, LGAs	-
			5.1.6.4	Under take follow up visit to defaulting facilities	100% of defaulting facilities visited quarter by 2011	Availability of fund and commitment	HOD (Health), PHC Coord, and M&E Officer	-
			5.1.6.5	Conduct household enumeration as part of assigning each JCHEW to 300 households for collection of vital statistics, etc.		Availability of fund and commitment	SPHCDA/LGA PHC Coord, and M&E Officer	-
		5.1.7	To ensure supportive supervision of data collection at all levels					**297,697,497**
			5.1.7.1	Print and distrubute Personal Health Record Book for the Pregnant women			State, LGAs	297,697,497
			5.1.7.2	Provide appropriate logistics for officers to supervise data collection at all levels	State & 50% of LGAs provide supportive supervision in health data collection by 2011	Availability of fund and commitment	SPHCDA/LGA, PHC Coordinator and LG M&E Officer	-
			5.1.7.3	Develop supervisory checklist for proper supervision		Availability of fund and commitment	SPHCDA/LGA, PHC Coordinator and LG M&E Officer	-
			5.1.7.4	Provide appropriate means of transport such as motorcycles, boats and vehicles at the state ,LGA and Health Facilities Level		Availability of fund and commitment	SPHCDA/LGA, PHC Coordinator and LG M&E Officer	-
	5.2	**To provide infrastructural support and ICT of health databases and staff training**			**ICT infrastructure and staff capable of using HMIS in 50% of States by 2012**			**-**
		5.2.1	To strengthen the use of information technology in HIS					**-**
			5.2.1.1	Procure and Install Internet facilities in all LGAs and health facilities			State, LGAs	-
			5.2.1.2	Train Programme/ M&E Officers at State, LGA and Health facilities (public and private operators) on the use of the internet facilities			State, LGAs	-
			5.2.1.3	Provide Computers and other office equipment to State,LGA and Health Facilities (Programme Officers, DSNOs/M&E and Record Officers)			State, LGAs	-
			5.2.1.4	Promote centralized software-based systems for data collection analysis			State, LGAs	-

			5.2.1.5	Procure and distribute NHMIS minimum package to LGAs			State, LGAs	-
		5.2.2	To provide HMIS Minimum Package at the different levels (FMOH, SMOH, LGA) of data management					-
			5.2.2.1	Provision of HMIS Minimum Package at State			State, LGAs	-
			5.2.2.2	Provision of HMIS Minimum Package at LGA & Community levels			State, LGAs	-
			5.2.2.3	Monitor appropiate use of computers hardware systems			State, LGAs	-
			5.2.2.4	Provision of HMIS working tools (stationery etc)			State, LGAs	-
			5.2.2.5	An HIS Minimum Package at both state and LGA levels of data management will be defined			State, LGAs	-
		5.2.3	Improve monitoring and evaluation					-
			5.2.3.1	Provision of ICT gadgets to M & E unit			State, LGAs	-
			5.2.3.2	Capacity building on data collection, M&E activities for PRS staff at State & LGA level			State, LGAs	-
	5.3	**To strengthen sub-systems in the Health Information System**			**1. NHMIS modules strengthened by end 2010 2. NHMIS annually reviewed and new versions released**			**-**
		5.3.1	To strengthen the Hospital Information System					-
			5.3.1.1	Strenghten vital registration system in the state and LGAs			State, LGAs	-
			5.3.1.2	Training and re-training of medical record officers and their assistants			State, LGAs	-
			5.3.1.3	Develop/adapt guidelines and standards for regulation of their practices and registration			State, LGAs	-
			5.3.1.4	Develop guidelines and technical specification for the establishment of disease mapping in LGA			State, LGAs	-
			5.3.1.5	Develop/adapt guidelines and technical specifications for the establishment and strengthening of patient information system			FMOH/State, LGAs	-
		5.3.2	Stengthen disease Surveillance System					-
			5.3.2.1	Develop/Adapt guidelines and implement the process for the regular reporting of notifiable disease by all health facilities			State, LGAs	-
			5.3.2.2	Develop/Adapt guidelines and initiate pilot project with selected LGAs to strengthen community based surveillance			State, LGAs	-
			5.3.2.3	Train DSN/M&E Officers and their assistants on epidemic preparedness and response			State, LGAs	-
			5.3.2.4	Train and retrain DSN/M&E Officers, their assistants and Focal persons on IDSR			State, LGAs	-
	5.4	**To monitor and evaluate the NHMIS**			**NHMIS evaluated annually**			**184,572,448**
		5.4.1	To establish monitoring protocol for NHMIS programme implementation at all levels in line with stated activities and expected outputs					**122,552,136**

			5.4.1.1	Conduct situation analysis to document baseline data including MNCH			State, LGAs	20,838,825
			5.4.1.2	Train key SMOH officers on the use of the field monitoring check list instructment for HMIS Programme			State, LGAs	59,539,499
			5.4.1.3	Train key LGA officers in the use of the field monitoring check list instructment for HMIS Programme			State, LGAs	29,769,750
			5.4.1.4	Provide HIS Quality Assurance (QA) manual (Handbook) to be used at each level of health care delivery		Quality data produced	State, LGAs	12,404,062
			5.4.1.5	Institute HIS quarterly review meetings at LGA level and bi-annual review meetings at state level.			State, LGAs	-
		5.4.2	To strengthen data transmission					**62,020,312**
			5.4.2.1	Build institutional and human capacities for timely and complete transmission of data in line with relevant guidelines	Timeliness of data transmission		DPRS	47,135,437
			5.4.2.2	Monitor monthly and quaterly transmission of HMIS data and evaluate the problems that prevent complete and regular transmission of HMIS data			DPRS	14,884,875
	5.5	**To strengthen analysis of data and dissemination of health information**			**1. 50% of States have Units capable of analysing health information by end 2010 2. All States disseminate available results regularly**			**-**
		5.5.1	To institutionalize data analysis and dissemination at all levels					**-**
			5.5.1.1	Strengthen institutional and human capacities for appropriate data analysis and dissemination of information for informed decision-making and programming		Availability of capacity to analyze data at LGA level	LGA, SMOH	-
			5.5.1.2	Produce periodic health data bulletin and annual reports by state Department of Planning, Research and Statistics	No of bulletin produced		LGA, SMOH	-
			5.5.1.3	Develop guidelines and a training programme on data analysis for use at all levels	No of health facilities with analyzed data		LGA, SMOH	-
			5.5.1.4	Promote the use of data at all levels for informed decision making using pilot sites	No of decision made based on analyzed data		LGA, SMOH	-
			5.5.1.5	Monitor Annual Reports of the National Director of Planning Research and Statistics by the State	Report of Director DPRS available		SMOH	-
COMMUNITY PARTICIPATION AND OWNERSHIP								0
6. To attain effective community participation in health development and management, as well as community ownership of sustainable health outcomes								**1,319,130,689**
	6.1	**To strengthen community participation in health development**			**All States have at least annual Fora to engage community leaders and CBOs on health**			**-**

					matters by end 2012			
		6.1.1	To provide an enabling policy framework for community participation					-
			6.1.1.1	Update guidelines for establishing community structures.	Guidelines updated by end of 2010	Existing guidelines at national level. Possible resistance by communities.	Department of Local Govt. Affairs	-
			6.1.1.2	The State House of Assembly should develop a bill mandating participation by all community stakeholders.	Develop bill by end of 2010	The State House of Assembly will willingly develop the bill. Availability of funds for State Assembly to develop the bill.	State House of Assembly.	-
			6.1.1.3	Update the policy framework for community participation as currently exists within the national health policy.	Update policy framework by end of 2010	Existing framework.	Department of Local Govt. Affairs(Direct of Local Govt)	-
			6.1.1.4	Update and enforce health policies as exists in the LG law.	2010-2015	Political will to enforce the policies. Existing policy.	Department of Local Govt. Affairs(Direct of Local Govt)	-
		6.1.2	To provide an enabling implementation framework and environment for community participation					-
			6.1.2.1	Update guidelines for establishing community structures.	Guidelines updated by end of 2010	Existing guidelines at national level. Possible resistance by communities.	Department of Local Govt. Affairs	-
		6.1.3	Promote the use of existing participatory tools for community involvement in planning and management.					-
			6.1.3.1	Re-orientate communities on the need for their involvement in micro-planning, supervision, monitoring and evaluation of their health programmes.	Quarterly training.	The willingness of the communities to participate.	Director of Planning DSPHCDA	-
			6.1.3.2	Sensitize Community Heads, CBOs and other community members on the need for health programmes to be community-owned and community-driven	Continuous process	Willingness of the proffesional bodies to carry out the sensitization.	DSPHCDA, LGA and Association of Community Pharmacists of Nigeria (ACPN)	-
		6.1.4	Establish an inter-sectoral committee to enhance collaboration at all levels.					-
			6.1.4.1	Update and re-orientate inter-sectoral stakeholder committees at LGA level for active participation in health programmes.	By end of 2010	Existing inter-sectoral committees	Director, Social mobilization DSPHCDA	-
	6.2	**To empower communities with skills for positive health actions**			**All States offer training to FBOs/CBOs and community leaders on engagement with the health system by end 2012**			**1,315,324,390**
		6.2.1	To build capacity within communities to 'own' their health services					-

			6.2.1.1	Identify and map out key community stakeholders at the LGA level (LGA Chairmen, Super Health, ward councillors, etc).	By end of 2010	There are stakeholders in the community	Directorate of Local Govt.	-
			6.2.1.2	Create a forum for assessment of the various needs of the communities	2010-2015	The stakeholders know their needs and are willing to reveal them.	LGA Health Educator	-
			6.2.1.3	The LGA to provide funding, supervision and monitoring of health programmes.	2010-2015	Political of the LGA Chairmen	LGA Chairman	-
			6.2.1.4	Educate community stakeholders on their participatory roles in health management.	Quarterly training.	Availability of funds.	State Health Educator and ACPN	-
			6.2.1.5	Ensure compliance with the set guidelines for establishing community structures.	2010-2015	Availability of funds.	Local Govt. Service Comm.	-
		6.2.2	to strengthen indiviual, family and community capacity to respond to MNCH issues at home and seek health care appropriately					**1,315,324,390**
			6.2.2.1	Training of Trainers of CORPs to promote key household and community practices				11,915,369
			6.2.2.2	Training of CORPS including SCHEWs, VHWs, CBOs, FBOs to counsel care givers on key household practices				41,372,810
			6.2.2.3	State to support LGA to conduct monthly meeting of Community Development Committee (CDC) and VDC/WDC to mobilize community resources for emergency transportation, blood donation, and other emergency preparedness for IMNCH involvement.				1,167,706,202
			6.2.2.4	Train other resource persons(Ambulance drivers, road transport workers, gatemen etc) for emergency response and preparedness for MNCH conditions.				41,372,810
			6.2.2.5	Establish community-based care models for mothers and new borns in various communities				52,957,197
		6.2.3	Establishing key roles and functions of community stakeholders and stuctures.					**-**
			6.2.3.1	Ward Councillors, Ward Heads and Community Heads should mobilize their communities.	As need arises	Willingness of stakeholders		-
			6.2.3.2	Training of health educators on relevant skills needed for implementation.	Quarterly Training	Need for update of their knowledge	All Programme Officers and Association of Pharmacists of Nigeria.	-
		6.2.4	Conduct orientation to community development committees, community resource persons on their roles and responsibilities.					**-**
			6.2.4.1	Identify the members of the CDC and Community Resource Persons (CORP).	By end of 2010		LGA Health Educator	-
			6.2.4.2	Assess the training needs of CDCs and CORPs.	As need arises	The CDCs and CORPs need to be trained	LGA Health Educator	-
			6.2.4.3	Training of CDCs and CORPs.	Quarterly Training		State and LGA Health Educator	-
		6.2.5		Provide Funding for Community Activities.				**-**

			6.2.5.1	Identify fund needs.	As need arises		All programme officers	-
			6.2.5.2	Identify the source of funding.	Funding to be provided by states and LG councils.		All programme officers	-
			6.2.5.3	Establishing dialogue between communities and government structure.	By end of 2010		State and LGA Educators	-
			6.2.5.4	Create a forum for community dialogue.	Quarterly	Community is willing to dialogue	State and LGA Educators	-
	6.3	**To strengthen the community - health services linkages**			**50% of public health facilities in all States have active Committees that include community representativ es by end 2011**			**3,806,299**
		6.3.1	To restructure and strengthen the interface between the community and the health services delivery points					**3,806,299**
			6.3.1.1	Establish an information process on how to reach the communities.	By end of 2010	Communities can be easily reached	State and LGA Health Educators, Ward focal persons.	-
			6.3.1.2	Sensitize community members on available health programmes via the various traditional communication channels.	Before the implementati on of health Programmes.	Existence of traditional communication channels	Community Heads, Town Announcers.	-
			6.3.1.3	Organize interactive session for exchange of experiences in community health services between community development committees	75% of LGAs organize interactive sessions between CDCs by the end of 2010	Availability of funds and commitment	PHC coord., Community Social Mobilzation / Development Officer CDC Members	3,806,299
		6.3.2	Develop guidelines for strenghtening the community health services linkage.					**-**
			6.3.2.1	Identify stakeholders at the inter-phase level.	By end of 2010	Political will	DTSG	-
			6.3.2.2	Organise periodic meetings with key community personnel.	Quarterly meetings	Availibility of funds and willingness of participants	State and LGA Health Educators	-
			6.3.2.3	Announce programmes through traditional communication channels.	As need arises	Availability of traditional channels of communication	Community Heads and focal persons.	-
			6.3.2.4	Monthly meetings of LGA Health Educators at the State capital.		Availability of funds.	Director Social Mobilization and Advocacy, State Health Educator.	-
		6.3.3	Restucture health delivery structures to ensure adequate promotion of community participation in health development.					**-**
			6.3.3.1	Identifying the health felt needs of the communities through community dialogue.	Before the implementati	Only the communities know their	Community Heads, State	-

					on of health Programmes.	health felt needs. Willingness of communities to reveal their health felt needs	and LGA Health Educators	
			6.3.3.2	Educate the community members based on the identified health needs.	Before the implementation of health Programmes.		State and LGA Health Educators.	-
			6.3.3.3	Provide for the health felt needs of the communities.	Before the implementation of health Programmes.		All Programme officers	-
		6.3.4	Provide technical guidance and support to community stakeholders.					-
			6.3.4.1	Educate communities on the skills to improve health behaviour.	2010-2015	Availability of funds.	State and LGA Health Educators.	-
		6.3.5	Facilitate exchange between and among communities.					-
			6.3.5.1	Create a forum where experiences are shared between and among the community members to ensure behavioural change.	Quarterly meetings	Willingness of community members to participate	State and LGA Educators	-
	6.4	**To increase national capacity for integrated multisectoral health promotion**			**50% of States have active intersectoral committees with other Ministries and private sector by end 2011**			-
		6.4.1	To develop and implement multisectoral policies and actions that facilitate community involvement in health development					-
			6.4.1.1	Adapt National Bahavioural and social Change Communication	2010-2015		Director Social Mobilization, Director of Information.	-
			6.4.1.2	Undertake advocacy to community gatekeepers to increase their awareness on community participation and health promotion at LGA.	50% of Health Depts in LGAs carry out advocacy visits to community gatekeepers by 2011	availability of funds and commitment	PHC Coord, Chairman CDC	-
			6.4.1.3	Develop and implement community health development programmes	2010-2015		State and LGA Health Educators.	-
		6.4.2	Undertake advocacy to community gatekeepers to increase awareness and support for the use of health promotion to facilitate involvement in health development.					-
			6.4.2.1	Identify the community gatekeepers.	By end of 2010		Director of Community Health and DSPHCDA	-
			6.4.2.2	Advocacy visits to community gatekeepers.	Quarterly			-
			6.4.2.3	Provide them with modern health programmes.	2010-2015			-

		6.4.3	Formulate action plans to facilitate the development of health promotion capacity and support at various levels linking health with other sectors.					-
			6.4.3.1	Identify the current health promotion capacity on ground.	By end of 2010			-
			6.4.3.2	Establish development needs.	2010-2015			-
			6.4.3.3	Strenghten the coordinating mechanism.	Quarterly			-
			6.4.3.4	Harmonise the coordination framework between the state Ministry of Health and the development partners.	By end of 2010			-
		6.4.4	Develop or adopt health promotion guidelines or framework on community development.					-
			6.4.4.1	Establish a health promotion guideline or framework for community development.	Quarterly			-
		6.4.5	Develop or adopt health promotion guidelines or framework on community development.					-
			6.4.5.1	Strenghten the health promotion component in priority health and health related programmes.	Quarterly			-
			6.4.5.2	Empower communities with knowledge for behavioural change.	Quarterly meetings			-
	6.5	**To strengthen evidence-based community participation and ownership efforts in health activities through researches**			**Health research policy adapted to include evidence-based community involvement guidelines by end 2010**			-
		6.5.1	To develop and implement systematic measurement of community involvement					-
			6.5.1.1	Develop goals/objectives.	By end of 2010			-
			6.5.1.2	Establish performance criteria.	By end of 2010			-
			6.5.1.3	Provide the necessary tools for performance.	2010-2015			-
			6.5.1.4	Determine the time frame.	By end of 2010			-
			6.5.1.5	Measure performance against the set objectives.	By end of 2015			-
		6.5.2	Measure the impact of specific community approaches, method and initiatives.					-
			6.5.2.1	Establish a feedback mechanism.	Quarterly			-
			6.5.2.2	Evaluate the information generated.	Quarterly			-
			6.5.2.3	Measure feedback against set objectives.	Quarterly			-
		6.5.3	Disseminate and harness experiences between community stakeholders.					-
			6.5.3.1	Establish a peer review mechanism among the communiity stakeholders.	Quarterly			-
			6.5.3.2	Evaluate and share information generated amongst the stakeholders.	Quarterly			-
PARTNERSHIPS FOR HEALTH								0
7. To enhance harmonized implementation of essential health services in line with national health policy goals								**1,319,130,689**

	7.1	**To ensure that collaborative mechanisms are put in place for involving all partners in the development and sustenance of the health sector**			**1. FMOH has an active ICC with Donor Partners that meets at least quarterly by end 2010 2. FMOH has an active PPP forum that meets quarterly by end 2010 3. All States have similar active committees by end 2011**			**1,319,130,689**
		7.1.1	To promote Public Private Partnerships (PPP)					**1,319,130,689**
			7.1.1.1	Advocacy visit to educate the Private and Public sector on the need to invest in Health programmes as part of their Corporate Social Responsibility (CSR)	70% of the Private and Public Sector Committed to invest in Health programmes in the State by the end of 2010			304,414,774
			7.1.1.2	Conduct meetings with private sectors to fund health services as part of their Corporate Social Responsibility (CSR) eg Banks, Industries, Oil companies etc	60% of the Public and Private Sectors and development partner have regular meeting foral for health programming in the State by the end of 2010	Willingness to partner with government and effective participation in health programmes in the State		1,014,715,914
			7.1.1.3	Conduct meetings to intensify PPP with corporate organizations in their respective areas of operation including local production of MNCH commodities (e,g zinc, ORS, Ready to use therapeutic food , Family Planning etc)	60% of the Public and Private Sectors and development partner have regular meeting foral for health programming in the State by the end of 2010	Capacity to coordinate and implement health programmes		-
			7.1.1.4	Facilitate the establishment of Private Health Institution in Rural and Under-served areas by granting incentives such as technical and financial support.	50% of Private Health Institutions established in rural and underserved area by the end of 2012	Creation of enabling environment and favourable government policy		-
			7.1.1.5	Establish the contracting and outsourcing of health services to private health providers and corporate	10% of government health	Profiteering, Compromise of Standards and		-

				organization in areas where government facilities are inadequate or over-stretched.	services in over-stretched area contracted to 5% of private health providers and corporate organizations by the end of 2011	Specification, Redundancy and labour on-rest for staff, and inadequate capacity to manage outsourced facilities.		
			7.1.1.6	Develop and operationalise a Joint and Participatory Monitoring and Feedback mechanism of both Pubic and Private Sector on quarterly basis.	An effective Jiont and Participatory monitoring and feedback meachanism developed and utilized by the end of 2010	Availabillty of funds and technical know-how for the development, willingness and utilization of the tools		-
		7.1.2	To institutionalize a framework for coordination of Development Partners					-
			7.1.2.1	Facilitate the formation of Health Partner Coordinating Committee (HPCC), comprising Development Partners, Donor Agencies, Corporate Organization and the Private Sector at the State.	Health Partner Coordinating Committee (HPCC) formed and functional in the State by the end of 2010	Political will and government bureaucracy, willingness of partners involvement		-
			7.1.2.2	Develop a framework to Coordinate, Harmonize and Align Health Activities of Development/ Donor Partners and Corporate Bodies in the State/LGA	Framework for coordination and harmonizatio n of health activities developed and operational in the State by the 3rd quarter of 2010.	Capacity to develop a comprehensive framework, political will and bureaucracy		-
			7.1.2.3	Establish and harmonize resource coordination mechanism with development and donor partners in the State	Resource coordination mechsnism developed and operational in the State by the end of 2011.	Capacity to develop a comprehensive framework, political will and bureaucracy		-
		7.1.3	To facilitate inter-sectoral collaboration					-
			7.1.3.1	Strengthen Inter-sectoral collaboration amongst all relevant MDAs directly engaged in the implementation of specific health programmes in the State	Effective collaboration amongst all relevant MDA's through annual 4th quarterly meetings in	Willingness of MDA's to collaborate and bureaucracy		-

					the State from 2011 to 2015			
			7.1.3.2	Establish regular inter-sectoral ministerial forum at all levels to facilitate inter-sectoral collaboration, synergy and information sharing	Effective inter-sectoral ministral forum put in place by the end of 2010 and in operation through 2015	willingness to collaborate and bureaucracy	SMOH/Chairman of LGA, PHC Coord, Super Health, HOD Health Representatives of Development Partners	-
			7.1.3.3	Develop a reporting model for all MDAs directly engaged in health programmes in the State	Uniform reporting model developed and in use by 2010 by 50% of all relevant MDA's in the State	availabillty of funds, willingness and usage of the forms		-
			7.1.3.4	Develop a uniform Monitoring and Evaluation (M&E) tool for all MDAs in health programme	Uniform monitoring model developed and in use by 2010 by 50% of all relevant MDA's in the State	availability of funds, willingness and usage of the tools		-
		7.1.4	To engage professional groups					-
			7.1.4.1	Establish a forum to coordinate the activities of professional groups in the State	Functional forum of 50% gender-based professional groups established in the State by mid 2010 all through 2015	willingness of both professional groups and government to partner in the State		-
			7.1.4.2	Promote effective partnership with professional groups through joint setting of standards of training by health institutions ,and regular assessment of practice and professional competencies.	Gender-based training standards in place to engender 40% (F) for all professional groups, and model for assessment of practice and competencies in the State by 2011	Availability and prompt release of funds		-
			7.1.4.3	Encourage and engage professional groups in planning,implementation,monitoring and evaluation of health plans and programmes in the State/LGA	70% of professional groups involved in planning, implementation and M&E processes in health programming in the State	Political will and government bureaucracy	SMOH/PHC Coord, Super Health, HOD Health Representatives of professional groups	-

					by the end of 2010			
								-
			7.1.4.4	Encourage and promote effective communication in order to facilitate relationships between professional groups and the state ministry of health.	Effective communication channels established between the SMOH and 60% of the professional groups by the mid 2011	Bottle-necks, political will and prompt release of funds		-
			7.1.4.5	Promote regular pubic lecture by professional groups to enhance the provision of skilled care by health professionals in the State.	55% of professional group engaged in regular public lecture, and providing skilled care in the State by 2011	Enabling environment, willingness and technical-know-how		-
			7.1.4.6	Influence regulation and legislation to allow for competency-based practice for health professionals according to the principle of 'Continuum of Care' in the State.	Regulations and legislation in place to enhance 60% competency and continum of care in the State by the 1st quarter 2011	political will and enabling environment		-
			7.1.4.8					-
		7.1.5	To engage with communities					-
			7.1.5.1	Encourage and support research activities of traditional health practitioners to gain better understanding and set a standard to evaluate them.	Increased awareness of research activities and standard of practice of traditional health practitioners by 60% of the population by 2012			-
			7.1.5.2	Integrate other traditional health practitioners into the existing body for easy identification, coordination and regulation of their practice in the State.	Standard in place to checkmate defaulters and measure adherence by 30% by the end of 2011	willingness, enabling envirnment and political will		-
			7.1.5.3	Scrutinise and adopt traditional practices and technologies of proven value into the State health care system and discourage those that are harmful.	40% improved technology and practice in use by traditional health practioners in the State by the mid 2012	willing to adopt innovative technology and practice in the State, political will		-

			7.1.5.4	Organise trainning programme for traditional health practitioners to improve their skill, to know their limitation, encourage and ensure their use of the referral system.	50% of traditional health practitioners skills improved in promoting health programme as well as the use of referral system by the end of 2012	poitical will and prompt funding		-
			7.1.5.5	Seek the coperation of traditional practitioners and incorporate them in promoting health programmes such as nutrition, environmental sanitation, personal hygiene, immunization and family planning.	50% of traditional health practitioners promoting health programme by the end of 2012	willingness and political will		-
			7.1.5.6	Disuade and screen traditional health practitioners from advertising themselves and making fasle claims in the Media	Standard in place to screen traditional health practioners by 50% by the end of 2011			-
		7.1.6	To engage with traditional health practitioners					-
RESEARCH FOR HEALTH								0
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								**2,638,261,377**
	8.1	**To strengthen the stewardship role of governments at all levels for research and knowledge management systems**			**1. ENHR Committee established by end 2009 to guide health research priorities 2. FMOH publishes an Essential Health Research agenda annually from 2010**			**2,638,261,377**
		8.1.1	To finalise the Health Research Policy at Federal level and develop health research policies at State levels and health research strategies at State and LGA levels					**485,640,517**
			8.1.1.1	Convene Technical Working Groups to finalise or develop health research policies and strategies in the state and LGAs	Establishmen t of Health research steering committees at all levels.	The political will at the State and local levels and technical capacity exists to develop the policies and strategies.	SMOH, LGA, Health units	148,390,158
			8.1.1.2	Develop and provide guidelines for the establishment of Health Research Steering Committees in the State/LGA.	Steering committees estabilished		SMOH, LGA, Health units	105,992,970

					by State Min of Health by 2010			
			8.1.1.3	Monitor the activities of Health Research Steering Committees at all levels and evaluate their function and value.			SMOH(DMST & DPRS)	231,257,389
		8.1.2	To establish and/or strengthen mechanisms for health research at all levels					-
			8.1.2.1	Provide techincal assistance to develop and strengthen the capacity of health research divisions and units at all levels in the State.	SMOH -DPRS research units s staffed by appropriately qualified people	There are a enough people willing to have a research work focus		-
			8.1.2.2	Provide techincal assistance to strengthen DPRS in the State and for creation of active research units in SMOH and 3 Senatorial Districts.	1. SMOH-DPRS either undertaking or actively collaborating in health research. 2) SMOH-DPRS research unit undertaking capacity building for staff on different aspects of health research.	Government at all levels and health research institutions provide enabling environment for collaborative research, political will and resources exists.	sMOH, LGA, Health units	-
			8.1.2.3	Create the dept. of planning, research and statistics at LGA level	20% of LGAs create dept. of PRS by 2012	Political will, availability of funds, human resources and commit ment	LGSC, LGA Chairman, Councillors	-
		8.1.3	To institutionalize processes for setting health research agenda and priorities					**1,005,969,641**
			8.1.3.1	Implement the Essential National Health Research (ENHR) programme.	ENHR undertaken annually by the SMOH and 50% of all the LGAs.	Research capacity exists for ENHR.	SMOH, LGA, Health units	38,542,898
			8.1.3.2	Promote the expansion of the health research agenda to include broad and multi-dimensional determinants of health and ensure cross-linkages with areas beyond its traditional boundaries and categories.			SMOH, LGA, Health units	138,754,433
			8.1.3.3	Provide technical assistance to develop and strengthen Health Research in all hospitals and health institutions in the state			State, LGAs, DPRS, SERVICOM	115,628,694
			8.1.3.4	Provide assistance to strengthen Clinical Governance and SERVICOM units in the state to enhance research in the hospitals			State, LGAs, DPRS, SERVICOM	192,714,491
			8.1.3.5	Strengthen Departments of Planning Research and Statistics (DPRS) as well as create active research units in the State and LGAs to undertake operations			State, LGAs, DPRS, SERVICOM	520,329,125

				research and other research-related activities				
		8.1.4	To promote cooperation and collaboration between Ministries of Health and LGA health authorities with Universities, communities, CSOs, OPS, NIMR, NIPRD, development partners and other sectors					**510,693,400**
			8.1.4.1	Develop and disseminate guidelines for a collaborative research agenda.	SMOH and 50% LGA/LGA research units have developed guidelines for collaborative research developed by 2011 at all levels.	Capacity exits to develop the guidelines.	SMOH, LGA, Health units	105,992,970
			8.1.4.2	Establish a forum of health research officers at the State Min of Health and LGAs.	SMOH and 50% LGA/LGA research units have estabilished credible forum for research officers.	Existence of political and administrative will as well as willingness of different actors to form the forums at all levels.	SMOH, LGA, Health units	57,814,347
			8.1.4.3	Convene a multi-stakeholder forum to identify research priorities and for harmonization of research efforts.	Annual multi-stakeholders research priority forum convened by SMOH and 50% of LGAs	Adequate resources exists as well as organisational sagacity	SMOH, LGA, Health units	173,443,042
			8.1.4.4	Support development of collaborative research proposals and their implementation.	Collaborative research proposals developed and undertaken.		SMOH, LGA, Health units	173,443,042
			8.1.4.5	Foster collaboration with Academic Institutions to encourage research, education and monitoring through existing networks.	Establish a strong link with academic institutions in research, education of health professional by 40% in the State by the end of 2011.	Bureaucracy and willingness to partner		-
		8.1.5	To mobilise adequate financial resources to support health research at all levels					**635,957,819**
			8.1.5.1	Promote the allocation of at least 2% of health budgets to health research at all levels.	SMOH and 50% of stated allocate at least 2% of health budgets for research at all levels.	Existence of political will by all by all arms of government and active cooperation of SMOH.	SMOH, LGA, Health units. Assembies at State and LGAs and SMOH Budget office.	248,601,693
			8.1.5.2	Encourage all health ministries to deploy mobilized funds for health research in a targeted manner.	More than 80% of moblilised research		SMOH, LGA, Health units, Assemblies at State and LGAs,	132,972,999

					funds used to undertake health research (human resources, financing, service delivery. ENHR etc) by SMOH and LGAs.		SMOH budget Office.	
			8.1.5.3	Mobilize adequate funds to support MNCH Research and dissemination of results			DPRS	254,383,128
		8.1.6	To establish ethical standards and practice codes for health research at all levels					-
			8.1.6.1	Develop and promote guidelines on ethical standards for research in health.		There are aduquate qualified human resources willing to undertake the role	SMOH, LGAs and Health units.	-
			8.1.6.2	Encourage the establishment of ethical review committees in LGAs and strenghten the ones at State level and in tertiary health and education institutions.	Functuonal ethical review committees estabilished and strengthened in the State and LGA levels and in all tertiary institutions by 2011.		SMOH, LGAs and Health units.	-
			8.1.6.3	Estabish mechanisms to monitor, evaluate and regulate research and use of research findings in the State.	Directories of major researches and researchers estabilished and evaluated annually at all levels from 2011.	Researchers are willing to submit their studies to the directory.	SMOH, LGA, and Health units	-
	8.2	**To build institutional capacities to promote, undertake and utilise research for evidence-based policy making in health at all levels**			**FMOH has an active forum with all medical schools and research agencies by end 2010**			**-**
		8.2.1	To strengthen identified health research institutions at all levels					-
			8.2.1.1	Take inventory of all public and private institutions and organisations undertaking health research .	Directory with special focus area listings of HR institutions and organizations estabilished at SMOH and 50% of the LGAs by 2011.	There are enough resources to produce the directory at all levels	SMOH, LGA and Health units.	-

			8.2.1.2	Conduct periodic capacity assessment of all research organizations and institutions.	1. Bi-annual research capacity assessment of HR institutions. 2. Number of research undertaken identified	Resources exists to undertake the assessment	SMOH, LGA and Health units.	-
			8.2.1.3	Develop and implement measures to address research capacity gaps/weaknesses at all levels.	20% increase in number of researches undertaken at all levels.		SMOH, LGA and Health units.	-
			8.2.1.4	Mobilise extra funds from the private sector, foundations and individuals for health research.	At least 5% of all development assistance earmarked for the Health sector is deployed for health research and MOUs signed with the private sector		SMOH, LGA and Health units.	-
		8.2.2	To create a critical mass of health researchers at all levels					-
			8.2.2.1	Develop appropriate training interventions for research based on the identified needs at all levels.	50% increase in number of researchers undertaking research relevant for evidence-based policy making.	Availability of resources	SMOH, LGA and Health units.	-
			8.2.2.2	Establish a fund and adjudication mechanism for provision of competitive research grants for prospective researchers.	60 grants awarded annually by SMOH and LGAs award at least 5 grants annually.	Ditto and political will exits.	SMOH, LGA, Health units, HR institutions	-
			8.2.2.3	Motivate tertiary education institutions to increase PhD level enrolment and graduation in health through the awarding of PhD student scholarships.	30 competitive PhD scholarships awarded annually	Political will exists	SMOH, LGA and tertiary institutions.	-
		8.2.3	To develop transparent approaches for using research findings to aid evidence-based policy making at all levels					-
			8.2.3.1	Establish mechanisms for improving liaison and links between research users (e.g policy makers, development patners) and researchers at State and LGAs.	One researcher-policy makers forum			-
			8.2.3.2	Involve wide range of actors including researchers in policy making.	Number of researchers involved in policy-making at all levels by 2011	Willingness of all the actors to work togther and political will on the part of the research	SMOH, LGA Health units, HR institutions, CSOs, Development partners,	-

						users to involve other actors in the policy making process.	Professional association, regulatory bodies, assemblies at nationa,state and local	
		8.2.4	To undertake research on identified critical priority areas					-
			8.2.4.1	Establish a process for the bi-annual estimation of the burden of identified priority diseases	Bi-annual Burden of deseases computed at State level and by 50% of the LGAs	Existence of political will by the government and development partners.	SMOH, LGA, Health units, HR institutions, CSOs, Development.	-
			8.2.4.2	Undertake studies in human resource for health (HRH) annually (manpower audit etc.)	Annual HSH studies conducted by th State and 50% of the LGAs		SMOH (DPRS, DA)/ LGA DPM & HOD HEALTH	-
			8.2.4.3	Undertake bi-ennial studies into health system governance (HSG).	Bi-ennial HSG studies conducted by th State and 50% of the LGAs			-
			8.2.4.4	Conduct bi-ennial studies into health delivery systems.	Bi-ennial Health system delivery studies conducted by the State and 50% of the LGAs			-
			8.2.4.5	Conduct studies of financial risk protection, equity, efficiency and value of different health financing mechanisms bi-ennially.	Bi-ennial Health financing studies conducted by the State and LGAs			-
	8.3	**To develop a comprehensive repository for health research at all levels (including public and non-public sectors)**			**1. All States have a Health Research Unit by end 2010 2. FMOH and State Health Research Units manage an accessible repository by end 2012**			-
		8.3.1	To develop strategies for getting research findings into strategies and practices					-
			8.3.1.1	Estabilish ways and means of Getting Research Into Strategies and Practices (GRISP) units at all levels in the State	More than 50% of the Health strategies at all levels informed by research findings	Political will and capacit exists at policy-makers level plus existence of readiness by research producers to openly share their findings	SMOH, LGAs and Health units, HR institutions, CSOs, Development partners, Professional associations, regulatory	-

							bodies and assemblies at state and local government	
		8.3.2	To enshrine mechanisms to ensure that funded researches produce new knowledge required to improve the health system					-
	8.4	**To develop, implement and institutionalize health research communication strategies at all levels**			**A national health research communicati on strategy is in place by end 2012**			-
		8.4.1	To create a framework for sharing research knowledge and its applications					-
			8.4.1.1	Develop and implement a framework for sharing research knowledge at all levels.	Framework for sharing research knowledge developed by 2011	The skills and other resources for developing the framework exists	SMOH, LGA, Health units, HR institutions, CSOs, Development.	-
		8.4.2	To establish channels for sharing of research findings between researchers, policy makers and development practitioners					-
			8.4.2.1	Support a critical mass of high quality journals.				-
			8.4.2.2	Undertake inventory of national journals according to priority health areas	Directory of state journals estabilished	Availablility of funds and political will	SMOH, HR institutions and Development partners	-
			8.4.2.3	Select journals to be supported whose information address issues related to Essential National Health Research (ENHR) and have discussions with the editors.	12 key journals selected	Having a transparent system for selection the journals.	SMOH, HR institutions and Development partners	-
			8.4.2.4	Circulate identified journals to SMOH and LGs regularly.	Jounals distibuted (electronically and in print) quaterly to SMOH, LGAs, Development partners and others.	Availability of resources and a good distribution system	SMOH, HR institutions and Development partners	-
TOTAL								**131,913,068,873**

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

DELTA STATE STRATEGIC HEALTH DEVELOPMENT PLAN RESULT MATRIX						
OVERARCHING GOAL: To significantly improve the health status of Nigerians through the development of a strengthened and sustainable health care delivery system						
OUTPUTS	**INDICATORS**	**SOURCES OF DATA**	**Baseline**	**Milestone**	**Milestone**	**Target**
			2008/9	**2011**	**2013**	**2015**
PRIORITY AREA 1: LEADERSHIP AND GOVERNANCE FOR HEALTH						
NSHDP Goal: To create and sustain an enabling environment for the delivery of quality health care and development in Nigeria						
OUTCOME: 1. Improved strategic health plans implemented at Federal and State levels						
OUTCOME 2. Transparent and accountable health systems management						
1. Improved Policy Direction for Health Development	1. % of LGAs with Operational Plans consistent with the state strategic health development plan (SSHDP) and priorities	LGA s Operational Plans	0	25	50	75%
	2. % stakeholders constituencies playing their assigned roles in the SSHDP (disaggregated by stakeholder constituencies)	SSHDP Annual Review Report	TBD	10	25	45%
2. Improved Legislative and Regulatory Frameworks for Health Development	3. State adopting the National Health Bill? (Yes/No)	SMOH	0	0	25	75%
	4. Number of Laws and by-laws regulating traditional medical practice at State and LGA levels	Laws and bye-Laws	TBD	0	25	50%
	5. % of LGAs enforcing traditional medical practice by-laws	LGA Annual Report	TBD	0%	25%	50%
3. Strengthened accountability, transparency and responsiveness of the State health system	6. % of LGAs which have established a Health Watch Group	LGA Annual Report	0	0	0	0
	7. % of recommendations from health watch groups being implemented	Health Watch Groups' Reports	No Baseline	0	0	0
	8. % LGAs aligning their health programmes to the SSHDP	LGA Annual Report	0	25	50	75
	9. % DPs aligning their health programmes to the SSHDP at the LGA level	LGA Annual Report	No Baseline	25	50	75
	10. % of LGAs with functional peer review mechanisms	SSHDP and LGA Annual Review Report	TBD	0	0	0%
	11. % LGAs implementing their peer review recommendations	LGA / SSHDP Annual Review Report	No Baseline	0	0	0%
	12. Number of LGA Health Watch Reports published	Health Watch Report	0	0	0	0
	13. Number of "Annual Health of the LGA" Reports published and disseminated annually	Health of the State Report	TBD	10	25	50%
4. Enhanced performance of the State health system	14. % LGA public health facilities using the essential drug list	Facility Survey Report	TBD	25	50	75%
	15. % private health facilities using the essential drug list by LGA	Private facility survey	TBD	0	0	0%
	16. % of LGA public sector institutions implementing the drug procurement policy	Facility Survey Report	TBD	0	25	50%
	17. % of private sector institutions implementing the drug	Facility Survey Report	TBD	0	0	0%

	procurement policy within each LGA					
	18. % LGA health facilities not experiencing essential drug/commodity stockouts in the last three months	Facility Survey Report	TBD	25	50	75%
	19. % of LGAs implementing a performance based budgeting system	Facility Survey Report	TBD	0	0	0%
	20. Number of MOUs signed between private sector facilities and LGAs in a Public-Private-Partnership by LGA	LGA Annual Review Report	TBD	0	0	0
	21. Number of facilities performing deliveries accredited as Basic EmOC facility (7 functions 24/7) and Comprehensive EmOC facility (9 functions 24/7)	States/ LGA Report and Facility Survey Report	TBD	20	30	50
STRATEGIC AREA 2: HEALTH SERVICES DELIVERY						
NSHDP GOAL: To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare						
Outcome 3: Universal availability and access to an essential package of primary health care services focusing in particular on vulnerable socio-economic groups and geographic areas						
Outcome 4: Improved quality of primary health care services						
Outcome 5: Increased use of primary health care services						
5. Improved access to essential package of Health care	22. % of LGAs with a functioning public health facility providing minimum health care package according to quality of care standards.	NPHCDA Survey Report	TBD	10	35	50%
	23. % health facilities implementing the complete package of essential health care	NPHCDA Survey Report	TBD	25	50	75%
	24. % of the population having access to an essential care package	MICS/NDHS	TBD	40	50	75%
	25. Contraceptive prevalence rate	NDHS	15%	20%	25%	30%
	26. Number of new users of modern contraceptive methods (male/female)	NDHS/HMIS	1	5%	10%	15%
	27. % of new users of modern contraceptive methods by type (male/female)	NDHS/HMIS	TBD	1%	5%	10%
	28. % service delivery points without stock out of family planning commodities in the last three months	Health facility Survey	TBD	10	25	30%
	29. % of facilities providing Youth Friendly RH services	Health facility Survey	TBD	5	10	15
	30. Adolescent (10-19 year old) Fertility rate (using teeenage pregnancy as proxy)	NDHS/MICS	8.3	6	4	2
	31. % of pregnant women with 4 ANC visits performed according to standards*	NDHS	12.3 - 96.3%	25 - 100%	50 - 100%	75 - 100%
	32. Proportion of births attended by skilled health personnel	HMIS	78.1	80	85	90
	33. Proportion of women with complications treated in an EmOC facility (Basic and/or comprehensive)	EmOC Sentinel Survey and Health Facility Survey	TBD	20%	30%	50%
	34. Caesarean section rate	EmOC Sentinel Survey and Health Facility Survey	6.00%	5%	4%	3%
	35. Case fatality rate among women with obstretic complications in EmOC facilities per complication	HMIS	TBD			

	36. Perinatal mortality rate**	HMIS	TBD			
	37. % women receiving immediate post partum family planning method before discharge	HMIS	TBD			
	38. % of women who received postnatal care based on standards within 48h after delivery	NDHS	22.40%	30%	35%	50%
	39. Number of women presented to the facility with or for an obstetric fistula	NDHS/HMIS	No Baseline			
	40. Number of interventions performed to repair an obstetric fistula	HMIS	No Baseline			
	41. Proportion of women screened for cervical cancer	HMIS	TBD			
	42. % of newborn with infection receiving treatment	MICS	No Baseline			
	43. % of children exclusively breastfed 0-6 months	NDHS/MICS	9%	12	15	20%
	44. Proportion of 12-23 months-old children fully immunized	NDHS/MICS	38.00%	45	50	55%
	45. % children <5 years stunted (height for age <2 SD)	NDHSMICS	35.00%	30	25	20%
	46. % of under-five that slept under LLINs the previous night	NDHS/MICS	6.00%	10	15	20%
	47. % of under-five children receiving appropriate malaria treatment within 24 hours	NDHS/MICS	17	25	30	40%
	48. % malaria successfully treated using the approved protocol and ACT;	MICS	TBD			
	49. Proportion of population in malaria-risk areas using effective malaria prevention and treatment measures	MICS	TBD			
	50. % of women who received intermittent preventive treatment for malaria during pregnancy	NDHS/MICS	2%	5	10	15%
	51. HIV prevalence rate among adults 15 years and above	NDHS/SENTINEL SURVEY	3.70%	3.5	3.2	3%
	52. HIV prevalence in pregnant women	NARHS/SMOH	3.60%	3.4	3.2	3%
	53. Proportion of population with advanced HIV infection with access to antiretroviral drugs	NMIS				
	54.Condom use at last high risk sex	NDHS/MICS				
	55. Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS	NDHS/MICS				
	56. Prevalence of tuberculosis	NARHS	2	1.5	1.3	1
	57.Death rates associated with tuberculosis	NMIS				
	58. Proportion of tuberculosis cases detected and cured under directly observed treatment short course	NMIS/SMOH	53%	58%	65%	70%
Output 6. Improved quality of Health care services	59. % of staff with skills to deliver quality health care appropriate for their categories	Facility Survey Report	TBD			
	60. % of facilities with capacity to deliver quality health care	Facility Survey Report	TBD			

	61. % of health workers who received personal supervision in the last 6 months by type of facility	Facility Survey Report	TBD			
	62. % of health workers who received in-service training in the past 12 months by category of worker	HR survey Report	TBD			
	63. % of health facilities with all essential drugs available at all times	Facility Survey Report	TBD	10	20	30%
	64. % of health institutions with basic medical equipment and functional logistic system appropriate to their levels	Facility Survey Report	TBD			
	65. % of facilities with deliveries organizing maternal and/or neonatal death reviews according to WHO guidelines on regular basis	Facility Survey Report	TBD	2	5	10%
Output 7. Increased demand for health services	66. Proportion of the population utilizing essential services package	MICS	TBD			
	67. % of the population adequately informed of the 5 most beneficial health practices	MICS	TBD			
PRIORITY AREA 3: HUMAN RESOURCES FOR HEALTH **NSHDP GOAL: To plan and implement strategies to address the human resources for health needs in order to ensure its availability as well as ensure equity and quality of health care**						
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	68. % of wards that have appropriate HRH complement as per service delivery norm (urban/rural).	Facility Survey Report	TBD			
	69. Retention rate of HRH	HR survey Report				
	70. % LGAs actively using adaptations of National/State HRH policy and plans	HR survey Report				
	71. Stock (and density) of HRH	HR survey Report	TBD			
	72. Distribution of HRH by geographical location	MICS	TBD			
	73. Increased number of trained staff based on approved staffing norms by qualification	HR survey Report	No Baseline			
	74. % of LGAs implementing performance-based managment systems	HR survey Report				
	75. % of staff satisfied with the performance based management system	HR survey Report				
Output 8: Improved framework for objective analysis, implementation and monitoring of HRH performance	76. % LGAs making availabile consistent flow of HRH information	NHMIS				
	77. CHEW/10,000 population density	MICS	TBD			
	78. Nurse density/10,000 population	MICS	TBD			

	79. Qualified registered midwives density per 10,000 population and per geographic area	NHIS/Facility survey report/EmOC Needs Assessment	TBD			
	80. Medical doctor density per 10,000 population	MICS	TBD			
	81. Other health service providers density/10,000 population	MICS	TBD			
	82. HRH database mechanism in place at LGA level	HRH Database				
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	83. % of LGAs implementing state specific safety nets	SSHDP review report				
	84. Decreased proportion of informal payments within the public health care system within each LGA	MICS				
	85. % of LGAs which allocate costed fund to fully implement essential care package at N5,000/capita (US$34)	State and LGA Budgets				
	86. LGAs allocating health funding increased by average of 5% every year	State and LGA Budgets				
Output 12: Improved efficiency and equity in the allocation and use of Health resources at State and LGA levels	87. LGAs health budgets fully alligned to support state health goals and policies	State and LGA Budgets	TBD	20	40	60%
	88.Out-of pocket expenditure as a % of total health expenditure	National Health Accounts 2003 - 2005				
	89. % of LGA budget allocated to the health sector.	National Health Accounts 2003 - 2005	2%	4%	5%	6%
	90. Proportion of LGAs having transparent budgeting and finacial management systems	SSHDP review report				

	91. % of LGAs having operational supportive supervision and monitoring systems	SSHDP review report	TBD	10%	20	30%
PRIORITY AREA 5: NATIONAL HEALTH INFORMATION SYSTEM						
Outcome 10. National health management information system and sub-systems provides public and private sector data to inform health plan development and implementation						
Outcome 11. National health management information system and sub-systems provide public and private sector data to inform health plan development and implementation at Federal, State and LGA levels						
Output 13: Improved Health Data Collection, Analysis, Dissemination, Monitoring and Evaluation	92. % of LGAs making routine NHMIS returns to states	NHMIS Report January to June 2008; March 2009	30	35	50	70%
	93. % of LGAs receiving feedback on NHMIS from SMOH	DSN Meeting Report	60	70	80	90%
	94. % of health facility staff trained to use the NHMIS infrastructure	Training Reports	TBD			
	95. % of health facilities benefitting from HMIS supervisory visits from SMOH	NHMIS Report	TBD			
	96.% of HMIS operators at the LGA level trained in analysis of data using the operational manual	Training Reports	80%	82%	85%	90%
	97. % of LGA PHC Coordinator trained in data dissemination	Training Reports	60%	70%	80%	90%
	98. % of LGAs publishing annual HMIS reports	HMIS Reports	0	0%	10%	20%
	99. % of LGA plans using the HMIS data	NHMIS Report	0	15%	25%	40%
PRIORITY AREA 6: COMMUNITY PARTICIPATION AND OWNERSHIP						
Outcome 12. Strengthened community participation in health development						
Outcome 13. Increased capacity for integrated multi-sectoral health promotion						
Output 14: Strengthened Community Participation in Health Development	100. Proportion of public health facilities having active committees that include community representatives (with meeting reports and actions recommended)	SSHDP review report	TBD	15%	25%	50%
	101. % of wards holding quarterly health committee meetings	HDC Reports	TBD			
	102. % HDCs whose members have had training in community mobilization	HDC Reports	TBD			
	103. % increase in community health actions	HDC Reports	TBD	5%	10%	15%
	104. % of health actions jointly implemented with HDCs and other related committees	HDC Reports				
	105. % of LGAs implementing an Integrated Health Communication Plan	HPC Reports				
PRIORITY AREA 7: PARTNERSHIPS FOR HEALTH						
Outcome 14. Functional multi partner and multi-sectoral participatory mechanisms at Federal and State levels contribute to achievement of the goals and objectives of the						
Output 15: Improved Health Sector Partners' Collaboration and Coordination	106. Increased number of new PPP initiatives per year per LGA	SSHDP Report	TBD			
	107. % LGAs holding annual multi-sectoral development partner meetings	SSHDP Report	TBD			
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	108. % of LGAs partnering with researchers	Research Reports	TBD			
	109. % of State health budget spent on health research and evaluation	State budget	TBD			
	110. % of LGAs holding quarterly knowledge sharing on research, HMIS and best practices	LGA Annual SHDP Reports	TBD			
	111. % of LGAs participating in state research ethics review board for researches in their locations	LGA Annual SHDP Reports	TBD			
	112. % of health research in LGAs available in the state health research depository	State Health Reseach Depository	TBD			
Output 17: Health research communication strategies developed and implemented	113. % LGAs aware of state health research communication strategy	Health Research Communication Strategy	TBD			